Department of Health Care Policy and Financing

Line Item Description and Department Reference Resource

FY 2017-18 Budget Request

November 2016

I. LINE ITEM DESCRIPTION

(1) EXECUTIVE DIRECTOR'S OFFICE

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

(A) GENERAL ADMINISTRATION

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

PERSONAL SERVICES

This line item funds the majority of the Department's expenditures for FTE, temporary staff, and some of its contractors. Allocated POTS for the FTE, including Salary Survey, Merit Pay, Health, Life, Dental, Short-Term Disability, Supplemental Amortization Equalization Disbursement, and Amortization Equalization Disbursement, are paid through this line item. It excludes expenditures for those FTE and temporary staff who work in the Division of Intellectual and Developmental Disabilities.

HEALTH, LIFE, AND DENTAL

This line item funds the Department's health, life, and dental insurance benefits, and is part of the POTS component paid jointly by the State and state employees. The calculated annual appropriation is based upon recommendations contained in the annual Total Compensation Report and associated guidance from OSPB, and is calculated based upon employee benefit enrollment selections.

SHORT-TERM DISABILITY

This line item, a component of POTS, provides partial payment of an employee's salary in the event that an individual becomes disabled and cannot perform his or her work duties. This benefit is calculated on an annual basis in accordance with OSPB Common Policy instructions.

AMORTIZATION EQUALIZATION DISBURSEMENT

This line item funds the increased employer contribution to the Public Employees' Retirement Association **(**PERA) Trust Fund to amortize the unfunded liability in the Trust Fund beginning January 2006. The request for this line item is computed in accordance with OSPB Common Policy Instructions, and is calculated using the sum of base salaries, Salary Survey, and Merit Pay adjustments. During the 2005 legislative session, the General Assembly created a single Amortization Equalization Disbursement line item in all departments to fund these expenses. The Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

SUPPLEMENTAL AMORTIZATION EQUALIZATION DISBURSEMENT

The Supplemental Amortization Equalization Disbursement increases the employee's contribution to the PERA Trust Fund to amortize the unfunded liability beginning January 2008. It is similar to the Amortization Equalization Disbursement discussed above, however, this line is funded through a reduction of the proposed Salary Survey increases for the upcoming fiscal year. The request for this line item is computed in accordance with OSPB Common Policy Instructions, and is calculated using the sum of base salaries, Salary Survey, and Merit Pay adjustments. During the 2006 legislative session, the General Assembly passed SB 06-235, which created this line item in all departments to fund these expenses. The Supplemental Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

SALARY SURVEY

The Salary Survey appropriation reflects the amounts appropriated to the Department to cover the cost of salary increases based on the Total Compensation survey performed annually by the Department of Personnel and Administration. The annual request for this line item is calculated based upon the annual Total Compensation recommendations from the State Personnel Director, along with guidance provided via the OSPB Common Policy Instructions.

MERIT PAY

Formerly known as "Performance Achievement Pay," Merit Pay represents the annual amount appropriated for periodic salary increases for State employees. Salary increases are based on demonstrated and documented ability of each employee to satisfy standards related to quantity and quality of work.

WORKERS' COMPENSATION

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

OPERATING EXPENSES

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

LEGAL SERVICES

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

ADMINISTRATIVE LAW JUDGE SERVICES

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

PAYMENT TO RISK MANAGEMENT AND PROPERTY FUNDS

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

LEASED SPACE

Previously called Commercial Leased Space, this line item was established in FY 2003-04 as part of the transfer of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and staff from the Department of Public Health and Environment to the Department via the Long Bill (SB 03-258). The line item is necessary to pay for the Department's obligations for leases of private office space and other facilities that are not State-owned.

CAPITOL COMPLEX LEASED SPACE

This Common Policy line item is appropriated to cover program and overhead costs associated with the maintenance and property management functions provided by the Division of Central Services, Facilities Maintenance for the 31,512 square feet of space the Department occupies at 1570 Grant Street.

PAYMENTS TO OIT

Starting in FY 2014-15, this Common Policy line item combines four OIT-related line items that were previously separated in the Long Bill. This line item funds the Department's allocation for services provided by OIT, including centralized computer services, provision and administration of the Colorado State Network, information technology security, new OIT initiatives, and OIT's internal office expenses.

CORE OPERATIONS

This Common Policy line item resulted from the passage of HB 12-1335, the FY 2012-13 Long Appropriations Bill, and was renamed from COFRS Modernization to CORE Operations in SB 15-234, the FY 2015-16 Long Appropriations Bill. It funds the Department's allocation for services related to the implementation and ongoing support of the new statewide accounting system used by the Office of the State Controller to record all state revenues and expenditures. The new system is needed to meet the State's fiduciary responsibilities, mitigate the risk of system failure, and upgrade functionality.

SCHOLARSHIPS FOR RESEARCH USING THE ALL-PAYERS CLAIMS DATABASE

This line item was created in the FY 2014-15 Long Bill (HB 14-1336) to fund scholarships for nonprofit and government entities to access and conduct research in the All-Payer Claims Database. The Database was created in 2010 and combines claims data from commercial health plans, Medicare, and Medicaid. It is administered by the Center for Improving Value in Health Care.

GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS

This line item was created in FY 2007-08 and contains appropriations for any special or temporary projects the General Assembly chooses to fund each year.

(B) TRANSFERS TO/FROM OTHER DEPARTMENTS

TRANSFER TO DPHE FOR FACILITY SURVEY AND CERTIFICATION

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

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

TRANSFER FROM DHS FOR NURSE HOME VISITOR PROGRAM

The Nurse Home Visitor Program was created by SB 00-071 with funding from the Tobacco Master Settlement Agreement. The program uses regular in-home, visiting nurse services for low-income (below 200% of the federal poverty level), first-time mothers with a baby

less than one month old. The nurses offer services during the mother's pregnancy and up to the child's second birthday. The overall goal of the program is to serve all low-income, first-time mothers who want to participate.

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

The Nurse Home Visitor Program received continuation funding in the FY 2013-14 Long Bill, SB 13-230. However, the arrangements for the funding, beginning in FY 2013-14 were changed by HB 13-1117. The program, previously funded through the Department of Public Health and Environment, will be funded going forward through the Department of Human Services. The Nurse Home Visitor Program will continue to provide services in a manner similar to when the program existed at the Department of Public Health and Environment.

TRANSFER TO DPHE FOR PRENATAL STATISTICAL INFORMATION

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

TRANSFER TO DORA FOR NURSE AIDE CERTIFICATION

Federal law requires certification of nurse aides working in any medical facility with Medicaid or Medicare patients (42 C.F.R. §483.150(b)). The Department of Regulatory Agencies (DORA) administers the Nurse Aide Certification program under an interagency agreement with the Department and the Department of Public Health and Environment (DPHE). The Department provides Medicaid funding for the program and DPHE provides Medicare funding for the program. Pursuant to section 12-38-101, C.R.S., the Colorado State Board of Nursing in DORA oversees regulation of certified nurse aides practicing in medical facilities throughout the state. The

regulation of nurse aides is carried out under the Nurse Aide Certification program, which includes a nurse aide training program, followed by testing and application for certification as a nurse aide as well as enforcement functions. The Nurse Aide Certification program is administered by the Division of Registrations located in DORA and is directly overseen by the five-member Nurse Aide Advisory Committee.

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

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

TRANSFER TO DORA FOR REVIEWS

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

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

TRANSFER TO DEPARTMENT OF EDUCATION FOR PUBLIC SCHOOL HEALTH SERVICES ADMINISTRATION

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

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

TRANSFER TO DOLA FOR HOME MODIFICATIONS BENEFIT ADMINISTRATION

This line item includes funding for the Division of Housing to administer the home modification benefit under the Elderly, Blind and Disabled, Spinal Cord Injury, Community Mental Health Supports, and Brain Injury Waivers. Funding ensures that bids for home modifications are correctly structured, and that home modifications are finished timely and meet housing codes.

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS

Beginning with the FY 2013-14 Long Bill (SB 13-230), this line item, formerly known as "Information Technology Contracts" was entitled "Medicaid Management Information Systems Maintenance and Projects."

The Medicaid Management Information Systems (MMIS) is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. The MMIS processes claims and capitations based on edits that determine payment or payment denial and performs prior authorization reviews for certain medical services and pharmacy prescriptions. Warrants are produced by the State based on the information electronically transmitted from MMIS.

The MMIS is federally required for states that participate in the Medicaid program (Section 1903(r) of the Social Security Act). The Centers for Medicare and Medicaid Services' (CMS) *State Medicaid Manual* identifies the specific types of MMIS costs that are allowable for federal reimbursement.

The Department's new MMIS being implemented in November 2016 consist of three interacting systems. Those systems include:

- Colorado interChange - the core system responsible for claims processing;
- Pharmacy Benefits Management System (PBMS) - the system responsible for processing pharmacy claims;
- Business Intelligence and Data Management Services (BIDM) - the system responsible for data analytics

MEDICAID MANAGEMENT INFORMATION SYSTEM REPROCUREMENT CONTRACTED STAFF

With the finalization of the MMIS Reprocurement in FY 2016-17, this line item is set to be removed from the FY 2017-18 Long Bill. Through the Department's FY 2013-14 R-5 "MMIS Reprocurement" request, funding was approved over the course of four years beginning in FY 2013-14 to procure a new MMIS. This funding was adjusted by FY 2014-15 S-7, BA-7 "MMIS Adjustments" to align with more detailed business requirements and updated funding needs developed since the original budget request. The new MMIS is transitioning from the design, development, and implementation (DDI) stage to its operational stage in November 2016. In addition to the technology implementation costs associated with reprocurement, the funding through this line item provides for temporary staffing to assist the Department during the implementation phase.

MEDICAID MANAGEMENT INFORMATION SYSTEM REPROCUREMENT CONTRACTS

With the finalization of the MMIS Reprocurement in FY 2016-17, this line item is set to be removed from the FY 2017-18 Long Bill. Through the Department's FY 2013-14 R-5 "MMIS Reprocurement" request, funding was approved over the course of four years beginning in FY 2013-14 to procure a new MMIS. This line item was created for the contract costs related to the MMIS reprocurement. The MMIS was reprocured because current federal fiscal agent contracting policies require reprocurement of the MMIS every eight years. The legacy MMIS is highly outdated resulting in significant operational inefficiencies, limitations to the Department's ability to implement policy changes, and risks of losing federal approval and federal financial participation (FFP), making reprocurement an opportunity to acquire a new, modern MMIS to address these problems. This funding was adjusted by FY 2014-15 S-7, BA-7 "MMIS Adjustments" to align with more detailed business requirements and updated funding needs developed since the original budget request.

The new MMIS is transitioning from the design, development, and implementation (DDI) stage to the operational stage beginning November 2016, replacing the legacy MMIS.

FRAUD DETECTION SOFTWARE CONTRACT

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

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

COLORADO BENEFITS MANAGEMENT SYSTEMS, OPERATING CONTRACT EXPENSES

The Colorado Benefits Management Systems (CBMS), Operating and Contract Expenses line item was created as a result of the Department's FY 2015-16 S-6, BA-6 CBMS Funding Simplification supplemental request to streamline billing processes related to CBMS. The new line item consolidates CBMS funding from line items formerly in the Department's DHS Medicaid-Funded Programs Long Bill group (7), including the former Colorado Benefits Management Systems; HCPF Only Projects; and CBMS SAS-70 Audit line items. This funding was consolidated to allow the Department to reimburse the Governor's Office of Information Technology (OIT) directly, rather than the previous administratively burdensome and unnecessary process of reimbursing OIT through transactions with the Department of Human Services (CDHS).

The system tracks client data, determines eligibility, and calculates benefits for medical, food, and financial-assistance programs in the State of Colorado. There is no specific authorization in statute that specifically mentions CBMS; however, authorization can be inferred from 25.5-5-101, C.R.S. The OIT currently has oversight of daily operations for the CBMS vendor. All OIT funding for CBMS is reappropriated from the Department and CDHS. Costs are allocated to the various State and federal programs participating in CBMS through the federally approved cost allocation process, primarily determined through polling results of the county departments of human/social services staff according to a federally approved Random Moment Sampling methodology.

A broad range of components are funded from this appropriation: including vendor payments; Department only projects; computer hardware maintenance and repairs; computer software maintenance and upgrades; non-computer equipment rental; building rental; rental of computers and network equipment; travel expenses; training expenses; telecommunication services; printing and reproduction of paper documents; legal services; freight and shipping charges; data-processing supplies; office supplies; postage; copy supplies; non-capitalized equipment purchases; dues and memberships; registration fees; capital lease principal payments; and capital lease interest payments.

COLORADO BENEFITS MANAGEMENT SYSTEMS, HEALTH CARE AND ECONOMIC SECURITY STAFF DEVELOPMENT CENTER

This line item, previously entitled CBMS Modernization Project Personal Service, Operating Expenses and Centrally Appropriated Expenses, was new funding to the Department in the FY 2014-15 Long Bill, HB 14-1336. The funding is used by the Department, in coordination with funding through the CDHS, to provide user training for county departments of human/social services staff.

HEALTH INFORMATION EXCHANGE MAINTENANCE AND PROJECTS

This line item was created in the FY 2014-15 Long Bill (HB 14-1336) to build infrastructure allowing for the secure and private exchange of electronic client health information among providers, labs, the Department, and other appropriate health care entities. The initial funding for this line item originated with the Department's FY 2014-15 R-5 Request "Medicaid Health Information Exchange."

Specifically, the Department is installing hardware and software infrastructure that allows Medicaid providers and hospitals to network together their individual electronic health record (EHR) systems. This allows for a client's EHR to be quickly called up and shared with any of the client's providers statewide when appropriate. This enables improved care coordination, better client experiences, better-informed care decisions, more opportunities for preventative care, and advanced analytics to help policy-makers. The Department works closely with the Colorado Regional Health Information Organization (CORHIO), which is the State-Designated Entity (SDE) in charge of coordinating electronic Health Information Exchange (HIE) statewide.

FY 2015-16 R-9 "Personal Health Records and Online Health Education" was approved to increase funding to this line item to implementation additional technology related to HIE. This includes online health education resources and Personal Health Record (PHR) technology, allowing Medicaid clients to securely view their electronic medical information and interact with providers online.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

MEDICAL IDENTIFICATION CARDS

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

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

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

CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

This line item provides funding for three Department functions: Disability Determination Services, Nursing Facility Preadmission Screening and Resident Review (PASRR), and Hospital Outstationing.

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

added as a result of the passage of HB 09-1293, "Colorado Health Care Affordability Act." The purposes for the funding are described below.

Disability Determination Services

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

Nursing Home Preadmission Screening And Resident Review (PASRR) Assessments

This budget item funds screenings and reviews mandated by the federal Omnibus Budget Reconciliation Act of 1987 to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. The federal financial participation rate for this program is 75%.
All admissions to nursing facilities with Medicaid certified beds, regardless of individual payer source, are subject to preadmission screening, and all current residents, regardless of individual payer source, are subject to an annual review. The purpose of these assessments is to ensure that residents receive appropriate care, that they remain in the nursing facility for the appropriate amount of time, and that the percentage of residents with a major mental illness or developmental disability does not exceed 50% of all patients in the facility. This is a federal requirement to receive Medicaid funds.

Hospital Outstationing

This line item funds outstationing activities at hospitals in order for hospitals to provide certain on-site services to inform, educate, and assist qualifying clients in gaining enrollment into the State's medical assistance programs. This line item was created as a result of the passage of HB 09-1293, the "Colorado Health Care Affordability Act," to assist with the anticipated increase in caseload due to the bill.

COUNTY ADMINISTRATION

This line item provides for partial reimbursement to local county departments of human/social services for costs associated with performing Medicaid, Children's Basic Health Plan, and Old Age Pension State Medical Program eligibility determinations. Prior to

July 1, 2006, this funding was included in the Department of Human Services (DHS) budget through an interagency transfer and was combined with the corresponding appropriation for non-Medicaid programs such as food stamps and cash assistance programs administered by DHS. However, with the passage of SB 06-219 beginning in FY 2006-07, oversight and funding for the Medicaid portion of county administration was transferred to the Department, thereby establishing a direct relationship between the Department and the counties performing these functions.

As part of the Department's fiscal note for SB 06-219, the Department and DHS agreed that the allocation and reimbursement methodology would remain the same as prior to July 1, 2006. This included: 1) using the existing federally-approved random moment sampling model performed by DHS to determine the allocation of expenditures between programs administered by the Department and those administered by DHS; 2) continuing using a cost-sharing allocation; 3) continuing to utilize the County Financial Management System for counties to have one-stop billing; and, 4) utilizing interagency transfers of General Fund between the Department and DHS pursuant to 24-75-106, C.R.S. in order to maximize Medicaid reimbursement to the counties. Subsequent appropriations for County Administration have been made without including a local share; as a result, the state, county and federal share of the appropriation do not follow the traditional 30% General Fund, 20% local share, and 50% federal funds that were historically seen.

The General Assembly appropriated additional funding to this line item in SB 13-200, which authorized Medicaid expansion under the Affordable Care Act. Additionally, to meet the expected high demand for eligibility determination services, the Centers for Medicare and Medicaid Services (CMS) examined its current practices under Medicaid Management Information Systems (MMIS) rules for approval of 75% federal match for maintenance and operations in the context of eligibility determinations and has confirmed that certain eligibility determination-related costs are eligible for 75% federal financial participation (FFP), which has reduced the state and federal share for certain activities that a reimbursed under this line item. Counties can access the enhanced funding through random moment sampling (RMS) or direct coding.

Additional funding was added to the line through the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" to support an incentive payment structure to counties. The incentive payment structure encourages faster and more accurate application processing and other process improvements in order to create a more efficient and effective eligibility determination process.

HOSPITAL PROVIDER FEE COUNTY ADMINISTRATION

This line item provides for reimbursement to local county departments of human/social services for costs associated with performing Medicaid eligibility determinations for the expansion population categories created in HB 09-1293, the "Colorado Health Care Affordability Act". This funding was included in the County Administration line item, showing up as Cash Funds and Federal Funds; however, the Department's FY 2012-13 S-7 "Hospital Provider Fee Administrative True-up," submitted with the January 3, 2012

Supplemental Budget Request, requested the separation of this funding, thereby establishing this line item to make the budget more transparent, allow for easier tracking of hospital provider fee funds, and to separate funding sources that are allocated based on differing methodologies. Subsequent appropriations, including those from SB 13-200, have expanded the use of this funding to other populations considered "newly eligible" under the Affordable Care Act.

While the County Administration line item reimburses county departments using a methodology including a random moment time study, a local funding match, and interagency transfers, this line item reimburses in a manner more reflective of the expansion of the Department's programs under HB 09-1293. Prior to FY 2014-15, these funds were distributed twice per state fiscal year based on total County Administration expenditures and each county's percentage of newly eligible clients funded by the Hospital Provider Fee relative to total Medicaid. Beginning in FY 2014-15, these funds are blended with the regular county administration appropriation and distributed periodically through the normal county reimbursement methodology. By blending the two appropriations together, the Department is able to reduce the administrative burden of additional payment while assuring the counties receive funding in a timely manner.

Additional funding was added to the line through the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" to support infrastructure grants to counties. The infrastructure grants provide counties one-time funding to improve the eligibility determination process.

MEDICAL ASSISTANCE SITES

This was a new line item in FY 2014-15 funded through the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" and will initially fund a review of eligibility assistance and determination sites in addition to funding Medical Assistance (MA) sites for their Medicaid eligibility determination activities.

This line item will fund MA sites to conduct Medicaid eligibility determination on location. MA sites offer additional points of contact for Medicaid eligibility determination and eligibility workers are stationed at places such as schools, clinics and hospitals in order to assist clients. These sites are required to meet the same application processing performance standards and requirements that counties are required to meet and support the Department's aim to have "no wrong door" in determining client eligibility. Previously, MA sites were unfunded for their eligibility determination activities.

ADMINISTRATIVE CASE MANAGEMENT

This line item funds administrative case management activities related to the Child Welfare program administered by the Department of Human Services (DHS). Administrative Case Management was approved by the federal Centers for Medicare and Medicaid Services

(CMS) for 50% federal financial participation in August 2005. With the passage of SB 06-219, the oversight of administrative case management was transferred from DHS, beginning July 1, 2006. Prior to FY 2006-07, Medicaid funding for these programs was transferred through interagency transfers, originating in the Department's Long Bill group (6) DHS – Medicaid Funded Programs appropriations.

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

Similar to the County Administration appropriation narrated above, State appropriated funding for these services is allocated across all 64 counties. Also similar to the County Administration appropriation, DHS has agreed to provide additional General Fund spending authority if necessary, to maximize Medicaid reimbursement. This allows the State to maximize available matching federal funds. There is no county share associated with this funding.

CUSTOMER OUTREACH

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

Early And Periodic Screening, Diagnosis, And Treatment (EPSDT) Program

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

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

Only administrative and outreach services are funded by this budget item. Services funded by this budget item are contracted primarily by county health department staff but may include other local outreach providers such as hospitals and community-based organizations. The funding for medical services provided through the EPSDT Program remain in the Department's Medical Services Premiums Long Bill group.

Enrollment Broker

Funding for a Medicaid managed care enrollment broker was appropriated to the Department through SB 97-05. The vendor contracted to serve as the enrollment broker is charged with providing information on basic Medicaid benefits offered through all health plans. In this, the vendor contacts all newly eligible Medicaid clients to inform them of Medicaid plan choices. If a client chooses the Primary Care Physician Program or a health maintenance organization, the vendor will enroll the client in the plan. The vendor also enrolls and disenrolls clients from the managed care plans in accordance with Medicaid rules. The enrollment broker vendor does this work under the name of Health*Colorado*. As of January 1, 2013, the enrollment broker vendor provides enrollment management services for the CHP+ program.

CENTRALIZED ELIGIBILITY VENDOR CONTRACT PROJECT

This line item was created in the FY 2008-09 Long Bill (HB 08-1375) for the implementation and administration of a centralized eligibility vendor modelThe line item was the result of the recommendation by The Blue Ribbon Commission for Health Care Reform (the "208 Commission") created to study and establish health care reform models for expanding coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents. Recommendation 10 in the Fifth Proposal suggested creating a single state-level entity for determining Medicaid and Children's Basic Health Plan eligibility. This line was moved from the Executive Director's Office (C) Information Technology Contracts and Projects Long Bill group into the Executive Director's Office (D) Eligibility Determinations and Client Services in the FY 2016-17 Long Bill (HB 16-1405).

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

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

PROFESSIONAL SERVICES CONTRACTS

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

Acute Care Utilization Review

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

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

Long-Term Care Utilization Review

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

- Uniform Long-Term Care 100.2 Form (ULTC 100.2) assessments for needed level of care;
- Pre-Admission Screening and Resident Review (PASRR Level I) to identify clients who need Level II screening;
- Administration of the Hospital Back-Up (HBU) Program, which provides cost-effective alternatives for clients who have extended acute hospitalizations by permitting transfer to nursing facilities capable of providing care;
- Assessments for the Children's Extensive Support (CES) waiver which provides Medicaid benefits, services and support for children with developmental disabilities or delays and require special services and provide an alternative to institutional placement;

- Assessments for Private Duty Nursing which provides eligible clients with skilled nursing services in a home setting;
- Data management; and,
- Training for case managers.

The Department's contractor maintains a long-term care database and performs prior authorization reviews for long-term care clients. The results of the prior authorization reviews are transmitted electronically to the Department's fiscal agent. The contractor also conducts reviews for the Level II PASRR Program.

