Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-01 CDPHE IDD Staffing

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$6,398,594**	**$0**	**$6,634,638**	**$417,435**	**$393,920**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,469,927	$0	$2,462,949	$208,718	$196,960
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,928,667	$0	$4,171,689	$208,717	$196,960

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (B) Transfers to/from Other Departments - Facility Survey and Certification, Transfer to CDPHE	**Total**	**$6,398,594**	**$0**	**$6,634,638**	**$417,435**	**$393,920**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,469,927	$0	$2,462,949	$208,718	$196,960
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,928,667	$0	$4,171,689	$208,717	$196,960

CF Letternote Text Revision Required?	Yes ___	No X	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes ___	No X	
FF Letternote Text Revision Required?	Yes ___	No X	
Requires Legislation?	Yes ___	No X	

Type of Request? Department of Health Care Policy and Financing Non-Prioritized Request

Interagency Approval or Related Schedule 13s: Department of Public Health and Environment

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-02 CDPHE Health Surveys

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$6,398,594**	**$0**	**$6,634,638**	**$184,574**	**$224,642**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,469,927	$0	$2,462,949	$92,287	$112,321
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,928,667	$0	$4,171,689	$92,287	$112,321

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
	Total	**$6,398,594**	**$0**	**$6,634,638**	**$184,574**	**$224,642**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (B) Transfers to/from Other Departments - Facility Survey and Certification, Transfer to CDPHE	GF	$2,469,927	$0	$2,462,949	$92,287	$112,321
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,928,667	$0	$4,171,689	$92,287	$112,321

CF Letternote Text Revision Required? Yes ___ No X **If Yes, see attached fund source detail.**

RF Letternote Text Revision Required? Yes ___ No X

FF Letternote Text Revision Required? Yes ___ No X

Requires Legislation? Yes ___ No X

Type of Request? Department of Health Care Policy and Financing Non-Prioritized Request

Interagency Approval or Related Schedule 13s: Department of Public Health and Environment

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-03 Resources for Administrative Courts

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$697,852**	**$0**	**$650,609**	**$6,134**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$271,159	$0	$252,803	$2,384	$0
	CF	$77,767	$0	$72,502	$683	$0
	RF	$0	$0	$0	$0	$0
	FF	$348,926	$0	$325,304	$3,067	$0

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
	Total	**$697,852**	**$0**	**$650,609**	**$6,134**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration - Administrative Law Judge Services	GF	$271,159	$0	$252,803	$2,384	$0
	CF	$77,767	$0	$72,502	$683	$0
	RF	$0	$0	$0	$0	$0
	FF	$348,926	$0	$325,304	$3,067	$0

CF Letternote Text Revision Required?	Yes ___	No X	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes ___	No X	
FF Letternote Text Revision Required?	Yes ___	No X	
Requires Legislation?	Yes ___	No X	

Type of Request? Department of Health Care Policy and Financing Non-Prioritized Request

Interagency Approval or Related Schedule 13s: Department of Personnel and Administration

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-04 DHS ADRC Claiming

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___	Supplemental FY 2016-17
X	Change Request FY 2017-18
___	Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$1,800**	**$0**	**$1,800**	**$1,000,000**	**$1,000,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$900	$0	$900	$500,000	$500,000
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$900	$0	$900	$500,000	$500,000

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
	Total	**$1,800**	**$0**	**$1,800**	**$1,000,000**	**$1,000,000**
	FTE	0.0	0.0	0.0	0.0	0.0
07. Department of Human Services Medicaid-Funded Programs, (I) Adult Assistance and Services for Elderly - Medicaid - Adult Assst. Medicaid Programs - Community Srvcs for Elderly	GF	$900	$0	$900	$500,000	$500,000
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$900	$0	$900	$500,000	$500,000

CF Letternote Text Revision Required?	Yes ___	No X	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes ___	No X	
FF Letternote Text Revision Required?	Yes ___	No X	
Requires Legislation?	Yes ___	No X	

Type of Request? Department of Health Care Policy and Financing Non-Prioritized Request

Interagency Approval or Related Schedule 13s: Department of Human Services

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-05 DHS OIT Deskside

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/24/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$647,220**	**$0**	**$729,396**	**$1,967**	**$2,057**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$322,316	$0	$363,404	$984	$1,029
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$324,904	$0	$365,992	$983	$1,028

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
	Total	**$647,220**	**$0**	**$729,396**	**$1,967**	**$2,057**
	FTE	0.0	0.0	0.0	0.0	0.0
07. Department of Human Services Medicaid-Funded Programs, (B) Office of Information Technology Services - Medicaid - Other Office Of Information Technology Services Line Items	GF	$322,316	$0	$363,404	$984	$1,029
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$324,904	$0	$365,992	$983	$1,028

CF Letternote Text Revision Required?	Yes ___	No X	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes ___	No X	
FF Letternote Text Revision Required?	Yes ___	No X	
Requires Legislation?	Yes ___	No X	

Type of Request? Department of Health Care Policy and Financing Non-Prioritized Request

Interagency Approval or Related Schedule 13s: Department of Human Services and OIT

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-06 DHS OIT Secure Colorado

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$647,220**	**$0**	**$729,396**	**$4,920**	**$8,410**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$322,316	$0	$363,404	$2,460	$4,205
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$324,904	$0	$365,992	$2,460	$4,205

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
	Total	**$647,220**	**$0**	**$729,396**	**$4,920**	**$8,410**
	FTE	0.0	0.0	0.0	0.0	0.0
07. Department of Human Services Medicaid-Funded Programs, (B) Office of Information Technology Services - Medicaid - Other Office Of Information Technology Services Line Items	GF	$322,316	$0	$363,404	$2,460	$4,205
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$324,904	$0	$365,992	$2,460	$4,205

CF Letternote Text Revision Required?	Yes ___	No X	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes ___	No X	
FF Letternote Text Revision Required?	Yes ___	No X	
Requires Legislation?	Yes ___	No X	

Type of Request? Department of Health Care Policy and Financing Non-Prioritized Request

Interagency Approval or Related Schedule 13s: Department of Human Services and OIT

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-07 OIT Secure Colorado

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$4,703,675**	**$0**	**$4,468,808**	**$44,731**	**$76,469**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,974,295	$0	$1,875,722	$18,774	$32,095
	CF	$377,545	$0	$358,685	$3,592	$6,140
	RF	$0	$0	$0	$0	$0
	FF	$2,351,835	$0	$2,234,401	$22,365	$38,234

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
	Total	**$4,703,675**	**$0**	**$4,468,808**	**$44,731**	**$76,469**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration - Payments to OIT	GF	$1,974,295	$0	$1,875,722	$18,774	$32,095
	CF	$377,545	$0	$358,685	$3,592	$6,140
	RF	$0	$0	$0	$0	$0
	FF	$2,351,835	$0	$2,234,401	$22,365	$38,234

CF Letternote Text Revision Required?	Yes ___	No X	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes ___	No X	
FF Letternote Text Revision Required?	Yes ___	No X	
Requires Legislation?	Yes ___	No X	

Type of Request? Department of Health Care Policy and Financing Non-Prioritized Request

Interagency Approval or Related Schedule 13s: Office of Information Technology

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

NPR-08 OIT Deskside

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$4,703,675**	**$0**	**$4,468,808**	**$127,669**	**$128,483**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,974,295	$0	$1,875,722	$53,583	$53,925
	CF	$377,545	$0	$358,685	$10,252	$10,317
	RF	$0	$0	$0	$0	$0
	FF	$2,351,835	$0	$2,234,401	$63,834	$64,241

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
	Total	**$4,703,675**	**$0**	**$4,468,808**	**$127,669**	**$128,483**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration - Payments to OIT	GF	$1,974,295	$0	$1,875,722	$53,583	$53,925
	CF	$377,545	$0	$358,685	$10,252	$10,317
	RF	$0	$0	$0	$0	$0
	FF	$2,351,835	$0	$2,234,401	$63,834	$64,241

CF Letternote Text Revision Required?	Yes X	No ___	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes ___	No X	Hospital Provider Fee
FF Letternote Text Revision Required?	Yes ___	No X	
Requires Legislation?	Yes ___	No X	

Type of Request? Department of Health Care Policy and Financing Non-Prioritized Request

Interagency Approval or Related Schedule 13s: Office of Information Technology

Exhibit A - Summary of Request

Calculation of Request						
FY 2016-17						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2016-17 Appropriation						
FY 2016-17 Long Bill Appropriation (HB 16-1405)	$6,762,815,547	$1,075,134,728	$873,835,000	$678,702,748	$5,240,893	$4,129,902,178
SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	($29,917)	($9,084)	$0	($409)	$0	($20,424)
HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	$55,694,236	($6,451,471)	$0	$27,008,330	$0	$35,137,377
HB 16-1097 "PUC Permit for Medicaid Transportation Providers"	($215,271)	($69,405)	$0	($2,549)	$0	($143,317)
FY 2016-17 Total Spending Authority	**$6,818,264,595**	**$1,068,604,768**	**$873,835,000**	**$705,708,120**	**$5,240,893**	**$4,164,875,814**
Total Projected FY 2016-17 Expenditure	$6,959,959,497	$1,100,822,761	$873,835,000	$707,358,313	$9,102,709	$4,268,840,714
FY 2016-17 Requested Change from Appropriation	**$141,694,902**	**$32,217,993**	**$0**	**$1,650,193**	**$3,861,816**	**$103,964,900**
Percent Change	2.08%	3.01%	0.00%	0.23%	73.69%	2.50%

Calculation of Request						
FY 2017-18						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2016-17 Appropriation Plus Special Bills	$6,818,264,595	$1,068,604,768	$873,835,000	$705,708,120	$5,240,893	$4,164,875,814
Bill Annualizations						
Annualization of Long Bill FY 2016-17 (HB 16-1405)	($7,767,108)	($3,156,180)	$0	$283	$0	($4,611,211)
SB 16-027 Annualization "Medicaid Option for Prescribed Drugs by Mail"	($1,737,180)	($528,579)	$0	($43,239)	$0	($1,165,362)
HB 16-1408 Annualization "Allocation of Cash Fund Revenues from Tobacco MSA"	($55,694,236)	$6,451,471	$0	($27,008,330)	$0	($35,137,377)
HB 16-1097 Annualization "PUC Permit for Medicaid Transportation Providers"	($234,492)	($67,441)	$0	($8,561)	$0	($158,490)
HB 16-1321 "Medicaid Buy-In Certain Medicaid Waivers"	$61,533	($138,758)	$0	$184,000	$0	$16,291
Total Annualizations	($65,371,483)	$2,560,513	$0	($26,875,847)	$0	($41,056,149)
FY 2017-18 Total Spending Authority	**$6,752,893,112**	**$1,071,165,281**	**$873,835,000**	**$678,832,273**	**$5,240,893**	**$4,123,819,665**
Total Projected FY 2017-18 Expenditure	$7,114,289,396	$1,195,496,083	$873,835,000	$689,180,826	$9,031,044	$4,346,746,443
FY 2017-18 Requested Change from Appropriation	**$361,396,284**	**$124,330,802**	**$0**	**$10,348,553**	**$3,790,151**	**$222,926,778**
Percent Change	5.35%	11.61%	0.00%	1.52%	72.32%	5.41%

Calculation of Request						
FY 2018-19						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2017-18 Appropriation Plus Special Bills	$6,752,893,112	$1,071,165,281	$873,835,000	$678,832,273	$5,240,893	$4,123,819,665
Bill Annualizations						
Annualization of Long Bill FY 2016-17 (HB 16-1405)	$0	$0	$0	$0	$0	$0
HB 16-1321 Annualization "Medicaid Buy-In Certain Medicaid Waivers"	$13,122	($36,325)	$0	$44,031	$0	$5,416
Total Annualizations	$13,122	($36,325)	$0	$44,031	$0	$5,416
FY 2018-19 Total Spending Authority	**$6,752,906,234**	**$1,071,128,956**	**$873,835,000**	**$678,876,304**	**$5,240,893**	**$4,123,825,081**
Total Projected FY 2018-19 Expenditures	$7,830,346,931	$1,264,111,385	$873,835,000	$962,480,570	$8,951,417	$4,720,968,559
FY 2018-19 Requested Change From Appropriation	**$1,077,440,697**	**$192,982,429**	**$0**	**$283,604,266**	**$3,710,524**	**$597,143,478**
Percent Change	15.96%	18.02%	0.00%	41.78%	70.80%	14.48%

Calculation of Fund Splits
FY 2016-17

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP[3]	Notes
Acute Care Services							
Base Acute	$2,132,351,795	$1,061,911,194	$0	$0	$1,070,440,601	50.20%	
Breast and Cervical Cancer Program	$3,403,741	$0	$1,186,884	$0	$2,216,857	65.13%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
Family Planning	$12,046,581	$1,204,658	$0	$0	$10,841,923	90.00%	
Indian Health Service	$4,291,193	$0	$0	$0	$4,291,193	100.00%	
Affordable Care Act Drug Rebate Offset	($17,092,043)	$0	$0	$0	($17,092,043)	100.00%	
Affordable Care Act Preventive Services	$54,301,189	$26,498,980	$0	$0	$27,802,209	51.20%	
Non-Emergency Medical Transportation	$0	$82,883	$0	$0	($82,883)	N/A	
SB 11-008: "Aligning Medicaid Eligibility for Children"	$93,867,448	$11,142,066	$0	$0	$82,725,382	88.13%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$18,621,450	$2,210,366	$0	$0	$16,411,084	88.13%	
MAGI Parents/Caretakers to 133% FPL	$246,755,252	$0	$6,213,707	$0	$240,541,545	97.48%	100% FFP January 1, 2014; 95% FFP January 1, 2017; CF: Hospital Provider Fee Fund; NEMT services receive administrative match
MAGI Adults	$1,300,462,803	$0	$34,176,072	$0	$1,266,286,731	97.37%	100% FFP January 1, 2014; 95% FFP January 1, 2017; CF: Hospital Provider Fee Fund; NEMT services receive administrative match
Continuous Eligibility for Children	$43,754,769	$0	$21,789,875	$0	$21,964,894	50.20%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$33,331,703	$0	$18,135,725	$0	$15,195,978	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$41,005,922	$0	$5,872,048	$0	$35,133,874	85.68%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$30,377,570	$0	$15,128,030	$0	$15,249,540	50.20%	CF: Hospital Provider Fee Fund
Adult Dental Benefit Financing	$64,632,877	$0	$32,092,650	$0	$32,540,227	Variable	CF: Adult Dental Fund
HB 16-1408 Primary Care Rate Increase Financing	$38,487,283	$0	$19,166,667	$0	$19,320,616	50.20%	CF: Primary Care Provider Sustainability Fund
HB 16-1408 State Plan Autism Treatment	$18,534,147	$2,778,534	$6,451,471	$0	$9,304,142	50.20%	CF: Colorado Autism Treatment Fund
Acute Care Services Sub-Total	$4,119,133,680	$1,105,828,681	$160,213,129	$0	$2,853,091,870		
Community Based Long-Term Care Services							
Base Community Based Long-Term Care	$827,207,224	$411,949,198	$0	$0	$415,258,026	50.20%	
Children with Autism Waiver Services	$447,565	$0	$222,887	$0	$224,678	50.20%	CF: Colorado Autism Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$1,503,657	$178,484	$0	$0	$1,325,173	88.13%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$0	$0	$0	$0	$0	88.13%	
MAGI Parents/Caretakers to 133% FPL	$163,864	$0	$18,155	$0	$145,709	88.92%	Waivers Services Standard Match; Hospice/PDN/LTHH 100% FFP January 1, 2014; 95% FFP January 1, 2017; CF: Hospital Provider Fee Fund
MAGI Adults	$6,952,557	$0	$834,579	$0	$6,117,978	88.00%	Waivers Services Standard Match; Hospice/PDN/LTHH 100% FFP January 1, 2014; 95% FFP January 1, 2017; CF: Hospital Provider Fee Fund
Continuous Eligibility for Children	$108,312	$0	$53,939	$0	$54,373	50.20%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$5,654,821	$0	$3,076,779	$0	$2,578,042	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$1,062,716	$0	$152,181	$0	$910,535	85.68%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$133,668	$0	$66,567	$0	$67,101	50.20%	CF: Hospital Provider Fee Fund
Community Based Long-Term Care Services Sub-Total	$843,234,384	$412,127,682	$4,425,087	$0	$426,681,615		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$643,079,163	$320,253,423	$0	$0	$322,825,740	50.20%	
Class II Nursing Facilities	$4,468,182	$2,225,155	$0	$0	$2,243,027	50.20%	
PACE	$147,293,793	$73,352,309	$0	$0	$73,941,484	50.20%	
Supplemental Medicare Insurance Benefit (SMIB)	$192,636,853	$104,023,901	$0	$0	$88,612,952	50.00%	Approximately 13% of Total is State-Only & 5% is 100% FFP.
Health Insurance Buy-In	$1,998,605	$995,305	$0	$0	$1,003,300	50.20%	
MAGI Parents/Caretakers to 133% FPL	$50,142	$0	$1,253	$0	$48,889	97.50%	100% FFP January 1, 2014; 95% FFP January 1, 2017; CF: Hospital Provider Fee Fund
MAGI Adults	$944,329	$0	$23,608	$0	$920,721	97.50%	100% FFP January 1, 2014; 95% FFP January 1, 2017; CF: Hospital Provider Fee Fund
Continuous Eligibility for Children	$0	$0	$0	$0	$0	50.20%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$167,943	$0	$91,377	$0	$76,566	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$1,554,243	$0	$222,568	$0	$1,331,675	85.68%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$27,220	$0	$13,556	$0	$13,664	50.20%	CF: Hospital Provider Fee Fund
Long-Term Care and Insurance Sub-Total	$992,220,473	$500,850,093	$352,362	$0	$491,018,018		

Calculation of Fund Splits
FY 2016-17

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP[3]	Notes
Service Management							
Base Service Management	$34,367,015	$17,183,507	$0	$0	$17,183,508	50.00%	
Accountable Care Collaborative	$93,760,020	$46,692,490	$0	$0	$47,067,530	50.20%	
Tobacco Quit Line	$1,285,726	$0	$642,863	$0	$642,863	50.00%	CF: Tobacco Education Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$8,379,219	$994,613	$0	$0	$7,384,606	88.13%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$170,837	$20,278	$0	$0	$150,559	88.13%	
MAGI Parents/Caretakers to 133% FPL	$10,980,884	$0	$274,522	$0	$10,706,362	97.50%	100% FFP January 1, 2014; 95% FFP January 1, 2017; CF: Hospital Provider Fee Fund
MAGI Adults	$43,897,925	$0	$1,097,448	$0	$42,800,477	97.50%	100% FFP January 1, 2014; 95% FFP January 1, 2017; CF: Hospital Provider Fee Fund
Continuous Eligibility for Children	$7,250,224	$0	$3,610,612	$0	$3,639,612	50.20%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$365,816	$0	$199,040	$0	$166,776	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$229,946	$0	$32,928	$0	$197,018	85.68%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$1,070,095	$0	$532,907	$0	$537,188	50.20%	CF: Hospital Provider Fee Fund
Service Management Sub-Total	$201,757,707	$64,890,888	$6,390,320	$0	$130,476,499		
FY 2016-17 Estimate of Total Expenditures for Medical Services to Clients	**$6,156,346,244**	**$2,083,697,344**	**$171,380,898**	**$0**	**$3,901,268,002**		
Financing							
Upper Payment Limit Financing	$3,420,352	($3,543,898)	$3,420,352	$0	$3,543,898	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($15,546,204)	$48,642,690	$0	($33,096,486)	68.04%	CF: Department Recoveries
Denver Health Outstationing	$13,978,962	$2,399,972	$3,560,950	$0	$8,018,040	57.36%	CF: Certified Public Expenditures
Hospital Provider Fee Supplemental Payments	$656,945,497	$0	$327,158,857	$0	$329,786,640	50.20%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$103,022,596	$0	$51,305,253	$0	$51,717,343	50.20%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$19,369,964	($1,019,472)	$10,194,718	$0	$10,194,718	Variable	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($67,372,681)	$67,372,681	$0	$0	N/A	CF: Health Care Expansion Fund
Intergovernmental Transfer for Difficult to Discharge Clients	$1,000,000	$0	$500,000	$0	$500,000	50.00%	CF: Intergovernmental Transfer
Repayment of Federal Funds for Physical and Occupational Therapy Unit Limit Policy	$0	$2,833,453	$0	$0	($2,833,453)	N/A	
Denver Health Ambulance Payments	$5,875,882	($312,840)	$3,060,323	$0	$3,128,399	50.55%	CF: Certified Public Expenditures, see Narrative
Technical Adjustment of Systems Issue for Children	$0	$688,206	($688,206)	$0	$0	N/A	CF: Hospital Provider Fee Cash Fund
Historical Adjustment for Non-Newly Eligible Definition	$0	$0	$3,386,387	$0	($3,386,387)	N/A	CF: Hospital Provider Fee Cash Fund
Cash Funds Financing[1]	$0	($27,166,119)	$18,063,410	$9,102,709	$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$803,613,253	($109,039,583)	$535,977,415	$9,102,709	$367,572,712		
Total Projected FY 2016-17 Expenditures[2]	**$6,959,959,497**	**$1,974,657,761**	**$707,358,313**	**$9,102,709**	**$4,268,840,714**		

Definitions: FMAP: Federal Medical Assistance Percentage MAGI: Modified Adjusted Gross Income PACE: Program of All-Inclusive Care for the Elderly ACA: Patient Protection and Affordable Care Act of 2010 FPL: Federal Poverty Level FFP: Federal Financial Participation

(1) This line adjusts for transfers from cash funds to the General Fund that are not broken out elsewhere. See Narrative for more information.

(2) Of the General Fund total, $873,835,000 is General Fund Exempt.

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

Calculation of Fund Splits
FY 2017-18

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP [3]	Notes
Acute Care Services							
Base Acute	$2,185,442,039	$1,092,721,019	$0	$0	$1,092,721,020	50.00%	
Breast and Cervical Cancer Program	$2,107,355	$0	$737,574	$0	$1,369,781	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
Family Planning	$12,748,897	$1,274,890	$0	$0	$11,474,007	90.00%	
Indian Health Service	$4,295,913	$0	$0	$0	$4,295,913	100.00%	
Affordable Care Act Drug Rebate Offset	($18,932,214)	$0	$0	$0	($18,932,214)	100.00%	
Affordable Care Act Preventive Services	$56,343,173	$27,608,155	$0	$0	$28,735,018	51.00%	
Non-Emergency Medical Transportation	$0	$59,384	$0	$0	($59,384)	N/A	
SB 11-008: "Aligning Medicaid Eligibility for Children"	$100,777,652	$12,093,318	$0	$0	$88,684,334	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$19,296,759	$2,315,611	$0	$0	$16,981,148	88.00%	
MAGI Parents/Caretakers to 133% FPL	$270,227,894	$0	$14,908,737	$0	$255,319,157	94.48%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Hospital Provider Fee Fund; NEMT services receive administrative match
MAGI Adults	$1,393,921,466	$0	$78,334,367	$0	$1,315,587,099	94.38%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Hospital Provider Fee Fund; NEMT services receive administrative match
Continuous Eligibility for Children	$45,497,101	$0	$22,748,550	$0	$22,748,551	50.00%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$38,813,714	$0	$21,354,448	$0	$17,459,266	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$43,593,138	$0	$7,245,180	$0	$36,347,958	83.38%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$30,832,803	$0	$15,416,401	$0	$15,416,402	50.00%	CF: Hospital Provider Fee Fund
Adult Dental Benefit Financing	$68,866,254	$0	$34,333,263	$0	$34,532,991	Variable	CF: Adult Dental Fund
HB 16-1408 Primary Care Rate Increase Financing	$1,666,666	$0	$833,333	$0	$833,333	50.00%	CF: Primary Care Provider Sustainability Fund
HB 16-1408 State Plan Autism Treatment	$18,534,147	$7,807,328	$1,459,745	$0	$9,267,074	50.00%	CF: Colorado Autism Treatment Fund
Acute Care Services Sub-Total	$4,274,032,757	$1,143,879,705	$197,371,598	$0	$2,932,781,454		
Community Based Long-Term Care Services							
Base Community Based Long-Term Care	$886,947,727	$443,473,863	$0	$0	$443,473,864	50.00%	
Children with Autism Waiver Services	$444,510	$0	$222,255	$0	$222,255	50.00%	CF: Colorado Autism Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$1,605,330	$192,640	$0	$0	$1,412,690	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$0	$0	$0	$0	$0	88.00%	
MAGI Parents/Caretakers to 133% FPL	$178,332	$0	$26,606	$0	$151,726	85.08%	Waivers receive standard match; 95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Hospital Provider Fee Fund
MAGI Adults	$7,393,551	$0	$1,154,133	$0	$6,239,418	84.39%	Waivers receive standard match; 95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Hospital Provider Fee Fund
Continuous Eligibility for Children	$116,522	$0	$58,261	$0	$58,261	50.00%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$6,193,097	$0	$3,407,305	$0	$2,785,792	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$1,169,383	$0	$194,351	$0	$975,032	83.38%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$143,779	$0	$71,889	$0	$71,890	50.00%	CF: Hospital Provider Fee Fund
Community Based Long-Term Care Sub-Total	$904,192,231	$443,666,503	$5,134,800	$0	$455,390,928		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$666,273,424	$333,136,712	$0	$0	$333,136,712	50.00%	
Class II Nursing Facilities	$4,680,867	$2,340,433	$0	$0	$2,340,434	50.00%	
PACE	$164,526,552	$82,263,276	$0	$0	$82,263,276	50.00%	
Supplemental Medicare Insurance Benefit (SMIB)	$201,034,320	$108,558,533	$0	$0	$92,475,787	50.00%*	Approximately 13% of Total is State-Only & 5% is 100% FFP.
Health Insurance Buy-In	$2,529,235	$1,264,617	$0	$0	$1,264,618	50.00%	
MAGI Parents/Caretakers to 133% FPL	$60,110	$0	$3,306	$0	$56,804	94.50%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Hospital Provider Fee Fund
MAGI Adults	$899,124	$0	$49,452	$0	$849,672	94.50%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Hospital Provider Fee Fund
Continuous Eligibility for Children	$0	$0	$0	$0	$0	50.00%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$174,004	$0	$95,733	$0	$78,271	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$1,696,971	$0	$282,037	$0	$1,414,934	83.38%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$28,987	$0	$14,493	$0	$14,494	50.00%	CF: Hospital Provider Fee Fund
Long-Term Care and Insurance Sub-Total	$1,041,903,594	$527,563,571	$445,021	$0	$513,895,002		

Exhibit A - Summary of Request

Calculation of Fund Splits
FY 2017-18

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP [3]	Notes
Service Management							
Base Service Management	$34,348,992	$17,174,496	$0	$0	$17,174,496	50.00%	
Accountable Care Collaborative	$100,638,705	$50,319,352	$0	$0	$50,319,353	50.00%	
Tobacco Quit Line	$1,352,408	$0	$676,204	$0	$676,204	50.00%	CF: Tobacco Education Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$9,082,618	$1,089,914	$0	$0	$7,992,704	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$185,981	$22,318	$0	$0	$163,663	88.00%	
MAGI Parents/Caretakers to 133% FPL	$12,379,502	$0	$680,873	$0	$11,698,629	94.50%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Hospital Provider Fee Fund
MAGI Adults	$46,617,500	$0	$2,563,962	$0	$44,053,538	94.50%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Hospital Provider Fee Fund
Continuous Eligibility for Children	$6,893,825	$0	$3,446,912	$0	$3,446,913	50.00%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$417,249	$0	$229,561	$0	$187,688	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$247,997	$0	$41,217	$0	$206,780	83.38%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$1,173,774	$0	$586,887	$0	$586,887	50.00%	CF: Hospital Provider Fee Fund
Service Management Sub-Total	$213,338,551	$68,606,080	$8,225,616	$0	$136,506,855		
FY 2017-18 Estimate of Total Expenditures for Medical Services to Clients	**$6,433,467,133**	**$2,183,715,859**	**$211,177,035**	**$0**	**$4,038,574,239**		
Financing							
Upper Payment Limit Financing	$3,528,549	($3,597,123)	$3,528,549	$0	$3,597,123	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($15,735,925)	$51,190,388	$0	($35,454,463)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$4,779,554	$1,672,844	$0	$0	$3,106,710	65.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$540,440,830	$0	$270,220,415	$0	$270,220,415	50.00%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$105,824,204	$0	$52,912,102	$0	$52,912,102	50.00%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$19,369,964	($1,019,472)	$10,194,718	$0	$10,194,718	Variable	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($68,301,086)	$68,301,086	$0	$0	N/A	CF: Health Care Expansion Fund
Intergovernmental Transfer for Difficult to Discharge Clients	$1,000,000	$0	$500,000	$0	$500,000	50.00%	CF: Intergovernmental Transfer
Denver Health Ambulance Payments	$5,879,162	($309,560)	$3,093,123	$0	$3,095,599	50.02%	CF: Certification of Public Expenditure
Cash Funds Financing[1]	$0	($27,094,454)	$18,063,410	$9,031,044	$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$680,822,263	($114,384,776)	$478,003,791	$9,031,044	$308,172,204		
Total Projected FY 2017-18 Expenditures[2]	**$7,114,289,396**	**$2,069,331,083**	**$689,180,826**	**$9,031,044**	**$4,346,746,443**		

Definitions: FMAP: Federal Medical Assistance Percentage MAGI: Modified Adjusted Gross Income PACE: Program of All-Inclusive Care for the Elderly ACA: Patient Protection and Affordable Care Act of 2010 FPL: Federal Poverty Level FFP: Federal Financial Participation

(1) This line adjusts for transfers from cash funds to the General Fund that are not broken out elsewhere. See Narrative for more information.

(2) Of the General Fund total, $873,835,000 is General Fund Exempt.

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

Calculation of Fund Splits
FY 2018-19

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP [3]	Notes
Acute Care Services							
Base Acute	$2,219,363,942	$1,109,681,971	$0	$0	$1,109,681,971	50.00%	
Breast and Cervical Cancer Program	$1,209,420	$0	$423,297	$0	$786,123	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
Family Planning	$13,492,158	$1,349,216	$0	$0	$12,142,942	90.00%	
Indian Health Service	$4,300,639	$0	$0	$0	$4,300,639	100.00%	
Affordable Care Act Drug Rebate Offset	($20,970,503)	$0	$0	$0	($20,970,503)	100.00%	
Affordable Care Act Preventive Services	$57,948,269	$28,394,652	$0	$0	$29,553,617	51.00%	
Non-Emergency Medical Transportation	$0	$61,777	$0	$0	($61,777)	N/A	
SB 11-008: "Aligning Medicaid Eligibility for Children"	$104,534,287	$12,544,114	$0	$0	$91,990,173	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$20,139,830	$2,416,780	$0	$0	$17,723,050	88.00%	
MAGI Parents/Caretakers to 133% FPL	$288,181,670	$0	$18,780,103	$0	$269,401,567	93.48%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Hospital Provider Fee Fund; NEMT services receive administrative match
MAGI Adults	$1,449,873,671	$0	$95,932,189	$0	$1,353,941,482	93.38%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Hospital Provider Fee Fund; NEMT services receive administrative match
Continuous Eligibility for Children	$46,586,013	$0	$23,293,006	$0	$23,293,007	50.00%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$44,254,122	$0	$24,375,101	$0	$19,879,021	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$45,630,274	$0	$7,925,979	$0	$37,704,295	82.63%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$31,013,836	$0	$15,506,918	$0	$15,506,918	50.00%	CF: Hospital Provider Fee Fund
Adult Dental Benefit Financing	$71,698,979	$0	$35,745,343	$0	$35,953,636	Variable	CF: Adult Dental Fund
HB 16-1408 State Plan Autism Treatment	$18,534,147	$8,101,886	$1,165,187	$0	$9,267,074	50.00%	CF: Colorado Autism Treatment Fund
Acute Care Services Sub-Total	$4,395,790,754	$1,162,550,396	$223,147,123	$0	$3,010,093,235		
Community Based Long-Term Care Services							
Base Community Based Long-Term Care	$947,740,687	$473,870,343	$0	$0	$473,870,344	50.00%	
Children with Autism Waiver Services	$441,626	$0	$220,813	$0	$220,813	50.00%	CF: Colorado Autism Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$1,701,734	$204,208	$0	$0	$1,497,526	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$0	$0	$0	$0	$0	88.00%	
MAGI Parents/Caretakers to 133% FPL	$191,076	$0	$30,763	$0	$160,313	83.90%	Waivers receive standard match; 94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Hospital Provider Fee Fund
MAGI Adults	$7,750,803	$0	$1,330,813	$0	$6,419,990	82.83%	Waivers receive standard match; 94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Hospital Provider Fee Fund
Continuous Eligibility for Children	$122,977	$0	$61,488	$0	$61,489	50.00%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$6,695,802	$0	$3,688,037	$0	$3,007,765	Variable	CF: Hospital Provider Fee and Disabled Buy-in Premiums
Non-Newly Eligibles	$1,262,437	$0	$219,285	$0	$1,043,152	82.63%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$152,728	$0	$76,364	$0	$76,364	50.00%	CF: Hospital Provider Fee Fund
Community Based Long-Term Care Sub-Total	$966,059,870	$474,074,551	$5,627,563	$0	$486,357,756		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$688,131,904	$344,065,952	$0	$0	$344,065,952	50.00%	
Class II Nursing Facilities	$4,842,957	$2,421,478	$0	$0	$2,421,479	50.00%	
PACE	$186,487,546	$93,243,773	$0	$0	$93,243,773	50.00%	
Supplemental Medicare Insurance Benefit (SMIB)	$195,242,084	$105,430,725	$0	$0	$89,811,359	50.00%*	Approximately 13% of Total is State-Only & 5% is 100% FFP.
Health Insurance Buy-In	$3,203,259	$1,601,629	$0	$0	$1,601,630	50.00%	
MAGI Parents/Caretakers to 133% FPL	$72,599	$0	$4,719	$0	$67,880	93.50%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Hospital Provider Fee Fund
MAGI Adults	$866,499	$0	$56,322	$0	$810,177	93.50%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Hospital Provider Fee Fund
Continuous Eligibility for Children	$0	$0	$0	$0	$0	50.00%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$179,718	$0	$98,988	$0	$80,730	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$1,824,311	$0	$316,883	$0	$1,507,428	82.63%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$30,591	$0	$15,295	$0	$15,296	50.00%	CF: Hospital Provider Fee Fund
Long-Term Care and Insurance Sub-Total	$1,080,881,468	$546,763,557	$492,207	$0	$533,625,704		

Calculation of Fund Splits
FY 2018-19

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP [3]	Notes
Service Management							
Base Service Management	$35,609,663	$17,804,831	$0	$0	$17,804,832	50.00%	
Accountable Care Collaborative	$104,194,954	$52,097,477	$0	$0	$52,097,477	50.00%	
Tobacco Quit Line	$1,396,317	$0	$698,158	$0	$698,159	50.00%	CF: Tobacco Education Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$9,771,491	$1,172,579	$0	$0	$8,598,912	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$194,752	$23,370	$0	$0	$171,382	88.00%	
MAGI Parents/Caretakers to 133% FPL	$13,603,850	$0	$884,250	$0	$12,719,600	93.50%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Hospital Provider Fee Fund
MAGI Adults	$48,904,660	$0	$3,178,803	$0	$45,725,857	93.50%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Hospital Provider Fee Fund
Continuous Eligibility for Children	$7,464,840	$0	$3,732,420	$0	$3,732,420	50.00%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$486,086	$0	$267,735	$0	$218,351	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$263,330	$0	$45,740	$0	$217,590	82.63%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$1,237,625	$0	$618,812	$0	$618,813	50.00%	CF: Hospital Provider Fee Fund
Service Management Sub-Total	$223,127,568	$71,098,257	$9,425,918	$0	$142,603,393		
FY 2018-19 Estimate of Total Expenditures for Medical Services to Clients	**$6,665,859,660**	**$2,254,486,761**	**$238,692,811**	**$0**	**$4,172,680,088**		
Financing							
Upper Payment Limit Financing	$3,644,465	($3,646,370)	$3,644,465	$0	$3,646,370	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($16,993,623)	$54,154,312	$0	($37,160,689)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$4,779,554	$1,672,844	$0	$0	$3,106,710	65.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$1,021,112,002	$0	$510,556,001	$0	$510,556,001	50.00%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$108,702,000	$0	$54,351,000	$0	$54,351,000	50.00%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$19,369,964	($1,019,472)	$10,194,718	$0	$10,194,718	50.00%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($69,229,492)	$69,229,492	$0	$0	N/A	CF: Health Care Expansion Fund
Intergovernmental Transfer for Difficult to Discharge Clients	$1,000,000	$0	$500,000	$0	$500,000	50.00%	CF: Intergovernmental Transfer
Denver Health Ambulance Payments	$5,879,286	($309,436)	$3,094,361	$0	$3,094,361	50.00%	CF: Certification of Public Expenditure
Cash Funds Financing[1]	$0	($27,014,827)	$18,063,410	$8,951,417	$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$1,164,487,271	($116,540,376)	$723,787,759	$8,951,417	$548,288,471		
Total Projected FY 2018-19 Expenditures[2]	**$7,830,346,931**	**$2,137,946,385**	**$962,480,570**	**$8,951,417**	**$4,720,968,559**		

Definitions: FMAP: Federal Medical Assistance Percentage MAGI: Modified Adjusted Gross Income PACE: Program of All-Inclusive Care for the Elderly ACA: Patient Protection and Affordable Care Act of 2010 FPL: Federal Poverty Level FFP: Federal Financial Participation

(1) This line adjusts for transfers from cash funds to the General Fund that are not broken out elsewhere. See Narrative for more information.

(2) Of the General Fund total, $873,835,000 is General Fund Exempt.

(3) On January 1, 2019, the ACA expansion FMAP decreases from a 94% FMAP rate to 93% FMAP rate.

Exhibit B - Medicaid Caseload

Final Request

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

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	MAGI Eligible Children	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 1997-98 Actuals	32,664	4,496	46,003	-	27,179	-	-	-	103,912	-	10,453	4,295	-	5,032	4,560	238,594
FY 1998-99 Actuals	33,007	4,909	46,310	-	22,852	-	-	-	102,074	-	11,526	5,017	-	5,799	6,104	237,598
% Change from FY 1997-98	1.05%	9.19%	0.67%	-	-15.92%	-	-	-	-1.77%	-	10.26%	16.81%	-	15.24%	33.86%	-0.42%
FY 1999-00 Actuals	33,135	5,092	46,386	-	23,515	-	-	-	109,816	-	12,474	6,174	-	9,065	7,597	253,254
% Change from FY 1998-99	0.39%	3.73%	0.16%	-	2.90%	-	-	-	7.58%	-	8.22%	23.06%	-	56.32%	24.46%	6.59%
FY 2000-01 Actuals	33,649	5,157	46,046	-	27,081	-	-	-	123,221	-	13,076	6,561	-	12,451	8,157	275,399
% Change from FY 1999-00	1.55%	1.28%	-0.73%	-	15.16%	-	-	-	12.21%	-	4.83%	6.27%	-	37.35%	7.37%	8.74%
FY 2001-02 Actuals	33,916	5,184	46,349	-	33,347	-	-	-	143,909	-	13,121	7,131	-	4,028	8,428	295,413
% Change from FY 2000-01	0.79%	0.52%	0.66%	-	23.14%	-	-	-	16.79%	-	0.34%	8.69%	-	-67.65%	3.32%	7.27%
FY 2002-03 Actuals	34,704	5,431	46,647	-	40,798	-	-	47	169,311	-	13,967	7,823	-	4,084	8,988	331,800
% Change from FY 2001-02	2.32%	4.76%	0.64%	-	22.34%	-	-	-	17.65%	-	6.45%	9.70%	-	1.39%	6.64%	12.32%
FY 2003-04 Actuals	34,329	5,548	46,789	-	47,562	-	-	105	195,279	-	14,914	8,398	-	4,793	9,842	367,559
% Change from FY 2002-03	-1.08%	2.15%	0.30%	-	16.58%	-	-	123.40%	15.34%	-	6.78%	7.35%	-	17.36%	9.50%	10.78%
FY 2004-05 Actuals	35,780	6,082	47,929	-	57,140	-	-	87	222,472	-	15,795	5,984	-	5,150	9,605	406,024
% Change from FY 2003-04	4.23%	9.63%	2.44%	-	20.14%	-	-	-17.14%	13.93%	-	5.91%	-28.74%	-	7.45%	-2.41%	10.46%
FY 2005-06 Actuals	36,207	6,042	47,855	-	58,885	-	-	188	214,158	-	16,460	5,119	-	6,212	11,092	402,218
% Change from FY 2004-05	1.19%	-0.66%	-0.15%	-	3.05%	-	-	116.09%	-3.74%	-	4.21%	-14.46%	-	20.62%	15.48%	-0.94%
FY 2006-07 Actuals	35,888	6,059	48,799	-	55,850	-	-	228	205,390	-	16,724	5,182	-	5,201	12,908	392,229
% Change from FY 2005-06	-0.88%	0.28%	1.97%	-	-5.15%	-	-	21.28%	-4.09%	-	1.60%	1.23%	-	-16.27%	16.37%	-2.48%
FY 2007-08 Actuals	36,284	6,146	49,933	-	53,473	-	-	270	204,022	-	17,141	6,288	-	4,191	14,214	391,962
% Change from FY 2006-07	1.10%	1.44%	2.32%	-	-4.26%	-	-	18.42%	-0.67%	-	2.49%	21.34%	-	-19.42%	10.12%	-0.07%
FY 2008-09 Actuals	37,619	6,447	51,355	-	61,874	-	-	317	235,129	-	18,033	6,976	-	3,987	15,075	436,812
% Change from FY 2007-08	3.68%	4.90%	2.85%	-	15.71%	-	-	17.41%	15.25%	-	5.20%	10.94%	-	-4.87%	6.06%	11.44%
FY 2009-10 Actuals	38,487	7,049	53,264	-	74,839	3,238	-	425	275,672	-	18,381	7,830	-	3,693	15,919	498,797
% Change from FY 2008-09	2.31%	9.34%	3.72%	-	20.95%	-	-	34.07%	17.24%	-	1.93%	12.24%	-	-7.37%	5.60%	14.19%
FY 2010-11 Actuals	38,921	7,767	56,285	-	81,114	27,167	-	531	302,410	-	18,393	7,868	-	3,213	17,090	560,759
% Change from FY 2009-10	1.13%	10.19%	5.67%	-	8.38%	739.01%	-	24.94%	9.70%	-	0.07%	0.49%	-	-13.00%	7.36%	12.42%
FY 2011-12 Actuals	39,740	8,383	59,434	52	93,224	35,461	1,134	597	334,633	-	18,034	7,630	-	2,770	18,871	619,963
% Change from FY 2010-11	2.10%	7.93%	5.59%	-	14.93%	30.53%	-	12.43%	10.66%	-	-1.95%	-3.02%	-	-13.79%	10.42%	10.56%
FY 2012-13 Actuals	40,827	9,051	61,920	888	99,392	41,545	10,634	623	359,843	8,236	17,777	8,024	344	2,684	21,206	682,994
% Change from FY 2011-12	2.74%	7.97%	4.18%	1607.69%	6.62%	17.16%	837.74%	4.36%	7.53%	-	-1.43%	5.16%	-	-3.10%	12.37%	10.17%
FY 2013-14 Actuals	41,836	9,853	64,424	2,560	124,680	47,082	87,243	559	399,032	25,345	18,267	13,160	1,057	2,481	23,378	860,957
% Change from FY 2012-13	2.47%	8.86%	4.04%	188.29%	25.44%	13.33%	720.42%	-10.27%	10.89%	207.73%	2.76%	64.01%	207.27%	-7.56%	10.24%	26.06%
FY 2014-15 Actuals	41,817	10,466	66,548	3,627	161,682	71,989	241,392	400	445,723	50,113	20,036	14,897	1,749	2,722	28,045	1,161,206
% Change from FY 2013-14	-0.05%	6.22%	3.30%	41.68%	29.68%	52.90%	176.69%	-28.44%	11.70%	97.72%	9.68%	13.20%	65.47%	9.71%	19.96%	34.87%
FY 2015-16 Actuals	42,403	10,529	68,800	6,217	163,342	86,964	320,374	322	467,193	59,501	19,935	14,413	1,759	2,649	32,585	1,296,986
% Change from FY 2014-15	1.40%	0.60%	3.38%	71.41%	1.03%	20.80%	32.72%	-19.50%	4.82%	18.73%	-0.50%	-3.25%	0.57%	-2.68%	16.19%	11.69%
FY 2016-17 Projection	43,412	11,087	69,028	5,844	192,317	98,910	366,209	286	486,863	65,529	20,185	14,765	1,926	2,646	35,909	1,414,916
% Change from FY 2015-16	2.38%	5.30%	0.33%	-6.00%	17.74%	13.74%	14.31%	-11.18%	4.21%	10.13%	1.25%	2.44%	9.49%	-0.11%	10.20%	9.09%
FY 2017-18 Projection	44,137	11,535	70,603	6,901	199,180	108,821	391,871	179	499,692	71,890	20,290	14,766	1,988	2,648	40,135	1,484,636
% Change from FY 2016-17	1.67%	4.04%	2.28%	18.09%	3.57%	10.02%	7.01%	-37.41%	2.64%	9.71%	0.52%	0.01%	3.22%	0.08%	11.77%	4.93%
FY 2018-19 Projection	44,870	12,024	71,719	7,913	204,433	116,361	406,112	103	507,864	74,803	20,305	14,767	2,050	2,649	44,859	1,530,832
% Change from FY 2017-18	1.66%	4.24%	1.58%	14.66%	2.64%	6.93%	3.63%	-42.46%	1.64%	4.05%	0.07%	0.01%	3.12%	0.04%	11.77%	3.11%
FY 2016-17 Appropriation	42,831	11,058	70,731	5,858	185,519	90,649	345,496	208	494,148	64,623	19,806	14,459	1,700	2,746	36,113	1,385,945
Difference between the Total FY 2016-17 Projection and Appropriation	581	29	(1,703)	(14)	6,798	8,261	20,713	78	(7,285)	906	379	306	226	(100)	(204)	28,971

Exhibit B - Medicaid Caseload

Medicaid Caseload Adjustments																
Item	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**MAGI Eligible Children**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	49	-	-	-	-	-	-	-	49
Total FY 2014-15 Adjustments	-	-	-	-	-	-	-	49	-	-	-	-		-	-	49
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	47	-	-	-	-	-	-	-	47
Total FY 2015-16 Adjustments	-	-	-	-	-	-	-	47	-	-	-	-	-	-	-	47
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	47	-	-	-	-	-	-	-	47
Parents/Caretakers with Dependent Children - Federal Compliance	-	-	-	-	4,745	-	(4,745)	-	-	-	-	-	-	-	-	-
HB 09-1353 Removing 5 Year Bar on Legal Immigrants	-	-	-	-	-	-	-	-	2,320	280	-	-	-	-	-	2,600
CDPHE R-04: Cervical Cancer Age Expansion of BCCP	-	-	-	-	-	-	-	54	-	-	-	-	-	-	-	54
Annualized Income	-	-	-	-	2,048	1,189	2,692	-	-	-	-	-	-	-	-	5,929
Total FY 2016-17 Adjustments	-	-	-	-	6,793	1,189	(2,053)	101	2,320	280	-	-	-	-	-	8,630
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	47	-	-	-	-	-	-	-	47
Parents/Caretakers with Dependent Children - Federal Compliance	-	-	-	-	7,225	-	(7,225)	-	-	-	-	-	-	-	-	-
HB 09-1353 Removing 5 Year Bar on Legal Immigrants	-	-	-	-	-	-	-	-	2,471	292	-	-	-	-	-	2,763
CDPHE R-04: Cervical Cancer Age Expansion of BCCP	-	-	-	-	-	-	-	54	-	-	-	-	-	-	-	54
Annualized Income	-	-	-	-	2,127	1,709	4,467	-	-	-	-	-	-	-	-	8,303
HB 16-1321 Medicaid Buy-In for SLS, SCI, and BI Waivers	-	-	(33)	38	-	-	-	-	-	-	-	-	-	-	-	5
Total FY 2017-18 Adjustments	-	-	(33)	38	9,352	1,709	(2,758)	101	2,471	292	-	-	-	-	-	11,172
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	47	-	-	-	-	-	-	-	47
Parents/Caretakers with Dependent Children - Federal Compliance	-	-	-	-	7,973	-	(7,973)	-	-	-	-	-	-	-	-	-
HB 09-1353 Removing 5 Year Bar on Legal Immigrants	-	-	-	-	-	-	-	-	2,551	298	-	-	-	-	-	2,849
CDPHE R-04: Cervical Cancer Age Expansion of BCCP	-	-	-	-	-	-	-	54	-	-	-	-	-	-	-	54
Annualized Income	-	-	-	-	2,209	2,083	5,449	-	-	-	-	-	-	-	-	9,741
HB 16-1321 Medicaid Buy-In for SLS, SCI, and BI Waivers	-	-	(35)	41	-	-	-	-	-	-	-	-	-	-	-	6
Total FY 2018-19 Adjustments	-	-	(35)	41	10,182	2,083	(2,524)	101	2,551	298	-	-	-	-	-	12,697

Prior to Adjustments - Not Official Department Request

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

Prior to Adjustments

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	MAGI Eligible Children	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 1997-98 Actuals	32,664	4,496	46,003	-	27,179	-	-	-	103,912	-	10,453	4,295	-	5,032	4,560	238,594
FY 1998-99 Actuals	33,007	4,909	46,310	-	22,852	-	-	-	102,074	-	11,526	5,017	-	5,799	6,104	237,598
% Change from FY 1997-98	1.05%	9.19%	0.67%	-	-15.92%	-	-	-	-1.77%	-	10.26%	16.81%	-	15.24%	33.86%	-0.42%
FY 1999-00 Actuals	33,135	5,092	46,386	-	23,515	-	-	-	109,816	-	12,474	6,174	-	9,065	7,597	253,254
% Change from FY 1998-99	0.39%	3.73%	0.16%	-	2.90%	-	-	-	7.58%	-	8.22%	23.06%	-	56.32%	24.46%	6.59%
FY 2000-01 Actuals	33,649	5,157	46,046	-	27,081	-	-	-	123,221	-	13,076	6,561	-	12,451	8,157	275,399
% Change from FY 1999-00	1.55%	1.28%	-0.73%	-	15.16%	-	-	-	12.21%	-	4.83%	6.27%	-	37.35%	7.37%	8.74%
FY 2001-02 Actuals	33,916	5,184	46,349	-	33,347	-	-	-	143,909	-	13,121	7,131	-	4,028	8,428	295,413
% Change from FY 2000-01	0.79%	0.52%	0.66%	-	23.14%	-	-	-	16.79%	-	0.34%	8.69%	-	-67.65%	3.32%	7.27%
FY 2002-03 Actuals	34,704	5,431	46,647	-	40,798	-	-	47	169,311	-	13,967	7,823	-	4,084	8,988	331,800
% Change from FY 2001-02	2.32%	4.76%	0.64%	-	22.34%	-	-	-	17.65%	-	6.45%	9.70%	-	1.39%	6.64%	12.32%
FY 2003-04 Actuals	34,329	5,548	46,789	-	47,562	-	-	105	195,279	-	14,914	8,398	-	4,793	9,842	367,559
% Change from FY 2002-03	-1.08%	2.15%	0.30%	-	16.58%	-	-	123.40%	15.34%	-	6.78%	7.35%	-	17.36%	9.50%	10.78%
FY 2004-05 Actuals	35,780	6,082	47,929	-	57,140	-	-	87	222,472	-	15,795	5,984	-	5,150	9,605	406,024
% Change from FY 2003-04	4.23%	9.63%	2.44%	-	20.14%	-	-	-17.14%	13.93%	-	5.91%	-28.74%	-	7.45%	-2.41%	10.46%
FY 2005-06 Actuals	36,207	6,042	47,855	-	58,885	-	-	188	214,158	-	16,460	5,119	-	6,212	11,092	402,218
% Change from FY 2004-05	1.19%	-0.66%	-0.15%	-	3.05%	-	-	116.09%	-3.74%	-	4.21%	-14.46%	-	20.62%	15.48%	-0.94%
FY 2006-07 Actuals	35,888	6,059	48,799	-	55,850	-	-	228	205,390	-	16,724	5,182	-	5,201	12,908	392,229
% Change from FY 2005-06	-0.88%	0.28%	1.97%	-	-5.15%	-	-	21.28%	-4.09%	-	1.60%	1.23%	-	-16.27%	16.37%	-2.48%
FY 2007-08 Actuals	36,284	6,146	49,933	-	53,473	-	-	270	204,022	-	17,141	6,288	-	4,191	14,214	391,962
% Change from FY 2006-07	1.10%	1.44%	2.32%	-	-4.26%	-	-	18.42%	-0.67%	-	2.49%	21.34%	-	-19.42%	10.12%	-0.07%
FY 2008-09 Actuals	37,619	6,447	51,355	-	61,874	-	-	317	235,129	-	18,033	6,976	-	3,987	15,075	436,812
% Change from FY 2007-08	3.68%	4.90%	2.85%	-	15.71%	-	-	17.41%	15.25%	-	5.20%	10.94%	-	-4.87%	6.06%	11.44%
FY 2009-10 Actuals	38,487	7,049	53,264	-	74,839	3,238	-	425	275,672	-	18,381	7,830	-	3,693	15,919	498,797
% Change from FY 2008-09	2.31%	9.34%	3.72%	-	20.95%	-	-	34.07%	17.24%	-	1.93%	12.24%	-	-7.37%	5.60%	14.19%
FY 2010-11 Actuals	38,921	7,767	56,285	-	81,114	27,167	-	531	302,410	-	18,393	7,868	-	3,213	17,090	560,759
% Change from FY 2009-10	1.13%	10.19%	5.67%	-	8.38%	739.01%	-	24.94%	9.70%	-	0.07%	0.49%	-	-13.00%	7.36%	12.42%
FY 2011-12 Actuals	39,740	8,383	59,434	52	93,224	35,461	1,134	597	334,633	-	18,034	7,630	-	2,770	18,871	619,963
% Change from FY 2010-11	2.10%	7.93%	5.59%	-	14.93%	30.53%	-	12.43%	10.66%	-	-1.95%	-3.02%	-	-13.79%	10.42%	10.56%
FY 2012-13 Actuals	40,827	9,051	61,920	888	99,392	41,545	10,634	623	359,843	8,236	17,777	8,024	344	2,684	21,206	682,994
% Change from FY 2011-12	2.74%	7.97%	4.18%	1607.69%	6.62%	17.16%	837.74%	4.36%	7.53%	-	-1.43%	5.16%	-	-3.10%	12.37%	10.17%
FY 2013-14 Actuals	41,836	9,853	64,424	2,560	124,680	47,082	87,243	559	399,032	25,345	18,267	13,160	1,057	2,481	23,378	860,957
% Change from FY 2012-13	2.47%	8.86%	4.04%	188.29%	25.44%	13.33%	720.42%	-10.27%	10.89%	207.73%	2.76%	64.01%	207.27%	-7.56%	10.24%	26.06%
FY 2014-15 Actuals	41,817	10,466	66,548	3,627	161,682	71,989	241,392	351	445,723	50,113	20,036	14,897	1,749	2,722	28,045	1,161,157
% Change from FY 2013-14	-0.05%	6.22%	3.30%	41.68%	29.68%	52.90%	176.69%	-37.21%	11.70%	97.72%	9.68%	13.20%	65.47%	9.71%	19.96%	34.87%
FY 2015-16 Actuals	42,403	10,529	68,800	6,217	163,342	86,964	320,374	275	467,193	59,501	19,935	14,413	1,759	2,649	32,585	1,296,939
% Change from FY 2014-15	1.40%	0.60%	3.38%	71.41%	1.03%	20.80%	32.72%	-21.65%	4.82%	18.73%	-0.50%	-3.25%	0.57%	-2.68%	16.19%	11.69%
FY 2016-17 Projection	43,412	11,087	69,028	5,844	185,524	97,721	368,262	185	484,543	65,249	20,185	14,765	1,926	2,646	35,909	1,406,286
% Change from FY 2015-16	2.38%	5.30%	0.33%	-6.00%	13.58%	12.37%	14.95%	-32.73%	3.71%	9.66%	1.25%	2.44%	9.49%	-0.11%	10.20%	8.43%
FY 2017-18 Projection	44,137	11,535	70,636	6,863	189,828	107,112	394,629	78	497,221	71,598	20,290	14,766	1,988	2,648	40,135	1,473,464
% Change from FY 2016-17	1.67%	4.04%	2.33%	17.44%	2.32%	9.61%	7.16%	-57.84%	2.62%	9.73%	0.52%	0.01%	3.22%	0.08%	11.77%	4.78%
FY 2018-19 Projection	44,870	12,024	71,754	7,872	194,251	114,278	408,636	2	505,313	74,505	20,305	14,767	2,050	2,649	44,859	1,518,135
% Change from FY 2017-18	1.66%	4.24%	1.58%	14.70%	2.33%	6.69%	3.55%	-97.44%	1.63%	4.06%	0.07%	0.01%	3.12%	0.04%	11.77%	3.03%
FY 2016-17 Appropriation	42,831	11,058	70,731	5,858	185,519	90,649	345,496	208	494,148	64,623	19,806	14,459	1,700	2,746	36,113	1,385,945
Difference between the Total FY 2016-17 Projection and Appropriation	581	29	(1,703)	(14)	6,798	8,261	20,713	78	(7,285)	906	379	306	226	(100)	(204)	28,971

Exhibit B - Medicaid Caseload Forecast

MEDICAID CASELOAD FY 2006-07 without RETROACTIVITY																	
FY 2006-07	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2006	36,264	5,927	48,080	-	58,380	-	-	202	215,937	-	16,499	5,074	-	6,703	12,145	405,211	3,511	0.87%
August 2006	36,356	5,989	48,443	-	58,084	-	-	211	216,226	-	16,574	4,852	-	6,364	12,316	405,415	204	0.05%
September 2006	36,113	6,032	48,576	-	57,484	-	-	220	214,255	-	16,524	4,761	-	6,011	12,443	402,419	(2,996)	-0.74%
October 2006	36,088	6,067	48,747	-	58,063	-	-	226	209,565	-	16,576	4,950	-	5,761	12,536	398,579	(3,840)	-0.95%
November 2006	35,939	6,113	48,736	-	56,313	-	-	232	205,572	-	16,554	5,002	-	5,226	12,693	392,380	(6,199)	-1.56%
December 2006	36,195	6,141	48,498	-	55,325	-	-	236	202,812	-	16,595	5,070	-	4,864	12,879	388,615	(3,765)	-0.96%
January 2007	35,947	6,102	48,829	-	55,748	-	-	231	202,963	-	16,683	5,181	-	4,798	12,905	389,387	772	0.20%
February 2007	35,929	6,116	48,948	-	55,347	-	-	228	202,656	-	16,761	5,353	-	4,690	13,060	389,088	(299)	-0.08%
March 2007	35,664	6,064	49,044	-	54,842	-	-	228	201,549	-	16,849	5,422	-	4,514	13,213	387,389	(1,699)	-0.44%
April 2007	35,526	6,083	48,903	-	54,747	-	-	241	200,833	-	16,962	5,526	-	4,547	13,547	386,915	(474)	-0.12%
May 2007	35,186	6,028	49,337	-	53,287	-	-	236	196,757	-	17,007	5,437	-	4,501	13,493	381,269	(5,646)	-1.46%
June 2007	35,448	6,048	49,449	-	52,574	-	-	246	195,549	-	17,100	5,561	-	4,437	13,669	380,081	(1,188)	-0.31%
Year-to-Date Average	**35,888**	**6,059**	**48,799**	**-**	**55,850**	**-**	**-**	**228**	**205,390**	**-**	**16,724**	**5,182**	**-**	**5,201**	**12,908**	**392,229**	**(1,802)**	**-0.46%**
MEDICAID CASELOAD FY 2007-08 without RETROACTIVITY																	
FY 2007-08	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2007	35,532	6,073	49,590	-	52,726	-	-	255	197,420	-	17,003	5,551	-	4,475	13,821	382,446	2,365	0.62%
August 2007	35,624	6,091	49,768	-	52,550	-	-	260	198,001	-	16,915	5,691	-	4,330	13,988	383,218	772	0.20%
September 2007	35,916	6,124	49,743	-	51,899	-	-	267	197,134	-	16,877	5,448	-	4,148	14,064	381,620	(1,598)	-0.42%
October 2007	36,104	6,141	49,853	-	53,700	-	-	273	201,710	-	16,968	5,479	-	4,136	14,105	388,469	6,849	1.79%
November 2007	36,059	6,127	49,889	-	53,464	-	-	261	201,378	-	16,995	5,759	-	4,069	14,144	388,145	(324)	-0.08%
December 2007	36,126	6,150	49,741	-	52,448	-	-	268	200,121	-	17,042	5,896	-	4,032	14,028	385,852	(2,293)	-0.59%
January 2008	36,329	6,158	49,785	-	52,759	-	-	268	201,816	-	17,050	6,233	-	4,007	14,066	388,471	2,619	0.68%
February 2008	36,418	6,128	49,891	-	53,099	-	-	272	203,657	-	17,117	6,827	-	4,026	14,212	391,647	3,176	0.82%
March 2008	36,702	6,145	49,989	-	53,672	-	-	282	206,695	-	17,208	7,035	-	4,130	14,333	396,191	4,544	1.16%
April 2008	36,771	6,188	50,237	-	54,432	-	-	280	210,620	-	17,358	7,142	-	4,178	14,479	401,685	5,494	1.39%
May 2008	36,897	6,203	50,358	-	55,124	-	-	280	213,554	-	17,537	7,191	-	4,371	14,628	406,143	4,458	1.11%
June 2008	36,932	6,227	50,351	-	55,797	-	-	270	216,154	-	17,620	7,200	-	4,389	14,700	409,640	3,497	0.86%
Year-to-Date Average	**36,284**	**6,146**	**49,933**	**-**	**53,473**	**-**	**-**	**270**	**204,022**	**-**	**17,141**	**6,288**	**-**	**4,191**	**14,214**	**391,962**	**2,463**	**0.63%**
MEDICAID CASELOAD FY 2008-09 without RETROACTIVITY																	
FY 2008-09	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2008	36,961	6,249	50,565	-	56,554	-	-	277	218,619	-	17,588	7,286	-	4,258	14,768	413,125	3,485	0.85%
August 2008	37,127	6,317	50,671	-	57,289	-	-	283	221,736	-	17,761	7,270	-	4,136	14,821	417,411	4,286	1.04%
September 2008	37,273	6,369	50,864	-	57,893	-	-	275	223,167	-	17,736	7,027	-	4,052	14,898	419,554	2,143	0.51%
October 2008	37,441	6,386	51,201	-	58,425	-	-	282	225,486	-	17,864	6,932	-	4,005	14,933	422,955	3,401	0.81%
November 2008	37,591	6,399	51,406	-	59,021	-	-	290	228,186	-	17,977	6,773	-	3,889	14,980	426,512	3,557	0.84%
December 2008	37,530	6,361	51,298	-	60,184	-	-	304	230,447	-	18,033	6,689	-	3,884	15,053	429,783	3,271	0.77%
January 2009	37,814	6,367	51,452	-	61,641	-	-	314	234,744	-	18,022	6,847	-	3,954	15,194	436,349	6,566	1.53%
February 2009	37,769	6,438	51,494	-	62,753	-	-	331	237,345	-	18,144	6,910	-	3,885	15,205	440,274	3,925	0.90%
March 2009	37,942	6,539	51,640	-	64,720	-	-	339	242,805	-	18,265	6,959	-	3,988	15,293	448,490	8,216	1.87%
April 2009	37,947	6,597	51,695	-	67,086	-	-	355	249,444	-	18,328	6,995	-	3,984	15,268	457,699	9,209	2.05%
May 2009	37,989	6,654	51,862	-	67,753	-	-	373	252,943	-	18,327	6,973	-	3,919	15,240	462,033	4,334	0.95%
June 2009	38,044	6,691	52,107	-	69,167	-	-	383	256,630	-	18,348	7,045	-	3,892	15,249	467,556	5,523	1.20%
Year-to-Date Average	**37,619**	**6,447**	**51,355**	**-**	**61,874**	**-**	**-**	**317**	**235,129**	**-**	**18,033**	**6,976**	**-**	**3,987**	**15,075**	**436,812**	**4,826**	**1.11%**

Exhibit B - Medicaid Caseload Forecast

MEDICAID CASELOAD FY 2009-10 without RETROACTIVITY																		
FY 2009-10	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2009	38,058	6,774	52,315	-	70,356	-	-	393	259,609	-	18,285	7,745	-	3,930	15,434	472,899	5,343	1.14%
August 2009	38,306	6,863	52,573	-	71,467	-	-	395	263,415	-	18,325	7,849	-	3,835	15,522	478,550	5,651	1.19%
September 2009	38,346	6,945	52,710	-	72,192	-	-	402	266,381	-	18,200	7,775	-	3,724	15,513	482,188	3,638	0.76%
October 2009	38,480	6,985	52,847	-	73,474	-	-	406	270,514	-	18,169	7,713	-	3,650	15,638	487,876	5,688	1.18%
November 2009	38,387	6,986	52,982	-	73,957	-	-	418	272,453	-	17,992	7,674	-	3,644	15,743	490,236	2,360	0.48%
December 2009	38,410	7,025	53,000	-	75,120	-	-	411	275,867	-	18,371	7,627	-	3,632	15,846	495,309	5,073	1.03%
January 2010	38,452	7,047	53,255	-	76,403	-	-	416	279,000	-	18,400	7,796	-	3,610	15,954	500,333	5,024	1.01%
February 2010	38,432	7,049	53,298	-	77,214	-	-	431	279,898	-	18,467	7,779	-	3,550	16,076	502,194	1,861	0.37%
March 2010	38,597	7,152	53,629	-	79,286	-	-	449	283,625	-	18,486	7,996	-	3,768	16,212	509,200	7,006	1.40%
April 2010	38,727	7,212	53,904	-	80,192	-	-	452	285,746	-	18,552	8,054	-	3,831	16,308	512,978	3,778	0.74%
May 2010	38,754	7,228	54,164	-	75,804	18,253	-	455	285,779	-	18,651	8,039	-	3,615	16,285	527,027	14,049	2.74%
June 2010	38,900	7,326	54,493	-	72,608	20,607	-	466	285,778	-	18,678	7,903	-	3,522	16,495	526,776	(251)	-0.05%
Year-to-Date Average	**38,487**	**7,049**	**53,264**	**-**	**74,839**	**3,238**	**-**	**425**	**275,672**	**-**	**18,381**	**7,830**	**-**	**3,693**	**15,919**	**498,797**	**4,935**	**1.00%**
MEDICAID CASELOAD FY 2010-11 without RETROACTIVITY																		
FY 2010-11	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2010	39,382	7,395	54,740	-	73,769	21,446	-	471	287,674	-	18,628	7,909	-	3,492	16,539	531,445	4,669	0.89%
August 2010	38,648	7,492	55,032	-	75,863	24,193	-	493	290,871	-	18,455	8,014	-	3,378	16,634	539,073	7,628	1.44%
September 2010	38,774	7,562	55,223	-	76,255	25,071	-	503	291,592	-	18,451	7,971	-	3,231	16,652	541,285	2,212	0.41%
October 2010	38,901	7,602	55,508	-	77,291	26,016	-	505	294,155	-	18,464	7,985	-	3,080	16,794	546,301	5,016	0.93%
November 2010	39,009	7,682	55,804	-	78,278	26,924	-	511	296,482	-	18,597	7,891	-	3,049	16,941	551,168	4,867	0.89%
December 2010	38,769	7,721	55,937	-	79,773	27,596	-	526	299,499	-	18,510	7,764	-	3,023	17,002	556,120	4,952	0.90%
January 2011	38,813	7,781	56,417	-	82,824	27,188	-	532	304,042	-	18,386	7,806	-	3,116	17,210	564,115	7,995	1.44%
February 2011	38,823	7,870	56,671	-	83,547	28,323	-	535	307,032	-	18,200	7,677	-	3,161	17,249	569,088	4,973	0.88%
March 2011	38,939	7,966	57,103	-	85,574	28,968	-	556	312,300	-	18,244	7,881	-	3,271	17,390	578,192	9,104	1.60%
April 2011	38,861	7,987	57,385	-	85,763	29,451	-	569	312,603	-	18,280	7,864	-	3,274	17,399	579,436	1,244	0.22%
May 2011	38,981	8,051	57,608	-	86,596	30,102	-	587	315,116	-	18,279	7,830	-	3,255	17,546	583,951	4,515	0.78%
June 2011	39,154	8,089	57,986	-	87,827	30,724	-	589	317,551	-	18,221	7,828	-	3,229	17,727	588,925	4,974	0.85%
Year-to-Date Average	**38,921**	**7,767**	**56,285**	**-**	**81,114**	**27,167**	**-**	**531**	**302,410**	**-**	**18,393**	**7,868**	**-**	**3,213**	**17,090**	**560,759**	**5,179**	**0.94%**
MEDICAID CASELOAD FY 2011-12 without RETROACTIVITY																		
FY 2011-12	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2011	39,341	8,133	58,294	-	87,556	31,920	-	587	319,065	-	18,125	7,810	-	3,089	17,923	591,843	2,918	0.50%
August 2011	39,537	8,222	58,712	-	88,518	32,462	-	586	322,779	-	18,084	7,786	-	2,973	18,046	597,705	5,862	0.99%
September 2011	39,600	8,280	58,937	-	90,001	33,152	-	590	325,673	-	18,119	7,628	-	2,774	18,156	602,910	5,205	0.87%
October 2011	39,697	8,328	59,159	-	91,662	33,838	-	592	328,632	-	18,096	7,558	-	2,657	18,314	608,533	5,623	0.93%
November 2011	39,789	8,343	59,298	-	92,441	34,915	-	602	332,183	-	18,077	7,371	-	2,543	18,584	614,146	5,613	0.92%
December 2011	39,843	8,355	59,384	-	94,778	34,886	-	606	336,053	-	18,172	7,333	-	2,591	18,798	620,799	6,653	1.08%
January 2012	39,742	8,373	59,709	-	93,523	35,481	-	603	336,096	-	17,968	7,445	-	2,617	18,985	620,542	(257)	-0.04%
February 2012	39,800	8,401	59,635	-	94,868	35,962	-	604	339,523	-	17,863	7,594	-	2,636	19,220	626,106	5,564	0.90%
March 2012	39,849	8,445	59,847	51	97,318	37,141	-	604	341,274	-	17,930	7,734	-	2,852	19,466	632,511	6,405	1.02%
April 2012	39,837	8,507	59,970	133	94,317	37,902	-	596	341,546	-	17,944	7,705	-	2,846	19,396	630,699	(1,812)	-0.29%
May 2012	39,924	8,600	60,167	202	95,581	38,955	5,860	597	344,523	-	18,012	7,744	-	2,844	19,640	642,649	11,950	1.89%
June 2012	39,923	8,605	60,091	240	98,120	38,921	7,753	601	348,253	-	18,022	7,846	-	2,818	19,929	651,122	8,473	1.32%
Year-to-Date Average	**39,740**	**8,383**	**59,434**	**52**	**93,224**	**35,461**	**1,134**	**597**	**334,633**	**-**	**18,034**	**7,630**	**-**	**2,770**	**18,871**	**619,963**	**5,183**	**0.84%**

Exhibit B - Medicaid Caseload Forecast

MEDICAID CASELOAD FY 2012-13 without RETROACTIVITY																		
FY 2012-13	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2012	40,117	8,689	60,389	338	93,088	38,961	9,652	607	348,510	-	17,959	7,824	-	2,764	20,117	649,015	(2,107)	-0.32%
August 2012	40,460	8,771	60,680	445	94,777	39,881	9,675	612	351,537	-	17,932	7,864	-	2,744	20,418	655,796	6,781	1.04%
September 2012	40,468	8,877	60,934	539	95,151	39,689	9,880	610	355,312	-	18,004	7,677	-	2,609	20,615	660,365	4,569	0.70%
October 2012	40,773	8,949	61,303	640	96,113	40,302	9,969	615	353,524	-	18,000	7,691	-	2,569	20,766	661,214	849	0.13%
November 2012	41,059	8,997	61,571	753	98,333	41,895	9,972	615	356,897	-	17,967	7,600	-	2,546	20,998	669,203	7,989	1.21%
December 2012	41,034	9,077	61,699	857	97,784	40,442	9,798	616	361,446	-	17,898	7,466	-	2,541	21,221	671,879	2,676	0.40%
January 2013	41,066	9,096	61,803	988	99,404	40,895	9,777	613	361,220	5,223	17,720	8,250	437	2,655	21,366	680,513	8,634	1.29%
February 2013	41,093	9,152	62,245	1,056	101,305	42,236	9,959	608	362,024	13,463	17,673	8,322	531	2,666	21,532	693,865	13,352	1.96%
March 2013	40,697	9,130	62,485	1,125	100,247	42,110	9,621	618	363,012	18,263	17,619	8,311	636	2,733	21,530	698,137	4,272	0.62%
April 2013	40,898	9,222	62,976	1,232	101,576	42,997	12,076	639	364,317	20,016	17,598	8,477	730	2,798	21,738	707,290	9,153	1.31%
May 2013	41,108	9,295	63,416	1,318	106,147	45,535	12,462	659	366,710	21,546	17,257	8,346	938	2,848	22,000	719,585	12,295	1.74%
June 2013	41,153	9,358	63,540	1,368	108,773	43,600	14,772	659	373,604	20,327	17,691	8,457	863	2,739	22,170	729,074	9,489	1.32%
Year-to-Date Average	**40,827**	**9,051**	**61,920**	**888**	**99,392**	**41,545**	**10,634**	**623**	**359,843**	**8,236**	**17,777**	**8,024**	**344**	**2,684**	**21,206**	**682,994**	**6,496**	**0.95%**
MEDICAID CASELOAD FY 2013-14 without RETROACTIVITY																		
FY 2013-14	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2013	41,243	9,466	63,919	1,494	105,843	43,321	16,073	660	379,057	11,487	17,652	9,053	334	2,754	22,368	724,724	(4,350)	-0.60%
August 2013	41,540	9,538	64,281	1,616	106,672	45,336	17,388	648	382,925	8,984	17,659	9,219	186	2,562	22,539	731,093	6,369	0.88%
September 2013	41,696	9,641	64,309	1,692	110,929	43,247	20,951	645	394,462	4,348	17,619	9,240	105	2,511	22,690	744,085	12,992	1.78%
October 2013	41,861	9,709	64,151	2,200	111,274	37,094	19,168	639	382,709	11,153	17,675	13,079	549	2,392	22,299	735,952	(8,133)	-1.09%
November 2013	42,098	9,748	64,396	2,749	112,290	41,332	17,976	547	386,326	18,980	17,712	13,740	1,022	2,352	22,539	753,807	17,855	2.43%
December 2013	42,265	9,797	64,478	2,690	119,836	40,228	17,092	540	389,900	28,057	17,793	14,140	1,293	2,311	22,534	772,954	19,147	2.54%
January 2014	41,861	9,838	64,838	2,217	122,548	40,659	120,068	543	398,421	29,967	17,684	14,582	1,390	2,309	22,740	889,665	116,711	15.10%
February 2014	42,003	9,919	64,798	3,146	129,759	51,272	125,369	527	403,888	33,263	17,744	14,691	1,471	2,374	23,302	923,526	33,861	3.81%
March 2014	42,145	10,027	64,312	3,188	138,165	53,923	157,246	498	408,290	38,398	17,704	14,991	1,596	2,426	24,063	976,972	53,446	5.79%
April 2014	41,762	10,129	64,148	3,288	144,089	55,524	171,950	492	415,666	39,128	19,526	15,093	1,559	2,467	24,662	1,009,483	32,511	3.33%
May 2014	41,991	10,162	64,492	3,257	145,211	54,497	176,827	488	420,786	39,624	20,168	15,086	1,549	2,487	25,120	1,021,745	12,262	1.21%
June 2014	41,564	10,263	64,968	3,186	149,545	58,549	186,802	477	425,952	40,754	20,268	15,007	1,634	2,821	25,676	1,047,466	25,721	2.52%
Year-to-Date Average	**41,836**	**9,853**	**64,424**	**2,560**	**124,680**	**47,082**	**87,243**	**559**	**399,032**	**25,345**	**18,267**	**13,160**	**1,057**	**2,481**	**23,378**	**860,957**	**26,533**	**3.14%**
MEDICAID CASELOAD FY 2014-15 without RETROACTIVITY																		
FY 2014-15	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2014	41,551	10,346	65,459	3,065	153,837	60,981	194,454	472	431,203	41,550	20,190	15,038	1,672	2,551	25,963	1,068,332	20,866	1.99%
August 2014	42,513	10,350	65,785	2,971	156,343	62,711	202,825	463	436,077	42,750	20,213	15,436	1,800	2,494	26,347	1,089,078	20,746	1.94%
September 2014	42,643	10,362	66,054	2,925	159,740	63,847	210,970	439	438,991	44,001	20,124	15,386	1,854	2,474	26,787	1,106,597	17,519	1.61%
October 2014	41,763	10,355	66,009	2,927	160,707	65,552	218,403	424	442,075	45,249	20,187	14,938	1,769	2,533	27,229	1,120,120	13,523	1.22%
November 2014	41,918	10,341	66,343	3,023	158,375	66,811	222,465	425	442,141	46,654	20,140	14,691	1,733	2,444	27,601	1,125,105	4,985	0.45%
December 2014	41,927	10,404	66,441	3,556	162,727	70,288	237,045	396	446,354	47,275	20,056	14,542	1,675	2,541	27,944	1,153,171	28,066	2.49%
January 2015	41,392	10,395	66,758	3,772	160,406	76,807	247,056	379	444,669	53,548	19,951	14,590	1,772	2,811	28,226	1,172,532	19,361	1.68%
February 2015	41,334	10,532	66,651	4,112	161,480	78,910	261,108	368	446,886	55,445	19,932	14,643	1,795	2,775	28,158	1,194,129	21,597	1.84%
March 2015	41,518	10,615	66,974	4,226	163,641	80,068	267,714	368	450,778	56,155	19,925	14,804	1,810	2,984	28,332	1,209,912	15,783	1.32%
April 2015	41,621	10,690	67,110	4,161	165,835	79,437	273,043	361	455,223	55,565	19,982	14,954	1,743	3,096	29,170	1,221,991	12,079	1.00%
May 2015	41,778	10,703	67,261	4,279	167,183	79,417	278,709	358	456,426	56,104	19,945	14,914	1,694	3,070	30,224	1,232,065	10,074	0.82%
June 2015	41,849	10,503	67,726	4,509	169,912	79,036	282,910	352	457,855	57,059	19,791	14,822	1,665	2,885	30,560	1,241,434	9,369	0.76%
Year-to-Date Average	**41,817**	**10,466**	**66,548**	**3,627**	**161,682**	**71,989**	**241,392**	**400**	**445,723**	**50,113**	**20,036**	**14,897**	**1,749**	**2,722**	**28,045**	**1,161,206**	**16,164**	**1.43%**

Notes:

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

Exhibit B - Medicaid Caseload Forecast

MEDICAID CASELOAD FY 2015-16 without RETROACTIVITY																		
FY 2015-16	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2015	41,661	10,437	72,760	5,670	169,316	79,502	287,183	344	454,996	56,220	19,578	14,627	1,596	2,774	30,877	1,247,541	6,107	0.49%
August 2015	41,909	10,423	71,167	9,733	169,140	81,001	293,155	342	457,343	57,355	19,676	14,466	1,615	2,699	31,244	1,261,268	13,727	1.10%
September 2015	42,134	10,348	68,765	10,175	169,127	82,010	297,680	342	461,317	58,330	19,776	14,204	1,614	2,635	31,278	1,269,735	8,467	0.67%
October 2015	41,817	10,190	68,576	6,030	167,734	82,642	302,362	336	466,623	58,336	19,814	13,139	1,568	2,491	31,293	1,272,951	3,216	0.25%
November 2015	42,456	10,429	69,113	5,539	162,975	85,784	310,294	324	466,734	59,640	19,936	14,428	1,743	2,605	31,903	1,283,903	10,952	0.86%
December 2015	42,628	10,451	68,813	5,717	163,088	87,548	320,093	318	469,009	59,867	19,975	14,252	1,846	2,616	32,143	1,298,364	14,461	1.13%
January 2016	42,301	10,462	67,571	5,311	162,764	88,891	327,653	314	470,109	59,934	19,987	14,399	1,811	2,593	33,921	1,308,021	9,657	0.74%
February 2016	42,504	10,531	67,298	5,393	162,650	89,610	331,622	310	470,758	59,950	19,963	14,381	1,846	2,631	33,939	1,313,386	5,365	0.41%
March 2016	42,733	10,664	67,979	5,424	163,417	90,244	335,451	311	472,221	60,614	20,028	14,619	1,856	2,722	33,442	1,321,725	8,339	0.63%
April 2016	42,778	10,749	67,828	5,192	161,967	90,644	340,862	308	472,964	60,790	20,133	14,675	1,846	2,675	33,478	1,326,889	5,164	0.39%
May 2016	42,900	10,788	67,842	5,152	155,252	92,385	347,731	308	472,199	61,169	20,196	14,884	1,870	2,707	33,693	1,329,076	2,187	0.16%
June 2016	43,015	10,876	67,891	5,265	152,679	93,307	350,396	304	472,050	61,808	20,162	14,883	1,893	2,635	33,813	1,330,977	1,901	0.14%
Year-to-Date Average	**42,403**	**10,529**	**68,800**	**6,217**	**163,342**	**86,964**	**320,374**	**322**	**467,193**	**59,501**	**19,935**	**14,413**	**1,759**	**2,649**	**32,585**	**1,296,986**	**7,462**	**0.58%**
Notes:																		
1. Due to rounding, the average monthly totals may differ slightly from annual totals reported elsewhere.																		

Exhibit C - History and Projections of Per Capita Costs

Per Capita Costs - Cash Based																
Fiscal Year	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
FY 1997-98	$13,133.89	$8,134.40	$6,854.18	-	$2,857.77	-	-	-	$1,294.26	-	$2,004.90	$6,346.56	-	$3,470.61	$1,351.80	$4,463.21
FY 1998-99	$14,044.48	$9,875.14	$7,786.31	-	$3,123.91	-	-	-	$1,463.55	-	$2,022.23	$6,262.47	-	$3,570.31	$1,013.03	$4,945.41
% Change from FY 1997-98	6.93%	21.40%	13.60%	-	9.31%	-	-	-	13.08%	-	0.86%	-1.32%	-	2.87%	-25.06%	10.80%
FY 1999-00	$15,040.64	$10,793.96	$8,772.23	-	$3,440.54	-	-	-	$1,544.54	-	$2,203.23	$5,430.89	-	$3,273.65	$917.32	$5,166.43
% Change from FY 1998-99	7.09%	9.30%	12.66%	-	10.14%	-	-	-	5.53%	-	8.95%	-13.28%	-	-8.31%	-9.45%	4.47%
FY 2000-01	$15,311.41	$11,851.80	$9,792.12	-	$3,277.51	-	-	-	$1,570.78	-	$2,351.36	$4,801.64	-	$2,966.03	$959.04	$5,143.57
% Change from FY 1999-00	1.80%	9.80%	11.63%	-	-4.74%	-	-	-	1.70%	-	6.72%	-11.59%	-	-9.40%	4.55%	-0.44%
FY 2001-02	$16,837.64	$11,821.86	$10,033.18	-	$3,125.56	-	-	-	$1,532.69	-	$2,530.78	$4,760.42	-	$9,774.69	$963.28	$5,202.27
% Change from FY 2000-01	9.97%	-0.25%	2.46%	-	-4.64%	-	-	-	-2.42%	-	7.63%	-0.86%	-	229.55%	0.44%	1.14%
FY 2002-03	$16,269.83	$11,909.35	$11,071.22	-	$3,425.30	-	-	$30,399.56	$1,346.59	-	$2,689.77	$5,435.44	-	$11,932.93	$882.68	$4,977.91
% Change from FY 2001-02	-3.37%	0.74%	10.35%	-	9.59%	-	-	-	-12.14%	-	6.28%	14.18%	-	22.08%	-8.37%	-4.31%
FY 2003-04	$17,945.57	$13,629.55	$11,928.04	-	$3,858.31	-	-	$25,417.70	$1,187.37	-	$3,037.79	$7,621.82	-	$11,504.23	$961.96	$5,010.73
% Change from FY 2002-03	10.30%	14.44%	7.74%	-	12.64%	-	-	-16.39%	-11.82%	-	12.94%	40.22%	-	-3.59%	8.98%	0.66%
FY 2004-05	$17,743.75	$13,289.25	$11,185.17	-	$3,358.68	-	-	$28,627.25	$1,361.10	-	$2,944.32	$7,040.94	-	$8,682.52	$1,137.98	$4,662.99
% Change from FY 2003-04	-1.12%	-2.50%	-6.23%	-	-12.95%	-	-	12.63%	14.63%	-	-3.08%	-7.62%	-	-24.53%	18.30%	-6.94%
FY 2005-06	$18,260.97	$14,352.34	$11,548.70	-	$3,390.82	-	-	$36,225.53	$1,476.94	-	$2,993.56	$8,031.97	-	$8,904.59	$1,204.47	$4,928.66
% Change from FY 2004-05	2.91%	8.00%	3.25%	-	0.96%	-	-	26.54%	8.51%	-	1.67%	14.08%	-	2.56%	5.84%	5.70%
FY 2006-07	$18,736.83	$14,870.06	$11,712.50	-	$3,664.68	-	-	$24,376.09	$1,608.92	-	$3,210.70	$9,371.52	-	$10,470.57	$1,313.15	$5,222.55
% Change from FY 2005-06	2.61%	3.61%	1.42%	-	8.08%	-	-	-32.71%	8.94%	-	7.25%	16.68%	-	17.59%	9.02%	5.96%
FY 2007-08	$19,419.11	$16,382.42	$13,078.77	-	$3,872.69	-	-	$26,305.08	$1,780.61	-	$3,739.87	$8,670.42	-	$12,797.32	$1,333.66	$5,681.77
% Change from FY 2006-07	3.64%	10.17%	11.67%	-	5.68%	-	-	7.91%	10.67%	-	16.48%	-7.48%	-	22.22%	1.56%	8.79%
FY 2008-09	$20,680.43	$17,762.70	$14,251.48	-	$3,858.15	-	-	$22,261.37	$1,836.99	-	$3,748.13	$8,702.15	-	$14,858.01	$1,254.95	$5,742.83
% Change from FY 2007-08	6.50%	8.43%	8.97%	-	-0.38%	-	-	-15.37%	3.17%	-	0.22%	0.37%	-	16.10%	-5.90%	1.07%
FY 2009-10	$19,455.97	$15,862.64	$13,373.23	-	$3,355.09	$689.29	-	$20,511.28	$1,632.88	-	$3,536.01	$8,401.86	-	$12,655.02	$1,213.77	$4,975.87
% Change from FY 2008-09	-5.92%	-10.70%	-6.16%	-	-13.04%	-	-	-7.86%	-11.11%	-	-5.66%	-3.45%	-	-14.83%	-3.28%	-13.36%
FY 2010-11	$20,336.39	$17,105.76	$14,635.16	-	$3,519.43	$2,316.20	-	$19,033.37	$1,711.49	-	$4,014.76	$8,894.53	-	$14,661.32	$1,428.00	$5,063.72
% Change from FY 2009-10	4.53%	7.84%	9.44%	-	4.90%	2.36	-	-7.21%	4.81%	-	13.54%	5.86%	-	15.85%	17.65%	1.77%
FY 2011-12	$20,300.66	$16,955.03	$14,209.99	$8,877.60	$3,311.46	$2,423.80	$2,185.53	$17,216.60	$1,569.28	-	$3,783.82	$8,354.70	-	$15,148.44	$1,298.38	$4,717.85
% Change from FY 2010-11	-0.18%	-0.88%	-2.91%	-	-5.91%	4.65%	-	-9.55%	-8.31%	-	-5.75%	-6.07%	-	3.32%	-9.08%	-6.83%
FY 2012-13	$20,575.23	$16,956.24	$14,026.17	$13,583.69	$3,305.17	$2,332.34	$5,389.53	$15,345.22	$1,589.28	$1,829.27	$3,794.33	$9,068.38	$8,340.08	$16,302.95	$1,196.39	$4,634.75
% Change from FY 2011-12	1.35%	0.01%	-1.29%	53.01%	-0.19%	-3.77%	146.60%	-10.87%	1.27%	-	0.28%	8.54%	-	7.62%	-7.86%	-1.76%
FY 2013-14	$21,409.29	$17,530.57	$15,039.24	$11,481.79	$2,976.47	$2,399.40	$3,765.62	$15,885.67	$1,708.01	$1,560.48	$4,167.05	$9,367.38	$8,228.78	$15,522.95	$1,313.55	$4,514.26
% Change from FY 2012-13	4.05%	3.39%	7.22%	-15.47%	-9.95%	2.88%	-30.13%	3.52%	7.47%	-14.69%	9.82%	3.30%	-1.33%	-4.78%	9.79%	-2.60%
FY 2014-15	$22,964.00	$18,735.69	$15,295.11	$7,186.24	$3,015.26	$2,473.13	$3,874.08	$12,734.19	$1,807.89	$1,478.91	$4,193.20	$10,491.56	$9,453.25	$14,894.00	$1,112.16	$4,318.46
% Change from FY 2013-14	7.26%	6.87%	1.70%	-37.41%	1.30%	3.07%	2.88%	-19.84%	5.85%	-5.23%	0.63%	12.00%	14.88%	-4.05%	-15.33%	-4.34%
FY 2015-16	$24,168.41	$19,636.54	$16,194.97	$6,650.84	$3,029.32	$2,535.29	$3,785.71	$12,069.49	$1,869.82	$1,587.23	$4,278.47	$10,894.51	$9,739.62	$14,865.67	$1,221.39	$4,337.58
% Change from FY 2014-15	5.24%	4.81%	5.88%	-7.45%	0.47%	2.51%	-2.28%	-5.22%	3.43%	7.32%	2.03%	3.84%	3.03%	-0.19%	9.82%	0.44%
FY 2016-17 Projection	$25,852.50	$19,820.16	$17,306.23	$6,765.31	$2,923.06	$2,609.03	$3,813.83	$11,956.32	$1,843.91	$1,583.27	$4,399.43	$10,931.50	$9,762.97	$14,811.64	$1,397.08	$4,351.03
% Change from FY 2015-16	6.97%	0.94%	6.86%	1.72%	-3.51%	2.91%	0.74%	-0.94%	-1.39%	-0.25%	2.83%	0.34%	0.24%	-0.36%	14.38%	0.31%
FY 2017-18 Projection	$26,676.18	$20,143.37	$17,638.40	$6,610.23	$2,834.74	$2,600.28	$3,817.91	$11,828.04	$1,818.47	$1,550.50	$4,488.28	$10,970.26	$9,800.17	$14,725.47	$1,376.94	$4,333.36
% Change from FY 2016-17	3.19%	1.63%	1.92%	-2.29%	-3.02%	-0.34%	0.11%	-1.07%	-1.38%	-2.07%	2.02%	0.35%	0.38%	-0.58%	-1.44%	-0.41%
FY 2018-19 Projection	$27,408.19	$20,333.99	$17,974.55	$6,525.67	$2,779.20	$2,596.89	$3,833.88	$11,797.31	$1,829.79	$1,550.84	$4,624.67	$11,104.55	$9,919.31	$14,715.37	$1,332.54	$4,354.40
% Change from FY 2017-18	2.74%	0.95%	1.91%	-1.28%	-1.96%	-0.13%	0.42%	-0.26%	0.62%	0.02%	3.04%	1.22%	1.22%	-0.07%	-3.22%	0.49%

Notes:

1. This exhibit does not include supplemental payments, outstationing payments, or upper payment limit financing.
2. See narrative for a description of events that alter trends.

Exhibit C - History and Projections of Per Capita Costs

Per Capita Costs - Adjusted for Payment Delays																
Fiscal Year	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
FY 1997-98	$13,133.89	$8,134.40	$6,854.18	-	$2,857.77	-	-	-	$1,294.26	-	$2,004.90	$6,346.56	-	$3,470.61	$1,351.80	$4,463.21
FY 1998-99	$14,044.48	$9,875.14	$7,786.31	-	$3,123.91	-	-	-	$1,463.55	-	$2,022.23	$6,262.47	-	$3,570.31	$1,013.03	$4,945.41
% Change from FY 1997-98	6.93%	21.40%	13.60%	-	9.31%	-	-	-	13.08%	-	0.86%	-1.32%	-	2.87%	-25.06%	10.80%
FY 1999-00	$15,040.64	$10,793.96	$8,772.23	-	$3,440.54	-	-	-	$1,544.54	-	$2,203.23	$5,430.89	-	$3,273.65	$917.32	$5,166.43
% Change from FY 1998-99	7.09%	9.30%	12.66%	-	10.14%	-	-	-	5.53%	-	8.95%	-13.28%	-	-8.31%	-9.45%	4.47%
FY 2000-01	$15,311.41	$11,851.80	$9,792.12	-	$3,277.51	-	-	-	$1,570.78	-	$2,351.36	$4,801.64	-	$2,966.03	$959.04	$5,143.57
% Change from FY 1999-00	1.80%	9.80%	11.63%	-	-4.74%	-	-	-	1.70%	-	6.72%	-11.59%	-	-9.40%	4.55%	-0.44%
FY 2001-02	$16,837.64	$11,821.86	$10,033.18	-	$3,125.56	-	-	-	$1,532.69	-	$2,530.78	$4,760.42	-	$9,774.69	$963.28	$5,202.27
% Change from FY 2000-01	9.97%	-0.25%	2.46%	-	-4.64%	-	-	-	-2.42%	-	7.63%	-0.86%	-	229.55%	0.44%	1.14%
FY 2002-03	$16,269.83	$11,909.35	$11,071.22	-	$3,425.30	-	-	$30,399.56	$1,346.59	-	$2,689.77	$5,435.44	-	$11,932.93	$882.68	$4,977.91
% Change from FY 2001-02	-3.37%	0.74%	10.35%	-	9.59%	-	-	-	-12.14%	-	6.28%	14.18%	-	22.08%	-8.37%	-4.31%
FY 2003-04	$17,945.57	$13,629.55	$11,928.04	-	$3,858.31	-	-	$25,417.70	$1,187.37	-	$3,037.79	$7,621.82	-	$11,504.23	$961.96	$5,010.73
% Change from FY 2002-03	10.30%	14.44%	7.74%	-	12.64%	-	-	-16.39%	-11.82%	-	12.94%	40.22%	-	-3.59%	8.98%	0.66%
FY 2004-05	$17,743.75	$13,289.25	$11,185.17	-	$3,358.68	-	-	$28,627.25	$1,361.10	-	$2,944.32	$7,040.94	-	$8,682.52	$1,137.98	$4,662.99
% Change from FY 2003-04	-1.12%	-2.50%	-6.23%	-	-12.95%	-	-	12.63%	14.63%	-	-3.08%	-7.62%	-	-24.53%	18.30%	-6.94%
FY 2005-06	$18,260.97	$14,352.34	$11,548.70	-	$3,390.82	-	-	$36,225.53	$1,476.94	-	$2,993.56	$8,031.97	-	$8,904.59	$1,204.47	$4,928.66
% Change from FY 2004-05	2.91%	8.00%	3.25%	-	0.96%	-	-	26.54%	8.51%	-	1.67%	14.08%	-	2.56%	5.84%	5.70%
FY 2006-07	$18,736.83	$14,870.06	$11,712.50	-	$3,664.68	-	-	$24,376.09	$1,608.92	-	$3,210.70	$9,371.52	-	$10,470.57	$1,313.15	$5,222.55
% Change from FY 2005-06	2.61%	3.61%	1.42%	-	8.08%	-	-	-32.71%	8.94%	-	7.25%	16.68%	-	17.59%	9.02%	5.96%
FY 2007-08	$19,419.11	$16,382.42	$13,078.77	-	$3,872.69	-	-	$26,305.08	$1,780.61	-	$3,739.87	$8,670.42	-	$12,797.32	$1,333.66	$5,681.77
% Change from FY 2006-07	3.64%	10.17%	11.67%	-	5.68%	-	-	7.91%	10.67%	-	16.48%	-7.48%	-	22.22%	1.56%	8.79%
FY 2008-09	$20,680.43	$17,762.70	$14,251.48	-	$3,858.15	-	-	$22,261.37	$1,836.99	-	$3,748.13	$8,702.15	-	$14,858.01	$1,254.95	$5,742.83
% Change from FY 2007-08	6.50%	8.43%	8.97%	-	-0.38%	-	-	-15.37%	3.17%	-	0.22%	0.37%	-	16.10%	-5.90%	1.07%
FY 2009-10 (DA)	$19,767.99	$16,303.29	$13,773.18	-	$3,484.92	$952.90	-	$21,192.52	$1,691.68	-	$3,669.73	$8,704.60	-	$13,125.32	$1,225.15	$5,116.67
% Change from FY 2008-09	-4.41%	-8.22%	-3.36%	-	-9.67%	-	-	-4.80%	-7.91%	-	-2.09%	0.03%	-	-11.66%	-2.37%	-10.90%
FY 2010-11 (DA)	$20,027.85	$16,705.85	$14,256.68	-	$3,399.65	$2,284.78	-	$18,488.13	$1,657.89	-	$3,881.13	$8,593.25	-	$14,120.76	$1,417.39	$4,938.48
% Change from FY 2009-10 (DA)	1.31%	2.47%	3.51%	-	-2.45%	139.77%	-	-12.76%	-2.00%	-	5.76%	-1.28%	-	7.58%	15.69%	-3.48%
FY 2011-12	$20,300.66	$16,955.03	$14,209.99	$8,877.60	$3,311.46	$2,423.80	$2,185.53	$17,216.60	$1,569.28	-	$3,783.82	$8,354.70	-	$15,148.44	$1,298.38	$4,717.85
% Change from FY 2010-11 (DA)	1.36%	1.49%	-0.33%	-	-2.59%	6.08%	-	-6.88%	-5.34%	-	-2.51%	-2.78%	-	7.28%	-8.40%	-4.47%
FY 2012-13	$20,575.23	$16,956.24	$14,026.17	$13,583.69	$3,305.17	$2,332.34	$5,389.53	$15,345.22	$1,589.28	$1,829.27	$3,794.33	$9,068.38	$8,340.08	$16,302.95	$1,196.39	$4,634.75
% Change from FY 2011-12	1.35%	0.01%	-1.29%	53.01%	-0.19%	-3.77%	146.60%	-10.87%	1.27%	-	0.28%	8.54%	-	7.62%	-7.86%	-1.76%
FY 2013-14	$21,409.29	$17,530.57	$15,039.24	$11,481.79	$2,976.47	$2,399.40	$3,765.62	$15,885.67	$1,708.01	$1,560.48	$4,167.05	$9,367.38	$8,228.78	$15,522.95	$1,313.55	$4,514.26
% Change from FY 2012-13	4.05%	3.39%	7.22%	-15.47%	-9.95%	2.88%	-30.13%	3.52%	7.47%	-14.69%	9.82%	3.30%	-1.33%	-4.78%	9.79%	-2.60%
FY 2014-15	$22,964.00	$18,735.69	$15,295.11	$7,186.24	$3,015.26	$2,473.13	$3,874.08	$12,734.19	$1,807.89	$1,478.91	$4,193.20	$10,491.56	$9,453.25	$14,894.00	$1,112.16	$4,318.46
% Change from FY 2013-14	7.26%	6.87%	1.70%	-37.41%	1.30%	3.07%	2.88%	-19.84%	5.85%	-5.23%	0.63%	12.00%	14.88%	-4.05%	-15.33%	-4.34%
FY 2015-16	$24,168.41	$19,636.54	$16,194.97	$6,650.84	$3,029.32	$2,535.29	$3,785.71	$12,069.49	$1,869.82	$1,587.23	$4,278.47	$10,894.51	$9,739.62	$14,865.67	$1,221.39	$4,337.58
% Change from FY 2014-15	5.24%	4.81%	5.88%	-7.45%	0.47%	2.51%	-2.28%	-5.22%	3.43%	7.32%	2.03%	3.84%	3.03%	-0.19%	9.82%	0.44%
FY 2016-17 Projection	$25,852.50	$19,820.16	$17,306.23	$6,765.31	$2,923.06	$2,609.03	$3,813.83	$11,956.32	$1,843.91	$1,583.27	$4,399.43	$10,931.50	$9,762.97	$14,811.64	$1,397.08	$4,351.03
% Change from FY 2015-16	6.97%	0.94%	6.86%	1.72%	-3.51%	2.91%	0.74%	-0.94%	-1.39%	-0.25%	2.83%	0.34%	0.24%	-0.36%	14.38%	0.31%
FY 2017-18 Projection	$26,676.18	$20,143.37	$17,638.40	$6,610.23	$2,834.74	$2,600.28	$3,817.91	$11,828.04	$1,818.47	$1,550.50	$4,488.28	$10,970.26	$9,800.17	$14,725.47	$1,376.94	$4,333.36
% Change from FY 2016-17	3.19%	1.63%	1.92%	-2.29%	-3.02%	-0.34%	0.11%	-1.07%	-1.38%	-2.07%	2.02%	0.35%	0.38%	-0.58%	-1.44%	-0.41%
FY 2018-19 Projection	$27,408.19	$20,333.99	$17,974.55	$6,525.67	$2,779.20	$2,596.89	$3,833.88	$11,797.31	$1,829.79	$1,550.84	$4,624.67	$11,104.55	$9,919.31	$14,715.37	$1,332.54	$4,354.40
% Change from FY 2017-18	2.74%	0.95%	1.91%	-1.28%	-1.96%	-0.13%	0.42%	-0.26%	0.62%	0.02%	3.04%	1.22%	1.22%	-0.07%	-3.22%	0.49%

Notes:

1. This exhibit does not include supplemental payments, outstationing payments, or upper payment limit financing.
2. See narrative for a description of events that alter trends.
3. The per capita costs reported here are adjusted for the two-week FY 2009-10 payment delay; that is, the claims which were delayed at the end of FY 2009-10 (and paid in FY 2010-11) are included in the FY 2009-10 totals and excluded from the FY 2010-11 totals.

Exhibit D - Cash Funds Report

Cash Funds Report

Cash Fund	FY 2016-17			FY 2017-18			FY 2018-19		
	Spending Authority	Request	Change	Base Spending Authority	Request	Change	Base Spending Authority	Request	Change
Cash Funds									
Certified Funds	$11,899,530	$20,236,343	$8,336,813	$11,899,530	$16,816,390	$4,916,860	$11,899,530	$16,933,544	$5,034,014
Hospital Provider Fee Cash Fund	$455,803,938	$453,545,390	($2,258,548)	$455,350,709	$454,259,046	($1,091,663)	$455,392,454	$721,452,016	$266,059,562
Medicaid Buy-In Fund	$3,873,100	$3,629,124	($243,976)	$3,902,056	$4,576,030	$673,974	$3,904,342	$5,243,998	$1,339,656
Tobacco Tax Cash Fund	$2,162,950	$2,162,950	$0	$2,162,950	$2,162,950	$0	$2,162,950	$2,162,950	$0
Health Care Expansion Fund	$66,262,914	$67,372,681	$1,109,767	$66,262,914	$68,301,086	$2,038,172	$66,262,914	$69,229,492	$2,966,578
Breast and Cervical Cancer Fund	$756,142	$1,186,884	$430,742	$756,425	$737,574	($18,851)	$756,425	$423,297	($333,128)
Colorado Autism Treatment Fund	$6,784,478	$6,674,358	($110,120)	$332,621	$1,682,000	$1,349,379	$332,621	$1,386,000	$1,053,379
Nursing Facility Fund	$48,739,031	$51,305,253	$2,566,222	$48,739,031	$52,912,102	$4,173,071	$48,739,031	$54,351,000	$5,611,969
Tobacco Education Program Fund	$523,944	$642,863	$118,919	$523,944	$676,204	$152,260	$523,944	$698,158	$174,214
Department Recoveries Fund	$53,597,465	$48,642,690	($4,954,775)	$53,597,465	$51,190,388	($2,407,077)	$53,597,465	$54,154,312	$556,847
ICF-IID Provider Fee	$200,460	$200,460	$0	$200,460	$200,460	$0	$200,460	$200,460	$0
Adult Dental Fund	$34,604,168	$32,092,650	($2,511,518)	$34,604,168	$34,333,263	($270,905)	$34,604,168	$35,745,343	$1,141,175
Transfer from Denver Health	$500,000	$500,000	$0	$500,000	$500,000	$0	$500,000	$500,000	$0
Primary Care Provider Sustainability Fund	$20,000,000	$19,166,667	($833,333)	$0	$833,333	$833,333	$0	$0	$0
Total Cash Funds	**$705,708,120**	**$707,358,313**	**$1,650,193**	**$678,832,273**	**$689,180,826**	**$10,348,553**	**$678,876,304**	**$962,480,570**	**$283,604,266**
Reappropriated Funds									
(6) Other Medical Services; (B) Old Age Pension State Medical Program	$5,240,893	$9,102,709	$3,861,816	$5,240,893	$9,031,044	$3,790,151	$5,240,893	$8,951,417	$3,710,524
Total Reappropriated Funds	**$5,240,893**	**$9,102,709**	**$3,861,816**	**$5,240,893**	**$9,031,044**	**$3,790,151**	**$5,240,893**	**$8,951,417**	**$3,710,524**

Note: Calculation of letternote changes for FY 2016-17 can be found on page ED-2. Request amounts shown above for FY 2016-17 and FY 2017-18 represent the total letternote amount that would appear in the Long Bill.

Exhibit D - Cash Funds Report

Cash Funds Spending Authority by Source of Authority
FY 2016-17

Spending Authority	FY 2016-17 Long Bill Appropriation (HB 16-1405)	SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	HB 16-1097 "PUC Permit for Medicaid Transportation Providers"	Total
Certified Funds	$11,899,530	$0	$0	$0	$11,899,530
Hospital Provider Fee Cash Fund	$455,249,922	($409)	$556,859	($2,434)	$455,803,938
Medicaid Buy-In Fund	$3,873,100	$0	$0	$0	$3,873,100
Tobacco Tax Cash Fund	$2,162,950	$0	$0	$0	$2,162,950
Health Care Expansion Fund	$66,262,914	$0	$0	$0	$66,262,914
Breast and Cervical Cancer Fund	$756,142	$0	$0	$0	$756,142
Colorado Autism Treatment Fund	$333,122	$0	$6,451,471	($115)	$6,784,478
Nursing Facility Fund	$48,739,031	$0	$0	$0	$48,739,031
Tobacco Education Program Fund	$523,944	$0	$0	$0	$523,944
Department Recoveries Fund	$53,597,465	$0	$0	$0	$53,597,465
ICF-IID Provider Fee	$200,460	$0	$0	$0	$200,460
Adult Dental Fund	$34,604,168	$0	$0	$0	$34,604,168
Transfer from Denver Health	$500,000	$0	$0	$0	$500,000
Primary Care Provider Sustainability Fund	$0	$0	$20,000,000	$0	$20,000,000
Total Cash Funds	**$678,702,748**	**($409)**	**$27,008,330**	**($2,549)**	**$705,708,120**

Exhibit D - Cash Funds Report

Revised Totals for Letternotes and Appropriation Clauses
FY 2016-17

FY 2016-17 Request	FY 2016-17 Long Bill Appropriation (HB 16-1405)	SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	HB 16-1097 "PUC Permit for Medicaid Transportation Providers"	Total
Certified Funds	**$20,236,343**	$0	$0	$0	$20,236,343
Hospital Provider Fee Cash Fund	**$452,991,374**	($409)	$556,859	($2,434)	$453,545,390
Medicaid Buy-In Fund	**$3,629,124**	$0	$0	$0	$3,629,124
Tobacco Tax Cash Fund	$2,162,950	$0	$0	$0	$2,162,950
Health Care Expansion Fund	**$67,372,681**	$0	$0	$0	$67,372,681
Breast and Cervical Cancer Fund	**$1,186,884**	$0	$0	$0	$1,186,884
Colorado Autism Treatment Fund	**$223,002**	$0	$6,451,471	($115)	$6,674,358
Nursing Facility Fund	**$51,305,253**	$0	$0	$0	$51,305,253
Tobacco Education Program Fund	**$642,863**	$0	$0	$0	$642,863
Department Recoveries Fund	**$48,642,690**	$0	$0	$0	$48,642,690
ICF-IID Provider Fee	$200,460	$0	$0	$0	$200,460
Adult Dental Fund	**$32,092,650**	$0	$0	$0	$32,092,650
Transfer from Denver Health	$500,000	$0	$0	$0	$500,000
Primary Care Provider Sustainability Fund	**($833,333)**	$0	$20,000,000	$0	$19,166,667
Total Cash Funds	**$680,352,941**	**($409)**	**$27,008,330**	**($2,549)**	**$707,358,313**

Cells in **bold and underline** font indicate a requested change from the appropriation. The font in the "Total" columns is intentionally left unchanged. Please note, this table shows the total change required to the letternotes and appropriation clauses and includes the incremental amounts from prior budget requests, if applicable.

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2016-17	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Acute Care	**$111,458,760**	**$92,842,694**	**$563,039,983**	**$33,331,703**	**$538,225,761**	**$246,755,252**	**$1,341,468,725**	**$3,403,741**	**$800,546,624**	**$93,867,448**	**$58,704,322**	**$159,970,329**	**$18,621,450**	**$39,191,610**	**$17,705,278**	**$4,119,133,680**
Community Based Long-Term Care																
Base CBLTC	$189,759,813	$42,067,397	$212,516,532	$2,382,846	$381,842	$36,893	$1,955,183	$0	$1,162,432	$2,210	$164,823	$36,893	$0	$0	$1,028,043	$451,494,907
Hospice	$38,313,586	$3,848,412	$6,579,534	$258,161	$341,299	$101,401	$3,862,653	$15,766	$146,052	$0	$1,120	$0	$0	$0	$0	$53,467,984
Private Duty Nursing & Long-Term Home Health	$36,817,568	$10,095,155	$224,097,393	$3,013,814	$511,404	$25,570	$2,197,437	$0	$33,038,200	$1,501,447	$26,973,505	$0	$0	$0	$0	$338,271,493
Subtotal CBLTC	**$264,890,967**	**$56,010,964**	**$443,193,459**	**$5,654,821**	**$1,234,545**	**$163,864**	**$8,015,273**	**$15,766**	**$34,346,684**	**$1,503,657**	**$27,139,448**	**$36,893**	**$0**	**$0**	**$1,028,043**	**$843,234,384**
Long-Term Care																
Class I Nursing Facilities	$506,320,346	$44,073,695	$92,227,365	$167,943	$299,156	$14,579	$2,466,566	$0	$0	$0	$168,689	$0	$0	$0	$84,701	$645,823,040
Class II Nursing Facilities	$438,810	$362,350	$3,667,022	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,468,182
PACE	$123,007,177	$16,244,606	$8,042,010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$147,293,793
Subtotal Long-Term Care	**$629,766,333**	**$60,680,651**	**$103,936,397**	**$167,943**	**$299,156**	**$14,579**	**$2,466,566**	**$0**	**$0**	**$0**	**$168,689**	**$0**	**$0**	**$0**	**$84,701**	**$797,585,015**
Insurance																
Supplemental Medicare Insurance Benefit	$102,126,789	$6,089,586	$52,695,410	$0	$375,389	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,349,679	$192,636,853
Heath Insurance Buy-In	$14,225	$17,781	$1,742,556	$0	$21,337	$35,563	$32,006	$0	$124,468	$0	$0	$10,669	$0	$0	$0	$1,998,605
Subtotal Insurance	**$102,141,014**	**$6,107,367**	**$54,437,966**	**$0**	**$396,726**	**$35,563**	**$32,006**	**$0**	**$124,468**	**$0**	**$0**	**$10,669**	**$0**	**$0**	**$31,349,679**	**$194,635,458**
Service Management																
Single Entry Points	$9,782,406	$2,713,478	$20,524,049	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,019,933
Disease Management	$10,474	$26,451	$181,826	$16,202	$249,010	$108,644	$548,663	$0	$0	$0	$36,509	$96,757	$11,190	$0	$0	$1,285,726
ACC and PIHP Administration	$4,258,561	$1,364,556	$9,300,654	$365,816	$21,749,814	$10,980,884	$44,127,871	$0	$62,711,387	$8,379,219	$2,753,538	$1,288,911	$170,837	$0	$0	$167,452,048
Subtotal Service Management	**$14,051,441**	**$4,104,485**	**$30,006,529**	**$382,018**	**$21,998,824**	**$11,089,528**	**$44,676,534**	**$0**	**$62,711,387**	**$8,379,219**	**$2,790,047**	**$1,385,668**	**$182,027**	**$0**	**$0**	**$201,757,707**
Medical Services Total	**$1,122,308,515**	**$219,746,161**	**$1,194,614,334**	**$39,536,485**	**$562,155,012**	**$258,058,786**	**$1,396,659,104**	**$3,419,507**	**$897,729,163**	**$103,750,324**	**$88,802,506**	**$161,403,559**	**$18,803,477**	**$39,191,610**	**$50,167,701**	**$6,156,346,244**
Caseload	43,412	11,087	69,028	5,844	192,317	98,910	366,209	286	486,863	65,529	20,185	14,765	1,926	2,646	35,909	1,414,916
Medical Services Per Capita	$25,852.50	$19,820.16	$17,306.23	$6,765.31	$2,923.06	$2,609.03	$3,813.83	$11,956.32	$1,843.91	$1,583.27	$4,399.43	$10,931.50	$9,762.97	$14,811.64	$1,397.08	$4,351.03
Financing	$107,326,025	$22,852,175	$100,792,642	$6,280,165	$83,187,733	$33,750,049	$249,858,883	$197,084	$121,564,500	$10,207,482	$7,553,739	$39,200,600	$4,248,096	$16,594,080	$0	$803,613,253
Grand Total Medical Services Premiums	**$1,229,634,540**	**$242,598,336**	**$1,295,406,976**	**$45,816,650**	**$645,342,745**	**$291,808,835**	**$1,646,517,987**	**$3,616,591**	**$1,019,293,663**	**$113,957,806**	**$96,356,245**	**$200,604,159**	**$23,051,573**	**$55,785,690**	**$50,167,701**	**$6,959,959,497**
Total Per Capita	$28,324.76	$21,881.33	$18,766.40	$7,839.95	$3,355.62	$2,950.25	$4,496.12	$12,645.42	$2,093.59	$1,739.04	$4,773.66	$13,586.47	$11,968.63	$21,083.03	$1,397.08	$4,918.99

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2017-18	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Acute Care	**$112,682,516**	**$97,331,680**	**$573,814,992**	**$38,813,714**	**$538,462,572**	**$270,227,894**	**$1,437,514,604**	**$2,107,355**	**$806,054,569**	**$100,777,652**	**$58,540,968**	**$160,524,324**	**$19,296,759**	**$38,993,036**	**$18,890,122**	**$4,274,032,757**
Community Based Long-Term Care																
Base CBLTC	$204,226,867	$45,196,599	$228,076,600	$2,660,371	$411,056	$39,711	$2,100,048	$0	$1,269,462	$2,391	$177,190	$39,711	$0	$0	$1,106,051	$485,306,057
Hospice	$40,164,560	$4,002,848	$6,727,860	$304,773	$354,697	$111,532	$4,132,223	$9,865	$149,860	$0	$1,126	$0	$0	$0	$0	$55,959,344
Private Duty Nursing & Long-Term Home Health	$39,170,569	$10,732,528	$240,517,001	$3,227,953	$541,771	$27,089	$2,330,663	$0	$35,479,728	$1,602,939	$29,296,589	$0	$0	$0	$0	$362,926,830
Subtotal CBLTC	**$283,561,996**	**$59,931,975**	**$475,321,461**	**$6,193,097**	**$1,307,524**	**$178,332**	**$8,562,934**	**$9,865**	**$36,899,050**	**$1,605,330**	**$29,474,905**	**$39,711**	**$0**	**$0**	**$1,106,051**	**$904,192,231**
Long-Term Care																
Class I Nursing Facilities	$524,594,881	$45,664,439	$95,556,111	$174,004	$309,953	$15,105	$2,555,591	$0	$0	$0	$174,778	$0	$0	$0	$87,758	$669,132,620
Class II Nursing Facilities	$459,697	$379,598	$3,841,572	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,680,867
PACE	$136,701,850	$18,388,115	$9,436,587	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$164,526,552
Subtotal Long-Term Care	**$661,756,428**	**$64,432,152**	**$108,834,270**	**$174,004**	**$309,953**	**$15,105**	**$2,555,591**	**$0**	**$0**	**$0**	**$174,778**	**$0**	**$0**	**$0**	**$87,758**	**$838,340,039**
Insurance																
Supplemental Medicare Insurance Benefit	$104,921,104	$6,404,259	$54,125,860	$0	$403,696	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,179,401	$201,034,320
Heath Insurance Buy-In	$18,002	$22,502	$2,205,205	$0	$27,001	$45,005	$40,504	$0	$157,515	$0	$0	$13,501	$0	$0	$0	$2,529,235
Subtotal Insurance	**$104,939,106**	**$6,426,761**	**$56,331,065**	**$0**	**$430,697**	**$45,005**	**$40,504**	**$0**	**$157,515**	**$0**	**$0**	**$13,501**	**$0**	**$0**	**$35,179,401**	**$203,563,555**
Service Management																
Single Entry Points	$10,179,572	$2,823,645	$21,357,325	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,360,542
Disease Management	$10,593	$27,569	$185,686	$19,116	$256,942	$119,703	$587,807	$0	$0	$0	$36,725	$96,717	$11,550	$0	$0	$1,352,408
ACC and PIHP Administration	$4,276,178	$1,380,036	$9,478,995	$417,249	$23,856,187	$12,379,502	$46,865,497	$0	$65,562,365	$9,082,618	$2,839,867	$1,312,676	$174,431	$0	$0	$177,625,601
Subtotal Service Management	**$14,466,343**	**$4,231,250**	**$31,022,006**	**$436,365**	**$24,113,129**	**$12,499,205**	**$47,453,304**	**$0**	**$65,562,365**	**$9,082,618**	**$2,876,592**	**$1,409,393**	**$185,981**	**$0**	**$0**	**$213,338,551**
Medical Services Total	**$1,177,406,389**	**$232,353,818**	**$1,245,323,794**	**$45,617,180**	**$564,623,875**	**$282,965,541**	**$1,496,126,937**	**$2,117,220**	**$908,673,499**	**$111,465,600**	**$91,067,243**	**$161,986,929**	**$19,482,740**	**$38,993,036**	**$55,263,332**	**$6,433,467,133**
Caseload	44,137	11,535	70,603	6,901	199,180	108,821	391,871	179	499,692	71,890	20,290	14,766	1,988	2,648	40,135	1,484,636
Medical Services Per Capita	$26,676.18	$20,143.37	$17,638.40	$6,610.23	$2,834.74	$2,600.28	$3,817.91	$11,828.04	$1,818.47	$1,550.50	$4,488.28	$10,970.26	$9,800.17	$14,725.47	$1,376.94	$4,333.36
Financing	$91,025,937	$19,335,352	$85,375,112	$5,310,414	$70,465,104	$28,594,535	$211,667,642	$136,164	$103,008,408	$8,646,443	$6,399,729	$33,224,126	$3,608,358	$14,024,939	$0	$680,822,263
Grand Total Medical Services Premiums	**$1,268,432,326**	**$251,689,170**	**$1,330,698,906**	**$50,927,594**	**$635,088,979**	**$311,560,076**	**$1,707,794,579**	**$2,253,384**	**$1,011,681,907**	**$120,112,043**	**$97,466,972**	**$195,211,055**	**$23,091,098**	**$53,017,975**	**$55,263,332**	**$7,114,289,396**
Total Per Capita	$28,738.53	$21,819.61	$18,847.63	$7,379.74	$3,188.52	$2,863.05	$4,358.05	$12,588.74	$2,024.61	$1,670.78	$4,803.70	$13,220.31	$11,615.24	$20,021.89	$1,376.94	$4,791.94

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2018-19	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Acute Care	**$115,100,207**	**$101,196,739**	**$581,305,882**	**$44,254,122**	**$540,619,950**	**$288,181,670**	**$1,495,503,945**	**$1,209,420**	**$821,843,124**	**$104,534,287**	**$58,999,743**	**$162,481,848**	**$20,139,830**	**$38,981,014**	**$21,438,973**	**$4,395,790,754**
Community Based Long-Term Care																
Base CBLTC	$219,837,556	$48,570,072	$244,081,793	$2,911,651	$442,626	$42,758	$2,256,051	$0	$1,328,265	$2,437	$189,911	$42,758	$0	$0	$1,189,759	$520,895,637
Hospice	$42,167,557	$4,192,271	$6,866,524	$351,119	$365,306	$119,824	$4,302,643	$5,703	$153,031	$0	$1,132	$0	$0	$0	$0	$58,525,110
Private Duty Nursing & Long-Term Home Health	$41,381,464	$11,330,008	$256,322,130	$3,433,032	$569,888	$28,494	$2,454,546	$0	$37,833,151	$1,699,297	$31,587,113	$0	$0	$0	$0	$386,639,123
Subtotal CBLTC	**$303,386,577**	**$64,092,351**	**$507,270,447**	**$6,695,802**	**$1,377,820**	**$191,076**	**$9,013,240**	**$5,703**	**$39,314,447**	**$1,701,734**	**$31,778,156**	**$42,758**	**$0**	**$0**	**$1,189,759**	**$966,059,870**
Long-Term Care																
Class I Nursing Facilities	$541,821,547	$47,163,970	$98,693,986	$179,718	$320,131	$15,601	$2,639,512	$0	$0	$0	$180,517	$0	$0	$0	$90,640	$691,105,622
Class II Nursing Facilities	$501,483	$390,417	$3,951,057	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,842,957
PACE	$154,127,772	$20,991,333	$11,368,441	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$186,487,546
Subtotal Long-Term Care	**$696,450,802**	**$68,545,720**	**$114,013,484**	**$179,718**	**$320,131**	**$15,601**	**$2,639,512**	**$0**	**$0**	**$0**	**$180,517**	**$0**	**$0**	**$0**	**$90,640**	**$882,436,125**
Insurance																
Supplemental Medicare Insurance Benefit	$99,931,117	$6,258,141	$51,606,543	$0	$389,307	$0	$0	$0	$0	$0	$0	$0	$0	$0	$37,056,976	$195,242,084
Heath Insurance Buy-In	$22,799	$28,499	$2,792,877	$0	$34,197	$56,998	$51,298	$0	$199,492	$0	$0	$17,099	$0	$0	$0	$3,203,259
Subtotal Insurance	**$99,953,916**	**$6,286,640**	**$54,399,420**	**$0**	**$423,504**	**$56,998**	**$51,298**	**$0**	**$199,492**	**$0**	**$0**	**$17,099**	**$0**	**$0**	**$37,056,976**	**$198,445,343**
Service Management																
Single Entry Points	$10,553,162	$2,927,273	$22,141,139	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,621,574
Disease Management	$10,769	$28,737	$188,621	$21,919	$263,719	$127,997	$609,168	$0	$0	$0	$36,752	$96,724	$11,911	$0	$0	$1,396,317
ACC and PIHP Administration	$4,350,234	$1,418,495	$9,797,587	$486,086	$25,154,159	$13,603,850	$49,167,990	$0	$67,925,653	$9,771,491	$2,908,842	$1,342,449	$182,841	$0	$0	$186,109,677
Subtotal Service Management	**$14,914,165**	**$4,374,505**	**$32,127,347**	**$508,005**	**$25,417,878**	**$13,731,847**	**$49,777,158**	**$0**	**$67,925,653**	**$9,771,491**	**$2,945,594**	**$1,439,173**	**$194,752**	**$0**	**$0**	**$223,127,568**
Medical Services Total	**$1,229,805,667**	**$244,495,955**	**$1,289,116,580**	**$51,637,647**	**$568,159,283**	**$302,177,192**	**$1,556,985,153**	**$1,215,123**	**$929,282,716**	**$116,007,512**	**$93,904,010**	**$163,980,878**	**$20,334,582**	**$38,981,014**	**$59,776,348**	**$6,665,859,660**
Caseload	44,870	12,024	71,719	7,913	204,433	116,361	406,112	103	507,864	74,803	20,305	14,767	2,050	2,649	44,859	1,530,832
Medical Services Per Capita	$27,408.19	$20,333.99	$17,974.55	$6,525.67	$2,779.20	$2,596.89	$3,833.88	$11,797.31	$1,829.79	$1,550.84	$4,624.67	$11,104.55	$9,919.31	$14,715.37	$1,332.54	$4,354.40
Financing	$155,691,948	$33,071,438	$146,026,704	$9,083,001	$120,524,433	$48,908,465	$362,039,093	$232,897	$176,186,924	$14,788,988	$10,946,180	$56,826,979	$6,171,783	$23,988,438	$0	$1,164,487,271
Grand Total Medical Services Premiums	**$1,385,497,615**	**$277,567,393**	**$1,435,143,284**	**$60,720,648**	**$688,683,716**	**$351,085,657**	**$1,919,024,246**	**$1,448,020**	**$1,105,469,640**	**$130,796,500**	**$104,850,190**	**$220,807,857**	**$26,506,365**	**$62,969,452**	**$59,776,348**	**$7,830,346,931**
Total Per Capita	$30,878.04	$23,084.45	$20,010.64	$7,673.53	$3,368.75	$3,017.21	$4,725.36	$14,058.45	$2,176.70	$1,748.55	$5,163.76	$14,952.79	$12,929.93	$23,771.03	$1,332.54	$5,115.09

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

Item	Long Bill and Special Bills	R-1 Request (November 2016)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Acute Care					
Base Acute Cost	$4,068,910,047	$4,118,888,981	$49,978,934	Driven primarily by caseload increases with small increases in per capita trends	Exhibit F
Bottom Line Impacts					
SB 10-117: "OTC MEDS"	($87,357)	($99,837)	($12,480)	Adjusted for new expected implementation date	Exhibit F
Accountable Care Collaborative Savings	($16,939,867)	($13,018,993)	$3,920,874	Adjusted assumptions based on actual enrollment in FY 2015-16	Exhibit F
FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	$0	($2,224,371)	($2,224,371)	Adjusted to account for program implemented on July 1, 2016	Exhibit F
Estimated Impact of Increasing PACE Enrollment	($2,321,507)	($2,649,301)	($327,794)	Increased enrollment expectations in PACE means more savings in Acute	Exhibit F
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($555,632)	($715,206)	($159,574)	Adjusted savings assumptions based on actual FY 2015-16 data.	Exhibit F
FY 2014-15 R-10: "Primary Care Specialty Collaboration"	($224,742)	($136,221)	$88,521	Full implementation of program delayed as software testing continues	Exhibit F
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase"'	($145,075,634)	($118,943,931)	$26,131,703	Adjusted assumptions based on actual utilization of procedures in FY 2015-16	Exhibit F
Annualization of FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	($13,225,626)	($12,627,581)	$598,045	Adjusted assumptions based on actual enrollment in FY 2015-16	Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase"	$3,233,700	$3,233,700	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Physical and Occupational Therapy Services	$326,116	$326,116	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prostate Biopsy	$499	$499	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Diabetic Self-Management	$44,130	$44,130	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental X-Rays	$33,190	$33,190	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prenatal and Postpartum Care	$56,773	$56,773	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Sealants	$134,955	$134,955	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Vision Retinal Services	$37,053	$37,053	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Eye Materials	$363,187	$363,187	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Fillings and Extractions	$1,368,932	$1,368,932	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Anesthesia	$1,169,336	$1,169,336	$0		Exhibit F
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - EMT	$100,842	$100,842	$0		Exhibit F
HB 15-1309: "Protective Restorations by Dental Hygienists"	$26,127	$12,620	($13,507)	Adjusted for new implementation assumption	Exhibit F
Accounting for SSI Parent Issue with Disabled Buy-In	$3,000,000	$0	($3,000,000)	Adjustment accounted for in trend selection rather than as a bottom line impact	Exhibit F
SB 11-177: Annualization "Sunset Teen Pregnancy & Dropout Program"	($183,897)	($183,897)	$0		Exhibit F
SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	($29,917)	($29,917)	$0		Exhibit F
HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	$55,694,236	$53,373,643	($2,320,593)	Adjusted for cash flow	Exhibit F
HB 16-1097 "PUC Permit for Medicaid Transportation Providers"	($215,271)	($215,271)	$0		Exhibit F
State Plan Autism Treatment	$0	$18,534,147	$18,534,147	Moves State Plan portion of autism treatment to Acute from CBLTC (net zero impact)	Exhibit F
Copay 5% of Income	$0	$2,199,573	$2,199,573	New BLI. New MMIS must demonstrate compliance with copays < 5% income rule	Exhibit F
Kaiser-Access Health Maintenance Organization	$0	$4,000,608	$4,000,608	New HMO, moves expenditure from ACC to Acute (net zero impact based on budget neutrality assumptions)	Exhibit F
Hepatitis C Criteria Change	$0	$66,099,921	$66,099,921	Changed Prior Authorization Criteria (PAR) based on drug review board recommendation	Exhibit F
Total Acute Care	**$3,955,639,673**	**$4,119,133,680**	**$163,494,007**		
Community Based Long-Term Care					
Base CBLTC Cost	$821,506,479	$826,866,152	$5,359,673	Driven by caseload increases	Exhibit G
Bottom Line Impacts					
Annualization of FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	($192,358)	($192,358)	$0		Exhibit G
Annualization of FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($185,234)	($185,234)	$0		Exhibit G
Annualization of HB 14-1357: "In-Home Support Services in Medicaid Program"	$1,117,446	$1,117,446	$0		Exhibit G
Annualization of FY 2014-15 JBC Action: "Raising Cap on Home Modifications"	$1,100,000	$1,100,000	$0		Exhibit G
Annualization of EPSDT Personal Care	($359,085)	($538,628)	($179,543)	Delayed Implementation	Exhibit G
Colorado Choice Transitions	$3,639,311	$1,752,975	($1,886,336)	Revised Forecast	Exhibit G
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" - HCBS	$155,332	$155,332	$0		Exhibit G
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - HCBS Personal Care/Homemaker	$11,995,124	$11,995,124	$0		Exhibit G
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - In-Home Respite (excludes CES Respite)	$52,617	$52,617	$0		Exhibit G
Annualization of FY 2015-16 JBC Action: "Raising Cap on Home Modifications"	$564,288	$564,288	$0		Exhibit G
Annualization of HB 15-1186: "Children with Autism Waiver Expansion"	$18,534,147	$0	($18,534,147)	Moves State Plan portion of autism treatment to Acute from CBLTC (net zero impact)	Exhibit G
Annualization of Independent Living Skills Training Rule Change	$201,735	$201,735	$0		Exhibit G
Annualization of Consumer Transition Services Rate Increase	$208,187	$193,590	($14,597)		Exhibit G
LTHH Impact - FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	($281,540)	($281,540)	$0		Exhibit G
FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($478,618)	($478,618)	$0		Exhibit G
Annualization of FY 2015-16 R#7 "Participant Directed Programs Expansion"	($2,299,208)	($411,177)	$1,888,031	Revised Forecast and Delayed Implementation	Exhibit G
EPSDT Personal Care	$740,200	$1,110,298	$370,098	Delayed Implementation	Exhibit G
Colorado Choice Transitions - LTHH Impact	$865,475	$802,344	($63,131)	Revised Forecast	Exhibit G
Savings from days incurred in FY 2015-16 and paid in FY 2016-17 under HB 13-1152	($62,470)	($59,540)	$2,930	Revised Forecast	Exhibit G
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($499,343)	($530,422)	($31,079)	Revised Forecast	Exhibit G
Total Community Based Long-Term Care	**$856,322,485**	**$843,234,384**	**($13,088,101)**		

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

Item	Long Bill and Special Bills	R-1 Request (November 2016)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Long-Term Care and Insurance					
Class I Nursing Facilities					
Base Class I Nursing Facility Cost	$678,089,836	$646,739,532	($31,350,304)	Decreased patient days expectations based on FY 15-16 actuals	Exhibit H
Bottom Line Impacts					
Hospital Back Up Program	$8,090,900	$9,126,756	$1,035,856	Increased utilization	Exhibit H
Recoveries from Department Overpayment Review	($1,643,520)	($1,000,000)	$643,520	Decreased recovery expectations	Exhibit H
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($10,499,803)	($9,043,248)	$1,456,555	Permanent BLI. Estimated less patient days in R-1 forecast	Exhibit H
Colorado Choice Transitions	($16,320,063)	$0	$16,320,063	Removed CCT as a BLI and assumed transitions were incorporated into base trends	Exhibit H
Total Class I Nursing Facilities	**$657,717,350**	**$645,823,040**	**($11,894,310)**		
Class II Nursing Facilities					
Base Class II Nursing Facilities Cost	$5,035,779	$4,468,182	($567,597)	Updated forecast	Exhibit H
Bottom Line Impacts					
Total Class II Nursing Facilities	**$5,035,779**	**$4,468,182**	**($567,597)**		
Program of All Inclusive Care for the Elderly (PACE)					
Base PACE Cost	$156,026,037	$147,293,793	($8,732,244)	Adjusted rates down and incorporated client contribution	Exhibit H
Bottom Line Impacts					
Total Program of All-Inclusive Care for the Elderly	**$156,026,037**	**$147,293,793**	**($8,732,244)**		
Supplemental Medicare Insurance Benefit (SMIB)					
Base SMIB Cost	$176,029,043	$192,636,853	$16,607,810	Updated forecast on Medicare Part B premium.	Exhibit H
Bottom Line Impacts					
Total Supplemental Medicare Insurance Benefit	**$176,029,043**	**$192,636,853**	**$16,607,810**		
Health Insurance Buy-In Program (HIBI)					
Base HIBI Cost	$1,529,019	$1,613,716	$84,697	Updated forecast on premiums and enrollment.	Exhibit H
Bottom Line Impacts					
Estimated FY 2016-17 Base Expenditure	$43,343	$46,642	$3,299	Updated forecast on premiums and enrollment.	Exhibit H
Estimated Incremental Expenditure for FY 2016-17	$299,186	$338,247	$39,061	Updated forecast on premiums and enrollment.	Exhibit H
Total Health Insurance Buy-In Program	**$1,871,548**	**$1,998,605**	**$127,057**		
Total Long-Term Care and Insurance	**$996,679,757**	**$992,220,473**	**($4,459,284)**		
Service Management					
Single Entry Points (SEP)					
Single Entry Points (SEP) Base	$33,019,933	$33,019,933	$0		Exhibit I
Bottom Line Impacts					
Total Single Entry Points	**$33,019,933**	**$33,019,933**	**$0**		
Disease Management					
Base Disease Management	$1,052,096	$1,285,726	$233,630	Updated to align with CDPHE appropriation	Exhibit I
Bottom Line Impacts					
Total Disease Management	**$1,052,096**	**$1,285,726**	**$233,630**		
Accountable Care Collaborative					
ACC Base	$163,391,197	$164,561,176	$1,169,979	Adjusted assumptions based on actual enrollment in FY 2015-16	Exhibit I
Bottom Line Impacts					
FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees" Annualization	$7,646,400	$7,332,335	($314,065)	Adjusted assumptions based on actual enrollment in FY 2015-16	Exhibit I
Recoupment of Incentive Overpayment (of Quarter 1 FY 2015-16)	$0	($440,855)	($440,855)	Recoups incentives overpaid in the first quarter of FY 2015-16	Exhibit I
Kaiser-Access Health Maintenance Organization	$0	($4,000,608)	($4,000,608)	New HMO, moves expenditure from ACC to Acute (net zero impact based on budget neutrality assumptions)	Exhibit I
Total Accountable Care Collaborative	**$171,037,597**	**$167,452,048**	**($3,585,549)**		
Total Service Management	**$205,109,626**	**$201,757,707**	**($3,351,919)**		
Grand Total Services	**$6,013,751,541**	**$6,156,346,244**	**$142,594,703**		

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

Item	Long Bill and Special Bills	R-1 Request (November 2016)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Bottom Line Financing					
Upper Payment Limit Financing	$3,412,681	$3,420,352	$7,671	Updated Model	Exhibit K
Denver Health Outstationing	$13,978,962	$13,978,962	$0		Exhibit A
Hospital Provider Fee Supplemental Payments	$679,000,000	$656,945,497	($22,054,503)		Exhibit J
Nursing Facility Provider Fee Supplemental Payments	$97,869,540	$103,022,596	$5,153,056	Updated Model	Exhibit H
Physician Supplemental Payments	$8,831,734	$19,369,964	$10,538,230	Updated estimates based on FY 2015-16 actuals	Exhibit A
Hospital High Volume Inpatient Payment	$555,237	$0	($555,237)	Department assumes hospitals will no longer meet criteria for high volume supplemental payment	Exhibit A
Intergovernmental Transfer for Difficult to Discharge Clients	$1,000,000	$1,000,000	$0		Exhibit A
Denver Health Ambulance Payments	$0	$5,875,882	$5,875,882	New supplemental payment not previously accounted for	Exhibit A
Cash Funds Financing	$0	$0	$0	Tobacco tax forecast adjustment	Exhibit A
Total Bottom Line Financing	**$804,648,154**	**$803,613,253**	**($1,034,901)**		
Grand Total[(1)]	**$6,818,399,695**	**$6,959,959,497**	**$141,559,802**		
Total Acute Care	$3,955,639,673	$4,119,133,680	$163,494,007		
Total Community Based Long-Term Care	$856,322,485	$843,234,384	($13,088,101)		
Total Class I Nursing Facilities	$657,717,350	$645,823,040	($11,894,310)		
Total Class II Nursing Facilities	$5,035,779	$4,468,182	($567,597)		
Total Program of All-Inclusive Care for the Elderly	$156,026,037	$147,293,793	($8,732,244)		
Total Supplemental Medicare Insurance Benefit	$176,029,043	$192,636,853	$16,607,810		
Total Health Insurance Buy-In Program	$1,871,548	$1,998,605	$127,057		
Total Single Entry Point	$33,019,933	$33,019,933	$0		
Total Disease Management	$1,052,096	$1,285,726	$233,630		
Total Prepaid Inpatient Health Plan Administration	$171,037,597	$167,452,048	($3,585,549)		
Total Bottom Line Financing	$804,648,154	$803,613,253	($1,034,901)		
Grand Total[(1)]	**$6,818,399,695**	**$6,959,959,497**	**$141,559,802**		

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

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills - FY 2017-18

Item	Base Spending Authority [(1)]	R-1 Request (November 2016)	Difference	Description of Difference from Base Request
Acute Care				
Base Acute Cost	$4,011,273,301	$4,313,982,639	$302,709,338	Increasing caseload and per capita costs
Bottom Line Impacts				
Annualization of SB 10-117: "OTC MEDS"	($87,357)	($149,755)	($62,398)	Adjusted for new implementation date
Accountable Care Collaborative Savings	($16,939,867)	($21,706,279)	($4,766,412)	Adjusted assumptions based on actual enrollment in FY 2015-16
Annualization of FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	$0	($2,321,083)	($2,321,083)	Adjusted to account for program implemented on July 1, 2016
Estimated Impact of Increasing PACE Enrollment	($2,321,507)	($5,423,931)	($3,102,424)	Increased enrollment expectations in PACE means more savings in Acute
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($555,632)	($1,856,904)	($1,301,272)	Adjusted savings assumptions based on actual FY 2015-16 data.
FY 2012-13 R-6: "Dental Efficiency"	$0	($1,704,632)	($1,704,632)	
Annualization of FY 2014-15 R-10: "Primary Care Specialty Collaboration"	($224,742)	($288,478)	($63,736)	Full implementation of program delayed as software testing continues
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase"'	($152,824,231)	($124,115,407)	$28,708,824	Adjusted assumptions based on actual utilization of procedures in FY 2015-16
Annualization of FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	($13,225,626)	($12,627,581)	$598,045	Adjusted assumptions based on actual enrollment in FY 2015-16
FY 2015-16 R-12: "Community Provider Rate Increase"	$3,233,700	$3,233,700	$0	
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Physical and Occupational Therapy Services	$326,116	$326,116	$0	
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prostate Biopsy	$499	$499	$0	
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Diabetic Self-Management	$44,130	$44,130	$0	
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental X-Rays	$33,190	$33,190	$0	
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prenatal and Postpartum Care	$56,773	$56,773	$0	
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Sealants	$134,955	$134,955	$0	
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Vision Retinal Services	$37,053	$37,053	$0	
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Eye Materials	$363,187	$363,187	$0	
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Fillings and Extractions	$1,368,932	$1,368,932	$0	
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Anesthesia	$1,169,336	$1,169,336	$0	
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - EMT	$100,842	$100,842	$0	
HB 15-1309: "Protective Restorations by Dental Hygienists"	$26,127	$12,620	($13,507)	Adjusted for new implementation assumption
Accounting for SSI Parent Issue with Disabled Buy-In	$3,000,000	$0	($3,000,000)	Adjustment accounted for in trend selection rather than as a bottom line impact
SB 11-177: Annualization "Sunset Teen Pregnancy & Dropout Program"	($202,408)	($220,676)	($18,268)	Correction to annualization calculation
Annualization of SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	($29,917)	($1,767,097)	($1,737,180)	
Annualization of HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	$55,694,236	$2,320,593	($53,373,643)	Adjusted for cash flow
Annualization of HB 16-1097 "PUC Permit for Medicaid Transportation Providers"	($215,271)	($449,763)	($234,492)	New request not previously accounted for
State Plan Autism Treatment	$0	$18,534,147	$18,534,147	Moves State Plan portion of autism treatment to Acute from CBLTC (net zero impact)
Annualization of Copay 5% of Income	$0	$6,939,678	$6,939,678	New BLI. New MMIS must demonstrate compliance with copays < 5% income rule.
Home Health Final Rule (Location Expansion)	$0	$687,809	$687,809	New federal regulation; state must demonstrate compliance by 7/1/2017
Kaiser-Access Health Maintenance Organization	$0	$4,000,608	$4,000,608	New HMO, moves expenditure from ACC to Acute (net zero impact based on budget neutrality assumptions)
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$0	$0	$0	Accounted for through caseload adjustment
Hepatitis C Criteria Change	$0	$93,317,535	$93,317,535	Changed Prior Authorization Criteria (PAR) based on drug review board recommendation
Total Acute Care	**$3,890,235,819**	**$4,274,032,757**	**$383,796,938**	
Community Based Long-Term Care				
Base CBLTC Cost	$821,506,479	$884,050,534	$62,544,055	Driven by increases in caseload
Bottom Line Impacts				
Annualization of FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	($192,358)	($192,358)	$0	
Annualization of FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($185,234)	($185,234)	$0	
Annualization of HB 14-1357: "In-Home Support Services in Medicaid Program"	$1,117,446	$1,117,446	$0	
Annualization of FY 2014-15 JBC Action: "Raising Cap on Home Modifications"	$1,100,000	$1,100,000	$0	
Annualization of EPSDT Personal Care	($359,085)	($538,628)	($179,543)	Delayed Implementation
Colorado Choice Transitions	$3,639,311	$3,671,491	$32,180	Revised Forecast
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" - HCBS	$155,332	$155,332	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - HCBS Personal Care/Homemaker	$11,995,124	$11,995,124	$0	
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - In-Home Respite (excludes CES Respite)	$52,617	$52,617	$0	
Annualization of FY 2015-16 JBC Action: "Raising Cap on Home Modifications"	$564,288	$564,288	$0	
Annualization of HB 15-1186: "Children with Autism Waiver Expansion"	$18,534,147	$0	($18,534,147)	Moves State Plan portion of autism treatment to Acute from CBLTC (net zero impact)
Annualization of Independent Living Skills Training Rule Change	$201,735	$201,735	$0	
Annualization of Consumer Transition Services Rate Increase	$208,187	$193,590	($14,597)	Implemented for CCT services only
LTHH Impact - FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	($281,540)	($281,540)	$0	
FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($478,618)	($478,618)	$0	
Annualization of FY 2015-16 R#7 "Participant Directed Programs Expansion"	($2,299,208)	($1,873,718)	$425,490	Revised Forecast
HB 15-1186: "Children with Autism Waiver Expansion"	$0	$0	$0	
EPSDT Personal Care	$740,200	$1,110,298	$370,098	Delayed Implementation
Colorado Choice Transitions - LTHH Impact	$865,475	$2,626,278	$1,760,803	Revised Forecast
Savings from days incurred in FY 2015-16 and paid in FY 2016-17 under HB 13-1152	($62,470)	($59,540)	$2,930	Revised Forecast
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($499,343)	($530,422)	($31,079)	Revised Forecast
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$31,659	($30,165)	($61,824)	A portion of this is accounted for through caseload adjustment but BI buy-in clients have lower expenditure than average BI client
Home Health Final Rule (Location Expansion)	$0	$1,523,721	$1,523,721	New Impact
Total Community Based Long-Term Care	**$856,354,144**	**$904,192,231**	**$47,838,087**	

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills - FY 2017-18

Item	Base Spending Authority [1]	R-1 Request (November 2016)	Difference	Description of Difference from Base Request
Long-Term Care and Insurance				
Class I Nursing Facilities				
Base Class I Nursing Facility Cost	$678,089,836	$671,088,945	($7,000,891)	Decreased patient days expectations based on FY 15-16 actuals
Bottom Line Impacts				
Hospital Back Up Program	$8,090,900	$9,126,756	$1,035,856	Increased utilization
Recoveries from Department Overpayment Review	($1,643,520)	($1,027,200)	$616,320	Decreased recovery expectations
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($10,499,803)	($10,055,881)	$443,922	Permanent BLI. Estimated less patient days in R-1 forecast
Colorado Choice Transitions	($16,320,063)	$0	$16,320,063	Removed CCT as a BLI and assumed transitions were incorporated into base trends
HB 16-1321 "Medicaid Buy-In Certain Medicaid Waivers"	$153	$0	($153)	Accounted for through caseload adjustment
Total Class I Nursing Facilities	**$657,717,503**	**$669,132,620**	**$11,415,117**	
Class II Nursing Facilities				
Base Class II Nursing Facilities	$5,035,779	$4,680,867	($354,912)	Reduced expenditure per-capita expectations.
Bottom Line Impacts				
Total Class II Nursing Facilities	**$5,035,779**	**$4,680,867**	**($354,912)**	
Program of All Inclusive Care for the Elderly (PACE)				
Base PACE Cost	$156,026,037	$164,526,552	$8,500,515	Adjusted enrollment expectations up
Bottom Line Impacts				
Total Program of All-Inclusive Care for the Elderly	**$156,026,037**	**$164,526,552**	**$8,500,515**	
Supplemental Medicare Insurance Benefit (SMIB)				
Base SMIB	$176,029,043	$201,034,320	$25,005,277	Updated caseload and Medicare Part B premiums forecast.
Bottom Line Impacts				
Total Supplemental Medicare Insurance Benefit	**$176,029,043**	**$201,034,320**	**$25,005,277**	
Health Insurance Buy-In Program (HIBI)				
Base HIBI Cost	$1,529,019	$1,613,716	$84,697	Updated forecast on premiums and enrollment.
Bottom Line Impacts				
Estimated FY 2016-17 Base Expenditure	$43,343	$110,945	$67,602	Updated forecast on premiums and enrollment.
Estimated Incremental Expenditure for FY 2016-17	$299,186	$804,574	$505,388	Updated forecast on premiums and enrollment.
Total Health Insurance Buy-In Program	**$1,871,548**	**$2,529,235**	**$657,687**	
Total Long-Term Care and Insurance	**$996,679,910**	**$1,041,903,594**	**$45,223,684**	
Service Management				
Single Entry Points (SEP)				
Single Entry Points (SEP) Base	$33,019,933	$34,360,542	$1,340,609	
Bottom Line Impacts				
Total Single Entry Points	**$33,019,933**	**$34,360,542**	**$1,340,609**	
Disease Management				
Base Disease Management	$1,052,096	$1,352,408	$300,312	Updated to align with CDPHE appropriation
Bottom Line Impacts				
Total Disease Management	**$1,052,096**	**$1,352,408**	**$300,312**	
Accountable Care Collaborative and Prepaid Inpatient Health Plan Administration				
Estimated FY 2017-18 Base Expenditures	$163,391,197	$174,269,827	$10,878,630	Updated forecast
Bottom Line Impacts				
FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees" Annualization	$7,646,400	$7,356,382	($290,018)	Adjusted assumptions based on actual enrollment in FY 2015-16
Recoupment of Incentive Overpayment (of Quarter 1 FY 2015-16)	$0	$0	$0	
Kaiser-Access Health Maintenance Organization	$0	($4,000,608)	($4,000,608)	New HMO, moves expenditure from ACC to Acute (net zero impact based on budget neutrality assumptions)
HB 16-1321 "Medicaid Buy-In Certain Medicaid Waivers"	$559	$0	($559)	Accounted for through caseload adjustment
Total Accountable Care Collaborative and Prepaid Inpatient Health Plan Administration	**$171,038,156**	**$177,625,601**	**$6,587,445**	
Total Service Management	**$205,110,185**	**$213,338,551**	**$8,228,366**	
Grand Total Services	**$5,948,380,058**	**$6,433,467,133**	**$485,087,075**	

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills - FY 2017-18

Item	Base Spending Authority [1]	R-1 Request (November 2016)	Difference	Description of Difference from Base Request
Bottom Line Financing				
Upper Payment Limit Financing	$3,412,681	$3,528,549	$115,868	Updated model based on FY 2015-16 HH CPE actuals
Department Recoveries Adjustment	$0	$0	$0	
Denver Health Outstationing	$13,978,962	$4,779,554	($9,199,408)	New GF methodology expected to be implemented
Hospital Provider Fee Supplemental Payments	$679,000,000	$540,440,830	($138,559,170)	Kept S-1 expectations that HPF would continue to be restricted
Nursing Facility Provider Fee Supplemental Payments	$97,869,540	$105,824,204	$7,954,664	Updated model
Physician Supplemental Payments	$8,831,734	$19,369,964	$10,538,230	Updated estimates based on FY 2015-16 actuals
Hospital High Volume Inpatient Payment	$555,237	$0	($555,237)	Memorial Hospital is not expected to qualify for these payments
Health Care Expansion Fund Transfer Adjustment	$0	$0	$0	GF offset increased
Intergovernmental Transfer for Difficult to Discharge Clients	$1,000,000	$1,000,000	$0	
Repayment of Federal Funds for Physical and Occupational Therapy Unit Limit Policy	$0	$0	$0	
Denver Health Ambulance Payments	$0	$5,879,162	$5,879,162	New CPE payment
Technical Adjustment of Systems Issue for Children	$0	$0	$0	
Cash Funds Financing	$0	$0	$0	Tobacco tax forecast adjustment
Total Bottom Line Financing	**$804,648,154**	**$680,822,263**	**($123,825,891)**	
Grand Total[2]	**$6,753,028,212**	**$7,114,289,396**	**$361,261,184**	
Total Acute Care	$3,890,235,819	$4,274,032,757	$383,796,938	
Total Community Based Long-Term Care	$856,354,144	$904,192,231	$47,838,087	
Total Class I Nursing Facilities	$657,717,503	$669,132,620	$11,415,117	
Total Class II Nursing Facilities	$5,035,779	$4,680,867	($354,912)	
Total Program of All-Inclusive Care for the Elderly	$156,026,037	$164,526,552	$8,500,515	
Total Supplemental Medicare Insurance Benefit	$176,029,043	$201,034,320	$25,005,277	
Total Health Insurance Buy-In Program	$1,871,548	$2,529,235	$657,687	
Total Single Entry Point	$33,019,933	$34,360,542	$1,340,609	
Total Disease Management	$1,052,096	$1,352,408	$300,312	
Total Prepaid Inpatient Health Plan Administration	$171,038,156	$177,625,601	$6,587,445	
Total Bottom Line Financing	$804,648,154	$680,822,263	($123,825,891)	
Rounding Adjustment	$0	$0	$0	
Grand Total[2]	**$6,753,028,212**	**$7,114,289,396**	**$361,261,184**	

(1) The Department has not received a FY 2017-18 appropriation as of this Budget Request. No annualizations are included.

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

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

Cash Based Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$82,865,413	$48,471,304	$410,013,129	$0	$205,881,573	$0	$0	$7,073,613	$358,939,975	$0	$54,744,366	$54,344,094	$0	$53,633,572	$3,198,260	$1,279,165,299
FY 2008-09	$84,634,236	$51,560,699	$401,887,052	$0	$237,329,869	$0	$0	$7,038,935	$426,055,244	$0	$52,144,060	$60,515,451	$0	$59,182,087	$3,783,765	$1,384,131,398
FY 2009-10 (DA)	$76,760,686	$49,677,596	$387,831,564	$0	$259,623,121	$3,085,478	$0	$9,006,243	$459,623,912	$0	$50,189,308	$68,066,556	$0	$48,429,083	$3,230,992	$1,415,524,539
FY 2010-11 (DA)	$78,498,148	$55,703,641	$419,754,485	$0	$274,174,108	$61,700,153	$0	$9,816,125	$493,871,755	$0	$52,506,031	$67,507,355	$0	$45,331,276	$4,976,271	$1,563,839,348
FY 2011-12	$75,155,191	$61,049,927	$443,766,632	$398,462	$301,104,198	$82,998,921	$2,393,150	$10,272,492	$509,353,569	$0	$49,175,549	$63,317,628	$0	$41,938,165	$5,279,710	$1,646,203,594
FY 2012-13	$78,805,339	$65,882,971	$441,467,295	$11,438,155	$316,833,427	$92,095,552	$55,270,434	$9,558,376	$548,721,374	$14,144,638	$46,515,535	$72,164,144	$2,846,306	$43,756,602	$6,211,623	$1,805,711,771
FY 2013-14	$85,675,110	$74,784,265	$486,297,328	$26,043,041	$357,736,561	$108,351,925	$319,790,154	$8,877,269	$627,878,215	$37,312,569	$51,698,815	$122,224,478	$8,648,792	$38,511,597	$8,664,131	$2,362,494,250
FY 2014-15	$95,567,853	$85,483,775	$500,691,236	$21,605,937	$470,241,709	$171,201,576	$906,500,652	$5,087,139	$729,537,416	$67,945,745	$56,793,953	$155,110,673	$16,403,019	$40,514,564	$8,801,588	$3,331,486,835
FY 2015-16	$111,368,637	$86,111,039	$537,735,807	$35,299,310	$475,764,032	$211,351,764	$1,167,713,990	$3,847,424	$783,264,022	$85,469,500	$57,930,983	$155,786,286	$16,986,750	$39,375,154	$14,592,130	$3,782,596,828
Estimated FY 2016-17	$111,458,760	$92,842,694	$563,039,983	$33,331,703	$538,225,761	$246,755,252	$1,341,468,725	$3,403,741	$800,546,624	$93,867,448	$58,704,322	$159,970,329	$18,621,450	$39,191,610	$17,705,278	$4,119,133,680
Estimated FY 2017-18	$112,682,516	$97,331,680	$573,814,992	$38,813,714	$538,462,572	$270,227,894	$1,437,514,604	$2,107,355	$806,054,569	$100,777,652	$58,540,968	$160,524,324	$19,296,759	$38,993,036	$18,890,122	$4,274,032,757
Estimated FY 2018-19	$115,100,207	$101,196,739	$581,305,882	$44,254,122	$540,619,950	$288,181,670	$1,495,503,945	$1,209,420	$821,843,124	$104,534,287	$58,999,743	$162,481,848	$20,139,830	$38,981,014	$21,438,973	$4,395,790,754

Percent Change in Cash Based Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	2.13%	6.37%	-1.98%	0.00%	15.27%	0.00%	0.00%	-0.49%	18.70%	0.00%	-4.75%	11.36%	0.00%	10.35%	18.31%	8.21%
FY 2009-10 (DA)	-9.30%	-3.65%	-3.50%	0.00%	9.39%	0.00%	0.00%	27.95%	7.88%	0.00%	-3.75%	12.48%	0.00%	-18.17%	-14.61%	2.27%
FY 2010-11 (DA)	2.26%	12.13%	8.23%	0.00%	5.60%	1899.70%	0.00%	8.99%	7.45%	0.00%	4.62%	-0.82%	0.00%	-6.40%	54.02%	10.48%
FY 2011-12	-4.26%	9.60%	5.72%	0.00%	9.82%	34.52%	0.00%	4.65%	3.13%	0.00%	-6.34%	-6.21%	0.00%	-7.49%	6.10%	5.27%
FY 2012-13	4.86%	7.92%	-0.52%	2770.58%	5.22%	10.96%	2209.53%	-6.95%	7.73%	0.00%	-5.41%	13.97%	0.00%	4.34%	17.65%	9.69%
FY 2013-14	8.72%	13.51%	10.15%	127.69%	12.91%	17.65%	478.59%	-7.13%	14.43%	163.79%	11.14%	69.37%	203.86%	-11.99%	39.48%	30.83%
FY 2014-15	11.55%	14.31%	2.96%	-17.04%	31.45%	58.01%	183.47%	-42.69%	16.19%	82.10%	9.86%	26.91%	89.66%	5.20%	1.59%	41.02%
FY 2015-16	16.53%	0.73%	7.40%	63.38%	1.17%	23.45%	28.82%	-24.37%	7.36%	25.79%	2.00%	0.44%	3.56%	-2.81%	65.79%	13.54%
Estimated FY 2016-17	0.08%	7.82%	4.71%	-5.57%	13.13%	16.75%	14.88%	-11.53%	2.21%	9.83%	1.33%	2.69%	9.62%	-0.47%	21.33%	8.90%
Estimated FY 2017-18	1.10%	4.84%	1.91%	16.45%	0.04%	9.51%	7.16%	-38.09%	0.69%	7.36%	-0.28%	0.35%	3.63%	-0.51%	6.69%	3.76%
Estimated FY 2018-19	2.15%	3.97%	1.31%	14.02%	0.40%	6.64%	4.03%	-42.61%	1.96%	3.73%	0.78%	1.22%	4.37%	-0.03%	13.49%	2.85%

Per Capita Cost

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$2,283.80	$7,886.64	$8,211.27	$0.00	$3,850.20	$0.00	$0.00	$26,198.57	$1,759.32	$0.00	$3,193.77	$8,642.51	$0.00	$12,797.32	$225.01	$3,263.49
FY 2008-09	$2,249.77	$7,997.63	$7,825.67	$0.00	$3,835.70	$0.00	$0.00	$22,204.84	$1,812.01	$0.00	$2,891.59	$8,674.81	$0.00	$14,843.76	$251.00	$3,168.71
FY 2009-10 (DA)	$1,994.46	$7,047.47	$7,281.31	$0.00	$3,469.09	$952.90	$0.00	$21,191.16	$1,667.29	$0.00	$2,730.50	$8,693.05	$0.00	$13,113.75	$202.96	$2,837.88
FY 2010-11 (DA)	$2,016.86	$7,171.83	$7,457.66	$0.00	$3,380.11	$2,271.14	$0.00	$18,486.11	$1,633.12	$0.00	$2,854.67	$8,579.99	$0.00	$14,108.71	$291.18	$2,788.79
FY 2011-12	$1,891.17	$7,282.59	$7,466.54	$7,662.73	$3,229.90	$2,340.57	$2,110.36	$17,206.85	$1,522.13	$0.00	$2,726.82	$8,298.51	$0.00	$15,140.13	$279.78	$2,655.33
FY 2012-13	$1,930.23	$7,279.08	$7,129.64	$12,880.81	$3,187.72	$2,216.77	$5,197.52	$15,342.50	$1,524.89	$1,717.42	$2,616.61	$8,993.54	$8,274.15	$16,302.76	$292.92	$2,643.82
FY 2013-14	$2,047.88	$7,590.00	$7,548.39	$10,173.06	$2,869.24	$2,301.34	$3,665.51	$15,880.62	$1,573.50	$1,472.19	$2,830.18	$9,287.57	$8,182.40	$15,522.61	$370.61	$2,744.03
FY 2014-15	$2,285.38	$8,167.76	$7,523.76	$5,956.97	$2,908.44	$2,378.16	$3,755.31	$12,717.85	$1,636.75	$1,355.85	$2,834.60	$10,412.21	$9,378.51	$14,884.12	$313.84	$2,868.99
FY 2015-16	$2,626.43	$8,178.46	$7,815.93	$5,677.87	$2,912.69	$2,430.34	$3,644.85	$11,948.52	$1,676.53	$1,436.44	$2,905.99	$10,808.73	$9,657.05	$14,864.16	$447.82	$2,916.45
Estimated FY 2016-17	$2,567.46	$8,374.01	$8,156.69	$5,703.58	$2,798.64	$2,494.75	$3,663.12	$11,901.19	$1,644.30	$1,432.46	$2,908.31	$10,834.43	$9,668.46	$14,811.64	$493.06	$2,911.22
Estimated FY 2017-18	$2,553.02	$8,437.94	$8,127.35	$5,624.36	$2,703.40	$2,483.23	$3,668.34	$11,772.93	$1,613.10	$1,401.83	$2,885.21	$10,871.21	$9,706.62	$14,725.47	$470.66	$2,878.84
Estimated FY 2018-19	$2,565.19	$8,416.23	$8,105.33	$5,592.58	$2,644.48	$2,476.62	$3,682.49	$11,741.94	$1,618.23	$1,397.46	$2,905.68	$11,003.04	$9,824.31	$14,715.37	$477.92	$2,871.50

Percent Change in Per Capita Cost

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	-1.49%	1.41%	-4.70%	0.00%	-0.38%	0.00%	0.00%	-15.24%	2.99%	0.00%	-9.46%	0.37%	0.00%	15.99%	11.55%	-2.90%
FY 2009-10 (DA)	-11.35%	-11.88%	-6.96%	0.00%	-9.56%	0.00%	0.00%	-4.57%	-7.99%	0.00%	-5.57%	0.21%	0.00%	-11.65%	-19.14%	-10.44%
FY 2010-11 (DA)	1.12%	1.76%	2.42%	0.00%	-2.56%	138.34%	0.00%	-12.76%	-2.05%	0.00%	4.55%	-1.30%	0.00%	7.59%	43.47%	-1.73%
FY 2011-12	-6.23%	1.54%	0.12%	0.00%	-4.44%	3.06%	0.00%	-6.92%	-6.80%	0.00%	-4.48%	-3.28%	0.00%	7.31%	-3.92%	-4.79%
FY 2012-13	2.07%	-0.05%	-4.51%	68.10%	-1.31%	-5.29%	146.29%	-10.83%	0.18%	0.00%	-4.04%	8.38%	0.00%	7.68%	4.70%	-0.43%
FY 2013-14	6.10%	4.27%	5.87%	-21.02%	-9.99%	3.82%	-29.48%	3.51%	3.19%	-14.28%	8.16%	3.27%	-1.11%	-4.79%	26.52%	3.79%
FY 2014-15	11.60%	7.61%	-0.33%	-41.44%	1.37%	3.34%	2.45%	-19.92%	4.02%	-7.90%	0.16%	12.11%	14.62%	-4.11%	-15.32%	4.55%
FY 2015-16	14.92%	0.13%	3.88%	-4.69%	0.15%	2.19%	-2.94%	-6.05%	2.43%	5.94%	2.52%	3.81%	2.97%	-0.13%	42.69%	1.65%
Estimated FY 2016-17	-2.25%	2.39%	4.36%	0.45%	-3.92%	2.65%	0.50%	-0.40%	-1.92%	-0.28%	0.08%	0.24%	0.12%	-0.35%	10.10%	-0.18%
Estimated FY 2017-18	-0.56%	0.76%	-0.36%	-1.39%	-3.40%	-0.46%	0.14%	-1.08%	-1.90%	-2.14%	-0.79%	0.34%	0.39%	-0.58%	-4.54%	-1.11%
Estimated FY 2018-19	0.48%	-0.26%	-0.27%	-0.57%	-2.18%	-0.27%	0.39%	-0.26%	0.32%	-0.31%	0.71%	1.21%	1.21%	-0.07%	1.54%	-0.25%

Per Capita Trends

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Actual FY 2015-16 Per Capita	$2,626.43	$8,178.46	$7,815.93	$5,677.87	$2,912.69	$2,430.34	$3,644.85	$11,948.52	$1,676.53	$1,436.44	$2,905.99	$10,808.73	$9,657.05	$14,864.16	$447.82	$2,916.45
Average of FY 2008-09 through FY 2013-14	-1.63%	-0.87%	-0.61%	0.00%	0.00%	27.99%	23.36%	-6.31%	-2.69%	-2.86%	-0.28%	1.46%	-0.22%	1.23%	10.33%	-2.72%
Average of FY 2009-10 through FY 2013-14	-1.66%	1.88%	0.98%	11.77%	-4.58%	34.98%	29.20%	-6.75%	-1.37%	-3.57%	1.05%	1.77%	-0.28%	4.45%	17.69%	-0.79%
Average of FY 2010-11 through FY 2013-14	0.77%	1.92%	0.49%	15.69%	-5.25%	0.53%	38.94%	-4.75%	-1.14%	-4.76%	-0.12%	2.79%	-0.37%	3.40%	9.10%	-0.48%
Average of FY 2011-12 through FY 2013-14	0.65%	2.11%	0.68%	23.54%	-5.65%	-0.74%	58.41%	-3.66%	1.69%	-7.14%	2.06%	5.83%	-0.56%	1.45%	15.61%	1.68%
Average of FY 2009-10 through FY 2014-15	0.55%	3.03%	0.71%	1.13%	-3.39%	28.65%	23.85%	-9.38%	-0.29%	-4.44%	0.87%	3.84%	2.70%	2.74%	11.09%	0.28%
Average of FY 2010-11 through FY 2014-15	2.93%	3.34%	0.29%	1.41%	-3.59%	1.23%	29.82%	-8.54%	0.15%	-5.55%	-0.05%	5.12%	3.38%	1.52%	3.00%	0.78%
Average of FY 2011-12 through FY 2014-15	3.39%	3.94%	0.34%	1.88%	-3.31%	0.62%	39.75%	-9.08%	2.46%	-7.39%	1.43%	7.92%	4.50%	-0.41%	5.30%	2.64%
Average of FY 2012-13 through FY 2014-15	6.59%	5.94%	2.77%	-31.23%	-4.31%	3.58%	-13.52%	-8.21%	3.61%	-11.09%	4.16%	7.69%	6.76%	-4.45%	5.60%	4.17%
Average of FY 2010-11 through FY 2015-16	4.93%	2.70%	1.01%	0.19%	-2.84%	1.42%	23.26%	-8.04%	0.60%	-3.25%	0.46%	4.86%	3.30%	1.19%	10.93%	0.95%
Average of FY 2011-12 through FY 2015-16	5.69%	2.99%	1.23%	0.24%	-2.45%	1.02%	29.08%	-8.32%	2.46%	-4.06%	1.70%	6.89%	4.12%	-0.34%	14.65%	2.39%
Average of FY 2012-13 through FY 2015-16	8.67%	4.00%	3.14%	-22.38%	-2.82%	3.12%	-9.99%	-7.49%	3.21%	-5.41%	3.61%	6.40%	5.49%	-3.01%	17.96%	3.33%
Average of FY 2013-14 through FY 2015-16	10.87%	3.87%	1.78%	-23.07%	0.76%	2.77%	-0.25%	-12.99%	3.23%	-0.98%	1.34%	7.96%	8.80%	-2.12%	13.69%	3.10%

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

Current Year Projection

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Percentage Selected to Modify Per Capita[1]	3.70%	0.48%	0.70%	0.70%	-2.80%	1.20%	-0.30%	-0.30%	0.20%	1.70%	1.06%	0.68%	0.68%	0.00%	20.00%	
Estimated FY 2016-17 Base Per Capita	$2,723.61	$8,217.72	$7,870.64	$5,717.62	$2,831.13	$2,459.50	$3,633.92	$11,912.67	$1,679.88	$1,460.86	$2,936.79	$10,882.23	$9,722.72	$14,864.16	$537.38	$2,911.05
Estimated FY 2016-17 Eligibles	43,412	11,087	69,028	5,844	192,317	98,910	366,209	286	486,863	65,529	20,185	14,765	1,926	2,646	35,909	1,414,916
Estimated FY 2016-17 Base Expenditures	$118,237,357	$91,109,862	$543,294,538	$33,413,771	$544,474,428	$243,269,145	$1,330,774,209	$3,407,024	$817,871,416	$95,728,695	$59,279,106	$160,676,126	$18,725,959	$39,330,567	$19,296,778	$4,118,888,981
Bottom Line Impacts																
SB 10-117: "OTC MEDS"	($955)	($3,287)	($22,497)	($912)	($15,053)	($5,608)	($30,653)	($50)	($14,748)	($2,027)	($3,070)	($897)	($79)	($1)	$0	($99,837)
Accountable Care Collaborative Savings	($1,743,665)	($569,774)	($1,527,027)	($273,621)	($2,078,225)	($1,038,231)	($3,280,639)	$0	($2,047,823)	($315,450)	($68,712)	($63,504)	($12,322)	$0	$0	($13,018,993)
FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	($12,551)	($35,169)	($242,834)	($14,083)	($399,104)	($141,145)	($770,705)	($2,492)	($463,574)	($45,438)	($33,247)	($48,795)	($4,419)	($10,801)	($14)	($2,224,371)
Estimated Impact of Increasing PACE Enrollment	($1,172,407)	($841,785)	($635,109)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($2,649,301)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($20,515)	($18,352)	($107,489)	($4,638)	($100,952)	($36,754)	($194,608)	($1,092)	($156,618)	($14,587)	($12,193)	($33,299)	($3,521)	($8,698)	($1,890)	($715,206)
FY 2014-15 R-10: "Primary Care Specialty Collaboration"	($780)	($2,054)	($13,785)	($859)	($20,049)	($7,480)	($37,009)	($158)	($37,930)	($3,175)	($2,791)	($8,025)	($924)	($1,199)	($3)	($136,221)
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase'"	($6,570,553)	($2,500,351)	($12,732,622)	($1,024,474)	($16,879,990)	($5,728,083)	($27,383,637)	($30,409)	($35,199,097)	($3,573,031)	($1,705,625)	($2,192,632)	($210,605)	($307,612)	($2,905,210)	($118,943,931)
Annualization of FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	($5,196,749)	($1,047,258)	($5,593,267)	($321)	($772,822)	($79)	($120)	$0	($5,133)	$0	($3,770)	($8,062)	$0	$0	$0	($12,627,581)
FY 2015-16 R-12: "Community Provider Rate Increase"	$92,762	$82,975	$485,995	$20,972	$456,439	$166,176	$879,893	$4,938	$708,124	$65,951	$55,127	$150,558	$15,922	$39,325	$8,543	$3,233,700
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Physical and Occupational Therapy Services	$147	$0	$179,009	$1,092	$0	$0	$50	$0	$112,974	$447	$32,397	$0	$0	$0	$0	$326,116
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prostate Biopsy	$42	$32	$191	$0	$0	$0	$234	$0	$0	$0	$0	$0	$0	$0	$0	$499
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Diabetic Self-Management	$12,549	$4,354	$9,484	$359	$6,426	$2,156	$6,829	$0	$1,033	$75	$148	$700	$17	$0	$0	$44,130
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental X-Rays	$981	$340	$1,992	$101	$3,840	$1,540	$5,797	$0	$15,320	$2,270	$726	$256	$27	$0	$0	$33,190
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Prenatal and Postpartum Care	$0	$0	$629	$0	$4,292	$1,050	$1,222	$0	$3,049	$449	$374	$40,873	$4,835	$0	$0	$56,773
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Sealants	$0	$0	$12,280	$504	$0	$0	$0	$0	$102,706	$12,021	$7,444	$0	$0	$0	$0	$134,955
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Vision Retinal Services	$1,231	$1,158	$3,232	$200	$5,632	$2,773	$16,980	$0	$4,296	$846	$432	$210	$63	$0	$0	$37,053
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Eye Materials	$0	$0	$33,050	$1,355	$0	$0	$0	$0	$276,398	$32,351	$20,033	$0	$0	$0	$0	$363,187
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Dental Fillings and Extractions	$40,399	$14,037	$82,156	$4,182	$158,363	$63,506	$239,103	$0	$631,862	$93,623	$29,934	$10,543	$1,109	$112	$3	$1,368,932
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - Anesthesia	$6,704	$17,629	$118,334	$7,370	$172,103	$64,213	$317,692	$1,352	$325,595	$27,255	$23,958	$68,887	$7,928	$10,289	$27	$1,169,336
FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - EMT	$4,775	$3,629	$19,649	$419	$12,384	$2,829	$37,435	$40	$13,290	$1,014	$2,021	$2,762	$136	$458	$1	$100,842
HB 15-1309: "Protective Restorations by Dental Hygienists"	$0	$0	$1,149	$47	$0	$0	$0	$0	$9,604	$1,124	$696	$0	$0	$0	$0	$12,620
SB 11-177: Annualization "Sunset Teen Pregnancy & Dropout Program"	$0	$0	($962)	$0	$0	$0	$0	$0	($153,678)	($24,291)	($3,992)	($974)	$0	$0	$0	($183,897)
SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	($169)	($473)	($3,267)	($189)	($5,368)	($1,898)	($10,366)	($34)	($6,235)	($611)	($447)	($656)	($59)	($145)	$0	($29,917)
HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	$2,948,401	$1,121,981	$5,713,502	$459,712	$7,574,548	$2,570,359	$12,287,845	$13,645	$15,794,870	$1,603,324	$765,364	$983,899	$94,505	$138,035	$1,303,653	$53,373,643
HB 16-1097 "PUC Permit for Medicaid Transportation Providers"	($1,215)	($3,404)	($23,501)	($1,363)	($38,625)	($13,660)	($74,587)	($241)	($44,864)	($4,397)	($3,218)	($4,722)	($428)	($1,045)	($1)	($215,271)
State Plan Autism Treatment	$0	$0	$17,553,657	$0	$0	$0	$0	$0	$900,774	$0	$79,716	$0	$0	$0	$0	$18,534,147
Copay 5% of Income	$88,253	$44,280	$309,410	$1,227	$558,779	$34,042	$1,141,330	$1,954	$0	$0	$14,582	$0	$0	$2,325	$3,391	$2,199,573
Kaiser-Access Health Maintenance Organization	$6,090	$12,354	$143,376	$4,350	$601,692	$361,398	$931,074	$0	$1,566,870	$281,010	$57,942	$31,146	$3,306	$0	$0	$4,000,608
Hepatitis C Criteria Change	$4,738,628	$5,451,970	$15,980,710	$736,502	$4,507,023	$7,189,003	$26,611,356	$9,264	$338,143	$0	$171,387	$365,935	$0	$0	$0	$66,099,921
Total Bottom Line Impacts	($6,778,597)	$1,732,832	$19,745,445	($82,068)	($6,248,667)	$3,486,107	$10,694,516	($3,283)	($17,324,792)	($1,861,247)	($574,784)	($705,797)	($104,509)	($138,957)	($1,591,500)	$244,699
Estimated FY 2016-17 Expenditures	**$111,458,760**	**$92,842,694**	**$563,039,983**	**$33,331,703**	**$538,225,761**	**$246,755,252**	**$1,341,468,725**	**$3,403,741**	**$800,546,624**	**$93,867,448**	**$58,704,322**	**$159,970,329**	**$18,621,450**	**$39,191,610**	**$17,705,278**	**$4,119,133,680**
Estimated FY 2016-17 Per Capita	$2,567.46	$8,374.01	$8,156.69	$5,703.58	$2,798.64	$2,494.75	$3,663.12	$11,901.19	$1,644.30	$1,432.46	$2,908.31	$10,834.43	$9,668.46	$14,811.64	$493.06	$2,911.22
% Change over FY 2015-16 Per Capita	-2.25%	2.39%	4.36%	0.45%	-3.92%	2.65%	0.50%	-0.40%	-1.92%	-0.28%	0.08%	0.24%	0.12%	-0.35%	10.10%	-0.18%

Request Year Projection

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Percentage Selected to Modify Per Capita[2]	2.30%	0.80%	0.10%	0.80%	-2.20%	-0.20%	0.30%	-0.20%	0.30%	-0.20%	0.62%	1.09%	1.09%	0.00%	1.83%	
Estimated FY 2017-18 Base Per Capita	$2,626.51	$8,441.00	$8,164.85	$5,749.21	$2,737.07	$2,489.76	$3,674.11	$11,877.39	$1,649.23	$1,429.60	$2,926.34	$10,952.53	$9,773.85	$14,811.64	$502.08	$2,905.92
Estimated FY 2017-18 Eligibles	44,137	11,535	70,603	6,901	199,180	108,821	391,871	179	499,692	71,890	20,290	14,766	1,988	2,648	40,135	1,484,636
Estimated FY 2017-18 Base Expenditure	$115,926,272	$97,366,935	$576,462,905	$39,675,298	$545,169,603	$270,938,173	$1,439,776,909	$2,126,052	$824,108,486	$102,773,590	$59,375,439	$161,725,058	$19,430,414	$39,221,223	$20,150,981	$4,314,227,338
Bottom Line Impacts																
Annualization of SB 10-117: "OTC MEDS"	($480)	($1,643)	($11,248)	($456)	($7,526)	($2,804)	($15,326)	($25)	($7,374)	($1,013)	($1,535)	($448)	($40)	$0	$0	($49,918)
Accountable Care Collaborative Savings	($1,046,433)	($280,595)	($2,443,647)	($664,133)	($1,071,896)	($752,584)	($1,163,482)	$0	($957,161)	($282,783)	($21,343)	($2,778)	($451)	$0	$0	($8,687,286)
Annualization of FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	($555)	($1,458)	($9,787)	($610)	($14,234)	($5,311)	($26,275)	($112)	($26,929)	($2,254)	($1,981)	($5,697)	($656)	($851)	($2)	($96,712)
Estimated Impact of Increasing PACE Enrollment	($1,353,745)	($809,412)	($611,473)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($2,774,630)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($32,753)	($29,295)	($171,587)	($7,404)	($161,151)	($58,671)	($310,657)	($1,743)	($250,012)	($23,285)	($19,463)	($53,156)	($5,621)	($13,884)	($3,016)	($1,141,698)
FY 2012-13 R-6: "Dental Efficiency"	($83,665)	($43,740)	($256,190)	($11,055)	($240,610)	($87,599)	($463,832)	($2,603)	($373,285)	$0	($29,060)	($79,366)	($8,393)	($20,730)	($4,504)	($1,704,632)
Annualization of FY 2014-15 R-10: "Primary Care Specialty Collaboration"	($860)	($2,407)	($16,622)	($964)	($27,318)	($9,661)	($52,754)	($171)	($31,731)	($3,110)	($2,276)	($3,340)	($303)	($739)	($1)	($152,257)
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase'"	($148,351)	($132,697)	($777,224)	($33,539)	($729,957)	($265,757)	($1,407,163)	($7,897)	($1,132,463)	($105,472)	($88,161)	($240,779)	($25,462)	($62,891)	($13,663)	($5,171,476)
SB 11-177: Annualization "Sunset Teen Pregnancy & Dropout Program"	$0	$0	($192)	$0	$0	$0	$0	$0	($30,735)	($4,858)	($798)	($195)	$0	$0	$0	($36,779)
Annualization of SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	($16,634)	($57,191)	($391,454)	($15,874)	($261,925)	($97,574)	($533,364)	($872)	($256,616)	($35,263)	($53,424)	($15,600)	($1,375)	($11)	($3)	($1,737,180)
Annualization of HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	($2,820,209)	($1,073,199)	($5,465,089)	($439,724)	($7,245,221)	($2,458,605)	($11,753,590)	($13,052)	($15,108,138)	($1,533,614)	($732,087)	($941,120)	($90,396)	($132,033)	($1,246,973)	($51,053,050)
Annualization of HB 16-1097 "PUC Permit for Medicaid Transportation Providers"	($1,345)	($3,535)	($23,730)	($1,478)	($34,513)	($12,877)	($63,708)	($271)	($65,293)	($5,466)	($4,804)	($13,814)	($1,590)	($2,063)	($5)	($234,492)
Annualization of Copay 5% of Income	$190,186	$95,424	$666,782	$2,645	$1,204,175	$73,360	$2,459,578	$4,211	$0	$0	$31,425	$0	$0	$5,011	$7,308	$4,740,105
Home Health Final Rule (Location Expansion)	$119,889	$59,564	$283,256	$7,742	$27,312	$7,626	$110,651	$23	$46,585	$1,180	$18,465	$4,880	$632	$4	$0	$687,809
Annualization of Hepatitis C Criteria Change	$1,951,199	$2,244,929	$6,580,292	$303,266	$1,855,833	$2,960,178	$10,957,617	$3,815	$139,235	$0	$70,571	$150,679	$0	$0	$0	$27,217,614
Total Bottom Line Impacts	($3,243,756)	($35,255)	($2,647,913)	($861,584)	($6,707,031)	($710,279)	($2,262,305)	($18,697)	($18,053,917)	($1,995,938)	($834,471)	($1,200,734)	($133,655)	($228,187)	($1,260,859)	($40,194,581)
Estimated FY 2017-18 Expenditure	**$112,682,516**	**$97,331,680**	**$573,814,992**	**$38,813,714**	**$538,462,572**	**$270,227,894**	**$1,437,514,604**	**$2,107,355**	**$806,054,569**	**$100,777,652**	**$58,540,968**	**$160,524,324**	**$19,296,759**	**$38,993,036**	**$18,890,122**	**$4,274,032,757**
Estimated FY 2017-18 Per Capita	$2,553.02	$8,437.94	$8,127.35	$5,624.36	$2,703.40	$2,483.23	$3,668.34	$11,772.93	$1,613.10	$1,401.83	$2,885.21	$10,871.21	$9,706.62	$14,725.47	$470.66	$2,878.84
% Change over FY 2016-17 Per Capita	-0.56%	0.76%	-0.36%	-1.39%	-3.40%	-0.46%	0.14%	-1.08%	-1.90%	-2.14%	-0.79%	0.34%	0.39%	-0.58%	-4.54%	-1.11%

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

Out Year Projection																
ACUTE CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Percentage Selected to Modify Per Capita[3]	2.50%	1.00%	0.30%	1.00%	-2.00%	0.00%	0.50%	0.00%	0.50%	0.00%	0.82%	1.29%	1.29%	0.00%	1.83%	
Estimated FY 2018-19 Base Per Capita	$2,616.85	$8,522.32	$8,151.73	$5,680.60	$2,649.33	$2,483.23	$3,686.68	$11,772.93	$1,621.17	$1,401.83	$2,908.87	$11,011.45	$9,831.84	$14,725.47	$479.27	$2,880.12
Estimated FY 2018-19 Eligibles	44,870	12,024	71,719	7,913	204,433	116,361	406,112	103	507,864	74,803	20,305	14,767	2,050	2,649	44,859	1,530,832
Estimated FY 2018-19 Base Expenditure	$117,418,060	$102,472,376	$584,633,924	$44,950,588	$541,610,480	$288,951,126	$1,497,204,988	$1,212,612	$823,333,881	$104,861,089	$59,064,605	$162,606,082	$20,155,272	$39,007,770	$21,499,573	$4,408,982,426
Bottom Line Impacts																
Accountable Care Collaborative Savings	($486,709)	($238,271)	($1,995,133)	($664,627)	($435,428)	($559,797)	($740,022)	$0	($392,135)	($221,456)	($1,939)	($356)	($2,862)	$0	$0	($5,738,735)
Estimated Impact of Increasing PACE Enrollment	($1,665,678)	($949,476)	($852,398)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($3,467,552)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($41,603)	($37,212)	($217,955)	($9,405)	($204,700)	($74,525)	($394,607)	($2,214)	($317,574)	($29,577)	($24,723)	($67,521)	($7,140)	($17,636)	($3,831)	($1,450,223)
Annualization of FY 2012-13 R-6: "Dental Efficiency"	($7,621)	($3,984)	($23,335)	($1,007)	($21,916)	($7,979)	($42,248)	($237)	($34,001)	$0	($2,647)	($7,229)	($764)	($1,888)	($410)	($155,266)
Annualization of SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	($1,688)	($4,729)	($32,656)	($1,894)	($53,670)	($18,981)	($103,642)	($335)	($62,340)	($6,110)	($4,471)	($6,562)	($594)	($1,452)	($2)	($299,126)
Annualization of HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	($128,191)	($48,782)	($248,413)	($19,987)	($329,328)	($111,755)	($534,254)	($593)	($686,733)	($69,710)	($33,277)	($42,778)	($4,109)	($6,002)	($56,681)	($2,320,593)
Annualization of Copay 5% of Income	$8,422	$4,226	$29,527	$117	$53,324	$3,249	$108,917	$186	$0	$0	$1,392	$0	$0	$222	$324	$209,906
Annualization of Home Health Final Rule (Location Expansion)	$5,215	$2,591	$12,321	$337	$1,188	$332	$4,813	$1	$2,026	$51	$803	$212	$27	$0	$0	$29,917
Total Bottom Line Impacts	($2,317,853)	($1,275,637)	($3,328,042)	($696,466)	($990,530)	($769,456)	($1,701,043)	($3,192)	($1,490,757)	($326,802)	($64,862)	($124,234)	($15,442)	($26,756)	($60,600)	($13,191,672)
Estimated FY 2018-19 Expenditure	**$115,100,207**	**$101,196,739**	**$581,305,882**	**$44,254,122**	**$540,619,950**	**$288,181,670**	**$1,495,503,945**	**$1,209,420**	**$821,843,124**	**$104,534,287**	**$58,999,743**	**$162,481,848**	**$20,139,830**	**$38,981,014**	**$21,438,973**	**$4,395,790,754**
Estimated FY 2018-19 Per Capita	$2,565.19	$8,416.23	$8,105.33	$5,592.58	$2,644.48	$2,476.62	$3,682.49	$11,741.94	$1,618.23	$1,397.46	$2,905.68	$11,003.04	$9,824.31	$14,715.37	$477.92	$2,871.50
% Change over FY 2017-18 Per Capita	0.48%	-0.26%	-0.27%	-0.57%	-2.18%	-0.27%	0.39%	-0.26%	0.32%	-0.31%	0.71%	1.21%	1.21%	-0.07%	1.54%	-0.25%

(1) Percentage selected to modify Per Capita amounts for Estimated FY 2016-17:	**OAP-A**	The Department has selected a positive trend to account for large increases in Co-Insurance expenditure for this category.	**MAGI Parents/ Caretakers 69% to 133% FPL**	The Department has maintained the FY 2015-16 per capita trend as actuals closely aligned with the forecast. The Department anticipates small positive growth in per capita for this population.	**Foster Care**	The Department has increased the per capita growth trend for this population driven by increases in expenditure for Prescription Drugs and Physician Services.
	OAP-B	The Department believes the higher than expected per capita is driven by higher expenditure in Prescription Drugs. The Department has slightly increased the previous trend selection to modify per capita costs.	**MAGI Adults**	The Department has lowered the trend for this population as per capita is beginning to level out for this population.	**MAGI Pregnant Adults**	The Department has slightly lowered per capita trend from FY 2015-16 due to lower than expected per capita expenditure. A small positive growth is anticipated for this population going forward.
	AND/AB	The Department has slightly increased the trend for this population to account for a higher per capita increase in FY 2015-16. The increase in trend is driven primarily by increases in Prescription Drugs and Inpatient Hospital.	**BCCP**	See Narrative	**SB 11-250 Eligible Pregnant Adults**	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.
	Disabled Buy-in	The Department anticipates the per capita costs for this population to level off and stabilize around the current per capita. A slight upward trend has been selected.	**Eligible Children (AFDC-C/BC)**	The Department has chosen not to change the trend for this population. This population is expected to continue with a small underlying positive trend.	**Non-Citizens Emergency Services**	The Department has maintained the per capita trend for this population given almost zero growth in per capita for this population in FY 2015-16.
	MAGI Parents/ Caretakers to 68% FPL	The Department has selected a downward trend as per capita increases seen in FY 2015-16 were primarily driven by an artificial reduction in caseload. The Department anticipates caseload will return to normal levels and negative per capita trends for the major service categories will continue to drive a negative per capita trend for this eligibility group.	**SB 11-008 Eligible Children**	The Department has chosen a positive trend for this population driven by positive per capita trends for the major service categories utilized by this population. Additionally, slowing of caseload growth puts positive pressure on per capita.	**Partial Dual Eligibles**	The Department has reduced the per capita growth trend for this population although the per capita trend remains very high. This population is driven primarily by large expenditure in Co-Insurance.
(2) Percentage selected to modify Per Capita amounts for Estimated FY 2017-18:	**OAP-A**	The Department has selected a positive trend to account for large increases in Co-Insurance expenditure for this category.	**MAGI Parents/ Caretakers 69% to 133% FPL**	The Department has maintained the FY 2015-16 per capita trend as actuals closely aligned with the forecast. The Department anticipates small positive growth in per capita for this population.	**Foster Care**	The Department has maintained the per capita growth trend for this population driven by increases in expenditure for Prescription Drugs and Physician Services.
	OAP-B	The Department has maintained the FY 2017-18 trend selected in the February request as the higher increase in FY 2016-17 is not expected to continue. The Department anticipates this population will continue to show small steady growth.	**MAGI Adults**	The Department has lowered the trend for this population as per capita is beginning to level out for this population.	**MAGI Pregnant Adults**	The Department has maintained the previous per capita trend from FY 2015-16 due to lower than expected per capita expenditure. A small positive growth is anticipated for this population going forward.
	AND/AB	The Department has slightly increased the trend for this population to account for a higher per capita increase in FY 2015-16. The increase in trend is driven primarily by increases in Prescription Drugs and Inpatient Hospital.	**BCCP**	See Narrative	**SB 11-250 Eligible Pregnant Adults**	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.
	Disabled Buy-in	The Department anticipates the per capita costs for this population to level off and stabilize around the current per capita. A slight upward trend has been selected.	**Eligible Children (AFDC-C/BC)**	The Department anticipates costs will stabilize for this population.	**Non-Citizens Emergency Services**	The Department has maintained the per capita trend for this population given almost zero growth in per capita for this population in FY 2015-16.
	MAGI Parents/ Caretakers to 68% FPL	The Department has selected a downward trend as per capita increases seen in FY 2015-16 were primarily driven by an artificial reduction in caseload. The Department anticipates caseload will return to normal levels and negative per capita trends for the major service categories will continue to drive a negative per capita trend for this eligibility group.	**SB 11-008 Eligible Children**	The Department has selected a flat trend as the Department anticipates per capita will level out over time for this population.	**Partial Dual Eligibles**	The Department believes the large Co-Insurance expenditure driving high per capita trends will reduce significantly in FY 2017-18 and has adjusted the trend downward to account for this change.
(3) Percentage selected to modify Per Capita amounts for Estimated FY 2018-19:	**OAP-A**	The Department has selected a positive trend to account for large increases in Co-Insurance expenditure for this category.	**MAGI Parents/ Caretakers 69% to 133% FPL**	The Department has maintained the previous trend as expenditure increases from previous years are not expected to continue.	**Foster Care**	The Department anticipates per capita costs will stabilize after the shifting caseload mix from expansion put downward pressure on per capita.
	OAP-B	The Department has maintained the FY 2017-18 trend selected in the February request as the higher increase in FY 2016-17 is not expected to continue. The Department anticipates this population will continue to show small steady growth.	**MAGI Adults**	The Department has lowered the trend for this population as per capita is beginning to level out for this population.	**MAGI Pregnant Adults**	The Department has slightly lowered per capita trend from FY 2015-16 due to lower than expected per capita expenditure. A small positive growth is anticipated for this population going forward.
	AND/AB	The Department has slightly increased the trend for this population to account for a higher per capita increase in FY 2015-16. The increase in trend is driven primarily by increases in Prescription Drugs and Inpatient Hospital.	**BCCP**	See Narrative	**SB 11-250 Eligible Pregnant Adults**	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.
	Disabled Buy-in	The Department anticipates the per capita costs for this population to level off and stabilize around the current per capita. A slight upward trend has been selected.	**Eligible Children (AFDC-C/BC)**	The Department anticipates costs will stabilize for this population.	**Non-Citizens Emergency Services**	The Department has maintained the per capita trend for this population given almost zero growth in per capita for this population in FY 2015-16.
	MAGI Parents/ Caretakers to 68% FPL	The Department has selected a downward trend as per capita increases seen in FY 2015-16 were primarily driven by an artificial reduction in caseload. The Department anticipates caseload will return to normal levels and negative per capita trends for the major service categories will continue to drive a negative per capita trend for this eligibility group.	**SB 11-008 Eligible Children**	The Department has selected a flat trend as the Department anticipates per capita will level out over time for this population.	**Partial Dual Eligibles**	The Department has reduced the per capita growth trend for this population although the per capita trend remains very high. This population is driven primarily by large expenditure in Co-Insurance.

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

Breast and Cervical Cancer Program Costs					
Month	**Total [1]**	**Caseload**	**Monthly Per Capita**	**Rolling 3-Month Per Capita**	**Percent Change**
October 2010	$731,130	505	$1,447.78	-	-
November 2010	$838,350	511	$1,640.61	-	-
December 2010	$641,895	526	$1,220.33	$4,308.72	-
January 2011	$858,219	532	$1,613.19	$4,474.13	3.84%
February 2011	$860,735	535	$1,608.85	$4,442.37	-0.71%
March 2011	$758,865	556	$1,364.87	$4,586.91	3.25%
April 2011	$842,553	569	$1,480.76	$4,454.48	-2.89%
May 2011	$977,078	587	$1,664.53	$4,510.16	1.25%
June 2011	$796,240	589	$1,351.85	$4,497.14	-0.29%
July 2011	$905,622	587	$1,542.80	$4,559.18	1.38%
August 2011	$1,098,058	586	$1,873.82	$4,768.47	4.59%
September 2011	$806,654	590	$1,367.21	$4,783.83	0.32%
October 2011	$840,959	592	$1,420.54	$4,661.57	-2.56%
November 2011	$777,937	602	$1,292.25	$4,080.00	-12.48%
December 2011	$948,163	606	$1,564.63	$4,277.42	4.84%
January 2012	$759,376	603	$1,259.33	$4,116.21	-3.77%
February 2012	$807,113	604	$1,336.28	$4,160.24	1.07%
March 2012	$896,406	604	$1,484.12	$4,079.73	-1.94%
April 2012	$931,643	596	$1,563.16	$4,383.56	7.45%
May 2012	$713,371	597	$1,194.93	$4,242.21	-3.22%
June 2012	$787,309	601	$1,310.00	$4,068.09	-4.10%
July 2012	$886,933	607	$1,461.17	$3,966.10	-2.51%
August 2012	$852,135	612	$1,392.38	$4,163.55	4.98%
September 2012	$632,389	610	$1,036.70	$3,890.25	-6.56%
October 2012	$935,272	615	$1,520.77	$3,949.85	1.53%
November 2012	$712,236	615	$1,158.11	$3,715.58	-5.93%
December 2012	$832,382	616	$1,351.27	$4,030.15	8.47%
January 2013	$782,163	613	$1,275.96	$3,785.34	-6.07%
February 2013	$690,923	608	$1,136.39	$3,763.62	-0.57%
March 2013	$766,740	618	$1,240.68	$3,653.03	-2.94%
April 2013	$919,733	639	$1,439.33	$3,816.40	4.47%
May 2013	$768,143	659	$1,165.62	$3,845.63	0.77%
June 2013	$810,981	659	$1,230.62	$3,835.57	-0.26%
July 2013	$1,122,185	660	$1,700.28	$4,096.52	6.80%
August 2013	$1,175,748	648	$1,814.43	$4,745.33	15.84%
September 2013	$1,002,170	645	$1,553.75	$5,068.46	6.81%
October 2013	$962,474	639	$1,506.22	$4,874.40	-3.83%
November 2013	$926,244	547	$1,693.32	$4,753.29	-2.48%
December 2013	$1,187,201	540	$2,198.52	$5,398.06	13.56%
January 2014	$611,981	543	$1,127.04	$5,018.88	-7.02%
February 2014	$366,871	527	$696.15	$4,021.71	-19.87%
March 2014	$320,858	498	$644.29	$2,467.48	-38.65%
April 2014	$288,153	492	$585.68	$1,926.12	-21.94%
May 2014	$180,838	488	$370.57	$1,600.54	-16.90%
June 2014	$288,405	477	$604.62	$1,560.87	-2.48%
July 2014	$267,297	472	$566.31	$1,541.50	-1.24%
August 2014	$300,220	463	$648.42	$1,819.35	18.02%
September 2014	$269,899	439	$614.80	$1,829.53	0.56%
October 2014	$221,649	424	$522.76	$1,785.98	-2.38%
November 2014	$240,183	425	$565.14	$1,702.70	-4.66%
December 2014	$254,288	396	$642.14	$1,730.04	1.61%
January 2015	$286,671	379	$756.39	$1,963.67	13.50%
February 2015	$255,665	368	$694.74	$2,093.27	6.60%
March 2015	$214,604	368	$583.16	$2,034.29	-2.82%
April 2015	$155,909	361	$431.88	$1,709.78	-15.95%
May 2015	$231,036	358	$645.35	$1,660.39	-2.89%
June 2015	$243,392	352	$691.45	$1,768.68	6.52%
July 2015	$209,532	344	$609.10	$1,945.90	10.02%
August 2015	$255,049	342	$745.76	$2,046.31	5.16%
September 2015	$191,741	342	$560.65	$1,915.51	-6.39%
October 2015	$142,919	336	$425.35	$1,731.76	-9.59%
November 2015	$287,605	324	$887.67	$1,873.67	8.19%
December 2015	$168,669	318	$530.41	$1,843.43	-1.61%
January 2016	$178,787	314	$569.39	$1,987.47	7.81%
February 2016	$275,628	310	$889.12	$1,988.92	0.07%
March 2016	$167,748	311	$539.38	$1,997.89	0.45%
April 2016	$256,038	308	$831.29	$2,259.79	13.11%
May 2016	$256,612	308	$833.16	$2,203.83	-2.48%
June 2016	$202,084	304	$664.75	$2,329.20	5.69%
FY 2015-16 Totals	$3,847,424	322	$11,948.52		
FY 2016-17 Totals [2]	$3,403,741	286	$11,912.67		**-0.30%**
FY 2017-18 Totals [2]	$2,107,355	179	$11,888.84		**-0.20%**
FY 2018-19 Totals [2]	$1,209,420	103	$11,888.84		**0.00%**

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

(2) The FY 2016-17 through FY 2018-19 totals are calculated on page EF-2 and include bottom line impacts. Caseload totals are taken from Exhibit B.

