Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-01 Resources for Administrative Courts

Dept. Approval By:	Josh Block [signature] 11/2/15	X	**Supplemental FY 2015-16**
			Change Request FY 2016-17
OSPB Approval By:	[signature] 10/28/15		**Base Reduction FY 2016-17**
			Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$568,419**	**$0**	**$647,518**	**$40,765**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$220,867	$0	$251,601	$15,840	$0
	CF	$63,343	$0	$72,158	$4,543	$0
	RF	$0	$0	$0	$0	$0
	FF	$284,209	$0	$323,759	$20,382	$0

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
01. Executive Director's Office - Administrative Law Judge Services	**Total**	**$568,419**	**$0**	**$647,518**	**$40,765**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$220,867	$0	$251,601	$15,840	$0
	CF	$63,343	$0	$72,158	$4,543	$0
	RF	$0	$0	$0	$0	$0
	FF	$284,209	$0	$323,759	$20,382	$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; CF: Hospital Provider Fee (24A0)

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: DPA

Other Information:

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-02 DHS Early Intervention

Dept. Approval By: Josh Block [signature] 11/2/15

OSPB Approval By: [signature] 10/28/15

	Supplemental FY 2015-16
X	Change Request FY 2016-17
	Base Reduction FY 2016-17
	Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$5,928,683	$0	$5,928,683	$634,670	$1,030,274
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,917,590	$0	$2,920,876	$314,669	$511,840
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,011,093	$0	$3,007,807	$320,001	$518,434

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
07. Department of Human Services Medicaid-Funded Programs - Div of Comm. and Family Support, Early Intervention Services	Total	$5,928,683	$0	$5,928,683	$634,670	$1,030,274
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,917,590	$0	$2,920,876	$314,669	$511,840
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,011,093	$0	$3,007,807	$320,001	$518,434

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:

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

Schedule 13s from Affected Departments: DHS

Other Information:

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-03 CBMS

Dept. Approval By: Josh Block [signature] 11/2/15 — X — **Change Request FY 2016-17**

OSPB Approval By: [signature] 10/28/15

- **Supplemental FY 2015-16**
- X **Change Request FY 2016-17**
- **Base Reduction FY 2016-17**
- **Budget Amendment FY 2016-17**

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$11,445,075	$0	$11,468,867	$10,780,031	$12,381,179
	FTE	$0	0.0	$0	0.0	0.0
	GF	$3,976,342	$0	$3,984,859	$3,404,335	$3,977,541
	CF	$1,749,909	$0	$1,753,319	$1,512,071	$1,741,554
	RF	$0	$0	$0	$0	$0
	FF	$5,718,824	$0	$5,730,689	$5,863,625	$6,662,084

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
01. Executive Director's Office - Colorado Benefits Management Systems, Operating & Contracts	Total	$10,885,261	$0	$10,885,261	$10,715,196	$12,316,344
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,770,869	$0	$3,770,869	$3,386,186	$3,959,392
	CF	$1,675,284	$0	$1,675,284	$1,497,168	$1,726,651
	RF	$0	$0	$0	$0	$0
	FF	$5,439,108	$0	$5,439,108	$5,831,842	$6,630,301
01. Executive Director's Office - Colorado Benefits Management System Administration	Total	$0	$0	$0	$648,441	$648,441
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$232,139	$232,139
	CF	$0	$0	$0	$92,938	$92,938
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$323,364	$323,364
07. Department of Human Services Medicaid-Funded Programs - Colorado Benefits Management System	Total	$559,814	$0	$583,606	($583,606)	($583,606)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$205,473	$0	$213,990	($213,990)	($213,990)
	CF	$74,625	$0	$78,035	($78,035)	($78,035)
	RF	$0	$0	$0	$0	$0
	FF	$279,716	$0	$291,581	($291,581)	($291,581)

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:			
Approval by OIT?	Yes X	No ___	**Not Required:** ___
Schedule 13s from Affected Departments:	DHS, OIT		
Other Information:			

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-04 DHS Provider Rate Adjustment

Dept. Approval By: Josh Block [signature] 11/2/15

OSPB Approval By: [signature] 10/28/15

___	Supplemental FY 2015-16
X	Change Request FY 2016-17
___	Base Reduction FY 2016-17
___	Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$24,545,218	$0	$24,550,524	($245,499)	($245,499)
	FTE	$0	0.0	$0	0.0	0.0
	GF	$12,079,957	$0	$12,099,909	($121,719)	($121,719)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$12,465,261	$0	$12,450,615	($123,780)	($123,780)

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
07. Department of Human Services Medicaid-Funded Programs - Child Welfare Services	Total	$15,222,606	$0	$15,222,606	($152,226)	($152,226)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,491,045	$0	$7,501,704	($75,474)	($75,474)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$7,731,561	$0	$7,720,902	($76,752)	($76,752)
07. Department of Human Services Medicaid-Funded Programs - Div of Comm. and Family Support, Early Intervention Services	Total	$5,928,683	$0	$5,928,683	($62,391)	($62,391)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,917,590	$0	$2,920,876	($30,933)	($30,933)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,011,093	$0	$3,007,807	($31,458)	($31,458)

07. Department of Human Services Medicaid-Funded Programs - Mental Health Treatment Services for Youth (H.B. 99-1116)	**Total**	**$123,624**	**$0**	**$123,624**	**($1,236)**	**($1,236)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$60,836	$0	$60,925	($613)	($613)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$62,788	$0	$62,699	($623)	($623)
07. Department of Human Services Medicaid-Funded Programs - High Risk Pregnant Women Program	**Total**	**$1,600,000**	**$0**	**$1,605,306**	**($16,000)**	**($16,000)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$787,360	$0	$791,039	($7,933)	($7,933)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$812,640	$0	$814,267	($8,067)	($8,067)
07. Department of Human Services Medicaid-Funded Programs - Division Of Youth Corrections - Medicaid Funding	**Total**	**$1,670,305**	**$0**	**$1,670,305**	**($13,646)**	**($13,646)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$823,126	$0	$825,365	($6,766)	($6,766)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$847,179	$0	$844,940	($6,880)	($6,880)

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:

Approval by OIT? Yes ___ No ___ **Not Required:** _X_

Schedule 13s from Affected Departments: DHS

Other Information:

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-05 Cervical Cancer Eligibility Expansion

Dept. Approval By: Josh Block [signature] 11/2/15

OSPB Approval By: [signature] 10/28/15

	Supplemental FY 2015-16
X	Change Request FY 2016-17
	Base Reduction FY 2016-17
	Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$7,251,741,008	$0	$7,204,749,738	$291,528	$252,757
	FTE	$0	0.0	$0	0.0	0.0
	GF	$2,008,476,738	$0	$1,991,521,504	$0	$0
	CF	$714,240,053	$0	$711,153,423	$107,119	$88,035
	RF	$0	$0	$0	$0	$0
	FF	$4,529,024,217	$0	$4,502,074,811	$184,409	$164,722

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
01. Executive Director's Office - Colorado Benefits Management Systems, Operating & Contracts	Total	$10,885,261	$0	$10,885,261	$38,771	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,770,869	$0	$3,770,869	$0	$0
	CF	$1,675,284	$0	$1,675,284	$19,386	$0
	RF	$0	$0	$0	$0	$0
	FF	$5,439,108	$0	$5,439,108	$19,385	$0
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	Total	$6,594,830,484	$0	$6,543,446,738	$236,245	$236,245
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,816,359,768	$0	$1,798,277,508	$0	$0
	CF	$703,597,288	$0	$700,504,787	$82,001	$82,284
	RF	$0	$0	$0	$0	$0
	FF	$4,074,873,428	$0	$4,044,664,443	$154,244	$153,961

03. Behavioral Health Community Programs - Behavioral Health Capitation Payments	**Total**	**$646,025,263**	**$0**	**$650,417,739**	**$16,512**	**$16,512**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$188,346,101	$0	$189,473,127	$0	$0
	CF	$8,967,481	$0	$8,973,352	$5,732	$5,751
	RF	$0	$0	$0	$0	$0
	FF	$448,711,681	$0	$451,971,260	$10,780	$10,761

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: Breast and Cervical Cancer Fund (15D0)

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: CDPHE

Other Information:

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-06 Secure Colorado

Dept. Approval By: Josh Block [signature] 11/2/15

OSPB Approval By: [signature] 10/28/15

	Supplemental FY 2015-16
X	**Change Request FY 2016-17**
	Base Reduction FY 2016-17
	Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$3,775,292	$0	$2,791,755	$13,851	$13,851
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,876,284	$0	$1,387,477	$6,884	$6,884
	CF	$11,360	$0	$8,401	$42	$42
	RF	$0	$0	$0	$0	$0
	FF	$1,887,648	$0	$1,395,877	$6,925	$6,925

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
01. Executive Director's Office - Payments to OIT	Total	$3,775,292	$0	$2,791,755	$13,851	$13,851
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,876,284	$0	$1,387,477	$6,884	$6,884
	CF	$11,360	$0	$8,401	$42	$42
	RF	$0	$0	$0	$0	$0
	FF	$1,887,648	$0	$1,395,877	$6,925	$6,925

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:

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

Schedule 13s from Affected Departments: OIT

Other Information:

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-07 DHS Secure Colorado

Dept. Approval By:	Josh Block [signature] 11/2/15		**Supplemental FY 2015-16**
		X	**Change Request FY 2016-17**
			Base Reduction FY 2016-17
OSPB Approval By:	[signature] 10/28/15		**Budget Amendment FY 2016-17**

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$647,220	$0	$639,584	$3,739	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$318,950	$0	$316,717	$1,854	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$328,270	$0	$322,867	$1,885	$0

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
07. Department of Human Services Medicaid-Funded Programs - Other Office Of Information Technology Services Line Items	Total	$647,220	$0	$639,584	$3,739	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$318,950	$0	$316,717	$1,854	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$328,270	$0	$322,867	$1,885	$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:

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

Schedule 13s from Affected Departments: OIT, DHS

Other Information:

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-08 DHS's Fleet Request

Dept. Approval By: Josh Block 11/2/15

OSPB Approval By: 10/28/15

	Supplemental FY 2015-16
X	**Change Request FY 2016-17**
	Base Reduction FY 2016-17
	Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$5,060,008	$0	$5,141,869	$13,536	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,493,572	$0	$2,539,297	$6,768	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,566,436	$0	$2,602,572	$6,768	$0

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
07. Department of Human Services Medicaid-Funded Programs - Office Of Operations - Medicaid Funding	Total	$5,060,008	$0	$5,141,869	$13,536	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,493,572	$0	$2,539,297	$6,768	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,566,436	$0	$2,602,572	$6,768	$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:

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

Schedule 13s from Affected Departments: DHS

Other Information:

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-09 DHS Utilities Increase

Dept. Approval By: Josh Block [signature] 11/2/15

OSPB Approval By: [signature] 10/28/15

___	**Supplemental FY 2015-16**
X	**Change Request FY 2016-17**
___	**Base Reduction FY 2016-17**
___	**Budget Amendment FY 2016-17**

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$5,060,008	$0	$5,141,869	$50,032	$50,032
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,493,572	$0	$2,539,297	$25,016	$25,016
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,566,436	$0	$2,602,572	$25,016	$25,016

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
07. Department of Human Services Medicaid-Funded Programs - Office Of Operations - Medicaid Funding	Total	$5,060,008	$0	$5,141,869	$50,032	$50,032
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,493,572	$0	$2,539,297	$25,016	$25,016
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,566,436	$0	$2,602,572	$25,016	$25,016

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:

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

Schedule 13s from Affected Departments: DHS

Other Information:

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-01 Medical Services Premiums

Dept. Approval By:	Josh Block 11/2/15		Supplemental FY 2015-16
		X	Change Request FY 2016-17
			Base Reduction FY 2016-17
OSPB Approval By:	10/26/15		Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$6,594,830,484	$0	$6,543,446,738	$60,280,818	$311,713,880
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,816,359,768	$0	$1,798,277,508	$141,702,419	$262,168,785
	CF	$703,597,288	$0	$700,504,787	($30,982,323)	$14,048,346
	RF	$0	$0	$0	$0	$0
	FF	$4,074,873,428	$0	$4,044,664,443	($50,439,278)	$35,496,749

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	Total	$6,594,830,484	$0	$6,543,446,738	$60,280,818	$311,713,880
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,816,359,768	$0	$1,798,277,508	$141,702,419	$262,168,785
	CF	$703,597,288	$0	$700,504,787	($30,982,323)	$14,048,346
	RF	$0	$0	$0	$0	$0
	FF	$4,074,873,428	$0	$4,044,664,443	($50,439,278)	$35,496,749

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: See Exhibit D

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: N/A

Other Information:

Department of Health Care Policy and Financing
Medical Services Premiums

FY 2015-16, FY 2016-17, and FY 2017-18 Budget Request

November 2015

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MEDICAL SERVICES PREMIUMS

MAJOR FORECAST CHANGES

- Acute Care – The current request is approximately $20 million over the February request. Accounting for new legislation, the current request is $30 million under the February request in total funds; however, this is primarily driven by the MAGI Adults category, which is 100% federally funded in FY 2015-16. The current request is $39.3 million over the February request in General Fund. The growth in General Fund is primarily due to changes in expected per capita in two eligibility categories: MAGI Parents/Caretakers to 68% FPL and Eligible Children. FY 2014-15 actual expenditure for the above mentioned categories was higher than the February 2015 estimates. The per capita estimate for Eligible Children and MAGI Parents/Caretakers to 68% FPL has been increased since the February request. For Eligible Children, this increase was driven by increased service utilization of physician services and hospital services related to respiratory illness and neonatal services, as well as increases in dental service utilization compared to prior years. For MAGI Parents/Caretakers to 68% FPL, this increase was driven by higher than previously anticipated utilization of physician services, outpatient hospital, and pharmaceuticals. The increased per capita estimates for these groups contribute to a $52 million increase in total funds since the February request. These increases were tempered by lower per capita estimates for MAGI Adults, which decreased the estimate by nearly $117 million in total funds.
- Community-Based Long-Term Care – The current request is approximately $14.8 million below the February request. The decrease is primarily due to expenditure for home- and community-based services and private duty nursing coming in lower than anticipated for FY 2014-15, as well as a reduction in expectations for Community Choice Transitions.
- Class I Nursing Facilities - The current request is approximately $3.3 million below the February request. The decrease is primarily due to lower average rate paid to facilities in FY 2014-15.
- Program of All-Inclusive Care for the Elderly – The current request is approximately $6.3 million below the February request. FY 2014-15 actual expenditure was lower than expected in the February request. The bulk of this reduction in request is due to an expected interim payment recoupment of $5.3 million dollars in FY 2015-16.
- Prepaid Inpatient Health Plan Administration - The current request is approximately $5.1 million below the February request. This is primarily driven by a reduction in the estimated number of clients enrolled in the Accountable Care Collaborative (ACC), based on actual enrollment in FY 2014-15.

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 FY 2014-15, rates were increased 2% across the board. Some services received varying targeted rate increases in FY 2014-15 as well. Rates were also increased in FY 2015-16, at 0.50% across the board along with various targeted rate increases for some services.

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 2015-16, FY 2016-17, and FY 2017-18. Some previous requests included only forecasts for the current and request years; therefore there are 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 on the Adult Dental Cash Fund, 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 2015-16, a 97.5% FMAP in FY 2016-17, and a 94.5% FMAP in FY 2017-18 as the federal match for these populations falls to 95% in January 2017 and 94% in January 2018. 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 65.55% FMAP for these populations in FY 2015-16. Previously, the Department assumed that this enhanced FMAP only applied to the SB 11-250 Eligible Pregnant Adults population through July 31, 2015, after which time the FMAP associated with this population would fall to the standard FMAP. However, the Department received permission from CMS to continue the enhanced FMAP for this population. The enhanced FMAP continues for the SB 11-008 Eligible Children and SB 11-250 Eligible Pregnant Adults populations until October 2015, when these populations will receive an additional 23 percentage point FMAP increase; the enhanced FMAP is expected to be 82.80% in FY 2015-16, 88.29% in FY 2016-17, and 88.17% in FY 2017-18.

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.

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 decrease from 51.01% to 50.72% beginning October 1, 2015. New to the current request, the Department has begun calculating FMAP estimates for the out year of the request and beyond, as well. With the new FMAP of 50.72% beginning October 2015, FMAP for FY 2015-16 would be 51.01% for the first quarter and 50.72% for the latter three quarters, resulting in an effective FMAP of 50.79% for the fiscal year. FMAP for FY 2016-17 has been estimated using data from the Bureau of Economic Analysis at 50.42%. Data from the Colorado Population Forecast, the U.S. Census, and the Legislative Council is used to estimate the FMAP for FY 2017-18, at 50.24%. These changes are outlined in Exhibit R. This FMAP change applies to Medicaid services only; Medicaid administrative costs would continue to receive a 50.00% FMAP. If the FMAP changes from Department estimates, the Department would submit a supplemental funding request to account for the change in federal funds.

15. Significant differences in the types and utilization of various home health services have caused the Department to evaluate the placement of these services. Previously, all home health services were placed under Acute Care. The Department has now separated home health services into two categories: Acute Home Health and Long-Term Home Health (LTHH). Acute Home Health is included in Acute Care and information about this change can be found in Exhibit F. LTHH is included in Community-Based Long-Term Care and information about this change can be found in Exhibit G.

16. The Colorado Operations Resource Engine (CORE) was implemented as a replacement for the Colorado Financial Reporting System (COFRS) in July 2014. Under COFRS, the previous fiscal year closed and the data became final at the beginning of the current fiscal year. Under CORE, the previous fiscal year may not close until March of the current fiscal year. This introduces a small degree of uncertainty regarding FY 2014-15 actuals that was not present previously. It is possible that the FY 2014-15 actuals may change in the next request. The Department does not expect major changes to FY 2014-15 actuals. The FY 2014-15 actuals contained within this request reflect data for FY 2014-15 as of August 24, 2015.

17. Beginning with the November 2015 request, the Department has forecast expected FMAP though the current year, request year, and out year rather than holding the most recent information constant throughout the request year and out year. More information can be found about this change in Exhibit R.

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 requests prior to February 2015 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
- Acute 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
- Long-Term Home Health
- 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
- Accountable Care Collaborative and 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 typically around 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 Centers for Medicare and Medicaid Services (CMS) has notified the Department that the State's FMAP for Medicaid services would decrease from 51.01% to 50.72% effective October 1, 2015. The Department has estimated the FMAP for Medicaid services going forward, based on data from the Bureau of Economic Analysis, the U.S. Census, the Department of Local Affairs' Population Forecasts, and the Colorado Legislative Council's U.S. and Colorado Personal Income forecasts, resulting in an estimated FMAP of 50.32% beginning October 1, 2016 and 50.21% beginning October 1, 2017. There is a possibility that the FMAP rate could change from the Department's estimate for October 1, 2016 in late Fall 2015. 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 50.72% that begins October 2015. This is summarized below. Clients transitioning from CHP+ to Medicaid receive the CHP+ FMAP, which is usually 65% but has been recalculated at 65.50% effective October 2015, 65.22% effective October 2016, and 65.15% effective October 2016. 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 82.80% FMAP in FY 2015-16, 88.29% FMAP in FY 2016-17, and 88.17% FMAP in FY 2017-18. Clients in the BCCP program also receive a 65% match, or 65.50% effective October 2015, 65.22% effective October 2016, and 65.15% effective October 2016. Since the FMAP decrease to 50.72% occurs at the start of the second quarter of FY 2015-16, the FMAP would be 51.01% for quarter one and 50.72% for the remainder of the year, resulting in a final FMAP of 50.79% for FY 2015-16. This logic is applied to the populations receiving 65.71% for quarter one and 65.50% the remainder of the fiscal year, resulting in a final FMAP of 65.55% for FY 2015-16. The expansion populations, MAGI Parents/Caretakers 69% to 133% and MAGI Adults, receive a match of 100% beginning January 1, 2014, though this falls to 95% beginning January 1, 2017, resulting in a final FMAP of 97.50% for these populations for FY 2016-17. The match for this population falls again to 94% beginning January 1, 2018, resulting in a final FMAP of 94.50% for these populations for FY 2017-18. A sub-group of MAGI Adults, non-newly eligible disabled individuals, receive the ACA expansion FMAP for 75% of their expenditure and the standard FMAP for the remaining 25% resulting in an effective FMAP of 87.70%, 85.73%, and 83.44% for FY 2015-16, 2016-17, and 2017-18 respectively. The Disabled Buy-In population receives the standard 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 2015-16	82.80%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.55%	Clients in the BCCP program	Please see Exhibit F
	100%	MAGI Parents/Caretakers 69% to 133%, FPL, MAGI Adults	Please see Exhibit J
	87.70%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.79%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.79%, Medicaid Buy-In Fund 0%
FY 2016-17	88.29%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.29%	Clients in the BCCP Program	Please see Exhibit F
	97.50%	MAGI Parents/Caretakers 69% to 133%, FPL, MAGI Adults	Please see Exhibit J
	85.73%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.42%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.79%, Medicaid Buy-In Fund 0%
FY 2017-18	88.17%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.17%	Clients in the BCCP Program	Please see Exhibit F
	94.50%	MAGI Parents/Caretakers 69% to 133%, FPL, MAGI Adults	Please see Exhibit J
	83.44%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.24%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.72%, Medicaid Buy-In Fund 0%

Service-Based FMAPs			
Fiscal Year	**FMAP**	**Service**	**Comments**
FY 2015-16	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51.79%	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
	51.42%	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
FY 2017-18	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51.24%	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 and 49.28% General Fund and 50.72% federal funds in October 2015. 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, and then decreased to 65.50% effective October 2015. 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 and then decreased to 65.50% effective October 2015. 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 2015-16, FY 2016-17, and FY 2017-18 is expected to be 82.80%, 88.29%, and 88.17% 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. Previously, the State had authority to claim the enhanced FMAP on this population through July 31, 2015; after which date, the FMAP would be reduced to the standard Medicaid match rate of 51.01%. However, the Department received permission from the Centers for Medicare and Medicaid Services (CMS) to continue receiving a higher match rate for this population, similar to the population under SB 11-008 "Aligning Medicaid Eligibility for Children". Therefore, FMAP for this population for FY 2015-16, FY 2016-17, and FY 2017-18 is expected to be 82.80%, 88.29%, and 88.17% respectively.

- 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% and in CY 2018, the federal match rate is reduced to 94%. 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, a 95% federal match rate in CY 2017, and a 94% federal match rate in CY 2018. This results in a 100% federal match rate for this population in FY 2015-16 and approximately a 97.50% federal match rate in FY 2016-17 and 94.50% federal match rate in FY 2017-18. 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 FMAP determined by a resource proxy with the State portion funded through the Hospital Provider Fee, as is required by statute. The Department can claim 75% of the expenditures for Non-Newly Eligible clients at the enhanced expansion FMAP and the remaining 25% at standard FMAP. 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.

- 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 were paid for by the federal government through an enhanced FMAP of 100%, through calendar year 2014. The State continued this physician rate increase from January 2015 through June 2016 at standard FMAP. Additional details are provided in sections IV and V.

- 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 2015-16, 84.5% in FY 2016-17, and 81.0% in FY 2017-18. 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 2015-16, FY 2016-17, and FY 2017-18 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. 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 2015-16, FY 2016-17, and FY 2017-18.

Cash Funds	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**
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	$25,294,841	$27,336,135	$29,339,874
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)	$5,369,479	$5,240,893	$5,109,213
Service Fee Fund (SB 13-167)	$200,460	$200,460	$200,460
Total	**$48,795,280**	**$50,707,988**	**$52,580,047**

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

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1997-98 through FY 2017-18. 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 2014-15.

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

Beginning with the February 2015 request, the Department chose 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 MAGI Eligible Pregnant Adults and SB 11-250 Eligible Pregnant Adults.

Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 68% FPL	Expansion Adults to 133% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles

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%-133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Eligible Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens	Partial Dual Eligibles

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 five 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.

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. 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 2014-15. 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 2015-16, FY 2016-17, and FY 2017-18. 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 clients from economically sensitive populations may have had health insurance previously 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 2015-16, FY 2016-17, and FY 2017-18, with the rationale for selection, are as follows:

Aid Category	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	Justification
Adults 65 and Older (OAP-A)	0.78%	0.78%	0.78%	Per capita growth was higher than expected for FY 2014-15. There was higher than expected utilization of services that were heavily influenced by policy. The Department has identified this as a level shift and expects future expenditure to reflect a small underlying growth in per capita. The Department has selected trends of less than 1% annual growth.
Disabled Adults 60 to 64 (OAP-B)	1.00%	1.00%	1.00%	While per capita in FY 2014-15 was higher than anticipated, the Department has identified that increases in per capita expenditure are largely attributable to anomalous expenditure from a very small group of individuals. Because utilization of services for this population is slowly, steadily increasing, the Department has selected a trend of 1% annual growth.

Aid Category	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	Justification
Disabled Individuals to 59 (AND/AB)	0.30%	0.30%	0.30%	Per capita expenditure in FY 2014-15 aligned very closely to the Department's forecast. There are few new policy and programs affecting this population, therefore the Department has selected a trend of less than 1% annual growth, in line with the previous forecast. Rate increases are added via bottom line impacts and need not be included in the base per capita trend.
Disabled Buy-in	2.00%	1.00%	1.00%	The Department believes per capita costs from FY 2012-13 through FY 2014-15 decreased as pent up demand for services from the most medically needy clients began to subside after large growth in the first year. Analysis of expenditure through FY 2014-15 indicates that per capita costs for this population are stabilizing. The Department has selected a 2% annual growth trend in the current year and a 1% annual growth trend in the request and out years as this population is expected to stabilize.
MAGI Parents/ Caretakers to 68% FPL	-2.00%	-2.00%	-2.00%	The Department has selected a downward trend despite FY 2014-15 having a slightly positive per capita. There were large increases in expenditure for outpatient hospital, physician services, and prescription drugs that are not expected to continue. The Department has selected a -2% annual growth trend 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.

Aid Category	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	Justification
MAGI Parents/ Caretakers 69% to 133% FPL	-1.18%	-1.18%	-1.18%	Per capita for this population was roughly 80% that of the MAGI Parents/Caretakers to 68% FPL in FY 2014-15. The Department believes that per capita costs for this population will remain below those of the MAGI to 68% FPL group. Additionally, caseload growth continues to be fairly strong for this population which is expected to put downward pressure on per capita costs.
MAGI Adults	2.50%	2.50%	1.25%	Analysis of expenditure for this population indicates the previous trend from the February Request may have been too aggressive. Pent-up demand for services was not as strong as previously assumed and FY 2014-15 saw smaller increases in per capita than anticipated. Therefore, the Department has chosen a less aggressive trend of 2.5%. The trend has been reduced for FY 2017-18 as the effects of pent-up demand are expected to continue to subside.
Breast & Cervical Cancer Program	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.
Eligible Children (AFDC-C/ BCKC-C)	0.50%	0.50%	0.50%	Analysis of expenditure for this population indicates that the previous trend selected in the February 2015 request was too low. Per capita costs grew over previous fiscal years, driven by respiratory illness. The Department increased the trend to 0.50% to reflect expenditure in FY 2014-15.

Aid Category	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	Justification
SB 11-008 Eligible Children	0.00%	0.00%	0.00%	Aggressive Caseload growth in prior fiscal years put downward pressure on per capita expenditure for this category. Caseload growth is expected to slow significantly in the current fiscal year and FY 2014-15 expenditure indicates per capita costs are stabilizing around the current value. A trend of 0.00% was selected to modify per capita.
Foster Care	0.82%	0.82%	0.82%	Analysis of expenditure for this population indicates that the previous trend selected in the February 2015 request was too low. Per capita costs grew over previous fiscal years. The Department increased the trend to 0.82% to reflect per capita growth in FY 2014-15.
MAGI Pregnant Adults	1.29%	1.29%	1.29%	The Department saw significantly higher than anticipated growth in per capita expenditure in FY 2014-15, partially driven by an increase in expenditure for health maintenance organizations. The Department expects per capita to continue to increase in FY 2015-16, but at a much slower rate than in the prior year.
SB 11-250 Eligible Pregnant Adults	1.29%	1.29%	1.29%	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.
Non-Citizens	-2.75%	0.00%	0.00%	The Department has decreased the per capita growth trend for this population given actual per capita decreases in FY 2014-15. Positive caseload growth for the first time in over six years is expected to contribute to the trend of -2.75% to modify per capita.

Aid Category	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	Justification
Partial Dual Eligibles	1.83%	1.83%	1.83%	The Department saw less expenditure than forecast for FY 2014-15, driven almost exclusively by significant decreases in co-insurance. The Department does not anticipate continued reductions in expenditure for this population and has selected a trend of 1.83%, in line with historical per capita growth, to modify per capita.

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 was effective January 1, 2013 through the end of calendar year 2014.
- Accountable Care Collaborative (ACC) savings accounts for reductions in Acute Care expenditure resulting from ACC program activities. Additional detail can be found both in section V and in Exhibit I.
- 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 December 2014, there were 470 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.
- 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, less expensive, communication assistance technology for clients with disabilities impairing their ability to communicate.
- 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.
- 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) and HB 14-1252 Client Movement to the DD Waiver: FY 2014-15 R-8: "Developmental Disabilities New Full Program Equivalents" and HB 14-1252: "Intellectual and Developmental Disabilities Service System Capacity" are combined into one bottom-line adjustment – FY 2014-15 R-8 allows for emergency enrollments onto the Division for Intellectual and Developmental Disabilities (DIDD) Developmental Disabilities (DD) waiver and HB 14-1252 is the bill that incorporates the Department's BA-5/S-5 request "Community Living Caseload and Per Capita Changes," which reduced the waitlist for the DD waiver. The impact to Acute Care is due to the increased caseload and per capita costs for the DIDD Medicaid waivers attributable to those formerly utilizing state plan services in Acute Care. This results in decreased costs in Acute Care.
- 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 Increases, accounts for added expenditure from targeted rate increases for the purpose of addressing issues with clients' access to cost-effective services. The separate components of the rate increases are broken out in Exhibit F.
- 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 Medicare in the Accountable Care Collaborative (ACC) so that they will receive care coordination.
- 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 FY 2014-15 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.
- R-12 (FY 2015-16), Community Provider Rate Increases, accounts for added expenditure from a 0.50% across the board increase for eligible providers.
- R-12 (FY 2015-16), Targeted Community Provider Rate Increases, accounts for added expenditure from targeted rate increases for the purpose of addressing issues with clients' access to cost-effective services. The separate components of the rate increases are broken out in Exhibit F.
- HB 15-1309, Protective Restorations by Dental Hygienists, allows a dental hygienist to apply to the Colorado Dental Board for a permit to place interim therapeutic restorations, when they have met specific criteria determined by the Interim Therapeutic Restorations Advisory Committee, increasing expenditure for dental services in Acute Care.
- HB 15-1186, Children with Autism Waiver Expansion, allows more clients to access Medicaid through this waiver, increasing expected expenditure in Acute Care.
- SB 11-177, Annualization of Sunset Teen Pregnancy and Dropout Program, removes the Teen Pregnancy and Dropout Program from Acute Care when the program sunsets September 1, 2016.

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.

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 65.55% federal match rate.

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 2014-15.

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.

Adult Dental Cash Fund-eligible 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, 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 Cash Fund-Eligible Dental Services Exhibit on pages EF-6 through EF-8 reports total Dental expenditure for populations that have the State share of expenditure funded with the Adult Dental Cash fund and subtracts out the estimated expenditure for emergency and co-occurring conditions to estimate expenditure that requires financing from the Adult 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, pages EF-9 through EF-10, 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 2013-14 due to several antipsychotic drugs going generic and per-unit costs decreasing significantly. FY 2014-15 resumed growth due to increases in cost, utilization, and caseload.

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 2014-15. 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-12 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 2015-16 estimate for total reported expenditure is the average of annual total reported expenditure increases since FY 2007-08, attributing 8.0% growth. 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 2016-17and FY 2017-18 total expenditures are the result of the application of the average of annual growth rates for FY 2005-06 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-12.

SB 11-177 "Sunset Teen Pregnancy and Dropout Program" was expected to contribute $29,000 in local funds for FY 2015-16. The Department had previously contracted with Montrose to provide the program, but because questions surrounding appropriate federal matching funds the contract was terminated. Therefore local cash funds will no longer be included in the estimate because the teen pregnancy program was the program receiving these funds. 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 FY 2014-15, the Department migrated from fee-for-service to encounter-based expenditure tracking per CMS. This allows the Department to allocate expenditure under Indian Health Service in a way that wasn't previously possible, especially for pharmacy expenditure. In an effort to forecast FY 2015-16 expenditure growth in a fashion representative of more regular patterns observed in other fiscal years, the average annual growth for FY 2008-09 through FY 2013-14 was applied to FY 2014-15 expenditure.

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 2014-15, the Department paid HCBS claims for an average of 26,043 clients per month.

Clients receiving CBLTC services have access to 12 HCBS waivers, each targeted to specific populations. Of the 12 waivers, 11 are administered by the Department, and the remaining waiver is managed by the Department of Human Services. Of the 11 waivers administered by the Department, 8 are included in the Medical Services Premiums line item and the remaining 3 fall under the Office

of Community Living Division of Intellectual and Developmental Disabilities. The Persons Living with AIDS adult waiver is no longer active and clients were phased into the Elderly, Blind and Disabled waiver by the end of FY 2013-14. The waivers included in the Medical Services Premiums line item are:

- Elderly, Blind and Disabled Adult Waiver
- Community Mental Health Supports Adult Waiver[1]
- Disabled Children's 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. From FY 2012-13 to FY 2014-15, the Department used enrollment from a static caseload report which places clients into their waiver. During FY 2014-15, the Department noticed that the enrollment was not trending with utilization and that clients enrolled in some waivers were actually enrolled in other waivers based upon their claims utilization. Thus, starting in FY 2015-16, the Department has decided to depict waiver enrollment as the average number of clients per month with an active prior authorization (PAR) for services on each

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

waiver. The Department believes this to be the most accurate depiction of waiver enrollment, as services under waivers cannot be rendered without an active PAR.

Furthermore, since the Department is using an enrollment based methodology to define caseload, a utilization adjustment must be used prior to developing final projected expenditure. The Department has chosen to use the historic ratio of average monthly utilizers to average monthly enrollment to adjust projected expenditure for each waiver. This maximum ratio of utilizers to enrolled participants in each waiver was utilized to adjust final expenditure in FY 2015-16, FY 2016-17, and FY 2017-18.

The selected enrollment trend factors for FY 2015-16, FY 2016-17, and FY 2017-18, 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 2015-16 through FY 2017-18: 4.34%, 4.79%, & 4.79% respectively.	FY 2015-16 through FY 2017-18: 3.88%	Enrollment history is very steady, growing at approximately 5% per year. The enrollment trend selected continues historical growth through the out year using a monthly linear regression. Per enrollee cost history has grown on average since FY 2008-09 at approximately 4%. The cost per enrollee trend continues historic growth through the out-year using the 4-year average growth rate.
Community Mental Health Supports Waiver (CMHS)	FY 2015-16 through FY 2017-18: 5.83%, 5.82%, & 5.83%, respectively.	FY 2015-16 through FY 2017-18: 2.55%	Enrollment history is very steady, growing at almost 6% per year. The enrollment trend selected continues historical growth through the out year using the last six year's average yearly growth. Per enrollee cost history has grown on average since FY 2009-10 at approximately 2.5%. The cost per enrollee trend continues historic growth through the out-year using the 5-year average growth rate.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Disabled Children's Waiver	FY 2015-16 through FY 2017-18: 1.55%, 1.52%, & 1.59%, respectively.	FY 2015-16 through FY 2017-18: 22.72%, 19.84%, & 16.78%, respectively.	Historically, enrollment growth has been negative; however, the Department has made significant efforts to better manage the waitlist. Therefore, the Department expects positive growth through the out-year using a monthly linear regression. 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, with slowing last fiscal year. Increased participation is IHSS is expected through the out-year, but at a decreased rate compared to previous fiscal years.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Consumer Directed Attendant Support-State Plan	FY 2015-16 through FY 2017-18: -11.11%, -12.50%, & -14.29%, respectively.	FY 2015-16 through FY 2017-18: 0.00%	Additional enrollment in this program is currently prohibited. The chosen negative growth rates reflect clients leaving the program as CDASS becomes available on other 1915(c) waivers. With the majority of clients leaving for CDASS expansion under the Supported Living Services waiver, enrollment is expected to only be one client after FY 2015-16. 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.
Brain Injury Waiver	FY 2015-16 through FY 2017-18: 6.51%, 3.67%, & 3.54%, respectively.	FY 2015-16 through FY 2017-18: 0.31%	Historically there has been slow and steady growth in BI enrollment. The Department saw this growth increase rapidly in FY 2012-13 and FY 2013-14, which continued at a higher pace in FY 2014-15. The Department expects waiver enrollment to grow through the out-year using a monthly linear regression. Historic cost per enrollee growth has been approximately 1%. The Department expects cost per enrollee growth to continue into the out year using the last four year’s average growth.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Children with Autism Waiver	FY 2015-16 through FY 2017-18: Growth matches House Bill 15-1186 “Children with Autism Expansion”	FY 2015-16 through FY 2017-18: Growth matches House Bill 15-1186 “Children with Autism Expansion”	Prior to FY 2015-16, this waiver was capped at 75 clients. With the passing of House Bill 15-1186, the waitlist will be eliminated, allow future enrollment growth, allow for enrollment up to age eight, and guarantee three years on the waiver.
Children with Life Limiting Illness Waiver	FY 2015-16 through FY 2017-18: 10.77%, 11.11%, & 10.63%, respectively.	FY 2014-15 through FY 2016-17: 6.91% per year.	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 in FY 2014-15 was 144 clients. While enrollment was lower than anticipated in FY 2014-15, enrollment is expected to increase as more providers become available as they become aware of recent rate increases and programmatic changes that at will be fully implemented in FY 2015-16; leading to positive growth. As with client enrollment, cost per enrollee growth is expected to be positive into the future due to pragmatic changes and rate increases; in FY 2014-15 cost per enrollee grew by 172.91%, from $1,335.13 to $3,643.65, as the programmatic changes are fully implemented in FY 2015-16, this growth is expected to continue, although at a drastically decreased rate.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Spinal Cord Injury Adult Waiver	FY 2015-16 through FY 2017-18: Growth matches Senate Bill 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine"	FY 2015-16 through FY 2017-18: Growth matches Senate Bill 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine"	Senate Bill 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine" reauthorizes the waiver for five years, allowing for increased enrollment beyond the previous cap of 67 and replaced administrative funding from gifts, grants, and donations with General Fund. The bill was signed by Governor Hickenlooper on June 5, 2015. The bill allows growth in enrollment beyond 100 at any point-in-time and assumes that cost per enrollee will grow at about 2.19% per year.

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 14-1357: "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. Due to delays in approval from CMS, the Department expects implementation by December 1, 2015.
- 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. Audit recommendations are expected to be fully implemented in FY 2015-16.
- 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. The program has seen enrollment expectations decrease due to issues with payment methodology and low rates. To address this, the Department increased rates to transition coordination agencies to deal with the emergency access issue. Low enrollment has caused long-term home health utilization and CCT service utilization decrease below expectations, which has decreased the amount of cumulative nursing facility cost avoidance.

- FY 2014-15 JBC Action "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. Due to delays in approval from CMS, the Department expects implementation by December 1, 2015.
- Annualization of 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.
- Annualization of FY 2014-15 R#8 and HB 14-1252 Client Movement to the DD Waiver: FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents" and HB 14-1252: "Intellectual and Developmental Disabilities Service System Capacity" are combined into one bottom-line adjustment – FY 2014-15 R#8 allows for emergency enrollments onto the Division for Intellectual and Developmental Disabilities (DIDD) Developmental Disabilities (DD) waiver and HB 14-1252 is the bill that incorporates the Department's BA-5/S-5 request "Community Living Caseload and Per Capita Changes," which reduced the waitlist for the DD waiver. The impact to HCBS waivers is due to the increased caseload and per capita costs for the 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.
- Annualization of 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.
- Annualization of 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.
- 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. The implementation of this has been delayed due to provider recruitment, training and systems issues. The benefit is expected to be implemented in late fall or early winter of 2015.

- Annualization of 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.
- Sunset of HB 09-1047 "Alternative Therapies for Medicaid" – This bill authorized the Spinal Cord Injury (SCI) waiver, and sunsets July 1, 2015. Two bottom-line adjustments account for this in FY 2015-16. The first is a caseload adjustment that moves enrollment from the SCI waiver to the Elderly, Blind and Disabled (EBD) waiver. The second is an expenditure adjustment that accounts for the incremental average cost difference between clients on the SCI waiver and clients on the EBD waiver, accounting for therapies that are currently available on the SCI waiver but not on the EBD waiver.
- FY 2015-16 R#12: "Community Provider Rate Increase" 0.5% Across the Board - – The Joint Budget Committee approved a 0.5% across-the-board rate increase, effective July 1, 2015, which affects services provided by HCBS waivers. Due to delays in approval from CMS, the Department expects implementation by October 1, 2015.
- FY 2015-16 R#12: "Community Provider Rate Increase" Targeted – Homemaker and Personal Care to $17 per hour, In-Home Respite to $4.87 - The Joint Budget Committee approved these targeted rate increases, effective July 1, 2014, which affects the Elderly, Blind, and Disabled, Brain Injury, Community Mental Health Supports, and Spinal Cord Injury waivers. Due to delays in approval from CMS, the Department expects implementation by December 1, 2015.
- FY 2015-16 JBC Action "Raising the Cap on Home Modifications" – A Joint Budget Committee action raised the cap on home modifications in FY 2015-16, resulting in an impact to waivers that include home modifications. Due to delays in approval from CMS, the Department expects implementation by December 1, 2015.
- HB 15-1186: "Children with Autism Waiver Expansion" – HB 15-1186 increases the age limit from six to eight, allows for 3 years stay on the waiver (regardless of entry age), eliminated with waitlist and allows for natural growth in enrollment and expenditure cap increases at the Joint Budget Committees purview. The legislation also allows for General Fund to be used for payment once the Autism Treatment Fund is exhausted. The expansion was expected to be implemented on July 1, 2015, but was denied by CMS on September 14, 2015. CMS requested that the state provide behavioral therapy to children with autism through the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program. The Department plans on transitioning clients from the waiver service to EPSDT over the next few years.
- SB 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine" – SB 15-011 reauthorized the Spinal Cord Injury Waiver for another five years, starting in FY 2015-16. The bill also eliminates the enrollment cap, allowing for natural growth in enrollment and changes administrative funding from gifts, grants, and donations to General Fund. The reauthorization and expansion was expected to be implemented June 1, 2015, but due to delays in approval from CMS, the Department expects implementation by October 1, 2015.
- Independent Living Skills Training (ILST) Provider Rule Change – the Department was not able to recruit providers under current rules in rural areas resulting in gaps in coverage. Provider rule changes will allow for ILST to be provided in rural areas, filling the gap in coverage.

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. Due to rate and rate methodology issues for Transition Coordination Agencies, enrollment has been less than anticipated. The Department anticipates that enrollment will be below 100 in FY 2015-16, but will approach 100 by FY 2016-17 as the Transition Coordination Agencies rates were adjusted to ensure clients receive the services they need. The Department estimates the total impact to Medical Services Premiums to be a reduction of $4,496,326 total funds in FY 2015-16 and a reduction of $6,589,611 in FY 2016-17. These figures do not include any expenditure from the rebalancing fund.

Prior-Year Expenditure

As an additional reasonableness check, the Department has split FY 2014-15 actual expenditure into two half-year increments to analyze the changing rates of expenditure over time.

Hospice

Hospice expenditure for FY 2015-16, FY 2016-17, and FY 2017-18 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 71% of total hospice expenditure in FY 2014-15. 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 2014-15, Hospice Routine Home Care expenditure was approximately $11.6 million and thus represented 85% of Hospice Services expenditure and 24% 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 2015-16, FY 2016-17, and FY 2017-18 by trending forward the growth rate observed in FY 2014-15 by an adjusted percentage. 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 2014-15.

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 2014-15, the Department paid approximately $2 million for Hospice General Inpatient Care. The Department trended forward an adjusted growth rate observed between FY 2013-14 and FY 2014-15 to estimate expenditures for FY 2015-16, FY 2016-17, and FY 2017-18.

The remaining components of hospice services expenditures in total represent approximately $96,000 of expenditure for FY 2014-15; in every prior year except FY 2012-13, they accounted for less than $50,000 of combined expenditure. FY 2015-16, FY 2016-17, and FY 2017-187 expenditure estimates are results of the application of the average growth rate for the past three fiscal years, 5.41%, to the previous fiscal year's estimate.

Hospice is not normally affected by bottom line impacts, except through items that also affect Class I Nursing Facilities, such as the HB 13-1152 1.5% permanent rate reduction on Nursing Facility core per-diem. However, the current request includes the estimated impacts of two rate increases that affect Hospice services other than Nursing Facility Room and Board: the annualization of a FY 2014-15 JBC action to increase the Hospice rate by 2.00% and the FY 2015-16 R-12 Community Provider Rate Increase, which increases the Hospice rate by 0.50%. Neither of these increases apply to Nursing Facility Room and Board.

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 similar rates. PDN rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change. However, during the FY 2015-16 Legislative Session, PDN RN received a targeted rate increase to bring the rate up 10.95% to $45, while the remaining four services received the .5% across the board rate increases. The rate increases were assumed to be implemented by 7/1/2015 but that date has been moved to 8/1/2015 due CMS approval delays.

As PDN expenditure is the product of the units utilized per client and the number of utilizers, and the Department expects rates to remain constant, expenditure forecasts for FY 2015-16, FY 2016-17, and FY 2017-18 are primarily based on units per utilizers and utilizers forecasts for those fiscal years. The units per utilizer and utilizers forecast are separated into three pieces: RN; LPN, and grouped RN Group, LPN Group, and Blended Group.

In FY 2014-15, the Department paid claims for 458 utilizers on average per month for PDN services; 379 of those utilizers billed for RN services. RN average utilizers per month have grown in the double digits since FY 2008-09, reaching maximum growth of 38.46% in FY 2013-14. In FY 2014-15, average utilizers per month yearly growth dropped to 23.86%. Average monthly growth has been growing steadily over time and the Department chose to apply a linear time trend to historical claims data over this time frame to produce estimates for FY 2015-16, FY 2016-17, and FY 2017-18. This model predicts growth at 17.41% per fiscal year.

RN units per client have been decreasing on average, every year since FY 2008-09, with average yearly growth of -1.23%, but reaching the largest percent decrease in FY 2014-15 of -8.69%. The Department expect growth in units per client to stay negative and then flatten out, but remain around the yearly average growth for FY 2015-16, and decrease to -0.60% in FY 2016-17, and remain flay in FY 2017-18.

Similar to RN, LPN average utilizers per month have grown mostly in the double digits over time, with an average of 17.48% per year, and reaching maximum growth in FY 2013-14 of 41.13%. In FY 2014-15, average utilizers per month yearly growth dropped to 22.29%. Average monthly growth has been growing steadily over time and the Department chose to apply a linear time trend to historical claims data over this time frame to produce estimates for FY 2015-16, FY 2016-17, and FY 2017-18. This model predicts growth at 14.95% per fiscal year.

Again, much like RN units per client, LPN units per client have been decreasing on average, every year since FY 2008-09, with average yearly growth of -2.95%, but reaching the second largest percent decrease in FY 2014-15 of -8.40%. The Department expect growth in units per client to stay negative and then flatten out, but remain decrease to in FY 2015-16 to -1.77%, and decrease to -.87% in FY 2016-17, and remain flay in FY 2017-18.

LPN-group, RN-group, and Blended RN/LPN drive only about 13.41% of expenditure in FY 2014-15 and represent the smallest number of average utilizers per month as well. Due to recent large growth years, the Department chose to forecast FY 2015-16, FY 2016-17, and FY 2017-18 linearly at 21.88%. For the grouped and blended PDN services, units per client growth has been erratic over the last few years, but is trending downward, for this reason the Department used weighted average yearly growth to forecast FY 2015-16, FY 2016-17, and FY 2017-18 which results growth rates of 2.37%, .94% and 1.19% respectively.

Final expenditure estimates for FY 2015-16, FY 2016-17, and FY 2017-18 are produced by multiplying average monthly utilizers by the average units per utilizer by the projected rate for RN, LPN, the grouped services and then summing these figures. The Department is forecasting large growth in FY 2015-16, 25.10%, which includes a 10.95% rate increase to RN, which accounts for about 67% of utilization, large growth in utilizer's, but is tempered by decreases in units per utilizer. The trend is decreased in the request and out-years to 16.98% and 17.83% respectively, which is on par with historical growth.

Long-Term Home Health

The Long-Term Home Health (LTHH) exhibit is new starting in FY 2015-16. LTHH services are considered Long-Term Services and Supports (LTSS) but have been previously forecasted in the acute care. Since these services are not acute, they were carved out of the acute care forecast, with only acute home health remaining in acute. LTHH services are deemed necessary by a medical need and are skilled nursing and therapy services that are generally provided in a client's home. LTHH services are either billed hourly or on a visit basis with a maximum number of hours. There are nine services under LTHH that are for both children under 21 and adults: clients under 21 that have a medical need can access Physical, Occupational, Speech and Language Therapies (PT, OT, and S/LT respectively), all clients have access to Registered Nursing/Licensed Practical Nursing (RN/LPN), Home Health Aid Basic and Extended (HHA), Registered Nursing – Brief first visit of day and Brief Second or More Visit of Day, and telehealth. The therapy and RN/LPN services are associated with the highest rates and HHA services with the lowest nursing rates since they are provided by a Certified Nursing Aid (CNA). The remaining RN visits services charge less than therapies and RN/LPN but more than HHA, with telehealth having the lowest rate. PDN rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change. Although during the FY 2015-16 Legislative Session, LTHH services received the 0.5% across the board rate increases. The rate increases were assumed to be implemented by July 1, 2015 but that date has been moved to October 1, 2015 due CMS approval delays.

All but one of the services in LTHH are forecasted individually using the average monthly service utilizers, the average units per utilizer and the rate. The rate is assumed to be constant beyond the current year legislative rate increases. Due to the low utilization, telehealth is forecasted by total expenditure.

Although, there rates for HHA Basic and Extended are lower in comparison with the rest of the services in LTHH, the two services account for 68.97% of the expenditure in LTHH. To utilize HHA extended, you must utilized HHA basic and have a need for extended services. Average utilizers per month for HHA Basic and Extended have been steadily increasing since FY 2008-09, and follow a linear path. As such, the Department pegged growth in FY 2015-16, FY 2016-17, and FY 2017-18 for both HHA Basic and Extended average utilizers per month using yearly average growth of 6.79% and 8.15%, respectively. HHA Basic units per utilizer have been slightly positive over time at 1.36% with lesser growth more recently. Consequently, the Department is using the last five years average growth, 0.81%, to forecast units per utilizer for FY 2015-16, FY 2016-17, and FY 2017-18. Unlike HHA Basic, HHA Extended has seen units

per utilizers decrease over time, average yearly growth since FY 2008-09 has been -0.98%. Similar to HHA Basic, the Department is using the average yearly historical growth to forecast HHA Extended for FY 2015-16, FY 2016-17, and FY 2017-18.

RN/LPN accounts for about 15.50% of LTHH utilization and has seen both average monthly utilizers and units per utilizer increase, on average, since FY 2008-09. Average monthly utilizers has been growing linearly since FY 2008-09, given the linear growth the Department chose to use a monthly linear regression to forecast average monthly utilizers for FY 2015-16, FY 2016-17, and FY 2017-18, which equates to about 5.37% growth per year. Units per utilizer have also grown over time, but have growth at about 1.98% per year on average, which is what the Department is using to forecast units per utilizer for FY 2015-16, FY 2016-17, and FY 2017-18.

RN Brief First of Day and RN Brief Second or more account for 4.93% of total expenditure have had positive historical growth for both average monthly utilizers and units per utilizer. For RN Brief First of Day, average monthly client growth has been linear overtime and therefore the Department chose a linear regression to model growth, which has average monthly clients growing by 9.59% in FY 2015-16, 8.75% in FY 2016-17, and 8.04% in FY 2017-18. Units per client growth for RN Brief First of Day has been relatively flat over time, the Department chose the average yearly growth to forecast FY 2015-16, FY 2016-17, and FY 2017-18, .36%. For the Second or more visit of the day, average monthly client growth has been about 12.56% prior to FY 2013-14, where clients decreased 24.34%, but then grew by 21.74% in FY 20147-15. The Department expects average monthly client growth to stabilize back to the average yearly growth prior to the last two fiscal years and used a 12.56% trend to forecast FY 2015-16, FY 2016-17, and FY 2017-18. Much like the First Visit of the Day units per utilizer. The Second or More Visit of the day have been slightly positive and steady since FY 2008-09, growth at 1.30%, which is what the Department is expected growth to be in FY 2015-16, FY 2016-17, and FY 2017-18.

Physical, Occupational, and Speech/Language Therapy accounted for 10.53% of expenditure in FY 2014-15, but with large utilizer growth over the last few years, that share of total expenditure is expected to increase. For both OT and PT, average monthly utilizers spiked in FY 2013-14 and then were cut in half in FY 2014-15. The Department expects average monthly utilizer growth into FY 2015-16, FY 2016-17, and FY 2017-18 to continue to grow, but at average historical rates of 13.51% for OT and 12.96% of PT. S/LT has grown dramatically over the past couple of years, and similar to OT and PT spiked in FY 2013-14 (61.37%) and decreased in FY 2014-15, but not by half (48.21%). The Department expects positive growth to continue along a similar pattern in FY 2015-16, FY 2016-17, and FY 2017-18 at 31.47%, 20.61% and 12.42% respectively. Unit per client growth for all three services has either been flat or decreased over-time. Overtime, S/LT and OT have moved around 55 and 52 units per client, respectively, with both matching those numbers in FY 2014-15. The Department does not expect any unit per client growth in S/LT and OT for FY 2015-16, FY 2016-17, and FY 2017-18. PT units per client, however, have decreased every year, but one, since FY 2008-09, with average yearly growth of -1.65%, which is what the Department chose to forecast units per client FY 2015-16, FY 2016-17, and FY 2017-18.

In the fall of 2015 the Department plans to implement personal care within the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. It is a CMS requirement that clients under the age of 20, and have the medical need, have access to personal care. The

Department expects most utilizers of personal care on waivers to move utilization from waiver personal care to EPSDT personal care. The Department is also expecting clients to substitute out of more costly HHA Basic and Extended and into EPSDT personal care. There is a bottom line adjustment listed under HHA basic for the net impact of implementing EPSDT personal care of about $647,638. The net increase is due to clients having access to personal care, who have a need for it but not a high enough need for HHA, and have never had access before. Once implemented and clients have access, EPSDT personal care will have its own forecast similar to the other services under LTHH, but until then, the net impact is listed under HHA Basic.

Final expenditure estimates for FY 2015-16, FY 2016-17, and FY 2017-18 are produced by multiplying average monthly utilizers by the average units per utilizer by the projected rate for all LTHH services and then summing these figures. The Department is forecasting growth in FY 2015-16 as 8.67%, which is right in line with historic year expenditure growth of 9.36% on average. The trend is increased in the request year to 9.48% and 8.30% in the out-year, which are, again, 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 of 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 changed to a slight negative trend in FY 2011-12 through FY 2013-14, but then grew in FY 2014-15.

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-5 through EH-8 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 2015-16.
- 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 2015-16. 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 2015-16 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2015-16.
- 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 2015-16.
- Of the estimated total reimbursement for claims incurred in FY 2015-16, only a portion of those claims will be paid in FY 2015-16. The remainder is assumed to be paid in FY 2016-17. The Department estimates that 92.48% of claims incurred in FY 2015-16 will also be paid during FY 2015-16. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2015-16.
- During FY 2015-16, the Department will also pay for some claims incurred during FY 2014-15 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2014-15 to calculate an estimate of outstanding claims to be paid in FY 2015-16.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2015-16 prior to adjustments.

[4] For clarity, FY 2015-16 is used as an example. The estimates for FY 2016-17 and FY 2017-18 are based on the estimate for FY 2015-16, and follow the same methodology.

- 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 2015-16, this includes HB 13-1152, which permanently continued the HB 12-1340 rate reduction effective July 1, 2013.
- 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 2015-16, FY 2016-17, and FY 2017-18 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom-line adjustments for FY 2015-16 through FY 2017-18. Please refer to Footnote 6 on page EH-7 for more detail. The estimate for FY 2015-16 is calculated by multiplying the average per diem in FY 2014-15 by the anticipated number of client days in FY 2015-16.
- 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 2015-16, FY 2016-17, and FY 2017-18. 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-7 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-8 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.

- 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. In FY 2014-15, enrollment in the CCT program was slower than anticipated, thereby reducing the amount of potential savings. Consequently, the bottom-line adjustments for FY 2015-16, FY 2016-17, and FY 2017-18 were adjusted down in magnitude. Please see Exhibit G for further explanation on CCT.

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 five 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-6. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2014-15 that will be paid in FY 2015-16 and the percentage of claims incurred in FY 2015-16 that will be paid in FY 2015-16 and subsequent years. The Department applies the same factor to the FY 2016-17 and FY 2017-18 estimates.

The Department uses the IBNR adjustment calculation for the November 2015 Request using paid claims data through June 2015. 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%
February 2015	92.64%
November 2015	92.48%

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 the month of May in 2014 to account for an unexpected drop in patient days.

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 0.9772, indicating that 97.7% of the variance in the data is explained by this model.

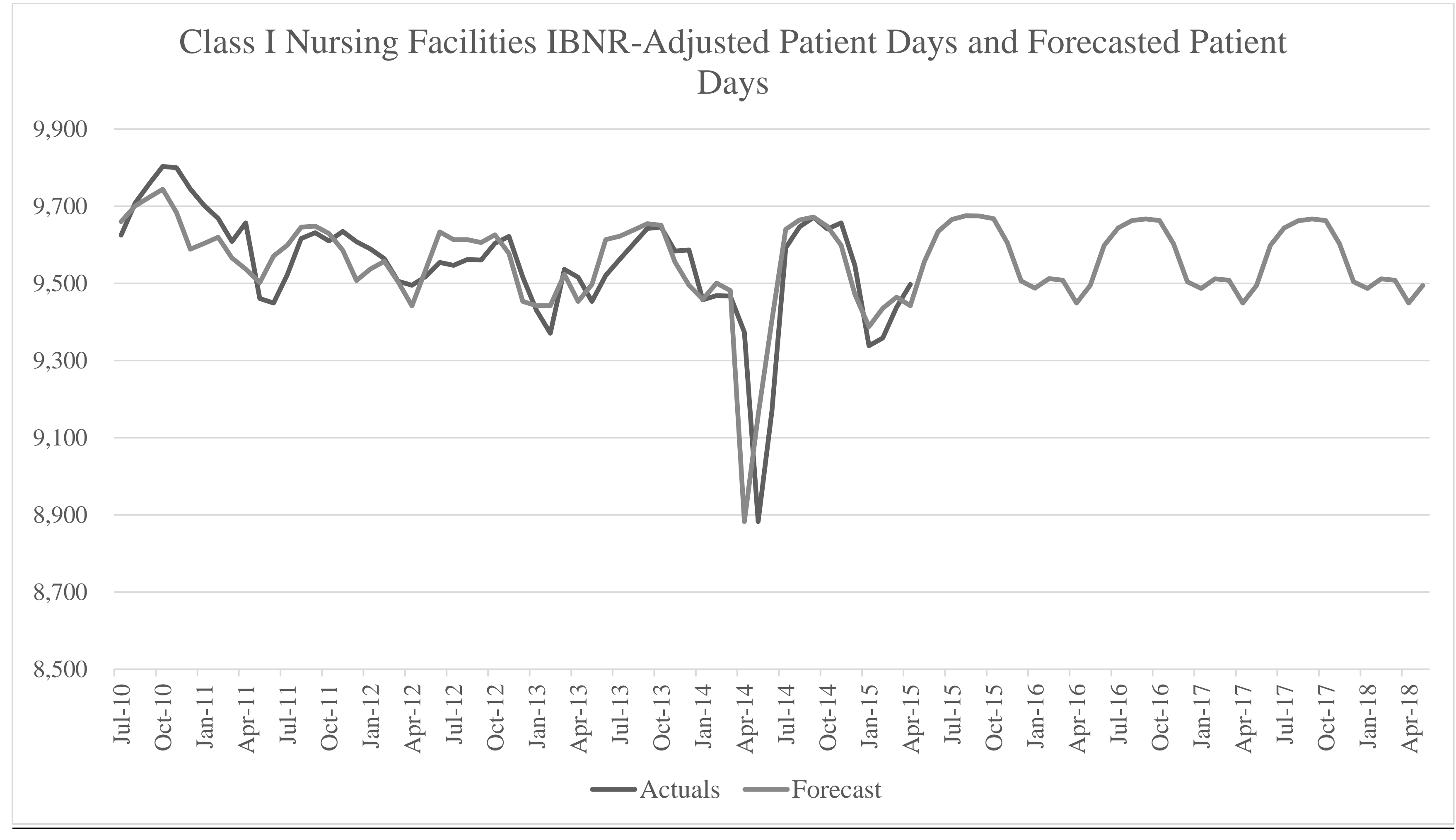
Testing the Overall Predictive Ability of the Model

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. Data from FY 2012-13 and FY 2013-14 had shown a drop in patient days of 0.79% and 0.70%, respectively. However, in the face of an aging population and ever-increasing demand for long-term care services, FY 2014-15 has displayed a return to marginal annual growth in patient days by 0.84%. As such, the Department assumes days will increase slightly in FY 2015-16 through FY 2017-18.


Class I Nursing Facilities IBNR-Adjusted Patient Days and Forecasted Patient Days
9,900
9,700
9,500
9,300
9,100
8,900
8,700
8,500
Jul-10
Oct-10
Jan-11
Apr-11
Jul-11
Oct-11
Jan-12
Apr-12
Jul-12
Oct-12
Jan-13
Apr-13
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Jan-16
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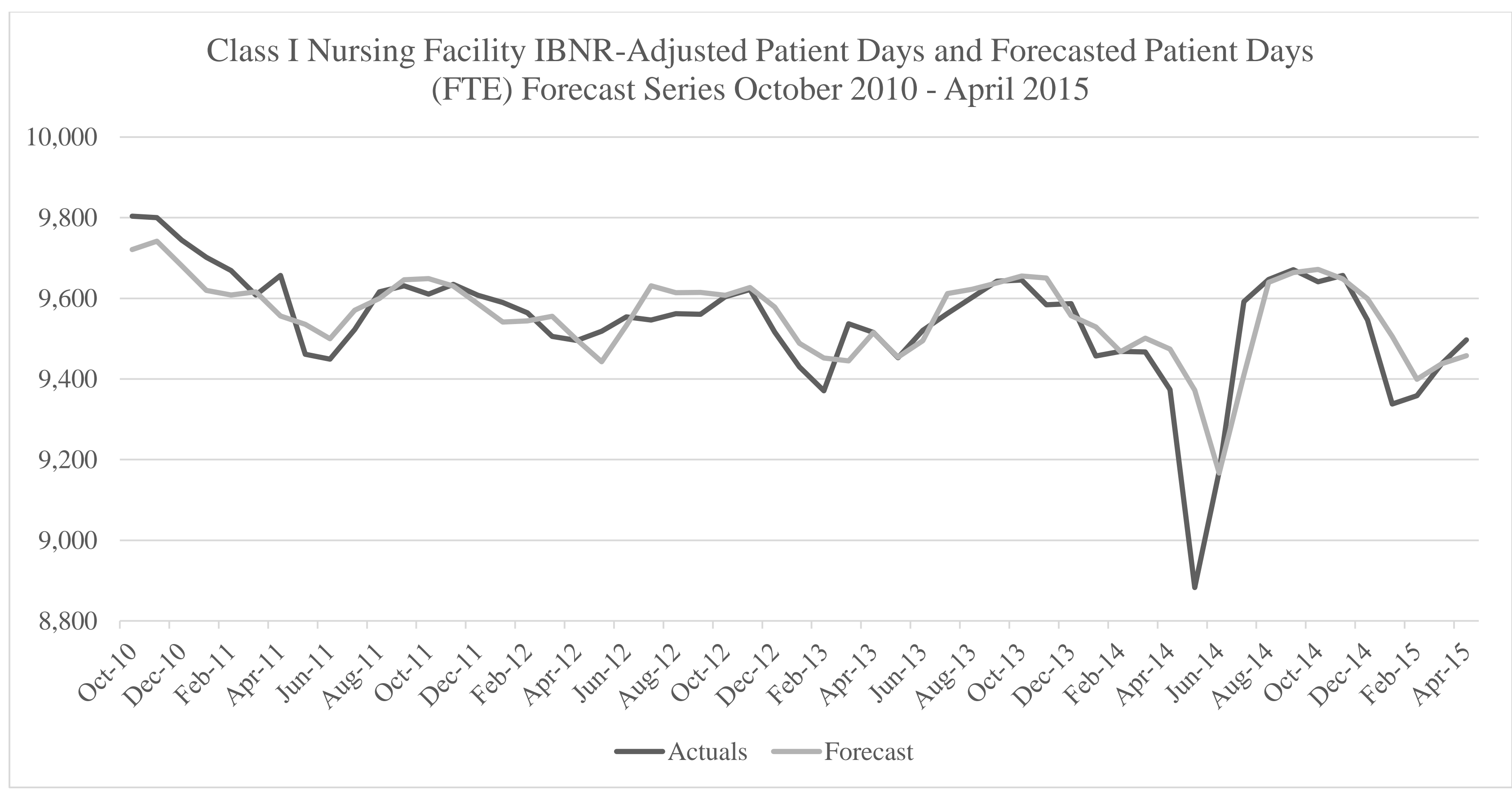
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Actuals
Forecast

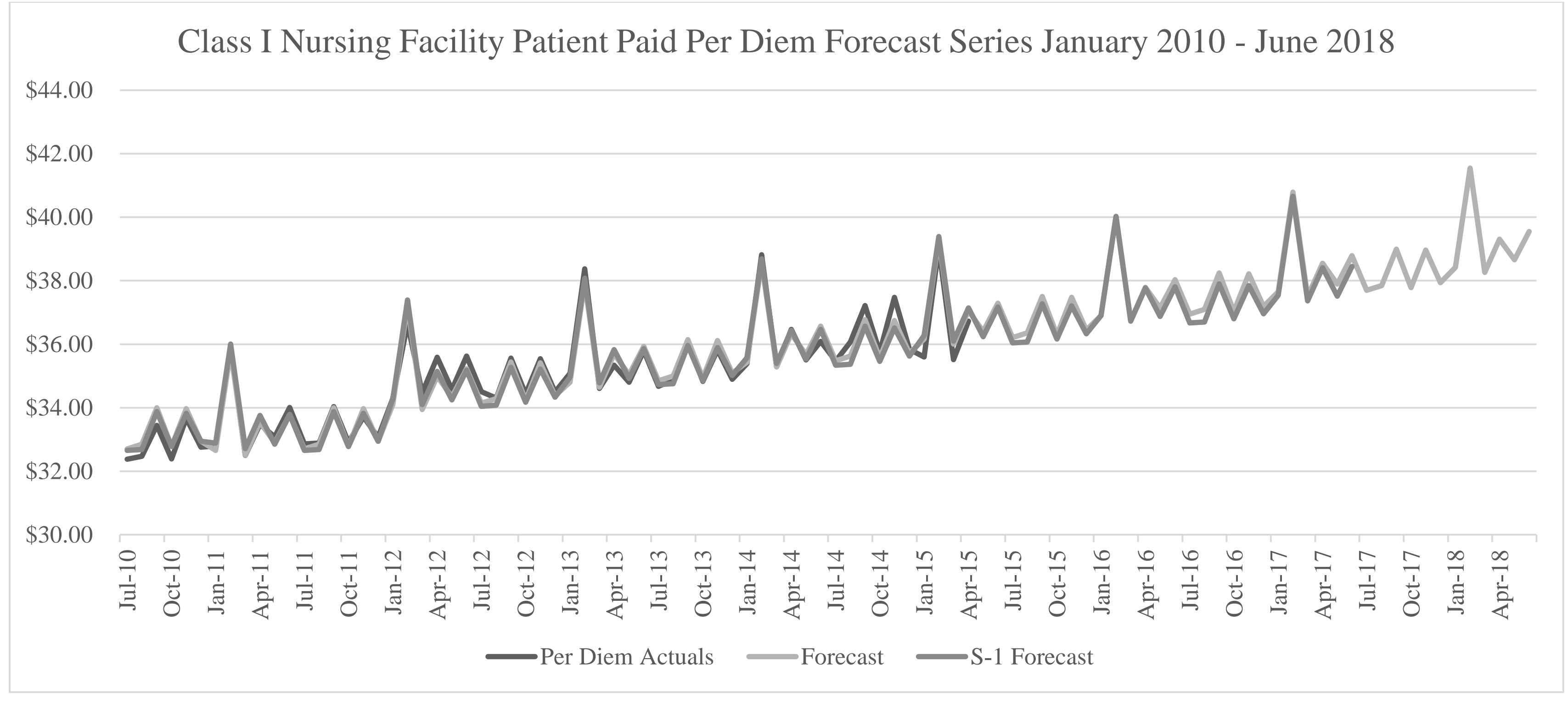
<u>Ex-Post/In-sample Forecasts</u>
Because ex-post/in-sample forecasts usually serve as an additional test of the reasonableness and robustness of forecasts, the Department calculated an in-sample forecast (using the data from July 2010 through April 2015) and compared the results to actual data reported for October 2014 through April 2015. 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 2014 through April 2015. Observed patient days in the end of FY 2013-14 and FY 2014-15 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 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.



<u>Testing the Overall Predictive Ability of the Model</u>

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 0.00000 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 individuals with intellectual 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-1. 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 11.38% for the per-diem rate for FY 2015-16, reducing the rate by half in both 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 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older (OAP-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB). PACE rates are adjusted once per year, generally on January 1 of each year.

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

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

To better forecast expenditure, the Department began providing two new metrics in FY 2008-09: average monthly enrollment and average cost per enrollee. The average monthly enrollment is based on the number of distinct clients for whom capitations were paid to PACE providers in each fiscal year, as determined by claims information from the Medicaid Management Information System (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 2015. The Department anticipates this new facility will begin serving clients during spring of 2016. 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 2015-16, FY 2016-17, and FY 2017-18 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 2014 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 was added to FY 2014-15 of the November 2014 Request, which accounts for an estimate of retroactive payments that would be made in FY 2014-15 for services accrued in FY 2013-14. The systems issues are ongoing, but the Department anticipates that they will follow similar patterns as they have previously. To account for fluctuation due to these systems issues, the Department incorporated enrollment on a date of service basis to inform estimates. This resulted in lower current projections for enrollment than were previously estimated.

Per-enrollee costs for FY 2015-16 are determined by cross-walking the actual FY 2015-16 rates for PACE services with an eligibility-type distribution estimate derived from FY 2015-16 enrollment projections. As such, they only represent an estimate to the extent that eligibility-type and provider distributions for FY 2015-16 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, and the increase in PACE rates for FY 2015-16 of approximately 2% over FY 2014-15 rates. To this end, the Department is projecting moderate growth in cost-per-enrollee figures for FY 2016-17 and FY 2017-18. The rate trend is the average of FY 2008-09 through FY 2014-15 cost-per-enrollee growth (2.43%) 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]

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[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

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%
2015	$407.00	-4.46%	$104.90	0.00%

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 2015-16, the Department inflates the actual expenditure in the second half FY 2014-15 by half the estimated increase in caseload from FY 2014-15 to FY 2015-16 to get the first half expenditure estimate for FY 2015-16. For the second half of FY 2015-16, the Department inflates the first half expenditure by half of the caseload growth along with the anticipated growth in Medicare Part B Premiums. The total estimated expenditure for FY 2015-16 is the sum of the first half actual expenditure and the second half estimated expenditure.

To forecast FY 2016-17, the Department first inflates the estimated expenditure from the second half of FY 2015-16 by half the estimated caseload trend for FY 2016-17 as reported in Exhibit B. This figure represents the approximate expenditure for the first half of FY 2016-17. Then, the Department inflates the estimated first half expenditure by half the estimated caseload trend for FY 2016-17 and the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2016-17 is the sum of the first half and second half estimates. The forecast of FY 2017-18 expenditure utilizes the same methodology as the forecast of FY 2016-17.

The Department is currently monitoring the CY 2016 increase to Medicare premiums. Due to rising healthcare costs, premiums are set to rise, but there are varying reports on what that could be. Reports suggest that premiums could rise as much as 52% in 2016, but the Department should have a better idea in mid-November. Should the premiums rise that much, a substantial revision would be required for the General Fund impact.

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 the past, 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.

Beginning with the November 2014 Request, contrary to previous budget submissions where the Department examined per capita growth trends to forecast the HIBI budget and the February 2014 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 2014 Request calculations for the Health Insurance Buy-In Program, but, beginning with the November 2014 Request, 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 2015-16 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 2015-16. 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 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 2015-16, the Department's projection uses the total base contracts amount, which is the current amount allocated to SEPs in the FY 2015-16 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds legislative impacts (see below). For the request and out-year, the Department uses HCBS waiver enrollment growth to project SEP expenditure growth and the projection uses the total waiver enrollment forecast and the number of clients utilizing services in FY 2014-15 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 2015-16 through FY 2017-18, 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 2015-16, FY 2016-17, and FY 2017-18 expenditures are affected only by caseload and bottom line impacts. Currently, no bottom line impacts affect this forecast.

Accountable Care Collaborative

In FY 2010-11, the Department implemented the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Collaborative Care 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.

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 745,000 by December 2014. 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 $3,250,000 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.

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. Two policy changes took place in fall of 2014 that impact the expected administrative payments for FY 2014-15 and future years. The first, which began September 2014, is a $0.50 reduction in the base PMPM for RCCOs. These funds would be spent in the following fiscal year as incentive payments to PCMPs. The second, which began October 2014, is that RCCOs would only be paid 65% of their PMPM for clients who have been unattributed to a PCMP for at least six consecutive months. These funds would be spent in the

following fiscal year as incentive payments to RCCOs that meet predetermined benchmarks. For this reason, administrative payments for the ACC were lower in FY 2014-15 than previously anticipated, as some portion of these payments were moved to the following fiscal year in an ongoing process.

Enrollment in the ACC grew at a high rate between FY 2012-13 and FY 2014-15, due to Medicaid expansion and the enrollment of clients who were eligible for Medicaid prior to expansion, but not enrolled previously.

Accountable Care Collaborative: Medicare-Medicaid Program (ACC:MMP)

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 ACC exhibit. The bottom-line impact in Exhibit I has been updated in this request to remove the impact of funding that is 100% federal grant funding from the budget.

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 a bottom-line impact for the implementation of the ACC:MMP, as detailed above.

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).

Currently, there are no prepaid inpatient health plans, as Rocky Mountain Health Plans ended in November of 2014. The exhibit contains historical information only.

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 began on September 1, 2014 and focuses on clients in certain counties within the state. As part of Rocky Mountain Health Plans' proposal, the pilot disenrolled clients in the prepaid inpatient health plan and enroll clients into this pilot, an at-risk health maintenance organization paid through monthly capitation payments. Administration fees associated with Rocky Mountain Health Plans still apply in FY 2014-15, but have been removed for FY 2015-16 through FY 2017-18.

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.

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 had funded this population up to 100% FPL in the interim before the Affordable Care Act's 100% enhanced federal match began and the population expanded to 133% FPL on January 1, 2014. Beginning January 1, 2017, the enhanced federal match falls to 95%, and on January 1, 2018, it falls to 94%.

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 populations.

For caseload estimates and methodology, please see the Acute Care section 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 had funded this population in the interim before the population expanded and the enhanced federal match began on January 1, 2014. Beginning January 1, 2017, the enhanced federal match falls to 95%, and on January 1, 2018, it falls to 94%.

To project caseload for this population, the Department originally 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 originally assumed 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.

Currently, the Department uses historical actuals as a basis for projecting both caseload and per capita costs for this population.

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, with the approval of a resource proxy for the non-newly eligibles, 75% of expenditures receive expansion FMAP while the remaining 25% receive the standard FMAP, funded from the Hospital Provider Fee Fund. The Department has incorporated the resource proxy in this request.

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. The large decrease since the November Request is due to changes in the hospital provider fee model based on lower than expected revenue to be collected in the current fiscal year.

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.

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 Operations Resource Engine (CORE) 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.

Effective with the February 2015 Budget Request, the Department has restated historical actuals for FY 2013-14 to account for continuous eligibility for children. The Department also restated historical actuals for FY 2013-14 to correct for a technical error that incorrectly split dollars spent for Pharmacy and Health Maintenance Organizations between the Eligible Children and SB 11-008 Eligible Children categories, and between the MAGI Pregnant Adults and SB 11-250 Eligible Pregnant Adults categories.

Effective with the November 2015 Budget Request, the Department has broken the Home Health service under Acute Care into two separate services: Acute Home Health, which remains under Acute Care, and Long-Term Home Health, which is now under Community-Based Long-Term Care.

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2002-03 through FY 2014-15 final actual expenditures are included in this Budget Request for historical purpose and comparison.

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

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

This exhibit displays the FY 2014-15 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2014-15 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 2014-15, FY 2015-16 and FY 2016-17 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.

EXHIBIT Q – TITLE XIX AND TITLE XXI TOTAL COST OF CARE

Effective with the November 1, 2014 Budget Request, the Department included a new exhibit detailing the total cost of Medicaid services, including lines outside of Medical Services Premiums, such as service expenses for Medicaid Behavioral Health, the Office of Community Living, Medicaid-funded DHS services, and CHP+, separating Title XIX and Title XXI fund sources, to show the total services cost of providing care to clients. This exhibit also includes a total cost of care per capita exhibit for these combined services, including both Title XIX expenditure and Title XXI expenditure, by eligibility category.

EXHIBIT R – FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

Effective with the November 2015 Budget Request, the Department included a new exhibit calculating expected FMAP for the current year, the request year, and the out year. CMS calculates FMAP using Bureau of Economic Analysis (BEA) personal income data and population data for the United States and each state. FMAP is calculated using the following formula:

$$FMAP_{state} = 1 - ((\text{Per capita income}_{state})^2/(\text{Per capita income}_{U.S.})^2 * 0.45)$$

where per capita incomes are based on a rolling three-year average and the FMAP for a given year is taken from the calculation from two years prior.

Due to the nature of this calculation, federal fiscal year FMAP for 2015-16 is calculated using data for calendar year 2013 at the latest. Therefore, FY 2015-16 and FY 2016-17 FMAP estimates are both calculated using historical data from the BEA. These FMAP calculations would only change if the BEA restates its historical data, which can sometimes occur. The FY 2017-18 FMAP estimate is based on data through calendar year 2015, which is not complete. The estimates for personal income come from the legislative council’s most recent estimates for the U.S. and Colorado, and the population estimates come from the U.S. census for U.S. data and the Department of Local Affair’s most recent estimates for Colorado.

Forecasts throughout this request use these FMAP estimates rather than holding FMAP constant in the request and out years, as was previously done.

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 2015-16 Budget Cycle Requests

This section describes the impact from legislation passed during the 2015 Legislative Session and includes impacts from the Department's FY 2015-16 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

SB 15-234 – FY 2015-16 Long Bill

The FY 2015-16 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2015 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.

- R-7 (FY 2015-16) Participant Directed Programs Expansion: The Department was approved funding to expand Consumer Directed Support Services (CDASS) to the Supported Living Services waiver. Savings to Community-Based Long-Term Care (CBLTC) result from clients substituting long-term home health for the health maintenance component of CDASS on the waiver, decreasing CBLTC expenditure by $1,251,123 in FY 2015-16.
- R-12 (FY 2015-16) Community Provider Rate Increases: The Department was approved funding to increase eligible provider rates 0.50% across the board. This is expected to increase expenditures by $14,394,125 in FY 2015-16. For some services, the expected increase in expenditure is different from appropriation due to the need for a State Plan Amendment and approval from CMS resulting in delays in the start date of the increase.
- R-12 (FY 2015-16) Targeted Community Provider Rate Increase: The Department was approved funding for the purpose of addressing issues with client access to cost-effective services. The separate components of the rate increase are broken out in Exhibit F and Exhibit G. The total impact of the targeted rate increases is $53,038,256 in FY 2015-16. For some services, the expected increase in expenditure is different from appropriation due to the need for a waiver or State Plan Amendment and approval from CMS resulting in delays in the start date of the increase.
- FY 2015-16 JBC Action, Raising the Cap on Home Modifications: The JBC increased the cap on home modifications during the 2015 Legislative Session. The Department is still awaiting CMS approval for this increase, resulting in a delay. The Department

expects this increase to go into effect by December 1, 2015. Therefore, the FY 2015-16 impact has been adjusted from the appropriation and is expected to be $387,948.

HB 15-1186 Children with Autism Waiver

HB 15-1186 reduces the wait list for the Children with Autism waiver, and also extends the maximum age from six years old to eight years old and guarantees three years of service once a child is on the waiver. This would help ensure that clients do not age out of the waiver before they are on the waiver. The bill would also allow for the use of General Fund to cover CWA services after the Autism Treatment Fund is exhausted. To comply with this bill, the Department requires a Waiver Amendment, which must be approved by CMS. On September 14, 2015, the expansion of the waiver was denied by CMS. CMS requested that behavioral therapies for children with autism be instead provided through the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program. The Department plans on transitioning clients receiving services from the waiver to EPSDT over the next few years.

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, was paid for by the federal government through an enhanced federal medical assistance percentage (FMAP). The increased FMAP rate applied 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.

This program ended December 31, 2014. Consequently, the bottom line impact in Acute Care, Exhibit F for FY 2015-16 accounts for the annualization of this program's funding, as 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 average monthly enrollment level of 704,702 for the first half of 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 Collaborative Care Organizations (RCCOs), the Primary Care Medical Providers (PCMPs), and the Statewide Data and Analytics Contractor (SDAC), which are outlined below.

The 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.

The 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 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.

Two new policy changes began in fall of FY 2014-15; a $0.50 base reduction for PMPM for RCCOs began in September 2014, and a 35% reduction in PMPM for clients who are unattributed to a PCMP for six consecutive months began in October 2014. The reduction in funding would be paid out the following fiscal year as an incentive payment to PCMPs for the former and to the RCCOs for the latter.

The chart below shows program expenditure and estimated savings for FY 2015-16, FY 2016-17, and FY 2017-18. RCCO administrative payments include the reductions attributable to the policy changes mentioned above.

Accountable Care Collaborative Expenditure and Assumed Savings

Service Category		FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Program Administration (Exhibit I, PIHP)	**SDAC**	$2,902,500	$2,950,000	$2,508,950	$3,000,000	$1,000,000	$0
	RCCO	$27,696,161	$52,945,462	$79,471,841	$106,868,808	$118,744,642	$126,294,758
	PCMP	$6,130,270	$12,674,868	$21,419,450	$31,516,838	$34,197,830	$36,296,507
	Total Administration	**$36,728,931**	**$68,570,330**	**$103,400,241**	**$141,385,646**	**$153,942,472**	**$162,591,265**
Program Savings (Exhibit F, Acute)	**Total**	**($43,647,968)**	**($98,000,000)**	**($141,062,535)**	**($187,998,320)**	**($205,932,406)**	**($209,290,827)**
	Incremental[(1)]	**($23,031,424)**	**($50,147,776)**	**($43,062,535)**	**($46,935,785)**	**($17,934,086)**	**($3,358,421)**
Net ACC Program Fiscal Impact			**($29,429,670)**	**($37,662,294)**	**($46,612,674)**	**($51,989,934)**	**($46,699,562)**

(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 $3,750,939 in FY 2015-16, $2,818,297 in FY 2016-17, and $2,834,700 in FY 2017-18.

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 that impact the current budget are as follows:

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 2015, there were 509 clients enrolled in HIBI. The Department assumes approximately 2% enrollment growth per month through FY 2017-18.

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 2014-15 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 2015-16 through FY 2017-18.

FY 2015-16 through FY 2017-18 Total HIBI Impact from SB 10-167

Item	FY 2015-16	FY 2016-17	FY 2017-18
Provider Payment	$196,862	$247,542	$311,930
Premiums Payment	$1,358,903	$1,708,739	$2,153,200
Total Savings (Realized in Acute Care)	($2,523,677)	($3,173,373)	($3,998,800)
Incremental Savings for Bottom-Line Impact in Exhibit F	($475,058)	($649,696)	($825,427)
Total Impact	**($785,712)**	**($967,912)**	**($1,217,092)**

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. Do rate issue for transition coordination agencies described in the narrative for CCT enrollment has stalled and CCT costs and cumulative nursing facility costs avoided have decreased. The Department estimates the total impact to Medical Services Premiums to be $4,496,326 total funds costs avoided in FY 2015-16, $6,589,611 costs avoided in FY 2016-17, and $9,042,847 costs avoided in FY 2017-18. 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 early 2016, full implementation of this reduction cannot be implemented. Full implementation is noted in FY 2016-17 with an additional reduction of $1,704,632.
- *Augmentative Communication Devices:* The Department's efforts to provide new, less expensive communication assistance technology for clients with disabilities impairing their ability to communicate met with initial difficulties that have since been resolved, though the program's full implementation was delayed. The adjustment of negative $423,262 in FY 2015-16 accounts for the annualization of the delayed implementation as the Department resolved these issues.

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 2014-15 R-7: 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. The annualization of this policy is expected to decrease expenditure by $2,072,134 in FY 2015-16.

FY 2014-15 R-8: Developmental Disabilities New Full Program Equivalents

The Department was approved funding to allow for emergency enrollments, youth transitions, and de-institutionalizations onto the DD waiver. This has been combined with the adjustment for HB 14-1252 as both would increase enrollment on the DD waiver but the Department is unable to disentangle the two policies when new clients are enrolled. 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 HBCS-CES waiver programs that was used to rebalance over-expenditure in the HBCS-SLS waiver program. The request included 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 annualization of these policies is expected to decrease expenditure by $619,388 in FY 2015-16.

FY 2014-15 R-9: Medicaid Community Living Initiative

The Department was approved funding for counseling nursing home residents regarding community-based living options. The impact of this policy is primarily in the base budget now; the annualization is expected to increase expenditure by $5,994 in FY 2015-16.

FY 2014-15 R-10: 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, resulting in savings through better management of medical conditions and proper use of specialty care. The software necessary for the implementation of this policy was delayed, and a test group of providers will be enrolled to test the software in fall of 2015. Due to this, the impact of this policy has also been delayed. This is expected to decrease expenditures by $86,994 in FY 2015-16.

FY 2014-15 R-11: 2% Community Provider Rate Increase

The Department increased provider rates for eligible services by 2.00% across the board. The annualization of these rate increases is expected to increase expenditures by $5,321,323in FY 2015-16.

FY 2014-15 R-11: Targeted Provider Rate Increases

The Department increased targeted provider rates for services identified as having rates that impacted client access to cost-effective services. The separate components of the rate increases are broken out in Exhibit F and Exhibit G. The annualization of these rate increases is expected to increase expenditures by $1,447,494 in FY 2015-16.

FY 2014-15 BA-10: Continuation of the "1202 Provider Rate Increase"

The Department continued the rate increases that were included in section 1202 of the Health Care and Education Reconciliation Act that required that states pay for primary care services at 100% of Medicare rates, through June 30, 2016. The annualization of this policy is expected to be an increase of $66,392,695 in FY 2015-16.

FY 2014-15 BA-12: State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees

The Department enrolled clients dually eligible for Medicaid and Medicare in the Accountable Care Collaborative (ACC) so that they can receive care coordination, reducing duplicative use of services. The annualization of this program is expected to decrease expenditure by $5,174,136 in FY 2015-16.

FY 2014-15 JBC Actions:

- *Matching Incentives to Ambulatory Surgery Center Facilities*
  The 2014 Long Bill included funding to match payments made to ambulatory surgery center facilities to payments made to surgeons accounted for with the FY 2014-15 R-11 Targeted Community Provider Rate Increases. The annualization of this policy is expected to increase expenditures by $148,148 in FY 2015-16.
- *Family Planning Rate Increase*
  The 2014 Long Bill included funding for the Department to standardize rates for oral contraceptives, as well as a 15% rate increase for family planning services. The annualization of this policy is expected to increase expenditures by $165,207 in FY 2015-16.
- *Raising Federally Qualified Health Center (FQHC) Rates to APM*

The 2014 Long Bill included funding to increase rates to FQHCs to Colorado's Alternative Payment Method. The annualization of this policy is expected to increase expenditures by $660,159 in FY 2015-16.

- *Full Denture Benefit*
  The 2014 Long Bill included funding for the Department to provide full dentures as part of the Adult Dental Benefit established in SB 13-242. The annualization of this policy is expected to increase expenditures by $2,228,156 in FY 2015-16.
- *2% Hospice Rate Increase*
  The 2014 Long Bill included funding for the Department to increase Hospice rates by 2%, in line with the across the board rate increase for other services with the FY 2014-15 R-11 Community Provider Rate Increases. The annualization of this policy is expected to increase expenditures by $12,221 in FY 2015-16.

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 ensures 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 comes from the Breast and Cervical Cancer Prevention and Treatment Fund. All Breast and Cervical Cancer Program expenditures receive a 65.55% federal match rate in FY 2015-16. See Exhibit F for more information on the fiscal impact of this bill.

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.

Because the impact of this bill and the Department's FY 2014-15 R-8 Developmental Disabilities Full Program Equivalents request are difficult to disentangle from one another, the bottom-line impact for this bill and the FY 2014-15 R-8 have been combined. Please see the FY 2014-15 R-8 description on page 88 for the dollar impact of these two changes.

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

HB 14-1357 made several changes to in-home support services (IHSS) provided by the Department. This bill allowed IHSS to be provided inside the home or within the community, added spouses as an eligible family member to act as an attendant providing IHSS to an HCBS waiver client, allowed eligible clients or their representative the ability to determine the amount of oversight needed, allowed family members to be reimbursed for providing IHSS, expanded IHSS to clients receiving services through the Spinal Cord Injury

waiver, and added IHSS to the list of services under the Elderly, Blind, and Disabled waiver program. Implementation of these program changes is awaiting approval from CMS and is expected to increase expenditure by $496,643 in FY 2015-16.

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Exhibit A - Summary of Request

Calculation of Request

FY 2015-16

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2015-16 Appropriation						
FY 2015-16 Long Bill Appropriation (SB 15-234)	$6,584,363,560	$967,942,644	$848,124,468	$698,756,395	$0	$4,069,540,053
HB 15-1186 "Children with Autism Waiver Expansion"	$10,205,160	$164,846	$0	$4,840,203	$0	$5,200,111
HB 15-1309 "Protective Restorations by Dental Hygenists"	$11,217	$4,515	$0	$690	$0	$6,012
SB 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine"	$250,547	$123,295	$0	$0	$0	$127,252
FY 2015-16 Total Spending Authority	**$6,594,830,484**	**$968,235,300**	**$848,124,468**	**$703,597,288**	**$0**	**$4,074,873,428**
Total Projected FY 2015-16 Expenditure	$6,801,990,609	$1,006,105,053	$848,124,468	$819,261,032	$0	$4,128,500,056
FY 2015-16 Requested Change from Appropriation	**$207,160,125**	**$37,869,753**	**$0**	**$115,663,744**	**$0**	**$53,626,628**
Percent Change	3.14%	3.91%	0.00%	16.44%	0.00%	1.32%

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	$6,594,830,484	$968,235,300	$848,124,468	$703,597,288	$0	$4,074,873,428
Bill Annualizations						
Annualization of Long Bill FY 2015-16 (SB 15-234)	($59,260,774)	($26,398,604)	$0	$1,263,468	$0	($34,125,638)
SB 11-177 Annualization "Sunset Teen Pregnancy & Dropout Program"	($183,897)	$32,490	$0	($25,022)	$0	($191,365)
HB 15-1186 Annualization "Children with Autism Waiver Expansion"	$8,029,482	$8,269,243	$0	($4,331,637)	$0	$4,091,876
HB 15-1309 Annualization "Protective Restorations by Dental Hygenists"	$12,620	$5,160	$0	$690	$0	$6,770
SB 15-011 Annualization "Pilot Program Spinal Cord Injury Alternative Medicine"	$18,823	$9,451	$0	$0	$0	$9,372
Total Annualizations	($51,383,746)	($18,082,260)	$0	($3,092,501)	$0	($30,208,985)
FY 2016-17 Total Spending Authority	**$6,543,446,738**	**$950,153,040**	**$848,124,468**	**$700,504,787**	**$0**	**$4,044,664,443**
Total Projected FY 2016-17 Expenditure	$6,603,727,556	$1,091,855,459	$848,124,468	$669,522,464	$0	$3,994,225,165
FY 2016-17 Requested Change from Appropriation	**$60,280,818**	**$141,702,419**	**$0**	**($30,982,323)**	**$0**	**($50,439,278)**
Percent Change	0.92%	14.91%	0.00%	-4.42%	0.00%	-1.25%

Calculation of Request

FY 2017-18

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2016-17 Appropriation Plus Special Bills	$6,543,446,738	$950,153,040	$848,124,468	$700,504,787	$0	$4,044,664,443
Bill Annualizations						
Annualization of Long Bill FY 2015-16 (SB 15-234)	($7,748,597)	($3,169,176)	$0	$0	$0	($4,579,421)
SB 15-011 Annualization "Pilot Program Spinal Cord Injury Alternative Medicine"	($23,515)	$12,996	$0	($5,004)	$0	($31,507)
Total Annualizations	($7,772,112)	($3,156,180)	$0	($5,004)	$0	($4,610,928)
FY 2017-18 Total Spending Authority	**$6,535,674,626**	**$946,996,860**	**$848,124,468**	**$700,499,783**	**$0**	**$4,040,053,515**
Total Projected FY 2017-18 Expenditures	$6,847,388,506	$1,209,165,645	$848,124,468	$714,548,129	$0	$4,075,550,264
FY 2017-18 Requested Change From Appropriation	**$311,713,880**	**$262,168,785**	**$0**	**$14,048,346**	**$0**	**$35,496,749**
Percent Change	4.77%	27.68%	0.00%	2.01%	0.00%	0.88%

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	$2,165,818,719	$1,065,799,392	$0	$0	$1,100,019,327	50.79%	
Breast and Cervical Cancer Program	$3,657,778	$0	$1,260,105	$0	$2,397,673	65.55%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
Family Planning	$12,111,051	$1,211,105	$0	$0	$10,899,946	90.00%	CF: Local Funds
Indian Health Service	$3,439,350	$0	$0	$0	$3,439,350	100.00%	
Affordable Care Act Drug Rebate Offset	($17,694,876)	$0	$0	$0	($17,694,876)	100.00%	
Affordable Care Act Preventive Services	$49,962,440	$24,086,892	$0	$0	$25,875,548	51.79%	
SB 11-008: "Aligning Medicaid Eligibility for Children"	$84,211,584	$14,484,392	$0	$0	$69,727,192	82.80%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$16,519,607	$2,841,372	$0	$0	$13,678,235	82.80%	
MAGI Parents/Caretakers to 133% FPL	$198,461,286	$0	$0	$0	$198,461,286	100.00%	100% FFP January 1, 2014
MAGI Adults	$1,114,224,454	$0	$0	$0	$1,114,224,454	100.00%	100% FFP January 1, 2014
Disabled Buy-In	$28,540,089	$0	$15,460,745	$0	$13,079,344	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$29,338,412	$0	$3,608,625	$0	$25,729,787	87.70%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$28,908,266	$0	$14,225,758	$0	$14,682,508	50.79%	CF: Hospital Provider Fee Fund
Adult Dental Benefit Financing	$47,161,557	$0	$23,144,878	$0	$24,016,679	Variable	CF: Adult Dental Fund
Acute Care Services Sub-Total	$3,764,659,717	$1,108,423,153	$57,700,111	$0	$2,598,536,453		
Community Based Long-Term Care Services							
Base Long-Term Services & Supports	$750,402,588	$369,273,114	$0	$0	$381,129,474	50.79%	
Children with Autism Waiver Services	$7,434,525	$0	$3,658,530	$0	$3,775,995	50.79%	CF: Colorado Autism Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$819,486	$140,951	$0	$0	$678,535	82.80%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$0	$0	$0	$0	$0	82.80%	
MAGI Parents/Caretakers to 133% FPL	$399,844	$0	$50,820	$0	$349,024	87.29%	Waivers Services Standard Match; PDN/LTHH 100% FFP January 1, 2014
MAGI Adults	$5,878,006	$0	$691,254	$0	$5,186,752	88.24%	Waivers Services Standard Match; PDN/LTHH 100% FFP January 1, 2014
Disabled Buy-In	$4,538,984	$0	$2,458,860	$0	$2,080,124	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$835,556	$0	$102,773	$0	$732,783	87.70%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$139,058	$0	$68,430	$0	$70,628	50.79%	CF: Hospital Provider Fee Fund
Community Based Long-Term Care Services Sub-Total	$770,448,047	$369,414,065	$7,030,667	$0	$394,003,315		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$593,076,455	$291,852,924	$0	$0	$301,223,531	50.79%	
Class II Nursing Facilities	$4,764,670	$2,344,694	$0	$0	$2,419,976	50.79%	
PACE	$133,853,042	$65,869,082	$0	$0	$67,983,960	50.79%	
Supplemental Medicare Insurance Benefit (SMIB)	$148,443,165	$85,725,928	$0	$0	$62,717,237	50.00%	Approximately 15.5% of Total is State-Only
Health Insurance Buy-In	$1,555,764	$765,591	$0	$0	$790,173	50.79%	
MAGI Parents/Caretakers to 133% FPL	$41,128	$0	$0	$0	$41,128	100.00%	100% FFP January 1, 2014
MAGI Adults	$1,092,038	$0	$0	$0	$1,092,038	100.00%	100% FFP January 1, 2014
Disabled Buy-In	$154,878	$0	$83,900	$0	$70,978	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$1,207,565	$0	$148,530	$0	$1,059,035	87.70%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$11,838	$0	$5,825	$0	$6,013	50.79%	CF: Hospital Provider Fee Fund
Long-Term Care and Insurance Sub-Total	$884,200,543	$446,558,219	$238,255	$0	$437,404,069		
Service Management							
Base Service Management	$33,174,147	$16,587,073	$0	$0	$16,587,074	50.00%	
Accountable Care Collaborative	$93,727,525	$46,123,315	$0	$0	$47,604,210	50.79%	
Tobacco Quit Line	$828,769	$0	$407,837	$0	$420,932	50.79%	CF: Tobacco Education Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$7,511,607	$1,291,996	$0	$0	$6,219,611	82.80%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$164,217	$28,245	$0	$0	$135,972	82.80%	
MAGI Parents/Caretakers to 133% FPL	$9,169,475	$0	$0	$0	$9,169,475	100.00%	100% FFP January 1, 2014
MAGI Adults	$32,599,883	$0	$0	$0	$32,599,883	100.00%	100% FFP January 1, 2014
Disabled Buy-In	$319,253	$0	$172,946	$0	$146,307	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$115,620	$0	$14,221	$0	$101,399	87.70%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$1,110,900	$0	$546,674	$0	$564,226	50.79%	CF: Hospital Provider Fee Fund
Service Management Sub-Total	$178,721,396	$64,030,629	$1,141,678	$0	$113,549,089		
FY 2015-16 Estimate of Total Expenditures for Medical Services to Clients	**$5,598,029,703**	**$1,988,426,066**	**$66,110,711**	**$0**	**$3,543,492,926**		
Financing							
Upper Payment Limit Financing	$3,930,874	($4,077,498)	$3,930,874	$0	$4,077,498	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($19,507,116)	$48,177,615	$0	($28,670,499)	59.51%	CF: Department Recoveries
Denver Health Outstationing	$6,964,536	$3,482,268	$0	$0	$3,482,268	50.00%	
Hospital Provider Fee Supplemental Payments	$1,086,400,000	$0	$534,600,000	$0	$551,800,000	50.79%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$95,278,525	$0	$46,886,562	$0	$48,391,963	50.79%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$8,831,734	($464,828)	$4,648,281	$0	$4,648,281	Variable	CF: Certification of Public Expenditure
Memorial Hospital High Volume Payment	$555,237	$0	$277,618	$0	$277,619	50.00%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($64,834,091)	$64,834,091	$0	$0	N/A	CF: Health Care Expansion Fund
Intergovernmental Transfer for Difficult to Discharge Clients	$2,000,000	$0	$1,000,000	$0	$1,000,000	50.00%	CF: Intergovernmental Transfer
Cash Funds Financing[1]	$0	($48,795,280)	$48,795,280		$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$1,203,960,906	($134,196,545)	$753,150,321	$0	$585,007,130		
Total Projected FY 2015-16 Expenditures[2]	**$6,801,990,609**	**$1,854,229,521**	**$819,261,032**	**$0**	**$4,128,500,056**		

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, $848,124,468 is General Fund Exempt.

Exhibit A - Summary of Request

Calculation of Fund Splits FY 2016-17							
Item	**Total Request**	**General Fund and General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP [3]**	**Notes**
Acute Care Services							
Base Acute	$2,153,310,877	$1,067,611,533	$0	$0	$1,085,699,344	50.42%	
Breast and Cervical Cancer Program	$1,903,368	$0	$660,659	$0	$1,242,709	65.29%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
Family Planning	$12,817,125	$1,281,712	$0	$0	$11,535,413	90.00%	CF: Local Funds
Indian Health Service	$3,683,888	$0	$0	$0	$3,683,888	100.00%	
Affordable Care Act Drug Rebate Offset	($20,204,009)	$0	$0	$0	($20,204,009)	100.00%	
Affordable Care Act Preventive Services	$49,356,148	$23,977,217	$0	$0	$25,378,931	51.42%	
SB 11-008: "Aligning Medicaid Eligibility for Children"	$87,502,055	$10,246,491	$0	$0	$77,255,564	88.29%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$16,477,397	$1,929,503	$0	$0	$14,547,894	88.29%	
MAGI Parents/Caretakers to 133% FPL	$199,817,846	$0	$4,995,446	$0	$194,822,400	97.50%	100% FFP January 1, 2014
MAGI Adults	$1,155,557,734	$0	$28,888,943	$0	$1,126,668,791	97.50%	100% FFP January 1, 2014
Disabled Buy-In	$31,808,879	$0	$17,422,988	$0	$14,385,891	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$30,967,820	$0	$4,419,108	$0	$26,548,712	85.73%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$30,443,583	$0	$15,093,928	$0	$15,349,655	50.42%	CF: Hospital Provider Fee Fund
Adult Dental Benefit Financing	$49,168,127	$0	$24,301,807	$0	$24,866,320	Variable	CF: Adult Dental Fund
Acute Care Services Sub-Total	$3,802,610,838	$1,105,046,456	$95,782,879	$0	$2,601,781,503		
Community Based Long-Term Care Services							
Base Community Based Long-Term Care	$831,686,291	$412,350,063	$0	$0	$419,336,228	50.42%	
Children with Autism Waiver Services	$19,791,616	$7,132,446	$2,680,237	$0	$9,978,933	50.42%	CF: Colorado Autism Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$899,670	$105,351	$0	$0	$794,319	88.29%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$0	$0	$0	$0	$0	88.29%	
MAGI Parents/Caretakers to 133% FPL	$428,463	$0	$64,912	$0	$363,551	84.85%	Waivers receive standard match; CF: Hospital Provider Fee Fund
MAGI Adults	$6,260,042	$0	$891,430	$0	$5,368,612	85.76%	Waivers receive standard match; CF: Hospital Provider Fee Fund
Disabled Buy-In	$5,206,384	$0	$2,851,744	$0	$2,354,640	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$889,840	$0	$126,980	$0	$762,860	85.73%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$145,904	$0	$72,339	$0	$73,565	50.42%	CF: Hospital Provider Fee Fund
Community Based Long-Term Care Sub-Total	$865,308,210	$419,587,860	$6,687,642	$0	$439,032,708		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$610,908,781	$302,888,574	$0	$0	$308,020,207	50.42%	
Class II Nursing Facilities	$5,035,779	$2,496,739	$0	$0	$2,539,040	50.42%	
PACE	$156,900,991	$77,791,511	$0	$0	$79,109,480	50.42%	
Supplemental Medicare Insurance Benefit (SMIB)	$162,436,498	$93,807,078	$0	$0	$68,629,420	50.00%*	Approximately 15.5% of Total is State-Only
Health Insurance Buy-In	$1,956,280	$969,924	$0	$0	$986,356	50.42%	
MAGI Parents/Caretakers to 133% FPL	$48,660	$0	$1,216	$0	$47,444	97.50%	100% FFP January 1, 2014
MAGI Adults	$1,083,086	$0	$27,077	$0	$1,056,009	97.50%	100% FFP January 1, 2014
Disabled Buy-In	$159,538	$0	$87,385	$0	$72,153	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$1,291,374	$0	$184,279	$0	$1,107,095	85.73%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$13,065	$0	$6,478	$0	$6,587	50.42%	CF: Hospital Provider Fee Fund
Long-Term Care and Insurance Sub-Total	$939,834,052	$477,953,826	$306,435	$0	$461,573,791		
Service Management							
Base Service Management	$33,508,208	$16,754,104	$0	$0	$16,754,104	50.00%	
Accountable Care Collaborative	$106,555,225	$52,830,081	$0	$0	$53,725,144	50.42%	
Tobacco Quit Line	$1,028,215	$0	$509,789	$0	$518,426	50.42%	CF: Tobacco Education Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$8,097,096	$948,170	$0	$0	$7,148,926	88.29%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$203,778	$23,862	$0	$0	$179,916	88.29%	
MAGI Parents/Caretakers to 133% FPL	$10,069,507	$0	$251,738	$0	$9,817,769	97.50%	100% FFP January 1, 2014
MAGI Adults	$35,445,499	$0	$886,137	$0	$34,559,362	97.50%	100% FFP January 1, 2014
Disabled Buy-In	$422,922	$0	$231,651	$0	$191,271	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$120,024	$0	$17,127	$0	$102,897	85.73%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$1,254,665	$0	$622,063	$0	$632,602	50.42%	CF: Hospital Provider Fee Fund
Service Management Sub-Total	$196,705,139	$70,556,217	$2,518,505	$0	$123,630,417		
FY 2016-17 Estimate of Total Expenditures for Medical Services to Clients	**$5,804,458,239**	**$2,073,144,359**	**$105,295,461**	**$0**	**$3,626,018,419**		
Financing							
Upper Payment Limit Financing	$4,048,270	($4,145,726)	$4,048,270	$0	$4,145,726	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($16,604,495)	$53,597,465	$0	($36,992,970)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$6,964,536	$3,482,268	$0	$0	$3,482,268	50.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$679,000,000	$0	$336,700,000	$0	$342,300,000	50.42%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$97,869,540	$0	$48,523,718	$0	$49,345,822	50.42%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$8,831,734	($464,828)	$4,648,281	$0	$4,648,281	Variable	CF: Certification of Public Expenditure
Memorial Hospital High Volume Payment	$555,237	$0	$277,618	$0	$277,619	50.00%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($64,723,663)	$64,723,663	$0	$0	N/A	CF: Health Care Expansion Fund
Intergovernmental Transfer for Difficult to Discharge Clients	$2,000,000	$0	$1,000,000	$0	$1,000,000	50.00%	CF: Intergovernmental Transfer
Cash Funds Financing[1]	$0	($50,707,988)	$50,707,988	$0	$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$799,269,317	($133,164,432)	$564,227,003	$0	$368,206,746		
Total Projected FY 2016-17 Expenditures[2]	**$6,603,727,556**	**$1,939,979,927**	**$669,522,464**	**$0**	**$3,994,225,165**		

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, $848,124,468 is General Fund Exempt.

(3) On January 1, 2017, the ACA expansion FMAP decreases from a 100% FMAP rate to 95% FMAP rate.

Exhibit A - Summary of Request

Calculation of Fund Splits FY 2017-18							
Item	**Total Request**	**General Fund and General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP [3]**	**Notes**
Acute Care Services							
Base Acute	$2,229,980,095	$1,109,638,095	$0	$0	$1,120,342,000	50.24%	
Breast and Cervical Cancer Program	$642,118	$0	$223,650	$0	$418,468	65.17%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
Family Planning	$13,564,363	$1,356,436	$0	$0	$12,207,927	90.00%	CF: Local Funds
Indian Health Service	$3,945,812	$0	$0	$0	$3,945,812	100.00%	
Affordable Care Act Drug Rebate Offset	($23,068,937)	$0	$0	$0	($23,068,937)	100.00%	
Affordable Care Act Preventive Services	$51,736,303	$25,226,621	$0	$0	$26,509,682	51.24%	
SB 11-008: "Aligning Medicaid Eligibility for Children"	$93,521,968	$11,063,649	$0	$0	$82,458,319	88.17%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$16,670,904	$1,972,168	$0	$0	$14,698,736	88.17%	
MAGI Parents/Caretakers to 133% FPL	$206,100,502	$0	$11,335,528	$0	$194,764,974	94.50%	CF: Hospital Provider Fee Fund
MAGI Adults	$1,186,014,038	$0	$65,230,772	$0	$1,120,783,266	94.50%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$35,732,783	$0	$19,657,939	$0	$16,074,844	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$31,883,213	$0	$5,279,860	$0	$26,603,353	83.44%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$31,541,968	$0	$15,695,283	$0	$15,846,685	50.24%	CF: Hospital Provider Fee Fund
Adult Dental Benefit Financing	$50,808,796	$0	$25,205,603	$0	$25,603,193	Variable	CF: Adult Dental Fund
Acute Care Services Sub-Total	$3,929,073,926	$1,149,256,969	$142,628,635	$0	$2,637,188,322		
Community Based Long-Term Care Services							
Base Community Based Long-Term Care	$910,231,353	$452,931,121	$0	$0	$457,300,232	50.24%	
Children with Autism Waiver Services	$20,248,106	$9,075,458	$1,000,000	$0	$10,172,648	50.24%	CF: Colorado Autism Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$977,920	$115,688	$0	$0	$862,232	88.17%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$0	$0	$0	$0	$0	88.17%	
MAGI Parents/Caretakers to 133% FPL	$456,854	$0	$80,680	$0	$376,174	82.34%	Waivers receive standard match; CF: Hospital Provider Fee Fund
MAGI Adults	$6,575,924	$0	$1,111,331	$0	$5,464,593	83.10%	Waivers receive standard match; CF: Hospital Provider Fee Fund
Disabled Buy-In	$5,693,617	$0	$3,132,271	$0	$2,561,346	Variable	CF: Hospital Provider Fee and Disabled Buy-in Premiums
Non-Newly Eligibles	$936,122	$0	$155,022	$0	$781,100	83.44%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$149,429	$0	$74,356	$0	$75,073	50.24%	CF: Hospital Provider Fee Fund
Community Based Long-Term Care Sub-Total	$945,269,325	$462,122,267	$5,553,660	$0	$477,593,398		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$628,351,554	$312,667,733	$0	$0	$315,683,821	50.24%	
Class II Nursing Facilities	$5,179,298	$2,577,219	$0	$0	$2,602,079	50.24%	
PACE	$174,713,989	$86,937,681	$0	$0	$87,776,308	50.24%	
Supplemental Medicare Insurance Benefit (SMIB)	$176,913,972	$105,263,813	$0	$0	$71,650,159	50.00%*	Approximately 19% of total is State-Only
Health Insurance Buy-In	$2,465,129	$1,226,648	$0	$0	$1,238,481	50.24%	
MAGI Parents/Caretakers to 133% FPL	$58,110	$0	$3,196	$0	$54,914	94.50%	CF: Hospital Provider Fee Fund
MAGI Adults	$1,091,389	$0	$60,026	$0	$1,031,363	94.50%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$164,098	$0	$90,276	$0	$73,822	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$1,358,182	$0	$224,915	$0	$1,133,267	83.44%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$14,111	$0	$7,022	$0	$7,089	50.24%	CF: Hospital Provider Fee Fund
Long-Term Care and Insurance Sub-Total	$990,309,832	$508,673,094	$385,435	$0	$481,251,303		
Service Management							
Base Service Management	$34,309,338	$17,154,669	$0	$0	$17,154,669	50.00%	
Accountable Care Collaborative	$113,114,108	$56,285,580	$0	$0	$56,828,528	50.24%	
Tobacco Quit Line	$1,058,995	$0	$526,956	$0	$532,039	50.24%	CF: Tobacco Education Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$8,748,776	$1,034,980	$0	$0	$7,713,796	88.17%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$217,428	$108,192	$0	$0	$109,236	50.24%	
MAGI Parents/Caretakers to 133% FPL	$10,766,046	$0	$592,133	$0	$10,173,913	94.50%	CF: Hospital Provider Fee Fund
MAGI Adults	$36,806,992	$0	$2,024,385	$0	$34,782,607	94.50%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$492,732	$0	$271,070	$0	$221,662	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$122,713	$0	$20,321	$0	$102,392	83.44%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$1,347,611	$0	$670,571	$0	$677,040	50.24%	CF: Hospital Provider Fee Fund
Service Management Sub-Total	$206,984,739	$74,583,421	$4,105,436	$0	$128,295,882		
FY 2017-18 Estimate of Total Expenditures for Medical Services to Clients	**$6,071,637,822**	**$2,194,635,751**	**$152,673,166**	**$0**	**$3,724,328,905**		
Financing							
Upper Payment Limit Financing	$4,168,162	($4,215,759)	$4,168,162	$0	$4,215,759	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($18,843,609)	$59,669,439	$0	($40,825,830)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$6,964,536	$3,482,268	$0	$0	$3,482,268	50.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$652,700,000	$0	$324,783,520	$0	$327,916,480	50.24%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$100,531,015	$0	$50,024,233	$0	$50,506,782	50.24%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$8,831,734	($464,828)	$4,648,281	$0	$4,648,281	50.00%	CF: Certification of Public Expenditure
Memorial Hospital High Volume Payment	$555,237	$0	$277,618	$0	$277,619	50.00%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($64,723,663)	$64,723,663	$0	$0	N/A	CF: Health Care Expansion Fund
Intergovernmental Transfer for Difficult to Discharge Clients	$2,000,000	$0	$1,000,000	$0	$1,000,000	50.00%	CF: Intergovernmental Transfer
Cash Funds Financing[1]	$0	($52,580,047)	$52,580,047	$0	$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$775,750,684	($137,345,638)	$561,874,963	$0	$351,221,359		
Total Projected FY 2017-18 Expenditures[2]	**$6,847,388,506**	**$2,057,290,113**	**$714,548,129**	**$0**	**$4,075,550,264**		

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

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

(2) Of the General Fund total, $848,124,468 is General Fund Exempt.

(3) On January 1, 2018, the ACA expansion FMAP decreases from a 95% FMAP rate to 94% FMAP rate.

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 1997-98 Actuals	32,664	4,496	46,003	-	27,179	-	-	-	103,912	-	10,453	4,295	-	5,032	4,560	238,594
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	38,921	7,767	56,285	-	81,114	27,167	-	531	302,410	-	18,393	7,868	-	3,213	17,090	560,759
% Change from FY 2009-10	1.13%	10.19%	5.67%	-	8.38%	739.01%	-	24.94%	9.70%	-	0.07%	0.49%	-	-13.00%	7.36%	12.42%
FY 2011-12 Actuals	39,740	8,383	59,434	52	93,224	35,461	1,134	597	334,633	-	18,034	7,630	-	2,770	18,871	619,963
% Change from FY 2010-11	2.10%	7.93%	5.59%	-	14.93%	30.53%	-	12.43%	10.66%	-	-1.95%	-3.02%	-	-13.79%	10.42%	10.56%
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	399,032	25,345	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%	10.89%	207.73%	2.76%	64.01%	207.27%	-7.56%	10.24%	26.06%
FY 2014-15 Actuals	41,817	10,466	66,548	3,627	162,698	71,609	240,758	398	445,722	50,114	20,036	14,897	1,749	2,722	28,045	1,161,206
% Change from FY 2013-14	-0.05%	6.22%	3.30%	41.68%	30.49%	52.09%	175.96%	-28.80%	11.70%	97.73%	9.68%	13.20%	65.47%	9.71%	19.96%	34.87%
FY 2015-16 Projection	42,218	11,035	68,897	4,859	181,652	82,897	293,091	283	474,429	59,802	19,923	14,830	1,728	2,992	32,835	1,291,471
% Change from FY 2014-15	0.96%	5.44%	3.53%	33.97%	11.65%	15.76%	21.74%	-28.89%	6.44%	19.33%	-0.56%	-0.45%	-1.20%	9.92%	17.08%	11.22%
FY 2016-17 Projection	42,830	11,585	71,569	5,721	194,331	86,948	303,341	153	494,175	64,629	19,943	14,916	1,725	3,104	37,035	1,352,005
% Change from FY 2015-16	1.45%	4.98%	3.88%	17.74%	6.98%	4.89%	3.50%	-45.94%	4.16%	8.07%	0.10%	0.58%	-0.17%	3.74%	12.79%	4.69%
FY 2017-18 Projection	43,468	12,162	74,263	6,482	204,533	91,000	307,941	52	515,425	69,364	19,966	15,020	1,725	3,144	41,235	1,405,780
% Change from FY 2016-17	1.49%	4.98%	3.76%	13.30%	5.25%	4.66%	1.52%	-66.01%	4.30%	7.33%	0.12%	0.70%	0.00%	1.29%	11.34%	3.98%
FY 2015-16 Appropriation	42,971	11,307	69,501	4,327	180,612	85,311	287,239	179	480,322	56,118	20,237	14,862	1,923	2,551	32,033	1,289,493
Difference between the Total FY 2015-16 Projection and Appropriation	(753)	(272)	(604)	532	1,040	(2,414)	5,852	104	(5,893)	3,684	(314)	(32)	(195)	441	802	1,978

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	-	-	-	-	432	-	-	184	-	7,760
Total FY 2013-14 Adjustments	-	-	-	-	-	7,144	-	-	-	-	432	-	-	184	-	7,760
SB 13-200 Medicaid Expansion	-	-	-	-	-	28,618	-	-	-	-	1,800	-	-	526	-	30,944
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	49	-	-	-	-	-	-	-	49
Total FY 2014-15 Adjustments	-	-	-	-	-	28,618	-	49	-	-	1,800	-	-	526	-	30,993
HB 09-1353 Remove 5 Year Bar for Legal Immigrants	-	-	-	-	-	-	-	-	1,518	181	-	-	-	-	-	1,699
Sunset of LARC Funding	-	-	-	-	-	-	-	-	627	-	-	-	-	-	-	627
SB 13-200 Medicaid Expansion	-	-	-	-	-	33,634	-	-	-	-	1,744	-	-	539	-	35,917
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	45	-	-	-	-	-	-	-	45
Changes to Verifying Lawful Presence	-	-	-	-	-	-	-	-	-	-	-	-	-	26	-	26
Total FY 2015-16 Adjustments	-	-	-	-	-	33,634	-	45	2,145	181	1,744	-	-	565	-	38,314
HB 09-1353 Remove 5 Year Bar for Legal Immigrants	-	-	-	-	-	-	-	-	2,320	280	-	-	-	-	-	2,600
SB 13-200 Medicaid Expansion	-	-	-	-	-	33,636	-	-	-	-	1,743	-	-	530	-	35,909
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	45	-	-	-	-	-	-	-	45
Changes to Verifying Lawful Presence	-	-	-	-	-	-	-	-	-	-	-	-	-	42	-	42
Total FY 2016-17 Adjustments	-	-	-	-	-	33,636	-	45	2,320	280	1,743	-	-	572	-	38,596
HB 09-1353 Remove 5 Year Bar for Legal Immigrants	-	-	-	-	-	-	-	-	2,471	292	-	-	-	-	-	2,763
SB 13-200 Medicaid Expansion	-	-	-	-	-	33,636	-	-	-	-	1,742	-	-	530	-	35,908
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	45	-	-	-	-	-	-	-	45
Changes to Verifying Lawful Presence	-	-	-	-	-	-	-	-	-	-	-	-	-	43	-	43
Total FY 2017-18 Adjustments	-	-	-	-	-	33,636	-	45	2,471	292	1,742	-	-	573	-	38,759

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 1997-98 Actuals	32,664	4,496	46,003	-	27,179	-	-	-	103,912	-	10,453	4,295	-	5,032	4,560	238,594
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	38,921	7,767	56,285	-	81,114	27,167	-	531	302,410	-	18,393	7,868	-	3,213	17,090	560,759
% Change from FY 2009-10	1.13%	10.19%	5.67%	-	8.38%	739.01%	-	24.94%	9.70%	-	0.07%	0.49%	-	-13.00%	7.36%	12.42%
FY 2011-12 Actuals	39,740	8,383	59,434	52	93,224	35,461	1,134	597	334,633	-	18,034	7,630	-	2,770	18,871	619,963
% Change from FY 2010-11	2.10%	7.93%	5.59%	-	14.93%	30.53%	-	12.43%	10.66%	-	-1.95%	-3.02%	-	-13.79%	10.42%	10.56%
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	39,938	87,243	559	399,032	25,345	17,835	13,160	1,057	2,297	23,378	853,197
% Change from FY 2012-13	2.47%	8.86%	4.04%	188.29%	25.44%	-3.87%	720.42%	-10.27%	10.89%	207.73%	0.33%	64.01%	207.27%	-14.42%	10.24%	24.92%
FY 2014-15 Actuals	41,817	10,466	66,548	3,627	162,698	42,991	240,758	349	445,722	50,114	18,236	14,897	1,749	2,196	28,045	1,130,213
% Change from FY 2013-14	-0.05%	6.22%	3.30%	41.68%	30.49%	7.64%	175.96%	-37.57%	11.70%	97.73%	2.25%	13.20%	65.47%	-4.40%	19.96%	32.47%
FY 2015-16 Projection	42,218	11,035	68,897	4,859	181,652	49,263	293,091	238	472,284	59,621	18,179	14,830	1,728	2,427	32,835	1,253,157
% Change from FY 2014-15	0.96%	5.44%	3.53%	33.97%	11.65%	14.59%	21.74%	-31.81%	5.96%	18.97%	-0.31%	-0.45%	-1.20%	10.52%	17.08%	10.88%
FY 2016-17 Projection	42,830	11,585	71,569	5,721	194,331	53,312	303,341	108	491,855	64,349	18,200	14,916	1,725	2,532	37,035	1,313,409
% Change from FY 2015-16	1.45%	4.98%	3.88%	17.74%	6.98%	8.22%	3.50%	-54.62%	4.14%	7.93%	0.12%	0.58%	-0.17%	4.33%	12.79%	4.81%
FY 2017-18 Projection	43,468	12,162	74,263	6,482	204,533	57,364	307,941	7	512,954	69,072	18,224	15,020	1,725	2,571	41,235	1,367,021
% Change from FY 2016-17	1.49%	4.98%	3.76%	13.30%	5.25%	7.60%	1.52%	-93.52%	4.29%	7.34%	0.13%	0.70%	0.00%	1.54%	11.34%	4.08%
FY 2015-16 Appropriation	42,971	11,307	69,501	4,327	180,612	53,304	287,239	113	480,411	54,330	18,401	14,862	1,923	2,040	32,033	1,253,374
Difference between the Total FY 2015-16 Projection and Appropriation	(753)	(272)	(604)	532	1,040	(4,041)	5,852	125	(8,127)	5,291	(222)	(32)	(195)	387	802	(217)

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	3,511	0.87%
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**	**(1,802)**	**-0.46%**

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**	**391,962**	**2,463**	**0.63%**

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**	**4,826**	**1.11%**

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**	**7,830**	**-**	**3,693**	**15,919**	**498,797**	**4,935**	**1.00%**

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**	**-**	**81,114**	**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**	**619,963**	**5,183**	**0.84%**

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**	**8,236**	**17,777**	**8,024**	**344**	**2,684**	**21,206**	**682,994**	**6,496**	**0.95%**

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	408,289	38,399	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	415,665	39,129	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	420,784	39,626	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	425,951	40,755	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**	**399,032**	**25,345**	**18,267**	**13,160**	**1,057**	**2,481**	**23,378**	**860,957**	**26,533**	**3.14%**

MEDICAID CASELOAD FY 2014-15 without RETROACTIVITY

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	Monthly Growth	Monthly Growth Rate
July 2014	41,551	10,346	65,459	3,065	153,837	60,981	194,454	472	431,202	41,551	20,190	15,038	1,672	2,551	25,963	1,068,332	20,866	1.99%
August 2014	42,513	10,350	65,785	2,971	156,343	62,711	202,825	463	436,076	42,751	20,213	15,436	1,800	2,494	26,347	1,089,078	20,746	1.94%
September 2014	42,643	10,362	66,054	2,925	159,740	63,847	210,970	439	438,991	44,001	20,124	15,386	1,854	2,474	26,787	1,106,597	17,519	1.61%
October 2014	41,763	10,355	66,009	2,927	160,707	65,552	218,403	424	442,075	45,249	20,187	14,938	1,769	2,533	27,229	1,120,120	13,523	1.22%
November 2014	41,918	10,341	66,343	3,023	158,375	66,811	222,465	425	442,141	46,654	20,140	14,691	1,733	2,444	27,601	1,125,105	4,985	0.45%
December 2014	41,927	10,404	66,441	3,556	162,727	70,288	237,045	396	446,352	47,277	20,056	14,542	1,675	2,541	27,944	1,153,171	28,066	2.49%
January 2015	41,392	10,395	66,758	3,772	160,543	75,327	248,423	355	444,667	53,550	19,951	14,590	1,772	2,811	28,226	1,172,532	19,361	1.68%
February 2015	41,334	10,532	66,651	4,112	161,599	77,372	262,527	368	446,885	55,446	19,932	14,643	1,795	2,775	28,158	1,194,129	21,597	1.84%
March 2015	41,518	10,615	66,974	4,226	163,719	78,530	269,174	368	450,777	56,156	19,925	14,804	1,810	2,984	28,332	1,209,912	15,783	1.32%
April 2015	41,621	10,690	67,110	4,161	169,637	79,437	269,243	359	455,222	55,566	19,982	14,954	1,743	3,096	29,170	1,221,991	12,079	1.00%
May 2015	41,778	10,703	67,261	4,279	171,142	79,417	274,752	358	456,425	56,105	19,945	14,914	1,694	3,070	30,224	1,232,067	10,076	0.82%
June 2015	41,849	10,503	67,726	4,509	174,009	79,036	278,815	350	457,854	57,060	19,791	14,822	1,665	2,885	30,560	1,241,434	9,367	0.76%
Year-to-Date Average	**41,817**	**10,466**	**66,548**	**3,627**	**162,698**	**71,609**	**240,758**	**398**	**445,722**	**50,114**	**20,036**	**14,897**	**1,749**	**2,722**	**28,045**	**1,161,206**	**16,164**	**1.43%**

Notes:

1. Due to rounding, the average monthly totals may differ slightly from annual totals reported elsewhere.
2. Caseload for MAGI Eligible Children and SB 11-008 Eligible Children has been adjusted from March 2014 to present to account for clients that are continuously eligible.

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 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
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	$20,336.39	$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	$5,063.72
% Change from FY 2009-10	4.53%	7.84%	9.44%	-	4.90%	2.36	-	-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	-0.18%	-0.88%	-2.91%	-	-5.91%	4.65%	-	-9.55%	-8.31%	-	-5.75%	-6.07%	-	3.32%	-9.08%	-6.83%
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	$8,340.08	$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	$1,708.01	$1,560.48	$4,167.05	$9,367.38	$8,228.78	$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%	7.47%	-14.69%	9.82%	3.30%	-1.33%	-4.78%	9.79%	-2.60%
FY 2014-15	$22,942.89	$18,710.61	$15,272.72	$7,176.93	$2,996.40	$2,486.74	$3,884.89	$12,800.29	$1,808.23	$1,479.06	$4,193.72	$10,494.89	$9,456.72	$14,897.00	$1,102.19	$4,316.27
% Change from FY 2013-14	7.16%	6.73%	1.55%	-37.49%	0.67%	3.64%	3.17%	-19.42%	5.87%	-5.22%	0.64%	12.04%	14.92%	-4.03%	-16.09%	-4.39%
FY 2015-16 Projection	$23,651.78	$18,363.18	$15,643.17	$6,905.37	$2,999.87	$2,510.00	$4,044.11	$12,941.68	$1,904.23	$1,547.54	$4,537.04	$10,724.85	$9,660.62	$14,543.94	$1,156.20	$4,334.62
% Change from FY 2014-15	3.09%	-1.86%	2.43%	-3.78%	0.12%	0.94%	4.10%	1.10%	5.31%	4.63%	8.19%	2.19%	2.16%	-2.37%	4.90%	0.43%
FY 2016-17 Projection	$24,452.11	$18,318.04	$15,926.55	$6,571.88	$2,860.53	$2,419.43	$4,060.17	$12,456.92	$1,849.96	$1,493.18	$4,677.95	$10,719.19	$9,670.25	$14,455.25	$1,142.29	$4,293.22
% Change from FY 2015-16	3.38%	-0.25%	1.81%	-4.83%	-4.64%	-3.61%	0.40%	-3.75%	-2.85%	-3.51%	3.11%	-0.05%	0.10%	-0.61%	-1.20%	-0.96%
FY 2017-18 Projection	$25,376.22	$18,510.83	$16,315.01	$6,492.32	$2,801.36	$2,388.81	$4,107.24	$12,365.08	$1,859.47	$1,488.56	$4,915.88	$10,849.00	$9,790.34	$14,447.70	$1,185.99	$4,319.05
% Change from FY 2016-17	3.78%	1.05%	2.44%	-1.21%	-2.07%	-1.27%	1.16%	-0.74%	0.51%	-0.31%	5.09%	1.21%	1.24%	-0.05%	3.83%	0.60%

Notes:

1. 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.

2. See narrative for a description of events that alter trends.

3. FY 2013-14 historical values restated for the Eligible Children and SB 11-008 Eligible Children, and the MAGI Pregnant Adults and SB 11-250 Eligible Pregnant Adults eligibility categories, to account for an error that resulted in clients who should have been in the SB populations showing up in Eligible Children or MAGI Pregnant Adults instead; and also to properly place Eligible Children eligible under continuous eligibility in the Eligible Children category rather than the SB 11-008 Eligible Chidlren category.