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

External Quality Review

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

- Collection and verification of the status of licensure;
- Validation of Drug Enforcement Agency or Controlled Dangerous Substances certification;
- Verification of relevant training, experience, and board certification;
- Maintenance of records on any past liability claims;
- Tracking of U.S. Department of Health and Human Services, Medicare and Medicaid sanctions; and,

- Verification of work history.

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

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

Drug Utilization Review

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

- Information on the prospective and retrospective drug review program;
- Steps taken by the Department and Drug Use Review Board to ensure compliance with the requirements for predetermined standards;
- Summary of the educational interventions used and an assessment of the effect of these educational efforts on quality of care; and,
- Estimate of the cost savings generated as a result of the drug use review program.

(F) PROVIDER AUDITS AND SERVICES

PROFESSIONAL AUDIT CONTRACTS

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

Nursing Facility Audits

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

Hospital And Federally Qualified Health Centers Audits

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

Single Entry Point Audits

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

Payment Error Rate Measurement Project Contract

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

In August 2006, the Centers for Medicare and Medicaid Services (CMS) issued an interim final rule stating that federal contractors would be hired to calculate national error rates and review states' fee-for-service and managed care payments for Medicaid and State Children's Health Insurance Programs. Under the rule, each state is required to calculate its state-specific eligibility error rates and measure improper payments once every three years, so that all states are reviewed on a rotating basis, with 17 states reviewed per federal fiscal year. Due to the three-year cycle, Colorado completed the eligibility and payment error reviews in FY 2013-14 and will do so again in FY 2016-17.

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

Nursing Facility Appraisals

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

Colorado Indigent Care Program Auditor

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

Through this budget item, the Department will utilize two types of audits to ensure proper payment of hospital fee funds to Colorado Indigent Care Program providers. The first are desk audits to: analyze cost reports to determine the accuracy and reasonableness of financial data reported by providers; identify problem areas that warrant additional review; and, obtain information for use in planning a site audit if deemed necessary. Second are on-site audits that will focus on specific payment issues that are potentially material in nature and a more detailed verification of data than the desk audit.

Disproportionate Share Hospital Audits

This budget item provides funding for Disproportionate Share Hospital (DSH) audits as a result of DI-6 "Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures" (November 2, 2009 FY 2010-11 Budget Request). This funding is for a contractor that is responsible for auditing the Department's DSH expenditures on an annual basis, pursuant to reporting requirements mandated by the federal Centers for Medicare and Medicaid Services (CMS) in rule (CMS-2198-F). This rule, which went into effect on January 19, 2009, institutes new auditing requirements that will clarify allowable expenditures under the DSH program and help the

Department prevent improper expenditure of DSH funds. The rule also requires states to submit an independent certified audit of their DSH expenditures on an annual basis to CMS, while specifying the data elements that need to be included in each submission.

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

Primary Care Fund Audits

This budget item provides funding for compliance audits of the data submitted by Primary Care Fund applicants as a result of R-14 "Primary Care Fund Audits" (November 1, 2014 FY 2015-16 Budget Request). This funding is used to hire a contractor for a compliance audit of the data submitted by Primary Care Fund applicant providers to verify the accuracy and validity of the data. Qualified providers must serve a medically underserved population and/or area of Colorado and funds are allocated to each qualified provider based on the number of medically indigent patients served in an amount proportionate to the total number of medically indigent patients served by all health care providers who qualify for Primary Care Funds. This budget line allows for one-third of the providers, or thirteen providers, to be audited each fiscal year to assure correct reporting of unduplicated patient counts and that patients are correctly categorized by payment source, by provider. For more information regarding the Primary Care Fund, please see the Primary Care Fund Program section of this document.

Managed Care Organization Audits

This budget item provides funding for Managed Care Organization Audits as a result of R-15 "Managed Care Organization Audits" (November 1, 2014 FY 2015-16 Budget Request). This funding is used to hire an auditing firm to perform audits on financial reports and encounter data from physical and behavioral health managed care organizations that contract with the Department. Prior to the passage of this funding, the Department did not audit the financial or encounter data beyond assessing the reasonableness of payment at a high level of aggregation based on summary statistics. This budget item allows for the Department's contractor to:

- Conduct a thorough review of current managed care contract language to identify weaknesses and recommend appropriate changes to specific language.

- Use selected algorithms on claims data of managed care plans to identify outlier populations that could be at risk of overpayment.

- Test identified outlier populations to ensure compliance with regulations for allowable medical expenses.
- Tie financial reports to supporting information to ensure reporting accuracy in accordance with standards established by the American Institute of Certified Public Accountants.
- Audit of administrative expenses to ensure reported expenses are allowable and accurate.

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

ESTATE RECOVERY

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

(H) INDIRECT COST RECOVERIES

INDIRECT COST ASSESSMENT

This line item resulted from the passage of SB 13-230, the FY 2013-14 Long Appropriations Bill. It was created to separately identify the overhead costs associated with the operation of general government functions. Indirect cost recoveries are intended to offset these overhead costs that otherwise would have been supported by the General Fund, from cash and federally funded sources. Recoveries from cash and federally-funded programs are calculated for statewide overhead costs by the Office of the State Controller.

(2) MEDICAL SERVICES PREMIUMS

MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS

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

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

(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS

BEHAVIORAL HEALTH CAPITATION PAYMENTS

The Behavioral Health Capitation Payments line item reflects the appropriation that funds Medicaid mental health and substance abuse services throughout Colorado through managed-care providers contracted by the Department. The Behavioral Health Organizations (BHOs) 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 that is covered by the BHO contract. For further information, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-2, "Request for Medicaid Behavioral Health Community Program."

BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

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

(4) OFFICE OF COMMUNITY LIVING

In 2012, Governor Hickenlooper issued Executive Order D 2012-027, establishing the Office of Community Living within the Department. The Office is charged with better aligning services and supports so that people with long-term services and supports needs, and their families, do not have to navigate a complicated and fragmented health care system. HB 13-1314, "Transfer Developmental Disabilities to HCPF" transferred funding from the Department of Human Services to the Department effective March 2014; this Long Bill group was established with the FY 2014-15 Long Bill (HB 14-1336).

The Office of Community Living Long Bill group of the Department's budget contains the administrative and programmatic funding for services and supports for persons with Intellectual and Developmental Disabilities and their families. Funding extends to FTE, operations support for a standalone case management system, and services and supports for eligible individuals and their families.

(A) DIVISION OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

(1) ADMINISTRATIVE COSTS

PERSONAL SERVICES

This line item funds the Department's expenditures for FTE and temporary staff who work in the Division of Intellectual and Developmental Disabilities. It was created as part of HB 13-1314 "Transfer Developmental Disabilities to HCPF", which transferred the administration of long-term services for persons with intellectual and developmental disabilities to the Department. Allocated POTS for the FTE, including Salary Survey, Merit Pay, Health, Life, Dental, Short-Term Disability, Supplemental Amortization Equalization Disbursement, and Amortization Equalization Disbursement, are paid through this line item.

OPERATING EXPENSES

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

COMMUNITY AND CONTRACT MANAGEMENT SYSTEM

Service providers assisting HCBS-SLS and HCBS-DD waiver clients are paid rates based on each individual's evaluated support level. In turn, the support level is based primarily on the Supports Intensity Scale (SIS) assessment tool, which has been in use since 2009. In

addition to the SIS evaluation, two external factors – "Danger to Self" and "Community Safety Risk" – are considered when determining an individual's support level. Community Centered Boards are reimbursed for the administration of the SIS and support level evaluations. This line funds 70% of the costs for the Community and Contract Management System (CCMS), which is used to authorize services, bill for services, and collect demographic data for people with intellectual and developmental disabilities. The CCMS also tracks disability resources and contracts, as well as waiting list information. This line funds approximately 95% of operating expenses and 100% of the support level administration costs.

SUPPORT LEVEL ADMINISTRATION

Service providers assisting HCBS-SLS and HCBS-DD waiver clients are paid rates based on each individual's evaluated support level. In turn, the support level is based primarily on the Supports Intensity Scale (SIS) assessment tool, which has been in use since 2009. In addition to the SIS evaluation, two external factors – "Danger to Self" and "Community Safety Risk" – are considered when determining an individual's support level. Community Centered Boards are reimbursed for the administration of the SIS and support level evaluations.

CROSS-SYSTEM RESPONSE FOR BEHAVIORAL HEALTH CRISES PROGRAM

In FY 2014-15, the General Assembly passed HB 15-1368, legislation that created the Cross-System Response for Behavioral Health Crises Program Cash Fund. The pilot program will support collaborative approaches to provide a cross-system response to behavioral health crises for individuals with intellectual and developmental disabilities and a mental health or behavioral disorder. The pilot program will coordinate services among Medicaid state plan services, Medicaid school-based health services, home- and community-based waiver services, and the capitated mental health care system. The Department will oversee multiple pilot sites representing different geographic regions of the state. The Department will enter into an interagency agreement with the Department of Human Services (DHS) to jointly manage the integration of the pilot program with the Colorado Behavioral Health Crisis Response System.

The bill requires that the pilot program will begin by March 1, 2016, and operate until March 1, 2019. By July 1, 2017, and every July 1 thereafter, the Department must conduct a cost analysis of the services that would need to be added to eliminate service gaps and ensure that individuals with intellectual and developmental disabilities are fully included in the Colorado behavioral health system. The bill also establishes the Cross-System Response for Behavioral Health Crises Pilot Program Fund in the Department. The pilot program repeals on July 1, 2019. This funding is appropriated from the Intellectual and Developmentally Disabled Cash Fund and then reappropriated to the Division of Intellectual and Developmental Disabilities Personal Services and Operating Expenses appropriations.

(2) PROGRAM COSTS

ADULT COMPREHENSIVE SERVICES

Funding supports the HCBS-DD waiver, which provides services and supports to persons with intellectual and developmental disabilities, allowing them to continue to live in the community, yet within a 24-hour care model. Services provided under this waiver include: day habilitation; prevocational; residential habilitation; supported employment; dental; vision; behavioral services; non-medical transportation; and specialized medical equipment and supplies.

ADULT SUPPORTED LIVING SERVICES

This line provides funding for the HCBS-SLS waiver and the State Supported Living Services option.

The HCBS-SLS waiver provides supported living in the home or community to persons with intellectual and developmental disabilities. Services include: day habilitation; homemaker; personal care; respite; supported employment; dental; vision; assistive technology; behavioral services; home accessibility adaptation; mentorship; non-medical transportation; personal emergency response systems; professional therapeutic services; specialized medical equipment and supplies; and vehicle modification.

The State Supported Living Services option provides the same service array as the HCBS-SLS waiver, but is available to individuals who do not meet Medicaid eligibility requirements. State Supported Living Services are locally administered by the Community Centered Boards. Individuals receiving services must not need 24-hour program support. Services are funded with General Fund

CHILDREN'S EXTENSIVE SUPPORT SERVICES

The HCBS-CES waiver provides various services for children who require nearly 24-hour supervision due to the severity of the child's intellectual or developmental disability. Services include: homemaker; personal care, respite, vision, adapted and therapeutic recreation equipment; assistive technology; behavioral services; community connector; home accessibility adaptation; professional therapeutic services; specialized medical equipment and supplies; vehicle modifications; and parent education.

CASE MANAGEMENT

This line funds 20 Community-Centered Boards (CCBs) to provide case-management, utilization review/quality assurance/supports intensity scale (UR/QA/SIS Case Management is provided for the three HCBS waivers, the State Supported Living Services delivery option, the State Supported Family Support Services Program, and the Family Support Loan Fund. Waiver services are delivered through

community providers, including CCBs and two state-operated regional centers. Case Management services are currently appropriated for approximately 10,068 Medicaid clients under the consolidated line item. Targeted Case Management is billed fee-for-service rates.

FAMILY SUPPORT SERVICES

The Family Support Services line provides financial support for families who have children, including adult children, with developmental disabilities or delays with costs that are beyond those normally experienced by other families. The primary purpose of the Family Support Services Program is to keep families together in the family home. In order to qualify, a family must have an eligible child living at home or be interested in facilitating a child's return to the home. Examples of services include: medical and dental expenses, additional insurance expenses, respite care and childcare, special equipment, home or vehicle modifications or repairs, family counseling and support groups, recreation and leisure needs, transportation, and homemaker services.

PREVENTIVE DENTAL HYGIENE

This line item supports outreach services to match individuals needing dental care with dentists willing to provide pro-bono dental care. Funding also goes to train clients receiving developmental disability services and staff about preventive dentistry and to educate both populations about how to access dental care.

ELIGIBILITY DETERMINATION AND WAITING LIST MANAGEMENT

This line provides reimbursement to Community-Centered Boards (CCBs) for administrative functions, including determination of intellectual and developmental disability and Pre-Admission Screening and Resident Reviews (PASRR) to clients throughout the State. Reimbursement for PASRR is only for Level II screenings, which ensures that individuals meet federal criteria for appropriateness of care delivered in a Nursing Facility, as well as determining if they need specialized services. In addition, CCBs are reimbursed for management of the waiting list for the Home and Community Based Services Supported Living Services (HCBS-SLS) waiver.

(5) INDIGENT CARE PROGRAM

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

COLORADO INDIGENT CARE PROGRAM

The Colorado Indigent Care Program provides funding to hospitals and clinics that have uncompensated costs from treating underinsured or low-income uninsured Coloradans. It is neither an insurance program nor an entitlement program, but rather a financial vehicle for providers to recoup some of their costs for providing medical services to the medically indigent. For FY 2014-15, the program consists of the following four line items: Safety-Net Provider Payments; The Children's Hospital Clinic Based Indigent Care; the Primary Care Fund Program; and, Pediatric Specialty Hospital. These line items allow providers to receive partial compensation for uncompensated costs due to services rendered to uninsured or underinsured low-income Colorado residents who are not eligible for Medicaid or the Children's Basic Health Plan (effective July 1, 2002). Clients can have third-party insurance, but this resource must be exhausted prior to the providers receiving any reimbursement from the program.

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

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

about funding mechanisms.

As required by HB 04-1438, the Department must include in the annual Budget Request the number of Medicaid eligible inpatient days and the total number of inpatient days by provider each year. This information can be found in Exhibit K in the Department's November 1, 2014 FY 2014-15 Budget Request.

SAFETY NET PROVIDER PAYMENTS

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

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

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

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

Under the Disproportionate Share Hospital payments, the total federal amount made available is a projection based on information in the Medicare Drug, Improvement, and Modernization Act of 2003. The CICP Disproportionate Share Hospital Payment is a payment of this type.

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

CLINIC-BASED INDIGENT CARE

The Clinic Based-Indigent Care line item was created in FY 2002-03 utilizing the Medicare Upper Payment Limit for inpatient hospital services. The Children's Hospital qualifies for this payment because the hospital is privately owned. Being privately owned, the certification of public expenditures for uncompensated Medicaid costs is not allowed. Instead, General Fund is required to draw down the matching federal funds. From this appropriation, The Children's Hospital distributes all but $60,000 in total funds to participating clinics. The $60,000 is retained by The Children's Hospital as an administration fee to cover expenses associated with operating the program. Reimbursement to participating clinics is based on a percentage of uncompensated indigent care costs relative to uncompensated costs reported by all recipients as reported in the Colorado Indigent Care Program Annual Report, increased for two years using the Consumer Price Index, All Workers, Denver Medical Costs for July of the most recent year.

PEDIATRIC SPECIALITY HOSPITAL

The creation of this line item was recommended during a Joint Budget Committee (JBC) meeting on March 24, 2005, to provide funding to the State's only pediatric specialty hospital, The Children's Hospital, in an effort to help offset the costs of providing care to large numbers of Medicaid and indigent care clients. Funding for the Pediatric Specialty Hospital line item originated from General Fund savings anticipated from the removal of the Medicaid Asset Test per HB 05-1262 (Tobacco Tax Bill). Payments are made using Upper Payment Limit financing.

APPROPRIATION FROM TOBACCO TAX CASH FUND TO THE GENERAL FUND

In FY 2004-05, the General Assembly passed HB 05-1262, legislation that created rules to govern the allocation of the Tobacco Tax revenues. Section 24-22-117 (1)(c)(I)(A), C.R.S. states that of the 3% of Tobacco Tax revenues appropriated into the Tobacco Tax Cash Fund, 20% should be appropriated to the General Fund.

PRIMARY CARE FUND PROGRAM

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

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

CHILDREN'S BASIC HEALTH PLAN

History and Background Information

In 1997, HB 97-1304 created the Colorado Children's Basic Health Plan. Title XXI of the Social Security Act created the State Children's Health Insurance Program through the Congressional Budget Reconciliation Act of 1997. The Children's Basic Health Plan was reauthorized at the federal level through the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). HB 98-1325 authorized Colorado to participate in Title XXI, and provided basic health insurance coverage for uninsured children of families with incomes below 185% of the federal poverty level (FPL). The Medical Services Board is the rule-making authority for the Plan. The General Assembly has specified that the Children's Basic Health Plan shall be a non-entitlement, non-Medicaid program that delivers coverage in accordance with the principles of private insurance. The Children's Basic Health Plan benefit package is substantially equivalent to the level of coverage mandated by the State for small, privately insured groups. A dental benefit, offered in a capitated managed care environment, was added for children in February 2002. Under HB 02-1155, prenatal, delivery, and postpartum benefits were added for uninsured pregnant women with incomes under 185% FPL. To participate in the plan, families with incomes over 150% FPL (with the exception of pregnant women) pay a nominal annual enrollment fee, based on family size and income. All State expenditures for benefits are matched with 65% Title XXI federal funds up to the federal allocation available. Annual enrollment fees collected from families are deposited in the Children's Basic Health Plan Trust Fund. However, there is no federal financial participation on the annual enrollment fees collected from families. Based on a memorandum of understanding with

the Centers for Medicare and Medicaid Services, Colorado's administrative expenditures are matched differently than the normal 65% federal financial participation rate for Title XXI, and may not exceed 10% of total expenditures.

Until FY 2010-11, the Children's Basic Health Plan consisted of several distinct line items in the Department's (4) Indigent Care Program Long Bill group. Effective in FY 2000-01, per Supplemental Bill SB 01-183, the line items and appropriations were moved from the (5) Other Medical Services Long Bill group to the (4) Indigent Care Program Long Bill group. In the Long Bill for FY 2003-04, the Children's Basic Health Plan Medical Premiums for children and the Prenatal and Delivery line created in HB 02-1155 for pregnant women were combined into a single Long Bill line item titled Children's Basic Health Plan Premium Costs. In the FY 2010-11 Supplemental Bill (SB 11-139), the Children's Basic Health Plan Premium Costs line item was combined with the Children's Basic Health Plan Dental Benefit costs line item into a single line item titled Children's Basic Health Plan Medical and Dental Costs.

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

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

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

During the 2011 Legislative Session, two bills were passed that altered Medicaid eligibility for children and pregnant women and changed the structure of the Children's Basic Health Plan. SB 11-008 increases Medicaid eligibility for children aged 6 through 18 with family incomes up to 133% FPL beginning in January 2013. SB 11-250 implements a federal mandate to expand Medicaid eligibility for pregnant women with family incomes from 134% to 185% FPL beginning in January 2013. Although the children and pregnant women newly eligible for Medicaid will receive standard Medicaid benefits, the Department will continue to receive federal funding through Title XXI and the enhanced 65% federal financial participation (FFP) rate for their expenditures. Beginning October 1, 2015, the Department will receive an additional 23 percentage point FFP, which increases the match to 88.50%. The Department has received

approval from the Centers for Medicare and Medicaid Services to convert its separate Title XXI program into a combination program that will allow this funding.

CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION

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

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

Cost Allocation Plan for Federal Funds		
Administrative Function	**Share of Funds at Title XXI Federal Match**	**Share of Funds at Title XIX Federal Match**
Marketing and Outreach Component	77.3%	22.7%

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

CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS

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

(6) OTHER MEDICAL SERVICES

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

OLD AGE PENSION STATE MEDICAL PROGRAM

The Old Age Pension State Medical Program line item, also known as the Old Age Pension Health and Medical Care Program, provides limited medical and dental care for non-Medicaid-eligible individuals receiving Old Age Pension grants. This program is 100% State-funded and is not a federal entitlement. Eligible recipients are over the age of 64 and ineligible for Medicaid. The Old Age Pension State Medical Program is currently funded through the Old Age Pension Health and Medical Care Fund established in Article XXIV of the constitution and supplemental General Fund appropriations to ensure adequate funding.

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

Both the administration and appropriation of the Old Age Pension State Medical Program, created in section 25.5-2-101, C.R.S., was transferred to the Department from the Department of Human Services, effective July 1, 2003. Beginning in FY 2003-04, this line item was placed in the "Other Medical Services" Long Bill group. The Department of Human Services continues to have statutory authority to administer the Old Age Pension, the State Old Age Pension Fund, and the Old Age Pension Stabilization Fund.

COMMISSION ON FAMILY MEDICINE RESIDENCY TRAINING PROGRAMS

The Commission on Family Medicine Residency Training Programs line item provides payments to nine hospitals to help offset their costs of participating in the Colorado Family Medicine Residency Training Program. The program is administered by the Advisory Commission on Family Medicine in the Department of Health Care Policy and Financing (Senate Bill 13-010). Before FY 1994-95, the program was funded entirely with General Fund appropriated to the Department of Higher Education, however, beginning in FY 1994-95, federal regulations allowed a federal financial participation rate of 50%. Since federal Medicaid funds were involved, a line item

appropriation to the Department was established. Also, effective July 1, 2013, a privately-owned hospital that receives Family Medicine Residency Training program payments is eligible to receive additional funds for the development and maintenance of family medicine residency training programs in rural areas.

STATE UNIVERSITY TEACHING HOSPITALS, DENVER HEALTH AND HOSPITAL AUTHORITY

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

STATE UNIVERSITY TEACHING HOSPITALS, UNIVERSITY OF COLORADO HOSPITAL AUTHORITY

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

MEDICARE MODERNIZATION ACT STATE CONTRIBUTION PAYMENT

On January 1, 2006, the Centers for Medicare and Medicaid Services assumed responsibility for the Part D prescription drug benefit, replacing Medicaid prescription drug coverage for clients dually eligible for both Medicare and Medicaid benefits. In lieu of the obligation of states to cover prescription drugs for this population, the Centers for Medicare and Medicaid Services began requiring states to pay a portion of what their anticipated dual eligible drug cost would have been had this cost shift not occurred. This is known as the "clawback" payment. For calendar year 2006, states were to pay 90% of the federal portion of their average dual eligible drug benefit from calendar year 2003, inflated to 2006 using the National Healthcare Expenditure average growth rate. As each calendar year passed, the 90% factor was reduced, or "phased down," by 1.67% each year, until it reached 75% in 2015, where it remains today and ongoing.

PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION

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

The line item contains all administrative funding for the program excluding the Department's personal services, the transfer of funds to the Department of Education, and costs associated with processing claims in the Medicaid Management Information System (MMIS). Funding for this line consists of a transfer of spending authority from the "(6) Other Medical Services; Public School Health Services" line item. Also included in this line item is funding for the Department's contract with Public Consulting Group, Inc. (PCG). PCG's scope of work includes planning and administering time studies to support the rate-setting methodology, training school staff, defining allowable cost, and providing assistance in the certification of public expenditures process.

PUBLIC SCHOOL HEALTH SERVICES

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

Unlike most other programs administered by the Department, the State's contribution of funding to the program is derived from certification of public expenditures. This process allows participating school district providers to certify the expenditure of state funds

on eligible services that can be matched by the federal government through Title XIX of the Social Security Act. It is important to note that 70% of the matched funds for this program must help expand health services for all children while the remaining 30% can be put towards initiatives that seek to expand the coverage for under or uninsured children.