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

Breast and Cervical Cancer Program Fund Splits								
FY 2016-17 Fund Splits	**Per Capita [2]**	**Allocation**	**Caseload**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Breast and Cervical Cancer Program Clients [1]	$11,901.19	100.00%	286	$3,403,741	$0	$1,186,884	$0	$2,216,857
Total	**$11,901.19**	**100.00%**	**286**	**$3,403,741**	**$0**	**$1,186,884**	**$0**	**$2,216,857**
FY 2017-18 Fund Splits	**Per Capita [2]**	**Allocation**	**Caseload**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Breast and Cervical Cancer Program Clients [1]	$11,772.93	100.00%	179	$2,107,354	$0	$737,574	$0	$1,369,780
Total	**$11,772.93**	**100.00%**	**179**	**$2,107,354**	**$0**	**$737,574**	**$0**	**$1,369,780**
FY 2018-19 Fund Splits	**Per Capita [2]**	**Allocation**	**Caseload**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Breast and Cervical Cancer Program Clients [1]	$11,741.94	100.00%	103	$1,209,420	$0	$423,297	$0	$786,123
Total	**$11,741.94**	**100.00%**	**103**	**$1,209,420**	**$0**	**$423,297**	**$0**	**$786,123**
(1) 25.5-5-308 (9) (g), C.R.S. (2014). 100% of the State share is from the Breast and Cervical Cancer Prevention and Treatment Fund, 65.00% federal financial participation beginning October 1, 2016.								
(2) Base per capita growth in FY 2016-17 through FY 2018-19 remains flat. All increases/decreases to per capita are the result of bottom line adjustments.								

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

Total Dental Expenditure for Populations Eligible for Adult Dental Cash Fund Funding

TOTAL DENTAL EXPENDITURE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2008-09	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2009-10 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2010-11 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2011-12	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2012-13	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2013-14	$1,724,207	$535,633	$3,064,480	$0	$7,673,356	$0	$0	$0	$0	$0	$0	$515,132	$37,738	$0	$0	$13,550,546
FY 2014-15	$7,169,838	$2,544,922	$11,692,964	$0	$27,021,394	$0	$0	$0	$0	$0	$124,035	$1,715,917	$224,850	$0	$0	$50,493,920
FY 2015-16	$9,640,672	$3,286,270	$15,550,126	$0	$30,998,068	$0	$0	$0	$0	$0	$157,955	$2,237,470	$244,911	$0	$0	$62,115,473
Estimated FY 2016-17	$10,694,112	$3,759,380	$16,710,298	$0	$38,244,159	$0	$0	$0	$0	$0	$165,719	$2,498,976	$277,999	$0	$0	$72,350,643
Estimated FY 2017-18	$11,326,437	$4,080,276	$17,698,760	$0	$40,557,032	$0	$0	$0	$0	$0	$169,624	$2,611,958	$292,216	$0	$0	$76,736,303
Estimated FY 2018-19	$11,755,043	$4,345,113	$18,297,668	$0	$42,125,464	$0	$0	$0	$0	$0	$171,374	$2,671,055	$304,097	$0	$0	$79,669,814

Percent Change in Total Dental Expenditure for Populations Eligible for Adult Dental Cash Fund Funding

TOTAL DENTAL EXPENDITURE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2009-10 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2010-11 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2011-12	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2012-13	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2013-14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2014-15	315.83%	375.12%	281.56%	0.00%	252.15%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	233.10%	495.82%	0.00%	0.00%	272.63%
FY 2015-16	34.46%	29.13%	32.99%	0.00%	14.72%	0.00%	0.00%	0.00%	0.00%	0.00%	27.35%	30.39%	8.92%	0.00%	0.00%	23.02%
Estimated FY 2016-17	10.93%	14.40%	7.46%	0.00%	23.38%	0.00%	0.00%	0.00%	0.00%	0.00%	4.92%	11.69%	13.51%	0.00%	0.00%	16.48%
Estimated FY 2017-18	5.91%	8.54%	5.92%	0.00%	6.05%	0.00%	0.00%	0.00%	0.00%	0.00%	2.36%	4.52%	5.11%	0.00%	0.00%	6.06%
Estimated FY 2018-19	3.78%	6.49%	3.38%	0.00%	3.87%	0.00%	0.00%	0.00%	0.00%	0.00%	1.03%	2.26%	4.07%	0.00%	0.00%	3.82%

Per Capita Cost for Total Dental Expenditure for Populations Eligible for Adult Dental Cash Fund Funding

TOTAL DENTAL EXPENDITURE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2008-09	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2009-10 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2010-11 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2011-12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2012-13	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2013-14	$41.21	$54.36	$47.57	$0.00	$61.54	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$39.14	$35.70	$0.00	$0.00	$15.74
FY 2014-15	$171.46	$243.16	$175.71	$0.00	$167.13	$0.00	$0.00	$0.00	$0.00	$0.00	$6.19	$115.19	$128.56	$0.00	$0.00	$43.48
FY 2015-16	$227.36	$312.12	$226.02	$0.00	$189.77	$0.00	$0.00	$0.00	$0.00	$0.00	$7.92	$155.24	$139.23	$0.00	$0.00	$47.89
Estimated FY 2016-17	$246.34	$339.08	$242.08	$0.00	$198.86	$0.00	$0.00	$0.00	$0.00	$0.00	$8.21	$169.25	$144.34	$0.00	$0.00	$51.13
Estimated FY 2017-18	$256.62	$353.73	$250.68	$0.00	$203.62	$0.00	$0.00	$0.00	$0.00	$0.00	$8.36	$176.89	$146.99	$0.00	$0.00	$51.69
Estimated FY 2018-19	$261.98	$361.37	$255.13	$0.00	$206.06	$0.00	$0.00	$0.00	$0.00	$0.00	$8.44	$180.88	$148.34	$0.00	$0.00	$52.04

Percent Change in Per Capita Cost for Total Dental Expenditure for Populations Eligible for Adult Dental Cash Fund Funding

TOTAL DENTAL EXPENDITURE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2009-10 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2010-11 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2011-12	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2012-13	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2013-14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2014-15	316.06%	347.31%	269.37%	0.00%	171.58%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	194.30%	260.11%	0.00%	0.00%	176.24%
FY 2015-16	32.60%	28.36%	28.63%	0.00%	13.55%	0.00%	0.00%	0.00%	0.00%	0.00%	27.95%	34.77%	8.30%	0.00%	0.00%	10.14%
Estimated FY 2016-17	8.35%	8.64%	7.11%	0.00%	4.79%	0.00%	0.00%	0.00%	0.00%	0.00%	3.66%	9.02%	3.67%	0.00%	0.00%	6.77%
Estimated FY 2017-18	4.17%	4.32%	3.55%	0.00%	2.39%	0.00%	0.00%	0.00%	0.00%	0.00%	1.83%	4.51%	1.84%	0.00%	0.00%	1.10%
Estimated FY 2018-19	2.09%	2.16%	1.78%	0.00%	1.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.96%	2.26%	0.92%	0.00%	0.00%	0.68%

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

Emergency and Co-Occurring Expenditure for Populations Eligible for Adult Dental Cash Fund Funding

EMERGENCY AND CO-OCCURRING EXPENDITURE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2008-09	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2009-10 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2010-11 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2011-12	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2012-13	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2013-14	$1,523,204	$458,063	$2,565,198	$0	$5,329,502	$0	$0	$0	$0	$0	$0	$363,972	$27,898	$0	$0	$10,267,837
FY 2014-15	$1,293,858	$414,266	$2,251,111	$0	$5,933,070	$0	$0	$0	$0	$0	$40,559	$350,446	$39,318	$0	$0	$10,322,628
FY 2015-16	$918,640	$291,759	$1,629,371	$0	$4,196,565	$0	$0	$0	$0	$0	$26,261	$237,239	$27,681	$0	$0	$7,327,516
Estimated FY 2016-17	$893,419	$291,810	$1,553,130	$0	$4,694,458	$0	$0	$0	$0	$0	$25,231	$230,925	$28,794	$0	$0	$7,717,767
Estimated FY 2017-18	$899,071	$300,602	$1,573,035	$0	$4,814,181	$0	$0	$0	$0	$0	$25,160	$228,578	$29,422	$0	$0	$7,870,049
Estimated FY 2018-19	$905,028	$310,219	$1,582,121	$0	$4,892,082	$0	$0	$0	$0	$0	$24,975	$226,378	$30,033	$0	$0	$7,970,836

Percent Change in Emergency and Co-Occurring Expenditure for Populations Eligible for Adult Dental Cash Fund Funding

EMERGENCY AND CO-OCCURRING EXPENDITURE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2009-10 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2010-11 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2011-12	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2012-13	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2013-14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2014-15	-15.06%	-9.56%	-12.24%	0.00%	11.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-3.72%	40.93%	0.00%	0.00%	0.53%
FY 2015-16	-29.00%	-29.57%	-27.62%	0.00%	-29.27%	0.00%	0.00%	0.00%	0.00%	0.00%	-35.25%	-32.30%	-29.60%	0.00%	0.00%	-29.02%
Estimated FY 2016-17	-2.75%	0.02%	-4.68%	0.00%	11.86%	0.00%	0.00%	0.00%	0.00%	0.00%	-3.92%	-2.66%	4.02%	0.00%	0.00%	5.33%
Estimated FY 2017-18	0.63%	3.01%	1.28%	0.00%	2.55%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.28%	-1.02%	2.18%	0.00%	0.00%	1.97%
Estimated FY 2018-19	0.66%	3.20%	0.58%	0.00%	1.62%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.74%	-0.96%	2.08%	0.00%	0.00%	1.28%

Per Capita Cost for Emergency and Co-Occurring Expenditure for Populations Eligible for Adult Dental Cash Fund Funding

EMERGENCY AND CO-OCCURRING EXPENDITURE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2008-09	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2009-10 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2010-11 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2011-12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2012-13	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2013-14	$36.41	$46.49	$39.82	$0.00	$42.75	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$27.66	$26.39	$0.00	$0.00	$11.93
FY 2014-15	$30.94	$39.58	$33.83	$0.00	$36.70	$0.00	$0.00	$0.00	$0.00	$0.00	$2.02	$23.52	$22.48	$0.00	$0.00	$8.89
FY 2015-16	$21.66	$27.71	$23.68	$0.00	$25.69	$0.00	$0.00	$0.00	$0.00	$0.00	$1.32	$16.46	$15.74	$0.00	$0.00	$5.65
Estimated FY 2016-17	$20.58	$26.32	$22.50	$0.00	$24.41	$0.00	$0.00	$0.00	$0.00	$0.00	$1.25	$15.64	$14.95	$0.00	$0.00	$5.45
Estimated FY 2017-18	$20.37	$26.06	$22.28	$0.00	$24.17	$0.00	$0.00	$0.00	$0.00	$0.00	$1.24	$15.48	$14.80	$0.00	$0.00	$5.30
Estimated FY 2018-19	$20.17	$25.80	$22.06	$0.00	$23.93	$0.00	$0.00	$0.00	$0.00	$0.00	$1.23	$15.33	$14.65	$0.00	$0.00	$5.21

Percent Change in Per Capita Cost for Emergency and Co-Occurring Expenditure for Populations Eligible for Adult Dental Cash Fund Funding

EMERGENCY AND CO-OCCURRING EXPENDITURE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2009-10 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2010-11 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2011-12	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2012-13	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2013-14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2014-15	-15.02%	-14.86%	-15.04%	0.00%	-14.15%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-14.97%	-14.82%	0.00%	0.00%	-25.48%
FY 2015-16	-29.99%	-29.99%	-30.00%	0.00%	-30.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-34.65%	-30.02%	-29.98%	0.00%	0.00%	-36.45%
Estimated FY 2016-17	-4.99%	-5.02%	-4.98%	0.00%	-4.98%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.30%	-4.98%	-5.02%	0.00%	0.00%	-3.54%
Estimated FY 2017-18	-1.02%	-0.99%	-0.98%	0.00%	-0.98%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.80%	-1.02%	-1.00%	0.00%	0.00%	-2.75%
Estimated FY 2018-19	-0.98%	-1.00%	-0.99%	0.00%	-0.99%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.81%	-0.97%	-1.01%	0.00%	0.00%	-1.70%

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

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

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2008-09	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2009-10 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2010-11 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2011-12	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2012-13	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2013-14	$201,003	$77,570	$499,282	$0	$2,343,854	$0	$0	$0	$0	$0	$0	$151,160	$9,840	$0	$0	$3,282,709
FY 2014-15	$5,875,980	$2,130,656	$9,441,853	$0	$21,088,324	$0	$0	$0	$0	$0	$83,476	$1,365,471	$185,532	$0	$0	$40,171,292
FY 2015-16	$8,722,032	$2,994,511	$13,920,756	$0	$26,801,503	$0	$0	$0	$0	$0	$131,694	$2,000,230	$217,230	$0	$0	$54,787,957
Estimated FY 2016-17	$9,800,693	$3,467,570	$15,157,168	$0	$33,549,701	$0	$0	$0	$0	$0	$140,488	$2,268,052	$249,205	$0	$0	$64,632,877
Estimated FY 2017-18	$10,427,366	$3,779,673	$16,125,725	$0	$35,742,851	$0	$0	$0	$0	$0	$144,465	$2,383,380	$262,794	$0	$0	$68,866,254
Estimated FY 2018-19	$10,850,015	$4,034,894	$16,715,547	$0	$37,233,382	$0	$0	$0	$0	$0	$146,399	$2,444,677	$274,065	$0	$0	$71,698,979

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

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2009-10 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2010-11 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2011-12	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2012-13	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2013-14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2014-15	2823.33%	2646.75%	1791.09%	0.00%	799.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	803.33%	1785.49%	0.00%	0.00%	1123.72%
FY 2015-16	48.44%	40.54%	47.44%	0.00%	27.09%	0.00%	0.00%	0.00%	0.00%	0.00%	57.76%	46.49%	17.08%	0.00%	0.00%	36.39%
Estimated FY 2016-17	12.37%	15.80%	8.88%	0.00%	25.18%	0.00%	0.00%	0.00%	0.00%	0.00%	6.68%	13.39%	14.72%	0.00%	0.00%	17.97%
Estimated FY 2017-18	6.39%	9.00%	6.39%	0.00%	6.54%	0.00%	0.00%	0.00%	0.00%	0.00%	2.83%	5.08%	5.45%	0.00%	0.00%	6.55%
Estimated FY 2018-19	4.05%	6.75%	3.66%	0.00%	4.17%	0.00%	0.00%	0.00%	0.00%	0.00%	1.34%	2.57%	4.29%	0.00%	0.00%	4.11%

Per Capita Cost for Adult Dental Benefit Expenditure with State Share Paid by the Adult Dental Cash Fund

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2008-09	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2009-10 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2010-11 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2011-12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2012-13	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2013-14	$4.80	$7.87	$7.75	$0.00	$18.80	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$11.49	$9.31	$0.00	$0.00	$3.81
FY 2014-15	$140.52	$203.58	$141.88	$0.00	$130.43	$0.00	$0.00	$0.00	$0.00	$0.00	$4.17	$91.66	$106.08	$0.00	$0.00	$34.59
FY 2015-16	$205.69	$284.41	$202.34	$0.00	$164.08	$0.00	$0.00	$0.00	$0.00	$0.00	$6.61	$138.78	$123.50	$0.00	$0.00	$42.24
Estimated FY 2016-17	$225.76	$312.76	$219.58	$0.00	$174.45	$0.00	$0.00	$0.00	$0.00	$0.00	$6.96	$153.61	$129.39	$0.00	$0.00	$45.68
Estimated FY 2017-18	$236.25	$327.67	$228.40	$0.00	$179.45	$0.00	$0.00	$0.00	$0.00	$0.00	$7.12	$161.41	$132.19	$0.00	$0.00	$46.39
Estimated FY 2018-19	$241.81	$335.57	$233.07	$0.00	$182.13	$0.00	$0.00	$0.00	$0.00	$0.00	$7.21	$165.55	$133.69	$0.00	$0.00	$46.84

Percent Change in Per Capita Cost for Adult Dental Benefit Expenditure with State Share Paid by the Adult Dental Cash Fund

ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2009-10 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2010-11 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2011-12	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2012-13	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2013-14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2014-15	2827.50%	2486.79%	1730.71%	0.00%	593.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	697.74%	1039.42%	0.00%	0.00%	807.87%
FY 2015-16	46.38%	39.70%	42.61%	0.00%	25.80%	0.00%	0.00%	0.00%	0.00%	0.00%	58.51%	51.41%	16.42%	0.00%	0.00%	22.12%
Estimated FY 2016-17	9.76%	9.97%	8.52%	0.00%	6.32%	0.00%	0.00%	0.00%	0.00%	0.00%	5.30%	10.69%	4.77%	0.00%	0.00%	8.14%
Estimated FY 2017-18	4.65%	4.77%	4.02%	0.00%	2.87%	0.00%	0.00%	0.00%	0.00%	0.00%	2.30%	5.08%	2.16%	0.00%	0.00%	1.55%
Estimated FY 2018-19	2.35%	2.41%	2.04%	0.00%	1.49%	0.00%	0.00%	0.00%	0.00%	0.00%	1.26%	2.56%	1.13%	0.00%	0.00%	0.97%

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

Current Year Projection

CALCULATION OF ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Total Dental																
Total Dental Per Capita Trend Factor	8.35%	8.64%	7.10%	0.00%	4.79%	0.00%	0.00%	0.00%	0.00%	0.00%	3.67%	9.03%	3.67%	0.00%	0.00%	
Estimated FY 2016-17 Total Dental Per Capita	$246.34	$339.08	$242.08	$0.00	$198.86	$0.00	$0.00	$0.00	$0.00	$0.00	$8.21	$169.25	$144.34	$0.00	$0.00	$1,348.16
Estimated FY 2016-17 Eligible Caseload	43,412	11,087	69,028	5,844	192,317	98,910	366,209	286	486,863	65,529	20,185	14,765	1,926	2,646	35,909	1,414,916
Estimated FY 2016-17 Total Dental Expenditure	**$10,694,112**	**$3,759,380**	**$16,710,298**	**$0**	**$38,244,159**	**$0**	**$0**	**$0**	**$0**	**$0**	**$165,719**	**$2,498,976**	**$277,999**	**$0**	**$0**	**$72,350,643**
Emergency and Co-Occurring Dental																
Emergency and Co-Occurring Dental Per Capita Trend Factor	-5.00%	-5.00%	-5.00%	0.00%	-5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.00%	-5.00%	-5.00%	0.00%	0.00%	
Estimated FY 2016-17 Emergency and Co-Occurring Dental Per Capita	$20.58	$26.32	$22.50	$0.00	$24.41	$0.00	$0.00	$0.00	$0.00	$0.00	$1.25	$15.64	$14.95	$0.00	$0.00	$125.65
Estimated FY 2016-17 Eligible Caseload	43,412	11,087	69,028	5,844	192,317	98,910	366,209	286	486,863	65,529	20,185	14,765	1,926	2,646	35,909	1,414,916
Estimated FY 2016-17 Emergency and Co-Occurring Dental Expenditure	**$893,419**	**$291,810**	**$1,553,130**	**$0**	**$4,694,458**	**$0**	**$0**	**$0**	**$0**	**$0**	**$25,231**	**$230,925**	**$28,794**	**$0**	**$0**	**$7,717,767**
Adult Dental Benefit																
Estimated FY 2016-17 Adult Dental Benefit Per Capita	$225.76	$312.76	$219.58	$0.00	$174.45	$0.00	$0.00	$0.00	$0.00	$0.00	$6.96	$153.61	$129.39	$0.00	$0.00	$1,222.51
Estimated FY 2016-17 Eligible Caseload	43,412	11,087	69,028	5,844	192,317	98,910	366,209	286	486,863	65,529	20,185	14,765	1,926	2,646	35,909	1,414,916
Estimated FY 2016-17 Adult Dental Benefit Expenditure	**$9,800,693**	**$3,467,570**	**$15,157,168**	**$0**	**$33,549,701**	**$0**	**$0**	**$0**	**$0**	**$0**	**$140,488**	**$2,268,052**	**$249,205**	**$0**	**$0**	**$64,632,877**

Request Year Projection

CALCULATION OF ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Total Dental																
Total Dental Per Capita Trend Factor	4.17%	4.32%	3.55%	0.00%	2.40%	0.00%	0.00%	0.00%	0.00%	0.00%	1.83%	4.51%	1.83%	0.00%	0.00%	0.00%
Estimated FY 2017-18 Total Dental Per Capita	$256.62	$353.73	$250.68	$0.00	$203.62	$0.00	$0.00	$0.00	$0.00	$0.00	$8.36	$176.89	$146.99	$0.00	$0.00	$1,396.89
Estimated FY 2017-18 Eligible Caseload	44,137	11,535	70,603	6,901	199,180	108,821	391,871	179	499,692	71,890	20,290	14,766	1,988	2,648	40,135	1,484,636
Estimated FY 2017-18 Total Dental Expenditure	**$11,326,437**	**$4,080,276**	**$17,698,760**	**$0**	**$40,557,032**	**$0**	**$0**	**$0**	**$0**	**$0**	**$169,624**	**$2,611,958**	**$292,216**	**$0**	**$0**	**$76,736,303**
Emergency and Co-Occurring Dental																
Emergency and Co-Occurring Dental Per Capita Trend Factor	-1.00%	-1.00%	-1.00%	0.00%	-1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.00%	-1.00%	-1.00%	0.00%	0.00%	0.00%
Estimated FY 2017-18 Emergency and Co-Occurring Dental Per Capita	$20.37	$26.06	$22.28	$0.00	$24.17	$0.00	$0.00	$0.00	$0.00	$0.00	$1.24	$15.48	$14.80	$0.00	$0.00	$124.40
Estimated FY 2017-18 Eligible Caseload	44,137	11,535	70,603	6,901	199,180	108,821	391,871	179	499,692	71,890	20,290	14,766	1,988	2,648	40,135	1,484,636
Estimated FY 2017-18 Emergency and Co-Occurring Dental Expenditure	**$899,071**	**$300,602**	**$1,573,035**	**$0**	**$4,814,181**	**$0**	**$0**	**$0**	**$0**	**$0**	**$25,160**	**$228,578**	**$29,422**	**$0**	**$0**	**$7,870,049**
Adult Dental Benefit																
Estimated FY 2017-18 Adult Dental Benefit Per Capita	$236.25	$327.67	$228.40	$0.00	$179.45	$0.00	$0.00	$0.00	$0.00	$0.00	$7.12	$161.41	$132.19	$0.00	$0.00	$1,272.49
Estimated FY 2017-18 Eligible Caseload	44,137	11,535	70,603	6,901	199,180	108,821	391,871	179	499,692	71,890	20,290	14,766	1,988	2,648	40,135	1,484,636
Estimated FY 2017-18 Adult Dental Benefit Expenditure	**$10,427,366**	**$3,779,673**	**$16,125,725**	**$0**	**$35,742,851**	**$0**	**$0**	**$0**	**$0**	**$0**	**$144,465**	**$2,383,380**	**$262,794**	**$0**	**$0**	**$68,866,254**

Out Year Projection

CALCULATION OF ADULT DENTAL CASH FUND-ELIGIBLE DENTAL SERVICES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Total Dental																
Total Dental Per Capita Trend Factor	2.09%	2.16%	1.78%	0.00%	1.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.92%	2.26%	0.92%	0.00%	0.00%	0.00%
Estimated FY 2018-19 Total Dental Per Capita	$261.98	$361.37	$255.13	$0.00	$206.06	$0.00	$0.00	$0.00	$0.00	$0.00	$8.44	$180.88	$148.34	$0.00	$0.00	$1,422.20
Estimated FY 2018-19 Eligible Caseload	44,870	12,024	71,719	7,913	204,433	116,361	406,112	103	507,864	74,803	20,305	14,767	2,050	2,649	44,859	1,530,832
Estimated FY 2018-19 Total Dental Expenditure	**$11,755,043**	**$4,345,113**	**$18,297,668**	**$0**	**$42,125,464**	**$0**	**$0**	**$0**	**$0**	**$0**	**$171,374**	**$2,671,055**	**$304,097**	**$0**	**$0**	**$79,669,814**
Emergency and Co-Occurring Dental																
Emergency and Co-Occurring Dental Per Capita Trend Factor	-1.00%	-1.00%	-1.00%	0.00%	-1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.00%	-1.00%	-1.00%	0.00%	0.00%	0.00%
Estimated FY 2018-19 Emergency and Co-Occurring Dental Per Capita	$20.17	$25.80	$22.06	$0.00	$23.93	$0.00	$0.00	$0.00	$0.00	$0.00	$1.23	$15.33	$14.65	$0.00	$0.00	$123.17
Estimated FY 2018-19 Eligible Caseload	44,870	12,024	71,719	7,913	204,433	116,361	406,112	103	507,864	74,803	20,305	14,767	2,050	2,649	44,859	1,530,832
Estimated FY 2018-19 Emergency and Co-Occurring Dental Expenditure	**$905,028**	**$310,219**	**$1,582,121**	**$0**	**$4,892,082**	**$0**	**$0**	**$0**	**$0**	**$0**	**$24,975**	**$226,378**	**$30,033**	**$0**	**$0**	**$7,970,836**
Adult Dental Benefit																
Estimated FY 2018-19 Adult Dental Benefit Per Capita	$241.81	$335.57	$233.07	$0.00	$182.13	$0.00	$0.00	$0.00	$0.00	$0.00	$7.21	$165.55	$133.69	$0.00	$0.00	$1,299.03
Estimated FY 2018-19 Eligible Caseload	44,870	12,024	71,719	7,913	204,433	116,361	406,112	103	507,864	74,803	20,305	14,767	2,050	2,649	44,859	1,530,832
Estimated FY 2018-19 Adult Dental Benefit Expenditure	**$10,850,015**	**$4,034,894**	**$16,715,547**	**$0**	**$37,233,382**	**$0**	**$0**	**$0**	**$0**	**$0**	**$146,399**	**$2,444,677**	**$274,065**	**$0**	**$0**	**$71,698,979**

Adult Dental Cash Fund - Fund Splits

FY 2016-17

Eligibility Category	Caseload	Per Capita	FMAP	Total Funds [1]	General Fund	Adult Dental Fund	Federal Funds
Adults 65 and Older (OAP-A)	43,412	$225.76	50.20%	$9,800,693	$0	$4,880,745	$4,919,948
Disabled Adults 60 to 64 (OAP-B)	11,087	$312.76	50.20%	$3,467,570	$0	$1,726,850	$1,740,720
Disabled Individuals to 59 (AND/AB)	69,028	$219.58	50.20%	$15,157,168	$0	$7,548,270	$7,608,898
MAGI Parents/Caretakers to 68% FPL	192,317	$174.45	50.20%	$33,549,701	$0	$16,707,751	$16,841,950
Foster Care	20,185	$6.96	50.20%	$140,488	$0	$69,963	$70,525
MAGI Pregnant Adults	14,765	$153.61	50.20%	$2,268,052	$0	$1,129,490	$1,138,562
SB 11-250 Eligible Pregnant Adults	1,926	$129.39	88.13%	$249,205	$0	$29,581	$219,624
Total	**352,720**	**$183.24**		**$64,632,877**	**$0**	**$32,092,650**	**$32,540,227**

FY 2017-18

Eligibility Category	Caseload	Per Capita	FMAP	Total Funds [1]	General Fund	Adult Dental Fund	Federal Funds
Adults 65 and Older (OAP-A)	44,137	$236.25	50.00%	$10,427,366	$0	$5,213,683	$5,213,683
Disabled Adults 60 to 64 (OAP-B)	11,535	$327.67	50.00%	$3,779,673	$0	$1,889,836	$1,889,837
Disabled Individuals to 59 (AND/AB)	70,603	$228.40	50.00%	$16,125,725	$0	$8,062,862	$8,062,863
MAGI Parents/Caretakers to 68% FPL	199,180	$179.45	50.00%	$35,742,851	$0	$17,871,425	$17,871,426
Foster Care	20,290	$7.12	50.00%	$144,465	$0	$72,232	$72,233
MAGI Pregnant Adults	14,766	$161.41	50.00%	$2,383,380	$0	$1,191,690	$1,191,690
SB 11-250 Eligible Pregnant Adults	1,988	$132.19	88.00%	$262,794	$0	$31,535	$231,259
Total	**362,499**	**$189.98**		**$68,866,254**	**$0**	**$34,333,263**	**$34,532,991**

FY 2018-19

Eligibility Category	Caseload	Per Capita	FMAP	Total Funds [1]	General Fund	Adult Dental Fund	Federal Funds
Adults 65 and Older (OAP-A)	44,870	$241.81	50.00%	$10,850,015	$0	$5,425,007	$5,425,008
Disabled Adults 60 to 64 (OAP-B)	12,024	$335.57	50.00%	$4,034,894	$0	$2,017,447	$2,017,447
Disabled Individuals to 59 (AND/AB)	71,719	$233.07	50.00%	$16,715,547	$0	$8,357,773	$8,357,774
MAGI Parents/Caretakers to 68% FPL	204,433	$182.13	50.00%	$37,233,382	$0	$18,616,691	$18,616,691
Foster Care	20,305	$7.21	50.00%	$146,399	$0	$73,199	$73,200
MAGI Pregnant Adults	14,767	$165.55	50.00%	$2,444,677	$0	$1,222,338	$1,222,339
SB 11-250 Eligible Pregnant Adults	2,050	$133.69	88.00%	$274,065	$0	$32,888	$241,177
Total	**370,168**	**$193.69**		**$71,698,979**	**$0**	**$35,745,343**	**$35,953,636**

(1) Figures may not sum due to rounding.

(1) Figures may not sum due to rounding.

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

Cash Based Actuals

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	$479,529	$1,222,769	$19,965,507	$0	$2,110,260	$0	$0	$183	$2,688,319	$0	$7,814,333	$13,828	$0	$0	$0	$34,294,729
FY 2007-08	$476,587	$1,416,439	$22,587,953	$0	$2,583,540	$0	$0	$7,201	$3,116,761	$0	$8,901,950	$23,191	$0	$0	$0	$39,113,622
FY 2008-09	$574,003	$1,594,319	$22,596,632	$0	$3,589,477	$0	$0	$13,539	$3,477,458	$0	$8,956,851	$50,359	$0	$0	$0	$40,852,638
FY 2009-10 (DA)	$624,336	$1,845,804	$23,477,770	$0	$4,244,208	$66,514	$0	$31,055	$3,652,240	$0	$8,663,502	$61,246	$0	$0	$0	$42,666,675
FY 2010-11 (DA)	$528,892	$2,236,572	$27,074,670	$0	$4,769,442	$469,727	$0	$41,477	$3,795,327	$0	$8,465,862	$77,588	$0	$0	$0	$47,459,557
FY 2011-12	$332,196	$2,736,142	$29,681,347	$3,181	$5,332,883	$1,369,338	$51,852	$45,428	$4,356,981	$0	$8,441,242	$76,112	$0	$0	$0	$52,426,702
FY 2012-13	$227,134	$1,750,998	$19,898,570	$84,657	$3,831,667	$1,085,249	$1,625,465	$45,947	$3,866,964	$0	$5,970,754	$34,100	$0	$0	$0	$38,421,504
FY 2013-14	$282,005	$1,757,115	$20,280,399	$245,383	$5,504,911	$1,214,763	$6,440,111	$27,008	$5,079,647	$0	$5,561,277	$127,504	$0	$0	$0	$46,520,123
FY 2014-15	$354,548	$1,913,420	$23,170,439	$350,257	$7,994,048	$2,036,423	$18,380,238	$8,559	$5,759,480	$1,439,830	$5,512,907	$246,279	$14,280	$0	$0	$67,180,708
FY 2015-16	$254,768	$2,138,042	$26,384,820	$512,151	$8,948,318	$1,193,397	$25,881,859	$1,859	$6,520,516	$1,328,294	$5,079,981	$234,283	$12,260	$0	$0	$78,490,548

Percent Change in Cash Based Actuals

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	-0.61%	15.84%	13.13%	0.00%	22.43%	0.00%	0.00%	3839.28%	15.94%	0.00%	13.92%	67.71%	0.00%	0.00%	0.00%	14.05%
FY 2008-09	20.44%	12.56%	0.04%	0.00%	38.94%	0.00%	0.00%	88.02%	11.57%	0.00%	0.62%	117.15%	0.00%	0.00%	0.00%	4.45%
FY 2009-10 (DA)	8.77%	15.77%	3.90%	0.00%	18.24%	0.00%	0.00%	129.37%	5.03%	0.00%	-3.28%	21.62%	0.00%	0.00%	0.00%	4.44%
FY 2010-11 (DA)	-15.29%	21.17%	15.32%	0.00%	12.38%	606.21%	0.00%	33.56%	3.92%	0.00%	-2.28%	26.68%	0.00%	0.00%	0.00%	11.23%
FY 2011-12	-37.19%	22.34%	9.63%	0.00%	11.81%	191.52%	0.00%	9.53%	14.80%	0.00%	-0.29%	-1.90%	0.00%	0.00%	0.00%	10.47%
FY 2012-13	-31.63%	-36.00%	-32.96%	2561.41%	-28.15%	-20.75%	3034.82%	1.14%	-11.25%	0.00%	-29.27%	-55.20%	0.00%	0.00%	0.00%	-26.71%
FY 2013-14	24.16%	0.35%	1.92%	189.86%	43.67%	11.93%	296.20%	-41.22%	31.36%	0.00%	-6.86%	273.92%	0.00%	0.00%	0.00%	21.08%
FY 2014-15	25.72%	8.90%	14.25%	42.74%	45.22%	67.64%	185.40%	-68.31%	13.38%	0.00%	-0.87%	93.15%	0.00%	0.00%	0.00%	44.41%
FY 2015-16	-28.14%	11.74%	13.87%	46.22%	11.94%	-41.40%	40.81%	-78.28%	13.21%	-7.75%	-7.85%	-4.87%	-14.15%	0.00%	0.00%	16.83%

Per Capita Cost

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	$13.36	$201.81	$409.14	$0.00	$37.78	$0.00	$0.00	$0.80	$13.09	$0.00	$467.25	$2.67	$0.00	$0.00	$0.00	$87.44
FY 2007-08	$13.13	$230.47	$452.37	$0.00	$48.31	$0.00	$0.00	$26.67	$15.28	$0.00	$519.34	$3.69	$0.00	$0.00	$0.00	$99.79
FY 2008-09	$15.26	$247.30	$440.01	$0.00	$58.01	$0.00	$0.00	$42.71	$14.79	$0.00	$496.69	$7.22	$0.00	$0.00	$0.00	$93.52
FY 2009-10 (DA)	$16.22	$261.85	$440.78	$0.00	$56.71	$20.54	$0.00	$73.07	$13.25	$0.00	$471.33	$7.82	$0.00	$0.00	$0.00	$85.54
FY 2010-11 (DA)	$13.59	$287.96	$481.03	$0.00	$58.80	$17.29	$0.00	$78.11	$12.55	$0.00	$460.28	$9.86	$0.00	$0.00	$0.00	$84.63
FY 2011-12	$8.36	$326.39	$499.40	$61.17	$57.21	$38.62	$45.72	$76.09	$13.02	$0.00	$468.07	$9.98	$0.00	$0.00	$0.00	$84.56
FY 2012-13	$5.56	$193.46	$321.36	$95.33	$38.55	$26.12	$152.86	$73.75	$10.75	$0.00	$335.87	$4.25	$0.00	$0.00	$0.00	$56.25
FY 2013-14	$6.74	$178.33	$314.80	$95.85	$44.15	$25.80	$73.82	$48.31	$12.73	$0.00	$304.44	$9.69	$0.00	$0.00	$0.00	$54.03
FY 2014-15	$8.48	$182.82	$348.18	$96.57	$49.44	$28.29	$76.14	$21.40	$12.92	$28.73	$275.15	$16.53	$8.16	$0.00	$0.00	$57.85
FY 2015-16	$6.01	$203.06	$383.50	$82.38	$54.78	$13.72	$80.79	$5.77	$13.96	$22.32	$254.83	$16.25	$6.97	$0.00	$0.00	$60.52

Percent Change in Per Capita Cost

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	-1.72%	14.20%	10.57%	0.00%	27.87%	0.00%	0.00%	3233.75%	16.73%	0.00%	11.15%	38.20%	0.00%	0.00%	0.00%	14.12%
FY 2008-09	16.22%	7.30%	-2.73%	0.00%	20.08%	0.00%	0.00%	60.14%	-3.21%	0.00%	-4.36%	95.66%	0.00%	0.00%	0.00%	-6.28%
FY 2009-10 (DA)	6.29%	5.88%	0.17%	0.00%	-2.24%	0.00%	0.00%	71.08%	-10.41%	0.00%	-5.11%	8.31%	0.00%	0.00%	0.00%	-8.53%
FY 2010-11 (DA)	-16.21%	9.97%	9.13%	0.00%	3.69%	-15.82%	0.00%	6.90%	-5.28%	0.00%	-2.34%	26.09%	0.00%	0.00%	0.00%	-1.06%
FY 2011-12	-38.48%	13.35%	3.82%	0.00%	-2.70%	123.37%	0.00%	-2.59%	3.75%	0.00%	1.69%	1.22%	0.00%	0.00%	0.00%	-0.08%
FY 2012-13	-33.49%	-40.73%	-35.65%	55.84%	-32.62%	-32.37%	234.34%	-3.08%	-17.43%	0.00%	-28.24%	-57.41%	0.00%	0.00%	0.00%	-33.48%
FY 2013-14	21.22%	-7.82%	-2.04%	0.55%	14.53%	-1.23%	-51.71%	-34.49%	18.42%	0.00%	-9.36%	128.00%	0.00%	0.00%	0.00%	-3.95%
FY 2014-15	25.82%	2.52%	10.60%	0.75%	11.98%	9.65%	3.14%	-55.70%	1.49%	0.00%	-9.62%	70.59%	0.00%	0.00%	0.00%	7.07%
FY 2015-16	-29.13%	11.07%	10.14%	-14.69%	10.80%	-51.50%	6.11%	-73.04%	8.05%	-22.31%	-7.39%	-1.69%	-14.58%	0.00%	0.00%	4.62%

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

Cash Based Actuals

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	$331,389	$845,022	$13,797,610	$0	$1,458,343	$0	$0	$126	$1,857,823	$0	$5,400,269	$9,556	$0	$0	$0	$23,700,138
FY 2007-08	$354,695	$1,054,171	$16,810,867	$0	$1,922,775	$0	$0	$5,359	$2,319,619	$0	$6,625,191	$17,260	$0	$0	$0	$29,109,937
FY 2008-09	$348,451	$967,839	$13,717,389	$0	$2,179,008	$0	$0	$8,219	$2,111,007	$0	$5,437,298	$30,571	$0	$0	$0	$24,799,782
FY 2009-10 (DA)	$348,638	$1,030,724	$13,110,335	$0	$2,370,029	$37,142	$0	$17,342	$2,039,465	$0	$4,837,828	$34,201	$0	$0	$0	$23,825,704
FY 2010-11 (DA)	$276,098	$1,167,559	$14,133,811	$0	$2,489,795	$245,212	$0	$21,652	$1,981,277	$0	$4,419,440	$40,503	$0	$0	$0	$24,775,347
FY 2011-12	$170,868	$1,407,362	$15,266,894	$1,636	$2,743,021	$704,332	$26,671	$23,366	$2,241,056	$0	$4,341,836	$39,149	$0	$0	$0	$26,966,191
FY 2012-13	$99,799	$769,359	$8,743,092	$37,197	$1,683,569	$476,840	$714,202	$20,188	$1,699,078	$0	$2,623,448	$14,983	$0	$0	$0	$16,881,755
FY 2013-14	$155,296	$967,616	$11,168,104	$135,129	$3,031,470	$668,951	$3,546,470	$14,873	$2,797,283	$0	$3,062,510	$70,214	$0	$0	$0	$25,617,916
FY 2014-15	$192,212	$1,037,326	$12,561,432	$189,885	$4,333,828	$1,104,010	$9,964,512	$4,640	$3,122,397	$780,578	$2,988,722	$133,516	$7,742	$0	$0	$36,420,800
FY 2014-15	$101,500	$851,797	$10,511,722	$204,041	$3,565,013	$475,450	$10,311,342	$741	$2,597,776	$529,193	$2,023,866	$93,338	$4,884	$0	$0	$31,270,663

Percent Change in Cash Based Actuals

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	7.03%	24.75%	21.84%	0.00%	31.85%	0.00%	0.00%	4153.17%	24.86%	0.00%	22.68%	80.62%	0.00%	0.00%	0.00%	22.83%
FY 2008-09	-1.76%	-8.19%	-18.40%	0.00%	13.33%	0.00%	0.00%	53.37%	-8.99%	0.00%	-17.93%	77.12%	0.00%	0.00%	0.00%	-14.81%
FY 2009-10 (DA)	0.05%	6.50%	-4.43%	0.00%	8.77%	0.00%	0.00%	111.00%	-3.39%	0.00%	-11.03%	11.87%	0.00%	0.00%	0.00%	-3.93%
FY 2010-11 (DA)	-20.81%	13.28%	7.81%	0.00%	5.05%	560.20%	0.00%	24.85%	-2.85%	0.00%	-8.65%	18.43%	0.00%	0.00%	0.00%	3.99%
FY 2011-12	-38.11%	20.54%	8.02%	0.00%	10.17%	187.23%	0.00%	7.92%	13.11%	0.00%	-1.76%	-3.34%	0.00%	0.00%	0.00%	8.84%
FY 2012-13	-41.59%	-45.33%	-42.73%	2173.66%	-38.62%	-32.30%	2577.82%	-13.60%	-24.18%	0.00%	-39.58%	-61.73%	0.00%	0.00%	0.00%	-37.40%
FY 2013-14	55.61%	25.77%	27.74%	263.28%	80.06%	40.29%	396.56%	-26.33%	64.64%	0.00%	16.74%	368.62%	0.00%	0.00%	0.00%	51.75%
FY 2014-15	23.77%	7.20%	12.48%	40.52%	42.96%	65.04%	180.97%	-68.80%	11.62%	0.00%	-2.41%	90.16%	0.00%	0.00%	0.00%	42.17%
FY 2015-16	-47.19%	-17.89%	-16.32%	7.46%	-17.74%	-56.93%	3.48%	-84.03%	-16.80%	-32.20%	-32.28%	-30.09%	-36.92%	0.00%	0.00%	-14.14%

Per Capita Cost

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	$9.23	$139.47	$282.74	$0.00	$26.11	$0.00	$0.00	$0.55	$9.05	$0.00	$322.91	$1.84	$0.00	$0.00	$0.00	$60.42
FY 2007-08	$9.78	$171.52	$336.67	$0.00	$35.96	$0.00	$0.00	$19.85	$11.37	$0.00	$386.51	$2.74	$0.00	$0.00	$0.00	$74.27
FY 2008-09	$9.26	$150.12	$267.11	$0.00	$35.22	$0.00	$0.00	$25.93	$8.98	$0.00	$301.52	$4.38	$0.00	$0.00	$0.00	$56.77
FY 2009-10 (DA)	$9.06	$146.22	$246.14	$0.00	$31.67	$11.47	$0.00	$40.80	$7.40	$0.00	$263.20	$4.37	$0.00	$0.00	$0.00	$47.77
FY 2010-11 (DA)	$7.09	$150.32	$251.11	$0.00	$30.70	$9.03	$0.00	$40.78	$6.55	$0.00	$240.28	$5.15	$0.00	$0.00	$0.00	$44.18
FY 2011-12	$4.30	$167.88	$256.87	$31.46	$29.42	$19.86	$23.52	$39.14	$6.70	$0.00	$240.76	$5.13	$0.00	$0.00	$0.00	$43.50
FY 2012-13	$2.44	$85.00	$141.20	$41.89	$16.94	$11.48	$67.16	$32.40	$4.72	$0.00	$147.58	$1.87	$0.00	$0.00	$0.00	$24.72
FY 2013-14	$3.71	$98.21	$173.35	$52.78	$24.31	$14.21	$40.65	$26.61	$7.01	$0.00	$167.65	$5.34	$0.00	$0.00	$0.00	$29.76
FY 2014-15	$4.60	$99.11	$188.76	$52.35	$26.80	$15.34	$41.28	$11.60	$7.01	$15.58	$149.17	$8.96	$4.43	$0.00	$0.00	$31.36
FY 2015-16	$2.39	$80.90	$152.79	$32.82	$21.83	$5.47	$32.19	$2.30	$5.56	$8.89	$101.52	$6.48	$2.78	$0.00	$0.00	$24.11

Percent Change in Per Capita Cost

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	5.96%	22.98%	19.07%	0.00%	37.73%	0.00%	0.00%	3509.09%	25.64%	0.00%	19.70%	48.91%	0.00%	0.00%	0.00%	22.92%
FY 2008-09	-5.32%	-12.48%	-20.66%	0.00%	-2.06%	0.00%	0.00%	30.63%	-21.02%	0.00%	-21.99%	59.85%	0.00%	0.00%	0.00%	-23.56%
FY 2009-10 (DA)	-2.16%	-2.60%	-7.85%	0.00%	-10.08%	0.00%	0.00%	57.35%	-17.59%	0.00%	-12.71%	-0.23%	0.00%	0.00%	0.00%	-15.85%
FY 2010-11 (DA)	-21.74%	2.80%	2.02%	0.00%	-3.06%	-21.27%	0.00%	-0.05%	-11.49%	0.00%	-8.71%	17.85%	0.00%	0.00%	0.00%	-7.52%
FY 2011-12	-39.35%	11.68%	2.29%	0.00%	-4.17%	119.93%	0.00%	-4.02%	2.29%	0.00%	0.20%	-0.39%	0.00%	0.00%	0.00%	-1.54%
FY 2012-13	-43.26%	-49.37%	-45.03%	33.15%	-42.42%	-42.20%	185.54%	-17.22%	-29.55%	0.00%	-38.70%	-63.55%	0.00%	0.00%	0.00%	-43.17%
FY 2013-14	52.05%	15.54%	22.77%	26.00%	43.51%	23.78%	-39.47%	-17.87%	48.52%	0.00%	13.60%	185.56%	0.00%	0.00%	0.00%	20.39%
FY 2014-15	23.99%	0.92%	8.89%	-0.81%	10.24%	7.95%	1.55%	-56.41%	0.00%	0.00%	-11.02%	67.79%	0.00%	0.00%	0.00%	5.38%
FY 2015-16	-48.04%	-18.37%	-19.06%	-37.31%	-18.54%	-64.34%	-22.02%	-80.17%	-20.68%	-42.94%	-31.94%	-27.68%	-37.25%	0.00%	0.00%	-23.12%

(1) Totals for FY 2009-10 and FY 2010-11 are adjusted to account for the June 2010 payment delays.

Exhibit F - ACUTE CARE - Pharmacy Rebates

Estimated Increase in Rebates Attributable to the Affordable Care Act						
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**Percentage Change[(1)]**
FY 2010-11	$2,623,793	$2,663,517	$2,986,818	$2,724,952	$10,999,080	-
FY 2011-12	$3,079,979	$3,164,919	$3,074,020	$3,278,629	$12,597,547	14.53%
FY 2012-13	$2,844,435	$2,078,580	$3,217,760	$1,876,367	$10,017,142	-20.48%
FY 2013-14	$3,665,910	$3,333,782	$2,724,407	$3,309,038	$13,033,137	30.11%
FY 2014-15	$3,163,574	$3,658,125	$3,515,812	$5,159,840	$15,497,352	18.91%
FY 2015-16	$4,276,352	$4,184,873	$4,358,848	($1,453,415)	$11,366,658	-26.65%
FY 2016-17[(1)]	$4,178,840	$4,294,085	$4,170,755	$4,448,363	$17,092,043	50.37%
FY 2017-18[(1)]	$4,628,744	$4,756,396	$4,619,789	$4,927,285	$18,932,214	10.77%
FY 2018-19[(1)]	$5,127,086	$5,268,482	$5,117,167	$5,457,768	$20,970,503	10.77%

(1) The estimated FY 2016-17 growth rate has been adjusted to account for a negative reconciliation in Quarter 4 of FY 2015-16. The growth rate for FY 2017-18 and FY 2018-19 is equal to the average percent growth from FY 2011-12 through FY 2014-15.

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

Total Family Planning Expenditure

Fiscal Year	Total Reported Expenditures	General Fund	Cash Funds [1]	Federal Funds (90% FMAP)	Change	% Change
FY 2002-03	$6,066,468	$606,647	$0	$5,459,821	($1,518,369)	-38.38%
FY 2003-04	$5,369,643	$536,964	$0	$4,832,679	($696,825)	-11.49%
FY 2004-05	$7,008,093	$700,809	$0	$6,307,284	$1,638,451	30.51%
FY 2005-06	$7,121,173	$712,117	$0	$6,409,056	$113,079	1.61%
FY 2006-07	$7,302,900	$730,290	$0	$6,572,610	$181,728	2.55%
FY 2007-08	$9,682,728	$968,273	$0	$8,714,455	$2,379,827	32.59%
FY 2008-09	$13,069,942	$1,306,994	$0	$11,762,948	$3,387,215	34.98%
FY 2009-10	$11,628,243	$1,162,825	$0	$10,465,418	($1,441,700)	-11.03%
FY 2010-11	$11,529,927	$1,152,993	$0	$10,376,934	($98,316)	-0.85%
FY 2011-12	$9,616,143	$961,614	$0	$8,654,529	($1,913,784)	-16.60%
FY 2012-13	$7,948,469	$775,944	$18,903	$7,153,622	($1,667,674)	-17.34%
FY 2013-14	$9,583,635	$939,071	$19,292	$8,625,272	$1,635,166	20.57%
FY 2014-15	$11,582,466	$1,129,087	$29,160	$10,424,219	$1,998,831	20.86%
FY 2015-16	$11,741,307	$1,174,131	$0	$10,567,176	$158,841	1.37%
FY 2016-17 Estimate [2]	$12,680,612	$1,520,405	$0	$11,160,207	$939,305	8.00%
FY 2017-18 Estimate [2]	$13,419,892	$1,610,387	$0	$11,809,505	$739,280	5.83%
FY 2018-19 Estimate [2]	$14,202,272	$1,704,273	$0	$12,497,999	$782,380	5.83%

(1) The teen pregnancy and dropout prevention program contract with Montrose was terminated in FY 2014-15. This program was previously funded via local cash funds and federal funds and as a result, FY 2015-16 and beyond will no longer include cash funds. Please see the Narrative for more information concerning the sunset

(2) The FY 2016-17 estimate for total reported expenditures is slightly higher than the average of annual total reported expenditures for FY 2007-08 though FY 2015-16. Estimates for FY 2017-18 and FY 2018-19 are slightly higher than the average growth rate for FY 2008-09 through FY 2015-16, applied to the previous year's estimated total reported expenditure.

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

Fiscal Year	Total Reported Expenditures	Fee-for-Service Expenditure	Managed Care Expenditure	Drug Rebates	Total Expenditure Net of Rebates	Percent Change Net of Rebates
FY 2002-03	$6,538,073	$3,094,894	$3,443,179	($471,606)	$6,066,468	-
FY 2003-04	$6,061,856	$4,058,413	$2,003,442	($692,213)	$5,369,643	-11.49%
FY 2004-05	$8,019,717	$6,902,883	$1,116,833	($1,011,623)	$7,008,093	30.51%
FY 2005-06	$8,260,397	$7,013,966	$1,246,431	($1,139,224)	$7,121,173	1.61%
FY 2006-07	$8,343,188	$7,431,084	$912,103	($1,040,287)	$7,302,900	2.55%
FY 2007-08	$9,902,250	$9,139,367	$762,883	($219,523)	$9,682,728	32.59%
FY 2008-09	$13,893,561	$13,472,771	$420,790	($823,619)	$13,069,942	34.98%
FY 2009-10	$12,619,883	$12,533,203	$86,680	($991,641)	$11,628,243	-11.03%
FY 2010-11	$13,895,800	$12,375,826	$1,519,974	($2,365,873)	$11,529,927	-0.85%
FY 2011-12	$11,795,916	$10,329,972	$1,465,944	($2,179,772)	$9,616,143	-16.60%
FY 2012-13	$11,806,126	$10,594,615	$1,211,511	($3,857,657)	$7,948,469	-17.34%
FY 2013-14	$13,703,377	$12,637,553	$1,065,824	($4,119,742)	$9,583,635	20.57%
FY 2014-15	$15,333,678	$13,509,576	$1,824,102	($3,751,212)	$11,582,466	20.86%
FY 2015-16	$19,537,317	$17,927,223	$1,610,094	($7,796,010)	$11,741,307	1.37%

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

Total Family Planning Expenditure
Fund Splits

Fiscal Year	Total Reported Expenditures	General Fund	Cash Funds	Federal Funds	FMAP
FY 2016-17 Estimate [3]	$12,046,581	$1,204,658	$0	$10,841,923	90.00%
	$634,031	$315,747	$0	$318,284	50.20%
FY 2017-18 Estimate [3]	$12,748,897	$1,274,890	$0	$11,474,007	90.00%
	$670,995	$335,497	$0	$335,498	50.00%
FY 2018-19 Estimate [3]	$13,492,158	$1,349,216	$0	$12,142,942	90.00%
	$710,114	$355,057	$0	$355,057	50.00%

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

Total Expenditure for Indian Health Service			
Fiscal Year	**Total Reported Expenditures: 100% FF**	**Change**	**% Change**
FY 2001-02	$100,299	$100,299	-
FY 2002-03	$511,451	$411,152	409.93%
FY 2003-04	$813,791	$302,340	59.11%
FY 2004-05	$922,761	$108,970	13.39%
FY 2005-06	$840,371	($82,390)	-8.93%
FY 2006-07	$899,521	$59,150	7.04%
FY 2007-08	$1,061,989	$162,468	18.06%
FY 2008-09	$1,534,327	$472,338	44.48%
FY 2009-10	$1,536,532	$2,205	0.14%
FY 2010-11	$1,672,353	$135,821	8.84%
FY 2011-12	$1,434,711	($237,642)	-14.21%
FY 2012-13	$1,238,524	($196,187)	-13.67%
FY 2013-14	$1,450,187	$211,663	17.09%
FY 2014-15[(1)]	$4,281,827	$2,831,640	195.26%
FY 2015-16	$4,286,478	$4,651	0.11%
FY 2016-17 Estimated Total[(2)]	$4,291,193	$4,715	0.11%
FY 2017-18 Estimated Total[(2)]	$4,295,913	$4,720	0.11%
FY 2018-19 Estimated Total[(2)]	$4,300,639	$4,726	0.11%

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

[(2)] The trend for FY 2016-17 through FY 2018-19 is the percent growth from FY 2014-15 to FY 2015-16.

Exhibit F - ACUTE CARE - Expenditure by Half-Year

FY 2013-14 July-December COFRS Total Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Physician Services & EPSDT	$2,126,380	$5,391,702	$36,200,871	$2,878,789	$42,656,116	$11,477,217	$8,768,648	$0	$71,699,516	$2,657,676	$6,047,201	$14,319,402	$1,100,790	$3,584,186	$2,621	$208,911,115
Emergency Transportation	$66,504	$200,380	$1,240,532	$44,246	$859,994	$179,231	$476,798	$0	$867,012	$40,094	$108,429	$160,654	$5,207	$36,487	$0	$4,285,568
Non-emergency Medical Transportation	$878,622	$492,615	$2,058,121	$33,069	$210,709	$46,398	$146,096	$0	$397,685	$5,014	$60,028	$22,379	$33	$288	$0	$4,351,057
Dental Services	$735,057	$228,184	$2,996,748	$93,421	$3,003,798	$860,293	$576,406	$0	$52,364,802	$2,370,685	$2,776,140	$210,708	$12,134	$1,510	$0	$66,229,886
Family Planning	$117	$146	$9,907	$256	$136,589	$45,235	$7,042	$0	$100,492	$4,369	$43,774	$15,155	$1,869	$0	$0	$364,951
Health Maintenance Organizations	$2,998,630	$4,238,163	$21,963,467	$209,563	$11,372,325	$3,876,839	$5,794	$0	$20,505,667	$669,190	$400,679	$1,070,955	$22,434	$0	$1,013	$67,334,719
Inpatient Hospitals	$6,178,058	$7,853,987	$54,302,483	$5,754,817	$32,505,371	$6,842,546	$10,750,120	$0	$40,529,056	$2,067,683	$2,534,222	$18,475,958	$1,798,799	$17,071,224	($11,971)	$206,652,353
Outpatient Hospitals	$1,936,308	$4,164,759	$31,523,907	$2,575,497	$39,123,091	$11,349,198	$10,883,542	$0	$43,088,896	$2,556,527	$3,100,785	$4,292,315	$366,588	$931,629	$0	$155,893,042
Lab & X-Ray	$266,509	$641,424	$3,873,295	$221,903	$8,787,987	$2,354,173	$1,585,800	$0	$3,386,217	$278,789	$629,608	$2,222,882	$189,519	$77,972	$0	$24,516,078
Durable Medical Equipment	$9,734,717	$3,220,923	$28,562,774	$563,023	$2,682,293	$841,403	$974,402	$0	$6,029,031	$178,849	$2,360,864	$134,178	$5,570	$0	$17,075	$55,305,102
Prescription Drugs	$3,611,551	$9,645,371	$66,667,184	$2,502,929	$32,079,198	$10,369,827	$10,168,488	$0	$34,760,245	$2,580,080	$9,044,408	$1,720,303	$37,834	$0	$111	$183,187,529
Drug Rebate	($1,535,519)	($4,100,912)	($28,344,816)	($1,064,168)	($13,639,079)	($4,408,929)	($4,323,325)	$0	($15,374,046)	($501,900)	($3,845,401)	($731,065)	($16,440)	$0	($47)	($77,885,647)
Rural Health Centers	$33,922	$127,596	$627,076	$29,424	$1,197,446	$416,216	$148,739	$0	$3,085,905	$124,705	$163,823	$148,297	$9,717	$3,782	$0	$6,116,648
Federally Qualified Health Centers	$464,276	$646,657	$4,282,377	$138,410	$8,575,366	$2,379,716	$2,638,073	$0	$28,576,111	$1,171,878	$937,379	$3,508,073	$275,846	$200,299	$0	$53,794,461
Co-Insurance (Title XVIII-Medicare)	$3,545,667	$605,785	$2,644,569	$57,508	$142,797	$184,805	$3,313	$0	$3,067	$282	$1,674	$5,167	$157	$0	$1,357,221	$8,552,012
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$6,376,022	$0	$0	$0	$0	$0	$0	$0	$6,376,022
Administrative Service Organizations - Services	$547,749	$1,593,095	$9,974,042	$1,519,050	$5,351,996	$1,071,156	$40,512	$0	$2,913,517	$47,345	$507,529	$4,117,957	$137,469	$0	$836	$27,822,253
Other Medical Services	$339	$277	$2,137	$102	$1,169	$328	$306	$43	$1,920	$128	$221	$288	$26	$141	$21	$7,446
Acute Home Health	$2,344,387	$1,072,522	$5,399,391	$94,388	$373,336	$138,180	$168,324	$0	$380,860	$80,049	$252,257	$42,278	$1,509	$0	$61,077	$10,408,558
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$33,933,274	$36,022,674	$243,984,065	$15,652,227	$175,420,502	$48,023,832	$43,019,078	$6,376,065	$293,315,953	$14,331,443	$25,123,620	$49,735,884	$3,949,061	$21,907,518	$1,427,957	$1,012,223,153
Caseload	41,784	9,650	64,256	2,074	111,141	41,760	18,108	613	385,897	13,835	17,685	11,412	582	2,480	22,495	743,769
Half -Year Per Capita	$812.11	$3,732.98	$3,797.08	$7,548.70	$1,578.36	$1,150.01	$2,375.69	$10,398.58	$760.09	$1,035.90	$1,420.62	$4,358.27	$6,791.16	$8,832.49	$63.48	$1,360.94

FY 2013-14 January-June COFRS Total Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Physician Services & EPSDT	$1,916,978	$4,372,320	$28,859,114	$1,568,705	$36,756,120	$11,269,427	$53,995,917	$0	$68,944,713	$3,906,643	$5,092,978	$18,573,354	$1,158,740	$2,412,483	$3,620	$238,831,111
Emergency Transportation	$56,263	$186,579	$1,051,749	$30,363	$828,412	$198,192	$2,052,310	$0	$969,682	$53,297	$109,302	$258,258	$6,922	$38,162	$793	$5,840,284
Non-emergency Medical Transportation	$1,922,846	$1,189,193	$4,656,743	$71,918	$577,149	$87,631	$738,322	$0	$912,188	$11,585	$126,620	$85,950	$125	$883	$2,733	$10,383,886
Dental Services	$1,059,795	$330,062	$3,517,797	$89,207	$6,149,997	$1,841,242	$6,432,666	$0	$51,651,133	$6,274,961	$2,651,760	$542,431	$25,759	$5,041	$2,203	$80,574,054
Family Planning	$54	$2	$11,550	$263	$187,434	$75,350	$101,498	$0	$134,725	$10,471	$44,146	$25,509	$2,623	$0	$0	$593,625
Health Maintenance Organizations	$2,679,213	$3,933,838	$20,287,797	$204,054	$12,957,332	$3,331,297	$984,249	$0	$20,592,110	$1,370,972	$441,456	$1,618,996	$154,719	$0	($30)	$68,556,003
Inpatient Hospitals	$6,036,371	$7,605,652	$46,421,041	$4,110,367	$20,513,889	$7,853,367	$71,521,048	$0	$56,746,845	$712,466	$2,920,082	$32,245,992	$2,138,168	$12,832,957	$693	$271,658,938
Outpatient Hospitals	$2,136,710	$4,509,718	$31,509,388	$2,006,328	$44,096,214	$17,059,686	$69,326,331	$0	$53,124,739	$4,827,127	$3,609,771	$7,591,661	$401,869	$1,058,695	$18,275	$241,276,512
Lab & X-Ray	$294,719	$666,820	$4,170,019	$190,813	$10,276,315	$3,242,963	$11,082,355	$0	$4,710,767	$292,738	$733,879	$4,115,803	$314,530	$76,587	$389	$40,168,697
Durable Medical Equipment	$10,258,949	$3,383,054	$29,819,077	$583,403	$3,447,960	$855,896	$5,096,618	$0	$7,732,137	$556,848	$2,403,335	$186,067	$8,836	$191	$24,202	$64,356,573
Prescription Drugs	$4,024,328	$10,744,651	$73,986,564	$2,567,396	$42,825,369	$12,912,380	$60,762,528	$0	$44,039,861	$5,392,354	$9,735,805	$2,687,195	$305,594	$0	$19,884	$270,003,909
Drug Rebate	($1,754,638)	($4,684,766)	($32,260,248)	($1,120,540)	($18,635,895)	($5,622,938)	($26,239,520)	$0	($18,579,444)	($2,933,272)	($4,246,641)	($1,168,043)	($131,537)	$0	($8,569)	($117,386,051)
Rural Health Centers	$42,342	$142,027	$633,398	$19,899	$1,645,263	$511,612	$1,403,590	$0	$3,531,107	$258,757	$174,783	$317,470	$22,912	$6,020	$68	$8,709,248
Federally Qualified Health Centers	$561,943	$751,624	$4,380,200	$120,401	$9,195,619	$3,692,682	$17,127,255	$0	$29,555,074	$2,079,623	$942,663	$5,416,507	$314,632	$172,897	$1,908	$74,313,028
Co-Insurance (Title XVIII-Medicare)	$19,189,244	$3,323,456	$13,760,657	$698,899	$1,570,580	$379,994	$273,710	$0	$21,381	$100	$5,247	$46,076	$1,319	$0	$7,081,704	$46,352,367
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$2,503,625	$0	$0	$0	$0	$0	$0	$0	$2,503,625
Administrative Service Organizations - Services	$914,084	$1,066,604	$5,914,612	($920,928)	$9,510,255	$2,555,467	$848,065	$0	$9,776,157	$149,436	$1,420,827	($99,587)	($26,704)	$0	$2,022	$31,110,310
Other Medical Services	$510	$409	$3,024	$125	$1,776	$575	$2,462	$25	$3,237	$184	$327	$651	$42	$163	$35	$13,545
Acute Home Health	$2,402,125	$1,240,348	$5,590,781	$170,141	$412,270	$83,270	$1,261,672	($2,446)	$695,849	$16,837	$408,855	$44,305	$1,182	$0	$86,244	$12,411,433
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$51,741,836	$38,761,591	$242,313,263	$10,390,814	$182,316,059	$60,328,093	$276,771,076	$2,501,204	$334,562,262	$22,981,126	$26,575,195	$72,488,594	$4,699,731	$16,604,079	$7,236,174	$1,350,271,097
Caseload	41,888	10,056	64,593	3,047	138,220	52,404	156,377	504	412,167	36,856	18,849	14,908	1,533	2,481	24,261	978,143
Half -Year Per Capita	$1,235.25	$3,854.45	$3,751.41	$3,410.18	$1,319.03	$1,151.21	$1,769.90	$4,961.07	$811.71	$623.54	$1,409.90	$4,862.29	$3,065.38	$6,693.39	$298.27	$1,380.44

Exhibit F - ACUTE CARE - Expenditure by Half-Year

FY 2014-15 July-December CORE Total Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Physician Services & EPSDT	$1,808,071	$4,416,891	$30,089,878	$1,835,069	$42,554,667	$13,869,704	$78,528,944	$909	$76,589,358	$6,049,956	$5,929,989	$18,417,319	$2,020,726	$2,842,821	$11,717	$284,966,019
Emergency Transportation	$75,640	$221,379	$1,215,703	$30,714	$1,051,055	$213,525	$3,072,083	$139	$1,061,536	$71,995	$147,069	$245,213	$16,646	$44,561	$728	$7,467,986
Non-emergency Medical Transportation	$1,006,855	$627,740	$2,389,255	$30,566	$338,838	$50,784	$813,120	$52	$447,966	$21,445	$72,627	$50,782	$3,157	$676	$82	$5,853,945
Dental Services	$3,040,526	$1,021,347	$6,711,402	$275,574	$13,188,190	$4,636,004	$18,132,051	$848	$53,714,284	$6,727,070	$2,531,308	$877,321	$89,296	$10,209	$514	$110,955,944
Family Planning	$52	$175	$8,084	$336	$167,298	$70,658	$151,177	$0	$123,269	$15,139	$39,682	$23,659	$1,671	$0	$75	$601,275
Health Maintenance Organizations	$4,211,877	$4,833,256	$26,077,759	$328,437	$29,380,352	$8,261,830	$10,188,768	$0	$22,321,938	$1,730,414	$471,051	$2,963,822	$298,018	$0	$771	$111,068,293
Inpatient Hospitals	$8,271,207	$12,845,824	$45,015,267	$3,021,447	$27,584,855	$7,758,474	$111,519,686	$0	$56,359,562	$2,014,097	$3,128,134	$31,833,352	$3,428,148	$16,256,192	$2,174	$329,038,419
Outpatient Hospitals	$1,532,286	$3,929,489	$28,176,641	$1,586,381	$45,598,917	$13,962,464	$87,546,924	($952)	$51,758,034	$5,337,722	$3,876,276	$5,603,371	$574,930	$1,336,384	$11,396	$250,830,263
Lab & X-Ray	$230,781	$646,128	$4,314,997	$193,932	$11,085,750	$3,466,398	$15,921,407	($93)	$4,960,253	$526,334	$913,185	$3,992,341	$411,258	$79,356	$1,716	$46,743,743
Durable Medical Equipment	$10,610,005	$3,427,816	$31,054,255	$633,733	$3,786,116	$1,083,286	$8,629,703	$0	$8,968,194	$711,147	$2,505,467	$211,112	$21,029	$10,060	$36,128	$71,688,051
Prescription Drugs	$3,224,400	$10,512,070	$71,281,146	$2,530,210	$45,963,895	$15,261,456	$92,126,776	$387	$44,294,709	$6,034,167	$9,484,209	$2,743,668	$232,787	$548	$9,305	$303,699,733
Drug Rebate	($1,299,746)	($4,237,385)	($28,733,226)	($1,019,920)	($18,527,915)	($6,151,849)	($37,136,040)	($156)	($17,855,071)	($2,432,355)	($3,823,058)	($1,105,964)	($93,836)	($221)	($3,751)	($122,420,493)
Rural Health Centers	$35,483	$147,242	$692,738	$15,672	$1,729,715	$546,905	$2,076,221	$0	$3,655,812	$332,712	$182,928	$309,033	$22,214	$4,298	($215)	$9,750,758
Federally Qualified Health Centers	$455,701	$745,723	$4,231,862	$79,497	$9,366,991	$3,572,340	$20,490,767	$534	$25,762,990	$2,141,928	$901,951	$5,439,521	$497,785	$198,877	$5,141	$73,891,608
Co-Insurance (Title XVIII-Medicare)	$8,387,335	$1,523,519	$5,889,554	$409,516	$1,033,220	$29,010	$339,319	$5,311	$12,298	$724	$6,264	$25,970	$855	$0	$3,261,146	$20,924,041
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$1,553,536	$0	$0	$0	$0	$0	$0	$0	$1,553,536
Administrative Service Organizations - Services	$1,066,058	$752,683	$8,738,579	$119,870	$9,297,700	$1,059,036	$3,551,123	$0	$6,680,595	$274,470	$1,067,643	$2,756,467	$141,046	$0	$8,391	$35,513,661
Other Medical Services	$228	$197	$1,288	$47	$914	$285	$1,785	$6	$1,406	$111	$144	$283	$31	$82	$13	$6,820
Acute Home Health	$2,544,679	$1,297,793	$6,443,729	$117,526	$466,850	$127,847	$2,036,681	$0	$900,690	$51,937	$261,341	$44,790	$5,459	$0	$1,213	$14,300,535
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$45,201,438	$42,711,887	$243,598,911	$10,188,607	$224,067,408	$67,818,157	$417,990,495	$1,560,521	$339,757,823	$29,609,013	$27,696,210	$74,432,060	$7,671,220	$20,783,843	$3,346,544	$1,556,434,137
Caseload	42,053	10,360	66,015	3,078	158,622	65,032	214,360	437	439,474	44,580	20,152	15,005	1,751	2,506	26,979	1,110,401
Half -Year Per Capita	$1,074.88	$4,122.90	$3,690.04	$3,310.32	$1,412.59	$1,042.85	$1,949.94	$3,575.08	$773.10	$664.18	$1,374.39	$4,960.43	$4,382.30	$8,293.08	$124.04	$1,401.69

FY 2014-15 January-June CORE Total Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Physician Services & EPSDT	$1,963,308	$5,500,090	$36,478,165	$2,310,846	$54,260,569	$22,252,662	$100,185,772	$759,781	$106,571,472	$9,282,154	$7,547,098	$20,334,277	$2,439,144	$2,944,888	$3,681	$372,833,907
Emergency Transportation	$783,401	$431,552	$2,319,499	$44,720	$1,177,046	$295,538	$3,663,174	$7,132	$1,329,614	$110,468	$216,528	$251,753	$7,875	$37,805	($555)	$10,675,550
Non-emergency Medical Transportation	$1,536,741	$745,502	$2,942,308	$50,155	$456,698	$75,493	$1,206,415	$8,926	$579,203	$62,292	$106,949	$43,096	$1,359	$655	$549	$7,816,341
Dental Services	$4,236,488	$1,525,094	$8,192,003	$483,001	$15,539,439	$6,884,204	$25,242,244	$50,562	$60,907,896	$10,256,427	$2,898,888	$1,035,308	$111,838	$10,186	$69	$137,373,647
Family Planning	$0	$5	$11,868	$290	$228,251	$104,517	$190,176	$3	$164,819	$20,910	$46,602	$43,798	$3,065	$131	$9	$814,444
Health Maintenance Organizations	$2,896,227	$6,539,908	$35,914,181	$816,541	$37,765,267	$18,524,500	$45,092,726	$34,393	$23,084,444	$2,571,598	$145,735	$8,630,263	$1,011,440	$0	($544)	$183,026,679
Inpatient Hospitals	$8,058,381	$8,759,248	$45,623,148	$2,329,420	$30,731,104	$11,392,137	$112,285,947	$304,758	$63,950,991	$2,300,205	$3,984,281	$32,231,615	$3,491,713	$15,170,105	$45,006	$340,658,059
Outpatient Hospitals	$1,471,383	$4,486,875	$29,936,765	$1,783,949	$49,912,060	$19,815,417	$96,892,908	$597,295	$59,181,302	$5,536,073	$4,080,212	$6,073,932	$482,706	$1,248,375	($8,151)	$281,491,101
Lab & X-Ray	$236,596	$610,941	$3,841,135	$233,504	$10,938,467	$4,499,354	$15,424,566	$55,821	$5,723,494	$661,467	$673,466	$4,262,092	$462,363	$103,035	($1,348)	$47,724,953
Durable Medical Equipment	$10,780,283	$3,818,242	$31,833,873	$736,727	$4,356,955	$1,588,009	$10,578,239	$53,121	$10,570,792	$891,185	$2,705,364	$226,181	$16,792	$1,784	$29,724	$78,187,271
Prescription Drugs	$3,183,076	$11,518,248	$79,510,084	$3,584,653	$54,931,858	$22,324,734	$113,328,990	$335,529	$54,555,673	$7,549,442	$11,095,183	$3,265,595	$296,999	$3,833	($8,273)	$365,475,624
Drug Rebate	($1,776,199)	($6,338,393)	($43,654,948)	($1,915,554)	($29,907,656)	($11,891,612)	($61,494,150)	($161,102)	($29,598,608)	($4,088,533)	($6,056,194)	($1,778,816)	($160,491)	($1,882)	$3,256	($198,820,882)
Rural Health Centers	$28,079	$155,043	$730,517	$23,251	$1,942,226	$906,560	$2,310,037	$5,175	$4,642,696	$410,420	$214,718	$375,317	$19,729	$4,327	$215	$11,768,310
Federally Qualified Health Centers	$396,567	$738,218	$4,193,475	$108,731	$9,703,443	$4,940,729	$21,074,824	$75,810	$25,323,050	$2,232,353	$851,937	$5,132,502	$434,857	$202,557	($2,933)	$75,406,120
Co-Insurance (Title XVIII-Medicare)	$13,742,745	$2,495,127	$9,569,092	$634,224	$1,798,147	$18,887	($46,520)	($4,675)	$11,278	$699	$7,075	$33,130	($102)	$4,799	$5,421,851	$33,685,757
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$1,391,965	$0	$0	$0	$0	$0	$0	$0	$1,391,965
Administrative Service Organizations - Services	$175,787	$277,673	$2,548,177	$68,222	$1,761,410	$1,446,513	$294,198	$0	$1,855,789	$324,369	$261,892	$448,398	$104,185	$0	($1,353)	$9,565,260
Other Medical Services	$394	$324	$2,232	$85	$1,647	$656	$3,297	$21	$2,529	$260	$249	$493	$51	$123	$29	$12,390
Acute Home Health	$2,653,158	$1,508,191	$7,100,751	$124,565	$577,370	$205,121	$2,277,314	$12,103	$923,159	$214,943	$317,760	$69,679	$8,276	$0	($26,188)	$15,966,202
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$50,366,415	$42,771,888	$257,092,325	$11,417,330	$246,174,301	$103,383,419	$488,510,157	$3,526,618	$389,779,593	$38,336,732	$29,097,743	$80,678,613	$8,731,799	$19,730,721	$5,455,044	$1,775,052,698
Caseload	41,582	10,573	67,080	4,177	164,743	78,946	268,423	364	451,973	55,646	19,921	14,788	1,747	2,937	29,112	1,212,011
Half -Year Per Capita	$1,211.26	$4,045.39	$3,832.62	$2,733.71	$1,494.29	$1,309.55	$1,819.92	$9,679.65	$862.40	$688.94	$1,460.66	$5,455.74	$4,999.60	$6,718.37	$187.38	$1,464.55

Exhibit F - ACUTE CARE - Expenditure by Half-Year

FY 2015-16 July-December CORE Total Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Physician Services & EPSDT	$2,033,518	$5,183,586	$35,539,652	$3,209,282	$49,072,812	$19,886,884	$104,313,382	$217,604	$101,289,345	$9,750,538	$7,041,532	$19,124,789	$2,091,223	$2,792,782	$7,950	$361,554,879
Emergency Transportation	$824,476	$557,785	$2,576,186	$97,511	$1,334,536	$300,871	$4,681,067	$648	$1,362,799	$117,835	$231,931	$303,669	$24,433	$52,457	$27,722	$12,493,926
Non-emergency Medical Transportation	$1,589,776	$866,318	$3,302,586	$79,912	$494,929	$75,641	$1,393,587	$3,034	$562,865	$52,412	$123,323	$64,149	$2,231	$474	$36,746	$8,647,983
Dental Services	$5,197,986	$1,780,025	$11,056,147	$1,207,633	$18,599,543	$8,343,521	$32,898,633	$37,720	$73,625,842	$12,497,355	$3,350,957	$1,265,350	$115,841	$240	$1,177	$169,977,970
Family Planning	$185	$0	$14,751	$2,057	$214,720	$102,535	$228,273	$0	$116,227	$20,082	$10,092	$35,750	$1,783	$459	$0	$746,914
Health Maintenance Organizations	$3,792,103	$5,588,084	$31,823,902	$1,333,193	$37,693,431	$18,754,609	$55,978,852	$32,182	$19,636,631	$2,156,843	$229,115	$6,137,172	$597,340	$0	$0	$183,753,457
Inpatient Hospitals	$8,525,862	$7,905,678	$44,125,956	$3,215,856	$26,498,652	$10,682,178	$123,180,088	$19,913	$55,376,506	$2,402,485	$3,049,514	$32,523,922	$3,433,161	$15,494,261	$13,631	$336,447,663
Outpatient Hospitals	$1,476,774	$4,039,566	$30,933,291	$2,490,309	$47,094,681	$19,428,113	$108,220,162	$109,276	$54,383,208	$6,697,357	$3,750,425	$5,717,064	$542,330	$991,150	($693)	$285,873,013
Lab & X-Ray	$233,796	$727,723	$4,792,017	$331,938	$12,796,155	$4,873,255	$20,276,496	$29,522	$5,511,646	$687,990	$811,676	$4,283,091	$458,559	$80,490	($90)	$55,894,264
Durable Medical Equipment	$10,912,493	$4,040,538	$32,017,568	$942,562	$4,117,584	$1,395,845	$11,789,966	$25,411	$10,545,429	$930,356	$2,662,811	$161,971	$30,055	$1,777	$28,712	$79,603,078
Prescription Drugs	$3,109,621	$11,546,421	$82,301,189	$5,458,490	$53,014,649	$22,150,986	$135,853,730	$124,513	$52,732,148	$7,990,992	$10,408,231	$3,385,380	$402,880	$395	$1,473	$388,481,098
Drug Rebate	($1,651,136)	($6,130,882)	($43,700,020)	($2,898,331)	($28,149,547)	($11,761,659)	($72,135,174)	($66,113)	($27,999,546)	($4,243,031)	($5,526,529)	($1,797,558)	($213,920)	($210)	($782)	($206,274,438)
Rural Health Centers	$32,831	$130,521	$642,538	$64,308	$1,635,088	$814,166	$2,295,000	$682	$3,934,167	$399,245	$174,180	$324,606	$29,550	$5,092	$0	$10,481,974
Federally Qualified Health Centers	$402,314	$697,115	$4,285,365	$234,004	$9,455,425	$4,148,507	$20,972,618	$26,276	$25,888,885	$2,373,844	$874,085	$4,687,562	$395,028	$173,115	$647	$74,614,790
Co-Insurance (Title XVIII-Medicare)	$13,461,566	$2,414,632	$9,829,933	$1,006,633	$1,373,401	$17,389	$171,146	$3,008	$9,608	$1,073	$11,396	$30,451	$19	$1,046	$6,354,416	$34,685,717
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$1,255,515	$0	$0	$0	$0	$0	$0	$0	$1,255,515
Administrative Service Organizations - Services	$53,644	$95,686	$1,756,128	$10,864	$251,549	$54,698	$156,248	$0	$568,256	$0	$41,156	$145,766	$56,902	$0	$247	$3,191,144
Other Medical Services	$125	$93	$682	$38	$481	$202	$1,141	$3	$750	$84	$72	$142	$15	$36	$12	$3,876
Acute Home Health	$2,902,569	$1,385,442	$6,532,763	$192,324	$610,513	$178,281	$2,449,807	$544	$1,007,039	$23,396	$455,268	$101,429	$15,490	$0	$0	$15,854,865
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$52,898,503	$40,828,331	$257,830,634	$16,978,583	$236,108,602	$99,446,022	$552,725,022	$1,819,738	$378,551,805	$41,858,856	$27,699,235	$76,494,705	$7,982,920	$19,593,564	$6,471,168	$1,817,287,688
Caseload	42,101	10,380	69,866	7,144	166,897	83,081	301,795	334	462,670	58,291	19,793	14,186	1,664	2,637	31,456	1,272,294
Half -Year Per Capita	$1,256.47	$3,933.49	$3,690.38	$2,376.62	$1,414.70	$1,196.97	$1,831.46	$5,442.89	$818.19	$718.10	$1,399.48	$5,392.27	$4,798.39	$7,431.19	$205.72	$1,428.36

FY 2015-16 January-June CORE Total Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Physician Services & EPSDT	$2,136,974	$5,348,940	$36,858,689	$3,241,744	$50,077,424	$23,372,157	$114,152,285	$245,948	$108,186,921	$9,867,072	$7,495,969	$19,401,289	$2,364,638	$2,747,362	$13	$385,497,425
Emergency Transportation	$1,175,570	$829,017	$3,910,207	$107,120	$1,881,341	$530,175	$7,398,839	$4,286	$2,274,140	$185,006	$313,873	$424,275	$35,815	$65,430	$6,336	$19,141,430
Non-emergency Medical Transportation	$1,671,095	$888,829	$3,667,029	$83,791	$520,100	$117,919	$1,803,835	$2,835	$778,826	$62,931	$148,885	$76,858	$1,473	$385	($392)	$9,824,399
Dental Services	$4,494,526	$1,475,645	$8,960,989	$675,122	$15,490,571	$8,285,053	$31,288,772	$37,126	$72,086,174	$12,028,188	$3,410,936	$1,152,679	$136,238	$105	$2,611	$159,524,735
Family Planning	$343	$992	$32,234	$834	$501,509	$262,695	$686,662	$0	$224,854	$41,582	$20,200	$66,023	$9,922	$0	$0	$1,847,850
Health Maintenance Organizations	$5,655,692	$6,640,388	$37,054,466	$1,906,172	$30,664,666	$18,973,252	$67,899,600	$24,718	$21,248,151	$2,370,469	$362,349	$7,489,226	$837,731	$0	$0	$201,126,880
Inpatient Hospitals	$9,770,178	$8,736,647	$46,586,477	$3,550,355	$28,622,856	$12,232,060	$136,504,087	$58,136	$58,982,430	$2,778,337	$3,172,765	$32,411,151	$3,822,937	$15,547,780	($3,556)	$362,772,640
Outpatient Hospitals	$1,538,257	$4,670,187	$32,489,068	$2,636,089	$50,838,381	$20,465,906	$104,661,892	$128,460	$59,575,068	$6,789,520	$3,976,941	$6,716,703	$632,176	$1,156,225	$1,904	$296,276,777
Lab & X-Ray	$247,478	$749,603	$4,900,956	$336,876	$12,907,990	$5,556,448	$22,610,028	$33,420	$6,214,009	$748,513	$859,094	$4,134,779	$464,469	$86,094	$133	$59,849,890
Durable Medical Equipment	$11,346,365	$3,862,034	$33,924,411	$892,300	$4,466,275	$1,827,405	$14,155,855	$27,463	$12,669,966	$1,108,375	$2,826,527	$186,658	$21,347	$643	$166,840	$87,482,464
Prescription Drugs	$3,117,878	$13,139,491	$91,851,848	$5,942,198	$56,960,566	$26,819,336	$160,808,710	$199,546	$61,368,815	$9,540,470	$11,797,095	$3,980,852	$393,902	$130	$536	$445,921,373
Drug Rebate	($1,400,506)	($5,965,880)	($41,639,659)	($2,688,313)	($25,741,271)	($12,235,118)	($73,237,412)	($92,685)	($27,912,999)	($4,347,858)	($5,354,679)	($1,812,094)	($176,524)	($47)	($203)	($202,605,248)
Rural Health Centers	$23,787	$116,682	$556,182	$25,332	$1,446,616	$844,766	$2,480,550	$1,493	$3,868,429	$341,674	$178,101	$333,384	$20,802	$5,384	$0	$10,243,182
Federally Qualified Health Centers	$368,202	$660,220	$3,982,722	$157,334	$8,653,754	$4,631,279	$20,935,703	$20,583	$23,925,419	$2,080,039	$767,234	$4,461,111	$386,479	$171,639	($348)	$71,201,370
Co-Insurance (Title XVIII-Medicare)	$16,149,089	$2,858,652	$11,212,295	$1,315,512	$1,569,224	$17,659	$189,256	$162	$10,103	$1,139	$9,109	$48,489	$35	$258	$7,946,916	$41,327,898
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$1,335,684	$0	$0	$0	$0	$0	$0	$0	$1,335,684
Administrative Service Organizations - Services	$36,972	$65,948	$1,210,326	$7,487	$173,368	$37,697	$107,687	$0	$391,642	$0	$28,365	$100,463	$39,217	$0	$171	$2,199,343
Other Medical Services	$2	$0	($1)	$0	($16)	$4	$14	$1	$0	($2)	($1)	($2)	$0	($1)	$1	($1)
Acute Home Health	$2,138,232	$1,205,313	$4,346,934	$130,774	$622,076	$167,049	$2,542,605	$510	$820,269	$15,189	$218,985	$119,737	$13,173	$203	$0	$12,341,049
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$58,470,134	$45,282,708	$279,905,173	$18,320,727	$239,655,430	$111,905,742	$614,988,968	$2,027,686	$404,712,217	$43,610,644	$30,231,748	$79,291,581	$9,003,830	$19,781,590	$8,120,962	$1,965,309,140
Caseload	42,705	10,678	67,735	5,290	159,788	90,847	338,953	309	471,717	60,711	20,078	14,640	1,854	2,661	33,714	1,321,679
Half -Year Per Capita	$1,369.16	$4,240.62	$4,132.37	$3,463.60	$1,499.83	$1,231.81	$1,814.38	$6,558.55	$857.96	$718.33	$1,505.70	$5,416.03	$4,857.31	$7,435.29	$240.88	$1,486.98

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

Cash Based Actuals

HCBS WAIVERS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$98,761,506	$14,013,387	$75,665,199	$0	$44,160	$0	$0	$0	$3,477	$0	$24,363	$0	$0	$0	$669,883	$189,181,976
FY 2008-09	$103,189,236	$16,600,418	$99,120,846	$0	$16,756	$0	$0	$0	$50	$0	$88,666	$0	$0	$0	$242,445	$219,258,416
FY 2009-10 (DA)	$108,935,300	$17,849,185	$105,282,776	$0	$19,344	$0	$0	$0	$0	$0	$105,173	$0	$0	$0	$194,577	$232,386,355
FY 2010-11 (DA)	$111,149,465	$20,210,587	$120,507,011	$0	$32,095	$12,129	$0	$0	$3,328	$0	$86,754	$0	$0	$0	$142,107	$252,143,476
FY 2011-12	$117,679,185	$23,268,051	$130,652,872	$0	$8,548	$20,511	$0	$0	$7,404	$0	$111,354	$0	$0	$0	$260,261	$272,008,186
FY 2012-13	$125,361,271	$24,829,149	$142,882,126	$47,542	$16,956	$39,770	$7,746	$0	$17,013	$0	$69,174	$0	$0	$0	$221,261	$293,492,008
FY 2013-14	$144,155,003	$29,761,079	$162,371,250	$771,736	$205,171	$30,048	$339,106	$0	$264,157	$0	$169,103	$35	$0	$0	$888,063	$338,954,751
FY 2014-15	$153,119,541	$33,092,909	$171,957,958	$1,583,713	$663,480	$108,582	$1,394,432	$0	$993,001	$953	$288,135	$29,231	$0	$1,164	$984,351	$364,217,450
FY 2015-16	$166,057,738	$36,756,795	$184,903,855	$2,098,865	$352,648	$42,535	$1,716,796	$0	$1,008,304	$2,152	$157,428	$34,316	$0	$0	$888,293	$394,019,725
Estimated FY 2016-17	$189,759,813	$42,067,397	$212,516,532	$2,382,846	$381,842	$36,893	$1,955,183	$0	$1,162,432	$2,210	$164,823	$36,893	$0	$0	$1,028,043	$451,494,907
Estimated FY 2017-18	$204,226,867	$45,196,599	$228,076,600	$2,660,371	$411,056	$39,711	$2,100,048	$0	$1,269,462	$2,391	$177,190	$39,711	$0	$0	$1,106,051	$485,306,057
Estimated FY 2018-19	$219,837,556	$48,570,072	$244,081,793	$2,911,651	$442,626	$42,758	$2,256,051	$0	$1,328,265	$2,437	$189,911	$42,758	$0	$0	$1,189,759	$520,895,637

Percent Change in Cash Based Actuals

HCBS WAIVERS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	4.48%	18.46%	31.00%	0.00%	-62.06%	0.00%	0.00%	0.00%	-98.57%	0.00%	263.94%	0.00%	0.00%	0.00%	-63.81%	15.90%
FY 2009-10 (DA)	5.57%	7.52%	6.22%	0.00%	15.45%	0.00%	0.00%	0.00%	-100.00%	0.00%	18.62%	0.00%	0.00%	0.00%	-19.74%	5.99%
FY 2010-11 (DA)	2.03%	13.23%	14.46%	0.00%	65.91%	100.00%	0.00%	0.00%	100.00%	0.00%	-17.51%	0.00%	0.00%	0.00%	-26.97%	8.50%
FY 2011-12	5.87%	15.13%	8.42%	0.00%	-73.37%	69.11%	0.00%	0.00%	122.48%	0.00%	28.36%	0.00%	0.00%	0.00%	83.14%	7.88%
FY 2012-13	6.53%	6.71%	9.36%	100.00%	98.36%	93.90%	100.00%	0.00%	129.78%	0.00%	-37.88%	0.00%	0.00%	0.00%	-14.98%	7.90%
FY 2013-14	14.99%	19.86%	13.64%	1523.27%	1110.02%	-24.45%	4277.82%	0.00%	1452.68%	0.00%	144.46%	100.00%	0.00%	0.00%	301.36%	15.49%
FY 2014-15	6.22%	11.20%	5.90%	105.21%	223.38%	261.36%	311.21%	0.00%	275.91%	100.00%	70.39%	83417.14%	0.00%	100.00%	10.84%	7.45%
FY 2015-16	8.45%	11.07%	7.53%	32.53%	-46.85%	-60.83%	23.12%	0.00%	1.54%	125.81%	-45.36%	17.40%	0.00%	-100.00%	-9.76%	8.18%
Estimated FY 2016-17	14.27%	14.45%	14.93%	13.53%	8.28%	-13.26%	13.89%	0.00%	15.29%	2.70%	4.70%	7.51%	0.00%	0.00%	15.73%	14.59%
Estimated FY 2017-18	7.62%	7.44%	7.32%	11.65%	7.65%	7.64%	7.41%	0.00%	9.21%	8.19%	7.50%	7.64%	0.00%	0.00%	7.59%	7.49%
Estimated FY 2018-19	7.64%	7.46%	7.02%	9.45%	7.68%	7.67%	7.43%	0.00%	4.63%	1.92%	7.18%	7.67%	0.00%	0.00%	7.57%	7.33%

Current Year Projections by Eligibility Category

HCBS WAIVERS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Elderly, Blind and Disabled Waiver	$181,163,143	$33,938,214	$147,298,467	$2,206,168	$367,695	$36,769	$1,617,856	$0	$36,769	$0	$147,078	$36,769	$0	$0	$845,698	$367,694,626
Community Mental Health Supports Waiver	$6,645,384	$5,667,385	$28,993,102	$108,667	$12,538	$0	$213,154	$0	$0	$0	$8,359	$0	$0	$0	$146,282	$41,794,871
Disabled Children's Waiver	$0	$0	$13,545,666	$36,586	$0	$0	$0	$0	$1,049,291	$1,463	$1,463	$0	$0	$0	$0	$14,634,469
Consumer Directed Attendant Support-State Plan	$612,049	$114,658	$497,638	$7,453	$1,242	$124	$5,466	$0	$124	$0	$497	$124	$0	$0	$2,857	$1,242,232
Brain Injury Waiver	$1,043,233	$2,252,873	$17,890,713	$19,201	$0	$0	$108,804	$0	$2,133	$0	$0	$0	$0	$0	$17,067	$21,334,024
Children with Autism Waiver	$0	$0	$423,396	$492	$0	$0	$0	$0	$21,752	$0	$1,925	$0	$0	$0	$0	$447,565
Children with Life Limiting Illness Waiver	$0	$0	$619,938	$611	$0	$0	$0	$0	$52,363	$747	$5,501	$0	$0	$0	$0	$679,160
Spinal Cord Injury Adult Waiver	$296,004	$94,267	$3,247,612	$3,668	$367	$0	$9,903	$0	$0	$0	$0	$0	$0	$0	$16,139	$3,667,960
Estimated FY 2016-17 Total Expenditure	$189,759,813	$42,067,397	$212,516,532	$2,382,846	$381,842	$36,893	$1,955,183	$0	$1,162,432	$2,210	$164,823	$36,893	$0	$0	$1,028,043	$451,494,907

Request Year Projections by Eligibility Category

HCBS WAIVERS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Elderly, Blind and Disabled Waiver	$195,478,783	$36,620,036	$158,938,098	$2,380,501	$396,750	$39,675	$1,745,701	$0	$39,675	$0	$158,700	$39,675	$0	$0	$912,525	$396,750,119
Community Mental Health Supports Waiver	$7,185,009	$6,127,595	$31,347,436	$117,491	$13,557	$0	$230,463	$0	$0	$0	$9,038	$0	$0	$0	$158,161	$45,188,750
Disabled Children's Waiver	$0	$0	$14,856,562	$40,127	$0	$0	$0	$0	$1,150,838	$1,605	$1,605	$0	$0	$0	$0	$16,050,737
Consumer Directed Attendant Support-State Plan	$179,026	$33,537	$145,559	$2,180	$363	$36	$1,599	$0	$36	$0	$145	$36	$0	$0	$836	$363,353
Brain Injury Waiver	$1,072,577	$2,316,239	$18,335,698	$77,968	$0	$0	$111,864	$0	$2,193	$0	$0	$0	$0	$0	$17,547	$21,934,086
Children with Autism Waiver	$0	$0	$420,507	$489	$0	$0	$0	$0	$21,603	$0	$1,911	$0	$0	$0	$0	$444,510
Children with Life Limiting Illness Waiver	$0	$0	$652,541	$643	$0	$0	$0	$0	$55,117	$786	$5,791	$0	$0	$0	$0	$714,878
Spinal Cord Injury Adult Waiver	$311,472	$99,192	$3,380,199	$40,972	$386	$0	$10,421	$0	$0	$0	$0	$0	$0	$0	$16,982	$3,859,624
Estimated FY 2017-18 Total Expenditure	$204,226,867	$45,196,599	$228,076,600	$2,660,371	$411,056	$39,711	$2,100,048	$0	$1,269,462	$2,391	$177,190	$39,711	$0	$0	$1,106,051	$485,306,057

Out Year Projections by Eligibility Category

HCBS WAIVERS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Elderly, Blind and Disabled Waiver	$210,632,290	$39,458,819	$171,258,971	$2,565,037	$427,506	$42,751	$1,881,027	$0	$42,751	$0	$171,002	$42,751	$0	$0	$983,264	$427,506,169
Community Mental Health Supports Waiver	$7,765,166	$6,622,369	$33,878,592	$126,978	$14,651	$0	$249,071	$0	$0	$0	$9,768	$0	$0	$0	$170,931	$48,837,526
Disabled Children's Waiver	$0	$0	$15,609,713	$42,161	$0	$0	$0	$0	$1,209,179	$1,686	$1,686	$0	$0	$0	$0	$16,864,425
Consumer Directed Attendant Support-State Plan	$36,305	$6,801	$29,517	$442	$74	$7	$324	$0	$7	$0	$29	$7	$0	$0	$169	$73,682
Brain Injury Waiver	$1,085,394	$2,380,684	$18,808,947	$134,064	$0	$0	$114,976	$0	$2,254	$0	$0	$0	$0	$0	$18,035	$22,544,353
Children with Autism Waiver	$0	$0	$417,778	$486	$0	$0	$0	$0	$21,463	$0	$1,899	$0	$0	$0	$0	$441,626
Children with Life Limiting Illness Waiver	$0	$0	$622,865	$614	$0	$0	$0	$0	$52,611	$751	$5,527	$0	$0	$0	$0	$682,368
Spinal Cord Injury Adult Waiver	$318,401	$101,399	$3,455,410	$41,870	$395	$0	$10,653	$0	$0	$0	$0	$0	$0	$0	$17,360	$3,945,488
Estimated FY 2018-19 Total Expenditure	$219,837,556	$48,570,072	$244,081,793	$2,911,651	$442,626	$42,758	$2,256,051	$0	$1,328,265	$2,437	$189,911	$42,758	$0	$0	$1,189,759	$520,895,637

Definitions: HCBS: Home- and Community-Based Services

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

Cash Based Actuals by Waiver

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Spinal Cord Injury Adult Waiver	TOTAL
FY 2008-09	$177,103,726	$22,958,866	$1,747,683	$4,125,973	$12,028,236	$1,293,932	$0	$0	$219,258,416
FY 2009-10 (DA)	$190,694,445	$23,040,615	$1,841,013	$3,516,917	$11,596,421	$1,594,734	$102,210	$0	$232,386,355
FY 2010-11 (DA)	$209,076,713	$24,587,535	$1,887,201	$2,961,259	$12,182,917	$1,328,578	$119,273	$0	$252,143,476
FY 2011-12	$225,701,747	$25,934,255	$3,130,073	$3,461,683	$12,587,131	$1,022,387	$170,910	$0	$272,008,186
FY 2012-13	$242,975,488	$28,309,412	$5,350,385	$2,661,977	$12,849,682	$885,424	$207,131	$252,509	$293,492,008
FY 2013-14	$279,658,921	$31,919,229	$8,101,781	$2,331,237	$14,184,077	$764,302	$221,632	$1,773,572	$338,954,751
FY 2014-15	$297,151,243	$33,989,393	$10,912,003	$2,572,697	$16,649,310	$710,058	$473,674	$1,759,072	$364,217,450
FY 2015-16	$321,321,224	$35,721,561	$12,558,473	$2,081,957	$19,160,548	$558,548	$642,990	$1,974,424	$394,019,725
Estimated FY 2016-17	$367,694,626	$41,794,871	$14,634,469	$1,242,232	$21,334,024	$447,565	$679,160	$3,667,960	$451,494,907
Estimated FY 2017-18	$396,750,119	$45,188,750	$16,050,737	$363,353	$21,934,086	$444,510	$714,878	$3,859,624	$485,306,057
Estimated FY 2018-19	$427,506,169	$48,837,526	$16,864,425	$73,682	$22,544,353	$441,626	$682,368	$3,945,488	$520,895,637

Percent Change in Cash Based Actuals

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Spinal Cord Injury Adult Waiver	TOTAL
FY 2009-10 (DA)	7.67%	0.36%	5.34%	-14.76%	-3.59%	23.25%	100.00%	0.00%	5.99%
FY 2010-11 (DA)	9.64%	6.71%	2.51%	-15.80%	5.06%	-16.69%	16.69%	0.00%	8.50%
FY 2011-12	7.95%	5.48%	65.86%	16.90%	3.32%	-23.05%	43.29%	0.00%	7.88%
FY 2012-13	7.65%	9.16%	70.93%	-23.10%	2.09%	-13.40%	21.19%	100.00%	7.90%
FY 2013-14	15.10%	12.75%	51.42%	-12.42%	10.38%	-13.68%	7.00%	602.38%	15.49%
FY 2014-15	6.25%	6.49%	34.69%	10.36%	17.38%	-7.10%	113.72%	-0.82%	7.45%
FY 2015-16	8.13%	5.10%	15.09%	-19.07%	15.08%	-21.34%	35.75%	12.24%	8.18%
Estimated FY 2016-17	14.43%	17.00%	16.53%	-40.33%	11.34%	-19.87%	5.63%	85.77%	14.59%
Estimated FY 2017-18	7.90%	8.12%	9.68%	-70.75%	2.81%	-0.68%	5.26%	5.23%	7.49%
Estimated FY 2018-19	7.75%	8.07%	5.07%	-79.72%	2.78%	-0.65%	-4.55%	2.22%	7.33%

HCBS Waiver Enrollment[1]

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's Waiver	Consumer Directed Attendant Support-State Plan[2]	Brain Injury Waiver	Children with Autism Waiver[2]	Children with Life Limiting Illness Waiver[2]	Spinal Cord Injury Adult Waiver[2]	TOTAL
FY 2008-09	15,920	2,150	1,252	N/A	235	N/A	N/A	0	19,676
FY 2009-10 (DA)	16,897	2,274	1,263	N/A	232	N/A	N/A	0	20,820
FY 2010-11 (DA)	17,800	2,398	1,193	39	229	63	120	0	21,842
FY 2011-12	18,491	2,522	1,118	36	223	55	151	0	22,596
FY 2012-13	19,237	2,688	1,125	N/A	237	N/A	171	N/A	23,522
FY 2013-14	20,500	2,908	1,040	N/A	258	N/A	166	N/A	24,974
FY 2014-15	21,472	3,042	1,100	N/A	307	N/A	130	N/A	26,153
FY 2015-16	21,674	3,059	1,186	N/A	336	N/A	131	N/A	26,481
Estimated FY 2016-17	23,046	3,352	1,345	17	360	43	145	101	28,369
Estimated FY 2017-18	23,941	3,352	1,436	5	371	44	161	104	29,371
Estimated FY 2018-19	24,839	3,500	1,468	1	382	45	178	104	30,474

Percent Change in Enrollment

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's Waiver	Consumer Directed Attendant Support-State Plan[2]	Brain Injury Waiver	Children with Autism Waiver[2]	Children with Life Limiting Illness Waiver[2]	Spinal Cord Injury Adult Waiver[2]	TOTAL
FY 2009-10 (DA)	6.14%	5.77%	0.88%	N/A	-1.28%	N/A	N/A	0.00%	5.81%
FY 2010-11 (DA)	5.34%	5.45%	-5.54%	N/A	-1.29%	N/A	N/A	0.00%	4.91%
FY 2011-12	3.88%	5.17%	-6.29%	-7.69%	-2.62%	-12.70%	25.83%	0.00%	3.45%
FY 2012-13	4.03%	6.58%	0.63%	N/A	6.28%	N/A	13.25%	100.00%	4.10%
FY 2013-14	6.57%	8.18%	-7.56%	N/A	8.86%	N/A	-2.92%	N/A	6.17%
FY 2014-15	4.74%	4.61%	5.77%	N/A	18.99%	N/A	-21.69%	N/A	4.72%
FY 2015-16	0.94%	0.54%	7.83%	N/A	9.42%	N/A	0.77%	N/A	1.25%
Estimated FY 2016-17	6.33%	9.60%	13.40%	N/A	7.17%	N/A	10.69%	N/A	7.13%
Estimated FY 2017-18	3.88%	0.00%	6.77%	-70.59%	3.06%	2.33%	11.03%	2.97%	3.53%
Estimated FY 2018-19	3.75%	4.42%	2.23%	-80.00%	2.96%	2.27%	10.56%	0.00%	3.76%

Per Enrollee Cost

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's Waiver	Consumer Directed Attendant Support-State Plan[2]	Brain Injury Waiver	Children with Autism Waiver[2]	Children with Life Limiting Illness Waiver[2]	Spinal Cord Injury Adult Waiver[2]	TOTAL
FY 2008-09	$11,124.61	$10,678.54	$1,395.91	N/A	$51,183.98	N/A	N/A	$0.00	$11,143.44
FY 2009-10 (DA)	$11,285.70	$10,132.20	$1,457.65	N/A	$49,984.57	N/A	N/A	$0.00	$11,161.69
FY 2010-11 (DA)	$11,745.88	$10,253.35	$1,581.90	$75,929.72	$53,200.51	$21,088.53	$993.94	$0.00	$11,543.97
FY 2011-12	$12,206.03	$10,283.21	$2,799.71	$96,157.86	$56,444.53	$18,588.85	$1,131.85	$0.00	$12,037.89
FY 2012-13	$12,630.63	$10,531.78	$4,755.90	N/A	$54,218.07	N/A	$1,211.29	N/A	$12,477.34
FY 2013-14	$13,641.90	$10,976.35	$7,790.17	N/A	$54,977.04	N/A	$1,335.13	N/A	$13,572.31
FY 2014-15	$13,839.01	$11,173.37	$9,920.00	N/A	$54,232.28	N/A	$3,643.65	N/A	$13,926.41
FY 2015-16	$14,825.19	$11,679.44	$10,588.19	N/A	$57,039.59	N/A	$4,908.32	N/A	$14,879.62
Estimated FY 2016-17	$15,954.81	$12,468.64	$10,880.65	$73,072.47	$59,261.18	$10,408.49	$4,683.86	$36,316.44	$15,915.08
Estimated FY 2017-18	$16,571.99	$13,481.13	$11,177.39	$72,670.60	$59,121.53	$10,102.50	$4,440.24	$37,111.77	$16,523.31
Estimated FY 2018-19	$17,211.09	$13,953.15	$11,488.03	$73,682.00	$59,016.63	$9,813.91	$3,833.53	$37,937.38	$17,093.05

Percent Change in Per Enrollee Cost

HCBS WAIVERS	Elderly, Blind and Disabled Waiver	Community Mental Health Supports Waiver	Disabled Children's Waiver	Consumer Directed Attendant Support-State Plan[2]	Brain Injury Waiver	Children with Autism Waiver[2]	Children with Life Limiting Illness Waiver[2]	Spinal Cord Injury Adult Waiver[2]	TOTAL
FY 2009-10 (DA)	1.45%	-5.12%	4.42%	N/A	-2.34%	N/A	N/A	0.00%	0.16%
FY 2010-11 (DA)	4.08%	1.20%	8.52%	N/A	6.43%	N/A	N/A	0.00%	3.42%
FY 2011-12	3.92%	0.29%	76.98%	N/A	6.10%	N/A	N/A	0.00%	4.28%
FY 2012-13	3.48%	2.42%	69.87%	N/A	-3.94%	N/A	7.02%	N/A	3.65%
FY 2013-14	8.01%	4.22%	63.80%	N/A	1.40%	N/A	10.22%	N/A	8.78%
FY 2014-15	1.44%	1.79%	27.34%	N/A	-1.35%	N/A	172.91%	N/A	2.61%
FY 2015-16	7.13%	4.53%	6.74%	N/A	5.18%	N/A	34.71%	N/A	6.84%
Estimated FY 2016-17	7.62%	6.76%	2.76%	N/A	3.89%	N/A	-4.57%	N/A	6.96%
Estimated FY 2017-18	3.87%	8.12%	2.73%	-0.55%	-0.24%	-2.94%	-5.20%	2.19%	3.82%
Estimated FY 2018-19	3.86%	3.50%	2.78%	1.39%	-0.18%	-2.86%	-13.66%	2.22%	3.45%

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

Current Year Projection									
HCBS WAIVERS	**Elderly, Blind and Disabled Waiver**	**Community Mental Health Supports Waiver**	**Disabled Children's Waiver**	**Consumer Directed Attendant Support-State Plan[2]**	**Brain Injury Waiver**	**Children with Autism Waiver[2]**	**Children with Life Limiting Illness Waiver[2]**	**Spinal Cord Injury Adult Waiver[2]**	**TOTAL**
FY 2015-16 Estimated Enrollment	21,674	3,059	1,186	N/A	336	N/A	131	N/A	26,481
Enrollment Trend Selected[3]	6.52%	9.58%	13.41%	N/A	7.14%	N/A	11.03%	N/A	7.32%
FY 2016-17 Estimated Enrollment	**23,087**	**3,352**	**1,345**	**25**	**360**	**43**	**145**	**61**	28,418
Bottom Line Impacts									
SB 15-011: "Pilot Program Spinal Cord Injury Alternative Medicine"	(40)	0	0	0	0	0	0	40	0
FY 2015-16 R-7: "Participant Directed Programs Expansion"	0	0	0	(8)	0	0	0	0	(8)
Total Bottom Line Impacts	**(40)**	**0**	**0**	**(8)**	**0**	**0**	**0**	**40**	**(8)**
FY 2016-17 Estimated Enrollment	**23,047**	**3,352**	**1,345**	**17**	**360**	**43**	**145**	**101**	**28,410**
FY 2015-16 Cost Per Enrollee	$14,825.19	$11,679.44	$10,588.19	N/A	$57,039.59	N/A	$4,908.32	N/A	$14,879.62
Percentage Selected to Modify Per Enrollee[4]	4.10%	3.67%	6.20%	N/A	0.03%	N/A	4.63%	N/A	6.96%
FY 2016-17 Estimate Cost Per Enrollee	**$15,433.02**	**$12,108.08**	**$11,244.66**	**$73,024.14**	**$57,056.70**	**$10,723.76**	**$5,135.58**	**$35,599.64**	**$15,915.08**
Estimated FY 2016-17 Base Expenditure	**$355,684,812**	**$40,586,284**	**$15,124,068**	**$1,241,410**	**$20,540,412**	**$461,122**	**$744,659**	**$3,595,564**	**$437,978,331**
Caseload Utilization Adjustment	**99.51%**	**99.48%**	**96.73%**	**100.00%**	**99.16%**	**97.06%**	**91.17%**	**100.00%**	**99.38%**
Cash Adjusted Estimated FY 2016-17 Expenditure	**$353,941,956**	**$40,375,235**	**$14,629,511**	**$1,241,410**	**$20,367,873**	**$447,565**	**$678,906**	**$3,595,564**	**$435,278,020**
Bottom Line Impacts									
Annualization of FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	($192,358)	$0	$0	$0	$0	$0	$0	$0	($192,358)
Annualization of FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($185,234)	$0	$0	$0	$0	$0	$0	$0	($185,234)
Annualization of HB 14-1357: "In-Home Support Services in Medicaid Program"	$1,117,446	$0	$0	$0	$0	$0	$0	$0	$1,117,446
Annualization of FY 2014-15 JBC Action: "Raising Cap on Home Modifications"	$934,622	$103,903	$0	$0	$55,732	$0	$0	$5,743	$1,100,000
Annualization of EPSDT Personal Care	($460,051)	($51,144)	$0	$0	($27,433)	$0	$0	$0	($538,628)
Colorado Choice Transitions	$1,497,244	$166,450	$0	$0	$89,281	$0	$0	$0	$1,752,975
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" - HCBS	$126,853	$14,102	$4,958	$822	$7,564	$0	$254	$779	$155,332
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - HCBS Personal Care/Homemaker	$10,191,737	$1,133,024	$0	$0	$607,738	$0	$0	$62,625	$11,995,124
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" Targeted - In-Home Respite (excludes CES Respite)	$49,370	$0	$0	$0	$2,944	$0	$0	$303	$52,617
Annualization of FY 2015-16 JBC Action: "Raising Cap on Home Modifications"	$479,451	$53,301	$0	$0	$28,590	$0	$0	$2,946	$564,288
Annualization of Independent Living Skills Training Rule Change	$0	$0	$0	$0	$201,735	$0	$0	$0	$201,735
Annualization of Consumer Transition Services Rate Increase	$193,590	$0	$0	$0	$0	$0	$0	$0	$193,590
Total Bottom Line Impacts	**$13,752,670**	**$1,419,636**	**$4,958**	**$822**	**$966,151**	**$0**	**$254**	**$72,396**	**$16,216,887**
Estimated FY 2016-17 Expenditure	**$367,694,626**	**$41,794,871**	**$14,634,469**	**$1,242,232**	**$21,334,024**	**$447,565**	**$679,160**	**$3,667,960**	**$451,494,907**
Estimated FY 2016-17 Per Enrollee	$15,954.12	$12,468.64	$10,880.65	$73,072.47	$59,261.18	$10,408.49	$4,683.86	$36,316.44	$15,892.11
% Change over FY 2015-16 Per Enrollee	7.61%	6.76%	2.76%	N/A	3.89%	N/A	-4.57%	N/A	6.80%

Request Year Projection									
HCBS WAIVERS	**Elderly, Blind and Disabled Waiver**	**Community Mental Health Supports Waiver**	**Disabled Children's Waiver**	**Consumer Directed Attendant Support-State Plan**	**Brain Injury Waiver**	**Children with Autism Waiver**	**Children with Life Limiting Illness Waiver**	**Spinal Cord Injury Adult Waiver**	**TOTAL**
Estimated FY 2016-17 Average HCBS Waiver Enrollment	23,047	3,352	1,345	17	360	43	145	101	28,410
Enrollment Trend Selected[3]	3.90%	4.42%	6.77%	0.00%	3.06%	2.33%	10.56%	0.00%	4.10%
FY 2017-18 Estimated Enrollment	**23,946**	**3,500**	**1,436**	**17**	**371**	**44**	**160**	**101**	29,575
Bottom Line Impacts									
HB 15-1186: "Children with Autism Waiver Expansion"	0	0	0	0	0	0	0	0	0
SB 15-011: "Pilot Program Spinal Cord Injury Alternative Medicine"	(3)	0	0	0	0	0	0	3	0
FY 2015-16 R-7: "Participant Directed Programs Expansion"	0	0	0	(12)	0	0	0	0	(12)
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	0	0	0	0	1	0	0	0	1
Total Bottom Line Impacts	**(3)**	**0**	**0**	**(12)**	**1**	**0**	**0**	**3**	**(11)**
FY 2017-18 Estimated Enrollment	**23,943**	**3,500**	**1,436**	**5**	**372**	**44**	**160**	**104**	**29,564**
FY 2016-17 Cost per Enrollee	$15,954.81	$12,468.64	$10,880.65	$73,072.47	$59,261.18	$10,408.49	$4,683.86	$36,316.44	$15,915.08
Percentage Selected to Modify Per Enrollee[4]	3.94%	3.67%	6.20%	-0.55%	0.03%	0.00%	4.63%	2.19%	3.82%
FY 2017-18 Estimate Cost Per Enrollee	**$16,583.43**	**$12,926.24**	**$11,555.25**	**$72,670.57**	**$59,278.96**	**$10,408.49**	**$4,900.72**	**$37,111.77**	**$16,523.31**
Estimated FY 2017-18 Base Expenditure	**$397,057,064**	**$45,241,840**	**$16,593,339**	**$363,353**	**$22,051,773**	**$457,974**	**$784,115**	**$3,859,624**	**$486,409,082**
Caseload Utilization Adjustment	**99.51%**	**99.48%**	**96.73%**	**100.00%**	**99.16%**	**97.06%**	**91.17%**	**100.00%**	**99.39%**
Cash Adjusted Estimated FY 2017-18 Expenditure	**$395,111,484**	**$45,006,582**	**$16,050,737**	**$363,353**	**$21,866,538**	**$444,510**	**$714,878**	**$3,859,624**	**$483,417,706**
Bottom Line Impacts									
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$0	$0	$0	$0	($30,165)	$0	$0	$0	($30,165)
Colorado Choice Transitions	$1,638,635	$182,168	$0	$0	$97,713	$0	$0	$0	$1,918,516
Total Bottom Line Impacts	**$1,638,635**	**$182,168**	**$0**	**$0**	**$67,548**	**$0**	**$0**	**$0**	**$1,888,351**
Estimated FY 2017-18 Total Expenditure	**$396,750,119**	**$45,188,750**	**$16,050,737**	**$363,353**	**$21,934,086**	**$444,510**	**$714,878**	**$3,859,624**	**$485,306,057**
Estimated FY 2017-18 Per Enrollee	$16,570.61	$12,911.07	$11,177.39	$72,670.60	$58,962.60	$10,102.50	$4,467.99	$37,111.77	$16,415.44
% Change over FY 2016-17 Per Enrollee	3.86%	3.55%	2.73%	N/A	-0.50%	N/A	-4.61%	N/A	3.14%

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

Out Year Projection									
HCBS WAIVERS	**Elderly, Blind and Disabled Waiver**	**Community Mental Health Supports Waiver**	**Disabled Children's Waiver**	**Consumer Directed Attendant Support-State Plan**	**Brain Injury Waiver**	**Children with Autism Waiver**	**Children with Life Limiting Illness Waiver**	**Spinal Cord Injury Adult Waiver**	**TOTAL**
Estimated FY 2017-18 Average HCBS Waiver Enrollment	23,943	3,500	1,436	5	372	44	160	104	29,564
Enrollment Trend Selected[3]	3.75%	4.23%	2.23%	0.00%	2.96%	2.27%	0.00%	0.00%	3.69%
FY 2018-19 Estimated Enrollment	**24,841**	**3,648**	**1,468**	**5**	**383**	**45**	**160**	**104**	30,654
Bottom Line Impacts									
FY 2015-16 R-7: "Participant Directed Programs Expansion"	0	0	0	(4)	0	0	0	0	(4)
Total Bottom Line Impacts	**0**	**0**	**0**	**(4)**	**0**	**0**	**0**	**0**	**(4)**
FY 2018-19 Estimated Enrollment	**24,841**	**3,648**	**1,468**	**1**	**383**	**45**	**160**	**104**	**30,650**
Estimated FY 2017-18 Cost per Enrollee	$16,570.61	$12,911.07	$11,177.39	$72,670.60	$58,962.60	$10,102.50	$4,467.99	$37,111.77	$16,415.44
Percentage Selected to Modify Per Enrollee[4]	3.79%	3.67%	6.20%	-0.55%	0.03%	0.00%	4.63%	2.19%	4.16%
FY 2018-19 Estimate Cost Per Enrollee	**$17,198.64**	**$13,384.91**	**$11,870.39**	**$72,270.91**	**$58,980.29**	**$10,102.50**	**$4,674.86**	**$37,924.52**	**$17,093.05**
Estimated FY 2018-19 Base Expenditure	**$427,231,416**	**$48,828,152**	**$17,425,733**	**$72,271**	**$22,589,451**	**$454,613**	**$747,978**	**$3,944,150**	**$521,293,764**
Caseload Utilization Adjustment	**99.51%**	**99.48%**	**96.73%**	**100.00%**	**99.16%**	**97.06%**	**91.17%**	**100.00%**	**99.39%**
Cash Adjusted Estimated FY 2018-19 Expenditure	**$425,137,982**	**$48,574,246**	**$16,855,912**	**$72,271**	**$22,399,700**	**$441,247**	**$681,932**	**$3,944,150**	**$518,107,440**
Bottom Line Impacts									
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$0	$0	$0	$0	$3,434	$0	$0	$0	$3,434
Colorado Choice Transitions	$2,150,363	$239,064	$0	$0	$128,230	$0	$0	$0	$2,517,657
SB 16-192 Single Assessment	$217,824	$24,216	$8,513	$1,411	$12,989	$379	$436	$1,338	$267,106
Total Bottom Line Impacts	**$2,368,187**	**$263,280**	**$8,513**	**$1,411**	**$144,653**	**$379**	**$436**	**$1,338**	**$2,788,197**
Estimated FY 2018-19 Total Expenditure	**$427,506,169**	**$48,837,526**	**$16,864,425**	**$73,682**	**$22,544,353**	**$441,626**	**$682,368**	**$3,945,488**	**$520,895,637**
Estimated FY 2018-19 Per Enrollee	$17,209.70	$13,387.48	$11,488.03	$73,682.00	$58,862.54	$9,813.91	$4,264.80	$37,937.38	$16,994.96
% Change over FY 2017-18 Per Enrollee	3.86%	3.69%	2.78%	1.39%	-0.17%	-2.86%	-4.55%	2.22%	3.53%

Definitions: HCBS: Home- and Community-Based Services

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

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

(3) Percentage selected to modify enrollment for FY 2016-17 through FY 2018-19	Elderly, Blind and Disabled Waiver	6.52%, 3.90%, 3.75%	Consumer Directed Attendant Support-State Plan	N/A, 0.00%, 0.00%	Children with Life Limiting Illness Waiver	11.03%, 10.56%, 0.00%
	Community Mental Health Supports Waiver	9.58%, 4.42%, 4.23%	Brain Injury Waiver	7.14%, 3.06%, 2.96%	Spinal Cord Injury Adult Waiver	N/A, 0.00%, 0.00%
	Disabled Children's Waiver	13.41%, 6.77%, 2.23%	Children with Autism Waiver	N/A, 2.33%, 2.27%		
(4) Percentage selected to modify per enrollee costs for FY 2016-17 through FY 2018-19	Elderly, Blind and Disabled Waiver	4.10%, 3.94%, 3.79%	Consumer Directed Attendant Support-State Plan	N/A, -0.55%, -0.55%	Children with Life Limiting Illness Waiver	4.63%, 4.63%, 4.63%
	Community Mental Health Supports Waiver	3.67%, 3.67%, 3.67%	Brain Injury Waiver	0.03%, 0.03%, 0.03%	Spinal Cord Injury Adult Waiver	N/A, 2.19%, 2.19%
	Disabled Children's Waiver	6.20%, 6.20%, 6.20%	Children with Autism Waiver	N/A, 0.00%, 0.00%		

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

HCBS Waivers Average Monthly Enrollment vs. Average Monthly Waiver Utilizers									
Fiscal Year		**Elderly, Blind and Disabled Wavier (HCBS-EBD)**	**Community Mental Health Supports Waiver (HCBS-CMHS)**	**Disabled Children's Waiver (HCBS-CHCBS)**	**Consumer Directed Attendant Support-State Plan (HCBS-1915(i) CDASS)**	**Brain Injury Waiver (HCBS-BI)**	**Children with Autism Waiver (HCBS-CWA)**	**Children with Life Limiting Illness Waiver (HCBS-CLLI) (4)**	**Spinal Cord Injury Adult Waiver (HCBS-SCI) (4)**
FY 2008-09	Average Monthly Enrollment(1)	15,920	2,150	1,252	0	235	68	N/A	0
	Average Monthly Wavier Utilizers(2)	15,052	2,038	1,187	0	228	65	N/A	0
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	94.55%	94.79%	94.81%	0.00%	97.02%	95.59%	47.06%	0.00%
FY 2009-10 (DA)	Average Monthly Enrollment(1)	16,897	2,274	1,263	42	232	68	N/A	0
	Average Monthly Wavier Utilizers(2)	16,005	2,169	1,176	42	224	66	N/A	0
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	94.72%	95.38%	93.11%	100.00%	96.55%	97.06%	60.47%	0.00%
FY 2010-11 (DA)	Average Monthly Enrollment(1)	17,800	2,398	1,193	39	229	63	120	0
	Average Monthly Wavier Utilizers(2)	16,839	2,280	1,113	39	224	59	74	0
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	94.60%	95.08%	93.29%	100.00%	97.82%	93.65%	61.67%	0.00%
FY 2011-12	Average Monthly Enrollment(1)	18,491	2,522	1,118	36	223	55	151	0
	Average Monthly Wavier Utilizers(2)	17,875	2,419	1,060	36	219	50	98	0
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	96.67%	95.92%	94.81%	100.00%	98.21%	90.91%	64.90%	0.00%
FY 2012-13	Average Monthly Enrollment(1)	19,237	2,688	1,125	33	237	50	171	N/A
	Average Monthly Wavier Utilizers(2)	19,143	2,674	1,075	33	235	43	100	N/A
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	99.51%	99.48%	95.56%	100.00%	99.16%	86.00%	58.48%	100.00%
FY 2013-14	Average Monthly Enrollment(1)	20,500	2,908	1,040	31	258	48	166	N/A
	Average Monthly Wavier Utilizers(2)	20,046	2,798	996	31	253	37	86	N/A
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	97.79%	96.22%	95.77%	100.00%	98.06%	77.08%	51.81%	100.00%
FY 2014-15	Average Monthly Enrollment(1)	21,472	3,042	1,100	N/A	307	49	130	53
	Average Monthly Wavier Utilizers(2)	20,736	2,897	1,064	N/A	297	35	90	51
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	96.57%	95.23%	96.73%	100.00%	96.74%	71.43%	69.23%	96.23%
FY 2015-16	Average Monthly Enrollment(1)	21,674	3,059	1,186	N/A	336	42	131	53
	Average Monthly Wavier Utilizers(2)	21,081	2,944	1,113	N/A	327	28	111	50
	Average Monthly Utilizers as a Percentage of Average Monthly Enrollment	97.26%	96.24%	93.84%	100.00%	97.32%	66.67%	84.41%	94.34%
	FY 2016-17 Selected Average Monthly Utilizers Conversion Factor(3)	**99.51%**	**99.48%**	**96.73%**	**100.00%**	**99.16%**	**97.06%**	**91.17%**	**100.00%**
	FY 2017-18 Selected Average Monthly Utilizers Conversion Factor(3)	**99.51%**	**99.48%**	**96.73%**	**100.00%**	**99.16%**	**97.06%**	**91.17%**	**100.00%**
	FY 2018-19 Selected Average Monthly Utilizers Conversion Factor(3)	**99.51%**	**99.48%**	**96.73%**	**100.00%**	**99.16%**	**97.06%**	**91.17%**	**100.00%**

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

(1) Average Monthly Enrollment is defined by the average number of active PARs, for each waiver, per month.

(2) Average Monthly Waiver Utilizers is defined by the average number of clients with a paid claim, for each waiver, per month of service.

(3) The selected FY 2016-17, FY 2017-18, and FY 2018-19 Average Monthly Utilizer Conversion Factor for HCBS-EBD, CMHS, and BI are set to the FY 2012-13 level, HCBS-CHCBS is set to the FY 2014-15 level, HCBS-1915(i) CDASS is set at 100% as claims are invoiced, HCBS-CWA is set to the FY 2009-10 level, HCBS-CLLI is trended from the FY 2015-16 level due to audit recommendations being fully implemented, and HCBS-SCI is set to the FY 2013-14 level. The selected factors are the maximum average monthly paid utilizers as a percentage of average monthly enrollment for the chosen year. For further detail please see the narrative.

(4) N/A - Data cannot be displayed due to HIPAA.

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

FY 2014-15 July - December COFRS Total Actuals

HCBS WAIVERS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
HCBS - Elderly, Blind, and Disabled	$73,057,304	$13,500,257	$61,306,273	$723,121	$317,868	$0	$0	$0	$2,527	$0	$158,828	$8,684	$0	$0	$402,379	$149,477,241
HCBS - Mental Illness	$2,662,964	$2,174,297	$11,892,413	$26,893	$7,786	$0	$0	$0	$0	$0	$263	$0	$0	$0	$74,218	$16,838,834
HCBS - Disabled Children	$0	$0	$4,706,233	$1,513	$0	$0	$0	$0	$469,657	$506	$0	$0	$0	$0	$0	$5,177,909
HCBS - Persons Living with AIDS	($323)	($27)	($4,113)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($4,463)
HCBS - Consumer Directed Attendant Support	$239,204	$44,202	$200,729	$2,368	$1,041	$0	$0	$0	$8	$0	$520	$28	$0	$0	$1,317	$489,417
HCBS - Brain Injury	$235,048	$833,862	$6,660,852	$1,328	$2,150	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,312	$7,736,552
HCBS - Children with Autism	$0	$0	$372,580	$465	$0	$0	$0	$0	$23,647	$0	$11,777	$0	$0	$0	$0	$408,469
HCBS - Pediatric Hospice	$0	$0	$142,819	$0	$0	$0	$0	$0	$7,672	$0	$1,274	$0	$0	$0	$0	$151,765
HCBS - Spinal Cord Injury	$102,267	$10,827	$818,969	$0	$11,592	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$943,655
Total	$76,296,464	$16,563,418	$86,096,755	$755,688	$340,437	$0	$0	$0	$503,511	$506	$172,662	$8,712	$0	$0	$481,226	$181,219,379
Caseload	42,053	10,360	66,015	3,078	158,622	65,032	214,360	437	439,474	44,580	20,152	15,005	1,751	2,506	26,979	1,110,401
Half -Year Per Capita	$1,814.31	$1,598.84	$1,304.20	$245.53	$2.15	$0.00	$0.00	$0.00	$1.15	$0.01	$8.57	$0.58	$0.00	$0.00	$17.84	$163.20

FY 2014-15 January - June COFRS Total Actuals

HCBS WAIVERS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
HCBS - Elderly, Blind, and Disabled	$72,719,055	$13,465,344	$58,764,896	$669,920	$268,772	$104,830	$1,134,300	$0	$5,765	$0	$102,405	$20,298	$0	$1,154	$420,840	$147,677,579
HCBS - Mental Illness	$2,685,548	$2,122,119	$12,126,221	$10,019	$10,484	$2,852	$126,168	$0	$0	$0	$6,373	$0	$0	$0	$60,775	$17,150,559
HCBS - Disabled Children	$0	$0	$5,203,149	$68,506	$0	$0	$0	$0	$461,854	$447	$138	$0	$0	$0	$0	$5,734,094
HCBS - Persons Living with AIDS	$64	$6	$816	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$886
HCBS - Consumer Directed Attendant Support	$1,015,985	$189,544	$845,336	$9,596	$3,997	$900	$10,152	$0	$63	$0	$1,723	$221	$0	$10	$5,753	$2,083,280
HCBS - Brain Injury	$336,013	$734,421	$7,612,036	$52,473	$39,330	$0	$122,805	$0	$0	$0	$0	$0	$0	$0	$15,680	$8,912,758
HCBS - Children with Autism	$0	$0	$293,654	$8,962	$0	$0	$0	$0	($1,926)	$0	$899	$0	$0	$0	$0	$301,589
HCBS - Pediatric Hospice	$0	$0	$292,491	$1,749	$0	$0	$0	$0	$23,734	$0	$3,935	$0	$0	$0	$0	$321,909
HCBS - Spinal Cord Injury	$66,412	$18,057	$722,604	$6,800	$460	$0	$1,007	$0	$0	$0	$0	$0	$0	$0	$77	$815,417
Total	$76,823,077	$16,529,491	$85,861,203	$828,025	$323,043	$108,582	$1,394,432	$0	$489,490	$447	$115,473	$20,519	$0	$1,164	$503,125	$182,998,071
Caseload	41,582	10,573	67,080	4,177	164,743	78,946	268,423	364	451,973	55,646	19,921	14,788	1,747	2,937	29,112	1,212,011
Half -Year Per Capita	$1,847.51	$1,563.37	$1,279.98	$198.26	$1.96	$1.38	$5.19	$0.00	$1.08	$0.01	$5.80	$1.39	$0.00	$0.40	$17.28	$150.99

FY 2015-16 July - December COFRS Total Actuals

HCBS WAIVERS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
HCBS - Elderly, Blind, and Disabled	$76,578,554	$14,393,157	$62,751,370	$824,909	$153,585	$18,974	$694,781	$0	$22,221	$0	$68,358	$21,555	$0	$0	$369,072	$155,896,536
HCBS - Mental Illness	$2,714,970	$2,282,928	$12,162,707	$29,691	$4,491	$0	$64,910	$0	$0	$0	$2,423	$0	$0	$0	$56,931	$17,319,051
HCBS - Disabled Children	$0	$0	$5,556,157	$21,763	$0	$0	$0	$0	$474,797	$769	$553	$0	$0	$0	$0	$6,054,039
HCBS - Persons Living with AIDS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Consumer Directed Attendant Support	$440,677	$83,351	$364,434	$4,770	$882	$109	$4,100	$0	$128	$0	$393	$123	$0	$0	$2,120	$901,087
HCBS - Brain Injury	$438,383	$911,877	$8,036,330	$16,777	$599	$0	$58,211	$0	$637	$0	$0	$0	$0	$0	$2,804	$9,465,618
HCBS - Children with Autism	$0	$0	$282,036	$589	$0	$0	$0	$0	$9,612	$0	$0	$0	$0	$0	$0	$292,237
HCBS - Pediatric Hospice	$0	$0	$283,223	$0	$0	$0	$0	$0	$21,173	$0	$3,482	$0	$0	$0	$0	$307,878
HCBS - Spinal Cord Injury	$76,084	$23,784	$839,961	$1,921	$0	$0	$5,240	$0	$0	$0	$0	$0	$0	$0	$0	$946,990
Total	$80,248,668	$17,695,097	$90,276,218	$900,420	$159,557	$19,083	$827,242	$0	$528,568	$769	$75,209	$21,678	$0	$0	$430,927	$191,183,436
Caseload	42,101	10,380	69,866	7,144	166,897	83,081	301,795	334	462,670	58,291	19,793	14,186	1,664	2,637	31,456	1,272,294
Half -Year Per Capita	$1,906.11	$1,704.78	$1,292.14	$126.04	$0.96	$0.23	$2.74	$0.00	$1.14	$0.01	$3.80	$1.53	$0.00	$0.00	$13.70	$150.27

FY 2015-16 January - June COFRS Total Actuals

HCBS WAIVERS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
HCBS - Elderly, Blind, and Disabled	$81,675,683	$15,252,247	$65,985,376	$1,116,948	$183,529	$23,287	$727,745	$0	$7,464	$0	$72,009	$12,540	$0	$0	$367,860	$165,424,688
HCBS - Mental Illness	$2,965,864	$2,561,914	$12,614,829	$63,044	$7,875	$0	$117,651	$0	$0	$0	$4,828	$0	$0	$0	$66,505	$18,402,510
HCBS - Disabled Children	$0	$0	$6,068,193	$9,025	$0	$0	$0	$0	$425,791	$699	$726	$0	$0	$0	$0	$6,504,434
HCBS - Persons Living with AIDS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Consumer Directed Attendant Support	$584,710	$108,732	$469,698	$7,812	$1,302	$165	$5,117	$0	$64	$0	$517	$98	$0	$0	$2,655	$1,180,870
HCBS - Brain Injury	$499,680	$1,111,839	$8,031,175	$981	$153	$0	$38,891	$0	$504	$0	$0	$0	$0	$0	$11,707	$9,694,930
HCBS - Children with Autism	$0	$0	$246,362	$26	$0	$0	$0	$0	$17,526	$0	$2,397	$0	$0	$0	$0	$266,311
HCBS - Pediatric Hospice	$0	$0	$303,745	$554	$0	$0	$0	$0	$28,387	$684	$1,742	$0	$0	$0	$0	$335,112
HCBS - Spinal Cord Injury	$83,133	$26,966	$908,259	$55	$232	$0	$150	$0	$0	$0	$0	$0	$0	$0	$8,639	$1,027,434
Total	$85,809,070	$19,061,698	$94,627,637	$1,198,445	$193,091	$23,452	$889,554	$0	$479,736	$1,383	$82,219	$12,638	$0	$0	$457,366	$202,836,289
Caseload	42,705	10,678	67,735	5,290	159,788	90,847	338,953	309	471,717	60,711	20,078	14,640	1,854	2,661	33,714	1,321,679
Half -Year Per Capita	$2,009.34	$1,785.08	$1,397.03	$226.57	$1.21	$0.26	$2.62	$0.00	$1.02	$0.02	$4.09	$0.86	$0.00	$0.00	$13.57	$153.47

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

Private Duty Nursing Total Expenditure by Fiscal Year																
PRIVATE DUTY NURSING	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
FY 2008-09	$725,106	$186,844	$14,728,104	$0	$0	$0	$0	$0	$250,793	$0	$5,460,562	$0	$0	$0	$0	$21,351,408
FY 2009-10 (DA)	$1,035,252	$240,541	$15,137,080	$0	$0	$0	$0	$0	$604,720	$0	$6,648,963	$0	$0	$0	$0	$23,666,555
FY 2010-11 (DA)	$1,319,815	$0	$17,252,161	$0	$0	$0	$0	$0	$502,792	$0	$8,251,187	$0	$0	$0	$0	$27,325,956
FY 2011-12	$1,832,636	$135,105	$20,720,340	$0	$0	$0	$0	$0	$601,939	$0	$7,854,133	$0	$0	$0	$0	$31,144,153
FY 2012-13	$2,364,123	$557,116	$24,342,047	$18,478	$0	$0	$0	$0	$1,069,272	$5,806	$8,490,119	$0	$0	$0	$0	$36,846,961
FY 2013-14	$3,039,698	$734,755	$35,345,893	$280,781	$0	$0	$43,544	$0	$3,373,711	$400	$10,310,507	$0	$0	$0	$25,614	$53,154,903
FY 2014-15	$2,110,022	$441,354	$39,608,590	$300,436	$0	$0	$41,377	$0	$7,416,333	$27,251	$11,553,619	$0	$0	$0	$0	$61,498,982
FY 2015-16	$2,646,577	$602,061	$49,469,896	$559,463	$0	$0	$40,514	$0	$7,627,485	$192,885	$11,470,454	$0	$0	$0	$0	$72,609,335
Estimated FY 2016-17	$3,013,794	$685,329	$56,254,745	$635,787	$0	$0	$49,542	$0	$8,669,820	$222,938	$13,037,758	$0	$0	$0	$0	$82,569,713
Estimated FY 2017-18	$3,359,510	$763,943	$62,707,780	$708,718	$0	$0	$55,225	$0	$9,664,343	$248,512	$14,533,331	$0	$0	$0	$0	$92,041,362
Estimated FY 2018-19	$3,711,873	$844,070	$69,284,916	$783,053	$0	$0	$61,017	$0	$10,677,992	$274,577	$16,057,667	$0	$0	$0	$0	$101,695,165
Private Duty Nursing Total Expenditure Percent Change by Fiscal Year																
PRIVATE DUTY NURSING	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
FY 2009-10 (DA)	42.77%	28.74%	2.78%	0.00%	0.00%	0.00%	0.00%	0.00%	141.12%	0.00%	21.76%	0.00%	0.00%	0.00%	0.00%	10.84%
FY 2010-11 (DA)	27.49%	-100.00%	13.97%	0.00%	0.00%	0.00%	0.00%	0.00%	-16.86%	0.00%	24.10%	0.00%	0.00%	0.00%	0.00%	15.46%
FY 2011-12	38.86%	0.00%	20.10%	0.00%	0.00%	0.00%	0.00%	0.00%	19.72%	0.00%	-4.81%	0.00%	0.00%	0.00%	0.00%	13.97%
FY 2012-13	29.00%	312.36%	17.48%	0.00%	0.00%	0.00%	0.00%	0.00%	77.64%	0.00%	8.10%	0.00%	0.00%	0.00%	0.00%	18.31%
FY 2013-14	28.58%	31.89%	45.21%	1419.54%	0.00%	0.00%	0.00%	0.00%	215.51%	-93.11%	21.44%	0.00%	0.00%	0.00%	0.00%	44.26%
FY 2014-15	-30.58%	-39.93%	12.06%	7.00%	0.00%	0.00%	-4.98%	0.00%	119.83%	6712.75%	12.06%	0.00%	0.00%	0.00%	-100.00%	15.70%
FY 2015-16	25.43%	36.41%	24.90%	86.22%	0.00%	0.00%	-2.09%	0.00%	2.85%	607.81%	-0.72%	0.00%	0.00%	0.00%	0.00%	18.07%
Estimated FY 2016-17	13.88%	13.83%	13.72%	13.64%	0.00%	0.00%	22.28%	0.00%	13.67%	15.58%	13.66%	0.00%	0.00%	0.00%	0.00%	13.72%
Estimated FY 2017-18	11.47%	11.47%	11.47%	11.47%	0.00%	0.00%	11.47%	0.00%	11.47%	11.47%	11.47%	0.00%	0.00%	0.00%	0.00%	11.47%
Estimated FY 2018-19	10.49%	10.49%	10.49%	10.49%	0.00%	0.00%	10.49%	0.00%	10.49%	10.49%	10.49%	0.00%	0.00%	0.00%	0.00%	10.49%

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

Private Duty Nursing (PDN) Cost Per Service Per Fiscal Year				
PRIVATE DUTY NURSING	**Registered Nursing (RN)**	**Licensed Practical Nursing (LPN)**	**Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[(1)]**	**TOTAL**
FY 2008-09	$12,337,437	$5,561,060	$3,452,912	$21,351,409
FY 2009-10 (DA)	$14,062,356	$5,817,255	$3,786,944	$23,666,555
FY 2010-11 (DA)	$16,031,747	$6,956,922	$4,337,287	$27,325,956
FY 2011-12	$19,803,988	$7,090,613	$4,249,552	$31,144,153
FY 2012-13	$24,122,140	$7,345,451	$5,379,370	$36,846,961
FY 2013-14	$35,604,519	$10,618,602	$6,931,782	$53,154,903
FY 2014-15	$41,159,263	$12,091,100	$8,248,619	$61,498,982
FY 2015-16	$50,697,452	$13,281,784	$8,630,099	$72,609,335
Estimated FY 2016-17	$58,150,800	$14,789,953	$9,628,960	$82,569,713
Estimated FY 2017-18	$65,157,120	$16,292,762	$10,591,480	$92,041,362
Estimated FY 2018-19	$72,349,200	$17,821,949	$11,524,016	$101,695,165
Private Duty Nursing (PDN) Percent Change in Cost Per Service Per Fiscal Year				
PRIVATE DUTY NURSING	**Registered Nursing (RN)**	**Licensed Practical Nursing (LPN)**	**Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[(1)]**	**TOTAL**
FY 2009-10 (DA)	13.98%	4.61%	9.67%	15.46%
FY 2010-11 (DA)	14.00%	19.59%	14.53%	13.97%
FY 2011-12	23.53%	1.92%	-2.02%	18.31%
FY 2012-13	21.80%	3.59%	26.59%	44.26%
FY 2013-14	47.60%	44.56%	28.86%	15.70%
FY 2014-15	15.60%	13.87%	19.00%	18.07%
FY 2015-16	23.17%	9.85%	4.62%	13.72%
Estimated FY 2016-17	14.70%	11.36%	11.57%	13.72%
Estimated FY 2017-18	12.05%	10.16%	10.00%	11.47%
Estimated FY 2018-19	11.04%	9.39%	8.80%	10.49%
Private Duty Nursing (PDN) Average Utilizers Per Month Per Service Per Fiscal Year[(3)]				
PRIVATE DUTY NURSING	**Registered Nursing (RN)**	**Licensed Practical Nursing (LPN)**	**Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[(1)(2)]**	**TOTAL[(4)]**
FY 2008-09	110	85	N/A	219
FY 2009-10 (DA)	124	87	N/A	241
FY 2010-11 (DA)	147	101	33	281
FY 2011-12	183	116	33	331
FY 2012-13	223	126	51	401
FY 2013-14	315	181	57	552
FY 2014-15	398	225	66	689
FY 2015-16	416	240	68	725
Estimated FY 2016-17	464	264	75	797
Estimated FY 2017-18	512	288	82	869
Estimated FY 2018-19	560	312	89	941
Private Duty Nursing (PDN) Percent Change Average Utilizers Per Month Per Service Per Fiscal Year				
PRIVATE DUTY NURSING	**Registered Nursing (RN)**	**Licensed Practical Nursing (LPN)**	**Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[(1)(2)]**	**TOTAL**
FY 2009-10 (DA)	12.73%	2.35%	N/A	10.05%
FY 2010-11 (DA)	18.55%	16.09%	N/A	16.60%
FY 2011-12	24.49%	14.85%	0.00%	17.79%
FY 2012-13	21.86%	8.62%	54.55%	21.15%
FY 2013-14	41.26%	43.65%	11.76%	37.66%
FY 2014-15	26.35%	24.31%	15.79%	24.82%
FY 2015-16	4.52%	6.67%	3.03%	5.22%
Estimated FY 2016-17	11.54%	10.00%	10.29%	9.93%
Estimated FY 2017-18	10.34%	9.09%	9.33%	9.03%
Estimated FY 2018-19	9.38%	8.33%	8.54%	8.29%

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

Private Duty Nursing (PDN) Cost Per Utilizer Per Service Per Fiscal Year

PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[(1)(2)]	TOTAL
FY 2008-09	$112,158.52	$65,424.24	N/A	$97,495.02
FY 2009-10 (DA)	$113,406.10	$66,865.00	N/A	$98,201.47
FY 2010-11 (DA)	$109,059.50	$68,880.42	$131,432.94	$97,245.40
FY 2011-12	$108,218.51	$61,125.97	$128,774.30	$94,091.10
FY 2012-13	$108,171.03	$58,297.23	$105,477.84	$91,887.68
FY 2013-14	$113,030.22	$58,666.31	$121,610.21	$96,295.11
FY 2014-15	$103,415.23	$53,738.22	$124,979.08	$89,258.32
FY 2015-16	$121,868.88	$55,340.77	$126,913.22	$100,150.8
Estimated FY 2016-17	$125,325.00	$56,022.55	$128,386.13	$103,600.6
Estimated FY 2017-18	$127,260.00	$56,572.09	$129,164.39	$105,916.4
Estimated FY 2018-19	$129,195.00	$57,121.63	$129,483.33	$108,071.4

Private Duty Nursing (PDN) Percent Change in Cost Per Utilizer Per Service Per Fiscal Year

PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[(1)(2)]	TOTAL
FY 2009-10 (DA)	1.11%	2.20%	N/A	0.72%
FY 2010-11 (DA)	-3.83%	3.01%	N/A	-0.97%
FY 2011-12	-0.77%	-11.26%	-2.02%	-3.24%
FY 2012-13	-0.04%	-4.63%	-18.09%	-2.34%
FY 2013-14	4.49%	0.63%	15.29%	4.80%
FY 2014-15	-8.51%	-8.40%	2.77%	-7.31%
FY 2015-16	17.84%	2.98%	1.55%	12.20%
Estimated FY 2016-17	2.84%	1.23%	1.16%	3.44%
Estimated FY 2017-18	1.54%	0.98%	0.61%	2.24%
Estimated FY 2018-19	1.52%	0.97%	0.25%	2.03%

Private Duty Nursing (PDN) Units Per Utilizer Per Service Per Fiscal Year

PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[(1)]
FY 2008-09	2,875	2,231	4,990
FY 2009-10 (DA)	2,952	2,316	4,172
FY 2010-11 (DA)	3,001	2,519	4,622
FY 2011-12	2,943	2,202	4,470
FY 2012-13	2,953	2,118	3,657
FY 2013-14	2,853	1,969	4,212
FY 2014-15	2,553	1,773	4,340
FY 2015-16	2,743	1,817	4,411
Estimated FY 2016-17	2,785	1,835	4,489
Estimated FY 2017-18	2,828	1,853	4,516
Estimated FY 2018-19	2,871	1,871	4,527

Private Duty Nursing (PDN) Percent Change in Units Per Utilizer Per Service Per Fiscal Year

PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[(1)]
FY 2009-10 (DA)	2.68%	3.81%	-16.39%
FY 2010-11 (DA)	1.66%	8.77%	10.79%
FY 2011-12	-1.93%	-12.58%	-3.29%
FY 2012-13	0.34%	-3.81%	-18.19%
FY 2013-14	-3.39%	-7.03%	15.18%
FY 2014-15	-10.52%	-9.95%	3.04%
FY 2015-16	7.44%	2.48%	1.64%
Estimated FY 2016-17	1.53%	0.99%	1.77%
Estimated FY 2017-18	1.54%	0.98%	0.60%
Estimated FY 2018-19	1.52%	0.97%	0.24%

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

Current Year Projection				
PRIVATE DUTY NURSING	**Registered Nursing (RN)**	**Licensed Practical Nursing (LPN)**	**Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[(1)]**	**TOTAL**
FY 2015-16 Average Paid Utilizers Per Month	416	240	68	725
Utilizer Trend Selected[(5)]	11.54%	10.00%	10.29%	9.93%
FY 2016-17 Estimated Average Paid Utilizers Per Month	464	264	75	797
Bottom Line Impacts				
Total Bottom Line Impacts	**0**	**0**	**0**	**0**
FY 2016-17 Estimated Average Paid Utilizers Per Month	**464**	**264**	**75**	**797**
FY 2015-16 Average Paid Units Per Utilizer Per Year	2,743	1,817	4,411	
Percentage Selected to Modify Per Client Utilization[(6)]	1.53%	0.99%	1.77%	
FY 2016-17 Estimated Average Paid Units Per Utilizer	**2,785**	**1,835**	**4,489**	
FY 2015-16 Average Paid Rate Per Unit	$45.00	$30.53	$28.60	
Unit Paid Rate Trend Selected	0.00%	0.00%	0.00%	
FY 2016-17 Average Paid Rate Per Unit	**$45.00**	**$30.53**	**$28.60**	
Estimated FY 2016-17 Base Expenditure	**$58,150,800**	**$14,789,953**	**$9,628,960**	**$82,569,713**
Bottom Line Impacts				
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**
Estimated FY 2016-17 Expenditure	**$58,150,800**	**$14,789,953**	**$9,628,960**	**$82,569,713**
Estimated FY 2016-17 Per Utilizer Cost	$125,325.00	$56,022.55	$128,386.13	$103,600.64
% Change Over FY 2015-16 Per Utilizer Cost	2.84%	1.23%	1.16%	3.44%
Request Year Projection				
PRIVATE DUTY NURSING	**Registered Nursing (RN)**	**Licensed Practical Nursing (LPN)**	**Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[(1)]**	**TOTAL**
FY 2016-17 Estimated Average Paid Utilizers Per Month	464	264	75	797
Utilizer Trend Selected[(5)]	10.34%	9.09%	9.33%	9.03%
FY 2017-18 Estimated Average Paid Utilizers Per Month	512	288	82	869
Bottom Line Impacts				
Total Bottom Line Impacts	**0**	**0**	**0**	**0**
FY 2017-18 Estimated Average Paid Utilizers Per Month	**512**	**288**	**82**	**869**
FY 2016-17 Average Paid Units Per Utilizer Per Year	2,785	1,835	4,489	
Percentage Selected to Modify Per Client Utilization[(6)]	1.54%	0.98%	0.60%	
FY 2017-18 Estimated Average Paid Units Per Utilizer	**2,828**	**1,853**	**4,516**	
FY 2016-17 Average Paid Rate Per Unit	$45.00	$30.53	$28.60	
Unit Paid Rate Trend Selected	0.00%	0.00%	0.00%	
FY 2017-18 Estimated Average Paid Rate Per Unit	**$45.00**	**$30.53**	**$28.60**	
Estimated FY 2017-18 Base Expenditure	**$65,157,120**	**$16,292,762**	**$10,591,480**	**$92,041,362**
Bottom Line Impacts				
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**
Estimated FY 2017-18 Expenditure	**$65,157,120**	**$16,292,762**	**$10,591,480**	**$92,041,362**
Estimated FY 2017-18 Per Utilizer Cost	$127,260.00	$56,572.09	$129,164.39	$105,916.41
% Change Over FY 2016-17 Per Utilizer Cost	1.54%	0.98%	0.61%	2.24%

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

Out Year Projection				
PRIVATE DUTY NURSING	**Registered Nursing (RN)**	**Licensed Practical Nursing (LPN)**	**Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[(1)]**	**TOTAL**
FY 2017-18 Estimated Average Paid Utilizers Per Month	512	288	82	869
Utilizer Trend Selected[(5)]	9.38%	8.33%	8.54%	8.29%
FY 2018-19 Estimated Average Paid Utilizers Per Month	560	312	89	941
Bottom Line Impacts				
Total Bottom Line Impacts	**0**	**0**	**0**	**0**
FY 2018-19 Estimated Average Paid Utilizers Per Month	**560**	**312**	**89**	**941**
FY 2017-18 Average Paid Units Per Utilizer Per Year	2,828	1,853	4,516	
Percentage Selected to Modify Per Client Utilization[(6)]	1.52%	0.97%	0.24%	
FY 2018-19 Estimated Average Paid Units Per Client	**2,871**	**1,871**	**4,527**	
FY 2017-18 Average Paid Rate Per Unit	$45.00	$30.53	$28.60	
Unit Paid Rate Trend Selected	0.00%	0.00%	0.00%	
FY 2018-19 Estimated Average Paid Rate Per Unit	**$45.00**	**$30.53**	**$28.60**	
Estimated FY 2018-19 Base Expenditure	**$72,349,200**	**$17,821,949**	**$11,524,016**	**$101,695,165**
Bottom Line Impacts				
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**
Estimated FY 2018-19 Expenditure	**$72,349,200**	**$17,821,949**	**$11,524,016**	**$101,695,165**
Estimated FY 2018-19 Per Utilizer Cost	$129,195.00	$57,121.63	$129,483.33	$108,071.38
% Change Over FY 2017-18 Per Utilizer Cost	1.52%	0.97%	0.25%	2.03%

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

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

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

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

(5) Percentages Selected to Modify Utilizers for FY 2016-17 through FY 2018-19	RN	11.54%, 10.34%, 9.38%
	LPN	10.00%, 9.09%, 8.33%
	Blended & Group	10.29%, 9.33%, 8.54%
	Total PDN Utilizers	9.93%, 9.03%, 8.29%
(6) Percentages Selected to Modifier Units Per Utilizer for FY 2016-17 through FY 2018-19	RN	1.53%, 1.54%, 1.52%
	LPN	0.99%, 0.98%, 0.97%
	Blended & Group	1.77%, 0.60%, 0.24%

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

Long-Term Home Health Total Expenditure by Fiscal Year

LONG-TERM HOME HEALTH	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	$17,604,990	$4,444,247	$90,735,722	$0	$29,485	$0	$0	$4,352	$2,591,906	$0	$9,570,085	$0	$0	$0	$102,711	$125,083,498
FY 2009-10 (DA)	$18,218,198	$4,520,382	$101,341,215	$0	$43,869	$0	$0	$167	$3,137,536	$0	$10,254,991	$0	$0	$0	$97,840	$137,614,198
FY 2010-11 (DA)	$18,890,472	$5,333,256	$109,459,274	$0	$55,655	$7,651	$0	$1,071	$3,447,255	$0	$10,296,687	$188	$0	$0	$90,417	$147,581,926
FY 2011-12	$19,241,801	$5,960,470	$112,026,204	$0	$70,804	$21,256	$0	$205	$3,621,831	$0	$10,150,245	$374	$0	$0	$128,231	$151,221,421
FY 2012-13	$21,401,061	$7,062,994	$115,530,465	$368,744	$151,443	$4,862	$0	$840	$3,609,745	$0	$10,404,821	$1,690	$0	$0	$93,867	$158,630,532
FY 2013-14	$26,251,582	$8,030,921	$130,369,940	$1,316,824	$235,386	$18,678	$172,588	$2,446	$7,825,402	$244,287	$11,792,931	$1,213	$0	$0	$252,997	$186,515,195
FY 2014-15	$28,375,632	$9,114,399	$139,389,238	$1,945,982	$310,179	$69,594	$1,335,165	$0	$18,387,951	$725,506	$12,889,124	$6,903	$0	$0	$27,780	$212,577,453
FY 2015-16	$31,647,015	$8,813,402	$157,177,050	$2,237,376	$468,105	$34,319	$2,001,772	$0	$22,807,220	$1,195,443	$13,045,361	$9,226	$0	$0	$0	$239,436,289
Estimated FY 2016-17	$33,803,774	$9,409,826	$167,842,648	$2,378,027	$511,404	$25,570	$2,147,895	$0	$24,368,380	$1,278,509	$13,935,747	$0	$0	$0	$0	$255,701,780
Estimated FY 2017-18	$35,811,059	$9,968,585	$177,809,221	$2,519,235	$541,771	$27,089	$2,275,438	$0	$25,815,385	$1,354,427	$14,763,258	$0	$0	$0	$0	$270,885,468
Estimated FY 2018-19	$37,669,591	$10,485,938	$187,037,214	$2,649,979	$569,888	$28,494	$2,393,529	$0	$27,155,159	$1,424,720	$15,529,446	$0	$0	$0	$0	$284,943,958

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

LONG-TERM HOME HEALTH	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	3.48%	1.71%	11.69%	0.00%	48.78%	0.00%	0.00%	-96.16%	21.05%	0.00%	7.16%	0.00%	0.00%	0.00%	-4.74%	10.02%
FY 2010-11 (DA)	3.69%	17.98%	8.01%	0.00%	26.87%	0.00%	0.00%	541.32%	9.87%	0.00%	0.41%	0.00%	0.00%	0.00%	-7.59%	7.24%
FY 2011-12	1.86%	11.76%	2.35%	0.00%	27.22%	177.82%	0.00%	-80.86%	5.06%	0.00%	-1.42%	98.94%	0.00%	0.00%	41.82%	2.47%
FY 2012-13	11.22%	18.50%	3.13%	0.00%	113.89%	-77.13%	0.00%	309.76%	-0.33%	0.00%	2.51%	351.87%	0.00%	0.00%	-26.80%	4.90%
FY 2013-14	22.66%	13.70%	12.84%	257.11%	55.43%	284.16%	0.00%	191.19%	116.79%	0.00%	13.34%	-28.22%	0.00%	0.00%	169.53%	17.58%
FY 2014-15	8.09%	13.49%	6.92%	47.78%	31.77%	272.60%	673.61%	-100.00%	134.98%	196.99%	9.30%	469.08%	0.00%	0.00%	-89.02%	13.97%
FY 2015-16	11.53%	-3.30%	12.76%	14.97%	50.91%	-50.69%	49.93%	0.00%	24.03%	64.77%	1.21%	33.65%	0.00%	0.00%	-100.00%	12.63%
Estimated FY 2016-17	6.82%	6.77%	6.79%	6.29%	9.25%	-25.49%	7.30%	0.00%	6.85%	6.95%	6.83%	-100.00%	0.00%	0.00%	0.00%	6.79%
Estimated FY 2017-18	5.94%	5.94%	5.94%	5.94%	5.94%	5.94%	5.94%	0.00%	5.94%	5.94%	5.94%	0.00%	0.00%	0.00%	0.00%	5.94%
Estimated FY 2018-19	5.19%	5.19%	5.19%	5.19%	5.19%	5.19%	5.19%	0.00%	5.19%	5.19%	5.19%	0.00%	0.00%	0.00%	0.00%	5.19%

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

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

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Telehealth[1]	Total
FY 2009-10 (DA)	$3,408,878	$3,468,057	$3,225,823	$21,789,837	$65,541,038	$34,386,681	$3,857,891	$1,935,993	$0	$137,614,198
FY 2010-11 (DA)	$3,488,805	$3,450,298	$3,463,479	$22,261,575	$71,222,845	$37,151,446	$4,217,007	$2,326,471	$0	$147,581,926
FY 2011-12	$3,626,606	$3,445,533	$3,374,158	$21,937,994	$73,088,477	$37,825,586	$5,154,767	$2,767,782	$516	$151,221,419
FY 2012-13	$3,971,740	$3,817,229	$3,511,343	$22,312,471	$77,554,317	$37,883,991	$6,436,658	$3,134,580	$8,204	$158,630,533
FY 2013-14	$5,478,336	$5,769,444	$5,772,910	$30,601,689	$89,319,041	$41,228,516	$6,162,682	$2,167,316	$15,260	$186,515,194
FY 2014-15	$6,426,151	$7,074,775	$8,909,669	$33,134,389	$99,806,644	$46,746,258	$7,699,746	$2,760,029	$19,792	$212,577,453
FY 2015-16	$7,082,199	$8,236,854	$10,558,320	$35,763,694	$115,697,949	$50,321,320	$8,713,140	$3,056,070	$6,742	$239,436,289
Estimated FY 2016-17	$7,647,858	$8,969,734	$12,167,262	$37,706,144	$123,394,406	$52,967,495	$9,494,669	$3,348,011	$6,201	$255,701,780
Estimated FY 2017-18	$8,241,692	$9,665,415	$13,110,257	$40,247,620	$129,649,049	$55,888,318	$10,366,381	$3,709,303	$7,433	$270,885,468
Estimated FY 2018-19	$8,835,525	$10,361,097	$14,053,253	$42,176,974	$135,863,668	$58,501,926	$11,099,958	$4,042,735	$8,822	$284,943,958

LTHH Percent Change in Cost Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Telehealth	Total
FY 2010-11 (DA)	2.34%	-0.51%	7.37%	2.16%	8.67%	8.04%	9.31%	20.17%	0.00%	7.24%
FY 2011-12	3.95%	-0.14%	-2.58%	-1.45%	2.62%	1.81%	22.24%	18.97%	0.00%	2.47%
FY 2012-13	9.52%	10.79%	4.07%	1.71%	6.11%	0.15%	24.87%	13.25%	1489.92%	4.90%
FY 2013-14	37.93%	51.14%	64.41%	37.15%	15.17%	8.83%	-4.26%	-30.86%	86.01%	17.58%
FY 2014-15	17.30%	22.62%	54.34%	8.28%	11.74%	13.38%	24.94%	27.35%	29.70%	13.97%
FY 2015-16	10.21%	16.43%	18.50%	7.94%	15.92%	7.65%	13.16%	10.73%	-65.94%	12.63%
Estimated FY 2016-17	7.99%	8.90%	15.24%	5.43%	6.65%	5.26%	8.97%	9.55%	-8.02%	6.79%
Estimated FY 2017-18	7.76%	7.76%	7.75%	6.74%	5.07%	5.51%	9.18%	10.79%	19.87%	5.94%
Estimated FY 2018-19	7.21%	7.20%	7.19%	4.79%	4.79%	4.68%	7.08%	8.99%	18.69%	5.19%

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

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total[3]
FY 2009-10 (DA)	555	618	514	2,300	2,593	1,748	197	100	6,503
FY 2010-11 (DA)	556	630	538	2,457	2,802	1,899	214	117	8,205
FY 2011-12	596	637	530	2,558	2,938	2,009	271	137	8,625
FY 2012-13	655	691	556	2,723	3,093	2,132	368	152	9,212
FY 2013-14	913	1,015	899	3,092	3,324	2,285	339	116	9,676
FY 2014-15	1,080	1,249	1,352	3,235	3,644	2,581	393	142	10,373
FY 2015-16	1,176	1,451	1,616	3,317	3,869	2,734	414	155	11,988
Estimated FY 2016-17	1,275	1,573	1,858	3,478	4,075	2,896	451	168	15,369
Estimated FY 2017-18	1,374	1,695	2,002	3,639	4,281	3,058	488	182	16,004
Estimated FY 2018-19	1,473	1,817	2,146	3,800	4,487	3,220	525	197	16,639

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

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2010-11 (DA)	0.18%	1.94%	4.67%	6.83%	8.06%	8.64%	8.63%	17.00%	26.17%
FY 2011-12	7.19%	1.11%	-1.49%	4.11%	4.85%	5.79%	26.64%	17.09%	5.12%
FY 2012-13	9.90%	8.48%	4.91%	6.45%	5.28%	6.12%	35.79%	10.95%	6.81%
FY 2013-14	39.39%	46.89%	61.69%	13.55%	7.47%	7.18%	-7.88%	-23.68%	5.04%
FY 2014-15	18.29%	23.05%	50.39%	4.62%	9.63%	12.95%	15.93%	22.41%	7.20%
FY 2015-16	8.89%	16.17%	19.53%	2.53%	6.17%	5.93%	5.34%	9.15%	15.57%
Estimated FY 2016-17	8.42%	8.41%	14.98%	4.85%	5.32%	5.93%	8.94%	8.39%	28.20%
Estimated FY 2017-18	7.76%	7.76%	7.75%	4.63%	5.06%	5.59%	8.20%	8.33%	4.13%
Estimated FY 2018-19	7.21%	7.20%	7.19%	4.42%	4.81%	5.30%	7.58%	8.24%	3.97%

LTHH Cost Per Utilizer Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2009-10 (DA)	$6,142.12	$5,611.74	$6,275.92	$9,473.84	$25,276.14	$19,672.01	$19,583.20	$19,359.93	$21,161.65
FY 2010-11 (DA)	$6,274.83	$5,476.66	$6,437.69	$9,060.47	$25,418.57	$19,563.69	$19,705.64	$19,884.37	$17,986.83
FY 2011-12	$6,084.91	$5,409.00	$6,366.34	$8,576.23	$24,876.95	$18,828.07	$19,021.28	$20,202.79	$17,532.92
FY 2012-13	$6,063.73	$5,524.21	$6,315.37	$8,194.08	$25,074.14	$17,769.23	$17,490.92	$20,622.24	$17,219.99
FY 2013-14	$6,000.37	$5,684.18	$6,421.48	$9,897.05	$26,870.95	$18,043.11	$18,179.00	$18,683.76	$19,276.06
FY 2014-15	$5,950.14	$5,664.35	$6,589.99	$10,242.47	$27,389.31	$18,111.68	$19,592.23	$19,436.82	$20,493.34
FY 2015-16	$6,022.28	$5,676.67	$6,533.61	$10,781.94	$29,903.84	$18,405.75	$21,046.23	$19,716.58	$19,973.00
Estimated FY 2016-17	$5,998.32	$5,702.31	$6,548.58	$10,841.33	$30,280.84	$18,289.88	$21,052.48	$19,928.64	$16,637.50
Estimated FY 2017-18	$5,998.32	$5,702.31	$6,548.58	$11,060.08	$30,284.76	$18,276.10	$21,242.58	$20,380.79	$16,926.11
Estimated FY 2018-19	$5,998.32	$5,702.31	$6,548.58	$11,099.20	$30,279.40	$18,168.30	$21,142.78	$20,521.50	$17,125.07

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

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2010-11 (DA)	2.16%	-2.41%	2.58%	-4.36%	0.56%	-0.55%	0.63%	2.71%	-15.00%
FY 2011-12	-3.03%	-1.24%	-1.11%	-5.34%	-2.13%	-3.76%	-3.47%	1.60%	-2.52%
FY 2012-13	-0.35%	2.13%	-0.80%	-4.46%	0.79%	-5.62%	-8.05%	2.08%	-1.78%
FY 2013-14	-1.04%	2.90%	1.68%	20.78%	7.17%	1.54%	3.93%	-9.40%	11.94%
FY 2014-15	-0.84%	-0.35%	2.62%	3.49%	1.93%	0.38%	7.77%	4.03%	6.31%
FY 2015-16	1.21%	0.22%	-0.86%	5.27%	9.18%	1.62%	7.42%	1.44%	-2.54%
Estimated FY 2016-17	-0.40%	0.45%	0.23%	0.55%	1.26%	-0.63%	0.03%	1.08%	-16.70%
Estimated FY 2017-18	0.00%	0.00%	0.00%	2.02%	0.01%	-0.08%	0.90%	2.27%	1.73%
Estimated FY 2018-19	0.00%	0.00%	0.00%	0.35%	-0.02%	-0.59%	-0.47%	0.69%	1.18%

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

LTHH Units Per Utilizer Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day
FY 2009-10 (DA)	60	53	56	96	724	1,878	284	399
FY 2010-11 (DA)	63	55	59	99	777	2,007	307	443
FY 2011-12	60	54	58	92	750	1,900	292	443
FY 2012-13	60	55	58	88	757	1,795	268	451
FY 2013-14	56	52	55	99	753	1,690	259	381
FY 2014-15	54	51	54	100	749	1,664	272	386
FY 2015-16	54	51	54	104	813	1,679	291	389
Estimated FY 2016-17	54	51	54	105	817	1,670	291	394
Estimated FY 2017-18	54	51	54	106	821	1,661	291	399
Estimated FY 2018-19	54	51	54	107	821	1,652	291	404

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

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day
FY 2010-11 (DA)	5.00%	3.77%	5.36%	3.13%	7.32%	6.87%	8.10%	11.03%
FY 2011-12	-4.76%	-1.82%	-1.69%	-7.07%	-3.47%	-5.33%	-4.89%	0.00%
FY 2012-13	0.00%	1.85%	0.00%	-4.35%	0.93%	-5.53%	-8.22%	1.81%
FY 2013-14	-6.67%	-5.45%	-5.17%	12.50%	-0.53%	-5.85%	-3.36%	-15.52%
FY 2014-15	-3.57%	-1.92%	-1.82%	1.01%	-0.53%	-1.54%	5.02%	1.31%
FY 2015-16	0.00%	0.00%	0.00%	4.00%	8.54%	0.90%	6.99%	0.78%
Estimated FY 2016-17	0.00%	0.00%	0.00%	0.96%	0.49%	-0.54%	0.00%	1.29%
Estimated FY 2017-18	0.00%	0.00%	0.00%	0.95%	0.49%	-0.54%	0.00%	1.27%
Estimated FY 2018-19	0.00%	0.00%	0.00%	0.94%	0.00%	-0.54%	0.00%	1.25%

Current Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2015-16 Average Utilizers Per Month	1,176	1,451	1,616	3,317	3,869	2,734	414	155	14,732
Utilizer Trend Selected[4]	8.42%	8.41%	14.98%	4.85%	5.32%	5.93%	8.94%	8.39%	7.07%
FY 2016-17 Estimated Average Utilizers Per Month	1,275	1,573	1,858	3,478	4,075	2,896	451	168	15,774
Bottom Line Impacts									
Total Bottom Line Impacts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY 2016-17 Estimated Average Utilizers Per Month	**1,275**	**1,573**	**1,858**	**3,478**	**4,075**	**2,896**	**451**	**168**	**15,774**
FY 2015-16 Average Units Per Utilizer Per Year	54	51	54	104	813	1,679	291	389	
Percentage Selected to Modify Units Per Utilizer[5]	0.00%	0.00%	0.00%	0.96%	0.49%	-0.54%	0.00%	1.29%	
FY 2016-17 Estimated Average Units Per Utilizer	**54**	**51**	**54**	**105**	**817**	**1,670**	**291**	**394**	
FY 2015-16 Average Paid Rate Per Unit	$111.08	$111.81	$121.27	$103.42	$36.79	$10.97	$72.46	$50.66	
Unit Paid Rate Trend Selected	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
FY 2016-17 Average Paid Rate Per Unit	**$111.08**	**$111.81**	**$121.27**	**$103.42**	**$36.79**	**$10.97**	**$72.46**	**$50.66**	
Estimated FY 2016-17 Base Expenditure	**$7,647,858**	**$8,969,734**	**$12,167,262**	**$37,767,950**	**$122,484,027**	**$53,054,430**	**$9,509,723**	**$3,353,287**	**$254,960,472**
Bottom Line Impacts									
FY 2014-15 R-8 & HB 14-1252 Client Movement to the DD Waiver	$0	$0	$0	($47,158)	($152,538)	($66,331)	($11,487)	($4,026)	($281,540)
FY 2014-15 R-7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	$0	$0	$0	($80,169)	($259,315)	($112,762)	($19,528)	($6,844)	($478,618)
Annualization of FY 2015-16 R#7 "Participant Directed Programs Expansion"	$0	$0	$0	($68,872)	($222,776)	($96,873)	($16,776)	($5,880)	($411,177)
EPSDT Personal Care	$0	$0	$0	$0	$1,110,298	$0	$0	$0	$1,110,298
Colorado Choice Transitions	$0	$0	$0	$134,393	$434,710	$189,032	$32,736	$11,474	$802,344
Total Bottom Line Impacts	$0	$0	$0	($61,806)	$910,379	($86,935)	($15,054)	($5,276)	$741,308
Estimated FY 2016-17 Expenditure	**$7,647,858**	**$8,969,734**	**$12,167,262**	**$37,706,144**	**$123,394,406**	**$52,967,495**	**$9,494,669**	**$3,348,011**	**$255,701,780**
Estimated FY 2016-17 Per Utilizer Cost	$5,998.32	$5,702.31	$6,548.58	$10,841.33	$30,280.84	$18,289.88	$21,052.48	$19,928.64	$16,210.33
% Change Over FY 2015-16 Per Utilizer Cost	-0.40%	0.45%	0.23%	0.55%	1.26%	-0.63%	0.03%	1.08%	-18.84%

Request Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2016-17 Estimated Average Utilizers Per Month	1,275	1,573	1,858	3,478	4,075	2,896	451	168	15,774
Utilizer Trend Selected[4]	7.76%	7.76%	7.75%	4.63%	5.06%	5.59%	8.20%	8.33%	5.99%
FY 2017-18 Estimated Average Utilizers Per Month	1,374	1,695	2,002	3,639	4,281	3,058	488	182	16,719
Bottom Line Impacts									
Total Bottom Line Impacts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY 2017-18 Estimated Average Utilizers Per Month	**1,374**	**1,695**	**2,002**	**3,639**	**4,281**	**3,058**	**488**	**182**	**16,719**
FY 2016-17 Average Units Per Utilizer Per Year	54	51	54	105	817	1,670	291	394	
Percentage Selected to Modify Units Per Utilizer[5]	0.00%	0.00%	0.00%	0.95%	0.49%	-0.54%	0.00%	1.27%	
FY 2017-18 Estimated Average Units Per Utilizer	**54**	**51**	**54**	**106**	**821**	**1,661**	**291**	**399**	
FY 2016-17 Average Paid Rate Per Unit	$111.08	$111.81	$121.27	$103.42	$36.79	$10.97	$72.46	$50.66	
Unit Paid Rate Trend Selected	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
FY 2017-18 Average Paid Rate Per Unit	**$111.08**	**$111.81**	**$121.27**	**$103.42**	**$36.79**	**$10.97**	**$72.46**	**$50.66**	
Estimated FY 2017-18 Base Expenditure	**$8,241,692**	**$9,665,415**	**$13,110,257**	**$39,892,610**	**$129,305,850**	**$55,720,338**	**$10,289,900**	**$3,678,828**	**$269,912,323**
Bottom Line Impacts									
Annualization of FY 2015-16 R#7 "Participant Directed Programs Expansion"	$0	$0	$0	($244,976)	($792,405)	($344,575)	($59,672)	($20,914)	($1,462,541)
Colorado Choice Transitions	$0	$0	$0	$152,754	$494,104	$214,859	$37,208	$13,041	$911,967
Home Health Final Rule (Location Expansion)	$0	$0	$0	$447,232	$641,500	$297,696	$98,945	$38,348	$1,523,721
Total Bottom Line Impacts	$0	$0	$0	$355,010	$343,199	$167,980	$76,481	$30,475	$973,145
Estimated FY 2017-18 Expenditure	**$8,241,692**	**$9,665,415**	**$13,110,257**	**$40,247,620**	**$129,649,049**	**$55,888,318**	**$10,366,381**	**$3,709,303**	**$270,885,468**
Estimated FY 2017-18 Per Utilizer Cost	$5,998.32	$5,702.31	$6,548.58	$11,060.08	$30,284.76	$18,276.10	$21,242.58	$20,380.79	$16,202.25
% Change Over FY 2016-17 Per Utilizer Cost	0.00%	0.00%	0.00%	2.02%	0.01%	-0.08%	0.90%	2.27%	-0.05%

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

Out Year									
LONG-TERM HOME HEALTH	**Physical Therapy (for 0-21 years LTHH)**	**Occupational Therapy (for 0-21 years LTHH)**	**Speech and Language Therapy (for 0-21 years LTHH)**	**Registered Nursing/Licensed Practical Nurse**	**Home Health Aid Basic**	**Home Health Aid Extended**	**Registered Nursing Brief First Visit of Day**	**Registered Nursing Brief Second or More Visit of Day**	**Total**
FY 2017-18 Estimated Average Utilizers Per Month	1,374	1,695	2,002	3,639	4,281	3,058	488	182	16,719
Utilizer Trend Selected[4]	7.21%	7.20%	7.19%	4.42%	4.81%	5.30%	7.58%	8.24%	5.66%
FY 2018-19 Estimated Average Utilizers Per Month	1,473	1,817	2,146	3,800	4,487	3,220	525	197	17,665
Bottom Line Impacts									
Total Bottom Line Impacts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY 2018-19 Estimated Average Utilizers Per Month	**1,473**	**1,817**	**2,146**	**3,800**	**4,487**	**3,220**	**525**	**197**	**17,665**
FY 2017-18 Average Units Per Utilizer Per Year	54	51	54	106	821	1,661	291	399	
Percentage Selected to Modify Units Per Utilizer[5]	0.00%	0.00%	0.00%	0.94%	0.00%	-0.54%	0.00%	1.25%	
FY 2018-19 Estimated Average Units Per Utilizer	**54**	**51**	**54**	**107**	**821**	**1,652**	**291**	**404**	
FY 2017-18 Average Paid Rate Per Unit	$111.08	$111.81	$121.27	$103.42	$36.79	$10.97	$72.46	$50.66	
Unit Paid Rate Trend Selected	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
FY 2018-19 Average Paid Rate Per Unit	**$111.08**	**$111.81**	**$121.27**	**$103.42**	**$36.79**	**$10.97**	**$72.46**	**$50.66**	
Estimated FY 2018-19 Base Expenditure	**$8,835,525**	**$10,361,097**	**$14,053,253**	**$42,050,572**	**$135,527,995**	**$58,354,257**	**$11,070,077**	**$4,031,928**	**$284,293,526**
Bottom Line Impacts									
Annualization of FY 2015-16 R#7 "Participant Directed Programs Expansi	$0	$0	$0	($122,270)	($395,498)	($171,981)	($29,783)	($10,438)	($729,970)
Home Health Final Rule (Location Expansion)	$0	$0	$0	$40,657	$58,319	$27,063	$8,995	$3,486	$138,520
Colorado Choice Transitions	$0	$0	$0	$208,015	$672,852	$292,587	$50,669	$17,759	$1,241,882
Total Bottom Line Impacts	$0	$0	$0	$126,402	$335,673	$147,669	$29,881	$10,807	$650,432
Estimated FY 2018-19 Expenditure	**$8,835,525**	**$10,361,097**	**$14,053,253**	**$42,176,974**	**$135,863,668**	**$58,501,926**	**$11,099,958**	**$4,042,735**	**$284,943,958**
Estimated FY 2018-19 Per Utilizer Cost	$5,998.32	$5,702.31	$6,548.58	$11,099.20	$30,279.40	$18,168.30	$21,142.78	$20,521.50	$16,130.43
% Change Over FY 2017-18 Per Utilizer Cost	0.00%	0.00%	0.00%	0.35%	-0.02%	-0.59%	-0.47%	0.69%	-0.44%

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

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

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

(4) Percentages Selected to Modify Utilizers for FY 2016-17 through FY 2018-19	Physical Therapy (for 0-21 years LTHH)	8.42%, 7.76%, 7.21%	Registered Nursing/Licensed Practical Nurse	4.85%, 4.63%, 4.42%	Registered Nursing Brief First Visit of Day	8.94%, 8.20%, 7.58%
	Occupational Therapy (for 0-21 years LTHH)	8.41%, 7.76%, 7.20%	Home Health Aid Basic	5.32%, 5.06%, 4.81%	Registered Nursing Brief Second or More Visit of Day	8.39%, 8.33%, 8.24%
	Speech and Language Therapy (for 0-21 years LTHH)	14.98%, 7.75%, 7.19%	Home Health Aid Extended	5.93%, 5.59%, 5.30%		
(5) Percentages Selected to Modifier Units Per Utilizer for FY 2016-17 through FY 2018-19	Physical Therapy (for 0-21 years LTHH)	0.00%, 0.00%, 0.00%	Registered Nursing/Licensed Practical Nurse	0.96%, 0.95%, 0.94%	Registered Nursing Brief First Visit of Day	0.00%, 0.00%, 0.00%
	Occupational Therapy (for 0-21 years LTHH)	0.00%, 0.00%, 0.00%	Home Health Aid Basic	0.49%, 0.49%, 0.00%	Registered Nursing Brief Second or More Visit of Day	1.29%, 1.27%, 1.25%
	Speech and Language Therapy (for 0-21 years LTHH)	0.00%, 0.00%, 0.00%	Home Health Aid Extended	-0.54%, -0.54%, -0.54%		

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

FY 2016-17 Colorado Choice Transitions (CCT) Budget Impact						
Row	**COLORADO CHOICE TRANSITIONS**	**Total**	**Developmental Disabilities/Supported Living Services/Dual Diagnosis Transitions**	**Elderly, Blind and Disabled/Brain Injury/Community Mental Health Supports Transitions**	**Calculation**	**Notes**
A	Estimated Average Monthly Enrollment	83	20	63		83 expected - 23.9% are expected to be enrolled on Division of Intellectual and Developmental Disabilities (DIDD) waivers under CCT
B	Estimated Demonstration Service Per Enrollee Annual Cost	$6,137.35	$4,183.75	$6,757.54		
C	**Estimated Demonstration Service Total Cost**	**$509,400**	**$83,675**	**$425,725**	**Row A * Row B**	**Demonstration expenses for all clients hit Medical Services Premiums (MSP)**
D	Estimated Qualified Service Per Enrollee Annual Cost	$14,982.83	$26,785.43	$11,235.97		All expenditure hits MSP, even clients enrolled on DIDD waivers while in CCT
E	**Estimated Qualified Service Total Cost**	**$1,243,575**	**$535,709**	**$707,866**	**Row A * Row D**	**DIDD Waiver Expenditure hits LBG 5 after 365 days in CCT program for DIDD clients**
F	Estimated Long-Term Home Health Per Enrollee Annual Cost	$9,666.80	$8,495.46	$10,038.65		Bottom line impact in Long-Term Home Health - include all clients
G	**Estimated Long-Term Home Health Total Cost**	**$802,344**	**$169,909**	**$632,435**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$2,555,319**	**$789,293**	**$1,766,026**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$438,244**	**$154,846**	**$283,398**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions [(1)]	64	15	49		Cumulative
K	Estimated HCBS Service Per Enrollee Annual Cost	$27,422.47	$69,209.09	$14,630.65		New waiver expenditure for clients successfully transitioned into a HCBS waiver - hits both MSP and DIDD
L	**Estimated Non CCT HCBS Service Costs Total (MSP)**	**$716,902**		**$716,902**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DIDD)**	**$1,038,136**	**$1,038,136**		**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per Full-Time Equivalent (FTE) Annual Cost		($65,714.60)	($65,714.60)		All from MSP
O	Estimated Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Per FTE Annual Cost		$276,044.81			FY 2015-16 ICF/IID Per FTE Cost
P	**Estimated Nursing Facility Total Cost Avoided - For Informational Purposes Only**	**($9,068,615)**	**($1,708,580)**	**($7,360,035)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from skilled nursing facilities (5/20 expected from ICF-IID)**
Q	**Estimated ICF-IID Total Cost Avoided - For Informational Purposes Only**	**$2,484,403**	**$2,484,403**		**(Row A * 25%) * Row O**	**Assume 25% DIDD from Regional Center**
R	**Total Cost Avoidance - For Informational Purposes Only**	**($6,584,212)**	**$775,823**	**($7,360,035)**	**Row P + Row Q**	
S	**Estimated Total Budget Impact - For Informational Purposes Only**	**($2,273,855)**	**$2,603,252**	**($4,877,107)**	**Row H + Row L + Row M + Row R**	
T	*Estimated Rebalancing Fund Balance*	*$438,244*	*$154,846*	*$283,398*	*Row I*	*Off budget balance - non appropriated line item*

FY 2017-18 Colorado Choice Transitions Budget Impact						
Row	**COLORADO CHOICE TRANSITIONS**	**Total**	**Developmental Disabilities/Supported Living Services/Dual Diagnosis Transitions**	**Elderly, Blind and Disabled/Brain Injury/Community Mental Health Supports Transitions**	**Calculation**	**Notes**
A	Estimated Average Monthly Enrollment	89	21	68		89 Expected - 23.9% are expected to be enrolled on Division of Intellectual and Developmental Disabilities (DIDD) waivers under CCT
B	Estimated Demonstration Service Per Enrollee Annual Cost	$6,402.78	$4,225.59	$7,075.14		
C	**Estimated Demonstration Service Total Cost**	**$569,847**	**$88,737**	**$481,110**	**Row A * Row B**	**Demo Expenses for all clients hit MSP**
D	Estimated Qualified Service Per Enrollee Annual Cost	$15,153.58	$27,053.28	$11,478.67		All Expenditure hits MSP, even clients enrolled on DIDD waivers while in CCT
E	**Estimated Qualified Service Total Cost**	**$1,348,669**	**$568,119**	**$780,550**	**Row A * Row D**	**DIDD Waiver Expenditure hits LBG 5 after 365 days in CCT program for DIDD clients**
F	Estimated Long-Term Home Health Per Enrollee Annual Cost	$10,246.82	$7,865.31	$10,982.28		Bottom line impact in Long-Term Home Health - include all clients
G	**Estimated Long-Term Home Health Total Cost**	**$911,967**	**$165,172**	**$746,795**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$2,830,483**	**$822,028**	**$2,008,455**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$479,629**	**$164,214**	**$315,415**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions [(1)]	129	31	98		Cumulative
K	Estimated HCBS Service Per Enrollee Annual Cost	$28,840.78	$68,381.03	$16,333.15		New waiver expenditure for clients successfully transitioned into a HCBS waiver - hits both MSP and DIDD
L	**Estimated Non CCT HCBS Service Costs Total (MSP)**	**$1,600,649**		**$1,600,649**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DIDD)**	**$2,119,812**	**$2,119,812**		**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per FTE Annual Cost		($67,685.60)	($67,685.60)		All from MSP
O	Estimated ICF-IID Per FTE Annual Cost		$282,504.26			Trended FY 2015-16 ICF/IID Per FTE Cost
P	**Estimated Nursing Facility Total Cost Avoided - For Informational Purposes Only**	**($13,875,548)**	**($2,639,738)**	**($11,235,810)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from skilled nursing facilities (8/30 expected from ICF/IID)**
Q	**Estimated ICF-IID Total Cost Avoided - For Informational Purposes Only**	**$3,672,555**	**$3,672,555**		**(Row A * 25%) * Row O**	**Assume 25% DIDD from Regional Center**
R	**Total Cost Avoidance - For Informational Purposes Only**	**($10,202,993)**	**$1,032,817**	**($11,235,810)**	**Row P + Row Q**	
S	**Estimated Total Budget Impact - For Informational Purposes Only**	**($3,652,049)**	**$3,974,657**	**($7,626,706)**	**Row H + Row L + Row M + Row R**	
T	*Estimated Rebalancing Fund Balance*	*$479,629*	*$164,214*	*$315,415*	*Row I*	*Off budget balance - non appropriated line item*

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

FY 2018-19 Colorado Choice Transitions Budget Impact						
Row	**COLORADO CHOICE TRANSITIONS**	**Total**	**Developmental Disabilities/Supported Living Services/Dual Diagnosis Transitions**	**Elderly, Blind and Disabled/Brain Injury/Community Mental Health Supports Transitions**	**Calculation**	**Notes**
A	Estimated Average Monthly Enrollment	114	27	87		114 Expected - 23.9% are expected to be enrolled on Division of Intellectual and Developmental Disabilities (DIDD) waivers under CCT
B	Estimated Demonstration Service Per Enrollee Annual Cost	$6,664.03	$4,267.85	$7,407.67		
C	**Estimated Demonstration Service Total Cost**	**$759,699**	**$115,232**	**$644,467**	**Row A * Row B**	**Demo Expenses for all clients hit MSP**
D	Estimated Qualified Service Per Enrollee Annual Cost	$15,420.68	$27,323.81	$11,726.61		All Expenditure hits MSP, even clients enrolled on DIDD waivers while in CCT
E	**Estimated Qualified Service Total Cost**	**$1,757,958**	**$737,743**	**$1,020,215**	**Row A * Row D**	**DIDD Waiver Expenditure hits LBG 5 after 365 days in CCT program for DIDD clients**
F	Estimated Long-Term Home Health Per Enrollee Annual Cost	$10,893.70	$7,281.90	$12,014.61		Bottom line impact in Long-Term Home Health - include all clients
G	**Estimated Long-Term Home Health Total Cost**	**$1,241,882**	**$196,611**	**$1,045,271**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$3,759,539**	**$1,049,586**	**$2,709,953**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$629,415**	**$213,244**	**$416,171**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions (1)	263	63	200		Cumulative
K	Estimated HCBS Service Per Enrollee Annual Cost	$29,103.59	$67,969.63	$16,860.79		New waiver expenditure for clients successfully transitioned into a HCBS waiver - hits both MSP and DIDD
L	**Estimated Non CCT HCBS Service Costs Total (MSP)**	**$3,372,158**		**$3,372,158**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DIDD)**	**$4,282,087**	**$4,282,087**		**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per FTE Annual Cost		($69,715.72)	($69,715.72)		All from MSP
O	Estimated ICF-IID Per FTE Annual Cost		$289,114.86			Trended FY 2015-16 ICF/IID Per FTE Cost
P	**Estimated Nursing Facility Total Cost Avoided - For Informational Purposes Only**	**($24,749,081)**	**($4,740,669)**	**($20,008,412)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from skilled nursing facilities (13/51 expected from ICF/IID)**
Q	**Estimated ICF-IID Total Cost Avoided - For Informational Purposes Only**	**$6,649,642**	**$6,649,642**		**(Row A * 25%) * Row O**	**Assume 25% DIDD from Regional Center**
R	**Total Cost Avoidance - For Informational Purposes Only**	**($18,099,439)**	**$1,908,973**	**($20,008,412)**	**Row P + Row Q**	
S	**Estimated Total Budget Impact - For Informational Purposes Only**	**($6,685,655)**	**$7,240,646**	**($13,926,301)**	**Row H + Row L + Row M + Row R**	
T	*Estimated Rebalancing Fund Balance*	*$629,415*	*$213,244*	*$416,171*	*Row I*	*Off budget balance - non appropriated line item*
(1) A completed transition means the client has received one year worth of demonstration services.						

Hospice Calculations for FY 2016-17, FY 2017-18, FY 2018-19

FY 2016-17 Calculation

Nursing Facility Room and Board

Service Expenditure:	Core Components	Reference
Estimate of FY 2016-17 Per Diem Rate	$170.35	Footnote 1
Estimate of Patient Days	232,621	Footnote 2
Total Estimated Costs for FY 2016-17 Days of Service	$39,626,987	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	89.07%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$35,295,757	
Estimated Expenditure for FY 2015-16 Dates of Service	$4,040,411	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2016-17 Prior to Adjustments	**$39,336,168**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2015-16 and paid in FY 2016-17 under HB 13-1152	($59,540)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($530,422)	Footnote 6
Total Bottom Line Adjustments:	**($589,962)**	
Total Estimated Nursing Facility Room and Board FY 2016-17 Total Fund Expenditure	**$38,746,206**	
Percentage Change in Core Component Expenditure Over Prior Year	3.52%	

Hospice Services

Service Expenditure:	Core Components	Reference
Hospice Routine Home Care	$11,862,403	Footnote 7
Hospice General Inpatient	$2,779,201	Footnote 7
Other Services	$68,618	Footnote 7
Estimated Hospice Services Expenditure in FY 2016-17 Prior to Adjustments	**$14,710,222**	
Bottom Line Adjustments:		
Annualization of FY 2015-16 R-12: "Community Provider Rate Increase" - Hospice	$11,556	
Total Bottom Line Adjustments:	**$11,556**	
Total Estimated Hospice Services FY 2016-17 Total Fund Expenditure	**$14,721,778**	
Percentage Change in Expenditure Over Prior Year	5.70%	
Total Estimated FY 2016-17 Expenditure	**$53,467,984**	

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HOSPICE

FY 2017-18 Calculation		
Nursing Facility Room and Board		
Service Expenditure:	**Core Components**	**Reference**
Estimate of FY 2017-18 Per Diem Rate	$175.45	Footnote 1
Estimate of Patient Days	234,844	Footnote 2
Total Estimated Costs for FY 2017-18 Days of Service	$41,203,380	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	89.07%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$36,699,851	
Estimated Expenditure for FY 2016-17 Dates of Service	$4,331,230	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2017-18 Prior to Adjustments	**$41,031,081**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2016-17 and paid in FY 2017-18 under HB 13-1152	($65,088)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($550,133)	Footnote 6
Total Bottom Line Adjustments:	**($615,221)**	
Total Estimated Nursing Facility Room and Board FY 2017-18 Total Fund Expenditure	**$40,415,860**	
Percentage Change in Core Component Expenditure Over Prior Year	4.31%	
Hospice Services		
Service Expenditure:	**Core Components**	**Reference**
Hospice Routine Home Care	$12,196,323	Footnote 7
Hospice General Inpatient	$3,274,830	Footnote 7
Other Services	$72,331	Footnote 7
Estimated Hospice Services Expenditure in FY 2017-18 Prior to Adjustments	**$15,543,484**	
Bottom Line Adjustments:		
Total Bottom Line Adjustments:	**$0**	
Total Estimated Hospice Services FY 2017-18 Total Fund Expenditure	**$15,543,484**	
Percentage Change in Expenditure Over Prior Year	5.58%	
Total Estimated FY 2017-18 Expenditure	**$55,959,344**	

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HOSPICE

FY 2018-19 Calculation		
Nursing Facility Room and Board		
Service Expenditure:	**Core Components**	**Reference**
Estimate of FY 2018-19 Per Diem Rate	$180.71	Footnote 1
Estimate of Patient Days	237,088	Footnote 2
Total Estimated Costs for FY 2018-19 Days of Service	$42,844,172	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	89.07%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$38,161,304	
Estimated Expenditure for FY 2017-18 Dates of Service	$4,503,529	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2018-19 Prior to Adjustments	**$42,664,833**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2017-18 and paid in FY 2018-19 under HB 13-1152	($67,507)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($572,282)	Footnote 6
Total Bottom Line Adjustments:	**($639,789)**	
Total Estimated Nursing Facility Room and Board FY 2018-19 Total Fund Expenditure	**$42,025,044**	
Percentage Change in Core Component Expenditure Over Prior Year	3.98%	
Hospice Services		
Service Expenditure:	**Core Components**	**Reference**
Hospice Routine Home Care	$12,564,699	Footnote 7
Hospice General Inpatient	$3,859,123	Footnote 7
Other Services	$76,244	Footnote 7
Estimated Hospice Services Expenditure in FY 2018-19 Prior to Adjustments	**$16,500,066**	
Bottom Line Adjustments:		
Total Bottom Line Adjustments:	**$0**	
Total Estimated Hospice Services FY 2018-19 Total Fund Expenditure	**$16,500,066**	
Percentage Change in Expenditure Over Prior Year	6.15%	
Total Estimated FY 2018-19 Expenditure	**$58,525,110**	

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HOSPICE
Footnotes

Hospice Nursing Facility Room and Board FY 2016-17 , FY 2017-18 and FY 2018-19 Footnotes:

(1) Fiscal year per diems are the quotient of annual IBNR-adjusted expenditure and patient days, by first-date-of-service. Estimates for FY 2016-17, FY 2017-18, and FY 2018-19 are computed by applying rate reductions where appropriate and projecting the maximum-allowable-growth (3%) in general fund expenditure. See footnote (4) for a detailed discussion of incurred-but-not-reported analysis. Rate reduction in FY 2016-17, FY 2017-18, and FY 2018-19 due to HB 13-1152; see footnote (6) for further detail.

Year	Per Diem After Reductions	Maximum Allowable Growth in General Fund Portion	Rate Reduction	Paid Rate Before Reductions	Percentage Change in Core Rate Before Reductions
FY 2007-08	$132.36			$132.36	
FY 2008-09	$148.16			$148.16	11.94%
FY 2009-10	$138.14	3.00%	0.50%	$138.83	-6.30%
FY 2010-11	$137.05	1.90%	2.50%	$140.56	1.25%
FY 2011-12	$140.19	3.00%	1.50%	$142.32	1.25%
FY 2012-13	$144.61	3.00%	1.50%	$146.81	3.15%
FY 2013-14	$151.64	3.00%	1.50%	$153.95	4.86%
FY 2014-15	$158.02	3.00%	1.50%	$160.43	4.21%
FY 2015-16	$162.90	3.00%	1.50%	$165.38	3.09%
Estimated FY 2016-17	$167.79	3.00%	1.50%	$170.35	3.01%
Estimated FY 2017-18	$172.82	3.00%	1.50%	$175.45	2.99%
Estimated FY 2018-19	$178.00	3.00%	1.50%	$180.71	3.00%

(2) The Department used patient day estimates from the February 2016 request based on FY 2015-16 actuals being within 0.6% of the previous forecast. The Department chose dampened trends in FY 2016-17, FY 2017-18 and FY 2018-19, anticipating patient days will level off.

Fiscal Year	Patient Days	Percentage Change	Full Time Equivalent	Percentage Change
FY 2007-08	206,269		564	
FY 2008-09	234,364	13.62%	642	13.83%
FY 2009-10	235,640	0.54%	646	0.62%
FY 2010-11	226,854	-3.73%	622	-3.72%
FY 2011-12	237,158	4.54%	648	4.18%
FY 2012-13	237,794	0.27%	651	0.46%
FY 2013-14	216,196	-9.08%	592	-9.06%
FY 2014-15	219,651	1.60%	602	1.69%
FY 2015-16	226,926	3.31%	622	3.32%
Estimated FY 2016-17	232,621	2.51%	637	2.41%
Estimated FY 2017-18	234,844	0.96%	643	0.94%
Estimated FY 2018-19	237,088	0.96%	650	1.09%

-0.59%

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

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HOSPICE
Footnotes

(4) Of the estimated costs for the current year dates of service, a portion of those claims will be paid during the same fiscal year in which they were incurred while the rest of the claims will be paid in a future period. In order to estimate how much of the total expenditure incurred in the current year will be paid in the current year, expenditure patterns must be analyzed by month. This is because, for example, a claim incurred in July 2015 has 11 more months to pay during FY 2015-16 (from August 2015 to June 2016), while a claim incurred in May 2016 only has one additional month to pay during FY 2015-16 (June 2016). Thus, more claims from May 2016 will pay in FY 2016-17 than claims from July 2015. Based on the Department's estimate of incurred but not reported (IBNR) claims, the Department estimates in the table below the portion of claims outstanding for any given fiscal year by analyzing estimated IBNR (based on 4 years of data) and averages the total to provide an estimate of the total percentage of claims that will pay in the same fiscal year that the claim was incurred.