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 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
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%	-	-	(0.16)	-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)	$19,307.43	$15,681.07	$11,919.35	-	$3,484.33	$952.90	-	$21,192.52	$1,680.51	-	$3,119.56	$8,704.60	-	$13,125.32	$1,219.04	$4,847.65
% Change from FY 2008-09	-6.64%	-11.72%	-16.36%	-	-9.69%	-	-	-4.80%	-8.52%	-	-16.77%	0.03%	-	-11.66%	-2.86%	-15.59%
FY 2010-11 (DA)	$19,529.83	$16,001.90	$12,266.07	-	$3,399.27	$2,283.57	-	$18,488.13	$1,646.29	-	$3,313.57	$8,593.23	-	$14,120.76	$1,412.07	$4,669.21
% Change from FY 2009-10 (DA)	1.15%	2.05%	2.91%	-	-2.44%	1.40	-	-12.76%	-2.04%	-	6.22%	-1.28%	-	7.58%	15.83%	-3.68%
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)	3.95%	5.96%	15.85%	-	-2.58%	6.14%	-	-6.88%	-4.68%	-	14.19%	-2.78%	-	7.28%	-8.05%	1.04%
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	$8,340.08	$16,302.95	$1,196.39	$4,634.75
% Change from FY 2011-12	1.35%	0.01%	-1.29%	0.53	-0.19%	-3.77%	1.47	-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	$1,708.01	$1,560.48	$4,167.05	$9,367.38	$8,228.78	$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%	7.47%	-14.69%	9.82%	3.30%	-1.33%	-4.78%	9.79%	-2.60%
FY 2014-15	$22,942.89	$18,710.61	$15,272.72	$7,176.93	$2,996.40	$2,486.74	$3,884.89	$12,800.29	$1,808.23	$1,479.06	$4,193.72	$10,494.89	$9,456.72	$14,897.00	$1,102.19	$4,316.27
% Change from FY 2013-14	7.16%	6.73%	1.55%	-37.49%	0.67%	3.64%	3.17%	-19.42%	5.87%	-5.22%	0.64%	12.04%	14.92%	-4.03%	-16.09%	-4.39%
FY 2015-16 Projection	$23,651.78	$18,363.18	$15,643.17	$6,905.37	$2,999.87	$2,510.00	$4,044.11	$12,941.68	$1,904.23	$1,547.54	$4,537.04	$10,724.85	$9,660.62	$14,543.94	$1,156.20	$4,334.62
% Change from FY 2014-15	3.09%	-1.86%	2.43%	-3.78%	0.12%	0.94%	4.10%	1.10%	5.31%	4.63%	8.19%	2.19%	2.16%	-2.37%	4.90%	0.43%
FY 2016-17 Projection	$24,452.11	$18,318.04	$15,926.55	$6,571.88	$2,860.53	$2,419.43	$4,060.17	$12,456.92	$1,849.96	$1,493.18	$4,677.95	$10,719.19	$9,670.25	$14,455.25	$1,142.29	$4,293.22
% Change from FY 2015-16	3.38%	-0.25%	1.81%	-4.83%	-4.64%	-3.61%	0.40%	-3.75%	-2.85%	-3.51%	3.11%	-0.05%	0.10%	-0.61%	-1.20%	-0.96%
FY 2017-18 Projection	$25,376.22	$18,510.83	$16,315.01	$6,492.32	$2,801.36	$2,388.81	$4,107.24	$12,365.08	$1,859.47	$1,488.56	$4,915.88	$10,849.00	$9,790.34	$14,447.70	$1,185.99	$4,319.05
% Change from FY 2016-17	3.78%	1.05%	2.44%	-1.21%	-2.07%	-1.27%	1.16%	-0.74%	0.51%	-0.31%	5.09%	1.21%	1.24%	-0.05%	3.83%	0.60%

Notes:
1. 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.
2. See narrative for a description of events that alter trends.
3. 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.
4. FY 2013-14 historical values restated for the Eligible Children and SB 11-008 Eligible Children, and the MAGI Pregnant Adults and SB 11-250 Eligible Pregnant Adults eligibility categories, to account for an error that resulted in clients who should have been in the SB populations showing up in Eligible Children or MAGI Pregnant Adults instead; and also to properly place Eligible Children eligible under continuous eligibility in the Eligible Children category rather than the SB 11-008 Eligible Chidlren category.

Cash Funds Report

Cash Fund	FY 2015-16			FY 2016-17			FY 2017-18		
	Spending Authority	Request	Change	Base Spending Authority	Request	Change	Base Spending Authority	Request	Change
Cash Funds									
Certified Funds	$12,461,584	$8,856,773	($3,604,811)	$12,461,584	$8,974,169	($3,487,415)	$12,461,584	$9,094,061	($3,367,523)
Local Funds	$29,000	$0	($29,000)	$3,978	$0	($3,978)	($1,026)	$0	$1,026
Hospital Provider Fee Cash Fund	$484,429,228	$609,956,156	$125,526,928	$485,149,710	$453,006,004	($32,143,706)	$485,149,710	$491,139,591	$5,989,881
Medicaid Buy-In Fund	$2,624,516	$3,278,046	$653,530	$2,624,516	$3,873,100	$1,248,584	$2,624,516	$4,400,760	$1,776,244
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	$65,564,260	$64,834,091	($730,169)	$65,564,260	$64,723,663	($840,597)	$65,564,260	$64,723,663	($840,597)
Breast and Cervical Cancer Prevention and Treatment Fund	$998,210	$1,260,105	$261,895	$1,001,782	$660,659	($341,123)	$1,001,782	$223,650	($778,132)
Colorado Autism Treatment Fund	$5,263,208	$3,658,530	($1,604,678)	$932,200	$2,680,237	$1,748,037	$932,200	$1,000,000	$67,800
Nursing Facility Cash Fund	$47,289,246	$46,886,562	($402,684)	$47,359,717	$48,523,718	$1,164,001	$47,359,717	$50,024,233	$2,664,516
Tobacco Education Program Fund	$624,680	$407,837	($216,843)	$625,607	$509,789	($115,818)	$625,607	$526,956	($98,651)
Old Age Pension Health and Medical Care Fund	$5,369,479	$5,369,479	$0	$5,369,479	$5,240,893	($128,586)	$5,369,479	$5,109,213	($260,266)
Department Recoveries	$45,511,288	$48,177,615	$2,666,327	$45,511,288	$53,597,465	$8,086,177	$45,511,288	$59,669,439	$14,158,151
ICF-IID Provider Fee	$200,460	$200,460	$0	$200,460	$200,460	$0	$200,460	$200,460	$0
Adult Dental Fund	$30,001,629	$23,144,878	($6,856,751)	$30,469,706	$24,301,807	($6,167,899)	$30,469,706	$25,205,603	($5,264,103)
Intergovernmental Transfer - Denver Health	$1,000,000	$1,000,000	$0	$1,000,000	$1,000,000	$0	$1,000,000	$1,000,000	$0
Total Cash Funds	**$703,597,288**	**$819,261,032**	**$115,663,744**	**$700,504,787**	**$669,522,464**	**($30,982,323)**	**$700,499,783**	**$714,548,129**	**$14,048,346**

Exhibit D - Cash Funds Report

Cash Funds Spending Authority by Source of Authority
FY 2015-16

Spending Authority	FY 2015-16 Long Bill Appropriation (SB 15-234)	HB 15-1186 "Children with Autism Waiver Expansion"	HB 15-1309 "Protective Restorations by Dental Hygenists"	SB 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine"	Total
Certified Funds	$12,461,584	$0	$0	$0	$12,461,584
Local Funds	$29,000	$0	$0	$0	$29,000
Hospital Provider Fee Cash Fund	$484,428,538	$0	$690	$0	$484,429,228
Medicaid Buy-In Fund	$2,624,516	$0	$0	$0	$2,624,516
Tobacco Tax Cash Fund	$2,230,500	$0	$0	$0	$2,230,500
Health Care Expansion Fund	$65,564,260	$0	$0	$0	$65,564,260
Breast and Cervical Cancer Prevention and Treatment Fund	$998,210	$0	$0	$0	$998,210
Colorado Autism Treatment Fund	$423,005	$4,840,203	$0	$0	$5,263,208
Nursing Facility Cash Fund	$47,289,246	$0	$0	$0	$47,289,246
Tobacco Education Program Fund	$624,680	$0	$0	$0	$624,680
Supplemental Old Age Pension Health and Medical Care Fund	$5,369,479	$0	$0	$0	$5,369,479
Department Recoveries	$45,511,288	$0	$0	$0	$45,511,288
ICF-IID Provider Fee	$200,460	$0	$0	$0	$200,460
Adult Dental Fund	$30,001,629	$0	$0	$0	$30,001,629
Intergovernmental Transfer - Denver Health	$1,000,000	$0	$0	$0	$1,000,000
Total Cash Funds	**$698,756,395**	**$4,840,203**	**$690**	**$0**	**$703,597,288**

Exhibit D - Cash Funds Report

Revised Totals for Letternotes and Appropriation Clauses
FY 2015-16

FY 2015-16 Request	FY 2015-16 Long Bill Appropriation (SB 15-234)	HB 15-1186 "Children with Autism Waiver Expansion"	HB 15-1309 "Protective Restorations by Dental Hygenists"	SB 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine"	Total
Certified Funds	**$8,856,773**	$0	$0	$0	$8,856,773
Local Funds	**$0**	$0	$0	$0	$0
Hospital Provider Fee Cash Fund	**$609,955,466**	$0	$690	$0	$609,956,156
Medicaid Buy-In Fund	**$3,278,046**	$0	$0	$0	$3,278,046
Tobacco Tax Cash Fund	$2,230,500	$0	$0	$0	$2,230,500
Health Care Expansion Fund	**$64,834,091**	$0	$0	$0	$64,834,091
Breast and Cervical Cancer Prevention and Treatment Fund	**$1,260,105**	$0	$0	$0	$1,260,105
Colorado Autism Treatment Fund	**($1,181,673)**	$4,840,203	$0	$0	$3,658,530
Nursing Facility Cash Fund	**$46,886,562**	$0	$0	$0	$46,886,562
Tobacco Education Program Fund	**$407,837**	$0	$0	$0	$407,837
Old Age Pension Health and Medical Care Fund	$5,369,479	$0	$0	$0	$5,369,479
Department Recoveries	**$48,177,615**	$0	$0	$0	$48,177,615
ICF-IID Provider Fee	$200,460	$0	$0	$0	$200,460
Adult Dental Fund	**$23,144,878**	$0	$0	$0	$23,144,878
Intergovernmental Transfer - Denver Health	$1,000,000	$0	$0	$0	$1,000,000
Total Cash Funds	**$814,420,139**	**$4,840,203**	**$690**	**$0**	**$819,261,032**

Cells in **bold and underline** font indicate a requested change from the appropriation. The font in the "Total" columns is 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 2015 S-1 request).

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	**$91,859,669**	**$87,012,782**	**$503,245,509**	**$28,540,089**	**$522,249,142**	**$198,461,286**	**$1,143,562,866**	**$3,657,778**	**$813,803,255**	**$84,211,584**	**$58,701,398**	**$157,703,813**	**$16,519,607**	**$43,515,454**	**$11,615,485**	**$3,764,659,717**
Community Based Long-Term Care																
Base CBLTC	$168,886,475	$36,506,203	$199,674,855	$1,818,140	$745,691	$103,268	$1,604,373	$0	$1,400,237	$3,310	$448,188	$33,165	$0	$0	$1,131,649	$412,355,554
Hospice	$34,333,673	$4,215,745	$6,918,149	$218,647	$374,192	$227,276	$3,600,030	$4,718	$217,874	$3,586	$40,912	$0	$0	$0	$0	$50,154,802
Private Duty Nursing & Long-Term Home Health	$33,477,506	$10,463,866	$201,022,271	$2,502,197	$346,501	$69,300	$1,509,159	$0	$29,260,171	$816,176	$28,447,444	$0	$0	$0	$23,100	$307,937,691
Subtotal CBLTC	**$236,697,654**	**$51,185,814**	**$407,615,275**	**$4,538,984**	**$1,466,384**	**$399,844**	**$6,713,562**	**$4,718**	**$30,878,282**	**$823,072**	**$28,936,544**	**$33,165**	**$0**	**$0**	**$1,154,749**	**$770,448,047**
Long-Term Care																
Class I Nursing Facilities	$466,933,245	$40,645,164	$85,052,917	$154,878	$275,884	$13,445	$2,274,690	$0	$0	$0	$155,567	$0	$0	$0	$78,112	$595,583,902
Class II Nursing Facilities	$457,791	$507,213	$3,799,666	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,764,670
PACE	$112,919,644	$14,678,686	$6,254,712	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$133,853,042
Subtotal Long-Term Care	**$580,310,680**	**$55,831,063**	**$95,107,295**	**$154,878**	**$275,884**	**$13,445**	**$2,274,690**	**$0**	**$0**	**$0**	**$155,567**	**$0**	**$0**	**$0**	**$78,112**	**$734,201,614**
Insurance																
Supplemental Medicare Insurance Benefit	$77,164,613	$4,652,887	$41,236,473	$0	$273,765	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,115,427	$148,443,165
Heath Insurance Buy-In	$11,074	$13,842	$1,356,448	$0	$16,610	$27,683	$24,913	$0	$96,890	$0	$0	$8,304	$0	$0	$0	$1,555,764
Subtotal Insurance	**$77,175,687**	**$4,666,729**	**$42,592,921**	**$0**	**$290,375**	**$27,683**	**$24,913**	**$0**	**$96,890**	**$0**	**$0**	**$8,304**	**$0**	**$0**	**$25,115,427**	**$149,998,929**
Service Management																
Single Entry Points	$9,319,240	$2,585,742	$19,556,026	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,461,008
Disease Management	$8,232	$21,647	$145,304	$9,050	$211,327	$78,847	$390,096	$0	$0	$0	$29,418	$84,586	$9,735	$0	$0	$988,242
ACC and PIHP Administration	$3,159,648	$1,333,890	$9,505,277	$310,203	$20,439,718	$9,090,628	$32,325,407	$0	$58,643,368	$7,511,607	$2,568,461	$1,219,722	$164,217	$0	$0	$146,272,146
Subtotal Service Management	**$12,487,120**	**$3,941,279**	**$29,206,607**	**$319,253**	**$20,651,045**	**$9,169,475**	**$32,715,503**	**$0**	**$58,643,368**	**$7,511,607**	**$2,597,879**	**$1,304,308**	**$173,952**	**$0**	**$0**	**$178,721,396**
Medical Services Total	**$998,530,810**	**$202,637,667**	**$1,077,767,607**	**$33,553,204**	**$544,932,830**	**$208,071,733**	**$1,185,291,534**	**$3,662,496**	**$903,421,795**	**$92,546,263**	**$90,391,388**	**$159,049,590**	**$16,693,559**	**$43,515,454**	**$37,963,773**	**$5,598,029,703**
Caseload	42,218	11,035	68,897	4,859	181,652	82,897	293,091	283	474,429	59,802	19,923	14,830	1,728	2,992	32,835	1,291,471
Medical Services Per Capita	$23,651.78	$18,363.18	$15,643.17	$6,905.37	$2,999.87	$2,510.00	$4,044.11	$12,941.68	$1,904.23	$1,547.54	$4,537.04	$10,724.85	$9,660.62	$14,543.94	$1,156.20	$4,334.62
Financing	$101,942,456	$38,472,015	$153,263,504	$8,682,448	$141,162,415	$41,953,356	$377,147,975	$0	$200,688,464	$19,008,631	$13,449,782	$68,994,172	$7,083,882	$32,102,278	$9,528	$1,203,960,906
Grand Total Medical Services Premiums	**$1,100,473,266**	**$241,109,682**	**$1,231,031,111**	**$42,235,652**	**$686,095,245**	**$250,025,089**	**$1,562,439,509**	**$3,662,496**	**$1,104,110,259**	**$111,554,894**	**$103,841,170**	**$228,043,762**	**$23,777,441**	**$75,617,732**	**$37,973,301**	**$6,801,990,609**
Total Per Capita	$26,066.45	$21,849.54	$17,867.70	$8,692.25	$3,776.98	$3,016.09	$5,330.90	$12,941.68	$2,327.24	$1,865.40	$5,212.13	$15,377.19	$13,760.09	$25,273.31	$1,156.49	$5,266.86

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	**$76,587,075**	**$86,106,473**	**$497,626,012**	**$31,808,879**	**$530,348,907**	**$199,817,846**	**$1,186,525,554**	**$1,903,368**	**$816,349,214**	**$87,502,055**	**$57,374,930**	**$158,466,274**	**$16,477,397**	**$44,869,095**	**$10,847,759**	**$3,802,610,838**
Community Based Long-Term Care																
Base CBLTC	$187,831,955	$40,536,510	$232,849,189	$2,182,239	$829,155	$115,155	$1,782,433	$0	$1,972,663	$3,788	$705,804	$36,989	$0	$0	$1,260,476	$470,106,356
Hospice	$35,846,499	$4,408,292	$7,157,921	$256,414	$406,423	$237,436	$3,711,138	$2,541	$226,041	$3,860	$40,790	$0	$0	$0	$0	$52,297,355
Private Duty Nursing & Long-Term Home Health	$36,849,962	$11,497,680	$223,798,504	$2,767,731	$379,360	$75,872	$1,656,311	$0	$32,730,167	$895,882	$32,227,741	$0	$0	$0	$25,289	$342,904,499
Subtotal CBLTC	**$260,528,416**	**$56,442,482**	**$463,805,614**	**$5,206,384**	**$1,614,938**	**$428,463**	**$7,149,882**	**$2,541**	**$34,928,871**	**$903,530**	**$32,974,335**	**$36,989**	**$0**	**$0**	**$1,285,765**	**$865,308,210**
Long-Term Care																
Class I Nursing Facilities	$480,982,861	$41,868,141	$87,612,086	$159,538	$284,185	$13,850	$2,343,133	$0	$0	$0	$160,247	$0	$0	$0	$80,463	$613,504,504
Class II Nursing Facilities	$483,839	$536,073	$4,015,867	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,035,779
PACE	$132,058,980	$17,600,421	$7,241,590	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$156,900,991
Subtotal Long-Term Care	**$613,525,680**	**$60,004,635**	**$98,869,543**	**$159,538**	**$284,185**	**$13,850**	**$2,343,133**	**$0**	**$0**	**$0**	**$160,247**	**$0**	**$0**	**$0**	**$80,463**	**$775,441,274**
Insurance																
Supplemental Medicare Insurance Benefit	$82,005,242	$5,130,755	$44,898,967	$0	$310,733	$0	$0	$0	$0	$0	$0	$0	$0	$0	$30,090,801	$162,436,498
Heath Insurance Buy-In	$13,924	$17,406	$1,705,652	$0	$20,886	$34,810	$31,327	$0	$121,833	$0	$0	$10,442	$0	$0	$0	$1,956,280
Subtotal Insurance	**$82,019,166**	**$5,148,161**	**$46,604,619**	**$0**	**$331,619**	**$34,810**	**$31,327**	**$0**	**$121,833**	**$0**	**$0**	**$10,442**	**$0**	**$0**	**$30,090,801**	**$164,392,778**
Service Management																
Single Entry Points	$9,846,709	$2,730,802	$20,660,941	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,238,452
Disease Management	$8,138	$22,707	$151,011	$10,641	$225,424	$82,601	$403,444	$0	$0	$0	$29,516	$85,021	$9,712	$0	$0	$1,028,215
ACC and PIHP Administration	$4,768,586	$1,759,185	$12,129,596	$412,281	$23,084,252	$9,986,906	$35,162,079	$0	$62,802,333	$8,097,096	$2,753,310	$1,288,782	$194,066	$0	$0	$162,438,472
Subtotal Service Management	**$14,623,433**	**$4,512,694**	**$32,941,548**	**$422,922**	**$23,309,676**	**$10,069,507**	**$35,565,523**	**$0**	**$62,802,333**	**$8,097,096**	**$2,782,826**	**$1,373,803**	**$203,778**	**$0**	**$0**	**$196,705,139**
Medical Services Total	**$1,047,283,770**	**$212,214,445**	**$1,139,847,336**	**$37,597,723**	**$555,889,325**	**$210,364,476**	**$1,231,615,419**	**$1,905,909**	**$914,202,251**	**$96,502,681**	**$93,292,338**	**$159,887,508**	**$16,681,175**	**$44,869,095**	**$42,304,788**	**$5,804,458,239**
Caseload	42,830	11,585	71,569	5,721	194,331	86,948	303,341	153	494,175	64,629	19,943	14,916	1,725	3,104	37,035	1,352,005
Medical Services Per Capita	$24,452.11	$18,318.04	$15,926.55	$6,571.88	$2,860.53	$2,419.43	$4,060.17	$12,456.92	$1,849.96	$1,493.18	$4,677.95	$10,719.19	$9,670.25	$14,455.25	$1,142.29	$4,293.22
Financing	$67,618,185	$25,576,618	$101,746,984	$5,754,739	$93,674,364	$27,814,572	$250,411,077	$0	$133,238,195	$12,628,455	$8,951,816	$45,798,132	$4,715,689	$21,340,491	$0	$799,269,317
Grand Total Medical Services Premiums	**$1,114,901,955**	**$237,791,063**	**$1,241,594,320**	**$43,352,462**	**$649,563,689**	**$238,179,048**	**$1,482,026,496**	**$1,905,909**	**$1,047,440,446**	**$109,131,136**	**$102,244,154**	**$205,685,640**	**$21,396,864**	**$66,209,586**	**$42,304,788**	**$6,603,727,556**
Total Per Capita	$26,030.87	$20,525.77	$17,348.21	$7,577.78	$3,342.56	$2,739.33	$4,885.68	$12,456.92	$2,119.57	$1,688.58	$5,126.82	$13,789.60	$12,403.98	$21,330.41	$1,142.29	$4,884.40

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2017-18	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	**$76,749,455**	**$89,877,132**	**$516,529,869**	**$35,732,783**	**$545,531,568**	**$206,100,502**	**$1,217,897,251**	**$642,118**	**$852,937,142**	**$93,521,968**	**$57,794,731**	**$161,476,567**	**$16,670,904**	**$45,423,565**	**$12,188,371**	**$3,929,073,926**
Community Based Long-Term Care																
Base CBLTC	$204,743,638	$44,093,319	$252,246,758	$2,362,812	$901,062	$125,550	$1,935,228	$0	$2,170,724	$4,228	$745,847	$40,333	$0	$0	$1,372,749	$510,742,248
Hospice	$37,456,314	$4,639,614	$7,446,240	$291,260	$434,292	$249,133	$3,776,992	$866	$236,360	$4,153	$40,941	$0	$0	$0	$0	$54,576,165
Private Duty Nursing & Long-Term Home Health	$40,203,565	$12,514,009	$247,903,666	$3,039,545	$410,856	$82,171	$1,799,826	$0	$36,481,963	$973,692	$36,514,229	$0	$0	$0	$27,390	$379,950,912
Subtotal CBLTC	**$282,403,517**	**$61,246,942**	**$507,596,664**	**$5,693,617**	**$1,746,210**	**$456,854**	**$7,512,046**	**$866**	**$38,889,047**	**$982,073**	**$37,301,017**	**$40,333**	**$0**	**$0**	**$1,400,139**	**$945,269,325**
Long-Term Care																
Class I Nursing Facilities	$494,728,552	$43,064,663	$90,115,894	$164,098	$292,307	$14,245	$2,410,096	$0	$0	$0	$164,827	$0	$0	$0	$82,762	$631,037,444
Class II Nursing Facilities	$497,628	$551,351	$4,130,319	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,179,298
PACE	$146,517,042	$20,042,429	$8,154,518	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$174,713,989
Subtotal Long-Term Care	**$641,743,222**	**$63,658,443**	**$102,400,731**	**$164,098**	**$292,307**	**$14,245**	**$2,410,096**	**$0**	**$0**	**$0**	**$164,827**	**$0**	**$0**	**$0**	**$82,762**	**$810,930,731**
Insurance																
Supplemental Medicare Insurance Benefit	$86,982,295	$5,632,976	$48,722,389	$0	$343,444	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,232,868	$176,913,972
Heath Insurance Buy-In	$17,546	$21,934	$2,149,310	$0	$26,318	$43,865	$39,475	$0	$153,523	$0	$0	$13,158	$0	$0	$0	$2,465,129
Subtotal Insurance	**$86,999,841**	**$5,654,910**	**$50,871,699**	**$0**	**$369,762**	**$43,865**	**$39,475**	**$0**	**$153,523**	**$0**	**$0**	**$13,158**	**$0**	**$0**	**$35,232,868**	**$179,379,101**
Service Management																
Single Entry Points	$10,321,320	$2,862,427	$21,654,732	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,838,479
Disease Management	$8,259	$23,838	$156,695	$12,057	$237,258	$86,450	$409,562	$0	$0	$0	$29,550	$85,614	$9,712	$0	$0	$1,058,995
ACC and PIHP Administration	$4,827,756	$1,804,992	$12,391,385	$480,675	$24,794,199	$10,679,596	$36,520,143	$0	$66,435,534	$8,748,776	$2,860,242	$1,336,251	$207,716	$0	$0	$171,087,265
Subtotal Service Management	**$15,157,335**	**$4,691,257**	**$34,202,812**	**$492,732**	**$25,031,457**	**$10,766,046**	**$36,929,705**	**$0**	**$66,435,534**	**$8,748,776**	**$2,889,792**	**$1,421,865**	**$217,428**	**$0**	**$0**	**$206,984,739**
Medical Services Total	**$1,103,053,370**	**$225,128,684**	**$1,211,601,775**	**$42,083,230**	**$572,971,304**	**$217,381,512**	**$1,264,788,573**	**$642,984**	**$958,415,246**	**$103,252,817**	**$98,150,367**	**$162,951,923**	**$16,888,332**	**$45,423,565**	**$48,904,140**	**$6,071,637,822**
Caseload	43,468	12,162	74,263	6,482	204,533	91,000	307,941	52	515,425	69,364	19,966	15,020	1,725	3,144	41,235	1,405,780
Medical Services Per Capita	$25,376.22	$18,510.83	$16,315.01	$6,492.32	$2,801.36	$2,388.81	$4,107.24	$12,365.08	$1,859.47	$1,488.56	$4,915.88	$10,849.00	$9,790.34	$14,447.70	$1,185.99	$4,319.05
Financing	$65,628,508	$24,824,022	$98,753,062	$5,585,405	$90,917,980	$26,996,124	$243,042,689	$0	$129,317,639	$12,256,861	$8,688,408	$44,450,514	$4,576,929	$20,712,543	$0	$775,750,684
Grand Total Medical Services Premiums	**$1,168,681,878**	**$249,952,706**	**$1,310,354,837**	**$47,668,635**	**$663,889,284**	**$244,377,636**	**$1,507,831,262**	**$642,984**	**$1,087,732,885**	**$115,509,678**	**$106,838,775**	**$207,402,437**	**$21,465,261**	**$66,136,108**	**$48,904,140**	**$6,847,388,506**
Total Per Capita	$26,886.03	$20,551.94	$17,644.79	$7,354.00	$3,245.88	$2,685.47	$4,896.49	$12,365.08	$2,110.36	$1,665.27	$5,351.04	$13,808.42	$12,443.63	$21,035.66	$1,185.99	$4,870.88

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

Item	Long Bill and Special Bills	R-1 Request (November 2015)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Acute Care					
Base Acute Cost	$3,784,165,354	$3,732,763,490	($51,401,864)	Decrease driven by federally-funded populations	Exhibit F
Bottom Line Impacts					
Annualization of Physicians to 100% of Medicare: 100% Federally Funded Portion	($39,365,571)	($35,980,518)	$3,385,053	Updated based on actuals	Exhibit F
Annualization of Physicians to 100% of Medicare: GF and FF Portion Due to Rate Decreases Since 2009	($4,207,240)	($3,162,394)	$1,044,846	Updated based on actuals	Exhibit F
Accountable Care Collaborative Savings	($54,713,941)	($46,935,785)	$7,778,156	Enrollment expectations dampened	Exhibit F
FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	$0	$0	$0		Exhibit F
Estimated Impact of Increasing PACE Enrollment	($2,441,737)	($3,750,939)	($1,309,202)	Enrollment expectations adjusted based on FY 2014-15 actuals	Exhibit F
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($454,078)	($475,058)	($20,980)	Costs slightly lower than anticipated in FY 2014-15, adjusted downward	Exhibit F
FY 2012-13 R-6: "Dental Efficiency"	($1,704,632)	$0	$1,704,632	Delayed one fiscal year, stakeholder process is taking longer than anticipated	Exhibit F
Annualization of FY 2012-13 R-6: "Augmentative Communication Devices"	($338,250)	($423,262)	($85,012)	Decreased savings utilization expectations based upon actuals	Exhibit F
Annualization of Fluoride Benefit Expansion for Children	$367,949	$367,949	$0		Exhibit F
Annualization of FY 2014-15 R-9: "Medicaid Community Living Initiative"	$5,994	$5,994	$0		Exhibit F
Annualization of FY 2014-15 R-10: "Primary Care Specialty Collaboration"	($368,269)	($86,994)	$281,276	Software delayed, expected savings pushed out accordingly	Exhibit F
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase"	$4,736,631	$4,736,631	$0		Exhibit F
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Extended Hours/After Hours Care 10% Rate Increase	$58,327	$58,327	$0		Exhibit F
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Incentives to Use Ambulatory Surgery Centers	$166,667	$148,148	($18,519)	Delayed one month, adjusted for implementation delay	Exhibit F
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - High-Value Specialist Services to 80% of Medicare	$1,028,403	$1,028,403	$0		Exhibit F
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Mammography Reimbursement to 80% of Medicare	$8,622	$8,622	$0		Exhibit F
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Assistive Technology Reimbursement Rate to 80% of Medicare	$2,003	$2,003	$0		Exhibit F
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase'"	$48,705,466	$66,392,695	$17,687,229	Higher utilization than originally anticipated	Exhibit F
Annualization of FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	($5,528,463)	($5,174,136)	$354,327	Enrollment ramp-up slower than anticipated	Exhibit F
Annualization of FY 2014-15 JBC Action: "Matching Incentives to Ambulatory Surgery Center Facilities"	$166,667	$148,148	($18,519)	Delayed one month, adjusted for implementation delay	Exhibit J
Annualization of FY 2014-15 JBC Action: "Family Planning Rate Increase"	$165,207	$165,207	$0		Exhibit F
Annualization of FY 2014-15 JBC Action: "Raising FQHC Rate Increase to APM"	$660,159	$660,159	$0		Exhibit F
Annualization of FY 2014-15 JBC Action: "Full Denture Benefit"	$2,228,156	$2,228,156	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase"	$11,566,794	$11,566,794	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Physical and Occupational Therapy Services	$3,587,268	$3,587,268	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prostate Biopsy	$5,485	$5,485	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Diabetic Self-Management	$485,433	$485,433	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental X-Rays	$365,089	$365,089	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prenatal and Postpartum Care	$624,511	$624,511	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Sealants	$1,484,511	$1,484,511	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Vision Retinal Services	$407,583	$407,583	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Eye Materials	$3,995,056	$3,995,056	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Fillings and Extractions	$15,058,255	$15,058,255	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Anesthesia	$12,862,698	$12,862,698	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - EMT	$1,109,263	$1,109,263	$0		Exhibit F
HB 15-1309: "Protective Restorations by Dental Hygienists"	$37,540	$37,540	$0		Exhibit F
HB 15-1186: "Children with Autism Waiver Expansion"	$518,075	$345,383	($172,692)	Delayed implementation	Exhibit F
Total Acute Care	**$3,785,450,985**	**$3,764,659,717**	**($20,791,268)**		
Community Based Long-Term Care					
Base CBLTC Cost	$754,653,651	$756,577,075	$1,923,423		Exhibit G
Bottom Line Impacts					
Annualization of FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	($427,463)	($427,463)	$0	Combined with the impact of FY 2014-15 R-8; separate impacts are difficult to isolate	Exhibit G
Annualization of FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($790,806)	($790,806)	$0		Exhibit G
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Pediatric Hospice Services 20% Rate Increase	$22,443	$201,991	$179,548	Delayed implementation, not yet approved by CMS	Exhibit G
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" 2% Across the Board Increase	$584,692	$584,692	$0		Exhibit G
Annualization of FY 2014-15 JBC Action: Hospice 2% Rate Increase	$16,295	$12,221	($4,074)	Original implementation was delayed, resulting in annualization difference	Exhibit G
HB 14-1357: "In-Home Support Services in Medicaid Program"	$893,956	$496,643	($397,313)	Delayed implementation, not yet approved by CMS	Exhibit G
FY 2014-15 JBC Action: "Raising Cap on Home Modifications"	$676,923	$676,923	$0		Exhibit G
EPSDT Personal Care	($374,663)	($314,181)	$60,482	Revised forecast	Exhibit G
Annualization of CDASS Administrative FMS & Training Contract Competitive Reprocurement	($2,232,723)	($2,232,723)	$0		Exhibit G
Colorado Choice Transitions	$4,368,985	$1,681,671	($2,687,314)	Revised forecast	Exhibit G
Children With Life Limiting Illnesses Audit Recommendations	$182,676	$182,676	$0		Exhibit G
FY 2015-16 R-12: "Community Provider Rate Increase"	$3,109,946	$2,827,330	($282,615)	Some rate increases have delayed implementation, not yet approved by CMS	Exhibit G
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - HCBS Personal Care/Homemaker	$15,291,977	$8,246,648	($7,045,329)	Delayed implementation, not yet approved by CMS	Exhibit G
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - In-Home Respite (excludes CES Respite)	$66,320	$36,175	($30,145)	Delayed implementation, not yet approved by CMS	Exhibit G
FY 2015-16 JBC Action: "Raising Cap on Home Modifications"	$711,238	$387,948	($323,290)	Delayed implementation, not yet approved by CMS	Exhibit G
HB 15-1186: "Children with Autism Waiver Expansion"	$9,656,526	$3,721,379	($5,935,147)	Delayed implementation	Exhibit G
Independent Living Skills Training Rule Change	$0	$201,735	$201,735	New information	Exhibit G
LTHH Impact - FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	($619,388)	($619,388)	$0		Exhibit G
LTHH Impact - FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($2,072,134)	($2,072,134)	$0		Exhibit G
LTHH Impact - HB 15-1186: "Children with Autism Waiver Expansion"	$30,559	$20,373	($10,186)	Delayed implementation	Exhibit G
LTHH Impact - EPSDT Personal Care	$777,975	$647,638	($130,337)	Revised forecast	Exhibit G
LTHH Impact - Colorado Choice Transitions	$1,655,557	$401,624	($1,253,933)	Revised forecast	Exhibit G
Total Community Based Long-Term Care	**$786,182,542**	**$770,448,047**	**($15,734,495)**		

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

Item	Long Bill and Special Bills	R-1 Request (November 2015)	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	$611,795,888	$606,125,971	($5,669,917)	Effective rate in FY 2014-15 slightly lower than anticipated, adjusted accordingly	Exhibit H
Bottom Line Impacts					
Hospital Back Up Program	$7,789,222	$6,379,244	($1,409,978)	Revised forecast	Exhibit H
Recoveries from Department Overpayment Review	($1,658,080)	($1,600,000)	$58,080	Updated	Exhibit H
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($9,180,452)	($8,457,671)	$722,781	Revised forecast	Exhibit H
Colorado Choice Transitions	($11,424,251)	($6,863,642)	$4,560,609	Revised forecast	Exhibit H
SB 14-130: "Increase Personal Care Allowance Nursing Facility"	$1,588,240	$0	($1,588,240)	Included in model	Exhibit H
Total Class I Nursing Facilities	**$598,910,567**	**$595,583,902**	**($3,326,665)**		
Class II Nursing Facilities					
Base Class II Nursing Facilities Cost	$4,711,461	$4,764,670	$53,209	Revised forecast	Exhibit H
Bottom Line Impacts					
Total Class II Nursing Facilities	**$4,711,461**	**$4,764,670**	**$53,209**		
Program of All Inclusive Care for the Elderly (PACE)					
Base PACE Cost	$140,174,136	$139,252,808	($921,328)	Revised forecast	Exhibit H
Bottom Line Impacts					
FY 2014-15 Interim Payment Recoupment	$0	($5,399,766)	($5,399,766)	New information	
Total Program of All-Inclusive Care for the Elderly	**$140,174,136**	**$133,853,042**	**($6,321,094)**		
Supplemental Medicare Insurance Benefit (SMIB)					
Base SMIB Cost	$146,971,337	$148,443,165	$1,471,828	Medicare Part B premium remained constant	Exhibit H
Bottom Line Impacts					
Total Supplemental Medicare Insurance Benefit	**$146,971,337**	**$148,443,165**	**$1,471,828**		
Health Insurance Buy-In Program (HIBI)					
Base HIBI Cost	$1,515,184	$1,262,907	($252,277)		Exhibit H
Bottom Line Impacts					
SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$29,293	$37,057	$7,764	Revised forecast	Exhibit H
SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$244,503	$255,800	$11,297	Revised forecast	Exhibit H
Total Health Insurance Buy-In Program	**$1,788,980**	**$1,555,764**	**($233,216)**		
Total Long-Term Care and Insurance	**$892,556,481**	**$884,200,543**	**($8,355,938)**		
Service Management					
Single Entry Points (SEP)					
Single Entry Points (SEP) Base	$31,191,905	$31,303,203	$111,298	Forecast adjusted based on enrollment expectations in CBLTC	Exhibit I
Bottom Line Impacts					
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Single Entry Point Case Management 10% Rate Increase	$111,799	$0	($111,799)	No annualization since this is a contract	Exhibit I
FY 2015-16 R-12: "Community Provider Rate Increase"	$157,805	$157,805	$0		
Total Single Entry Points	**$31,461,509**	**$31,461,008**	**($501)**		
Disease Management					
Base Disease Management	$1,269,417	$988,242	($281,175)		Exhibit I
Bottom Line Impacts					
Total Disease Management	**$1,269,417**	**$988,242**	**($281,175)**		
Accountable Care Collaborative					
ACC Base	$151,419,686	$146,272,146	($5,147,540)	Revised forecast	Exhibit I
Bottom Line Impacts					
Total Accountable Care Collaborative	**$151,419,686**	**$146,272,146**	**($5,147,540)**		
Total Service Management	**$184,150,612**	**$178,721,396**	**($5,429,216)**		
Grand Total Services	**$5,648,340,620**	**$5,598,029,703**	**($50,310,917)**		

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

Item	Long Bill and Special Bills	R-1 Request (November 2015)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Bottom Line Financing					
Upper Payment Limit Financing	$4,053,417	$3,930,874	($122,543)	Revised forecast	Exhibit K
Department Recoveries Adjustment	$0	$0	$0		Exhibit A
Denver Health Outstationing	$6,964,536	$6,964,536	$0		Exhibit A
Hospital Provider Fee Supplemental Payments	$827,988,116	$1,086,400,000	$258,411,884		Exhibit J
Nursing Facility Provider Fee Supplemental Payments	$96,096,822	$95,278,525	($818,297)	Revised forecast	Exhibit H
Physician Supplemental Payments	$8,831,734	$8,831,734	$0		Exhibit A
Memorial Hospital High Volume Supplemental Payments	$555,237	$555,237	$0		Exhibit A
Health Care Expansion Fund Transfer Adjustment	$0	$0	$0		Exhibit A
Intergovernmental Transfer for Difficult to Discharge Clients	$2,000,000	$2,000,000	$0		Exhibit A
Cash Funds Financing	$0	$0	$0		Exhibit A
Total Bottom Line Financing	**$946,489,862**	**$1,203,960,906**	**$257,471,044**		
Grand Total[1]	**$6,594,830,482**	**$6,801,990,609**	**$207,160,127**		
Total Acute Care	$3,785,450,985	$3,764,659,717	($20,791,268)		
Total Community Based Long-Term Care	$786,182,542	$770,448,047	($15,734,495)		
Total Class I Nursing Facilities	$598,910,567	$595,583,902	($3,326,665)		
Total Class II Nursing Facilities	$4,711,461	$4,764,670	$53,209		
Total Program of All-Inclusive Care for the Elderly	$140,174,136	$133,853,042	($6,321,094)		
Total Supplemental Medicare Insurance Benefit	$146,971,337	$148,443,165	$1,471,828		
Total Health Insurance Buy-In Program	$1,788,980	$1,555,764	($233,216)		
Total Single Entry Point	$31,461,509	$31,461,008	($501)		
Total Disease Management	$1,269,417	$988,242	($281,175)		
Total Prepaid Inpatient Health Plan Administration	$151,419,686	$146,272,146	($5,147,540)		
Total Bottom Line Financing	$946,489,862	$1,203,960,906	$257,471,044		
Rounding Adjustment	$2	$0	($2)		
Grand Total[1]	**$6,594,830,484**	**$6,801,990,609**	**$207,160,125**		

(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 2016-17

Item	Base Spending Authority [1]	R-1 Request (November 2015)	Difference	Description of Difference from Base Request
Acute Care				
Base Acute Cost	$3,783,429,430	$3,888,914,221	$105,484,792	Increasing caseload and per capita costs
Bottom Line Impacts				
SB 10-117: "OTC MEDS"	($87,357)	($87,357)	$0	
Accountable Care Collaborative Savings	($76,913,852)	($64,869,871)	$12,043,981	Different assumptions of savings
Estimated Impact of Increasing PACE Enrollment	($4,342,086)	($6,569,236)	($2,227,150)	Enrollment expectations adjusted based on FY 2014-15 actuals
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($1,212,784)	($1,124,754)	$88,030	Updated savings with most recent information available
FY 2012-13 R-6: "Dental Efficiency"	($1,859,598)	($1,704,632)	$154,966	Delayed one fiscal year, stakeholder process is taking longer than anticipated
Annualization of FY 2014-15 R-10: "Primary Care Specialty Collaboration"	($368,269)	($224,742)	$143,527	Implementation delayed due to software issues
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase'"	($36,529,099)	($51,071,303)	($14,542,204)	Higher utilization in prior years will cause additional savings when rate increase ends
Annualization of FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	($21,221,511)	($19,840,536)	$1,380,975	Enrollment ramp-up slower than anticipated
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase"	$14,800,494	$14,800,494	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Physical and Occupational Therapy Services	$3,913,384	$3,913,384	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prostate Biopsy	$5,984	$5,984	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Diabetic Self-Management	$529,563	$529,563	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental X-Rays	$398,279	$398,279	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prenatal and Postpartum Care	$681,284	$681,284	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Sealants	$1,619,466	$1,619,466	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Vision Retinal Services	$444,636	$444,636	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Eye Materials	$4,358,243	$4,358,243	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Fillings and Extractions	$16,427,187	$16,427,187	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Anesthesia	$14,032,034	$14,032,034	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - EMT	$1,210,105	$1,210,105	$0	
Annualization of HB 15-1309: "Protective Restorations by Dental Hygienists"	$63,667	$63,667	$0	
Annualization of HB 15-1186: "Children with Autism Waiver Expansion"	$888,619	$888,619	$0	
SB 11-177: Annualization "Sunset Teen Pregnancy & Dropout Program"	($183,897)	($183,897)	$0	
Total Acute Care	**$3,700,083,922**	**$3,802,610,838**	**$102,526,916**	
Community Based Long-Term Care				
Base CBLTC Cost	$781,113,928	$831,198,843	$50,084,915	
Bottom Line Impacts				
Annualization of FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	($619,821)	($619,821)	$0	Updated based on FY 2015-16 S-5/BA-5 and combined with HB 14-1252; slow ramp up
Annualization of FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($976,040)	($976,040)	$0	Updated based on FY 2015-16 S-5/BA-5, slow ramp up pushed savings into FY 2015-16
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Pediatric Hospice Services 20% Rate Increase	$22,443	$269,321	$246,878	Delayed implementation
Annualization of HB 14-1357: "In-Home Support Services in Medicaid Program"	$893,956	$1,191,942	$297,986	Delayed implementation
Annualization of FY 2014-15 JBC Action: "Raising Cap on Home Modifications"	$676,923	$1,353,846	$676,923	Delayed implementation
Annualization of EPSDT Personal Care	($374,663)	($538,628)	($163,965)	Delayed implementation
Colorado Choice Transitions	$10,713,191	$4,278,309	($6,434,882)	Revised forecast
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase"	$3,270,485	$3,374,121	$103,635	Some rate increases have delayed implementation, not yet approved by CMS
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - HCBS EBD Personal Care/Homemaker	$15,291,977	$16,493,296	$1,201,319	Delayed implementation, not yet approved by CMS
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - In-Home Respite (excludes CES Respite)	$66,320	$72,349	$6,029	Delayed implementation, not yet approved by CMS
Annualization of FY 2015-16 JBC Action: "Raising Cap on Home Modifications"	$711,238	$775,896	$64,658	Delayed implementation, not yet approved by CMS
Annualization of HB 15-1186: "Children with Autism Waiver Expansion"	$9,354,427	$9,354,427	$0	
Annualization of Independent Living Skills Training Rule Change	$0	$345,832	$345,832	New information
LTHH Impact - Annualization of FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	($900,928)	($900,928)	$0	
LTHH Impact - Annualization of FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($2,550,752)	($2,550,752)	$0	
LTHH Impact - Annualization of HB 15-1186: "Children with Autism Waiver Expansion"	$52,416	$52,416	$0	
LTHH Impact - EPSDT Personal Care	$777,975	$1,110,298	$332,323	Revised forecast
LTHH Impact - Colorado Choice Transitions	$2,637,967	$1,023,483	($1,614,484)	Revised forecast
Total Community Based Long-Term Care	**$820,161,042**	**$865,308,210**	**$45,147,168**	

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills - FY 2016-17

Item	Base Spending Authority [1]	R-1 Request (November 2015)	Difference	Description of Difference from Base Request
Long-Term Care and Insurance				
Class I Nursing Facilities				
Base Class I Nursing Facility Cost	$638,029,307	$638,794,061	$764,754	
Bottom Line Impacts				
Hospital Back Up Program	$16,248,317	$12,931,913	($3,316,404)	Revised forecast
Recoveries from Department Overpayment Review	($3,376,348)	($3,243,520)	$132,828	Updated
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($18,596,535)	($18,191,709)	$404,826	Revised forecast
Colorado Choice Transitions	($33,394,174)	($16,786,241)	$16,607,933	Revised forecast
Total Class I Nursing Facilities	**$598,910,567**	**$613,504,504**	**$14,593,937**	
Class II Nursing Facilities				
Base Class II Nursing Facilities	$4,711,461	$5,035,779	$324,318	Revised forecast
Bottom Line Impacts				
Total Class II Nursing Facilities	**$4,711,461**	**$5,035,779**	**$324,318**	
Program of All Inclusive Care for the Elderly (PACE)				
Base PACE Cost	$140,174,136	$145,181,513	$5,007,377	Revised forecast
Bottom Line Impacts				
Total Program of All-Inclusive Care for the Elderly	**$140,174,136**	**$156,900,991**	**$16,726,855**	
Supplemental Medicare Insurance Benefit (SMIB)				
Base SMIB	$146,971,337	$143,021,819	($3,949,518)	Revised forecast
Bottom Line Impacts				
Total Supplemental Medicare Insurance Benefit	**$146,971,337**	**$162,436,498**	**$15,465,161**	
Health Insurance Buy-In Program (HIBI)				
Base HIBI Cost	$1,057,705	$1,262,907	$205,202	
Bottom Line Impacts				
SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$78,238	$87,737	$9,499	Revised forecast
SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$653,037	$605,636	($47,401)	Revised forecast
Total Health Insurance Buy-In Program	**$1,788,980**	**$1,956,280**	**$167,300**	
Total Long-Term Care and Insurance	**$892,556,481**	**$939,834,052**	**$47,277,571**	
Service Management				
Single Entry Points (SEP)				
FY 2012-13 Base Contracts	$31,466,328	$33,238,452	$1,772,124	Forecast adjusted based on enrollment expectations in CBLTC
Bottom Line Impacts				
Total Single Entry Points	**$31,466,328**	**$33,238,452**	**$1,772,124**	
Disease Management				
Base Disease Management	$1,269,417	$254,356	($1,015,061)	Revised forecast
Bottom Line Impacts				
Total Disease Management	**$1,269,417**	**$1,028,215**	**($241,202)**	
Accountable Care Collaborative and Prepaid Inpatient Health Plan Administration				
Estimated FY 2010-11 Base Expenditures	$151,419,686	$162,438,472	$11,018,786	Revised forecast
Bottom Line Impacts				
Total Accountable Care Collaborative and Prepaid Inpatient Health Plan Administration	**$151,419,686**	**$162,438,472**	**$11,018,786**	
Total Service Management	**$184,155,431**	**$196,705,139**	**$12,549,708**	
Grand Total Services	**$5,596,956,876**	**$5,804,458,239**	**$207,501,363**	

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills - FY 2016-17

Item	Base Spending Authority [1]	R-1 Request (November 2015)	Difference	Description of Difference from Base Request
Bottom Line Financing				
Upper Payment Limit Financing	$4,053,417	$4,048,270	($5,147)	Revised forecast
Department Recoveries Adjustment	$0	$0	$0	
Denver Health Outstationing	$6,964,536	$6,964,536	$0	
Hospital Provider Fee Supplemental Payments	$827,988,116	$679,000,000	($148,988,116)	Revised forecast
Nursing Facility Provider Fee Supplemental Payments	$96,096,822	$97,869,540	$1,772,718	Revised forecast
Physician Supplemental Payments	$8,831,734	$8,831,734	$0	
Memorial Hospital High Volume Supplemental Payments	$555,237	$555,237	$0	
Health Care Expansion Fund Transfer Adjustment	$0	$0	$0	
Intergovernmental Transfer for Difficult to Discharge Clients	$2,000,000	$2,000,000	$0	
Cash Funds Financing	$0	$0	$0	
Total Bottom Line Financing	**$946,489,862**	**$799,269,317**	**($147,220,545)**	
Grand Total[2]	**$6,543,446,738**	**$6,603,727,556**	**$60,280,818**	
Total Acute Care	$3,700,083,922	$3,802,610,838	$102,526,916	
Total Community Based Long-Term Care	$820,161,042	$865,308,210	$45,147,168	
Total Class I Nursing Facilities	$598,910,567	$613,504,504	$14,593,937	
Total Class II Nursing Facilities	$4,711,461	$5,035,779	$324,318	
Total Program of All-Inclusive Care for the Elderly	$140,174,136	$156,900,991	$16,726,855	
Total Supplemental Medicare Insurance Benefit	$146,971,337	$162,436,498	$15,465,161	
Total Health Insurance Buy-In Program	$1,788,980	$1,956,280	$167,300	
Total Single Entry Point	$31,466,328	$33,238,452	$1,772,124	
Total Disease Management	$1,269,417	$1,028,215	($241,202)	
Total Prepaid Inpatient Health Plan Administration	$151,419,686	$162,438,472	$11,018,786	
Total Bottom Line Financing	$946,489,862	$799,269,317	($147,220,545)	
Rounding Adjustment	$0	$0	$0	
Grand Total[2]	**$6,543,446,738**	**$6,603,727,556**	**$60,280,818**	

(1) The Department has not received a FY 2016-17 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 2006-07	$69,287,729	$40,815,863	$322,592,598	$0	$203,687,759	$0	$0	$5,546,117	$325,188,990	$0	$42,779,524	$48,456,939	$0	$54,457,313	$2,564,389	$1,115,377,221
FY 2007-08	$82,865,413	$48,471,304	$410,013,129	$0	$205,881,573	$0	$0	$7,073,613	$358,939,975	$0	$54,744,366	$54,344,094	$0	$53,633,572	$3,198,260	$1,279,165,299
FY 2008-09	$84,634,236	$51,560,699	$401,887,052	$0	$237,329,869	$0	$0	$7,038,935	$426,055,244	$0	$52,144,060	$60,515,451	$0	$59,182,087	$3,783,765	$1,384,131,398
FY 2009-10 (DA)	$59,035,232	$45,291,572	$289,088,989	$0	$259,579,314	$3,085,478	$0	$9,006,243	$456,546,700	$0	$40,076,733	$68,066,556	$0	$48,429,083	$3,133,701	$1,281,339,601
FY 2010-11 (DA)	$59,114,932	$50,236,027	$307,712,970	$0	$274,143,602	$61,667,292	$0	$9,816,125	$490,364,176	$0	$42,066,929	$67,507,167	$0	$45,331,276	$4,885,305	$1,412,845,801
FY 2011-12	$75,155,191	$61,049,927	$443,766,632	$398,462	$301,104,198	$82,998,921	$2,393,150	$10,272,492	$509,353,569	$0	$49,175,549	$63,317,628	$0	$41,938,165	$5,279,710	$1,646,203,594
FY 2012-13	$78,805,339	$65,882,971	$441,467,295	$11,438,155	$316,833,427	$92,095,552	$55,270,434	$9,558,376	$548,721,374	$14,144,638	$46,515,535	$72,164,144	$2,846,306	$43,756,602	$6,211,623	$1,805,711,771
FY 2013-14	$85,675,110	$74,784,265	$486,297,328	$26,043,041	$357,736,561	$108,351,925	$319,790,154	$8,877,269	$627,878,215	$37,312,569	$51,698,815	$122,224,478	$8,648,792	$38,511,597	$8,664,131	$2,362,494,250
FY 2014-15	$94,799,170	$85,333,588	$500,156,178	$21,576,529	$470,269,908	$171,248,784	$906,697,528	$5,087,980	$729,775,200	$67,965,681	$56,808,436	$155,162,261	$16,409,327	$40,522,763	$8,523,860	$3,330,337,193
Estimated FY 2015-16	$91,859,669	$87,012,782	$503,245,509	$28,540,089	$522,249,142	$198,461,286	$1,143,562,866	$3,657,778	$813,803,255	$84,211,584	$58,701,398	$157,703,813	$16,519,607	$43,515,454	$11,615,485	$3,764,659,717
Estimated FY 2016-17	$76,587,075	$86,106,473	$497,626,012	$31,808,879	$530,348,907	$199,817,846	$1,186,525,554	$1,903,368	$816,349,214	$87,502,055	$57,374,930	$158,466,274	$16,477,397	$44,869,095	$10,847,759	$3,802,610,838
Estimated FY 2017-18	$76,749,455	$89,877,132	$516,529,869	$35,732,783	$545,531,568	$206,100,502	$1,217,897,251	$642,118	$852,937,142	$93,521,968	$57,794,731	$161,476,567	$16,670,904	$45,423,565	$12,188,371	$3,929,073,926

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 2007-08	19.60%	18.76%	27.10%	0.00%	1.08%	0.00%	0.00%	27.54%	10.38%	0.00%	27.97%	12.15%	0.00%	-1.51%	24.72%	14.68%
FY 2008-09	2.13%	6.37%	-1.98%	0.00%	15.27%	0.00%	0.00%	-0.49%	18.70%	0.00%	-4.75%	11.36%	0.00%	10.35%	18.31%	8.21%
FY 2009-10 (DA)	-30.25%	-12.16%	-28.07%	0.00%	9.37%	0.00%	0.00%	27.95%	7.16%	0.00%	-23.14%	12.48%	0.00%	-18.17%	-17.18%	-7.43%
FY 2010-11 (DA)	0.14%	10.92%	6.44%	0.00%	5.61%	1898.63%	0.00%	8.99%	7.41%	0.00%	4.97%	-0.82%	0.00%	-6.40%	55.90%	10.26%
FY 2011-12	27.13%	21.53%	44.21%	0.00%	9.83%	34.59%	0.00%	4.65%	3.87%	0.00%	16.90%	-6.21%	0.00%	-7.49%	8.07%	16.52%
FY 2012-13	4.86%	7.92%	-0.52%	2770.58%	5.22%	10.96%	2209.53%	-6.95%	7.73%	0.00%	-5.41%	13.97%	0.00%	4.34%	17.65%	9.69%
FY 2013-14	8.72%	13.51%	10.15%	127.69%	12.91%	17.65%	478.59%	-7.13%	14.43%	163.79%	11.14%	69.37%	203.86%	-11.99%	39.48%	30.83%
FY 2014-15	10.65%	14.11%	2.85%	-17.15%	31.46%	58.05%	183.53%	-42.69%	16.23%	82.15%	9.88%	26.95%	89.73%	5.22%	-1.62%	40.97%
Estimated FY 2015-16	-3.10%	1.97%	0.62%	32.27%	11.05%	15.89%	26.12%	-28.11%	11.51%	23.90%	3.33%	1.64%	0.67%	7.39%	36.27%	13.04%
Estimated FY 2016-17	-16.63%	-1.04%	-1.12%	11.45%	1.55%	0.68%	3.76%	-47.96%	0.31%	3.91%	-2.26%	0.48%	-0.26%	3.11%	-6.61%	1.01%
Estimated FY 2017-18	0.21%	4.38%	3.80%	12.34%	2.86%	3.14%	2.64%	-66.26%	4.48%	6.88%	0.73%	1.90%	1.17%	1.24%	12.36%	3.33%

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	$1,930.67	$6,736.40	$6,610.64	$0.00	$3,647.05	$0.00	$0.00	$24,325.07	$1,583.28	$0.00	$2,557.97	$9,351.01	$0.00	$10,470.55	$198.67	$2,843.69
FY 2007-08	$2,283.80	$7,886.64	$8,211.27	$0.00	$3,850.20	$0.00	$0.00	$26,198.57	$1,759.32	$0.00	$3,193.77	$8,642.51	$0.00	$12,797.32	$225.01	$3,263.49
FY 2008-09	$2,249.77	$7,997.63	$7,825.67	$0.00	$3,835.70	$0.00	$0.00	$22,204.84	$1,812.01	$0.00	$2,891.59	$8,674.81	$0.00	$14,843.76	$251.00	$3,168.71
FY 2009-10 (DA)	$1,533.90	$6,425.25	$5,427.47	$0.00	$3,468.50	$952.90	$0.00	$21,191.16	$1,656.12	$0.00	$2,180.33	$8,693.05	$0.00	$13,113.75	$196.85	$2,568.86
FY 2010-11 (DA)	$1,518.84	$6,467.88	$5,467.05	$0.00	$3,379.73	$2,269.93	$0.00	$18,486.11	$1,621.52	$0.00	$2,287.12	$8,579.97	$0.00	$14,108.71	$285.86	$2,519.52
FY 2011-12	$1,891.17	$7,282.59	$7,466.54	$7,662.73	$3,229.90	$2,340.57	$2,110.36	$17,206.85	$1,522.13	$0.00	$2,726.82	$8,298.51	$0.00	$15,140.13	$279.78	$2,655.33
FY 2012-13	$1,930.23	$7,279.08	$7,129.64	$12,880.81	$3,187.72	$2,216.77	$5,197.52	$15,342.50	$1,524.89	$1,717.42	$2,616.61	$8,993.54	$8,274.15	$16,302.76	$292.92	$2,643.82
FY 2013-14	$2,047.88	$7,590.00	$7,548.39	$10,173.06	$2,869.24	$2,301.34	$3,665.51	$15,880.62	$1,573.50	$1,472.19	$2,830.18	$9,287.57	$8,182.40	$15,522.61	$370.61	$2,744.03
FY 2014-15	$2,267.00	$8,153.41	$7,515.72	$5,948.86	$2,890.45	$2,391.44	$3,766.01	$12,783.87	$1,637.29	$1,356.22	$2,835.32	$10,415.67	$9,382.12	$14,887.13	$303.94	$2,868.00
Estimated FY 2015-16	$2,175.84	$7,885.16	$7,304.32	$5,873.65	$2,875.00	$2,394.07	$3,901.73	$12,925.01	$1,715.33	$1,408.17	$2,946.41	$10,634.11	$9,559.96	$14,543.94	$353.75	$2,915.02
Estimated FY 2016-17	$1,788.16	$7,432.58	$6,953.09	$5,560.02	$2,729.10	$2,298.13	$3,911.52	$12,440.31	$1,651.94	$1,353.91	$2,876.95	$10,623.91	$9,552.11	$14,455.25	$292.91	$2,812.57
Estimated FY 2017-18	$1,765.65	$7,390.00	$6,955.41	$5,512.62	$2,667.21	$2,264.84	$3,954.97	$12,348.42	$1,654.82	$1,348.28	$2,894.66	$10,750.77	$9,664.29	$14,447.70	$295.58	$2,794.94

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 2007-08	18.29%	17.07%	24.21%	0.00%	5.57%	0.00%	0.00%	7.70%	11.12%	0.00%	24.86%	-7.58%	0.00%	22.22%	13.26%	14.76%
FY 2008-09	-1.49%	1.41%	-4.70%	0.00%	-0.38%	0.00%	0.00%	-15.24%	2.99%	0.00%	-9.46%	0.37%	0.00%	15.99%	11.55%	-2.90%
FY 2009-10 (DA)	-31.82%	-19.66%	-30.65%	0.00%	-9.57%	0.00%	0.00%	-4.57%	-8.60%	0.00%	-24.60%	0.21%	0.00%	-11.65%	-21.57%	-18.93%
FY 2010-11 (DA)	-0.98%	0.66%	0.73%	0.00%	-2.56%	138.21%	0.00%	-12.76%	-2.09%	0.00%	4.90%	-1.30%	0.00%	7.59%	45.22%	-1.92%
FY 2011-12	24.51%	12.60%	36.57%	0.00%	-4.43%	3.11%	0.00%	-6.92%	-6.13%	0.00%	19.23%	-3.28%	0.00%	7.31%	-2.13%	5.39%
FY 2012-13	2.07%	-0.05%	-4.51%	68.10%	-1.31%	-5.29%	146.29%	-10.83%	0.18%	0.00%	-4.04%	8.38%	0.00%	7.68%	4.70%	-0.43%
FY 2013-14	6.10%	4.27%	5.87%	-21.02%	-9.99%	3.82%	-29.48%	3.51%	3.19%	-14.28%	8.16%	3.27%	-1.11%	-4.79%	26.52%	3.79%
FY 2014-15	10.70%	7.42%	-0.43%	-41.52%	0.74%	3.92%	2.74%	-19.50%	4.05%	-7.88%	0.18%	12.15%	14.66%	-4.09%	-17.99%	4.52%
Estimated FY 2015-16	-4.02%	-3.29%	-2.81%	-1.26%	-0.53%	0.11%	3.60%	1.10%	4.77%	3.83%	3.92%	2.10%	1.90%	-2.31%	16.39%	1.64%
Estimated FY 2016-17	-17.82%	-5.74%	-4.81%	-5.34%	-5.07%	-4.01%	0.25%	-3.75%	-3.70%	-3.85%	-2.36%	-0.10%	-0.08%	-0.61%	-17.20%	-3.51%
Estimated FY 2017-18	-1.26%	-0.57%	0.03%	-0.85%	-2.27%	-1.45%	1.11%	-0.74%	0.17%	-0.42%	0.62%	1.19%	1.17%	-0.05%	0.91%	-0.63%

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 2014-15 Per Capita	$2,267.00	$8,153.41	$7,515.72	$5,948.86	$2,890.45	$2,391.44	$3,766.01	$12,783.87	$1,637.29	$1,356.22	$2,835.32	$10,415.67	$9,382.12	$14,887.13	$303.94	$2,868.00
Average of FY 2007-08 through FY 2012-13	1.76%	-1.01%	-0.51%	0.00%	0.00%	27.21%	29.26%	-10.06%	-2.73%	0.00%	-2.79%	0.88%	0.00%	5.38%	7.55%	-3.76%
Average of FY 2008-09 through FY 2012-13	-1.54%	-1.61%	0.54%	17.03%	-4.47%	34.01%	36.57%	-8.77%	-4.16%	0.00%	-1.13%	1.00%	0.00%	2.73%	6.56%	-3.97%
Average of FY 2009-10 through FY 2012-13	-1.56%	4.40%	10.93%	22.70%	-2.77%	45.34%	48.76%	-10.17%	-2.68%	0.00%	6.70%	1.27%	0.00%	7.53%	15.93%	1.01%
Average of FY 2010-11 through FY 2012-13	8.53%	6.28%	16.03%	34.05%	-2.87%	-1.09%	73.15%	-8.88%	-2.98%	0.00%	7.60%	2.55%	0.00%	7.50%	1.29%	2.48%
Average of FY 2008-09 through FY 2013-14	-0.27%	-0.44%	1.60%	9.42%	-5.57%	27.97%	23.36%	-6.31%	-2.69%	-2.86%	0.73%	1.46%	-0.22%	1.23%	10.55%	-2.42%
Average of FY 2009-10 through FY 2013-14	-0.02%	4.37%	9.67%	11.77%	-4.57%	34.96%	29.20%	-6.75%	-1.21%	-3.57%	7.06%	1.77%	-0.28%	4.45%	18.58%	1.71%
Average of FY 2010-11 through FY 2013-14	7.93%	5.61%	12.64%	15.69%	-5.24%	0.55%	38.94%	-4.75%	-0.92%	-4.76%	7.78%	2.79%	-0.37%	3.40%	9.70%	2.92%
Average of FY 2011-12 through FY 2013-14	10.89%	2.11%	0.68%	23.54%	-5.65%	-0.74%	58.41%	-3.66%	1.69%	-7.14%	2.06%	5.83%	-0.56%	1.45%	15.61%	1.68%
Average of FY 2009-10 through FY 2014-15	1.76%	4.98%	7.65%	1.11%	-3.51%	28.75%	23.91%	-9.30%	-0.16%	-4.43%	5.69%	3.84%	2.71%	2.74%	11.26%	2.27%
Average of FY 2010-11 through FY 2014-15	8.48%	6.06%	9.38%	1.39%	-3.75%	1.39%	29.89%	-8.44%	0.32%	-5.54%	5.88%	5.13%	3.39%	1.53%	2.78%	3.32%
Average of FY 2011-12 through FY 2014-15	10.85%	3.88%	0.31%	1.85%	-3.52%	0.82%	39.85%	-8.94%	2.47%	-7.39%	1.43%	7.93%	4.52%	-0.40%	4.41%	2.63%
Average of FY 2012-13 through FY 2014-15	6.29%	5.85%	2.72%	-31.27%	-4.63%	3.87%	-13.37%	-8.00%	3.62%	-11.08%	4.17%	7.71%	6.78%	-4.44%	4.27%	4.16%

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]	0.78%	1.00%	0.30%	2.00%	-2.00%	-1.18%	2.50%	0.00%	0.50%	0.00%	0.82%	1.29%	1.29%	-2.75%	1.83%	
Estimated FY 2015-16 Base Per Capita	$2,284.68	$8,234.94	$7,538.27	$6,067.84	$2,832.64	$2,363.22	$3,860.16	$12,783.87	$1,645.48	$1,356.22	$2,858.57	$10,550.34	$9,503.43	$14,477.73	$309.50	$2,885.63
Estimated FY 2015-16 Eligibles	42,218	11,035	68,897	4,859	181,652	82,897	293,091	283	474,429	59,802	19,923	14,830	1,728	2,992	32,835	1,291,471
Estimated FY 2015-16 Base Expenditures	$96,454,620	$90,872,563	$519,364,188	$29,483,635	$514,554,721	$195,903,848	$1,131,378,155	$3,617,835	$780,663,431	$81,104,668	$56,951,290	$156,461,542	$16,421,927	$43,317,368	$10,162,433	$3,726,712,224
Bottom Line Impacts																
Annualization of Physicians to 100% of Medicare: 100% Federally Funded Portion	($206,288)	($542,442)	($3,641,157)	($226,774)	($5,295,626)	($1,975,831)	($9,775,386)	($41,608)	($10,018,581)	($838,640)	($737,173)	($2,119,645)	($243,947)	($316,578)	($842)	($35,980,518)
Annualization of Physicians to 100% of Medicare: GF and FF Portion Due to Rate Decreases Since 2009	($18,130)	($47,676)	($320,028)	($19,932)	($465,442)	($173,659)	($859,177)	($3,657)	($880,551)	($73,710)	($64,792)	($186,300)	($21,441)	($27,825)	($74)	($3,162,394)
Accountable Care Collaborative Savings	($5,945,628)	($3,547,462)	($25,085,051)	($1,340,392)	($1,744,216)	($1,062,645)	($4,724,303)	$0	($2,644,695)	($633,690)	($124,252)	($65,251)	($18,200)	$0	$0	($46,935,785)
Estimated Impact of Increasing PACE Enrollment	($1,603,952)	($1,633,434)	($513,553)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($3,750,939)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($13,524)	($12,172)	($71,345)	($3,078)	($67,082)	($24,428)	($129,336)	($726)	($104,099)	($9,695)	($8,103)	($22,133)	($2,341)	($5,780)	($1,216)	($475,058)
Annualization of FY 2012-13 R-6: "Augmentative Communication Devices"	($64,933)	($20,464)	($177,602)	($3,870)	($22,997)	($7,544)	($54,245)	($150)	($55,180)	$0	($14,716)	($1,235)	($107)	($33)	($186)	($423,262)
Annualization of Fluoride Benefit Expansion for Children	$0	$0	$0	$0	$0	$0	$0	$0	$315,012	$39,708	$13,229	$0	$0	$0	$0	$367,949
Annualization of FY 2014-15 R-9: "Medicaid Community Living Initiative"	$4,666	$427	$871	$1	$2	$0	$26	$0	$0	$0	$1	$0	$0	$0	$0	$5,994
Annualization of FY 2014-15 R-10: "Primary Care Specialty Collaboration"	($498)	($1,312)	($8,804)	($548)	($12,804)	($4,777)	($23,635)	($101)	($24,223)	($2,028)	($1,782)	($5,125)	($590)	($765)	($2)	($86,994)
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase"	$134,830	$121,367	$711,356	$30,688	$668,850	$243,562	$1,289,567	$7,236	$1,037,936	$96,665	$80,797	$220,682	$23,338	$57,634	$12,123	$4,736,631
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Extended Hours/After Hours Care 10% Rate Increase	$335	$879	$5,903	$368	$8,585	$3,203	$15,847	$67	$16,241	$1,359	$1,195	$3,436	$395	$513	$1	$58,327
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Incentives to Use Ambulatory Surgery Centers	$837	$2,342	$16,173	$938	$26,581	$9,401	$51,331	$166	$30,875	$3,026	$2,214	$3,250	$294	$719	$1	$148,148
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - High-Value Specialist Services to 80% of Medicare	$25,149	$33,177	$139,187	$8,217	$89,551	$29,408	$343,682	$468	$184,752	$6,625	$10,922	$98,380	$10,626	$48,259	$0	$1,028,403
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Mammography Reimbursement to 80% of Medicare	$531	$139	$868	$61	$2,288	$1,044	$3,691	$0	$0	$0	$0	$0	$0	$0	$0	$8,622
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Assistive Technology Reimbursement Rate to 80% of Medicare	$286	$97	$840	$18	$109	$36	$257	$0	$261	$21	$70	$6	$1	$0	$1	$2,003
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase'"	$3,954,298	$1,412,785	$7,374,381	$463,928	$8,820,038	$3,188,491	$14,877,563	$44,665	$20,197,782	$1,928,475	$1,063,934	$1,343,317	$132,326	$177,880	$1,412,832	$66,392,695
Annualization of FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	($2,493,185)	($452,743)	($1,741,579)	($117,588)	($318,983)	($5,396)	($32,987)	($72)	($2,656)	($160)	($1,503)	($6,658)	($85)	($541)	$0	($5,174,136)
Annualization of FY 2014-15 JBC Action: "Matching Incentives to Ambulatory Surgery Center Facilities"	$837	$2,342	$16,173	$938	$26,581	$9,401	$51,331	$166	$30,875	$3,026	$2,214	$3,250	$294	$719	$1	$148,148
Annualization of FY 2014-15 JBC Action: "Family Planning Rate Increase"	$4,276	$4,028	$23,024	$1,307	$22,810	$8,685	$50,155	$160	$34,607	$3,595	$2,525	$6,936	$728	$1,920	$451	$165,207
Annualization of FY 2014-15 JBC Action: "Raising FQHC Rate Increase to APM"	$3,769	$6,562	$37,255	$832	$84,325	$37,643	$183,793	$338	$225,890	$19,342	$7,755	$46,746	$4,124	$1,775	$10	$660,159
Annualization of FY 2014-15 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
FY 2015-16 R-12: "Community Provider Rate Increase"	$329,253	$296,377	$1,737,122	$74,939	$1,633,323	$594,774	$3,149,106	$17,671	$2,534,626	$236,056	$197,305	$538,903	$56,992	$140,742	$29,605	$11,566,794
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Physical and Occupational Therapy Services	$1,636	$0	$1,969,095	$12,007	$0	$0	$546	$0	$1,242,709	$4,912	$356,363	$0	$0	$0	$0	$3,587,268
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prostate Biopsy	$415	$392	$2,239	$0	$0	$0	$2,439	$0	$0	$0	$0	$0	$0	$0	$0	$5,485
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Diabetic Self-Management	$138,058	$47,890	$104,325	$3,946	$70,686	$23,713	$75,116	$0	$11,359	$821	$1,626	$7,704	$189	$0	$0	$485,433
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental X-Rays	$10,804	$3,744	$21,911	$1,115	$42,235	$16,937	$63,768	$0	$168,515	$24,969	$7,983	$2,812	$296	$0	$0	$365,089
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prenatal and Postpartum Care	$0	$0	$6,914	$0	$47,213	$11,551	$13,439	$0	$33,544	$4,935	$4,117	$449,612	$53,186	$0	$0	$624,511
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Sealants	$0	$0	$136,629	$5,171	$0	$0	$0	$0	$1,140,942	$118,535	$83,234	$0	$0	$0	$0	$1,484,511
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Vision Retinal Services	$13,523	$12,733	$35,557	$2,198	$61,947	$30,506	$186,783	$0	$47,258	$9,311	$4,757	$2,312	$698	$0	$0	$407,583
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Eye Materials	$0	$0	$367,691	$13,916	$0	$0	$0	$0	$3,070,456	$318,996	$223,997	$0	$0	$0	$0	$3,995,056
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Fillings and Extractions	$444,384	$154,412	$903,715	$45,999	$1,741,991	$698,564	$2,630,138	$0	$6,950,481	$1,029,848	$329,277	$115,978	$12,196	$1,237	$35	$15,058,255
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Anesthesia	$73,744	$193,918	$1,301,679	$81,070	$1,893,137	$706,341	$3,494,609	$14,875	$3,581,549	$299,806	$263,533	$757,753	$87,209	$113,174	$301	$12,862,698
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - EMT	$52,518	$39,919	$216,136	$4,612	$136,222	$31,123	$411,782	$445	$146,191	$11,155	$22,230	$30,384	$1,499	$5,036	$11	$1,109,263
HB 15-1309: "Protective Restorations by Dental Hygienists"	$0	$0	$3,455	$131	$0	$0	$0	$0	$28,852	$2,997	$2,105	$0	$0	$0	$0	$37,540
HB 15-1186: "Children with Autism Waiver Expansion"	$0	$0	$34,546	$1,307	$0	$0	$0	$0	$288,484	$0	$21,046	$0	$0	$0	$0	$345,383
Sunset of Long-Acting Reversible Contraceptive (LARC) Funding	$0	$0	$0	$0	$0	$0	$0	$0	$5,550,612	$500,656	$0	$0	$0	$0	$0	$6,051,268
Total Bottom Line Impacts	($4,594,951)	($3,859,781)	($16,118,679)	($943,546)	$7,694,421	$2,557,438	$12,184,711	$39,943	$33,139,824	$3,106,916	$1,750,108	$1,242,271	$97,680	$198,086	$1,453,052	$37,947,493
Estimated FY 2015-16 Expenditures	**$91,859,669**	**$87,012,782**	**$503,245,509**	**$28,540,089**	**$522,249,142**	**$198,461,286**	**$1,143,562,866**	**$3,657,778**	**$813,803,255**	**$84,211,584**	**$58,701,398**	**$157,703,813**	**$16,519,607**	**$43,515,454**	**$11,615,485**	**$3,764,659,717**
Estimated FY 2015-16 Per Capita	$2,175.84	$7,885.16	$7,304.32	$5,873.65	$2,875.00	$2,394.07	$3,901.73	$12,925.01	$1,715.33	$1,408.17	$2,946.41	$10,634.11	$9,559.96	$14,543.94	$353.75	$2,915.02
% Change over FY 2014-15 Per Capita	-4.02%	-3.29%	-2.81%	-1.26%	-0.53%	0.11%	3.60%	1.10%	4.77%	3.83%	3.92%	2.10%	1.90%	-2.31%	16.39%	1.64%

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]	0.78%	1.00%	0.30%	1.00%	-2.00%	-1.18%	2.50%	0.00%	0.50%	0.00%	0.82%	1.29%	1.29%	0.00%	1.83%	
Estimated FY 2016-17 Base Per Capita	$2,192.81	$7,964.01	$7,326.23	$5,932.39	$2,817.50	$2,365.82	$3,999.27	$12,925.01	$1,723.91	$1,408.17	$2,970.57	$10,771.29	$9,683.28	$14,543.94	$360.22	$2,922.19
Estimated FY 2016-17 Eligibles	42,830	11,585	71,569	5,721	194,331	86,948	303,341	153	494,175	64,629	19,943	14,916	1,725	3,104	37,035	1,352,005
Estimated FY 2016-17 Base Expenditure	$93,918,052	$92,263,056	$524,330,955	$33,939,203	$547,527,593	$205,703,317	$1,213,143,547	$1,977,527	$851,911,569	$91,008,619	$59,242,078	$160,664,562	$16,703,658	$45,144,390	$13,340,748	$3,950,818,874
Bottom Line Impacts																
SB 10-117: "OTC MEDS"	($837)	($2,876)	($19,685)	($798)	($13,171)	($4,907)	($26,821)	($44)	($12,904)	($1,773)	($2,687)	($784)	($69)	($1)	$0	($87,357)
Accountable Care Collaborative Savings	($2,198,415)	($1,355,299)	($8,980,128)	($1,003,940)	($1,167,106)	($408,387)	($1,169,510)	$0	($1,366,378)	($183,660)	($60,498)	($24,397)	($16,368)	$0	$0	($17,934,086)
Estimated Impact of Increasing PACE Enrollment	($1,194,615)	($1,120,855)	($502,827)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($2,818,297)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($31,753)	($16,647)	($97,573)	($4,209)	($91,742)	($33,408)	($176,882)	($993)	($142,368)	$0	($11,082)	($30,270)	($3,201)	($7,905)	($1,663)	($649,696)
FY 2012-13 R-6: "Dental Efficiency"	$0	$0	($102,303)	($5,207)	($197,198)	($79,079)	($297,738)	($353)	($786,812)	($116,581)	($104,707)	($13,129)	($1,381)	($140)	($4)	($1,704,632)
Annualization of FY 2014-15 R-10: "Primary Care Specialty Collaboration"	($791)	($2,077)	($13,940)	($868)	($20,274)	($7,564)	($37,424)	($159)	($38,355)	($3,211)	($2,822)	($8,115)	($934)	($1,212)	($3)	($137,749)
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase'"	($6,996,067)	($2,499,542)	($13,046,982)	($820,795)	($15,604,682)	($5,641,177)	($26,321,841)	($79,022)	($35,734,537)	($3,411,918)	($1,882,345)	($2,376,637)	($234,116)	($314,710)	($2,499,627)	($117,463,998)
Annualization of FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	($7,067,085)	($1,283,326)	($4,936,610)	($333,311)	($904,177)	($15,296)	($93,503)	($203)	($7,529)	($454)	($4,260)	($18,873)	($240)	($1,533)	$0	($14,666,400)
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase"	$92,048	$82,857	$485,643	$20,950	$456,624	$166,280	$880,388	$4,940	$708,599	$65,994	$55,160	$150,660	$15,933	$39,347	$8,277	$3,233,700
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Physical and Occupational Therapy Services	$147	$0	$179,009	$1,092	$0	$0	$50	$0	$112,974	$447	$32,397	$0	$0	$0	$0	$326,116
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prostate Biopsy	$35	$35	$199	$0	$0	$0	$230	$0	$0	$0	$0	$0	$0	$0	$0	$499
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Diabetic Self-Management	$12,549	$4,354	$9,484	$359	$6,426	$2,156	$6,829	$0	$1,033	$75	$148	$700	$17	$0	$0	$44,130
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental X-Rays	$981	$340	$1,992	$101	$3,840	$1,540	$5,797	$0	$15,320	$2,270	$726	$256	$27	$0	$0	$33,190
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prenatal and Postpartum Care	$0	$0	$629	$0	$4,292	$1,050	$1,222	$0	$3,049	$449	$374	$40,873	$4,835	$0	$0	$56,773
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Sealants	$0	$0	$11,573	$499	$0	$0	$0	$0	$104,460	$11,159	$7,264	$0	$0	$0	$0	$134,955
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Vision Retinal Services	$1,231	$1,158	$3,232	$200	$5,632	$2,773	$16,980	$0	$4,296	$846	$432	$210	$63	$0	$0	$37,053
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Eye Materials	$0	$0	$31,143	$1,344	$0	$0	$0	$0	$281,119	$30,032	$19,549	$0	$0	$0	$0	$363,187
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Fillings and Extractions	$40,116	$14,037	$82,156	$4,182	$158,363	$63,506	$239,103	$283	$631,862	$93,623	$29,934	$10,543	$1,109	$112	$3	$1,368,932
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Anesthesia	$6,704	$17,629	$118,334	$7,370	$172,103	$64,213	$317,692	$1,352	$325,595	$27,255	$23,958	$68,887	$7,928	$10,289	$27	$1,169,336
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - EMT	$4,775	$3,629	$19,649	$419	$12,384	$2,829	$37,435	$40	$13,290	$1,014	$2,021	$2,762	$136	$458	$1	$100,842
Annualization of HB 15-1309: "Protective Restorations by Dental Hygienists"	$0	$0	$2,241	$97	$0	$0	$0	$0	$20,223	$2,160	$1,406	$0	$0	$0	$0	$26,127
Annualization of HB 15-1186: "Children with Autism Waiver Expansion"	$0	$0	$50,783	$2,191	$0	$0	$0	$0	$458,386	$0	$31,876	$0	$0	$0	$0	$543,236
SB 11-177: Annualization "Sunset Teen Pregnancy & Dropout Program"	$0	$0	($962)	$0	$0	$0	$0	$0	($153,678)	($24,291)	($3,992)	($974)	$0	$0	$0	($183,897)
Total Bottom Line Impacts	($17,330,977)	($6,156,583)	($26,704,943)	($2,130,324)	($17,178,686)	($5,885,471)	($26,617,993)	($74,159)	($35,562,355)	($3,506,564)	($1,867,148)	($2,198,288)	($226,261)	($275,295)	($2,492,989)	($148,208,036)
Estimated FY 2016-17 Expenditure	**$76,587,075**	**$86,106,473**	**$497,626,012**	**$31,808,879**	**$530,348,907**	**$199,817,846**	**$1,186,525,554**	**$1,903,368**	**$816,349,214**	**$87,502,055**	**$57,374,930**	**$158,466,274**	**$16,477,397**	**$44,869,095**	**$10,847,759**	**$3,802,610,838**
Estimated FY 2016-17 Per Capita	$1,788.16	$7,432.58	$6,953.09	$5,560.02	$2,729.10	$2,298.13	$3,911.52	$12,440.31	$1,651.94	$1,353.91	$2,876.95	$10,623.91	$9,552.11	$14,455.25	$292.91	$2,812.57
% Change over FY 2015-16 Per Capita	-17.82%	-5.74%	-4.81%	-5.34%	-5.07%	-4.01%	0.25%	-3.75%	-3.70%	-3.85%	-2.36%	-0.10%	-0.08%	-0.61%	-17.20%	-3.51%

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

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
	Out Year Projection															
Percentage Selected to Modify Per Capita[3]	0.78%	1.00%	0.30%	1.00%	-2.00%	-1.18%	1.25%	0.00%	0.50%	0.00%	0.82%	1.29%	1.29%	0.00%	1.83%	
Estimated FY 2017-18 Base Per Capita	$1,802.11	$7,506.91	$6,973.95	$5,615.62	$2,674.52	$2,271.01	$3,960.41	$12,440.31	$1,660.20	$1,353.91	$2,900.54	$10,760.96	$9,675.33	$14,455.25	$298.27	$2,803.74
Estimated FY 2017-18 Eligibles	43,468	12,162	74,263	6,482	204,533	91,000	307,941	52	515,425	69,364	19,966	15,020	1,725	3,144	41,235	1,405,780
Estimated FY 2017-18 Base Expenditure	$78,334,117	$91,299,039	$517,906,449	$36,400,449	$547,027,599	$206,661,910	$1,219,572,616	$646,896	$855,708,585	$93,912,613	$57,912,182	$161,629,619	$16,689,944	$45,447,306	$12,299,163	$3,941,448,487
Bottom Line Impacts																
SB 10-117: "OTC MEDS"	($927)	($3,191)	($21,841)	($886)	($14,614)	($5,444)	($29,758)	($49)	($14,318)	($1,967)	($2,981)	($870)	($77)	($1)	$0	($96,924)
Accountable Care Collaborative Savings	($102,962)	($135,250)	($122,239)	($625,377)	($668,469)	($261,062)	($249,386)	$0	($951,932)	($212,039)	($16,040)	($9,074)	($4,591)	$0	$0	($3,358,421)
Estimated Impact of Increasing PACE Enrollment	($1,148,559)	($1,152,051)	($534,090)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($2,834,700)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($23,496)	($21,150)	($123,964)	($5,348)	($116,557)	($42,444)	($224,726)	($1,261)	($180,875)	($16,845)	($14,080)	($38,457)	($4,067)	($10,044)	($2,113)	($825,427)
Annualization of FY 2012-13 R-6: "Dental Efficiency"	($4,541)	($1,589)	($9,300)	($473)	($17,927)	($7,189)	($27,067)	($32)	($71,528)	($10,598)	($3,389)	($1,194)	($126)	($13)	$0	($154,966)
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase"	($304,177)	($108,676)	($567,260)	($35,687)	($678,464)	($245,269)	($1,144,428)	($3,436)	($1,553,675)	($148,344)	($81,841)	($103,332)	($10,179)	($13,683)	($108,679)	($5,107,130)
Annualization of HB 15-1309: "Protective Restorations by Dental Hygienists"	$0	$0	$2,237	$105	$0	$0	$0	$0	$20,536	$2,254	$1,390	$0	$0	$0	$0	$26,522
Annualization of SB 11-177: Annualization "Sunset Teen Pregnancy & Dropout Program"	$0	$0	($123)	$0	$0	$0	$0	$0	($19,651)	($3,106)	($510)	($125)	$0	$0	$0	($23,515)
Total Bottom Line Impacts	($1,584,662)	($1,421,907)	($1,376,580)	($667,666)	($1,496,031)	($561,408)	($1,675,365)	($4,778)	($2,771,443)	($390,645)	($117,451)	($153,052)	($19,040)	($23,741)	($110,792)	($12,374,561)
Estimated FY 2017-18 Expenditure	**$76,749,455**	**$89,877,132**	**$516,529,869**	**$35,732,783**	**$545,531,568**	**$206,100,502**	**$1,217,897,251**	**$642,118**	**$852,937,142**	**$93,521,968**	**$57,794,731**	**$161,476,567**	**$16,670,904**	**$45,423,565**	**$12,188,371**	**$3,929,073,926**
Estimated FY 2017-18 Per Capita	$1,765.65	$7,390.00	$6,955.41	$5,512.62	$2,667.21	$2,264.84	$3,954.97	$12,348.42	$1,654.82	$1,348.28	$2,894.66	$10,750.77	$9,664.29	$14,447.70	$295.58	$2,794.94
% Change over FY 2016-17 Per Capita	-1.26%	-0.57%	0.03%	-0.85%	-2.27%	-1.45%	1.11%	-0.74%	0.17%	-0.42%	0.62%	1.19%	1.17%	-0.05%	0.91%	-0.63%

Note	Population	Explanation	Population	Explanation	Population	Explanation
(1) Percentage selected to modify Per Capita amounts for Estimated FY 2015-16: Where applicable, percentage selections have been bolded for clarification.	**OAP-A**	The Department believes the high growth in FY 2014-15 was due to higher than anticipated expenditure for inpatient hospital and health maintenance organizations. The trend selected accounts for underlying growth for this population.	**MAGI Parents/ Caretakers 69% to 133% FPL**	The Department has increased the trend to account for higher than expected expenditure in FY 2014-15. The per capita for this population is still expected to decrease and remain lower than the MAGI to 68% FPL population.	**Foster Care**	A negative caseload forecast and higher than anticipated expenditure across the top service categories contribute to the small positive per capita trend.
	OAP-B	Similar to OAP-A, the Department believes the increase in per capita costs in FY 2014-15 were due to higher than expected expenditure for inpatient hospital and health maintenance organizations. The Department has slightly increased the previous trend selection to modify per capita costs.	**MAGI Adults**	The Department has lowered the per capita trend for this population to reflect significantly lower than forecast expenditure in FY 2014-15.	**MAGI Pregnant Adults**	The Department expects a negative caseload forecast to put upward pressure from the previous trend. A small positive growth is anticipated for this population going forward.
	AND/AB	Per capita costs for this population aligned very closely with the previous forecast. The Department has not changed the trend for this population.	**BCCP**	See Narrative	**SB 11-250 Eligible Pregnant Adults**	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.
	Disabled Buy-in	The Department anticipates the per capita costs for this population to level off and stabilize around the current per capita. A slight upward trend has been selected.	**Eligible Children (AFDC-C/BC)**	The Department has updated the trend selected for this population based on actual expenditure in FY 2014-15 that was higher than anticipated, but not expected to continue at the same levels.	**Non-Citizens Emergency Services**	The Department has lowered the per capita growth trend for this population given actual per capita decreases in FY 2014-15.
	MAGI Parents/ Caretakers to 68% FPL	The Department has selected a downward trend as per capita decreases seen in FY 2014-15 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 lower than the standard population.	**SB 11-008 Eligible Children**	The Department had assumed strong caseload growth would put strong downward pressure on per capita in FY 2014-15. The trend has been set to 0% as the per capita for this population is expected to stabilize around the current value.	**Partial Dual Eligibles**	The Department has increased the per capita growth trend for this population given higher than expected growth in FY 2014-15, driven primarily by co-insurance.
(2) 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 high growth in FY 2014-15 was due to higher than anticipated expenditure for inpatient hospital and health maintenance organizations. The trend selected accounts for underlying growth for this population.	**MAGI Parents/ Caretakers 69% to 133% FPL**	The Department has increased the trend to account for higher than expected expenditure in FY 2014-15. The per capita for this population is still expected to decrease and remain lower than the MAGI to 68% FPL population.	**Foster Care**	A negative caseload forecast and higher than anticipated expenditure across the top service categories contribute to the small positive per capita trend.
	OAP-B	Similar to OAP-A, the Department believes the increase in per capita costs in FY 2014-15 were due to higher than expected expenditure for inpatient hospital and health maintenance organizations. The Department has maintained the previous trend selection to modify per capita costs.	**MAGI Adults**	The Department has lowered the per capita trend for this population to reflect significantly lower than forecast expenditure in FY 2014-15.	**MAGI Pregnant Adults**	The Department expects a negative caseload forecast to put upward pressure from the previous trend. A small positive growth is anticipated for this population going forward.
	AND/AB	Per capita costs for this population aligned very closely with the previous forecast. The Department has not changed the trend for this population.	**BCCP**	See Narrative	**SB 11-250 Eligible Pregnant Adults**	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.
	Disabled Buy-in	The Department anticipates the per capita costs for this population to level off and stabilize around the current per capita. A slight upward trend has been selected.	**Eligible Children (AFDC-C/BC)**	The Department anticipates costs will stabilize for this population.	**Non-Citizens Emergency Services**	The Department has lowered the per capita growth trend for this population given actual per capita decreases in FY 2014-15.
	MAGI Parents/ Caretakers to 68% FPL	The Department has selected a downward trend as per capita decreases seen in FY 2014-15 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 lower than the standard population.	**SB 11-008 Eligible Children**	The Department anticipates costs will stabilize for this population after the aggressive downward trend in FY 2014-15.	**Partial Dual Eligibles**	The Department has increased the per capita growth trend for this population given higher than expected growth in FY 2014-15, driven primarily by co-insurance.
(3) Percentage selected to modify Per Capita amounts for Estimated FY 2017-18: Where applicable, percentage selections have been italicized for clarification.	**OAP-A**	The Department believes the high growth in FY 2014-15 was due to higher than anticipated expenditure for inpatient hospital and health maintenance organizations. The trend selected accounts for underlying growth for this population.	**MAGI Parents/ Caretakers 69% to 133% FPL**	The Department has made a slight downward adjustment to the trend selected for this population as aggressive caseload growth is expected to continue.	**Foster Care**	The Department anticipates per capita costs will stabilize after the shifting caseload mix from expansion put downward pressure on per capita.
	OAP-B	Similar to OAP-A, the Department believes the increase in per capita costs in FY 2014-15 were due to higher than expected expenditure for inpatient hospital and health maintenance organizations. The Department has maintained the previous trend selection to modify per capita costs.	**MAGI Adults**	The Department has lowered the per capita trend for this population to reflect significantly lower than forecast expenditure in FY 2014-15.	**MAGI Pregnant Adults**	The Department expects a negative caseload forecast to put upward pressure from the previous trend. A small positive growth is anticipated for this population going forward.
	AND/AB	Per capita costs for this population aligned very closely with the previous forecast. The Department has not changed the trend for this population.	**BCCP**	See Narrative	**SB 11-250 Eligible Pregnant Adults**	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.
	Disabled Buy-in	The Department anticipates the per capita costs for this population to level off and stabilize around the current per capita. A slight upward trend has been selected.	**Eligible Children (AFDC-C/BC)**	The Department anticipates costs will stabilize for this population.	**Non-Citizens Emergency Services**	The Department has lowered the per capita growth trend for this population given actual per capita decreases in FY 2014-15.
	MAGI Parents/ Caretakers to 68% FPL	The Department has selected a downward trend as per capita decreases seen in FY 2014-15 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 lower than the standard population.	**SB 11-008 Eligible Children**	The Department anticipates costs will stabilize for this population after the aggressive downward trend in FY 2014-15.	**Partial Dual Eligibles**	The Department has increased the per capita growth trend for this population given higher than expected growth in FY 2014-15, driven primarily by co-insurance.

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%
July 2014	$267,297	472	$566.31	$1,541.50	-1.24%
August 2014	$300,220	463	$648.42	$1,819.35	18.02%
September 2014	$269,899	439	$614.80	$1,829.53	0.56%
October 2014	$221,649	424	$522.76	$1,785.98	-2.38%
November 2014	$240,183	425	$565.14	$1,702.70	-4.66%
December 2014	$254,288	396	$642.14	$1,730.04	1.61%
January 2015	$286,671	379	$756.39	$1,963.67	13.50%
February 2015	$255,665	368	$694.74	$2,093.27	6.60%
March 2015	$214,604	368	$583.16	$2,034.29	-2.82%
April 2015	$155,909	361	$431.88	$1,709.78	-15.95%
May 2015	$231,036	358	$645.35	$1,660.39	-2.89%
June 2015	$243,392	352	$691.45	$1,768.68	6.52%
FY 2014-15 Totals	$5,087,980	398	$12,783.87		
FY 2015-16 Totals [2]	$3,657,778	283	$12,783.87		**0.00%**
FY 2016-17 Totals [2]	$1,903,368	153	$12,783.87		**0.00%**
FY 2017-18 Totals [2]	$642,118	52	$12,783.87		**0.00%**

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

(2) The FY 2015-16 through FY 2017-18 totals are calculated on page EF-2 and include bottom line impacts. Caseload totals are taken from Exhibit B.

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

Breast and Cervical Cancer Program Fund Splits								
FY 2015-16 Fund Splits	**Per Capita [2]**	**Allocation**	**Caseload**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Breast and Cervical Cancer Program Clients[1]	$12,925.01	100.00%	283	$3,657,778	$0	$1,260,105	$0	$2,397,673
Total	**$12,925.01**	**100.00%**	**283**	**$3,657,778**	**$0**	**$1,260,105**	**$0**	**$2,397,673**
FY 2016-17 Fund Splits	**Per Capita [2]**	**Allocation**	**Caseload**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Breast and Cervical Cancer Program Clients[1]	$12,440.31	100.00%	153	$1,903,367	$0	$660,659	$0	$1,242,708
Total	**$12,440.31**	**100.00%**	**153**	**$1,903,367**	**$0**	**$660,659**	**$0**	**$1,242,708**
FY 2017-18 Fund Splits	**Per Capita [2]**	**Allocation**	**Caseload**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Breast and Cervical Cancer Program Clients[1]	$12,348.42	100.00%	52	$642,118	$0	$223,650	$0	$418,468
Total	**$12,348.42**	**100.00%**	**52**	**$642,118**	**$0**	**$223,650**	**$0**	**$418,468**

(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, 65.50% federal financial participation beginning October 1, 2015.
(2) Base per capita growth in FY 2015-16 through FY 2017-18 remains flat. All increases/decreases to per capita are the result of bottom line adjustments.

Exhibit F - ACUTE CARE - Adult Dental Cash Fund-Eligible Dental Services - Projection and Fund Splits

Adult Dental Benefit Expenditure with State Share Paid by the Adult Dental Cash Fund

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	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	$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	$0	$0	$0	$0	$0	$0	$151,160	$9,840	$0	$0	$3,282,709
FY 2014-15	$5,875,980	$2,130,656	$9,441,853	$0	$21,088,324	$0	$0	$0	$0	$0	$83,476	$1,365,471	$185,532	$0	$0	$40,171,292
Estimated FY 2015-16	$6,937,866	$2,468,700	$10,784,321	$0	$25,173,201	$0	$0	$0	$0	$0	$96,229	$1,503,419	$197,821	$0	$0	$47,161,557
Estimated FY 2016-17	$7,093,077	$2,617,747	$11,236,333	$0	$26,392,093	$0	$0	$0	$0	$0	$97,122	$1,531,724	$200,031	$0	$0	$49,168,127
Estimated FY 2017-18	$7,254,810	$2,775,612	$11,694,195	$0	$27,221,297	$0	$0	$0	$0	$0	$98,033	$1,562,230	$202,619	$0	$0	$50,808,796

Percent Change in Adult Dental Benefit Expenditure with State Share Paid by the Adult Dental Cash Fund

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	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	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%
FY 2014-15	2823.33%	2646.75%	1791.09%	0.00%	799.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	803.33%	1785.49%	0.00%	0.00%	1123.72%
Estimated FY 2015-16	18.07%	15.87%	14.22%	0.00%	19.37%	0.00%	0.00%	0.00%	0.00%	0.00%	15.28%	10.10%	6.62%	0.00%	0.00%	17.40%
Estimated FY 2016-17	2.24%	6.04%	4.19%	0.00%	4.84%	0.00%	0.00%	0.00%	0.00%	0.00%	0.93%	1.88%	1.12%	0.00%	0.00%	4.25%
Estimated FY 2017-18	2.28%	6.03%	4.07%	0.00%	3.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.94%	1.99%	1.29%	0.00%	0.00%	3.34%

Per Capita Cost

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	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	$4.80	$7.87	$7.75	$0.00	$18.80	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$11.49	$9.31	$0.00	$0.00	$3.81
FY 2014-15	$140.52	$203.58	$141.88	$0.00	$129.62	$0.00	$0.00	$0.00	$0.00	$0.00	$4.17	$91.66	$106.08	$0.00	$0.00	$34.59
Estimated FY 2015-16	$164.33	$223.72	$156.53	$0.00	$138.58	$0.00	$0.00	$0.00	$0.00	$0.00	$4.83	$101.38	$114.48	$0.00	$0.00	$36.52
Estimated FY 2016-17	$165.61	$225.96	$157.00	$0.00	$135.81	$0.00	$0.00	$0.00	$0.00	$0.00	$4.87	$102.69	$115.96	$0.00	$0.00	$36.37
Estimated FY 2017-18	$166.90	$228.22	$157.47	$0.00	$133.09	$0.00	$0.00	$0.00	$0.00	$0.00	$4.91	$104.01	$117.46	$0.00	$0.00	$36.14

Percent Change in Per Capita Cost

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	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	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%
FY 2014-15	2827.50%	2486.79%	1730.71%	0.00%	589.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	697.74%	1039.42%	0.00%	0.00%	807.87%
Estimated FY 2015-16	16.94%	9.89%	10.33%	0.00%	6.91%	0.00%	0.00%	0.00%	0.00%	0.00%	15.83%	10.60%	7.92%	0.00%	0.00%	5.58%
Estimated FY 2016-17	0.78%	1.00%	0.30%	0.00%	-2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.83%	1.29%	1.29%	0.00%	0.00%	-0.41%
Estimated FY 2017-18	0.78%	1.00%	0.30%	0.00%	-2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.82%	1.29%	1.29%	0.00%	0.00%	-0.63%

Exhibit F - ACUTE CARE - Adult Dental Cash Fund-Eligible Dental Services - Projection and Fund Splits

Previous Fiscal Years

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	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 Adult Dental Expenditure	$1,724,207	$535,633	$3,064,480	$0	$7,673,356	$0	$0	$0	$0	$0	$0	$515,132	$37,738	$0	$0	$13,550,546
Estimated FY 2013-14 Emergency and Co-Occurring Dental Expenditure	$1,523,204	$458,063	$2,565,198	$0	$5,329,502	$0	$0	$0	$0	$0	$0	$363,972	$27,898	$0	$0	$10,267,837
Estimated FY 2013-14 Adult Dental Benefit Expenditure	$201,003	$77,570	$499,282	$0	$2,343,854	$0	$0	$0	$0	$0	$0	$151,160	$9,840	$0	$0	$3,282,709
FY 2013-14 Caseload	41,836	9,853	64,424	2,560	124,680	47,082	87,243	559	399,032	25,345	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	$0.00	$61.54	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$39.14	$35.70	$0.00	$0.00	$15.74
Estimated FY 2013-14 Emergency and Co-Occurring Dental Per Capita	$36.41	$46.49	$39.82	$0.00	$42.75	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$27.66	$26.39	$0.00	$0.00	$11.93
Estimated FY 2013-14 Adult Dental Benefit Per Capita	$4.80	$7.87	$7.75	$0.00	$18.80	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$11.49	$9.31	$0.00	$0.00	$3.81
FY 2014-15 Total Adult Dental Expenditure	$7,169,838	$2,544,922	$11,692,964	$0	$27,021,394	$0	$0	$0	$0	$0	$124,035	$1,715,917	$224,850	$0	$0	$50,493,920
Estimated FY 2014-15 Emergency and Co-Occurring Dental Expenditure	$1,293,858	$414,266	$2,251,111	$0	$5,933,070	$0	$0	$0	$0	$0	$40,559	$350,446	$39,318	$0	$0	$10,322,628
Estimated FY 2014-15 Adult Dental Benefit Expenditure	$5,875,980	$2,130,656	$9,441,853	$0	$21,088,324	$0	$0	$0	$0	$0	$83,476	$1,365,471	$185,532	$0	$0	$40,171,292
FY 2014-15 Caseload	41,817	10,466	66,548	3,627	162,698	71,609	240,758	398	445,722	50,114	20,036	14,897	1,749	2,722	28,045	1,161,206
FY 2014-15 Total Dental Per Capita	$171.46	$243.16	$175.71	$0.00	$166.08	$0.00	$0.00	$0.00	$0.00	$0.00	$6.19	$115.19	$128.56	$0.00	$0.00	$43.48
Estimated FY 2014-15 Emergency and Co-Occurring Dental Per Capita	$30.94	$39.58	$33.83	$0.00	$36.47	$0.00	$0.00	$0.00	$0.00	$0.00	$2.02	$23.52	$22.48	$0.00	$0.00	$8.89
Estimated FY 2014-15 Adult Dental Benefit Per Capita	$140.52	$203.58	$141.88	$0.00	$129.62	$0.00	$0.00	$0.00	$0.00	$0.00	$4.17	$91.66	$106.08	$0.00	$0.00	$34.59

Current Year Projection

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	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	0.78%	1.00%	0.30%	2.00%	-2.00%	-1.18%	2.50%	0.00%	0.50%	0.00%	0.82%	1.29%	1.29%	-2.75%	1.83%	
Estimated FY 2015-16 Total Dental Per Capita	$172.80	$245.59	$176.24	$0.00	$162.76	$0.00	$0.00	$0.00	$0.00	$0.00	$6.24	$116.68	$130.22	$0.00	$0.00	
Emergency and Co-Occurring Dental Per Capita Trend Factor	-30.00%	-30.00%	-30.00%	0.00%	-30.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-30.00%	-30.00%	-30.00%	0.00%	0.00%	
Estimated FY 2015-16 Emergency and Co-Occurring Dental Per Capita	$21.66	$27.71	$23.68	$0.00	$25.53	$0.00	$0.00	$0.00	$0.00	$0.00	$1.41	$16.46	$15.74	$0.00	$0.00	
Estimated FY 2015-16 Eligible Caseload	42,218	11,035	68,897	4,859	181,652	82,897	293,091	283	474,429	59,802	19,923	14,830	1,728	2,992	32,835	1,291,471
Estimated FY 2015-16 Total Dental Expenditure	$7,295,270	$2,710,086	$12,142,407	$0	$29,565,680	$0	$0	$0	$0	$0	$124,320	$1,730,364	$225,020	$0	$0	$53,793,147
Estimated FY 2015-16 Emergency and Co-Occurring Dental Expenditure	$914,442	$305,780	$1,631,481	$0	$4,637,576	$0	$0	$0	$0	$0	$28,091	$244,102	$27,199	$0	$0	$7,788,671
Bottom Line Impacts																
Annualization of FY 2014-15 JBC Action: "Full Denture Benefit"	$557,038	$64,394	$273,395	$0	$245,097	$0	$0	$0	$0	$0	$0	$17,157	$0	$0	$0	$1,157,081
Total Bottom Line Impacts	$557,038	$64,394	$273,395	$0	$245,097	$0	$0	$0	$0	$0	$0	$17,157	$0	$0	$0	$1,157,081
Estimated FY 2015-16 Adult Dental Benefit Expenditure	$6,937,866	$2,468,700	$10,784,321	$0	$25,173,201	$0	$0	$0	$0	$0	$96,229	$1,503,419	$197,821	$0	$0	$47,161,557
% Change over Estimated FY 2014-15 Adult Dental Benefit Expenditure	18.07%	15.87%	14.22%	0.00%	19.37%	0.00%	0.00%	0.00%	0.00%	0.00%	15.28%	10.10%	6.62%	0.00%	0.00%	17.40%
Estimated FY 2015-16 Adult Dental Benefit Per Capita	$164.33	$223.72	$156.53	$0.00	$138.58	$0.00	$0.00	$0.00	$0.00	$0.00	$4.83	$101.38	$114.48	$0.00	$0.00	$36.52
% Change over Estimated FY 2014-15 Adult Dental Benefit Per Capita	16.94%	9.89%	10.33%	0.00%	6.91%	0.00%	0.00%	0.00%	0.00%	0.00%	15.83%	10.60%	7.92%	0.00%	0.00%	5.58%

Request Year Projection

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	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	0.78%	1.00%	0.30%	1.00%	-2.00%	-1.18%	2.50%	0.00%	0.50%	0.00%	0.82%	1.29%	1.29%	0.00%	1.83%	
Estimated FY 2016-17 Total Dental Per Capita	$186.19	$252.28	$179.50	$0.00	$160.06	$0.00	$0.00	$0.00	$0.00	$0.00	$6.21	$118.33	$130.91	$0.00	$0.00	
Emergency and Co-Occurring Dental Per Capita Trend Factor	-5.00%	-5.00%	-5.00%	0.00%	-5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.00%	-5.00%	-5.00%	0.00%	0.00%	
Estimated FY 2016-17 Emergency and Co-Occurring Dental Per Capita	$20.58	$26.32	$22.50	$0.00	$24.25	$0.00	$0.00	$0.00	$0.00	$0.00	$1.34	$15.64	$14.95	$0.00	$0.00	
Estimated FY 2016-17 Caseload	42,830	11,585	71,569	5,721	194,331	86,948	303,341	153	494,175	64,629	19,943	14,916	1,725	3,104	37,035	1,352,005
Estimated FY 2016-17 Total Adult Dental Expenditure	$7,974,518	$2,922,664	$12,846,636	$0	$31,104,620	$0	$0	$0	$0	$0	$123,846	$1,765,010	$225,820	$0	$0	$56,963,114
Estimated FY 2016-17 Emergency and Co-Occurring Dental Expenditure	$881,441	$304,917	$1,610,303	$0	$4,712,527	$0	$0	$0	$0	$0	$26,724	$233,286	$25,789	$0	$0	$7,794,987
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	$7,093,077	$2,617,747	$11,236,333	$0	$26,392,093	$0	$0	$0	$0	$0	$97,122	$1,531,724	$200,031	$0	$0	$49,168,127
% Change over Estimated FY 2015-16 Adult Dental Benefit Expenditure	2.24%	6.04%	4.19%	0.00%	4.84%	0.00%	0.00%	0.00%	0.00%	0.00%	0.93%	1.88%	1.12%	0.00%	0.00%	4.25%
Estimated FY 2016-17 Adult Dental Benefit Per Capita	$165.61	$225.96	$157.00	$0.00	$135.81	$0.00	$0.00	$0.00	$0.00	$0.00	$4.87	$102.69	$115.96	$0.00	$0.00	$36.37
% Change over Estimated FY 2015-16 Adult Dental Benefit Per Capita	0.78%	1.00%	0.30%	0.00%	-2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.83%	1.29%	1.29%	0.00%	0.00%	-0.41%

Out Year Projection

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	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	0.78%	1.00%	0.30%	1.00%	-2.00%	-1.18%	1.25%	0.00%	0.50%	0.00%	0.82%	1.29%	1.29%	0.00%	1.83%	
Estimated FY 2017-18 Total Dental Per Capita	$186.45	$253.22	$178.85	$0.00	$156.13	$0.00	$0.00	$0.00	$0.00	$0.00	$6.18	$118.87	$131.66	$0.00	$0.00	
Emergency and Co-Occurring Dental Per Capita Trend Factor	-5.00%	-5.00%	-5.00%	0.00%	-5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.00%	-5.00%	-5.00%	0.00%	0.00%	
Estimated FY 2017-18 Emergency and Co-Occurring Dental Per Capita	$19.55	$25.00	$21.38	$0.00	$23.04	$0.00	$0.00	$0.00	$0.00	$0.00	$1.27	$14.86	$14.20	$0.00	$0.00	
Estimated FY 2017-18 Caseload	43,468	12,162	74,263	6,482	204,533	91,000	307,941	52	515,425	69,364	19,966	15,020	1,725	3,144	41,235	1,405,780
Estimated FY 2017-18 Total Dental Expenditure	$8,104,609	$3,079,662	$13,281,938	$0	$31,933,737	$0	$0	$0	$0	$0	$123,390	$1,785,427	$227,114	$0	$0	$58,535,877
Estimated FY 2017-18 Emergency and Co-Occurring Dental Expenditure	$849,799	$304,050	$1,587,743	$0	$4,712,440	$0	$0	$0	$0	$0	$25,357	$223,197	$24,495	$0	$0	$7,727,081
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 2017-18 Adult Dental Benefit Expenditure	$7,254,810	$2,775,612	$11,694,195	$0	$27,221,297	$0	$0	$0	$0	$0	$98,033	$1,562,230	$202,619	$0	$0	$50,808,796
% Change over Estimated FY 2016-17 Adult Dental Benefit Expenditure	2.28%	6.03%	4.07%	0.00%	3.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.94%	1.99%	1.29%	0.00%	0.00%	3.34%
Estimated FY 2017-18 Adult Dental Benefit Per Capita	$166.90	$228.22	$157.47	$0.00	$133.09	$0.00	$0.00	$0.00	$0.00	$0.00	$4.91	$104.01	$117.46	$0.00	$0.00	$36.14
% Change over Estimated FY 2016-17 Adult Dental Benefit Per Capita	0.78%	1.00%	0.30%	0.00%	-2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.82%	1.29%	1.29%	0.00%	0.00%	-0.63%

Adult Dental Cash Fund - Fund Splits

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)	42,218	$164.33	50.79%	$6,937,866	$0	$3,414,124	$3,523,742
Disabled Adults 60 to 64 (OAP-B)	11,035	$223.72	50.79%	$2,468,700	$0	$1,214,847	$1,253,853
Disabled Individuals to 59 (AND/AB)	68,897	$156.53	50.79%	$10,784,321	$0	$5,306,964	$5,477,357
MAGI Parents/Caretakers to 68% FPL	181,652	$138.58	50.79%	$25,173,201	$0	$12,387,732	$12,785,469
Foster Care	19,923	$4.83	50.79%	$96,229	$0	$47,354	$48,875
MAGI Pregnant Adults	14,830	$101.38	50.79%	$1,503,419	$0	$739,832	$763,587
SB 11-250 Eligible Pregnant Adults	1,728	$114.48	82.80%	$197,821	$0	$34,025	$163,796
Total	**340,283**	**$138.60**		**$47,161,557**	**$0**	**$23,144,878**	**$24,016,679**

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)	42,830	$165.61	50.42%	$7,093,077	$0	$3,516,748	$3,576,329
Disabled Adults 60 to 64 (OAP-B)	11,585	$225.96	50.42%	$2,617,747	$0	$1,297,879	$1,319,868
Disabled Individuals to 59 (AND/AB)	71,569	$157.00	50.42%	$11,236,333	$0	$5,570,974	$5,665,359
MAGI Parents/Caretakers to 68% FPL	194,331	$135.81	50.42%	$26,392,093	$0	$13,085,200	$13,306,893
Foster Care	19,943	$4.87	50.42%	$97,122	$0	$48,153	$48,969
MAGI Pregnant Adults	14,916	$102.69	50.42%	$1,531,724	$0	$759,429	$772,295
SB 11-250 Eligible Pregnant Adults	1,725	$115.96	88.29%	$200,031	$0	$23,424	$176,607
Total	**356,899**	**$137.76**		**$49,168,127**	**$0**	**$24,301,807**	**$24,866,320**

FY 2017-18

Eligibility Category	Caseload	Per Capita	FMAP	Total Funds [1]	General Fund	Adult Dental Fund	Federal Funds
Adults 65 and Older (OAP-A)	43,468	$166.90	50.24%	$7,254,810	$0	$3,609,993	$3,644,817
Disabled Adults 60 to 64 (OAP-B)	12,162	$228.22	50.24%	$2,775,612	$0	$1,381,145	$1,394,467
Disabled Individuals to 59 (AND/AB)	74,263	$157.47	50.24%	$11,694,195	$0	$5,819,031	$5,875,164
MAGI Parents/Caretakers to 68% FPL	204,533	$133.09	50.24%	$27,221,297	$0	$13,545,317	$13,675,980
Foster Care	19,966	$4.91	50.24%	$98,033	$0	$48,781	$49,252
MAGI Pregnant Adults	15,020	$104.01	50.24%	$1,562,230	$0	$777,366	$784,864
SB 11-250 Eligible Pregnant Adults	1,725	$117.46	88.17%	$202,619	$0	$23,970	$178,649
Total	**371,137**	**$136.90**		**$50,808,796**	**$0**	**$25,205,603**	**$25,603,193**

(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 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
FY 2014-15	$354,548	$1,913,420	$23,170,439	$350,257	$7,994,048	$2,036,423	$18,380,238	$8,559	$5,759,480	$1,439,830	$5,512,907	$246,279	$14,280	$0	$0	$67,180,708

Percent Change in Cash Based Actuals

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	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	-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%
FY 2014-15	25.72%	8.90%	14.25%	42.74%	45.22%	67.64%	185.40%	-68.31%	13.38%	0.00%	-0.87%	93.15%	0.00%	0.00%	0.00%	44.41%

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	$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)	$13.59	$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	$84.63
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	$12.73	$0.00	$304.44	$9.69	$0.00	$0.00	$0.00	$54.03
FY 2014-15	$8.48	$182.82	$348.18	$96.57	$49.13	$28.44	$76.34	$21.51	$12.92	$28.73	$275.15	$16.53	$8.16	$0.00	$0.00	$57.85

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 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)	-16.21%	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%	-1.06%
FY 2011-12	-38.48%	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%	-0.08%
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%	18.42%	0.00%	-9.36%	128.00%	0.00%	0.00%	0.00%	-3.95%
FY 2014-15	25.82%	2.52%	10.60%	0.75%	11.28%	10.23%	3.41%	-55.48%	1.49%	0.00%	-9.62%	70.59%	0.00%	0.00%	0.00%	7.07%

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 2005-06	$3,004,627	$1,255,904	$18,011,430	$0	$1,217,198	$0	$0	$243	$1,441,985	$0	$5,355,765	$16,860	$0	$0	$0	$30,304,012
FY 2006-07	$319,512	$814,736	$13,303,091	$0	$1,406,074	$0	$0	$122	$1,791,237	$0	$5,206,719	$9,214	$0	$0	$0	$22,850,705
FY 2007-08	$329,356	$978,862	$15,609,909	$0	$1,785,413	$0	$0	$4,976	$2,153,907	$0	$6,151,891	$16,027	$0	$0	$0	$27,030,341
FY 2008-09	$427,196	$1,186,557	$16,817,326	$0	$2,671,434	$0	$0	$10,076	$2,588,065	$0	$6,666,050	$37,479	$0	$0	$0	$30,404,183
FY 2009-10 (DA)	$379,006	$1,120,504	$14,252,288	$0	$2,576,466	$40,378	$0	$18,852	$2,217,109	$0	$5,259,219	$37,180	$0	$0	$0	$25,901,002
FY 2010-11 (DA)	$285,788	$1,208,538	$14,629,873	$0	$2,577,181	$253,818	$0	$22,412	$2,050,815	$0	$4,574,552	$41,925	$0	$0	$0	$25,644,902
FY 2011-12	$173,417	$1,428,350	$15,494,576	$1,661	$2,783,929	$714,836	$27,068	$23,715	$2,274,478	$0	$4,406,588	$39,733	$0	$0	$0	$27,368,351
FY 2012-13	$116,829	$900,643	$10,235,026	$43,544	$1,970,856	$558,209	$836,074	$23,633	$1,989,011	$0	$3,071,116	$17,539	$0	$0	$0	$19,762,480
FY 2013-14	$123,908	$772,046	$8,910,861	$107,817	$2,418,764	$533,746	$2,829,675	$11,867	$2,231,910	$0	$2,443,530	$56,023	$0	$0	$0	$20,440,147
FY 2014-15	$195,244	$1,053,691	$12,759,604	$192,881	$4,402,199	$1,121,427	$10,121,714	$4,713	$3,171,657	$792,892	$3,035,873	$135,622	$7,864	$0	$0	$36,995,381

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 2006-07	-89.37%	-35.13%	-26.14%	0.00%	15.52%	0.00%	0.00%	-49.79%	24.22%	0.00%	-2.78%	-45.35%	0.00%	0.00%	0.00%	-24.60%
FY 2007-08	3.08%	20.14%	17.34%	0.00%	26.98%	0.00%	0.00%	3978.69%	20.25%	0.00%	18.15%	73.94%	0.00%	0.00%	0.00%	18.29%
FY 2008-09	29.71%	21.22%	7.73%	0.00%	49.63%	0.00%	0.00%	102.49%	20.16%	0.00%	8.36%	133.85%	0.00%	0.00%	0.00%	12.48%
FY 2009-10 (DA)	-11.28%	-5.57%	-15.25%	0.00%	-3.55%	0.00%	0.00%	87.10%	-14.33%	0.00%	-21.10%	-0.80%	0.00%	0.00%	0.00%	-14.81%
FY 2010-11 (DA)	-24.60%	7.86%	2.65%	0.00%	0.03%	528.60%	0.00%	18.88%	-7.50%	0.00%	-13.02%	12.76%	0.00%	0.00%	0.00%	-0.99%
FY 2011-12	-39.32%	18.19%	5.91%	0.00%	8.02%	181.63%	0.00%	5.81%	10.91%	0.00%	-3.67%	-5.23%	0.00%	0.00%	0.00%	6.72%
FY 2012-13	-32.63%	-36.95%	-33.94%	2521.55%	-29.21%	-21.91%	2988.79%	-0.35%	-12.55%	0.00%	-30.31%	-55.86%	0.00%	0.00%	0.00%	-27.79%
FY 2013-14	6.06%	-14.28%	-12.94%	147.60%	22.73%	-4.38%	238.45%	-49.79%	12.21%	0.00%	-20.44%	219.42%	0.00%	0.00%	0.00%	3.43%
FY 2014-15	57.57%	36.48%	43.19%	78.90%	82.00%	110.10%	257.70%	-60.28%	42.11%	0.00%	24.24%	142.08%	0.00%	0.00%	0.00%	80.99%

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	$82.98	$207.86	$376.38	$0.00	$20.67	$0.00	$0.00	$1.29	$6.73	$0.00	$325.38	$3.29	$0.00	$0.00	$0.00	$75.34
FY 2006-07	$8.90	$134.47	$272.61	$0.00	$25.18	$0.00	$0.00	$0.54	$8.72	$0.00	$311.33	$1.78	$0.00	$0.00	$0.00	$58.26
FY 2007-08	$9.08	$159.27	$312.62	$0.00	$33.39	$0.00	$0.00	$18.43	$10.56	$0.00	$358.90	$2.55	$0.00	$0.00	$0.00	$68.96
FY 2008-09	$11.36	$184.05	$327.47	$0.00	$43.18	$0.00	$0.00	$31.79	$11.01	$0.00	$369.66	$5.37	$0.00	$0.00	$0.00	$69.60
FY 2009-10 (DA)	$9.85	$158.96	$267.58	$0.00	$34.43	$12.47	$0.00	$44.36	$8.04	$0.00	$286.12	$4.75	$0.00	$0.00	$0.00	$51.93
FY 2010-11 (DA)	$7.34	$155.60	$259.92	$0.00	$31.77	$9.34	$0.00	$42.21	$6.78	$0.00	$248.71	$5.33	$0.00	$0.00	$0.00	$45.73
FY 2011-12	$4.36	$170.39	$260.70	$31.94	$29.86	$20.16	$23.87	$39.72	$6.80	$0.00	$244.35	$5.21	$0.00	$0.00	$0.00	$44.15
FY 2012-13	$2.86	$99.51	$165.29	$49.04	$19.83	$13.44	$78.62	$37.93	$5.53	$0.00	$172.76	$2.19	$0.00	$0.00	$0.00	$28.94
FY 2013-14	$2.96	$78.36	$138.32	$42.12	$19.40	$11.34	$32.43	$21.23	$5.59	$0.00	$133.77	$4.26	$0.00	$0.00	$0.00	$23.74
FY 2014-15	$4.67	$100.68	$191.74	$53.18	$27.06	$15.66	$42.04	$11.84	$7.12	$15.82	$151.52	$9.10	$4.50	$0.00	$0.00	$31.86

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 2006-07	-89.27%	-35.31%	-27.57%	0.00%	21.82%	0.00%	0.00%	-58.14%	29.57%	0.00%	-4.32%	-45.90%	0.00%	0.00%	0.00%	-22.67%
FY 2007-08	2.02%	18.44%	14.68%	0.00%	32.61%	0.00%	0.00%	3312.96%	21.10%	0.00%	15.28%	43.26%	0.00%	0.00%	0.00%	18.37%
FY 2008-09	25.11%	15.56%	4.75%	0.00%	29.32%	0.00%	0.00%	72.49%	4.26%	0.00%	3.00%	110.59%	0.00%	0.00%	0.00%	0.93%
FY 2009-10 (DA)	-13.29%	-13.63%	-18.29%	0.00%	-20.26%	0.00%	0.00%	39.54%	-26.98%	0.00%	-22.60%	-11.55%	0.00%	0.00%	0.00%	-25.39%
FY 2010-11 (DA)	-25.48%	-2.11%	-2.86%	0.00%	-7.73%	-25.10%	0.00%	-4.85%	-15.67%	0.00%	-13.07%	12.21%	0.00%	0.00%	0.00%	-11.94%
FY 2011-12	-40.60%	9.51%	0.30%	0.00%	-6.01%	115.85%	0.00%	-5.90%	0.29%	0.00%	-1.75%	-2.25%	0.00%	0.00%	0.00%	-3.46%
FY 2012-13	-34.40%	-41.60%	-36.60%	53.54%	-33.59%	-33.33%	229.37%	-4.51%	-18.68%	0.00%	-29.30%	-57.97%	0.00%	0.00%	0.00%	-34.45%
FY 2013-14	3.50%	-21.25%	-16.32%	-14.11%	-2.17%	-15.63%	-58.75%	-44.03%	1.08%	0.00%	-22.57%	94.52%	0.00%	0.00%	0.00%	-17.97%
FY 2014-15	57.77%	28.48%	38.62%	26.26%	39.48%	38.10%	29.63%	-44.23%	27.37%	0.00%	13.27%	113.62%	0.00%	0.00%	0.00%	34.20%

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]	$3,665,910	$3,333,782	$2,724,407	$3,309,038	$13,033,137	30.11%
FY 2014-15[1]	$3,163,574	$3,658,125	$3,515,812	$5,159,840	$15,497,352	18.91%
FY 2015-16[2]	$4,326,227	$4,445,536	$4,317,857	$4,605,256	$17,694,876	14.18%
FY 2016-17[2]	$4,939,686	$5,075,913	$4,930,129	$5,258,281	$20,204,009	14.18%
FY 2017-18[2]	$5,640,133	$5,795,677	$5,629,221	$6,003,906	$23,068,937	14.18%

(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 2015-16, FY 2016-17 and FY 2017-18 growth rate is held constant for the request and out years and is equal to three-quarters of the percent growth from FY 2013-14 to FY 2014-15.

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

Total Family Planning Expenditure

Fiscal Year	Total Reported Expenditures	General Fund	Cash Funds [1]	Federal Funds (90% FMAP) [2]	Change	% Change
FY 2001-02	$4,627,488	$462,749	$0	$4,164,739	($1,518,369)	-38.38%
FY 2002-03	$5,981,966	$598,197	$0	$5,383,769	$1,354,478	29.27%
FY 2003-04	$5,590,250	$559,025	$0	$5,031,225	($391,716)	-6.55%
FY 2004-05	$7,327,504	$732,750	$0	$6,594,754	$1,737,254	31.08%
FY 2005-06	$7,248,773	$724,877	$0	$6,523,896	($78,731)	-1.07%
FY 2006-07	$7,203,964	$720,396	$0	$6,483,568	($44,809)	-0.62%
FY 2007-08	$8,861,963	$886,197	$0	$7,975,766	$1,657,999	23.02%
FY 2008-09	$13,674,039	$1,367,404	$0	$12,306,635	$4,812,076	54.30%
FY 2009-10	$11,796,264	$1,179,626	$0	$10,616,638	($1,877,774)	-13.73%
FY 2010-11	$12,904,159	$1,290,416	$0	$11,613,743	$1,107,895	9.39%
FY 2011-12	$9,430,042	$943,004	$0	$8,487,038	($3,474,117)	-26.92%
FY 2012-13	$9,626,353	$943,732	$18,903	$8,663,718	$196,311	2.08%
FY 2013-14	$9,845,720	$965,280	$19,292	$8,861,148	$219,367	2.28%
FY 2014-15	$11,213,936	$1,092,234	$29,160	$10,092,542	$1,368,215	13.90%
FY 2015-16 Estimate [3]	$12,111,051	$1,448,724	$0	$10,662,327	$897,115	8.00%
FY 2016-17 Estimate [3]	$12,817,125	$1,532,992	$0	$11,284,133	$706,074	5.83%
FY 2017-18 Estimate [3]	$13,564,363	$1,624,874	$0	$11,939,489	$747,238	5.83%

(1) The teen pregnancy and dropout prevention program contract with Montrose has been terminated in FY 2014-15. This program was previously funded via local cash funds and federal funds and as a result, the FY 2015-16 estimate and beyond will no longer include cash funds.

(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

(3) The FY 2015-16 estimate for total reported expenditures is based on the average of annual total reported expenditures for FY 2007-08 though FY 2014-15. Estimates for FY 2016-17 and FY 2017-18 are based on the average growth rate for FY 2008-09 through FY 2014-15, applied to the previous year's estimated total reported expenditure.

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

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 2001-02	$5,111,123	$2,763,372	$2,347,751	($483,635)	$4,627,488	-
FY 2002-03	$6,538,073	$3,094,894	$3,443,179	($556,107)	$5,981,966	29.27%
FY 2003-04	$6,061,856	$4,058,413	$2,003,442	($471,606)	$5,590,250	-6.55%
FY 2004-05	$8,019,717	$6,902,883	$1,116,833	($692,213)	$7,327,504	31.08%
FY 2005-06	$8,260,397	$7,013,966	$1,246,431	($1,011,623)	$7,248,773	-1.07%
FY 2006-07	$8,343,188	$7,431,084	$912,103	($1,139,224)	$7,203,964	-0.62%
FY 2007-08	$9,902,250	$9,139,367	$762,883	($1,040,287)	$8,861,963	23.02%
FY 2008-09	$13,893,561	$13,472,771	$420,790	($219,523)	$13,674,039	54.30%
FY 2009-10	$12,619,883	$12,533,203	$86,680	($823,619)	$11,796,264	-13.73%
FY 2010-11	$13,895,800	$12,375,826	$1,519,974	($991,641)	$12,904,159	9.39%
FY 2011-12	$11,795,916	$10,329,972	$1,465,944	($2,365,873)	$9,430,042	-26.92%
FY 2012-13	$11,806,126	$10,594,615	$1,211,511	($2,179,772)	$9,626,353	2.08%
FY 2013-14	$13,703,377	$12,637,553	$1,065,824	($3,857,657)	$9,845,720	2.28%
FY 2014-15	$15,333,678	$13,413,692	$1,919,986	($4,119,742)	$11,213,936	13.90%

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 Family Planning Expenditure
Fund Splits

Fiscal Year	Total Reported Expenditures [2]	General Fund	Cash Funds	Federal Funds	FMAP
FY 2015-16 Estimate [4]	$11,505,498	$1,150,550	$0	$10,354,948	90.00%
	$605,553	$298,174	$0	$307,379	50.76%
FY 2016-17 Estimate [4]	$12,176,269	$1,217,627	$0	$10,958,642	90.00%
	$640,856	$315,365	$0	$325,491	50.79%
FY 2017-18 Estimate [4]	$12,886,145	$1,288,614	$0	$11,597,531	90.00%
	$678,218	$336,260	$0	$341,958	50.42%

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

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[1]	$3,211,045	$1,760,858	121.42%
FY 2015-16 Estimated Total[2]	$3,439,350	$228,305	7.11%
FY 2016-17 Estimated Total[2]	$3,683,888	$244,538	7.11%
FY 2017-18 Estimated Total[2]	$3,945,812	$261,924	7.11%

[1] Expenditure increased significantly in FY 2014-15 due to how pharmaceutical expenditure is tracked. Prior to FY 2014-15, pharmaceutical expenditure was tracked in a different area of the budget; beginning FY 2014-15, IHS expenditure for pharmaceuticals is tracked in this exhibit.