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

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT TRAINING GRANT PROGRAM

Pursuant to Section 25.5-5-208, C.R.S., this program grants funding from the Marijuana Tax Cash Fund to organizations to train health professionals on providing services related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. Specifically, the funding is used for the following:

- Training for health professional statewide that is evidence-based and that may be either in person or web based;
- Consultation and technical assistance to providers, healthcare organizations, and stakeholders;
- Outreach, communication, and education of providers and patients;
- Coordination with primary care, mental health, integrated health care, and substance use prevention, treatment and recovery efforts; and
- Campaigning to increase public awareness of the risks related to alcohol, marijuana, tobacco, and drug use and to reduce the stigma of treatment.

(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

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

Until FY 2001-02, Medicaid funding for DHS was appropriated in one line item. In FY 2001-02, the General Assembly separated the DHS appropriations into 18 separate line items to improve expenditure tracking and reconciliation. A description of each of the line items currently within the Department's budget follows.

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

(A) EXECUTIVE DIRECTOR'S OFFICE – MEDICAID FUNDING

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

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

(B) OFFICE OF INFORMATION TECHNOLOGY SERVICES – MEDICAID FUNDING

This line item includes Medicaid funding for expenses associated with the DHS Information Systems but specifically excludes CBMS funding. The Office of Information Technology is responsible for developing and maintaining the major DHS centralized computer systems, including systems that link to all counties in the State. Not all of these systems support Medicaid functions, and, therefore, not all receive Medicaid funding. The Office supports centralized databases and provides support and training to users, including county staff and private social services providers. The Office of Information Technology Services also helps set policies and strategic directions for de-centralized information technology systems that are operated by individual divisions within DHS.

(C) OFFICE OF OPERATIONS – MEDICAID FUNDING

The Department of Human Services' (DHS) Office of Operations appropriation contains funding for four divisions: Facilities Management, Accounting, Procurement, and Contract Management, of which some are partially funded with Medicaid funding. This appropriation is for the cost of salaries and operating expenses associated with some of the positions in this Office, as well as for utilities costs and Common Policy items such as Vehicle Lease Payments. POTS funding is centrally appropriated in the Executive Director's Office for these positions and is transferred into the Office of Operations as the fiscal year progresses.

(D) DIVISION OF CHILD WELFARE – MEDICAID FUNDING

ADMINISTRATION

The Division of Child Welfare is located under the Deputy Executive Director of the Office of Children, Youth, and Families. The Administration of Child Welfare oversees a group of services intended to protect children from harm and to assist families in caring for and protecting their children. Although the Administration line item was created as a separate line item in the budget for DHS in FY 2000-01, the separate line for the Department titled "(D) Division of Child Welfare: Administration" was added to the Department's budget in FY 2005-06. Prior to that fiscal year, both administration and services were in a blended appropriation titled "Division of Child Welfare – Medicaid Funding." The child welfare program receives Medicaid funding under federal Title XIX for the medical needs of children who are in the custody of the county departments of human/social services.

The Division of Child Welfare has two staff who are responsible for oversight of the county work to enroll the children in the Child Welfare system for Medicaid services and who administer the Children's Habilitation Residential Program (CHRP) waiver. The Medicaid funding in this administration line item pays for the staff salaries related to these workers that provide Medicaid-oversight work.

CHILD WELFARE SERVICES

The Child Welfare Services line item supports funding for counties to deliver Medicaid associated services for children and families. The line item provides Medicaid funding for the Children's Residential Habilitation Program (CHRP) Medicaid waiver; out-of-home placement in psychiatric residential treatment facilities; and therapeutic services for children in residential child care facilities.

(E) OFFICE OF EARLY CHILDHOOD – MEDICAID FUNDING

During the 2013 Legislative Session, the General Assembly passed HB 13-1117 "Concerning Alignment of Child Development Programs." The legislation was signed into law by the Governor on May 7, 2013. One result was the creation of the Office of Early Childhood at the Department of Human Services. The early childhood system in Colorado includes four system sectors that address the needs of children, including early learning, child health, child mental health, and family support and parent education. Research confirms that these areas, along with prenatal health, are interrelated and that it is difficult if not impossible to separates children's emotional, behavioral, and learning needs from their prenatal and child health and wellness or from the involvement and support of their families.

DIVISION OF COMMUNITY AND FAMILY SUPPORT, EARLY INTERVENTION SERVICES

Early Intervention Services Case Management previously existed at DHS under Services for People with Disabilities as Community Services for People with Developmental Disabilities. The case management of these services is aimed at families who have infants and toddlers through age two, with developmental disabilities or developmental delays that have been identified at a young age. Therefore, HB 13-1117 has repositioned this service under the Office of Early Childhood to improve the delivery of services to very young children.

(F) OFFICE OF SELF SUFFICIENCY – MEDICAID FUNDING

SYSTEMATIC ALIEN VERIFICATION FOR ELIGIBILITY

The Systematic Alien Verification for Eligibility (SAVE) was a new line item beginning with the FY 2010-11 Long Bill (HB 10-1376). The system is part of the website for U.S. Citizenship and Immigration Services that is now part of the federal Department of Homeland Security. The database is a nationally accessible database of selected immigration-status information on legal immigrants entering the United States. SAVE enables federal, state, and local government agencies and licensing bureaus to obtain immigration status information that they need to determine a non-citizen applicant's eligibility for many public benefits. The SAVE database also administers employment verification programs to enable employers to verify quickly and easily the work authorization of their newly hired employees.

Previously, the Department's share of the funding for SAVE was included in the Department's Medical Services Premiums line item, and costs related to Medical Assistance Sites checking immigration status for clients presenting for medical care at those sites are still charged to Medical Services Premiums.

(G) BEHAVIORAL HEALTH SERVICES – MEDICAID FUNDING

COMMUNITY BEHAVIORAL HEALTH ADMINISTRATION

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

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

MENTAL HEALTH TREATMENT SERVICES FOR YOUTH

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

HIGH-RISK PREGNANT WOMEN PROGRAM

This line item provides Medicaid funding for prenatal and postpartum substance abuse treatment services for women at risk of a poor birth outcome due to alcohol or substance abuse. The High-Risk Pregnant Women Program, also called "Special Connections," is a statewide voluntary alcohol and drug treatment program for pregnant women who are at risk of poor birth outcomes due to substance

abuse-related disorders. The program is an entitlement program fully funded by Medicaid but administered by the Alcohol and Drug Abuse Division in DHS.

MENTAL HEALTH INSTITUTES

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

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

(H) SERVICES FOR PEOPLE WITH DISABILITIES – MEDICAID FUNDING

REGIONAL CENTERS

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

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

REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS

This line item enables the State to capture depreciation payments from federal authorities associated with regional centers of the Department of Human Services (DHS). The line item was added through the FY 2003-04 Supplemental Bill (HB 04-1320) to reflect historic department practice.

(I) ADULT ASSISTANCE PROGRAMS, COMMUNITY SERVICES FOR THE ELDERLY – MEDICAID FUNDING

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

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

(J) DIVISION OF YOUTH CORRECTIONS – MEDICAID FUNDING

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

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

(K) OTHER

FEDERAL MEDICAID INDIRECT COST REIMBURSEMENT FOR DHS PROGRAMS

This line item was created in the FY 2009-10 Long Bill (SB 09-259). An indirect cost is for a service that is provided for one department but used jointly by several divisions within the Department. As such, it is difficult to assign costs to a particular cost center such as a specific division. Indirect costs are usually constant for a wide range of services and are grouped under fixed costs because the cost is still occurring even if there is a change in work activities. Indirect costs go by other names as well, including common costs, overhead costs, or joint costs.

II. PRIOR-YEAR LEGISLATION

The following is a summary of major legislation enacted in 2016 that affects Department policies and procedures.

HB 16-1081 (Ransom, Esgar, Lundberg, Newell) Removing Obsolete Reporting Provisions in Title 25.5 of the Colorado Revised Statutes

The bill repeals the requirements that the Department submit certain reports to the General Assembly.

HB 16-1097 (Coram, Moreno, Scott) Regulation of Medicaid Non-emergency Transportation Providers

The bill allows providers on non-emergency transportation to Medicaid clients to operate under a limited regulation permit from the Public Utilities Commission (PUC).

HB 16-1277 (Lontine, Landgraf, Kefalas, Roberts) Appeal Process for Medical Assistance Benefits

The bill requires the Department to give Medicaid clients at least 10 days advanced notice prior to suspending, terminating or modifying a client's medical assistance benefits. The bill also extends the deadline to appeal for a client to appeal the intended action to 60 days after the date of the notice, up from 30 days under current law. For clients filing an appeal prior to the date of the intended action, medical benefits must be provided until the appeal is complete. For clients filing an appeal after the date of intended action, the Department may make an exception and continue to provide medical benefits. The Department must promulgate rules for these continuing benefits that are consistent with federal law.

HB 16-1321 (Young, Merrifield, Tate) Medicaid Buy-In for Persons Eligible for Certain Medicaid Waivers

The bill directs the Department to seek federal authorization to implement a Medicaid buy-in program for adults who are eligible to receive home-and community-based services under the Supported Living Services, Brain Injury and the Spinal Cord Injury waiver programs.

HB 16-1407 (Young, Hamner, Rankin, Steadman, Grantham, Lambert) Continuation of the Medicaid Payment Reform and Innovation Pilot Program

The bill allows the Medicaid Payment Reform and Pilot Program to continue on an ongoing basis in the Department. Specifically, the bill removes the July 1, 2013 deadline for the Department to review and select payment projects for inclusion in the pilot program, and removes the June 30, 2016 deadline by which payment projects must be completed. The bill also modifies statute concerning higher education fee-for-service contracts paid to the University of Colorado for specialty education services, specifying that these contracts include care provided by faculty of the University of Colorado Health Sciences Center and are eligible for payment under the state's Medicaid provider reimbursement.

HB 16-1408 (Young, Hamner, Rankin, Steadman, Grantham, Lambert) Allocation of Cash Fund Revenues to Health-Related Programs

The bill creates a new Primary Care Provider Sustainability Fund in the Department to fund increased access to primary care office visits, immunization administration, health screening services, and newborn care, including neonatal critical care. On July 1, 2016 $20.0 million is transferred from the Children's Basic Health Plan Trust to this new fund.

SB 16-027 (Martinez Humenik, Todd, Primavera, Landgraf) Allowing the Option for Medicaid Clients to Obtain Prescribed Drugs Through the Mail

The bill expands the option to receive maintenance medication through the mail to all Medicaid recipients, including medications supplied in three-month quantities and specialty drugs only receivable by mail-order.

SB 16-038 (Aguilar, Young, Sias) Measures to Promote the Transparency of Community-Centered Boards

The bill requires a community centered board (CCB) that receives more than 75 percent of its annual funding from federal, state or local governments, or any combination thereof, to be subject to the Colorado Local Government Audit Act. This bill also requires each CCB to post information on their websites related to the board of directors and their meetings, financial statements, annual budgets and other CCB business related information.

SB 16-077 (Kefalas, Ginal, Primavera) Collaborative Multi-Agency Approach to Increasing Competitive Integrated Employment Opportunities for Persons with Disabilities and Advancing an Employment First Policy

The bill outlines policies designed to increase employment policies for persons with intellectual and developmental disabilities.

SB 16-120 (Roberts, Coram) Providing an Explanation of Benefits to Medicaid Recipients for Purposes of Discovering Potential Medicaid Fraud

The bill requires the Department to provide Explanation of Benefits (EOB) statements to Medicaid clients beginning July 1, 2017. The EOB statements must be distributed at least bimonthly and the Department may determine the most cost effective means of sending out the statements, including email or web-based distribution, with mailed copies sent by request only.

SB 16-178 (Lambert, Kefalas, Young, Brown) Grand Junction Regional Center Campus

The bill directs the Department of Human Services to vacate the Grand Junction Regional center campus, within the parameters of certain guiding principles related to relocating individuals receiving services on the campus to home-like settings of their choosing, and to list the campus for sale no later than July 1, 2018.

SB 16-190 (Steadman, Grantham, Lambert, Rankin, Hamner, Young) Improving the Process for County Administration of Public Assistance Programs

The bill establishes performance standards to improve the administration of Supplemental Nutrition Assistance Program (SNAP). The Department of Human Services (DHS) and counties must endeavor to exceed federal performance measures and must establish a formula for distributing federal monetary bonuses or sanctions associated with SNAP administration to the counties. The DHS is required to contract with an external vendor to collect and analyze data related to county department costs and performance associated with the administration of public assistance programs.

SB 16-192 (Lambert, Grantham, Steadman, Young, Hamner, Rankin) Needs Assessment Tool for Persons Eligible for Long-Term Services and Supports, including Persons with Intellectual and Developmental Disabilities

The bill requires the Department to select a new needs assessment tool for persons receiving long-term services and supports, including services for persons with intellectual and developmental disabilities, by July 1, 2018. The Department is required to use its existing stakeholder process concerning eligibility

SB 16-199 (Scott, Steadman, DelGrosso, Ginal) Program for All-Inclusive Care for the Elderly, Determining the Capitated Rate for Services and Creating an Ombudsman Program for Participants

The bill requires that contracts between the organization that provide program for all-inclusive care for the elderly (PACE providers) include the negotiated monthly capitated rate for services. The rate must be less than the amount that would have been paid for services

to the PACE participate under the Medicaid state plan if the person were not enrolled in PACE. In addition, the bill requires the Department, with participation from PACE organizations, to develop an actuarially sound upper payment limit methodology that meets federal requirements and other standards. The Department must contract with an actuary with relevant experience concerning Medicaid and PACE. Until the upper payment limit methodology is developed, the bill requires that the percentage of the upper payment limit used to determine the monthly capitated rate not be less than the percentage negotiated with providers for FY 2016-17. The Department is not required to develop this new methodology if sufficient gifts, grants and donations are not received for this purpose.

III. WORKLOAD REPORTS

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

HEALTH EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

The Health Effectiveness Data and Information Set (HEDIS®)[1] is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans. The performance measures address many significant health care issues such as access to care, effectiveness of care, and use of services. Each year, different HEDIS measures are selected that relate to quality initiatives outlined in the State Quality Improvement Work Plan. Since different measures are selected annually, variations may occur in data presentation and reported level of detail.

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

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
Childhood Immunization Status (H)						
Combination 2	75.92%	BR	53.24%	75.92%	55.00%	56.25%
Combination 3	75.40%	BR	50.63%	75.40%	52.56%	53.35%

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

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
Combination 4	74.99%	BR	47.23%	74.99%	49.39%	49.45%
Combination 5	64.68%	BR	41.45%	64.68%	43.25%	42.53%
Combination 6	52.87%	BR	23.73%	52.87%	25.99%	35.32%
Combination 7	64.42%	BR	38.85%	64.42%	40.84%	39.70%
Combination 8	52.67%	BR	22.55%	52.67%	24.90%	33.39%
Combination 9	47.02%	BR	20.35%	47.02%	22.42%	29.47%
Combination 10	46.87%	BR	19.35%	46.87%	21.49%	27.93%
Diptheria, Tetanus, Pertussis	76.13%	BR	62.13%	76.13%	63.22%	64.99%
Polio Virus immunizations	84.88%	BR	78.19%	84.88%	78.71%	81.60%
Measles, Mumps, and Rubella	85.14%	BR	79.94%	85.14%	80.34%	82.05%
Haemophilus Influenza Type b	84.46%	BR	72.97%	84.46%	73.86%	77.59%
Hepatitis B immunizations	87.16%	BR	79.64%	87.16%	80.22%	79.90%
VZV (Chicken Pox) vaccine	85.03%	BR	79.28%	85.03%	79.73%	81.49%
Pneumococcal Conjugate	79.18%	BR	65.49%	79.18%	66.56%	66.94%
Hepatitis A	84.10%	BR	70.48%	84.10%	71.54%	71.90%
Rotavirus	67.69%	BR	58.81%	67.69%	59.50%	59.91%

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
Influenza	55.98%	BR	34.44%	55.98%	36.12%	49.08%
Immunizations for Adolescents (H)						
Combination 1	76.72%	BR	63.79%	76.72%	64.85%	62.33%
Meningococcal	77.72%	BR	64.94%	77.72%	65.99%	64.65%
Tdap/Td	78.56%	BR	78.88%	78.56%	78.86%	77.71%
Percent of Children with Well-Child Visits in the First 15 Months of Life (H)						
0 visits (lower indicates better performance)	7.69%	NA	4.72%	7.69%	4.89%	3.97%
6 or more	3.36%	NA	47.02%	3.36%	44.49%	43.97%
Percent of Children with Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (H)	60.87%	BR	56.65%	60.87%	56.96%	57.19%
Percent of Adolescents Receiving a Well-Care Visit (H)	38.27%	BR	31.67%	38.27%	32.13%	32.91%
Annual Dental Vists[4] (FFS Only)						
Ages 2 to 3 Years	NB	NB	54.11%	—	54.11%	54.58%
Ages 4 to 6 Years	NB	NB	65.53%	—	65.53%	65.50%
Ages 7 to 10 Years	NB	NB	68.81%	—	68.81%	69.25%
Ages 11 to 14 Years	NB	NB	64.18%	—	64.18%	64.40%

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
Ages 15 to 18 Years	NB	NB	53.62%	—	53.62%	53.84%
Ages 19 to 21 Years	NB	NB	34.54%	—	34.54%	31.56%
Total	NB	NB	60.59%	—	60.59%	60.32%
Percent of Children/Adolescents Receiving Weight Assessment and Counseling for Nutrition and Physical Activity (H)						
BMI Assessment - 3-11 Years	82.95%	BR	59.36%	82.95%	60.99%	68.04%
Nutrition Counseling - 3-11 Years	82.20%	BR	60.16%	82.20%	61.68%	58.44%
Physical Activity Counseling - 3-11 Yrs	61.74%	BR	46.61%	61.74%	47.66%	48.82%
BMI Assessment - 12-17 Years	71.43%	BR	58.75%	71.43%	59.66%	71.26%
Nutrition Counseling - 12-17 Years	68.71%	BR	56.25%	68.71%	57.15%	55.28%
Physical Activity Counseling - 12-17 Yr	65.99%	BR	50.00%	65.99%	51.15%	52.06%
BMI Assessment - Total	78.83%	BR	59.12%	78.83%	60.50%	69.11%
Nutrition Counseling - Total	77.37%	BR	58.64%	77.37%	59.95%	57.41%
Physical Activity Counseling - Total	63.26%	BR	47.93%	63.26%	49.01%	49.88%
Testing for Children with Pharyngitis	76.34%	89.14%	72.82%	81.12%	73.15%	74.20%
Appropriate Treatment for Children with Upper Respiratory Infection	97.48%	94.98%	91.59%	96.85%	91.92%	N/A
Prenatal and Postpartum Care (H)**						

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
Timeliness of Prenatal Care	81.75%	BR	48.42%	81.75%	50.13%	50.62%
Postpartum Care	54.74%	BR	30.36%	54.74%	31.61%	33.14%
Percent of Children and Adolescents' Accessing Primary Care Practitioner						
Ages 12 to 24 Months	89.33%	NA	91.97%	89.30%	91.77%	92.91%
Ages 25 Months to 6 Years	73.66%	84.93%	79.33%	73.74%	78.92%	79.34%
Ages 7 to 11 Years	78.22%	91.67%	83.17%	78.33%	82.77%	83.78%
Ages 12 to 19 Years	79.00%	89.60%	82.62%	79.12%	82.34%	83.69%
Percent of Adults Accessing Preventive Care						
Ages 20 to 44 Years	60.52%	68.38%	63.77%	64.77%	63.86%	68.84%
Ages 45 to 64 Years	73.59%	76.95%	74.61%	75.44%	74.67%	78.78%
Ages 65 Years and Older	78.35%	89.05%	74.72%	81.40%	75.14%	75.52%
Total	65.78%	71.69%	67.91%	68.91%	67.99%	72.46%
Percent of Women Receiving Chlamydia Screening						
Total	69.33%	46.27%	51.17%	60.91%	52.00%	59.60%
Ages 16 to 20 Years	69.43%	43.70%	46.75%	65.47%	48.19%	55.08%
Ages 21 to 24 Years	69.18%	46.86%	55.50%	57.23%	55.66%	57.49%

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
Percent of Women Receiving Breast Cancer Screening	49.17%	47.38%	29.79%	48.70%	31.40%	32.41%
Percent of Women Receiving Cervical Cancer Screening (H)	56.93%	BR	47.45%	56.93%	47.87%	56.64%
Percent of Adolescent Females Receiving Non-Recommended Cervical Cancer Screening (lower rate indicates better performance)	0.17%	4.04%	1.39%	0.66%	1.33%	1.74%
Percent of Adults Receiving BMI Assessment (H)	84.43%	BR	71.53%	84.43%	72.16%	82.64%
Anti-depressant Medication Management						
Effective Acute Phase Treatment	46.35%	69.92%	67.72%	56.96%	66.97%	65.37%
Effective Continuation Phase Treatment	31.41%	57.47%	53.53%	43.14%	52.81%	49.82%
Follow-up Care for Children Prescribed ADHD Medication						
Initiation	29.41%	35.19%	35.26%	31.97%	35.03%	33.56%
Continuation	NA	NA	35.36%	NA	34.95%	33.37%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents						
Ages 1 to 5 Years	NA	NA	0.00%	NA	0.00%	N/A
Ages 6 to 11 Years	NA	NA	3.78%	NA	3.77%	N/A
Ages 12 to 17 Years	3.23%	NA	7.90%	2.13%	7.79%	N/A
Total	4.55%	0	6.51%	2.70%	6.43%	N/A

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
Controlling High Blood Pressure (H)	70.32%	68.44%	52.31%	69.66%	53.54%	53.54%
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	75.64%	75.00%	75.60%	N/A
Comprehensive Diabetes Care (H)						
HbA1c Testing	89.78%	BR	77.13%	89.78%	77.76%	82.16%
HbA1c Poor Control (>9.0%)	36.74%	BR	55.96%	36.74%	55.00%	44.18%
HbA1c Control (<8.0%)	48.66%	BR	36.74%	48.66%	37.34%	43.61%
Eye Exam	55.96%	BR	39.66%	55.96%	40.47%	45.85%
Medical Attention for Nephropathy	89.29%	BR	85.16%	89.29%	85.36%	73.64%
Blood Pressure Controlled <140/90 mm Hg	73.72%	BR	57.42%	73.72%	58.24%	61.91%
Percent of Clients on Persistent Medications Receiving Annual Monitoring						
ACE Inhibitors or ARBs	85.22%	84.54%	83.49%	84.92%	83.62%	85.32%
Digoxin	NA	NA	55.51%	0.5806	55.78%	59.26%
Diuretics	85.05%	84.17%	83.57%	84.65%	83.68%	85.47%
Total	85.14%	84.05%	83.37%	84.65%	83.49%	85.20%
Use of Imaging Studies for Low Back Pain	81.26%	78.35%	76.92%	79.96%	77.16%	78.71%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	45.54%	42.11%	30.46%	43.16%	31.13%	29.52%