Estimate of Claims Incurred and Paid in the Same Fiscal Year

Month Incurred	Additional Months Until End of Fiscal Year	Estimated Percent Complete at End of Fiscal Year (IBNR Factor)
July	11	99.98%
August	10	99.90%
September	9	99.83%
October	8	99.71%
November	7	99.52%
December	6	99.24%
January	5	98.75%
February	4	98.11%
March	3	96.71%
April	2	92.97%
May	1	84.15%
June	0	0.00%
Average		89.07%

(5) As calculated in the table below, the estimated FY 2016-17 expenditure for core components with FY 2015-16 dates of service is the estimated FY 2015-16 core components per diem rate multiplied by the estimated number of patient days. This calculation is then multiplied by one minus the calculated IBNR rate.

Calculation of Expenditure From Claims in Previous Fiscal Year	FY 2015-16	Source
IBNR Factor	89.07%	Footnote (4)
Estimated Patient Days from previous fiscal year	226,926	Footnote (2)
Estimated Per Diem Rate for Core Components for previous fiscal year	$162.90	Footnote (1)
Estimated claims expenditure for core components from previous fiscal year to be paid in the current fiscal year	$4,040,411	As described in Footnote (5) narrative

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HOSPICE
Footnotes

(6) HB 10-1324 imposed a rate reduction of 1.5% effective March 1, 2010 and effective until June 30, 2011. HB 10-1379 imposed a rate reduction of 1% in addition to the rate reduction of HB 10-1324 for the period of July 1, 2010 to June 30, 2011. SB 11-215 imposed a rate reduction of 1.5% effective July 1, 2011 for FY 2011-12 that was extended for FY 2012-13 by HB 12-1340. HB 13-1152 extended the 1.5% rate reduction indefinitely, effective July 1, 2013. The rate reductions apply to all days incurred under the effective periods of each bill. As not all days will be reported in the fiscal year in which they are incurred, the impact of the rate cuts extends over multiple fiscal years. The tables below show the incremental impact of HB 13-1152. These figures may vary from previous submissions of the Department's requests due to revised forecasts for rates and patient days. Because HB 13-1152 made the 1.5% rate reduction permanent, potential rate reductions of 1.5% for FY 2016-17, FY 2017-18, and FY 2018-19 are accounted for here.

HB 13-1152	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
Estimated FY 2015-16 Rates	1.50%	$165.38	$162.90	($2.48)
Estimated FY 2015-16 Patient Days				219,651
Estimated FY 2015-16 Days Paid in FY 2015-16				195,643
Total FY 2015-16 Impact				**($485,195)**
Estimated FY 2015-16 Days Paid in FY 2016-17				24,008
FY 2016-17 Impact from Carryover from FY 2015-16				($59,540)
Estimated FY 2016-17 Rates	1.50%	$170.35	$167.79	($2.56)
Estimated FY 2016-17 Patient Days				232,621
Estimated FY 2016-17 Days Paid in FY 2015-16				207,196
FY 2016-17 Impact from FY 2016-17				($530,422)
Total FY 2016-17 Impact				**($589,962)**
Estimated FY 2016-17 Days Paid in FY 2017-18				25,425
FY 2017-18 Impact from Carryover from FY 2016-17				($65,088)
Estimated FY 2017-18 Rates	1.50%	$175.45	$172.82	($2.63)
Estimated FY 2017-18 Patient Days				234,844
Estimated FY 2017-18 Days Paid in FY 2017-18				209,176
FY 2017-18 Impact from FY 2017-18				($550,133)
Total FY 2017-18 Impact				**($615,221)**
Estimated FY 2017-18 Days Paid in FY 2018-19				25,668
FY 2018-19 Impact from Carryover from FY 2017-18				($67,507)
Estimated FY 2018-19 Rates	1.50%	$180.71	$178.00	($2.71)
Estimated FY 2018-19 Patient Days				237,088
Estimated FY 2018-19 Days Paid in FY 2018-19				211,174
FY 2018-19 Impact from FY 2018-19				($572,282)
Total FY 2018-19 Impact				**($639,789)**

(7) Hospice Services refers here to the following categories of service: hospice routine home care, hospice general inpatient, continuous home care, hospice inpatient respite, hospice physician visit, and hearing, vision, dental, and other PETI services. Hospice routine home care (HRHC) expenditure is forecast by multiplying estimated patient days by estimated rates in FY 2016-17, FY 2017-18, and FY 2018-19. FY 2016-17 HRHC patient days are estimated by trending forward FY 2015-16 patient days by 2.0%, while FY 2017-18 and FY 2018-19 patient days were estimated by trending forward the previous year's patient days estimate by 1.0%. HRHC rates are estimated using a linear regression and rates data in the second half of FY 2015-16. Hospice general inpatient expenditure estimates are produced by inflating FY 2015-16 actuals by the average growth observed between FY 2014-15 and FY 2015-16. Estimates for the remaining service categories are the result of aggregating all remaining expenditure and applying the average annual percentage growth rate from FY 2012-13 through FY 2014-15 to observed expenditure in FY 2015-16.

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

Cash Based Actuals

HOSPICE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$25,148,153	$2,134,632	$5,123,646	$0	$77,203	$0	$0	$0	$86,351	$0	$0	$0	$0	$0	$240,791	$32,810,776
FY 2008-09	$31,767,623	$2,005,681	$5,941,975	$0	$45,064	$0	$0	$0	$77,422	$0	$3,390	$2,017	$0	$0	$59,700	$39,902,873
FY 2009-10 (DA)	$34,017,386	$3,025,452	$6,115,615	$0	$203,862	$0	$0	$0	$231,678	$0	$34,952	$0	$0	$1,279	$6,603	$43,636,827
FY 2010-11 (DA)	$30,229,237	$2,102,621	$6,889,024	$0	$228,536	$39,141	$0	$0	$60,107	$0	$3,517	$0	$0	$0	($4,548)	$39,547,635
FY 2011-12	$32,103,872	$2,846,601	$6,969,248	$15,185	$114,106	$67,245	$4,370	$0	$116,333	$0	$1,215	$1,787	$0	$0	$86,846	$42,326,808
FY 2012-13	$33,427,166	$2,868,294	$6,505,178	$140,227	$168,345	$92,875	$117,103	$0	$37,390	$0	$0	$0	$0	$0	$40,522	$43,397,100
FY 2013-14	$31,935,985	$3,814,200	$7,418,711	$344,667	$158,722	$144,242	$1,024,926	$0	$149,582	$0	$0	$0	$0	$0	$26,219	$45,017,254
FY 2014-15	$33,254,147	$3,938,226	$6,581,768	$160,754	$330,107	$193,375	$2,912,744	$6,536	$201,612	$2,960	$40,525	$0	$0	$0	$0	$47,622,754
FY 2015-16	$37,009,391	$3,642,171	$6,535,276	$273,695	$288,882	$88,848	$3,367,593	$17,689	$139,670	$0	$1,102	$0	$0	$2,599	$0	$51,366,916
Estimated FY 2016-17	$38,313,586	$3,848,412	$6,579,534	$258,161	$341,299	$101,401	$3,862,653	$15,766	$146,052	$0	$1,120	$0	$0	$0	$0	$53,467,984
Estimated FY 2017-18	$40,164,560	$4,002,848	$6,727,860	$304,773	$354,697	$111,532	$4,132,223	$9,865	$149,860	$0	$1,126	$0	$0	$0	$0	$55,959,344
Estimated FY 2018-19	$42,167,557	$4,192,271	$6,866,524	$351,119	$365,306	$119,824	$4,302,643	$5,703	$153,031	$0	$1,132	$0	$0	$0	$0	$58,525,110

Percent Change in Cash Based Actuals

HOSPICE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	26.32%	-6.04%	15.97%	0.00%	-41.63%	0.00%	0.00%	0.00%	-10.34%	0.00%	0.00%	0.00%	0.00%	0.00%	-75.21%	21.62%
FY 2009-10 (DA)	7.08%	50.84%	2.92%	0.00%	352.38%	0.00%	0.00%	0.00%	199.24%	0.00%	931.03%	-100.00%	0.00%	0.00%	-88.94%	9.36%
FY 2010-11 (DA)	-11.14%	-30.50%	12.65%	0.00%	12.10%	0.00%	0.00%	0.00%	-74.06%	0.00%	-89.94%	0.00%	0.00%	-100.00%	-168.88%	-9.37%
FY 2011-12	6.20%	35.38%	1.16%	0.00%	-50.07%	71.80%	0.00%	0.00%	93.54%	0.00%	-65.45%	100.00%	0.00%	0.00%	-2009.54%	7.03%
FY 2012-13	4.12%	0.76%	-6.66%	823.46%	47.53%	38.11%	2579.70%	0.00%	-67.86%	0.00%	-100.00%	-100.00%	0.00%	0.00%	-53.34%	2.53%
FY 2013-14	-4.46%	32.98%	14.04%	145.79%	-5.72%	55.31%	775.23%	0.00%	300.06%	0.00%	0.00%	0.00%	0.00%	0.00%	-35.30%	3.73%
FY 2014-15	4.13%	3.25%	-11.28%	-53.36%	107.98%	34.06%	184.19%	0.00%	34.78%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	5.79%
FY 2015-16	11.29%	-7.52%	-0.71%	70.26%	-12.49%	-54.05%	15.62%	170.64%	-30.72%	-100.00%	-97.28%	0.00%	0.00%	0.00%	0.00%	7.86%
Estimated FY 2016-17	3.52%	5.66%	0.68%	-5.68%	18.14%	14.13%	14.70%	-10.87%	4.57%	0.00%	1.63%	0.00%	0.00%	-100.00%	0.00%	4.09%
Estimated FY 2017-18	4.83%	4.01%	2.25%	18.06%	3.93%	9.99%	6.98%	-37.43%	2.61%	0.00%	0.54%	0.00%	0.00%	0.00%	0.00%	4.66%
Estimated FY 2018-19	4.99%	4.73%	2.06%	15.21%	2.99%	7.43%	4.12%	-42.19%	2.12%	0.00%	0.53%	0.00%	0.00%	0.00%	0.00%	4.59%

Per Capita Cost

HOSPICE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$693.09	$347.32	$102.61	$0.00	$1.44	$0.00	$0.00	$0.00	$0.42	$0.00	$0.00	$0.00	$0.00	$0.00	$16.94	$83.71
FY 2008-09	$844.46	$311.10	$115.70	$0.00	$0.73	$0.00	$0.00	$0.00	$0.33	$0.00	$0.19	$0.29	$0.00	$0.00	$3.96	$91.35
FY 2009-10 (DA)	$883.87	$429.20	$114.82	$0.00	$2.72	$0.00	$0.00	$0.00	$0.84	$0.00	$1.90	$0.00	$0.00	$0.35	$0.41	$87.48
FY 2010-11 (DA)	$776.68	$270.71	$122.40	$0.00	$2.82	$1.44	$0.00	$0.00	$0.20	$0.00	$0.19	$0.00	$0.00	$0.00	($0.27)	$70.53
FY 2011-12	$807.85	$339.57	$117.26	$292.02	$1.22	$1.90	$3.85	$0.00	$0.35	$0.00	$0.07	$0.23	$0.00	$0.00	$4.60	$68.27
FY 2012-13	$818.75	$316.90	$105.06	$157.91	$1.69	$2.24	$11.01	$0.00	$0.10	$0.00	$0.00	$0.00	$0.00	$0.00	$1.91	$63.54
FY 2013-14	$763.36	$387.11	$115.15	$134.64	$1.27	$3.06	$11.75	$0.00	$0.37	$0.00	$0.00	$0.00	$0.00	$0.00	$1.12	$52.29
FY 2014-15	$795.23	$376.29	$98.90	$44.32	$2.04	$2.69	$12.07	$16.34	$0.45	$0.06	$2.02	$0.00	$0.00	$0.00	$0.00	$41.01
FY 2015-16	$872.80	$345.92	$94.99	$44.02	$1.77	$1.02	$10.51	$54.93	$0.30	$0.00	$0.06	$0.00	$0.00	$0.98	$0.00	$39.60
Estimated FY 2016-17	$882.56	$347.11	$95.32	$44.18	$1.77	$1.03	$10.55	$55.13	$0.30	$0.00	$0.06	$0.00	$0.00	$0.00	$0.00	$37.79
Estimated FY 2017-18	$910.00	$347.02	$95.29	$44.16	$1.78	$1.02	$10.54	$55.11	$0.30	$0.00	$0.06	$0.00	$0.00	$0.00	$0.00	$37.69
Estimated FY 2018-19	$939.77	$348.66	$95.74	$44.37	$1.79	$1.03	$10.59	$55.37	$0.30	$0.00	$0.06	$0.00	$0.00	$0.00	$0.00	$38.23

Percent Change in Per Capita Cost

HOSPICE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	21.84%	-10.43%	12.76%	0.00%	-49.31%	0.00%	0.00%	0.00%	-21.43%	0.00%	0.00%	0.00%	0.00%	0.00%	-76.62%	9.13%
FY 2009-10 (DA)	4.67%	37.96%	-0.76%	0.00%	272.60%	0.00%	0.00%	0.00%	154.55%	0.00%	900.00%	-100.00%	0.00%	0.00%	-89.65%	-4.24%
FY 2010-11 (DA)	-12.13%	-36.93%	6.60%	0.00%	3.68%	0.00%	0.00%	0.00%	-76.19%	0.00%	-90.00%	0.00%	0.00%	-100.00%	-165.85%	-19.38%
FY 2011-12	4.01%	25.44%	-4.20%	0.00%	-56.74%	31.94%	0.00%	0.00%	75.00%	0.00%	-63.16%	100.00%	0.00%	0.00%	-1803.70%	-3.20%
FY 2012-13	1.35%	-6.68%	-10.40%	-45.92%	38.52%	17.89%	185.97%	0.00%	-71.43%	0.00%	-100.00%	-100.00%	0.00%	0.00%	-58.48%	-6.93%
FY 2013-14	-6.77%	22.16%	9.60%	-14.74%	-24.85%	36.61%	6.72%	0.00%	270.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-41.36%	-17.71%
FY 2014-15	4.17%	-2.80%	-14.11%	-67.08%	60.63%	-12.09%	2.72%	0.00%	21.62%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	-21.57%
FY 2015-16	9.75%	-8.07%	-3.95%	-0.68%	-13.24%	-62.08%	-12.92%	236.17%	-33.33%	-100.00%	-97.03%	0.00%	0.00%	0.00%	0.00%	-3.44%
Estimated FY 2016-17	1.12%	0.34%	0.35%	0.36%	0.00%	0.98%	0.38%	0.36%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	0.00%	-4.57%
Estimated FY 2017-18	3.11%	-0.03%	-0.03%	-0.05%	0.56%	-0.97%	-0.09%	-0.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.26%
Estimated FY 2018-19	3.27%	0.47%	0.47%	0.48%	0.56%	0.98%	0.47%	0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.43%

Exhibit H - LONG-TERM CARE AND INSURANCE
Summary

FY 2016-17 Long-Term Care and Insurance Request															
FY 2016-17	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Class I Nursing Facilities	$506,320,346	$44,073,695	$92,227,365	$167,943	$299,156	$14,579	$2,466,566	$0	$0	$0	$168,689	$0	$0	$0	$84,701	$645,823,040
Class II Nursing Facilities	$438,810	$362,350	$3,667,022	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,468,182
Program for All-Inclusive Care for the Elderly	$123,007,177	$16,244,606	$8,042,010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$147,293,793
Subtotal Long-Term Care	**$629,766,333**	**$60,680,651**	**$103,936,397**	**$167,943**	**$299,156**	**$14,579**	**$2,466,566**	**$0**	**$0**	**$0**	**$168,689**	**$0**	**$0**	**$0**	**$84,701**	**$797,585,015**
Supplemental Medicare Insurance Benefit	$102,126,789	$6,089,586	$52,695,410	$0	$375,389	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,349,679	$192,636,853
Health Insurance Buy-In	$14,225	$17,781	$1,742,556	$0	$21,337	$35,563	$32,006	$0	$124,468	$0	$0	$10,669	$0	$0	$0	$1,998,605
Subtotal Insurance	**$102,141,014**	**$6,107,367**	**$54,437,966**	**$0**	**$396,726**	**$35,563**	**$32,006**	**$0**	**$124,468**	**$0**	**$0**	**$10,669**	**$0**	**$0**	**$31,349,679**	**$194,635,458**
Total Long-Term Care and Insurance	**$731,907,347**	**$66,788,018**	**$158,374,363**	**$167,943**	**$695,882**	**$50,142**	**$2,498,572**	**$0**	**$124,468**	**$0**	**$168,689**	**$10,669**	**$0**	**$0**	**$31,434,380**	**$992,220,473**
Class I Nursing Facility Supplemental Payments	$80,768,929	$7,030,698	$14,712,238	$26,791	$47,722	$2,326	$393,470	$0	$0	$0	$26,910	$0	$0	$0	$13,512	$103,022,596
Total Long-Term Care and Insurance Including Financing	**$812,676,276**	**$73,818,716**	**$173,086,601**	**$194,734**	**$743,604**	**$52,468**	**$2,892,042**	**$0**	**$124,468**	**$0**	**$195,599**	**$10,669**	**$0**	**$0**	**$31,447,892**	**$1,095,243,069**

FY 2017-18 Long-Term Care and Insurance Request															
FY 2017-18	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Class I Nursing Facilities	$524,594,881	$45,664,439	$95,556,111	$174,004	$309,953	$15,105	$2,555,591	$0	$0	$0	$174,778	$0	$0	$0	$87,758	$669,132,620
Class II Nursing Facilities	$459,697	$379,598	$3,841,572	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,680,867
Program for All-Inclusive Care for the Elderly	$136,701,850	$18,388,115	$9,436,587	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$164,526,552
Subtotal Long-Term Care	**$661,756,428**	**$64,432,152**	**$108,834,270**	**$174,004**	**$309,953**	**$15,105**	**$2,555,591**	**$0**	**$0**	**$0**	**$174,778**	**$0**	**$0**	**$0**	**$87,758**	**$838,340,039**
Supplemental Medicare Insurance Benefit	$104,921,104	$6,404,259	$54,125,860	$0	$403,696	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,179,401	$201,034,320
Health Insurance Buy-In	$18,002	$22,502	$2,205,205	$0	$27,001	$45,005	$40,504	$0	$157,515	$0	$0	$13,501	$0	$0	$0	$2,529,235
Subtotal Insurance	**$104,939,106**	**$6,426,761**	**$56,331,065**	**$0**	**$430,697**	**$45,005**	**$40,504**	**$0**	**$157,515**	**$0**	**$0**	**$13,501**	**$0**	**$0**	**$35,179,401**	**$203,563,555**
Total Long-Term Care and Insurance	**$766,695,534**	**$70,858,913**	**$165,165,335**	**$174,004**	**$740,650**	**$60,110**	**$2,596,095**	**$0**	**$157,515**	**$0**	**$174,778**	**$13,501**	**$0**	**$0**	**$35,267,159**	**$1,041,903,594**
Class I Nursing Facility Supplemental Payments	$82,965,371	$7,221,891	$15,112,325	$27,519	$49,019	$2,389	$404,170	$0	$0	$0	$27,641	$0	$0	$0	$13,879	$105,824,204
Total Long-Term Care and Insurance Including Financing	**$849,660,905**	**$78,080,804**	**$180,277,660**	**$201,523**	**$789,669**	**$62,499**	**$3,000,265**	**$0**	**$157,515**	**$0**	**$202,419**	**$13,501**	**$0**	**$0**	**$35,281,038**	**$1,147,727,798**

FY 2018-19 Long-Term Care and Insurance Request															
FY 2018-19	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Class I Nursing Facilities	$541,821,547	$47,163,970	$98,693,986	$179,718	$320,131	$15,601	$2,639,512	$0	$0	$0	$180,517	$0	$0	$0	$90,640	$691,105,622
Class II Nursing Facilities	$501,483	$390,417	$3,951,057	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,842,957
Program for All-Inclusive Care for the Elderly	$154,127,772	$20,991,333	$11,368,441	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$186,487,546
Subtotal Long-Term Care	**$696,450,802**	**$68,545,720**	**$114,013,484**	**$179,718**	**$320,131**	**$15,601**	**$2,639,512**	**$0**	**$0**	**$0**	**$180,517**	**$0**	**$0**	**$0**	**$90,640**	**$882,436,125**
Supplemental Medicare Insurance Benefit	$99,931,117	$6,258,141	$51,606,543	$0	$389,307	$0	$0	$0	$0	$0	$0	$0	$0	$0	$37,056,976	$195,242,084
Health Insurance Buy-In	$22,799	$28,499	$2,792,877	$0	$34,197	$56,998	$51,298	$0	$199,492	$0	$0	$17,099	$0	$0	$0	$3,203,259
Subtotal Insurance	**$99,953,916**	**$6,286,640**	**$54,399,420**	**$0**	**$423,504**	**$56,998**	**$51,298**	**$0**	**$199,492**	**$0**	**$0**	**$17,099**	**$0**	**$0**	**$37,056,976**	**$198,445,343**
Total Long-Term Care and Insurance	**$796,404,718**	**$74,832,360**	**$168,412,904**	**$179,718**	**$743,635**	**$72,599**	**$2,690,810**	**$0**	**$199,492**	**$0**	**$180,517**	**$17,099**	**$0**	**$0**	**$37,147,616**	**$1,080,881,468**
Class I Nursing Facility Supplemental Payments	$85,221,541	$7,418,284	$15,523,291	$28,267	$50,352	$2,454	$415,161	$0	$0	$0	$28,393	$0	$0	$0	$14,257	$108,702,000
Total Long-Term Care and Insurance Including Financing	**$881,626,259**	**$82,250,644**	**$183,936,195**	**$207,985**	**$793,987**	**$75,053**	**$3,105,971**	**$0**	**$199,492**	**$0**	**$208,910**	**$17,099**	**$0**	**$0**	**$37,161,873**	**$1,189,583,468**

Class I Nursing Home Calculations for FY 2016-17, FY 2017-18 and FY 2018-19

FY 2016-17 Calculation

Service Expenditure:	Core Components	Reference
Estimate of FY 2016-17 Total Fund Portion of Per Diem Rate	$215.96	Footnote 1
Estimate of FY 2016-17 Patient Payment (per day)	($35.92)	Footnote 1
Estimated FY 2016-17 Medicaid Reimbursement (per day)	**$180.04**	
Estimate of Patient Days (without Hospital Back Up)	3,606,106	Footnote 2
Total Estimated Costs for FY 2016-17 Days of Service	$649,243,324	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.88%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$603,017,199	
Estimated Expenditure for FY 2015-16 Dates of Service	$43,722,333	Footnote 5
Estimated Expenditure in FY 2016-17 Prior to Adjustments	**$646,739,532**	
Bottom Line Adjustments:		
Hospital Back Up Program	$9,126,756	Footnote 6
Recoveries from Department Overpayment Review	($1,000,000)	Footnote 7
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($9,043,248)	Footnote 8
Total Bottom Line Adjustments:	**($916,492)**	
Total Estimated FY 2016-17 Total Fund Expenditure	**$645,823,040**	
Percentage Change in Core Component Expenditure Over Prior Year	4.22%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$0	Page EH-9
Prior Year Rate Reconciliation	$56,312,301	Page EH-9
Rate Cut Backfill	$0	Page EH-9
Cognitive Performance Scale	$645,904	Page EH-9
PASRR - Resident	$2,820,102	Page EH-9
PASRR - Facility	$1,039,725	Page EH-9
Medicaid Supplemental Payment	$36,647,929	Page EH-9
Pay for Performance	$5,556,635	Page EH-9
Total Estimated Supplemental Payments	**$103,022,596**	
Total Estimated FY 2016-17 Expenditure	**$748,845,636**	

Class I Nursing Home Calculations for FY 2016-17, FY 2017-18 and FY 2018-19

FY 2017-18 Calculation

Service Expenditure:	Core Components	Reference
Estimate of FY 2017-18 Total Fund Portion of Per Diem Rate	$221.48	Footnote 1
Estimate of FY 2017-18 Patient Payment (per day)	($36.04)	Footnote 1
Estimated FY 2017-18 Medicaid Reimbursement (per day)	**$185.44**	
Estimate of Patient Days (without Hospital Back Up)	3,626,030	Footnote 2
Total Estimated Costs for FY 2017-18 Days of Service	$672,411,003	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.88%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$624,535,340	
Estimated Expenditure for FY 2016-17 Dates of Service	$46,226,125	Footnote 5
Estimated Expenditure in FY 2017-18 Prior to Adjustments	**$670,761,465**	
Bottom Line Adjustments:		
Hospital Back Up Program	$9,454,236	Footnote 6
Recoveries from Department Overpayment Review	($1,027,200)	Footnote 7
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($10,055,881)	Footnote 8
Total Bottom Line Adjustments:	**($1,628,845)**	
Total Estimated FY 2017-18 Expenditure	**$669,132,620**	
Percentage Change in Core Component Expenditure Over Prior Year	3.61%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$0	Page EH-9
Prior Year Rate Reconciliation	$57,843,664	Page EH-9
Rate Cut Backfill	$0	Page EH-9
Cognitive Performance Scale	$663,469	Page EH-9
PASRR - Resident	$2,896,792	Page EH-9
PASRR - Facility	$1,067,999	Page EH-9
Medicaid Supplemental Payment	$37,644,537	Page EH-9
Pay for Performance	$5,707,743	Page EH-9
Total Estimated Supplemental Payments	**$105,824,204**	
Total Estimated FY 2017-18 Expenditure	**$774,956,824**	

Class I Nursing Home Calculations for FY 2016-17, FY 2017-18 and FY 2018-19

FY 2018-19 Calculation

Service Expenditure:	**Core Components**	**Reference**
Estimate of FY 2018-19 Total Fund Portion of Per Diem Rate	$227.26	Footnote 1
Estimate of FY 2018-19 Patient Payment (per day)	($36.26)	Footnote 1
Estimated FY 2018-19 Medicaid Reimbursement (per day)	**$191.00**	
Estimate of Patient Days (without Hospital Back Up)	3,636,047	Footnote 2
Total Estimated Costs for FY 2018-19 Days of Service	$694,484,977	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.88%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$645,037,647	
Estimated Expenditure for FY 2017-18 Dates of Service	$47,875,663	Footnote 5
Estimated Expenditure in FY 2018-19 Prior to Adjustments	**$692,913,310**	
Bottom Line Adjustments:		
Hospital Back Up Program	$9,623,851	Footnote 6
Recoveries from Department Overpayment Review	($1,055,140)	Footnote 7
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($10,376,399)	Footnote 8
Total Bottom Line Adjustments:	**($1,807,688)**	
Total Estimated FY 2018-19 Expenditure	**$691,105,622**	
Percentage Change in Core Component Expenditure Over Prior Year	3.28%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$0	Page EH-9
Prior Year Rate Reconciliation	$59,416,671	Page EH-9
Rate Cut Backfill	$0	Page EH-9
Cognitive Performance Scale	$681,511	Page EH-9
PASRR - Resident	$2,975,568	Page EH-9
PASRR - Facility	$1,097,043	Page EH-9
Medicaid Supplemental Payment	$38,668,247	Page EH-9
Pay for Performance	$5,862,960	Page EH-9
Total Estimated Supplemental Payments	**$108,702,000**	
Total Estimated FY 2018-19 Expenditure	**$799,807,622**	

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

Class I Nursing Home Calculations for FY 2016-17 , FY 2017-18 and FY 2018-19 Footnotes:

(1) Per HB 08-1114 and SB 09-263, the Department implemented significant changes in the reimbursement rate methodology for nursing facilities. Beginning in FY 2008-09, instead of reimbursement based on an overall per diem rate, facilities are reimbursed based on a per diem rate for core components as well as supplemental per diem rates for eligible facilities. The core components include fair rental value; direct and indirect health care; and administrative and general costs. Supplemental payments are made for providers who have residents with moderate to severe mental health conditions, cognitive dementia, or acquired brain injury; and to providers who meet performance standards. In addition, supplemental payments are made as part of the prior year rate reconciliation process and as a provider fee offset. The following table includes the historical per diem reimbursement rates and the estimated and projected per diem rates for FY 2002-03 through FY 2018-19. The Core Per Diem less patient payment represents the Total Fund portion of nursing facility reimbursement.

Year	Per Diem	Patient Payment	Final Paid Rate	Rate Reduction	Per Diem Before Rate Reduction
FY 2002-03	$131.06	$24.75	$106.31	-	$131.06
FY 2003-04	$143.49	$24.93	$118.56	-	$143.49
FY 2004-05	$150.15	$25.89	$124.26	-	$150.15
FY 2005-06	$157.34	$27.52	$129.82	-	$157.34
FY 2006-07	$166.30	$30.25	$136.05	-	$166.30
FY 2007-08	$169.28	$31.20	$138.08	-	$169.28
FY 2008-09	$190.34	$33.10	$157.24	-	$190.34
FY 2009-10	$178.91	$33.57	$145.34	0.50%	$179.81
FY 2010-11	$173.57	$33.22	$140.35	2.50%	$178.02
FY 2011-12	$183.73	$34.19	$149.54	1.50%	$186.53
FY 2012-13	$188.96	$35.12	$153.84	1.50%	$191.84
FY 2013-14	$198.24	$35.73	$162.51	1.50%	$201.26
FY 2014-15	$201.48	$36.20	$165.28	1.50%	$204.55
FY 2015-16	$207.72	$35.55	$172.17	1.50%	$210.88
Estimated FY 2016-17	$213.26	$35.92	$177.34	1.50%	$215.96
Estimated FY 2017-18	$218.70	$36.04	$182.66	1.50%	$221.48
Estimated FY 2018-19	$224.40	$36.26	$188.14	1.50%	$227.26

(2) The patient days estimate is a trended value using incurred but not reported (IBNR) adjusted data. Values for prior years differ slightly from prior Budget Requests due to the inclusion of claims paid between those Requests and this Request. Hospital Back Up days are removed from this calculation. The Department observed a positive trend in patient days in the first six months of FY 2015-16 and in the subsequent months a slight decline. As a result, the Department selected trends reduced from the February 2016 request for the current, request, and out year patient days estimates to remain conservative.

Fiscal Year	Patient Days	Percentage Change	Full Time Equivalent Clients	Percentage Change
FY 2000-01	3,712,731	-	10,172	-
FY 2001-02	3,618,218	-2.55%	9,913	-2.55%
FY 2002-03	3,538,295	-2.21%	9,694	-2.21%
FY 2003-04	3,502,849	-1.00%	9,571	-1.27%
FY 2004-05	3,519,234	0.47%	9,642	0.74%
FY 2005-06	3,529,589	0.29%	9,670	0.29%
FY 2006-07	3,546,807	0.49%	9,717	0.49%
FY 2007-08	3,435,003	-3.15%	9,385	-3.42%
FY 2008-09	3,427,547	-0.22%	9,391	0.06%
FY 2009-10	3,452,652	0.73%	9,459	0.72%
FY 2010-11	3,527,753	2.18%	9,665	2.18%
FY 2011-12	3,502,587	-0.71%	9,570	-0.98%
FY 2012-13	3,474,994	-0.79%	9,521	-0.51%
FY 2013-14	3,453,162	-0.63%	9,461	-0.63%
FY 2014-15	3,489,640	1.06%	9,561	1.06%
FY 2015-16	3,566,694	2.21%	9,745	1.92%
Estimated FY 2016-17	3,606,106	1.11%	9,880	1.39%
Estimated FY 2017-18	3,626,030	0.55%	9,934	0.55%
Estimated FY 2018-19	3,636,047	0.28%	9,962	0.28%

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

(4) Of the estimated costs for the current year dates of service, a portion of those claims will be paid during the same fiscal year in which they were incurred while the rest of the claims will be paid in a future period. In order to estimate how much of the total expenditure incurred in the current year will be paid in the current year, expenditure patterns must be analyzed by month. This is because, for example, a claim incurred in July 2015 has 11 more months to pay during FY 2015-16 (from August 2015 to June 2016), while a claim incurred in May 2016 only has one additional month to pay during FY 2015-16 (June 2016). Thus, more claims from May 2016 will pay in FY 2016-17 than claims from July 2015. Based on the Department's estimate of incurred but not reported (IBNR) claims, the Department estimates in the table below the portion of claims outstanding for any given fiscal year by analyzing estimated IBNR (based on five years of data) and averages the total to provide an estimate of the total percentage of claims that will pay in the same fiscal year that the claim was incurred.

Estimate of Claims Incurred and Paid in the Same Fiscal Year

Month Incurred	Additional Months Until End of Fiscal Year	Estimated Percent Complete at End of Fiscal Year (IBNR Factor)
July	11	99.94%
August	10	99.90%
September	9	99.82%
October	8	99.72%
November	7	99.55%
December	6	99.32%
January	5	98.97%
February	4	98.43%
March	3	97.39%
April	2	95.51%
May	1	91.65%
June	0	34.40%
Average		92.88%

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

(5) As calculated in the table below, the estimated FY 2016-17 expenditure for core components with FY 2015-16 dates of service is the estimated FY 2015-16 core components per diem rate, less the estimated per diem patient payment rate, multiplied by the estimated number of patient days. This calculation is then multiplied by one minus the calculated IBNR rate.

Calculation of Expenditure From Claims in Previous Fiscal Year	FY 2015-16	Source
IBNR Factor	92.88%	Footnote (4)
Estimated Patient Days from previous fiscal year	3,566,694	Footnote (2)
Estimated Per Diem Rate for Core Components for previous fiscal year	$207.72	Footnote (1)
Less: Estimated Patient Payment Rate for previous fiscal year	$35.55	Footnote (1)
Estimated claims expenditure for core components from previous fiscal year to be paid in the current fiscal year	$43,722,333	As described in Footnote (5) narrative

(6) Hospital Back Up (HBU) and out of state placements are programs where the Department pays a much higher per diem for specialized clients which can be several times the statewide average Nursing Facilities Medicaid reimbursement rate. This is an intermediate level of care in between the hospital and a skilled nursing facility. Types of clients treated under this program include ventilator, wound care, medically complex and traumatic brain injury with severe behaviors. This group is difficult to budget for due to the fluctuation in client base. FY 2007-08 expenditure was lower than previous years due to a facility which was placed under a "Denial of Payment for New Admissions" status for failure to comply with certain standards, although this has since been rectified. In FY 2008-09, expenditure rose sharply due to an increase in billed patient days. In FY 2009-10 no facilities were accepting new clients. In FY 2010-11 one new client was added to the program. In FY 2013-14, there was a spike in enrollment. It appears there was a level shift in enrollment in FY 2013-14 with enrollment figures staying consistent into FY 2014-15. Currently, the Department is working to evaluate the efficacy and design of the HBU program. As the Department continues through this process, client admission into the program will be evaluated on a case by case basis. Based on growth in enrollment in FY 2015-16, the Department adjusted its trend up to account for new clients.

Fiscal Year	Hospital Back Up	Percent Difference
FY 2003-04	$4,907,936	-
FY 2004-05	$5,731,131	16.77%
FY 2005-06	$5,033,659	-12.17%
FY 2006-07	$5,615,794	11.56%
FY 2007-08	$5,309,178	-5.46%
FY 2008-09	$6,920,964	30.36%
FY 2009-10	$4,376,832	-36.76%
FY 2010-11	$4,731,471	8.10%
FY 2011-12	$3,549,186	-24.99%
FY 2012-13	$4,284,618	20.72%
FY 2013-14	$6,604,416	54.14%
FY 2014-15	$5,796,191	-12.24%
FY 2015-16	$8,617,205	48.67%
Estimated FY 2016-17	$9,126,756	5.91%
Estimated FY 2017-18	$9,454,236	3.59%
Estimated FY 2018-19	$9,623,851	1.79%

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

(7) Overpayment review recoveries are amounts that the Department recovers from nursing homes. The Department contracted with a contingency based contractor to do a five year historical audit of all the facilities, and the contract expired at the end of FY 2005-06. In FY 2015-16, the Department audited a number of facilities with fewer overpayment issues and thus did not recover as much.

Fiscal Year	Overpayment Recoveries	Percent Difference
FY 2010-11	$1,797,766	-
FY 2011-12	$2,063,191	14.76%
FY 2012-13	$1,751,203	-15.12%
FY 2013-14	$1,363,500	-22.14%
FY 2014-15	$1,794,661	31.62%
FY 2015-16	$695,367	-61.25%
Estimated FY 2016-17	$1,000,000	43.81%
Estimated FY 2017-18	$1,027,200	2.72%
Estimated FY 2018-19	$1,055,140	2.72%

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

HB 13-1152	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
Estimated FY 2016-17 Rates	1.50%	$215.96	$213.26	($2.70)
Estimated FY 2016-17 Patient Days				3,606,106
Estimated FY 2016-17 Days Paid in FY 2016-17				3,349,351
Total FY 2016-17 Impact				**($9,043,248)**
Estimated FY 2016-17 Days Paid in FY 2017-18				256,755
FY 2017-18 Impact from Carryover from FY 2016-17				($693,239)
Estimated FY 2017-18 Rates	1.50%	$221.48	$218.70	($2.78)
Estimated FY 2017-18 Patient Days				3,626,030
Estimated FY 2017-18 Days Paid in FY 2017-18				3,367,857
FY 2017-18 Impact from FY 2017-18				($9,362,642)
Total FY 2017-18 Impact				**($10,055,881)**
Estimated FY 2017-18 Days Paid in FY 2018-19				258,173
FY 2018-19 Impact from Carryover from FY 2017-18				($717,721)
Estimated FY 2018-19 Rates	1.50%	$227.26	$224.40	($2.86)
Estimated FY 2018-19 Patient Days				3,636,047
Estimated FY 2018-19 Days Paid in FY 2018-19				3,377,160
FY 2018-19 Impact from FY 2018-19				($9,658,678)
Total FY 2018-19 Impact				**($10,376,399)**

(9) As of July 1, 2014, SB 14-130 raised the basic minimum amount payable for personal needs to any recipient admitted to a nursing facility or intermediate care facility for individuals with intellectual disabilities from $50.00 to $75.00, monthly. This amount increases by 3.0% annually on January 1st of each year.

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

Class I Nursing Facilities Supplemental Payments

Year	Provider Fee Per Non Medicare Day Paid by Low Medicaid Volume Facilities	Provider Fee Per Non Medicare Day Paid by High Medicaid Volume Facilities	Growth Beyond General Fund Cap	Prior Year Rate Reconciliation [1]	Rate Cut Backfill	Cognitive Performance Scale	PASRR - Resident[2]	PASRR - Facility[2]	Medicaid Supplemental Payment	Pay for Performance	Total Effective Add-on/ Supplemental
FY 2009-10	$5.90	$0.28	$31,277,211	$0	$2,995,689	$958,621	$2,713,717	$418,432	$12,830,094	$2,525,948	**$53,719,712**
FY 2010-11	$7.62	$1.17	$48,220,038	$6,575,460	$0	$81,245	$198,782	$49,344	$17,743,388	$1,174,416	**$74,042,673**
FY 2011-12	$12.35	$1.90	$43,446,400	$5,277,654	$0	$807,125	$2,773,147	$641,003	$29,614,476	$4,227,680	**$86,787,485**
FY 2012-13	$12.67	$1.95	$34,456,677	$7,746,924	$0	$886,643	$2,966,460	$440,770	$30,669,660	$6,675,579	**$83,842,713**
FY 2013-14	$12.96	$1.99	$40,051,460	$5,697,344	$0	$630,925	$2,796,344	$686,768	$32,429,057	$6,067,966	**$88,359,864**
FY 2014-15	$13.30	$2.04	$45,483,952	$4,304,753	$0	$767,427	$1,884,606	$564,926	$33,000,199	$6,750,242	**$92,756,105**
FY 2015-16	$13.64	$2.09	$28,411,979	$26,857,074	$0	$840,830	$2,368,440	$847,630	$34,370,573	$6,880,724	**$100,577,250**
Projected FY 2016-17	$13.98	$2.14	$0	$56,312,301	$0	$645,904	$2,820,102	$1,039,725	$36,647,929	$5,556,635	**$103,022,596**
Projected FY 2017-18	$14.36	$2.20	$0	$57,843,664	$0	$663,469	$2,896,792	$1,067,999	$37,644,537	$5,707,743	**$105,824,204**
Projected FY 2018-19	$14.75	$2.26	$0	$59,416,671	$0	$681,511	$2,975,568	$1,097,043	$38,668,247	$5,862,960	**$108,702,000**

Class I Nursing Facilities Supplemental Payments - Percent Change

Year	Provider Fee Per Non Medicare Day Paid by Low Medicaid Volume Facilities	Provider Fee Per Non Medicare Day Paid by High Medicaid Volume Facilities	Growth Beyond General Fund Cap	Prior Year Rate Reconciliation	Rate Cut Backfill	Cognitive Performance Scale	PASRR - Resident[2]	PASRR - Facility[2]	Medicaid Supplemental Payment	Pay for Performance	Total Effective Add-on/ Supplemental
FY 2010-11	29.15%	317.86%	54.17%	-	-100.00%	-91.52%	-92.67%	-88.21%	38.30%	-53.51%	**37.83%**
FY 2011-12	62.07%	62.4%	-9.90%	-19.74%	-	893.45%	1295.07%	1199.05%	66.90%	259.98%	**17.21%**
FY 2012-13	2.59%	2.6%	-20.69%	46.79%	-	9.85%	6.97%	-31.24%	3.56%	57.90%	**-3.39%**
FY 2013-14	2.29%	2.1%	16.24%	-26.46%	-	-28.84%	-5.73%	55.81%	5.74%	-9.10%	**5.39%**
FY 2014-15	2.62%	2.5%	13.56%	-24.44%	-	21.64%	-32.60%	-17.74%	1.76%	11.24%	**4.98%**
FY 2015-16	2.56%	2.5%	-37.53%	523.89%	-	9.56%	25.67%	50.04%	4.15%	1.93%	**8.43%**
Projected FY 2016-17	2.49%	2.4%	-100.00%	109.67%	-	-23.18%	19.07%	22.66%	6.63%	-19.24%	**2.43%**
Projected FY 2017-18	2.72%	2.8%	-	2.72%	-	2.72%	2.72%	2.72%	2.72%	2.72%	**2.72%**
Projected FY 2018-19	2.72%	2.7%	-	2.72%	-	2.72%	2.72%	2.72%	2.72%	2.72%	**2.72%**

(1) Supplemental payments made under Growth Beyond General Fund Cap were discontinued in FY 2016-17. These payments will instead be made as part of the Prior Year Rate Reconciliation.
(2) PASRR: Preadmission Screening and Resident Review

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

Cash Based Actuals

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$389,399,454	$25,395,243	$69,952,848	$0	$6,325	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,814,628	$486,568,498
FY 2008-09	$423,682,370	$29,953,087	$77,004,135	$0	$22,194	$0	$0	$0	$0	$0	$0	$0	$0	$0	$256,886	$530,918,672
FY 2009-10 (DA)	$393,028,828	$28,956,277	$73,847,716	$0	$5,285	$0	$0	$0	$0	$0	$0	$0	$0	$0	$62,686	$495,900,792
FY 2010-11 (DA)	$390,609,241	$31,625,231	$76,509,001	$0	$7,615	$0	$0	$0	$0	$0	$0	$0	$0	$0	$564,302	$499,315,390
FY 2011-12	$411,201,009	$33,559,826	$76,088,316	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$395,618	$521,244,769
FY 2012-13	$418,131,480	$35,559,417	$78,452,737	$0	$0	$0	$12,430	$0	$0	$0	$0	$0	$0	$0	$249,186	$532,405,250
FY 2013-14	$440,587,143	$38,148,380	$81,720,674	$387,966	$125,945	$0	$570,397	$0	$0	$0	$0	$0	$0	$0	$784,886	$562,325,391
FY 2014-15	$450,965,898	$41,239,990	$84,210,839	$82,897	$195,582	$40,448	$2,542,746	$0	$0	$0	$76,579	$0	$0	$0	($25,076)	$579,329,903
FY 2015-16	$471,762,532	$48,104,528	$95,971,531	$185,970	$167,980	$15,396	$3,458,057	$0	$0	$0	$5,103	$0	$0	$0	$2,391	$619,673,488
Estimated FY 2016-17	$506,320,346	$44,073,695	$92,227,365	$167,943	$299,156	$14,579	$2,466,566	$0	$0	$0	$168,689	$0	$0	$0	$84,701	$645,823,040
Estimated FY 2017-18	$524,594,881	$45,664,439	$95,556,111	$174,004	$309,953	$15,105	$2,555,591	$0	$0	$0	$174,778	$0	$0	$0	$87,758	$669,132,620
Estimated FY 2018-19	$541,821,547	$47,163,970	$98,693,986	$179,718	$320,131	$15,601	$2,639,512	$0	$0	$0	$180,517	$0	$0	$0	$90,640	$691,105,622

Percent Change in Cash Based Actuals

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	8.80%	17.95%	10.08%	0.00%	250.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-85.84%	9.11%
FY 2009-10 (DA)	-7.24%	-3.33%	-4.10%	0.00%	-76.19%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-75.60%	-6.60%
FY 2010-11 (DA)	-0.62%	9.22%	3.60%	0.00%	44.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	800.20%	0.69%
FY 2011-12	5.27%	6.12%	-0.55%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-29.89%	4.39%
FY 2012-13	1.69%	5.96%	3.11%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-37.01%	2.14%
FY 2013-14	5.37%	7.28%	4.17%	0.00%	0.00%	0.00%	4488.87%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	214.98%	5.62%
FY 2014-15	2.36%	8.10%	3.05%	-78.63%	55.29%	0.00%	345.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-103.19%	3.02%
FY 2015-16	4.61%	16.65%	13.97%	124.34%	-14.11%	-61.94%	36.00%	0.00%	0.00%	0.00%	-93.34%	0.00%	0.00%	0.00%	-109.54%	6.96%
Estimated FY 2016-17	7.33%	-8.38%	-3.90%	-9.69%	78.09%	-5.31%	-28.67%	0.00%	0.00%	0.00%	3205.68%	0.00%	0.00%	0.00%	3442.49%	4.22%
Estimated FY 2017-18	3.61%	3.61%	3.61%	3.61%	3.61%	3.61%	3.61%	0.00%	0.00%	0.00%	3.61%	0.00%	0.00%	0.00%	3.61%	3.61%
Estimated FY 2018-19	3.28%	3.28%	3.28%	3.28%	3.28%	3.28%	3.28%	0.00%	0.00%	0.00%	3.28%	0.00%	0.00%	0.00%	3.28%	3.28%

Per Capita Cost

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$10,731.99	$4,132.00	$1,400.93	$0.00	$0.12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$127.66	$1,241.37
FY 2008-09	$11,262.46	$4,646.05	$1,499.45	$0.00	$0.36	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.04	$1,215.44
FY 2009-10 (DA)	$10,211.99	$4,107.86	$1,386.45	$0.00	$0.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.94	$994.19
FY 2010-11 (DA)	$10,035.95	$4,071.74	$1,359.31	$0.00	$0.09	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$33.02	$890.43
FY 2011-12	$10,347.28	$4,003.32	$1,280.22	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$20.96	$840.77
FY 2012-13	$10,241.54	$3,928.78	$1,267.00	$0.00	$0.00	$0.00	$1.17	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$11.75	$779.52
FY 2013-14	$10,531.29	$3,871.75	$1,268.48	$151.55	$1.01	$0.00	$6.54	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$33.57	$653.14
FY 2014-15	$10,784.27	$3,940.38	$1,265.42	$22.86	$1.21	$0.56	$10.53	$0.00	$0.00	$0.00	$3.82	$0.00	$0.00	$0.00	($0.89)	$498.90
FY 2015-16	$11,125.69	$4,568.77	$1,394.94	$29.91	$1.03	$0.18	$10.79	$0.00	$0.00	$0.00	$0.26	$0.00	$0.00	$0.00	$0.07	$477.78
Estimated FY 2016-17	$11,663.14	$3,975.26	$1,336.09	$28.74	$1.56	$0.15	$6.74	$0.00	$0.00	$0.00	$8.36	$0.00	$0.00	$0.00	$2.36	$456.44
Estimated FY 2017-18	$11,885.60	$3,958.77	$1,353.43	$25.21	$1.56	$0.14	$6.52	$0.00	$0.00	$0.00	$8.61	$0.00	$0.00	$0.00	$2.19	$450.70
Estimated FY 2018-19	$12,075.36	$3,922.49	$1,376.12	$22.71	$1.57	$0.13	$6.50	$0.00	$0.00	$0.00	$8.89	$0.00	$0.00	$0.00	$2.02	$451.46

Percent Change in Per Capita Cost

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	4.94%	12.44%	7.03%	0.00%	200.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-86.65%	-2.09%
FY 2009-10 (DA)	-9.33%	-11.58%	-7.54%	0.00%	-80.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-76.88%	-18.20%
FY 2010-11 (DA)	-1.72%	-0.88%	-1.96%	0.00%	28.57%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	738.07%	-10.44%
FY 2011-12	3.10%	-1.68%	-5.82%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-36.52%	-5.58%
FY 2012-13	-1.02%	-1.86%	-1.03%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-43.94%	-7.28%
FY 2013-14	2.83%	-1.45%	0.12%	100.00%	100.00%	0.00%	458.97%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	185.70%	-16.21%
FY 2014-15	2.40%	1.77%	-0.24%	-84.92%	19.80%	100.00%	61.01%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	-102.65%	-23.62%
FY 2015-16	3.17%	15.95%	10.24%	30.84%	-14.88%	-67.86%	2.47%	0.00%	0.00%	0.00%	-93.19%	0.00%	0.00%	0.00%	-107.87%	-4.23%
Estimated FY 2016-17	4.83%	-12.99%	-4.22%	-3.91%	51.46%	-16.67%	-37.53%	0.00%	0.00%	0.00%	3115.38%	0.00%	0.00%	0.00%	3271.43%	-4.47%
Estimated FY 2017-18	1.91%	-0.41%	1.30%	-12.28%	0.00%	-6.67%	-3.26%	0.00%	0.00%	0.00%	2.99%	0.00%	0.00%	0.00%	-7.20%	-1.26%
Estimated FY 2018-19	1.60%	-0.92%	1.68%	-9.92%	0.64%	-7.14%	-0.31%	0.00%	0.00%	0.00%	3.25%	0.00%	0.00%	0.00%	-7.76%	0.17%

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

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

Cash Based Actuals

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$74,970	$191,024	$1,924,394	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$45,248	$2,235,636
FY 2008-09	$0	$335,754	$1,935,960	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,271,714
FY 2009-10 (DA)	($38,446)	$264,098	$989,694	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,215,347
FY 2010-11 (DA)	($84,407)	$729,155	$2,518,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,163,194
FY 2011-12	$0	$583,751	$1,915,323	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,499,074
FY 2012-13	$180,939	$825,327	$4,101,296	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,107,562
FY 2013-14	$393,954	$298,879	$2,748,163	$0	$0	$0	$43,770	$0	$0	$0	$0	$0	$0	$0	$0	$3,484,766
FY 2014-15	$411,017	$455,389	$3,411,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,277,851
FY 2015-16	$397,005	$327,830	$3,317,671	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,042,506
Estimated FY 2016-17	$438,810	$362,350	$3,667,022	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,468,182
Estimated FY 2017-18	$459,697	$379,598	$3,841,572	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,680,867
Estimated FY 2018-19	$501,483	$390,417	$3,951,057	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,842,957

Percent Change in Cash Based Actuals

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	-100.00%	75.77%	0.60%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	1.61%
FY 2009-10 (DA)	100.00%	-21.34%	-48.88%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-46.50%
FY 2010-11 (DA)	119.55%	176.09%	154.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	160.27%
FY 2011-12	-100.00%	-19.94%	-23.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-21.00%
FY 2012-13	100.00%	41.38%	114.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	104.38%
FY 2013-14	117.73%	-63.79%	-32.99%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-31.77%
FY 2014-15	4.33%	52.37%	24.14%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	22.76%
FY 2015-16	-3.41%	-28.01%	-2.75%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.50%
Estimated FY 2016-17	10.53%	10.53%	10.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.53%
Estimated FY 2017-18	4.76%	4.76%	4.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.76%
Estimated FY 2018-19	9.09%	2.85%	2.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.46%

Percent Change in Enrollment

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.00%
FY 2009-10 (DA)	100.00%	33.33%	12.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	26.32%
FY 2010-11 (DA)	-100.00%	0.00%	-27.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-29.17%
FY 2011-12	0.00%	0.00%	7.69%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.88%
FY 2012-13	100.00%	0.00%	-7.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.56%
FY 2013-14	0.00%	-75.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.53%
FY 2014-15	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2015-16	0.00%	0.00%	15.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.76%
Estimated FY 2016-17	0.00%	0.00%	13.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.53%
Estimated FY 2017-18	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.76%
Estimated FY 2018-19	50.00%	50.00%	11.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.09%

Per Capita Cost

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$2.07	$31.08	$38.54	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.18	$5.70
FY 2008-09	$0.00	$52.08	$37.70	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.20
FY 2009-10 (DA)	($1.00)	$37.47	$18.58	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.44
FY 2010-11 (DA)	($2.17)	$93.88	$44.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.64
FY 2011-12	$0.00	$69.64	$32.23	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.03
FY 2012-13	$4.43	$91.19	$66.24	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.48
FY 2013-14	$9.42	$30.33	$42.66	$0.00	$0.00	$0.00	$0.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.05
FY 2014-15	$9.83	$43.51	$51.26	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.68
FY 2015-16	$9.36	$31.14	$48.22	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.12
Estimated FY 2016-17	$10.11	$32.68	$53.12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.16
Estimated FY 2017-18	$10.42	$32.91	$54.41	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.15
Estimated FY 2018-19	$11.18	$32.47	$55.09	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.16

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

Percent Change in Per Capita Cost																
CLASS II NURSING FACILITIES	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
FY 2008-09	-100.00%	67.57%	-2.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	-8.77%
FY 2009-10 (DA)	100.00%	-28.05%	-50.72%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-53.08%
FY 2010-11 (DA)	117.00%	150.55%	140.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	131.15%
FY 2011-12	-100.00%	-25.82%	-27.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-28.55%
FY 2012-13	100.00%	30.94%	105.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	85.61%
FY 2013-14	112.64%	-66.74%	-35.60%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-45.86%
FY 2014-15	4.35%	43.46%	20.16%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-9.14%
FY 2015-16	-4.78%	-28.43%	-5.93%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-15.22%
Estimated FY 2016-17	8.01%	4.95%	10.16%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.28%
Estimated FY 2017-18	3.07%	0.70%	2.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.32%
Estimated FY 2018-19	7.29%	-1.34%	1.25%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.32%

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

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Current Year Projection																
FY 2015-16 Expenditure	$397,005	$327,830	$3,317,671	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,042,506
Percentage Selected to Modify Expenditure[(1)]	10.53%	10.53%	10.53%	10.53%	10.53%	10.53%	10.53%	10.53%	10.53%	10.53%	10.53%	10.53%	10.53%	10.53%	10.53%	10.53%
Estimated FY 2016-17 Base Expenditure	$438,810	$362,350	$3,667,022	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,468,182
Bottom Line Impacts																
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2016-17 Total Expenditure	**$438,810**	**$362,350**	**$3,667,022**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,468,182**
Request Year Projection																
FY 2016-17 Expenditure	$438,810	$362,350	$3,667,022	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,468,182
Percentage Selected to Modify Expenditure[(1)]	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%
Estimated FY 2017-18 Base Expenditure	$459,697	$379,598	$3,841,572	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,680,867
Bottom Line Impacts																
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2017-18 Total Expenditure	**$459,697**	**$379,598**	**$3,841,572**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,680,867**
Out Year Projection																
FY 2017-18 Expenditure	$459,697	$379,598	$3,841,572	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,680,867
Percentage Selected to Modify Expenditure[(1)]	9.09%	2.85%	2.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.46%
Estimated FY 2018-19 Base Expenditure	$501,483	$390,417	$3,951,057	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,842,957
Bottom Line Impacts																
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2018-19 Total Expenditure	**$501,483**	**$390,417**	**$3,951,057**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,842,957**

(1) The percentages selected to trend expenditure for FY 2016-17 is 10.53%, FY 2017-18 is 4.76%, and FY 2018-19 is 9.09%. The trend has been set to match expected increases in C2NFcost per-client.

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

Cash Based Actuals

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$44,272,143	$3,549,809	$1,596,904	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$49,418,855
FY 2008-09	$54,470,714	$4,395,937	$2,183,184	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$61,049,836
FY 2009-10 (DA)	$61,924,559	$4,986,130	$2,345,339	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$69,256,028
FY 2010-11 (DA)	$73,232,308	$7,892,082	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$84,414,278
FY 2011-12	$73,671,387	$8,052,921	$3,756,277	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$85,480,585
FY 2012-13	$84,386,436	$8,794,508	$4,165,414	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$97,346,358
FY 2013-14	$85,832,165	$10,249,500	$4,393,152	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$100,474,817
FY 2014-15	$112,128,644	$14,440,173	$6,335,950	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$132,904,767
FY 2015-16	$108,848,065	$13,681,759	$6,481,645	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$129,011,469
Estimated FY 2016-17	$123,007,177	$16,244,606	$8,042,010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$147,293,793
Estimated FY 2017-18	$136,701,850	$18,388,115	$9,436,587	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$164,526,552
Estimated FY 2018-19	$154,127,772	$20,991,333	$11,368,441	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$186,487,546

Percent Change in Cash Based Actuals

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	23.04%	23.84%	36.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	23.54%
FY 2009-10 (DA)	13.68%	13.43%	7.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.44%
FY 2010-11 (DA)	18.26%	58.28%	40.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	21.89%
FY 2011-12	0.60%	2.04%	14.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.26%
FY 2012-13	14.54%	9.21%	10.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.88%
FY 2013-14	1.71%	16.54%	5.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.21%
FY 2014-15	30.64%	40.89%	44.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	32.28%
FY 2015-16	-2.93%	-5.25%	2.30%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.93%
Estimated FY 2016-17	13.01%	18.73%	24.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	14.17%
Estimated FY 2017-18	11.13%	13.20%	17.34%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.70%
Estimated FY 2018-19	12.75%	14.16%	20.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.35%

Per Capita Cost

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$1,220.16	$577.58	$31.98	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$126.08
FY 2008-09	$1,447.96	$681.86	$42.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$139.76
FY 2009-10 (DA)	$1,608.97	$707.35	$44.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$138.85
FY 2010-11 (DA)	$1,881.56	$1,016.10	$58.45	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$150.54
FY 2011-12	$1,853.83	$960.63	$63.20	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$137.88
FY 2012-13	$2,066.93	$971.66	$67.27	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$142.53
FY 2013-14	$2,051.63	$1,040.24	$68.19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$116.70
FY 2014-15	$2,681.41	$1,379.72	$95.21	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$114.45
FY 2015-16	$2,566.99	$1,299.44	$94.21	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$99.47
Estimated FY 2016-17	$2,833.48	$1,465.19	$116.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$104.10
Estimated FY 2017-18	$3,097.22	$1,594.11	$133.66	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$110.82
Estimated FY 2018-19	$3,434.98	$1,745.79	$158.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$121.82

Percent Change in Per Capita Cost

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	18.67%	18.05%	32.93%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.85%
FY 2009-10 (DA)	11.12%	3.74%	3.58%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.65%
FY 2010-11 (DA)	16.94%	43.65%	32.75%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.42%
FY 2011-12	-1.47%	-5.46%	8.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-8.41%
FY 2012-13	11.50%	1.15%	6.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.37%
FY 2013-14	-0.74%	7.06%	1.37%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-18.12%
FY 2014-15	30.70%	32.63%	39.62%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.93%
FY 2015-16	-4.27%	-5.82%	-1.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-13.09%
Estimated FY 2016-17	10.38%	12.76%	23.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.65%
Estimated FY 2017-18	9.31%	8.80%	14.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.46%
Estimated FY 2018-19	10.91%	9.52%	18.59%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.93%

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

PACE Enrollment and Cost Per Enrollee

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
PACE Average Monthly Paid Enrollment[1]																
FY 2008-09	1,273	100	49	0	0	0	0	0	0	0	0	0	0	0	0	1,422
FY 2009-10 (DA)	1,439	120	60	0	0	0	0	0	0	0	0	0	0	0	0	1,619
FY 2010-11 (DA)	1,600	171	75	0	0	0	0	0	0	0	0	0	0	0	0	1,846
FY 2011-12	1,754	204	96	0	0	0	0	0	0	0	0	0	0	0	0	2,054
FY 2012-13	2,047	238	117	0	0	0	0	0	0	0	0	0	0	0	0	2,402
FY 2013-14	1,924	232	101	0	0	0	0	0	0	0	0	0	0	0	0	2,257
FY 2014-15	2,393	320	143	0	0	0	0	0	0	0	0	0	0	0	0	2,856
FY 2015-16	2,510	336	157	0	0	0	0	0	0	0	0	0	0	0	0	3,003
Estimated FY 2016-17	2,697	373	184	0	0	0	0	0	0	0	0	0	0	0	0	3,254
Estimated FY 2017-18	2,969	417	214	0	0	0	0	0	0	0	0	0	0	0	0	3,600
Estimated FY 2018-19	3,298	469	254	0	0	0	0	0	0	0	0	0	0	0	0	4,021
Percent Changes in Enrollment																
FY 2009-10 (DA)	13.04%	20.00%	22.45%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.85%
FY 2010-11 (DA)	11.19%	42.50%	25.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	14.02%
FY 2011-12	9.62%	19.30%	28.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.27%
FY 2012-13	16.70%	16.67%	21.88%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.94%
FY 2013-14	-6.01%	-2.52%	-13.68%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-6.04%
FY 2014-15	24.38%	37.93%	41.58%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	26.54%
FY 2015-16	4.89%	5.00%	9.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.15%
Estimated FY 2016-17	7.45%	11.01%	17.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.36%
Estimated FY 2017-18	10.09%	11.80%	16.30%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.63%
Estimated FY 2018-19	11.08%	12.47%	18.69%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.69%
Average Cost Per Enrollee[3][4]																
FY 2008-09	$42,789.25	$43,959.37	$44,554.78	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,932.37
FY 2009-10 (DA)	$43,033.05	$41,551.08	$39,088.98	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,777.04
FY 2010-11 (DA)	$45,770.19	$46,152.53	$43,865.17	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45,728.21
FY 2011-12	$42,001.93	$39,475.10	$39,127.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$41,616.64
FY 2012-13	$41,224.44	$36,951.71	$35,601.83	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$40,527.21
FY 2013-14	$44,611.31	$44,178.88	$43,496.55	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$44,516.98
FY 2014-15	$46,856.93	$45,125.54	$44,307.34	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$46,535.28
FY 2015-16	$43,365.76	$40,719.52	$41,284.36	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,960.86
Estimated FY 2016-17	$45,362.62	$43,444.53	$43,444.53	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45,034.29
Estimated FY 2017-18	$46,043.06	$44,096.20	$44,096.20	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45,701.82
Estimated FY 2018-19	$46,733.71	$44,757.64	$44,757.64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$46,378.40
Percent Changes in Cost Per Enrollee																
FY 2009-10 (DA)	0.57%	-5.48%	-12.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.36%
FY 2010-11 (DA)	6.36%	11.07%	12.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.90%
FY 2011-12	-8.23%	-14.47%	-10.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-8.99%
FY 2012-13	-1.85%	-6.39%	-9.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.62%
FY 2013-14	8.22%	19.56%	22.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.84%
FY 2014-15	5.03%	2.14%	1.86%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.53%
FY 2015-16	-7.45%	-9.76%	-6.82%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-7.68%
Estimated FY 2016-17	4.60%	6.69%	5.23%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.83%
Estimated FY 2017-18	1.50%	1.50%	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.48%
Estimated FY 2018-19	1.50%	1.50%	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.48%

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

Current Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2015-16 Average Monthly Paid Enrollment	2,510	336	157	-	-	-	-	-	-	-	-	-	-	-	-	3,003
Trend Factor[5]	7.45%	11.01%	17.20%	-	-	-	-	-	-	-	-	-	-	-	-	8.36%
Estimated FY 2016-17 Monthly Paid Enrollment	2,697	373	184	-	-	-	-	-	-	-	-	-	-	-	-	3,254
FY 2016-17 Estimated Cost Per Enrollee	$45,362.62	$43,444.53	$43,444.53	-	-	-	-	-	-	-	-	-	-	-	-	$45,034.29
Bottom Line Impacts																
InnovAge Loveland 2015-16 Retroactive Payments	$664,191	$39,796	$48,216	-	-	-	-	-	-	-	-	-	-	-	-	$752,203
Total Bottom Line Impacts	$664,191	$39,796	$48,216	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$752,203
Estimated FY 2016-17 Expenditure	**$123,007,177**	**$16,244,606**	**$8,042,010**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$147,293,793**
Estimated FY 2016-17 Per Capita	$2,833.48	$1,465.19	$116.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$104.10
% Change over FY 2015-16 Per Capita	10.38%	12.76%	23.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.65%

Request Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Estimated FY 2016-17 Monthly Paid Enrollment	2,697	373	184	-	-	-	-	-	-	-	-	-	-	-	-	3,254
Trend Factor[5]	10.09%	11.80%	16.30%	-	-	-	-	-	-	-	-	-	-	-	-	10.63%
Estimated FY 2017-18 Monthly Paid Enrollment	2,969	417	214	-	-	-	-	-	-	-	-	-	-	-	-	3,600
FY 2017-18 Estimated Cost Per Enrollee	$46,043.06	$44,096.20	$44,096.20	-	-	-	-	-	-	-	-	-	-	-	-	$45,701.82
Bottom Line Impacts																
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2017-18 Expenditure	**$136,701,850**	**$18,388,115**	**$9,436,587**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$164,526,552**
Estimated FY 2017-18 Per Capita	$3,097.22	$1,594.11	$133.66	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$110.82
% Change over FY 2016-17 Per Capita	9.31%	8.80%	14.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.46%

Out Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Estimated FY 2017-18 Monthly Paid Enrollment	2,969	417	214	-	-	-	-	-	-	-	-	-	-	-	-	3,600
Trend Factor[5]	11.08%	12.47%	18.69%	-	-	-	-	-	-	-	-	-	-	-	-	11.69%
Estimated FY 2018-19 Monthly Paid Enrollment	3,298	469	254	-	-	-	-	-	-	-	-	-	-	-	-	4,021
FY 2018-19 Estimated Cost Per Enrollee	$46,733.71	$44,757.64	$44,757.64	-	-	-	-	-	-	-	-	-	-	-	-	$46,378.40
Bottom Line Impacts																
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2018-19 Expenditure	**$154,127,772**	**$20,991,333**	**$11,368,441**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$186,487,546**
Estimated FY 2018-19 Per Capita	$3,434.98	$1,745.79	$158.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$121.82
% Change over FY 2017-18 Per Capita	10.91%	9.52%	18.59%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.93%

Footnotes

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

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

(3) Per-enrollee costs for FY 2016-17 are a weighted average of FY 2016-17 rates by forecasted FY 2016-17 provider distribution and FY 2014-15 third-party-liability status. FY 2017-18 per-enrollee costs are estimated using a 1.5% trend (half of the Nursing Facility statutory rate increase) applied to FY 2016-17 estimates. FY 2018-19 per-enrollee costs are estimated by application of the same growth rate to estimated FY 2017-18 per-enrollee costs.

(4) Estimated cost per enrollee in this exhibit is not necessarily equivalent to what actual rates will be in FY 2017-18 forward, as information that is necessary to accurately calculate actuarially sound rates is not available at this time. The cost per enrollee information in this exhibit is for informational purposes only. Please see the Narrative for more information on PACE rates.

(5) Monthly Paid Enrollment figures for FY 2016-17, FY 2017-18, and FY 2018-19 are estimated via linear regression of historical enrollment by provider and eligibility type.

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

Cash Based Actuals

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$43,978,504	$2,564,572	$23,052,905	$0	$144,195	$0	$0	$0	$0	$0	$0	$0	$0	$0	$12,725,770	$82,465,946
FY 2008-09	$49,992,538	$2,915,276	$26,205,375	$0	$163,913	$0	$0	$0	$0	$0	$0	$0	$0	$0	$14,466,011	$93,743,114
FY 2009-10 (DA)	$54,965,748	$3,205,285	$28,812,261	$0	$180,219	$0	$0	$0	$0	$0	$0	$0	$0	$0	$15,905,077	$103,068,590
FY 2010-11 (DA)	$63,751,826	$3,717,638	$33,417,797	$0	$209,027	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,447,446	$119,543,734
FY 2011-12	$63,201,668	$3,688,256	$33,153,682	$46,299	$207,374	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,301,648	$118,598,927
FY 2012-13	$63,920,416	$3,727,469	$33,506,170	$0	$209,579	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,496,230	$119,859,864
FY 2013-14	$68,884,741	$4,016,960	$36,108,399	$0	$225,857	$0	$0	$0	$0	$0	$0	$0	$0	$0	$19,932,724	$129,168,681
FY 2014-15	$73,205,694	$4,268,933	$38,373,381	$0	$240,024	$0	$0	$0	$0	$0	$0	$0	$0	$0	$21,183,050	$137,271,082
FY 2015-16	$83,423,470	$4,864,774	$43,729,393	$0	$273,526	$0	$0	$0	$0	$0	$0	$0	$0	$0	$24,139,700	$156,430,863
Estimated FY 2016-17	$102,126,789	$6,089,586	$52,695,410	$0	$375,389	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,349,679	$192,636,853
Estimated FY 2017-18	$104,921,104	$6,404,259	$54,125,860	$0	$403,696	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,179,401	$201,034,320
Estimated FY 2018-19	$99,931,117	$6,258,141	$51,606,543	$0	$389,307	$0	$0	$0	$0	$0	$0	$0	$0	$0	$37,056,976	$195,242,084

Percent Change in Cash Based Actuals

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	13.67%	13.67%	13.67%	0.00%	13.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.67%	13.67%
FY 2009-10 (DA)	9.95%	9.95%	9.95%	0.00%	9.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.95%	9.95%
FY 2010-11 (DA)	15.98%	15.98%	15.98%	0.00%	15.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.98%	15.98%
FY 2011-12	-0.86%	-0.79%	-0.79%	0.00%	-0.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.79%	-0.79%
FY 2012-13	1.14%	1.06%	1.06%	-100.00%	1.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.06%	1.06%
FY 2013-14	7.77%	7.77%	7.77%	0.00%	7.77%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.77%	7.77%
FY 2014-15	6.27%	6.27%	6.27%	0.00%	6.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.27%	6.27%
FY 2015-16	13.96%	13.96%	13.96%	0.00%	13.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.96%	13.96%
Estimated FY 2016-17	22.42%	25.18%	20.50%	0.00%	37.24%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	29.87%	23.15%
Estimated FY 2017-18	2.74%	5.17%	2.71%	0.00%	7.54%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	12.22%	4.36%
Estimated FY 2018-19	-4.76%	-2.28%	-4.65%	0.00%	-3.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.34%	-2.88%

Per Capita Cost

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$1,212.06	$417.27	$461.68	$0.00	$2.70	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$895.30	$210.39
FY 2008-09	$1,328.92	$452.19	$510.28	$0.00	$2.65	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$959.60	$214.61
FY 2009-10 (DA)	$1,428.16	$454.71	$540.93	$0.00	$2.41	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$999.13	$206.63
FY 2010-11 (DA)	$1,637.98	$478.65	$593.72	$0.00	$2.58	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,079.43	$213.18
FY 2011-12	$1,590.38	$439.97	$557.82	$890.37	$2.22	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$969.83	$191.30
FY 2012-13	$1,565.64	$411.83	$541.12	$0.00	$2.11	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$872.22	$175.49
FY 2013-14	$1,646.54	$407.69	$560.48	$0.00	$1.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$852.63	$150.03
FY 2014-15	$1,750.62	$407.89	$576.63	$0.00	$1.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$755.32	$118.21
FY 2015-16	$1,967.40	$462.04	$635.60	$0.00	$1.67	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$740.82	$120.61
Estimated FY 2016-17	$2,352.50	$549.25	$763.39	$0.00	$1.95	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$873.03	$136.15
Estimated FY 2017-18	$2,377.17	$555.20	$766.62	$0.00	$2.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$876.53	$135.41
Estimated FY 2018-19	$2,227.13	$520.47	$719.57	$0.00	$1.90	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$826.08	$127.54

Percent Change in Per Capita Cost

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	9.64%	8.37%	10.53%	0.00%	-1.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.18%	2.01%
FY 2009-10 (DA)	7.47%	0.56%	6.01%	0.00%	-9.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.12%	-3.72%
FY 2010-11 (DA)	14.69%	5.26%	9.76%	0.00%	7.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.04%	3.17%
FY 2011-12	-2.91%	-8.08%	-6.05%	0.00%	-13.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.15%	-10.26%
FY 2012-13	-1.56%	-6.40%	-2.99%	-100.00%	-4.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.06%	-8.26%
FY 2013-14	5.17%	-1.01%	3.58%	0.00%	-14.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.25%	-14.51%
FY 2014-15	6.32%	0.05%	2.88%	0.00%	-18.23%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-11.41%	-21.21%
FY 2015-16	12.38%	13.28%	10.23%	0.00%	12.84%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.92%	2.03%
Estimated FY 2016-17	19.57%	18.87%	20.11%	0.00%	16.77%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.85%	12.88%
Estimated FY 2017-18	1.05%	1.08%	0.42%	0.00%	4.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.40%	-0.54%
Estimated FY 2018-19	-6.31%	-6.26%	-6.14%	0.00%	-6.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.76%	-5.81%

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

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Current Year Projection																
FY 2015-16 Expenditure	**$83,423,470**	**$4,864,774**	**$43,729,393**	**$0**	**$273,526**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$24,139,700**	**$156,430,863**
FY 2015-16 First Half Expenditure	$38,324,525	$2,234,865	$20,089,169	$0	$125,657	$0	$0	$0	$0	$0	$0	$0	$0	$0	$11,089,715	$71,863,931
FY 2015-16 Second Half Expenditure	$45,098,945	$2,629,909	$23,640,224	$0	$147,869	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,049,985	$84,566,932
Estimated FY 2016-17 First Half Caseload Trend	1.19%	2.65%	0.17%	-3.00%	8.87%	6.87%	7.16%	-5.59%	2.11%	5.07%	0.63%	1.22%	4.75%	-0.06%	5.10%	4.55%
Estimated FY 2016-17 First Half Expenditure	$45,635,622	$2,699,602	$23,680,412	$0	$160,985	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,715,534	$85,892,155
Estimated FY 2016-17 Second Half Caseload Trend	1.19%	2.65%	0.16%	-3.00%	8.87%	6.87%	7.15%	-5.59%	2.10%	5.06%	0.62%	1.22%	4.74%	-0.05%	5.10%	4.54%
Estimated Increase in Medicare Part B Premium (Effective January 1, 2017)[1]	22.33%	22.33%	22.33%	22.33%	22.33%	22.33%	22.33%	22.33%	22.33%	22.33%	22.33%	22.33%	22.33%	22.33%	22.33%	22.33%
Estimated FY 2016-17 Second Half Expenditure	$56,491,167	$3,389,984	$29,014,998	$0	$214,404	$0	$0	$0	$0	$0	$0	$0	$0	$0	$17,634,145	$106,744,698
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2016-17 Total Expenditure(2)	**$102,126,789**	**$6,089,586**	**$52,695,410**	**$0**	**$375,389**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$31,349,679**	**$192,636,853**
Estimated FY 2016-17 Per Capita	$2,352.50	$549.25	$763.39	$0.00	$1.95	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$873.03	$136.15
% Change over FY 2015-16 Per Capita	19.57%	18.87%	20.11%	0.00%	16.77%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.85%	12.88%
Request Year Projection																
Estimated FY 2016-17 Expenditure	$102,126,789	$6,089,586	$52,695,410	$0	$375,389	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,349,679	$192,636,853
Estimated FY 2016-17 First Half Expenditure	$45,635,622	$2,699,602	$23,680,412	$0	$160,985	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,715,534	$85,892,155
Estimated FY 2016-17 Second Half Expenditure	$56,491,167	$3,389,984	$29,014,998	$0	$214,404	$0	$0	$0	$0	$0	$0	$0	$0	$0	$17,634,145	$106,744,698
Estimated FY 2017-18 First Half Caseload Trend	0.84%	2.02%	1.14%	9.05%	1.79%	5.01%	3.51%	-18.71%	1.32%	4.86%	0.26%	0.01%	1.61%	0.04%	5.89%	2.47%
Estimated FY 2017-18 First Half Expenditure	$56,965,693	$3,458,462	$29,345,769	$0	$218,242	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,672,796	$108,660,962
Estimated FY 2017-18 Second Half Caseload Trend	0.83%	2.02%	1.14%	9.04%	1.78%	5.01%	3.50%	-18.70%	1.32%	4.85%	0.26%	0.00%	1.61%	0.04%	5.88%	2.46%
Estimated Increase in Medicare Part B Premium (Effective January 1, 2018)[1]	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%	-16.51%
Estimated FY 2017-18 Second Half Expenditure	$47,955,411	$2,945,797	$24,780,091	$0	$185,454	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,506,605	$92,373,358
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2017-18 Total Expenditure(2)	**$104,921,104**	**$6,404,259**	**$54,125,860**	**$0**	**$403,696**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$35,179,401**	**$201,034,320**
Estimated FY 2017-18 Per Capita	$2,377.17	$555.20	$766.62	$0.00	$2.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$876.53	$135.41
% Change over FY 2016-17 Per Capita	1.05%	1.08%	0.42%	0.00%	4.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.40%	-0.54%
Out Year Projection																
Estimated FY 2017-18 Expenditure	$104,921,104	$6,404,259	$54,125,860	$0	$403,696	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,179,401	$201,034,320
Estimated FY 2017-18 First Half Expenditure	$56,965,693	$3,458,462	$29,345,769	$0	$218,242	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,672,796	$108,660,962
Estimated FY 2017-18 Second Half Expenditure	$47,955,411	$2,945,797	$24,780,091	$0	$185,454	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,506,605	$92,373,358
Estimated FY 2018-19 First Half Caseload Trend	0.83%	2.12%	0.79%	7.33%	1.32%	3.47%	1.82%	-21.23%	0.82%	2.03%	0.04%	0.01%	1.56%	0.02%	5.89%	1.56%
Estimated FY 2018-19 First Half Expenditure	$48,353,441	$3,008,248	$24,975,854	$0	$187,902	$0	$0	$0	$0	$0	$0	$0	$0	$0	$17,478,844	$94,004,289
Estimated FY 2018-19 Second Half Caseload Trend	0.83%	2.12%	0.79%	7.33%	1.32%	3.46%	1.81%	-21.23%	0.82%	2.02%	0.03%	0.00%	1.56%	0.02%	5.88%	1.55%
Estimated Increase in Medicare Part B Premium (Effective January 1, 2019)[1]	5.79%	5.79%	5.79%	5.79%	5.79%	5.79%	5.79%	5.79%	5.79%	5.79%	5.79%	5.79%	5.79%	5.79%	5.79%	5.79%
Estimated FY 2018-19 Second Half Expenditure	$51,577,676	$3,249,893	$26,630,689	$0	$201,405	$0	$0	$0	$0	$0	$0	$0	$0	$0	$19,578,132	$101,237,795
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2018-19 Total Expenditure(2)	**$99,931,117**	**$6,258,141**	**$51,606,543**	**$0**	**$389,307**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$37,056,976**	**$195,242,084**
Estimated FY 2018-19 Per Capita	$2,227.13	$520.47	$719.57	$0.00	$1.90	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$826.08	$127.54
% Change over Estimated FY 2017-18 Per Capita	-6.31%	-6.26%	-6.14%	0.00%	-6.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.76%	-5.81%

[1]The Part B premium is $121.80 effective January 1, 2016. The projected growth in premiums of 22.33% in CY 2017, -16.51% in CY 2018, and 5.79% in CY 2019 are found in the 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, dated June 22, 2016.

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

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

Cash Based Actuals

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$3,274	$1,762	$877,995	$0	$1,605	$0	$0	$0	$16,916	$0	$1,188	$2,208	$0	$0	$0	$904,948
FY 2008-09	($177)	$3,200	$917,027	$0	$5,034	$0	$0	$0	$16,561	$0	$0	$500	$0	$0	$0	$942,145
FY 2009-10 (DA)	$3,552	$8,333	$993,384	$0	$3,197	$0	$0	$0	$11,314	$0	$210	$0	$0	$0	$0	$1,019,990
FY 2010-11 (DA)	$1,979	$625	$1,025,861	$0	$5,098	$0	$0	$0	$2,021	$0	$1,059	$0	$0	$0	$0	$1,036,643
FY 2011-12	$2,162	$6,655	$1,122,186	$0	$9,727	$0	$0	$0	$12,996	$0	$2,223	$3,358	$0	$0	$0	$1,159,307
FY 2012-13	$2,767	$1,630	$1,345,692	$0	$6,506	$0	$0	$0	$3,632	$0	$1,304	$0	$0	$0	$0	$1,361,531
FY 2013-14	$11,744	$20,552	$1,215,523	$0	$26,425	$0	$0	$0	$60,491	$0	$21,718	$8,808	$0	$0	$0	$1,365,261
FY 2014-15	$8,989	$11,236	$1,101,111	$0	$13,483	$22,472	$20,224	$0	$78,651	$0	$0	$6,741	$0	$0	$0	$1,262,907
FY 2015-16	$11,486	$14,357	$1,406,977	$0	$17,228	$28,714	$25,842	$0	$100,498	$0	$0	$8,614	$0	$0	$0	$1,613,716
Estimated FY 2016-17	$14,225	$17,781	$1,742,556	$0	$21,337	$35,563	$32,006	$0	$124,468	$0	$0	$10,669	$0	$0	$0	$1,998,605
Estimated FY 2017-18	$18,002	$22,502	$2,205,205	$0	$27,001	$45,005	$40,504	$0	$157,515	$0	$0	$13,501	$0	$0	$0	$2,529,235
Estimated FY 2018-19	$22,799	$28,499	$2,792,877	$0	$34,197	$56,998	$51,298	$0	$199,492	$0	$0	$17,099	$0	$0	$0	$3,203,259

Percent Change in Cash Based Actuals

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	-105.41%	81.61%	4.45%	0.00%	213.64%	0.00%	0.00%	0.00%	-2.10%	0.00%	-100.00%	-77.36%	0.00%	0.00%	0.00%	4.11%
FY 2009-10 (DA)	-2106.78%	160.41%	8.33%	0.00%	-36.49%	0.00%	0.00%	0.00%	-31.68%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	8.26%
FY 2010-11 (DA)	-44.28%	-92.50%	3.27%	0.00%	59.46%	0.00%	0.00%	0.00%	-82.14%	0.00%	404.29%	0.00%	0.00%	0.00%	0.00%	1.63%
FY 2011-12	9.25%	964.80%	9.39%	0.00%	90.80%	0.00%	0.00%	0.00%	543.05%	0.00%	109.92%	0.00%	0.00%	0.00%	0.00%	11.83%
FY 2012-13	27.98%	-75.51%	19.92%	0.00%	-33.11%	0.00%	0.00%	0.00%	-72.05%	0.00%	-41.34%	-100.00%	0.00%	0.00%	0.00%	17.44%
FY 2013-14	324.43%	1160.86%	-9.67%	0.00%	306.16%	0.00%	0.00%	0.00%	1565.50%	0.00%	1565.49%	0.00%	0.00%	0.00%	0.00%	0.27%
FY 2014-15	-23.46%	-45.33%	-9.41%	0.00%	-48.98%	0.00%	0.00%	0.00%	30.02%	0.00%	-100.00%	-23.47%	0.00%	0.00%	0.00%	-7.50%
FY 2015-16	27.78%	27.78%	27.78%	0.00%	27.78%	27.78%	27.78%	0.00%	27.78%	0.00%	0.00%	27.79%	0.00%	0.00%	0.00%	27.78%
Estimated FY 2016-17	23.84%	23.85%	23.85%	0.00%	23.85%	23.85%	23.85%	0.00%	23.85%	0.00%	0.00%	23.86%	0.00%	0.00%	0.00%	23.85%
Estimated FY 2017-18	26.55%	26.55%	26.55%	0.00%	26.55%	26.55%	26.55%	0.00%	26.55%	0.00%	0.00%	26.54%	0.00%	0.00%	0.00%	26.55%
Estimated FY 2018-19	26.65%	26.65%	26.65%	0.00%	26.65%	26.65%	26.65%	0.00%	26.65%	0.00%	0.00%	26.65%	0.00%	0.00%	0.00%	26.65%

Per Capita Cost

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$0.09	$0.29	$17.58	$0.00	$0.03	$0.00	$0.00	$0.00	$0.08	$0.00	$0.07	$0.35	$0.00	$0.00	$0.00	$2.31
FY 2008-09	$0.00	$0.50	$17.86	$0.00	$0.08	$0.00	$0.00	$0.00	$0.07	$0.00	$0.00	$0.07	$0.00	$0.00	$0.00	$2.16
FY 2009-10 (DA)	$0.09	$1.18	$18.65	$0.00	$0.04	$0.00	$0.00	$0.00	$0.04	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$2.04
FY 2010-11 (DA)	$0.05	$0.08	$18.23	$0.00	$0.06	$0.00	$0.00	$0.00	$0.01	$0.00	$0.06	$0.00	$0.00	$0.00	$0.00	$1.85
FY 2011-12	$0.05	$0.79	$18.88	$0.00	$0.10	$0.00	$0.00	$0.00	$0.04	$0.00	$0.12	$0.44	$0.00	$0.00	$0.00	$1.87
FY 2012-13	$0.07	$0.18	$21.73	$0.00	$0.07	$0.00	$0.00	$0.00	$0.01	$0.00	$0.07	$0.00	$0.00	$0.00	$0.00	$1.99
FY 2013-14	$0.28	$2.09	$18.87	$0.00	$0.21	$0.00	$0.00	$0.00	$0.15	$0.00	$1.19	$0.67	$0.00	$0.00	$0.00	$1.59
FY 2014-15	$0.21	$1.07	$16.55	$0.00	$0.08	$0.31	$0.08	$0.00	$0.18	$0.00	$0.00	$0.45	$0.00	$0.00	$0.00	$1.09
FY 2015-16	$0.27	$1.36	$20.45	$0.00	$0.11	$0.33	$0.08	$0.00	$0.22	$0.00	$0.00	$0.60	$0.00	$0.00	$0.00	$1.24
Estimated FY 2016-17	$0.33	$1.60	$25.24	$0.00	$0.11	$0.36	$0.09	$0.00	$0.26	$0.00	$0.00	$0.72	$0.00	$0.00	$0.00	$1.41
Estimated FY 2017-18	$0.41	$1.95	$31.23	$0.00	$0.14	$0.41	$0.10	$0.00	$0.32	$0.00	$0.00	$0.91	$0.00	$0.00	$0.00	$1.70
Estimated FY 2018-19	$0.51	$2.37	$38.94	$0.00	$0.17	$0.49	$0.13	$0.00	$0.39	$0.00	$0.00	$1.16	$0.00	$0.00	$0.00	$2.09

Percent Change in Per Capita Cost

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	-100.00%	72.41%	1.59%	0.00%	166.67%	0.00%	0.00%	0.00%	-12.50%	0.00%	-100.00%	-80.00%	0.00%	0.00%	0.00%	-6.49%
FY 2009-10 (DA)	0.00%	136.00%	4.42%	0.00%	-50.00%	0.00%	0.00%	0.00%	-42.86%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	-5.56%
FY 2010-11 (DA)	-44.44%	-93.22%	-2.25%	0.00%	50.00%	0.00%	0.00%	0.00%	-75.00%	0.00%	500.00%	0.00%	0.00%	0.00%	0.00%	-9.31%
FY 2011-12	0.00%	887.50%	3.57%	0.00%	66.67%	0.00%	0.00%	0.00%	300.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	1.08%
FY 2012-13	40.00%	-77.22%	15.10%	0.00%	-30.00%	0.00%	0.00%	0.00%	-75.00%	0.00%	-41.67%	-100.00%	0.00%	0.00%	0.00%	6.42%
FY 2013-14	300.00%	1061.11%	-13.16%	0.00%	200.00%	0.00%	0.00%	0.00%	1400.00%	0.00%	1600.00%	0.00%	0.00%	0.00%	0.00%	-20.10%
FY 2014-15	-25.00%	-48.80%	-12.29%	0.00%	-61.90%	0.00%	0.00%	0.00%	20.00%	0.00%	-100.00%	-32.84%	0.00%	0.00%	0.00%	-31.45%
FY 2015-16	28.57%	27.10%	23.56%	0.00%	37.50%	6.45%	0.00%	0.00%	22.22%	0.00%	0.00%	33.33%	0.00%	0.00%	0.00%	13.76%
Estimated FY 2016-17	22.22%	17.65%	23.42%	0.00%	0.00%	9.09%	12.50%	0.00%	18.18%	0.00%	0.00%	20.00%	0.00%	0.00%	0.00%	13.71%
Estimated FY 2017-18	24.24%	21.88%	23.73%	0.00%	27.27%	13.89%	11.11%	0.00%	23.08%	0.00%	0.00%	26.39%	0.00%	0.00%	0.00%	20.57%
Estimated FY 2018-19	24.39%	21.54%	24.69%	0.00%	21.43%	19.51%	30.00%	0.00%	21.88%	0.00%	0.00%	27.47%	0.00%	0.00%	0.00%	22.94%

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

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Expenditure Trends																
Actual FY 2015-16 Expenditure	$11,486	$14,357	$1,406,977	$0	$17,228	$28,714	$25,842	$0	$100,498	$0	$0	$8,614	$0	$0	$0	$1,613,716
Average of FY 2009-10 through FY 2013-14	-357.88%	423.61%	6.25%	0.00%	77.36%	0.00%	0.00%	0.00%	384.54%	0.00%	407.67%	-40.00%	0.00%	0.00%	0.00%	7.89%
Average of FY 2010-11 through FY 2013-14	79.35%	489.41%	5.73%	0.00%	105.83%	0.00%	0.00%	0.00%	488.59%	0.00%	509.59%	-25.00%	0.00%	0.00%	0.00%	7.79%
Average of FY 2011-12 through FY 2013-14	120.55%	683.38%	6.55%	0.00%	121.28%	0.00%	0.00%	0.00%	678.83%	0.00%	544.69%	-33.33%	0.00%	0.00%	0.00%	9.85%
Average of FY 2012-13 through FY 2013-14	176.21%	542.68%	5.13%	0.00%	136.53%	0.00%	0.00%	0.00%	746.73%	0.00%	762.08%	-50.00%	0.00%	0.00%	0.00%	8.86%
Average of FY 2010-11 through FY 2014-15	58.78%	382.46%	2.70%	0.00%	74.87%	0.00%	0.00%	0.00%	396.88%	0.00%	387.67%	-24.69%	0.00%	0.00%	0.00%	4.73%
Average of FY 2011-12 through FY 2014-15	84.55%	501.21%	2.56%	0.00%	78.72%	0.00%	0.00%	0.00%	516.63%	0.00%	383.52%	-30.87%	0.00%	0.00%	0.00%	5.51%
Average of FY 2012-13 through FY 2014-15	109.65%	346.67%	0.28%	0.00%	74.69%	0.00%	0.00%	0.00%	507.82%	0.00%	474.72%	-41.16%	0.00%	0.00%	0.00%	3.40%
Average of FY 2013-14 through FY 2014-15	150.49%	557.77%	-9.54%	0.00%	128.59%	0.00%	0.00%	0.00%	797.76%	0.00%	732.75%	-11.74%	0.00%	0.00%	0.00%	-3.62%
Average of FY 2011-12 through FY 2015-16	73.20%	406.52%	7.60%	0.00%	68.53%	5.56%	5.56%	0.00%	418.86%	0.00%	306.81%	-19.14%	0.00%	0.00%	0.00%	9.96%
Average of FY 2012-13 through FY 2015-16	89.18%	266.95%	7.16%	0.00%	62.96%	6.95%	6.95%	0.00%	387.81%	0.00%	356.04%	-23.92%	0.00%	0.00%	0.00%	9.50%
Average of FY 2013-14 through FY 2015-16	109.58%	381.10%	2.90%	0.00%	94.99%	9.26%	9.26%	0.00%	541.10%	0.00%	488.50%	1.44%	0.00%	0.00%	0.00%	6.85%
Average of FY 2014-15 through FY 2015-16	2.16%	-8.78%	9.19%	0.00%	-10.60%	13.89%	13.89%	0.00%	28.90%	0.00%	-50.00%	2.16%	0.00%	0.00%	0.00%	10.14%
Current Year Projection																
FY 2015-16 Expenditure	$11,486	$14,357	$1,406,977	$0	$17,228	$28,714	$25,842	$0	$100,498	$0	$0	$8,614	$0	$0	$0	$1,613,716
Estimated Incremental Expenditure for FY 2016-17																
SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$332	$415	$40,666	$0	$498	$830	$747	$0	$2,905	$0	$0	$249	$0	$0	$0	$46,642
SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$2,407	$3,009	$294,913	$0	$3,611	$6,019	$5,417	$0	$21,065	$0	$0	$1,806	$0	$0	$0	$338,247
Total Incremental Expenditure	$2,739	$3,424	$335,579	$0	$4,109	$6,849	$6,164	$0	$23,970	$0	$0	$2,055	$0	$0	$0	$384,889
Estimated FY 2016-17 Total Expenditure	**$14,225**	**$17,781**	**$1,742,556**	**$0**	**$21,337**	**$35,563**	**$32,006**	**$0**	**$124,468**	**$0**	**$0**	**$10,669**	**$0**	**$0**	**$0**	**$1,998,605**
Estimated FY 2016-17 Per Capita	$0.33	$1.60	$25.24	$0.00	$0.11	$0.36	$0.09	$0.00	$0.26	$0.00	$0.00	$0.72	$0.00	$0.00	$0.00	$1.41
% Change over FY 2015-16 Per Capita	22.22%	17.65%	23.42%	0.00%	0.00%	9.09%	12.50%	0.00%	18.18%	0.00%	0.00%	20.00%	0.00%	0.00%	0.00%	13.71%
Request Year Projection																
Estimated FY 2016-17 Expenditure	$14,225	$17,781	$1,742,556	$0	$21,337	$35,563	$32,006	$0	$124,468	$0	$0	$10,669	$0	$0	$0	$1,998,605
Estimated Incremental Expenditure for FY 2017-18																
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$458	$572	$56,065	$0	$686	$1,144	$1,030	$0	$4,005	$0	$0	$343	$0	$0	$0	$64,303
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$3,319	$4,149	$406,584	$0	$4,978	$8,298	$7,468	$0	$29,042	$0	$0	$2,489	$0	$0	$0	$466,327
Total Incremental Expenditure	$3,777	$4,721	$462,649	$0	$5,664	$9,442	$8,498	$0	$33,047	$0	$0	$2,832	$0	$0	$0	$530,630
Estimated FY 2017-18 Total Expenditure	**$18,002**	**$22,502**	**$2,205,205**	**$0**	**$27,001**	**$45,005**	**$40,504**	**$0**	**$157,515**	**$0**	**$0**	**$13,501**	**$0**	**$0**	**$0**	**$2,529,235**
Estimated FY 2017-18 Per Capita	$0.41	$1.95	$31.23	$0.00	$0.14	$0.41	$0.10	$0.00	$0.32	$0.00	$0.00	$0.91	$0.00	$0.00	$0.00	$1.70
% Change over FY 2016-17 Per Capita	24.24%	21.88%	23.73%	0.00%	27.27%	13.89%	11.11%	0.00%	23.08%	0.00%	0.00%	26.39%	0.00%	0.00%	0.00%	20.57%
Out Year Projection																
Estimated FY 2017-18 Expenditure	$18,002	$22,502	$2,205,205	$0	$27,001	$45,005	$40,504	$0	$157,515	$0	$0	$13,501	$0	$0	$0	$2,529,235
Estimated Incremental Expenditure for FY 2018-19																
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$582	$727	$71,215	$0	$872	$1,453	$1,308	$0	$5,087	$0	$0	$436	$0	$0	$0	$81,680
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$4,216	$5,270	$516,457	$0	$6,324	$10,540	$9,486	$0	$36,890	$0	$0	$3,162	$0	$0	$0	$592,345
Total Incremental Expenditure	$4,797	$5,997	$587,672	$0	$7,196	$11,993	$10,794	$0	$41,977	$0	$0	$3,598	$0	$0	$0	$674,024
Estimated FY 2018-19 Total Expenditure	**$22,799**	**$28,499**	**$2,792,877**	**$0**	**$34,197**	**$56,998**	**$51,298**	**$0**	**$199,492**	**$0**	**$0**	**$17,099**	**$0**	**$0**	**$0**	**$3,203,259**
Estimated FY 2018-19 Per Capita	$0.51	$2.37	$38.94	$0.00	$0.17	$0.49	$0.13	$0.00	$0.39	$0.00	$0.00	$1.16	$0.00	$0.00	$0.00	$2.09
% Change over FY 2017-18 Per Capita	24.39%	21.54%	24.69%	0.00%	21.43%	19.51%	30.00%	0.00%	21.88%	0.00%	0.00%	27.47%	0.00%	0.00%	0.00%	22.94%

Exhibit I - SERVICE MANAGEMENT

Summary

FY 2016-17 Service Management Request															
SERVICE MANAGEMENT	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Single Entry Points	$9,782,406	$2,713,478	$20,524,049	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,019,933
Disease Management	$10,474	$26,451	$181,826	$16,202	$249,010	$108,644	$548,663	$0	$0	$0	$36,509	$96,757	$11,190	$0	$0	$1,285,726
Accountable Care Collaborative	$4,258,561	$1,364,556	$9,300,654	$365,816	$21,749,814	$10,980,884	$44,127,871	$0	$62,711,387	$8,379,219	$2,753,538	$1,288,911	$170,837	$0	$0	$167,452,048
Prepaid Inpatient Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Service Management	**$14,051,441**	**$4,104,485**	**$30,006,529**	**$382,018**	**$21,998,824**	**$11,089,528**	**$44,676,534**	**$0**	**$62,711,387**	**$8,379,219**	**$2,790,047**	**$1,385,668**	**$182,027**	**$0**	**$0**	**$201,757,707**

FY 2017-18 Service Management Request															
SERVICE MANAGEMENT	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Single Entry Points	$10,179,572	$2,823,645	$21,357,325	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,360,542
Disease Management	$10,593	$27,569	$185,686	$19,116	$256,942	$119,703	$587,807	$0	$0	$0	$36,725	$96,717	$11,550	$0	$0	$1,352,408
Accountable Care Collaborative	$4,276,178	$1,380,036	$9,478,995	$417,249	$23,856,187	$12,379,502	$46,865,497	$0	$65,562,365	$9,082,618	$2,839,867	$1,312,676	$174,431	$0	$0	$177,625,601
Prepaid Inpatient Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Service Management	**$14,466,343**	**$4,231,250**	**$31,022,006**	**$436,365**	**$24,113,129**	**$12,499,205**	**$47,453,304**	**$0**	**$65,562,365**	**$9,082,618**	**$2,876,592**	**$1,409,393**	**$185,981**	**$0**	**$0**	**$213,338,551**

FY 2018-19 Service Management Request															
SERVICE MANAGEMENT	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Single Entry Points	$10,553,162	$2,927,273	$22,141,139	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,621,574
Disease Management	$10,769	$28,737	$188,621	$21,919	$263,719	$127,997	$609,168	$0	$0	$0	$36,752	$96,724	$11,911	$0	$0	$1,396,317
Accountable Care Collaborative	$4,350,234	$1,418,495	$9,797,587	$486,086	$25,154,159	$13,603,850	$49,167,990	$0	$67,925,653	$9,771,491	$2,908,842	$1,342,449	$182,841	$0	$0	$186,109,677
Prepaid Inpatient Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Service Management	**$14,914,165**	**$4,374,505**	**$32,127,347**	**$508,005**	**$25,417,878**	**$13,731,847**	**$49,777,158**	**$0**	**$67,925,653**	**$9,771,491**	**$2,945,594**	**$1,439,173**	**$194,752**	**$0**	**$0**	**$223,127,568**

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

Cash Based Actuals

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	$11,356,087	$1,927,170	$9,708,485	$0	$3,228	$0	$0	$0	$1,507	$0	$7,102	$0	$0	$56,818	$6,779	$23,067,175
FY 2009-10 (DA)	$11,622,897	$2,068,951	$9,956,430	$0	$2,637	$0	$0	$0	$1,458	$0	$8,329	$0	$0	$41,435	$5,414	$23,707,551
FY 2010-11 (DA)	$11,482,516	$2,211,295	$10,261,280	$0	$6,052	$0	$0	$0	$4,841	$0	$9,683	$0	$0	$38,731	$7,262	$24,021,660
FY 2011-12	$11,748,349	$2,505,790	$10,910,528	$0	$5,343	$1,263	$0	$0	$1,749	$0	$8,355	$0	$0	$0	$45,369	$25,226,746
FY 2012-13	$11,133,931	$2,768,715	$11,274,336	$8,561	$1,712	$5,993	$0	$856	$1,443,430	$0	$285,947	$0	$0	$0	$53,080	$26,976,561
FY 2013-14	$7,836,051	$2,131,642	$15,256,301	$107,844	$14,555	$3,169	$35,876	$376	$1,156,908	$0	$248,772	$161	$0	$0	$107,361	$26,899,016
FY 2014-15	$9,072,052	$2,528,512	$18,428,482	$201,793	$44,524	$5,745	$170,913	$0	$1,712,006	$9,336	$315,974	$2,154	$0	$0	$127,826	$32,619,317
FY 2015-16	$8,758,028	$2,502,485	$18,504,336	$200,734	$28,772	$4,015	$171,962	$0	$788,216	$9,368	$223,484	$669	$0	$0	$90,999	$31,283,068
Estimated FY 2016-17	$9,782,406	$2,713,478	$20,524,049	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,019,933
Estimated FY 2017-18	$10,179,572	$2,823,645	$21,357,325	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,360,542
Estimated FY 2018-19	$10,553,162	$2,927,273	$22,141,139	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,621,574

Percent Change in Cash Based Actuals

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	2.35%	7.36%	2.55%	0.00%	-18.32%	0.00%	0.00%	0.00%	-3.22%	0.00%	17.27%	0.00%	0.00%	-27.07%	-20.14%	2.78%
FY 2010-11 (DA)	-1.21%	6.88%	3.06%	0.00%	129.50%	0.00%	0.00%	0.00%	232.03%	0.00%	16.26%	0.00%	0.00%	-6.53%	34.13%	1.32%
FY 2011-12	2.32%	13.32%	6.33%	0.00%	-11.72%	100.00%	0.00%	0.00%	-63.87%	0.00%	-13.71%	0.00%	0.00%	-100.00%	524.75%	5.02%
FY 2012-13	-5.23%	10.49%	3.33%	100.00%	-67.96%	374.51%	0.00%	100.00%	82428.87%	0.00%	3322.47%	0.00%	0.00%	0.00%	17.00%	6.94%
FY 2013-14	-29.62%	-23.01%	35.32%	1159.71%	750.18%	-47.12%	100.00%	-56.07%	-19.85%	0.00%	-13.00%	100.00%	0.00%	0.00%	102.26%	-0.29%
FY 2014-15	15.77%	18.62%	20.79%	87.12%	205.90%	81.29%	376.40%	-100.00%	47.98%	100.00%	27.01%	1237.89%	0.00%	0.00%	19.06%	21.27%
FY 2015-16	-3.46%	-1.03%	0.41%	-0.52%	-35.38%	-30.11%	0.61%	0.00%	-53.96%	0.34%	-29.27%	-68.94%	0.00%	0.00%	-28.81%	-4.10%
Estimated FY 2016-17	11.70%	8.43%	10.91%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%	5.55%
Estimated FY 2017-18	4.06%	4.06%	4.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.06%
Estimated FY 2018-19	3.67%	3.67%	3.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.67%

Per Capita Cost

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	$301.87	$298.93	$189.05	$0.00	$0.05	$0.00	$0.00	$0.00	$0.01	$0.00	$0.39	$0.00	$0.00	$14.25	$0.45	$52.81
FY 2009-10 (DA)	$302.00	$293.51	$186.93	$0.00	$0.04	$0.00	$0.00	$0.00	$0.01	$0.00	$0.45	$0.00	$0.00	$11.22	$0.34	$47.53
FY 2010-11 (DA)	$295.02	$284.70	$182.31	$0.00	$0.07	$0.00	$0.00	$0.00	$0.02	$0.00	$0.53	$0.00	$0.00	$12.05	$0.42	$42.84
FY 2011-12	$295.63	$298.91	$183.57	$0.00	$0.06	$0.04	$0.00	$0.00	$0.01	$0.00	$0.46	$0.00	$0.00	$0.00	$2.40	$40.69
FY 2012-13	$272.71	$305.90	$182.08	$9.64	$0.02	$0.14	$0.00	$1.37	$4.01	$0.00	$16.09	$0.00	$0.00	$0.00	$2.50	$39.50
FY 2013-14	$187.30	$216.34	$236.81	$42.13	$0.12	$0.07	$0.41	$0.67	$2.90	$0.00	$13.62	$0.01	$0.00	$0.00	$4.59	$31.24
FY 2014-15	$216.95	$241.59	$276.92	$55.64	$0.28	$0.08	$0.71	$0.00	$3.84	$0.19	$15.77	$0.14	$0.00	$0.00	$4.56	$28.09
FY 2015-16	$206.54	$237.68	$268.96	$32.29	$0.18	$0.05	$0.54	$0.00	$1.69	$0.16	$11.21	$0.05	$0.00	$0.00	$2.79	$24.12
Estimated FY 2016-17	$225.34	$244.74	$297.33	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$23.34
Estimated FY 2017-18	$230.64	$244.79	$302.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$23.14
Estimated FY 2018-19	$235.19	$243.45	$308.72	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$23.27

Percent Change in Per Capita Cost

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	0.04%	-1.81%	-1.12%	0.00%	-20.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.38%	0.00%	0.00%	-21.26%	-24.44%	-10.00%
FY 2010-11 (DA)	-2.31%	-3.00%	-2.47%	0.00%	75.00%	0.00%	0.00%	0.00%	100.00%	0.00%	17.78%	0.00%	0.00%	7.40%	23.53%	-9.87%
FY 2011-12	0.21%	4.99%	0.69%	0.00%	-14.29%	0.00%	0.00%	0.00%	-50.00%	0.00%	-13.21%	0.00%	0.00%	-100.00%	471.43%	-5.02%
FY 2012-13	-7.75%	2.34%	-0.81%	0.00%	-66.67%	250.00%	0.00%	0.00%	40000.00%	0.00%	3397.83%	0.00%	0.00%	0.00%	4.17%	-2.92%
FY 2013-14	-31.32%	-29.28%	30.06%	337.03%	500.00%	-50.00%	0.00%	-51.09%	-27.68%	0.00%	-15.35%	0.00%	0.00%	0.00%	83.60%	-20.91%
FY 2014-15	15.83%	11.67%	16.94%	32.07%	133.33%	14.29%	73.17%	-100.00%	32.41%	0.00%	15.79%	1300.00%	0.00%	0.00%	-0.65%	-10.08%
FY 2015-16	-4.80%	-1.62%	-2.87%	-41.97%	-35.71%	-37.50%	-23.94%	0.00%	-55.99%	-15.79%	-28.92%	-64.29%	0.00%	0.00%	-38.82%	-14.13%
Estimated FY 2016-17	9.10%	2.97%	10.55%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%	-3.23%
Estimated FY 2017-18	2.35%	0.02%	1.74%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.86%
Estimated FY 2018-19	1.97%	-0.55%	2.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.56%

Current Year Projection

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2016-17 Base Contracts	$9,782,406	$2,713,478	$20,524,049	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,019,933
Estimated Increase in HCBS Enrollment[1][2]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2016-17 Base Expenditure	$9,782,406	$2,713,478	$20,524,049	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,019,933
Bottom Line Impacts																
Estimated FY 2016-17 Total Expenditure	**$9,782,406**	**$2,713,478**	**$20,524,049**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$33,019,933**
Estimated FY 2016-17 Per Capita	$225.34	$244.74	$297.33	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$23.34
% Change over FY 2015-16 Per Capita	9.10%	1.30%	7.37%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-16.91%

Request Year Projection

Estimated FY 2017-18 Base Contracts	$9,782,406	$2,713,478	$20,524,049	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,019,933
Estimated Increase in HCBS Enrollment[1][2]	4.06%	4.06%	4.06%	4.06%	4.06%	4.06%	4.06%	0.00%	4.06%	4.06%	4.06%	4.06%	0.00%	0.00%	4.06%	4.06%
Estimated FY 2017-18 Base Expenditure	$10,179,572	$2,823,645	$21,357,325	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,360,542
Bottom Line Impacts																
Estimated FY 2017-18 Total Expenditure	**$10,179,572**	**$2,823,645**	**$21,357,325**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$34,360,542**
Estimated FY 2017-18 Per Capita	$230.64	$244.79	$302.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$23.14
% Change over FY 2016-17 Per Capita	2.35%	0.02%	1.74%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.86%

Out Year Projection

FY 2018-19 Base Contracts	$10,179,572	$2,823,645	$21,357,325	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,360,542
Estimated Increase in HCBS Enrollment[1][2]	3.67%	3.67%	3.67%	3.67%	3.67%	3.67%	3.67%	0.00%	3.67%	3.67%	3.67%	3.67%	0.00%	0.00%	3.67%	3.67%
Estimated FY 2018-19 Base Expenditure	$10,553,162	$2,927,273	$22,141,139	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,621,574
Bottom Line Impacts																
Estimated FY 2018-19 Total Expenditure	**$10,553,162**	**$2,927,273**	**$22,141,139**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$35,621,574**
Estimated FY 2018-19 Per Capita	$235.19	$243.45	$308.72	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$23.27
% Change over FY 2017-18 Per Capita	1.97%	-0.55%	2.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.56%

Footnotes
(1) Home and Community Based Services (HCBS) enrollment is not the only factor which influences Single Entry Point expenditure. However, the Department believes that enrollment trends are a good proxy for other Single Entry Point functions. Please see the Narrative for further information.
(2) FY 2016-17 expenditure is the amount of the base contracts in place with the SEPs; to trend expenditure for FY 2017-18 and FY 2018-19, the Department selected the estimated growth rate in HCBS Enrollment.

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

Cash Based Actuals

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	$4,570	$2,655	$23,534	$0	$12,589	$0	$0	$409	$21,785	$0	$3,047	$3,027	$0	$0	$0	$71,616
FY 2010-11 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2011-12	$51,573	$36,611	$303,654	$218	$164,545	$45,358	$1,307	$5,612	$280,261	$0	$32,412	$34,593	$0	$22,913	$2,955	$982,012
FY 2012-13	$18,845	$38,614	$282,411	$10,185	$329,787	$91,251	$48,349	$0	$0	$0	$49,301	$88,367	$0	$0	$0	$957,110
FY 2013-14	$7,234	$17,469	$116,400	$7,957	$142,079	$40,697	$112,294	$0	$0	$0	$19,931	$62,892	$0	$0	$0	$526,953
FY 2014-15	$8,232	$21,647	$145,304	$9,050	$211,327	$78,847	$390,096	$0	$0	$0	$29,418	$84,586	$9,735	$0	$0	$988,242
FY 2015-16	$4,417	$11,155	$76,681	$6,833	$105,014	$45,818	$231,386	$0	$0	$0	$15,397	$40,805	$4,719	$0	$0	$542,225
Estimated FY 2016-17	$10,474	$26,451	$181,826	$16,202	$249,010	$108,644	$548,663	$0	$0	$0	$36,509	$96,757	$11,190	$0	$0	$1,285,726
Estimated FY 2017-18	$10,593	$27,569	$185,686	$19,116	$256,942	$119,703	$587,807	$0	$0	$0	$36,725	$96,717	$11,550	$0	$0	$1,352,408
Estimated FY 2018-19	$10,769	$28,737	$188,621	$21,919	$263,719	$127,997	$609,168	$0	$0	$0	$36,752	$96,724	$11,911	$0	$0	$1,396,317

Percent Change in Cash Based Actuals

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2010-11 (DA)	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	0.00%	0.00%	-100.00%	-100.00%	0.00%	-100.00%	-100.00%	0.00%	0.00%	0.00%	-100.00%
FY 2011-12	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	100.00%	100.00%	100.00%
FY 2012-13	-63.46%	5.47%	-7.00%	4572.02%	100.42%	101.18%	3599.23%	-100.00%	-100.00%	0.00%	52.11%	155.45%	0.00%	-100.00%	-100.00%	-2.54%
FY 2013-14	-61.61%	-54.76%	-58.78%	-21.88%	-56.92%	-55.40%	132.26%	0.00%	0.00%	0.00%	-59.57%	-28.83%	0.00%	0.00%	0.00%	-44.94%
FY 2014-15	13.80%	23.92%	24.83%	13.74%	48.74%	93.74%	247.39%	0.00%	0.00%	0.00%	47.60%	34.49%	100.00%	0.00%	0.00%	87.54%
FY 2015-16	-46.34%	-48.47%	-47.23%	-24.50%	-50.31%	-41.89%	-40.68%	0.00%	0.00%	0.00%	-47.66%	-51.76%	-51.53%	0.00%	0.00%	-45.13%
Estimated FY 2016-17	137.13%	137.12%	137.12%	137.11%	137.12%	137.12%	137.12%	0.00%	0.00%	0.00%	137.12%	137.12%	137.13%	0.00%	0.00%	137.12%
Estimated FY 2017-18	1.14%	4.23%	2.12%	17.99%	3.19%	10.18%	7.13%	0.00%	0.00%	0.00%	0.59%	-0.04%	3.22%	0.00%	0.00%	5.19%
Estimated FY 2018-19	1.66%	4.24%	1.58%	14.66%	2.64%	6.93%	3.63%	0.00%	0.00%	0.00%	0.07%	0.01%	3.13%	0.00%	0.00%	3.25%

Per Capita Cost

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	$0.12	$0.38	$0.44	$0.00	$0.17	$0.00	$0.00	$0.96	$0.08	$0.00	$0.17	$0.39	$0.00	$0.00	$0.00	$0.14
FY 2010-11 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2011-12	$1.30	$4.37	$5.11	$4.19	$1.77	$1.28	$1.15	$9.40	$0.84	$0.00	$1.80	$4.53	$0.00	$8.27	$0.16	$1.58
FY 2012-13	$0.46	$4.27	$4.56	$11.47	$3.32	$2.20	$4.55	$0.00	$0.00	$0.00	$2.77	$11.01	$0.00	$0.00	$0.00	$1.40
FY 2013-14	$0.17	$1.77	$1.81	$3.11	$1.14	$0.86	$1.29	$0.00	$0.00	$0.00	$1.09	$4.78	$0.00	$0.00	$0.00	$0.61
FY 2014-15	$0.20	$2.07	$2.18	$2.50	$1.31	$1.10	$1.62	$0.00	$0.00	$0.00	$1.47	$5.68	$5.57	$0.00	$0.00	$0.85
FY 2015-16	$0.10	$1.06	$1.11	$1.10	$0.64	$0.53	$0.72	$0.00	$0.00	$0.00	$0.77	$2.83	$2.68	$0.00	$0.00	$0.42
Estimated FY 2016-17	$0.24	$2.39	$2.63	$2.77	$1.29	$1.10	$1.50	$0.00	$0.00	$0.00	$1.81	$6.55	$5.81	$0.00	$0.00	$0.91
Estimated FY 2017-18	$0.24	$2.39	$2.63	$2.77	$1.29	$1.10	$1.50	$0.00	$0.00	$0.00	$1.81	$6.55	$5.81	$0.00	$0.00	$0.91
Estimated FY 2018-19	$0.24	$2.39	$2.63	$2.77	$1.29	$1.10	$1.50	$0.00	$0.00	$0.00	$1.81	$6.55	$5.81	$0.00	$0.00	$0.91

Percent Change in Per Capita Cost

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2010-11 (DA)	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	0.00%	0.00%	-100.00%	-100.00%	0.00%	-100.00%	-100.00%	0.00%	0.00%	0.00%	-100.00%
FY 2011-12	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	100.00%	100.00%	0.00%	100.00%	100.00%	100.00%
FY 2012-13	-64.62%	-2.29%	-10.76%	173.75%	87.57%	71.88%	295.65%	0.00%	0.00%	0.00%	53.89%	143.05%	0.00%	-100.00%	-100.00%	-11.39%
FY 2013-14	-63.04%	-58.55%	-60.31%	-72.89%	-65.66%	-60.91%	-71.65%	0.00%	0.00%	0.00%	-60.65%	-56.58%	0.00%	0.00%	0.00%	-56.43%
FY 2014-15	17.65%	16.95%	20.44%	-19.61%	14.91%	27.91%	25.58%	0.00%	0.00%	0.00%	34.86%	18.83%	100.00%	0.00%	0.00%	39.34%
FY 2015-16	-50.00%	-48.79%	-49.08%	-56.00%	-51.15%	-51.82%	-55.56%	0.00%	0.00%	0.00%	-47.62%	-50.18%	-51.89%	0.00%	0.00%	-50.59%
Estimated FY 2016-17	140.00%	125.47%	136.94%	151.82%	101.56%	107.55%	108.33%	0.00%	0.00%	0.00%	135.06%	131.45%	116.79%	0.00%	0.00%	116.67%
Estimated FY 2017-18	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2018-19	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

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

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2016-17 Projection																
Percentage Selected to Modify Per Capita	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2016-17 Base Per Capita	$0.24	$2.39	$2.63	$2.77	$1.29	$1.10	$1.50	$0.00	$0.00	$0.00	$1.81	$6.55	$5.81	$0.00	$0.00	$0.91
Estimated FY 2016-17 Eligibles	43,412	11,087	69,028	5,844	192,317	98,910	366,209	286	486,863	65,529	20,185	14,765	1,926	2,646	35,909	1,414,916
Estimated FY 2016-17 Base Expenditure	**$10,474**	**$26,451**	**$181,826**	**$16,202**	**$249,010**	**$108,644**	**$548,663**	**$0**	**$0**	**$0**	**$36,509**	**$96,757**	**$11,190**	**$0**	**$0**	**$1,285,726**
Bottom Line Impacts																
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2016-17 Total Expenditure	**$10,474**	**$26,451**	**$181,826**	**$16,202**	**$249,010**	**$108,644**	**$548,663**	**$0**	**$0**	**$0**	**$36,509**	**$96,757**	**$11,190**	**$0**	**$0**	**$1,285,726**
Estimated FY 2016-17 Per Capita	$0.24	$2.39	$2.63	$2.77	$1.29	$1.10	$1.50	$0.00	$0.00	$0.00	$1.81	$6.55	$5.81	$0.00	$0.00	$0.91
% Change over FY 2015-16 Per Capita	99.47%	100.18%	99.84%	99.91%	99.63%	100.14%	100.12%	0.00%	0.00%	0.00%	100.07%	99.95%	100.00%	0.00%	0.00%	100.14%
FY 2017-18 Projection																
Percentage Selected to Modify Per Capita	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2017-18 Base Per Capita	$0.24	$2.39	$2.63	$2.77	$1.29	$1.10	$1.50	$0.00	$0.00	$0.00	$1.81	$6.55	$5.81	$0.00	$0.00	$0.91
Estimated FY 2017-18 Eligibles	44,137	11,535	70,603	6,901	199,180	108,821	391,871	179	499,692	71,890	20,290	14,766	1,988	2,648	40,135	1,484,636
Estimated FY 2017-18 Base Expenditure	**$10,593**	**$27,569**	**$185,686**	**$19,116**	**$256,942**	**$119,703**	**$587,807**	**$0**	**$0**	**$0**	**$36,725**	**$96,717**	**$11,550**	**$0**	**$0**	**$1,352,408**
Bottom Line Impacts																
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2017-18 Total Expenditure	**$10,593**	**$27,569**	**$185,686**	**$19,116**	**$256,942**	**$119,703**	**$587,807**	**$0**	**$0**	**$0**	**$36,725**	**$96,717**	**$11,550**	**$0**	**$0**	**$1,352,408**
Estimated FY 2017-18 Per Capita	$0.24	$2.39	$2.63	$2.77	$1.29	$1.10	$1.50	$0.00	$0.00	$0.00	$1.81	$6.55	$5.81	$0.00	$0.00	$0.91
% Change over FY 2016-17 Per Capita	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2018-19 Projection																
Percentage Selected to Modify Per Capita	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2018-19 Base Per Capita	$0.24	$2.39	$2.63	$2.77	$1.29	$1.10	$1.50	$0.00	$0.00	$0.00	$1.81	$6.55	$5.81	$0.00	$0.00	$0.91
Estimated FY 2018-19 Eligibles	44,870	12,024	71,719	7,913	204,433	116,361	406,112	103	507,864	74,803	20,305	14,767	2,050	2,649	44,859	1,530,832
Estimated FY 2018-19 Base Expenditure	**$10,769**	**$28,737**	**$188,621**	**$21,919**	**$263,719**	**$127,997**	**$609,168**	**$0**	**$0**	**$0**	**$36,752**	**$96,724**	**$11,911**	**$0**	**$0**	**$1,396,317**
Bottom Line Impacts																
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2018-19 Total Expenditure	**$10,769**	**$28,737**	**$188,621**	**$21,919**	**$263,719**	**$127,997**	**$609,168**	**$0**	**$0**	**$0**	**$36,752**	**$96,724**	**$11,911**	**$0**	**$0**	**$1,396,317**
Estimated FY 2018-19 Per Capita	$0.24	$2.39	$2.63	$2.77	$1.29	$1.10	$1.50	$0.00	$0.00	$0.00	$1.81	$6.55	$5.81	$0.00	$0.00	$0.91
% Change over FY 2017-18 Per Capita	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Cash Based Actuals

ACCOUNTABLE CARE COLLABORATIVE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2011-12	$345,078	$256,950	$2,052,795	$377	$5,690,110	$2,269,608	$79,568	$0	$6,360,605	$0	$576,072	$275,408	$0	$107	$1,155	$17,907,833
FY 2012-13	$576,537	$452,652	$3,916,914	$19,706	$9,740,443	$4,141,282	$1,856,177	$0	$13,291,533	$887,610	$1,388,883	$429,730	$22,052	$518	$4,894	$36,728,931
FY 2013-14	$547,729	$468,561	$4,052,232	$88,828	$10,681,279	$3,955,017	$6,302,817	$0	$38,151,110	$1,949,462	$1,594,103	$714,315	$40,255	$842	$23,780	$68,570,330
FY 2014-15	$1,548,799	$747,258	$5,551,796	$158,419	$14,847,436	$6,198,632	$19,585,930	$0	$46,840,789	$5,347,941	$1,943,616	$952,332	$111,815	$25,749	$90,254	$103,950,766
FY 2015-16	$2,537,026	$997,903	$7,402,115	$468,572	$17,348,606	$8,867,763	$34,091,693	$21,262	$57,830,620	$7,572,598	$2,441,964	$1,142,668	$140,521	$1,411	$84,513	$140,949,235
Estimated FY 2016-17	$4,258,561	$1,364,556	$9,300,654	$365,816	$21,749,814	$10,980,884	$44,127,871	$0	$62,711,387	$8,379,219	$2,753,538	$1,288,911	$170,837	$0	$0	$167,452,048
Estimated FY 2017-18	$4,276,178	$1,380,036	$9,478,995	$417,249	$23,856,187	$12,379,502	$46,865,497	$0	$65,562,365	$9,082,618	$2,839,867	$1,312,676	$174,431	$0	$0	$177,625,601
Estimated FY 2018-19	$4,350,234	$1,418,495	$9,797,587	$486,086	$25,154,159	$13,603,850	$49,167,990	$0	$67,925,653	$9,771,491	$2,908,842	$1,342,449	$182,841	$0	$0	$186,109,677

Percent Change in Cash Based Actuals

ACCOUNTABLE CARE COLLABORATIVE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2010-11 (DA)	23.91%	80.79%	54.76%	0.00%	11.24%	100.00%	0.00%	0.00%	12.82%	0.00%	3.96%	0.92%	0.00%	0.00%	0.00%	26.67%
FY 2011-12	-16.11%	21.48%	41.40%	100.00%	616.89%	851.53%	100.00%	0.00%	107.62%	0.00%	166.02%	212.01%	0.00%	100.00%	100.00%	176.56%
FY 2012-13	67.07%	76.16%	90.81%	5127.06%	71.18%	82.47%	2232.82%	0.00%	108.97%	100.00%	141.10%	56.03%	100.00%	384.11%	323.72%	105.10%
FY 2013-14	-5.00%	3.51%	3.45%	350.77%	9.66%	-4.50%	239.56%	0.00%	187.03%	119.63%	14.78%	66.22%	82.55%	62.55%	385.90%	86.69%
FY 2014-15	182.77%	59.48%	37.01%	78.34%	39.00%	56.73%	210.75%	0.00%	22.78%	174.33%	21.93%	33.32%	177.77%	2958.08%	279.54%	51.60%
FY 2015-16	63.81%	33.54%	33.33%	195.78%	16.85%	43.06%	74.06%	100.00%	23.46%	41.60%	25.64%	19.99%	25.67%	-94.52%	-6.36%	35.59%
Estimated FY 2016-17	67.86%	36.74%	25.65%	-21.93%	25.37%	23.83%	29.44%	-100.00%	8.44%	10.65%	12.76%	12.80%	21.57%	-100.00%	-100.00%	18.80%
Estimated FY 2017-18	0.41%	1.13%	1.92%	14.06%	9.68%	12.74%	6.20%	0.00%	4.55%	8.39%	3.14%	1.84%	2.10%	0.00%	0.00%	6.08%
Estimated FY 2018-19	1.73%	2.79%	3.36%	16.50%	5.44%	9.89%	4.91%	0.00%	3.60%	7.58%	2.43%	2.27%	4.82%	0.00%	0.00%	4.78%

Per Capita Cost

ACCOUNTABLE CARE COLLABORATIVE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	$8.63	$16.60	$17.61	$0.00	$9.53	$0.00	$0.00	$0.00	$9.85	$0.00	$11.33	$11.17	$0.00	$0.00	$0.00	$10.25
FY 2010-11 (DA)	$10.57	$27.23	$25.79	$0.00	$9.79	$8.78	$0.00	$0.00	$10.13	$0.00	$11.77	$11.22	$0.00	$0.00	$0.00	$11.55
FY 2011-12	$8.68	$30.65	$34.54	$7.25	$61.04	$64.00	$70.17	$0.00	$19.01	$0.00	$31.94	$36.10	$0.00	$0.04	$0.06	$28.89
FY 2012-13	$14.12	$50.01	$63.26	$22.19	$98.00	$99.68	$174.55	$0.00	$36.94	$107.77	$78.13	$53.56	$64.10	$0.19	$0.23	$53.78
FY 2013-14	$13.09	$47.56	$62.90	$34.70	$85.67	$84.00	$72.24	$0.00	$95.61	$76.92	$87.27	$54.28	$38.08	$0.34	$1.02	$79.64
FY 2014-15	$37.04	$71.40	$83.43	$43.68	$91.83	$86.11	$81.14	$0.00	$105.09	$106.72	$97.01	$63.93	$63.93	$9.46	$3.22	$89.52
FY 2015-16	$59.83	$94.78	$107.59	$75.37	$106.21	$101.97	$106.41	$66.03	$123.78	$127.27	$122.50	$79.28	$79.89	$0.53	$2.59	$108.67
Estimated FY 2016-17	$98.10	$123.08	$134.74	$62.60	$113.09	$111.02	$120.50	$0.00	$128.81	$127.87	$136.42	$87.30	$88.70	$0.00	$0.00	$118.35
Estimated FY 2017-18	$96.88	$119.64	$134.26	$60.46	$119.77	$113.76	$119.59	$0.00	$131.21	$126.34	$139.96	$88.90	$87.74	$0.00	$0.00	$119.64
Estimated FY 2018-19	$96.95	$117.97	$136.61	$61.43	$123.04	$116.91	$121.07	$0.00	$133.75	$130.63	$143.26	$90.91	$89.19	$0.00	$0.00	$121.57

Percent Change in Per Capita Cost

ACCOUNTABLE CARE COLLABORATIVE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2010-11 (DA)	22.48%	64.04%	46.45%	0.00%	2.73%	100.00%	0.00%	0.00%	2.84%	0.00%	3.88%	0.45%	0.00%	0.00%	0.00%	12.68%
FY 2011-12	-17.88%	12.56%	33.93%	100.00%	523.49%	628.93%	100.00%	0.00%	87.66%	0.00%	171.37%	221.75%	0.00%	100.00%	100.00%	150.13%
FY 2012-13	62.67%	63.16%	83.15%	206.07%	60.55%	55.75%	148.75%	0.00%	94.32%	100.00%	144.61%	48.37%	100.00%	375.00%	283.33%	86.15%
FY 2013-14	-7.29%	-4.90%	-0.57%	56.38%	-12.58%	-15.73%	-58.61%	0.00%	158.83%	-28.63%	11.70%	1.34%	-40.59%	78.95%	343.48%	48.08%
FY 2014-15	182.96%	50.13%	32.64%	25.88%	7.19%	2.51%	12.32%	0.00%	9.92%	38.74%	11.16%	17.78%	67.88%	2682.35%	215.69%	12.41%
FY 2015-16	61.53%	32.75%	28.96%	72.55%	15.66%	18.42%	31.14%	100.00%	17.78%	19.26%	26.28%	24.01%	24.96%	-94.40%	-19.57%	21.39%
Estimated FY 2016-17	63.96%	29.86%	25.23%	-16.94%	6.48%	8.88%	13.24%	-100.00%	4.06%	0.47%	11.36%	10.12%	11.03%	-100.00%	-100.00%	8.91%
Estimated FY 2017-18	-1.24%	-2.79%	-0.36%	-3.42%	5.91%	2.47%	-0.76%	0.00%	1.86%	-1.20%	2.59%	1.83%	-1.08%	0.00%	0.00%	1.09%
Estimated FY 2018-19	0.07%	-1.40%	1.75%	1.60%	2.73%	2.77%	1.24%	0.00%	1.94%	3.40%	2.36%	2.26%	1.65%	0.00%	0.00%	1.61%

Exhibit I - SERVICE MANAGEMENT - ACCOUNTABLE CARE COLLABORATIVE

Current Year Projection

ACCOUNTABLE CARE COLLABORATIVE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RCCOs in the ACC	$988,915	$583,714	$4,699,207	$281,936	$16,519,156	$8,556,376	$33,989,235	$0	$48,584,449	$6,543,771	$2,122,786	$994,067	$131,537	$0	$0	$123,995,149
ACC: Medicare-Medicaid Program (RCCOs in the ACC)	$2,557,242	$515,340	$2,752,363	$158	$380,294	$39	$59	$0	$2,526	$0	$1,855	$3,967	$0	$0	$0	$6,213,843
Estimated Expenditure for PCMPs in the ACC	$275,113	$173,634	$1,411,095	$84,096	$5,134,196	$2,660,154	$10,570,127	$0	$14,983,573	$2,021,038	$655,578	$306,738	$40,685	$0	$0	$38,316,027
ACC: Medicare-Medicaid Program (PCMPs in the ACC)	$430,590	$96,068	$515,004	$25	$75,250	$5	$5	$0	$431	$0	$309	$805	$0	$0	$0	$1,118,492
Bottom Line Impacts: Recoupment of Incentive Overpayment	($3,364)	($2,042)	($16,502)	($987)	($58,881)	($30,502)	($121,182)	$0	($172,590)	($23,260)	($7,545)	($3,532)	($468)	$0	$0	($440,855)
Bottom Line Impacts: Kaiser-Access Health Maintenance Organization	($6,090)	($12,354)	($143,376)	($4,350)	($601,692)	($361,398)	($931,074)	$0	($1,566,870)	($281,010)	($57,942)	($31,146)	($3,306)	$0	$0	($4,000,608)
Estimated Expenditure for SDAC in the ACC	$16,155	$10,196	$82,863	$4,938	$301,491	$156,210	$620,701	$0	$879,868	$118,680	$38,497	$18,012	$2,389	$0	$0	$2,250,000
Estimated FY 2016-17 Total Expenditure	$4,258,561	$1,364,556	$9,300,654	$365,816	$21,749,814	$10,980,884	$44,127,871	$0	$62,711,387	$8,379,219	$2,753,538	$1,288,911	$170,837	$0	$0	$167,452,048
Estimated FY 2016-17 Per Capita Cost	$98.10	$123.08	$134.74	$62.60	$113.09	$111.02	$120.50	$0.00	$128.81	$127.87	$136.42	$87.30	$88.70	$0.00	$0.00	$118.35

Request Year Projection

ACCOUNTABLE CARE COLLABORATIVE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RCCOs in the ACC	$979,111	$594,136	$4,838,694	$320,879	$18,293,791	$9,707,695	$36,450,000	$0	$51,198,592	$7,138,068	$2,209,066	$1,021,737	$135,619	$0	$0	$132,887,388
ACC: Medicare-Medicaid Program (RCCOs in the ACC)	$2,567,139	$517,335	$2,763,014	$158	$381,765	$40	$59	$0	$2,536	$0	$1,862	$3,982	$0	$0	$0	$6,237,890
Estimated Expenditure for PCMPs in the ACC	$305,428	$184,851	$1,505,659	$100,537	$5,707,073	$3,033,160	$11,346,507	$0	15,927,676	$2,225,560	$686,572	$317,298	$42,118	$0	$0	$41,382,439
ACC: Medicare-Medicaid Program (PCMPs in the ACC)	$430,590	$96,068	$515,004	$25	$75,250	$5	$5	$0	$431	$0	$309	$805	$0	$0	$0	$1,118,492
Bottom Line Impacts: Kaiser-Access Health Maintenance Organization	($6,090)	($12,354)	($143,376)	($4,350)	($601,692)	($361,398)	($931,074)	$0	($1,566,870)	($281,010)	($57,942)	($31,146)	($3,306)	$0	$0	($4,000,608)
Estimated Expenditure for SDAC in the ACC	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2017-18 Total Expenditure	$4,276,178	$1,380,036	$9,478,995	$417,249	$23,856,187	$12,379,502	$46,865,497	$0	$65,562,365	$9,082,618	$2,839,867	$1,312,676	$174,431	$0	$0	$177,625,601
Estimated FY 2017-18 Per Capita Cost	$96.88	$119.64	$134.26	$60.46	$119.77	$113.76	$119.59	$0.00	$131.21	$126.34	$139.96	$88.90	$87.74	$0.00	$0.00	$119.64

Out Year Projection

ACCOUNTABLE CARE COLLABORATIVE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RCCOs in the ACC	$1,036,585	$623,756	$5,084,134	$373,532	$19,303,647	$10,649,471	$38,229,217	$0	53,035,873	$7,668,035	$2,263,035	$1,044,895	$142,042	$0	$0	$139,454,222
ACC: Medicare-Medicaid Program (RCCOs in the ACC)	$2,567,139	$517,335	$2,763,014	$158	$381,765	$40	$59	$0	$2,536	$0	$1,862	$3,982	$0	$0	$0	$6,237,890
Estimated Expenditure for PCMPs in the ACC	$322,010	$193,690	$1,578,811	$116,721	$5,995,189	$3,315,732	$11,869,783	$0	16,453,683	$2,384,466	$701,578	$323,913	$44,105	$0	$0	$43,299,681
ACC: Medicare-Medicaid Program (PCMPs in the ACC)	$430,590	$96,068	$515,004	$25	$75,250	$5	$5	$0	$431	$0	$309	$805	$0	$0	$0	$1,118,492
Bottom Line Impacts: Kaiser-Access Health Maintenance Organization	($6,090)	($12,354)	($143,376)	($4,350)	($601,692)	($361,398)	($931,074)	$0	($1,566,870)	($281,010)	($57,942)	($31,146)	($3,306)	$0	$0	($4,000,608)
Estimated Expenditure for SDAC in the ACC	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2018-19 Total Expenditure	$4,350,234	$1,418,495	$9,797,587	$486,086	$25,154,159	$13,603,850	$49,167,990	$0	$67,925,653	$9,771,491	$2,908,842	$1,342,449	$182,841	$0	$0	$186,109,677
Estimated FY 2018-19 Per Capita Cost	$96.95	$117.97	$136.61	$61.43	$123.04	$116.91	$121.07	$0.00	$133.75	$130.63	$143.26	$90.91	$89.19	$0.00	$0.00	$121.57

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

Exhibit I - SERVICE MANAGEMENT - ACCOUNTABLE CARE COLLABORATIVE

Cash Based Actuals by Provider				
ACCOUNTABLE CARE COLLABORATIVE	**ACC: Regional Care Collaboration Organizations (RCCOs)**	**ACC: Primary Care Medical Providers (PCMPs)**	**ACC: Statewide Data and Analytics Contractor (SDAC)**	**TOTAL**
FY 2011-12	$12,303,473	$2,904,360	$2,700,000	$17,907,833
FY 2012-13	$27,696,161	$6,130,270	$2,902,500	$36,728,931
FY 2013-14	$52,945,462	$12,674,868	$2,950,000	$68,570,330
FY 2014-15	$79,471,841	$21,419,450	$3,059,475	$103,950,766
FY 2015-16	$102,794,192	$30,705,518	$3,375,525	$136,875,235
Estimated FY 2016-17	$127,062,875	$38,139,173	$2,250,000	$167,452,048
Estimated FY 2017-18	$136,228,286	$41,397,315	$0	$177,625,601
Estimated FY 2018-19	$142,795,120	$43,314,557	$0	$186,109,677
Percent Change in Cash Based Actuals				
ACCOUNTABLE CARE COLLABORATIVE	**ACC: Regional Care Collaboration Organizations (RCCOs)**	**ACC: Primary Care Medical Providers (PCMPs)**	**ACC: Statewide Data and Analytics Contractor (SDAC)**	**TOTAL**
FY 2012-13	125.11%	111.07%	7.50%	105.10%
FY 2013-14	91.17%	106.76%	1.64%	86.69%
FY 2014-15	50.10%	68.99%	3.71%	51.60%
FY 2015-16	29.35%	43.35%	10.33%	31.67%
Estimated FY 2016-17	23.61%	24.21%	-33.34%	22.34%
Estimated FY 2017-18	7.21%	8.54%	-100.00%	6.08%
Estimated FY 2018-19	4.82%	4.63%	0.00%	4.78%
Accountable Care Collaborative Enrollment[(1)]				
ACCOUNTABLE CARE COLLABORATIVE	**ACC: Regional Care Collaboration Organizations (RCCOs)**	**ACC: Primary Care Medical Providers (PCMPs)**	**ACC: Statewide Data and Analytics Contractor (SDAC)**	**TOTAL[(2)]**
FY 2011-12	78,870	60,540	78,870	218,280
FY 2012-13	226,499	169,874	226,499	622,871
FY 2013-14	455,426	334,992	455,426	455,426
FY 2014-15	751,742	550,486	751,742	751,742
FY 2015-16	931,919	707,113	931,919	931,919
Estimated FY 2016-17	1,052,031	798,251	1,052,031	1,052,031
Estimated FY 2017-18	1,136,225	862,134	-	1,136,225
Estimated FY 2018-19	1,188,866	902,077	-	1,188,866
Annual Percent Change in Enrollment				
FY 2012-13	187.18%	180.60%	187.18%	185.35%
FY 2013-14	101.07%	97.20%	101.07%	-26.88%
FY 2014-15	65.06%	64.33%	65.06%	65.06%
FY 2015-16	23.97%	28.45%	23.97%	23.97%
Estimated FY 2016-17	12.89%	12.89%	12.89%	12.89%
Estimated FY 2017-18	8.00%	8.00%	-100.00%	8.00%
Estimated FY 2018-19	4.63%	4.63%	0.00%	4.63%

Exhibit I - SERVICE MANAGEMENT - ACCOUNTABLE CARE COLLABORATIVE

Cost Per Enrollee				
ACCOUNTABLE CARE COLLABORATIVE	**ACC: Regional Care Collaboration Organizations (RCCOs)**	**ACC: Primary Care Medical Providers (PCMPs)**	**ACC: Statewide Data and Analytics Contractor (SDAC)**	**TOTAL**
FY 2011-12	$156.00	$47.97	$34.23	$82.04
FY 2012-13	$122.28	$36.09	$12.81	$58.97
FY 2013-14	$116.25	$37.84	$6.48	$150.56
FY 2014-15	$105.72	$38.91	$4.07	$138.28
FY 2015-16	$110.30	$43.42	$3.62	$146.87
Estimated FY 2016-17	$120.78	$47.78	$2.14	$159.17
Estimated FY 2017-18	$119.90	$48.02	$0.00	$156.33
Estimated FY 2018-19	$120.11	$48.02	$0.00	$156.54
Percent Change in Cost Per Enrollee				
ACCOUNTABLE CARE COLLABORATIVE	**ACC: Regional Care Collaboration Organizations (RCCOs)**	**ACC: Primary Care Medical Providers (PCMPs)**	**ACC: Statewide Data and Analytics Contractor (SDAC)**	**TOTAL**
FY 2012-13	-21.62%	-24.77%	-62.58%	-28.12%
FY 2013-14	-4.93%	4.85%	-49.41%	155.32%
FY 2014-15	-9.06%	2.83%	-37.19%	-8.16%
FY 2015-16	4.33%	11.59%	-11.06%	6.21%
Estimated FY 2016-17	9.50%	10.04%	-40.88%	8.37%
Estimated FY 2017-18	-0.73%	0.50%	-100.00%	-1.78%
Estimated FY 2018-19	0.18%	0.00%	0.00%	0.13%
Current Year Projection				
Estimated FY 2016-17 Enrollment	1,052,031	798,251	N/A	1,052,031
FY 2016-17 PMPM Administration Fee	$9.82	$4.00	N/A	
Number of Months Paid	12	12	N/A	
Estimated FY 2016-17 Base Expenditure	$123,995,149	$38,316,027	$2,250,000	$164,561,176
FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	$6,213,843	$1,118,492	$0	$7,332,335
Recoupment of Incentive Overpayment (of Quarter 1 FY 2015-16)	($249,125)	($191,730)	$0	($440,855)
Kaiser-Access Health Maintenance Organization	($2,896,992)	($1,103,616)	$0	($4,000,608)
Total Bottom Line Impacts	$3,067,726	($176,854)	$0	$2,890,872
Estimated FY 2016-17 Total Expenditure	**$127,062,875**	**$38,139,173**	**$2,250,000**	**$167,452,048**
Estimated FY 2016-17 Cost Per Enrollee	$120.78	$47.78	$2.14	$159.17
% Change over FY 2015-16 Cost Per Enrollee	9.50%	10.04%	-40.88%	8.37%
Request Year Projection				
ACCOUNTABLE CARE COLLABORATIVE	**ACC: Regional Care Collaboration Organizations (RCCOs)**	**ACC: Primary Care Medical Providers (PCMPs)**	**ACC: Statewide Data and Analytics Contractor (SDAC)**	**TOTAL**
Estimated FY 2017-18 Enrollment	1,136,225	862,134	N/A	1,136,225
FY 2017-18 PMPM Administration Fee	$9.75	$4.00	N/A	
Number of Months Paid	12	12	N/A	
Estimated FY 2017-18 Base Expenditure	$132,887,388	$41,382,439	$0	$174,269,827
FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees" Annualization	$6,237,890	$1,118,492	$0	$7,356,382
Kaiser-Access Health Maintenance Organization	($2,896,992)	($1,103,616)	$0	($4,000,608)
Total Bottom Line Impacts	$3,340,898	$14,876	$0	$3,355,774
Estimated FY 2017-18 Total Expenditure	**$136,228,286**	**$41,397,315**	**$0**	**$177,625,601**
Estimated FY 2017-18 Cost Per Enrollee	$119.90	$48.02	$0.00	$156.33
% Change over FY 2016-17 Cost Per Enrollee	-0.73%	0.50%	-100.00%	-1.78%
Out Year Projection				
ACCOUNTABLE CARE COLLABORATIVE	**ACC: Regional Care Collaboration Organizations (RCCOs)**	**ACC: Primary Care Medical Providers (PCMPs)**	**ACC: Statewide Data and Analytics Contractor (SDAC)**	**TOTAL**
Estimated FY 2018-19 Enrollment	1,188,866	902,077	N/A	1,188,866
FY 2018-19 PMPM Administration Fee	$9.78	$4.00	N/A	
Number of Months Paid	12	12	N/A	
Estimated FY 2018-19 Base Expenditure	$139,454,222	$43,299,681	$0	$182,753,903
FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees" Annualization	$6,237,890	$1,118,492	$0	$7,356,382
Kaiser-Access Health Maintenance Organization	($2,896,992)	($1,103,616)	$0	($4,000,608)
Total Bottom Line Impacts	$3,340,898	$14,876	$0	$3,355,774
Estimated FY 2018-19 Total Expenditure	**$142,795,120**	**$43,314,557**	**$0**	**$186,109,677**
Estimated FY 2018-19 Cost Per Enrollee	$120.11	$48.02	$0.00	$156.54
% Change over FY 2017-18 Cost Per Enrollee	0.18%	0.00%	0.00%	0.13%

Footnotes:

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

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

Exhibit I - SERVICE MANAGEMENT - PREPAID INPATIENT HEALTH PLAN ADMINISTRATION

Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	$352,841	$75,159	$520,646	$0	$626,486	$0	$0	$0	$2,101,664	$0	$184,279	$74,059	$0	$0	$0	$3,935,134
FY 2009-10 (DA)	$331,989	$116,999	$938,116	$0	$713,502	$0	$0	$0	$2,715,378	$0	$208,304	$87,465	$0	$0	$0	$5,111,753
FY 2010-11 (DA)	$411,355	$211,517	$1,451,792	$0	$793,726	$238,521	$0	$0	$3,063,511	$0	$216,554	$88,268	$0	$0	$0	$6,475,244
FY 2011-12	$514,348	$183,069	$1,118,391	$1,094	$1,332,529	$526,053	$0	$0	$4,776,807	$0	$325,880	$113,177	$0	$0	$0	$8,891,348
FY 2012-13	$314,516	$102,047	$728,309	$10,723	$1,049,127	$425,319	$0	$0	$3,699,162	$27,783	$246,713	$80,747	$629	$0	$0	$6,685,075
FY 2013-14	$521,003	$251,547	$1,474,302	$43,729	$1,553,848	$424,799	$88,292	$0	$2,691,223	$43,733	$263,625	$262,766	$8,772	$0	$2,499	$7,630,138
FY 2014-15	$131,201	$52,198	$339,287	$15,518	$415,468	$119,209	$229,248	$0	$652,475	$52,903	$83,940	$100,164	$9,170	$0	$705	$2,201,486

Percent Change in Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	-5.91%	55.67%	80.18%	0.00%	13.89%	0.00%	0.00%	0.00%	29.20%	0.00%	13.04%	18.10%	0.00%	0.00%	0.00%	29.90%
FY 2010-11 (DA)	23.91%	80.79%	54.76%	0.00%	11.24%	100.00%	0.00%	0.00%	12.82%	0.00%	3.96%	0.92%	0.00%	0.00%	0.00%	26.67%
FY 2011-12	25.04%	-13.45%	-22.96%	100.00%	67.88%	120.55%	0.00%	0.00%	55.93%	0.00%	50.48%	28.22%	0.00%	0.00%	0.00%	37.31%
FY 2012-13	-38.85%	-44.26%	-34.88%	880.16%	-21.27%	-19.15%	0.00%	0.00%	-22.56%	100.00%	-24.29%	-28.65%	100.00%	0.00%	0.00%	-24.81%
FY 2013-14	65.65%	146.50%	102.43%	307.81%	48.11%	-0.12%	100.00%	0.00%	-27.25%	57.41%	6.85%	225.42%	1294.59%	0.00%	100.00%	14.14%
FY 2014-15	-74.82%	-79.25%	-76.99%	-64.51%	-73.26%	-71.94%	159.65%	0.00%	-75.76%	20.97%	-68.16%	-61.88%	4.54%	0.00%	-71.79%	-71.15%

Per Capita Cost

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	$9.38	$11.66	$10.14	$0.00	$10.13	$0.00	$0.00	$0.00	$8.94	$0.00	$10.22	$10.62	$0.00	$0.00	$0.00	$9.01
FY 2009-10 (DA)	$8.63	$16.60	$17.61	$0.00	$9.53	$0.00	$0.00	$0.00	$9.85	$0.00	$11.33	$11.17	$0.00	$0.00	$0.00	$10.25
FY 2010-11 (DA)	$10.57	$27.23	$25.79	$0.00	$9.79	$8.78	$0.00	$0.00	$10.13	$0.00	$11.77	$11.22	$0.00	$0.00	$0.00	$11.55
FY 2011-12	$12.94	$21.84	$18.82	$21.04	$14.29	$14.83	$0.00	$0.00	$14.27	$0.00	$18.07	$14.83	$0.00	$0.00	$0.00	$14.34
FY 2012-13	$7.70	$11.27	$11.76	$12.08	$10.56	$10.24	$0.00	$0.00	$10.28	$3.37	$13.88	$10.06	$1.83	$0.00	$0.00	$9.79
FY 2013-14	$12.45	$25.53	$22.88	$17.08	$12.46	$9.02	$1.01	$0.00	$6.74	$1.73	$14.43	$19.97	$8.30	$0.00	$0.11	$8.86
FY 2014-15	$3.14	$4.99	$5.10	$4.28	$2.57	$1.66	$0.95	$0.00	$1.46	$1.06	$4.19	$6.72	$5.24	$0.00	$0.03	$1.90

Percent Change in Per Capita Cost

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	-8.00%	42.37%	73.67%	0.00%	-5.92%	0.00%	0.00%	0.00%	10.18%	0.00%	10.86%	5.18%	0.00%	0.00%	0.00%	13.76%
FY 2010-11 (DA)	22.48%	64.04%	46.45%	0.00%	2.73%	100.00%	0.00%	0.00%	2.84%	0.00%	3.88%	0.45%	0.00%	0.00%	0.00%	12.68%
FY 2011-12	22.42%	-19.79%	-27.03%	100.00%	45.97%	68.91%	0.00%	0.00%	40.87%	0.00%	53.53%	32.17%	0.00%	0.00%	0.00%	24.16%
FY 2012-13	-40.49%	-48.40%	-37.51%	-42.59%	-26.10%	-30.95%	0.00%	0.00%	-27.96%	100.00%	-23.19%	-32.16%	100.00%	0.00%	0.00%	-31.73%
FY 2013-14	61.69%	126.53%	94.56%	41.39%	17.99%	-11.91%	100.00%	0.00%	-34.44%	-48.66%	3.96%	98.51%	353.55%	0.00%	100.00%	-9.50%
FY 2014-15	-74.78%	-80.45%	-77.71%	-74.94%	-79.37%	-81.60%	-5.94%	0.00%	-78.34%	-38.73%	-70.96%	-66.35%	-36.87%	0.00%	-72.73%	-78.56%

Exhibit I - SERVICE MANAGEMENT - PREPAID INPATIENT HEALTH PLAN ADMINISTRATION

Cash Based Actuals by Provider

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	TOTAL
FY 2008-09	$3,935,134	$0	$0	$0	$3,935,134
FY 2009-10 (DA)	$4,744,734	$258,779	$65,940	$42,300	$5,111,753
FY 2010-11 (DA)	$5,437,512	$705,541	$130,440	$201,750	$6,475,244
FY 2011-12	$8,387,798	$0	$240,000	$263,550	$8,891,348
FY 2012-13	$6,685,075	$0	$0	$0	$6,685,075
FY 2013-14	$7,630,138	$0	$0	$0	$7,630,138
FY 2014-15	$2,201,486	$0	$0	$0	$2,201,486

Percent Change in Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	TOTAL
FY 2008-09	9.02%	0.00%	0.00%	0.00%	-14.83%
FY 2009-10 (DA)	20.57%	100.00%	100.00%	100.00%	29.90%
FY 2010-11 (DA)	14.60%	172.64%	97.82%	376.95%	26.67%
FY 2011-12	54.26%	-100.00%	83.99%	30.63%	37.31%
FY 2012-13	-20.30%	0.00%	-100.00%	-100.00%	-24.81%
FY 2013-14	14.14%	0.00%	0.00%	0.00%	14.14%
FY 2014-15	-71.15%	0.00%	0.00%	0.00%	-71.15%

Prepaid Inpatient Health Plan Enrollment

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	TOTAL[(1)]
FY 2008-09	13,051	-	-	-	13,051
FY 2009-10 (DA)	16,123	2,186	275	24	18,608
FY 2010-11 (DA)	19,045	1,826	544	112	21,527
FY 2011-12	21,138	-	-	163	21,301
FY 2012-13	29,875	-	-	-	29,875
FY 2013-14	31,185	-	-	-	31,185
FY 2014-15	8,835	-	-	-	8,835

Annual Percent Change in Enrollment

FY 2009-10 (DA)	23.54%	100.00%	100.00%	100.00%	42.58%
FY 2010-11 (DA)	18.12%	-16.47%	97.82%	366.67%	15.69%
FY 2011-12	10.99%	-100.00%	-100.00%	45.54%	-1.05%
FY 2012-13	41.33%	0.00%	0.00%	-100.00%	40.25%
FY 2013-14	4.38%	0.00%	0.00%	0.00%	4.38%
FY 2014-15	-71.67%	0.00%	0.00%	0.00%	-71.67%

Cost Per Enrollee

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

Percent Change in Cost Per Enrollee

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	TOTAL
FY 2009-10 (DA)	-2.40%	100.00%	100.00%	100.00%	-8.89%
FY 2010-11 (DA)	-2.98%	226.40%	0.00%	2.20%	9.50%
FY 2011-12	38.98%	-100.00%	-100.00%	-10.24%	38.77%
FY 2012-13	-43.61%	0.00%	0.00%	-100.00%	-46.39%
FY 2013-14	9.34%	0.00%	0.00%	0.00%	9.34%
FY 2014-15	1.84%	0.00%	0.00%	0.00%	1.84%

(1) Enrollment Modifications:

RMHP: Program ended November 30, 2014; all clients were disenrolled from the program.

Colorado Access: Program ended June 30, 2011; all clients were disenrolled from the program.

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

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

Exhibit J - Health Care Affordability Act of 2009 Estimates

Cash Funded Expansion Populations
Source of Funding

FY 2016-17 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Hospital Provider Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
HB 09-1293 Medicaid Expansion Clients							
MAGI Parents/Caretakers 69% to 133% FPL	98,910	$257,950,142	$0	$6,507,637	$0	$251,442,505	97.48%
Buy-In for Individuals with Disabilities	5,844	$39,520,283	$0	$17,873,797	$3,629,124	$18,017,362	50.20%
MAGI Adults	363,387	$1,352,257,614	$0	$36,131,707	$0	$1,316,125,907	97.37%
Non-Newly Eligibles	2,822	$43,852,827	$0	$6,279,725	$0	$37,573,102	85.68%
MAGI Parents/Caretakers 60% to 68% FPL	10,589	$31,608,553	$0	$15,741,060	$0	$15,867,493	50.20%
Continuous Eligibility for Children	38,353	$51,113,305	$0	$25,454,426	$0	$25,658,879	50.20%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$1,776,302,724	$0	$107,988,352	$3,629,124	$1,664,685,248	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$323,856,456	$0	$161,280,515	$0	$162,575,941	50.20%
Outpatient Hospital Rates		$243,313,147	$0	$121,169,947	$0	$122,143,200	50.20%
Hospital Quality Incentive Payment		$89,775,894	$0	$44,708,395	$0	$45,067,499	50.20%
Supplemental Hospital Payments (DSH)		$0	$0	$0	$0	$0	
Subtotal from HB 09-1293 Supplemental Payments		$656,945,497	$0	$327,158,857	$0	$329,786,640	
Cash Fund Financing		$0	($15,700,000)	$15,700,000	$0	$0	
Other Adjustments		$0	$688,206	$2,698,181	$0	($3,386,387)	
HB 09-1293 Total		**$2,433,248,221**	**($15,011,794)**	**$453,545,390**	**$3,629,124**	**$1,991,085,501**	

FY 2017-18 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Hospital Provider Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
HB 09-1293 Medicaid Expansion Clients							
MAGI Parents/Caretakers 69% to 133% FPL	108,821	$282,845,838	$0	$15,619,522	$0	$267,226,316	94.48%
Buy-in for Individuals with Disabilities	6,901	$45,598,064	$0	$20,511,017	$4,576,030	$20,511,017	50.00%
MAGI Adults	388,880	$1,448,831,641	$0	$82,101,914	$0	$1,366,729,727	94.38%
Non-Newly Eligibles	2,991	$46,707,489	$0	$7,762,785	$0	$38,944,704	83.38%
MAGI Parents/Caretakers 60% to 68% FPL	10,967	$32,179,343	$0	$16,089,670	$0	$16,089,673	50.00%
Continuous Eligibility for Children	39,706	$52,507,448	$0	$26,253,723	$0	$26,253,725	50.00%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$1,908,669,823	$0	$168,338,631	$4,576,030	$1,735,755,162	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$250,501,666	$0	$125,250,833	$0	$125,250,833	50.00%
Outpatient Hospital Rates		$200,163,270	$0	$100,081,635	$0	$100,081,635	50.00%
Hospital Quality Incentive Payment		$89,775,894	$0	$44,887,947	$0	$44,887,947	50.00%
Supplemental Hospital Payments (DSH)		$0	$0	$0	$0	$0	
Subtotal from HB 09-1293 Supplemental Payments		$540,440,830	$0	$270,220,415	$0	$270,220,415	
Cash Fund Financing		$0	($15,700,000)	$15,700,000	$0	$0	
HB 09-1293 Total		**$2,449,110,653**	**($15,700,000)**	**$454,259,046**	**$4,576,030**	**$2,005,975,577**	

FY 2018-19 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Hospital Provider Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
HB 09-1293 Medicaid Expansion Clients							
MAGI Parents/Caretakers 69% to 133% FPL	116,361	$302,049,195	$0	$19,699,835	$0	$282,349,360	93.48%
Buy-in for Individuals with Disabilities	7,913	$51,615,728	$0	$23,185,863	$5,243,998	$23,185,867	50.00%
MAGI Adults	402,990	$1,507,395,633	$0	$100,498,127	$0	$1,406,897,506	93.38%
Non-Newly Eligibles	3,122	$48,980,352	$0	$8,507,887	$0	$40,472,465	82.63%
MAGI Parents/Caretakers 60% to 68% FPL	11,256	$32,434,780	$0	$16,217,389	$0	$16,217,391	50.00%
Continuous Eligibility for Children	40,480	$54,173,830	$0	$27,086,914	$0	$27,086,916	50.00%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$1,996,649,518	$0	$195,196,015	$5,243,998	$1,796,209,505	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$553,146,478	$0	$276,573,239	$0	$276,573,239	50.00%
Outpatient Hospital Rates		$378,189,630	$0	$189,094,815	$0	$189,094,815	50.00%
Hospital Quality Incentive Payment		$89,775,894	$0	$44,887,947	$0	$44,887,947	50.00%
Subtotal from HB 09-1293 Supplemental Payments		$1,021,112,002	$0	$510,556,001	$0	$510,556,001	
Cash Fund Financing		$0	($15,700,000)	$15,700,000	$0	$0	
HB 09-1293 Total		**$3,017,761,520**	**($15,700,000)**	**$721,452,016**	**$5,243,998**	**$2,306,765,506**	

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

MAGI Parents/Caretakers 69% to 133% FPL[1]	Caseload	Per Capita	Total Funds [2]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$2,494.75	$246,755,252	$0	$6,213,707	$0	$240,541,545
Community Based Long-Term Care		$1.66	$163,864	$0	$18,155	$0	$145,709
Long-Term Care		$0.15	$14,579	$0	$364	$0	$14,215
Insurance		$0.36	$35,563	$0	$889	$0	$34,674
Service Management		$111.02	$10,980,884	$0	$274,522	$0	$10,706,362
Total	**98,910**	**$2,607.94**	**$257,950,142**	**$0**	**$6,507,637**	**$0**	**$251,442,505**

Buy-In for Individuals with Disabilities	Caseload	Per Capita	Total Funds [2]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$5,703.58	$33,331,703	$0	$15,074,895	$3,060,830	$15,195,978
Community Based Long-Term Care		$967.63	$5,654,821	$0	$2,557,500	$519,279	$2,578,042
Long-Term Care		$28.74	$167,943	$0	$75,955	$15,422	$76,566
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$62.60	$365,816	$0	$165,447	$33,593	$166,776
Total	**5,844**	**$6,762.54**	**$39,520,283**	**$0**	**$17,873,797**	**$3,629,124**	**$18,017,362**

MAGI Adults[1]	Caseload	Per Capita	Total Funds [2]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds[1]
Acute Care		$3,578.73	$1,300,462,803	$0	$34,176,072	$0	$1,266,286,731
Community Based Long-Term Care		$19.13	$6,952,557	$0	$834,579	$0	$6,117,978
Long-Term Care		$2.51	$912,323	$0	$22,808	$0	$889,515
Insurance		$0.09	$32,006	$0	$800	$0	$31,206
Service Management		$120.80	$43,897,925	$0	$1,097,448	$0	$42,800,477
Total	**363,387**	**$3,721.26**	**$1,352,257,614**	**$0**	**$36,131,707**	**$0**	**$1,316,125,907**

Non-Newly Eligibles	Caseload	Per Capita	Total Funds [2]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$14,530.70	$41,005,922	$0	$5,872,048	$0	$35,133,874
Community Based Long-Term Care		$376.58	$1,062,716	$0	$152,181	$0	$910,535
Long-Term Care		$550.76	$1,554,243	$0	$222,568	$0	$1,331,675
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$81.48	$229,946	$0	$32,928	$0	$197,018
Total	**2,822**	**$15,539.52**	**$43,852,827**	**$0**	**$6,279,725**	**$0**	**$37,573,102**

MAGI Parents/Caretakers 60% to 68% FPL	Caseload	Per Capita	Total Funds [2]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$2,868.88	$30,377,570	$0	$15,128,030	$0	$15,249,540
Community Based Long-Term Care		$12.62	$133,668	$0	$66,567	$0	$67,101
Long-Term Care		$2.57	$27,220	$0	$13,556	$0	$13,664
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$101.06	$1,070,095	$0	$532,907	$0	$537,188
Total	**10,589**	**$2,985.13**	**$31,608,553**	**$0**	**$15,741,060**	**$0**	**$15,867,493**

Continuous Eligibility for Children	Caseload	Per Capita	Total Funds [2]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$1,140.84	$43,754,769	$0	$21,789,875	$0	$21,964,894
Community Based Long-Term Care		$2.82	$108,312	$0	$53,939	$0	$54,373
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$189.04	$7,250,224	$0	$3,610,612	$0	$3,639,612
Total	**38,353**	**$1,332.70**	**$51,113,305**	**$0**	**$25,454,426**	**$0**	**$25,658,879**

FY 2016-17 Summary	Caseload	Per Capita	Total Funds [2]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Total	**519,905**	**$3,416.59**	**$1,776,302,724**	**$0**	**$107,988,352**	**$3,629,124**	**$1,664,685,248**

(1) The matching federal funds for this population will decrease from 100% to 95% effective January 1, 2017 in accordance with the Affordable Care Act.
(2) Figures may not sum due to rounding.

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

MAGI Parents/Caretakers 69% to 133% FPL[1]							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,483.23	$270,227,894	$0	$14,908,737	$0	$255,319,157
Community Based Long-Term Care		$1.64	$178,332	$0	$26,606	$0	$151,726
Long-Term Care		$0.14	$15,105	$0	$831	$0	$14,274
Insurance		$0.41	$45,005	$0	$2,475	$0	$42,530
Service Management		$113.76	$12,379,502	$0	$680,873	$0	$11,698,629
Total	**108,821**	**$2,599.18**	**$282,845,838**	**$0**	**$15,619,522**	**$0**	**$267,226,316**
Buy-In for Individuals with Disabilities							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$5,624.36	$38,813,714	$0	$17,459,266	$3,895,182	$17,459,266
Community Based Long-Term Care		$897.42	$6,193,097	$0	$2,785,792	$621,513	$2,785,792
Long-Term Care		$25.21	$174,004	$0	$78,271	$17,462	$78,271
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$60.46	$417,249	$0	$187,688	$41,873	$187,688
Total	**6,901**	**$6,607.46**	**$45,598,064**	**$0**	**$20,511,017**	**$4,576,030**	**$20,511,017**
MAGI Adults[1]							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds[1]**
Acute Care		$3,584.45	$1,393,921,466	$0	$78,334,367	$0	$1,315,587,099
Community Based Long-Term Care		$19.01	$7,393,551	$0	$1,154,133	$0	$6,239,418
Long-Term Care		$2.21	$858,620	$0	$47,224	$0	$811,396
Insurance		$0.10	$40,504	$0	$2,228	$0	$38,276
Service Management		$119.88	$46,617,500	$0	$2,563,962	$0	$44,053,538
Total	**388,880**	**$3,725.65**	**$1,448,831,641**	**$0**	**$82,101,914**	**$0**	**$1,366,729,727**
Non-Newly Eligibles							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$14,574.77	$43,593,138	$0	$7,245,180	$0	$36,347,958
Community Based Long-Term Care		$390.97	$1,169,383	$0	$194,351	$0	$975,032
Long-Term Care		$567.36	$1,696,971	$0	$282,037	$0	$1,414,934
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$82.91	$247,997	$0	$41,217	$0	$206,780
Total	**2,991**	**$15,616.01**	**$46,707,489**	**$0**	**$7,762,785**	**$0**	**$38,944,704**
MAGI Parents/Caretakers 60% to 68% FPL							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,811.50	$30,832,803	$0	$15,416,401	$0	$15,416,402
Community Based Long-Term Care		$13.11	$143,779	$0	$71,889	$0	$71,890
Long-Term Care		$2.64	$28,987	$0	$14,493	$0	$14,494
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$107.03	$1,173,774	$0	$586,887	$0	$586,887
Total	**10,967**	**$2,934.28**	**$32,179,343**	**$0**	**$16,089,670**	**$0**	**$16,089,673**
Continuous Eligibility for Children							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$1,145.85	$45,497,101	$0	$22,748,550	$0	$22,748,551
Community Based Long-Term Care		$2.93	$116,522	$0	$58,261	$0	$58,261
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$173.62	$6,893,825	$0	$3,446,912	$0	$3,446,913
Total	**39,706**	**$1,322.40**	**$52,507,448**	**$0**	**$26,253,723**	**$0**	**$26,253,725**
FY 2017-18 Summary							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**558,266**	**$3,418.93**	**$1,908,669,823**	**$0**	**$168,338,631**	**$4,576,030**	**$1,735,755,162**

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

Hospital Provider Fee - Fund Splits and Service Category Impacts by Expansion Population
FY 2018-19

MAGI Parents/Caretakers 69% to 133% FPL[1]							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,476.62	$288,181,670	$0	$18,780,103	$0	$269,401,567
Community Based Long-Term Care		$1.64	$191,076	$0	$30,763	$0	$160,313
Long-Term Care		$0.13	$15,601	$0	$1,014	$0	$14,587
Insurance		$0.49	$56,998	$0	$3,705	$0	$53,293
Service Management		$116.91	$13,603,850	$0	$884,250	$0	$12,719,600
Total	**116,361**	**$2,595.79**	**$302,049,195**	**$0**	**$19,699,835**	**$0**	**$282,349,360**
Buy-In for Individuals with Disabilities							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$5,592.58	$44,254,122	$0	$19,879,020	$4,496,081	$19,879,021
Community Based Long-Term Care		$846.18	$6,695,802	$0	$3,007,764	$680,273	$3,007,765
Long-Term Care		$22.71	$179,718	$0	$80,729	$18,259	$80,730
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$61.43	$486,086	$0	$218,350	$49,385	$218,351
Total	**7,913**	**$6,522.90**	**$51,615,728**	**$0**	**$23,185,863**	**$5,243,998**	**$23,185,867**
MAGI Adults[1]							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds[1]**
Acute Care		$3,597.79	$1,449,873,671	$0	$95,932,189	$0	$1,353,941,482
Community Based Long-Term Care		$19.23	$7,750,803	$0	$1,330,813	$0	$6,419,990
Long-Term Care		$2.02	$815,201	$0	$52,988	$0	$762,213
Insurance		$0.13	$51,298	$0	$3,334	$0	$47,964
Service Management		$121.35	$48,904,660	$0	$3,178,803	$0	$45,725,857
Total	**402,990**	**$3,740.53**	**$1,507,395,633**	**$0**	**$100,498,127**	**$0**	**$1,406,897,506**
Non-Newly Eligibles							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$14,615.72	$45,630,274	$0	$7,925,979	$0	$37,704,295
Community Based Long-Term Care		$404.37	$1,262,437	$0	$219,285	$0	$1,043,152
Long-Term Care		$584.34	$1,824,311	$0	$316,883	$0	$1,507,428
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$84.35	$263,330	$0	$45,740	$0	$217,590
Total	**3,122**	**$15,688.77**	**$48,980,352**	**$0**	**$8,507,887**	**$0**	**$40,472,465**
MAGI Parents/Caretakers 60% to 68% FPL							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,755.27	$31,013,836	$0	$15,506,918	$0	$15,506,918
Community Based Long-Term Care		$13.57	$152,728	$0	$76,364	$0	$76,364
Long-Term Care		$2.72	$30,591	$0	$15,295	$0	$15,296
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$109.95	$1,237,625	$0	$618,812	$0	$618,813
Total	**11,256**	**$2,881.51**	**$32,434,780**	**$0**	**$16,217,389**	**$0**	**$16,217,391**
Continuous Eligibility for Children							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$1,150.84	$46,586,013	$0	$23,293,006	$0	$23,293,007
Community Based Long-Term Care		$3.04	$122,977	$0	$61,488	$0	$61,489
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$184.41	$7,464,840	$0	$3,732,420	$0	$3,732,420
Total	**40,480**	**$1,338.29**	**$54,173,830**	**$0**	**$27,086,914**	**$0**	**$27,086,916**
FY 2018-19 Summary							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**582,122**	**$3,429.95**	**$1,996,649,518**	**$0**	**$195,196,015**	**$5,243,998**	**$1,796,209,505**

(1) The matching federal funds for this population will decrease from 94% to 93% effective January 1, 2019 in accordance with the Affordable Care Act.
(2) Figures may not sum due to rounding.

Exhibit K - Upper Payment Limit Financing

Summary of Upper Payment Limit Financing

Nursing Facilities UPL	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
Total Funds	$2,977,225	$3,070,292	$3,175,445
General Fund	($3,091,004)	($3,138,590)	($3,177,350)
Cash Funds	$2,977,225	$3,070,292	$3,175,445
Federal Funds	$3,091,004	$3,138,590	$3,177,350
Home Health UPL			
Total Funds	$443,127	$458,257	$469,020
General Fund	($452,894)	($458,533)	($469,020)
Cash Funds	$443,127	$458,257	$469,020
Federal Funds	$452,894	$458,533	$469,020
Total Upper Payment Limit Financing			
Total Funds	$3,420,352	$3,528,549	$3,644,465
General Fund	($3,543,898)	($3,597,123)	($3,646,370)
Cash Funds	$3,420,352	$3,528,549	$3,644,465
Federal Funds	$3,543,898	$3,597,123	$3,646,370

Exhibit K - Upper Payment Limit Financing

Nursing Facilities Upper Payment Limit Calculation
Estimate Based on Calendar Year 2015 Actual Upper Payment Limit

State Nursing Facilities		
Provider Name	**Upper Payment Limit (Amount Remaining after Medicaid Payment)**	**Certified Uncompensated Cost[(1)]**
Colorado St. Veterans - Fitzsimmons	$1,641,199	$1,118,661
Colorado St. Veterans - Florence	$974,907	$874,133
Colorado St. Veterans - Homelake	($104,829)	$86,289
Colorado St. Veterans - Rifle	$1,051,583	$664,150
Colorado St. Veterans - Walsenburg	$454,270	($11,593)
State Nursing Facilities Total	**$4,017,129**	**$2,731,640**
Government Nursing Facilities		
Arkansas Valley	$1,970,596	$1,020,285
Bent County Healthcare Center	($480,086)	($546,695)
Cheyenne Manor	$335,093	$342,814
Cripple Creek Rehabilitation & Wellness Center	($90,648)	($78,821)
E. Dene Moore Care Center	$1,246,541	$1,592,246
Gunnison Valley Health Senior Care	($82,025)	($195,970)
Lincoln Community Hospital & Nursing Home	$595,459	$528,974
Prospect Park Living Center	$298,216	($106,437)
Sedgwick County Hospital & Nursing Home	($75,747)	($181,593)
Southeast Colorado Hospital & LTC Center	$316,515	$203,649
Walbridge Memorial Convalescent Wing	$672,481	$649,406
Walsh Healthcare Center	$237,897	$19,005
Washington County Nursing Home	($30,858)	($47,863)
Government Nursing Facilities Total	**$4,913,432**	**$3,198,999**

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

Exhibit K - Upper Payment Limit Financing

Supplemental Medicaid Nursing Facilities Payment	
Estimated CY 2015 Upper Payment Limit	$6,068,229
Estimated CY 2016 Upper Payment Limit	$6,208,882
Estimated CY 2017 Upper Payment Limit	$6,352,795
Supplemental Medicaid Nursing Facility Payment FY 2016-17	
Total Funds	$2,977,225
General Fund (offset by Federal Funds)	($3,091,004)
Cash Funds	$2,977,225
Federal Funds	$3,091,004
Supplemental Medicaid Nursing Facility Payment FY 2017-18	
Total Funds	$3,070,292
General Fund (offset by Federal Funds)	($3,138,590)
Cash Funds	$3,070,292
Federal Funds	$3,138,590
Supplemental Medicaid Nursing Facility Payment FY 2018-19	
Total Funds	$3,175,445
General Fund (offset by Federal Funds)	($3,177,350)
Cash Funds	$3,175,445
Federal Funds	$3,177,350
CY 2014 Inflation Factor [(1)]	**2.32%**
(1) Consumer Price Index for Urban Wage Earners and Clerical Workers, Medical Care, US City Average	

Exhibit K - Upper Payment Limit Financing

Home Health Certified Public Expenditure Calculation
Estimate Based on Calendar Year 2016 Actuals (Based on CY 2015 Expenditures)

Provider Name	Total Funds by Provider
Alamosa County Nursing Service	$45,948
Delta Montrose Home Health Services	$183,424
Estes Park Home Health	$155,737
Grand County Nursing Service	$168,703
Kit Carson County Home Health	$51,324
Lincoln Community Home Health	$46,258
Pioneers Hospital Home Health	$25,876
Prowers Home Health	$48,711
Southeast Colorado Hospital Home Health	$40,339
Yuma District Home Health Care	$109,403
Home Health Total	**$875,723**

Exhibit K - Upper Payment Limit Financing

Supplemental Medicaid Home Health Payment	
CY 2016 Upper Payment Limit	$896,021
CY 2017 Upper Payment Limit	$916,790
CY 2018 Upper Payment Limit	$938,040
Supplemental Medicaid Home Health Payment FY 2016-17	
Total Funds	$443,127
General Fund	($452,894)
Cash Funds	$443,127
Federal Funds	$452,894
Supplemental Medicaid Home Health Payment FY 2017-18	
Total Funds	$458,257
General Fund	($458,533)
Cash Funds	$458,257
Federal Funds	$458,533
Supplemental Medicaid Home Health Payment FY 2018-19	
Total Funds	$469,020
General Fund	($469,020)
Cash Funds	$469,020
Federal Funds	$469,020
CY 2014 Inflation Factor [(1)]	**2.32%**
(1) Consumer Price Index for Urban Wage Earners and Clerical Workers, Medical Care, US City Average.	

Exhibit K - Upper Payment Limit Financing

Medicaid Eligible Inpatient Days from the Cost Report ending in Calendar Year 2013 for FY 2014-15 Participating Colorado Indigent Care Program Providers per HB 04-1438

Hospitals	Medicaid Eligible Inpatient Days	Total Inpatient Days	Percent of Medicaid Eligible Inpatient Days
State Owned			
University of Colorado Hospital	35,353	141,229	25.03%
Non State Owned Public			
Arkansas Valley Regional Medical Center	1,145	5,086	22.51%
Aspen Valley Hospital	246	2,863	8.59%
Delta County Memorial Hospital	1,080	5,707	18.92%
Denver Health Medical Center	55,887	109,413	51.08%
East Morgan County Hospital	59	1,335	4.42%
Estes Park Medical Center	199	1,339	14.86%
Grand River Medical Center	105	1,128	9.31%
Gunnison Valley Hospital	110	1,383	7.95%
Heart of the Rockies Regional Medical Center	536	3,684	14.55%
Kremmling Memorial Hospital	34	294	11.56%
Melissa Memorial Hospital	16	528	3.03%
Memorial Hospital	26,895	118,588	22.68%
The Memorial Hospital	592	2,528	23.42%
Montrose Memorial Hospital	1,871	10,994	17.02%
North Colorado Medical Center	11,861	48,694	24.36%
Poudre Valley Hospital	11,165	58,332	19.14%
Prowers Medical Center	610	2,029	30.06%
Sedgwick County Memorial Hospital	90	361	24.93%
Southeast Colorado Hospital	38	422	9.00%
Southwest Memorial Hospital	646	3,857	16.75%
Spanish Peaks Regional Health Center	75	757	9.91%
St. Vincent General Hospital District	37	460	8.04%
Wray Community District Hospital	406	966	42.03%
Yuma District Hospital	25	651	3.84%

Exhibit K - Upper Payment Limit Financing

Medicaid Eligible Inpatient Days from the Cost Report ending in Calendar Year 2013 for FY 2014-15 Participating Colorado Indigent Care Program Providers per HB 04-1438

Hospitals	Medicaid Eligible Inpatient Days	Total Inpatient Days	Percent of Medicaid Eligible Inpatient Days
Private			
Banner Health Fort Collins	820	4,553	18.01%
Boulder Community Hospital	4,514	39,741	11.36%
Centura Health - St. Thomas More Hospital	1,142	6,574	17.37%
Children's Hospital Colorado	42,500	84,945	50.03%
Colorado Plains Medical Center	1,041	7,400	14.07%
Community Hospital	350	4,690	7.46%
Conejos County Hospital	33	344	9.59%
Family Health West Hospital	49	708	6.92%
Longmont United Hospital	5,461	29,892	18.27%
McKee Medical Center	3,028	15,207	19.91%
Medical Center of the Rockies	2,917	37,404	7.80%
Mercy Medical Center	3,311	14,932	22.17%
Mount San Rafael Hospital	311	2,316	13.43%
National Jewish Health	72	152	47.37%
Parkview Medical Center	14,965	79,125	18.91%
Centura Health - Penrose -St. Francis Health Services	14,280	91,708	15.57%
Pikes Peak Regional Hospital	141	1,387	10.17%
Platte Valley Medical Center	3,067	11,074	27.70%
Rio Grande Hospital	57	967	5.89%
San Luis Valley Regional Medical Center	2,200	6,522	33.73%
Centura Health - St. Mary-Corwin Medical Center	3,464	27,973	12.38%
St. Mary's Hospital and Medical Center	14,406	60,896	23.66%
Sterling Regional Medical Center	698	4,160	16.78%
Valley View Hospital	4,534	10,252	44.23%
Yampa Valley Medical Center	605	4,500	13.44%

Note: Figures from Cost Report Year End (CRYE) 2013. Totals will be updated with CRYE 2014 data in the Department's February 2017 Medical Services Premiums request.

Exhibit L - Recoveries

Department Recovery Revenue											
Recovery Category	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**	**Estimated FY 2016-17**	**Estimated FY 2017-18**	**Estimated FY 2018-19**
Estate Recoveries[(1)]	$3,168,376	$3,682,865	$3,006,302	$2,993,722	$4,679,459	$5,283,510	$6,969,380	$5,526,967	$5,846,788	$7,912,763	$8,370,912
Income Trust and Repayments[(1)]	$3,242,100	$3,217,373	$4,021,065	$4,202,267	$3,976,905	$3,467,692	$4,074,355	$6,716,046	$7,104,674	$5,193,333	$5,494,027
Third Party Health Insurance	$8,705,554	$14,857,476	$17,714,457	$19,834,962	$27,406,316	$21,063,474	$26,598,141	$28,691,812	$30,352,079	$31,545,372	$33,371,849
Third Party Casualty	$3,812,718	$3,917,944	$4,664,590	$6,983,907	$5,660,459	$7,093,986	$8,809,174	$8,457,430	$8,946,824	$10,624,193	$11,239,334
Total Recoveries Including Bottom Line Impacts[(2)]	**$18,928,748**	**$25,675,658**	**$29,406,414**	**$34,014,858**	**$41,723,139**	**$36,908,662**	**$46,451,050**	**$49,392,255**	**$52,250,365**	**$55,275,661**	**$58,476,122**

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

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

Contingency and Contractor Payments											
Recovery Category	**Contingency Amount[(4)]**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**	**Estimated FY 2016-17**	**Estimated FY 2017-18**	**Estimated FY 2018-19**
Estate Recoveries	11.50%	$386,701	$315,662	$314,341	$491,343	$554,769	$801,479	$635,601	$672,381	$909,968	$962,655
Income Trust and Repayments[(3)]	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Third Party Health Insurance	6.90%	$876,591	$1,045,153	$1,170,263	$1,616,973	$1,242,745	$1,835,272	$1,979,735	$2,094,293	$2,176,631	$2,302,658
Third Party Casualty	9.40%	$329,107	$391,826	$586,648	$475,479	$595,895	$828,062	$794,998	$841,001	$998,674	$1,056,497
Total		**$1,592,399**	**$1,752,641**	**$2,071,252**	**$2,583,795**	**$2,393,409**	**$3,464,813**	**$3,410,334**	**$3,607,675**	**$4,085,273**	**$4,321,810**

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

(4) The Department's recovery contract was reprocured at the end of CY 2012. Contingency rates shown reflect the new contract amounts.

Fund Splits					
Total Medical Services Premiums Impact	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**
FY 2016-17	$0	($15,546,204)	$48,642,690	($33,096,486)	68.04%
FY 2017-18	$0	($15,735,925)	$51,190,388	($35,454,463)	69.26%
FY 2018-19	$0	($16,993,623)	$54,154,312	($37,160,689)	68.62%

Recovery Trend for FY 2015-16 to FY 2016-17	5.79%
Recovery Trend for FY 2016-17 to FY 2017-18	5.79%
Recovery Trend for FY 2017-18 to FY 2018-19	5.79%

Exhibit M

Cash-based Actuals

FY 2015-16 Actuals	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	CORE TOTAL
Acute Care																
Physician Services & EPSDT	$4,170,492	$10,532,526	$72,398,341	$6,451,026	$99,150,236	$43,259,041	$218,465,667	$463,552	$209,476,266	$19,617,610	$14,537,501	$38,526,078	$4,455,861	$5,540,144	$7,963	$747,052,304
Emergency Transportation	$2,000,046	$1,386,802	$6,486,393	$204,631	$3,215,877	$831,046	$12,079,906	$4,934	$3,636,939	$302,841	$545,804	$727,944	$60,248	$117,887	$34,058	$31,635,356
Non-emergency Medical Transportation	$3,260,871	$1,755,147	$6,969,615	$163,703	$1,015,029	$193,560	$3,197,422	$5,869	$1,341,691	$115,343	$272,208	$141,007	$3,704	$859	$36,354	$18,472,382
Dental Services	$9,692,512	$3,255,670	$20,017,136	$1,882,755	$34,090,114	$16,628,574	$64,187,405	$74,846	$145,712,016	$24,525,543	$6,761,893	$2,418,029	$252,079	$345	$3,788	$329,502,705
Family Planning	$528	$992	$46,985	$2,891	$716,229	$365,230	$914,935	$0	$341,081	$61,664	$30,292	$101,773	$11,705	$459	$0	$2,594,764
Health Maintenance Organizations	$9,447,795	$12,228,472	$68,878,368	$3,239,365	$68,358,097	$37,727,861	$123,878,452	$56,900	$40,884,782	$4,527,312	$591,464	$13,626,398	$1,435,071	$0	$0	$384,880,337
Inpatient Hospitals	$18,296,040	$16,642,325	$90,712,433	$6,766,211	$55,121,508	$22,914,238	$259,684,175	$78,049	$114,358,936	$5,180,822	$6,222,279	$64,935,073	$7,256,098	$31,042,041	$10,075	$699,220,303
Outpatient Hospitals	$3,015,031	$8,709,753	$63,422,359	$5,126,398	$97,933,062	$39,894,019	$212,882,054	$237,736	$113,958,276	$13,486,877	$7,727,366	$12,433,767	$1,174,506	$2,147,375	$1,211	$582,149,790
Lab & X-Ray	$481,274	$1,477,326	$9,692,973	$668,814	$25,704,145	$10,429,703	$42,886,524	$62,942	$11,725,655	$1,436,503	$1,670,770	$8,417,870	$923,028	$166,584	$43	$115,744,154
Durable Medical Equipment	$22,258,858	$7,902,572	$65,941,979	$1,834,862	$8,583,859	$3,223,250	$25,945,821	$52,874	$23,215,395	$2,038,731	$5,489,338	$348,629	$51,402	$2,420	$195,552	$167,085,542
Prescription Drugs	$6,227,499	$24,685,912	$174,153,037	$11,400,688	$109,975,215	$48,970,322	$296,662,440	$324,059	$114,100,963	$17,531,462	$22,205,326	$7,366,232	$796,782	$525	$2,009	$834,402,471
Drug Rebate	($3,051,642)	($12,096,762)	($85,339,679)	($5,586,644)	($53,890,818)	($23,996,777)	($145,372,586)	($158,798)	($55,912,545)	($8,590,889)	($10,881,208)	($3,609,652)	($390,444)	($257)	($985)	($408,879,686)
Rural Health Centers	$56,618	$247,203	$1,198,720	$89,640	$3,081,704	$1,658,932	$4,775,550	$2,175	$7,802,596	$740,919	$352,281	$657,990	$50,352	$10,476	$0	$20,725,156
Federally Qualified Health Centers	$770,516	$1,357,335	$8,268,087	$391,338	$18,109,179	$8,779,786	$41,908,321	$46,859	$49,814,304	$4,453,883	$1,641,319	$9,148,673	$781,507	$344,754	$299	$145,816,160
Co-Insurance (Title XVIII-Medicare)	$29,610,655	$5,273,284	$21,042,228	$2,322,145	$2,942,625	$35,048	$360,402	$3,170	$19,711	$2,212	$20,505	$78,940	$54	$1,304	$14,301,332	$76,013,615
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$2,591,199	$0	$0	$0	$0	$0	$0	$0	$2,591,199
Prepaid Inpatient Health Plan Services	$90,616	$161,634	$2,966,454	$18,351	$424,917	$92,395	$263,935	$0	$959,898	$0	$69,521	$246,229	$96,119	$0	$418	$5,390,487
Other Medical Services	$127	$93	$681	$38	$465	$206	$1,155	$4	$750	$82	$71	$140	$15	$35	$13	$3,875
Acute Home Health	$5,040,801	$2,590,755	$10,879,697	$323,098	$1,232,589	$345,330	$4,992,412	$1,054	$1,827,308	$38,585	$674,253	$221,166	$28,663	$203	$0	$28,195,914
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$111,368,637**	**$86,111,039**	**$537,735,807**	**$35,299,310**	**$475,764,032**	**$211,351,764**	**$1,167,713,990**	**$3,847,424**	**$783,264,022**	**$85,469,500**	**$57,930,983**	**$155,786,286**	**$16,986,750**	**$39,375,154**	**$14,592,130**	**$3,782,596,828**
Community Based Long Term Care																
HCBS - Elderly, Blind, and Disabled	$158,254,237	$29,645,404	$128,736,746	$1,941,857	$337,114	$42,261	$1,422,526	$0	$29,685	$0	$140,367	$34,095	$0	$0	$736,932	$321,321,224
HCBS - Mental Illness	$5,680,834	$4,844,842	$24,777,536	$92,735	$12,366	$0	$182,561	$0	$0	$0	$7,251	$0	$0	$0	$123,436	$35,721,561
HCBS - Disabled Children	$0	$0	$11,624,350	$30,788	$0	$0	$0	$0	$900,588	$1,468	$1,279	$0	$0	$0	$0	$12,558,473
HCBS - Persons Living with AIDS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Consumer Directed Attendant Support	$1,025,387	$192,083	$834,132	$12,582	$2,184	$274	$9,217	$0	$192	$0	$910	$221	$0	$0	$4,775	$2,081,957
HCBS - Brain Injury	$938,063	$2,023,716	$16,067,505	$17,758	$752	$0	$97,102	$0	$1,141	$0	$0	$0	$0	$0	$14,511	$19,160,548
HCBS - Children with Autism	$0	$0	$528,398	$615	$0	$0	$0	$0	$27,138	$0	$2,397	$0	$0	$0	$0	$558,548
HCBS - Pediatric Hospice	$0	$0	$586,968	$554	$0	$0	$0	$0	$49,560	$684	$5,224	$0	$0	$0	$0	$642,990
HCBS - Spinal Cord Injury	$159,217	$50,750	$1,748,220	$1,976	$232	$0	$5,390	$0	$0	$0	$0	$0	$0	$0	$8,639	$1,974,424
CCT - Services	$341,658	$322,842	$1,501,784	$17,425	$0	$0	$23,638	$0	$0	$0	$0	$0	$0	$0	$1,047	$2,208,394
Private Duty Nursing	$2,646,577	$602,061	$49,469,896	$559,463	$0	$0	$40,514	$0	$7,627,485	$192,885	$11,470,454	$0	$0	$0	$0	$72,609,335
Long Term Home Health	$31,647,015	$8,813,402	$157,177,050	$2,237,376	$468,105	$34,319	$2,001,772	$0	$22,807,220	$1,195,443	$13,045,361	$9,226	$0	$0	$0	$239,436,289
Hospice	$37,009,391	$3,642,171	$6,535,276	$273,695	$288,882	$88,848	$3,367,593	$17,689	$139,670	$0	$1,102	$0	$0	$2,599	$0	$51,366,916
Subtotal Community Based Long Term Care	**$237,702,379**	**$50,137,271**	**$399,587,861**	**$5,186,824**	**$1,109,635**	**$165,702**	**$7,150,313**	**$17,689**	**$31,582,679**	**$1,390,480**	**$24,674,345**	**$43,542**	**$0**	**$2,599**	**$889,340**	**$759,640,659**
Long Term Care																
Class I Nursing Facilities	$471,762,532	$48,104,528	$95,971,531	$185,970	$167,980	$15,396	$3,458,057	$0	$0	$0	$5,103	$0	$0	$0	$2,391	$619,673,488
Class II Nursing Facilities	$397,005	$327,830	$3,317,671	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,042,506
Program of All-Inclusive Care for the Elderly	$108,848,065	$13,681,759	$6,481,645	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$129,011,469
Subtotal Long Term Care	**$581,007,602**	**$62,114,117**	**$105,770,847**	**$185,970**	**$167,980**	**$15,396**	**$3,458,057**	**$0**	**$0**	**$0**	**$5,103**	**$0**	**$0**	**$0**	**$2,391**	**$752,727,463**
Insurance																
Supplemental Medicare Insurance Benefit	$83,423,470	$4,864,774	$43,729,393	$0	$273,526	$0	$0	$0	$0	$0	$0	$0	$0	$0	$24,139,700	$156,430,863
Health Insurance Buy-In Program	$11,486	$14,357	$1,406,977	$0	$17,228	$28,714	$25,842	$0	$100,498	$0	$0	$8,614	$0	$0	$0	$1,613,716
Subtotal Insurance	**$83,434,956**	**$4,879,131**	**$45,136,370**	**$0**	**$290,754**	**$28,714**	**$25,842**	**$0**	**$100,498**	**$0**	**$0**	**$8,614**	**$0**	**$0**	**$24,139,700**	**$158,044,579**
Service Management																
Single Entry Points	$8,758,028	$2,502,485	$18,504,336	$200,734	$28,772	$4,015	$171,962	$0	$788,216	$9,368	$223,484	$669	$0	$0	$90,999	$31,283,068
Disease Management	$4,417	$11,155	$76,681	$6,833	$105,014	$45,818	$231,386	$0	$0	$0	$15,397	$40,805	$4,719	$0	$0	$542,225
Prepaid Inpatient Health Plan Administration	$10	$3	$27	$2	$31	$11	$9	$0	$18	$0	$2	$7	$1	$0	$0	$121
Accountable Care Collaborative	$2,537,026	$997,903	$7,402,115	$468,572	$17,348,606	$8,867,763	$34,091,693	$21,262	$57,830,620	$7,572,598	$2,441,964	$1,142,668	$140,521	$1,411	$84,513	$140,949,235
Subtotal Service Management	**$11,299,481**	**$3,511,546**	**$25,983,159**	**$676,141**	**$17,482,423**	**$8,917,607**	**$34,495,050**	**$21,262**	**$58,618,854**	**$7,581,966**	**$2,680,847**	**$1,184,149**	**$145,241**	**$1,411**	**$175,512**	**$172,774,649**
Total Services	**$1,024,813,055**	**$206,753,104**	**$1,114,214,044**	**$41,348,245**	**$494,814,824**	**$220,479,183**	**$1,212,843,252**	**$3,886,375**	**$873,566,053**	**$94,441,946**	**$85,291,278**	**$157,022,591**	**$17,131,991**	**$39,379,164**	**$39,799,073**	**$5,625,784,178**
Financing & Supplemental Payments																
Upper Payment Limit Financing	$1,180,837	$159,293	$772,916	$19,199	$248,355	$100,314	$554,716	$595	$341,619	$36,491	$51,404	$31,516	$2,993	$5,350	$9	$3,505,607
Hospital Supplemental Payments	$17,612,702	$21,281,118	$130,055,992	$10,049,700	$131,387,251	$53,897,863	$399,925,058	$273,370	$193,933,661	$16,123,936	$11,897,959	$64,037,549	$6,966,370	$27,266,164	$9,303	$1,084,717,996
Nursing Facility Supplemental Payments	$76,548,979	$7,805,521	$15,572,502	$30,176	$27,257	$2,498	$561,110	$0	$0	$0	$828	$0	$0	$0	$388	$100,549,259
Physician Supplemental Payments	$108,135	$273,093	$1,877,182	$167,266	$2,570,819	$1,121,643	$5,664,492	$12,019	$5,431,411	$508,656	$376,936	$998,924	$115,534	$143,648	$206	$19,369,964
Outstationing Payments	$33,372	$96,404	$701,991	$56,742	$1,083,973	$441,567	$2,356,287	$2,631	$1,261,348	$149,280	$85,531	$137,623	$13,000	$23,768	$13	$6,443,530
Accounting Adjustments	($177,517)	($39,872)	($213,189)	($8,784)	($101,163)	($44,825)	($252,226)	($768)	($164,545)	($17,945)	($17,725)	($30,322)	($3,289)	($7,512)	($2,915)	($1,082,597)
Subtotal Financing & Supplemental Payments	**$95,306,508**	**$29,575,557**	**$148,767,394**	**$10,314,299**	**$135,216,492**	**$55,519,060**	**$408,809,437**	**$287,847**	**$200,803,494**	**$16,800,418**	**$12,394,933**	**$65,175,290**	**$7,094,608**	**$27,431,418**	**$7,004**	**$1,213,503,759**
Grand Total	**$1,120,119,563**	**$236,328,661**	**$1,262,981,438**	**$51,662,544**	**$630,031,316**	**$275,998,243**	**$1,621,652,689**	**$4,174,222**	**$1,074,369,547**	**$111,242,364**	**$97,686,211**	**$222,197,881**	**$24,226,599**	**$66,810,582**	**$39,806,077**	**$6,839,287,937**

Notes:

FY 2015-16 actuals are from data accessed in CORE on August 29, 2016.