[2] The trend for FY 2015-16 through FY 2017-18 is the average percent growth from FY 2008-09 to 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	$36,200,871	$2,878,789	$42,656,116	$11,477,217	$8,768,648	$0	$71,699,516	$2,657,676	$6,047,201	$14,319,402	$1,100,790	$3,584,186	$2,621	$208,911,115
Emergency Transportation	$66,504	$200,380	$1,240,532	$44,246	$859,994	$179,231	$476,798	$0	$867,012	$40,094	$108,429	$160,654	$5,207	$36,487	$0	$4,285,568
Non-emergency Medical Transportation	$878,622	$492,615	$2,058,121	$33,069	$210,709	$46,398	$146,096	$0	$397,685	$5,014	$60,028	$22,379	$33	$288	$0	$4,351,057
Dental Services	$735,057	$228,184	$2,996,748	$93,421	$3,003,798	$860,293	$576,406	$0	$52,364,802	$2,370,685	$2,776,140	$210,708	$12,134	$1,510	$0	$66,229,886
Family Planning	$117	$146	$9,907	$256	$136,589	$45,235	$7,042	$0	$100,492	$4,369	$43,774	$15,155	$1,869	$0	$0	$364,951
Health Maintenance Organizations	$2,998,630	$4,238,163	$21,963,467	$209,563	$11,372,325	$3,876,839	$5,794	$0	$20,505,667	$669,190	$400,679	$1,070,955	$22,434	$0	$1,013	$67,334,719
Inpatient Hospitals	$6,178,058	$7,853,987	$54,302,483	$5,754,817	$32,505,371	$6,842,546	$10,750,120	$0	$40,529,056	$2,067,683	$2,534,222	$18,475,958	$1,798,799	$17,071,224	($11,971)	$206,652,353
Outpatient Hospitals	$1,936,308	$4,164,759	$31,523,907	$2,575,497	$39,123,091	$11,349,198	$10,883,542	$0	$43,088,896	$2,556,527	$3,100,785	$4,292,315	$366,588	$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	$3,386,217	$278,789	$629,608	$2,222,882	$189,519	$77,972	$0	$24,516,078
Durable Medical Equipment	$9,734,717	$3,220,923	$28,562,774	$563,023	$2,682,293	$841,403	$974,402	$0	$6,029,031	$178,849	$2,360,864	$134,178	$5,570	$0	$17,075	$55,305,102
Prescription Drugs	$3,611,551	$9,645,371	$66,667,184	$2,502,929	$32,079,198	$10,369,827	$10,168,488	$0	$34,760,245	$2,580,080	$9,044,408	$1,720,303	$37,834	$0	$111	$183,187,529
Drug Rebate	($1,535,519)	($4,100,912)	($28,344,816)	($1,064,168)	($13,639,079)	($4,408,929)	($4,323,325)	$0	($15,374,046)	($501,900)	($3,845,401)	($731,065)	($16,440)	$0	($47)	($77,885,647)
Rural Health Centers	$33,922	$127,596	$627,076	$29,424	$1,197,446	$416,216	$148,739	$0	$3,085,905	$124,705	$163,823	$148,297	$9,717	$3,782	$0	$6,116,648
Federally Qualified Health Centers	$464,276	$646,657	$4,282,377	$138,410	$8,575,366	$2,379,716	$2,638,073	$0	$28,576,111	$1,171,878	$937,379	$3,508,073	$275,846	$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	$3,067	$282	$1,674	$5,167	$157	$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	$2,913,517	$47,345	$507,529	$4,117,957	$137,469	$0	$836	$27,822,253
Other Medical Services	$339	$277	$2,137	$102	$1,169	$328	$306	$43	$1,920	$128	$221	$288	$26	$141	$21	$7,446
Acute Home Health	$2,344,387	$1,072,522	$5,399,391	$94,388	$373,336	$138,180	$168,324	$0	$380,860	$80,049	$252,257	$42,278	$1,509	$0	$61,077	$10,408,558
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$33,933,274	$36,022,674	$243,984,065	$15,652,227	$175,420,502	$48,023,832	$43,019,078	$6,376,065	$293,315,953	$14,331,443	$25,123,620	$49,735,884	$3,949,061	$21,907,518	$1,427,957	$1,012,223,153
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	$812.11	$3,732.98	$3,797.08	$7,548.70	$1,578.36	$1,150.01	$2,375.69	$10,398.58	$760.09	$1,035.90	$1,420.62	$4,358.72	$6,791.16	$8,832.49	$63.48	$1,360.94

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	$28,859,114	$1,568,705	$36,756,120	$11,269,427	$53,995,917	$0	$68,944,713	$3,906,643	$5,092,978	$18,573,354	$1,158,740	$2,412,483	$3,620	$238,831,111
Emergency Transportation	$56,263	$186,579	$1,051,749	$30,363	$828,412	$198,192	$2,052,310	$0	$969,682	$53,297	$109,302	$258,258	$6,922	$38,162	$793	$5,840,284
Non-emergency Medical Transportation	$1,922,846	$1,189,193	$4,656,743	$71,918	$577,149	$87,631	$738,322	$0	$912,188	$11,585	$126,620	$85,950	$125	$883	$2,733	$10,383,886
Dental Services	$1,059,795	$330,062	$3,517,797	$89,207	$6,149,997	$1,841,242	$6,432,666	$0	$51,651,133	$6,274,961	$2,651,760	$542,431	$25,759	$5,041	$2,203	$80,574,054
Family Planning	$54	$2	$11,550	$263	$187,434	$75,350	$101,498	$0	$134,725	$10,471	$44,146	$25,509	$2,623	$0	$0	$593,625
Health Maintenance Organizations	$2,679,213	$3,933,838	$20,287,797	$204,054	$12,957,332	$3,331,297	$984,249	$0	$20,592,110	$1,370,972	$441,456	$1,618,996	$154,719	$0	($30)	$68,556,003
Inpatient Hospitals	$6,036,371	$7,605,652	$46,421,041	$4,110,367	$20,513,889	$7,853,367	$71,521,048	$0	$56,746,845	$712,466	$2,920,082	$32,245,992	$2,138,168	$12,832,957	$693	$271,658,938
Outpatient Hospitals	$2,136,710	$4,509,718	$31,509,388	$2,006,328	$44,096,214	$17,059,686	$69,326,331	$0	$53,124,739	$4,827,127	$3,609,771	$7,591,661	$401,869	$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	$4,710,767	$292,738	$733,879	$4,115,803	$314,530	$76,587	$389	$40,168,697
Durable Medical Equipment	$10,258,949	$3,383,054	$29,819,077	$583,403	$3,447,960	$855,896	$5,096,618	$0	$7,732,137	$556,848	$2,403,335	$186,067	$8,836	$191	$24,202	$64,356,573
Prescription Drugs	$4,024,328	$10,744,651	$73,986,564	$2,567,396	$42,825,369	$12,912,380	$60,762,528	$0	$44,039,861	$5,392,354	$9,735,805	$2,687,195	$305,594	$0	$19,884	$270,003,909
Drug Rebate	($1,754,638)	($4,684,766)	($32,260,248)	($1,120,540)	($18,635,895)	($5,622,938)	($26,239,520)	$0	($18,579,444)	($2,933,272)	($4,246,641)	($1,168,043)	($131,537)	$0	($8,569)	($117,386,051)
Rural Health Centers	$42,342	$142,027	$633,398	$19,899	$1,645,263	$511,612	$1,403,590	$0	$3,531,107	$258,757	$174,783	$317,470	$22,912	$6,020	$68	$8,709,248
Federally Qualified Health Centers	$561,943	$751,624	$4,380,200	$120,401	$9,195,619	$3,692,682	$17,127,255	$0	$29,555,074	$2,079,623	$942,663	$5,416,507	$314,632	$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	$21,381	$100	$5,247	$46,076	$1,319	$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	$9,776,157	$149,436	$1,420,827	($99,587)	($26,704)	$0	$2,022	$31,110,310
Other Medical Services	$510	$409	$3,024	$125	$1,776	$575	$2,462	$25	$3,237	$184	$327	$651	$42	$163	$35	$13,545
Acute Home Health	$2,402,125	$1,240,348	$5,590,781	$170,141	$412,270	$83,270	$1,261,672	($2,446)	$695,849	$16,837	$408,855	$44,305	$1,182	$0	$86,244	$12,411,433
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$51,741,836	$38,761,591	$242,313,263	$10,390,814	$182,316,059	$60,328,093	$276,771,076	$2,501,204	$334,562,262	$22,981,126	$26,575,195	$72,488,594	$4,699,731	$16,604,079	$7,236,174	$1,350,271,097
Caseload	41,888	10,056	64,593	3,047	138,220	52,404	156,377	504	412,168	36,855	18,849	14,908	1,533	2,481	24,261	978,143
Half -Year Per Capita	$1,235.25	$3,854.45	$3,751.41	$3,410.18	$1,319.03	$1,151.21	$1,769.90	$4,961.07	$811.71	$623.55	$1,409.90	$4,862.29	$3,065.38	$6,693.39	$298.27	$1,380.44

Exhibit F - ACUTE CARE - Expenditure by Half-Year

FY 2014-15 July-December CORE 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	$1,808,071	$4,416,891	$30,089,878	$1,835,069	$42,554,667	$13,869,704	$78,528,944	$909	$76,589,358	$6,049,956	$5,929,989	$18,417,319	$2,020,726	$2,842,821	$11,717	$284,966,019
Emergency Transportation	$75,640	$221,379	$1,215,703	$30,714	$1,051,055	$213,525	$3,072,083	$139	$1,061,536	$71,995	$147,069	$245,213	$16,646	$44,561	$728	$7,467,986
Non-emergency Medical Transportation	$1,006,855	$627,740	$2,389,255	$30,566	$338,838	$50,784	$813,120	$52	$447,966	$21,445	$72,627	$50,782	$3,157	$676	$82	$5,853,945
Dental Services	$3,040,526	$1,021,347	$6,711,402	$275,574	$13,188,190	$4,636,004	$18,132,051	$848	$53,714,284	$6,727,070	$2,531,308	$877,321	$89,296	$10,209	$514	$110,955,944
Family Planning	$52	$175	$8,084	$336	$167,298	$70,658	$151,177	$0	$123,269	$15,139	$39,682	$23,659	$1,671	$0	$75	$601,275
Health Maintenance Organizations	$4,211,877	$4,833,256	$26,077,759	$328,437	$29,380,352	$8,261,830	$10,188,768	$0	$22,321,938	$1,730,414	$471,051	$2,963,822	$298,018	$0	$771	$111,068,293
Inpatient Hospitals	$8,271,207	$12,845,824	$45,015,267	$3,021,447	$27,584,855	$7,758,474	$111,519,686	$0	$56,359,562	$2,014,097	$3,128,134	$31,833,352	$3,428,148	$16,256,192	$2,174	$329,038,419
Outpatient Hospitals	$1,532,286	$3,929,489	$28,176,641	$1,586,381	$45,598,917	$13,962,464	$87,546,924	($952)	$51,758,034	$5,337,722	$3,876,276	$5,603,371	$574,930	$1,336,384	$11,396	$250,830,263
Lab & X-Ray	$230,781	$646,128	$4,314,997	$193,932	$11,085,750	$3,466,398	$15,921,407	($93)	$4,960,253	$526,334	$913,185	$3,992,341	$411,258	$79,356	$1,716	$46,743,743
Durable Medical Equipment	$10,610,005	$3,427,816	$31,054,255	$633,733	$3,786,116	$1,083,286	$8,629,703	$0	$8,968,194	$711,147	$2,505,467	$211,112	$21,029	$10,060	$36,128	$71,688,051
Prescription Drugs	$3,224,400	$10,512,070	$71,281,146	$2,530,210	$45,963,895	$15,261,456	$92,126,776	$387	$44,294,709	$6,034,167	$9,484,209	$2,743,668	$232,787	$548	$9,305	$303,699,733
Drug Rebate	($1,299,746)	($4,237,385)	($28,733,226)	($1,019,920)	($18,527,915)	($6,151,849)	($37,136,040)	($156)	($17,855,071)	($2,432,355)	($3,823,058)	($1,105,964)	($93,836)	($221)	($3,751)	($122,420,493)
Rural Health Centers	$35,483	$147,242	$692,738	$15,672	$1,729,715	$546,905	$2,076,221	$0	$3,655,812	$332,712	$182,928	$309,033	$22,214	$4,298	($215)	$9,750,758
Federally Qualified Health Centers	$455,701	$745,723	$4,231,862	$79,497	$9,366,991	$3,572,340	$20,490,767	$534	$25,762,990	$2,141,928	$901,951	$5,439,521	$497,785	$198,877	$5,141	$73,891,608
Co-Insurance (Title XVIII-Medicare)	$8,387,335	$1,523,519	$5,889,554	$409,516	$1,033,220	$29,010	$339,319	$5,311	$12,298	$724	$6,264	$25,970	$855	$0	$3,261,146	$20,924,041
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$1,553,536	$0	$0	$0	$0	$0	$0	$0	$1,553,536
Administrative Service Organizations - Services	$1,066,058	$752,683	$8,738,579	$119,870	$9,297,700	$1,059,036	$3,551,123	$0	$6,680,595	$274,470	$1,067,643	$2,756,467	$141,046	$0	$8,391	$35,513,661
Other Medical Services	$228	$197	$1,288	$47	$914	$285	$1,785	$6	$1,406	$111	$144	$283	$31	$82	$13	$6,820
Acute Home Health	$2,544,679	$1,297,793	$6,443,729	$117,526	$466,850	$127,847	$2,036,681	$0	$900,690	$51,937	$261,341	$44,790	$5,459	$0	$1,213	$14,300,535
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$45,201,438	$42,711,887	$243,598,911	$10,188,607	$224,067,408	$67,818,157	$417,990,495	$1,560,521	$339,757,823	$29,609,013	$27,696,210	$74,432,060	$7,671,220	$20,783,843	$3,346,544	$1,556,434,137
Caseload	42,053	10,360	66,015	3,078	158,622	65,032	214,360	437	439,473	44,581	20,152	15,005	1,751	2,506	26,979	1,110,401
Half -Year Per Capita	$1,074.88	$4,122.90	$3,690.04	$3,310.32	$1,412.59	$1,042.85	$1,949.94	$3,575.08	$773.10	$664.17	$1,374.39	$4,960.43	$4,382.30	$8,293.08	$124.04	$1,401.69

FY 2013-14 historical values restated for the Eligible Children and SB 11-008 Eligible Children, and the MAGI Pregnant Adults and SB 11-250 Eligible Pregnant Adults eligibility categories, to account for an error that resulted in clients who should have been in the SB populations showing up in Eligible Children or MAGI Pregnant Adults instead; and also to properly place Eligible Children eligible under continuous eligibility in the Eligible Children category rather than the SB 11-008 Eligible Chidlren category.

FY 2014-15 January-June CORE 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	$1,968,772	$5,514,458	$36,574,610	$2,316,853	$54,400,838	$22,304,997	$100,444,699	$760,883	$106,836,841	$9,304,368	$7,566,624	$20,390,421	$2,445,606	$2,953,273	$3,704	$373,786,947
Emergency Transportation	$783,401	$431,552	$2,319,499	$44,720	$1,177,046	$295,538	$3,663,175	$7,132	$1,329,614	$110,468	$216,527	$251,753	$7,875	$37,805	($555)	$10,675,550
Non-emergency Medical Transportation	$1,468,874	$708,861	$2,800,052	$48,001	$435,472	$72,124	$1,152,531	$8,687	$551,796	$60,058	$102,158	$40,591	$1,239	$619	$532	$7,451,595
Dental Services	$4,236,460	$1,525,084	$8,191,944	$482,998	$15,539,325	$6,884,158	$25,242,072	$50,561	$60,907,441	$10,256,359	$2,898,866	$1,035,301	$111,837	$10,186	$69	$137,372,661
Family Planning	$0	$4	$11,802	$288	$226,952	$103,942	$189,055	$3	$163,873	$20,791	$46,319	$43,576	$3,050	$131	$9	$809,795
Health Maintenance Organizations	$2,896,227	$6,539,908	$35,914,181	$816,541	$37,765,267	$18,524,500	$45,092,726	$34,393	$23,084,444	$2,571,598	$145,735	$8,630,263	$1,011,440	$0	($544)	$183,026,679
Inpatient Hospitals	$8,058,382	$8,759,249	$45,623,148	$2,329,420	$30,731,104	$11,392,137	$112,285,947	$304,758	$63,950,990	$2,300,205	$3,984,281	$32,231,615	$3,491,713	$15,170,105	$45,005	$340,658,059
Outpatient Hospitals	$1,471,386	$4,486,883	$29,936,822	$1,783,952	$49,912,155	$19,815,451	$96,893,090	$597,295	$59,181,412	$5,536,084	$4,080,220	$6,073,943	$482,707	$1,248,378	($8,151)	$281,491,627
Lab & X-Ray	$236,596	$610,941	$3,841,135	$233,504	$10,938,467	$4,499,354	$15,424,566	$55,821	$5,723,494	$661,467	$673,466	$4,262,092	$462,363	$103,035	($1,348)	$47,724,953
Durable Medical Equipment	$10,781,857	$3,818,775	$31,838,499	$736,827	$4,357,555	$1,588,206	$10,579,652	$53,125	$10,572,230	$891,303	$2,705,747	$226,213	$16,794	$1,785	$29,728	$78,198,296
Prescription Drugs	$3,183,104	$11,518,344	$79,510,741	$3,584,679	$54,932,297	$22,324,898	$113,329,885	$335,530	$54,556,104	$7,549,501	$11,095,273	$3,265,621	$297,002	$3,833	($8,274)	$365,478,538
Drug Rebate	($1,776,199)	($6,338,393)	($43,654,948)	($1,915,554)	($29,907,656)	($11,891,612)	($61,494,150)	($161,102)	($29,598,608)	($4,088,533)	($6,056,194)	($1,778,816)	($160,491)	($1,882)	$3,256	($198,820,882)
Rural Health Centers	$28,079	$155,043	$730,517	$23,251	$1,942,226	$906,560	$2,310,037	$5,175	$4,642,696	$410,420	$214,718	$375,317	$19,729	$4,327	$215	$11,768,310
Federally Qualified Health Centers	$396,567	$738,218	$4,193,476	$108,731	$9,703,443	$4,940,729	$21,074,824	$75,810	$25,323,050	$2,232,353	$851,937	$5,132,502	$434,857	$202,556	($2,933)	$75,406,120
Co-Insurance (Title XVIII-Medicare)	$13,034,887	$2,366,586	$9,074,629	$600,839	$1,707,582	$17,355	($55,886)	($4,695)	$10,524	$653	$6,648	$31,240	($126)	$4,646	$5,144,115	$31,938,997
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$1,391,959	$0	$0	$0	$0	$0	$0	$0	$1,391,959
Administrative Service Organizations - Services	$175,787	$277,673	$2,548,177	$68,222	$1,761,410	$1,446,513	$294,198	$0	$1,855,789	$324,369	$261,892	$448,398	$104,185	$0	($1,353)	$9,565,260
Other Medical Services	$394	$324	$2,232	$85	$1,647	$656	$3,297	$21	$2,529	$261	$249	$492	$51	$123	$29	$12,390
Acute Home Health	$2,653,158	$1,508,191	$7,100,751	$124,565	$577,370	$205,121	$2,277,315	$12,103	$923,158	$214,943	$317,760	$69,679	$8,276	$0	($26,188)	$15,966,202
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$49,597,732	$42,621,701	$256,557,267	$11,387,922	$246,202,500	$103,430,627	$488,707,033	$3,527,459	$390,017,377	$38,356,668	$29,112,226	$80,730,201	$8,738,107	$19,738,920	$5,177,316	$1,773,903,056
Caseload	41,582	10,573	67,080	4,177	166,775	78,187	267,156	360	451,972	55,647	19,921	14,788	1,747	2,937	29,112	1,212,011
Half -Year Per Capita	$1,192.77	$4,031.18	$3,824.65	$2,726.67	$1,476.26	$1,322.87	$1,829.30	$9,807.58	$862.92	$689.28	$1,461.38	$5,459.23	$5,003.21	$6,721.16	$177.84	$1,463.60

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HCBS WAIVERS
Cash Based Actuals and Projections by Eligibility

Cash Based Actuals

HCBS WAIVERS	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	$88,671,456	$11,964,141	$65,079,569	$0	$47,107	$0	$0	$0	$264	$0	$7,029	$0	$0	$0	$269,817	$166,039,383
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)	$108,935,300	$17,849,185	$105,282,776	$0	$19,344	$0	$0	$0	$0	$0	$105,173	$0	$0	$0	$194,577	$232,386,355
FY 2010-11 (DA)	$111,149,465	$20,210,587	$120,507,011	$0	$32,095	$12,129	$0	$0	$3,328	$0	$86,754	$0	$0	$0	$142,107	$252,143,476
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
FY 2014-15	$153,386,531	$33,233,849	$172,746,871	$1,579,670	$660,616	$108,528	$1,434,002	$0	$992,997	$953	$288,001	$29,216	$0	$1,163	$982,755	$365,445,152
Estimated FY 2015-16	$168,886,475	$36,506,203	$199,674,855	$1,818,140	$745,691	$103,268	$1,604,373	$0	$1,400,237	$3,310	$448,188	$33,165	$0	$0	$1,131,649	$412,355,554
Estimated FY 2016-17	$187,831,955	$40,536,510	$232,849,189	$2,182,239	$829,155	$115,155	$1,782,433	$0	$1,972,663	$3,788	$705,804	$36,989	$0	$0	$1,260,476	$470,106,356
Estimated FY 2017-18	$204,743,638	$44,093,319	$252,246,758	$2,362,812	$901,062	$125,550	$1,935,228	$0	$2,170,724	$4,228	$745,847	$40,333	$0	$0	$1,372,749	$510,742,248

Percent Change in Cash Based Actuals

HCBS WAIVERS	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	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%	122.48%	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%
FY 2014-15	6.40%	11.67%	6.39%	104.69%	221.98%	261.18%	322.88%	0.00%	275.91%	100.00%	70.31%	83374.29%	0.00%	100.00%	10.66%	7.82%
Estimated FY 2015-16	10.11%	9.85%	15.59%	15.10%	12.88%	-4.85%	11.88%	0.00%	41.01%	247.32%	55.62%	13.52%	0.00%	-100.00%	15.15%	12.84%
Estimated FY 2016-17	11.22%	11.04%	16.61%	20.03%	11.19%	11.51%	11.10%	0.00%	40.88%	14.44%	57.48%	11.53%	0.00%	0.00%	11.38%	14.01%
Estimated FY 2017-18	9.00%	8.77%	8.33%	8.27%	8.67%	9.03%	8.57%	0.00%	10.04%	11.62%	5.67%	9.04%	0.00%	0.00%	8.91%	8.64%

Current Year Projections by Eligibility Category

HCBS WAIVERS	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 Waiver	$161,612,526	$30,080,559	$135,047,448	$1,525,585	$663,298	$99,495	$1,326,596	$0	$0	$0	$298,484	$33,165	$0	$0	$961,782	$331,648,938
Community Mental Health Supports Waiver	$5,931,008	$4,765,181	$26,670,676	$41,502	$18,865	$3,773	$139,598	$0	$0	$0	$7,546	$0	$0	$0	$150,916	$37,729,065
Disabled Children's Waiver	$0	$0	$11,904,303	$83,898	$0	$0	$0	$0	$1,119,510	$1,311	$0	$0	$0	$0	$0	$13,109,022
Consumer Directed Attendant Support-State Plan	$456,324	$82,431	$370,076	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$908,831
Brain Injury Waiver	$554,737	$1,521,217	$14,905,519	$51,683	$39,624	$0	$136,100	$0	$0	$0	$0	$0	$0	$0	$18,951	$17,227,831
Children with Autism Waiver	$0	$0	$6,975,072	$98,879	$0	$0	$0	$0	$227,496	$0	$133,078	$0	$0	$0	$0	$7,434,525
Children with Life Limiting Illness Waiver	$0	$0	$765,641	$3,082	$0	$0	$0	$0	$53,231	$1,999	$9,080	$0	$0	$0	$0	$833,033
Spinal Cord Injury Adult Waiver	$331,880	$56,815	$3,036,120	$13,511	$23,904	$0	$2,079	$0	$0	$0	$0	$0	$0	$0	$0	$3,464,309
Estimated FY 2015-16 Total Expenditure	$168,886,475	$36,506,203	$199,674,855	$1,818,140	$745,691	$103,268	$1,604,373	$0	$1,400,237	$3,310	$448,188	$33,165	$0	$0	$1,131,649	$412,355,554

Request Year Projections by Eligibility Category

HCBS WAIVERS	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 Waiver	$180,247,515	$33,549,045	$150,619,306	$1,701,495	$739,780	$110,967	$1,479,561	$0	$0	$0	$332,901	$36,989	$0	$0	$1,072,682	$369,890,241
Community Mental Health Supports Waiver	$6,583,211	$5,289,184	$29,603,515	$46,066	$20,939	$4,188	$154,948	$0	$0	$0	$8,376	$0	$0	$0	$167,512	$41,877,939
Disabled Children's Waiver	$0	$0	$13,897,011	$97,942	$0	$0	$0	$0	$1,306,910	$1,530	$0	$0	$0	$0	$0	$15,303,393
Consumer Directed Attendant Support-State Plan	$46,149	$8,336	$37,426	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$91,911
Brain Injury Waiver	$593,705	$1,628,081	$15,952,611	$55,314	$42,408	$0	$145,661	$0	$0	$0	$0	$0	$0	$0	$20,282	$18,438,062
Children with Autism Waiver	$0	$0	$18,568,495	$263,228	$0	$0	$0	$0	$605,623	$0	$354,270	$0	$0	$0	$0	$19,791,616
Children with Life Limiting Illness Waiver	$0	$0	$864,881	$3,482	$0	$0	$0	$0	$60,130	$2,258	$10,257	$0	$0	$0	$0	$941,008
Spinal Cord Injury Adult Waiver	$361,375	$61,864	$3,305,944	$14,712	$26,028	$0	$2,263	$0	$0	$0	$0	$0	$0	$0	$0	$3,772,186
Estimated FY 2016-17 Total Expenditure	$187,831,955	$40,536,510	$232,849,189	$2,182,239	$829,155	$115,155	$1,782,433	$0	$1,972,663	$3,788	$705,804	$36,989	$0	$0	$1,260,476	$470,106,356

Out Year Projections by Eligibility Category

HCBS WAIVERS	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 Waiver	$196,543,121	$36,582,107	$164,236,319	$1,855,322	$806,662	$120,999	$1,613,323	$0	$0	$0	$362,998	$40,333	$0	$0	$1,169,659	$403,330,843
Community Mental Health Supports Waiver	$7,154,556	$5,748,221	$32,172,745	$50,064	$22,756	$4,551	$168,396	$0	$0	$0	$9,102	$0	$0	$0	$182,050	$45,512,441
Disabled Children's Waiver	$0	$0	$15,789,155	$111,277	$0	$0	$0	$0	$1,484,852	$1,739	$0	$0	$0	$0	$0	$17,387,023
Consumer Directed Attendant Support-State Plan	$46,149	$8,336	$37,426	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$91,911
Brain Injury Waiver	$615,896	$1,688,933	$16,548,868	$57,382	$43,993	$0	$151,105	$0	$0	$0	$0	$0	$0	$0	$21,040	$19,127,217
Children with Autism Waiver	$0	$0	$18,996,773	$269,300	$0	$0	$0	$0	$619,592	$0	$362,441	$0	$0	$0	$0	$20,248,106
Children with Life Limiting Illness Waiver	$0	$0	$953,331	$3,838	$0	$0	$0	$0	$66,280	$2,489	$11,306	$0	$0	$0	$0	$1,037,244
Spinal Cord Injury Adult Waiver	$383,916	$65,722	$3,512,141	$15,629	$27,651	$0	$2,404	$0	$0	$0	$0	$0	$0	$0	$0	$4,007,463
Estimated FY 2017-18 Total Expenditure	$204,743,638	$44,093,319	$252,246,758	$2,362,812	$901,062	$125,550	$1,935,228	$0	$2,170,724	$4,228	$745,847	$40,333	$0	$0	$1,372,749	$510,742,248

Definitions: HCBS: Home- and Community-Based Services

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HCBS WAIVERS
Cash Based Actuals and Projections by Waiver

Cash Based Actuals by Waiver

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's 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 2006-07	$124,176,566	$17,246,320	$904,883	$12,580,285	$11,112,528	$18,801	$0	$0	$166,039,384
FY 2007-08	$141,827,250	$20,409,887	$1,353,847	$14,109,819	$10,785,587	$695,586	$0	$0	$189,181,976
FY 2008-09	$177,074,414	$22,958,866	$1,747,683	$4,125,973	$12,028,236	$1,293,932	$29,312	$0	$219,258,416
FY 2009-10	$190,694,445	$23,040,614	$1,841,013	$3,516,917	$11,596,421	$1,594,735	$102,210	$0	$232,386,355
FY 2010-11	$209,076,713	$24,587,535	$1,887,201	$2,961,259	$12,182,916	$1,328,577	$119,273	$0	$252,143,475
FY 2011-12	$225,701,747	$25,934,255	$3,130,073	$3,461,683	$12,587,131	$1,022,387	$170,910	$0	$272,008,186
FY 2012-13	$242,975,488	$28,309,412	$5,350,385	$2,661,977	$12,849,682	$885,424	$207,131	$252,509	$293,492,008
FY 2013-14	$279,658,921	$31,919,229	$8,101,781	$2,331,237	$14,184,077	$764,302	$221,632	$1,773,572	$338,954,751
FY 2014-15	$299,565,911	$33,990,405	$10,912,003	$2,412,881	$15,621,148	$710,058	$473,674	$1,759,072	$365,445,152
Estimated FY 2015-16	$331,648,938	$37,729,065	$13,109,022	$908,831	$17,227,831	$7,434,525	$833,033	$3,464,309	$412,355,554
Estimated FY 2016-17	$369,890,241	$41,877,939	$15,303,393	$91,911	$18,438,062	$19,791,616	$941,008	$3,772,186	$470,106,356
Estimated FY 2017-18	$403,330,843	$45,512,441	$17,387,023	$91,911	$19,127,217	$20,248,106	$1,037,244	$4,007,463	$510,742,248

Percent Change in Cash Based Actuals

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's 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	24.85%	12.49%	29.09%	-70.76%	11.52%	86.02%	100.00%	0.00%	15.90%
FY 2009-10	7.69%	0.36%	5.34%	-14.76%	-3.59%	23.25%	248.70%	0.00%	5.99%
FY 2010-11	9.64%	6.71%	2.51%	-15.80%	5.06%	-16.69%	16.69%	0.00%	8.50%
FY 2011-12	7.95%	5.48%	65.86%	16.90%	3.32%	-23.05%	43.29%	0.00%	7.88%
FY 2012-13	7.65%	9.16%	70.93%	-23.10%	2.09%	-13.40%	21.19%	100.00%	7.90%
FY 2013-14	15.10%	12.75%	51.42%	-12.42%	10.38%	-13.68%	7.00%	602.38%	15.49%
FY 2014-15	7.12%	6.49%	34.69%	3.50%	10.13%	-7.10%	113.72%	-0.82%	7.82%
Estimated FY 2015-16	10.71%	11.00%	20.13%	-62.33%	10.29%	947.03%	75.87%	96.94%	12.84%
Estimated FY 2016-17	11.53%	11.00%	16.74%	-89.89%	7.02%	166.21%	12.96%	8.89%	14.01%
Estimated FY 2017-18	9.04%	8.68%	13.62%	0.00%	3.74%	2.31%	10.23%	6.24%	8.64%

HCBS Waiver Enrollment[1]

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's Waiver	Consumer Directed Attendant Support-State Plan[2]	Brain Injury Waiver	Children with Autism Waiver[2]	Children with Life Limiting Illness Waiver[2]	Spinal Cord Injury Adult Waiver[2]	TOTAL
FY 2007-08	14,991	1,967	1,281	N/A	243	N/A	N/A	0	18,536
FY 2008-09	15,920	2,150	1,252	N/A	235	N/A	N/A	0	19,676
FY 2009-10	16,897	2,274	1,263	N/A	232	N/A	N/A	0	20,862
FY 2010-11	17,800	2,398	1,193	39	229	63	120	0	21,842
FY 2011-12	18,491	2,522	1,118	36	223	55	151	0	22,596
FY 2012-13	19,237	2,688	1,125	N/A	237	N/A	171	N/A	23,555
FY 2013-14	20,500	2,908	1,040	N/A	258	N/A	166	N/A	25,005
FY 2014-15	21,358	3,019	1,100	N/A	307	N/A	130	N/A	26,043
Estimated FY 2015-16	22,285	3,195	1,117	10	327	264	144	96	27,438
Estimated FY 2016-17	23,352	3,381	1,134	1	339	518	160	101	28,986
Estimated FY 2017-18	24,471	3,578	1,152	1	351	546	177	105	30,381

Percent Change in Enrollment

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's Waiver	Consumer Directed Attendant Support-State Plan[2]	Brain Injury Waiver	Children with Autism Waiver[2]	Children with Life Limiting Illness Waiver[2]	Spinal Cord Injury Adult Waiver[2]	TOTAL
FY 2008-09	6.20%	9.30%	-2.26%	N/A	-3.29%	N/A	N/A	0.00%	6.15%
FY 2009-10	6.14%	5.77%	0.88%	N/A	-1.28%	N/A	N/A	0.00%	6.03%
FY 2010-11	5.34%	5.45%	-5.54%	N/A	-1.29%	N/A	N/A	0.00%	4.70%
FY 2011-12	3.88%	5.17%	-6.29%	-7.69%	-2.62%	N/A	N/A	0.00%	3.45%
FY 2012-13	4.03%	6.58%	0.63%	N/A	6.28%	N/A	13.25%	100.00%	4.24%
FY 2013-14	6.57%	8.18%	-7.56%	N/A	8.86%	N/A	-2.92%	N/A	6.16%
FY 2014-15	4.19%	3.82%	5.77%	N/A	18.99%	N/A	-21.69%	N/A	4.15%
Estimated FY 2015-16	4.34%	5.83%	1.55%	N/A	6.51%	N/A	10.77%	N/A	5.36%
Estimated FY 2016-17	4.79%	5.82%	1.52%	-90.00%	3.67%	96.21%	11.11%	5.21%	5.64%
Estimated FY 2017-18	4.79%	5.83%	1.59%	0.00%	3.54%	5.41%	10.63%	3.96%	4.81%

Per Enrollee Cost

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's Waiver	Consumer Directed Attendant Support-State Plan[2]	Brain Injury Waiver	Children with Autism Waiver[2]	Children with Life Limiting Illness Waiver[2]	Spinal Cord Injury Adult Waiver[2]	TOTAL
FY 2007-08	$9,460.83	$10,376.15	$1,056.87	N/A	$44,385.13	N/A	N/A	$0.00	$10,206.19
FY 2008-09	$11,122.76	$10,678.54	$1,395.91	N/A	$51,183.98	N/A	N/A	$0.00	$11,143.44
FY 2009-10	$11,285.70	$10,132.20	$1,457.65	N/A	$49,984.57	N/A	N/A	$0.00	$11,139.22
FY 2010-11	$11,745.88	$10,253.35	$1,581.90	N/A	$53,200.51	N/A	N/A	$0.00	$11,543.97
FY 2011-12	$12,206.03	$10,283.21	$2,799.71	$96,157.86	$56,444.53	$18,588.85	$1,131.85	$0.00	$12,037.89
FY 2012-13	$12,630.63	$10,531.78	$4,755.90	N/A	$54,218.07	N/A	$1,211.29	N/A	$12,459.86
FY 2013-14	$13,641.90	$10,976.35	$7,790.17	N/A	$54,977.04	N/A	$1,335.13	N/A	$13,555.48
FY 2014-15	$14,025.93	$11,258.83	$9,920.00	N/A	$50,883.22	N/A	$3,643.65	N/A	$14,032.38
Estimated FY 2015-16	$14,882.16	$11,808.78	$11,735.92	$90,883.10	$52,684.50	$28,161.08	$5,784.95	$36,086.55	$15,028.63
Estimated FY 2016-17	$15,839.77	$12,386.26	$13,495.06	$91,911.00	$54,389.56	$38,207.75	$5,881.30	$37,348.38	$16,218.39
Estimated FY 2017-18	$16,481.99	$12,720.08	$15,092.90	$91,911.00	$54,493.50	$37,084.44	$5,860.14	$38,166.31	$16,811.24

Percent Change in Per Enrollee Cost

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's Waiver	Consumer Directed Attendant Support-State Plan[2]	Brain Injury Waiver	Children with Autism Waiver[2]	Children with Life Limiting Illness Waiver[2]	Spinal Cord Injury Adult Waiver[2]	TOTAL
FY 2008-09	17.57%	2.91%	32.08%	N/A	15.32%	N/A	N/A	0.00%	9.18%
FY 2009-10	1.46%	-5.12%	4.42%	N/A	-2.34%	N/A	N/A	0.00%	-0.04%
FY 2010-11	4.08%	1.20%	8.52%	N/A	6.43%	N/A	N/A	0.00%	3.63%
FY 2011-12	3.92%	0.29%	76.98%	N/A	6.10%	N/A	N/A	0.00%	4.28%
FY 2012-13	3.48%	2.42%	69.87%	N/A	-3.94%	N/A	7.02%	N/A	3.51%
FY 2013-14	8.01%	4.22%	63.80%	N/A	1.40%	N/A	10.22%	N/A	8.79%
FY 2014-15	2.82%	2.57%	27.34%	N/A	-7.45%	N/A	172.91%	N/A	3.52%
Estimated FY 2015-16	6.10%	4.88%	18.31%	N/A	3.54%	N/A	58.77%	N/A	7.10%
Estimated FY 2016-17	6.43%	4.89%	14.99%	1.13%	3.24%	35.68%	1.67%	3.50%	7.92%
Estimated FY 2017-18	4.05%	2.70%	11.84%	0.00%	0.19%	-2.94%	-0.36%	2.19%	3.66%

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HCBS WAIVERS
Cash Based Actuals and Projections by Waiver

Current Year Projection

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's Waiver	Consumer Directed Attendant Support-State Plan[2]	Brain Injury Waiver	Children with Autism Waiver[2]	Children with Life Limiting Illness Waiver[2]	Spinal Cord Injury Adult Waiver[2]	TOTAL
FY 2014-15 Average HCBS Waiver Enrollment	21,358	3,019	1,100	N/A	307	N/A	130	N/A	26,043
Enrollment Trend Selected[3]	4.79%	5.83%	1.55%	N/A	6.51%	N/A	10.77%	N/A	4.60%
FY 2015-16 Estimated Enrollment	**22,381**	**3,195**	**1,117**	**24**	**327**	**52**	**144**	**0**	27,240
Bottom Line Impacts									
HB 15-1186: "Children with Autism Waiver Expansion"	0	0	0	0	0	212	0	0	212
SB 15-011: "Pilot Program Spinal Cord Injury Alternative Medicine"	(96)	0	0	0	0	0	0	96	-
FY 2015-16 R-7: "Participant Directed Programs Expansion"	0	0	0	(14)	0	0	0	0	(14)
Total Bottom Line Impacts	**(96)**	**0**	**0**	**(14)**	**0**	**212**	**0**	**96**	**198**
FY 2015-16 Estimated Enrollment	**22,285**	**3,195**	**1,117**	**10**	**327**	**264**	**144**	**96**	**27,438**
FY 2014-15 Cost per Enrollee	$14,025.93	$11,258.83	$9,920.00	N/A	$50,883.22	N/A	$3,643.65	N/A	$14,032.38
Percentage Selected to Modify Per Enrollee[4]	3.88%	2.55%	22.72%	N/A	0.31%	N/A	6.91%	N/A	7.10%
FY 2015-16 Estimate Cost Per Enrollee	**$14,570.14**	**$11,545.93**	**$12,173.82**	**$89,365.96**	**$51,040.96**	**$14,490.98**	**$3,895.43**	**$35,599.64**	**$15,028.63**
Estimated FY 2015-16 Base Expenditure	**$324,695,570**	**$36,889,246**	**$13,598,157**	**$893,660**	**$16,690,394**	**$3,825,619**	**$560,942**	**$3,417,565**	**$400,571,153**
Caseload Utilization Adjustment	**99.51%**	**99.48%**	**95.77%**	**100.00%**	**99.16%**	**97.06%**	**79.40%**	**100.00%**	**99.32%**
Cash Adjusted Estimated FY 2015-16 Expenditure	**$323,104,562**	**$36,697,422**	**$13,022,955**	**$893,660**	**$16,550,195**	**$3,713,146**	**$445,388**	**$3,417,565**	**$397,844,893**
Bottom Line Impacts									
Annualization of FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	($427,463)	$0	$0	$0	$0	$0	$0	$0	($427,463)
Annualization of FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($790,806)	$0	$0	$0	$0	$0	$0	$0	($790,806)
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Pediatric Hospice Services 20% Rate Increase	$0	$0	$0	$0	$0	$0	$201,991	$0	$201,991
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" 2% Across the Board Increase	$480,221	$54,489	$17,493	$3,868	$25,042	$0	$759	$2,820	$584,692
HB 14-1357: "In-Home Support Services in Medicaid Program"	$479,188	$0	$17,455	$0	$0	$0	$0	$0	$496,643
FY 2014-15 JBC Action: "Raising Cap on Home Modifications"	$577,834	$65,564	$0	$0	$30,132	$0	$0	$3,393	$676,923
EPSDT Personal Care	($269,541)	($30,584)	$0	$0	($14,056)	$0	$0	$0	($314,181)
Annualization of CDASS Administrative FMS & Training Contract Competitive Reprocurement	($1,905,893)	($216,253)	$0	$0	($99,385)	$0	$0	($11,192)	($2,232,723)
Colorado Choice Transitions	$1,443,935	$162,880	$0	$0	$74,856	$0	$0	$0	$1,681,671
Children With Life Limiting Illnesses Audit Recommendations	$0	$0	$0	$0	$0	$0	$182,676	$0	$182,676
FY 2015-16 R-12: "Community Provider Rate Increase" - Waivers	$1,403,355	$159,232	$51,119	$11,303	$73,179	$0	$2,219	$8,241	$1,708,648
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - HCBS Personal Care/Homemaker	$7,039,491	$798,740	$0	$0	$367,081	$0	$0	$41,336	$8,246,648
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - In-Home Respite (excludes CES Respite)	$34,191	$0	$0	$0	$1,783	$0	$0	$201	$36,175
FY 2015-16 JBC Action: "Raising Cap on Home Modifications"	$331,159	$37,575	$0	$0	$17,269	$0	$0	$1,945	$387,948
HB 15-1186: "Children with Autism Waiver Expansion"	$0	$0	$0	$0	$0	$3,721,379	$0	$0	$3,721,379
Independent Living Skills Training Rule Change	$0	$0	$0	$0	$201,735	$0	$0	$0	$201,735
Consumer Transition Services Rate Increase	$148,705	$0	$0	$0	$0	$0	$0	$0	$148,705
Total Bottom Line Impacts	**$8,544,376**	**$1,031,643**	**$86,067**	**$15,171**	**$677,636**	**$3,721,379**	**$387,645**	**$46,744**	**$14,510,661**
Estimated FY 2015-16 Expenditure	**$331,648,938**	**$37,729,065**	**$13,109,022**	**$908,831**	**$17,227,831**	**$7,434,525**	**$833,033**	**$3,464,309**	**$412,355,554**
Estimated FY 2015-16 Per Enrollee	$14,882.16	$11,808.78	$11,735.92	$90,883.10	$52,684.50	$28,161.08	$5,784.95	$36,086.55	$15,028.63
% Change over FY 2014-15 Per Enrollee	6.10%	4.88%	18.31%	N/A	3.54%	N/A	58.77%	N/A	7.10%

Request Year Projection

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's 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	22,285	3,195	1,117	10	327	264	144	96	27,438
Enrollment Trend Selected[3]	4.79%	5.82%	1.52%	-12.50%	3.67%	5.77%	11.11%	5.21%	4.80%
FY 2016-17 Estimated Enrollment	**23,352**	**3,381**	**1,134**	**9**	**339**	**279**	**160**	**101**	28,755
Bottom Line Impacts									
Annualization of HB 15-1186: "Children with Autism Waiver Expansion"	0	0	0	0	0	239	0	0	239
FY 2015-16 R-7: "Participant Directed Programs Expansion"	0	0	0	(8)	0	0	0	0	(8)
Total Bottom Line Impacts	**0**	**0**	**0**	**(8)**	**0**	**239**	**0**	**0**	**231**
FY 2015-16 Estimated Enrollment	**23,352**	**3,381**	**1,134**	**1**	**339**	**518**	**160**	**101**	**28,986**
FY 2015-16 Cost per Enrollee	$14,882.16	$11,808.78	$11,735.92	$90,883.10	$52,684.50	$28,161.08	$5,784.95	$36,086.55	$15,028.63
Percentage Selected to Modify Per Enrollee[4]	3.88%	2.55%	19.84%	0.00%	0.31%	0.00%	6.91%	2.19%	7.92%
FY 2016-17 Estimate Cost Per Enrollee	**$15,459.59**	**$12,109.90**	**$14,064.33**	**$90,883.10**	**$52,847.82**	**$28,161.08**	**$6,184.69**	**$36,876.85**	**$16,218.39**
Estimated FY 2015-16 Base Expenditure	**$361,012,346**	**$40,943,572**	**$15,948,950**	**$90,883**	**$17,915,411**	**$14,587,439**	**$989,550**	**$3,724,562**	**$455,212,713**
Caseload Utilization Adjustment	**99.51%**	**99.48%**	**95.77%**	**100.00%**	**99.16%**	**97.06%**	**88.27%**	**100.00%**	**99.26%**
Cash Adjusted Estimated FY 2016-17 Expenditure	**$359,243,386**	**$40,730,665**	**$15,274,309**	**$90,883**	**$17,764,922**	**$14,158,568**	**$873,476**	**$3,724,562**	**$451,860,771**
Bottom Line Impacts									
Annualization of FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	($192,358)	$0	$0	$0	$0	$0	$0	$0	($192,358)
Annualization of FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($185,234)	$0	$0	$0	$0	$0	$0	$0	($185,234)
Annualization of FY 2014-15 R-11: "Community Provider Rate Increase" Targeted - Pediatric Hospice Services 20% Rate Increase	$0	$0	$0	$0	$0	$0	$67,330	$0	$67,330
Annualization of HB 14-1357: "In-Home Support Services in Medicaid Program"	$670,862	$0	$24,437	$0	$0	$0	$0	$0	$695,299
Annualization of FY 2014-15 JBC Action: "Raising Cap on Home Modifications"	$577,834	$65,564	$0	$0	$30,132	$0	$0	$3,393	$676,923
Annualization of EPSDT Personal Care	($192,557)	($21,849)	$0	$0	($10,041)	$0	$0	$0	($224,447)
Colorado Choice Transitions	$2,227,704	$252,768	$0	$0	$116,166	$0	$0	$0	$2,596,638
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" - Waivers	$127,577	$14,476	$4,647	$1,028	$6,653	$0	$202	$749	$155,332
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - HCBS Personal Care/Homemaker	$7,039,491	$798,740	$0	$0	$367,081	$0	$0	$41,336	$8,246,648
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - In-Home Respite (excludes CES Respite)	$34,190	$0	$0	$0	$1,783	$0	$0	$201	$36,174
Annualization of FY 2015-16 JBC Action: "Raising Cap on Home Modifications"	$331,159	$37,575	$0	$0	$17,269	$0	$0	$1,945	$387,948
Annualization of HB 15-1186: "Children with Autism Waiver Expansion"	$0	$0	$0	$0	$0	$5,633,048	$0	$0	$5,633,048
Annualization of Independent Living Skills Training Rule Change	$0	$0	$0	$0	$144,097	$0	$0	$0	$144,097
Annualization of Consumer Transition Services Rate Increase	$208,187	$0	$0	$0	$0	$0	$0	$0	$208,187
Total Bottom Line Impacts	**$10,646,855**	**$1,147,274**	**$29,084**	**$1,028**	**$673,140**	**$5,633,048**	**$67,532**	**$47,624**	**$18,245,585**
Estimated FY 2016-17 Total Expenditure	**$369,890,241**	**$41,877,939**	**$15,303,393**	**$91,911**	**$18,438,062**	**$19,791,616**	**$941,008**	**$3,772,186**	**$470,106,356**
Estimated FY 2016-17 Per Enrollee	$15,839.77	$12,386.26	$13,495.06	$91,911.00	$54,389.56	$38,207.75	$5,881.30	$37,348.38	$16,218.39
% Change over FY 2015-16 Per Enrollee	6.43%	4.89%	14.99%	1.13%	3.24%	35.68%	1.67%	3.50%	7.92%

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HCBS WAIVERS
Cash Based Actuals and Projections by Waiver

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's 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
Out Year Projection									
Estimated FY 2016-17 Average HCBS Waiver Enrollment	23,352	3,381	1,134	1	339	518	160	101	28,986
Enrollment Trend Selected[3]	4.79%	5.83%	1.59%	-14.29%	3.54%	5.45%	10.63%	3.96%	4.81%
FY 2017-18 Estimated Enrollment	**24,471**	**3,578**	**1,152**	**1**	**351**	**546**	**177**	**105**	30,381
Bottom Line Impacts									
Total Bottom Line Impacts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY 2016-17 Estimated Enrollment	**24,471**	**3,578**	**1,152**	**1**	**351**	**546**	**177**	**105**	**30,381**
FY 2016-17 Cost per Enrollee	$15,839.77	$12,386.26	$13,495.06	$91,911.00	$54,389.56	$38,207.75	$5,881.30	$37,348.38	$16,218.39
Percentage Selected to Modify Per Enrollee[4]	3.88%	2.55%	16.78%	0.00%	0.31%	0.00%	6.91%	2.19%	4.00%
FY 2017-18 Estimate Cost Per Enrollee	**$16,454.35**	**$12,702.11**	**$15,759.53**	**$91,911.00**	**$54,558.17**	**$38,207.75**	**$6,287.70**	**$38,166.31**	$16,811.24
Estimated FY 2017-18 Base Expenditure	**$402,654,399**	**$45,448,150**	**$18,154,979**	**$91,911**	**$19,149,918**	**$20,861,432**	**$1,112,923**	**$4,007,463**	**$511,481,175**
Caseload Utilization Adjustment	**99.51%**	**99.48%**	**95.77%**	**100.00%**	**99.16%**	**97.06%**	**93.20%**	**100.00%**	**99.25%**
Cash Adjusted Estimated FY 2017-18 Expenditure	**$400,681,392**	**$45,211,820**	**$17,387,023**	**$91,911**	**$18,989,059**	**$20,248,106**	**$1,037,244**	**$4,007,463**	**$507,654,018**
Bottom Line Impacts									
Colorado Choice Transitions	$2,649,451	$300,621	$0	$0	$138,158	$0	$0	$0	$3,088,230
Total Bottom Line Impacts	**$2,649,451**	**$300,621**	**$0**	**$0**	**$138,158**	**$0**	**$0**	**$0**	**$3,088,230**
Estimated FY 2017-18 Total Expenditure	**$403,330,843**	**$45,512,441**	**$17,387,023**	**$91,911**	**$19,127,217**	**$20,248,106**	**$1,037,244**	**$4,007,463**	**$510,742,248**
Estimated FY 2017-18 Per Enrollee	$16,481.99	$12,720.08	$15,092.90	$91,911.00	$54,493.50	$37,084.44	$5,860.14	$38,166.31	$16,811.24
% Change over FY 2016-17 Per Enrollee	4.05%	2.70%	11.84%	0.00%	0.19%	-2.94%	-0.36%	2.19%	3.66%

Definitions: HCBS: Home- and Community-Based Services

(1) Presented information regarding the enrolled clients in each waiver is derived from the average number of clients with an approved prior authorization (PAR) for services on the waiver. The Department chose to use this information to present the number of clients enrolled in each waiver as it is static and reflects the exact number of clients that could receive a service under each waiver each month; without an approved PAR, clients cannot receive HCBS. The Department believes this to be a more accurate representation of enrollment as compared to a claim based methodology.

(2) N/A - Data cannot be displayed due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Note	Waiver	Percentages	Waiver	Percentages	Waiver	Percentages
(3) Percentage selected to modify enrollment for FY 2015-16 through FY 2017-18	Elderly, Blind and Disabled Waiver	4.79%, 4.79%, 4.79%	Consumer Directed Attendant Support-State Plan	N/A, -12.50%, -14.29%	Children with Life Limiting Illness Waiver	10.77%, 11.11%, 10.63%
	Community Mental Health Supports Waiver	5.83%, 5.82%, 5.83%	Brain Injury Waiver	6.51%, 3.67%, 3.54%	Spinal Cord Injury Adult Waiver	N/A, 5.21%, 3.96%
	Disabled Children's Waiver	1.55%, 1.52%, 1.59%	Children with Autism Waiver	N/A, 5.77%, 5.45%		
(4) Percentage selected to modify per enrollee costs for FY 2015-16 through FY 2017-18	Elderly, Blind and Disabled Waiver	3.88%, 3.88%, 3.88%	Consumer Directed Attendant Support-State Plan	N/A, 0.00%, 0.00%	Children with Life Limiting Illness Waiver	6.91%, 6.91%, 6.91%
	Community Mental Health Supports Waiver	2.55%, 2.55%, 2.55%	Brain Injury Waiver	0.31%, 0.31%, 0.31%	Spinal Cord Injury Adult Waiver	N/A, 2.19%, 2.19%
	Disabled Children's Waiver	22.72%, 19.84%, 16.78%	Children with Autism Waiver	N/A, 0.00%, 0.00%		

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HCBS WAIVERS
Average Monthly Enrollment Utilization Adjustment

HCBS Waivers Average Monthly Enrollment vs. Average Monthly Waiver Utilizers									
Fiscal Year		Elderly, Blind and Disabled Wavier (HCBS-EBD)	Community Mental Health Supports Waiver (HCBS-CMHS)	Disabled Children's Waiver (HCBS-CHCBS)	Consumer Directed Attendant Support-State Plan (HCBS-1915(i) CDASS)	Brain Injury Waiver (HCBS-BI)	Children with Autism Waiver (HCBS-CWA)	Children with Life Limiting Illness Waiver (HCBS-CLLI) (4)	Spinal Cord Injury Adult Waiver (HCBS-SCI) (4)
FY 2007-08	Average Monthly Enrollment(1)	14,991	1,967	1,281	0	243	40	N/A	0
	Average Monthly Wavier Utilizers(2)	14,026	1,855	1,207	0	235	38	N/A	0
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	93.56%	94.31%	94.22%	0.00%	96.71%	95.00%	21.43%	0.00%
FY 2008-09	Average Monthly Enrollment(1)	15,920	2,150	1,252	0	235	68	N/A	0
	Average Monthly Wavier Utilizers(2)	15,052	2,038	1,187	0	228	65	N/A	0
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	94.55%	94.79%	94.81%	0.00%	97.02%	95.59%	47.06%	0.00%
FY 2009-10	Average Monthly Enrollment(1)	16,897	2,274	1,263	42	232	68	N/A	0
	Average Monthly Wavier Utilizers(2)	16,005	2,169	1,176	42	224	66	N/A	0
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	94.72%	95.38%	93.11%	100.00%	96.55%	97.06%	60.47%	0.00%
FY 2010-11	Average Monthly Enrollment(1)	17,800	2,398	1,193	39	229	63	120	0
	Average Monthly Wavier Utilizers(2)	16,839	2,280	1,113	39	224	59	74	0
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	94.60%	95.08%	93.29%	100.00%	97.82%	93.65%	61.67%	0.00%
FY 2011-12	Average Monthly Enrollment(1)	18,491	2,522	1,118	36	223	55	151	0
	Average Monthly Wavier Utilizers(2)	17,875	2,419	1,060	36	219	50	98	0
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	96.67%	95.92%	94.81%	100.00%	98.21%	90.91%	64.90%	0.00%
FY 2012-13	Average Monthly Enrollment(1)	19,237	2,688	1,125	33	237	50	171	N/A
	Average Monthly Wavier Utilizers(2)	19,143	2,674	1,075	33	235	43	100	N/A
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	99.51%	99.48%	95.56%	100.00%	99.16%	86.00%	58.48%	100.00%
FY 2013-14	Average Monthly Enrollment(1)	20,500	2,908	1,040	31	258	48	166	N/A
	Average Monthly Wavier Utilizers(2)	20,046	2,798	996	31	253	37	86	N/A
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	97.79%	96.22%	95.77%	100.00%	98.06%	77.08%	51.81%	100.00%
FY 2015-16 Selected Average Monthly Utilizers Conversion Factor(3)		**99.51%**	**99.48%**	**95.77%**	**100.00%**	**99.16%**	**97.06%**	**79.40%**	**100.00%**
FY 2016-17 Selected Average Monthly Utilizers Conversion Factor(3)		**99.51%**	**99.48%**	**95.77%**	**100.00%**	**99.16%**	**97.06%**	**88.27%**	**100.00%**
FY 2017-18 Selected Average Monthly Utilizers Conversion Factor(3)		**99.51%**	**99.48%**	**95.77%**	**100.00%**	**99.16%**	**97.06%**	**93.20%**	**100.00%**

Definitions: HCBS: Home- and Community-Based Services; PAR: Prior Authorization; HIPAA: Health Insurance Portability and Accountability Act of 1996

(1) Average Monthly Enrollment is defined by the average number of active PARs, for each waiver, per month.
(2) Average Monthly Waiver Utilizers is defined by the average number of clients with a paid claim, for each waiver, per month of service.
(3) The selected FY 2015-16, FY 2016-17, and FY 2017-18 Average Monthly Utilizer Conversion Factor for HCBS-EBD is set to the FY 2012-13 level, HCBS-CMHS is set to the FY 2013-14 level, HCBS-CHCBS is set to the FY 2013-14 level, HCBS-1915(i) CDASS is set at 100% as claims are invoiced, HCBS-BI is set to the FY 2012-13 level, HCBS-CWA is set to the FY 2009-10 level, HCBS-CLLI is trended from the FY 2013-14 level due to audit recommendations being fully implemented, and HCBS-SCI is set to the FY 2013-14 level. The selected factors are the maximum average monthly paid utilizers as a percentage of average monthly enrollment for the chosen year. For further detail please see the narrative.
(4) N/A - Data cannot be displayed due to HIPAA.

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HCBS WAIVERS
6 Month Cash Based Actuals by Eligibility

FY 2013-14 July - December COFRS Total Actuals

HCBS WAIVERS	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	$56,351,816	$201,391	$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	$392,793	$1,404	$198	$78	$20	$0	$9	$0	$413	$0	$0	$0	$1,158	$940,482
HCBS - Brain Injury	$185,894	$521,248	$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	$14,154,416	$79,396,446	$205,583	$37,385	$11,331	$4,858	$0	$11,302	$0	$60,865	$35	$0	$0	$204,388	$163,663,583
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

HCBS WAIVERS	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	$59,328,882	$523,532	$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	$571,990	$4,642	$1,355	$170	$2,180	$0	$5	$0	$827	$0	$0	$0	$5,002	$1,390,755
HCBS - Brain Injury	$226,928	$733,303	$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	$15,606,663	$82,974,804	$566,153	$167,786	$18,717	$334,248	$0	$252,855	$0	$108,238	$0	$0	$0	$683,675	$175,291,168
Caseload	41,888	10,056	64,593	3,047	138,220	52,404	156,377	504	412,168	36,855	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	$0.61	$0.00	$5.74	$0.00	$0.00	$0.00	$28.18	$179.21

FY 2014-15 July - December COFRS Total Actuals

HCBS WAIVERS	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	$73,057,304	$13,500,257	$61,306,273	$723,121	$317,868	$0	$0	$0	$2,527	$0	$158,828	$8,684	$0	$0	$402,379	$149,477,241
HCBS - Mental Illness	$2,662,964	$2,174,297	$11,892,413	$26,893	$7,786	$0	$0	$0	$0	$0	$263	$0	$0	$0	$74,218	$16,838,834
HCBS - Disabled Children	$0	$0	$4,706,233	$1,513	$0	$0	$0	$0	$469,657	$506	$0	$0	$0	$0	$0	$5,177,909
HCBS - Persons Living with AIDS	($323)	($27)	($4,113)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($4,463)
HCBS - Consumer Directed Attendant Support	$239,204	$44,202	$200,729	$2,368	$1,041	$0	$0	$0	$8	$0	$520	$28	$0	$0	$1,317	$489,417
HCBS - Brain Injury	$235,048	$833,862	$6,660,852	$1,328	$2,150	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,312	$7,736,552
HCBS - Children with Autism	$0	$0	$372,580	$465	$0	$0	$0	$0	$23,647	$0	$11,777	$0	$0	$0	$0	$408,469
HCBS - Pediatric Hospice	$0	$0	$142,819	$0	$0	$0	$0	$0	$7,672	$0	$1,274	$0	$0	$0	$0	$151,765
HCBS - Spinal Cord Injury	$102,267	$10,827	$818,969	$0	$11,592	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$943,655
Total	$76,296,464	$16,563,418	$86,096,755	$755,688	$340,437	$0	$0	$0	$503,511	$506	$172,662	$8,712	$0	$0	$481,226	$181,219,379
Caseload	42,053	10,360	66,015	3,078	158,622	65,032	214,360	437	439,473	44,581	20,152	15,005	1,751	2,506	26,979	1,110,401
Half -Year Per Capita	$1,814.31	$1,598.84	$1,304.20	$245.53	$2.15	$0.00	$0.00	$0.00	$1.15	$0.01	$8.57	$0.58	$0.00	$0.00	$17.84	$163.20

FY 2014-15 January - June COFRS Total Actuals

HCBS WAIVERS	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	$73,099,124	$13,717,525	$60,499,484	$669,941	$268,781	$104,832	$1,182,080	$0	$5,765	$0	$102,410	$20,299	$0	$1,154	$420,852	$150,092,247
HCBS - Mental Illness	$2,685,707	$2,122,247	$12,126,936	$10,020	$10,485	$2,852	$126,172	$0	$0	$0	$6,373	$0	$0	$0	$60,779	$17,151,571
HCBS - Disabled Children	$0	$0	$5,203,149	$68,506	$0	$0	$0	$0	$461,854	$447	$138	$0	$0	$0	$0	$5,734,094
HCBS - Persons Living with AIDS	$64	$6	$816	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$886
HCBS - Consumer Directed Attendant Support	$938,013	$175,023	$780,355	$8,853	$3,684	$844	$9,521	$0	$59	$0	$1,584	$205	$0	$9	$5,314	$1,923,464
HCBS - Brain Injury	$300,748	$637,573	$6,730,627	$49,150	$36,769	$0	$115,222	$0	$0	$0	$0	$0	$0	$0	$14,507	$7,884,596
HCBS - Children with Autism	$0	$0	$293,654	$8,962	$0	$0	$0	$0	($1,926)	$0	$899	$0	$0	$0	$0	$301,589
HCBS - Pediatric Hospice	$0	$0	$292,491	$1,749	$0	$0	$0	$0	$23,734	$0	$3,935	$0	$0	$0	$0	$321,909
HCBS - Spinal Cord Injury	$66,411	$18,057	$722,604	$6,801	$460	$0	$1,007	$0	$0	$0	$0	$0	$0	$0	$77	$815,417
Total	$77,090,067	$16,670,431	$86,650,116	$823,982	$320,179	$108,528	$1,434,002	$0	$489,486	$447	$115,339	$20,504	$0	$1,163	$501,529	$184,225,773
Caseload	41,582	10,573	67,080	4,177	166,775	78,187	267,156	360	451,972	55,647	19,921	14,788	1,747	2,937	29,112	1,212,011
Half -Year Per Capita	$1,853.93	$1,576.70	$1,291.74	$197.29	$1.92	$1.39	$5.37	$0.00	$1.08	$0.01	$5.79	$1.39	$0.00	$0.40	$17.23	$152.00

Exhibit G - COMMUNITY BASED LONG-TERM CARE - PRIVATE DUTY NURSING
Cash Based Actuals and Projections by Eligibility

Private Duty Nursing Total Expenditure by Fiscal Year

PRIVATE DUTY NURSING	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	$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	$21,351,409
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	$27,325,956
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
FY 2014-15	$2,110,022	$441,354	$39,608,590	$300,436	$0	$0	$41,377	$0	$7,416,332	$27,252	$11,553,619	$0	$0	$0	$0	$61,498,982
Estimated FY 2015-16	$2,638,949	$553,948	$49,555,292	$376,993	$0	$0	$53,856	$0	$9,278,634	$30,775	$14,448,818	$0	$0	$0	$0	$76,937,265
Estimated FY 2016-17	$3,086,926	$647,985	$57,967,625	$440,990	$0	$0	$62,999	$0	$10,853,743	$35,999	$16,901,599	$0	$0	$0	$0	$89,997,866
Estimated FY 2017-18	$3,637,419	$763,540	$68,305,001	$519,631	$0	$0	$74,233	$0	$12,789,292	$42,419	$19,915,664	$0	$0	$0	$0	$106,047,199

Private Duty Nursing Total Expenditure Percent Change by Fiscal Year

PRIVATE DUTY NURSING	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	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	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%	0.00%	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%	0.00%	0.00%	0.00%	0.00%	0.00%	77.64%	0.00%	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%	0.00%	0.00%	215.51%	-93.11%	21.44%	0.00%	0.00%	0.00%	0.00%	44.26%
FY 2014-15	-30.58%	-39.93%	12.06%	7.00%	0.00%	0.00%	-4.98%	0.00%	119.83%	6713.00%	12.06%	0.00%	0.00%	0.00%	-100.00%	15.70%
Estimated FY 2015-16	25.07%	25.51%	25.11%	25.48%	0.00%	0.00%	30.16%	0.00%	25.11%	12.93%	25.06%	0.00%	0.00%	0.00%	0.00%	25.10%
Estimated FY 2016-17	16.98%	16.98%	16.98%	16.98%	0.00%	0.00%	16.98%	0.00%	16.98%	16.97%	16.98%	0.00%	0.00%	0.00%	0.00%	16.98%
Estimated FY 2017-18	17.83%	17.83%	17.83%	17.83%	0.00%	0.00%	17.83%	0.00%	17.83%	17.83%	17.83%	0.00%	0.00%	0.00%	0.00%	17.83%

Exhibit G - COMMUNITY BASED LONG-TERM CARE - PRIVATE DUTY NURSING
Cash Based Actuals and Projections by Service

Private Duty Nursing (PDN) Cost Per Service Per Fiscal Year				
PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[1]	TOTAL
FY 2007-08	$11,598,382	$5,606,433	$2,544,447	$19,749,262
FY 2008-09	$12,337,437	$5,561,060	$3,452,912	$21,351,409
FY 2009-10	$14,062,356	$5,817,255	$3,786,944	$23,666,555
FY 2010-11	$16,031,747	$6,956,922	$4,337,287	$27,325,956
FY 2011-12	$19,803,988	$7,090,613	$4,249,552	$31,144,153
FY 2012-13	$24,122,140	$7,345,451	$5,379,370	$36,846,961
FY 2013-14	$35,604,519	$10,618,602	$6,931,782	$53,154,903
FY 2014-15	$41,159,263	$12,091,100	$8,248,619	$61,498,982
Estimated FY 2015-16	$53,026,200	$13,733,489	$10,177,576	$76,937,265
Estimated FY 2016-17	$61,825,680	$15,661,036	$12,511,150	$89,997,866
Estimated FY 2017-18	$72,603,720	$17,985,289	$15,458,190	$106,047,199

Private Duty Nursing (PDN) Percent Change in Cost Per Service Per Fiscal Year				
PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[1]	TOTAL
FY 2008-09	6.37%	-0.81%	35.70%	8.11%
FY 2009-10	13.98%	4.61%	9.67%	10.84%
FY 2010-11	14.00%	19.59%	14.53%	15.46%
FY 2011-12	23.53%	1.92%	-2.02%	13.97%
FY 2012-13	21.80%	3.59%	26.59%	18.31%
FY 2013-14	47.60%	44.56%	28.86%	44.26%
FY 2014-15	15.60%	13.87%	19.00%	15.70%
Estimated FY 2015-16	28.83%	13.58%	23.39%	25.10%
Estimated FY 2016-17	16.59%	14.04%	22.93%	16.98%
Estimated FY 2017-18	17.43%	14.84%	23.56%	17.83%

Private Duty Nursing (PDN) Average Utilizers Per Month Per Service Per Fiscal Year[3]				
PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[1][2]	TOTAL[4]
FY 2007-08	113	88	N/A	149
FY 2008-09	109	84	N/A	149
FY 2009-10	123	86	N/A	164
FY 2010-11	146	100	33	186
FY 2011-12	181	114	33	221
FY 2012-13	221	124	50	268
FY 2013-14	306	175	55	368
FY 2014-15	379	214	64	458
Estimated FY 2015-16	445	246	78	547
Estimated FY 2016-17	522	283	95	646
Estimated FY 2017-18	613	325	116	763

Private Duty Nursing (PDN) Percent Change Average Utilizers Per Month Per Service Per Fiscal Year				
PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[1][2]	TOTAL
FY 2008-09	-3.54%	-4.55%	N/A	0.00%
FY 2009-10	12.84%	2.38%	N/A	10.07%
FY 2010-11	18.70%	16.28%	N/A	13.41%
FY 2011-12	23.97%	14.00%	N/A	18.82%
FY 2012-13	22.10%	8.77%	51.52%	21.27%
FY 2013-14	38.46%	41.13%	10.00%	37.31%
FY 2014-15	23.86%	22.29%	16.36%	24.46%
Estimated FY 2015-16	17.41%	14.95%	21.88%	19.43%
Estimated FY 2016-17	17.30%	15.04%	21.79%	18.10%
Estimated FY 2017-18	17.43%	14.84%	22.11%	18.11%

Exhibit G - COMMUNITY BASED LONG-TERM CARE - PRIVATE DUTY NURSING
Cash Based Actuals and Projections by Service

Private Duty Nursing (PDN) Cost Per Utilizer Per Service Per Fiscal Year				
PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN(1)(2)	TOTAL
FY 2007-08	$102,640.55	$63,709.47	N/A	$132,545.38
FY 2008-09	$113,187.50	$66,203.10	N/A	$143,298.05
FY 2009-10	$114,328.10	$67,642.50	N/A	$144,308.26
FY 2010-11	$109,806.49	$69,569.22	N/A	$146,913.74
FY 2011-12	$109,414.30	$62,198.36	$128,774.30	$140,923.77
FY 2012-13	$109,149.95	$59,237.51	$107,587.40	$137,488.66
FY 2013-14	$116,354.64	$60,677.73	$126,032.40	$144,442.67
FY 2014-15	$108,599.64	$56,500.47	$128,884.67	$134,277.25
Estimated FY 2015-16	$119,160.00	$55,827.19	$130,481.74	$140,653.14
Estimated FY 2016-17	$118,440.00	$55,339.35	$131,696.32	$139,315.58
Estimated FY 2017-18	$118,440.00	$55,339.35	$133,260.26	$138,987.15

Private Duty Nursing (PDN) Percent Change in Cost Per Utilizer Per Service Per Fiscal Year				
PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN(1)(2)	TOTAL
FY 2008-09	10.28%	3.91%	N/A	8.11%
FY 2009-10	1.01%	2.17%	N/A	0.70%
FY 2010-11	-3.95%	2.85%	N/A	1.81%
FY 2011-12	-0.36%	-10.60%	N/A	-4.08%
FY 2012-13	-0.24%	-4.76%	-16.45%	-2.44%
FY 2013-14	6.60%	2.43%	17.14%	5.06%
FY 2014-15	-6.66%	-6.88%	2.26%	-7.04%
Estimated FY 2015-16	9.72%	-1.19%	1.24%	4.75%
Estimated FY 2016-17	-0.60%	-0.87%	0.93%	-0.95%
Estimated FY 2017-18	0.00%	0.00%	1.19%	-0.24%

Private Duty Nursing (PDN) Units Per Utilizer Per Service Per Fiscal Year			
PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN(1)
FY 2007-08	2,674	2,212	4,413
FY 2008-09	2,902	2,257	4,990
FY 2009-10	3,040	2,399	4,529
FY 2010-11	2,968	2,499	4,559
FY 2011-12	2,976	2,251	4,467
FY 2012-13	2,979	2,148	3,732
FY 2013-14	2,936	2,035	4,372
FY 2014-15	2,681	1,864	4,471
Estimated FY 2015-16	2,648	1,831	4,577
Estimated FY 2016-17	2,632	1,815	4,620
Estimated FY 2017-18	2,632	1,815	4,675

Private Duty Nursing (PDN) Percent Change in Units Per Utilizer Per Service Per Fiscal Year			
PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN(1)
FY 2008-09	8.53%	2.03%	13.08%
FY 2009-10	4.76%	6.29%	-9.24%
FY 2010-11	-2.37%	4.17%	0.66%
FY 2011-12	0.27%	-9.92%	-2.02%
FY 2012-13	0.10%	-4.58%	-16.45%
FY 2013-14	-1.44%	-5.26%	17.15%
FY 2014-15	-8.69%	-8.40%	2.26%
Estimated FY 2015-16	-1.23%	-1.77%	2.37%
Estimated FY 2016-17	-0.60%	-0.87%	0.94%
Estimated FY 2017-18	0.00%	0.00%	1.19%

Exhibit G - COMMUNITY BASED LONG-TERM CARE - PRIVATE DUTY NURSING
Cash Based Actuals and Projections by Service

Current Year Projection				
PRIVATE DUTY NURSING	**Registered Nursing (RN)**	**Licensed Practical Nursing (LPN)**	**Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[1]**	**TOTAL**
FY 2014-15 Average Paid Utilizers Per Month	379	214	64	458
Utilizer Trend Selected[5]	17.41%	14.95%	21.88%	19.43%
FY 2015-16 Estimated Average Paid Utilizers Per Month	445	246	78	547
Bottom Line Impacts				
Total Bottom Line Impacts	**0**	**0**	**0**	**0**
FY 2015-16 Estimated Average Paid Utilizers Per Month	**445**	**246**	**78**	**547**
FY 2014-15 Average Paid Units Per Utilizer	2,681	1,864	4,471	
Percentage Selected to Modify Per Client Utilization[6]	-1.23%	-1.77%	2.37%	
FY 2015-16 Estimated Average Paid Units Per Utilizer	**2,648**	**1,831**	**4,577**	
FY 2014-15 Average Paid Rate Per Unit	$40.56	$30.34	$28.36	
FY 2015-16 R-12: "Community Provider Rate Increase & Targeted Rate Increase"	10.95%	0.50%	0.50%	
FY 2015-16 Average Paid Rate Per Unit	**$45.00**	**$30.49**	**$28.50**	
Estimated FY 2015-16 Base Expenditure	**$53,026,200**	**$13,733,489**	**$10,177,576**	**$76,937,265**
Bottom Line Impacts				
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**
Estimated FY 2015-16 Expenditure	**$53,026,200**	**$13,733,489**	**$10,177,576**	**$76,937,265**
Estimated FY 2015-16 Per Utilizer Cost	$119,160.00	$55,827.19	$130,481.74	$140,653.14
% Change Over FY 2014-15 Per Utilizer Cost	9.72%	-1.19%	1.24%	4.75%

Request Year Projection				
PRIVATE DUTY NURSING	**Registered Nursing (RN)**	**Licensed Practical Nursing (LPN)**	**Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[1]**	**TOTAL**
FY 2015-16 Estimated Average Paid Utilizers Per Month	445	246	78	547
Utilizer Trend Selected[5]	17.30%	15.04%	21.79%	18.10%
FY 2016-17 Estimated Average Paid Utilizers Per Month	522	283	95	646
Bottom Line Impacts				
Total Bottom Line Impacts	**0**	**0**	**0**	**0**
FY 2016-17 Estimated Average Paid Utilizers Per Month	**522**	**283**	**95**	**646**
FY 2015-16 Average Paid Units Per Utilizer	2,648	1,831	4,577	
Percentage Selected to Modify Per Client Utilization[6]	-0.60%	-0.87%	0.94%	
FY 2016-17 Estimated Average Paid Units Per Utilizer	**2,632**	**1,815**	**4,620**	
FY 2015-16 Average Paid Rate Per Unit	$45.00	$30.49	$28.50	
Rate Increase	0.00%	0.00%	0.00%	
FY 2016-17 Estimated Average Paid Rate Per Unit	**$45.00**	**$30.49**	**$28.50**	
Estimated FY 2016-17 Base Expenditure	**$61,825,680**	**$15,661,036**	**$12,511,150**	**$89,997,866**
Bottom Line Impacts				
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**
Estimated FY 2016-17 Expenditure	**$61,825,680**	**$15,661,036**	**$12,511,150**	**$89,997,866**
Estimated FY 2016-17 Per Utilizer Cost	$118,440.00	$55,339.35	$131,696.32	$139,315.58
% Change Over FY 2015-16 Per Utilizer Cost	-0.60%	-0.87%	0.93%	-0.95%

Exhibit G - COMMUNITY BASED LONG-TERM CARE - PRIVATE DUTY NURSING
Cash Based Actuals and Projections by Service

Out Year Projection				
PRIVATE DUTY NURSING	**Registered Nursing (RN)**	**Licensed Practical Nursing (LPN)**	**Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[1]**	**TOTAL**
FY 2016-17 Estimated Average Paid Utilizers Per Month	522	283	95	646
Utilizer Trend Selected[5]	17.43%	14.84%	22.11%	18.11%
FY 2017-18 Estimated Average Paid Utilizers Per Month	613	325	116	763
Bottom Line Impacts				
Total Bottom Line Impacts	**0**	**0**	**0**	**0**
FY 2017-18 Estimated Average Paid Utilizers Per Month	**613**	**325**	**116**	**763**
FY 2016-17 Average Paid Units Per Utilizer	2,632	1,815	4,620	
Percentage Selected to Modify Per Client Utilization[6]	0.00%	0.00%	1.19%	
FY 2017-18 Estimated Average Paid Units Per Client	**2,632**	**1,815**	**4,675**	
FY 2016-17 Average Paid Rate Per Unit	$45.00	$30.49	$28.50	
Rate Increase	0.00%	0.00%	0.00%	
FY 2017-18 Estimated Average Paid Rate Per Unit	**$45.00**	**$30.49**	**$28.50**	
Estimated FY 2017-18 Base Expenditure	**$72,603,720**	**$17,985,289**	**$15,458,190**	**$106,047,199**
Bottom Line Impacts				
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**
Estimated FY 2017-18 Expenditure	**$72,603,720**	**$17,985,289**	**$15,458,190**	**$106,047,199**
Estimated FY 2017-18 Per Utilizer Cost	$118,440.00	$55,339.35	$133,260.26	$138,987.15
% Change Over FY 2016-17 Per Utilizer Cost	0.00%	0.00%	1.19%	-0.24%

(1) RN Group/LPN Group and Blended RN/LPN Services are forecasted individually, but due to small cells sizes, the three services are grouped together. The rate is weighted across the three services based on utilization. The unit of service (hour) is constant across the three services.

(2) N/A - Rows cannot be displayed due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(3) Presented information regarding the utilizer per service is derived from the average number of clients with a paid claim per month. The Department believes this to be an accurate representation of utilizers for PDN services as clients typically continue services once a need is identified.

(4) Since clients can access multiple services, the average caseload doesn't reflect the sum of the services but rather the total average paid monthly caseload for PDN as a benefit.

(5) Percentages Selected to Modify Utilizers for FY 2015-16 through FY 2017-18	RN	17.41%, 17.30%, 17.43%
	LPN	14.95%, 15.04%, 14.84%
	Blended & Group	21.88%, 21.79%, 22.11%
	Total PDN Utilizers	19.43%, 18.10%, 18.11%
(6) Percentages Selected to Modifier Units Per Utilizer for FY 2015-16 through FY 2017-18	RN	-1.23%, -0.60%, 0.00%
	LPN	-1.77%, -0.87%, 0.00%
	Blended & Group	2.37%, 0.94%, 1.19%

Exhibit G - COMMUNITY BASED LONG-TERM CARE - LONG-TERM HOME HEALTH
Cash Based Actuals and Projections by Eligibility

Long-Term Home Health Total Expenditure by Fiscal Year

LONG-TERM HOME HEALTH	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	$8,358,525	$2,246,421	$40,623,872	$0	$51,486	$0	$0	$0	$1,216,098	$0	$4,210,240	$0	$0	$0	$132,345	$56,838,987
FY 2008-09	$17,604,990	$4,444,247	$90,740,074	$0	$29,485	$0	$0	$0	$2,591,906	$0	$9,570,085	$0	$0	$0	$102,711	$125,083,498
FY 2009-10 (DA)	$18,218,198	$4,520,382	$101,341,382	$0	$43,869	$0	$0	$0	$3,137,536	$0	$10,254,991	$0	$0	$0	$97,840	$137,614,198
FY 2010-11 (DA)	$18,890,472	$5,333,256	$109,460,345	$0	$55,655	$7,651	$0	$0	$3,447,255	$0	$10,296,687	$188	$0	$0	$90,417	$147,581,926
FY 2011-12	$19,241,801	$5,960,470	$112,026,409	$0	$70,804	$21,256	$0	$0	$3,621,831	$0	$10,150,245	$374	$0	$0	$128,231	$151,221,421
FY 2012-13	$21,401,061	$7,062,994	$115,531,305	$368,744	$151,443	$4,862	$0	$0	$3,609,745	$0	$10,404,821	$1,690	$0	$0	$93,867	$158,630,532
FY 2013-14	$26,251,582	$8,030,921	$130,372,386	$1,316,824	$235,386	$18,678	$172,588	$0	$7,825,402	$244,287	$11,792,931	$1,213	$0	$0	$252,997	$186,515,195
FY 2014-15	$28,375,633	$9,114,399	$139,389,239	$1,945,982	$310,179	$69,594	$1,335,165	$0	$18,387,951	$725,506	$12,889,124	$6,903	$0	$0	$27,780	$212,577,453
Estimated FY 2015-16	$30,838,557	$9,909,918	$151,466,979	$2,125,204	$346,501	$69,300	$1,455,303	$0	$19,981,537	$785,401	$13,998,626	$0	$0	$0	$23,100	$231,000,426
Estimated FY 2016-17	$33,763,036	$10,849,695	$165,830,879	$2,326,741	$379,360	$75,872	$1,593,312	$0	$21,876,424	$859,883	$15,326,142	$0	$0	$0	$25,289	$252,906,633
Estimated FY 2017-18	$36,566,146	$11,750,469	$179,598,665	$2,519,914	$410,856	$82,171	$1,725,593	$0	$23,692,671	$931,273	$16,598,565	$0	$0	$0	$27,390	$273,903,713

Long-Term Home Health Total Expenditure Percent Change by Fiscal Year

LONG-TERM HOME HEALTH	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	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	110.62%	97.84%	123.37%	0.00%	-42.73%	0.00%	0.00%	0.00%	113.13%	0.00%	127.30%	0.00%	0.00%	0.00%	-22.39%	120.07%
FY 2009-10 (DA)	3.48%	1.71%	11.68%	0.00%	48.78%	0.00%	0.00%	0.00%	21.05%	0.00%	7.16%	0.00%	0.00%	0.00%	-4.74%	10.02%
FY 2010-11 (DA)	3.69%	17.98%	8.01%	0.00%	26.87%	0.00%	0.00%	0.00%	9.87%	0.00%	0.41%	0.00%	0.00%	0.00%	-7.59%	7.24%
FY 2011-12	1.86%	11.76%	2.34%	0.00%	27.22%	177.82%	0.00%	0.00%	5.06%	0.00%	-1.42%	98.94%	0.00%	0.00%	41.82%	2.47%
FY 2012-13	11.22%	18.50%	3.13%	0.00%	113.89%	-77.13%	0.00%	0.00%	-0.33%	0.00%	2.51%	351.87%	0.00%	0.00%	-26.80%	4.90%
FY 2013-14	22.66%	13.70%	12.85%	257.11%	55.43%	284.16%	0.00%	0.00%	116.79%	0.00%	13.34%	-28.22%	0.00%	0.00%	169.53%	17.58%
FY 2014-15	8.09%	13.49%	6.92%	47.78%	31.77%	272.60%	673.61%	0.00%	134.98%	196.99%	9.30%	469.06%	0.00%	0.00%	-89.02%	13.97%
Estimated FY 2015-16	8.68%	8.73%	8.66%	9.21%	11.71%	-0.42%	9.00%	0.00%	8.67%	8.26%	8.61%	-100.00%	0.00%	0.00%	-16.85%	8.67%
Estimated FY 2016-17	9.48%	9.48%	9.48%	9.48%	9.48%	9.48%	9.48%	0.00%	9.48%	9.48%	9.48%	0.00%	0.00%	0.00%	9.48%	9.48%
Estimated FY 2017-18	8.30%	8.30%	8.30%	8.30%	8.30%	8.30%	8.30%	0.00%	8.30%	8.30%	8.30%	0.00%	0.00%	0.00%	8.31%	8.30%

Exhibit G - COMMUNITY BASED LONG-TERM CARE - LONG-TERM HOME HEALTH
Cash Based Actuals and Projections by Service

Long-Term Home Health (LTHH) Cost Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Telehealth[1]	Total
FY 2008-09	$3,338,322	$3,556,304	$3,153,526	$21,204,523	$58,782,571	$29,613,523	$3,727,926	$1,706,805	$0	$125,083,500
FY 2009-10	$3,408,878	$3,468,057	$3,225,823	$21,789,837	$65,541,038	$34,386,681	$3,857,891	$1,935,993	$0	$137,614,198
FY 2010-11	$3,488,805	$3,450,298	$3,463,479	$22,261,575	$71,222,845	$37,151,446	$4,217,007	$2,326,471	$0	$147,581,926
FY 2011-12	$3,626,606	$3,445,533	$3,374,158	$21,937,994	$73,088,477	$37,825,586	$5,154,767	$2,767,782	$516	$151,221,419
FY 2012-13	$3,971,740	$3,817,229	$3,511,343	$22,312,471	$77,554,317	$37,883,991	$6,436,658	$3,134,580	$8,204	$158,630,533
FY 2013-14	$5,478,336	$5,769,444	$5,772,910	$30,601,689	$89,319,041	$41,228,516	$6,162,682	$2,167,316	$15,260	$186,515,194
FY 2014-15	$6,426,151	$7,074,775	$8,909,669	$33,134,389	$99,806,644	$46,746,258	$7,699,746	$2,760,029	$19,792	$212,577,453
Estimated FY 2015-16	$7,176,954	$8,130,957	$11,709,381	$35,059,386	$107,521,848	$49,800,891	$8,432,777	$3,143,215	$25,017	$231,000,426
Estimated FY 2016-17	$7,959,748	$9,238,084	$14,128,584	$38,245,315	$116,570,910	$53,826,946	$9,289,250	$3,617,923	$29,873	$252,906,633
Estimated FY 2017-18	$8,819,394	$10,486,342	$15,883,661	$41,286,226	$125,355,335	$57,808,400	$10,103,145	$4,126,736	$34,474	$273,903,713

LTHH Percent Change in Cost Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Telehealth	Total
FY 2009-10	2.11%	-2.48%	2.29%	2.76%	11.50%	16.12%	3.49%	13.43%	0.00%	10.02%
FY 2010-11	2.34%	-0.51%	7.37%	2.16%	8.67%	8.04%	9.31%	20.17%	0.00%	7.24%
FY 2011-12	3.95%	-0.14%	-2.58%	-1.45%	2.62%	1.81%	22.24%	18.97%	0.00%	2.47%
FY 2012-13	9.52%	10.79%	4.07%	1.71%	6.11%	0.15%	24.87%	13.25%	1489.92%	4.90%
FY 2013-14	37.93%	51.14%	64.41%	37.15%	15.17%	8.83%	-4.26%	-30.86%	86.01%	17.58%
FY 2014-15	17.30%	22.62%	54.34%	8.28%	11.74%	13.38%	24.94%	27.35%	29.70%	13.97%
Estimated FY 2015-16	11.68%	14.93%	31.42%	5.81%	7.73%	6.53%	9.52%	13.88%	26.40%	8.67%
Estimated FY 2016-17	10.91%	13.62%	20.66%	9.09%	8.42%	8.08%	10.16%	15.10%	19.41%	9.48%
Estimated FY 2017-18	10.80%	13.51%	12.42%	7.95%	7.54%	7.40%	8.76%	14.06%	15.40%	8.30%

LTHH Average Utilizers Per Month Per Service Per Fiscal Year[2]

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total[3]
FY 2008-09	526	605	484	2,344	2,391	1,564	182	95	5,715
FY 2009-10	558	622	517	2,317	2,601	1,752	197	101	5,933
FY 2010-11	552	623	534	2,429	2,783	1,889	212	116	6,245
FY 2011-12	595	635	529	2,549	2,930	2,005	270	137	6,508
FY 2012-13	653	689	554	2,716	3,085	2,128	367	152	6,900
FY 2013-14	906	1,008	894	3,066	3,286	2,257	336	115	8,642
FY 2014-15	1,055	1,223	1,325	3,185	3,545	2,499	386	140	10,517
Estimated FY 2015-16	1,192	1,388	1,742	3,356	3,786	2,703	423	158	12,166
Estimated FY 2016-17	1,346	1,576	2,101	3,536	4,043	2,923	460	178	14,074
Estimated FY 2017-18	1,520	1,789	2,362	3,726	4,318	3,161	497	200	16,281

LTHH Percent Change Average Utilizers Per Month Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2009-10	6.08%	2.81%	6.82%	-1.15%	8.78%	12.02%	8.24%	6.32%	3.81%
FY 2010-11	-1.08%	0.16%	3.29%	4.83%	7.00%	7.82%	7.61%	14.85%	5.26%
FY 2011-12	7.79%	1.93%	-0.94%	4.94%	5.28%	6.14%	27.36%	18.10%	4.21%
FY 2012-13	9.75%	8.50%	4.73%	6.55%	5.29%	6.13%	35.93%	10.95%	6.02%
FY 2013-14	38.74%	46.30%	61.37%	12.89%	6.52%	6.06%	-8.45%	-24.34%	25.25%
FY 2014-15	16.45%	21.33%	48.21%	3.88%	7.88%	10.72%	14.88%	21.74%	21.70%
Estimated FY 2015-16	12.99%	13.49%	31.47%	5.37%	6.80%	8.16%	9.59%	12.86%	15.68%
Estimated FY 2016-17	12.92%	13.54%	20.61%	5.36%	6.79%	8.14%	8.75%	12.66%	15.68%
Estimated FY 2017-18	12.93%	13.52%	12.42%	5.37%	6.80%	8.14%	8.04%	12.36%	15.68%

LTHH Cost Per Utilizer Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2008-09	$6,346.62	$5,878.19	$6,515.55	$9,046.30	$24,584.93	$18,934.48	$20,483.11	$17,966.37	$21,886.88
FY 2009-10	$6,109.10	$5,575.65	$6,239.50	$9,404.33	$25,198.40	$19,627.10	$19,583.20	$19,168.25	$23,194.71
FY 2010-11	$6,320.30	$5,538.20	$6,485.92	$9,164.91	$25,592.11	$19,667.26	$19,891.54	$20,055.78	$23,632.01
FY 2011-12	$6,095.14	$5,426.04	$6,378.37	$8,606.51	$24,944.87	$18,865.63	$19,091.73	$20,202.79	$23,236.24
FY 2012-13	$6,082.30	$5,540.25	$6,338.16	$8,215.20	$25,139.16	$17,802.63	$17,538.58	$20,622.24	$22,989.93
FY 2013-14	$6,046.73	$5,723.65	$6,457.39	$9,980.98	$27,181.69	$18,266.95	$18,341.32	$18,846.23	$21,582.41
FY 2014-15	$6,091.14	$5,784.77	$6,724.28	$10,403.26	$28,154.20	$18,705.99	$19,947.53	$19,714.49	$20,212.75
Estimated FY 2015-16	$6,020.93	$5,858.04	$6,721.80	$10,446.78	$28,399.85	$18,424.30	$19,935.64	$19,893.77	$18,987.38
Estimated FY 2016-17	$5,913.63	$5,861.73	$6,724.69	$10,815.98	$28,832.78	$18,414.97	$20,194.02	$20,325.41	$17,969.78
Estimated FY 2017-18	$5,802.23	$5,861.57	$6,724.67	$11,080.58	$29,030.88	$18,288.01	$20,328.26	$20,633.68	$16,823.52

LTHH Percent Change in Cost Per Utilizer Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2009-10	-3.74%	-5.15%	-4.24%	3.96%	2.50%	3.66%	-4.39%	6.69%	5.98%
FY 2010-11	3.46%	-0.67%	3.95%	-2.55%	1.56%	0.20%	1.57%	4.63%	1.89%
FY 2011-12	-3.56%	-2.03%	-1.66%	-6.09%	-2.53%	-4.08%	-4.02%	0.73%	-1.67%
FY 2012-13	-0.21%	2.10%	-0.63%	-4.55%	0.78%	-5.63%	-8.14%	2.08%	-1.06%
FY 2013-14	-0.58%	3.31%	1.88%	21.49%	8.12%	2.61%	4.58%	-8.61%	-6.12%
FY 2014-15	0.73%	1.07%	4.13%	4.23%	3.58%	2.40%	8.76%	4.61%	-6.35%
Estimated FY 2015-16	-1.15%	1.27%	-0.04%	0.42%	0.87%	-1.51%	-0.06%	0.91%	-6.06%
Estimated FY 2016-17	-1.78%	0.06%	0.04%	3.53%	1.52%	-0.05%	1.30%	2.17%	-5.36%
Estimated FY 2017-18	-1.88%	0.00%	0.00%	2.45%	0.69%	-0.69%	0.66%	1.52%	-6.38%

Exhibit G - COMMUNITY BASED LONG-TERM CARE - LONG-TERM HOME HEALTH
Cash Based Actuals and Projections by Service

LTHH Units Per Utilizer Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day
FY 2008-09	61	56	57	91	711	1,831	295	370
FY 2009-10	60	54	56	98	740	1,927	291	408
FY 2010-11	63	55	59	98	766	1,969	303	436
FY 2011-12	61	54	58	92	752	1,904	293	443
FY 2012-13	60	55	58	88	759	1,798	269	451
FY 2013-14	56	53	55	100	762	1,711	262	384
FY 2014-15	55	52	55	101	770	1,718	277	392
Estimated FY 2015-16	54	52	55	103	776	1,701	278	397
Estimated FY 2016-17	53	52	55	105	782	1,684	279	402
Estimated FY 2017-18	52	52	55	107	788	1,667	280	407

LTHH Percent Change in Units Per Utilizer Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day
FY 2009-10	-1.64%	-3.57%	-1.75%	7.69%	4.08%	5.24%	-1.36%	10.27%
FY 2010-11	5.00%	1.85%	5.36%	0.00%	3.51%	2.18%	4.12%	6.86%
FY 2011-12	-3.17%	-1.82%	-1.69%	-6.12%	-1.83%	-3.30%	-3.30%	1.61%
FY 2012-13	-1.64%	1.85%	0.00%	-4.35%	0.93%	-5.57%	-8.19%	1.81%
FY 2013-14	-6.67%	-3.64%	-5.17%	13.64%	0.40%	-4.84%	-2.60%	-14.86%
FY 2014-15	-1.79%	-1.89%	0.00%	1.00%	1.05%	0.41%	5.73%	2.08%
Estimated FY 2015-16	-1.82%	0.00%	0.00%	1.98%	0.78%	-0.99%	0.36%	1.28%
Estimated FY 2016-17	-1.85%	0.00%	0.00%	1.94%	0.77%	-1.00%	0.36%	1.26%
Estimated FY 2017-18	-1.89%	0.00%	0.00%	1.90%	0.77%	-1.01%	0.36%	1.24%

Current Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2014-15 Average Utilizers Per Month	1,055	1,223	1,325	3,185	3,545	2,499	386	140	10,517
Utilizer Trend Selected[4]	12.99%	13.49%	31.47%	5.37%	6.80%	8.16%	9.59%	12.86%	15.68%
FY 2015-16 Estimated Average Utilizers Per Month	1,192	1,388	1,742	3,356	3,786	2,703	423	158	12,166
Bottom Line Impacts									
Total Bottom Line Impacts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY 2015-16 Estimated Average Utilizers Per Month	**1,192**	**1,388**	**1,742**	**3,356**	**3,786**	**2,703**	**423**	**158**	**12,166**
FY 2014-15 Average Units Per Utilizer	55	52	55	101	770	1,718	277	392	
Percentage Selected to Modify Units Per Utilizer[5]	-1.82%	0.00%	0.00%	1.98%	0.78%	-0.99%	0.36%	1.28%	
FY 2015-16 Estimated Average Units Per Utilizer	**54**	**52**	**55**	**103**	**776**	**1,701**	**278**	**397**	
FY 2014-15 Average Paid Rate Per Unit	$110.75	$111.90	$121.42	$102.76	$36.56	$10.89	$72.05	$50.33	
FY 2015-16 R-12: "Community Provider Rate Increase"	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	
FY 2015-16 Average Paid Rate Per Unit	**$111.30**	**$112.46**	**$122.03**	**$103.27**	**$36.74**	**$10.94**	**$72.41**	**$50.58**	
Estimated FY 2015-16 Base Expenditure	**$7,164,158**	**$8,116,913**	**$11,691,694**	**$35,697,134**	**$107,939,769**	**$50,299,965**	**$8,514,982**	**$3,172,681**	**$232,622,313**
Bottom Line Impacts									
FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	$0	$0	$0	($161,899)	($290,807)	($136,205)	($22,435)	($8,042)	($619,388)
FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	$0	$0	$0	($541,626)	($972,882)	($455,667)	($75,055)	($26,904)	($2,072,134)
HB 15-1186: "Children with Autism Waiver Expansion"	$617	$678	$854	$3,176	$9,565	$4,480	$738	$265	$20,373
EPSDT Personal Care	$0	$0	$0	$0	$647,638	$0	$0	$0	$647,638
Colorado Choice Transitions	$12,179	$13,366	$16,833	$62,601	$188,565	$88,318	$14,547	$5,215	$401,624
Total Bottom Line Impacts	$12,796	$14,044	$17,687	($637,748)	($417,921)	($499,074)	($82,205)	($29,466)	($1,621,887)
Estimated FY 2015-16 Expenditure	**$7,176,954**	**$8,130,957**	**$11,709,381**	**$35,059,386**	**$107,521,848**	**$49,800,891**	**$8,432,777**	**$3,143,215**	**$231,000,426**
Estimated FY 2015-16 Per Utilizer Cost	$6,020.93	$5,858.04	$6,721.80	$10,446.78	$28,399.85	$18,424.30	$19,935.64	$19,893.77	$18,987.38
% Change Over FY 2014-15 Per Utilizer Cost	-1.15%	1.27%	-0.04%	0.42%	0.87%	-1.51%	-0.06%	0.91%	-6.06%

Request Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2015-16 Estimated Average Utilizers Per Month	1,192	1,388	1,742	3,356	3,786	2,703	423	158	12,166
Utilizer Trend Selected[4]	12.92%	13.54%	20.61%	5.36%	6.79%	8.14%	8.75%	12.66%	15.68%
FY 2016-17 Estimated Average Utilizers Per Month	1,346	1,576	2,101	3,536	4,043	2,923	460	178	14,074
Bottom Line Impacts									
Total Bottom Line Impacts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY 2016-17 Estimated Average Utilizers Per Month	**1,346**	**1,576**	**2,101**	**3,536**	**4,043**	**2,923**	**460**	**178**	**14,074**
FY 2015-16 Average Units Per Utilizer	54	52	55	103	776	1,701	278	397	
Percentage Selected to Modify Units Per Utilizer[5]	-1.85%	0.00%	0.00%	1.94%	0.77%	-1.00%	0.36%	1.26%	
FY 2016-17 Estimated Average Units Per Utilizer	**53**	**52**	**55**	**105**	**782**	**1,684**	**279**	**402**	
FY 2015-16 Average Paid Rate Per Unit	$111.30	$112.46	$122.03	$103.27	$36.74	$10.94	$72.41	$50.58	
Rate Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
FY 2016-17 Average Paid Rate Per Unit	**$111.30**	**$112.46**	**$122.03**	**$103.27**	**$36.74**	**$10.94**	**$72.41**	**$50.58**	
Estimated FY 2016-17 Base Expenditure	**$7,939,919**	**$9,216,322**	**$14,101,177**	**$38,342,086**	**$116,158,139**	**$53,850,312**	**$9,293,099**	**$3,619,302**	**$252,550,229**
Bottom Line Impacts									
FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	$0	$0	$0	($73,591)	($132,185)	($61,911)	($10,198)	($3,655)	($281,540)
FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	$0	$0	$0	($125,104)	($224,715)	($105,249)	($17,336)	($6,214)	($478,618)
HB 15-1186: "Children with Autism Waiver Expansion"	$972	$1,066	$1,343	$4,995	$15,044	$7,046	$1,161	$416	$32,043
EPSDT Personal Care	$0	$0	$0	$0	$462,660	$0	$0	$0	$462,660
Colorado Choice Transitions	$18,857	$20,696	$26,064	$96,929	$291,967	$136,748	$22,524	$8,074	$621,859
Total Bottom Line Impacts	$19,829	$21,762	$27,407	($96,771)	$412,771	($23,366)	($3,849)	($1,379)	$356,404
Estimated FY 2016-17 Expenditure	**$7,959,748**	**$9,238,084**	**$14,128,584**	**$38,245,315**	**$116,570,910**	**$53,826,946**	**$9,289,250**	**$3,617,923**	**$252,906,633**
Estimated FY 2016-17 Per Utilizer Cost	$5,913.63	$5,861.73	$6,724.69	$10,815.98	$28,832.78	$18,414.97	$20,194.02	$20,325.41	$17,969.78
% Change Over FY 2015-16 Per Utilizer Cost	-1.78%	0.06%	0.04%	3.53%	1.52%	-0.05%	1.30%	2.17%	-5.36%

Exhibit G - COMMUNITY BASED LONG-TERM CARE - LONG-TERM HOME HEALTH
Cash Based Actuals and Projections by Service

	Out Year								
LONG-TERM HOME HEALTH	**Physical Therapy (for 0-21 years LTHH)**	**Occupational Therapy (for 0-21 years LTHH)**	**Speech and Language Therapy (for 0-21 years LTHH)**	**Registered Nursing/Licensed Practical Nurse**	**Home Health Aid Basic**	**Home Health Aid Extended**	**Registered Nursing Brief First Visit of Day**	**Registered Nursing Brief Second or More Visit of Day**	**Total**
FY 2016-17 Estimated Average Utilizers Per Month	1,346	1,576	2,101	3,536	4,043	2,923	460	178	14,074
Utilizer Trend Selected[4]	12.93%	13.52%	12.42%	5.37%	6.80%	8.14%	8.04%	12.36%	15.68%
FY 2017-18 Estimated Average Utilizers Per Month	1,520	1,789	2,362	3,726	4,318	3,161	497	200	16,281
Bottom Line Impacts									
Total Bottom Line Impacts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY 2017-18 Estimated Average Utilizers Per Month	**1,520**	**1,789**	**2,362**	**3,726**	**4,318**	**3,161**	**497**	**200**	**16,281**
FY 2016-17 Average Units Per Utilizer	53	52	55	105	782	1,684	279	402	
Percentage Selected to Modify Units Per Utilizer[5]	-1.89%	0.00%	0.00%	1.90%	0.77%	-1.01%	0.36%	1.24%	
FY 2017-18 Estimated Average Units Per Utilizer	**52**	**52**	**55**	**107**	**788**	**1,667**	**280**	**407**	
FY 2016-17 Average Paid Rate Per Unit	$111.30	$112.46	$122.03	$103.27	$36.74	$10.94	$72.41	$50.58	
Rate Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
FY 2017-18 Average Paid Rate Per Unit	**$111.30**	**$112.46**	**$122.03**	**$103.27**	**$36.74**	**$10.94**	**$72.41**	**$50.58**	
Estimated FY 2017-18 Base Expenditure	**$8,797,152**	**$10,461,929**	**$15,852,917**	**$41,171,890**	**$125,010,936**	**$57,647,094**	**$10,076,576**	**$4,117,212**	**$273,170,180**
Bottom Line Impacts									
Colorado Choice Transitions	$22,242	$24,413	$30,744	$114,336	$344,399	$161,306	$26,569	$9,524	$733,533
Total Bottom Line Impacts	$22,242	$24,413	$30,744	$114,336	$344,399	$161,306	$26,569	$9,524	$733,533
Estimated FY 2017-18 Expenditure	**$8,819,394**	**$10,486,342**	**$15,883,661**	**$41,286,226**	**$125,355,335**	**$57,808,400**	**$10,103,145**	**$4,126,736**	**$273,903,713**
Estimated FY 2017-18 Per Utilizer Cost	$5,802.23	$5,861.57	$6,724.67	$11,080.58	$29,030.88	$18,288.01	$20,328.26	$20,633.68	$16,823.52
% Change Over FY 2016-17 Per Utilizer Cost	-1.88%	0.00%	0.00%	2.45%	0.69%	-0.69%	0.66%	1.52%	-6.38%

(1) Due to cell sizes the Telehealth forecast is done at the total expenditure level. Telehealth is not a widely utilized service and displaying utilization figures would violate The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(2) Presented information regarding the utilizers per service is derived from the average number of clients with a paid claim per month. The Department believes this to be an accurate representation of utilizers for LTHH services as clients typically continue services once a need is identified.

(3) Since clients can access multiple services, the average utilizers doesn't reflect the sum of the services but rather the total Average Utilizers Per Month for LTHH as a benefit.

(4) Percentages Selected to Modify Caseload for FY 2015-16 through FY 2017-18	Physical Therapy (for 0-21 years LTHH)	12.99%, 12.92%, 12.93%	Registered Nursing/Licensed Practical Nurse	5.37%, 5.36%, 5.37%	Registered Nursing Brief First Visit of Day	9.59%, 8.75%, 8.04%
	Occupational Therapy (for 0-21 years LTHH)	13.49%, 13.54%, 13.52%	Home Health Aid Basic	6.80%, 6.79%, 6.80%	Registered Nursing Brief Second or More Visit of Day	12.86%, 12.66%, 12.36%
	Speech and Language Therapy (for 0-21 years LTHH)	31.47%, 20.61%, 12.42%	Home Health Aid Extended	8.16%, 8.14%, 8.14%		
(5) Percentages Selected to Modifier Units Per Utilizer for FY 2015-16 through FY 2017-18	Physical Therapy (for 0-21 years LTHH)	-1.82%, -1.85%, -1.89%	Registered Nursing/Licensed Practical Nurse	1.98%, 1.94%, 1.90%	Registered Nursing Brief First Visit of Day	0.36%, 0.36%, 0.36%
	Occupational Therapy (for 0-21 years LTHH)	0.00%, 0.00%, 0.00%	Home Health Aid Basic	0.78%, 0.77%, 0.77%	Registered Nursing Brief Second or More Visit of Day	1.28%, 1.26%, 1.24%
	Speech and Language Therapy (for 0-21 years LTHH)	0.00%, 0.00%, 0.00%	Home Health Aid Extended	-0.99%, -1.00%, -1.01%		

Exhibit G - COMMUNITY BASED LONG-TERM CARE - COLORADO CHOICE TRANSITIONS
Projected Expenditure and Avoided Expenditure

FY 2015-16 Colorado Choice Transitions (CCT) Budget Impact						
Row	**COLORADO CHOICE TRANSITIONS**	**Total**	**Developmental Disabilities/Supported Living Services/Dual Diagnosis Transitions**	**Elderly, Blind and Disabled/Brain Injury/Community Mental Health Supports Transitions**	**Calculation**	**Notes**
A	Estimated Average Monthly Enrollment	64	14	50		64 expected - 22% are expected to be enrolled on Division of Intellectual and Developmental Disabilities (DIDD) waivers under CCT
B	Estimated Demonstration Service Per Enrollee Annual Cost	$6,024.78	$6,017.48	$6,026.81		
C	**Estimated Demonstration Service Total Cost**	**$385,586**	**$84,245**	**$301,341**	**Row A * Row B**	**Demonstration expenses for all clients hit Medical Services Premiums (MSP)**
D	Estimated Qualified Service Per Enrollee Annual Cost	$20,251.33	$45,413.18	$13,205.99		All expenditure hits MSP, even clients enrolled on DIDD waivers while in CCT
E	**Estimated Qualified Service Total Cost**	**$1,296,085**	**$635,785**	**$660,300**	**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 Enrollee Annual Cost	$6,275.38	$6,275.37	$6,275.37		Bottom line impact in Acute Care - include all clients
G	**Estimated Long-Term Home Health Total Cost**	**$401,624**	**$87,855**	**$313,769**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$2,083,295**	**$807,885**	**$1,275,410**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$420,418**	**$180,008**	**$240,410**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions [1]	50	11	39		Cumulative
K	Estimated HCBS Service Per Enrollee Annual Cost	$26,928.22	$70,660.31	$14,593.53		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)**	**$569,148**		**$569,148**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DIDD)**	**$777,263**	**$777,263**		**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per Full-Time Equivalent (FTE) Annual Cost		($63,552.24)	($63,552.24)		All from MSP
O	Estimated Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Per FTE Annual Cost		($177,064.92)			Trended FY 2011-12 ICF-IID Per FTE Cost; from FY 2011-12 LTSS data book
P	**Estimated Nursing Facility Total Cost Avoided**	**($6,863,642)**	**($1,207,493)**	**($5,656,149)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from skilled nursing facilities (5/20 expected from ICF-IID)**
Q	**Estimated ICF-IID Total Cost Avoided**	**($1,062,390)**	**($1,062,390)**		**(Row A * 25%) * Row O**	**Assume 25% DIDD from Regional Center**
R	**Total Cost Avoidance**	**($7,926,032)**	**($2,269,883)**	**($5,656,149)**	**Row P + Row Q**	
S	**Estimated Total Budget Impact**	**($4,496,326)**	**($684,735)**	**($3,811,591)**	**Row H + Row L + Row M + Row R**	
T	*Estimated Rebalancing Fund Balance*	*$420,418*	*$180,008*	*$240,410*	*Row I*	*Off budget balance - non appropriated line item*

FY 2016-17 Colorado Choice Transitions Budget Impact						
Row	**COLORADO CHOICE TRANSITIONS**	**Total**	**Developmental Disabilities/Supported Living Services/Dual Diagnosis Transitions**	**Elderly, Blind and Disabled/Brain Injury/Community Mental Health Supports Transitions**	**Calculation**	**Notes**
A	Estimated Average Monthly Enrollment	97	21	76		97 Expected - 22% are expected to be enrolled on Division of Intellectual and Developmental Disabilities (DIDD) waivers under CCT
B	Estimated Demonstration Service Per Enrollee Annual Cost	$6,154.93	$6,147.46	$6,156.99		
C	**Estimated Demonstration Service Total Cost**	**$597,028**	**$129,097**	**$467,931**	**Row A * Row B**	**Demo Expenses for all clients hit MSP**
D	Estimated Qualified Service Per Enrollee Annual Cost	$20,614.54	$46,394.10	$13,491.24		All Expenditure hits MSP, even clients enrolled on DIDD waivers while in CCT
E	**Estimated Qualified Service Total Cost**	**$1,999,610**	**$974,276**	**$1,025,334**	**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 Enrollee 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**	**$621,859**	**$134,629**	**$487,230**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$3,218,497**	**$1,238,002**	**$1,980,495**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$649,159**	**$275,843**	**$373,316**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions [1]	64	14	50		Cumulative
K	Estimated HCBS Service Per Enrollee Annual Cost	$27,271.34	$71,423.44	$14,908.75		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)**	**$745,438**		**$745,438**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DIDD)**	**$999,928**	**$999,928**		**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per FTE Annual Cost		($65,280.25)	($65,280.25)		All from MSP
O	Estimated ICF-IID Per FTE Annual Cost		($181,208.28)			Trended FY 2011-12 ICF/IID Per FTE Cost; from FY 2011-12 LTSS data book
P	**Estimated Nursing Facility Total Cost Avoided**	**($9,922,599)**	**($1,697,287)**	**($8,225,312)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from skilled nursing facilities (8/30 expected from ICF/IID)**
Q	**Estimated ICF-IID Total Cost Avoided**	**($1,630,875)**	**($1,630,875)**		**(Row A * 25%) * Row O**	**Assume 25% DIDD from Regional Center**
R	**Total Cost Avoidance**	**($11,553,474)**	**($3,328,162)**	**($8,225,312)**	**Row P + Row Q**	
S	**Estimated Total Budget Impact**	**($6,589,611)**	**($1,090,232)**	**($5,499,379)**	**Row H + Row L + Row M + Row R**	
T	*Estimated Rebalancing Fund Balance*	*$649,159*	*$275,843*	*$373,316*	*Row I*	*Off budget balance - non appropriated line item*

Exhibit G - COMMUNITY BASED LONG-TERM CARE - COLORADO CHOICE TRANSITIONS
Projected Expenditure and Avoided Expenditure

FY 2017-18 Colorado Choice Transitions Budget Impact						
Row	**COLORADO CHOICE TRANSITIONS**	**Total**	**Developmental Disabilities/Supported Living Services/Dual Diagnosis Transitions**	**Elderly, Blind and Disabled/Brain Injury/Community Mental Health Supports Transitions**	**Calculation**	**Notes**
A	Estimated Average Monthly Enrollment	112	25	87		145 Expected - 22% are expected to be enrolled on Division of Intellectual and Developmental Disabilities (DIDD) waivers under CCT
B	Estimated Demonstration Service Per Enrollee Annual Cost	$6,287.80	$6,280.25	$6,289.98		
C	**Estimated Demonstration Service Total Cost**	**$704,234**	**$157,006**	**$547,228**	**Row A * Row B**	**Demo Expenses for all clients hit MSP**
D	Estimated Qualified Service Per Enrollee Annual Cost	$21,285.68	$47,396.21	$13,782.65		All Expenditure hits MSP, even clients enrolled on DIDD waivers while in CCT
E	**Estimated Qualified Service Total Cost**	**$2,383,996**	**$1,184,905**	**$1,199,091**	**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 Enrollee 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**	**$733,533**	**$163,735**	**$569,798**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$3,821,763**	**$1,505,646**	**$2,316,117**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$772,058**	**$335,478**	**$436,580**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions [(1)]	97	21	76		Cumulative
K	Estimated HCBS Service Per Enrollee Annual Cost	$27,563.20	$72,194.81	$15,230.77		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)**	**$1,157,539**		**$1,157,539**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DIDD)**	**$1,516,091**	**$1,516,091**		**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per FTE Annual Cost		($67,236.65)	($67,236.65)		All from MSP
O	Estimated ICF-IID Per FTE Annual Cost		($185,448.60)			Trended FY 2011-12 ICF/IID Per FTE Cost; from FY 2011-12 LTSS data book
P	**Estimated Nursing Facility Total Cost Avoided**	**($13,312,857)**	**($2,353,283)**	**($10,959,574)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from skilled nursing facilities (13/51 expected from ICF/IID)**
Q	**Estimated ICF-IID Total Cost Avoided**	**($2,225,383)**	**($2,225,383)**		**(Row A * 25%) * Row O**	**Assume 25% DIDD from Regional Center**
R	**Total Cost Avoidance**	**($15,538,240)**	**($4,578,666)**	**($10,959,574)**	**Row P + Row Q**	
S	**Estimated Total Budget Impact**	**($9,042,847)**	**($1,556,929)**	**($7,485,918)**	**Row H + Row L + Row M + Row R**	
T	*Estimated Rebalancing Fund Balance*	*$772,058*	*$335,478*	*$436,580*	*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 - HOSPICE

Hospice Calculations for FY 2015-16, FY 2016-17, FY 2017-18

FY 2015-16 Calculation

Nursing Facility Room and Board

Service Expenditure:	Core Components	Reference
Estimate of FY 2015-16 Per Diem Rate	$165.17	Footnote 1
Estimate of Patient Days	219,699	Footnote 2
Total Estimated Costs for FY 2015-16 Days of Service	$36,287,684	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	88.20%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$32,005,737	
Estimated Expenditure for FY 2014-15 Dates of Service	$4,009,114	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2015-16 Prior to Adjustments	**$36,014,851**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2014-15 and paid in FY 2015-16 under HB 13-1152	($60,917)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($480,562)	Footnote 6
Total Bottom Line Adjustments:	**($541,479)**	
Total Estimated Nursing Facility Room and Board FY 2015-16 General Fund Expenditure	**$35,473,372**	
Percentage Change in Core Component Expenditure Over Prior Year	4.41%	

Hospice Services

Service Expenditure:	Core Components	Reference
Hospice Routine Home Care	$12,239,093	Footnote 7
Hospice General Inpatient	$2,294,113	Footnote 7
Other Services	$101,334	Footnote 7
Estimated Hospice Services Expenditure in FY 2015-16 Prior to Adjustments	**$14,634,540**	
Bottom Line Adjustments:		
Annualization of FY 2014-15 JBC Action: Hospice 2% Rate Increase	$12,221	
FY 2015-16 R-12: "Community Provider Rate Increase" - Hospice	$34,669	
Total Bottom Line Adjustments:	**$46,890**	
Total Estimated Hospice Services FY 2015-16 General Fund Expenditure	**$14,681,430**	
Percentage Change in Expenditure Over Prior Year	6.99%	
Total Estimated FY 2015-16 Expenditure	**$50,154,802**	

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	$170.12	Footnote 1
Estimate of Patient Days	221,226	Footnote 2
Total Estimated Costs for FY 2016-17 Days of Service	$37,634,967	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	88.20%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$33,194,041	
Estimated Expenditure for FY 2015-16 Dates of Service	$4,281,947	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2016-17 Prior to Adjustments	**$37,475,988**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2015-16 and paid in FY 2016-17 under HB 13-1152	($64,292)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($497,559)	Footnote 6
Total Bottom Line Adjustments:	**($561,851)**	
Total Estimated Nursing Facility Room and Board FY 2016-17 General Fund Expenditure	**$36,914,137**	
Percentage Change in Core Component Expenditure Over Prior Year	4.06%	
Hospice Services		
Service Expenditure:	**Core Components**	**Reference**
Hospice Routine Home Care	$12,674,813	Footnote 7
Hospice General Inpatient	$2,590,032	Footnote 7
Other Services	$106,817	Footnote 7
Estimated Hospice Services Expenditure in FY 2016-17 Prior to Adjustments	**$15,371,662**	
Bottom Line Adjustments:		
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" - Hospice	$11,556	
Total Bottom Line Adjustments:	**$11,556**	
Total Estimated Hospice Services FY 2016-17 General Fund Expenditure	**$15,383,218**	
Percentage Change in Expenditure Over Prior Year	4.78%	
Total Estimated FY 2016-17 Expenditure	**$52,297,355**	

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HOSPICE

FY 2017-18 Calculation		
Nursing Facility Room and Board		
Service Expenditure:	**Core Components**	**Reference**
Estimate of FY 2017-18 Per Diem Rate	$175.23	Footnote 1
Estimate of Patient Days	223,374	Footnote 2
Total Estimated Costs for FY 2017-18 Days of Service	$39,141,813	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	88.20%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$34,523,079	
Estimated Expenditure for FY 2016-17 Dates of Service	$4,440,926	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2017-18 Prior to Adjustments	**$38,964,005**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2016-17 and paid in FY 2017-18 under HB 13-1152	($66,568)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($518,152)	Footnote 6
Total Bottom Line Adjustments:	**($584,720)**	
Total Estimated Nursing Facility Room and Board FY 2017-18 General Fund Expenditure	**$38,379,285**	
Percentage Change in Core Component Expenditure Over Prior Year	3.97%	
Hospice Services		
Service Expenditure:	**Core Components**	**Reference**
Hospice Routine Home Care	$13,160,161	Footnote 7
Hospice General Inpatient	$2,924,123	Footnote 7
Other Services	$112,596	Footnote 7
Estimated Hospice Services Expenditure in FY 2017-18 Prior to Adjustments	**$16,196,880**	
Bottom Line Adjustments:		
Total Bottom Line Adjustments:	**$0**	
Total Estimated Hospice Services FY 2017-18 General Fund Expenditure	**$16,196,880**	
Percentage Change in Expenditure Over Prior Year	5.29%	
Total Estimated FY 2017-18 Expenditure	**$54,576,165**	

Hospice Nursing Facility Room and Board FY 2015-16 , FY 2016-17 and FY 2017-18 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 2015-16, FY 2016-17, and FY 2017-18 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 2015-16, FY 2016-17, and FY 2017-18 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	$140.19	3.00%	1.50%	$142.32	1.25%
FY 2012-13	$144.61	3.00%	1.50%	$146.81	3.15%
FY 2013-14	$151.64	3.00%	1.50%	$153.95	4.86%
FY 2014-15	$157.95	3.00%	1.50%	$160.35	4.16%
Estimated FY 2015-16	$162.69	3.00%	1.50%	$165.17	3.01%
Estimated FY 2016-17	$167.57	3.00%	1.50%	$170.12	3.00%
Estimated FY 2017-18	$172.60	3.00%	1.50%	$175.23	3.00%

(2) The patient days estimates for FY 2015-16, FY 2016-17, and FY 2017-18 are estimated using incurred-but-not-reported (IBNR) adjusted data from FY 2007-08 to FY 2014-15.

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	237,794	0.27%	651	0.46%
FY 2013-14	216,196	-9.08%	592	-9.06%
FY 2014-15	215,106	-0.50%	589	-0.51%
Estimated FY 2015-16	219,699	2.14%	602	2.21%
Estimated FY 2016-17	221,226	0.70%	604	0.33%
Estimated FY 2017-18	223,374	0.97%	612	1.32%

(3) Estimated cost 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	99.98%
August	10	99.90%
September	9	99.77%
October	8	99.55%
November	7	99.22%
December	6	98.81%
January	5	98.30%
February	4	97.60%
March	3	95.74%
April	2	91.86%
May	1	77.66%
June	-	0.06%
Average		88.20%

(5) As calculated in the table below, the estimated FY 2015-16 expenditure for core components with FY 2014-15 dates of service is the estimated FY 2014-15 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 2014-15	Source
IBNR Factor	88.20%	Footnote (4)
Estimated Patient Days from previous fiscal year	215,106	Footnote (2)
Estimated Per Diem Rate for Core Components for previous fiscal year	$157.95	Footnote (1)
Estimated claims expenditure for core components from previous fiscal year to be paid in the current fiscal year	$4,009,114	As described in Footnote (5) narrative

(6) HB 10-1324 imposed a rate reduction of 1.5% effective March 1, 2010 and effective until June 30, 2011. HB 10-1379 imposed a rate reduction of 1% in addition to the rate reduction of HB 10-1324 for the period of July 1, 2010 to June 30, 2011. SB 11-215 imposed a rate reduction of 1.5% effective July 1, 2011 for FY 2011-12 that was extended for FY 2012-13 by HB 12-1340. 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 2015-16, FY 2016-17, and FY 2017-18 are accounted for here.