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
Pharmacotherapy Management of COPD Exacerbation						
Systemic corticosteroid	61.54%	53.99%	68.45%	58.22%	66.77%	59.73%
Bronchodilator	73.08%	57.06%	82.29%	66.04%	79.63%	75.65%
Medication Management for People with Asthma						
Medication Compliance 50%: 5-11 Years	30.47%	NA	71.42%	30.58%	69.33%	67.45%
Medication Compliance 75%: 5-11 Years	36.13%	NA	65.54%	37.65%	64.14%	44.40%
Medication Compliance 50%: 12-18 Years	46.26%	66.67%	70.80%	52.58%	69.77%	62.26%
Medication Compliance 75%: 12-18 Years	78.26%	NA	81.16%	80.77%	81.13%	38.26%
Medication Compliance 50%: 19-50 Years	39.76%	65.91%	70.44%	43.20%	69.00%	68.26%
Medication Compliance 75%: 19-50 Years	9.01%	NA	47.88%	9.50%	45.92%	46.06%
Medication Compliance 50%: 51-64 Years	14.84%	NA	42.53%	15.43%	41.17%	75.26%
Medication Compliance 75%: 51-64 Years	21.77%	0.5	49.02%	30.52%	47.97%	56.19%
Medication Compliance 50%: Total	47.83%	NA	58.84%	48.08%	58.23%	66.46%
Medication Compliance 75%: Total	16.87%	45.45%	47.64%	20.63%	46.21%	43.49%
Asthma Medication Ratio						
5-11 years	39.53%	NA	72.46%	41.22%	70.83%	71.77%

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
12-18 years	29.21%	NA	61.45%	30.65%	59.87%	72.22%
19-50 years	25.74%	58.82%	51.73%	35.54%	50.74%	77.08%
51-64 years	33.77%	NA	61.85%	33.33%	59.64%	72.33%
Total	32.39%	58.26%	62.20%	36.00%	60.71%	73.17%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.13%	35.42%	25.11%	27.94%	25.39%	22.87%
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	83.33%	65.00%	80.72%	73.37%	79.89%	75.33%
Ambulatory Care (Per 1,000 Member Months)						
Outpatient Visits	207.09	306.76	277.74	239.20	274.59	289.9
ED Visits	43.97	71.40	59.69	52.81	59.12	62.03
Inpatient Utilization - General Hospital/Acute Care						
Discharges per 1,000 MM (Total Inpatient)	5.48	9.35	7.21	6.73	7.17	7.87
Days per 1,000 MM (Total Inpatient)	24.92	32.7	31.36	27.43	31.04	9.58
Average Length of Stay (Total Inpatient)	4.55	3.50	4.35	4.08	4.33	1.22
Discharges per 1,000 MM (Medicine)	3.06	0.65	3.5	2.28	3.40	3.76
Days per 1,000 MM (Medicine)	13.46	2.53	13.81	9.94	13.50	4.83

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
Average Length of Stay (Medicine)	4.41	3.90	3.95	4.36	3.97	1.28
Discharges per 1,000 MM (Surgery)	0.81	6.37	1.71	2.60	1.78	1.84
Days per 1,000 MM (Surgery)	7.12	25.02	12.48	12.89	12.51	2.34
Average Length of Stay (Surgery)	8.77	3.93	7.31	4.95	7.02	1.27
Discharges per 1,000 MM (Maternity)	2.61	2.42	2.86	2.53	2.83	3.34
Days per 1,000 MM (Maternity)	7.03	5.34	7.23	6.31	7.15	3.55
Average Length of Stay (Maternity)	2.69	2.21	2.53	2.49	2.53	1.06
Antibiotic Utilization						
Average Scrips for PMPY for Antibiotics (All Ages)	0.34	1.02	0.99	0.56	0.96	0.9
Averages Days Supplied per Antibiotic Scrip (All Ages)	9.33	9.30	9.75	9.31	9.72	9.67
Average Scrips PMPY for Antibiotics of Concern (All Ages)	0.10	0.44	0.38	0.21	0.36	0.34
Percentage of Antibiotics of Concern of all Antibiotic Scrips (All Ages)	28.12%	43.15%	38.20%	36.89%	38.13%	38.29%
Frequency of Selected Procedures (Per 1,000 Member Months)						
Bariatric weight loss surgery (0-19 Male)	0	0	0	0	0	0
Bariatric weight loss surgery (0-19 Female)	0	0	0	0	0	0
Bariatric weight loss surgery (20-44 Male)	0	0.05	0.01	0.03	0.01	0.01

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
Bariatric weight loss surgery (20-44 Female)	0.05	0.11	0.05	0.08	0.06	0.06
Bariatric weight loss surgery (45-64 Male)	0.02	0.06	0.01	0.04	0.01	0.01
Bariatric weight loss surgery (45-64 Female)	0.12	0.16	0.07	0.14	0.08	0.06
Tonsillectomy (0-9 Male & Female)	0.31	0.84	0.59	0.32	0.57	0.53
Tonsillectomy (10-19 Male & Female)	0.18	0.33	0.36	0.19	0.35	0.33
Hysterectomy, Abdominal (15-44 Female)	0.06	0.15	0.1	0.1	0.1	0.08
Hysterectomy, Abdominal (45-64 Female)	0.26	0.26	0.24	0.26	0.24	0.18
Hysterectomy, Vaginal (15-44 Female)	0.06	0.49	0.14	0.26	0.15	0.16
Hysterectomy, Vaginal (45-64 Female)	0.07	0.47	0.18	0.31	0.19	0.18
Cholecystectomy, Open (30-64 Male)	0.04	0	0.05	0.02	0.05	0.03
Cholecystectomy, Open (15-44 Female)	0.01	0	0.02	0	0.01	0.01
Cholecystectomy, Open (45-64 Female)	0	0.03	0.04	0.02	0.04	0.03
Cholecystectomy(laparoscopic) (30-64 Male)	0.09	0.35	0.38	0.24	0.37	0.29
Cholecystectomy(laparoscopic) (15-44 Female)	0.47	0.99	0.73	0.71	0.73	0.7
Cholecystectomy(laparoscopic) (45-64 Female)	0.33	0.91	0.72	0.67	0.72	0.67
Back Surgery (20-44 Male)	0.1	0.35	0.29	0.26	0.29	0.23

HEDIS 2016 Medicaid Measures*	DHMC	RMHP	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	2015 Colorado Medicaid Weighted Average
Back Surgery (20-44 Female)	0.05	0.24	0.24	0.15	0.23	0.17
Back Surgery (45-64 Male)	0.62	0.92	0.88	0.79	0.87	0.54
Back Surgery (45-64 Female)	0.23	0.58	0.85	0.44	0.82	0.55
Mastectomy (15-44 Female)	0	0.04	0.04	0.02	0.04	0.02
Mastectomy (45-64 Female)	0.23	0.21	0.25	0.22	0.25	0.17
Lumpectomy (15-44 Female)	0.04	0.21	0.1	0.12	0.1	0.09
Lumpectomy (45-64 Female)	0.19	0.36	0.3	0.29	0.3	0.35

* SMCN rates were deemed invalid, and therefore, were not included.

** The Department's HEDIS 2015 reporting requirement for this measure was hybrid for the health plans and administrative for FFS. Therefore, comparison of the health plan and FFS rates may not accurately reflect performance differences as the data collection methodology differed.

§ Due to changes in member eligibility for children in RMHP-MP, rates that include children in the eligible population may not be comparable to that of DHMC or FFS.

1 HMO Weighted Averages were derived based on data submitted for DHMC and RMHP-MP.

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

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

NR indicates that the rate could not be publically reported because the calculated rate was materially biased, or the health plan chose not to report the measure, or the health plan was not required to report measure.

DEMOGRAPHICS AND EXPENDITURES

Demographic statistics provide valuable insight on the demand for medical care within each region. More populated areas tend to have a greater demand for medical care. Therefore, a region that is more populated is likely to have higher medical expenditures and caseloads. Likewise, as Colorado's population increases, the demand for medical care will also increase. The Department is reporting county-level data from the 2010-2014 American Community Survey conducted by the United States Census Bureau as well as 2016 demographic forecasts from the Department of Local Affairs (DOLA).

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

Medicaid

Using the Department's decision support system database, FY 2015-16 Medicaid data was collected for the following statistics and reported in the following table for the State by county:

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

Please note monthly expenditures reported to the Joint Budget Committee are derived from the Colorado Operations Resource Engine (CORE). The decision support system extracts data on a different time span and from a different source (i.e., Medicaid Management Information System – MMIS) than CORE. In addition, Medicaid expenditures reported include those for Medical Services Premiums, Medicaid Mental Health, and certain claims-based costs for Medicaid-funded programs administered by the Department of Human Services. Therefore, total expenditures presented in this document will not reconcile with the actual medical services expenditures reported in Exhibit M in the November 1, 2016 FY 2017-18 Budget Request.

Children's Basic Health Plan

Using FY 2015-16 expenditures and caseload data for the Children's Basic Health Plan (CHP+), the Department compiled the following data and reported it by county in the following table:

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

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

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

Colorado's Demographics, Medicaid, CHP+, and CICP – A Statewide View	
Characteristics	**Colorado**
Demographic Characteristics	
Population (2016) [1]	5,538,580
Population (2010-14) [2]	5,197,580
Percent of Population 16+ in Labor Force (2010-14) [2]	68.67%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	16.89%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	8.85%
Percent of Female-Headed Households (2010-14) [2]	10.31%
Medicaid Characteristics (FY 2015-16) [3]	
Average Number of Medicaid Clients per Month	1,296,938
Percent of Population Who are Medicaid Clients	23.42%
Medicaid Expenditures	$6,981,449,181
Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]	
Average Number of CHP+ Clients per Month	51,709
Percent of Population Who are CHP+ Clients	0.93%

CHP+ Expenditures	$118,599,698
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)	
Unduplicated Client Count	58,224
Number of CICP Providers [5]	71
CICP Expenditures	$144,043,878

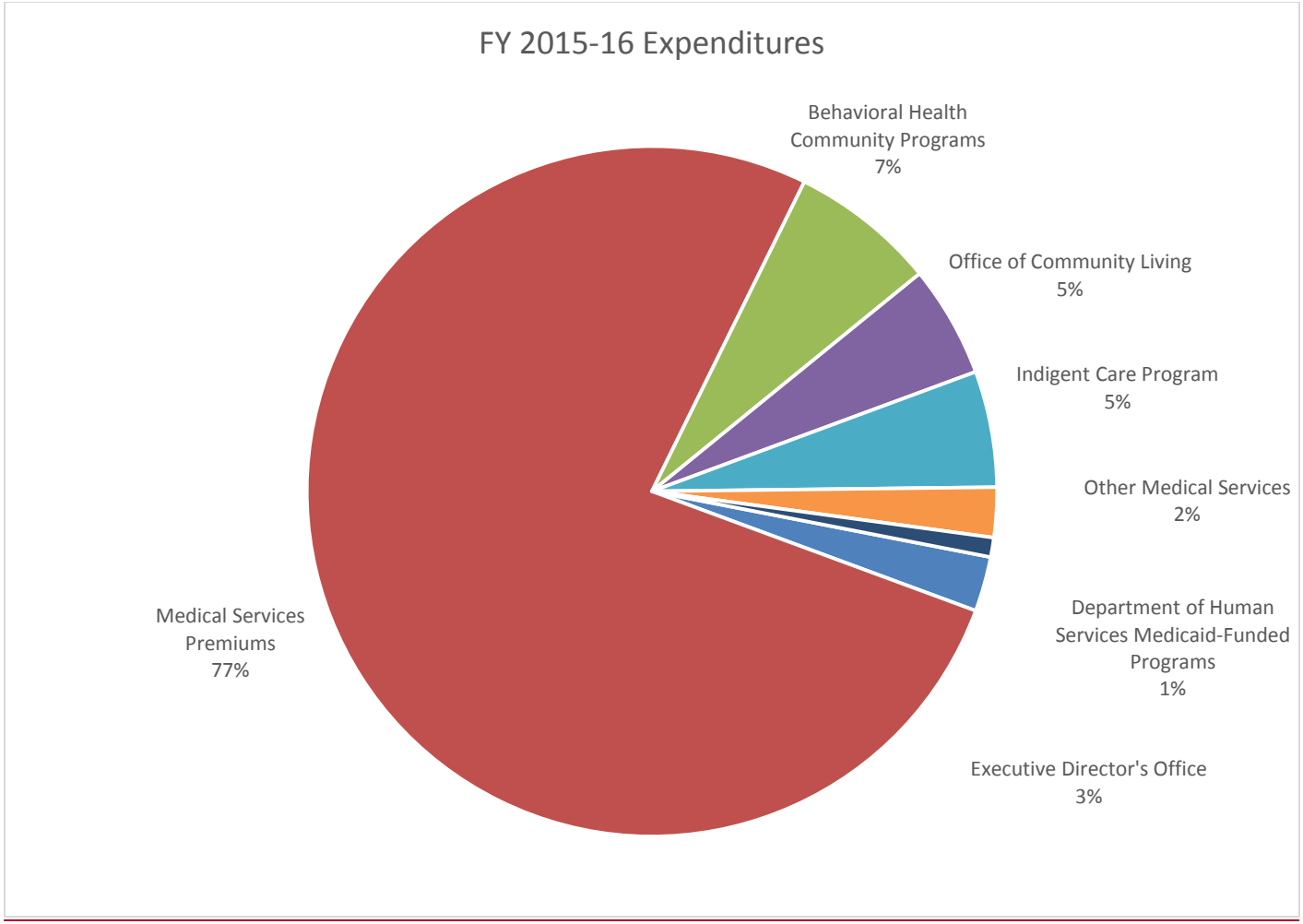
1) Source: Department of Local Affairs, Components of Change - County (2000 to 2050), 1-year Increments, September 2016

2) Source: 20010-2014 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

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

4) CHP+ caseload does not include "CHP+ at Work" clients. Counties with fewer than 30 clients have been assigned a value of NR

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



Source: November 2016 FY 2017-18 Budget Request, Schedule 2.

MEDICAID AND THE CHILDREN'S BASIC HEALTH PLAN

The following table provides insight on the variations of Medicaid and the Children's Basic Health Plan (CHP+) usage across Colorado counties. Some important caveats must be mentioned concerning the Medicaid and CHP+ data presented in the county table. Overall, Medicaid and CHP+ expenditure figures by county will not equal the year-to-date FY 2015-16 appropriated or actual amounts. This is due to several factors:

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

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

3. Expenditures reported to the Joint Budget Committee are derived from the Colorado Operations Resource Engine (CORE), whereas the Decision Support System database extracts its data from the Medicaid Management Information System (MMIS). Therefore, total Medicaid and CHP+ expenditures presented in the table below will not reconcile with the numbers for actual medical services reported in the June 2016 Premiums, Caseload, and Expenditure Report to the Joint Budget Committee. Some Medicaid expenditures are not linked to an eligibility type or to a unique client identification number for the following reasons:

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

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

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

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

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Adams**	**Alamosa**	**Arapahoe**	**Archuleta**
Demographic Characteristics				
Population (2016) [1]	500,890	16,108	639,337	12,680
Percent of Colorado Population (2016)	9.04%	0.29%	11.54%	0.23%
Population (2010-14) [2]	461,558	16,111	596,684	12,132
Percent of Colorado Population (2010-14)	8.88%	0.31%	11.48%	0.23%
Percent of Population 16+ in Labor Force (2010-14) [2]	70.80%	56.50%	71.50%	59.80%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	28.70%	22.90%	22.20%	12.40%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	10.60%	17.40%	8.60%	9.30%
Percent of Female-Headed Households (2010-14) [2]	13.59%	11.98%	12.21%	10.05%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	146,426	7,326	140,866	3,438
Percent of Population Who are Medicaid Clients	29.23%	45.48%	22.03%	27.11%
Medicaid Expenditures	$716,034,795	$35,523,728	$775,994,644	$16,685,608
Percent of Total Medicaid Expenditures	10.26%	0.51%	11.12%	0.24%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	6,457	217	6,115	175
Percent of Population Who are CHP+ Clients	1.29%	1.35%	0.96%	1.38%
CHP+ Expenditures	$14,261,704	$489,323	$13,596,092	$437,075
Percent of Total CHP+ Expenditures	12.03%	0.41%	11.46%	0.37%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	5,212	1,446	3,555	0
Number of CICP Providers [5]	3	2	2	0
CICP Expenditures	$32,701,325	$748,345	$1,681,395	$0
Percent of Total CICP Expenditures	22.70%	0.52%	1.17%	0.00%

1) Source: Department of Local Affairs, Components of Change - County (2000 to 2050), 1-year Increments, September 2016

2) Source: 2010-2014 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

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

4) CHP+ caseload does not include "CHP+ at Work" clients. Counties with fewer than 30 clients have been assigned a value of NR

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

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Baca**	**Bent**	**Boulder**	**Broomfield**
Demographic Characteristics				
Population (2016) [1]	3,621	5,722	321,872	65,130
Percent of Colorado Population (2016)	0.07%	0.10%	5.81%	1.18%
Population (2010-14) [2]	3,735	6,000	305,166	59,027
Percent of Colorado Population (2010-14)	0.07%	0.12%	5.87%	1.14%
Percent of Population 16+ in Labor Force (2010-14) [2]	60.70%	32.00%	70.10%	71.50%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	6.50%	15.90%	16.20%	13.90%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	13.30%	15.40%	7.00%	4.30%
Percent of Female-Headed Households (2010-14) [2]	6.60%	13.81%	8.32%	7.60%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	1,267	1,859	51,833	7,125
Percent of Population Who are Medicaid Clients	34.99%	32.49%	16.10%	10.94%
Medicaid Expenditures	$9,197,634	$12,608,149	$272,523,401	$44,506,718
Percent of Total Medicaid Expenditures	0.13%	0.18%	3.90%	0.64%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	62	40	2,240	450
Percent of Population Who are CHP+ Clients	1.71%	0.70%	0.70%	0.69%
CHP+ Expenditures	$141,493	$89,880	$5,024,701	$1,041,540
Percent of Total CHP+ Expenditures	0.12%	0.08%	4.24%	0.88%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	74	0	4,117	0
Number of CICP Providers [5]	1	0	3	0
CICP Expenditures	$49,938	$0	$4,439,850	$0
Percent of Total CICP Expenditures	0.03%	0.00%	3.08%	0.00%

1) Source: Department of Local Affairs, Components of Change - County (2000 to 2050), 1-year Increments, September 2016

2) Source: 2010-2014 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

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

4) CHP+ caseload does not include "CHP+ at Work" clients. Counties with fewer than 30 clients have been assigned a value of NR

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

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Chaffee**	**Cheyenne**	**Clear Creek**	**Conejos**
Demographic Characteristics				
Population (2016) [1]	19,040	1,868	9,119	8,309
Percent of Colorado Population (2016)	0.34%	0.03%	0.16%	0.15%
Population (2010-14) [2]	18,121	2,153	9,114	8,276
Percent of Colorado Population (2010-14)	0.35%	0.04%	0.18%	0.16%
Percent of Population 16+ in Labor Force (2010-14) [2]	56.60%	70.30%	70.90%	54.60%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	6.50%	11.60%	3.90%	35.10%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	6.10%	3.50%	6.30%	16.00%
Percent of Female-Headed Households (2010-14) [2]	8.30%	3.05%	5.41%	13.07%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	4,008	467	1,698	3,534
Percent of Population Who are Medicaid Clients	21.05%	25.00%	18.62%	42.53%
Medicaid Expenditures	$19,502,815	$2,648,101	$7,780,066	$18,822,467
Percent of Total Medicaid Expenditures	0.28%	0.04%	0.11%	0.27%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	319	NR	55	164
Percent of Population Who are CHP+ Clients	1.68%	N/A	0.60%	1.97%
CHP+ Expenditures	$751,978	$72,482	$134,422	$369,728
Percent of Total CHP+ Expenditures	0.63%	0.06%	0.11%	0.31%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	154	0	0	48
Number of CICP Providers [5]	1	0	0	1
CICP Expenditures	$442,161	$0	$0	$59,231
Percent of Total CICP Expenditures	0.31%	0.00%	0.00%	0.04%

1) Source: Department of Local Affairs, Components of Change - County (2000 to 2050), 1-year Increments, September 2016

2) Source: 2010-2014 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

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

4) CHP+ caseload does not include "CHP+ at Work" clients. Counties with fewer than 30 clients have been assigned a value of NR

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Costilla**	**Crowley**	**Custer**	**Delta**
Demographic Characteristics				
Population (2016) [1]	3,613	5,601	4,585	30,552
Percent of Colorado Population (2016)	0.07%	0.10%	0.08%	0.55%
Population (2010-14) [2]	3,578	5,558	4,274	30,378
Percent of Colorado Population (2010-14)	0.07%	0.11%	0.08%	0.58%
Percent of Population 16+ in Labor Force (2010-14) [2]	49.90%	40.50%	44.00%	54.10%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	44.60%	15.40%	6.20%	10.10%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	23.10%	23.20%	12.60%	11.60%
Percent of Female-Headed Households (2010-14) [2]	8.38%	13.64%	2.64%	9.31%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	2,012	1,482	907	9,822
Percent of Population Who are Medicaid Clients	55.69%	26.46%	19.78%	32.15%
Medicaid Expenditures	$8,527,738	$8,470,068	$3,837,973	$49,159,072
Percent of Total Medicaid Expenditures	0.12%	0.12%	0.05%	0.70%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	NR	40	49	394
Percent of Population Who are CHP+ Clients	N/A	0.71%	1.07%	1.29%
CHP+ Expenditures	$54,863	$73,900	$117,276	$953,829
Percent of Total CHP+ Expenditures	0.05%	0.06%	0.10%	0.80%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	0	0	16	112
Number of CICP Providers [5]	0	0	1	1
CICP Expenditures	$0	$0	$5,202	$219,931
Percent of Total CICP Expenditures	0.00%	0.00%	0.00%	0.15%

1) Source: Department of Local Affairs, Components of Change - County (2000 to 2050), 1-year Increments, September 2016

2) Source: 2010-2014 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Denver**	**Dolores**	**Douglas**	**Eagle**
Demographic Characteristics				
Population (2016) [1]	691,406	2,000	326,306	53,861
Percent of Colorado Population (2016)	12.48%	0.04%	5.89%	0.97%
Population (2010-14) [2]	633,777	1,736	299,794	52,233
Percent of Colorado Population (2010-14)	12.19%	0.03%	5.77%	1.00%
Percent of Population 16+ in Labor Force (2010-14) [2]	71.00%	54.60%	73.60%	80.60%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	27.50%	3.20%	9.00%	30.30%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	13.70%	14.90%	3.00%	6.30%
Percent of Female-Headed Households (2010-14) [2]	10.41%	9.75%	7.53%	7.92%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	206,312	544	25,995	7,450
Percent of Population Who are Medicaid Clients	29.84%	27.20%	7.97%	13.83%
Medicaid Expenditures	$1,118,331,760	$2,642,774	$143,873,716	$27,910,698
Percent of Total Medicaid Expenditures	16.02%	0.04%	2.06%	0.40%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	6,118	36	1,777	760
Percent of Population Who are CHP+ Clients	0.88%	1.80%	0.54%	1.41%
CHP+ Expenditures	$13,486,162	$83,535	$3,969,464	$1,814,994
Percent of Total CHP+ Expenditures	11.37%	0.07%	3.35%	1.53%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	10,289	69	0	0
Number of CICP Providers [5]	5	1	0	0
CICP Expenditures	$33,640,532	$20,901	$0	$0
Percent of Total CICP Expenditures	23.35%	0.01%	0.00%	0.00%

1) Source: Department of Local Affairs, Components of Change - County (2000 to 2050), 1-year Increments, September 2016