Exhibit M

Cash-based Actuals

FY 2014-15	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	CORE TOTAL
Acute Care																
Physician Services & EPSDT	$3,771,379	$9,916,981	$66,568,043	$4,145,915	$96,815,236	$36,122,366	$178,714,716	$760,690	$183,160,830	$15,332,110	$13,477,087	$38,751,596	$4,459,870	$5,787,709	$15,398	$657,799,926
Emergency Transportation	$859,041	$652,931	$3,535,202	$75,434	$2,228,101	$509,063	$6,735,257	$7,271	$2,391,150	$182,463	$363,597	$496,966	$24,521	$82,366	$173	$18,143,536
Non-emergency Medical Transportation	$2,543,596	$1,373,242	$5,331,563	$80,721	$795,536	$126,277	$2,019,535	$8,978	$1,027,169	$83,737	$179,576	$93,878	$4,516	$1,331	$631	$13,670,286
Dental Services	$7,277,014	$2,546,441	$14,903,405	$758,575	$28,727,629	$11,520,208	$43,374,295	$51,410	$114,622,180	$16,983,497	$5,430,196	$1,912,629	$201,134	$20,395	$583	$248,329,591
Family Planning	$52	$180	$19,952	$626	$395,549	$175,175	$341,353	$3	$288,088	$36,049	$86,284	$67,457	$4,736	$131	$84	$1,415,719
Health Maintenance Organizations	$7,108,104	$11,373,164	$61,991,940	$1,144,978	$67,145,619	$26,786,330	$55,281,494	$34,393	$45,406,382	$4,302,012	$616,786	$11,594,085	$1,309,458	$0	$227	$294,094,972
Inpatient Hospitals	$16,329,588	$21,605,072	$90,638,415	$5,350,867	$58,315,959	$19,150,611	$223,805,633	$304,758	$120,310,553	$4,314,302	$7,112,415	$64,064,967	$6,919,861	$31,426,297	$47,180	$669,696,478
Outpatient Hospitals	$3,003,669	$8,416,364	$58,113,406	$3,370,330	$95,510,977	$33,777,881	$184,439,832	$596,343	$110,939,336	$10,873,795	$7,956,488	$11,677,303	$1,057,636	$2,584,759	$3,245	$532,321,364
Lab & X-Ray	$467,377	$1,257,069	$8,156,132	$427,436	$22,024,217	$7,965,752	$31,345,973	$55,728	$10,683,747	$1,187,801	$1,586,651	$8,254,433	$873,621	$182,391	$368	$94,468,696
Durable Medical Equipment	$21,390,288	$7,246,058	$62,888,128	$1,370,460	$8,143,071	$2,671,295	$19,207,942	$53,121	$19,538,986	$1,602,332	$5,210,831	$437,293	$37,821	$11,844	$65,852	$149,875,322
Prescription Drugs	$6,407,476	$22,030,318	$150,791,230	$6,114,863	$100,895,753	$37,586,190	$205,455,766	$335,916	$98,850,382	$13,583,609	$20,579,392	$6,009,263	$529,786	$4,381	$1,032	$669,175,357
Drug Rebate	($3,075,945)	($10,575,778)	($72,388,174)	($2,935,474)	($48,435,571)	($18,043,461)	($98,630,190)	($161,258)	($47,453,679)	($6,520,888)	($9,879,252)	($2,884,780)	($254,327)	($2,103)	($495)	($321,241,375)
Rural Health Centers	$63,562	$302,285	$1,423,255	$38,923	$3,671,941	$1,453,465	$4,386,258	$5,175	$8,298,508	$743,132	$397,646	$684,350	$41,943	$8,625	$0	$21,519,068
Federally Qualified Health Centers	$852,268	$1,483,941	$8,425,337	$188,228	$19,070,434	$8,513,069	$41,565,591	$76,344	$51,086,040	$4,374,281	$1,753,888	$10,572,023	$932,642	$401,434	$2,208	$149,297,728
Co-Insurance (Title XVIII-Medicare)	$22,130,080	$4,018,646	$15,458,646	$1,043,740	$2,831,367	$47,897	$292,799	$636	$23,576	$1,423	$13,339	$59,100	$753	$4,799	$8,682,997	$54,609,798
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$2,945,501	$0	$0	$0	$0	$0	$0	$0	$2,945,501
Prepaid Inpatient Health Plan Services	$1,241,845	$1,030,356	$11,286,756	$188,092	$11,059,110	$2,505,549	$3,845,321	$0	$8,536,384	$598,839	$1,329,535	$3,204,865	$245,231	$0	$7,038	$45,078,921
Other Medical Services	$622	$521	$3,520	$132	$2,561	$941	$5,082	$27	$3,935	$371	$393	$776	$82	$205	$42	$19,210
Acute Home Health	$5,197,837	$2,805,984	$13,544,480	$242,091	$1,044,220	$332,968	$4,313,995	$12,103	$1,823,849	$266,880	$579,101	$114,469	$13,735	$0	($24,975)	$30,266,737
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$95,567,853**	**$85,483,775**	**$500,691,236**	**$21,605,937**	**$470,241,709**	**$171,201,576**	**$906,500,652**	**$5,087,139**	**$729,537,416**	**$67,945,745**	**$56,793,953**	**$155,110,673**	**$16,403,019**	**$40,514,564**	**$8,801,588**	**$3,331,486,835**
Community Based Long Term Care																
HCBS - Elderly, Blind, and Disabled	$145,776,359	$26,965,601	$120,071,169	$1,393,041	$586,640	$104,830	$1,134,300	$0	$8,292	$0	$261,233	$28,982	$0	$1,154	$823,219	$297,154,820
HCBS - Mental Illness	$5,348,512	$4,296,416	$24,018,634	$36,912	$18,270	$2,852	$126,168	$0	$0	$0	$6,636	$0	$0	$0	$134,993	$33,989,393
HCBS - Disabled Children	$0	$0	$9,909,382	$70,019	$0	$0	$0	$0	$931,511	$953	$138	$0	$0	$0	$0	$10,912,003
HCBS - Persons Living with AIDS	($259)	($21)	($3,297)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($3,577)
HCBS - Consumer Directed Attendant Support	$1,255,189	$233,746	$1,046,065	$11,964	$5,038	$900	$10,152	$0	$71	$0	$2,243	$249	$0	$10	$7,070	$2,572,697
HCBS - Brain Injury	$571,061	$1,568,283	$14,272,888	$53,801	$41,480	$0	$122,805	$0	$0	$0	$0	$0	$0	$0	$18,992	$16,649,310
HCBS - Children with Autism	$0	$0	$666,234	$9,427	$0	$0	$0	$0	$21,721	$0	$12,676	$0	$0	$0	$0	$710,058
HCBS - Pediatric Hospice	$0	$0	$435,310	$1,749	$0	$0	$0	$0	$31,406	$0	$5,209	$0	$0	$0	$0	$473,674
HCBS - Spinal Cord Injury	$168,679	$28,884	$1,541,573	$6,800	$12,052	$0	$1,007	$0	$0	$0	$0	$0	$0	$0	$77	$1,759,072
CCT - Services	$377,824	$251,763	$1,732,716	$0	$0	$0	$47,763	$0	$0	$0	$0	$0	$0	$0	$0	$2,410,066
Private Duty Nursing	$2,110,022	$441,354	$39,608,590	$300,436	$0	$0	$41,377	$0	$7,416,333	$27,251	$11,553,619	$0	$0	$0	$0	$61,498,982
Long Term Home Health	$28,375,632	$9,114,399	$139,389,238	$1,945,982	$310,179	$69,594	$1,335,165	$0	$18,387,951	$725,506	$12,889,124	$6,903	$0	$0	$27,780	$212,577,453
Hospice	$33,254,147	$3,938,226	$6,581,768	$160,754	$330,107	$193,375	$2,912,744	$6,536	$201,612	$2,960	$40,525	$0	$0	$0	$0	$47,622,754
Subtotal Community Based Long Term Care	**$217,237,166**	**$46,838,651**	**$359,270,270**	**$3,990,885**	**$1,303,766**	**$371,551**	**$5,731,481**	**$6,536**	**$26,998,897**	**$756,670**	**$24,771,403**	**$36,134**	**$0**	**$1,164**	**$1,012,131**	**$688,326,705**
Long Term Care																
Class I Nursing Facilities	$450,965,898	$41,239,990	$84,210,839	$82,897	$195,582	$40,448	$2,542,746	$0	$0	$0	$76,579	$0	$0	$0	($25,076)	$579,329,903
Class II Nursing Facilities	$411,017	$455,389	$3,411,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,277,851
Program of All-Inclusive Care for the Elderly	$112,128,644	$14,440,173	$6,335,950	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$132,904,767
Subtotal Long Term Care	**$563,505,559**	**$56,135,552**	**$93,958,234**	**$82,897**	**$195,582**	**$40,448**	**$2,542,746**	**$0**	**$0**	**$0**	**$76,579**	**$0**	**$0**	**$0**	**($25,076)**	**$716,512,521**
Insurance																
Supplemental Medicare Insurance Benefit	$73,205,694	$4,268,933	$38,373,381	$0	$240,024	$0	$0	$0	$0	$0	$0	$0	$0	$0	$21,183,050	$137,271,082
Health Insurance Buy-In Program	$8,989	$11,236	$1,101,111	$0	$13,483	$22,472	$20,224	$0	$78,651	$0	$0	$6,741	$0	$0	$0	$1,262,907
Subtotal Insurance	**$73,214,683**	**$4,280,169**	**$39,474,492**	**$0**	**$253,507**	**$22,472**	**$20,224**	**$0**	**$78,651**	**$0**	**$0**	**$6,741**	**$0**	**$0**	**$21,183,050**	**$138,533,989**
Service Management																
Single Entry Points	$9,072,052	$2,528,512	$18,428,482	$201,793	$44,524	$5,745	$170,913	$0	$1,712,006	$9,336	$315,974	$2,154	$0	$0	$127,826	$32,619,317
Disease Management	$8,232	$21,647	$145,304	$9,050	$211,327	$78,847	$390,096	$0	$0	$0	$29,418	$84,586	$9,735	$0	$0	$988,242
Prepaid Inpatient Health Plan Administration	$131,201	$52,198	$339,287	$15,518	$415,468	$119,209	$229,248	$0	$652,475	$52,903	$83,940	$100,164	$9,170	$0	$705	$2,201,486
Accountable Care Collaborative	$1,548,799	$747,258	$5,551,796	$158,419	$14,847,436	$6,198,632	$19,585,930	$0	$46,840,789	$5,347,941	$1,943,616	$952,332	$111,815	$25,749	$90,254	$103,950,766
Subtotal Service Management	**$10,760,284**	**$3,349,615**	**$24,464,869**	**$384,780**	**$15,518,755**	**$6,402,433**	**$20,376,187**	**$0**	**$49,205,270**	**$5,410,180**	**$2,372,948**	**$1,139,236**	**$130,720**	**$25,749**	**$218,785**	**$139,759,811**
Total Services	**$960,285,545**	**$196,087,762**	**$1,017,859,101**	**$26,064,499**	**$487,513,319**	**$178,038,480**	**$935,171,290**	**$5,093,675**	**$805,820,234**	**$74,112,595**	**$84,014,883**	**$156,292,784**	**$16,533,739**	**$40,541,477**	**$31,190,478**	**$5,014,619,861**
Financing & Supplemental Payments																
Upper Payment Limit Financing	$1,258,632	$161,115	$777,086	$15,459	$276,197	$97,407	$546,766	$1,731	$368,268	$33,548	$57,588	$33,592	$3,050	$7,366	($48)	$3,637,757
Hospital Supplemental Payments	$9,195,746	$14,455,669	$72,396,216	$4,242,802	$76,528,890	$26,374,862	$199,860,824	$450,028	$113,514,255	$7,623,848	$7,431,061	$36,022,112	$3,785,914	$16,050,425	$23,769	$587,956,421
Nursing Facility Supplemental Payments	$72,414,594	$6,622,180	$13,522,294	$13,311	$31,406	$6,495	$408,306	$0	$0	$0	$12,297	$0	$0	$0	($4,027)	$93,026,856
Physician Supplemental Payments	$26,713	$70,243	$471,506	$29,366	$685,748	$255,857	$1,265,848	$5,388	$1,297,340	$108,598	$95,459	$274,480	$31,589	$40,995	$109	$4,659,239
Outstationing Payments	$110,302	$309,069	$2,134,061	$123,767	$3,507,388	$1,240,403	$6,773,065	$21,899	$4,073,954	$399,311	$292,181	$428,818	$38,839	$94,918	$119	$19,548,094
Accounting Adjustments	$1,000,099	$225,772	$1,161,859	$32,635	$586,057	$215,217	$1,168,113	$6,085	$908,238	$84,852	$103,408	$177,135	$18,726	$46,776	$10,593	$5,745,565
Subtotal Financing & Supplemental Payments	**$84,006,086**	**$21,844,048**	**$90,463,022**	**$4,457,340**	**$81,615,686**	**$28,190,241**	**$210,022,922**	**$485,131**	**$120,162,055**	**$8,250,157**	**$7,991,994**	**$36,936,137**	**$3,878,118**	**$16,240,480**	**$30,515**	**$714,573,932**
Grand Total	**$1,044,291,631**	**$217,931,810**	**$1,108,322,123**	**$30,521,839**	**$569,129,005**	**$206,228,721**	**$1,145,194,212**	**$5,578,806**	**$925,982,289**	**$82,362,752**	**$92,006,877**	**$193,228,921**	**$20,411,857**	**$56,781,957**	**$31,220,993**	**$5,729,193,793**

Note:

1. Effective February 2016, the Department has restated actuals between categories (MAGI Parents/Caretakers to 68% FPL, MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults, Breast & Cervical Cancer Program, Eligible Children (AFDC-C/BC), and SB 11-008 Eligible Children) to account for an error in the distribution of clients between these categories. These adjustments affect FY 2013-14 and FY 2014-15, and are from data accessed in CORE on January 18, 2016.

Exhibit M

Cash-based Actuals

FY 2013-14	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	COFRS TOTAL
Acute Care																
Physician Services & EPSDT	$4,043,358	$9,764,022	$65,059,985	$4,447,494	$79,412,236	$22,746,644	$62,764,565	$0	$140,644,229	$6,564,319	$11,140,179	$32,892,756	$2,259,530	$5,996,669	$6,241	$447,742,226
Emergency Transportation	$122,767	$386,959	$2,292,281	$74,609	$1,688,406	$377,423	$2,529,108	$0	$1,836,694	$93,391	$217,731	$418,912	$12,129	$74,649	$793	$10,125,852
Non-emergency Medical Transportation	$2,801,468	$1,681,808	$6,714,864	$104,987	$787,858	$134,029	$884,418	$0	$1,309,873	$16,599	$186,648	$108,329	$158	$1,171	$2,733	$14,734,943
Dental Services	$1,794,852	$558,246	$6,514,545	$182,628	$9,153,795	$2,701,535	$7,009,072	$0	$104,015,935	$8,645,646	$5,427,900	$753,139	$37,893	$6,551	$2,203	$146,803,940
Family Planning	$171	$148	$21,457	$519	$324,023	$120,585	$108,540	$0	$235,217	$14,840	$87,920	$40,664	$4,492	$0	$0	$958,576
Health Maintenance Organizations	$5,677,843	$8,172,001	$42,251,264	$413,617	$24,329,657	$7,208,136	$990,043	$0	$41,097,777	$2,040,162	$842,135	$2,689,951	$177,153	$0	$983	$135,890,722
Inpatient Hospitals	$12,214,429	$15,459,639	$100,723,524	$9,865,184	$53,019,260	$14,695,913	$82,271,168	$0	$97,275,901	$2,780,149	$5,454,304	$50,721,950	$3,936,967	$29,904,181	($11,278)	$478,311,291
Outpatient Hospitals	$4,073,018	$8,674,477	$63,033,295	$4,581,825	$83,219,305	$28,408,884	$80,209,873	$0	$96,213,635	$7,383,654	$6,710,556	$11,883,976	$768,457	$1,990,324	$18,275	$397,169,554
Lab & X-Ray	$561,228	$1,308,244	$8,043,314	$412,716	$19,064,302	$5,597,136	$12,668,155	$0	$8,096,984	$571,527	$1,363,487	$6,338,685	$504,049	$154,559	$389	$64,684,775
Durable Medical Equipment	$19,993,666	$6,603,977	$58,381,851	$1,146,426	$6,130,253	$1,697,299	$6,071,020	$0	$13,761,168	$735,697	$4,764,199	$320,245	$14,406	$191	$41,277	$119,661,675
Prescription Drugs	$7,635,879	$20,390,022	$140,653,748	$5,070,325	$74,904,567	$23,282,207	$70,931,016	$0	$78,800,106	$7,972,434	$18,780,213	$4,407,498	$343,428	$0	$19,995	$453,191,438
Drug Rebate	($3,290,157)	($8,785,678)	($60,605,064)	($2,184,708)	($32,274,974)	($10,031,867)	($30,562,845)	$0	($33,953,490)	($3,435,172)	($8,092,042)	($1,899,108)	($147,977)	$0	($8,616)	($195,271,698)
Rural Health Centers	$76,264	$269,623	$1,260,474	$49,323	$2,842,709	$927,828	$1,552,329	$0	$6,617,012	$383,462	$338,606	$465,767	$32,629	$9,802	$68	$14,825,896
Federally Qualified Health Centers	$1,026,219	$1,398,281	$8,662,577	$258,811	$17,770,985	$6,072,398	$19,765,328	$0	$58,131,185	$3,251,501	$1,880,042	$8,924,580	$590,478	$373,196	$1,908	$128,107,489
Co-Insurance (Title XVIII-Medicare)	$22,734,911	$3,929,241	$16,405,226	$756,407	$1,713,377	$564,799	$277,023	$0	$24,448	$382	$6,921	$51,243	$1,476	$0	$8,438,925	$54,904,379
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$8,879,647	$0	$0	$0	$0	$0	$0	$0	$8,879,647
Prepaid Inpatient Health Plan Services	$1,461,833	$2,659,699	$15,888,654	$598,122	$14,862,251	$3,626,623	$888,577	$0	$12,689,674	$196,781	$1,928,356	$4,018,370	$110,765	$0	$2,858	$58,932,563
Other Medical Services	$849	$686	$5,161	$227	$2,945	$903	$2,768	$68	$5,157	$312	$548	$939	$68	$304	$56	$20,991
Acute Home Health	$4,746,512	$2,312,870	$10,990,172	$264,529	$785,606	$221,450	$1,429,996	($2,446)	$1,076,709	$96,886	$661,112	$86,583	$2,691	$0	$147,321	$22,819,991
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$85,675,110**	**$74,784,265**	**$486,297,328**	**$26,043,041**	**$357,736,561**	**$108,351,925**	**$319,790,154**	**$8,877,269**	**$627,878,215**	**$37,312,569**	**$51,698,815**	**$122,224,478**	**$8,648,792**	**$38,511,597**	**$8,664,131**	**$2,362,494,250**
Community Based Long Term Care																
HCBS - Elderly, Blind, and Disabled	$137,529,774	$24,219,087	$115,680,698	$724,923	$186,239	$29,760	$263,750	$0	$1,630	$0	$148,720	$0	$0	$0	$738,607	$279,523,188
HCBS - Mental Illness	$4,841,365	$4,065,194	$22,793,556	$33,366	$4,185	$40	$54,018	$0	$0	$0	$649	$35	$0	$0	$126,821	$31,919,229
HCBS - Disabled Children	$0	$0	$7,856,110	$17	$0	$0	$0	$0	$245,654	$0	$0	$0	$0	$0	$0	$8,101,781
HCBS - Persons Living with AIDS	$9,821	$813	$125,099	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$135,733
HCBS - Consumer Directed Attendant Support	$1,147,005	$201,988	$964,783	$6,046	$1,553	$248	$2,200	$0	$14	$0	$1,240	$0	$0	$0	$6,160	$2,331,237
HCBS - Brain Injury	$412,822	$1,254,551	$12,464,998	$4,821	$12,089	$0	$18,321	$0	$0	$0	$0	$0	$0	$0	$16,475	$14,184,077
HCBS - Children with Autism	$0	$0	$733,096	$2,563	$0	$0	$0	$0	$13,349	$0	$15,294	$0	$0	$0	$0	$764,302
HCBS - Pediatric Hospice	$0	$0	$214,922	$0	$0	$0	$0	$0	$3,510	$0	$3,200	$0	$0	$0	$0	$221,632
HCBS - Spinal Cord Injury	$214,216	$19,446	$1,537,988	$0	$1,105	$0	$817	$0	$0	$0	$0	$0	$0	$0	$0	$1,773,572
CCT - Services	$0	$0	$0		$0	$0		$0	$0		$0	$0		$0	$0	$0
Private Duty Nursing	$3,039,698	$734,755	$35,345,893	$280,781	$0	$0	$43,544	$0	$3,373,711	$400	$10,310,507	$0	$0	$0	$25,614	$53,154,903
Long Term Home Health	$26,251,582	$8,030,921	$130,369,940	$1,316,824	$235,386	$18,678	$172,588	$2,446	$7,825,402	$244,287	$11,792,931	$1,213	$0	$0	$252,997	$186,515,195
Hospice	$31,935,985	$3,814,200	$7,418,711	$344,667	$158,722	$144,242	$1,024,926	$0	$149,582	$0	$0	$0	$0	$0	$26,219	$45,017,254
Subtotal Community Based Long Term Care	**$205,382,268**	**$42,340,955**	**$335,505,794**	**$2,714,008**	**$599,279**	**$192,968**	**$1,580,164**	**$2,446**	**$11,612,852**	**$244,687**	**$22,272,541**	**$1,248**	**$0**	**$0**	**$1,192,893**	**$623,642,103**
Long Term Care																
Class I Nursing Facilities	$440,587,143	$38,148,380	$81,720,674	$387,966	$125,945	$0	$570,397	$0	$0	$0	$0	$0	$0	$0	$784,886	$562,325,391
Class II Nursing Facilities	$393,954	$298,879	$2,748,163	$0	$0	$0	$43,770	$0	$0	$0	$0	$0	$0	$0	$0	$3,484,766
Program of All-Inclusive Care for the Elderly	$85,832,165	$10,249,500	$4,393,152	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$100,474,817
Subtotal Long Term Care	**$526,813,262**	**$48,696,759**	**$88,861,989**	**$387,966**	**$125,945**	**$0**	**$614,167**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$784,886**	**$666,284,974**
Insurance																
Supplemental Medicare Insurance Benefit	$68,884,741	$4,016,960	$36,108,399	$0	$225,857	$0	$0	$0	$0	$0	$0	$0	$0	$0	$19,932,724	$129,168,681
Health Insurance Buy-In Program	$11,744	$20,552	$1,215,523	$0	$26,425	$0	$0	$0	$60,491	$0	$21,718	$8,808	$0	$0	$0	$1,365,261
Subtotal Insurance	**$68,896,485**	**$4,037,512**	**$37,323,922**	**$0**	**$252,282**	**$0**	**$0**	**$0**	**$60,491**	**$0**	**$21,718**	**$8,808**	**$0**	**$0**	**$19,932,724**	**$130,533,942**
Service Management																
Single Entry Points	$7,836,051	$2,131,642	$15,256,301	$107,844	$14,555	$3,169	$35,876	$376	$1,156,908	$0	$248,772	$161	$0	$0	$107,361	$26,899,016
Disease Management	$7,234	$17,469	$116,400	$7,957	$142,079	$40,697	$112,294	$0	$0	$0	$19,931	$62,892	$0	$0	$0	$526,953
Prepaid Inpatient Health Plan Administration	$521,003	$251,547	$1,474,302	$43,729	$1,553,848	$424,799	$88,292	$0	$2,691,223	$43,733	$263,625	$262,766	$8,772	$0	$2,499	$7,630,138
Accountable Care Collaborative	$547,729	$468,561	$4,052,232	$88,828	$10,681,279	$3,955,017	$6,302,817	$0	$38,151,110	$1,949,462	$1,594,103	$714,315	$40,255	$842	$23,780	$68,570,330
Subtotal Service Management	**$8,912,017**	**$2,869,219**	**$20,899,235**	**$248,358**	**$12,391,761**	**$4,423,682**	**$6,539,279**	**$376**	**$41,999,241**	**$1,993,195**	**$2,126,431**	**$1,040,134**	**$49,027**	**$842**	**$133,640**	**$103,626,437**
Total Services	**$895,679,142**	**$172,728,710**	**$968,888,268**	**$29,393,373**	**$371,105,828**	**$112,968,575**	**$328,523,764**	**$8,880,091**	**$681,550,799**	**$39,550,451**	**$76,119,505**	**$123,274,668**	**$8,697,819**	**$38,512,439**	**$30,708,274**	**$3,886,581,706**
Financing & Supplemental Payments																
Upper Payment Limit Financing	$2,285,513	$275,715	$1,380,129	$32,126	$417,977	$141,962	$407,973	$0	$519,465	$38,175	$92,728	$59,326	$3,821	$9,866	$5,774	$5,670,550
Hospital Supplemental Payments	$11,507,426	$17,112,897	$116,213,340	$10,229,747	$97,403,214	$30,866,151	$115,720,548	$0	$137,873,040	$7,242,327	$8,680,400	$44,141,616	$3,317,657	$22,394,362	$5,329	$622,708,054
Nursing Facility Supplemental Payments	$70,338,750	$6,090,303	$13,046,522	$61,938	$20,107	$0	$91,063	$0	$0	$0	$0	$0	$0	$0	$125,305	$89,773,988
Physician Supplemental Payments	$50,744	$122,537	$816,497	$55,816	$996,616	$285,468	$787,689	$0	$1,765,072	$82,382	$139,808	$412,801	$28,357	$75,258	$78	$5,619,123
Outstationing Payments	$65,720	$139,967	$1,017,072	$73,930	$1,342,783	$458,391	$1,294,224	$0	$1,552,452	$119,139	$108,278	$191,754	$12,399	$32,115	$295	$6,408,519
Accounting Adjustments	$436,709	$90,753	$505,639	$16,283	$198,896	$61,001	$187,748	$4,585	$350,522	$20,341	$42,577	$63,459	$4,477	$20,535	$4,735	$2,008,260
Subtotal Financing & Supplemental Payments	**$84,684,862**	**$23,832,172**	**$132,979,199**	**$10,469,840**	**$100,379,593**	**$31,812,973**	**$118,489,245**	**$4,585**	**$142,060,551**	**$7,502,364**	**$9,063,791**	**$44,868,956**	**$3,366,711**	**$22,532,136**	**$141,516**	**$732,188,494**
Grand Total	**$980,364,004**	**$196,560,882**	**$1,101,867,467**	**$39,863,213**	**$471,485,421**	**$144,781,548**	**$447,013,009**	**$8,884,676**	**$823,611,350**	**$47,052,815**	**$85,183,296**	**$168,143,624**	**$12,064,530**	**$61,044,575**	**$30,849,790**	**$4,618,770,200**

Note:

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

Cash-based Actuals																
FY 2012-13	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care																
Physician Services & EPSDT	$3,733,246	$7,649,554	$55,946,660	$2,017,690	$65,332,114	$18,077,268	$9,578,088	$0	$113,235,322	$2,820,853	$9,766,797	$16,755,632	$750,233	$5,679,532	$1,154	$311,344,143
Emergency Transportation	$124,218	$323,127	$2,163,425	$32,160	$1,485,643	$369,950	$641,885	$0	$1,637,796	$26,420	$187,373	$167,195	$8,312	$106,156	$0	$7,273,660
Non-emergency Medical Transportation	$2,046,589	$978,360	$4,716,005	$41,726	$433,180	$97,299	$194,838	$0	$914,535	$3,640	$102,262	$47,670	$334	$188	$129	$9,576,755
Dental Services	$1,392,227	$396,231	$5,433,896	$53,656	$5,859,871	$1,742,902	$662,572	$0	$92,806,672	$2,680,354	$5,018,241	$309,878	$16,150	$13,185	$203	$116,386,038
Family Planning	$30	$103	$22,595	$693	$263,357	$91,428	$11,356	$0	$192,173	$7,719	$77,522	$30,742	$1,502	$0	$0	$699,220
Health Maintenance Organizations	$5,627,161	$7,554,375	$40,140,958	$244,617	$23,044,932	$8,493,510	$0	$0	$38,756,103	$544,994	$785,911	$1,295,209	$43,813	$0	$0	$126,531,583
Inpatient Hospitals	$15,837,813	$18,086,253	$113,024,520	$3,818,807	$68,007,485	$13,393,053	$15,941,298	$0	$85,415,409	$2,638,015	$5,291,669	$28,564,111	$1,274,916	$35,472,048	$19,522	$406,784,919
Outpatient Hospitals	$3,353,219	$7,133,724	$57,838,186	$2,506,283	$71,204,056	$22,620,079	$14,655,972	$0	$85,203,477	$2,151,345	$5,978,631	$6,306,950	$276,268	$1,919,513	$302	$281,148,005
Lab & X-Ray	$488,758	$1,018,642	$7,339,265	$205,214	$16,311,375	$4,656,054	$1,995,854	$0	$7,258,518	$467,903	$1,468,092	$4,130,559	$161,187	$151,951	$13	$45,653,385
Durable Medical Equipment	$19,066,652	$6,220,600	$54,238,022	$369,556	$4,767,095	$1,520,743	$1,349,129	$0	$10,732,598	$160,536	$4,520,423	$142,596	$6,366	$3,137	$28,801	$103,126,254
Prescription Drugs	$6,719,553	$18,246,448	$126,656,626	$2,095,797	$58,302,300	$21,010,283	$12,450,869	$0	$65,383,399	$2,300,381	$18,488,514	$2,447,209	$102,473	$0	$262	$334,204,114
Drug Rebate	($3,599,458)	($9,774,062)	($67,846,065)	($1,122,654)	($31,230,752)	($11,254,563)	($6,669,548)	$0	($35,023,879)	($1,232,243)	($9,903,729)	($1,310,895)	($54,892)	$0	($140)	($179,022,880)
Rural Health Centers	$68,840	$302,964	$1,310,864	$32,728	$2,371,639	$886,068	$187,860	$0	$6,447,858	$122,104	$296,822	$294,754	$14,997	$7,574	$521	$12,345,593
Federally Qualified Health Centers	$944,509	$1,199,727	$8,478,727	$140,279	$16,982,037	$4,871,971	$4,036,338	$0	$54,024,086	$1,245,246	$1,894,311	$5,363,217	$207,877	$402,879	$0	$99,791,204
Co-Insurance (Title XVIII-Medicare)	$17,569,039	$3,024,606	$12,446,112	$274,031	$537,695	$888,995	$8,564	$0	$13,711	$1,394	$3,037	$34,811	$375	$112	$6,036,730	$40,839,212
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$9,559,144	$0	$0	$0	$0	$0	$0	$0	$9,559,144
Prepaid Inpatient Health Plan Services	$1,059,766	$1,577,317	$9,663,961	$647,691	$12,557,982	$4,456,972	$0	$0	$21,163,282	$158,949	$1,869,895	$4,464,891	$34,808	$0	$0	$57,655,514
Other Medical Services	$752	$599	$4,562	$92	$2,518	$741	$467	$72	$4,354	$0	$486	$517	$0	$327	$45	$15,532
Acute Home Health	$4,372,425	$1,944,403	$9,888,976	$79,789	$600,900	$172,799	$224,892	($840)	$555,960	$47,028	$669,278	$44,098	$1,587	$0	$124,081	$18,725,376
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,075,000	$0	$0	$0	$3,075,000
Subtotal of Acute Care	**$78,805,339**	**$65,882,971**	**$441,467,295**	**$11,438,155**	**$316,833,427**	**$92,095,552**	**$55,270,434**	**$9,558,376**	**$548,721,374**	**$14,144,638**	**$46,515,535**	**$72,164,144**	**$2,846,306**	**$43,756,602**	**$6,211,623**	**$1,805,711,771**
Community Based Long-Term Care																
HCBS - Elderly, Blind, and Disabled	$119,755,823	$19,994,030	$102,379,886	$47,026	$14,857	$39,338	$5,289	$0	$0	$0	$57,950	$0	$0	$0	$200,361	$242,494,560
HCBS - Mental Illness	$3,978,510	$3,706,685	$20,590,876	$0	$1,936	$0	$2,399	$0	$0	$0	$10,306	$0	$0	$0	$18,700	$28,309,412
HCBS - Disabled Children	$0	$0	$5,350,385	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,350,385
HCBS - Persons Living with AIDS	$30,653	$8,994	$441,281	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$480,928
HCBS - Consumer Directed Attendant Support	$1,314,616	$219,484	$1,123,872	$516	$163	$432	$58	$0	$0	$0	$636	$0	$0	$0	$2,200	$2,661,977
HCBS - Brain Injury	$274,983	$899,956	$11,674,531	$0	$0	$0	$0	$0	$0	$0	$212	$0	$0	$0	$0	$12,849,682
HCBS - Children with Autism	$0	$0	$868,411	$0	$0	$0	$0	$0	$17,013	$0	$0	$0	$0	$0	$0	$885,424
HCBS - Pediatric Hospice	$0	$0	$207,061	$0	$0	$0	$0	$0	$0	$0	$70	$0	$0	$0	$0	$207,131
HCBS - Spinal Cord Injury	$6,686	$0	$245,823	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$252,509
CCT - Services	$0	$0	$0		$0	$0		$0	$0		$0	$0		$0	$0	$0
Private Duty Nursing	$2,364,123	$557,116	$24,342,047	$18,478	$0	$0	$0	$0	$1,069,272	$5,806	$8,490,119	$0	$0	$0	$0	$36,846,961
Long Term Home Health	$21,401,061	$7,062,994	$115,530,465	$368,744	$151,443	$4,862	$0	$840	$3,609,745	$0	$10,404,821	$1,690	$0	$0	$93,867	$158,630,532
Hospice	$33,427,166	$2,868,294	$6,505,178	$140,227	$168,345	$92,875	$117,103	$0	$37,390	$0	$0	$0	$0	$0	$40,522	$43,397,100
Subtotal Community Based Long-Term Care	**$182,553,621**	**$35,317,553**	**$289,259,816**	**$574,991**	**$336,744**	**$137,507**	**$124,849**	**$840**	**$4,733,420**	**$5,806**	**$18,964,114**	**$1,690**	**$0**	**$0**	**$355,650**	**$532,366,601**
Long-Term Care																
Class I Nursing Facilities	$418,131,480	$35,559,417	$78,452,737	$0	$0	$0	$12,430	$0	$0	$0	$0	$0	$0	$0	$249,186	$532,405,250
Class II Nursing Facilities	$180,939	$825,327	$4,101,296	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,107,562
Program of All-Inclusive Care for the Elderly	$84,386,436	$8,794,508	$4,165,414	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$97,346,358
Subtotal Long-Term Care	**$502,698,855**	**$45,179,252**	**$86,719,447**	**$0**	**$0**	**$0**	**$12,430**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$249,186**	**$634,859,170**
Insurance																
Supplemental Medicare Insurance Benefit	$63,920,416	$3,727,469	$33,506,170	$0	$209,579	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,496,230	$119,859,864
Health Insurance Buy-In Program	$2,767	$1,630	$1,345,692	$0	$6,506	$0	$0	$0	$3,632	$0	$1,304	$0	$0	$0	$0	$1,361,531
Subtotal Insurance	**$63,923,183**	**$3,729,099**	**$34,851,862**	**$0**	**$216,085**	**$0**	**$0**	**$0**	**$3,632**	**$0**	**$1,304**	**$0**	**$0**	**$0**	**$18,496,230**	**$121,221,395**
Service Management																
Single Entry Points	$11,133,931	$2,768,715	$11,274,336	$8,561	$1,712	$5,993	$0	$856	$1,443,430	$0	$285,947	$0	$0	$0	$53,080	$26,976,561
Disease Management	$18,845	$38,614	$282,411	$10,185	$329,787	$91,251	$48,349	$0	$0	$0	$49,301	$88,367	$0	$0	$0	$957,110
Prepaid Inpatient Health Plan Administration	$314,516	$102,047	$728,309	$10,723	$1,049,127	$425,319	$0	$0	$3,699,162	$27,783	$246,713	$80,747	$629	$0	$0	$6,685,075
Accountable Care Collaborative	$576,537	$452,652	$3,916,914	$19,706	$9,740,443	$4,141,282	$1,856,177	$0	$13,291,533	$887,610	$1,388,883	$429,730	$22,052	$518	$4,894	$36,728,931
Subtotal Service Management	**$12,043,829**	**$3,362,028**	**$16,201,970**	**$49,175**	**$11,121,069**	**$4,663,845**	**$1,904,526**	**$856**	**$18,434,125**	**$915,393**	**$1,970,844**	**$598,844**	**$22,681**	**$518**	**$57,974**	**$71,347,677**
Total Services	**$840,024,827**	**$153,470,903**	**$868,500,390**	**$12,062,321**	**$328,507,325**	**$96,896,904**	**$57,312,239**	**$9,560,072**	**$571,892,551**	**$15,065,837**	**$67,451,797**	**$72,764,678**	**$2,868,987**	**$43,757,120**	**$25,370,663**	**$3,165,506,614**
Financing and Supplemental Payments																
Upper Payment Limit Financing	$2,595,353	$301,488	$1,530,078	$17,718	$433,958	$137,505	$89,799	$0	$551,431	$0	$100,170	$39,993	$0	$11,581	$2,709	$5,811,783
Hospital Supplemental Payments	$17,975,042	$23,731,862	$161,163,996	$5,980,773	$132,279,730	$34,389,153	$29,033,679	$0	$166,578,858	$0	$10,717,741	$34,123,275	$0	$34,836,430	$18,440	$650,828,979
Nursing Facility Supplemental Payments	$66,564,067	$5,660,850	$12,489,213	$0	$0	$0	$1,979	$0	$0	$0	$0	$0	$0	$0	$39,669	$84,755,778
Physician Supplemental Payments	$161,698	$331,324	$2,423,211	$87,392	$2,829,723	$782,979	$414,855	$0	$5,026,728	$0	$423,028	$758,230	$0	$245,997	$50	$13,485,215
Outstationing Payments	$183,823	$391,070	$3,170,686	$137,394	$3,903,403	$1,240,032	$803,440	$0	$4,788,787	$0	$327,748	$360,892	$0	$105,228	$17	$15,412,520
Accounting Adjustments	$395,443	$79,505	$451,107	$6,504	$174,992	$51,549	$32,482	$5,040	$297,169	$5,883	$38,144	$34,940	$949	$22,723	$3,415	$1,599,845
Subtotal Financing and Supplemental Payments	**$87,875,426**	**$30,496,099**	**$181,228,291**	**$6,229,781**	**$139,621,806**	**$36,601,218**	**$30,376,234**	**$5,040**	**$177,242,973**	**$5,883**	**$11,606,831**	**$35,317,330**	**$949**	**$35,221,959**	**$64,300**	**$771,894,120**
Grand Total	**$927,900,253**	**$183,967,002**	**$1,049,728,681**	**$18,292,102**	**$468,129,131**	**$133,498,122**	**$87,688,473**	**$9,565,112**	**$749,135,524**	**$15,071,720**	**$79,058,628**	**$108,082,008**	**$2,869,936**	**$78,979,079**	**$25,434,963**	**$3,937,400,734**

Cash-based Actuals														
FY 2011-12	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care														
Physician Services & EPSDT	$3,496,026	$7,111,322	$54,312,685	$65,386	$64,061,263	$16,729,289	$254,561	$0	$108,220,089	$10,282,293	$16,641,874	$5,841,664	$3,787	$287,020,239
Emergency Transportation	$127,388	$284,073	$2,131,467	$133	$1,416,682	$326,160	$26,001	$0	$1,599,438	$194,707	$167,590	$87,424	($5)	$6,361,058
Non-emergency Medical Transportation	$2,170,701	$1,007,841	$5,235,088	$443	$509,852	$130,804	$1,752	$0	$1,217,489	$131,419	$55,775	$1,230	($228)	$10,462,166
Dental Services	$1,227,623	$328,572	$5,016,624	$1,339	$5,415,654	$1,489,789	$36,007	$0	$85,091,328	$4,962,709	$336,789	$5,353	$0	$103,911,787
Family Planning	$0	$168	$16,872	$94	$239,510	$88,899	$1,072	$0	$157,184	$52,601	$22,557	$0	$0	$578,957
Health Maintenance Organizations	$6,436,982	$6,682,350	$39,413,533	$6,100	$22,554,171	$7,791,492	$0	$0	$35,919,341	$845,047	$1,066,895	$0	$0	$120,715,911
Inpatient Hospitals	$13,661,835	$15,340,090	$114,582,636	$177,773	$63,034,133	$12,964,966	$891,142	$0	$76,041,187	$4,890,304	$26,947,586	$33,984,087	($13,122)	$362,502,617
Outpatient Hospitals	$2,955,034	$6,281,086	$52,781,917	$73,670	$64,165,414	$19,539,773	$570,577	$0	$73,411,714	$5,760,929	$5,461,418	$1,478,314	$0	$232,479,846
Lab & X-Ray	$459,363	$872,743	$6,962,429	$4,882	$14,880,312	$3,943,322	$72,092	$0	$7,263,261	$1,727,639	$3,649,035	$142,603	$322	$39,978,003
Durable Medical Equipment	$18,449,168	$5,367,881	$50,025,626	$5,509	$4,189,111	$1,297,015	$19,968	$0	$9,835,195	$4,337,018	$159,994	$0	$19,967	$93,706,452
Prescription Drugs	$6,894,276	$18,586,340	$132,005,966	$66,035	$56,328,543	$17,910,509	$486,584	$0	$63,118,535	$21,082,476	$2,262,197	$0	$0	$318,741,461
Drug Rebate	($3,239,849)	($8,734,338)	($62,033,986)	($31,032)	($26,470,652)	($8,416,743)	($228,662)	$0	($29,661,495)	($9,907,355)	($1,063,081)	$0	$0	($149,787,193)
Rural Health Centers	$59,913	$297,322	$1,232,984	$272	$2,175,921	$650,762	$8,863	$0	$5,497,429	$310,962	$310,347	$23,141	$0	$10,567,916
Federally Qualified Health Centers	$945,395	$1,068,432	$8,305,722	$7,949	$17,414,509	$4,922,023	$252,682	$0	$54,487,052	$1,927,134	$5,087,649	$371,769	$167	$94,790,483
Co-Insurance (Title XVIII-Medicare)	$16,681,939	$2,722,367	$11,215,656	$5,057	$461,993	$629,323	$0	$0	$26,223	$17,454	$41,240	$1,973	$5,233,327	$37,036,552
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$10,272,613	$0	$0	$0	$0	$0	$10,272,613
Prepaid Inpatient Health Plan Services	$1,808,943	$2,331,859	$18,074,087	$14,849	$10,256,623	$2,867,598	$0	$0	$16,657,333	$2,332,229	$2,119,598	$0	$0	$56,463,119
Other Medical Services	$766	$590	$4,856	$3	$2,573	$718	$21	$84	$4,256	$543	$504	$339	$42	$15,295
Acute Home Health	$3,019,688	$1,501,229	$4,482,470	$0	$468,586	$133,222	$490	($205)	$468,010	$227,440	$49,661	$268	$35,453	$10,386,312
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$75,155,191**	**$61,049,927**	**$443,766,632**	**$398,462**	**$301,104,198**	**$82,998,921**	**$2,393,150**	**$10,272,492**	**$509,353,569**	**$49,175,549**	**$63,317,628**	**$41,938,165**	**$5,279,710**	**$1,646,203,594**
Community Based Long-Term Care														
HCBS - Elderly, Blind, and Disabled	$112,080,401	$18,862,257	$93,931,903	$0	$2,834	$17,029	$0	$0	$0	$69,862	$0	$0	$221,425	$225,185,711
HCBS - Mental Illness	$3,683,462	$3,266,023	$18,943,039	$0	$507	$3,220	$0	$0	$0	$10,762	$0	$0	$27,242	$25,934,255
HCBS - Disabled Children	$0	$0	$3,129,357	$0	$0	$0	$0	$0	$716	$0	$0	$0	$0	$3,130,073
HCBS - Persons Living with AIDS	$27,143	($1,798)	$482,666	$0	$0	$0	$0	$0	$0	$0	$0	$0	$8,025	$516,036
HCBS - Consumer Directed Attendant Support	$1,722,964	$289,961	$1,443,974	$0	$44	$262	$0	$0	$0	$1,074	$0	$0	$3,404	$3,461,683
HCBS - Brain Injury	$165,215	$851,608	$11,535,816	$0	$5,163	$0	$0	$0	$0	$29,164	$0	$0	$165	$12,587,131
HCBS - Children with Autism	$0	$0	$1,015,699	$0	$0	$0	$0	$0	$6,688	$0	$0	$0	$0	$1,022,387
HCBS - Pediatric Hospice	$0	$0	$170,418	$0	$0	$0	$0	$0	$0	$492	$0	$0	$0	$170,910
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CCT - Services	$0	$0	$0		$0	$0		$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$1,832,636	$135,105	$20,720,340	$0	$0	$0	$0	$0	$601,939	$7,854,133	$0	$0	$0	$31,144,153
Long Term Home Health	$19,241,801	$5,960,470	$112,026,204	$0	$70,804	$21,256	$0	$205	$3,621,831	$10,150,245	$374	$0	$128,231	$151,221,421
Hospice	$32,103,872	$2,846,601	$6,969,248	$15,185	$114,106	$67,245	$4,370	$0	$116,333	$1,215	$1,787	$0	$86,846	$42,326,808
Subtotal Community Based Long-Term Care	**$170,857,494**	**$32,210,227**	**$270,368,664**	**$15,185**	**$193,458**	**$109,012**	**$4,370**	**$205**	**$4,347,507**	**$18,116,947**	**$2,161**	**$0**	**$475,338**	**$496,700,568**
Long-Term Care														
Class I Nursing Facilities	$411,201,009	$33,559,826	$76,088,316	$0	$0	$0	$0	$0	$0	$0	$0	$0	$395,618	$521,244,769
Class II Nursing Facilities	$0	$583,751	$1,915,323	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,499,074
Program of All-Inclusive Care for the Elderly	$73,671,387	$8,052,921	$3,756,277	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$85,480,585
Subtotal Long-Term Care	**$484,872,396**	**$42,196,498**	**$81,759,916**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$395,618**	**$609,224,428**
Insurance														
Supplemental Medicare Insurance Benefit	$63,201,668	$3,688,256	$33,153,682	$46,299	$207,374	$0	$0	$0	$0	$0	$0	$0	$18,301,648	$118,598,927
Health Insurance Buy-In Program	$2,162	$6,655	$1,122,186	$0	$9,727	$0	$0	$0	$12,996	$2,223	$3,358	$0	$0	$1,159,307
Subtotal Insurance	**$63,203,830**	**$3,694,911**	**$34,275,868**	**$46,299**	**$217,101**	**$0**	**$0**	**$0**	**$12,996**	**$2,223**	**$3,358**	**$0**	**$18,301,648**	**$119,758,234**
Service Management														
Single Entry Points	$11,748,349	$2,505,790	$10,910,528	$0	$5,343	$1,263	$0	$0	$1,749	$8,355	$0	$0	$45,369	$25,226,746
Disease Management	$51,573	$36,611	$303,654	$218	$164,545	$45,358	$1,307	$5,612	$280,261	$32,412	$34,593	$22,913	$2,955	$982,012
Prepaid Inpatient Health Plan Administration	$514,348	$183,069	$1,118,391	$1,094	$1,332,529	$526,053	$0	$0	$4,776,807	$325,880	$113,177	$0	$0	$8,891,348
Accountable Care Collaborative	$345,078	$256,950	$2,052,795	$377	$5,690,110	$2,269,608	$79,568	$0	$6,360,605	$576,072	$275,408	$107	$1,155	$17,907,833
Subtotal Service Management	**$12,659,348**	**$2,982,420**	**$14,385,368**	**$1,689**	**$7,192,527**	**$2,842,282**	**$80,875**	**$5,612**	**$11,419,422**	**$942,719**	**$423,178**	**$23,020**	**$49,479**	**$53,007,939**
Total Services	**$806,748,259**	**$142,133,983**	**$844,556,448**	**$461,635**	**$308,707,284**	**$85,950,215**	**$2,478,395**	**$10,278,309**	**$525,133,494**	**$68,237,438**	**$63,746,325**	**$41,961,185**	**$24,501,793**	**$2,924,894,763**
Financing and Supplemental Payments														
Upper Payment Limit Financing	$3,006,644	$328,259	$1,725,903	$520	$457,096	$139,126	$4,034	$0	$547,701	$114,617	$38,935	$10,444	$3,886	$6,377,165
Hospital Supplemental Payments	$17,049,970	$22,262,870	$172,465,286	$258,926	$131,847,819	$33,793,401	$1,509,784	$0	$154,850,875	$11,052,910	$33,244,021	$36,231,786	($13,389)	$614,554,259
Nursing Facility Supplemental Payments	$68,465,150	$5,587,726	$12,668,738	$0	$0	$0	$0	$0	$0	$0	$0	$0	$65,871	$86,787,485
Physician Supplemental Payments	$60,715	$123,502	$943,247	$1,136	$1,112,553	$290,538	$4,421	$0	$1,879,459	$178,573	$289,020	$101,452	$66	$4,984,682
Outstationing Payments	$18,395	$39,101	$328,574	$459	$399,437	$121,637	$3,552	$0	$456,997	$35,862	$33,998	$9,203	$0	$1,447,215
Accounting Adjustments	$763,823	$147,724	$878,727	$451	$337,808	$94,928	$2,831	$9,629	$556,699	$78,990	$65,448	$43,897	$6,238	$2,987,193
Subtotal Financing and Supplemental Payments	**$89,364,697**	**$28,489,182**	**$189,010,475**	**$261,492**	**$134,154,713**	**$34,439,630**	**$1,524,622**	**$9,629**	**$158,291,731**	**$11,460,952**	**$33,671,422**	**$36,396,782**	**$62,672**	**$717,137,999**
Grand Total	**$896,112,956**	**$170,623,165**	**$1,033,566,923**	**$723,127**	**$442,861,997**	**$120,389,845**	**$4,003,017**	**$10,287,938**	**$683,425,225**	**$79,698,390**	**$97,417,747**	**$78,357,967**	**$24,564,465**	**$3,642,032,762**

Exhibit M

Cash-based Actuals												
FY 2010-11	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,269,992	$6,951,129	$52,819,492	$61,394,491	$12,531,062	$0	$108,898,551	$10,934,900	$18,198,453	$6,592,130	$1,842	$282,592,042
Emergency Transportation	$135,881	$262,494	$2,067,024	$1,347,570	$236,352	$0	$1,665,110	$236,484	$196,837	$88,493	$5	$6,236,250
Non-emergency Medical Transportation	$2,248,810	$1,043,480	$5,199,711	$500,754	$72,340	$0	$1,156,790	$195,450	$48,109	$3,420	$243	$10,469,107
Dental Services	$980,947	$296,165	$5,001,213	$5,332,025	$1,211,640	$0	$89,583,233	$5,780,945	$379,656	$4,838	$30	$108,570,692
Family Planning	$0	$16	$12,731	$193,371	$60,160	$0	$120,830	$38,845	$15,461	$0	$0	$441,414
Health Maintenance Organizations	$6,832,995	$6,431,178	$38,459,466	$21,704,093	$6,456,182	$0	$35,589,978	$823,759	$1,190,805	$0	$0	$117,488,456
Inpatient Hospitals	$13,928,315	$14,401,355	$109,555,356	$64,961,507	$10,000,540	$0	$83,895,044	$6,584,854	$30,244,597	$38,292,048	($1,668)	$371,861,948
Outpatient Hospitals	$3,159,881	$5,575,085	$50,038,984	$57,298,855	$14,717,844	$0	$73,155,361	$6,071,798	$6,013,521	$1,460,551	$1,031	$217,492,911
Lab & X-Ray	$558,717	$853,427	$6,862,072	$13,332,748	$2,936,506	$0	$7,589,083	$1,757,292	$3,807,140	$164,351	$784	$37,862,120
Durable Medical Equipment	$19,960,510	$4,911,081	$48,169,450	$3,505,807	$797,869	$0	$8,735,551	$4,353,214	$180,213	$5	$14,245	$90,627,945
Prescription Drugs	$8,014,198	$16,245,119	$119,835,487	$46,135,231	$11,840,965	$0	$56,157,222	$20,762,963	$2,287,737	$23	$4	$281,278,949
Drug Rebate	($3,615,910)	($7,329,604)	($54,068,344)	($20,815,666)	($5,342,502)	$0	($25,337,470)	($9,368,002)	($1,032,200)	($10)	($2)	($126,909,710)
Rural Health Centers	$53,270	$206,418	$1,122,812	$1,871,661	$557,927	$0	$5,357,537	$698,495	$285,879	$33,931	$75	$10,188,005
Federally Qualified Health Centers	$916,375	$1,051,613	$7,588,335	$15,885,638	$3,802,322	$0	$53,308,981	$2,132,545	$5,192,824	$427,890	$0	$90,306,523
Co-Insurance (Title XVIII-Medicare)	$16,505,219	$2,494,667	$11,474,583	$349,523	$446,438	$0	$43,461	$31,683	$56,279	$44	$4,985,517	$36,387,414
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$10,106,643	$0	$0	$0	$0	$0	$10,106,643
Prepaid Inpatient Health Plan Services	$2,221,510	$2,361,149	$19,107,158	$10,370,751	$2,076,156	$0	$9,365,354	$2,583,913	$2,763,503	$0	$0	$50,849,494
Other Medical Services	$770	$518	$4,450	$2,275	$509	$78	$4,077	$555	$525	$361	$40	$14,158
Acute Home Health	$5,093,934	$2,031,276	$11,832,652	$537,458	$126,179	$0	$712,181	$1,112,785	$48,496	$0	$145,260	$21,640,221
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$81,265,414**	**$57,786,566**	**$435,082,632**	**$283,908,092**	**$62,528,489**	**$10,106,721**	**$510,000,874**	**$54,732,478**	**$69,877,835**	**$47,068,075**	**$5,147,406**	**$1,617,504,582**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$107,968,359	$16,811,191	$87,178,266	$19,464	$11,962	$0	$0	$72,439	$0	$0	$134,462	$212,196,143
HCBS - Mental Illness	$3,642,260	$2,685,012	$18,587,745	$9,419	$0	$0	$0	$14,257	$0	$0	$8,097	$24,946,790
HCBS - Disabled Children	$0	$0	$1,963,855	$0	$0	$0	$572	$577	$0	$0	$0	$1,965,004
HCBS - Persons Living with AIDS	$29,837	$3,598	$532,418	$0	$0	$0	$0	$0	$0	$0	$1,682	$567,535
HCBS - Consumer Directed Attendant Support	$1,506,730	$234,605	$1,216,870	$0	$167	$0	$0	$1,011	$0	$0	$1,876	$2,961,259
HCBS - Brain Injury	$158,989	$815,885	$11,318,640	$3,254	$0	$0	$0	$0	$0	$0	$497	$12,297,265
HCBS - Children with Autism	$0	$0	$1,355,067	$0	$0	$0	$2,545	$0	$0	$0	$0	$1,357,612
HCBS - Pediatric Hospice	$0	$0	$126,096	$0	$0	$0	$211	$395	$0	$0	$0	$126,702
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CCT - Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$1,328,952	$0	$17,573,121	$0	$0	$0	$521,410	$8,338,211	$0	$0	$0	$27,761,694
Long Term Home Health	$19,383,216	$5,467,614	$112,041,515	$30,506	$32,861	$0	$3,507,579	$10,439,102	$188	$0	$90,966	$150,993,547
Hospice	$30,470,765	$2,124,046	$6,934,494	$235,444	$39,141	$0	$60,107	$3,517	$0	$0	($4,548)	$39,862,966
Subtotal Community Based Long-Term Care	**$164,489,108**	**$28,141,951**	**$258,828,087**	**$298,087**	**$84,131**	**$0**	**$4,092,424**	**$18,869,509**	**$188**	**$0**	**$233,032**	**$475,036,517**
Long-Term Care												
Class I Nursing Facilities	$397,056,172	$32,228,696	$78,280,022	$7,615	$0	$0	$0	$0	$0	$0	$569,344	$508,141,849
Class II Nursing Facilities	($200,939)	$647,887	$1,915,758	$0	$0	$0	$0	$0	$0	$0	$0	$2,362,706
Program of All-Inclusive Care for the Elderly	$73,242,923	$7,896,872	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$84,429,683
Subtotal Long-Term Care	**$470,098,156**	**$40,773,455**	**$83,485,668**	**$7,615**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$569,344**	**$594,934,238**
Insurance												
Supplemental Medicare Insurance Benefit	$63,751,826	$3,717,638	$33,417,797	$209,027	$0	$0	$0	$0	$0	$0	$18,447,446	$119,543,734
Health Insurance Buy-In Program	$2,287	$1,347	$1,111,909	$5,375	$0	$0	$3,001	$1,077	$0	$0	$0	$1,124,996
Subtotal Insurance	**$63,754,113**	**$3,718,985**	**$34,529,706**	**$214,402**	**$0**	**$0**	**$3,001**	**$1,077**	**$0**	**$0**	**$18,447,446**	**$120,668,730**
Service Management												
Single Entry Points	$11,482,516	$2,211,295	$10,261,280	$6,052	$0	$0	$4,841	$9,683	$0	$38,731	$7,262	$24,021,660
Disease Management	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$411,355	$211,517	$1,451,792	$793,726	$238,521	$0	$3,063,511	$216,554	$88,268	$0	$0	$6,475,244
Accountable Care Collaborative	$11,931	$16,697	$100,967	$246,920	$73,004	$0	$407,791	$14,196	$15,905	$0	$0	$887,411
Subtotal Service Management	**$11,905,802**	**$2,439,509**	**$11,814,039**	**$1,046,698**	**$311,525**	**$0**	**$3,476,143**	**$240,433**	**$104,173**	**$38,731**	**$7,262**	**$31,384,315**
Total Services	**$791,512,593**	**$132,860,466**	**$823,740,132**	**$285,474,894**	**$62,924,145**	**$10,106,721**	**$517,572,442**	**$73,843,497**	**$69,982,196**	**$47,106,806**	**$24,404,490**	**$2,839,528,382**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$7,676,809	$823,929	$4,599,470	$1,105,520	$284,166	$0	$1,474,141	$323,850	$115,813	$27,916	$14,559	$16,446,173
Hospital Supplemental Payments	$13,043,327	$15,343,201	$122,857,357	$95,078,024	$19,381,431	$0	$122,110,435	$9,849,776	$27,640,610	$30,044,551	($428)	$455,348,284
Nursing Facility Supplemental Payments	$59,632,155	$4,840,289	$11,756,539	$1,144	$0	$0	$0	$0	$0	$0	$85,507	$76,315,634
Physician Supplemental Payments	$41,037	$66,804	$507,620	$590,030	$120,429	$0	$1,046,566	$105,089	$174,896	$63,353	$18	$2,715,842
Outstationing Payments	$76,764	$135,437	$1,215,606	$1,391,971	$357,543	$0	$1,777,176	$147,503	$146,088	$35,481	$25	$5,283,594
Accounting Adjustments	($2,642)	($483)	($3,002)	($1,102)	($247)	($38)	($1,975)	($299)	($254)	($175)	($22)	($10,239)
Subtotal Financing and Supplemental Payments	**$80,467,450**	**$21,209,177**	**$140,933,590**	**$98,165,587**	**$20,143,322**	**($38)**	**$126,406,343**	**$10,425,919**	**$28,077,153**	**$30,171,126**	**$99,659**	**$556,099,288**
Grand Total	**$871,980,043**	**$154,069,643**	**$964,673,722**	**$383,640,481**	**$83,067,467**	**$10,106,683**	**$643,978,785**	**$84,269,416**	**$98,059,349**	**$77,277,932**	**$24,504,149**	**$3,395,627,670**

Cash-based Actuals												
FY 2010-11 Adjusted Totals for June 2010 Payment Delay	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,130,718	$6,703,561	$51,097,852	$59,291,660	$12,375,689	$0	$105,296,010	$10,585,051	$17,581,872	$6,320,750	$1,842	$273,385,004
Emergency Transportation	$132,219	$249,128	$1,981,657	$1,308,793	$234,529	$0	$1,614,807	$227,759	$191,791	$83,441	$5	$6,024,129
Non-emergency Medical Transportation	$2,229,276	$1,030,710	$5,146,701	$497,276	$72,195	$0	$1,144,272	$191,775	$47,503	$3,420	$243	$10,363,372
Dental Services	$955,956	$287,848	$4,837,630	$5,162,280	$1,188,067	$0	$86,467,469	$5,552,511	$362,348	$4,838	$30	$104,818,977
Family Planning	$0	$16	$12,280	$185,275	$59,388	$0	$117,776	$38,636	$15,103	$0	$0	$428,473
Health Maintenance Organizations	$6,832,995	$6,431,178	$38,459,477	$21,704,066	$6,456,182	$0	$35,589,961	$823,759	$1,190,805	$0	$0	$117,488,424
Inpatient Hospitals	$13,226,398	$13,708,601	$104,724,510	$62,699,943	$9,835,760	$0	$80,955,351	$6,191,811	$29,151,219	$36,914,043	$3,263	$357,410,899
Outpatient Hospitals	$3,056,720	$5,426,119	$48,146,249	$55,076,726	$14,489,888	$0	$70,566,037	$5,827,169	$5,797,920	$1,403,889	$510	$209,791,226
Lab & X-Ray	$536,134	$822,885	$6,615,373	$12,854,214	$2,895,486	$0	$7,328,814	$1,689,199	$3,680,612	$157,642	$784	$36,581,144
Durable Medical Equipment	$19,273,723	$4,734,880	$46,704,499	$3,394,827	$780,295	$0	$8,456,548	$4,218,566	$167,275	$5	$14,696	$87,745,314
Prescription Drugs	$7,696,196	$15,713,437	$116,023,969	$44,475,389	$11,693,984	$0	$54,593,080	$20,062,946	$2,210,846	$23	$4	$272,469,874
Drug Rebate	($3,615,910)	($7,329,604)	($54,068,344)	($20,815,666)	($5,342,502)	$0	($25,337,470)	($9,368,002)	($1,032,200)	($10)	($2)	($126,909,710)
Rural Health Centers	$51,237	$201,149	$1,081,153	$1,802,214	$549,705	$0	$5,208,165	$685,199	$277,916	$30,833	$75	$9,887,646
Federally Qualified Health Centers	$877,183	$1,014,344	$7,353,061	$15,328,948	$3,746,392	$0	$51,735,998	$2,065,438	$4,996,706	$411,997	$0	$87,530,066
Co-Insurance (Title XVIII-Medicare)	$15,904,615	$2,389,850	$11,036,287	$332,809	$438,294	$0	$42,211	$30,661	$55,401	$44	$4,813,375	$35,043,547
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$9,817,118	$0	$0	$0	$0	$0	$9,817,118
Prepaid Inpatient Health Plan Services	$2,221,510	$2,361,149	$19,107,158	$10,370,751	$2,076,156	$0	$9,365,354	$2,583,913	$2,763,503	$0	$0	$50,849,494
Other Medical Services	$770	$518	$4,450	$2,275	$509	$78	$4,077	$555	$525	$361	$40	$14,158
Acute Home Health	$4,988,407	$1,957,872	$11,490,524	$502,329	$150,136	($1,071)	$723,296	$1,099,085	$48,211	$0	$141,405	$21,100,194
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$78,498,148**	**$55,703,641**	**$419,754,485**	**$274,174,108**	**$61,700,153**	**$9,816,125**	**$493,871,755**	**$52,506,031**	**$67,507,355**	**$45,331,276**	**$4,976,271**	**$1,563,839,348**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$105,868,153	$16,511,174	$85,914,478	$19,422	$11,962	$0	$0	$71,172	$0	$0	$129,955	$208,526,316
HCBS - Mental Illness	$3,587,367	$2,652,010	$18,317,043	$9,419	$0	$0	$0	$13,599	$0	$0	$8,097	$24,587,535
HCBS - Disabled Children	$0	$0	$1,886,052	$0	$0	$0	$572	$577	$0	$0	$0	$1,887,201
HCBS - Persons Living with AIDS	$29,046	$3,471	$516,199	$0	$0	$0	$0	$0	$0	$0	$1,682	$550,398
HCBS - Consumer Directed Attendant Support	$1,506,730	$234,605	$1,216,870	$0	$167	$0	$0	$1,011	$0	$0	$1,876	$2,961,259
HCBS - Brain Injury	$158,168	$809,327	$11,211,671	$3,254	$0	$0	$0	$0	$0	$0	$497	$12,182,917
HCBS - Children with Autism	$0	$0	$1,326,033	$0	$0	$0	$2,545	$0	$0	$0	$0	$1,328,578
HCBS - Pediatric Hospice	$0	$0	$118,667	$0	$0	$0	$211	$395	$0	$0	$0	$119,273
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CCT - Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$1,319,815	$0	$17,252,161	$0	$0	$0	$502,792	$8,251,187	$0	$0	$0	$27,325,956
Long Term Home Health	$18,890,472	$5,333,256	$109,459,274	$55,655	$7,651	$1,071	$3,447,255	$10,296,687	$188	$0	$90,417	$147,581,926
Hospice	$30,229,237	$2,102,621	$6,889,024	$228,536	$39,141	$0	$60,107	$3,517	$0	$0	($4,548)	$39,547,635
Subtotal Community Based Long-Term Care	**$161,588,989**	**$27,646,464**	**$254,107,471**	**$316,286**	**$58,921**	**$1,071**	**$4,013,482**	**$18,638,145**	**$188**	**$0**	**$227,976**	**$466,598,993**
Long-Term Care												
Class I Nursing Facilities	$390,609,241	$31,625,231	$76,509,001	$7,615	$0	$0	$0	$0	$0	$0	$564,302	$499,315,390
Class II Nursing Facilities	($84,406)	$729,155	$2,518,446	$0	$0	$0	$0	$0	$0	$0	$0	$3,163,194
Program of All-Inclusive Care for the Elderly	$73,232,308	$7,892,082	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$84,414,278
Subtotal Long-Term Care	**$463,757,142**	**$40,246,468**	**$82,317,335**	**$7,615**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$564,302**	**$586,892,863**
Insurance												
Supplemental Medicare Insurance Benefit	$63,751,826	$3,717,638	$33,417,797	$209,027	$0	$0	$0	$0	$0	$0	$18,447,446	$119,543,734
Health Insurance Buy-In Program	$1,979	$625	$1,025,861	$5,098	$0	$0	$2,021	$1,059	$0	$0	$0	$1,036,644
Subtotal Insurance	**$63,753,805**	**$3,718,263**	**$34,443,658**	**$214,125**	**$0**	**$0**	**$2,021**	**$1,059**	**$0**	**$0**	**$18,447,446**	**$120,580,378**
Service Management												
Single Entry Points	$11,482,516	$2,211,295	$10,261,280	$6,052	$0	$0	$4,841	$9,683	$0	$38,731	$7,262	$24,021,660
Disease Management	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$411,355	$211,517	$1,451,792	$793,726	$238,521	$0	$3,063,511	$216,554	$88,268	$0	$0	$6,475,244
Accountable Care Collaborative	$11,931	$16,697	$100,967	$246,920	$73,004	$0	$407,791	$14,196	$15,905	$0	$0	$887,411
Subtotal Service Management	**$11,905,802**	**$2,439,509**	**$11,814,039**	**$1,046,698**	**$311,525**	**$0**	**$3,476,143**	**$240,433**	**$104,173**	**$38,731**	**$7,262**	**$31,384,315**
Total Services	**$779,503,887**	**$129,754,346**	**$802,436,987**	**$275,758,832**	**$62,070,599**	**$9,817,196**	**$501,363,402**	**$71,385,669**	**$67,611,716**	**$45,370,007**	**$24,223,257**	**$2,769,295,896**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$7,676,809	$823,929	$4,599,470	$1,105,520	$284,166	$0	$1,474,141	$323,850	$115,813	$27,916	$14,559	$16,446,173
Hospital Supplemental Payments	$13,043,327	$15,343,201	$122,857,357	$95,078,024	$19,381,431	$0	$122,110,435	$9,849,776	$27,640,610	$30,044,551	($428)	$455,348,284
Nursing Facility Supplemental Payments	$59,632,155	$4,840,289	$11,756,539	$1,144	$0	$0	$0	$0	$0	$0	$85,507	$76,315,634
Physician Supplemental Payments	$41,037	$66,804	$507,620	$590,030	$120,429	$0	$1,046,566	$105,089	$174,896	$63,353	$18	$2,715,842
Outstationing Payments	$76,764	$135,437	$1,215,606	$1,391,971	$357,543	$0	$1,777,176	$147,503	$146,088	$35,481	$25	$5,283,594
Accounting Adjustments	($2,642)	($483)	($3,002)	($1,102)	($247)	($38)	($1,975)	($299)	($254)	($175)	($22)	($10,239)
Subtotal Financing and Supplemental Payments	**$80,467,450**	**$21,209,177**	**$140,933,590**	**$98,165,587**	**$20,143,322**	**($38)**	**$126,406,343**	**$10,425,919**	**$28,077,153**	**$30,171,126**	**$99,659**	**$556,099,288**
Grand Total	**$859,971,337**	**$150,963,523**	**$943,370,577**	**$373,924,419**	**$82,213,921**	**$9,817,158**	**$627,769,745**	**$81,811,588**	**$95,688,869**	**$75,541,133**	**$24,322,916**	**$3,325,395,184**

Exhibit M

Cash-based Actuals												
FY 2009-10	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,504,959	$5,841,290	$45,027,403	$57,248,711	$379,950	$0	$97,071,331	$9,752,159	$16,382,526	$6,720,532	$553	$242,929,414
Emergency Transportation	$132,013	$206,450	$1,629,960	$1,215,599	$5,733	$0	$1,553,739	$202,199	$184,865	$87,075	$0	$5,217,633
Non-emergency Medical Transportation	$2,230,609	$868,873	$4,556,037	$365,170	$463	$0	$964,382	$100,146	$44,731	$1,244	$0	$9,131,655
Dental Services	$790,484	$236,617	$4,188,551	$4,364,415	$54,703	$0	$73,534,295	$5,281,907	$353,118	$2,724	$43	$88,806,857
Family Planning	$0	$24	$11,970	$149,434	$1,828	$0	$110,955	$30,688	$17,076	$0	$0	$321,975
Health Maintenance Organizations	$6,690,235	$6,808,868	$45,687,859	$21,208,184	$149,518	$0	$35,072,614	$902,745	$1,131,694	$0	$0	$117,651,717
Inpatient Hospitals	$15,121,066	$10,933,612	$94,203,357	$60,316,941	$225,968	$0	$82,963,155	$5,813,909	$29,535,689	$38,240,653	$4,098	$337,358,448
Outpatient Hospitals	$2,483,053	$3,912,610	$33,983,522	$42,016,658	$591,764	$0	$51,528,634	$4,616,132	$4,813,849	$1,009,919	$0	$144,956,141
Lab & X-Ray	$542,175	$702,690	$5,366,358	$11,597,242	$113,194	$0	$6,592,607	$1,625,242	$3,462,744	$145,427	$638	$30,148,317
Durable Medical Equipment	$18,160,548	$3,979,784	$40,816,114	$3,035,899	$21,565	$0	$8,177,251	$3,905,570	$172,313	$559	$3,359	$78,272,962
Prescription Drugs	$7,741,380	$13,544,934	$97,612,578	$41,216,168	$524,963	$618	$44,622,097	$18,661,722	$2,189,164	$0	$462	$226,114,086
Drug Rebate	($3,418,708)	($5,981,643)	($43,107,160)	($18,201,670)	($231,831)	($273)	($19,705,779)	($8,241,293)	($966,767)	$0	($204)	($99,855,328)
Rural Health Centers	$40,614	$147,085	$904,243	$1,585,161	$22,504	$0	$4,562,102	$405,207	$300,495	$26,268	$142	$7,993,821
Federally Qualified Health Centers	$903,859	$792,591	$6,070,347	$13,704,904	$182,692	$0	$47,091,191	$1,962,149	$5,080,079	$456,394	$154	$76,244,360
Co-Insurance (Title XVIII-Medicare)	$9,563,469	$1,441,719	$6,576,135	$269,357	$4,014	$0	$21,034	$17,428	$24,075	$32	$2,934,912	$20,852,175
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$8,716,269	$0	$0	$0	$0	$0	$8,716,269
Prepaid Inpatient Health Plan Services	$2,375,072	$2,021,423	$17,073,019	$9,355,563	$183,288	$0	$8,648,317	$2,128,848	$2,918,289	$0	$0	$44,703,819
Other Medical Services	$3,033	$1,762	$15,618	$8,354	$0	$271	$14,457	$2,022	$2,008	$1,457	$158	$49,140
Acute Home Health	$6,129,559	$2,135,982	$11,903,905	$458,258	$1,616	$0	$672,411	$796,082	$50,128	$0	$115,542	$22,263,483
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$73,993,420**	**$47,594,671**	**$372,519,816**	**$249,914,348**	**$2,231,932**	**$8,716,885**	**$443,494,793**	**$47,962,862**	**$65,696,076**	**$46,692,284**	**$3,059,857**	**$1,361,876,944**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$101,286,004	$14,326,522	$70,577,472	$13,343	$0	$0	$0	$77,881	$0	$0	$144,853	$186,426,075
HCBS - Mental Illness	$3,418,565	$2,358,037	$16,839,277	$80	$0	$0	$0	$22,942	$0	$0	$42,459	$22,681,360
HCBS - Disabled Children	$0	$0	$1,762,739	$0	$0	$0	$0	$471	$0	$0	$0	$1,763,210
HCBS - Persons Living with AIDS	$19,745	$28,343	$533,292	$0	$0	$0	$0	$0	$0	$0	$25	$581,405
HCBS - Consumer Directed Attendant Support	$1,910,754	$270,269	$1,331,531	$161	$0	$0	$0	$1,469	$0	$0	$2,733	$3,516,917
HCBS - Brain Injury	$143,522	$526,310	$10,806,523	$5,718	$0	$0	$0	$0	$0	$0	$0	$11,482,073
HCBS - Children with Autism	$0	$0	$1,565,700	$0	$0	$0	$0	$0	$0	$0	$0	$1,565,700
HCBS - Pediatric Hospice	$0	$0	$94,296	$0	$0	$0	$0	$485	$0	$0	$0	$94,781
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CCT - Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$1,026,115	$240,541	$14,816,120	$0	$0	$0	$586,102	$6,561,939	$0	$0	$0	$23,230,817
Long Term Home Health	$17,725,454	$4,386,024	$98,742,575	$43,807	$0	$0	$3,077,212	$10,112,575	$0	$0	$97,291	$134,184,938
Hospice	$33,775,858	$3,004,027	$6,070,145	$196,954	$0	$0	$231,678	$34,952	$0	$1,279	$6,603	$43,321,496
Subtotal Community Based Long-Term Care	**$159,306,017**	**$25,140,073**	**$223,139,670**	**$260,063**	**$0**	**$0**	**$3,894,992**	**$16,812,714**	**$0**	**$1,279**	**$293,964**	**$428,848,772**
Long-Term Care												
Class I Nursing Facilities	$386,581,897	$28,352,812	$72,076,695	$5,285	$0	$0	$0	$0	$0	$0	$57,644	$487,074,333
Class II Nursing Facilities	$78,087	$345,366	$1,592,382	$0	$0	$0	$0	$0	$0	$0	$0	$2,015,835
Program of All-Inclusive Care for the Elderly	$61,913,944	$4,981,340	$2,345,339	$0	$0	$0	$0	$0	$0	$0	$0	$69,240,623
Subtotal Long-Term Care	**$448,573,928**	**$33,679,518**	**$76,014,416**	**$5,285**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$57,644**	**$558,330,791**
Insurance												
Supplemental Medicare Insurance Benefit	$54,965,748	$3,205,285	$28,812,261	$180,219	$0	$0	$0	$0	$0	$0	$15,905,077	$103,068,590
Health Insurance Buy-In Program	$3,244	$7,611	$907,336	$2,920	$0	$0	$10,334	$192	$0	$0	$0	$931,637
Subtotal Insurance	**$54,968,992**	**$3,212,896**	**$29,719,597**	**$183,139**	**$0**	**$0**	**$10,334**	**$192**	**$0**	**$0**	**$15,905,077**	**$104,000,227**
Service Management												
Single Entry Points	$11,622,897	$2,068,951	$9,956,430	$2,637	$0	$0	$1,458	$8,329	$0	$41,435	$5,414	$23,707,551
Disease Management	$4,570	$2,655	$23,534	$12,589	$0	$409	$21,785	$3,047	$3,027	$0	$0	$71,616
Prepaid Inpatient Health Plan Administration	$331,989	$116,999	$938,116	$713,502	$0	$0	$2,715,378	$208,304	$87,465	$0	$0	$5,111,753
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,959,456**	**$2,188,605**	**$10,918,080**	**$728,728**	**$0**	**$409**	**$2,738,621**	**$219,680**	**$90,492**	**$41,435**	**$5,414**	**$28,890,920**
Total Services	**$748,801,813**	**$111,815,763**	**$712,311,579**	**$251,091,563**	**$2,231,932**	**$8,717,294**	**$450,138,740**	**$64,995,448**	**$65,786,568**	**$46,734,998**	**$19,321,956**	**$2,481,947,654**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$11,041,603	$915,688	$3,009,973	$1,192,576	$16,794	$0	$1,462,375	$131,005	$136,616	$28,661	$1,636	$17,936,927
Hospital Supplemental Payments	$11,404,873	$9,618,163	$83,046,197	$66,297,084	$529,770	$0	$87,130,849	$6,757,129	$22,253,436	$25,428,583	$2,655	$312,468,739
Nursing Facility Supplemental Payments	$37,661,309	$2,762,168	$7,021,804	$515	$0	$0	$0	$0	$0	$0	$5,616	$47,451,412
Physician Supplemental Payments	$268,976	$348,764	$2,688,433	$3,418,128	$22,686	$0	$5,795,803	$582,269	$978,146	$401,260	$33	$14,504,498
Outstationing Payments	$60,301	$95,018	$825,287	$1,020,373	$14,371	$0	$1,251,371	$112,103	$116,904	$24,526	$0	$3,520,254
Accounting Adjustments	($5,210)	($778)	($4,955)	($1,747)	($16)	($61)	($3,132)	($452)	($458)	($325)	($134)	($17,268)
Subtotal Financing and Supplemental Payments	**$60,431,852**	**$13,739,023**	**$96,586,739**	**$71,926,929**	**$583,605**	**($61)**	**$95,637,266**	**$7,582,054**	**$23,484,644**	**$25,882,705**	**$9,806**	**$395,864,562**
Grand Total	**$809,233,665**	**$125,554,786**	**$808,898,318**	**$323,018,492**	**$2,815,537**	**$8,717,233**	**$545,776,006**	**$72,577,502**	**$89,271,212**	**$72,617,703**	**$19,331,762**	**$2,877,812,216**

Exhibit M

Cash-based Actuals												
FY 2009-10 Adjusted Totals for June 2010 Payment Delay	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,644,233	$6,088,858	$46,749,043	$59,351,542	$535,323	$0	$100,673,872	$10,102,008	$16,999,107	$6,991,912	$553	$252,136,452
Emergency Transportation	$135,675	$219,816	$1,715,327	$1,254,376	$7,556	$0	$1,604,042	$210,924	$189,911	$92,127	$0	$5,429,754
Non-emergency Medical Transportation	$2,250,143	$881,643	$4,609,047	$368,648	$608	$0	$976,900	$103,821	$45,337	$1,244	$0	$9,237,391
Dental Services	$815,475	$244,934	$4,352,134	$4,534,160	$78,276	$0	$76,650,059	$5,510,341	$370,426	$2,724	$43	$92,558,572
Family Planning	$0	$24	$12,421	$157,531	$2,601	$0	$114,009	$30,897	$17,434	$0	$0	$334,916
Health Maintenance Organizations	$6,690,235	$6,808,868	$45,687,848	$21,208,211	$149,518	$0	$35,072,631	$902,745	$1,131,694	$0	$0	$117,651,749
Inpatient Hospitals	$15,822,983	$11,626,366	$99,034,203	$62,578,505	$390,748	$0	$85,902,848	$6,206,952	$30,629,067	$39,618,658	($833)	$351,809,497
Outpatient Hospitals	$2,586,214	$4,061,576	$35,876,257	$44,238,787	$819,720	$0	$54,117,958	$4,860,761	$5,029,450	$1,066,581	$521	$152,657,826
Lab & X-Ray	$564,758	$733,232	$5,613,057	$12,075,776	$154,214	$0	$6,852,876	$1,693,335	$3,589,272	$152,136	$638	$31,429,293
Durable Medical Equipment	$18,847,335	$4,155,985	$42,281,065	$3,146,879	$39,139	$0	$8,456,254	$4,040,218	$185,251	$559	$2,908	$81,155,593
Prescription Drugs	$8,059,382	$14,076,616	$101,424,096	$42,876,010	$671,944	$618	$46,186,239	$19,361,739	$2,266,055	$0	$462	$234,923,161
Drug Rebate	($3,418,708)	($5,981,643)	($43,107,160)	($18,201,670)	($231,831)	($273)	($19,705,779)	($8,241,293)	($966,767)	$0	($204)	($99,855,328)
Rural Health Centers	$42,647	$152,354	$945,902	$1,654,608	$30,726	$0	$4,711,474	$418,503	$308,458	$29,366	$142	$8,294,180
Federally Qualified Health Centers	$943,051	$829,860	$6,305,621	$14,261,594	$238,622	$0	$48,664,174	$2,029,256	$5,276,197	$472,287	$154	$79,020,817
Co-Insurance (Title XVIII-Medicare)	$10,164,073	$1,546,536	$7,014,431	$286,071	$12,158	$0	$22,284	$18,450	$24,953	$32	$3,107,054	$22,196,042
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$9,005,794	$0	$0	$0	$0	$0	$9,005,794
Prepaid Inpatient Health Plan Services	$2,375,072	$2,021,423	$17,073,019	$9,355,563	$183,288	$0	$8,648,317	$2,128,848	$2,918,289	$0	$0	$44,703,819
Other Medical Services	$3,033	$1,762	$15,618	$8,354	$0	$271	$14,457	$2,022	$2,008	$1,457	$158	$49,140
Acute Home Health	$6,235,086	$2,209,386	$12,229,634	$468,176	$2,869	($167)	$661,296	$809,781	$50,413	$0	$119,397	$22,785,871
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$76,760,686**	**$49,677,596**	**$387,831,564**	**$259,623,121**	**$3,085,478**	**$9,006,243**	**$459,623,912**	**$50,189,308**	**$68,066,556**	**$48,429,083**	**$3,230,992**	**$1,415,524,539**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$103,386,210	$14,626,539	$71,841,260	$13,385	$0	$0	$0	$79,148	$0	$0	$149,360	$190,095,902
HCBS - Mental Illness	$3,473,458	$2,391,039	$17,109,979	$80	$0	$0	$0	$23,600	$0	$0	$42,459	$23,040,615
HCBS - Disabled Children	$0	$0	$1,840,542	$0	$0	$0	$0	$471	$0	$0	$0	$1,841,013
HCBS - Persons Living with AIDS	$20,536	$28,470	$549,511	$0	$0	$0	$0	$0	$0	$0	$25	$598,542
HCBS - Consumer Directed Attendant Support	$1,910,754	$270,269	$1,331,531	$161	$0	$0	$0	$1,469	$0	$0	$2,733	$3,516,917
HCBS - Brain Injury	$144,343	$532,868	$10,913,492	$5,718	$0	$0	$0	$0	$0	$0	$0	$11,596,421
HCBS - Children with Autism	$0	$0	$1,594,734	$0	$0	$0	$0	$0	$0	$0	$0	$1,594,734
HCBS - Pediatric Hospice	$0	$0	$101,725	$0	$0	$0	$0	$485	$0	$0	$0	$102,210
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CCT - Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$1,035,252	$240,541	$15,137,080	$0	$0	$0	$604,720	$6,648,963	$0	$0	$0	$23,666,555
Long Term Home Health	$18,218,198	$4,520,382	$101,341,215	$43,869	$0	$167	$3,137,536	$10,254,991	$0	$0	$97,840	$137,614,198
Hospice	$34,017,386	$3,025,452	$6,115,615	$203,862	$0	$0	$231,678	$34,952	$0	$1,279	$6,603	$43,636,827
Subtotal Community Based Long-Term Care	**$162,206,136**	**$25,635,560**	**$227,876,685**	**$267,075**	**$0**	**$167**	**$3,973,934**	**$17,044,079**	**$0**	**$1,279**	**$299,020**	**$437,303,935**
Long-Term Care												
Class I Nursing Facilities	$393,028,828	$28,956,277	$73,847,716	$5,285	$0	$0	$0	$0	$0	$0	$62,686	$495,900,792
Class II Nursing Facilities	($38,446)	$264,098	$989,694	$0	$0	$0	$0	$0	$0	$0	$0	$1,215,347
Program of All-Inclusive Care for the Elderly	$61,924,559	$4,986,130	$2,345,339	$0	$0	$0	$0	$0	$0	$0	$0	$69,256,028
Subtotal Long-Term Care	**$454,914,942**	**$34,206,505**	**$77,182,749**	**$5,285**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$62,686**	**$566,372,166**
Insurance												
Supplemental Medicare Insurance Benefit	$54,965,748	$3,205,285	$28,812,261	$180,219	$0	$0	$0	$0	$0	$0	$15,905,077	$103,068,590
Health Insurance Buy-In Program	$3,552	$8,333	$993,384	$3,197	$0	$0	$11,314	$210	$0	$0	$0	$1,019,989
Subtotal Insurance	**$54,969,300**	**$3,213,618**	**$29,805,645**	**$183,416**	**$0**	**$0**	**$11,314**	**$210**	**$0**	**$0**	**$15,905,077**	**$104,088,579**
Service Management												
Single Entry Points	$11,622,897	$2,068,951	$9,956,430	$2,637	$0	$0	$1,458	$8,329	$0	$41,435	$5,414	$23,707,551
Disease Management	$4,570	$2,655	$23,534	$12,589	$0	$409	$21,785	$3,047	$3,027	$0	$0	$71,616
Prepaid Inpatient Health Plan Administration	$331,989	$116,999	$938,116	$713,502	$0	$0	$2,715,378	$208,304	$87,465	$0	$0	$5,111,753
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,959,456**	**$2,188,605**	**$10,918,080**	**$728,728**	**$0**	**$409**	**$2,738,621**	**$219,680**	**$90,492**	**$41,435**	**$5,414**	**$28,890,920**
Total Services	**$760,810,519**	**$114,921,883**	**$733,614,724**	**$260,807,625**	**$3,085,478**	**$9,006,819**	**$466,347,780**	**$67,453,276**	**$68,157,048**	**$48,471,797**	**$19,503,189**	**$2,552,180,140**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$11,041,603	$915,688	$3,009,973	$1,192,576	$16,794	$0	$1,462,375	$131,005	$136,616	$28,661	$1,636	$17,936,927
Hospital Supplemental Payments	$11,404,873	$9,618,163	$83,046,197	$66,297,084	$529,770	$0	$87,130,849	$6,757,129	$22,253,436	$25,428,583	$2,655	$312,468,739
Nursing Facility Supplemental Payments	$37,661,309	$2,762,168	$7,021,804	$515	$0	$0	$0	$0	$0	$0	$5,616	$47,451,412
Physician Supplemental Payments	$268,976	$348,764	$2,688,433	$3,418,128	$22,686	$0	$5,795,803	$582,269	$978,146	$401,260	$33	$14,504,498
Outstationing Payments	$60,301	$95,018	$825,287	$1,020,373	$14,371	$0	$1,251,371	$112,103	$116,904	$24,526	$0	$3,520,254
Accounting Adjustments	($5,210)	($778)	($4,955)	($1,747)	($16)	($61)	($3,132)	($452)	($458)	($325)	($134)	($17,268)
Subtotal Financing and Supplemental Payments	**$60,431,852**	**$13,739,023**	**$96,586,739**	**$71,926,929**	**$583,605**	**($61)**	**$95,637,266**	**$7,582,054**	**$23,484,644**	**$25,882,705**	**$9,806**	**$395,864,562**
Grand Total	**$821,242,371**	**$128,660,906**	**$830,201,463**	**$332,734,554**	**$3,669,083**	**$9,006,758**	**$561,985,046**	**$75,035,330**	**$91,641,692**	**$74,354,502**	**$19,512,995**	**$2,948,044,702**

Exhibit M

Cash-based Actuals												
FY 2008-09	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,994,147	$6,222,450	$45,788,069	$52,318,152	$0	$0	$89,495,781	$9,896,241	$15,568,366	$8,628,882	$603	$232,912,692
Emergency Transportation	$137,865	$236,302	$1,633,597	$1,114,036	$0	$0	$1,342,177	$176,882	$183,755	$109,310	$157	$4,934,082
Non-emergency Medical Transportation	$2,169,408	$784,497	$4,355,943	$402,309	$0	$0	$809,400	$131,628	$35,042	$791	$0	$8,689,018
Dental Services	$982,210	$236,181	$3,967,399	$3,888,603	$0	$0	$61,485,476	$5,488,468	$396,626	$11,462	$0	$76,456,424
Family Planning	$0	$120	$9,036	$150,297	$0	$0	$101,028	$34,059	$23,734	$1,150	$0	$319,424
Health Maintenance Organizations	$8,589,196	$7,896,327	$59,131,526	$17,895,483	$0	$0	$33,428,257	$1,052,528	$1,081,509	$0	$0	$129,074,827
Inpatient Hospitals	$16,801,697	$13,598,479	$98,702,338	$62,944,719	$0	$0	$84,101,547	$6,535,184	$27,109,511	$46,764,468	$18,694	$356,576,636
Outpatient Hospitals	$3,004,874	$3,827,049	$40,287,696	$42,356,575	$0	$0	$52,180,563	$5,471,149	$5,159,881	$1,612,752	$1,216	$153,901,754
Lab & X-Ray	$541,036	$700,896	$5,345,769	$10,575,314	$0	$0	$5,923,803	$1,888,019	$3,098,394	$364,434	$158	$28,437,823
Durable Medical Equipment	$19,191,857	$4,023,304	$40,203,019	$2,422,621	$0	$0	$7,113,934	$3,897,828	$147,294	$8,611	$3,345	$77,011,816
Prescription Drugs	$8,113,773	$12,092,935	$104,378,704	$38,493,946	$0	$1,722	$47,409,911	$21,136,869	$1,959,449	$78,621	$378	$233,666,309
Drug Rebate	($3,188,270)	($4,751,863)	($41,015,133)	($15,126,019)	$0	($677)	($18,629,507)	($8,305,636)	($769,957)	($30,894)	($148)	($91,818,104)
Rural Health Centers	$50,160	$147,174	$965,699	$1,418,805	$0	$0	$4,193,025	$300,376	$348,898	$34,346	$0	$7,458,484
Federally Qualified Health Centers	$964,422	$691,839	$5,907,249	$12,590,508	$0	$0	$44,940,460	$2,237,254	$4,162,016	$1,595,266	$0	$73,089,013
Co-Insurance (Title XVIII-Medicare)	$13,247,112	$1,936,238	$8,768,139	$362,516	$0	$0	$31,202	$20,241	$41,983	$1,112	$3,689,845	$28,098,389
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$7,042,030	$0	$0	$0	$0	$0	$7,042,030
Prepaid Inpatient Health Plan Services	$2,208,485	$1,744,095	$12,109,816	$5,020,548	$0	$0	$11,378,089	$1,586,101	$1,942,062	$0	$0	$35,989,196
Other Medical Services	$3,147	$1,760	$15,560	$7,453	$0	$212	$13,048	$2,059	$1,783	$1,776	$148	$46,946
Acute Home Health	$6,823,115	$2,172,916	$11,332,626	$494,003	$0	($4,352)	$737,049	$594,810	$25,103	$0	$69,370	$22,244,640
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$84,634,236**	**$51,560,699**	**$401,887,052**	**$237,329,869**	**$0**	**$7,038,935**	**$426,055,244**	**$52,144,060**	**$60,515,451**	**$59,182,087**	**$3,783,765**	**$1,384,131,398**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$97,156,797	$13,604,791	$65,434,378	$15,400	$0	$0	$0	$77,857	$0	$0	$192,447	$176,481,671
HCBS - Mental Illness	$3,588,896	$2,137,938	$17,180,010	$1,005	$0	$0	$0	$6,584	$0	$0	$44,433	$22,958,866
HCBS - Disabled Children	$0	$0	$1,747,600	$0	$0	$0	$50	$33	$0	$0	$0	$1,747,683
HCBS - Persons Living with AIDS	$12,764	$32,458	$546,457	$0	$0	$0	$0	$0	$0	$0	$1,066	$592,744
HCBS - Consumer Directed Attendant Support	$2,271,433	$318,067	$1,529,803	$351	$0	$0	$0	$1,820	$0	$0	$4,499	$4,125,973
HCBS - Brain Injury	$159,346	$507,164	$11,361,726	$0	$0	$0	$0	$0	$0	$0	$0	$12,028,236
HCBS - Children with Autism	$0	$0	$1,293,932	$0	$0	$0	$0	$0	$0	$0	$0	$1,293,932
HCBS - Pediatric Hospice	$0	$0	$26,940	$0	$0	$0	$0	$2,372	$0	$0	$0	$29,312
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CCT - Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$725,106	$186,844	$14,728,104	$0	$0	$0	$250,793	$5,460,562	$0	$0	$0	$21,351,408
Long Term Home Health	$17,604,990	$4,444,247	$90,735,722	$29,485	$0	$4,352	$2,591,906	$9,570,085	$0	$0	$102,711	$125,083,498
Hospice	$31,767,623	$2,005,681	$5,941,975	$45,064	$0	$0	$77,422	$3,390	$2,017	$0	$59,700	$39,902,873
Subtotal Community Based Long-Term Care	**$153,286,954**	**$23,237,190**	**$210,526,647**	**$91,305**	**$0**	**$4,352**	**$2,920,171**	**$15,122,703**	**$2,017**	**$0**	**$404,856**	**$405,596,195**
Long-Term Care												
Class I Nursing Facilities	$423,682,370	$29,953,087	$77,004,135	$22,194	$0	$0	$0	$0	$0	$0	$256,886	$530,918,672
Class II Nursing Facilities	$0	$335,754	$1,935,960	$0	$0	$0	$0	$0	$0	$0	$0	$2,271,714
Program of All-Inclusive Care for the Elderly	$54,470,714	$4,395,937	$2,183,184	$0	$0	$0	$0	$0	$0	$0	$0	$61,049,836
Subtotal Long-Term Care	**$478,153,084**	**$34,684,778**	**$81,123,279**	**$22,194**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$256,886**	**$594,240,222**
Insurance												
Supplemental Medicare Insurance Benefit	$49,992,538	$2,915,276	$26,205,375	$163,913	$0	$0	$0	$0	$0	$0	$14,466,011	$93,743,114
Health Insurance Buy-In Program	($177)	$3,200	$917,027	$5,034	$0	$0	$16,561	$0	$500	$0	$0	$942,145
Subtotal Insurance	**$49,992,361**	**$2,918,475**	**$27,122,403**	**$168,948**	**$0**	**$0**	**$16,561**	**$0**	**$500**	**$0**	**$14,466,011**	**$94,685,260**
Service Management												
Single Entry Points	$11,356,087	$1,927,170	$9,708,485	$3,228	$0	$0	$1,507	$7,102	$0	$56,818	$6,779	$23,067,175
Disease Management	$201,459	$112,661	$996,159	$477,141	$0	$13,568	$835,312	$131,805	$114,165	$0	$0	$2,882,271
Prepaid Inpatient Health Plan Administration	$352,841	$75,159	$520,646	$626,486	$0	$0	$2,101,664	$184,279	$74,059	$0	$0	$3,935,134
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,910,387**	**$2,114,989**	**$11,225,291**	**$1,106,856**	**$0**	**$13,568**	**$2,938,483**	**$323,187**	**$188,224**	**$56,818**	**$6,779**	**$29,884,581**
Total Services	**$777,977,023**	**$114,516,131**	**$731,884,672**	**$238,719,172**	**$0**	**$7,056,855**	**$431,930,459**	**$67,589,950**	**$60,706,191**	**$59,238,905**	**$18,918,298**	**$2,508,537,655**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$11,596,400	$918,068	$3,187,728	$959,312	$0	$0	$1,418,150	$148,694	$140,234	$43,831	$7,015	$18,419,432
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$10,655	$1,568	$10,023	$3,269	$0	$97	$5,915	$926	$831	$811	$259	$34,355
Subtotal Financing and Supplemental Payments	**$11,607,055**	**$919,637**	**$3,197,752**	**$962,581**	**$0**	**$97**	**$1,424,066**	**$149,619**	**$141,065**	**$44,642**	**$7,274**	**$18,453,787**
Grand Total	**$789,584,078**	**$115,435,768**	**$735,082,424**	**$239,681,753**	**$0**	**$7,056,952**	**$433,354,524**	**$67,739,569**	**$60,847,257**	**$59,283,547**	**$18,925,572**	**$2,526,991,443**

Exhibit M

Cash-based Actuals												
FY 2007-08	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$3,469,726	$5,866,568	$39,253,495	$42,993,990	$0	$0	$71,109,993	$8,011,424	$12,603,872	$7,354,450	$309	$190,663,827
Emergency Transportation	$76,213	$207,485	$1,572,693	$981,840	$0	$0	$1,291,389	$163,859	$150,448	$106,578	$0	$4,550,505
Non-emergency Medical Transportation	$1,890,521	$807,146	$3,907,628	$289,364	$0	$0	$713,422	$99,207	$24,313	$2,348	$0	$7,733,949
Dental Services	$692,450	$171,089	$3,093,306	$2,871,537	$0	$0	$42,256,276	$4,543,616	$250,711	$14,716	$189	$53,893,890
Family Planning	$101	$0	$7,167	$83,516	$0	$0	$70,705	$30,651	$8,462	$1,470	$0	$202,073
Health Maintenance Organizations	$9,349,039	$5,367,124	$44,519,944	$13,895,038	$0	$0	$27,309,963	$873,700	$902,068	$0	$0	$102,216,877
Inpatient Hospitals	$12,490,039	$11,578,942	$87,911,992	$58,686,715	$0	$0	$77,716,643	$6,608,100	$23,195,257	$42,710,199	$1,406	$320,899,293
Outpatient Hospitals	$2,279,079	$3,626,609	$36,371,235	$33,981,921	$0	$0	$44,067,264	$4,594,124	$3,998,659	$1,273,061	$243	$130,192,196
Lab & X-Ray	$415,678	$628,260	$4,813,487	$8,199,820	$0	$0	$4,844,562	$1,480,894	$2,110,120	$281,245	$175	$22,774,240
Durable Medical Equipment	$19,099,564	$3,724,534	$40,421,276	$2,088,605	$0	$0	$6,388,678	$3,963,555	$114,866	$7,053	$7,843	$75,815,972
Prescription Drugs	$6,819,298	$11,618,863	$102,291,859	$34,081,457	$0	$1,305	$39,162,305	$21,130,262	$1,689,121	$69,578	$90	$216,864,136
Drug Rebate	($1,744,101)	($2,971,636)	($26,162,127)	($8,716,660)	$0	($334)	($10,016,136)	($5,404,268)	($432,009)	($17,795)	($23)	($55,465,088)
Rural Health Centers	$33,486	$118,828	$885,721	$1,140,150	$0	$0	$3,411,821	$384,803	$239,581	$28,394	$0	$6,242,784
Federally Qualified Health Centers	$686,433	$672,208	$5,232,210	$10,292,590	$0	$0	$38,528,501	$2,053,130	$3,358,983	$1,797,419	$0	$62,621,473
Co-Insurance (Title XVIII-Medicare)	$10,666,122	$1,603,558	$7,081,693	$206,011	$0	$0	$13,250	$8,349	$30,611	$1,086	$2,896,987	$22,507,668
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$7,088,411	$0	$0	$0	$0	$0	$7,088,411
Prepaid Inpatient Health Plan Services	$2,144,360	$1,683,438	$11,566,837	$4,327,500	$0	$0	$10,068,498	$1,601,890	$2,289,781	$0	$0	$33,682,305
Other Medical Services	$2,310	$1,293	$11,593	$5,267	$0	$178	$8,985	$1,584	$1,224	$1,347	$106	$33,888
Acute Home Health	$14,495,095	$3,766,994	$47,233,118	$472,912	$0	($15,947)	$1,993,857	$4,599,486	$37,335	$2,426	$290,935	$72,876,211
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$3,770,690	$0	$0	$3,770,690
Subtotal of Acute Care	**$82,865,413**	**$48,471,304**	**$410,013,129**	**$205,881,573**	**$0**	**$7,073,613**	**$358,939,975**	**$54,744,366**	**$54,344,094**	**$53,633,572**	**$3,198,260**	**$1,279,165,299**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$86,813,975	$10,527,340	$43,329,761	$37,887	$0	$0	$0	$13,583	$0	$0	$509,299	$141,231,844
HCBS - Mental Illness	$3,181,676	$1,943,044	$15,184,323	$2,509	$0	$0	$0	$9,277	$0	$0	$89,059	$20,409,887
HCBS - Disabled Children	$0	$0	$1,352,728	$0	$0	$0	$973	$147	$0	$0	$0	$1,353,847
HCBS - Persons Living with AIDS	$12,757	$31,627	$549,627	$0	$0	$0	$0	$0	$0	$0	$1,395	$595,406
HCBS - Consumer Directed Attendant Support	$8,673,182	$1,051,738	$4,328,897	$3,764	$0	$0	$0	$1,357	$0	$0	$50,882	$14,109,819
HCBS - Brain Injury	$79,917	$459,639	$10,226,782	$0	$0	$0	$0	$0	$0	$0	$19,249	$10,785,587
HCBS - Children with Autism	$0	$0	$693,081	$0	$0	$0	$2,504	$0	$0	$0	$0	$695,586
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CCT - Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$313,936	$207,166	$13,885,052	$0	$0	$0	$500,847	$4,832,273	$0	$0	$9,988	$19,749,262
Long Term Home Health	$8,358,525	$2,246,421	$40,607,925	$51,486	$0	$15,947	$1,216,098	$4,210,240	$0	$0	$132,345	$56,838,987
Hospice	$25,148,153	$2,134,632	$5,123,646	$77,203	$0	$0	$86,351	$0	$0	$0	$240,791	$32,810,776
Subtotal Community Based Long-Term Care	**$132,582,120**	**$18,601,606**	**$135,281,822**	**$172,850**	**$0**	**$15,947**	**$1,806,773**	**$9,066,876**	**$0**	**$0**	**$1,053,007**	**$298,581,001**
Long-Term Care												
Class I Nursing Facilities	$389,399,454	$25,395,243	$69,952,848	$6,325	$0	$0	$0	$0	$0	$0	$1,814,628	$486,568,498
Class II Nursing Facilities	$74,970	$191,024	$1,924,394	$0	$0	$0	$0	$0	$0	$0	$45,248	$2,235,636
Program of All-Inclusive Care for the Elderly	$44,272,143	$3,549,809	$1,596,904	$0	$0	$0	$0	$0	$0	$0	$0	$49,418,855
Subtotal Long-Term Care	**$433,746,567**	**$29,136,075**	**$73,474,146**	**$6,325**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$1,859,876**	**$538,222,989**
Insurance												
Supplemental Medicare Insurance Benefit	$43,978,504	$2,564,572	$23,052,905	$144,195	$0	$0	$0	$0	$0	$0	$12,725,770	$82,465,946
Health Insurance Buy-In Program	$3,274	$1,762	$877,995	$1,605	$0	$0	$16,916	$1,188	$2,208	$0	$0	$904,947
Subtotal Insurance	**$43,981,778**	**$2,566,334**	**$23,930,899**	**$145,800**	**$0**	**$0**	**$16,916**	**$1,188**	**$2,208**	**$0**	**$12,725,770**	**$83,370,893**
Service Management												
Single Entry Points	$10,894,815	$1,743,587	$8,992,484	$2,602	$0	$0	$1,301	$2,602	$0	$0	$119,709	$21,757,100
Disease Management	$165,996	$92,931	$833,085	$378,473	$0	$12,812	$645,653	$113,811	$87,964	$0	$0	$2,330,726
Prepaid Inpatient Health Plan Administration	$366,151	$74,505	$536,817	$496,755	$0	$0	$1,873,683	$176,254	$85,306	$0	$0	$3,609,472
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,426,962**	**$1,911,023**	**$10,362,386**	**$877,831**	**$0**	**$12,812**	**$2,520,636**	**$292,668**	**$173,270**	**$0**	**$119,709**	**$27,697,298**
Total Services	**$704,602,839**	**$100,686,342**	**$653,062,382**	**$207,084,379**	**$0**	**$7,102,372**	**$363,284,302**	**$64,105,098**	**$54,519,572**	**$53,633,572**	**$18,956,623**	**$2,227,037,481**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$7,640,056	$566,098	$2,073,951	$584,574	$0	$0	$859,573	$89,613	$77,998	$24,832	$35,401	$11,952,096
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$33,799	$4,830	$31,327	$9,934	$0	$341	$17,426	$3,075	$2,615	$2,573	$909	$106,828
Subtotal Financing and Supplemental Payments	**$7,673,855**	**$570,928**	**$2,105,277**	**$594,508**	**$0**	**$341**	**$877,000**	**$92,688**	**$80,613**	**$27,405**	**$36,310**	**$12,058,924**
Grand Total	**$712,276,694**	**$101,257,270**	**$655,167,660**	**$207,678,887**	**$0**	**$7,102,713**	**$364,161,301**	**$64,197,785**	**$54,600,185**	**$53,660,977**	**$18,992,933**	**$2,239,096,405**

Exhibit M

Cash-based Actuals												
FY 2006-07	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$2,557,590	$4,913,899	$32,157,433	$40,209,605	$0	$0	$61,863,460	$6,843,560	$9,019,205	$6,665,024	$2,652	$164,232,428
Emergency Transportation	$75,398	$169,825	$1,386,996	$955,546	$0	$0	$1,313,302	$139,118	$129,933	$114,504	$0	$4,284,622
Non-emergency Medical Transportation	($18,672)	($8,454)	($25,794)	($1,823)	$0	$0	($4,150)	($1,652)	($176)	($17)	($2)	($60,740)
Dental Services	$662,760	$164,830	$2,924,310	$2,833,345	$0	$0	$38,168,661	$4,365,105	$239,992	$8,130	$0	$49,367,133
Family Planning	$0	$0	$464	$7,050	$0	$0	$7,323	$3,119	$422	$55	$0	$18,433
Health Maintenance Organizations	$9,906,026	$5,316,092	$44,014,281	$19,171,730	$0	$0	$28,259,688	$667,693	$1,093,523	$0	$0	$108,429,033
Inpatient Hospitals	$12,785,899	$10,333,981	$77,352,935	$61,110,745	$0	$0	$74,070,764	$5,149,408	$19,508,543	$44,375,127	$0	$304,687,402
Outpatient Hospitals	$1,996,199	$3,500,504	$31,579,126	$31,901,572	$0	$0	$38,657,701	$3,944,746	$2,972,677	$1,214,531	$217	$115,767,273
Lab & X-Ray	$336,966	$575,229	$4,080,667	$7,908,380	$0	($112)	$4,565,655	$1,172,479	$1,552,063	$255,725	$91	$20,447,143
Durable Medical Equipment	$17,788,206	$3,417,083	$34,532,449	$2,022,631	$0	$0	$5,382,698	$3,535,980	$114,018	$7,737	$21,364	$66,822,166
Prescription Drugs	$6,520,078	$10,234,109	$88,778,681	$30,668,561	$0	$1,088	$33,279,711	$19,027,403	$1,277,899	$45,745	$174	$189,833,449
Drug Rebate	($2,014,232)	($3,161,599)	($27,426,192)	($9,474,367)	$0	($336)	($10,281,023)	($5,878,091)	($394,778)	($14,132)	($54)	($58,644,804)
Rural Health Centers	$33,187	$105,329	$792,378	$1,087,608	$0	$0	$3,407,281	$221,847	$212,217	$20,555	$0	$5,880,402
Federally Qualified Health Centers	$603,731	$558,662	$4,565,903	$10,480,699	$0	$0	$36,599,910	$1,514,903	$2,874,034	$1,762,260	$0	$58,960,102
Co-Insurance (Title XVIII-Medicare)	$9,351,692	$1,308,275	$5,742,590	$100,441	$0	$0	$6,279	$8,956	$17,869	$0	$2,440,303	$18,976,405
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$5,554,934	$0	$0	$0	$0	$0	$5,554,934
Prepaid Inpatient Health Plan Services	$2,175,087	$1,620,965	$10,503,018	$4,341,534	$0	$0	$9,283,867	$1,386,666	$1,974,179	$0	$0	$31,285,316
Other Medical Services	$1,879	$1,007	$8,697	$4,562	$0	$122	$7,155	$1,185	$855	$1,192	$82	$26,736
Acute Home Health	$6,525,935	$1,766,126	$11,624,656	$359,940	$0	($9,579)	$600,708	$677,099	$15,120	$877	$99,562	$21,660,444
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$7,849,344	$0	$0	$7,849,344
Subtotal of Acute Care	**$69,287,729**	**$40,815,863**	**$322,592,598**	**$203,687,759**	**$0**	**$5,546,117**	**$325,188,990**	**$42,779,524**	**$48,456,939**	**$54,457,313**	**$2,564,389**	**$1,115,377,221**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$77,897,470	$9,019,369	$36,497,817	$40,463	$0	$0	$0	$5,953	$0	$0	$211,964	$123,673,036
HCBS - Mental Illness	$2,759,506	$1,696,177	$12,752,277	$2,377	$0	$0	$0	$470	$0	$0	$35,513	$17,246,320
HCBS - Disabled Children	$0	$0	$904,544	$0	$0	$0	$264	$0	$0	$0	$75	$904,883
HCBS - Persons Living with AIDS	$16,836	$17,189	$468,801	$0	$0	$0	$0	$0	$0	$0	$704	$503,530
HCBS - Consumer Directed Attendant Support	$7,923,897	$917,469	$3,712,636	$4,116	$0	$0	$0	$606	$0	$0	$21,561	$12,580,285
HCBS - Brain Injury	$73,747	$313,937	$10,724,693	$151	$0	$0	$0	$0	$0	$0	$0	$11,112,528
HCBS - Children with Autism	$0	$0	$18,801	$0	$0	$0	$0	$0	$0	$0	$0	$18,801
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CCT - Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$354,877	$155,949	$12,205,855	$0	$0	$0	$562,535	$3,983,279	$0	$0	$37,261	$17,299,756
Long Term Home Health	$14,122,434	$3,665,712	$61,157,442	$142,257	$0	$9,579	$2,021,380	$6,680,702	$3,250	$134	$183,729	$87,986,619
Hospice	$23,913,110	$1,986,641	$5,611,231	$46,496	$0	$0	$141,295	$0	$0	$0	$88,575	$31,787,348
Subtotal Community Based Long-Term Care	**$127,061,877**	**$17,772,443**	**$144,054,097**	**$235,860**	**$0**	**$9,579**	**$2,725,474**	**$10,671,010**	**$3,250**	**$134**	**$579,382**	**$303,113,106**
Long-Term Care												
Class I Nursing Facilities	$384,275,629	$24,171,304	$68,903,820	$1,596	$0	$0	$0	$0	$0	$0	$951,138	$478,303,487
Class II Nursing Facilities	$106,064	$27,660	$2,100,702	$0	$0	$0	$0	$0	$0	$0	$35,710	$2,270,136
Program of All-Inclusive Care for the Elderly	$37,878,793	$3,182,900	$1,810,588	$0	$0	$0	$0	$0	$0	$0	$0	$42,872,281
Subtotal Long-Term Care	**$422,260,486**	**$27,381,864**	**$72,815,110**	**$1,596**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$986,848**	**$523,445,904**
Insurance												
Supplemental Medicare Insurance Benefit	$44,106,993	$2,572,065	$23,120,257	$144,616	$0	$0	$0	$0	$0	$0	$12,762,950	$82,706,881
Health Insurance Buy-In Program	$1,797	$20,389	$704,579	$2,008	$0	$0	$9,795	$651	$3,133	$0	$0	$742,352
Subtotal Insurance	**$44,108,790**	**$2,592,454**	**$23,824,836**	**$146,624**	**$0**	**$0**	**$9,795**	**$651**	**$3,133**	**$0**	**$12,762,950**	**$83,449,233**
Service Management												
Single Entry Points	$9,171,616	$1,415,981	$7,352,685	$4,528	$0	$0	$0	$1,132	$0	$0	$56,594	$18,002,536
Disease Management	$31,652	$16,971	$146,541	$76,859	$0	$2,053	$120,548	$19,962	$14,413	$0	$0	$428,999
Prepaid Inpatient Health Plan Administration	$505,046	$102,136	$772,630	$519,429	$0	$0	$2,412,273	$223,401	$85,502	$0	$0	$4,620,417
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$9,708,314**	**$1,535,088**	**$8,271,856**	**$600,816**	**$0**	**$2,053**	**$2,532,821**	**$244,495**	**$99,915**	**$0**	**$56,594**	**$23,051,952**
Total Services	**$672,427,196**	**$90,097,712**	**$571,558,497**	**$204,672,655**	**$0**	**$5,557,749**	**$330,457,080**	**$53,695,680**	**$48,563,237**	**$54,457,447**	**$16,950,163**	**$2,048,437,416**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$8,446,320	$605,079	$2,197,186	$666,891	$0	$0	$845,299	$86,257	$65,001	$26,557	$20,803	$12,959,393
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Financing and Supplemental Payments	**$8,446,320**	**$605,079**	**$2,197,186**	**$666,891**	**$0**	**$0**	**$845,299**	**$86,257**	**$65,001**	**$26,557**	**$20,803**	**$12,959,393**
Grand Total	**$680,873,516**	**$90,702,791**	**$573,755,683**	**$205,339,546**	**$0**	**$5,557,749**	**$331,302,379**	**$53,781,937**	**$48,628,238**	**$54,484,004**	**$16,970,966**	**$2,061,396,809**

Exhibit M

Cash-based Actuals												
FY 2005-06	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$3,975,272	$3,688,514	$26,408,980	$36,098,754	$0	$0	$53,028,974	$6,111,311	$8,343,332	$6,611,091	$195	$144,266,423
Emergency Transportation	$84,353	$126,114	$1,133,549	$817,029	$0	$0	$1,140,132	$130,357	$86,656	$93,252	($1)	$3,611,441
Non-emergency Medical Transportation	($3,432)	($1,554)	($4,741)	($335)	$0	$0	($763)	($304)	($32)	($3)	$0	($11,164)
Dental Services	$1,262,181	$236,029	$2,930,118	$3,071,227	$0	$0	$34,885,122	$4,088,844	$217,730	$11,716	$2,547	$46,705,514
Family Planning	($2)	$0	$10,347	$210,459	$0	$0	$106,209	$69,728	$11,612	$765	$1	$409,119
Health Maintenance Organizations	$11,735,631	$9,400,251	$75,960,961	$23,941,548	$0	$0	$32,559,940	$460,293	$718,326	$0	$5,241	$154,782,191
Inpatient Hospitals	$10,886,225	$8,621,491	$71,253,901	$62,945,736	$0	$0	$74,754,190	$4,709,489	$18,737,044	$44,892,047	$1	$296,800,124
Outpatient Hospitals	$3,098,381	$2,915,529	$26,382,059	$28,536,153	$0	$0	$35,812,801	$4,051,514	$2,854,896	$1,562,291	$119	$105,213,743
Lab & X-Ray	$425,283	$446,360	$3,377,104	$7,490,295	$0	$0	$4,504,927	$1,169,897	$1,570,143	$266,156	($128)	$19,250,037
Durable Medical Equipment	$16,326,787	$2,961,537	$29,468,163	$1,671,729	$0	$0	$4,639,863	$3,416,206	$88,577	$10,521	$68,786	$58,652,169
Prescription Drugs	$50,125,835	$12,867,087	$104,466,003	$24,828,668	$0	$2,157	$26,344,076	$17,140,550	$1,101,109	$46,195	$26,145	$236,947,825
Drug Rebate	($16,726,807)	($4,293,700)	($34,859,921)	($8,285,235)	$0	($720)	($8,790,921)	($5,719,738)	($367,436)	($15,415)	($8,724)	($79,068,617)
Rural Health Centers	$32,519	$90,334	$605,016	$864,162	$0	$0	$2,760,432	$214,943	$151,959	$31,966	($1)	$4,751,330
Federally Qualified Health Centers	$641,668	$452,609	$3,870,384	$11,207,906	$0	$0	$39,458,275	$1,483,125	$3,048,685	$1,795,167	($101)	$61,957,718
Co-Insurance (Title XVIII-Medicare)	$8,937,877	$1,204,618	$5,757,919	$38,324	$0	$0	$5,379	$7,029	$17,058	$0	$1,954,240	$17,922,444
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$6,808,264	$0	$0	$0	$0	$0	$6,808,264
Prepaid Inpatient Health Plan Services	$3,077,446	$1,637,924	$11,060,481	$4,851,825	$0	$0	$9,484,138	$1,116,719	$1,758,697	$0	$0	$32,987,230
Other Medical Services	$3,822	$1,206	$10,800	$4,420	$0	$61	$5,670	$1,074	$1,445	$1,344	$61	$29,903
Acute Home Health	$5,861,654	$1,238,685	$9,469,748	$307,616	$0	($364)	$439,354	$587,718	$23,889	($67)	$11,608	$17,939,841
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$2,644,540	$0	$0	$2,644,540
Subtotal of Acute Care	**$99,744,693**	**$41,593,034**	**$337,300,871**	**$198,600,281**	**$0**	**$6,809,398**	**$311,137,798**	**$39,038,755**	**$41,008,230**	**$55,307,026**	**$2,059,989**	**$1,132,600,075**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$66,647,516	$7,757,981	$32,802,759	$37,971	$0	$0	$0	$0	$0	$0	$30,338	$107,276,565
HCBS - Mental Illness	$2,278,956	$1,441,905	$11,259,932	$0	$0	$0	$0	$1,113	$0	$0	$2,267	$14,984,173
HCBS - Disabled Children	($1)	$0	$658,623	$0	$0	$0	$3,201	$0	$0	$0	$0	$661,823
HCBS - Persons Living with AIDS	$16,218	$0	$456,565	$0	$0	$0	$0	$0	$0	$0	$0	$472,783
HCBS - Consumer Directed Attendant Support	$4,916,492	$401,883	$1,919,448	$66	$0	$0	$0	$0	$0	$0	$0	$7,237,889
HCBS - Brain Injury	$12,788	$11,846	$8,788,436	$616	$0	$0	$0	$0	$0	$0	$0	$8,813,686
HCBS - Children with Autism	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CCT - Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$157,164	$405,549	$10,536,627	$0	$0	$0	$397,273	$4,120,147	$0	$0	$0	$15,616,760
Long Term Home Health	$12,674,533	$3,758,347	$50,290,735	$94,785	$0	$364	$1,569,963	$5,888,365	$3,069	$67	$7,382	$74,287,610
Hospice	$21,266,594	$2,111,240	$4,880,020	$111,898	$0	$0	$128,732	$0	$0	$0	$8,603	$28,507,087
Subtotal Community Based Long-Term Care	**$107,970,260**	**$15,888,751**	**$121,593,145**	**$245,336**	**$0**	**$364**	**$2,099,169**	**$10,009,625**	**$3,069**	**$67**	**$48,590**	**$257,858,376**
Long-Term Care												
Class I Nursing Facilities	$370,539,529	$22,631,623	$63,039,217	($10,541)	$0	$0	$1,810	$0	$0	$0	$318,690	$456,520,328
Class II Nursing Facilities	$69,154	$0	$1,367,696	$0	$0	$0	$0	$0	$0	$0	$0	$1,436,850
Program of All-Inclusive Care for the Elderly	$35,666,638	$2,962,484	$1,841,368	$0	$0	$0	$0	$0	$0	$0	$0	$40,470,490
Subtotal Long-Term Care	**$406,275,321**	**$25,594,107**	**$66,248,281**	**($10,541)**	**$0**	**$0**	**$1,810**	**$0**	**$0**	**$0**	**$318,690**	**$498,427,668**
Insurance												
Supplemental Medicare Insurance Benefit	$37,744,128	$2,201,019	$19,784,933	$123,754	$0	$0	$0	$0	$0	$0	$10,921,770	$70,775,604
Health Insurance Buy-In Program	$212,695	$18,547	$157,102	$37,769	$0	$0	$63,030	$10,566	$13,231	$8,200	$3,054	$524,194
Subtotal Insurance	**$37,956,823**	**$2,219,566**	**$19,942,035**	**$161,523**	**$0**	**$0**	**$63,030**	**$10,566**	**$13,231**	**$8,200**	**$10,924,824**	**$71,299,798**
Service Management												
Single Entry Points	$8,671,602	$1,294,860	$6,568,161	$2,262	$0	$0	$2,262	$0	$0	$0	$7,916	$16,547,063
Disease Management	$38,074	$13,320	$114,902	$52,228	$0	$637	$80,668	$12,989	$9,537	$0	$0	$322,355
Prepaid Inpatient Health Plan Administration	$518,021	$113,193	$895,454	$617,504	$0	$0	$2,912,859	$202,140	$81,570	$0	$0	$5,340,741
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$9,227,697**	**$1,421,373**	**$7,578,517**	**$671,994**	**$0**	**$637**	**$2,995,789**	**$215,129**	**$91,107**	**$0**	**$7,916**	**$22,210,159**
Total Services	**$661,174,794**	**$86,716,831**	**$552,662,849**	**$199,668,593**	**$0**	**$6,810,399**	**$316,297,596**	**$49,274,075**	**$41,115,637**	**$55,315,293**	**$13,360,009**	**$1,982,396,076**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$9,224,466	$630,714	$2,207,656	$704,247	$0	$0	$884,200	$100,025	$70,482	$38,570	$7,871	$13,868,231
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$0	$0	$1	$0	$0	$0	$0	$0	$0	$0	$0	$1
Subtotal Financing and Supplemental Payments	**$9,224,466**	**$630,714**	**$2,207,657**	**$704,247**	**$0**	**$0**	**$884,200**	**$100,025**	**$70,482**	**$38,570**	**$7,871**	**$13,868,232**
Grand Total	**$670,399,260**	**$87,347,545**	**$554,870,506**	**$200,372,840**	**$0**	**$6,810,399**	**$317,181,796**	**$49,374,100**	**$41,186,119**	**$55,353,863**	**$13,367,880**	**$1,996,264,308**

Exhibit N - Expenditure History by Service Category

ACUTE CARE	FY 2015-16	Percent Change from Prior	FY 2014-15	Percent Change from Prior Year	FY 2013-14	Percent Change from Prior Year	FY 2012-13	Percent Change from Prior Year	FY 2011-12	Percent Change From Prior Year	FY 2010-11	Percent Change From Prior Year	FY 2009-10	Percent Change From Prior Year	FY 2008-09	Percent Change From Prior Year	FY 2007-08	Percent Change From Prior Year	FY 2006-07
Physician Services & EPSDT	$747,052,304	13.57%	$657,799,926	46.91%	$447,742,226	43.81%	$311,344,143	8.47%	$287,020,239	1.57%	$282,592,042	16.33%	$242,929,414	4.30%	$232,912,692	22.16%	$190,663,827	16.09%	$164,232,428
Emergency Transportation	$31,635,356	74.36%	$18,143,536	79.18%	$10,125,852	39.21%	$7,273,660	14.35%	$6,361,058	2.00%	$6,236,250	19.52%	$5,217,633	5.75%	$4,934,082	8.43%	$4,550,505	6.21%	$4,284,622
Non-Emergency Medical Transportation	$18,472,382	35.13%	$13,670,286	-7.23%	$14,734,943	53.86%	$9,576,755	-8.46%	$10,462,166	-0.07%	$10,469,107	14.65%	$9,131,655	5.09%	$8,689,018	12.35%	$7,733,949	-12832.88%	($60,740)
Dental Services	$329,502,705	32.69%	$248,329,591	69.16%	$146,803,940	26.14%	$116,386,038	12.00%	$103,911,787	-4.29%	$108,570,692	22.25%	$88,806,857	16.15%	$76,456,424	41.86%	$53,893,890	9.17%	$49,367,133
Family Planning	$2,594,764	83.28%	$1,415,719	47.69%	$958,576	37.09%	$699,220	20.77%	$578,957	31.16%	$441,414	37.10%	$321,975	0.80%	$319,424	58.07%	$202,073	996.25%	$18,433
Health Maintenance Organizations	$384,880,337	30.87%	$294,094,972	116.42%	$135,890,722	7.40%	$126,531,583	4.82%	$120,715,911	2.75%	$117,488,456	-0.14%	$117,651,717	-8.85%	$129,074,827	26.28%	$102,216,877	-5.73%	$108,429,033
Inpatient Hospitals	$699,220,303	4.41%	$669,696,478	40.01%	$478,311,291	17.58%	$406,784,919	12.22%	$362,502,617	-2.52%	$371,861,948	10.23%	$337,358,448	-5.39%	$356,576,636	11.12%	$320,899,293	5.32%	$304,687,402
Outpatient Hospitals	$582,149,790	9.36%	$532,321,364	34.03%	$397,169,554	41.27%	$281,148,005	20.93%	$232,479,846	6.89%	$217,492,911	50.04%	$144,956,141	-5.81%	$153,901,754	18.21%	$130,192,196	12.46%	$115,767,273
Lab & X-Ray	$115,744,154	22.52%	$94,468,696	46.04%	$64,684,775	41.69%	$45,653,385	14.20%	$39,978,003	5.59%	$37,862,120	25.59%	$30,148,317	6.01%	$28,437,823	24.87%	$22,774,240	11.38%	$20,447,143
Durable Medical Equipment	$167,085,542	11.48%	$149,875,322	25.25%	$119,661,675	16.03%	$103,126,254	10.05%	$93,706,452	3.40%	$90,627,945	15.78%	$78,272,962	1.64%	$77,011,816	1.58%	$75,815,972	13.46%	$66,822,166
Prescription Drugs	$834,402,471	24.69%	$669,175,357	47.66%	$453,191,438	35.60%	$334,204,114	4.85%	$318,741,461	13.32%	$281,278,949	24.40%	$226,114,086	-3.23%	$233,666,309	7.75%	$216,864,136	14.24%	$189,833,449
Drug Rebate	($408,879,686)	27.28%	($321,241,375)	64.51%	($195,271,698)	9.08%	($179,022,880)	19.52%	($149,787,193)	18.03%	($126,909,710)	27.09%	($99,855,328)	8.75%	($91,818,104)	65.54%	($55,465,088)	-5.42%	($58,644,804)
Rural Health Centers	$20,725,156	-3.69%	$21,519,068	45.15%	$14,825,896	20.09%	$12,345,593	16.82%	$10,567,916	3.73%	$10,188,005	27.45%	$7,993,821	7.18%	$7,458,484	19.47%	$6,242,784	6.16%	$5,880,402
Federally Qualified Health Centers	$145,816,160	-2.33%	$149,297,728	16.54%	$128,107,489	28.38%	$99,791,204	5.28%	$94,790,483	4.97%	$90,306,523	18.44%	$76,244,360	4.32%	$73,089,013	16.72%	$62,621,473	6.21%	$58,960,102
Co-Insurance (Title XVIII-Medicare)	$76,013,615	39.19%	$54,609,798	-0.54%	$54,904,379	34.44%	$40,839,212	10.27%	$37,036,552	1.78%	$36,387,414	74.50%	$20,852,175	-25.79%	$28,098,389	24.84%	$22,507,668	18.61%	$18,976,405
Breast and Cervical Cancer Treatment Program	$2,591,199	-12.03%	$2,945,501	-66.83%	$8,879,647	-7.11%	$9,559,144	-6.95%	$10,272,613	1.64%	$10,106,643	15.95%	$8,716,269	23.77%	$7,042,030	-0.65%	$7,088,411	27.61%	$5,554,934
Prepaid Inpatient Health Plan Services	$5,390,487	-88.04%	$45,078,921	-23.51%	$58,932,563	2.21%	$57,655,514	2.11%	$56,463,119	11.04%	$50,849,494	13.75%	$44,703,819	24.21%	$35,989,196	6.85%	$33,682,305	7.66%	$31,285,316
Other Medical Services	$3,875	-79.83%	$19,210	-8.48%	$20,991	35.15%	$15,532	1.55%	$15,295	8.03%	$14,158	-71.19%	$49,140	4.67%	$46,946	38.53%	$33,888	26.75%	$26,736
Acute Home Health	$28,195,914	-6.84%	$30,266,737	32.63%	$22,819,991	21.87%	$18,725,376	80.29%	$10,386,312	-52.00%	$21,640,221	-2.80%	$22,263,483	0.08%	$22,244,640	-69.48%	$72,876,211	236.45%	$21,660,444
Presumptive Eligibility	$0	0.00%	$0	0.00%	$0	-100.00%	$3,075,000	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	-100.00%	$3,770,690	-51.96%	$7,849,344
Subtotal of Acute Care	**$3,782,596,828**	**13.54%**	**$3,331,486,835**	**41.02%**	**$2,362,494,250**	**30.83%**	**$1,805,711,771**	**9.69%**	**$1,646,203,594**	**1.77%**	**$1,617,504,582**	**18.77%**	**$1,361,876,944**	**-1.61%**	**$1,384,131,398**	**8.21%**	**$1,279,165,299**	**14.68%**	**$1,115,377,221**
COMMUNITY BASED LONG-TERM CARE																			
HCBS - Elderly, Blind, and Disabled	$321,321,224	8.13%	$297,154,820	6.31%	$279,523,188	15.27%	$242,494,560	7.69%	$225,185,711	6.12%	$212,196,143	13.82%	$186,426,075	5.63%	$176,481,671	24.96%	$141,231,844	14.20%	$123,673,036
HCBS - Mental Illness	$35,721,561	5.10%	$33,989,393	6.49%	$31,919,229	12.75%	$28,309,412	9.16%	$25,934,255	3.96%	$24,946,790	9.99%	$22,681,360	-1.21%	$22,958,866	12.49%	$20,409,887	18.34%	$17,246,320
HCBS - Disabled Children	$12,558,473	15.09%	$10,912,003	34.69%	$8,101,781	51.42%	$5,350,385	70.93%	$3,130,073	59.29%	$1,965,004	11.44%	$1,763,210	0.89%	$1,747,683	29.09%	$1,353,847	49.62%	$904,883
HCBS - Persons Living with AIDS	$0	-100.00%	($3,577)	-102.64%	$135,733	-71.78%	$480,928	-6.80%	$516,036	-9.07%	$567,535	-2.39%	$581,405	-1.91%	$592,744	-0.45%	$595,406	18.25%	$503,530
HCBS - Consumer Directed Attendant Support	$2,081,957	-19.07%	$2,572,697	10.36%	$2,331,237	-12.42%	$2,661,977	-23.10%	$3,461,683	16.90%	$2,961,259	-15.80%	$3,516,917	-14.76%	$4,125,973	-70.76%	$14,109,819	12.16%	$12,580,285
HCBS - Brain Injury	$19,160,548	15.08%	$16,649,310	17.38%	$14,184,077	10.38%	$12,849,682	2.09%	$12,587,131	2.36%	$12,297,265	7.10%	$11,482,073	-4.54%	$12,028,236	11.52%	$10,785,587	-2.94%	$11,112,528
HCBS - Children with Autism	$558,548	-21.34%	$710,058	-7.10%	$764,302	-13.68%	$885,424	-13.40%	$1,022,387	-24.69%	$1,357,612	-13.29%	$1,565,700	21.00%	$1,293,932	86.02%	$695,586	3599.73%	$18,801
HCBS - Pediatric Hospice	$642,990	35.75%	$473,674	113.72%	$221,632	7.00%	$207,131	21.19%	$170,910	34.89%	$126,702	33.68%	$94,781	223.36%	$29,312	0.00%	$0	0.00%	$0
HCBS - Spinal Cord Injury	$1,974,424	12.24%	$1,759,072	-0.82%	$1,773,572	602.38%	$252,509	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
CCT - Services	$2,208,394	-8.37%	$2,410,066	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Private Duty Nursing	$72,609,335	18.07%	$61,498,982	15.70%	$53,154,903	44.26%	$36,846,961	18.31%	$31,144,153	12.18%	$27,761,694	19.50%	$23,230,817	8.80%	$21,351,408	8.11%	$19,749,262	14.16%	$17,299,756
Long Term Home Health	$239,436,289	12.63%	$212,577,453	13.97%	$186,515,195	17.58%	$158,630,532	4.90%	$151,221,421	0.15%	$150,993,547		$134,184,938	7.28%	$125,083,498		$56,838,987	-35.40%	$87,986,619
Hospice	$51,366,916	7.86%	$47,622,754	5.79%	$45,017,254	3.73%	$43,397,100	2.53%	$42,326,808	6.18%	$39,862,966	-7.98%	$43,321,496	8.57%	$39,902,873	21.62%	$32,810,776	3.22%	$31,787,348
Subtotal of Community Based Long-Term Care	**$759,640,659**	**10.36%**	**$688,326,705**	**10.37%**	**$623,642,103**	**17.15%**	**$532,366,601**	**7.18%**	**$496,700,568**	**4.56%**	**$475,036,517**	**10.77%**	**$428,848,772**	**5.73%**	**$405,596,195**	**35.84%**	**$298,581,001**	**-1.50%**	**$303,113,106**
LONG-TERM CARE AND INSURANCE																			
Class I Nursing Facilities	$619,673,488	6.96%	$579,329,903	3.02%	$562,325,391	5.62%	$532,405,250	2.14%	$521,244,769	2.58%	$508,141,849	4.33%	$487,074,333	-8.26%	$530,918,672	9.11%	$486,568,498	1.73%	$478,303,487
Class II Nursing Facilities	$4,042,506	-5.50%	$4,277,851	22.76%	$3,484,766	-31.77%	$5,107,562	104.38%	$2,499,074	5.77%	$2,362,706	17.21%	$2,015,835	-11.26%	$2,271,714	1.61%	$2,235,636	-1.52%	$2,270,136
Program of All-Inclusive Care for the Elderly	$129,011,469	-2.93%	$132,904,767	32.28%	$100,474,817	3.21%	$97,346,358	13.88%	$85,480,585	1.24%	$84,429,683	21.94%	$69,240,623	13.42%	$61,049,836	23.54%	$49,418,855	15.27%	$42,872,281
Supplemental Medicare Insurance Benefit	$156,430,863	13.96%	$137,271,082	6.27%	$129,168,681	7.77%	$119,859,864	1.06%	$118,598,927	-0.79%	$119,543,734	15.98%	$103,068,590	9.95%	$93,743,114	13.67%	$82,465,946	-0.29%	$82,706,881
Health Insurance Buy-In Program	$1,613,716	27.78%	$1,262,907	-7.50%	$1,365,261	0.27%	$1,361,531	17.44%	$1,159,307	3.05%	$1,124,996	20.75%	$931,637	-1.12%	$942,145	4.11%	$904,947	21.90%	$742,352
Subtotal of Long-Term Care and Insurance	**$910,772,042**	**6.52%**	**$855,046,510**	**7.31%**	**$796,818,916**	**5.39%**	**$756,080,565**	**3.72%**	**$728,982,662**	**1.87%**	**$715,602,968**	**8.04%**	**$662,331,018**	**-3.86%**	**$688,925,481**	**10.83%**	**$621,593,882**	**2.42%**	**$606,895,137**
SERVICE MANAGEMENT																			
Single Entry Points	$31,283,068	-4.10%	$32,619,317	21.27%	$26,899,016	-0.29%	$26,976,561	6.94%	$25,226,746	5.02%	$24,021,660	1.32%	$23,707,551	2.78%	$23,067,175	6.02%	$21,757,100	20.86%	$18,002,536
Disease Management	$542,225	-45.13%	$988,242	87.54%	$526,953	-44.94%	$957,110	-2.54%	$982,012	0.00%	$0	-100.00%	$71,616	-97.52%	$2,882,271	23.66%	$2,330,726	443.29%	$428,999
Prepaid Inpatient Health Plan Administration	$121	-99.99%	$2,201,486	-71.15%	$7,630,138	14.14%	$6,685,075	-24.81%	$8,891,348	37.31%	$6,475,244	26.67%	$5,111,753	29.90%	$3,935,134	9.02%	$3,609,472	-21.88%	$4,620,417
Accountable Care Collaborative	$140,949,235	35.59%	$103,950,766	51.60%	$68,570,330	86.69%	$36,728,931	105.10%	$17,907,833	1917.99%	$887,411	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Subtotal Service Management	$172,774,649	**23.62%**	$139,759,811	**34.87%**	$103,626,437	**45.24%**	$71,347,677	**34.60%**	$53,007,939	**68.90%**	$31,384,315	**8.63%**	$28,890,920	**-3.32%**	$29,884,581	**7.90%**	$27,697,298	**20.15%**	$23,051,952
Total Services	**$5,625,784,178**	**12.19%**	**$5,014,619,861**	**29.02%**	**$3,886,581,706**	**22.78%**	**$3,165,506,614**	**8.23%**	**$2,924,894,763**	**3.01%**	**$2,839,528,382**	**14.41%**	**$2,481,947,654**	**-1.06%**	**$2,508,537,655**	**12.64%**	**$2,227,037,481**	**8.72%**	**$2,048,437,416**
FINANCING AND SUPPLEMENTAL PAYMENTS																			
Upper Payment Limit Financing	$3,505,607	-3.63%	$3,637,757	-35.85%	$5,670,550	-2.43%	$5,811,783	-8.87%	$6,377,165	-61.22%	$16,446,173	-8.31%	$17,936,927	-2.62%	$18,419,432	54.11%	$11,952,096	-7.77%	$12,959,393
Hospital Supplemental Payments	$1,084,717,996	84.49%	$587,956,421	-5.58%	$622,708,054	-4.32%	$650,828,979	5.90%	$614,554,259	34.96%	$455,348,284	45.73%	$312,468,739	0.00%	$0	0.00%	$0	0.00%	$0
Nursing Facility Supplemental Payments	$100,549,259	8.09%	$93,026,856	3.62%	$89,773,988	5.92%	$84,755,778	-2.34%	$86,787,485	13.72%	$76,315,634	60.83%	$47,451,412	0.00%	$0	0.00%	$0	0.00%	$0
Physician Supplemental Payments	$19,369,964	315.73%	$4,659,239	-17.08%	$5,619,123	-58.33%	$13,485,215	170.53%	$4,984,682	83.54%	$2,715,842	-81.28%	$14,504,498	0.00%	$0	0.00%	$0	0.00%	$0
Outstationing Payments	$6,443,530	-67.04%	$19,548,094	205.03%	$6,408,519	-58.42%	$15,412,520	964.98%	$1,447,215	-72.61%	$5,283,594	50.09%	$3,520,254	0.00%	$0	0.00%	$0	0.00%	$0
Accounting Adjustments	($1,082,597)	-118.84%	$5,745,565	186.10%	$2,008,260	25.53%	$1,599,845	-46.44%	$2,987,193	-29274.66%	($10,239)	-40.71%	($17,268)	-150.26%	$34,355	-67.84%	$106,828	0.00%	$0
Subtotal Financing and Supplemental Payments	**$1,213,503,759**	**69.82%**	**$714,573,932**	**-2.41%**	**$732,188,494**	**-5.14%**	**$771,894,120**	**7.64%**	**$717,137,999**	**28.96%**	**$556,099,288**	**40.48%**	**$395,864,562**	**2045.17%**	**$18,453,787**	**53.03%**	**$12,058,924**	**-6.95%**	**$12,959,393**
Grand Total	**$6,839,287,937**	**19.38%**	**$5,729,193,793**	**24.04%**	**$4,618,770,200**	**17.31%**	**$3,937,400,734**	**8.11%**	**$3,642,032,762**	**7.26%**	**$3,395,627,670**	**17.99%**	**$2,877,812,216**	**13.88%**	**$2,526,991,443**	**12.86%**	**$2,239,096,405**	**8.62%**	**$2,061,396,809**

Exhibit N - Expenditure History by Service Category - Delay Adjusted

ACUTE CARE	FY 2015-16	Percent Change from Prior Year	FY 2014-15	Percent Change from Prior Year	FY 2013-14	Percent Change from Prior Year	FY 2012-13	Percent Change from Prior Year	FY 2011-12	Percent Change From Prior Year	FY 2010-11 (DA)	Percent Change From Prior Year	FY 2009-10 (DA)	Percent Change From Prior Year	FY 2008-09	Percent Change From Prior Year	FY 2007-08	Percent Change From Prior Year	FY 2006-07
Physician Services & EPSDT	$747,052,304	13.57%	$657,799,926	46.91%	$447,742,226	43.81%	$311,344,143	8.47%	$287,020,239	4.99%	$273,385,004	8.43%	$252,136,452	8.25%	$232,912,692	22.16%	$190,663,827	16.09%	$164,232,428
Emergency Transportation	$31,635,356	74.36%	$18,143,536	79.18%	$10,125,852	39.21%	$7,273,660	14.35%	$6,361,058	5.59%	$6,024,129	10.95%	$5,429,754	10.05%	$4,934,082	8.43%	$4,550,505	6.21%	$4,284,622
Non-emergency Medical Transportation	$18,472,382	35.13%	$13,670,286	-7.23%	$14,734,943	53.86%	$9,576,755	-8.46%	$10,462,166	0.95%	$10,363,372	12.19%	$9,237,391	6.31%	$8,689,018	12.35%	$7,733,949	-12832.88%	($60,740)
Dental Services	$329,502,705	32.69%	$248,329,591	69.16%	$146,803,940	26.14%	$116,386,038	12.00%	$103,911,787	-0.87%	$104,818,977	13.25%	$92,558,572	21.06%	$76,456,424	41.86%	$53,893,890	9.17%	$49,367,133
Family Planning	$2,594,764	83.28%	$1,415,719	47.69%	$958,576	37.09%	$699,220	20.77%	$578,957	35.12%	$428,473	27.93%	$334,916	4.85%	$319,424	58.07%	$202,073	996.25%	$18,433
Health Maintenance Organizations	$384,880,337	30.87%	$294,094,972	116.42%	$135,890,722	7.40%	$126,531,583	4.82%	$120,715,911	2.75%	$117,488,424	-0.14%	$117,651,749	-8.85%	$129,074,827	26.28%	$102,216,877	-5.73%	$108,429,033
Inpatient Hospitals	$699,220,303	4.41%	$669,696,478	40.01%	$478,311,291	17.58%	$406,784,919	12.22%	$362,502,617	1.42%	$357,410,899	1.59%	$351,809,497	-1.34%	$356,576,636	11.12%	$320,899,293	5.32%	$304,687,402
Outpatient Hospitals	$582,149,790	9.36%	$532,321,364	34.03%	$397,169,554	41.27%	$281,148,005	20.93%	$232,479,846	10.81%	$209,791,226	37.43%	$152,657,826	-0.81%	$153,901,754	18.21%	$130,192,196	12.46%	$115,767,273
Lab & X-Ray	$115,744,154	22.52%	$94,468,696	46.04%	$64,684,775	41.69%	$45,653,385	14.20%	$39,978,003	9.29%	$36,581,144	16.39%	$31,429,293	10.52%	$28,437,823	24.87%	$22,774,240	11.38%	$20,447,143
Durable Medical Equipment	$167,085,542	11.48%	$149,875,322	25.25%	$119,661,675	16.03%	$103,126,254	10.05%	$93,706,452	6.79%	$87,745,314	8.12%	$81,155,593	5.38%	$77,011,816	1.58%	$75,815,972	13.46%	$66,822,166
Prescription Drugs	$834,402,471	24.69%	$669,175,357	47.66%	$453,191,438	35.60%	$334,204,114	4.85%	$318,741,461	16.98%	$272,469,874	15.98%	$234,923,161	0.54%	$233,666,309	7.75%	$216,864,136	14.24%	$189,833,449
Drug Rebate	($408,879,686)	27.28%	($321,241,375)	64.51%	($195,271,698)	9.08%	($179,022,880)	19.52%	($149,787,193)	18.03%	($126,909,710)	27.09%	($99,855,328)	8.75%	($91,818,104)	65.54%	($55,465,088)	-5.42%	($58,644,804)
Rural Health Centers	$20,725,156	-3.69%	$21,519,068	45.15%	$14,825,896	20.09%	$12,345,593	16.82%	$10,567,916	6.88%	$9,887,646	19.21%	$8,294,180	11.20%	$7,458,484	19.47%	$6,242,784	6.16%	$5,880,402
Federally Qualified Health Centers	$145,816,160	-2.33%	$149,297,728	16.54%	$128,107,489	28.38%	$99,791,204	5.28%	$94,790,483	8.29%	$87,530,066	10.77%	$79,020,817	8.12%	$73,089,013	16.72%	$62,621,473	6.21%	$58,960,102
Co-Insurance (Title XVIII-Medicare)	$76,013,615	39.19%	$54,609,798	-0.54%	$54,904,379	34.44%	$40,839,212	10.27%	$37,036,552	5.69%	$35,043,547	57.88%	$22,196,042	-21.01%	$28,098,389	24.84%	$22,507,668	18.61%	$18,976,405
Breast and Cervical Cancer Treatment Program	$2,591,199	-12.03%	$2,945,501	-66.83%	$8,879,647	-7.11%	$9,559,144	-6.95%	$10,272,613	4.64%	$9,817,118	9.01%	$9,005,794	27.89%	$7,042,030	-0.65%	$7,088,411	27.61%	$5,554,934
Prepaid Inpatient Health Plan Services	$5,390,487	-88.04%	$45,078,921	-23.51%	$58,932,563	2.21%	$57,655,514	2.11%	$56,463,119	11.04%	$50,849,494	13.75%	$44,703,819	24.21%	$35,989,196	6.85%	$33,682,305	7.66%	$31,285,316
Other Medical Services	$3,875	-79.83%	$19,210	-8.48%	$20,991	35.15%	$15,532	1.55%	$15,295	8.03%	$14,158	-71.19%	$49,140	4.67%	$46,946	38.53%	$33,888	26.75%	$26,736
Acute Home Health	$28,195,914	-6.84%	$30,266,737	32.63%	$22,819,991	21.87%	$18,725,376	80.29%	$10,386,312	-50.78%	$21,100,194	-7.40%	$22,785,871	2.43%	$22,244,640	-69.48%	$72,876,211	236.45%	$21,660,444
Presumptive Eligibility	$0	0.00%	$0	0.00%	$0	-100.00%	$3,075,000	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	-100.00%	$3,770,690	-51.96%	$7,849,344
Subtotal of Acute Care	**$3,782,596,828**	**13.54%**	**$3,331,486,835**	**41.02%**	**$2,362,494,250**	**30.83%**	**$1,805,711,771**	**9.69%**	**$1,646,203,594**	**5.27%**	**$1,563,839,348**	**10.48%**	**$1,415,524,539**	**2.27%**	**$1,384,131,398**	**8.21%**	**$1,279,165,299**	**14.68%**	**$1,115,377,221**
COMMUNITY BASED LONG-TERM CARE																			
HCBS - Elderly, Blind, and Disabled	$321,321,224	8.13%	$297,154,820	6.31%	$279,523,188	15.27%	$242,494,560	7.69%	$225,185,711	7.99%	$208,526,316	9.70%	$190,095,902	7.71%	$176,481,671	24.96%	$141,231,844	14.20%	$123,673,036
HCBS - Mental Illness	$35,721,561	5.10%	$33,989,393	6.49%	$31,919,229	12.75%	$28,309,412	9.16%	$25,934,255	5.48%	$24,587,535	6.71%	$23,040,615	0.36%	$22,958,866	12.49%	$20,409,887	18.34%	$17,246,320
HCBS - Disabled Children	$12,558,473	15.09%	$10,912,003	34.69%	$8,101,781	51.42%	$5,350,385	70.93%	$3,130,073	65.86%	$1,887,201	2.51%	$1,841,013	5.34%	$1,747,683	29.09%	$1,353,847	49.62%	$904,883
HCBS - Persons Living with AIDS	$0	-100.00%	($3,577)	-102.64%	$135,733	-71.78%	$480,928	-6.80%	$516,036	-6.24%	$550,398	-8.04%	$598,542	0.98%	$592,744	-0.45%	$595,406	18.25%	$503,530
HCBS - Consumer Directed Attendant Support	$2,081,957	-19.07%	$2,572,697	10.36%	$2,331,237	-12.42%	$2,661,977	-23.10%	$3,461,683	16.90%	$2,961,259	-15.80%	$3,516,917	-14.76%	$4,125,973	-70.76%	$14,109,819	12.16%	$12,580,285
HCBS - Brain Injury	$19,160,548	15.08%	$16,649,310	17.38%	$14,184,077	10.38%	$12,849,682	2.09%	$12,587,131	3.32%	$12,182,917	5.06%	$11,596,421	-3.59%	$12,028,236	11.52%	$10,785,587	-2.94%	$11,112,528
HCBS - Children with Autism	$558,548	-21.34%	$710,058	-7.10%	$764,302	-13.68%	$885,424	-13.40%	$1,022,387	-23.05%	$1,328,578	-16.69%	$1,594,734	23.25%	$1,293,932	86.02%	$695,586	3599.73%	$18,801
HCBS - Pediatric Hospice	$642,990	35.75%	$473,674	113.72%	$221,632	7.00%	$207,131	21.19%	$170,910	43.29%	$119,273	16.69%	$102,210	248.70%	$29,312	0.00%	$0	0.00%	$0
HCBS - Spinal Cord Injury	$1,974,424	12.24%	$1,759,072	-0.82%	$1,773,572	602.38%	$252,509	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
CCT - Services	$2,208,394	-8.37%	$2,410,066	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Private Duty Nursing	$72,609,335	18.07%	$61,498,982	15.70%	$53,154,903	44.26%	$36,846,961	18.31%	$31,144,153	13.97%	$27,325,956	15.46%	$23,666,555	10.84%	$21,351,408	8.11%	$19,749,262	14.16%	$17,299,756
Long Term Home Health	$239,436,289	12.63%	$212,577,453	13.97%	$186,515,195	17.58%	$158,630,532	4.90%	$151,221,421	2.47%	$147,581,926	7.24%	$137,614,198	10.02%	$125,083,498		$56,838,987	-35.40%	$87,986,619
Hospice	$51,366,916	7.86%	$47,622,754	5.79%	$45,017,254	3.73%	$43,397,100	2.53%	$42,326,808	7.03%	$39,547,635	-9.37%	$43,636,827	9.36%	$39,902,873	21.62%	$32,810,776	3.22%	$31,787,348
Subtotal Community Based Long-Term Care	**$759,640,659**	**10.36%**	**$688,326,705**	**10.37%**	**$623,642,103**	**17.15%**	**$532,366,601**	**7.18%**	**$496,700,568**	**6.45%**	**$466,598,993**	**6.70%**	**$437,303,935**	**7.82%**	**$405,596,195**	**35.84%**	**$298,581,001**	**-1.50%**	**$303,113,106**
LONG-TERM CARE AND INSURANCE																			
Class I Nursing Facilities	$619,673,488	6.96%	$579,329,903	3.02%	$562,325,391	5.62%	$532,405,250	2.14%	$521,244,769	4.39%	$499,315,390	0.69%	$495,900,792	-6.60%	$530,918,672	9.11%	$486,568,498	1.73%	$478,303,487
Class II Nursing Facilities	$4,042,506	-5.50%	$4,277,851	22.76%	$3,484,766	-31.77%	$5,107,562	104.38%	$2,499,074	-21.00%	$3,163,194	160.27%	$1,215,347	-46.50%	$2,271,714	1.61%	$2,235,636	-1.52%	$2,270,136
Program of All-Inclusive Care for the Elderly	$129,011,469	-2.93%	$132,904,767	32.28%	$100,474,817	3.21%	$97,346,358	13.88%	$85,480,585	1.26%	$84,414,278	21.89%	$69,256,028	13.44%	$61,049,836	23.54%	$49,418,855	15.27%	$42,872,281
Supplemental Medicare Insurance Benefit	$156,430,863	13.96%	$137,271,082	6.27%	$129,168,681	7.77%	$119,859,864	1.06%	$118,598,927	-0.79%	$119,543,734	15.98%	$103,068,590	9.95%	$93,743,114	13.67%	$82,465,946	-0.29%	$82,706,881
Health Insurance Buy-In Program	$1,613,716	27.78%	$1,262,907	-7.50%	$1,365,261	0.27%	$1,361,531	17.44%	$1,159,307	11.83%	$1,036,644	1.63%	$1,019,989	8.26%	$942,145	4.11%	$904,947	21.90%	$742,352
Subtotal Long-Term Care and Insurance	**$910,772,042**	**6.52%**	**$855,046,510**	**7.31%**	**$796,818,916**	**5.39%**	**$756,080,565**	**3.72%**	**$728,982,662**	**3.04%**	**$707,473,240**	**5.52%**	**$670,460,746**	**-2.68%**	**$688,925,481**	**10.83%**	**$621,593,882**	**2.42%**	**$606,895,137**
SERVICE MANAGEMENT																			
Single Entry Points	$31,283,068	-4.10%	$32,619,317	21.27%	$26,899,016	-0.29%	$26,976,561	6.94%	$25,226,746	5.02%	$24,021,660	1.32%	$23,707,551	2.78%	$23,067,175	6.02%	$21,757,100	20.86%	$18,002,536
Disease Management	$542,225	-45.13%	$988,242	87.54%	$526,953	-44.94%	$957,110	-2.54%	$982,012	0.00%	$0	-100.00%	$71,616	-97.52%	$2,882,271	23.66%	$2,330,726	443.29%	$428,999
Prepaid Inpatient Health Plan Administration	$121	-99.99%	$2,201,486	-71.15%	$7,630,138	14.14%	$6,685,075	-24.81%	$8,891,348	37.31%	$6,475,244	26.67%	$5,111,753	29.90%	$3,935,134	9.02%	$3,609,472	-21.88%	$4,620,417
Accountable Care Collaborative	$140,949,235	35.59%	$103,950,766	51.60%	$68,570,330	86.69%	$36,728,931	105.10%	$17,907,833	0.00%	$887,411	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Subtotal Service Management	$172,774,649	**23.62%**	$139,759,811	**34.87%**	$103,626,437	**45.24%**	$71,347,677	**34.60%**	$53,007,939	**68.90%**	$31,384,315	**8.63%**	$28,890,920	**-3.32%**	$29,884,581	**7.90%**	$27,697,298	**20.15%**	$23,051,952
Total Services	**$5,625,784,178**	**12.19%**	**$5,014,619,861**	**29.02%**	**$3,886,581,706**	**22.78%**	**$3,165,506,614**	**8.23%**	**$2,924,894,763**	**5.62%**	**$2,769,295,896**	**8.51%**	**$2,552,180,140**	**1.74%**	**$2,508,537,655**	**12.64%**	**$2,227,037,481**	**8.72%**	**$2,048,437,416**
FINANCING AND SUPPLEMENTAL PAYMENTS																			
Upper Payment Limit Financing	$3,505,607	-3.63%	$3,637,757	-35.85%	$5,670,550	-2.43%	$5,811,783	-8.87%	$6,377,165	-61.22%	$16,446,173	-8.31%	$17,936,927	-2.62%	$18,419,432	54.11%	$11,952,096	-7.77%	$12,959,393
Hospital Supplemental Payments	$1,084,717,996	84.49%	$587,956,421	-5.58%	$622,708,054	-4.32%	$650,828,979	5.90%	$614,554,259	34.96%	$455,348,284	45.73%	$312,468,739	0.00%	$0	0.00%	$0	0.00%	$0
Nursing Facility Supplemental Payments	$100,549,259	8.09%	$93,026,856	3.62%	$89,773,988	5.92%	$84,755,778	-2.34%	$86,787,485	13.72%	$76,315,634	60.83%	$47,451,412	0.00%	$0	0.00%	$0	0.00%	$0
Physician Supplemental Payments	$19,369,964	315.73%	$4,659,239	-17.08%	$5,619,123	-58.33%	$13,485,215	170.53%	$4,984,682	83.54%	$2,715,842	-81.28%	$14,504,498	0.00%	$0	0.00%	$0	0.00%	$0
Outstationing Payments	$6,443,530	-67.04%	$19,548,094	205.03%	$6,408,519	-58.42%	$15,412,520	964.98%	$1,447,215	-72.61%	$5,283,594	50.09%	$3,520,254	0.00%	$0	0.00%	$0	0.00%	$0
Accounting Adjustments	($1,082,597)	-118.84%	$5,745,565	186.10%	$2,008,260	25.53%	$1,599,845	-46.44%	$2,987,193	-29274.66%	($10,239)	-40.71%	($17,268)	-150.26%	$34,355	-67.84%	$106,828	0.00%	$0
Subtotal Financing and Supplemental Payments	**$1,213,503,759**	**69.82%**	**$714,573,932**	**-2.41%**	**$732,188,494**	**-5.14%**	**$771,894,120**	**7.64%**	**$717,137,999**	**28.96%**	**$556,099,288**	**40.48%**	**$395,864,562**	**2045.17%**	**$18,453,787**	**53.03%**	**$12,058,924**	**-6.95%**	**$12,959,393**
Grand Total	**$6,839,287,937**	**19.38%**	**$5,729,193,793**	**24.04%**	**$4,618,770,200**	**17.31%**	**$3,937,400,734**	**8.11%**	**$3,642,032,762**	**9.52%**	**$3,325,395,184**	**12.80%**	**$2,948,044,702**	**16.66%**	**$2,526,991,443**	**12.86%**	**$2,239,096,405**	**8.62%**	**$2,061,396,809**

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

Exhibit O - Appropriations and Expenditures

Final FY 2015-16 Funding Splits

	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
SB 15-234 FY 2015-16 Long Bill Appropriation	**$6,584,363,560**	**$967,942,644**	**$848,124,468**	**$698,756,395**	**$0**	**$4,069,540,053**
SB 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine"	$250,547	$123,295	$0	$0	$0	$127,252
HB 15-1186 "Services for Children with Autism"	$10,205,160	$164,846	$0	$4,840,203	$0	$5,200,111
HB 15-1309 "Protective Restorations By Dental Hygienists"	$11,217	$4,515	$0	$690	$0	$6,012
HB 16-1240 FY 2015-16 Supplemental Bill FY16	$213,234,125	$34,093,714	$0	$110,294,265	$9,145,518	$59,700,628
HB 16-1405 FY 2016-17 Long Bill Add-on	$69,360,066	$27,324,406	($39,100,001)	$5,425,739	$0	$75,709,922
Appropriations Totals	$6,877,424,675	$1,029,653,420	$809,024,467	$819,317,292	$9,145,518	$4,210,283,978
Final Expenditures	$6,839,287,937	$1,029,807,052	$809,024,467	$822,942,823	$9,214,192	$4,168,299,403
Remaining Balance	**$38,136,738**	**($153,632)**	**$0**	**($3,625,531)**	**($68,674)**	**$41,984,575**

Notes:

1. Totals reflect final CORE close as of August 29, 2016; they do not include post-closing entries past this date.
2. Totals may not match those found elsewhere, due to rounding.
3. Remaining Balance is an over-expenditure if it is in parentheses. The balance is an under-expenditure if it is not in parentheses.

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

FY 2015-16 Final Actuals			
Aid Category	**Caseload**	**Per Capita**	**Total**
Adults 65 and Older (OAP-A)	42,403	$26,416.05	$1,120,119,563
Disabled Adults 60 to 64 (OAP-B)	10,529	$22,445.50	$236,328,661
Disabled Individuals to 59 (AND/AB)	68,800	$18,357.29	$1,262,981,438
Disabled Buy-In	6,217	$8,309.88	$51,662,544
MAGI Parents/Caretakers to 68% FPL	163,342	$3,857.13	$630,031,316
MAGI Parents/Caretakers 69% to 133% FPL	86,964	$3,173.71	$275,998,243
MAGI Adults	320,374	$5,061.75	$1,621,652,689
Breast & Cervical Cancer Program	322	$12,963.42	$4,174,222
Eligible Children (AFDC-C/BC)	467,193	$2,299.63	$1,074,369,547
SB 11-008 Eligible Children	59,501	$1,869.59	$111,242,364
Foster Care	19,935	$4,900.24	$97,686,211
MAGI Pregnant Adults	14,413	$15,416.49	$222,197,881
SB 11-250 Eligible Pregnant Adults	1,759	$13,772.94	$24,226,599
Non-Citizens- Emergency Services	2,649	$25,221.06	$66,810,582
Partial Dual Eligibles	32,585	$1,221.61	$39,806,077
TOTAL	**1,296,986**	**TF**	**$6,839,287,937**
Total Funds include upper payment limit financing and supplemental payments and other Medicaid financing. Totals may not match due to rounding.		**GF**	$1,029,807,052
		GFE	$809,024,467
		CF	$822,942,823
		CFE	$9,214,192
		FF	$4,168,299,403

Exhibit O - Comparison of Budget Requests and Appropriations

FY 2015-16 Comparison of Requests and Appropriations										
FY 2015-16	November 1, 2014	February 15, 2015	% Change	FY 2015-16 Long Bill and Special Bills Appropriation	November 1, 2015	February 15, 2016	% Change over Appropriation	FY 2015-16 Final Appropriation	FY 2015-16 Actuals	% Change over Feb.
Acute Care	$3,562,496,596	$3,750,491,579	5.28%	$3,800,901,873	$3,780,455,987	$3,831,913,200	0.82%	$3,831,913,200	$3,808,410,322	-0.61%
Community Based Long-Term Care	$745,158,037	$753,587,483	1.13%	$786,527,925	$770,448,047	$750,692,124	-4.56%	$750,692,124	$759,640,659	1.19%
Long-Term Care	$836,879,748	$839,892,986	0.36%	$839,892,987	$829,480,139	$861,154,625	2.53%	$861,154,625	$853,276,722	-0.91%
Insurance	$145,436,492	$148,760,317	2.29%	$148,760,317	$149,998,929	$158,550,619	6.58%	$158,550,619	$158,044,579	-0.32%
Service Management	$175,685,324	$183,992,306	4.73%	$184,150,612	$178,721,396	$179,265,861	-2.65%	$185,339,861	$172,774,649	-3.62%
Financing	$860,870,575	$905,312,468	5.16%	$834,596,770	$1,092,886,111	$1,089,774,246	30.57%	$1,089,774,246	$1,087,141,006	-0.24%
Total	$6,326,526,772	$6,582,037,139	4.04%	$6,594,830,484	$6,801,990,609	$6,871,350,675	4.19%	$6,877,424,675	$6,839,287,937	-0.47%
Class I Nursing Facilities	$686,986,774	$695,007,389	1.17%	$695,007,389	$690,862,427	$720,698,794	3.70%	$695,007,389	$720,222,747	-0.07%

FY 2016-17 Comparison of Requests and Appropriations										
FY 2016-17	November 1, 2015	February 15, 2016	% Change	FY 2016-17 Long Bill and Special Bills Appropriation	November 1, 2016	February 15, 2017	% Change over Appropriation	FY 2016-17 Final Appropriation	FY 2016-17 Actuals	% Change over Feb.
Acute Care	$3,818,407,108	$3,922,765,076	2.73%	$3,978,315,269	$4,152,482,606		4.38%			
Community Based Long-Term Care	$865,308,210	$856,322,485	-1.04%	$856,322,485	$843,234,384		-1.53%			
Long-Term Care	$873,310,814	$916,648,706	4.96%	$916,648,706	$900,607,611		-1.75%			
Insurance	$164,392,778	$177,900,591	8.22%	$177,900,591	$194,635,458		9.41%			
Service Management	$196,705,139	$205,109,626	4.27%	$205,109,626	$201,757,707		-1.63%			
Financing	$685,603,507	$683,967,918	-0.24%	$683,967,918	$667,241,731		-2.45%			
Total	$6,603,727,556	$6,762,714,402	2.41%	$6,818,264,595	$6,959,959,497		2.08%			
Class I Nursing Facilities	$711,374,044	$755,586,890	6.22%	$755,586,890	$748,845,636		-0.89%			

FY 2017-18 Comparison of Requests and Appropriations										
FY 2017-18	November 1, 2016	February 15, 2017	% Change	FY 2017-18 Long Bill and Special Bills Appropriation	November 1, 2017	February 15, 2018	% Change over Appropriation	FY 2017-18 Final Appropriation	FY 2017-18 Actuals	% Change over Feb.
Acute Care	$4,298,182,275									
Community Based Long-Term Care	$904,192,231									
Long-Term Care	$944,164,243									
Insurance	$203,563,555									
Service Management	$213,338,551									
Financing	$550,848,541									
Total	$7,114,289,396									
Class I Nursing Facilities	$774,956,824									

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

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	COFRS TOTAL
FY 2000-01	$515,213,506	$61,119,754	$450,888,114	$0	$88,758,327	$0	$0	$0	$193,552,834	$0	$30,746,407	$31,503,592	$0	$36,930,022	$7,822,852	$1,416,535,408
FY 2001-02	$571,065,382	$61,284,519	$465,027,758	$0	$104,227,966	$0	$0	$0	$220,555,126	$0	$33,206,413	$33,946,549	$0	$39,372,440	$8,118,537	$1,536,804,691
FY 2002-03	$564,628,021	$64,679,670	$516,439,288	$0	$139,745,425	$0	$0	$1,428,780	$227,992,629	$0	$37,567,968	$42,521,465	$0	$48,734,092	$7,933,536	$1,651,670,874
FY 2003-04	$634,138,712	$76,646,130	$562,700,004	$0	$184,736,556	$0	$0	$2,668,992	$233,391,821	$0	$45,491,729	$64,293,820	$0	$55,212,960	$9,469,507	$1,868,750,230
FY 2004-05	$652,991,016	$82,003,665	$540,574,590	$0	$193,239,971	$0	$0	$2,490,659	$304,520,783	$0	$46,710,822	$42,305,572	$0	$44,773,436	$10,931,012	$1,920,541,525
FY 2005-06	$670,399,260	$87,347,545	$554,870,506	$0	$200,372,840	$0	$0	$6,810,399	$317,181,796	$0	$49,374,100	$41,186,119	$0	$55,353,863	$13,367,880	$1,996,264,308
FY 2006-07	$680,873,516	$90,702,791	$573,755,683	$0	$205,339,546	$0	$0	$5,557,749	$331,302,379	$0	$53,781,937	$48,628,238	$0	$54,484,004	$16,970,966	$2,061,396,809
FY 2007-08	$712,276,694	$101,257,270	$655,167,660	$0	$207,678,887	$0	$0	$7,102,713	$364,161,301	$0	$64,197,785	$54,600,185	$0	$53,660,977	$18,992,933	$2,239,096,405
FY 2008-09	$789,584,078	$115,435,768	$735,082,424	$0	$239,681,753	$0	$0	$7,056,952	$433,354,524	$0	$67,739,569	$60,847,257	$0	$59,283,547	$18,925,572	$2,526,991,443
FY 2009-10 (DA)	$821,242,371	$128,660,906	$830,201,463	$0	$332,734,554	$3,669,083	$0	$9,006,758	$561,985,046	$0	$75,035,330	$91,641,692	$0	$74,354,502	$19,512,995	$2,948,044,702
FY 2010-11 (DA)	$859,971,337	$150,963,523	$943,370,577	$0	$373,924,419	$82,213,921	$0	$9,817,158	$627,769,745	$0	$81,811,588	$95,688,869	$0	$75,541,133	$24,322,916	$3,325,395,184
FY 2011-12	$896,112,956	$170,623,165	$1,033,566,923	$723,127	$442,861,997	$120,389,845	$4,003,017	$10,287,938	$683,425,225	$0	$79,698,390	$97,417,747	$0	$78,357,967	$24,564,465	$3,642,032,762
FY 2012-13	$927,900,253	$183,967,002	$1,049,728,681	$18,292,102	$468,129,131	$133,498,122	$87,688,473	$9,565,112	$749,135,524	$15,071,720	$79,058,628	$108,082,008	$2,869,936	$78,979,079	$25,434,963	$3,937,400,734
FY 2013-14	$980,364,004	$196,560,882	$1,101,867,467	$39,863,213	$471,485,421	$144,781,548	$447,013,009	$8,884,676	$823,611,350	$47,052,815	$85,183,296	$168,143,624	$12,064,530	$61,044,575	$30,849,790	$4,618,770,200
FY 2014-15	$1,044,291,631	$217,931,810	$1,108,322,123	$30,521,839	$569,129,005	$206,228,721	$1,145,194,212	$5,578,806	$925,982,289	$82,362,752	$92,006,877	$193,228,921	$20,411,857	$56,781,957	$31,220,993	$5,729,193,793
FY 2015-16	$1,120,119,563	$236,328,661	$1,262,981,438	$51,662,544	$630,031,316	$275,998,243	$1,621,652,689	$4,174,222	$1,074,369,547	$111,242,364	$97,686,211	$222,197,881	$24,226,599	$66,810,582	$39,806,077	$6,839,287,937

Fiscal Year	Expenditures	Percent Change	Dollar Increase/ Decrease	Average Yearly Percent Change From FY 2000-01	Percent Change	Three-year Moving Average	Percent Change
FY 2000-01	$1,416,535,408						
FY 2001-02	$1,536,804,691	8.49%	$120,269,284				
FY 2002-03	$1,651,670,874	7.47%	$114,866,182	7.98%			
FY 2003-04	$1,868,750,230	13.14%	$217,079,357	9.70%	21.55%	9.70%	
FY 2004-05	$1,920,541,525	2.77%	$51,791,295	7.97%	-17.86%	7.80%	-19.65%
FY 2005-06	$1,996,264,308	3.94%	$75,722,783	7.16%	-10.11%	6.62%	-15.10%
FY 2006-07	$2,061,396,809	3.26%	$65,132,501	6.51%	-9.08%	3.33%	-49.76%
FY 2007-08	$2,239,096,405	8.62%	$177,699,596	6.82%	4.62%	5.28%	58.62%
FY 2008-09	$2,526,991,443	12.86%	$287,895,038	7.57%	11.08%	8.25%	56.33%
FY 2009-10 (DA)	$2,948,044,702	16.66%	$421,053,259	8.58%	13.34%	12.71%	54.16%
FY 2010-11 (DA)	$3,325,395,184	12.80%	$377,350,482	9.00%	4.92%	14.11%	10.96%
FY 2011-12	$3,642,032,762	9.52%	$316,637,578	9.05%	0.52%	12.99%	-7.88%
FY 2012-13	$3,937,400,734	8.11%	$295,367,972	8.97%	-0.87%	10.14%	-21.94%
FY 2013-14	$4,618,770,200	17.31%	$681,369,466	9.61%	7.15%	11.65%	14.80%
FY 2014-15	$5,729,193,793	24.04%	$1,110,423,593	10.64%	10.72%	16.49%	41.56%
FY 2015-16	$6,839,287,937	19.38%	$1,110,094,144	11.23%	5.47%	20.24%	22.78%

	Official Projection	Percent Change	Dollar Increase/ Decrease	Projection Using Most Recent Average Change	Percent Change over Official Projection	Projection Using Most Recent Three-year Average	Percent Change over Premium Workbook Projection
FY 2016-17 Projection	$6,959,959,497	1.76%	$120,671,560	$7,607,018,168	9.30%	$8,223,621,299	18.16%
FY 2017-18 Projection	$7,114,289,396	2.22%	$154,329,899	$7,741,235,466	8.81%	$8,368,717,867	17.63%
FY 2018-19 Projection	$7,830,346,931	10.07%	$716,057,535	$7,912,889,351	1.05%	$8,554,285,525	9.25%
FY 2016-17 Appropriation	$6,818,264,595						
Difference Between FY 2016-17 Projections and FY 2016-17 Appropriation	$141,694,902	2.08%		$788,753,573	11.57%	$1,405,356,704	20.61%
Difference Between FY 2017-18 Projections and FY 2016-17 Appropriation	$296,024,801	4.34%		$922,970,871	13.54%	$1,550,453,272	22.74%
Difference Between FY 2018-19 Projections and FY 2016-17 Appropriation	$1,012,082,336	14.84%		$1,094,624,756	16.05%	$1,736,020,930	25.46%

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

Fiscal Year	Total Expenditures (1)	Annual % Change	Total Caseload (2)	Annual % Change
FY 1998-99	$1,176,233,410		237,598	
FY 1999-00	$1,308,420,100	11.24%	253,254	6.59%
FY 2000-01	$1,416,535,408	8.26%	275,399	8.74%
FY 2001-02	$1,536,804,691	8.49%	295,413	7.27%
FY 2002-03	$1,651,670,874	7.47%	331,800	12.32%
FY 2003-04	$1,868,750,230	13.14%	367,559	10.78%
FY 2004-05	$1,920,541,525	2.77%	406,024	10.46%
FY 2005-06	$1,996,264,308	3.94%	402,218	-0.94%
FY 2006-07	$2,061,396,809	3.26%	392,229	-2.48%
FY 2007-08	$2,239,096,405	8.62%	391,962	-0.07%
FY 2008-09	$2,526,991,443	12.86%	436,812	11.44%
FY 2009-10	$2,948,044,702	16.66%	498,797	14.19%
FY 2010-11	$3,325,395,184	12.80%	560,759	12.42%
FY 2011-12	$3,642,032,762	9.52%	619,963	10.56%
FY 2012-13	$3,937,400,734	8.11%	682,994	10.17%
FY 2013-14	$4,618,770,200	17.31%	860,957	26.06%
FY 2014-15	$5,729,193,793	24.04%	1,161,206	34.87%
FY 2015-16	$6,839,287,937	19.38%	1,296,986	11.69%
FY 2016-17 Projection	$6,959,959,497	1.76%	1,414,916	9.09%
FY 2017-18 Projection	$7,114,289,396	2.22%	1,484,636	4.93%
FY 2018-19 Projection	$7,830,346,931	10.07%	1,530,832	3.11%

(1) Expenditures are for Medical Services Premiums only.

(2) Caseload does not include retroactivity.

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

	FY 2018-19 Projection	Percent Change from Prior Year	FY 2017-18 Projection	Percent Change from Prior Year	FY 2016-17 Projection	Percent Change from Prior Year	FY 2015-16	Percent Change from Prior Year	FY 2014-15	Percent Change from Prior Year	FY 2013-14	Percent Change from Prior Year	FY 2012-13	Percent Change from Prior Year	FY 2011-12
Title XIX - Medical Services Premiums															
Acute Care	$4,271,116,637	2.82%	$4,153,958,346	3.68%	$4,006,644,782	8.87%	$3,680,140,578	13.33%	$3,247,138,071	40.17%	$2,316,532,889	29.51%	$1,788,720,827	8.66%	$1,646,203,594
Community-Based Long-Term Care	$964,358,136	6.84%	$902,586,901	7.23%	$841,730,727	11.01%	$758,250,179	10.28%	$687,570,035	10.29%	$623,397,416	17.10%	$532,360,795	7.18%	$496,700,568
Long-Term Care and Insurance	$1,080,881,468	3.74%	$1,041,903,594	5.01%	$992,220,473	8.94%	$910,772,042	6.52%	$855,046,510	7.31%	$796,818,916	5.39%	$756,080,565	3.72%	$728,982,662
Service Management	$213,161,325	4.46%	$204,069,952	5.63%	$193,196,461	17.06%	$165,047,442	22.97%	$134,218,911	32.13%	$101,584,215	44.28%	$70,409,603	32.83%	$53,007,939
Total Services	**$6,529,517,566**	**3.60%**	**$6,302,518,793**	**4.45%**	**$6,033,792,443**	**9.42%**	**$5,514,210,241**	**11.99%**	**$4,923,973,527**	**28.28%**	**$3,838,333,436**	**21.95%**	**$3,147,571,790**	**7.61%**	**$2,924,894,763**
Financing and Supplemental Payments	$1,143,526,500	71.04%	$668,567,462	-15.28%	$789,157,675	-33.66%	$1,189,608,733	69.35%	$702,445,657	-2.62%	$721,319,419	-6.55%	$771,887,288	7.63%	$717,137,999
Total Medical Services Premiums Expenditure	**$7,673,044,066**	**10.07%**	**$6,971,086,255**	**2.17%**	**$6,822,950,118**	**1.78%**	**$6,703,818,974**	**19.15%**	**$5,626,419,184**	**23.40%**	**$4,559,652,855**	**16.33%**	**$3,919,459,078**	**7.62%**	**$3,642,032,762**
Title XIX - Medicaid Mental Health															
Capitations	$691,067,094	5.26%	$656,515,374	12.99%	$581,054,557	-1.39%	$589,248,607	6.28%	$554,440,757	33.66%	$414,828,541	37.68%	$301,303,046	10.97%	$271,506,635
Fee-for-Service	$9,214,182	2.84%	$8,959,739	4.61%	$8,564,581	9.05%	$7,853,643	8.83%	$7,216,638	38.34%	$5,216,732	14.17%	$4,569,198	17.39%	$3,892,397
Total Mental Health Expenditure	**$700,281,276**	**5.23%**	**$665,475,113**	**12.87%**	**$589,619,138**	**-1.25%**	**$597,102,250**	**6.31%**	**$561,657,395**	**33.71%**	**$420,045,273**	**37.33%**	**$305,872,244**	**11.07%**	**$275,399,032**
Title XIX - Other Medicaid Services															
Office of Community Living	$511,473,619	5.10%	$486,675,408	6.49%	$457,008,276	7.02%	$427,050,636	8.15%	$394,879,029	13.36%	$348,330,959	100.00%	$0	0.00%	$0
Medicare Modernization Act	$163,907,186	9.02%	$150,341,733	13.86%	$132,037,056	15.81%	$114,014,334	5.94%	$107,620,224	1.17%	$106,376,992	4.48%	$101,817,855	8.80%	$93,582,494
Public School Health Services[1]	$82,046,488	0.00%	$82,046,488	2.41%	$80,112,910	13.84%	$70,374,889	13.01%	$62,272,311	43.17%	$43,494,624	-5.33%	$45,945,267	12.81%	$40,726,548
Total Other Medicaid Services Expenditure	**$757,427,293**	**5.34%**	**$719,063,629**	**7.46%**	**$669,158,242**	**9.44%**	**$611,439,859**	**8.26%**	**$564,771,564**	**13.36%**	**$498,202,575**	**237.16%**	**$147,763,122**	**10.02%**	**$134,309,042**
Title XIX - DHS - Medicaid Funded [2]															
Child Welfare Services	$6,524,564	0.00%	$6,524,564	0.00%	$6,524,564	0.00%	$6,524,564	-4.23%	$6,812,425	-14.16%	$7,935,965	-5.83%	$8,427,164	-22.94%	$10,935,478
Mental Health Institutes	$7,176,700	0.00%	$7,176,700	0.00%	$7,176,700	0.00%	$7,176,700	-9.70%	$7,947,547	28.03%	$6,207,423	18.97%	$5,217,447	9.71%	$4,755,641
High Risk Pregnant Women Program	$735,467	0.00%	$735,467	0.00%	$735,467	0.00%	$735,467	-24.16%	$969,806	-14.78%	$1,138,015	8.15%	$1,052,271	-6.57%	$1,126,309
Regional Centers	$48,586,422	0.00%	$48,586,422	0.00%	$48,586,422	0.00%	$48,586,422	16.07%	$41,860,712	-22.94%	$54,324,467	-1.63%	$55,222,864	8.09%	$51,089,926
Division of Youth Corrections Medicaid Funding	$1,328,061	0.00%	$1,328,061	0.00%	$1,328,061	0.00%	$1,328,061	1.91%	$1,303,119	-20.38%	$1,636,744	12.24%	$1,458,298	0.12%	$1,456,613
Mental Health Treatment Services for Youth (HB 99-1116)	$8,133	0.00%	$8,133	0.00%	$8,133	0.00%	$8,133	-6.28%	$8,678	-57.92%	$20,624	-53.37%	$44,226	-78.06%	$201,543
DHS Office of Community Living	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	-100.00%	$325,077,613	-0.54%	$326,845,621
Total DHS - Medicaid Funded Expenditure	**$64,359,347**	**0.00%**	**$64,359,347**	**0.00%**	**$64,359,347**	**0.00%**	**$64,359,347**	**9.26%**	**$58,902,287**	**-17.35%**	**$71,263,238**	**-82.03%**	**$396,499,883**	**0.02%**	**$396,411,131**
Total Title XIX Services Expenditure	**$9,195,111,982**	**9.21%**	**$8,419,984,344**	**3.36%**	**$8,146,086,845**	**2.12%**	**$7,976,720,430**	**17.10%**	**$6,811,750,430**	**22.75%**	**$5,549,163,941**	**16.34%**	**$4,769,594,327**	**7.23%**	**$4,448,151,967**
Title XXI															
CHP+ Children	$156,446,006	5.20%	$148,717,620	3.13%	$144,208,767	25.92%	$114,522,947	-9.77%	$126,924,334	-25.66%	$170,744,026	0.36%	$170,136,500	5.65%	$161,043,047
Medicaid SB 11-008 Eligible Children Services	$134,540,482	4.39%	$128,880,390	7.74%	$119,623,851	10.64%	$108,123,287	21.12%	$89,270,353	119.43%	$40,683,465	170.04%	$15,065,837	100.00%	$0
Medicaid SB 11-008 Eligible Children Financing and Supplemental Payments	$14,788,988	71.04%	$8,646,443	-15.29%	$10,207,482	-39.24%	$16,800,418	103.64%	$8,250,157	9.97%	$7,502,364	127426.16%	$5,883	100.00%	$0
CHP+ Prenatal	$10,800,857	1.65%	$10,625,810	2.61%	$10,355,214	21.19%	$8,544,303	196.90%	$2,877,791	-76.04%	$12,009,028	-43.97%	$21,433,958	0.11%	$21,411,076
Medicaid SB 11-250 Eligible Pregnant Adults Services	$21,071,446	4.41%	$20,181,356	3.60%	$19,479,844	10.34%	$17,653,907	2.61%	$17,204,409	96.64%	$8,749,216	204.96%	$2,868,987	100.00%	$0
Medicaid SB 11-250 Eligible Pregnant Adults Financing and Supplemental Payments	$6,171,783	71.04%	$3,608,358	-15.06%	$4,248,096	-40.12%	$7,094,608	82.94%	$3,878,118	15.19%	$3,366,711	354664.07%	$949	100.00%	$0
Total Title XXI Services Expenditure	**$343,819,562**	**7.22%**	**$320,659,977**	**4.07%**	**$308,123,254**	**12.97%**	**$272,739,470**	**9.80%**	**$248,405,162**	**2.20%**	**$243,054,810**	**16.01%**	**$209,512,114**	**14.83%**	**$182,454,123**
Total Services Expenditure	**$9,538,931,544**	**9.13%**	**$8,740,644,321**	**3.39%**	**$8,454,210,099**	**2.48%**	**$8,249,459,900**	**16.85%**	**$7,060,155,592**	**21.89%**	**$5,792,218,751**	**16.33%**	**$4,979,106,441**	**7.53%**	**$4,630,606,090**

Footnotes:

(1) Projections for Public School Health Services are the appropriation without the administrative costs, in FY 2016-17, and the annualization from FY 2016-17 S-14/BA-13 "Public School Health Services Funding Adjustment" without the administrative costs, in FY 2017-18. This value is held constant in FY 2018-19.

(2) The Department of Human Services Medicaid Funded services are not forecast in a budget request by the Department. Due to this, the Department has held the FY 2015-16 spending constant in FY 2016-17 and beyond, for the purpose of this exhibit. This does not represent an actual request by the Department.

Notes:

1. Due to prior year reconciliations and adjustments made for payment delays, figures for FY 2009-10 and FY 2010-11 will not match figures reported on the Schedule 3.
2. FY 2015-16 expenditure shows data as of August 29, 2016. Figures may change in the February 2017 Request for transactions completed in CORE after that date.

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

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

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	MAGI Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL Title XIX		Title XXI Children	Title XXI Prenatal	TOTAL Title XXI
FY 2007-08	$20,832.53	$24,595.06	$20,330.18	-	$4,148.36	-	-	$26,529.23	$2,005.83	$8,036.90	$9,163.19	$12,803.86	$2,474.70	$7,257.42		$1,661.71	$11,058.59	$1,910.23
FY 2008-09	$22,218.30	$26,686.38	$22,274.92	-	$4,145.23	-	-	$22,492.20	$2,087.81	$7,969.45	$9,155.31	$14,869.21	$2,372.72	$7,346.31		$1,828.45	$10,863.01	$2,066.29
% Change from FY 2007-08	6.65%	8.50%	9.57%	-	-0.08%	-	-	-15.22%	4.09%	-0.84%	-0.09%	16.13%	-4.12%	1.22%		10.03%	-1.77%	8.17%
FY 2009-10 (DA)	$22,306.66	$26,933.19	$23,626.46	-	$4,718.29	$1,339.80	-	$21,422.85	$2,266.51	$7,919.81	$12,099.92	$20,133.90	$2,043.19	$7,308.33		$2,364.08	$10,265.14	$2,539.55
% Change from FY 2008-09	0.40%	0.92%	6.07%	-	13.82%	-	-	-4.75%	8.56%	-0.62%	32.16%	35.41%	-13.89%	-0.52%		29.29%	-5.50%	22.90%
FY 2010-11 (DA)	$23,253.81	$28,282.07	$25,013.54	-	$4,904.25	$3,318.40	-	$18,741.34	$2,304.39	$7,764.07	$12,538.81	$23,511.09	$2,376.70	$7,284.79		$2,307.33	$12,673.12	$2,569.00
% Change from FY 2009-10 (DA)	4.25%	5.01%	5.87%	-	3.94%	1.48	-	-12.52%	1.67%	-1.97%	3.63%	16.77%	16.32%	-0.32%		-2.40%	23.46%	1.16%
FY 2011-12	$23,940.41	$28,675.39	$25,333.78	$15,677.48	$5,054.50	$3,690.91	$3,622.13	$17,497.51	$2,308.33	$7,531.36	$13,153.20	$28,288.07	$2,451.06	$7,174.87		$2,168.46	$10,373.58	$2,390.33
% Change from FY 2010-11 (DA)	2.95%	1.39%	1.28%	-	3.06%	11.23%	-	-6.64%	0.17%	-3.00%	4.90%	20.32%	3.13%	-1.51%		-6.02%	-18.15%	-6.95%
FY 2012-13	$24,183.33	$28,378.59	$24,690.21	$22,761.17	$5,027.66	$3,504.94	$9,490.42	$15,597.84	$2,362.18	$7,347.17	$13,857.61	$29,425.89	$2,339.84	$7,072.21		$2,151.81	$12,431.66	$2,380.12
% Change from FY 2011-12	1.01%	-1.04%	-2.54%	0.45	-0.53%	-5.04%	1.62	-10.86%	2.33%	-2.45%	5.36%	4.02%	-4.54%	-1.43%		-0.77%	19.84%	-0.43%
FY 2013-14	$24,870.78	$27,925.75	$24,880.88	$17,772.27	$4,125.45	$3,296.76	$6,200.46	$16,347.85	$2,344.15	$7,530.11	$13,142.92	$24,604.83	$2,501.58	$6,649.25		$2,519.36	$12,002.47	$2,733.75
% Change from FY 2012-13	2.84%	-1.60%	0.77%	-21.92%	-17.94%	-5.94%	-34.67%	4.81%	-0.76%	2.49%	-5.16%	-16.38%	6.91%	-5.98%		17.08%	-3.45%	14.86%
FY 2014-15	$26,233.77	$29,409.01	$24,626.44	$11,438.63	$3,880.18	$3,307.18	$5,452.20	$14,284.32	$2,388.06	$7,844.50	$13,309.04	$20,899.18	$2,232.30	$6,140.34		$2,162.02	$9,835.25	$2,337.96
% Change from FY 2013-14	5.48%	5.31%	-1.02%	-35.64%	-5.95%	0.32%	-12.07%	-12.62%	1.87%	4.18%	1.26%	-15.06%	-10.76%	-7.65%		-14.18%	-18.06%	-14.48%
FY 2015-16	$27,736.52	$31,073.85	$26,402.87	$10,646.13	$4,206.83	$3,801.53	$5,715.62	$13,363.31	$2,616.70	$7,441.34	$15,739.39	$25,263.30	$2,237.84	$6,455.09		$2,166.11	$13,717.68	$2,414.29
% Change from FY 2014-15	5.73%	5.66%	7.21%	-6.93%	8.42%	14.95%	4.83%	-6.45%	9.57%	-5.14%	18.26%	20.88%	0.25%	5.13%		0.19%	39.47%	3.26%
FY 2016-17 Projection	$29,786.22	$30,671.85	$27,254.03	$10,346.61	$3,703.05	$3,156.38	$5,152.62	$13,008.39	$2,401.08	$6,782.36	$13,950.02	$21,132.00	$2,461.60	$6,045.51		$2,163.79	$12,353.44	$2,381.04
% Change from FY 2015-16	7.39%	-1.29%	3.22%	-2.81%	-11.98%	-16.97%	-9.85%	-2.66%	-8.24%	-8.86%	-11.37%	-16.35%	10.00%	-6.35%		-0.11%	-9.95%	-1.38%
FY 2017-18 Projection	$30,364.62	$31,017.33	$27,829.05	$9,817.91	$3,591.03	$3,066.94	$5,014.44	$12,951.79	$2,363.64	$7,006.54	$13,629.20	$20,077.61	$2,458.73	$5,910.25		$2,131.19	$12,191.12	$2,338.28
% Change from FY 2016-17	1.94%	1.13%	2.11%	-5.11%	-3.03%	-2.83%	-2.68%	-0.44%	-1.56%	3.31%	-2.30%	-4.99%	-0.12%	-2.24%		-1.51%	-1.31%	-1.80%
FY 2018-19 Projection	$32,598.98	$32,390.48	$29,277.22	$10,087.77	$3,789.36	$3,225.55	$5,396.47	$14,429.57	$2,523.64	$7,410.37	$15,370.24	$23,831.75	$2,386.19	$6,267.67		$2,204.55	$13,191.43	$2,428.34
% Change from FY 2017-18	7.36%	4.43%	5.20%	2.75%	5.52%	5.17%	7.62%	11.41%	6.77%	5.76%	12.77%	18.70%	-2.95%	6.05%		3.44%	8.21%	3.85%

Notes:

1. See Page EQ-1 for a list of services that are included in the calculations for per capita costs for Title XIX and Title XXI services.
2. See Narrative for a description of events that alter trends.
3. The per capita costs reported here are adjusted for the two-week FY 2009-10 payment delay; that is, the claims which were delayed at the end of FY 2009-10 (and paid in FY 2010-11) are included in the FY 2009-10 totals and excluded from the FY 2010-11 totals.

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

FMAP Forecast																
Calendar Year	United States			Colorado			Colorado 3-year Average Per Capita	U.S. 3-year Average Per Capita	FMAP[(1)] Calculation	eFMAP[(2)] Calculation		FFY/ SFY	FFY FMAP[(3)]	FFY eFMAP[(3)]	SFY FMAP[(4)]	SFY eFMAP[(4)]
	Personal Income	Population	Per Capita Personal Income	Personal Income	Population	Per Capita Personal Income										
2000	$8,634,847,000,000	282,162,411	$30,602.40	$148,128,340,000	4,326,921	$34,234.12	-	-	-	-		2000-01	50.00%	65.00%	50.00%	65.00%
2001	$8,987,890,000,000	284,968,955	$31,539.89	$155,992,188,000	4,425,687	$35,247.00	-	-	-	-		2001-02	50.00%	65.00%	50.00%	65.00%
2002	$9,150,761,000,000	287,625,193	$31,814.88	$157,172,883,000	4,490,406	$35,001.93	$34,827.68	$31,319.06	50.00%	65.00%		2002-03	50.00%	65.00%	50.00%	65.00%
2003	$9,484,225,000,000	290,107,933	$32,692.06	$160,369,195,000	4,528,732	$35,411.50	$35,220.14	$32,015.61	50.00%	65.00%		2003-04	50.00%	65.00%	50.00%	65.00%
2004	$10,047,876,000,000	292,805,298	$34,315.90	$167,793,881,000	4,575,013	$36,676.15	$35,696.53	$32,940.95	50.00%	65.00%		2004-05	50.00%	65.00%	50.00%	65.00%
2005	$10,610,320,000,000	295,516,599	$35,904.31	$179,089,828,000	4,631,888	$38,664.54	$36,917.40	$34,304.09	50.00%	65.00%		2005-06	50.00%	65.00%	50.00%	65.00%
2006	$11,381,350,000,000	298,379,912	$38,143.82	$192,161,658,000	4,720,423	$40,708.57	$38,683.09	$36,121.34	50.00%	65.00%		2006-07	50.00%	65.00%	50.00%	65.00%
2007	$11,995,419,000,000	301,231,207	$39,821.30	$203,034,950,000	4,803,868	$42,264.89	$40,546.00	$37,956.48	50.00%	65.00%		2007-08	50.00%	65.00%	50.00%	65.00%
2008	$12,492,705,000,000	304,093,966	$41,081.73	$213,342,148,000	4,889,730	$43,630.66	$42,201.37	$39,682.28	50.00%	65.00%		2008-09	50.00%	65.00%	50.00%	65.00%
2009	$12,079,444,000,000	306,771,529	$39,376.03	$206,385,419,000	4,972,195	$41,507.91	$42,467.82	$40,093.02	50.00%	65.00%		2009-10	50.00%	65.00%	50.00%	65.00%
2010	$12,459,613,000,000	309,347,057	$40,277.13	$211,419,677,000	5,048,575	$41,877.10	$42,338.56	$40,244.96	50.20%	65.14%		2010-11	50.00%	65.00%	50.00%	65.00%
2011	$13,233,436,000,000	311,721,632	$42,452.74	$227,052,222,000	5,119,661	$44,349.07	$42,578.03	$40,701.97	50.76%	65.53%		2011-12	50.00%	65.00%	50.00%	65.00%
2012	$13,904,485,000,000	314,112,078	$44,266.00	$240,905,431,000	5,191,709	$46,401.95	$44,209.37	$42,331.96	50.92%	65.64%		2012-13	50.00%	65.00%	50.00%	65.00%
2013	$14,064,468,000,000	316,497,531	$44,437.84	$246,447,709,000	5,272,086	$46,745.77	$45,832.26	$43,718.86	50.54%	65.38%		2013-14	50.00%	65.00%	50.00%	65.00%
2014	$14,683,147,000,000	318,857,056	$46,049.31	$261,735,447,000	5,355,866	$48,868.93	$47,338.88	$44,917.72	50.02%	65.01%		2014-15	51.01%	65.71%	50.76%	65.53%
2015	$15,324,108,725,000	321,467,160	$47,669.28	$275,107,294,000	5,457,432	$50,409.66	$48,674.79	$46,052.14	50.00%	65.00%		2015-16	50.72%	65.50%	50.79%	65.55%
2016	$15,967,721,291,450	324,103,191	$49,267.40	$288,587,551,406	5,538,580	$52,104.97	$50,461.19	$47,662.00	50.00%	65.00%		2016-17	50.02%	65.01%	**50.20%**	**65.13%**
2017	$16,702,236,470,857	326,760,837	$51,114.56	$302,728,341,425	5,635,874	$53,714.53	$52,076.39	$49,350.41	50.00%	65.00%		2017-18	50.00%	65.00%	**50.00%**	**65.00%**
2018	$17,487,241,584,987	329,407,600	$53,086.94	$317,864,758,496	5,735,248	$55,423.02	$53,747.51	$51,156.30	50.32%	65.22%		2018-19	50.00%	65.00%	**50.00%**	**65.00%**

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

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

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

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

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

(5) FY 2017-18 and FY 2018-19 estimated FMAP is calculated based on historical actuals from the Bureau of Economic Analysis (BEA), and will only change if the BEA restates these actuals. FY 2018-19 estimated FMAP is calculated based on forecasts of Personal Income from www.leg.state.co.us and Population from www.census.gov.

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-01 Medical Services Premiums

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___	Supplemental FY 2016-17
X	Change Request FY 2017-18
___	Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$6,818,264,595**	**$0**	**$6,752,893,112**	**$361,396,284**	**$1,077,440,697**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,942,439,768	$0	$1,945,000,281	$124,330,802	$192,982,429
	CF	$705,708,120	$0	$678,832,273	$10,348,553	$283,604,266
	RF	$5,240,893	$0	$5,240,893	$3,790,151	$3,710,524
	FF	$4,164,875,814	$0	$4,123,819,665	$222,926,778	$597,143,478

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
	Total	**$6,818,264,595**	**$0**	**$6,752,893,112**	**$361,396,284**	**$1,077,440,697**
	FTE	0.0	0.0	0.0	0.0	0.0
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	GF	$1,942,439,768	$0	$1,945,000,281	$124,330,802	$192,982,429
	CF	$705,708,120	$0	$678,832,273	$10,348,553	$283,604,266
	RF	$5,240,893	$0	$5,240,893	$3,790,151	$3,710,524
	FF	$4,164,875,814	$0	$4,123,819,665	$222,926,778	$597,143,478

			If Yes, see attached fund source detail.
CF Letternote Text Revision Required?	Yes X	No ___	
RF Letternote Text Revision Required?	Yes X	No ___	
FF Letternote Text Revision Required?	Yes ___	No X	
Requires Legislation?	Yes ___	No X	
Type of Request?	Department of Health Care Policy and Financing Prioritized Request		
Interagency Approval or Related Schedule 13s: None			

Department of Health Care Policy and Financing
Medical Services Premiums

FY 2016-17, FY 2017-18, and FY 2018-19 Budget Request

November 2016

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MEDICAL SERVICES PREMIUMS

MAJOR FORECAST CHANGES

- Acute Care – The current request is approximately $163.5 million over the February request in total funds. The $163.5 million increase consists of a $114.6 million increase in federal funds and an increase of $47.2 million General Fund compared to the February request. The increase in federal funds is primarily driven by the MAGI Adults category and MAGI Parents/Caretakers to 133% FPL. Caseload estimates increased by 20,713 (5.9%) for MAGI Adults and 8,261 (9.1%) for MAGI Parents/Caretakers to 133% FPL compared to the February Request which more than offset a decrease to the per capita trend for the MAGI Adults population. The increase in General Fund is primarily due to anticipated increase in expenditure resulting from changing Hepatitis C coverage criteria as well as under forecasted trends for several populations resulting in a higher base expenditure. Caseload estimates for MAGI Parents/Caretakers to 68% FPL increased by 6,798 (3.66%) and Eligible Children decreased by 7,285 (-1.47%) compared to the February Request. Several small reductions in per capita trends for General Fund populations were offset by caseload increases.
- Community-Based Long-Term Care – The current request is approximately $13.1 million below the February request. The decrease is primarily due to the Children with Autism waiver expansion being denied, causing services to be offered through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) in the future and costs moving to Acute Care; a slight decrease in PDN enrollment; and the restructuring of Hospice routine home care rate. This decrease was slightly dampened by an increase in enrollment for the waivers (specifically for 1915i Consumer-Directed Attendant Support Services (CDASS)).
- Class I Nursing Facilities - The current request is approximately $11.9 million below the February request. The decrease is due to a dampened trend in the number of nursing facility days. Nursing facility patient days did not increase as aggressively in the last six months of FY 2015-16 as observed in the first six months of FY 2015-16.
- Program of All-Inclusive Care for the Elderly – The current request is approximately $8.7 million less than the February request. The forecast was adjusted to include patient contributions, driving down the aggregate final paid rates.
- Supplemental Medicare Insurance Benefit – The current request takes into account the 2016 Medicare Trustees Report forecast of Medicare Part B premiums for calendar year (CY) 2017. The Department's February forecast included a modest growth for CY 2017. According to the Trustees forecast, Part B premiums will likely increase significantly, upwards of $149.00 from the current $121.80. This caused a significant increase to the General Fund financed component of the benefit.