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%	$160.35	$157.95	($2.40)
Estimated FY 2014-15 Patient Days				215,106
Estimated FY 2014-15 Days Paid in FY 2014-15				189,724
Total FY 2014-15 Impact				**($455,338)**
Estimated FY 2014-15 Days Paid in FY 2015-16				25,382
FY 2015-16 Impact from Carryover from FY 2014-15				($60,917)
Estimated FY 2015-16 Rates	1.50%	$165.17	$162.69	($2.48)
Estimated FY 2015-16 Patient Days				219,699
Estimated FY 2015-16 Days Paid in FY 2015-16				193,775
FY 2015-16 Impact from FY 2015-16				($480,562)
Total FY 2015-16 Impact				**($541,479)**
Estimated FY 2015-16 Days Paid in FY 2016-17				25,924
FY 2016-17 Impact from Carryover from FY 2015-16				($64,292)
Estimated FY 2016-17 Rates	1.50%	$170.12	$167.57	($2.55)
Estimated FY 2016-17 Patient Days				221,226
Estimated FY 2016-17 Days Paid in FY 2016-17				195,121
FY 2016-17 Impact from FY 2016-17				($497,559)
Total FY 2016-17 Impact				**($561,851)**
Estimated FY 2016-17 Days Paid in FY 2017-18				26,105
FY 2017-18 Impact from Carryover from FY 2016-17				($66,568)
Estimated FY 2017-18 Rates	1.50%	$175.23	$172.60	($2.63)
Estimated FY 2017-18Patient Days				223,374
Estimated FY 2017-18 Days Paid in FY 2017-18				197,016
FY 2017-18 Impact from FY 2017-18				($518,152)
Total FY 2017-18 Impact				**($584,720)**

(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 2015-16, FY 2016-17, and FY 2017-18 usage and rate using data from FY 2007-08 through FY 2014-15 . Hospice general inpatient expenditure estimates are produced by applying a linear time trend to annual expenditure for FY 2007-08 through FY 2014-15. 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 2014-15 to observed expenditure in FY 2014-15. The aforementioned average annual growth rate is applied to the estimate for FY 2015-16 to derive the estimate for FY 2016-17 and again to the estimate for FY 2016-17 expenditure in order to estimate FY 2017-18 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 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	$39,902,872
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	$43,636,827
FY 2010-11 (DA)	$30,229,237	$2,102,621	$6,889,024	$0	$228,536	$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
FY 2014-15	$33,254,147	$3,938,226	$6,581,768	$160,754	$330,107	$193,375	$2,912,744	$6,536	$201,612	$2,960	$40,525	$0	$0	$0	$0	$47,622,754
Estimated FY 2015-16	$34,333,673	$4,215,745	$6,918,149	$218,647	$374,192	$227,276	$3,600,030	$4,718	$217,874	$3,586	$40,912	$0	$0	$0	$0	$50,154,802
Estimated FY 2016-17	$35,846,499	$4,408,292	$7,157,921	$256,414	$406,423	$237,436	$3,711,138	$2,541	$226,041	$3,860	$40,790	$0	$0	$0	$0	$52,297,355
Estimated FY 2017-18	$37,456,314	$4,639,614	$7,446,240	$291,260	$434,292	$249,133	$3,776,992	$866	$236,360	$4,153	$40,941	$0	$0	$0	$0	$54,576,165

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 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%	931.03%	-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%	-2009.54%	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%
FY 2014-15	4.13%	3.25%	-11.28%	-53.36%	107.98%	34.06%	184.19%	0.00%	34.78%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	5.79%
Estimated FY 2015-16	3.25%	7.05%	5.11%	36.01%	13.35%	17.53%	23.60%	-27.82%	8.07%	21.15%	0.95%	0.00%	0.00%	0.00%	0.00%	5.32%
Estimated FY 2016-17	4.41%	4.57%	3.47%	17.27%	8.61%	4.47%	3.09%	-46.14%	3.75%	7.64%	-0.30%	0.00%	0.00%	0.00%	0.00%	4.27%
Estimated FY 2017-18	4.49%	5.25%	4.03%	13.59%	6.86%	4.93%	1.77%	-65.92%	4.57%	7.59%	0.37%	0.00%	0.00%	0.00%	0.00%	4.36%

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	$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)	$776.68	$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	$0.37	$0.00	$0.00	$0.00	$0.00	$0.00	$1.12	$52.29
FY 2014-15	$795.23	$376.29	$98.90	$44.32	$2.03	$2.70	$12.10	$16.42	$0.45	$0.06	$2.02	$0.00	$0.00	$0.00	$0.00	$41.01
Estimated FY 2015-16	$813.25	$382.03	$100.41	$45.00	$2.06	$2.74	$12.28	$16.67	$0.46	$0.06	$2.05	$0.00	$0.00	$0.00	$0.00	$38.84
Estimated FY 2016-17	$836.95	$380.52	$100.01	$44.82	$2.09	$2.73	$12.23	$16.61	$0.46	$0.06	$2.05	$0.00	$0.00	$0.00	$0.00	$38.68
Estimated FY 2017-18	$861.70	$381.48	$100.27	$44.93	$2.12	$2.74	$12.27	$16.65	$0.46	$0.06	$2.05	$0.00	$0.00	$0.00	$0.00	$38.82

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 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)	-12.13%	-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	4.01%	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%	270.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-41.36%	-17.71%
FY 2014-15	4.17%	-2.80%	-14.11%	-67.08%	59.84%	-11.76%	2.98%	0.00%	21.62%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	-21.57%
Estimated FY 2015-16	2.27%	1.53%	1.53%	1.53%	1.48%	1.48%	1.49%	1.52%	2.22%	0.00%	1.49%	0.00%	0.00%	0.00%	0.00%	-5.29%
Estimated FY 2016-17	2.91%	-0.40%	-0.40%	-0.40%	1.46%	-0.36%	-0.41%	-0.36%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.41%
Estimated FY 2017-18	2.96%	0.25%	0.26%	0.25%	1.44%	0.37%	0.33%	0.24%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.36%

Exhibit H - LONG-TERM CARE AND INSURANCE
Summary

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	$466,933,245	$40,645,164	$85,052,917	$154,878	$275,884	$13,445	$2,274,690	$0	$0	$0	$155,567	$0	$0	$0	$78,112	$595,583,902
Class II Nursing Facilities	$457,791	$507,213	$3,799,666	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,764,670
Program for All-Inclusive Care for the Elderly	$112,919,644	$14,678,686	$6,254,712	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$133,853,042
Subtotal Long-Term Care	**$580,310,680**	**$55,831,063**	**$95,107,295**	**$154,878**	**$275,884**	**$13,445**	**$2,274,690**	**$0**	**$0**	**$0**	**$155,567**	**$0**	**$0**	**$0**	**$78,112**	**$734,201,614**
Supplemental Medicare Insurance Benefit	$77,164,613	$4,652,887	$41,236,473	$0	$273,765	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,115,427	$148,443,165
Health Insurance Buy-In	$11,074	$13,842	$1,356,448	$0	$16,610	$27,683	$24,913	$0	$96,890	$0	$0	$8,304	$0	$0	$0	$1,555,764
Subtotal Insurance	**$77,175,687**	**$4,666,729**	**$42,592,921**	**$0**	**$290,375**	**$27,683**	**$24,913**	**$0**	**$96,890**	**$0**	**$0**	**$8,304**	**$0**	**$0**	**$25,115,427**	**$149,998,929**
Total Long-Term Care and Insurance	**$657,486,367**	**$60,497,792**	**$137,700,216**	**$154,878**	**$566,259**	**$41,128**	**$2,299,603**	**$0**	**$96,890**	**$0**	**$155,567**	**$8,304**	**$0**	**$0**	**$25,193,539**	**$884,200,543**
Class I Nursing Facility Supplemental Payments	$74,697,638	$6,502,209	$13,606,339	$24,777	$44,135	$2,151	$363,893	$0	$0	$0	$24,887	$0	$0	$0	$12,496	$95,278,525
Total Long-Term Care and Insurance Including Financing	**$732,184,005**	**$67,000,001**	**$151,306,555**	**$179,655**	**$610,394**	**$43,279**	**$2,663,496**	**$0**	**$96,890**	**$0**	**$180,454**	**$8,304**	**$0**	**$0**	**$25,206,035**	**$979,479,068**

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	$480,982,861	$41,868,141	$87,612,086	$159,538	$284,185	$13,850	$2,343,133	$0	$0	$0	$160,247	$0	$0	$0	$80,463	$613,504,504
Class II Nursing Facilities	$483,839	$536,073	$4,015,867	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,035,779
Program for All-Inclusive Care for the Elderly	$132,058,980	$17,600,421	$7,241,590	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$156,900,991
Subtotal Long-Term Care	**$613,525,680**	**$60,004,635**	**$98,869,543**	**$159,538**	**$284,185**	**$13,850**	**$2,343,133**	**$0**	**$0**	**$0**	**$160,247**	**$0**	**$0**	**$0**	**$80,463**	**$775,441,274**
Supplemental Medicare Insurance Benefit	$82,005,242	$5,130,755	$44,898,967	$0	$310,733	$0	$0	$0	$0	$0	$0	$0	$0	$0	$30,090,801	$162,436,498
Health Insurance Buy-In	$13,924	$17,406	$1,705,652	$0	$20,886	$34,810	$31,327	$0	$121,833	$0	$0	$10,442	$0	$0	$0	$1,956,280
Subtotal Insurance	**$82,019,166**	**$5,148,161**	**$46,604,619**	**$0**	**$331,619**	**$34,810**	**$31,327**	**$0**	**$121,833**	**$0**	**$0**	**$10,442**	**$0**	**$0**	**$30,090,801**	**$164,392,778**
Total Long-Term Care and Insurance	**$695,544,846**	**$65,152,796**	**$145,474,162**	**$159,538**	**$615,804**	**$48,660**	**$2,374,460**	**$0**	**$121,833**	**$0**	**$160,247**	**$10,442**	**$0**	**$0**	**$30,171,264**	**$939,834,052**
Class I Nursing Facility Supplemental Payments	$76,728,976	$6,679,031	$13,976,351	$25,450	$45,335	$2,209	$373,789	$0	$0	$0	$25,563	$0	$0	$0	$12,836	$97,869,540
Total Long-Term Care and Insurance Including Financing	**$772,273,822**	**$71,831,827**	**$159,450,513**	**$184,988**	**$661,139**	**$50,869**	**$2,748,249**	**$0**	**$121,833**	**$0**	**$185,810**	**$10,442**	**$0**	**$0**	**$30,184,100**	**$1,037,703,592**

FY 2017-18 Long-Term Care and Insurance Request

FY 2017-18	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	$494,728,552	$43,064,663	$90,115,894	$164,098	$292,307	$14,245	$2,410,096	$0	$0	$0	$164,827	$0	$0	$0	$82,762	$631,037,444
Class II Nursing Facilities	$497,628	$551,351	$4,130,319	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,179,298
Program for All-Inclusive Care for the Elderly	$146,517,042	$20,042,429	$8,154,518	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$174,713,989
Subtotal Long-Term Care	**$641,743,222**	**$63,658,443**	**$102,400,731**	**$164,098**	**$292,307**	**$14,245**	**$2,410,096**	**$0**	**$0**	**$0**	**$164,827**	**$0**	**$0**	**$0**	**$82,762**	**$810,930,731**
Supplemental Medicare Insurance Benefit	$86,982,295	$5,632,976	$48,722,389	$0	$343,444	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,232,868	$176,913,972
Health Insurance Buy-In	$17,546	$21,934	$2,149,310	$0	$26,318	$43,865	$39,475	$0	$153,523	$0	$0	$13,158	$0	$0	$0	$2,465,129
Subtotal Insurance	**$86,999,841**	**$5,654,910**	**$50,871,699**	**$0**	**$369,762**	**$43,865**	**$39,475**	**$0**	**$153,523**	**$0**	**$0**	**$13,158**	**$0**	**$0**	**$35,232,868**	**$179,379,101**
Total Long-Term Care and Insurance	**$728,743,063**	**$69,313,353**	**$153,272,430**	**$164,098**	**$662,069**	**$58,110**	**$2,449,571**	**$0**	**$153,523**	**$0**	**$164,827**	**$13,158**	**$0**	**$0**	**$35,315,630**	**$990,309,832**
Class I Nursing Facility Supplemental Payments	$78,815,550	$6,860,661	$14,356,426	$26,143	$46,568	$2,269	$383,954	$0	$0	$0	$26,259	$0	$0	$0	$13,185	$100,531,015
Total Long-Term Care and Insurance Including Financing	**$807,558,613**	**$76,174,014**	**$167,628,856**	**$190,241**	**$708,637**	**$60,379**	**$2,833,525**	**$0**	**$153,523**	**$0**	**$191,086**	**$13,158**	**$0**	**$0**	**$35,328,815**	**$1,090,840,847**

Class I Nursing Home Calculations for FY 2015-16, FY 2016-17 and FY 2017-18

FY 2015-16 Calculation

Service Expenditure:	Core Components	Reference
Estimate of FY 2015-16 General Fund Portion of Per Diem Rate	$210.76	Footnote 1
Estimate of FY 2015-16 Patient Payment (per day)	($37.12)	Footnote 1
Estimated FY 2015-16 Medicaid Reimbursement (per day)	**$173.64**	
Estimate of Patient Days (without Hospital Back Up)	3,503,987	Footnote 2
Total Estimated Costs for FY 2015-16 Days of Service	$608,432,292	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.48%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$562,678,184	
Estimated Expenditure for FY 2014-15 Dates of Service	$43,447,787	Footnote 5
Estimated Expenditure in FY 2015-16 Prior to Adjustments	**$606,125,971**	
Bottom Line Adjustments:		
Hospital Back Up Program	$6,379,244	Footnote 6
Recoveries from Department Overpayment Review	($1,600,000)	Footnote 7
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($8,457,671)	Footnote 8
Colorado Choice Transitions	($6,863,642)	Exhibit G
Total Bottom Line Adjustments:	**($10,542,069)**	
Total Estimated FY 2015-16 General Fund Expenditure	**$595,583,902**	
Percentage Change in Core Component Expenditure Over Prior Year	2.81%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$39,156,431	Page EH-9
Prior Year Rate Reconciliation	$8,803,574	Page EH-9
Rate Cut Backfill	$0	Page EH-9
Cognitive Performance Scale	$1,007,578	Page EH-9
PASRR - Resident	$3,371,073	Page EH-9
PASRR - Facility	$500,889	Page EH-9
Medicaid Supplemental Payment	$34,852,879	Page EH-9
Pay for Performance	$7,586,101	Page EH-9
Total Estimated Supplemental Payments	**$95,278,525**	
Total Estimated FY 2015-16 Expenditure	**$690,862,427**	

Class I Nursing Home Calculations for FY 2015-16, FY 2016-17 and FY 2017-18

FY 2016-17 Calculation

Service Expenditure:	Core Components	Reference
Estimate of FY 2016-17 General Fund Portion of Per Diem Rate	$216.81	Footnote 1
Estimate of FY 2016-17 Patient Payment (per day)	($37.96)	Footnote 1
Estimated FY 2016-17 Medicaid Reimbursement (per day)	**$178.85**	
Estimate of Patient Days (without Hospital Back Up)	3,521,742	Footnote 2
Total Estimated Costs for FY 2016-17 Days of Service	$629,863,629	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.48%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$582,497,884	
Estimated Expenditure for FY 2015-16 Dates of Service	$45,754,108	Footnote 5
Estimated Expenditure in FY 2016-17 Prior to Adjustments	**$628,251,992**	
Bottom Line Adjustments:		
Hospital Back Up Program	$6,552,669	Footnote 6
Recoveries from Department Overpayment Review	($1,643,520)	Footnote 7
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($9,734,038)	Footnote 8
Colorado Choice Transitions	($9,922,599)	Exhibit G
Total Bottom Line Adjustments:	**($14,747,488)**	
Total Estimated FY 2016-17 Expenditure	**$613,504,504**	
Percentage Change in Core Component Expenditure Over Prior Year	3.01%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$40,221,253	Page EH-9
Prior Year Rate Reconciliation	$9,042,979	Page EH-9
Rate Cut Backfill	$0	Page EH-9
Cognitive Performance Scale	$1,034,978	Page EH-9
PASRR - Resident	$3,462,747	Page EH-9
PASRR - Facility	$514,511	Page EH-9
Medicaid Supplemental Payment	$35,800,673	Page EH-9
Pay for Performance	$7,792,399	Page EH-9
Total Estimated Supplemental Payments	**$97,869,540**	
Total Estimated FY 2016-17 Expenditure	**$711,374,044**	

Class I Nursing Home Calculations for FY 2015-16, FY 2016-17 and FY 2017-18

FY 2017-18 Calculation

Service Expenditure:	Core Components	Reference
Estimate of FY 2017-18 General Fund Portion of Per Diem Rate	$222.93	Footnote 1
Estimate of FY 2017-18 Patient Payment (per day)	($38.72)	Footnote 1
Estimated FY 2017-18 Medicaid Reimbursement (per day)	**$184.21**	
Estimate of Patient Days (without Hospital Back Up)	3,531,737	Footnote 2
Total Estimated Costs for FY 2017-18 Days of Service	$650,581,281	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.48%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$601,657,569	
Estimated Expenditure for FY 2016-17 Dates of Service	$47,365,745	Footnote 5
Estimated Expenditure in FY 2017-18 Prior to Adjustments	**$649,023,314**	
Bottom Line Adjustments:		
Hospital Back Up Program	$6,749,249	Footnote 6
Recoveries from Department Overpayment Review	($1,688,224)	Footnote 7
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($9,734,038)	Footnote 8
Colorado Choice Transitions	($13,312,857)	Exhibit G
Total Bottom Line Adjustments:	**($17,985,870)**	
Total Estimated FY 2017-18 Expenditure	**$631,037,444**	
Percentage Change in Core Component Expenditure Over Prior Year	2.86%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$41,315,036	Page EH-9
Prior Year Rate Reconciliation	$9,288,895	Page EH-9
Rate Cut Backfill	$0	Page EH-9
Cognitive Performance Scale	$1,063,123	Page EH-9
PASRR - Resident	$3,556,913	Page EH-9
PASRR - Facility	$528,502	Page EH-9
Medicaid Supplemental Payment	$36,774,240	Page EH-9
Pay for Performance	$8,004,306	Page EH-9
Total Estimated Supplemental Payments	**$100,531,015**	
Total Estimated FY 2017-18 Expenditure	**$731,568,459**	

Class I Nursing Home Calculations for FY 2015-16 , FY 2016-17 and FY 2017-18 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 2017-18. 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	$189.04	$35.20	$153.84	1.50%	$191.92
FY 2013-14	$198.31	$35.70	$162.61	1.50%	$201.33
FY 2014-15	$202.49	$36.44	$166.05	1.50%	$205.57
Estimated FY 2015-16	$208.15	$37.12	$171.03	1.50%	$210.76
Estimated FY 2016-17	$214.12	$37.96	$176.16	1.50%	$216.81
Estimated FY 2017-18	$220.16	$38.72	$181.44	1.50%	$222.93

(2) The patient days estimate is a trended value using incurred but not reported (IBNR) adjusted data. Values for prior years differ slightly from prior Budget Requests due to the inclusion of claims paid between those Requests and this Request. 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 9,580 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	3,527,753	2.18%	9,665	2.18%
FY 2011-12	3,502,587	-0.71%	9,570	-0.98%
FY 2012-13	3,474,994	-0.79%	9,521	-0.51%
FY 2013-14	3,450,541	-0.70%	9,454	-0.70%
FY 2014-15	3,479,453	0.84%	9,533	0.84%
Estimated FY 2015-16	3,503,987	0.71%	9,574	0.43%
Estimated FY 2016-17	3,521,742	0.51%	9,622	0.50%
Estimated FY 2017-18	3,531,737	0.28%	9,676	0.56%

(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 five 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	99.82%
August	10	99.77%
September	9	99.70%
October	8	99.57%
November	7	99.40%
December	6	99.13%
January	5	98.62%
February	4	97.87%
March	3	96.52%
April	2	94.28%
May	1	90.20%
June	0	34.84%
Average		92.48%

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 2014-15 expenditure for core components with FY 2013-14 dates of service is the estimated FY 2013-14 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 2014-15	Source
IBNR Factor	92.48%	Footnote (4)
Estimated Patient Days from previous fiscal year	3,479,453	Footnote (2)
Estimated Per Diem Rate for Core Components for previous fiscal year	$202.49	Footnote (1)
Less: Estimated Patient Payment Rate for previous fiscal year	$36.44	Footnote (1)
Estimated claims expenditure for core components from previous fiscal year to be paid in the current fiscal year	$43,447,787	As described in Footnote (5) narrative

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

(6) Hospital Back Up (HBU) 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 has monitored enrollment through June 2015 and it appears there was a level shift in enrollment in FY 2013-14 with enrollment figures staying consistent into FY 2014-15. 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%
FY 2014-15	$5,796,191	-12.24%
Estimated FY 2015-16	$6,379,244	10.06%
Estimated FY 2016-17	$6,552,669	2.72%
Estimated FY 2017-18	$6,749,249	3.00%

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

(7) Overpayment review recoveries are amounts that the Department recovers from nursing homes. The Department contracted with a contingency based contractor to do a five year historical audit of all the facilities, and the contract expired at the end of FY 2005-06. The Department continues to do internal audits of nursing facilities, and estimates that, on average, each audit recovers approximately $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%
FY 2014-15	$1,794,661	31.62%
Estimated FY 2015-16	$1,600,000	17.35%
Estimated FY 2016-17	$1,643,520	2.72%
Estimated FY 2017-18	$1,688,224	2.72%

(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 2015-16 Rates	1.50%	$210.76	$208.15	($2.61)
Estimated FY 2015-16 Patient Days				3,503,987
Estimated FY 2015-16 Days Paid in FY 2014-15				3,240,487
Total FY 2015-16 Impact				**($8,457,671)**
Estimated FY 2015-16 Days Paid in FY 2016-17				263,500
FY 2016-17 Impact from Carryover from FY 2015-16				($687,735)
Estimated FY 2016-17 Rates	1.50%	$216.81	$214.12	($2.69)
Estimated FY 2016-17 Patient Days				3,521,742
Estimated FY 2016-17 Days Paid in FY 2016-17				3,256,907
FY 2016-17 Impact from FY 2016-17				($8,761,080)
Total FY 2016-17 Impact				**($9,448,815)**
Estimated FY 2016-17 Days Paid in FY 2017-18				264,835
FY 2017-18 Impact from Carryover from FY 2016-17				($712,406)
Estimated FY 2017-18 Rates	1.50%	$222.93	$220.16	($2.77)
Estimated FY 2017-18 Patient Days				3,521,742
Estimated FY 2017-18 Days Paid in FY 2017-18				3,256,907
FY 2017-18 Impact from FY 2017-18				($9,021,632)
Total FY 2017-18 Impact				**($9,734,038)**

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

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**
FY 2014-15	$13.30	$2.04	$45,483,952	$4,304,753	$0	$767,427	$1,884,606	$564,926	$33,000,199	$6,750,242	**$92,756,105**
Projected FY 2015-16	$13.66	$2.10	$39,156,431	$8,803,574	$0	$1,007,578	$3,371,073	$500,889	$34,852,879	$7,586,101	**$95,278,525**
Projected FY 2016-17	$14.03	$2.16	$40,221,253	$9,042,979	$0	$1,034,978	$3,462,747	$514,511	$35,800,673	$7,792,399	**$97,869,540**
Projected FY 2017-18	$14.41	$2.22	$41,315,036	$9,288,895	$0	$1,063,123	$3,556,913	$528,502	$36,774,240	$8,004,306	**$100,531,015**

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	29.15%	317.86%	54.17%	-	-100.00%	-91.52%	-92.67%	-88.21%	38.30%	-53.51%	**37.83%**
FY 2011-12	62.07%	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%**
FY 2014-15	2.62%	2.5%	13.56%	-24.44%	-	21.64%	-32.60%	-17.74%	1.76%	11.24%	**4.98%**
Projected FY 2015-16	2.71%	2.9%	-13.91%	104.51%	-	31.29%	78.87%	-11.34%	5.61%	12.38%	**2.72%**
Projected FY 2016-17	2.71%	2.9%	2.72%	2.72%	-	2.72%	2.72%	2.72%	2.72%	2.72%	**2.72%**
Projected FY 2017-18	2.71%	2.8%	2.72%	2.72%	-	2.72%	2.72%	2.72%	2.72%	2.72%	**2.72%**

(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 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	$62,686	$495,900,792
FY 2010-11 (DA)	$390,609,241	$31,625,231	$76,509,001	$0	$7,615	$0	$0	$0	$0	$0	$0	$0	$0	$0	$564,302	$499,315,390
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
FY 2014-15	$450,965,898	$41,239,990	$84,210,839	$82,897	$195,582	$40,448	$2,542,746	$0	$0	$0	$76,579	$0	$0	$0	($25,076)	$579,329,903
Estimated FY 2015-16	$466,933,245	$40,645,164	$85,052,917	$154,878	$275,884	$13,445	$2,274,690	$0	$0	$0	$155,567	$0	$0	$0	$78,112	$595,583,902
Estimated FY 2016-17	$480,982,861	$41,868,141	$87,612,086	$159,538	$284,185	$13,850	$2,343,133	$0	$0	$0	$160,247	$0	$0	$0	$80,463	$613,504,504
Estimated FY 2017-18	$494,728,552	$43,064,663	$90,115,894	$164,098	$292,307	$14,245	$2,410,096	$0	$0	$0	$164,827	$0	$0	$0	$82,762	$631,037,444

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 2007-08	1.33%	5.06%	1.52%	0.00%	296.30%	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%	44.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	800.20%	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%
FY 2014-15	2.36%	8.10%	3.05%	-78.63%	55.29%	0.00%	345.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-103.19%	3.02%
Estimated FY 2015-16	3.54%	-1.44%	1.00%	86.83%	41.06%	-66.76%	-10.54%	0.00%	0.00%	0.00%	103.15%	0.00%	0.00%	0.00%	-411.50%	2.81%
Estimated FY 2016-17	3.01%	3.01%	3.01%	3.01%	3.01%	3.01%	3.01%	0.00%	0.00%	0.00%	3.01%	0.00%	0.00%	0.00%	3.01%	3.01%
Estimated FY 2017-18	2.86%	2.86%	2.86%	2.86%	2.86%	2.85%	2.86%	0.00%	0.00%	0.00%	2.86%	0.00%	0.00%	0.00%	2.86%	2.86%

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	$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)	$10,035.95	$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	$890.43
FY 2011-12	$10,347.28	$4,003.32	$1,280.22	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$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
FY 2014-15	$10,784.27	$3,940.38	$1,265.42	$22.86	$1.20	$0.56	$10.56	$0.00	$0.00	$0.00	$3.82	$0.00	$0.00	$0.00	($0.89)	$498.90
Estimated FY 2015-16	$11,060.05	$3,683.30	$1,234.49	$31.87	$1.52	$0.16	$7.76	$0.00	$0.00	$0.00	$7.81	$0.00	$0.00	$0.00	$2.38	$461.17
Estimated FY 2016-17	$11,230.05	$3,614.00	$1,224.16	$27.89	$1.46	$0.16	$7.72	$0.00	$0.00	$0.00	$8.04	$0.00	$0.00	$0.00	$2.17	$453.77
Estimated FY 2017-18	$11,381.44	$3,540.92	$1,213.47	$25.32	$1.43	$0.16	$7.83	$0.00	$0.00	$0.00	$8.26	$0.00	$0.00	$0.00	$2.01	$448.89

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 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)	-1.72%	-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%	-10.44%
FY 2011-12	3.10%	-1.68%	-5.82%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	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%
FY 2014-15	2.40%	1.77%	-0.24%	-84.92%	18.81%	100.00%	61.47%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	-102.65%	-23.62%
Estimated FY 2015-16	2.56%	-6.52%	-2.44%	39.41%	26.67%	-71.43%	-26.52%	0.00%	0.00%	0.00%	104.45%	0.00%	0.00%	0.00%	-367.42%	-7.56%
Estimated FY 2016-17	1.54%	-1.88%	-0.84%	-12.49%	-3.95%	0.00%	-0.52%	0.00%	0.00%	0.00%	2.94%	0.00%	0.00%	0.00%	-8.82%	-1.60%
Estimated FY 2017-18	1.35%	-2.02%	-0.87%	-9.21%	-2.05%	0.00%	1.42%	0.00%	0.00%	0.00%	2.74%	0.00%	0.00%	0.00%	-7.37%	-1.08%

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

Exhibit H - LONG-TERM CARE - CLASS II NURSING FACILITIES
Actual and Projected Expenditure by Eligibility

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 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
FY 2014-15	$411,017	$455,390	$3,411,444	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,277,851
Estimated FY 2015-16	$457,791	$507,213	$3,799,666	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,764,670
Estimated FY 2016-17	$483,839	$536,073	$4,015,867	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,035,779
Estimated FY 2017-18	$497,628	$551,351	$4,130,319	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,179,298

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 2008-09	-100.00%	75.77%	0.60%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	1.61%
FY 2009-10 (DA)	100.00%	-21.34%	-48.88%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-46.50%
FY 2010-11 (DA)	119.55%	176.09%	154.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	160.27%
FY 2011-12	-100.00%	-19.94%	-23.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-21.00%
FY 2012-13	100.00%	41.38%	114.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	104.38%
FY 2013-14	117.73%	-63.79%	-32.99%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-31.77%
FY 2014-15	4.33%	52.37%	24.14%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	22.76%
Estimated FY 2015-16	11.38%	11.38%	11.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.38%
Estimated FY 2016-17	5.69%	5.69%	5.69%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.69%
Estimated FY 2017-18	2.85%	2.85%	2.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.85%

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 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
FY 2014-15	$9.83	$43.51	$51.26	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.68
Estimated FY 2015-16	$10.84	$45.96	$55.15	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.69
Estimated FY 2016-17	$11.30	$46.27	$56.11	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.72
Estimated FY 2017-18	$11.45	$45.33	$55.62	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.68

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 2008-09	-100.00%	67.57%	-2.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	-8.77%
FY 2009-10 (DA)	100.00%	-28.05%	-50.72%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-53.08%
FY 2010-11 (DA)	117.00%	150.55%	140.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	131.15%
FY 2011-12	-100.00%	-25.82%	-27.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-28.55%
FY 2012-13	100.00%	30.94%	105.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	85.61%
FY 2013-14	112.64%	-66.74%	-35.60%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-45.86%
FY 2014-15	4.35%	43.46%	20.16%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-9.14%
Estimated FY 2015-16	10.27%	5.63%	7.59%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.27%
Estimated FY 2016-17	4.24%	0.67%	1.74%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.81%
Estimated FY 2017-18	1.33%	-2.03%	-0.87%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.08%

Exhibit H - LONG-TERM CARE - CLASS II NURSING FACILITIES
Actual and Projected Expenditure by Eligibility

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 2014-15 Expenditure	$411,017	$455,390	$3,411,444	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,277,851
Percentage Selected to Modify Expenditure[1]	11.38%	11.38%	11.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.38%
Estimated FY 2015-16 Base Expenditure	$457,791	$507,213	$3,799,666	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,764,670
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	**$457,791**	**$507,213**	**$3,799,666**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,764,670**
Request Year Projection																
FY 2015-16 Expenditure	$457,791	$507,213	$3,799,666	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,764,670
Percentage Selected to Modify Expenditure[1]	5.69%	5.69%	5.69%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.69%
Estimated FY 2016-17 Base Expenditure	$483,839	$536,073	$4,015,867	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,035,779
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	**$483,839**	**$536,073**	**$4,015,867**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$5,035,779**
Out Year Projection																
FY 2016-17 Expenditure	$483,839	$536,073	$4,015,867	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,035,779
Percentage Selected to Modify Expenditure[1]	2.85%	2.85%	2.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.85%
Estimated FY 2017-18 Base Expenditure	$497,628	$551,351	$4,130,319	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,179,298
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 2017-18 Total Expenditure	**$497,628**	**$551,351**	**$4,130,319**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$5,179,298**

(1) The percentages selected to trend expenditure for FY 2015-16 is 11.38%, FY 2016-17 is 5.69%, and FY 2017-18 is 2.85%. The trend has been set to match half of the previous year's growth for Class II Nursing Facilities.

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 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)	$61,924,559	$4,986,130	$2,345,339	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$69,256,028
FY 2010-11 (DA)	$73,232,308	$7,892,082	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$84,414,278
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
FY 2014-15	$112,128,644	$14,440,173	$6,335,950	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$132,904,767
Estimated FY 2015-16	$112,919,644	$14,678,686	$6,254,712	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$133,853,042
Estimated FY 2016-17	$132,058,980	$17,600,421	$7,241,590	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$156,900,991
Estimated FY 2017-18	$146,517,042	$20,042,429	$8,154,518	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$174,713,989

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 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%
FY 2014-15	30.64%	40.89%	44.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	32.28%
Estimated FY 2015-16	0.71%	1.65%	-1.28%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.71%
Estimated FY 2016-17	16.95%	19.90%	15.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.22%
Estimated FY 2017-18	10.95%	13.87%	12.61%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.35%

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	$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)	$1,881.56	$1,016.10	$58.45	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$150.54
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 2013-14	$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
FY 2012-13	$2,681.41	$1,379.72	$95.21	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$114.45
Estimated FY 2015-16	$2,674.68	$1,330.19	$90.78	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$103.64
Estimated FY 2016-17	$3,083.33	$1,519.24	$101.18	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$116.05
Estimated FY 2017-18	$3,370.69	$1,647.96	$109.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$124.28

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 2007-08	15.60%	9.95%	-13.80%	-	-	-	-	-	-	-	-	-	-	-	-	15.35%
FY 2008-09	18.67%	18.05%	32.93%	-	-	-	-	-	-	-	-	-	-	-	-	10.85%
FY 2009-10 (DA)	11.12%	3.74%	3.58%	-	-	-	-	-	-	-	-	-	-	-	-	-0.65%
FY 2010-11 (DA)	16.94%	43.65%	32.75%	-	-	-	-	-	-	-	-	-	-	-	-	8.42%
FY 2011-12	-1.47%	-5.46%	8.13%	-	-	-	-	-	-	-	-	-	-	-	-	-8.41%
FY 2012-13	11.50%	1.15%	6.44%	-	-	-	-	-	-	-	-	-	-	-	-	3.37%
FY 2013-14	-0.74%	7.06%	1.37%	-	-	-	-	-	-	-	-	-	-	-	-	-18.12%
FY 2014-15	30.70%	32.63%	39.62%	-	-	-	-	-	-	-	-	-	-	-	-	-1.93%
Estimated FY 2015-16	-0.25%	-3.59%	-4.65%	-	-	-	-	-	-	-	-	-	-	-	-	-9.45%
Estimated FY 2016-17	15.28%	14.21%	11.46%	-	-	-	-	-	-	-	-	-	-	-	-	11.97%
Estimated FY 2017-18	9.32%	8.47%	8.53%	-	-	-	-	-	-	-	-	-	-	-	-	7.09%

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 2007-08	1,121	82	37	0	0	0	0	0	0	0	0	0	0	0	0	1,240
FY 2008-09	1,273	100	49	0	0	0	0	0	0	0	0	0	0	0	0	1,422
FY 2009-10 (DA)	1,439	120	60	0	0	0	0	0	0	0	0	0	0	0	0	1,619
FY 2010-11 (DA)	1,600	171	75	0	0	0	0	0	0	0	0	0	0	0	0	1,846
FY 2011-12	1,754	204	96	0	0	0	0	0	0	0	0	0	0	0	0	2,054
FY 2012-13	2,047	238	117	0	0	0	0	0	0	0	0	0	0	0	0	2,402
FY 2013-14	1,924	232	101	0	0	0	0	0	0	0	0	0	0	0	0	2,257
FY 2014-15	2,393	320	143	0	0	0	0	0	0	0	0	0	0	0	0	2,856
Estimated FY 2015-16	2,434	326	138	0	0	0	0	0	0	0	0	0	0	0	0	2,898
Estimated FY 2016-17	2,670	367	151	0	0	0	0	0	0	0	0	0	0	0	0	3,188
Estimated FY 2017-18	2,892	408	166	0	0	0	0	0	0	0	0	0	0	0	0	3,466
Percent Changes in Enrollment																
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%
FY 2014-15	24.38%	37.93%	41.58%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	26.54%
Estimated FY 2015-16	1.71%	1.88%	-3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.47%
Estimated FY 2016-17	9.70%	12.58%	9.42%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.01%
Estimated FY 2017-18	8.31%	11.17%	9.93%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.72%
Average Cost Per Enrollee[3]																
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
FY 2014-15	$46,856.93	$45,125.54	$44,307.34	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$46,535.28
Estimated FY 2015-16	$48,286.24	$46,819.18	$46,819.18	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$48,051.35
Estimated FY 2016-17	$49,460.29	$47,957.55	$47,957.55	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$49,216.12
Estimated FY 2017-18	$50,662.88	$49,123.60	$49,123.60	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50,407.96
Percent Changes in Cost Per Enrollee																
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%
FY 2014-15	5.03%	2.14%	1.86%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.53%
Estimated FY 2015-16	3.05%	3.75%	5.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.26%
Estimated FY 2016-17	2.43%	2.43%	2.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.42%
Estimated FY 2017-18	2.43%	2.43%	2.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.42%

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 2014-15 Average Monthly Paid Enrollment	2,393	320	143	-	-	-	-	-	-	-	-	-	-	-	-	2,856
Trend Factor[4]	1.71%	1.88%	-3.50%	-	-	-	-	-	-	-	-	-	-	-	-	1.47%
Estimated FY 2015-16 Monthly Paid Enrollment	2,434	326	138	-	-	-	-	-	-	-	-	-	-	-	-	2,898
FY 2015-16 Estimated Cost Per Enrollee	$48,286.24	$46,819.18	$46,819.18	-	-	-	-	-	-	-	-	-	-	-	-	$48,051.35
Bottom Line Impacts																
FY 2014-15 Interim Payment Recoupment	($4,609,064)	($584,367)	($206,335)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($5,399,766)
Total Bottom Line Impacts	($4,609,064)	($584,367)	($206,335)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($5,399,766)
Estimated FY 2015-16 Expenditure	**$112,919,644**	**$14,678,686**	**$6,254,712**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$133,853,042**
Estimated FY 2015-16 Per Capita	$2,674.68	$1,330.19	$90.78	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$103.64
% Change over FY 2014-15 Per Capita	-0.25%	-3.59%	-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%	-9.45%

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 2015-16 Monthly Paid Enrollment	2,434	326	138	-	-	-	-	-	-	-	-	-	-	-	-	2,898
Trend Factor	9.70%	12.58%	9.42%	-	-	-	-	-	-	-	-	-	-	-	-	10.01%
Estimated FY 2016-17 Monthly Paid Enrollment	2,670	367	151	-	-	-	-	-	-	-	-	-	-	-	-	3,188
FY 2016-17 Estimated Cost Per Enrollee	$49,460.29	$47,957.55	$47,957.55	-	-	-	-	-	-	-	-	-	-	-	-	$49,216.12
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 Expenditure	**$132,058,980**	**$17,600,421**	**$7,241,590**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$156,900,991**
Estimated FY 2016-17 Per Capita	$3,083.33	$1,519.24	$101.18	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$116.05
% Change over FY 2015-16 Per Capita	15.28%	14.21%	11.46%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.97%

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	2,670	367	151	-	-	-	-	-	-	-	-	-	-	-	-	3,188
Trend Factor	8.31%	11.17%	9.93%	-	-	-	-	-	-	-	-	-	-	-	-	8.72%
FY 2015-16 Estimated Monthly Paid Enrollment	2,892	408	166	-	-	-	-	-	-	-	-	-	-	-	-	3,466
FY 2015-16 Estimated Cost Per Enrollee	$50,662.88	$49,123.60	$49,123.60	-	-	-	-	-	-	-	-	-	-	-	-	$50,407.96
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	**$146,517,042**	**$20,042,429**	**$8,154,518**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$174,713,989**
Estimated FY 2017-18 Per Capita	$3,370.69	$1,647.96	$109.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$124.28
% Change over FY 2016-17 Per Capita	9.32%	8.47%	8.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.09%

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 2015-16 are a weighted average of FY 2015-16 rates by forecasted FY 2015-16 provider distribution and FY 2014-15 third-party-liability status. FY 2016-17 per-enrollee costs are estimated using the average growth in per-enrollee cost between FY 2008-09 and FY 2014-15 applied to FY 2015-16 estimates. FY 2017-18 per-enrollee costs are estimated by application of the same growth rate to estimated FY 2016-17 per-enrollee costs.

(4) Monthly Paid Enrollment figures for FY 2015-16, FY 2016-17, and FY 2017-18 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 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	$33,417,797	$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
FY 2014-15	$73,205,694	$4,268,933	$38,373,381	$0	$240,024	$0	$0	$0	$0	$0	$0	$0	$0	$0	$21,183,050	$137,271,082
Estimated FY 2015-16	$77,164,613	$4,652,887	$41,236,473	$0	$273,765	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,115,427	$148,443,165
Estimated FY 2016-17	$82,005,242	$5,130,755	$44,898,967	$0	$310,733	$0	$0	$0	$0	$0	$0	$0	$0	$0	$30,090,801	$162,436,498
Estimated FY 2017-18	$86,982,295	$5,632,976	$48,722,389	$0	$343,444	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,232,868	$176,913,972

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 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%
FY 2014-15	6.27%	6.27%	6.27%	0.00%	6.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.27%	6.27%
Estimated FY 2015-16	5.41%	8.99%	7.46%	0.00%	14.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.56%	8.14%
Estimated FY 2016-17	6.27%	10.27%	8.88%	0.00%	13.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	19.81%	9.43%
Estimated FY 2017-18	6.07%	9.79%	8.52%	0.00%	10.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.09%	8.91%

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	$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)	$1,637.98	$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	$213.18
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
FY 2014-15	$1,750.62	$407.89	$576.63	$0.00	$1.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$755.32	$118.21
Estimated FY 2015-16	$1,827.77	$421.65	$598.52	$0.00	$1.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$764.90	$114.94
Estimated FY 2016-17	$1,914.67	$442.88	$627.35	$0.00	$1.60	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$812.50	$120.14
Estimated FY 2017-18	$2,001.07	$463.16	$656.08	$0.00	$1.68	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$854.44	$125.85

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 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)	14.69%	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%	3.17%
FY 2011-12	-2.91%	-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%	-10.26%
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%
FY 2014-15	6.32%	0.05%	2.88%	0.00%	-18.23%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-11.41%	-21.21%
Estimated FY 2015-16	4.41%	3.37%	3.80%	0.00%	2.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.27%	-2.77%
Estimated FY 2016-17	4.75%	5.03%	4.82%	0.00%	5.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.22%	4.52%
Estimated FY 2017-18	4.51%	4.58%	4.58%	0.00%	5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.16%	4.75%

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 2014-15 Expenditure	**$73,205,694**	**$4,268,933**	**$38,373,381**	**$0**	**$240,024**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$21,183,050**	**$137,271,082**
FY 2014-15 First Half Expenditure	$35,932,530	$2,095,377	$18,835,319	$0	$117,814	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10,397,559	$67,378,599
FY 2014-15 Second Half Expenditure	$37,273,164	$2,173,556	$19,538,062	$0	$122,210	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10,785,491	$69,892,483
Estimated FY 2015-16 First Half Caseload Trend	0.48%	2.72%	1.77%	16.99%	5.83%	7.88%	10.87%	-14.45%	3.22%	9.67%	-0.28%	-0.23%	-0.60%	4.96%	8.54%	5.61%
Estimated FY 2015-16 First Half Expenditure	$37,452,075	$2,232,677	$19,883,886	$0	$129,335	$0	$0	$0	$0	$0	$0	$0	$0	$0	$11,706,572	$71,404,545
Estimated FY 2015-16 Second Half Caseload Trend	0.48%	2.72%	1.76%	16.98%	5.82%	7.88%	10.87%	-14.44%	3.22%	9.66%	-0.28%	-0.22%	-0.60%	4.96%	8.54%	5.61%
Increase in Medicare Part B Premium for CY 2016	5.53%	5.53%	5.53%	5.53%	5.53%	5.53%	5.53%	5.53%	5.53%	5.53%	5.53%	5.53%	5.53%	5.53%	5.53%	5.53%
Estimated FY 2015-16 Second Half Expenditure	$39,712,538	$2,420,210	$21,352,587	$0	$144,430	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,408,855	$77,038,620
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)	**$77,164,613**	**$4,652,887**	**$41,236,473**	**$0**	**$273,765**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$25,115,427**	**$148,443,165**
Estimated FY 2015-16 Per Capita	$1,827.77	$421.65	$598.52	$0.00	$1.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$764.90	$114.94
% Change over FY 2014-15 Per Capita	4.41%	3.37%	3.80%	0.00%	2.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.27%	-2.77%
Request Year Projection																
Estimated FY 2015-16 Expenditure	$77,164,613	$4,652,887	$41,236,473	$0	$273,765	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,115,427	$148,443,165
Estimated FY 2015-16 First Half Expenditure	$37,452,075	$2,232,677	$19,883,886	$0	$129,335	$0	$0	$0	$0	$0	$0	$0	$0	$0	$11,706,572	$71,404,545
Estimated FY 2015-16 Second Half Expenditure	$39,712,538	$2,420,210	$21,352,587	$0	$144,430	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,408,855	$77,038,620
Estimated FY 2016-17 First Half Caseload Trend	0.73%	2.49%	1.94%	8.87%	3.49%	2.45%	1.75%	-22.97%	2.08%	4.04%	0.05%	0.29%	-0.09%	1.87%	6.40%	2.35%
Estimated FY 2016-17 First Half Expenditure	$40,002,440	$2,480,473	$21,766,827	$0	$149,471	$0	$0	$0	$0	$0	$0	$0	$0	$0	$14,267,022	$78,666,233
Estimated FY 2016-17 Second Half Caseload Trend	0.72%	2.49%	1.94%	8.87%	3.49%	2.44%	1.75%	-22.97%	2.08%	4.03%	0.05%	0.29%	-0.08%	1.87%	6.39%	2.34%
Estimated Increase in Medicare Part B Premium (Effective January 1, 2017)[1]	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%
Estimated FY 2016-17 Second Half Expenditure	$42,002,802	$2,650,282	$23,132,140	$0	$161,262	$0	$0	$0	$0	$0	$0	$0	$0	$0	$15,823,779	$83,770,265
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)	**$82,005,242**	**$5,130,755**	**$44,898,967**	**$0**	**$310,733**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$30,090,801**	**$162,436,498**
Estimated FY 2016-17 Per Capita	$1,914.67	$442.88	$627.35	$0.00	$1.60	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$812.50	$120.14
% Change over FY 2015-16 Per Capita	4.75%	5.03%	4.82%	0.00%	5.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.22%	4.52%
Out Year Projection																
Estimated FY 2016-17 Expenditure	$82,005,242	$5,130,755	$44,898,967	$0	$310,733	$0	$0	$0	$0	$0	$0	$0	$0	$0	$30,090,801	$162,436,498
Estimated FY 2016-17 First Half Expenditure	$40,002,440	$2,480,473	$21,766,827	$0	$149,471	$0	$0	$0	$0	$0	$0	$0	$0	$0	$14,267,022	$78,666,233
Estimated FY 2016-17 Second Half Expenditure	$42,002,802	$2,650,282	$23,132,140	$0	$161,262	$0	$0	$0	$0	$0	$0	$0	$0	$0	$15,823,779	$83,770,265
Estimated FY 2017-18 First Half Caseload Trend	0.75%	2.49%	1.88%	6.65%	2.63%	2.33%	0.76%	-33.01%	2.15%	3.67%	0.06%	0.35%	0.00%	0.65%	5.67%	1.99%
Estimated FY 2017-18 First Half Expenditure	$42,317,823	$2,716,274	$23,567,024	$0	$165,503	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,720,987	$85,487,611
Estimated FY 2017-18 Second Half Caseload Trend	0.74%	2.49%	1.88%	6.65%	2.62%	2.33%	0.76%	-33.00%	2.15%	3.66%	0.06%	0.35%	0.00%	0.64%	5.67%	1.99%
Estimated Increase in Medicare Part B Premium (Effective January 1, 2018)[1]	4.77%	4.77%	4.77%	4.77%	4.77%	4.77%	4.77%	4.77%	4.77%	4.77%	4.77%	4.77%	4.77%	4.77%	4.77%	4.77%
Estimated FY 2017-18 Second Half Expenditure	$44,664,472	$2,916,702	$25,155,365	$0	$177,941	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,511,881	$91,426,361
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2017-18 Total Expenditure(2)	**$86,982,295**	**$5,632,976**	**$48,722,389**	**$0**	**$343,444**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$35,232,868**	**$176,913,972**
Estimated FY 2017-18 Per Capita	$2,001.07	$463.16	$656.08	$0.00	$1.68	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$854.44	$125.85
% Change over Estimated FY 2016-17 Per Capita	4.51%	4.58%	4.58%	0.00%	5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.16%	4.75%

(1)The Part B premium remained at $104.90 effective January 1, 2015. The January 1, 2016 and January 1, 2017 rates have not yet been issued by CMS. The projected growth in premiums 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 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	$8,333	$993,384	$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	$5,098	$0	$0	$0	$2,021	$0	$1,059	$0	$0	$0	$0	$1,036,643
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
FY 2014-15	$8,989	$11,236	$1,101,111	$0	$13,483	$22,472	$20,224	$0	$78,651	$0	$0	$6,741	$0	$0	$0	$1,262,907
Estimated FY 2015-16	$11,074	$13,842	$1,356,448	$0	$16,610	$27,683	$24,913	$0	$96,890	$0	$0	$8,304	$0	$0	$0	$1,555,764
Estimated FY 2016-17	$13,924	$17,406	$1,705,652	$0	$20,886	$34,810	$31,327	$0	$121,833	$0	$0	$10,442	$0	$0	$0	$1,956,280
Estimated FY 2017-18	$17,546	$21,934	$2,149,310	$0	$26,318	$43,865	$39,475	$0	$153,523	$0	$0	$13,158	$0	$0	$0	$2,465,129

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 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%	160.41%	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%	59.46%	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%	90.80%	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%
FY 2014-15	-23.46%	-45.33%	-9.41%	0.00%	-48.98%	0.00%	0.00%	0.00%	30.02%	0.00%	-100.00%	-23.47%	0.00%	0.00%	0.00%	-7.50%
Estimated FY 2015-16	23.20%	23.19%	23.19%	0.00%	23.19%	23.19%	23.19%	0.00%	23.19%	0.00%	0.00%	23.19%	0.00%	0.00%	0.00%	23.19%
Estimated FY 2016-17	25.74%	25.75%	25.74%	0.00%	25.74%	25.75%	25.75%	0.00%	25.74%	0.00%	0.00%	25.75%	0.00%	0.00%	0.00%	25.74%
Estimated FY 2017-18	26.01%	26.01%	26.01%	0.00%	26.01%	26.01%	26.01%	0.00%	26.01%	0.00%	0.00%	26.01%	0.00%	0.00%	0.00%	26.01%

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 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
FY 2014-15	$0.21	$1.07	$16.55	$0.00	$0.08	$0.31	$0.08	$0.00	$0.18	$0.00	$0.00	$0.45	$0.00	$0.00	$0.00	$1.09
Estimated FY 2015-16	$0.26	$1.25	$19.69	$0.00	$0.09	$0.33	$0.09	$0.00	$0.20	$0.00	$0.00	$0.56	$0.00	$0.00	$0.00	$1.20
Estimated FY 2016-17	$0.33	$1.50	$23.83	$0.00	$0.11	$0.40	$0.10	$0.00	$0.25	$0.00	$0.00	$0.70	$0.00	$0.00	$0.00	$1.45
Estimated FY 2017-18	$0.40	$1.80	$28.94	$0.00	$0.13	$0.48	$0.13	$0.00	$0.30	$0.00	$0.00	$0.88	$0.00	$0.00	$0.00	$1.75

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 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%	100.00%	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%
FY 2014-15	-25.00%	-48.80%	-12.29%	0.00%	-61.90%	0.00%	0.00%	0.00%	20.00%	0.00%	-100.00%	-32.84%	0.00%	0.00%	0.00%	-31.45%
Estimated FY 2015-16	23.81%	16.82%	18.97%	0.00%	12.50%	6.45%	12.50%	0.00%	11.11%	0.00%	0.00%	24.44%	0.00%	0.00%	0.00%	10.09%
Estimated FY 2016-17	26.92%	20.00%	21.03%	0.00%	22.22%	21.21%	11.11%	0.00%	25.00%	0.00%	0.00%	25.00%	0.00%	0.00%	0.00%	20.83%
Estimated FY 2017-18	21.21%	20.00%	21.44%	0.00%	18.18%	20.00%	30.00%	0.00%	20.00%	0.00%	0.00%	25.71%	0.00%	0.00%	0.00%	20.69%

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

Expenditure Trends																
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**
Actual FY 2014-15 Expenditure	$8,989	$11,236	$1,101,111	$0	$13,483	$22,472	$20,224	$0	$78,651	$0	$0	$6,741	$0	$0	$0	$1,262,907
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%	239.30%	10.23%	0.00%	20.17%	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%	28.85%	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%	121.28%	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%
Average of FY 2010-11 through FY 2014-15	58.78%	382.46%	2.70%	0.00%	74.87%	0.00%	0.00%	0.00%	396.88%	0.00%	387.67%	-24.69%	0.00%	0.00%	0.00%	4.73%
Average of FY 2011-12 through FY 2014-15	84.55%	501.21%	2.56%	0.00%	78.72%	0.00%	0.00%	0.00%	516.63%	0.00%	383.52%	-30.87%	0.00%	0.00%	0.00%	5.51%
Average of FY 2012-13 through FY 2014-15	109.65%	346.67%	0.28%	0.00%	74.69%	0.00%	0.00%	0.00%	507.82%	0.00%	474.72%	-41.16%	0.00%	0.00%	0.00%	3.40%
Average of FY 2013-14 through FY 2014-15	150.49%	557.77%	-9.54%	0.00%	128.59%	0.00%	0.00%	0.00%	797.76%	0.00%	732.75%	-11.74%	0.00%	0.00%	0.00%	-3.62%
Current Year Projection																
FY 2014-15 Expenditure	$8,989	$11,236	$1,101,111	$0	$13,483	$22,472	$20,224	$0	$78,651	$0	$0	$6,741	$0	$0	$0	$1,262,907
Estimated Incremental Expenditure for FY 2015-16																
SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$264	$330	$32,309	$0	$396	$659	$593	$0	$2,308	$0	$0	$198	$0	$0	$0	$37,057
SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$1,821	$2,276	$223,028	$0	$2,731	$4,552	$4,096	$0	$15,931	$0	$0	$1,365	$0	$0	$0	$255,800
Total Incremental Expenditure	$2,085	$2,606	$255,337	$0	$3,127	$5,211	$4,689	$0	$18,239	$0	$0	$1,563	$0	$0	$0	$292,857
Estimated FY 2015-16 Total Expenditure	**$11,074**	**$13,842**	**$1,356,448**	**$0**	**$16,610**	**$27,683**	**$24,913**	**$0**	**$96,890**	**$0**	**$0**	**$8,304**	**$0**	**$0**	**$0**	**$1,555,764**
Estimated FY 2015-16 Per Capita	$0.26	$1.25	$19.69	$0.00	$0.09	$0.33	$0.09	$0.00	$0.20	$0.00	$0.00	$0.56	$0.00	$0.00	$0.00	$1.20
% Change over FY 2014-15 Per Capita	23.81%	16.82%	18.97%	0.00%	12.50%	6.45%	12.50%	0.00%	11.11%	0.00%	0.00%	24.44%	0.00%	0.00%	0.00%	10.09%
Request Year Projection																
Estimated FY 2015-16 Expenditure	$11,074	$13,842	$1,356,448	$0	$16,610	$27,683	$24,913	$0	$96,890	$0	$0	$8,304	$0	$0	$0	$1,555,764
Estimated Incremental Expenditure for FY 2016-17																
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$360	$451	$44,187	$0	$541	$902	$812	$0	$3,156	$0	$0	$271	$0	$0	$0	$50,680
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$2,490	$3,113	$305,017	$0	$3,735	$6,225	$5,602	$0	$21,787	$0	$0	$1,867	$0	$0	$0	$349,836
Total Incremental Expenditure	$2,850	$3,564	$349,204	$0	$4,276	$7,127	$6,414	$0	$24,943	$0	$0	$2,138	$0	$0	$0	$400,516
Estimated FY 2016-17 Total Expenditure	**$13,924**	**$17,406**	**$1,705,652**	**$0**	**$20,886**	**$34,810**	**$31,327**	**$0**	**$121,833**	**$0**	**$0**	**$10,442**	**$0**	**$0**	**$0**	**$1,956,280**
Estimated FY 2016-17 Per Capita	$0.33	$1.50	$23.83	$0.00	$0.11	$0.40	$0.10	$0.00	$0.25	$0.00	$0.00	$0.70	$0.00	$0.00	$0.00	$1.45
% Change over FY 2015-16 Per Capita	26.92%	20.00%	21.03%	0.00%	22.22%	21.21%	11.11%	0.00%	25.00%	0.00%	0.00%	25.00%	0.00%	0.00%	0.00%	20.83%
Out Year Projection																
Estimated FY 2016-17 Expenditure	$13,924	$17,406	$1,705,652	$0	$20,886	$34,810	$31,327	$0	$121,833	$0	$0	$10,442	$0	$0	$0	$1,956,280
Estimated Incremental Expenditure for FY 2017-18																
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$458	$573	$56,139	$0	$687	$1,146	$1,031	$0	$4,010	$0	$0	$344	$0	$0	$0	$64,388
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$3,164	$3,955	$387,519	$0	$4,745	$7,909	$7,117	$0	$27,680	$0	$0	$2,372	$0	$0	$0	$444,461
Total Incremental Expenditure	$3,622	$4,528	$443,658	$0	$5,432	$9,055	$8,148	$0	$31,690	$0	$0	$2,716	$0	$0	$0	$508,849
Estimated FY 2017-18 Total Expenditure	**$17,546**	**$21,934**	**$2,149,310**	**$0**	**$26,318**	**$43,865**	**$39,475**	**$0**	**$153,523**	**$0**	**$0**	**$13,158**	**$0**	**$0**	**$0**	**$2,465,129**
Estimated FY 2017-18 Per Capita	$0.40	$1.80	$28.94	$0.00	$0.13	$0.48	$0.13	$0.00	$0.30	$0.00	$0.00	$0.88	$0.00	$0.00	$0.00	$1.75
% Change over FY 2016-17 Per Capita	21.21%	20.00%	21.44%	0.00%	18.18%	20.00%	30.00%	0.00%	20.00%	0.00%	0.00%	25.71%	0.00%	0.00%	0.00%	20.69%

Exhibit I - SERVICE MANAGEMENT
Summary

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	$9,319,240	$2,585,742	$19,556,026	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,461,008
Disease Management	$8,232	$21,647	$145,304	$9,050	$211,327	$78,847	$390,096	$0	$0	$0	$29,418	$84,586	$9,735	$0	$0	$988,242
Accountable Care Collaborative	$3,159,648	$1,333,890	$9,505,277	$310,203	$20,439,718	$9,090,628	$32,325,407	$0	$58,643,368	$7,511,607	$2,568,461	$1,219,722	$164,217	$0	$0	$146,272,146
Prepaid Inpatient Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Service Management	**$12,487,120**	**$3,941,279**	**$29,206,607**	**$319,253**	**$20,651,045**	**$9,169,475**	**$32,715,503**	**$0**	**$58,643,368**	**$7,511,607**	**$2,597,879**	**$1,304,308**	**$173,952**	**$0**	**$0**	**$178,721,396**

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	$9,846,709	$2,730,802	$20,660,941	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,238,452
Disease Management	$8,138	$22,707	$151,011	$10,641	$225,424	$82,601	$403,444	$0	$0	$0	$29,516	$85,021	$9,712	$0	$0	$1,028,215
Accountable Care Collaborative	$4,768,586	$1,759,185	$12,129,596	$412,281	$23,084,252	$9,986,906	$35,162,079	$0	$62,802,333	$8,097,096	$2,753,310	$1,288,782	$194,066	$0	$0	$162,438,472
Prepaid Inpatient Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Service Management	**$14,623,433**	**$4,512,694**	**$32,941,548**	**$422,922**	**$23,309,676**	**$10,069,507**	**$35,565,523**	**$0**	**$62,802,333**	**$8,097,096**	**$2,782,826**	**$1,373,803**	**$203,778**	**$0**	**$0**	**$196,705,139**

FY 2017-18 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	$10,321,320	$2,862,427	$21,654,732	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,838,479
Disease Management	$8,259	$23,838	$156,695	$12,057	$237,258	$86,450	$409,562	$0	$0	$0	$29,550	$85,614	$9,712	$0	$0	$1,058,995
Accountable Care Collaborative	$4,827,756	$1,804,992	$12,391,385	$480,675	$24,794,199	$10,679,596	$36,520,143	$0	$66,435,534	$8,748,776	$2,860,242	$1,336,251	$207,716	$0	$0	$171,087,265
Prepaid Inpatient Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Service Management	**$15,157,335**	**$4,691,257**	**$34,202,812**	**$492,732**	**$25,031,457**	**$10,766,046**	**$36,929,705**	**$0**	**$66,435,534**	**$8,748,776**	**$2,889,792**	**$1,421,865**	**$217,428**	**$0**	**$0**	**$206,984,739**

Exhibit I - SERVICE MANAGEMENT - SINGLE ENTRY POINT
Projections Expenditure by Eligibility

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 2007-08	$10,894,815	$1,743,587	$9,118,698	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$21,757,100
FY 2008-09	$11,356,087	$1,927,170	$9,783,918	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$23,067,175
FY 2009-10 (DA)	$11,622,897	$2,068,951	$10,015,703	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$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
FY 2014-15	$9,072,052	$2,528,512	$21,018,753	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$32,619,317
Estimated FY 2015-16	$9,319,240	$2,585,742	$19,556,026	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,461,008
Estimated FY 2016-17	$9,846,709	$2,730,802	$20,660,941	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,238,452
Estimated FY 2017-18	$10,321,320	$2,862,427	$21,654,732	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,838,479
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 2007-08	30.94%	-12.74%	26.38%	0.00%	-100.00%	0.00%	0.00%	0.00%	-100.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	-100.00%	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%
FY 2014-15	15.77%	18.62%	24.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	21.27%
Estimated FY 2015-16	2.72%	2.26%	-6.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-3.55%
Estimated FY 2016-17	5.66%	5.61%	5.65%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.65%
Estimated FY 2017-18	4.82%	4.82%	4.81%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.81%
Current Year Projection																
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 2015-16 Base Contracts	$9,272,496	$2,572,772	$19,457,935	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,303,203
Estimated Increase in HCBS Enrollment(1)(2)	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 Expenditure	$9,272,496	$2,572,772	$19,457,935	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,303,203
Bottom Line Impacts																
FY 2015-16 R-12: "Community Provider Rate Increase"	$46,744	$12,970	$98,091	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$157,805
Total Bottom Line Impacts	$46,744	$12,970	$98,091	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$157,805
Estimated FY 2015-16 Total Expenditure	**$9,319,240**	**$2,585,742**	**$19,556,026**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$31,461,008**
Estimated FY 2015-16 Per Capita	$768.03	$848.90	$1,778.31	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,146.62
% Change over FY 2014-15 Per Capita	-2.50%	-2.94%	-11.68%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-8.45%
Request Year Projection																
Estimated FY 2016-17 Base Contracts	$9,319,240	$2,585,742	$19,556,026	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,461,008
Estimated Increase in HCBS Enrollment(1)(2)	5.66%	5.61%	5.65%	5.45%	4.90%	0.00%	5.80%	0.00%	5.86%	0.00%	0.00%	0.00%	0.00%	0.00%	5.50%	5.65%
Estimated FY 2016-17 Base Expenditure	$9,846,709	$2,730,802	$20,660,941	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,238,452
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	**$9,846,709**	**$2,730,802**	**$20,660,941**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$33,238,452**
Estimated FY 2016-17 Per Capita	$768.01	$848.87	$1,778.36	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,146.71
% Change over FY 2015-16 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%	0.01%
Out Year Projection																
FY 2017-18 Base Contracts	$9,846,709	$2,730,802	$20,660,941	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,238,452
Estimated Increase in HCBS Enrollment(1)(2)	4.82%	4.82%	4.81%	4.60%	4.67%	7.14%	4.70%	0.00%	4.62%	0.00%	7.14%	0.00%	0.00%	0.00%	4.89%	4.81%
Estimated FY 2016-17 Base Expenditure	$10,321,320	$2,862,427	$21,654,732	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,838,479
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2017-18 Total Expenditure	**$10,321,320**	**$2,862,427**	**$21,654,732**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$34,838,479**
Estimated FY 2017-18 Per Capita	$768.01	$848.88	$1,778.33	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,146.72
% Change over FY 2016-17 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%

(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 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
FY 2014-15	$8,232	$21,647	$145,304	$9,050	$211,327	$78,847	$390,096	$0	$0	$0	$29,418	$84,586	$9,735	$0	$0	$988,242
Estimated FY 2015-16	$8,232	$21,647	$145,304	$9,050	$211,327	$78,847	$390,096	$0	$0	$0	$29,418	$84,586	$9,735	$0	$0	$988,242
Estimated FY 2016-17	$8,138	$22,707	$151,011	$10,641	$225,424	$82,601	$403,444	$0	$0	$0	$29,516	$85,021	$9,712	$0	$0	$1,028,215
Estimated FY 2017-18	$8,259	$23,838	$156,695	$12,057	$237,258	$86,450	$409,562	$0	$0	$0	$29,550	$85,614	$9,712	$0	$0	$1,058,995

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 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%
FY 2014-15	13.80%	23.92%	24.83%	13.74%	48.74%	93.74%	247.39%	0.00%	0.00%	0.00%	47.60%	34.49%	100.00%	0.00%	0.00%	87.54%
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	-1.14%	4.90%	3.93%	17.58%	6.67%	4.76%	3.42%	0.00%	0.00%	0.00%	0.33%	0.51%	-0.24%	0.00%	0.00%	4.04%
Estimated FY 2017-18	1.49%	4.98%	3.76%	13.31%	5.25%	4.66%	1.52%	0.00%	0.00%	0.00%	0.12%	0.70%	0.00%	0.00%	0.00%	2.99%

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	$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
FY 2014-15	$0.20	$2.07	$2.18	$2.50	$1.30	$1.10	$1.62	$0.00	$0.00	$0.00	$1.47	$5.68	$5.57	$0.00	$0.00	$0.85
Estimated FY 2015-16	$0.19	$1.96	$2.11	$1.86	$1.16	$0.95	$1.33	$0.00	$0.00	$0.00	$1.48	$5.70	$5.63	$0.00	$0.00	$0.77
Estimated FY 2016-17	$0.19	$1.96	$2.11	$1.86	$1.16	$0.95	$1.33	$0.00	$0.00	$0.00	$1.48	$5.70	$5.63	$0.00	$0.00	$0.76
Estimated FY 2017-18	$0.19	$1.96	$2.11	$1.86	$1.16	$0.95	$1.33	$0.00	$0.00	$0.00	$1.48	$5.70	$5.63	$0.00	$0.00	$0.75

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 2009-10 (DA)	-97.76%	-97.82%	-97.73%	0.00%	-97.80%	0.00%	0.00%	-97.76%	-97.75%	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%	0.00%	0.00%	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%
FY 2014-15	17.65%	16.95%	20.44%	-19.61%	14.04%	27.91%	25.58%	0.00%	0.00%	0.00%	34.86%	18.83%	100.00%	0.00%	0.00%	39.34%
Estimated FY 2015-16	-5.00%	-5.31%	-3.21%	-25.60%	-10.77%	-13.64%	-17.90%	0.00%	0.00%	0.00%	0.68%	0.35%	1.08%	0.00%	0.00%	-9.41%
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%	-1.30%
Estimated FY 2017-18	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.32%

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 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	$0.19	$1.96	$2.11	$1.86	$1.16	$0.95	$1.33	$0.00	$0.00	$0.00	$1.48	$5.70	$5.63	$0.00	$0.00	$0.77
Estimated FY 2015-16 Eligibles	42,218	11,035	68,897	4,859	181,652	82,897	293,091	283	474,429	59,802	19,923	14,830	1,728	2,992	32,835	1,291,471
Estimated FY 2015-16 Base Expenditure	**$8,232**	**$21,647**	**$145,304**	**$9,050**	**$211,327**	**$78,847**	**$390,096**	**$0**	**$0**	**$0**	**$29,418**	**$84,586**	**$9,735**	**$0**	**$0**	**$988,242**
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	**$8,232**	**$21,647**	**$145,304**	**$9,050**	**$211,327**	**$78,847**	**$390,096**	**$0**	**$0**	**$0**	**$29,418**	**$84,586**	**$9,735**	**$0**	**$0**	**$988,242**
Estimated FY 2015-16 Per Capita	$0.19	$1.96	$2.11	$1.86	$1.16	$0.95	$1.33	$0.00	$0.00	$0.00	$1.48	$5.70	$5.63	$0.00	$0.00	$0.77
% Change over FY 2014-15 Per Capita	97.44%	99.91%	100.05%	99.86%	99.71%	99.88%	99.93%	0.00%	0.00%	0.00%	100.23%	99.93%	99.93%	0.00%	0.00%	100.63%
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	$0.19	$1.96	$2.11	$1.86	$1.16	$0.95	$1.33	$0.00	$0.00	$0.00	$1.48	$5.70	$5.63	$0.00	$0.00	$0.76
Estimated FY 2016-17 Eligibles	42,830	11,585	71,569	5,721	194,331	86,948	303,341	153	494,175	64,629	19,943	14,916	1,725	3,104	37,035	1,352,005
Estimated FY 2016-17 Base Expenditure	**$8,138**	**$22,707**	**$151,011**	**$10,641**	**$225,424**	**$82,601**	**$403,444**	**$0**	**$0**	**$0**	**$29,516**	**$85,021**	**$9,712**	**$0**	**$0**	**$1,028,215**
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	**$8,138**	**$22,707**	**$151,011**	**$10,641**	**$225,424**	**$82,601**	**$403,444**	**$0**	**$0**	**$0**	**$29,516**	**$85,021**	**$9,712**	**$0**	**$0**	**$1,028,215**
Estimated FY 2016-17 Per Capita	$0.19	$1.96	$2.11	$1.86	$1.16	$0.95	$1.33	$0.00	$0.00	$0.00	$1.48	$5.70	$5.63	$0.00	$0.00	$0.76
% Change over FY 2015-16 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%	-1.30%
FY 2017-18 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 2017-18 Base Per Capita	$0.19	$1.96	$2.11	$1.86	$1.16	$0.95	$1.33	$0.00	$0.00	$0.00	$1.48	$5.70	$5.63	$0.00	$0.00	$0.73
Estimated FY 2017-18 Eligibles	43,468	12,162	74,263	6,482	204,533	91,000	307,941	52	515,425	69,364	19,966	15,020	1,725	3,144	41,235	1,405,780
Estimated FY 2017-18 Base Expenditure	**$8,259**	**$23,838**	**$156,695**	**$12,057**	**$237,258**	**$86,450**	**$409,562**	**$0**	**$0**	**$0**	**$29,550**	**$85,614**	**$9,712**	**$0**	**$0**	**$1,028,215**
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 2017-18 Total Expenditure	**$8,259**	**$23,838**	**$156,695**	**$12,057**	**$237,258**	**$86,450**	**$409,562**	**$0**	**$0**	**$0**	**$29,550**	**$85,614**	**$9,712**	**$0**	**$0**	**$1,058,995**
Estimated FY 2017-18 Per Capita	$0.19	$1.96	$2.11	$1.86	$1.16	$0.95	$1.33	$0.00	$0.00	$0.00	$1.48	$5.70	$5.63	$0.00	$0.00	$0.75
% Change over FY 2016-17 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%	-1.32%

Cash Based Actuals

ACCOUNTABLE CARE COLLABORATIVE	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)	$11,931	$16,697	$100,967	$0	$246,920	$73,004	$0	$0	$407,791	$0	$14,196	$15,905	$0	$0	$0	$887,411
FY 2011-12	$345,078	$256,950	$2,052,795	$377	$5,690,110	$2,269,608	$79,568	$0	$6,360,605	$0	$576,072	$275,408	$0	$107	$1,155	$17,907,833
FY 2012-13	$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
FY 2013-14	$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
FY 2014-15	$1,545,628	$745,776	$5,540,782	$158,094	$14,817,457	$6,186,010	$19,544,268	$0	$46,748,576	$5,337,255	$1,939,708	$950,390	$111,580	$25,697	$90,070	$103,741,291
Estimated FY 2015-16	$3,159,648	$1,333,890	$9,505,277	$310,203	$20,439,718	$9,090,628	$32,325,407	$0	$58,643,368	$7,511,607	$2,568,461	$1,219,722	$164,217	$0	$0	$146,272,146
Estimated FY 2016-17	$4,768,586	$1,759,185	$12,129,596	$412,281	$23,084,252	$9,986,906	$35,162,079	$0	$62,802,333	$8,097,096	$2,753,310	$1,288,782	$194,066	$0	$0	$162,438,472
Estimated FY 2017-18	$4,827,756	$1,804,992	$12,391,385	$480,675	$24,794,199	$10,679,596	$36,520,143	$0	$66,435,534	$8,748,776	$2,860,242	$1,336,251	$207,716	$0	$0	$171,087,265

Percent Change in Cash Based Actuals

ACCOUNTABLE CARE COLLABORATIVE	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 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)	100.00%	100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%	0.00%	100.00%	100.00%	0.00%	0.00%	0.00%	100.00%
FY 2011-12	2792.28%	1438.90%	1933.13%	100.00%	2204.43%	3008.88%	100.00%	0.00%	1459.77%	0.00%	3957.99%	1631.58%	0.00%	100.00%	100.00%	1917.99%
FY 2012-13	67.07%	76.16%	90.81%	5127.06%	71.18%	82.47%	2232.82%	0.00%	108.97%	100.00%	141.10%	56.03%	100.00%	384.11%	323.72%	105.10%
FY 2013-14	-5.00%	3.51%	3.45%	350.77%	9.66%	-4.50%	239.56%	0.00%	187.03%	119.63%	14.78%	66.22%	82.55%	62.55%	385.90%	86.69%
FY 2014-15	182.19%	59.16%	36.73%	77.98%	38.72%	56.41%	210.09%	0.00%	22.54%	173.78%	21.68%	33.05%	177.18%	2951.90%	278.76%	51.29%
Estimated FY 2015-16	104.42%	78.86%	71.55%	96.21%	37.94%	46.95%	65.40%	0.00%	25.44%	40.74%	32.41%	28.34%	47.17%	-100.00%	-100.00%	41.00%
Estimated FY 2016-17	50.92%	31.88%	27.61%	32.91%	12.94%	9.86%	8.78%	0.00%	7.09%	7.79%	7.20%	5.66%	18.18%	0.00%	0.00%	11.05%
Estimated FY 2017-18	1.24%	2.60%	2.16%	16.59%	7.41%	6.94%	3.86%	0.00%	5.79%	8.05%	3.88%	3.68%	7.03%	0.00%	0.00%	5.32%

Per Capita Cost

ACCOUNTABLE CARE COLLABORATIVE	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	$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)	$0.31	$2.15	$1.79	$0.00	$3.04	$2.69	$0.00	$0.00	$1.35	$0.00	$0.77	$2.02	$0.00	$0.00	$0.00	$1.58
FY 2011-12	$8.68	$30.65	$34.54	$7.25	$61.04	$64.00	$70.17	$0.00	$19.01	$0.00	$31.94	$36.10	$0.00	$0.04	$0.06	$28.89
FY 2012-13	$14.12	$50.01	$63.26	$22.19	$98.00	$99.68	$174.55	$0.00	$36.94	$107.77	$78.13	$53.56	$64.10	$0.19	$0.23	$53.78
FY 2013-14	$13.09	$47.56	$62.90	$34.70	$85.67	$84.00	$72.24	$0.00	$95.61	$76.92	$87.27	$54.28	$38.08	$0.34	$1.02	$79.64
FY 2014-15	$36.96	$71.26	$83.26	$43.59	$91.07	$86.39	$81.18	$0.00	$104.88	$106.50	$96.81	$63.80	$63.80	$9.44	$3.21	$89.34
Estimated FY 2015-16	$74.84	$120.88	$137.96	$63.84	$112.52	$109.66	$110.29	$0.00	$123.61	$125.61	$128.92	$82.25	$95.03	$0.00	$0.00	$113.26
Estimated FY 2016-17	$111.34	$151.85	$169.48	$72.06	$118.79	$114.86	$115.92	$0.00	$127.09	$125.29	$138.06	$86.40	$112.50	$0.00	$0.00	$120.15
Estimated FY 2017-18	$111.06	$148.41	$166.86	$74.16	$121.22	$117.36	$118.59	$0.00	$128.89	$126.13	$143.26	$88.96	$120.42	$0.00	$0.00	$121.70

Percent Change in Per Capita Cost

ACCOUNTABLE CARE COLLABORATIVE	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 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)	100.00%	100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%	0.00%	100.00%	100.00%	0.00%	0.00%	0.00%	100.00%
FY 2011-12	2700.00%	1325.58%	1829.61%	100.00%	1907.89%	2279.18%	100.00%	0.00%	1308.15%	0.00%	4048.05%	1687.13%	0.00%	100.00%	100.00%	1728.48%
FY 2012-13	62.67%	63.16%	83.15%	206.07%	60.55%	55.75%	148.75%	0.00%	94.32%	100.00%	144.61%	48.37%	100.00%	375.00%	283.33%	86.15%
FY 2013-14	-7.29%	-4.90%	-0.57%	56.38%	-12.58%	-15.73%	-58.61%	0.00%	158.83%	-28.63%	11.70%	1.34%	-40.59%	78.95%	343.48%	48.08%
FY 2014-15	182.35%	49.83%	32.37%	25.62%	6.30%	2.85%	12.38%	0.00%	9.70%	38.46%	10.93%	17.54%	67.54%	2676.47%	214.71%	12.18%
Estimated FY 2015-16	102.49%	69.63%	65.70%	46.46%	23.55%	26.94%	35.86%	0.00%	17.86%	17.94%	33.17%	28.92%	48.95%	-100.00%	-100.00%	26.77%
Estimated FY 2016-17	48.77%	25.62%	22.85%	12.88%	5.57%	4.74%	5.10%	0.00%	2.82%	-0.25%	7.09%	5.05%	18.38%	0.00%	0.00%	6.08%
Estimated FY 2017-18	-0.25%	-2.27%	-1.55%	2.91%	2.05%	2.18%	2.30%	0.00%	1.42%	0.67%	3.77%	2.96%	7.04%	0.00%	0.00%	1.29%

Exhibit I - SERVICE MANAGEMENT - ACCOUNTABLE CARE COLLABORATIVE

Current Year Projection

ACCOUNTABLE CARE COLLABORATIVE	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 RCCOs in the ACC	$1,000,604	$719,261	$5,501,927	$226,255	$15,117,024	$6,867,266	$24,400,233	$0	$44,373,275	$5,675,594	$1,942,652	$920,631	$124,086	$0	$0	$106,868,808
ACC: Medicare-Medicaid Program (RCCOs in the ACC)	$1,366,545	$276,828	$1,615,725	$6,822	$317,400	$359	$718	$0	$2,872	$0	$718	$2,513	$0	$0	$0	$3,590,500
Estimated Expenditure for PCMPs in the ACC	$299,741	$214,483	$1,637,892	$67,819	$4,451,572	$2,029,674	$7,235,590	$0	$13,026,370	$1,676,438	$570,525	$270,091	$36,643	$0	$0	$31,516,838
ACC: Medicare-Medicaid Program (PCMPs in the ACC)	$464,227	$102,902	$593,827	$2,851	$129,989	$130	$130	$0	$907	$0	$259	$778	$0	$0	$0	$1,296,000
Estimated Expenditure for SDAC in the ACC	$28,531	$20,416	$155,906	$6,456	$423,733	$193,199	$688,736	$0	$1,239,944	$159,575	$54,307	$25,709	$3,488	$0	$0	$3,000,000
Estimated FY 2015-16 Total Expenditure	$3,159,648	$1,333,890	$9,505,277	$310,203	$20,439,718	$9,090,628	$32,325,407	$0	$58,643,368	$7,511,607	$2,568,461	$1,219,722	$164,217	$0	$0	$146,272,146
Estimated FY 2015-16 Per Capita Cost	$74.84	$120.88	$137.96	$63.84	$112.52	$109.66	$110.29	$0.00	$123.61	$125.61	$128.92	$82.25	$95.03	$0.00	$0.00	$113.26

Request Year Projection

ACCOUNTABLE CARE COLLABORATIVE	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 RCCOs in the ACC	$1,204,898	$848,569	$6,394,467	$304,275	$17,206,174	$7,701,709	$27,124,096	$0	$48,450,641	$6,247,156	$2,123,014	$990,180	$149,463	$0	$0	$118,744,642
ACC: Medicare-Medicaid Program (RCCOs in the ACC)	$2,740,320	$555,120	$3,240,000	$13,680	$636,480	$720	$1,440	$0	$5,760	$0	$1,440	$5,040	$0	$0	$0	$7,200,000
Estimated Expenditure for PCMPs in the ACC	$348,936	$245,418	$1,847,284	$88,876	$4,966,384	$2,219,447	$7,808,092	$0	13,937,471	$1,797,382	$610,738	$284,466	$43,336	$0	$0	$34,197,830
ACC: Medicare-Medicaid Program (PCMPs in the ACC)	$464,227	$102,902	$593,827	$2,851	$129,989	$130	$130	$0	$907	$0	$259	$778	$0	$0	$0	$1,296,000
Estimated Expenditure for SDAC in the ACC	$10,205	$7,176	$54,018	$2,599	$145,225	$64,900	$228,321	$0	$407,554	$52,558	$17,859	$8,318	$1,267	$0	$0	$1,000,000
Estimated FY 2016-17 Total Expenditure	$4,768,586	$1,759,185	$12,129,596	$412,281	$23,084,252	$9,986,906	$35,162,079	$0	$62,802,333	$8,097,096	$2,753,310	$1,288,782	$194,066	$0	$0	$162,438,472
Estimated FY 2016-17 Per Capita Cost	$111.34	$151.85	$169.48	$72.06	$118.79	$114.86	$115.92	$0.00	$127.09	$125.29	$138.06	$86.40	$112.50	$0.00	$0.00	$120.15

Out Year Projection

ACCOUNTABLE CARE COLLABORATIVE	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 RCCOs in the ACC	$1,261,401	$891,230	$6,650,672	$359,886	$18,657,408	$8,292,890	$28,375,600	$0	51,596,898	$6,792,575	$2,221,107	$1,033,771	$161,320	$0	$0	$126,294,758
ACC: Medicare-Medicaid Program (RCCOs in the ACC)	$2,740,320	$555,120	$3,240,000	$13,680	$636,480	$720	$1,440	$0	$5,760	$0	$1,440	$5,040	$0	$0	$0	$7,200,000
Estimated Expenditure for PCMPs in the ACC	$361,808	$255,740	$1,906,886	$104,258	$5,370,322	$2,385,856	$8,142,973	$0	14,831,969	$1,956,201	$637,436	$296,662	$46,396	$0	$0	$36,296,507
ACC: Medicare-Medicaid Program (PCMPs in the ACC)	$464,227	$102,902	$593,827	$2,851	$129,989	$130	$130	$0	$907	$0	$259	$778	$0	$0	$0	$1,296,000
Estimated Expenditure for SDAC in the ACC	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2017-18 Total Expenditure	$4,827,756	$1,804,992	$12,391,385	$480,675	$24,794,199	$10,679,596	$36,520,143	$0	$66,435,534	$8,748,776	$2,860,242	$1,336,251	$207,716	$0	$0	$171,087,265
Estimated FY 2017-18 Per Capita Cost	$111.06	$148.41	$166.86	$74.16	$121.22	$117.36	$118.59	$0.00	$128.89	$126.13	$143.26	$88.96	$120.42	$0.00	$0.00	$121.70

Note: Current and Request Year Projections are calculated in pages EI-7 and EI-8.

Exhibit I - SERVICE MANAGEMENT - ACCOUNTABLE CARE COLLABORATIVE

Cash Based Actuals by Provider				
ACCOUNTABLE CARE COLLABORATIVE	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2010-11 (DA)	$182,819	$54,592	$650,000	$887,411
FY 2011-12	$12,303,473	$2,904,360	$2,700,000	$17,907,833
FY 2012-13	$27,696,161	$6,130,270	$2,902,500	$36,728,931
FY 2013-14	$52,945,462	$12,674,868	$2,950,000	$68,570,330
FY 2014-15	$79,471,841	$21,419,450	$2,850,000	$103,741,291
Estimated FY 2015-16	$110,459,308	$32,812,838	$3,000,000	$146,272,146
Estimated FY 2016-17	$125,944,642	$35,493,830	$1,000,000	$162,438,472
Estimated FY 2017-18	$133,494,758	$37,592,507	$0	$171,087,265

Percent Change in Cash Based Actuals				
ACCOUNTABLE CARE COLLABORATIVE	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2011-12	6629.87%	5220.12%	315.38%	1917.99%
FY 2012-13	125.11%	111.07%	7.50%	105.10%
FY 2013-14	91.17%	106.76%	1.64%	86.69%
FY 2014-15	50.10%	68.99%	-3.39%	51.29%
Estimated FY 2015-16	38.99%	53.19%	5.26%	41.00%
Estimated FY 2016-17	14.02%	8.17%	-66.67%	11.05%
Estimated FY 2017-18	5.99%	5.91%	-100.00%	5.32%

Accountable Care Collaborative Enrollment				
ACCOUNTABLE CARE COLLABORATIVE	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL[1]
Enrollment in the Accountable Care Collaborative				
FY 2010-11 (DA)	1,172	1,172	1,172	3,516
FY 2011-12	78,870	60,540	78,870	218,280
FY 2012-13	226,499	169,874	226,499	226,499
FY 2013-14	455,426	334,992	455,426	455,426
FY 2014-15	751,742	550,486	751,742	751,742
Estimated FY 2015-16	892,657	656,601	892,657	892,657
Estimated FY 2016-17	968,591	712,455	968,591	968,591
Estimated FY 2017-18	1,028,032	756,177	1,028,032	1,028,032

Annual Percent Change in Enrollment				
FY 2011-12	6629.52%	5065.53%	6629.52%	6108.19%
FY 2012-13	187.18%	180.60%	187.18%	3.77%
FY 2013-14	101.07%	97.20%	101.07%	101.07%
FY 2014-15	65.06%	64.33%	65.06%	65.06%
Estimated FY 2015-16	18.75%	19.28%	18.75%	18.75%
Estimated FY 2016-17	8.51%	8.51%	8.51%	8.51%
Estimated FY 2017-18	6.14%	6.14%	6.14%	6.14%

Exhibit I - SERVICE MANAGEMENT - ACCOUNTABLE CARE COLLABORATIVE

Cost Per Enrollee

ACCOUNTABLE CARE COLLABORATIVE	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2010-11 (DA)	$155.99	$46.58	$554.61	$252.39
FY 2011-12	$156.00	$47.97	$34.23	$82.04
FY 2012-13	$122.28	$36.09	$12.81	$162.16
FY 2013-14	$116.25	$37.84	$6.48	$150.56
FY 2014-15	$105.72	$38.91	$3.79	$138.00
Estimated FY 2015-16	$123.74	$49.97	$3.36	$163.86
Estimated FY 2016-17	$130.03	$49.82	$1.03	$167.71
Estimated FY 2017-18	$129.85	$49.71	$0.00	$166.42

Percent Change in Cost Per Enrollee

ACCOUNTABLE CARE COLLABORATIVE	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2011-12	0.01%	2.98%	-93.83%	-67.49%
FY 2012-13	-21.62%	-24.77%	-62.58%	97.66%
FY 2013-14	-4.93%	4.85%	-49.41%	-7.15%
FY 2014-15	-9.06%	2.83%	-41.51%	-8.34%
Estimated FY 2015-16	17.05%	28.42%	-11.35%	18.74%
Estimated FY 2016-17	5.08%	-0.30%	-69.35%	2.35%
Estimated FY 2017-18	-0.14%	-0.22%	-100.00%	-0.77%

Current Year Projection

ACCOUNTABLE CARE COLLABORATIVE	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	892,657	656,601	N/A	892,657
FY 2015-16 PMPM Administration Fee	$9.98	$4.00	N/A	
Number of Months Paid	12	12	N/A	
Estimated FY 2015-16 Base Expenditure	$106,868,808	$31,516,838	$3,000,000	$141,385,646
FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	$3,590,500	$1,296,000	$0	$4,886,500
Total Bottom Line Impacts	$3,590,500	$1,296,000	$0	$4,886,500
Estimated Contract Payment to PIHP for Cost Avoidance	$0	$0	$0	$0
Estimated FY 2015-16 Total Expenditure	**$110,459,308**	**$32,812,838**	**$3,000,000**	**$146,272,146**
Estimated FY 2015-16 Cost Per Enrollee	$123.74	$49.97	$3.36	$163.86
% Change over FY 2014-15 Cost Per Enrollee	17.05%	28.42%	-11.35%	18.74%

Request Year Projection

ACCOUNTABLE CARE COLLABORATIVE	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	968,591	712,455	N/A	968,591
FY 2016-17 PMPM Administration Fee	$10.22	$4.00	N/A	
Number of Months Paid	12	12	N/A	
Estimated FY 2016-17 Base Expenditure	$118,744,642	$34,197,830	$1,000,000	$153,942,472
FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees" Annualization	$7,200,000	$1,296,000	$0	$8,496,000
Total Bottom Line Impacts	$7,200,000	$1,296,000	$0	$8,496,000
Estimated FY 2016-17 Total Expenditure	**$125,944,642**	**$35,493,830**	**$1,000,000**	**$162,438,472**
Estimated FY 2016-17 Cost Per Enrollee	$130.03	$49.82	$1.03	$167.71
% Change over FY 2015-16 Cost Per Enrollee	5.08%	-0.30%	-69.35%	2.35%

Out Year Projection

ACCOUNTABLE CARE COLLABORATIVE	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
Estimated FY 2017-18 Enrollment	1,028,032	756,177	N/A	1,028,032
FY 2017-18 PMPM Administration Fee	$10.24	$4.00	N/A	
Number of Months Paid	12	12	N/A	
Estimated FY 2017-18 Base Expenditure	$126,294,758	$36,296,507	$0	$162,591,265
FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees" Annualization	$7,200,000	$1,296,000	$0	$8,496,000
Total Bottom Line Impacts	$7,200,000	$1,296,000	$0	$8,496,000
Estimated FY 2017-18 Total Expenditure	**$133,494,758**	**$37,592,507**	**$0**	**$171,087,265**
Estimated FY 2017-18 Cost Per Enrollee	$129.85	$49.71	$0.00	$166.42
% Change over FY 2016-17 Cost Per Enrollee	-0.14%	-0.22%	-100.00%	-0.77%

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

(2) Enrollment Modifications: Estimates for enrollment are based on the Department's implementation plan. SDAC is paid on a fixed-price contract and is not a function of enrollment.

Exhibit I - SERVICE MANAGEMENT - PREPAID INPATIENT HEALTH PLAN ADMINISTRATION

Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	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	$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)	$411,355	$211,517	$1,451,792	$0	$793,726	$238,521	$0	$0	$3,063,511	$0	$216,554	$88,268	$0	$0	$0	$6,475,244
FY 2011-12	$514,348	$183,069	$1,118,391	$1,094	$1,332,529	$526,053	$0	$0	$4,776,807	$0	$325,880	$113,177	$0	$0	$0	$8,891,348
FY 2012-13	$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
FY 2013-14	$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
FY 2014-15	$131,201	$52,198	$339,287	$15,518	$415,468	$119,209	$229,248	$0	$652,475	$52,903	$83,940	$100,164	$9,170	$0	$705	$2,201,486

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 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)	23.91%	80.79%	54.76%	0.00%	11.24%	100.00%	0.00%	0.00%	12.82%	0.00%	3.96%	0.92%	0.00%	0.00%	0.00%	26.67%
FY 2011-12	25.04%	-13.45%	-22.96%	100.00%	67.88%	120.55%	0.00%	0.00%	55.93%	0.00%	50.48%	28.22%	0.00%	0.00%	0.00%	37.31%
FY 2012-13	-38.85%	-44.26%	-34.88%	880.16%	-21.27%	-19.15%	0.00%	0.00%	-22.56%	100.00%	-24.29%	-28.65%	100.00%	0.00%	0.00%	-24.81%
FY 2013-14	65.65%	146.50%	102.43%	307.81%	48.11%	-0.12%	100.00%	0.00%	-27.25%	57.41%	6.85%	225.42%	1294.59%	0.00%	100.00%	14.14%
FY 2014-15	-74.82%	-79.25%	-76.99%	-64.51%	-73.26%	-71.94%	159.65%	0.00%	-75.76%	20.97%	-68.16%	-61.88%	4.54%	0.00%	-71.79%	-71.15%

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	$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)	$10.57	$27.23	$25.79	$0.00	$9.79	$8.78	$0.00	$0.00	$10.13	$0.00	$11.77	$11.22	$0.00	$0.00	$0.00	$11.55
FY 2011-12	$12.94	$21.84	$18.82	$21.04	$14.29	$14.83	$0.00	$0.00	$14.27	$0.00	$18.07	$14.83	$0.00	$0.00	$0.00	$14.34
FY 2012-13	$7.70	$11.27	$11.76	$12.08	$10.56	$10.24	$0.00	$0.00	$10.28	$3.37	$13.88	$10.06	$1.83	$0.00	$0.00	$9.79
FY 2013-14	$12.45	$25.53	$22.88	$17.08	$12.46	$9.02	$1.01	$0.00	$6.74	$1.73	$14.43	$19.97	$8.30	$0.00	$0.11	$8.86
FY 2014-15	$3.14	$4.99	$5.10	$4.28	$2.55	$1.66	$0.95	$0.00	$1.46	$1.06	$4.19	$6.72	$5.24	$0.00	$0.03	$1.90

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 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)	22.48%	64.04%	46.45%	0.00%	2.73%	100.00%	0.00%	0.00%	2.84%	0.00%	3.88%	0.45%	0.00%	0.00%	0.00%	12.68%
FY 2011-12	22.42%	-19.79%	-27.03%	100.00%	45.97%	68.91%	0.00%	0.00%	40.87%	0.00%	53.53%	32.17%	0.00%	0.00%	0.00%	24.16%
FY 2012-13	-40.49%	-48.40%	-37.51%	-42.59%	-26.10%	-30.95%	0.00%	0.00%	-27.96%	100.00%	-23.19%	-32.16%	100.00%	0.00%	0.00%	-31.73%
FY 2013-14	61.69%	126.53%	94.56%	41.39%	17.99%	-11.91%	100.00%	0.00%	-34.44%	-48.66%	3.96%	98.51%	353.55%	0.00%	100.00%	-9.50%
FY 2014-15	-74.78%	-80.45%	-77.71%	-74.94%	-79.53%	-81.60%	-5.94%	0.00%	-78.34%	-38.73%	-70.96%	-66.35%	-36.87%	0.00%	-72.73%	-78.56%

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)	TOTAL
FY 2008-09	$3,935,134	$0	$0	$0	$3,935,134
FY 2009-10 (DA)	$4,744,734	$258,779	$65,940	$42,300	$5,111,753
FY 2010-11 (DA)	$5,437,512	$705,541	$130,440	$201,750	$6,475,244
FY 2011-12	$8,387,798	$0	$240,000	$263,550	$8,891,348
FY 2012-13	$6,685,075	$0	$0	$0	$6,685,075
FY 2013-14	$7,630,138	$0	$0	$0	$7,630,138
FY 2014-15	$2,201,486	$0	$0	$0	$2,201,486

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)	TOTAL
FY 2008-09	9.02%	0.00%	0.00%	0.00%	-14.83%
FY 2009-10 (DA)	20.57%	100.00%	100.00%	100.00%	29.90%
FY 2010-11 (DA)	14.60%	172.64%	97.82%	376.95%	26.67%
FY 2011-12	54.26%	-100.00%	83.99%	30.63%	37.31%
FY 2012-13	-20.30%	0.00%	-100.00%	-100.00%	-24.81%
FY 2013-14	14.14%	0.00%	0.00%	0.00%	14.14%
FY 2014-15	-71.15%	0.00%	0.00%	0.00%	-71.15%

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)	TOTAL[1]
Enrollment in Current Prepaid Inpatient Health Plans					
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	21,527
FY 2011-12	21,138	-	-	163	21,301
FY 2012-13	29,875	-	-	-	29,875
FY 2013-14	31,185	-	-	-	31,185
FY 2014-15	8,835	-	-	-	8,835

Annual Percent Change in Enrollment

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	TOTAL
FY 2009-10 (DA)	23.54%	100.00%	100.00%	100.00%	42.58%
FY 2010-11 (DA)	18.12%	-16.47%	97.82%	366.67%	15.69%
FY 2011-12	10.99%	-100.00%	-100.00%	45.54%	-1.05%
FY 2012-13	41.33%	0.00%	0.00%	-100.00%	40.25%
FY 2013-14	4.38%	0.00%	0.00%	0.00%	4.38%
FY 2014-15	-71.67%	0.00%	0.00%	0.00%	-71.67%

Cost Per Enrollee

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	TOTAL
FY 2008-09	$301.52	$0.00	$0.00	$0.00	$301.52
FY 2009-10 (DA)	$294.28	$118.38	$239.78	$1,762.50	$274.71
FY 2010-11 (DA)	$285.51	$386.39	$239.78	$1,801.34	$300.80
FY 2011-12	$396.81	$0.00	$0.00	$1,616.87	$417.41
FY 2012-13	$223.77	$0.00	$0.00	$0.00	$223.77
FY 2013-14	$244.67	$0.00	$0.00	$0.00	$244.67
FY 2014-15	$249.18	$0.00	$0.00	$0.00	$249.18

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)	TOTAL
FY 2009-10 (DA)	-2.40%	100.00%	100.00%	100.00%	-8.89%
FY 2010-11 (DA)	-2.98%	226.40%	0.00%	2.20%	9.50%
FY 2011-12	38.98%	-100.00%	-100.00%	-10.24%	38.77%
FY 2012-13	-43.61%	0.00%	0.00%	-100.00%	-46.39%
FY 2013-14	9.34%	0.00%	0.00%	0.00%	9.34%
FY 2014-15	1.84%	0.00%	0.00%	0.00%	1.84%

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

(2) Enrollment Modifications:
- **RMHP:** Program ended November 30, 2014; all clients were disenrolled from program.
- **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.

Exhibit J - Health Care Affordability Act of 2009 Estimates

Cash Funded Expansion Populations
Source of Funding

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	82,897	$208,071,733	$0	$50,820	$0	$208,020,913	100.00%
Buy-In for Individuals with Disabilities	4,859	$33,553,204	$0	$14,898,405	$3,278,046	$15,376,753	50.79%
MAGI Adults	291,149	$1,153,794,381	$0	$691,254	$0	$1,153,103,127	100.00%
Non-Newly Eligibles	1,942	$31,497,153	$0	$3,874,149	$0	$27,623,004	87.70%
MAGI Parents/Caretakers 60% to 68% FPL	12,218	$30,170,062	$0	$14,846,687	$0	$15,323,375	50.79%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$1,457,086,533	$0	$34,361,315	$3,278,046	$1,419,447,172	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$598,100,000	$0	$293,800,000	$0	$304,300,000	50.88%
Outpatient Hospital Rates		$288,000,000	$0	$142,000,000	$0	$146,000,000	50.69%
Uncompensated Care Payment		$115,500,000	$0	$57,000,000	$0	$58,500,000	50.65%
Hospital Quality Incentive Payment		$84,800,000	$0	$41,800,000	$0	$43,000,000	50.71%
Subtotal from HB 09-1293 Supplemental Payments		$1,086,400,000	$0	$534,600,000	$0	$551,800,000	
Cash Fund Financing		$0	($40,994,841)	$40,994,841	$0	$0	
HB 09-1293 Total		**$2,543,486,533**	**($40,994,841)**	**$609,956,156**	**$3,278,046**	**$1,971,247,172**	

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	86,948	$210,364,476	$0	$5,313,312	$0	$205,051,164	97.50%
Buy-in for Individuals with Disabilities	5,721	$37,597,723	$0	$16,720,668	$3,873,100	$17,003,955	50.42%
MAGI Adults	301,325	$1,198,346,361	$0	$30,693,587	$0	$1,167,652,774	97.50%
Non-Newly Eligibles	2,016	$33,269,058	$0	$4,747,494	$0	$28,521,564	85.73%
MAGI Parents/Caretakers 60% to 68% FPL	13,071	$31,857,217	$0	$15,794,808	$0	$16,062,409	50.42%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$1,511,434,835	$0	$73,269,869	$3,873,100	$1,434,291,866	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$339,000,000	$0	$168,100,000	$0	$170,900,000	50.41%
Outpatient Hospital Rates		$139,700,000	$0	$69,300,000	$0	$70,400,000	50.39%
Uncompensated Care Payment		$115,500,000	$0	$57,300,000	$0	$58,200,000	50.39%
Hospital Quality Incentive Payment		$84,800,000	$0	$42,000,000	$0	$42,800,000	50.47%
Subtotal from HB 09-1293 Supplemental Payments		$679,000,000	$0	$336,700,000	$0	$342,300,000	
Cash Fund Financing		$0	($43,036,135)	$43,036,135	$0	$0	
HB 09-1293 Total		**$2,190,434,835**	**($43,036,135)**	**$453,006,004**	**$3,873,100**	**$1,776,591,866**	

FY 2017-18 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	91,000	$217,381,512	$0	$12,011,537	$0	$205,369,975	94.50%
Buy-in for Individuals with Disabilities	6,482	$42,083,230	$0	$18,750,796	$4,400,760	$18,931,674	50.24%
MAGI Adults	305,880	$1,230,488,343	$0	$68,426,514	$0	$1,162,061,829	94.50%
Non-Newly Eligibles	2,061	$34,300,230	$0	$5,680,118	$0	$28,620,112	83.44%
MAGI Parents/Caretakers 60% to 68% FPL	13,757	$33,053,119	$0	$16,447,232	$0	$16,605,887	50.24%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$1,557,306,434	$0	$121,316,197	$4,400,760	$1,431,589,477	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$318,900,000	$0	$158,700,000	$0	$160,200,000	50.24%
Outpatient Hospital Rates		$133,500,000	$0	$66,400,000	$0	$67,100,000	50.26%
Uncompensated Care Payment		$115,500,000	$0	$57,500,000	$0	$58,000,000	50.22%
Hospital Quality Incentive Payment		$84,800,000	$0	$42,200,000	$0	$42,600,000	50.24%
Subtotal from HB 09-1293 Supplemental Payments		$652,700,000	$0	$324,800,000	$0	$327,900,000	
Cash Fund Financing		$0	($45,039,874)	$45,039,874	$0	$0	
HB 09-1293 Total		**$2,210,006,434**	**($45,039,874)**	**$491,156,071**	**$4,400,760**	**$1,759,489,477**	

Exhibit J - Health Care Affordability Act of 2009 Estimates

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

MAGI Parents/Caretakers 69% to 133% FPL[1]	Caseload	Per Capita	Total Funds [2]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$2,394.07	$198,461,286	$0	$0	$0	$198,461,286
Community Based Long-Term Care		$4.82	$399,844	$0	$50,820	$0	$349,024
Long-Term Care		$0.16	$13,445	$0	$0	$0	$13,445
Insurance		$0.33	$27,683	$0	$0	$0	$27,683
Service Management		$110.61	$9,169,475	$0	$0	$0	$9,169,475
Total	**82,897**	**$2,509.99**	**$208,071,733**	**$0**	**$50,820**	**$0**	**$208,020,913**
Buy-In for Individuals with Disabilities							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$5,873.65	$28,540,089	$0	$12,672,465	$2,788,280	$13,079,344
Community Based Long-Term Care		$934.14	$4,538,984	$0	$2,015,415	$443,445	$2,080,124
Long-Term Care		$31.87	$154,878	$0	$68,769	$15,131	$70,978
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$65.70	$319,253	$0	$141,756	$31,190	$146,307
Total	**4,859**	**$6,905.37**	**$33,553,204**	**$0**	**$14,898,405**	**$3,278,046**	**$15,376,753**
MAGI Adults[1]							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$3,826.99	$1,114,224,454	$0	$0	$0	$1,114,224,454
Community Based Long-Term Care		$20.19	$5,878,006	$0	$691,254	$0	$5,186,752
Long-Term Care		$3.67	$1,067,125	$0	$0	$0	$1,067,125
Insurance		$0.09	$24,913	$0	$0	$0	$24,913
Service Management		$111.97	$32,599,883	$0	$0	$0	$32,599,883
Total	**291,149**	**$3,962.90**	**$1,153,794,381**	**$0**	**$691,254**	**$0**	**$1,153,103,127**
Non-Newly Eligibles							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$15,107.32	$29,338,412	$0	$3,608,625	$0	$25,729,787
Community Based Long-Term Care		$430.26	$835,556	$0	$102,773	$0	$732,783
Long-Term Care		$621.82	$1,207,565	$0	$148,530	$0	$1,059,035
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$59.54	$115,620	$0	$14,221	$0	$101,399
Total	**1,942**	**$16,218.94**	**$31,497,153**	**$0**	**$3,874,149**	**$0**	**$27,623,004**
MAGI Parents/Caretakers 60% to 68% FPL							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,365.99	$28,908,266	$0	$14,225,758	$0	$14,682,508
Community Based Long-Term Care		$11.38	$139,058	$0	$68,430	$0	$70,628
Long-Term Care		$0.97	$11,838	$0	$5,825	$0	$6,013
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$90.92	$1,110,900	$0	$546,674	$0	$564,226
Total	**12,218**	**$2,469.26**	**$30,170,062**	**$0**	**$14,846,687**	**$0**	**$15,323,375**
FY 2015-16 Summary							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**393,065**	**$3,706.98**	**$1,457,086,533**	**$0**	**$34,361,315**	**$3,278,046**	**$1,419,447,172**

(1) The matching federal funds for this population increased from 50% to 100% effective January 1, 2014 in accordance with the Affordable Care Act.
(2) Figures may not sum due to rounding.

Exhibit J - Health Care Affordability Act of 2009 Estimates

Hospital Provider Fee - Fund Splits and Service Category Impacts by Expansion Population FY 2016-17							
MAGI Parents/Caretakers 69% to 133% FPL[1]							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,298.13	$199,817,846	$0	$4,995,446	$0	$194,822,400
Community Based Long-Term Care		$4.93	$428,463	$0	$64,912	$0	$363,551
Long-Term Care		$0.16	$13,850	$0	$346	$0	$13,504
Insurance		$0.40	$34,810	$0	$870	$0	$33,940
Service Management		$115.81	$10,069,507	$0	$251,738	$0	$9,817,769
Total	**86,948**	**$2,419.43**	**$210,364,476**	**$0**	**$5,313,312**	**$0**	**$205,051,164**
Buy-In for Individuals with Disabilities							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$5,560.02	$31,808,879	$0	$14,146,222	$3,276,766	$14,385,891
Community Based Long-Term Care		$910.05	$5,206,384	$0	$2,315,412	$536,332	$2,354,640
Long-Term Care		$27.89	$159,538	$0	$70,950	$16,435	$72,153
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$73.92	$422,922	$0	$188,084	$43,567	$191,271
Total	**5,721**	**$6,571.88**	**$37,597,723**	**$0**	**$16,720,668**	**$3,873,100**	**$17,003,955**
MAGI Adults[1]							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds[2]**
Acute Care		$3,834.92	$1,155,557,734	$0	$28,888,943	$0	$1,126,668,791
Community Based Long-Term Care		$20.78	$6,260,042	$0	$891,430	$0	$5,368,612
Long-Term Care		$3.49	$1,051,759	$0	$26,294	$0	$1,025,465
Insurance		$0.10	$31,327	$0	$783	$0	$30,544
Service Management		$117.63	$35,445,499	$0	$886,137	$0	$34,559,362
Total	**301,325**	**$3,976.92**	**$1,198,346,361**	**$0**	**$30,693,587**	**$0**	**$1,167,652,774**
Non-Newly Eligibles							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$15,361.02	$30,967,820	$0	$4,419,108	$0	$26,548,712
Community Based Long-Term Care		$441.39	$889,840	$0	$126,980	$0	$762,860
Long-Term Care		$640.56	$1,291,374	$0	$184,279	$0	$1,107,095
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$59.54	$120,024	$0	$17,127	$0	$102,897
Total	**2,016**	**$16,502.51**	**$33,269,058**	**$0**	**$4,747,494**	**$0**	**$28,521,564**
MAGI Parents/Caretakers 60% to 68% FPL							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,329.08	$30,443,583	$0	$15,093,928	$0	$15,349,655
Community Based Long-Term Care		$11.16	$145,904	$0	$72,339	$0	$73,565
Long-Term Care		$1.00	$13,065	$0	$6,478	$0	$6,587
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$95.99	$1,254,665	$0	$622,063	$0	$632,602
Total	**13,071**	**$2,437.23**	**$31,857,217**	**$0**	**$15,794,808**	**$0**	**$16,062,409**
FY 2016-17 Summary							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**409,081**	**$3,694.71**	**$1,511,434,835**	**$0**	**$73,269,869**	**$3,873,100**	**$1,434,291,866**

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

(2) Figures may not sum due to rounding.

Exhibit J - Health Care Affordability Act of 2009 Estimates

Hospital Provider Fee - Fund Splits and Service Category Impacts by Expansion Population
FY 2017-18

MAGI Parents/Caretakers 69% to 133% FPL[1]	Caseload	Per Capita	Total Funds [2]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$2,264.84	$206,100,502	$0	$11,335,528	$0	$194,764,974
Community Based Long-Term Care		$5.02	$456,854	$0	$80,680	$0	$376,174
Long-Term Care		$0.16	$14,245	$0	$783	$0	$13,462
Insurance		$0.48	$43,865	$0	$2,413	$0	$41,452
Service Management		$118.31	$10,766,046	$0	$592,133	$0	$10,173,913
Total	**91,000**	**$2,388.81**	**$217,381,512**	**$0**	**$12,011,537**	**$0**	**$205,369,975**
Buy-In for Individuals with Disabilities	**Caseload**	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$5,512.62	$35,732,783	$0	$15,921,262	$3,736,677	$16,074,844
Community Based Long-Term Care		$878.37	$5,693,617	$0	$2,536,874	$595,397	$2,561,346
Long-Term Care		$25.32	$164,098	$0	$73,116	$17,160	$73,822
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$76.02	$492,732	$0	$219,544	$51,526	$221,662
Total	**6,482**	**$6,492.32**	**$42,083,230**	**$0**	**$18,750,796**	**$4,400,760**	**$18,931,674**
MAGI Adults[1]	**Caseload**	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds[1]**
Acute Care		$3,877.38	$1,186,014,038	$0	$65,230,772	$0	$1,120,783,266
Community Based Long-Term Care		$21.50	$6,575,924	$0	$1,111,331	$0	$5,464,593
Long-Term Care		$3.44	$1,051,914	$0	$57,855	$0	$994,059
Insurance		$0.13	$39,475	$0	$2,171	$0	$37,304
Service Management		$120.33	$36,806,992	$0	$2,024,385	$0	$34,782,607
Total	**305,880**	**$4,022.78**	**$1,230,488,343**	**$0**	**$68,426,514**	**$0**	**$1,162,061,829**
Non-Newly Eligibles	**Caseload**	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$15,469.78	$31,883,213	$0	$5,279,860	$0	$26,603,353
Community Based Long-Term Care		$454.21	$936,122	$0	$155,022	$0	$781,100
Long-Term Care		$658.99	$1,358,182	$0	$224,915	$0	$1,133,267
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$59.54	$122,713	$0	$20,321	$0	$102,392
Total	**2,061**	**$16,642.52**	**$34,300,230**	**$0**	**$5,680,118**	**$0**	**$28,620,112**
MAGI Parents/Caretakers 60% to 68% FPL	**Caseload**	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,292.75	$31,541,968	$0	$15,695,283	$0	$15,846,685
Community Based Long-Term Care		$10.86	$149,429	$0	$74,356	$0	$75,073
Long-Term Care		$1.03	$14,111	$0	$7,022	$0	$7,089
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$97.96	$1,347,611	$0	$670,571	$0	$677,040
Total	**13,757**	**$2,402.60**	**$33,053,119**	**$0**	**$16,447,232**	**$0**	**$16,605,887**
FY 2017-18 Summary	**Caseload**	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**419,180**	**$3,715.12**	**$1,557,306,434**	**$0**	**$121,316,197**	**$4,400,760**	**$1,431,589,477**

(1) The matching federal funds for this population will decrease from 95% to 94% effective January 1, 2018 in accordance with the Affordable Care Act.
(2) Figures may not sum due to rounding.

Exhibit K - Upper Payment Limit Financing

Summary of Upper Payment Limit Financing

Nursing Facilities UPL	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**
Total Funds	$3,627,458	$3,735,747	$3,847,880
General Fund	($3,766,463)	($3,829,556)	($3,892,776)
Cash Funds	$3,627,458	$3,735,747	$3,847,880
Federal Funds	$3,766,463	$3,829,556	$3,892,776
Home Health UPL			
Total Funds	$303,416	$312,523	$320,282
General Fund	($311,035)	($316,170)	($322,983)
Cash Funds	$303,416	$312,523	$320,282
Federal Funds	$311,035	$316,170	$322,983
Total Upper Payment Limit Financing			
Total Funds	$3,930,874	$4,048,270	$4,168,162
General Fund	($4,077,498)	($4,145,726)	($4,215,759)
Cash Funds	$3,930,874	$4,048,270	$4,168,162
Federal Funds	$4,077,498	$4,145,726	$4,215,759

Exhibit K - Upper Payment Limit Financing

Nursing Facilities Upper Payment Limit Calculation
Estimate Based on Calendar Year 2014 Actual Upper Payment Limit

State Nursing Facilities		
Provider Name	**Upper Payment Limit (Amount Remaining after Medicaid Payment)**	**Certified Uncompensated Cost**
Colorado St. Veterans - Fitzsimmons	$2,161,723	$1,299,994
Colorado St. Veterans - Florence	$1,043,312	$1,108,673
Colorado St. Veterans - Homelake	($524,888)	$3,246
Colorado St. Veterans - Rifle	$1,152,403	$758,537
Colorado St. Veterans - Walsenburg	$504,011	$371,815
State Nursing Facilities Total	**$4,336,561**	**$3,542,265**
Government Nursing Facilities		
Arkansas Valley	$2,298,875	$615,040
Bent County Healthcare Center	($156,524)	($505,210)
Cheyenne Manor	$277,354	$319,820
Cripple Creek Rehabilitation & Wellness Center	$85,291	($23,717)
E. Dene Moore Care Center	$1,059,750	$1,392,563
Gunnison Valley Health Senior Care	$11,020	($244,547)
Lincoln Community Hospital & Nursing Home	$462,678	$604,051
Prospect Park Living Center	$309,016	$235,750
Sedgwick County Hospital & Nursing Home	$2,730	($36,353)
Southeast Colorado Hospital & LTC Center	$324,445	$425,234
Walbridge Memorial Convalescent Wing	$620,712	$665,100
Walsh Healthcare Center	$272,231	$187,901
Washington County Nursing Home	($35,328)	$48,375
Weisbrod Memorial County Hospital & Nursing Home	$0	$0
Government Nursing Facilities Total	**$5,532,250**	**$3,684,007**

(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 2014 Upper Payment Limit	$7,393,922
Estimated CY 2015 Upper Payment Limit	$7,565,303
Estimated CY 2016 Upper Payment Limit	$7,740,656
Supplemental Medicaid Nursing Facility Payment FY 2015-16	
Total Funds	$3,627,458
General Fund (offset by Federal Funds)	($3,766,463)
Cash Funds	$3,627,458
Federal Funds	$3,766,463
Supplemental Medicaid Nursing Facility Payment FY 2016-17	
Total Funds	$3,735,747
General Fund (offset by Federal Funds)	($3,829,556)
Cash Funds	$3,735,747
Federal Funds	$3,829,556
Supplemental Medicaid Nursing Facility Payment FY 2017-18	
Total Funds	$3,847,880
General Fund (offset by Federal Funds)	($3,892,776)
Cash Funds	$3,847,880
Federal Funds	$3,892,776
CY 2013 Inflation Factor (1)	**2.32%**
(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 2015 Estimate (Based on CY 2014 Expenditures)

Provider Name	Total Funds by Provider
Alamosa County Nursing Service	($46,703)
Bent County Nursing Service	$42,928
Delta Montrose Home Health Services	$150,815
Estes Park Home Health	$93,930
Grand County Nursing Service	$22,159
Kiowa Home Health	$51,100
Kit Carson County Home Health	$12,721
Lincoln Community Home Health	$18,283
Pioneers Hospital Home Health	$9,160
Prowers Home Health	$25,717
Rangely District Home Health	$0
Southeast Colorado Hospital Home Health	$27,520
St Vincent Home Health Care	$102,085
Yuma District Home Health Care	$90,817
Home Health Total	**$600,532**

Exhibit K - Upper Payment Limit Financing

Supplemental Medicaid Home Health Payment	
CY 2015 Upper Payment Limit	$614,451
CY 2016 Upper Payment Limit	$628,693
CY 2017 Upper Payment Limit	$643,265
Supplemental Medicaid Home Health Payment FY 2015-16	
Total Funds	$303,416
General Fund	($311,035)
Cash Funds	$303,416
Federal Funds	$311,035
Supplemental Medicaid Home Health Payment FY 2016-17	
Total Funds	$312,523
General Fund	($316,170)
Cash Funds	$312,523
Federal Funds	$316,170
Supplemental Medicaid Home Health Payment FY 2017-18	
Total Funds	$320,282
General Fund	($322,983)
Cash Funds	$320,282
Federal Funds	$322,983
CY 2014 Inflation Factor [1]	**2.32%**
(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 2013 for FY 2014-15 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 2013 for FY 2014-15 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%

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**	**FY 2014-15**	**Estimated FY 2015-16**	**Estimated FY 2016-17**	**Estimated FY 2017-18**
Estate Recoveries[1]	$3,168,376	$3,682,865	$3,006,302	$2,993,722	$4,679,459	$5,283,510	$6,969,380	$7,753,700	$8,224,337	$9,149,575
Income Trust and Repayments[1]	$3,242,100	$3,217,373	$4,021,065	$4,202,267	$3,976,905	$3,467,692	$4,041,881	$4,496,746	$5,397,826	$6,005,082
Third Party Health Insurance	$8,705,554	$14,857,476	$17,714,457	$19,834,962	$27,406,316	$21,063,474	$26,598,141	$29,591,442	$32,787,505	$36,476,099
Third Party Casualty	$3,812,718	$3,917,944	$4,664,590	$6,983,907	$5,660,459	$7,093,986	$8,809,174	$9,800,540	$11,042,533	$12,284,818
Total Recoveries Including Bottom Line Impacts[2]	**$18,928,748**	**$25,675,658**	**$29,406,414**	**$34,014,858**	**$41,723,139**	**$36,908,662**	**$46,418,576**	**$51,642,428**	**$57,452,201**	**$63,915,574**

(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**	**FY 2014-15**	**Estimated FY 2015-16**	**Estimated FY 2016-17**	**Estimated FY 2017-18**
Estate Recoveries	11.50%	$386,701	$315,662	$314,341	$491,343	$554,769	$801,479	$891,676	$945,799	$1,052,201
Income Trust and Repayments[3]	0.00%	$0	$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	$1,835,272	$2,041,809	$2,262,338	$2,516,851
Third Party Casualty	9.40%	$329,107	$391,826	$586,648	$475,479	$595,895	$828,062	$921,251	$1,037,998	$1,154,773
Total		**$1,592,399**	**$1,752,641**	**$2,071,252**	**$2,583,795**	**$2,393,409**	**$3,464,813**	**$3,854,736**	**$4,246,135**	**$4,723,825**

(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 2012. 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 2015-16	$0	($19,507,116)	$48,177,615	($28,670,499)	59.51%
FY 2016-17	$0	($16,604,495)	$53,597,465	($36,992,970)	69.02%
FY 2017-18	$0	($18,843,609)	$59,669,439	($40,825,830)	68.42%

Recovery Trend for FY 2014-15 to FY 2015-16	11.25%
Recovery Trend for FY 2015-16 to FY 2016-17	11.25%
Recovery Trend for FY 2016-17 to FY 2017-18	11.25%

Exhibit M

	Cash-based Actuals															
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	COFRS TOTAL
Acute Care																
Physician Services & EPSDT	$3,776,843	$9,931,349	$66,664,488	$4,151,922	$96,955,505	$36,174,701	$178,973,643	$761,792	$183,426,199	$15,354,324	$13,496,613	$38,807,740	$4,466,332	$5,796,094	$15,421	$658,752,966
Emergency Transportation	$859,041	$652,931	$3,535,202	$75,434	$2,228,101	$509,063	$6,735,258	$7,271	$2,391,150	$182,463	$363,596	$496,966	$24,521	$82,366	$173	$18,143,536
Non-emergency Medical Transportation	$2,475,729	$1,336,601	$5,189,307	$78,567	$774,310	$122,908	$1,965,651	$8,739	$999,762	$81,503	$174,785	$91,373	$4,396	$1,295	$614	$13,305,540
Dental Services	$7,276,986	$2,546,431	$14,903,346	$758,572	$28,727,515	$11,520,162	$43,374,123	$51,409	$114,621,725	$16,983,429	$5,430,174	$1,912,622	$201,133	$20,395	$583	$248,328,605
Family Planning	$52	$179	$19,886	$624	$394,250	$174,600	$340,232	$3	$287,142	$35,930	$86,001	$67,235	$4,721	$131	$84	$1,411,070
Health Maintenance Organizations	$7,108,104	$11,373,164	$61,991,940	$1,144,978	$67,145,619	$26,786,330	$55,281,494	$34,393	$45,406,382	$4,302,012	$616,786	$11,594,085	$1,309,458	$0	$227	$294,094,972
Inpatient Hospitals	$16,329,589	$21,605,073	$90,638,415	$5,350,867	$58,315,959	$19,150,611	$223,805,633	$304,758	$120,310,552	$4,314,302	$7,112,415	$64,064,967	$6,919,861	$31,426,297	$47,179	$669,696,478
Outpatient Hospitals	$3,003,672	$8,416,372	$58,113,463	$3,370,333	$95,511,072	$33,777,915	$184,440,014	$596,343	$110,939,446	$10,873,806	$7,956,496	$11,677,314	$1,057,637	$2,584,762	$3,245	$532,321,890
Lab & X-Ray	$467,377	$1,257,069	$8,156,132	$427,436	$22,024,217	$7,965,752	$31,345,973	$55,728	$10,683,747	$1,187,801	$1,586,651	$8,254,433	$873,621	$182,391	$368	$94,468,696
Durable Medical Equipment	$21,391,862	$7,246,591	$62,892,754	$1,370,560	$8,143,671	$2,671,492	$19,209,355	$53,125	$19,540,424	$1,602,450	$5,211,214	$437,325	$37,823	$11,845	$65,856	$149,886,347
Prescription Drugs	$6,407,504	$22,030,414	$150,791,887	$6,114,889	$100,896,192	$37,586,354	$205,456,661	$335,917	$98,850,813	$13,583,668	$20,579,482	$6,009,289	$529,789	$4,381	$1,031	$669,178,271
Drug Rebate	($3,075,945)	($10,575,778)	($72,388,174)	($2,935,474)	($48,435,571)	($18,043,461)	($98,630,190)	($161,258)	($47,453,679)	($6,520,888)	($9,879,252)	($2,884,780)	($254,327)	($2,103)	($495)	($321,241,375)
Rural Health Centers	$63,562	$302,285	$1,423,255	$38,923	$3,671,941	$1,453,465	$4,386,258	$5,175	$8,298,508	$743,132	$397,646	$684,350	$41,943	$8,625	$0	$21,519,068
Federally Qualified Health Centers	$852,268	$1,483,941	$8,425,338	$188,228	$19,070,434	$8,513,069	$41,565,591	$76,344	$51,086,040	$4,374,281	$1,753,888	$10,572,023	$932,642	$401,433	$2,208	$149,297,728
Co-Insurance (Title XVIII-Medicare)	$21,422,222	$3,890,105	$14,964,183	$1,010,355	$2,740,802	$46,365	$283,433	$616	$22,822	$1,377	$12,912	$57,210	$729	$4,646	$8,405,261	$52,863,038
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$2,945,495	$0	$0	$0	$0	$0	$0	$0	$2,945,495
Prepaid Inpatient Health Plan Services	$1,241,845	$1,030,356	$11,286,756	$188,092	$11,059,110	$2,505,549	$3,845,321	$0	$8,536,384	$598,839	$1,329,535	$3,204,865	$245,231	$0	$7,038	$45,078,921
Other Medical Services	$622	$521	$3,520	$132	$2,561	$941	$5,082	$27	$3,935	$372	$393	$775	$82	$205	$42	$19,210
Acute Home Health	$5,197,837	$2,805,984	$13,544,480	$242,091	$1,044,220	$332,968	$4,313,996	$12,103	$1,823,848	$266,880	$579,101	$114,469	$13,735	$0	($24,975)	$30,266,737
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$94,799,170**	**$85,333,588**	**$500,156,178**	**$21,576,529**	**$470,269,908**	**$171,248,784**	**$906,697,528**	**$5,087,980**	**$729,775,200**	**$67,965,681**	**$56,808,436**	**$155,162,261**	**$16,409,327**	**$40,522,763**	**$8,523,860**	**$3,330,337,193**
Community Based Long Term Care																
HCBS - Elderly, Blind, and Disabled	$146,156,428	$27,217,782	$121,805,757	$1,393,062	$586,649	$104,832	$1,182,080	$0	$8,292	$0	$261,238	$28,983	$0	$1,154	$823,231	$299,569,488
HCBS - Mental Illness	$5,348,671	$4,296,544	$24,019,349	$36,913	$18,271	$2,852	$126,172	$0	$0	$0	$6,636	$0	$0	$0	$134,997	$33,990,405
HCBS - Disabled Children	$0	$0	$9,909,382	$70,019	$0	$0	$0	$0	$931,511	$953	$138	$0	$0	$0	$0	$10,912,003
HCBS - Persons Living with AIDS	($259)	($21)	($3,297)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($3,577)
HCBS - Consumer Directed Attendant Support	$1,177,217	$219,225	$981,084	$11,221	$4,725	$844	$9,521	$0	$67	$0	$2,104	$233	$0	$9	$6,631	$2,412,881
HCBS - Brain Injury	$535,796	$1,471,435	$13,391,479	$50,478	$38,919	$0	$115,222	$0	$0	$0	$0	$0	$0	$0	$17,819	$15,621,148
HCBS - Children with Autism	$0	$0	$666,234	$9,427	$0	$0	$0	$0	$21,721	$0	$12,676	$0	$0	$0	$0	$710,058
HCBS - Pediatric Hospice	$0	$0	$435,310	$1,749	$0	$0	$0	$0	$31,406	$0	$5,209	$0	$0	$0	$0	$473,674
HCBS - Spinal Cord Injury	$168,678	$28,884	$1,541,573	$6,801	$12,052	$0	$1,007	$0	$0	$0	$0	$0	$0	$0	$77	$1,759,072
Private Duty Nursing	$2,110,022	$441,354	$39,608,590	$300,436	$0	$0	$41,377	$0	$7,416,332	$27,252	$11,553,619	$0	$0	$0	$0	$61,498,982
Long Term Home Health	$28,375,632	$9,114,399	$139,389,238	$1,945,982	$310,179	$69,594	$1,335,165	$0	$18,387,951	$725,506	$12,889,124	$6,903	$0	$0	$27,780	$212,577,453
Hospice	$33,254,147	$3,938,226	$6,581,768	$160,754	$330,107	$193,375	$2,912,744	$6,536	$201,612	$2,960	$40,525	$0	$0	$0	$0	$47,622,754
Subtotal Community Based Long Term Care	**$217,126,332**	**$46,727,828**	**$358,326,467**	**$3,986,842**	**$1,300,902**	**$371,497**	**$5,723,288**	**$6,536**	**$26,998,892**	**$756,671**	**$24,771,269**	**$36,119**	**$0**	**$1,163**	**$1,010,535**	**$687,144,341**
Long Term Care																
Class I Nursing Facilities	$450,965,898	$41,239,990	$84,210,839	$82,897	$195,582	$40,448	$2,542,746	$0	$0	$0	$76,579	$0	$0	$0	($25,076)	$579,329,903
Class II Nursing Facilities	$411,017	$455,390	$3,411,444	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,277,851
Program of All-Inclusive Care for the Elderly	$112,128,644	$14,440,173	$6,335,950	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$132,904,767
Subtotal Long Term Care	**$563,505,559**	**$56,135,553**	**$93,958,233**	**$82,897**	**$195,582**	**$40,448**	**$2,542,746**	**$0**	**$0**	**$0**	**$76,579**	**$0**	**$0**	**$0**	**($25,076)**	**$716,512,521**
Insurance																
Supplemental Medicare Insurance Benefit	$73,205,694	$4,268,933	$38,373,381	$0	$240,024	$0	$0	$0	$0	$0	$0	$0	$0	$0	$21,183,050	$137,271,082
Health Insurance Buy-In Program	$8,989	$11,236	$1,101,111	$0	$13,483	$22,472	$20,224	$0	$78,651	$0	$0	$6,741	$0	$0	$0	$1,262,907
Subtotal Insurance	**$73,214,683**	**$4,280,169**	**$39,474,492**	**$0**	**$253,507**	**$22,472**	**$20,224**	**$0**	**$78,651**	**$0**	**$0**	**$6,741**	**$0**	**$0**	**$21,183,050**	**$138,533,989**
Service Management																
Single Entry Points	$9,072,052	$2,528,512	$18,428,481	$201,793	$44,524	$5,745	$170,914	$0	$1,712,006	$9,336	$315,974	$2,154	$0	$0	$127,826	$32,619,317
Disease Management	$8,232	$21,647	$145,304	$9,050	$211,327	$78,847	$390,096	$0	$0	$0	$29,418	$84,586	$9,735	$0	$0	$988,242
Prepaid Inpatient Health Plan Administration	$131,201	$52,198	$339,287	$15,518	$415,468	$119,209	$229,248	$0	$652,475	$52,903	$83,940	$100,164	$9,170	$0	$705	$2,201,486
Accountable Care Collaborative	$1,545,628	$745,776	$5,540,782	$158,094	$14,817,457	$6,186,010	$19,544,268	$0	$46,748,576	$5,337,255	$1,939,708	$950,390	$111,580	$25,697	$90,070	$103,741,291
Subtotal Service Management	**$10,757,113**	**$3,348,133**	**$24,453,854**	**$384,455**	**$15,488,776**	**$6,389,811**	**$20,334,526**	**$0**	**$49,113,057**	**$5,399,494**	**$2,369,040**	**$1,137,294**	**$130,485**	**$25,697**	**$218,601**	**$139,550,336**
Total Services	**$959,402,857**	**$195,825,271**	**$1,016,369,224**	**$26,030,723**	**$487,508,675**	**$178,073,012**	**$935,318,312**	**$5,094,516**	**$805,965,800**	**$74,121,846**	**$84,025,324**	**$156,342,415**	**$16,539,812**	**$40,549,623**	**$30,910,970**	**$5,012,078,380**
Financing & Supplemental Payments																
Upper Payment Limit Financing	$1,258,632	$161,114	$777,086	$15,459	$276,197	$97,407	$546,766	$1,731	$368,268	$33,548	$57,588	$33,593	$3,050	$7,366	($48)	$3,637,757
Hospital Supplemental Payments	$9,195,809	$14,455,768	$72,396,710	$4,242,831	$76,529,413	$26,375,042	$199,862,190	$450,030	$113,515,030	$7,623,900	$7,431,112	$36,022,359	$3,785,940	$16,050,535	$23,769	$587,960,438
Nursing Facility Supplemental Payments	$72,442,886	$6,624,766	$13,527,578	$13,317	$31,418	$6,498	$408,465	$0	$0	$0	$12,302	$0	$0	$0	($4,028)	$93,063,202
Physician Supplemental Payments	$26,713	$70,243	$471,506	$29,366	$685,748	$255,857	$1,265,848	$5,388	$1,297,340	$108,598	$95,459	$274,480	$31,589	$40,995	$109	$4,659,239
Outstationing Payments	$110,302	$309,069	$2,134,061	$123,766	$3,507,388	$1,240,403	$6,773,065	$21,899	$4,073,954	$399,312	$292,181	$428,818	$38,839	$94,918	$119	$19,548,094
Accounting Adjustments	$896,698	$202,430	$1,041,735	$29,261	$525,465	$192,966	$1,047,341	$5,456	$814,336	$76,079	$92,717	$158,821	$16,790	$41,940	$9,498	$5,151,533
Subtotal Financing & Supplemental Payments	**$83,931,040**	**$21,823,390**	**$90,348,676**	**$4,454,000**	**$81,555,629**	**$28,168,173**	**$209,903,675**	**$484,504**	**$120,068,928**	**$8,241,437**	**$7,981,359**	**$36,918,071**	**$3,876,208**	**$16,235,754**	**$29,419**	**$714,020,263**
Grand Total	**$1,043,333,897**	**$217,648,661**	**$1,106,717,900**	**$30,484,723**	**$569,064,304**	**$206,241,185**	**$1,145,221,987**	**$5,579,020**	**$926,034,728**	**$82,363,283**	**$92,006,683**	**$193,260,486**	**$20,416,020**	**$56,785,377**	**$30,940,389**	**$5,726,098,643**

Notes:

FY 2014-15 actuals are from data accessed in CORE on August 24, 2015.

Exhibit M

	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	$140,644,229	$6,564,319	$11,140,179	$32,892,756	$2,259,530	$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	$1,836,694	$93,391	$217,731	$418,912	$12,129	$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	$1,309,873	$16,599	$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	$104,015,935	$8,645,646	$5,427,900	$753,139	$37,893	$6,551	$2,203	$146,803,940
Family Planning	$171	$148	$21,457	$519	$324,023	$120,585	$108,540	$0	$235,217	$14,840	$87,920	$40,664	$4,492	$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	$41,097,777	$2,040,162	$842,135	$2,689,951	$177,153	$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	$97,275,901	$2,780,149	$5,454,304	$50,721,950	$3,936,967	$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	$96,213,635	$7,383,654	$6,710,556	$11,883,976	$768,457	$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	$8,096,984	$571,527	$1,363,487	$6,338,685	$504,049	$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	$13,761,168	$735,697	$4,764,199	$320,245	$14,406	$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	$78,800,106	$7,972,434	$18,780,213	$4,407,498	$343,428	$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	($33,953,490)	($3,435,172)	($8,092,042)	($1,899,108)	($147,977)	$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	$6,617,012	$383,462	$338,606	$465,767	$32,629	$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	$58,131,185	$3,251,501	$1,880,042	$8,924,580	$590,478	$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	$24,448	$382	$6,921	$51,243	$1,476	$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	$12,689,674	$196,781	$1,928,356	$4,018,370	$110,765	$0	$2,858	$58,932,563
Other Medical Services	$849	$686	$5,161	$227	$2,945	$903	$2,768	$68	$5,157	$312	$548	$939	$68	$304	$56	$20,991
Acute Home Health	$4,746,512	$2,312,870	$10,990,172	$264,529	$785,606	$221,450	$1,429,996	($2,446)	$1,076,709	$96,886	$661,112	$86,583	$2,691	$0	$147,321	$22,819,991
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$85,675,110**	**$74,784,265**	**$486,297,328**	**$26,043,041**	**$357,736,561**	**$108,351,925**	**$319,790,154**	**$8,877,269**	**$627,878,215**	**$37,312,569**	**$51,698,815**	**$122,224,478**	**$8,648,792**	**$38,511,597**	**$8,664,131**	**$2,362,494,250**
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
Long Term Home Health	$26,251,582	$8,030,921	$130,369,940	$1,316,824	$235,386	$18,678	$172,588	$2,446	$7,825,402	$244,287	$11,792,931	$1,213	$0	$0	$252,997	$186,515,195
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	**$205,382,268**	**$42,340,955**	**$335,505,794**	**$2,714,008**	**$599,279**	**$192,968**	**$1,580,164**	**$2,446**	**$11,612,852**	**$244,687**	**$22,272,541**	**$1,248**	**$0**	**$0**	**$1,192,893**	**$623,642,103**
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**	**$681,550,799**	**$39,550,451**	**$76,119,505**	**$123,274,668**	**$8,697,819**	**$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	$519,465	$38,175	$92,728	$59,326	$3,821	$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	$137,873,040	$7,242,327	$8,680,400	$44,141,616	$3,317,657	$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	$1,765,072	$82,382	$139,808	$412,801	$28,357	$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	$1,552,452	$119,139	$108,278	$191,754	$12,399	$32,115	$295	$6,408,519
Accounting Adjustments	$436,709	$90,753	$505,639	$16,283	$198,896	$61,001	$187,748	$4,585	$350,522	$20,341	$42,577	$63,459	$4,477	$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**	**$142,060,551**	**$7,502,364**	**$9,063,791**	**$44,868,956**	**$3,366,711**	**$22,532,136**	**$141,516**	**$732,188,494**
Grand 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**	**$823,611,350**	**$47,052,815**	**$85,183,296**	**$168,143,624**	**$12,064,530**	**$61,044,575**	**$30,849,790**	**$4,618,770,200**

* Historicals have been restated for the Eligible Children (AFDC-C/BC), SB 11-008 Eligible Children, MAGI Pregnant Adults, and SB 11-250 Eligible Pregnant Adults to correct an error in the previous distribution of dollars between the populations within Eligible Children and Pregnant Adults categories respectively.