2) Source: 2010-2014 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

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

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Elbert**	**El Paso**	**Fremont**	**Garfield**
Demographic Characteristics				
Population (2016) [1]	26,641	684,579	47,353	59,386
Percent of Colorado Population (2016)	0.48%	12.36%	0.85%	1.07%
Population (2010-14) [2]	23,545	645,707	46,879	56,684
Percent of Colorado Population (2010-14)	0.45%	12.42%	0.90%	1.09%
Percent of Population 16+ in Labor Force (2010-14) [2]	69.30%	68.50%	39.20%	72.40%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	5.00%	11.50%	11.30%	24.50%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	4.30%	9.00%	14.30%	8.50%
Percent of Female-Headed Households (2010-14) [2]	4.33%	11.47%	9.07%	9.37%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	3,093	175,463	13,222	14,104
Percent of Population Who are Medicaid Clients	11.61%	25.63%	27.92%	23.75%
Medicaid Expenditures	$16,518,141	$897,527,598	$82,372,946	$78,836,666
Percent of Total Medicaid Expenditures	0.24%	12.86%	1.18%	1.13%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	1634,642	4,642	360	1,142
Percent of Population Who are CHP+ Clients	0.61%	0.68%	0.76%	1.92%
CHP+ Expenditures	$373,840	$11,064,959	$861,484	$2,741,029
Percent of Total CHP+ Expenditures	0.32%	9.33%	0.73%	2.31%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	0	11,354	369	976
Number of CICP Providers [5]	0	3	1	3
CICP Expenditures	$0	$22,392,907	$1,033,356	$2,746,719
Percent of Total CICP Expenditures	0.00%	15.55%	0.72%	1.91%

1) Source: Department of Local Affairs, Components of Change - County (2000 to 2050), 1-year Increments, September 2016

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Gilpin**	**Grand**	**Gunnison**	**Hinsdale**
Demographic Characteristics				
Population (2016) [1]	5,917	15,186	16,145	808
Percent of Colorado Population (2016)	0.11%	0.27%	0.29%	0.01%
Population (2010-14) [2]	5,557	14,478	15,503	871
Percent of Colorado Population (2010-14)	0.11%	0.28%	0.30%	0.02%
Percent of Population 16+ in Labor Force (2010-14) [2]	70.80%	73.30%	74.90%	55.30%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	4.40%	10.40%	8.40%	9.10%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	6.90%	6.10%	7.90%	4.30%
Percent of Female-Headed Households (2010-14) [2]	4.99%	5.97%	7.56%	0.96%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	1,075	2,276	3,300	153
Percent of Population Who are Medicaid Clients	18.17%	14.99%	20.44%	18.94%
Medicaid Expenditures	$5,177,082	$10,108,273	$17,967,320	$502,180
Percent of Total Medicaid Expenditures	0.07%	0.14%	0.26%	0.01%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	41	169	255	NR
Percent of Population Who are CHP+ Clients	0.69%	1.11%	1.58%	N/A
CHP+ Expenditures	$88,225	$416,410	$643,642	$49,517
Percent of Total CHP+ Expenditures	0.07%	0.35%	0.54%	0.04%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	0	102	51	0
Number of CICP Providers [5]	0	1	1	0
CICP Expenditures	$0	$234,700	$78,911	$0
Percent of Total CICP Expenditures	0.00%	0.16%	0.05%	0.00%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Huerfano**	**Jackson**	**Jefferson**	**Kiowa**
Demographic Characteristics				
Population (2016) [1]	6,617	1,420	571,459	1,400
Percent of Colorado Population (2016)	0.12%	0.03%	10.32%	0.03%
Population (2010-14) [2]	6,550	1,389	546,162	1,407
Percent of Colorado Population (2010-14)	0.13%	0.03%	10.51%	0.03%
Percent of Population 16+ in Labor Force (2010-14) [2]	47.30%	70.10%	69.70%	65.40%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	13.30%	14.60%	10.40%	3.00%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	13.70%	11.10%	5.70%	7.90%
Percent of Female-Headed Households (2010-14) [2]	7.72%	3.88%	9.75%	6.98%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	2,855	327	98,898	391
Percent of Population Who are Medicaid Clients	43.15%	23.04%	17.31%	27.93%
Medicaid Expenditures	$16,429,980	$1,568,681	$618,315,475	$2,084,536
Percent of Total Medicaid Expenditures	0.24%	0.02%	8.86%	0.03%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	41	NR	3,975	NR
Percent of Population Who are CHP+ Clients	0.62%	N/A	0.70%	N/A
CHP+ Expenditures	$94,023	$48,955	$9,034,385	$55,811
Percent of Total CHP+ Expenditures	0.08%	0.04%	7.62%	0.05%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	56	0	0	0
Number of CICP Providers [5]	1	0	0	0
CICP Expenditures	$63,960	$0	$0	$0
Percent of Total CICP Expenditures	0.04%	0.00%	0.00%	0.00%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Kit Carson**	**Lake**	**La Plata**	**Larimer**
Demographic Characteristics				
Population (2016) [1]	7,964	7,524	56,291	335,427
Percent of Colorado Population (2016)	0.14%	0.14%	1.02%	6.06%
Population (2010-14) [2]	8,122	7,311	52,547	311,435
Percent of Colorado Population (2010-14)	0.16%	0.14%	1.01%	5.99%
Percent of Population 16+ in Labor Force (2010-14) [2]	59.10%	74.70%	66.80%	68.10%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	16.30%	23.70%	9.30%	8.50%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	11.60%	6.70%	5.80%	6.90%
Percent of Female-Headed Households (2010-14) [2]	9.30%	7.53%	8.45%	8.25%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	1,957	1,917	11,286	64,222
Percent of Population Who are Medicaid Clients	24.57%	25.48%	20.05%	19.15%
Medicaid Expenditures	$8,871,665	$6,676,674	$49,024,998	$326,525,832
Percent of Total Medicaid Expenditures	0.13%	0.10%	0.70%	4.68%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	157	103	728	3,077
Percent of Population Who are CHP+ Clients	1.97%	1.37%	1.29%	0.92%
CHP+ Expenditures	$364,500	$250,323	$1,755,328	$7,177,508
Percent of Total CHP+ Expenditures	0.31%	0.21%	1.48%	6.05%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	0	2	51	3,303
Number of CICP Providers [5]	0	1	1	5
CICP Expenditures	$0	$8,925	$434,244	$15,432,882
Percent of Total CICP Expenditures	0.00%	0.01%	0.30%	10.71%

1) Source: Department of Local Affairs, Components of Change - County (2000 to 2050), 1-year Increments, September 2016

2) Source: 2010-2014 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Las Animas**	**Lincoln**	**Logan**	**Mesa**
Demographic Characteristics				
Population (2016) [1]	14,515	5,585	22,369	152,357
Percent of Colorado Population (2016)	0.26%	0.10%	0.40%	2.75%
Population (2010-14) [2]	14,789	5,462	22,604	147,509
Percent of Colorado Population (2010-14)	0.28%	0.11%	0.43%	2.84%
Percent of Population 16+ in Labor Force (2010-14) [2]	56.70%	38.70%	64.10%	63.20%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	14.50%	9.60%	11.30%	7.00%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	10.20%	10.80%	11.50%	11.10%
Percent of Female-Headed Households (2010-14) [2]	11.66%	10.24%	10.82%	10.63%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	5,456	1,364	4,880	44,597
Percent of Population Who are Medicaid Clients	37.59%	24.42%	21.82%	29.27%
Medicaid Expenditures	$39,790,076	$7,171,306	$30,181,064	$291,923,394
Percent of Total Medicaid Expenditures	0.57%	0.10%	0.43%	4.18%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	135	45	254	1,774
Percent of Population Who are CHP+ Clients	0.93%	0.81%	1.14%	1.16%
CHP+ Expenditures	$332,073	$100,938	$585,030	$4,353,828
Percent of Total CHP+ Expenditures	0.28%	0.09%	0.49%	3.67%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	175	0	248	1,148
Number of CICP Providers [5]	1	0	1	4
CICP Expenditures	$191,383	$0	$724,026	$2,923,718
Percent of Total CICP Expenditures	0.13%	0.00%	0.50%	2.03%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Mineral**	**Moffat**	**Montezuma**	**Montrose**
Demographic Characteristics				
Population (2016) [1]	706	12,875	26,948	42,769
Percent of Colorado Population (2016)	0.01%	0.23%	0.49%	0.77%
Population (2010-14) [2]	704	13,286	25,569	40,885
Percent of Colorado Population (2010-14)	0.01%	0.26%	0.49%	0.79%
Percent of Population 16+ in Labor Force (2010-14) [2]	51.30%	68.40%	60.50%	59.80%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	1.40%	11.00%	12.80%	13.90%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	0.00%	8.20%	13.90%	12.30%
Percent of Female-Headed Households (2010-14) [2]	0.53%	5.24%	9.79%	8.56%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	158	3,853	9,176	12,762
Percent of Population Who are Medicaid Clients	22.37%	29.93%	34.05%	29.84%
Medicaid Expenditures	$735,445	$20,610,202	$50,104,435	$76,589,325
Percent of Total Medicaid Expenditures	0.01%	0.30%	0.72%	1.10%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	NR	155	397	816
Percent of Population Who are CHP+ Clients	N/A	1.20%	1.47%	1.91%
CHP+ Expenditures	$20,425	$376,865	$979,465	$1,930,153
Percent of Total CHP+ Expenditures	0.02%	0.32%	0.83%	1.63%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	0	133	293	793
Number of CICP Providers [5]	0	1	1	3
CICP Expenditures	$0	$250,706	$545,772	$1,306,898
Percent of Total CICP Expenditures	0.00%	0.17%	0.38%	0.91%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Morgan**	**Otero**	**Ouray**	**Park**
Demographic Characteristics				
Population (2016) [1]	28,796	18,711	4,856	17,394
Percent of Colorado Population (2016)	0.52%	0.34%	0.09%	0.31%
Population (2010-14) [2]	28,342	18,712	4,532	16,174
Percent of Colorado Population (2010-14)	0.55%	0.36%	0.09%	0.31%
Percent of Population 16+ in Labor Force (2010-14) [2]	65.10%	55.70%	60.90%	69.90%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	27.00%	19.50%	7.50%	3.90%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	9.20%	17.60%	5.40%	4.00%
Percent of Female-Headed Households (2010-14) [2]	13.63%	12.51%	4.72%	6.11%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	8,543	7,884	834	3,189
Percent of Population Who are Medicaid Clients	29.67%	42.13%	17.17%	18.33%
Medicaid Expenditures	$44,917,230	$47,540,375	$3,125,978	$14,714,399
Percent of Total Medicaid Expenditures	0.64%	0.68%	0.04%	0.21%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	400	216	80	132
Percent of Population Who are CHP+ Clients	1.39%	1.15%	1.65%	0.76%
CHP+ Expenditures	$932,776	$473,470	$189,019	$303,361
Percent of Total CHP+ Expenditures	0.79%	0.40%	0.16%	0.26%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	659	294	0	0
Number of CICP Providers [5]	2	1	0	0
CICP Expenditures	$535,942	$572,773	$0	$0
Percent of Total CICP Expenditures	0.37%	0.40%	0.00%	0.00%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Phillips**	**Pitkin**	**Prowers**	**Pueblo**
Demographic Characteristics				
Population (2016) [1]	4,346	18,004	11,822	163,874
Percent of Colorado Population (2016)	0.08%	0.33%	0.21%	2.96%
Population (2010-14) [2]	4,385	17,303	12,359	160,757
Percent of Colorado Population (2010-14)	0.08%	0.33%	0.24%	3.09%
Percent of Population 16+ in Labor Force (2010-14) [2]	63.90%	75.00%	62.70%	58.20%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	21.60%	15.70%	23.00%	14.90%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	14.30%	4.70%	17.40%	14.20%
Percent of Female-Headed Households (2010-14) [2]	6.76%	4.51%	11.41%	14.22%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	1,048	1,585	5,204	67,561
Percent of Population Who are Medicaid Clients	24.11%	8.80%	44.02%	41.23%
Medicaid Expenditures	$6,475,580	$8,468,984	$28,340,364	$405,313,719
Percent of Total Medicaid Expenditures	0.09%	0.12%	0.41%	5.81%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	77	125	205	1,159
Percent of Population Who are CHP+ Clients	1.77%	0.69%	1.73%	0.71%
CHP+ Expenditures	$167,979	$313,215	$485,612	$2,658,165
Percent of Total CHP+ Expenditures	0.14%	0.26%	0.41%	2.24%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	110	114	769	2,603
Number of CICP Providers [5]	1	1	2	3
CICP Expenditures	$39,796	$663,911	$971,012	$8,871,293
Percent of Total CICP Expenditures	0.03%	0.46%	0.67%	6.16%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Rio Blanco**	**Rio Grande**	**Routt**	**Saguache**
Demographic Characteristics				
Population (2016) [1]	6,615	11,535	24,971	6,237
Percent of Colorado Population (2016)	0.12%	0.21%	0.45%	0.11%
Population (2010-14) [2]	6,739	11,840	23,428	6,211
Percent of Colorado Population (2010-14)	0.13%	0.23%	0.45%	0.12%
Percent of Population 16+ in Labor Force (2010-14) [2]	66.90%	58.70%	75.80%	58.90%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	9.60%	24.80%	6.10%	33.70%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	10.30%	15.00%	6.80%	17.40%
Percent of Female-Headed Households (2010-14) [2]	6.88%	11.77%	7.03%	10.35%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	1,215	4,889	3,929	2,756
Percent of Population Who are Medicaid Clients	18.37%	42.38%	15.73%	44.19%
Medicaid Expenditures	$6,957,630	$24,221,998	$19,586,878	$10,634,882
Percent of Total Medicaid Expenditures	0.10%	0.35%	0.28%	0.15%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	69	182	346	82
Percent of Population Who are CHP+ Clients	1.04%	1.58%	1.39%	1.31%
CHP+ Expenditures	$156,920	$415,173	$812,464	$181,535
Percent of Total CHP+ Expenditures	0.13%	0.35%	0.69%	0.15%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	0	110	347	0
Number of CICP Providers [5]	0	1	2	0
CICP Expenditures	$0	$103,606	$705,322	$0
Percent of Total CICP Expenditures	0.00%	0.07%	0.49%	0.00%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**San Juan**	**San Miguel**	**Sedgwick**	**Summit**
Demographic Characteristics				
Population (2016) [1]	725	8,325	2,333	30,248
Percent of Colorado Population (2016)	0.01%	0.15%	0.04%	0.55%
Population (2010-14) [2]	653	7,597	2,365	28,482
Percent of Colorado Population (2010-14)	0.01%	0.15%	0.05%	0.55%
Percent of Population 16+ in Labor Force (2010-14) [2]	75.60%	77.60%	59.00%	78.30%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	4.80%	9.90%	9.90%	14.10%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	9.30%	6.70%	11.60%	6.60%
Percent of Female-Headed Households (2010-14) [2]	8.58%	6.55%	9.33%	5.33%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	178	1,292	730	4,278
Percent of Population Who are Medicaid Clients	24.55%	15.52%	31.29%	14.14%
Medicaid Expenditures	$722,919	$3,769,435	$4,013,559	$13,853,723
Percent of Total Medicaid Expenditures	0.01%	0.05%	0.06%	0.20%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	NR	133	NR	385
Percent of Population Who are CHP+ Clients	N/A	1.60%	N/A	1.27%
CHP+ Expenditures	$28,465	$308,064	$39,699	$882,689
Percent of Total CHP+ Expenditures	0.02%	0.26%	0.03%	0.74%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	0	218	17	127
Number of CICP Providers [5]	0	1	1	1
CICP Expenditures	$0	$40,873	$20,158	$23,651
Percent of Total CICP Expenditures	0.00%	0.03%	0.01%	0.02%

1) Source: Department of Local Affairs, Components of Change - County (2000 to 2050), 1-year Increments, September 2016

2) Source: 2010-2014 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

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

4) CHP+ caseload does not include "CHP+ at Work" clients. Counties with fewer than 30 clients have been assigned a value of NR

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

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Teller**	**Washington**	**Weld**	**Yuma**
Demographic Characteristics				
Population (2016) [1]	23,902	4,675	297,032	10,317
Percent of Colorado Population (2016)	0.43%	0.08%	5.36%	0.19%
Population (2010-14) [2]	23,363	4,781	265,066	10,131
Percent of Colorado Population (2010-14)	0.45%	0.09%	5.10%	0.19%
Percent of Population 16+ in Labor Force (2010-14) [2]	64.90%	59.90%	68.00%	64.80%
Percent of Population 5+ where Non-English is Spoken at Home (2010-14) [2]	5.20%	5.90%	18.70%	14.80%
Percent of Families and People Whose Incomes in the Past 12 Months is Below the Poverty Level (2010-14) [2]	4.40%	10.60%	9.30%	6.20%
Percent of Female-Headed Households (2010-14) [2]	8.21%	7.40%	10.33%	5.58%
Medicaid Characteristics (FY 2015-16) [3]				
Average Number of Medicaid Clients per Month	5,429	1,157	71,392	2,689
Percent of Population Who are Medicaid Clients	22.71%	24.75%	24.04%	26.06%
Medicaid Expenditures	$27,937,461	$6,440,832	$339,921,033	$14,296,987
Percent of Total Medicaid Expenditures	0.40%	0.09%	4.87%	0.20%

Children's Basic Health Plan (CHP+) Characteristics (FY 2015-16) [4]				
Average Number of CHP+ Clients per Month	196	79	3,620	178
Percent of Population Who are CHP+ Clients	0.82%	1.69%	1.22%	1.73%
CHP+ Expenditures	$445,667	$177,072	$8,575,948	$389,248
Percent of Total CHP+ Expenditures	0.38%	0.15%	7.23%	0.33%
Colorado Indigent Care Program (CICP) Characteristics (FY 2014-15)				
Unduplicated Client Count	145	0	8,400	165
Number of CICP Providers [5]	1	0	3	2
CICP Expenditures	$222,238	$0	$8,562,024	$333,361
Percent of Total CICP Expenditures	0.15%	0.00%	5.94%	0.23%

1) Source: Department of Local Affairs, Components of Change - County (2000 to 2050), 1-year Increments, September 2016

2) Source: 2010-2014 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

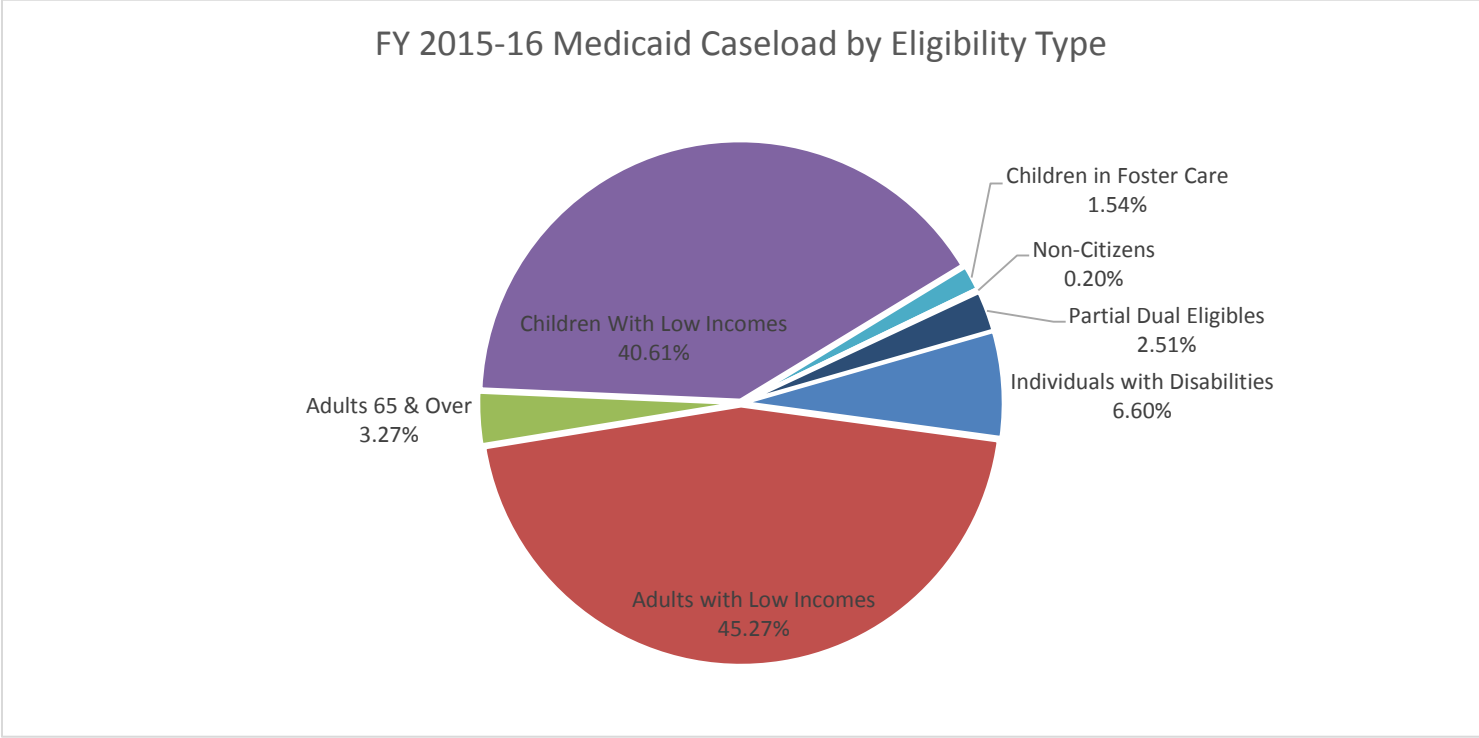
3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

4) CHP+ caseload does not include "CHP+ at Work" clients. Counties with fewer than 30 clients have been assigned a value of NR

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

MEDICAID CASELOAD

Medicaid caseload trends are influenced by a number of factors including: population trends, in-State migration, age of the population, length of stay, economic conditions, and State and federal policy changes. Projecting annual caseload is complicated by the fact that each of these factors can contribute to categorical changes, some of which may be contradictory. For example, the State may enact legislation that removes clients from a Medicaid category who are aged 65 and older, while the population of adults aged 65 and older is increasing. The chart below shows Medicaid caseload by category as a percentage of the overall caseload for FY 2015-16.[2]



[2] Source: November 1, 2016 FY 2017-18 Budget Request, Exhibit B, "Medicaid Caseload Forecast"

A. Clients

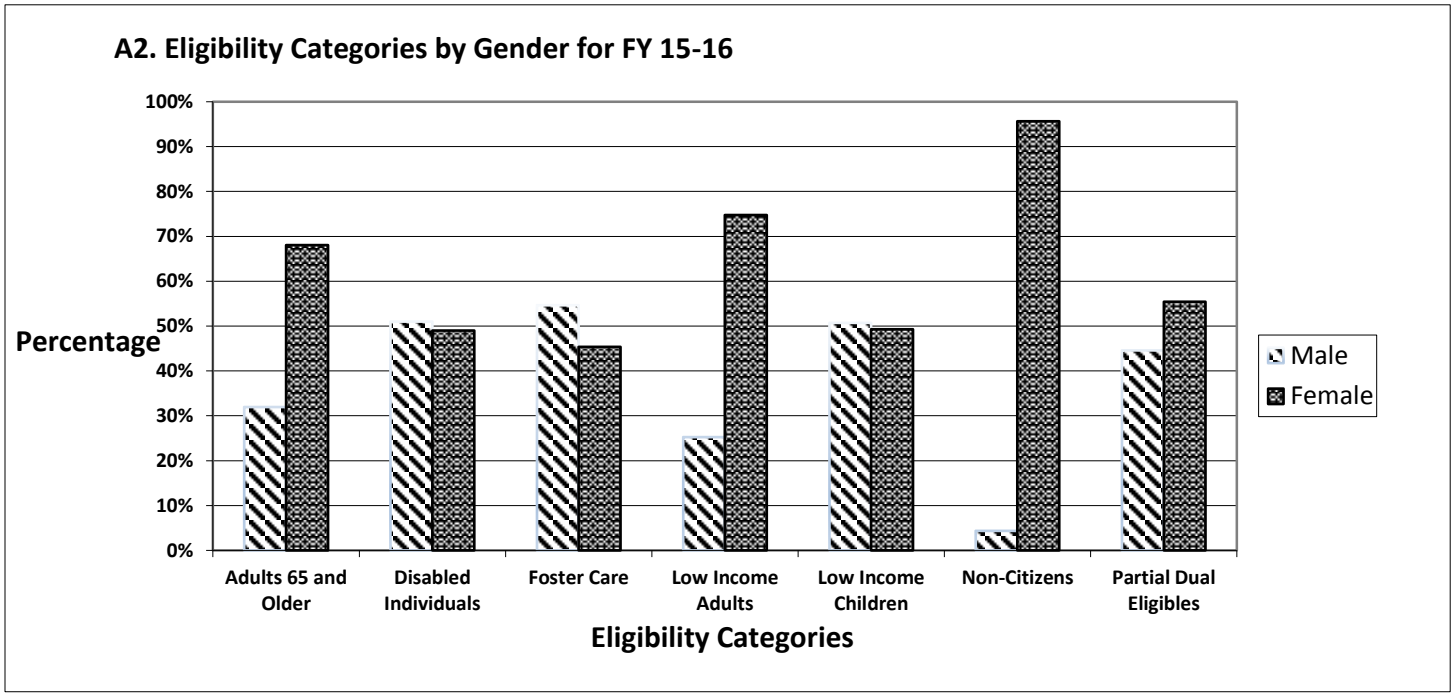
A1. 2016 Federal Poverty Levels

The table below reports the federal poverty levels (FPLs) for all states except Hawaii and Alaska from the Department of Health and Human Services. For family units of more than eight members, add $4,160 for each additional family member.