I. BACKGROUND

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

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

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

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

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

2. The Department's request includes a number of references to various budget items and early supplemental budget reductions. July 1, 2009, September 1, 2009, December 1, 2009, July 1, 2010, July 1, 2011, and July 1, 2012, the Department implemented various reductions to reduce its budget in order to meet the revenue shortages being predicted by the various revenue forecasts and to bring the State into compliance with its balanced-budget requirement. In response, the Department began a process of identifying possible targets for reduction, engaging stakeholders regarding those possibilities, and submitting various budget change requests to reduce funding. Since experiencing economic recovery, the Department has continued to implement efficiencies, but has been able to restore provider rate increases. In FY 2013-14, rates were increased by 2% for Acute Care services and 8.26% for HCBS services, and in FY 2014-15, rates were increased 2% across the board. Some services received varying targeted rate increases in FY 2014-15 as well. Rates were also increased in FY 2015-16, at 0.50% across the board along with various targeted rate increases for some services.

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

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

5. The presence of varying funding mechanisms makes the Department's request more complex. Different Medicaid services have different federal match rates and are pertinent to different populations under Medicaid. Certain categories of service have historically been federally matched at different percentages than others. Indian Health Services, described further in this narrative, have historically received a 100% federal medical assistance percentage (FMAP) while Family Planning Services receive a 90% FMAP. Breast and Cervical Cancer Program (BCCP) services are matched at 65% FMAP. Medicaid expansion populations receive a different match rate than existing populations. Expansion Adults to 133% and the MAGI Adults populations, for instance, receive a 97.5% FMAP in FY 2016-17, a 94.5% FMAP in FY 2017-18, and a 93.5% FMAP in FY 2018-19 as the federal match for these populations falls from 100% to 95% in January 2017, 94% in January 2018, and 93% in January 2019. The former CHP+ population that transferred to Medicaid with SB 11-008 (Eligible Children) and SB 11-250 (Eligible Pregnant Adults) receives the enhanced CHP+ FMAP of approximately 65% with an additional 23 percentage point FMAP increase; the enhanced FMAP is expected to be 88.13% in FY 2016-17 and 88.00% in FY 2017-18 and FY 2018-19.

6. Under the Affordable Care Act, states are eligible for a one percentage point increase in the FMAP for adult vaccines and clinical preventive services if the state covers all of the recommended services without cost-sharing. The recommended services are those that have been given an A or B rating by the United States Preventive Services Task Force.

7. The State's FMAP for Medicaid services will decrease from 50.72% to 50.02% beginning October 1, 2016. With the new FMAP of 50.02% beginning October 2016, FMAP for FY 2016-17 will be 50.72% for the first quarter and 50.02% for the latter three quarters, resulting in an effective FMAP of 50.20% for the fiscal year. Data from the Colorado Population Forecast, the U.S. Census, and the Legislative Council is used to estimate the FMAP for FY 2017-18 and FY 2018-19, at 50.00%. These changes are outlined in Exhibit R. This FMAP change applies to Medicaid services only; Medicaid administrative costs would continue to receive a 50.00% FMAP. If the FMAP changes from Department estimates, the Department would submit a supplemental funding request to account for the change in federal funds. More information can be found about the FMAP estimates in Exhibit R.

8. Significant differences in the types and utilization of various home health services have caused the Department to evaluate the placement of these services. Previously, all home health services were placed under Acute Care. Effective in the November 2015 request, the Department has now separated home health services into two categories: Acute Home Health and Long-Term Home Health (LTHH). Acute Home Health is included in Acute Care and information about this change can be found in Exhibit F. LTHH is included in Community-Based Long-Term Care and information about this change can be found in Exhibit G.

9. The Colorado Operations Resource Engine (CORE) was implemented as a replacement for the Colorado Financial Reporting System (COFRS) in July 2014. Under COFRS, the previous fiscal year closed and the data became final at the beginning of the current fiscal year. Under CORE, the previous fiscal year may not close until March of the current fiscal year. This introduces a small degree of uncertainty regarding actuals that was not present previously. It is possible that the FY 2015-16 actuals may change in the next request. The Department does not expect major changes to FY 2015-16 actuals. The FY 2015-16 actuals contained within this request reflect data for FY 2015-16 as of August 29, 2016.

10. CHIPRA Audit: The Office of the Inspector General (OIG) began auditing the Department in 2014 as to whether bonus payments awarded to the State through the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) were consistent with CHIPRA statute. In August 2016, the OIG concluded the Department incorrectly included blind or disabled children in the State's reported caseload numbers, artificially inflating the bonus payments. OIG recommended to Centers for Medicare & Medicaid Services (CMS) that the State return $38.4 million of the $157.5 million in bonus payments the State received between 2010 and 2014. OIG made similar findings in audits of other states, including Washington, New Mexico, Alabama, Wisconsin, and North Carolina. The Department strongly disagreed with the audit findings. Colorado maintains that all bonus payments received were fully allowable and that CMS's methodology and rationale for excluding blind and disabled children from the bonus payment program was contrary to the express language of the federal statute. In a letter dated September 28, 2016, CMS states it does not concur with the State's response and will provide further guidance to the State for returning the overpayments.

11. School Health Services Program Disallowance: The School Health Services Program allows participating school districts and Boards of Cooperative Education Services to receive federal Medicaid funds for health services provided to students who are

enrolled in Medicaid and have an Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). On September 16, 2016, the Department received a disallowance of $594,318 in federal funds drawn through the School Health Services Program in FY 2008-09. This disallowance is the result of an audit conducted by the OIG and finalized in April 2012. The audit report recommended that the Department return $871,246 in federal funds. The Department agreed with several of the findings and promptly returned $276,328 of federal funds related to the issues not in dispute. The Department disagrees with findings related to $594,918 in federal funds, which have now been disallowed. The disputed findings concern when interim and reconciling payments were reported to CMS and how the Department coded random moment time study responses. The Department followed CMS guidance and reasonable accounting procedures when reporting quarterly payments and followed a CMS-approved time study methodology when coding responses. Therefore, the Department will request reconsideration of the disallowance with the Secretary of the U.S. Department of Health and Human Services and appeal to the appeals board if the request for reconsideration is denied. Because the Department retains a portion of the federal funds drawn under this program for administrative expenses and has sufficient reserves to repay the disallowed funds, no impact to participating school districts or the General Fund is expected if the Department does not prevail.

12. CMS 64 Eligibility Reviews: CMS is currently performing reviews of the client eligibility information used to process claims to ensure the correct FMAP was claimed. They have completed reviews for FFY 2013-14 Q2 through FFY 2014-15 Q4 and are still reviewing FFY 2015-16 Q1 – Q3. For the completed reviews, CMS has issued deferral letters for FFY 2013-14 Q3 through FFY 2014-15 Q4 in the amount of $90,242,474, but did not issue a deferral letter for FFY 2013-14 Q2. The Department disagrees with many of the findings in each of the deferral letters.

13. Ongoing Audits: The Department is currently in the process of working with the Department of Health and Human Services Office OIG on several potential audit findings. The three audits listed below may have an impact on the Department's expenditure.

    - OIG performed an audit on the Department and issued a report entitled Colorado Did Not Properly Pay Some Medicare Part B Deductibles and Co Insurance. One of OIG's recommendations was that the Department refund the federal government $1,670,386 for unallowable Medicaid payments for Medicare Part B deductibles and coinsurances. The Department finds no justification to refund any amount related to this audit. The Department has been consistent in both the interpretation and the intent of the "lower of" pricing rule, applying the same pricing logic to all Medicare crossover claims. The audit findings are based on a minor technical variation in routine claims processing, contradict the policy guidance provided by CMS and general State Plan guidelines, and are based on a hypothetical re-pricing exercise. Such

findings fail to justify a change to the State Plan. The Department cannot concur with the audit recommendations in this report.

- The Department is currently being audited by OIG to determine whether the Department complied with federal and state Medicaid requirements for billing manufacturers for rebates for physician-administered drugs. The audit is currently in progress, and no formal audit report has been issued at this time.

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

II. MEDICAID CASELOAD

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

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

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

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

Rationale for Grouping Services for Projection Purposes

The Medical Services Premiums calculations are grouped into like kinds of services and similar calculation considerations. Actual collection of data for expenditures is very detailed, but for purposes of preparing projections, premium calculations are clustered into several groupings. This is done to improve the reasonableness of the projections that result from the calculations. The objective is to

cluster services that have like characteristics (e.g., community-based long-term care services) or which demonstrate a high degree of relationship (e.g., the impact of health maintenance organization service utilization on inpatient hospital, outpatient, physician services, etc.). Adversely, the approach of projecting the budget by individual service category and applying historic rates generates a materially higher forecast.

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

Acute Care:

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

Community Based Long-Term Care:

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

- Home-and Community-Based Services: Consumer Directed Attendant Support
- Home-and Community-Based Services: Brain Injury
- Home-and Community-Based Services: Children with Autism
- Home-and Community-Based Services: Children with Life Limiting Illness
- Home-and Community-Based Services: Spinal Cord Injury Adult
- Colorado Choice Transitions - Services
- Private Duty Nursing
- Long-Term Home Health
- Hospice

Long-Term Care:

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

Insurance:

- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management:

- Single Entry Points
- Disease Management
- Accountable Care Collaborative
- Prepaid Inpatient Health Plan Administration

Financing:

- Hospital Provider Fee Financed Programs and Populations
- Department Recoveries
- Upper Payment Limit Financing

- Outstationing Payments
- Other Supplemental Payments

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

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

EXHIBIT A - CALCULATION OF TOTAL REQUEST AND FUND SPLITS

Summary of Request

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

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

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

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

Federal Medical Assistance Percentages

The Department's standard federal medical assistance percentage (FMAP) is typically around 50%. The FMAP for Medicaid is recomputed by the Federal Funds Information Service (FFIS) each year and is based on a statewide per capita earnings formula that is set in federal law. In October 2014, the FMAP for Medicaid services increased to 51.01%. The State's FMAP for Medicaid services

decreased from 51.01% to 50.72% effective October 1, 2015, and decreased from 50.72% to 50.02% effective October 1, 2016. The Department has estimated the FMAP for Medicaid services going forward, based on data from the Bureau of Economic Analysis, the U.S. Census, the Department of Local Affairs' Population Forecasts, and the Colorado Legislative Council's U.S. and Colorado Personal Income forecasts, resulting in an estimated FMAP of 50.00% beginning October 1, 2017.

Certain populations and services receive different FMAPs than the new standard 50.02% that begins October 2016. This is summarized below. Clients transitioning from CHP+ to Medicaid receive the CHP+ FMAP, which is usually 65% but has been recalculated at 65.01% effective October 2016 and 65.00% effective October 2017 forward. Section 2105(b) of the Social Security Act further modifies the enhanced FMAP for CHP+ clients, and thus clients transitioning from CHP+ to Medicaid who are funded under Title XXI, by an additional 23 percentage points, effective October 1, 2015 through September 30, 2019. Therefore, FMAP for clients transitioning from CHP+ to Medicaid receive 88.13% FMAP in FY 2016-17, and 88.00% FMAP in FY 2017-18 forward. Clients in the BCCP program also receive a 65% match, or 65.01% effective October 2016 and 65.00% effective October 2017 forward. Since the FMAP decrease to 50.02% occurs at the start of the second quarter of FY 2016-17, the FMAP would be 50.72% for quarter one and 50.02% for the remainder of the year, resulting in a final FMAP of 50.20% for FY 2016-17. This logic is applied to the populations receiving 65.50% for quarter one and 65.01% the remainder of the fiscal year, resulting in a final FMAP of 65.13% for FY 2016-17. The expansion populations, MAGI Parents/Caretakers 69% to 133%, and MAGI Adults, receive a match of 100% beginning January 1, 2014, though this falls to 95% beginning January 1, 2017, resulting in a final FMAP of 97.50% for these populations for FY 2016-17. The match for this population falls again to 94% beginning January 1, 2018, resulting in a final FMAP of 94.50% for these populations for FY 2017-18, and falls to 93% beginning January 1, 2019, resulting in a final FMAP of 93.50% for FY 2018-19. However, any Community-Based Long-Term Care waiver services for these individuals must be claimed at the standard match as they are not eligible to receive the enhanced FMAP. A sub-group of MAGI Adults, non-newly eligible individuals with disabilities, receive the ACA expansion FMAP for 75% of their expenditure and the standard FMAP for the remaining 25%, resulting in an effective FMAP of 85.68%, 83.38%, and 82.63% for FY 2016-17, FY 2017-18, and FY 2018-19 respectively. The Disabled Buy-In population receives the standard match for expenditures net of patient premiums.

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

Population-Based FMAPs			
Fiscal Year	**FMAP**	**Population(s)**	**Comments**
FY 2016-17	88.13%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.13%	Clients in the BCCP program	Please see Exhibit F
	97.50%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	85.68%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.20%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.20%, Medicaid Buy-In Fund 0%
FY 2017-18	88.00%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.00%	Clients in the BCCP Program	Please see Exhibit F
	94.50%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	83.38%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.00%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%
FY 2018-19	88.00%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.00%	Clients in the BCCP Program	Please see Exhibit F
	93.50%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	82.63%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.00%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%

Service-Based FMAPs			
Fiscal Year	**FMAP**	**Service**	**Comments**
FY 2016-17	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51.20%	ACA Preventive Services	Please see Exhibit A
	90%	Family Planning Services	Please see Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2017-18	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51%	ACA Preventive Services	Please see Exhibit A
	90%	Family Planning Services	Please see Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2018-19	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51%	ACA Preventive Services	Please see Exhibit A
	90%	Family Planning Services	Please see Exhibit F
	100%	Indian Health Services	Please see Exhibit F

Calculation of Fund Splits

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

In order to calculate appropriate fund splits, the Department selectively breaks out the large service groups (e.g., Acute Care) by programs funded with either a different state source or a different FMAP rate. The majority of programs in Medical Services Premiums are paid with 50% General Fund and 50% federal funds, though this changed to 48.99% General Fund and 51.01% federal funds in October 2014, 49.28% General Fund and 50.72% federal funds in October 2015, and 49.98% General Fund and 50.02% federal funds in October 2016. However, the following programs are paid for using different funding mechanisms:

- Breast and Cervical Cancer Program: This program receives a 65% federal financial participation rate, increased to 65.71% effective October 2014, and then decreased to 65.50% effective October 2015 and 65.13 effective October 2016. Per 25.5-5-308(9)(g), C.R.S (2014), enacted in HB 14-1045, the state's share of expenditure shall be appropriated one hundred percent from the Breast and Cervical Cancer Prevention and Treatment Fund.

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

- Indian Health Services: The federal financial participation rate for this program is 100%. Please see Exhibit F for calculations.

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

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

- Non-Emergency Medical Transportation (NEMT): These services receive the administrative federal financial participation (FFP) rate of 50% rather than the various service FMAP rates. This entry adjusts the fund splits between federal and State funding to properly account for this service receiving FFP.

- SB 11-008 "Aligning Medicaid Eligibility for Children": This bill specifies that the income eligibility criteria for Medicaid that applies to children aged five and under shall also apply to children from ages 6 to 19. Effective January 1, 2013, children under the age of 19 are eligible for Medicaid if their family income is less than 133% of the federal poverty level (FPL). The Department assumes FMAP for these clients will remain at the same level as if the clients had enrolled in the Children's Basic Health Plan (CHP+) instead of Medicaid, or 65%, though the enhanced FMAP increased to 65.71% effective October 2014 and then decreased to 65.50% effective October 2015 and 65.01% effective October 2016. Section 1205(b) of the Social Security Act increases the enhanced FMAP by an additional 23 percentage points, effective October 2015 through September 2019. Therefore, FMAP for this population for FY 2016-17, FY 2017-18, and FY 2018-19 is expected to be 88.13%, 88.00%, and 88.00% respectively.

- SB 11-250 "Eligibility for Pregnant Women in Medicaid": This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133% to 185% of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to move from CHP+ to Medicaid effective January 1, 2013. As with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients, though the enhanced FMAP increased to 65.71% effective October 2014 and then decreased to 65.50% effective October 2015 and 65.01% effective October 2016. Previously, the State had authority to claim the enhanced FMAP on this population through July 31, 2015; after which date, the FMAP would be reduced to the standard Medicaid match rate. However, the Department received permission from the Centers for Medicare and Medicaid Services (CMS) to continue receiving a higher match rate for this population, including Section 1205(b) of the Social Security Act, similar to the population under SB 11-008 "Aligning Medicaid Eligibility for Children". Therefore, FMAP for this population for FY 2016-17, FY 2017-18, and FY 2018-19 is expected to be 88.13%, 88.00%, and 88.00% respectively.

- MAGI Parents/Caretakers 69% to 133% FPL: HB 09-1293, the Colorado Health Care Affordability Act of 2009, authorizes the Department to collect provider fees from hospitals for the purpose of obtaining FMAP for the State's medical assistance programs and using the combined funds to: 1) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program, 2) increase the number of persons covered by public medical assistance to 100% of the federal poverty line, and 3) pay the administrative costs to the Department in implementing and administering the program. These adjustments allocate the hospital provider fee to each applicable service category. Additionally, SB 13-200 amended Medicaid eligibility for parents and caretakers of eligible children from 100% of the federal poverty line to 133% of the federal poverty line in keeping with Medicaid expansion under the Affordable Care Act, which also ensures that MAGI Parents/Caretakers 69% to 133% of the federal poverty line receive a 100% federal match rate through the end of CY 2016, effective January 1, 2014. In CY 2017, the federal match rate for this population is reduced to 95% and to 94% in CY 2018 and to 93% in CY 2019. This results in a 97.50% federal match rate for this population in FY 2016-17 and a 94.50% federal match rate in FY 2017-18 and 93.50% federal match rate in FY 2018-19. See Exhibit J for additional information and detailed calculations.

- MAGI Adults: This population began participation in Medicaid in FY 2011-12 and was previously labeled Adults without Dependent Children (AwDC). The population is funded with a combination of federal funds and Hospital Provider Fee. SB 13-200 amended the Medicaid eligibility criteria for MAGI Adults to 133% of the federal poverty line in accordance with Medicaid expansion under the Affordable Care Act. Effective January 1, 2014, the Affordable Care Act provides this population a 100% federal match rate from CY 2014 through CY 2016, a 95% federal match rate in CY 2017, a 94% federal match rate in CY 2018, and a 93% federal match rate in CY 2019. This results in a 97.50% federal match rate for this population in FY 2016-17 and a 94.50% federal match rate in FY 2017-18 and 93.50% federal match rate in FY 2018-19. However, waiver services for this population receive the standard FMAP and not the enhanced FMAP per CMS. Calculations and information regarding this population can be found in Exhibit J.

- Continuous Eligibility for Children: HB 09-1293, the Colorado Health Care Affordability Act of 2009, established continuous eligibility for twelve months for children on Medicaid, beginning March 2014, even if the family experiences an income change during any given year. The Department has the authority to use the Hospital Provider Fee Cash Fund to fund the State share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives the standard federal financial participation rate. Previously, the Department showed this adjustment in funding as a General Fund offset under Cash Funds Financing. Effective with the November 2016 request, the Department has broken this population out in its respective service categories to better show the impact of continuous eligibility for children. Calculations and information regarding this population can be found in Exhibit J.

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

- Non-Newly Eligibles: MAGI Parents/Caretakers 69% to 133% FPL and MAGI Adults are funded with a combination of federal funds and Hospital Provider Fee. As explained above under those categories, the Affordable Care Act provides both populations with a 100% federal match rate, effective January 1, 2014, though it ramps down over time beginning in CY 2017. A caveat of this enhanced federal match rate is that the expansion population cannot have been eligible for Medicaid services prior to 2009 (or else those individuals are not considered part of the Medicaid expansion population). A subset of the population may have been eligible for Medicaid services prior to 2009 under disability criteria, had the clients chosen to provide asset information when they applied for Medicaid services. For this population, the Department is unable to prove that these clients would not have been eligible for Medicaid services prior to 2009 if they had provided asset information, and therefore cannot claim the full enhanced expansion FMAP on their expenditure. These clients are now eligible for Medicaid under the expansion, and receive FMAP determined by a resource proxy with the State portion funded through the Hospital Provider Fee, as required by statute. The Department can claim 75% of the expenditures for Non-Newly Eligible clients at the enhanced expansion FMAP and the remaining 25% at standard FMAP. Please refer to Exhibit J for calculations and additional details.

- MAGI Parents/Caretakers 60% to 68% FPL: Parents/Caretakers over 60% FPL are funded with a combination of federal funds and Hospital Provider Fee. As explained above, the Affordable Care Act provides MAGI Parents/Caretakers 69% to 133% FPL with a 100% federal match rate, effective January 1, 2014, with a ramp down beginning January 1, 2017. Due to new MAGI conversion rules (please refer to the Caseload Narrative for additional details), the non-expansion eligibility category MAGI Parents/Caretakers to 68% FPL now includes FPL levels over 60%. The MAGI Parents/Caretakers to 68% FPL clients who have FPL levels over 60% are funded with Hospital Provider Fee for the State's contribution, rather than General Fund, as required by statute. Please refer to Exhibit J for calculations and additional details.

- Adult Dental Benefit Financing: SB 13-242 created a limited dental benefit for adults in the Medicaid program, implemented April 1, 2014. To fund the design and implementation of the adult dental benefit, SB 13-242 created the Adult Dental Fund effective July 1, 2013, financed by the Unclaimed Property Trust Fund. Please refer to Exhibit F for calculations and additional details.

- HB 16-1408 Primary Care Rate Increase Financing: This bill created a new cash fund, the Primary Care Provider Sustainability Fund, which received funding from the CHP+ Trust fund balance in order to continue the Physician Rate Increase to 100% Medicare (Section 1202 of the Health Care and Education Reconciliation Act) through June 2017. The bill continued the rate increase at a lower rate than the original increase and for select primary care procedures only. This accounts for the impact of the rate increases that are paid for with the Primary Care Provider Sustainability Fund, adjusting for claims runout. Please refer to Exhibit F for additional details.

- HB 16-1408 State Plan Autism Treatment: CMS denied the Department's request to expand the Children with Autism Waiver, which was authorized through HB 15-1186. CMS directed the Department to provide behavioral therapy services deemed medically necessary under EPSDT. HB 16-1408 increased the General Fund offset for these services, funded through the Colorado Autism Treatment Fund. Effective with the November 2016 request, the Department is accounting for the state plan costs under Acute Care rather than under Community Based Long-Term Care Services.

- Children with Autism Wavier Services: Home and Community Based Services for children with autism are paid through The Children with Autism Cash Fund, created by SB 04-177.

- Supplemental Medicare Insurance Benefit: Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive federal financial participation (FFP) and certain individuals with limited resources qualify as a "Qualified Individual", which receives 100% FFP. In aggregate, the Department estimates that approximately 13.0% of the total will receive receives no FFP, while 5.00% receives 100% FFP. These assumptions are held constant in FY 2016-17, 2017-18, and in FY 2018-19.

- Tobacco Quit Line: The Tobacco Quit Line is administered by the Department of Public Health and Environment (DPHE); the Department pays for the share of costs for the quit line related to serving Medicaid members. The costs are administrative and therefore receive FFP rather than the applicable FMAP by eligibility category.

- Memorial Hospital High Volume Payment: Colorado public hospitals that meet the definition of a high volume Medicaid and Colorado Indigent Care Program (CICP) Hospital qualify to receive an additional supplemental reimbursement for uncompensated inpatient hospital care for Medicaid clients. To meet the definition of a high volume Medicaid and CICP Hospital a hospital must be: licensed as a General Hospital by the Department, classified as a state-owned government or non-state owned government

hospital, a High Volume Medicaid and CICP hospital, defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000 and whose Medicaid and CICP days combined equal at least 30% of their total inpatient days, and maintain the hospital's percentage of Medicaid inpatient days compared total days at or above the prior State Fiscal Year's level. Historically, Memorial Health has been the only hospital to qualify for this payment but did not meet the requirements to receive this supplemental payment in FY 2015-16. The Department assumes Memorial Hospital will not meet the criteria to receive this supplemental payment in the current year, request year and out year.

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

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

- Denver Health Outstationing: Federal funds are drawn to reimburse Denver Health Federally Qualified Health Centers for the federal share of their actual expenditures in excess of the current reimbursement methodology. These payments are to be made with General Fund rather than certified public expenditures going forward; however, the Department is currently pursuing approval of the new payment model from CMS and cannot change payment methods without that approval. Also, payments that are for prior fiscal years would still be paid with certified public expenditures. The Department anticipates the State share of these payments to be a mix of certified public expenditures and General Fund in FY 2016-17 and fully General Funded with federal financial participation in FY 2017-18 and FY 2018-19. The Department expects to receive approval by FY 2017-18 for a portion of this expenditure to receive a 75% FMAP; the Department anticipates a weighted FMAP of 65% at that time. The FY 2016-17, FY 2017-18, and FY 2018-19 totals are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.

- Hospital Provider Fee Supplemental Payments: Hospital payments are increased for Medicaid hospital services through a total of 13 supplemental payments, 11 of which are paid out of Medical Services Premiums directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, Colorado Indigent Care Program (CICP) and Disproportionate Share Hospital (DSH) payments, and targeted payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to ensure access to hospital services for Medicaid and CICP clients.

- Nursing Facility Supplemental Payments: HB 08-1114 and SB 09-263 directed the Department to implement a new methodology for calculating nursing facility reimbursement rates, introduced a cap on General Fund growth for core components of the reimbursement rate, and authorized the Department to collect a provider fee from nursing facilities statewide. Any growth in the

portion of the per-diem reimbursement rate for core components beyond the General Fund cap is paid from the Nursing Facility Provider Fee cash fund, as are all supplemental payments. Please refer to Exhibit H for calculations and additional details.

- Physician Supplemental Payments: Federal funds are drawn to reimburse Denver Health and the Memorial Health Systems in Colorado Springs for physician services provided in excess of the current reimbursement methodology. The Department retains 10% of the federally matched dollars as a General Fund offset. The FY 2016-17, FY 2017-18, and FY 2018-19 totals are based on the total amounts Denver Health and Memorial Health Systems were able to certify in prior fiscal years.

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

- Intergovernmental Transfer for Difficult to Discharge Clients: Privately owned nursing facilities are eligible for receiving supplemental Medicaid reimbursements for costs incurred treating medically complex clients, such that the sum of all Medicaid reimbursement remains below the Upper Payment Limit for privately-owned nursing facilities. In order to be eligible for these payments, nursing facilities must be privately owned; enter into an agreement with the discharging hospital regarding timelines and initial plans of care for the affected medically complex patients; and provide long term care services and supports in the least restrictive manner for medically complex clients residing in an inpatient hospital setting for whom no other suitable discharge arrangements are available. The transfer is an annual payment of $1,000,000 total funds with the State share being transferred through Denver Health & Hospital Authority. The Department is waiting for the State Plan Amendment (SPA) associated with this program to be approved by CMS and anticipates payments to begin in FY 2016-17.

- Repayment of Federal Funds for Physical and Occupational Therapy Unit Limit Policy: The Department submitted a state plan amendment (SPA) to implement a limit on the number of physical and occupational therapy units that adults can receive to 48 total units of service per year, regardless of prior authorization, which was approved on October 1, 2011. The Department was unable to implement the policy until July 1, 2016 due to system issues. Any claims paid for services delivered in the interim above the 48 unit limit are out of compliance with the State Plan and unallowable. The Department will repay those funds in FY 2016-17.

- Denver Health Ambulance Payments: Federal funds are drawn to reimburse Denver Health for ambulance services in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund; the Department retains

10% of the federally matched dollars as a General Fund offset. The FY 2016-17, FY 2017-18, and FY 2018-19 totals are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.

- Technical Adjustment of Systems Issue for Children: Adjusts for a data issue that took place July 2015 through December 2015 that incorrectly moved clients from Children's Health Plan (CHP) and Eligible Children into categories for individuals with disabilities, including Children with Disabilities – Buy In. Because of the issue, the Department incorrectly funded services for certain affected clients with Hospital Provider Fee instead of General Fund and will adjust the funding source in FY 2016-17. See the Medicaid caseload narrative for more information.

- Historic Adjustment for Non-Newly Eligible Definition: Starting in FY 2015-16 Q3, the Department updated the income criteria used to identify non-newly eligible population to be consistent with the SPA[1] submitted to CMS. The previously used income criteria did not account for the income limit of couples and consequently excluded members who should have received the blended FMAP for the non-newly eligible population, rather than the expansion FMAP. In FY 2016-17, the $3,386,387 in Hospital Provider Fee accounts for the amount the Department should have paid for non-newly eligible members; there is also a corresponding decrease of $3,386,387 federal funds.

- Cash and Reappropriated Funds Financing: This item includes the impact of legislation which reduces General Fund expenditure through cash and reappropriated fund transfers. Starting in FY 2016-17, the General Fund offset from the Old Age Pension Health and Medical Care Fund will come entirely from reappropriated funds based on JBC approval of JBC staff recommendations. This methodology ensures that the full $10 million authorized by Colorado's constitution can be allocated to people who qualify for services from the Old Age Pension Medical Program and that these funds are not tied up in another line. Please refer to Section V for more detailed information on the legislation which authorized the transfers.

  The table below shows the impact by cash fund for FY 2016-17, FY 2017-18, and FY 2018-19.

Cash and Reappropriated Funds	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
Tobacco Tax Cash Fund (SB 11-210)	$2,162,950	$2,162,950	$2,162,950
Hospital Provider Fee Cash Fund (SB 13-230) - Upper Payment Limit Backfill	$15,700,000	$15,700,000	$15,700,000
Old Age Pension Health and Medical Care Fund (SB 13-200)	$9,102,709	$9,031,044	$8,951,417
Service Fee Fund (SB 13-167)	$200,460	$200,460	$200,460
Total	**$27,166,119**	**$27,094,454**	**$27,014,827**

[1] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-14-035.pdf

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1997-98 through FY 2018-19. Adjustments for caseload effects which are not captured in trends are shown on page EB-2. Totals unadjusted for special populations are shown on EB-3.

Pages EB-4 through EB-6 provide historical monthly caseload without retroactivity for each of the eligibility types for FY 2006-07 through FY 2015-16.

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

EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS

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

For FY 2002-03 through FY 2008-09, expenditures for the Prenatal State-Only program are included in the Non-Citizens aid category. The Prenatal State-Only program allows legal immigrants that entered the United States after August 22, 1996 to have State funded prenatal care and Emergency only Medicaid benefits for labor and delivery. These expenditures are included in the MAGI Pregnant Adults aid category beginning in FY 2009-10. HB 09-1353 was passed in FY 2009-10, which allowed legal immigrants that have lived in the United States less than five years to qualify for Medicaid as pregnant adults, Medicaid children, or CHP+ clients, provided there is available funding. Funding for Medicaid pregnant adults was available July 2010. The population that was Prenatal State-Only now represents pregnant adults that are eligible under HB 09-1353. These expenditures are still included in the MAGI Pregnant Adults aid category. Funding for Medicaid children was available July 2015.

EXHIBIT D - CASH FUNDS REPORT

This exhibit displays spending authority, total request, and incremental request for each source of cash funds in the Medical Services Premiums line item. This information is a summary of the information presented in Exhibit A. In addition, for the current year, total

spending authority is broken out between the Long Bill and other special bills; this information is used to calculate the revised letternote amount on the Schedule 13. The Department also provides the specific requested changes to special bill appropriation clauses, when appropriate.

EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

Summary of Total Requested Expenditure by Service Group

This exhibit is a summary of the requests by service group and by eligibility category for the current year, request year, and out year. It aggregates information from the calculations contained in Exhibits F, G, H, I, and J and caseload information from Exhibit B.

Comparison of November 2016 Request to FY 2016-17 Appropriation and FY 2017-18 Base Spending Authority

This exhibit contains a detailed summary of the Department's Budget Request by service category. In addition, this exhibit directly compares the Department's November 2016 Budget Request to the Department's Long Bill plus Special Bills appropriation for FY 2016-17 and the Department's base spending authority for FY 2017-18. The Department has isolated individual components of the appropriation based on information provided by the Joint Budget Committee during Figure Setting and subsequent actions, including additional information provided by Joint Budget Committee staff. This exhibit includes all bottom-line impacts and financing but does not break the request down by eligibility type or funding source. Totals on this portion of the exhibit match the totals on Exhibit A and the Schedule 13.

EXHIBIT F – ACUTE CARE

Calculation of Acute Care Expenditure

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

Calculation of Per Capita Percent Change

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. At the bottom of page EF-1, the Department has provided a list of historic trends. Included are two-year, three-year, four-year, and five-year trends, ending in the three most recent historical years. Typically, the same percentage selected to modify current-year per capita costs is used to modify the request-year per capita costs, although the Department makes adjustments to the selected trend where necessary.

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

The table below describes the trend selections for FY 2016-17, FY 2017-18, and FY 2018-19. In some cases, though not all, the Department has held the trend constant among the three years. As described in the Department's caseload narrative, populations sensitive to economic conditions are growing at substantial rates. Historically, rapid caseload growth has led to per capita declines due to several factors. First, clients may not receive services immediately upon receiving eligibility; there is typically a lag between when eligibility is determined to when clients receive services and when those services are billed. For this reason, under cash accounting where services are accounted for in the period where the claim is paid, expenditure growth will typically lag caseload growth, causing a per capita decline. Additionally, new clients from economically sensitive populations may have had health insurance previously and may generally be healthier than populations who have not had access to care. These clients may require fewer services, further lowering the overall per capita cost.

In aggregate, the Department has selected trends that are slightly lower than may be suggested by historical data. The Department believes that the long term effect of enrolling clients into the Accountable Care Collaborative program, which helps to manage the care of clients, will provide downward pressure on cost growth, which will ultimately be reflected in lower than expected per capita cost trends.

The selected trend factors for FY 2016-17, FY 2017-18, and FY 2018-19, with the rationale for selection, are as follows:

Aid Category	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	Justification
Adults 65 and Older (OAP-A)	3.70%	2.30%	2.50%	The Department has selected a positive trend to account for large increases in co-insurance expenditure for this category.
Disabled Adults 60 to 64 (OAP-B)	0.48%	0.80%	1.00%	The Department believes the higher than expected per capita is driven by higher prescription drug costs. The Department has slightly increased the previous trend selection to modify per capita costs.
Disabled Individuals to 59 (AND/AB)	0.70%	0.10%	0.30%	The Department has slightly increased the trend for this population to account for a higher per capita increase in FY 2015-16. The increase in trend is driven primarily by increases in prescription drugs and inpatient hospital costs.
Disabled Buy-in	0.70%	0.80%	1.00%	The Department anticipates the per capita costs for this population to level off and stabilize around the current per capita. A slight upward trend has been selected.

Aid Category	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	Justification
MAGI Parents/ Caretakers to 68% FPL	-2.80%	-2.20%	-2.00%	The Department has selected a downward trend as per capita increases seen in FY 2015-16 were primarily driven by reductions in caseload. The Department anticipates caseload will return to normal levels and negative per capita trends for the major service categories will continue to drive a negative per capita trend for this eligibility group.
MAGI Parents/ Caretakers 69% to 133% FPL	1.20%	-0.20%	0.00%	The Department has maintained the FY 2015-16 per capita trend as actuals closely aligned with the forecast. The Department anticipates small positive growth in per capita for this population.
MAGI Adults	-0.30%	0.30%	0.50%	The Department has lowered the trend for this population as per capita costs are beginning to level out for this population.
Breast and Cervical Cancer Program	0.00%	0.00%	0.00%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program per Capita Detail and Fund Splits" for a description of this trend factor.
Eligible Children (AFDC-C/ BCKC-C)	0.20%	0.30%	0.50%	The Department has chosen not to change the trend for this population. This population is expected to continue with a small underlying positive trend.

Aid Category	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	Justification
SB 11-008 Eligible Children	1.70%	-0.20%	0.00%	The Department has chosen a positive trend for this population driven by positive per capita trends for the major service categories utilized by this population. Additionally, slowing caseload growth puts positive pressure on per capita.
Foster Care	1.06 %	0.62%	0.82%	The Department has increased the per capita growth trend for this population driven by increases in expenditure for prescription drugs and physician services.
MAGI Pregnant Adults	0.68%	1.09%	1.29%	The Department has slightly lowered per capita trend from FY 2015-16 due to lower than expected per capita expenditure. A small positive growth is anticipated for this population going forward.
SB 11-250 Eligible Pregnant Adults	0.68%	1.09%	1.29%	The trend for this category is tied to MAGI Pregnant Adults, as the Department assumes similar utilization within these populations.
Non-Citizens	0.00%	0.00%	0.00%	The Department has maintained the per capita trend for this population given almost zero growth in per capita for this population in FY 2015-16.
Partial Dual Eligibles	20.00%	1.83%	1.83%	The Department has reduced the per capita growth trend for this population although the per capita trend remains very high. This population is driven primarily by large expenditure in co-insurance.

Legislative Impacts and Bottom-line Adjustments

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

- SB 10-117, Over the Counter (OTC) Medications allows for pharmacists to prescribe certain over-the-counter drugs to Medicaid Clients. The program reduces expenditure by reducing more costly visits to the emergency room or physicians for over-the-counter prescriptions.
- Accountable Care Collaborative (ACC) savings accounts for reductions in Acute Care expenditure resulting from ACC program activities. Additional detail can be found both in section V and in Exhibit I.
- BA-9 (FY 2011-12), Limit Number of Physical and Occupational Therapy Units for Adults, limited the number of units of therapy an adult can receive to 48 per year, regardless of prior authorization.
- Estimated Impact of Increasing PACE Enrollment accounts for the Department's initiative to increase enrollment of new PACE clients. The Department anticipates that this increased enrollment will cause a shift in expenditure from the Acute Care service group to the PACE service category.
- SB 10-167, Colorado False Claims Act increases enrollment in the Health Insurance Buy-In (HIBI) program. As of June 2016, there were 623 enrollees in the program. The Department expects to increase enrollment by approximately 2% per month through FY 2017-18.
- R-6 (FY 2012-13), Dental Efficiency, will reduce expenditure through refinement of Department policy regarding provision of orthodontics. Payment structure and clinical qualifying criteria for authorization are being evaluated and revised.
- R-10 (FY 2014-15), Primary Care Specialty Collaboration, accounts for added expenditure for primary care providers and specialists to acquire and utilize technology that allows remote specialty consultation.
- BA-10 (FY 2014-15), Continuation of 1202 Provider Rate Increases, accounts for added expenditure to pay for primary care services at 100% of Medicare Rates through June 30, 2016.
- BA-12 (FY 2014-15), State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees, accounts for anticipated reductions in expenditure related to enrolling clients dually eligible for Medicaid and Medicare in the Accountable Care Collaborative (ACC) so that they will receive care coordination.
- R-12 (FY 2015-16), Community Provider Rate Increases, accounts for added expenditure from a 0.50% across the board increase for eligible providers.
- R-12 (FY 2015-16), Targeted Community Provider Rate Increases, accounts for added expenditure from targeted rate increases for the purpose of addressing issues with clients' access to cost-effective services. The separate components of the rate increases are broken out in Exhibit F.

- HB 15-1309, Protective Restorations by Dental Hygienists, allows a dental hygienist to apply to the Colorado Dental Board for a permit to place interim therapeutic restorations, when they have met specific criteria determined by the Interim Therapeutic Restorations Advisory Committee, increasing expenditure for dental services in Acute Care.
- SB 11-177, Annualization of Sunset Teen Pregnancy and Dropout Program, removes the Teen Pregnancy and Dropout Program from Acute Care when the program sunsets September 1, 2016.
- SB 16-027, Medicaid Option for Prescribed Drugs by Mail, allows Medicaid clients to receive maintenance medications through the mail, regardless of physical hardship or third-party insurance status as previously required by SB 08-90. As many maintenance medication prescriptions delivered by mail come in ninety-day supplies, the Department anticipates a shift towards receiving medications in larger supplies. This shift would result in a decrease in prescription drug expenditures due to the avoided dispensing fees that are more frequent when a client receives drugs in smaller quantities.
- HB 16-1408, Allocation of Cash Fund Revenues from Tobacco MSA, accounts for partially maintaining the rate increases authorized under Section 1202 of the Affordable Care Act for specific services through FY 2016-17.
- HB 16-1097, PUC Permit for Medicaid Transportation Providers, changes the requirements of Medicaid providers of Non-Emergent Medical Transportation (NEMT) to register with the Public Utilities Commission (PUC) as a limited liability carrier instead of as a common carrier. There are fewer restrictions to registering as a limited liability carrier which will have the effect of increasing the number of NEMT providers, which will increase access to transportation and produce savings through increased access to preventive services through NEMT.
- State Plan Autism Treatment, adds in the cost of providing autism services through EPSDT to Acute Care and removing the impact from Community Based Long Term Care (CBLTC).
- Copay 5% of Income, adjusts for the additional amount the Department will need to pay providers to comply with a federal rule stating that copays cannot exceed 5% of a Medicaid client's income. The new MMIS, which will be implemented March 1, 2017, must demonstrate compliance with this rule; the current MMIS is unable to take the 5% cap into consideration, causing some clients to pay over the cap. The new system will prevent clients from paying copays that exceed 5% of their household income, and as a result, the Department will need to reimburse providers for the full cost of the service without subtracting copay for these clients.
- Kaiser-Access Health Maintenance Organization (HMO), moves expenditure related to clients enrolled in this new HMO from the regular ACC program. This has the effect of shifting expenditure from the ACC to Acute Care.
- Home Health Final Rule (Location Expansion), expands where home health services can be received. As part of 42 CFR 440 "Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health," CMS specified that states may not restrict beneficiaries from receiving home health services in any setting in which normal life activities take place. The adjustment accounts for an increase in utilization due to clients desiring to receive additional acute home health services in the community. The Department must demonstrate compliance with this rule by July 1, 2017.

- Hepatitis C Criteria Change, accounts for an increase in hepatitis C drug treatments. After reviewing hepatitis C criteria in place, the Department expanded treatment to members with a fibrosis score of F2 and other members who were previously restricted from treatment through the PAR process.

Breast and Cervical Cancer Program Per Capita Detail and Fund Splits

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

HB 14-1045 extended the repeal date of the program through July 1, 2019. Per 25.5-5-308(9)(g), C.R.S (2014), enacted in HB 14-1045, the State's share of expenditure shall be appropriated one hundred percent from the Breast and Cervical Cancer Prevention and Treatment Fund. All Breast and Cervical Cancer Program expenditures receive an enhanced federal match rate of approximately 65%. Please refer to Exhibit A and Exhibit R for more specific information on the federal match rate for this program.

Beginning January 2017, the age range for clients receiving cervical cancer screening and treatment will expand to include ages 21 through 39, based on CDPHE's FY 2016-17 R-4 "Cervical Cancer Eligibility Expansion." This change has been accounted for in the request as a caseload adjustment.

Per Capita Cost

The Department assumes base per capita growth for this population will remain flat and that all increases or decreases to per capita are a result of bottom line adjustments.

Fund Splits

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

Adult Dental Cash Fund-eligible Per Capita Detail

In 2013, the General Assembly passed SB 13-242, which established the Adult Dental Benefit program along with the Adult Dental Cash Fund, funded through the Unclaimed Property Tax Fund. The Adult Dental Cash Fund provides the funding for the State share of the Dental Benefit program, for expenditure that would otherwise be funded by General Fund for the State share. In 2014, the General Assembly passed HB 14-1336 which provided funding for the addition of full dentures as part of the Adult Dental Benefit. The Department previously covered dental services for adults only in emergencies or in the case of co-occurring conditions that required dental services. The Department does not have a way to systematically distinguish between dental services received in the case of emergency or co-occurring conditions and those covered under the Adult Dental Benefit. The Adult Dental Cash Fund-Eligible Dental Services Exhibit on pages EF-6 through EF-8 reports total Dental expenditure for populations that have the State share of expenditure funded with the Adult Dental Cash Fund and subtracts out the estimated expenditure for emergency and co-occurring conditions to estimate expenditure that requires financing from the Adult Dental Cash Fund.

Antipsychotic Drugs

Antipsychotic drugs were moved from the Department's premiums line to the Department of Human Services for FY 2001-02. For FY 2003-04, the General Assembly moved antipsychotic drugs from the Department of Human Services' portion of the budget to the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group within the Prescription Drugs service category. Exhibit F, pages EF-11 through EF-12, shows annual costs by aid category and per capita cost in two versions: with and without the estimated impact of drug rebate. The Department has eliminated the projection of expenditure in this area due to the elimination of the informational-only line item in Long Bill group (3), effective with HB 08-1375.

The Department experienced a large decrease in gross aggregate and per-capita acute antipsychotic pharmaceutical expenditure in FY 2012-13 due to several antipsychotic drugs going generic and per-unit costs decreasing significantly. FY 2014-15 resumed growth due to increases in cost, utilization, and caseload, which continued in FY 2015-16.

Federal Funds Only Pharmacy Rebates

The Patient Protection and Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. Drug rebates are recorded as an offset to total funds expenditure in Acute Care (Exhibit F), and the Department's total funds expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure. In this exhibit, the Department estimates the incremental amount of rebates that are federal funds only. Estimates are based on data through quarter four of FY 2015-16. Quarter four of FY 2015-16 appears artificially low due to large historic adjustments. The trend for FY 2016-17 has been adjusted to account for the negative expenditure that appears in that quarter. Historical actuals have been restated as the Department has transitioned from accrual-based accounting to cash-based accounting.

Family Planning - Calculation of Enhanced Federal Match

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must uniquely identify these services. Some family planning services are provided through fee-for-service, and, beginning in late FY 2001-02, the Department was also able to identify those family planning services provided by health maintenance organizations. Therefore, the State receives the enhanced match on about 95% of the family planning services provided to Medicaid clients. Totals listed on page EF-14 are taken directly from the Department's reporting to the Centers for Medicare and Medicaid Services for enhanced federal funds.

As of FY 2005-06, the Department no longer has contingency-fee based contracts to calculate the managed care portion of the enhanced family planning match rate. This calculation is now done by the Department. Historically, calculations for fee-for-service and health maintenance organizations were done independently. However, due to changes in the Department's managed care program, the totals were combined beginning in FY 2008-09, and a single combined estimate is now produced. In FY 2009-10 the Department submitted a managed care claiming methodology proposal to the Center for Medicare and Medicaid Services (CMS). The Department did not claim managed care family planning until the methodology was approved in FY 2010-11. As a result, managed care claims for the stagnant period were realized in FY 2010-11 through a large, but temporary, increase in managed care expenditure.

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

In light of the Department's view of the increase between FY 2007-08 and FY 2008-09 as a one-time level shift, the FY 2016-17 estimate for total reported expenditure is the average of annual total reported expenditure increases since FY 2007-08, attributing 8.0% growth. This methodology is motivated by the Department's expectation of an upward expenditure trend, despite the sporadic behavior of total annual expenditures observed over the previous fiscal years. As the Department anticipates family planning expenditures to resolve into a more stable growth pattern, estimates for FY 2017-18 and FY 2018-19 total expenditures are the result of the application of the average of annual growth rates for FY 2007-08 and FY 2015-16 to the previous year's estimated expenditure. The Department selected this time period as a model for future expenditure growth because it represents the most recent occasion for which moderate growth was observed in consecutive fiscal years.

As drug rebates become an increasingly larger component of total reported expenditure, the Department has begun to explicitly show the impact of rebates on the total expenditure with this request. After analyzing recent data on family planning expenditure, it has been determined that the Department is ineligible to claim the 90% federal match on about five percent of total expenditure. Expenditure not eligible for the enhanced match is claimed at the standard Medicaid match. Fund split calculations for the current year and the request year are shown in EF-14.

SB 11-177 "Sunset Teen Pregnancy and Dropout Program" was expected to contribute $29,000 in local funds for FY 2015-16. The Department had previously contracted with Montrose to provide the program, but because questions surrounding appropriate federal matching funds the contract was terminated. Therefore local cash funds will no longer be included in the estimate. The Department continues to explore opportunities to expand this program.

Indian Health Service

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

The Department uses historical expenditure to estimate total expenditure for services to these clients. In FY 2008-09, Indian Health Service expenditure grew by 44.48%; in FY 2011-12, expenditure decreased by 14.21%. In FY 2014-15, the Department migrated from fee-for-service to encounter-based expenditure tracking per CMS. This allows the Department to allocate expenditure under Indian Health Service in a way that wasn't previously possible, especially for pharmacy expenditure. Because pharmacy related Indian Health

Service expenditure was not tracked prior to FY 2014-15, the Department applied the growth from FY 2014-15 to FY 2015-16 to FY 2015-16 expenditure to forecast FY 2016-17.

Expenditure by Half-Year

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

EXHIBIT G - COMMUNITY-BASED LONG-TERM CARE

Community-Based Long-Term Care (CBLTC) services are designed to provide clients who meet the nursing facility level of care with services in the community. The increased emphasis on utilizing community-based services has served to keep the census in Class I Nursing Facilities relatively flat. In FY 1981-82, with the implementation of the first wave of Home- and Community-Based Service (HCBS) waivers, Class I Nursing Facility census was over 12,500 clients. Almost immediately, the census dropped to just over 10,000 clients. The HCBS census generally remained in this range though FY 2002-03. However, since that time, HCBS utilization has risen sharply; in FY 2015-16, the Department paid HCBS claims for an average of 26,481 clients per month.

Clients receiving CBLTC services have access to 12 HCBS waivers, each targeted to specific populations. Of the 12 waivers, 11 are administered by the Department, and the remaining waiver is managed by the Department of Human Services. Of the 11 waivers administered by the Department, 8 are included in the Medical Services Premiums line item and the remaining 3 fall under the Office of Community Living Division of Intellectual and Developmental Disabilities. The Persons Living with AIDS adult waiver is no longer active and clients were phased into the Elderly, Blind and Disabled waiver by the end of FY 2013-14. The waivers included in the Medical Services Premiums line item are:

- Elderly, Blind and Disabled Adult Waiver
- Community Mental Health Supports Adult Waiver[2]
- Disabled Children's Waiver
- Consumer Direct Attendant Support State Plan Waiver
- Brain Injury Adult Waiver
- Children with Autism Waiver

[2] Previously known as "Persons with Mental Illness"

- Children with Life Limiting Illness Waiver[3]
- Spinal Cord Injury Adult Waiver[4]

Calculation of Community-Based Long-Term Care Waiver Expenditure

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

The new methodology includes a forecast for each waiver's enrollment and cost per enrollee. Percentages selected to modify enrollment or per-enrollee costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, trend factors must not take into account changes accounted for as bottom-line adjustments. Because each HCBS waiver differs in eligibility requirements, demographics, and utilization, different trends are used for each waiver. From FY 2012-13 to FY 2014-15, the Department used enrollment from a static caseload report which places clients into their waiver. During FY 2014-15, the Department noticed that the enrollment was not trending with utilization and that clients enrolled in some waivers were actually enrolled in other waivers based upon their claims utilization. Thus, starting in FY 2015-16, the Department has decided to depict waiver enrollment as the average number of clients per month with an active prior authorization (PAR) for services on each waiver. The Department believes this to be the most accurate depiction of waiver enrollment, as services under waivers cannot be rendered without an active PAR.

Furthermore, since the Department is using an enrollment based methodology to define caseload, a utilization adjustment must be used prior to developing final projected expenditure. The Department has chosen to use the historic ratio of average monthly utilizers to average monthly enrollment to adjust projected expenditure for each waiver. This maximum ratio of utilizers to enrolled participants in each waiver was utilized to adjust final expenditure in FY 2016-17, FY 2017-18, and FY 2018-19.

[3] Previously known as "Pediatric Hospice Waiver"
[4] Previously known as "Alternative Therapies Waiver"

The selected enrollment and cost per enrollee trend factors for FY 2016-17, FY 2017-18, and FY 2018-19, with the rationale for selection, are below. In most cases, the Department kept the cost per enrollee trend for the out year the same as the request year. In situations where the out years do not carry the same trend, the variation is noted.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Elderly, Blind and Disabled Waiver	FY 2016-17 through FY 2018-19: 6.52%, 3.90%, and 3.75% respectively.	FY 2016-17 through FY 2018-19: 4.10%, 3.94%, 3.79% respectively.	Enrollment history is very steady, growing at approximately 4.5% per year. Enrollment in FY 2015-16 slowed, and the annual total came in approximately 1% higher than FY 2014-15. The enrollment trend selected in FY 2016-17 is similar to historical growth and is then slightly decreased through the out year using a monthly linear regression. Per enrollee cost history has grown on average since FY 2008-09 at approximately 6%. The cost per enrollee trend continues at slightly below historic growth through the out-year using a yearly linear regression.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Community Mental Health Supports Waiver (CMHS)	FY 2016-17 through FY 2018-19: 9.58%, 4.42%, and 4.23%, respectively.	FY 2016-17 through FY 2018-19: 3.67%	Enrollment history is very steady, growing at almost 6% per year. Enrollment growth was minimal in FY 2015-16, with the annual enrollment coming in less than 1% growth. The enrollment trend selected for FY 2016-17 brings enrollment back up to historical trend levels in FY 2016-17 and then decreases to slightly below to historic growth through the out year using a yearly linear regression. Per enrollee cost history has grown on average since FY 2009-10 at 1.5%. The cost per enrollee trend continues at slightly higher than historic growth through the out-year using the 4-year average growth rate.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Disabled Children's Waiver	FY 2016-17 through FY 2018-19: 13.41%, 6.77%, and 2.23%, respectively.	FY 2016-17 through FY 2018-19: 6.20%.	Historically, enrollment growth has been negative; however, the Department has made significant efforts to better manage the waitlist, and enrollment has increased over the last two years. Enrollment during FY 15-16 came in higher than expected, the growth trends chosen reflect that growth and have been incorporated into the out-year using an adjusted average growth trend that shows high growth in the first year and positive but diminishing trends through the out year. Only two services are offered on the waiver: In-home Supportive Services (IHSS) - Health Maintenance Activities and case management. While IHSS is expensive, it is less costly than Long-Term Home Health services. Very large historical growth in per-utilizer costs were driven by IHSS - Health Maintenance Activities client utilization. The number of clients utilizing this service has increased dramatically in the past few fiscal years, but slowed in FY 2015-16. The Department has lowered the positive growth trend of per enrollee expectations from the previous request due to the further slowing of the per enrollee cost and expects the growth to continue at the same level through the out-year.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Consumer Directed Attendant Support-State Plan	FY 2016-17 through FY 2018-19: 0.00%	FY 2016-17 through FY 2018-19: 2.75%, -0.55%, -0.55%	Additional enrollment in this program is currently prohibited. When CDASS becomes available on other 1915(c) waivers, members will leave this program. The adjustment for this decrease in enrollment is shown as a bottom line impact and is not captured in the selected growth trend. With the majority of clients leaving for CDASS expansion under the Supported Living Services waiver, enrollment is expected to only be one client after FY 2018-19. The Department moved to a needs-based allocation plan in FY 2011-12 to align with the CDASS waiver benefit; interestingly, the average cost per enrollee reached its peak in FY 2011-12 and has decreased every year after, suggesting that client allocations have reached stability. FY 2015-16 average cost per enrollee were lower than previous estimates. The Department chose a positive growth trend in FY 16-17 and then approximately zero growth trend through FY 2018-19.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Brain Injury Waiver	FY 2016-17 through FY 2018-19: 7.14%, 3.06%, and 2.96%, respectively.	FY 2016-17 through FY 2018-19: 0.03%	Historically there has been slow and steady growth in BI enrollment. The Department saw this growth increase rapidly in FY 2012-13 and FY 2013-14, which continued at a higher pace in FY 2014-15 and then returned to a slightly higher than historical trend in FY 15-16. The first half of FY 2015-16 grew higher than expectations in the November request but slowed in the second half of the year. The Department expects waiver enrollment to grow through the out-year using a monthly linear regression. Historic cost per enrollee growth has been approximately 3%. The Department expects cost per enrollee growth to continue into the out year using a monthly linear regression of the past 24 months.
Children with Autism Waiver	FY 2016-17 through FY 2018-19: 0.00%	FY 2016-17 through FY 2018-19: -4.55%, 0.00%, 0.00%	CMS has denied the Department's request to expand the CWA Waiver which was authorized through House Bill 15-1186. The Department is waiting further direction from CMS regarding the current waiver. CMS has directed the Department to provide services authorized that are deemed medically necessary under EPSDT. The Department expects the enrollment trends to stay relatively flat, with one new client joining each year through FY 2018-19. Average cost per enrollee came in significantly below expectations and past values; the Department estimates a small negative growth trend in FY 2016-17 and then a flat trend for all request years.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Children with Life Limiting Illness Waiver	FY 2016-17 through FY 2018-19: 11.03%, 10.56%, and 0.00%, respectively.	FY 2016-17 through FY 2018-19: 4.63%	Waiver programmatic changes have improved the program resulting in large positive growth, though recent growth has been negative or close to zero. The waiver is capped at 200 clients and average enrollment in FY 2015-16 was 131 clients. Enrollment was slightly lower than anticipated in FY 2015-16, enrollment is expected to increase as more providers become available as they become aware of recent rate increases and programmatic changes were fully implemented in FY 2015-16, leading to positive growth. As with client enrollment, cost per enrollee growth is expected to be positive into the future due to pragmatic changes and rate increases; in FY 2014-15 cost per enrollee grew by 172.91%, from $1,335.13 to $3,643.65 and in FY 2015-16 growth was approximately 24%. Programmatic changes have been fully implemented and the Department has selected a modest positive growth trend for future years.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Spinal Cord Injury Adult Waiver	FY 2016-17 through FY 2018-19: 15.09%. 0.00%, 0.00%	FY 2016-17 through FY 2018-19: Growth matches Senate Bill 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine"	Senate Bill 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine" reauthorizes the waiver for five years, allowing for increased enrollment beyond the previous cap of 67 and replaced administrative funding from gifts, grants, and donations with General Fund. The bill allows growth in enrollment beyond 100 at any point-in-time. For FY 2017-18 and FY 2018-19, the Department adjusts enrollment through the bottom line impact of Senate Bill 15-011 instead of through the enrollment growth trend. The positive growth trend in per capita costs reflects the anticipated increases in both service utilization and number of service providers due to changes in minimum qualifications for Complementary and Integrative Health Service (CIHS) providers. This rule change modifies minimum qualifications in order to allow more providers to enroll to better serve the SCI waiver population.

Legislative Impacts and Bottom-Line Adjustments

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

Expenditure

- HB 14-1357: "In-Home Support Services in Medicaid Program" – HB 14-1357 expands In-Home Support Services (IHSS) into the Spinal Cord Injury Waiver, allows for the delivery of IHSS in the community, permits the person receiving services, or his or her representative, in conjunction with the in-home support services agency to determine the amount of nurse oversight needed in connection with the person's in-home support services, and permits family members to be reimbursed for in-home support services

provided to eligible persons and requiring the medical services board to promulgate rules, as necessary, regarding reimbursement for services. Program implementation occurred in March 2016.

- Colorado Choice Transitions – The Department was awarded Money Follows the Person federal grant monies to implement a program designed to transition clients from nursing facilities into community-based services. The program began enrolling clients in May 2013. The program has seen enrollment expectations decrease due to issues with payment methodology and low rates; however, with recent access changes, enrollment is expected to increase in each year of this request. To address this, the Department increased rates to transition coordination agencies to deal with the emergency access issue. Low enrollment caused long-term home health utilization and CCT service utilization to decrease below original expectations, which decreased the amount of cumulative nursing facility cost avoidance. The Department has decreased enrollment expectations which also decreased the cumulative nursing facility cost avoidance from the February request.
- Consumer Transition Services (CTS) Rate Increase – Implemented on January 1, 2016, this policy increased rates for two services included in the Colorado Choice Transitions (CCT) program for HCBS clients. The rate increases address Transition Coordination Agency (TCA) capacity issues and will encourage more transitions per year from institutionalized care to HCBS or DIDD waivers.
- FY 2014-15 JBC Action "Raising the Cap on Home Modifications" – A Joint Budget Committee action raised the cap on home modifications in FY 2014-15, resulting in an impact to waivers that include home modifications. Due to delays in approval from CMS, the Department expected implementation by December 1, 2015 but did not receive approval to implement until late January 2016, and the increased lifetime cap on home modifications was implemented March 1, 2016.
- Annualization of FY 2014-15 R#7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase" – This impact shows as savings to HCBS waivers (the Elderly, Blind, and Disabled Adult Waiver) due to the waitlist reduction of the DIDD Adult Supported Living Services waiver for the clients formerly on the EBD waiver who transitioned over.
- Annualization of FY 2014-15 R#8 and HB 14-1252 Client Movement to the DD Waiver: FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents" and HB 14-1252: "Intellectual and Developmental Disabilities Service System Capacity" are combined into one bottom-line adjustment – FY 2014-15 R#8 allows for emergency enrollments onto the Division for Intellectual and Developmental Disabilities (DIDD) Developmental Disabilities (DD) waiver and HB 14-1252 is the bill that incorporates the Department's BA-5/S-5 request "Community Living Caseload and Per Capita Changes," which reduced the waitlist for the DD waiver. The impact to HCBS waivers is due to the increased caseload and per capita costs for the DIDD Medicaid waivers attributable to those formerly on Medicaid HCBS waivers (in this case, the Elderly, Blind, and Disabled Adult Waiver). This shows as savings to HCBS waivers.
- EPSDT Personal Care – accounts for a decrease in expenditure from personal care services in the waivers deemed medically necessary for EPSDT eligible children, which accompanied by an increase in state plan expenditure. In late FY 2013-14 the Department received notice from CMS that personal care is a covered benefit under EPSDT if deemed medically necessary. The Department anticipates that clients utilizing personal care under EPSDT will fall into three categories: clients substituting long-term home services with less costly personal care services; resulting in savings in acute care, clients directly substituting units under the

state plan from waivers, resulting in an increase in acute care expenditure and decrease to HCBS wavier expenditure, and clients who have never had access to personal care that have a medical necessity, resulting in an increase in acute care expenditure. The implementation of this has been delayed due to provider recruitment, training and systems issues. The Departments expects utilization to keep increasing and the FY 2016-17 impact has not changed since the previous request.

- FY 2015-16 R#12: "Community Provider Rate Increase" 0.5% Across the Board – The Joint Budget Committee approved a 0.5% across-the-board rate increase, effective July 1, 2015, which affects services provided by HCBS waivers. Due to delays in approval from CMS, implementation occurred March 1, 2016.
- FY 2015-16 R#12: "Community Provider Rate Increase" Targeted – Homemaker and Personal Care to $17 per hour, In-Home Respite to $4.87 - The Joint Budget Committee approved these targeted rate increases, effective July 1, 2014, which affects the Elderly, Blind, and Disabled, Brain Injury, Community Mental Health Supports, and Spinal Cord Injury waivers. Implementation of the new rates occurred March 1, 2016.
- FY 2015-16 JBC Action "Raising the Cap on Home Modifications" – A Joint Budget Committee action raised the cap on home modifications in FY 2015-16, resulting in an impact to waivers that include home modifications. The new lifetime cap of approximately $14,000 was implemented on March 1, 2016.
- HB 15-1186: "Children with Autism Waiver Expansion" – HB 15-1186 increases the age limit from six to eight, allows for 3 years stay on the waiver (regardless of entry age), eliminated with waitlist and allows for natural growth in enrollment and expenditure cap increases at the Joint Budget Committees purview. The legislation also allows for General Fund to be used for payment once the Autism Treatment Fund is exhausted. The expansion was expected to be implemented on July 1, 2015, but was denied by CMS on September 14, 2015. CMS requested that the state provide behavioral therapy to children with autism through the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program. The Department expects increased utilization in FY 2016-17 as the EPSDT benefit is further established. As such, Department has left the impact of the waiver expansion in FY 2016-17 to ensure proper funding in case a substantial amount of behavioral therapy is deemed medically necessary for current Medicaid eligible clients. This impact, however, has been moved from a CBLTC impact to an increase acute care costs.
- SB 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine" – SB 15-011 reauthorized the Spinal Cord Injury Waiver for another five years, starting in FY 2015-16. The bill also eliminates the enrollment cap, allowing for natural growth in enrollment and changes administrative funding from gifts, grants, and donations to General Fund. The reauthorization and expansion was implemented on March 1, 2016.
- Independent Living Skills Training (ILST) Provider Rule Change – the Department was not able to recruit providers under current rules in rural areas resulting in gaps in coverage. Provider rule changes implemented on January 1, 2016 will allow for ILST to be provided in rural areas, filling the gap in coverage.
- SB 16-192: "Single Assessment Tool" – SB 16-192 requires the state to select a needs assessment tool for persons receiving Long Term Services and Supports, including persons with intellectual and developmental disabilities. FY 2018-19 costs to CLTBC result from reassessing a sample of Long Term Services and Supports members in the pilot program. The Department assumes pilot

program implementation will begin January 1, 2019 with full program implementation estimated on August 1, 2019. Costs in the years after FY 2018-19 include reassessing every Long Term Services and Supports members with the selected needs assessment tool.

- HB 16-1321: "Medicaid Buy-In Certain Medicaid Waivers" – HB 16-1321 authorizes the Department to seek federal approval to implement a buy-in program for people eligible to receive services through the Home and Community Based Services - Supported Livings Services (HCBS-SLS) waiver, the Home and Community Based Services - Brain Injury Waiver (HCBS-BI), and the Home and Community Based Services – Spinal Cost Injury Waiver (HCBS-SCI) and that it shall be implemented no later than three months after receiving federal approval. The Department assumes it will be able to begin enrolling HCBS-SLS, HCBS-BI, and HCBS-SCI clients into the Buy-In program on July 1, 2017. Starting in FY 2017-18, there will be a mix of existing HCBS-BI and HCBS-SCI clients transitioning into the Buy-In program for the respective waivers and new clients entering CBLTC through the Buy-In program.

Colorado Choice Transitions

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

The Department delayed implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The program was implemented on March 1, 2013, with the first client transitioning in May 2013. The Department currently anticipates approximately 100 clients will transition per 365 days beginning in May 2013. Due to rate and rate methodology issues for Transition Coordination Agencies, enrollment has been less than anticipated. The Department anticipates that enrollment will be below 100 in FY 2016-17 and FY 2017-18, and less than February expectations, but will exceed 100 by FY 2018-19 as the Transition Coordination Agencies rates were adjusted to ensure clients receive the services they need. The Department estimates the total impact

to Medical Services Premiums to be a reduction of $2,273,855 total funds in FY 2016-17 and a reduction of $3,652,049 in FY 2017-18. These figures do not include any expenditure from the rebalancing fund.

Prior-Year Expenditure

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

Hospice

Hospice expenditure for FY 2016-17, FY 2017-18, and FY 2018-19 is forecasted as the sum of two primary categories of services. The first – Nursing Facility Room and Board expenditure – are expenses incurred on a per-diem basis for clients receiving hospice services in a full-time capacity at a nursing facility. These expenditures represented approximately 70% of total hospice expenditure in FY 2015-16. The remaining portion of hospice expenditure is represented under the Hospice Services category and includes Hospice General Inpatient Care, Hospice Routine Home Care, Hospice Inpatient Respite, Hospice Continuous Home Care, and vision, dental, hearing, and other Post-Eligibility Treatment of Income (PETI) benefits.

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

To create the patient days forecast, the Department used claims information adjusted by an incurred-but-not-reported (IBNR) analysis to determine historical patient day counts. The Department used the same patient days forecasts for FY 2016-17 and FY 2017-18 based on the accuracy of the February 2016 forecast in predicting FY 2015-16 actuals; the difference between the forecast and assumed actuals[5] was 0.5%. The assumed growth rate for patient days in FY 2016-17 is 2.51%, and the assumed growth rate for patient days in FY 2017-18 and FY 2018-19 is 0.96%. These trend estimates were made with the assumption that patient days would level off. As hospice client nursing facility per diems are linked to the per diem for Class I Nursing Facility clients, they are assumed to grow at the same 3% per-year rate. Rate reductions are accounted for in the same fashion as they are for nursing facilities: their impact is included in calculations as a bottom-line impact. Hospice nursing facility room-and-board total expenditure estimates for a particular fiscal year are the product

[5] FY 2015-16 patient days were adjusted by a factor to take into account incurred-but-not-reported (IBNR) days.

of forecasted patient days and forecasted patient per diem, with additional bottom-line impact adjustments made for rate cuts applied to claims paid that were incurred in the previous fiscal year.

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

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

The largest component of this expenditure category is Hospice Routine Home Care; this is considered the standard level of hospice care provided to hospice clients in their homes typically two to three times per week, generally by nurses. In FY 2015-16, Hospice Routine Home Care expenditure was approximately $11.5 million and thus represented 82% of Hospice Services expenditure and 22% of total hospice expenditure. Hospice Routine Home Care expenditure is computed as a product of patient days and the daily rate. The Department arrived at estimates for days by trending forward total patient days in FY 2015-16 by 2.0% for FY 2016-17 estimates, 1.0% for FY 2017-18 estimates, and 1.0% for FY 2017-18 estimates; the trends were selected with the assumption that patient days would level off over time. The Hospice Routine Home Care per diem is forecasted by applying a linear time trend to observed daily rates in the last six months of FY 2015-16. Starting on January 1, 2016, the Department was instructed by CMS to implement a tiered rate system for Routine Home Care Services.[6] Patient days incurred in the first sixty days of service would be billed a higher rate than days incurred beyond the sixty day threshold; a majority of the days the Department reimburses under this service fall into the latter category, leading to lower aggregate rates than previously observed for Routine Home Care.

The next-largest component of hospice services expenditures is Hospice General Inpatient Care. These expenditures are incurred for services provided to hospice patients at inpatient facilities under severe circumstances. In FY 2015-16, the Department paid approximately $2.4 million for Hospice General Inpatient Care. The Department estimated FY 2016-17, FY 2017-18, and FY 2018-19 service costs by forecasting its rates and patient days. Patient days were estimated by applying a 17.82% growth trend (growth in patient days between FY 2014-15 and FY 2015-16) and rates were estimated by applying a 5.27% trend (growth in rates between FY 2014-15 and FY 2015-16) to FY 2015-16 observed rates.

[6] For more information, refer to: https://www.colorado.gov/pacific/sites/default/files/2016%20Hospice%20Rates%20and%20Rules.pdf

The remaining components of hospice services expenditures in total represent approximately $54,000 of expenditure for FY 2015-16. FY 2016-17, FY 2017-18, and FY 2018-19 expenditure estimates are results of the application of the average growth rate between FY 2012-13 and FY 2014-15, 5.41%, to the previous fiscal year's estimate.

Hospice is not normally affected by bottom line impacts, except through items that also affect Class I Nursing Facilities, such as the HB 13-1152 1.5% permanent rate reduction on Nursing Facility core per-diem. However, the current request includes the estimated impacts of a rate increase that affect Hospice services other than Nursing Facility Room and Board: the annualization of the FY 2015-16 R-12 Community Provider Rate Increase, which increases the Hospice rate by 0.50%. This increase does not apply to Nursing Facility Room and Board.

Private Duty Nursing

Private Duty Nursing (PDN) services are face-to-face skilled nursing services provided in a more individualized fashion than comparable services available under the home health benefit or in hospitals or nursing facilities and are generally provided in a client's home. PDN services are billed hourly; maximum daily eligibility is 16 hours for adults and 24 hours for pediatric clients. There are five categories of PDN expenditure: individual services provided by a registered nurse (RN), group services provided by a registered nurse (RN-group), individual services provided by a licensed practical nurse (LPN), group services provided by a licensed practical nurse (LPN-group), and blended services. RN services are associated with the highest hourly rate and LPN-group services with the lowest. The remaining three services – RN-group, LPN, and blended – charge similar rates. PDN rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change. However, during the FY 2015-16 Legislative Session, PDN RN received a targeted rate increase to bring the rate up 10.95% to $45, while the remaining four services received the 0.5% across the board rate increases. The rate increases were implemented on August 1, 2015.

As PDN expenditure is the product of the units utilized per client and the number of utilizers, and the Department expects rates to remain constant, expenditure forecasts for FY 2016-17, FY 2017-18, and FY 2018-19 are primarily based on units per utilizers and utilizers forecasts for those fiscal years. The units per utilizer and utilizers forecast are separated into three pieces: RN; LPN; and grouped RN Group, LPN Group, and Blended Group.

Final expenditure estimates for FY 2016-17, FY 2017-18, and FY 2018-19 are produced by multiplying average monthly utilizers by the average units per utilizer by the projected rate for RN, LPN, the grouped services and then summing these figures. The Department is forecasting growth in FY 2016-17, 13.72%, which accounts for about 70.4% of utilization, and is increased by increases in units per utilizer. The trend is decreased in the request and out-years to 11.47% and 10.49% respectively, which is lower than historical growth.

As a result of differences in the way data used to forecast for the PDN exhibit was pulled in the current forecast and previous forecasts, the historical average utilizers per month and units per utilizer differ between this request and previous requests. Expenditure remains constant however, so only trends are affected.

Private Duty Nursing Utilization Trends and Justification			
Service	**Average Month Utilizer Trend Selection**	**Units Per Client Trend Selection**	**Justification**
Registered Nursing (RN)	FY 2016-17 through FY 2018-19: 11.54%, 10.34%, and 9.34% respectively.	FY 2016-17 through FY 2018-19: 1.53%, 1.54%, 1.52%, respectively.	In FY 2015-16, the Department paid claims for 725 utilizers on average per month for PDN services; 416 of those utilizers billed for RN services. RN average utilizers per month had grown in the double digits from FY 2008-09 to FY 2014-15, reaching a maximum growth of 38.46% in FY 2013-14. This growth slowed down significantly in FY 2015-16, where average utilizers per month yearly growth dropped to 4.52%. Average monthly growth has been growing steadily over time and the Department chose to apply a linear time trend to historical claims data over this time frame to produce estimates for FY 2016-17, FY 2017-18, and FY 2018-19. This model predicts linear growth at 11.54% in the current year, and then at 10.34% in the request year and 9.34% in the out-year. RN units per client have been decreasing on average, almost every year since FY 2011-12, with average yearly growth of -3.88%, but reaching the largest percent decrease in FY 2014-15 of -10.52%. In FY 2015-16 there was growth of 7.44% however. The Department expects growth in units per client to become positive, which it did in FY 2015-16. Units Per Client are expected to increase in FY 2016-17 by 1.53%, 1.54% in FY 2017-18, and 1.52% in FY 2017-18. This differs from the February forecast that predicted the units per client to drop and level off.

Private Duty Nursing Utilization Trends and Justification			
Service	**Average Month Utilizer Trend Selection**	**Units Per Client Trend Selection**	**Justification**
Licensed Practical Nursing (LPN)	FY 2016-17 through FY 2018-19: 10.00%, 9.09%, and 8.33%, respectively.	FY 2016-17 through FY 2018-19: 0.99%, 0.98%, and 0.97%, respectively.	Similar to RN, LPN average utilizers per month have grown mostly in the double digits over time, with an average of 16.65% per year, and reaching maximum growth in FY 2013-14 of 43.65%. In FY 2015-16, average utilizers per month yearly growth dropped to 6.67%. Average monthly growth has been growing steadily over time and the Department chose to apply a linear time trend to historical claims data over this time frame to produce estimates for FY 2016-17, FY 2017-18, and FY 2018-19. This model predicts growth at 10.00%, 9.09%, and 8.33% respectively. Average Utilizers per month grew slower than the Department's February expectations. Again, much like RN units per client, LPN units per client have been decreasing on average, every year since FY 20011-12, with average yearly growth of -8.34%, however in FY 2015-16 growth became positive again at 2.48%. Growth in units per clients in FY 2015-16 outpaced the February requests expectations. Therefore, the Department has increased the expectations for the years being forecasted and has held growth in the current, request and out year almost constant at 0.99%, 0.98%, and 0.97% respectively.

Private Duty Nursing Utilization Trends and Justification			
Service	**Average Month Utilizer Trend Selection**	**Units Per Client Trend Selection**	**Justification**
Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN	FY 2016-17 through FY 2018-19: 10.29%, 9.33%, and 8.54%, respectively.	FY 2016-17 through FY 2018-19: 1.77%, 0.60%, and 0.24%, respectively.	LPN-group, RN-group, and Blended RN/LPN drive only about 11.8% of expenditure in FY 2015-16 and represent the smallest number of average utilizers per month as well. Due to recent large growth years and slow growth in FY 2015-16, the Department has chosen to forecast FY 2016-17, FY 2017-18, and FY 2018-19 linearly at 10.29%, 9.33%, and 8.54%. This represents a decrease over expectations in the February request. For the grouped and blended PDN services, units per client growth has been very positive over the last few years, but trended downward in FY 2015-16. For this reason the Department used weighted average yearly growth to forecast FY 2016-17, FY 2017-18, and FY 2018-19 which resulted in growth rates of 1.77%, 0.60% and 0.24% respectively.

Long-Term Home Health

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

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

In the fall of 2015 the Department implemented personal care within the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. It is a CMS requirement that clients under the age of 20, and have the medical need, have access to personal care. The Department expects most utilizers of personal care on waivers to move utilization from waiver personal care to EPSDT personal care. The Department is also expecting clients to substitute out of more costly HHA Basic and Extended and into EPSDT personal care. There is a bottom line adjustment listed under HHA basic for the net impact of implementing EPSDT personal care of $1,110,298. The net increase is due to clients having access to personal care, who have a need for it but not a high enough need for HHA, and have never had access before. Once implemented and clients have access, EPSDT personal care will have its own forecast similar to the other services under LTHH, but until then, the net impact is listed under HHA Basic. Clients have been slow to utilize the EPSDT Personal Care Benefit and the impact has been shifted more into FY 2016-17 than in the February request. After this year the impact will have become fully incorporated into the budget and will no longer be seen in the bottom line impacts.

Final expenditure estimates for FY 2016-17, FY 2017-18, and FY 2018-19 are produced by multiplying average monthly utilizers by the average units per utilizer by the projected rate for all LTHH services and then summing these figures. The Department is forecasting growth in FY 2016-17 as 6.79%, which has been decreased from February's expected growth of 9.26%. The trend is decreased in the

request year to 5.94%, which has decreased from the February expected growth of 9.06%, and decreased to 5.19% in the out year, which is a decrease from the February projections of 8.87%. Total expenditure growth for all years is lower than historic average yearly growth, due to the drop in average utilizers per month in FY 2015-16.

As a result of differences in the way data used to forecast for the LTHH exhibit was pulled in the current forecast and previous forecasts, the historical average utilizers per month and units per utilizer differ between this request and previous requests. Expenditure remains constant however, so only trends are affected.

Similar to Acute Care in Exhibit F, the LTHH exhibit includes a bottom line adjustment to account for the implementation of new federal rules related to home health. As part of 42 CFR 440 "Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health," CMS specified that states may not restrict beneficiaries from receiving home health services in any setting in which normal life activities take place. The adjustment accounts for an increase in utilization due to clients desiring to receive additional long term home health services in the community.

Long-Term Home Health Utilization Trends and Justification			
Service	**Average Monthly Utilizer Trend Selection**	**Average Units Per Client Trend Selection**	**Justification**
Home Health Aid Basic and Home Health Aid Extended	Home Health Aid Basic: FY 2016-17 through FY 2018-19: 5.32%, 5.06%, and 4.81% respectively. Home Health Aid Extended: FY 2016-17 through FY 2018-19: 5.93%, 5.59%, and 5.30% respectively.	Home Health Aid Basic: FY 2016-17 through FY 2018-19: 0.49%, 0.49%, and 0.00% respectively. Home Health Aid Extended: FY 2016-17 through FY 2018-19: -0.54%, -0.54%, and -0.54% respectively.	Average utilizers per month for HHA Basic and Extended have steadily increased along a linear path since FY 2008-09. In FY 2015-16 both services continued to increased, albeit at a lower rate than usual. The Department brought down both forecasts from the February levels to compensate for the decrease in growth. HHA Basic units per utilizer has been positive at 0.74% with lesser growth more recently. In FY 2015-16, units per client increased over the February expectations, however the Department felt it was unlikely for units per clients to continue increasing at a consistent rate, and so the forecast was brought down and eventually to 0%. HHA Extended has seen units per utilizers increase slightly in FY 2015-16, and still came in lower than expected, average yearly growth since FY 2008-09 has been -0.98%. Given that HHA Extended had positive growth in FY 2015-16, it made sense to bring the trend down to -0.54% and leave it flat. Similar to HHA Basic, the Department is using the average yearly historical growth to forecast HHA Extended for FY 2016-17, FY 2017-18, and FY 2018-19.

Long-Term Home Health Utilization Trends and Justification			
Service	**Average Monthly Utilizer Trend Selection**	**Average Units Per Client Trend Selection**	**Justification**
Registered Nursing/Licensed Practical Nurse	FY 2016-17 through FY 2018-19: 4.85%, 4.63%, and 4.42%, respectively.	FY 2016-17 through FY 2018-19: 0.96%, 0.95%, and 0.94%, respectively.	RN/LPN accounts for about 14.93% of LTHH utilization and has seen both average monthly utilizers and units per utilizer increase, on average, since FY 2008-09. Average monthly utilizers has been growing linearly since FY 2012-13. Given the linear growth, the Department chose to use a yearly linear regression to forecast average monthly utilizers for FY 2016-17, FY 2017-18, and FY 2018-19, which equates to an average of 5.65% growth per year. Growth in the first half of FY 2015-16 was as expected in November. Units per utilizer have also grown over time, but have growth at about 1.98% per year on average, which is what the Department is using to forecast units per utilizer for FY 2015-16, FY 2016-17, and FY 2017-18. Growth in FY 2015-16 was slightly higher than expected in February.

Long-Term Home Health Utilization Trends and Justification			
Service	**Average Monthly Utilizer Trend Selection**	**Average Units Per Client Trend Selection**	**Justification**
RN Brief First of Day and RN Brief Second or more	RN Brief First of Day: FY 2016-17 through FY 2018-19: 8.94%, 8.20%, and 7.58%, respectively. RN Brief Second or more: FY 2016-17 through FY 2018-19: 8.39%, 8.33%, and 8.24%, respectively.	RN Brief First of Day: FY 2016-17 through FY 2018-19: 0%. RN Brief Second or more: FY 2016-17 through FY 2017-18: 1.29%, 1.27%, and 1.25%, respectively	RN Brief First of Day and RN Brief Second or more account for 4.92% of total expenditure and have had on average positive historical growth for both average monthly utilizers and units per utilizer. For RN Brief First of Day, the Department chose a linear regression to model growth. For the Second or more visit of the day, average monthly client growth has fluctuated over time. The Department expects average monthly client growth to stabilize at historic growth and used average yearly growth to forecast FY 2016-17, FY 2017-18, and FY 2018-19. In FY 2015-16, both services were underutilized compared to what was expected in February. Units per client growth for RN Brief First of Day has been relatively flat over time, the Department chose to leave this flat at 0% for all years in the forecast. Much like the First Visit of the Day units per utilizer, the Second or More Visit of the day have been slightly positive and steady since FY 2008-09, except FY 2013-14 which had a large negative spike in growth. The Department is expecting growth to be consistent in FY 2016-17, FY 2017-18, and FY 2018-19, hovering around an average of 1.27%. In FY 2015-16, RN Brief Second or More services were utilized as expected in February, however RN First Visit of the day saw a much larger increase than expected.

Long-Term Home Health Utilization Trends and Justification			
Service	**Average Monthly Utilizer Trend Selection**	**Average Units Per Client Trend Selection**	**Justification**
Physical (PT), Occupational (OT), and Speech/Language Therapy (S/LT)	Physical Therapy: FY 2016-17 through FY 2018-19: 8.42%, 7.76%, and 7.21%, respectively. Occupational Therapy: FY 2016-17 through FY 2018-19: 8.41%, 7.76%, and 7.20%, respectively. Speech/Language Therapy: FY 2016-17 through FY 2018-19: 14.98%, 7.75%, and 7.19%, respectively.	Physical Therapy: FY 2016-17 through FY 2018-19: 0.00% Occupational Therapy: FY 2016-17 through FY 2018-19: 0.00% Speech/Language Therapy: FY 2016-17 through FY 2018-19: 0.00%	PT, OT, and S/LT accounted for 10.81% of expenditure in FY 2015-16, but with large utilizer growth over the last few years, that share is expected to increase. In FY 2015-16 all three services came in lower than expected. Due to this decrease in growth the Department adjusted monthly averages of all services downward from February levels until they were right around 7.75% in FY 2017-18 and 7.20% in FY 2018-19. All of the services are still positive, however it seemed unlikely, given the lack of explosive growth in FY 2015-16 for the very high trends to continue, as a result all three services were brought down to levels that seemed more sustainable and likely. In FY 2015-16 units per client utilization followed expectations, so no changes have been made to the forecast for OT and S/LT. PT came in lower than expected and as a result was reduced to a flat 0% trend for all forecasted years identical to OT and S/LT.

EXHIBIT H - LONG TERM CARE AND INSURANCE SERVICES

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

- Class I Nursing Facilities

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

Summary of Long Term Care and Insurance Request

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

Class I Nursing Facilities

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

Overall, patient days have declined since FY 1999-00, although caseload in the Department's Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories has increased by approximately 20.8% between FY 1999-00 and FY 2009-10. This is due to efforts by the Department to place clients in Home- and Community-Based Services (HCBS) and in the Department's Program of All-Inclusive Care for the Elderly (PACE). Recent history makes it difficult for the Department to anticipate the behavior of patient days; patient days had been trending upward, but changed to a slight negative trend in FY 2011-12 through FY 2013-14. Most recently, patient days increased in FY 2014-15, and continued to increase in FY 2015-16; the Department is closely monitoring this growth.

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

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

reimbursement method from the federal Centers for Medicare and Medicaid Services (CMS) on March 26, 2009, effective retroactive to July 1, 2008.

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

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

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

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

HB 13-1152 extended the 1.5% rate reduction of HB 12-1340 permanently, effective July 1, 2013. As all other rate reductions expired before the start of FY 2013-14, this reduction represents the total value of the rate reduction for FY 2013-14. For complete information regarding specific calculations, the footnotes in pages EH-5 through EH-8 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[7]:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2016-17.

[7] For clarity, FY 2016-17 is used as an example. The estimates for FY 2017-18 and FY 2018-19 are based on the estimate for FY 2016-17, and follow the same methodology.

- Using historic claims data from the Medicaid Management Information System (MMIS), the Department calculates the estimated patient payment for claims that will be incurred in FY 2016-17. The difference between the estimated per-diem rate for core components and the estimated patient payment is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2016-17 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2016-17.
- The product of the estimated Medicaid reimbursement per day for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2016-17.
- Of the estimated total reimbursement for claims incurred in FY 2016-17, only a portion of those claims will be paid in FY 2016-17. The remainder is assumed to be paid in FY 2017-18. The Department estimates that 92.88% of claims incurred in FY 2016-17 will also be paid during FY 2016-17. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2016-17
- During FY 2016-17, the Department will also pay for some claims incurred during FY 2015-16 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2015-16 to calculate an estimate of outstanding claims to be paid in FY 2016-17.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2016-17 prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in Footnotes 6 and 7.
- Legislative impacts are added as bottom-line adjustments. For FY 2016-17, this includes HB 13-1152, which permanently continued the HB 12-1340 rate reduction effective July 1, 2013.
- Once the "non-rate" factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2016-17 expenditure.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes that are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2016-17, FY 2017-18, and FY 2018-19 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom-line adjustments for FY 2016-17 through FY 2018-19. Please refer to Footnote 6 on page EH-7 for more detail. The estimate for FY 2016-17 is calculated by multiplying the average per diem between January 2015 and April 2016 by the anticipated number of client days in FY 2016-17.

- Prior to FY 2010-11, the Department reduced expenditure by the amount received in estate and income trust recoveries. The Department will no longer be including these recoveries as an offset to expenditure. See the narrative section of Exhibit L for further detail.
- The Department recovers funds from in-house audits of nursing facilities; the estimated amount of recoveries is included as a bottom line impact for FY 2016-17, FY 2017-18, and FY 2018-19. FY 2010-11 BRI-2, "Coordinated Payment and Payment Reform," increased the number of Department auditors resulting in additional audits of nursing facilities. As such, there was a large increase in recoveries observed in FY 2011-12 related to the prior fiscal year and the following fiscal years. This bottom line impact has been incorporated into the forecast of overpayment recoveries. Footnote 7 on page EH-7 contains additional detail about these recoveries.
- HB 12-1340 implemented a 1.5% rate reduction for Class I Nursing Facilities per diems effective July 1, 2012, through June 30, 2013. As a result of claims run-out, the fiscal impact of this bill extended into FY 2013-14. Footnote 8 on page EH-8 contains additional detail regarding the fiscal impact of this bill.
- SB 11-125 reprioritized the components of nursing facility supplemental payments. Growth beyond the General Fund cap now has the lowest priority. Quality incentives and acuity adjustments now take higher priority. Additionally, the maximum allowable fee per non-Medicare day increased to $12.00 per day plus inflation with this legislation. As a result, the Nursing Facility Provider Fee is able to fully fund quality/performance incentives and acuity based adjustments but is unable to fully fund growth beyond the General Fund cap. Starting in FY 2015-16, the supplemental payments formerly made as part of the growth beyond the General Fund cap will instead be made as part of the prior year rate reconciliation; the payments in this latter category still represent the components of the per diem rate greater than the 3% growth cap. Historically, the Department would set a nursing facility's interim rate at the lesser of the facility's unaudited "as-filed" rate as determined by the MED-13 cost report and the individual-facility growth limit rate that targets the aggregate 3% growth. It was these interim rates, some of them based on the "as-filed" rate from the MED-13, that were used to calculate the supplemental payments that were part of the growth beyond the General Fund cap. The issue with this approach was that once the rate based on the MED-13 cost sheet was audited and finalized, it would need to be reconciled with the chosen interim rate. To simplify this process, the Department chose to instead use the maximum allowable growth rate of the facility as the facility's interim rate and then reconcile this allowable growth rate with the final audited rate. Due to this change in methodology, the supplemental payment previously attributed to growth beyond the General Fund cap is instead considered a rate true-up payment to the final audited rate.
- HB 13-1152 extended the 1.5% nursing facility per diem rate cut of HB 12-1340 permanently, effective July 1, 2013.
- Previous to the current request, the Colorado Choice Transitions adjustment accounted for the reduction in Class I Nursing Facility expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. This adjustment was taken out as it was assumed that these transitions are already incorporated into the base trends. Additional detail can be found in Exhibit G. Estimates of Class I Nursing Facility costs avoided are for informational purposes only.

Incurred-But-Not-Reported Adjustments

As part of the estimates for the allowable per-diem rate, patient payment, and patient days, the Department utilizes the most recent five years of incurred claims to calculate estimates for the current year and the request year. However, because not all claims which have been incurred have been reported, the Department must adjust the incurred data for the expected incidence of claims which will be paid in the future for prior dates of service. Without such an adjustment, the claims data would appear to drop off at the end of the year, erroneously introducing a negative trend into the estimate.

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

Separate IBNR adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department's estimate of claims paid in the current year for current year dates of service, particularly Footnotes 4 and 5 of Exhibit H, page EH-6. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2015-16 that will be paid in FY 2016-17 and the percentage of claims incurred in FY 2016-17 that will be paid in FY 2017-18 and subsequent years. The Department applies the same factor to the FY 2017-18 and FY 2018-19 estimates.

The Department uses the IBNR adjustment calculation for the November 2016 Request using paid claims data through June 2015. For reference, the following table lists IBNR factors calculated for previous Change Requests and compares them with the current IBNR factor. There is a slight increase in the factors over time, suggesting the time between the date of service and the payment date of a typical claim may be decreasing.

Date of Change Request:	IBNR Factor:
November 2006	91.54%
February 2007	91.82%
November 2007	91.78%
February 2008	91.94%
November 2008	92.75%
February 2009	92.27%
November 2009	92.27%
February 2010	92.27%
November 2010	92.89%
February 2011	92.46%
November 2011	92.30%
February 2012	92.47%
November 2012	92.43%
February 2013	92.75%
November 2013	92.95%
February 2014	93.35%
November 2014	92.86%
February 2015	92.64%
November 2015	92.48%
February 2016	92.61%
November 2016	92.88%

Patient Days Forecast[8]

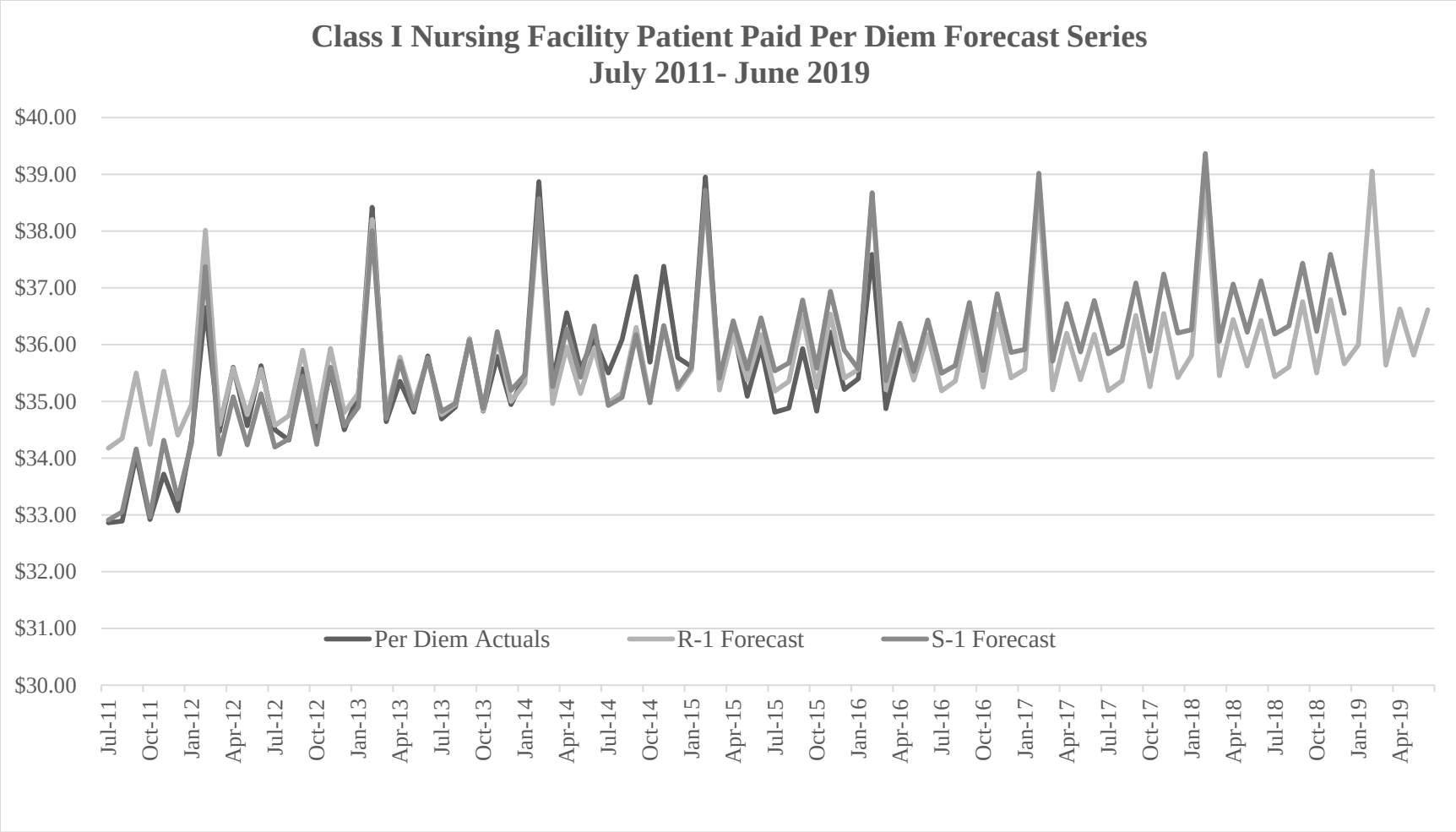
The Department observed a 2.21% increase in patient days as a result of new clients using the service in FY 2015-16. This increase in patient days was less than the 6.30% trend predicted at the time of the February 2016 request. As such, the Department forecasted patient days by trending forward FY 2015-16 patient days by lowered trends; these trends were 1.11% for FY 2016-17, 0.55% in FY 2017-18, and 0.28% in FY 2018-19, with the assumption that patient days would level out in later fiscal years. The Department will

[8] In previous requests, the Department forecasted patient days by using an auto-regressive model using IBNR-adjusted days. This methodology introduced a large negative trend that seemed unlikely given the growth in patient days in FY 2015-16.

continue to monitor this growth in patient days to determine whether it represents a change in the underlying trend and update the February 2017 Request accordingly.

Patient Payment Forecast Model

The Department utilizes a seasonally adjusted model to account for cost of living adjustment (COLA) increases and SB 14-130 "Increase to Personal Care Allowance" to forecast patient payment. Neither the current time period nor the previous time period are relevant to this forecast. The only indicators of patient payment are the number of days in the month and the COLA increase for a given year. For this reason, neither a linear nor an autoregressive model was used, as they did not add value to the forecast.



Testing the Overall Predictive Ability of the Model

Utilizing the F-statistic, an analysis of the model's overall statistical significance can be done. The patient payment model has a p-value of 0.00000 and is statistically significant at the 99% confidence level. The Adjusted R-squared for the model is 0.9686, suggesting

96.86% of the variation in this series can be explained by the monthly seasonality, COLA increases, and SB 14-130 "Increase to Personal Care Allowance."

Nursing Facility Rate Methodology Changes

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

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

implementing pay-for-performance payments. HB 10-1324 implemented a 1.5% rate reduction to the core rate components effective March 1, 2010 through June 30, 2010.

FY 2010-11 HB 10-1379 implemented a 2.5% rate reduction to the core rate components effective July 1, 2010, through June 30, 2011. This bill also reduced the maximum general funds portion of the core per-diem rate to 1.9% growth for FY 2010-11.

FY 2011-12 SB 11-125 increased the level of the provider fee to $12.00 per non-Medicare day plus annual inflation. Additionally the bill reprioritized the hierarchy for the components of nursing facility supplemental payments. Growth beyond the General Fund cap is prioritized last under the new hierarchy.

FY 2011-12 SB 11-215 extended the 1.5% rate reduction from the prior year. The rate reduction expired July 1, 2012.

FY 2012-13 HB 12-1340 extended the 1.5% rate reduction from the prior year. The rate reduction expired July 1, 2013.

FY 2013-14 HB 13-1152 extended the 1.5% rate reduction from the prior year. The rate reduction is permanent.

FY 2014-15 SB 14-130 raises the basic minimum payable for personal needs to any recipient admitted to a nursing facility or intermediate care facility for individuals with intellectual disabilities from $50.00 to $75.00 monthly; this increase was effective as of July 1, 2014. This amount increases by 3.0% annually on January 1st of each year.

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

For comparison purposes to other service categories, this exhibit lists prior-year expenditure along with the projected expenditure from page EH-1. Estimated totals by aid category are split proportionally to the most recent year of actual expenditure. Additionally, the Department calculates per capita costs for each year. Supplemental payments made to Class I Nursing Facilities through the Nursing Facility Provider Fee program are not included in total expenditure.

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

Class II Nursing Facilities

This service category is for specialized private nursing facility care for developmentally disabled clients, which was the focus of the Department of Human Services' initiative to deinstitutionalize these clients by placing them in appropriate care settings. The deinstitutionalization strategy was completed in April of FY 1997-98. There is currently one Class II Nursing Facility provider in Colorado: Bethesda Lutheran Communities (Bethesda). As of June 30, 2016 Bethesda operates 4 facilities with a total of 21 beds. There are no plans to eliminate this facility, as it functions more like a group home than an institutional facility. Class II nursing facilities are authorized to receive an annual cost-based rate adjustment, similar to Class I Nursing Facilities. As a result, this service category is

expected to see increased per-capita costs in the current, request, and out years. Enrollment has remained steady over the FY 2014-15 and FY 2015-16 periods. Because the number of available Class II Nursing Facility beds is limited, the Department did not place a trend on caseload in this request. Should additional facilities open the Department will revise the caseload forecast accordingly. Cost per-capita saw steady increases over the FY 2014-15 and FY 2015-16 time periods. The Department assumes that cost per-capita will continue to grow in the current, request, and out years based on current trends in cost per-capita growth. The Department anticipates that expenditure per aid category will only change if enrollment varies by aid category. However, total expenditure would still remain the same; therefore, differences between aid categories are less relevant.

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

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older (OAP-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB). PACE rates are adjusted once per year, generally on January 1 of each year.

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

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

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

In recent years, the Department has added a number of new PACE providers. Senior Community Care of Colorado (Volunteers of America), a new provider, began serving clients on August 1, 2008, in Montrose and Delta counties. Rocky Mountain Health Care began serving clients on December 1, 2008, in El Paso County. InnovAge (formerly Total Long Term Care), the Department's oldest PACE organization, opened a facility in late 2009 to serve clients in Pueblo, and another facility opened in northern Colorado in

November 2015. Two new facilities, TRU Community Care and HopeWest, are expected to open within the next couple of years. TRU Community Care is expected to open in fall of 2016 to serve Weld and Boulder counties and HopeWest is expected to open in winter of 2017.

Expenditure estimates for PACE for FY 2016-17, FY 2017-18, and FY 2018-19 are the product of two pieces: projected enrollment and cost per enrollee. As is consistent with convincing historical enrollment data suggesting linear trends for PACE enrollment, linear regression models are used to estimate future enrollment on a by-provider by-eligibility-type basis. Enrollment caps are not anticipated to limit growth for the forecast period as a result of the manner in which PACE services are provided: that is, clients are not full-time residents of PACE facilities. Systems issues since CY 2013 have resulted in clients who are eligible for Medicaid and receiving PACE services showing up in the MMIS as not having an enrollment span in the program, causing a delay in monthly capitation payments for these clients. The Department added a bottom line impact to FY 2015-16 in the February 2016 Request to account for an estimate of retroactive payments that would be made in FY 2015-16 for services accrued in FY 2014-15, and similarly incorporated a bottom line impact to FY 2016-17 in the November 2016 Request for services received in FY 2015-16. The Department assumes the systems issues have been resolved as of the November 2016 Request, but will continue to monitor them. To account for fluctuation due to these historic systems issues, the Department incorporated enrollment on a date of service basis to inform estimates. Based on date of service measures, enrollment in PACE programs has been slightly greater than expected in the February 2016 request, and the linear regression models have captured this increase.

Per-enrollee costs for FY 2016-17 are determined by cross-walking the actual FY 2016-17 rates net of patient payment for PACE services with an eligibility-type distribution estimate derived from FY 2016-17 enrollment projections. As such, they only represent an estimate to the extent that eligibility-type and provider distributions for FY 2016-17 are unknown. The rates were determined at the beginning of the fiscal year and are known for this forecast. PACE rates for FY 2013-14 increased by an average of approximately 10% over the previous year's rates, considered to be due to the rate increase for Home- and Community-based Long-Term Care. Rates continued to increase in aggregate in FY 2014-15 and FY 2015-16. For FY 2016-17, rates were set at a slightly lower level than in the previous fiscal year.

SB 16-199 requires the Department to develop a new actuarially sound Upper Payment Limit (UPL) methodology that uses "grade of membership methods to characterize the health deficit structure of long-term services and supports populations," provided that sufficient gifts, grants, and donations are received to fund the work done by the actuarial firm contracted to assist with developing this methodology. Until the new methodology is developed, the Department is required to keep rates at or above the percentage of the upper payment limit used to calculate capitations for FY 2016-17. As the upper payment limit is based on nursing facility rates and home and community-based waivers rates, the Department assumed for FY 2017-18 and FY 2018-19 that PACE rates would grow by an average of 1.5% or half of the statutory allowed maximum growth in nursing facilities rates per HB 08-1114, as approximately 50% to 55% of

clients in the PACE program are assumed to be high-cost institutional-level clients. The Department anticipates developing the new UPL methodology within the next fiscal year.

The Department notes that the table showing the average cost per enrollee on page EH-15 represents the total net amount spent in a fiscal year on PACE programs divided by the average number of monthly capitations paid in that specific year. These figures include retroactive capitations and recoupments and do not completely reflect the cost of services received in that fiscal year. For example, the average cost per enrollee in FY 2014-15 factors in approximately $12.9 million in retroactive payments, while the average cost per enrollee in FY 2015-16 encompasses approximately $5.4 million in recoupments.

Supplemental Medicare Insurance Benefit (SMIB)

The Supplemental Medicare Insurance Benefit (SMIB) consists of two parts: Medicare Part A, the insurance premium for hospital care, and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients who have both Medicaid and Medicare coverage) or Partial Dual Eligible receive payment for Medicare Part B and, in some cases, Medicare Part A. The Partial Dual Eligible aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility group only.[9] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

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

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

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:[10]

History of Medicare Premiums

Calendar Year	Part A	% Change	Part B	% Change
2003	$316.00	-	$58.70	-
2004	$343.00	8.54%	$66.60	13.46%
2005	$375.00	9.33%	$78.20	17.42%
2006	$393.00	4.80%	$88.50	13.17%
2007	$410.00	4.33%	$93.50	5.65%
2008	$423.00	3.17%	$96.40	3.10%
2009	$443.00	4.73%	$96.40	0.00%
2010	$461.00	4.06%	$110.50	14.63%
2011	$450.00	-2.39%	$115.40	4.43%
2012	$451.00	0.22%	$99.90	-13.43%
2013	$441.00	-2.21%	$104.90	5.01%
2014	$426.00	-3.40%	$104.90	0.00%
2015	$407.00	-4.46%	$104.90	0.00%
2016	$411.00	0.98%	$123.70	17.92%

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

To forecast FY 2016-17, the Department inflates the actual expenditure in the second half of FY 2015-16 by half the estimated increase in caseload from FY 2015-16 to FY 2016-17 to get the first half expenditure estimate for FY 2016-17. For the second half of FY 2016-17, the Department inflates the first half expenditure by half of the caseload growth along with the anticipated growth in Medicare Part

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

B Premiums. The total estimated expenditure for FY 2016-17 is the sum of the first half actual expenditure and the second half estimated expenditure.

To forecast FY 2017-18, the Department first inflates the estimated expenditure from the second half of FY 2016-17 by half the estimated caseload trend for FY 2017-18 as reported in Exhibit B. This figure represents the approximate expenditure for the first half of FY 2017-18. Then, the Department inflates the estimated first half expenditure by half the estimated caseload trend for FY 2017-18 and the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2017-18 is the sum of the first half and second half estimates. The forecast of FY 2018-19 expenditure utilizes the same methodology as the forecast of FY 2017-18.

Health Insurance Buy-In (HIBI)

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

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

Beginning with the November 2014 Request, contrary to previous budget submissions where the Department examined per capita growth trends to forecast the HIBI budget and the February 2014 Request where the Department examined total expenditure trends to estimate expenditure, the Department instead estimated expenditure based directly on the contractor's program enrollment estimates, in order to calculate provider and premiums payments for clients enrolled in HIBI. The Department believes this methodology to be more accurate as HIBI enrollment does not bear a direct relationship to Medicaid caseload and enrollment is the primary driver in differences between cost estimates and actuals.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the per capita or trend factors, the Department previously added total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts were included in February 2014 Request calculations for the Health Insurance Buy-In Program, but, beginning with the November 2014 Request, are the sole source of the estimates in the current Budget Request:

- SB 10-167 "Medicaid Efficiency and Colorado False Claims Act" impacts the HIBI program in FY 2016-17 forward by requesting the purchase of private health insurance coverage through the Health Insurance Buy-In Program for eligible clients to create cost savings for the State. The contractor estimates approximately 2% growth in enrollment per month for FY 2016-17. Savings as a result of SB 10-167 are captured in the Acute Care exhibit. The Department has adjusted costs associated with this bill by changing the payment methodology for the contractor from a contingency fee to a per-member per-month payment. In addition, adjustments were made to reflect additional premium payments that would be made as the number of clients utilizing the program increases. The estimate was adjusted for enrollment capabilities of the contractor. Please see section V for a complete description of the bill and changes.

EXHIBIT I – SERVICE MANAGEMENT

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

Summary of Service Management

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

Single Entry Points

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

The SEP is required to serve clients of publicly funded long-term care programs including nursing facility care, Home- and Community-Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons with brain injury, HCBS for persons with mental illness,

HCBS for persons with spinal cord injuries, long-term home health care, home care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965.

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

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

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

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

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

Also fully annualized in the budget request is the impact of HB 05-1243, which allowed the Department to add consumer-directed care to home- and community-based waiver services. These services must be approved by SEPs. The Department received approval from CMS to add consumer-directed care to the Elderly, Blind, and Disabled waiver and the Mental Illness waiver in 2007. The Department

began to provide these services effective January 1, 2008. Consumer-directed care has since been expanded to the Spinal Cord Injury and Brain Injury waivers.

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

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

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

For FY 2016-17, the Department's projection uses the total base contracts amount, which is the current amount allocated to SEPs in the FY 2016-17 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds legislative impacts (see below). For the request and out-year, the Department uses HCBS waiver enrollment growth to project SEP expenditure growth.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department does not anticipate any new changes that impact expenditure for SEPs from FY 2016-17 through FY 2018-19.

Disease Management

Beginning in July 2002, the Department implemented several targeted disease management pilot programs, as permitted by HB 02-1003. Specifically, the Department was authorized "to address over- or under-utilization or the inappropriate use of services or prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease

or combination of diseases" (25.5-5-316, C.R.S. (2013)). Initially, pilot programs were funded solely by pharmaceutical companies; the programs began and ended at different times between July 2002 and December 2004.

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

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

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

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

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

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

The only remaining expenditure in the Disease Management program is for the tobacco quit line, administered by the Department of Public Health and Environment (DPHE). The Department pays for the share of costs for the quit line related to serving Medicaid members. The November 2016 request aligns the Department's projected expenditure with the reappropriated funds in DPHE's budget that are funded by Medicaid. FY 2017-18 and FY 2018-19 expenditures are affected only by caseload and bottom line impacts. Currently, no bottom line impacts affect this forecast.

Accountable Care Collaborative

In FY 2010-11, the Department implemented the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Collaborative Care Organizations (RCCOs), the Primary Care Providers (PCPs), and the Statewide Data Analytic Contractor (SDAC) are administrative fees that are incorporated in the prepaid inpatient health plan exhibit.

Accountable Care Collaborative (ACC)

The Accountable Care Collaborative (ACC) is a Department initiative requested originally in FY 2009-10 DI-6 "Medicaid Value Based Care Coordination Initiative" and revised in FY 2010-11 S-6/BA-5 "Accountable Care Collaborative." The Department enrolled the first clients into the program in May 2011 and enrollment increased to 60,000 by December 2011. Enrollment expanded to 123,000 clients in May 2012, which was requested in FY 2011-12 BA-9 "Medicaid Budget Balancing Reductions." The Department has since expanded enrollment in the program and reached an enrollment total of approximately 966,000 by June 2016. The cost savings estimated for this program are included in Acute Care; please see Exhibit F and Section V for more information on its impact to Acute Care. The monthly management fees are estimated in the Accountable Care Collaborative exhibit. The fees in FY 2015-16 include payments for the SDAC, a weighted average PMPM of $9.50 PMPM paid to the RCCOs, $3.00 PMPM paid to the primary care providers for each client who has been enrolled with them for at least a month, and a $2.00 monthly incentive payment divided between the providers and the RCCOs. An additional $3 PMPM was added to AwDC PMPMs to RCCOs in FY 2012-13 but is no longer included in AwDC PMPMs.

Based on program operation experience, the Department assumes that approximately 25% of clients enrolled in the ACC program will not be attributed to a PCMP and that only the RCCO administrative fee will be paid for these clients. In the current and request years, the Department assumes the full $2.00 incentive will be paid out to the RCCOs and PCMPs for each of their members even though the

incentive payment will only be paid out if the providers meet certain predetermined benchmarks; the total PMPM for the program may be less if providers are not meeting their benchmarks. Two policy changes took place in fall of 2014 that impact the expected administrative payments for FY 2014-15 and future years. The first, which began September 2014, is a $0.50 reduction in the base PMPM for RCCOs. A portion of these funds would be spent in the following fiscal year as incentive payments to PCMPs with the rest paid as incentive payments to RCCOs or to State Innovation Model (SIM) practices. The second, which began October 2014, is that RCCOs would only be paid 65% of their PMPM for clients who have been unattributed to a PCMP for at least six consecutive months. These funds would be spent in the current fiscal year or the following fiscal year as incentive payments to RCCOs that meet predetermined benchmarks as well as to support SIM practices. For this reason, administrative payments for the ACC were lower in FY 2014-15 and FY 2015-16 than previously anticipated, as some portion of these payments were moved to the following fiscal year in an ongoing process.

Enrollment in the ACC grew at a high rate between FY 2012-13 and FY 2014-15, due to Medicaid expansion and the enrollment of clients who were eligible for Medicaid prior to expansion, but not enrolled previously. Enrollment for populations that the Department assumes the highest level of savings through care coordination for (primarily individuals with disabilities and the elderly populations) was lower in FY 2015-16 than anticipated in the previous request. The Department therefore revised its estimates of the savings from the ACC to Acute Care in Exhibit F, to a lower level than was previously assumed.

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

The Department negotiated with the Centers for Medicare and Medicaid Services (CMS) throughout FY 2013-14 regarding the implementation of a pilot program targeting clients fully eligible for both Medicare and Medicaid. Research has shown that coordinating care for this population has the potential to create significant cost savings. However, to achieve these savings, both payers must work collaboratively to ensure providers have the support and data needed to provide coordinated care, and that savings are distributed between the payers equitably. To provide this coordinated care environment, the Department proposed to leverage existing infrastructure and enroll dually eligible clients in the Accountable Care Collaborative with an enhanced $20.00 PMPM to account for the greater resource intensity needed to provide care coordination for this complex population. The pilot was approved late FY 2013-14 and enrollment of full benefit Medicare-Medicaid eligible clients into the ACC began September 1, 2014. Extensive analysis by the Department and the Department's actuaries has shown that, even with an enhanced PMPM, there is significant savings opportunity. The impact of this pilot program is incorporated as a bottom-line impact for savings to Acute Care, and is also accounted for as a bottom-line impact to the ACC exhibit.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department has added a bottom-line impact for the implementation of the ACC:MMP, as detailed above.

The Department also added a one-time bottom-line impact to account for the recoupment of an overpayment of incentive payments in the first quarter of FY 2015-16.

Finally, the Department added a bottom-line impact to account for movement of clients from the PMPM-based ACC to the new Kaiser-Access health maintenance organization, a pilot payment reform initiative under HB 12-1281. A similar bottom-line impact appears under Acute Care, where health maintenance organization expenditure is accounted for.

Prepaid Inpatient Health Plan Administration

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

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

EXHIBIT J - HOSPITAL PROVIDER FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

These exhibits summarize the source of funding for Health Care Affordability Act of 2009 cash-funded expansion populations. These estimates are incorporated into the Calculation of Fund Splits in Exhibit A. Information regarding Tobacco Tax funds has been removed from this exhibit with the Department's November 1, 2011 request as Tobacco Tax funding is now appropriated to the Department at a

fixed value that is independent of the actual caseload or per capita costs associated with clients that would have otherwise been funded by Tobacco Tax.

Hospital Provider Fee Fund

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

MAGI Parents/Caretakers 69% to 133% FPL

While the Health Care Expansion Fund originally provided funding for parents of children enrolled in Medicaid from approximately 24% to at least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund extends eligibility to parents from 61% to 100% of the federal poverty level (FPL). This expansion population receives the standard Medicaid benefits. SB 13-200 extended this eligibility through 133% FPL, effective July 1, 2013; the Hospital Provider Fee Fund had funded this population up to 100% FPL in the interim before the Affordable Care Act's 100% enhanced federal match began and the population expanded to 133% FPL on January 1, 2014. Beginning January 1, 2017, the enhanced federal match falls to 95%, and on January 1, 2018, it falls to 94%.

For caseload estimates and methodology, please see the Acute Care section of this narrative.

MAGI Adults

This expansion allows MAGI Adults to be eligible for Medicaid benefits. Eligibility for this population began in May 2012. The Department was granted a Section 1115 Demonstration Waiver in order to implement eligibility of the population. The Department submitted the Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) in December 2011, and rules were approved by the State Medical Services Board (MSB) in January 2012. With the advent of SB 13-200, effective July 1, 2013, MAGI Adults are now covered up to 133% FPL as of January 1, 2014. Similar to MAGI Parents/Caretakers 69% to 133% FPL, the Hospital Provider Fee Fund had funded this population in the interim before the population expanded and the enhanced federal match began on January 1, 2014. Beginning January 1, 2017, the enhanced federal match falls to 95%, and on January 1, 2018, it falls to 94%. Clients in this category are not eligible to receive HCBS Waiver services; in cases where it appears that these clients have received waiver services, those expenditures receive the standard match rate and not the expansion match rate. This incidence can occur for numerous reasons, including clients awaiting disability redeterminations that have caused them to be temporarily moved from their usual eligibility category to this one.

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

Non-Newly Eligibles

Medicaid expansion clients who were eligible for Medicaid prior to 2009 are not eligible for the 100% federal medical assistance percentage (FMAP) that occurred January 1, 2014. Clients who may be eligible for Medicaid through Home- and Community-Based Services waivers due to a disability are required to provide asset information in order to be determined eligible for Medicaid waiver services. With Medicaid expansion, clients who may have been eligible but did not provide asset information can still be eligible under different eligibility categories, such as MAGI Adults. It is difficult for the State to prove whether these clients would have been eligible for Medicaid services prior to 2009, had they provided their asset information at that time. For this reason, some clients under expansion categories are not eligible for 100% FMAP. Instead, with the approval of a resource proxy for the non-newly eligibles, 75% of expenditures receive expansion FMAP while the remaining 25% receive the standard FMAP, funded from the Hospital Provider Fee Fund. The Department has incorporated the resource proxy in this request.

MAGI Parents/Caretakers 60% to 68% FPL

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

Continuous Eligibility for Children

HB 09-1293, the Colorado Health Care Affordability Act of 2009, established continuous eligibility for twelve months for children on Medicaid, even if the family experiences an income change during any given year, contingent on available funding. The Department implemented continuous eligibility for children in March 2014 and has the authority to use the Hospital Provider Fee Cash Fund to fund the state share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives the standard federal financial participation rate. Previously, the Department showed this adjustment in funding as a General Fund offset under Cash Funds Financing. Effective with the November 2016 request, the Department has broken this population out in its respective service categories in Exhibit J to better show the impact of continuous eligibility for children.

Medicaid Buy-in Fund

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

Buy-in for Individuals with Disabilities

This expansion allows for disabled individuals with income up to 450% of the federal poverty level to purchase Medicaid benefits. Eligibility for the working adults with disabilities with income up to 450% of the FPL began in March 2012, with eligibility to children

with disabilities with income up to 300% of the FPL following in June 2012. The Department does not have an implementation timeframe for non-working adults with disabilities at this time.

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

Hospital Provider Fee Supplemental Payments

Hospital payments are increased for Medicaid hospital services through a total of 13 supplemental payments, 11 of which are paid out of Medical Services Premiums directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, Colorado Indigent Care Program (CICP) and Disproportionate Share Hospital (DSH) payments, and targeted payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to ensure access to hospital services for Medicaid and CICP clients.

Cash Fund Financing

An offset of $15,700,000 is made from the Hospital Provider Fee to offset the loss of federal matching funds due to the decrease in certification of public expenditure for outpatient hospital services resulting from the authorization of the Hospital Provider Fee in HB 09-1293.

Other Adjustments

- Technical Adjustments of Systems Issue for Children: Adjusts for a data issue that took place July 2015 through December 2015 that incorrectly moved clients from Children's Health Plan (CHP) and Eligible Children into categories for individuals with disabilities, including Children with Disabilities – Buy In. Because of the issue, the Department incorrectly funded services for certain affected clients with Hospital Provider Fee instead of General Fund and will adjust the funding source in FY 2016-17. See the Medicaid caseload narrative for more information.
- Historic Adjustment for Non-Newly Eligible Definition: Starting in FY 2015-16 Q3, the Department updated the income criteria used to identify non-newly eligible population to be consistent with the SPA[11] submitted to CMS. The previously used income criteria did not account for the income limit of couples and consequently excluded members who should have received the blended FMAP for the non-newly eligible population, rather than the expansion FMAP. In FY 2016-17, the $3,386,387 in Hospital Provider Fee accounts for the amount the Department should have paid for non-newly eligible members; there is also a corresponding decrease of $3,386,387 federal funds.

[11] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-14-035.pdf

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

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

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

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

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

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

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

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

EXHIBIT L – DEPARTMENT RECOVERIES

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

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

Recoveries made for dates of service under periods where the State received an enhanced federal match are given the same federal match as was applicable when the services were rendered.

EXHIBIT M – CASH-BASED ACTUALS

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

Effective with the November 2016 Budget Request, the Department has included a breakout for Community Choice Transitions (CCT) – Services under the Community-Based Long-Term Care Services section of these exhibits. This category represents services that individuals consume on waivers while they are transitioning through the CCT program. Prior to this breakout, these services appeared under the HCBS Elderly, Blind, and Disabled waiver.

The Colorado Operations Resource Engine (CORE) was implemented as a replacement for the Colorado Financial Reporting System (COFRS) in July 2014. Under COFRS, the previous fiscal year closed and the data became final at the beginning of the current fiscal year. Under CORE, the previous fiscal year may not close until March of the current fiscal year. This introduces a small degree of uncertainty regarding FY 2015-16 actuals that was not present previously. It is possible that the FY 2015-16 actuals may change in the next request. The Department does not expect major changes to FY 2015-16 actuals. The FY 2015-16 actuals contained within this request reflect data for FY 2015-16 as of August 29, 2016.

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2006-07 through FY 2015-16 final actual expenditures are included in this Budget Request for historical purpose and comparison.

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

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

This exhibit displays the FY 2015-16 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2015-16 appropriation, and the per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

Additionally, this exhibit compares the Department's Budget Requests by broad service category to the Department's Long Bill and special bills appropriations for FY 2015-16, FY 2016-17 and FY 2017-18 in the chronological order of the requests/appropriations.

EXHIBIT P – GLOBAL REASONABLENESS

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

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

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

Effective with the November 2014 Budget Request, the Department included a new exhibit detailing the total cost of Medicaid services, including lines outside of Medical Services Premiums, such as service expenses for Medicaid Behavioral Health, the Office of Community Living, Medicaid-funded Department of Human Services (DHS) services, and CHP+, separating Title XIX and Title XXI fund sources, to show the total services cost of providing care to clients. This exhibit also includes a total cost of care per capita exhibit for these combined services, including both Title XIX expenditure and Title XXI expenditure, by eligibility category. Effective with the November 2016 Budget Request, the Department added the request amounts for the current, request, and out years to this exhibit.

EXHIBIT R – FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

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

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

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

Due to the nature of this calculation, federal fiscal year FMAP for 2015-16 is calculated using data for calendar year 2013 at the latest. Therefore, FY 2017-18 and FY 2018-19 FMAP estimates are both calculated using historical data from the BEA. These FMAP calculations would only change if the BEA restates its historical data, which can sometimes occur. However, CMS has informed the Department of the FMAP the Department is eligible for beginning both October 1, 2015 and October 1, 2016. Therefore, FMAP for FY 2015-16 and FY 2016-17 is not subject to change, as CMS does not restate announced FMAP even in cases where the BEA's updated data results in different calculations. The FY 2017-18 and FY 2018-19 FMAP estimates are based on data after calendar year 2015, which the BEA does not estimate. The estimates for personal income come from the legislative council's most recent estimates for the U.S. and Colorado, and the population estimates come from the U.S. census for U.S. data and the Department of Local Affair's most recent estimates for Colorado.

Forecasts throughout this request use these FMAP estimates rather than holding FMAP constant in the request and out years, as was previously done. In cases where a restatement of the BEA's data would result in a different FMAP than was previously anticipated, the Department would submit a supplemental funding request to account for the change in federal funds.

V. ADDITIONAL CALCULATION CONSIDERATIONS

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

New Legislation and Impacts from FY 2016-17 Budget Cycle Requests

This section describes the impact from legislation passed during the 2016 Legislative Session, including impacts from the Department's FY 2016-17 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

HB 16-1405 – FY 2016-17 Long Bill - Non-Prioritized Cervical Cancer Eligibility Expansion

CDPHE's FY 2016-17 R-4 "Cervical Cancer Eligibility Expansion" extended cervical cancer screenings and treatment to women ages 21 to 39, which will increase enrollment in the Breast and Cervical Cancer Program. Previously, this service was limited to women between the ages of 40 and 64. The cash fund source of this program is the Breast and Cervical Cancer Prevention and Treatment Fund.

SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"

SB 16-027, Medicaid Option for Prescribed Drugs by Mail, allows Medicaid clients to receive maintenance medications through the mail, regardless of physical hardship or third-party insurance status as previously required by SB 08-90. As many maintenance medication prescriptions delivered by mail come in ninety-day supplies, the Department anticipates a shift in receiving medications in larger supplies. This shift would result in a decrease in prescription drug expenditures due to the avoided dispensing fees that are more frequent when a client receives drugs in smaller quantities.

HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"

HB 16-1408, Allocation of Cash Fund Revenues from Tobacco MSA, establishes a new formula for the allocation of the annual payment received by the state as part of the Tobacco Master Settlement Agreement (Tobacco MSA), impacting the Department's allocations for the Children's Basic Health Plan Trust and the Autism Treatment Fund. In addition, the bill increased the General Fund offset for early and periodic screening diagnosis and treatment services provided to eligible children from the Autism Treatment Fund in FY 2016-17 and accounts for partially maintaining the rate increases authorized under Section 1202 of the Affordable Care Act for specific services through FY 2016-17.

The Department requested to continue the rate increases implemented under HB 16-1408 in FY 2017-18 and as part of ongoing payment reform efforts in FY 2018-19 and ongoing in FY 2017-18 R-6 "Delivery System and Payment Reform". In that request, the Department adjusted the estimated impact from the rate increases based on FY 2015-16 actual utilization, resulting in a lower total amount. The Department has not adjusted the impact of the rate increases in this request for FY 2016-17, as the costs accrued in that year are paid from a specific cash fund source that may not be able to support an overexpenditure if the Department's estimates are below actual costs.

HB 16-1097 "PUC Permit for Medicaid Transportation Providers"

HB 16-1097, PUC Permit for Medicaid Transportation Providers, changes the requirements of Medicaid providers of Non-Emergent Medical Transportation (NEMT) to register with the Public Utilities Commission (PUC) as a limited liability carrier instead of as a common carrier. There are fewer restrictions to registering as a limited liability carrier which will have the effect of increasing the number of NEMT providers, which will increase access to transportation and produce savings through increased access to preventive services through NEMT.

HB 16-1321 "Medicaid Buy-In Certain Medicaid Waivers"

HB 16-1321 allows the Department to seek federal approval to implement a buy-in program for people eligible to receive services through the Supported Livings Services waiver, the Persons with Brian Injury Waiver, and the Spinal Cord Injury Waiver Pilot Program and that it shall be implemented no later than three months after federal approval. The Department assumes enrollment into the Buy-In programs will begin July 1, 2017. Starting in FY 2017-18, there will be a mix of existing HCBS-BI and HCBS-SCI clients transitioning into the Buy-In program for the respective waivers and new clients entering the HCBS waiver program through the Buy-In program. The Department included a corresponding increase to the Supported Living Services waiver in FY 2017-18 R-5, Office of Community Living Cost and Caseload Adjustments.

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

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

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

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

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

Over-the-counter medications such as fever reducers are likely to reduce the utilization of emergency/urgent care services when easily accessible. While the Department has not estimated the savings associated with avoided emergency/urgent care service utilization, the Department believes that, as the estimated costs are sufficiently low, costs are offset by savings from other drugs on the list, and there are likely cost savings, that inclusion of these drugs on the list are appropriate.

Implementation of this program is currently on hold until November FY 2016-17 when the new Pharmacy Benefit Management System is expected to be implemented.

ACC Savings

The Accountable Care Collaborative (ACC) was originally requested in FY 2010-11 S-6, BA-5 as a pilot program of 60,000 clients and expanded in FY 2011-12 BA-9 to 123,000 clients. The program is designed to improve clients' health and reduce costs. Clients in the ACC receive the regular Medicaid benefits package, and the Department makes additional payments to doctors and care coordination organizations to help manage clients' care. The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds providers accountable for health outcomes. The program began in the spring of 2011, and enrollment reached 123,000 Medicaid clients statewide in FY 2011-12. The program continues to expand and is currently at an average monthly enrollment level of 931,919 in FY 2015-16. The central goals of the program are to improve health outcomes through a coordinated, client-centered system and to control costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources.

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

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

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

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

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

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

The Department estimates the PMPM costs for the RCCOs and PCMPs, as well as the fixed-price contract for the SDAC, in Exhibit I. The Department estimates the savings that will accrue as a result of the program in Exhibit F. Due to attrition and replacement enrollments, it is no longer possible to isolate an original 60,000 member cohort or expansion cohort. Consequently, expenditure and savings adjustments are shown in aggregate for the program. Because children make up a large portion of caseload in Medicaid, the greatest opportunity for ACC expansion lies within this population. As children also have relatively lower per capita expenditure, the savings opportunity from enrollment in the ACC for this population is smaller than other populations. The Department has assumed a decreasing return to investment in each subsequent year on a per client basis. Further, RCCO rates have been adjusted to reflect the new case mix under an expanded program. In FY 2013-14 and subsequent years, the savings distribution has been adjusted to account for more actual savings in the populations of individuals with disabilities than children. Six-month actual data for FY 2015-16 shows that enrollment of individuals with disabilities and the elderly into the ACC was slower than anticipated in the November 2015 request. While the Department estimates savings for the ACC, these estimates have been reduced from the previous request.

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

The chart below shows program expenditure and estimated savings for FY 2016-17, FY 2017-18, and FY 2018-19. RCCO administrative payments include the reductions attributable to the policy changes mentioned above.

Accountable Care Collaborative Expenditure and Assumed Savings

Service Category		FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Program Administration (Exhibit I, PIHP)	**SDAC**	$2,950,000	$3,059,475	$3,375,525	$2,250,000	$0	$0
	RCCO	$52,945,462	$79,471,841	$102,794,192	$123,995,149	$132,887,388	$139,454,222
	PCMP	$12,674,868	$21,419,450	$30,705,518	$38,316,027	$41,382,439	$43,299,681
	Total Administration	**$68,570,330**	**$103,950,766**	**$136,875,235**	**$164,561,176**	**$174,269,827**	**$182,753,903**
Program Savings (Exhibit F, Acute)	**Total[(1)]**	**($98,000,000)**	**($141,062,535)**	**($169,339,922)**	**($182,358,915)**	**($191,046,201)**	**($196,784,936)**
	Incremental[(2)]	**($50,147,776)**	**($43,062,535)**	**($28,277,387)**	**($13,018,993)**	**($8,687,286)**	**($5,738,735)**
Net ACC Program Fiscal Impact		**($29,429,670)**	**($37,111,769)**	**($32,464,687)**	**($17,797,739)**	**($16,776,374)**	**($14,031,033)**

(1) Total savings is calculated using estimated savings per member from the 2015 Legislative Request for Information (LRFI) on the implementation of the ACC. These figures will be updated in the February request based on the 2016 LRFI.

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

Client Overutilization Program Expansion (BRI-1)

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

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

In this budget amendment, the Department proposed to reduce Medicaid expenditure through a series of initiatives, including: an expansion of the Accountable Care Collaborative, deinstitutionalization efforts through the Department's "Money Follows the Person"

federal grant, and a combination of service limitations and rate reductions. The Department previously implemented all but one of the policy initiatives from this request; the remaining one was implemented July 1, 2016.

- Limit Number of Physical and Occupational Therapy Units for Adults: Limit number of physical and occupational therapy units that adults can receive to 48 total units of service per year, regardless of prior authorization.

Estimated Impact of Increasing PACE Enrollment

As described in the narrative for Exhibits F and H, the Department is currently in the process of adding several new Program of All-Inclusive Care for the Elderly (PACE) providers to the Medicaid program. Like other risk-based managed care organizations (including the Department's health maintenance organizations and behavioral health organizations), the monthly payment to the provider covers all services provided by the provider –in the instance of a PACE provider, the payment covers acute care and long-term care. The Department adjusts its request for new clients enrolled in PACE and assumes each additional client will cause an expenditure shift from fee-for-service categories to the PACE service category.

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

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

The estimated decrease in expenditures due to increased PACE enrollment to Acute Care is $2,649,301 in FY 2016-17, $2,785,828 in FY 2017-18, and $3,481,333 in FY 2018-19.

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

This bill creates efficiencies in the Department by creating the Colorado Medicaid False Claims Act, as described below. The bill originally reduced Department expenditure $2,390,570 in FY 2010-11, and annualizing to $3,699,827 in FY 2011-12, by requiring the Department to implement a number of initiatives. The Department has been able to partially implement the components of SB 10-167,

though full implementation is ongoing. Consequently, a portion of the savings originally anticipated in FY 2012-13 has been shifted to FY 2013-14 and subsequent years. The initiatives that impact the current budget are as follows:

Health Insurance Buy-In Program Expansion

The Department anticipates purchasing private health insurance coverage through the Health Insurance Buy-In (HIBI) Program for an additional 1,500 eligible clients to create cost savings for the State by enrolling clients into individual insurance plans where enrollment is deemed cost-effective. This initiative was delayed to implement in FY 2013-14 to allow for contract execution. The Department has begun the enrollment process, but it has gone more slowly than anticipated. As of June 2016, there were 623 clients enrolled in HIBI. The Department assumes approximately 2% enrollment growth per month through FY 2018-19.

In addition to adjusting savings estimates for implementation delays in the HIBI expansion, the Department has revised both cost and savings estimates to better reflect the impact the Department anticipates with the increased enrollment in this program. First, the Department changed the payment methodology from a contingency based payment plan to PMPM payment. The Department believes this methodology better allows the Department to reimburse for managing payments to clients' primary insurance agencies. In addition, the Department adjusted the monthly savings based on FY 2015-16 per capita costs. Finally the Department added costs associated with premium reimbursement to the estimated cost of the bill. This captures the additional costs to the Department for increased enrollment in the HIBI program. The following table illustrated the full impact of SB 10-167 on the HIBI program for FY 2016-17 through FY 2018-19.

FY 2016-17 through FY 2018-19 Total HIBI Impact from SB 10-167

Item	FY 2016-17	FY 2017-18	FY 218-19
Provider Payment	$242,195	$306,498	$388,178
Premiums Payment	$1,756,410	$2,222,737	$2,815,082
Total Savings (Realized in Acute Care)	($4,300,175)	($5,441,873)	($6,892,096)
Incremental Savings for Bottom-Line Impact in Exhibit F	($715,206)	($1,141,698)	($1,450,223)
Total Impact	**($2,301,570)**	**($2,912,638)**	**($3,688,836)**

Colorado Choice Transitions (Money Follows the Person Grant)

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

The Department had to delay implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The program was implemented March 1, 2013, with the first client transitioning in May 2013. The Department estimates the total impact to Medical Services Premiums to be $2,273,855 total funds costs avoided in FY 2016-17, $3,652,049 costs avoided in FY 2017-18, and $6,685,655 costs avoided in FY 2018-19. These figures do not include any expenditure from the rebalancing fund. Please see the narrative on CCT in Exhibit G for more detail.

Medicaid Budget Reductions (2012-13 R-6)

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

- *Dental Efficiencies*: The Department will clarify rules regarding eligibility for orthodontics and evaluate payment structure and methods. These clarifications are expected to reduce utilization of orthodontics for all cases except those where the client has a severely handicapping malocclusion. Full implementation is noted in FY 2017-18 due to delays in the stakeholder and rulemaking processes, with an additional reduction of $1,704,632.

FY 2014-15 R-7: Adult Supported Living Service Waiting List Reduction

The Department was approved funding to decrease the waitlist for the Supported Living Services waiver. Savings to Community-Based Long-Term Care result from clients utilizing waiver services in place of State Plan services. The annualization of this policy is expected to decrease expenditure by $185,234 in FY 2016-17

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

The Department was approved funding to allow for emergency enrollments, youth transitions, and de-institutionalizations onto the DD waiver. This has been combined with the adjustment for HB 14-1252 as both would increase enrollment on the DD waiver but the Department is unable to disentangle the two policies when new clients are enrolled. HB 14-1252 was an adjustment to existing appropriations between waiver services. The Department had experienced significant under-expenditure in the HCBS-DD and the HBCS-CES waiver programs that was used to rebalance over-expenditure in the HBCS-SLS waiver program. The request included for additional FPE to allow more clients to be served on the waiver programs in place of State Plan services, resulting in a negative fiscal impact. The annualization of these policies is expected to decrease expenditure by $281,540 in FY 2016-17.

FY 2014-15 R-10: Primary Care Specialty Collaboration

The Department was approved funding to establish and maintain a system for primary care doctors to communicate with specialty care providers, resulting in savings through better management of medical conditions and proper use of specialty care. The software necessary for the implementation of this policy was delayed and the Department currently expects this program to fully implement in January 2017. Due to this, the impact of this policy has also been delayed. This is expected to decrease expenditures by $136,221 in FY 2016-17.

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

The Department continued the rate increases that were included in section 1202 of the Health Care and Education Reconciliation Act that required that states pay for primary care services at 100% of Medicare rates, through June 30, 2016. The annualization of this policy is expected to be a decrease of $118,943,931 in FY 2016-17, to remove the impact of the higher rates accounting for runout.

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

The Department enrolled clients dually eligible for Medicaid and Medicare in the Accountable Care Collaborative (ACC) so that they can receive care coordination, reducing duplicative use of services. The annualization of this program is expected to decrease expenditure by $12,627,581 in FY 2016-17.

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

HB 14-1252 was an adjustment to existing appropriations between waiver services. The Department had experienced significant under-expenditure in the HCBS-DD and the HCBS-CES waiver programs that was used to rebalance over-expenditure in the HCBS-SLS

waiver program. The request included funding for additional FPE to allow more clients to be served on the waiver programs in place of State Plan services, resulting in a negative fiscal impact.

Because the impact of this bill and the Department's FY 2014-15 R-8 Developmental Disabilities Full Program Equivalents request are difficult to disentangle from one another, the bottom-line impact for this bill and the FY 2014-15 R-8 have been combined.

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

HB 14-1357 made several changes to in-home support services (IHSS) provided by the Department. This bill allowed IHSS to be provided inside the home or within the community, added spouses as an eligible family member to act as an attendant providing IHSS to an HCBS waiver client, allowed eligible clients or their representative the ability to determine the amount of oversight needed, allowed family members to be reimbursed for providing IHSS, expanded IHSS to clients receiving services through the Spinal Cord Injury waiver, and added IHSS to the list of services under the Elderly, Blind, and Disabled waiver program. These program changes were implemented after several delays in March 2016 and are expected to increase expenditure by $1,117,446 in FY 2016-17.

FY 2015-16 R-7 Participant Directed Programs Expansion

The Department was approved funding to expand Consumer Directed Support Services (CDASS) to the Supported Living Services waiver. Savings to Community-Based Long-Term Care (CBLTC) result from clients substituting long-term home health for the health maintenance component of CDASS on the waiver. The Department is still awaiting CMS approval and implementation and anticipates a decrease to CBLTC expenditure by $411,177 in FY 2016-17.

FY 2015-16 R-12 Community Provider Rate Increases

The Department was approved funding to increase eligible provider rates 0.50% across the board. The FY 2016-17 annualization amount for this policy is estimated at $3,400,588. For some services, the expected increase in expenditure is different from appropriation due to the need for a State Plan Amendment and approval from CMS resulting in delays in the start date of the increase.

FY 2015-16 R-12 Targeted Community Provider Rate Increase

The Department was approved funding for the purpose of addressing issues with client access to cost-effective services. The separate components of the rate increase are broken out in Exhibit F and Exhibit G. The annualization amount of the targeted rate increases is an

estimated $12,871,891 in FY 2016-17. For some services, the expected increase in expenditure is different from appropriation due to the need for a waiver or State Plan Amendment and approval from CMS resulting in delays in the start date of the increase.

FY 2015-16 JBC Action, Raising the Cap on Home Modifications

The JBC increased the cap on home modifications during the 2015 Legislative Session. The Department received approval in late January and was implemented March 1, 2016. The annualization of this policy is expected to increase expenditure by $564,288 in FY 2016-17.

HB 15-1186 Children with Autism Waiver

HB 15-1186 reduces the wait list for the Children with Autism waiver, and also extends the maximum age from six years old to eight years old and guarantees three years of service once a child is on the waiver. This would help ensure that clients do not age out of the waiver before they are on the waiver. The bill would also allow for the use of General Fund to cover CWA services after the Autism Treatment Fund is exhausted. To comply with this bill, the Department requires a Waiver Amendment, which must be approved by CMS. On September 14, 2015, the expansion of the waiver was denied by CMS. CMS directed the Department to provide medically necessary behavioral therapies for children with autism provided through the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program instead. The Department is waiting for CMS guidance on what to do with the current waiver and will properly adjust accordingly as information is obtained. Currently, the Department is removing the impact of the expansion from FY 2016-17, but keeping the impact in FY 2016-17 to account for utilization of EPSDT services that are medically necessary.

Other Adjustments to the November 2016 Budget Request

- Copay 5% of Income, adjusts for the additional amount the Department will need to pay providers to comply with a federal rule stating that copays cannot exceed 5% of a Medicaid client's income. The new MMIS, which will be implemented March 1, 2017, must demonstrate compliance with this rule; the current MMIS is unable to take the 5% cap into consideration, causing some clients to pay over the cap. The new system will prevent clients from paying copays that exceed 5% of their household income, and as a result, the Department will need to reimburse providers for the full cost of the service without subtracting copay for these clients.
- Home Health Final Rule (Location Expansion), expands where home health services can be received. As part of 42 CFR 440 "Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health," CMS specified that states may not restrict beneficiaries from receiving home health services in any setting in which normal life activities take place. The adjustment accounts for an increase in utilization due to clients desiring to receive additional home health services in the community. The Department must demonstrate compliance with this rule by July 1, 2017.

- Hepatitis C Criteria Change, accounts for an increase in hepatitis C drug treatments. After reviewing hepatitis C criteria in place, the Department expanded treatment to members with a fibrosis score of F2 and other members who were previously restricted from treatment through the PAR process.

Policy Changes with an Indeterminate Fiscal Impact

- Transgender Policy Change – A recently issued Department of Health and Human Services rule, titled Nondiscrimination in Health Programs and Activities, takes effect this year. This final rule implements Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. The rule mandates that Medicaid agencies cover gender transition-related services if those services are currently covered for other medically necessary reasons. The Department is not creating a new benefit in response to this rule, but codifying an existing benefit to ensure that transgender individuals can access existing services, such as mastectomy or hysterectomy, when medically necessary for the purpose of gender transition.
- Face-to-Face Federal Requirements for Home Health – 42 CFR 440 "Face-to-Face Requirements for Home Health Services: Policy Changes and Clarifications Related to Home Health" requires physicians to document a face-to-face encounter that is related to the primary reason the member requires home health services no more than 90 days before or 30 days after the start of services. For the initial ordering of medical supplies, equipment, or appliances, an authorized medical care giver must document a face-to-face encounter occurred no more than six months prior to the member receiving those medical supplies. The Department estimates an indeterminate fiscal impact in physician's visits as a result of these sections of the Face-to-Face rules as it is unable to determine currently to what extent members are receiving home health and DME services without an initial encounter with a physician.

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Exhibits for the Medical Services Premiums Budget Request

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-02 Behavioral Health

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	Total	$662,617,330	$0	$662,625,975	$20,962,544	$56,925,135
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$183,627,684	$0	$183,599,168	($406,491)	$7,156,343
	CF	$16,633,015	$0	$16,665,871	$11,420,458	$16,634,600
	RF	$0	$0	$0	$0	$0
	FF	$462,356,631	$0	$462,360,936	$9,948,577	$33,134,192

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
03. Behavioral Health Community Programs - Behavioral Health Capitation Payments	Total	$653,650,029	$0	$653,658,674	$20,688,700	$56,385,495
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$181,949,404	$0	$181,920,888	($738,391)	$6,796,957
	CF	$16,383,180	$0	$16,416,036	$11,287,683	$16,437,093
	RF	$0	$0	$0	$0	$0
	FF	$455,317,445	$0	$455,321,750	$10,139,408	$33,151,445
03. Behavioral Health Community Programs - Behavioral Health Fee-for-Service Payments	Total	$8,967,301	$0	$8,967,301	$273,844	$539,640
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,678,280	$0	$1,678,280	$331,900	$359,386
	CF	$249,835	$0	$249,835	$132,775	$197,507
	RF	$0	$0	$0	$0	$0
	FF	$7,039,186	$0	$7,039,186	($190,831)	($17,253)

CF Letternote Text Revision Required?	Yes	X	No		**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes		No	X	**See Exhibit BB.**
FF Letternote Text Revision Required?	Yes		No	X	
Requires Legislation?	Yes		No	X	

Type of Request? Department of Health Care Policy and Financing Prioritized Request

Interagency Approval or Related Schedule 13s: None

COLORADO

Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
Behavioral Health Community Programs

FY 2016-17, FY 2017-18, and FY 2018-19 Budget Request

November 2016

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BEHAVIORAL HEALTH COMMUNITY PROGRAMS

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

History and Background Information

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

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

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

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

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

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

- SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL for parents of Medicaid eligible children and adults without dependent children, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 133% FPL and all adults without dependent children will receive a 100% federal match rate, while adults up to 60% FPL will receive the standard Medicaid match.

- As of January 1, 2014, the Medicaid benefit for the Behavioral Health Community Programs also includes a substance use disorder benefit. This expands the range of services that will be covered under Medicaid for disorders relating to substance use for currently enrolled members.

- HB 14-1045, "Continuation of the Breast and Cervical Cancer Prevention and Treatment Program", extends the repeal date by five years for the program, through June 30, 2019. One hundred percent of the State's share will come from the Breast and Cervical Cancer Prevention and Treatment fund.

- SB 14-215, "Disposition of Marijuana Revenue", expands on the current school-based prevention and early intervention benefit within the BHO contract as well as creates a grant program that extends this benefit beyond just the Medicaid population. The expansion within the BHOs and the grant program provides additional resources in schools to target at risk youth as a result of the legalization of marijuana. This funding was only available for one year (FY 2014-15).

- For the most recent rate setting cycle, rates effective July 1, 2016 to June 30, 2017, the Department experienced a significant drop in a few eligibility categories for most BHOs. This is the result of BHO encounter data not supporting the current level of rates,

specifically in the Individuals with Disabilities, MAGI Adults, Expansion Parents & Caretakers, and Foster Care eligibility categories. New rates will be set for FY 2017-18, July 1, 2017 to June 30, 2017, and current BHO encounter data will be analyzed to assess the rates. Adjustments will be made as data supports.

Program Administration

In FY 2005-06, SB 05-112 transferred all of Behavioral Health Community Programs - Program Administration expenditures into the Executive Director's Office Long Bill group and is reflected in the lines for Personal Services, Operating Expenses, and Mental Health External Quality Review Organization. The current year and out-year requests for Program Administration are included in the Executive Director's Office Long Bill group.

Medicaid Anti-Psychotic Pharmaceuticals

Prior to FY 2008-09, as part of the Long Bill, estimated expenditures for anti-psychotic pharmaceuticals were appropriated to this Long Bill group as Cash Funds Exempt. This was an informational-only line item; the costs for these drugs were and are paid in the Department's Medical Services Premiums Long Bill group, and no actual transfer took place. Because there was no corresponding decrease to the Medical Services Premiums Long Bill group, this double counted the funding for these drugs.

In its November 1, 2007 Budget Request, the Department officially requested the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item and subsequently received approval. The Department continues to report expenditure for anti-psychotics in its Budget Request (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan).

Significant Changes between FY 2016-17 S-2A and FY 2017-18 R-2

<u>FY 2016-17</u>

- Primarily Caseload and Rates updates for a few eligibility categories that contribute about a $22.2 million decrease.
    - MAGI Adults rate forecast decreased by $5.81 or 9.8%
    - Foster Care rate forecast decreased by $49.61 or 28.3%
    - Children rates forecast decreased by $1.00 or 4.8%
    - Individuals with Disabilities rates forecast increased by $5.16 or 3.8%
    - MAGI Adult caseload forecast increased by 248,556 or 6.0% member months
    - Low-income Adults caseload forecast increased by 87,960 or 3.6% member months

- The Department also updated its reconciliation estimates for the MAGI Adult and Expansion Parent risk corridor reconciliations. The prior forecast didn't estimate this reconciliation, but current estimates are $24.1 million.
- The Department updated its estimate of payments made to the BHOs as a result of the system overpayment issue. Due to system limitations, eligibility categories are incorrectly assigned for a subset of the population. Expansion parents are being incorrectly classified as MAGI Adults which leads to paying about $30.00 more per member per month. The Department projects recouping $18.7 million in FY 2016-17 in the current estimate versus $13.1 million in the prior forecast. See Exhibit II for more detail.
- The Department has also paid additional capitation payments for children that were incorrectly classified as Individuals with Disabilities, resulting in about a $3.1 million overpayment. These payments will be recouped in FY 2016-17. Please see Exhibit II and the caseload narrative for additional information on this issue.
- The Department revised the methodology for calculating claims paid in the current period from prior periods. This revision corrects a technical error and reduces the budget by $3.2 million compared to the prior forecast.

FY 2017-18

- The changes in caseload, rates, and the IBNR factor for FY 2017-18 from the S-2A to the R-2 are primarily the result of flow through of the caseload and rate forecast changes in FY 2016-17.
- The Department does not expect to make other reconciliations on an on-going basis related to the risk corridor because current rates are supported by actual historical data and assumptions are no longer being used.

BEHAVIORAL HEALTH CAPITATION PAYMENTS AND MEDICAID BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

The Behavioral Health Capitation Payments line item reflects the appropriation that funds behavioral health services throughout Colorado through managed care providers contracted by the Department. As a result of competitive procurement, five behavioral health organizations were awarded contracts with updated capitation rates and services effective January 1, 2005. Payments for Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program were separate payments prior to FY 2005-06 and incorporated into the Behavioral Health Capitation Payments line item in FY 2005-06. Effective July 1, 2009, the five behavioral health organizations were reprocured through a competitive bid process. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged. Effective July 1, 2014, the behavioral health services contracts were up for reprocurement through a competitive bid process. Four of the five BHO's from the previous rebid won their respective regions with the exception of the northeast region. That region is now managed by Access Behavioral Health – Northeast.

The behavioral health organizations are responsible for providing or arranging all medically necessary behavioral health services to Medicaid-eligible members within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category. Amounts are prorated for partial months of service and retroactive eligibility is covered. Payments vary across behavioral health organizations, as well as eligibility categories.

The Medicaid populations that are eligible for behavioral health services covered by capitation rates are combined into eight categories, as indicated below. Partial dual-eligible members and non-citizens are ineligible for behavioral health services.

The eligible behavioral health populations are:

- Adults 65 and Older
- Individuals with Disabilities
- Low Income Adults
- Expansion Parents & Caretakers
- MAGI Adults
- Eligible Children
- Foster Care
- Breast and Cervical Cancer Prevention and Treatment Program

Analysis of Historical Expenditure Allocations across Eligibility Categories

At the beginning of a contract cycle, behavioral health organization capitation rates were entered in the Medicaid Management Information System (MMIS). Monthly payments were paid based on eligibility categories. The MMIS provided detailed expenditures by behavioral health organization and eligibility category but did not include offline transactions and accounting adjustments. The only source that included all actual expenditure activity was the Colorado Financial Reporting System (COFRS). The drawback was the COFRS provided total expenditures, but not by eligibility category. The exception was the Breast and Cervical Cancer Treatment Program eligibility category, which was reported separately in the COFRS. Since an allocation had to be calculated to determine the amount of actual expenditures across the other eligibility categories, a ratio was calculated for each eligibility category by dividing the MMIS eligibility category expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) by the total MMIS expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category). The ratio for each category was multiplied by the total expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) from the COFRS. This calculation estimated actual COFRS expenditures across each eligibility category. Beginning July 1, 2014, the Department is using a new financial

reporting tool. The Colorado Operations Resource Engine (CORE) is used in place of COFRS and the same overlay methodology is used between CORE and the MMIS.

Description of Methodology

The Department utilizes a capitation trend forecast model. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends directly, rather than through a per-capita methodology, future expenditures are forecasted directly through the primary cost drivers: the actuarially agreed-upon capitation rate and caseload. By tying forecasts directly to capitation rates, the methodology may provide more accurate estimates of expenditures by eligibility category, rather than simply in aggregate, as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to behavioral health organizations.

Additionally, the forecast utilizes an incurred but not reported methodology similar to other portions of this Request submitted by the Department (e.g., Nursing Facilities; see Section E, Exhibit H). The Department adjusts its request to capture the reality that some behavioral health claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

The following narrative describes in greater detail the assumptions and calculations used in developing the current year and out-year requests for Behavioral Health Community Programs. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted.

EXHIBIT AA - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

Effective with the November 2, 2009 Budget Request, in this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from Exhibit BB. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

Exhibit AA now presents a concise summary of spending authority affecting the Behavioral Health Community Programs. In previous budget requests, the Department presented historical expenditure and caseload figures in graphical form. This information can be found in table form in Exhibit DD (see below).

For the request year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected estimated request year expenditure from Exhibit BB. The difference between the two figures is the Department's Funding Request in the November Budget Request and the Department's Budget Amendment in the February Supplemental Budget Request.

EXHIBIT BB - CALCULATION OF FUND SPLITS

Exhibit BB details fund splits for all Behavioral Health Community Programs budget lines for the current fiscal year supplemental and the out-year Budget Request. For all of the capitation payments for the base traditional members, the state receives the standard Medicaid federal match with the State's share coming from General Fund. In FY 2016-17 the federal match is 50.20%. Payments for members in the Breast and Cervical Cancer Program receive an enhanced federal match rate, which in FY 2015-16 is 65.13% and is described separately below. Capitation expenditures are split between traditional members and expansion members. Expansion members are funded from Hospital Provider Fee funds. Finally, the reconciliation from prior years for behavioral health capitation overpayments, retractions for capitations paid for members later determined to be deceased, and system issues are also presented (see Exhibit II for reconciliation calculations). A summary of applicable FMAP rates for each of the forecast years is provided below:

Population	FY 2016-17 Match Rate	FY 2017-18 Match Rate	FY 2018-19 Match Rate
Standard Medicaid	50.20%	50.00%	50.00%
Former CHP+ Children	88.13%	88.00%	88.00%
Former CHP+ Prenatal	88.13%	88.00%	88.00%
Expansion Adults	97.50%	94.50%	93.50%
BCCP	65.13%	65.00%	65.00%

The Department also calculates the fund splits for the fee-for-service expenditure in Exhibit BB. The make-up of the fee-for-service population is the same as the capitation program and therefore the same funding mechanisms are used for the same populations mentioned above in the fee-for-service environment (see Exhibit JJ and Exhibit KK for fee-for-service calculations).

Medicaid Behavioral Health Fee-for-Service base traditional members also receive the standard Medicaid federal match with the State's share coming from General Fund. In FY 2016-17 the federal match is 50.20%. Similar to the populations within the capitation payments line, as of July 1, 2014, the Department is breaking out the fee-for-service expenditure by funding source according to population so that it may claim the correct federal match associated with who is obtaining services. The sum of the capitations and the fee-for-service payments comprise the Department's request.

Behavioral Health Services for Breast and Cervical Cancer Program Adults

SB 01S2-012 created the Breast and Cervical Cancer Prevention and Treatment Program. SB 05-209 and HB 08-1373 incorporated funding for the Breast and Cervical Cancer patients into the appropriation for Behavioral Health Community Programs Capitation Payments, effective with the FY 2005-06 budget. Behavioral health care for members in the Breast and Cervical Cancer Program is managed through the capitation contracts with the behavioral health organizations. Therefore, the budget is based on the behavioral health caseload that includes the Breast and Cervical Cancer Program eligibility category. For this reason, they are shown as a separate eligibility category where appropriate.

Annual designations of General Fund contributions to program costs are specified in sections 25.5-5-308(9), C.R.S. (2015). Exhibit BB details funds splits for the Behavioral Health Community Programs Capitations line. The funding for the members enrolled in the program, is 34.87% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund, and 65.13% federal funds in FY 2016-17. The program was reauthorized in FY 2014-15 and sunsets at the end of FY 2018-19, with the potential to extend the program through new legislation. Beginning in FY 2016-17, the Breast and Cervical Cancer Prevention and Treatment Program expanded the age of eligibility for women being screened for cervical cancer from 39 to 21, which impacts the caseload forecast.

Behavioral Health Services for Hospital Provider Fee Expansion Members

HB 09-1293 established a funding mechanism for a series of expansion members. The first set of expansion members that are funded through the bill was parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these members were funded through the Hospital Provider Fee cash fund. Starting in FY 2011-12, additional expansion populations also received funding through the Hospital Provider Fee cash fund. These include individuals with disabilities with income limits up to 450% of the federal poverty level and MAGI Adults, both of which received services through the BHOs as part of their benefit package. Individuals with disabilities with income limits up to 450% are assumed to be similar to other members with disabilities, and expenditure for these members is therefore calculated using the same per-capita rate as other members with disabilities (see exhibit JJ). For MAGI Adults, the BHOs are reimbursed at a separate capitation rate than other eligibility categories. The Department is currently using actual expenditure and utilization data for the MAGI Adult population to set rates and now that the Department has a few years of data, a risk corridor is no

longer necessary and final reconciliations for prior year risk corridors will take place in FY 2016-17. See exhibits EE, GG, II, and JJ for more detailed explanations of these assumptions.

Behavioral Health Services for Expansion Populations in SB 11-008 and SB 11-250

SB 11-008, "Aligning Medicaid Eligibility for Children," extended Medicaid eligibility up to 133% of the federal poverty level (FPL) for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifted impacted children from CHP+ to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive the enhanced federal match rate, which in FY 2016-17 is 88.13%.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extended Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifted impacted women from CHP+ to Medicaid on January 1, 2013. The Department assumes that the expenditure for these women will continue to receive the enhanced federal match rate, which is 88.13% in FY 2016-17.

Behavioral Health Services for Expansion populations in SB 13-200

SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL parents of Medicaid eligible children and MAGI Adults, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 68% FPL will receive the standard Medicaid match rate, with the state share coming from Hospital Provider Fee cash fund, and all parents from 69% - 133% FPL and newly eligible MAGI Adults will receive the expansion federal match rate, while adults up to 60% FPL will continue to receive the standard Medicaid match. The Department also estimates the non-newly eligible MAGI Adult population. Because some of these members may have been eligible prior to the expansion, the Department is unable to claim the expansion federal match. Therefore, the Department estimates that it can claim the expansion match on 75% percent of the population and the standard match on the other 25%. As such, the federal match percentage in FY 2016-17 is 85.68%. Beginning January 1, 2017, all expansion populations will begin a stepdown in federal matching. As a result, the match rate for those populations in FY 2016-17 will by 97.50%,94.50% in FY 2017-18, and 93.50% in FY 2018-19.

EXHIBIT CC - BEHAVIORAL HEALTH COMMUNITY PROGRAMS SUMMARY

Exhibit CC presents a summary of behavioral health caseload and capitation expenditures itemized by eligibility category as well as a summary of the rest of the Behavioral Health Community Programs. The net capitation payments include the impacts of actions with perpetual effect, such as caseload driven impacts such as the various reconciliations and retractions for members determined to be ineligible. Exhibit EE illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT DD - BEHAVIORAL HEALTH CASELOAD, PER CAPITA, AND EXPENDITURE HISTORY

Exhibit DD contains the caseload, per-capita, and expenditure history for each of the 13 eligibility categories. Each of the tables that comprise Exhibit DD is described below.

Behavioral Health Community Programs Caseload

Behavioral Health Community Programs caseload is displayed in two tables. The first table shows total caseload for each of the rate cells which the Department pays a capitation on. The second table displays caseload by all behavioral health eligibility categories that make up the eight rate cells. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The behavioral health caseload excludes the caseload for partial dual eligible members and non-citizens and ties to the caseload presented in the Request for Medical Services Premiums, Section E, Exhibit B. Please see the Medicaid Caseload section of the Medical Services Premiums narrative for further discussion of Medicaid caseload projections. The caseload numbers are used in numerous exhibits throughout the Behavioral Health Community Programs exhibits and narrative.

Behavioral Health Community Programs Per-Capita Historical Summary

As with caseload, Behavioral Health Community Programs per-capita is displayed in two tables. The first table sets forth total per-capita for each rate cell the Department pays a capitation on. The second table displays per-capita for all behavioral health eligibility categories. However, since the actual per capita from the first table for the combined categories have a single per-capita, the true per-capita is shown in those categories and will not mathematically be the same as dividing each individual category expenditure by the caseload. Figures for fiscal years up to the present fiscal year are actual per-capita, while the current fiscal year and the request year per-capita are estimates.

Behavioral Health Community Programs Expenditures Historical Summary

The history of expenditures includes combined category and expanded category tables as well as total expenditures for both capitation and fee-for-service expenditures. For fee-for-service expenditure, service categories are listed separately.

Actual expenditures are only available from the Colorado Operations Resource Engine (CORE). Expenditures by eligibility category are not available from the CORE. The Medicaid Management Information System (MMIS) does provide expenditures by eligibility category but does not include offline transactions and accounting adjustments. The two systems typically have minor discrepancies in reported expenditure, often due to accounting adjustments made to the CORE as fiscal periods close. Because the variance is minor, data from the MMIS can be used to distribute total expenditures from the CORE across eligibility categories.

A ratio is calculated for each eligibility category by dividing the MMIS eligibility category expenditures by the total MMIS expenditures. The ratio is multiplied by the total expenditures from the CORE. This calculation estimates actual CORE expenditures across each eligibility category. The Breast and Cervical Cancer Treatment Program expenditures are carved out of both totals before the calculations are done, since this is the only category that does not need to be estimated. Once the overall expenditures by eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category.

EXHIBIT EE - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

Exhibit EE provides capitation expenditure calculations for the current fiscal year and the request year.

The Department has adopted a methodology based on forecasting a capitation rate, multiplying that rate by monthly caseload, multiplying again by the number of months that the forecasted rate will be in effect, and then adjusting for incurred claims that will be paid in subsequent years as well as for claims from former years that will be paid in the year of the request. The methodology is a zero-based budget tool that allows the Department to examine projected expenditures each year without building in inappropriate assumptions, estimates, or calculations from preceding years.

The forecasted capitation rate is derived from exhibits FF through HH and will be presented in more detail below. The caseload is the same as presented in Medicaid Medical Services Premiums, Section E, Exhibit B (excepting partial dual eligible members and non-citizens, as discussed above).

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown starting on page E.EE-4.

After calculating total expenditure, the anticipated date-of-death retractions for each fiscal year are estimated and added to total expenditure. The Department began an aggressive retraction of payments for deceased members in FY 2009-10; this activity resulted in retraction of payments originally made between FY 2004-05 and FY 2008-09 and reduced prior period dates of service expenditure. The Department is continuing to identify these claims and retracts payments twice a year. For the current year, the retractions are estimated as a 10% reduction in the total amount retracted in the previous year. For the request year, the retractions are estimated as a

10% reduction in the estimated amount that will be retracted in the current year. The retractions are expected to decline, as there is a smaller pool of historical members from which to retract and current processes of identification become more effective.

Incurred-but-not-Reported Estimates

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred-but-not-reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims incurred in July of the current fiscal year have 11 more months of the fiscal year in which the claims can be paid; however, claims incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years and determined the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Pages E.EE-4 through E.EE-5 presents the percentage of claims paid in a six-month period that come from that same period and those which come from previous periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

It is of note that beginning January 1, 2014, the Department instituted a policy of denying retroactive capitation claims that are from a period beyond three months prior to the payment month. Since capitations are calculated to pay for actual services delivered by spreading that cost to caseload regardless of whether services are received, the net effect of eliminating cap payments and reimbursing for services may be cost neutral. The Department will monitor this policy change, and, should there be any expenditure fluctuations, the Department will seek to adjust through future budget requests.

On pages E.EE-6 through E.EE-7, the Department calculates the estimated outstanding expenditure from claims remaining from previous period by aid category. The sums are then carried forward to the calculations on pages E.EE-1, E.EE-2, and E.EE-3.

Actuarially Certified Capitation Rates

Capitated rates for the behavioral health organizations are required to be actuarially certified and approved by CMS, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit EE. The methodology for determining the forecasted capitation rate is the subject of Exhibits FF through HH.

EXHIBIT FF - BEHAVIORAL HEALTH RETROACTIVITY ADJUSTMENT AND PARTIAL MONTH ADJUSTMENT MULTIPLIER

Capitations are paid for members from the date the client's eligibility is effective, resulting in claims paid retroactively. As such, any projection which derives expenditure by using non-retroactive caseload must take into account these retroactive claims. Since expenditures are calculated as the estimated capitation rate multiplied by the non-retroactive caseload, an adjustment for retroactivity can be applied to either the forecasted capitation rate or the caseload figure. In order to maintain the uniform presentation of caseload across all Departmental estimates and requests, the Department chose to make its retroactivity adjustment to the forecasted capitation rate itself.

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the behavioral health organizations to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can (and indeed do) trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the Behavioral Health Capitation program. This difference is captured through a partial-month adjustment multiplier.

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last six months of claims and caseload data. Historically the Department would analyze the previous five years of data, but due to the policy change relating to retroactivity beginning January 1, 2014, that data would not provide an accurate depiction of retroactivity based on current policy. Page E.FF-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The relatively steady percentage values across each respective eligibility category suggest the ratio is indeed systemic (as created by retroactivity) rather than a unique circumstance. The Department analyzed the data, however, and determined the amount of retroactivity in the claims incurred each period is steadily changing over time and has trended downward for all eligibility categories. For this reason, the Department previously assumed the most recent period with adequate time for run-out of claims is the best representation of how much retroactivity will affect the claims-to-caseload ratio in the current and request years. As a result of the retroactivity policy change noted above the Department has seen a substantial decline in retroactivity.

Partial Month Adjustment Multiplier

As presented on page E. FF-2, for each eligibility category, the weighted average claims-based rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was compared to the weighted capitation

rate (similarly weighted). Then, the claims-based rate as a percentage of the capitation rate was calculated, providing a simple comparison of any trend in claims-based rates as compared to capitation rates. The percentages are similar across years, indicating claims-based trends are matching capitation trends. The Department analyzed the data, however, and determined the amount of partial months paid each period is steadily changing over time within each eligibility category. For this reason, the Department assumes the most recent period with adequate time for run out of claims is the best representation of how much partial-month payments will affect the claims-based rate in the current and request years.

EXHIBIT GG - BEHAVIORAL HEALTH CAPITATION RATE TRENDS AND FORECASTS

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e., the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was examined. Exhibit GG presents historical data as well as the forecasted weighted rates.

The weighted rate is presented along with the percentage change from the previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit HH.

Based on the Department's calculations and rate-setting process and input from the behavioral health organizations, the Department's actuaries certify a capitation rate for each BHO and eligibility type as the rate point estimate for each fiscal year.

It is important to note the overall weighted rate point estimate presented in the exhibit is weighted across two factors. First, the rate is weighted within an eligibility category (that is, weighted by the behavioral health organizations' proportion of claims processed within that eligibility category). Second, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the Weighted Behavioral Health Total rate may not be a clear indicator of the rate trends across all eligibility categories.

Exhibit GG presents the weighted point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit GG in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years.

The Department added a new rate cell in FY 2011-12 for the MAGI Adults population, which was funded through the Hospital Provider Fee Cash Fund initially, but with the passage of the Affordable Care Act is funded entirely with federal funds through January 1, 2017

at which point it will revert back to Hospital Provider Fee with an enhanced federal match. The MAGI Adults rate was based on data from Disabled Adults and Low-Income Adults rates. In prior budget requests, the Department assumed a large reconciliation component to be completed retroactively; this was, in part, due to the fact there were a great number of unknowns related to the rate setting process. With the new rate setting methodology used beginning July 1, 2014, the Department still expects a number of unknowns and therefore expects to continue the reconciliation process in FY 2015-16. Beginning in FY 2016-17, the Department no longer has a risk corridor on either expansion population rates and does not expect to make these recoupments beyond FY 2016-17. The Department currently estimates that it will recover $17.5 million for FY 2014-15 and $6.6 million for FY 2015-16 dates of service.

EXHIBIT HH - FORECAST MODEL COMPARISONS

Exhibit HH produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in Exhibit EE. Pages E.HH-1 and E.HH-2 present the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in Exhibit FF.

On page E.HH-3, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into pages E.HH-1 and E.HH-2. Based on the point estimates, the adjustments presented in Exhibit FF are then applied and the final, adjusted point estimate is then used in the expenditure calculations of Exhibit EE.

Final Forecasts

Page E. HH-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page E. HH-3 (see below).

The projected rate is then adjusted by any policy impacts. In accordance with the FY 2010-11 ES-2 budget action, beginning September 1, 2009, the Department paid rates that were 2.5% below the actuarial midpoint. This rate cut is now incorporated in the data used during the rate-setting process and is no longer included as an adjustment factor in exhibit HH. There are currently no additional policy changes that impact the rates and therefore the only other adjustments are those to the account for partial month and retroactive eligibility (see below).

The forecasted rate is also adjusted by the partial month adjustment multiplier, calculated on page E.FF-2. The multiplier is applied to adjust for the fact that the full capitation rate is not paid for every member month. The rate for paid claims is impacted by payments made for partial months of eligibility; this type of payment will not be for a "whole" capitation payment at the current fiscal period's capitation rate. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Finally the claims-based rate is adjusted a third time, this time by the retroactivity adjustment. From Exhibit FF, page E.FF-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit FF, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep behavioral health caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to drive the expenditure calculation presented in Exhibit EE. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page E.HH-3 and historical midpoint rates are presented in Exhibit GG.

For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

Capitation rates are required to be actuarially sound and are built from a blend of historical rates and recent year encounter data (provider expenditure on services). The trend models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. As such, the Department believes the most recent years' experience is the most predictive of the likely current year and future year experiences. The following table shows the trends selected for the current and request years by eligibility category.

Trend Selection

Aid Category	FY 2017-18 Trend	FY 2018-19 Trend
Adults 65 and Older (OAP-A)	0.00%	1.21%
	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.	Trend is the average growth from FY 2010-11 to FY 2014-15.
Individuals with disabilities Through 64 (AND/AB, OAP-B)	0.00%	2.23%
	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.	Trend is average of FY 2013-14 and FY 2014-15.
Low Income Adults / Expansion Parents & Caretakers	0.00%	2.30%
	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.	Trend is half of the average growth from FY 2008-09 to FY 2012-13.
MAGI Adults	0.00%	2.30%
	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.	Due to lack of available data, trend is equal to Low Income Adults.
Eligible Children (AFDC-C/BC)	0.00%	2.30%
	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.	Trend is half of the average growth from FY 2010-11 to FY 2012-13.
Foster Care	0.00%	2.92%
	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.	Trend is growth from FY 2012-13 to FY 2013-14.

Trend Justification

The rate setting methodology changed effective January 1, 2014. The previous rate setting process involved the actuaries setting rates that were actuarially sound in aggregate. The new methodology involves setting actuarially sounds rates for each aid category. Based on current analysis of the behavioral health organizations cost data, the Department does not anticipate that rates will increase in FY 2017-18. If anything the Department may experience a rate decrease. The flat rates are also based on more complete and accurate cost data provided by the BHOs. The Department expects that the new base rates are representative of actual costs and expects a positive trend to the rates beginning in FY 2018-19 from expected inflation in national medical costs.

The selected point estimates of the capitation rates are adjusted on pages E.HH-1 and E.HH-2, as described above, for use in the expenditure calculations presented in Exhibit EE.

EXHIBIT II - MAGI ADULTS RECONCILIATION

Recoupments

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System (MMIS). When members are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the MMIS. When members are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is completed separately. When known, this exhibit also shows the impact of the reconciliation process surrounding all populations. For this request, as in years past, there is a risk corridor placed on the MAGI Adults and Expansion Parents and Caretaker's rate due to the uncertainty of the true cost of this population. This risk corridor allows the risk of not setting an accurate rate to be split between the Department and the BHOs. Depending on how far off the rate is from the actual encounter based rate, either the Department or the BHOs may receive money; for example, if the rates were set too high, the Department would recoup funding. Exhibit II summarizes the expected fiscal impacts.

The Department is expecting to make two reconciliations surrounding the MAGI Adults and Expansion Parents and Caretakers populations. The first is the reconciliation related to the risk corridor from January to June 2015 rates and all of FY 2015-16. The Department is estimating that it will recoup $17.5 million as a result of capitation rates being set higher than actual costs for January to June 2015 and $6.6 million for FY 2015-16. The Department also experienced a systems issue that resulted in paying some Expansion Parents and Caretakers the MAGI Adult rate, which is considerably higher. Therefore, a recoupment related to this issue is expected to be about a $18.9 million. Because this involves a population that was 100% federally funded in the applicable time period, there is

no impact to state funds. With the implementation of the new interchange, the Department will be able to correctly identify all populations and pay correctly so there will be no need to reconcile this in future years. As mentioned above, the Department currently has enough data on the expansion populations to accurately set rates. Therefore, risk corridors will no longer be used for the Expansion Parents and MAGI Adults populations. The Department also expects to make a recoupment with the BHOs of $3.1 million in FY 2016-17 from a system issue that changed several members' eligibility from Eligible Children and CHP+ Children to the Individuals with disabilities category, which has a significantly higher rate than for Eligible Children. Please see caseload narrative for additional information.

The Department has worked to reduce the payments to the behavioral health organizations for members later deemed ineligible for Medicaid. Historically, monthly capitation payments were made on a prospective basis. In February 2004, the Department converted to concurrent capitation payments. FY 2004-05 was the first full year for monthly capitation payments on a concurrent basis.

The Department previously reconciled through a complex manual reconciliation process. Due to the nature of the various reporting practices of the BHOs, the Department decided that the manual reconciliation process would not be continued starting in FY 2012-13 because of timely filing issues. The Department began adjusting capitation rates accordingly in FY 2012-13 to account for most of the reconciliations that would need to be made for members later deemed ineligible for Medicaid.

EXHIBIT JJ – ALTERNATIVE FINANCING POPULATIONS

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Colorado Health Care Affordability Act (HB 09-1293), Aligning Medicaid Eligibility for Children (SB 11-008), Eligibility for Pregnant Women in Medicaid (SB 11-250), and Expanding Medicaid Eligibility in Colorado (SB 13-200) to the Behavioral Health Community Programs fund splits. This exhibit presents projected caseload and costs itemized by eligibility category for the current year and the request year. The exhibit also separates out the funding source and the calculation of federal match associated with each category. Note the caseloads shown are the average monthly number over each year and will fluctuate throughout the year.

Colorado Health Care Affordability Act

HB 09-1293, the "Colorado Health Care Affordability Act" provided funding to provide health care coverage for uninsured Coloradans in FY 2009-10 and beyond. The Department began collecting fees from hospitals in April 2010 for the Hospital Provider Fee cash fund and started extending benefits to expansion members in May 2010.

The Department also expanded eligibility to cover MAGI Adults, formerly known as adults without dependent children in FY 2011-12. The program was initially limited to 10,000 members. In February 2013, additional enrollees were added from the waitlist beginning

in April through September 2013 because the Department had sufficient funding to support the addition. Beginning January 1, 2014, with the passage and implementation of SB 13-200 referenced below, that cap was lifted on the amount of members served with the MAGI Adults population. This population received the full range of behavioral health services provided by the BHOs, and the BHOs are paid at a different capitation rate for these members than any of its other eligibility categories. The Department's caseload projections for all expansion populations are provided in this Budget Request (see exhibit B in Medical Services Premiums).

Aligning Medicaid Eligibility for Children and Eligibility for Pregnant Women in Medicaid

SB 11-008, "Aligning Medicaid Eligibility for Children," extended Medicaid eligibility to up to 133% of the FPL for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifted impacted children from the CHP+ to Medicaid beginning January 1, 2013. As with most of the Hospital Provider Fee populations, the Department assumed the per-capita costs for this expansion population would be the same as for the traditional population since the majority of behavioral health expenditure is paid through the capitation program.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extended Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifted impacted women from CHP+ Medicaid on January 1, 2013. The Department assumes the expenditure for these women will continue to have per-capita costs that will be the same as for the traditional population.

Expanding Medicaid Eligibility in Colorado

SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL parents and caretakers of Medicaid eligible children and MAGI Adults, effective January 1, 2014. The Department assumes that the expenditure for parents and caretakers from 60% to 68% FPL will be funded with the standard Medicaid match, with the State's share coming from the Hospital Provider Fee fund. The Department assumes that Expansion Parents and Caretakers from 69% to 133% FPL and all MAGI Adults will receive the enhanced federal match rate, while parents up to 60% FPL will receive the standard Medicaid match, with the State's share coming from General Fund.

EXHIBIT KK - MEDICAID BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

Medicaid Behavioral Health Fee-for-Service Payments is a separate budget line item in Behavioral Health Community Programs. Expenditures for this line are calculated in Exhibit KK. The data from Exhibit KK also appear in Exhibit BB, where the fund splits relating to the fee-for-service payments are calculated.

The Medicaid Behavioral Health Fee-for-Service Payments appropriation allows Medicaid members not enrolled in a behavioral health organization to receive behavioral health services or enrolled Medicaid members to receive behavioral health services not covered by the behavioral health organizations. The services are not covered either because the client is not enrolled in a behavioral health organization or the services are outside the scope of the behavioral health organization contract. Medicare crossover claims are included in the fee-for-service category; these are behavioral health organization covered services for members enrolled in a behavioral health organization who are eligible for both Medicare and Medicaid.

Fee-for-service providers include, but are not limited to hospitals, psychiatrists, psychologists, primary care physicians, and behavioral health centers. The State also reimburses providers through fee-for-service if either the diagnosis or the procedure is not included in the behavioral health organization contract or the patient is not enrolled in a behavioral health organization.

History and Background Information

The nature of Medicaid Behavioral Health Fee-for-Service Payments has changed in recent years. Prior to FY 2002-03, Fee-for-Service Payments were included in the Behavioral Health Capitation base appropriation. During FY 2002-03, case management services provided by community mental health centers were included in the Behavioral Health Fee-for-Service Payments appropriation. During FY 2003-04, case management services were provided by Single Entry Point agencies and were still part of the Behavioral Health Fee-for-Service Payments appropriation, but they were moved to the Medical Services Premiums appropriation in FY 2004-05. Also during FY 2004-05, fee-for-service behavioral health care for developmentally disabled members living in Regional Centers was transferred from the Department of Human Services to the Department's Behavioral Health Fee-for-Service Payments appropriation. The changes to case management services and behavioral health care for developmentally disabled members are discussed below.

Historically, community mental health centers provided case management services to the Children's Home- and Community-Based Services for the Mentally Ill waiver members on a fee-for-service basis. Effective July 1, 2003, the Department began utilizing contracted Single Entry Point agencies for these services instead of the community mental health centers. Funding for these case management services remained in the fee-for-service payments appropriation for FY 2003-04. However, since Single Entry Point contracts are customarily paid from the Medical Services Premiums, the Department requested these services be transferred to the Medical Services Premiums Long Bill group. The supplemental appropriation to the Department (SB 05-112) moved Single Entry Point case management from the Behavioral Health Fee-for-Service Payments line item to the Medical Services Premiums line item in FY 2004-05 and was effective July 1, 2004.

The supplemental appropriation to the Department (SB 05-112) also authorized the transfer of the fee-for-service behavioral health care for developmentally disabled members living in Regional Centers from the Department of Human Services to the Department. This followed a September 3, 2004 1331 Supplemental which was approved by the Joint Budget Committee on September 21, 2004, for the

transfer of funds from the Department of Human Services for Developmental Disability State Plan services. This action funded State Plan services provided to members in the Developmentally Disabled waiver for Children's Home and Community Based Services as required by the Centers for Medicare and Medicaid Services, effective October 1, 2004.

The expenditures in Exhibit KK are broken out into the three major categories which make up Medicaid Behavioral Health Fee-for-Service: inpatient services, outpatient services, and physician services.

Current Calculations

The current fiscal year's total estimated expenditure is based on the actual expenditures from FY 2014-15, trended forward based upon the expected change in caseload from FY 2014-15 to FY 2015-16. The request year estimate is the result of a forward trend of the current-year estimate by the factor of the anticipated change in caseload, and this is then trended forward by the anticipated change in caseload for the out-year estimate.

Beginning July 1, 2014, the Department has changed the fund split methodology for fee-for-service expenditure. Previously, fee-for-service expenditure made up a significantly smaller portion of the behavioral health programs total expenditure and it was assumed that the Department would claim the standard Medicaid federal match on all expenditure. As the fee-for-service component continues to grow and expenditure for populations that receive a match other than the standard Medicaid match continue to grow and make up a larger portion of total fee-for-service expenditure, the Department felt it would be best to forecast expenditure for each population separately in order to better estimate the actual cost to the state.

The Departments current method for determining expenditure in the current year, request year, and out year is to apply the same proportion of total expenditure attributed to each population from the most recent complete fiscal year to the current estimated total fee-for-service expenditure in the years being forecasted. Although this method may not accurately forecast the correct proportions from one year to the next, the Department believes this will give the most accurate representation at this time. The Department will continue to evaluate the methodology in the future and make changes as more information becomes available. Fund splits for fee-for-service expenditure is broken out in more detail in Exhibit BB.

No rate or utilization increases are forecasted, although the Department is currently investigating the feasibility and necessity of incorporating such adjustments. Behavioral health fee-for-service expenditure has increased over previous years. The Department has been performing data analysis using fee-for-service claims in an attempt to determine what caused the increase and whether or not it will continue to grow in the future. The Department will continue to monitor its impact as more data becomes available over time and may request for a decrease in its appropriation if the expenditure decreases as expected through the standard budget process.

EXHIBIT LL - GLOBAL REASONABLENESS TEST FOR BEHAVIORAL HEALTH CAPITATION PAYMENTS

The Global Reasonableness Test presented in Exhibit LL compares the percent change between behavioral health capitation expenditures as reported in Exhibit DD and forecasted in Exhibit EE. The FY 2016-17 appropriation is 13.19% higher than FY 2015-16 actual expenditures, primarily due to caseload growth. The FY 2016-17 estimate incorporates increased caseload projections along with various rate adjustments and results in a 3.44% increase from FY 2015-16 actual expenditures and an 8.61% decrease from the current appropriation. The FY 2017-18 estimate is built on the FY 2016-17 estimate and presents a 12.89% expenditure increase. This increase is primarily due to: 1) increased caseload projections for traditional members; 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations; and 3) projected increases in capitation rates from FY 2016-17 to FY 2017-18. The FY 2017-18 request represents a 3.17% increase over the current FY 2016-17 appropriation. The FY 2018-19 Budget Request is built on the FY 2017-18 estimate and represents a 5.29% expenditure increase over the FY 2017-18 request and a 8.63% increase over the FY 2016-17 appropriation.

Exhibit	Title of Exhibit
Exhibit AA	Calculation of Current Total Long Bill Group Impact
Exhibit BB	Calculation of Fund Splits
Exhibit BB	Cash Funds Report
Exhibit CC	Behavioral Health Community Programs Summary
Exhibit DD	Behavioral Health Community Programs, Caseload
Exhibit DD	Behavioral Health Community Programs, Behavioral Health Capitation Payments Per Capita Historical Summary
Exhibit DD	Behavioral Health Community Programs, Expenditures Historical Summary
Exhibit EE	Expenditure Calculations by Eligibility Category
Exhibit EE	Incurred But Not Reported Runout by Fiscal Period
Exhibit EE	Incurred But Not Reported Expenditures by Fiscal Period
Exhibit FF	Medicaid Behavioral Health Retroactivity Adjustment
Exhibit FF	Medicaid Behavioral Health Partial Month Adjustment Multiplier
Exhibit GG	Medicaid Behavioral Health Capitation Rate Trends and Forecasts
Exhibit HH	Forecast Model Comparisons - Final Forecasts
Exhibit HH	Forecast Model Comparisons - Capitation Trend Models
Exhibit II	Reconciliations
Exhibit JJ	Alternative Financing Populations
Exhibit KK	Medicaid Behavioral Health Fee For Service Forecast
Exhibit LL	Global Reasonableness Test for Medicaid Behavioral Health Capitation Payments

Exhibit AA - Calculation of Current Total Long Bill Group Impact						
FY 2016-17 Behavioral Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2016-17 Behavioral Health Capitation Appropriation						
FY 2016-17 Long Bill Appropriation (HB 16-1405)	$653,650,029	$181,949,404	$0	$16,383,180	$0	$455,317,445
FY 2016-17 Total Behavioral Heath Capitation Spending Authority	**$653,650,029**	**$181,949,404**	**$0**	**$16,383,180**	**$0**	**$455,317,445**
Projected Total FY 2016-17 Behavioral Health Capitation Expenditure	**$597,347,639**	**$175,277,005**	**$0**	**$16,977,191**	**$0**	**$405,093,443**
FY 2016-17 Behavioral Health Capitation Estimated Change from Appropriation	**($56,302,390)**	**($6,672,399)**	**$0**	**$594,011**	**$0**	**($50,224,002)**
Percent Change from Spending Authority	-8.61%	-3.67%	0.00%	3.63%	0.00%	-11.03%
FY 2016-17 Behavioral Health Fee-for-Service						
FY 2016-17 Behavioral Health Fee-For-Service Appropriation						
FY 2016-17 Long Bill Appropriation (HB 16-1405)	$8,967,301	$1,678,280	$0	$249,835	$0	$7,039,186
FY 2016-17 Total Behavioral Heath Fee-For-Service Spending Authority	**$8,967,301**	**$1,678,280**	**$0**	**$249,835**	**$0**	**$7,039,186**
Projected Total FY 2016-17 Behavioral Health Fee-for-Service Expenditure	**$8,821,393**	**$1,970,933**	**$0**	**$225,347**	**$0**	**$6,625,113**
Total FY 2016-17 Behavioral Health Fee-For-Service Change from Appropriation	**($145,908)**	**$292,653**	**$0**	**($24,488)**	**$0**	**($414,073)**
Percent Change from Spending Authority	-1.63%	17.44%	0.00%	-9.80%	0.00%	-5.88%
FY 2016-17 Medicaid Behavioral Health Programs						
FY 2016-17 Total Spending Authority	**$662,617,330**	**$183,627,684**	**$0**	**$16,633,015**	**$0**	**$462,356,631**
Total Projected FY 2016-17 Expenditures	$606,169,032	$177,247,938	$0	$17,202,538	$0	$411,718,556
FY 2016-17 Estimated Change from Appropriation	**($56,448,298)**	**($6,379,746)**	**$0**	**$569,523**	**$0**	**($50,638,075)**
Percent Change from Spending Authority	-8.52%	-3.47%	0.00%	3.42%	0.00%	-10.95%

Exhibit AA - Calculation of Current Total Long Bill Group Impact						
FY 2017-18 Behavioral Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2016-17 Behavioral Health Capitation Appropriation Plus Special Bills	**$653,650,029**	**$181,949,404**	**$0**	**$16,383,180**	**$0**	**$455,317,445**
Bill Annualizations	$8,645	($28,516)	$0	$32,856	$0	$4,305
FY 2017-18 Behavioral Health Capitation Base Amount	**$653,658,674**	**$181,920,888**	**$0**	**$16,416,036**	**$0**	**$455,321,750**
Projected Total FY 2017-18 Behavioral Health Capitation Expenditure	**$674,347,374**	**$181,182,497**	**$0**	**$27,703,719**	**$0**	**$465,461,158**
Total FY 2017-18 Behavioral Health Capitation Request	**$20,688,700**	**($738,391)**	**$0**	**$11,287,683**	**$0**	**$10,139,408**
Percent Change from FY 2017-18 Behavioral Health Capitation Base	3.17%	-0.41%	0.00%	68.76%	0.00%	2.23%
Percent Change from FY 2016-17 Estimated Behavioral Health Capitation Expenditure	12.89%	3.37%	0.00%	63.18%	0.00%	14.90%
FY 2017-18 Behavioral Health Fee-for-Service						
FY 2016-17 Behavioral Health Fee-For-Service Appropriation Plus Special Bills	**$8,967,301**	**$1,678,280**	**$0**	**$249,835**	**$0**	**$7,039,186**
Bill Annualizations	$0	$0	$0	$0	$0	$0
FY 2017-18 Behavioral Health Fee-For-Service Base Amount	**$8,967,301**	**$1,678,280**	**$0**	**$249,835**	**$0**	**$7,039,186**
Projected Total FY 2017-18 Behavioral Health Fee-for-Service Expenditure	**$9,241,145**	**$2,010,180**	**$0**	**$382,610**	**$0**	**$6,848,355**
Total FY 2017-18 Behavioral Health Fee-For-Service Request	**$273,844**	**$331,900**	**$0**	**$132,775**	**$0**	**($190,831)**
Percent Change from FY 2017-18 Behavioral Health Fee-For-Service Base	3.05%	19.78%	0.00%	53.15%	0.00%	-2.71%
Percent Change from FY 2016-17 Estimated Behavioral Health Fee-For-Service Expenditure	4.76%	1.99%	0.00%	69.79%	0.00%	3.37%
FY 2017-18 Medicaid Behavioral Health Programs						
FY 2017-18 Base Amount	**$662,625,975**	**$183,599,168**	**$0**	**$16,665,871**	**$0**	**$462,360,936**
Total Projected FY 2017-18 Expenditure	$683,588,519	$183,192,677	$0	$28,086,329	$0	$472,309,513
Total FY 2017-18 Request	**$20,962,544**	**($406,491)**	**$0**	**$11,420,458**	**$0**	**$9,948,577**
Percent Change from Spending Authority	3.16%	-0.22%	0.00%	68.53%	0.00%	2.15%

Exhibit AA - Calculation of Current Total Long Bill Group Impact						
FY 2018-19 Behavioral Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2017-18 Behavioral Health Capitation Appropriation Plus Special Bills	**$653,658,674**	**$181,920,888**	**$0**	**$16,416,036**	**$0**	**$455,321,750**
FY 2018-19 Behavioral Health Capitation Base Amount	**$653,658,674**	**$181,920,888**	**$0**	**$16,416,036**	**$0**	**$455,321,750**
Projected Total FY 2018-19 Behavioral Health Capitation Expenditure	**$710,044,169**	**$188,717,845**	**$0**	**$32,853,129**	**$0**	**$488,473,195**
Total FY 2018-19 Behavioral Health Capitation Continuation Amount	**$56,385,495**	**$6,796,957**	**$0**	**$16,437,093**	**$0**	**$33,151,445**
Percent Change from FY 2018-19 Behavioral Health Capitation Base	8.63%	3.74%	0.00%	100.13%	0.00%	7.28%
Percent Change from FY 2017-18 Estimated Behavioral Health Capitation Expenditure	5.29%	4.16%	0.00%	18.59%	0.00%	4.94%
FY 2018-19 Behavioral Health Fee-for-Service						
FY 2017-18 Behavioral Health Fee-For-Service Appropriation Plus Special Bills	**$8,967,301**	**$1,678,280**	**$0**	**$249,835**	**$0**	**$7,039,186**
FY 2018-19 Behavioral Health Fee-For-Service Base Amount	**$8,967,301**	**$1,678,280**	**$0**	**$249,835**	**$0**	**$7,039,186**
Projected Total FY 2018-19 Behavioral Health Fee-for-Service Expenditure	**$9,506,941**	**$2,037,666**	**$0**	**$447,342**	**$0**	**$7,021,933**
Total FY 2018-19 Behavioral Health Fee-For-Service Continuation Amount	**$539,640**	**$359,386**	**$0**	**$197,507**	**$0**	**($17,253)**
Percent Change from FY 2017-18 Behavioral Health Fee-For-Service Base	6.02%	21.41%	0.00%	79.05%	0.00%	-0.25%
Percent Change from FY 2017-18 Estimated Behavioral Health Fee-For-Service Expenditure	2.88%	1.37%	0.00%	16.92%	0.00%	2.53%
FY 2018-19 Medicaid Behavioral Health Programs						
FY 2018-19 Base Amount	**$662,625,975**	**$183,599,168**	**$0**	**$16,665,871**	**$0**	**$462,360,936**
Total Projected FY 2018-19 Expenditure	$719,551,110	$190,755,511	$0	$33,300,471	$0	$495,495,128
Total FY 2018-19 Continuation Amount	**$56,925,135**	**$7,156,343**	**$0**	**$16,634,600**	**$0**	**$33,134,192**
Percent Change from Spending Authority	8.59%	3.90%	0.00%	99.81%	0.00%	7.17%

Exhibit BB - Calculation of Fund Splits

Calculation of Fund Splits - FY 2016-17 Behavioral Health Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate [1]	Source of Funding
Behavioral Health Capitation Base Traditional Clients	$349,936,414	$174,268,334	$0	$0	$175,668,080	50.20%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$99,798	$0	$34,800	$0	$64,998	65.13%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$3,690,009	$0	$1,837,624	$0	$1,852,385	50.20%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$253,435,576	$0	$6,335,889	$0	$247,099,687	97.50%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$1,814,189	$0	$259,792	$0	$1,554,397	50.20%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$9,783,725	$0	$4,872,295	$0	$4,911,430	50.20%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility for Children	$9,143,228	$0	$4,553,328	$0	$4,589,900	50.20%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$15,621,896	$1,854,319	$0	$0	$13,767,577	88.13%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$671,186	$79,670	$0	$0	$591,516	88.13%	General Fund
Estimated FY 2016-17 Capitation Expenditure Before Adjustments	**$644,196,021**	**$176,202,323**	**$17,893,728**	**$0**	**$450,099,970**		
Date of Death Retractions	($667,151)	($332,241)	$0	$0	($334,910)	50.20%	General Fund
Risk Corridor Reconciliation [2]	($24,165,590)	$0	$0	$0	($24,165,590)	100.00%	Federal Funds
Expansion Adult Payment Rate BLI [3]	($18,947,943)	$0	$0	$0	($18,947,943)	100.00%	Federal Funds
Adjustment for Clients Placed in Incorrect Eligibility Types [4]	($3,067,698)	($593,077)	($916,537)	$0	($1,558,084)	50.79%	Variable
Estimated FY 2016-17 Capitation Expenditure	**$597,347,639**	**$175,277,005**	**$16,977,191**	**$0**	**$405,093,443**		
Behavioral Health Fee-for-Service Traditional Clients	$3,896,484	$1,940,449	$0	$0	$1,956,035	50.20%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$4,010	$0	$1,398	$0	$2,612	65.13%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$89,262	$0	$44,452	$0	$44,810	50.20%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$4,414,700	$0	$110,367	$0	$4,304,333	97.50%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$29,913	$0	$4,284	$0	$25,629	50.20%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$28,343	$0	$14,115	$0	$14,228	50.20%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility for Children	$101,869	$0	$50,731	$0	$51,138	50.20%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$251,631	$29,869	$0	$0	$221,762	88.13%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$5,181	$615	$0	$0	$4,566	88.13%	General Fund
Estimated FY 2016-17 Fee-for-Service Payments	**$8,821,393**	**$1,970,933**	**$225,347**	**$0**	**$6,625,113**		
Final Estimated FY 2016-17 Medicaid Behavioral Health Community Programs Expenditure	**$606,169,032**	**$177,247,938**	**$17,202,538**	**$0**	**$411,718,556**		

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

[2] The reconciliation of the MAGI Adult rate risk corridor is expected to be -$17.5 million in FY 2016-17 for capitations paid in FY 2014-15 and -$5.7 million for capitations paid in FY 2015-16. The Expansion Parent risk corridor reconciliation is expected to be $973,545 in FY 2016-17 for capitations paid in FY 2015-16.

[3] Due to a systems issue, an increasing percentage of low income parents were incorrectly identified as single adults and thus paid an incorrect rate. This happened beginning in FY 2014-15 and will be corrected with the implementation of the interChange on 10/31/16. Recoupment will be for dates of service in FY 2015-16.

[4] A systems issue cause some clients' eligibility to be incorrectly adjusted, moving them primarily into the individuals with disabilities categories from a childrens category. As a result, the Department overpaid on those clients and will be recouping capitations for that amount once a client list of the impacted individuals is complete.