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
Acute Home Health	$4,372,425	$1,944,403	$9,888,976	$79,789	$600,900	$172,799	$224,892	($840)	$555,960	$47,028	$669,278	$44,098	$1,587	$0	$124,081	$18,725,376
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	**$78,805,339**	**$65,882,971**	**$441,467,295**	**$11,438,155**	**$316,833,427**	**$92,095,552**	**$55,270,434**	**$9,558,376**	**$548,721,374**	**$14,144,638**	**$46,515,535**	**$72,164,144**	**$2,846,306**	**$43,756,602**	**$6,211,623**	**$1,805,711,771**
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
Long Term Home Health	$21,401,061	$7,062,994	$115,530,465	$368,744	$151,443	$4,862	$0	$840	$3,609,745	$0	$10,404,821	$1,690	$0	$0	$93,867	$158,630,532
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	**$182,553,621**	**$35,317,553**	**$289,259,816**	**$574,991**	**$336,744**	**$137,507**	**$124,849**	**$840**	**$4,733,420**	**$5,806**	**$18,964,114**	**$1,690**	**$0**	**$0**	**$355,650**	**$532,366,601**
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**
Grand 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

FY 2011-12	Cash-based Actuals													
	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	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
Acute Home Health	$3,019,688	$1,501,229	$4,482,470	$0	$468,586	$133,222	$490	($205)	$468,010	$227,440	$49,661	$268	$35,453	$10,386,312
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$75,155,191**	**$61,049,927**	**$443,766,632**	**$398,462**	**$301,104,198**	**$82,998,921**	**$2,393,150**	**$10,272,492**	**$509,353,569**	**$49,175,549**	**$63,317,628**	**$41,938,165**	**$5,279,710**	**$1,646,203,594**
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
Long Term Home Health	$19,241,801	$5,960,470	$112,026,204	$0	$70,804	$21,256	$0	$205	$3,621,831	$10,150,245	$374	$0	$128,231	$151,221,421
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	**$170,857,494**	**$32,210,227**	**$270,368,664**	**$15,185**	**$193,458**	**$109,012**	**$4,370**	**$205**	**$4,347,507**	**$18,116,947**	**$2,161**	**$0**	**$475,338**	**$496,700,568**
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**
Grand 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

FY 2010-11	Cash-based Actuals											
	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	$2,067,024	$1,347,570	$236,352	$0	$1,665,110	$236,484	$196,837	$88,493	$5	$6,236,250
Non-emergency Medical Transportation	$2,248,810	$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	$5,001,213	$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	$109,555,356	$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	$57,298,855	$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	$8,735,551	$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	$56,157,222	$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	$1,871,661	$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
Acute Home Health	$5,093,934	$2,031,276	$11,832,652	$537,458	$126,179	$0	$712,181	$1,112,785	$48,496	$0	$145,260	$21,640,221
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$81,265,414**	**$57,786,566**	**$435,082,632**	**$283,908,092**	**$62,528,489**	**$10,106,721**	**$510,000,874**	**$54,732,478**	**$69,877,835**	**$47,068,075**	**$5,147,406**	**$1,617,504,582**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$107,968,359	$16,811,191	$87,178,266	$19,464	$11,962	$0	$0	$72,439	$0	$0	$134,462	$212,196,143
HCBS - Mental Illness	$3,642,260	$2,685,012	$18,587,745	$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	$11,318,640	$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	$126,096	$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	$8,338,211	$0	$0	$0	$27,761,694
Long Term Home Health	$19,383,216	$5,467,614	$112,041,515	$30,506	$32,861	$0	$3,507,579	$10,439,102	$188	$0	$90,966	$150,993,547
Hospice	$30,470,765	$2,124,046	$6,934,494	$235,444	$39,141	$0	$60,107	$3,517	$0	$0	($4,548)	$39,862,966
Subtotal Community Based Long-Term Care	**$164,489,108**	**$28,141,951**	**$258,828,087**	**$298,087**	**$84,131**	**$0**	**$4,092,424**	**$18,869,509**	**$188**	**$0**	**$233,032**	**$475,036,517**
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	$73,242,923	$7,896,872	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$84,429,683
Subtotal Long-Term Care	**$470,098,156**	**$40,773,455**	**$83,485,668**	**$7,615**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$569,344**	**$594,934,238**
Insurance												
Supplemental Medicare Insurance Benefit	$63,751,826	$3,717,638	$33,417,797	$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**	**$34,529,706**	**$214,402**	**$0**	**$0**	**$3,001**	**$1,077**	**$0**	**$0**	**$18,447,446**	**$120,668,730**
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	$1,451,792	$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	$407,791	$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	**$791,512,593**	**$132,860,466**	**$823,740,132**	**$285,474,894**	**$62,924,145**	**$10,106,721**	**$517,572,442**	**$73,843,497**	**$69,982,196**	**$47,106,806**	**$24,404,490**	**$2,839,528,382**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$7,676,809	$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	$30,044,551	($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	$105,089	$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	($2,642)	($483)	($3,002)	($1,102)	($247)	($38)	($1,975)	($299)	($254)	($175)	($22)	($10,239)
Subtotal Financing and Supplemental Payments	**$80,467,450**	**$21,209,177**	**$140,933,590**	**$98,165,587**	**$20,143,322**	**($38)**	**$126,406,343**	**$10,425,919**	**$28,077,153**	**$30,171,126**	**$99,659**	**$556,099,288**
Grand Total	**$871,980,043**	**$154,069,643**	**$964,673,722**	**$383,640,481**	**$83,067,467**	**$10,106,683**	**$643,978,785**	**$84,269,416**	**$98,059,349**	**$77,277,932**	**$24,504,149**	**$3,395,627,670**

Exhibit M

FY 2010-11 Adjusted Totals for June 2010 Payment Delay	Cash-based Actuals											
	Adults 65 and Older (OAP-A)	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**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	$4,130,718	$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	$273,385,004
Emergency Transportation	$132,219	$249,128	$1,981,657	$1,308,793	$234,529	$0	$1,614,807	$227,759	$191,791	$83,441	$5	$6,024,129
Non-emergency Medical Transportation	$2,229,276	$1,030,710	$5,146,701	$497,276	$72,195	$0	$1,144,272	$191,775	$47,503	$3,420	$243	$10,363,372
Dental Services	$955,956	$287,848	$4,837,630	$5,162,280	$1,188,067	$0	$86,467,469	$5,552,511	$362,348	$4,838	$30	$104,818,977
Family Planning	$0	$16	$12,280	$185,275	$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	$35,589,961	$823,759	$1,190,805	$0	$0	$117,488,424
Inpatient Hospitals	$13,226,398	$13,708,601	$104,724,510	$62,699,943	$9,835,760	$0	$80,955,351	$6,191,811	$29,151,219	$36,914,043	$3,263	$357,410,899
Outpatient Hospitals	$3,056,720	$5,426,119	$48,146,249	$55,076,726	$14,489,888	$0	$70,566,037	$5,827,169	$5,797,920	$1,403,889	$510	$209,791,226
Lab & X-Ray	$536,134	$822,885	$6,615,373	$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	$19,273,723	$4,734,880	$46,704,499	$3,394,827	$780,295	$0	$8,456,548	$4,218,566	$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	$54,593,080	$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	$1,802,214	$549,705	$0	$5,208,165	$685,199	$277,916	$30,833	$75	$9,887,646
Federally Qualified Health Centers	$877,183	$1,014,344	$7,353,061	$15,328,948	$3,746,392	$0	$51,735,998	$2,065,438	$4,996,706	$411,997	$0	$87,530,066
Co-Insurance (Title XVIII-Medicare)	$15,904,615	$2,389,850	$11,036,287	$332,809	$438,294	$0	$42,211	$30,661	$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
Acute Home Health	($14,394,809)	($3,509,742)	($100,550,991)	$471,823	$117,275	($1,071)	($2,784,283)	($9,340,017)	$48,023	$0	$50,439	($129,893,353)
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$59,114,932**	**$50,236,027**	**$307,712,970**	**$274,143,602**	**$61,667,292**	**$9,816,125**	**$490,364,176**	**$42,066,929**	**$67,507,167**	**$45,331,276**	**$4,885,305**	**$1,412,845,801**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$105,868,153	$16,511,174	$85,914,478	$19,422	$11,962	$0	$0	$71,172	$0	$0	$129,955	$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	$3,471	$516,199	$0	$0	$0	$0	$0	$0	$0	$1,682	$550,398
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	$12,182,917
HCBS - Children with Autism	$0	$0	$1,326,033	$0	$0	$0	$2,545	$0	$0	$0	$0	$1,328,578
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	$8,251,187	$0	$0	$0	$27,325,956
Long Term Home Health	$18,890,472	$5,333,256	$109,459,274	$55,655	$7,651	$1,071	$3,447,255	$10,296,687	$188	$0	$90,417	$147,581,926
Hospice	$30,229,237	$2,102,621	$6,889,024	$228,536	$39,141	$0	$60,107	$3,517	$0	$0	($4,548)	$39,547,635
Subtotal Community Based Long-Term Care	**$161,588,989**	**$27,646,464**	**$254,107,471**	**$316,286**	**$58,921**	**$1,071**	**$4,013,482**	**$18,638,145**	**$188**	**$0**	**$227,976**	**$466,598,993**
Long-Term Care												
Class I Nursing Facilities	$390,609,241	$31,625,231	$76,509,001	$7,615	$0	$0	$0	$0	$0	$0	$564,302	$499,315,390
Class II Nursing Facilities	($84,406)	$729,155	$2,518,446	$0	$0	$0	$0	$0	$0	$0	$0	$3,163,194
Program of All-Inclusive Care for the Elderly	$73,232,308	$7,892,082	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$84,414,278
Subtotal Long-Term Care	**$463,757,142**	**$40,246,468**	**$82,317,335**	**$7,615**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$564,302**	**$586,892,863**
Insurance												
Supplemental Medicare Insurance Benefit	$63,751,826	$3,717,638	$33,417,797	$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	$5,098	$0	$0	$2,021	$1,059	$0	$0	$0	$1,036,644
Subtotal Insurance	**$63,753,805**	**$3,718,263**	**$34,443,658**	**$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	$1,451,792	$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	$407,791	$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	**$760,120,671**	**$124,286,732**	**$690,395,472**	**$275,728,326**	**$62,037,738**	**$9,817,196**	**$497,855,823**	**$60,946,567**	**$67,611,528**	**$45,370,007**	**$24,132,291**	**$2,618,302,349**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$7,676,809	$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	$30,044,551	($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	$105,089	$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	($2,642)	($483)	($3,002)	($1,102)	($247)	($38)	($1,975)	($299)	($254)	($175)	($22)	($10,239)
Subtotal Financing and Supplemental Payments	**$80,467,450**	**$21,209,177**	**$140,933,590**	**$98,165,587**	**$20,143,322**	**($38)**	**$126,406,343**	**$10,425,919**	**$28,077,153**	**$30,171,126**	**$99,659**	**$556,099,288**
Grand Total	**$840,588,121**	**$145,495,909**	**$831,329,062**	**$373,893,913**	**$82,181,060**	**$9,817,158**	**$624,262,166**	**$71,372,486**	**$95,688,681**	**$75,541,133**	**$24,231,950**	**$3,174,401,637**

Exhibit M

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
	Cash-based Actuals											
Acute Care												
Physician Services & EPSDT	$4,504,959	$5,841,290	$45,027,403	$57,248,711	$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	$1,629,960	$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	$149,434	$1,828	$0	$110,955	$30,688	$17,076	$0	$0	$321,975
Health Maintenance Organizations	$6,690,235	$6,808,868	$45,687,859	$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	$51,528,634	$4,616,132	$4,813,849	$1,009,919	$0	$144,956,141
Lab & X-Ray	$542,175	$702,690	$5,366,358	$11,597,242	$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	$44,622,097	$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	$6,070,347	$13,704,904	$182,692	$0	$47,091,191	$1,962,149	$5,080,079	$456,394	$154	$76,244,360
Co-Insurance (Title XVIII-Medicare)	$9,563,469	$1,441,719	$6,576,135	$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
Acute Home Health	$6,129,559	$2,135,982	$11,903,905	$458,258	$1,616	$0	$672,411	$796,082	$50,128	$0	$115,542	$22,263,483
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$73,993,420**	**$47,594,671**	**$372,519,816**	**$249,914,348**	**$2,231,932**	**$8,716,885**	**$443,494,793**	**$47,962,862**	**$65,696,076**	**$46,692,284**	**$3,059,857**	**$1,361,876,944**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$101,286,004	$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	$1,910,754	$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	$94,296	$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	$14,816,120	$0	$0	$0	$586,102	$6,561,939	$0	$0	$0	$23,230,817
Long Term Home Health	$17,725,454	$4,386,024	$98,742,575	$43,807	$0	$0	$3,077,212	$10,112,575	$0	$0	$97,291	$134,184,938
Hospice	$33,775,858	$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	**$159,306,017**	**$25,140,073**	**$223,139,670**	**$260,063**	**$0**	**$0**	**$3,894,992**	**$16,812,714**	**$0**	**$1,279**	**$293,964**	**$428,848,772**
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	$1,592,382	$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	**$448,573,928**	**$33,679,518**	**$76,014,416**	**$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	$907,336	$2,920	$0	$0	$10,334	$192	$0	$0	$0	$931,637
Subtotal Insurance	**$54,968,992**	**$3,212,896**	**$29,719,597**	**$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	**$11,959,456**	**$2,188,605**	**$10,918,080**	**$728,728**	**$0**	**$409**	**$2,738,621**	**$219,680**	**$90,492**	**$41,435**	**$5,414**	**$28,890,920**
Total Services	**$748,801,813**	**$111,815,763**	**$712,311,579**	**$251,091,563**	**$2,231,932**	**$8,717,294**	**$450,138,740**	**$64,995,448**	**$65,786,568**	**$46,734,998**	**$19,321,956**	**$2,481,947,654**
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	$11,404,873	$9,618,163	$83,046,197	$66,297,084	$529,770	$0	$87,130,849	$6,757,129	$22,253,436	$25,428,583	$2,655	$312,468,739
Nursing Facility Supplemental Payments	$37,661,309	$2,762,168	$7,021,804	$515	$0	$0	$0	$0	$0	$0	$5,616	$47,451,412
Physician Supplemental Payments	$268,976	$348,764	$2,688,433	$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	$825,287	$1,020,373	$14,371	$0	$1,251,371	$112,103	$116,904	$24,526	$0	$3,520,254
Accounting Adjustments	($5,210)	($778)	($4,955)	($1,747)	($16)	($61)	($3,132)	($452)	($458)	($325)	($134)	($17,268)
Subtotal Financing and Supplemental Payments	**$60,431,852**	**$13,739,023**	**$96,586,739**	**$71,926,929**	**$583,605**	**($61)**	**$95,637,266**	**$7,582,054**	**$23,484,644**	**$25,882,705**	**$9,806**	**$395,864,562**
Grand Total	**$809,233,665**	**$125,554,786**	**$808,898,318**	**$323,018,492**	**$2,815,537**	**$8,717,233**	**$545,776,006**	**$72,577,502**	**$89,271,212**	**$72,617,703**	**$19,331,762**	**$2,877,812,216**

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	$6,088,858	$46,749,043	$59,351,542	$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	$1,715,327	$1,254,376	$7,556	$0	$1,604,042	$210,924	$189,911	$92,127	$0	$5,429,754
Non-emergency Medical Transportation	$2,250,143	$881,643	$4,609,047	$368,648	$608	$0	$976,900	$103,821	$45,337	$1,244	$0	$9,237,391
Dental Services	$815,475	$244,934	$4,352,134	$4,534,160	$78,276	$0	$76,650,059	$5,510,341	$370,426	$2,724	$43	$92,558,572
Family Planning	$0	$24	$12,421	$157,531	$2,601	$0	$114,009	$30,897	$17,434	$0	$0	$334,916
Health Maintenance Organizations	$6,690,235	$6,808,868	$45,687,848	$21,208,211	$149,518	$0	$35,072,631	$902,745	$1,131,694	$0	$0	$117,651,749
Inpatient Hospitals	$15,822,983	$11,626,366	$99,034,203	$62,578,505	$390,748	$0	$85,902,848	$6,206,952	$30,629,067	$39,618,658	($833)	$351,809,497
Outpatient Hospitals	$2,586,214	$4,061,576	$35,876,257	$44,238,787	$819,720	$0	$54,117,958	$4,860,761	$5,029,450	$1,066,581	$521	$152,657,826
Lab & X-Ray	$564,758	$733,232	$5,613,057	$12,075,776	$154,214	$0	$6,852,876	$1,693,335	$3,589,272	$152,136	$638	$31,429,293
Durable Medical Equipment	$18,847,335	$4,155,985	$42,281,065	$3,146,879	$39,139	$0	$8,456,254	$4,040,218	$185,251	$559	$2,908	$81,155,593
Prescription Drugs	$8,059,382	$14,076,616	$101,424,096	$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	$829,860	$6,305,621	$14,261,594	$238,622	$0	$48,664,174	$2,029,256	$5,276,197	$472,287	$154	$79,020,817
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	$9,005,794	$0	$0	$0	$0	$0	$9,005,794
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
Acute Home Health	($11,490,368)	($2,176,638)	($86,512,941)	$424,369	$2,869	($167)	($2,415,916)	($9,302,794)	$50,413	$0	$22,106	($111,399,067)
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$59,035,232**	**$45,291,572**	**$289,088,989**	**$259,579,314**	**$3,085,478**	**$9,006,243**	**$456,546,700**	**$40,076,733**	**$68,066,556**	**$48,429,083**	**$3,133,701**	**$1,281,339,601**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$103,386,210	$14,626,539	$71,841,260	$13,385	$0	$0	$0	$79,148	$0	$0	$149,360	$190,095,902
HCBS - Mental Illness	$3,473,458	$2,391,039	$17,109,979	$80	$0	$0	$0	$23,600	$0	$0	$42,459	$23,040,615
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	$1,910,754	$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	$10,913,492	$5,718	$0	$0	$0	$0	$0	$0	$0	$11,596,421
HCBS - Children with Autism	$0	$0	$1,594,734	$0	$0	$0	$0	$0	$0	$0	$0	$1,594,734
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	$15,137,080	$0	$0	$0	$604,720	$6,648,963	$0	$0	$0	$23,666,555
Long Term Home Health	$18,218,198	$4,520,382	$101,341,215	$43,869	$0	$167	$3,137,536	$10,254,991	$0	$0	$97,840	$137,614,198
Hospice	$34,017,386	$3,025,452	$6,115,615	$203,862	$0	$0	$231,678	$34,952	$0	$1,279	$6,603	$43,636,827
Subtotal Community Based Long-Term Care	**$162,206,136**	**$25,635,560**	**$227,876,685**	**$267,075**	**$0**	**$167**	**$3,973,934**	**$17,044,079**	**$0**	**$1,279**	**$299,020**	**$437,303,935**
Long-Term Care												
Class I Nursing Facilities	$393,028,828	$28,956,277	$73,847,716	$5,285	$0	$0	$0	$0	$0	$0	$62,686	$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	$61,924,559	$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**	**$62,686**	**$566,372,166**
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	$8,333	$993,384	$3,197	$0	$0	$11,314	$210	$0	$0	$0	$1,019,989
Subtotal Insurance	**$54,969,300**	**$3,213,618**	**$29,805,645**	**$183,416**	**$0**	**$0**	**$11,314**	**$210**	**$0**	**$0**	**$15,905,077**	**$104,088,579**
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	**$11,959,456**	**$2,188,605**	**$10,918,080**	**$728,728**	**$0**	**$409**	**$2,738,621**	**$219,680**	**$90,492**	**$41,435**	**$5,414**	**$28,890,920**
Total Services	**$743,085,065**	**$110,535,859**	**$634,872,149**	**$260,763,818**	**$3,085,478**	**$9,006,819**	**$463,270,568**	**$57,340,701**	**$68,157,048**	**$48,471,797**	**$19,405,898**	**$2,417,995,202**
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	$11,404,873	$9,618,163	$83,046,197	$66,297,084	$529,770	$0	$87,130,849	$6,757,129	$22,253,436	$25,428,583	$2,655	$312,468,739
Nursing Facility Supplemental Payments	$37,661,309	$2,762,168	$7,021,804	$515	$0	$0	$0	$0	$0	$0	$5,616	$47,451,412
Physician Supplemental Payments	$268,976	$348,764	$2,688,433	$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	$825,287	$1,020,373	$14,371	$0	$1,251,371	$112,103	$116,904	$24,526	$0	$3,520,254
Accounting Adjustments	($5,210)	($778)	($4,955)	($1,747)	($16)	($61)	($3,132)	($452)	($458)	($325)	($134)	($17,268)
Subtotal Financing and Supplemental Payments	**$60,431,852**	**$13,739,023**	**$96,586,739**	**$71,926,929**	**$583,605**	**($61)**	**$95,637,266**	**$7,582,054**	**$23,484,644**	**$25,882,705**	**$9,806**	**$395,864,562**
Grand Total	**$803,516,917**	**$124,274,882**	**$731,458,888**	**$332,690,747**	**$3,669,083**	**$9,006,758**	**$558,907,834**	**$64,922,755**	**$91,641,692**	**$74,354,502**	**$19,415,704**	**$2,813,859,764**

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
Acute Home Health	$6,823,115	$2,172,916	$11,332,626	$494,003	$0	($4,352)	$737,049	$594,810	$25,103	$0	$69,370	$22,244,640
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$84,634,236**	**$51,560,699**	**$401,887,052**	**$237,329,869**	**$0**	**$7,038,935**	**$426,055,244**	**$52,144,060**	**$60,515,451**	**$59,182,087**	**$3,783,765**	**$1,384,131,398**
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
Long Term Home Health	$17,604,990	$4,444,247	$90,735,722	$29,485	$0	$4,352	$2,591,906	$9,570,085	$0	$0	$102,711	$125,083,498
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	**$153,286,954**	**$23,237,190**	**$210,526,647**	**$91,305**	**$0**	**$4,352**	**$2,920,171**	**$15,122,703**	**$2,017**	**$0**	**$404,856**	**$405,596,195**
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
Acute Home Health	$14,495,095	$3,766,994	$47,233,118	$472,912	$0	($15,947)	$1,993,857	$4,599,486	$37,335	$2,426	$290,935	$72,876,211
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$3,770,690	$0	$0	$3,770,690
Subtotal of Acute Care	**$82,865,413**	**$48,471,304**	**$410,013,129**	**$205,881,573**	**$0**	**$7,073,613**	**$358,939,975**	**$54,744,366**	**$54,344,094**	**$53,633,572**	**$3,198,260**	**$1,279,165,299**
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
Long Term Home Health	$8,358,525	$2,246,421	$40,607,925	$51,486	$0	$15,947	$1,216,098	$4,210,240	$0	$0	$132,345	$56,838,987
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	**$132,582,120**	**$18,601,606**	**$135,281,822**	**$172,850**	**$0**	**$15,947**	**$1,806,773**	**$9,066,876**	**$0**	**$0**	**$1,053,007**	**$298,581,001**
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	$10,503,018	$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
Acute Home Health	$6,525,935	$1,766,126	$11,624,656	$359,940	$0	($9,579)	$600,708	$677,099	$15,120	$877	$99,562	$21,660,444
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$7,849,344	$0	$0	$7,849,344
Subtotal of Acute Care	**$69,287,729**	**$40,815,863**	**$322,592,598**	**$203,687,759**	**$0**	**$5,546,117**	**$325,188,990**	**$42,779,524**	**$48,456,939**	**$54,457,313**	**$2,564,389**	**$1,115,377,221**
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
Long Term Home Health	$14,122,434	$3,665,712	$61,157,442	$142,257	$0	$9,579	$2,021,380	$6,680,702	$3,250	$134	$183,729	$87,986,619
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	**$127,061,877**	**$17,772,443**	**$144,054,097**	**$235,860**	**$0**	**$9,579**	**$2,725,474**	**$10,671,010**	**$3,250**	**$134**	**$579,382**	**$303,113,106**
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**	**$571,558,497**	**$204,672,655**	**$0**	**$5,557,749**	**$330,457,080**	**$53,695,680**	**$48,563,237**	**$54,457,447**	**$16,950,163**	**$2,048,437,416**
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**	**$573,755,683**	**$205,339,546**	**$0**	**$5,557,749**	**$331,302,379**	**$53,781,937**	**$48,628,238**	**$54,484,004**	**$16,970,966**	**$2,061,396,809**

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
Acute Home Health	$5,861,654	$1,238,685	$9,469,748	$307,616	$0	($364)	$439,354	$587,718	$23,889	($67)	$11,608	$17,939,841
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$2,644,540	$0	$0	$2,644,540
Subtotal of Acute Care	**$99,744,693**	**$41,593,034**	**$337,300,871**	**$198,600,281**	**$0**	**$6,809,398**	**$311,137,798**	**$39,038,755**	**$41,008,230**	**$55,307,026**	**$2,059,989**	**$1,132,600,075**
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
Long Term Home Health	$12,674,533	$3,758,347	$50,290,735	$94,785	$0	$364	$1,569,963	$5,888,365	$3,069	$67	$7,382	$74,287,610
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	**$107,970,260**	**$15,888,751**	**$121,593,145**	**$245,336**	**$0**	**$364**	**$2,099,169**	**$10,009,625**	**$3,069**	**$67**	**$48,590**	**$257,858,376**
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	$2,207,656	$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**	**$2,207,657**	**$704,247**	**$0**	**$0**	**$884,200**	**$100,025**	**$70,482**	**$38,570**	**$7,871**	**$13,868,232**
Grand Total	**$670,399,260**	**$87,347,545**	**$554,870,506**	**$200,372,840**	**$0**	**$6,810,399**	**$317,181,796**	**$49,374,100**	**$41,186,119**	**$55,353,863**	**$13,367,880**	**$1,996,264,308**

Exhibit N - Expenditure History by Service Category

ACUTE CARE	FY 2014-15	Percent Change from Prior Year	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
Physician Services & EPSDT	$658,752,966	47.13%	$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
Emergency Transportation	$18,143,536	79.18%	$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
Non-Emergency Medical Transportation	$13,305,540	-9.70%	$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)
Dental Services	$248,328,605	69.16%	$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
Family Planning	$1,411,070	47.20%	$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	996.25%	$18,433	-95.49%	$409,119
Health Maintenance Organizations	$294,094,972	116.42%	$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
Inpatient Hospitals	$669,696,478	40.01%	$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
Outpatient Hospitals	$532,321,890	34.03%	$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
Lab & X-Ray	$94,468,696	46.04%	$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
Durable Medical Equipment	$149,886,347	25.26%	$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
Prescription Drugs	$669,178,271	47.66%	$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
Drug Rebate	($321,241,375)	64.51%	($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)
Rural Health Centers	$21,519,068	45.15%	$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
Federally Qualified Health Centers	$149,297,728	16.54%	$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
Co-Insurance (Title XVIII-Medicare)	$52,863,038	-3.72%	$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
Breast and Cervical Cancer Treatment Program	$2,945,495	-66.83%	$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
Prepaid Inpatient Health Plan Services	$45,078,921	-23.51%	$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
Other Medical Services	$19,210	-8.48%	$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
Acute Home Health	$30,266,737	32.63%	$22,819,991	21.87%	$18,725,376	80.29%	$10,386,312	-52.00%	$21,640,221	-2.80%	$22,263,483	0.08%	$22,244,640	-69.48%	$72,876,211	236.45%	$21,660,444	20.74%	$17,939,841
Presumptive Eligibility	$0	0.00%	$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
Subtotal of Acute Care	**$3,330,337,193**	**40.97%**	**$2,362,494,250**	**30.83%**	**$1,805,711,771**	**9.69%**	**$1,646,203,594**	**1.77%**	**$1,617,504,582**	**18.77%**	**$1,361,876,944**	**-1.61%**	**$1,384,131,398**	**8.21%**	**$1,279,165,299**	**14.68%**	**$1,115,377,221**	**-1.52%**	**$1,132,600,075**
COMMUNITY BASED LONG-TERM CARE																			
HCBS - Elderly, Blind, and Disabled	$299,569,488	7.17%	$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
HCBS - Mental Illness	$33,990,405	6.49%	$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
HCBS - Disabled Children	$10,912,003	34.69%	$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
HCBS - Persons Living with AIDS	($3,577)	-102.64%	$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
HCBS - Consumer Directed Attendant Support	$2,412,881	3.50%	$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
HCBS - Brain Injury	$15,621,148	10.13%	$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
HCBS - Children with Autism	$710,058	-7.10%	$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	3599.73%	$18,801	0.00%	$0
HCBS - Pediatric Hospice	$473,674	113.72%	$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
HCBS - Spinal Cord Injury	$1,759,072	-0.82%	$1,773,572	0.00%	$252,509	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Private Duty Nursing	$61,498,982	15.70%	$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
Long Term Home Health	$212,577,453	13.97%	$186,515,195	17.58%	$158,630,532	4.90%	$151,221,421	0.15%	$150,993,547		$134,184,938	7.28%	$125,083,498		$56,838,987	-35.40%	$87,986,619	18.44%	$74,287,610
Hospice	$47,622,754	5.79%	$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
Subtotal of Community Based Long-Term Care	**$687,144,341**	**10.18%**	**$623,642,103**	**17.15%**	**$532,366,601**	**7.18%**	**$496,700,568**	**4.56%**	**$475,036,517**	**10.77%**	**$428,848,772**	**5.73%**	**$405,596,195**	**35.84%**	**$298,581,001**	**-1.50%**	**$303,113,106**	**17.55%**	**$257,858,376**
LONG-TERM CARE AND INSURANCE																			
Class I Nursing Facilities	$579,329,903	3.02%	$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
Class II Nursing Facilities	$4,277,851	22.76%	$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
Program of All-Inclusive Care for the Elderly	$132,904,767	32.28%	$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
Supplemental Medicare Insurance Benefit	$137,271,082	6.27%	$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
Health Insurance Buy-In Program	$1,262,907	-7.50%	$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
Subtotal of Long-Term Care and Insurance	**$855,046,510**	**7.31%**	**$796,818,916**	**5.39%**	**$756,080,565**	**3.72%**	**$728,982,662**	**1.87%**	**$715,602,968**	**8.04%**	**$662,331,018**	**-3.86%**	**$688,925,481**	**10.83%**	**$621,593,882**	**2.42%**	**$606,895,137**	**6.52%**	**$569,727,466**
SERVICE MANAGEMENT																			
Single Entry Points	$32,619,317	21.27%	$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
Disease Management	$988,242	87.54%	$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
Prepaid Inpatient Health Plan Administration	$2,201,486	-71.15%	$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
Accountable Care Collaborative	$103,741,291	51.29%	$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
Subtotal Service Management	$139,550,336	**34.67%**	$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
Total Services	**$5,012,078,380**	**28.96%**	**$3,886,581,706**	**22.78%**	**$3,165,506,614**	**8.23%**	**$2,924,894,763**	**3.01%**	**$2,839,528,382**	**14.41%**	**$2,481,947,654**	**-1.06%**	**$2,508,537,655**	**12.64%**	**$2,227,037,481**	**8.72%**	**$2,048,437,416**	**3.33%**	**$1,982,396,076**
FINANCING AND SUPPLEMENTAL PAYMENTS																			
Upper Payment Limit Financing	$3,637,757	-35.85%	$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
Hospital Supplemental Payments	$587,960,438	-5.58%	$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
Nursing Facility Supplemental Payments	$93,063,202	3.66%	$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
Physician Supplemental Payments	$4,659,239	-17.08%	$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
Outstationing Payments	$19,548,094	205.03%	$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
Accounting Adjustments	$5,151,533	156.52%	$2,008,260	25.53%	$1,599,845	-46.44%	$2,987,193	-29274.66%	($10,239)	-40.71%	($17,268)	-150.26%	$34,355	-67.84%	$106,828	0.00%	$0	-100.00%	$1
Subtotal Financing and Supplemental Payments	**$714,020,263**	**-2.48%**	**$732,188,494**	**-5.14%**	**$771,894,120**	**7.64%**	**$717,137,999**	**28.96%**	**$556,099,288**	**40.48%**	**$395,864,562**	**2045.17%**	**$18,453,787**	**53.03%**	**$12,058,924**	**-6.95%**	**$12,959,393**	**-6.55%**	**$13,868,232**
Grand Total	**$5,726,098,643**	**23.97%**	**$4,618,770,200**	**17.31%**	**$3,937,400,734**	**8.11%**	**$3,642,032,762**	**7.26%**	**$3,395,627,670**	**17.99%**	**$2,877,812,216**	**13.88%**	**$2,526,991,443**	**12.86%**	**$2,239,096,405**	**8.62%**	**$2,061,396,809**	**3.26%**	**$1,996,264,308**

Exhibit N - Expenditure History by Service Category - Delay Adjusted

ACUTE CARE	FY 2014-15	Percent Change from Prior Year	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
Physician Services & EPSDT	$658,752,966	47.13%	$447,742,226	43.81%	$311,344,143	8.47%	$287,020,239	4.99%	$273,385,004	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
Emergency Transportation	$18,143,536	79.18%	$10,125,852	39.21%	$7,273,660	14.35%	$6,361,058	5.59%	$6,024,129	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
Non-emergency Medical Transportation	$13,305,540	-9.70%	$14,734,943	53.86%	$9,576,755	-8.46%	$10,462,166	0.95%	$10,363,372	12.19%	$9,237,391	6.31%	$8,689,018	12.35%	$7,733,949	-12832.88%	($60,740)	444.07%	($11,164)
Dental Services	$248,328,605	69.16%	$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
Family Planning	$1,411,070	47.20%	$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	996.25%	$18,433	-95.49%	$409,119
Health Maintenance Organizations	$294,094,972	116.42%	$135,890,722	7.40%	$126,531,583	4.82%	$120,715,911	2.75%	$117,488,424	-0.14%	$117,651,749	-8.85%	$129,074,827	26.28%	$102,216,877	-5.73%	$108,429,033	-29.95%	$154,782,191
Inpatient Hospitals	$669,696,478	40.01%	$478,311,291	17.58%	$406,784,919	12.22%	$362,502,617	1.42%	$357,410,899	1.59%	$351,809,497	-1.34%	$356,576,636	11.12%	$320,899,293	5.32%	$304,687,402	2.66%	$296,800,124
Outpatient Hospitals	$532,321,890	34.03%	$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
Lab & X-Ray	$94,468,696	46.04%	$64,684,775	41.69%	$45,653,385	14.20%	$39,978,003	9.29%	$36,581,144	16.39%	$31,429,293	10.52%	$28,437,823	24.87%	$22,774,240	11.38%	$20,447,143	6.22%	$19,250,037
Durable Medical Equipment	$149,886,347	25.26%	$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
Prescription Drugs	$669,178,271	47.66%	$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
Drug Rebate	($321,241,375)	64.51%	($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)
Rural Health Centers	$21,519,068	45.15%	$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
Federally Qualified Health Centers	$149,297,728	16.54%	$128,107,489	28.38%	$99,791,204	5.28%	$94,790,483	8.29%	$87,530,066	10.77%	$79,020,817	8.12%	$73,089,013	16.72%	$62,621,473	6.21%	$58,960,102	-4.84%	$61,957,718
Co-Insurance (Title XVIII-Medicare)	$52,863,038	-3.72%	$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
Breast and Cervical Cancer Treatment Program	$2,945,495	-66.83%	$8,879,647	-7.11%	$9,559,144	-6.95%	$10,272,613	4.64%	$9,817,118	9.01%	$9,005,794	27.89%	$7,042,030	-0.65%	$7,088,411	27.61%	$5,554,934	-18.41%	$6,808,264
Prepaid Inpatient Health Plan Services	$45,078,921	-23.51%	$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
Other Medical Services	$19,210	-8.48%	$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
Acute Home Health	$30,266,737	32.63%	$22,819,991	21.87%	$18,725,376	80.29%	$10,386,312	-108.00%	($129,893,353)	16.60%	($111,399,067)	-600.79%	$22,244,640	-69.48%	$72,876,211	236.45%	$21,660,444	20.74%	$17,939,841
Presumptive Eligibility	$0	0.00%	$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
Subtotal of Acute Care	**$3,330,337,193**	**40.97%**	**$2,362,494,250**	**30.83%**	**$1,805,711,771**	**9.69%**	**$1,646,203,594**	**16.52%**	**$1,412,845,801**	**10.26%**	**$1,281,339,601**	**-7.43%**	**$1,384,131,398**	**8.21%**	**$1,279,165,299**	**14.68%**	**$1,115,377,221**	**-1.52%**	**$1,132,600,075**
COMMUNITY BASED LONG-TERM CARE																			
HCBS - Elderly, Blind, and Disabled	$299,569,488	7.17%	$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
HCBS - Mental Illness	$33,990,405	6.49%	$31,919,229	12.75%	$28,309,412	9.16%	$25,934,255	5.48%	$24,587,535	6.71%	$23,040,615	0.36%	$22,958,866	12.49%	$20,409,887	18.34%	$17,246,320	15.10%	$14,984,173
HCBS - Disabled Children	$10,912,003	34.69%	$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
HCBS - Persons Living with AIDS	($3,577)	-102.64%	$135,733	-71.78%	$480,928	-6.80%	$516,036	-6.24%	$550,398	-8.04%	$598,542	0.98%	$592,744	-0.45%	$595,406	18.25%	$503,530	6.50%	$472,783
HCBS - Consumer Directed Attendant Support	$2,412,881	3.50%	$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
HCBS - Brain Injury	$15,621,148	10.13%	$14,184,077	10.38%	$12,849,682	2.09%	$12,587,131	3.32%	$12,182,917	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
HCBS - Children with Autism	$710,058	-7.10%	$764,302	-13.68%	$885,424	-13.40%	$1,022,387	-23.05%	$1,328,578	-16.69%	$1,594,734	23.25%	$1,293,932	86.02%	$695,586	3599.73%	$18,801	0.00%	$0
HCBS - Pediatric Hospice	$473,674	113.72%	$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
HCBS - Spinal Cord Injury	$1,759,072	-0.82%	$1,773,572	602.38%	$252,509	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Private Duty Nursing	$61,498,982	15.70%	$53,154,903	44.26%	$36,846,961	18.31%	$31,144,153	13.97%	$27,325,956	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
Long Term Home Health	$212,577,453	13.97%	$186,515,195	17.58%	$158,630,532	4.90%	$151,221,421	2.47%	$147,581,926	7.24%	$137,614,198	10.02%	$125,083,498		$56,838,987	-35.40%	$87,986,619	18.44%	$74,287,610
Hospice	$47,622,754	5.79%	$45,017,254	3.73%	$43,397,100	2.53%	$42,326,808	7.03%	$39,547,635	-9.37%	$43,636,827	9.36%	$39,902,873	21.62%	$32,810,776	3.22%	$31,787,348	11.51%	$28,507,087
Subtotal Community Based Long-Term Care	**$687,144,341**	**10.18%**	**$623,642,103**	**17.15%**	**$532,366,601**	**7.18%**	**$496,700,568**	**6.45%**	**$466,598,993**	**6.70%**	**$437,303,935**	**7.82%**	**$405,596,195**	**35.84%**	**$298,581,001**	**-1.50%**	**$303,113,106**	**17.55%**	**$257,858,376**
LONG-TERM CARE AND INSURANCE																			
Class I Nursing Facilities	$579,329,903	3.02%	$562,325,391	5.62%	$532,405,250	2.14%	$521,244,769	4.39%	$499,315,390	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
Class II Nursing Facilities	$4,277,851	22.76%	$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
Program of All-Inclusive Care for the Elderly	$132,904,767	32.28%	$100,474,817	3.21%	$97,346,358	13.88%	$85,480,585	1.26%	$84,414,278	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
Supplemental Medicare Insurance Benefit	$137,271,082	6.27%	$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
Health Insurance Buy-In Program	$1,262,907	-7.50%	$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
Subtotal Long-Term Care and Insurance	**$855,046,510**	**7.31%**	**$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**
SERVICE MANAGEMENT																			
Single Entry Points	$32,619,317	21.27%	$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
Disease Management	$988,242	87.54%	$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
Prepaid Inpatient Health Plan Administration	$2,201,486	-71.15%	$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
Accountable Care Collaborative	$103,741,291	51.29%	$68,570,330	86.69%	$36,728,931	105.10%	$17,907,833	0.00%	$887,411	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Subtotal Service Management	$139,550,336	**34.67%**	$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
Total Services	**$5,012,078,380**	**28.96%**	**$3,886,581,706**	**22.78%**	**$3,165,506,614**	**8.23%**	**$2,924,894,763**	**11.71%**	**$2,618,302,349**	**8.28%**	**$2,417,995,202**	**-3.61%**	**$2,508,537,655**	**12.64%**	**$2,227,037,481**	**8.72%**	**$2,048,437,416**	**3.33%**	**$1,982,396,076**
FINANCING AND SUPPLEMENTAL PAYMENTS																			
Upper Payment Limit Financing	$3,637,757	-35.85%	$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
Hospital Supplemental Payments	$587,960,438	-5.58%	$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
Nursing Facility Supplemental Payments	$93,063,202	3.66%	$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
Physician Supplemental Payments	$4,659,239	-17.08%	$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
Outstationing Payments	$19,548,094	205.03%	$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
Accounting Adjustments	$5,151,533	156.52%	$2,008,260	25.53%	$1,599,845	-46.44%	$2,987,193	-29274.66%	($10,239)	-40.71%	($17,268)	-150.26%	$34,355	-67.84%	$106,828	0.00%	$0	-100.00%	$1
Subtotal Financing and Supplemental Payments	**$714,020,263**	**-2.48%**	**$732,188,494**	**-5.14%**	**$771,894,120**	**7.64%**	**$717,137,999**	**28.96%**	**$556,099,288**	**40.48%**	**$395,864,562**	**2045.17%**	**$18,453,787**	**53.03%**	**$12,058,924**	**-6.95%**	**$12,959,393**	**-6.55%**	**$13,868,232**
Grand Total	**$5,726,098,643**	**23.97%**	**$4,618,770,200**	**17.31%**	**$3,937,400,734**	**8.11%**	**$3,642,032,762**	**14.73%**	**$3,174,401,637**	**12.81%**	**$2,813,859,764**	**11.35%**	**$2,526,991,443**	**12.86%**	**$2,239,096,405**	**8.62%**	**$2,061,396,809**	**3.26%**	**$1,996,264,308**

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

Exhibit O - Appropriations and Expenditures

Final FY 2014-15 Funding Splits						
	Total Funds	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
HB 14-1336 FY 2014-15 Long Bill Appropriation	**$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
SB 15-147 FY 2014-15 Supplemental Bill FY15	$141,891,780	$83,683,422	$0	$25,167,600	$0	$33,040,758
SB 15-234 FY 2015-16 Long Bill Add-on	($63,078,747)	($93,280,474)	$102,300,000	($91,738,528)	$0	$19,640,255
Appropriations Totals	$5,803,165,803	$888,379,445	$813,135,957	$556,327,440	$0	$3,545,322,961
Final Expenditures	$5,726,098,643	$890,023,730	$813,135,957	$544,927,148	$0	$3,478,011,808
Remaining Balance (Over Expenditure)	**$77,067,160**	**($1,644,285)**	**$0**	**$11,400,292**	**$0**	**$67,311,153**
Totals reflect final CORE close as of 24 August 2015; 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 2014-15 Final Actuals			
Aid Category	**Caseload**	**Per Capita**	**Total**
Adults 65 and Older (OAP-A)	41,817	$24,949.99	$1,043,333,897
Disabled Adults 60 to 64 (OAP-B)	10,466	$20,795.78	$217,648,661
Disabled Individuals to 59 (AND/AB)	66,548	$16,630.37	$1,106,717,900
Disabled Buy-In	3,627	$8,404.94	$30,484,723
MAGI Parents/Caretakers to 68% FPL	162,698	$3,497.67	$569,064,304
MAGI Parents/Caretakers 69% to 133% FPL	71,609	$2,880.10	$206,241,185
MAGI Adults	240,758	$4,756.73	$1,145,221,987
Breast & Cervical Cancer Program	398	$14,017.64	$5,579,020
Eligible Children (AFDC-C/BC)	445,722	$2,077.61	$926,034,728
SB 11-008 Eligible Children	50,114	$1,643.52	$82,363,283
Foster Care	20,036	$4,592.07	$92,006,683
MAGI Pregnant Adults	14,897	$12,973.11	$193,260,486
SB 11-250 Eligible Pregnant Adults	1,749	$11,672.97	$20,416,020
Non-Citizens- Emergency Services	2,722	$20,861.64	$56,785,377
Partial Dual Eligibles	28,045	$1,103.24	$30,940,389
TOTAL	**1,161,206**	**TF**	**$5,726,098,643**
Total Funds include upper payment limit financing and supplemental payments and other Medicaid financing. Totals may not match due to rounding.		**GF**	$890,023,730
		GFE	$813,135,957
		CF	$544,927,148
		CFE	$0
		FF	$3,478,011,808

Exhibit O - Comparison of Budget Requests and Appropriations

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	$2,990,770,216	$3,035,311,912	1.49%	$3,237,663,512	$3,266,397,475	$3,390,197,235	4.71%	$3,390,197,235	$3,354,544,526	-1.05%
Community Based Long-Term Care	$686,331,853	$692,848,307	0.95%	$696,659,082	$682,316,437	$693,567,822	-0.44%	$691,249,274	$687,144,341	-0.93%
Long-Term Care	$784,692,921	$782,898,539	-0.23%	$778,144,517	$816,580,653	$817,710,804	5.08%	$817,710,804	$809,575,723	-0.99%
Insurance	$152,376,558	$140,231,303	-7.97%	$140,231,303	$137,528,242	$137,881,824	-1.68%	$137,881,824	$138,533,989	0.47%
Service Management	$120,357,559	$150,709,318	25.22%	$150,709,318	$165,739,685	$147,346,400	-2.23%	$147,346,400	$139,550,336	-5.29%
Financing	$770,252,284	$771,289,309	0.13%	$720,945,038	$797,682,058	$618,780,266	-14.17%	$618,780,266	$596,749,728	-3.56%
Total	$5,504,781,391	$5,573,288,688	1.24%	$5,724,352,770	$5,866,244,550	$5,805,484,351	1.42%	$5,803,165,803	$5,726,098,643	-1.37%
Class I Nursing Facilities	$648,830,813	$648,605,818	-0.03%	$643,851,796	$672,758,697	$679,778,419	5.58%	$679,778,419	$672,393,105	-1.09%

FY 2015-16 Comparison of Requests and Appropriations

FY 2015-16	November 1, 2014	February 15, 2015	% Change	FY 2015-16 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	$3,562,496,596	$3,750,491,579	5.28%	$3,800,901,873	$3,780,455,987		-0.54%			
Community Based Long-Term Care	$745,158,037	$753,587,483	1.13%	$786,527,925	$770,448,047		-2.04%			
Long-Term Care	$836,879,748	$839,892,986	0.36%	$839,892,987	$829,480,139		-1.24%			
Insurance	$145,436,492	$148,760,317	2.29%	$148,760,317	$149,998,929		0.83%			
Service Management	$175,685,324	$183,992,306	4.73%	$184,150,612	$178,721,396		-2.95%			
Financing	$860,870,575	$905,312,468	5.16%	$834,596,770	$1,092,886,111		30.95%			
Total	$6,326,526,772	$6,582,037,139	4.04%	$6,594,830,484	$6,801,990,609		3.14%			
Class I Nursing Facilities	$686,986,774	$695,007,389	1.17%	$695,007,389	$690,862,427		-0.60%			

FY 2016-17 Comparison of Requests and Appropriations

FY 2016-17	November 1, 2015	February 15, 2016	% Change	FY 2016-17 Long Bill and Special Bills Appropriation	November 1, 2016	February 15, 2017	% Change over Appropriation	FY 2016-17 Final Appropriation	FY 2016-17 Actuals	% Change over Feb.
Acute Care	$3,818,407,108									
Community Based Long-Term Care	$865,308,210									
Long-Term Care	$873,310,814									
Insurance	$164,392,778									
Service Management	$196,705,139									
Financing	$685,603,507									
Total	$6,603,727,556									
Class I Nursing Facilities	$711,374,044									

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 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	$87,347,545	$554,870,506	$0	$200,372,840	$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	$573,755,683	$0	$205,339,546	$0	$0	$5,557,749	$331,302,379	$0	$53,781,937	$48,628,238	$0	$54,484,004	$16,970,966	$2,061,396,809
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)	$803,516,917	$124,274,882	$731,458,888	$0	$332,690,747	$3,669,083	$0	$9,006,758	$558,907,834	$0	$64,922,755	$91,641,692	$0	$74,354,502	$19,415,704	$2,813,859,764
FY 2010-11 (DA)	$840,588,121	$145,495,909	$831,329,062	$0	$373,893,913	$82,181,060	$0	$9,817,158	$624,262,166	$0	$71,372,486	$95,688,681	$0	$75,541,133	$24,231,950	$3,174,401,637
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	$823,611,350	$47,052,815	$85,183,296	$168,143,624	$12,064,530	$61,044,575	$30,849,790	$4,618,770,200
FY 2014-15	$1,043,333,897	$217,648,661	$1,106,717,900	$30,484,723	$569,064,304	$206,241,185	$1,145,221,987	$5,579,020	$926,034,728	$82,363,283	$92,006,683	$193,260,486	$20,416,020	$56,785,377	$30,940,389	$5,726,098,643

Fiscal Year	Expenditures	Percent Change	Dollar Increase/ Decrease	Average Yearly Percent Change From FY 98-99	Percent Change	Three-year Moving Average	Percent Change
FY 1999-00	$1,308,420,100						
FY 2000-01	$1,416,535,408	8.26%	$108,115,307				
FY 2001-02	$1,536,804,691	8.49%	$120,269,284	8.38%			
FY 2002-03	$1,651,670,874	7.47%	$114,866,182	8.08%	-3.59%	8.08%	
FY 2003-04	$1,868,750,230	13.14%	$217,079,357	9.34%	15.69%	9.70%	20.14%
FY 2004-05	$1,920,541,525	2.77%	$51,791,295	8.03%	-14.07%	7.80%	-19.65%
FY 2005-06	$1,996,264,308	3.94%	$75,722,783	7.35%	-8.48%	6.62%	-15.10%
FY 2006-07	$2,061,396,809	3.26%	$65,132,501	6.76%	-7.94%	3.33%	-49.76%
FY 2007-08	$2,239,096,405	8.62%	$177,699,596	7.00%	3.43%	5.28%	58.62%
FY 2008-09	$2,526,991,443	12.86%	$287,895,038	7.65%	9.31%	8.25%	56.33%
FY 2009-10 (DA)	$2,813,859,764	11.35%	$286,868,321	8.02%	4.84%	10.94%	32.70%
FY 2010-11 (DA)	$3,174,401,637	12.81%	$360,541,873	8.45%	5.44%	12.34%	12.77%
FY 2011-12	$3,642,032,762	14.73%	$467,631,125	8.98%	6.19%	12.97%	5.06%
FY 2012-13	$3,937,400,734	8.11%	$295,367,972	8.91%	-0.74%	11.88%	-8.34%
FY 2013-14	$4,618,770,200	17.31%	$681,369,466	9.51%	6.73%	13.38%	12.60%
FY 2014-15	$5,726,098,643	23.97%	$1,107,328,443	10.47%	10.14%	16.46%	23.02%
	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 2015-16 Projection	$6,801,990,609	18.79%	$1,075,891,966	$6,325,857,262	-7.00%	$6,668,797,013	-1.96%
FY 2016-17 Projection	$6,603,727,556	-2.91%	($198,263,053)	$7,514,439,477	13.79%	$7,921,815,093	19.96%
FY 2017-18 Projection	$6,847,388,506	3.69%	$243,660,950	$7,295,410,108	6.54%	$7,690,911,622	12.32%
FY 2015-16 Appropriation	$6,594,830,484						
Difference Between FY 2015-16 Projections and FY 2015-16 Appropriation	$207,160,125	3.14%		($268,973,222)	-4.08%	$73,966,529	1.12%
Difference Between FY 2016-17 Projections and FY 2015-16 Appropriation	$8,897,072	0.13%		$919,608,993	13.94%	$1,326,984,609	20.12%
Difference Between FY 2017-18 Projections and FY 2015-16 Appropriation	$252,558,022	3.83%		$700,579,624	10.62%	$1,096,081,138	16.62%

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

Fiscal Year	Total Expenditures (1)	Annual % Change	Total Caseload (2)	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 2014-15	$5,726,098,643	23.97%	1,161,206	34.87%
FY 2015-16 Projection	$6,801,990,609	18.79%	1,291,471	11.22%
FY 2016-17 Projection	$6,603,727,556	-2.91%	1,352,005	4.69%
FY 2017-18 Projection	$6,847,388,506	3.69%	1,405,780	3.98%

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

(2) Caseload does not include retroactivity.

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

	FY 2014-15	Percent Change from Prior Year	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	$3,245,962,185	40.12%	$2,316,532,889	29.51%	$1,788,720,827	8.66%	$1,646,203,594	16.52%	$1,412,845,801	10.26%	$1,281,339,601	-7.43%	$1,384,131,398	8.21%	$1,279,165,299	14.68%	$1,115,377,221
Community-Based Long-Term Care	$686,387,670	10.10%	$623,397,416	17.10%	$532,360,795	7.18%	$496,700,568	6.45%	$466,598,993	6.70%	$437,303,935	7.82%	$405,596,195	35.84%	$298,581,001	-1.50%	$303,113,106
Long-Term Care and Insurance	$855,046,510	7.31%	$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	$134,020,357	31.93%	$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	**$4,921,416,722**	**28.22%**	**$3,838,333,436**	**21.95%**	**$3,147,571,790**	**7.61%**	**$2,924,894,763**	**11.71%**	**$2,618,302,349**	**8.28%**	**$2,417,995,202**	**-3.61%**	**$2,508,537,655**	**12.64%**	**$2,227,037,481**	**8.72%**	**$2,048,437,416**
Financing and Supplemental Payments	$701,902,618	-2.69%	$721,319,419	-6.55%	$771,887,288	7.63%	$717,137,999	28.96%	$556,099,288	40.48%	$395,864,562	2045.17%	$18,453,787	53.03%	$12,058,924	-6.95%	$12,959,393
Total Medical Services Premiums Expenditure	**$5,623,319,340**	**23.33%**	**$4,559,652,855**	**16.33%**	**$3,919,459,078**	**7.62%**	**$3,642,032,762**	**14.73%**	**$3,174,401,637**	**12.81%**	**$2,813,859,764**	**11.35%**	**$2,526,991,442**	**12.86%**	**$2,239,096,405**	**8.62%**	**$2,061,396,809**
Title XIX - Medicaid Mental Health		0.00%															
Capitations	$554,440,757	33.66%	$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	$7,216,638	38.34%	$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	**$561,657,395**	**33.71%**	**$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		0.00%															
Office of Community Living	$394,735,121	13.32%	$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	$107,776,447	1.32%	$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	$55,261,689	27.05%	$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	**$557,773,257**	**11.96%**	**$498,202,575**	**237.16%**	**$147,763,122**	**10.02%**	**$134,309,042**	**45.14%**	**$92,537,467**	**14.94%**	**$80,511,150**	**-14.55%**	**$94,219,459**	**14.59%**	**$82,225,084**	**-9.77%**	**$91,132,574**
Title XIX - DHS - Medicaid Funded		0.00%															
Child Welfare Services	$6,813,116	-14.15%	$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	$6,088,675	-1.91%	$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]	$0	-100.00%	$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	$50,826,274	-6.44%	$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	$1,303,119	-20.38%	$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)	$8,678	-57.92%	$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	0.00%	$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	**$65,039,862**	**-8.73%**	**$71,263,238**	**-82.03%**	**$396,499,883**	**0.02%**	**$396,411,131**	**-3.80%**	**$412,062,370**	**6.31%**	**$387,608,755**	**4.73%**	**$370,107,294**	**13.54%**	**$325,964,500**	**10.49%**	**$295,028,702**
Total Title XIX Services Expenditure	**$6,807,789,854**	**22.68%**	**$5,549,163,941**	**16.34%**	**$4,769,594,327**	**7.23%**	**$4,448,151,967**	**13.07%**	**$3,934,018,095**	**12.04%**	**$3,511,188,149**	**9.42%**	**$3,208,955,385**	**12.81%**	**$2,844,632,758**	**8.01%**	**$2,633,566,520**
Title XXI		0.00%															
CHP+ Children	$126,621,572	-25.84%	$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	$74,121,846	82.19%	$40,683,465	170.04%	$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	$8,241,437	9.85%	$7,502,364	127426.16%	$5,883	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
CHP+ Prenatal	$9,580,452	-20.22%	$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	$16,539,812	89.04%	$8,749,216	204.96%	$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	$3,876,208	15.13%	$3,366,711	354664.07%	$949	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Total Title XXI Services Expenditure	**$238,981,327**	**-1.68%**	**$243,054,810**	**16.01%**	**$209,512,114**	**14.83%**	**$182,454,123**	**2.92%**	**$177,283,900**	**-0.68%**	**$178,495,021**	**36.58%**	**$130,686,358**	**15.24%**	**$113,400,543**	**17.52%**	**$96,492,275**
Total Services Expenditure	**$7,046,771,181**	**21.66%**	**$5,792,218,751**	**16.33%**	**$4,979,106,441**	**7.53%**	**$4,630,606,090**	**12.63%**	**$4,111,301,995**	**11.43%**	**$3,689,683,170**	**10.48%**	**$3,339,641,743**	**12.90%**	**$2,958,033,301**	**8.35%**	**$2,730,058,795**

(1) The FY 2014-15 expenditure for this service was not processed in CORE until after October 1, 2015, for $969,806. This will be updated in the February 2016 Request.

Notes:

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.

FY 2014-15 expenditure shows data as of August 24, 2015. Figures may change in the February 2016 Request for transactions completed in CORE after that date.

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 2007-08	$20,832.53	$25,532.15	$20,214.84	-	$4,148.36	-	-	$26,529.23	$2,005.83	$8,036.90	$9,163.19	$12,803.86	$2,474.70	$7,257.42		$1,839.84	$12,998.74	$2,118.25
FY 2008-09	$22,218.30	$27,726.97	$22,144.28	-	$4,145.23	-	-	$22,492.20	$2,087.81	$7,969.45	$9,155.31	$14,869.21	$2,372.72	$7,346.31		$1,948.26	$11,520.32	$2,201.40
% Change from FY 2007-08	6.65%	8.60%	9.54%	-	-0.08%	-	-	-15.22%	4.09%	-0.84%	-0.09%	16.13%	-4.12%	1.22%		5.89%	-11.37%	3.93%
FY 2009-10 (DA)	$21,846.10	$27,717.17	$21,586.53	-	$4,717.71	$1,339.80	-	$21,422.85	$2,255.35	$7,369.64	$12,099.92	$20,133.90	$2,037.08	$7,039.31		$2,638.29	$9,623.95	$2,822.19
% Change from FY 2008-09	-1.68%	-0.04%	-2.52%	-	13.81%	-	-	-4.75%	8.02%	-7.53%	32.16%	35.41%	-14.15%	-4.18%		35.42%	-16.46%	28.20%
FY 2010-11 (DA)	$22,755.80	$28,967.19	$22,831.24	-	$4,903.87	$3,317.19	-	$18,741.34	$2,292.80	$7,196.51	$12,538.79	$23,511.09	$2,371.38	$7,015.52		$2,258.38	$14,151.65	$2,522.36
% Change from FY 2009-10 (DA)	4.16%	4.51%	5.77%	-	3.95%	1.48	-	-12.52%	1.66%	-2.35%	3.63%	16.77%	16.41%	-0.34%		-14.40%	47.05%	-10.62%
FY 2011-12	$23,940.41	$29,754.22	$25,181.61	$15,677.48	$5,054.50	$3,690.91	$3,622.13	$17,497.51	$2,308.33	$7,531.36	$13,153.20	$28,288.07	$2,451.06	$7,174.87		$2,407.87	$12,298.15	$2,658.79
% Change from FY 2010-11 (DA)	5.21%	2.72%	10.29%	-	3.07%	11.27%	-	-6.64%	0.68%	4.65%	4.90%	20.32%	3.36%	2.27%		6.62%	-13.10%	5.41%
FY 2012-13	$24,183.33	$29,157.12	$24,576.41	$22,761.17	$5,027.66	$3,504.94	$9,490.42	$15,597.84	$2,362.18	$7,347.17	$13,857.61	$29,425.89	$2,339.84	$6,983.36		$2,493.85	$11,775.14	$2,744.82
% Change from FY 2011-12	1.01%	-2.01%	-2.40%	0.45	-0.53%	-5.04%	1.62	-10.86%	2.33%	-2.45%	5.36%	4.02%	-4.54%	-2.67%		3.57%	-4.25%	3.24%
FY 2013-14	$24,870.78	$22,576.81	$20,292.09	$17,772.27	$4,125.45	$3,296.76	$6,200.46	$16,347.85	$2,344.15	$7,530.11	$13,142.92	$24,604.83	$2,501.58	$6,231.86		$2,121.80	$9,042.34	$2,296.24
% Change from FY 2012-13	2.84%	-22.57%	-17.43%	-21.92%	-17.94%	-5.94%	-34.67%	4.81%	-0.76%	2.49%	-5.16%	-16.38%	6.91%	-10.76%		-14.92%	-23.21%	-16.34%
FY 2014-15	$26,210.18	$27,882.82	$24,909.17	$11,456.17	$3,855.77	$3,324.90	$5,466.78	$14,356.64	$2,379.24	$7,813.96	$13,246.07	$20,900.50	$2,216.71	$6,136.78		$2,013.08	$12,312.98	$2,249.24
% Change from FY 2013-14	5.39%	23.50%	22.75%	-35.54%	-6.54%	0.85%	-11.83%	-12.18%	1.50%	3.77%	0.78%	-15.06%	-11.39%	-1.53%		-5.12%	36.17%	-2.05%

See Exhibit Q 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.

Exhibit R - Estimate of Federal Medicaid Assistance Percentage (FMAP)

FMAP Forecast

Calendar Year	United States			Colorado			Colorado 3-year Average Per Capita	U.S. 3-year Average Per Capita	FMAP(1) Calculation	eFMAP(2) Calculation	FFY/ SFY	FFY FMAP(3)	FFY eFMAP(3)	SFY FMAP(4)	SFY eFMAP(4)
	Personal Income	Population	Per Capita Personal Income	Personal Income	Population	Per Capita Personal Income									
2000	$8,630,550,000,000	282,162,411	$30,587.17	$148,098,695,000	4,326,921	$34,227.27	-	-	-	-	2000-01	50.00%	65.00%	50.00%	65.00%
2001	$8,983,398,000,000	284,968,955	$31,524.13	$155,918,402,000	4,425,687	$35,230.33	-	-	-	-	2001-02	50.00%	65.00%	50.00%	65.00%
2002	$9,146,428,000,000	287,625,193	$31,799.82	$156,031,593,000	4,490,406	$34,747.77	$34,735.12	$31,303.71	50.00%	65.00%	2002-03	50.00%	65.00%	50.00%	65.00%
2003	$9,479,763,000,000	290,107,933	$32,676.68	$159,330,219,000	4,528,732	$35,182.08	$35,053.39	$32,000.21	50.00%	65.00%	2003-04	50.00%	65.00%	50.00%	65.00%
2004	$10,043,231,000,000	292,805,298	$34,300.03	$166,624,930,000	4,575,013	$36,420.65	$35,450.17	$32,925.51	50.00%	65.00%	2004-05	50.00%	65.00%	50.00%	65.00%
2005	$10,605,595,000,000	295,516,599	$35,888.32	$177,818,529,000	4,631,888	$38,390.08	$36,664.27	$34,288.34	50.00%	65.00%	2005-06	50.00%	65.00%	50.00%	65.00%
2006	$11,376,405,000,000	298,379,912	$38,127.25	$191,699,362,000	4,720,423	$40,610.63	$38,473.79	$36,105.20	50.00%	65.00%	2006-07	50.00%	65.00%	50.00%	65.00%
2007	$11,990,104,000,000	301,231,207	$39,803.66	$202,598,581,000	4,803,868	$42,174.05	$40,391.59	$37,939.74	50.00%	65.00%	2007-08	50.00%	65.00%	50.00%	65.00%
2008	$12,429,234,000,000	304,093,966	$40,873.00	$212,101,724,000	4,889,730	$43,376.98	$42,053.89	$39,601.30	50.00%	65.00%	2008-09	50.00%	65.00%	50.00%	65.00%
2009	$12,080,223,000,000	306,771,529	$39,378.57	$206,437,621,000	4,972,195	$41,518.41	$42,356.48	$40,018.41	50.00%	65.00%	2009-10	50.00%	65.00%	50.00%	65.00%
2010	$12,417,659,000,000	309,326,295	$40,144.21	$210,454,100,000	5,048,196	$41,688.97	$42,194.79	$40,131.93	50.26%	65.18%	2010-11	50.00%	65.00%	50.00%	65.00%
2011	$13,189,935,000,000	311,582,564	$42,332.07	$226,144,657,000	5,118,400	$44,182.69	$42,463.36	$40,618.28	50.82%	65.57%	2011-12	50.00%	65.00%	50.00%	65.00%
2012	$13,873,161,000,000	313,873,685	$44,199.82	$240,349,703,000	5,189,458	$46,314.99	$44,062.22	$42,225.37	51.00%	65.70%	2012-13	50.00%	65.00%	50.00%	65.00%
2013	$14,151,427,000,000	316,128,839	$44,764.75	$247,068,771,000	5,268,367	$46,896.65	$45,798.11	$43,765.55	50.72%	65.50%	2013-14	50.00%	65.00%	50.00%	65.00%
2014	$14,708,582,165,000	318,857,056	$46,129.08	$260,992,867,000	5,355,866	$48,730.28	$47,313.97	$45,031.22	50.32%	65.22%	2014-15	51.01%	65.71%	50.76%	65.53%
2015	$15,367,526,645,992	321,368,864	$47,818.97	$273,520,524,616	5,439,290	$50,286.07	$48,637.67	$46,237.60	50.21%	65.15%	2015-16	50.72%	65.50%	**50.79%**	**65.55%**
2016	$16,105,167,925,000	323,995,528	$49,707.99	$289,931,756,093	5,532,049	$52,409.47	$50,475.27	$47,885.35	50.00%	65.00%	2016-17	50.32%	65.22%	**50.42%**	**65.29%**
2017	$16,894,321,153,325	326,625,791	$51,723.78	$307,617,593,215	5,628,099	$54,657.46	$52,451.00	$49,750.25	50.00%	65.00%	2017-18	50.21%	65.15%	**50.24%**	**65.17%**

Definitions: FMAP: Federal medical assistance percentage eFMAP: Enhanced FMAP SFY: State fiscal year FFY: Federal fiscal year

(1) FMAP is calculated with the following formula: $FMAP_{state} = 1 - ((\text{Per capita income}_{state})^2/(\text{Per capita income}_{U.S.})^2 * 0.45)$, where per capita incomes are based on a rolling three-year average. (Source: http://aspe.hhs.gov/health/reports/2014/FMAP2015/ fmap15.cfm)

(2) eFMAP is calculated by lowering the State share under the regular FMAP rate by 30% (Source: http://aspe.hhs.gov/health/reports/2014/FMAP2015/fmap15.cfm)

(3) There is a lag between the time period that an FMAP is calculated in, and the time period it goes into effect. For example, the FFY 2014-15 FMAP of 51.01% was calculated based on data from CY 2012.

(4) The SFY FMAP and eFMAP are calculated as one quarter of the previous FFY FMAP/eFMAP and three quarters of the current FFY FMAP/eFMAP. This is due to FMAP changes going into effect on the FFY on October 1, which is one quarter through the SFY.

(5) FY 2015-16 and FY 2016-17 estimated FMAP is calculated based on historical actuals from the Bureau of Economic Analysis (BEA), and will only change if the BEA restates these actuals. FY 2017-18 estimated FMAP is calculated based on forecasts of Personal Income from www.leg.state.co.us and Population from www.census.gov.

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-02 Behavioral Health Community Programs

Dept. Approval By: Josh Block [signature] 11/2/15

OSPB Approval By: [signature] 10/28/15

	Supplemental FY 2015-16
X	Change Request FY 2016-17
	Base Reduction FY 2016-17
	Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$654,435,622	$0	$658,855,709	$13,430,867	$53,440,793
	FTE	$0	0.0	$0	0.0	0.0
	GF	$191,031,785	$0	$192,166,924	($3,793,986)	$8,721,997
	CF	$9,111,432	$0	$9,117,715	$7,447,782	$17,149,982
	RF	$0	$0	$0	$0	$0
	FF	$454,292,405	$0	$457,571,070	$9,777,071	$27,568,814

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
03. Behavioral Health Community Programs - Behavioral Health Capitation Payments	Total	$646,025,263	$0	$650,417,739	$13,135,639	$52,815,806
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$188,346,101	$0	$189,473,127	($2,946,514)	$9,459,721
	CF	$8,967,481	$0	$8,973,352	$7,364,246	$16,918,142
	RF	$0	$0	$0	$0	$0
	FF	$448,711,681	$0	$451,971,260	$8,717,907	$26,437,943
03. Behavioral Health Community Programs - Behavioral Health Fee-for-Service Payments	Total	$8,410,359	$0	$8,437,970	$295,228	$624,987
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,685,684	$0	$2,693,797	($847,472)	($737,724)
	CF	$143,951	$0	$144,363	$83,536	$231,840
	RF	$0	$0	$0	$0	$0
	FF	$5,580,724	$0	$5,599,810	$1,059,164	$1,130,871

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); Breast and Cervical Cancer Fund (15D0)	
Reappropriated Funds Source, by Department and Line Item Name:				
Approval by OIT?	Yes ___	No ___	**Not Required:**	X
Schedule 13s from Affected Departments:	N/A			
Other Information:				

Department of Health Care Policy and Financing
Behavioral Health Community Programs

FY 2015-16, FY 2016-17, and FY 2017-18 Budget Request

November 2015

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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 again procured 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 rebids. 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, physician care, substance use disorder; 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 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", extends 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).

- For the most recent rate setting cycle, rates effective January 1, 2016 to June 30, 2016, the Department experienced a significant drop in a few eligibility categories for most BHOs. This is the result of BHO encounter data not supporting the current level of rates, specifically in the Disabled and Foster Care eligibility categories. New rates will be set for the six-month period July 1, 2016 to December 31, 2016 and current BHO encounter data will be analyzed to assess the rates. Adjustments will be made as data supports.

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 2015-16 S-2A and FY 2016-17 R-2

FY 2015-16

- The Department revised the caseload and rates forecasts. For Disabled Individuals and Foster Care populations, new data caused rates to drop considerably. Financials submitted by the BHOs did not support the current rate levels, and resulted in a downward adjustment. Additionally, the Department now forecasts a separate rate for Expansion Parents, where previously the Expansion Adult rate was used.

- Caseload
  - The Department decreased the Expansion Parents forecast by 28,968 (3.0%).
  - The Department decreased the MAGI Adults forecast by 57,708 (5.0%).
- Rates
  - Disabled Individuals dropped by about $18.00 (12%).
  - Expansion Parents dropped by about $7.00 (25%).
  - Foster Care dropped by about $34.00 (16%).

FY 2016-17

- The changes in caseload and rates for FY 2016-17 from the S-2A to the R-2 are primarily the result of flow through of the caseload and rate forecast changes in FY 2015-16.

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 eight 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
- Low Income Adults
- Expansion 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 was 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 0.48%. Beginning July 1, 2014, the Department is using a new financial reporting tool. The Colorado Operations Resource Engine (CORE) is 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.

<u>EXHIBIT BB - CALCULATION OF FUND SPLITS</u>

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 2015-16 the federal match is 50.79%. Payments for clients in the Breast and Cervical Cancer Program receive an enhanced federal match rate, which in FY 2014-15 is 65.55% 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 expansion parents and caretakers from 69% to 133% FPL and MAGI Adults, which are 100% federally funded through January 1, 2017. Finally, the reconciliation from prior years for behavioral health capitation overpayments, retractions for capitations paid for clients later determined to be deceased 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 2015-16 Match Rate	FY 2016-17 Match Rate	FY 2017-18 Match Rate
Standard Medicaid	50.79%	50.42%	50.24%
Former CHP+ Children	82.80%	88.29%	88.17%
Former CHP+ Prenatal	82.80%	88.29%	88.17%
Expansion Adults	100.00%	97.50%	94.50%
BCCP	65.55%	65.29%	65.17%

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 2015-16 the federal match is 50.79%. 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. (2015). Exhibit BB details funds splits for the Behavioral Health Community Programs Capitations line. The funding for the clients enrolled in the program, is 34.45% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund, and 65.55% federal funds in FY 2015-16. 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. 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. 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 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 2015-16 is 82.80%.

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 82.80% in FY 2015-16

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. Beginning January 1, 2017, all 100% federally funded expansion populations will begin there stepdown in federal matching. As a result the match rate for those populations in FY 2016-17 will by 97.50% and 94.50% in FY 2017-18.

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. In this request, FY 2015-16 point estimate rates are known for Q1 and Q2, where FY 2015-16 Q3/Q4, FY 2016-17, and FY 2017-18 are estimates. In January 2015, a six month rate was set between the Department and the BHOs and it is likely that the Department and the BHOs will continue to set rates

on a six month basis. 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.

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. 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 of 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.

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 most likely be moving to a six-month cycle beginning with FY 2015-16.

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 through January 1, 2017 at which point it will revert back to Hospital Provider Fee with an enhanced federal match. 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 2015-16 and the foreseeable future. The Department is currently in the process of analyzing the data surrounding the MAGI Adults rate from CY 2014 and estimates a recoupment of $20.6 million for just the first six months of 2014.

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. For FY 2015-16 Q1 & Q2, the Department will set a six month rate with the anticipation of a six-month rate setting cycle on a go forward basis.

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.

Trend Selection

Aid Category	CY 2016 Trend Selection	CY 2017 Trend	CY 2018 Trend
Adults 65 and Older (OAP-A)	1.21%	1.21%	1.21%
	Trend is the average growth of previous five years.	Trend is the average growth of previous five years.	Trend is the average growth of previous five years.
Disabled Individuals Through 64 (AND/AB, OAP-B)	7.37%	2.23%	2.23%
	Trend is average of FY 2014-15 and FY 2015-16 Q1/Q2 rates. This cohort had a significant decrease in rate between periods, but the Department expects data to support a rate increase in FY 2015-16 Q3/Q4.	Trend is average of FY 2014-15 and FY 2015-16 Q1/Q2 rates. This cohort had a significant decrease in rate between periods, but the Department expects data to support a rate increase in FY 2015-16 Q3/Q4.	Trend is average of FY 2014-15 and FY 2015-16 Q1/Q2 rates. This cohort had a significant decrease in rate between periods, but the Department expects data to support a rate increase in FY 2015-16 Q3/Q4.
Low Income Adults / Expansion Adults	2.30%	3.06%	3.06%
	Trend is half of the average growth of previous five years.	Trend is half of the average growth of previous five years.	Trend is half of the average growth of previous five years.

MAGI Adults	2.30%	3.06%	3.06%
	Due to lack of available data, trend is equal to Low Income Adults	Due to lack of available data, trend is equal to Low Income Adults	Due to lack of available data, trend is equal to Low Income Adults
Eligible Children (AFDC-C/BC)	2.30%	2.30%	2.30%
	Trend is half of the average growth of last two years of rates.	Trend is half of the average growth of last two years of rates.	Trend is half of the average growth of last two years of rates.
Foster Care	11.45%	2.92%	2.92%
	Trend is average of FY 2014-15 and FY 2015-16 Q1/Q2 rates. This cohort had a significant decrease in rate between periods, but the Department expects data to support a rate increase in FY 2015-16 Q3/Q4.	Trend is growth from FY 2012-13 to FY 2013-14.	Trend is growth from FY 2012-13 to FY 2013-14.

Trend Justification

The rate setting methodology changed effective January 1, 2014. The previous rate setting process involved the actuaries setting rates that were actuarially sound in aggregate. The new methodology 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 CY 2016 is an average of several of the previous year's growth rates for all categories except Disabled and Foster Care. For those categories, the trend chosen was significantly higher because of the large decrease in rates for FY 2015-16 Q1/Q2. The Department does anticipate a bounce back with these rates, but in order to be conservative, it chose to have a large trend. The CY 2017 and CY 2018 trends were chosen because the Department can't 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 Department is expecting to make two reconciliations surrounding the MAGI Adults and Low Income Adults populations. The first is the reconciliation related to the risk corridor from January to June 2014 rates. The Department is estimating that it will recoup $20.6 million as a result of capitation rates being set higher than actual costs. The Department also experienced a systems issue that resulted in paying some expansion adults in the low income adults population the MAGI Adult rate, which is considerably higher. Therefore, recoupments related to this issue are expected to be about $3.7 million net because the issue is ongoing. Because this involves a population that is 100% federally funded, there is no impact to state funds.

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. 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 have per-capita costs that 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 2014-15, trended forward based upon the expected change in caseload from FY 2014-15 to FY 2015-16. 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 2015-16 appropriation is 11.87% higher than FY 2014-15 actual expenditures, primarily due to caseload growth. The FY 2015-16 estimate incorporates increased caseload projections along with various rate adjustments and results in a 3.86% increase from FY 2014-15 actual expenditures and a 7.16% decrease from the current appropriation. The FY 2016-17 estimate is built on the FY 2015-16 estimate and presents a 10.63% 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 2014 to CY 2016. The FY 2016-17 request represents a 2.71% increase over the current FY 2015-16 appropriation. The FY 2017-18 Budget Request is built on the FY 2016-17 estimate and represents a 5.98% expenditure increase over the FY 2016-17 request and an 8.86% increase over the FY 2015-16 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 2015-16 Behavioral Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2015-16 Behavioral Health Capitation Appropriation						
FY 2015-16 Long Bill Appropriation (SB 15-234)	$645,729,591	$188,201,251	$0	$8,967,481	$0	$448,560,859
HB 15-1186 "Children with Autism Wavier Expansion"	$295,672	$144,850	$0	$0	$0	$150,822
FY 2015-16 Total Behavioral Heath Capitation Spending Authority	**$646,025,263**	**$188,346,101**	**$0**	**$8,967,481**	**$0**	**$448,711,681**
Projected Total FY 2015-16 Behavioral Health Capitation Expenditure	**$599,933,435**	**$172,292,297**	**$0**	**$8,724,804**	**$0**	**$418,916,334**
FY 2015-16 Behavioral Health Capitation Estimated Change from Appropriation	**($46,091,828)**	**($16,053,804)**	**$0**	**($242,677)**	**$0**	**($29,795,347)**
Percent Change from Spending Authority	-7.13%	-8.52%	-	-2.71%	-	-6.64%
FY 2015-16 Behavioral Health Fee-for-Service						
FY 2015-16 Behavioral Health Fee-For-Service Appropriation						
FY 2015-16 Long Bill Appropriation (SB 15-234)	$8,410,359	$2,685,684	$0	$143,951	$0	$5,580,724
FY 2015-16 Total Behavioral Heath Fee-For-Service Spending Authority	**$8,410,359**	**$2,685,684**	**$0**	**$143,951**	**$0**	**$5,580,724**
Projected Total FY 2015-16 Behavioral Health Fee-for-Service Expenditure	**$8,358,923**	**$1,764,653**	**$0**	**$108,027**	**$0**	**$6,486,243**
Total FY 2015-16 Behavioral Health Fee-For-Service Change from Appropriation	**($51,436)**	**($921,031)**	**$0**	**($35,924)**	**$0**	**$905,519**
Percent Change from Spending Authority	-0.61%	-34.29%	-	-	-	16.23%
FY 2015-16 Medicaid Behavioral Health Programs						
FY 2015-16 Total Spending Authority	**$654,435,622**	**$191,031,785**	**$0**	**$9,111,432**	**$0**	**$454,292,405**
Total Projected FY 2015-16 Expenditures	$608,292,358	$174,056,950	$0	$8,832,831	$0	$425,402,577
FY 2015-16 Estimated Change from Appropriation	**($46,143,264)**	**($16,974,835)**	**$0**	**($278,601)**	**$0**	**($28,889,828)**
Percent Change from Spending Authority	-7.05%	-8.89%	-	-3.06%	-	-6.36%

Exhibit AA - Calculation of Current Total Long Bill Group Impact

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2016-17 Behavioral Health Capitation						
FY 2015-16 Behavioral Health Capitation Appropriation Plus Special Bills	**$646,025,263**	**$188,346,101**	**$0**	**$8,967,481**	**$0**	**$448,711,681**
Bill Annualizations	$4,392,476	$1,127,026	$0	$5,871	$0	$3,259,579
FY 2016-17 Behavioral Health Capitation Base Amount	**$650,417,739**	**$189,473,127**	**$0**	**$8,973,352**	**$0**	**$451,971,260**
Projected Total FY 2016-17 Behavioral Health Capitation Expenditure	**$663,553,378**	**$186,526,613**	**$0**	**$16,337,598**	**$0**	**$460,689,167**
Total FY 2016-17 Behavioral Health Capitation Request	**$13,135,639**	**($2,946,514)**	**$0**	**$7,364,246**	**$0**	**$8,717,907**
Percent Change from FY 2016-17 Behavioral Health Capitation Base	2.02%	-1.56%	-	82.07%	-	1.93%
Percent Change from FY 2015-16 Estimated Behavioral Health Capitation Expenditure	10.60%	8.26%	-	87.25%	-	9.97%
FY 2016-17 Behavioral Health Fee-for-Service						
FY 2015-16 Behavioral Health Fee-For-Service Appropriation Plus Special Bills	**$8,410,359**	**$2,685,684**	**$0**	**$143,951**	**$0**	**$5,580,724**
Bill Annualizations	$27,611	$8,113	$0	$412	$0	$19,086
FY 2016-17 Behavioral Health Fee-For-Service Base Amount	**$8,437,970**	**$2,693,797**	**$0**	**$144,363**	**$0**	**$5,599,810**
Projected Total FY 2016-17 Behavioral Health Fee-for-Service Expenditure	**$8,733,198**	**$1,846,325**	**$0**	**$227,899**	**$0**	**$6,658,974**
Total FY 2016-17 Behavioral Health Fee-For-Service Request	**$295,228**	**($847,472)**	**$0**	**$83,536**	**$0**	**$1,059,164**
Percent Change from FY 2016-17 Behavioral Health Fee-For-Service Base	3.50%	-31.46%	-	57.87%	-	18.91%
Percent Change from FY 2015-16 Estimated Behavioral Health Fee-For-Service Expenditure	4.48%	4.63%	-	110.96%	-	2.66%
FY 2016-17 Medicaid Behavioral Health Programs						
FY 2016-17 Base Amount	**$658,855,709**	**$192,166,924**	**$0**	**$9,117,715**	**$0**	**$457,571,070**
Total Projected FY 2016-17 Expenditure	$672,286,576	$188,372,938	$0	$16,565,497	$0	$467,348,141
Total FY 2016-17 Request	**$13,430,867**	**($3,793,986)**	**$0**	**$7,447,782**	**$0**	**$9,777,071**
Percent Change from Spending Authority	2.04%	-1.97%	-	81.68%	-	2.14%

Exhibit AA - Calculation of Current Total Long Bill Group Impact						
FY 2017-18 Behavioral Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2016-17 Behavioral Health Capitation Appropriation Plus Special Bills	**$650,417,739**	**$189,473,127**	**$0**	**$8,973,352**	**$0**	**$451,971,260**
FY 2017-18 Behavioral Health Capitation Base Amount	**$650,417,739**	**$189,473,127**	**$0**	**$8,973,352**	**$0**	**$451,971,260**
Projected Total FY 2017-18 Behavioral Health Capitation Expenditure	**$703,233,545**	**$198,932,848**	**$0**	**$25,891,494**	**$0**	**$478,409,203**
Total FY 2017-18 Behavioral Health Capitation Continuation Amount	**$52,815,806**	**$9,459,721**	**$0**	**$16,918,142**	**$0**	**$26,437,943**
Percent Change from FY 2017-18 Behavioral Health Capitation Base	8.12%	4.99%	-	188.54%	-	5.85%
Percent Change from FY 2016-17 Estimated Behavioral Health Capitation Expenditure	5.98%	6.65%	-	58.48%	-	3.85%
FY 2017-18 Behavioral Health Fee-for-Service						
FY 2016-17 Behavioral Health Fee-For-Service Appropriation Plus Special Bills	**$8,437,970**	**$2,693,797**	**$0**	**$144,363**	**$0**	**$5,599,810**
FY 2017-18 Behavioral Health Fee-For-Service Base Amount	**$8,437,970**	**$2,693,797**	**$0**	**$144,363**	**$0**	**$5,599,810**
Projected Total FY 2017-18 Behavioral Health Fee-for-Service Expenditure	**$9,062,957**	**$1,956,073**	**$0**	**$376,203**	**$0**	**$6,730,681**
Total FY 2017-18 Behavioral Health Fee-For-Service Continuation Amount	**$624,987**	**($737,724)**	**$0**	**$231,840**	**$0**	**$1,130,871**
Percent Change from FY 2016-17 Behavioral Health Fee-For-Service Base	7.41%	-27.39%	-	160.60%	-	20.19%
Percent Change from FY 2016-17 Estimated Behavioral Health Fee-For-Service Expenditure	3.78%	5.94%	-	65.07%	-	1.08%
FY 2017-18 Medicaid Behavioral Health Programs						
FY 2017-18 Base Amount	**$658,855,709**	**$192,166,924**	**$0**	**$9,117,715**	**$0**	**$457,571,070**
Total Projected FY 2017-18 Expenditure	$712,296,502	$200,888,921	$0	$26,267,697	$0	$485,139,884
Total FY 2017-18 Continuation Amount	**$53,440,793**	**$8,721,997**	**$0**	**$17,149,982**	**$0**	**$27,568,814**
Percent Change from Spending Authority	8.11%	4.54%	-	188.10%	-	6.03%

Exhibit BB - Calculation of Fund Splits

Calculation of Fund Splits - FY 2015-16 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	$352,963,055	$173,693,119	$0	$0	$179,269,936	50.79%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$88,005	$0	$30,318	$0	$57,687	65.55%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$2,676,374	$0	$1,317,044	$0	$1,359,330	50.79%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$239,307,670	$0	$0	$0	$239,307,670	100.00%	Federal Funds
Non Newly Eligible	$448,608	$0	$220,760	$0	$227,848	50.79%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$7,743,934	$0	$3,810,790	$0	$3,933,144	50.79%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility Financing	$0	($3,345,892)	$3,345,892	$0	$0		CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$14,322,579	$2,463,484	$0	$0	$11,859,095	82.80%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$538,704	$92,657	$0	$0	$446,047	82.80%	General Fund
Estimated FY 2015-16 Capitation Expenditure Before Adjustments	**$618,088,929**	**$172,903,368**	**$8,724,804**	**$0**	**$436,460,757**		
Date of Death Retractions	($1,241,762)	($611,071)	$0	$0	($630,691)	50.79%	General Fund
MAGI Adult Risk Corridor Reconciliation [2]	($20,613,732)	$0	$0	$0	($20,613,732)	100.00%	Federal Funds
Expansion Adult Payment Rate BLI [3]	$3,700,000	$0	$0	$0	$3,700,000	100.00%	Federal Funds
Estimated FY 2015-16 Capitation Expenditure	**$599,933,435**	**$172,292,297**	**$8,724,804**	**$0**	**$418,916,334**		
Behavioral Health Fee-for-Service Traditional Clients	$3,568,954	$1,756,282	$0	$0	$1,812,672	50.79%	General Fund
MAGI Parents and Caretakers 60% - 68% FPL	$67,374	$0	$33,155	$0	$34,219	50.79%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$4,314,721	$0	$0	$0	$4,314,721	100.00%	Federal Funds
Non Newly Eligible	$19,025	$0	$9,362	$0	$9,663	50.79%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$21,866	$0	$10,760	$0	$11,106	50.79%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility Financing	$0	($54,750)	$54,750	$0	$0		CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$359,775	$61,881	$0	$0	$297,894	82.80%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$7,208	$1,240	$0	$0	$5,968	82.80%	General Fund
Estimated FY 2015-16 Fee-for-Service Payments	**$8,358,923**	**$1,764,653**	**$108,027**	**$0**	**$6,486,243**		
Final Estimated FY 2015-16 Medicaid Behavioral Health Community Programs Expenditure	**$608,292,358**	**$174,056,950**	**$8,832,831**	**$0**	**$425,402,577**		

[1] Using a weighted average FFP because the match rate changes on a federal fiscal year.

[2] The reconciliation of the MAGI Adult rate risk corridor is expected to be $20.6 million in FY 2015-16 for capitations paid between January and June 2014.

[3] Due to a systems issue, an increasing percentage of low income parents were incorrectly identified as single adults and thus paid an incorrect rate. This indentification error will continue to impact a larger percerntage of the Medicaid population moving forward. As a result, the Department must reconcile with the BHOs once identified. The adjustment accounts for the fact that in FY 2015-16, the Department expects to pay an additional $24.0 million in capitations for that population, but recoup $20.3 million from prior periods.

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	$380,489,535	$188,646,711	$0	$0	$191,842,824	50.42%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$48,809	$0	$16,942	$0	$31,867	65.29%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$3,033,250	$0	$1,503,885	$0	$1,529,365	50.42%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$254,698,401	$0	$6,367,460	$0	$248,330,941	97.50%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$460,782	$0	$228,456	$0	$232,326	50.42%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$9,551,782	$0	$4,735,774	$0	$4,816,008	50.42%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility Financing	$0	($3,485,081)	$3,485,081	$0	$0		CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$15,836,044	$1,854,401	$0	$0	$13,981,643	88.29%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$552,362	$64,682	$0	$0	$487,680	88.29%	General Fund
Estimated FY 2016-17 Capitation Expenditure Before Adjustments	**$664,670,965**	**$187,080,713**	**$16,337,598**	**$0**	**$461,252,654**		
Date of Death Retractions	($1,117,587)	($554,100)	$0	$0	($563,487)	50.42%	General Fund
Estimated FY 2016-17 Capitation Expenditure	**$663,553,378**	**$186,526,613**	**$16,337,598**	**$0**	**$460,689,167**		
Behavioral Health Fee-for-Service Traditional Clients	$3,745,421	$1,856,980	$0	$0	$1,888,441	50.42%	General Fund
MAGI Parents and Caretakers 60% - 68% FPL	$74,341	$0	$36,858	$0	$37,483	50.42%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$4,472,655	$0	$111,816	$0	$4,360,839	97.50%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$19,025	$0	$9,433	$0	$9,592	50.42%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$25,745	$0	$12,764	$0	$12,981	50.42%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility Financing	$0	($57,028)	$57,028	$0	$0		CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$388,815	$45,530	$0	$0	$343,285	88.29%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$7,196	$843	$0	$0	$6,353	88.29%	General Fund
Estimated FY 2016-17 Fee-for-Service Payments	**$8,733,198**	**$1,846,325**	**$227,899**	**$0**	**$6,658,974**		
Final Estimated FY 2016-17 Medicaid Behavioral Health Community Programs Expenditure	**$672,286,576**	**$188,372,938**	**$16,565,497**	**$0**	**$467,348,141**		

Exhibit BB - Calculation of Fund Splits

Calculation of Fund Split - FY 2017-18 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	$404,038,095	$201,049,356	$0	$0	$202,988,739	50.24%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$17,179	$0	$5,983	$0	$11,196	65.17%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$3,417,535	$0	$1,700,565	$0	$1,716,970	50.24%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$267,262,349	$0	$14,699,429	$0	$252,562,920	94.50%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$474,899	$0	$236,310	$0	$238,589	50.24%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$11,070,478	$0	$5,508,670	$0	$5,561,808	50.24%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility Financing	$0	($3,740,537)	$3,740,537	$0	$0		CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$17,389,555	$2,057,184	$0	$0	$15,332,371	88.17%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$569,285	$67,346	$0	$0	$501,939	88.17%	General Fund
Estimated FY 2017-18 Capitation Expenditure Before Adjustments	**$704,239,375**	**$199,433,349**	**$25,891,494**	**$0**	**$478,914,532**		
Date of Death Retractions	($1,005,830)	($500,501)	$0	$0	($505,329)	50.24%	General Fund
Estimated FY 2017-18 Capitation Expenditure	**$703,233,545**	**$198,932,848**	**$25,891,494**	**$0**	**$478,409,203**		
Behavioral Health Fee-for-Service Traditional Clients	$3,953,101	$1,967,063	$0	$0	$1,986,038	50.24%	General Fund
MAGI Parents and Caretakers 60% - 68% FPL	$81,269	$0	$40,439	$0	$40,830	50.24%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$4,555,895	$0	$250,574	$0	$4,305,321	94.50%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$19,025	$0	$9,467	$0	$9,558	50.24%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$29,170	$0	$14,515	$0	$14,655	50.24%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility Financing	$0	($61,208)	$61,208	$0	$0		CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$417,301	$49,367	$0	$0	$367,934	88.17%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$7,196	$851	$0	$0	$6,345	88.17%	General Fund
Estimated FY 2017-18 Fee-for-Service Payments	**$9,062,957**	**$1,956,073**	**$376,203**	**$0**	**$6,730,681**		
Final Estimated FY 2017-18 Medicaid Behavioral Health Community Programs Expenditure	**$712,296,502**	**$200,888,921**	**$26,267,697**	**$0**	**$485,139,884**		

Cash Funds Report									
Cash Fund	**FY 2015-16**			**FY 2016-17**			**FY 2017-18**		
	Spending Authority	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**
Cash Funds									
Hospital Provider Fee Cash Fund	$9,090,691	$8,802,513	($288,178)	$9,096,974	$16,548,555	$7,451,581	$9,096,974	$26,261,714	$17,164,740
Breast and Cervical Cancer Prevention and Treatment Fund	$20,741	$30,318	$9,577	$20,741	$16,942	($3,799)	$20,741	$5,983	($14,758)
Total Cash Funds	**$9,111,432**	**$8,832,831**	**($278,601)**	**$9,117,715**	**$16,565,497**	**$7,447,782**	**$9,117,715**	**$26,267,697**	**$17,149,982**

Exhibit CC - Medicaid Behavioral Health Community Programs Expenditure Summary

Actuals, Appropriations and Estimates Prior to Recoupments

ITEM	FY 2014-15 Actual		FY 2015-16 Appropriated		FY 2015-16 Estimate		FY 2015-16 Change from Appropriation		FY 2016-17 Estimate		FY 2016-17 Change from FY 2015-16 Estimate		FY 2016-17 Change from FY 2015-16 Appropriation		FY 2017-18 Estimate		FY 2017-18 Change from FY 2016-17 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)	41,817	$7,140,433	42,971	$7,277,158	42,218	$7,547,824	(753)	$270,666	42,830	$7,752,850	612	$205,026	(141)	$475,692	43,468	$7,962,697	638	$209,847
Disabled Individuals	80,641	$142,401,570	85,135	$154,906,187	84,791	$135,824,683	(344)	($19,081,504)	88,875	$149,007,395	4,084	$13,182,712	3,740	($5,898,792)	92,907	$159,233,874	4,032	$10,226,479
Low Income Adults	179,344	$55,921,704	197,397	$66,715,087	198,210	$61,823,610	813	($4,891,477)	210,972	$67,584,562	12,762	$5,760,952	13,575	$869,475	221,278	$73,052,306	10,306	$5,467,744
Expansion Adults	71,609	$31,462,810	85,311	$28,832,914	82,897	$21,251,172	(2,414)	($7,581,742)	86,948	$22,730,270	4,051	$1,479,098	1,637	($6,102,644)	91,000	$24,515,183	4,052	$1,784,913
MAGI Adults	240,758	$166,992,116	287,239	$208,653,660	293,091	$219,403,218	5,852	$10,749,558	303,341	$233,317,240	10,250	$13,914,022	16,102	$24,663,580	307,941	$244,106,336	4,600	$10,789,096
Eligible Children	495,836	$115,226,727	536,440	$126,732,162	534,231	$127,960,239	(2,209)	$1,228,077	558,804	$136,936,202	24,573	$8,975,963	22,364	$10,204,040	584,789	$146,618,275	25,985	$9,682,073
Foster Care	20,036	$52,049,345	20,237	$53,264,149	19,923	$44,190,178	(314)	($9,073,971)	19,943	$47,293,637	20	$3,103,459	(294)	($5,970,512)	19,966	$48,733,525	23	$1,439,888
Breast and Cervical Cancer Program	398	$136,529	179	$60,207	283	$88,005	104	$27,798	153	$48,809	(130)	($39,196)	(26)	($11,398)	52	$17,179	(101)	($31,630)
Sub-total Behavioral Health Capitation Payments	**1,130,439**	**$571,331,234**	**1,254,909**	**$646,441,524**	**1,255,644**	**$618,088,929**	**735**	**($28,352,595)**	**1,311,866**	**$664,670,965**	**56,222**	**$46,582,036**	**56,957**	**$18,229,441**	**1,361,401**	**$704,239,375**	**49,535**	**$39,568,410**
Date of Death Retractions		($1,370,836)		($416,261)		($1,241,762)		($825,501)		($1,117,587)		$124,175		($701,326)		($1,005,830)		$111,757
MAGI Adult Risk Corridor Reconciliation						($20,613,732)		($20,613,732)										
MAGI Adults Rate Reconciliation						$3,700,000		$3,700,000										
Total Behavioral Health Capitation Payments	**1,130,439**	**$569,960,398**	**1,254,909**	**$646,025,263**	**1,255,644**	**$599,933,435**	**735**	**($46,091,828)**	**1,311,866**	**$663,553,378**	**56,222**	**$63,619,943**	**56,957**	**$17,528,115**	**1,361,401**	**$703,233,545**	**49,535**	**$39,680,167**
Incremental Percent Change							0.06%	-7.13%			4.48%	10.60%	4.54%	2.71%			3.78%	5.98%
Behavioral Health Fee-for Service-Payments																		
Inpatient Services		$1,037,617		$1,159,633		$1,152,541		($7,092)		$1,204,147		$51,606		$44,514		$1,249,615		$45,468
Outpatient Services		$6,421,463		$7,176,580		$7,132,690		($43,890)		$7,452,059		$319,369		$275,479		$7,733,443		$281,384
Physician Services		$66,344		$74,146		$73,692		($454)		$76,992		$3,300		$2,846		$79,899		$2,907
Total Behavioral Health Fee-for-Service Payments		**$7,525,424**		**$8,410,359**		**$8,358,923**		**($51,436)**		**$8,733,198**		**$374,275**		**$322,839**		**$9,062,957**		**$329,759**
Total Behavioral Health Community Programs		**$577,485,822**		**$654,435,622**		**$608,292,358**		**($46,143,264)**		**$672,286,576**		**$63,994,218**		**$17,850,954**		**$712,296,502**		**$40,009,926**
Incremental Percent Change								-7.05%				10.52%		2.73%				5.95%

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	Expansion 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	82,669	3,238	-	275,672	18,381	425	479,185
% Change from FY 2008-09	2.31%	4.34%	20.07%	-	-	17.24%	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,921	64,052	88,982	27,167	-	302,410	18,393	531	540,456
% Change from FY 2009-10	1.13%	6.20%	7.64%	739.01%	-	9.70%	0.07%	24.94%	12.79%
FY 2011-12 Actuals	39,740	67,869	100,854	35,461	1,134	334,633	18,034	597	598,322
% Change from FY 2010-11	2.10%	5.96%	13.34%	30.53%	-	10.66%	-1.95%	12.43%	10.71%
FY 2012-13 Actuals	40,827	71,859	107,760	41,545	10,634	368,079	17,777	623	659,104
% Change from FY 2011-12	2.74%	5.88%	6.85%	17.16%	837.74%	9.99%	-1.43%	4.36%	10.16%
FY 2013-14 Actuals	41,836	76,837	138,897	47,082	87,243	424,377	18,267	559	835,098
% Change from FY 2012-13	2.47%	6.93%	28.89%	13.33%	720.42%	15.30%	2.76%	-10.27%	26.70%
FY 2014-15 Actuals	41,817	80,641	179,344	71,609	240,758	495,836	20,036	398	1,130,439
% Change from FY 2013-14	-0.05%	4.95%	29.12%	52.09%	175.96%	16.84%	9.68%	-28.80%	35.37%
FY 2015-16 Projection	42,218	84,791	198,210	82,897	293,091	534,231	19,923	283	1,255,644
% Change from FY 2014-15	0.96%	5.15%	10.52%	16.00%	22.00%	8.00%	-1.00%	-29.00%	11.08%
FY 2016-17 Projection	42,830	88,875	210,972	86,948	303,341	558,804	19,943	153	1,311,866
% Change from FY 2015-16	1.45%	4.82%	6.44%	4.89%	3.50%	4.60%	0.10%	-46.00%	4.48%
FY 2017-18 Projection	43,468	92,907	221,278	91,000	307,941	584,789	19,966	52	1,361,401
% Change from FY 2016-17	1.49%	4.54%	4.89%	4.66%	1.52%	4.65%	0.12%	-66.00%	3.78%
FY 2015-16 Appropriation	42,971	85,135	197,397	85,311	287,239	536,440	20,237	179	1,254,909
Difference between the FY 2015-16 Appropriation and the FY 2015-16 Projection	(753)	(344)	813	(2,414)	5,852	(2,209)	(314)	104	735

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 Pregnant Adults	SB 11-250 Eligible Pregnant Adults	MAGI Parents/ Caretakers 69% to 133% FPL	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%	0.00%	-4.26%	21.34%	0.00%	0.00%	0.00%	-0.67%	0.00%	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%	0.00%	15.71%	10.94%	0.00%	0.00%	0.00%	15.25%	0.00%	5.20%	17.41%	11.83%
FY 2009-10 Actuals	38,487	7,049	53,264	-	74,839	7,830	-	3,238	-	275,672	-	18,381	425	479,185
% Change from FY 2008-09	2.31%	9.34%	3.72%	0.00%	20.95%	12.24%	0.00%	0.00%	0.00%	17.24%	0.00%	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,921	7,767	56,285	-	81,114	7,868	-	27,167	-	302,410	-	18,393	531	540,456
% Change from FY 2009-10	1.13%	10.19%	5.67%	0.00%	8.38%	0.49%	0.00%	739.01%	0.00%	9.70%	0.00%	0.07%	24.94%	12.79%
FY 2011-12 Actuals	39,740	8,383	59,434	52	93,224	7,630	-	35,461	1,134	334,633	-	18,034	597	598,322
% Change from FY 2010-11	2.10%	7.93%	5.59%	0.00%	14.93%	-3.02%	0.00%	30.53%	0.00%	10.66%	0.00%	-1.95%	12.43%	10.71%
FY 2012-13 Actuals	40,827	9,051	61,920	888	99,392	8,024	344	41,545	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%	5.16%	0.00%	17.16%	837.74%	7.53%	0.00%	-1.43%	4.36%	10.16%
FY 2013-14 Actuals	41,836	9,853	64,424	2,560	124,680	13,160	1,057	47,082	87,243	399,032	25,345	18,267	559	835,098
% Change from FY 2012-13	2.47%	8.86%	4.04%	188.29%	25.44%	64.01%	207.27%	13.33%	720.42%	10.89%	207.73%	2.76%	-10.27%	26.70%
FY 2014-15 Actuals	41,817	10,466	66,548	3,627	162,698	14,897	1,749	71,609	240,758	445,722	50,114	20,036	398	1,130,439
% Change from FY 2013-14	-0.05%	6.22%	3.30%	41.68%	30.49%	13.20%	65.47%	52.09%	175.96%	11.70%	97.73%	9.68%	-28.80%	35.37%
FY 2015-16 Projection	42,218	11,035	68,897	4,859	181,652	14,830	1,728	82,897	293,091	474,429	59,802	19,923	283	1,255,644
% Change from FY 2014-15	0.96%	5.44%	3.53%	33.97%	11.65%	-0.45%	-1.20%	15.76%	21.74%	6.30%	19.33%	-0.56%	-28.89%	11.08%
FY 2016-17 Projection	42,830	11,585	71,569	5,721	194,331	14,916	1,725	86,948	303,341	494,175	64,629	19,943	153	1,311,866
% Change from FY 2015-16	1.45%	4.98%	3.88%	17.74%	6.98%	0.58%	-0.17%	4.89%	3.50%	4.30%	8.07%	0.10%	-45.94%	4.48%
FY 2017-18 Projection	43,468	12,162	74,263	6,482	204,533	15,020	1,725	91,000	307,941	515,425	69,364	19,966	52	1,361,401
% Change from FY 2016-17	1.49%	4.98%	3.76%	13.30%	5.25%	0.70%	0.00%	4.66%	1.52%	4.30%	7.33%	0.12%	-66.01%	3.78%
FY 2015-16 Appropriation	42,971	11,307	69,501	4,327	180,612	14,862	1,923	85,311	287,239	480,322	56,118	20,237	179	1,254,909
Difference between the FY 2015-16 Appropriation and the FY 2015-16 Projection	(753)	(272)	(604)	532	1,040	(32)	(195)	(2,414)	5,852	(5,893)	3,684	(314)	104	735

Exhibit DD - Medicaid Behvaioral Health Community Programs, Expenditures Historical Summary										
Annual Total Expenditures										
Item		Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults	Expansion Adults	MAGI Adults	Eligible Children	Foster Care	Breast & Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2007-08	Capitations	$5,785,556	$82,620,046	$14,524,307	$0	$0	$37,565,608	$55,455,338	$60,178	$196,011,033
	Fee-For-Service									
	Inpatient Services	$7,069	$221,467	$45,469	$0	$0	$93,439	$46,660	$0	$414,104
	Outpatient Services	$12,721	$267,020	$231,300	$0	$0	$282,037	$74,411	$0	$867,489
	Physician Services	$479	$32,552	$9,170	$0	$0	$8,970	$2,972	$0	$54,143
	Sub-Total Fee-For-Service	$20,269	$521,039	$285,939	$0	$0	$384,446	$124,043	$0	$1,335,736
	Total FY 2007-08 Expenditures	**$5,805,825**	**$83,141,085**	**$14,810,246**	**$0**	**$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	$0	$43,714,042	$56,764,896	$73,074	$215,860,937
	Fee-For-Service									
	Inpatient Services	$22,235	$331,864	$107,478	$0	$0	$171,764	$8,913	$0	$642,254
	Outpatient Services	$9,657	$284,108	$300,557	$0	$0	$364,710	$103,091	$0	$1,062,123
	Physician Services	$285	$37,367	$12,386	$0	$0	$13,685	$8,153	$0	$71,876
	Sub-Total Fee-For-Service	$32,177	$653,339	$420,421	$0	$0	$550,159	$120,157	$0	$1,776,253
	Total FY 2008-09 Expenditures	**$6,181,959**	**$92,785,938**	**$17,446,965**	**$0**	**$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%**	**0.00%**	**16.64%**	**2.35%**	**21.43%**	**10.28%**
FY 2009-10 [1]	Capitations	$5,714,066	$98,475,008	$20,606,973	$643,078	$0	$49,749,580	$51,334,158	$97,955	$226,620,818
	Fee-For-Service									
	Inpatient Services	$36,707	$327,355	$23,679	$1,024	$0	$184,094	$23,702	$0	$596,561
	Outpatient Services	$18,805	$528,618	$598,850	$24,891	$0	$601,664	$139,423	$0	$1,912,251
	Physician Services	$61	$45,659	$6,338	$205	$0	$22,296	$4,291	$0	$78,850
	Sub-Total Fee-For-Service	$55,573	$901,632	$628,867	$26,120	$0	$808,054	$167,416	$0	$2,587,662
	Total FY 2009-10 Expenditures	**$5,769,639**	**$99,376,640**	**$21,235,840**	**$669,198**	**$0**	**$50,557,634**	**$51,501,574**	**$97,955**	**$229,208,480**
	% Change from FY 2007-08	**-6.67%**	**7.10%**	**21.72%**	**0.00%**	**0.00%**	**14.22%**	**-9.46%**	**34.05%**	**5.32%**
FY 2010-11 [1]	Capitations	$6,265,262	$112,579,810	$23,487,736	$7,654,920	$0	$57,953,130	$43,070,676	$134,493	$251,146,027
	Fee-For-Service									
	Inpatient Services	$26,281	$462,018	$54,952	$18,405	$0	$209,493	$31,297	$0	$802,446
	Outpatient Services	$19,668	$838,729	$805,357	$260,702	$0	$843,338	$204,022	$0	$2,971,816
	Physician Services	$44	$53,652	$10,651	$2,892	$0	$19,019	$10,074	$0	$96,331
	Sub-Total Fee-For-Service	$45,993	$1,354,399	$870,960	$281,999	$0	$1,071,850	$245,393	$0	$3,870,594
	Total FY 2010-11 Expenditures	**$6,311,255**	**$113,934,209**	**$24,358,696**	**$7,936,919**	**$0**	**$59,024,980**	**$43,316,069**	**$134,493**	**$255,016,621**
	% Change from FY 2009-10	**9.39%**	**14.65%**	**14.71%**	**1086.03%**	**0.00%**	**16.75%**	**-15.89%**	**37.30%**	**11.26%**
FY 2011-12	Capitations	$6,501,731	$120,858,807	$27,163,937	$10,138,129	$91,244	$67,777,256	$38,817,457	$158,074	$271,506,635
	Fee-For-Service									
	Inpatient Services	$21,297	$355,817	$48,185	$18,329	$0	$176,653	$11,869	$0	$632,151
	Outpatient Services	$19,808	$762,862	$898,679	$332,229	$13,232	$980,428	$156,434	$0	$3,163,672
	Physician Services	$0	$49,001	$13,561	$4,718	$0	$23,508	$5,786	$0	$96,575
	Sub-Total Fee-For-Service	$41,105	$1,167,680	$960,426	$355,276	$13,232	$1,180,589	$174,089	$0	$3,892,397
	Total FY 2011-12 Expenditures	**$6,542,836**	**$122,026,487**	**$28,124,363**	**$10,493,405**	**$104,476**	**$68,957,845**	**$38,991,546**	**$158,074**	**$275,399,032**
	% Change from FY 2010-11	**3.67%**	**7.10%**	**15.46%**	**32.21%**	**0.00%**	**16.83%**	**-9.98%**	**17.53%**	**7.99%**
FY 2012-13	Capitations	$6,533,297	$126,772,700	$29,964,300	$11,805,595	$12,914,408	$76,537,197	$36,623,205	$152,344	$301,303,046
	Fee-For-Service									
	Inpatient Services	$23,759	$667,573	$56,164	$5,318	$47,488	$147,305	$26,023	$0	$973,629
	Outpatient Services	$15,873	$746,068	$1,003,284	$301,289	$270,481	$1,035,757	$140,576	$0	$3,513,329
	Physician Services	$0	$61,602	$5,800	$2,561	$256	$9,712	$2,308	$0	$82,240
	Sub-Total Fee-For-Service	$39,632	$1,475,243	$1,065,248	$309,168	$318,226	$1,192,774	$168,907	$0	$4,569,198
	Total FY 2012-13 Expenditures	**$6,572,929**	**$128,247,943**	**$31,029,548**	**$12,114,763**	**$13,232,634**	**$77,729,971**	**$36,792,112**	**$152,344**	**$305,872,244**
	% Change from FY 2011-12	**0.46%**	**5.10%**	**10.33%**	**15.45%**	**12565.72%**	**12.72%**	**-5.64%**	**-3.62%**	**11.07%**
FY 2013-14	Capitations	$6,794,071	$135,811,614	$42,468,350	$10,148,824	$92,611,488	$88,922,742	$38,922,470	$253,774	$415,933,333
	Fee-For-Service									
	Inpatient Services	$12,637	$701,499	$138,091	$9,711	$199,734	$181,770	$33,646	$0	$1,277,088
	Outpatient Services	$10,423	$555,506	$1,039,616	$276,800	$1,113,265	$885,140	$75,378	$0	$3,956,127
	Physician Services	$50	$32,316	$7,787	$1,262	$9,088	$10,754	$1,877	$0	$63,135
	Sub-Total Fee-For-Service	$23,110	$1,289,321	$1,185,495	$287,773	$1,322,086	$1,077,664	$110,901	$0	$5,296,351
	Total FY 2013-14 Expenditures	**$6,817,181**	**$137,100,935**	**$43,653,845**	**$10,436,597**	**$93,933,574**	**$90,000,406**	**$39,033,371**	**$253,774**	**$421,229,684**
	% Change from FY 2012-13	**3.72%**	**6.90%**	**40.68%**	**-13.85%**	**609.86%**	**15.79%**	**6.09%**	**66.58%**	**37.71%**
FY 2014-15	Capitations	$6,926,061	$141,634,009	$55,885,779	$31,455,667	$166,708,082	$115,210,684	$52,005,193	$134,923	$569,960,398
	Fee-For-Service									
	Inpatient Services	$68,648	$419,127	$41,495	$8,711	$338,450	$117,114	$44,071	$0	$1,037,617
	Outpatient Services	$15,159	$578,816	$1,289,044	$386,626	$2,835,698	$1,206,136	$109,984	$0	$6,421,463
	Physician Services	$0	$40,084	$7,568	$909	$8,980	$7,396	$1,407	$0	$66,344
	Sub-Total Fee-For-Service	$83,807	$1,038,027	$1,338,106	$396,247	$3,183,128	$1,330,646	$155,462	$0	$7,525,424
	Total FY 2014-15 Expenditures	**$7,009,868**	**$142,672,036**	**$57,223,885**	**$31,851,914**	**$169,891,210**	**$116,541,330**	**$52,160,655**	**$134,923**	**$577,485,822**
	% Change from FY 2013-14	**2.83%**	**4.06%**	**31.09%**	**205.19%**	**80.86%**	**29.49%**	**33.63%**	**-46.83%**	**37.10%**

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

Exhibit DD - Medicaid Behavioral 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 Pregnant Adults	SB 11-250 Eligible Pregnant Adults	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Breast & Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2007-08	Capitations	$5,785,556	$8,604,645	$74,015,401	$0	$13,045,420	$1,478,887	$0	$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
	Outpatient Services	$12,721	$14,262	$252,758	$0	$225,351	$5,949	$0	$0	$0	$282,037	$0	$74,411	$0	$867,489
	Physician Services	$479	$2,275	$30,277	$0	$7,745	$1,425	$0	$0	$0	$8,970	$0	$2,972	$0	$54,143
	Sub-Total Fee-For-Service	$20,269	$29,647	$491,392	$0	$278,565	$7,374	$0	$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**	**$1,486,261**	**$0**	**$0**	**$0**	**$37,950,054**	**$0**	**$55,579,381**	**$60,178**	**$197,346,769**
FY 2008-09	Capitations	$6,149,782	$9,745,116	$82,387,483	$0	$15,504,797	$1,521,747	$0	$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
	Outpatient Services	$9,657	$19,613	$264,495	$0	$291,393	$9,164	$0	$0	$0	$364,710	$0	$103,091	$0	$1,062,123
	Physician Services	$285	$1,580	$35,787	$0	$10,873	$1,513	$0	$0	$0	$13,685	$0	$8,153	$0	$71,876
	Sub-Total Fee-For-Service	$32,177	$30,846	$622,493	$0	$409,744	$10,677	$0	$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**	**$1,532,424**	**$0**	**$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%**	**19.44%**	**3.11%**	**0.00%**	**0.00%**	**0.00%**	**16.64%**	**0.00%**	**2.35%**	**21.43%**	**10.28%**
FY 2009-10 [1]	Capitations	$5,714,066	$10,837,828	$87,637,180	$0	$19,027,843	$1,579,130	$0	$643,078	$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	$0	$0	$1,024	$0	$184,094	$0	$23,702	$0	$596,561
	Outpatient Services	$18,805	$35,433	$493,185	$0	$575,312	$23,538	$0	$24,891	$0	$601,664	$0	$139,423	$0	$1,912,251
	Physician Services	$61	$631	$45,028	$0	$4,747	$1,591	$0	$205	$0	$22,296	$0	$4,291	$0	$78,850
	Sub-Total Fee-For-Service	$55,573	$36,064	$865,568	$0	$603,738	$25,129	$0	$26,120	$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**	**$1,604,259**	**$0**	**$669,198**	**$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%**	**23.36%**	**4.69%**	**0.00%**	**0.00%**	**0.00%**	**14.22%**	**0.00%**	**-9.46%**	**34.05%**	**5.32%**
FY 2010-11 [1]	Capitations	$6,265,262	$12,890,748	$99,689,062	$0	$21,770,317	$1,717,419	$0	$7,654,920	$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	$0	$0	$18,405	$0	$209,493	$0	$31,297	$0	$802,446
	Outpatient Services	$19,668	$54,047	$784,682	$0	$778,402	$26,955	$0	$260,702	$0	$843,338	$0	$204,022	$0	$2,971,816
	Physician Services	$44	$559	$53,093	$0	$8,634	$2,017	$0	$2,892	$0	$19,019	$0	$10,074	$0	$96,331
	Sub-Total Fee-For-Service	$45,993	$54,606	$1,299,792	$0	$841,988	$28,972	$0	$281,999	$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**	**$1,746,391**	**$0**	**$7,936,919**	**$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%**	**15.18%**	**8.86%**	**0.00%**	**1086.03%**	**0.00%**	**16.75%**	**0.00%**	**-15.89%**	**37.30%**	**11.26%**
FY 2011-12	Capitations	$6,501,731	$14,198,785	$106,568,343	$91,679	$25,412,054	$1,751,883	$0	$10,138,129	$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	$0	$0	$18,329	$0	$176,653	$0	$11,869	$0	$632,151
	Outpatient Services	$19,808	$66,220	$696,219	$423	$873,401	$25,278	$0	$332,229	$13,232	$980,428	$0	$156,434	$0	$3,163,672
	Physician Services	$0	$580	$48,421	$0	$12,402	$1,159	$0	$4,718	$0	$23,508	$0	$5,786	$0	$96,575
	Sub-Total Fee-For-Service	$41,105	$79,389	$1,087,868	$423	$933,988	$26,438	$0	$355,276	$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**	**$1,778,321**	**$0**	**$10,493,405**	**$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%**	**1.83%**	**0.00%**	**32.21%**	**0.00%**	**16.83%**	**0.00%**	**-9.98%**	**17.53%**	**7.99%**
FY 2012-13	Capitations	$6,533,297	$15,283,706	$109,667,124	$1,821,870	$27,973,392	$1,990,908	$0	$11,805,595	$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	$0	$0	$5,318	$47,488	$147,305	$0	$26,023	$0	$973,629
	Outpatient Services	$15,873	$70,123	$667,130	$8,815	$977,747	$25,538	$0	$301,289	$270,481	$1,035,757	$0	$140,576	$0	$3,513,329
	Physician Services	$0	$355	$61,247	$0	$5,234	$566	$0	$2,561	$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	$26,104	$0	$309,168	$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**	**$2,017,012**	**$0**	**$12,114,763**	**$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%**	**13.42%**	**0.00%**	**15.45%**	**12565.72%**	**12.72%**	**0.00%**	**-5.64%**	**-3.62%**	**11.07%**
FY 2013-14	Capitations	$6,794,071	$16,991,711	$113,813,015	$5,006,888	$38,834,657	$3,584,933	$48,760	$10,148,824	$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	$0	$0	$9,711	$199,734	$169,677	$12,092	$33,646	$0	$1,277,088
	Outpatient Services	$10,423	$38,587	$501,652	$15,268	$987,859	$49,120	$2,637	$276,800	$1,113,265	$820,427	$64,713	$75,378	$0	$3,956,127
	Physician Services	$50	$1,324	$30,834	$158	$6,611	$1,176	$0	$1,262	$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	$50,296	$2,637	$287,773	$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**	**$3,635,229**	**$51,397**	**$10,436,597**	**$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%**	**80.23%**	**0.00%**	**-13.85%**	**609.86%**	**14.33%**	**0.00%**	**6.09%**	**66.58%**	**37.71%**
FY 2014-15	Capitations	$6,926,061	$18,002,789	$116,688,242	$6,942,978	$51,278,862	$3,943,543	$663,374	$31,455,667	$166,708,082	$100,354,417	$14,856,267	$52,005,193	$134,923	$569,960,398
	Fee-For-Service														
	Inpatient Services	$68,648	$24,636	$391,086	$3,405	$41,495	$0	$0	$8,711	$338,450	$106,174	$10,940	$44,071	$0	$1,037,617
	Outpatient Services	$15,159	$52,567	$513,707	$12,542	$1,229,177	$53,357	$6,510	$386,626	$2,835,698	$916,742	$289,394	$109,984	$0	$6,421,463
	Physician Services	$0	$2,696	$37,013	$375	$6,170	$613	$786	$909	$8,980	$6,239	$1,156	$1,407	$0	$66,344
	Sub-Total Fee-For-Service	$83,807	$79,898	$941,806	$16,323	$1,276,841	$53,969	$7,296	$396,247	$3,183,128	$1,029,155	$301,491	$155,462	$0	$7,525,424
	Total FY 2014-15 Expenditures	**$7,009,868**	**$18,082,687**	**$117,630,048**	**$6,959,301**	**$52,555,703**	**$3,997,512**	**$670,670**	**$31,851,914**	**$169,891,210**	**$101,383,572**	**$15,157,758**	**$52,160,655**	**$134,923**	**$577,485,822**
	% Change from FY 2013-14	**2.83%**	**6.05%**	**2.31%**	**37.03%**	**31.50%**	**9.97%**	**0.00%**	**205.19%**	**80.86%**	**14.08%**	**0.00%**	**33.63%**	**-46.83%**	**37.10%**

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

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

Behavioral Health Capitation Payments Per Capita History

Item	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults	Expansion 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	$249.27	$198.60	-	$180.47	$2,792.78	$230.48	$472.93
% Change from FY 2008-09	-9.18%	2.43%	0.80%	-	-	-2.93%	-11.28%	-0.02%	-8.47%
FY 2010-11 Actuals	$160.97	$1,757.63	$263.96	$281.77	-	$191.64	$2,341.69	$253.28	$464.69
% Change from FY 2009-10	8.42%	7.65%	5.89%	41.88%	-	6.19%	-16.15%	9.89%	-1.74%
FY 2011-12 Actuals	$163.61	$1,780.77	$269.34	$285.90	$80.46	$202.54	$2,152.46	$264.78	$453.78
% Change from FY 2010-11	1.64%	1.32%	2.04%	1.47%	-	5.69%	-8.08%	4.54%	-2.35%
FY 2012-13 Actuals	$160.02	$1,764.19	$278.07	$284.16	$1,214.44	$207.94	$2,060.15	$244.53	$457.14
% Change from FY 2011-12	-2.19%	-0.93%	3.24%	-0.61%	1409.37%	2.66%	-4.29%	-7.65%	0.74%
FY 2013-14 Actuals	$162.40	$1,767.53	$305.75	$215.56	$1,061.53	$209.54	$2,130.75	$453.98	$498.07
% Change from FY 2012-13	1.49%	0.19%	9.96%	-24.14%	-12.59%	0.77%	3.43%	85.65%	8.95%
FY 2014-15 Actuals	$165.63	$1,756.35	$311.61	$439.27	$692.43	$232.36	$2,595.59	$339.00	$504.19
% Change from FY 2013-14	1.99%	-0.63%	1.92%	103.78%	-34.77%	10.89%	21.82%	-25.33%	1.23%
FY 2015-16 Projection	$174.21	$1,593.73	$311.75	$256.18	$747.71	$239.50	$2,216.05	$305.87	$491.26
% Change from FY 2014-15	5.18%	-9.26%	0.04%	-41.68%	7.98%	3.07%	-14.62%	-9.77%	-2.56%
FY 2016-17 Projection	$176.96	$1,669.60	$320.21	$261.27	$768.40	$245.03	$2,369.65	$310.51	$505.81
% Change from FY 2015-16	1.58%	4.76%	2.71%	1.99%	2.31%	2.31%	6.93%	1.52%	2.96%
FY 2017-18 Projection	$179.59	$1,707.88	$330.02	$269.27	$792.03	$250.70	$2,439.21	$307.85	$516.55
% Change from FY 2016-17	1.49%	2.29%	3.06%	3.06%	3.08%	2.31%	2.94%	($0.01)	2.12%

Expanded Medicaid Per Capita Summary for Behavioral 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 Pregnant Adults	SB 11-250 Eligible Pregnant Adults	MAGI Parents/ Caretakers 69% to 133% FPL	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	$201.68	-	$198.60	-	$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	$160.97	$1,659.68	$1,771.15	-	$268.39	$218.28	-	$281.77	-	$191.64	-	$2,341.69	$253.28	$464.69
% Change from FY 2009-10	8.42%	7.95%	7.65%	-	5.56%	8.23%	-	41.88%	-	6.19%	-	-16.15%	9.89%	-1.74%
FY 2011-12 Actuals	$163.61	$1,693.76	$1,793.05	$1,763.06	$272.59	$229.60	-	$285.90	$80.46	$202.54	-	$2,152.46	$264.78	$453.78
% Change from FY 2010-11	1.64%	2.05%	1.24%	-	1.56%	5.19%	-	1.47%	-	5.69%	-	-8.08%	4.54%	-2.35%
FY 2012-13 Actuals	$160.02	$1,688.62	$1,771.11	$2,051.66	$281.45	$248.12	-	$284.16	$1,214.44	$212.70	-	$2,060.15	$244.53	$457.14
% Change from FY 2011-12	-2.19%	-0.30%	-1.22%	16.37%	3.25%	8.07%	-	-0.61%	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	$272.41	$46.13	$215.56	$1,061.53	$220.20	$41.67	$2,130.75	$453.98	$498.07
% Change from FY 2012-13	1.49%	2.13%	-0.25%	-4.67%	10.67%	9.79%	-	-24.14%	-12.59%	3.53%	-	3.43%	85.65%	8.95%
FY 2014-15 Actuals	$165.63	$1,720.12	$1,753.44	$1,914.25	$315.18	$264.72	$379.29	$439.27	$692.43	$225.15	$296.45	$2,595.59	$339.00	$504.19
% Change from FY 2013-14	1.99%	-0.26%	-0.75%	-2.13%	1.19%	-2.82%	-	103.78%	-34.77%	2.25%	-	21.82%	-25.33%	1.23%
FY 2015-16 Projection	$174.21	$1,593.73	$1,593.73	$1,593.73	$311.75	$311.75	$311.75	$256.18	$747.71	$239.50	$239.50	$2,216.05	$305.87	$491.26
% Change from FY 2014-15	5.18%	-7.35%	-9.11%	-16.74%	-1.09%	17.77%	-17.81%	-41.68%	7.98%	6.37%	-19.21%	-14.62%	-9.77%	-2.56%
FY 2016-17 Projection	$176.96	$1,669.60	$1,669.60	$1,669.60	$320.21	$320.21	$320.21	$261.27	$768.40	$245.03	$245.03	$2,369.65	$310.51	$505.81
% Change from FY 2015-16	1.58%	4.76%	4.76%	4.76%	2.71%	2.71%	2.71%	1.99%	2.77%	2.31%	2.31%	6.93%	1.52%	2.96%
FY 2017-18 Projection	$179.59	$1,707.88	$1,707.88	$1,707.88	$330.02	$330.02	$330.02	$269.27	$792.03	$250.70	$250.70	$2,439.21	$307.85	$516.55
% Change from FY 2016-17	1.49%	2.29%	2.29%	2.29%	3.06%	3.06%	3.06%	3.06%	3.08%	2.31%	2.31%	2.94%	-0.86%	2.12%

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	Expansion Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Weighted Capitation Rate	$14.75	$128.42	$25.55	$20.74	$61.28	$19.67	$174.57	$25.55	
Estimated Monthly Caseload	42,046	83,835	194,598	81,084	288,584	525,198	19,861	312	1,235,518
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2015-16 Q1 and Q2 Capitated Payments	$3,721,071	$64,596,544	$29,831,873	$10,090,093	$106,106,565	$61,983,868	$20,802,809	$47,830	$297,180,653
Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	99.57%	99.79%	99.39%	98.83%	99.26%	99.69%	99.88%	99.57%	
Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,705,070	$64,460,891	$29,649,899	$9,972,039	$105,321,376	$61,791,718	$20,777,846	$47,624	$295,726,463
Expenditures for Prior Period Dates of Service	$29,592	$299,542	$346,260	$383,178	$1,408,473	$372,203	$63,043	$455	$2,902,746
Total Estimated Expenditures in FY 2015-16 Q1 and Q2	**$3,734,662**	**$64,760,433**	**$29,996,159**	**$10,355,217**	**$106,729,849**	**$62,163,921**	**$20,840,889**	**$48,079**	**$298,629,209**

FY 2015-16 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	Expansion Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Weighted Capitation Rate	$14.93	$137.89	$26.14	$21.22	$62.68	$20.13	$194.56	$26.14	
Estimated Monthly Caseload [1]	42,388	85,747	201,821	84,708	297,598	543,264	19,983	253	1,275,762
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2015-16 Q3 and Q4 Capitated Payments	$3,797,117	$70,941,923	$31,653,606	$10,785,023	$111,920,593	$65,615,426	$23,327,355	$39,681	$318,080,724
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	99.57%	99.79%	99.39%	98.83%	99.26%	99.69%	99.88%	99.57%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,780,789	$70,792,945	$31,460,519	$10,658,838	$111,092,381	$65,412,018	$23,299,362	$39,510	$316,536,362
Estimated Expenditures for Prior Period Dates of Service	$32,373	$271,305	$366,932	$237,117	$1,580,988	$384,300	$49,927	$416	$2,923,358
Total Estimated Expenditures in FY 2015-16 Q3 and Q4	**$3,813,162**	**$71,064,250**	**$31,827,451**	**$10,895,955**	**$112,673,369**	**$65,796,318**	**$23,349,289**	**$39,926**	**$319,459,720**
Total Estimated FY 2015-16 Expenditures	**$7,547,824**	**$135,824,683**	**$61,823,610**	**$21,251,172**	**$219,403,218**	**$127,960,239**	**$44,190,178**	**$88,005**	**$618,088,929**
Estimated Date of Death Retractions	($192,935)	($690,805)	($32,332)	($14,439)	($255,630)	($14,439)	($39,737)	($1,445)	($1,241,762)
Total Estimated FY 2015-16 Expenditures Including Date of Death Retractions	**$7,354,889**	**$135,133,878**	**$61,791,278**	**$21,236,733**	**$219,147,588**	**$127,945,800**	**$44,150,441**	**$86,560**	**$616,847,167**
Estimated FY 2015-16 Monthly Caseload	42,218	84,791	198,210	82,897	293,091	534,231	19,923	283	1,255,644
Estimated FY 2015-16 Per Capita Expenditure	**$174.21**	**$1,593.73**	**$311.75**	**$256.18**	**$747.71**	**$239.50**	**$2,216.05**	**$305.87**	**$491.26**

[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	Expansion Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$14.93	$137.89	$26.14	$21.22	$62.68	$20.13	$194.56	$26.14	
Estimated Monthly Caseload (1)	42,691	87,794	208,139	86,629	301,819	555,160	19,985	183	1,302,400
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2016-17 Q1 and Q2 Capitated Payments	$3,824,260	$72,635,488	$32,644,521	$11,029,604	$113,508,090	$67,052,225	$23,329,690	$28,702	$324,052,580
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	99.57%	99.79%	99.39%	98.83%	99.26%	99.69%	99.88%	99.57%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,807,816	$72,482,953	$32,445,389	$10,900,558	$112,668,130	$66,844,363	$23,301,694	$28,579	$322,479,482
Estimated Expenditures for Prior Period Dates of Service	$33,035	$297,956	$389,339	$253,448	$1,667,617	$406,816	$55,986	$345	$3,104,542
Total Estimated Expenditures in FY 2016-17 Q1 and Q2	**$3,840,851**	**$72,780,909**	**$32,834,728**	**$11,154,006**	**$114,335,747**	**$67,251,179**	**$23,357,680**	**$28,924**	**$325,584,024**

FY 2016-17 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	Expansion Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$15.11	$140.96	$26.94	$21.87	$64.60	$20.59	$200.24	$26.94	
Estimated Monthly Caseload (1)	42,968	89,956	213,803	87,266	304,862	562,447	19,900	122	1,321,324
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2016-17 Q3 and Q4 Capitated Payments	$3,895,479	$76,081,187	$34,559,117	$11,451,045	$118,164,640	$69,484,702	$23,908,656	$19,720	$337,564,546
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	99.57%	99.79%	99.39%	98.83%	99.26%	99.69%	99.88%	99.57%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,878,728	$75,921,417	$34,348,306	$11,317,068	$117,290,222	$69,269,299	$23,879,966	$19,635	$335,924,641
Estimated Expenditures for Prior Period Dates of Service	$33,271	$305,069	$401,528	$259,196	$1,691,271	$415,724	$55,991	$250	$3,162,300
Total Estimated Expenditures in FY 2016-17 Q3 and Q4	**$3,911,999**	**$76,226,486**	**$34,749,834**	**$11,576,264**	**$118,981,493**	**$69,685,023**	**$23,935,957**	**$19,885**	**$339,086,941**
Total Estimated FY 2016-17 Expenditures	**$7,752,850**	**$149,007,395**	**$67,584,562**	**$22,730,270**	**$233,317,240**	**$136,936,202**	**$47,293,637**	**$48,809**	**$664,670,965**
Estimated Date of Death Retractions	($173,642)	($621,725)	($29,099)	($12,995)	($230,067)	($12,995)	($35,763)	($1,301)	($1,117,587)
Total Estimated FY 2016-17 Expenditures Including Date of Death Retractions	**$7,579,208**	**$148,385,670**	**$67,555,463**	**$22,717,275**	**$233,087,173**	**$136,923,207**	**$47,257,874**	**$47,508**	**$663,553,378**
Estimated FY 2016-17 Monthly Caseload	42,830	88,875	210,972	86,948	303,341	558,804	19,943	153	1,311,866
Estimated FY 2016-17 Per Capita Expenditure	**$176.96**	**$1,669.60**	**$320.21**	**$261.27**	**$768.40**	**$245.03**	**$2,369.65**	**$310.51**	**$505.81**

[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 2017-18

FY 2017-18 Q1 and Q2 Calculation

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	Expansion Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$15.11	$140.96	$26.94	$21.87	$64.60	$20.59	$200.24	$26.94	
Estimated Monthly Caseload (1)	43,290	91,959	218,916	89,377	307,109	575,783	19,919	69	1,346,422
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2017-18 Q1 and Q2 Capitated Payments	$3,924,671	$77,775,244	$35,385,582	$11,728,050	$119,035,448	$71,132,232	$23,931,483	$11,153	$342,923,863
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	99.57%	99.79%	99.39%	98.83%	99.26%	99.69%	99.88%	99.57%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,907,795	$77,611,916	$35,169,730	$11,590,832	$118,154,586	$70,911,722	$23,902,765	$11,105	$341,260,451
Estimated Expenditures for Prior Period Dates of Service	$33,891	$319,541	$425,077	$269,100	$1,760,653	$430,805	$57,381	$172	$3,296,620
Total Estimated Expenditures in FY 2017-18 Q1 and Q2	**$3,941,686**	**$77,931,457**	**$35,594,807**	**$11,859,932**	**$119,915,239**	**$71,342,527**	**$23,960,146**	**$11,277**	**$344,557,071**

FY 2017-18 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	Expansion Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$15.29	$144.10	$27.76	$22.54	$66.57	$21.07	$206.09	$27.76	
Estimated Monthly Caseload (1)	43,646	93,854	223,640	92,622	308,773	593,794	20,012	35	1,376,376
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2017-18 Q3 and Q4 Capitated Payments	$4,004,084	$81,146,168	$37,249,478	$12,526,199	$123,330,112	$75,067,437	$24,745,638	$5,830	$358,074,946
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	99.57%	99.79%	99.39%	98.83%	99.26%	99.69%	99.88%	99.57%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,986,866	$80,975,761	$37,022,256	$12,379,642	$122,417,469	$74,834,728	$24,715,943	$5,805	$356,338,470
Estimated Expenditures for Prior Period Dates of Service	$34,145	$326,656	$435,243	$275,609	$1,773,628	$441,020	$57,436	$97	$3,343,834
Total Estimated Expenditures in FY 2017-18 Q3 and Q4	**$4,021,011**	**$81,302,417**	**$37,457,499**	**$12,655,251**	**$124,191,097**	**$75,275,748**	**$24,773,379**	**$5,902**	**$359,682,304**
Total Estimated FY 2016-17 Expenditures	**$7,962,697**	**$159,233,874**	**$73,052,306**	**$24,515,183**	**$244,106,336**	**$146,618,275**	**$48,733,525**	**$17,179**	**$704,239,375**
Estimated Date of Death Retractions	($156,278)	($559,553)	($26,189)	($11,696)	($207,060)	($11,696)	($32,187)	($1,171)	($1,005,830)
Total Estimated FY 2017-18 Expenditures Including Date of Death Retractions	**$7,806,419**	**$158,674,321**	**$73,026,117**	**$24,503,487**	**$243,899,276**	**$146,606,579**	**$48,701,338**	**$16,008**	**$703,233,545**
Estimated FY 2017-18 Monthly Caseload	43,468	92,907	221,278	91,000	307,941	584,789	19,966	52	1,361,401
Estimated FY 2017-18 Per Capita Expenditure	**$179.59**	**$1,707.88**	**$330.02**	**$269.27**	**$792.03**	**$250.70**	**$2,439.21**	**$307.85**	**$516.55**

[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 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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	0.87%	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	99.13%	0.87%	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	99.13%	0.87%	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	99.13%	0.87%	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	99.13%	0.87%	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	99.13%	0.87%
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	99.13%

Incurred But Not Reported (IBNR) Estimate for Disabled Individuals

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	0.42%	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	99.58%	0.42%	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	99.58%	0.42%	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	99.58%	0.42%	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	99.58%	0.42%	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	99.58%	0.42%
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	99.58%

Incurred But Not Reported (IBNR) Estimate for Parents and Caretakers

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	1.23%	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	98.77%	1.23%	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	98.77%	1.23%	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	98.77%	1.23%	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	98.77%	1.23%	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	98.77%	1.23%
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	98.77%

Incurred But Not Reported (IBNR) Estimate for Expansion Parents and Caretakers

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	2.35%	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	97.65%	2.35%	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	97.65%	2.35%	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	97.65%	2.35%	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	97.65%	2.35%	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	97.65%	2.35%
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	97.65%

Exhibit EE - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for MAGI Adults

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	1.49%	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	98.51%	1.49%	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	98.51%	1.49%	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	98.51%	1.49%	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	98.51%	1.49%	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	98.51%	1.49%
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	98.51%

Incurred But Not Reported (IBNR) Estimate for Eligible Children

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	0.62%	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	99.38%	0.62%	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	99.38%	0.62%	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	99.38%	0.62%	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	99.38%	0.62%	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	99.38%	0.62%
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	99.38%

Incurred But Not Reported (IBNR) Estimate for Foster Care

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	0.24%	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	99.76%	0.24%	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	99.76%	0.24%	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	99.76%	0.24%	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	99.76%	0.24%	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	99.76%	0.24%
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	99.76%

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

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	0.87%	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	99.13%	0.87%	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	99.13%	0.87%	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	99.13%	0.87%	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	99.13%	0.87%	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	99.13%	0.87%
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	99.13%

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

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

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	$29,592	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	$3,688,698	$32,373	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	$3,764,082	$33,035	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	$3,790,989	$33,271	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	$3,861,588	$33,891	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	$3,890,526	$34,145
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	$3,969,248
Total Paid in Current Period	$3,688,698	$3,764,082	$3,790,989	$3,861,588	$3,890,526	$3,969,248
Total IBNR Amount	$29,592	$32,373	$33,035	$33,271	$33,891	$34,145
Total Paid for All Incurred Dates	$3,718,290	$3,796,455	$3,824,024	$3,894,859	$3,924,417	$4,003,393

Incurred But Not Reported (IBNR) Estimate for Disabled Individuals

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	$299,542	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	$64,325,239	$271,305	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	$70,643,967	$297,956	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	$72,330,419	$305,069	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	$75,761,646	$319,541	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	$77,448,588	$326,656
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	$80,805,354
Total Paid in Current Period	$64,325,239	$70,643,967	$72,330,419	$75,761,646	$77,448,588	$80,805,354
Total IBNR Amount	$299,542	$271,305	$297,956	$305,069	$319,541	$326,656
Total Paid for All Incurred Dates	$64,624,781	$70,915,272	$72,628,375	$76,066,715	$77,768,129	$81,132,010

Incurred But Not Reported (IBNR) Estimate for Parents and Caretakers

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	$346,260	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	$29,464,941	$366,932	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	$31,264,267	$389,339	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	$32,242,993	$401,528	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	$34,134,040	$425,077	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	$34,950,339	$435,243
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	$36,791,309
Total Paid in Current Period	$29,464,941	$31,264,267	$32,242,993	$34,134,040	$34,950,339	$36,791,309
Total IBNR Amount	$346,260	$366,932	$389,339	$401,528	$425,077	$435,243
Total Paid for All Incurred Dates	$29,811,201	$31,631,199	$32,632,332	$34,535,568	$35,375,416	$37,226,552

Incurred But Not Reported (IBNR) Estimate for Expansion Parents and Caretakers

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	$383,178	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	$9,852,976	$237,117	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	$10,531,575	$253,448	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	$10,770,408	$259,196	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	$11,181,945	$269,100	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	$11,452,441	$275,609
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	$12,231,833
Total Paid in Current Period	$9,852,976	$10,531,575	$10,770,408	$11,181,945	$11,452,441	$12,231,833
Total IBNR Amount	$383,178	$237,117	$253,448	$259,196	$269,100	$275,609
Total Paid for All Incurred Dates	$10,236,154	$10,768,692	$11,023,856	$11,441,141	$11,721,541	$12,507,442

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for MAGI Adults

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	$1,408,473	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	$104,525,577	$1,580,988	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	$110,252,976	$1,667,617	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	$111,816,819	$1,691,271	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	$116,403,987	$1,760,653	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	$117,261,820	$1,773,628
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	$121,492,493
Total Paid in Current Period	$104,525,577	$110,252,976	$111,816,819	$116,403,987	$117,261,820	$121,492,493
Total IBNR Amount	$1,408,473	$1,580,988	$1,667,617	$1,691,271	$1,760,653	$1,773,628
Total Paid for All Incurred Dates	$105,934,050	$111,833,964	$113,484,436	$118,095,258	$119,022,473	$123,266,121

Incurred But Not Reported (IBNR) Estimate for Eligible Children

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	$372,203	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	$61,599,568	$384,300	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	$65,208,610	$406,816	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	$66,636,501	$415,724	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	$69,053,897	$430,805	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	$70,691,212	$441,020
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	$74,602,019
Total Paid in Current Period	$61,599,568	$65,208,610	$66,636,501	$69,053,897	$70,691,212	$74,602,019
Total IBNR Amount	$372,203	$384,300	$406,816	$415,724	$430,805	$441,020
Total Paid for All Incurred Dates	$61,971,771	$65,592,910	$67,043,317	$69,469,621	$71,122,017	$75,043,039

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Foster Care

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	$63,043	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	$20,752,882	$49,927	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	$23,271,369	$55,986	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	$23,273,699	$55,991	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	$23,851,275	$57,381	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	$23,874,047	$57,436
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	$24,686,248
Total Paid in Current Period	$20,752,882	$23,271,369	$23,273,699	$23,851,275	$23,874,047	$24,686,248
Total IBNR Amount	$63,043	$49,927	$55,986	$55,991	$57,381	$57,436
Total Paid for All Incurred Dates	$20,815,925	$23,321,296	$23,329,685	$23,907,266	$23,931,428	$24,743,684

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

	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	Paid in FY 2017-18 Q1 and Q2	Paid in FY 2017-18 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	$455	-	-	-	-	-
Incurred in FY 2015-16 Q1 and Q2	$47,414	$416	-	-	-	-
Incurred in FY 2015-16 Q3 and Q4	-	$39,336	$345	-	-	-
Incurred in FY 2016-17 Q1 and Q2	-	-	$28,452	$250	-	-
Incurred in FY 2016-17 Q3 and Q4	-	-	-	$19,548	$172	-
Incurred in FY 2017-18 Q1 and Q2	-	-	-	-	$11,056	$97
Incurred in FY 2017-18 Q3 and Q4	-	-	-	-	-	$5,779
Total Paid in Current Period	$47,414	$39,336	$28,452	$19,548	$11,056	$5,779
Total IBNR Amount	$455	$416	$345	$250	$172	$97
Total Paid for All Incurred Dates	$47,869	$39,752	$28,797	$19,798	$11,228	$5,876

Exhibit FF - Medicaid Behavioral Health Retroactivity Adjustment

Fiscal Year		Adults 65 and Older	Disabled Individuals	Low Income Adults [1]	Expansion Adults [2]	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	82,669	-	-	275,672	18,381
	Claims as a Percentage of Caseload	100.41%	108.33%	114.28%	-	-	105.55%	102.51%
FY 2010-11	Average Monthly Claims	38,337	68,739	127,056	-	-	323,244	18,792
	Average Caseload	38,921	64,052	116,149	-	-	302,410	18,393
	Claims as a Percentage of Caseload	98.50%	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 [3]	Estimated Average Monthly Claims	40,782	77,257	199,988	-	90,902	429,909	18,610
	Average Caseload	41,836	76,837	185,979	-	87,243	424,377	18,267
	Claims as a Percentage of Caseload	97.48%	100.55%	107.53%	-	104.19%	101.30%	101.88%
FY 2014-15 [3]	Estimated Average Monthly Claims	40,647	80,567	182,459	74,792	240,015	500,198	20,160
	Average Caseload	41,817	80,641	179,344	71,609	240,758	495,836	20,036
	Claims as a Percentage of Caseload	97.20%	99.91%	101.74%	104.44%	99.69%	100.88%	100.62%
Weighted Average Claims as a Percentage of Caseload [4]		97.48%	100.55%	101.74%	101.74%	104.19%	101.30%	101.88%
Retroactivity Adjustment Factor		-2.52%	0.55%	1.74%	1.74%	4.19%	1.30%	1.88%

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

[2] Expansion Adults is being reported as it's own category beginning FY 2013-14. Prior to that, the category was baked in to the Low Income Adults category.