2016 Federal Poverty Guidelines for Annual Income									
Family Size	**100%**	**120%**	**133%**	**150%**	**175%**	**185%**	**190%**	**200%**	**250%**
1	$11,880	$14,256	$15,800	$17,820	$20,790	$21,978	$22,572	$23,760	$29,700
2	$16,020	$19,224	$21,307	$24,030	$28,035	$29,637	$30,438	$32,040	$40,050
3	$20,160	$24,192	$26,813	$30,240	$35,280	$37,296	$38,304	$40,320	$50,400
4	$24,300	$29,160	$32,319	$36,450	$42,525	$44,955	$46,170	$48,600	$60,750
5	$28,440	$34,128	$37,825	$42,660	$49,770	$52,614	$54,036	$56,880	$71,100
6	$32,580	$39,096	$43,331	$48,870	$57,015	$60,273	$61,902	$65,160	$81,450
7	$36,730	$44,076	$48,851	$55,095	$64,278	$67,951	$69,787	$73,460	$91,825
8	$40,890	$49,068	$54,384	$61,335	$71,558	$75,647	$77,691	$81,780	$102,225

Source: Federal Register / Vol. 81, No. 15 / Monday, January 25, 2016 / Notices

A2. Eligibility Categories by Gender for FY 2015-16[3]



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

1) Low-Income Adults also includes Baby Care Program Adults and Breast and Cervical Cancer Program Clients.

2) Disabled Individuals includes Disabled Adults 60 to 64 and Disabled Individuals to 59.

3) Partial Dual Eligibles includes Qualified and Supplemental Low-Income Medicare Beneficiaries.

4) Percent based on member months in each category.

A3. Medicaid Enrollment by Type of Managed Care Provider

The following table shows the breakdown by client count for FY 2011-12 through FY 2015-16 for clients enrolled in health maintenance organizations, prepaid inpatient health plan, Primary Care Physician Program, and unassigned fee-for-service. Health maintenance organizations, prepaid inpatient health plan and Primary Care Physician Program enrollment figures were subtracted from total caseload numbers (without retroactivity) to calculate the fee-for-service enrollment figures and, as a result, may cause the fee-for-service counts to be underrepresented.[4]

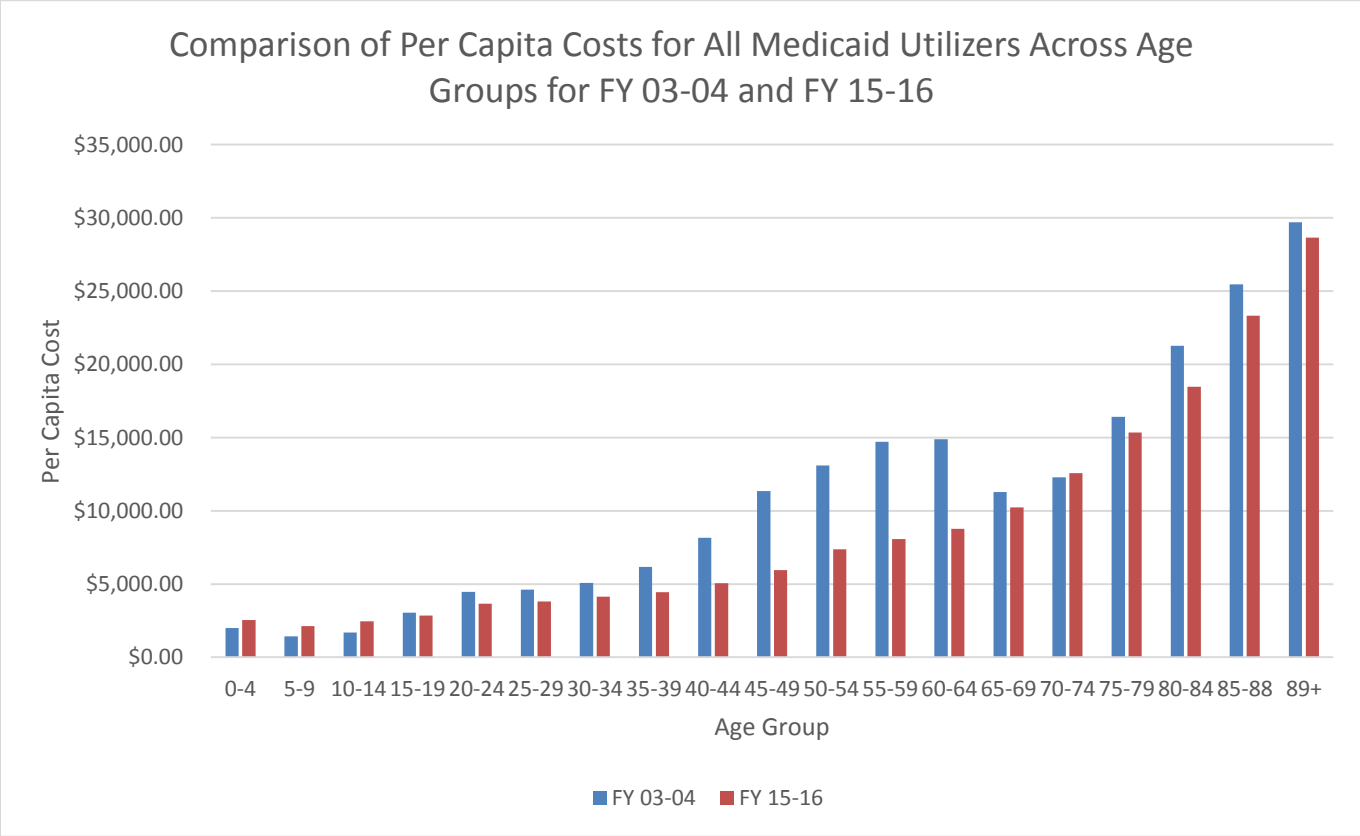
Average Medicaid Enrollment for FY 2011-12 through FY 2015-16					
Membership Category	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16[4]**
HMOs and Prepaid Inpatient Health Plans	70,351	75,416	93,232	98,572	108,117
Primary Care Physician Program	23,264	22,953	26,790	284	0
Fee-for-Service	526,349	580,437	958,686	1,062,350	1,188,869
TOTAL	**619,964**	**678,806**	**1,078,708**	**1,161,206**	**1,296,986**

[4] Department of Health Care Policy and Financing July 2016 Premiums, Caseload, and Expenditures Report (JBC Monthly Report).

Fee-for-service enrollment is derived by the total enrollment minus enrollment in administrative service organizations, health maintenance organizations, and the Primary Care Physician Program.

B. Services

B1. Paid Medical Services Per-Capita Costs (from all claims) Across Age Groups[5]



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

B2. FY 2015-16 Services by County

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

Acute Care, including:

- Federal Qualified Health Centers (FQHCs)
- Physician and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Prescription Drugs
- Inpatient Hospital
- Outpatient Hospital

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

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

- Home- and Community-Based Services (HCBS)
- Program for All-Inclusive Care for the Elderly (PACE)
- Home Health
- Nursing Facilities

B4. FY 2014-15 Deliveries

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

- Deliveries by County
- Delivery Types
- Age Group of Mother

- Low Birthweight, Preterm, and Neonatal Intensive Care Unit
- Neonatal Intensive Care Unit

B5. FY 2015-16 Top Tens

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

- Inpatient Hospital
- Outpatient Hospital
- Federal Qualified Health Centers (FQHCs)
- Rural Health Centers
- Physician and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Dental
- Laboratory
- Durable Medical Equipment and Supplies

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

The following should be noted:

- Clients with no county designation are not included.
- The Department's decision support system (MMIS-DSS), extracts data on a different time span and from a different source (i.e., the Medicaid Management Information System, or MMIS) than the Colorado Financial Reporting System. This decision support system contains a full extract of all county level data in the MMIS.
- The Department administers the following Home- and Community-Based Services waivers: Elderly, Blind and Disabled; Persons with Mental Illness; Children with Life-Limiting Illness; Brain Injury waiver; Children's; Children with Autism; Pediatric Hospice Waiver; Spinal Cord Injury; Developmentally Disabled, Supported Living Services, and Children's Extensive Support (effective April 2014)

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

B2a: FY 2015-16 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
ADAMS	36,916	106,624	84,457	9,766	61,850
ALAMOSA	3,992	4,999	4,904	417	3,225
ARAPAHOE	17,940	104,761	81,634	9,426	59,167
ARCHULETA	48	2,237	2,059	213	1,568
BACA	150	691	735	62	485
BENT	1,043	1,154	1,301	90	801
BOULDER	15,185	35,809	28,712	2,892	20,188
BROOMFIELD	1,213	5,570	4,426	461	2,923
CHAFFEE	59	2,910	2,303	188	1,737
CHEYENNE	31	299	345	34	228
CLEAR CREEK	97	1,233	1,060	99	634
CONEJOS	1,149	2,098	2,353	187	1,494
COSTILLA	1,028	1,219	1,179	96	761
CROWLEY	426	979	997	78	587
CUSTER	33	600	548	50	355

B2a: FY 2015-16 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
DELTA	284	7,468	5,723	516	4,425
DENVER	45,100	106,726	89,991	11,840	69,850
DOLORES	204	398	349	NR	211
DOUGLAS	855	19,284	15,356	1,446	9,078
EAGLE	1,961	5,589	4,164	551	3,115
ELBERT	793	2,178	1,871	215	1,170
EL PASO	50,796	121,667	105,075	10,616	74,018
FREMONT	1,058	9,893	8,867	733	6,211
GARFIELD	2,192	6,754	5,002	514	3,920
GILPIN	72	806	669	61	397
GRAND	48	1,841	1,431	158	991
GUNNISON	NR	1,301	755	96	647
HINSDALE	NR	60	64	NR	39
HUERFANO	151	1,942	1,653	142	1,321
JACKSON	NR	218	201	NR	127

B2a: FY 2015-16 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
JEFFERSON	12,937	70,714	57,478	5,929	38,061
KIOWA	63	232	265	NR	158
KIT CARSON	54	1,378	1,195	103	853
LAKE	143	1,569	1,144	94	776
LA PLATA	790	8,675	6,487	645	4,726
LARIMER	12,030	48,248	39,514	3,671	26,105
LAS ANIMAS	168	3,829	3,437	334	2,915
LINCOLN	480	812	853	90	524
LOGAN	1,037	3,732	3,464	309	2,493
MESA	188	21,296	14,784	957	8,921
MINERAL	NR	124	93	NR	76
MOFFAT	1,004	2,985	2,526	274	1,804
MONTEZUMA	867	6,062	5,758	493	4,256
MONTROSE	582	6,351	3,993	268	3,025
MORGAN	2,201	6,271	5,292	620	4,256

B2a: FY 2015-16 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
OTERO	3,311	5,686	5,375	446	3,736
OURAY	NR	664	493	44	316
PARK	295	2,325	1,911	172	1,165
PHILLIPS	111	681	665	69	508
PITKIN	154	494	412	43	283
PROWERS	2,927	3,432	3,471	356	2,360
PUEBLO	15,642	50,351	43,644	4,035	31,871
RIO BLANCO	NR	465	456	34	331
RIO GRANDE	2,102	3,201	3,263	281	2,134
ROUTT	532	3,001	2,387	217	1,612
SAGUACHE	1,399	1,723	1,676	159	1,143
SAN JUAN	NR	110	79	*	48
SAN MIGUEL	277	951	740	50	330
SEDGWICK	38	440	503	35	370
SUMMIT	703	3,155	2,295	267	1,431

B2a: FY 2015-16 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
TELLER	1,539	3,774	3,300	299	2,549
WASHINGTON	73	727	796	71	479
WELD	21,273	55,503	44,325	4,452	32,366
YUMA	130	1,852	1,620	166	1,064
SUPPRESSED COUNTIES	68	-	-	98	-
STATEWIDE	260,331	850,219	698,860	74,830	502,207

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

B2b: FY 2015-16 Expenditures for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$20,348,132	$92,170,839	$84,615,282	$85,682,856	$76,410,411
Alamosa	$2,367,874	$3,249,602	$4,186,813	$3,534,046	$3,285,859
Arapahoe	$10,027,564	$94,903,198	$96,297,240	$89,293,056	$71,833,495
Archuleta	$19,559	$1,665,825	$1,975,220	$1,985,652	$3,073,171
Baca	$88,578	$377,970	$908,276	$547,910	$682,779
Bent	$692,043	$718,951	$1,955,150	$822,781	$874,725
Boulder	$7,759,305	$30,616,530	$36,501,500	$23,947,158	$23,530,679
Broomfield	$660,533	$4,922,068	$5,320,707	$4,652,981	$3,356,893
Chaffee	$22,621	$2,046,422	$2,758,022	$1,660,013	$2,448,344
Cheyenne	$14,820	$128,613	$290,188	$210,347	$331,601
Clear Creek	$48,037	$1,088,988	$1,539,191	$867,926	$1,082,985
Conejos	$666,615	$1,349,334	$2,119,452	$1,932,906	$2,207,384
Costilla	$601,936	$708,310	$1,068,337	$901,094	$844,280
Crowley	$235,077	$696,108	$1,339,738	$716,735	$753,385

B2b: FY 2015-16 Expenditures for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Custer	$14,232	$514,959	$892,542	$397,400	$545,571
Delta	$257,454	$5,074,057	$5,642,484	$3,528,378	$5,798,602
Denver	$28,013,451	$93,117,555	$99,077,875	$138,760,601	$87,593,819
Dolores	$123,507	$246,172	$470,262	NR	$248,965
Douglas	$446,643	$18,474,632	$19,679,205	$11,954,892	$13,106,778
Eagle	$1,402,755	$3,269,826	$4,964,475	$5,477,311	$4,223,531
El Paso	$433,421	$2,193,851	$3,015,856	$2,155,267	$2,002,219
Elbert	$28,605,326	$114,754,422	$127,435,867	$81,368,529	$87,017,317
Fremont	$596,235	$8,815,223	$13,085,762	$6,830,741	$6,811,867
Garfield	$1,183,719	$3,239,874	$2,457,703	$3,905,989	$4,274,893
Gilpin	$27,673	$848,489	$858,551	$731,563	$561,259
Grand	$21,383	$1,427,260	$1,502,030	$1,525,038	$2,088,044
Gunnison	NR	$661,315	$329,753	$800,385	$737,418
Hinsdale	NR	$48,358	$77,187	NR	$122,433

B2b: FY 2015-16 Expenditures for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Huerfano	$98,873	$1,324,996	$2,213,426	$1,234,281	$1,476,346
Jackson	NR	$163,682	$215,321	NR	$251,337
Jefferson	$7,804,638	$64,418,306	$76,459,227	$54,148,979	$51,158,654
Kiowa	$39,939	$123,633	$336,072	NR	$197,362
Kit Carson	$26,090	$793,632	$1,019,386	$705,517	$1,155,126
La Plata	$74,716	$964,946	$1,097,636	$786,302	$1,083,035
Lake	$490,799	$6,994,395	$6,263,538	$5,328,444	$5,740,279
Larimer	$6,107,926	$40,401,174	$50,146,321	$28,874,039	$35,567,959
Las Animas	$112,512	$3,381,852	$4,897,423	$2,649,910	$4,347,794
Lincoln	$342,006	$616,233	$1,055,744	$725,361	$846,578
Logan	$474,070	$2,548,149	$5,176,607	$2,188,481	$3,580,720
Mesa	$67,319	$11,894,669	$6,915,267	$6,931,129	$9,140,334
Mineral	NR	$111,101	$149,201	NR	$110,269
Moffat	$520,056	$2,185,759	$2,724,964	$2,392,708	$3,766,225

B2b: FY 2015-16 Expenditures for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Montezuma	$684,435	$3,746,601	$6,016,385	$4,148,823	$5,931,752
Montrose	$343,518	$3,266,119	$1,975,965	$2,001,082	$2,430,550
Morgan	$1,048,572	$4,373,727	$6,271,705	$4,154,873	$5,191,148
Otero	$2,051,595	$3,671,554	$6,174,041	$3,614,404	$3,610,107
Ouray	NR	$401,599	$351,809	$357,845	$522,684
Park	$145,894	$2,133,529	$2,771,783	$1,641,100	$1,998,157
Phillips	$47,556	$498,835	$801,009	$431,026	$889,578
Pitkin	$73,119	$292,732	$167,231	$354,158	$434,197
Prowers	$2,014,409	$1,856,383	$3,970,217	$2,759,270	$2,839,621
Pueblo	$10,312,069	$46,136,987	$57,650,724	$32,482,170	$38,325,574
Rio Blanco	NR	$189,403	$145,393	$234,234	$399,055
Rio Grande	$1,252,914	$1,942,954	$3,064,361	$2,398,222	$2,452,554
Routt	$265,551	$2,134,966	$2,782,575	$2,289,558	$2,952,404
Saguache	$870,009	$1,113,451	$1,169,502	$1,254,191	$1,420,612

B2b: FY 2015-16 Expenditures for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
San Juan	NR	$74,385	$176,289	NR	$74,209
San Miguel	$145,015	$531,895	$830,027	$353,959	$416,006
Sedgwick	$16,653	$171,038	$443,192	$378,289	$479,882
Summit	$390,372	$2,215,354	$2,337,564	$1,986,767	$2,128,072
Teller	$723,191	$3,315,413	$4,431,452	$2,508,294	$2,911,026
Washington	$31,043	$494,152	$971,414	$571,055	$792,786
Weld	$10,755,767	$44,810,184	$52,281,969	$36,461,393	$39,660,560
Yuma	$40,771	$1,171,942	$1,720,922	$1,511,840	$1,986,616
Suppressed Counties - NR	$31,936	$0	$0	$931,592	$0
STATEWIDE	**$152,081,824**	**$747,794,481**	**$835,540,330**	**$682,980,851**	**$642,117,877**

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

B2c: FY 2015-16 Average Cost Per Client for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$551	$864	$1,002	$8,774	$1,235
Alamosa	$593	$650	$854	$8,475	$1,019
Arapahoe	$559	$906	$1,180	$9,473	$1,214
Archuleta	$407	$745	$959	$9,322	$1,960
Baca	$591	$547	$1,236	$8,837	$1,408
Bent	$664	$623	$1,503	$9,142	$1,092
Boulder	$511	$855	$1,271	$8,280	$1,166
Broomfield	$545	$884	$1,202	$10,093	$1,148
Chaffee	$383	$703	$1,198	$8,830	$1,410
Cheyenne	$478	$430	$841	$6,187	$1,454
Clear Creek	$495	$883	$1,452	$8,767	$1,708
Conejos	$580	$643	$901	$10,336	$1,477
Costilla	$586	$581	$906	$9,386	$1,109
Crowley	$552	$711	$1,344	$9,189	$1,283
Custer	$431	$858	$1,629	$7,948	$1,537

B2c: FY 2015-16 Average Cost Per Client for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Delta	$907	$679	$986	$6,838	$1,310
Denver	$621	$872	$1,101	$11,720	$1,254
Dolores	$605	$619	$1,347	$8,469	$1,180
Douglas	$522	$958	$1,282	$8,268	$1,444
Eagle	$715	$585	$1,192	$9,941	$1,356
El Paso	$547	$1,007	$1,612	$10,024	$1,711
Elbert	$563	$943	$1,213	$7,665	$1,176
Fremont	$564	$891	$1,476	$9,319	$1,097
Garfield	$540	$480	$491	$7,599	$1,091
Gilpin	$384	$1,053	$1,283	$11,993	$1,414
Grand	$445	$775	$1,050	$9,652	$2,107
Gunnison	$350	$508	$437	$8,337	$1,140
Hinsdale	$0	$806	$1,206	$8,193	$3,139
Huerfano	$655	$682	$1,339	$8,692	$1,118
Jackson	$522	$751	$1,071	$12,857	$1,979

B2c: FY 2015-16 Average Cost Per Client for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Jefferson	$603	$911	$1,330	$9,133	$1,344
Kiowa	$634	$533	$1,268	$7,229	$1,249
Kit Carson	$483	$576	$853	$6,850	$1,354
La Plata	$522	$615	$959	$8,365	$1,396
Lake	$621	$806	$966	$8,261	$1,215
Larimer	$508	$837	$1,269	$7,865	$1,362
Las Animas	$670	$883	$1,425	$7,934	$1,492
Lincoln	$713	$759	$1,238	$8,060	$1,616
Logan	$457	$683	$1,494	$7,082	$1,436
Mesa	$358	$559	$468	$7,243	$1,025
Mineral	$293	$896	$1,604	$8,395	$1,451
Moffat	$518	$732	$1,079	$8,733	$2,088
Montezuma	$789	$618	$1,045	$8,415	$1,394
Montrose	$590	$514	$495	$7,467	$803
Morgan	$476	$697	$1,185	$6,701	$1,220

B2c: FY 2015-16 Average Cost Per Client for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Otero	$620	$646	$1,149	$8,104	$966
Ouray	$576	$605	$714	$8,133	$1,654
Park	$495	$918	$1,450	$9,541	$1,715
Phillips	$428	$733	$1,205	$6,247	$1,751
Pitkin	$475	$593	$406	$8,236	$1,534
Prowers	$688	$541	$1,144	$7,751	$1,203
Pueblo	$659	$916	$1,321	$8,050	$1,203
Rio Blanco	$214	$407	$319	$6,889	$1,206
Rio Grande	$596	$607	$939	$8,535	$1,149
Routt	$499	$711	$1,166	$10,551	$1,832
Saguache	$622	$646	$698	$7,888	$1,243
San Juan	$951	$676	$2,232	$9,983	$1,546
San Miguel	$524	$559	$1,122	$7,079	$1,261
Sedgwick	$438	$389	$881	$10,808	$1,297
Summit	$555	$702	$1,019	$7,441	$1,487