Exhibit BB - Calculation of Fund Splits

Calculation of Fund Splits - FY 2017-18 Behavioral Health Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate [1]	Source of Funding
Behavioral Health Capitation Base Traditional Clients	$358,685,749	$179,342,874	$0	$0	$179,342,875	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$62,476	$0	$21,867	$0	$40,609	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$3,824,362	$0	$1,912,181	$0	$1,912,181	50.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$271,595,567	$0	$14,937,756	$0	$256,657,811	94.50%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$1,923,044	$0	$319,610	$0	$1,603,434	50.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$11,558,615	$0	$5,779,307	$0	$5,779,308	50.00%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility for Children	$9,465,996	$0	$4,732,998	$0	$4,732,998	50.00%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$17,138,732	$2,056,648	$0	$0	$15,082,084	88.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$693,268	$83,192	$0	$0	$610,076	88.00%	General Fund
Estimated FY 2017-18 Capitation Expenditure Before Adjustments	**$674,947,809**	**$181,482,714**	**$27,703,719**	**$0**	**$465,761,376**		
Date of Death Retractions	($600,435)	($300,217)	$0	$0	($300,218)	50.00%	General Fund
Estimated FY 2017-18 Capitation Expenditure	**$674,347,374**	**$181,182,497**	**$27,703,719**	**$0**	**$465,461,158**		
Behavioral Health Fee-for-Service Traditional Clients	$3,952,823	$1,976,411	$0	$0	$1,976,412	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$2,510	$0	$878	$0	$1,632	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$92,449	$0	$46,224	$0	$46,225	50.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$4,741,319	$0	$260,773	$0	$4,480,546	94.50%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$31,705	$0	$5,269	$0	$26,436	50.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$33,470	$0	$16,735	$0	$16,735	50.00%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility for Children	$105,463	$0	$52,731	$0	$52,732	50.00%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$276,058	$33,127	$0	$0	$242,931	88.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$5,348	$642	$0	$0	$4,706	88.00%	General Fund
Estimated FY 2017-18 Fee-for-Service Payments	**$9,241,145**	**$2,010,180**	**$382,610**	**$0**	**$6,848,355**		
Final Estimated FY 2017-18 Medicaid Behavioral Health Community Programs Expenditure	**$683,588,519**	**$183,192,677**	**$28,086,329**	**$0**	**$472,309,513**		

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

Exhibit BB - Calculation of Fund Splits

Calculation of Fund Splits - FY 2018-19 Behavioral Health Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate [1]	Source of Funding
Behavioral Health Capitation Base Traditional Clients	$373,421,585	$186,710,792	$0	$0	$186,710,793	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$36,782	$0	$12,874	$0	$23,908	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$4,015,706	$0	$2,007,853	$0	$2,007,853	50.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$288,653,410	$0	$18,762,472	$0	$269,890,938	93.50%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$2,053,544	$0	$356,701	$0	$1,696,843	50.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$13,552,697	$0	$6,776,348	$0	$6,776,349	50.00%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility for Children	$9,873,762	$0	$4,936,881	$0	$4,936,881	50.00%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$18,245,726	$2,189,487	$0	$0	$16,056,239	88.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$731,349	$87,762	$0	$0	$643,587	88.00%	General Fund
Estimated FY 2018-19 Capitation Expenditure Before Adjustments	**$710,584,561**	**$188,988,041**	**$32,853,129**	**$0**	**$488,743,391**		
Date of Death Retractions	($540,392)	($270,196)	$0	$0	($270,196)	50.00%	General Fund
Estimated FY 2018-19 Capitation Expenditure	**$710,044,169**	**$188,717,845**	**$32,853,129**	**$0**	**$488,473,195**		
Behavioral Health Fee-for-Service Traditional Clients	$4,005,070	$2,002,535	$0	$0	$2,002,535	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$1,444	$0	$505	$0	$939	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$94,890	$0	$47,445	$0	$47,445	50.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$4,933,788	$0	$320,696	$0	$4,613,092	93.50%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$33,093	$0	$5,748	$0	$27,345	50.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$38,378	$0	$19,189	$0	$19,189	50.00%	CF: Hospital Provider Fee Cash Fund
Continuous Eligibility for Children	$107,519	$0	$53,759	$0	$53,760	50.00%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$287,244	$34,469	$0	$0	$252,775	88.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$5,515	$662	$0	$0	$4,853	88.00%	General Fund
Estimated FY 2018-19 Fee-for-Service Payments	**$9,506,941**	**$2,037,666**	**$447,342**	**$0**	**$7,021,933**		
Final Estimated FY 2018-19 Medicaid Behavioral Health Community Programs Expenditure	**$719,551,110**	**$190,755,511**	**$33,300,471**	**$0**	**$495,495,128**		

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

Cash Funds Report

Cash Fund	FY 2016-17			FY 2017-18			FY 2018-19		
	Spending Authority	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**
Behavioral Health Capitations									
Hospital Provider Fee Cash Fund	$16,359,487	$16,942,391	$582,904	$16,392,324	$27,681,852	$11,289,528	$16,392,324	$32,840,255	$16,447,931
Breast and Cervical Cancer Prevention and Treatment Fund	$23,693	$34,800	$11,107	$23,712	$21,867	($1,845)	$23,712	$12,874	($10,838)
Behavioral Health Capitations Total Cash Funds	**$16,383,180**	**$16,977,191**	**$594,011**	**$16,416,036**	**$27,703,719**	**$11,287,683**	**$16,416,036**	**$32,853,129**	**$16,437,093**
Behavioral Health Fee-for-service									
Hospital Provider Fee Cash Fund	$249,835	$223,949	($25,886)	$249,835	$381,732	$131,897	$249,835	$446,837	$197,002
Breast and Cervical Cancer Prevention and Treatment Fund	$0	$1,398	$1,398	$0	$878	$878	$0	$505	$505
Behavioral Health Fee-for-service Total Cash Funds	**$249,835**	**$225,347**	**($24,488)**	**$249,835**	**$382,610**	**$132,775**	**$249,835**	**$447,342**	**$197,507**

Exhibit CC - Medicaid Behavioral Health Community Programs Expenditure Summary
Actuals, Appropriations and Estimates Prior to Recoupments

ITEM	FY 2015-16 Actual		FY 2016-17 Appropriated		FY 2016-17 Estimate		FY 2016-17 Change from Appropriation		FY 2017-18 Estimate		FY 2017-18 Change from FY 2016-17 Estimate		FY 2017-18 Change from FY 2016-17 Appropriation		FY 2018-19 Estimate		FY 2018-19 Change from FY 2017-18 Estimate	
	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure
Behavioral Health Capitation Payments																		
Adults 65 and Older (OAP-A)	42,403	$7,607,747	42,831	$8,289,655	43,412	$9,385,692	581	$1,096,037	44,137	$9,548,634	725	$162,942	1,306	$1,258,979	44,870	$9,819,679	733	$271,045
Disabled Individuals	85,546	$126,792,664	87,647	$142,275,072	85,959	$144,279,296	(1,688)	$2,004,224	89,039	$149,467,123	3,080	$5,187,827	1,392	$7,192,051	91,656	$157,281,043	2,617	$7,813,920
Low Income Adults	179,514	$54,063,464	201,678	$68,322,042	209,008	$72,853,993	7,330	$4,531,951	215,934	$75,317,477	6,926	$2,463,484	14,256	$6,995,435	221,250	$78,946,257	5,316	$3,628,780
Expansion Parents & Caretakers	86,964	$80,657,096	90,649	$22,363,544	98,910	$19,833,190	8,261	($2,530,354)	108,821	$21,574,725	9,911	$1,741,535	18,172	($788,819)	116,361	$23,586,742	7,540	$2,012,017
MAGI Adults	320,374	$224,182,368	345,496	$247,583,714	366,209	$235,561,673	20,713	($12,022,041)	391,871	$252,074,474	25,662	$16,512,801	46,375	$4,490,760	406,112	$267,237,741	14,241	$15,163,267
Eligible Children	526,694	$118,719,897	558,771	$140,363,874	552,392	$131,696,180	(6,379)	($8,667,694)	571,582	$136,273,370	19,190	$4,577,190	12,811	($4,090,504)	582,667	$142,128,691	11,085	$5,855,321
Foster Care	19,935	$37,304,687	19,806	$41,746,583	20,185	$30,486,199	379	($11,260,384)	20,290	$30,629,530	105	$143,331	484	($11,117,053)	20,305	$31,547,626	15	$918,096
Breast and Cervical Cancer Program	322	$125,101	208	$68,021	286	$99,798	78	$31,777	179	$62,476	(107)	($37,322)	(29)	($5,545)	103	$36,782	(76)	($25,694)
Sub-total Behavioral Health Capitation Payments	**1,261,752**	**$649,453,024**	**1,347,086**	**$671,012,505**	**1,376,361**	**$644,196,021**	**29,275**	**($26,816,484)**	**1,441,853**	**$674,947,809**	**65,492**	**$30,751,788**	**94,767**	**$3,935,304**	**1,483,324**	**$710,584,561**	**41,471**	**$35,636,752**
Date of Death Retractions		($736,498)		($1,117,587)		($667,151)		$450,436		($600,435)		$66,716		$517,152		($540,392)		$60,043
Risk Corridor Reconciliation		($18,949,334)		($13,177,191)		($24,165,590)		($10,988,399)		$0		$24,165,590		$13,177,191		$0		$0
Expansion Parent Payment Rate Reconciliation		($26,548,524)		$0		($18,947,943)		($18,947,943)		$0		$18,947,943		$0		$0		$0
Adjustment for Clients Placed in Incorrect Eligibility Types		$0		($3,067,698)		($3,067,698)		$0		$0		$3,067,698		$3,067,698		$0		$0
Total Behavioral Health Capitation Payments	**1,261,752**	**$603,218,668**	**1,347,086**	**$653,650,029**	**1,376,361**	**$597,347,639**	**29,275**	**($56,302,390)**	**1,441,853**	**$674,347,374**	**65,492**	**$76,999,735**	**94,767**	**$20,697,345**	**1,483,324**	**$710,044,169**	**41,471**	**$35,696,795**
Incremental Percent Change							2.17%	-8.61%			4.76%	12.89%	7.03%	3.17%			2.88%	5.29%
Behavioral Health Fee-for Service-Payments																		
Inpatient Services		$1,084,479		$1,202,553		$1,182,986		($19,567)		$1,239,277		$56,291		$36,724		$1,274,921		$35,644
Outpatient Services		$6,937,930		$7,693,303		$7,568,124		($125,179)		$7,928,241		$360,117		$234,938		$8,156,275		$228,034
Physician Services		$64,431		$71,446		$70,283		($1,163)		$73,627		$3,344		$2,181		$75,745		$2,118
Total Behavioral Health Fee-for-Service Payments		**$8,086,839**		**$8,967,302**		**$8,821,393**		**($145,909)**		**$9,241,145**		**$419,752**		**$273,843**		**$9,506,941**		**$265,796**
Total Behavioral Health Community Programs		**$611,305,507**		**$662,617,331**		**$606,169,032**		**($56,448,299)**		**$683,588,519**		**$77,419,487**		**$20,971,188**		**$719,551,110**		**$35,962,591**
Incremental Percent Change								-8.52%				12.77%		3.16%				5.26%

Exhibit DD - Medicaid Behavioral Health Community Programs, Caseload

Medicaid Behavioral Health Community Programs Average Monthly Caseload

Item	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults	Expansion Parents and Caretakers	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2006-07 Actuals	35,888	54,858	61,032	-	-	205,390	16,724	228	374,120
FY 2007-08 Actuals	36,284	56,079	59,761	-	-	204,022	17,141	270	373,557
% Change from FY 2006-07	1.10%	2.23%	-2.08%	0.00%	0.00%	-0.67%	2.49%	18.42%	-0.15%
FY 2008-09 Actuals	37,619	57,802	68,850	-	-	235,129	18,033	317	417,750
% Change from FY 2007-08	3.68%	3.07%	15.21%	0.00%	0.00%	15.25%	5.20%	17.41%	11.83%
FY 2009-10 Actuals	38,487	60,313	82,669	3,238	-	275,672	18,381	425	479,185
% Change from FY 2008-09	2.31%	4.34%	20.07%	0.00%	0.00%	17.24%	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,921	64,052	88,982	27,167	-	302,410	18,393	531	540,456
% Change from FY 2009-10	1.13%	6.20%	7.64%	739.01%	0.00%	9.70%	0.07%	24.94%	12.79%
FY 2011-12 Actuals	39,740	67,869	100,854	35,461	1,134	334,633	18,034	597	598,322
% Change from FY 2010-11	2.10%	5.96%	13.34%	30.53%	0.00%	10.66%	-1.95%	12.43%	10.71%
FY 2012-13 Actuals	40,827	71,859	107,760	41,545	10,634	368,079	17,777	623	659,104
% Change from FY 2011-12	2.74%	5.88%	6.85%	17.16%	837.74%	9.99%	-1.43%	4.36%	10.16%
FY 2013-14 Actuals	41,836	76,837	138,897	47,082	87,243	424,377	18,267	559	835,098
% Change from FY 2012-13	2.47%	6.93%	28.89%	13.33%	720.42%	15.30%	2.76%	-10.27%	26.70%
FY 2014-15 Actuals	41,817	80,641	178,328	71,989	241,392	495,836	20,036	400	1,130,439
% Change from FY 2013-14	-0.05%	4.95%	28.39%	52.90%	176.69%	16.84%	9.68%	-28.44%	35.37%
FY 2015-16 Actuals	42,403	85,546	179,514	86,964	320,374	526,694	19,935	322	1,261,752
% Change from FY 2014-15	1.40%	6.08%	0.67%	20.80%	32.72%	6.22%	-0.50%	-19.50%	11.62%
FY 2016-17 Projection	43,412	85,959	209,008	98,910	366,209	552,392	20,185	286	1,376,361
% Change from FY 2015-16	3.81%	6.59%	17.20%	37.00%	52.00%	11.00%	1.00%	-29.00%	21.75%
FY 2017-18 Projection	44,137	89,039	215,934	108,821	391,871	571,582	20,290	179	1,441,853
% Change from FY 2016-17	1.67%	3.58%	3.31%	10.02%	7.01%	3.47%	0.52%	-37.00%	4.76%
FY 2018-19 Projection	44,870	91,656	221,250	116,361	406,112	582,667	20,305	103	1,483,324
% Change from FY 2017-18	1.66%	2.94%	2.46%	6.93%	3.63%	1.94%	0.07%	-42.00%	2.88%
FY 2016-17 Appropriation	42,831	87,647	201,678	90,649	345,496	558,771	19,806	208	1,347,086
Difference between the FY 2016-17 Appropriation and the FY 2016-17 Projection	581	(1,688)	7,330	8,261	20,713	(6,379)	379	78	29,275

Expanded Medicaid Average Monthly Caseload for Behavioral Health Community Programs

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Breast & Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2006-07 Actuals	35,888	6,059	48,799	-	55,850	5,182	-	-	-	205,390	-	16,724	228	374,120
FY 2007-08 Actuals	36,284	6,146	49,933	-	53,473	6,288	-	-	-	204,022	-	17,141	270	373,557
% Change from FY 2006-07	1.10%	1.44%	2.32%	0.00%	-4.26%	21.34%	0.00%	0.00%	0.00%	-0.67%	0.00%	2.49%	18.42%	-0.15%
FY 2008-09 Actuals	37,619	6,447	51,355	-	61,874	6,976	-	-	-	235,129	-	18,033	317	417,750
% Change from FY 2007-08	3.68%	4.90%	2.85%	0.00%	15.71%	10.94%	0.00%	0.00%	0.00%	15.25%	0.00%	5.20%	17.41%	11.83%
FY 2009-10 Actuals	38,487	7,049	53,264	-	74,839	7,830	-	3,238	-	275,672	-	18,381	425	479,185
% Change from FY 2008-09	2.31%	9.34%	3.72%	0.00%	20.95%	12.24%	0.00%	0.00%	0.00%	17.24%	0.00%	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,921	7,767	56,285	-	81,114	7,868	-	27,167	-	302,410	-	18,393	531	540,456
% Change from FY 2009-10	1.13%	10.19%	5.67%	0.00%	8.38%	0.49%	0.00%	739.01%	0.00%	9.70%	0.00%	0.07%	24.94%	12.79%
FY 2011-12 Actuals	39,740	8,383	59,434	52	93,224	7,630	-	35,461	1,134	334,633	-	18,034	597	598,322
% Change from FY 2010-11	2.10%	7.93%	5.59%	0.00%	14.93%	-3.02%	0.00%	30.53%	0.00%	10.66%	0.00%	-1.95%	12.43%	10.71%
FY 2012-13 Actuals	40,827	9,051	61,920	888	99,392	8,024	344	41,545	10,634	359,843	8,236	17,777	623	659,104
% Change from FY 2011-12	2.74%	7.97%	4.18%	1607.69%	6.62%	5.16%	0.00%	17.16%	837.74%	7.53%	0.00%	-1.43%	4.36%	10.16%
FY 2013-14 Actuals	41,836	9,853	64,424	2,560	124,680	13,160	1,057	47,082	87,243	399,032	25,345	18,267	559	835,098
% Change from FY 2012-13	2.47%	8.86%	4.04%	188.29%	25.44%	64.01%	207.27%	13.33%	720.42%	10.89%	207.73%	2.76%	-10.27%	26.70%
FY 2014-15 Actuals	41,817	10,466	66,548	3,627	161,682	14,897	1,749	71,989	241,392	445,723	50,113	20,036	400	1,130,439
% Change from FY 2013-14	-0.05%	6.22%	3.30%	41.68%	29.68%	13.20%	65.47%	52.90%	176.69%	11.70%	97.72%	9.68%	-28.44%	35.37%
FY 2015-16 Actuals	42,403	10,529	68,800	6,217	163,342	14,413	1,759	86,964	320,374	467,193	59,501	19,935	322	1,261,752
% Change from FY 2014-15	1.40%	0.60%	3.38%	71.41%	1.03%	-3.25%	0.57%	20.80%	32.72%	4.82%	18.73%	-0.50%	-19.50%	11.62%
FY 2016-17 Projection	43,412	11,087	69,028	5,844	192,317	14,765	1,926	98,910	366,209	486,863	65,529	20,185	286	1,376,361
% Change from FY 2015-16	2.38%	5.30%	0.33%	-6.00%	17.74%	2.44%	9.49%	13.74%	14.31%	4.21%	10.13%	1.25%	-11.18%	21.75%
FY 2017-18 Projection	44,137	11,535	70,603	6,901	199,180	14,766	1,988	108,821	391,871	499,692	71,890	20,290	179	1,441,853
% Change from FY 2016-17	1.67%	4.04%	2.28%	18.09%	3.57%	0.01%	3.22%	10.02%	7.01%	2.64%	9.71%	0.52%	-37.41%	4.76%
FY 2018-19 Projection	44,870	12,024	71,719	7,913	204,433	14,767	2,050	116,361	406,112	507,864	74,803	20,305	103	1,483,324
% Change from FY 2017-18	1.66%	4.24%	1.58%	14.66%	2.64%	0.01%	3.12%	6.93%	3.63%	1.64%	4.05%	0.07%	-42.46%	2.88%
FY 2016-17 Appropriation	42,831	11,058	70,731	5,858	185,519	14,459	1,700	90,649	345,496	494,148	64,623	19,806	208	1,347,086
Difference between the FY 2016-17 Appropriation and the FY 2016-17 Projection	581	29	(1,703)	(14)	6,798	306	226	8,261	20,713	(7,285)	906	379	78	29,275

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

Behavioral Health Capitation Payments Per Capita History

Item	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults	Expansion Parents & Caretakers	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	TOTAL PER CAPITA
FY 2007-08 Actuals	$159.45	$1,473.28	$243.04	-	-	$184.13	$3,235.25	$222.88	$524.72
FY 2008-09 Actuals	$163.48	$1,593.93	$247.30	-	-	$185.92	$3,147.83	$230.52	$516.72
% Change from FY 2007-08	2.53%	8.19%	1.75%	0.00%	0.00%	0.97%	-2.70%	3.43%	-1.52%
FY 2009-10 Actuals	$148.47	$1,632.73	$249.27	$198.60	-	$180.47	$2,792.78	$230.48	$472.93
% Change from FY 2008-09	-9.18%	2.43%	0.80%	0.00%	0.00%	-2.93%	-11.28%	-0.02%	-8.47%
FY 2010-11 Actuals	$160.97	$1,757.63	$263.96	$281.77	-	$191.64	$2,341.69	$253.28	$464.69
% Change from FY 2009-10	8.42%	7.65%	5.89%	41.88%	0.00%	6.19%	-16.15%	9.89%	-1.74%
FY 2011-12 Actuals	$163.61	$1,780.77	$269.34	$285.90	$80.46	$202.54	$2,152.46	$264.78	$453.78
% Change from FY 2010-11	1.64%	1.32%	2.04%	1.47%	0.00%	5.69%	-8.08%	4.54%	-2.35%
FY 2012-13 Actuals	$160.02	$1,764.19	$278.07	$284.16	$1,214.44	$207.94	$2,060.15	$244.53	$457.14
% Change from FY 2011-12	-2.19%	-0.93%	3.24%	-0.61%	1409.37%	2.66%	-4.29%	-7.65%	0.74%
FY 2013-14 Actuals	$162.40	$1,767.53	$305.75	$215.56	$1,061.53	$209.54	$2,130.75	$453.98	$498.07
% Change from FY 2012-13	1.49%	0.19%	9.96%	-24.14%	-12.59%	0.77%	3.43%	85.65%	8.95%
FY 2014-15 Actuals	$165.63	$1,756.35	$313.39	$436.95	$690.61	$232.36	$2,595.59	$337.31	$504.19
% Change from FY 2013-14	1.99%	-0.63%	2.50%	102.70%	-34.94%	10.89%	21.82%	-25.70%	1.23%
FY 2015-16 Actuals	$176.94	$1,478.28	$301.07	$622.13	$639.84	$225.39	$1,870.14	$385.86	$478.08
% Change from FY 2014-15	6.83%	-15.83%	-3.93%	42.38%	-7.35%	-3.00%	-27.95%	14.39%	-5.18%
FY 2016-17 Projection	$213.81	$1,674.15	$348.49	$200.44	$642.87	$238.40	$1,509.28	$346.23	$467.56
% Change from FY 2015-16	20.84%	13.25%	15.75%	-67.78%	0.47%	5.77%	-19.30%	-10.27%	-2.20%
FY 2017-18 Projection	$214.23	$1,674.92	$348.73	$198.19	$642.94	$238.40	$1,508.64	$345.13	$467.69
% Change from FY 2016-17	0.19%	0.05%	0.07%	-1.12%	0.00%	0.00%	-0.04%	-0.32%	0.03%
FY 2018-19 Projection	$216.98	$1,712.71	$356.76	$202.65	$657.77	$243.92	$1,552.84	$351.01	$478.68
% Change from FY 2017-18	1.28%	2.26%	2.30%	2.25%	2.31%	2.31%	2.93%	$0.02	2.35%

Expanded Medicaid Per Capita Summary for Behavioral Health Capitation Payments

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Breast & Cervical Cancer Program	TOTAL PER CAPITA
FY 2007-08 Actuals	$159.45	$1,400.04	$1,482.29	-	$243.96	$235.19	-	-	-	$184.13	-	$3,235.25	$222.88	$524.72
FY 2008-09 Actuals	$163.48	$1,511.57	$1,604.27	-	$250.59	$218.14	-	-	-	$185.92	-	$3,147.83	$230.52	$516.72
% Change from FY 2007-08	2.53%	7.97%	8.23%	0.00%	2.72%	-7.25%	0.00%	0.00%	0.00%	0.97%	0.00%	-2.70%	3.43%	-1.52%
FY 2009-10 Actuals	$148.47	$1,537.50	$1,645.34	-	$254.25	$201.68	-	$198.60	-	$180.47	-	$2,792.78	$230.48	$472.93
% Change from FY 2008-09	-9.18%	1.72%	2.56%	0.00%	1.46%	-7.55%	0.00%	0.00%	0.00%	-2.93%	0.00%	-11.28%	-0.02%	-8.47%
FY 2010-11 Actuals	$160.97	$1,659.68	$1,771.15	-	$268.39	$218.28	-	$281.77	-	$191.64	-	$2,341.69	$253.28	$464.69
% Change from FY 2009-10	8.42%	7.95%	7.65%	0.00%	5.56%	8.23%	0.00%	41.88%	0.00%	6.19%	0.00%	-16.15%	9.89%	-1.74%
FY 2011-12 Actuals	$163.61	$1,693.76	$1,793.05	$1,763.06	$272.59	$229.60	-	$285.90	$80.46	$202.54	-	$2,152.46	$264.78	$453.78
% Change from FY 2010-11	1.64%	2.05%	1.24%	0.00%	1.56%	5.19%	0.00%	1.47%	0.00%	5.69%	0.00%	-8.08%	4.54%	-2.35%
FY 2012-13 Actuals	$160.02	$1,688.62	$1,771.11	$2,051.66	$281.45	$248.12	-	$284.16	$1,214.44	$212.70	-	$2,060.15	$244.53	$457.14
% Change from FY 2011-12	-2.19%	-0.30%	-1.22%	16.37%	3.25%	8.07%	0.00%	-0.61%	1409.37%	5.02%	0.00%	-4.29%	-7.65%	0.74%
FY 2013-14 Actuals	$162.40	$1,724.52	$1,766.62	$1,955.82	$311.47	$272.41	$46.13	$215.56	$1,061.53	$220.20	$41.67	$2,130.75	$453.98	$498.07
% Change from FY 2012-13	1.49%	2.13%	-0.25%	-4.67%	10.67%	9.79%	0.00%	-24.14%	-12.59%	3.53%	0.00%	3.43%	85.65%	8.95%
FY 2014-15 Actuals	$165.63	$1,720.12	$1,753.44	$1,914.25	$317.16	$264.72	$379.29	$436.95	$690.61	$225.15	$296.46	$2,595.59	$337.31	$504.19
% Change from FY 2013-14	1.99%	-0.26%	-0.75%	-2.13%	1.83%	-2.82%	722.22%	102.70%	-34.94%	2.25%	611.45%	21.82%	-25.70%	1.23%
FY 2015-16 Actuals	$176.94	$1,436.10	$1,471.07	$1,629.51	$304.54	$262.60	$294.03	$622.13	$639.84	$225.30	$226.09	$1,870.14	$385.86	$478.08
% Change from FY 2014-15	6.83%	-16.51%	-16.10%	-14.87%	-3.98%	-0.80%	-22.48%	42.38%	-7.35%	0.07%	-23.74%	-27.95%	14.39%	-5.18%
FY 2016-17 Projection	$213.81	$1,674.15	$1,674.15	$1,674.15	$348.49	$348.49	$348.49	$200.44	$642.87	$238.40	$238.40	$1,509.28	$346.23	$467.56
% Change from FY 2015-16	20.84%	16.58%	13.80%	2.74%	14.43%	32.71%	18.52%	-67.78%	0.47%	5.81%	5.44%	-19.30%	-10.27%	-2.20%
FY 2017-18 Projection	$214.23	$1,674.92	$1,674.92	$1,674.92	$348.73	$348.73	$348.73	$198.19	$642.94	$238.40	$238.40	$1,508.64	$345.13	$467.69
% Change from FY 2016-17	0.19%	0.05%	0.05%	0.05%	0.07%	0.07%	0.07%	-1.12%	0.01%	0.00%	0.00%	-0.04%	-0.32%	0.03%
FY 2018-19 Projection	$216.98	$1,712.71	$1,712.71	$1,712.71	$356.76	$356.76	$356.76	$202.65	$657.77	$243.92	$243.92	$1,552.84	$351.01	$478.68
% Change from FY 2017-18	1.28%	2.26%	2.26%	2.26%	2.30%	2.30%	2.30%	2.25%	2.31%	2.31%	2.31%	2.93%	1.70%	2.35%

Exhibit DD - Medicaid Behvaioral Health Community Programs, Expenditures Historical Summary

Annual Total Expenditures

Item		Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults	Expansion Parents & Caretakers	MAGI Adults	Eligible Children	Foster Care	Breast & Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2007-08	Capitations	$5,785,556	$82,620,046	$14,524,307	$0	$0	$37,565,608	$55,455,338	$60,178	$196,011,033
	Fee-For-Service									
	Inpatient Services	$7,069	$221,467	$45,469	$0	$0	$93,439	$46,660	$0	$414,104
	Outpatient Services	$12,721	$267,020	$231,300	$0	$0	$282,037	$74,411	$0	$867,489
	Physician Services	$479	$32,552	$9,170	$0	$0	$8,970	$2,972	$0	$54,143
	Sub-Total Fee-For-Service	$20,269	$521,039	$285,939	$0	$0	$384,446	$124,043	$0	$1,335,736
	Total FY 2007-08 Expenditures	**$5,805,825**	**$83,141,085**	**$14,810,246**	**$0**	**$0**	**$37,950,054**	**$55,579,381**	**$60,178**	**$197,346,769**
FY 2008-09	Capitations	$6,149,782	$92,132,599	$17,026,544	$0	$0	$43,714,042	$56,764,896	$73,074	$215,860,937
	Fee-For-Service									
	Inpatient Services	$22,235	$331,864	$107,478	$0	$0	$171,764	$8,913	$0	$642,254
	Outpatient Services	$9,657	$284,108	$300,557	$0	$0	$364,710	$103,091	$0	$1,062,123
	Physician Services	$285	$37,367	$12,386	$0	$0	$13,685	$8,153	$0	$71,876
	Sub-Total Fee-For-Service	$32,177	$653,339	$420,421	$0	$0	$550,159	$120,157	$0	$1,776,253
	Total FY 2008-09 Expenditures	**$6,181,959**	**$92,785,938**	**$17,446,965**	**$0**	**$0**	**$44,264,201**	**$56,885,053**	**$73,074**	**$217,637,190**
	% Change from FY 2007-08	**6.48%**	**11.60%**	**17.80%**	**0.00%**	**0.00%**	**16.64%**	**2.35%**	**21.43%**	**10.28%**
FY 2009-10 [1]	Capitations	$5,714,066	$98,475,008	$20,606,973	$643,078	$0	$49,749,580	$51,334,158	$97,955	$226,620,818
	Fee-For-Service									
	Inpatient Services	$36,707	$327,355	$23,679	$1,024	$0	$184,094	$23,702	$0	$596,561
	Outpatient Services	$18,805	$528,618	$598,850	$24,891	$0	$601,664	$139,423	$0	$1,912,251
	Physician Services	$61	$45,659	$6,338	$205	$0	$22,296	$4,291	$0	$78,850
	Sub-Total Fee-For-Service	$55,573	$901,632	$628,867	$26,120	$0	$808,054	$167,416	$0	$2,587,662
	Total FY 2009-10 Expenditures	**$5,769,639**	**$99,376,640**	**$21,235,840**	**$669,198**	**$0**	**$50,557,634**	**$51,501,574**	**$97,955**	**$229,208,480**
	% Change from FY 2008-09	**-6.67%**	**7.10%**	**21.72%**	**0.00%**	**0.00%**	**14.22%**	**-9.46%**	**34.05%**	**5.32%**
FY 2010-11 [1]	Capitations	$6,265,262	$112,579,810	$23,487,736	$7,654,920	$0	$57,953,130	$43,070,676	$134,493	$251,146,027
	Fee-For-Service									
	Inpatient Services	$26,281	$462,018	$54,952	$18,405	$0	$209,493	$31,297	$0	$802,446
	Outpatient Services	$19,668	$838,729	$805,357	$260,702	$0	$843,338	$204,022	$0	$2,971,816
	Physician Services	$44	$53,652	$10,651	$2,892	$0	$19,019	$10,074	$0	$96,331
	Sub-Total Fee-For-Service	$45,993	$1,354,399	$870,960	$281,999	$0	$1,071,850	$245,393	$0	$3,870,594
	Total FY 2010-11 Expenditures	**$6,311,255**	**$113,934,209**	**$24,358,696**	**$7,936,919**	**$0**	**$59,024,980**	**$43,316,069**	**$134,493**	**$255,016,621**
	% Change from FY 2009-10	**9.39%**	**14.65%**	**14.71%**	**1086.03%**	**0.00%**	**16.75%**	**-15.89%**	**37.30%**	**11.26%**
FY 2011-12	Capitations	$6,501,731	$120,858,807	$27,163,937	$10,138,129	$91,244	$67,777,256	$38,817,457	$158,074	$271,506,635
	Fee-For-Service									
	Inpatient Services	$21,297	$355,817	$48,185	$18,329	$0	$176,653	$11,869	$0	$632,151
	Outpatient Services	$19,808	$762,862	$898,679	$332,229	$13,232	$980,428	$156,434	$0	$3,163,672
	Physician Services	$0	$49,001	$13,561	$4,718	$0	$23,508	$5,786	$0	$96,575
	Sub-Total Fee-For-Service	$41,105	$1,167,680	$960,426	$355,276	$13,232	$1,180,589	$174,089	$0	$3,892,397
	Total FY 2011-12 Expenditures	**$6,542,836**	**$122,026,487**	**$28,124,363**	**$10,493,405**	**$104,476**	**$68,957,845**	**$38,991,546**	**$158,074**	**$275,399,032**
	% Change from FY 2010-11	**3.67%**	**7.10%**	**15.46%**	**32.21%**	**0.00%**	**16.83%**	**-9.98%**	**17.53%**	**7.99%**
FY 2012-13	Capitations	$6,533,297	$126,772,700	$29,964,300	$11,805,595	$12,914,408	$76,537,197	$36,623,205	$152,344	$301,303,046
	Fee-For-Service									
	Inpatient Services	$23,759	$667,573	$56,164	$5,318	$47,488	$147,305	$26,023	$0	$973,629
	Outpatient Services	$15,873	$746,068	$1,003,284	$301,289	$270,481	$1,035,757	$140,576	$0	$3,513,329
	Physician Services	$0	$61,602	$5,800	$2,561	$256	$9,712	$2,308	$0	$82,240
	Sub-Total Fee-For-Service	$39,632	$1,475,243	$1,065,248	$309,168	$318,226	$1,192,774	$168,907	$0	$4,569,198
	Total FY 2012-13 Expenditures	**$6,572,929**	**$128,247,943**	**$31,029,548**	**$12,114,763**	**$13,232,634**	**$77,729,971**	**$36,792,112**	**$152,344**	**$305,872,244**
	% Change from FY 2011-12	**0.46%**	**5.10%**	**10.33%**	**15.45%**	**12565.72%**	**12.72%**	**-5.64%**	**-3.62%**	**11.07%**
FY 2013-14	Capitations	$6,794,071	$135,811,614	$42,468,350	$10,148,824	$92,611,488	$88,922,742	$38,922,470	$253,774	$415,933,333
	Fee-For-Service									
	Inpatient Services	$12,637	$701,499	$138,091	$9,711	$199,734	$181,770	$33,646	$0	$1,277,088
	Outpatient Services	$10,423	$555,506	$1,039,616	$276,800	$1,113,265	$885,140	$75,378	$0	$3,956,127
	Physician Services	$50	$32,316	$7,787	$1,262	$9,088	$10,754	$1,877	$0	$63,135
	Sub-Total Fee-For-Service	$23,110	$1,289,321	$1,185,495	$287,773	$1,322,086	$1,077,664	$110,901	$0	$5,296,351
	Total FY 2013-14 Expenditures	**$6,817,181**	**$137,100,935**	**$43,653,845**	**$10,436,597**	**$93,933,574**	**$90,000,406**	**$39,033,371**	**$253,774**	**$421,229,684**
	% Change from FY 2012-13	**3.72%**	**6.90%**	**40.68%**	**-13.85%**	**609.86%**	**15.79%**	**6.09%**	**66.58%**	**37.71%**
FY 2014-15	Capitations	$6,926,061	$141,634,009	$55,885,779	$31,455,667	$166,708,082	$115,210,684	$52,005,193	$134,923	$569,960,398
	Fee-For-Service									
	Inpatient Services	$68,648	$419,127	$41,495	$8,711	$338,450	$117,114	$44,071	$0	$1,037,617
	Outpatient Services	$15,159	$578,816	$1,289,044	$386,626	$2,835,698	$1,206,136	$109,984	$0	$6,421,463
	Physician Services	$0	$40,084	$7,568	$909	$8,980	$7,396	$1,407	$0	$66,344
	Sub-Total Fee-For-Service	$83,807	$1,038,027	$1,338,106	$396,247	$3,183,128	$1,330,646	$155,462	$0	$7,525,424
	Total FY 2014-15 Expenditures	**$7,009,868**	**$142,672,036**	**$57,223,885**	**$31,851,914**	**$169,891,210**	**$116,541,330**	**$52,160,655**	**$134,923**	**$577,485,822**
	% Change from FY 2013-14	**2.83%**	**4.06%**	**31.09%**	**205.19%**	**80.86%**	**29.49%**	**33.63%**	**-46.83%**	**37.10%**
FY 2015-16	Capitations	$7,502,928	$126,461,139	$54,045,657	$54,103,151	$204,989,597	$118,710,699	$37,281,250	$124,247	$603,218,668
	Fee-For-Service									
	Inpatient Services	$196,797	$329,254	$24,417	$15,147	$371,092	$112,391	$35,382	$0	$1,084,479
	Outpatient Services	$14,779	$591,149	$1,409,045	$478,376	$3,016,043	$1,284,583	$139,439	$4,516	$6,937,930
	Physician Services	$117	$40,917	$9,413	$935	$8,821	$1,974	$2,254	$0	$64,431
	Sub-Total Fee-For-Service	$211,694	$961,320	$1,442,875	$494,457	$3,395,956	$1,398,948	$177,074	$4,516	$8,086,839
	Total FY 2015-16 Expenditures	**$7,714,622**	**$127,422,459**	**$55,488,532**	**$54,597,608**	**$208,385,553**	**$120,109,647**	**$37,458,324**	**$128,763**	**$611,305,507**
	% Change from FY 2014-15	**10.05%**	**-10.69%**	**-3.03%**	**71.41%**	**22.66%**	**3.06%**	**-28.19%**	**-4.57%**	**5.86%**

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

Exhibit DD - Medicaid Behavioral Health Community Programs Expenditures Historical Summary

Expanded Annual Total Expenditures

Item		Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Breast & Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2007-08	Capitations	$5,785,556	$8,604,645	$74,015,401	$0	$13,045,420	$1,478,887	$0	$0	$0	$37,565,608	$0	$55,455,338	$60,178	$196,011,033
	Fee-For-Service														
	Inpatient Services	$7,069	$13,110	$208,357	$0	$45,469	$0	$0	$0	$0	$93,439	$0	$46,660	$0	$414,104
	Outpatient Services	$12,721	$14,262	$252,758	$0	$225,351	$5,949	$0	$0	$0	$282,037	$0	$74,411	$0	$867,489
	Physician Services	$479	$2,275	$30,277	$0	$7,745	$1,425	$0	$0	$0	$8,970	$0	$2,972	$0	$54,143
	Sub-Total Fee-For-Service	$20,269	$29,647	$491,392	$0	$278,565	$7,374	$0	$0	$0	$384,446	$0	$124,043	$0	$1,335,736
	Total FY 2007-08 Expenditures	**$5,805,825**	**$8,634,292**	**$74,506,793**	**$0**	**$13,323,985**	**$1,486,261**	**$0**	**$0**	**$0**	**$37,950,054**	**$0**	**$55,579,381**	**$60,178**	**$197,346,769**
FY 2008-09	Capitations	$6,149,782	$9,745,116	$82,387,483	$0	$15,504,797	$1,521,747	$0	$0	$0	$43,714,042	$0	$56,764,896	$73,074	$215,860,937
	Fee-For-Service														
	Inpatient Services	$22,235	$9,653	$322,211	$0	$107,478	$0	$0	$0	$0	$171,764	$0	$8,913	$0	$642,254
	Outpatient Services	$9,657	$19,613	$264,495	$0	$291,393	$9,164	$0	$0	$0	$364,710	$0	$103,091	$0	$1,062,123
	Physician Services	$285	$1,580	$35,787	$0	$10,873	$1,513	$0	$0	$0	$13,685	$0	$8,153	$0	$71,876
	Sub-Total Fee-For-Service	$32,177	$30,846	$622,493	$0	$409,744	$10,677	$0	$0	$0	$550,159	$0	$120,157	$0	$1,776,253
	Total FY 2008-09 Expenditures	**$6,181,959**	**$9,775,962**	**$83,009,976**	**$0**	**$15,914,541**	**$1,532,424**	**$0**	**$0**	**$0**	**$44,264,201**	**$0**	**$56,885,053**	**$73,074**	**$217,637,190**
	% Change from FY 2007-08	**6.48%**	**13.22%**	**11.41%**	**0.00%**	**19.44%**	**3.11%**	**0.00%**	**0.00%**	**0.00%**	**16.64%**	**0.00%**	**2.35%**	**21.43%**	**10.28%**
FY 2009-10 [1]	Capitations	$5,714,066	$10,837,828	$87,637,180	$0	$19,027,843	$1,579,130	$0	$643,078	$0	$49,749,580	$0	$51,334,158	$97,955	$226,620,818
	Fee-For-Service														
	Inpatient Services	$36,707	$0	$327,355	$0	$23,679	$0	$0	$1,024	$0	$184,094	$0	$23,702	$0	$596,561
	Outpatient Services	$18,805	$35,433	$493,185	$0	$575,312	$23,538	$0	$24,891	$0	$601,664	$0	$139,423	$0	$1,912,251
	Physician Services	$61	$631	$45,028	$0	$4,747	$1,591	$0	$205	$0	$22,296	$0	$4,291	$0	$78,850
	Sub-Total Fee-For-Service	$55,573	$36,064	$865,568	$0	$603,738	$25,129	$0	$26,120	$0	$808,054	$0	$167,416	$0	$2,587,662
	Total FY 2009-10 Expenditures	**$5,769,639**	**$10,873,892**	**$88,502,748**	**$0**	**$19,631,581**	**$1,604,259**	**$0**	**$669,198**	**$0**	**$50,557,634**	**$0**	**$51,501,574**	**$97,955**	**$229,208,480**
	% Change from FY 2008-09	**-6.67%**	**11.23%**	**6.62%**	**0.00%**	**23.36%**	**4.69%**	**0.00%**	**0.00%**	**0.00%**	**14.22%**	**0.00%**	**-9.46%**	**34.05%**	**5.32%**
FY 2010-11 [1]	Capitations	$6,265,262	$12,890,748	$99,689,062	$0	$21,770,317	$1,717,419	$0	$7,654,920	$0	$57,953,130	$0	$43,070,676	$134,493	$251,146,027
	Fee-For-Service														
	Inpatient Services	$26,281	$0	$462,018	$0	$54,952	$0	$0	$18,405	$0	$209,493	$0	$31,297	$0	$802,446
	Outpatient Services	$19,668	$54,047	$784,682	$0	$778,402	$26,955	$0	$260,702	$0	$843,338	$0	$204,022	$0	$2,971,816
	Physician Services	$44	$559	$53,093	$0	$8,634	$2,017	$0	$2,892	$0	$19,019	$0	$10,074	$0	$96,331
	Sub-Total Fee-For-Service	$45,993	$54,606	$1,299,792	$0	$841,988	$28,972	$0	$281,999	$0	$1,071,850	$0	$245,393	$0	$3,870,594
	Total FY 2010-11 Expenditures	**$6,311,255**	**$12,945,354**	**$100,988,854**	**$0**	**$22,612,305**	**$1,746,391**	**$0**	**$7,936,919**	**$0**	**$59,024,980**	**$0**	**$43,316,069**	**$134,493**	**$255,016,621**
	% Change from FY 2009-10	**9.39%**	**19.05%**	**14.11%**	**0.00%**	**15.18%**	**8.86%**	**0.00%**	**1086.03%**	**0.00%**	**16.75%**	**0.00%**	**-15.89%**	**37.30%**	**11.26%**
FY 2011-12	Capitations	$6,501,731	$14,198,785	$106,568,343	$91,679	$25,412,054	$1,751,883	$0	$10,138,129	$91,244	$67,777,256	$0	$38,817,457	$158,074	$271,506,635
	Fee-For-Service														
	Inpatient Services	$21,297	$12,590	$343,228	$0	$48,185	$0	$0	$18,329	$0	$176,653	$0	$11,869	$0	$632,151
	Outpatient Services	$19,808	$66,220	$696,219	$423	$873,401	$25,278	$0	$332,229	$13,232	$980,428	$0	$156,434	$0	$3,163,672
	Physician Services	$0	$580	$48,421	$0	$12,402	$1,159	$0	$4,718	$0	$23,508	$0	$5,786	$0	$96,575
	Sub-Total Fee-For-Service	$41,105	$79,389	$1,087,868	$423	$933,988	$26,438	$0	$355,276	$13,232	$1,180,589	$0	$174,089	$0	$3,892,397
	Total FY 2011-12 Expenditures	**$6,542,836**	**$14,278,174**	**$107,656,211**	**$92,102**	**$26,346,042**	**$1,778,321**	**$0**	**$10,493,405**	**$104,476**	**$68,957,845**	**$0**	**$38,991,546**	**$158,074**	**$275,399,032**
	% Change from FY 2010-11	**3.67%**	**10.30%**	**6.60%**	**0.00%**	**16.51%**	**1.83%**	**0.00%**	**32.21%**	**0.00%**	**16.83%**	**0.00%**	**-9.98%**	**17.53%**	**7.99%**
FY 2012-13	Capitations	$6,533,297	$15,283,706	$109,667,124	$1,821,870	$27,973,392	$1,990,908	$0	$11,805,595	$12,914,408	$76,537,197	$0	$36,623,205	$152,344	$301,303,046
	Fee-For-Service														
	Inpatient Services	$23,759	$89,128	$568,472	$9,972	$56,164	$0	$0	$5,318	$47,488	$147,305	$0	$26,023	$0	$973,629
	Outpatient Services	$15,873	$70,123	$667,130	$8,815	$977,747	$25,538	$0	$301,289	$270,481	$1,035,757	$0	$140,576	$0	$3,513,329
	Physician Services	$0	$355	$61,247	$0	$5,234	$566	$0	$2,561	$256	$9,712	$0	$2,308	$0	$82,240
	Sub-Total Fee-For-Service	$39,632	$159,606	$1,296,849	$18,788	$1,039,144	$26,104	$0	$309,168	$318,226	$1,192,774	$0	$168,907	$0	$4,569,198
	Total FY 2012-13 Expenditures	**$6,572,929**	**$15,443,312**	**$110,963,973**	**$1,840,658**	**$29,012,536**	**$2,017,012**	**$0**	**$12,114,763**	**$13,232,634**	**$77,729,971**	**$0**	**$36,792,112**	**$152,344**	**$305,872,244**
	% Change from FY 2011-12	**0.46%**	**8.16%**	**3.07%**	**1898.50%**	**10.12%**	**13.42%**	**0.00%**	**15.45%**	**12565.72%**	**12.72%**	**0.00%**	**-5.64%**	**-3.62%**	**11.07%**
FY 2013-14	Capitations	$6,794,071	$16,991,711	$113,813,015	$5,006,888	$38,834,657	$3,584,933	$48,760	$10,148,824	$92,611,488	$87,866,710	$1,056,032	$38,922,470	$253,774	$415,933,333
	Fee-For-Service														
	Inpatient Services	$12,637	$19,104	$626,179	$56,216	$138,091	$0	$0	$9,711	$199,734	$169,677	$12,092	$33,646	$0	$1,277,088
	Outpatient Services	$10,423	$38,587	$501,652	$15,268	$987,859	$49,120	$2,637	$276,800	$1,113,265	$820,427	$64,713	$75,378	$0	$3,956,127
	Physician Services	$50	$1,324	$30,834	$158	$6,611	$1,176	$0	$1,262	$9,088	$10,578	$176	$1,877	$0	$63,135
	Sub-Total Fee-For-Service	$23,110	$59,015	$1,158,665	$71,641	$1,132,562	$50,296	$2,637	$287,773	$1,322,086	$1,000,682	$76,982	$110,901	$0	$5,296,351
	Total FY 2013-14 Expenditures	**$6,817,181**	**$17,050,726**	**$114,971,680**	**$5,078,529**	**$39,967,219**	**$3,635,229**	**$51,397**	**$10,436,597**	**$93,933,574**	**$88,867,392**	**$1,133,014**	**$39,033,371**	**$253,774**	**$421,229,684**
	% Change from FY 2012-13	**3.72%**	**10.41%**	**3.61%**	**175.91%**	**37.76%**	**80.23%**	**0.00%**	**-13.85%**	**609.86%**	**14.33%**	**0.00%**	**6.09%**	**66.58%**	**37.71%**
FY 2014-15	Capitations	$6,926,061	$18,002,789	$116,688,242	$6,942,978	$51,278,862	$3,943,543	$663,374	$31,455,667	$166,708,082	$100,354,417	$14,856,267	$52,005,193	$134,923	$569,960,398
	Fee-For-Service														
	Inpatient Services	$68,648	$24,636	$391,086	$3,405	$41,495	$0	$0	$8,711	$338,450	$106,174	$10,940	$44,071	$0	$1,037,617
	Outpatient Services	$15,159	$52,567	$513,707	$12,542	$1,229,177	$53,357	$6,510	$386,626	$2,835,698	$916,742	$289,394	$109,984	$0	$6,421,463
	Physician Services	$0	$2,696	$37,013	$375	$6,170	$613	$786	$909	$8,980	$6,239	$1,156	$1,407	$0	$66,344
	Sub-Total Fee-For-Service	$83,807	$79,898	$941,806	$16,323	$1,276,841	$53,969	$7,296	$396,247	$3,183,128	$1,029,155	$301,491	$155,462	$0	$7,525,424
	Total FY 2014-15 Expenditures	**$7,009,868**	**$18,082,687**	**$117,630,048**	**$6,959,301**	**$52,555,703**	**$3,997,512**	**$670,670**	**$31,851,914**	**$169,891,210**	**$101,383,572**	**$15,157,758**	**$52,160,655**	**$134,923**	**$577,485,822**
	% Change from FY 2013-14	**2.83%**	**6.05%**	**2.31%**	**37.03%**	**31.50%**	**9.97%**	**0.00%**	**205.19%**	**80.86%**	**14.08%**	**0.00%**	**33.63%**	**-46.83%**	**37.10%**
FY 2015-16	Capitations	$7,502,928	$15,120,720	$101,209,755	$10,130,664	$49,743,555	$3,784,911	$517,191	$54,103,151	$204,989,597	$105,257,829	$13,452,870	$37,281,250	$124,247	$603,218,668
	Fee-For-Service														
	Inpatient Services	$196,797	$103,706	$224,056	$1,491	$24,417	$0	$0	$15,147	$371,092	$101,655	$10,736	$35,382	$0	$1,084,479
	Outpatient Services	$14,779	$58,715	$504,056	$28,379	$1,348,307	$56,200	$4,538	$478,376	$3,016,043	$1,067,081	$217,502	$139,439	$4,516	$6,937,930
	Physician Services	$117	$1,385	$39,249	$282	$3,924	$5,301	$187	$935	$8,821	$1,741	$233	$2,254	$0	$64,431
	Sub-Total Fee-For-Service	$211,694	$163,807	$767,361	$30,152	$1,376,648	$61,502	$4,725	$494,457	$3,395,956	$1,170,477	$228,471	$177,074	$4,516	$8,086,839
	Total FY 2015-16 Expenditures	**$7,714,622**	**$15,284,527**	**$101,977,116**	**$10,160,816**	**$51,120,203**	**$3,846,413**	**$521,916**	**$54,597,608**	**$208,385,553**	**$106,428,306**	**$13,681,341**	**$37,458,324**	**$128,763**	**$611,305,508**
	% Change from FY 2014-15	**10.05%**	**-15.47%**	**-13.31%**	**46.00%**	**-2.73%**	**-3.78%**	**-22.18%**	**71.41%**	**22.66%**	**4.98%**	**-9.74%**	**-28.19%**	**-4.57%**	**5.86%**

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

Exhibit EE - Expenditure Calculations by Eligibility Category

Behavioral Health Capitation Calculations by Eligibility Category for FY 2016-17

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	Expansion Parents & Caretakers	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Weighted Capitation Rate	$18.03	$139.91	$29.07	$16.53	$53.62	$19.87	$125.80	$29.07	
Estimated Monthly Caseload [1]	43,412	85,959	209,008	98,910	366,209	552,392	20,185	286	1,376,361
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	
Total Estimated Costs for FY 2016-17 Q1 and Q2 Capitated Payments	$9,392,620	$144,318,284	$72,910,351	$19,619,788	$235,633,519	$131,712,348	$30,471,276	$99,768	$644,157,954
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	99.46%	99.57%	99.63%	99.44%	99.57%	99.68%	99.84%	99.91%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$9,341,900	$143,697,715	$72,640,583	$19,509,917	$234,620,295	$131,290,868	$30,422,522	$99,678	$641,623,478
Estimated Expenditures for Prior Period Dates of Service	$43,792	$581,581	$213,410	$323,273	$941,378	$405,312	$63,677	$120	$2,572,543
Total Estimated Expenditures in FY 2016-17 Before Adjustments	**$9,385,692**	**$144,279,296**	**$72,853,993**	**$19,833,190**	**$235,561,673**	**$131,696,180**	**$30,486,199**	**$99,798**	**$644,196,021**
Estimated Date of Death Retractions	($103,656)	($371,143)	($17,371)	($7,758)	($137,340)	($7,758)	($21,349)	($776)	($667,151)
Risk Corridor Reconciliation	$0	$0	$0	($973,545)	($23,192,045)	$0	$0	$0	($24,165,590)
Expansion Parents Rate Reconciliation	$0	$0	$0	($18,947,943)	$0	$0	$0	$0	($18,947,943)
Adjustment for Clients Placed in Incorrect Eligibility Types	$0	($3,348,474)	$0	$0	$0	$280,776	$0	$0	($3,067,698)
Total Estimated FY 2016-17 Expenditures Including Adjustments	**$9,282,036**	**$140,559,679**	**$72,836,622**	**($96,056)**	**$212,232,288**	**$131,969,198**	**$30,464,850**	**$99,022**	**$597,347,639**
Estimated FY 2016-17 Adjusted Per Capita Expenditure	**$213.81**	**$1,674.15**	**$348.49**	**$200.44**	**$642.87**	**$238.40**	**$1,509.28**	**$346.23**	**$467.56**

[1] This number is based on the projected average monthly caseload for the entire fiscal year, as applied through each month's trended growth in caseload.

[2] Exhibit EE, pages 4 and 5 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

Exhibit EE - Expenditure Calculations by Eligibility Category

Behavioral Health Capitation Calculations by Eligibility Category for FY 2017-18

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	Expansion Parents & Caretakers	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$18.03	$139.91	$29.07	$16.53	$53.62	$19.87	$125.80	$29.07	
Estimated Monthly Caseload [1]	44,137	89,039	215,934	108,821	391,871	571,582	20,290	179	1,441,853
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	
Total Estimated Costs for FY 2017-18 Capitated Payments	$9,549,481	$149,489,358	$75,326,417	$21,585,734	$252,145,476	$136,288,012	$30,629,784	$62,442	$675,076,704
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	99.46%	99.57%	99.63%	99.44%	99.57%	99.68%	99.84%	99.91%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$9,497,914	$148,846,554	$75,047,709	$21,464,854	$251,061,250	$135,851,890	$30,580,776	$62,386	$672,413,333
Estimated Expenditures for Prior Period Dates of Service	$50,720	$620,569	$269,768	$109,871	$1,013,224	$421,480	$48,754	$90	$2,534,476
Total Estimated Expenditures in FY 2017-18	**$9,548,634**	**$149,467,123**	**$75,317,477**	**$21,574,725**	**$252,074,474**	**$136,273,370**	**$30,629,530**	**$62,476**	**$674,947,809**
Estimated Date of Death Retractions	($93,290)	($334,029)	($15,634)	($6,982)	($123,606)	($6,982)	($19,214)	($698)	($600,435)
Risk Corridor Reconciliation	$0	$0	$0	$0	$0	$0	$0	$0	$0
Expansion Parents Rate Reconciliation	$0	$0	$0	$0	$0	$0	$0	$0	$0
Adjustment for Clients Placed in Incorrect Eligibility Types	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Estimated FY 2017-18 Expenditures Including Adjustments	**$9,455,344**	**$149,133,094**	**$75,301,843**	**$21,567,743**	**$251,950,868**	**$136,266,388**	**$30,610,316**	**$61,778**	**$674,347,374**
Estimated FY 2017-18 Adjusted Per Capita Expenditure	**$214.23**	**$1,674.92**	**$348.73**	**$198.19**	**$642.94**	**$238.40**	**$1,508.64**	**$345.13**	**$467.69**

[1] This number is based on the projected average monthly caseload for the entire fiscal year, as applied through each month's trended growth in caseload.

[2] Exhibit EE, pages 4 and 5 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

Exhibit EE - Expenditure Calculations by Eligibility Category

Behavioral Health Capitation Calculations by Eligibility Category for FY 2018-19

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	Expansion Parents & Caretakers	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$18.24	$143.03	$29.74	$16.90	$54.85	$20.33	$129.48	$29.74	
Estimated Monthly Caseload [1]	44,870	91,656	221,250	116,361	406,112	582,667	20,305	103	1,483,324
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	
Total Estimated Costs for FY 2018-19 Capitated Payments	$9,821,146	$157,314,692	$78,959,700	$23,598,011	$267,302,918	$142,147,441	$31,549,097	$36,759	$710,729,764
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	99.46%	99.57%	99.63%	99.44%	99.57%	99.68%	99.84%	99.91%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$9,768,112	$156,638,239	$78,667,549	$23,465,862	$266,153,515	$141,692,569	$31,498,618	$36,726	$707,921,190
Estimated Expenditures for Prior Period Dates of Service	$51,567	$642,804	$278,708	$120,880	$1,084,226	$436,122	$49,008	$56	$2,663,371
Total Estimated Expenditures in FY 2018-19	**$9,819,679**	**$157,281,043**	**$78,946,257**	**$23,586,742**	**$267,237,741**	**$142,128,691**	**$31,547,626**	**$36,782**	**$710,584,561**
Estimated Date of Death Retractions	($83,961)	($300,626)	($14,071)	($6,284)	($111,245)	($6,284)	($17,293)	($628)	($540,392)
Risk Corridor Reconciliation	$0	$0	$0	$0	$0	$0	$0	$0	$0
Expansion Parents Rate Reconciliation	$0	$0	$0	$0	$0	$0	$0	$0	$0
Adjustment for Clients Placed in Incorrect Eligibility Types	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Estimated FY 2018-19 Expenditures Including Adjustments	**$9,735,718**	**$156,980,417**	**$78,932,186**	**$23,580,458**	**$267,126,496**	**$142,122,407**	**$31,530,333**	**$36,154**	**$710,044,169**
Estimated FY 2018-19 Adjusted Per Capita Expenditure	**$216.98**	**$1,712.71**	**$356.76**	**$202.65**	**$657.77**	**$243.92**	**$1,552.84**	**$351.01**	**$478.68**

[1] This number is based on the projected average monthly caseload for the entire fiscal year, as applied through each month's trended growth in caseload.

[2] Exhibit EE, pages 4 and 5 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

Exhibit EE - Incurred But Not Reported Runout by Fiscal Period

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

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	0.54%	-	-
Incurred in FY 2016-17	99.46%	0.54%	-
Incurred in FY 2017-18	-	99.46%	0.54%
Incurred in FY 2018-19	-	-	99.46%

Incurred But Not Reported (IBNR) Estimate for Disabled Individuals

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	0.43%	-	-
Incurred in FY 2016-17	99.57%	0.43%	-
Incurred in FY 2017-18	-	99.57%	0.43%
Incurred in FY 2018-19	-	-	99.57%

Incurred But Not Reported (IBNR) Estimate for Low Income Adults

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	0.37%	-	-
Incurred in FY 2016-17	99.63%	0.37%	-
Incurred in FY 2017-18	-	99.63%	0.37%
Incurred in FY 2018-19	-	-	99.63%

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

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	0.56%	-	-
Incurred in FY 2016-17	99.44%	0.56%	-
Incurred in FY 2017-18	-	99.44%	0.56%
Incurred in FY 2018-19	-	-	99.44%

Exhibit EE - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for MAGI Adults

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	0.43%	-	-
Incurred in FY 2016-17	99.57%	0.43%	-
Incurred in FY 2017-18	-	99.57%	0.43%
Incurred in FY 2018-19	-	-	99.57%

Incurred But Not Reported (IBNR) Estimate for Eligible Children

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	0.32%	-	-
Incurred in FY 2016-17	99.68%	0.32%	-
Incurred in FY 2017-18	-	99.68%	0.32%
Incurred in FY 2018-19	-	-	99.68%

Incurred But Not Reported (IBNR) Estimate for Foster Care

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	0.16%	-	-
Incurred in FY 2016-17	99.84%	0.16%	-
Incurred in FY 2017-18	-	99.84%	0.16%
Incurred in FY 2018-19	-	-	99.84%

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

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	0.09%	-	-
Incurred in FY 2016-17	99.91%	0.09%	-
Incurred in FY 2017-18	-	99.91%	0.09%
Incurred in FY 2018-19	-	-	99.91%

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

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

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	$43,792	-	-
Incurred in FY 2016-17	$9,341,900	$50,720	-
Incurred in FY 2017-18	-	$9,497,914	$51,567
Incurred in FY 2018-19	-	-	$9,768,112
Total Paid in Current Period	$9,341,900	$9,497,914	$9,768,112
Total IBNR Amount	$43,792	$50,720	$51,567
Total Paid for All Incurred Dates	$9,385,692	$9,548,634	$9,819,679

Incurred But Not Reported (IBNR) Estimate for Disabled Individuals

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	$581,581	-	-
Incurred in FY 2016-17	$143,697,715	$620,569	-
Incurred in FY 2017-18	-	$148,846,554	$642,804
Incurred in FY 2018-19	-	-	$156,638,239
Total Paid in Current Period	$143,697,715	$148,846,554	$156,638,239
Total IBNR Amount	$581,581	$620,569	$642,804
Total Paid for All Incurred Dates	$144,279,296	$149,467,123	$157,281,043

Incurred But Not Reported (IBNR) Estimate for Low Income Adults

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	$213,410	-	-
Incurred in FY 2016-17	$72,640,583	$269,768	-
Incurred in FY 2017-18	-	$75,047,709	$278,708
Incurred in FY 2018-19	-	-	$78,667,549
Total Paid in Current Period	$72,640,583	$75,047,709	$78,667,549
Total IBNR Amount	$213,410	$269,768	$278,708
Total Paid for All Incurred Dates	$72,853,993	$75,317,477	$78,946,257

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

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	$323,273	-	-
Incurred in FY 2016-17	$19,509,917	$109,871	-
Incurred in FY 2017-18	-	$21,464,854	$120,880
Incurred in FY 2018-19	-	-	$23,465,862
Total Paid in Current Period	$19,509,917	$21,464,854	$23,465,862
Total IBNR Amount	$323,273	$109,871	$120,880
Total Paid for All Incurred Dates	$19,833,190	$21,574,725	$23,586,742

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for MAGI Adults

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	$941,378	-	-
Incurred in FY 2016-17	$234,620,295	$1,013,224	-
Incurred in FY 2017-18	-	$251,061,250	$1,084,226
Incurred in FY 2018-19	-	-	$266,153,515
Total Paid in Current Period	$234,620,295	$251,061,250	$266,153,515
Total IBNR Amount	$941,378	$1,013,224	$1,084,226
Total Paid for All Incurred Dates	$235,561,673	$252,074,474	$267,237,741

Incurred But Not Reported (IBNR) Estimate for Eligible Children

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	$405,312	-	-
Incurred in FY 2016-17	$131,290,868	$421,480	-
Incurred in FY 2017-18	-	$135,851,890	$436,122
Incurred in FY 2018-19	-	-	$141,692,569
Total Paid in Current Period	$131,290,868	$135,851,890	$141,692,569
Total IBNR Amount	$405,312	$421,480	$436,122
Total Paid for All Incurred Dates	$131,696,180	$136,273,370	$142,128,691

Incurred But Not Reported (IBNR) Estimate for Foster Care

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	$63,677	-	-
Incurred in FY 2016-17	$30,422,522	$48,754	-
Incurred in FY 2017-18	-	$30,580,776	$49,008
Incurred in FY 2018-19	-	-	$31,498,618
Total Paid in Current Period	$30,422,522	$30,580,776	$31,498,618
Total IBNR Amount	$63,677	$48,754	$49,008
Total Paid for All Incurred Dates	$30,486,199	$30,629,530	$31,547,626

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

	Paid in FY 2016-17	Paid in FY 2017-18	Paid in FY 2018-19
Incurred in all other previous periods	$120	-	-
Incurred in FY 2016-17	$99,678	$90	-
Incurred in FY 2017-18	-	$62,386	$56
Incurred in FY 2018-19	-	-	$36,726
Total Paid in Current Period	$99,678	$62,386	$36,726
Total IBNR Amount	$120	$90	$56
Total Paid for All Incurred Dates	$99,798	$62,476	$36,782

Exhibit FF - Medicaid Behavioral Health Retroactivity Adjustment

Fiscal Year		Adults 65 and Older	Disabled Individuals	Low Income Adults [1]	Expansion Parents & Caretakers [2]	MAGI Adults	Eligible Children	Foster Care
FY 2007-08	Average Monthly Claims	36,907	61,336	69,407	-	-	225,162	17,810
	Average Caseload	36,284	56,079	59,761	-	-	204,022	17,141
	Claims as a Percentage of Caseload	101.72%	109.37%	116.14%	-	-	110.36%	103.90%
FY 2008-09	Average Monthly Claims	37,865	62,496	77,211	-	-	251,445	18,597
	Average Caseload	37,619	57,802	68,850	-	-	235,129	18,033
	Claims as a Percentage of Caseload	100.65%	108.12%	112.14%	-	-	106.94%	103.13%
FY 2009-10	Average Monthly Claims	38,645	65,337	94,478	-	-	290,971	18,842
	Average Caseload	38,487	60,313	82,669	-	-	275,672	18,381
	Claims as a Percentage of Caseload	100.41%	108.33%	114.28%	-	-	105.55%	102.51%
FY 2010-11	Average Monthly Claims	38,337	68,739	127,056	-	-	323,244	18,792
	Average Caseload	38,921	64,052	116,149	-	-	302,410	18,393
	Claims as a Percentage of Caseload	98.50%	107.32%	109.39%	-	-	106.89%	102.17%
FY 2011-12	Average Monthly Claims	39,691	72,084	145,631	-	6,856	351,100	18,402
	Average Caseload	39,740	67,869	136,315	-	6,810	334,633	18,034
	Claims as a Percentage of Caseload	99.88%	106.21%	106.83%	-	100.68%	104.92%	102.04%
FY 2012-13	Estimated Average Monthly Claims	40,123	74,703	159,244	-	10,729	380,186	18,072
	Average Caseload	40,827	71,859	149,305	-	10,634	368,079	17,777
	Claims as a Percentage of Caseload	98.27%	103.96%	106.66%	-	100.89%	103.29%	101.66%
FY 2013-14	Estimated Average Monthly Claims	40,782	77,257	199,988	-	90,902	429,909	18,610
	Average Caseload	41,836	76,837	185,979	-	87,243	424,377	18,267
	Claims as a Percentage of Caseload	97.48%	100.55%	107.53%	-	104.19%	101.30%	101.88%
FY 2014-15 [3]	Estimated Average Monthly Claims	40,840	81,219	179,955	75,187	244,890	501,502	20,194
	Average Caseload	41,817	80,641	178,328	71,989	241,392	495,836	20,036
	Claims as a Percentage of Caseload	97.66%	100.72%	100.91%	104.44%	101.45%	101.14%	100.79%
FY 2015-16 [3]	Estimated Average Monthly Claims	41,084	86,194	179,678	39,378	371,342	530,848	20,020
	Average Caseload	42,403	85,546	179,514	86,964	320,374	526,694	19,935
	Claims as a Percentage of Caseload	96.89%	100.76%	100.09%	45.28%	115.91%	100.79%	100.43%
Weighted Average Claims as a Percentage of Caseload [4]		97.66%	100.72%	100.91%	104.44%	101.45%	101.14%	100.79%
Retroactivity Adjustment Factor		-2.34%	0.72%	0.91%	4.44%	1.45%	1.14%	0.79%

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

[2] Expansion Parents & Caretakers is being reported as its own category beginning FY 2014-15. Prior to that, the category was baked into the Low Income Adults category.

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

[4] The retroactivity adjustment captures the actual monthly claims paid versus average caseload reported. After analyzing the data and historical trends, the Department determined that the most recent year with adequate runout, which in this request is FY 2014-15, most accurately represents the relationship between the claims-based rate and the capitation rate for all eligibility categories.

Exhibit FF - Medicaid Behavioral Health Partial Month Adjustment Multiplier

Fiscal Year		Adults 65 and Older	Disabled Individuals	Low Income Adults [1]	Expansion Parents and Caretakers [5]	MAGI Adults	Eligible Children	Foster Care
FY 2007-08	Weighted Claims-Based Rate	$13.07	$113.61	$17.48	-	-	$13.87	$260.01
	Weighted Capitation Rate	$13.15	$114.07	$17.51	-	-	$13.94	$262.46
	Claims as a Percentage of Capitation	99.36%	99.60%	99.84%	-	-	99.49%	99.07%
FY 2008-09	Weighted Claims-Based Rate	$13.49	$122.69	$18.40	-	-	$14.47	$253.56
	Weighted Capitation Rate [3]	$13.57	$123.19	$18.47	-	-	$14.57	$255.41
	Claims as a Percentage of Capitation	99.42%	99.59%	99.62%	-	-	99.34%	99.27%
FY 2009-10	Weighted Claims-Based Rate	$13.21	$127.20	$18.74	-	-	$14.21	$225.86
	Weighted Capitation Rate [3]	$13.29	$127.70	$18.82	-	-	$14.29	$227.45
	Claims as a Percentage of Capitation	99.40%	99.61%	99.56%	-	-	99.44%	99.30%
FY 2010-11	Weighted Claims-Based Rate	$13.50	$136.46	$20.56	-	-	$15.11	$191.24
	Weighted Capitation Rate [3]	$13.58	$137.00	$20.64	-	-	$15.19	$192.53
	Claims as a Percentage of Capitation	99.44%	99.61%	99.62%	-	-	99.44%	99.33%
FY 2011-12	Weighted Claims-Based Rate	$13.69	$139.19	$21.46	-	$100.82	$16.12	$176.56
	Weighted Capitation Rate	$13.77	$139.69	$21.49	-	$100.83	$16.20	$177.70
	Claims as a Percentage of Capitation	99.42%	99.64%	99.84%	-	100.00%	99.53%	99.36%
FY 2012-13	Weighted Claims-Based Rate	$13.57	$139.85	$21.86	-	$100.67	$16.70	$171.02
	Weighted Capitation Rate	$13.65	$140.33	$21.90	-	$100.97	$16.76	$171.84
	Claims as a Percentage of Capitation	99.40%	99.66%	99.84%	-	99.70%	99.65%	99.52%
FY 2013-14 [2]	Weighted Claims-Based Rate	$13.89	$144.72	$23.99	$23.99	$79.25	$17.18	$174.11
	Weighted Capitation Rate	$13.96	$144.99	$24.05	$24.05	$79.38	$17.22	$174.80
	Claims as a Percentage of Capitation	99.49%	99.82%	99.73%	99.73%	99.84%	99.78%	99.61%
FY 2014-15	Weighted Claims-Based Rate	$14.14	$146.38	$25.95	$25.95	$55.52	$19.18	$215.25
	Weighted Capitation Rate	$14.22	$146.82	$25.96	$25.96	$55.53	$19.20	$215.41
	Claims as a Percentage of Capitation	99.46%	99.70%	99.97%	99.97%	99.98%	99.88%	99.93%
FY 2015-16	Weighted Claims-Based Rate	$16.39	$130.07	$26.64	$54.08	$56.01	$19.84	$165.40
	Weighted Capitation Rate	$16.21	$129.82	$26.87	$19.43	$56.40	$19.96	$166.72
	Claims as a Percentage of Capitation	101.14%	100.19%	99.15%	278.35%	99.32%	99.40%	99.21%
Average Claims as a Percentage of Capitation [4]		99.46%	99.70%	99.97%	99.97%	99.98%	99.88%	99.93%
Partial Month Adjustment Multiplier		-0.54%	-0.30%	-0.03%	-0.03%	-0.02%	-0.12%	-0.07%

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

[2] Expansion Parents and Caretakers is being reported as its own category beginning FY 2013-14. Prior to that, the category was baked in to the Low Income Adults category.

[3] The Department has adjusted the rates paid to the BHOs in FY 2008-09 through FY 2010-11 due to budget actions. The numbers provided here reflects the actual paid rates and therefore do not match the numbers in Exhibit GG, which demonstrate the trend on the actuarial point estimates.

[4] The partial month adjustment captures the difference in the amount paid per claim versus the capitation rate due to paying an adjusted rate for clients enrolled for only part of a month. After analyzing the data and historical trends, the Department determined that the most recent year with adequate runout, which in this request is FY 2014-15, most accurately represents the relationship between the claims-based rate and the capitation rate for all eligibility categories.

[5] Due to system limitations resulting in an incorrect payment rate for Expansion Parents and Caretakers, the partial month multiplier used is set equal to Low Income Adults FY 2015-16 result.

Exhibit GG - Medicaid Behavioral Health Capitation Rate Trends and Forecasts

Capitation Rate Trends

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults [1]	Expansion Parents & Caretakers	MAGI Adults	Eligible Children	Foster Care	Weighted Behavioral Health Total [2]
FY 2007-08 Actuals	**$13.15**	**$114.07**	**$17.51**	**$0.00**	**$0.00**	**$13.94**	**$262.46**	**$40.87**
FY 2008-09 Actuals [3]	**$13.37**	**$121.31**	**$18.18**	**$0.00**	**$0.00**	**$14.34**	**$251.88**	**$39.96**
% Change from FY 2007-08	1.67%	6.35%	3.83%	-	-	2.87%	-4.03%	-2.24%
FY 2009-10 Actuals [3]	**$13.40**	**$131.64**	**$19.33**	**$19.33**	**$0.00**	**$14.71**	**$220.67**	**$38.07**
% Change from FY 2008-09	0.22%	8.52%	6.33%	-	-	2.58%	-12.39%	-4.72%
FY 2010-11 Actuals [3]	**$13.79**	**$139.14**	**$20.94**	**$20.94**	**$0.00**	**$15.41**	**$195.38**	**$37.27**
% Change from FY 2009-10	2.91%	5.70%	8.33%	8.33%	-	4.76%	-11.46%	-2.11%
FY 2011-12 Actuals	**$13.89**	**$140.82**	**$21.69**	**$21.69**	**$100.85**	**$16.33**	**$179.30**	**$36.58**
% Change from FY 2010-11	0.73%	1.21%	3.58%	3.58%	-	5.97%	-8.23%	-1.85%
FY 2012-13 Actuals	**$13.66**	**$140.28**	**$21.89**	**$21.89**	**$100.98**	**$16.75**	**$171.85**	**$36.73**
% Change from FY 2011-12	-1.66%	-0.38%	0.92%	0.92%	0.13%	2.57%	-4.16%	0.43%
FY 2013-14 Actuals	**$13.96**	**$144.99**	**$23.98**	**$23.98**	**$79.38**	**$17.22**	**$174.80**	**$40.27**
% Change from FY 2012-13	2.20%	3.36%	9.55%	9.55%	-21.39%	2.81%	1.72%	9.62%
FY 2014-15 Actuals	**$14.22**	**$146.82**	**$25.97**	**$26.01**	**$55.53**	**$19.20**	**$215.41**	**$40.84**
% Change from FY 2013-14	1.86%	1.26%	8.30%	8.47%	-30.05%	11.50%	23.23%	1.43%
FY 2015-16 Actuals	**$16.21**	**$129.82**	**$26.87**	**$19.43**	**$56.40**	**$19.96**	**$166.72**	**$39.80**
% Change from FY 2014-15	13.99%	-11.58%	3.47%	-25.30%	1.57%	3.96%	-22.60%	-2.56%
FY 2016-17 Estimated Weighted Average Rate	**$18.56**	**$139.32**	**$28.82**	**$15.83**	**$52.86**	**$19.67**	**$124.90**	**$38.61**
% Change from FY 2015-16	14.50%	7.32%	7.26%	-18.53%	-6.28%	-1.45%	-25.08%	-2.99%
FY 2017-18 Estimated Weighted Average Rate	**$18.56**	**$139.32**	**$28.82**	**$15.83**	**$52.86**	**$19.67**	**$124.90**	**$38.62**
% Change from FY 2016-17	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%
FY 2018-19 Estimated Weighted Average Rate	**$18.78**	**$142.43**	**$29.48**	**$16.19**	**$54.08**	**$20.12**	**$128.55**	**$39.51**
% Change from FY 2017-18	1.19%	2.23%	2.29%	2.27%	2.31%	2.29%	2.92%	2.30%

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

[2] The Weighted Behavioral Health Total is the weighted capitation rate distributed by Behavioral Health Organization (BHO) across each eligibility category based on the total number of claims processed (i.e. Elderly clients age 65 and over make up a percentage of all client claims, and each BHO services some subset of the total number of claims for Elderly clients).

[3] The Department has adjusted the rates paid to the BHOs in FY 2008-09 through FY 2010-11 due to budget actions. The numbers provided, here, reflects the actuarial point estimates prior to budget actions and therefore do not match the numbers in Exhibit FF, which demonstrate the actual paid rates to the BHOs.

Exhibit GG - Medicaid Behavioral Health Capitation Rate Trends and Forecasts

Capitation Rate Across Eligibility Categories

Fiscal Year	Adults 65 and Older	Disabled Individuals	Low Income Adults	Expansion Parents & Caretakers	MAGI Adults	Eligible Children	Foster Care	Total
FY 2007-08 Average Caseload	36,284	56,079	60,031			204,022	17,141	373,557
Percentage of Total Caseload	9.71%	15.01%	16.07%			54.62%	4.59%	100.00%
FY 2007-08 Average Weighted Capitation Rate	$13.15	$114.07	$17.51			$13.94	$262.46	$40.87
FY 2008-09 Average Caseload	37,619	57,802	69,167			235,129	18,033	417,750
Percentage of Total Caseload	9.01%	13.84%	16.56%			56.28%	4.32%	100.00%
FY 2008-09 Average Weighted Capitation Rate	$13.37	$121.31	$18.18			$14.34	$251.88	$39.96
FY 2009-10 Average Caseload	38,487	60,313	83,094	3,238		275,672	18,381	479,185
Percentage of Total Caseload	8.03%	12.59%	17.34%	0.68%		57.53%	3.84%	100.00%
FY 2009-10 Average Weighted Capitation Rate	$13.40	$131.64	$19.33	$19.33		$14.71	$220.67	$38.07
FY 2010-11 Average Caseload	38,921	64,052	89,513	27,167		302,410	18,393	540,456
Percentage of Total Caseload	7.20%	11.85%	16.56%	5.03%		55.95%	3.40%	100.00%
FY 2010-11 Average Weighted Capitation Rate	$13.79	$139.14	$20.94	$20.94		$15.41	$195.38	$37.27
FY 2011-12 Average Caseload	39,740	67,869	101,451	35,461	1,134	334,633	18,034	598,322
Percentage of Total Caseload	6.64%	11.34%	16.96%	5.93%	0.19%	55.93%	3.01%	100.00%
FY 2011-12 Average Weighted Capitation Rate	$13.89	$140.82	$21.69	$21.69	$100.85	$16.33	$179.30	$36.58
FY 2012-13 Average Caseload	40,827	71,859	108,383	41,545	10,634	368,079	17,777	659,104
Percentage of Total Caseload	6.19%	10.90%	16.44%	6.30%	1.61%	55.85%	2.70%	100.00%
FY 2012-13 Average Weighted Capitation Rate	$13.66	$140.28	$21.89	$21.89	$100.98	$16.75	$171.85	$36.73
FY 2013-14 Average Caseload	41,836	76,837	139,456	47,082	87,243	424,377	18,267	835,098
Percentage of Total Caseload	5.01%	9.20%	16.70%	5.64%	10.45%	50.82%	2.19%	100.00%
FY 2013-14 Average Weighted Capitation Rate	$13.96	$144.99	$23.98	$23.98	$79.38	$17.22	$174.80	$40.27
FY 2014-15 Average Caseload	41,817	80,641	178,728	71,989	241,392	495,836	20,036	1,130,439
Percentage of Total Caseload	3.70%	7.13%	15.81%	6.37%	21.35%	43.86%	1.77%	100.00%
FY 2014-15 Average Weighted Capitation Rate	$14.22	$146.82	$25.97	$25.97	$55.53	$19.20	$215.41	$40.84
FY 2015-16 Average Caseload	42,403	85,546	179,836	86,964	320,374	526,694	19,935	1,261,752
Percentage of Total Caseload	3.36%	6.78%	14.25%	6.89%	25.39%	41.74%	1.58%	100.00%
FY 2015-16 Average Weighted Capitation Rate	$16.21	$129.82	$26.87	$19.43	$56.40	$19.96	$166.72	$39.80
FY 2016-17 Estimated Average Caseload	43,412	85,959	209,294	98,910	366,209	552,392	20,185	1,376,361
Percentage of Total Caseload	3.15%	6.25%	15.21%	7.19%	26.61%	40.13%	1.47%	100.00%
FY 2016-17 Average Weighted Capitation Rate	$18.56	$139.32	$28.82	$15.83	$52.86	$19.67	$124.90	$38.61
FY 2017-18 Average Estimated Caseload	44,137	89,039	216,113	108,821	391,871	571,582	20,290	1,441,853
Percentage of Total Caseload	3.06%	6.18%	14.99%	7.55%	27.18%	39.64%	1.41%	100.00%
FY 2017-18 Average Weighted Capitation Rate	$18.56	$139.32	$28.82	$15.83	$52.86	$19.67	$124.90	$38.62
FY 2018-19 Average Estimated Caseload	44,870	91,656	221,353	116,361	406,112	582,667	20,305	1,483,324
Percentage of Total Caseload	3.02%	6.18%	14.92%	7.84%	27.38%	39.28%	1.37%	100.00%
FY 2018-19 Average Weighted Capitation Rate	$18.78	$142.43	$29.48	$16.19	$54.08	$20.12	$128.55	$39.51

Exhibit HH - Forecast Model Comparisons - Final Forecasts

Adjustment Factors for Forecasted Rates

Model	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults [1]	Expansion Parents & Caretakers	MAGI Adults	Eligible Children	Foster Care
FY 2016-17 Rate							
Weighted Capitation Point Estimate	**$18.56**	**$139.32**	**$28.82**	**$15.83**	**$52.86**	**$19.67**	**$124.90**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.34%	0.72%	0.91%	4.44%	1.45%	1.14%	0.79%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.54%	-0.30%	-0.03%	-0.03%	-0.02%	-0.12%	-0.07%
Final Adjustment Factor [2]	**-2.87%**	**0.42%**	**0.88%**	**4.41%**	**1.43%**	**1.02%**	**0.72%**
FY 2016-17 Final Estimated Paid Rate [3]	**$18.03**	**$139.91**	**$29.07**	**$16.53**	**$53.62**	**$19.87**	**$125.80**
FY 2017-18 Estimated Rate							
Weighted Capitation Point Estimate	**$18.56**	**$139.32**	**$28.82**	**$15.83**	**$52.86**	**$19.67**	**$124.90**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.34%	0.72%	0.91%	4.44%	1.45%	1.14%	0.79%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.54%	-0.30%	-0.03%	-0.03%	-0.02%	-0.12%	-0.07%
Final Adjustment Factor [2]	**-2.87%**	**0.42%**	**0.88%**	**4.41%**	**1.43%**	**1.02%**	**0.72%**
FY 2017-18 Final Estimated Rate [3]	**$18.03**	**$139.91**	**$29.07**	**$16.53**	**$53.62**	**$19.87**	**$125.80**
FY 2018-19 Estimated Rate							
Weighted Capitation Point Estimate	**$18.78**	**$142.43**	**$29.48**	**$16.19**	**$54.08**	**$20.12**	**$128.55**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.34%	0.72%	0.91%	4.44%	1.45%	1.14%	0.79%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.54%	-0.30%	-0.03%	-0.03%	-0.02%	-0.12%	-0.07%
Final Adjustment Factor [2]	**-2.87%**	**0.42%**	**0.88%**	**4.41%**	**1.43%**	**1.02%**	**0.72%**
FY 2018-19 Final Estimated Rate [3]	**$18.24**	**$143.03**	**$29.74**	**$16.90**	**$54.85**	**$20.33**	**$129.48**

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

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

[3] The number presented here reflects the final outcome of payment of partial capitations and the estimate of full IBNR based on that component of IBNR runout that has been completed. Because the IBNR component is estimated, this final figure is estimated and may change in future requests.

Exhibit HH - Forecast Model Comparisons - Capitation Trend Models

Capitation Rate Forecast Model for FY 2017-18 & FY 2018-19

Model	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults [1]	Expansion Parents & Caretakers	MAGI Adults	Eligible Children	Foster Care
FY 2015-16 Actual Rate	$14.22	$146.82	$25.97	$26.01	$55.53	$19.20	$215.41
FY 2016-17 Estimated Average Rate	$18.56	$139.32	$28.82	$15.83	$52.86	$19.67	$124.90
% Growth from FY 2015-16 to FY 2016-17 Rate	30.52%	-5.11%	10.97%	-39.14%	-4.81%	2.45%	-42.02%
Selected Trend Models							
Average Growth Model	$19.31	$142.69	$30.47	$15.78	$47.16	$20.44	$116.01
% Difference from FY 2016-17	4.05%	2.42%	5.73%	-0.31%	-10.78%	3.94%	-7.12%
Two Period Moving Average Model	$17.39	$134.57	$27.85	$17.63	$54.63	$19.82	$145.81
% Difference from FY 2016-17	-6.33%	-3.41%	-3.38%	11.37%	3.35%	0.74%	16.74%
Exponential Growth Model	$17.16	$183.52	$33.46	$26.41	$41.53	$21.38	$146.65
% Difference from FY 2016-17	-7.54%	31.73%	16.12%	66.85%	-21.43%	8.72%	17.41%
Linear Growth Model	$16.86	$166.16	$29.91	$24.68	$33.53	$20.51	$141.34
% Difference from FY 2016-17	-9.17%	19.26%	3.78%	55.93%	-36.57%	4.29%	13.16%
CY 2016 Forecast Minimum	$16.86	$134.57	$27.85	$15.78	$33.53	$19.82	$116.01
CY 2016 Forecast Maximum	$19.31	$183.52	$33.46	$26.41	$54.63	$21.38	$146.65
% change from FY 2016-17 Rate to Selected FY 2017-18 Capitaltion Rate [2]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2017-18 Forecast Point Estimate	**$18.56**	**$139.32**	**$28.82**	**$15.83**	**$52.86**	**$19.67**	**$124.90**
% change from FY 2017-18 Rate to Selected FY 2018-19 Capitation Rate [3]	1.21%	2.23%	2.30%	2.30%	2.30%	2.30%	2.92%
FY 2018-19 Forecast Point Estimate	**$18.78**	**$142.43**	**$29.48**	**$16.19**	**$54.08**	**$20.12**	**$128.55**

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

[2] Percentage selected to modify capitation rates for FY 2017-18	Adults 65 and Older (OAP-A)	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.	2 Percentage selected to modify capitation rates for FY 2017-18	MAGI Adults/ Expansion Parents & Caretakers	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.
	Disabled Individuals	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.		Eligible Children	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.
	Low Income Adults	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.		Foster Care	The Department does not anticipate that rates will increase. Please reference the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" budget request for more information.
[3] Percentage selected to modify capitation rates for FY 2018-19	Adults 65 and Older (OAP-A)	Trend is the average growth from FY 2010-11 to FY 2014-15.	3 Percentage selected to modify capitation rates for FY 2018-19	MAGI Adults/ Expansion Parents & Caretakers	Trend is equal to Low Income Adults
	Disabled Individuals	Trend is average of FY 2013-14 and FY 2014-15.		Eligible Children	Trend is half of the average growth from FY 2010-11 to FY 2012-13.
	Low Income Adults	Trend is half of the average growth from FY 2008-09 to FY 2012-13.		Foster Care	Trend is growth from FY 2012-13 to FY 2013-14.

Exhibit II - Reconciliations

Total Reconciliations by Fiscal Year

	FY 2014-15 Actuals	FY 2015-16 Actuals	FY 2016-17 Estimate	FY 2017-18 Estimate	FY 2018-19 Estimate
Estimated Reconciliation for FY 2014-15 [1]	$0	$0	($17,524,964)	$0	$0
Estimated Reconciliation for FY 2015-16 [2]	$0	$0	($28,656,267)	$0	$0
Estimated Reconciliation for FY 2016-17	$0	$0	$0	$0	$0
Net Impact of Estimated Reconciliations	$0	$0	($46,181,231)	$0	$0

[1] The reconciliation amount is for the MAGI Adult risk corridor for dates of service in FY 2014-15.

[2] The reconciliation amount is made up of $5,667,081 for the MAGI Adult risk corridor for dates of service in FY 2015-16, $973,545 for the Expansion Parent risk corridor for dates of service in FY 2015-16, and $18,947,943 for system issue that paid the MAGI Adult rate for Expansion Parents for dates of service in FY 2015-16. The Department also expects to recover about $3.1 million for a systems issue that incorrectly paid eligible children the individuals with disabilities rate in FY 2015-16 for a subset of the population.

Reconciliation Fund Splits

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Estimated Reconciliation for FY 2016-17	($46,181,231)	($593,077)	($916,537)	$0	($44,671,617)
Estimated Reconciliation for FY 2017-18	$0	$0	$0	$0	$0
Estimated Reconciliation for FY 2018-19	$0	$0	$0	$0	$0

Exhibit JJ - Alternative Financing Populations [1]

FY 2016-17 Calculation

Capitations

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	10,589	$348.49	$3,690,009	$0	$1,837,624	$0	$1,852,385	50.20%
MAGI Parents and Caretakers 69% - 133% FPL	98,910	$200.44	$19,825,432	$0	$495,636	$0	$19,329,796	97.50%
MAGI Adults	363,387	$642.87	$233,610,144	$0	$5,840,254	$0	$227,769,890	97.50%
Non Newly Eligible	2,822	$642.87	$1,814,189	$0	$259,792	$0	$1,554,397	85.68%
Buy-In for Disabled Individuals	5,844	$1,674.15	$9,783,725	$0	$4,872,295	$0	$4,911,430	50.20%
Continuous Eligibility Financing	38,353	$238.40	$9,143,228	$0	$4,553,328	$0	$4,589,900	50.20%
Total from Hospital Provider Fee Fund	**-**	**-**	**$277,866,727**	**$0**	**$17,858,929**	**$0**	**$260,007,798**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	65,529	$238.40	$15,621,896	$1,854,319	$0	$0	$13,767,577	88.13%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,926	$348.49	$671,186	$79,670	$0	$0	$591,516	88.13%

Fee-for-Service

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
Magi Parents and Caretakers 60% - 68% FPL	10,589	$8.43	$89,262	$0	$44,452	$0	$44,810	50.20%
MAGI Parents and Caretakers 69% - 133% FPL	98,910	$5.69	$562,798	$0	$14,070	$0	$548,728	97.50%
MAGI Adults	363,387	$10.60	$3,851,902	$0	$96,298	$0	$3,755,604	97.50%
Non Newly Eligible	2,822	$10.60	$29,913	$0	$4,284	$0	$25,629	85.68%
Buy-In for Disabled Individuals	5,844	$4.85	$28,343	$0	$14,115	$0	$14,228	50.20%
Continuous Eligibility Financing	38,353	$2.66	$101,869	$0	$50,731	$0	$51,138	50.20%
Total from Hospital Provider Fee Fund	**-**	**-**	**$4,664,087**	**$0**	**$223,950**	**$0**	**$4,440,137**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	65,529	$3.84	$251,631	$29,869	$0	$0	$221,762	88.13%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,926	$2.69	$5,181	$615	$0	$0	$4,566	88.13%

[1] The Department's allocation methodology is described in the Alternative Financing Populations section of this Budget Request.

Exhibit JJ - Alternative Financing Populations [1]

FY 2017-18 Calculation

Capitations

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	10,967	$348.73	$3,824,362	$0	$1,912,181	$0	$1,912,181	50.00%
MAGI Parents and Caretakers 69% - 133% FPL	108,821	$198.19	$21,567,743	$0	$1,186,226	$0	$20,381,517	94.50%
MAGI Adults	388,880	$642.94	$250,027,824	$0	$13,751,530	$0	$236,276,294	94.50%
Non Newly Eligible	2,991	$642.94	$1,923,044	$0	$319,610	$0	$1,603,434	83.38%
Buy-In for Disabled Individuals	6,901	$1,674.92	$11,558,615	$0	$5,779,307	$0	$5,779,308	50.00%
Continuous Eligibility for Children	39,706	$238.40	$9,465,996	$0	$4,732,998	$0	$4,732,998	50.00%
Total from Hospital Provider Fee Fund	**-**	**-**	**$298,367,584**	**$0**	**$27,681,852**	**$0**	**$270,685,732**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	71,890	$238.40	$17,138,732	$2,056,648	$0	$0	$15,082,084	88.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,988	$348.73	$693,268	$83,192	$0	$0	$610,076	88.00%

Fee-for-Service

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	10,967	$8.43	$92,449	$0	$46,224	$0	$46,225	50.00%
MAGI Parents and Caretakers 69% - 133% FPL	108,821	$5.69	$619,191	$0	$34,056	$0	$585,135	94.50%
MAGI Adults	388,880	$10.60	$4,122,128	$0	$226,717	$0	$3,895,411	94.50%
Non Newly Eligible	2,991	$10.60	$31,705	$0	$5,269	$0	$26,436	83.38%
Buy-In for Disabled Individuals	6,901	$4.85	$33,470	$0	$16,735	$0	$16,735	50.00%
Continuous Eligibility Financing	39,706	$2.66	$105,463	$0	$52,731	$0	$52,732	50.00%
Total from Hospital Provider Fee Fund	**-**	**-**	**$5,004,406**	**$0**	**$381,732**	**$0**	**$4,622,674**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	71,890	$3.84	$276,058	$33,127	$0	$0	$242,931	88.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,988	$2.69	$5,348	$642	$0	$0	$4,706	88.00%

[1] The Department's allocation methodology is described in the Alternative Financing Populations section of this Budget Request.

Exhibit JJ - Alternative Financing Populations [1]

FY 2018-19 Calculation

Capitations

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	11,256	$356.76	$4,015,706	$0	$2,007,853	$0	$2,007,853	50.00%
MAGI Parents and Caretakers 69% - 133% FPL	116,361	$202.65	$23,580,458	$0	$1,532,730	$0	$22,047,728	93.50%
MAGI Adults	402,990	$657.77	$265,072,952	$0	$17,229,742	$0	$247,843,210	93.50%
Non Newly Eligible	3,122	$657.77	$2,053,544	$0	$356,701	$0	$1,696,843	82.63%
Buy-In for Disabled Individuals	7,913	$1,712.71	$13,552,697	$0	$6,776,348	$0	$6,776,349	50.00%
Continuous Eligibility Financing	40,480	$243.92	$9,873,762	$0	$4,936,881	$0	$4,936,881	50.00%
Total from Hospital Provider Fee Fund	**-**	**-**	**$318,149,119**	**$0**	**$32,840,255**	**$0**	**$285,308,864**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	74,803	$243.92	$18,245,726	$2,189,487	$0	$0	$16,056,239	88.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	2,050	$356.76	$731,349	$87,762	$0	$0	$643,587	88.00%

Fee-for-Service

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	11,256	$8.43	$94,890	$0	$47,445	$0	$47,445	50.00%
MAGI Parents and Caretakers 69% - 133% FPL	116,361	$5.69	$662,094	$0	$43,036	$0	$619,058	93.50%
MAGI Adults	402,990	$10.60	$4,271,694	$0	$277,660	$0	$3,994,034	93.50%
Non Newly Eligible	3,122	$10.60	$33,093	$0	$5,748	$0	$27,345	82.63%
Buy-In for Disabled Individuals	7,913	$4.85	$38,378	$0	$19,189	$0	$19,189	50.00%
Continuous Eligibility Financing	40,480	$2.66	$107,519	$0	$53,759	$0	$53,760	50.00%
Total from Hospital Provider Fee Fund	**-**	**-**	**$5,207,668**	**$0**	**$446,837**	**$0**	**$4,760,831**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	74,803	$3.84	$287,244	$34,469	$0	$0	$252,775	88.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	2,050	$2.69	$5,515	$662	$0	$0	$4,853	88.00%

[1] The Department's allocation methodology is described in the Alternative Financing Populations section of this Budget Request.

Exhibit KK - Medicaid Behavioral Health Fee-For-Service Forecast

FY 2016-17 Calculation

Components	FY 2015-16 Actual	FY 2016-17 Appropriation	Estimated Change in Total Behavioral Health Caseload			FY 2016-17 Estimate	FY 2016-17 Change from Appropriation
			FY 2015-16 Average Monthly Caseload	FY 2016-17 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$1,084,479	$1,202,553	1,261,752	1,376,361	9.08%	$1,182,986	($19,567)
Outpatient Services	$6,937,930	$7,693,303	1,261,752	1,376,361	9.08%	$7,568,124	($125,179)
Physician Services	$64,431	$71,446	1,261,752	1,376,361	9.08%	$70,283	($1,163)
Total After Prior Year Adjustments	**$8,086,839**	$8,967,301				**$8,821,393**	**($145,909)**

FY 2017-18 Calculation

Components	FY 2016-17 Estimate [(1)]	Estimated Change in Total Behavioral Health Caseload			FY 2017-18 Estimate	FY 2017-18 Change from FY 2016-17 Estimate
		FY 2016-17 Forecasted Average Monthly Caseload	FY 2017-18 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$1,182,986	1,376,361	1,441,853	4.76%	$1,239,277	$56,291
Outpatient Services	$7,568,124	1,376,361	1,441,853	4.76%	$7,928,241	$360,117
Physician Services	$70,283	1,376,361	1,441,853	4.76%	$73,627	$3,344
Total After Prior Year Adjustments	**$8,821,393**				**$9,241,145**	**$419,752**

[1] The FY 2016-17 estimates are the base for the FY 2017-18 estimates.

FY 2018-19 Calculation

Components	FY 2017-18 Estimate [(2)]	Estimated Change in Total Behavioral Health Caseload			FY 2018-19 Estimate	FY 2018-19 Change from FY 2017-18 Estimate
		FY 2017-18 Forecasted Average Monthly Caseload	FY 2018-19 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$1,239,277	1,441,853	1,483,324	2.88%	$1,274,921	$35,644
Outpatient Services	$7,928,241	1,441,853	1,483,324	2.88%	$8,156,275	$228,034
Physician Services	$73,627	1,441,853	1,483,324	2.88%	$75,745	$2,118
Total After Prior Year Adjustments	**$9,241,145**				**$9,506,941**	**$265,796**

[2] The FY 2017-18 estimates are the base for the FY 2018-19 estimates.

Exhibit LL - Global Reasonableness Test for Medicaid Behavioral Health Capitation Payments [1]

	Actual/Estimated Expenditures	Percent Change	Dollar Change	Two-year Rolling Average	Percent Change Two-year Average	Three-year Rolling Average	Percent Change Three-year Average
FY 2007-08 Actual	$197,346,769	-	-	-	-	-	-
FY 2008-09 Actual	$217,637,190	10.28%	$20,290,421	$207,491,980	-	-	-
FY 2009-10 Actual	$229,208,480	5.32%	$11,571,290	$223,422,835	7.68%	$214,730,813	-
FY 2010-11 Actual	$255,016,621	11.26%	$25,808,141	$242,112,551	8.37%	$233,954,097	8.95%
FY 2011-12 Actual	$275,399,032	7.99%	$20,382,411	$265,207,827	9.54%	$253,208,045	8.23%
FY 2012-13 Actual	$305,872,244	11.07%	$30,473,212	$290,635,638	9.59%	$278,762,633	10.09%
FY 2013-14 Actual	$421,229,684	37.71%	$115,357,440	$363,550,964	25.09%	$334,166,987	19.88%
FY 2014-15 Actual	$577,485,822	37.10%	$156,256,138	$499,357,753	37.36%	$434,862,583	30.13%
FY 2015-16 Actual	$611,305,508	5.86%	$33,819,686	$594,395,665	19.03%	$536,673,671	23.41%
FY 2016-17 Appropriation vs. FY 2015-16 Actual	$653,650,029	13.19%	$76,164,207	$614,147,120	22.99%	$565,917,761	30.14%
FY 2016-17 Estimate vs. FY 2015-16 Actual	$597,347,639	3.44%	$19,861,817	$587,416,731	17.63%	$532,021,048	22.34%
FY 2016-17 Estimate vs. FY 2016-17 Appropriation	$597,347,639	-8.61%	($56,302,390)	$587,416,731	-4.35%	$532,021,048	-5.99%
FY 2017-18 Estimate vs. FY 2016-17 Appropriation	$674,347,374	3.17%	$20,697,345	$663,998,702	8.12%	$629,197,183	11.18%
FY 2017-18 Estimate vs. FY 2016-17 Estimate	$674,347,374	12.89%	$76,999,735	$635,847,507	8.24%	$616,393,612	15.86%
FY 2018-19 Estimate vs. FY 2016-17 Appropriation	$710,044,169	8.63%	$56,394,140	$681,847,099	11.02%	$679,347,191	20.04%
FY 2018-19 Estimate vs. FY 2017-18 Estimate	$710,044,169	5.29%	$35,696,795	$692,195,772	8.86%	$660,579,727	7.17%

[1] This analysis compares the percent change between Mental Behavioral Capitation Payments Reported in Exhibit DD. Other Medicaid Behavioral Health Payments have been excluded.

Exhibit	Title of Exhibit
Exhibit C1	Calculation of Current Total Long Bill Group Impact
Exhibit C2	Calculation of Fund Splits
Exhibit C2	Cash Fund Report
Exhibit C2	Disallowance Repayment Schedule
Exhibit C3	CBHP Expenditure Summary
Exhibit C4	CBHP Caseload by Fiscal Year
Exhibit C4	CBHP Caseload by Month
Exhibit C4	CBHP Capitation Payments Per Capita Historical Summary
Exhibit C4	CBHP Historical Expenditure Summary
Exhibit C5	CBHP Trust Fund Population Exhibit
Exhibit C5	Hospital Provider Fee Population Exhibit
Exhibit C5	Enrollment Fees Exhibit
Exhibit C6	Expenditure Calculations by Eligibility Category
Exhibit C6	Incurred But Not Reported Runout by Fiscal Period
Exhibit C6	Incurred But Not Reported Expenditures by Fiscal Period
Exhibit C7	Bottom Line Impact Summary
Exhibit C7	Bottom Line Impact Calculations
Exhibit C8	CBHP Retroactivity Adjustment
Exhibit C8	CBHP Claims Distribution Adjustment Multiplier
Exhibit C9	CBHP Capitation Rate Trends and Forecasts
Exhibit C10	Forecast Model Comparisons - Capitation Trend Models - Final Forecasts

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-03 CHP+

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/20/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	Total	$146,488,318	$0	$146,488,318	$18,510,002	$25,791,819
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,500,441	$0	$2,500,441	($1,878,825)	($2,500,441)
	CF	$19,897,778	$0	$19,897,778	$1,665,246	$2,664,108
	RF	$0	$0	$0	$0	$0
	FF	$124,090,099	$0	$124,090,099	$18,723,581	$25,628,152

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
05. Indigent Care Program - Children's Basic Health Plan Administration	Total	$5,033,274	$0	$5,033,274	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$2,363,824	$0	$2,363,824	($1,759,831)	($1,759,831)
	RF	$0	$0	$0	$0	$0
	FF	$2,669,450	$0	$2,669,450	$1,759,831	$1,759,831
05. Indigent Care Program - Children's Basic Health Plan Medical and Dental Costs	Total	$141,455,044	$0	$141,455,044	$18,510,002	$25,791,819
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,500,441	$0	$2,500,441	($1,878,825)	($2,500,441)
	CF	$17,533,954	$0	$17,533,954	$3,425,077	$4,423,939
	RF	$0	$0	$0	$0	$0
	FF	$121,420,649	$0	$121,420,649	$16,963,750	$23,868,321

CF Letternote Text Revision Required?	Yes	X	No		**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes		No	X	**See Exhibit C2**
FF Letternote Text Revision Required?	Yes		No	X	
Requires Legislation?	Yes		No	X	

Type of Request? Department of Health Care Policy and Financing Prioritized Request

Interagency Approval or Related Schedule 13s: None

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

FY 2016-17, FY 2017-18, and FY 2018-19 Budget Request

November 2016

TABLE OF CONTENTS

CHILDREN'S BASIC HEALTH PLAN

The following is a description of the budget projection for the Children's Basic Health Plan.

Points of Interest

- Beginning in January 2013, Medicaid eligibility expanded to include children ages 6 to 18 up to 133% Federal Poverty Level (FPL) per SB 11-008 and prenatal clients up to 185% FPL per SB 11-250. Senate bills 11-008 and 11-250 led to a significant decrease in caseload for CHP+ and the effects were previously reported as bottom line adjustments in caseload.
- The Modified Adjusted Gross Income (MAGI), required by the Affordable Care Act of 2010 (ACA) began in October 2013. States are required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in Health Care Exchanges, as well as Medicaid and federal CHIP programs. The changes from the implementation of MAGI were previously reported as bottom line adjustments and are now considered a part of the base caseload. As expected, the implementation of MAGI has resulted in a decrease in caseload.
- Continuous eligibility was implemented for Medicaid Eligible Children and CHP+ Children in March 2014 and the Department has experienced increased growth as a result.
- Beginning in January 2013, systems issues created duplicate payments for CHP+ clients in the State Managed Care Network. The magnitude of these duplication errors has waned considerably.
- In FY 2013-14, prenatal capitations for some clients within 201%-260% FPL experienced systems issues. The issues have been tied to individual income rating codes that represent the following FPL brackets; 185%-200%, 201%-213%, and 214%-225%. This issue was resolved in FY 2014-15.
- After January 2014, an income rating code used to identify clients from 201%-205% changed to 201%-213% as part of the MAGI conversion. Clients under 205% FPL receive funding from the CHP Trust Fund while clients over 205% FPL receive funding from the Hospital Provider Fee (HB 09-1293). The Department is working to identify a discrete FPL for all CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-260% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- The contracted rates for prenatal clients in FY 2016-17 are unchanged from the contracted rates in FY 2014-15.
- In FY 2013-14, a budget amendment was passed to expand dental services in CHP+ in order to bring the program into compliance with the CHIPRA Legislation of 2009. This has resulted in a substantial increase in rates for dental services in FY 2014-15.
- In FY 2014-15, the Department had submitted an estimate for the implementation of HB 09-1353, removing the five-year bar on legal immigrant children and pregnant women. The five-year bar had been removed for Medicaid eligible pregnant adults, but not

for Medicaid Eligible Children and CHP+ clients. The Department's estimate in FY 2013-14 assumed implementation in FY 2014-15, but was actually implemented in FY 2015-16.

- The Department began paying a disallowance in FY 2014-15 due to the expiration of the prenatal waiver used to pay for prenatal clients within the 206%-260% FPL range. Payment details can be found on page R-3.C2-6.

History and Background Information

Children's Basic Health Plan (CBHP), also known as Children's Health Plan *Plus* (CHP+), provides affordable health insurance to children under the age of 19 and pregnant women in low-income families (up to 260% of the federal poverty level) who do not qualify for Medicaid and do not have private insurance. CHP+ offers a defined benefit package that uses privatized administration.

The federal government implemented this program in 1997, giving states an enhanced match on state expenditures for the program. Colorado began serving children in April of 1998. Where available, children enroll in a health maintenance organization. CHP+ also has an extensive self-insured managed care network that provides services to children until they enroll in a selected health maintenance organization, and to those children who do not have geographic access to a health maintenance organization. All pregnant women enrolled in CHP+ receive services through the State's self-funded network.

The number of CHP+ enrollees and their per capita costs fluctuate due to changes in economic conditions, federal and state policies, and a number of other factors, resulting in changes in CHP+ program expenditures. Changes in funding from sources such as the Tobacco Master Settlement Agreement and Tobacco Taxes also increase the volatility in funding needs. Thus, the Department periodically updates its caseload and expenditure forecast based on recent experience and submits funding requests to the General Assembly. This ensures that the Department has sufficient spending authority to cover expenditures for CHP+ clients and the program's administration.

The eligible CHP+ populations are:

- Children to 205% FPL (Medical and Dental)
- Children 206%-260% FPL (Medical and Dental)
- Prenatal to 205% FPL
- Prenatal 206%-260% FPL

CBHP CAPITATION PAYMENTS

The CBHP Capitation Payments line item reflects the appropriation that funds CBHP services throughout Colorado through managed care providers contracted by the Department. CHP+ children are served by either a health maintenance organization (HMO) at a fixed monthly cost, or by the State's managed care network (SMCN), which is administered by a no-risk provider. Actual and estimated caseload ratios between HMOs and the self-funded network are used to develop blended capitation rates and per capita costs. All clients in the prenatal program are served by the self-funded program (SMCN) administered by Colorado Access and the costs of their services are billed in full directly to the State.

The CHP+ Third Party Administrator (TPA) contract was re-bid for FY 2008-09, and Colorado Access was selected as the new vendor.

The dental vendor contract was re-bid for FY 2007-08, and a new contract was executed with Delta Dental. As part of the re-bid process, Delta Dental was able to offer an increased benefits package. These changes included increasing the cap on dental benefits from $500 to $600 per year, removing the age limit on sealants and fluoride varnishes, and increasing the cap on fluoride varnishes from one to two per year. In FY 2013-14, there was a budget amendment passed (BA-11) to align the CHP+ oral health care benefits with the CHIPRA legislation of 2009. CHP+ dental coverage had been lacking periodontics care, orthodontic care, prosthodontic care, and the required coverage of all medically necessary oral health care. Such services were added to the scope of coverage and the dental program's annual maximum was increased from $600 to $1000. These changes in the oral health care benefits led to significant increases in the dental rates for FY 2014-15.

Effective July 1, 2010, the Department implemented a new reimbursement schedule for hospital payments. While the hospitals were paid 44% of billed charges in FY 2009-10, in FY 2010-11 they were paid 135% of the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and 135% of the Colorado Medicaid Outpatient Cost-to-Charge ratio for outpatient services. This means that the program has essentially adopted the Medicaid reimbursement methodologies. This change in reimbursement methodologies resulted in significant savings in the SMCN, which is reflected in the negative trend in the children's per capita cost in FY 2010-11.

Analysis of Historical Expenditure Allocations across Eligibility Categories

Historical expenditure allocations across eligibility categories reflects the expenditures reported in the Colorado Financial Reporting System (COFRS). Beginning July 1, 2014, the Department transitioned from COFRS to Colorado Operations Resource Engine (CORE). Historical expenditure through FY 2013-14 is from COFRS and historical expenditure from FY 2014-15 and ongoing is from CORE.

Description of Transition to New Methodology

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per-capita rates, the Department has moved to a capitation trend forecast model beginning with the FY 2014-15 Request. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends for each eligibility category, rather than a weighted rate for all categories, future expenditures are forecasted per the characteristics of a specific eligibility category: the actuarially agreed-upon capitation rate and caseload for the nine categories rather than the previous three (children's medical, children's dental, and prenatal). In addition to viewing the nine eligibility categories separately, the Department has divided up the categories further to analyze each group that has a specific rate. This grouping separates by age as well as FPL. The different age groups apply only to children: 0-1, 2-5, and 6-18. The same FPL brackets apply to both children and prenatal: under 100%, 101%-150%, 151%-200%, 201%-205%, and 206%-260%. These individual analyses are then aggregated in the FPL brackets 0%-205% and 206%-260%. The age groups are each considered separately. By tying forecasted capitation rates directly to each category, the methodology may provide more accurate estimates of expenditures by eligibility category as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to health maintenance organizations and the state managed care network.

In estimating the future per capita costs, the Department has also started incorporating claims distribution and retroactivity adjustments to the projected rates beginning with the November 2013 request. The adjustments are described in further detail in Exhibit C8 (page R-3.12)

Additionally, the Department has incorporated an incurred but not reported methodology similar to the Medicaid Behavioral Health Program Request submitted by the Department. The Department is adjusting its request to capture the reality that some CBHP claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

The following narrative describes in greater detail the assumptions and calculations used in developing the current year and out-year for the Children's Basic Health Plan. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted.

EXHIBIT C1 - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

Effective with the November 1, 2013 Budget Request, the Department includes Exhibit C1 which presents a concise summary of spending authority affecting Children's Basic Health Plan. In this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected current year expenditures from Exhibit C2. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

For the request year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected request year expenditure from exhibit C2 (pages R-3.C2-1 through R-3.C2-3). The difference between the two figures is the Department's Funding Request in the November Budget Request and the Department's Budget Amendment in the February Supplemental Budget Request.

EXHIBIT C2 - CALCULATION OF FUND SPLITS

Exhibit C2 details fund splits for all Children's Basic Health Plan budget lines for the current fiscal year Supplemental and the out-year Budget Request. Capitation expenditures are split between traditional clients and expansion clients. The State share for the traditional clients (0%-205% FPL) is funded from the CBHP Trust fund and the State share for expansion clients (206%-260% FPL) is funded from Hospital Provider Fee funds (HB 09-1293).

The enhanced CHP+ FMAP was raised from 65.71% to 88.50% in October 2015. The average for the State Fiscal Year 2015-16 was 82.80%. The Patient Protection and Affordable Care Act (Sec. 2101 (a)) enhanced the CHP+ FMAP 23 percentage points beginning October 1, 2015 through September 30, 2019 (SSA 2105 (b)). The projected FMAP for FY 2016-17 is 88.13% and the projected FMAP for FY 2017-18 is 88.00%. Due to this 23 percentage point increase, the Department forecasts that the CBHP Trust Fund will be sufficient for the State share of CHP+ expenditures beginning in FY 2015-16 and ongoing. The total amount attributed to the General Fund in FY 2016-17 and FY 2017-18 is due to the disallowance payments, discussed above. The Department is also expecting to recover payments in FY 2016-17 for prior year dates of service. Due to state fiscal rules, the Department is unable to offset current year expenditure for prior year recoveries, and therefore, the recoveries are counted as revenue to cash funds.

EXHIBIT C3 - CHILDREN'S BASIC HEALTH PLAN SUMMARY

Exhibit C3 presents a summary of Children's Basic Health Plan caseload and capitation expenditures itemized by eligibility category and a summary of the bottom line adjustments to expenditure, as well as expenditures for CBHP Administration. The net capitation payments include the impacts of the reconciliations for manual enrollments. Exhibit C6 illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT C4 - CBHP CASELOAD

Exhibit C4 contains the caseload history for each of the eligibility categories broken down by poverty level (0%-205% and 206%-260%) and also broken down by age group for children's categories (ages 0-1, 2-5, and 6-18). Each of the tables that comprise Exhibit C4 is described below. Forecast details for CHP+ caseload can be found starting on page R-3.22 of this narrative.

Children's Basic Health Plan Caseload by Fiscal Year

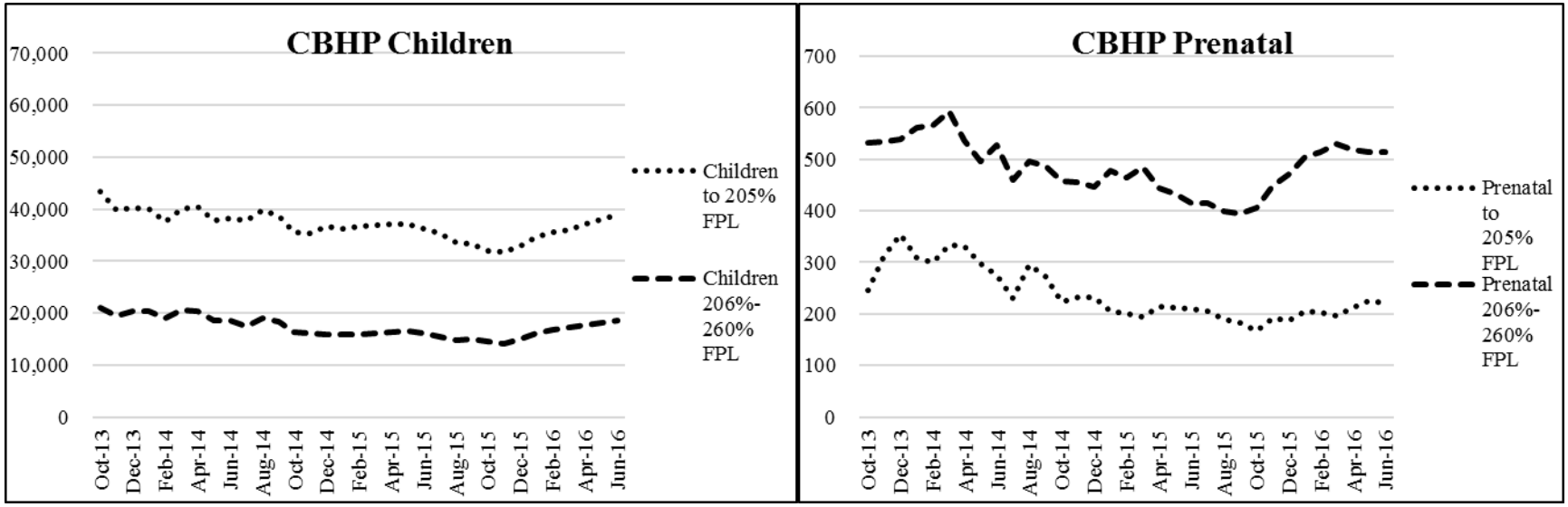
Caseload for the Children's Basic Health Plan is displayed in one table showing caseload by all CHP+ eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The caseload numbers are used in numerous exhibits throughout the Children's Basic Health Plan Exhibits and narrative. Caseload numbers for children are used twice, once for medical and once for dental.

Caseload forecast by fiscal year shows the final estimated caseload, caseload adjustments, and base caseload. Caseload adjustments in this request include the estimates for the implementation of HB 09-1353 (which removes the 5 year bar on legal immigrant children and pregnant women).

Children's Basic Health Plan Caseload by Month

These tables show the actual caseload by month as reported in the JBC monthly report for the three most recent fiscal years. The data in this table is what the Department uses to forecast monthly caseload. The Department experienced variance between MMIS and CMBS numbers for the first half of FY 2015-16, but the data normalized back to historical levels in the second half of the year. The variance no longer seems to be a concern.

As can be seen in the graphs shown below and on page R-3.C4-5, From January 2013 to January 2014 caseload decreased steadily for populations under 205% FPL, due to the implementation of SB 11-008 and SB 11-250 and the MAGI conversion, and increasing for populations above 205% FPL. The most recent months (October 2013 – June 2016) seem to have remained relatively steady.



Children's Basic Health Plan Per Capita Historical Summary

Children's Basic Health Plan per capita is displayed in one table. The table displays per capita by all CBHP eligibility categories; children categories are displayed twice to show medical and dental per capita. Figures for fiscal years up to the present fiscal year are actual per capita, while the current fiscal year and the request year per capita are estimates. Calculated per capita in Exhibit C4-Per Capita Historical Summary represent the estimated per capita including all expenditure adjustments for the given fiscal year. Forecasted per capita without bottom line adjustments can be found in exhibit C6, pages R-3.C6-1 through R-3.C6-3. Calculations are described in exhibits C6 through C10 (pages R-3.10 through R-3.16).

The final per capita for Children's Medical and Dental expenditures increased greatly for all FPL categories in FY 2013-14. This is due to a large increase in reconciliation payments for manual enrollments. In FY 2012-13, the Department paid approximately $8.5 million for reconciliation payments for manual enrollments. In FY 2013-14, these payments increased to $18.4 million. This resulted in a large increase in final per capita for all children's expenditure categories, and a subsequent decrease in FY 2014-15.

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

Children's Basic Health Plan Historical Expenditures Summary

The history of expenditures shows total capitation expenditures for all CBHP eligibility categories. Medical and dental expenditures are listed separately. Actual expenditures through FY 2013-14 by eligibility category are available from the Colorado Financial Reporting System (COFRS) and actual expenditures for FY 2013-14 are also reported in exhibit C3-Expenditure Summary, page R-3.C3-1. Actual expenditure from FY 2014-15 and forward are from the Colorado Operations Resource Engine (CORE). This exhibit also includes a similar summary of expenditure for all forecast years.

EXHIBIT C5 - CHILDREN'S BASIC HEALTH PLAN FUNDING SOURCES

Traditional Population Expenditures and Funding

This exhibit shows expenditures for the traditional population in isolation and provides additional detail to the calculation of fund splits. Traditional populations include those from 0%-205% FPL. These populations receive the enhanced CHP+ Federal Match and receive cash funds from the CHP Trust Fund, CO Immunization Fund, and Health Care Expansion Fund. Once the available cash funds have been used, the General Fund covers the remaining State share of expenditures for clients under 205% FPL. The available funding from the CHP Trust Fund and the CO Immunization Fund is forecasted using the published projections in the 2016 Tobacco MSA Payment Forecast, allocation changes from HB 16-1408 "Cash Fund Allocations for Health-related Programs", and the actual expenditures from prior years. Calculations can be seen in exhibit C5, page R-3.C5-2.

As described above for exhibit C2, the CHP+ Federal Match increases by 23 percentage points in October 2015. After this increased match, the Department forecasts that the CHP Trust Fund will have sufficient revenue to cover the expenditures of the CHP+ population under 205% FPL. This results in $0 General Fund expenditure for capitation payments. These calculations are shown on page R-3.C5-2.

Expansion Population Expenditures and Funding

HB 09-1293 established a funding mechanism for a series of expansion clients. The set of expansion clients that are funded through the bill are children and prenatal clients with income 206%-260% FPL. These populations also receive the enhanced CHP+ Federal Match.

Services for these clients are funded through the Hospital Provider Fee Cash Fund. This exhibit shows expenditures for the expansion population in isolation and provides additional detail to the calculation of fund splits.

Children's Health Plan Plus Enrollment Fees

Clients above 157% FPL owe an enrollment fee prior to accessing benefits. There is a fee for enrolling either one child, or more than one child. This exhibit shows the assumptions and calculations used to predict the collected enrollment fees. The amount accrued in enrollment fees is exempt from the federal match, so this amount is subtracted from the estimated CHP+ expenditures that can receive a federal match for fund split calculations seen in exhibits C2 and C5 (pages R-3.C2-1 through R-3.C2-3, R-3.C5-2, and R-3.C5-4).

EXHIBIT C6 - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

Exhibit C6 provides capitation expenditure calculations for the current fiscal year and the request year.

The Department has adopted a methodology based on forecasting a capitation rate, multiplying that rate by monthly caseload, multiplying again by the number of months that the forecasted rate will be in effect, and then adjusting for incurred claims that will be paid in subsequent years as well as for claims from former years that will be paid in the year of the request. The methodology is a zero-based budget tool that allows the Department to examine projected expenditures each year without building in inappropriate assumptions, estimates, or calculations from preceding years.

The forecasted capitation rate is derived from exhibits C8 through C10 and will be presented in more detail below. The caseload is the same as displayed in exhibit C4.

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown in the exhibits starting on page R-3.C6-1.

After calculating total expenditure for capitations, the anticipated reconciliation payments for manual enrollments for each fiscal year are estimated and added to total expenditure. The sum of expenditure for capitation payments and reconciliation payments for manual

enrollments is the total CBHP Capitation Payments summarized in exhibit C3. Following the addition of projected reconciliation payments for manual enrollments are any applicable bottom-line impacts to expenditure. Details are discussed below in exhibit C7.

Actuarially Certified Capitation Rates

Capitated rates for the health maintenance organizations are required to be actuarially certified and approved by CMS, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit C6. The methodology for determining the forecasted capitation rate is the subject of exhibits C8 through C10.

Incurred-but-not-Reported Estimates

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred-but-not-reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims incurred in July of the current fiscal year have 11 more months of the fiscal year in which the claims can be paid; however, claims incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years and determined the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Page R-3.C6-4 presents the percentage of claims paid in a twelve-month period that come from that same period and those which come from previous periods.

EXHIBIT C7 - CHILDREN'S BASIC HEALTH PLAN BOTTOM LINE IMPACTS TO EXPENDITURE

Reconciliation payments for manual enrollments

As mentioned above, the Department makes reconciliation payments for clients that were manually enrolled. These are projected by applying growth rates from projected caseload (exhibit C4) and rate inflation (exhibit C9) to the expenditure for reconciliation payments for manual enrollments in the previous fiscal year.

Payments to Federally Qualified Health Centers (FQHCs)/ Rural Health Centers (RHCs)

The Department began making reconciliation payments to FQHCs/RHCs in FY 2013-14, referred to as CHP+ PPS Implementation in the February 2014 request. Services at FQHCs and RHCs are now taken into consideration in the rate setting process as of FY 2014-15,

but there are still reconciliation payments to be made. In FY 2015-16, the Department paid $1,563,307 in reconciliation payments to FQHCs and RHCs for prior years. In FY 2016-17, The Department expects to recoup about $1,000,000 for FQHC/RHC reconciliations and does not expect to recoup any funds thereafter.

Payment for clients that were incorrectly dis-enrolled from CBHP and enrolled into Medicaid

Clients were incorrectly dis-enrolled from CBHP in the first half of FY 2015-16 and enrolled into Medicaid under an individuals with disabilities eligibility. It was determined that this should not have taken place and system issues are being corrected to get all members properly enrolled. As a result of this issue, some HMOs did not receive capitation payments for clients that should have been enrolled. Therefore, the Department expects to make payments of about $1,857,191 in FY 2016-17 to reconcile. Please see caseload narrative for more detail on this issue.

EXHIBIT C8 - CBHP RETROACTIVITY ADJUSTMENT AND CLAIMS DISTRIBUTION ADJUSTMENT MULTIPLIER

Capitations are paid for clients from the date the client's eligibility is effective, resulting in claims paid retroactively. As such, any projection which derives expenditure by using non-retroactive caseload must take into account these retroactive claims. Since expenditures are calculated as the estimated capitation rate multiplied by the non-retroactive caseload, an adjustment for retroactivity can be applied to either the forecasted capitation rate or the caseload figure. In order to maintain the uniform presentation of caseload across all Departmental estimates and requests, the Department chose to make its retroactivity adjustment to the forecasted capitation rate itself.

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the health maintenance organizations (HMOs) and State Managed Care Network (SMCN) to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the CBHP Capitation program. This difference is captured through a partial-month adjustment multiplier.

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last seven years of claims and caseload data. Page R-3.C8-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The Department did experience a significant amount of duplicate claims through calendar year 2013, but these duplicate claims have been removed from this analysis. Historically, the Department's methodology for calculating the retroactivity factor was to use claims and caseload data for each cohort (i.e. Children to 205% FPL Medical, Children to 205% FPL Dental, Children 206%-260% FPL Medical, etc.), but due to trouble identifying a subset of the population, 201%-205% FPL, retroactivity is skewed. As a result, the new methodology used is to calculated an aggregate retroactivity factor based on all children for medical and dental, and all prenatal adults across all FPL groups and use that single factor for both FPL groups for children and prenatal women. Details on the selected retroactivity adjustment can be found on page R-3.C8-1.

Claims Distribution Adjustment Multiplier

To derive the claims distribution adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last seven years of data were examined.

As presented on page R-3.C8-2, for each eligibility category, the amount paid divided by claims was compared to the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual HMO or SMCN). Then, the claims-based rate as a percentage of the capitation rate was calculated, providing a simple comparison of any trend in claims-based rates as compared to capitation rates. Details on the selected claims distribution adjustment for each eligibility can be found on page R-3.C8-2.

EXHIBIT C9 - CBHP CAPITATION RATE TRENDS AND FORECASTS

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e., the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual health maintenance organization or state managed care network) was examined. Exhibit C9 presents historical data as well as the forecasted weighted rates. Rates are first presented by poverty level and age group, and then aggregated by poverty level for all ages.

The weighted rate is presented along with the percentage change from the previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit C10.

Based on the Department's calculations and rate-setting process and input from the health maintenance organizations, the Department's actuaries certify a capitation rate range for each HMO, SMCN, and eligibility type; the Department is permitted to pay any rate within this range and maintain an actuarially sound capitation payment. To develop the range, the actuaries calculate a single rate (the "point estimate") and the upper and lower bounds around this rate that maintain actuarial soundness.

It is important to note the overall weighted point estimate presented in the exhibit is weighted across several factors. First, the rate is weighted within an eligibility category. Within an eligibility category, the rate is weighted by the health maintenance organizations' and state managed care network's proportion of claims processed within that eligibility category, the proportion attributable to each FPL category (0%-100%, 101%-150%, 150%-200%, and above 200%), and for children the proportion for each age range (ages 0-1, 2-5, and 6-18). Next, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the weighted CBHP total rate may not be a clear indicator of the rate trends across all eligibility categories.

Exhibit C9 presents the weighted point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit C6 in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years. Below is a table showing the actual weighted rate for FY 2015-16, and the projected weighted rates through FY 2018-19.

Fiscal Year	Children Medical to 205% FPL	Children Medical 206%-259% FPL	Children Dental to 205% FPL	Children Dental 206%-259% FPL	Prenatal to 205% FPL	Prenatal 206%-259% FPL	Weighted CBHP Total
FY 2015-16 Actuals	**$142.91**	**$140.61**	**$19.25**	**$18.78**	**$980.40**	**$970.08**	**$171.77**
FY 2016-17 Estimated Rate	**$157.18**	**$157.79**	**$20.30**	**$19.04**	**$980.36**	**$970.08**	**187.97**
% Change from FY 2015-16	9.99%	12.22%	5.45%	1.38%	0.00%	0.00%	9.43%
FY 2017-18 Estimated Rate	**$160.57**	**$162.76**	**$21.11**	**$20.00**	**$1,003.17**	**$991.16**	**$192.77**
% Change from FY 2016-17	2.16%	3.15%	3.99%	5.04%	2.33%	2.17%	2.55%
FY 2018-19 Estimated Rate	**$164.41**	**$167.62**	**$22.00**	**$20.86**	**$1,021.52**	**$1,008.20**	**$197.73**
% Change from FY 2017-18	2.39%	2.99%	4.22%	4.30%	1.83%	1.72%	2.57%

EXHIBIT C10 - FORECAST MODEL COMPARISONS

Exhibit C10 produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in exhibit C6. Pages R-3.C10-1 and R-3.C10-2 present the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in exhibit C8.

On page R-3.C10-2, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into page S-3A/BA-3.C10-1. Based on the point estimates, the adjustments presented in Exhibit C8 are then applied and the final, adjusted point estimate is then used in the expenditure calculations of exhibit C6.

Final Forecasts

Page R-3.C10-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page R-3.C10-2 (see below).

The forecasted rate is then adjusted by the claims distribution adjustment multiplier, calculated on page R-3.C8-2. The multiplier is applied to account for the distribution of clients amongst the different HMO's and the SMCN. The average amount paid may not perfectly reflect the estimated claims distribution. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Then the claims-based rate is adjusted a second time, this time by the retroactivity adjustment. From exhibit C8, page R-3.C8-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for exhibit C8, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep CBHP caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to derive the expenditure calculation presented in exhibit C6. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

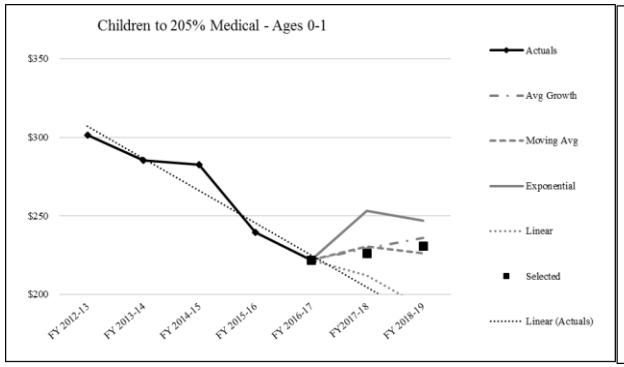
The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page R-3.C10-2.

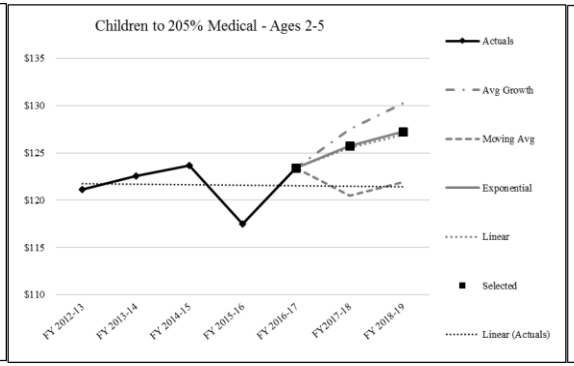
For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

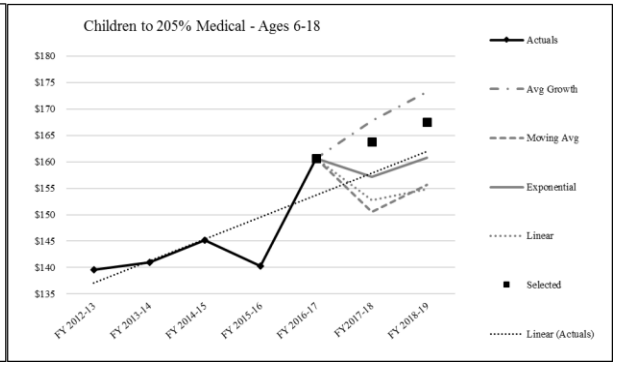
The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

Capitation rates are required to be actuarially sound and are built from a blend of historical rates. The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. The tables beginning on the next page show the trends selected for the current and request years by eligibility category.

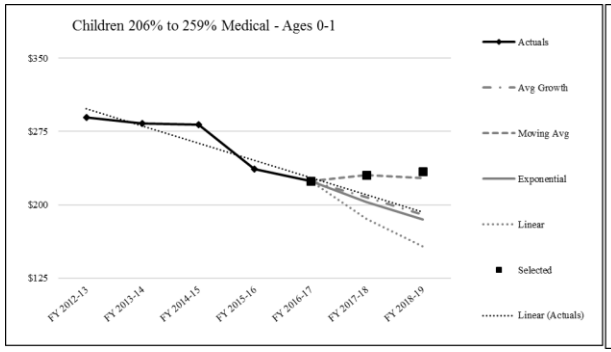
Rate Trends for Children Medical to 205% FPL			
Aid Category	**FY 2017-18 Trend Selection**	**FY 2018-19 Trend Selection**	**Justification**
Children to 205% FPL Medical Ages 0-1	**1.99%**	**1.99%**	Rates for clients ages 0-1 decreased in FY 2016-17. The trend selected is only slightly positive.
	½ Two Period Moving Average Model	Trend selected for FY 2016-17	
Children to 205% FPL Medical Ages 2-5	**1.90%**	**1.90%**	Rates for clients ages 2-5 increased in FY 2016-17. The trend selected is comparable to the growth in rates seen in FY 201-15 and FY 2016-17.
	Exponential Growth Model	Exponential Growth Model	
Children to 205% FPL Medical Ages 6-18	**1.90%**	**2.30%**	Rates for clients ages 6-18 increased significantly in FY 2016-17. In prior years, the rates have been volatile. The trend selected is equal to that of the 2-5 age group.
	Exponential Growth Model of Ages 2-5.	Exponential Growth Model	

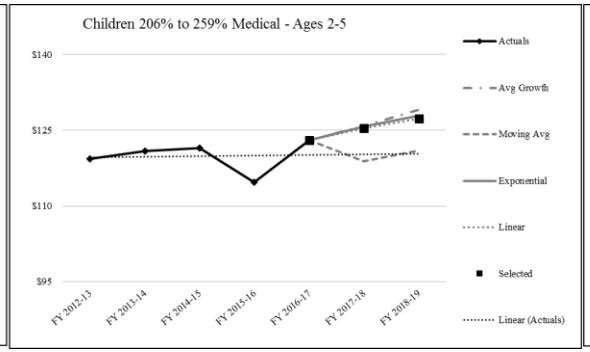


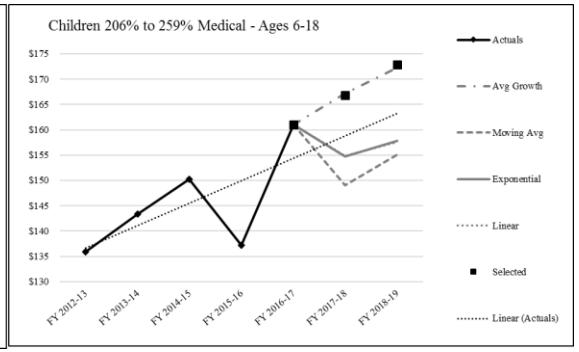




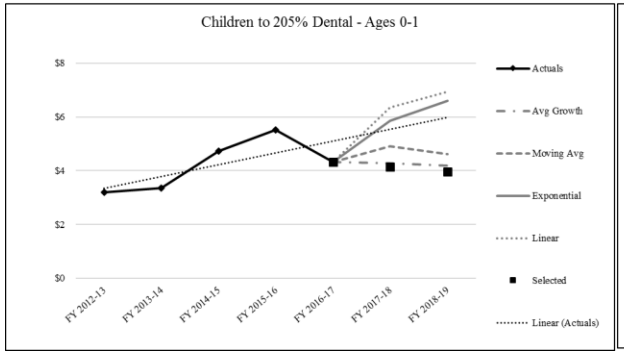
Rate Trends for Children Medical 206% to 260% FPL			
Aid Category	**FY 2017-18 Trend Selection**	**FY 2018-19 Trend Selection**	**Justification**
Children 206% to 260% FPL Medical Ages 0-1	**2.78%%**	**1.39%**	Rates for clients ages 0-1 decreased in FY 2016-17. The trend selected is only slightly positive.
	Two Period Moving Average	½ trend selected for FY 2017-18.	
Children 206% to 260% FPL Medical Ages 2-5	**1.88%**	**1.55%**	Rates for clients ages 2-5 decreased in FY 2015-16. The trend selected is comparable to the growth in rates in FY 2013-14 and FY 2014-15.
	Linear Growth Model	Linear Growth Model	
Children 206% to 260% FPL Medical Ages 6-18	**3.59%**	**3.59%**	Rates for clients ages 6-18 increased in FY 2016-17. In prior years the rates have been volatile. The trend selected is the average of growth in FY 2015-16 and FY 2016-17.
	½ growth from FY 2014-15 to FY 2015-16.	Trend selected for FY 2017-18.	

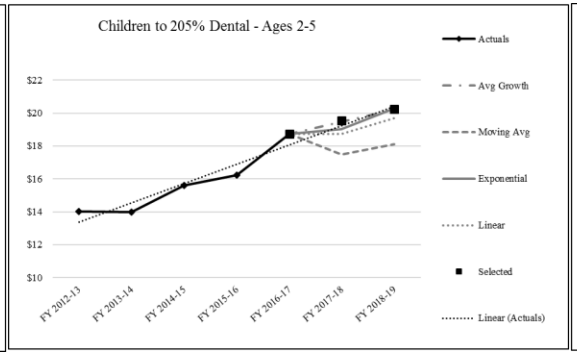


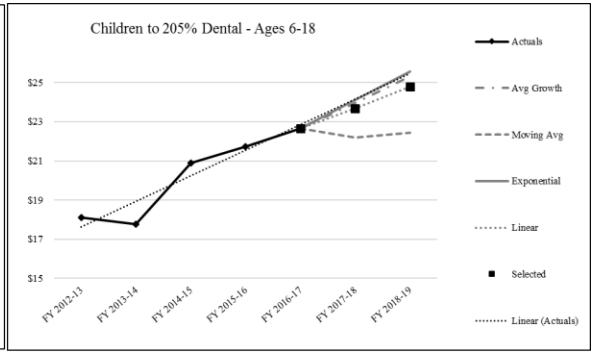




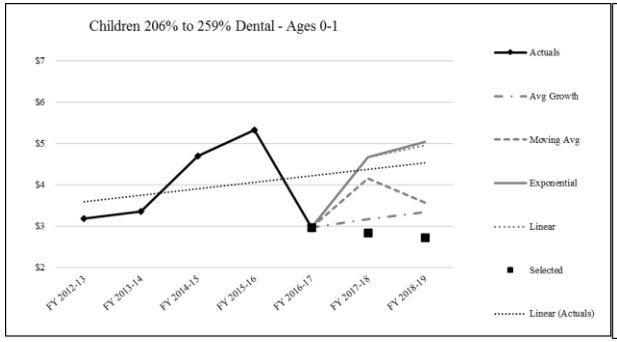
Rate Trends for Children Dental to 205% FPL			
Aid Category	**FY 2017-18 Trend Selection**	**FY 2018-19 Trend Selection**	**Justification**
Children to 205% FPL Dental Ages 0-1	**4.65%** ½ growth from FY 2014-15 to FY 2016-17.	**4.65%** Trend selected for FY 2017-18.	The sharp decline seen in FY 2016-17 is due to an expansion in dental benefits for CHP+ with full data. The Department expects these decreases to slow now that the new benefit package has been available for two years.
Children to 205% FPL Dental Ages 2-5	**4.17%** Growth from FY 2014-15 to FY 2015-16	**3.75%** Average Growth Model	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
Children to 205% FPL Dental Ages 6-18	**4.48%** Linear Growth Model	**4.73%** Linear Growth Model	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.

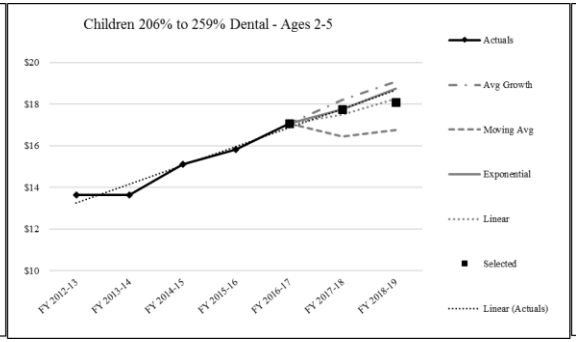


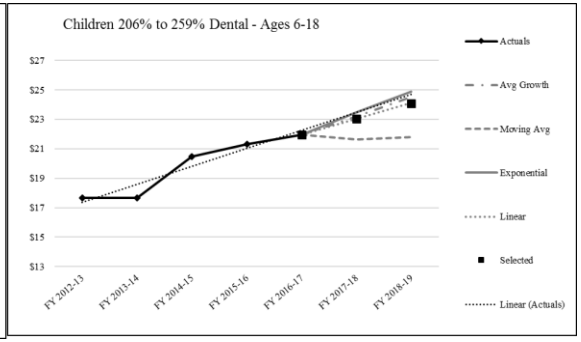




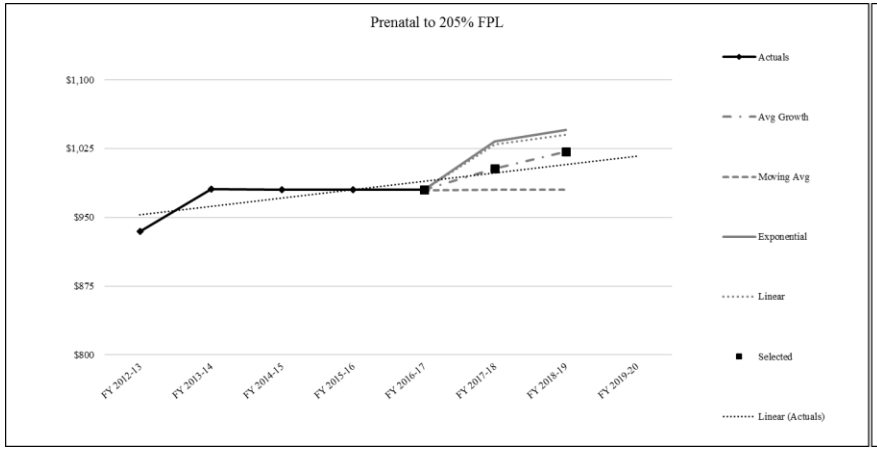
Rate Trends for Children Dental 206% to 260% FPL			
Aid Category	**FY 2017-18 Trend Selection**	**FY 2018-19 Trend Selection**	**Justification**
Children 206% to 260% FPL Dental Ages 0-1	**4.65%**	**4.65%**	The sharp decline seen in FY 2016-17 is due to an expansion in dental benefits for CHP+ with full data. The Department expects these decreases to slow now that the new benefit package has been available for two years.
	Trend selected for Children 0%-205% FPL	Trend selected for Children 0%-205% FPL	
Children 206% to 260% FPL Dental Ages 2-5	**4.11%**	**1.87%**	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
	Growth from FY 2014-15 to FY 2015-16	Average Growth Model	
Children 206% to 260% FPL Dental Ages 6-18	**5.03%**	**4.57%**	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
	Linear Growth Model	Linear Growth Model	

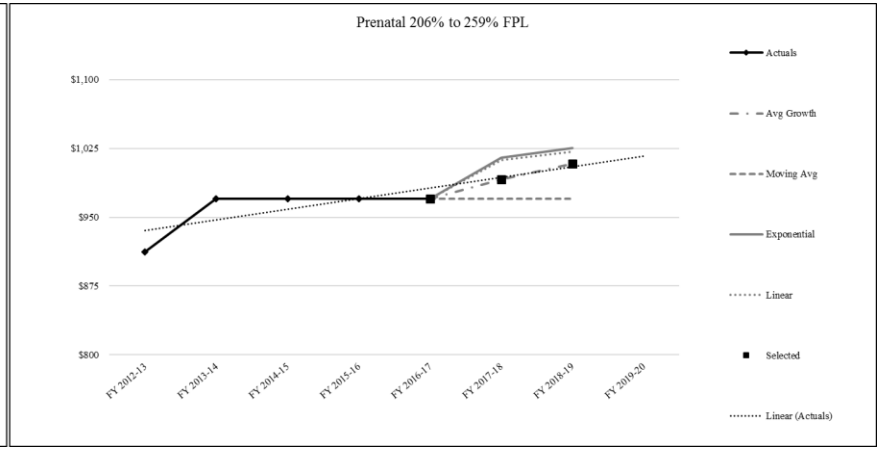






Rate Trends for Prenatal			
Aid Category	**FY 2017-18 Trend Selection**	**FY 2018-19 Trend Selection**	**Justification**
Prenatal to 205% FPL	**2.33%**	**1.83%**	Rates for prenatal clients did not change from FY 2013-14 through FY 2016-17. The trend selected is slightly positive.
	Average Growth Model	Average Growth Model	
Prenatal 206%-260% FPL	**2.17%**	**1.72%**	Rates for prenatal clients did not change from FY 2013-14 through FY 2016-17. The trend selected is slightly positive.
	Average Growth Model	Average Growth Model	





CBHP CASELOAD

Length of Stay

CBHP caseload is not only affected by the number of individuals served but also the length of time they remain in the program. The Department has started tracking the average length of stay for each eligibility category to further understand the behavior of the CHP+ clients. Results for FY 2014-15 (shaded) is subject to change as there may not be sufficient run out to capture the true length of stay for all clients. The Department anticipates an increase in the average length of stay as continuous eligibility for Medicaid Eligible Children and CHP+ Children was implemented March 1st, 2014.

		CHP Children 0%-205%	CHP Children 206%-260%	CHP Prenatal 0%-205%	CHP Prenatal 206%-260%
FY 2010-11	Avg. LOS Mo's	11.55	12.83	6.96	6.82
	% > 12 Mo's	40.92%	51.30%	1.94%	1.68%
FY 2011-12	Avg. LOS Mo's	9.18	11.26	6.35	6.38
	% > 12 Mo's	32.86%	49.21%	1.41%	0.91%
FY 2012-13	Avg. LOS Mo's	8.53	11.37	5.19	6.35
	% > 12 Mo's	26.63%	42.59%	0.84%	0.62%
FY 2013-14	Avg. LOS Mo's	11.62	13.34	5.29	6.61
	% > 12 Mo's	37.13%	47.16%	1.33%	3.48%
FY 2014-15	Avg. LOS Mo's	12.67	12.63	6.89	6.82
	% > 12 Mo's	48.27%	48.18%	1.50%	1.25%

CBHP Caseload Models

The Department's caseload projections utilize statistical forecasting methodologies to predict CBHP caseload by eligibility category. Historical monthly caseload data is used from July 2007 to June 2016. The following forecasting models are used to forecast CBHP caseload: trend and monthly seasonal dummy variables, ARIMA models, trend stationary, and difference stationary. The Department is now using the software EViews 6 to estimate these models.

Trend and Seasonality Model
CBHP caseload is a non-stationary series with a positive trend and many of the categories experience some level of seasonality. One of the models used incorporates a time trend and monthly seasonal dummy variables.

ARIMA Model
ARIMA models, once referred to as Box-Jenkins models, rely on the past behavior of the series being forecasted. Relying on the past behavior of a series mandates that a series be stationary. Most of the eligibilities in Medicaid caseload have a positive growth trend (non-stationary) and require differencing to be made stationary.

Trend Stationary and Difference Stationary
Series that are stationary have a constant mean, caseload series frequently do not have this characteristic and often have a trending mean. Two popular models used for non-stationary series with a trending mean are trend stationary and difference stationary. The trend stationary serves as an effective model if the series has a deterministic trend. The difference stationary model proves effect should the trend be stochastic. Differencing the dependent variable gives a stationary series. The basic forms of the two models are listed below.

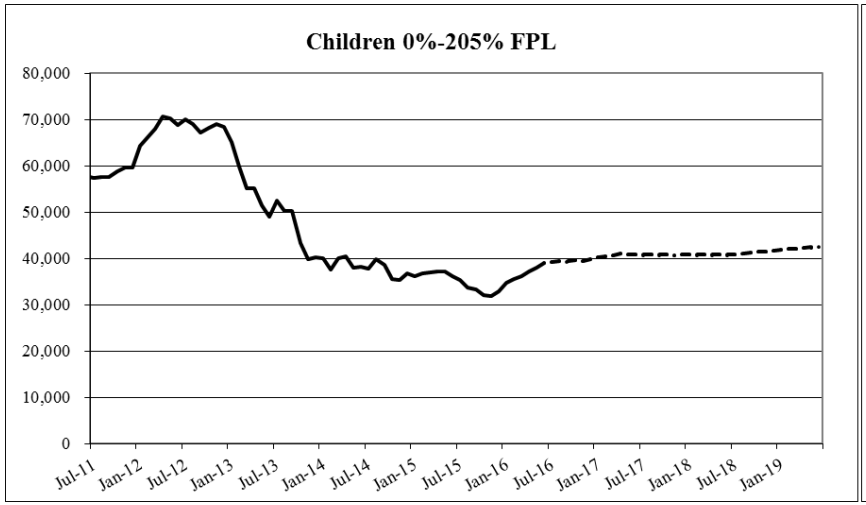
- Trend Stationary: $\log(y) = c + \text{trend} + \varepsilon$
- Difference Stationary: $\text{differenced}(\log(y)) = c + \varepsilon$

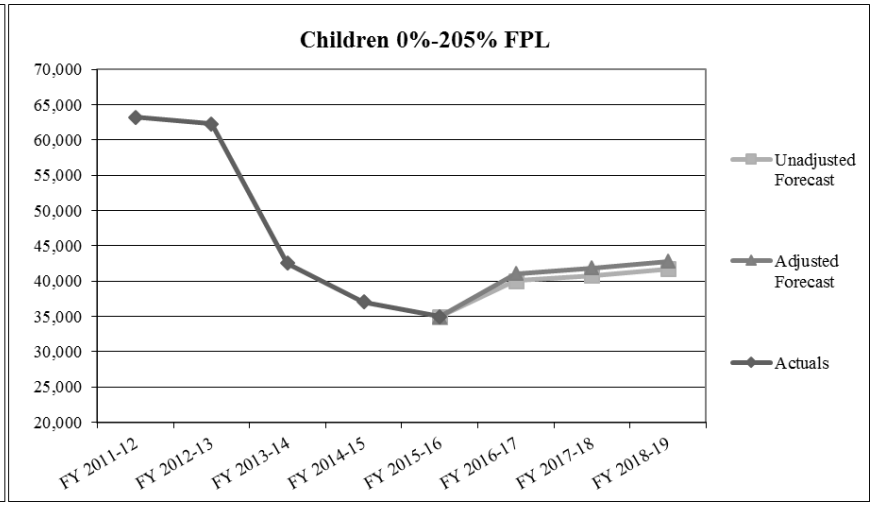
Model Selection

Models are created for each individual group that receives a separate rate. These groups are separated by FPL for both children and prenatal: under 100%, 101%-150%, 151%-200%, 201%-205%, and 206%-260%. Children's groups are also separated by age: age groups 0-1, 2-5, and 6-18. A model is selected to forecast each group After several different forecasts are produced, the Department normally chooses one for each category and then aggregated to the FPL categories for children and prenatal; under 205% and 206%-260%. When selecting a model, the Department closely analyzes the historical data as well as the goodness of fit of the model.

CHILDREN'S BASIC HEALTH PLAN CASELOAD FORECAST

Children's Caseload Projections (Exhibit C4)





- Average monthly caseload for FY 2015-16 for CHP+ Children 0%-205% FPL was 34,940, which is lower than what was forecasted in the February 2016 forecast by 4,452. Actual enrollment data for the first half of FY 2015-16 was significantly lower than the prior forecast and the second half was significantly higher. The Department believes that the drop in caseload in the first half of FY 2015-16 was artificial and the significant growth in the second half returned caseload back to normal values and a moderate growth trend will take place between June 2016 and beyond.

- This population includes the subpopulation created through SB 07-097, and was implemented beginning March 1, 2008. Children in this population have family incomes between 201% and 205% FPL.

    - This population is identified with an income rating code that represented 201%-205% FPL. After the MAGI conversion, this income rating code changed from 201%-205% to 201%-213%. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-260% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.

- There is one bottom-line adjustment to the Children to 205% FPL caseload. It is the projected impact from the continued implementation of HB 09-1353, which removes the five year bar on legal immigrant children and pregnant adults. This five year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department implemented this for CHP+ children in FY 2015-16.

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

	Actuals	Monthly Change	% Change
Jun-14	38,258	-	-
Jul-14	37,832	(426)	-1.11%
Aug-14	39,858	2,026	5.36%
Sep-14	38,675	(1,183)	-2.97%
Oct-14	35,543	(3,132)	-8.10%
Nov-14	35,405	(138)	-0.39%
Dec-14	36,771	1,366	3.86%
Jan-15	36,177	(594)	-1.62%
Feb-15	36,686	509	1.41%
Mar-15	36,909	223	0.61%
Apr-15	37,175	266	0.72%
May-15	37,114	(61)	-0.16%
Jun-15	36,236	(878)	-2.37%
Jul-15	35,269	(967)	-2.67%
Aug-15	33,608	(1,661)	-4.71%
Sep-15	33,333	(275)	-0.82%
Oct-15	32,011	(1,322)	-3.97%
Nov-15	31,821	(190)	-0.59%
Dec-15	32,921	1,100	3.46%
Jan-16	34,658	1,737	5.28%
Feb-16	35,557	899	2.59%
Mar-16	36,075	518	1.46%
Apr-16	37,075	1,000	2.77%
May-16	38,019	944	2.55%
Jun-16	38,938	919	2.42%

February 2016 Forecast	
Forecasted June 2016 Level	37,713

Base trend from June 2016 level			
FY 2016-17	38,938	11.44%	3,998

	Caseload	% Change	Level Change
FY 2008-09	61,582	0.00%	0
FY 2009-10	68,589	11.38%	7,007
FY 2010-11	63,244	-7.79%	(5,345)
FY 2011-12	63,217	-0.04%	(27)
FY 2012-13	62,260	-1.51%	(957)
FY 2013-14	42,511	-31.72%	(19,749)
FY 2014-15	37,032	-12.89%	(5,479)
FY 2015-16	34,940	-5.65%	(2,092)
FY 2016-17	40,031	14.57%	5,091
FY 2017-18	40,800	1.92%	769
FY 2018-19	41,734	2.29%	934

HB 09-1353 Adjustment	
FY 2015-16	-
FY 2016-17	991
FY 2017-18	1,028
FY 2018-19	1,068

November 2016 Projections After Adjustments			
FY 2015-16	34,940	-5.65%	(2,092)
FY 2016-17	41,022	17.41%	6,082
FY 2017-18	41,828	1.96%	806
FY 2018-19	42,802	2.33%	974

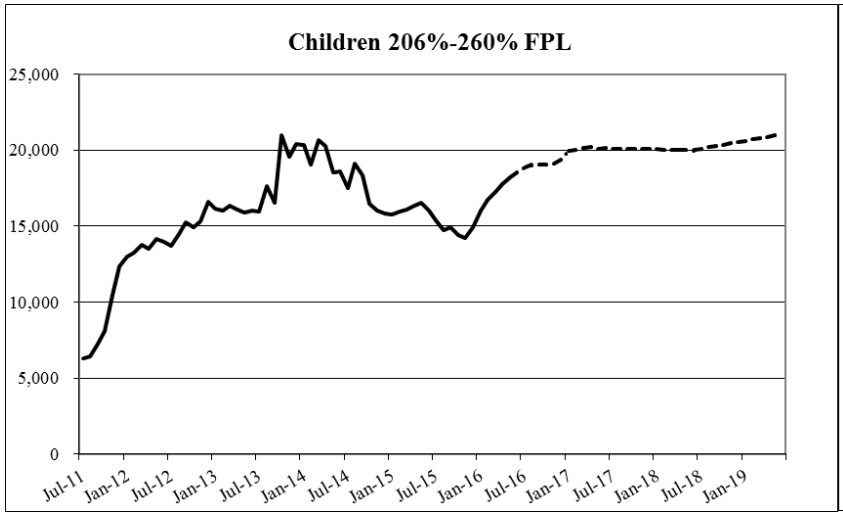
Actuals		
	Monthly Change	% Change
6-month average	1,003	2.84%
12-month average	225	0.65%
18-month average	120	0.35%
24-month average	28	0.12%

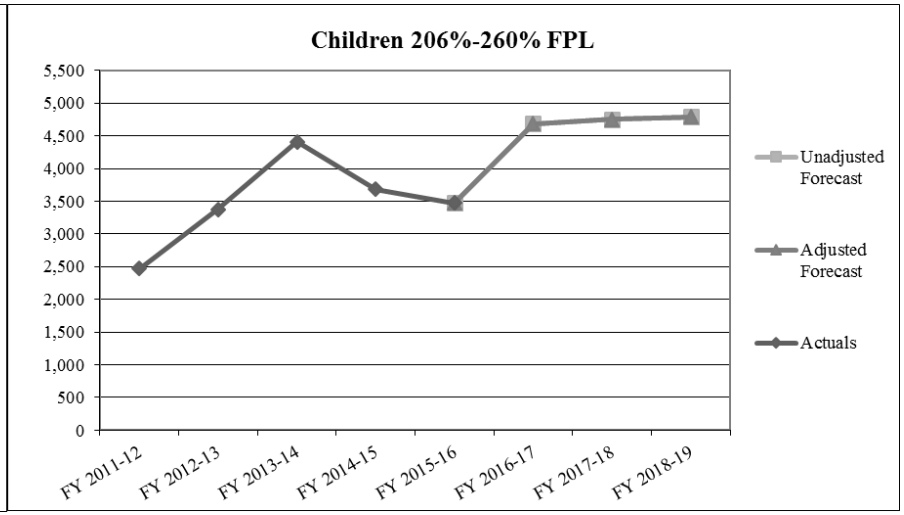
February 2016 Projections before Adjustments			
FY 2014-15	37,032	-12.89%	(5,479)
FY 2015-16	36,077	-2.58%	(955)
FY 2016-17	38,296	6.15%	2,219
FY 2017-18	39,460	3.04%	1,164

HB 09-1353 Adjustment	
FY 2014-15	-
FY 2015-16	634
FY 2016-17	991
FY 2017-18	1,028

February 2016 Projection After Adjustments			
FY 2014-15	37,032	-12.89%	(5,479)
FY 2015-16	36,711	-0.87%	(321)
FY 2016-17	39,287	7.02%	2,576
FY 2017-18	40,488	3.06%	1,201

Monthly Average Growth Comparisons		
February 2016 Forecast	123	0.36%
FY 2015-16 Actuals	225	0.65%
FY 2015-16 1st Half	(553)	-1.55%
FY 2015-16 2nd Half	1,003	2.84%
FY 2016-17 Forecast	155	0.48%
February 2016 Forecast	93	0.24%
FY 2017-18 Forecast	(3)	-0.02%
February 2016 Forecast	97	0.25%





- Average monthly caseload for FY 2015-16 for CHP+ Children 206%-260% FPL was 16,100, which is lower than what was forecasted in February 2016 by 568 clients. Actual enrollment data for the first half of FY 2015-16 was significantly lower than the prior forecast and the second half was significantly higher. The Department believes that the drop in caseload in the first half of FY 2015-16 was artificial and the significant growth in the second half returned caseload back to normal values and a moderate growth trend will take place between June 2016 and beyond. This November 2016 forecast has been adjusted accordingly.
- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Children in this population have family incomes between 206% and 260% of the federal poverty level.
- After the MAGI conversion, an income rating code used to identify clients from 201%-205% changed to 201%-213%. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- There is one bottom-line adjustment to the Children 206%-260% FPL caseload. It is the projected impact from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This five year bar was originally removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department implemented this for CHP+ children in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 affects all FPL categories in CHP+.

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

	Actuals	Monthly Change	% Change
Jun-14	18,613	-	-
Jul-14	17,496	(1,117)	-6.00%
Aug-14	19,106	1,610	9.20%
Sep-14	18,350	(756)	-3.96%
Oct-14	16,449	(1,901)	-10.36%
Nov-14	16,027	(422)	-2.57%
Dec-14	15,851	(176)	-1.10%
Jan-15	15,780	(71)	-0.45%
Feb-15	15,980	200	1.27%
Mar-15	16,068	88	0.55%
Apr-15	16,327	259	1.61%
May-15	16,573	246	1.51%
Jun-15	16,005	(568)	-3.43%
Jul-15	15,382	(623)	-3.89%
Aug-15	14,765	(617)	-4.01%
Sep-15	14,936	171	1.16%
Oct-15	14,444	(492)	-3.29%
Nov-15	14,212	(232)	-1.61%
Dec-15	14,908	696	4.90%
Jan-16	16,036	1,128	7.57%
Feb-16	16,728	692	4.32%
Mar-16	17,257	529	3.16%
Apr-16	17,763	506	2.93%
May-16	18,204	441	2.48%
Jun-16	18,568	364	2.00%

February 2016 Forecast	
Forecasted June 2016 level	17,477

Base trend from June 2016 level			
FY 2016-17	18,568	15.33%	2,468

	Caseload	% Change	Level Change
FY 2010-11	4,023	0.00%	0
FY 2011-12	11,049	174.65%	7,026
FY 2012-13	15,575	40.96%	4,526
FY 2013-14	19,043	22.27%	3,468
FY 2014-15	16,668	-12.47%	(2,375)
FY 2015-16	16,100	-3.41%	(568)
FY 2016-17	19,595	21.71%	3,495
FY 2017-18	20,067	2.41%	472
FY 2018-19	20,573	2.52%	506

HB 09-1353 Adjustment	
FY 2015-16	-
FY 2016-17	502
FY 2017-18	535
FY 2018-19	550

November 2016 Projections After Adjustments			
FY 2015-16	16,100	-3.41%	(568)
FY 2016-17	20,097	24.83%	3,997
FY 2017-18	20,602	2.51%	505
FY 2018-19	21,123	2.53%	521

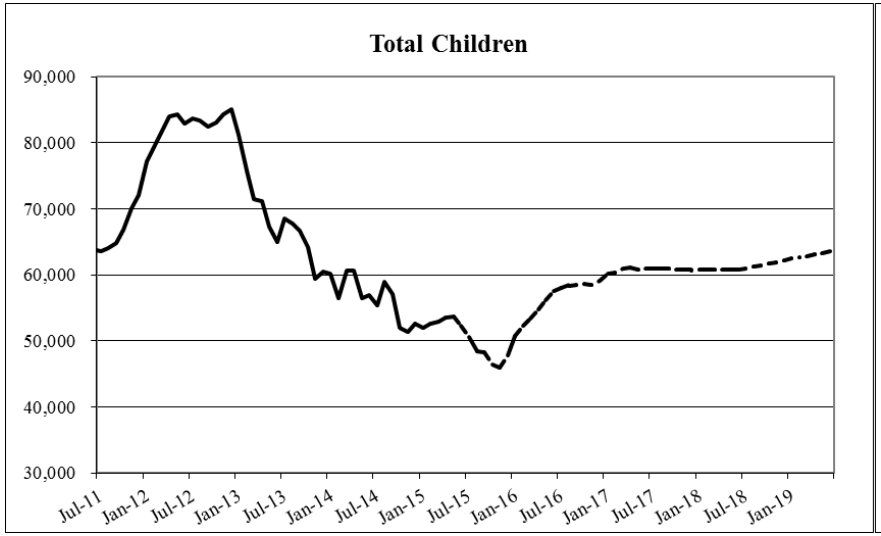
Actuals		
	Monthly Change	% Change
6-month average	610	3.74%
12-month average	214	1.31%
18-month average	151	0.93%
24-month average	(2)	0.08%

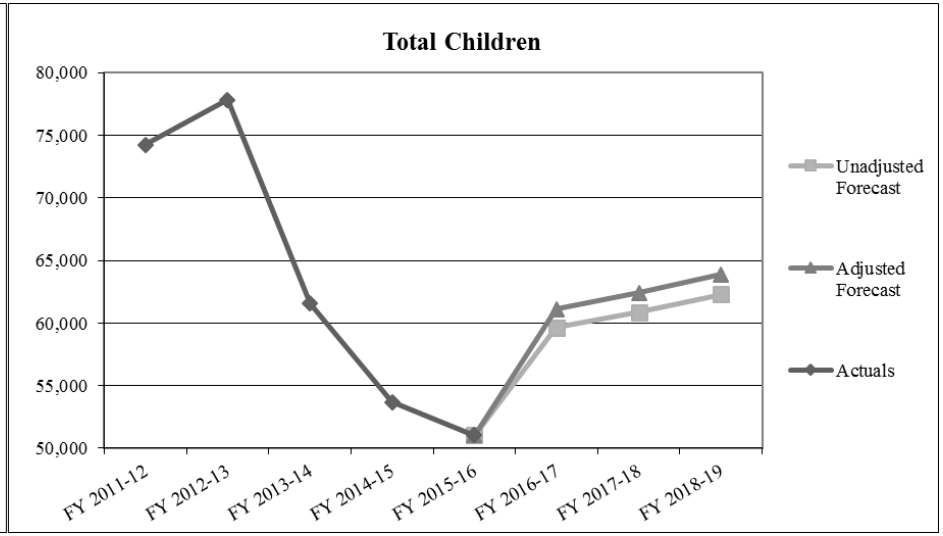
February 2016 Projection Before Adustments			
FY 2014-15	16,668	-12.47%	(2,375)
FY 2015-16	16,553	-0.69%	(115)
FY 2016-17	18,230	10.13%	1,677
FY 2017-18	19,205	5.35%	975

HB 09-1353 Adjustment	
FY 2014-15	-
FY 2015-16	311
FY 2016-17	502
FY 2017-18	535

February 2016 Projection After Adjustments			
FY 2014-15	16,668	-12.47%	(2,375)
FY 2015-16	16,864	1.18%	196
FY 2016-17	18,732	11.08%	1,868
FY 2017-18	19,740	5.38%	1,008

Monthly Average Growth Comparisons		
February 2016 Forecast	123	0.78%
FY 2015-16 Actuals	214	1.31%
FY 2015-16 1st Half	(183)	-1.12%
FY 2015-16 2nd Half	610	3.74%
FY 2016-17 Forecast	130	1.48%
February 2016 Forecast	84	0.47%
FY 2017-18 Forecast	(10)	-0.05%
February 2016 Forecast	79	0.42%





- Average monthly caseload for FY 2015-16 for CHP+ Children was 51,040, which is 2,717 clients, or 5.05% under the February 2016 forecast. Actual caseload for the first half of FY 2015-16 came in significantly lower than what was predicted and second half caseload came in significantly higher than in the February 2016 forecast. The Department believed that the decrease in the first half of FY 2015-16 was artificial and the second half increase returned caseload to normal values. The Department anticipates moderate growth in FY 2016-17 and beyond.
- After the MAGI conversion, an income rating code used to identify clients from 201%-205% changed to 201%-213%. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- As described above, there is one bottom-line adjustment to the CHP+ children's caseload. It is the projected impact is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This five year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department implemented this for CHP+ children in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 affects all FPL categories in CHP+.

Total Children 0% -260% FPL: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-14	56,871		
Jul-14	55,328	(1,543)	-2.71%
Aug-14	58,964	3,636	6.57%
Sep-14	57,025	(1,939)	-3.29%
Oct-14	51,992	(5,033)	-8.83%
Nov-14	51,432	(560)	-1.08%
Dec-14	52,622	1,190	2.31%
Jan-15	51,957	(665)	-1.26%
Feb-15	52,666	709	1.36%
Mar-15	52,977	311	0.59%
Apr-15	53,502	525	0.99%
May-15	53,687	185	0.35%
Jun-15	52,241	(1,446)	-2.69%
Jul-15	50,651	(1,590)	-3.04%
Aug-15	48,373	(2,278)	-4.50%
Sep-15	48,269	(104)	-0.21%
Oct-15	46,455	(1,814)	-3.76%
Nov-15	46,033	(422)	-0.91%
Dec-15	47,829	1,796	3.90%
Jan-16	50,694	2,865	5.99%
Feb-16	52,285	1,591	3.14%
Mar-16	53,332	1,047	2.00%
Apr-16	54,838	1,506	2.82%
May-16	56,223	1,385	2.53%
Jun-16	57,506	1,283	2.28%

February 2016 Forecast	
Forecasted June 2016 level	55,190

Base trend from June 2016 level			
FY 2016-17	57,506	12.67%	6,466

	Caseload	% Change	Level Change
FY 2010-11	67,267		
FY 2011-12	74,266	10.40%	6,999
FY 2012-13	77,835	4.81%	3,569
FY 2013-14	61,554	-20.92%	(16,281)
FY 2014-15	53,700	-12.76%	(7,854)
FY 2015-16	51,040	-4.95%	(2,660)
FY 2016-17	59,626	16.82%	8,586
FY 2017-18	60,867	2.08%	1,241
FY 2018-19	62,307	2.37%	1,440

HB 09-1353 Adjustment	
FY 2015-16	-
FY 2016-17	1,493
FY 2017-18	1,563
FY 2018-19	1,618

November 2016 Projections After Adjustments			
FY 2015-16	51,040	-4.95%	(2,660)
FY 2016-17	61,119	19.75%	10,079
FY 2017-18	62,430	2.14%	1,311
FY 2018-19	63,925	2.39%	1,495

Actuals		
	Monthly Change	% Change
6-month average	1,613	3.13%
12-month average	439	0.85%
18-month average	271	0.53%
24-month average	26	0.11%

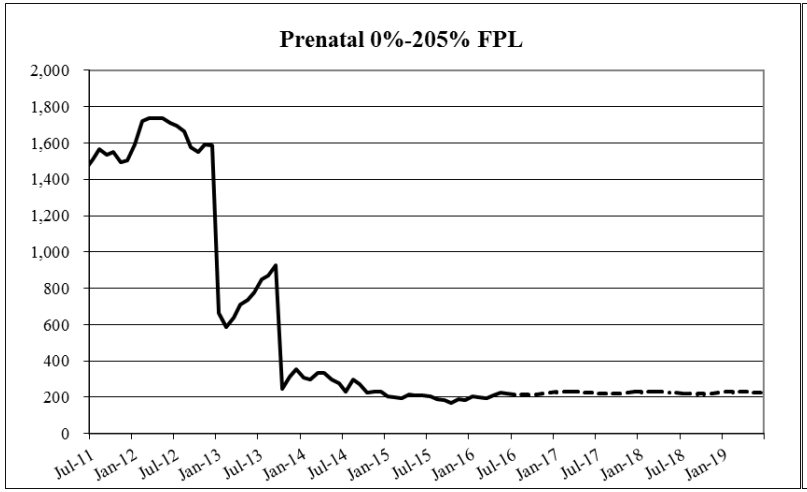
February 2016 Projection Before Adjustments			
FY 2014-15	53,700	-12.76%	(7,854)
FY 2015-16	52,630	-1.99%	(1,070)
FY 2016-17	56,526	7.40%	3,896
FY 2017-18	58,665	3.78%	2,139

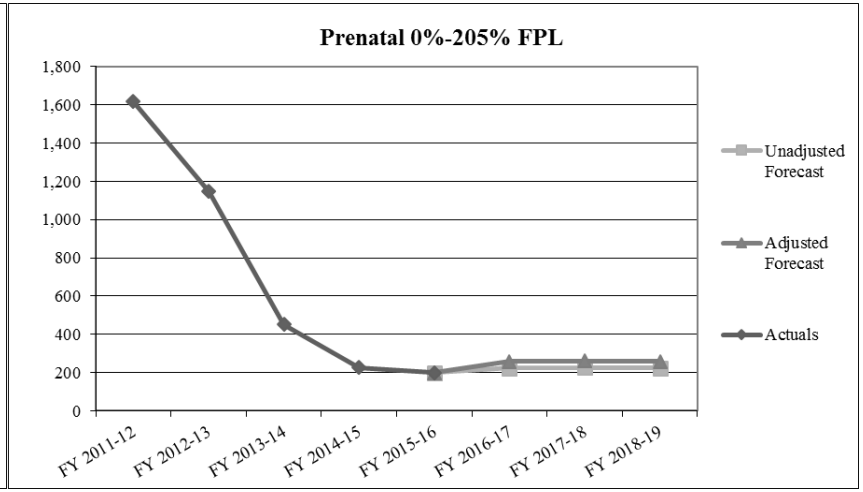
HB 09-1353 Adjustment	
FY 2014-15	-
FY 2015-16	945
FY 2016-17	1,493
FY 2017-18	1,563

February 2016 Projection After Adjustments			
FY 2014-15	53,700	-12.76%	(7,854)
FY 2015-16	53,575	-0.23%	(125)
FY 2016-17	58,019	8.29%	4,444
FY 2017-18	60,228	3.81%	2,209

Monthly Average Growth Comparisons		
February 2016 Forecast	744	1.35%
FY 2015-16 Actuals	439	0.85%
FY 2015-16 1st Half	(735)	-1.42%
FY 2015-16 2nd Half	1,613	3.13%
FY 2016-17 Forecast	10,079	0.00%
February 2016 Forecast	(485)	-0.83%
FY 2017-18 Forecast	1,311	0.00%
February 2016 Forecast	748	1.26%

Prenatal Caseload Projections (Exhibit C4)





- Average monthly caseload for FY 2015-16 for CHP+ Prenatal clients 0%-205% was 199, which is lower than what was forecasted in February 2016 by 46 clients or 18.77%. Actual caseload for the first half of FY 2015-16 came in significantly lower than what was predicted and second half of the year came in higher, averaging out to a flat trend.
- Along with the children's expansion to 205% FPL, this population includes the subpopulation that was created through SB 07-097 and was implemented beginning March 1, 2008. Prenatal women in this subpopulation have family incomes between 201 and 205% of the federal poverty level.
    - Similar to children, this population is identified with an income rating code that represented 201%-205% FPL. After the MAGI conversion, this income rating code changed from 201%-205% to 201%-213% FPL. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-260% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- There is one bottom-line adjustment to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the five year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department implemented this for CHP+ prenatal clients in FY 2015-16.

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

	Actuals	Monthly Change	% Change
Jun-14	276	-	-
Jul-14	229	(47)	-17.03%
Aug-14	296	67	29.26%
Sep-14	273	(23)	-7.77%
Oct-14	224	(49)	-17.95%
Nov-14	233	9	4.02%
Dec-14	232	(1)	-0.43%
Jan-15	205	(27)	-11.64%
Feb-15	200	(5)	-2.44%
Mar-15	195	(5)	-2.50%
Apr-15	214	19	9.74%
May-15	212	(2)	-0.93%
Jun-15	210	(2)	-0.94%
Jul-15	206	(4)	-1.90%
Aug-15	189	(17)	-8.25%
Sep-15	183	(6)	-3.17%
Oct-15	167	(16)	-8.74%
Nov-15	192	25	14.97%
Dec-15	187	(5)	-2.60%
Jan-16	205	18	9.63%
Feb-16	202	(3)	-1.46%
Mar-16	196	(6)	-2.97%
Apr-16	212	16	8.16%
May-16	225	13	6.13%
Jun-16	220	(5)	-2.22%

February 2016 Forecast	
Forecasted June 2016 level	239

Base trend from June 2016 level			
FY 2016-17	220	10.55%	21

	Caseload	% Change	Level Change
FY 2008-09	1,665	0.00%	0
FY 2009-10	1,550	-6.91%	(115)
FY 2010-11	1,470	-5.16%	(80)
FY 2011-12	1,616	9.93%	146
FY 2012-13	1,148	-28.96%	(468)
FY 2013-14	451	-60.71%	(697)
FY 2014-15	227	-49.67%	(224)
FY 2015-16	199	-12.33%	(28)
FY 2016-17	223	12.06%	24
FY 2017-18	226	1.35%	3
FY 2018-19	225	-0.44%	(1)

HB 09-1353 Adjustment	
FY 2015-16	-
FY 2016-17	35
FY 2017-18	34
FY 2018-19	34

November 2016 Projections After Adjustments			
FY 2015-16	199	-12.33%	(28)
FY 2016-17	258	29.65%	59
FY 2017-18	260	0.78%	2
FY 2018-19	259	-0.38%	(1)

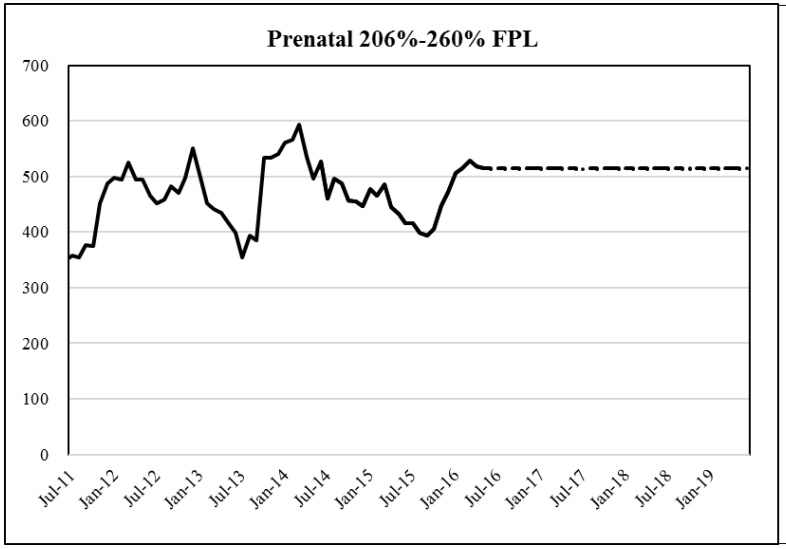
Actuals		
	Monthly Change	% Change
6-month average	6	2.88%
12-month average	1	0.63%
18-month average	(1)	-0.06%
24-month average	(2)	-0.46%

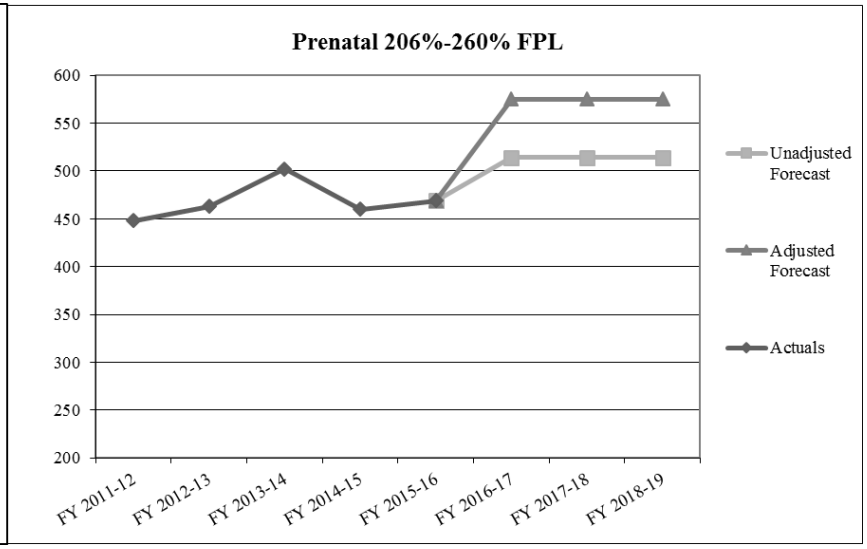
February 2016 Projection Before Adjustments			
FY 2014-15	227	-49.67%	(224)
FY 2015-16	223	-1.76%	(4)
FY 2016-17	238	6.73%	15
FY 2017-18	233	-2.10%	(5)

HB 09-1353 Adjustment	
FY 2014-15	-
FY 2015-16	22
FY 2016-17	35
FY 2017-18	34

February 2016 Projection After Adjustments			
FY 2014-15	227	-49.67%	(224)
FY 2015-16	245	7.93%	18
FY 2016-17	273	11.43%	28
FY 2017-18	267	-2.20%	(6)

Monthly Average Growth Comparisons		
February 2016 Forecast	2	1.37%
FY 2015-16 Actuals	1	0.63%
FY 2015-16 1st Half	(4)	-1.64%
FY 2015-16 2nd Half	6	2.88%
FY 2016-17 Forecast	0	0.19%
February 2016 Forecast	0	-0.16%
FY 2017-18 Forecast	0	0.04%
February 2016 Forecast	0	-0.16%





- Average monthly caseload for FY 2015-16 for CHP+ Prenatal 206%-260% FPL was 469, which is lower than what was forecasted in February 2016 by 47 clients or 9.09%. Caseload grew at about 1 client per month.
- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Pregnant women in this population have family incomes between 206% and 260% of the federal poverty level.
- There is one bottom-line adjustments to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the five year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department implemented this for CHP+ prenatal clients in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 affects all FPL categories in CHP+.

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

	Actuals	Monthly Change	% Change
Jun-14	527	-	-
Jul-14	460	(67)	-12.71%
Aug-14	496	36	7.83%
Sep-14	488	(8)	-1.61%
Oct-14	457	(31)	-6.35%
Nov-14	455	(2)	-0.44%
Dec-14	446	(9)	-1.98%
Jan-15	478	32	7.17%
Feb-15	465	(13)	-2.72%
Mar-15	485	20	4.30%
Apr-15	444	(41)	-8.45%
May-15	433	(11)	-2.48%
Jun-15	416	(17)	-3.93%
Jul-15	415	(1)	-0.24%
Aug-15	398	(17)	-4.10%
Sep-15	394	(4)	-1.01%
Oct-15	405	11	2.79%
Nov-15	449	44	10.86%
Dec-15	472	23	5.12%
Jan-16	506	34	7.20%
Feb-16	515	9	1.78%
Mar-16	529	14	2.72%
Apr-16	519	(10)	-1.89%
May-16	515	(4)	-0.77%
Jun-16	514	(1)	-0.19%

February 2016 Forecast	
Forecasted June 2016 level	517

Base trend from June 2016 level			
FY 2016-17	514	9.59%	45

	Caseload	% Change	Level Change
FY 2009-10	11	0.00%	0
FY 2010-11	272	0.00%	0
FY 2011-12	448	64.71%	176
FY 2012-13	463	3.35%	15
FY 2013-14	502	8.42%	39
FY 2014-15	460	-8.37%	(42)
FY 2015-16	469	1.96%	9
FY 2016-17	514	9.59%	45
FY 2017-18	514	0.00%	0
FY 2018-19	514	0.00%	0

HB 09-1353 Adjustment	
FY 2015-16	-
FY 2016-17	61
FY 2017-18	61
FY 2018-19	61

November 2016 Projections After Adjustments			
FY 2015-16	469	1.96%	9
FY 2016-17	575	22.60%	106
FY 2017-18	575	0.00%	-
FY 2018-19	575	0.00%	-

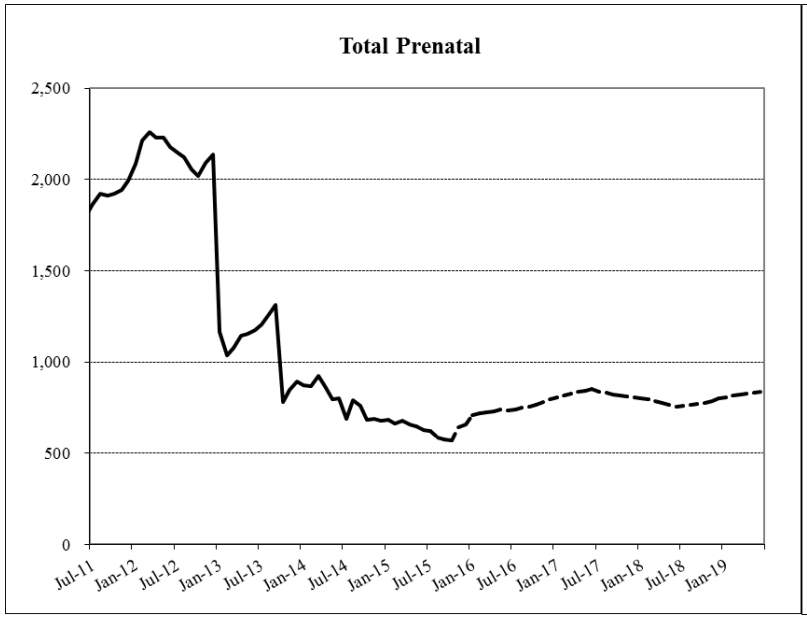
Actuals		
	Monthly Change	% Change
6-month average	7	1.47%
12-month average	8	1.86%
18-month average	4	0.90%
24-month average	(1)	0.04%

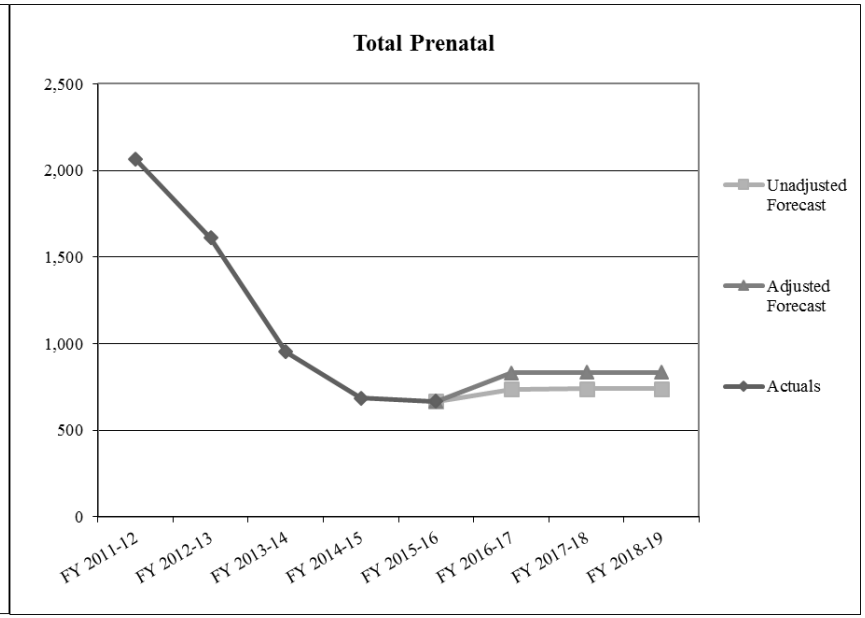
February 2016 Projection Before Adjustments			
FY 2014-15	460	-8.37%	(42)
FY 2015-16	476	3.48%	16
FY 2016-17	517	8.61%	41
FY 2017-18	517	0.00%	0

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

February 2016 Projections After Adjustments			
FY 2014-15	460	-8.37%	(42)
FY 2015-16	517	12.39%	57
FY 2016-17	578	11.80%	61
FY 2017-18	578	0.00%	-

Monthly Average Growth Comparisons		
February 2016 Forecast	8	1.89%
FY 2015-16 Actuals	8	1.86%
FY 2015-16 1st Half	9	2.24%
FY 2015-16 2nd Half	7	1.47%
FY 2016-17 Forecast	0	0.01%
February 2016 Forecast	0	0.00%
FY 2017-18 Forecast	0	0.00%
February 2016 Forecast	0	0.00%





- Average monthly caseload for FY 2015-16 for CHP+ prenatal was 668, which is 94 clients, or 12.33% under what was forecast in February 2016. Actual caseload for FY 2015-16 came in significantly lower than what was predicted in the February 2016 forecast and trends were revised downward to reflect actual data.
- As described above, there is one bottom-line adjustments to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department implemented this for CHP+ prenatal clients in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 affects all FPL categories in CHP+.

Total Prenatal 0% -260% FPL: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-14	803		
Jul-14	689	(114)	-14.20%
Aug-14	792	103	14.95%
Sep-14	761	(31)	-3.91%
Oct-14	681	(80)	-10.51%
Nov-14	688	7	1.03%
Dec-14	678	(10)	-1.45%
Jan-15	683	5	0.74%
Feb-15	665	(18)	-2.64%
Mar-15	680	15	2.26%
Apr-15	658	(22)	-3.24%
May-15	645	(13)	-1.98%
Jun-15	626	(19)	-2.95%
Jul-15	621	(5)	-0.80%
Aug-15	587	(34)	-5.48%
Sep-15	577	(10)	-1.70%
Oct-15	572	(5)	-0.87%
Nov-15	641	69	12.06%
Dec-15	659	18	2.81%
Jan-16	711	52	7.89%
Feb-16	717	6	0.84%
Mar-16	725	8	1.12%
Apr-16	731	6	0.83%
May-16	740	9	1.23%
Jun-16	734	(6)	-0.81%

February 2016 Forecast	
Forecasted June 2016 level	756

Base trend from June 2016 level			
FY 2016-17	734	8.99%	66

	Caseload	% Change	Level Change
FY 2008-09	1,665		
FY 2009-10	1,561	-6.25%	(104)
FY 2010-11	1,742	11.60%	181
FY 2011-12	2,064	18.48%	322
FY 2012-13	1,611	-21.95%	(453)
FY 2013-14	953	-40.84%	(658)
FY 2014-15	687	-27.91%	(266)
FY 2015-16	668	-2.77%	(19)
FY 2016-17	737	10.33%	69
FY 2017-18	740	0.41%	3
FY 2018-19	739	-0.14%	(1)

HB 09-1353 Adjustment	
FY 2015-16	-
FY 2016-17	96
FY 2017-18	95
FY 2018-19	95

November 2016 Projections After Adjustments			
FY 2015-16	668	-2.77%	(19)
FY 2016-17	833	24.70%	165
FY 2017-18	835	0.24%	2
FY 2018-19	834	-0.12%	(1)

Actuals		
	Monthly Change	% Change
6-month average	13	1.85%
12-month average	9	1.43%
18-month average	3	0.52%
24-month average	(3)	-0.20%

February 2016 Projection Before Adjustments			
FY 2014-15	687	-27.91%	(266)
FY 2015-16	699	1.75%	12
FY 2016-17	755	8.01%	56
FY 2017-18	750	-0.66%	(5)

HB 09-1353 Adjustment	
FY 2014-15	-
FY 2015-16	63
FY 2016-17	96
FY 2017-18	95

February 2016 Projection After Adjustments			
FY 2014-15	687	-27.91%	(266)
FY 2015-16	762	10.92%	75
FY 2016-17	851	11.68%	89
FY 2017-18	845	-0.71%	(6)

Monthly Average Growth Comparisons		
February 2016 Forecast	12	1.41%
FY 2015-16 Actuals	9	1.43%
FY 2015-16 1st Half	6	1.00%
FY 2015-16 2nd Half	13	1.85%
FY 2016-17 Forecast	165	24.70%
February 2016 Forecast	(27)	-3.15%
FY 2017-18 Forecast	2	0.24%
February 2016 Forecast	22	2.73%

Exhibit C1 - Calculation of Current Total Long Bill Group Impact						
FY 2016-17 Children's Basic Health Plan Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2016-17 Children's Basic Health Plan Capitation Appropriation						
FY 2016-17 Long Bill Appropriation (HB 16-1405)	$141,455,044	$2,067,851	$432,590	$17,533,954	$0	$121,420,649
FY 2016-17 Total Children's Basic Heath Plan Capitation Spending Authority	**$141,455,044**	**$2,067,851**	**$432,590**	**$17,533,954**	**$0**	**$121,420,649**
Projected Total FY 2016-17 CBHP Capitation Expenditure	**$157,065,937**	**$2,069,366**	**$432,590**	**$21,215,152**	**$0**	**$133,348,829**
FY 2016-17 Children's Basic Health Plan Capitation Estimated Change from Appropriation	**$15,610,893**	**$1,515**	**$0**	**$3,681,198**	**$0**	**$11,928,180**
Percent Change from Spending Authority	11.04%	0.07%	0.00%	20.99%	0.00%	9.82%
FY 2016-17 CBHP External Admin						
FY 2016-17 CBHP External Admin Appropriation						
FY 2016-17 Long Bill Appropriation (HB 16-1405)	$5,033,274	$0	$0	$2,363,824	$0	$2,669,450
FY 2016-17 Total CBHP External Admin Spending Authority	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
Projected Total FY 2016-17 CBHP External Admin Expenditure	**$5,033,274**	**$0**	**$0**	**$597,450**	**$0**	**$4,435,824**
Total FY 2016-17 CBHP External Admin Change from Appropriation	**$0**	**$0**	**$0**	**($1,766,374)**	**$0**	**$1,766,374**
Percent Change from Spending Authority	0.00%	0.00%	0.00%	-74.73%	0.00%	66.17%

Exhibit C1 - Calculation of Current Total Long Bill Group Impact						
FY 2017-18 Children's Basic Health Plan Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2016-17 CBHP Capitation Appropriation Plus Special Bills	**$141,455,044**	**$2,067,851**	**$432,590**	**$17,533,954**	**$0**	**$121,420,649**
FY 2017-18 CBHP Capitation Base Amount	**$141,455,044**	**$2,070,036**	**$430,405**	**$17,533,954**	**$0**	**$121,420,649**
Projected Total FY 2017-18 CBHP Capitation Expenditure	**$159,965,046**	**$191,211**	**$430,405**	**$20,959,031**	**$0**	**$138,384,399**
Total FY 2017-18 CBHP Capitation Request	**$18,510,002**	**($1,878,825)**	**$0**	**$3,425,077**	**$0**	**$16,963,750**
Percent Change from FY 2017-18 CBHP Capitation Base	13.09%	-90.76%	0.00%	19.53%	0.00%	13.97%
Percent Change from FY 2016-17 Estimated CBHP Capitation Expenditure	1.85%	-90.76%	-0.51%	-1.21%	0.00%	3.78%
FY 2017-18 CBHP External Admin						
FY 2016-17 CBHP External Admin Appropriation Plus Special Bills	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
FY 2017-18 CBHP External Admin Base Amount	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
Projected Total FY 2017-18 CBHP External Admin Expenditure	**$5,033,274**	**$0**	**$0**	**$603,993**	**$0**	**$4,429,281**
Total FY 2017-18 CBHP External Admin Request	**$0**	**$0**	**$0**	**($1,759,831)**	**$0**	**$1,759,831**
Percent Change from FY 2017-18 CBHP External Admin Base	0.00%	0.00%	0.00%	-74.45%	0.00%	65.92%
Percent Change from FY 2016-17 Estimated CBHP External Admin Expenditure	0.00%	0.00%	0.00%	1.10%	0.00%	-0.15%

Exhibit C1 - Calculation of Current Total Long Bill Group Impact						
FY 2018-19 Children's Basic Health Plan Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2017-18 CBHP Capitation Appropriation Plus Special Bills	**$141,455,044**	**$2,070,036**	**$430,405**	**$17,533,954**	**$0**	**$121,420,649**
FY 2018-19 CBHP Capitation Base Amount	**$141,455,044**	**$2,070,036**	**$430,405**	**$17,533,954**	**$0**	**$121,420,649**
Projected Total FY 2018-19 CBHP Capitation Expenditure	**$167,246,863**	**$0**	**$0**	**$21,957,893**	**$0**	**$145,288,970**
Total FY 2018-19 CBHP Capitation Continuation Amount	**$25,791,819**	**($2,070,036)**	**($430,405)**	**$4,423,939**	**$0**	**$23,868,321**
Percent Change from FY 2018-19 CBHP Capitation Base	18.23%	-100.00%	-100.00%	25.23%	0.00%	19.66%
Percent Change from FY 2017-18 Estimated CBHP Capitation Expenditure	4.55%	-100.00%	-100.00%	4.77%	0.00%	4.99%
FY 2018-19 CBHP External Admin						
FY 2017-18 CBHP External Admin Appropriation Plus Special Bills	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
FY 2018-19 CBHP External Admin Base Amount	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
Projected Total FY 2018-19 CBHP External Admin Expenditure	**$5,033,274**	**$0**	**$0**	**$603,993**	**$0**	**$4,429,281**
Total FY 2018-19 CBHP External Admin Continuation Amount	**$0**	**$0**	**$0**	**($1,759,831)**	**$0**	**$1,759,831**
Percent Change from FY 2018-19 CBHP External Admin Base	0.00%	0.00%	0.00%	-74.45%	0.00%	65.92%
Percent Change from FY 2017-18 Estimated CBHP External Admin Expenditure	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Exhibit C10 - Forecast Model Comparisons - Final Forecasts

Adjustment Factors for Forecasted Rates

Item	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2016-17 Known Rate	$221.82	$123.42	$160.69	$224.38	$123.07	$161.03	$4.33	$18.75	$22.67	$2.97	$17.07	$21.95	$980.36	$970.08
Retroactivity Adjustment Multiplier (Exhibit C8)	19.58%	9.11%	6.85%	19.58%	9.11%	6.85%	-0.94%	-3.10%	-4.77%	-0.94%	-3.10%	-4.77%	7.00%	7.00%
Claims Distribution Adjustment Multiplier (Exhibit C8)	-0.16%	-0.08%	-0.17%	-0.08%	-1.06%	-0.04%	-4.65%	-5.06%	-5.03%	-4.48%	-5.02%	-4.98%	-1.03%	-0.02%
Final Adjustment Factor	19.39%	9.02%	6.67%	19.48%	7.95%	6.81%	-5.55%	-8.00%	-9.56%	-5.38%	-7.96%	-9.51%	5.90%	6.98%
FY 2016-17 Final Estimated Rate	$264.83	$134.55	$171.41	$268.09	$132.85	$172.00	$4.09	$17.25	$20.50	$2.81	$15.71	$19.86	$1,038.20	$1,037.79

Item	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2017-18 Estimated Rate	$226.24	$125.77	$163.75	$230.61	$125.38	$166.82	$4.53	$19.53	$23.69	$3.11	$17.77	$23.05	$1,003.17	$991.16
Retroactivity Adjustment Multiplier (Exhibit C8)	19.58%	9.11%	6.85%	19.58%	9.11%	6.85%	-0.94%	-3.10%	-4.77%	-0.94%	-3.10%	-4.77%	7.00%	7.00%
Claims Distribution Adjustment Multiplier (Exhibit C8)	-0.16%	-0.08%	-0.17%	-0.08%	-1.06%	-0.04%	-4.65%	-5.06%	-5.03%	-4.48%	-5.02%	-4.98%	-1.03%	-0.02%
Final Adjustment Factor	19.39%	9.02%	6.67%	19.48%	7.95%	6.81%	-5.55%	-8.00%	-9.56%	-5.38%	-7.96%	-9.51%	5.90%	6.98%
FY 2017-18 Final Estimated Rate	$270.11	$137.11	$174.67	$275.53	$135.35	$178.18	$4.28	$17.97	$21.43	$2.94	$16.36	$20.86	$1,062.36	$1,060.34

Item	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2018-19 Estimated Rate	$230.75	$127.27	$167.52	$233.81	$127.33	$172.82	$4.74	$20.26	$24.81	$3.25	$18.10	$24.10	$1,021.52	$1,008.20
Retroactivity Adjustment Multiplier (Exhibit C8)	19.58%	9.11%	6.85%	19.58%	9.11%	6.85%	-0.94%	-3.10%	-4.77%	-0.94%	-3.10%	-4.77%	7.00%	7.00%
Claims Distribution Adjustment Multiplier (Exhibit C8)	-0.16%	-0.08%	-0.17%	-0.08%	-1.06%	-0.04%	-4.65%	-5.06%	-5.03%	-4.48%	-5.02%	-4.98%	-1.03%	-0.02%
Final Adjustment Factor	19.39%	9.02%	6.67%	19.48%	7.95%	6.81%	-5.55%	-8.00%	-9.56%	-5.38%	-7.96%	-9.51%	5.90%	6.98%
FY 2018-19 Final Estimated Rate	$275.49	$138.75	$178.69	$279.36	$137.45	$184.59	$4.48	$18.64	$22.44	$3.08	$16.66	$21.81	$1,081.79	$1,078.57

Exhibit C10 - Forecast Model Comparisons - Capitation Trend Models

Capitation Rate Forecast Model for FY 2016-17

Model	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2014-15 Full Year Average Rate	$282.53	$123.65	$145.21	$281.79	$121.48	$150.23	$4.73	$15.60	$20.89	$4.69	$15.13	$20.47	$980.16	$970.08
FY 2015-16 Full Year Average Rate	$239.51	$117.49	$140.31	$236.84	$114.73	$137.16	$5.51	$16.25	$21.74	$5.33	$15.84	$21.32	$980.42	$970.08
FY 2016-17 Estimated Average Rate	$221.82	$123.42	$160.69	$224.38	$123.07	$161.03	$4.33	$18.75	$22.67	$2.97	$17.07	$21.95	$980.36	$970.08
Recent Growth Rates														
% Growth from FY 2014-15 to FY 2015-16 Rate	-15.23%	-4.98%	-3.37%	-15.95%	-5.56%	-8.70%	16.49%	4.17%	4.07%	13.65%	4.69%	4.15%	0.03%	0.00%
% Growth from FY 2015-16 to FY 2016-17 Rate	-7.39%	5.05%	14.52%	-5.26%	7.27%	17.40%	-21.42%	15.38%	4.28%	-44.28%	7.77%	2.95%	-0.01%	0.00%
Selected Trend Models														
Average Growth Model	$212.38	$133.96	$192.10	$197.00	$135.08	$196.31	$3.36	$22.47	$24.97	$1.76	$19.63	$23.89	$1,003.17	$991.16
% Difference from FY 2016-17 Rate	-4.25%	8.54%	19.55%	-12.20%	9.76%	21.91%	-22.50%	19.82%	10.17%	-40.71%	15.03%	8.82%	2.33%	2.17%
% Difference from FY 2017-18 Rate	2.96%	2.14%	3.25%	-8.69%	2.54%	3.03%	-2.11%	3.75%	5.72%	5.70%	4.77%	5.65%	1.83%	1.72%
Two Period Moving Average Model	$230.67	$120.46	$150.50	$230.61	$118.90	$149.10	$4.92	$17.50	$22.21	$4.15	$16.46	$21.64	$980.39	$970.08
% Difference from FY 2016-17 Rate	3.99%	-2.40%	-6.34%	2.78%	-3.39%	-7.41%	13.63%	-6.67%	-2.05%	39.73%	-3.60%	-1.44%	0.00%	0.00%
% Difference from FY 2017-18 Rate	-1.92%	1.23%	3.39%	-1.35%	1.75%	4.00%	-6.00%	3.57%	1.05%	-14.22%	1.87%	0.73%	0.00%	0.00%
Exponential Growth Model	$253.24	$125.77	$157.17	$202.83	$125.79	$154.76	$5.87	$19.04	$24.10	$4.66	$17.77	$23.50	$1,032.64	$1,014.62
% Difference from FY 2016-17 Rate	14.16%	1.90%	-2.19%	-9.60%	2.21%	-3.89%	35.50%	1.55%	6.31%	56.98%	4.11%	7.06%	5.33%	4.59%
% Difference from FY 2017-18 Rate	-2.42%	1.20%	2.30%	-8.74%	1.73%	1.95%	12.55%	6.51%	6.06%	7.94%	5.56%	5.90%	1.24%	1.05%
Linear Growth Model	$212.01	$125.56	$152.76	$185.84	$125.38	$154.82	$6.35	$18.73	$23.69	$4.67	$17.51	$23.05	$1,029.33	$1,012.38
% Difference from FY 2016-17 Rate	-4.42%	1.73%	-4.93%	-17.18%	1.88%	-3.86%	46.65%	-0.11%	4.48%	57.34%	2.55%	5.03%	5.00%	4.36%
% Difference from FY 2017-18 Rate	-9.58%	1.10%	1.34%	-15.27%	1.55%	1.82%	9.29%	5.08%	4.73%	5.99%	4.43%	4.57%	1.06%	0.91%
% change from FY 2016-17 Rate to Selected FY 2017-18 Capitation Rate [1]	1.99%	1.90%	1.90%	2.78%	1.88%	3.59%	4.65%	4.17%	4.48%	4.65%	4.11%	5.03%	2.33%	2.17%
FY 2017-18 Forecast Point Estimate	**$226.24**	**$125.77**	**$163.75**	**$230.61**	**$125.38**	**$166.82**	**$4.53**	**$19.53**	**$23.69**	**$3.11**	**$17.77**	**$23.05**	**$1,003.17**	**$991.16**
% change from FY 2017-18 Rate to Selected FY 2018-19 Capitation Rate [1]	1.99%	1.20%	2.30%	1.39%	1.55%	3.59%	4.65%	3.75%	4.73%	4.65%	1.87%	4.57%	1.83%	1.72%
FY 2018-19 Forecast Point Estimate	**$230.75**	**$127.27**	**$167.52**	**$233.81**	**$127.33**	**$172.82**	**$4.74**	**$20.26**	**$24.81**	**$3.25**	**$18.10**	**$24.10**	**$1,021.52**	**$1,008.20**

[1] Selected trends are described below.