[3] Factors for Expansion Adults and MAGI Adults are incorrectly skewed. Due to a system issue, which incorrectly associated Expansion Adults claims with MAGI Adults, the retroactivity is understated in Expansion Adults and overstated in MAGI Adults.

[4] The retroactivity adjustment captures the actual monthly claims paid versus average caseload reported. After analyzing the data and historical trends, the Department determined that the most recent year with adequate runout, which in this request is FY 2013-14, most accurately represents the relationship between the claims-based rate and the capitation rate for all eligibility categories.

Exhibit FF - Medicaid Behavioral Health Partial Month Adjustment Multiplier

Fiscal Year		Adults 65 and Older	Disabled Individuals	Parents and Caretakers [1]	Expansion Parents and Caretakers	MAGI Adults	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 [3]	$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 [3]	$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 [3]	$13.58	$137.00	$20.64	-	-	$15.19	$192.53
	Claims as a Percentage of Capitation	99.44%	99.61%	99.62%	-	-	99.44%	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 [2]	Weighted Claims-Based Rate	$13.89	$144.72	$23.99	-	$79.25	$17.18	$174.11
	Weighted Capitation Rate	$13.96	$144.99	$24.05	-	$79.38	$17.22	$174.80
	Claims as a Percentage of Capitation	99.49%	99.82%	99.73%	-	99.84%	99.78%	99.61%
FY 2014-15	Weighted Claims-Based Rate	$14.16	$146.66	$25.96	$25.96	$55.52	$19.18	$215.34
	Weighted Capitation Rate	$14.22	$146.82	$25.97	$26.01	$55.53	$19.20	$215.41
	Claims as a Percentage of Capitation	99.54%	99.89%	99.96%	99.80%	99.97%	99.92%	99.97%
Average Claims as a Percentage of Capitation [4]		99.49%	99.82%	99.73%	99.73%	99.84%	99.78%	99.61%
Partial Month Adjustment Multiplier		-0.51%	-0.18%	-0.27%	-0.27%	-0.16%	-0.22%	-0.39%

[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] Expansion Parents and Caretakers is being reported as it's own category beginning FY 2013-14. Prior to that, the category was baked in to the Parents and Caretakers category.

[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 actual paid rates and therefore do not match the numbers in Exhibit GG, which demonstrate the trend on the actuarial point estimates.

[4] 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 2013-14, most accurately represents the relationship between the claims-based rate and the capitation rate for all eligibility categories.

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]	Expansion Adults	MAGI Adults	Eligible Children	Foster Care	Weighted Behavioral Health Total [2]
FY 2007-08 Actuals	**$13.15**	**$114.07**	**$17.51**	**$0.00**	**$0.00**	**$13.94**	**$262.46**	**$40.87**
FY 2008-09 Actuals [3]	**$13.37**	**$121.31**	**$18.18**	**$0.00**	**$0.00**	**$14.34**	**$251.88**	**$39.96**
% Change from FY 2007-08	1.67%	6.35%	3.83%	-	-	2.87%	-4.03%	-2.24%
FY 2009-10 Actuals [3]	**$13.40**	**$131.64**	**$19.33**	**$19.33**	**$0.00**	**$14.71**	**$220.67**	**$38.07**
% 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**	**$20.94**	**$0.00**	**$15.41**	**$195.38**	**$37.27**
% Change from FY 2009-10	2.91%	5.70%	8.33%	8.33%	-	4.76%	-11.46%	-2.11%
FY 2011-12 Actuals	**$13.89**	**$140.82**	**$21.69**	**$21.69**	**$100.85**	**$16.33**	**$179.30**	**$36.58**
% Change from FY 2010-11	0.73%	1.21%	3.58%	3.58%	-	5.97%	-8.23%	-1.85%
FY 2012-13 Actuals	**$13.66**	**$140.28**	**$21.89**	**$21.89**	**$100.98**	**$16.75**	**$171.85**	**$36.73**
% Change from FY 2011-12	-1.66%	-0.38%	0.92%	0.92%	0.13%	2.57%	-4.16%	0.43%
FY 2013-14 Actuals	**$13.96**	**$144.99**	**$23.98**	**$23.98**	**$79.38**	**$17.22**	**$174.80**	**$40.27**
% Change from FY 2012-13	2.20%	3.36%	9.55%	9.55%	-21.39%	2.81%	1.72%	9.62%
FY 2014-15 Actuals	**$14.22**	**$146.82**	**$25.97**	**$26.01**	**$55.53**	**$19.20**	**$215.41**	**$40.83**
% Change from FY 2013-14	1.86%	1.26%	8.30%	8.47%	-30.05%	11.50%	23.23%	1.39%
FY 2015-16 Q1 and Q2 Known Rate	$15.21	$127.95	$25.18	$20.44	$58.91	$19.46	$172.02	$39.32
% Change from FY 2014-15	6.96%	-12.85%	-3.04%	-21.41%	6.09%	1.35%	-20.14%	-3.69%
FY 2015-16 Q3 and Q4 Estimated Rate	$15.39	$137.38	$25.76	$20.91	$60.26	$19.91	$191.72	$40.76
% Change from FY 2015-16 Q1 and Q2	1.18%	7.37%	2.30%	2.30%	2.29%	2.31%	11.45%	3.65%
% Change from FY 2014-15	8.23%	-6.43%	-0.81%	-19.61%	8.52%	3.70%	-11.00%	-0.17%
FY 2015-16 Estimated Weighted Average Rate [4]	**$15.30**	**$132.72**	**$25.48**	**$20.68**	**$59.60**	**$19.69**	**$181.90**	**$39.97**
% Change from FY 2014-15	7.59%	-9.60%	-1.89%	-20.49%	7.33%	2.55%	-15.56%	-2.10%
FY 2016-17 Q1 and Q2 Estimated Rate	$15.39	$137.38	$25.76	$20.91	$60.26	$19.91	$191.72	$39.32
% Change from FY 2015-16 Q3 and Q4 Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-3.52%
% Change from FY 2015-16 Average Rate	0.59%	3.51%	1.10%	1.11%	1.11%	1.12%	5.40%	-1.62%
FY 2016-17 Q3 and Q4 Estimated Rate	$15.58	$140.44	$26.55	$21.55	$62.10	$20.37	$197.32	$40.76
% Change from FY 2016-17 Q1 and Q2 Rate	1.23%	2.23%	3.07%	3.06%	3.05%	2.31%	2.92%	3.65%
% Change from FY 2015-16 Average Rate	1.83%	5.82%	4.20%	4.21%	4.19%	3.45%	8.48%	1.97%
FY 2016-17 Estimated Weighted Average Rate [4]	**$15.49**	**$138.93**	**$26.16**	**$21.23**	**$61.69**	**$20.21**	**$191.91**	**$40.05**
% Change from FY 2015-16 Average Rate	1.24%	4.68%	2.67%	2.66%	3.51%	2.64%	5.50%	0.20%
FY 2017-18 Q1 and Q2 Estimated Rate	$15.58	$140.44	$26.55	$21.55	$62.10	$20.37	$197.32	$40.66
% Change from FY 2016-17 Q3 and Q4 Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.24%
% Change from FY 2016-17 Average Rate	0.58%	1.09%	1.49%	1.51%	0.66%	0.79%	2.82%	1.52%
FY 2017-18 Q3 and Q4 Estimated Rate	$15.77	$143.57	$27.36	$22.21	$64.00	$20.84	$203.08	$41.77
% Change from FY 2017-18 Q1 and Q2 Rate	1.22%	2.23%	3.05%	3.06%	3.06%	2.31%	2.92%	2.73%
% Change from FY 2016-17 Average Rate	1.81%	3.34%	4.59%	4.62%	3.74%	3.12%	5.82%	4.29%
FY 2017-18 Estimated Weighted Average Rate [4]	**$15.68**	**$142.02**	**$26.96**	**$21.89**	**$63.05**	**$20.61**	**$200.21**	**$41.32**
% Change from FY 2016-17 Average Rate	1.23%	2.22%	3.06%	3.11%	2.20%	1.98%	4.32%	3.16%

[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 Behavioral 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 Behavioral Health Capitation Rate Trends and Forecasts

Capitation Rate Across Eligibility Categories

Fiscal Year	Adults 65 and Older	Disabled Individuals	Low Income Adults	Expansion Adults	MAGI Adults	Eligible Children	Foster Care	Total
FY 2007-08 Average Caseload	36,284	56,079	60,031			204,022	17,141	373,557
Percentage of Total Caseload	9.71%	15.01%	16.07%			54.62%	4.59%	100.00%
FY 2007-08 Average Weighted Capitation Rate	$13.15	$114.07	$17.51			$13.94	$262.46	$40.87
FY 2008-09 Average Caseload	37,619	57,802	69,167			235,129	18,033	417,750
Percentage of Total Caseload	9.01%	13.84%	16.56%			56.28%	4.32%	100.00%
FY 2008-09 Average Weighted Capitation Rate	$13.37	$121.31	$18.18			$14.34	$251.88	$39.96
FY 2009-10 Average Caseload	38,487	60,313	83,094	3,238		275,672	18,381	479,185
Percentage of Total Caseload	8.03%	12.59%	17.34%	0.68%		57.53%	3.84%	100.00%
FY 2009-10 Average Weighted Capitation Rate	$13.40	$131.64	$19.33	$19.33		$14.71	$220.67	$38.07
FY 2010-11 Average Caseload	38,921	64,052	89,513	27,167		302,410	18,393	540,456
Percentage of Total Caseload	7.20%	11.85%	16.56%	5.03%		55.95%	3.40%	100.00%
FY 2010-11 Average Weighted Capitation Rate	$13.79	$139.14	$20.94	$20.94		$15.41	$195.38	$37.27
FY 2011-12 Average Caseload	39,740	67,869	101,451	35,461	1,134	334,633	18,034	598,322
Percentage of Total Caseload	6.64%	11.34%	16.96%	5.93%	0.19%	55.93%	3.01%	100.00%
FY 2011-12 Average Weighted Capitation Rate	$13.89	$140.82	$21.69	$21.69	$100.85	$16.33	$179.30	$36.58
FY 12-13 Average Caseload	40,827	71,859	108,383	41,545	10,634	368,079	17,777	659,104
Percentage of Total Caseload	6.19%	10.90%	16.44%	6.30%	1.61%	55.85%	2.70%	100.00%
FY 2012-13 Average Weighted Capitation	$13.66	$140.28	$21.89	$21.89	$100.98	$16.75	$171.85	$36.73
FY 2013-14 Average Caseload	41,836	76,837	139,456	47,082	87,243	424,377	18,267	835,098
Percentage of Total Caseload	5.01%	9.20%	16.70%	5.64%	10.45%	50.82%	2.19%	100.00%
FY 2013-14 Average Weighted Capitation	$13.96	$144.99	$23.98	$23.98	$79.38	$17.22	$174.80	$40.27
FY 2014-15 Average Caseload	41,817	80,641	179,742	71,609	240,758	495,836	20,036	1,130,439
Percentage of Total Caseload	3.70%	7.13%	15.90%	6.33%	21.30%	43.86%	1.77%	100.00%
FY 2014-15 Average Weighted Capitation	$14.22	$146.82	$25.97	$25.97	$55.53	$19.20	$215.41	$40.83
FY 2015-16 Average Caseload	42,218	84,791	198,493	82,897	293,091	534,231	19,923	1,255,644
Percentage of Total Caseload	3.36%	6.75%	15.81%	6.60%	23.34%	42.55%	1.59%	100.00%
FY 2015-16 Average Weighted Capitation	$15.30	13272.00%	2548.00%	2068.00%	5960.00%	1969.00%	18190.00%	$40.05
FY 2015-16 Q1 and Q2 Estimated Caseload	42,046	83,835	194,910	81,084	288,584	525,198	19,861	1,235,518
Percentage of Caseload	3.40%	6.79%	15.78%	6.56%	23.36%	42.51%	1.61%	100.00%
FY 2015-16 Q1 and Q2 Weighted Capitation Rate	$15.21	$127.95	$25.18	$20.44	$58.91	$19.46	$172.02	$39.32
FY 2015-16 Q3 and Q4 Estimated Caseload	42,388	85,747	202,074	84,708	297,598	543,264	19,983	1,275,762
Percentage of Caseload	3.32%	6.72%	15.84%	6.64%	23.33%	42.58%	1.57%	100.00%
FY 2015-16 Q3 and Q4 Weighted Capitation Rate	$15.39	$137.38	$25.76	$20.91	$60.26	$19.91	$191.72	$40.76
FY 2016-17 Average Estimated Caseload	42,830	88,875	211,125	86,948	303,341	558,804	19,943	1,311,866
Percentage of Total Caseload	3.26%	6.77%	16.09%	6.63%	23.12%	42.60%	1.52%	100.00%
FY 2016-17 Average Weighted Capitation	$15.49	$138.93	$26.16	$21.23	$61.69	$20.21	$191.91	$41.32
FY 2016-17 Q1 and Q2 Estimated Caseload	42,691	87,794	208,322	86,629	301,819	555,160	19,985	1,302,400
Percentage of Caseload	3.28%	6.74%	16.00%	6.65%	23.17%	42.63%	1.53%	100.00%
FY 2016-17 Q1 and Q2 Weighted Capitation Rate	$15.39	$137.38	$25.76	$20.91	$60.26	$19.91	$191.72	$40.66
FY 2016-17 Q3 and Q4 Estimated Caseload	42,968	89,956	213,925	87,266	304,862	562,447	19,900	1,321,324
Percentage of Caseload	3.25%	6.81%	16.19%	6.60%	23.07%	42.57%	1.51%	100.00%
FY 2016-17 Q3 and Q4 Weighted Capitation Rate	$15.58	$140.44	$26.55	$21.55	$62.10	$20.37	$197.32	$41.77
FY 2017-18 Average Estimated Caseload	43,468	92,907	221,330	91,000	307,941	584,789	19,966	1,361,401
Percentage of Total Caseload	3.19%	6.82%	16.26%	6.68%	22.62%	42.95%	1.47%	100.00%
FY 2017-18 Average Weighted Capitation	$15.68	$142.02	$26.96	$21.89	$63.05	$20.61	$200.21	$42.09
FY 2017-18 Q1 and Q2 Estimated Caseload	43,290	91,959	218,985	89,377	307,109	575,783	19,919	1,346,422
Percentage of Caseload	3.22%	6.83%	16.26%	6.64%	22.81%	42.76%	1.48%	100.00%
FY 2017-18 Q1 and Q2 Weighted Capitation Rate	$15.58	$140.44	$26.55	$21.55	$62.10	$20.37	$197.32	$41.64
FY 2017-18 Q3 and Q4 Estimated Caseload	43,646	93,854	223,675	92,622	308,773	593,794	20,012	1,376,376
Percentage of Caseload	3.17%	6.82%	16.25%	6.73%	22.43%	43.14%	1.45%	100.00%
FY 2017-18 Q3 and Q4 Weighted Capitation Rate	$15.77	$143.57	$27.36	$22.21	$64.00	$20.84	$203.08	$42.52

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]	Expansion Adults	MAGI Adults	Eligible Children	Foster Care
FY 2015-16 Q1/Q2 Rate							
Weighted Capitation Point Estimate	**$15.21**	**$127.95**	**$25.18**	**$20.44**	**$58.91**	**$19.46**	**$172.02**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.52%	0.55%	1.74%	1.74%	4.19%	1.30%	1.88%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.51%	-0.18%	-0.27%	-0.27%	-0.16%	-0.22%	-0.39%
Final Adjustment Factor [2]	**-3.02%**	**0.37%**	**1.47%**	**1.47%**	**4.02%**	**1.08%**	**1.48%**
FY 2015-16 Final Estimated Paid Q1/Q2 Rate [3]	**$14.75**	**$128.42**	**$25.55**	**$20.74**	**$61.28**	**$19.67**	**$174.57**
FY 2015-16 Estimated Q3/Q4 Rate							
Weighted Capitation Point Estimate	**$15.39**	**$137.38**	**$25.76**	**$20.91**	**$60.26**	**$19.91**	**$191.72**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.52%	0.55%	1.74%	1.74%	4.19%	1.30%	1.88%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.51%	-0.18%	-0.27%	-0.27%	-0.16%	-0.22%	-0.39%
Final Adjustment Factor [2]	**-3.02%**	**0.37%**	**1.47%**	**1.47%**	**4.02%**	**1.08%**	**1.48%**
FY 2015-16 Final Estimated Q3/Q4 Rate [3]	**$14.93**	**$137.89**	**$26.14**	**$21.22**	**$62.68**	**$20.13**	**$194.56**
FY 2016-17 Estimated Q1/Q2 Rate							
Weighted Capitation Point Estimate	**$15.39**	**$137.38**	**$25.76**	**$20.91**	**$60.26**	**$19.91**	**$191.72**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.52%	0.55%	1.74%	1.74%	4.19%	1.30%	1.88%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.51%	-0.18%	-0.27%	-0.27%	-0.16%	-0.22%	-0.39%
Final Adjustment Factor [2]	**-3.02%**	**0.37%**	**1.47%**	**1.47%**	**4.02%**	**1.08%**	**1.48%**
FY 2016-17 Final Estimated Q1/Q2 Rate [3]	**$14.93**	**$137.89**	**$26.14**	**$21.22**	**$62.68**	**$20.13**	**$194.56**
FY 2016-17 Estimated Q3/Q4 Rate							
Weighted Capitation Point Estimate	**$15.58**	**$140.44**	**$26.55**	**$21.55**	**$62.10**	**$20.37**	**$197.32**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.52%	0.55%	1.74%	1.74%	4.19%	1.30%	1.88%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.51%	-0.18%	-0.27%	-0.27%	-0.16%	-0.22%	-0.39%
Final Adjustment Factor [2]	**-3.02%**	**0.37%**	**1.47%**	**1.47%**	**4.02%**	**1.08%**	**1.48%**
FY 2016-17 Final Estimated Q3/Q4 Rate [3]	**$15.11**	**$140.96**	**$26.94**	**$21.87**	**$64.60**	**$20.59**	**$200.24**
FY 2017-18 Estimated Q1/Q2 Rate [2]							
Weighted Capitation Point Estimate	**$15.58**	**$140.44**	**$26.55**	**$21.55**	**$62.10**	**$20.37**	**$197.32**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.52%	0.55%	1.74%	1.74%	4.19%	1.30%	1.88%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.51%	-0.18%	-0.27%	-0.27%	-0.16%	-0.22%	-0.39%
Final Adjustment Factor [3]	**-3.02%**	**0.37%**	**1.47%**	**1.47%**	**4.02%**	**1.08%**	**1.48%**
FY 2017-18 Final Estimated Q1/Q2 Rate [4]	**$15.11**	**$140.96**	**$26.94**	**$21.87**	**$64.60**	**$20.59**	**$200.24**
FY 2017-18 Estimated Q3/Q4 Rate							
Weighted Capitation Point Estimate	**$15.77**	**$143.57**	**$27.36**	**$22.21**	**$64.00**	**$20.84**	**$203.08**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.52%	0.55%	1.74%	1.74%	4.19%	1.30%	1.88%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.51%	-0.18%	-0.27%	-0.27%	-0.16%	-0.22%	-0.39%
Final Adjustment Factor [3]	**-3.02%**	**0.37%**	**1.47%**	**1.47%**	**4.02%**	**1.08%**	**1.48%**
FY 2017-18 Final Estimated Q3/Q4 Rate [4]	**$15.29**	**$144.10**	**$27.76**	**$22.54**	**$66.57**	**$21.07**	**$206.09**

[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 set for Q3 and Q4 of FY 2015-16 will be the same rate in effect for Q1 and Q2 of FY 2016-17.

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

[4] The 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.

Exhibit HH - Forecast Model Comparisons - Capitation Trend Models

Capitation Rate Forecast Model for FY 2015-16 Q3 and Q4

Model	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults [1]	Expansion Adults	MAGI Adults	Eligible Children	Foster Care [2]
FY 2013-14 Actual Rate	$13.96	$144.99	$23.98	$23.98	$79.38	$17.22	$174.80
FY 2014-15 Q1 and Q2 Weighted Average Rate	$14.21	$146.88	$25.96	$26.02	$55.51	$18.74	$212.29
FY 2014-15 Q3 and Q4 Weighted Average Rate	$14.23	$146.77	$25.97	$26.00	$55.54	$19.63	$218.57
FY 2014-15 Full Year Average Rate	$14.22	$146.82	$25.97	$26.01	$55.53	$19.20	$215.41
FY 2015-16 Q1 and Q2 Weighted Average Rate	$15.21	$127.95	$25.18	$20.44	$58.91	$19.46	$172.02
Recent Growth Rates							
% Growth from FY 2013-14 to FY 2014-15 Rate	1.86%	1.26%	8.30%	8.47%	-30.05%	11.50%	23.23%
% Growth from CY 2014 to CY 2015 Rate	7.04%	-12.89%	-3.00%	-21.45%	6.13%	3.84%	-18.97%
Selected Trend Models							
Average Growth Model	$13.44	$176.40	$29.77	$34.57	$34.05	$19.48	$239.78
% Difference from FY 2016-17 Q1 and Q2 Rate	-11.65%	37.87%	18.23%	69.12%	-42.21%	0.10%	39.39%
% Difference from FY 2015-16 Full Year Average Rate	-5.50%	20.15%	14.63%	32.91%	-38.69%	1.45%	11.31%
Two Period Moving Average Model	$12.98	$163.50	$24.77	$29.45	$3,883.69	-$0.26	$11,175.07
% Difference from FY 2016-17 Q1 and Q2 Rate	-14.67%	27.78%	-1.61%	44.10%	6492.59%	-101.35%	6396.38%
% Difference from FY 2015-16 Full Year Average Rate	-8.73%	11.36%	-4.60%	13.24%	6893.86%	-101.37%	5087.81%
Exponential Growth Model	$15.54	$248.59	$34.90	$39.62	$39.71	$19.66	$174.10
% Difference from FY 2016-17 Q1 and Q2 Rate	2.17%	94.29%	38.60%	93.85%	-32.60%	1.05%	1.21%
% Difference from FY 2015-16 Full Year Average Rate	9.28%	69.32%	34.38%	52.34%	-28.50%	2.42%	-19.18%
Linear Growth Model	$15.00	$210.13	$29.12	$33.84	$30.81	$18.35	$167.38
% Difference from FY 2016-17 Q1 and Q2 Rate	-1.38%	64.23%	15.64%	65.56%	-47.71%	-5.73%	-2.70%
% Difference from FY 2015-16 Full Year Average Rate	5.49%	43.12%	12.12%	30.10%	-44.53%	-4.45%	-22.30%
CY 2016 Forecast Minimum	$12.98	$163.50	$24.77	$29.45	$30.81	-$0.26	$167.38
CY 2016 Forecast Maximum	$15.54	$248.59	$34.90	$39.62	$3,883.69	$19.66	$11,175.07
% change from FY 2014-15 Rate to Selected FY 2015-16 Q1 & Q2 Capitation Rate [3]	1.21%	7.37%	2.30%	2.30%	2.30%	2.30%	11.45%
CY 2016 Forecast Point Estimate	**$15.39**	**$137.38**	**$25.76**	**$20.91**	**$60.26**	**$19.91**	**$191.72**
% change from CY 2015 Rate to Selected CY 2016 Capitation Rate [4]	1.21%	2.23%	3.06%	3.06%	3.06%	2.30%	2.92%
CY 2017 Forecast Point Estimate	**$15.58**	**$140.44**	**$26.55**	**$21.55**	**$62.10**	**$20.37**	**$197.32**
% change from CY 2016 Rate to Selected CY 2017 Capitaltion Rate [5]	1.21%	2.23%	3.06%	3.06%	3.06%	2.30%	2.92%
CY 2018 Forecast Point Estimate	**$15.77**	**$143.57**	**$27.36**	**$22.21**	**$64.00**	**$20.84**	**$203.08**

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

[2] The rate methodology changed beginning CY 2014 and we are using known values in the rate development. Therefore, the forecast point estimate for CY 2016, CY 2017, CY 2018 may not fit into the forecasted min and max range because the range is based on historical data and methodologies.

Footnote	Population	Trend	Footnote	Population	Trend
[3] 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 the average growth of previous five years.	3 Percentage selected to modify capitation rates for CY 2016: Where applicable, percentage selections have been bolded for clarification.	MAGI Adults	Due to lack of avaiable data, trend is equal to Low Income Adults
	Disabled Individuals	Trend is average of FY 2014-15 and FY 2015-16 Q1/Q2 rates. This cohort had a significant decrease in rate between periods, but the Department expects data to support a rate increase in FY 2015-16 Q3/Q4.		Eligible Children	Trend is half of the average growth of last two years of rates.
	Low Income Adults/ Expansion Low Income Adults	Trend is half of the average growth of previous five years.		Foster Care	Trend is average of FY 2014-15 and FY 2015-16 Q1/Q2 rates. This cohort had a significant decrease in rate between periods, but the Department expects data to support a rate increase in FY 2015-16 Q3/Q4.
[4] 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 the average growth of previous five years.	4 Percentage selected to modify capitation rates for CY 2017: Where applicable, percentage selections have been bolded for clarification.	MAGI Adults	Due to lack of avaiable data, trend is equal to Low Income Adults
	Disabled Individuals	Trend is average of FY 2014-15 and FY 2015-16 Q1/Q2 rates. This cohort had a significant decrease in rate between periods, but the Department expects data to support a rate increase in FY 2015-16 Q3/Q4.		Eligible Children	Trend is half of the average growth of last two years of rates.
	Low Income Adults/ Expansion Low Income Adults	Trend is half of the average growth of previous five years.		Foster Care	Trend is growth from FY 2012-13 to FY 2013-14.
[5] Percentage selected to modify capitation rates for CY 2018: Where applicable, percentage selections have been bolded for clarification.	Adults 65 and Older (OAP-A)	Trend is the average growth of previous five years.	5 Percentage selected to modify capitation rates for CY 2018: Where applicable, percentage selections have been bolded for clarification.	MAGI Adults	Due to lack of avaiable data, trend is equal to Low Income Adults
	Disabled Individuals	Trend is average of FY 2014-15 and FY 2015-16 Q1/Q2 rates. This cohort had a significant decrease in rate between periods, but the Department expects data to support a rate increase in FY 2015-16 Q3/Q4.		Eligible Children	Trend is half of the average growth of last two years of rates.
	Low Income Adults/ Expansion Low Income Adults	Trend is half of the average growth of previous five years.		Foster Care	Trend is growth from FY 2012-13 to FY 2013-14.

Exhibit II - Reconciliations

Total Reconciliations by Fiscal Year

	FY 2013-14 Actuals	FY 2014-15 Actuals	FY 2015-16 Estimate [1]	FY 2016-17 Estimate	FY 2017-18 Estimate
Estimated Reconciliation for FY 2013-14	$0	$0	$20,613,732	$0	$0
Estimated Reconciliation for FY 2014-15	$0	$0	$0	$0	$0
Estimated Reconciliation for FY 2015-16	$0	$0	$0	$0	$0
Net Impact of Estimated Reconciliations	$0	$0	$20,613,732	$0	$0

[1] Reconciliation amount is for the MAGI Adult rate risk corridor reconcilation for dates of service from January through June 2014.

Reconciliation Fund Splits

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Estimated Reconciliation for FY 2015-16	$20,613,732	$0	$0	$0	$20,613,732
Estimated Reconciliation for FY 2016-17	$0	$0	$0	$0	$0
Estimated Reconciliation for FY 2017-18	$0	$0	$0	$0	$0

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	8,585	$311.75	$2,676,374	$0	$1,317,044	$0	$1,359,330	50.79%
MAGI Parents and Caretakers 69% - 133% FPL	82,897	$256.18	$21,236,553	$0	$0	$0	$21,236,553	100.00%
MAGI Adults	291,652	$747.71	$218,071,117	$0	$0	$0	$218,071,117	100.00%
Non Newly Eligible	1,439	$311.75	$448,608	$0	$220,760	$0	$227,848	50.79%
Buy-In for Disabled Individuals	4,859	$1,593.73	$7,743,934	$0	$3,810,790	$0	$3,933,144	50.79%
Continuous Eligibility Financing				($3,345,892)	$3,345,892	$0	$0	
Total from Hospital Provider Fee Fund	**-**	**-**	**$250,176,586**	**($3,345,892)**	**$8,694,486**	**$0**	**$244,827,992**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	59,802	$239.50	$14,322,579	$2,463,484	$0	$0	$11,859,095	82.80%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,728	$311.75	$538,704	$92,657	$0	$0	$446,047	82.80%

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	8,585	$7.85	$67,374	$0	$33,155	$0	$34,219	50.79%
MAGI Parents and Caretakers 69% - 133% FPL	82,897	$5.53	$458,709	$0	$0	$0	$458,709	100.00%
MAGI Adults	291,652	$13.22	$3,856,012	$0	$0	$0	$3,856,012	100.00%
Non Newly Eligible	1,439	$13.22	$19,025	$0	$9,362	$0	$9,663	50.79%
Buy-In for Disabled Individuals	4,859	$4.50	$21,866	$0	$10,760	$0	$11,106	50.79%
Continuous Eligibility Financing				($54,750)	$54,750	$0	$0	
Total from Hospital Provider Fee Fund	**-**	**-**	**$4,422,986**	**($54,750)**	**$108,027**	**$0**	**$4,369,709**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	59,802	$6.02	$359,775	$61,881	$0	$0	$297,894	82.80%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,728	$4.17	$7,208	$1,240	$0	$0	$5,968	82.80%

[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	9,473	$320.21	$3,033,250	$0	$1,503,885	$0	$1,529,365	50.42%
MAGI Parents and Caretakers 69% - 133% FPL	86,948	$261.27	$22,716,904	$0	$567,923	$0	$22,148,981	97.50%
MAGI Adults	301,902	$768.40	$231,981,497	$0	$5,799,537	$0	$226,181,960	97.50%
Non Newly Eligible	1,439	$320.21	$460,782	$0	$228,456	$0	$232,326	50.42%
Buy-In for Disabled Individuals	5,721	$1,669.60	$9,551,782	$0	$4,735,774	$0	$4,816,008	50.42%
Continuous Eligibility Financing				($3,485,081)	$3,485,081	$0	$0	
Total from Hospital Provider Fee Fund	**-**	**-**	**$267,744,215**	**($3,485,081)**	**$16,320,656**	**$0**	**$254,908,640**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	64,629	$245.03	$15,836,044	$1,854,401	$0	$0	$13,981,643	88.29%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,725	$320.21	$552,362	$64,682	$0	$0	$487,680	88.29%

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	9,473	$7.85	$74,341	$0	$36,858	$0	$37,483	50.42%
MAGI Parents and Caretakers 69% - 133% FPL	86,948	$5.53	$481,125	$0	$12,028	$0	$469,097	97.50%
MAGI Adults	301,902	$13.22	$3,991,530	$0	$99,788	$0	$3,891,742	97.50%
Non Newly Eligible	1,439	$13.22	$19,025	$0	$9,433	$0	$9,592	50.42%
Buy-In for Disabled Individuals	5,721	$4.50	$25,745	$0	$12,764	$0	$12,981	50.42%
Continuous Eligibility Financing				($57,028)	$57,028	$0	$0	
Total from Hospital Provider Fee Fund	**-**	**-**	**$4,591,766**	**($57,028)**	**$227,899**	**$0**	**$4,420,895**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	64,629	$6.02	$388,815	$45,530	$0	$0	$343,285	88.29%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,725	$4.17	$7,196	$843	$0	$0	$6,353	88.29%

[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 2017-18 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	10,356	$330.02	$3,417,535	$0	$1,700,565	$0	$1,716,970	50.24%
MAGI Parents and Caretakers 69% - 133% FPL	91,000	$269.27	$24,503,570	$0	$1,347,696	$0	$23,155,874	94.50%
MAGI Adults	306,502	$792.03	$242,758,779	$0	$13,351,733	$0	$229,407,046	94.50%
Non Newly Eligible	1,439	$330.02	$474,899	$0	$236,310	$0	$238,589	50.24%
Buy-In for Disabled Individuals	6,482	$1,707.88	$11,070,478	$0	$5,508,670	$0	$5,561,808	50.24%
Continuous Eligibility Financing				($3,740,537)	$3,740,537	$0	$0	
Total from Hospital Provider Fee Fund	**-**	**-**	**$282,225,261**	**($3,740,537)**	**$25,885,511**	**$0**	**$260,080,287**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	69,364	$250.70	$17,389,555	$2,057,184	$0	$0	$15,332,371	88.17%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,725	$330.02	$569,285	$67,346	$0	$0	$501,939	88.17%

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	10,356	$7.85	$81,269	$0	$40,439	$0	$40,830	50.24%
MAGI Parents and Caretakers 69% - 133% FPL	91,000	$5.53	$503,547	$0	$27,695	$0	$475,852	94.50%
MAGI Adults	306,502	$13.22	$4,052,348	$0	$222,879	$0	$3,829,469	94.50%
Non Newly Eligible	1,439	$13.22	$19,025	$0	$9,467	$0	$9,558	50.24%
Buy-In for Disabled Individuals	6,482	$4.50	$29,170	$0	$14,515	$0	$14,655	50.24%
Continuous Eligibility Financing				($61,208)	$61,208	$0	$0	
Total from Hospital Provider Fee Fund	**-**	**-**	**$4,685,359**	**($61,208)**	**$376,203**	**$0**	**$4,370,364**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	69,364	$6.02	$417,301	$49,367	$0	$0	$367,934	88.17%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,725	$4.17	$7,196	$851	$0	$0	$6,345	88.17%

[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 2015-16 Calculation

Components	FY 2014-15 Actual	FY 2015-16 Appropriation	Estimated Change in Total Behavioral Health Caseload			FY 2015-16 Estimate	FY 2015-16 Change from Appropriation
			FY 2014-15 Average Monthly Caseload	FY 2015-16 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$1,037,617	$1,159,633	1,130,439	1,255,644	11.08%	$1,152,541	($7,092)
Outpatient Services	$6,421,463	$7,176,580	1,130,439	1,255,644	11.08%	$7,132,690	($43,890)
Physician Services	$66,344	$74,146	1,130,439	1,255,644	11.08%	$73,692	($454)
Total After Prior Year Adjustments	**$7,525,424**	$8,410,359				**$8,358,923**	**($51,436)**

FY 2016-17 Calculation

Components	FY 2015-16 Estimate [1]	Estimated Change in Total Behavioral Health Caseload			FY 2016-17 Estimate	FY 2016-176 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	$1,152,541	1,255,644	1,311,866	4.48%	$1,204,147	$51,606
Outpatient Services	$7,132,690	1,255,644	1,311,866	4.48%	$7,452,059	$319,369
Physician Services	$73,692	1,255,644	1,311,866	4.48%	$76,992	$3,300
Total After Prior Year Adjustments	**$8,358,923**				**$8,733,198**	**$374,275**

[1] The FY 2015-16 estimates are the base for the FY 2016-17 estimates.

FY 2017-18 Calculation

Components	FY 2016-17 Estimate [2]	Estimated Change in Total Behavioral Health Caseload			FY 2017-18 Estimate	FY 2017-18 Change from FY 2016-17 Estimate
		FY 2016-17 Forecasted Average Monthly Caseload	FY 2017-18 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$1,204,147	1,311,866	1,361,401	3.78%	$1,249,615	$45,468
Outpatient Services	$7,452,059	1,311,866	1,361,401	3.78%	$7,733,443	$281,384
Physician Services	$76,992	1,311,866	1,361,401	3.78%	$79,899	$2,907
Total After Prior Year Adjustments	**$8,733,198**				**$9,062,957**	**$329,759**

[2] The FY 2016-17 estimates are the base for the FY 2017-18 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 Actual	$577,485,822	37.10%	$156,256,138	$499,357,753	37.36%	$434,862,583	30.13%
FY 2015-16 Appropriation vs. FY 2014-15 Actual	$646,025,263	11.87%	$68,539,441	$611,755,543	22.51%	$548,246,923	26.07%
FY 2015-16 Estimate vs. FY 2014-15 Actual	$599,933,435	3.89%	$22,447,613	$588,709,629	17.89%	$532,882,980	22.54%
FY 2015-16 Estimate vs. 2015-16 Appropriation	$599,933,435	-7.13%	($46,091,828)	$588,709,629	-3.77%	$532,882,980	-2.80%
FY 2016-17 Estimate vs. FY 2015-16 Appropriation	$663,553,378	2.71%	$17,528,115	$654,789,321	7.03%	$629,021,488	14.73%
FY 2016-17 Estimate vs. FY 2015-16 Estimate	$663,553,378	10.60%	$63,619,943	$631,743,407	7.31%	$613,657,545	15.16%
FY 2017-18 Estimate vs. FY 2015-16 Appropriation	$703,233,545	8.86%	$57,208,282	$674,629,404	10.28%	$670,937,395	22.38%
FY 2017-18 Estimate vs. FY 2016-17 Estimate	$703,233,545	5.98%	$39,680,167	$683,393,462	8.18%	$655,573,453	6.83%

[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 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-03 CHP+

Dept. Approval By: Josh Block [signature] 11/2/15 | X | **Supplemental FY 2015-16**

OSPB Approval By: [signature] 10/28/15

	Supplemental FY 2015-16
X	**Change Request FY 2016-17**
	Base Reduction FY 2016-17
	Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$166,723,024**	**$0**	**$166,724,351**	**($17,605,016)**	**($10,596,184)**
	FTE	$0	0.0	$0	0.0	0.0
	GF	$2,525,718	$0	$2,525,718	($25,277)	($1,904,512)
	CF	$29,111,476	$0	$29,219,879	($11,208,331)	($10,118,625)
	RF	$0	$0	$0	$0	$0
	FF	$135,085,830	$0	$134,978,754	($6,371,408)	$1,426,953

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
05. Indigent Care Program - Children's Basic Health Plan Administration	**Total**	**$0**	**$0**	**$0**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
05. Indigent Care Program - Children's Basic Health Plan Medical and Dental Costs	**Total**	**$166,723,024**	**$0**	**$166,724,351**	**($17,605,016)**	**($10,596,184)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,525,718	$0	$2,525,718	($25,277)	($1,904,512)
	CF	$29,111,476	$0	$29,219,879	($11,208,331)	($10,118,625)
	RF	$0	$0	$0	$0	$0
	FF	$135,085,830	$0	$134,978,754	($6,371,408)	$1,426,953

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 XXI CF: See Exhibit C2	
Reappropriated Funds Source, by Department and Line Item Name:						
Approval by OIT?	Yes	___	No	___	**Not Required:**	X
Schedule 13s from Affected Departments:		N/A				
Other Information:						

Department of Health Care Policy and Financing
Children's Basic Health Plan

FY 2015-16, FY 2016-17, and FY 2017-18 Budget Request

November 2015

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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 2015 Forecast

- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for children was 53,832, which is 929, or 1.70%, under what was forecasted in February 2015. Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for prenatal is 693, which is 31, or 4.29% under what was forecasted in February 2015. This has resulted in a decreased caseload forecast for all forecast years and a lower estimated expenditure in FY 2015-16 than previously forecasted in February 2015.
- The CHP+ program makes reconciliation payments for manual enrollments that are not part of the capitation payments. These payments decreased significantly in FY 2014-15. In FY 2013-14, the Department paid $18.4 million in reconciliation payments for manual enrollments. In FY 2014-15, this type of expenditure dropped to $3.6 million. These payments are expected to remain at this lower level. This resulted in a much lower expenditure in FY 2014-15 than projected in February 2015, and a much lower projected expenditure in FY 2015-16.
- Rates for children's medical capitation payments decreased by 5% for children to 205% FPL and 9% for children 206%-260% FPL. This has resulted in a lower projected expenditure for FY 2015-16.

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.
- The Modified Adjusted Gross Income (MAGI), required by the Affordable Care Act of 2010 (ACA) began in October 2013. States are 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. The 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.
- 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.
- 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.

- In FY 2013-14, prenatal capitations for some clients within 201%-259% 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%. This issue was 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%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- The contracted rates for prenatal clients in FY 2015-16 are unchanged from the contracted rates in FY 2014-15.
- 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. This has resulted in a substantial increase in rates for dental services in FY 2014-15.
- In FY 2014-15, the Department had submitted an estimate for the implementation of HB 09-1353, removing the five year bar on legal immigrant children and pregnant women. The five 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 Department began paying a disallowance in FY 2014-15 due to the expiration of the prenatal waiver used to pay for prenatal clients within the 206%-250% FPL range. Payment details can be found on page R-3.C2-6.

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 2015-16 in February 2016.

The eligible CHP+ populations are:

- Children to 205% FPL (Medical and Dental)
- Children 206%-260% FPL (Medical and Dental)
- Prenatal to 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 through FY 2013-14 is from COFRS, historical expenditure from FY 2014-15 is from CORE.

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 nine categories rather than the previous three (children's medical, children's dental, and prenatal). In addition to viewing the nine 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%-259%. These individual analyses are then aggregated in the FPL brackets 0%-205% and 206%-260%. The age groups are each considered separately. 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 claims distribution 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-3.12)

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).

The enhanced CHP+ FMAP was raised from 65% to 65.71% in October 2014. The average for the State Fiscal Year 2014-15 was 65.53%. Per the Patient Protection and Affordable Care Act (Sec. 2101 (a)), the enhanced CHP+ FMAP will be raised 23 percentage points from October 1, 2015 through September 30, 2019 (SSA 2105 (b)). The projected FMAP for FY 2015-16 is 82.80% and the projected FMAP for FY 2016-17 is 88.5%. 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. The total amount attributed to the General Fund in FY 2015-16, FY 2016-17, and FY 2017-18 is due to the disallowance payments, discussed above.

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 eligibility categories broken down by poverty level (0%-205% and 206%-260%) and also broken down by age group for children's categories (ages 0-1, 2-5, and 6-18). 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.

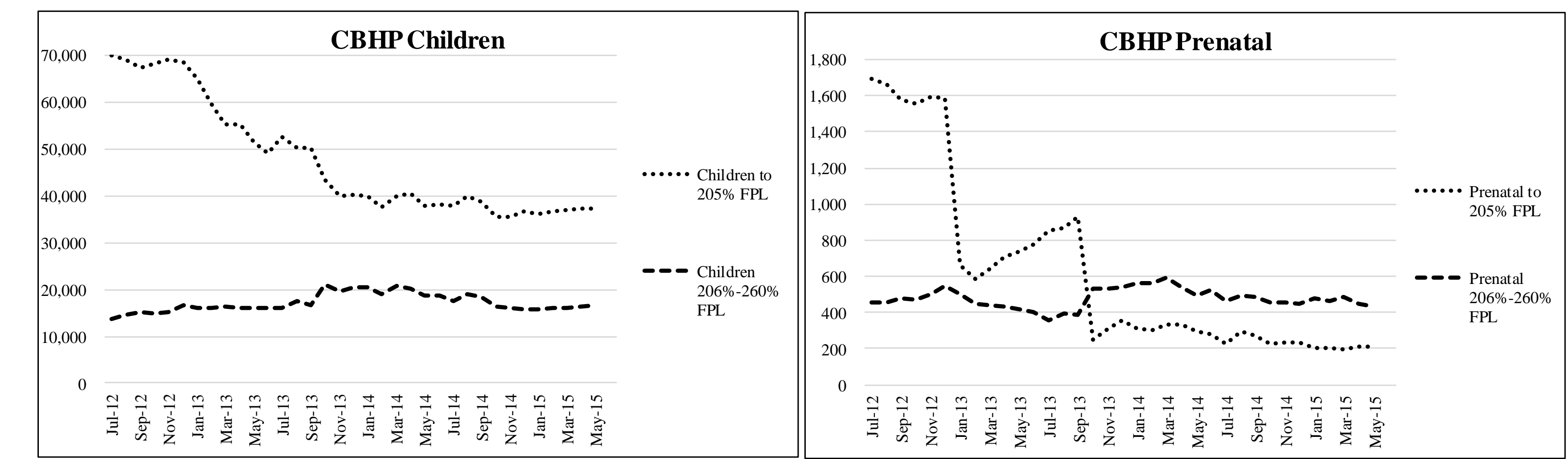
Children's Basic Health Plan Caseload by Fiscal Year

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).

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 three most recent fiscal years. As can be seen in the graphs shown below and on page R-3.C4-5, caseload steadily decreased for populations under 205% FPL from January 2013 through January 2014, 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. The most recent months seem to have remained steady.



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 capita. 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. Calculated per capita in Exhibit C4-Per Capita Historical Summary represent the estimated per capita including all expenditure adjustments for the given fiscal year. Forecasted per capita 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-3.10 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 capita for all children's expenditure categories, and a subsequent decrease in FY 2014-15.

For prenatal clients to 205% FPL, the actual per capita in FY 2013-14 decreased by 0.61%. This is due to a systems issue with capitation payments beginning in January 2014, discussed above. These capitation issues were seen in clients within 186%-200%, 201%-213%, and 214%-225%. This issue was resolved in FY 2014-15.

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 through FY 2013-14 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. Actual expenditure from FY 2014-15 and forward are from the Colorado Operations Resource Engine (CORE). 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 2015 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 for capitation payments. 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 either one child, or 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, R-3.C5-2, and R-3.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. Page R-3.C6-4 presents the percentage of claims paid in a twelve-month period that come from that same period and those which come from previous periods.

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 Federally Qualified Health Centers (FQHC's)/ Rural Health Centers (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. In FY 2014-15, the Department paid $6,216,390 in reconciliation payments to FQHC's and RHC's. This includes a payment that required a good cause waiver. Approval for the good cause waiver was received from CMS in April 2015, and the payments were made in June 2015. The Department estimates a total of $6,423,983 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.

EXHIBIT C8 - CBHP RETROACTIVITY ADJUSTMENT AND CLAIMS DISTRIBUTION 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 seven 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 Department did experience a significant amount of duplicate claims through calendar year 2013, but these duplicate claims have been removed from this analysis. Details on the selected retroactivity adjustment can be found on page R-3.C8-1.

Claims Distribution Adjustment Multiplier

To derive the claims distribution 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 amount paid divided by claims was compared to the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual HMO or SMCN). 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 claims distribution 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. Rates are first presented by poverty level and age group, and then aggregated by poverty level for all ages.

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 2014-15, and the projected weighted rates through FY 2017-18.

Fiscal Year	Children Medical to 205% FPL	Children Medical 206%-259% FPL	Children Dental to 205% FPL	Children Dental 206%-259% FPL	Prenatal to 205% FPL	Prenatal 206%-259% FPL	Weighted CBHP Total
FY 2014-15 Actuals	**$151.22**	**$154.78**	**$18.45**	**$18.02**	**$980.09**	**$970.08**	**$180.83**
FY 2015-16 Estimated Rate	**$143.22**	**$140.41**	**$19.28**	**$18.89**	**$980.13**	**$970.08**	**$172.39**
% Change from FY 2014-15	-5.29%	-9.28%	4.50%	4.83%	0.00%	0.00%	-4.67%
FY 2016-17 Estimated Rate	**$146.77**	**$141.67**	**$19.91**	**$19.54**	**$1,005.81**	**$993.85**	**$176.31**
% Change from FY 2015-16	2.48%	0.90%	3.27%	3.44%	2.62%	2.45%	2.28%
FY 2017-18 Estimated Rate	**$149.30**	**$142.99**	**$20.56**	**$20.19**	**$1,026.83**	**$1,013.43**	**$178.83**
% Change from FY 2016-17	1.72%	0.93%	3.26%	3.33%	2.09%	1.97%	1.97%

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 S-3A/BA-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.

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 claims distribution adjustment multiplier, calculated on page R-3.C8-2. The multiplier is applied to account for the distribution of clients amongst the different HMO's and the SMCN. The average amount paid may not perfectly reflect the estimated claims distribution. 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.

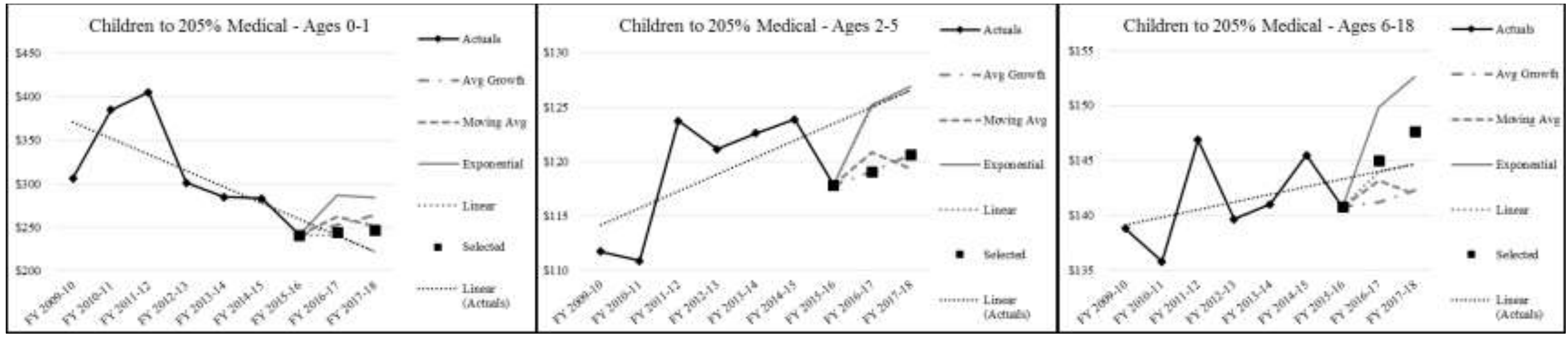
For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate 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.

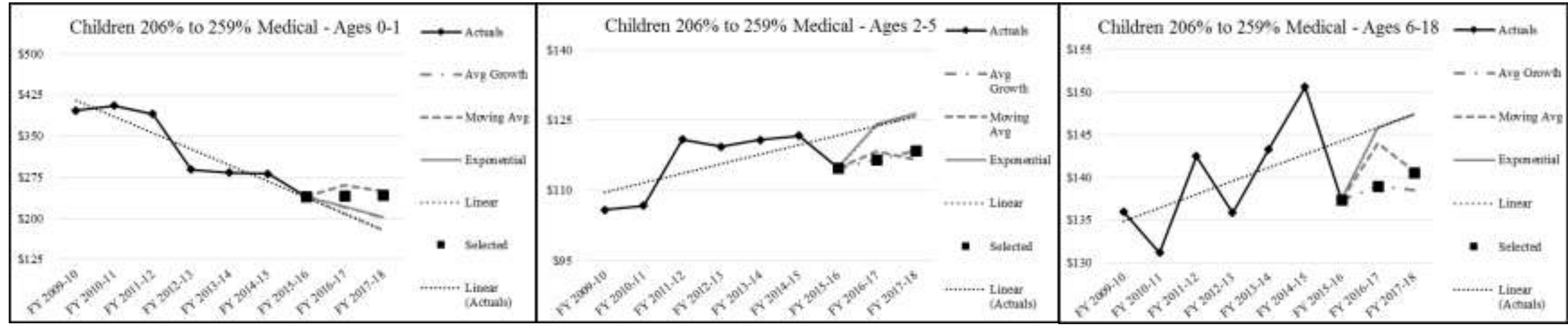
Capitation rates are required to be actuarially sound and are built from a blend of historical rates. The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future 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 beginning on the next page show the trends selected for the current and request years by eligibility category.

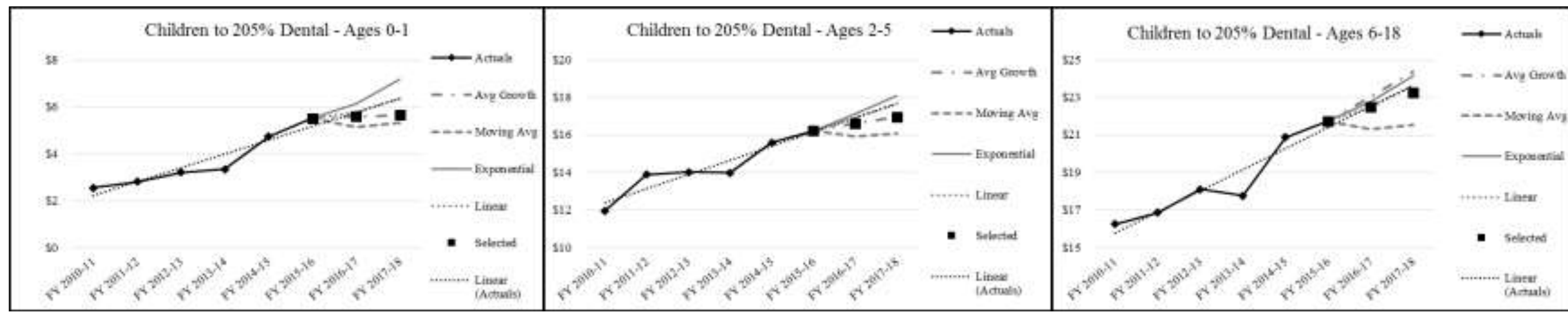
Rate Trends for Children Medical to 205% FPL			
Aid Category	**FY 2016-17 Trend Selection**	**FY 2017-18 Trend Selection**	**Justification**
Children to 205% FPL Medical Ages 0-1	**1.23%** Exponential Growth Model	**1.23%** Trend selected for FY 2016-17	Rates for clients' ages 0-1 decreased in FY 2015-16, but remained relatively flat in FY 2013-14 and FY 2014-15. The trend selected is only slightly positive.
Children to 205% FPL Medical Ages 2-5	**1.03%** Average Growth Model	**1.32%** Average Growth Model	Rates for clients ages 2-5 decreased in FY 2015-16. The trend selected is comparable to the growth rates seen in FY 2013-14 and FY 2014-15.
Children to 205% FPL Medical Ages 6-18	**3.00%** Exponential Growth Model	**1.85%** Exponential Growth Model	Rates for clients ages 6-18 decreased in FY 2015-16. In prior years the rates have been volatile. The trend selected is comparable to the growth seen in FY 2014-15.



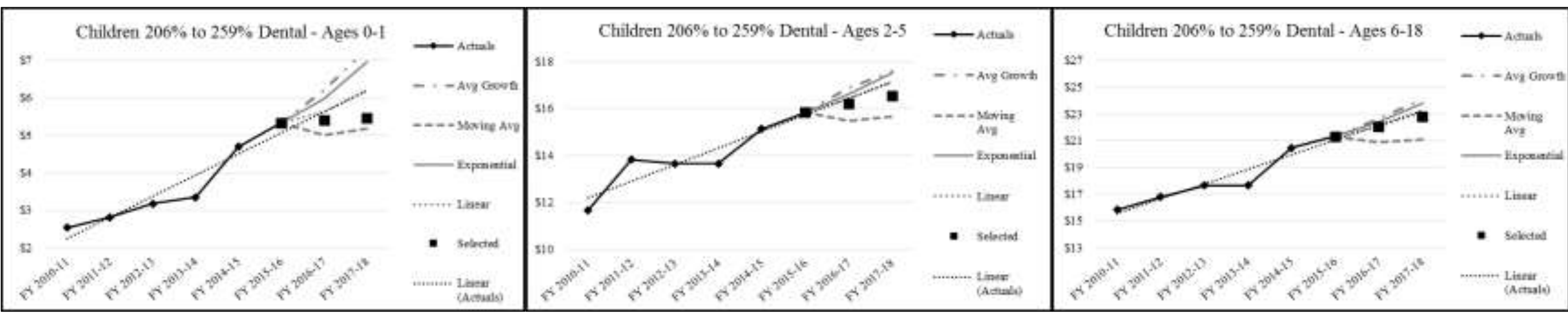
Rate Trends for Children Medical 206% to 259% FPL			
Aid Category	**FY 2016-17 Trend Selection**	**FY 2017-18 Trend Selection**	**Justification**
Children 206% to 259% FPL Medical Ages 0-1	**0.62%** Average of Average Growth Model and Two Period Moving Average	**0.62%** Trend selected for FY 2016-17	Rates for clients ages 0-1 decreased in FY 2015-16, but remained relatively flat in FY 2013-14 and FY 2014-15. The trend selected is only slightly positive.
Children 206% to 259% FPL Medical Ages 2-5	**1.52%** Average Growth Model	**1.65%** Average Growth Model	Rates for clients ages 2-5 decreased in FY 2015-16. The trend selected is comparable to the growth rates seen in FY 2013-14 and FY 2014-15.
Children 206% to 259% FPL Medical Ages 6-18	**1.16%** Average Growth Model	**1.16%** Trend selected for FY 2016-17	Rates for clients ages 6-18 decreased in FY 2015-16. In prior years the rates have been volatile. The trend selected is slightly positive.



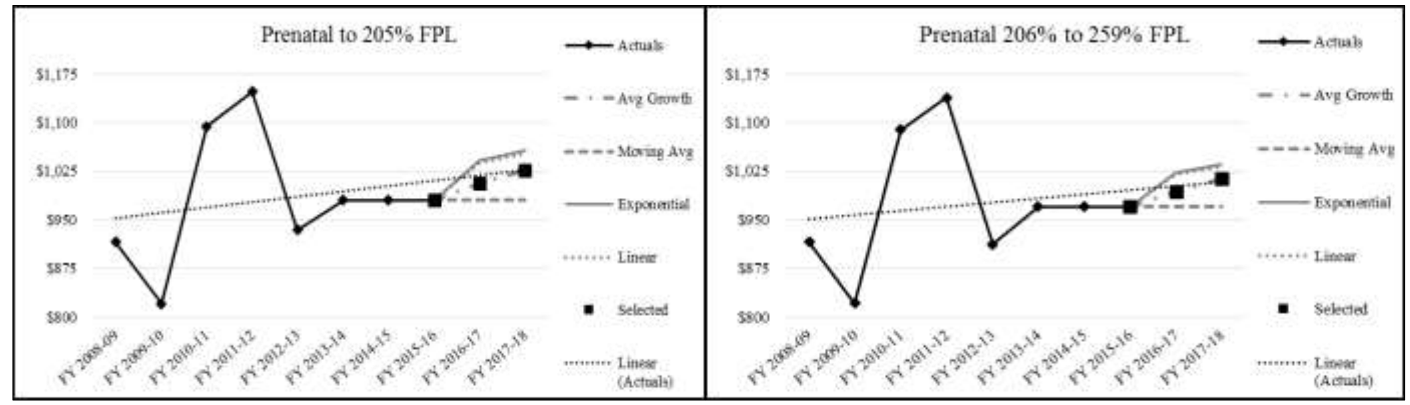
Rate Trends for Children Dental to 205% FPL			
Aid Category	**FY 2016-17 Trend Selection**	**FY 2017-18 Trend Selection**	**Justification**
Children to 205% FPL Dental Ages 0-1	**1.27%** Average Growth Model	**1.27%** Trend selected for FY 2016-17	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
Children to 205% FPL Dental Ages 2-5	**2.40%** Average Growth Model	**2.05%** Average Growth Model	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
Children to 205% FPL Dental Ages 6-18	**3.44%** Linear Growth Model	**3.44%** Trend selected for FY 2016-17	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.



Rate Trends for Children Dental 206% to 259% FPL			
Aid Category	**FY 2016-17 Trend Selection**	**FY 2017-18 Trend Selection**	**Justification**
Children 206% to 259% FPL Dental Ages 0-1	**1.27%** Trend selected for Children 0%-205% FPL	**1.27%** Trend selected for Children 0%-205% FPL	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
Children 206% to 259% FPL Dental Ages 2-5	**2.40%** Trend selected for Children 0%-205% FPL	**2.05%** Trend selected for Children 0%-205% FPL	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
Children 206% to 259% FPL Dental Ages 6-18	**3.36%** Linear Growth Model	**3.36%** Trend selected for FY 2016-17	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.



Rate Trends for Prenatal			
Aid Category	**FY 2015-16 Trend Selection**	**FY 2016-17 Trend Selection**	**Justification**
Prenatal to 205% FPL	**2.62%** Average Growth Model	**2.09%** Average Growth Model	Rates for prenatal clients did not change from FY 2013-14 to FY 2014-15. The trend selected is from the percent change seen from FY 2012-13 to FY 2013-14.
Prenatal 206%-259% FPL	**2.45%** Average Growth Model	**1.97%** Average Growth Model	This population is still relatively new. Trends are identical to what was selected for prenatal clients to 205% FPL.



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 (shaded) is subject to change as there may not be sufficient run out to capture the true length of stay for all clients. 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%-205%	**CHP Children 206%-259%**	**CHP Prenatal 0%-205%**	**CHP Prenatal 206%-259%**
FY 2009-10	Avg. LOS Mo's	14.50	15.60	7.72	6.48
	% > 12 Mo's	51.66%	49.72%	3.03%	1.08%
FY 2010-11	Avg. LOS Mo's	11.55	12.83	6.96	6.82
	% > 12 Mo's	40.92%	51.30%	1.94%	1.68%
FY 2011-12	Avg. LOS Mo's	9.18	11.26	6.35	6.38
	% > 12 Mo's	32.86%	49.21%	1.41%	0.91%
FY 2012-13	Avg. LOS Mo's	8.41	11.32	5.16	6.34
	% > 12 Mo's	26.55%	42.53%	0.78%	0.63%
FY 2013-14	Avg. LOS Mo's	9.31	11.45	5.18	6.60
	% > 12 Mo's	23.19%	32.41%	1.16%	3.48%

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 2015. The following forecasting models are used to forecast CBHP caseload: trend and monthly seasonal dummy variables, ARIMA models, trend stationary, and difference stationary. The Department is now using the software EViews 6 to estimate these models.

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 incorporates 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.

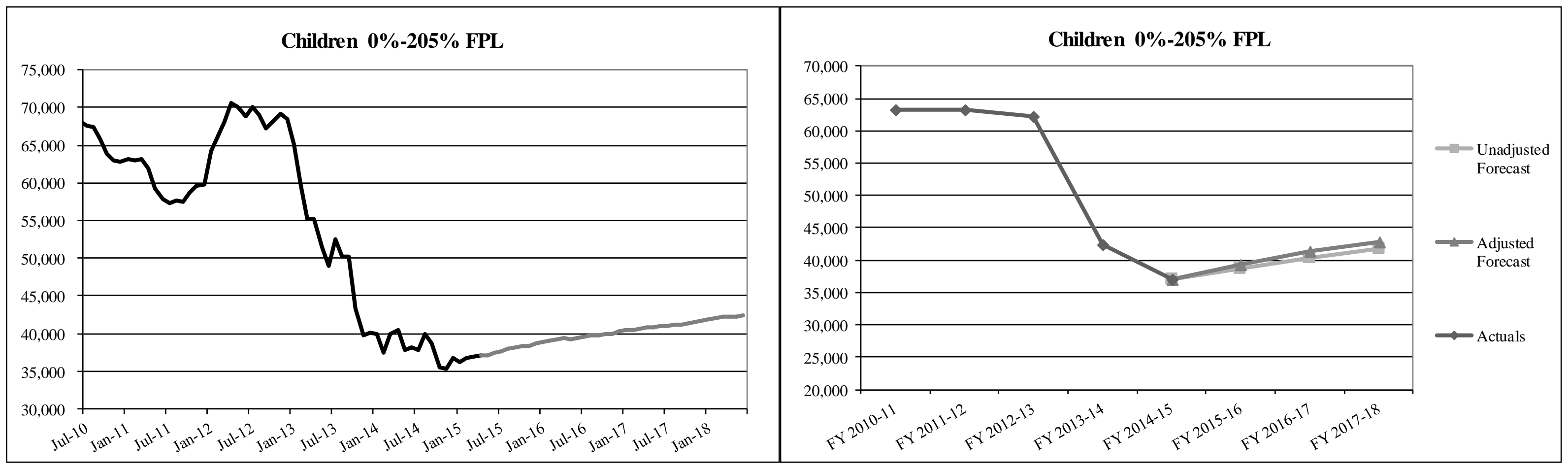
- Trend Stationary: $\log(y) = c + \text{trend} + \varepsilon$
- Difference Stationary: $\text{differenced}(\log(y)) = c + \varepsilon$

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: age groups 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 FPL categories for children and prenatal; under 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 for FY 2014-15 (July 2014 through May 2015) for CHP+ Children 0%-205% FPL is 37,104, which is lower than what was forecasted in the February 2015 forecast. This has resulted in lower forecast trends for this November 2015 request. The selected trend would result in average monthly growth of 282 per month. This is comparable to the average monthly growth seen over the last 6 months, which is 285 per month.

- This population includes the subpopulation 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%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.

- There is one bottom-line adjustment to the Children to 205% FPL caseload. It is the projected impact from the continued implementation of HB 09-1353, which removes the five year bar on legal immigrant children and pregnant adults. This five 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.

Children 0%-205% FPL: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-13	48,895	-	-
Jul-13	52,548	3,653	7.47%
Aug-13	50,183	(2,365)	-4.50%
Sep-13	50,143	(40)	-0.08%
Oct-13	43,294	(6,849)	-13.66%
Nov-13	39,834	(3,460)	-7.99%
Dec-13	40,151	317	0.80%
Jan-14	39,925	(226)	-0.56%
Feb-14	37,491	(2,434)	-6.10%
Mar-14	39,972	2,481	6.62%
Apr-14	40,436	464	1.16%
May-14	37,893	(2,543)	-6.29%
Jun-14	38,258	365	0.96%
Jul-14	37,832	(426)	-1.11%
Aug-14	39,858	2,026	5.36%
Sep-14	38,675	(1,183)	-2.97%
Oct-14	35,543	(3,132)	-8.10%
Nov-14	35,405	(138)	-0.39%
Dec-14	36,771	1,366	3.86%
Jan-15	36,177	(594)	-1.62%
Feb-15	36,686	509	1.41%
Mar-15	36,909	223	0.61%
Apr-15	37,175	266	0.72%
May-15	37,114	(61)	-0.16%

February 2015 Forecast	
Forecasted June 2015 Level	39,321

Base trend from May 2015 level			
FY 2015-16	37,114	0.02%	9

	Caseload	% Change	Level Change
FY 2007-08	57,796		
FY 2008-09	61,582	6.55%	3,786
FY 2009-10	68,589	11.38%	7,007
FY 2010-11	63,244	-7.79%	(5,345)
FY 2011-12	63,217	-0.04%	(27)
FY 2012-13	62,260	-1.51%	(957)
FY 2013-14	42,511	-31.72%	(19,749)
FY 2014-15	37,104	-12.72%	(5,407)
FY 2015-16	38,722	4.36%	1,618
FY 2016-17	40,294	4.06%	1,572
FY 2017-18	41,749	3.61%	1,455

HB 09-1353 Adjustment	
FY 2014-15	-
FY 2015-16	634
FY 2016-17	991
FY 2017-18	1,026

November 2015 Projections After Adjustments			
FY 2014-15	37,104	-12.72%	(5,407)
FY 2015-16	39,356	4.36%	2,252
FY 2016-17	41,285	4.06%	1,929
FY 2017-18	42,775	3.61%	1,490

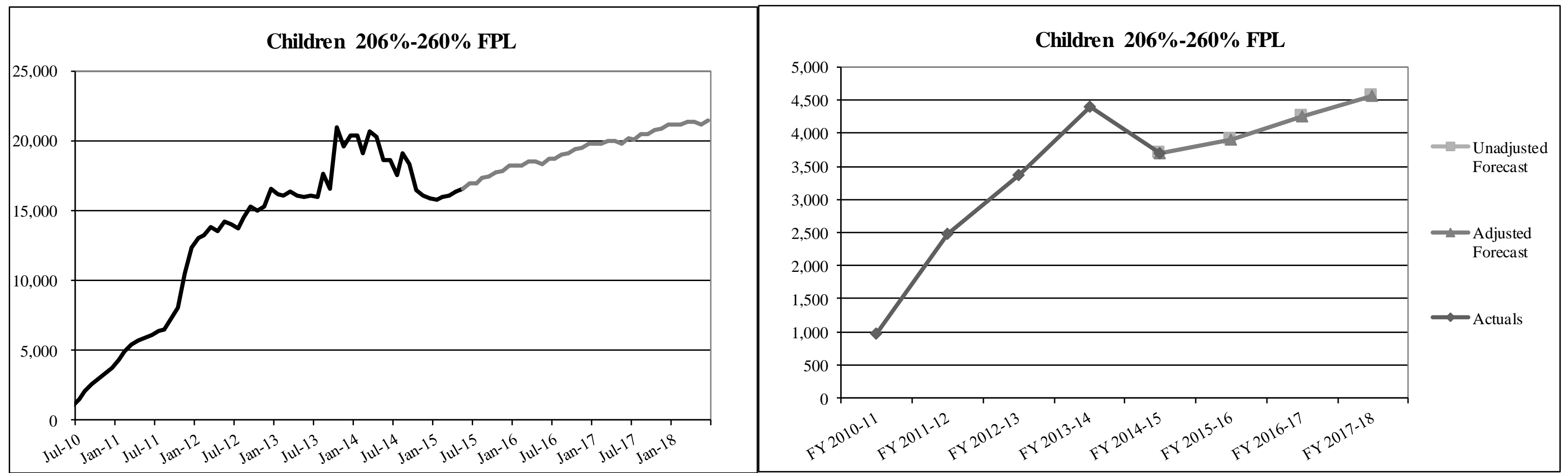
Actuals	Monthly Change	% Change
6-month average	285	0.80%
12-month average	(65)	-0.12%
18-month average	(151)	-0.32%
23-month average	(512)	-1.07%

February 2015 Projection Before Adjustments			
FY 2013-14	42,511	-31.72%	(19,749)
FY 2014-15	37,803	-11.07%	(4,708)
FY 2015-16	39,496	4.48%	1,693
FY 2016-17	41,317	4.61%	1,821

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	634
FY 2016-17	991

February 2015 Projection After Adjustments			
FY 2013-14	42,511	-31.72%	(19,749)
FY 2014-15	37,803	-11.07%	(4,708)
FY 2015-16	40,130	6.16%	2,327
FY 2016-17	42,308	5.43%	2,178

Monthly Average Growth Comparisons		
February 2015 Forecast	89	0.28%
FY 2014-15 Actuals	(104)	-0.22%
FY 2014-15 1st Half	(248)	-0.56%
FY 2014-15 2nd Half	69	0.19%
FY 2015-16 Forecast	282	0.72%
February 2015 Forecast	124	0.31%
FY 2016-17 Forecast	58	0.14%



- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for CHP+ Children 206%-260% FPL is 16,728 which is lower than what was forecasted in February 2015. This November 2015 forecast has adjusted accordingly. Three of the last four months saw monthly growth of 200 or more. The projected average monthly growth for FY 2015-16 is 209 per month.
- 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 259% 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%-259% 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 Children 206%-259% FPL caseload. It is the projected impact from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This five 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+.

Children 206%-260% FPL: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-13	16,047	-	-
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	20,377	835	4.27%
Jan-14	20,324	(53)	-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	18,613	59	0.32%
Jul-14	17,496	(1,117)	-6.00%
Aug-14	19,106	1,610	9.20%
Sep-14	18,350	(756)	-3.96%
Oct-14	16,449	(1,901)	-10.36%
Nov-14	16,027	(422)	-2.57%
Dec-14	15,851	(176)	-1.10%
Jan-15	15,780	(71)	-0.45%
Feb-15	15,980	200	1.27%
Mar-15	16,068	88	0.55%
Apr-15	16,327	259	1.61%
May-15	16,573	246	1.51%

February 2015 Forecast	
Forecasted June 2015 Level	18,059

Base trend from May 2015 level			
FY 2015-16	16,573	-0.85%	(142)

	Caseload	% Change	Level Change
FY 2009-10	136		
FY 2010-11	4,023	2858.09%	3,887
FY 2011-12	11,049	174.65%	7,026
FY 2012-13	15,575	40.96%	4,526
FY 2013-14	19,043	22.27%	3,468
FY 2014-15	16,728	-12.16%	(2,315)
FY 2015-16	17,989	7.54%	1,261
FY 2016-17	19,559	8.73%	1,570
FY 2017-18	20,924	6.98%	1,365

HB 09-1353 Adjustment	
FY 2014-15	-
FY 2015-16	311
FY 2016-17	502
FY 2017-18	537

November 2015 Projections After Adjustments			
FY 2014-15	16,728	-12.16%	(2,315)
FY 2015-16	18,300	7.54%	1,572
FY 2016-17	20,061	8.73%	1,761
FY 2017-18	21,461	6.98%	1,400

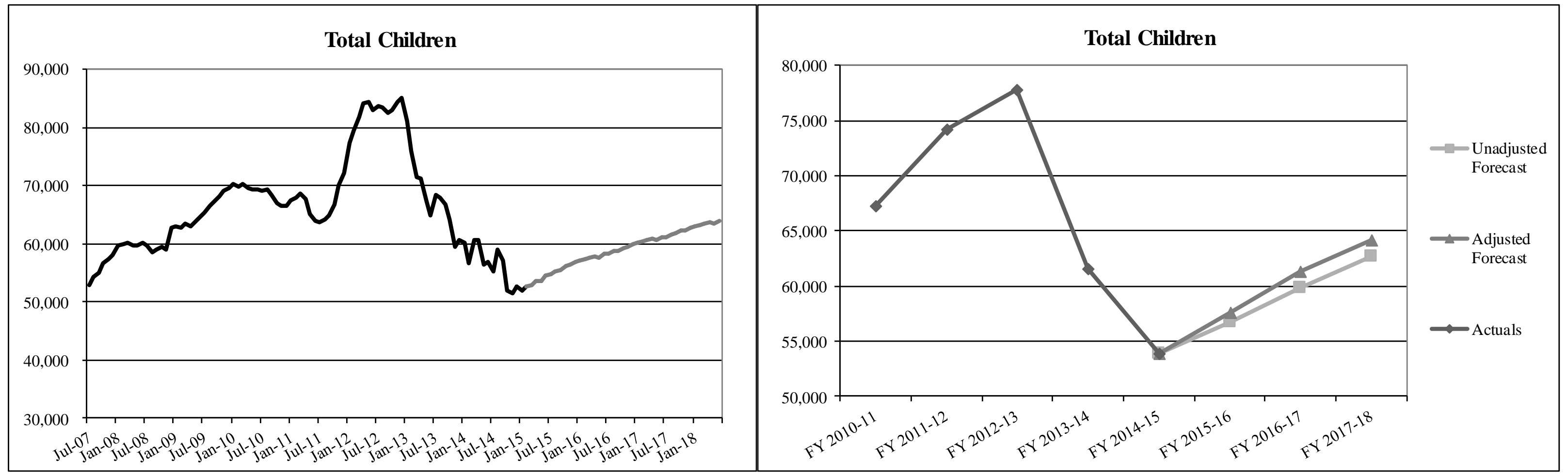
Actuals	Monthly Change	% Change
6-month average	91	0.57%
12-month average	(165)	-0.83%
18-month average	(165)	-0.78%
23-month average	23	0.42%

February 2015 Projection Before Adjustments			
FY 2013-14	19,043	22.27%	3,468
FY 2014-15	17,176	-9.80%	(1,867)
FY 2015-16	18,140	5.61%	964
FY 2016-17	19,132	5.47%	992

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	311
FY 2016-17	502

February 2015 Projection After Adjustments			
FY 2013-14	19,043	22.27%	3,468
FY 2014-15	17,176	-9.80%	(1,867)
FY 2015-16	18,451	7.42%	1,275
FY 2016-17	19,634	6.41%	1,183

Monthly Average Growth Comparisons		
February 2015 Forecast	(46)	-0.13%
FY 2014-15 Actuals	(185)	-0.94%
FY 2014-15 1st Half	(460)	-2.46%
FY 2014-15 2nd Half	144	0.90%
FY 2015-16 Forecast	209	1.16%
February 2015 Forecast	60	0.33%
FY 2016-17 Forecast	94	0.47%



- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for CHP+ Children was 53,832, which was 929 clients, or 1.70% under the February 2015 forecast. Forecasts have been reduced for this February 2015 estimate.
- 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%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- As described above, there is one bottom-line adjustment to the CHP+ children's caseload. It is the projected impact is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This five 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 Children: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-13	64,942	-	-
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	59,376	(4,890)	-7.61%
Dec-13	60,528	1,152	1.94%
Jan-14	60,249	(279)	-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%
Jul-14	55,328	(1,543)	-2.71%
Aug-14	58,964	3,636	6.57%
Sep-14	57,025	(1,939)	-3.29%
Oct-14	51,992	(5,033)	-8.83%
Nov-14	51,432	(560)	-1.08%
Dec-14	52,622	1,190	2.31%
Jan-15	51,957	(665)	-1.26%
Feb-15	52,666	709	1.36%
Mar-15	52,977	311	0.59%
Apr-15	53,502	525	0.99%
May-15	53,687	185	0.35%

February 2015 Forecast	
Forecasted June 2015 Level	57,380

Base trend from May 2015 level			
FY 2015-16	53,687	-0.25%	(133)

	Caseload	% Change	Level Change
FY 2007-08	57,796		
FY 2008-09	61,582	6.55%	3,786
FY 2009-10	68,725	11.60%	7,143
FY 2010-11	67,267	-2.12%	(1,458)
FY 2011-12	74,266	10.40%	6,999
FY 2012-13	77,835	4.81%	3,569
FY 2013-14	61,554	-20.92%	(16,281)
FY 2014-15	53,832	-12.55%	(7,722)
FY 2015-16	56,711	5.35%	2,879
FY 2016-17	59,853	5.54%	3,142
FY 2017-18	62,673	4.71%	2,820

HB 09-1353 Adjustment	
FY 2014-15	-
FY 2015-16	945
FY 2016-17	1,493
FY 2017-18	1,563

November 2015 Projections After Adjustments			
FY 2014-15	53,832	-12.55%	(7,722)
FY 2015-16	57,656	5.35%	3,824
FY 2016-17	61,346	5.54%	3,690
FY 2017-18	64,236	4.71%	2,890

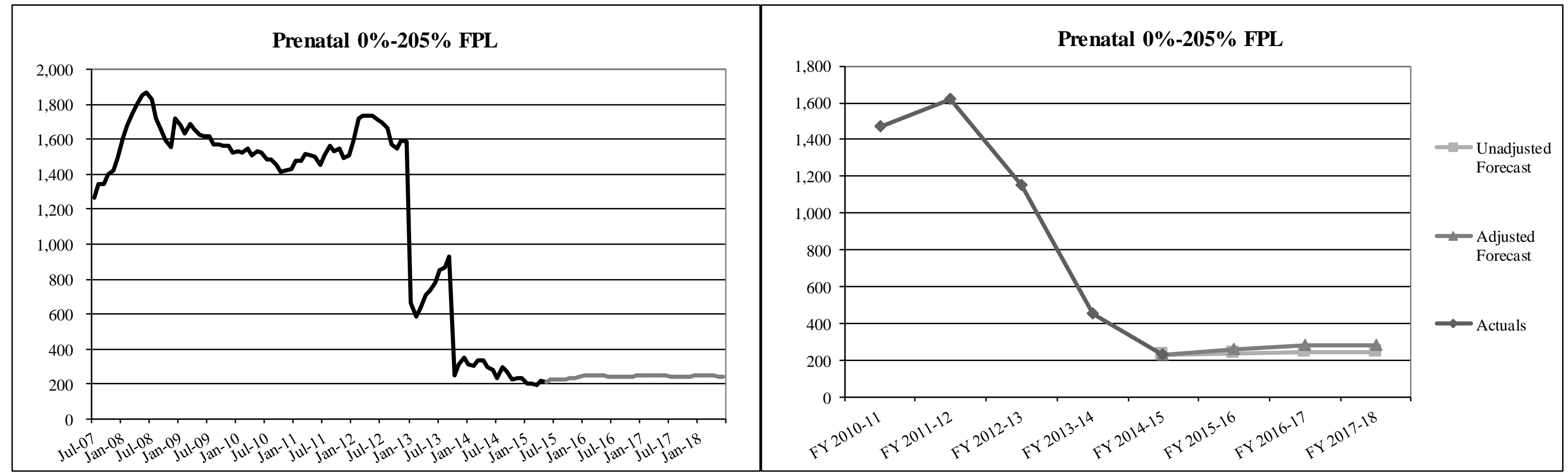
Actuals	Monthly Change	% Change
6-month average	376	0.72%
12-month average	(230)	-0.35%
18-month average	(316)	-0.48%
23-month average	(489)	-0.74%

February 2015 Projection Before Adjustments			
FY 2013-14	61,554	-20.92%	(16,281)
FY 2014-15	54,979	-10.68%	(6,575)
FY 2015-16	57,636	4.83%	2,657
FY 2016-17	60,449	4.88%	2,813

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	945
FY 2016-17	1,493

February 2015 Projection After Adjustments			
FY 2013-14	61,554	-20.92%	(16,281)
FY 2014-15	54,979	-10.68%	(6,575)
FY 2015-16	58,581	6.55%	3,602
FY 2016-17	61,942	5.74%	3,361

Monthly Average Growth Comparisons		
February 2015 Forecast	42	0.14%
FY 2014-15 Actuals	(289)	-0.45%
FY 2014-15 1st Half	(708)	-1.17%
FY 2014-15 2nd Half	213	0.41%
FY 2015-16 Forecast	491	0.86%
February 2015 Forecast	185	0.32%
FY 2016-17 Forecast	152	0.25%



- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for CHP+ Prenatal clients 0%-205% was 228, which is lower than what was forecasted in February 2015. This November 2015 forecast has decreased accordingly.
- Along with the children's expansion to 205% FPL, this population includes the subpopulation that was created through SB 07-097 and was implemented beginning March 1, 2008. Prenatal women in this subpopulation 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%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- There is one bottom-line adjustment to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the five 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+.

Prenatal 0%-205% FPL: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-13	778	-	-
Jul-13	850	72	9.25%
Aug-13	869	19	2.24%
Sep-13	928	59	6.79%
Oct-13	246	(682)	-73.49%
Nov-13	313	67	27.24%
Dec-13	354	41	13.10%
Jan-14	310	(44)	-12.43%
Feb-14	300	(10)	-3.23%
Mar-14	333	33	11.00%
Apr-14	332	(1)	-0.30%
May-14	298	(34)	-10.24%
Jun-14	276	(22)	-7.38%
Jul-14	229	(47)	-17.03%
Aug-14	296	67	29.26%
Sep-14	273	(23)	-7.77%
Oct-14	224	(49)	-17.95%
Nov-14	233	9	4.02%
Dec-14	232	(1)	-0.43%
Jan-15	205	(27)	-11.64%
Feb-15	200	(5)	-2.44%
Mar-15	195	(5)	-2.50%
Apr-15	214	19	9.74%
May-15	212	(2)	-0.93%

	Caseload	% Change	Level Change
FY 2007-08	1,571		
FY 2008-09	1,665	5.98%	94
FY 2009-10	1,550	-6.91%	(115)
FY 2010-11	1,470	-5.16%	(80)
FY 2011-12	1,616	9.93%	146
FY 2012-13	1,148	-28.96%	(468)
FY 2013-14	451	-60.71%	(697)
FY 2014-15	228	-49.45%	(223)
FY 2015-16	239	4.82%	11
FY 2016-17	245	2.51%	6
FY 2017-18	243	-0.82%	(2)

HB 09-1353 Adjustment	
FY 2014-15	-
FY 2015-16	22
FY 2016-17	35
FY 2017-18	35

November 2015 Projections After Adjustments			
FY 2014-15	228	-49.45%	(223)
FY 2015-16	261	4.82%	33
FY 2016-17	280	2.51%	19
FY 2017-18	278	-0.82%	(2)

February 2015 Projection Before Adjustments			
FY 2013-14	451	-60.71%	(697)
FY 2014-15	252	-44.12%	(199)
FY 2015-16	286	13.49%	34
FY 2016-17	297	3.85%	11

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	22
FY 2016-17	35

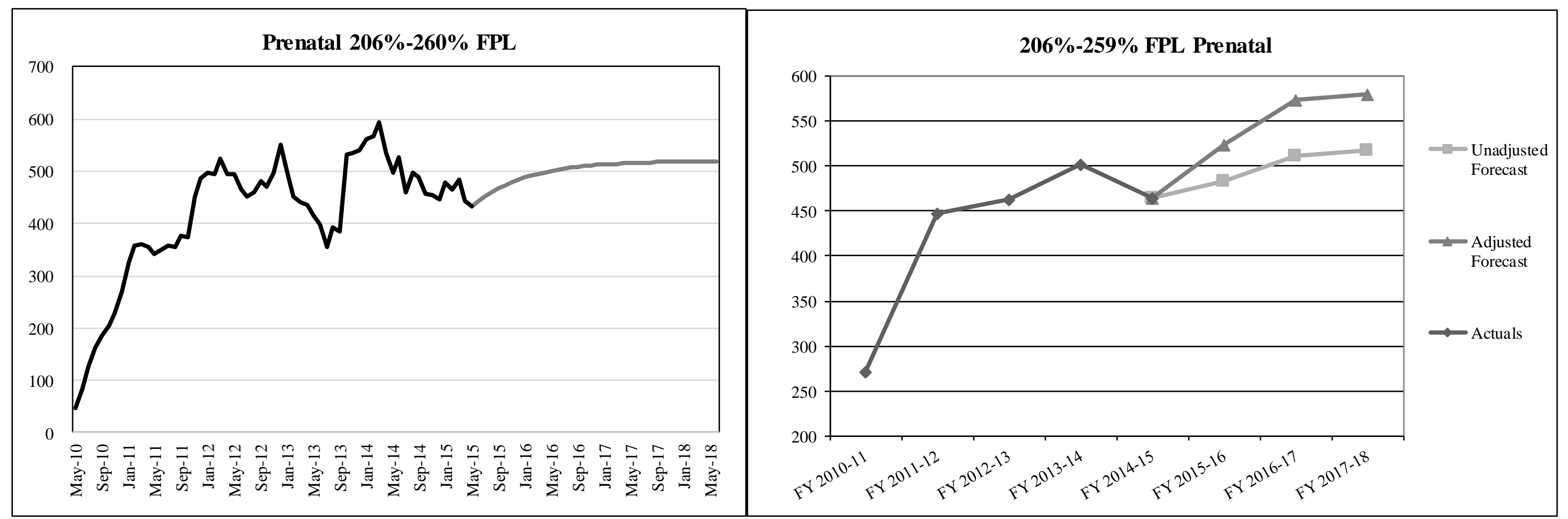
February 2015 Projection After Adjustments			
FY 2013-14	451	-60.71%	(697)
FY 2014-15	252	-44.12%	(199)
FY 2015-16	308	22.22%	56
FY 2016-17	332	7.79%	24

February 2015 Forecast	
Forecasted June 2015 Level	273

Base trend from May 2015 level			
FY 2015-16	212	-6.64%	(15)

Actuals	Monthly Change	% Change
6-month average	(4)	-1.37%
12-month average	(7)	-2.09%
18-month average	(6)	-1.51%
23-month average	(25)	-2.40%

Monthly Average Growth Comparisons		
February 2015 Forecast	(0)	0.56%
FY 2014-15 Actuals	(6)	-1.61%
FY 2014-15 1st Half	(7)	-1.65%
FY 2014-15 2nd Half	(4)	-1.55%
FY 2015-16 Forecast	6	2.42%
February 2015 Forecast	5	1.63%
FY 2016-17 Forecast	(2)	-0.80%



- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for CHP+ Prenatal 206%-259% FPL was 464, which is lower than what was forecasted in February 2015. This November 2015 forecast has decreased accordingly.

- 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 259% 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 five 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+.

206%-259% FPL Prenatal: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-13	399	-	-
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%
Jul-14	460	(67)	-12.71%
Aug-14	496	36	7.83%
Sep-14	488	(8)	-1.61%
Oct-14	457	(31)	-6.35%
Nov-14	455	(2)	-0.44%
Dec-14	446	(9)	-1.98%
Jan-15	478	32	7.17%
Feb-15	465	(13)	-2.72%
Mar-15	485	20	4.30%
Apr-15	444	(41)	-8.45%
May-15	433	(11)	-2.48%

February 2015 Forecast	
Forecasted June 2015 Level	505

Base trend from May 2015 level			
FY 2015-16	433	-6.21%	(29)

	Caseload	% Change	Level Change
FY 2008-09	-		
FY 2009-10	11		
FY 2010-11	272	2372.73%	261
FY 2011-12	448	64.71%	176
FY 2012-13	463	3.35%	15
FY 2013-14	502	8.42%	39
FY 2014-15	464	-7.57%	(38)
FY 2015-16	483	4.09%	19
FY 2016-17	512	6.00%	29
FY 2017-18	518	1.17%	6

HB 09-1353 Adjustment	
FY 2014-15	-
FY 2015-16	41
FY 2016-17	61
FY 2017-18	62

November 2015 Projections After Adjustments			
FY 2014-15	464	-7.57%	(38)
FY 2015-16	524	12.93%	60
FY 2016-17	573	9.35%	49
FY 2017-18	580	1.22%	7

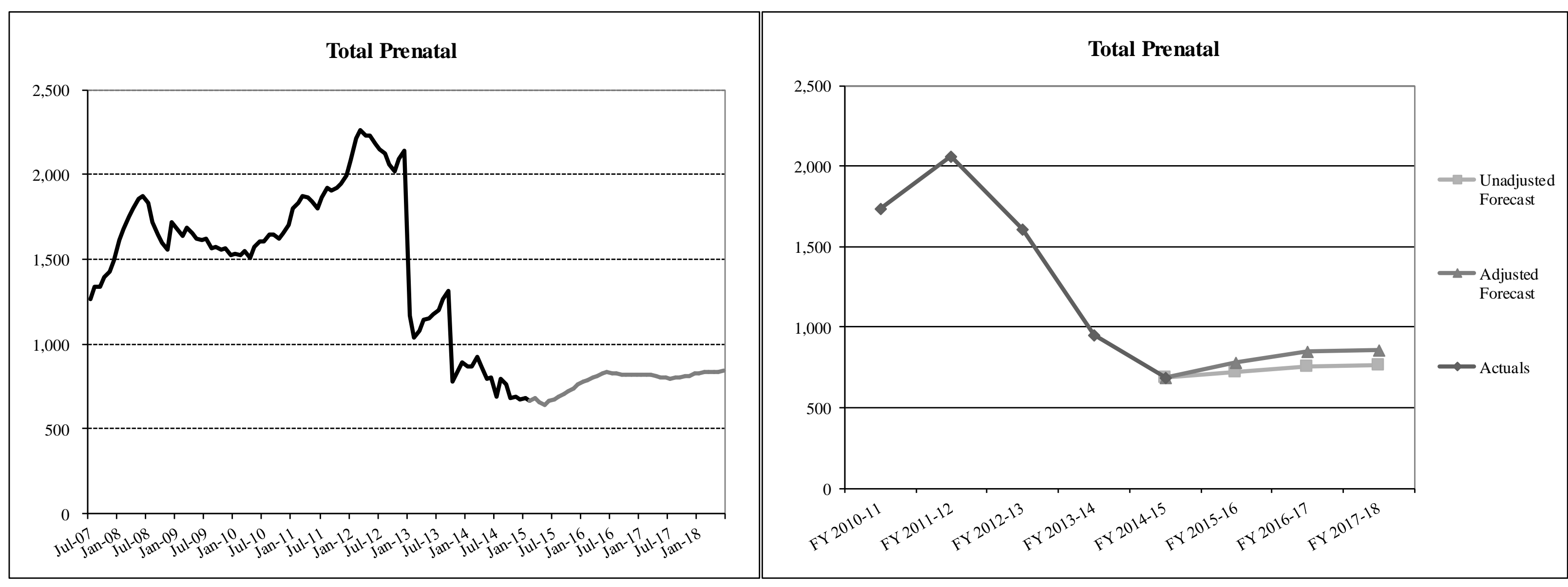
Actuals	Monthly Change	% Change
6-month average	(4)	-0.69%
12-month average	(5)	-0.93%
18-month average	(6)	-0.98%
23-month average	1	0.81%

February 2015 Projection Before Adjustments			
FY 2013-14	502	8.42%	39
FY 2014-15	476	-5.18%	(26)
FY 2015-16	519	9.03%	43
FY 2016-17	524	0.96%	5

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	41
FY 2016-17	61

February 2015 Projection After Adjustments			
FY 2013-14	502	8.42%	39
FY 2014-15	476	-5.18%	(26)
FY 2015-16	560	17.65%	84
FY 2016-17	585	4.46%	25

Monthly Average Growth Comparisons		
February 2015 Forecast	(2)	-0.22%
FY 2014-15 Actuals	(9)	-1.59%
FY 2014-15 1st Half	(14)	-2.54%
FY 2014-15 2nd Half	(3)	-0.43%
FY 2015-16 Forecast	12	2.45%
February 2015 Forecast	2	0.29%
FY 2016-17 Forecast	(3)	-0.52%



- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for CHP+ prenatal was 693, which was 31 clients, or 4.29% under what was forecast in February 2015.
- As described above, 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+.

Total Prenatal: Historical Caseload and Projections

	Actuals	**Monthly Change**	**% Change**
Jun-13	1,177	-	-
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%
Jul-14	689	(114)	-14.20%
Aug-14	792	103	14.95%
Sep-14	761	(31)	-3.91%
Oct-14	681	(80)	-10.51%
Nov-14	688	7	1.03%
Dec-14	678	(10)	-1.45%
Jan-15	683	5	0.74%
Feb-15	665	(18)	-2.64%
Mar-15	680	15	2.26%
Apr-15	658	(22)	-3.24%
May-15	645	(13)	-1.98%

	Caseload	**% Change**	**Level Change**
FY 2007-08	1,571		
FY 2008-09	1,665	5.98%	94
FY 2009-10	1,561	-6.25%	(104)
FY 2010-11	1,742	11.60%	181
FY 2011-12	2,064	18.48%	322
FY 2012-13	1,611	-21.95%	(453)
FY 2013-14	953	-40.84%	(658)
FY 2014-15	692	-27.39%	(261)
FY 2015-16	722	4.34%	30
FY 2016-17	757	4.85%	35
FY 2017-18	761	0.53%	4

HB 09-1353 Adjustment	
FY 2014-15	-
FY 2015-16	63
FY 2016-17	96
FY 2017-18	97

November 2015 Projections After Adjustments			
FY 2014-15	692	-27.39%	(261)
FY 2015-16	785	10.26%	93
FY 2016-17	853	7.21%	68
FY 2017-18	858	0.61%	5

February 2015 Projection Before Adjustments			
FY 2013-14	953	-40.84%	(658)
FY 2014-15	728	-23.61%	(225)
FY 2015-16	805	10.58%	77
FY 2016-17	821	1.99%	16

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	63
FY 2016-17	96

February 2015 Projection After Adjustments			
FY 2013-14	953	-40.84%	(658)
FY 2014-15	728	-23.61%	(225)
FY 2015-16	868	19.23%	140
FY 2016-17	917	5.65%	49

February 2015 Forecast	
Forecasted June 2015 Level	778

Base trend from May 2015 level			
FY 2015-16	645	-6.35%	(44)

Actuals	**Monthly Change**	**% Change**
6-month average	(7)	-1.05%
12-month average	(12)	-1.48%
18-month average	(11)	-1.29%
23-month average	(23)	-1.92%

Monthly Average Growth Comparisons		
February 2015 Forecast	(2)	-0.05%
FY 2014-15 Actuals	(14)	-1.72%
FY 2014-15 1st Half	(21)	-2.35%
FY 2014-15 2nd Half	(7)	-0.97%
FY 2015-16 Forecast	19	2.44%
February 2015 Forecast	12	1.41%
FY 2016-17 Forecast	(5)	-0.61%

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	Disallowance Repayment Schedule
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 Claims Distribution 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 2015-16 Children's Basic Health Plan Capitation

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2015-16 Chilldren's Basic Health Plan Capitation Appropriation						
FY 2015-16 Long Bill Appropriation (SB 15-234)	$166,721,835	$2,098,125	$427,593	$29,111,333	$0	$135,084,784
FY 2015-16 Total Children's Basic Heath Plan Capitation Spending Authority	**$166,723,024**	**$2,098,125**	**$427,593**	**$29,111,476**	**$0**	**$135,085,830**
Projected Total FY 2015-16 CBHP Capitation Expenditure	**$143,968,479**	**$2,098,126**	**$427,593**	**$25,326,308**	**$0**	**$116,116,452**
FY 2015-16 Children's Basic Health Plan Capitation Estimated Change from Appropriation	**($22,754,545)**	**$1**	**$0**	**($3,785,168)**	**$0**	**($18,969,378)**
Percent Change from Spending Authority	-13.65%	0.00%	0.00%	-13.00%	0.00%	-14.04%
FY 2015-16 CBHP External Admin						
FY 2015-16 CBHP External Admin Appropriation						
FY 2015-16 Long Bill Appropriation (SB 15-234)	$5,033,274	$0	$0	$2,363,824	$0	$2,669,450
FY 2015-16 Total CBHP External Admin Spending Authority	**$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 Change from Appropriation	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Percent Change from Spending Authority	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

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	**$166,723,024**	**$2,098,125**	**$427,593**	**$29,111,476**	**$0**	**$135,085,830**
FY 2016-17 CBHP Capitation Base Amount	**$166,724,351**	**$2,114,734**	**$410,984**	**$29,219,879**	**$0**	**$134,978,754**
Projected Total FY 2016-17 CBHP Capitation Expenditure	**$149,119,335**	**$2,089,457**	**$410,984**	**$18,011,548**	**$0**	**$128,607,346**
Total FY 2016-17 CBHP Capitation Request	**($17,605,016)**	**($25,277)**	**$0**	**($11,208,331)**	**$0**	**($6,371,408)**
Percent Change from FY 2016-17 CBHP Capitation Base	-10.56%	-1.20%	0.00%	-38.36%	0.00%	-4.72%
Percent Change from FY 2015-16 Estimated CBHP Capitation Expenditure	3.58%	-0.41%	-3.88%	-28.88%	0.00%	10.76%
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 Request	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Percent Change from FY 2016-17 CBHP External Admin Base	0.00%	0.00%	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%	0.00%	0.00%	0.00%

Exhibit C1 - Calculation of Current Total Long Bill Group Impact						
FY 2017-18 Children's Basic Health Plan Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2016-17 CBHP Capitation Appropriation Plus Special Bills	**$166,724,351**	**$2,114,734**	**$410,984**	**$29,219,879**	**$0**	**$134,978,754**
FY 2017-18 CBHP Capitation Base Amount	**$166,724,351**	**$2,114,734**	**$410,984**	**$29,219,879**	**$0**	**$134,978,754**
Projected Total FY 2017-18 CBHP Capitation Expenditure	**$156,128,167**	**$210,222**	**$410,984**	**$19,101,254**	**$0**	**$136,405,707**
Total FY 2017-18 CBHP Capitation Continuation Amount	**($10,596,184)**	**($1,904,512)**	**$0**	**($10,118,625)**	**$0**	**$1,426,953**
Percent Change from FY 2017-18 CBHP Capitation Base	-6.36%	-90.06%	0.00%	-34.63%	0.00%	1.06%
Percent Change from FY 2016-17 Estimated CBHP Capitation Expenditure	4.70%	-89.94%	0.00%	6.05%	0.00%	6.06%
FY 2017-18 CBHP External Admin						
FY 2016-17 CBHP External Admin Appropriation Plus Special Bills	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
FY 2017-18 CBHP External Admin Base Amount	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
Projected Total FY 2017-18 CBHP External Admin Expenditure	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
Total FY 2017-18 CBHP External Admin Continuation Amount	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Percent Change from FY 2017-18 CBHP External Admin Base	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Percent Change from FY 2016-17 Estimated CBHP External Admin Expenditure	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Exhibit C10 - Forecast Model Comparisons - Final Forecasts

Adjustment Factors for Forecasted Rates

Item	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2015-16 Known Rate	$241.10	$117.84	$140.75	$239.40	$114.86	$137.38	$5.52	$16.23	$21.74	$5.33	$15.84	$21.32	$980.13	$970.08
Retroactivity Adjustment Multiplier (Exhibit C8)	26.39%	20.09%	14.26%	9.66%	0.27%	-4.44%	-6.94%	-5.04%	-2.36%	-4.05%	-11.58%	-13.51%	26.31%	1.51%
Claims Distribution Adjustment Multiplier (Exhibit C8)	-0.02%	0.02%	0.07%	-0.02%	0.01%	-0.02%	-2.84%	-2.53%	-2.73%	-2.68%	-2.49%	-2.55%	-1.76%	-0.01%
Final Adjustment Factor	26.36%	20.11%	14.34%	9.64%	0.28%	-4.46%	-9.58%	-7.44%	-5.03%	-6.62%	-13.78%	-15.72%	24.09%	1.50%
FY 2015-16 Final Estimated Rate	$304.65	$141.54	$160.93	$262.48	$115.18	$131.25	$4.99	$15.02	$20.65	$4.98	$13.66	$17.97	$1,216.24	$984.63

Item	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2016-17 Estimated Rate	$244.07	$119.05	$144.97	$240.88	$116.61	$138.97	$5.59	$16.62	$22.49	$5.40	$16.22	$22.04	$1,005.81	$993.85
Retroactivity Adjustment Multiplier (Exhibit C8)	26.39%	20.09%	14.26%	9.66%	0.27%	-4.44%	-6.94%	-5.04%	-2.36%	-4.05%	-11.58%	-13.51%	26.31%	1.51%
Claims Distribution Adjustment Multiplier (Exhibit C8)	-0.02%	0.02%	0.07%	-0.02%	0.01%	-0.02%	-2.84%	-2.53%	-2.73%	-2.68%	-2.49%	-2.55%	-1.76%	-0.01%
Final Adjustment Factor	26.36%	20.11%	14.34%	9.64%	0.28%	-4.46%	-9.58%	-7.44%	-5.03%	-6.62%	-13.78%	-15.72%	24.09%	1.50%
FY 2016-17 Final Estimated Rate	$308.41	$142.99	$165.76	$264.10	$116.94	$132.77	$5.05	$15.38	$21.36	$5.04	$13.98	$18.58	$1,248.11	$1,008.76

Item	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2017-18 Estimated Rate	$247.07	$120.62	$147.65	$242.37	$118.53	$140.58	$5.66	$16.96	$23.26	$5.47	$16.55	$22.78	$1,026.83	$1,013.43
Retroactivity Adjustment Multiplier (Exhibit C8)	26.39%	20.09%	14.26%	9.66%	0.27%	-4.44%	-6.94%	-5.04%	-2.36%	-4.05%	-11.58%	-13.51%	26.31%	1.51%
Claims Distribution Adjustment Multiplier (Exhibit C8)	-0.02%	0.02%	0.07%	-0.02%	0.01%	-0.02%	-2.84%	-2.53%	-2.73%	-2.68%	-2.49%	-2.55%	-1.76%	-0.01%
Final Adjustment Factor	26.36%	20.11%	14.34%	9.64%	0.28%	-4.46%	-9.58%	-7.44%	-5.03%	-6.62%	-13.78%	-15.72%	24.09%	1.50%
FY 2017-18 Final Estimated Rate	$312.20	$144.88	$168.82	$265.73	$118.86	$134.31	$5.12	$15.70	$22.09	$5.11	$14.27	$19.20	$1,274.19	$1,028.63

Exhibit C10 - Forecast Model Comparisons - Capitation Trend Models

Capitation Rate Forecast Model for FY 2015-16

Model	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2013-14 Full Year Average Rate	$285.21	$122.59	$141.00	$283.41	$120.79	$143.35	$3.35	$13.99	$17.78	$3.35	$13.65	$17.67	$980.64	$970.08
FY 2014-15 Full Year Average Rate	$283.15	$123.86	$145.49	$281.30	$121.73	$150.63	$4.73	$15.60	$20.89	$4.69	$15.13	$20.47	$980.13	$970.08
FY 2015-16 Estimated Average Rate	$241.10	$117.84	$140.75	$239.40	$114.86	$137.38	$5.52	$16.23	$21.74	$5.33	$15.84	$21.32	$980.13	$970.08
Recent Growth Rates														
% Growth from FY 2013-14 to FY 2014-15 Rate	-0.72%	1.04%	3.18%	-0.74%	0.78%	5.08%	41.19%	11.51%	17.49%	40.00%	10.84%	15.85%	-0.05%	0.00%
% Growth from FY 2014-15 to FY 2015-16 Rate	-14.85%	-4.86%	-3.26%	-14.90%	-5.64%	-8.80%	16.70%	4.04%	4.07%	13.65%	4.69%	4.15%	0.00%	0.00%
Selected Trend Models														
Average Growth Model	$252.67	$119.05	$141.21	$221.40	$116.61	$138.97	$5.59	$16.62	$23.01	$6.21	$16.88	$22.65	$1,005.81	$993.85
% Difference from FY 2015-16 Rate	4.80%	1.03%	0.33%	-7.52%	1.52%	1.16%	1.27%	2.40%	5.84%	16.51%	6.57%	6.24%	2.62%	2.45%
% Difference from FY 2016-17 Rate	4.50%	1.32%	0.74%	-9.14%	1.65%	-0.35%	0.72%	2.05%	5.95%	17.71%	4.15%	6.31%	2.09%	1.97%
Two Period Moving Average Model	$262.12	$120.84	$143.11	$260.35	$118.29	$144.02	$5.13	$15.92	$21.32	$5.01	$15.49	$20.90	$980.13	$970.08
% Difference from FY 2015-16 Rate	8.72%	2.55%	1.68%	8.75%	2.99%	4.83%	-7.07%	-1.91%	-1.93%	-6.00%	-2.21%	-1.97%	0.00%	0.00%
% Difference from FY 2016-17 Rate	-4.01%	-1.24%	-0.82%	-4.02%	-1.45%	-2.30%	3.90%	1.01%	0.98%	3.19%	1.16%	1.00%	0.00%	0.00%
Exponential Growth Model	$244.07	$119.11	$144.97	$188.93	$117.23	$132.98	$7.15	$17.83	$23.69	$6.79	$17.41	$23.33	$1,041.39	$1,022.46
% Difference from FY 2015-16 Rate	1.23%	1.08%	3.00%	-21.08%	2.06%	-3.20%	29.59%	9.86%	8.99%	27.43%	9.94%	9.44%	6.25%	5.40%
% Difference from FY 2016-17 Rate	-0.70%	1.34%	1.85%	-8.77%	1.82%	1.13%	16.84%	5.48%	6.11%	16.33%	5.27%	6.13%	1.58%	1.34%
Linear Growth Model	$241.00	$125.00	$143.96	$208.30	$123.87	$145.84	$5.77	$16.92	$22.49	$5.63	$16.44	$22.04	$1,038.35	$1,020.72
% Difference from FY 2015-16 Rate	-0.04%	6.08%	2.28%	-12.99%	7.84%	6.16%	4.47%	4.28%	3.44%	5.55%	3.77%	3.36%	5.94%	5.22%
% Difference from FY 2016-17 Rate	-7.72%	1.24%	0.48%	-14.20%	1.64%	1.08%	10.26%	4.46%	4.92%	10.04%	4.30%	4.81%	1.36%	1.17%
% change from FY 2015-16 Rate to Selected FY 2016-17 Capitation Rate [1]	1.23%	1.03%	3.00%	0.62%	1.52%	1.16%	1.27%	2.40%	3.44%	1.27%	2.40%	3.36%	2.62%	2.45%
FY 2016-17 Forecast Point Estimate	**$244.07**	**$119.05**	**$144.97**	**$240.88**	**$116.61**	**$138.97**	**$5.59**	**$16.62**	**$22.49**	**$5.40**	**$16.22**	**$22.04**	**$1,005.81**	**$993.85**
% change from FY 2016-17 Rate to Selected FY 2017-18 Capitation Rate [1]	1.23%	1.32%	1.85%	0.62%	1.65%	1.16%	1.27%	2.05%	3.44%	1.27%	2.05%	3.36%	2.09%	1.97%
FY 2017-18 Forecast Point Estimate	**$247.07**	**$120.62**	**$147.65**	**$242.37**	**$118.53**	**$140.58**	**$5.66**	**$16.96**	**$23.26**	**$5.47**	**$16.55**	**$22.78**	**$1,026.83**	**$1,013.43**

[1] Selected trends are described below.

Children Medical	FY 2015-16	Children 0%-205%: Ages 0-1 - Exponential Growth Model; Ages 2-5 - Average Growth Model; Ages 6-18 - Exponential Growth Model Children 206%-260%: Ages 0-1 - Average of Avg Growth Model and Two Period Moving Avg; Ages 2-5 - Average Growth Model; Ages 6-18 - Average Growth Model
	FY 2016-17	Children 0%-205%: Ages 0-1 - FY17 selected trend; Ages 2-5 - Average Growth Model; Ages 6-18 - FY16 Exponential Growth Model Children 206%-260%: Ages 0-1 - FY17 selected trend; Ages 2-5 - Average Growth Model; Ages 6-18 - FY17 selected trend
Children Dental	FY 2015-16	Children 0%-205%: Ages 0-1 - Average Growth Model; Ages 2-5 - Average Growth Model; Ages 6-18 - Linear Growth Model Children 206%-260%: Ages 0-1 - Trend selected for Children 0%-205%; Ages 2-5 - Trend selected for Children 0%-205%; Ages 6-18 - Linear Growth Model
	FY 2016-17	Children 0%-205%: Ages 0-1 - FY17 selected trend; Ages 2-5 - Average Growth Model; Ages 6-18 - FY17 selected trend Children 206%-260%: Ages 0-1 - Trend selected for Children 0%-205%; Ages 2-5 - Trend selected for Children 0%-205%; Ages 6-18 - FY17 selected trend
Prenatal	FY 2015-16	Prenatal 0%-205%: Average Growth Model Prenatal 206%-260%: Average Growth Model
	FY 2016-17	Prenatal 0%-205%: Average Growth Model Prenatal 206%-260%: Average Growth Model

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	$140,237,262	$24,120,810	$0	$0	$116,116,452	82.80%
Enrollment Fees CBHP Trust Fund	$355,828	$0	$355,828	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$849,671	$0	$849,671	$0	$0	0.00%
Total CBHP Expenditure	**$141,442,761**	**$24,120,810**	**$1,205,499**	**$0**	**$116,116,452**	82.09%
Cash Fund Financing						
CBHP Trust Fund	$0	($16,502,234)	$16,502,234	$0	$0	NA
CO Immunization Fund	$0	($202,371)	$202,371	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Hospital Provider Fee Fund	$0	($7,416,203)	$7,416,203	$0	$0	NA
Estimated FY 2015-16 Capitation Expenditure	**$141,442,761**	**$1**	**$25,326,308**	**$0**	**$116,116,452**	82.09%
Disallowance Payments	$2,525,718	$2,525,718	$0	$0	$0	0.00%
Final Estimated FY 2015-16 Capitation Expenditure	**$143,968,479**	**$2,525,719**	**$25,326,308**	**$0**	**$116,116,452**	80.65%
CBHP Admin Payments	**$5,033,274**	**$0**	**$2,363,824**	**$0**	**$2,669,450**	53.04%
Final Estimated FY 2015-16 CBHP Expenditure	**$149,001,753**	**$2,525,719**	**$27,690,132**	**$0**	**$118,785,902**	79.72%

[1]Starting October 1, 2015, CBHP programs will receive an additional 23 percentage points on the federal match. The weighted average federal match is 82.80%.

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	$145,319,036	$16,711,690	$0	$0	$128,607,346	88.50%
Enrollment Fees CBHP Trust Fund	$368,426	$0	$368,426	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$931,432	$0	$931,432	$0	$0	0.00%
Total CBHP Expenditure	**$146,618,894**	**$16,711,690**	**$1,299,858**	**$0**	**$128,607,346**	87.72%
Cash Fund Financing						
CBHP Trust Fund	$0	($11,411,092)	$11,411,092	$0	$0	NA
CO Immunization Fund	$0	($202,664)	$202,664	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Hospital Provider Fee Fund	$0	($5,097,933)	$5,097,933	$0	$0	NA
Estimated FY 2016-17 Capitation Expenditure	**$146,618,894**	**$0**	**$18,011,548**	**$0**	**$128,607,346**	87.72%
Disallowance Payments	$2,500,441	$2,500,441	$0	$0	$0	0.00%
Estimated FY 2016-17 Capitation Expenditure	**$149,119,335**	**$2,500,441**	**$18,011,548**	**$0**	**$128,607,346**	86.24%
CBHP Admin Payments	**$5,033,274**	**$0**	**$2,363,824**	**$0**	**$2,669,450**	53.04%
Final Estimated FY 2016-17 CBHP Expenditure	**$154,152,609**	**$2,500,441**	**$20,375,372**	**$0**	**$131,276,796**	85.16%

[1]Starting October 1, 2015, CBHP programs will receive an additional 23 percentage points on the federal match. The weighted average federal match is 88.50%.

Exhibit C2 - Calculation of Fund Splits

Calculation of Fund Splits - FY 2017-18 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	$154,130,743	$17,725,036	$0	$0	$136,405,707	88.50%
Enrollment Fees CBHP Trust Fund	$379,777	$0	$379,777	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$996,440	$0	$996,440	$0	$0	0.00%
Total CBHP Expenditure	**$155,506,960**	**$17,725,036**	**$1,376,217**	**$0**	**$136,405,707**	87.72%
Cash Fund Financing						
CBHP Trust Fund	$0	($12,039,450)	$12,039,450	$0	$0	NA
CO Immunization Fund	$0	($204,497)	$204,497	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Hospital Provider Fee Fund	$0	($5,481,089)	$5,481,089	$0	$0	NA
Estimated FY 2017-18 Capitation Expenditure	**$155,506,960**	**($1)**	**$19,101,254**	**$0**	**$136,405,707**	**87.72%**
Disallowance Payments	$621,207	$621,207	$0	$0	$0	0.00%
Final Estimated FY 2017-18 Capitation Expenditure	**$156,128,167**	**$621,206**	**$19,101,254**	**$0**	**$136,405,707**	87.37%
CBHP Admin Payments	**$5,033,274**	**$0**	**$2,363,824**	**$0**	**$2,669,450**	53.04%
Final Estimated FY 2017-18 CBHP Expenditure	**$161,161,441**	**$621,206**	**$21,465,078**	**$0**	**$139,075,157**	86.30%

[1] Starting October 1, 2015, CBHP programs will receive an additional 23 percentage points on the federal match. The projected federal match is 88.5%.

Exhibit C2 - Cash Funds Report for CBHP

Cash Funds Report for CBHP Capitation Payments

Cash Fund	FY 2015-16			FY 2016-17			FY 2017-18		
	Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change
Cash Funds									
CBHP Trust Fund[1]	$19,178,598	$16,858,062	($2,320,536)	$19,249,811	$11,779,518	($7,470,293)	$19,249,811	$12,419,227	($6,830,584)
CO Immunization Fund	$229,297	$202,371	($26,926)	$229,297	$202,664	($26,633)	$229,297	$204,497	($24,800)
Health Care Expansion Fund	$1	$1	$0	$1	$1	$0	$1	$1	$0
Hospital Provider Fee Fund	$9,703,580	$8,265,874	($1,437,706)	$9,740,770	$6,029,365	($3,711,405)	$9,740,770	$6,477,529	($3,263,241)
Recoveries	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Cash Funds	**$29,111,476**	**$25,326,308**	**($3,785,168)**	**$29,219,879**	**$18,011,548**	**($11,208,331)**	**$29,219,879**	**$19,101,254**	**($10,118,625)**

[1]Estimated revenues to the CBHP Trust Fund are based on the 2015 Tobacco MSA Payment Forecast. See Exhibit C5.

Cash Funds Report for CBHP Admin Payments

Cash Fund	FY 2015-16			FY 2016-17			FY 2017-18		
	Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change
Cash Funds									
CBHP Trust Fund[1]	$2,354,463	$2,354,463	$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	**$2,363,824**	**$2,363,824**	**$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 2015 Tobacco MSA Payment Forecast. See Exhibit C5 for more details.