B2c: FY 2015-16 Average Cost Per Client for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Teller	$470	$878	$1,343	$8,389	$1,142
Washington	$425	$680	$1,220	$8,043	$1,655
Weld	$506	$807	$1,180	$8,190	$1,225
Yuma	$314	$633	$1,062	$9,107	$1,867
Statewide	**$584**	**$880**	**$1,196**	**$9,128**	**$1,279**

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

B3a: FY 2015-16 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Adams	2,209	1,096	562	2,365	1,304
Alamosa	314	63	NR	113	95
Arapahoe	3,389	1,720	546	2,748	1,358

B3a: FY 2015-16 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Archuleta	97	NR	NR	NR	71
Baca	122	NR	NR	NR	74
Bent	134	NR	NR	82	53
Boulder	1,315	856	NR	854	712
Broomfield	181	161	NR	161	142
Chaffee	141	57	NR	65	73
Cheyenne	NR	NR	NR	NR	NR
Clear Creek	60	NR	NR	NR	NR
Conejos	189	NR	NR	61	65
Costilla	173	NR	NR	46	NR
Crowley	106	NR	NR	39	33
Custer	NR	NR	NR	NR	NR

B3a: FY 2015-16 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Delta	350	76	155	154	124
Denver	5,004	1,023	907	2,843	2,160
Dolores	NR	NR	NR	NR	NR
Douglas	667	430	NR	460	293
Eagle	52	33	NR	41	NR
El Paso	52	NR	NR	47	NR
Elbert	3,436	1,462	450	2,873	1,504
Fremont	456	129	NR	249	366
Garfield	354	121	NR	41	201
Gilpin	50	NR	NR	NR	NR
Grand	43	NR	NR	NR	NR

B3a: FY 2015-16 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Gunnison	66	NR	NR	NR	39
Hinsdale	NR	NR	NR	NR	NR
Huerfano	161	31	NR	54	75
Jackson	NR	NR	NR	NR	NR
Jefferson	2,405	1,261	594	1,735	1,788
Kiowa	NR	NR	NR	NR	NR
Kit Carson	61	NR	NR	NR	NR
Lake	31	NR	NR	NR	NR
La Plata	352	58	NR	137	141
Larimer	1,621	670	33	1,005	1,036
Las Animas	421	71	NR	86	111
Lincoln	65	NR	NR	NR	34

B3a: FY 2015-16 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Logan	183	108	NR	54	132
Mesa	1,814	522	NR	418	515
Mineral	NR	NR	NR	NR	NR
Moffat	92	35	NR	43	65
Montezuma	396	56	NR	164	138
Montrose	410	128	209	122	202
Morgan	263	70	NR	107	242
Otero	524	97	NR	245	162
Ouray	NR	NR	NR	NR	NR
Park	52	NR	NR	38	NR
Phillips	50	NR	NR	NR	48

B3a: FY 2015-16 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Pitkin	NR	NR	NR	NR	NR
Prowers	346	56	NR	115	98
Pueblo	2,136	660	331	1,845	897
Rio Blanco	65	NR	NR	NR	33
Rio Grande	180	NR	NR	82	91
Routt	56	44	NR	NR	59
Saguache	128	NR	NR	51	NR
San Juan	NR	NR	NR	NR	NR
San Miguel	NR	NR	NR	NR	NR
Sedgwick	NR	NR	NR	NR	NR
Summit	NR	NR	NR	NR	NR
Teller	151	31	NR	76	65
Washington	NR	NR	NR	NR	33

B3a: FY 2015-16 Unduplicated Client Count for Selected Long-Term Care Categories by County

County	LTSS HCBS Waivers	DIDD HCBS Waivers	Program of All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and II)
Weld	1,688	507	NR	1,234	693
Yuma	124	NR	NR	NR	79
Suppressed Counties	212	264	40	301	147
Statewide	**31,846**	**11,459**	**3,741**	**20,639**	**14,831**

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

B3b: FY 2015-16 Expenditures for Selected Long-Term Care Categories by County

County	LTSS HCBS Waivers	DIDD HCBS Waivers	Program of All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and II)
Adams	$25,378,926	$39,857,086	$20,610,285	$25,457,192	$57,533,280
Alamosa	$2,446,169	$2,696,461		$352,763	$3,280,123

B3b: FY 2015-16 Expenditures for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Arapahoe	$45,315,612	$63,977,972	$19,140,537	$34,521,580	$58,557,312
Archuleta	$988,634	NR		NR	$2,130,549
Baca	$452,745	NR		NR	$3,553,440
Bent	$1,005,733	NR		$542,331	$2,185,799
Boulder	$14,971,552	$28,225,772		$9,602,680	$28,036,154
Broomfield	$2,230,543	$3,976,987	NR	$2,542,149	$5,180,313
Chaffee	$850,053	$1,708,773		$429,546	$2,551,396
Cheyenne	NR	NR		NR	NR
Clear Creek	$501,660	NR		NR	NR
Conejos	$1,763,545	NR	NR	$185,981	$2,775,759
Costilla	$1,294,730	NR		$171,619	NR
Crowley	$795,662	NR		$240,776	$1,297,684
Custer	NR	NR		NR	
Delta	$4,128,145	$2,235,850	$5,214,052	$1,077,657	$4,654,190
Denver	$67,601,776	$32,425,598	$32,011,351	$31,804,788	$94,185,172

B3b: FY 2015-16 Expenditures for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Dolores	NR	NR		NR	NR
Douglas	$9,087,974	$8,978,397	NR	$8,620,456	$13,635,701
Eagle	$673,034	$938,148		$110,562	NR
El Paso	$45,580,180	$44,735,005	$14,950,271	$61,172,861	$62,810,454
Elbert	$655,029	NR		$907,328	NR
Fremont	$3,972,941	$6,043,042		$2,791,911	$13,582,899
Garfield	$3,911,473	$5,965,350		$277,128	$9,459,622
Gilpin	$485,491	NR		NR	
Grand	$583,465	NR		NR	NR
Gunnison	$467,122	NR		NR	$1,664,117
Hinsdale	NR				NR
Huerfano	$1,665,442	$1,079,322	NR	$167,365	$2,704,617
Jackson	NR	NR			NR
Jefferson	$30,975,470	$45,372,760	$20,956,196	$23,544,354	$94,744,221
Kiowa	NR	NR		NR	NR

B3b: FY 2015-16 Expenditures for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Kit Carson	$471,200	NR		NR	NR
Lake	$4,131,430	$1,897,518		$476,453	$5,241,043
La Plata	$317,484	NR		NR	
Larimer	$13,513,882	$23,963,199	$596,682	$11,452,448	$38,910,985
Las Animas	$6,582,538	$2,367,655		$262,849	$4,728,867
Lincoln	$641,230	NR	NR	NR	$1,214,000
Logan	$1,466,862	$4,373,623		$243,015	$3,765,212
Mesa	$26,024,786	$31,263,788		$4,101,008	$26,973,672
Mineral	NR			NR	
Moffat	$686,056	$1,483,466		$147,897	$2,203,606
Montezuma	$5,104,839	$1,925,408		$936,855	$5,335,649
Montrose	$3,564,206	$4,264,569	$6,671,398	$2,049,221	$6,740,135
Morgan	$2,104,964	$1,998,506	NR	$464,341	$9,206,571
Otero	$3,401,631	$4,471,395		$3,034,152	$6,021,973
Ouray	NR	NR		NR	NR

B3b: FY 2015-16 Expenditures for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Park	$717,205	NR		$519,593	NR
Phillips	$285,858	NR		NR	$1,735,719
Pitkin	NR	NR		NR	NR
Prowers	$1,407,927	$2,043,697		$590,737	$3,444,182
Pueblo	$18,639,513	$32,598,944	$11,988,853	$30,345,695	$31,308,899
Rio Blanco	$294,140	NR		NR	$1,675,228
Rio Grande	$1,518,814	NR		$223,036	$3,614,233
Routt	$434,531	$1,670,651		NR	$3,133,709
Saguache	$994,941			$148,102	NR
San Juan	NR				NR
San Miguel	NR	NR		NR	NR
Sedgwick	NR	NR		NR	NR

Summit	NR	NR		NR	NR
eller	$2,109,692	$755,999		$1,762,016	$2,511,923
Washington	NR	NR		NR	$1,103,604
Weld	$20,575,918	$18,689,224	NR	$11,916,049	$24,310,345
Yuma	$1,048,878	$384,147	NR	NR	$2,622,034
Suppressed Counties	$2,383,324	$7,043,939	$964,715	$1,275,569	$5,364,822
STATEWIDE	**$386,204,954**	**$429,412,250**	**$133,104,342**	**$274,470,063**	**$655,689,214**

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

B3c: FY 2015-16 Average Cost Per Client for Selected Long-Term Care Categories by County

County	LTSS HCBS Waivers	DIDD HCBS Waivers	Program of All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and II)
Adams	$11,489	$36,366	$36,673	$10,764	$44,121
Alamosa	$7,790	$42,801		$3,122	$34,528
Arapahoe	$13,371	$37,197	$35,056	$12,562	$43,120
Archuleta	$10,192	$4,297		$1,377	$30,008
Baca	$3,711	$23,319		$7,654	$48,019

B3c: FY 2015-16 Average Cost Per Client for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Bent	$7,505	$50,102		$6,614	$41,241
Boulder	$11,385	$32,974		$11,244	$39,377
Broomfield	$12,323	$24,702	$28,131	$15,790	$36,481
Chaffee	$6,029	$29,978		$6,608	$34,951
Cheyenne	$1,958	$9,461		$1,762	$54,608
Clear Creek	$8,361	$26,859		$2,890	$27,759
Conejos	$9,331	$13,668	$3,375	$3,049	$42,704
Costilla	$7,484	$17,269		$3,731	$6,184
Crowley	$7,506	$9,793		$6,174	$39,324
Custer	$6,003	$18,891		$917	
Delta	$11,795	$29,419	$33,639	$6,998	$37,534
Denver	$13,510	$31,697	$35,294	$11,187	$43,604
Dolores	$24,080	$16,105		$3,825	$10,981
Douglas	$13,625	$20,880	$14,970	$18,740	$46,538
Eagle	$12,943	$28,429		$2,697	$38,994

B3c: FY 2015-16 Average Cost Per Client for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
El Paso	$13,265	$30,599	$33,223	$21,292	$41,762
Elbert	$12,597	$16,898		$19,305	$44,495
Fremont	$8,713	$46,845		$11,212	$37,112
Garfield	$11,049	$49,300		$6,759	$47,063
Gilpin	$9,710	$6,320		$6,117	
Grand	$13,569	$16,563		$6,820	$18,229
Gunnison	$7,078	$19,615		$3,543	$42,670
Hinsdale	$624				$15,568
Huerfano	$10,344	$34,817	$18,713	$3,099	$36,062
Jackson	$7,802	$89			$37,040
Jefferson	$12,880	$35,982	$35,280	$13,570	$52,989
Kiowa	$5,615	$8,227		$4,414	$45,816
Kit Carson	$7,725	$40,272		$3,479	$37,985
Lake	$11,737	$32,716		$3,478	$37,171
La Plata	$10,241	$17,088		$2,025	

B3c: FY 2015-16 Average Cost Per Client for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Larimer	$8,337	$35,766	$18,081	$11,395	$37,559
Las Animas	$15,635	$33,347		$3,056	$42,602
Lincoln	$9,865	$21,873	$11,228	$2,300	$35,706
Logan	$8,016	$40,497		$4,500	$28,524
Mesa	$14,347	$59,892		$9,811	$52,376
Mineral	$360			$54,022	
Moffat	$7,457	$42,385		$3,439	$33,902
Montezuma	$12,891	$34,382		$5,713	$38,664
Montrose	$8,693	$33,317	$31,921	$16,797	$33,367
Morgan	$8,004	$28,550	$11,228	$4,340	$38,044
Otero	$6,492	$46,097		$12,384	$37,173
Ouray	$12,389	$7,719		$8,316	$40,050
Park	$13,792	$46,955		$13,673	$2,523
Phillips	$5,717	$17,765		$25,357	$36,161
Pitkin	$26,336	$9,454		$1,201	$18,581

B3c: FY 2015-16 Average Cost Per Client for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Prowers	$4,069	$36,495		$5,137	$35,145
Pueblo	$8,726	$49,392	$36,220	$16,448	$34,904
Rio Blanco	$4,525	$8,301		$1,150	$50,764
Rio Grande	$8,438	$41,665		$2,720	$39,717
Routt	$7,759	$37,969		$2,293	$53,114
Saguache	$7,773			$2,904	$13,371
San Juan	$9,771				$28,902
San Miguel	$14,945	$7,830		$1,628	$26,460
Sedgwick	$6,144	$47,866		$780	$35,042
Summit	$13,823	$32,406		$3,924	$15,730
Teller	$13,971	$24,387		$23,184	$38,645
Washington	$6,948	$38,823		$5,739	$33,443
Weld	$12,190	$36,862	$23,134	$9,656	$35,080
Yuma	$8,459	$19,207	$18,713	$1,968	$33,190
STATEWIDE	**$12,127**	**$37,474**	**$35,580**	**$13,299**	**$44,211**

Source: Medicaid Paid Claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts

B3c: FY 2015-16 Average Cost Per Client for Selected Long-Term Care Categories by County					
County	**LTSS HCBS Waivers**	**DIDD HCBS Waivers**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
represent the number of unique clients who received a service in each category in that specific county only. Statewide totals represent an unduplicated client count for the entire state. Statewide totals are not a sum of the county as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple counties. “NR” denotes county included in "Suppressed Counties" category.					

B3d: Home and Community Based Services Waivers for non-Intellectual and Developmental Disabilities								
Fiscal Year	**Elderly Blind and Disabled; and Consumer Directed Care for the Elderly*^**	**Children's Home and Community-Based Services**	**Persons with Brain Injury**	**Community Mental Health Supports**	**Persons Living with AIDS**	**Children with Autism**	**Children with Life Limiting Illness**	**Total LTSS Waivers**
FY 2010-11	20,890	1,285	249	2,786	60	108	120	**25,118**
FY 2011-12	22,385	1,179	255	2,966	57	99	151	**26,901**
FY 2012-13	23,527	1,204	275	3,248	57	85	162	**28,324**
FY 2013-14	24,642	1,202	298	3,407	49	87	167	**29,479**
FY 2014-15	25,485	1,242	363	3,520	0	87	146	**30,518**
FY 2015-16	26,389	1,444	395	3,751	0	62	162	**31,846**

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

^ The Persons Living with AIDS waiver was consolidated with the Elderly Blind and Disabled Waiver in FY 2014

B3e: Home and Community Based Waivers for Intellectual and Developmental Disabilities					
Fiscal Year	**Children's Habilitation Residential Program**	**Supported Living Services**	**Developmentally Disabled**	**Children's Extensive Support**	**Total Clients Utilizing DIDD waivers**
FY 2010-11	150	3,235	4,395	422	**8,114**
FY 2011-12	120	3,307	4,371	399	**8,136**
FY 2012-13	90	3,350	4,490	433	**8,204**

B3e: Home and Community Based Waivers for Intellectual and Developmental Disabilities					
Fiscal Year	**Children's Habilitation Residential Program**	**Supported Living Services**	**Developmentally Disabled**	**Children's Extensive Support**	**Total Clients Utilizing DIDD waivers**
FY 2013-14	82	3,519	4,848	800	**8,856**
FY 2014-15	69	4,233	5,040	1,190	**10,360**
FY 2015-16	52	4,730	5,299	1,618	**11,459**
Unduplicated client counts represent the number of unique clients who received a service in each category only.					

B3f: Long-Term Care Programs Administered by Department of Health Care Policy and Financing					
Fiscal Year	**Home Health**	**Program for All-Inclusive Care for the Elderly**	**Class I Nursing Facilities**	**Class II Nursing Facilities**	**Total Nursing Facilities (Classes I and II)**
FY 2010-11	11,859	2,214	13,650	167	**13,685**
FY 2011-12	12,079	2,665	13,939	185	**13,959**
FY 2012-13	13,047	2,765	14,122	207	**14,143**
FY 2013-14	15,674	2,601	14,015	197	**14,038**
FY 2014-15	18,768	3,066	14,308	184	14,487
FY 2015-16	20,639	3,741	14,810	187	14,831
Source: Medicaid paid claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months (FY 2003-06) one and one-half months (FY 2006-07) after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Totals are not the sum of categories.					

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B4a: FY 2015-16 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Adams	4,053	$34,998,386	$8,635
Alamosa	140	$1,408,626	$10,062
Arapahoe	3,614	$32,255,831	$8,925
Archuleta	68	$649,542	$9,552
Baca	NR	NR	$7,712
Bent	NR	NR	$9,206
Boulder	1,032	$8,176,253	$7,923
Broomfield	180	$1,477,163	$8,206
Chaffee	60	$502,515	$8,375
Cheyenne	NR	NR	$10,750
Clear Creek	NR	NR	$8,969
Conejos	58	$602,633	$10,390
Costilla	NR	NR	$8,557
Crowley	NR	NR	$8,526
Custer	NR	NR	$6,042

B4a: FY 2015-16 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Delta	193	$1,431,136	$7,415
Denver	4,841	$46,256,364	$9,555
Dolores	NR	NR	$5,637
Douglas	484	$3,701,671	$7,648
Eagle	317	$2,890,789	$9,119
El Paso	3,743	$31,423,098	$8,395
Elbert	60	$448,833	$7,481
Fremont	244	$2,274,991	$9,324
Garfield	298	$2,503,323	$8,400
Gilpin	NR	NR	$8,605
Grand	53	$490,141	$9,248
Gunnison	32	$304,217	$9,507
Hinsdale	NR	NR	$6,601
Huerfano	NR	NR	$9,465
Jackson	NR	NR	$11,232

B4a: FY 2015-16 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Jefferson	1,918	$16,912,861	$8,818
Kiowa	NR	NR	$5,726
Kit Carson	49	$441,750	$9,015
La Plata	272	$2,196,007	$8,074
Lake	37	$295,724	$7,993
Larimer	1,368	$10,777,581	$7,878
Las Animas	88	$854,814	$9,714
Lincoln	NR	NR	$7,218
Logan	122	$1,192,100	$9,771
Mesa	465	$4,408,128	$9,480
Mineral	NR	NR	$11,049
Moffat	105	$946,824	$9,017
Montezuma	188	$2,019,193	$10,740
Montrose	139	$1,172,531	$8,435
Morgan	268	$2,348,405	$8,763

B4a: FY 2015-16 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Otero	161	$1,512,815	$9,396
Ouray	NR	NR	$5,669
Park	46	$399,027	$8,675
Phillips	39	$314,307	$8,059
Pitkin	NR	NR	$6,496
Prowers	152	$1,408,097	$9,264
Pueblo	1,311	$11,770,804	$8,978
Rio Blanco	NR	NR	$6,192
Rio Grande	88	$828,162	$9,411
Routt	86	$806,251	$9,375
Saguache	51	$421,046	$8,256
San Juan	NR	NR	$6,532
San Miguel	NR	NR	$5,611
Sedgwick	NR	NR	$9,719
Summit	140	$1,071,165	$7,651

B4a: FY 2015-16 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date

County Name	Unique Deliveries	Total Payments	Average Payment
Teller	96	$787,572	$8,204
Washington	NR	NR	$8,909
Weld	2,086	$16,837,591	$8,072
Yuma	75	$636,531	$8,487
Suppressed Counties	338	$2,720,721	$8,049
STATEWIDE	29,158	$254,875,517	$8,741

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

Unduplicated client counts represent the number of unique clients who received a service in each category only. "NR" denotes county included in "Suppressed Counties" category.

B4b: FY 2015-16 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Delivery Type

Delivery Type	Unique Deliveries	Total Payments	Average Payment
Caesarian	6,378	$67,580,929	$10,596
Vaginal	20,903	$171,645,640	$8,212
Unknown/No Delivery Information	1,877	$15,648,949	$8,337
Total	29,158	$254,875,517	$8,741

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

B4c: FY 2015-16 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Age on Delivery Date

Age Group	Unique Deliveries	Total Payments	Average Payment
<=14	NR	NR	$10,653
15-19	2,763	$24,313,984	$8,800
20	1,442	$12,715,479	$8,818
21-24	7,143	$61,735,151	$8,643
25-34	14,406	$126,192,085	$8,760
35+	3,366	$29,551,885	$8,780
Unknown	NR	NR	$1,179
Total	29,158	$254,875,517	$8,741

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

B4d: FY 2015-16 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit Claims, by Eligibility type			
Eligibility Type	**Unique Deliveries**	**Total Payments**	**Average Payment**
MAGI Children	7,150	$56,026,356	$7,836
Aid to Need Disabled, Children with Disabilities Buy-In, & Foster Care	281	$1,679,402	$5,977
Total	**7,431**	**$57,705,758**	**$7,766**

B4e: FY 2015-16 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit (NICU) Claims by Severity of Condition and Needy Newborn Status

Most Severe Classification*	Unique Clients	Unique Clients: Not Needy Newborn	Unique Clients: Needy Newborn	Total LBW / Preterm / NICU Payments	Payments: Not Needy Newborn	Payments: Needy Newborn
Low Birthweight Infants						
Extremely Low BW (<1000 grams)	273	62	211	$12,011,293.78	$449,779.75	$11,561,514.03
Very Low BW (1000 - 1499 grams)	1,886	210	1,676	$18,846,717.13	$992,552.36	$17,854,164.77
Low BW (1500-2499 grams)	715	36	679	$6,545,672.92	$210,893.42	$6,334,779.50
All LBW Clients	**2,874**	**308**	**2,566**	**$30,858,011**	**$1,442,332**	**$29,415,679**
Preterm Infants Not Classified as Low Birthweight						
Very Preterm (<32 weeks gestation)	652	NR	NR	$5,539,877.53	$815,372.75	$4,724,504.78
Moderately Preterm (32 to 36 weeks gestation)	209	NR	NR	$673,190.86	$62,096.44	$611,094.42
All Preterm Infants not identified via LBW	**861**	**158**	**703**	**$6,213,068**	**$877,469**	**$5,335,599**
Infants Treated in the NICU Not Due to LBW or Preterm						
NICU - Other, Including Normal Birthweight	3,696	243	3,453	$14,089,005.98	$792,338.83	$13,296,667.15
TOTAL	**7,431**	**709**	**6,722**	**$57,705,758**	**$3,323,034**	**$54,382,725**

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

B4F: FY 2015-16 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit Claims by County		
County Name	**Unique Clients (Assigned to County by Earliest Claim in FY14-15)**	**Payment (Assigned via Client County as of First Date of Service on Specific Claim)**
Adams	977	$7,276,810
Alamosa	38	$483,636
Arapahoe	957	$8,759,954
Archuleta	NR	$46,120
Baca	NR	<10,000
Bent	NR	<10,000
Boulder	240	$1,686,380
Broomfield	38	$330,967
Chaffee	NR	$81,034
Cheyenne	NR	<10,000
Clear Creek	NR	$54,539
Conejos	NR	$107,134
Costilla	NR	$19,427
Crowley	NR	$66,504
Custer	NR	$11,730

B4F: FY 2015-16 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit Claims by County		
County Name	**Unique Clients (Assigned to County by Earliest Claim in FY14-15)**	**Payment (Assigned via Client County as of First Date of Service on Specific Claim)**
Delta	NR	$112,651
Denver	1,111	$10,066,467
Dolores	NR	<10,000
Douglas	162	$765,614
Eagle	90	$522,864
El Paso	1,105	$8,759,313
Elbert	NR	$66,880
Fremont	79	$579,478
Garfield	111	$609,490
Gilpin	NR	$150,880
Grand	NR	$13,233
Gunnison	NR	$108,487
Hinsdale	NR	<10,000
Huerfano	NR	$43,761
Jackson	NR	<10,000