Children Medical	FY 2017-18	Children 0%-205%: Ages 0-1 - 1/2 Two Period Moving Average; Ages 2-5 - Exponential Growth Model; Ages 6-18 - Exponential Growth Model for Ages 2-5 Children 206%-260%: Ages 0-1 - Two Period Moving Avg; Ages 2-5 - Linear Growth Model; Ages 6-18 - 1/2 growth from FY2014-15 to FY2016-17
	FY 2018-19	Children 0%-205%: Ages 0-1 - FY 2016-17 selected trend; Ages 2-5 - Exponential Growth Model; Ages 6-18 - FY 2015-16 Exponential Growth Model Children 206%-260%: Ages 0-1 - 1/2 FY 2016-17 selected trend; Ages 2-5 - Linear Growth Model; Ages 6-18 - FY 2016-17 selected trend
Children Dental	FY 2017-18	Children 0%-205%: Ages 0-1 - 1/2 Linear Growth Model for FY 2018-19; Ages 2-5 - FY14 to FY15 growth; Ages 6-18 - Linear Growth Model Children 206%-260%: Ages 0-1 - Trend selected for FY2 017-18; Ages 2-5 - Average Growth Model; Ages 6-18 - Linear Growth Model
	FY 2018-19	Children 0%-205%: Ages 0-1 - FY 2016-17 selected trend; Ages 2-5 - Exponential Growth Model; Ages 6-18 - Linear Growth Model Children 206%-260%: Ages 0-1 - Trend Selected for FY 2017-18; Ages 2-5 - Two Period Moving Average Model; Ages 6-18 - Linear Growth Model
Prenatal	FY 2017-18	Prenatal 0%-205%: Average Growth Model Prenatal 206%-260%: Average Growth Model
	FY 2018-19	Prenatal 0%-205%: Average Growth Model Prenatal 206%-260%: Average Growth Model

Exhibit C2 - Calculation of Fund Splits

Calculation of Fund Splits - FY 2016-17 Children's Basic Health Plan Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FMAP Rate[1]
CBHP Expenditure to be matched	$152,524,656	$18,104,677	$0	$0	$134,419,979	88.13%
Enrollment Fees CBHP Trust Fund	$661,836	$0	$661,836	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$1,377,489	$0	$1,377,489	$0	$0	0.00%
Total CBHP Expenditure	**$154,563,981**	**$18,104,677**	**$2,039,325**	**$0**	**$134,419,979**	86.97%
Cash Fund Financing						
CBHP Trust Fund	$0	($11,478,057)	$11,478,057	$0	$0	NA
CO Immunization Fund	$0	($442,697)	$442,697	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Hospital Provider Fee Fund	$0	($6,183,922)	$6,183,922	$0	$0	NA
Estimated FY 2016-17 Capitation Expenditure	**$154,563,981**	**$0**	**$20,144,002**	**$0**	**$134,419,979**	86.97%
Department Recoveries for Prior Year Expenditure [2]						
Department Recoveries	$1,500,000	$0	$1,500,000	$0	$0	0.00%
Impact to CHP+ Trust Fund	($1,500,000)	$0	($428,850)	$0	($1,071,150)	71.41%
Disallowance Payments	$2,501,956	$2,501,956	$0	$0	$0	0.00%
Final Estimated FY 2016-17 Capitation Expenditure	**$157,065,937**	**$2,501,956**	**$21,215,152**	**$0**	**$133,348,829**	84.90%
CBHP Admin Payments	**$5,033,274**	**$0**	**$597,450**	**$0**	**$4,435,824**	88.13%
Final Estimated FY 2016-17 CBHP Expenditure	**$162,099,211**	**$2,501,956**	**$21,812,602**	**$0**	**$137,784,653**	85.00%

[1]Starting October 1, 2015, CBHP programs received an additional 23 percentage points on the federal match. The FY 2016-17 weighted average federal match is 88.13%.

[2] The Department expects to recover expenditure in FY 2016-17 from prior years, which cannot offset expenditure in the current year due to State fiscal rules. Therefore, the Department's estimate shows that recovery as an increase to cash funds.

Exhibit C2 - Calculation of Fund Splits

Calculation of Fund Splits - FY 2017-18 Children's Basic Health Plan Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FMAP Rate[(1)]
CBHP Expenditure to be matched	$157,254,999	$18,870,600	$0	$0	$138,384,399	88.00%
Enrollment Fees CBHP Trust Fund	$677,759	$0	$677,759	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$1,410,672	$0	$1,410,672	$0	$0	0.00%
Total CBHP Expenditure	**$159,343,430**	**$18,870,600**	**$2,088,431**	**$0**	**$138,384,399**	86.85%
Cash Fund Financing						
CBHP Trust Fund	$0	($11,838,455)	$11,838,455	$0	$0	NA
CO Immunization Fund	$0	($445,574)	$445,574	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Hospital Provider Fee Fund	$0	($6,586,570)	$6,586,570	$0	$0	NA
Estimated FY 2017-18 Capitation Expenditure	**$159,343,430**	**$0**	**$20,959,031**	**$0**	**$138,384,399**	86.85%
Disallowance Payments	$621,616	$621,616	$0	$0	$0	0.00%
Estimated FY 2017-18 Capitation Expenditure	**$159,965,046**	**$621,616**	**$20,959,031**	**$0**	**$138,384,399**	86.51%
CBHP Admin Payments	**$5,033,274**	**$0**	**$603,993**	**$0**	**$4,429,281**	88.00%
Final Estimated FY 2017-18 CBHP Expenditure	**$164,998,320**	**$621,616**	**$21,563,024**	**$0**	**$142,813,680**	86.55%

[(1)]Starting October 1, 2015, CBHP programs received an additional 23 percentage points on the federal match. The FY 2017-18 projected federal match is 88.00%.

Exhibit C2 - Calculation of Fund Splits

Calculation of Fund Splits - FY 2018-19 Children's Basic Health Plan Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FMAP Rate[(1)]
CBHP Expenditure to be matched	$165,101,102	$19,812,133	$0	$0	$145,288,969	88.00%
Enrollment Fees CBHP Trust Fund	$699,546	$0	$699,546	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$1,446,215	$0	$1,446,215	$0	$0	0.00%
Total CBHP Expenditure	**$167,246,863**	**$19,812,133**	**$2,145,761**	**$0**	**$145,288,969**	86.87%
Cash Fund Financing						
CBHP Trust Fund	$0	($12,506,386)	$12,506,386	$0	$0	NA
CO Immunization Fund	$0	($375,675)	$375,675	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Hospital Provider Fee Fund	$0	($6,930,070)	$6,930,070	$0	$0	NA
Estimated FY 2018-19 Capitation Expenditure	**$167,246,863**	**$0**	**$21,957,893**	**$0**	**$145,288,969**	**86.87%**
Disallowance Payments	$0	$0	$0	$0	$0	0.00%
Final Estimated FY 2018-19 Capitation Expenditure	**$167,246,863**	**$0**	**$21,957,893**	**$0**	**$145,288,970**	86.87%
CBHP Admin Payments	**$5,033,274**	**$0**	**$603,993**	**$0**	**$4,429,281**	88.00%
Final Estimated FY 2018-19 CBHP Expenditure	**$172,280,137**	**$0**	**$22,561,886**	**$0**	**$149,718,251**	86.90%

[(1)]Starting October 1, 2015, CBHP programs received an additional 23 percentage points on the federal match. The FY 2018-19 projected federal match is 88.00%.

Exhibit C2 - Cash Funds Report for CBHP

Cash Funds Report for CBHP Capitation Payments

Cash Fund	FY 2016-17			FY 2017-18			FY 2018-19		
	Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change
Cash Funds									
CBHP Trust Fund[(1)]	$11,488,720	$11,711,043	$222,323	$11,488,720	$12,516,214	$1,027,494	$11,488,720	$13,205,932	$1,717,212
CO Immunization Fund	$202,664	$442,697	$240,033	$202,664	$445,574	$242,910	$202,664	$375,675	$173,011
Health Care Expansion Fund	$1	$1	$0	$1	$1	$0	$1	$1	$0
Hospital Provider Fee Fund	$5,842,569	$7,561,411	$1,718,842	$5,842,569	$7,997,242	$2,154,673	$5,842,569	$8,376,285	$2,533,716
Department Recoveries	$0	$1,500,000	$1,500,000	$0	$0	$0	$0	$0	$0
Total Cash Funds	**$17,533,954**	**$21,215,152**	**$3,681,198**	**$17,533,954**	**$20,959,031**	**$3,425,077**	**$17,533,954**	**$21,957,893**	**$4,423,939**

[(1)]Estimated revenues to the CBHP Trust Fund are based on the 2016 Tobacco MSA Payment Forecast along with HB 16-1408, which altered the distribution of revenue. See Exhibit C5.

Cash Funds Report for CBHP Admin Payments

Cash Fund	FY 2016-17			FY 2017-18			FY 2018-19		
	Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change
Cash Funds									
CBHP Trust Fund[(1)]	$2,354,463	$595,060	($1,759,403)	$2,354,463	$601,577	($1,752,886)	$2,354,463	$601,577	($1,752,886)
CO Immunization Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Care Expansion Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Hospital Provider Fee Fund	$9,361	$2,390	($6,971)	$9,361	$2,416	($6,945)	$9,361	$2,416	($6,945)
Total Cash Funds	**$2,363,824**	**$597,450**	**($1,766,374)**	**$2,363,824**	**$603,993**	**($1,759,831)**	**$2,363,824**	**$603,993**	**($1,759,831)**

[(1)]Estimated revenues to the CBHP Trust Fund are based on the 2016 Tobacco MSA Payment Forecast along with HB 16-1408, which altered the distribution of revenue. See Exhibit C5.

Exhibit C2-Disallowance Repayment Schedule

Summary of Payments by Quarter		
Fiscal Year	**Quarter**	**Payment Due**
FY 2014-15	QE December 31, 2014	$684,674
	QE March 31, 2015	$636,871
FY 2015-16	QE June 30, 2015	$635,512
	QE September 30, 2015	$634,119
	QE December 31,2015	$632,556
	QE March 31, 2016	$630,874
	QE June 30, 2016	$629,328
FY 2016-17	QE September 30, 2016	$627,867
	QE December 31, 2016	$626,304
	QE March 31, 2017	$624,640
	QE June 30, 2017	$623,145
FY 2017-18	QE September 30, 2017	$621,616
Total All Payments		**$7,607,507**

Summary of Payments by Fiscal Year	
FY 2014-15	$1,321,545
FY 2015-16	$3,162,389
FY 2016-17	$2,501,956
FY 2017-18	$621,616
Total	**$7,607,506**

Disallowances 12-001 CHIP, 12-003 CHIP, & 13-004 CHIP

Exhibit C3 - Children's Basic Health Plan Programs Expenditure Summary
Actuals, Appropriations and Estimates Prior to Recoupments

ITEM	FY 2015-16 Actual		FY 2016-17 Appropriated		FY 2016-17 Estimate		FY 2016-17 Change from Appropriation		FY 2017-18 Estimate		FY 2017-18 Change from FY 2016-17 Estimate		FY 2017-18 Change from FY 2016-17 Appropriation		FY 2018-19 Estimate		FY 2018-19 Change from FY 2017-18 Estimate	
	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure
CHP+ Capitation Payments																		
Children to 205% FPL Medical	34,940	$67,206,831	39,287	$82,584,307	41,022	$84,750,615	1,735	$2,166,308	41,826	$89,336,863	804	$4,586,248	2,539	$6,752,556	42,784	$93,608,946	958	$4,272,083
Children 206%-260% FPL Medical	16,100	$30,317,390	18,732	$32,020,150	20,097	$41,133,183	1,365	$9,113,033	20,596	$44,199,460	499	$3,066,277	1,864	$12,179,310	21,115	$46,639,481	519	$2,440,021
Children to 205% FPL Dental	34,940	$7,596,208	39,287	$9,459,234	41,022	$9,698,995	1,735	$239,761	41,826	$10,395,177	804	$696,182	2,539	$935,943	42,784	$11,079,809	958	$684,632
Children 206%-260% FPL Dental	16,100	$3,339,187	18,732	$3,783,950	20,097	$4,396,271	1,365	$612,321	20,596	$4,786,120	499	$389,849	1,864	$1,002,170	21,115	$5,117,770	519	$331,650
Prenatal to 205% FPL	199	$2,276,348	273	$4,130,692	258	$3,184,435	(15)	($946,257)	260	$3,312,635	2	$128,200	(13)	($818,057)	259	$3,361,303	(1)	$48,668
Prenatal 206%-260% FPL	469	$5,893,047	578	$6,976,270	575	$7,043,291	(3)	$67,021	575	$7,313,175	0	$269,884	(3)	$336,905	575	$7,439,554	0	$126,379
Bottom Line Impacts																		
FQHC Payments		*$1,563,307*		*$0*		*$1,000,000*		*$1,000,000*		*$0*		*($1,000,000)*		*$0*		*$0*		*$0*
Department Recoveries		*$4,467,551*		*$0*		*$1,500,000*		*$1,500,000*		*$0*		*($1,500,000)*		*$0*		*$0*		*$0*
Other Payments		*$407,379*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*
Adjustment for Clients Placed in Incorrect Eligibility Types		*$0*		*$0*		*$1,857,191*		*$1,857,191*		*$0*		*($1,857,191)*		*$0*		*$0*		*$0*
Disallowance Payments		*$3,162,548*		*$2,500,441*		*$2,501,956*		*$1,515*		*$621,616*		*($1,880,340)*		*($1,878,825)*		*$0*		*($621,616)*
Sub-total CBHP Program Expenditure	**51,709**	**$126,229,798**	**58,870**	**$141,455,044**	**61,952**	**$157,065,937**	**3,082**	**$15,610,893**	**63,257**	**$159,965,046**	**1,305**	**$2,899,109**	**4,387**	**$18,510,002**	**64,733**	**$167,246,863**	**1,476**	**$7,281,817**
Enrollment Fees		$1,123,169		$1,180,123		$2,039,325		$859,202		$2,088,431		$49,106		$908,308		$2,145,761		$57,330
Children to 200%		*$598,249*		*$306,109*		*$648,596*		*$342,486*		*$664,194*		*$15,599*		*$358,085*		*$685,658*		*$21,463*
Children 201%-205%		*$49,063*		*$6,501*		*$13,240*		*$6,739*		*$13,565*		*$324*		*$7,064*		*$13,889*		*$324*
Children 206%-260%		*$475,856*		*$867,513*		*$1,377,489*		*$509,977*		*$1,410,672*		*$33,183*		*$543,159*		*$1,446,215*		*$35,543*
Total CBHP Program Expenditure	**51,709**	**$126,229,798**	**58,870**	**$141,455,044**	**61,952**	**$157,065,937**	**3,082**	**$15,610,893**	**63,257**	**$159,965,046**	**1,305**	**$2,899,109**	**4,387**	**$18,510,002**	**64,733**	**$167,246,863**	**1,476**	**$7,281,817**
Incremental Percent Change							5.24%	11.04%			2.11%	1.85%	7.45%	13.09%			2.33%	4.55%
CBHP Admin Payments																		
External Admin		$1,562,906		$5,033,274		$5,033,274		$0		$5,033,274		$0		$0		$5,033,274		$0
Incremental Percent Change								0.00%				0.00%						0.00%
Total CBHP Admin Payments		**$1,562,906**		**$5,033,274**		**$5,033,274**		**$0**		**$5,033,274**		**$0**		**$0**		**$5,033,274**		**$0**
Total CBHP Programs		**$127,792,704**		**$146,488,318**		**$162,099,211**		**$15,610,893**		**$164,998,320**		**$2,899,109**		**$18,510,002**		**$172,280,137**		**$7,281,817**
Incremental Percent Change								10.66%				1.79%		12.64%				4.41%

Exhibit C4 - Children's Basic Health Plan, Caseload													
Children's Basic Health Plan Average Caseload By Fiscal Year													
Item	**Children 0%-205%**			**Children 0%-205% All Ages**	**Children 206%-260%**			**Children 206%-260% All Ages**	**Total Children**	**Prenatal 0%-205%**	**Prenatal 206%-260%**	**Total Prenatal**	**Total**
	Ages 0-1	**Ages 2-5**	**Ages 6-18**		**Ages 0-1**	**Ages 2-5**	**Ages 6-18**						
FY 2008-09 Actuals	4,820	11,426	45,336	61,582	-	-	-	-	-	1,665	-	1,665	63,247
FY 2009-10 Actuals	5,123	11,520	51,946	68,589	13	32	91	136	68,725	1,550	11	1,561	70,286
% Change from FY 2008-09	6.29%	0.82%	14.58%	11.38%	0.00%	0.00%	0.00%	0.00%	0.00%	-6.91%	0.00%	-6.25%	11.13%
FY 2010-11 Actuals	4,407	10,467	48,370	63,244	430	982	2,611	4,023	67,267	1,470	272	1,742	69,009
% Change from FY 2009-10	-13.98%	-9.14%	-6.88%	-7.79%	3207.69%	2968.75%	2769.23%	2858.09%	-2.12%	-5.16%	2373%	11.60%	-1.82%
FY 2011-12 Actuals	4,750	10,374	48,093	63,217	1,055	2,471	7,523	11,049	74,266	1,616	448	2,064	76,330
% Change from FY 2010-11	7.78%	-0.89%	-0.57%	-0.04%	145.35%	151.63%	188.13%	174.65%	10.40%	9.93%	64.71%	18.48%	10.61%
FY 2012-13 Actuals	5,187	11,300	45,773	62,260	1,398	3,377	10,800	15,575	77,835	1,148	463	1,611	79,446
% Change from FY 2011-12	9.20%	8.93%	-4.82%	-1.51%	32.51%	36.67%	43.56%	40.96%	4.81%	-28.96%	3.35%	-21.95%	4.08%
FY 2013-14 Actuals	3,081	9,993	29,437	42,511	1,319	4,411	13,313	19,043	61,554	451	502	953	62,507
% Change from FY 2012-13	-40.60%	-11.57%	-35.69%	-31.72%	-5.65%	30.62%	23.27%	22.27%	-20.92%	-60.71%	8.42%	-40.84%	-21.32%
FY 2014-15 Actuals	2,870	8,375	25,787	37,032	1,349	3,680	11,639	16,668	53,699	227	460	687	54,386
% Change from FY 2013-14	-6.84%	-16.20%	-12.40%	-12.89%	2.26%	-16.57%	-12.57%	-12.47%	-12.76%	-49.67%	-8.37%	-27.91%	-12.99%
FY 2015-16 Actuals	2,736	8,025	24,179	34,940	1,446	3,475	11,179	16,100	51,041	199	469	668	51,709
% Change from FY 2014-15	-4.67%	-4.17%	-6.24%	-5.65%	7.20%	-5.56%	-3.95%	-3.40%	-4.95%	-12.33%	1.96%	-2.77%	-4.92%
FY 2016-17 Projection	3,319	9,308	28,395	41,022	1,850	4,805	13,442	20,097	61,119	258	575	833	61,952
% Change from FY 2015-16	21.30%	15.98%	17.44%	17.41%	27.95%	38.26%	20.24%	24.82%	19.75%	29.65%	22.60%	24.70%	19.81%
FY 2017-18 Projection	3,589	9,408	28,829	41,826	1,861	4,880	13,855	20,596	62,422	260	575	835	63,257
% Change from FY 2016-17	8.13%	1.07%	1.53%	1.96%	0.59%	1.56%	3.07%	2.48%	2.13%	0.78%	0.00%	0.24%	2.11%
FY 2018-19 Projection	3,863	9,375	29,546	42,784	1,866	4,916	14,333	21,115	63,899	259	575	834	64,733
% Change from FY 2017-18	7.63%	-0.35%	2.49%	2.29%	0.27%	0.74%	3.45%	2.52%	2.37%	-0.38%	0.00%	-0.12%	2.33%
FY 2016-17 Appropriation	2,962	9,327	26,998	39,287	1,547	4,001	13,184	18,732	58,019	273	578	851	58,870
Difference between the FY 2016-17 Appropriation and Projection	357	(19)	1,397	1,735	303	804	258	1,365	3,100	(15)	(3)	(18)	3,082

Exhibit C4 - Children's Basic Health Plan, Caseload													
Children's Basic Health Plan Caseload Adjustments By Fiscal Year													
Item	**Children 0%-205%**			**Children 0%-205% All Ages**	**Children 206%-260%**			**Children 206%-260% All Ages**	**Total Children**	**Prenatal 0%-205%**	**Prenatal 206%-260%**	**Total Prenatal**	**Total**
	Ages 0-1	**Ages 2-5**	**Ages 6-18**		**Ages 0-1**	**Ages 2-5**	**Ages 6-18**						
HB 09-1353 Removal of 5-Year Bar on Legal Immigrants	80	225	686	991	46	120	336	502	1,493	35	61	96	1,589
Total 2016-17 Adjustments	**80**	**225**	**686**	**991**	**46**	**120**	**336**	**502**	**1,493**	**35**	**61**	**96**	**1,589**
HB 09-1353 Removal of 5-Year Bar on Legal Immigrants	88	231	707	1,026	48	125	356	529	1,555	34	61	95	1,650
Total 2017-18 Adjustments	**88**	**231**	**707**	**1,026**	**48**	**125**	**356**	**529**	**1,555**	**34**	**61**	**95**	**1,650**
HB 09-1353 Removal of 5-Year Bar on Legal Immigrants	95	230	725	1,050	48	126	368	542	1,592	34	61	95	1,687
Total 2018-19 Adjustments	**95**	**230**	**725**	**1,050**	**48**	**126**	**368**	**542**	**1,592**	**34**	**61**	**95**	**1,687**

Exhibit C4 - Children's Basic Health Plan, Caseload													
Children's Basic Health Plan Average Monthly Caseload - Without Adjustments													
Item	**Children 0%-205%**			**Children 0%-205% All Ages**	**Children 206%-260%**			**Children 206%-260% All Ages**	**Total Children**	**Prenatal 0%-205%**	**Prenatal 206%-260%**	**Total Prenatal**	**Total**
	Ages 0-1	**Ages 2-5**	**Ages 6-18**		**Ages 0-1**	**Ages 2-5**	**Ages 6-18**						
FY 2008-09 Actuals	4,820	11,426	45,336	61,582	-	-	-	-	61,582	1,665	-	1,665	63,247
FY 2009-10 Actuals	5,123	11,520	51,946	68,589	13.00	32	91	136	68,725	1,550	11	1,561	70,286
% Change from FY 2008-09	6.29%	0.82%	14.58%	11.38%	0.00%	0.00%	0.00%	0.00%	11.60%	-6.91%	0.00%	-6.25%	11.13%
FY 2010-11 Actuals	4,407	10,467	48,370	63,244	430	982	2,611	4,023	67,267	1,470	272	1,742	69,009
% Change from FY 2009-10	-13.98%	-9.14%	-6.88%	-7.79%	3207.69%	2968.75%	2769.23%	2858.09%	-2.12%	-5.16%	2372.73%	11.60%	-1.82%
FY 2011-12 Actuals	4,750	10,374	48,093	63,217	1,055	2,471	7,523	11,049	74,266	1,616	448	2,064	76,330
% Change from FY 2010-11	7.78%	-0.89%	-0.57%	-0.04%	145.35%	151.63%	188.13%	174.65%	10.40%	9.93%	64.71%	18.48%	10.61%
FY 2012-13 Actuals	5,187	11,300	45,773	62,260	1,398	3,377	10,800	15,575	77,835	1,148	463	1,611	79,446
% Change from FY 2011-12	9.20%	8.93%	-4.82%	-1.51%	32.51%	36.67%	43.56%	40.96%	4.81%	-28.96%	3.35%	-21.95%	4.08%
FY 2013-14 Actuals	3,081	9,993	29,437	42,511	1,319	4,411	13,313	19,043	61,554	451	502	953	62,507
% Change from FY 2012-13	-40.60%	-11.57%	-35.69%	-31.72%	-5.65%	30.62%	23.27%	22.27%	-20.92%	-60.71%	8.42%	-40.84%	-21.32%
FY 2014-15 Actuals	2,870	8,375	25,787	37,032	1,349	3,680	11,639	16,668	53,700	227	460	687	54,387
% Change from FY 2013-14	-6.84%	-16.20%	-12.40%	-12.89%	2.26%	-16.57%	-12.57%	-12.47%	-12.76%	-49.67%	-8.37%	-27.91%	-12.99%
FY 2015-16 Actuals	2,736	8,025	24,179	34,940	1,446	3,475	11,179	16,100	51,040	199	469	668	51,708
% Change from FY 2014-15	-4.67%	-4.17%	-6.24%	-5.65%	7.20%	-5.56%	-3.95%	-3.41%	-4.95%	-12.33%	1.96%	-2.77%	-4.93%
FY 2016-17 Projection	3,239	9,083	27,709	40,031	1,804	4,685	13,106	19,595	59,626	223	514	737	60,363
% Change from FY 2015-16	18.37%	13.18%	14.60%	14.57%	24.77%	34.80%	17.24%	21.71%	16.82%	12.06%	9.59%	10.33%	16.74%
FY 2017-18 Projection	3,501	9,177	28,122	40,800	1,813	4,755	13,499	20,067	60,867	226	514	740	61,607
% Change from FY 2016-17	8.09%	1.03%	1.49%	1.92%	3.62%	0.00%	10.98%	2.41%	2.08%	1.35%	0.00%	0.41%	2.06%
FY 2018-19 Projection	3,768	9,145	28,821	41,734	1,818	4,790	13,965	20,573	62,307	225	514	739	63,046
% Change from FY 2017-18	7.63%	-0.35%	2.49%	2.29%	2.45%	0.00%	11.00%	2.52%	2.37%	-0.44%	0.00%	-0.14%	2.34%
FY 2016-17 Appropriation	2,962	9,327	26,998	39,287	1,547	4,001	13,184	18,732	58,019	273	578	851	58,870
Difference between the FY 2016-17 Appropriation and Projection	357	(19)	1,397	1,735	303	804	258	1,365	3,100	(15)	(3)	(18)	3,082

Exhibit C4 - Children's Basic Health Plan Monthly Caseload Historical Summary

CBHP CASELOAD FY 2012-13 without RETROACTIVITY

FY 2012-13	Children to 205% FPL	Children 206%-260% FPL	Total Children	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Total Prentatal	TOTAL CBHP	Monthly Growth	Monthly Growth Rate
July 2012	69,977	13,731	83,708	1,694	452	2,146	85,854	819	0.96%
August 2012	68,938	14,509	83,447	1,663	459	2,122	85,569	(285)	-0.33%
September 2012	67,196	15,267	82,463	1,575	482	2,057	84,520	(1,049)	-1.23%
October 2012	68,080	14,955	83,035	1,552	470	2,022	85,057	537	0.64%
November 2012	69,082	15,289	84,371	1,593	498	2,091	86,462	1,405	1.65%
December 2012	68,453	16,575	85,028	1,589	550	2,139	87,167	705	0.82%
January 2013	65,022	16,159	81,181	662	504	1,166	82,347	(4,820)	-5.53%
February 2013	59,761	16,028	75,789	585	451	1,036	76,825	(5,522)	-6.71%
March 2013	55,167	16,337	71,504	636	442	1,078	72,582	(4,243)	-5.52%
April 2013	55,115	16,091	71,206	709	435	1,144	72,350	(232)	-0.32%
May 2013	51,438	15,914	67,352	737	417	1,154	68,506	(3,844)	-5.31%
June 2013	48,895	16,047	64,942	778	399	1,177	66,119	(2,387)	-3.48%
Year-to-Date Average	**62,260**	**15,575**	**77,835**	**1,148**	**463**	**1,611**	**79,446**	**(1,576)**	**-2.03%**

CBHP CASELOAD FY 2013-14 without RETROACTIVITY

FY 2013-14[(1)]	Children to 205% FPL	Children 206%-260% FPL	Total Children	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Total Prentatal	TOTAL CBHP	Monthly Growth	Monthly Growth Rate
July 2013	52,548	15,933	68,481	850	354	1,204	69,685	3,566	5.39%
August 2013	50,183	17,642	67,825	869	393	1,262	69,087	(598)	-0.86%
September 2013	50,143	16,564	66,707	928	385	1,313	68,020	(1,067)	-1.54%
October 2013	43,294	20,972	64,266	246	533	779	65,045	(2,975)	-4.37%
November 2013	39,832	19,542	59,374	313	534	847	60,221	(4,824)	-7.42%
December 2013	40,150	20,376	60,526	354	540	894	61,420	1,199	1.99%
January 2014	39,924	20,324	60,248	310	561	871	61,119	(301)	-0.49%
February 2014	37,490	19,050	56,540	300	566	866	57,406	(3,713)	-6.08%
March 2014	39,972	20,690	60,662	333	593	926	61,588	4,182	7.28%
April 2014	40,436	20,255	60,691	332	536	868	61,559	(29)	-0.05%
May 2014	37,893	18,554	56,447	298	496	794	57,241	(4,318)	-7.01%
June 2014	38,258	18,612	56,870	276	527	803	57,673	432	0.75%
Year-to-Date Average	**42,511**	**19,043**	**61,554**	**451**	**502**	**953**	**62,507**	**(704)**	**-1.03%**

[(1)] Caseload has been restated for Children above 200% FPL and Prenatal above 200% FPL back to January 2014 and going forward. Due to the MAGI conversion in January 2014, clients that are between 201%-205% of FPL can not be explicitly identified. The Department is using a rolling 6 month average (prior to the MAGI conversion) of the proportion of clients that are 201%-205% and 206%-260% FPL and applying this distribution to the total caseload that is above 200% FPL.

CBHP CASELOAD FY 2014-15 without RETROACTIVITY

FY 2014-15[(1)]	Children to 205% FPL	Children 206%-260% FPL	Total Children	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Total Prentatal	TOTAL CBHP	Monthly Growth	Monthly Growth Rate
July 2014	37,832	17,496	55,328	229	460	689	56,017	(1,656)	-2.87%
August 2014	39,858	19,106	58,964	296	496	792	59,756	3,739	6.67%
September 2014	38,675	18,350	57,025	273	488	761	57,786	(1,970)	-3.30%
October 2014	35,543	16,449	51,992	224	457	681	52,673	(5,113)	-8.85%
November 2014	35,405	16,027	51,432	233	455	688	52,120	(553)	-1.05%
December 2014	36,771	15,851	52,622	232	446	678	53,300	1,180	2.26%
January 2015	36,177	15,780	51,957	205	478	683	52,640	(660)	-1.24%
February 2015	36,686	15,980	52,666	200	465	665	53,331	691	1.31%
March 2015	36,909	16,068	52,977	195	485	680	53,657	326	0.61%
April 2015	37,175	16,327	53,502	214	444	658	54,160	503	0.94%
May 2015	37,114	16,573	53,687	212	433	645	54,332	172	0.32%
June 2015	36,236	16,005	52,241	210	416	626	52,867	(1,465)	-2.70%
Year-to-Date Average	**37,032**	**16,668**	**53,699**	**227**	**460**	**687**	**54,387**	**(401)**	**-0.66%**

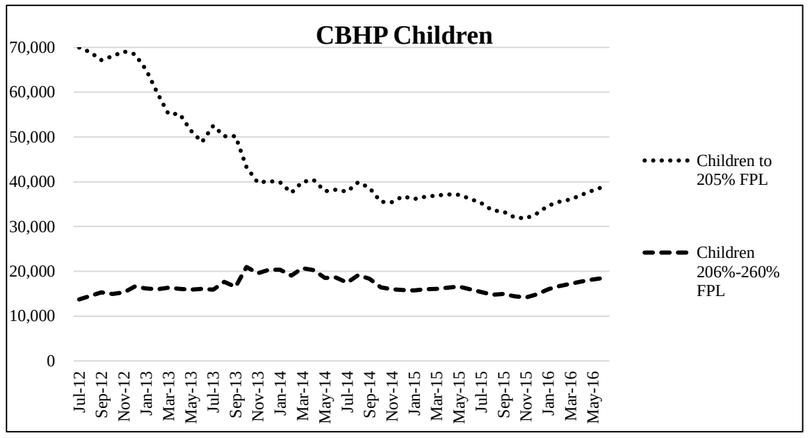
[(1)] Caseload has been restated for Children above 200% FPL and Prenatal above 200% FPL back to January 2014 and going forward. Due to the MAGI conversion in January 2014, clients that are 201%-205% FPL's can not be explicitly identified. The Department is using a rolling 6 month average (prior to the MAGI conversion) of the proportion of clients that are 201%-205% and 206%-260% FPL and applying this distribution to the total caseload that is above 200% FPL.

CBHP CASELOAD FY 2015-16 without RETROACTIVITY

FY 2015-16[(1)]	Children to 205% FPL	Children 206%-260% FPL	Total Children	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Total Prentatal	TOTAL CBHP	Monthly Growth	Monthly Growth Rate
July 2015	35,269	15,382	50,651	206	415	621	51,272	(1,595)	-3.02%
August 2015	33,608	14,765	48,373	189	398	587	48,960	(2,312)	-4.51%
September 2015	33,333	14,936	48,269	183	394	577	48,846	(114)	-0.23%
October 2015	32,011	14,444	46,455	167	405	572	47,027	(1,819)	-3.72%
November 2015	31,821	14,212	46,033	192	449	641	46,674	(353)	-0.75%
December 2015	32,921	14,908	47,829	187	472	659	48,488	1,814	3.89%
January 2016	34,658	16,036	50,694	205	506	711	51,405	2,917	6.02%
February 2016	35,557	16,728	52,285	202	515	717	53,002	1,597	3.11%
March 2016	36,075	17,257	53,332	196	529	725	54,057	1,055	1.99%
April 2016	37,075	17,763	54,838	212	519	731	55,569	1,512	2.80%
May 2016	38,019	18,204	56,223	225	515	740	56,963	1,394	2.51%
June 2016	38,938	18,568	57,506	220	514	734	58,240	1,277	2.24%
Year-to-Date Average	**34,940**	**16,100**	**51,041**	**199**	**469**	**668**	**51,709**	**448**	**0.86%**

[(1)] Caseload has been restated for Children above 200% FPL and Prenatal above 200% FPL back to January 2014 and going forward. Due to the MAGI conversion in January 2014, clients that are between 201%-205% of FPL can not be explicitly identified. The Department is using a rolling 6 month average (prior to the MAGI conversion) of the proportion of clients that are 201%-205% and 206%-259% FPL and applying this distribution to the total caseload that is above 200% FPL.

Exhibit C4 - Children's Basic Health Plan Monthly Caseload Historical Summary



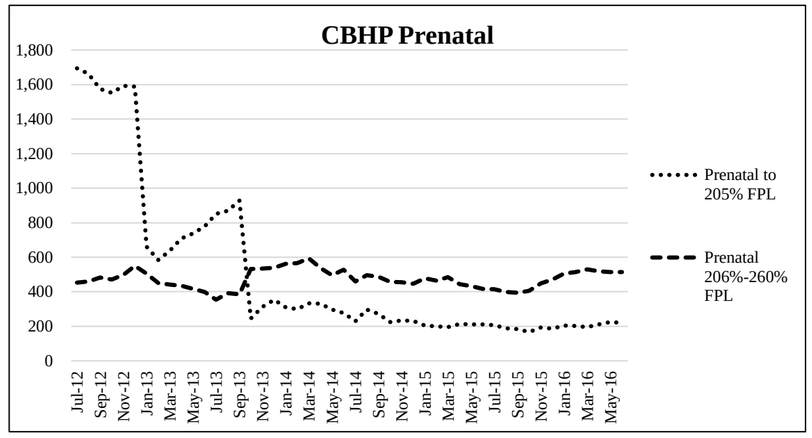


Exhibit C4 - Children's Basic Health Plan Capitation Payments Per Capita Historical Summary							
Item	**Children 0%-205% FPL Medical**	**Children 206%-260% FPL Medical**	**Children 0%-205% FPL Dental**	**Children 206%-260% FPL Dental**	**Prenatal 0%-205% FPL**	**Prenatal 206%-260% FPL**	**Total**
FY 2009-10 Actuals	$2,208.41	1,540.48	$157.15	76.04	$10,297.88	5,651.89	$2,539.55
FY 2010-11 Actuals	$2,130.28	$2,439.89	$159.17	$148.60	$12,583.11	$13,159.54	$2,569.00
% Change from FY 2009-10	-3.54%	58.38%	1.29%	95.42%	22.19%	132.83%	1.16%
FY 2011-12 Actuals	$2,014.43	$1,926.19	$168.30	$160.66	$10,528.68	$9,814.12	$2,390.33
% Change from FY 2010-11	-5.44%	-21.05%	5.73%	8.12%	-16.33%	-25.42%	-6.95%
FY 2012-13 Actuals	$2,063.72	$1,817.94	$176.81	$149.39	$14,259.74	$10,936.88	$2,411.33
% Change from FY 2011-12	2.45%	-5.62%	5.06%	-7.01%	35.44%	11.44%	0.88%
FY 2013-14 Actuals	$2,715.44	$2,178.76	$232.14	$207.37	$14,172.67	$11,189.55	$2,923.72
% Change from FY 2012-13	31.58%	19.85%	31.29%	38.81%	-0.61%	2.31%	21.25%
FY 2014-15 Actuals	$2,230.69	$1,941.36	$227.63	$193.64	$16,784.57	$12,544.25	$2,504.34
% Change from FY 2013-14	-17.85%	-10.90%	-1.94%	-6.62%	18.43%	12.11%	-14.34%
FY 2015-16 Actuals	$2,012.88	$1,993.69	$232.21	$221.88	$12,036.03	$13,111.16	$2,372.13
% Change from FY 2014-15	-9.76%	2.70%	2.01%	14.59%	-28.29%	4.52%	-5.28%
FY 2016-17 Projection	$2,141.50	$2,085.07	$244.17	$220.94	$12,498.15	$12,401.20	$2,494.90
% Change from FY 2015-16	6.39%	4.58%	5.15%	-0.43%	3.84%	-5.41%	5.18%
FY 2017-18 Projection	$2,135.92	$2,146.02	$248.53	$232.38	$12,740.90	$12,718.57	$2,518.98
% Change from FY 2016-17	-0.26%	2.92%	1.79%	5.18%	1.94%	2.56%	0.97%
FY 2018-19 Projection	$2,187.94	$2,208.83	$258.97	$242.38	$12,978.00	$12,938.35	$2,583.64
% Change from FY 2017-18	2.44%	2.93%	4.20%	4.30%	1.86%	1.73%	2.57%
[(1)]Per capita in FY 2013-14 increased for Children's Medical and Children's Dental categories due to a substantial increase in reconciliation payments for manual enrollments.							

Exhibit C4 - Children's Basic Health Plan Program, Historical Expenditures Summary

Annual Total Expenditures

Item		Children to 205% FPL	Children 206%-260% FPL	Prenatal to 200% FPL	Prenatal 206%-260% FPL	Other Payments	CBHP TOTAL
FY 2010-11 Actuals	*Medical Per Capita*	$2,130.28	$2,439.89	$12,583.11	$13,159.54		
	Dental Per Capita	$159.17	$148.60	-	-		
	Caseload	63,244	4,023	1,470	272		69,009
	Medical Expenditure	$134,727,164	$9,815,685	$18,497,179	$3,579,395		$166,619,422
	Dental Expenditure	$10,066,675	$597,802	-	-		$10,664,477
	Total FY 2010-11 Expenditures	**$144,793,839**	**10,413,487**	**$18,497,179**	**3,579,395**		**$177,283,899**
FY 2011-12 Actuals	*Medical Per Capita*	$2,014.43	$1,926.19	$10,528.68	$9,814.12		
	Dental Per Capita	$168.30	$160.66	-	-		
	Caseload	63,217	11,049	1,616	448		76,330
	Medical Expenditure	$127,346,190	$21,282,480	$17,014,352	$4,396,724		$170,039,746
	Dental Expenditure	$10,639,205	$1,775,172	-	-		$12,414,377
	Total FY 2011-12 Expenditures	**$137,985,395**	**$23,057,652**	**$17,014,352**	**$4,396,724**		**$182,454,123**
	% Change from FY 2010-11	**-4.70%**	**121.42%**	**-8.02%**	**22.83%**		**2.92%**
FY 2012-13 Actuals	*Medical Per Capita*	$2,063.72	$1,817.94	$14,259.74	$10,936.88		
	Dental Per Capita	$176.81	$149.39	-	-		
	Caseload	62,260	15,575	1,148	463		79,446
	Medical Expenditure	$128,487,079	$28,314,344	$16,370,185	$5,063,773		$178,235,380
	Dental Expenditure	$11,008,265	$2,326,813	-	-		$13,335,077
	Total FY 2012-13 Expenditures	**$139,495,343**	**$30,641,156**	**$16,370,185**	**$5,063,773**		**$191,570,458**
	% Change from FY 2011-12	**1.09%**	**32.89%**	**-3.79%**	**15.17%**		**5.00%**
FY 2013-14 Actuals	*Medical Per Capita*	$2,715.44	$2,178.76	$14,172.67	$11,189.55		
	Dental Per Capita	$232.14	$207.37	-	-		
	Caseload	42,511	19,043	451	502		62,507
	Medical Expenditure	$115,436,127	$41,490,209	$6,391,873	$5,617,155		$168,935,364
	Dental Expenditure	$9,868,652	$3,949,038	-	-		$13,817,690
	Recoveries	($22,724,002)	($4,221,003)	($4,012,518)	($769,110)	$31,726,633	
	Total FY 2013-14 Expenditures	**$102,580,776**	**$41,218,245**	**$2,379,355**	**$4,848,045**	**$31,726,633**	**$182,753,054**
	% Change from FY 2012-13	**-26.46%**	**34.52%**	**-85.47%**	**-4.26%**		**-4.60%**
FY 2014-15 Actuals	*Medical Per Capita*	$2,230.69	$1,941.36	$16,784.57	$12,544.25		
	Dental Per Capita	$227.63	$193.64	-	-		
	Caseload	37,032	16,668	227	460		54,386
	Medical Expenditure	$82,606,338	$32,358,023	$3,810,098	$5,770,354		$124,544,813
	Dental Expenditure	$8,429,697	$3,227,513	-	-		$11,657,211
	Other Payments	$242,154	$60,609	($6,702,661)	$0	$970,237	($5,429,661)
	Recoveries	($8,087,772)	($2,709,359)	($1,292,200)	($514,542)	$12,603,873	-
	Total FY 2014-15 Expenditures	**$83,190,418**	**$32,936,786**	**-$4,184,763**	**$5,255,812**	**$13,574,110**	**$130,772,362**
	% Change from FY 2013-14	**-18.90%**	**-20.09%**	**-275.88%**	**8.41%**		**-28.44%**
FY 2015-16 Actuals	*Medical Per Capita*	$2,012.88	$1,993.69	$12,036.03	$13,111.16		
	Dental Per Capita	$232.21	$221.88	-	-		
	Caseload	34,940	16,100	199	469		51,709
	Medical Expenditure	$70,330,793	$32,098,866	$2,395,170	$6,149,132		$110,973,962
	Dental Expenditure	$8,113,517	$3,572,391	-	-		$11,685,908
	Other Payments	$279,825	$127,554	$0	-	$3,162,548	$3,569,928
	Recoveries	($2,679,982)	($1,452,293)	($105,868)	($229,408)	$4,467,551	-
	Total FY 2015-16 Expenditures	**$76,044,154**	**$34,346,518**	**$2,289,302**	**$5,919,724**	**$7,630,099**	**$126,229,798**
	% Change from FY 2014-15	**-8.59%**	**4.28%**	**-154.71%**	**12.63%**	**-43.79%**	**-3.47%**

Exhibit C4 - Children's Basic Health Plan Program, Historical Expenditures Summary							
Projected Total Expenditures							
Item		**Children to 205% FPL**	**Children 206%-260% FPL**	**Prenatal to 205% FPL**	**Prenatal 206%-260% FPL**	**Other Payments**	**CBHP TOTAL**
FY 2016-17 Projection	*Medical Per Capita*	$2,141.50	$2,085.07	$12,498.15	$12,401.20		
	Dental Per Capita	$244.17	$220.94	-	-		
	Caseload	41,022	20,097	258	575		61,952
	Medical Expenditure	$87,848,752	$41,903,690	$3,224,522	$7,130,692		$140,107,656
	Dental Expenditure	$10,016,152	$4,440,173	-	-		$14,456,325
	Disallowance Repayment	-	-	-	-	$2,501,956	$2,501,956
	Recoveries	(899,816)	(487,614)	(35,546)	(77,024)	$1,500,000	$0
	Total FY 2016-17 Expenditures	**$96,965,088**	**$45,856,249**	**$3,188,976**	**$7,053,668**	**$4,001,956**	**$157,065,937**
	% Change from FY 2015-16	**27.51%**	**33.51%**	**39.30%**	**19.16%**	**-47.55%**	**24.43%**
FY 2017-18 Projection	*Medical Per Capita*	$2,135.92	$2,146.02	$12,740.90	$12,718.57		
	Dental Per Capita	$248.53	$232.38	-	-		
	Caseload	41,826	20,596	260	575		63,257
	Medical Expenditure	$89,336,863	$44,199,460	$3,312,635	$7,313,175		$144,162,133
	Dental Expenditure	$10,395,177	$4,786,120	-	-		$15,181,297
	Disallowance Repayment	-	-	-	-	$621,616	$621,616
	Total FY 2017-18 Expenditures	**$99,732,040**	**$48,985,580**	**$3,312,635**	**$7,313,175**	**$621,616**	**$159,965,046**
	% Change from FY 2016-17	**2.85%**	**6.82%**	**3.88%**	**3.68%**	**-84.47%**	**1.85%**
FY 2018-19 Projection	*Medical Per Capita*	$2,187.94	$2,208.83	$12,978.00	$12,938.35		
	Dental Per Capita	$258.97	$242.38	-	-		
	Caseload	42,784	21,115	259	575		64,733
	Medical Expenditure	$93,608,946	$46,639,481	$3,361,303	$7,439,554		$151,049,284
	Dental Expenditure	$11,079,809	$5,117,770	-	-		$16,197,579
	Disallowance Repayment	-	-	-	-		$0
	Total FY 2018-19 Expenditures	**$104,688,755**	**$51,757,251**	**$3,361,303**	**$7,439,554**	**$0**	**$167,246,863**
	% Change from FY 2017-18	**4.97%**	**5.66%**	**1.47%**	**1.73%**	**-100.00%**	**4.55%**

Exhibit C5 - Traditional Population Expenditures and Funding				
FY 2016-17 Projected Expenditures				
	Children 0%-205% Medical	**Children 0%-205% Dental**	**Prenatal 0%-205%**	**Totals**
Caseload	41,022	41,022	258	41,280
Estimated Per Capita Cost	$2,141.50	$244.17	$12,498.15	$2,448.87
Total Estimated Expenditures FY 2016-17	**$87,848,752**	**$10,016,152**	**$3,224,522**	**$101,089,426**
FY 2017-18 Projected Expenditures				
	Children 0%-205% Medical	**Children 0%-205% Dental**	**Prenatal 0%-205%**	**Totals**
Caseload	41,826	41,826	260	42,086
Estimated Per Capita Cost	$2,135.92	$248.53	$12,740.90	$2,448.43
Total Estimated Expenditures FY 2017-18	**$89,336,863**	**$10,395,177**	**$3,312,635**	**$103,044,675**
FY 2018-19 Projected Expenditures				
	Children 0%-205% Medical	**Children 0%-205% Dental**	**Prenatal 0%-205%**	**Totals**
Caseload	42,784	42,784	259	43,043
Estimated Per Capita Cost	$2,187.94	$258.97	$12,978.00	$2,510.28
Total Estimated Expenditures FY 2018-19	**$93,608,946**	**$11,079,809**	**$3,361,303**	**$108,050,058**

Exhibit C5 - Traditional Population Expenditures and Funding

Cash Funds Forecast[1]

Row		FY 2013-14 Actuals	FY 2014-15 Actuals	FY 2015-16 Actuals	FY 2016-17 Forecast	FY 2017-18 Forecast	FY 2018-19 Forecast	Notes
A	CHP+ Trust Fund - 18% of settlement	$24,500,000	$24,000,000	$23,800,000	$15,138,000	$12,474,000	$12,474,000	2016 Tobacco MSA Payment Forecast and HB 16-1408.[1]
B	Autism Treatment Fund - 2% of settlement	$4,200,000	$3,800,000	$3,700,000	$1,682,000	$1,386,000	$1,386,000	2016 Tobacco MSA Payment Forecast and HB 16-1408.[1]
C	Projected Amount	$28,700,000	$27,800,000	$27,500,000	$16,820,000	$13,860,000	$13,860,000	Row A + Row B
D	**Total Trust Fund Expenditure**	**$26,062,316**	**$26,124,596**	**$14,045,152**	**$27,889,272**	**$27,611,075**	**$19,223,820**	Actuals: Reported in COFRS Forecast: Row C * Row G [2]
E	CHP Premiums	$24,562,287	$24,919,221	$13,906,826	$27,294,212	$27,009,498	$18,622,243	Actuals: Reported in COFRS Forecast: Row D - Row F
F	CHP+ Admin	$1,500,029	$1,205,375	$138,326	$595,060	$601,577	$601,577	Actuals: Reported in COFRS Forecast: Exhibit C1
G	% of Projection	90.81%	93.97%	51.07%	165.81%	199.21%	138.70%	Actuals: Row D / Row C Forecast: Rolling 3 year average
H	Immunizations - 2.5% of settlement	$1,100,000	$1,100,000	$1,000,000	$2,115,000	$2,102,500	$1,732,500	2016 Tobacco MSA Payment Forecast and HB 16-1408.[1]
I	% Appropriated to CHP+	19.50%	19.50%	19.50%	19.50%	19.50%	19.50%	Percentage appropriated to CHP+
J	Projected Amount	$214,500	$214,500	$195,000	$412,425	$409,988	$337,838	Row H * Row I
K	**Total CO Immunization Fund Expenditure**	**$221,635**	**$216,871**	**$229,297**	**$442,697**	**$445,574**	**$375,675**	Actuals: Reported in COFRS Forecast: Row J * Row L
L	% of Projection	103.33%	101.11%	117.59%	107.34%	108.68%	111.20%	Actuals: Row K / Row J Forecast: Rolling 3 year average

[1] https://www.colorado.gov/pacific/sites/default/files/2016%20Tobacco%20MSA%20Forecast.pdf

[2] Values in FY 2014-15 and FY 2015-16 are from the February 4, 2015 Tobacco Master Settlement and Amendment 35 Funding.

FY 2016-17 - Calculation of Fund Splits

Item	Total Funds	General Fund	CBHP Trust Fund[1]	CO Immunization Fund[2]	Health Care Expansion Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$100,427,590	$11,920,755	$0	$0	$0	$0	$88,506,835	88.13%
Estimated Enrollment Fees	*$661,836*	*$0*	*$661,836*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$101,089,426**	**$11,920,755**	**$661,836**	**$0**	**$0**	**$0**	**$88,506,835**	87.55%
Offset From Cash Funds [3]	$0	($27,075,074)	$26,632,376	$442,697	$1	$0	$0	NA
Total Estimated Expenditures FY 2016-17	**$101,089,426**	**($15,154,319)**	**$27,294,212**	**$442,697**	**$1**	**$0**	**$88,506,835**	87.55%
Offset from General Fund [3]	$0	*$15,154,319*	*($15,154,319)*	$0	$0	$0	$0	NA
Total Estimated Expenditures FY 2016-17	**$101,089,426**	**$0**	**$12,139,893**	**$442,697**	**$1**	**$0**	**$88,506,835**	**87.55%**

[1] Forecasted above in Cash Funds Forecast Table, Row D

[2] Forecasted above in Cash Funds Forecast Table, Row K

[3] Due to the increased FMAP, the projected funds from the CHP Trust Fund are sufficient to cover forecasted expenditures without funding from the General Fund.

FY 2017-18 - Calculation of Fund Splits

Item	Total Funds	General Fund	CBHP Trust Fund[1]	CO Immunization Fund[2]	Health Care Expansion Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$102,366,916	$12,284,030	$0	$0	$0	$0	$90,082,886	88.00%
Estimated Enrollment Fees	*$677,759*	*$0*	*$677,759*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$103,044,675**	**$12,284,030**	**$677,759**	**$0**	**$0**	**$0**	**$90,082,886**	87.42%
Offset From Cash Funds [3]	*$0*	*($26,777,314)*	*$26,331,739*	*$445,574*	*$1*	*$0*	*$0*	NA
Total Estimated Expenditures FY 2017-18	**$103,044,675**	**($14,493,284)**	**$27,009,498**	**$445,574**	**$1**	**$0**	**$90,082,886**	87.42%
Offset from General Fund [3]	*$0*	*$14,493,284*	*($14,493,284)*	*$0*	*$0*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2017-18	**$103,044,675**	**$0**	**$12,516,214**	**$445,574**	**$1**	**$0**	**$90,082,886**	87.42%

[1] Forecasted above in Cash Funds Forecast Table, Row D

[2] Forecasted above in Cash Funds Forecast Table, Row K

[3] Due to the increased FMAP, the projected funds from the CHP Trust Fund are sufficient to cover forecasted expenditures without funding from the General Fund.

FY 2018-19 - Calculation of Fund Splits

Item	Total Funds	General Fund	CBHP Trust Fund[1]	CO Immunization Fund[2]	Health Care Expansion Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$107,350,512	$12,882,062	$0	$0	$0	$0	$94,468,450	88.00%
Estimated Enrollment Fees	*$699,546*	*$0*	*$699,546*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$108,050,058**	**$12,882,062**	**$699,546**	**$0**	**$0**	**$0**	**$94,468,450**	87.43%
Offset From Cash Funds [3]	*$0*	*($18,298,373)*	*$17,922,697*	*$375,675*	*$1*	*$0*	*$0*	NA
Total Estimated Expenditures FY 2018-19	**$108,050,058**	**($5,416,311)**	**$18,622,243**	**$375,675**	**$1**	**$0**	**$94,468,450**	87.43%
Offset from General Fund [3]	*$0*	*$5,416,311*	*($5,416,311)*	*$0*	*$0*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2018-19	**$108,050,058**	**$0**	**$13,205,932**	**$375,675**	**$1**	**$0**	**$94,468,450**	87.43%

[1] Forecasted above in Cash Funds Forecast Table, Row D

[2] Forecasted above in Cash Funds Forecast Table, Row K

[3] Due to the increased FMAP Rate, the projected funds from the CHP Trust Fund are sufficient to cover forecasted expenditures without funding from the General Fund.

Exhibit C5 - Expansion Population Expenditures and Funding

FY 2016-17 Projected Expenditures

	Children 206%-260% Medical	Children 206%-260% Dental	Prenatal 206%-260%	Totals
Caseload	20,097	20,097	575	20,672
Estimated Per Capita Cost	$2,085.07	$220.94	$12,401.20	$2,586.81
Total Estimated Expenditures FY 2016-17	$41,903,690	$4,440,173	$7,130,692	$53,474,555

FY 2017-18 Projected Expenditures

	Children 206%-260% Medical	Children 206%-260% Dental	Prenatal 206%-260%	Totals
Caseload	20,596	20,596	575	21,171
Estimated Per Capita Cost	$2,146.02	$232.38	$12,718.57	$2,659.24
Total Estimated Expenditures FY 2017-18	$44,199,460	$4,786,120	$7,313,175	$56,298,755

FY 2018-19 Projected Expenditures

	Children 206%-260% Medical	Children 206%-260% Dental	Prenatal 206%-260%	Totals
Caseload	21,115	21,115	575	21,690
Estimated Per Capita Cost	$2,208.83	$242.38	$12,938.35	$2,729.22
Total Estimated Expenditures FY 2018-19	$46,639,481	$5,117,770	$7,439,554	$59,196,805

Exhibit C5 - Expansion Population Expenditures and Funding

FY 2016-17 - Calculation of Fund Splits

Item	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$52,097,066	$0	$6,183,922	$0	$45,913,144	88.13%
Estimated Enrollment Fees	*$1,377,489*	*$0*	*$1,377,489*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2016-17	$53,474,555	$0	$7,561,411	$0	$45,913,144	85.86%

FY 2017-18 - Calculation of Fund Splits

Item	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$54,888,083	$0	$6,586,570	$0	$48,301,513	88.00%
Estimated Enrollment Fees	*$1,410,672*	*$0*	*$1,410,672*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2017-18	$56,298,755	$0	$7,997,242	$0	$48,301,513	85.79%

FY 2018-19 - Calculation of Fund Splits

Item	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$57,750,590	$0	$6,930,070	$0	$50,820,520	88.00%
Estimated Enrollment Fees	*$1,446,215*	*$0*	*$1,446,215*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2018-19	$59,196,805	$0	$8,376,285	$0	$50,820,520	85.85%

Exhibit C5 - Enrollment Fees Historical Summary and Projection

Historical Enrollment Fees and Projections

	Children 157%-200%	Children 201%-205%	Children 206%-260%	Enrollment Fees[(1)]	Average Enrollment Fee[(2)]
FY 2010-11 Actuals	18,265	1,164	-	$428,326	$22.05
FY 2011-12 Actuals	19,517	1,402	11,049	$620,097	$19.40
% Change from FY 2010-11	6.85%	20.45%	-	44.77%	-12.01%
FY 2012-13 Actuals	22,168	1,614	15,575	$932,439	$23.69
% Change from FY 2011-12	13.58%	15.12%	40.96%	50.37%	22.14%
FY 2013-14 Actuals	25,507	1,950	19,043	$904,328	$19.45
% Change from FY 2012-13	15.06%	20.82%	22.27%	-3.01%	-17.91%
FY 2014-15 Actuals	23,607	1,714	16,668	$893,287	$21.27
% Change from FY 2013-14	-7.45%	-12.10%	-12.47%	-1.22%	9.39%
FY 2015-16 Actuals	20,241	1,660	16,100	$1,123,169	$29.56
% Change from FY 2014-15	-14.26%	-3.15%	-3.41%	25.73%	38.93%
FY 2016-17 Projection	23,304	1,986	19,595	$2,039,325	$45.43
% Change from FY 2015-16	15.13%	19.64%	21.71%	81.57%	53.72%
FY 2017-18 Projection	23,865	2,037	20,067	$2,088,431	$45.43
% Change from FY 2016-17	2.41%	2.57%	2.41%	2.41%	-0.01%
FY 2018-19 Projection	24,636	2,088	20,573	$2,145,761	$45.37
% Change from FY 2017-18	3.23%	2.50%	2.52%	2.75%	-0.14%

[(1)]Enrollment Fees collected is amount reported in CORE.

[(2)]This is the total enrollment fees collected reported in CORE divided by children's caseload over 157% FPL

Exhibit C5 - Enrollment Fees Historical Summary and Projection

Projected Number of Enrollment Fees Calculations

		Children 157%-200%	Children 201%-205%	Children 206%-212%	Children 213%-260%	Total
FY 2016-17	Projected New Enrollees[1]	29,792	599	6,011	18,744	55,146
	Projected New Cases[2]	21,788	449	4,503	14,066	40,806
	Projected Average Fee[3]	$29.77	$29.49	$29.49	$88.49	$49.98
	Total Estimated Paid	$648,596	$13,240	$132,785	$1,244,705	$2,039,325
FY 2017-18	Projected New Enrollees[1]	30,509	614	6,156	19,196	56,475
	Projected New Cases[2]	22,312	460	4,611	14,405	41,788
	Projected Average Fee[3]	$29.77	$29.49	$29.49	$88.49	$49.98
	Total Estimated Paid	$664,194	$13,565	$135,970	$1,274,703	$2,088,431
FY 2018-19	Projected New Enrollees[1]	31,495	629	6,311	19,680	58,115
	Projected New Cases[2]	23,033	471	4,727	14,768	42,999
	Projected Average Fee[3]	$29.77	$29.49	$29.49	$88.49	$49.90
	Total Estimated Paid	$685,658	$13,889	$139,390	$1,306,825	$2,145,761

[1] This is the number of new enrollees in FY 2015-16 with the projected growth trend for FY 2016-17, FY 2017-18, and FY 2018-19.

[2] This is estimated by applying FY 2015-16 distribution of the number of children one parent or caretaker has enrolled in the CHP+ program to the projected number of newly enrolled clients.

[3]This is estimated by applying FY 2015-16 distribution of the number of children one parent or caretaker has enrolled in the CHP+ program to the known enrollment fee.

Assumptions Used in Estimations

	Children 157%-200%	Children 201%-213%	Children 214%-260%
Fee to enroll one child[4]	$25.00	$25.00	$75.00
Fee to enroll more than one child[4]	$35.00	$35.00	$105.00

Distribution of household size in CHP+ in FY 2014-15[5]

HH Size	157%-200%	201%-213%	214%-260%
1	52.32%	55.12%	55.03%
2	31.87%	30.90%	31.72%
3	11.77%	10.62%	10.48%
4	3.20%	2.64%	2.17%
5	0.61%	0.60%	0.44%
6	0.16%	0.08%	0.13%
7	0.03%	0.00%	0.00%
8	0.02%	0.00%	0.01%
9	0.02%	0.04%	0.01%
10	0.01%	0.00%	0.00%

[4] https://www.colorado.gov/pacific/sites/default/files/2015%20Agency%20Letters%20CHP+Income%20Chart%20Final.pdf

[5] This is the average distribution of the number of children one parent or caretaker has enrolled in the CHP+ program in FY 2015-16, applied to all forecasted fiscal years.

Exhibit C6 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2016-17

FY 2016-17 Calculations

Service Expenditure	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal	Total
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%	
Weighted Capitation Rate	$264.83	$134.55	$171.41	$268.09	$132.85	$172.00	$4.09	$17.25	$20.50	$2.81	$15.71	$19.86	$1,038.20	$1,037.79	$200.37
Estimated Monthly Caseload	3,319	9,308	28,395	1,850	4,805	13,442	3,319	9,308	28,395	1,850	4,805	13,442	258	575	61,952
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
Total Estimated Costs for FY 2016-17 Capitated Payments	$10,547,649	$15,028,697	$58,406,243	$5,951,598	$7,660,131	$27,744,288	$162,897	$1,926,756	$6,985,170	$62,382	$905,839	$3,203,497	$3,214,267	$7,160,751	$148,960,165
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service	96.59%	97.98%	98.05%	96.38%	98.08%	98.04%	99.61%	99.49%	99.55%	99.62%	99.57%	99.62%	98.05%	98.01%	98.00%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$10,187,974	$14,725,117	$57,267,321	$5,736,150	$7,513,056	$27,200,500	$162,262	$1,916,930	$6,953,737	$62,145	$901,944	$3,191,324	$3,151,589	$7,018,252	$145,988,301
Estimated Expenditure for Prior Period Dates of Service	$379,077	$274,510	$954,405	$153,289	$85,680	$337,441	$645	$7,502	$27,252	$232	$2,078	$7,863	$64,647	$95,375	$2,389,996
Total Estimated Expenditure in FY 2016-17	**$10,567,051**	**$14,999,627**	**$58,221,726**	**$5,889,439**	**$7,598,736**	**$27,537,941**	**$162,907**	**$1,924,432**	**$6,980,989**	**$62,377**	**$904,022**	**$3,199,187**	**$3,216,236**	**$7,113,627**	**$148,378,297**
Unadjusted Per Capitas in FY 2016-17	$3,183.81	$1,611.48	$2,050.42	$3,183.48	$1,581.42	$2,048.65	$49.08	$206.75	$245.85	$33.72	$188.14	$238.00	$12,466.03	$12,371.53	$2,395.05

	Children's Medical 0%-205%	Children's Medical 206%-260%	Children's Dental 0%-205%	Children's Dental 206%-260%	Prenatal 0%-205%	Prenatal 206%-260%	Total
Total Estimated Expenditure in FY 2016-17	**$83,788,404**	**$41,026,116**	**$9,068,328**	**$4,165,586**	**$3,216,236**	**$7,113,627**	**$148,378,297**
Reconciliation Payments	$1,808,550	$517,833	$727,523	$274,587	$0	$0	$3,328,493
FQHC Payments	$614,908	$359,741	$0	$0	$8,286	$17,065	$1,000,000
Adjustment for Clients Placed in Incorrect Eligibility Types	$1,636,890	$0	$220,301	$0	$0	$0	$1,857,191
Total Estimated FY 2016-17 Expenditure Including Bottom Line Impacts	**$87,848,752**	**$41,903,690**	**$10,016,152**	**$4,440,173**	**$3,224,522**	**$7,130,692**	**$154,563,981**
Estimated Monthly Caseload	41,022	20,097	41,022	20,097	258	575	61,952
Final Estimated Per Capita	$2,141.50	$2,085.07	$244.17	$220.94	$12,498.15	$12,401.20	$2,494.90
Unadjusted Per Capita	$2,042.52	$2,041.40	$221.06	$207.27	$12,466.03	$12,371.53	$2,395.05

Exhibit C6 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2017-18

FY 2017-18 Calculations

Service Expenditure	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal 0%-205%	Prenatal 206%-260%	Total
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18			
Weighted Capitation Rate	$270.11	$137.11	$174.67	$275.53	$135.35	$178.18	$4.28	$17.97	$21.43	$2.94	$16.36	$20.86	$1,062.36	$1,060.34	$205.50
Estimated Monthly Caseload	3,589	9,408	28,829	1,861	4,880	13,855	3,589	9,408	28,829	1,861	4,880	13,855	260	575	63,257
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
Total Estimated Costs for FY 2017-18 Capitated Payments	$11,633,097	$15,479,171	$60,426,737	$6,153,136	$7,926,096	$29,624,207	$184,331	$2,028,741	$7,413,666	$65,656	$958,042	$3,468,184	$3,314,563	$7,316,346	$155,991,973
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service	96.59%	97.98%	98.05%	96.38%	98.08%	98.04%	99.61%	99.49%	99.55%	99.62%	99.57%	99.62%	98.05%	98.01%	98.00%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$11,236,408	$15,166,492	$59,248,416	$5,930,392	$7,773,915	$29,043,573	$183,612	$2,018,394	$7,380,305	$65,407	$953,922	$3,455,005	$3,249,929	$7,170,751	$152,876,521
Estimated Expenditure for Prior Period Dates of Service	$359,983	$302,830	$1,139,686	$215,322	$146,787	$542,462	$629	$9,766	$31,386	$234	$3,934	$12,238	$62,706	$142,424	$2,970,387
Total Estimated Expenditure in FY 2017-18	**$11,596,391**	**$15,469,322**	**$60,388,102**	**$6,145,714**	**$7,920,702**	**$29,586,035**	**$184,241**	**$2,028,160**	**$7,411,691**	**$65,641**	**$957,856**	**$3,467,243**	**$3,312,635**	**$7,313,175**	**$155,846,908**
Unadjusted Per Capitas in FY 2017-18	$3,231.09	$1,644.27	$2,094.70	$3,302.37	$1,623.09	$2,135.40	$51.33	$215.58	$257.09	$35.27	$196.28	$250.25	$12,740.90	$12,718.57	$2,463.71

	Children's Medical 0%-205%	Children's Medical 206%-260%	Children's Dental 0%-205%	Children's Dental 206%-260%	Prenatal 0%-205%	Prenatal 206%-260%	Total
Total Estimated Expenditure in FY 2017-18	**$87,453,815**	**$43,652,451**	**$9,624,092**	**$4,490,740**	**$3,312,635**	**$7,313,175**	**$155,846,908**
Reconciliation Payments	$1,883,048	$547,009	$771,085	$295,380	$0	$0	$3,496,522
FQHC Payments	$0	$0	$0	$0	$0	$0	$0
Total Estimated FY 2017-18 Expenditure Including Bottom Line Impacts	**$89,336,863**	**$44,199,460**	**$10,395,177**	**$4,786,120**	**$3,312,635**	**$7,313,175**	**$159,343,430**
Estimated Monthly Caseload	41,826	20,596	41,826	20,596	260	575	63,257
Final Estimated Per Capita	$2,135.92	$2,146.02	$248.53	$232.38	$12,740.90	$12,718.57	$2,518.98
Unadjusted Per Capita	$2,090.90	$2,119.46	$230.10	$218.04	$12,740.90	$12,718.57	$2,463.71

Exhibit C6 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2018-19

FY 2018-19 Calculations

Service Expenditure	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal 0%-205%	Prenatal 206%-260%	Total
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18			
Weighted Capitation Rate	$275.49	$138.75	$178.69	$279.36	$137.45	$184.59	$4.48	$18.64	$22.44	$3.08	$16.66	$21.81	$1,081.79	$1,078.57	$210.76
Estimated Monthly Caseload	3,863	9,375	29,546	1,866	4,916	14,333	3,863	9,375	29,546	1,866	4,916	14,333	259	575	64,733
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
Total Estimated Costs for FY 2018-19 Capitated Payments	$12,770,614	$15,609,375	$63,354,897	$6,255,429	$8,108,450	$31,748,742	$207,675	$2,097,000	$7,956,147	$68,967	$982,807	$3,751,233	$3,362,203	$7,442,133	$163,715,672
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service	96.59%	97.98%	98.05%	96.38%	98.08%	98.04%	99.61%	99.49%	99.55%	99.62%	99.57%	99.62%	98.05%	98.01%	98.00%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$12,335,136	$15,294,066	$62,119,477	$6,028,982	$7,952,768	$31,126,467	$206,865	$2,086,305	$7,920,344	$68,705	$978,581	$3,736,978	$3,296,640	$7,294,035	$160,445,349
Estimated Expenditure for Prior Period Dates of Service	$397,029	$311,907	$1,179,112	$222,614	$151,884	$579,218	$711	$10,283	$33,311	$247	$4,161	$13,249	$64,663	$145,519	$3,113,908
Total Estimated Expenditure in FY 2018-19	**$12,732,165**	**$15,605,973**	**$63,298,589**	**$6,251,596**	**$8,104,652**	**$31,705,685**	**$207,576**	**$2,096,588**	**$7,953,655**	**$68,952**	**$982,742**	**$3,750,227**	**$3,361,303**	**$7,439,554**	**$163,559,257**
Unadjusted Per Capitas in FY 2018-19	$3,295.93	$1,664.64	$2,142.37	$3,350.27	$1,648.63	$2,212.08	$53.73	$223.64	$269.20	$36.95	$199.91	$261.65	$12,978.00	$12,938.35	$2,526.68

	Children's Medical 0%-205%	Children's Medical 206%-260%	Children's Dental 0%-205%	Children's Dental 206%-260%	Prenatal 0%-205%	Prenatal 206%-260%	Total
Total Estimated Expenditure in FY 2018-19	**$91,636,727**	**$46,061,933**	**$10,257,819**	**$4,801,921**	**$3,361,303**	**$7,439,554**	**$163,559,257**
Reconciliation Payments	$1,972,219	$577,548	$821,990	$315,849	$0	$0	$3,687,606
FQHC Payments	$0	$0	$0	$0	$0	$0	$0
Total Estimated FY 2018-19 Expenditure Including Bottom Line Impacts	**$93,608,946**	**$46,639,481**	**$11,079,809**	**$5,117,770**	**$3,361,303**	**$7,439,554**	**$167,246,863**
Estimated Monthly Caseload	42,784	21,115	42,784	21,115	259	575	64,733
Final Estimated Per Capita	$2,187.94	$2,208.83	$258.97	$242.38	$12,978.00	$12,938.35	$2,583.64
Unadjusted Per Capita	$2,141.85	$2,181.48	$239.76	$227.42	$12,978.00	$12,938.35	$2,526.68

Exhibit C6 - Incurred But Not Reported Expenditure by Fiscal Period

Incurred But Not Reported Estimated Percentages for all Fiscal Periods

	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal	Total
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%	
Estimated Percent of Claims Paid in Current Period	96.59%	97.98%	98.05%	96.38%	98.08%	98.04%	99.61%	99.49%	99.55%	99.62%	99.57%	99.62%	98.05%	98.01%	98.48%
Estimated Percent of Claims Paid in Prior Period	3.41%	2.02%	1.95%	3.62%	1.92%	1.96%	0.39%	0.51%	0.45%	0.38%	0.43%	0.38%	1.95%	1.99%	1.52%

FY 2016-17 Estimated Expenditure for Prior Period Dates of Service

Estimated Expenditure for Claims Incurred in Prior Period	$11,107,090	$13,623,247	$48,911,032	$4,236,976	$4,471,239	$17,258,480	$167,213	$1,479,964	$6,065,156	$61,734	$478,432	$2,058,212	$3,313,768	$4,795,223	$118,027,766
Estimated Percent of Prior Period Claims Paid in Current Period	3.41%	2.02%	1.95%	3.62%	1.92%	1.96%	0.39%	0.51%	0.45%	0.38%	0.43%	0.38%	1.95%	1.99%	2.02%
Estimated Expenditure for Prior Period Dates of Service	$379,077	$274,510	$954,405	$153,289	$85,680	$337,441	$645	$7,502	$27,252	$232	$2,078	$7,863	$64,647	$95,375	$2,389,996

FY 2017-18 Estimated Expenditure for Prior Period Dates of Service

Estimated Expenditure for Claims Incurred in Prior Period	$10,547,649	$15,028,697	$58,406,243	$5,951,598	$7,660,131	$27,744,288	$162,897	$1,926,756	$6,985,170	$62,382	$905,839	$3,203,497	$3,214,267	$7,160,751	$148,960,165
Estimated Percent of Prior Period Claims Paid in Current Period	3.41%	2.02%	1.95%	3.62%	1.92%	1.96%	0.39%	0.51%	0.45%	0.38%	0.43%	0.38%	1.95%	1.99%	1.99%
Estimated Expenditure for Prior Period Dates of Service	$359,983	$302,830	$1,139,686	$215,322	$146,787	$542,462	$629	$9,766	$31,386	$234	$3,934	$12,238	$62,706	$142,424	$2,970,387

FY 2018-19 Estimated Expenditure for Prior Period Dates of Service

Estimated Expenditure for Claims Incurred in Prior Period	$11,633,097	$15,479,171	$60,426,737	$6,153,136	$7,926,096	$29,624,207	$184,331	$2,028,741	$7,413,666	$65,656	$958,042	$3,468,184	$3,314,563	$7,316,346	$155,991,973
Estimated Percent of Prior Period Claims Paid in Current Period	3.41%	2.02%	1.95%	3.62%	1.92%	1.96%	0.39%	0.51%	0.45%	0.38%	0.43%	0.38%	1.95%	1.99%	2.00%
Estimated Expenditure for Prior Period Dates of Service	$397,029	$311,907	$1,179,112	$222,614	$151,884	$579,218	$711	$10,283	$33,311	$247	$4,161	$13,249	$64,663	$145,519	$3,113,908

Exhibit C7 - Bottom Line Impacts Summary

	Item	Children Medical to 205% FPL	Children Medical 206%-260% FPL	Children Dental to 205% FPL	Children Dental 206%-260% FPL	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Total
FY 2015-16 Actuals	Reconciliation Payments[1]	$1,435,250	$379,152	$602,162	$222,534	$0	$0	$2,639,098
	FQHC Payments[2]	$961,290	$562,386	$0	$0	$12,954	$26,677	$1,563,307
	Total Bottom Line Adjustments for FY 2014-15	**$2,396,540**	**$941,538**	**$602,162**	**$222,534**	**$12,954**	**$26,677**	**$4,202,405**
FY 2016-17 Projections	Reconciliation Payments[1]	$1,808,550	$517,833	$727,523	$274,587	$0	$0	$3,328,493
	FQHC Payments[2]	$614,908	$359,741	$0	$0	$8,286	$17,065	$1,000,000
	Adjustment for Clients Placed in Incorrect Eligibility Types [3]	$1,636,890	$0	$220,301	$0	$0	$0	$1,857,191
	Total Bottom Line Adjustments for FY 2015-16	**$4,060,348**	**$877,574**	**$947,824**	**$274,587**	**$8,286**	**$17,065**	**$6,185,684**
FY 2017-18 Projections	Reconciliation Payments[1]	$1,883,048	$547,009	$771,085	$295,380	$0	$0	$3,496,522
	FQHC Payments[2]	$0	$0	$0	$0	$0	$0	$0
	Total Bottom Line Adjustments for FY 2016-17	**$1,883,048**	**$547,009**	**$771,085**	**$295,380**	**$0**	**$0**	**$3,496,522**
FY 2018-19 Projections	Reconciliation Payments[1]	$1,972,219	$577,548	$821,990	$315,849	$0	$0	$3,687,606
	FQHC Payments[2]	$0	$0	$0	$0	$0	$0	$0
	Total Bottom Line Adjustments for FY 2017-18	**$1,972,219**	**$577,548**	**$821,990**	**$315,849**	**$0**	**$0**	**$3,687,606**

[1]There exists a manual reconciliation process for CHP+ clients. These claims are accounted for as expenditure adjustments, calculations can be found on page R-3.C7-2

[2]FQHC Payments were implemented in FY 2013-14. Final reconciliation payments will be made in FY 2016-17 for prior dates of service. The Department does not expect to make this reconcilation payment any longer.

[3] Adjustment accounts for capitations that may be paid from clients being incorrectly disenrolled from CHP+ and into Medicaid.

Exhibit C7 - Bottom Line Impact Calculations

Projected Reconciliation Payments Calculations

Estimated FY 2016-17 Reconciliations

	Children Medical to 205% FPL	Children Medical 206%-260% FPL	Children Dental to 205% FPL	Children Dental 206%-260% FPL	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Average Total
Actual FY 2015-16 Reconciliation Payments	$1,435,250	$379,152	$602,162	$222,534	$0	$0	$2,639,098
FY 2016-17 Projected Rate Inflation Exhibit C9	9.99%	12.22%	5.45%	1.38%	0.00%	0.00%	8.55%
Estimated Reconciliations After Rate Inflation	$1,578,564	$425,478	$635,007	$225,615	$0	$0	$2,864,664
FY 2016-17 Projected Base Caseload Growth Exhibit C4	14.57%	21.71%	14.57%	21.71%	12.06%	9.59%	16.19%
Final Estimated FY 2016-17 Reconciliations	**$1,808,550**	**$517,833**	**$727,523**	**$274,587**	**$0**	**$0**	**$3,328,493**

Estimated FY 2017-18 Reconciliations

	Children Medical to 205% FPL	Children Medical 206%-260% FPL	Children Dental to 205% FPL	Children Dental 206%-260% FPL	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Average Total
FY 2016-17 Projected Reconciliation Payments	$1,808,550	$517,833	$727,523	$274,587	$0	$0	$3,328,493
FY 2017-18 Projected Rate Inflation Exhibit C9	2.16%	3.15%	3.99%	5.04%	2.33%	2.17%	2.95%
Estimated Reconciliations After Rate Inflation	$1,847,556	$534,143	$756,552	$288,432	$0.00	$0.00	$3,426,683
FY 2017-18 Projected Base Caseload Growth Exhibit C4	1.92%	2.41%	1.92%	2.41%	1.35%	0.00%	2.04%
Final Estimated FY 2017-18 Reconciliations	**$1,883,048**	**$547,009**	**$771,085**	**$295,380**	**$0**	**$0**	**$3,496,522**

Estimated FY 2018-19 Reconciliations

	Children Medical to 205% FPL	Children Medical 206%-260% FPL	Children Dental to 205% FPL	Children Dental 206%-260% FPL	Prenatal to 205% FPL	Prenatal 206%-260% FPL	Average Total
FY 2017-18 Projected Reconciliation Payments	$1,883,048	$547,009	$771,085	$295,380	$0	$0	$3,496,522
FY 2018-19 Projected Rate Inflation Exhibit C9	2.39%	2.99%	4.22%	4.30%	1.83%	1.72%	3.05%
Estimated Reconciliations After Rate Inflation	$1,928,081	$563,343	$803,594	$308,081	$0.00	$0.00	$3,603,099
FY 2018-19 Projected Base Caseload Growth Exhibit C4	2.29%	2.52%	2.29%	2.52%	-0.44%	0.00%	2.35%
Final Estimated FY 2018-19 Reconciliations	**$1,972,219**	**$577,548**	**$821,990**	**$315,849**	**$0**	**$0**	**$3,687,606**

Exhibit C8 - Children's Basic Health Plan Retroactivity Adjustment[1]

		Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
		Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2008-09	Average Monthly Claims	5,841	12,108	45,609	0	0	0	4,674	10,451	40,577	0	0	0	1,715	0
	Average Caseload	4,820	11,426	45,336	0	0	0	4,820	11,426	45,336	0	0	0	1,665	0
	Claims as a Percentage of Caseload	121.19%	105.97%	100.60%	0.00%	0.00%	0.00%	96.98%	91.47%	89.50%	0.00%	0.00%	0.00%	103.03%	0.00%
FY 2009-10	Average Monthly Claims	5,931	12,158	51,911	20	43	117	4,763	10,346	45,695	4	14	48	1,563	14
	Average Caseload	5,123	11,520	51,946	13	32	91	5,123	11,520	51,946	13	32	91	1,550	11
	Claims as a Percentage of Caseload	115.77%	105.53%	99.93%	155.13%	134.38%	128.39%	92.97%	89.81%	87.97%	31.41%	42.71%	52.56%	100.85%	124.24%
FY 2010-11	Average Monthly Claims	5,272	11,068	48,435	564	1,160	3,020	4,116	9,397	42,115	368	873	2,366	1,481	293
	Average Caseload	4,407	10,467	48,370	430	982	2,611	4,407	10,467	48,370	430	982	2,611	1,470	272
	Claims as a Percentage of Caseload	119.63%	105.75%	100.13%	131.14%	118.17%	115.67%	93.40%	89.77%	87.07%	85.68%	88.93%	90.61%	100.76%	107.57%
FY 2011-12	Average Monthly Claims	4,241	9,006	38,373	909	1,942	5,147	4,395	9,255	41,666	951	2,139	6,220	1,412	347
	Average Caseload	4,750	10,374	48,093	1,055	2,471	7,523	4,750	10,374	48,093	1,055	2,471	7,523	1,616	448
	Claims as a Percentage of Caseload	89.29%	86.81%	79.79%	86.14%	78.58%	68.42%	92.54%	89.21%	86.64%	90.13%	86.57%	82.68%	87.40%	77.42%
FY 2012-13	Average Monthly Claims	6,556	13,570	52,298	1,533	3,386	10,320	4,827	10,102	41,267	1,215	2,815	8,723	1,450	470
	Average Caseload	5,187	11,300	45,773	1,398	3,377	10,800	5,187	11,300	45,773	1,398	3,377	10,800	1,148	463
	Claims as a Percentage of Caseload	126.39%	120.09%	114.26%	109.66%	100.26%	95.56%	93.06%	89.40%	90.16%	86.89%	83.36%	80.76%	126.28%	101.40%
FY 2013-14	Average Monthly Claims	4,725	12,191	34,517	1,710	4,448	13,145	3,667	10,173	29,089	1,313	3,772	11,163	546	468
	Average Caseload	3,081	9,993	29,437	1,319	4,411	13,313	3,081	9,993	29,437	1,319	4,411	13,313	451	502
	Claims as a Percentage of Caseload	153.35%	121.99%	117.26%	129.64%	100.85%	98.74%	119.02%	101.80%	98.82%	99.51%	85.51%	83.85%	121.16%	93.13%
FY 2014-15	Average Monthly Claims	3,664	9,632	28,959	1,381	3,521	11,032	3,068	8,588	25,958	1,111	3,093	9,682	300	435
	Average Caseload	2,870	8,375	25,787	1,349	3,680	11,639	2,870	8,375	25,787	1,349	3,680	11,639	227	460
	Claims as a Percentage of Caseload	127.67%	115.01%	112.30%	102.38%	95.67%	94.78%	106.91%	102.55%	100.66%	82.36%	84.04%	83.18%	132.20%	94.57%
FY 2015-16	Average Monthly Claims	3,494	9,597	28,733	1,403	3,158	10,039	2,943	8,470	25,632	1,170	2,792	8,913	284	431
	Average Caseload	2,736	8,025	24,179	1,446	3,475	11,179	2,736	8,025	24,179	1,446	3,475	11,179	199	469
	Claims as a Percentage of Caseload	127.72%	119.59%	118.83%	96.99%	90.88%	89.81%	107.56%	105.54%	106.01%	80.88%	80.33%	79.73%	142.88%	91.79%
Weighted Average Claims as a Percentage of Caseload[2]		119.58%	109.11%	106.85%	119.58%	109.11%	106.85%	99.06%	96.90%	95.23%	99.06%	96.90%	95.23%	107.00%	107.00%
Retroactivity Adjustment Factor		19.58%	9.11%	6.85%	19.58%	9.11%	6.85%	-0.94%	-3.10%	-4.77%	-0.94%	-3.10%	-4.77%	7.00%	7.00%

[1] The retroactivity adjustment captures the difference in total claims paid versus caseload due to retroactive eligibility.

[2]Percentage selected to modify capitation rates	Children Medical	Children Medical to 260% - Due to methodology used to identify the 201% to 205% FPL grouping, the Department calculates a single retroactivity factor for all children within each age category and uses that factor for both the 0% - 205% FPL and 206% - 260% FPL groups. FY 2014-15 was chosen due to it being the most recent period with complete run-out.
	Children Dental	Children Dental to 260% - Due to methodology used to identify the 201% to 205% FPL grouping, the Department calculates a single retroactivity factor for all children within each age category and uses that factor for both the 0% - 205% FPL and 206% - 260% FPL groups. FY 2014-15 was chosen due to it being the most recent period with complete run-out.
	Prenatal	Prenatal to 260% - Due to methodology used to identify the 201% to 205% FPL grouping, the Department calculates a single retroactivity factor for all prenatal women within each age category and uses that factor for both the 0% - 205% FPL and 206% - 260% FPL groups. FY 2014-15 was chosen due to it being the most recent period with complete run-out.

Exhibit C8 - Children's Basic Health Plan Claims Distribution Adjustment Multiplier[1]

		Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal	Prenatal
		Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	0%-205%	206%-260%
FY 2008-09	Weighted Claims-Based Rate	$208.62	$87.77	$117.77	$0.00	$0.00	$0.00	$14.66	$14.66	$14.66	$0.00	$0.00	$0.00	$912.34	$0.00
	Weighted Capitation Rate	$208.69	$87.76	$117.91	$0.00	$0.00	$0.00	$14.66	$14.66	$14.66	$0.00	$0.00	$0.00	$915.80	$0.00
	Claims as a Percentage of Capitation	99.97%	100.01%	99.88%	0.00%	0.00%	0.00%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	99.62%	0.00%
FY 2009-10	Weighted Claims-Based Rate	$306.23	$107.47	$138.74	$440.63	$106.41	$136.86	$14.81	$14.81	$14.81	$14.64	$14.64	$14.64	$827.81	$827.08
	Weighted Capitation Rate	$306.62	$111.70	$138.79	$396.96	$105.89	$135.97	$14.81	$14.81	$14.81	$14.81	$14.81	$14.81	$821.12	$0.00
	Claims as a Percentage of Capitation	99.87%	96.21%	99.96%	111.00%	100.49%	100.65%	100.00%	100.00%	100.00%	98.85%	98.85%	98.85%	100.81%	0.00%
FY 2010-11	Weighted Claims-Based Rate	$392.40	$110.87	$137.53	$415.80	$107.46	$133.20	$4.59	$12.41	$15.98	$4.56	$12.17	$15.63	$1,185.01	$1,185.01
	Weighted Capitation Rate	$385.28	$110.86	$135.78	$405.65	$106.73	$131.15	$2.56	$11.97	$16.26	$2.54	$11.67	$15.83	$1,094.18	$1,089.34
	Claims as a Percentage of Capitation	101.85%	100.01%	101.29%	102.50%	100.68%	101.56%	179.30%	103.68%	98.28%	179.53%	104.28%	98.74%	108.30%	108.78%
FY 2011-12	Weighted Claims-Based Rate	$397.04	$122.31	$143.98	$382.70	$119.61	$139.71	$2.82	$13.87	$16.85	$2.79	$13.52	$16.43	$1,138.60	$1,138.60
	Weighted Capitation Rate	$405.13	$123.72	$146.88	$390.50	$120.89	$142.51	$2.81	$13.89	$16.87	$2.81	$13.83	$16.79	$1,147.46	$1,138.60
	Claims as a Percentage of Capitation	98.00%	98.86%	98.03%	98.00%	98.94%	98.04%	100.36%	99.86%	99.88%	99.29%	97.76%	97.86%	99.23%	100.00%
FY 2012-13	Weighted Claims-Based Rate	$301.19	$121.06	$139.61	$289.34	$119.37	$135.81	$3.20	$14.02	$18.10	$3.18	$13.65	$17.66	$912.11	$912.11
	Weighted Capitation Rate	$301.26	$121.14	$139.64	$289.34	$119.37	$135.86	$3.21	$14.03	$18.11	$3.18	$13.65	$17.67	$934.69	$912.11
	Claims as a Percentage of Capitation	99.98%	99.93%	99.98%	100.00%	100.00%	99.96%	99.69%	99.93%	99.94%	100.00%	100.00%	99.94%	97.58%	100.00%
FY 2013-14	Weighted Claims-Based Rate	$285.21	$122.68	$141.23	$283.04	$120.84	$143.41	$3.17	$13.29	$16.82	$3.17	$12.97	$16.79	$970.08	$970.08
	Weighted Capitation Rate	$285.21	$122.59	$141.00	$283.41	$120.79	$143.35	$3.35	$13.99	$17.78	$3.35	$13.65	$17.67	$980.64	$970.08
	Claims as a Percentage of Capitation	100.00%	100.07%	100.16%	99.87%	100.04%	100.04%	94.63%	95.00%	94.60%	94.63%	95.02%	95.02%	98.92%	100.00%
FY 2014-15	Weighted Claims-Based Rate	$282.07	$123.55	$145.47	$281.56	$121.50	$150.23	$4.51	$14.81	$19.84	$4.48	$14.37	$19.45	$970.08	$969.91
	Weighted Capitation Rate	$282.53	$123.65	$145.21	$281.79	$121.48	$150.23	$4.73	$15.60	$20.89	$4.69	$15.13	$20.47	$980.16	$970.08
	Claims as a Percentage of Capitation	99.84%	99.92%	100.18%	99.92%	100.02%	100.00%	95.35%	94.94%	94.97%	95.52%	94.98%	95.02%	98.97%	99.98%
FY 2015-16	Weighted Claims-Based Rate	$239.12	$117.33	$140.07	$236.67	$114.74	$137.16	$5.23	$15.41	$20.62	$5.07	$15.05	$20.25	$970.08	$969.77
	Weighted Capitation Rate	$239.51	$117.49	$140.31	$236.84	$114.73	$137.16	$5.51	$16.25	$21.74	$5.33	$15.84	$21.32	$980.42	$970.08
	Claims as a Percentage of Capitation	99.84%	99.86%	99.83%	99.93%	100.01%	100.00%	94.92%	94.83%	94.85%	95.12%	95.01%	94.98%	98.95%	99.97%
Average Claims as a Percentage of Capitation [2]		99.84%	99.92%	99.83%	99.92%	98.94%	99.96%	95.35%	94.94%	94.97%	95.52%	94.98%	95.02%	98.97%	99.98%
Claims Distribution Adjustment Multiplier		-0.16%	-0.08%	-0.17%	-0.08%	-1.06%	-0.04%	-4.65%	-5.06%	-5.03%	-4.48%	-5.02%	-4.98%	-1.03%	-0.02%

[1] The claims distribution adjustment captures the difference in the amount paid per claim and the weighted capitation rate.

[2] Percentage selected to modify capitation rates	Children Medical	Children Medical to 205% - FY 2014-15 for Ages 0-5 and FY 2015-16 for Ages 6-18; Children Medical 206%-260% - FY 2014-15 for Ages 0-1 and FY 2011-12 for Ages 2-5 & FY 2012-13 for Ages 6-18
	Children Dental	Children Dental to 205% - FY 2014-15; Children Dental 206%-260% - FY 2014-15
	Prenatal	Prenatal to 205% - FY 2014-15; Prenatal 206%-260% - FY 2014-15

Exhibit C9 - Children's Basic Health Plan Capitation Rate Trends and Forecasts														
Capitation Rate Trends														
	Children's Medical 0%-205%			**Children's Medical 206%-260%**			**Children's Dental 0%-205%**			**Children's Dental 206%-260%**			**Prenatal**	**Prenatal**
	Ages 0-1	**Ages 2-5**	**Ages 6-18**	**Ages 0-1**	**Ages 2-5**	**Ages 6-18**	**Ages 0-1**	**Ages 2-5**	**Ages 6-18**	**Ages 0-1**	**Ages 2-5**	**Ages 6-18**	**0%-205%**	**206%-260%**
FY 2008-09 Actuals	$208.69	$87.76	$117.91	$0.00	$0.00	$0.00	$14.66	$14.66	$14.66	$0.00	$0.00	$0.00	$915.80	$0.00
FY 2009-10 Actuals	$306.62	$111.70	$138.79	$396.96	$105.89	$135.97	$14.81	$14.81	$14.81	$14.81	$14.81	$14.81	$821.12	$821.35
% Change	*46.93%*	*27.28%*	*17.71%*	*0.00%*	*0.00%*	*0.00%*	*1.02%*	*1.02%*	*1.02%*	*0.00%*	*0.00%*	*0.00%*	*-10.34%*	*0.00%*
FY 2010-11 Actuals	$385.28	$110.86	$135.78	$405.65	$106.73	$131.15	$2.56	$11.97	$16.26	$2.54	$11.67	$15.83	$1,094.18	$1,089.34
% Change	*25.65%*	*-0.75%*	*-2.17%*	*2.19%*	*0.79%*	*-3.54%*	*-82.71%*	*-19.18%*	*9.79%*	*-82.85%*	*-21.20%*	*6.89%*	*33.25%*	*32.63%*
FY 2011-12 Actuals	$405.13	$123.72	$146.88	$390.50	$120.89	$142.51	$2.81	$13.89	$16.87	$2.81	$13.83	$16.79	$1,147.46	$1,138.60
% Change	*5.15%*	*11.60%*	*8.17%*	*-3.73%*	*13.27%*	*8.66%*	*9.77%*	*16.04%*	*3.75%*	*10.63%*	*18.51%*	*6.06%*	*4.87%*	*4.52%*
FY 2012-13 Actuals	$301.26	$121.14	$139.64	$289.34	$119.37	$135.86	$3.21	$14.03	$18.11	$3.18	$13.65	$17.67	$934.69	$912.11
% Change	*-25.64%*	*-2.09%*	*-4.93%*	*-25.91%*	*-1.26%*	*-4.67%*	*14.23%*	*1.01%*	*7.35%*	*13.17%*	*-1.30%*	*5.24%*	*-18.54%*	*-19.89%*
FY 2013-14 Actuals	$285.21	$122.59	$141.00	$283.41	$120.79	$143.35	$3.35	$13.99	$17.78	$3.35	$13.65	$17.67	$980.64	$970.08
% Change	*-5.33%*	*1.20%*	*0.97%*	*-2.05%*	*1.19%*	*5.51%*	*4.36%*	*-0.29%*	*-1.82%*	*5.35%*	*0.00%*	*0.00%*	*4.92%*	*6.36%*
FY 2014-15 Actuals	$282.53	$123.65	$145.21	$281.79	$121.48	$150.23	$4.73	$15.60	$20.89	$4.69	$15.13	$20.47	$980.16	$970.08
% Change	*-0.94%*	*0.86%*	*2.99%*	*-0.57%*	*0.57%*	*4.80%*	*41.19%*	*11.51%*	*17.49%*	*40.00%*	*10.84%*	*15.85%*	*-0.05%*	*0.00%*
FY 2015-16 Actuals	$239.51	$117.49	$140.31	$236.84	$114.73	$137.16	$5.51	$16.25	$21.74	$5.33	$15.84	$21.32	$980.42	$970.08
% Change	*-15.23%*	*-4.98%*	*-3.37%*	*-15.95%*	*-5.56%*	*-8.70%*	*16.49%*	*4.17%*	*4.07%*	*13.65%*	*4.69%*	*4.15%*	*0.03%*	*0.00%*
FY 2016-17 Projected Weighted Rate	$221.82	$123.42	$160.69	$224.38	$123.07	$161.03	$4.33	$18.75	$22.67	$2.97	$17.07	$21.95	$980.36	$970.08
% Change	*-7.39%*	*5.05%*	*14.52%*	*-5.26%*	*7.27%*	*17.40%*	*-21.42%*	*15.38%*	*4.28%*	*-44.28%*	*7.77%*	*2.95%*	*-0.01%*	*0.00%*
FY 2017-18 Estimated Rate	$226.24	$125.77	$163.75	$230.61	$125.38	$166.82	$4.53	$19.53	$23.69	$3.11	$17.77	$23.05	$1,003.17	$991.16
% Change	*1.99%*	*1.90%*	*1.90%*	*2.78%*	*1.88%*	*3.60%*	*4.62%*	*4.16%*	*4.50%*	*4.71%*	*4.10%*	*5.01%*	*2.33%*	*2.17%*
FY 2018-19 Estimated Rate	$230.75	$127.27	$167.52	$233.81	$127.33	$172.82	$4.74	$20.26	$24.81	$3.25	$18.10	$24.10	$1,021.52	$1,008.20
% Change	*1.99%*	*1.19%*	*2.30%*	*1.39%*	*1.56%*	*3.60%*	*4.64%*	*3.74%*	*4.73%*	*4.50%*	*1.86%*	*4.56%*	*1.83%*	*1.72%*

Exhibit C9 - Children's Basic Health Plan Capitation Rate Trends and Forecasts						
Weighted Capitation Rate Trends						
	Children's Medical 0%-205%	**Children's Medical 206%-260%**	**Children's Dental 0%-205%**	**Children's Dental 206%-260%**	**Prenatal 0%-205%**	**Prenatal 206%-260%**
FY 2008-09 Actuals	$119.42	$0.00	$14.66	$0.00	$915.80	$0.00
FY 2009-10 Actuals	$146.77	$153.84	$14.81	$14.81	$821.12	$821.35
% Change	*22.90%*	*0.00%*	*1.02%*	*0.00%*	*-10.34%*	*0.00%*
FY 2010-11 Actuals	$149.04	$154.52	$14.59	$13.39	$1,094.18	$1,089.34
% Change	*1.55%*	*0.44%*	*-1.49%*	*-9.59%*	*33.25%*	*32.63%*
FY 2011-12 Actuals	$162.49	$161.35	$15.33	$14.79	$1,147.48	$1,138.60
% Change	*9.02%*	*4.42%*	*5.07%*	*10.46%*	*4.87%*	*4.52%*
FY 2012-13 Actuals	$149.77	$146.06	$16.13	$15.50	$934.90	$912.11
% Change	*-7.83%*	*-9.48%*	*5.22%*	*4.80%*	*-18.53%*	*-19.89%*
FY 2013-14 Actuals	$147.19	$147.83	$15.84	$15.75	$981.44	$970.08
% Change	*-1.72%*	*1.21%*	*-1.80%*	*1.61%*	*4.98%*	*6.36%*
FY 2014-15 Actuals	$150.98	$154.53	$18.44	$18.01	$980.15	$970.08
% Change	*2.57%*	*4.53%*	*16.41%*	*14.35%*	*-0.13%*	*0.00%*
FY 2015-16 Actuals	$142.91	$140.61	$19.25	$18.78	$980.40	$970.08
% Change	*-5.35%*	*-9.01%*	*4.39%*	*4.28%*	*0.03%*	*0.00%*
FY 2016-17 Projected Weighted Rate	$157.18	$157.79	$20.30	$19.04	$980.36	$970.08
% Change	*9.99%*	*12.22%*	*5.45%*	*1.38%*	*0.00%*	*0.00%*
FY 2017-18 Estimated Rate	$160.57	$162.76	$21.11	$20.00	$1,003.17	$991.16
% Change	*2.16%*	*3.15%*	*3.99%*	*5.04%*	*2.33%*	*2.17%*
FY 2018-19 Estimated Rate	$164.41	$167.62	$22.00	$20.86	$1,021.52	$1,008.20
% Change	*2.39%*	*2.99%*	*4.22%*	*4.30%*	*1.83%*	*1.72%*

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-04 Medicare Modernization Act

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___	Supplemental FY 2016-17
X	Change Request FY 2017-18
___	Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$130,667,733**	**$0**	**$130,667,733**	**$19,674,000**	**$33,239,453**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$130,667,733	$0	$130,667,733	$19,674,000	$33,239,453
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
	Total	**$130,667,733**	**$0**	**$130,667,733**	**$19,674,000**	**$33,239,453**
	FTE	0.0	0.0	0.0	0.0	0.0
06. Other Medical Services - Medicare Modernization Act State Contribution Payment	GF	$130,667,733	$0	$130,667,733	$19,674,000	$33,239,453
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

CF Letternote Text Revision Required?	Yes ___	No X	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes ___	No X	
FF Letternote Text Revision Required?	Yes ___	No X	
Requires Legislation?	Yes ___	No X	

Type of Request? Department of Health Care Policy and Financing Prioritized Request

Interagency Approval or Related Schedule 13s: None

Cost and FTE

- The Department requests $1,369,323 General Fund for FY 2016-17; $19,674,000 General Fund for FY 2017-18; and $33,239,453 General Fund for FY 2018-19 to the Medicare Modernization Act State Contribution Payment line item to cover the State's share of the costs of the Medicare Part D outpatient prescription drug benefit for dual-eligible clients. This request does not require any additional FTE.

Current Program

- The Department serves clients who are eligible for both Medicaid and Medicare.
- Dual-eligible clients are provided prescription drug coverage through the federal Medicare program.
- The State is required to reimburse the federal government for the amount the federal Centers for Medicare and Medicaid Services (CMS) determines is the State's obligation for such prescription drug coverage, which is also called the "clawback" payment.

Problem or Opportunity

- The State's obligation varies from year to year and is affected by changes in caseload and the per member per month (PMPM) rate, which is also determined by CMS.
- The Department must annually forecast both anticipated caseload and PMPM rate to ensure the State is adequately funded to meet its reimbursement obligation to the federal government.

Consequences of the Problem

- If this request is not approved and the State is unable to meet its reimbursement obligation to the federal government, the Department would be at risk of having the amount due for the clawback payment – plus interest – deducted from the federal funds received for the Medicaid program, generating overexpenditures on other line items.

Proposed Solution

- The Department requests adjustment to the appropriation in the Medicare Modernization Act State Contribution Payment line item to meet the State's obligation to the federal government for prescription drug coverage for dual-eligible clients while reducing the risk of reverting funds that could be used for other purposes.

Department Priority: ***R-4***
Request Detail: ***Medicare Modernization Act State Contribution Payment***

Summary of Incremental Funding Change for FY 2016-17	Total Funds	General Fund
Medicare Modernization Act State Contribution Payment	$1,369,323	$1,369,323

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Medicare Modernization Act State Contribution Payment	$19,674,000	$19,674,000

Problem or Opportunity:

On January 1, 2006, the federal Centers for Medicare and Medicaid Services (CMS) assumed responsibility for the Medicare Part D prescription-drug benefit that replaced the Medicaid prescription-drug coverage for dual-eligible clients, who are individuals eligible for both Medicare and Medicaid. States are required to make mandatory state payments to the federal government, known as the "clawback" payment, to help finance the Medicaid Part D benefit for the dual-eligible population for the states' share of the costs of outpatient prescription drugs. The amount of each state's clawback payment roughly reflects the expenditures of its own funds that the state would make if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual-eligible clients. These clawback payments, if left unpaid, are subject to automatic deduction – plus interest – from the federal funds the State receives for the Medicaid program. Current projections indicate that incremental funding increases to the appropriation for FY 2016-17, and FY 2018-19 are needed.

Proposed Solution:

The Department requests $1,369,323 General Fund for FY 2016-17; $19,674,000 General Fund for FY 2017-18; and $33,239,453 General Fund for FY 2018-19 for funding adjustment to the Medicare Modernization Act State Contribution Payment line item to cover the State's share of the costs of the Medicare Part D outpatient prescription drug benefit for dual-eligible clients. The Medicare Modernization Act State Contribution Payment line item is entirely General Fund, as it is a state reimbursement to the federal government and is not eligible to receive a federal match.

If the Department does not receive the requested appropriations and subsequently cannot make the required federal payment within the Department's existing spending authority, the Department would be required to

use overexpenditure authority to make the payment, pursuant to section 24-75-109(1)(a.6), C.R.S. or risk of having the amount due for the clawback payment – plus interest – deducted from the federal funds received for the Medicaid program, generating overexpenditures on other line items.

Anticipated Outcomes:

One of the Department's strategies in its FY 2016-17 Performance Plan is to "promote rigorous compliance with federal and state laws and regulations, fiscal rules, and internal operating procedures." The approval of this request would be a direct implementation of this goal by allowing the Department to meet its obligation to the federal government, ensuring that no amount of federal funds owed to the State for Medicaid would be subject to deduction plus interest.

Assumptions and Calculations:

Detailed calculations for the request are included in the attached appendix.

A summary of the funding request for the Medicare Modernization Act State Contribution Payment line item by fund type is provided for FY 2016-17, FY 2017-18, and FY 2018-19 in tables 1.1, 1.2, and 1.3, respectively. Row C in each of these tables provides the amount of incremental change requested.

The State´s clawback payment is calculated according to the following three factors:

- The projected number of Medicare and Medicaid dual-eligible clients enrolled in a Part D plan;
- A per member per month (PMPM) estimate of the amount the State otherwise would have spent on Medicaid prescription drugs for dual-eligible clients; and
- A "phasedown" percentage of the State's obligation for the PMPM rate is 75% in Calendar Year (CY) 2015 forward.

The Department's estimates of the clawback payment are $132,037,056 for FY 2016-17; $150,341,733 for FY 2017-18; and $163,907,186 for FY 2018-19 based on the Department's most recent caseload projections and projections of the per member per month (PMPM) rate paid by the State as required by federal regulations (see row Q and S in tables 3.1, 3.2, and 3.3 of the appendix).

The total caseload and expenditure estimates for FY 2016-17, FY 2017-18, and FY 2018-19 are calculated in tables 2.1, 2.2, and 2.3, respectively. The Department assumes the changes in dual-eligible caseload will follow a 3.38% growth trend determined by annualizing the monthly average growth over the past two years from July 2014 through June 2016. Retroactivity is also considered in this forecast because clients are able to be retroactively enrolled and disenrolled for up to 24 months. This method estimates caseload by increasing the total caseload incurred each month by 0.28% to forecast the total caseload for the following month. Rows A through L on tables 2.1a, 2.2a and 2.3a of the appendix show the breakdown of actual and projected caseload for a given month by the calendar year for which the caseload is attributed. Due to a two-month delay between when the Department receives an invoice from CMS and when the invoice is paid, the amount paid in the state fiscal year includes invoices received between May and April. Tables 2.1b, 2.2b, and 2.3b provide calculations of caseload and expenditures by the various PMPM rates for each calendar year resulting from changes in the Federal Medical Assistance Percentage (FMAP).

The changes in the PMPM rate are based on a prescribed methodology established by CMS. The PMPM rates are calculated by calendar year in tables 3.1, 3.2, and 3.3 of the appendix. The CY 2017 change in percentage of growth in table 3.2 row G is calculated by subtracting the average growth rate of per capita prescription drug expenditure between years 2003 and 2006 from the annual growth of National Health Expenditure (NHE) percentage of growth from 2016 NHE estimates in row F from the percentage of growth from 2015 NHE estimates in row C. The annual percentage increase (API) in average per capita aggregate Part D expenditures in row J for CY 2017 is provided in the "Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies"[1] issued by CMS on April 4, 2016. For CY 2018 and CY 2019, the Department uses the median of the last five years of the annual percentage increase in average per capita Part D expenditures from CY 2011 to CY 2015 to project the percentage change in the rate (found in row J of tables 3.2 and 3.3). The final percentage change in the PMPM rate is calculated in row K of tables 3.1-3.3. The 5.42% API for CY 2018 shown in table 3.2 row J is calculated using the median annual percentage trend and the average prior year revision of the annual percentage trend from CY 2011 to CY 2016 data. The CY 2017 API of 11.75%, shown in table 3.1 row J, is unusually high, which is attributed to the increased Medicare Part D costs associated with availability of new classifications of prescription drugs, including a new high cost drug for treatment of Hepatitis C. However, the Department does not anticipate this growth trend to continue, therefore a less aggressive projection is provided.

To calculate the CY 2017 PMPM rate before the phasedown (found in row M), the prior year's PMPM (found in row L) is increased by the final percentage change in the PMPM rate (found in row K). The PMPM rates are also adjusted based on changes in the Federal Medicaid Assistance Percentage (FMAP) rate which occur on a federal fiscal year (October 1 through September 30 timespan) as follows:

- FFY 2015: 51.01%
- FFY 2016: 50.72%
- FFY 2017: 50.02%
- FFY 2018: 50.00%
- FFY 2019: 50.00%

To determine the State's share of the PMPM (found in row Q), the total projected rate (found in row M) is multiplied by the State share of the FMAP (found in row N) and by the 75% phasedown percentage to estimate the PMPM rates for January through September (found in row P) and the rate for October through December is adjusted for the change in FMAP (found in row R). Table 4.1 provides actual caseload history from FY 2006-07 through FY 2015-16 and caseload projections based on current trends for FY 2016-17 through FY 2018-19. Table 4.2 provides actual and projected aggregate monthly caseload history by number of member months and average monthly caseload. Table 4.3 provides a summary of the various actual and projected PMPM rates and FMAP rates associated with each time period within each calendar year. This information is used to project costs in tables 2.2a through 2.4b. Table 4.4 shows the quarterly PMPM rate history from CY 2006 to CY 2016, and projected PMPM rates for CY 2017 to CY 2019.

[1] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf

Table 1.1
FY 2016-17 Summary of Incremental Funding Request
LBG (6) Other Medical Services, Medicare Modernization Act State Contribution Payment Line Item

Row	Item	Total Funds	General Fund	Source
A	FY 2016-17 Spending Authority	$130,667,733	$130,667,733	Long Bill Appropriation (SB 16-234)
B	Projected FY 2016-17 Expenditures	$132,037,056	$132,037,056	Table 2.1a Row O
C	**Incremental Change**	**$1,369,323**	**$1,369,323**	Row B - Row A

Table 1.2
FY 2017-18 Summary of Incremental Funding Request
LBG (6) Other Medical Services, Medicare Modernization Act State Contribution Payment Line Item

Row	Item	Total Funds	General Fund	Source
A	FY 2017-18 Spending Authority	$130,667,733	$130,667,733	Long Bill Appropriation (SB 16-234)
B	Projected FY 2017-18 Expenditures	$150,341,733	$150,341,733	Table 2.2a Row O
C	**Incremental Change**	**$19,674,000**	**$19,674,000**	Row B - Row A

Table 1.3
FY 2018-19 Summary of Incremental Funding Request
LBG (6) Other Medical Services, Medicare Modernization Act State Contribution Payment Line Item

Row	Item	Total Funds	General Fund	Source
A	FY 2018-19 Spending Authority	$130,667,733	$130,667,733	Long Bill Appropriation (SB 16-234)
B	Projected FY 2018-19 Expenditures	$163,907,186	$163,907,186	Table 2.3a Row O
C	**Incremental Change**	**$33,239,453**	**$33,239,453**	Row B - Row A

Table 2.1a
FY 2016-17 Projected Caseload and Expenditures

Row	Month	CY 2014	CY 2015	CY 2016	CY 2017	FY 2016-17 TOTAL
A	May 2016	(118)	967	73,612	0	74,461
B	June 2016	44	195	73,062	0	73,301
C	July 2016	(1,155)	2	75,897	0	74,744
D	August 2016	(43)	(150)	74,649	0	74,456
E	September 2016	(33)	(183)	74,876	0	74,660
F	October 2016	(20)	(199)	75,095	0	74,876
G	November 2016	(8)	(212)	75,299	0	75,079
H	December 2016	0	(203)	75,493	0	75,290
I	January 2017	0	(191)	3,192	72,503	75,504
J	February 2017	0	(164)	1,686	74,189	75,711
K	March 2017	0	(135)	875	75,187	75,927
L	April 2017	0	(117)	455	75,802	76,140
M	CY Client Total	(1,333)	(390)	604,191	297,681	900,149
N	CY PMPM Rate [1]	Varies [2]	Varies [2]	Varies [2]	Varies [2]	N/A
O	**Expenditures [3]**	**($165,086)**	**($48,181)**	**$85,023,232**	**$47,227,091**	**$132,037,056**

(1) PMPM rates for Row N are shown in Table 2.1b
(2) PMPM rates changes occured for calendar years 2014, 2015, 2016 and 2017 due to FMAP changes shown in Table 4.4
(3) Expenditures are calculated by multiplying caseload by the respective PMPM rates shown in Table 2.1b

Table 2.1b
Caseload Breakdown for FY 2016-17 with CY 2014, CY 2015, CY 2016, and CY 2017 Rates

Row	Rate Period	Caseload Forecast	PMPM Rates	Total	Source
A	Jan - Sept 2014	(462)	$125.50	($57,981)	Caseload Forecast * Actual Rate
B	Oct - Dec 2014	(871)	$122.97	($107,105)	Caseload Forecast * Actual Rate
C	**CY 2014 Total**	**(1,333)**		**($165,086)**	Row A + Row B
D	Jan - Sept 2015	(991)	$124.68	($123,558)	Caseload Forecast * Actual Rate
E	Oct - Dec 2015	601	$125.42	$75,377	Caseload Forecast * Actual Rate
F	**CY 2015 Total**	**(390)**		**($48,181)**	Row D + Row E
G	Jan - Sept 2016	378,776	$139.98	$53,021,064	Caseload Forecast * Actual Rate
H	Oct - Dec 2016	225,415	$141.97	$32,002,168	Caseload Forecast * Actual Rate
I	**CY 2016 Total**	**604,191**		**$85,023,232**	Row G + Row H
J	Jan - April 2017	297,681	$158.65	$47,227,091	Caseload Forecast * Table 3.1 row Q
K	**CY 2017 Total**	**297,681**		**$47,227,091**	Row J

Table 2.2a
FY 2017-18 Projected Caseload and Expenditures

Row	Month	CY 2015	CY 2016	CY 2017	CY 2018	FY 2017-18 TOTAL
A	May 2017	(93)	192	76,252	0	76,351
B	June 2017	(70)	(4)	76,640	0	76,566
C	July 2017	(53)	(96)	76,930	0	76,781
D	August 2017	(42)	(152)	77,190	0	76,996
E	September 2017	(33)	(187)	77,430	0	77,210
F	October 2017	(21)	(204)	77,652	0	77,427
G	November 2017	(8)	(213)	77,869	0	77,648
H	December 2017	0	(208)	78,071	0	77,863
I	January 2018	0	(194)	3,298	74,977	78,081
J	February 2018	0	(169)	1,746	76,720	78,297
K	March 2018	0	(139)	905	77,754	78,520
L	April 2018	0	(120)	469	78,387	78,736
M	CY Client Total	(320)	(1,494)	624,452	307,838	930,476
N	CY PMPM Rate [1]	Varies [2]	Varies [2]	Varies [2]	$167.32	
O	**Expenditures [3]**	**($40,058)**	**($208,959)**	**$99,083,296**	**$51,507,454**	**$150,341,733**

(1) PMPM rates in Row N are shown in Table 2.2b
(2) PMPM rates changes occured for calendar years 2015, 2016, and 2017 due to FMAP changes shown in Table 4.4
(3) Expenditures are calculated by multiplying caseload by the respective PMPM rates shown in Table 2.2b

Table 2.2b
Caseload Breakdown for FY 2017-18 with CY 2015, CY 2016 and CY 2017 Rates

Row	Rate Period	Caseload Forecast	Rates	Total	Source
A	Jan-Sept 2015	(103)	$124.68	($12,842)	Caseload Forecast * Actual Rate
B	Oct-Dec 2015	(217)	$125.42	($27,216)	Caseload Forecast * Actual Rate
C	**CY 2015 Total**	**(320)**		**($40,058)**	Row A + Row B
D	Jan-Sept 2016	(1,580)	$139.98	($221,168)	Caseload Forecast * Actual Rate
E	Oct-Dec 2016	86	$141.97	$12,209	Caseload Forecast * Actual Rate
F	**CY 2016 Total**	**(1,494)**		**($208,959)**	Row D + Row E
G	Jan-Sept 2017	391,346	$158.65	$62,087,043	Caseload Forecast * Table 3.1 row Q
H	Oct-Dec 2017	233,106	$158.71	$36,996,253	Caseload Forecast * Table 3.1 row S
I	**CY 2017 Total**	**624,452**		**$99,083,296**	Row G + Row H

Table 2.3a
FY 2018-19 Projected Caseload and Expenditures

Row	Month	CY 2016	CY 2017	CY 2018	CY 2019	FY 2018-19 TOTAL
A	May 2018	(95)	200	78,856	0	78,961
B	June 2018	(71)	(3)	79,255	0	79,181
C	July 2018	(55)	(99)	79,554	0	79,400
D	August 2018	(43)	(159)	79,824	0	79,622
E	September 2018	(33)	(190)	80,073	0	79,850
F	October 2018	(21)	(213)	80,303	0	80,069
G	November 2018	(9)	(220)	80,524	0	80,295
H	December 2018	0	(214)	80,734	0	80,520
I	January 2019	0	(201)	3,410	77,535	80,744
J	February 2019	0	(176)	1,806	79,338	80,968
K	March 2019	0	(142)	937	80,405	81,200
L	April 2019	0	(124)	486	81,063	81,425
M	CY Client Total	(327)	(1,541)	645,762	318,341	962,235
N	CY PMPM Rate [1]	Varies [2]	Varies [2]	$167.32	$176.38	
O	**Expenditures [3]**	**($46,205)**	**($244,493)**	**$108,048,898**	**$56,148,986**	**$163,907,186**

(1) PMPM Rates in Row N are shown in table 2.3b
(2) Rate changes occured for calendar years 2015, 2016 and 2017 due to FMAP changes shown in Table 4.4
(3) Expenditures are calculated by multiplying caseload by the respective PMPM rates shown in Table 2.3b

Table 2.3b
Caseload Breakdown for FY 2018-19 with CY 2016 and CY 2017 Rates

Row	Rate Period	Caseload Forecast	Rates	Total	Source
D	Jan - Sept 2016	(110)	$139.98	($15,398)	Caseload Forecast * Actual Rate
E	Oct - Dec 2016	(217)	$141.97	($30,807)	Caseload Forecast * Actual Rate
F	**CY 2016 Total**	**(327)**		**($46,205)**	Row D + Row E
G	Jan - Sept 2017	(1,320)	$158.65	($209,418)	Caseload Forecast * Table 3.1 row Q
H	Oct - Dec 2017	(221)	$158.71	($35,075)	Caseload Forecast * Table 3.1 row S
I	**CY 2017 Total**	**(1,541)**		**($244,493)**	Row G + Row H

Table 3.1
Estimated CY 2017 PMPM Rate Calculation

Row	Item		Source
2015 NHE Estimates			
A	2003 Per Capita Rx Drug Expenditures	$610	Centers for Medicare and Medicaid Services (CMS) (1)
B	2006 Per Capita Rx Drug Expenditures	$752	Centers for Medicare and Medicaid Services (CMS) (1)
C	Percentage Growth	23.28%	(Row B ÷ Row A) - 1
Projected 2016 NHE Estimates			
D	2003 Per Capita Rx Drug Expenditures	$610	Department estimate
E	2006 Per Capita Rx Drug Expenditures	$752	Department estimate
F	Percentage Growth	23.28%	(Row E ÷ Row D) - 1
G	Change in Percentage Growth	0.00%	(1 + Row F) ÷ (1 + Row C) - 1
H	Annual percentage trend for July 2016	6.99%	Centers for Medicare and Medicaid Services (CMS) (2)
I	Prior Year Revisions of Annual percentage Trend	4.45%	Centers for Medicare and Medicaid Services (CMS) (2)
J	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2017	11.75%	Centers for Medicare and Medicaid Services (CMS) (2)
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2017**	**11.75%**	Row G + Row J
L	CY 2016 PMPM Rate Prior to FMAP and Phasedown	$378.73	Actual
M	Projected CY 2017 PMPM Rate Prior to FMAP and Phasedown	$423.23	Row L × (1 + Row K)
N	FFY 17 FMAP State Share	49.98%	FFY 17 FMAP is 50.02%
O	Projected CY 2017 PMPM Rate Prior to Phasedown	$211.53	Row M × Row N
P	Phasedown Percentage Rate	75.00%	Sec. 1935. (C) (5) Title XIX of the Social Security Act
Q	**Estimated CY 2017 PMPM Rate (January through September 2017 with 50.02% FMAP)**	**$158.65**	Row O × Row P
R	Projected FFY 18 FMAP State Share	50.00%	Estimated FFY 18 FMAP is 50%
S	**Estimated CY 2017 PMPM Rate (October through December 2017 with projected 50.00% FMAP)**	**$158.71**	Row M x Row R x Row P

(1) Centers for Medicare and Medicaid Services (CMS), CY 2015 NHE estimates
(2) From Announcement of CY 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, Table V. 3.

Table 3.2
Estimated CY 2018 PMPM Rate Calculation

Row	Item		Source
Projected 2016 NHE Estimates			
A	Estimated 2003 Per Capita Rx Drug Expenditures	$610	Department estimate
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
C	Percentage Growth	23.28%	(Row B ÷ Row A) - 1
Projected 2017 NHE Estimates			
D	Estimated 2003 Per Capita Rx Drug Expenditures	$610	Department estimate
E	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
F	Percentage Growth	23.28%	(Row E ÷ Row D) - 1
G	Change in Percentage Growth	0.00%	(1 + Row F) ÷ (1 + Row C) - 1
Projected Figures from Announcements of CY 2011 through CY 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies			
H	Projected Annual percentage trend for July 2017	4.37%	Median Change from CY 2011 to CY 2017
I	Projected Prior Year Revisions of the Annual percentage trend	1.01%	Average Change from CY 2011 to CY 2017
J	Projected Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2018	5.42%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2018**	**5.42%**	Row G + Row J
L	Projected CY 2017 PMPM Rate Prior to FMAP and Phasedown	$423.23	Table 3.1 Row M
M	Projected CY 2018 PMPM Rate Prior to FMAP and Phasedown	$446.17	Row L × (1 + Row K)
N	Projected FFY 18 FMAP State Share	50.00%	Estimated FFY 18 FMAP is 50%
O	Projected CY 2018 PMPM Rate Prior to Phasedown	$223.09	Row M × Row N
P	Ongoing Phasedown Percentage Rate	75.00%	Sec. 1935. (C) (5) Title XIX of the Social Security Act
Q	**Estimated CY 2018 PMPM Rate (January through December 2018 with 50.00% FMAP)**	**$167.32**	Row O × Row P

Table 3.3
Estimated CY 2019 PMPM Rate Calculation

Row	Item		Source
Projected 2017 NHE Estimates			
A	Estimated 2003 Per Capita Rx Drug Expenditures	$610	Department estimate
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
C	Percentage Growth	23.28%	(Row B ÷ Row A) - 1
Projected 2018 NHE Estimates			
D	Estimated 2003 Per Capita Rx Drug Expenditures	$610	Department estimate
E	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
F	Percentage Growth	23.28%	(Row E ÷ Row D) - 1
G	Change in Percentage Growth	0.00%	(1 + Row F) ÷ (1 + Row C) - 1
Projected Figures from Announcements of CY 2011 through CY 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies			
H	Projected Annual percentage trend for July 2018	4.37%	Median Change from CY 2011 to CY 2017
I	Projected Prior Year Revisions of the Annual percentage trend	1.01%	Average Change from CY 2011 to CY 2017
J	Projected Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2018	5.42%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2018**	**5.42%**	Row G + Row H
L	CY 2018 PMPM Rate Prior to FMAP and Phasedown	$446.17	Table 3.3 Row M
M	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2018	5.42%	Row K
M	Projected CY 2018 PMPM Rate Prior to FMAP and Phasedown	$470.36	Row L × (1 + Row K)
N	Projected FFY 18 FMAP State Share	50.00%	Estimated FFY 18 FMAP is 50%
O	Projected CY 2018 PMPM Rate Prior to Phasedown	$235.18	Row M × Row N
P	Ongoing Phasedown Percentage Rate	75.00%	Sec. 1935. (C) (5) Title XIX of the Social Security Act
Q	**Estimated CY 2018 PMPM Rate (January through December 2019 with 50.00% FMAP)**	**$176.38**	Row O × Row P

Table 4.1
Invoice Caseload History

Item	Total Member Months Caseload	Average Monthly Caseload
FY 2006-07	611,212	50,934
FY 2007-08	642,840	53,570
% Change from FY 2006-07	5.17%	5.18%
FY 2008-09	651,968	54,331
% Change from FY 2007-08	1.42%	1.42%
FY 2009-10	664,292	55,358
% Change from FY 2008-09	1.89%	1.89%
FY 2010-11	697,817	58,151
% Change from FY 2009-10	5.05%	5.05%
FY 2011-12	725,075	60,423
% Change from FY 2010-11	3.91%	3.91%
FY 2012-13	750,509	62,542
% Change from FY 2011-12	3.51%	3.51%
FY 2013-14	812,812	67,734
% Change from FY 2012-13	8.30%	8.30%
FY 2014-15	865,253	72,104
% Change from FY 2013-14	6.45%	6.45%
FY 2015-16	877,707	73,142
% Change from FY 2014-15	1.44%	1.44%
FY 2016-17 Projection	900,149	75,012
% Change from FY 2015-16 Projection	2.56%	2.56%
FY 2017-18 Projection	930,476	77,540
% Change from FY 2016-17 Projection	3.37%	3.37%
FY 2018-19 Projection	962,235	80,186
% Change from FY 2017-18 Projection	3.41%	3.37%

Table 4.2
Aggregate Monthly Caseload History

Item	Total Member Months Caseload	Average Monthly Caseload
FY 2006-07	618,862	51,572
FY 2007-08	630,715	52,560
% Change from FY 2006-07	1.92%	1.92%
FY 2008-09	621,662	51,805
% Change from FY 2007-08	-1.44%	-1.44%
FY 2009-10	665,732	55,478
% Change from FY 2008-09	7.09%	7.09%
FY 2010-11	693,267	57,772
% Change from FY 2009-10	4.14%	4.13%
FY 2011-12	728,875	60,740
% Change from FY 2010-11	5.14%	5.14%
FY 2012-13	757,424	63,119
% Change from FY 2011-12	3.92%	3.92%
FY 2013-14	803,212	66,934
% Change from FY 2012-13	6.05%	6.04%
FY 2014-15	864,907	72,076
% Change from FY 2013-14	7.68%	7.68%
FY 2015-16	877,957	73,163
% Change from FY 2014-15	1.51%	1.51%
FY 2016-17 Projection	900,116	75,010
% Change from FY 2015-16 Projection	2.52%	2.52%
FY 2017-18 Projection	930,604	77,550
% Change from FY 2016-17 Projection	3.39%	3.39%
FY 2018-19 Projection	962,356	80,196
% Change from FY 2017-18 Projection	3.41%	3.41%

Table 4.3
Summary of PMPM Rates by Calendar Year (CY) with FMAP

Row	Year	Rate	FMAP	Source
	CY 2014			
A	Jan-Sept 2014	$125.50	50.00%	Actual CMS
B	Oct-Dec 2014	$122.97	51.01%	Actual CMS
	CY 2015			
C	Jan-Sept 2015	$124.68	51.01%	Actual CMS
D	Oct-Dec 2015	$125.42	50.72%	Actual CMS
	CY 2016			
E	Jan-Sept 2016	$139.98	50.72%	Actual CMS
F	Oct-Dec 2016	$141.97	50.02%	Actual CMS
	CY 2017			
G	Jan-Sept 2017	$158.65	50.02%	Table 3.1 Row Q
H	Estimated Oct-Dec 2017	$158.71	50.00%	Table 3.1 Row S
	CY 2018			
I	Estimated Jan-Dec 2018	$167.32	50.00%	Table 3.2 Row Q
	CY 2019			
J	Estimated Jan-Dec 2019	$176.38	50.00%	Table 3.3 Row Q

Table 4.4
Quarterly PMPM Rate History

Item	Q1	Q2	Q3	Q4	Average PMPM Rate
CY 2006	$114.71	$114.71	$114.71	$114.71	**$114.71**
CY 2007	$120.30	$120.30	$120.30	$120.30	**$120.30**
% Change from CY 2006					4.87%
CY 2008	$120.03	$120.03	$120.03	$98.95	**$114.76**
% Change from CY 2007					-4.61%
CY 2009	$106.03	$98.81	$98.81	$98.81	**$100.62**
% Change from CY 2008					-12.33%
CY 2010	$101.49	$101.49	$101.49	$101.49	**$101.49**
% Change from CY 2009					0.87%
CY 2011	$107.07	$111.97	$129.84	$129.84	**$119.68**
% Change from CY 2010					17.92%
CY 2012	$132.41	$132.41	$132.41	$132.41	**$132.41**
% Change from CY 2011					10.64%
CY 2013	$133.62	$133.62	$133.62	$133.62	**$133.62**
% Change from CY 2012					0.91%
CY 2014	$125.50	$125.50	$125.50	$122.97	**$124.87**
% Change from CY 2013					-6.55%
CY 2015	$124.68	$124.68	$124.68	$125.42	**$124.87**
% Change from CY 2014					0.00%
CY 2016	$139.98	$139.98	$139.98	$141.97	**$140.48**
% Change from CY 2015					12.50%
CY 2017 Projection	$158.65	$158.65	$158.65	$158.71	**$158.67**
% Change from CY 2016					12.95%
CY 2018 Projection	$167.32	$167.32	$167.32	$167.32	**$167.32**
% Change from CY 2017					5.45%
CY 2019 Projection	$176.38	$176.38	$176.38	$176.38	**$176.38**
% Change from CY 2018					5.41%

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-05 Office of Community Living

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$490,594,151**	**$0**	**$490,659,237**	**$9,869,672**	**$34,757,017**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$248,833,350	$0	$248,581,190	($2,025,296)	$18,882,493
	CF	$1	$0	$284,697	$8,427,248	($36,875)
	RF	$0	$0	$0	$0	$0
	FF	$241,760,800	$0	$241,793,350	$3,467,720	$15,911,399

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs - Adult Comprehensive Services	**Total**	**$362,346,433**	**$0**	**$362,346,433**	**$7,469,531**	**$24,472,717**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$180,448,523	$0	$180,448,523	($4,001,748)	$12,961,051
	CF	$1	$0	$1	$8,461,206	$0
	RF	$0	$0	$0	$0	$0
	FF	$181,897,909	$0	$181,897,909	$3,010,073	$11,511,666
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs - Adult Supported Living Services	**Total**	**$69,681,391**	**$0**	**$69,734,980**	**$1,561,123**	**$7,271,228**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$38,677,034	$0	$38,469,418	$928,806	$3,784,415
	CF	$0	$0	$234,405	($24,590)	($25,152)
	RF	$0	$0	$0	$0	$0
	FF	$31,004,357	$0	$31,031,157	$656,907	$3,511,965

	Total	**$26,310,826**	**$0**	**$26,310,826**	**$463,632**	**$1,179,438**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs - Children's Extensive Support Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$13,102,791	$0	$13,102,791	$284,438	$642,341
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$13,208,035	$0	$13,208,035	$179,194	$537,097

	Total	**$32,255,501**	**$0**	**$32,266,998**	**$375,386**	**$1,833,634**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs - Case Management	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$16,605,002	$0	$16,560,458	$763,208	$1,494,686
	CF	$0	$0	$50,291	($9,368)	($11,723)
	RF	$0	$0	$0	$0	$0
	FF	$15,650,499	$0	$15,656,249	($378,454)	$350,671

CF Letternote Text Revision Required?	Yes	X	No	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes		No	X
FF Letternote Text Revision Required?	Yes		No	X
Requires Legislation?	Yes		No	X

Type of Request? Department of Health Care Policy and Financing Prioritized Request

Interagency Approval or Related Schedule 13s: None

Cost and FTE

- In FY 2016-17, the Department requests a decrease of $18,626,814 total funds, including a decrease of $8,707,629 General Fund. For FY 2017-18, the Department requests an increase of $9,869,672 total funds, including a decrease $2,025,296 General Fund and an increase of $8,427,248 Intellectual and Developmental Disabilities Cash Funds. For FY 2018-19, the Department requests an increase of $34,757,017 total funds, including an increase $18,882,493 General Fund and a decrease of $36,875 Hospital Provider Fee Cash Funds. These funds would be used to fund Home and Community Based Services (HCBS) waiver program costs.

Current Program

- Effective March 2014, the Department manages three Medicaid HCBS waiver programs for people with developmental disabilities, Adult Comprehensive Services (HCBS-DD), Supported Living Services (HCBS-SLS) and Children's Extensive Services (HCBS-CES).
- These programs provide services such as residential care, day habilitation services and behavioral services, as well as case management, and are delivered through a variety of approved providers.

Problem or Opportunity

- Appropriations do not accurately reflect the estimated number of enrollments, full program equivalents (FPE), or cost per FPE, based upon current enrollment and spending trends as well as program information.
- This issue poses the problem of under-expenditure in the current year without action because the Department estimates cost per FPE will be lower than expected.
- In the request year and out year, higher than expected emergency enrollments in the HCBS-DD waiver pose the risk of over-expenditure.

Consequences of Problem

- If the appropriations are not adjusted, the Department expects to under-spend its appropriation, necessitating a reversion of General Fund at the end of the year. Additionally, in the request and out years, over-expenditure is expected if additional funding is not appropriated through this request.
- Under-expending funds in the current year would withhold funding needed for other state programs. Over-expending funds in the request and out years would compromise the Department's ability to provide services to the maximum number of people with intellectual and developmental disabilities.

Proposed Solution

- The Department requests to adjust existing expenditure and enrollment appropriations and designated full program equivalents (FPE) within three Medicaid waiver programs for people with intellectual and developmental disabilities to maintain the current policy of having no waiting lists for the HCBS-SLS and HCBS-CES waivers and to accommodate emergency enrollments, foster care transitions, Colorado Choice Transitions (CCT), and youth transitions.
- The outcomes of this proposed solution would be a more accurate budget that would be measured by comparing estimated expenditure to actual expenditure once the data is available.

Department Priority: R-5
Request Detail: Office of Community Living Cost and Caseload Adjustments

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Office of Communty Living Cost and Caseload Adjustments	$9,869,672	($2,025,296)

Problem or Opportunity:

Each year, the Department's appropriations for programs serving individuals with intellectual and developmental disabilities are set in advance of the fiscal year, based on prior year utilization and expenditure. As more recent data becomes available, the appropriation needs to be adjusted to account for the most recent projections of expenditure and caseload, in order to minimize any potential over or under-expenditures. The Department requests to adjust existing appropriations and designated full program equivalents (FPE) within three Medicaid waiver programs for people with developmental disabilities: Home and Community Based Services Adult Comprehensive Services (HCBS-DD), Supported Living Services (HCBS-SLS), and Children's Extensive Services (HCBS-CES); further, the Department's request accounts for associated changes to the Targeted Case Management (TCM) service. Adjustments to targeted appropriations accurately reflect the current cost per FPE, based upon current spending trends, and maximize the number of individuals that can be served in the programs.

The Home and Community Based Services, Adult Comprehensive services program (HCBS-DD) provides services to adults with developmental disabilities who require extensive supports to live safely in the community and who do not have the resources available to meet their needs. The Home and Community Based Services - Supported Living Services program (HCBS-SLS) is for adults who can either live independently with limited to moderate supports or who need more extensive support provided by other persons, such as their family. The Home and Community Based Services - Children's Extensive Services program (HCBS-CES) provides benefits to children who have a developmental disability or delay, and who need near constant line of sight supervision due to behavioral or medical needs.

In FY 2012-13, the Department of Human Services requested and received funding to eliminate the waiting list for the HCBS-CES program. In FY 2013-14, the Department of Health Care Policy and Financing requested and received funding to eliminate the waiting list for the HCBS-SLS program. In order to prevent new waiting lists, the General Assembly must provide new funding each year to allow for growth in both programs. In contrast, the HCBS-DD program continues to have a waiting list for services; as of the June 30, 2016 Medicaid Funding Requested Waiting List Report, there are 2,250 people waiting to receive HCBS-DD waiver services. The waiting lists may include those requiring emergency enrollments as well as those transitioning out of institutional settings. Additionally, the list may include current Medicaid recipients being served in an alternative waiver that does not fully meet their needs, and may also include individuals being served in nursing facilities or hospitals that are not as cost-effective as the HCBS waivers.

Each year, additional enrollments in the HCBS-DD waiver are needed to provide resources for emergency placements, individuals transitioning out of foster care, from HCBS-CES, or Colorado Choice Transition (CCT) clients transitioning from an institutional setting. Without additional enrollments each year, people with intellectual and developmental disabilities would transition to other less appropriate, more costly settings or become vulnerable to abuse, neglect or homelessness as an increasing number of people continue to wait on the list to receive the services they need.

Proposed Solution:

In order to adjust the current appropriations for the programs administered by the Office of Community Living in FY 2016-17, the Department requests a decrease of $18,626,814 total funds, including a decrease of $8,707,629 General Fund. For FY 2017-18, the Department requests an increase of $9,869,672 total funds, including a decrease $2,025,296 General Fund and an increase of $8,427,248 from the Intellectual and Developmental Disabilities Cash Fund. For FY 2018-19, the Department requests an increase of $34,757,017 total funds, including an increase $18,882,493 General Fund and a decrease of $36,875 from the Hospital Provider Fee Cash Fund.

Based on the assumptions used in this request, the Department calculated maximum enrollment figures for each waiver program and TCM services and the number of full-program equivalents (FPE) for each fiscal year. If this request is approved, the Department calculates that by the end of FY 2016-17 it would serve: 5,346 people on the HCBS-DD waiver (including people in Regional Centers); 4,783 people on the HCBS-SLS waiver; and, 1,639 people on the HCBS-CES waiver. For the years covered in the request, the Department would limit HCBS-DD enrollments to the maximum enrollment figure. However, for the HCBS-SLS and HCBS-CES programs, the Department would adhere to the policy of maintaining no waiting lists; therefore, the maximum enrollment numbers are for information only, and the Department would exceed those figures if necessary and use the regular budget process to account for any change in the estimates. The number of associated FPE for each fiscal year is shown in exhibit D.3 of the appendix.

Anticipated Outcomes:

The Office of Community Living finances long term services and supports in the community to adults and children with developmental disabilities who would otherwise receive services in more restrictive and expensive institutional settings or who would be without services altogether. As part of the Triple Aim, the Department strives to provide the right services to the right people at the right time and place.

The Department's request includes funding to provide needed services for the highest number as well as most at-risk eligible people as possible. If the Department's request is approved, the Department would have resources to cover 11,537 people on average per month in FY 2016-17, and 12,253 people on average per month in FY 2017-18, thereby improving their physical, mental, and social well-being and quality of life.

Assumptions and Calculations:

The Department's calculations are contained in the appendix. The appendix is organized into a series of exhibits, providing both calculation information and historical cost and caseload detail. The section below describes each exhibit individually. In many cases, the specific assumptions and calculations are contained in the exhibits directly; the narrative information below provides additional information and clarification where necessary.

Exhibit A.1: Calculation of Request

This exhibit provides the final calculation of the incremental request, by line item. Values in the total request column are taken from calculations in exhibits A.2 through A.4, as well as exhibit C which relates to projected expenditure. The adjusted spending authority amounts reflect the estimate appropriation for each line and can be found in Tables G.1 through G.3. The incremental request is the sum of the differences between total request and spending authority for each line item.

Exhibit A.2 through A.4: Current, Request, and Out Year Fund Splits

These exhibits provide a breakdown for each line item's expenditure estimate including fund splits for each program. This exhibit also allows for adjustments in the federal financial participation rate (FFP) based on the type of services delivered within each program. The Federal Medical Assistance Percentage (FMAP) Colorado decreased in October 2015 to 50.72%. The Department uses a blended rate to account for the implementation of the new match rate in the middle of the fiscal year. The Department predicts that the FMAP for FFY 2016-17 will decrease to 50.02% and further decrease in FFY 2017-18 to 50.01%. For state fiscal years this translates to an FMAP of 50.20% in FY 2016-17, 50.01% in FY 2017-18, and 50.00% in FY 2018-19. FMAP forecasts can be found in exhibit R of the Department's FY 2016-17 R-1 "Medical Services Premiums Request".

HB 16-1321 "Medicaid Buy-In Certain Waivers" created a buy-in option for working adults who would otherwise not qualify due to income or asset limits for the HCBS-SLS waiver with the expected implementation date of July 1, 2017. The state portion of Buy-In expenditure will be paid for with Hospital Provider Fee Cash Fund dollars, while standard HCBS-SLS and TCM are paid for with General Fund dollars. Costs associated with Buy-In HCBS-SLS and TCM services are separated in these exhibits to reflect the difference in funding source.

Exhibit A.5: Cash Funds Report

This iteration of the Department's forecast includes the addition of several cash fund sources. In light of this, the Department has added Exhibit A.5 to clarify the amount of and source of cash funds allocated and requested in each year.

Exhibit B: Summary of Program Costs

This exhibit provides a summary of historical program expenditure, as paid for through the Department's Medicaid Management Information System (MMIS), and projected totals as calculated in exhibit C.

Exhibit C: Calculation of Projected Expenditure

This exhibit provides the calculation of projected expenditure using revised assumptions about caseload and per FPE cost (calculated in exhibits D.3 and E, respectively). The exhibit then calculates the difference between the appropriated or base request amounts which results in the estimated over/under-expenditure for each waiver, by fiscal year. In fiscal years where systemic under-expenditure exists, this exhibit would also calculate an additional number of people that could be enrolled within existing resources, and converts the total enrollment figures into new paid enrollments, and calculate the new cost for additional enrollments for each fiscal year. This exhibit calculates costs for Medicaid matched services only and does not include State-Only programs. Therefore, the appropriation reflected in this exhibit does not match the adjusted appropriation in Exhibit A.1.

Exhibit D.1: Calculation of Maximum Enrollment

To forecast the number of enrollments, the Department took the appropriated enrollments from the Long Bill and estimates a base trend. Selection of trends for each waiver are discussed below. Once the base enrollments are determined, the Department adds in additional enrollments authorized through special bills or other initiatives, as Bottom Line Adjustments, to reach the final estimated maximum enrollment. This process is repeated for the request year and the out year. Information on trend selection and Bottom Line Adjustments for each program are provided below.

As of FY 2014-15 there is no longer a waiver cap in the HCBS-SLS or HCBS-CES so the maximum enrollment forecast for these waivers has been removed from the exhibits. Because TCM enrollment is derivative of HCBS-SLS and HCBS-CES enrollment, the maximum TCM enrollment forecast has also been removed from the exhibits.

Adult Comprehensive Waiver (DD)

For FY 2016-17 the Department was appropriated funding for 5,257 enrollments through HB 16-1405 "FY 2016-17 Long Appropriations Bill" which included a request to increase the HCBS-DD enrollment cap by 157 clients as bottom line adjustments. These bottom line adjustments were composed of 40 emergency enrollments, 55 foster care transitions as requested in the Department's FY 2014-15 R-8 "Developmental Disabilities New Full Program Equivalents", 30 Colorado Choice Transitions (CCT) clients expected to move from an institutional setting into the HCBS-DD waiver in FY 2016-17, and 32 youth transitions expected to move to the HCBS-DD waiver as they age out of the HCBS-CES waiver.

In FY 2016-17 the Department requests an additional 89 HCBS-DD enrollments, including an increase of 110 emergency enrollments, a reduction of 9 foster care transitions, and a reduction of 12 CCT transitions to reach a maximum enrollment figure of 5,346 enrollments. In FY 2017-18 the Department requests an additional 248 enrollments, including 150 emergency enrollments, 46 foster care transitions, 32 youth transitions, and 20 CCT enrollments, to reach a maximum enrollment figure of 5,594.

This request represents a sizeable increase in the number of expected emergency enrollments over the Department's previous forecast. The Department bases its updated figure on the number of emergency enrollments that enrolled in the HCBS-DD waiver in FY 2015-16. Between FY 2013-14 and FY 2015-16 the number of emergency enrollments authorized each month has been steadily increasing. The Department believes that this is the result of several compounding factors. Over the past two years the Department has provided increased training to Community Centered Boards (CCBs) on the emergency enrollment criteria and process, while at the same time updating the forms necessary to initiate an emergency enrollment. The Department believes that part of the increase in emergency enrollments is a result of CCBs becoming more adept at identifying potential emergency enrollments, and more aware of the steps necessary enroll a client as an emergency enrollment.

The Department also believes that trends in the Colorado housing market have impacted the number of emergency enrollments into the HCBS-DD waiver. A common cause of an emergency enrollment is impending homelessness. Many individuals have lost housing due to rent increases, homes being sold after elderly care givers and parents pass away, and limited access to Section 8 housing. The Department has received feedback from stakeholders that there has been an increase in the age of caregivers. As caregivers age, some become less willing or able to provide the level

of care needed by the client, leaving them neglected and more likely to qualify as an emergency enrollment.

Clients authorized as emergency enrollments, who may or may not be on the HCBS-DD waitlist, are allowed to enroll in the HCBS-DD waiver prior to clients on the waitlist. Without additional enrollments allocated for these clients, they will continue to take priority over clients on the HCBS-DD waitlist thereby increasing the size of the waitlist and waiting period for clients on the waitlist. If there are no allocated enrollments available, clients meeting the emergency criteria may find themselves in settings that do not meet their needs, leave them open to abuse or neglect, or leave them vulnerable to homelessness.

Using updated data through June 2016, the Department estimates that 46 clients are likely to transition to HCBS-DD as foster care transitions in FY 2016-17, which represents a reduction of 9 clients from expected enrollment forecasted in the in the FY 2016-17 S-5. This estimate is based on lower than anticipated foster care transitions in FY 2015-16 and program feedback.

Additionally, the Department is now predicting that 18 CCT clients will transition from institutions to the HCBS-DD waiver in FY 2016-17, which represents a reduction of 12 clients from expected enrollment forecasted in the S-5. The Department has revised its CCT forecast downward based on lower than expected utilization of CCT services in FY 2015-16. CCT enrollments are forecasted in exhibit R of the Department's S-1 "Medical Services Premiums Request", see this exhibit for more information on the Department's revised CCT forecast.

Exhibit D.2: Conversion of Enrollment to Full Program Equivalent (FPE)

In order to properly calculate expenditure, the Department must use a consistent caseload metric that directly ties to expenditure. In this exhibit, and throughout the request, the Department uses average monthly paid enrollment to determine the number of clients for which it anticipates paying claims for in each fiscal year. This caseload metric is referred to as "full-program equivalents," or FPE. The Department notes, however, that the number of FPE is not always equal to the enrollment for each waiver. The relationship of FPE to maximum enrollment can vary based on a large number of factors including lag between enrollment and delivery of services and the lag between delivery of services and billing of claims; however, in order to accurately set the appropriation and manage the program, it is critical to explicitly identify both the number of FPE, enrollment, and the interaction between the two.

The Department's methodology to account for the above mentioned variation includes the selection of an FPE conversion factor which is based on the ratio of average monthly enrollments (as calculated in Exhibit D.3) to FPE in historical data. Enrollments are derived from the number of unique waiver clients in a given month with an active prior authorization request (PAR) which means that these clients have been authorized by the CCBs to receive services. The Department

then uses this metric to convert the average monthly enrollment forecast to projected FPE in Exhibit D.3.

For the HCBS-DD waiver and TCM, the selected FPE conversion factor is the average FPE conversion factor from the previous year. The lack of major structural changes in the HCBS-DD waiver or TCM leads the Department to believe that the previous year's rate of service utilization, and therefore conversion factor, is a good prediction of utilization in the coming year.

The HCBS-CES and HCBS-SLS waivers are expected to continue to experience rapid enrollment as a result of cap removal in FY 2013-14 and FY 2014-15 respectively. The Department believes that the volume of services used by clients will be artificially low in the HCBS-CES and HCBS-SLS waiver until all clients previously on the waitlists are receiving services. In HCBS-SLS the Department expects rapid enrollment to continue through the request year, and therefore chose to hold the conversion factor constant at the FY 2015-16 level in the current, request, and out year. The Department expects enrollment growth to slow in the HCBS-CES waiver, and chose a progressively higher conversion factor in the current, request, and out year that approaches a natural rate. The natural conversion factor is assumed to be the conversion factor seen in FY 2012-13, the year before the removal of the HCBS-CES waiver cap.

The Department assumes that the conversion factor for HCBS-SLS and TCM Buy-In services will match those of non-Buy-In HCBS-SLS and TCM services because Buy-In clients will exist in the same provider environment, with the same barriers to access, as non-Buy-In clients. Furthermore, the Department expects Buy-In clients to exhibit fluctuations in service demand similar to those of non-Buy-In clients based on their similar medical conditions that qualify them for the service, though varying due to their unique physical, psychological, and social states. The Department will reassess this assumption after the program begins and adequate data is collected.

Exhibit D.3: Calculation of Average Monthly Enrollment and FPE

This exhibit provides a summary of historical average monthly enrollment and estimates average monthly enrollment and FPE for the years covered in this request. The Department's methodology involves three steps and begins with the enrollment level at the end of the prior fiscal year. First, the final estimated average monthly enrollment under current policy is calculated by adding the additional enrollments described in the maximum enrollment exhibit, or in the case of HCBS-SLS and HCBS-CES to the maximum assumed enrollment, to the enrollment level at the end of the prior fiscal year; these enrollments are adjusted based on a linear enrollment ramp-up over the fiscal year. The Department assumes that by the end of each fiscal year, enrollment will be at the maximum appropriated or maximum assumed level and that the increase in enrollments from the beginning of the fiscal year to the end will happen evenly across 12 months. TCM enrollment is calculated as the sum of HCBS-DD, HCBS-SLS, and HCBS-CES enrollment.

If gross under-expenditure across the waivers in the request and out years exists, requested enrollments from reallocation of existing resources would be added to arrive at the final estimated average monthly enrollment; these enrollments would be in addition to those based on current policy. At this time, the Department is not requesting additional enrollments from reallocation of existing resources, but may reassess based on actual current year expenditure during the supplemental process.

Finally, the FPE adjustment factor, described in the conversion of enrollment to FPE, Exhibit D.2, is applied to the final estimated average monthly enrollment to arrive at the estimated FPE for the fiscal year. The steps described above are repeated for each waiver and fiscal year with the request and out years beginning with the estimated FY 2015-16 and FY 2016-17 maximum enrollment levels.

Maximum Appropriated Enrollment for the HCBS-DD Waiver

For the HCBS-DD waiver, maximum enrollment comes from total appropriated enrollments. This is due to the existence of the enrollment cap in this waiver. The Department assumes that the appropriated enrollment amount will be reached for each year in this request.

Maximum Assumed Enrollment for the HCBS-SLS and HCBS-CES Waivers

Due to the removal of the enrollment cap for the HCBS-SLS waiver in FY 2014-15 and the HCBS-CES waiver in 2013-14 the Department no longer uses appropriated enrollments to forecast end of year enrollment. In light of this the Department now estimates maximum assumed enrollment.

All clients previously on the HCBS-SLS and HCBS-CES waiting list have been authorized by the Department to enroll in the waiver for which they were waiting. These clients are either enrolled and receiving services or are working with CCBs to connect with service providers and begin receiving services. Previously waitlisted clients who are not yet receiving services are referred to here as pending clients or pending enrollments and are managed internally by each CCB. The Department has requested that CCBs with pending enrollments submit a comprehensive plan to the Department by October 31, 2016 detailing how they plan to enroll all clients by the end of FY 2016-17.

Maximum assumed enrollment for the HCBS-SLS and HCBS-CES waiver are based on linear enrollment projections from FY 2015-16. The Department assumes that growth in these waivers will continue at a similar pace until all pending clients are enrolled. Once all pending clients are enrolled, the Department assumes that enrollment on these waivers will return to a natural rate of growth. This natural rate of growth was estimated based on the growth of the waitlist before cap removal in both of these waivers.

In the HCBS-SLS waiver, the pace of enrollment of pending clients slowed significantly in FY 2015-16. Assuming that the rate of reduction remains constant, all pending clients would not be enrolled until March 2019. The Department believes that an average of approximately 27 clients will enroll in the waiver each month until all pending clients are enrolled. After March 2019, the Department reduces enrollment expectations to 19 enrollments per-month based on growth in the waitlist prior to waitlist elimination.

Nearly all clients previously on the HCBS-CES waitlist have been enrolled in the waiver. The Department assumes that all pending enrollments for HCBS-CES services will be enrolled by August 2016, and that after August 2016 the pace of enrollment will return to a slower natural rate. The Department believes that approximately 29 clients will enroll in the waiver each month until all pending clients are enrolled. After August 2016 the Department expects growth in this waiver to return to a normal rate based on the growth rate of the waitlist in the year before HCBS-CES cap removal.

Enrollment in HCBS-SLS and TCM Buy-In programs was calculated in the Department's fiscal note for HB 16-1321 "Medicaid Buy-In Certain Waivers", and the Department assumes that these enrollment assumptions still hold. The fiscal note assumed that the majority of clients that will use the HCBS-SLS Buy-In option are already enrolled in the HCBS-SLS waiver. To account for this, the Department subtracted the number clients expected to move from standard HCBS-SLS and TCM to Buy-In from average monthly enrollment in standard HCBS-SLS and TCM. Detailed enrollment predictions can be found in Exhibit D.3.

Exhibit D.5.1: Regional Center Information

This exhibit details the historical average enrollment and costs for clients receiving HCBS-DD services in Regional Centers. Regional Center claims are paid for from an appropriation within the Department via a transfer to the Department of Human Services (CDHS) who manages Regional Center programs. The cost of these clients is not forecasted in this request. Clients in Regional Centers do however receive TCM services as well as Quality Assurance and Utilization Reviews (QA/UR) which are managed and paid for by HCPF, so Regional Center enrollment information is included in this request to fully account for these costs. To determine utilization of these services the Department predicts that enrollment will remain constant over the request period.

Exhibit E: Calculation of Per-FPE Expenditure

This exhibit provides a summary of historical per FPE expenditure, and calculates estimated per FPE expenditure for the years covered in this request.

The Department's methodology begins with per FPE expenditure calculated using final FY 2015-16 expenditure per-FPE. The calculation of per FPE expenditure for the current year and request years includes three components. The first component is a base trend adjustment which accounts

for factors including shifts in the service-level mix, changes in billing patterns or utilization, and other factors.

The Department performed a service level trend analysis within each waiver and TCM to identify possible justification for base trends. In HCBS-DD, HCBS-SLS, and HCBS-CES most services displayed no trend in utilization per-FPE. A small trend was applied to HCBS-DD to account for increasing utilization of In Home Residential Services and Supports, and other low dollar services. HCBS-SLS cost per-FPE was trended upwards driven primarily by increasing utilization of Non-Medical Transportation and Personal Care services. HCBS-CES cost per-FPE was trended downwards primarily as a result of decreasing utilization of Movement Therapy services. No trend was identified within TCM utilization per-FPE.

The Department implemented a 1.7% across the board provider rate increase in July 2015 for the HCBS-DD, HCBS-SLS, and HCBS-CES waivers. The 1.7% rate increase was implemented in September 2015 for TCM. The Department anticipates that the 1.7% rate increase will not be fully realized until July, 2016 for waivers and September, 2016 for TCM because of the lag between the date that services are provided and the date that claims are paid. A fraction of this rate increase is therefore included in FY 2016-17. The Department does not anticipate any additional rate increases in FY 2016-17 or FY 2017-18 at this time.

Bottom line adjustments account for the expected effect of approved policy in the Long Bill and any special bills. A bottom line adjustment was added to account for increased costs in the HCBS-SLS waiver due to the expansion of access to Consumer Directed Attendant Support Services (CDASS) as requested in the Departments FY 2015-16 R-7: "Participant Directed Programs Expansion". The Department has revised the expected implementation date from April, 2016 to January, 2017 pending the Centers for Medicare and Medicaid Services (CMS) approval. Using the assumption that CDASS will take a one year ramp up period to reach full utilization, the increase in costs for the HCBS-SLS waiver were annualized for FY 2016-17 and FY 2017-18 with full utilization expected to be reached in January, 2018.

Exhibit F: Quality Assurance, Utilization Review and Support Intensity Scale Services Forecast

This exhibit forecasts Quality Assurance (QA), Utilization Review (UR), and Support Intensity Scale (SIS) service costs. These services are provided on a monthly, yearly or periodic basis for clients. As a result, utilization and expenditure for these services are directly tied to the number of clients enrolled in the IDD programs.

The Department pays QA costs monthly for each client related to performance of activities related to the waiver Quality Improvement Strategy (QIS) as well as the mechanisms for overall quality assurance and system improvement. Such activities include application of policies and procedures for the resolution of complaints and grievances, critical incident reporting and response, and the

assessment and reporting of process and outcome performance measures. To calculate QA costs the exhibit takes the estimated monthly enrollment from Table D.3 and multiplies that by the rate and then by 12 months for the year.

The Department pays UR costs on a monthly basis for each client. UR activities include the implementation of processes to ensure that waiver services have been authorized in conformance to waiver requirements and monitoring service utilization to ensure that the amount of services is within the levels authorized in the service plan. This also includes identifying instances when individuals are not receiving services authorized in the service plan or the amount of services utilized is substantially less than the amount authorized to identify potential problems in service access. For UR the exhibit multiples monthly enrollment and the current rate and then by 12 months for the year.

The Department performs SIS assessments for IDD clients. SIS includes an assessment of the individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The Scale ranks each activity according to *frequency* (none, at least once a month), *amount* (none, less than 30 minutes), and *type* of support (monitoring, verbal gesturing). Finally, a Supports Intensity Level is determined based on the Total Support Needs Index, which is a standard score generated from scores on all the items tested by the Scale. For SIS, the exhibit calculates expenditure by assuming that all new enrollments would receive an assessment and an additional ten percent of the current population would receive assessments. This would be a result of clients requesting a new assessment and churn within the programs. Children receiving services through the HCBS-CES waiver do not receive SIS assessments.

Exhibit G.1 through G.3: Appropriation Build

Exhibit G.1 through G.3 build the appropriation for the current, request and out years based on Long Bill and special bill appropriations and changes made to spending authority through budget requests. The appropriation build for each year then separates out the programs within each appropriation with assumed amounts attributed to each of them.

To build the request and out year the Department begins each exhibit with the prior year's final estimated appropriation for each program and adjusts the appropriation based on incremental amounts for each approved request or bill.

Table A.1.1 - Calculation of Request					
FY 2016-17					
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Adult Comprehensive Services (HCBS-DD)					
Total Request	$349,681,912	$174,141,591	$1	$0	$175,540,320
Adjusted Spending Authority	$362,346,433	$180,448,523	$1	$0	$181,897,909
Incremental Request	($12,664,521)	($6,306,932)	$0	$0	($6,357,589)
Adult Supported Living Services (HCBS-SLS)					
Total Request	$65,572,176	$36,630,645	$0	$0	$28,941,531
Adjusted Spending Authority	$69,681,391	$38,677,034	$0	$0	$31,004,357
Incremental Request	($4,109,215)	($2,046,389)	$0	$0	($2,062,826)
Children's Extensive Support Services (HCBS-CES)					
Total Request	$25,716,019	$12,806,577	$0	$0	$12,909,442
Adjusted Spending Authority	$26,310,826	$13,102,791	$0	$0	$13,208,035
Incremental Request	($594,807)	($296,214)	$0	$0	($298,593)
Case Management					
Total Request	$30,997,230	$16,546,908	$0	$0	$14,450,322
Adjusted Spending Authority	$32,255,501	$16,605,002	$0	$0	$15,650,499
Incremental Request	($1,258,271)	($58,094)	$0	$0	($1,200,177)
Family Support Services					
Total Request	$6,960,460	$6,960,460	$0	$0	$0
Adjusted Spending Authority	$6,960,460	$6,960,460	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Preventive Dental Hygiene					
Total Request	$63,311	$63,311	$0	$0	$0
Adjusted Spending Authority	$63,311	$63,311	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,121,194	$3,100,556	$0	$0	$20,638
Adjusted Spending Authority	$3,121,194	$3,100,556	$0	$0	$20,638
Incremental Request	$0	$0	$0	$0	$0
Office of Community Living Total					
Total Request	$482,112,302	$250,250,048	$1	$0	$231,862,253
Adjusted Spending Authority	$500,739,116	$258,957,677	$1	$0	$241,781,438
Incremental Request	**($18,626,814)**	**($8,707,629)**	**$0**	**$0**	**($9,919,185)**

Table A.1.2 - Calculation of Request FY 2017-18					
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Adult Comprehensive Services (HCBS-DD)					
Total Request	$369,815,964	$176,446,775	$8,461,207	$0	$184,907,982
Adjusted Spending Authority	$362,346,433	$180,448,523	$1	$0	$181,897,909
Incremental Request	$7,469,531	($4,001,748)	$8,461,206	$0	$3,010,073
Adult Supported Living Services (HCBS-SLS)					
Total Request	$72,557,722	$40,028,908	$209,815	$0	$32,318,999
Adjusted Spending Authority	$70,996,599	$39,100,102	$234,405	$0	$31,662,092
Incremental Request	$1,561,123	$928,806	($24,590)	$0	$656,907
Children's Extensive Support Services (HCBS-CES)					
Total Request	$26,774,458	$13,387,229	$0	$0	$13,387,229
Adjusted Spending Authority	$26,310,826	$13,102,791	$0	$0	$13,208,035
Incremental Request	$463,632	$284,438	$0	$0	$179,194
Case Management					
Total Request	$32,642,384	$17,323,666	$40,924	$0	$15,277,794
Adjusted Spending Authority	$32,266,998	$16,560,458	$50,292	$0	$15,656,248
Incremental Request	$375,386	$763,208	($9,368)	$0	($378,454)
Family Support Services					
Total Request	$6,960,460	$6,960,460	$0	$0	$0
Adjusted Spending Authority	$6,960,460	$6,960,460	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Preventive Dental Hygiene					
Total Request	$63,311	$63,311	$0	$0	$0
Adjusted Spending Authority	$63,311	$63,311	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,121,194	$3,100,556	$0	$0	$20,638
Adjusted Spending Authority	$3,121,194	$3,100,556	$0	$0	$20,638
Incremental Request	$0	$0	$0	$0	$0
Office of Community Living Total					
Total Request	$511,935,493	$257,310,905	$8,711,946	$0	$245,912,642
Adjusted Spending Authority	$502,065,821	$259,336,201	$284,698	$0	$242,444,922
Incremental Request	**$9,869,672**	**($2,025,296)**	**$8,427,248**	**$0**	**$3,467,720**

Table A.1.3 - Calculation of Request FY 2018-19					
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Adult Comprehensive Services (HCBS-DD)					
Total Request	$386,819,150	$193,409,574	$1	$0	$193,409,575
Adjusted Spending Authority	$362,346,433	$180,448,523	$1	$0	$181,897,909
Incremental Request	$24,472,717	$12,961,051	$0	$0	$11,511,666
Adult Supported Living Services (HCBS-SLS)					
Total Request	$78,287,314	$42,858,290	$245,229	$0	$35,183,795
Adjusted Spending Authority	$71,016,086	$39,073,875	$270,381	$0	$31,671,830
Incremental Request	$7,271,228	$3,784,415	($25,152)	$0	$3,511,965
Children's Extensive Support Services (HCBS-CES)					
Total Request	$27,490,264	$13,745,132	$0	$0	$13,745,132
Adjusted Spending Authority	$26,310,826	$13,102,791	$0	$0	$13,208,035
Incremental Request	$1,179,438	$642,341	$0	$0	$537,097
Case Management					
Total Request	$34,247,707	$18,120,964	$46,288	$0	$16,080,455
Adjusted Spending Authority	$32,414,073	$16,626,278	$58,011	$0	$15,729,784
Incremental Request	$1,833,634	$1,494,686	($11,723)	$0	$350,671
Family Support Services					
Total Request	$6,960,460	$6,960,460	$0	$0	$0
Adjusted Spending Authority	$6,960,460	$6,960,460	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Preventive Dental Hygiene					
Total Request	$63,311	$63,311	$0	$0	$0
Adjusted Spending Authority	$63,311	$63,311	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,121,194	$3,100,556	$0	$0	$20,638
Adjusted Spending Authority	$3,121,194	$3,100,556	$0	$0	$20,638
Incremental Request	$0	$0	$0	$0	$0
Office of Community Living Total					
Total Request	$536,989,400	$278,258,287	$291,518	$0	$258,439,595
Adjusted Spending Authority	$502,232,383	$259,375,794	$328,393	$0	$242,528,196
Incremental Request	**$34,757,017**	**$18,882,493**	**($36,875)**	**$0**	**$15,911,399**

Table A.2 - Calculation of Fund Splits						
FY 2016-17						
Item	**Total Request**	**General Fund**	**Cash Funds**	**Federal Funds**	FFP	**Source**
Adult Comprehensive Services (HCBS-DD)						
Subtotal[(1)]	$349,681,912	$174,141,591	$1	$175,540,320	50.20%	Table B.1 Row J
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services	$57,652,453	$28,710,922	$0	$28,941,531	50.20%	Table B.1 Row J
State Only Services	$7,919,723	$7,919,723	$0	$0	0.00%	Table G.1 Row J
Subtotal	$65,572,176	$36,630,645	$0	$28,941,531		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$25,716,019	$12,806,577	$0	$12,909,442	50.20%	Table B.1 Row I
Case Management						
Medicaid Services	$23,957,892	$11,931,030	$0	$12,026,862	50.20%	Table B.1 Row J
State Only Services	$2,192,419	$2,192,419	$0	$0	0.00%	Table G.1 Row M + Correction for Technical Error in 2016-17 S-5
Quality Assurance, Utilization Review, Support Intensity Scale	$4,846,919	$2,423,459	$0	$2,423,460	50.00%	Table F.1 Row J
Subtotal	$30,997,230	$16,546,908	$0	$14,450,322		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,093,677	$3,093,677	$0	$0	0.00%	Table G.1 Row V
PASRR	$27,517	$6,879	$0	$20,638	75.00%	Table G.1 Row U
Subtotal	$3,121,194	$3,100,556	$0	$20,638		
Other Programs						
Family Support Services	$6,960,460	$6,960,460	$0	$0	0.00%	Table G.1 Row N
Preventive Dental Hygiene	$63,311	$63,311	$0	$0	0.00%	Table G.1 Row R
Subtotal	$7,023,771	$7,023,771	$0	$0		
Grand Total	**$482,112,302**	**$250,250,048**	**$1**	**$231,862,253**		
Definitions: FFP: Federal financial participation rate						
(1) Cash funds sourced from the Health Care Expansion Fund.						

Table A.3 - Calculation of Fund Splits						
FY 2017-18						
Item	**Total Request**	**General Fund**	**Cash Funds**	**Federal Funds**	FFP	**Source**
Adult Comprehensive Services (HCBS-DD)						
Medicaid Services[(1)]	$369,815,964	$184,907,981	$1	$184,907,982	50.00%	Table B.1 Row K
Cash Fund Financing[(2)]	$0	($8,461,206)	$8,461,206	$0	0.00%	FY 2015-16 Reversion to IDD Cash Fund
Subtotal	$369,815,964	$176,446,775	$8,461,207	$184,907,982	0.00%	
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services (Standard)	$64,218,369	$32,109,185	$0	$32,109,184	50.00%	Table B.1 Row K
Medicaid Services (Buy-In)[(3)]	$419,630	$0	$209,815	$209,815	50.00%	Table B.1 Row K
State Only Services	$7,919,723	$7,919,723	$0	$0	0.00%	Table G.2 Row H
Subtotal	$72,557,722	$40,028,908	$209,815	$32,318,999		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$26,774,458	$13,387,229	$0	$13,387,229	50.00%	Table B.1 Row K
Case Management						
Medicaid Services (Standard)	$25,380,355	$12,690,178	$0	$12,690,177	50.00%	Table B.1 Row K
Medicaid Services (Buy-In)[(3)]	$66,632	$0	$33,316	$33,316	50.00%	Table B.1 Row K
State Only Services	$2,086,794	$2,086,794	$0	$0	0.00%	Table G.2 Row P + Correction for Technical Error in 2016-17 S-5
Quality Assurance, Utilization Review, Support Intensity Scale (Standard)	$5,093,388	$2,546,694	$0	$2,546,694	50.00%	Table F.2 Row J
Quality Assurance, Utilization Review, Support Intensity Scale (Buy-In)[(3)]	$15,215	$0	$7,608	$7,607	50.00%	Table F.2 Row J
Subtotal	$32,642,384	$17,323,666	$40,924	$15,277,794		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,093,677	$3,093,677	$0	$0	0.00%	Table G.2 Row X
PASRR	$27,517	$6,879	$0	$20,638	75.00%	Table G.2 Row W
Subtotal	$3,121,194	$3,100,556	$0	$20,638		
Other Programs						
Family Support Services	$6,960,460	$6,960,460	$0	$0	0.00%	Table G.2 Row R
Preventive Dental Hygiene	$63,311	$63,311	$0	$0	0.00%	Table G.2 Row T
Subtotal	$7,023,771	$7,023,771	$0	$0		
Grand Total	**$511,935,493**	**$257,310,905**	**$8,711,946**	**$245,912,642**		
Definitions: FFP: Federal financial participation rate						
(1) Cash funds sourced from the Health Care Expansion Fund.						
(2) Cash funds sourced from the Intellectual and Developmental Disabilities Cash Fund.						
(3) Cash funds sourced from the Hospital Provider Fee Cash Fund. Premiums from clients in Buy-In programs are credited to the Medical Services Premiums line item, and as such are excluded from this request.						

Table A.4 - Calculation of Fund Splits						
FY 2018-19						
Item	**Total Request**	**General Fund**	**Cash Funds**	**Federal Funds**	FFP	**Source**
Adult Comprehensive Services (HCBS-DD)						
Subtotal[(1)]	$386,819,150	$193,409,574	$1	$193,409,575	50.00%	Table B.1.1 Row L
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services (Standard)	$69,877,134	$34,938,567	$0	$34,938,567	50.00%	Table B.1.1 Row L
Medicaid Services (Buy-In)[(3)]	$490,457	$0	$245,229	$245,228	50.00%	Table B.1.1 Row L
State Only Services	$7,919,723	$7,919,723	$0	$0	0.00%	Table G.3 Row G
Subtotal	$78,287,314	$42,858,290	$245,229	$35,183,795		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$27,490,264	$13,745,132	$0	$13,745,132	50.00%	Table B.1.1 Row L
Case Management						
Medicaid Services (Standard)	$26,719,773	$13,359,887	$0	$13,359,886	50.00%	Table B.1.1 Row L
Medicaid Services (Buy-In)[(3)]	$76,841	$0	$38,421	$38,420	50.00%	Table B.1.1 Row L
State Only Services	$2,086,794	$2,086,794	$0	$0	0.00%	Table G.3 Row P + Correction for Technical Error in 2016-17 S-5
Quality Assurance, Utilization Review, Support Intensity Scale (Standard)	$5,348,566	$2,674,283	$0	$2,674,283	50.00%	Table F.3 Row J
Quality Assurance, Utilization Review, Support Intensity Scale (Buy-In)[(3)]	$15,733	$0	$7,867	$7,866	50.00%	Table F.3 Row J
Subtotal	$34,247,707	$18,120,964	$46,288	$16,080,455		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,093,677	$3,093,677	$0	$0	0.00%	Table G.3 Row X
PASRR	$27,517	$6,879	$0	$20,638	75.00%	Table G.3 Row W
Subtotal	$3,121,194	$3,100,556	$0	$20,638		
Other Programs						
Family Support Services	$6,960,460	$6,960,460	$0	$0	0.00%	Table G.3 Row Q
Preventive Dental Hygiene	$63,311	$63,311	$0	$0	0.00%	Table G.3 Row T
Subtotal	$7,023,771	$7,023,771	$0	$0		
Grand Total	**$536,989,400**	**$278,258,287**	**$291,518**	**$258,439,595**		
Definitions: FFP: Federal financial participation rate						
(1) Cash funds sourced from the Health Care Expansion Fund						
(2) Cash funds sourced from the Hospital Provider Fee Cash Fund. Premiums from clients in Buy-In programs are credited to the Medical Services Premiums line item, and as such are excluded from this request.						

Table A.5 - Office of Community Living Cash Funds Report									
Cash Fund	**FY 2016-17**			**FY 2017-18**			**FY 2018-19**		
	Spending Authority	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**
Cash Funds									
Health Care Expansion Fund	$1	$1	$0	$1	$1	$0	$1	$1	$0
Intellectual and Developmental Disabilities Cash Fund	$0	$0	$0	$0	$8,461,206	$8,461,206	$0	$0	$0
Hospital Provider Fee Cash Fund	$0	$0	$0	$284,697	$250,739	($33,958)	$328,392	$291,517	($36,875)
Total Cash Funds	**$1**	**$1**	**$0**	**$284,698**	**$8,711,946**	**$8,427,248**	**$328,393**	**$291,518**	**($36,875)**

Table B.1.1 - Division for Intellectual and Developmental Disabilities (DIDD) Total Program Expenditure and Forecast

Row	Fiscal Year	HCBS - Waiver for Persons with Developmental Disabilities (HCBS-DD)	HCBS - Supported Living Services Waiver (HCBS-SLS)	HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In	HCBS - Children's Extensive Support Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	HCBS - Targeted Case Management (TCM) Buy-In	Total
A	FY 2007-08	$202,943,588	$39,607,629	$0	$5,894,263	$13,661,560	$0	$262,107,040
B	FY 2008-09	$223,362,025	$46,391,718	$0	$6,913,410	$13,848,967	$0	$290,516,120
C	FY 2009-10	$253,798,612	$37,399,799	$0	$7,158,025	$16,484,735	$0	$314,841,171
D	FY 2010-11	$273,096,876	$37,579,497	$0	$7,956,073	$19,114,672	$0	$337,747,118
E	FY 2011-12	$264,899,518	$37,030,578	$0	$7,361,601	$16,875,522	$0	$326,167,219
F	FY 2012-13	$261,817,957	$37,273,663	$0	$7,015,707	$16,117,073	$0	$322,224,400
G	FY 2013-14	$282,475,249	$39,288,448	$0	$9,125,302	$17,441,960	$0	$348,330,959
H	FY 2014-15	$314,878,204	$44,654,327	$0	$14,967,843	$20,230,023	$0	$394,730,397
I	FY 2015-16	$330,217,987	$53,275,897	$0	$21,074,423	$22,103,255	$0	$426,671,562
J	Estimated FY 2016-17	$349,681,912	$57,652,453	$0	$25,716,019	$23,957,892	$0	$457,008,276
K	Estimated FY 2017-18	$369,815,964	$64,218,369	$419,630	$26,774,458	$25,380,355	$66,632	$486,675,408
L	Estimated FY 2018-19	$386,819,150	$69,877,134	$490,457	$27,490,264	$26,719,773	$76,841	$511,473,619

Table B.1.2 - Percent Change in Division for Intellectual and Developmental Disabilities (DIDD) Total Program Expenditure

Row	Fiscal Year	HCBS - Waiver for Persons with Developmental Disabilities (HCBS-DD)	HCBS - Supported Living Services Waiver (HCBS-SLS)	HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In	HCBS - Children's Extensive Support Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	HCBS - Targeted Case Management (TCM) Buy-In	Total
A	FY 2007-08							
B	FY 2008-09	10.06%	17.13%	0.00%	17.29%	1.37%	0.00%	10.84%
C	FY 2009-10	13.63%	-19.38%	0.00%	3.54%	19.03%	0.00%	8.37%
D	FY 2010-11	7.60%	0.48%	0.00%	11.15%	15.95%	0.00%	7.28%
E	FY 2011-12	-3.00%	-1.46%	0.00%	-7.47%	-11.71%	0.00%	-3.43%
F	FY 2012-13	-1.16%	0.66%	0.00%	-4.70%	-4.49%	0.00%	-1.21%
G	FY 2013-14	7.89%	5.41%	0.00%	30.07%	8.22%	0.00%	8.10%
H	FY 2014-15	11.47%	13.66%	0.00%	64.03%	15.98%	0.00%	13.32%
I	FY 2015-16	4.87%	19.31%	0.00%	40.80%	9.26%	0.00%	8.09%
J	Estimated FY 2016-17	5.89%	8.21%	0.00%	22.02%	8.39%	0.00%	7.11%
K	Estimated FY 2017-18	5.76%	11.39%	100.00%	4.12%	5.94%	100.00%	6.49%
L	Estimated FY 2018-19	4.60%	8.81%	16.88%	2.67%	5.28%	15.32%	5.10%

Table C.1 - FY 2016-17 Projected Expenditure

Row	Item	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	Total	Source/Calculation
A	Adjusted Appropriation	$362,346,433	$61,761,668	$26,310,826	$26,586,856	$477,005,783	See Footnote (1)
B	Projected FPE	5,111.79	4,188.65	1,465.92	9,693.39	N/A	Table D.3.3, Row E
C	Projected Per FPE Expenditure	$68,406.94	$13,763.97	$17,542.58	$2,471.57	N/A	Table E.1, Row I.
D	Total Projected Expenditure	$349,681,912	$57,652,453	$25,716,019	$23,957,892	$457,008,276	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**($12,664,521)**	**($4,109,215)**	**($594,807)**	**($2,628,964)**	**($19,997,507)**	**Row D - Row A**

Table C.2 - FY 2017-18 Projected Expenditure

Row	Item	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	Total	Source/Calculation
A	FY 2016-17 Base Request	$362,346,433	$63,076,876	$26,310,826	$26,410,817	$478,144,952	See Footnote (1)
B	Projected FPE	5,400.54	4,483.26	1,532.47	10,298.33	N/A	Table D.3.4, Row E. See Footnote (2)
C	Projected Per FPE Expenditure	$68,477.59	$14,417.63	$17,471.44	$2,470.98	N/A	Table E.1 Row J, SLS and TCM are the weighted average of Buy-In and Standard cost Per-FPE.
D	Total Projected Expenditure	$369,815,964	$64,637,999	$26,774,458	$25,446,987	$486,675,408	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**$7,469,531**	**$1,561,123**	**$463,632**	**($963,830)**	**$8,530,456**	**Row D - Row A**

Table C.3 - FY 2018-19 Projected Expenditure

Row	Item	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	Total	Source/Calculation
A	FY 2017-18 Base Request	$362,346,433	$63,096,363	$26,310,826	$26,414,545	$478,168,167	See Footnote (1)
B	Projected FPE	5,645.93	4,797.75	1,576.65	10,841.94	N/A	Table D.3.5, Row E
C	Projected Per FPE Expenditure	$68,512.92	$14,666.79	$17,435.87	$2,471.57	N/A	Table E.1 Row K.
D	Total Projected Expenditure	$386,819,150	$70,367,591	$27,490,264	$26,796,614	$511,473,619	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**$24,472,717**	**$7,271,228**	**$1,179,438**	**$382,069**	**$33,305,452**	**Row D - Row A**

(1) All appropriation amounts above are for Medicaid funded individuals only and do not include State-only funded individuals, services provided to individuals in the Early Intervention program, payments made through client cash sources, or administrative costs.

(2) HCBS-SLS and TCM cost per-capita as shown in this table are the weighted average of cost per-capita for the buy-in and the standard options in these programs.

Table D.1.1 - FY 2016-17 HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) Maximum Enrollment Forecast		
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**
A	FY 2015-16 Maximum Enrollment	5,100
B	Base Trend Increase	0.00%
C	Initial Estimated FY 2016-17 Enrollment	5,100
	Bottom Line Adjustments	
D	Colorado Choice Transitions (CCT)	18
E	Emergency Enrollments	150
F	Foster Care Transitions	46
G	Youth Transitions	32
H	Total Bottom Line Adjustments	246
I	**Estimated FY 2016-17 Maximum Enrollment**	**5,346**

Table D.1.2 - FY 2017-18 HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) Maximum Enrollment Forecast		
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**
A	Estimated FY 2016-17 Maximum Enrollment	5,346
B	Base Trend Increase	0.00%
C	Initial Estimated FY 2017-18 Enrollment	5,346

	Bottom Line Adjustments	
D	Colorado Choice Transitions (CCT)	20
E	Emergency Enrollments	150
F	Foster Care Transitions	46
G	Youth Transitions	32
H	Total Bottom Line Adjustments	248
I	**Estimated FY 2017-18 Maximum Enrollment**	**5,594**

Table D.1.3 - FY 2018-19 HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) Maximum Enrollment Forecast		
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**
A	Estimated FY 2017-18 Maximum Enrollment	5,594
B	Base Trend Increase	0.00%
C	Initial Estimated FY 2017-18 Enrollment	5,594
	Bottom Line Adjustments	
D	Colorado Choice Transitions (CCT)	21
E	Emergency Enrollments	150
F	Foster Care Transitions	46
G	Youth Transitions	32
H	Total Bottom Line Adjustments	249
I	**Estimated FY 2018-19 Maximum Enrollment**	**5,843**

Table D.2 - DIDD Average Monthly Enrollment vs. Full Program Equivalent (FPE)								
Row	**Fiscal Year**		**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**HCBS - Targeted Case Management (TCM) Buy-In**
A	FY 2007-08	Average Monthly Enrollment	4,399	2,871	0	383	7,773	0
B		FPE	3,654.00	2,287.00	0.00	291.00	6,165.00	0.00
C		FPE as a Percentage of Average Monthly Enrollment	83.06%	79.66%	N/A	75.98%	79.31%	N/A
D	FY 2008-09	Average Monthly Enrollment	4,390	2,992	0	400	7,911	0
E		FPE	3,854.00	2,369.00	0.00	328.00	6,420.00	0.00
F		FPE as a Percentage of Average Monthly Enrollment	87.79%	79.18%	N/A	82.00%	81.15%	N/A
G	FY 2009-10	Average Monthly Enrollment	4,401	3,104	0	404	8,027	0
H		FPE	4,063.00	2,625.00	0.00	325.00	6,049.00	0.00
I		FPE as a Percentage of Average Monthly Enrollment	92.32%	84.57%	N/A	80.45%	75.36%	N/A
J	FY 2010-11	Average Monthly Enrollment	4,397	3,116	0	385	8,020	0
K		FPE	4,123.00	2,848.00	0.00	358.00	7,045.00	0.00
L		FPE as a Percentage of Average Monthly Enrollment	93.77%	91.40%	N/A	92.99%	87.84%	N/A
M	FY 2011-12	Average Monthly Enrollment	4,397	3,140	0	373	8,032	0
N		FPE	4,113.00	2,860.00	0.00	338.00	6,578.00	0.00
O		FPE as a Percentage of Average Monthly Enrollment	93.54%	91.08%	N/A	90.62%	81.90%	N/A
P	FY 2012-13	Average Monthly Enrollment	4,384	3,178	0	377	8,074	0
Q		FPE	4,156.00	3,021.00	0.00	347.00	6,760.00	0.00
R		FPE as a Percentage of Average Monthly Enrollment	94.80%	95.06%	N/A	92.04%	83.73%	N/A
S	FY 2013-14	Average Monthly Enrollment	4,392	3,183	0	607	8,309	0
T		FPE	4,339.00	3,015.00	0.00	498.00	6,795.00	0.00
U		FPE as a Percentage of Average Monthly Enrollment	98.79%	94.72%	N/A	82.04%	81.78%	N/A
V	FY 2014-15	Average Monthly Enrollment	4,685	3,678	0	971	9,458	0
W		FPE	4,617.00	3,381.00	0.00	836.00	7,812.00	0.00
X		FPE as a Percentage of Average Monthly Enrollment	98.55%	91.92%	N/A	86.10%	82.60%	N/A
V	FY 2015-16	Average Monthly Enrollment	4,903	4,311	0	1,373	10,704	0
W		FPE	4,832	3,896	0.00	1,200	8,994	0.00
X		FPE as a Percentage of Average Monthly Enrollment	98.55%	90.37%	N/A	87.40%	84.02%	N/A
Y		**FY 2016-17 Selected FPE Conversion Factor(1)**	**98.55%**	**90.37%**	**90.37%**	**91.68%**	**84.02%**	**84.02%**
Z		**FY 2017-18 and FY 2018-19 Selected FPE Conversion Factor(1)**	**98.55%**	**90.37%**	**90.37%**	**92.04%**	**84.02%**	**84.02%**

(1) The selected FPE Conversion Factor for HCBS-DD and TCM are the Conversion Factor from FY 2015-16 in these waivers. The Department believes that as the HCBS-CES and HCBS-SLS waiver continue to experience rapid enrollment as a result of cap removal in FY 2013-14 and FY 2014-15 respectively, the volume of services used by clients, and consequentially the FPE Conversion Factor, will be artificially low. To compensate for this, a lower conversion factor is used in the current year that approaches a natural rate based on the rate prior to cap removal in the request and out years. The Department assumes a 100% conversion factor for Buy-in clients due to the small number of clients, this will be adjusted based on actuals.