Exhibit C2-Disallowance Repayment Schedule

Summary of Payments by Quarter		
Fiscal Year	**Quarter**	**Payment Due**
FY 2014-15	QE December 31, 2014	$684,674
	QE March 31, 2015	$636,712
	QE June 30, 2015	$635,309
FY 2015-16	QE September 30, 2015	$633,876
	QE December 31,2015	$632,278
	QE March 31, 2016	$630,569
	QE June 30, 2016	$628,996
FY 2016-17	QE September 30, 2016	$627,509
	QE December 31, 2016	$625,928
	QE March 31, 2017	$624,257
	QE June 30, 2017	$622,747
FY 2017-18	QE September 30, 2017	$621,207
Total All Payments		**$7,604,061**

Disallowances 12-001 CHIP, 12-003 CHIP, & 13-004 CHIP

Summary of Payments by Fiscal Year	
FY 2014-15	$1,956,695
FY 2015-16	$2,525,718
FY 2016-17	$2,500,441
FY 2017-18	$621,207
Total	**$7,604,061**

Exhibit C3 - Children's Basic Health Plan Programs Expenditure Summary

Actuals, Appropriations and Estimates Prior to Recoupments

ITEM	FY 2014-15 Actual		FY 2015-16 Appropriated		FY 2015-16 Estimate		FY 2015-16 Change from Appropriation		FY 2016-17 Estimate		FY 2016-17 Change from FY 2015-16 Estimate		FY 2016-17 Change from FY 2015-16 Appropriation		FY 2017-18 Estimate		FY 2017-18 Change from FY 2016-17 Estimate	
	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure
CHP+ Capitation Payments																		
Children to 205% FPL Medical	37,032	$70,591,253	40,130	$93,979,237	39,392	$81,200,903	(738)	($12,778,334)	41,319	$87,178,204	1,927	$5,977,301	1,189	($6,801,033)	42,810	$91,876,115	1,491	$4,697,911
Children 206%-260% FPL Medical	16,668	$29,655,907	18,450	$41,081,110	18,301	$30,844,536	(149)	($10,236,574)	20,063	$34,055,191	1,762	$3,210,655	1,613	($7,025,919)	21,463	$36,756,777	1,400	$2,701,586
Children to 205% FPL Dental	37,032	$7,436,496	40,130	$11,088,316	39,392	$9,349,792	(738)	($1,738,524)	41,319	$10,122,704	1,927	$772,912	1,189	($965,612)	42,810	$10,833,716	1,491	$711,012
Children 206%-260% FPL Dental	16,668	$2,846,568	18,450	$4,537,216	18,301	$3,791,824	(149)	($745,392)	20,063	$4,297,341	1,762	$505,517	1,613	($239,875)	21,463	$4,750,264	1,400	$452,923
Prenatal to 205% FPL	227	($4,603,746)	308	$4,383,393	254	$3,685,061	(54)	($698,332)	273	$4,056,706	19	$371,645	(35)	($326,687)	271	$4,139,053	(2)	$82,347
Prenatal 206%-260% FPL	460	$5,055,384	560	$6,878,034	524	$6,146,662	(36)	($731,372)	573	$6,908,748	49	$762,086	13	$30,714	580	$7,151,035	7	$242,287
Bottom Line Impacts																		
FQHC Payments		*$6,216,390*		*$2,250,000*		*$6,423,983*		*$4,173,983*		*$0*		*($6,423,983)*		*($2,250,000)*		*$0*		*$0*
Recoveries		*$12,603,873*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*
Other Payments		*($986,458)*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*
Disallowance Payments		*$1,956,695*		*$2,525,718*		*$2,525,718*		*$0*		*$2,500,441*		*($25,277)*		*($25,277)*		*$621,207*		*($1,879,234)*
Sub-total CBHP Program Expenditure	**54,386**	**$130,772,362**	**59,448**	**$166,723,024**	**58,471**	**$143,968,479**	**(977)**	**($22,754,545)**	**62,228**	**$149,119,335**	**3,757**	**$5,150,856**	**2,780**	**($17,603,689)**	**65,124**	**$156,128,167**	**2,896**	**$7,008,832**
Enrollment Fees		$11,534		$1,050,242		$1,205,499		$155,256		$1,299,858		$94,359		$249,616		$1,376,216		$76,358
Children to 200%		*$6,485*		*$343,218*		*$348,789*		*$5,571*		*$361,066*		*$12,277*		*$17,849*		*$372,125*		*$11,059*
Children 201%-205%		*$471*		*$38,788*		*$7,039*		*($31,749)*		*$7,360*		*$321*		*($31,428)*		*$7,652*		*$292*
Children 206%-260%		*$4,578*		*$668,237*		*$849,671*		*$181,434*		*$931,432*		*$81,761*		*$263,195*		*$996,440*		*$65,008*
Total CBHP Program Expenditure	**54,386**	**$130,772,362**	**59,448**	**$166,723,024**	**58,471**	**$143,968,479**	**(977)**	**($22,754,545)**	**62,228**	**$149,119,335**	**3,757**	**$5,150,856**	**2,780**	**($17,603,689)**	**65,124**	**$156,128,167**	**2,896**	**$7,008,832**
Incremental Percent Change							-1.64%	-13.65%			6.43%	3.58%	4.68%	-10.56%			4.65%	4.70%
CBHP Admin Payments																		
External Admin		$4,634,041		$5,033,274		$5,033,274		$0		$5,033,274		$0		$0		$5,033,274		$0
Incremental Percent Change								0.00%				0.00%						0.00%
Total CBHP Admin Payments		**$4,634,041**		**$5,033,274**		**$5,033,274**		**$0**		**$5,033,274**		**$0**		**$0**		**$5,033,274**		**$0**
Total CBHP Programs		**$135,406,403**		**$171,756,298**		**$149,001,753**		**($22,754,545)**		**$154,152,609**		**$5,150,856**		**($17,603,689)**		**$161,161,441**		**$7,008,832**
Incremental Percent Change								-13.25%				3.46%		-10.25%				4.55%

Exhibit C4 - Children's Basic Health Plan, Caseload

Children's Basic Health Plan Average Caseload By Fiscal Year

Item	Children 0%-205%			Children 0%-205% All Ages	Children 206%-260%			Children 206%-260% All Ages	Total Children	Prenatal 0%-205%	Prenatal 206%-260%	Total Prenatal	Total
	Ages 0-1	Ages 2-5	Ages 6-18		Ages 0-1	Ages 2-5	Ages 6-18						
FY 2007-08 Actuals	4,395	11,798	41,603	57,796	-	-	-	-	57,796	1,571	-	1,571	59,367
FY 2008-09 Actuals	4,820	11,426	45,336	61,582	-	-	-	-	61,582	1,665	-	1,665	63,247
% Change from FY 2007-08	9.67%	-3.15%	8.97%	6.55%	-	-	-	-	6.55%	5.98%	-	5.98%	6.54%
FY 2009-10 Actuals	5,123	11,520	51,946	68,589	13	32	91	136	68,725	1,550	11	1,561	70,286
% Change from FY 2008-09	6.29%	0.82%	14.58%	11.38%	-	-	-	-	11.60%	-6.91%	-	-6.25%	11.13%
FY 2010-11 Actuals	4,407	10,467	48,370	63,244	430	982	2,611	4,023	67,267	1,470	272	1,742	69,009
% Change from FY 2009-10	-13.98%	-9.14%	-6.88%	-7.79%	3207.69%	2968.75%	2769.23%	-	-2.12%	-5.16%	24	11.60%	-1.82%
FY 2011-12 Actuals	4,750	10,374	48,093	63,217	1,055	2,471	7,523	11,049	74,266	1,616	448	2,064	76,330
% Change from FY 2010-11	7.78%	-0.89%	-0.57%	-0.04%	145.35%	151.63%	188.13%	174.65%	10.40%	9.93%	64.71%	18.48%	10.61%
FY 2012-13 Actuals	5,187	11,300	45,773	62,260	1,398	3,377	10,800	15,575	77,835	1,148	463	1,611	79,446
% Change from FY 2011-12	9.20%	8.93%	-4.82%	-1.51%	32.51%	36.67%	43.56%	40.96%	4.81%	-28.96%	3.35%	-21.95%	4.08%
FY 2013-14 Actuals	3,081	9,993	29,437	42,511	1,319	4,411	13,313	19,043	61,554	451	502	953	62,507
% Change from FY 2012-13	-40.60%	-11.57%	-35.69%	-31.72%	-5.65%	30.62%	23.27%	22.27%	-20.92%	-60.71%	8.42%	-40.84%	-21.32%
FY 2014-15 Actuals	2,870	8,375	25,787	37,032	1,349	3,680	11,639	16,668	53,699	227	460	687	54,386
% Change from FY 2013-14	-6.84%	-16.20%	-12.40%	-12.89%	2.26%	-16.57%	-12.57%	-12.47%	-12.76%	-49.67%	-8.37%	-27.91%	-12.99%
FY 2015-16 Projection	2,979	8,824	27,589	39,392	1,418	3,965	12,918	18,301	57,693	254	524	778	58,471
% Change from FY 2014-15	3.79%	5.37%	6.99%	6.37%	5.13%	7.75%	10.99%	9.80%	7.44%	11.89%	13.91%	13.25%	7.51%
FY 2016-17 Projection	3,133	9,129	29,057	41,319	1,488	4,357	14,218	20,063	61,382	273	573	846	62,228
% Change from FY 2015-16	5.17%	3.46%	5.32%	4.89%	4.94%	9.89%	10.06%	9.63%	6.39%	7.48%	9.35%	8.74%	6.43%
FY 2017-18 Projection	3,231	9,295	30,284	42,810	1,521	4,679	15,263	21,463	64,273	271	580	851	65,124
% Change from FY 2016-17	3.13%	1.82%	4.22%	3.61%	2.22%	7.39%	7.35%	6.98%	4.71%	-0.73%	1.22%	0.59%	4.65%
FY 2015-16 Appropriation	3,245	8,855	28,030	40,130	1,539	4,296	12,615	18,450	58,580	308	560	868	59,448
Difference between the FY 2015-16 Appropriation and Projection	(266)	(31)	(441)	(738)	(121)	(331)	303	(149)	(887)	(54)	(36)	(90)	(977)

Exhibit C4 - Children's Basic Health Plan, Caseload

Children's Basic Health Plan Caseload Adjustments By Fiscal Year

Item	Children 0%-205%			Children 0%-205% All Ages	Children 206%-260%			Children 206%-260% All Ages	Total Children	Prenatal 0%-205%	Prenatal 206%-260%	Total Prenatal	Total
	Ages 0-1	Ages 2-5	Ages 6-18		Ages 0-1	Ages 2-5	Ages 6-18						
HB 09-1353 Removal of 5-Year Bar on Legal Immigrants	-	-	-	-	-	-	-	-	-	-	-	-	-
Total 2014-15 Adjustments	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
HB 09-1353 Removal of 5-Year Bar on Legal Immigrants	48	142	444	634	24	67	220	311	945	22	41	63	1,008
Total 2015-16 Adjustments	**48**	**142**	**444**	**634**	**24**	**67**	**220**	**311**	**945**	**22**	**41**	**63**	**1,008**
HB 09-1353 Removal of 5-Year Bar on Legal Immigrants	75	219	697	991	37	109	356	502	1,493	35	61	96	1,589
Total 2016-17 Adjustments	**75**	**219**	**697**	**991**	**37**	**109**	**356**	**502**	**1,493**	**35**	**61**	**96**	**1,589**
HB 09-1353 Removal of 5-Year Bar on Legal Immigrants	77	223	726	1,026	38	117	382	537	1,563	35	62	97	1,660
Total 2017-18 Adjustments	**77**	**223**	**726**	**1,026**	**38**	**117**	**382**	**537**	**1,563**	**35**	**62**	**97**	**1,660**

Exhibit C4 - Children's Basic Health Plan, Caseload

Children's Basic Health Plan Average Monthly Caseload - Without Adjustments

Item	Children 0%-205%			Children 0%-205% All Ages	Children 206%-260%			Children 206%-260% All Ages	Total Children	Prenatal 0%-205%	Prenatal 206%-260%	Total Prenatal	Total
	Ages 0-1	Ages 2-5	Ages 6-18		Ages 0-1	Ages 2-5	Ages 6-18						
FY 2007-08 Actuals	4,395	11,798	41,603	57,796	-	-	-	-	57,796	1,571	-	1,571	59,367
FY 2008-09 Actuals	4,820	11,426	45,336	61,582	-	-	-	-	61,582	1,665	-	1,665	63,247
% Change from FY 2007-08	9.67%	-3.15%	8.97%	6.55%	-	-	-	-	6.55%	5.98%	-	5.98%	6.54%
FY 2009-10 Actuals	5,123	11,520	51,946	68,589	13	32	91	136	68,725	1,550	11	1,561	70,286
% Change from FY 2008-09	6.29%	0.82%	14.58%	11.38%	-	-	-	-	11.60%	-6.91%	-	-6.25%	11.13%
FY 2010-11 Actuals	4,407	10,467	48,370	63,244	430	982	2,611	4,023	67,267	1,470	272	1,742	69,009
% Change from FY 2009-10	-13.98%	-9.14%	-6.88%	-7.79%	3207.69%	2968.75%	2769.23%	29	-2.12%	-5.16%	24	11.60%	-1.82%
FY 2011-12 Actuals	4,750	10,374	48,093	63,217	1,055	2,471	7,523	11,049	74,266	1,616	448	2,064	76,330
% Change from FY 2010-11	7.78%	-0.89%	-0.57%	-0.04%	145.35%	151.63%	188.13%	174.65%	10.40%	9.93%	64.71%	18.48%	10.61%
FY 2012-13 Actuals	5,187	11,300	45,773	62,260	1,398	3,377	10,800	15,575	77,835	1,148	463	1,611	79,446
% Change from FY 2011-12	9.20%	8.93%	-4.82%	-1.51%	32.51%	36.67%	43.56%	40.96%	4.81%	-28.96%	3.35%	-21.95%	4.08%
FY 2013-14 Actuals	3,081	9,993	29,437	42,511	1,319	4,411	13,313	19,043	61,554	451	502	953	62,507
% Change from FY 2012-13	-40.60%	-11.57%	-35.69%	-31.72%	-5.65%	30.62%	23.27%	22.27%	-20.92%	-60.71%	8.42%	-40.84%	-21.32%
FY 2014-15 Actuals	2,870	8,375	25,787	37,032	1,349	3,680	11,639	16,668	53,699	227	460	687	54,386
% Change from FY 2013-14	-6.84%	-16.20%	-12.40%	-12.89%	2.26%	-16.57%	-12.57%	-12.47%	-12.76%	-49.67%	-8.37%	-27.91%	-12.99%
FY 2015-16 Projection	2,931	8,682	27,145	38,758	1,394	3,898	12,698	17,990	56,748	232	483	715	57,463
% Change from FY 2014-15	2.12%	3.67%	5.27%	4.66%	3.35%	5.93%	9.10%	7.93%	5.68%	2.20%	5.00%	4.08%	5.66%
FY 2016-17 Projection	3,058	8,910	28,360	40,328	1,451	4,248	13,862	19,561	59,889	238	512	750	60,639
% Change from FY 2015-16	4.33%	2.63%	4.48%	4.05%	4.09%	8.98%	9.17%	8.73%	5.53%	2.59%	6.00%	4.90%	5.53%
FY 2017-18 Projection	3,154	9,072	29,558	41,784	1,483	4,562	14,881	20,926	62,710	236	518	754	63,464
% Change from FY 2016-17	3.14%	1.82%	4.22%	3.61%	2.21%	7.39%	7.35%	6.98%	4.71%	-0.84%	1.17%	0.53%	4.66%
FY 2015-16 Appropriation	3,245	8,855	28,030	40,130	1,539	4,296	12,615	18,450	58,580	308	560	868	59,448
Difference between the FY 2015-16 Appropriation and Projection	(314)	(173)	(885)	(1,372)	(145)	(398)	83	(460)	(1,832)	(76)	(77)	(153)	(1,985)

Exhibit C4 - Children's Basic Health Plan Monthly Caseload Historical Summary									
CBHP CASELOAD FY 2012-13 without RETROACTIVITY									
FY 2012-13	**Children to 205% FPL**	**Children 206%-260% FPL**	**Total Children**	**Prenatal to 205% FPL**	**Prenatal 206%-260% FPL**	**Total Prentatal**	**TOTAL CBHP**	**Monthly Growth**	**Monthly Growth Rate**
July 2012	69,977	13,731	83,708	1,694	452	2,146	85,854	819	0.96%
August 2012	68,938	14,509	83,447	1,663	459	2,122	85,569	(285)	-0.33%
September 2012	67,196	15,267	82,463	1,575	482	2,057	84,520	(1,049)	-1.23%
October 2012	68,080	14,955	83,035	1,552	470	2,022	85,057	537	0.64%
November 2012	69,082	15,289	84,371	1,593	498	2,091	86,462	1,405	1.65%
December 2012	68,453	16,575	85,028	1,589	550	2,139	87,167	705	0.82%
January 2013	65,022	16,159	81,181	662	504	1,166	82,347	(4,820)	-5.53%
February 2013	59,761	16,028	75,789	585	451	1,036	76,825	(5,522)	-6.71%
March 2013	55,167	16,337	71,504	636	442	1,078	72,582	(4,243)	-5.52%
April 2013	55,115	16,091	71,206	709	435	1,144	72,350	(232)	-0.32%
May 2013	51,438	15,914	67,352	737	417	1,154	68,506	(3,844)	-5.31%
June 2013	48,895	16,047	64,942	778	399	1,177	66,119	(2,387)	-3.48%
Year-to-Date Average	**62,260**	**15,575**	**77,835**	**1,148**	**463**	**1,611**	**79,446**	**(1,576)**	**-2.03%**

CBHP CASELOAD FY 2013-14 without RETROACTIVITY

FY 2013-14[1]	Children to 205% FPL	Children 206%-260% FPL	Total Children	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Total Prentatal	TOTAL CBHP	Monthly Growth	Monthly Growth Rate
July 2013	52,548	15,933	68,481	850	354	1,204	69,685	3,566	5.39%
August 2013	50,183	17,642	67,825	869	393	1,262	69,087	(598)	-0.86%
September 2013	50,143	16,564	66,707	928	385	1,313	68,020	(1,067)	-1.54%
October 2013	43,294	20,972	64,266	246	533	779	65,045	(2,975)	-4.37%
November 2013	39,832	19,542	59,374	313	534	847	60,221	(4,824)	-7.42%
December 2013	40,150	20,376	60,526	354	540	894	61,420	1,199	1.99%
January 2014	39,924	20,324	60,248	310	561	871	61,119	(301)	-0.49%
February 2014	37,490	19,050	56,540	300	566	866	57,406	(3,713)	-6.08%
March 2014	39,972	20,690	60,662	333	593	926	61,588	4,182	7.28%
April 2014	40,436	20,255	60,691	332	536	868	61,559	(29)	-0.05%
May 2014	37,893	18,554	56,447	298	496	794	57,241	(4,318)	-7.01%
June 2014	38,258	18,612	56,870	276	527	803	57,673	432	0.75%
Year-to-Date Average	**42,511**	**19,043**	**61,554**	**451**	**502**	**953**	**62,507**	**(704)**	**-1.03%**

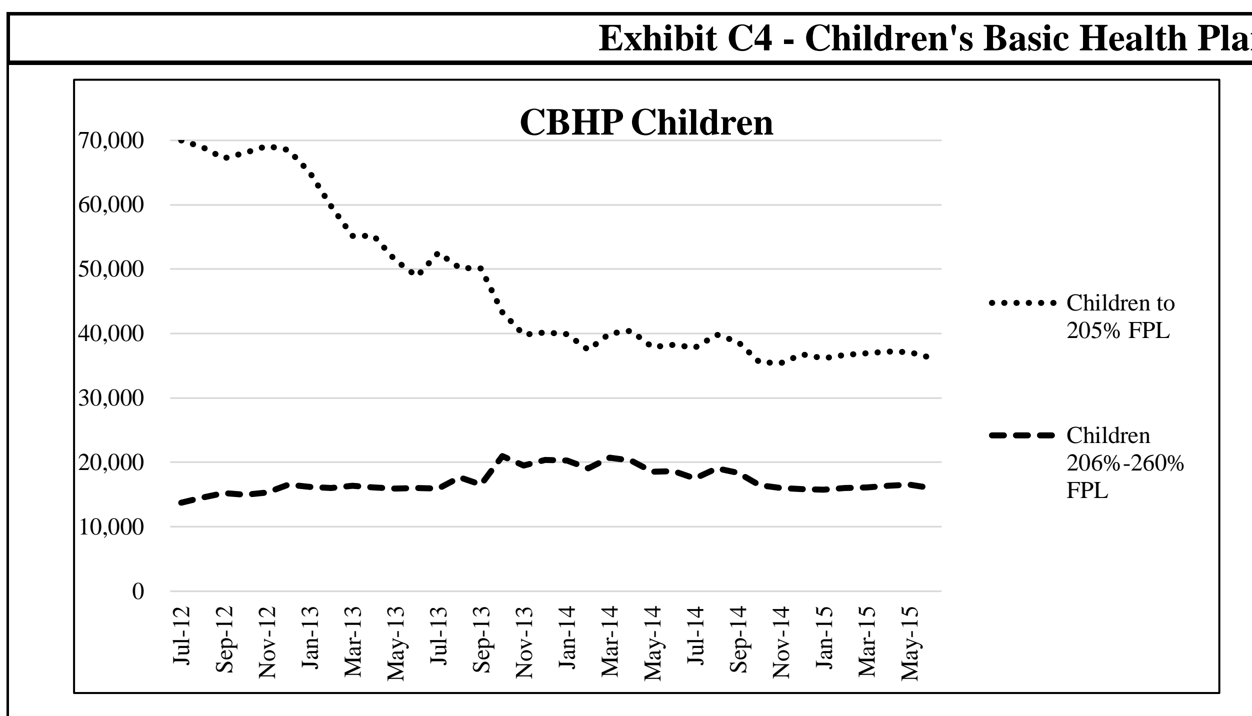
(1) Caseload has been restated for Children above 200% FPL and Prenatal above 200% FPL back to January 2014 and going forward. Due to the MAGI conversion in January 2014, clients that are 201%-205% FPL's can not be explicitly identified. The Department is using a rolling 6 month average (prior to the 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.

CBHP CASELOAD FY 2014-15 without RETROACTIVITY

FY 2014-15[1]	Children to 205% FPL	Children 206%-260% FPL	Total Children	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Total Prentatal	TOTAL CBHP	Monthly Growth	Monthly Growth Rate
July 2014	37,832	17,496	55,328	229	460	689	56,017	(1,656)	-2.87%
August 2014	39,858	19,106	58,964	296	496	792	59,756	3,739	6.67%
September 2014	38,675	18,350	57,025	273	488	761	57,786	(1,970)	-3.30%
October 2014	35,543	16,449	51,992	224	457	681	52,673	(5,113)	-8.85%
November 2014	35,405	16,027	51,432	233	455	688	52,120	(553)	-1.05%
December 2014	36,771	15,851	52,622	232	446	678	53,300	1,180	2.26%
January 2015	36,177	15,780	51,957	205	478	683	52,640	(660)	-1.24%
February 2015	36,686	15,980	52,666	200	465	665	53,331	691	1.31%
March 2015	36,909	16,068	52,977	195	485	680	53,657	326	0.61%
April 2015	37,175	16,327	53,502	214	444	658	54,160	503	0.94%
May 2015	37,114	16,573	53,687	212	433	645	54,332	172	0.32%
June 2015	36,236	16,005	52,241	210	416	626	52,867	(1,465)	-2.70%
Year-to-Date Average	**37,032**	**16,668**	**53,699**	**227**	**460**	**687**	**54,387**	**(401)**	**-0.66%**

(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



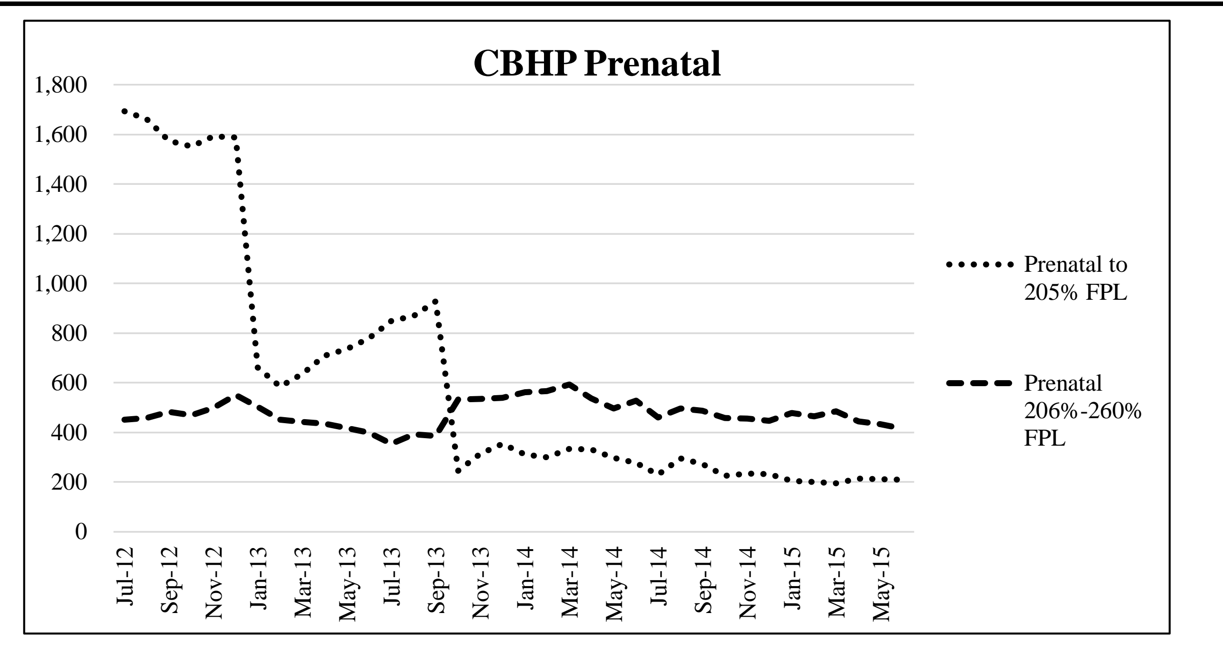


Exhibit C4 - Children's Basic Health Plan Capitation Payments Per Capita Historical Summary							
Item	**Children 0%-205% FPL Medical**	**Children 206%-260% FPL Medical**	**Children 0%-205% FPL Dental**	**Children 206%-260% FPL Dental**	**Prenatal 0%-205% FPL**	**Prenatal 206%-260% FPL**	**Total**
FY 2008-09 Actuals	$1,668.06	-	$160.38	-	$10,863.01	-	$2,066.29
FY 2009-10 Actuals	$2,208.41	$1,540.48	$157.15	$76.04	$10,297.88	$5,651.89	$2,539.55
% Change from FY 2008-09	32.39%	-	-2.02%	-	-5.20%	-	22.90%
FY 2010-11 Actuals	$2,130.28	$2,439.89	$159.17	$148.60	$12,583.11	$13,159.54	$2,569.00
% Change from FY 2009-010	-3.54%	58.38%	1.29%	95.42%	22.19%	132.83%	1.16%
FY 2011-12 Actuals	$2,014.43	$1,926.19	$168.30	$160.66	$10,528.68	$9,814.12	$2,390.33
% Change from FY 2010-11	-5.44%	-21.05%	5.73%	8.12%	-16.33%	-25.42%	-6.95%
FY 2012-13 Actuals	$2,063.72	$1,817.94	$176.81	$149.39	$14,259.74	$10,936.88	$2,411.33
% Change from FY 2011-12	2.45%	-5.62%	5.06%	-7.01%	35.44%	11.44%	0.88%
FY 2013-14 Actuals	$2,715.44	$2,178.76	$232.14	$207.37	$14,172.67	$11,189.55	$2,923.72
% Change from FY 2012-13	31.58%	19.85%	31.29%	38.81%	-0.61%	2.31%	21.25%
FY 2014-15 Actuals	$2,230.69	$1,941.36	$227.63	$193.64	$16,784.57	$12,544.25	$2,504.34
% Change from FY 2013-14	-17.85%	-10.90%	-1.94%	-6.62%	18.43%	12.11%	-14.34%
FY 2015-16 Projection	$2,143.60	$1,859.39	$237.35	$207.19	$14,508.11	$11,730.27	$2,419.02
% Change from FY 2014-15	-3.90%	-4.22%	4.27%	7.00%	-13.56%	-6.49%	-3.41%
FY 2016-17 Projection	$2,109.88	$1,697.41	$244.99	$214.19	$14,859.73	$12,057.15	$2,356.16
% Change from FY 2015-16	-1.57%	-8.71%	3.22%	3.38%	2.42%	2.79%	-2.60%
FY 2017-18 Projection	$2,146.14	$1,712.56	$253.07	$221.32	$15,273.26	$12,329.37	$2,387.86
% Change from FY 2016-17	1.72%	0.89%	3.30%	3.33%	2.78%	2.26%	1.35%

(1) 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.

Exhibit C4 - Children's Basic Health Plan Program, Historical Expenditures Summary							
Annual Total Expenditures							
Item		**Children to 205% FPL**	**Children 206%-260% FPL**	**Prenatal to 200% FPL**	**Prenatal 206%-260% FPL**	**Other Payments**	**CBHP TOTAL**
FY 2009-10 Actuals	*Medical Per Capita*	$2,208.41	1,540	$10,297.88	5,652		
	Dental Per Capita	$157.15	76	-	-		
	Caseload	68,589	136	1,550	11		70,286
	Medical Expenditure	$151,472,802	209,506	$15,961,707	62,171		$167,706,185
	Dental Expenditure	$10,778,494	10,342	-	-		$10,788,836
	Total FY 2009-10 Expenditures	**$162,251,296**	**219,847**	**$15,961,707**	**62,171**		**$178,495,021**
FY 2010-11 Actuals	*Medical Per Capita*	$2,130.28	$2,439.89	$12,583.11	$13,159.54		
	Dental Per Capita	$159.17	$148.60	-	-		
	Caseload	63,244	4,023	1,470	272		69,009
	Medical Expenditure	$134,727,164	$9,815,685	$18,497,179	$3,579,395		$166,619,422
	Dental Expenditure	$10,066,675	$597,802	-	-		$10,664,477
	Total FY 2010-11 Expenditures	**$144,793,839**	**$10,413,487**	**$18,497,179**	**$3,579,395**		**$177,283,899**
	% Change from FY 2009-10	**-10.76%**	**4636.70%**	**15.88%**	**5657.36%**		**-0.68%**
FY 2011-12 Actuals	*Medical Per Capita*	$2,014.43	$1,926.19	$10,528.68	$9,814.12		
	Dental Per Capita	$168.30	$160.66	-	-		
	Caseload	63,217	11,049	1,616	448		76,330
	Medical Expenditure	$127,346,190	$21,282,480	$17,014,352	$4,396,724		$170,039,746
	Dental Expenditure	$10,639,205	$1,775,172	-	-		$12,414,377
	Total FY 2011-12 Expenditures	**$137,985,395**	**$23,057,652**	**$17,014,352**	**$4,396,724**		**$182,454,123**
	% Change from FY 2010-11	**-4.70%**	**121.42%**	**-8.02%**	**22.83%**		**2.92%**
FY 2012-13 Actuals	*Medical Per Capita*	$2,063.72	$1,817.94	$14,259.74	$10,936.88		
	Dental Per Capita	$176.81	$149.39	-	-		
	Caseload	62,260	15,575	1,148	463		79,446
	Medical Expenditure	$128,487,080	$28,314,344	$16,370,185	$5,063,773		$178,235,381
	Dental Expenditure	$11,008,264	$2,326,813	-	-		$13,335,076
	Total FY 2012-13 Expenditures	**$139,495,343**	**$30,641,156**	**$16,370,185**	**$5,063,773**		**$191,570,458**
	% Change from FY 2011-12	**1.09%**	**32.89%**	**-3.79%**	**15.17%**		**5.00%**
FY 2013-14 Actuals	*Medical Per Capita*	$2,715.44	$2,178.76	$14,172.67	$11,189.55		
	Dental Per Capita	$232.14	$207.37	-	-		
	Caseload	42,511	19,043	451	502		62,507
	Medical Expenditure	$115,436,127	$41,490,209	$6,391,873	$5,617,155		$168,935,364
	Dental Expenditure	$9,868,652	$3,949,038	-	-		$13,817,690
	Recoveries	($22,724,002)	($4,221,003)	($4,012,518)	($769,110)	$31,726,633	$0
	Total FY 2013-14 Expenditures	**$102,580,776**	**$41,218,245**	**$2,379,355**	**$4,848,045**	**$31,726,633**	**$182,753,054**
	% Change from FY 2012-13	**-26.46%**	**34.52%**	**-85.47%**	**-4.26%**		**-4.60%**
FY 2014-15 Actuals	*Medical Per Capita*	$2,230.69	$1,941.36	$16,784.57	$12,544.25		
	Dental Per Capita	$227.63	$193.64	-	-		
	Caseload	37,032	16,668	227	460		54,386
	Medical Expenditure	$82,606,338	$32,358,023	$3,810,098	$5,770,354		$124,544,813
	Dental Expenditure	$8,429,697	$3,227,513	-	-		$11,657,211
	Other Payments	$242,154	$60,609	($6,702,661)	$0	$970,237	($5,429,661)
	Recoveries	($8,087,772)	($2,709,359)	($1,292,200)	($514,542)	$12,603,873	$0
	Total FY 2014-15 Expenditures	**$83,190,418**	**$32,936,786**	**-$4,184,763**	**$5,255,812**	**$13,574,110**	**$130,772,362**
	% Change from FY 2013-14	**-18.90%**	**-20.09%**	**-275.88%**	**8.41%**	**-57.22%**	**-28.44%**

Exhibit C4 - Children's Basic Health Plan Program, Historical Expenditures Summary							
Projected Total Expenditures							
Item		**Children to 205% FPL**	**Children 206%-260% FPL**	**Prenatal to 205% FPL**	**Prenatal 206%-260% FPL**	**Other Payments**	**CBHP TOTAL**
FY 2015-16 Projection	*Medical Per Capita*	$2,143.60	$1,859.39	$14,508.11	$11,730.27		
	Dental Per Capita	$237.35	$207.19	-	-		
	Caseload	39,392	18,301	254	524		58,471
	Medical Expenditure	$84,440,776	$34,028,646	$3,685,061	$6,146,662		$128,301,145
	Dental Expenditure	$9,349,792	$3,791,824	-	-		$13,141,616
	Disallowance Repayment	-	-	-	-	$2,525,718	$2,525,718
	Total FY 2015-16 Expenditures	**$93,790,568**	**$37,820,470**	**$3,685,061**	**$6,146,662**	**$2,525,718**	**$143,968,479**
	% Change from FY 2014-15	**12.74%**	**14.83%**	**-188.06%**	**16.95%**	**-81.39%**	**10.09%**
FY 2016-17 Projection	*Medical Per Capita*	$2,109.88	$1,697.41	$14,859.73	$12,057.15		
	Dental Per Capita	$244.99	$214.19	-	-		
	Caseload	41,319	20,063	273	573		62,228
	Medical Expenditure	$87,178,204	$34,055,191	$4,056,706	$6,908,748		$132,198,849
	Dental Expenditure	$10,122,704	$4,297,341	-	-		$14,420,045
	Disallowance Repayment	-	-	-	-	$2,500,441	$2,500,441
	Total FY 2016-17 Expenditures	**$97,300,908**	**$38,352,532**	**$4,056,706**	**$6,908,748**	**$2,500,441**	**$149,119,335**
	% Change from FY 2015-16	**3.74%**	**1.41%**	**10.09%**	**12.40%**	**-1.00%**	**3.58%**
FY 2017-18 Projection	*Medical Per Capita*	$2,146.14	$1,712.56	$15,273.26	$12,329.37		
	Dental Per Capita	$253.07	$221.32	-	-		
	Caseload	42,810	21,463	271	580		65,124
	Medical Expenditure	$91,876,115	$36,756,777	$4,139,053	$7,151,035		$139,922,980
	Dental Expenditure	$10,833,716	$4,750,264	-	-		$15,583,980
	Disallowance Repayment	-	-	-	-	$621,207	$621,207
	Total FY 2017-18 Expenditures	**$102,709,831**	**$41,507,041**	**$4,139,053**	**$7,151,035**	**$621,207**	**$156,128,167**
	% Change from FY 2016-17	**5.56%**	**8.23%**	**2.03%**	**3.51%**	**-75.16%**	**4.70%**

Exhibit C5 - Traditional Population Expenditures and Funding

FY 2015-16 Projected Expenditures

	Children 0%-205% Medical	Children 0%-205% Dental	Prenatal 0%-205%	Totals
Caseload	39,392	39,392	254	39,646
Estimated Per Capita Cost	$2,143.60	$237.35	$14,508.11	$2,458.65
Total Estimated Expenditures FY 2015-16	**$84,440,776**	**$9,349,792**	**$3,685,061**	**$97,475,629**

FY 2016-17 Projected Expenditures

	Children 0%-205% Medical	Children 0%-205% Dental	Prenatal 0%-205%	Totals
Caseload	41,319	41,319	273	41,592
Estimated Per Capita Cost	$2,109.88	$244.99	$14,859.73	$2,436.95
Total Estimated Expenditures FY 2016-17	**$87,178,204**	**$10,122,704**	**$4,056,706**	**$101,357,614**

FY 2017-18 Projected Expenditures

	Children 0%-205% Medical	Children 0%-205% Dental	Prenatal 0%-205%	Totals
Caseload	42,810	42,810	271	43,081
Estimated Per Capita Cost	$2,146.14	$253.07	$15,273.26	$2,480.19
Total Estimated Expenditures FY 2017-18	**$91,876,115**	**$10,833,716**	**$4,139,053**	**$106,848,884**

Exhibit C5 - Traditional Population Expenditures and Funding

Cash Funds Forecast[1]

Row		FY 2012-13 Actuals	FY 2013-14 Actuals	FY 2014-15 Actuals	FY 2015-16 Forecast	FY 2016-17 Forecast	FY 2017-18 Forecast	Notes
A	Tier 1 CHP+ Trust Fund	$24,500,000	$24,000,000	$24,000,000	$23,900,000	$23,800,000	$23,600,000	2015 Tobacco MSA Payment Forecast[1]
B	Tier 2 CHP+ Trust Fund	$4,200,000	$4,900,000	$3,800,000	$3,700,000	$3,700,000	$3,600,000	2015 Tobacco MSA Payment Forecast[1]
C	Projected Amount	$28,700,000	$28,900,000	$27,800,000	$27,600,000	$27,500,000	$27,200,000	Row A + Row B
D	**Total Trust Fund Expenditure**	**$27,652,698**	**$26,465,326**	**$26,418,097**	**$27,889,272**	**$27,611,075**	**$26,881,760**	Actuals: Reported in COFRS Forecast: Row D * Row G [2]
E	CHP Premiums	$25,718,442	$24,588,447	$24,919,221	$25,534,809	$25,256,612	$24,527,297	Actuals: Reported in COFRS Forecast: Row D - Row F
F	CHP+ Admin	$1,934,256	$1,876,879	$1,498,876	$2,354,463	$2,354,463	$2,354,463	Actuals: Reported in COFRS Forecast: Exhibit C1
G	% of Projection	96.35%	91.58%	95.03%	101.05%	100.40%	98.83%	Actuals: Row D / Row C Forecast: Rolling 3 year average
H	Tier 2 Immunizations	$1,100,000	$1,100,000	$1,100,000	$1,000,000	$1,000,000	$1,000,000	2014 Tobacco MSA Payment Forecast[1]
I	% Appropriated to CHP+	19.50%	19.50%	19.50%	19.50%	19.50%	19.50%	Percentage appropriated to CHP+
J	Projected Amount	$214,500	$214,500	$214,500	$195,000	$195,000	$195,000	Row H * Row I
K	**Total CO Immunization Fund Expenditure**	**$221,635**	**$216,871**	**$229,297**	**$202,371**	**$202,664**	**$204,497**	Actuals: Reported in COFRS Forecast: Row J * Row L
L	% of Projection	103.33%	101.11%	106.90%	103.78%	103.93%	104.87%	Actuals: Row K / Row J Forecast: Rolling 3 year average

[1] https://www.colorado.gov/pacific/sites/default/files/2015%20Tobacco%20MSA%20Payment.pdf

[2] Values in FY 2014-15 and FY 2015-16 are from the February 4, 2015 Tobacco Master Settlement and Amendment 35 Funding.

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	$97,119,801	$16,704,606	$0	$0	$0	$0	$80,415,195	82.80%
Estimated Enrollment Fees	*$355,828*	*$0*	*$355,828*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$97,475,629**	**$16,704,606**	**$355,828**	**$0**	**$0**	**$0**	**$80,415,195**	82.50%
Offset From Cash Funds [3]	$0	($25,381,353)	$25,178,981	$202,371	$1	$0	$0	NA
Total Estimated Expenditures FY 2015-16	**$97,475,629**	**($8,676,747)**	**$25,534,809**	**$202,371**	**$1**	**$0**	**$80,415,195**	82.50%
Offset from General Fund [3]	$0	*$8,676,747*	*($8,676,747)*	$0	$0	$0	$0	NA
Total Estimated Expenditures FY 2015-16	**$97,475,629**	**$0**	**$16,858,062**	**$202,371**	**$1**	**$0**	**$80,415,195**	**82.50%**

[1] Forecasted above Cash Funds Forecast Table, Row E

[2] Forecasted above in Cash Funds Forecast Table, Row K

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	$100,989,188	$11,613,757	$0	$0	$0	$0	$89,375,431	88.50%
Estimated Enrollment Fees	*$368,426*	*$0*	*$368,426*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$101,357,614**	**$11,613,757**	**$368,426**	**$0**	**$0**	**$0**	**$89,375,431**	88.18%
Offset From Cash Funds [3]	*$0*	*($25,090,851)*	*$24,888,186*	*$202,664*	*$1*	*$0*	*$0*	NA
Total Estimated Expenditures FY 2016-17	**$101,357,614**	**($13,477,094)**	**$25,256,612**	**$202,664**	**$1**	**$0**	**$89,375,431**	88.18%
Offset from General Fund [3]	*$0*	*$13,477,094*	*($13,477,094)*	*$0*	*$0*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2016-17	**$101,357,614**	**$0**	**$11,779,518**	**$202,664**	**$1**	**$0**	**$89,375,431**	88.18%

[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 2017-18 - 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	$106,469,107	$12,243,948	$0	$0	$0	$0	$94,225,159	88.50%
Estimated Enrollment Fees	*$379,777*	*$0*	*$379,777*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$106,848,884**	**$12,243,948**	**$379,777**	**$0**	**$0**	**$0**	**$94,225,159**	88.19%
Offset From Cash Funds [3]	*$0*	*($24,352,018)*	*$24,147,520*	*$204,497*	*$1*	*$0*	*$0*	NA
Estimated Expenditures FY 2017-18	**$106,848,884**	**($12,108,070)**	**$24,527,297**	**$204,497**	**$1**	**$0**	**$94,225,159**	88.19%
Offset from General Fund [3]	*$0*	*$12,108,070*	*($12,108,070)*	*$0*	*$0*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2017-18	**$106,848,884**	**$0**	**$12,419,227**	**$204,497**	**$1**	**$0**	**$94,225,159**	88.19%

[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 2015-16 Projected Expenditures				
	Children 206%-260% Medical	**Children 206%-260% Dental**	**Prenatal 206%-260%**	**Totals**
Caseload	18,301	18,301	524	18,825
Estimated Per Capita Cost	$1,859.39	$207.19	$11,730.27	$2,335.57
Total Estimated Expenditures FY 2015-16	$34,028,646	$3,791,824	$6,146,662	$43,967,132

FY 2016-17 Projected Expenditures				
	Children 206%-260% Medical	**Children 206%-260% Dental**	**Prenatal 206%-260%**	**Totals**
Caseload	20,063	20,063	573	20,636
Estimated Per Capita Cost	$1,697.41	$214.19	$12,057.15	$2,193.32
Total Estimated Expenditures FY 2016-17	$34,055,191	$4,297,341	$6,908,748	$45,261,280

FY 2017-18 Projected Expenditures				
	Children 206%-260% Medical	**Children 206%-260% Dental**	**Prenatal 206%-260%**	**Totals**
Caseload	21,463	21,463	580	22,043
Estimated Per Capita Cost	$1,712.56	$221.32	$12,329.37	$2,207.42
Total Estimated Expenditures FY 2017-18	$36,756,777	$4,750,264	$7,151,035	$48,658,076

Exhibit C5 - Expansion Population Expenditures and Funding

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	$43,117,461	$0	$7,416,203	$0	$35,701,258	82.80%
Estimated Enrollment Fees	*$849,671*	*$0*	*$849,671*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2015-16	$43,967,132	$0	$8,265,874	$0	$35,701,258	81.20%

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	$44,329,848	$0	$5,097,933	$0	$39,231,915	88.50%
Estimated Enrollment Fees	*$931,432*	*$0*	*$931,432*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2016-17	$45,261,280	$0	$6,029,365	$0	$39,231,915	86.68%

FY 2017-18 - Calculation of Fund Splits

Item	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$47,661,636	$0	$5,481,089	$0	$42,180,547	88.50%
Estimated Enrollment Fees	*$996,440*	*$0*	*$996,440*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2017-18	$48,658,076	$0	$6,477,529	$0	$42,180,547	86.69%

Exhibit C5 - Enrollment Fees Historical Summary and Projection

Historical Enrollment Fees and Projections

	Children 157%-200%	Children 201%-205%	Children 206%-259%	Enrollment Fees[1]	Average Enrollment Fee[2]
FY 2009-10 Actuals	19,259	1,649	-	$346,589	$16.58
FY 2010-11 Actuals	18,265	1,164	4,023	$428,326	$18.26
% Change from FY 2009-10	-5.16%	-29.41%	-	23.58%	10.18%
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	1,950	19,043	$904,328	$19.45
% Change from FY 2012-13	15.06%	20.82%	22.27%	-3.01%	-17.91%
FY 2014-15 Actuals	23,607	1,714	16,668	$11,534	$0.27
% Change from FY 2013-14	-7.45%	-12.10%	-12.47%	-98.72%	-98.59%
FY 2015-16 Projection	23,956	1,780	18,301	$1,205,499	$27.37
% Change from FY 2014-15	1.48%	3.85%	9.80%	10351.70%	9865.55%
FY 2016-17 Projection	24,800	1,864	20,063	$1,299,858	$27.82
% Change from FY 2015-16	3.52%	4.72%	9.63%	7.83%	1.62%
FY 2017-18 Projection	25,559	1,938	21,463	$1,376,216	$28.11
% Change from FY 2016-17	3.06%	3.97%	6.98%	5.87%	1.05%

[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 156%-200%	Children 201%-205%	Children 206%-212%	Children 213%-260%	Total
FY 2015-16	Projected New Enrollees[1]	15,992	314	3,417	11,663	31,386
	Projected New Cases[2]	11,733	241	2,617	8,730	23,321
	Projected Average Fee[3]	$29.73	$29.21	$29.21	$88.57	$51.69
	Total Estimated Paid	$348,789	$7,039	$76,432	$773,239	$1,205,499
FY 2016-17	Projected New Enrollees[1]	16,555	329	3,746	12,786	33,416
	Projected New Cases[2]	12,146	252	2,869	9,570	24,837
	Projected Average Fee[3]	$29.73	$29.21	$29.21	$88.57	$52.34
	Total Estimated Paid	$361,066	$7,360	$83,792	$847,640	$1,299,858
FY 2017-18	Projected New Enrollees[1]	17,062	342	4,007	13,678	35,089
	Projected New Cases[2]	12,518	262	3,069	10,238	26,087
	Projected Average Fee[3]	$29.73	$29.21	$29.21	$88.57	$52.75
	Total Estimated Paid	$372,125	$7,652	$89,633	$906,807	$1,376,216

[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%-213%	Children 214%-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 2014-15[5]

HH Size	157%-200%	201%-213%	214%-260%
1	52.68%	57.85%	54.73%
2	31.75%	29.95%	31.79%
3	11.68%	9.21%	10.56%
4	3.01%	2.25%	2.41%
5	0.64%	0.56%	0.39%
6	0.19%	0.08%	0.08%
7	0.02%	0.05%	0.01%
8	0.02%	0.03%	0.01%
9	0.01%	0.00%	0.00%
10	0.00%	0.03%	0.01%

[4] https://www.colorado.gov/pacific/sites/default/files/2015%20Agency%20Letters%20CHP+Income%20Chart%20Final.pdf

[5] This is the average distribution of the number of children one parent or caretaker has enrolled in the CHP+ program in FY 2014-15, applied to all forecasted fiscal years.

Exhibit C6 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2015-16

FY 2015-16 Calculations

Service Expenditure	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal 0%-205%	Prenatal 206%-260%	Total
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18			
Weighted Capitation Rate	$304.65	$141.54	$160.93	$262.48	$115.18	$131.25	$4.99	$15.02	$20.65	$4.98	$13.66	$17.97	$1,216.24	$984.63	$187.38
Estimated Monthly Caseload	2,979	8,824	27,589	1,418	3,965	12,918	2,979	8,824	27,589	1,418	3,965	12,918	254	524	58,471
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
Total Estimated Costs for FY 2015-16 Capitated Payments	$10,890,628	$14,987,388	$53,278,773	$4,466,360	$5,480,264	$20,345,850	$178,383	$1,590,438	$6,836,554	$84,740	$649,943	$2,785,638	$3,707,100	$6,191,353	$131,473,412
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service	96.97%	98.65%	98.72%	96.76%	98.34%	98.44%	99.72%	99.75%	99.75%	99.69%	99.66%	99.65%	91.59%	96.31%	98.22%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$10,560,642	$14,785,058	$52,596,805	$4,321,650	$5,389,292	$20,028,455	$177,884	$1,586,462	$6,819,463	$84,477	$647,733	$2,775,888	$3,395,333	$5,962,892	$129,132,034
Estimated Expenditure for Prior Period Dates of Service	$364,031	$188,987	$633,339	$145,755	$83,590	$304,066	$464	$3,808	$15,412	$184	$1,808	$7,886	$289,728	$183,770	$2,222,828
Total Estimated Expenditure in FY 2015-16	**$10,924,673**	**$14,974,045**	**$53,230,144**	**$4,467,405**	**$5,472,882**	**$20,332,521**	**$178,348**	**$1,590,270**	**$6,834,875**	**$84,661**	**$649,541**	**$2,783,774**	**$3,685,061**	**$6,146,662**	**$131,354,862**
Unadjusted Per Capitas in FY 2015-16	$3,667.23	$1,696.97	$1,929.40	$3,150.50	$1,380.30	$1,573.97	$59.87	$180.22	$247.74	$59.70	$163.82	$215.50	$14,508.11	$11,730.27	$2,246.50

	Children's Medical 0%-205%	Children's Medical 206%-260%	Children's Dental 0%-205%	Children's Dental 206%-260%	Prenatal 0%-205%	Prenatal 206%-260%	Total
Total Estimated Expenditure in FY 2015-16	**$79,128,862**	**$30,272,808**	**$8,603,493**	**$3,517,976**	**$3,685,061**	**$6,146,662**	**$131,354,862**
Reconciliation Payments	$2,072,041	$571,728	$746,299	$273,848	$0	$0	$3,663,916
FQHC Payments	$3,239,873	$3,184,110	$0	$0	$0	$0	$6,423,983
Total Estimated FY 2015-16 Expenditure Including Bottom Line Impacts	**$84,440,776**	**$34,028,646**	**$9,349,792**	**$3,791,824**	**$3,685,061**	**$6,146,662**	**$141,442,761**
Estimated Monthly Caseload	39,392	18,301	39,392	18,301	254	524	58,471
Final Estimated Per Capita	$2,143.60	$1,859.39	$237.35	$207.19	$14,508.11	$11,730.27	$2,419.02
Unadjusted Per Capita	$2,008.75	$1,654.16	$218.41	$192.23	$14,508.11	$11,730.27	$2,246.50

Exhibit C6 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2016-17

FY 2016-17 Calculations

Service Expenditure	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal 0%-205%	Prenatal 206%-260%	Total
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18			
Weighted Capitation Rate	$308.41	$142.99	$165.76	$264.10	$116.94	$132.77	$5.05	$15.38	$21.36	$5.04	$13.98	$18.58	$1,248.11	$1,008.76	$191.34
Estimated Monthly Caseload	3,133	9,129	29,057	1,488	4,357	14,218	3,133	9,129	29,057	1,488	4,357	14,218	273	573	62,228
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
Total Estimated Costs for FY 2016-17 Capitated Payments	$11,594,982	$15,664,269	$57,797,860	$4,715,770	$6,114,091	$22,652,686	$189,860	$1,684,848	$7,447,890	$89,994	$730,930	$3,170,045	$4,088,808	$6,936,234	$142,878,267
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service	96.97%	98.65%	98.72%	96.76%	98.34%	98.44%	99.72%	99.75%	99.75%	99.69%	99.66%	99.65%	91.59%	96.31%	98.22%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$11,243,654	$15,452,801	$57,058,047	$4,562,979	$6,012,597	$22,299,304	$189,328	$1,680,636	$7,429,270	$89,715	$728,445	$3,158,950	$3,744,939	$6,680,287	$140,330,952
Estimated Expenditure for Prior Period Dates of Service	$329,986	$202,330	$681,968	$144,710	$90,972	$317,395	$499	$3,976	$17,091	$263	$2,210	$9,750	$311,767	$228,461	$2,341,378
Total Estimated Expenditure in FY 2016-17	**$11,573,640**	**$15,655,131**	**$57,740,015**	**$4,707,689**	**$6,103,569**	**$22,616,699**	**$189,827**	**$1,684,612**	**$7,446,361**	**$89,978**	**$730,655**	**$3,168,700**	**$4,056,706**	**$6,908,748**	**$142,672,330**
Unadjusted Per Capitas in FY 2016-17	$3,694.11	$1,714.88	$1,987.13	$3,163.77	$1,400.87	$1,590.71	$60.59	$184.53	$256.27	$60.47	$167.70	$222.87	$14,859.73	$12,057.15	$2,292.74

	Children's Medical 0%-205%	Children's Medical 206%-260%	Children's Dental 0%-205%	Children's Dental 206%-260%	Prenatal 0%-205%	Prenatal 206%-260%	Total
Total Estimated Expenditure in FY 2016-17	**$84,968,786**	**$33,427,957**	**$9,320,800**	**$3,989,333**	**$4,056,706**	**$6,908,748**	**$142,672,330**
Reconciliation Payments	$2,209,418	$627,234	$801,904	$308,008	$0	$0	$3,946,564
FQHC Payments	$0	$0	$0	$0	$0	$0	$0
Total Estimated FY 2016-17 Expenditure Including Bottom Line Impacts	**$87,178,204**	**$34,055,191**	**$10,122,704**	**$4,297,341**	**$4,056,706**	**$6,908,748**	**$146,618,894**
Estimated Monthly Caseload	41,319	20,063	41,319	20,063	273	573	62,228
Final Estimated Per Capita	$2,109.88	$1,697.41	$244.99	$214.19	$14,859.73	$12,057.15	$2,356.16
Unadjusted Per Capita	$2,056.41	$1,666.15	$225.58	$198.84	$14,859.73	$12,057.15	$2,292.74

Exhibit C6 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2017-18

FY 2017-18 Calculations

Service Expenditure	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal 0%-205%	Prenatal 206%-260%	Total
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18			
Weighted Capitation Rate	$312.20	$144.88	$168.82	$265.73	$118.86	$134.31	$5.12	$15.70	$22.09	$5.11	$14.27	$19.20	$1,274.19	$1,028.63	$193.77
Estimated Monthly Caseload	3,231	9,295	30,284	1,521	4,679	15,263	3,231	9,295	30,284	1,521	4,679	15,263	271	580	65,124
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
Total Estimated Costs for FY 2017-18 Capitated Payments	$12,104,618	$16,159,915	$61,350,539	$4,850,104	$6,673,751	$24,599,682	$198,513	$1,751,178	$8,027,683	$93,268	$801,232	$3,516,595	$4,143,666	$7,159,265	$151,430,009
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service	96.97%	98.65%	98.72%	96.76%	98.34%	98.44%	99.72%	99.75%	99.75%	99.69%	99.66%	99.65%	91.59%	96.31%	98.23%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$11,737,848	$15,941,756	$60,565,252	$4,692,961	$6,562,967	$24,215,927	$197,957	$1,746,800	$8,007,614	$92,979	$798,508	$3,504,287	$3,795,184	$6,895,088	$148,755,128
Estimated Expenditure for Prior Period Dates of Service	$351,328	$211,468	$739,813	$152,791	$101,494	$353,382	$532	$4,212	$18,620	$279	$2,485	$11,095	$343,869	$255,947	$2,547,315
Total Estimated Expenditure in FY 2017-18	**$12,089,176**	**$16,153,224**	**$61,305,065**	**$4,845,752**	**$6,664,461**	**$24,569,309**	**$198,489**	**$1,751,012**	**$8,026,234**	**$93,258**	**$800,993**	**$3,515,382**	**$4,139,053**	**$7,151,035**	**$151,302,443**
Unadjusted Per Capitas in FY 2017-18	$3,741.62	$1,737.84	$2,024.34	$3,185.90	$1,424.33	$1,609.73	$61.43	$188.38	$265.03	$61.31	$171.19	$230.32	$15,273.26	$12,329.37	$2,323.30

	Children's Medical 0%-205%	Children's Medical 206%-260%	Children's Dental 0%-205%	Children's Dental 206%-260%	Prenatal 0%-205%	Prenatal 206%-260%	Total
Total Estimated Expenditure in FY 2017-18	**$89,547,465**	**$36,079,522**	**$9,975,735**	**$4,409,633**	**$4,139,053**	**$7,151,035**	**$151,302,443**
Reconciliation Payments	$2,328,650	$677,255	$857,981	$340,631	$0	$0	$4,204,517
FQHC Payments	$0	$0	$0	$0	$0	$0	$0
Total Estimated FY 2017-18 Expenditure Including Bottom Line Impacts	**$91,876,115**	**$36,756,777**	**$10,833,716**	**$4,750,264**	**$4,139,053**	**$7,151,035**	**$155,506,960**
Estimated Monthly Caseload	42,810	21,463	42,810	21,463	271	580	65,124
Final Estimated Per Capita	$2,146.14	$1,712.56	$253.07	$221.32	$15,273.26	$12,329.37	$2,387.86
Unadjusted Per Capita	$2,091.74	$1,681.01	$233.02	$205.45	$15,273.26	$12,329.37	$2,323.30

Exhibit C6 - Incurred But Not Reported Expenditure by Fiscal Period

Incurred But Not Reported Estimated Percentages for all Fiscal Periods	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal	Total
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%	
Estimated Percent of Claims Paid in Current Period	96.97%	98.65%	98.72%	96.76%	98.34%	98.44%	99.72%	99.75%	99.75%	99.69%	99.66%	99.65%	91.59%	96.31%	98.14%
Estimated Percent of Claims Paid in Prior Period	3.03%	1.35%	1.28%	3.24%	1.66%	1.56%	0.28%	0.25%	0.25%	0.31%	0.34%	0.35%	8.41%	3.69%	1.86%
FY 2015-16 Estimated Expenditure for Prior Period Dates of Service															
Estimated Expenditure for Claims Incurred in Prior Period	$12,014,237	$13,999,015	$49,479,589	$4,498,602	$5,035,566	$19,491,409	$165,802	$1,523,079	$6,164,613	$59,487	$531,894	$2,253,127	$3,445,036	$4,980,222	$123,641,676
Estimated Percent of Prior Period Claims Paid in Current Period	3.03%	1.35%	1.28%	3.24%	1.66%	1.56%	0.28%	0.25%	0.25%	0.31%	0.34%	0.35%	8.41%	3.69%	1.80%
Estimated Expenditure for Prior Period Dates of Service	$364,031	$188,987	$633,339	$145,755	$83,590	$304,066	$464	$3,808	$15,412	$184	$1,808	$7,886	$289,728	$183,770	$2,222,828
FY 2016-17 Estimated Expenditure for Prior Period Dates of Service															
Estimated Expenditure for Claims Incurred in Prior Period	$10,890,628	$14,987,388	$53,278,773	$4,466,360	$5,480,264	$20,345,850	$178,383	$1,590,438	$6,836,554	$84,740	$649,943	$2,785,638	$3,707,100	$6,191,353	$131,473,412
Estimated Percent of Prior Period Claims Paid in Current Period	3.03%	1.35%	1.28%	3.24%	1.66%	1.56%	0.28%	0.25%	0.25%	0.31%	0.34%	0.35%	8.41%	3.69%	1.78%
Estimated Expenditure for Prior Period Dates of Service	$329,986	$202,330	$681,968	$144,710	$90,972	$317,395	$499	$3,976	$17,091	$263	$2,210	$9,750	$311,767	$228,461	$2,341,378
FY 2017-18 Estimated Expenditure for Prior Period Dates of Service															
Estimated Expenditure for Claims Incurred in Prior Period	$11,594,982	$15,664,269	$57,797,860	$4,715,770	$6,114,091	$22,652,686	$189,860	$1,684,848	$7,447,890	$89,994	$730,930	$3,170,045	$4,088,808	$6,936,234	$142,878,267
Estimated Percent of Prior Period Claims Paid in Current Period	3.03%	1.35%	1.28%	3.24%	1.66%	1.56%	0.28%	0.25%	0.25%	0.31%	0.34%	0.35%	8.41%	3.69%	1.78%
Estimated Expenditure for Prior Period Dates of Service	$351,328	$211,468	$739,813	$152,791	$101,494	$353,382	$532	$4,212	$18,620	$279	$2,485	$11,095	$343,869	$255,947	$2,547,315

Exhibit C7 - Bottom Line Impacts Summary

	Item	Children Medical to 205% FPL	Children Medical 206%-260% FPL	Children Dental to 205% FPL	Children Dental 206%-260% FPL	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Total
FY 2014-15 Actuals	Reconciliation Payments[1]	$2,090,485	$583,916	$682,362	$242,033	$0	$0	$3,598,796
	FQHC Payments[2]	$5,162,668	$434,310	$0	$0	$418,984	$200,428	$6,216,390
	Total Bottom Line Adjustments for FY 2014-15	**$7,253,154**	**$1,018,226**	**$682,362**	**$242,033**	**$418,984**	**$200,428**	**$9,815,186**
FY 2015-16 Projections	Reconciliation Payments[1]	$2,072,041	$571,728	$746,299	$273,848	$0	$0	$3,663,916
	FQHC Payments[2]	$3,239,873	$3,184,110	$0	$0	$0	$0	$6,423,983
	Total Bottom Line Adjustments for FY 2015-16	**$5,311,914**	**$3,755,838**	**$746,299**	**$273,848**	**$0**	**$0**	**$10,087,899**
FY 2016-17 Projections	Reconciliation Payments[1]	$2,209,418	$627,234	$801,904	$308,008	$0	$0	$3,946,564
	FQHC Payments[2]	$0	$0	$0	$0	$0	$0	$0
	Total Bottom Line Adjustments for FY 2016-17	**$2,209,418**	**$627,234**	**$801,904**	**$308,008**	**$0**	**$0**	**$3,946,564**
FY 2017-18 Projections	Reconciliation Payments[1]	$2,328,650	$677,255	$857,981	$340,631	$0	$0	$4,204,517
	FQHC Payments[2]	$0	$0	$0	$0	$0	$0	$0
	Total Bottom Line Adjustments for FY 2017-18	**$2,328,650**	**$677,255**	**$857,981**	**$340,631**	**$0**	**$0**	**$4,204,517**

[1] There exists a manual reconciliation process for CHP+ clients. These claims are accounted for as expenditure adjustments, calculations can be found on page S-3A/BA-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.

Exhibit C7 - Bottom Line Impact Calculations

Projected Reconciliation Payments Calculations

Estimated FY 2015-16 Reconciliations

	Children Medical to 205% FPL	Children Medical 206%-260% FPL	Children Dental to 205% FPL	Children Dental 206%-260% FPL	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Average Total
Actual FY 2014-15 Reconciliation Payments	$2,090,485	$583,916	$682,362	$242,033	$0	$0	$3,598,796
FY 2015-16 Projected Rate Inflation Exhibit C9	-5.30%	-9.28%	4.50%	4.83%	0.00%	0.00%	-3.41%
Estimated Reconciliations After Rate Inflation	$1,979,754	$529,704	$713,059	$253,719	$0	$0	$3,476,236
FY 2015-16 Projected Base Caseload Growth Exhibit C4	4.66%	7.93%	4.66%	7.93%	2.20%	5.00%	5.40%
Final Estimated FY 2015-16 Reconciliations	**$2,072,041**	**$571,728**	**$746,299**	**$273,848**	**$0**	**$0**	**$3,663,916**

Estimated FY 2016-17 Reconciliations

	Children Medical to 205% FPL	Children Medical 206%-260% FPL	Children Dental to 205% FPL	Children Dental 206%-260% FPL	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Average Total
FY 2015-16 Projected Reconciliation Payments	$2,072,041	$571,728	$746,299	$273,848	$0	$0	$3,663,916
FY 2016-17 Projected Rate Inflation Exhibit C9	2.48%	0.90%	3.27%	3.44%	2.62%	2.45%	2.46%
Estimated Reconciliations After Rate Inflation	$2,123,404	$576,859	$770,685	$283,271	$0.00	$0.00	$3,754,219
FY 2016-17 Projected Base Caseload Growth Exhibit C4	4.05%	8.73%	4.05%	8.73%	2.59%	6.00%	5.12%
Final Estimated FY 2016-17 Reconciliations	**$2,209,418**	**$627,234**	**$801,904**	**$308,008**	**$0**	**$0**	**$3,946,564**

Estimated FY 2017-18 Reconciliations

	Children Medical to 205% FPL	Children Medical 206%-260% FPL	Children Dental to 205% FPL	Children Dental 206%-260% FPL	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Average Total
FY 2016-17 Projected Reconciliation Payments	$2,209,418	$627,234	$801,904	$308,008	$0	$0	$3,946,564
FY 2017-18 Projected Rate Inflation Exhibit C9	1.72%	0.93%	3.26%	3.38%	2.09%	1.97%	2.04%
Estimated Reconciliations After Rate Inflation	$2,247,506	$633,078	$828,084	$318,412	$0.00	$0.00	$4,027,080
FY 2017-18 Projected Base Caseload Growth Exhibit C4	3.61%	6.98%	3.61%	6.98%	-0.84%	1.17%	4.41%
Final Estimated FY 2017-18 Reconciliations	**$2,328,650**	**$677,255**	**$857,981**	**$340,631**	**$0**	**$0**	**$4,204,517**

Exhibit C8 - Children's Basic Health Plan Retroactivity Adjustment[1]

		Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal 0%-205%	Prenatal 206%-260%
		Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18		
FY 2007-08	Average Monthly Claims	5,741	12,960	43,884				4,256	10,894	37,525				1,680	
	Average Caseload	4,395	11,798	41,603	-	-	-	4,395	11,798	41,603	-	-	-	1,571	-
	Claims as a Percentage of Caseload	130.63%	109.85%	105.48%	-	-	-	96.84%	92.34%	90.20%	-	-	-	106.94%	-
FY 2008-09	Average Monthly Claims	5,841	12,108	45,609				4,674	10,451	40,577				1,715	-
	Average Caseload	4,820	11,426	45,336	-	-	-	4,820	11,426	45,336	-	-	-	1,665	-
	Claims as a Percentage of Caseload	121.18%	105.97%	100.60%	-	-	-	96.97%	91.47%	89.50%	-	-	-	103.00%	-
FY 2009-10	Average Monthly Claims	5,931	12,158	51,911	20	43	117	4,763	10,346	45,695	4	14	48	1,563	14
	Average Caseload	5,123	11,520	51,946	13	32	91	5,123	11,520	51,946	13	32	91	1,550	11
	Claims as a Percentage of Caseload	115.77%	105.54%	99.93%	153.85%	134.38%	128.57%	92.97%	89.81%	87.97%	30.77%	43.75%	52.75%	100.84%	127.27%
FY 2010-11	Average Monthly Claims	5,272	11,068	48,435	564	1,160	3,020	4,116	9,397	42,115	368	873	2,366	1,481	293
	Average Caseload	4,407	10,467	48,370	430	982	2,611	4,407	10,467	48,370	430	982	2,611	1,470	272
	Claims as a Percentage of Caseload	119.63%	105.74%	100.13%	131.16%	118.13%	115.66%	93.40%	89.78%	87.07%	85.58%	88.90%	90.62%	100.75%	107.72%
FY 2011-12	Average Monthly Claims	4,241	9,006	38,373	909	1,942	5,147	4,395	9,255	41,666	951	2,139	6,220	1,412	347
	Average Caseload	4,750	10,374	48,093	1,055	2,471	7,523	4,750	10,374	48,093	1,055	2,471	7,523	1,616	448
	Claims as a Percentage of Caseload	89.28%	86.81%	79.79%	86.16%	78.59%	68.42%	92.53%	89.21%	86.64%	90.14%	86.56%	82.68%	87.38%	77.46%
FY 2012-13	Average Monthly Claims	6,556	13,570	52,298	1,533	3,386	10,320	4,827	10,102	41,267	1,215	2,815	8,723	1,450	470
	Average Caseload	5,187	11,300	45,773	1,398	3,377	10,800	5,187	11,300	45,773	1,398	3,377	10,800	1,148	463
	Claims as a Percentage of Caseload	126.39%	120.09%	114.26%	109.66%	100.27%	95.56%	93.06%	89.40%	90.16%	86.91%	83.36%	80.77%	126.31%	101.51%
FY 2013-14	Average Monthly Claims	4,629	12,043	34,107	1,806	4,596	13,555	3,595	10,045	28,742	1,385	3,900	11,515	528	486
	Average Caseload	3,081	9,993	29,437	1,319	4,411	13,313	3,081	9,993	29,437	1,319	4,411	13,313	451	502
	Claims as a Percentage of Caseload	150.24%	120.51%	115.86%	136.92%	104.19%	101.82%	116.68%	100.52%	97.64%	105.00%	88.42%	86.49%	117.07%	96.81%
FY 2014-15	Average Monthly Claims	3,305	8,968	26,905	1,603	3,871	12,078	2,832	8,180	24,695	1,338	3,474	10,858	225	496
	Average Caseload	2,979	8,824	27,589	1,418	3,965	12,918	2,979	8,824	27,589	1,418	3,965	12,918	254	524
	Claims as a Percentage of Caseload[2]	110.94%	101.63%	97.52%	113.05%	97.63%	93.50%	95.07%	92.70%	89.51%	94.36%	87.62%	84.05%	88.58%	94.66%
Weighted Average Claims as a Percentage of Caseload[3]		126.39%	120.09%	114.26%	109.66%	100.27%	95.56%	93.06%	94.96%	97.64%	95.96%	88.42%	86.49%	126.31%	101.51%
Retroactivity Adjustment Factor		26.39%	20.09%	14.26%	9.66%	0.27%	-4.44%	-6.94%	-5.04%	-2.36%	-4.05%	-11.58%	-13.51%	26.31%	1.51%

[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%-259% 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 205% - FY 2012-13; Children Medical 206%-260% - FY 2012-13;
	Children Dental	Children Dental to 205% Ages 0-1 - FY 2012-13; Children Dental to 205% Ages 2-5 - Average FY 2012-13 and FY 2013-14; Children Dental to 205% Ages 6-18 - FY 2013-14; Children Dental 206%-260% Ages 0-1 - Average FY 2012-13 and FY 2013-14; Children Dental 206%-260% Ages 2-18 - FY 2013-14
	Prenatal	Prenatal to 205% - FY 2012-13; Prenatal 206%-260% - FY 2012-13

Exhibit C8 - Children's Basic Health Plan Claims Distribution Adjustment Multiplier[1]

		Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
		Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2007-08	Weighted Claims-Based Rate	$209.40	$97.21	$112.74				$13.84	$13.84	$13.84				$861.66	
	Weighted Capitation Rate	$194.67	$95.70	$111.68	-	-	-	$13.97	$13.97	$13.97	-	-	-	$856.98	-
	Claims as a Percentage of Capitation	107.57%	101.58%	100.95%	-	-	-	99.07%	99.07%	99.07%	-	-	-	100.55%	-
FY 2008-09	Weighted Claims-Based Rate	$208.62	$87.77	$117.77	-	-	-	$14.66	$14.66	$14.66	-	-	-	$912.34	-
	Weighted Capitation Rate	$208.69	$87.76	$117.91	-	-	-	$14.66	$14.66	$14.66	-	-	-	$915.80	-
	Claims as a Percentage of Capitation	99.97%	100.01%	99.88%	-	-	-	100.00%	100.00%	100.00%	-	-	-	99.62%	-
FY 2009-10	Weighted Claims-Based Rate	$306.23	$107.47	$138.74	$440.63	$106.41	$136.86	$14.81	$14.81	$14.81	$14.64	$14.64	$14.64	$827.81	$827.08
	Weighted Capitation Rate	$306.62	$111.70	$138.79	$396.96	$105.89	$135.97	$14.81	$14.81	$14.81	$14.81	$14.81	$14.81	$821.12	$821.35
	Claims as a Percentage of Capitation	99.87%	96.21%	99.96%	111.00%	100.49%	100.65%	100.00%	100.00%	100.00%	98.85%	98.85%	98.85%	100.81%	100.70%
FY 2010-11	Weighted Claims-Based Rate	$392.40	$110.87	$137.53	$415.80	$107.46	$133.20	$4.59	$12.41	$15.98	$4.56	$12.17	$15.63	$1,185.01	$1,185.01
	Weighted Capitation Rate	$385.28	$110.86	$135.78	$405.65	$106.73	$131.15	$2.56	$11.97	$16.26	$2.54	$11.67	$15.83	$1,094.18	$1,089.34
	Claims as a Percentage of Capitation	101.85%	100.01%	101.29%	102.50%	100.68%	101.56%	179.30%	103.68%	98.28%	179.53%	104.28%	98.74%	108.30%	108.78%
FY 2011-12	Weighted Claims-Based Rate	$397.04	$122.31	$143.98	$382.70	$119.61	$139.71	$2.82	$13.87	$16.85	$2.79	$13.52	$16.43	$1,138.60	$1,138.60
	Weighted Capitation Rate	$405.13	$123.72	$146.88	$390.50	$120.89	$142.51	$2.81	$13.89	$16.87	$2.81	$13.83	$16.79	$1,147.46	$1,138.60
	Claims as a Percentage of Capitation	98.00%	98.86%	98.03%	98.00%	98.94%	98.04%	100.36%	99.86%	99.88%	99.29%	97.76%	97.86%	99.23%	100.00%
FY 2012-13	Weighted Claims-Based Rate	$301.19	$121.06	$139.61	$289.34	$119.37	$135.81	$3.20	$14.02	$18.10	$3.18	$13.65	$17.66	$912.11	$912.11
	Weighted Capitation Rate	$301.26	$121.14	$139.64	$289.34	$119.37	$135.86	$3.21	$14.03	$18.11	$3.18	$13.65	$17.67	$934.69	$912.11
	Claims as a Percentage of Capitation	99.98%	99.93%	99.98%	100.00%	100.00%	99.96%	99.69%	99.93%	99.94%	100.00%	100.00%	99.94%	97.58%	100.00%
FY 2013-14	Weighted Claims-Based Rate	$285.13	$122.73	$141.22	$283.29	$120.80	$143.35	$3.17	$13.29	$16.82	$3.17	$12.97	$16.78	$969.79	$969.79
	Weighted Capitation Rate	$285.21	$122.59	$141.00	$283.41	$120.79	$143.35	$3.35	$13.99	$17.78	$3.35	$13.65	$17.67	$980.64	$970.08
	Claims as a Percentage of Capitation	99.97%	100.11%	100.16%	99.96%	100.01%	100.00%	94.63%	95.00%	94.60%	94.63%	95.02%	94.96%	98.89%	99.97%
FY 2014-15	Weighted Claims-Based Rate	$280.64	$124.26	$145.89	$279.23	$122.04	$151.03	$4.51	$14.83	$19.85	$4.48	$14.37	$19.45	$969.72	$969.72
	Weighted Capitation Rate	$283.15	$123.86	$145.49	$281.30	$121.73	$150.63	$4.73	$15.60	$20.89	$4.69	$15.13	$20.47	$980.13	$970.08
	Claims as a Percentage of Capitation	99.11%	100.32%	100.27%	99.26%	100.25%	100.27%	95.35%	95.06%	95.02%	95.52%	94.98%	95.02%	98.94%	99.96%
Average Claims as a Percentage of Capitation[2]		99.98%	100.02%	100.07%	99.98%	100.01%	99.98%	97.16%	97.47%	97.27%	97.32%	97.51%	97.45%	98.24%	99.99%
Claims Distribution Adjustment Multiplier		-0.02%	0.02%	0.07%	-0.02%	0.01%	-0.02%	-2.84%	-2.53%	-2.73%	-2.68%	-2.49%	-2.55%	-1.76%	-0.01%

[1] The claims distribution adjustment captures the difference in the amount paid per claim and the weighted capitation rate.

[2] Percentage selected to modify capitation rates		
	Children Medical	Children Medical to 205% - Average FY 2012-13 and FY 2013-14; Children Medical 206%-260% - Average FY 2012-13 and FY 2013-14
	Children Dental	Children Dental to 205% - Average FY 2012-13 and FY 2013-14; Children Dental 206%-260% - Average FY 2012-13 and FY 2013-14
	Prenatal	Prenatal to 205% - Average FY 2012-13 and FY 2013-14; Prenatal 206%-260% - Average FY 2012-13 and FY 2013-14

Exhibit C9 - Children's Basic Health Plan Capitation Rate Trends and Forecasts

Capitation Rate Trends

	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2007-08 Actuals	$194.67	$95.70	$111.68	-	-	-	$13.97	$13.97	$13.97	-	-	-	$856.98	
FY 2008-09 Actuals	$208.69	$87.76	$117.91	-	-	-	$14.66	$14.66	$14.66	-	-	-	$915.80	
% Change	*7.20%*	*-8.30%*	*5.58%*				*4.94%*	*4.94%*	*4.94%*				*6.86%*	
FY 2009-10 Actuals	$306.62	$111.70	$138.79	$396.96	$105.89	$135.97	$14.81	$14.81	$14.81	$14.81	$14.81	$14.81	$821.12	$821.35
% Change	*46.93%*	*27.28%*	*17.71%*	-	-	-	*1.02%*	*1.02%*	*1.02%*	-	-	-	*-10.34%*	-
FY 2010-11 Actuals	$385.28	$110.86	$135.78	$405.65	$106.73	$131.15	$2.56	$11.97	$16.26	$2.54	$11.67	$15.83	$1,094.18	$1,089.34
% Change	*25.65%*	*-0.75%*	*-2.17%*	*2.19%*	*0.79%*	*-3.54%*	*-82.71%*	*-19.18%*	*9.79%*	*-82.85%*	*-21.20%*	*6.89%*	*33.25%*	-
FY 2011-12 Actuals	$405.13	$123.72	$146.88	$390.50	$120.89	$142.51	$2.81	$13.89	$16.87	$2.81	$13.83	$16.79	$1,147.46	$1,138.60
% Change	*5.15%*	*11.60%*	*8.17%*	*-3.73%*	*13.27%*	*8.66%*	*9.77%*	*16.04%*	*3.75%*	*10.63%*	*18.51%*	*6.06%*	*4.87%*	*4.52%*
FY 2012-13 Actuals	$301.26	$121.14	$139.64	$289.34	$119.37	$135.86	$3.21	$14.03	$18.11	$3.18	$13.65	$17.67	$934.69	$912.11
% Change	*-25.64%*	*-2.09%*	*-4.93%*	*-25.91%*	*-1.26%*	*-4.67%*	*14.23%*	*1.01%*	*7.35%*	*13.17%*	*-1.30%*	*5.24%*	*-18.54%*	*-19.89%*
FY 2013-14 Actuals	$285.21	$122.59	$141.00	$283.41	$120.79	$143.35	$3.35	$13.99	$17.78	$3.35	$13.65	$17.67	$980.64	$970.08
% Change	*-5.33%*	*1.20%*	*0.97%*	*-2.05%*	*1.19%*	*5.51%*	*4.36%*	*-0.29%*	*-1.82%*	*5.35%*	*0.00%*	*0.00%*	*4.92%*	*6.36%*
FY 2014-15 Actuals	$283.15	$123.86	$145.49	$281.30	$121.73	$150.63	$4.73	$15.60	$20.89	$4.69	$15.13	$20.47	$980.13	$970.08
% Change	*-0.72%*	*1.04%*	*3.18%*	*-0.74%*	*0.78%*	*5.08%*	*41.19%*	*11.51%*	*17.49%*	*40.00%*	*10.84%*	*15.85%*	*-0.05%*	*0.00%*
FY 2015-16 Projected Weighted Rate	$241.10	$117.84	$140.75	$239.40	$114.86	$137.38	$5.52	$16.23	$21.74	$5.33	$15.84	$21.32	$980.13	$970.08
% Change	*-14.85%*	*-4.86%*	*-3.26%*	*-14.90%*	*-5.64%*	*-8.80%*	*16.70%*	*4.04%*	*4.07%*	*13.65%*	*4.69%*	*4.15%*	*0.00%*	*0.00%*
FY 2016-17 Estimated Rate	$244.07	$119.05	$144.97	$240.88	$116.61	$138.97	$5.59	$16.62	$22.49	$5.40	$16.22	$22.04	$1,005.81	$993.85
% Change	*1.23%*	*1.03%*	*3.00%*	*0.62%*	*1.52%*	*1.16%*	*1.27%*	*2.40%*	*3.45%*	*1.31%*	*2.40%*	*3.38%*	*2.62%*	*2.45%*
FY 2017-18 Estimated Rate	$247.07	$120.62	$147.65	$242.37	$118.53	$140.58	$5.66	$16.96	$23.26	$5.47	$16.55	$22.78	$1,026.83	$1,013.43
% Change	*1.23%*	*1.32%*	*1.85%*	*0.62%*	*1.65%*	*1.16%*	*1.25%*	*2.05%*	*3.42%*	*1.30%*	*2.03%*	*3.36%*	*2.09%*	*1.97%*

Exhibit C9 - Children's Basic Health Plan Capitation Rate Trends and Forecasts						
Weighted Capitation Rate Trends						
	Children's Medical 0%-205%	**Children's Medical 206%-260%**	**Children's Dental 0%-205%**	**Children's Dental 206%-260%**	**Prenatal 0%-205%**	**Prenatal 206%-260%**
FY 2007-08 Actuals	$114.70	-	$13.97		$865.23	
FY 2008-09 Actuals	$119.42	-	$14.66	-	$915.80	-
% Change	*4.12%*	*0.00%*	*4.94%*	-	*5.84%*	-
FY 2009-10 Actuals	$146.77	$153.84	$14.81	$14.81	$821.12	$821.35
% Change	*22.90%*	*0.00%*	*1.02%*	-	*-10.34%*	-
FY 2010-11 Actuals	$149.04	$154.52	$14.59	$13.39	$1,094.18	$1,089.34
% Change	*1.55%*	*0.00%*	*-1.49%*	-	*33.25%*	*32.63%*
FY 2011-12 Actuals	$162.49	$161.35	$15.33	$14.79	$1,147.48	$1,138.60
% Change	*9.02%*	*4.42%*	*5.07%*	*10.46%*	*4.87%*	*4.52%*
FY 2012-13 Actuals	$149.77	$146.06	$16.13	$15.50	$934.90	$912.11
% Change	*-7.83%*	*-9.48%*	*5.22%*	*4.80%*	*-18.53%*	*-19.89%*
FY 2013-14 Actuals	$147.19	$147.83	$15.84	$15.75	$981.44	$970.08
% Change	*-1.72%*	*1.21%*	*-1.80%*	*1.61%*	*4.98%*	*6.36%*
FY 2014-15 Actuals	$151.22	$154.78	$18.45	$18.02	$980.09	$970.08
% Change	*2.74%*	*4.70%*	*16.48%*	*14.41%*	*-0.14%*	*0.00%*
FY 2015-16 Projected Weighted Rate	$143.21	$140.41	$19.28	$18.89	$980.13	$970.08
% Change	*-5.30%*	*-9.28%*	*4.50%*	*4.83%*	*0.00%*	*0.00%*
FY 2016-17 Estimated Rate	$146.76	$141.67	$19.91	$19.54	$1,005.81	$993.85
% Change	*2.48%*	*0.90%*	*3.27%*	*3.44%*	*2.62%*	*2.45%*
FY 2017-18 Estimated Rate	$149.29	$142.99	$20.56	$20.20	$1,026.83	$1,013.43
% Change	*1.72%*	*0.93%*	*3.26%*	*3.38%*	*2.09%*	*1.97%*

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-04 Medicare Modernization Act

Dept. Approval By: Josh Block [signature] 11/2/15

OSPB Approval By: [signature] 10/28/15

	Supplemental FY 2015-16
X	Change Request FY 2016-17
	Base Reduction FY 2016-17
	Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$116,816,749**	**$0**	**$116,816,749**	**$16,865,498**	**$29,880,484**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$116,816,749	$0	$116,816,749	$16,865,498	$29,880,484
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
06. Other Medical Services - Medicare Modernization Act State Contribution Payment	**Total**	**$116,816,749**	**$0**	**$116,816,749**	**$16,865,498**	**$29,880,484**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$116,816,749	$0	$116,816,749	$16,865,498	$29,880,484
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Letternote Text Revision Required? Yes ___ No X

If Yes, describe the Letternote Text Revision:

Cash or Federal Fund Name and CORE Fund Number: N/A

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: N/A

Other Information:

Cost and FTE

- The Department requests a reduction of $1,318,801 General Fund for FY 2015-16; an increase of $16,865,498 General Fund for FY 2016-17; and an increase of $29,880,484 General Fund for FY 2017-18 to the Medicare Modernization Act State Contribution Payment line item. This request does not require any additional FTE.

Current Program

- The Department serves clients who are eligible for both Medicaid and Medicare.
- 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 requests adjustment to the appropriation in the Medicare Modernization Act State Contribution Payment line item to meet the State's obligation to the federal government for prescription drug coverage for dual-eligible clients while reducing the risk of reverting funds that could be used for other purposes.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-4
Request Detail: Medicare Modernization Act State Contribution Payment

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Medicare Modernization Act State Contribution Payment	($1,318,801)	($1,318,801)

Summary of Incremental Funding Change for FY 2016-17	Total Funds	General Fund
Medicare Modernization Act State Contribution Payment	$16,865,498	$16,865,498

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Medicare Modernization Act State Contribution Payment	$29,880,484	$29,880,484

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 a decrease of $1,318,801 General Fund for FY 2015-16; an increase of $16,865,498 General Fund for FY 2016-17; and an increase of $29,880,484 General Fund for FY 2017-18 for funding adjustment to the Medicare Modernization Act 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. The Medicare Modernization Act 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.

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:

Detailed calculations for the request are included in the attached appendix.

A summary of the funding request for the Medicare Modernization Act State Contribution Payment line item by fund type is provided for FY 2015-16, FY 2016-17, and FY 2017-18 in tables 1.1, 1.2, and 1.3, respectively. Row C in each of these tables provides the amount of incremental change requested.

The State´s clawback payment is calculated according to three factors:

1. The projected number of Medicare and Medicaid dual-eligible clients enrolled in a Part D plan;
2. A per member per month (PMPM) 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 was set forth by the MMA starting at 90% in 2006 and declined by 1.67% each year thereafter until 2015 when it reached 75%, where it will remain ongoing.

The Department's estimates of the clawback payment are $115,497,948 for FY 2015-16; $133,682,247 for FY 2016-17; and $146,697,233 for FY 2017-18, 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).

The total caseload and expenditure estimates for FY 2015-16, FY 2016-17, and FY 2017-18 are calculated in tables 2.1, 2.3, and 2.5, respectively. The Department assumes the changes in dual-eligible caseload will follow a 5.96% growth trend determined by annualizing the monthly average growth over the past two years from July 2013 through June 2015. Retroactivity is also considered in this forecast because clients are able to be retroactively enrolled and disenrolled for up to 24 months. This method estimates caseload by increasing the total caseload incurred each month by 0.50% to forecast the total caseload for the following month. Rows A through L on tables 2.1, 2.3 and 2.5 of the appendix show the breakdown of actual and projected caseload for a given month by the calendar year for which the caseload is attributed. 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 includes invoices received between May and April. Tables 2.2, 2.4, and 2.6 provide calculations of caseload and expenditures by the various PMPM rates for each calendar year for dual-eligible clients.

The changes in the PMPM rate are based on a prescribed methodology established by CMS. The PMPM rates are calculated by calendar year in tables 3.1, 3.2, 3.3, and 3.4 of the appendix. The change in percentage of growth in row G is calculated by subtracting the average growth rate of per capita prescription drug expenditure between years 2003 and 2006 from the annual growth of National Health Expenditure (NHE) percentage of growth from 2014 NHE estimates in row F from the percentage of growth from 2013 NHE estimates in row C. The annual percentage increase (API) in average per capita aggregate Part D expenditures in row J for CY 2016 is provided in the "Announcement of CY 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies" document issued by CMS on April 6, 2015. For CY 2017 and CY 2018, the Department uses the median of the last five years of the annual percentage increase in average per capita Part D expenditures from CY 2011 to CY 2015 to project the percentage change in the rate (found in row J of tables 3.3 and 3.4). The final percentage change in the PMPM rate is calculated in row K of tables 3.1-3.4. The 11.76% API for CY 2016 shown in table 3.2 row J grew 7.74% higher than the 4.02% shown in table 3.1 row J. This growth trend is primarily attributed to the increased Medicare Part D costs associated with a new high cost drug for treatment of Hepatitis C.

To calculate the CY 2016 PMPM rate before the phasedown, the prior year's PMPM is increased by the final percentage change in the PMPM rate (found in row M). The PMPM rates are also adjusted based on changes in the Federal Medicaid Assistance Percentage (FMAP) rate which occur on a federal fiscal year (October 1 through September 30 timespan) as follows:

- FFY 2014: 50.00%
- FFY 2015: 51.01%
- FFY 2016: 50.72%
- FFY 2017: 50.32%

To determine the State's share of the PMPM, the total projected rate (found in row N) is multiplied by the State share of the FMAP (100% minus applicable FMAP percentage above) and by the 75% phasedown percentage to estimate the PMPM rates shown in row R (rate for January through September) and row S (rate for October through December).

Table 4.1 provides actual caseload history from FY 2006-07 through FY 2014-15 and caseload projections based on current trends for FY 2015-16 through FY 2017-18. Table 4.2 provides actual and projected aggregate monthly caseload history by number of member months and average monthly caseload. Table 4.3 shows the PMPM rate history from CY 2006 to CY 2015, and projected PMPM rates for CY 2016 to CY 2018.

R-4 Medicare Modernization Act of 2003 State Contribution Payment
Appendix A: Calculations and Assumptions

Table 1.1
FY 2015-16 Summary of Incremental Funding Request
LBG (6) Other Medical Services, Medicare Modernization Act State Contribution Payment Line Item

Row	Item	Total Funds	General Fund	Source
A	FY 2015-16 Spending Authority	$116,816,749	$116,816,749	Long Bill Appropriation (SB 15-234)
B	Projected FY 2015-16 Expenditures	$115,497,948	$115,497,948	Table 2.3 Row O
C	**FY 2015-16 Incremental Change**	**($1,318,801)**	**($1,318,801)**	Row B - Row A

Table 1.2
FY 2016-17 Summary of Incremental Funding Request
LBG (6) Other Medical Services, Medicare Modernization Act State Contribution Payment Line Item

A	FY 2016-17 Spending Authority	$116,816,749	$116,816,749	Long Bill Appropriation (SB 15-234)
B	Projected FY 2016-17 Expenditures	$133,682,247	$133,682,247	Table 2.5 Row O
C	**FY 2016-17 Incremental Change**	**$16,865,498**	**$16,865,498**	Row B - Row A

Table 1.3
FY 2017-18 Summary of Incremental Funding Request
LBG (6) Other Medical Services, Medicare Modernization Act State Contribution Payment Line Item

Row	Item	Total Funds	General Fund	Source
A	FY 2017-18 Spending Authority	$116,816,749	$116,816,749	Long Bill Appropriation (SB 15-234)
B	Projected FY 2017-18 Expenditures	$146,697,233	$146,697,233	Table 2.5 Row O
C	**FY 2017-18 Incremental Change**	**$29,880,484**	**$29,880,484**	Row B - Row A

Table 2.1 FY 2015-16 Projected Caseload and Expenditures						
Row	**Month**	**CY 2013**	**CY 2014**	**CY 2015**	**CY 2016**	**FY 2015-16 TOTAL**
A	May 2015	(48)	52	71,529	0	71,533
B	June 2015	(118)	168	73,022	0	73,072
C	July 2015	(62)	425	72,478	0	72,841
D	August 2015	(53)	324	72,920	0	73,191
E	September 2015	(45)	245	73,351	0	73,551
F	October 2015	(29)	170	73,774	0	73,915
G	November 2015	(15)	108	74,187	0	74,280
H	December 2015	0	55	74,593	0	74,648
I	January 2016	0	25	2,732	72,266	75,023
J	February 2016	0	(12)	1,679	73,721	75,388
K	March 2016	0	(37)	1,140	74,667	75,770
L	April 2016	0	(55)	848	75,351	76,144
M	CY Client Total	(370)	1,468	592,253	296,005	889,356
N	CY PMPM Rate (1)	$133.62	Varies (2)	Varies (2)	Varies (2)	
O	**Expenditures (3)**	**($49,439)**	**$180,687**	**$74,002,962**	**$41,363,739**	**$115,497,948**

(1) PMPM Rates in row N are calculated in tables 3.1, 3.3 and 3.5
(2) Rate changes occured in calendar year's 2014, 2015 and 2016 due to FMAP changes from 50.0% in FFY 2014, 51.01% in FFY 2015; and 50.72% in FFY 2016.
(3) Expenditures are calculated by summing the caseload for a given CY and then multiplying that sum (row M) by its respective CY PMPM rate (table 2.2) to get total CY expenditures (row O) for FY 2015-16.

Table 2.2 Caseload Breakdown for FY 2015-16 with CY 2014, CY 2015, and CY 2016 Rates					
Row	**Rate Period**	**FY 2015-16 Dual-Eligible Caseload**	**Rates**	**Total**	**Source**
A	Jan - Sept 2014	66	$125.50	$8,283	
B	Oct - Dec 2014	1,402	$122.97	$172,404	
C	**CY 2014 Total**	**1,468**		**$180,687**	Row A + Row B
D	Jan - Sept 2015	374,878	$124.68	$46,739,789	
E	Oct - Dec 2015	217,375	$125.42	$27,263,173	
F	**CY 2015 Total**	**592,253**		**$74,002,962**	Row D + Row E
G	Jan - Sept 2016	296,005	$139.74	$41,363,739	
H	Oct - Dec 2016	0	$140.59	$0	
I	**CY 2016 Total**	**296,005**		**$41,363,739**	Row G + Row I

Table 2.3
FY 2016-17 Projected Caseload and Expenditures

Row	Month	CY 2014	CY 2015	CY 2016	CY 2017	FY 2016-17 TOTAL
A	May 2016	(64)	668	75,919	0	76,523
B	June 2016	(67)	542	76,432	0	76,907
C	July 2016	(67)	431	76,924	0	77,288
D	August 2016	(59)	334	77,402	0	77,677
E	September 2016	(48)	247	77,862	0	78,061
F	October 2016	(33)	172	78,316	0	78,455
G	November 2016	(16)	111	78,754	0	78,849
H	December 2016	0	52	79,186	0	79,238
I	January 2017	0	24	2,893	76,723	79,640
J	February 2017	0	(13)	1,781	78,269	80,037
K	March 2017	0	(40)	1,205	79,272	80,437
L	April 2017	0	(55)	898	79,999	80,842
M	CY Client Total	(354)	2,473	627,572	314,263	943,954
N	CY PMPM Rate [1]	Varies [2]	Varies [2]	Varies [2]	$144.86	
O	**Expenditures [3]**	**($43,919)**	**$308,951**	**$87,893,077**	**$45,524,138**	**$133,682,247**

(1) PMPM Rates in row N are calculated in tables 3.1-3.5
(2) Rate changes occured for calendar year's 2014, 2015 and 2016 due to FMAP changes from 50.0% in FFY 2014, 51.01% in FFY 2015; and 50.72% in FFY 2016. Expenditure for CY 2014 and CY 2015 in row O is calculated in table 2.2.
(3) Expenditures are calculated by multiplying caseload by the respective PMPM rate shown in table 2.2.

Table 2.4
Caseload Breakdown for FY 2016-17 with CY 2014, CY 2015, and CY 2016 Rates

Row	Rate Period	FY 2016-17 Dual-Eligible Caseload	Rates	Total	Source
A	Jan - Sept 2014	(153)	$125.50	($19,202)	
B	Oct - Dec 2014	(201)	$122.97	($24,717)	
C	**CY 2014 Total**	**(354)**		**($43,919)**	Row A + Row B
D	Jan - Sept 2015	1,639	$124.68	$204,351	
E	Oct - Dec 2015	834	$125.42	$104,600	
F	**CY 2015 Total**	**2,473**		**$308,951**	Row D + Row E
G	Jan - Sept 2016	396,789	$139.74	$55,447,295	
H	Oct - Dec 2016	230,783	$140.59	$32,445,782	
I	**CY 2016 Total**	**627,572**		**$87,893,077**	Row G + Row H

Table 2.5
FY 2017-18 Projected Caseload and Expenditures

Row	Month	CY 2015	CY 2016	CY 2017	CY 2018	FY 2017-18 TOTAL
A	May 2017	(63)	705	80,601	0	81,243
B	June 2017	(39)	709	81,147	0	81,817
C	July 2017	(7)	716	81,669	0	82,378
D	August 2017	35	718	82,174	0	82,927
E	September 2017	83	725	82,666	0	83,474
F	October 2017	125	722	83,143	0	83,990
G	November 2017	165	729	83,612	0	84,506
H	December 2017	210	731	84,068	0	85,009
I	January 2018	0	736	3,071	81,453	85,260
J	February 2018	0	738	1,890	81,860	84,488
K	March 2018	0	744	1,280	82,269	84,293
L	April 2018	0	745	951	82,680	84,376
M	CY Client Total	509	8,718	666,272	328,262	1,003,761
N	CY PMPM Rate [1]	Varies [2]	Varies [2]	$144.86	$148.96	
O	**Expenditures [3]**	**$63,416**	**$1,219,748**	**$96,516,162**	**$48,897,908**	**$146,697,233**

(1) PMPM Rates in row N are calculated in tables 3.1-3.5
(2) Rate change occured in CY 2015 due to FMAP change from 51.01% in FFY 2015 to 50.72% in FFY 2016. Expenditure for CY 2015 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 with CY 2015 and CY 2016 Rates

Row	Rate Period	FY 2017-18 Dual-Eligible Caseload	Rates	Total	Source
A	Jan - Sept 2015	572	$124.68	$71,317	
B	Oct - Dec 2015	(63)	$125.42	($7,901)	
C	**CY 2015 Total**	**509**		**$63,416**	Row A + Row B
D	Jan - Sept 2016	6,960	$139.74	$972,590	
E	Oct - Dec 2016	1,758	$140.59	$247,157	
F	**CY 2016 Total**	**8,718**		**$1,219,748**	Row D + Row E

Table 3.1
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 4/7/2014		
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 J
L	CY 2014 PMPM Rate Prior to FMAP and Phasedown	$327.40	
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%	FFY 2015 FMAP is 51.01%
P	Projected CY 2015 PMPM Rate Prior to Phasedown	$166.26	Row N × Row O
Q	CY 2015 Phasedown Percentage	75.00%	CY 2015 Phasedown %
R	**CY 2015 PMPM Rate (January through September 2015 with 51.01% FMAP)**	**$124.68**	Actual Rate
S	**CY 2015 PMPM Rate (October through December 2015 with 50.72% FMAP)**	**$125.42**	(Row R/48.99%)*49.28%

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 3.2
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 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 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies 4/6/2015		
H	Annual percentage increase trend for 2015	6.37%	
I	Revisions of Prior Year Annual Percentage Trend	5.07%	
J	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2015 (Attachment V, Table V-1)	11.76%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2016**	**11.40%**	Row G + Row J
L	CY 2015 PMPM Rate Prior to FMAP and Phasedown	$339.38	Table 3.1 Row N
M	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2016	11.40%	Row K
N	Projected CY 2016 PMPM Rate Prior to FMAP and Phasedown	$378.08	Row L × (1 + Row M)
O	FMAP State Share	49.28%	FFY 16 FMAP is 50.72%
P	Projected CY 2016 PMPM Rate Prior to Phasedown	$186.32	Row N × Row O
Q	CY 2016 Phasedown Percentage	75.00%	CY 2016 Phasedown %
R	**Estimated CY 2016 PMPM Rate (January through September 2016 with 50.72% FMAP)**	**$139.74**	Row P × Row Q
S	**Estimated CY 2016 PMPM Rate (October through December 2016 with 50.42% FMAP)**	**$140.59**	(Row R/48.22%)*49.58%

Source: Centers for Medicare and Medicaid Services (CMS), 2013 and 2014 NHE estimates; and Announcement of CY 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table V-3.

Table 3.3
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 2016	4.07%	Median Change from FY 2011-FY 2015
I	Projected Prior Year Revisions of Annual percentage Trend	-0.85%	Median Change from FY 2011-FY 2015
J	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2016	3.19%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2017**	**2.83%**	Row G + Row H
L	CY 2016 PMPM Rate Prior to FMAP and Phasedown	$378.08	Table 3.2 Row N
M	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2017	2.83%	Row K
N	Projected CY 2017 PMPM Rate Prior to FMAP and Phasedown	$388.78	Row L × (1 + Row M)
O	FMAP State Share	49.68%	FFY 17 FMAP is 50.32%
P	Projected CY 2017 PMPM Rate Prior to Phasedown	$193.14	Row N × Row O
Q	CY 2017 Phasedown Percentage	75.00%	CY 2017 Phasedown %
R	**Estimated CY 2017 PMPM Rate (January through December 2017 with 50.42% FMAP)**	**$144.86**	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 2018 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%	Median Change from FY 2011-FY 2015
I	Projected Prior Year Revisions of the Annual percentage trend for July 201	-0.85%	Median Change from FY 2011-FY 2015
J	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2015 (Attachment V, Table V-3)	3.19%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2018**	**2.83%**	Row G + Row H
L	CY 2017 PMPM Rate Prior to FMAP and Phasedown	$388.78	Table 3.3 Row N
M	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2018	2.83%	Row K
N	Projected CY 2017 PMPM Rate Prior to FMAP and Phasedown	$399.78	Row L × (1 + Row M)
O	FMAP State Share	49.68%	Using FFY 17 FMAP is 50.32% as FFY 18 FMAP is unknown
P	Projected CY 2017 PMPM Rate Prior to Phasedown	$198.61	Row N × Row O
Q	CY 2017 Phasedown Percentage	75.00%	
R	**Estimated CY 2018 PMPM Rate (January through December 2018 with 50.42% FMAP)**	**$148.96**	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
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	865,253	72,133
% Change from FY 2013-14	6.45%	6.49%
FY 2015-16 Projection	889,356	74,475
% Change from FY 2014-15 Projection	2.79%	3.25%
FY 2016-17 Projection	943,954	78,663
% Change from FY 2015-16 Projection	6.14%	5.62%
FY 2017-18 Projection	1,002,172	83,514
% Change from FY 2016-17 Projection	6.17%	6.17%

Table 4.2 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	757,424	63,119
% Change from FY 2011-12	3.92%	3.92%
FY 2013-14	803,330	66,944
% Change from FY 2012-13	6.06%	6.06%
FY 2014-15	869,445	72,454
% Change from FY 2013-14	8.23%	8.23%
FY 2015-16 Projection	890,014	74,168
% Change from FY 2014-15 Projection	2.37%	2.37%
FY 2016-17 Projection	944,479	78,707
% Change from FY 2015-16 Projection	6.12%	6.12%
FY 2017-18 Projection	1,002,713	83,559
% Change from FY 2016-17 Projection	6.17%	6.16%

Table 4.3
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	$124.68	$124.68	$124.68	$125.42	**$124.87**
% Change from CY 2014					0.00%
CY 2016 Projection	$139.74	$139.74	$139.74	$140.59	**$139.95**
% Change from CY 2015-16 Projection					12.08%
CY 2017 Projection	$144.86	$144.86	$144.86	$144.86	**$144.86**
% Change from CY 2016-17 Projection					3.51%
CY 2018 Projection	$148.96	$148.96	$148.96	$148.96	**$148.96**
% Change from CY 2016-17 Projection					2.83%

Table 4.4
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
FY 2014-15	$107,620,224	$107,190,799	$429,425

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-05 Office of Community Living Caseload Adjustment

Dept. Approval By:	Josh Block [signature] 11/2/15		**Supplemental FY 2015-16**
		X	**Change Request FY 2016-17**
			Base Reduction FY 2016-17
OSPB Approval By:	[signature] 10/28/15		**Budget Amendment FY 2016-17**

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$504,504,712	$0	$506,940,205	$11,910,323	$25,586,833
	FTE	$0	0.0	$0	0.0	0.0
	GF	$238,074,321	$0	$239,650,321	$6,969,260	$14,441,858
	CF	$31,281,639	$0	$31,298,006	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$235,148,752	$0	$235,991,878	$4,941,063	$11,144,975

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
04. Office of Community Living - Adult Comprehensive Services	Total	$368,974,132	$0	$369,166,299	$17,832,584	$27,764,712
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$166,178,462	$0	$166,523,728	$9,832,767	$15,415,255
	CF	$31,281,639	$0	$31,298,006	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$171,514,031	$0	$171,344,565	$7,999,817	$12,349,457
04. Office of Community Living - Adult Supported Living Services	Total	$78,378,376	$0	$80,624,804	($2,735,044)	($196,134)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$42,592,426	$0	$43,739,911	($1,356,035)	($97,596)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$35,785,950	$0	$36,884,893	($1,379,009)	($98,538)

04. Office of Community Living - Children's Extensive Support Services	**Total**	**$22,574,419**	**$0**	**$22,575,320**	**($591,901)**	**($3,997)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$11,108,871	$0	$11,127,403	($228,024)	$104,087
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$11,465,548	$0	$11,447,917	($363,877)	($108,084)
04. Office of Community Living - Case Management	**Total**	**$34,577,785**	**$0**	**$34,573,782**	**($2,595,316)**	**($1,977,748)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$18,194,562	$0	$18,259,279	($1,279,448)	($979,888)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$16,383,223	$0	$16,314,503	($1,315,868)	($997,860)

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:

Approval by OIT? Yes ___ No ___ **Not Required:** _X_

Schedule 13s from Affected Departments: N/A

Other Information:

Cost and FTE

- In FY 2015-16, the Department requests a reduction of $14,834,944 total funds, including a decrease of $7,288,014 General Fund. For FY 2016-17, the Department requests an increase $11,910,323 total funds, including an increase $6,969,260 General Fund. For FY 2017-18, the Department requests an increase of $25,586,833 total funds, including an increase $14,441,858 General Fund. These funds will be used to fund Home and Community Based Services (HCBS) waiver program costs.

Current Program

- Effective March 2014, the Department manages three Medicaid –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

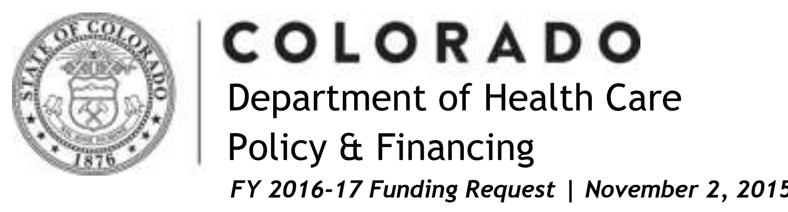
- Appropriations do not accurately reflect the estimated number of enrollments, full program equivalents (FPE), or cost per FPE, based upon current enrollment and spending trends as well as input from program information.
- This issue poses the problem of under-expenditure in the current year without action 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, higher than expected estimated per-capita waiver costs pose the problem of over-expenditure without action.

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 intellectual and 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 intellectual and 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, Colorado Choice Transitions (CCT), and youth 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.



John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: ***R-5***
Request Detail: ***Office of Community Living Cost and Caseload Adjustments***

Summary of Incremental Funding Change for FY 2016-17	Total Funds	General Fund
Office of Communty Living Cost and Caseload Adjustments	$11,910,323	$6,969,260

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 contrast, the HCBS-DD program continues to have a waiting list for services; as of the July 31,

2015 Medicaid Funding Requested Waiting List Report, there are 2,050 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, individuals transitioning out of foster care, from youth waiver, or Colorado Choice Transition (CCT) clients transitioning from 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 $14,834,944 in FY 2015-16, including a decrease of $7,288,014 General Fund; an increase of $11,910,323 in FY 2016-17, including an increase of $6,969,260 General Fund; and, an increase of $25,586,833 in FY 2017-18, including an increase of $14,441,858 General Fund.

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 2015-16 it would serve: 5,117 people on the HCBS-DD waiver (including people in Regional Centers); 4,846 people on the HCBS-SLS waiver; and, 1,290 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 D.3 of the appendix.[1]

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

[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.

resources to cover 10,769 people on average per month in FY 2015-16, and 11,535 people on average per month in FY 2016-17, 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.

Exhibit A.1: Calculation of Request

This exhibit provides the final calculation of the incremental request, by line item. Values in the total request column are taken from calculations in exhibits A.2 through A.4, as well as exhibit C which relates to projected expenditure. The adjusted spending authority amounts reflect the estimate appropriation for each line and can be found in Tables G.1 through G.3. The incremental request is the sum of the differences between total request and spending authority for each line item.

Exhibit A.2 through A.4: Current, Request, and Out Year Fund Splits

These exhibits provide a breakdown for each line item's expenditure estimate including fund splits for each program. This exhibit also allows for adjustments in the federal financial participation rate (FFP) based on the type of services delivered within each program. The Federal Medical Assistance Percentage (FMAP) is set to decrease for Colorado in October 2015 to 50.72%. 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 predicts that the FMAP for FFY 2016-17 will decrease to 50.32% and further decrease in FFY 2017-18 to 50.21%. For state fiscal years this translates to an FMAP of 50.79% in FY 2015-16, 50.42% in FY 2016-17, and 50.24% in FY 2017-18. FMAP forecasts can be found in exhibit R of the Department's FY 2016-17 R-1 "Medical Services Premiums Request".

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.3 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. This exhibit calculates costs for Medicaid matched services only and does not include State-

Only programs. Therefore, the appropriation reflected in this exhibit does not match the adjusted appropriation in Exhibit A.1.

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 2015-16 the Department was appropriated 5,065 enrollments through SB 15-234 "2015-16 Long Appropriations Bill". To forecast maximum enrollments in FY 2015-16, 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. Bottom line adjustments were composed of 40 emergency enrollments and 55 foster care transitions as requested in the Department's FY 2014-15 R-8 "Developmental Disabilities New Full Program Equivalents". These bottom line adjustments were added to the FY 2014-15 maximum enrollment to reach the FY 2015-16 maximum.

The Department requests to adjust the FY 2015-16 maximum enrollment figure to 5,117 due to additional bottom line adjustments. These additional 52 enrollments would accommodate the transition of 20 Colorado Choice Transitions (CCT) clients expected to move from an institutional setting into the HCBS-DD wavier in FY 2015-16 and 32 youth transitions expected to move to the HCBS-DD waiver as they age out of the HCBS-CES waiver. CCT transitions are forecasted in exhibit R of the Department's R-1 "Medical Services Premiums Request". The 32 youth transitions are based on a change in policy that occurred in FY 2014-15. This policy allows clients to choose whether they want to move to the HCBS-SLS or HCBS-DD waiver when they age out of the HCBS-CES waiver. In FY 2014-15, 32 out of 60 clients chose to enroll on the HCBS-DD waiver. To be consistent with the experience in FY 2014-15, the Department assumes 32 out of the estimated 61 clients will transition to the HCBS-DD waiver in FY 2015-16 and beyond.

In the request and out year the Department uses the same methodology to forecast maximum enrollment. In FY 2016-17 the Department requests an additional 141 enrollments, including 14 CCT enrollments, to reach a maximum enrollment figure of 5,258. In FY 2017-18 the Department requests an additional 148 enrollments, including 21 CCT enrollments, to reach a maximum enrollment figure of 5,406.

If additional CCT clients are not allocated, it is likely they would have to request to utilize an emergency HCBS-DD enrollment opening, or return to an institutional setting once their one year transition period out on the CCT program is exhausted. More detail about the CCT program can be found in the Department's R-1 "Medical Services Premiums Request". If the additional youth transitions are not allocated for these clients will likely enroll on the HCBS-SLS waiver, receiving less than the comprehensive care that they require.

Supported Living Services Waiver (SLS)

For FY 2015-16 the Department was appropriated 5,561 enrollments through SB 15-234 "2015-16 Long Appropriations Bill". *Note that as of FY 2014-15 there is no longer a waiver cap in the HCBS-SLS or HCBS-CES waiver so the maximum enrollment forecast in these waivers is now for information only, and is no longer used in calculating year end enrollment.*

Children's Extensive Services Waiver (CES)

For FY 2015-16 the Department was appropriated 1,300 enrollments through SB 15-234 "2015-16 Long Appropriations Bill". *Note that as of FY 2014-15 there is no longer a waiver cap in the SLS or CES waiver so the maximum enrollment forecast in these waivers is now for information only, and is no longer used in calculating year end enrollment.*

Targeted Case Management (TCM)

For FY 2015-16 the Department was appropriated 12,049 enrollments through SB 15-234 "2015-16 Long Appropriations Bill". TCM is provided for all clients receiving services under an HCBS waiver, including clients using the HCBS-DD waiver in regional centers. *Because TCM enrollment is tied to HCBS-SLS and HCBS-CES waiver enrollment, and because there is no longer a cap on enrollment in both of these waivers, the TCM maximum enrollment forecast is now information only and is no longer used in calculating end of year enrollment.*

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 conversion 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 the HCBS-DD waiver and the HCBS-TCM waiver the selected FPE conversion factor is the average FPE conversion factor from the previous year. The lack of major structural changes in the HCBS-DD or HCBS-TCM waiver leads the Department to believe that the previous year's rate of service utilization, and therefore Conversion Factor, is a good prediction of utilization in the coming year.

Because of rapid enrollment growth currently taking place in the HCBS-SLS and HCBS-CES waiver due to elimination of the waitlist in these waivers, and because new clients are expected to utilize services at a lower rate than long-term clients, the Department believes that the previous year's conversion factor in these waivers was unnaturally low. To compensate for this, a natural conversion factor was chosen based on the relationship of FPE to maximum enrollment in the year before the waiver cap was removed in each waiver. This natural conversion factor is approached linearly at a rate based on a 12 month upward trend for both waivers to reach the selected conversion factors.

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, or in the case of HCBS-SLS and HCBS-CES to the maximum assumed enrollment, 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 or maximum assumed level and that the increase in enrollments from the beginning of the fiscal year to the end will happen evenly across 12 months.

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 2015-16 and FY 2016-17 maximum enrollment levels, respectively.

Maximum Appropriated Enrollment for the HCBS-DD Waiver

For the HCBS-DD waiver, maximum enrollment comes from total appropriated enrollments. This is due to the existence of the enrollment cap in this waiver. The Department assumes that the appropriated enrollment amount will be reached for each year in this request.

Maximum Assumed Enrollment for the HCBS-SLS and HCBS-CES Waivers

Due to the removal of the enrollment cap for the HCBS-SLS waiver in FY 2014-15 and the HCBS-CES waiver in 2013-14 the Department no longer uses appropriated enrollments to forecast end of year enrollment. In light of this the Department now estimates maximum assumed enrollment.

Maximum assumed enrollment for the HCBS-SLS waiver includes projected waitlist enrollments, an enrollment base trend, and a bottom line adjustment for youth transitioning from the HCBS-CES waiver to the HCBS-SLS Waiver. In this request, compared to the previous S-5, the Department modified the 61 bottom line adjustments allocated in SB-234 to 29 for FY 2015-16 and all subsequent years. These enrollments account for youth transitions from the HCBS-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. The modification accounts for clients who are now expected to transition to the HCBS-DD waiver instead of the HCBS-SLS waiver as discussed in section D.1.

Waitlist enrollments were calculated using the pace of waitlist enrollment from FY 2014-15. The enrollment base trend was calculated using waitlist growth in FY 2013-14, the year prior to removal of the enrollment cap. Maximum and Average Enrollment are shown in the tables below.

HCBS-SLS Enrollment Adjustments			Source/Comment
FY 2015-16	HCBS-SLS June (end of year) Enrollment	4,078	Medicaid Management Information System Data
	HCBS-SLS Waitlist Listed to Enroll "As Soon as Possible"	570	Community Contract Management System Data
	Portion of HCBS-SLS or HCBS-DD Expected to Enroll (30%)	179	30% of 597 from the Waitlist Report
	Projected Waitlist Enrollment	739	Using 14-15 pace of waitlist enrollment
	Youth Transitions	29	Assumed in Maximum Enrollment
	Year End Enrollments	**4,846**	
	Average Monthly Enrollment	**4,494**	
FY 2016-17	Base Growth Trend	4,950	2.16% Growth over Final 14-15
	Later Waitlist Enrollments	10	Using 14-15 pace of waitlist enrollment
	Youth Transitions	29	Assumed in Maximum Enrollment
	Year End Enrollments	**4,989**	
	Average Monthly Enrollment	**4,923**	
FY 2017-18	Base Growth Trend	5,097	2.16% growth over final 15-16
	Youth Transitions	29	Assumed in Maximum Enrollment
	Year End Enrollments	**5126**	
	Average Monthly Enrollment	**5,063**	

Maximum assumed enrollment for the HCBS-CES waiver includes projected waitlist enrollments and an enrollment base trend. Waitlist enrollments were calculated using the pace of waitlist enrollment from FY 2014-15. The enrollment base trend was calculated using waitlist growth in FY 2012-13, the year prior to removal of the enrollment cap. Maximum and Average Enrollment are shown in the tables below.

HCBS-CES Enrollment Adjustments			Source/Comment
FY 2015-16	HCBS- CES June (EOY) Enrollment	1,120	Medicaid Management Information System Data
	Base Growth Trend	1,150	2.71% Growth over Final 14-15
	HCBS- CES Waitlist Listed to Enroll "As Soon as Possible"	140	Community Contract Management System Data
	Projected Waitlist Enrollment	140	Using 14-15 pace of waitlist enrollment
	Year End Enrollments	**1,290**	
	Average Monthly Enrollment	**1,212**	
FY 2016-17	Base Growth Trend	35	2.71% Growth over Final 15-16
	Year End Enrollments	**1,325**	
	Average Monthly Enrollment	**1,309**	
FY 2017-18	Base Growth Trend	36	2.71% growth over final 16-17
	Year End Enrollments	**1,361**	
	Average Monthly Enrollment	**1,344**	

Exhibit D.4.1: Regional Center Information

This Exhibit details the historical average enrollment and costs for clients receiving HCBS-DD services in Regional Centers. Regional Center claims are paid for from an appropriation within the Department of Healthcare Policy and Financing (HCPF) via an end-of-year transfer to the Department of Human Services (DHS) who manages Regional Center programs. The cost of these clients is not forecasted in this request. Clients in Regional centers do however receive TCM services as well as Quality Assurance and Utilization Reviews (QA/UR) which are managed and paid for by HCPF, so regional center enrollment information is included in this request to fully account for these costs. To determine utilization of these services the Department predicts that enrollment will remain constant at the June 2015 level of 110 clients for the current, request, and out years.

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 2014-15 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 2014-15 and FY 2015-16, the General Assembly appropriated funding to implement 2.50% and 1.7% 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 2014-15 will not be paid until FY 2015-16, and similarly for claims incurred in FY 2015-16. The Department assumed a 0% rate increase for FY 2016-17 and FY 2017-18.

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. The Department assumed in the November 2014 budget request that the SPAL increase would be approximately 90% implemented in FY 2014-15. However, given per FPE expenditure to date, the Department slowed this implementation and assumed that half of the total impact would be implemented in FY 2014-15 and half in FY 2015-16. The Department assumes this is likely a result of the time it takes to adjust each client's SPAL amount. SPALs are reviewed and adjusted on the client's annual basis which results in a staggering of adjustments to reflect the SPAL increase.

An additional Bottom Line Adjustment was made to account for increased costs in the HCBS-SLS waiver due to the expansion of access to Consumer Directed Attendant Support Services (CDASS) as requested in the Departments FY 2015-16 R-7: "Participant Directed Programs Expansion". The Department has revised the expected implementation date from July, 2015 to January, 2016. Using the assumption that CDASS will take a one year ramp up period to reach full utilization, the increase in costs for the HCBS-SLS waiver were annualized for FY 2015-16 and FY 2016-17 with full utilization expected to be reached in January, 2017.

Exhibit F: Quality Assurance, Utilization Review and Support Intensity Scale Services Forecast

This exhibit forecasts Quality Assurance (QA), Utilization Review (UR), and Support Intensity Scale (SIS) service costs. These services are provided on a monthly, yearly or periodic basis for clients. As a result, utilization and expenditure for these services are directly tied to the number of clients enrolled in the IDD programs.

The Department pays QA costs monthly for each client related to performance of activities related to the waiver Quality Improvement Strategy (QIS) as well as the mechanisms for overall quality assurance and system improvement. Such activities include application of policies and procedures for the resolution of complaints and grievances, critical incident reporting and response, and the assessment and reporting of

process and outcome performance measures. To calculate QA costs the exhibit takes the estimated monthly enrollment from Table D.3 and multiplies that by the rate and 12 months for the year.

The Department pays UR costs on a monthly basis for each client. UR activities include the implementation of processes to ensure that waiver services have been authorized in conformance to waiver requirements and monitoring service utilization to ensure that the amount of services is within the levels authorized in the service plan. This also includes identifying instances when individuals are not receiving services authorized in the service plan or the amount of services utilized is substantially less than the amount authorized to identify potential problems in service access. For UR the exhibit multiples monthly enrollment and the current rate.

The Department performs SIS assessments for IDD clients. SIS includes an assessment of the individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The Scale ranks each activity according to *frequency* (none, at least once a month), *amount* (none, less than 30 minutes), and *type* of support (monitoring, verbal gesturing). Finally, a Supports Intensity Level is determined based on the Total Support Needs Index, which is a standard score generated from scores on all the items tested by the Scale. For SIS, the exhibit calculates expenditure by assuming that all new enrollments as calculated by subtracting estimated enrollments in Table D.3 would receive an assessment and an additional ten percent of the current population would receive assessments. This would be a result of clients requesting a new assessment and churn within the programs. Children receiving services through the HCBS-CES waiver do not receive SIS assessments.

Exhibit G.1 through G.3: Appropriation Build

Exhibit G.1 through G.3 build the appropriation for the current, request and out years based on Long Bill and special bill appropriations and changes made to spending authority through budget requests. The appropriation build for each year then separates out the programs within each appropriation with assumed amounts attributed to each of them.

To build the request and out year the Department begins each exhibit with the prior year's final estimated appropriation for each program and adjusts the appropriation based on incremental amounts for each approved request or bill.

Table A.1.1 - Calculation of Request					
FY 2015-16					
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Adult Comprehensive Services (HCBS-DD)					
Total Request	$370,069,114	$166,717,316	$31,281,639	$0	$172,070,159
Adjusted Spending Authority	$368,974,132	$166,178,462	$31,281,639	$0	$171,514,031
Incremental Request	$1,094,982	$538,854	$0	$0	$556,128
Adult Supported Living Services (HCBS-SLS)					
Total Request	$69,633,214	$38,288,932	$0	$0	$31,344,282
Adjusted Spending Authority	$78,378,376	$42,592,426	$0	$0	$35,785,950
Incremental Request	($8,745,162)	($4,303,494)	$0	$0	($4,441,668)
Children's Extensive Support Services (HCBS-CES)					
Total Request	$19,798,414	$9,742,800	$0	$0	$10,055,614
Adjusted Spending Authority	$22,574,419	$11,108,871	$0	$0	$11,465,548
Incremental Request	($2,776,005)	($1,366,071)	$0	$0	($1,409,934)
Case Management					
Total Request	$30,169,026	$16,037,259	$0	$0	$14,131,767
Adjusted Spending Authority	$34,577,785	$18,194,562	$0	$0	$16,383,223
Incremental Request	($4,408,759)	($2,157,303)	$0	$0	($2,251,456)
Family Support Services					
Total Request	$6,960,204	$6,960,204	$0	$0	$0
Adjusted Spending Authority	$6,960,204	$6,960,204	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Preventive Dental Hygiene					
Total Request	$67,012	$63,334	$3,678	$0	$0
Adjusted Spending Authority	$67,012	$63,334	$3,678	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,121,079	$3,100,442	$0	$0	$20,637
Adjusted Spending Authority	$3,121,079	$3,100,442	$0	$0	$20,637
Incremental Request	$0	$0	$0	$0	$0
Waiver Enrollment					
Total Request	$1,586,987	$0	$1,586,987	$0	$0
Adjusted Spending Authority	$1,586,987	$0	$1,586,987	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Office of Community Living Total					
Total Request	$501,405,050	$240,910,287	$32,872,304	$0	$227,622,459
Adjusted Spending Authority	$516,239,994	$248,198,301	$32,872,304	$0	$235,169,389
Incremental Request	**($14,834,944)**	**($7,288,014)**	**$0**	**$0**	**($7,546,930)**

Table A.1.2 - Calculation of Request					
FY 2016-17					
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Adult Comprehensive Services (HCBS-DD)					
Total Request	$386,998,883	$176,356,495	$31,298,006	$0	$179,344,382
Adjusted Spending Authority	$369,166,299	$166,523,728	$31,298,006	$0	$171,344,565
Incremental Request	$17,832,584	$9,832,767	$0	$0	$7,999,817
Adult Supported Living Services (HCBS-SLS)					
Total Request	$77,889,760	$42,383,876	$0	$0	$35,505,884
Adjusted Spending Authority	$80,624,804	$43,739,911	$0	$0	$36,884,893
Incremental Request	($2,735,044)	($1,356,035)	$0	$0	($1,379,009)
Children's Extensive Support Services (HCBS-CES)					
Total Request	$21,983,419	$10,899,379	$0	$0	$11,084,040
Adjusted Spending Authority	$22,575,320	$11,127,403	$0	$0	$11,447,917
Incremental Request	($591,901)	($228,024)	$0	$0	($363,877)
Case Management					
Total Request	$31,978,466	$16,979,831	$0	$0	$14,998,635
Adjusted Spending Authority	$34,573,782	$18,259,279	$0	$0	$16,314,503
Incremental Request	($2,595,316)	($1,279,448)	$0	$0	($1,315,868)
Family Support Services					
Total Request	$6,960,460	$6,960,460	$0	$0	$0
Adjusted Spending Authority	$6,960,460	$6,960,460	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Preventive Dental Hygiene					
Total Request	$66,988	$63,311	$3,677	$0	$0
Adjusted Spending Authority	$66,988	$63,311	$3,677	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,121,194	$3,100,556	$0	$0	$20,638
Adjusted Spending Authority	$3,121,194	$3,100,556	$0	$0	$20,638
Incremental Request	$0	$0	$0	$0	$0
Office of Community Living Total					
Total Request	$528,999,170	$256,743,908	$31,301,683	$0	$240,953,579
Adjusted Spending Authority	$517,088,847	$249,774,648	$31,301,683	$0	$236,012,516
Incremental Request	**$11,910,323**	**$6,969,260**	**$0**	**$0**	**$4,941,063**

Table A.1.3 - Calculation of Request					
FY 2017-18					
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Adult Comprehensive Services (HCBS-DD)					
Total Request	$396,931,011	$181,938,983	$31,298,006	$0	$183,694,022
Adjusted Spending Authority	$369,166,299	$166,523,728	$31,298,006	$0	$171,344,565
Incremental Request	$27,764,712	$15,415,255	$0	$0	$12,349,457
Adult Supported Living Services (HCBS-SLS)					
Total Request	$80,428,670	$43,642,315	$0	$0	$36,786,355
Adjusted Spending Authority	$80,624,804	$43,739,911	$0	$0	$36,884,893
Incremental Request	($196,134)	($97,596)	$0	$0	($98,538)
Children's Extensive Support Services (HCBS-CES)					
Total Request	$22,571,323	$11,231,490	$0	$0	$11,339,833
Adjusted Spending Authority	$22,575,320	$11,127,403	$0	$0	$11,447,917
Incremental Request	($3,997)	$104,087	$0	$0	($108,084)
Case Management					
Total Request	$32,596,034	$17,279,391	$0	$0	$15,316,643
Adjusted Spending Authority	$34,573,782	$18,259,279	$0	$0	$16,314,503
Incremental Request	($1,977,748)	($979,888)	$0	$0	($997,860)
Family Support Services					
Total Request	$6,960,460	$6,960,460	$0	$0	$0
Adjusted Spending Authority	$6,960,460	$6,960,460	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Preventive Dental Hygiene					
Total Request	$67,012	$63,334	$3,678	$0	$0
Adjusted Spending Authority	$67,012	$63,334	$3,678	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,121,079	$3,100,442	$0	$0	$20,637
Adjusted Spending Authority	$3,121,079	$3,100,442	$0	$0	$20,637
Incremental Request	$0	$0	$0	$0	$0
Office of Community Living Total					
Total Request	$542,675,589	$264,216,415	$31,301,684	$0	$247,157,490
Adjusted Spending Authority	$517,088,756	$249,774,557	$31,301,684	$0	$236,012,515
Incremental Request	**$25,586,833**	**$14,441,858**	**$0**	**$0**	**$11,144,975**

Table A.2 - Calculation of Fund Splits						
FY 2015-16						
Item	**Total Request**	**General Fund**	**Cash Funds**	**Federal Funds**	FFP	**Source**
Adult Comprehensive Services (HCBS-DD)						
Medicaid Services	$338,787,475	$166,717,316	$0	$172,070,159	50.79%	Table B.1 Row I
Client Cash Sources Payments	$31,281,639	$0	$31,281,639	$0	0.00%	Table G.1 Row D
Subtotal	$370,069,114	$166,717,316	$31,281,639	$172,070,159		
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services	$61,713,491	$30,369,209	$0	$31,344,282	50.79%	Table B.1 Row I
State Only Services	$7,919,723	$7,919,723	$0	$0	0.00%	Table G.1 Row H
Subtotal	$69,633,214	$38,288,932	$0	$31,344,282		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$19,798,414	$9,742,800	$0	$10,055,614	50.79%	Table B.1 Row I
Case Management						
Medicaid Services	$23,442,828	$11,536,216	$0	$11,906,612	50.79%	Table B.1 Row I
State Only Services	$2,275,889	$2,275,889	$0	$0	0.00%	Table G.1 Row O
Quality Assurance, Utilization Review, Support Intensity Scale	$4,450,309	$2,225,154	$0	$2,225,155	50.00%	Table F.1 Row J
Subtotal	$30,169,026	$16,037,259	$0	$14,131,767		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,093,563	$3,093,563	$0	$0	0.00%	Table G.1 Row W
PASRR	$27,516	$6,879	$0	$20,637	75.00%	Table G.1 Row V
Subtotal	$3,121,079	$3,100,442	$0	$20,637		
Other Programs						
Family Support Services	$6,960,204	$6,960,204	$0	$0	0.00%	Table G.1 Row Q
Preventive Dental Hygiene	$67,012	$63,334	$3,678	$0	0.00%	Table G.1 Row S
Waiver Enrollment	$1,586,987	$0	$1,586,987	$0	0.00%	Table G.1 Row Y
Subtotal	$8,614,203	$7,023,538	$1,590,665	$0		
Grand Total	**$501,405,050**	**$240,910,287**	**$32,872,304**	**$227,622,459**		
Definitions: FFP: Federal financial participation rate						

Table A.3 - Calculation of Fund Splits						
FY 2016-17						
Item	**Total Request**	**General Fund**	**Cash Funds**	**Federal Funds**	FFP	**Source**
Adult Comprehensive Services (HCBS-DD)						
Medicaid Services	$355,700,877	$176,356,495	$0	$179,344,382	50.42%	Table B.1 Row J
Client Cash Sources Payments	$31,298,006	$0	$31,298,006	$0	0.00%	Table G.2 Row D
Subtotal	$386,998,883	$176,356,495	$31,298,006	$179,344,382		
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services	$70,420,238	$34,914,354	$0	$35,505,884	50.42%	Table B.1 Row J
State Only Services	$7,469,522	$7,469,522	$0	$0	0.00%	Table G.2 Row K
Subtotal	$77,889,760	$42,383,876	$0	$35,505,884		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$21,983,419	$10,899,379	$0	$11,084,040	50.42%	Table B.1 Row J
Case Management						
Medicaid Services	$25,145,488	$12,467,133	$0	$12,678,355	50.42%	Table B.1 Row J
State Only Services	$2,192,419	$2,192,419	$0	$0	0.00%	Table G.2 Row V
Quality Assurance, Utilization Review, Support Intensity Scale	$4,640,559	$2,320,279	$0	$2,320,280	50.00%	Table F.2 Row J
Subtotal	$31,978,466	$16,979,831	$0	$14,998,635		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,093,677	$3,093,677	$0	$0	0.00%	Table G.2 Row AF
PASRR	$27,517	$6,879	$0	$20,638	75.00%	Table G.2 Row AG
Subtotal	$3,121,194	$3,100,556	$0	$20,638		
Other Programs						
Family Support Services	$6,960,460	$6,960,460	$0	$0	0.00%	Table G.2 Row Y
Preventive Dental Hygiene	$66,988	$63,311	$3,677	$0	0.00%	Table G.2 Row AC
Subtotal	$7,027,448	$7,023,771	$3,677	$0		
Grand Total	**$528,999,170**	**$256,743,908**	**$31,301,683**	**$240,953,579**		
Definitions: FFP: Federal financial participation rate						

Table A.4 - Calculation of Fund Splits						
FY 2017-18						
Item	**Total Request**	**General Fund**	**Cash Funds**	**Federal Funds**	FFP	**Source**
Adult Comprehensive Services (HCBS-DD)						
Medicaid Services	$365,633,005	$181,938,983	$0	$183,694,022	50.24%	Table B.1 Row K
Client Cash Sources Payments	$31,298,006	$0	$31,298,006	$0	0.00%	Table G.3 Row D
Subtotal	$396,931,011	$181,938,983	$31,298,006	$183,694,022		
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services	$73,221,249	$36,434,894	$0	$36,786,355	50.24%	Table B.1 Row K
State Only Services	$7,207,421	$7,207,421	$0	$0	0.00%	Table G.3 Row H
Subtotal	$80,428,670	$43,642,315	$0	$36,786,355		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$22,571,323	$11,231,490	$0	$11,339,833	50.24%	Table B.1 Row K
Case Management						
Medicaid Services	$25,843,066	$12,859,510	$0	$12,983,556	50.24%	Table B.1 Row K
State Only Services	$2,086,794	$2,086,794	$0	$0	0.00%	Table G.3 Row O
Quality Assurance, Utilization Review, Support Intensity Scale	$4,666,174	$2,333,087	$0	$2,333,087	50.00%	Table F.3 Row J
Subtotal	$32,596,034	$17,279,391	$0	$15,316,643		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,093,563	$3,093,563	$0	$0	0.00%	Table G.3 Row X
PASRR	$27,516	$6,879	$0	$20,637	75.00%	Table G.3 Row W
Subtotal	$3,121,079	$3,100,442	$0	$20,637		
Other Programs						
Family Support Services	$6,960,460	$6,960,460	$0	$0	0.00%	Table G.3 Row Q
Preventive Dental Hygiene	$67,012	$63,334	$3,678	$0	0.00%	Table G.3 Row T
Subtotal	$7,027,472	$7,023,794	$3,678	$0		
Grand Total	**$542,675,589**	**$264,216,415**	**$31,301,684**	**$247,157,490**		
Definitions: FFP: Federal financial participation rate						

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 - 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	$39,607,629	$5,894,263	$13,661,560	$281,921,262
B	FY 2008-09	$223,362,025	$46,391,718	$6,913,410	$13,848,967	$316,544,850
C	FY 2009-10	$253,798,612	$37,399,799	$7,158,025	$16,484,735	$343,201,205
D	FY 2010-11	$273,096,876	$37,579,497	$7,956,073	$19,114,672	$361,889,133
E	FY 2011-12	$264,899,518	$37,030,578	$7,361,601	$16,875,522	$351,443,939
F	FY 2012-13	$261,817,957	$37,273,663	$7,015,707	$16,117,073	$346,391,496
G	FY 2013-14	$282,475,249	$39,288,448	$9,125,302	$17,441,960	$370,556,323
H	FY 2014-15	$314,878,204	$44,654,327	$14,967,843	$20,230,023	$416,184,420
I	Estimated FY 2015-16	$338,787,475	$61,713,491	$19,798,414	$23,442,828	$462,774,002
J	Estimated FY 2016-17	$355,700,877	$70,420,238	$21,983,419	$25,145,488	$492,281,816
K	Estimated FY 2017-18	$365,633,005	$73,221,249	$22,571,323	$25,843,066	$506,300,437

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 - 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%	17.13%	17.29%	1.37%	12.28%
C	FY 2009-10	13.63%	-19.38%	3.54%	19.03%	8.42%
D	FY 2010-11	7.60%	0.48%	11.15%	15.95%	5.45%
E	FY 2011-12	-3.00%	-1.46%	-7.47%	-11.71%	-2.89%
F	FY 2012-13	-1.16%	0.66%	-4.70%	-4.49%	-1.44%
G	FY 2013-14	7.89%	5.41%	30.07%	8.22%	6.98%
H	FY 2014-15	11.47%	13.66%	64.03%	15.98%	12.31%
I	Estimated FY 2015-16	7.59%	38.20%	32.27%	15.88%	11.19%
J	Estimated FY 2016-17	4.99%	14.11%	11.04%	7.26%	6.38%
K	Estimated FY 2017-18	2.79%	3.98%	2.67%	2.77%	2.85%

Table C.1 - FY 2015-16 Projected Expenditure							
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Total**	**Source/Calculation**
A	Adjusted Appropriation	$337,692,493	$70,458,653	$22,574,419	$29,401,896	$460,127,461	See Footnote (1)
B	Projected FPE	4,881.18	4,220.71	1,086.57	8,895.19	$19,084	Table D.3.3, Row E
C	Projected Per FPE Expenditure	$69,406.88	$14,621.59	$18,221.02	$2,635.45	$104,885	Table E.1, Row I
D	Total Projected Expenditure	$338,787,475	$61,713,491	$19,798,414	$23,442,828	$443,742,208	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**$1,094,982**	**($8,745,162)**	**($2,776,005)**	**($5,959,068)**	**($16,385,253)**	**Row D - Row A**

Table C.2 - FY 2016-17 Projected Expenditure							
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Total**	**Source/Calculation**
A	FY 2016-17 Base Request	$337,868,293	$73,155,282	$22,575,320	$29,481,363	$463,080,258	See Footnote (1)
B	Projected FPE	5,117.70	4,663.07	1,204.80	9,527.91	20513.48	Table D.3.4, Row E
C	Projected Per FPE Expenditure	$69,504.05	$15,101.69	$18,246.53	$2,639.14	$105,491	Table E.1 Row J
D	Total Projected Expenditure	$355,700,877	$70,420,238	$21,983,419	$25,145,488	$473,250,022	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**$17,832,584**	**($2,735,044)**	**($591,901)**	**($4,335,875)**	**$10,169,764**	**Row D - Row A**

Table C.3 - FY 2017-18 Projected Expenditure							
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Total**	**Source/Calculation**
A	FY 2017-18 Base Request	$337,868,293	$73,417,383	$22,575,320	$29,586,988	$463,447,984	See Footnote (1)
B	Projected FPE	5,260.60	4,795.67	1,237.02	9,792.23	$21,086	Table D.3.5, Row E
C	Projected Per FPE Expenditure	$69,504.05	$15,268.20	$18,246.53	$2,639.14	$105,658	Table E.1 Row K
D	Total Projected Expenditure	$365,633,005	$73,221,249	$22,571,323	$25,843,066	$487,268,643	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**$27,764,712**	**($196,134)**	**($3,997)**	**($3,743,922)**	**$23,820,659**	**Row D - Row A**

(1) All appropriation amounts above are for Medicaid funded individuals only and do not include State-only funded individuals, services provided to individuals in the Early Intervention program, or administrative costs.