B4F: FY 2015-16 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit Claims by County		
County Name	**Unique Clients (Assigned to County by Earliest Claim in FY14-15)**	**Payment (Assigned via Client County as of First Date of Service on Specific Claim)**
Jefferson	423	$3,309,435
Kiowa	NR	<10,000
Kit Carson	NR	$37,549
Lake	51	$306,656
La Plata	NR	$60,832
Larimer	394	$2,429,234
Las Animas	NR	$82,358
Lincoln	NR	$11,092
Logan	NR	$84,770
Mesa	256	$1,549,954
Moffat	NR	<10,000
Montezuma	30	$136,907
Montrose	44	$242,750
Morgan	44	$248,333
Otero	74	$377,229

B4F: FY 2015-16 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit Claims by County		
County Name	**Unique Clients (Assigned to County by Earliest Claim in FY14-15)**	**Payment (Assigned via Client County as of First Date of Service on Specific Claim)**
Park	NR	$256,231
Phillips	NR	<10,000
Pitkin	NR	$40,269
Prowers	NR	$18,436
Pueblo	NR	$25,686
Rio Blanco	NR	$172,504
Rio Grande	308	$1,723,233
Routt	NR	<10,000
Saguache	NR	$218,138
San Juan	NR	$344,841
San Miguel	NR	$67,093
Sedgwick	NR	<10,000
Summit	NR	$37,232
Teller	NR	<10,000
Washington	NR	$199,197

B4F: FY 2015-16 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit Claims by County

County Name	Unique Clients (Assigned to County by Earliest Claim in FY14-15)	Payment (Assigned via Client County as of First Date of Service on Specific Claim)
Weld	30	$332,247
Yuma	NR	<10,000
Total LBW / Preterm / NICU Clients & Payments	464	$4,403,213

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

B4G: FY 2014-15 Clients with and without a Neonatal Abstinence Syndrome Diagnosis Code

Client Type	Unique Clients	Total LBW/Preterm/NICU Claim Payments	Average Cost per Client
Clients with a Neonatal Abstinence Syndrome Diagnosis (NAS) in FY15-16	269	2,716,525	10,099
Clients without an NAS Diagnosis in FY15-16	7,162	54,989,233	7,678
Total	**7,431**	**57,705,758**	**7,766**

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

B5a1: FY 2015-16 Top 10 Major Diagnostic Categories (Inpatient) Ranked by Expenditures (DRG)					
Rank	**MDC**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	14	Pregnancy, childbirth and the puerperium	$105,423,339	26,158	$4,030.25
2	8	Musculoskeletal system and connective tissue	$65,786,943	5,585	$11,779.22
3	18	Infectious & parasitic diseases	$56,221,414	5,146	$10,925.27
4		Pre-MDC Other	$54,396,120	1,712	$31,773.43
5	4	Respiratory system	$51,791,461	7,124	$7,270.00
6	5	Circulatory system	$48,702,046	4,045	$12,040.06
7	15	Conditions of newborns	$47,487,128	5,674	$8,369.25
8	6	Digestive system	$45,035,166	6,070	$7,419.30
9	1	Nervous System	$41,260,836	4,385	$9,409.54
10	10	Endocrine, nutritional and metabolic disorders	$29,429,346	2,824	$10,421.16
		Top Ten Totals	**$545,533,798**	**68,723**	**$7,938.15**

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

B5b1: FY 2015-16 Top 10 Inpatient Hospital Diagnosis Related Groups Ranked by Expenditures (APR-DRG)

Rank	DRG	Description	Expenditures	Unduplicated Client Count	Average Cost
1	560	Vaginal Delivery	$66,198,282	18,432	$3,591.49
2	720	Septicemia & Disseminated Infections	$30,375,566	3,497	$8,686.18
3	540	Cesarean Section	$28,841,794	6,070	$4,751.53
4	710	Infectious & Parasitic Disease with Operating Room Procedure	$18,455,185	884	$20,876.91
5	004	Tracheostomy With Long Term Mechanical Ventilation	$18,399,879	213	$86,384.41
6	425	Electrolyte Disorders Except Hypovolemia Related	$13,417,963	425	$31,571.68
7	304	Dorsal & Lumbar Fusion Proc Except for Curvature of Back	$12,573,729	562	$22,373.18
8	860	Rehabilitation	$12,558,097	738	$17,016.39
9	775	Alcohol Abuse & Dependence	$11,280,637	1,482	$7,611.77
10	912	Musculoskeletal & other procedures for multiple significant trauma	$9,144,305	250	$36,577.22
		Top Ten Totals	$66,198,282	32,553	$6,796.47

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

B5c1: FY 2015-16 Top 10 Outpatient Hospital Principal Diagnosis (ICD-9 Pre October 1, 2015) Categories Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count	Average Cost
1	789	Other Symptoms Involving Abdomen and Pelvis	$8,459,800	11,939	$708.59
2	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$5,666,878	9,723	$582.83
3	V58	Other and Unspecified Aftercare	$4,594,573	3,090	$1,486.92
4	780	General Symptoms	$4,257,952	8,504	$500.70
5	V57	Care Involving Use of Rehabilitation Procedures	$3,416,376	9,112	$374.93
6	521	Diseases of Hard Tissues of Teeth	$2,930,615	1,925	$1,522.40
7	305	Nondependent Abuse of Drugs	$2,680,806	3,857	$695.05
8	724	Other and Unspecified Disorders of Back	$2,528,872	6,886	$367.25
9	787	Symptoms Involving Digestive System	$2,339,910	5,801	$403.36
10	784	Symptoms Involving Head and Neck	$2,207,212	4,765	$463.21
		Top Ten Totals	**$39,082,994**	**65,602**	**$595.76**

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

B5c2: FY 2015-16 Top 10 Outpatient Hospital Principal Diagnosis Categories (ICD-10 Post October 1, 2015) Ranked by Expenditures

Rank	Principal Diagnosis Category	Description	Expenditures	Unduplicated Client Count	Average Cost
1	R10–R19	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: Symptoms and signs involving the digestive system and abdomen	$35,566,672	50,007	$711.23
2	R00–R09	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: Symptoms and signs involving the circulatory and respiratory systems	$20,858,113	35,048	$595.13
3	Z40–Z53	Factors influencing health status and contact with health services: Encounters for other specific health care	$18,104,816	10,702	$1,691.72
4	R50–R69	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: General symptoms and signs	$15,402,824	28,550	$539.50
5	M50-M54	Diseases of the musculoskeletal system and connective tissue: Other dorsopathies	$14,451,999	26,476	$545.85
6	S00–S09	Injury, poisoning and certain other consequences of external causes: Injuries to the head	$14,355,310	25,825	$555.87
7	G40–G47	Diseases of the nervous system: Episodic and paroxysmal disorders	$12,902,536	15,060	$856.74
8	M20-M25	Diseases of the musculoskeletal system and connective tissue: Other joint disorders	$12,388,444	25,571	$484.47
9	F10–F19	Mental and behavioral disorders: Mental and behavioral disorders due to psychoactive substance use	$11,977,286	12,698	$943.24
10	S80–S89	Injury, poisoning and certain other consequences of external causes: Injuries to the knee and lower leg	$10,766,990	11,867	$907.31
		Top Ten Totals	**$166,774,990**	**241,804**	**$689.71**

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

B5d1: FY 2015-16 Top 10 Outpatient Surgical Procedures (ICD-9 Pre October 1, 2015) Ranked by Expenditures

Rank	Surgical Procedure Code	Description	Expenditures	Unduplicated Client Count	Average Cost
1	66.29	Other bilateral endoscopic destruction or occlusion of fallopian tubes	$44,509	NR	N/A
2	86.59	Closure of skin and subcutaneous tissue of other sites	$15,468	NR	N/A
3	93.54	Application of splint	$13,119	NR	N/A
4	99.29	Injection or infusion of other therapeutic or prophylactic substance	$11,928	NR	N/A
5	65.31	Laparoscopic unilateral oophorectomy	$10,650	NR	N/A
6	66.32	Other bilateral ligation and division of fallopian tubes	$9,629	NR	N/A
7	79.01	Closed reduction of fracture without internal fixation, humerus	$7,838	NR	N/A
8	59.79	Other	$7,770	NR	N/A
9	81.45	Other repair of the cruciate ligaments	$7,765	NR	N/A
10	66.39	Other bilateral destruction or occlusion of fallopian tubes	$7,404	NR	N/A
		Top Ten Totals	**$136,079**	**87**	**$1,564.12**

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

B5d2: FY 2015-16 Top 10 Outpatient Surgical Procedures (ICD-10 Post October 1, 2015) Ranked by Expenditures

Rank	Surgical Procedure Code	Description	Expenditures	Unduplicated Client Count	Average Cost
1	0UL	Female Reproductive System, Occlusion	$98,731	39	$2,531.56
2	0UT	Female Reproductive System, Resection	$84,104	NR	N/A
3	0UB	Female Reproductive System, Excision	$27,631	NR	N/A
4	0FT	Hepatobiliary System and Pancreas, Resec	$13,111	NR	N/A
5	0U5	Female Reproductive System, Destruction	$11,429	NR	N/A
6	0BH	Respiratory System, Insertion	$9,231	NR	N/A
7	0U9	Female Reproductive System, Drainage	$7,717	NR	N/A
8	0HQ	Skin and Breast, Repair	$7,233	NR	N/A
9	0WU	Anatomical Regions, General, Supplement	$5,060	NR	N/A
10	0DT	Gastrointestinal System, Resection	$5,004	NR	N/A
		Top Ten Totals	$269,250	106	$2,540.09

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

B5e1: FY 2015-16 Top 10 Federally Qualified Health Center (FQHC) Principal Diagnosis Categories (ICD-9 Pre October 1, 2015) Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count	Average Cost
1	V20	Health Supervision of Infant or Child	$20,757,379	74,698	$277.88
2	V22	Normal Pregnancy	$8,107,363	8,681	$933.92
3	250	Diabetes Mellitus	$5,316,159	11,860	$448.24
4	724	Other and Unspecified Disorders of Back	$4,805,064	21,780	$220.62
5	V70	General Medical Examination	$4,306,790	13,471	$319.71
6	719	Other and Unspecified Disorder of Joint	$3,893,914	13,646	$285.35
7	V25	Encounter For Contraceptive Management	$3,755,199	19,263	$194.94
8	401	Essential Hypertension	$3,529,573	11,713	$301.34
9	780	General Symptoms	$3,320,559	10,048	$330.47
10	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$2,678,079	11,954	$224.03
		Top Ten Totals	**$16,196,169**	**69,503**	$233.03

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

*Diagnosis V72 - Special Investigations and Examinations - may include a substantial amount of dental claims.

B5e2: FY 2015-16 Top 10 Federally Qualified Health Center (FQHC) Principal Diagnosis Categories (ICD-10 Post October 1, 2015) Ranked by Expenditures

Rank	Principal Diagnosis Category	Description	Expenditures	Unduplicated Client Count	Average Cost
1	Z00–Z13	Factors influencing health status and contact with health services: Persons encountering health services for examinations	$19,803,718	76,549	$258.71
2	Z30–Z39	Factors influencing health status and contact with health services: Persons encountering health services in circumstances related to reproduction	$8,156,303	16,408	$497.09
3	J00–J06	Diseases of the respiratory system: Acute upper respiratory infections	$6,596,719	28,848	$228.67
4	Z20-Z28	Factors influencing health status and contact with health services: Persons with potential health hazards related to communicable diseases	$4,300,755	21,019	$204.61
5	E08-E13	Endocrine, nutritional and metabolic diseases: Diabetes mellitus	$4,020,428	10,565	$380.54
6	M50-M54	Diseases of the musculoskeletal system and connective tissue: Other dorsopathies	$3,847,399	12,800	$300.58
7	R10–R19	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: Symptoms and signs involving the digestive system and abdomen	$3,209,583	13,656	$235.03
8	M20-M25	Diseases of the musculoskeletal system and connective tissue: Other joint disorders	$2,865,658	11,273	$254.21
9	I10–I15	Diseases of the circulatory system: Hypertensive diseases	$2,798,950	9,874	$283.47
10	R00–R09	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: Symptoms and signs involving the circulatory and respiratory systems	$2,779,050	12,390	$224.30
		Top Ten Totals	**$58,378,564**	**213,382**	$273.59

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

*Diagnosis V72 - Special Investigations and Examinations - may include a substantial amount of dental claims.

B5f1: FY 2015-16 Top 10 Rural Health Center (RHC) Principal Diagnosis Categories (ICD-9 Pre October 1, 2015) Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count	Average Cost
1	V20	Health Supervision of Infant or Child	$573,474	3,477	$164.93
2	V72	Special Investigations and Examinations	$199,627	587	$340.08
3	724	Other and Unspecified Disorders of Back	$144,260	697	$206.97
4	719	Other and Unspecified Disorder of Joint	$131,774	679	$194.07
5	V70	General Medical Examination	$115,618	742	$155.82
6	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$114,432	643	$177.97
7	250	Diabetes Mellitus	$111,573	478	$233.42
8	780	General Symptoms	$105,636	618	$170.93
9	462	Acute Pharyngitis	$101,267	617	$164.13
10	V22	Normal Pregnancy	$95,420	186	$513.01
		Top Ten Totals	**$2,652,004**	**14,033**	**$188.98**

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

*Diagnosis V72 - Special Investigations and Examinations - may include a substantial amount of dental claims.

B5f2: FY 2015-16 Top 10 Rural Health Center (RHC) Principal Diagnosis Categories (ICD-10 Post October 1, 2015) Ranked by Expenditures

Rank	Principal Diagnosis Group Category	Description	Expenditures	Unduplicated Client Count	Average Cost
1	J00–J06	Diseases of the respiratory system: Acute upper respiratory infections	$1,716,233	7,456	$230.18
2	Z00–Z13	Factors influencing health status and contact with health services: Persons encountering health services for examinations	$1,706,899	6,947	$245.70
3	Z30–Z39	Factors influencing health status and contact with health services: Persons encountering health services in circumstances related to reproduction	$565,623	1,293	$437.45
4	M50-M54	Diseases of the musculoskeletal system and connective tissue: Other dorsopathies	$525,980	1,840	$285.86
5	R10–R19	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: Symptoms and signs involving the digestive system and abdomen	$462,525	2,194	$210.81
6	H65–H75	Diseases of the ear and mastoid process: Diseases of middle ear and mastoid	$455,245	1,988	$229.00
7	R50–R69	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: General symptoms and signs	$427,252	2,169	$196.98
8	R00–R09	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: Symptoms and signs involving the circulatory and respiratory systems	$420,906	2,208	$190.63
9	M20-M25	Diseases of the musculoskeletal system and connective tissue: Other joint disorders	$373,661	1,695	$220.45
10	J30–J39	Diseases of the respiratory system: Other diseases of upper respiratory tract	$367,737	1,628	$225.88
		Top Ten Totals	**$7,022,062**	**29,418**	**$238.70**

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

B5g1: FY 2015-16 Top 10 Physician and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Principal Diagnosis Categories (ICD-9 Pre October 1, 2015), Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count	Average Cost
1	V20	Health Supervision of Infant or Child	$10,784,030	76,105	$141.70
2	367	Disorders of Refraction and Accommodation	$9,015,374	43,459	$207.45
3	789	Other Symptoms Involving Abdomen and Pelvis	$4,992,084	27,138	$183.95
4	V25	Encounter For Contraceptive Management	$4,385,024	14,693	$298.44
5	315	Specific Delays in Development	$3,887,128	4,917	$790.55
6	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$3,645,560	32,977	$110.55
7	780	General Symptoms	$3,599,021	24,713	$145.63
8	724	Other and Unspecified Disorders of Back	$3,269,299	17,755	$184.13
9	719	Other and Unspecified Disorder of Joint	$2,842,669	24,508	$115.99
10	650	Normal Delivery	$2,510,151	3,162	$793.85
		Top Ten Totals	**$72,341,121**	**424,747**	$170.32

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

B5g2: FY 2015-16 Top 10 Physician and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Principal Diagnosis Categories (ICD-10 Post October 1, 2015), Ranked by Expenditures

Rank	Principal Diagnosis Group Category	Description	Expenditures	Unduplicated Client Count	Average Cost
1	Z00–Z13	Factors influencing health status and contact with health services: Persons encountering health services for examinations	$35,635,423	224,746	$158.56
2	H49–H52	Diseases of the eye and adnexa: Disorders of ocular muscles, binocular movement, accommodation and refraction	$27,633,555	112,036	$246.65
3	R10–R19	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: Symptoms and signs involving the digestive system and abdomen	$22,704,018	103,539	$219.28
4	R50–R69	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: General symptoms and signs	$19,078,063	89,524	$213.11
5	Z30–Z39	Factors influencing health status and contact with health services: Persons encountering health services in circumstances related to reproduction	$19,036,050	62,654	$303.83
6	J00–J06	Diseases of the respiratory system: Acute upper respiratory infections	$16,554,751	138,740	$119.32
7	M50-M54	Diseases of the musculoskeletal system and connective tissue: Other dorsopathies	$16,153,990	56,284	$287.01
8	R00–R09	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: Symptoms and signs involving the circulatory and respiratory systems	$15,989,201	121,077	$132.06
9	F80–F89	Mental and behavioral disorders: Pervasive and specific developmental disorders	$14,159,898	10,185	$1,390.27
10	M20-M25	Diseases of the musculoskeletal system and connective tissue: Other joint disorders	$11,000,979	63,811	$172.40

		Top Ten Totals	**$197,945,928**	**982,596**	**$201.45**

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

B5h: FY 2015-16 Top 10 Dental Procedures Ranked by Expenditures

Rank	Procedure Code	Procedure Description	Expenditures	Unduplicated Client Count	Average Cost
1	D8090	Comprehensive Ortho Adult Dentition	$25,042,025	7,882	$3,177.12
2	D2392	Resin Based Comp Two Surfaces Posterior	$19,606,276	76,934	$254.85
3	D7140	Extraction Erupted Tooth/Exposed Root	$17,790,763	75,914	$234.35
4	D2391	Resin Based Comp One Surface Posterior	$12,376,359	67,278	$183.96
5	D1110	Prophylaxis Adult	$8,845,657	172,953	$51.14
6	D2930	Prefab Stainless Steel Crown Primary	$8,796,473	26,898	$327.03
7	D5110	Complete Denture Maxillary	$8,609,688	11,420	$753.91
8	D0120	Periodic Oral Evaluation	$8,156,314	278,218	$29.32
9	D1120	Prophylaxis Child	$8,071,124	198,155	$40.73
10	D0210	Intraor Complete Film Series	$7,265,141	97,620	$74.42
		Top Ten Totals	**$124,559,821**	**1,013,272**	**$122.93**

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

B5i: FY 2015-16 Top 10 Laboratory Procedures Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count	Average Cost
1	87491	Chlamydia Tracholmatis, DNA, Amplified Probe Technique	$5,319,966	89,596	$59.38
2	87591	Nisseria Gonorrhea, DNA, Amplified Probe Technique	$5,296,718	89,211	$59.37
3	80053	Comprehensive Metabolic Panel	$4,042,445	173,826	$23.26
4	81220	Cystic Fibrosis Transmembrane Conductance Regulator Gene Common Variants	$3,554,662	3,324	$1,069.39
5	85025	Complete Blood Count with Automated White Blood Cells Differential	$3,358,536	198,654	$16.91
6	80050	General Health Panel	$2,992,636	61,990	$48.28
7	84443	Thyroid Stimulus Hormone	$2,976,751	106,044	$28.07
8	80061	Lipid Panel	$2,416,741	118,908	$20.32
9	88305	Tissue Exam by Pathologist	$2,340,835	34,290	$68.27
10	82306	Vitamin D Testing	$2,254,808	48,389	$46.60
		Top Ten Totals	**$34,554,099**	**924,232**	**$37.39**

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

B5j: FY 2014-15 Top 10 Durable Medical Equipment and Supplies Procedures Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	E1390	Oxygen concentrator	$29,629,063	24,757	$1,196.80
2	B4160	Enteral Formula for Pediatrics, Calorie Dense >/=0.7kc	$6,379,632	2,206	$2,891.95
3	E0442	Stationary Oxygen, Liquid	$5,762,599	4,733	$1,217.54
4	E0441	Stationary Oxygen, Gas	$5,251,229	5,339	$983.56
5	B4161	Enteral formula for pediatrics, hydrolyzed/amino acids and peptide chain proteins	$4,194,546	931	$4,505.42
6	B4035	Enteral Feed Supplement, Pump, per day	$3,195,669	1,761	$1,814.69
7	T4527	Adult Sized Disposable Incontinence Product Large	$3,074,546	3,820	$804.85
8	A4253	Blood Glucose/Reagent Strips	$3,068,069	20,025	$153.21
9	A4554	Disposable Underpads	$2,871,711	9,424	$304.72
10	T4526	Adult Sized Disposable Incontinence Product Medium	$2,436,506	4,000	$609.13
		Top Ten Totals	**$65,863,569**	**76,996**	**$855.42**

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

B5k: FY 2015-16 Top 10 Prescription Drugs Ranked by Expenditures					
Rank	**Drug Name**	**Therapeutic Class**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	ABILIFY	Antipsychotics	$45,144,830	10,293	$4,385.97
2	HUMIRA	Anti-Inflammatory Tumor Necrosis	$25,066,137	1,046	$23,963.80
3	LEVEMIR	Insulins	$22,377,851	10,997	$2,034.91
4	NOVOLOG	Insulins	$19,348,995	8,342	$2,319.47
5	ADVAIR	Beta-Adrenergics and Glucocort	$19,230,879	17,330	$1,109.69
6	GENOTROPIN	Growth hormone (GH)	$14,962,842	522	$28,664.45
7	LYRICA	Anti-Convulsants	$14,694,423	8,135	$1,806.32
8	PROAIR	Beta-Adrenergic Agents	$14,240,276	105,184	$135.38
9	LATUDA	Antipsychotics/Atypical/Dopami	$13,261,245	3,184	$4,164.96
10	ENBREL	Anti-Inflammatory Tumor Necrosis	$11,705,619	621	$18,849.63
		Top Ten Total	**$200,033,095**	**165,654**	**$1,207.54**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within 45 day of the end of the fiscal year.

B5l: FY 2015-16 Top 10 Prescription Drugs Ranked by Number of Prescriptions Filled					
Rank	**Drug Name**	**Therapeutic Class**	**Total Prescriptions Filled**	**Expenditures**	**Average Cost**
1	OXYCODONE	Analgesic	322,521	$7,893,165	$24.47
2	HYDROCODON	Analgesic	245,255	$4,174,263	$17.02
3	PROAIR	Beta-adrenergic agents	215,474	$14,240,276	$66.09
4	AMOXICILLIN	Antibiotics	181,485	$2,231,123	$12.29
5	LISINOPRIL	ACE Inhibitor	179,510	$1,754,625	$9.77
6	GABAPENTIN	Anti-Convulsants	146,092	$2,897,347	$19.83
7	LEVOTHYROXINE	Thyroid Hormone	145,505	$2,669,916	$18.35
8	IBUPROFEN	NSAID	130,631	$1,448,018	$11.08
9	AMOX	Penicillins	120,703	$3,219,751	$26.67
10	SERTRALINE	Selective Serotonin reuptake/Antidepressant	115,399	$1,578,604	$13.68
		Top Ten Total	**1,802,575**	**$42,107,090**	**$23.36**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within 45 day of the end of the fiscal year.