Table D.1.1 - FY 2015-16 Division for Intellectual and Developmental Disabilities (DIDD) Maximum Enrollment Forecast						
Row	**Item**	**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"	4,970	110	5,408	1,251	11,739
B	Base Trend Increase	0.00%	0.00%	0.00%	0.00%	0.00%
C	Initial Estimated FY 2015-16 Enrollment	4,970	110	5,408	1,251	11,739
	Bottom Line Adjustments					
D	Colorado Choice Transitions (CCT)	20	0	0	0	20
E	Emergency Enrollments	40	0	0	0	40
F	Foster Care Transitions	55	0	0	0	55
G	Youth Transitions	32	0	29	0	61
H	Total Bottom Line Adjustments	147	0	29	0	176
I	**FY 2015-16 Maximum Enrollment**	**5,117**	**110**	**5,437**	**1,251**	**11,915**

Table D.1.2 - FY 2016-17 Division for Intellectual and Developmental Disabilities (DIDD) Maximum Enrollment Forecast						
Row	**Item**	**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 2015-16 Maximum Enrollment	5,117	110	5,437	1,251	11,915
B	Base Trend Increase	0.00%	0.00%	0.00%	0.00%	0.00%
C	Initial Estimated FY 2016-17 Enrollment	5,117	110	5,437	1,251	11,915
	Bottom Line Adjustments					
D	Colorado Choice Transitions (CCT)	14	0	0	0	14
E	Emergency Enrollments	40	0	0	0	40
F	Foster Care Transitions	55	0	0	0	55
G	Youth Transitions	32	0	29	0	61
H	Total Bottom Line Adjustments	141	0	29	0	170
I	**Estimated FY 2016-17 Maximum Enrollment**	**5,258**	**110**	**5,466**	**1,251**	**12,085**

Table D.1.3 - FY 2017-18 Division for Intellectual and Developmental Disabilities (DIDD) Maximum Enrollment Forecast						
Row	**Item**	**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 2016-17 Maximum Enrollment	5,258	110	5,466	1,251	12,085
B	Base Trend Increase	0.00%	0.00%	0.00%	0.00%	0.00%
C	Initial Estimated FY 2017-18 Enrollment	5,258	110	5,466	1,251	12,085
	Bottom Line Adjustments					
D	Colorado Choice Transitions (CCT)	21	0	0	0	21
E	Emergency Enrollments	40	0	0	0	40
F	Foster Care Transitions	55	0	0	0	55
G	Youth Transitions	32	0	29	0	61
H	Total Bottom Line Adjustments	148	0	29	0	177
I	**Estimated FY 2017-18 Maximum Enrollment**	**5,406**	**110**	**5,495**	**1,251**	**12,262**

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)
Table D.2 - DIDD Average Monthly Enrollment vs. Full Program Equivalent (FPE)							
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	Average Monthly Enrollment	4,685	124	3,678	971	9,458
W		FPE	4,617	124	3,381	836	7,812
X		FPE as a Percentage of Average Monthly Enrollment	98.55%	100.00%	91.92%	86.10%	82.60%
Y	**FY 2015-16 Selected FPE Conversion Factor[1]**		**98.55%**	**100.00%**	**93.92%**	**89.65%**	**82.60%**
Z	**FY 2016-17 and FY 2017-18 Selected FPE Conversion Factor [1]**		**98.55%**	**100.00%**	**94.72%**	**92.04%**	**82.60%**

(1) The selected FPE Conversion Factor for DD and TCM are the Conversion Factor from FY 2014-15 in these waivers. Due to the influx of clients coming on to the SLS and CES waivers after waitlist elimination the Department believes that the previous year's FPE was unnaturally low. To compensate for this, a natural Conversion Factor was calculated which is approached linearly at a rate based on a 12 month upward trend in FPE for both waivers.

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	FY 2014-15	4,685	124	3,678	971	9,458
I	Estimated FY 2015-16	4,953	110	4,494	1,212	10,769
J	Estimated FY 2016-17	5,193	110	4,923	1,309	11,535
K	Estimated FY 2017-18	5,338	110	5,063	1,344	11,855

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	FY 2014-15	6.67%	-2.36%	15.55%	59.97%	13.83%
I	Estimated FY 2015-16	5.72%	-11.29%	22.19%	24.82%	13.86%
J	Estimated FY 2016-17	4.85%	0.00%	9.55%	8.00%	7.11%
K	Estimated FY 2017-18	2.79%	0.00%	2.84%	2.67%	2.77%

Table D.3.3 - 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	FY 2014-15 Year-End Enrollment	4,760	110	4,078	1,120	10,068	MMIS Prior Authorization Request Data; June 2015
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	193	0	416	92	701	See narrative
C	**Final Estimated FY 2015-16 Average Monthly Enrollment**	**4,953**	**110**	**4,494**	**1,212**	**10,769**	**Row A + Row B**
D	FPE Adjustment Factor	98.55%	100.00%	93.92%	89.65%	82.60%	Table D.2, Row Y
E	**Estimated FY 2015-16 FPE**	**4,881.18**	**110.00**	**4,220.71**	**1,086.57**	**8,895.19**	**Row C * Row D**

Table D.3.4 - 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	5,117	110	4,846	1,290	11,362	Table D.1.1, Row J
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	76	0	77	19	173	See narrative
C	**Final Estimated FY 2016-17 Average Monthly Enrollment**	**5,193**	**110**	**4,923**	**1,309**	**11,535**	**Row A + Row B**
D	FPE Adjustment Factor	98.55%	100.00%	94.72%	92.04%	82.60%	Table D.2, Row Z
E	**Estimated FY 2016-17 FPE**	**5,117.70**	**110.00**	**4,663.07**	**1,204.80**	**9,527.91**	**Row C * Row D**

Table D.3.5 - Calculation of FY 2017-18 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)							
Row	**FY 2017-18**	**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 2016-17 Year-End Enrollment; June 2017	5,258	110	4,989	1,325	11,682	Table D.1.2, Row I
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	80	0	74	19	173	See narrative
C	**Final Estimated FY 2017-18 Average Monthly Enrollment**	**5,338**	**110**	**5,063**	**1,344**	**11,855**	**Row A + Row B**
D	FPE Adjustment Factor	98.55%	100.00%	94.72%	92.04%	82.60%	Table D.2, Row Z
E	**Estimated FY 2017-18 FPE**	**5,260.60**	**110.00**	**4,795.67**	**1,237.02**	**9,792.23**	**Row C * Row D**

Table D.4.1 - HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers							
Row	**Fiscal Year**	**Average Monthly Enrollment**	**Total Cost**	**Per Utilizer Cost**	**Percent Change in Enrollment**	**Percent Change in Total Cost**	**Percent Change in Per-Utilizer Cost**
A	FY 2007-08	120	$19,814,222	$165,119			
B	FY 2008-09	129	$26,028,730	$201,773	7.50%	31.36%	22.20%
C	FY 2009-10	118	$28,360,034	$240,339	-8.53%	8.96%	19.11%
D	FY 2010-11	122	$24,142,015	$197,885	3.39%	-14.87%	-17.66%
E	FY 2011-12	122	$25,276,720	$207,186	0.00%	4.70%	4.70%
F	FY 2012-13	135	$24,167,096	$179,016	10.66%	-4.39%	-13.60%
G	FY 2013-14	127	$22,225,364	$175,003	-5.93%	-8.03%	-2.24%
H	FY 2014-15	124	$21,454,023	$173,016	-2.36%	-3.47%	-1.14%
I	Average	125	$23,933,525	$192,417			

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 - 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	$17,318.60	$20,255.20	$2,215.99
B	FY 2008-09	$57,955.90	$19,582.83	$21,077.47	$2,157.16
C	FY 2009-10	$62,465.82	$14,247.54	$22,024.69	$2,725.20
D	FY 2010-11	$66,237.42	$13,195.05	$22,223.67	$2,713.23
E	FY 2011-12	$64,405.43	$12,947.75	$21,779.88	$2,565.45
F	FY 2012-13	$62,997.58	$12,338.19	$20,218.18	$2,384.18
G	FY 2013-14	$65,101.46	$13,030.99	$18,323.90	$2,566.88
H	FY 2014-15	$68,199.74	$13,207.43	$17,904.12	$2,589.61
I	Estimated FY 2015-16	$69,406.88	$14,621.59	$18,221.02	$2,635.45
J	Estimated FY 2016-17	$69,504.05	$15,101.69	$18,246.53	$2,639.14
K	Estimated FY 2017-18	$69,504.05	$15,268.20	$18,246.53	$2,639.14

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 - 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%	13.07%	4.06%	-2.65%
C	FY 2009-10	7.78%	-27.24%	4.49%	26.33%
D	FY 2010-11	6.04%	-7.39%	0.90%	-0.44%
E	FY 2011-12	-2.77%	-1.87%	-2.00%	-5.45%
F	FY 2012-13	-2.19%	-4.71%	-7.17%	-7.07%
G	FY 2013-14	3.34%	5.62%	-9.37%	7.66%
H	FY 2014-15	4.76%	1.35%	-2.29%	0.89%
I	Estimated FY 2015-16	1.77%	10.71%	1.77%	1.77%
J	Estimated FY 2016-17	0.14%	3.28%	0.14%	0.14%
K	Estimated FY 2017-18	0.00%	1.10%	0.00%	0.00%

Table E.3 - 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 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	$68,199.74	$13,207.43	$17,904.12	$2,589.61
B	Base Trend	0.00%	0.00%	0.00%	0.00%
C	Estimated Base FY 2015-16 Per FPE Expenditure	$68,199.74	$13,207.43	$17,904.12	$2,589.61
	Rate Adjustments (1)				
D	FY 2015-16 1.7% Rate Increase	1.56%	1.56%	1.56%	1.56%
E	Annualization of FY 2014-15 2.5% Rate Increase	0.21%	0.21%	0.21%	0.21%
F	Estimated Base FY 2015-16 Per FPE after Rate Adjustments	$69,406.88	$13,441.20	$18,221.02	$2,635.45
	Bottom Line Adjustments				
G	FY 2015-16 R-7 "Participant Directed Programs Expansion"[2]	$0.00	$97.70	$0.00	$0.00
H	Annualization of FY 2014-15 R-7 "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"[3]	$0.00	$1,082.69	$0.00	$0.00
I	**Total Estimated FY 2015-16 Per FPE Expenditure**	**$69,406.88**	**$14,621.59**	**$18,221.02**	**$2,635.45**

Table E.4 - 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 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	$69,406.88	$14,621.59	$18,221.02	$2,635.45
B	Base Trend	0.00%	0.00%	0.00%	0.00%
C	Estimated Base FY 2016-17 Per FPE Expenditure	$69,406.88	$14,621.59	$18,221.02	$2,635.45
	Rate Adjustments (1)				
D	Annualization of FY 2015-16 1.7% Rate Increase	0.14%	0.14%	0.14%	0.14%
E	Estimated Base FY 2016-17 Per FPE after Rate Adjustments	$69,504.05	$14,642.06	$18,246.53	$2,639.14
	Bottom Line Adjustments				
F	Annualization of FY 2015-16 R-7 "Participant Directed Programs Expansion"	$0.00	$459.63	$0.00	$0.00
G	**Total Estimated FY 2016-17 Per FPE Expenditure**	**$69,504.05**	**$15,101.69**	**$18,246.53**	**$2,639.14**

Table E.5 - Calculation of FY 2017-18 Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure					
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**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 2016-17 Per Full Program Equivalent (FPE) Expenditure	$69,504.05	$15,101.69	$18,246.53	$2,639.14
B	Base Trend	0.00%	0.00%	0.00%	0.00%
C	Estimated Base FY 2017-18 Per FPE Expenditure	$69,504.05	$15,101.69	$18,246.53	$2,639.14
	Bottom Line Adjustments				
D	Annualization of FY 2015-16 R-7 "Participant Directed Programs Expansion"	$0.00	$166.51	$0.00	$0.00
E	**Total Estimated FY 2017-18 Per FPE Expenditure**	**$69,504.05**	**$15,268.20**	**$18,246.53**	**$2,639.14**

1. A 2.50% Provider Rate increase was added during FY 2014-15 and 1.7% for FY 2015-16. 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 will have a slight carryover effect into the request year.

2. The Department will begin offering Consumer Directed Attendant Support Services (CDASS) to clients on the SLS waiver in October 2015. The Department Assumes that participation in the program will ramp-up at a uniform rate over FY 2015-16 and reach full enrollment in October FY 2016-17 at 12.65% of the SLS waiver population, with each SLS-CDASS client costing an additional $5722.06 above non-CDASS SLS clients.

3. A 25.00% service plan authorization limit (SPAL) increase was added for FY 2014-15. The amount appropriated for the SPAL increase was $2,165.38 per FPE on average. Because client prior authorization requests (PARs) are updated on an annual basis or at the clients' request, the Department assumes that the full impact of the SPAL increase will not be realized until FY 2015-16. As a result, the costs associated are divided between FY 2014-15 and FY 2015-16.

Row	Service	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)	Total	Source/Calculation
Table F.1 - Division for Intellectual and Developmental Disabilities (DIDD) FY 2015-16 Quality Assurance, Utilization Review and Support Intensity Scale Service Forecast								
A	Quality Assurance	Estimated Total Average Monthly Enrollment	4,953	110	4,494	1,212	10,769	Table D.3 Row I
B		Rate	$25.51	$25.51	$25.51	$25.51		Given
C		Estimated Total Expenditure	$1,516,212	$33,673	$1,375,703	$371,017	$3,296,605	Row A * Row B * 12
D	Utilization Review	Estimated Total Average Monthly Enrollment	4,953	110	4,494	1,212	10,769	Table D.3 Row I
E		Rate	$81.31	$81.31	$81.31	$81.31		Given
F		Estimated Total Expenditure	$402,728	$8,944	$365,407	$98,548	$875,627	Row D * Row E
G	Support Intensity Scale	Estimated New and Renewal Average Monthly Enrollment	295	0	898	265	1,458	Table D.3 Row I - Row H + 10%
H		Rate	$233.09	$233.09	$233.09	$0.00		Given
I		Estimated Total Expenditure	$68,762	$0	$209,315	$0	$278,077	Row G * Row H
J	**Estimated Total Expenditure**		**$1,987,702**	**$42,617**	**$1,950,425**	**$469,565**	**$4,450,309**	**Row C + Row F + Row I**

Row	Service	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)	Total	Source/Calculation
Table F.2 - Division for Intellectual and Developmental Disabilities (DIDD) FY 2016-17 Quality Assurance, Utilization Review and Support Intensity Scale Service Forecast								
A	Quality Assurance	Estimated Total Average Monthly Enrollment	5,193	110	4,923	1,309	11,535	Table D.3 Row J
B		Rate	$25.51	$25.51	$25.51	$25.51		Given
C		Estimated Total Expenditure	$1,589,681	$33,673	$1,507,029	$400,711	$3,531,094	Row A * Row B * 12
D	Utilization Review	Estimated Total Average Monthly Enrollment	5,193	110	4,923	1,309	11,535	Table D.3 Row J
E		Rate	$81.31	$81.31	$81.31	$81.31		Given
F		Estimated Total Expenditure	$422,243	$8,944	$400,289	$106,435	$937,911	Row D* Row E
G	Support Intensity Scale	Estimated New and Renewal Average Monthly Enrollment	264	0	472	107	843	Table D.3 Row J - Row I + 10%
H		Rate	$233.09	$233.09	$233.09	$0.00		Given
I		Estimated Total Expenditure	$61,536	$0	$110,018	$0	$171,554	Row G * Row H
J	**Estimated Total Expenditure**		**$2,073,460**	**$42,617**	**$2,017,336**	**$507,146**	**$4,640,559**	**Row C + Row F + Row I**

Table F.3 - Division for Intellectual and Developmental Disabilities (DIDD) FY 2017-18 Quality Assurance, Utilization Review and Support Intensity Scale Service Forecast								
Row	**Service**	**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)**	**Total**	**Source/Calculation**
A	**Quality Assurance**	Estimated Total Average Monthly Enrollment	5,338	110	5,063	1,344	11,855	Table D.3 Row K
B		Rate	$25.51	$25.51	$25.51	$25.51		Given
C		Estimated Total Expenditure	$1,634,069	$33,673	$1,549,886	$411,425	$3,629,053	Row A * Row B * 12
D	**Utilization Review**	Estimated Total Average Monthly Enrollment	5,338	110	5,063	1,344	11,855	Table D.3 Row K
E		Rate	$81.31	$81.31	$81.31	$81.31		Given
F		Estimated Total Expenditure	$434,033	$8,944	$411,673	$109,281	$963,931	Row D* Row E
G	**Support Intensity Scale**	Estimated New and Renewal Average Monthly Enrollment	160	0	154	39	353	Table D.3 Row J - Row I + 10%
H		Rate	$233.09	$233.09	$233.09	$0.00		Given
I		Estimated Total Expenditure	$37,294	$0	$35,896	$0	$73,190	Row G * Row H
J	**Estimated Total Expenditure**		**$2,105,396**	**$42,617**	**$1,997,455**	**$520,706**	**$4,666,174**	**Row C + Row F + Row I**

Table G.1 FY 2015-16 Office of Community Living Appropriation Build								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
	Adult Comprehensive Services							
A	FY 2015-16 Long Bill Appropriation (SB 15-234)	$368,974,132	0.0	$166,178,462	$0	$31,281,639	$0	$171,514,031
B	Total FY 2015-16 Spending Authority	$368,974,132	0.0	$166,178,462	$0	$31,281,639	$0	$171,514,031
C	**HCBS-DD Services**	$337,692,493	0.0	$166,178,462	$0	$0	$0	$171,514,031
D	**HCBS-DD Information Only Client Payments**	$31,281,639	0.0	$0	$0	$31,281,639	$0	$0
	Adult Supported Living Services							
E	FY 2015-16 Long Bill Appropriation (SB 15-234)	$78,378,376	0.0	$42,592,426	$0	$0	$0	$35,785,950
F	Total FY 2015-16 Spending Authority	$78,378,376	0.0	$42,592,426	$0	$0	$0	$35,785,950
G	**SLS Services**	$70,458,653	0.0	$34,672,703	$0	$0	$0	$35,785,950
H	**SLS State-Only**	$7,919,723	0.0	$7,919,723	$0	$0	$0	$0
	Children's Extensive Support Services							
I	FY 2015-16 Long Bill Appropriation (SB 15-234)	$22,574,419	0.0	$11,108,871	$0	$0	$0	$11,465,548
J	Total FY 2015-16 Spending Authority	$22,574,419	0.0	$11,108,871	$0	$0	$0	$11,465,548
	Case Management							
K	FY 2015-16 Long Bill Appropriation (SB 15-234)	$34,577,785	0.0	$18,194,562	$0	$0	$0	$16,383,223
L	Total FY 2015-16 Spending Authority	$34,577,785	0.0	$18,194,562	$0	$0	$0	$16,383,223
M	**Targeted Case Management**	$29,401,896	0.0	$14,468,673	$0	$0	$0	$14,933,223
N	**QU, AR and SIS**	$2,900,000	0.0	$1,450,000	$0	$0	$0	$1,450,000
O	**Case Management - State Only**	$2,275,889	0.0	$2,275,889	$0	$0	$0	$0
	Family Support Services							
P	FY 2015-16 Long Bill Appropriation (SB 15-234)	$6,960,204	0.0	$6,960,204	$0	$0	$0	$0
Q	Total FY 2015-16 Spending Authority	$6,960,204	0.0	$6,960,204	$0	$0	$0	$0
	Preventive Dental Hygiene							
R	FY 2015-16 Long Bill Appropriation (SB 15-234)	$67,012	0.0	$63,334	$0	$3,678	$0	$0
S	Total FY 2015-16 Spending Authority	$67,012	0.0	$63,334	$0	$3,678	$0	$0
	Eligibility Determination and Waitlist Management							
T	FY 2015-16 Long Bill Appropriation (SB 15-234)	$3,121,079	0.0	$3,100,442	$0	$0	$0	$20,637
U	Total FY 2015-16 Spending Authority	$3,121,079	0.0	$3,100,442	$0	$0	$0	$20,637
V	**PASRR**	$27,516		$6,879	$0	$0	$0	$20,637
W	**Med Eligibility Determination**	$3,093,563	0.0	$3,093,563	$0	$0	$0	$0
	Waiver Enrollment							
X	FY 2015-16 Long Bill Appropriation (SB 15-234)	$1,586,987	0.0	$0	$0	$1,586,987	$0	$0
Y	Total FY 2015-16 Spending Authority	$1,586,987	$0	$0	$0	$1,586,987	$0	$0

Table G.2 FY 2016-17 Office of Community Living Appropriation Build								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
	Adult Comprehensive Services							
A	FY 2015-16 Final Spending Authority	$368,974,132	0.0	$166,178,462	$0	$31,281,639	$0	$171,514,031
B	Annualization of FY 2015-16 BA17: "Decreased FMAP"	$0	0.0	$258,755	$0	$0	$0	($258,755)
C	Annualization of FY 2015-16 R#12 "Community Provider Rate Increase and Targeted Rate Increase"	$192,167	0.0	$86,511	$0	$16,367	$0	$89,289
B	Total FY 2016-17 Spending Authority	$369,166,299	0.0	$166,523,728	$0	$31,298,006	$0	$171,344,565
C	**HCBS-DD Services**	$337,868,293	0.0	$166,523,728	$0	$0	$0	$171,344,565
D	**HCBS-DD Information Only Client Payments**	$31,298,006	0.0	$0	$0	$31,298,006	$0	$0
	Adult Supported Living Services							
E	FY 2015-16 Final Spending Authority	$78,378,376	0.0	$42,592,426	$0	$0	$0	$35,785,950
F	Annualization of FY 2015-16 BA17: "Decreased FMAP"	$0	0.0	$35,066	$0	$0	$0	($35,066)
G	Annualization of FY 2015-16 R#7 Participant Directed Programs Expansion	$2,168,204	0.0	$1,070,163	$0	$0	$0	$1,098,041
H	Annualization of FY 2015-16 R#12 "Community Provider Rate Increase and Targeted Rate Increase"	$78,224	0.0	$42,256	$0	$0	$0	$35,968
I	Total FY 2016-17 Spending Authority	$80,624,804	0.0	$43,739,911	$0	$0	$0	$36,884,893
J	**SLS Services**	$73,155,282	0.0	$36,270,389	$0	$0	$0	$36,884,893
K	**SLS State-Only**	$7,469,522	0.0	$7,469,522	$0	$0	$0	$0
	Children's Extensive Support Services							
L	FY 2015-16 Final Spending Authority	$22,574,419	0.0	$11,108,871	$0	$0	$0	$11,465,548
M	Annualization of FY 2015-16 BA17: "Decreased FMAP"	$0	0.0	$18,088	$0	$0	$0	($18,088)
N	Annualization of FY 2015-16 R#12 "Community Provider Rate Increase and Targeted Rate Increase"	$901	0.0	$444	$0	$0	$0	$457
O	Total FY 2016-17 Spending Authority	$22,575,320	0.0	$11,127,403	$0	$0	$0	$11,447,917
	Case Management							
P	FY 2015-16 Final Spending Authority	$34,577,785	0.0	$18,194,562	$0	$0	$0	$16,383,223
Q	Annualization of FY 2015-16 BA17: "Decreased FMAP"	$0	0.0	$66,687	$0	$0	$0	($66,687)
R	Annualization of FY 2015-16 R#12 "Community Provider Rate Increase and Targeted Rate Increase"	($4,003)	0.0	($1,970)	$0	$0	$0	($2,033)
S	Total FY 2016-17 Spending Authority	$34,573,782	0.0	$18,259,279	$0	$0	$0	$16,314,503
T	**Targeted Case Management**	$29,481,363	0.0	$14,616,860	$0	$0	$0	$14,864,503
U	**QU, AR and SIS**	$2,900,000	0.0	$1,450,000	$0	$0	$0	$1,450,000
V	**Case Management - State Only**	$2,192,419	0.0	$2,192,419	$0	$0	$0	$0

	Family Support Services							
W	FY 2015-16 Final Spending Authority	$6,960,204	0.0	$6,960,204	$0	$0	$0	$0
X	Annualization of FY 2015-16 R#12 "Community Provider Rate Increase and Targeted Rate Increase"	$256	0.0	$256	$0	$0	$0	$0
Y	Total FY 2016-17 Spending Authority	$6,960,460	0.0	$6,960,460	$0	$0	$0	$0
Z	**Preventive Dental Hygiene**							
AA	FY 2015-16 Final Spending Authority	$67,012	0.0	$63,334	$0	$3,678	$0	$0
AB	Annualization of FY 2015-16 R#12 "Community Provider Rate Increase and Targeted Rate Increase"	($24)	0.0	($23)	$0	($1)	$0	$0
AC	Total FY 2016-17 Spending Authority	$66,988	0.0	$63,311	$0	$3,677	$0	$0
	Eligibility Determination and Waitlist Management							
AD	FY 2015-16 Final Spending Authority	$3,121,079	0.0	$3,100,442	$0	$0	$0	$20,637
AE	Annualization of FY 2015-16 R#12 "Community Provider Rate Increase and Targeted Rate Increase"	$115	0.0	$114	$0	$0	$0	$1
AF	Total FY 2016-17 Spending Authority	$3,121,194	0.0	$3,100,556	$0	$0	$0	$20,638
AG	**PASRR**	$27,517		$6,879	$0	$0	$0	$20,638
AH	**Med Eligibility Determination**	$3,093,677	0.0	$3,093,677	$0	$0	$0	$0
	Waiver Enrollment							
AI	FY 2015-16 Final Spending Authority	$1,586,987	0.0	$0	$0	$1,586,987	$0	$0
AJ	Annualization of FY 2014-15 Long Bill Add On	($1,586,987)	0.0	$0	$0	($1,586,987)	$0	$0
AK	Total FY 2016-17 Spending Authority	$0	0.0	$0	$0	$0	$0	$0

Table G.3 FY 2017-18 Office of Community Living Appropriation Build								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
	Adult Comprehensive Services							
A	FY 2016-17 Final Spending Authority	$369,166,299	0.0	$166,523,728	$0	$31,298,006	$0	$171,344,565
B	Total FY 2017-18 Spending Authority	$369,166,299	0.0	$166,523,728	$0	$31,298,006	$0	$171,344,565
C	**HCBS-DD Services**	$337,868,293	0.0	$166,523,728	$0	$0	$0	$171,344,565
D	**HCBS-DD Information Only Client Payments**	$31,298,006	0.0	$0	$0	$31,298,006	$0	$0
	Adult Supported Living Services							
E	FY 2016-17 Final Spending Authority	$80,624,804	0.0	$43,739,911	$0	$0	$0	$36,884,893
F	Total FY 2017-18 Spending Authority	$80,624,804	0.0	$43,739,911	$0	$0	$0	$36,884,893
G	**SLS Services**	$73,417,383	0.0	$36,532,490	$0	$0	$0	$36,884,893
H	**SLS State-Only**	$7,207,421	0.0	$7,207,421	$0	$0	$0	$0
	Children's Extensive Support Services							
I	FY 2016-17 Final Spending Authority	$22,575,320	0.0	$11,127,403	$0	$0	$0	$11,447,917
J	Total FY 2017-18 Spending Authority	$22,575,320	0.0	$11,127,403	$0	$0	$0	$11,447,917
	Case Management							
K	FY 2016-17 Final Spending Authority	$34,573,782	0.0	$18,259,279	$0	$0	$0	$16,314,503
L	Total FY 2017-18 Spending Authority	$34,573,782	0.0	$18,259,279	$0	$0	$0	$16,314,503
M	**Targeted Case Management**	$29,586,988	0.0	$14,722,485	$0	$0	$0	$14,864,503
N	**QU, AR and SIS**	$2,900,000	0.0	$1,450,000	$0	$0	$0	$1,450,000
O	**Case Management - State Only**	$2,086,794	0.0	$2,086,794	$0	$0	$0	$0
	Family Support Services							
P	FY 2016-17 Final Spending Authority	$6,960,460	0.0	$6,960,460	$0	$0	$0	$0
Q	Total FY 2017-18 Spending Authority	$6,960,460	0.0	$6,960,460	$0	$0	$0	$0
R	**Preventive Dental Hygiene**							
S	FY 2016-17 Final Spending Authority	$67,012	0.0	$63,334	$0	$3,678	$0	$0
T	Total FY 2017-18 Spending Authority	$67,012	0.0	$63,334	$0	$3,678	$0	$0
	Eligibility Determination and Waitlist Management							
U	FY 2016-17 Final Spending Authority	$3,121,079	0.0	$3,100,442	$0	$0	$0	$20,637
V	Total FY 2017-18 Spending Authority	$3,121,079	0.0	$3,100,442	$0	$0	$0	$20,637
W	**PASRR**	$27,516		$6,879	$0	$0	$0	$20,637
X	**Med Eligibility Determination**	$3,093,563	0.0	$3,093,563	$0	$0	$0	$0
	Waiver Enrollment							
Y	FY 2016-17 Final Spending Authority	$0	0.0	$0	$0	$0	$0	$0
Z	Total FY 2017-18 Spending Authority	$0	0.0	$0	$0	$0	$0	$0

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-07 County Administration Financing

Dept. Approval By: Josh Block [signature] 11/2/15 — X — **Supplemental FY 2015-16** / **Change Request FY 2016-17** / **Base Reduction FY 2016-17** / **Budget Amendment FY 2016-17**

OSPB Approval By: [signature] 10/31/15

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$61,226,774	$0	$61,226,774	$7,105,769	$7,105,769
	FTE	$0	0.0	$0	0.0	0.0
	GF	$11,114,448	$0	$11,114,448	$0	$0
	CF	$12,953,395	$0	$12,953,395	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$37,158,931	$0	$37,158,931	$7,105,769	$7,105,769

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
01. Executive Director's Office - Centralized Eligibility Vendor Contract Project	Total	$9,133,612	$0	$9,133,612	($9,133,612)	($9,133,612)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$3,145,326	$0	$3,145,326	($3,145,326)	($3,145,326)
	RF	$0	$0	$0	$0	$0
	FF	$5,988,286	$0	$5,988,286	($5,988,286)	($5,988,286)
01. Executive Director's Office - Centralized Eligibility Vendor Contract Project	Total	$0	$0	$0	$5,053,644	$5,053,644
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$1,745,342	$1,745,342
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$3,308,302	$3,308,302

01. Executive Director's Office - County Administration	**Total**	**$39,536,478**	**$0**	**$39,536,478**	**$6,461,585**	**$6,461,585**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$11,114,448	$0	$11,114,448	$0	$0
	CF	$5,859,623	$0	$5,859,623	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$22,562,407	$0	$22,562,407	$6,461,585	$6,461,585
01. Executive Director's Office - Hospital Provider Fee County Administration	**Total**	**$11,104,684**	**$0**	**$11,104,684**	**$4,644,184**	**$4,644,184**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$3,585,446	$0	$3,585,446	$1,360,000	$1,360,000
	RF	$0	$0	$0	$0	$0
	FF	$7,519,238	$0	$7,519,238	$3,284,184	$3,284,184
01. Executive Director's Office - Medical Assistance Sites	**Total**	**$1,452,000**	**$0**	**$1,452,000**	**$79,968**	**$79,968**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$363,000	$0	$363,000	$39,984	$39,984
	RF	$0	$0	$0	$0	$0
	FF	$1,089,000	$0	$1,089,000	$39,984	$39,984

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: CHP Trust Fund (11G0) Hospital Provider Fee (24A0)

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: N/A

Other Information:

Cost and FTE

- The Department requests $7,105,769 total funds, $0 General Fund, $0 cash funds and $7,105,769 federal funds to increase the federal funds appropriation for county administration to more accurately reflect the percentage of activities eligible for the enhanced match rate.
- The request also includes transferring existing funding between line items related to eligibility determination and to re-organize the Long Bill to more accurately reflect the Department's current strategy as the eligibility vendor has been re-procured and certain activities previously performed by the vendor have been transferred to counties.

Current Program

- The eligibility vendor and Colorado's counties are reimbursed for Medicaid and Children's Health Plan Plus (CHP+) eligibility determination based upon staffing and related costs necessary to provide service to Coloradans.

Problem or Opportunity

- The current appropriations for eligibility determination do not include the appropriate amount of federal funds to reflect the current programs.
- As the Department's strategy for eligibility determination and ongoing case management has evolved, the General Assembly's organization of the Department's Long Bill and spending authority has not been completely updated.

Consequences of Problem

- If additional federal funding spending authority is not approved, the General Fund restriction due to the (M) headnote would limit the Department's ability to fully reimburse counties for the state share of expenditures, requiring additional county funds be used to cover costs, which in turn limits the funding available for counties to reinvest in other programs.

Proposed Solution

- The Department requests to align the County Administration federal funds appropriation with the expected percentage of enhanced match eligible activities, 65%, in order to reimburse the counties as much of their cost to process applications and provide case maintenance as possible and to encourage counties to continue to meet timeliness and backlog requirements.
- The Department requests to move funding from the Centralized Eligibility Vendor line item to other contracts, as the re-procured contract has shifted activities and costs to other vendors and the counties. Adjustments to the Long Bill structure and spending authority are imperative to ensure transparency and allocate funding efficiently across contracts.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2016-17 Funding Request | November 2, 2015

Department Priority: R-7
Request Detail: County Administration Financing

Summary of Incremental Funding Change for FY 2016-17	Total Funds	General Fund
County Administration Financing	$7,105,769	$0

Problem or Opportunity:

As the Department's strategy for eligibility determination and ongoing case management has evolved, the Department's spending authority has not been completely updated and adjustments to spending authority are imperative to ensure the system is able to function in the most efficient and effective way. Based upon county expenditures in FY 2014-15, the first full year since the enhanced match rate had been implemented, the federal funds received in subsequent years is expected to be higher than appropriated in the Long Bill. Due to the (M) headnote restriction on the county administration appropriation, which requires a General Fund restriction equal to the amount of the additional federal funds received, without additional federal funding appropriated the Department would be unable to fully reimburse counties the state's share of their costs. This could lead to counties reducing staffing or having to contribute more county funds than anticipated. Additionally, the request includes changes to the organization of the Department's Long Bill related to eligibility determination activities.

Since the implementation of the Affordable Care Act and the expansion of Medicaid through SB 13-200 "Expand Medicaid Eligibility" the Department has experienced a number of changes in both the strategy and funding streams for efficiently and effectively determining eligibility and enrolling clients into Medicaid and Children's Health Insurance Program (referred to in Colorado as the Child Health Plan Plus, or "CHP+"). In order to support the state's "no wrong door" approach which allows clients to receive service at state-wide locations of their choice, Colorado has a complex and sprawling web of people, processes and technologies that enable Medicaid eligibility determinations to be made. The Department pays some, but not all of these partners for this work. As of June 2015 there are 64 county departments of human/social services, 284 certified application assistance sites (CAAS), 128 presumptive eligibility (PE) sites and 9 medical assistance (MA) sites. Additionally, the Department funds hospitals to help get clients enrolled in Medicaid and CHP+. Applicants can apply online through the Program Eligibility Application Kit (PEAK) website or receive in-person and phone assistance through the applicant's local county office, a CAAS, PE or MA site. This diversity of organizations spread across the state provides the large number of access points needed to adequately support a "high-touch" medical application process for those who prefer this type of assistance.

Despite the challenges of system limitations and organizational alignments, Colorado has been steadily improving service delivery and administrative efficiencies.

County Administration and Hospital Provider Fee County Administration[1]
The changing eligibility and enrollment environment has also resulted in significant changes to the management and funding available for county administration. Counties received additional funding through SB 13-200 "Expand Medicaid Eligibility", the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" budget request and received federal approval through the Maintenance and Operations Advanced Planning Document (MOAPD). However, with the current restrictions placed on the funding, the Department is at risk of being unable to fully reimburse counties for their costs related to Medicaid and CHP+ because the Department's County Administration appropriation does not contain sufficient federal funds spending authority and because the line item is restricted by an (M) headnote.

The Department believes that it is critical to have flexibility in the amount of funding appropriated to counties. Counties are reimbursed below cost for the processing of Medicaid and other major public assistance programs applications. For example, for Medicaid programs, counties are required to contribute between 9% and 18% of the total cost of processing applications. When the State is not able to fully fund the state and federal portion of the costs, those unreimbursed costs are fully financed by the counties themselves. Colorado county human services department staff provide critical services to Coloradans, including assisting with eligibility determination and annual re-determination for Medicaid and CHP+ programs. County workloads associated with Medicaid and CHP+ eligibility processing have increased dramatically, with Medicaid caseload increasing from 860,957 in June 2014 to 1,247,541 in July 2015, a 30% increase. Caseload is expected to increase an additional 11% in FY 2015-16 and activities related to new application processing are generally eligible for the enhanced match rate. Therefore, as caseload continues to increase it is expected that enhanced match activities would remain higher than currently assumed in the budget.

In Fall 2013, when estimating the amount of federal funds that could be drawn with the enhanced match, the Department evaluated historical data of county worker activities and cost pool data in the County Financial Management System (CFMS) and estimated that 56% of county administration activities would be eligible for the enhanced match. However, as JBC staff noted, on page 6 of the document "JBC Staff Interim Supplemental Recommendations: FY 2013-14" dated September 20, 2013, due to the uncertainties about what portion of county activities would qualify for the enhanced match, future revisions to the appropriation may be required if the 56% assumption needs modification. As the counties implemented the enhanced funding, closer to 65% of their activities were attributable to the 75% enhanced match rate. As a result, in FY 2014-15 the Department was headed towards an overexpenditure of federal funds which would have required a General Fund restriction due to the (M) headnote and would have prevented the Department from reimbursing counties the full amount of the General Fund appropriated. The Department expects that with caseload increases that the level of enhanced match activities will continue to be higher than the current

[1] (1) Executive Director's Office, (D) Eligibility and Client Services, County Administration, and (1) Executive Director's Office, (D) Eligibility and Client Services, Hospital Provider Fee County Administration

amount in the Long Bill and this problem is likely to continue without additional federal funds in the appropriation.

In an effort to ensure that counties could be reimbursed for the full state share of their costs, the Department submitted, and had approved, an interim supplemental request in June 2015 to allow an overexpenditure of federal funds so that the Department could reimburse counties for their enhanced match eligible activities without restricting General Fund. Even with the approval of the supplemental request, the Department was unable to reimburse counties for $175,530 of costs related to Medicaid and CHP+ eligibility determination. If the interim supplemental had not been approved, this problem would have been worse and the Department would have been required to restrict $719,000 General Fund which would have decreased the amount reimbursed to counties, resulting in counties having to cover $894,530 of costs instead of $175,530. Additionally, the General Assembly's action in 2014 to eliminate the Department's ability to overexpend any of the lines in Executive Director's Office and the presence of the (M) headnote on the County Administration line item have increased the likelihood that counties will have uncovered costs in addition to the required county share.

The (M) headnote requires the Department to restrict, and ultimately revert, General Fund spending authority in the event that additional federal funds are available. Because the counties are able to attribute nearly 10% more of their activities to the enhanced match than was originally estimated and appropriated, the Department expects to have to restrict General Fund in the future without supplemental appropriations. This had not been an issue in the past as the counties historically had underspent the Medicaid appropriation and since the Department had unlimited overexpenditure authority. However, as stated above, for the first time in recent history, in FY 2014-15, counties fully expended the state share and were not reimbursed for $175,530 of costs which had to be covered with county only funds. The Department believes this will continue to be a problem in the future due to increased caseload.

County Incentive and Grant Program Flexibility

Additionally, counties received funding for a county incentive program through the Department's R-6 "Eligibility Determination Enhanced Match" budget request. As efficiencies are realized through real time eligibility determination, the strategy of the Department and the role of the counties continues to evolve. In order to continue that progress the Department needs full flexibility in the types of incentives and grants that are provided in order to incent not only timely application processing but collaboration with other state agencies to create efficiencies, reporting, etc.

Centralized Eligibility Vendor[2]

The purpose and structure of the centralized eligibility vendor has changed significantly in the last two years. In order to fully incorporate these changes, an adjustment to the structure of the Long Bill and its components is required to accurately reflect how the Department processes Medicaid and CHP+ applications. With the passage of HB 09-1293 "Medicaid Hospital Provider Fee", which expanded eligibility in Medicaid and

[2] (1) Executive Director's Office, (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project

CHP+, the General Assembly provided funding for a contract with a centralized eligibility vendor in order to provide assistance to the county departments of social services in processing cases and providing ongoing case management. The Department received additional funding for the centralized eligibility vendor with the passage of the Affordable Care Act and SB 13-200 "Expand Medicaid Eligibility" to support the dramatic caseload increase that resulted. Through the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" budget request, the fund splits were adjusted for this line item to include a 75% enhanced federal match rate for activities related to application processing, which became effective in October 2013.

In addition to funding changes, the centralized eligibility vendor contract ended June 30, 2015 and required re-procurement. As the Department evaluated the roles and responsibilities of the vendor and reviewed performance metrics across all eligibility determination sites, the review indicated that the centralized eligibility vendor performance in areas of timeliness and customer service standards were far below the performance of the counties and other sites. In addition to the performance concerns, the Department had received feedback from county staff and clients reporting that having a centralized vendor in place for ongoing case management led to customer confusion as clients were transferred from one site to another to have issues resolved since the county could not access the cases assigned to the vendor.

Based upon this review and consultation with stakeholders, some of the duties were transferred to the counties, who are the primary eligibility determination sites in the state. The scope of work transferred to the counties is similar to the core services that the counties provide to Coloradans state-wide and includes including ongoing case maintenance of thousands of additional cases and completion of online applications that do not receive Real Time Eligibility (RTE) determination. Although the counties have already started this work, the Long Bill does not reflect the transfer of funding from the Centralized Eligibility Vendor line item to the County Administration Line item. Updating the Long Bill will increase which transparency in the Department's activities. Additionally, while counties will provide case maintenance and assistance related to application processing and redeterminations, a number of activities including case management of the Department's Medicaid Buy-In Program, CHP+ enrollment fee processing and CHP+ case management were transferred to the new eligibility vendor, Denver Health and Hospital Authority. The current structure of the Long Bill does not reflect this change in policy and needs to be updated to reflect current practice.

Proposed Solution:

The Department requests $7,105,769 total funds, comprised of only federal funds, in order to update the county administration appropriations federal funds spending authority to more accurately reflect county activities. The Department requests to remove the (M) headnote restriction on county administration to allow the Department to reimburse counties for the full amount of expenditures associated with the General Fund appropriation. Additionally, The Department requests to increase flexibility in the county incentive and grant program to allow the Department to incentivize activities other than those related to eligibility determination. The Department requests shifting funding from the Centralized Eligibility Vendor line item to the County Administration and to Medical Assistance Sites line items. Finally, the Department requests a correction related to the cash fund for the Centralized Eligibility Vendor contract line item.

County Administration and Hospital Provider Fee County Administration

The Department requests to increase the federal funds portion of the FY 2016-17 County Administration appropriation by $6,461,585. This would align the appropriation with the expected percentage of enhanced match eligible activities, 65%. Through the Department's R-6 "Eligibility Determination Enhanced Match" budget request the appropriation was set assuming 56% of activities would be eligible for enhanced funding.

As the 75% enhanced match was implemented, counties were able to attribute closer to 65% of their activities to the enhanced funding. Increasing the FY 2016-17 and ongoing fiscal years' federal funds appropriations would allow the counties to provide a higher percentage of enhanced activities and receive reimbursement for doing so without needing to restrict the General Fund portion of the appropriation. Additional federal funding in the appropriation gives the counties the flexibility to maximize federal funding which not only increases how much funding is available to reimburse counties but also decreases the portion that counties are required to share in their costs, which in turn frees up funds for counties to reinvest in other programs.

Additionally, the Department requests to remove the (M) headnote from the County Administration line item. FY 2014-15 was the first full year that the Department had experience with the enhanced match related to eligibility determination. Although the experience of the Department after implementation of the enhanced match is that on average 65% of the counties activities are eligible for the additional funding, changes through the shift in the eligibility vendor activities to the counties and open enrollment, could change the percentage of activities eligible. Removing the (M) headnote would allow the Department the flexibility to reimburse counties within the limitation of the appropriated General Fund, rather than the total funds amount.

This request also includes a similar increase of $644,184 federal funds spending authority for the hospital provider fee county administration line item to more accurately reflect the amount of enhanced match activities experienced in FY 2014-15.

<u>County Incentive and Grant Program Flexibility</u>
The Department requests that the incentive and grant program could be broadened to provide flexibility to provide grants and to incentivize counties in other areas in addition to eligibility determination infrastructure. This may include initiatives related to the Colorado Opportunity Project or other key initiatives that involve counties and promote the Department's goals and mission.

Centralized Eligibility Vendor
The Department requests to adjust the centralized eligibility vendor line item to reflect new contract negotiations and desired transfer of responsibilities. The Department requests to decrease the entire appropriation in the current Long Bill line item group in the amount of $9,133,612 total funds, $3,145,326 Hospital Provider Fee cash funds and to create a new Long Bill line item in the amount of $5,053,644 total funds, $1,745,342 Hospital Provider Fee cash funds fund to:

- Shift funding to Hospital Provider Fee County Administration line item
- Shift funding to Medical Assistance Sites line item
- Re-name and move the line item

- Adjust the cash fund source to correct a technical error

Shift funding to Hospital Provider Fee County Administration line item

This request includes shifting $4,000,000 total funds comprised of $1,360,000 Hospital Provider Fee cash fund and $2,640,000 federal funds to the Hospital Provider Fee County Administration line item. The scopeof work transferred is similar to the core services that the counties provide to Coloradans state-wide; however, the increased caseload requires additional funding to maintain eligibility determination timeliness and accuracy.

Shift funding to Medical Assistance Sites line item

In addition to shifting funds to the counties, the Department requests to shift $79,968 total funds comprised of $39,984 Hospital Provider Fee cash fund and $39,984 federal funds to the Medical Assistance (MA) Sites line item to cover the contractor costs of implementing the Random Moment Sampling process which is required for cost allocation. As is with all eligibility determination sites, MA sites are required by the Center for Medicare and Medicaid Services (CMS) to have a cost allocation methodology in place to not only show which costs are being attributed to the enhanced match, but to also ensure the Department is not paying more than its share of costs.

Re-name and move the line item

The Department also requests to move the re-named line item Eligibility Vendor Contract to (1) Executive Director's Office (D) Eligibility Determination and Client Services Long Bill Group. Moving eligibility and enrollment contracts to the same Long Bill group and updating the appropriation as requested provides greater transparency to the amount of funding spent on these services and more accurately reflects the work being performed, the cost of this contract and also creates administrative efficiencies for the Department.

Adjust the cash fund source to correct a technical error

Additionally, this request includes changing the cash fund appropriation amount of $991,235 from the Children's Basic Health Plan Trust Fund to the Hospital Provider Fee cash fund. This is to correct a technical error in the FY 2015-16 Long Bill. This amount represents the final annualization to the Centralized Eligibility Vendor line item from SB 13-200 "Expand Medicaid Eligibility". The base request incorrectly referenced the Trust Fund and not the Hospital Provider Fee cash fund for this annualization and the Department did not catch and correct this error before the Long Bill was finalized.

Anticipated Outcomes:

Approval of this request would encourage counties to provide staffing levels necessary to provide excellent customer service to Coloradans without requiring them to contribute higher levels of county funding to support the increased workload.

Approval of this request would allow the Department's eligibility contractors to maintain and improve timeliness and reduce backlog, while also improving improve customer service and administrative efficiencies for the Department.

This request links to the customer portion of its performance plan by improving the customer experience related to eligibility determination and providing funding for sites to provide adequate staffing levels.

By streamlining Medicaid application processing and customer service related to it, the Department assumes that the transition will result in improved coordination efforts and improved client experience. The Department also expects that the timeliness and backlog metrics measuring the counties and new vendor's performance will improve.

Assumptions and Calculations:

Detailed calculations can be found in the appendix, Tables 1 through 4.

Table 2.1 and 2.2 demonstrate the re-organization of the Long Bill being requested and the total appropriations for each of the line items in order to demonstrate the impact of the request to each of the line items total spending authority.

Table 3.1 summarizes the request related to the Eligibility Vendor Contract and shows the shifts in funding being requested.

The Department assumes that 65.89% of county administration activities will be eligible for the enhanced match and therefore, increased federal funds in the estimate to reflect that increase. The Department assumes that due to the transition of work from the eligibility vendor and increased caseload counties are likely to have greater expenditure related to county administration responsibilities than in FY 2014-15 and the Department may not be able to fully cover the state share of expenditure in FY 2015-16 and FY 2016-17, and therefore all federal funding available would be needed to reimburse counties as much as possible while limiting expenditure to the state share of funding.

Table 3.2 summarizes the request related to the County Administration line item. In order to determine the amount of additional federal funds spending authority to be requested, this table starts with the total appropriation, then subtracts the Public Assistance Reporting Information System (PARIS) and incentive program funding which are not part of the allocation development process, to determine the remaining appropriation amount to be allocated to counties. Further the Department assumes that 65.89% of expenditure would be eligible for the enhanced 75% FFP and has estimated enhanced and non-enhanced expenditure based upon this percentage calculated from Table 4.1 which shows the percentage of enhanced activities for FY 2014-15.

Table 3.3 summarizes the request related to Hospital Provider Fee County Administration line item. In order to determine the amount of additional federal funds spending authority, this tables shows the total appropriation, then subtracts the amount expected for the grant program, adds the amount to be shifted from the Eligibility Vendor Contract line item to determine the remaining appropriation to be used to calculate allocations. Enhanced allocations were calculated assuming 65.89% of expenditure would be eligible for the enhanced 75% FFP and has estimated enhanced and non-enhanced expenditure based upon this percentage calculated from Table 4.1 which shows the percentage of enhanced activities for FY 2014-15.

Table 3.4 summarizes the request related to Medical Assistance sites. The Department assumes that the RMS contract will cost $79,968 total funds in FY 2016-17 and ongoing and would be eligible for 50% Federal

Financial Participation (FFP). This is based upon the cost of the current year contract which is being paid for out of the centralized eligibility vendor line item.

The Department assumes that $5,053,644 total funds, $1,745,342 hospital provider fee cash fund would be utilized to pay the current contractor, Denver Health and Hospital Authority, to provide eligibility determination services as outlined in the contract.

Table 1.1 - County Administration Financing FY 2016-17 Summary by Line Item								
FY 2016-17	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
Total Request	**$7,105,769**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$7,105,769**	
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	($9,133,612)	0.0	$0	$0	($3,145,326)	$0	($5,988,286)	Table 2.1 Row C *-1
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Eligibility Vendor Contract	$5,053,644	0.0	$0	$0	$1,745,342	$0	$3,308,302	Table 3.1 Row D
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration	$6,461,585	0.0	$0	$0	$0	$0	$6,461,585	Table 3.2 Row H
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration	$4,644,184	0.0	$0	$0	$1,360,000	$0	$3,284,184	Table 3.3 Row H
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Assistance Sites	$79,968	0.0	$0	$0	$39,984	$0	$39,984	Table 3.4 Row D

Table 1.2 - County Administration Financing FY 2017-18 Summary by Line Item								
FY 2016-17	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
Total Request	**$7,105,769**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$7,105,769**	
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Eligibility Vendor Contract	$5,053,644	0.0	$0	$0	$1,745,342	$0	$3,308,302	Table 3.1 Row D. See Table 2.2 for requested change in name and group structure
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration	$6,461,585	0.0	$0	$0	$0	$0	$6,461,585	Table 3.2 Row H
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration	$4,644,184	0.0	$0	$0	$1,360,000	$0	$3,284,184	Table 3.3 Row H
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Assistance Sites	$79,968	0.0	$0	$0	$39,984	$0	$39,984	Table 3.4 Row D

Table 2.1 Current Organization of Long Bill

Row	Long Bill Category	Total Funds	General Fund	Cash Funds	Federal Funds	Notes/Calculations
A	**(1) Executive Director's Office**					
B	**(C) Information Technology Contracts and Projects (1)**					
C	Centralized Eligibility Vendor Contract Project	$9,133,612	$0	$3,145,326	$5,988,286	SB 15-234
D	**(D) Eligibility Determinations and Client Services (1)**					
E	County Administration	$39,536,478	$11,114,448	$5,859,623	$22,562,407	SB 15-234
F	Hospital Provider Fee County Administration	$11,104,684		$3,585,446	$7,519,238	SB 15-234
G	Medical Assistance Sites	$1,452,000	$0	$363,000	$1,089,000	SB 15-234
H	**Total**	**$61,226,774**	**$11,114,448**	**$12,953,395**	**$37,158,931**	**Row C + Row E + Row F + Row G**

(1) This Long Bill Group also includes other appropriations not listed and not impacted by this request.

Table 2.2 Requested Revised Organization of Long Bill

Row	Long Bill Category	Total Funds	General Fund	Cash Funds	Federal Funds	Notes/Calculations
A	**(1) Executive Director's Office**					
B	**(D) Eligibility Determinations and Client Services** (1)					
C	Eligibility Vendor Contract	$5,053,644	$0	$1,745,342	$3,308,302	Table 3.1: Row A + Row E
D	County Administration	$45,998,063	$11,114,448	$5,859,623	$29,023,992	Table 3.2: Row A + Row H
E	Hospital Provider Fee County Administration	$15,748,868	$0	$4,945,446	$10,803,422	Table 3.3: Row A + Row H
F	Medical Assistance Sites	$1,531,968	$0	$402,984	$1,128,984	Table 3.4: Row A + Row D
G	**Total**	**$68,332,543**	**$11,114,448**	**$12,953,395**	**$44,264,700**	**Row C + Row D + Row E + Row F**

(1) This Long Bill Group also includes other appropriations not listed and not impacted by this request.

Table 3.1: Summary of Request: FY 2016-17 (1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Eligibility Vendor Contract

Row	Label	Total Funds	General Fund	Cash Funds (1)	Federal Funds	Notes/Calculations
A	**Appropriation**	**$9,133,612**	**$0**	**$3,145,326**	**$5,988,286**	**SB 15-234 Long Bill**
B	Transfer Random Moment Sampling Contractor funding to Medical Assistance Sites line item	($79,968)	$0	($39,984)	($39,984)	$19,992 per quarter based upon current contract
C	Transfer to Hospital Provider Fee County Administration	($4,000,000)	$0	($1,360,000)	($2,640,000)	Amount agreed upon with stakeholder input to transfer to counties for FY 2015-16
D	Total Projected Expenditure	$5,053,644	$0	$1,745,342	$3,308,302	Amount estimated for eligibility vendor contract
E	**Total Request**	**($4,079,968)**	**$0**	**($1,399,984)**	**($2,679,984)**	**Row D - Row A**

(1) This request is also to change cash funding source in the amount of $991, 235 from Children's Basic Health Plan Trust to hospital provider fee as intended by the General Assembly. Currently, a portion of the funding was appropriated from the Children's Basic Health Plan trust fund incorrectly.

Table 3.2 Summary of Request: FY 2016-17 (1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration

Row	Item	Total Funds	General Fund	Local Funds	Federal Funds	Notes/Calculations
A	**Appropriation**	**$39,536,478**	**$11,114,448**	**$5,859,623**	**$22,562,407**	**SB 15-234 Long Bill**
B	PARIS	$200,000	$100,000	$0	$100,000	PARIS allocation
C	Incentive	$4,394,717	$4,394,717	$0	$0	FY 2014-15 R-6 "Eligibility Determination Enhanced Match"
D	Remaining Appropriation	$34,941,761	$6,619,731	$5,859,623	$22,462,407	Row A - Row B - Row C
E	Projected Expenditure- Enhanced	$32,889,276	$4,361,567	$3,860,752	$24,666,957	General Fund and Local Funds: Row D * Table 4.1 Percentage enhanced
F	Projected Expenditure- Non-Enhanced	$8,514,070	$2,258,164	$1,998,871	$4,257,035	General Fund and Local Funds: Row D - Row E. Federal funds: General Fund + Local Funds
G	Total Projected Expenditure	$45,998,063	$11,114,448	$5,859,623	$29,023,992	Row B + Row C + Row E + Row F
H	**Total Request**	**$6,461,585**	**$0**	**$0**	**$6,461,585**	**Row G - Row A**

Table 3.3 Summary of Request: FY 2016-17 (1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration

Row	Label	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Federal Funds	Notes/Calculations
A	**Appropriation**	**$11,104,684**	**$0**	**$3,585,446**	**$7,519,238**	**SB 15-234 Long Bill**
B	Grant Payments	$1,000,000	**$0**	**$500,000**	$500,000	FY 2014-15 R-6 "Eligibility Determination Enhanced M
C	Increase from Centralized Eligibility Vendor Contract Project	$4,000,000	$0	$1,360,000	$2,640,000	Amount agreed upon with stakeholder input to transfer to counties for FY 2015-16
D	Remaining Appropriation	$14,104,684	$0	$4,445,446	$9,659,238	Row A- Row B + Row C
E	Allocations- Enhanced	$11,715,952	$0	$2,928,988	$8,786,964	Cash funds: Row D cash fund amount* Table 4.1 Percentage Enhanced
F	Allocations- Non-Enhanced	$3,032,916	$0	$1,516,458	$1,516,458	Cash Funds: Row D - Row E
G	Total Projected Expenditure	$15,748,868	$0	$4,945,446	$10,803,422	Row B + Row E + Row F
H	**Total Request**	**$4,644,184**	**$0**	**$1,360,000**	**$3,284,184**	**Row H- Row A**

Table 3.4 Summary of Request: FY 2016-17 (1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Assistance Sites

Row	Label	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Federal Funds	Notes/Calculations
A	**Appropriation**	**$1,452,000**	**$0**	**$363,000**	**$1,089,000**	**SB 15-234 Long Bill**
B	Transfer Random Moment Sampling Contractor funding to Medical Assistance Sites line item	$79,968	$0	$39,984	$39,984	$19,992 per quarter based upon current contract
C	Total Projected Expenditure	$1,531,968	$0	$402,984	$1,128,984	Row A + Row B
D	**Total Request**	**$79,968**	**$0**	**$39,984**	**$39,984**	**Row C - Row A**

Table 4.1 FY 2014-15 County Administration and Hospital Provider Fee County Administration Allocation Expenditure			
Item	**Medicaid Enhanced Expenditures**	**Non-Enhanced Medicaid Expenditures**	**Percentage Enhanced**
Total Expenditure	$32,122,861	$16,631,333	65.89%

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-09 OAP State Only Funding Adjustment

Dept. Approval By:	Josh Block	11/2/15		**Supplemental FY 2015-16**
			X	**Change Request FY 2016-17**
				Base Reduction FY 2016-17
OSPB Approval By:		10/28/15		**Budget Amendment FY 2016-17**

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,574,103**	**$0**	**$7,574,103**	**($3,939,225)**	**($3,926,452)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,962,510	$0	$2,962,510	$0	$0
	CF	$4,611,593	$0	$4,611,593	($3,939,225)	($3,926,452)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
06. Other Medical Services - Old Age Pension State Medical	**Total**	**$7,574,103**	**$0**	**$7,574,103**	**($3,939,225)**	**($3,926,452)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,962,510	$0	$2,962,510	$0	$0
	CF	$4,611,593	$0	$4,611,593	($3,939,225)	($3,926,452)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Letternote Text Revision Required? Yes ___ No X

If Yes, describe the Letternote Text Revision:

Cash or Federal Fund Name and CORE Fund Number: CF: Old Age Pension State Medical Program Fund (28P0)

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: N/A

Other Information:

Cost and FTE

- FY 2016-17: the Department requests a reduction of $3,939,225 total funds, consisting entirely of cash funds from the Old Age Pension Health and Medical Care Fund; and
- FY 2017-18 and ongoing: the Department requests a reduction of $3,926,452 total funds from cash funds from the Old Age Pension Health and Medical Care Fund.
- The decrease in funding will allow the Department's budget to more accurately reflect the forecasted expenditures in the Old Age Pension Health and Medical Care Program, otherwise known as the OAP State Only (OAP-SO) Medical Care Program.

Current Program

- The OAP-SO program provides limited medical care for Coloradans who are recipients of benefits through Colorado's Old Age Pension Cash Assistance Program, administered by the Department of Human Services. The OAP-SO program is 100% State-funded and is not a federal entitlement.
- Eligible recipients for the OAP-SO program benefits are over the age of sixty and are ineligible for Medicaid.
- The OAP-SO program is currently funded through the Old Age Pension Health and Medical Care Fund established in Article XXIV of the Colorado Constitution, Section 7(C), and section 25.5-2-101 C.R.S.

Problem or Opportunity

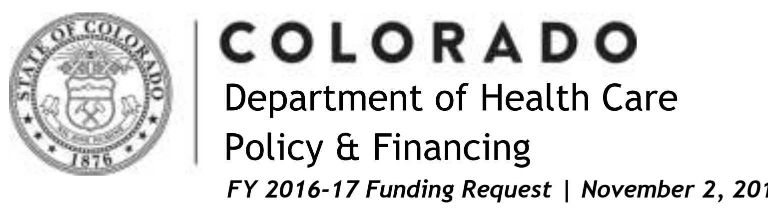
- Caseload and expenditures for OAP-SO Program have decreased significantly primarily resulting from new provisions of SB 13-200 which expand Medicaid eligibility to clients previously eligible for OAP-SO, and as a result the appropriation is much larger than necessary to support the costs of the program.
- The caseload and costs have shifted to the Medical Services Premiums line where State obligation of costs is less due to the federal financial participation through Medicaid.

Consequences of Problem

- Without a funding adjustment, the Department's spending authority will exceed the program's forecasted expenditures.

Proposed Solution

- The Department requests a reduction in funding to align the Department's appropriation with the forecasted expenditures in the OAP-SO program.



John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-9
Request Detail: Old Age Pension State Medical Program Funding Adjustment

Summary of Incremental Funding Change for FY 2016-17	Total Funds	General Fund
Old Age Pension State Medical Program	($3,939,225)	$0

Problem or Opportunity:

Caseload and expenditures for the Old Age Pension (OAP) Health and Medical Program, also known as the OAP State Only (OAP-SO) Medical Program, have decreased significantly, and as a result the appropriation is much larger than necessary to support the costs of the program.

In accordance with the Constitution of Colorado, Article XXIV, Section 7, the OAP-SO program was established to provide necessary medical care for Old Age Pension Cash Assistance recipients, 60 years of age or older, who do not qualify for Medicaid under Title XIX of the Social Security Act and Colorado statutes. State funded benefits provided through the OAP-SO program are comparable to those provided through the Medicaid program.

The OAP-SO program is funded with cash funds from the Old Age Pension Health and Medical Care Fund established in Article XXIV of the Colorado Constitution and 25.5-2-101 C.R.S. The OAP Health and Medical Fund cannot exceed ten million dollars in any fiscal year. Funds in excess of ten million dollars in any fiscal year are to be transferred to the General Fund.

The primary factor driving the OAP-SO caseload reduction is due to a change through SB 13-200, “Concerning an Increase in the Income Eligibility for Certain Optional Groups in the Medicaid Program to One Hundred Thirty-three Percent Of The Federal Poverty Line”, which expanded Medicaid eligibility to individuals under 65 years of age with income below 133 percent of the federal poverty level (FPL), effective January 1, 2014. This change shifted the caseload and costs of medical services for many of the OAP-SO clients to the Medical Services Premiums Long Bill line item where the State funding obligation is less. Another factor affecting caseload is the implementation of a provision of HB 10-1384 “Concerning the Alignment of Eligibility of the Old Age Pension with Eligibility of Other Public Benefit Programs”.

The OAP-SO caseload dropped from 2,878 in December 2013 to 693 in January 2014. There has been considerable caseload fluctuation from month to month. Since January 1, 2014, the caseload declined to a low of 62 clients in February 2015, but has since then been growing at an average of 7.5 clients per month through June 2015. The FY 2014-15 OAP-SO average monthly caseload was 147 clients.

Proposed Solution:

The Department requests a reduction of $3,939,225 in cash funds in FY 2016-17, and a reduction of $3,926,452 in cash funds in FY 2017-18 in the (6) Other Medical Services, Old Age Pension State Medical Program line item. The cash funds are from the Old Age Pension Health and Medical Care Fund.

Anticipated Outcomes:

This line item reduction would align the Department's budget with the current expenditure forecast for the program and allow any funds in excess the ten million dollar OAP Health and Medical Fund cap to transfer to the General Fund for other purposes to be determined by the Colorado Legislature.

Assumptions and Calculations:

Detailed calculations for this request are provided in the attached appendix.

Tables 1.1 and 1.2 show the summary of the total reduction requested with funding splits for FY 2016-17 and FY 2017-18, respectively.

Tables 2.1 and 2.2 show the calculations to determine the incremental request for FY 2016-17 and FY 2017-18, respectively. There are no federal funds associated with this program as the entirety of the program is funded from the Old Age Pension Health & Medical Care Cash Fund. Row E shows the FY 2016-17 Base Request which includes $2,962,510 in General Fund for the Colorado Dental Health Care (CDHC) program and $4,611,593 for the OAP-SO Program. The CDHC program is new, effective July 1, 2015. There is insufficient information to make new projections for the CDHC program; therefore, the Department is maintaining the FY 2016-17 and FY 2017-18 amount shown in Row C for that program at the FY 2015-16 appropriation. The incremental request for the appropriation, shown in Row F, is determined by taking the total program forecast in Row D and subtracting the amount of the Base Request in Row E. Row B provide the amount of OAP-SO funds that are reappropriated from OAP State Medical Program line to other HCPF line items further detailed in table 4., which includes the Medicaid Management Information System (MMIS) and the Medical Identification Cards lines.

Table 3 shows the actual and forecasted caseload and expenditures from FY 2011-12 through FY 2017-18. A projected caseload increase of three clients per year during this forecast period is consistent with the Department's growth rate forecasts for the OAP-A and OAP-B Medicaid populations, which when combined, reflect similar segments of Colorado's elderly population and provide a proxy for the growth rate in the OAP-SO program. The projected per capita of $3,743.79 for FY 2016-17 and FY 2017-18 is based on the highest per capita for the program in recent years from FY 2013-14 ($3,652.12), factoring in the 2.0 percent provider rate increase from FY 2014-15 and the 0.5 percent provider rate increase for FY 2015-16. Due to the erratic fluctuations in monthly caseload and expenditures over the past two fiscal years, the Department is using a more generous per capita estimate to obtain sufficient spending authority as to avoid overexpenditure in the program.

Table 1.1 FY 2016-17 Summary by Line Item with Fund Splits			
Item	**Total Funds**	**Cash Funds[1]**	**Source**
(6) Other Medical Services, Old Age Pension State Medical Program	($3,939,225)	($3,939,225)	Table 2.1 Row E

[1] Old Age Pension Health and Medical Care Fund

Table 1.2 FY 2017-18 Summary by Line Item with Fund Splits			
Item	**Total Funds**	**Cash Funds[1]**	**Source**
(6) Other Medical Services, Old Age Pension State Medical Program	($3,926,452)	($3,926,452)	Table 2.2 Row E

[1] Old Age Pension Health and Medical Care Fund

Table 2.1 FY 2016-17 Incremental Request					
Row	**Description**	**Total Funds**	**General Fund**	**Old Age Pension Health & Medical Care Fund**	**Source**
A	OAP-SO Program Expenditures	$572,794	$0	$572,794	Table 3, Row E (FY 2016-17)
B	Administrative Expenditures Reappropriated to Other HCPF Lines	$99,574	$0	$99,574	Table 4, Row C (FY 2016-17)
C	Colorado Dental Health Program for Low-Income Seniors	$2,962,510	$2,962,510	$0	FY 2015-16 GF Appropriation (SB 15-234)
D	**Total Line Item Forecast**	**$3,634,878**	**$2,962,510**	**$672,368**	Row A + Row B + Row C
E	FY 2016-17 Base Request	$7,574,103	$2,962,510	$4,611,593	FY 2015-16 Appropriation (SB 15-234)
F	**Incremental Request**	**($3,939,225)**	**$0**	**($3,939,225)**	Row D - Row E

Table 2.2 FY 2017-18 and Ongoing Incremental Request					
Row	**Description**	**Total Funds**	**General Fund**	**Old Age Pension Health & Medical Care Fund**	**Source**
A	OAP-SO Program Expenditures	$585,567	$0	$585,567	Table 3, Row E (FY 2017-18)
B	Administrative Expenditures	$99,574	$0	$99,574	Table 4, Row C (FY 2017-18)
C	Colorado Dental Health Program for Low-Income Seniors	$2,962,510	$2,962,510	$0	FY 2015-16 GF Appropriation (SB 15-234)
D	**Total Line Item Forecast**	**$3,647,651**	**$2,962,510**	**$685,141**	Row A + Row B + Row C
E	FY 2016-17 Base Request	$7,574,103	$2,962,510	$4,611,593	FY 2015-16 Appropriation (SB 15-234)
F	**Incremental Request**	**($3,926,452)**	**$0**	**($3,926,452)**	Row D - Row E

Table 3
OAP-SO Program Expenditure Forecast

Row	Description	FY 2012-13 Actuals	FY 2013-14 Actuals	FY 2014-15 Actuals	FY 2015-16 Projected	FY 2016-17 Projected	FY 2017-18 Projected	Source
A	Average Monthly Caseload	3,596	1,787	147	150	153	156	FY 2015-16, FY 2016-17 and FY 2017-18 caseload projections are based on growth rate of 3.22%[1]
B	% yearly change	-5.94%	-50.31%	-91.77%	1.86%	2.18%	2.23%	Yearly incremental of Average Monthly Caseload divided by prior year Average Monthy Caseload
C	Per Capita	$2,408.50	$3,652.12	$2,931.97	$3,743.79	$3,743.79	$3,743.79	FY 2015-16, FY 2016-17 and FY 2017-18 per capita projections are based on the FY 2013-14 per capita with FY 2014-15 and FY 2015-16 provider rate increases[2]
D	% yearly change	0.65%	51.63%	-19.72%	27.69%	0.00%	0.00%	Yearly incremental of Per Capita divided by prior year Per Capita
E	**Total Program Expenditures**	**$8,660,961**	**$6,526,336**	**$431,000**	**$560,573**	**$572,794**	**$585,567**	**Row A * Row C**

[1]From Department's caseload projections, using OAP-A & OAP-B (Medicaid) combined as proxy population, found in R-1 Medical Services Premium, November 2015 Budget Request

[2]The FY 2014-15 Medicaid provider rate increase was 2.0% and 0.5% for FY 2015-16.

Table 4
OAP-SO Administrative Expenditures

Row	Description	FY 2012-13 Actuals	FY 2013-14 Actuals	FY 2014-15 Actuals	FY 2015-16 Projected	FY 2016-17 Projected	FY 2017-18 Projected	Source
A	Medicaid Management Information System (MMIS)	$97,981	$89,817	$97,981	$97,981	$97,981	$97,981	FY 2013-14 & FY 2014-15: COFRS/CORE Year-end reports; FY 2015-16: Long Bill Appropriation (SB 15-234); FY 2016-17 & FY 2017-18 amounts are assumed to be identical to prior year
B	Medical Identification Cards	$1,593	$1,593	$1,593	$1,593	$1,593	$1,593	
C	**Total**	**$99,574**	**$91,410**	**$99,574**	**$99,574**	**$99,574**	**$99,574**	**Row A + Row B**

Cost and FTE

- The Department estimates that it will require $35,367,854 total funds, including $20,067,127 General fund in FY 2015-16 and $74,436,815 total funds, including $42,479,001 General fund in FY 2016-17 to account for the potential increase to the Medicare Part B premiums as well as an increase to Medicare deductibles by 52 percent. This funding is for FY 2015-16 and FY 2016-17 and does not require additional FTE.

Current Program

- The Department currently pays premiums for Medicare Part B and in some cases Part A for clients who are dually eligible for both Medicaid and Medicare.
- The Department also pays coinsurance for these clients, so any changes to the required deductibles for these clients are the responsibility of the Department.

Problem or Opportunity

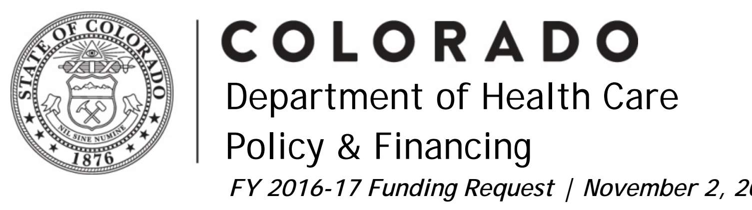
- As proposed in the 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, Medicare Part B premiums may increase by about 52 percent, from $104.90 in calendar year 2015 to $159.30 in calendar year 2016.
- Long-term medical costs related to Medicare beneficiaries are expected to increase significantly; in order to ensure there is sufficient revenue to meet projected expenses in future years, the trustees are recommending an increase to premiums beginning January 1, 2016.
- The Department pays coinsurance and premiums for the dually eligible population and if the premiums rise, the Department will be responsible for covering the cost increases.

Consequences of Problem

- A premium increase of this magnitude will require the Department to use General Fund to fund a significant portion of the increase.
- If the problem is not addressed, the Department risks a significant General Fund over expenditure.

Proposed Solution

- The Department proposes to increase the appropriation for Medical Services Premiums by $35,367,854 total funds, $20,067,127 General Fund in FY 2015-16 and $74,436,815 total funds, $42,479,001 General Fund in FY 2016-17 in order to pay the State's portion of Medicare premiums and deductibles should the current levels increase by what the trustees propose.



COLORADO
Department of Health Care
Policy & Financing
FY 2016-17 Funding Request | November 2, 2015

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-1I
Request Detail: Supplemental Medicare Insurance Benefit Increase

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Supplemental Medicare Insurance Benefit Increase	$35,367,854	$20,067,127

Summary of Incremental Funding Change for FY 2016-17	Total Funds	General Fund
Supplemental Medicare Insurance Benefit Increase	$74,436,815	$42,479,001

Problem or Opportunity:

On July 22, 2015, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance recommended an increase of about 52% to Medicare Part B premiums as well as increasing Medicare deductibles by 52%. The Department currently pays the Medicare premiums for a subset of the Medicaid population that is dually eligible for both Medicare and Medicaid through the Qualified Medicare Beneficiary (QMB) program as well as deductibles and coinsurance for some clients.

The Department makes these payments as required by federal law under 42 CFR 431.625(d)(3) and failure to do so results in the loss of federal financial participation[1]. In the Department's FY 2016-17 R-1 "Request for Medical Service Premiums", the methodology used for forecasting expenditure for Medicare premiums (referred to as the "Supplemental Medicare Insurance Benefit, or SMIB) takes the prior year expenditure and inflates it by projected caseload growth as well as projected growth in Medicare Part B Premiums. According to the Kaiser Family Foundation forecast[2] from January 2014, which was the basis for the R-1 request, premiums were projected to rise about 5.5% to $110.70 in calendar year 2016. There had been no formal guidance on where premiums should be set for 2016 until the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance annual report was released in July. The report

[1] No FFP is available in State Medicaid expenditures that could have been paid for under Medicare Part B but were not because the person was not enrolled in Part B. This limit applies to all beneficiaries eligible for enrollment under Part B, whether individually or through an agreement under section 1843(a) of the Act. However, FFP is available in expenditures required by §§ 435.914 and 436.901 of this subchapter for retroactive coverage of beneficiaries.

[2] See table 3 from http://kff.org/report-section/raising-medicare-premiums-for-higher-income-beneficiaries-assessing-the-implications-tables/

recommended that Medicare Part B premiums and Medicare deductibles increase by about 52% over 2015 levels. This increase is to ensure that the fund stays solvent with the projected increase to medical costs expected to be paid out. This recommendation results in Medicare Part B premiums increasing from $104.90 in 2015 to $159.30 in 2016 and Medicare deductibles increasing from $147.00 in 2015 to $223.00 in 2016. Not only would the increase in premiums affect the Department, but the increase to the Part B deductibles would also result in significant cost increases. As a result of the increase, the Department would incur costs based on the difference in the deductible.

At this time, the proposed increases have not been finalized. There is still uncertainty on where the federal government will set the Medicare Part B premiums and deductibles and a final decision is not expected until after the November 1 budget request is final.

Proposed Solution:

The Department estimates that it will require $35,367,854 total funds including $20,067,127 General Fund in FY 2015-16 and $74,436,815 total funds including $42,479,001 General Fund in FY 2016-17 to pay for the cost of the benefit and reduce the likelihood of an over expenditure to the Medical Services Premiums line. Costs for FY 2017-18 and future years would be requested through the regular budget process. If the premiums are set at the level identified by the Board of Trustees' report, the Department would be at risk of significant over expenditure without additional appropriations.

Anticipated Outcomes:

The Department anticipates that the requested funds would be sufficient to cover the increase in costs if Medicare premiums and deductibles were increased as proposed in the Board of Trustees' annual report.

Assumptions and Calculations:

Assumptions

Supplemental Medicare Insurance Benefit (SMIB)

Calculations for SMIB can be found in Tables 2 and 3.1-3.4. The Department assumes that the 2016 Medicare Part B premiums would be set at $159.30, which is based on the recommendation made in the 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance. Calendar year 2017 premiums would increase by 4.25%, which is the projected growth from 2016 to 2017 in the Kaiser Family Foundation Report. The Department assumed that the 2016 Part B premium would increase to $110.70 in the FY 2016-17 R-1 "Request for Medical Services Premiums", so the incremental increase would be the difference of $159.30 and $110.70. The Department calculations utilize the same methodology as the FY 2016-16 R-1, and includes the same assumptions for caseload growth and fund splits. Calculations for FY 2015-16 and FY 2016-17 expenditure with both old and new premiums can be found in Tables: 3.1-3.4. For detailed information on caseload and fund split assumptions, see pages 63-64 in FY 2016-17 R-1 narrative.

Coinsurance

Calculations for coinsurance can be found in Table 4. The Department assumes that coinsurance related expenditure in FY 2015-16 and FY 2016-17 would remain at the FY 2014-15 level and make up 1.59% of total Acute Care expenditure. The Department also assumed that the estimated clients would grow at the rate

of total coinsurance expenditure, which is 12.75% and 1.01% in FY 2015-16 and FY 2016-17, respectively. The Department assumes that Medicare Part B deductibles would increase to $223.00 in January 2016, which is the recommended increase from the 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance. Prior to the deductibles being met, the Department assumed it would pay 100% of the medical costs. After deductibles are met, the Department assumes it would pay the 20% coinsurance on additional expenditure. As a result, the Department assumes that the incremental increase would be 80% of the difference in premiums.

For detailed calculations, please see attached exhibits.

Table 1a: Calculation of Fund Splits by Fiscal Year

Row	Fiscal Year	Total Funds	General Fund	Cash Funds	Federal Funds	FMAP	Source / Notes
A	FY 2015-16	$35,367,854	$20,067,127	$0	$15,300,727	43.26%	Table 1b: Row A + Row B
B	FY 2016-17	$74,436,815	$42,479,001	$0	$31,957,814	42.93%	Table 1c: Row A + Row B

Table 1b: Calculation of FY 2015-16 Fund Splits

Row	Item	Total Funds	General Fund	Cash Funds	Federal Funds	FMAP	Source / Notes
A	SMIB	$33,821,832	$19,306,330	$0	$14,515,502	42.92%	Table 2: Row C
B	Coinsurance	$1,546,022	$760,797	$0	$785,225	50.79%	Table 4: Row I

Table 1c: Calculation of FY 2016-17 Fund Splits

Row	Item	Total Funds	General Fund	Cash Funds	Federal Funds	FMAP	Source / Notes
A	SMIB	$71,313,580	$40,930,501	$0	$30,383,079	42.60%	Table 2: Row C
B	Coinsurance	$3,123,235	$1,548,500	$0	$1,574,735	50.42%	Table 4: Row I

Table 2: Calculation of Incremental Request

Row	Item	FY 2015-16	FY 2016-17	Source / Notes
A	Estimated Expenditure with $110.30 Premium	$148,443,165	$162,436,498	Tables 3.1 & 3.3 Row I
B	Estimated Expenditure with $159.30 Premium	$182,264,997	$233,750,078	Tables 3.2 & 3.4 Row I
C	Incremental Difference	$33,821,832	$71,313,580	Row B - Row A

Table 3.1: Calculation of FY 2015-16 Expenditure With Premium From FY 2016-17 R-1

Row	Item	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	Partial Dual Eligibles	TOTAL
A	FY 2014-15 Expenditure	$73,205,694	$4,268,933	$38,373,381	$240,024	$21,183,050	$137,271,082
B	FY 2014-15 First Half Expenditure	$35,932,530	$2,095,377	$18,835,319	$117,814	$10,397,559	$67,378,599
C	FY 2014-15 Second Half Expenditure	$37,273,164	$2,173,556	$19,538,062	$122,210	$10,785,491	$69,892,483
D	Estimated FY 2015-16 First Half Caseload Trend	0.48%	2.72%	1.77%	5.83%	8.54%	-
E	Estimated FY 2015-16 First Half Expenditure	$37,452,075	$2,232,677	$19,883,886	$129,335	$11,706,572	$71,404,545
F	Estimated FY 2015-16 Second Half Caseload Trend	0.48%	2.72%	1.76%	5.82%	8.54%	-
G	Estimated Increase in Medicare Part B Premium for CY 2016	5.53%	5.53%	5.53%	5.53%	5.53%	-
H	Estimated FY 2015-16 Second Half Expenditure	$39,712,538	$2,420,210	$21,352,587	$144,430	$13,408,855	$77,038,620
I	Estimated FY 2015-16 Total Expenditure	$77,164,613	$4,652,887	$41,236,473	$273,765	$25,115,427	$148,443,165

Table 3.2: Calculation of FY 2015-16 Expenditure With New Premium

Row	Item	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	Partial Dual Eligibles	TOTAL
A	FY 2014-15 Expenditure	$73,205,694	$4,268,933	$38,373,381	$240,024	$21,183,050	$137,271,082
B	FY 2014-15 First Half Expenditure	$35,932,530	$2,095,377	$18,835,319	$117,814	$10,397,559	$67,378,599
C	FY 2014-15 Second Half Expenditure	$37,273,164	$2,173,556	$19,538,062	$122,210	$10,785,491	$69,892,483
D	Estimated FY 2015-16 First Half Caseload Trend	0.48%	2.72%	1.77%	5.83%	8.54%	-
E	Estimated FY 2015-16 First Half Expenditure	$37,452,075	$2,232,677	$19,883,886	$129,335	$11,706,572	$71,404,545
F	Estimated FY 2015-16 Second Half Caseload Trend	0.48%	2.72%	1.76%	5.82%	8.54%	-
G	Estimated Increase in Medicare Part B Premium for CY 2016	51.86%	51.86%	51.86%	51.86%	51.86%	-
H	Estimated FY 2015-16 Second Half Expenditure	$57,147,311	$3,482,741	$30,726,893	$207,838	$19,295,669	$110,860,452
I	Estimated FY 2015-16 Total Expenditure	$94,599,386	$5,715,418	$50,610,779	$337,173	$31,002,241	$182,264,997

Table 3.3: Calculation of FY 2016-17 Expenditure With Premium From FY 2016-17 R-1

Row	Item	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	Partial Dual Eligibles	TOTAL
A	FY 2015-16 Estimated Expenditure	$77,164,613	$4,652,887	$41,236,473	$273,765	$25,115,427	$148,443,165
B	FY 2015-16 First Half Estimated Expenditure	$37,452,075	$2,232,677	$19,883,886	$129,335	$11,706,572	$71,404,545
C	FY 2015-16 Second Half Estimated Expenditure	$39,712,538	$2,420,210	$21,352,587	$144,430	$13,408,855	$77,038,620
D	Estimated FY 2016-17 First Half Caseload Trend	0.73%	2.49%	1.94%	3.49%	6.40%	-
E	Estimated FY 2016-17 First Half Expenditure	$40,002,440	$2,480,473	$21,766,827	$149,471	$14,267,022	$78,666,233
F	Estimated FY 2016-17 Second Half Caseload Trend	0.72%	2.49%	1.94%	3.49%	6.39%	-
G	Estimated Increase in Medicare Part B Premium for CY 2017	4.25%	4.25%	4.25%	4.25%	4.25%	-
H	Estimated FY 2016-17 Second Half Expenditure	$42,002,802	$2,650,282	$23,132,140	$161,262	$15,823,779	$83,770,265
I	Estimated FY 2016-17 Total Expenditure	$82,005,242	$5,130,755	$44,898,967	$310,733	$30,090,801	$162,436,498

Table 3.4: Calculation of FY 2016-17 Expenditure With New Premium

Row	Item	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	Partial Dual Eligibles	TOTAL
A	FY 2015-16 Estimated Expenditure	$94,599,386	$5,715,418	$50,610,779	$337,173	$31,002,241	$182,264,997
B	FY 2015-16 First Half Estimated Expenditure	$37,452,075	$2,232,677	$19,883,886	$129,335	$11,706,572	$71,404,545
C	FY 2015-16 Second Half Estimated Expenditure	$57,147,311	$3,482,741	$30,726,893	$207,838	$19,295,669	$110,860,452
D	Estimated FY 2016-17 First Half Caseload Trend	0.73%	2.49%	1.94%	3.49%	6.40%	-
E	Estimated FY 2016-17 First Half Expenditure	$57,564,486	$3,569,461	$31,322,995	$215,092	$20,530,592	$113,202,626
F	Estimated FY 2016-17 Second Half Caseload Trend	0.72%	2.49%	1.94%	3.49%	6.39%	-
G	Estimated Increase in Medicare Part B Premium for CY 2017	4.25%	4.25%	4.25%	4.25%	4.25%	-
H	Estimated FY 2016-17 Second Half Expenditure	$60,443,056	$3,813,820	$33,287,714	$232,059	$22,770,803	$120,547,452
I	Estimated FY 2016-17 Total Expenditure	$118,007,542	$7,383,281	$64,610,709	$447,151	$43,301,395	$233,750,078

Table 4: Calculation of Incremental Request by Fiscal Year

Row	Item	FY 2014-15	FY 2015-16	FY 2016-17	Source / Notes
A	Estimated Acute Care Expenditure	$3,330,337,193	$3,754,885,211	$3,792,725,695	From FY 2016-17 R-1 "Request for Medical Services Premiums".
B	Coinsurance as a percentage of Acute Care	1.59%	1.59%	1.59%	FY 2014-15 actual held constant.
C	Estimated Coinsurance Expenditure	$52,863,038	$59,601,965	$60,202,613	Row A * Row B
D	Growth in Coinsurance Expenditure	-	12.75%	1.01%	Row C: (Current Year / Prior Year - 1)
E	Estimated Clients	45,106	50,856	51,369	(1 + Row D: Current Year) * Row E : Prior Year
F	Average Cost per client	$1,171.97	$1,171.98	$1,171.96	Row C / Row E
G	Deductible	$147.00	$185.00	$223.00	Projected deductible from 2015 Trustees Annual Report.
H	Additional cost from new policy	$0	$30.40	$60.80	Row F: (Current Year - Prior Year) * .80
I	Estimated Incremental Cost	$0	$1,546,022	$3,123,235	Row E * Row G

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-11 Decreased FMAP

Dept. Approval By: Josh Block [signature] 11/2/15

OSPB Approval By: [signature] 10/28/15

	Supplemental FY 2015-16
X	Change Request FY 2016-17
	Base Reduction FY 2016-17
	Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$140,948,230	$0	$140,667,328	$0	$0
	FTE	$0	0.0	$0	0.0	0.0
	GF	$65,949,527	$0	$65,926,162	$538,543	$0
	CF	$1,866,142	$0	$1,866,142	$0	$0
	RF	$1,481,221	$0	$1,483,428	$8,930	$0
	FF	$71,651,340	$0	$71,391,596	($547,473)	$0

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
01. Executive Director's Office - Nurse Home Visitor Program, Transfer from CDHS	Total	$3,010,000	$0	$3,010,000	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$1,481,221	$0	$1,483,428	$8,930	$0
	FF	$1,528,779	$0	$1,526,572	($8,930)	$0
05. Indigent Care Program - Clinic Based Indigent Care	Total	$6,119,760	$0	$6,119,760	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,011,534	$0	$3,012,197	$21,980	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,108,226	$0	$3,107,563	($21,980)	$0

05. Indigent Care Program - Pediatric Specialty Hospital	**Total**	**$13,455,012**	**$0**	**$13,455,012**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,621,212	$0	$6,622,669	$48,326	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$6,833,800	$0	$6,832,343	($48,326)	$0
06. Other Medical Services - Commission on Family Medicine Residency Training Programs	**Total**	**$8,145,188**	**$0**	**$8,145,188**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,013,374	$0	$4,017,335	$21,049	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,131,814	$0	$4,127,853	($21,049)	$0
06. Other Medical Services - Teaching Hospital -- Denver Health and Hospital Authority	**Total**	**$2,804,714**	**$0**	**$2,804,714**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,380,200	$0	$1,379,896	$10,681	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,424,514	$0	$1,424,818	($10,681)	$0
06. Other Medical Services - Teaching Hospital -- University of Colorado Hospital	**Total**	**$633,314**	**$0**	**$633,314**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$311,654	$0	$312,118	$1,879	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$321,660	$0	$321,196	($1,879)	$0
07. Department of Human Services Medicaid-Funded Programs - Executive Director's Office - Medicaid Funding	**Total**	**$16,709,224**	**$0**	**$15,609,321**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$8,223,190	$0	$7,738,678	$48,631	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$8,486,034	$0	$7,870,643	($48,631)	$0
07. Department of Human Services Medicaid-Funded Programs - Other Office Of Information Technology Services Line Items	**Total**	**$647,220**	**$0**	**$639,584**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$318,950	$0	$316,717	$3,495	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$328,270	$0	$322,867	($3,495)	$0

07. Department of Human Services Medicaid-Funded Programs - Office Of Operations - Medicaid Funding	Total	$5,060,008	$0	$5,141,869	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,493,572	$0	$2,539,297	$10,385	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,566,436	$0	$2,602,572	($10,385)	$0
07. Department of Human Services Medicaid-Funded Programs - Child Welfare Services	Total	$15,222,606	$0	$15,222,606	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,491,045	$0	$7,501,704	$45,664	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$7,731,561	$0	$7,720,902	($45,664)	$0
07. Department of Human Services Medicaid-Funded Programs - Div of Comm. and Family Support, Early Intervention Services	Total	$5,928,683	$0	$5,928,683	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,917,590	$0	$2,920,876	$21,851	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,011,093	$0	$3,007,807	($21,851)	$0
07. Department of Human Services Medicaid-Funded Programs - Mental Health Treatment Services for Youth (H.B. 99-1116)	Total	$123,624	$0	$123,624	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$60,836	$0	$60,925	$368	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$62,788	$0	$62,699	($368)	$0
07. Department of Human Services Medicaid-Funded Programs - High Risk Pregnant Women Program	Total	$1,600,000	$0	$1,605,306	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$787,360	$0	$791,039	$4,872	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$812,640	$0	$814,267	($4,872)	$0
07. Department of Human Services Medicaid-Funded Programs - Mental Health Institutes	Total	$6,000,000	$0	$6,000,000	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,952,600	$0	$2,957,000	$43,000	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,047,400	$0	$3,043,000	($43,000)	$0

07. Department of Human Services Medicaid-Funded Programs - Regional Centers	Total	$52,774,028	$0	$53,513,498	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$24,029,264	$0	$24,415,642	$250,210	$0
	CF	$1,866,142	$0	$1,866,142	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$26,878,622	$0	$27,231,714	($250,210)	$0
07. Department of Human Services Medicaid-Funded Programs - Regional Center Depreciation and Annual Adjustments	Total	$1,044,544	$0	$1,044,544	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$514,020	$0	$514,704	$3,181	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$530,524	$0	$529,840	($3,181)	$0
07. Department of Human Services Medicaid-Funded Programs - Division Of Youth Corrections - Medicaid Funding	Total	$1,670,305	$0	$1,670,305	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$823,126	$0	$825,365	$2,971	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$847,179	$0	$844,940	($2,971)	$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: DHS, Nurse Home Visitor Program

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

Schedule 13s from Affected Departments: DHS

Other Information:

Cost and FTE

- The Department requests an increase of $0 total funds, including an increase of $538,543 General Fund, $8,930 reappropriated funds and a decrease of $547,473 in federal funds for FY 2016-17.

Current Program

- Pursuant to Section 1905(b) of the Social Security Act, a state's FMAP is a function of the state's per capita personal income relative to national per capita personal incomes.
- FMAP is determined by the Secretary of Health and Human Services each year; historically, Colorado's FMAP has been 50%, with the exception of years when the FMAP was temporarily increased to combat the effects of recession and, most recently, FY 2014-15 when the FMAP was increased because the State's per capita personal income was below the national average.

Problem or Opportunity

- The Department anticipates a decrease of 0.30% points to its FMAP, resulting in an FMAP of 50.42% respectively effective October 2016 through September 2017.
- The decrease in FMAP is not accounted for in several line items in the November 1, 2015 request. These line items are from the (1) Executive Director's Office, (5) Indigent Care Program, (6) Other Medical Services, and (7) Department of Human Services Medicaid-Funded Programs Long Bill groups.

Consequences of Problem

- The previously assumed FMAP of 50.72% for FY 2016-17 understates General Fund and cash funds need, and, additional State funding is necessary to continue providing services for Medicaid clients.

Proposed Solution

- The Department requests a decrease in the federal funds appropriation and an increase in General Fund and reappropriated funds for FY 2016-17 to account for the decreased FMAP.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2016-17 Funding Request | November 2, 2015

Department Priority: ***R-11***
Request Detail: ***Decreased Federal Medical Assistance Percentage***

Summary of Incremental Funding Change for FY 2016-17	Total Funds	General Fund
Decreased Federal Medical Assistance Percentage	$0	$538,543

Problem or Opportunity:

Currently, the Federal Medical Assistance Percentage (FMAP) is 50.72% for most Medicaid programs. Pursuant to section 1905(b) of the Social Security Act, a state's FMAP is a function of the state's per capita personal income relative to national per capita personal incomes. Each state's FMAP is evaluated annually and can range from 50.00% to 83.00%. Based on information from the Bureau of Economic Analysis, the Department estimates an FMAP of 50.42% for FY 2016-17.

In FY 2013-14, the Department received notification from CMS of an increased FMAP for FFY 2014-15, primarily due to the income losses experienced in Colorado during the recession. According to income data released by the Bureau of Economic Analysis, Colorado experienced a larger per capita personal income decline in 2009 than the nation overall, and a smaller growth rate in 2010. This caused the gap between Colorado's per capita personal income and the national per capita personal income to shrink; although Colorado's per capita personal income had grown faster than the national average in 2011 and 2012, the declines from prior years triggered an increase in FMAP for FFY 2014-15. Because the formula to calculate the State's FMAP and eFMAP uses the average of the most recent three years of per capita income, the declines related to the recession are no longer a factor in the FMAP calculation.[1] Consequently, the State's FMAP is expected to return to 50.00% over time.

[1] The formula for FMAP is: $\text{FMAP}_{state} = 1 - \left[\left(\frac{Per\ Capita\ Income_{Colorado}{}^2}{Per\ Capita\ Income_{U.S.}{}^2}\right) \times 0.45\right]$. The per capita income statistics are the average of the most recent 3 years of data published by the Bureau of Economic Analysis

Per Capita Personal Income 2006-2014				
Year	**National**	**Percent Change**	**Colorado**	**Percent Change**
2006	$38,127		$40,611	
2007	$39,804	4.40%	$42,174	3.85%
2008	$40,873	2.69%	$43,377	2.85%
2009	$39,379	-3.66%	$41,518	-4.29%
2010	$40,144	1.94%	$41,689	0.41%
2011	$42,332	5.45%	$44,183	5.98%
2012	$44,200	4.41%	$46,315	4.83%
2013	$44,765	1.28%	$46,897	1.26%
2014	$46,129	3.05%	$48,730	3.91%

Source: Bureau of Economic Analysis, SA1-3 Personal Income Summary

Proposed Solution:

The Department requests an increase in State funding due to the decrease in FMAP to continue to provide services for Medicaid clients. This specific request only accounts for line items in which the new FMAP is not factored into the line item's respective November 1, 2015 request. The Decreased Federal Medical Assistance Percentage (FMAP) request accounts for changes in FMAP for certain line items from the (1) Executive Director's Office, (5) Indigent Care Program, (6) Other Medical Services, (7) Department of Human Services Medicaid-Funded Programs. Line items from (2) Medical Services Premiums, (3) Behavioral Health Community Programs, (4) Office of Community, and the Child Health Plan Plus already fully account for the decrease in FMAP in their respective November 1, 2015 requests.

The Department requests an increase of $0 total funds, including an increase of $538,543 General Fund, and $8,930 reappropriated funds and a decrease of $547,473 federal funds for FY 2016-17.

Anticipated Outcomes:

Additional funding is required for the Department to continue providing services to Medicaid clients.

Assumptions and Calculations:

The Department assumes that only medical assistance payments will be eligible for the increased FMAP; expenditure classified as administrative is ineligible. It is unclear how the relationship between Colorado's per capita personal income and national personal per capita income may change in the future. Therefore, the Department anticipates that it would use the regular budget process in subsequent years to account for any future changes to FMAP.

Please see the Appendix for detailed calculations.

Table 1.1 - FY 2016-17 Impact of Decreased FMAP by Long Bill Line Item								
Row	**Summary of Request FY 2015-16**	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source/Comments**
A	(1) Executive Director's Office (B) Transfers to Other Departments; Transfer from Department of Human Services for Nurse Home	$0	$0	$0	$0	$8,930	($8,930)	Table 4.1 Row A
B	(5) Indigent Care Programs; Clinic Based Indigent Care	$0	$21,980	$0	$0		($21,980)	Table 4.2 Row A
C	(5) Indigent Care Programs; Pediatric Specialty Hospital	$0	$48,326	$0	$0		($48,326)	Table 4.2 Row B
D	(6) Other Medical Services; Commission on Family Medicine Residency Training Programs	$0	$21,049	$0	$0	$0	($21,049)	Table 4.3 Row A
E	(6) Other Medical Services; State University Teaching Hospitals - Denver Health and Hospital Authority	$0	$10,681	$0	$0	$0	($10,681)	Table 4.3 Row B
F	(6) Other Medical Services; State University Teaching Hospitals - University of Colorado Hospital Authorit	$0	$1,879	$0	$0	$0	($1,879)	Table 4.3 Row C
G	(7) Department of Human Services (A) Executive Director's Office Medicaid Funding	$0	$48,631	$0	$0	$0	($48,631)	Table 4.4 Row A
H	(7) Department of Human Services (B) Office of Information Technology Services - Medicaid Funding; Other Office of Information Technology Services line item	$0	$3,495	$0	$0	$0	($3,495)	Table 4.4 Row B
I	(7) Department of Human Services (C) Office of Operations - Medicaid Funding	$0	$10,385	$0	$0	$0	($10,385)	Table 4.4 Row C
J	(7) Department of Human Services (D) Division of Child Welfare - Medicaid Funding; Child Welfare Service	$0	$45,664	$0	$0	$0	($45,664)	Table 4.4 Row D
K	(7) Department of Human Services (E) Office of Early Childhood - Medicaid Funding; Division of Community and Family Support, Early Intervention Services	$0	$21,851	$0	$0	$0	($21,851)	Table 4.4 Row E
L	(7) Department of Human Services (G) Behavioral Health Services Medicaid Funding; Mental Health Treatment Services for Youth (H.B. 99-1116)	$0	$368	$0	$0	$0	($368)	Table 4.4 Row F
M	(7) Department of Human Services (G) Behavioral Health Services Medicaid Funding; High Risk Pregnant Women Program	$0	$4,872	$0	$0	$0	($4,872)	Table 4.4 Row G
N	(7) Department of Human Services (G) Behavioral Health Services Medicaid Funding; Mental Health Institution	$0	$43,000	$0	$0	$0	($43,000)	Table 4.4 Row H
O	(7) Department of Human Services (H) Services for People with Disabilities - Medicaid Funding; Regional Center	$0	$250,210	$0	$0	$0	($250,210)	Table 4.4 Row I
P	(7) Department of Human Services (H) Services for People with Disabilities - Medicaid Funding; Regional Center Depreciation and Annual Adjustments	$0	$3,181	$0	$0	$0	($3,181)	Table 4.4 Row J
Q	(7) Department of Human Services (J) Division of Youth Corrections - Medicaid Funding	$0	$2,971	$0	$0	$0	($2,971)	Table 4.4 Row K
R	**Total Impact**	**$0**	**$538,543**	**$0**	**$0**	**$8,930**	**($547,473)**	Sum of All Rows

Table 2.1: (1) Executive Director's Office
FY 2016-17 Base Appropriation

Row	Line Item	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
A	(B) Transfers to Other Departments; Transfer from Department of Human Services for Nurse Home Visitor Program	$3,010,000	$0	$0	$0	$1,483,428	$1,526,572
B	**(1) Executive Director's Office**	**$3,010,000**	**$0**	**$0**	**$0**	**$1,483,428**	**$1,526,572**

Table 2.2: (5) Indigent Care Program
FY 2016-17 Base Appropriation

Row	Population/Line Item	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
A	Clinic Based Indigent Care	$6,119,760	$3,012,197	$0	$0	$0	$3,107,563
B	Pediatric Specialty Hospital	$13,455,012	$6,622,669	$0	$0	$0	$6,832,343
C	**(5) Indigent Care Program Totals (minus CHP+)**	**$19,574,772**	**$9,634,866**	**$0**	**$0**	**$0**	**$9,939,906**

Table 2.3: (6) Other Medical Services
FY 2016-17 Base Appropriation

Row	Line Item	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
A	Commission on Family Medicine Residency Training Programs	$8,145,188	$4,017,335	$0	$0	$0	$4,127,853
B	State University Teaching Hospitals - Denver Health and Hospital Authority	$2,804,714	$1,379,896	$0	$0	$0	$1,424,818
C	State University Teaching Hospitals - University of Colorado Hospital Authority	$633,314	$312,118	$0	$0	$0	$321,196
D	**(6) Other Medical Services Totals**	**$11,583,216**	**$5,709,349**	**$0**	**$0**	**$0**	**$5,873,867**

Table 2.4: (7) Department of Human Services Medicaid-Funded Programs
FY 2016-17 Base Appropriation

Row	Line Item	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
A	(A) Executive Director's Office - Medicaid Funding	$16,709,224	$8,235,216	$0	$0	$0	$8,474,008
B	(B) Office of Information Technology Services - Medicaid Funding; Other Office of Information Technology Services line items	$647,220	$317,397	$0	$0	$0	$329,823
C	(C) Office of Operations - Medicaid Funding	$5,060,008	$2,498,367	$0	$0	$0	$2,561,641
D	(D) Division of Child Welfare - Medicaid Funding; Child Welfare Services	$15,222,606	$7,501,704	$0	$0	$0	$7,720,902
E	(E) Office of Early Childhood - Medicaid Funding; Division of Community and Family Support, Early Intervention Services	$5,928,683	$2,917,590	$0	$0	$0	$3,011,093
F	(G) Behavioral Health Services - Medicaid Funding; Mental Health Treatment Services for Youth (H.B. 99-1116)	$123,624	$60,925	$0	$0	$0	$62,699
G	(G) Behavioral Health Services - Medicaid Funding; High Risk Pregnant Women Program	$1,605,306	$791,039	$0	$0	$0	$814,267
H	(G) Behavioral Health Services - Medicaid Funding; Mental Health Institutions	$6,000,000	$2,957,000	$0	$0	$0	$3,043,000
I	(H) Services for People with Disabilities - Medicaid Funding; Regional Centers	$52,774,028	$24,049,011	$0	$1,866,142	$0	$26,858,875
J	(H) Services for People with Disabilities - Medicaid Funding; Regional Center Depreciation and Annual Adjustments	$1,044,544	$514,704	$0	$0	$0	$529,840
K	(J) Division of Youth Corrections - Medicaid Funding	$1,670,305	$825,365	$0	$0	$0	$844,940
L	**(7) Department of Human Services Medicaid-Funded Programs Totals**	**$106,785,548**	**$50,668,318**	**$0**	**$1,866,142**	**$0**	**$54,251,088**

Table 3.1: (1) Executive Director's Office
FY 2016-17 Totals with Updated FMAP

Row	Line Item	Total Funds	General Funds	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Match Rate
A	(B) Transfers to Other Departments; Transfer to Department of Public Health and Environment for Nurse Home Visitor Program	$3,010,000	$0	$0	$0	$1,492,358	$1,517,642	50.42%
B	**(1) Executive Director's Office**	**$3,010,000**	**$0**	**$0**	**$0**	**$1,492,358**	**$1,517,642**	**50.42%**

Table 3.2: (5) Indigent Care Program
FY 2016-17 Totals with Updated FMAP

Row	Population/Line Item	Total Funds	General Funds	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Match Rate
A	Clinic Based Indigent Care	$6,119,760	$3,034,177	$0	$0	$0	$3,085,583	50.42%
B	Pediatric Specialty Hospital	$13,455,012	$6,670,995	$0	$0	$0	$6,784,017	50.42%
C	**(5) Indigent Care Program Totals (minus CHP+)**	**$19,574,772**	**$9,705,172**	**$0**	**$0**	**$0**	**$9,869,600**	**50.42%**

Table 3.3: (6) Other Medical Services
FY 2016-17 Totals with Updated FMAP

Row	Line Item	Total Funds	General Funds	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Match Rate
A	Commission on Family Medicine Residency Training Programs	$8,145,188	$4,038,384	$0	$0	$0	$4,106,804	50.42%
B	State University Teaching Hospitals - Denver Health and Hospital Authority	$2,804,714	$1,390,577	$0	$0	$0	$1,414,137	50.42%
C	State University Teaching Hospitals - University of Colorado Hospital Authority	$633,314	$313,997	$0	$0	$0	$319,317	50.42%
D	**(6) Other Medical Services Totals**	**$11,583,216**	**$5,742,958**	**$0**	**$0**	**$0**	**$5,840,258**	**50.42%**

Table 3.4: (7) Department of Human Services Medicaid-Funded Programs
FY 2016-17 Totals with Updated FMAP

Row	Line Item	Total Funds	General Funds	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Match Rate
A	(A) Executive Director's Office - Medicaid Funding	$16,709,224	$8,284,433	$0	$0	$0	$8,424,791	50.42%
B	(B) Office of Information Technology Services - Medicaid Funding; Other Office of Information Technology Services line items	$647,220	$320,892	$0	$0	$0	$326,328	50.42%
C	(C) Office of Operations - Medicaid Funding	$5,060,008	$2,508,752	$0	$0	$0	$2,551,256	50.42%
D	(D) Division of Child Welfare - Medicaid Funding; Child Welfare Services	$15,222,606	$7,547,368	$0	$0	$0	$7,675,238	50.42%
E	(E) Office of Early Childhood - Medicaid Funding; Division of Community and Family Support, Early Intervention Services	$5,928,683	$2,939,441	$0	$0	$0	$2,989,242	50.42%
F	(G) Behavioral Health Services - Medicaid Funding; Mental Health Treatment Services for Youth (H.B. 99-1116)	$123,624	$61,293	$0	$0	$0	$62,331	50.42%
G	(G) Behavioral Health Services - Medicaid Funding; High Risk Pregnant Women Program	$1,605,306	$795,911	$0	$0	$0	$809,395	50.42%
H	(G) Behavioral Health Services - Medicaid Funding; Mental Health Institutions	$6,000,000	$3,000,000	$0	$0	$0	$3,000,000	50.00%
I	(H) Services for People with Disabilities - Medicaid Funding; Regional Centers	$52,774,028	$24,299,221	$0	$1,866,142	$0	$26,608,665	50.42%
J	(H) Services for People with Disabilities - Medicaid Funding; Regional Center Depreciation and Annual Adjustments	$1,044,544	$517,885	$0	$0	$0	$526,659	50.42%
K	(J) Division of Youth Corrections - Medicaid Funding	$1,670,305	$828,471	$0	$0	$0	$841,834	50.40%
L	**(7) Department of Human Services Medicaid-Funded Programs Totals**	**$106,785,548**	**$51,103,667**	**$0**	**$1,866,142**	**$0**	**$53,815,739**	**50.40%**

Table 4.1: (1) Executive Director's Office
Calculation of Incremental Change in Federal & State Funds

Row	Line Item	FY 2016-17 Total Appropriated Funds	Change in Federal Funds	Change in State Funds	Estimated Proportion of Funds Attributable to Medical Assistance Payments	Change in Federal Funds Attributable to Medical Assistance Payments	Change in State Funds Attributable to Medical Assistance Payments	Source of State Funding
A	(B) Transfers to Other Departments; Transfer to Department of Public Health and Environment for Nurse Home Visitor Program	$3,010,000	($8,930)	$8,930	100%	($8,930)	$8,930	Reappropriated Funds
B	**(1) Executive Director's Office**	**$3,010,000**	**($8,930)**	**$8,930**		**($8,930)**	**$8,930**	

(1) This figure is calculated by summing total funds from the R-1 exhibit A3 for any population/service that receives the standard FMAP that is subject to change, it does not include any admin funds that receive a flat 50% Federal Matching Assistance Percentage.

(2) The Previously assumed FMAP and Actual FMAP listed here do not apply to all populations and services, however the incremental difference in FMAP is the same across populations and services so it listed here as 51.01 and 50.79 for reference.

Table 4.2: (5) Indigent Care Program
Calculation of Incremental Change in Federal & State Funds

Row	Population/Line Item	FY 2016-17 Total Appropriated Funds	Change in Federal Funds	Change in State Funds	Estimated Proportion of Funds Attributable to Medical Assistance Payments	Change in Federal Funds Attributable to Medical Assistance Payments	Change in State Funds Attributable to Medical Assistance Payments	Source of State Funding
A	Clinic Based Indigent Care	$6,119,760	($21,980)	$21,980	100.00%	($21,980)	$21,980	General Funds
B	Pediatric Specialty Hospital	$13,455,012	($48,326)	$48,326	100.00%	($48,326)	$48,326	General Funds
C	**(5) Indigent Care Program Totals (minus CHP+)**	**$19,574,772**	**($70,306)**	**$70,306**		**($70,306)**	**$70,306**	

Table 4.3: (6) Other Medical Services
Calculation of Incremental Change in Federal & State Funds

Row	Line Item	FY 2016-17 Total Appropriated Funds	Change in Federal Funds	Change in State Funds	Estimated Proportion of Funds Attributable to Medical Assistance Payments	Change in Federal Funds Attributable to Medical Assistance Payments	Change in State Funds Attributable to Medical Assistance Payments	Source of State Funding
A	Commission on Family Medicine Residency Training Programs	$8,145,188	($21,049)	$21,049	100.00%	($21,049)	$21,049	General Funds
B	State University Teaching Hospitals - Denver Health and Hospital Authority	$2,804,714	($10,681)	$10,681	100.00%	($10,681)	$10,681	General Funds
C	State University Teaching Hospitals - University of Colorado Hospital Authority	$633,314	($1,879)	$1,879	100.00%	($1,879)	$1,879	General Funds
D	**(6) Other Medical Services Totals**	**$11,583,216**	**($33,609)**	**$33,609**		**($33,609)**	**$33,609**	

(1)The remaining 37.46% is done as a prior period adjustment certified public expenditure (which is refunded at the FMAP available at the time of expense). This portion should lag the rest of the annual percentage rate.

Table 4.4: (7) Department of Human Services Medicaid-Funded Programs
Calculation of Incremental Change in Federal & State Funds

Row	Line Item	FY 2016-17 Total Appropriated Funds	Change in Federal Funds	Change in State Funds	Estimated Proportion of Funds Attributable to Medical Assistance Payments	Change in Federal Funds Attributable to Medical Assistance Payments	Change in State Funds Attributable to Medical Assistance Payments	Source of State Funding
A	(A) Executive Director's Office - Medicaid Funding	$16,709,224	($49,217)	$49,217	98.81%	($48,631)	$48,631	General Funds
B	(B) Office of Information Technology Services - Medicaid Funding; Other Office of Information Technology Services line items	$647,220	($3,495)	$3,495	100.00%	($3,495)	$3,495	General Funds
C	(C) Office of Operations - Medicaid Funding	$5,060,008	($10,385)	$10,385	100.00%	($10,385)	$10,385	General Funds
D	(D) Division of Child Welfare - Medicaid Funding; Child Welfare Services	$15,222,606	($45,664)	$45,664	100.00%	($45,664)	$45,664	General Funds
E	(E) Office of Early Childhood - Medicaid Funding; Division of Community and Family Support, Early Intervention Services	$5,928,683	($21,851)	$21,851	100.00%	($21,851)	$21,851	General Funds
F	(G) Behavioral Health Services - Medicaid Funding; Mental Health Treatment Services for Youth (H.B. 99-1116)	$123,624	($368)	$368	100.00%	($368)	$368	General Funds
G	(G) Behavioral Health Services - Medicaid Funding; High Risk Pregnant Women Program	$1,605,306	($4,872)	$4,872	100.00%	($4,872)	$4,872	General Funds
H	(G) Behavioral Health Services - Medicaid Funding; Mental Health Institutions	$6,000,000	($43,000)	$43,000	100.00%	($43,000)	$43,000	General Funds
I	(H) Services for People with Disabilities - Medicaid Funding; Regional Centers	$52,774,028	($250,210)	$250,210	100.00%	($250,210)	$250,210	General Funds
J	(H) Services for People with Disabilities - Medicaid Funding; Regional Center Depreciation and Annual Adjustments	$1,044,544	($3,181)	$3,181	100.00%	($3,181)	$3,181	General Funds
K	(J) Division of Youth Corrections - Medicaid Funding	$1,670,305	($3,106)	$3,106	95.66%	($2,971)	$2,971	General Funds
L	**(7) Department of Human Services Medicaid-Funded Programs Totals**	**$106,785,548**	**($435,349)**	**$435,349**		**($434,628)**	**$434,628**	

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-12 Medicaid Provider Rate Reductions

Dept. Approval By: Josh Block [signature] 11/2/15 — X — Change Request FY 2016-17

OSPB Approval By: [signature] 10/28/15

Supplemental FY 2015-16
X Change Request FY 2016-17
Base Reduction FY 2016-17
Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
Total of All Line Items Impacted by Change Request	Total	$7,117,893,850	$0	$7,068,973,555	($35,753,121)	($40,010,683)
	FTE	$0	0.0	$0	0.0	0.0
	GF	$2,067,243,753	$0	$2,050,745,953	($12,886,073)	($14,515,473)
	CF	$735,026,556	$0	$731,950,833	($945,958)	($1,291,984)
	RF	$0	$0	$0	$0	$0
	FF	$4,315,623,541	$0	$4,286,276,769	($21,921,090)	($24,203,226)

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	FY 2016-17 Base Request	FY 2016-17 Change Request	FY 2017-18 Continuation
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	Total	$6,594,830,484	$0	$6,543,446,738	($30,375,797)	($34,493,298)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,816,359,768	$0	$1,798,277,508	($10,300,170)	($11,854,148)
	CF	$703,597,288	$0	$700,504,787	($630,662)	($976,602)
	RF	$0	$0	$0	$0	$0
	FF	$4,074,873,428	$0	$4,044,664,443	($19,444,965)	($21,662,548)
03. Behavioral Health Community Programs - Behavioral Health Fee-for-Service Payments	Total	$8,410,359	$0	$8,437,970	($87,332)	($90,630)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,685,684	$0	$2,693,797	($18,463)	($19,161)
	CF	$143,951	$0	$144,363	($2,279)	($2,365)
	RF	$0	$0	$0	$0	$0
	FF	$5,580,724	$0	$5,599,810	($66,590)	($69,104)

04. Office of Community Living - Adult Comprehensive Services	**Total**	**$368,974,132**	**$0**	**$369,166,299**	**($3,869,989)**	**($3,969,310)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$166,178,462	$0	$166,523,728	($1,763,565)	($1,819,390)
	CF	$31,281,639	$0	$31,298,006	($312,980)	($312,980)
	RF	$0	$0	$0	$0	$0
	FF	$171,514,031	$0	$171,344,565	($1,793,444)	($1,836,940)
04. Office of Community Living - Adult Supported Living Services	**Total**	**$78,378,376**	**$0**	**$80,624,804**	**($778,898)**	**($804,287)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$42,592,426	$0	$43,739,911	($423,839)	($436,423)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$35,785,950	$0	$36,884,893	($355,059)	($367,864)
04. Office of Community Living - Children's Extensive Support Services	**Total**	**$22,574,419**	**$0**	**$22,575,320**	**($219,834)**	**($225,713)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$11,108,871	$0	$11,127,403	($108,994)	($112,315)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$11,465,548	$0	$11,447,917	($110,840)	($113,398)
04. Office of Community Living - Case Management	**Total**	**$34,577,785**	**$0**	**$34,573,782**	**($319,784)**	**($325,960)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$18,194,562	$0	$18,259,279	($169,798)	($172,794)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$16,383,223	$0	$16,314,503	($149,986)	($153,166)
04. Office of Community Living - Family Support Services	**Total**	**$6,960,204**	**$0**	**$6,960,460**	**($69,605)**	**($69,605)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,960,204	$0	$6,960,460	($69,605)	($69,605)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
04. Office of Community Living - Preventive Dental Hygiene	**Total**	**$67,012**	**$0**	**$66,988**	**($670)**	**($670)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$63,334	$0	$63,311	($633)	($633)
	CF	$3,678	$0	$3,677	($37)	($37)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

	Total	**$3,121,079**	**$0**	**$3,121,194**	**($31,212)**	**($31,210)**
04. Office of Community Living - Eligibility Determination and Waiting List Management	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,100,442	$0	$3,100,556	($31,006)	($31,004)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$20,637	$0	$20,638	($206)	($206)

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: Adult Dental Fund (28C0) Breast and Cervical Cancer Fund (15D0) Hospital Provider Fee (24A0) Cash from Clients (1000) Local Funds (9900)

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: DHS

Other Information:

Cost and FTE

- The Department proposes to permanently reduce rates paid to most Medicaid physical health fee-for-service and managed care providers by 1% effective July 1, 2016, in order to meet State budget balancing requirements in FY 2016-17. The Department estimates that the proposed rate reductions will reduce expenditure by approximately $35,753,121 total funds, $12,886,073 General Fund, and $945,958 cash funds in FY 2016-17, with a reduction of $40,010,683 total funds, $14,515,473 General Fund, and $1,291,984 cash funds in FY 2017-18.

Current Program

- Colorado's Medicaid program currently provides health care access to more than 1,161,206 individuals, encompassing Colorado's most vulnerable populations.
- Medicaid includes physical and mental health fee-for-service and physical and mental health managed care.

Problem or Opportunity

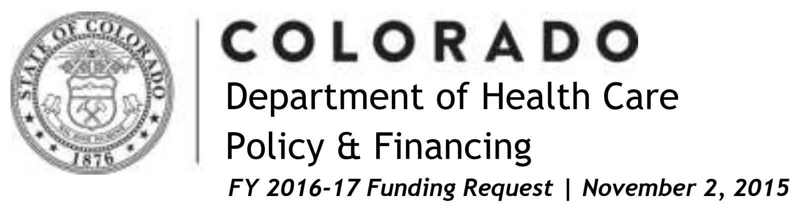
- The Department requests to reduce Medicaid expenditure, based on the revenue projections and projected budget deficit for the State for FY 2016-17.

Consequences of Problem

- The State is required to balance its budget each fiscal year. Provider rate reductions are necessary to satisfy this requirement.

Proposed Solution

- This requested expenditure reduction would be accomplished through a 1% across the board rate reduction for most Medicaid physical health fee-for-service and managed care providers, effective July 1, 2016.



John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: ***R-12***
Request Detail: ***Medicaid Provider Rate Reductions***

Summary of Incremental Funding Change for FY 2016-17	Total Funds	General Fund
R-12 Medicaid Provider Rate Reductions	($35,753,121)	($12,886,073)

Problem or Opportunity:

The Department proposes to permanently reduce rates paid to most Medicaid physical health fee-for-service and managed care providers by 1% effective July 1, 2016, in order to reduce Medicaid expenditure to meet State budget balancing requirements in FY 2016-17. The Department estimates that the proposed rate reductions would reduce Medicaid expenditure by approximately $35,753,121 total funds, $12,886,073 General Fund, and $945,958 cash funds in FY 2016-17, with a reduction of $40,010,683 total funds, $14,515,473 General Fund, and $1,291,984 cash funds in FY 2017-18.

Proposed Solution:

The Department requests to reduce expenditure by $35,753,121 total funds, $12,886,073 General Fund, and $945,958 cash funds in FY 2016-17 and $40,010,683 total funds, $14,515,473 General Fund, and $1,291,984 cash funds in FY 2017-18, based on the revenue projections and projected budget deficit for the State for FY 2016-17. This requested expenditure reduction would be accomplished through a 1% across the board rate reduction for most Medicaid physical and behavioral health fee-for-service, effective July 1, 2016. Managed care providers would be impacted indirectly as well.

Anticipated Outcomes:

Implementing the reductions would allow the State to achieve constitutional budget balancing requirements.

Assumptions and Calculations:

The proposed reduction would affect most providers and services paid within the Department's Medical Services Premiums line item, the Behavioral Health fee-for-service line item, and the Office of Community Living's Division of Intellectual and Developmental Disabilities line items. Rates paid to managed care organizations, including the Program of All-Inclusive Care for the Elderly (PACE), would also include indirect decreases, but the specific impact could vary depending on the underlying rate setting methodology.

This reduction would affect all fee-for-service providers and services paid within the Department's Medical Services Premiums line item, with the following exceptions: physician services; early and periodic screening,

diagnostic, and treatment (EPSDT); pharmacy reimbursement; rural health centers (RHCs); federally qualified health centers (FQHCs); home- and community-based services: children with autism waiver (HCBS-CWA); hospice care that takes place in nursing facilities; Class I and Class II nursing facilities; disease management; and administrative contracts. Many of the listed services are not traditionally eligible for either across the board rate decreases or increases; physician services and EPSDT are not included as they are already receiving a rate reduction effective July 1, 2016 with the end of the Department's FY 2014-15 BA-10, which continued section 1202 of the Affordable Care Act (ACA) with State funds at the standard federal medical assistance percentage (FMAP) for medical services through June 30, 2016.

Due to cash accounting, savings estimates are calculated under the assumption that there will be a constant one month lag between the time the cuts are implemented and the time savings are achieved. This gap incorporates the approximate time between when a claim is incurred and the time that the claim is paid by the Department.

Please see appendix A for more information on calculations.

Table 1a: FY 2016-17 - Amounts Eligible for Rate Reduction 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	$2,257,938,967	$656,164,304	$56,871,920	$1,544,902,743
Community Based Long Term Care	$746,402,268	$361,930,381	$5,768,663	$378,703,224
Program for All-Inclusive Care for the Elderly	$0	$0	$0	$0
Service Management	$33,238,452	$11,922,309	$425,567	$20,890,576
Total Medical Services Premiums	**$3,037,579,687**	**$1,030,016,994**	**$63,066,150**	**$1,944,496,543**
Impact of 1% Rate Reduction	**($30,375,797)**	**($10,300,170)**	**($630,662)**	**($19,444,965)**
(1) Amount of cash fund by cash fund: Hospital Provider Fee: ($482,465); Breast and Cervical Cancer Prevention and Treatment Fund: ($3,923); Adult Dental Fund: ($144,274)				
(3) Behavioral Health Community Programs				
Mental Health Fee-for-Service	$8,733,198	$1,846,325	$227,899	$6,658,974
Impact of 1% Rate Reduction	**($87,332)**	**($18,463)**	**($2,279)**	**($66,590)**
(1) Amount of cash fund by cash fund Hospital Provider Fee: ($2,279)				

Table 1a: FY 2016-17 - Amounts Eligible for Rate Reduction by Funding Source (Continued)				
Long Bill Group	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
(4) Office of Community Living				
Adult Comprehensive Services	$386,998,883	$176,356,495	$31,298,006	$179,344,382
Impact of 1% Rate Reduction	**($3,869,989)**	**($1,763,565)**	**($312,980)**	**($1,793,444)**
Adult Supported Living Services	$77,889,760	$42,383,876	$0	$35,505,884
Impact of 1% Rate Reduction	**($778,898)**	**($423,839)**	**$0**	**($355,059)**
Family Support Services	$6,960,460	$6,960,460	$0	$0
Impact of 1% Rate Reduction	**($69,605)**	**($69,605)**	**$0**	**$0**
Children's Extensive Support Services	$21,983,419	$10,899,379	$0	$11,084,040
Impact of 1% Rate Reduction	**($219,834)**	**($108,994)**	**$0**	**($110,840)**

Table 1a: FY 2016-17 - Amounts Eligible for Rate Reduction by Funding Source (Continued)				
Long Bill Group	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
Case Management	$31,978,466	$16,979,831	$0	$14,998,635
Impact of 1% Rate Reduction	**($319,784)**	**($169,798)**	**$0**	**($149,986)**
Eligibility Determination and Waiting List Management	$3,121,194	$3,100,556	$0	$20,638
Impact of 1% Rate Reduction	**($31,212)**	**($31,006)**	**$0**	**($206)**
Preventive Dental Hygiene	$66,988	$63,311	$3,677	$0
Impact of 1% Rate Reduction	**($670)**	**($633)**	**($37)**	**$0**
Total Impact	**($35,753,121)**	**($12,886,073)**	**($945,958)**	**($21,921,090)**
(1) Amount of cash fund by cash fund Cash from Clients: ($312,980); Local Funds: ($37)				

Table 1b: FY 2017-18 - Amounts Eligible for Rate Reduction by Funding Source				
Long Bill Group	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
(2) Medical Services Premiums				
Acute Care	$2,527,849,377	$739,400,786	$91,759,991	$1,696,688,600
Community Based Long Term Care	$886,641,934	$433,460,570	$5,209,212	$447,972,152
Program for All-Inclusive Care for the Elderly	$0	$0	$0	$0
Service Management	$34,838,479	$12,553,452	$691,003	$21,594,024
Total Medical Services Premiums	**$3,449,329,790**	**$1,185,414,808**	**$97,660,206**	**$2,166,254,776**
Impact of 1% Rate Reduction	**($34,493,298)**	**($11,854,148)**	**($976,602)**	**($21,662,548)**
(1) Amount of cash fund by cash fund Hospital Provider Fee: ($813,028); Breast and Cervical Cancer Prevention and Treatment Fund: ($1,439); Adult Dental Fund: ($162,135)				
(3) Behavioral Health Community Programs				
Mental Health Fee-for-Service	$9,062,957	$1,916,041	$236,504	$6,910,412
Impact of 1% Rate Reduction	**($90,630)**	**($19,161)**	**($2,365)**	**($69,104)**
(1) Amount of cash fund by cash fund Hospital Provider Fee: ($2,365)				

Table 1b: FY 2017-18 - Amounts Eligible for Rate Reduction by Funding Source (Continued)				
Long Bill Group	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
(4) Office of Community Living				
Adult Comprehensive Services	$396,931,011	$181,938,983	$31,298,006	$183,694,022
Impact of 1% Rate Reduction	**($3,969,310)**	**($1,819,390)**	**($312,980)**	**($1,836,940)**
Adult Supported Living Services	$80,428,670	$43,642,315	$0	$36,786,355
Impact of 1% Rate Reduction	**($804,287)**	**($436,423)**	**$0**	**($367,864)**
Family Support Services	$6,960,460	$6,960,460	$0	$0
Impact of 1% Rate Reduction	**($69,605)**	**($69,605)**	**$0**	**$0**
Children's Extensive Support Services	$22,571,323	$11,231,490	$0	$11,339,833
Impact of 1% Rate Reduction	**($225,713)**	**($112,315)**	**$0**	**($113,398)**

Table 1b: FY 2017-18 - Amounts Eligible for Rate Reduction by Funding Source (Continued)				
Long Bill Group	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Federal Funds**
Case Management	$32,596,034	$17,279,391	$0	$15,316,643
Impact of 1% Rate Reduction	**($325,960)**	**($172,794)**	**$0**	**($153,166)**
Eligibility Determination and Waiting List Management	$3,121,079	$3,100,442	$0	$20,637
Impact of 1% Rate Reduction	**($31,210)**	**($31,004)**	**$0**	**($206)**
Preventive Dental Hygiene	$67,012	$63,334	$3,678	$0
Impact of 1% Rate Reduction	**($670)**	**($633)**	**($37)**	**$0**
Total Impact	**($40,010,683)**	**($14,515,473)**	**($1,291,984)**	**($24,203,226)**
(1) Amount of cash fund by cash fund Cash from Clients: ($312,980); Local Funds: ($37)				