Table D.3.1 - Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment Forecast							
Row	**Fiscal Year**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**HCBS - Targeted Case Management (TCM) Buy-In**
A	FY 2007-08	4,399	2,871	0	383	7,773	0
B	FY 2008-09	4,390	2,992	0	400	7,911	0
C	FY 2009-10	4,401	3,104	0	404	8,027	0
D	FY 2010-11	4,397	3,116	0	385	8,020	0
E	FY 2011-12	4,397	3,140	0	373	8,032	0
F	FY 2012-13	4,384	3,178	0	377	8,074	0
G	FY 2013-14	4,392	3,183	0	607	8,309	0
H	FY 2014-15	4,685	3,678	0	971	9,458	0
I	FY 2015-16	4,903	4,311	0	1,373	10,704	0
J	Estimated FY 2016-17	5,187	4,635	0	1,599	11,537	0
K	Estimated FY 2017-18	5,480	4,926	35	1,665	12,222	35
L	Estimated FY 2018-19	5,729	5,272	37	1,713	12,867	37

Table D.3.2 - Percent Change in Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment							
Row	**Fiscal Year**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**HCBS - Targeted Case Management (TCM) Buy-In**
A	FY 2007-08						
B	FY 2008-09	-0.20%	4.21%	0.00%	4.44%	1.78%	0.00%
C	FY 2009-10	0.25%	3.74%	0.00%	1.00%	1.47%	0.00%
D	FY 2010-11	-0.09%	0.39%	0.00%	-4.70%	-0.09%	0.00%
E	FY 2011-12	0.00%	0.77%	0.00%	-3.12%	0.15%	0.00%
F	FY 2012-13	-0.30%	1.21%	0.00%	1.07%	0.52%	0.00%
G	FY 2013-14	0.18%	0.16%	0.00%	61.01%	2.91%	0.00%
H	FY 2014-15	6.67%	15.55%	0.00%	59.97%	13.83%	0.00%
I	FY 2015-16	4.65%	17.21%	0.00%	41.40%	13.17%	0.00%
J	Estimated FY 2016-17	5.79%	7.52%	0.00%	16.46%	7.78%	0.00%
K	Estimated FY 2017-18	5.65%	6.28%	100.00%	4.13%	5.94%	100.00%
L	Estimated FY 2018-19	4.54%	7.02%	5.71%	2.88%	5.28%	5.71%

Table D.3.3 - Calculation of FY 2016-17 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)

Row	FY 2016-17	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	HCBS - Targeted Case Management (TCM) Buy-In	Source/Calculation
A	FY 2015-16 Year-End Enrollment; June 2016	5,000	4,470	0	1,511	11,097	0	Actuals
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	187	165	0	88	440	0	See narrative
C	**Final Estimated FY 2016-17 Average Monthly Enrollment**	**5,187**	**4,635**	**0**	**1,599**	**11,537**	**0**	**Row A + Row B**
D	FPE Adjustment Factor	98.55%	90.37%	90.37%	91.68%	84.02%	84.02%	Table D.2, Row Z
E	**Estimated FY 2016-17 FPE**	**5,111.79**	**4,188.65**	**0.00**	**1,465.92**	**9,693.39**	**0.00**	**Row C * Row D**

Table D.3.4 - Calculation of FY 2017-18 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)

Row	FY 2017-18	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	HCBS - Targeted Case Management (TCM) Buy-In	Source/Calculation
A	Estimated FY 2016-17 Year-End Enrollment; June 2017	5,346	4,783	0	1,639	11,884	0	
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	134	174	35	26	369	35	See narrative
C	Adjustments from HB-16-1321: Medicaid Buy-In Certain Medicaid Waivers	0	(31)	35	0	(31)	35	See narrative
D	Total Bottom Line Adjustments	134	143	35	26	338	35	Row B
E	**Final Estimated FY 2017-18 Average Monthly Enrollment**	**5,480**	**4,926**	**35**	**1,665**	**12,222**	**35**	**Row A + Row E**
F	FPE Adjustment Factor	98.55%	90.37%	90.37%	92.04%	84.02%	84.02%	Table D.2, Row Z
G	**Estimated FY 2017-18 FPE**	**5,400.54**	**4,451.63**	**31.03**	**1,532.47**	**10,268.92**	**29.41**	**Row C * Row D**

Table D.3.5 - Calculation of FY 2018-19 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)

Row	FY 2017-18	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	HCBS - Targeted Case Management (TCM) Buy-In	Source/Calculation
A	Estimated FY 2017-18 Year-End Enrollment; June 2018	5,594	5,105	35	1,687	12,537	35	
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	135	167	2	26	330	2	See narrative
C	Adjustments from HB-16-1321: Medicaid Buy-In Certain Medicaid Waivers	0	(32)	37	0	(32)	37	See narrative
D	Total Bottom Line Adjustments	135	167	2	26	330	2	Row B
E	**Final Estimated FY 2017-18 Average Monthly Enrollment**	**5,729**	**5,272**	**37**	**1,713**	**12,867**	**37**	**Row A + Row B**
F	FPE Adjustment Factor	98.55%	90.37%	90.37%	92.04%	84.02%	84.02%	Table D.2, Row Z
G	**Estimated FY 2017-18 FPE**	**5,645.93**	**4,764.31**	**33.44**	**1,576.65**	**10,810.85**	**31.09**	**Row C * Row D**

Table D.5.1 - HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers							
Row	Fiscal Year	**Average Monthly Enrollment**	**Total Cost**	**Per Utilizer Cost**	**Percent Change in Enrollment**	**Percent Change in Total Cost**	**Percent Change in Per-Utilizer Cost**
A	FY 2007-08	120	$19,814,222	$165,119			
B	FY 2008-09	129	$26,028,730	$201,773	7.50%	31.36%	22.20%
C	FY 2009-10	118	$28,360,034	$240,339	-8.53%	8.96%	19.11%
D	FY 2010-11	122	$24,142,015	$197,885	3.39%	-14.87%	-17.66%
E	FY 2011-12	122	$25,276,720	$207,186	0.00%	4.70%	4.70%
F	FY 2012-13	135	$24,167,096	$179,016	10.66%	-4.39%	-13.60%
G	FY 2013-14	127	$22,225,364	$175,003	-5.93%	-8.03%	-2.24%
H	FY 2014-15	124	$21,454,023	$173,016	-2.36%	-3.47%	-1.14%
I	FY 2015-16	116	$19,900,398	$171,186	-6.25%	-7.24%	-1.06%

Table E.1 - Division for Intellectual and Developmental Disabilities (DIDD) Per Full Program Equivalent (FPE) Expenditure and Forecast							
Row	**Fiscal Year**	**HCBS - Waiver for Persons with Developmental Disabilities (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In**	**HCBS - Children's Extensive Support Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**HCBS - Targeted Case Management (TCM) Buy-In**
A	FY 2007-08	$55,540.12	$17,318.60	$0.00	$20,255.20	$2,215.99	$0.00
B	FY 2008-09	$57,955.90	$19,582.83	$0.00	$21,077.47	$2,157.16	$0.00
C	FY 2009-10	$62,465.82	$14,247.54	$0.00	$22,024.69	$2,725.20	$0.00
D	FY 2010-11	$66,237.42	$13,195.05	$0.00	$22,223.67	$2,713.23	$0.00
E	FY 2011-12	$64,405.43	$12,947.75	$0.00	$21,779.88	$2,565.45	$0.00
F	FY 2012-13	$62,997.58	$12,338.19	$0.00	$20,218.18	$2,384.18	$0.00
G	FY 2013-14	$65,101.46	$13,030.99	$0.00	$18,323.90	$2,566.88	$0.00
H	FY 2014-15	$68,199.74	$13,207.43	$0.00	$17,904.12	$2,589.61	$0.00
I	FY 2015-16	$68,339.82	$13,674.51	$0.00	$17,562.02	$2,457.56	$0.00
J	Estimated FY 2016-17	$68,406.94	$13,763.97	$0.00	$17,542.58	$2,471.57	$0.00
K	Estimated FY 2017-18	$68,477.59	$14,425.81	$13,266.85	$17,471.44	$2,471.57	$2,265.61
L	Estimated FY 2018-19	$68,512.92	$14,666.79	$14,666.79	$17,435.87	$2,471.57	$2,471.57

Table E.2 - Percent Change in Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure							
Row	**Fiscal Year**	**HCBS - Waiver for Persons with Developmental Disabilities (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In**	**HCBS - Children's Extensive Support Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**HCBS - Targeted Case Management (TCM) Buy-In**
A	FY 2007-08						
B	FY 2008-09	4.35%	13.07%	0.00%	4.06%	-2.65%	0.00%
C	FY 2009-10	7.78%	-27.24%	0.00%	4.49%	26.33%	0.00%
D	FY 2010-11	6.04%	-7.39%	0.00%	0.90%	-0.44%	0.00%
E	FY 2011-12	-2.77%	-1.87%	0.00%	-2.00%	-5.45%	0.00%
F	FY 2012-13	-2.19%	-4.71%	0.00%	-7.17%	-7.07%	0.00%
G	FY 2013-14	3.34%	5.62%	0.00%	-9.37%	7.66%	0.00%
H	FY 2014-15	4.76%	1.35%	0.00%	-2.29%	0.89%	0.00%
I	FY 2015-16	0.21%	3.54%	0.00%	-1.91%	-5.10%	0.00%
J	Estimated FY 2016-17	0.10%	0.65%	0.00%	-0.11%	0.57%	0.00%
K	Estimated FY 2017-18	0.10%	4.81%	100.00%	-0.41%	0.00%	100.00%
L	Estimated FY 2018-19	0.05%	1.67%	10.55%	-0.20%	0.00%	9.09%

Table E.3 - Calculation of FY 2016-17 Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure

Row	Item	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	HCBS - Targeted Case Management (TCM) Buy-In	Source/Calculation
A	FY 2015-16 Per Full Program Equivalent (FPE) Expenditure	$68,339.82	$13,674.51	$0.00	$17,562.02	$2,457.56	$0.00	Table E.1 Row I
B	Base Trend	-0.04%	0.23%	0.00%	-0.25%	0.00%	0.00%	Based on Analysis of Individual Service Trends
C	Estimated Base FY 2016-17 Per FPE Expenditure	$68,311.30	$13,705.70	$0.00	$17,518.05	$2,457.56	$0.00	Row A * (1 + Row B)
	Rate Adjustments [(1)]							
D	Annualization of FY 2015-16 1.7% Rate Increase	0.14%	0.14%	0.00%	0.14%	0.57%	0.00%	TCM adjusted for delayed rate increase implementation.
E	Estimated Base FY 2016-17 Per FPE after Rate Adjustments	$68,406.94	$13,724.89	$0.00	$17,542.58	$2,471.57	$0.00	Row C * (1 + Row D).
	Bottom Line Adjustments							
F	Annualization of FY 2015-16 R-7 "Participant Directed Programs Expansion"[(2)]	$0.00	$39.08	$0.00	$0.00	$0.00	$0.00	Adjusted for delayed start date.
G	**Total Estimated FY 2016-17 Per FPE Expenditure**	**$68,406.94**	**$13,763.97**	**$0.00**	**$17,542.58**	**$2,471.57**	**$0.00**	**Row E + Row F**

(1) A 1.7% Provider Rate increase was added during FY 2015-16. Because of lag between the dates services are provided and the dates claims are paid, the increases are realized gradually (i.e. some claims paid early in each fiscal year were for services provided in the prior year).

(2) The Department expects to begin offering Consumer Directed Attendant Support Services (CDASS) to clients on the HCBS-SLS waiver by January 1, 2017. The Department assumes that participation in the program will ramp-up at a uniform rate over FY 2016-17 and reach full enrollment by July 1, 2017 at 12.65% of the HCBS-SLS waiver population, with each SLS-CDASS client costing an additional $5,722.06 in waiver services above non-CDASS HCBS-SLS clients.

Table E.4 - Calculation of FY 2017-18 Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure

Row	Item	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	HCBS - Targeted Case Management (TCM) Buy-In	Source/Calculation
A	FY 2016-17 Per Full Program Equivalent (FPE) Expenditure	$68,406.94	$13,763.97	$0.00	$17,542.58	$2,471.57	$0.00	Table E.3 Row E, Buy-In Set Equal to Respective Non-Buy-In Service
B	Base Trend	0.10%	1.04%	0.00%	-0.41%	0.00%	0.00%	Based on Analysis of Individual Service Trends
C	Estimated Base FY 2017-18 Per FPE Expenditure	$68,477.59	$13,907.56	$0.00	$17,471.44	$2,471.57	$0.00	Row A * (1 + Row B)
	Rate Adjustments [(1)]							
D	None	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
E	Estimated Base FY 2017-18 Per FPE after Rate Adjustments	$68,477.59	$13,907.56	$12,748.60	$17,471.44	$2,471.57	$2,265.61	Row C * (1 + Row D). Buy-In programs adjusted for expected 8/1/2017 implementation date.
	Bottom Line Adjustments							
F	Annualization of FY 2015-16 R-7 "Participant Directed Programs Expansion"[(1)]	$0.00	$518.25	$518.25	$0.00	$0.00	$0.00	Adjusted for delayed start date.
G	**Total Estimated FY 2017-18 Per FPE Expenditure**	**$68,477.59**	**$14,425.81**	**$13,266.85**	**$17,471.44**	**$2,471.57**	**$2,265.61**	**Row E + Row F**

(1) The Department expects to begin offering Consumer Directed Attendant Support Services (CDASS) to clients on the HCBS-SLS waiver by January 1, 2017. The Department assumes that participation in the program will ramp-up at a uniform rate over FY 2016-17 and reach full enrollment by July 1, 2017 at 12.65% of the HCBS-SLS waiver population, with each SLS-CDASS client costing an additional $5,722.06 in waiver services above non-CDASS HCBS-SLS clients.

Table E.5 - Calculation of FY 2018-19 Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure								
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Supported Living Services Waiver (HCBS-SLS) Buy-In**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**HCBS - Targeted Case Management (TCM) Buy-In**	**Source/Calculation**
A	FY 2017-18 Per Full Program Equivalent (FPE) Expenditure	$68,477.59	$14,425.81	$14,425.81	$17,471.44	$2,471.57	$2,471.57	Table E.4 Row E. Buy-in Increased to match corresponding non-buy in serivce.
B	Base Trend	0.05%	0.52%	0.52%	-0.20%	0.00%	0.00%	Based on Analysis of Individual Service Trends
C	Estimated Base FY 2017-18 Per FPE Expenditure	$68,512.92	$14,500.28	$14,500.28	$17,435.87	$2,471.57	$2,471.57	Row A * (1 + Row B)
	Rate Adjustments [(1)]							
D	None	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
E	Estimated Base FY 2017-18 Per FPE after Rate Adjustments	$68,512.92	$14,500.28	$14,500.28	$17,435.87	$2,471.57	$2,471.57	Row C * (1 + Row D).
	Bottom Line Adjustments							
F	Annualization of FY 2015-16 R-7 "Participant Directed Programs Expansion"[(1)]	$0.00	$166.51	$166.51	$0.00	$0.00	$0.00	Adjusted for delayed start date.
G	**Total Estimated FY 2018-19 Per FPE Expenditure**	**$68,512.92**	**$14,666.79**	**$14,666.79**	**$17,435.87**	**$2,471.57**	**$2,471.57**	**Row E + Row F**

(1) The Department expects to begin offering Consumer Directed Attendant Support Services (CDASS) to clients on the HCBS-SLS waiver by January 1, 2017. The Department assumes that participation in the program will ramp-up at a uniform rate over FY 2016-17 and reach full enrollment by July 1, 2017 at 12.65% of the HCBS-SLS waiver population, with each SLS-CDASS client costing an additional $5,722.06 in waiver services above non-CDASS HCBS-SLS clients.

Table F.1 - Division for Intellectual and Developmental Disabilities (DIDD) FY 2016-17 Quality Assurance, Utilization Review and Support Intensity Scale Service Forecast								
Row	**Service**	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS) Buy-In**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**Total**	**Source/Calculation**
A	**Quality Assurance**	Estimated Total Average Monthly Enrollment	5,187	4,635	0	1,599	11,537	Table D.3.1 Row J
B		Rate	$25.51	$25.51	$25.51	$25.51		FY 2016-17 Actuals
C		Estimated Total Expenditure	$1,587,844	$1,418,866	$0	$489,486	$3,531,706	Row A * Row B * 12
D	**Utilization Review**	Estimated Total Average Monthly Enrollment	5,187	4,635	0	1,599	11,537	Table D.3.1 Row J
E		Rate	$81.31	$81.31	$81.31	$81.31		FY 2016-17 Actuals
F		Estimated Total Expenditure	$421,755	$376,872	$0	$130,015	$938,074	Row D* Row E
G	**Support Intensity Scale**	Estimated New and Renewal Average Monthly Enrollment	846	760	0	0	1,618	Estimated June 2017 Enrollment - June 2016 Enrollment + 10% of June 2016 Enrollment
H		Rate	$233.09	$233.09	$233.09	$0.00		FY 2016-17 Actuals
I		Estimated Total Expenditure	$197,194	$177,148	$0	$0	$377,139	Row G * Row H
J	**Estimated Total Expenditure**		**$2,206,793**	**$1,972,886**	**$0**	**$619,501**	**$4,846,919**	**Row C + Row F + Row I**

Table F.2 - Division for Intellectual and Developmental Disabilities (DIDD) FY 2017-18 Quality Assurance, Utilization Review and Support Intensity Scale Service Forecast								
Row	**Service**	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS) Buy-In**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**Total**	**Source/Calculation**
A	**Quality Assurance**	Estimated Total Average Monthly Enrollment	5,480	4,926	35	1,665	12,222	Table D.3.1 Row K
B		Rate	$25.51	$25.51	$25.51	$25.51		FY 2016-17 Actuals
C		Estimated Total Expenditure	$1,677,538	$1,507,947	$10,714	$509,690	$3,741,399	Row A * Row B * 12
D	**Utilization Review**	Estimated Total Average Monthly Enrollment	5,480	4,926	35	1,665	12,222	Table D.3.1 Row K
E		Rate	$81.31	$81.31	$81.31	$81.31		FY 2016-17 Actuals
F		Estimated Total Expenditure	$445,579	$400,533	$2,846	$135,381	$993,771	Row D* Row E
G	**Support Intensity Scale**	Estimated New and Renewal Average Monthly Enrollment	783	800	7	0	1,602	Estimated June 2018 Enrollment - Estimated June 2017 Enrollment + 10% of Estimated June 2017 Enrollment
H		Rate	$233.09	$233.09	$233.09	$0.00		FY 2016-17 Actuals
I		Estimated Total Expenditure	$182,509	$186,472	$1,655	$0	$373,433	Row G * Row H
J	**Estimated Total Expenditure**		**$2,305,626**	**$2,094,952**	**$15,215**	**$645,071**	**$5,108,603**	**Row C + Row F + Row I**

Table F.3 - Division for Intellectual and Developmental Disabilities (DIDD) FY 2018-19 Quality Assurance, Utilization Review and Support Intensity Scale Service Forecast								
Row	**Service**	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS) Buy-In**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**Total**	**Source/Calculation**
A	**Quality Assurance**	Estimated Total Average Monthly Enrollment	5,729	5,272	37	1,713	12,867	Table D.3.1 Row L
B		Rate	$25.51	$25.51	$25.51	$25.51		FY 2016-17 Actuals
C		Estimated Total Expenditure	$1,753,761	$1,613,865	$11,326	$524,384	$3,938,846	Row A * Row B * 12
D	**Utilization Review**	Estimated Total Average Monthly Enrollment	5,729	5,272	37	1,713	12,867	Table D.3.1 Row L
E		Rate	$81.31	$81.31	$81.31	$81.31		FY 2016-17 Actuals
F		Estimated Total Expenditure	$465,825	$428,666	$3,008	$139,284	$1,046,215	Row D* Row E
G	**Support Intensity Scale**	Estimated New and Renewal Average Monthly Enrollment	808	801	6	0	1,627	Estimated June 2019 Enrollment - Estimated June 2018 Enrollment + 10% of Estimated June 2018 Enrollment
H		Rate	$233.09	$233.09	$233.09	$0.00		FY 2016-17 Actuals
I		Estimated Total Expenditure	$188,337	$186,705	$1,399	$0	$379,238	Row G * Row H
J	**Estimated Total Expenditure**		**$2,407,923**	**$2,229,236**	**$15,733**	**$663,668**	**$5,364,299**	**Row C + Row F + Row I**

Table G.1 FY 2016-17 Office of Community Living Appropriation Build								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
	Adult Comprehensive Services							
A	FY 2016-17 Long Bill Appropriation (HB 16-1405)	$362,346,433	0.0	$180,448,523	$0	$1	$0	$181,897,909
B	Total FY 2016-17 Spending Authority	$362,346,433	0.0	$180,448,523	$0	$1	$0	$181,897,909
	Adult Supported Living Services							
C	FY 2016-17 Long Bill Appropriation (HB 16-1405)	$69,681,391	0.0	$38,677,034	$0	$0	$0	$31,004,357
D	Total FY 2016-17 Spending Authority	$69,681,391	0.0	$38,677,034	$0	$0	$0	$31,004,357
E	**SLS Services**	$61,761,668	0.0	$30,757,311	$0	$0	$0	$31,004,357
F	**SLS State-Only**	$7,919,723	0.0	$7,919,723	$0	$0	$0	$0
	Children's Extensive Support Services							
G	FY 2016-17 Long Bill Appropriation (HB 16-1405)	$26,310,826	0.0	$13,102,791	$0	$0	$0	$13,208,035
H	Total FY 2016-17 Spending Authority	$26,310,826	0.0	$13,102,791	$0	$0	$0	$13,208,035
	Case Management							
I	FY 2016-17 Long Bill Appropriation (HB 16-1405)	$32,255,501	0.0	$16,605,002	$0	$0	$0	$15,650,499
J	Total FY 2016-17 Spending Authority	$32,255,501	0.0	$16,605,002	$0	$0	$0	$15,650,499
K	**Targeted Case Management**	$26,586,856	0.0	$13,240,254	$0	$0	$0	$13,346,602
L	**QA, UR and SIS**	$4,607,793	0.0	$2,303,896	$0	$0	$0	$2,303,897
M	**Case Management - State Only**	$1,060,852	0.0	$1,060,852	$0	$0	$0	$0
	Family Support Services							
N	FY 2016-17 Long Bill Appropriation (HB 16-1405)	$6,960,460	0.0	$6,960,460	$0	$0	$0	$0
O	Total FY 2016-17 Spending Authority	$6,960,460	0.0	$6,960,460	$0	$0	$0	$0
P	**Preventive Dental Hygiene**							
Q	FY 2016-17 Long Bill Appropriation (HB 16-1405)	$63,311	0.0	$63,311	$0	$0	$0	$0
R	Total FY 2016-17 Spending Authority	$63,311	0.0	$63,311	$0	$0	$0	$0
	Eligibility Determination and Waitlist Management							
S	FY 2016-17 Long Bill Appropriation (HB 16-1405)	$3,121,194	0.0	$3,100,556	$0	$0	$0	$20,638
T	Total FY 2016-17 Spending Authority	$3,121,194	0.0	$3,100,556	$0	$0	$0	$20,638
U	**PASRR**	$27,517	0.0	$6,879	$0	$0	$0	$20,638
V	**Medicaid Eligibility Determination**	$3,093,677	0.0	$3,093,677	$0	$0	$0	$0
W	Grand Total FY 2016-17 Spending Authority	$500,739,116	0.0	$258,957,677	$0	$1	$0	$241,781,438

Table G.2 FY 2017-18 Office of Community Living Appropriation Build								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
	Adult Comprehensive Services							
A	FY 2016-17 Final Spending Authority	$362,346,433	$0	$180,448,523	$0	$1	$0	$181,897,909
B	Total FY 2017-18 Spending Authority	$362,346,433	$0	$180,448,523	$0	$1	$0	$181,897,909
	Adult Supported Living Services							
C	FY 2016-17 Final Spending Authority	$69,681,391	$0	$38,677,034	$0	$0	$0	$31,004,357
D	HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$53,589	$0	($207,615)	$0	$234,405	$0	$26,799
E	Annualization of FY 2015-16 R#7 "Participant Directed Programs Expansion"	$1,261,619	$0	$630,683	$0	$0	$0	$630,936
F	Total FY 2017-18 Spending Authority	$70,996,599	$0	$39,100,102	$0	$234,405	$0	$31,662,092
G	**SLS Services**	$63,076,876	$0	$31,180,379	$0	$234,405	$0	$31,662,092
H	**SLS State-Only**	$7,919,723	$0	$7,919,723	$0	$0	$0	$0
	Children's Extensive Support Services							
I	FY 2016-17 Final Spending Authority	$26,310,826	$0	$13,102,791	$0	$0	$0	$13,208,035
J	Total FY 2017-18 Spending Authority	$26,310,826	$0	$13,102,791	$0	$0	$0	$13,208,035
	Case Management							
K	FY 2016-17 Final Spending Authority	$32,255,501	$0	$16,605,002	$0	$0	$0	$15,650,499
L	HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$11,497	$0	($44,544)	$0	$50,292	$0	$5,749
M	Total FY 2017-18 Spending Authority	$32,266,998	$0	$16,560,458	$0	$50,292	$0	$15,656,248
N	**Targeted Case Management**	$26,410,817	$0	$13,107,394	$0	$44,840	$0	$13,258,583
O	**QA, UR and SIS**	$4,795,329	$0	$2,392,212	$0	$5,452	$0	$2,397,665
P	**Case Management - State Only**	$1,060,852	$0	$1,060,852	$0	$0	$0	$0
	Family Support Services							
Q	FY 2016-17 Final Spending Authority	$6,960,460	$0	$6,960,460	$0	$0	$0	$0
R	Total FY 2017-18 Spending Authority	$6,960,460	$0	$6,960,460	$0	$0	$0	$0
	Preventive Dental Hygiene							
S	FY 2016-17 Final Spending Authority	$63,311	$0	$63,311	$0	$0	$0	$0
T	Total FY 2017-18 Spending Authority	$63,311	$0	$63,311	$0	$0	$0	$0
	Eligibility Determination and Waitlist Management							
U	FY 2016-17 Final Spending Authority	$3,121,194	$0	$3,100,556	$0	$0	$0	$20,638
V	Total FY 2017-18 Spending Authority	$3,121,194	$0	$3,100,556	$0	$0	$0	$20,638
W	**PASRR**	$27,517	$0	$6,879	$0	$0	$0	$20,638
X	**Medicaid Eligibility Determination**	$3,093,677	$0	$3,093,677	$0	$0	$0	$0
Y	Total FY 2017-18 Spending Authority	$502,065,821	$0	$259,336,201	$0	$284,698	$0	$242,444,922

Table G.3 FY 2018-19 Office of Community Living Appropriation Build								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
	Adult Comprehensive Services							
A	FY 2017-18 Final Spending Authority	$362,346,433	0.0	$180,448,523	$0	$1	$0	$181,897,909
B	Total FY 2018-19 Spending Authority	$362,346,433	0.0	$180,448,523	$0	$1	$0	$181,897,909
	Adult Supported Living Services							
C	FY 2017-18 Final Spending Authority	$70,996,599	0.0	$39,100,102	$0	$234,405	$0	$31,662,092
D	Annualization of HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$19,487	0.0	($26,227)	$0	$35,976	$0	$9,738
E	Total FY 2018-19 Spending Authority	$71,016,086	0.0	$39,073,875	$0	$270,381	$0	$31,671,830
F	**SLS Services**	$63,096,363	0.0	$31,154,152	$0	$270,381	$0	$31,671,830
G	**SLS State-Only**	$7,919,723	0.0	$7,919,723	$0	$0	$0	$0
	Children's Extensive Support Services							
H	FY 2017-18 Final Spending Authority	$26,310,826	0.0	$13,102,791	$0	$0	$0	$13,208,035
I	Total FY 2018-19 Spending Authority	$26,310,826	0.0	$13,102,791	$0	$0	$0	$13,208,035
	Case Management							
J	FY 2017-18 Final Spending Authority	$32,266,998	0.0	$16,560,458	$0	$50,292	$0	$15,656,248
K	Annualization of HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$4,181	0.0	($5,627)	$0	$7,719	$0	$2,089
L	SB 16-192 Single Assessment	$142,894	0.0	$71,447	$0	$0	$0	$71,447
M	Total FY 2018-19 Spending Authority	$32,414,073	0.0	$16,626,278	$0	$58,011	$0	$15,729,784
N	**Targeted Case Management**	$26,414,545	0.0	$13,102,377	$0	$51,722	$0	$13,260,446
O	**QA, UR and SIS**	$4,938,676	0.0	$2,463,049	$0	$6,289	$0	$2,469,338
P	**Case Management - State Only**	$1,060,852	0.0	$1,060,852	$0	$0	$0	$0
	Family Support Services							
Q	FY 2017-18 Final Spending Authority	$6,960,460	0.0	$6,960,460	$0	$0	$0	$0
R	Total FY 2018-19 Spending Authority	$6,960,460	0.0	$6,960,460	$0	$0	$0	$0
	Preventive Dental Hygiene							
S	FY 2017-18 Final Spending Authority	$63,311	0.0	$63,311	$0	$0	$0	$0
T	Total FY 2018-19 Spending Authority	$63,311	0.0	$63,311	$0	$0	$0	$0
	Eligibility Determination and Waitlist Management							
U	FY 2017-18 Final Spending Authority	$3,121,194	0.0	$3,100,556	$0	$0	$0	$20,638
V	Total FY 2018-19 Spending Authority	$3,121,194	0.0	$3,100,556	$0	$0	$0	$20,638
W	**PASRR**	$27,517	0.0	$6,879	$0	$0	$0	$20,638
X	**Medicaid Eligibility Determination**	$3,093,677	0.0	$3,093,677	$0	$0	$0	$0
Y	Grand Total FY 2018-19 Spending Authority	$502,232,383	0.0	$259,375,794	$0	$328,393	$0	$242,528,196

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-06 Delivery System and Payment Reform

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	Total	$7,523,128,643	$0	$7,459,234,975	$3,213,375	($33,540,103)
	FTE	400.3	0.0	400.6	0.0	4.6
	GF	$2,142,452,586	$0	$2,145,762,319	($200,342)	($11,049,780)
	CF	$727,601,371	$0	$700,405,967	($187,409)	($1,453,007)
	RF	$6,994,451	$0	$6,995,349	$0	$0
	FF	$4,646,080,235	$0	$4,605,628,397	$3,601,126	($21,037,316)

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (A) General Administration - Personal Services	Total	$29,707,221	$0	$29,797,905	$0	$307,185
	FTE	400.3	0.0	400.6	0.0	4.6
	GF	$10,211,448	$0	$10,355,331	$0	$153,593
	CF	$2,994,337	$0	$2,952,905	$0	$0
	RF	$1,564,801	$0	$1,566,597	$0	$0
	FF	$14,936,635	$0	$14,923,072	$0	$153,592
01. Executive Director's Office, (A) General Administration - Health, Life, and Dental	Total	$3,434,070	$0	$3,673,458	$0	$39,636
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,230,952	$0	$1,316,506	$0	$19,818
	CF	$337,577	$0	$349,778	$0	$0
	RF	$104,755	$0	$104,635	$0	$0
	FF	$1,760,786	$0	$1,902,539	$0	$19,818

01. Executive Director's Office, (A) General Administration - Short-term Disability	**Total**	**$55,072**	**$0**	**$57,991**	**$0**	**$524**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$20,569	$0	$21,560	$0	$262
	CF	$4,588	$0	$4,796	$0	$0
	RF	$1,393	$0	$1,365	$0	$0
	FF	$28,522	$0	$30,270	$0	$262
01. Executive Director's Office, (A) General Administration - Amortization Equalization Disbursement	**Total**	**$1,434,489**	**$0**	**$1,613,687**	**$0**	**$13,764**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$535,695	$0	$600,009	$0	$6,882
	CF	$119,586	$0	$133,459	$0	$0
	RF	$36,269	$0	$37,816	$0	$0
	FF	$742,939	$0	$842,403	$0	$6,882
01. Executive Director's Office, (A) General Administration - Supplemental Amortization Equalization Disbursement	**Total**	**$1,419,546**	**$0**	**$1,613,662**	**$0**	**$13,764**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$530,115	$0	$600,009	$0	$6,882
	CF	$118,340	$0	$133,459	$0	$0
	RF	$35,891	$0	$37,791	$0	$0
	FF	$735,200	$0	$842,403	$0	$6,882
01. Executive Director's Office, (A) General Administration - Operating Expenses	**Total**	**$2,058,538**	**$0**	**$2,035,574**	**$0**	**$27,869**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$930,699	$0	$923,963	$0	$13,934
	CF	$71,522	$0	$67,439	$0	$0
	RF	$10,449	$0	$10,449	$0	$0
	FF	$1,045,868	$0	$1,033,723	$0	$13,935
01. Executive Director's Office, (A) General Administration - General Professional Services and Special Projects	**Total**	**$7,200,237**	**$0**	**$7,975,237**	**$0**	**$225,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,047,261	$0	$2,622,261	$0	$112,500
	CF	$1,527,500	$0	$1,227,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,625,476	$0	$4,125,476	$0	$112,500

	Total	**$6,818,264,595**	**$0**	**$6,752,893,112**	**$29,930,444**	**($32,753,794)**
	FTE	0.0	0.0	0.0	0.0	0.0
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	GF	$1,942,439,768	$0	$1,945,000,281	$7,014,977	($11,075,966)
	CF	$705,708,120	$0	$678,832,273	$903,427	($1,237,656)
	RF	$5,240,893	$0	$5,240,893	$0	$0
	FF	$4,164,875,814	$0	$4,123,819,665	$22,012,040	($20,440,172)
	Total	**$653,650,029**	**$0**	**$653,658,674**	**($26,717,069)**	**($1,414,051)**
	FTE	0.0	0.0	0.0	0.0	0.0
03. Behavioral Health Community Programs - Behavioral Health Capitation Payments	GF	$181,949,404	$0	$181,920,888	($7,215,319)	($287,685)
	CF	$16,383,180	$0	$16,416,036	($1,090,836)	($215,351)
	RF	$0	$0	$0	$0	$0
	FF	$455,317,445	$0	$455,321,750	($18,410,914)	($911,015)

CF Letternote Text Revision Required?	Yes	X	No	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes		No	X
FF Letternote Text Revision Required?	Yes		No	X
Requires Legislation?	Yes		No	X

Type of Request? Department of Health Care Policy and Financing Prioritized Request

Interagency Approval or Related Schedule 13s: None

Cost and FTE

- The Department requests an increase of $3,213,375 total funds, including a reduction of $200,342 General Fund in FY 2017-18 in order to continue the provider rate increase for select primary care codes, implement behavioral health payment reform, and account for technical adjustments for payment methodology changes.
- The Department requests a reduction of $33,540,103 total funds, including a reduction of $11,049,780 General Fund, and an increase of 4.6 FTE in FY 2018-19 in order to implement the Accountable Care Collaborative Phase II and primary care payment reform initiatives, and account for technical adjustments for payment methodology changes.

Current Program

- The Accountable Care Collaborative (ACC) Program is the core of the Medicaid program. It promotes improved health for members by delivering care in an increasingly seamless way. It is easier for members and providers to navigate and makes smarter use of every dollar spent.
- Current program successes include:
  - approximately $139 million in cumulative net costs avoided from FY 2011-12 through FY 2015-16;
  - an increase in payments tied to value;
  - lower emergency department use, hospital readmissions and high-cost imaging;
  - prevention of condition exacerbation through primary care; and
  - higher member satisfaction.

Problem or Opportunity

- The contracts for the Accountable Care Collaborative Regional Collaborative Care Organizations (RCCOs) will be reprocured for FY 2018-19, creating an opportunity to continue to strengthen the primary care system, advance the integration of physical and behavioral health care and increase payment tied to value.
- Physical and behavioral health are often connected through various comorbid conditions, but care is currently delivered through two separate, siloed systems.
- Many Department and federal initiatives share similar goals but payment mechanisms are not fully aligned.

Consequences of the Problem

- Clients who are not enrolled in the Accountable Care Collaborative may have difficulty navigating the current health care system, which is detrimental to client outcomes, especially for vulnerable populations with poor health literacy and limited access to resources.
- Disparate physical and behavioral health care systems result in worse outcomes for clients.
- Misaligned payment and incentive structures promote provider confusion and administrative burden.

Proposed Solution

- Implement the Accountable Care Collaborative Phase II in FY 2018-19, including mandatory enrollment, a focus on integrating physical and behavioral health care, and greater emphasis on value-based payments.
- Implement value-based payment components, including incentive alignment across initiatives and continuation of the primary care rate increases authorized in HB 16-1408.
- Implement behavioral health payment reform with payments tied to quality in FY 2017-18 and beyond.
- Account for technical adjustments for ongoing payment methodology changes.

Department Priority:	***R-6***
Request Detail:	***Delivery System and Payment Reform***

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Delivery System and Payment Reform	$3,213,375	($200,342)

Problem or Opportunity:

Nationwide, health care leaders, policymakers, stakeholders, and federal agencies such as the Centers for Medicare & Medicaid Services (CMS) have adjusted their focus to policies that reward integrated and value-based care in an attempt to improve health outcomes and bend the cost curve of medical care downward. Value-based purchasing, the foundation of value-based care, is defined as "any activity that a state Medicaid program is undertaking to hold a provider… accountable for the costs and quality of the care they provide."[1] The goal is to tie payments or incentives to behaviors that enhance effective care management, positive health outcomes, high quality care, and client engagement. The system transition can take many forms, including delivery system reform, improved care coordination and integration, payment reform, and incentive alignment.

Colorado has been taking steps to drive both delivery system and payment reform, to improve overall effectiveness of the system and ensure greater value-based purchasing through the Accountable Care Collaborative. The Department now has the opportunity to continue delivery system and payment reform activities through the next phase of the Accountable Care Collaborative.

This request addresses delivery system reforms through the Accountable Care Collaborative, such as the integration of physical and behavioral health, as well as value-based payment reforms associated with primary care services, vaccine stock rates, and behavioral health capitation rates. The Department is engaged in a number of other delivery system and payment reforms that are not reflected in this request, such as the consolidation of home and community based waivers and developing a conflict-free case management system.

Delivery System Reform

<u>The Accountable Care Collaborative Phase II</u>

The contracts for the Accountable Care Collaborative regional vendors, currently called Regional Collaborative Care Organizations (RCCOs), are scheduled to be reprocured for FY 2018-19 and the

[1] http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf

Department is taking this opportunity to implement major changes to evolve the program. This next iteration of the Accountable Care Collaborative, referred to as the "Accountable Care Collaborative Phase II", would advance the integration of physical and behavioral health care by creating one administrative entity responsible for managing physical and behavioral health, establishing mandatory enrollment of all Medicaid clients into the program and implementing value-based payment methodologies.

The Accountable Care Collaborative Phase II would leverage and build upon the successes of both the Accountable Care Collaborative and the Community Behavioral Health Services Program to enhance the member and provider experience, improve member health, and use state resources to their highest good in an efficient and effective system of care. Current successes of the Accountable Care Collaborative include approximately $139 million in net costs avoided from its inception in FY 2011-12 through FY 2015-16; lower rates of hospital readmissions and high-cost imaging; preventing the exacerbation of conditions through primary care use; and increased member satisfaction[2].

Integration of Physical and Behavioral Health

The Department currently has distinct systems for the delivery of physical health and behavioral health care. The coordination of physical and behavioral health presents an opportunity to improve outcomes for all members enrolled in the Accountable Care Collaborative; per the Health Home Information Resource Center brief: "More than 70 randomized controlled trials have shown collaborative care for common mental disorders such as depression to be more effective and cost-effective than usual care, across diverse practice settings and patient populations."[3]

That said, the Department anticipates the most benefit would be for members with complex behavioral health conditions with co-occurring physical health conditions. For example, a 2006 report, "Morbidity and Mortality in People with Serious Mental Illness," found that individuals "with serious mental illness (SMI) die, on average, 25 years earlier than the general population," and that the "increased mortality and morbidity are largely due to preventable conditions" such as cardiovascular disease, diabetes, respiratory disease, and infectious disease[4].

One of the most significant differences between the current Accountable Care Collaborative and the Accountable Care Collaborative Phase II would be the integration of physical and behavioral health under one administrative entity. This new entity would be called the Regional Accountable Entity (RAE) and would be responsible for promoting the population's health and functioning, coordinating care across disparate providers, interfacing with long-term services and supports (LTSS) providers, and collaborating with social, educational, and justice agencies to foster healthy communities and to address complex needs that span multiple agencies and jurisdictions. A critical function of the RAEs is to create a cohesive network of providers that work together seamlessly and effectively to provide coordinated health care services to all

[2] November 1, 2016 Legislative Request for Information #3 Accountable Care Collaborative Organization

[3] Unützer J, et al., (2013.) The Collaborative Care Model: An approach for integrating physical and mental health care in Medicaid health homes, *Health Home IRC*, available at: http://www.medicaid.gov/

[4] http://nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

members. Having one entity would improve the member experience by creating one point of contact and clear accountability for care.

In addition to the creation of the RAEs, the Department would support increased integration of physical and behavioral health care and support increased access to behavioral health service for clients by making changes to the delivery and reimbursement of behavioral health services. For the core behavioral health services, the Department would retain a capitation payment methodology and the capitation would be paid to the RAEs, which would be responsible for optimizing mental health and wellness for all Medicaid enrollees in their region. In addition, the Department would limit the covered diagnosis requirements for capitated behavioral health benefits and reimburse more behavioral health services delivered within primary care settings for low acuity and brief episodic conditions.

Mandatory Enrollment

Client engagement is linked to improved client outcomes. There is evidence that more than client behavior influences client engagement. Health care providers and their contact with clients play a role in client engagement as well, especially in behavioral health, and can increase client compliance with treatment recommendations and adherence to treatment plans[5].

In the current Accountable Care Collaborative, new Medicaid clients are not enrolled in the Accountable Care Collaborative for one to three months following their eligibility determination, missing an opportunity to quickly affect change in the lives of all clients, especially those who are particularly vulnerable, such as those newly released from prison or jail. Navigating the complex health care system and getting physical and behavioral health needs met can be difficult for clients who are not enrolled in the Accountable Care Collaborative and lack such program supports.

All eligible full-benefit Medicaid clients[6] would be mandatorily enrolled in the Accountable Care Collaborative in Phase II, to ensure that clients are able to benefit from the program immediately upon being determined eligible for Medicaid. Clients would have their choice of primary care medical providers (PCMPs), but would not be able to dis-enroll from the Accountable Care Collaborative. Mandatory enrollment would encourage engagement in health care services and outcomes, especially for vulnerable populations such as clients receiving long-term services and supports, clients transitioning between health care settings, and populations who are served by multiple systems, such as children involved with Child Welfare, individuals newly released from jails, and those who are homeless.

Value-Based Payment

The Accountable Care Collaborative was designed to support the shift in payment within Medicaid to value-based models. For Phase II, the Department is committed to implementing innovative payment practices that reward efficiency, quality, coordination and health improvement and disincentive duplication of services, overuse of low value services, and fragmentation of care. Similar to the current Accountable Care Collaborative, the RAEs would receive an administrative per-member per-month (PMPM) payment to

[5] Bright, F. A. S., Kayes, N. M., Worrall, L., & McPherson, K. M. (2015). A conceptual review of engagement in healthcare and rehabilitation, *Disability and Rehabilitation*, 37:8, 643-654, DOI: 10.3109/09638288.2014.933899

[6] Clients in managed care programs such as the Program of All-Inclusive Care for the Elderly are not eligible for the Accountable Care Collaborative.

support health promotion activities within the region, investments for the efficient, affordable delivery of care within the region, and to ensure appropriate coordination of care for members. In the next iteration of the Accountable Care Collaborative, the Department is changing the way the PMPM is currently distributed to primary care medical providers. Instead of making a medical home payment directly to providers the Department would make the entire payment to the RAE. This would enable the RAE to design flexible funding arrangements to support primary care medical providers and other regional health care providers for participation in working to achieve the goals and objectives of the Accountable Care Collaborative. A minimum percentage of the RAE's PMPM must be distributed to the regional network of providers. The RAEs would have flexibility to negotiate with PCMPs in how they receive their funding but all PCMPs would have an option of receiving a PMPM payment, similar to the current arrangement.

The Department would pay the RAEs approximately $15.50 PMPM. This is comprised of: (1) the RCCOs' current PMPM and withhold for incentives; (2) the current primary care medical provider PMPM and withhold for incentives; and (3) an additional $1.00 PMPM to reflect the increased workload associated with increased contract requirements and more accountability for health outcomes and total cost of care in Phase II of the Accountable Care Collaborative.

The Department would continue to withhold $3.75 PMPM of the $15.50 administrative PMPM for a Pay for Performance program. RAEs would be able to earn performance payments based on meeting or exceeding targets for up to nine Key Performance Indicators that indicate progress toward program goals. Any monies not distributed for performance on Key Performance Indicators would be used to reinforce and align evolving program goals, such as funding provider participation in new state or federal initiatives aligned with the Accountable Care Collaborative or new priority performance targets for the RAEs. As with the administrative PMPM, the RAE would have responsibility for sharing incentive payments with network providers in a way that furthers the goals and objectives of the program.

Payment Reforms

Initiative Alignment

The Department has had the opportunity to observe various value-based purchasing initiatives in other states and at the federal level. The Department has also participated in numerous initiatives with a focus on increasing value-based payments, including the current Accountable Care Collaborative, CMS's Comprehensive Primary Care Initiative (CPCi) and the State Innovation Model (SIM) Initiative[7].

One of the Department's goals is to further align payment reform initiatives, such as CPCi and its next iteration, Comprehensive Primary Care Plus (CPC+), SIM, and the Accountable Care Collaborative, and those outlined under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Alignment across initiatives and across payers increases the likelihood that providers will participate and that the initiative will be successful.

[7] The SIM initiative is a CMS initiative that provides financial and technical support to states for developing and testing innovative payment and service delivery models. More information can be found at https://innovation.cms.gov/initiatives/state-innovations

Primary Care

Investing in primary care is a critical component of addressing the rising cost of health care as primary care is frequently the earliest point of intervention for conditions that get more expensive to treat the longer they go untreated; primary care is the foundation of wellness and prevention. While it is important that the State continue to invest in primary care, it is also important to continue to drive improvements and innovation in the delivery system. The Department is working with stakeholders to explore different value-based payment models that increase provider flexibility, reward performance, and align with other state and national payment reform initiatives while holding providers accountable for quality and access.

To maintain investment in primary care and create a glide-path for practices to earn reimbursement based on performance, the Department requests to continue rate increases on par with the HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA" primary care rate bump in FY 2017-18. In FY 2018-19 and beyond, primary care providers (excluding Federally Qualified Health Centers (FQHCs)) would receive regular fee-for-service (FFS) payments based on the fee schedule set prior to the primary care rate bump for primary care services. Providers that are PCMPs in the Accountable Care Collaborative Phase II and meet certain criteria and performance standards would also be eligible to earn higher reimbursement equivalent in aggregate to what they could have earned under the provider rate bump. For the highest performers, reimbursement could be higher than they would have earned at current reimbursement rates. Reimbursement would be linked to a PCMP's ability to leverage team-based care practices, enhanced care management activities, member engagement, and quality improvement strategies to deliver more efficient, cost effective care and to improve client health. The Department would continue to work with stakeholders to develop the payment methodology in an effort to ensure that the model achieves the desired goals.

As referenced above, PCMPs would also receive payment from the RAEs to help ensure they are able to overcome obstacles that would otherwise prevent them from achieving their quality goals. Providers would work with their RAE to determine the best methodology for these payments.

Though FQHCs provide primary care under the Accountable Care Collaborative, their payments are currently paid above federally required reimbursement and they do not have incentives built into their rates. The current payment structure creates an opportunity to tie a portion of FQHC payments to quality and outcomes in order to align with other primary care providers in the Accountable Care Collaborative. Similar to work with primary care, the Department would work with FQHCs through a technical support grant from the National Academy for State Health Policy (NASHP) to develop a monthly payment model for FQHC services that would allow FQHCs greater flexibility in the provision of services to better meet the needs of clients and ultimately drive down the cost of care. The additional flexibility provided under this model would be coupled with accountability for quality and access similar to other primary care payment models.

Vaccine Stock Rates

Many of the vaccine stock rates used by the Department are outdated and result in inefficient reimbursement for providers. When a new vaccine enters the market, the rate for that immunization is set equal to the retail price from a price list published by Center for Disease Control (CDC), but the rate is not adjusted on an ongoing basis after its initial setting. The CDC Vaccine Price List provides the current private sector vaccine prices and is recognized as a transparent methodologic basis for vaccine rates by the American Academy of

Pediatrics as well as the Academy of Family Physicians[8]. Private sector prices are those reported by vaccine manufacturers annually to the CDC and serve as a benchmark for vaccine prices.

Currently, after the rates are set, they remain unchanged year-over-year, even as the costs of the vaccine stocks change as drugs enter or leave the market. Upon review of current rates, many immunizations are above the retail price published by the CDC and some are below the retail price. When an immunization patent expires, the price for that immunization generally decreases in order to stay competitive with the generic version of that immunization. Without a benchmark to annually adjust rates, the Department continues to pay the higher, brand-name cost for the immunization, resulting in over-reimbursement to providers. Conversely, without a benchmark to set rates, the Department is unable to adjust prices to keep up with smaller inflationary price increases, resulting in under-reimbursing providers in some circumstances. The inconsistency of vaccine stock rates results in a lack of transparency for providers and, overall, overpayment to providers for the cost of vaccine stock. To address this, the Department would set reimbursement rates for vaccine stock equal to the private sector cost based on the immunization list published by the CDC. In doing so, the Department would increase transparency in the immunization rate setting process for providers and more accurately reimburse providers for the cost of vaccine stock. The CDC Vaccine Price List provides the private sector vaccine prices, which are reported by vaccine manufacturers annually to the CDC and serve as a strong benchmark by which to base rates. The Department would update immunizations rates annually to account for changes in the retail price published by the CDC.

Behavioral Health

The behavioral health capitation rates decreased significantly in FY 2016-17, in part due to a change in pricing methodology of the behavioral health encounter data to comply with new federal managed care regulations[9]. The Department anticipates that there will be a further reduction in rates in FY 2017-18, as described in the Technical Adjustments section below.

To mitigate these reductions and ensure that providers have adequate flexibility to address the complex needs of the Coloradans they serve, the Department proposes to pay an offsetting increase over the capitation rate for BHOs (and, later, RAEs) as an incentive payment for improved performance beginning in FY 2017-18. This additional increase would be paid as incentive payments for community mental health centers (CMHCs) and BHOs meeting innovation and quality goals.

The incentive payment would reward performance and quality, such as rewarding growth of behavioral health treatment capacity in the primary care setting while also creating alignment with other payment reform initiatives. This methodology change would also help mitigate the expected rate reductions in FY 2017-18 and allow BHOs and, later, RAEs more flexibility to implement innovative behavioral health programs based on evidence-based practices.

[8] http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf
[9] The new regulations are based on significant changes to 42 CFR Parts 431, 433, 438, 440, 457, and 495.

Colorado received a planning grant[10] for certified community behavioral health clinics (CCBHCs), designed to fund Colorado's preparation for participation in a demonstration program[11] under Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA). While Colorado is not guaranteed for selection in the CCBHC demonstration program, CMS expects all states that received a planning grant to submit an application to participate in the two-year demonstration. If selected for the demonstration, Colorado would have the opportunity to earn an enhanced 65% federal medical assistance percentage (FMAP) for standard match clients for qualifying services provided by CCBHCs.

The Department assumes that, if it is selected for participation in the demonstration program, this would result in General Fund savings that would offset a portion of the cost of paying incentive payments over the capitation rate. The Department would ensure that the net impact of the savings from the enhanced match, the rate reduction, and the increase for incentive payments would be budget neutral or budget negative.

Technical Adjustments

The Department has included two technical adjustments in this request for the impacts of ongoing payment reform work in FY 2017-18 and forward.

Reimbursement Methodology Change for Outpatient Services

On October 31, 2016, the Department switched to the Enhanced Ambulatory Patient Grouping (EAPG) system, a form of bundled payment, for reimbursement for outpatient hospital services. Previously, outpatient hospital services were paid as a percent of cost. This payment reform aligns with inpatient hospital services' Diagnosis-Related Group (DRG) payment methodology and removes the need to pay outpatient hospital services at an inflated rate and reconcile retroactively. This will result in savings during the interim when the Department pays for these services appropriately up front but still receives reconciliation payments from hospitals for overpayments in previous fiscal years. The Department has been unable to make this methodology change until the implementation of the new MMIS. While the Department expects this methodology change to be budget neutral in the long term, it is budget negative in the short term while the Department continues to receive reconciliations for past overpayments. The savings for FY 2016-17 forward are accounted for in this request.

Federal Managed Care Regulations Impact on Behavioral Health Capitation Rates

The Department anticipates a drop of approximately 4% in behavioral health capitation rates from FY 2016-17 to FY 2017-18 due to new federal managed care regulations. In FY 2017-18, federal regulations require the Department to set an actuarially certified rate point, rather than negotiating a rate within the actuarially certified rate range. The Department expects this point to be lower than the FY 2016-17 rate by approximately 4%, since the FY 2016-17 rate is near the top of the rate range. Therefore, the Department expects another reduction in the behavioral health capitation rate in FY 2017-18, and the effects of that reduction are accounted for in this request.

[10] http://www.samhsa.gov/section-223/about
[11] http://www.samhsa.gov/section-223

Proposed Solution:

The Department requests an increase of $3,213,375 total funds, including a reduction of $200,342 General Fund in FY 2017-18 and a reduction of $33,540,103 total funds, including a reduction of $11,049,780 General Fund and an increase of 4.6 FTE in FY 2018-19 and future years in order to implement the Accountable Care Collaborative Phase II and associated payment reform. In FY 2017-18, the requested funding would be used to prepare for implementation of the Accountable Care Collaborative Phase II, continue the primary care provider rate increase approved in HB 16-1408, as well as develop behavioral health care incentives to reward innovation and value-based care. In FY 2018-19, the requested funding would be used to implement the Accountable Care Collaborative Phase II as well as value-based payment reform within primary care and federally qualified health centers (FQHCs).

The Department has broken down the components of the requested funding below.

Delivery System Reform

FY 2017-18

The Accountable Care Collaborative Phase II

During FY 2017-18, the Department would continue to prepare for the implementation of the Accountable Care Collaborative Phase II. This work includes activities such as meeting with stakeholders, working with CMS on waiver authority for the program, and drafting the vendor contracts. Any transition costs needed as the new RAE vendors become fully operational are included in a separate request, FY 2017-18 R-11 "Vendor Transitions."

FY 2018-19

The Accountable Care Collaborative Phase II

The Department intends to implement the Accountable Care Collaborative Phase II on July 1, 2018. The Accountable Care Collaborative Phase II has multiple components including the integration of physical and behavioral health under one administrative entity, implementing mandatory enrollment for all eligible clients and changing the Regional Accountable Entities' PMPM to promote value-based care. The Department anticipates that this portion of the request would result in a reduction of $68,581,872 total funds, including a reduction of $21,901,670 General Fund, due to improved clinical outcomes as a result of increased integrated and coordinated care. The Department's request includes 4.6 FTE in FY 2018-19, annualizing to 5.0 FTE in FY 2019-20, as described in the 'Assumptions and Calculations' section and appendix A of this request.

Payment Reform

Primary Care

For FY 2017-18, the Department requests $54,085,240 total funds, $18,772,007 General Fund[12] to continue the primary care rate increases authorized in HB 16-1408 into FY 2017-18, trended forward for expected caseload growth. For FY 2018-19, the Department requests $58,062,151 total funds, $20,231,923 General Fund, for primary care rate reform. A half-month of expected claims runout from the request to continue the

[12] HB 16-1408 appropriated funding from the Children's Basic Health Plan Trust fund for this purpose; the Department is requesting General Fund for FY 2017-18. In addition, this figure is adjusted for actual utilization of these codes in FY 2015-16, trended by caseload growth.

primary rate increase in HB 16-1408 in FY 2017-18 would increase this amount by $2,351,532 total funds, $819,398 General Fund for a total of $60,413,683 total funds, $21,051,321 General Fund.

Continued funding of the primary care rate increases authorized in HB 16-1408 would allow primary care providers and the Department to continue to work together to develop a value-based payment model for primary care to be implemented for FY 2018-19. The Department has been working with primary care stakeholders since the end of the 2016 legislative session and would continue this collaboration through FY 2017-18 leading up to implementation. Further, by leveraging this opportunity to engage in primary care payment reform, Colorado physicians would make progress towards meeting MACRA payment reform targets. This would allow physicians to receive not just increased Medicaid reimbursement, but also increased Medicare reimbursement.

The Department would work closely with stakeholders to develop and implement a primary care alternative payment methodology to replace the temporary primary care rate bump authorized under the Affordable Care Act Section 1202 and in HB 16-1408 This would align with other national payment reform initiatives, and increase the amount of payments tied to quality.

Vaccine Stock Rates

The Department requests a reduction of $994,353 total funds, including a reduction of $250,958 General Fund in FY 2017-18, and a reduction of $1,022,420 total funds, including a reduction of $255,171 General Fund in FY 2018-19, in order to annually set reimbursement rates for vaccine stock equal to the private sector cost based on the immunization list published by the CDC. Going forward, the Department would update immunizations rates annually to account for changes in the retail price published by the CDC.

Behavioral Health

The Department requests to pay incentive payments in addition to the capitation rate for behavioral health services, as authorized under 42 CFR § 483.6(c)(5)(iii), beginning in FY 2017-18. This additional funding would be paid as incentive payments for CMHCs and BHOs meeting innovation and quality goals. The Department does not anticipate a payment for this purpose in FY 2017-18, as payments attributable to a given fiscal year would be made in the following fiscal year.

The Department requests $26,717,069 total funds, $7,215,319 General Fund, in FY 2018-19 to pay incentive payments from the rate reduction in FY 2017-18.

The Department also requests $225,000 total funds, $112,500 General Fund, in one-time funding in FY 2018-19 for contractor costs for actuarial equivalency certification and rate rebasing for the CCBHC demonstration and would include analysis, certification, and answering follow-up questions with CMS, as well as actuarial work for rebasing rates due to programmatic changes. The requested funding is based on contracts with similar scope.

Technical Adjustments

The Department requests a reduction of $49,877,512 total funds, including a reduction of $18,795,541 General Fund, in FY 2017-18, and a reduction of $51,291,563 total funds, including a reduction of $17,272,079 General Fund, in FY 2018-19, to account for technical adjustments of ongoing rate reform work,

specifically the change in outpatient hospital services reimbursement methodology to an EAPG methodology and the expected 4% reduction in behavioral health capitation rates.

Program Evaluation

In addition to the continuation of the delivery system and payment reform initiatives, the Department requests $150,000 total funds, $75,000 General Fund in FY 2019-20 to hire a contractor to evaluate the effectiveness of each of the initiatives. The contractor would produce a report that studies whether the desired outcomes were achieved and would make recommendations on how to increase the effectiveness of the reforms. The Department requests that this funding be appropriated each year thereafter, to allow for annual program evaluations.

Anticipated Outcomes:

The components of this request focus on strengthening the primary care system, advancing the integration of physical and behavioral care and increasing payment tied to value. These activities strongly align with the Department's mission of improving health care access and outcomes for the people the Department serves while demonstrating sound stewardship of financial resources.

Delivery System Reform

The Accountable Care Collaborative Phase II

Integration of Physical and Behavioral Health Care

An integrated physical and behavioral health care system would help clients receive the care they need to optimize their health and well-being. Studies have shown that especially clients with complex physical and behavioral health conditions face obstacles which prevent them from receiving appropriate care. Inappropriate or inadequate care can worsen preventable conditions and result in higher cost care, poor client experience and decreases in health outcomes. Integrating the administration of physical and behavioral health care would potentially create savings opportunities and improve health outcomes and client experience. This aligns with State Innovation Model (SIM) Initiative and work that other payers in Colorado are advancing.

This initiative falls under the Department Performance Plan goals of creating an integrated delivery system for improving client outcomes and containing costs.

Mandatory Enrollment

Mandatorily enrolling all full-benefit Medicaid clients in the Accountable Care Collaborative Phase II would immediately connect clients with a PCMP if they do not already have one, and would give clients access to the full benefits of the Accountable Care Collaborative program. Client engagement has been shown to make health care service delivery more effective and is crucial to high-quality care, improving outcomes and preventing waste of resources[13].

This aligns with the Department Performance Plan's customer-focused strategies, specifically improving health outcomes and member experience, and the goal of member engagement.

[13] Graffigna, G., Barello, S., & Triberti, S. (2015, November). Patient Engagement: A Consumer-Centered Model to Innovate Healthcare. Retrieved from http://www.degruyter.com/view/product/466090

Value-Based Payment
The RAEs would be responsible for making payments directly to the PCMPs which allows for more flexible funding arrangements to support primary care medical providers and other regional health care providers for participation in working to achieve the goals and objectives of the Accountable Care Collaborative. Implementing this approach would allow the RAE to reward efficiency, quality, coordination and health improvement. This approach would also support providers in providing appropriate and cost-effective care, improve health outcomes, and enhance member and provider satisfaction. Finally, this would disincentivize duplication of services, overuse of low value services, and fragmentation of care.

This falls under the Department Performance Plan's goals of improving benefit and program design and payment methodology, and supports sustaining effective external relationships with providers.

Payment Reform
Initiative Alignment
Alignment across initiatives at both the State and federal level would drive multiple positive outcomes for providers. Aligned incentives reduce administrative burden for providers, create an opportunity for providers to leverage multiple streams of funding including federal initiatives, and furthers providers' ability to achieve practice transformation goals. Experts suggest a need for federal government and states "to align on a broad set of payment reform goals" and that aligning with Medicare reform initiatives can help ensure that state initiatives are sustainable.[14]

This falls under the Department Performance Plan's goals of improving benefit and program design and payment methodology, as well as supporting an integrated delivery system, and supports sustaining effective external relationships with providers.

Primary Care and Behavioral Health
Tying a greater proportion of payments to value for non-FQHC primary care providers, FQHCs and CMHCs would allow the Department to pay providers at rates that maintain access to care and, at the same time, reward innovation and quality and contribute to lower costs. Clearly defined and aligned objectives would incentivize providers to provide care that would improve health outcomes and lower costs.

This meets the Department Performance Plan's goals of improved benefit and program design, payment methodology, and cost containment and aligns with the strategies of improving health outcomes, member experience, and lower per capita costs, sustaining effective external relationships with providers, and ensuring sound stewardship of financial resources.

Assumptions and Calculations:

Please see Appendix A for detailed descriptions of the 5 FTE requested to support implementation of the Accountable Care Collaborative Phase II and payment reform initiatives, and appendix B for more information on calculations.

[14] http://www.nashp.org/sites/default/files/Aligning.Federal.State_.Payment.Reform.pdf

Delivery System Reform

The Accountable Care Collaborative Phase II

Integration of Physical and Behavioral Health

The Department assumes that a source of new savings in the Accountable Care Collaborative Phase II would come from the integration of physical and behavioral health. Many studies and reports propose the opportunity for significant savings in this arena, especially for clients with physical and behavioral health conditions. However, very little statistical evidence currently exists to determine what to expect with this integration of care.

A 2001 study[15], rated "fair" due to large loss to follow-up in a literature review[16] on the subject, suggests that patients with serious and persistent mental illness (SPMI) in an integrated care clinic cost approximately $1,533 less for total care than patients with SPMI treated in a general medicine clinic. The study suggests that while primary costs were estimated at $1,582 per patient in the integrated clinic, versus $398 per patient in the general medicine clinic, this increase was offset by a reduction in inpatient costs from $2,673 per patient in the general medicine clinic to $410 per patient in the integrated care clinic. These findings are supported in the significant improvement to client outcomes found in a 2010 study[17], as well, which was rated as "good" in the same literature review, though it did not investigate changes to costs. The literature review was referenced as an integration resource by the Substance Abuse and Mental Health Services Administration (SAMHSA)[18].

It is difficult to determine what components make up the decrease in costs of $1,533 for clients in the integrated care clinic, so instead calculated the offset between inpatient savings and primary care costs, for a total decrease of $1,079. In order to remain conservative, due to the age and small sample size of the study, the Department used half of this estimated cost savings to calculate savings due to whole-person, integrated care for individuals with SPMI. The study relied on 6- and 12-month follow up data, so the Department divided by 12 for an estimated monthly savings per client of $44.96.

Another study from 2003[19], rated "good" in the same literature review referenced above, suggests that integrating substance abuse treatment and primary care resulted in a reduction in total medical costs of $231.09 per member month for clients treated in integrated care versus a matched sample of clients treated in independent care. Depending on whether clients had substance abuse-related medical conditions, at least one medical condition in addition to substance use disorder, or at least one psychiatric condition, total medical

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[15] Druss, B. G., Rohrbaugh, R. M., Levinson, C. M., Rosenheck, R. A. (2001). Integrated Medical Care for Patients with Serious Psychiatric Illness: A Randomized Trial. *Archives of General Psychiatry*. 58(9): 861-868. doi:10.1001/archpsyc.58.9.861

[16] Gerrity, M., Zoller, E., Pinson, N., Pettinari, C., & King, V. (2014). Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. New York, NY: Milbank Memorial Fund. Retrieved from: http://www.milbank.org/uploads/documents/papers/Integrating-Primary-Care-Report.pdf

[17] Druss, B. G., von Esenwein, S. A., Compton, M. T., Rask, K. J., Zhao, L., & Parker, R. M. (2010). A Randomized Trial of Medical Care Management for Community Mental Health Settings: The Primary Care Access, Referral, and Evaluation (PCARE) Study. *The American Journal of Psychiatry.* 167(2):151-159. doi: 10.1176/appi.ajp.2009.09050691

[18] http://www.integration.samhsa.gov/integrated-care-models/primary-care-in-behavioral-health

[19] Parthasarathy, S., Mertens, J., Moore, C., & Weisner, C. (2003). Utilization and Cost Impact of Integrating Substance Abuse Treatment and Primary Care. *Medical Care*. 41(3): 357-367. doi:10.1097/00005650-200303000-00004

savings estimates ranged up to $343.67 per member month, primarily due to a reduction in inpatient hospital use as well as emergency room use.

To remain conservative, the Department chose the savings estimate of $231.09 and divided it by three due to the age of the study and lack of clarity around milder cost reductions for the control population in the study, for a total monthly savings estimate of $77.03 per client.

To estimate the populations that would achieve savings, the Department trended forward FY 2014-15 data for clients with SPMI and clients with substance use disorder (SUD) by half of actual and estimated caseload growth from FY 2015-16 forward. The Department assumes that the penetration rate of these clients enrolling in the Accountable Care Collaborative Phase II would be similar to the penetration rate of the populations of elderly and individuals with disabilities (discussed further under Mandatory Enrollment) due to their medical complexity. The Department also assumes that only 75% of these clients enrolled in the Accountable Care Collaborative Phase II would be receiving integrated, coordinated care. Therefore savings would only be attributable to this percentage of Accountable Care Collaborative Phase II enrollees estimated to have these conditions. The Department has accounted for estimated clients with comorbidities between SUD and SPMI under the expected savings for clients with SUD.

The Department assumes that there would be a six-month delay from the start of the Accountable Care Collaborative Phase II before beginning to see savings to accommodate for time lag related to first visit and claims submission Please see tables 4.1 through 4.5 of Appendix B for more detailed information on these calculations.

Mandatory Enrollment and Value-Based Payment

The Department estimates savings separately for three distinct client groups in the Accountable Care Collaborative: Elderly and Individuals with Disabilities, Adults without Disabilities, and Children without Disabilities[20]. The Department assumes a higher penetration rate as a result of the change to mandatory enrollment. Clients in the Program of All-Inclusive Care for the Elderly, would not be eligible for the Accountable Care Collaborative Phase II and would therefore not be mandatorily enrolled into the program. Please see tables 6.1 through 6.3 of Appendix B for more detailed information on these calculations.

The Department calculated the difference in expected enrollment in the Accountable Care Collaborative Phase II with the higher penetration rate and expected enrollment in the current Accountable Care Collaborative with the lower penetration rate, for an incremental new enrollment estimate due to the Accountable Care Collaborative Phase II. This incremental enrollment would drive both costs and savings, and so the Department calculates both separately.

Costs stem from the additional expense of PMPM payments made to RAEs for these new clients. The Department assumes that the total PMPM would increase by $1.00 in the Accountable Care Collaborative Phase II, so the change in cost would be due to a combination of factors. These factors include the current

[20] More information can be found in the November 1, 2015 Legislative Request for Information #7 Accountable Care Collaborative Organization located at: https://www.colorado.gov/pacific/sites/default/files/Legislative%20Request%20For%20Information%20-%20Accountable%20 Care%20Collaborative%20%20-%20November%201,%202015.pdf

PMPM of approximately $14.50 on average (combining the current PMPMs for RCCOs and PCMPs) multiplied by the incremental increase in enrollment estimates, or the incremental cost due to new enrollment; the $1.00 PMPM increase multiplied by the enrollment estimates for the current Accountable Care Collaborative, or the incremental cost due to the change in PMPM; and the $1.00 PMPM increase multiplied by the incremental increase in enrollment estimates, or the compounded effect of the change in PMPM and the change in enrollment expectations. Please see tables 3.1 and 3.2 of Appendix B for more detailed information on these calculations.

The Department did not adjust its savings estimates for each population, in order to remain conservative in its estimates. Little cost savings information exists on the effect of integrated care coordination on relatively healthy populations, rather than specific, medically complex subpopulations such as those with SPMI or SUD diagnoses discussed above. Because savings assumptions are held constant between the current Accountable Care Collaborative and the Accountable Care Collaborative Phase II for the enrolled population, the Department calculates incremental savings due to new enrollment in the Accountable Care Collaborative Phase II as new enrollment for each savings category multiplied by estimated savings per capita for that category. To account for mandatory enrollment and all eligible Medicaid clients enrolling into the Accountable Care Collaborative Phase II within the first month of program implementation, the Department assumes that there would be a six-month delay before realizing savings in order to account for factors such as the time for patients to have their first visits and billing lag. The Department believes this represents a conservative lower bound for estimated savings due to incremental enrollment in the Accountable Care Collaborative Phase II over the current Accountable Care Collaborative. Please see Table 5.1 of Appendix B for more detailed information on these calculations.

Payment Reform

Primary Care

Primary Care (non-Federally Qualified Health Centers) Medical Providers

In order to calculate a base amount for the request to continue the primary care rate increase of HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA", the Department adds an adjustment for updated actual utilization rates for FY 2015-16 to the total amount appropriated for the increase in HB 16-1408. The Department assumes the Primary Care Sustainability Cash Fund would only be available for the primary care rate increase in HB 16-1408, and that any continuation thereafter would be funded with General Fund. To achieve an equivalent General Fund impact, the Department trends the estimated General Fund impact for FY 2016-17 forward by expected growth in caseload and calculates the corresponding cash and federal funds amounts based on expected utilization by eligibility for FY 2017-18 forward.

The Department calculates half a month of claims runout in FY 2018-19 for the request to continue the primary care rate increase into FY 2017-18. Otherwise, for FY 2018-19 forward, the Department would design an alternative payment model, with stakeholder feedback, that targets the General Fund calculation trended forward by caseload growth and anticipates payout as incentive payments. The Department would continue to work on the operational details of these payments, including timing and reimbursement mechanism. This methodology would ensure that the payment reform would be equivalent to the primary care payment increase currently appropriated by the General Assembly, with the benefit of tying payment to

quality and outcomes. Please see tables 7.1 through 7.3 of Appendix B for more detailed information on these calculations.

Federally Qualified Health Centers

The Department would lower the current payment to FQHCs at the alternate payment methodology (APM) rate to the payment at the prospective payment system (PPS) rate, but would offer the difference back to FQHCs as incentive payments tied to quality outcomes. The Department assumes that the FQHCs would achieve their full incentive payments, and so the Department expects this change to be budget neutral.

Vaccine Stock Rates

Tables 8.2 and 8.5 of Appendix B summarize the total estimated savings to vaccine stock by setting reimbursement for vaccine stock equal to the retail price published annually by the CDC. Tables 8.3 and 8.6 of Appendix B show FY 2017-18 and FY 2018-19 forecasted expenditure broken out by eligibility categories for vaccine stock under current rates, based on FY 2015-16 actual expenditure trended forward by estimated caseload growth. Tables 8.4 and 8.7 of Appendix B show FY 2017-18 and FY 2018-19 estimated expenditure broken out by eligibility categories for vaccine stock with rates set equal to the CDC price list trended forward by estimated caseload growth. The Department assumes utilization of vaccine stock would be unchanged if rates are set equal to the CDC price list.

Tables 8.11 and 8.12 of Appendix B show the projected FY 2017-18 impact to expenditure for individual vaccines due to the change in methodology, with the ten vaccinations with the highest expenditure shown separately. As an example, the most commonly used vaccination, the tetanus vaccination, is currently priced $37.24 over the retail rate from the CDC and would result in a projected $1,123,386 less expenditure in FY 2017-18 if set equal to the CDC rate.

Behavioral Health

The Department currently pays BHOs different capitation rates depending on the population. This would continue for the RAEs in the Accountable Care Collaborative Phase II. In order to calculate the amount of incentive payments, the Department estimates each of the populations with a different capitation rate separately, trended forward by expected caseload growth from the February 2016 S-2 "Behavioral Health Community Programs" budget request's FY 2017-18 estimates.

Federal regulations allow incentive payments up to 5% over capitation rates for behavioral health, but the Department only expects a 4% reduction in rates in FY 2017-18 (discussed further under Technical Adjustments). The Department assumes that each fiscal year's incentive payments would be paid out in the following fiscal year, to allow time to verify achievement of quality goals. Due to budget neutrality assumptions and design, these calculations are shown in detail in the tables calculating the impact of the rate reduction for the previous fiscal year, multiplied by -1. This represents the total cost of incentive payments for behavioral health tied to value. Please see Table 9.1 of Appendix B for more detailed information on these calculations.

Technical Adjustments

To calculate savings due to the continued receipt of reconciliation payments from hospitals for overpayments for outpatient services in previous fiscal years, after the Department has switched to an EAPG payment

methodology for these services, the Department calculated the average reconciliations for past time periods where the Department assumes reconciliation has fully taken place and trended this average forward by the average growth rate of reconciliations between fiscal years. To remain conservative, the Department has held the FY 2017-18 savings expectations constant through each of the fiscal years in this request. The Department assumes, based on historical information, that the majority of reconciliations take place for fiscal years approximately 4 to 7 years in the past. Therefore, the Department does not expect higher FMAP due to expansion in FY 2013-14 to appear in the reconciliations until approximately FY 2018-19.

To calculate savings due to the reduction of the behavioral health capitation rate in FY 2017-18 because of new federal managed care regulations, the Department assumes that the FY 2017-18 rates would have otherwise remained constant at the FY 2016-17 rate, with a small positive growth trend for rates in FY 2018-19, and calculates 4% of the capitation for each population forward for each fiscal year. The Department multiplies this amount by -1 and then multiplies by expected caseload for each population to calculate the estimated savings due to this reduction.

Please see tables 10.1 through 10.5 of Appendix B for more detailed information on these calculations.

Appendix A: FTE Descriptions

Position Name	Position Classification	Number of FTE	Description
Primary Care Payment Reform Analyst	Rate/Financial Analyst IV	1.0	This position would be tasked with transitioning the primary care fee schedule from the current static fee schedule to a dynamic fee schedule that is provider specific and changes frequently due to provider performance. The position would evaluate fee levels under the value-based purchasing models to ensure incentive payments remain within budget and that the Department pays the appropriate level of incentive to encourage behavior change and performance. Transitioning from a single fee schedule for primary care physicians to a model that adjusts based on provider specific performance is a major increase in the operational oversight required and rate policy analysis needed for the primary care benefit.
Program Evaluation Analyst	Analyst IV	1.0	The proposed position would measure and evaluate the performance and quality outcomes of the behavioral health integration efforts and the practice supports and program interventions implemented through the Accountable Care Collaborative Phase II. Position would conduct evaluations on a multitude of interventions in the Accountable Care Collaborative, specifically related to physical and behavioral health interventions, to ensure interventions are making the intended changes. Starting in FY 2019-20, position would also oversee and monitor the work of the contractor hired to evaluate the effectiveness of each of the initiatives. Position would provide recommendations for changes to the Accountable Care Collaborative based on evaluation activities.
Integrated Care Specialist	Analyst IV	1.0	This position would provide additional expertise in behavioral health and the integration of behavioral health and primary care to reflect the changed program oversight needs. As the current BHO program is run in 5 regions, additional staff are required to effectively monitor the behavioral health component for the 7 contracts of the Accountable Care Collaborative Phase II. Position responsibilities would include contract management and program oversight. In addition, this position would review audited and other financial reports to monitor the cost-effectiveness and value of integrated care services.

Position Name	Position Classification	Number of FTE	Description
Integrated Care Specialist - Communications	Administrator III	1.0	This position would provide additional expertise in behavioral health and the integration of behavioral health and primary care to reflect the changed program oversight needs. As the current BHO program is run in 5 regions, additional staff are required to effectively monitor the behavioral health component for the 7 contracts of the Accountable Care Collaborative Phase II. Position responsibilities would include contract management and program oversight. In addition, this position would provide communication expertise to support communicating with providers, clients, advocates, media, and national organizations regarding the integrated care policies and outcomes of the Accountable Care Collaborative.
Accountable Care Collaborative Client, Provider, and Special Populations Relations Specialist	Administrator III	1.0	This position would be responsible for managing client and provider complaints as well as with serving as a liaison for special populations. Transition across delivery system design can be confusing, creating higher work load as clients, providers, and other agency partners learn the new processes and systems. Position would ensure collaboration with other agencies to address systemic barriers to care and services and the role as client and provider liaison would ensure understanding of barriers at both the systemic and individual level. Position would work with the RAEs to ensure appropriate and necessary focus on high-risk, high-cost populations such as individuals receiving LTSS, children in the child welfare system, individuals with criminal justice involvement, and individuals experiencing housing insecurity.
	Total FTE	**5.0**	

Table 1.1 FY 2016-17 Cost Estimates with Fund Splits, by Appropriation (INFORMATIONAL ONLY)								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**		**Federal Funds**	**Notes/Calculations**
					Hospital Provider Fee	**BCCP Cash Fund**		
A	(1) EDO; (A) General Administration, Personal Services	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
B	(1) EDO; (A) General Administration, Health, Life, and Dental	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
C	(1) EDO; (A) General Administration, Short-term Disability	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
D	(1) EDO; (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
E	(1) EDO; (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
F	(1) EDO; (A) General Administration, Operating Expenses	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
G	(1) EDO; (A) General Administration, General Professional Services and Special Projects	$0	0.0	$0	$0	$0	$0	Table 2.1 Row G
H	(2) Medical Services Premiums	($15,440,295)	0.0	($7,720,148)	$0	$0	($7,720,147)	Table 2.1 Row B + Table 2.1 Row D + Table 2.1 Row E + Table 2.1 Row H + Table 2.1 Row I + Table 2.1 Row K + Table 2.1 Row L
I	(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	$0	0.0	$0	$0	$0	$0	Table 2.1 Row J + Table 2.1 Row M
J	Total Costs	($15,440,295)	0.0	($7,720,148)	$0	$0	($7,720,147)	Sum Row A through Row I

Table 1.2 FY 2017-18 Cost Estimates with Fund Splits, by Appropriation

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	(1) EDO; (A) General Administration, Personal Services	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
B	(1) EDO; (A) General Administration, Health, Life, and Dental	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
C	(1) EDO; (A) General Administration, Short-term Disability	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
D	(1) EDO; (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
E	(1) EDO; (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
F	(1) EDO; (A) General Administration, Operating Expenses	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
G	(1) EDO; (A) General Administration, General Professional Services and Special Projects	$0	0.0	$0	$0	$0	$0	Table 2.2 Row G
H	(2) Medical Services Premiums	$29,930,444	0.0	$7,014,977	$889,558	$13,869	$22,012,040	Table 2.2 Row B + Table 2.2 Row D + Table 2.2 Row E + Table 2.2 Row H + Table 2.2 Row I + Table 2.2 Row K + Table 2.2 Row L
I	(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	($26,717,069)	0.0	($7,215,319)	($1,090,537)	($299)	($18,410,914)	Table 2.2 Row J + Table 2.2 Row M
J	Total Costs	$3,213,375	0.0	($200,342)	($200,979)	$13,570	$3,601,126	Sum Row A through Row I

Table 1.3 FY 2018-19 Cost Estimates with Fund Splits, by Appropriation

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	(1) EDO; (A) General Administration, Personal Services	$307,185	4.6	$153,593	$0	$0	$153,592	From FTE Calculations
B	(1) EDO; (A) General Administration, Health, Life, and Dental	$39,636	0.0	$19,818	$0	$0	$19,818	From FTE Calculations
C	(1) EDO; (A) General Administration, Short-term Disability	$524	0.0	$262	$0	$0	$262	From FTE Calculations
D	(1) EDO; (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$13,764	0.0	$6,882	$0	$0	$6,882	From FTE Calculations
E	(1) EDO; (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$13,764	0.0	$6,882	$0	$0	$6,882	From FTE Calculations
F	(1) EDO; (A) General Administration, Operating Expenses	$27,869	0.0	$13,934	$0	$0	$13,935	From FTE Calculations
G	(1) EDO; (A) General Administration, General Professional Services and Special Projects	$225,000	0.0	$112,500	$0	$0	$112,500	Table 2.3 Row G
H	(2) Medical Services Premiums	($32,753,794)	0.0	($11,075,966)	($1,237,653)	($3)	($20,440,172)	Table 2.3 Row B + Table 2.3 Row D + Table 2.3 Row E + Table 2.3 Row H + Table 2.3 Row I + Table 2.3 Row K + Table 2.3 Row L
I	(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	($1,414,051)	0.0	($287,685)	($215,140)	($211)	($911,015)	Table 2.3 Row J + Table 2.3 Row M
J	Total Costs	($33,540,103)	4.6	($11,049,780)	($1,452,793)	($214)	($21,037,316)	Sum Row A through Row I

Table 1.4 FY 2019-20 Cost Estimates with Fund Splits, by Appropriation

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	(1) EDO; (A) General Administration, Personal Services	$335,135	5.0	$167,567	$0	$0	$167,568	From FTE Calculations
B	(1) EDO; (A) General Administration, Health, Life, and Dental	$39,636	0.0	$19,818	$0	$0	$19,818	From FTE Calculations
C	(1) EDO; (A) General Administration, Short-term Disability	$570	0.0	$285	$0	$0	$285	From FTE Calculations
D	(1) EDO; (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$15,015	0.0	$7,508	$0	$0	$7,507	From FTE Calculations
E	(1) EDO; (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$15,015	0.0	$7,508	$0	$0	$7,507	From FTE Calculations
F	(1) EDO; (A) General Administration, Operating Expenses	$4,750	0.0	$2,375	$0	$0	$2,375	From FTE Calculations
G	(1) EDO; (A) General Administration, General Professional Services and Special Projects	$150,000	0.0	$75,000	$0	$0	$75,000	Table 2.4 Row G
H	(2) Medical Services Premiums	($145,847,884)	0.0	($47,815,357)	($6,029,611)	($16,721)	($91,986,195)	Table 2.4 Row B + Table 2.4 Row D + Table 2.4 Row E + Table 2.4 Row H + Table 2.4 Row I + Table 2.4 Row K + Table 2.4 Row L
I	(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	($405,343)	0.0	($106,321)	($263,157)	$0	($35,865)	Table 2.4 Row J + Table 2.4 Row M
J	Total Costs	($145,693,106)	5.0	($47,641,617)	($6,292,768)	($16,721)	($91,742,000)	Sum Row A through Row I

Table 2.1 FY 2016-17 Cost Estimates with Fund Splits, by Component (INFORMATIONAL ONLY)								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**		**Federal Funds**	**Notes/Calculations**
					Hospital Provider Fee	**BCCP Cash Fund**		
A	*Delivery System Reform*							
B	Accountable Care Collaborative Phase II PMPM Costs	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
C	Accountable Care Collaborative Phase II Administrative Costs - FTE	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
D	Accountable Care Collaborative Phase II Savings Due to Enrollment	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
E	Accountable Care Collaborative Phase II Savings Due to Physical-Behavioral Health Care Coordination	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
F	*Payment Reform*							
G	Administrative Costs - Contractor Costs	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
H	Primary Care Rate Increase Continuation	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
I	Vaccine Stock Rate Methodology Change	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
J	Behavioral Health Incentive Payments	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
K	Federally Qualified Health Center Payment Reform	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
L	Outpatient Hospital Services Methodology Change	($15,440,295)	0.0	($7,720,148)	$0	$0	($7,720,147)	Table 10.1 Row A
M	Behavioral Health Capitation Rate Reduction	$0	0.0	$0	$0	$0	$0	Table 10.1 Row B
N	Total Costs	($15,440,295)	0.0	($7,720,148)	$0	$0	($7,720,147)	Sum Row B through Row M

Definitions:
PMPM - Per Member Per Month

Table 2.2 FY 2017-18 Cost Estimates with Fund Splits, by Component

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	*Delivery System Reform*							
B	Accountable Care Collaborative Phase II PMPM Costs	$0	0.0	$0	$0	$0	$0	Table 3.1 Row H
C	Accountable Care Collaborative Phase II Administrative Costs - FTE	$0	0.0	$0	$0	$0	$0	From FTE Calculations
D	Accountable Care Collaborative Phase II Savings Due to Enrollment	$0	0.0	$0	$0	$0	$0	Table 5.1 Row AA
E	Accountable Care Collaborative Phase II Savings Due to Physical-Behavioral Health Care Coordination	$0	0.0	$0	$0	$0	$0	Table 4.1 Row C
F	*Payment Reform*							
G	Payment Reform Administrative Costs - Contractor Costs	$0	0.0	$0	$0	$0	$0	See Narrative
H	Primary Care Rate Increase Continuation	$54,085,240	0.0	$18,846,157	$922,457	$13,869	$34,302,757	Table 7.4 Row C
I	Vaccine Stock Rate Methodology Change	($994,353)	0.0	($250,958)	($32,899)	$0	($710,496)	Table 8.1 Row A
J	Behavioral Health Incentive Payments	$0	0.0	$0	$0	$0	$0	Table 9.1 Row A
K	Federally Qualified Health Center Payment Reform	$0	0.0	$0	$0	$0	$0	See Narrative
L	Outpatient Hospital Services Methodology Change	($23,160,443)	0.0	($11,580,222)	$0	$0	($11,580,221)	Table 10.2 Row A
M	Behavioral Health Capitation Rate Reduction	($26,717,069)	0.0	($7,215,319)	($1,090,537)	($299)	($18,410,914)	Table 10.2 Row B
N	Total Costs	$3,213,375	0.0	($200,342)	($200,979)	$13,570	$3,601,126	Sum Row B through Row M

Table 2.3 FY 2018-19 Cost Estimates with Fund Splits, by Component

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	*Delivery System Reform*							
B	Accountable Care Collaborative Phase II PMPM Costs	$45,343,338	0.0	$17,599,750	$1,778,624	$839	$25,964,125	Table 3.1 Row H
C	Accountable Care Collaborative Phase II Administrative Costs - FTE	$402,742	4.6	$201,371	$0	$0	$201,371	From FTE Calculations
D	Accountable Care Collaborative Phase II Savings Due to Enrollment	($55,567,996)	0.0	($24,079,004)	($2,247,134)	($1,500)	($29,240,358)	Table 5.1 Row AA
E	Accountable Care Collaborative Phase II Savings Due to Physical-Behavioral Health Care Coordination	($58,759,956)	0.0	($15,623,787)	($1,914,619)	($14,762)	($41,206,788)	Table 4.2 Row C
F	*Payment Reform*							
G	Payment Reform Administrative Costs - Contractor Costs	$225,000	0.0	$112,500	$0	$0	$112,500	See Narrative
H	Payment Reform Primary Care Incentives	$60,413,683	0.0	$21,051,321	$1,184,492	$15,420	$38,162,450	Table 7.5 Row C
I	Vaccine Stock Rate Methodology Change	($1,022,420)	0.0	($255,171)	($39,016)	$0	($728,233)	Table 8.1 Row B
J	Behavioral Health Incentive Payments	$26,717,069	0.0	$7,215,319	$1,090,537	$299	$18,410,914	Table 9.1 Row B
K	Federally Qualified Health Center Payment Reform	$0	0.0	$0	$0	$0	$0	See Narrative
L	Outpatient Hospital Services Methodology Change	($23,160,443)	0.0	($9,769,075)	$0	$0	($13,391,368)	Table 10.3 Row A
M	Behavioral Health Capitation Rate Reduction	($28,131,120)	0.0	($7,503,004)	($1,305,677)	($510)	($19,321,929)	Table 10.3 Row B
N	Total Costs	($33,540,103)	4.6	($11,049,780)	($1,452,793)	($214)	($21,037,316)	Sum Row B through Row M

Table 2.4 FY 2019-20 Cost Estimates with Fund Splits, by Component

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	*Delivery System Reform*							
B	Accountable Care Collaborative Phase II PMPM Costs	$44,094,310	0.0	$17,012,125	$1,852,378	$808	$25,228,999	Table 3.1 Row H
C	Accountable Care Collaborative Phase II Administrative Costs - FTE	$410,121	5.0	$205,061	$0	$0	$205,060	From FTE Calculations
D	Accountable Care Collaborative Phase II Savings Due to Enrollment	($105,604,954)	0.0	($45,807,852)	($4,346,903)	($2,910)	($55,447,289)	Table 5.1 Row AA
E	Accountable Care Collaborative Phase II Savings Due to Physical-Behavioral Health Care Coordination	($119,183,550)	0.0	($31,689,953)	($4,962,730)	($29,942)	($82,500,925)	Table 4.3 Row C
F	*Payment Reform*							
G	Payment Reform Administrative Costs - Contractor Costs	$150,000	0.0	$75,000	$0	$0	$75,000	See Narrative
H	Payment Reform Primary Care Incentives	$59,055,014	0.0	$20,577,889	$1,477,023	$15,323	$36,984,779	Table 7.6 Row C
I	Vaccine Stock Rate Methodology Change	($1,048,261)	0.0	($262,303)	($49,379)	$0	($736,579)	Table 8.1 Row C
J	Behavioral Health Incentive Payments	$28,131,120	0.0	$7,503,004	$1,305,677	$510	$19,321,929	Table 9.1 Row C
K	Federally Qualified Health Center Payment Reform	$0	0.0	$0	$0	$0	$0	See Narrative
L	Outpatient Hospital Services Methodology Change	($23,160,443)	0.0	($7,645,263)	$0	$0	($15,515,180)	Table 10.4 Row A
M	Behavioral Health Capitation Rate Reduction	($28,536,463)	0.0	($7,609,325)	($1,568,834)	($510)	($19,357,794)	Table 10.4 Row B
N	Total Costs	($145,693,106)	5.0	($47,641,617)	($6,292,768)	($16,721)	($91,742,000)	Sum Row B through Row M

Definitions:
PMPM - Per Member Per Month

Table 3.1 Accountable Care Collaborative Phase II PMPM Cost Estimates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Incremental Member Month Estimates for Accountable Care Collaborative Phase II	0	2,004,963	1,892,397	Table 6.1 Row Y * 12
B	Current Accountable Care Collaborative Member Month Estimates	13,634,688	14,266,404	14,762,160	Table 6.3 Row Y * 12
C	Additional PMPM for Accountable Care Collaborative Phase II	$0.00	$1.00	$1.00	Table 3.2 Row H
D	Current Accountable Care Collaborative PMPM	$14.50	$14.50	$14.50	Table 3.2 Row F
E	Cost Due to Change in Enrollment	$0	$29,071,970	$27,439,753	Row A * Row D
F	Cost Due to Change in PMPM	$0	$14,266,404	$14,762,160	Row B * Row C
G	Compounded Cost	$0	$2,004,963	$1,892,397	Row A * Row C
H	Total Cost	$0	$45,343,338	$44,094,310	Row E + Row F + Row G

Definitions:

PMPM - Per Member Per Month

Table 3.2 Accountable Care Collaborative Phase II Difference in PMPM					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Current Accountable Care Collaborative PMPM				
B	*Base RCCO PMPM*	$9.00	$9.00	$9.00	Average across RCCOs, from current contracts
C	*RCCO Incentive PMPM*	$1.50	$1.50	$1.50	From current contracts
D	*Base PCMP PMPM*	$3.00	$3.00	$3.00	From current contracts
E	*PCMP Incentive PMPM*	$1.00	$1.00	$1.00	From current contracts
F	Total Current Accountable Care Collaborative PMPM	$14.50	$14.50	$14.50	Row B + Row C + Row D + Row E
G	Accountable Care Collaborative Phase II PMPM	$14.50	$15.50	$15.50	See Narrative
H	Difference in PMPM	$0.00	$1.00	$1.00	Row G - Row F

Definitions:

PMPM - Per Member Per Month; RCCO - Regional Collaborative Care Organization; PCMP - Primary Care Medical Provider

Table 4.1 FY 2017-18 Fund Splits for Savings to Acute Care for Integration of Physical and Behavioral Health Care						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Estimated Savings for the Integration of Care for Medicaid Clients with SPMI	$0	$0	$0	$0	Table 4.4 Row G
B	Estimated Savings for the Integration of Care for Medicaid Clients with SUD	$0	$0	$0	$0	Table 4.5 Row G
C	Total Estimated Savings for the Integration of Physical and Behavioral Health Care	$0	$0	$0	$0	Row A + Row B

Table 4.2 FY 2018-19 Fund Splits for Savings to Acute Care for Integration of Physical and Behavioral Health Care						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Estimated Savings for the Integration of Care for Medicaid Clients with SPMI	($16,566,157)	($5,448,968)	($418,886)	($10,698,303)	Table 4.4 Row G
B	Estimated Savings for the Integration of Care for Medicaid Clients with SUD	($42,193,799)	($10,174,819)	($1,510,495)	($30,508,485)	Table 4.5 Row G
C	Total Estimated Savings for the Integration of Physical and Behavioral Health Care	($58,759,956)	($15,623,787)	($1,929,381)	($41,206,788)	Row A + Row B

Table 4.3 FY 2019-20 Fund Splits for Savings to Acute Care for Integration of Physical and Behavioral Health Care						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Estimated Savings for the Integration of Care for Medicaid Clients with SPMI	($33,601,679)	($11,052,321)	($1,060,804)	($21,488,554)	Table 4.4 Row G
B	Estimated Savings for the Integration of Care for Medicaid Clients with SUD	($85,581,871)	($20,637,632)	($3,931,868)	($61,012,371)	Table 4.5 Row G
C	Total Estimated Savings for the Integration of Physical and Behavioral Health Care	($119,183,550)	($31,689,953)	($4,992,672)	($82,500,925)	Row A + Row B

Definitions:

SPMI - Serious and Persistent Mental Illness; SUD - Substance Use Disorder

Table 4.4 Estimated Savings for Individuals with Serious and Persistent Mental Illness					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Estimated Number of Medicaid Clients with SPMI	91,955	93,252	94,572	See Narrative
B	Estimated Penetration Rate of Accountable Care Collaborative Phase II	0.00%	87.81%	87.81%	Table 6.2 Row B
C	Estimated Percent of Accountable Care Collaborative Phase II Enrollees with SPMI Receiving Coordinated Care	0.00%	75.00%	75.00%	See Narrative
D	Estimated Number of Medicaid Clients with SPMI Receiving Integrated Care	0	61,413	62,283	Row A * Row B * Row C
E	Estimated Savings Per Month Per Client Due to Integration of Care	($44.96)	($44.96)	($44.96)	Half of estimate based on research[1]
F	Number of Months with Savings Due to Integration of Care	0	6	12	Based on start date of July 1, 2018 and estimated 6-month delay before savings
G	Total Estimated Savings for Integration of Care for Medicaid Clients with SPMI	$0	($16,566,157)	($33,601,679)	Row D * Row E * Row F

Definitions:
SPMI - Serious and Persistent Mental Illness
Footnotes:
1. Druss, B. G., Rohrbaugh, R. M., Levinson, C. M., Rosenheck, R. A. Integrated Medical Care for Patients with Serious Psychiatric Illness: A Randomized Trial. *Archives of General Psychiatry* . 2001; 58(9): 861-868. doi:10.1001/archpsyc.58.9.861

Table 4.5 Estimated Savings for Individuals with Substance Use Disorder					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Estimated Number of Medicaid Clients with SUD	136,694	138,622	140,584	See Narrative
B	Estimated Penetration Rate of Accountable Care Collaborative Phase II	0.00%	87.81%	87.81%	Table 6.2 Row B
C	Estimated Percent of Accountable Care Collaborative Phase II Enrollees with SUD Receiving Coordinated Care	0.00%	75.00%	75.00%	See Narrative
D	Estimated Number of Medicaid Clients with SUD Receiving Integrated Care	0	91,293	92,585	Row A * Row B
E	Estimated Savings Per Month Per Client Due to Integration of Care	($77.03)	($77.03)	($77.03)	A third of estimate based on research[1]
F	Number of Months with Savings Due to Integration of Care	0	6	12	Based on start date of July 1, 2018 and estimated 6-month delay before savings
G	Total Estimated Savings for Integration of Care for Medicaid Clients with SUD	$0	($42,193,799)	($85,581,871)	Row D * Row E * Row F

Definitions:
SUD - Substance Use Disorder
Footnotes:
1. Parthasarathy, S., Mertens, J., Moore, C., & Weisner, C. Utilization and Cost Impact of Integrating Substance Abuse Treatment and Primary Care. *Medical Care* . 2003; 41(3): 357-367. doi:10.1097/00005650-200303000-00004

Table 5.1 Savings to Acute Care for New Enrollment					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Elderly and Individuals with Disabilities Populations				
B	*Standard FMAP General Fund Populations*	0	55,427	54,678	Table 6.1 Row B
C	*Standard FMAP Hospital Provider Fee Populations*	0	3,743	3,566	Table 6.1 Row F
D	*Enhanced FMAP Non-Newly Eligible Populations*	0	894	928	Table 6.1 Row N
E	Total Elderly and Individuals with Disabilities	0	60,064	59,172	Row B + Row C + Row D
F	Estimated Cost Savings Per Month	($145.65)	($141.28)	($137.04)	Based on estimates in the November 2015 LRFI #7 ACC Organization
G	Estimated Number of Months with Savings	0	6	12	Assumes 6-month delay in achieving savings
H	Subtotal Elderly and Individuals with Disabilities Savings	$0	($50,914,911)	($97,308,462)	Row E * Row F * Row G
I	Adult Populations				
J	*Standard FMAP General Fund Populations*	0	24,081	18,440	Table 6.1 Row C
K	*Standard FMAP Hospital Provider Fee Populations*	0	1,867	1,465	Table 6.1 Row G
L	*Enhanced FMAP Expansion Populations*	0	57,560	56,201	Table 6.1 Row K
M	*Enhanced FMAP BCCP Program Population*	0	94	94	Table 6.1 Row S
N	*Enhanced FMAP Title XXI-funded Populations*	0	654	655	Table 6.1 Row W
O	Total Adults	0	84,257	76,854	Row J + Row K + Row L + Row M + Row N
P	Estimated Cost Savings Per Month	($7.86)	($7.62)	($7.39)	Based on estimates in the November 2015 LRFI #7 ACC Organization
Q	Estimated Number of Months with Savings	0	6	12	Assumes 6-month delay in achieving savings
R	Subtotal Adults Savings	$0	($3,852,632)	($6,817,737)	Row O * Row P * Row Q
S	Children Populations				
T	*Standard FMAP General Fund Populations*	0	926	0	Table 6.1 Row D
U	*Standard FMAP Hospital Provider Fee Populations*	0	17,924	18,694	Table 6.1 Row H
V	*Enhanced FMAP Title XXI-funded Populations*	0	3,910	2,979	Table 6.1 Row X
W	Total Children	0	22,760	21,673	Row T + Row U + Row V
X	Estimated Cost Savings Per Month	($6.04)	($5.86)	($5.69)	Based on estimates in the November 2015 LRFI #7 ACC Organization
Y	Estimated Number of Months with Savings	0	6	12	Assumes 6-month delay in achieving savings
Z	Subtotal Children Savings	$0	($800,453)	($1,478,755)	Row W * Row X * Row Y
AA	Total Estimated Savings	$0	($55,567,996)	($105,604,954)	Row H + Row R + Row Z

Definitions:

FMAP - Federal Medical Assistance Percentage; LRFI - Legislative Request for information; ACC - Accountable Care Collaborative; BCCP - Breast and Cervical Cancer Prevention and Treatment Program; Title XXI - Title XXI of the Social Security Act (Child Health Plan *Plus*)

Table 6.1 Population Breakout of Difference in Enrollment Estimates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Standard FMAP General Fund Populations	0	80,434	73,118	Row B + Row C + Row D
B	*Elderly and Individuals with Disabilities*	*0*	*55,427*	*54,678*	*Table 6.2 Row F - Table 6.3 Row B*
C	*Adults*	*0*	*24,081*	*18,440*	*Table 6.2 Row G - Table 6.3 Row C*
D	*Children*	*0*	*926*	*0*	*Table 6.2 Row H - Table 6.3 Row D*
E	Standard FMAP Hospital Provider Fee Populations	0	23,534	23,725	Row F + Row G + Row H
F	*Elderly and Individuals with Disabilities*	*0*	*3,743*	*3,566*	*Table 6.2 Row J - Table 6.3 Row F*
G	*Adults*	*0*	*1,867*	*1,465*	*Table 6.2 Row K - Table 6.3 Row G*
H	*Children*	*0*	*17,924*	*18,694*	*Table 6.2 Row L - Table 6.3 Row H*
I	Enhanced FMAP Expansion Populations	0	57,560	56,201	Row J + Row K + Row L
J	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.2 Row N - Table 6.3 Row J*
K	*Adults*	*0*	*57,560*	*56,201*	*Table 6.2 Row O - Table 6.3 Row K*
L	*Children*	*0*	*0*	*0*	*Table 6.2 Row P - Table 6.3 Row L*
M	Enhanced FMAP Non-Newly Eligible Populations	0	894	928	Row N + Row O + Row P
N	*Elderly and Individuals with Disabilities*	*0*	*894*	*928*	*Table 6.2 Row R - Table 6.3 Row N*
O	*Adults*	*0*	*0*	*0*	*Table 6.2 Row S - Table 6.3 Row O*
P	*Children*	*0*	*0*	*0*	*Table 6.2 Row T - Table 6.3 Row P*
Q	Enhanced FMAP BCCP Program Population	0	94	94	Row R + Row S + Row T
R	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.2 Row V - Table 6.3 Row R*
S	*Adults*	*0*	*94*	*94*	*Table 6.2 Row W - Table 6.3 Row S*
T	*Children*	*0*	*0*	*0*	*Table 6.2 Row X - Table 6.3 Row T*
U	Enhanced FMAP Title XXI-funded Populations	0	4,564	3,633	Row V + Row W + Row X
V	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.2 Row Z - Table 6.3 Row V*
W	*Adults*	*0*	*654*	*655*	*Table 6.2 Row AA - Table 6.3 Row W*
X	*Children*	*0*	*3,910*	*2,979*	*Table 6.2 Row AB - Table 6.3 Row X*
Y	**Total Difference in Enrollment Estimates**	**0**	**167,080**	**157,700**	**Row A + Row E + Row I + Row M + Row Q + Row U**

Definitions:
FMAP - Federal Medical Assistance Percentage; BCCP - Breast and Cervical Cancer Prevention and Treatment Program; Title XXI - Title XXI of the Social Security Act (Child Health Plan *Plus*)

Table 6.2 Population Breakout of Accountable Care Collaborative Phase II Enrollment Estimates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Accountable Care Collaborative Phase II Enrollment Percentage of Medicaid Caseload Estimates				
B	*Elderly and Individuals with Disabilities*	*54.12%*	*87.81%*	*87.81%*	*Percent of Medicaid population eligible for the Accountable Care Collaborative Phase II, based on FY 2015-16 actuals*
C	*Adults*	*83.29%*	*90.99%*	*90.99%*	*Percent of Medicaid population eligible for the Accountable Care Collaborative Phase II, based on FY 2015-16 actuals*
D	*Children*	*87.34%*	*92.75%*	*92.75%*	*Percent of Medicaid population eligible for the Accountable Care Collaborative Phase II, based on FY 2015-16 actuals*
E	Standard FMAP General Fund Populations	648,497	753,320	771,345	Row F + Row G + Row H
F	*Elderly and Individuals with Disabilities*	*54,802*	*112,935*	*115,026*	*Table 6.4 Row B * Row B*
G	*Adults*	*157,202*	*188,761*	*190,954*	*Table 6.4 Row C * Row C*
H	*Children*	*436,493*	*451,624*	*465,365*	*Table 6.4 Row D * Row D*
I	Standard FMAP Hospital Provider Fee Populations	30,646	55,890	57,930	Row J + Row K + Row L
J	*Elderly and Individuals with Disabilities*	*2,760*	*6,948*	*7,288*	*Table 6.4 Row F * Row B*
K	*Adults*	*8,207*	*10,689*	*10,948*	*Table 6.4 Row G * Row C*
L	*Children*	*19,679*	*38,253*	*39,694*	*Table 6.4 Row H * Row D*
M	Enhanced FMAP Expansion Populations	392,957	472,557	482,836	Row N + Row O + Row P
N	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.4 Row J * Row B*
O	*Adults*	*392,957*	*472,557*	*482,836*	*Table 6.4 Row K * Row C*
P	*Children*	*0*	*0*	*0*	*Table 6.4 Row L * Row D*
Q	Enhanced FMAP Non-Newly Eligible Populations	1,861	2,841	2,965	Row R + Row S + Row T
R	*Elderly and Individuals with Disabilities*	*1,861*	*2,841*	*2,965*	*Table 6.4 Row N * Row B*
S	*Adults*	*0*	*0*	*0*	*Table 6.4 Row O * Row C*
T	*Children*	*0*	*0*	*0*	*Table 6.4 Row P * Row D*
U	Enhanced FMAP BCCP Program Population	0	94	94	Row V + Row W + Row X
V	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.4 Row R * Row B*
W	*Adults*	*0*	*94*	*94*	*Table 6.4 Row S * Row C*
X	*Children*	*0*	*0*	*0*	*Table 6.4 Row T * Row D*
Y	Enhanced FMAP Title XXI-funded Populations	62,263	71,245	72,709	Row Z + Row AA + Row AB
Z	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.4 Row V * Row B*
AA	*Adults*	*1,156*	*1,865*	*1,924*	*Table 6.4 Row W * Row C*
AB	*Children*	*61,107*	*69,380*	*70,786*	*Table 6.4 Row X * Row D*
AC	**Total Accountable Care Collaborative Phase II Enrollment Estimates**	**1,136,224**	**1,355,947**	**1,387,880**	**Row E + Row I + Row M + Row Q + Row U + Row Y**

Definitions:
FMAP - Federal Medical Assistance Percentage; BCCP - Breast and Cervical Cancer Prevention and Treatment Program; Title XXI - Title XXI of the Social Security Act (Child Health Plan *Plus*)

Table 6.3 Population Breakout of Current Accountable Care Collaborative Enrollment Estimates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Standard FMAP General Fund Populations	648,497	672,886	698,227	Row B + Row C + Row D
B	*Elderly and Individuals with Disabilities*	*54,802*	*57,508*	*60,348*	*November 2016 forecast Medical Services Premiums, trended forward*
C	*Adults*	*157,202*	*164,680*	*172,514*	*November 2016 forecast Medical Services Premiums, trended forward*
D	*Children*	*436,493*	*450,698*	*465,365*	*November 2016 forecast Medical Services Premiums, trended forward*
E	Standard FMAP Hospital Provider Fee Populations	30,646	32,356	34,205	Row F + Row G + Row H
F	*Elderly and Individuals with Disabilities*	*2,760*	*3,205*	*3,722*	*November 2016 forecast Medical Services Premiums, trended forward*
G	*Adults*	*8,207*	*8,822*	*9,483*	*November 2016 forecast Medical Services Premiums, trended forward*
H	*Children*	*19,679*	*20,329*	*21,000*	*November 2016 forecast Medical Services Premiums, trended forward*
I	Enhanced FMAP Expansion Populations	392,957	414,997	426,635	Row J + Row K + Row L
J	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
K	*Adults*	*392,957*	*414,997*	*426,635*	*November 2016 forecast Medical Services Premiums, trended forward*
L	*Children*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
M	Enhanced FMAP Non-Newly Eligible Populations	1,861	1,947	2,037	Row N + Row O + Row P
N	*Elderly and Individuals with Disabilities*	*1,861*	*1,947*	*2,037*	*November 2016 forecast Medical Services Premiums, trended forward*
O	*Adults*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
P	*Children*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
Q	Enhanced FMAP BCCP Program Population	0	0	0	Row R + Row S + Row T
R	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
S	*Adults*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
T	*Children*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
U	Enhanced FMAP Title XXI-funded Populations	62,263	66,681	69,076	Row V + Row W + Row X
V	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
W	*Adults*	*1,156*	*1,211*	*1,269*	*November 2016 forecast Medical Services Premiums, trended forward*
X	*Children*	*61,107*	*65,470*	*67,807*	*November 2016 forecast Medical Services Premiums, trended forward*
Y	**Total Current Accountable Care Collaborative Enrollment Estimates**	**1,136,224**	**1,188,867**	**1,230,180**	**Row A + Row E + Row I + Row M + Row Q + Row U**

Definitions:
FMAP - Federal Medical Assistance Percentage; BCCP - Breast and Cervical Cancer Prevention and Treatment Program; Title XXI - Title XXI of the Social Security Act (Child Health Plan *Plus*)

Table 6.4 Population Breakout of Medicaid Caseload Estimates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Standard FMAP General Fund Populations	810,645	822,992	833,138	Row B + Row C + Row D
B	*Elderly and Individuals with Disabilities*	*126,275*	*128,613*	*130,994*	*November 2016 "Medical Services Premiums" Request, trended forward*
C	*Adults*	*202,741*	*207,453*	*209,863*	*November 2016 "Medical Services Premiums" Request, trended forward*
D	*Children*	*481,629*	*486,926*	*492,281*	*November 2016 "Medical Services Premiums" Request, trended forward*
E	Standard FMAP Hospital Provider Fee Populations	56,459	60,903	63,129	Row F + Row G + Row H
F	*Elderly and Individuals with Disabilities*	*6,901*	*7,913*	*8,300*	*November 2016 "Medical Services Premiums" Request, trended forward*
G	*Adults*	*11,205*	*11,747*	*12,032*	*November 2016 "Medical Services Premiums" Request, trended forward*
H	*Children*	*38,353*	*41,243*	*42,797*	*November 2016 "Medical Services Premiums" Request, trended forward*
I	Enhanced FMAP Expansion Populations	497,701	519,351	530,647	Row J + Row K + Row L
J	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
K	*Adults*	*497,701*	*519,351*	*530,647*	*November 2016 "Medical Services Premiums" Request, trended forward*
L	*Children*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
M	Enhanced FMAP Non-Newly Eligible Populations	2,991	3,122	3,259	Row N + Row O + Row P
N	*Elderly and Individuals with Disabilities*	*2,991*	*3,122*	*3,259*	*November 2016 "Medical Services Premiums" Request, trended forward*
O	*Adults*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
P	*Children*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
Q	Enhanced FMAP BCCP Program Population	179	103	103	Row R + Row S + Row T
R	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
S	*Adults*	*179*	*103*	*103*	*November 2016 "Medical Services Premiums" Request, trended forward*
T	*Children*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
U	Enhanced FMAP Title XXI-funded Populations	73,878	76,853	78,433	Row V + Row W + Row X
V	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
W	*Adults*	*1,988*	*2,050*	*2,114*	*November 2016 "Medical Services Premiums" Request, trended forward*
X	*Children*	*71,890*	*74,803*	*76,319*	*November 2016 "Medical Services Premiums" Request, trended forward*
Y	**Total Medicaid Caseload Estimates**	**1,441,853**	**1,483,324**	**1,508,709**	**Row A + Row E + Row I + Row M + Row Q + Row U**

Definitions:
FMAP - Federal Medical Assistance Percentage; BCCP - Breast and Cervical Cancer Prevention and Treatment Program; Title XXI - Title XXI of the Social Security Act (Child Health Plan *Plus*)

Table 7.1 Primary Care Payment Reform Total Funds Summary						
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Total Impact of Initiative**	**Notes/Calculations**
A	FY 2017-18 Continuation of HB 16-1408 Primary Care Rate Increase	$54,085,240	$2,351,532	$0	$56,436,772	Table 7.2 Row I annualized for cash flow
B	FY 2018-19 Estimated Increase to Primary Care Funding with Payment Reform	$0	$58,062,151	$0	$58,062,151	Table 7.2 Row I
C	FY 2019-20 Estimated Increase to Primary Care Funding with Payment Reform	$0	$0	$59,055,014	$59,055,014	Table 7.2 Row I
D	Total Estimated Cost of Primary Care Rate Increase	$54,085,240	$60,413,683	$59,055,014		Row A + Row B + Row C

Table 7.2 Primary Care Payment Reform Fund Splits						
Row	**Item**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Percent of Fund Use					
B	*General Fund*	34.53%	34.85%	34.85%	34.85%	Based on expected utilization by eligibility of selected primary care codes.
C	*Cash Funds*	0.93%	1.73%	2.00%	2.53%	Based on expected utilization by eligibility of selected primary care codes.
D	*Federal Funds*	64.54%	63.42%	63.16%	62.63%	Based on expected utilization by eligibility of selected primary care codes.
E	Estimated Caseload Growth	N/A	4.76%	2.88%	1.71%	Growth between fiscal years in Table 6.4 Row Y
F	*General Fund*	$18,772,007	$19,665,555	$20,231,923	$20,577,889	FY 2016-17: Table 7.3 Row D General Fund; Else: (Previous year Row F) * Row E
G	*Cash Funds*	$506,879	$977,036	$1,159,202	$1,492,346	FY 2016-17: Table 7.3 Row D Cash Funds; Else: Row I * Row C
H	*Federal Funds*	$35,080,038	$35,794,181	$36,671,026	$36,984,779	FY 2016-17: Table 7.3 Row D Federal Funds; Else: Row I * Row D
I	**Primary Care Payment Reform Impact**	**$54,358,924**	**$56,436,772**	**$58,062,151**	**$59,055,014**	**FY 2016-17: Table 7.3 Row D Total Funds; Else: Row F / Row B**

Table 7.3 FY 2016-17 HB 16-1408 Fund Splits						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Percent of Fund Use	100.00%	34.53%	0.93%	64.54%	Estimated fund splits based on changes in FMAP
B	HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA" Primary Care Rate Increase	$55,694,236	$20,000,000	$556,859	$35,137,377	HB 16-1408, with General Fund in place of the Primary Care Provider Sustainability Fund
C	Impact of Update for Actual Utilization in FY 2015-16	($1,335,312)	($1,227,993)	($49,980)	($57,339)	Adjustment to expected expenditure based on actual utilization of these codes in FY 2015-16
D	Cost of the HB 16-1408 Primary Care Rate Increase without Immunization	$54,358,924	$18,772,007	$506,879	$35,080,038	Row B + Row C

Definitions:
FMAP - Federal Medical Assistance Percentage

Table 8.1 Vaccine Stock Rate Methodology Change Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	FY 2017-18 Estimated Impact to Vaccine Stock Costs	($994,353)	($250,958)	($32,899)	($710,496)	Table 8.2 Row E
B	FY 2018-19 Estimated Impact to Vaccine Stock Costs	($1,022,420)	($255,171)	($39,016)	($728,233)	Table 8.5 Row E
C	FY 2019-20 Estimated Impact to Vaccine Stock Costs	($1,048,261)	($262,303)	($49,379)	($736,579)	Table 8.8 Row E

Table 8.2 FY 2017-18 Vaccine Stock Fund Splits - Request Amount						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	($445,715)	$0	($24,514)	($421,201)	Table 8.3 Row A - Table 8.4 Row A
B	Children[1]	$4,492	$1,805	$0	$2,687	Table 8.3 Row B - Table 8.4 Row B
C	Elderly and Individuals with Disabilities	$27,107	$14,597	($1,043)	$13,553	Table 8.3 Row C - Table 8.4 Row C
D	All Other Adults	($580,237)	($267,360)	($7,342)	($305,535)	Table 8.3 Row D - Table 8.4 Row D
E	**Total Cost**	**($994,353)**	**($250,958)**	**($32,899)**	**($710,496)**	Row A + Row B + Row C + Row D

Table 8.3 FY 2017-18 Vaccine Stock Fund Splits - Estimated Costs with Vaccine Stock Rates Set Equal to CDC Price List						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,180,071	$0	$174,904	$3,005,167	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$354,255	$173,689	$0	$180,566	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$725,691	$348,977	$13,869	$362,845	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$1,740,909	$805,283	$40,811	$894,815	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$6,000,926**	**$1,327,949**	**$229,584**	**$4,443,393**	Row A + Row B + Row C + Row D

Table 8.4 FY 2017-18 Vaccine Stock Fund Splits - Estimated Costs at Current Vaccine Stock Rates						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,625,786	$0	$199,418	$3,426,368	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$349,763	$171,884	$0	$177,879	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$698,584	$334,380	$14,912	$349,292	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$2,321,146	$1,072,643	$48,153	$1,200,350	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$6,995,279**	**$1,578,907**	**$262,483**	**$5,153,889**	Row A + Row B + Row C + Row D

Footnotes:

1. Vaccine stock for children ages 0-18 are reimbursed through the Vaccines for Children program, and therefore total expenditure for children is lower than other categories.

Table 8.5 FY 2018-19 Vaccine Stock Fund Splits - Request Amount						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	($463,418)	$0	($30,122)	($433,296)	Table 8.6 Row A - Table 8.7 Row A
B	Children[1]	$4,692	$1,887	$0	$2,805	Table 8.6 Row B - Table 8.7 Row B
C	Elderly and Individuals with Disabilities	$28,315	$15,353	($1,196)	$14,158	Table 8.6 Row C - Table 8.7 Row C
D	All Other Adults	($592,009)	($272,411)	($7,698)	($311,900)	Table 8.6 Row D - Table 8.7 Row D
E	**Total Cost**	**($1,022,420)**	**($255,171)**	**($39,016)**	**($728,233)**	Row A + Row B + Row C + Row D

Table 8.6 FY 2018-19 Vaccine Stock Fund Splits - Estimated Costs with Vaccine Stock Rates Set Equal to CDC Price List						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,303,893	$0	$214,753	$3,089,140	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$364,494	$178,669	$0	$185,825	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$752,308	$360,252	$15,902	$376,154	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$1,801,139	$832,691	$42,786	$925,662	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$6,221,834**	**$1,371,612**	**$273,441**	**$4,576,781**	Row A + Row B + Row C + Row D

Table 8.7 FY 2018-19 Vaccine Stock Fund Splits - Estimated Costs at Current Vaccine Stock Rates						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,767,311	$0	$244,875	$3,522,436	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$359,802	$176,782	$0	$183,020	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$723,993	$344,899	$17,098	$361,996	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$2,393,148	$1,105,102	$50,484	$1,237,562	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$7,244,254**	**$1,626,783**	**$312,457**	**$5,305,014**	Row A + Row B + Row C + Row D

Footnotes:
1. Vaccine stock for children ages 0-18 are reimbursed through the Vaccines for Children program, and therefore total expenditure for children is lower than other categories.

Table 8.8 FY 2019-20 Vaccine Stock Fund Splits - Request Amount						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	($473,566)	$0	($40,253)	($433,313)	Table 8.9 Row A - Table 8.10 Row A
B	Children[1]	$4,796	$1,926	$0	$2,870	Table 8.9 Row B - Table 8.10 Row B
C	Elderly and Individuals with Disabilities	$29,032	$15,771	($1,255)	$14,516	Table 8.9 Row C - Table 8.10 Row C
D	All Other Adults	($608,523)	($280,000)	($7,871)	($320,652)	Table 8.9 Row D - Table 8.10 Row D
E	**Total Cost**	**($1,048,261)**	**($262,303)**	**($49,379)**	**($736,579)**	Row A + Row B + Row C + Row D

Table 8.9 FY 2019-20 Vaccine Stock Fund Splits - Estimated Costs with Vaccine Stock Rates Set Equal to CDC Price List						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,376,249	$0	$286,981	$3,089,268	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$371,969	$182,305	$0	$189,664	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$773,460	$370,051	$16,679	$386,730	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$1,846,457	$853,601	$43,753	$949,103	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$6,368,135**	**$1,405,957**	**$347,413**	**$4,614,765**	Row A + Row B + Row C + Row D

Table 8.10 FY 2019-20 Vaccine Stock Fund Splits - Estimated Costs at Current Vaccine Stock Rates						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,849,815	$0	$327,234	$3,522,581	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$367,173	$180,379	$0	$186,794	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$744,428	$354,280	$17,934	$372,214	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$2,454,980	$1,133,601	$51,624	$1,269,755	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$7,416,396**	**$1,668,260**	**$396,792**	**$5,351,344**	Row A + Row B + Row C + Row D

Footnotes:
1. Vaccine stock for children ages 0-18 are reimbursed through the Vaccines for Children program, and therefore total expenditure for children is lower than other categories.

Table 8.11 FY 2017-18 Vaccine Stock Total Expenditure Comparison

Procedure Code	Description[1]	FY 2017-18 Projected Utilization	FY 2017-18 Projected Expenditure Under Current Rates	FY 2017-18 Projected Expenditure Using CDC Price List	Difference
90715	Tetanus Shot	30,247	$2,439,663	$1,316,277	($1,123,386)
90378	Respiratory Syncytial Virus Prevention	445	$592,000	$614,966	$22,966
90746	Hepatitis B Vaccine	6,757	$488,397	$414,581	($73,816)
90649	Human Papillomavirus Vaccine	2,798	$447,042	$498,404	$51,362
90670	Pneumococcal Conjugate Vaccine	2,824	$394,829	$451,672	$56,843
90732	Influenza Virus Vaccine	3,727	$281,496	$294,690	$13,194
90686	Influenza Virus Vaccine	17,802	$277,585	$329,899	$52,314
90658	Influenza Virus Vaccine	18,937	$267,872	$273,500	$5,628
90651	Human Papillomavirus Vaccine	1,527	$241,458	$272,027	$30,569
90632	Hepatitis A Vaccine	3,125	$241,026	$209,564	($31,462)
	All Other Vaccines	35,050	$1,323,910	$1,325,345	$1,435
	Total of All Vaccines	**123,239**	**$6,995,278**	**$6,000,925**	**($994,353)**

Footnotes:
1. Vaccines that treat the same virus vary by brand, intended age range, as well as other factors

Table 8.12 FY 2017-18 Vaccine Stock Per Unit Expenditure Comparison

Procedure Code	Description[1]	FY 2017-18 Projected Utilization	FY 2017-18 Projected Price Per Unit Under Current Rates	FY 2017-18 Projected Price Per Unit Using CDC Price List	Difference
90715	Tetanus Shot	30,247	$80.66	$43.42	($37.24)
90378	Respiratory Syncytial Virus Prevention	445	$1,331.06	$1,379.60	$48.54
90746	Hepatitis B Vaccine	6,757	$72.28	$61.22	($11.06)
90649	Human Papillomavirus Vaccine	2,798	$159.75	$177.70	$17.95
90670	Pneumococcal Conjugate Vaccine	2,824	$139.80	$159.57	$19.77
90732	Influenza virus Vaccine	3,727	$75.54	$78.90	$3.36
90686	Influenza virus Vaccine	17,802	$15.59	$18.49	$2.90
90658	Flu Vaccine	18,937	$14.15	$14.41	$0.26
90651	Human Papillomavirus Vaccine	1,527	$158.09	$177.70	$19.61
90632	Hepatitis A Vaccine	3,125	$77.13	$66.91	($10.22)
	All Other Vaccines	35,050	$37.77	$37.73	($0.04)

Footnotes:
1. Vaccines that treat the same virus vary by brand, intended age range, as well as other factors

Table 9.1 Behavorial Health Incentive Payment Fund Split Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	FY 2017-18 Estimated Cost of Behavioral Health Incentive Payments	$0	$0	$0	$0	The Department would not pay out incentive payments until after the fiscal year closes, so does not anticipate payments in FY 2017-18
B	FY 2018-19 Estimated Cost of Behavioral Health Incentive Payments	$26,717,069	$7,215,319	$1,090,836	$18,410,914	Table 10.2 Row B * -1
C	FY 2019-20 Estimated Cost of Behavioral Health Incentive Payments	$28,131,120	$7,503,004	$1,306,187	$19,321,929	Table 10.3 Row B * -1

Table 10.1 FY 2016-17 Technical Adjustments Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Savings from EAPG Methodology for Outpatient Services	($15,440,295)	($7,720,148)	$0	($7,720,147)	See Narrative, Pages 8-9
B	Savings from Expected 4% Reduction in Capitation Rates	$0	$0	$0	$0	
C	Total Impact of Behavioral Health Payment Reform	($15,440,295)	($7,720,148)	$0	($7,720,147)	Row A + Row B

Table 10.2 FY 2017-18 Technical Adjustments Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Savings from EAPG Methodology for Outpatient Services	($23,160,443)	($11,580,222)	$0	($11,580,221)	See Narrative, Pages 8-9
B	Savings from Expected 4% Reduction in Capitation Rates	($26,717,069)	($7,215,319)	($1,090,836)	($18,410,914)	Table 10.5 Row AC
C	Total Impact of Behavioral Health Payment Reform	($49,877,512)	($18,795,541)	($1,090,836)	($29,991,135)	Row A + Row B

Table 10.3 FY 2018-19 Technical Adjustments Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Savings from EAPG Methodology for Outpatient Services	($23,160,443)	($9,769,075)	$0	($13,391,368)	See Narrative, Pages 8-9
B	Savings from Expected 4% Reduction in Capitation Rates	($28,131,120)	($7,503,004)	($1,306,187)	($19,321,929)	Table 10.5 Row AC
C	Total Impact of Behavioral Health Payment Reform	($51,291,563)	($17,272,079)	($1,306,187)	($32,713,297)	Row A + Row B

Table 10.4 FY 2019-20 Technical Adjustments Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Savings from EAPG Methodology for Outpatient Services	($23,160,443)	($7,645,263)	$0	($15,515,180)	See Narrative, Pages 8-9
B	Savings from Expected 4% Reduction in Capitation Rates	($28,536,463)	($7,609,325)	($1,569,344)	($19,357,794)	Table 10.5 Row AC
C	Total Impact of Behavioral Health Payment Reform	($51,696,906)	($15,254,588)	($1,569,344)	($34,872,974)	Row A + Row B

Definitions:

EAPG - Enhanced Ambulatory Patient Grouping

Table 10.5 Technical Adjustment: Behavorial Health Payment Reform 4% Reduction in Capitation Rates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Population of Elderly Individuals on Medicaid	44,137	44,870	45,539	See Narrative
B	Behavioral Health Per Capita	$222.72	$225.36	$225.36	See Narrative
C	4% of Behavioral Health Per Capita	($8.91)	($9.01)	($9.01)	Row B * .04 * -1
D	Savings for Elderly Individuals	($393,261)	($404,279)	($410,306)	Row A * Row C
E	Population of Individuals with Disabilities on Medicaid	89,039	91,656	93,755	See Narrative
F	Behavioral Health Per Capita	$1,671.84	$1,709.16	$1,709.16	See Narrative
G	4% of Behavioral Health Per Capita	($66.87)	($68.37)	($68.37)	Row F * .04 * -1
H	Savings for Individuals with Disabilities	($5,954,038)	($6,266,521)	($6,410,029)	Row E * Row G
I	Population of Non-Expansion Adults on Medicaid	216,113	221,353	224,112	See Narrative
J	Behavioral Health Per Capita	$345.84	$353.76	$353.76	See Narrative
K	4% of Behavioral Health Per Capita	($13.83)	($14.15)	($14.15)	Row J * .04 * -1
L	Savings for Non-Expansion Adults on Medicaid	($2,988,843)	($3,132,145)	($3,171,185)	Row I * Row K
M	Population of Expansion Parents on Medicaid	108,821	116,361	125,235	See Narrative
N	Behavioral Health Per Capita	$189.96	$194.28	$194.28	See Narrative
O	4% of Behavioral Health Per Capita	($7.60)	($7.77)	($7.77)	Row N * .04 * -1
P	Savings for Expansion Parents	($827,040)	($904,125)	($973,076)	Row M * Row O
Q	Population of Expansion Adults on Medicaid	391,871	406,112	408,671	See Narrative
R	Behavioral Health Per Capita	$634.32	$648.96	$648.96	See Narrative
S	4% of Behavioral Health Per Capita	($25.37)	($25.96)	($25.96)	Row R * .04 * -1
T	Savings for Expansion Adults	($9,941,767)	($10,542,668)	($10,609,099)	Row Q * Row S
U	Population of Children on Medicaid	571,582	582,667	591,092	See Narrative
V	Behavioral Health Per Capita	$236.04	$241.44	$241.44	See Narrative
W	4% of Behavioral Health Per Capita	($9.44)	($9.66)	($9.66)	Row V * .04 * -1
X	Savings for Children	($5,395,734)	($5,628,563)	($5,709,949)	Row U * Row W
Y	Population of Foster Care on Medicaid	20,290	20,305	20,305	See Narrative
Z	Behavioral Health Per Capita	$1,498.80	$1,542.60	$1,542.60	See Narrative
AA	4% of Behavioral Health Per Capita	($59.95)	($61.70)	($61.70)	Row Z * .04 * -1
AB	Savings for Foster Care	($1,216,386)	($1,252,819)	($1,252,819)	Row Y * Row AA
AC	Total Estimated Cost of 4% Increase to Capitation Rates	($26,717,069)	($28,131,120)	($28,536,463)	Row D + Row H + Row L + Row P + Row T + Row X + Row AB

FTE Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- New full-time General Fund positions are reflected in Year 1 as 0.9166 FTE to account for the pay-date shift. This applies to personal services costs only; operating costs are not subject to the pay-date shift.

Expenditure Detail		FY 2018-19		FY 2019-20	
Personal Services:					
Classification Title	Monthly Salary	FTE		FTE	
Rate/Financial Analyst IV	$5,005	0.9	$55,051	1.0	$60,060
PERA			$5,588		$6,096
AED			$2,753		$3,003
SAED			$2,753		$3,003
Medicare			$798		$871
STD			$105		$114
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1, 1.0 FTE		**0.9**	**$74,975**	**1.0**	**$81,074**
Classification Title	Monthly Salary	FTE		FTE	
Analyst IV	$5,005	2.7	$165,153	3.0	$180,180
PERA			$16,763		$18,288
AED			$8,258		$9,009
SAED			$8,258		$9,009
Medicare			$2,395		$2,613
STD			$314		$342
Health-Life-Dental			$23,782		$23,782
Subtotal Position 2, 3.0 FTE		**2.7**	**$224,923**	**3.0**	**$243,223**
Classification Title	Monthly	FTE		FTE	
Administrator IV	$5,005	0.9	$55,051	1.0	$60,060
PERA			$5,588		$6,096
AED			$2,753		$3,003
SAED			$2,753		$3,003
Medicare			$798		$871
STD			$105		$114
Health-Life-Dental			$7,927		$7,927
Subtotal Position 3, 1.0 FTE		**0.9**	**$74,975**	**1.0**	**$81,074**
Subtotal Personal Services		4.6	**$374,873**	5.0	**$405,371**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	4.6	$2,292	5.0	$2,500
Telephone Expenses	$450	4.6	$2,062	5.0	$2,250
PC, One-Time	$1,230	5.0	$6,150		
Office Furniture, One-Time	$3,473	5.0	$17,365		
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$27,869**		**$4,750**
TOTAL REQUEST		4.6	**$402,742**	5.0	**$410,121**
	General Fund:		*$201,371*		*$205,061*
	Cash funds:		*$0*		*$0*
	Reappropriated Funds:		*$0*		*$0*
	Federal Funds:		*$201,371*		*$205,061*

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-07 Oversight of State Resources

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$6,866,975,675**	**$0**	**$6,802,474,032**	**$1,486,941**	**$1,979,221**
	FTE	400.3	0.0	400.6	13.2	14.0
	GF	$1,959,212,915	$0	$1,962,559,203	($1,658,036)	($1,534,694)
	CF	$711,296,978	$0	$684,014,029	$100,685	$70,716
	RF	$6,994,451	$0	$6,999,546	$0	$0
	FF	$4,189,471,331	$0	$4,148,901,254	$3,044,292	$3,443,199

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (A) General Administration - Personal Services	**Total**	**$29,707,221**	**$0**	**$29,797,905**	**$832,311**	**$881,836**
	FTE	400.3	0.0	400.6	13.2	14.0
	GF	$10,211,448	$0	$10,355,331	$415,282	$440,740
	CF	$2,994,337	$0	$2,952,905	$31,170	$31,170
	RF	$1,564,801	$0	$1,566,597	$0	$0
	FF	$14,936,635	$0	$14,923,072	$385,859	$409,926
01. Executive Director's Office, (A) General Administration - Health, Life, and Dental	**Total**	**$3,434,070**	**$0**	**$3,673,458**	**$103,052**	**$103,052**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,230,952	$0	$1,316,506	$46,079	$46,079
	CF	$337,577	$0	$349,778	$3,964	$3,964
	RF	$104,755	$0	$104,635	$0	$0
	FF	$1,760,786	$0	$1,902,539	$53,009	$53,009

01. Executive Director's Office, (A) General Administration - Short-term Disability	**Total**	**$55,072**	**$0**	**$57,991**	**$1,278**	**$1,360**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$20,569	$0	$21,560	$571	$611
	CF	$4,588	$0	$4,796	$53	$53
	RF	$1,393	$0	$1,365	$0	$0
	FF	$28,522	$0	$30,270	$654	$696
01. Executive Director's Office, (A) General Administration - Amortization Equalization Disbursement	**Total**	**$1,434,489**	**$0**	**$1,613,687**	**$33,679**	**$35,835**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$535,695	$0	$600,009	$14,997	$16,074
	CF	$119,586	$0	$133,459	$1,397	$1,397
	RF	$36,269	$0	$37,816	$0	$0
	FF	$742,939	$0	$842,403	$17,285	$18,364
01. Executive Director's Office, (A) General Administration - Supplemental Amortization Equalization Disbursement	**Total**	**$1,419,546**	**$0**	**$1,613,662**	**$33,679**	**$35,835**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$530,115	$0	$600,009	$14,997	$16,074
	CF	$118,340	$0	$133,459	$1,397	$1,397
	RF	$35,891	$0	$37,791	$0	$0
	FF	$735,200	$0	$842,403	$17,285	$18,364
01. Executive Director's Office, (A) General Administration - Operating Expenses	**Total**	**$2,058,538**	**$0**	**$2,035,574**	**$60,142**	**$13,112**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$930,699	$0	$923,963	$27,020	$5,856
	CF	$71,522	$0	$67,439	$2,827	$475
	RF	$10,449	$0	$10,449	$0	$0
	FF	$1,045,868	$0	$1,033,723	$30,295	$6,781
01. Executive Director's Office, (A) General Administration - General Professional Services and Special Projects	**Total**	**$7,200,237**	**$0**	**$7,975,237**	**$1,621,365**	**$1,469,748**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,047,261	$0	$2,622,261	$510,683	$434,874
	CF	$1,527,500	$0	$1,227,500	$300,000	$300,000
	RF	$0	$0	$0	$0	$0
	FF	$3,625,476	$0	$4,125,476	$810,682	$734,874

	Total	**$3,401,907**	**$0**	**$2,813,406**	**$204,000**	**$204,000**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (F) Provider Audits and Services - Professional Audit Contracts	GF	$1,266,408	$0	$1,119,283	$102,000	$102,000
	CF	$415,408	$0	$312,420	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,720,091	$0	$1,381,703	$102,000	$102,000
	Total	**$6,818,264,595**	**$0**	**$6,752,893,112**	**($1,402,565)**	**($765,557)**
	FTE	0.0	0.0	0.0	0.0	0.0
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	GF	$1,942,439,768	$0	$1,945,000,281	($2,789,665)	($2,597,002)
	CF	$705,708,120	$0	$678,832,273	($240,123)	($267,740)
	RF	$5,240,893	$0	$5,240,893	$0	$0
	FF	$4,164,875,814	$0	$4,123,819,665	$1,627,223	$2,099,185

CF Letternote Text Revision Required?	Yes	X	No	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes		No	X
FF Letternote Text Revision Required?	Yes		No	X
Requires Legislation?	Yes		No	X

Type of Request? Department of Health Care Policy and Financing Prioritized Request

Interagency Approval or Related Schedule 13s: Department of Human Services

Cost and FTE

- The Department requests $1,567,569 total funds, including a reduction of $1,577,408 General Fund, and 14.1 FTE in FY 2017-18, and $2,061,245 total funds, a reduction of $1,452,670 General Fund, and 15.0 FTE in FY 2018-19 ongoing to provide increased stewardship of State resources as required by outside compliance actions and recommended in industry best practices.

Current Program

- The Department manages a budget of approximately $9 billion for over 1.3 million Medicaid members. The Department is responsible for correctly processing medical claims, setting payment rates for services, working with stakeholder and providers to determine members benefit packages, improve member health outcomes and ensuring that all payments and members are eligible for programs under state and federal law.

Problem or Opportunity

- The Department has identified several operational issues and opportunities to improve oversight that it hopes to address in FY 2017-18 that fall into two categories: compliance actions and industry best practices. They range from verifying member assets to coordinating health services with the federal government. These issues are diverse and interconnected but have a common theme; not addressing these issues hinders the ability of the Department to be a sound financial steward of taxpayer resources.

Consequences of Problem

- If the Department does not address the compliance issues it risks being out of compliance with federal law and State Auditor recommendations. Being out of compliance with federal law may result in the withholding of federal funds.
- If the Department does not implement the best practices, it risks losing opportunities to capture cost savings from the proposed initiatives and increases the risk of mismanagement of state resources.

Proposed Solution

- The Department has identified nine initiatives that would increase the oversight of State resources.
- Of the initiatives, three are related to compliance with outside mandates, including: implementation of an asset verification program; an evaluation of the Department's Consumer Directed Care programs; and, proper maintenance of the Department's audit tracking database.
- The remaining initiatives are related to adhering to best practice to allow for proper oversight of the Department's program, including: hiring dedicated project management staff; performing annual audits of Community Mental Health Centers, increasing the Department's resources related to maintaining member and provider integrity; coordinating services for American Indians and Alaskan Natives; increasing the Department's resources related to the development and monitoring of the Hospital Provider Fee model; and, providing a dedicated benefit manager and updating provider rates for office administered drugs.

Department Priority:	***R-7***
Request Detail:	***Oversight of State Resources***

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Oversight of State Resources	$1,567,569	($1,577,408)

Problem or Opportunity:

The Department has been appropriated approximately $9 billion to provide services to eligible members; this represents the largest single agency budget for the entire State. Given the size of the Department's budget, proper oversight is critical to ensuring that members are receiving the services that they need and that taxpayers are getting sufficient returns on the use of these funds. As part of the Department's focus on continual improvement to provide sound financial review, the Department has identified several compliance and best practices issues that limit the Department's ability to provide necessary oversight over State resources. The Department has classified each issue as either a compliance or best practices initiative. Compliance initiatives are needed to comply with federal law or State Auditor recommendations; best practices initiatives are improvements that have been identified by internal staff that increase oversight of State resources, improve Department transparency, improve stakeholder relationships and provide cost effective care to Medicaid members. Each issue is described below, along with the proposed solution.

Proposed Solution:

The Department requests $1,567,569 in total funds, including a reduction of $1,577,408 in General Fund, and 14.1 FTE in FY 2017-18, $2,061,245 in total funds, a reduction of $1,452,670 General Fund and 15.0 FTE in FY 2018-19 and ongoing in order to provide adequate oversight resources for both contracted services and State FTE. The Department will use those resources to:

- Deploy an electronic asset verification program
- Evaluate the consumer directed care services offered by Medicaid
- Develop a robust audit tracking and reporting database
- Create a centralized Project Management Office
- Audit the cost reports of every Community Mental Health Center
- Increase the number of provider and member investigators
- Increase coordination of care between the federal Indian Health Services, Medicaid, the Office of Behavioral Health, and the Colorado Commission on Indian Affairs
- Provide necessary FTE and contract resources for the Hospital Provider Fee

- Hire a dedicated benefit manager for office administered drugs and raise the average rates for this class of drugs to 2.5% above average sale price.

Compliance Initiatives

Asset Verification Program

The Department requests $529,183 total funds including $264,592 General Fund in FY 2017-18 and $858,366 total funds, $429,183 General Fund in ongoing funding for an electronic asset verification contract in order to comply with federal regulations passed as part of the Federal Supplemental Appropriations Act of 2008. The Department also anticipates needing $100,000 total funds, $50,000 General Fund in supplemental funding in FY 2016-17 for this program. The Department asks for roll forward authority for this funding to provide flexibility for any possible delays in FY 2016-17.

The Federal Supplemental Appropriations Act modifies section 1940 of the Social Security Act and requires every state to create a Medicaid Asset Verification Program (AVP) that automatically and electronically verifies the liquid assets of aged, blind, and disabled applicants for Medicaid. Electronic Asset Verification Systems are already in place in several states and an AVP is used by the Social Security Administration for Social Security Insurance (SSI) benefits. Colorado's existing asset verification program requires Coloradans who apply for Medicaid due to age or a disability to list all assets on their application. This information must be provided in the initial application for Medicaid and during the redetermination process in order to qualify for Medicaid. Eligibility workers verify the listed assets from the application and members have ten business days to provide supporting documents for those assets in order to complete the application and redetermination process. If the member provides the documentation, the information is validated and updated within the Colorado Benefits Management System (CBMS) to determine eligibility. If the individual fails to provide the required asset documentation, they are denied enrollment into Medicaid.

In obtaining this information, counties are currently limited to paper sources provided by the applicant since banks do not accept signed Medicaid applications as authorization to obtain information. Additionally, obtaining this information can frequently pose a challenge for eligibility workers because members may not always understand the request or may not be able to provide a timely response to maintain eligibility.

Federal regulations previously required that Medicaid verify the assets through a credible electronic data source or through paper documentations such as bank statements, however, these requirements changed with passage of the Federal Supplemental Appropriations Act of 2008 which required an electronic verification system be in place. Although this mandate occurred in 2008 with targeted implementation date between 2009 and 2013, very few states have implemented an electronic AVP. Many states, like Colorado, encountered initial challenges in trying to establish policies and processes with financial institutions to meet this requirement. In addition, the Centers for Medicare and Medicaid Services (CMS) encouraged states to prioritize changes to state eligibility systems required under the Affordable Care Act over AVP implementation. In November 2015 the Department received a letter from the Centers for Medicare and Medicaid Services (CMS) requesting a work plan and timeline detailing how the State would fully implement an AVP. On December 31, 2015 the Department submitted a response to CMS that detailed the timeline for coming into compliance with section 1940, which included a planned request for funding from the Colorado General Assembly for FY 2017-18.

In June 2016, the Department was informed by CMS that Colorado was one of several states that has failed to make a good faith effort to implement the AVP requirement. CMS warned that without prompt action CMS would institute a corrective action plan. To avoid this corrective action plan, the Department must implement the program by December 2017. This notification has moved up the Department's original implementation date and timeline from March 2018 to December 2017. In order to meet the December 2017 deadline, the Department needs to award a contract in April 2017 and has prepared an estimate of $100,000 in FY 2016-17 costs related to this contract. Without funding, the Department will be put on a corrective action plan from CMS as well as other possible consequences such as the reduction of Federal Financial Participation (FFP).

The Department requests funding to hire a contractor to provide automatic electronic asset verification services for Medicaid programs that require an asset test. This vendor would have agreements with financial services institutions to be able to electronically confirm liquid assets, held by the applicant, in financial institutions (checking & savings accounts, certificates of deposits, etc.). Applicant information would be provided to the vendor, through CBMS, for new applications and during the redetermination process. The Department has reviewed proposal that were submitted for other states' AVP program have used that information to estimate the cost of implementing a program in Colorado. These estimates are detailed in Table 6.2 and 6.3. This estimate is a services-only estimate and does not include the cost of Colorado system changes. The required system changes will be absorbed using existing CBMS pool hours and therefore does not require additional funding.

In addition to the benefit of being in compliance with federal law, an electronic AVP would reduce the number of paper records that need to be submitted for Medicaid programs that have an asset test. The Department predicts efficiency improvements with an AVP with liquid asset verification since the AVP minimizes the need for paper documentation and allows for real-time information during eligibility determination. One state that recently implemented an AVP found that the program cut down the number of instances of members needing to submit paper document. If a member did not have any other assets, the Department estimates that the time needed to process an application could decrease by approximately 20 days using an AVP. This decrease in application time would allow members with simpler finances to start receiving services closer to the date of application and help eligibility sites meet the federally required 90 day determination timeline for non-MAGI (Modified Adjusted Gross Income) populations.

Consumer Directed Care Evaluation

The Department requests $422,000 total funds, including $211,000 General Fund in FY 2017-18 in order to hire an independent contractor to complete an analysis of Consumer Directed Services like Consumer-Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS) programs. The requested analysis would serve as the Department's response to a May 2015 audit from the Office of the State Auditor which recommended the Department look at the benefits, health outcomes achieved, and costs of CDASS compared to other service delivery options. A comprehensive analysis that includes both CDASS and IHSS would allow the Department to better understand cost drivers, member outcomes and possible areas for program improvement.

CDASS gives Home and Community Based Services (HCBS) waiver members the ability to direct and manage the attendants who provide personal care, homemaker and health maintenance services, rather than working through an agency. The following Home and Community Based Services (HCBS) waivers offer, or are in the process of offering, CDASS: Brain Injury (HCBS-BI), Spinal Cord Injury (HCBS-SCI), Elderly, Blind and Disabled (HCBS-EBD), Community Mental Health Supports (HCBS-CMHS), and Supported Living Services (HCBS-SLS). CDASS allows members to hire attendants who they may already know and who have been trained to provide the services, but who may not be licensed to provide skilled services through a home health agency. These services allow members to have more control over managing their services which can be especially beneficial to members in rural areas that may live far from a home care agency. Additionally, access to CDASS could improve a member's quality of life by empowering them to select, train, and manage the attendants of their choice and to have more control in scheduling their services.

In-Home Support Services (IHSS) also allows members to receive health maintenance, homemaker and personal care services in the community through attendants that the member choses. The significant difference in program is that IHSS attendants work through home health agencies to provide care rather than directly for the member. The member exercises employer authority but does not have budget authority under IHSS. These services are currently offered in the Spinal Cord Injury (HCBS-SCI), Elderly, Blind and Disabled (HCBS-EBD) and the Children's Home and Community Based Services (HCBS-CHBS) waivers.

In May 2015, the Office of the State Auditor recommended that "…the Department of Health Care Policy and Financing conduct a comprehensive analysis of the Consumer-Directed Attendant Support Services Program, including the benefits, health outcomes achieved, and costs compared to other service delivery options". However, the Department has neither the resources nor the expertise to conduct this analysis internally. Because expansion of the program to the HCBS-SLS waiver is currently pending approval from the Centers for Medicare and Medicaid Services (CMS), it is especially important that the Department fully understand the benefits, drawbacks, and changes in health outcomes offered by the program. An independent contractor could objectively show how the CDASS and IHSS programs could continue to serve the unmet needs of waiver members in a financially responsible manner.

The Department is requesting funding to hire a contractor to perform the following tasks:

- Develop an appropriate methodology to select a representative sample of survey participants.
- Create a survey instrument and survey methodology.
- Conduct cost analysis of CDASS and IHSS programs versus other agency based care.
- Perform data analysis examining costs of different service delivery methods.
- Combine survey results with claims data to gather a sense of financial and health outcomes associated with CDASS and IHSS participation.
- Provide the Department with monthly status updates.
- Present information and deliverables to CDASS and IHSS stakeholder groups.
- Design the analysis so that the study is comparable to other CDASS and IHSS analyses which have been performed by other states.

The Department envisions that the contractor would be able to quantify the impact CDASS and IHSS programs have had in health status or outcomes, quality of life of the members, member independence, and service satisfaction vs other care options. The Department also wants to quantify these benefits given the direct costs currently associated with CDASS and IHSS. The Department hopes to use the findings of this analysis to help direct future decisions on integrating Consumer Direct Services into other Medicaid benefits, such as respite services.

Audit Database

The Department requests $70,182 total funds, $35,091 General Fund in FY 2017-18 to correct, transition and modernize the Department's Audit Database. The Department also requests $11,382 total funds, $5,691 General Fund in ongoing funding to maintain software licenses.

The Department's Audit Database documents audit findings and the Department's mitigation efforts. The Department cannot effectively or efficiently fulfill the Office of the State Auditor's (OSA's) requirement to track the status of audit findings and recommendations because the reporting functionality of the Audit Database is partially inoperative. This occurred because part of the reporting functionality was unable to be preserved when the Department transitioned the underlying software from Microsoft Access to Microsoft SharePoint at the beginning of FY 2014-15. The transition to Microsoft SharePoint was necessary because the database had outgrown the storage limitations of Microsoft Access. The Department had previously requested funding for the Database in 2015-16 S-8, BA-8 "Legacy Systems and Technology Support" but JBC staff did not recommend the funding, instead recommending that the Department work with Governor's Office of Information Technology (OIT) to use existing operating funding to fix the database. In response, the Department has included the project as part of the Health Information Technology (HIT) projects list that the Department works on with OIT to prioritize IT projects. The project was given a low prioritization score due to unsecured funding, limited state wide impact of the project and the relative importance of other existing projects already in the queue. The project has also changed from a Microsoft SharePoint platform to a Salesforce platform based on feedback from OIT; this has resulted in a change in the cost estimate when compared to the database proposed in S-8, BA-8. The Department's goal is that with dedicated, secured funding, the database would move up in prioritization and become operational early in FY 2017-18. The Department anticipates that these expenses would have a startup cost of $70,182 and have ongoing costs of $11,382. See Table 10.2 for a breakdown of the costs.

Best Practices Initiatives

Project Management Staff

The Department requests $202,436 total funds, including $88,578 General Fund in FY 2017-18 and ongoing for 3.0 project management positions. These positions would provide necessary project management services for the Department as it continues to manage large and medium scale projects like Accountable Care Collaborate (ACC) Phase II. Additionally, project management resources will allow the department to better align with Centers Medicare and Medicaid Services (CMS) Medicaid Enterprise Life Cycle (MECL) and Medicaid Information Technology Architecture (MITA) frameworks.

Project management techniques helps organizations carry out projects on time, on budget, and with minimal disruption to the rest of the work of the organization. Many of the Department's projects involve large-scale

planning that affects every Office in the Department multiple program areas within the Department. When the Department implements programmatic changes in Medicaid, CHP+, or Office of Community Living these projects may mean dealing with multiple divisions within the Department like budget, accounting, human resources, communications, and systems. Accredited and trained project managers are skilled in project management techniques specific to dealing with organizing and managing these one-time projects. They can create plans to manage interdependence and address resource conflict. Organizations that use project management to monitor and control processes and schedules can more effectively complete their projects on time and on budget.

MECL and MITA are frameworks that have been created by CMS that fosters a project management mindset with an integrated business, information and technological approach to building management systems that are member-based and capable of sharing information across organizational silos based upon nationally recognized standards. MITA is most clearly visible in how CMS governs IT projects and associated business process need to be set up in order to receive enhanced federal funding that is typically associated with Medicaid technology projects like the Medicaid Management Information System (MMIS). This framework governs how states interact with CMS through the implementation, development, maintenance and operations stages of a technology system's life. While the focus on MECL and MITA are IT systems driven, CMS views MITA as a framework that applies to all of the Department's Medicaid business processes that interact with these system and impacts policy, financial operations and process design.

An example of a project that has MITA implications is Accountable Care Collaborate (ACC) re-procurement. For this project, the project manager is not overseeing an information technology project, but is responsible for assuring work on the design, drafting, and implementation of the solicitation is on time and work is done appropriately. Specifically the project manager is tasked to:

- Maintain the project work plan, timeline(s), action items lists, daily task lists, and issue log using project management software.
- Develop a reporting mechanism and reports in order to track and communicate the status, risks and accomplishments to Department leadership, staff, and external stakeholders.
- Monitor and verify milestones and completion dates contained in any staffer's project management.
- Assign work, monitor progress, and renegotiate problem resolution, so that each stage of the ACC re-procurement and implementation is completed on time.
- Assure that Department staff are not independently duplicating effort on tasks, but are working in a unified manner.
- Coordinate all work groups writing sections of the solicitation and shall coordinate with the Department's Purchasing and Contracting Services Section to assure the proposed drafts are drafted and reviewed for inclusion in the final solicitation.
- Present to senior leadership, updating it on project status and issues.
- Provide recommendations and guidance in addressing stakeholder concerns, from identification through resolution.
- Assist in monitoring budgets related to the work plan.

Because the Department did not have accredited, trained, and dedicated project management resources available, the Department will pay more than $200,000 per fiscal year for a project manager on this project. In addition, the Department continues to ask for resources through individual budget requests to manage the transition of vendors when large contracts are transitioned to another vendor. The Department believes that with additional resources and a central Project Management Office (PMO), the Department would not have needed the contracted project management resources and that future vendor transitions would require less additional resources.

The Department currently has two project management units in the Department's Health Information Office (HIO) which provide necessary project management services in accordance with CMS MECL, MITA framework and industry best practices; one unit is focused on eligibility projects and cross functional projects, with the other unit primarily being focused on the Department's Colorado Medicaid Management Innovation and Transformation (COMMIT) Project. The goal of the COMMIT Project is to redefine systems and business processes for the Medical Assistance program by procuring technical and business services to replace the legacy MMIS model with a service delivery model and modern system. The Department's COMMIT-focused project management unit currently has a team of six project management professionals (ranging from program assistants to certified project managers) who are responsible for ensuring that project is in compliance with the MECL framework, which is a requirement for CMS certification of the MMIS, in order to ensure continuing enhanced funding for MMIS development and operations. Furthermore, future changes or enhancement to the MMIS system will require adherence to these frameworks. This includes new additions and modifications to the MMIS that are the result of new programs or benefits proposed by the Department or included in legislation proposed by the General Assembly.

The Department has already seen the benefits of including the services of project management staff in these technology based projects and in private and federal grants, which has resulted in better coordination between different areas of the Department as those areas satisfy the terms and expectations of these projects. Based on this experience, the Department is proposing merging these two units into a central PMO and supplementing the number of project managers as part of this request. The Department expects similar efficiency improvements from a dedicated PMO as it implements the ACC Phase II, the State Innovation Model (SIM), HCBS waiver consolidation, implementation of Community Living Advisory Group recommendations and other large scale and medium scale projects that broadly affect the Department.

CMS has further emphasized the importance of project management by granting 90% federal financial participation (FFP) for project management positions used in the Design, Development and Implementation (DDI) and 75% FFP for Maintenance and Operations funding related to the MMIS. Currently four of the six project management positions in the COMMIT focused project management unit are dependent on 90% FFP and would need to be eliminated when that funding expires in June 2017. The Department currently would only be able to hire temporary employees to fill these job duties when the enhanced funding from DDI expires without an additional appropriation from the General Assembly. This would represent a sizeable amount of knowledge drain from the Department which would take years to rebuild, especially knowledge related to MECL and MITA frameworks. The Department believes that due to the need to adapt to new systems, new health benefits, eligibility changes, new programs, new state processes and new federal mandates that the Department would benefit from an increase in the use of project management principals provided by trained

project managers. The Department expects that given Department's strategic policies, of providing innovative delivery systems, implementing value based payments and adapting new health technologies, dedicated project managers are key to ensuring that the Department is able to successfully accomplish these goals, on time and within budgets. Because these positions have a large overlap with MITA, which is an enterprise-wide initiative for the improvement of Medicaid management, the Department believes that their responsibilities could be structured so that the positions would be eligible to receive some 75% FFP from CMS but still provide project management value to other non-system based areas of the Department, such as the Office of Community Living, Finance Office and the Health Programs Office. In order to claim the 75% FFP rate the Department would need these positions to time track and the Department has included Clarity time tracking licenses as part of the request. The Department assumes that 25% of the PMO's time will be spent on MMIS projects that qualify for 75% FFP and 75% would be on activities that are eligible 50% FFP, resulting in a blended rate of 56.25%. The Department's FTE cost estimate can be found in Table 2.1. For further detail on position descriptions see Appendix A below.

Community Mental Health Centers Audits

The Department requests ongoing funding of $204,000 in total funds, $102,000 General Fund in FY 2017-18 and ongoing to support yearly audits of cost reports for all 17 Community Mental Health Centers (CMHCs) in Colorado in order to ensure correct capitations payments are made to the Behavioral Health Organization (BHO), who manage the Department's community behavioral health services.

Community behavioral health services provide comprehensive mental health and substance use disorder services to all Colorado Medicaid members. A member is assigned to a BHO based on where the member lives. The BHO arranges for the member to get medically necessary behavioral health services, like therapy or medications. The Department funds behavioral health services through capitation payments to BHOs who provide care coordination and are responsible for paying for the member care provided by the CMHCs and other behavioral health providers. The BHO capitation payments are largely based on costs incurred and reported by the CMHCs in their yearly cost reports, as the CMHC provide a majority of the mental health and substance use disorder services to all Colorado Medicaid members. Recent results from an audit of the four largest CMHCs found $12 million of incorrectly reported costs that flow directly into the BHO rate calculation. These incorrectly reported costs artificially increase the amount of the BHO capitation payment by inflating the true and allowable costs experienced by the CMHC, who received cost based sub capitation rates from the BHO.

Currently the Department is using audit funding approved in the Department's FY 2015-16 "R-15 Managed Care Organization Audits" request to audit four to eight CMHCs each year. This request also included funding for conducting a thorough review of current managed care contract language to identify weaknesses, providing guidance to the Department with implementing medical loss ratios across all managed care plans, using selected algorithms on claims data of one or more managed care plans to identify outlier populations that could be at risk of overpayment and testing identified outlier populations to ensure compliance with regulations for allowable medical expenses. Based on the results of the audit the Department believes it is in the State's best interest to audit every CMHC's cost report on a yearly basis. However, there are not enough existing resources to pay for the increase in CMHC audits and still provide the other services that were included in the Department's 2015-16 request.

Other providers are also paid rates based on costs such as Federal Qualified Health Centers (FQHC) and Rural Health Centers (RHC). All FQHC's financial cost reports are audited on a yearly basis. Without an in-depth analysis to ensure the reported charges are both reasonable and allowable, the Department risks over payment for services provided to Medicaid members under BHO contracts. These overpayments may put the Department at risk for disallowance of federal funds by the Centers for Medicare and Medicaid Services (CMS).

The Department requests funding to hire an auditor to conduct a thorough financial review of all CMHC cost reports, on an annual basis, to ensure that all capitation payments represent the true cost of delivering services. The Department has prepared an estimate in table 6.2.

At a minimum the auditor would need to review cost reports submitted by the CMHCs and would be responsible for:

- Determining allowable costs per the Mental Health Accounting and Auditing Guidelines.
- Evaluating the allocation of costs between the relative value unit (RVU) and the non-relative value unit cost centers.
- Proposing adjustments to the cost report and send proposed adjustments to the CMHCs for review.
- Reviewing the CMHCs response(s) to propose adjustments and make modification to cost reports, as necessary.

After reviewing the cost reports, the auditor would provide an adjusted cost report to the Department. The adjusted cost report would then be used by the Department's Payment Reform Division to calculate the new BHO capitation rates, which are then sent to CMS for approval.

Though the Department cannot guarantee savings would result from audit findings, savings could result from avoidance of future overpayments in BHO capitations. Ensuring proper payment for services aligns with the Department's performance plan by ensuring sound stewardship of financial resources and are consistent with other best practices used by the Department for other cost-based providers.

Member and Provider Investigators

The Department requests a reduction of $391,760 total funds, including a reduction of $13,732 General Fund, including an increase of 5.5 FTE in FY 2017-18 and a reduction of $1,247,003 total funds, a reduction of $259,211 General Fund and an increase of 6.0 FTE in FY 2018-19 and ongoing to target provider recoveries and to assist outside parties with member investigations. This request includes $470,675 total funds for new FTE and $862,435 total funds in cost savings in FY 2017-18.

In recent years, the programs administered by the Department have grown dramatically in scope and complexity as Medicaid caseload continues to grow. In 2007-08 the Department had 391,962 members and expenses of $3.5 billion; in FY 2016-17 the Department expects 1.3 million members and has a budget of $9.1 billion. This growth increases the potential for waste, and abuse of the payment system. The Department does not have enough resources to keep pace in monitoring provider compliance within that system. Benefit Managers monitor the utilization of services offered by the Department and, among other things, refers suspicious activity to the Department's Program Integrity section. The Program Integrity section searches

for and identifies potential improper claims from providers, investigates the cases, and recovers payments. The section works closely with the Attorney General's Medicaid Fraud Control Unit and the U.S. Attorney's Office on cases in which sanctions are pursued against providers. Staff in these positions must have a high level of expertise in program rules and requirements in order to make a determination on whether an overpayment was made. As these programs become more complex, the Department needs resources who can become subject matter experts on individual programs to effectively monitor payments and ensure they are made in compliance with all rules and policies. Currently, any new programs are assigned to staff who already have a full-time workload and are unable to complete reviews as frequently as needed.

In addition, the Department does not have any dedicated resources to monitor member integrity issues, which have primarily been administered by the counties. SB 12-060 "Improving Medicaid Fraud Prosecution" directed that state share of all claims that are determined to be fraudulently obtained are retained by the counties that investigate the claims. However, if the claim is determined to be a recovery (i.e. the claim does not meet the fraud threshold) then the state share is returned to the Department and is used to offset the Medical Services Premium service expenditure line. The Department has collaborated with county investigators, law enforcement agencies, US Drug Enforcement Agency, District Attorneys, Attorney General, and US Assistant Attorney on cases but does not have dedicated staff to assist these agencies with their investigations. Currently internal audit staff are diverted from their Department compliance roles to assist these investigators, who are backfilled with sub-recipient monitoring staff. In addition, counties have traditionally not pursued cases that cross multiple county lines, deal with opioids or durable medical equipment as they are considerably more complicated to investigate, especially with the limited resources counties have to investigate cases. The Department believes that having dedicated resources assigned to these areas would benefit Colorado's Medicaid Program by removing members that are abusing the Medicaid program by obtaining benefits that they do not either qualify for or need. For further detail on position descriptions see Appendix A below. The Department's FTE cost estimate can be found in Table 2.1

With additional resources, these sections would be able to assign staff to specific program areas in which they can become subject matter experts on the rules and policies. Staff would have the capacity to perform regular reviews on providers and members, which would lead to a higher rate of identification of cases to investigate. This would lead to an increase in recoveries over time, on a pace more consistent with the increase in services and claims. The Department has prepared an estimate of the increase in cost savings in Table 11.1. For this analysis, the Department assumes that new integrity positions would have similar level of cost savings seen with existing program integrity staff. The Department assumes that the member integrity cost savings would primarily be avoided in future costs from ineligible members rather than member recoupments; this is due to the member integrity positions primarily being focused on assisting outside investigators.

Indian Health Services (IHS) Coordination

The Department requests $322,508 total funds, including $2,139,555 in General Fund savings for 3.67 FTE in FY 2017-18 and $328,096 total funds, including a savings of $2,135,367 General fund and 4.0 FTE to better address American Indian/Alaska Native health, with a focus on eligible Medicaid members, and to better coordinate services with IHS facilities to obtain federal funding at a higher match rate than currently being received. Two of the requested FTE would be charged with implementing a coordination program

between the Accountable Care Collaborative (ACC), Indian Health Services (IHS) and tribal governments and two FTE would focus on outreach and assistance with eligible members and stakeholders. One of the outreach FTE would a part of the Department's budget but operate through a Memorandum of Understanding (MOU) in the Lieutenant Governor's Office, in the Colorado Commission of Indian Affairs (CCIA) and the other would be an FTE at the Department of Human Services, Office of Behavioral Health.

IHS is the federal agency within the Department of Health and Human Services that provides services to American Indians and Alaskan Natives directly through its hospitals, health centers, and health stations, as well as indirectly by coordinating with tribe-administered health care facilities and contract health services (CHS), which are provided by non-IHS/tribal facilities. CHS is not an entitlement program; an IHS referral to a non-IHS/tribal facility does not imply the care will be paid for by IHS. If IHS is requested to pay, then a patient must meet residency requirements, notification requirements, medical priority, and use of alternative resources as defined by IHS. American Indian/Alaska Native Medicaid member costs are 100% federally funded when those members receive their services from an IHS facility. Traditionally if these members are served at a non-IHS facility, their claims are processed using the standard federal match rates under Medicaid.

In a letter dated February 26, 2016, CMS issued guidance to state Medicaid agencies clarifying that American Indian/Alaska native Medicaid members' claims could receive 100% federal funding if those services were coordinated through IHS, even if the services were not provided at an IHS facility.[1] This guidance provides additional financial incentives for the State to increase the coordination of care provided in the ACC to American Indian/Alaska Native Medicaid members served by IHS. CMS has not fully defined what coordination means and what level of coordination would be sufficient to claim 100% federal funding for these services, but has stated that they intent to issue additional guidance materials.

The Department and the Colorado Commission of Indian Affairs recently produced a study that looked at "key statewide and county specific data points and stakeholder comments regarding Medicaid enrollment, tribal enrollment, health care needs, cost changes, and care coordination." The report focused on issues affecting the Denver Indian Health and Family Services, Inc. (DIHFS) in the City & County of Denver, the Southern Ute Indian Tribe (SUIT) in La Plata County, and the Ute Mountain Ute Tribe (UMUT) in Montezuma County. The report identified major access to care issues in both urban and rural settings, including issues with eligible tribal members having to travel long distances to visit an IHS/tribal clinic or hospital. The report also identified areas where coordination and information sharing between IHS/Tribal facilities and outside providers were underperforming, which resulted in members either foregoing care or having to pay out-of-pocket costs that would have been covered by IHS in other situations. Based on the interview with the three tribal facilities, the report recommends "that HCPF gather deeper and more accurate information on tribal enrollment and affiliation, health care needs, cost changes, and care coordination along with tribal participation in the newly developed [Regional Accountable Entities] contracts."

The Department proposes creating four new positions to address the recommendations of the report and to coordinate health care issues between tribal members and the State; two positions would be at the Department working on coordinating services between IHS/Tribal and Medicaid providers, one position would be in the

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf

Lieutenant Governor's Office, in the Colorado Commission of Indian Affairs who would lead this cross functional health team and the final position would be at the Department of Human Services, Office of Behavioral Health, who would be responsible for providing training and technical assistance to behavioral health providers in delivering culturally responsive treatment to American Indian and Alaskan Native people seeking care throughout the state. The Department's position would help facilitate the coordination between IHS and tribal members as well as coordination with the Regional Collaborative Care Organizations (RCCOs) that provide for the coordination and integration of care within the ACC framework. These positions would also be responsible for developing the policies and procedures for documenting coordination with IHS and gaining the necessary federal approval for 100% federal funding. The other FTE based outside of the Department would focus on outreach and assistance with eligible members and stakeholders. Based on the lessons gained from the report done with CCIA, there is a major information gap between the services that are provided by State programs and eligible tribal populations. This request would create a cross agency group, with a diverse knowledge base, that would be able to address the unique health and wellness issues that affect American Indian/Alaska Native populations in Colorado. For further detail on position descriptions see Appendix A below.

Funding this request would improve care coordination and ensure that American Indian/Alaska Native Medicaid members access the care they need at appropriate times, free up IHS/Tribal funding for non-Medicaid eligible tribal members and would result in savings for the State. In FY 2014-15 the Department spent $73.2 million on self-identified American Indian/Alaska Natives, but only $2.3 million of total expenditure qualified for 100% federal funding; if the State is able to coordinate 10% of the remaining care offered at non-IHS facilities, making the expenses eligible for 100% federal funding, the Department estimates it would result in approximately $2.38 million General Fund savings. The Department's FTE cost estimate can be found in Table 2.1. The Department's estimated savings can be found in Table 9.1, 9.2 and 9.3 and is based on FY 2014-15 expenses paid by the Department for self-identified American Indian/Alaska Natives.

Hospital Provider Fee Model Resources

The Department requests $681,612 total funds, including $340,808 Hospital Provider Fee in FY 2017-18 and $676,909 total funds, including $338,456 Hospital Provider Fee in FY 2018-19 and ongoing funding to hire 1.0 FTE and provide ongoing contractor funding to provide oversight, development and review of the Hospital Provider Fee Model, with a major focus on the new Hospital Quality Incentive Payments (HQIP) and Delivery Service Reform Incentive payments (DSRIP). Additionally, the Department requests $100,000 in dedicated ongoing funding for HQIP data analysis starting in FY 2016-17.

The Colorado Health Care Affordability Act, HB 09-1293, created several Medicaid populations in Colorado (MAGI Adults, MAGI Parents/Caretakers above 60% FPL, continuous eligibility for eligible children, and the Buy-In Program for Working Adults and Children with Disabilities), a hospital supplemental payment program, and administration related to supporting the populations and supplemental payment program are funded with the Hospital Provider Fee. Colorado then expanded Medicaid under the Affordable Care Act (ACA) in SB 13-200, which further expanded eligibility of Hospital Provider Fee funded populations. The current Hospital Provider Fee (HPF) model involves $670 million in assessed fees, and supports $1.1 billion in direct supplemental payments to hospitals.

Responsibility for the preparation development, maintenance and modifications to the model rests with two financial analysts. Due to the sheer volume of data, the number of disparate sources of data, and the calculations and estimations required by the model, the current level of staffing and contractor resources is inadequate to ensure the timely development of a model that has been adequately reviewed. The 2015-16 hospital provider fee was approved by the Oversight and Advisory Board in February 2016 and by CMS in July 2016, with a retroactive effective date of October 2015. Approval of the model months after the effective date results in the need for substantial retroactive reconciling adjustments to both the fees charged and direct supplemental payments made to hospitals. This lack of resources has also contributed to a perceived lack of the transparency for the Hospital Provider Fee model. This lack of transparency was brought up by several members of the General Assembly during the last legislative session, during the debate on HB 16-1420, which would have turned the Hospital Provider Fee into a TABOR-exempt entity. Since high level staff are tasked with preparing the model and actively managing contracts, they are less available to provide educational outreach to outside parties.

Given the limited number of staff, it is difficult to provide the necessary time to both fully develop the model and provide the necessary outreach and assistance required for such a large program. These lack of resources have also caused delays in model approval, have caused uncertainty in the state budget, and have resulted in the need for large reconciliation payments to be made every year once the model is approved by the Centers for Medicare and Medicaid Services (CMS). In addition, the Hospital Provider Fee model has received $8 million in disallowances from CMS that have had to be paid by the participating hospitals that have resulted from errors in the model.

The Department has also proposed new supplemental payments that are tied to incentivizing quality and efficient care, consistent with other initiatives persued by the Department to better utilize financial resources and improve health outcome for members. The Colorado Health Care Affordability Act established performance-based hospital quality incentive payments to those hospitals that provide services that improve health care outcomes for their patients. Each year, HQIP funding in total equals up to 7% of the total hospital reimbursements made in the prior year. A hospital's HQIP funding is based upon its scoring on nationally recognized performance metrics, which are consistent with federal quality standards. Determining hospitals' HQIP scores involves data gathering from disparate sources, calculations and analysis. Currently the Department has $50,000 per year available for a contractor to gather and validate data from hospitals and other sources, calculate HQIP performance scores and payments, manage hospital communications and appeals of HQIP scoring results. This vendor must also have expertise to identify and develop the quality metrics and scoring methodology selected each year. The current amount of funding is inadequate to secure a vendor who can perform these functions satisfactorily, resulting in HQIP scoring errors and re-work by Department staff. The Department requests $100,000 in FY 2016-17 and ongoing funding to secure a more qualified vendor for HQIP scoring.

The Department is also pursuing transformation of the current provider fee-financed hospital payments to Delivery System Reform Incentive Payments (DSRIP) under the authority of a Section 1115 demonstration waiver. The DSRIP waiver will focus on improving population health across targeted communities through the development of the significant infrastructure, delivery system integration, and care interventions needed to allow the state's hospitals to join the ongoing improvements in care efforts already underway throughout

the state's Accountable Care Collaborative (ACC) and other initiatives. The Department needs ongoing funding for consultants to develop the Section 1115 demonstration waiver application, gather and document stakeholder input, respond to stakeholder feedback, assist in negotiating waiver terms and conditions with CMS, develop hospital guidance documents, conduct valuation and scoring of hospitals' DSRIP projects, evaluate hospital program performance, determine hospital scoring and payments, and assist with program evaluation and reporting to CMS. These payments need full and ongoing analysis to ensure the desired outcomes are achieved. Currently, the Department is funding the analysis and development of these payment with funds that were appropriated to the Department in FY 2014-15 in S-10, BA-10 "Provider Fee Analytics" causing the Department to not be able to fund some of the projects that were included as part of that request.

The Department requests one additional financial analyst to provide the necessary staffing needed to successfully run the Hospital provider Fee Model and programs. For further detail on position descriptions see Appendix A below. The Department's FTE cost estimate can be found in Table 2.1. Additionally, the Department requests $100,000 in dedicated ongoing funding for HQIP data analysis and $500,000 in ongoing funding for development and analysis of Delivery Service Reform Incentive Payments. These additional funds would ensure that all projects proposed in the S-10, BA-10 would be fully funded and the new supplemental payments would have the necessary contractual support to provide hospitals incentives to provide quality and efficient care.

Office Administered Drug Management

The Department requests a reduction of $472,592 total funds, $125,382 General Fund and 0.9 FTE in FY 2017-18 and an increase of $1,027,059 total funds, $316,456 General Fund in 2018-19 and ongoing in order to update the pricing for office administered drugs on a periodic basis consistent with pricing for other drugs, for 1.0 FTE to act as benefits manager for the office administered drugs services, and to account for savings associated with reduced hospital visits as a result of better availability of office administered drugs. The Department also proposes raising reimbursement rates for office administered drugs, on average, to 2.5% over the average sales price (ASP). This request assumes $67,538 total funds in FTE expenses and $540,130 total funds in net cost savings between rate increases and cost avoidance in FY 2017-18.

When a patient is administered a drug at a physician's office, the Department reimburses the provider for the drugs administered. The rate at which the physician are reimbursed are static, listed in the Department's fee schedule and are not currently adjusted to reflect average acquisition costs, like the pharmacy drug benefits offered by Medicaid. After the rates are set, they remain unchanged year-over-year, even as the costs of the office to administer drugs changes, as drugs enter or leave the market. Upon review of current rates, many rates were found to be below the average sales price and some are above the average retail price. The static nature of the payment list can result in a large variance between what a provider pays to purchase the drug and what price Medicaid reimburses the physician. This price disparity can result in providers administering drugs that are less effective for the patient (such as a once-a-day oral anti-psychotic versus an injected anti-psychotic that last for 30 days) or providers not administering the drug in their office but advising members to receive the drug at a hospital, who are reimbursed for the cost of the drug and are allowed to charge an additional facility fee to Medicaid.

The Department used claims data from FY 2014-15 to quantify the cost associated with members receiving an office administered drug at a higher cost facility. The Department identified all members who had received a noffice administered drug at outpatient facility within one week of visiting a physician's office and compared the list of drugs administered to the list of office administer drugs that have been identified by stakeholders as below acquisition cost. The result of that analysis is summarized in Tables 10.1 and 10.2 and represent the estimated cost savings associated with reducing the number of members who have to go to an outpatient setting to get their office administered drug.

The Department has also prepared an estimate of the expected costs associated with tying reimbursements for office administered drugs to 2.5% over the average sales price (ASP) of the drug class, which is essential to obtaining these savings. This analysis is detailed in Table 10.3. The Department proposes setting the rates for the total class of drugs to 2.5% over ASP requests flexibility to allow for incentive based pricing of some drugs over the 2.5% in order to incentives the use of those drugs; The Department would lower rates of other drugs to maintain an average rate of 2.5% over ASP. The Department believes that this incentive based pricing would allow for better, more cost effective treatment of members.

The requested position would be responsible for adjusting the Department's drug reimbursement fee schedule to incentivize physicians to provide cost efficient care that provides the best health outcomes to members. The position would also research the costs and benefits of a prior authorization program for physician administer drugs, update pharmacy and procedural codes for new and reformulated drugs codes, and prepare Medicaid State Plan Amendments for changes in physician administer drugs services. For further detail on position descriptions see Appendix A below. The Department's FTE cost estimate can be found in Table 2.1. The Department believes that having a benefits manager for office administered drugs would result in provider reimbursements that improve access to appropriate treatment, better track costs, create the ability to better incentivizes providers to provide cost effective care and a reduction in costs associated with members receiving office administered drugs in higher cost settings.

Anticipated Outcomes:

Approving this request would ensure the Department has sufficient funding and FTE to administer and support its programs. One of the Department's Performance Plan's primary goals of "ensuring sound stewardship of financial resources" would be met by this request, as it would allow financial resources to be allocated more efficiently. Approval of this request would put measures in place to ensure the Department's members have their needs met appropriately and that funds are correctly spent. Finally, The Department anticipates that several of these proposed changes will decrease the amount of General Fund needed by the Department and will ensure that Colorado obtains the maximum amount of federal funding that is available to the State.

In addition to the cost savings, the increase in oversight funding will ensure that the that members are receiving the services that they need, that providers are correctly billing the Department for those services, that benefits are correctly priced and that the Department continues to effectively incentive wellbeing. By demonstrating sound stewardship of financial resources, the Department is able to improve health care access and outcomes for the people it serves.

Assumptions and Calculations:

Where applicable, notable assumptions for each calculations have been shown in the 'Proposed Solution' section of this document. The Department has included an appendix that details the calculations used to determine the fiscal impact for each request and includes:

- A list of each FTE proposed including the applicable initiative, FTE position title, position type, number of FTE requested and description of position tasks.
- FTE cost calculation.
- Cost breakouts for contractor costs for CMHC audit, consumer directed services evaluation, AVP services, Hospital Provider Fee contracts and audit database.
- Estimated cost savings calculations for IHS services coordination, office administered drugs and provider/consumer fraud savings.

Appendix A: FTE Descriptions

Position Name	Position Classification	Number of FTE	Description
Member Investigators			
Member Integrity Investigator	Compliance Investigator II	**2.0**	The proposed positions would have two major focuses: assisting outside investigators and investigating complicated member integrity cases. These position would work closely with counties' investigators, Department eligibility and program staff, law enforcement, other state agencies and other external agencies investigating Medicaid members. They would provide Medicaid claims payment data to outside investigators or law enforcement, testify on behalf of the Department and represent the Department in external meetings. They would also provide training and technical guidance and support to Colorado's 64 counties with the goals of improving information sharing, implementing best practices and encouraging consistency in investigations across counties. The positions would also collect data from counties and produce the annual legislative report required by SB 12-060. Internally these positions would monitor and conduct assessment of tips and complaints received and determine appropriate actions, conduct investigation (especially cases that counties traditional do not pursue such as opioids, other controlled substances and durable medical equipment. Staff would prepare and refer these cases to law enforcement for prosecution.

Provider Investigators			
Nurse Reviewer	Compliance Specialist IV	1.0	The proposed position would be responsible for reviewing claims post-payment and conducting the preliminary investigations, preparing summary reports which are used as the basis for making a demand for repayment request. This position would also evaluate and respond to informal request for reconsiderations made by providers and would provide technical assistance in cases of fraud. The proposed position would focus on utilizing professional nursing education and experience in reviews of medical records to identify possible overpayments or possible fraud, such as private duty nursing or overlapping billings by providers which perform multiple roles for the Department, e.g. a provider who provides home health; home and community based services; early and periodic screening, diagnostic, and treatment; and transition coordination services.
Benefits Managers	Administrator III	1.0	The proposed position would be located in the Health Programs Office and would specialize in identifying utilization outliers that appear to be provider specific. This position would perform both facility and services analysis. Duties would include data analysis of claims data, investigations of outliers and referral to Program Integrity section for formal investigation of suspicious providers. This position would act as a liaisons with the Program Integrity section for all investigations that involve the Department's Health Programs Office.
Certified Billing Coding Specialist	Compliance Specialist IV	1.0	The proposed position would be responsible for reviewing claims post-payment and conducting the preliminary investigations. The position will focus on billing code issues and provide technical assistance on interpretation and application of billing codes to other reviewers and analysts. The position would have a medical background that would allow them to evaluate the appropriateness of the billing coding used by the providers.
Claims Reviewers	Compliance Specialist IV	1.0	The proposed position would be responsible for reviewing claims post-payment and conducting the preliminary investigations, preparing summary reports which are used as the basis for making a demand for repayment request. This position would also evaluate and respond to informal request for reconsiderations made by providers and would provide technical assistance in cases of fraud. This positions would focus on the Child Health Plan *Plus* program, full risk managed care, consumer directed attendant support services, other waiver services, dental and state plan personal care services.
	Total FTE	**4.0**	

Office Administered Drugs			
Benefits Manager	Administrator III	**1.0**	The proposed position would be responsible for management of the physician administered drug benefit. Duties would include data analysis of claims data, assessing the effectiveness of different value based reimbursement models, developing clinical criteria for utilization, and insuring these drugs and devices are being administered in the most cost effective place of service. The position would perform both facility and physician service analysis. In addition this position would be responsible for regularly monitoring and adjusting reimbursement for office administered drugs and devices.
Hospital Provider Fee Resources			
Financial Modeling Analyst	Rate/Financial Analyst II	**1.0**	The proposed position would assist with the development and modeling of the hospital provider fee, the related supplemental payments to hospitals and calculate federally-required Upper Payment Limit (UPL) and Disproportionate Share Hospital (DSH) limits. This position would assume a number of the fee, payment, and federal limit calculations that are currently being performed by the unit lead. The position would assist with the calculations of proposed alternate payment and calculation methodologies that may more effectively achieve the hospital provider fee program's goals. The additional analyst would reduce the risk of calculation errors and improve the timeliness of hospital provider fee model development by allowing for a more robust internal review process.

Project Management			
Project Manager	Project Manager I	1.0	The proposed position, which is an existing position moving from 90% federal funding to 56.25%, would act as consultants to provide strategy, create systems, processes, guidelines and rules related to project management practices. The positions would provide support to the Department's project team by coordinating activities, providing guidance on project management processes used for the project, and communication of project information to stakeholders. In conjunction with the project sponsor and other key project stakeholders, the position define, document, and establish the project scope of work, the project schedule, procurements, budget, risks, communication needs, and required resources. The position would also works with Office Division Directors to identify changes needed for improved performance and coordinates with policy staff to appropriately prioritize and implement needed systems, policy and operations changes. Finally, the position is responsible for ensuring current compliance and strategic planning to achieve required compliance with Medicaid Enterprise Life Cycle (MECL) and Medicaid Information Technology Architecture (MITA) frameworks, and for providing department-wide project management assistance.
Assistant Project Manager	Liaison II	1.0	The existing position, which are moving from 90% federal funding to 56.25%, manages compliance activities that include business needs assessment and system and operational solutions for timely and successful implementation and maintenance of compliance objectives. The position would manage processes to ensure that program, systems, and/or operations impacts are identified in advance to provide notification of change to stakeholders as well as gain appropriate federal and state approvals. The position would analyze complex vendor project plans and following defined project management principles, makes corrections as requested by Department management.
Program Assistance	Program Assistant II	1.0	This existing position, which is moving from 90% federal funding to 56.25%, is responsible for supporting communication for project activities among the project team, staff and others to optimize access and to ensure timely communication and facilitation of activities relating to projects. The position coordinates and produces presentations for division/section meetings, project meetings, stakeholder meetings, etc., communicates proficiently with a variety of policy and technical staff in written and verbal formats. The position also collaborates with budget and accounting staff and contract vendors to identify costs, schedule, and resources for project initiatives.
	Total FTE	**3.0**	

Indian Health Services Coordination			
Outreach Coordinator	Administrator IV	1.0	The proposed FTE would be a part of the Department's budget but would operate through a Memorandum of Understanding (MOU) with the Lieutenant Governor's Office, specifically the Colorado Commission of Indian Affairs (CCIA). The position would facilitate formal tribal consultations with the Southern Ute Indian Tribe (SUIT) and Ute Mountain Ute Tribe (UMUT) for the Department and work to improve government-to-government relations between the Department and the Tribes on health issues. The position would travel to and interface directly with tribal partners regarding implementation of State policies. The position would develop strong relationships with the SUIT and UMUT staff at multiple levels and coordinate with tribal council members, human services, public health, attorneys, public information officers, community partner organizations, staff of American Indian organizations such as the Denver Indian Family Resource Center, Denver Indian Health and Family Services to inform and engage tribal partners on eligibility and policy changes from the State.
Training and Technical Assistance Project Manager	Project Manager 1	1.0	The position will represent the Office of Behavioral Health on inter-agency efforts aimed at improving the health and wellness of American Indian and Alaskan Native. This will assure that the efforts of OBH to improve access and effectiveness of behavioral health services for this population are aligned with that of the Department of Healthcare Policy and Financing and their Regional Collaborative Care Organizations (RCCOs) and Behavioral Health Organizations (BHOs), as well as the Lieutenant Governor's Office and the Colorado Commission on Indian Affairs. This position will be knowledgeable about the two tribes in Colorado, the Southern Ute and the Ute Mountain Ute, and will offer liaison services between the Indian Health Medical Centers in Towaoc and Ignacio and the Tribal Health Medical Center in Denver and the behavioral health providers delivering care to shared members.
Coordination Specialists	Administrator IV	2.0	These proposed positions would be responsible for assisting the Regional Care Collaborative Organizations (RCCOs) in their efforts to coordinate services for American Indian and Alaska Native between Indian Health Services (IHS) and Non-IHS providers. These proposed positions would assist Department staff on the Colorado Commission of Indian Affairs and related subcommittees These positions would work with outreach staff to find and correct pain points in for American Indian and Alaska Native Medicaid members. This would include developing and distributing resource guides and aids that can assist tribal agencies and health facilities with Medicaid processes and services. The positions would identify and help the Department act on opportunities to maximized federal matching funds per new CMS guidance related to 100% match for services offered in non-IHS facilities.
	Total FTE	**4.00**	
Grand Total		**15.00**	

Table 1.0 Summary by Line Item					
FY 2016-17	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
Total Request	**$200,000**	**0.0**	**$50,000**	**$50,000**	**$100,000**
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$200,000	0.0	$50,000	$50,000	$100,000
[1] Cash Fund Portion is Hospital Provider Fee					

Table 1.1 Summary by Line Item					
FY 2017-18	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
Total Request	**$1,567,569**	**14.1**	**($1,577,408)**	**$100,685**	**$3,044,292**
(1) Executive Director's Office; (A) General Administration, Personal Services	$832,311	13.2	$415,282	$31,170	$385,859
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$103,052	0.0	$46,079	$3,964	$53,009
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$1,278	0.0	$571	$53	$654
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$33,679	0.0	$14,997	$1,397	$17,285
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$33,679	0.0	$14,997	$1,397	$17,285
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$60,142	0.0	$27,020	$2,827	$30,295
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$1,621,365	0.0	$510,683	$300,000	$810,682
(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$204,000	0.0	$102,000	$0	$102,000
(2) Medical Services Premiums; Medical Services Premiums	($1,402,565)	0.0	($2,789,665)	($240,123)	$1,627,223
DHS (8) Behavioral Health Services; (A) Community Behavioral Health Administration	$80,628	0.9	$80,628	$0	$0
[1] Cash Fund Portion is Hospital Provider Fee					

Table 1.2 Summary by Line Item					
FY 2018-19	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
Total Request	**$2,061,245**	**15.0**	**($1,452,670)**	**$70,716**	**$3,443,199**
(1) Executive Director's Office; (A) General Administration, Personal Services	$881,836	14.0	$440,740	$31,170	$409,926
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$103,052	0.0	$46,079	$3,964	$53,009
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$1,360	0.0	$611	$53	$696
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$35,835	0.0	$16,074	$1,397	$18,364
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$35,835	0.0	$16,074	$1,397	$18,364
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$13,112	0.0	$5,856	$475	$6,781
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$1,469,748	0.0	$434,874	$300,000	$734,874
(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$204,000	0.0	$102,000	$0	$102,000
(2) Medical Services Premiums; Medical Services Premiums	($765,557)	0.0	($2,597,002)	($267,740)	$2,099,185
DHS (8) Behavioral Health Services; (A) Community Behavioral Health Administration	$82,024	1.0	$82,024	$0	$0
[1] Cash Fund Portion is Hospital Provider Fee					

Table 2.0 Summary by Initiative FY 2016-17							
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**Source/Calculation**
A	**Electronic Asset Verification Program (AVP)**	**$100,000**	**0.0**	**$50,000**	**$0**	**$50,000**	**Row B**
B	Contractor Costs	$100,000	0.0	$50,000	$0	$50,000	Table 6.1
C	**Hospital Provider Fee Model Resources**	**$100,000**	**0.0**	**$0**	**$50,000**	**$50,000**	**Row D**
D	Contractor Costs	$100,000	0.0	$0	$50,000	$50,000	Table 7.1
E	**Total**	**$200,000**	**0.0**	**$50,000**	**$50,000**	**$100,000**	

Table 2.1 Summary by Initiative FY 2017-18							
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**Source/Calculation**
A	**Electronic Asset Verification Program (AVP)**	**$529,183**	**0.00**	**$264,592**	**$0**	**$264,591**	**Row B**
B	Contractor Costs	$529,183	0.00	$264,592	$0	$264,591	Table 6.1
C	**Consumer Directed Care Evaluation**	**$422,000**	**0.00**	**$211,000**	**$0**	**$211,000**	**Table 5.1**
D	**Audit Database**	**$70,182**	**0.00**	**$35,091**	**$0**	**$35,091**	**Table 8.1**
E	**Project Management Staff**	**$202,436**	**3.00**	**$88,578**	**$0**	**$113,858**	**Row F + Row G**
F	Extension of Existing FTE	$198,824	3.00	$86,997	$0	$111,827	Table 3.1, FTE Calculator Assumes 56.25% Federal Financial Participation (FFP)
G	FTE Operating Costs	$3,612	0.00	$1,581	$0	$2,031	Table 3.1, FTE Calculator Assumes 56.25% FFP
H	**Community Mental Health Center Audits**	**$204,000**	**0.00**	**$102,000**	**$0**	**$102,000**	**Table 4.1**
I	**Client and Provider Investigators**	**($391,760)**	**5.50**	**($13,732)**	**($86,696)**	**($291,332)**	**Row J + Row K +Row L +Row M**
J	Client FTE	$149,946	1.83	$74,975	$0	$74,971	Table 3.1, FTE Calculator
K	Provider FTE	$286,811	3.67	$143,406	$0	$143,405	Table 3.1, FTE Calculator
L	FTE Operating Costs	$33,918	0.00	$16,959	$0	$16,959	Table 3.1, FTE Calculator
M	Anticipated Cost Savings	($862,435)	0.00	($249,072)	($86,696)	($526,667)	Table 11.1
N	**Indian Health Services Coordination**	**$322,508**	**3.67**	**($2,139,555)**	**($133,388)**	**$2,595,451**	**Row O + Row P + Row Q + Row R + Row S**
O	Department FTE Costs	$149,946	1.83	$74,975	$0	$74,971	Table 3.1, FTE Calculator
P	FTE Operating Costs	$11,306	0.00	$5,653	$0	$5,653	Table 3.1, FTE Calculator
Q	Other Agency FTE	$149,950	1.83	$149,950	$0	$0	Table 3.1, FTE Calculator
R	FTE Operating Costs	$11,306	0.00	$11,306	$0	$0	Table 3.1, FTE Calculator
S	Anticipated Cost Savings	$0	0.00	($2,381,439)	($133,388)	$2,514,827	Table 9.1
T	**Hospital Provider Fee Model Resources**	**$681,612**	**1.00**	**$0**	**$340,808**	**$340,804**	**Row U + Row V+ Row W**
U	FTE Costs	$75,959	1.00	$0	$37,981	$37,978	Table 3.1, FTE Calculator
V	FTE Operating Costs	$5,653	0.00	$0	$2,827	$2,826	Table 3.1, FTE Calculator
W	Contractor Costs	$600,000	0.00	$0	$300,000	$300,000	Table 7.1
X	**Office Administered Drug Management**	**($472,592)**	**0.92**	**($125,382)**	**($20,039)**	**($327,171)**	**Row Y + Row Z + Row AA**
Y	FTE Costs	$61,885	0.92	$30,945	$0	$30,940	Table 3.1, FTE Calculator
Z	FTE Operating Costs	$5,653	0.00	$2,827	$0	$2,826	Table 3.1, FTE Calculator
AA	Cost Avoidance	($579,450)	0.00	($170,740)	($21,498)	($387,212)	Table 10.1
AB	Rate Impact	$39,320	0.00	$11,586	$1,459	$26,275	Table 10.1
AC	**Total**	**$1,567,569**	**14.1**	**($1,577,408)**	**$100,685**	**$3,044,292**	

Table 2.2 Summary by Initiative FY 2018-19 and Ongoing							
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**Source/Calculation**
A	**Electronic Asset Verification Program (AVP)**	**$858,366**	**0.00**	**$429,183**	**$0**	**$429,183**	**Row B**
B	Contractor Costs	$858,366	0.00	$429,183	$0	$429,183	Table 6.1
C	**Consumer Directed Care Evaluation**	**$0**	**0.00**	**$0**	**$0**	**$0**	**Table 5.1**
D	**Audit Database**	**$11,382**	**0.00**	**$5,691**	**$0**	**$5,691**	**Table 8.1**
E	**Project Management Staff**	**$202,436**	**3.00**	**$88,578**	**$0**	**$113,858**	**Row F + Row G**
F	Extension of Existing FTE	$198,824	3.00	$86,997	$0	$111,827	Table 3.1, FTE Calculator Assumes 56.25% Federal Financial Participation (FFP)
G	FTE Operating Costs	$3,612	0.00	$1,581	$0	$2,031	Table 3.1, FTE Calculator Assumes 56.25% FFP
H	**Community Mental Health Center Audits**	**$204,000**	**0.00**	**$102,000**	**$0**	**$102,000**	**Table 4.1**
I	**Client and Provider Investigators**	**($1,247,003)**	**6.00**	**($259,211)**	**($173,392)**	**($814,400)**	**Row J + Row K +Row L +Row M**
J	Client Fraud FTE	$162,148	2.00	$81,074	$0	$81,074	Table 3.1, FTE Calculator
K	Provider Fraud FTE	$310,019	4.00	$155,009	$0	$155,010	Table 3.1, FTE Calculator
L	FTE Operating Costs	$5,700	0.00	$2,850	$0	$2,850	Table 3.1, FTE Calculator
M	Anticipated Cost Savings	($1,724,870)	0.00	($498,144)	($173,392)	($1,053,334)	Table 11.1
N	**Indian Health Services Coordination**	**$328,096**	**4.00**	**($2,135,367)**	**($133,388)**	**$2,596,851**	**Row O + Row P + Row Q + Row R + Row S**
O	Department FTE Costs	$162,148	2.00	$81,074	$0	$81,074	Table 3.1, FTE Calculator
P	FTE Operating Costs	$1,900	0.00	$950	$0	$950	Table 3.1, FTE Calculator
Q	Other Agency FTE	$162,148	2.00	$162,148	$0	$0	Table 3.1, FTE Calculator
R	FTE Operating Costs	$1,900	0.00	$1,900	$0	$0	Table 3.1, FTE Calculator
S	Anticipated Cost Savings	$0	0.00	($2,381,439)	($133,388)	$2,514,827	Table 9.1
T	**Hospital Provider Fee Model Resources**	**$676,909**	**1.00**	**$0**	**$338,456**	**$338,453**	**Row U + Row V+ Row W**
U	FTE Costs	$75,959	1.00	$0	$37,981	$37,978	Table 3.1, FTE Calculator
V	FTE Operating Costs	$950	0.00	$0	$475	$475	Table 3.1, FTE Calculator
W	Contractor Costs	$600,000	0.00	$0	$300,000	$300,000	Table 7.1
X	**Office Administered Drug Management**	**$1,027,059**	**1.00**	**$316,456**	**$39,040**	**$671,563**	**Row Y + Row Z + Row AA**
Y	FTE Costs	$66,796	1.00	$33,400	$0	$33,396	Table 3.1, FTE Calculator
Z	FTE Operating Costs	$950	0.00	$475	$0	$475	Table 3.1, FTE Calculator
AA	Cost Avoidance	($1,205,488)	0.00	($355,098)	($49,057)	($801,333)	Table 10.1
AB	Rate Impact	$2,164,801	0.00	$637,679	$88,097	$1,439,025	Table 10.1
AC	**Total**	**$2,061,245**	**15.0**	**($1,452,670)**	**$70,716**	**$3,443,199**	

Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- New full-time General Fund positions are reflected in Year 1 as 0.9166 FTE to account for the pay-date shift. This applies to personal services costs only; operating costs are not subject to the pay-date shift.

Expenditure Detail		FY 2017-18			FY 2018-19	
	Monthly Salary	FTE			FTE	
Compliance Investigator II	$ 5,005	1.83		110,102	2.00	120,120
PERA				11,175		12,192
AED				5,505		6,006
SAED				5,505		6,006
Medicare				1,596		1,742
STD				209		228
Health-Life-Dental				15,854		15,854
Subtotal Position 1, 2.0 FTE		1.83	**$**	**149,946**	2.00	**$ 162,148**
	Monthly Salary	FTE			FTE	
Compliance Specialist IV	$ 5,005	2.75		165,153	3.00	180,180
PERA				16,763		18,288
AED				8,258		9,009
SAED				8,258		9,009
Medicare				2,395		2,613
STD				314		342
Health-Life-Dental				23,782		23,782
Subtotal Position 2, 3.0 FTE		2.75	**$**	**224,923**	3.00	**$ 243,223**
	Monthly Salary	FTE			FTE	
Administrator III	$ 4,028	1.83		88,610	2.00	96,672
PERA				8,994		9,812
AED				4,431		4,834
SAED				4,431		4,834
Medicare				1,285		1,402
STD				168		184
Health-Life-Dental				15,854		15,854
Subtotal Position 3, 2.0 FTE		1.83	**$**	**123,773**	2.00	**$ 133,592**

	Monthly Salary	FTE		FTE	
Rate/Financial Analyst II	$ 4,655	1.00	55,860	1.00	55,860
PERA			5,670		5,670
AED			2,793		2,793
SAED			2,793		2,793
Medicare			810		810
STD			106		106
Health-Life-Dental			7,927		7,927
Subtotal Position 4, 1.0 FTE		1.00	**$ 75,959**	1.00	**$ 75,959**
	Monthly Salary	FTE		FTE	
Administrator IV (Department)	$ 5,005	1.83	110,102	2.00	120,120
PERA			11,175		12,192
AED			5,505		6,006
SAED			5,505		6,006
Medicare			1,596		1,742
STD			209		228
Health-Life-Dental			15,854		15,854
Subtotal Position 5, 2.0 FTE		1.83	**$ 149,946**	2.00	**$ 162,148**
	Monthly Salary	FTE		FTE	
Administrator IV (Other Agencies via MOU)	$ 5,005	0.92	55,051	1.00	60,060
PERA			5,588		6,096
AED			2,753		3,003
SAED			2,753		3,003
Medicare			798		871
STD			105		114
Health-Life-Dental			7,927		7,927
Subtotal Position 6, 1.0 FTE		0.92	**$ 74,975**	1.00	**$ 81,074**
	Monthly Salary	FTE		FTE	
Project Manager I (Other Agencies)	$ 5,005	0.92	55,051	1.00	60,060
PERA			5,588		6,096
AED			2,753		3,003
SAED			2,753		3,003
Medicare			798		871
STD			105		114
Health-Life-Dental			7,927		7,927
Subtotal Position 7, 1.0 FTE		0.92	**$ 74,975**	1.00	**$ 81,074**

	Monthly Salary	FTE			FTE		
Project Manager (Existing FTE)	$ 5,005	1.00		60,060	1.00		60,060
PERA				6,096			6,096
AED				3,003			3,003
SAED				3,003			3,003
Medicare				871			871
STD				114			114
Health-Life-Dental				7,927			7,927
Subtotal Position 8, 1.0 FTE		1.00	**$**	**81,074**	1.00	**$**	**81,074**
	Monthly Salary	FTE			FTE		
Liaison II (Existing FTE)	$ 3,486	1.00		41,832	1.00		41,832
PERA				4,246			4,246
AED				2,092			2,092
SAED				2,092			2,092
Medicare				607			607
STD				79			79
Health-Life-Dental				7,927			7,927
Subtotal Position 9, 1.0 FTE		1.00	**$**	**58,875**	1.00	**$**	**58,875**
	Monthly Salary	FTE			FTE		
Program Assistant II (Existing FTE)	$ 3,486	1.00		41,832	1.00		41,832
PERA				4,246			4,246
AED				2,092			2,092
SAED				2,092			2,092
Medicare				607			607
STD				79			79
Health-Life-Dental				7,927			7,927
Subtotal Position 10, 1.0 FTE		1.00	**$**	**58,875**	1.00	**$**	**58,875**
New FTE Subtotal		11.08	**$**	**874,497**	12.00	**$**	**939,218**
Continued FTE Subtotal		3.00	**$**	**198,824**	3.00	**$**	**198,824**
Subtotal Personal Services		14.1	**$**	**1,073,321**	15.00	**$**	**1,138,042**
Operating Expenses							
Regular FTE Operating Expenses	500.00	15.00		7,500	15.00		7,500
Telephone Expenses	450.00	15.00		6,750	15.00		6,750
PC, One-Time	1,230.00	12.00		14,760	-		
Office Furniture, One-Time	3,473.00	12.00		41,676	-		
Clarity License	254.00	3.00		762	3.00		762
New FTE Subtotal		12.00		**67,836**	12.00		**11,400**
Continued FTE Subtotal		3.00		**3,612**	3.00		**3,612**
Subtotal Operating Expenses		15.00		**71,448**	15.00		**15,012**
TOTAL REQUEST		**14.1**	**$**	**1,144,769**	**15.00**	**$**	**1,153,054**
General Fund:			$	599,574		$	607,458
Cash funds:			$	40,808		$	38,456
Reappropriated Funds:				-			-
Federal Funds:			$	504,387		$	507,140

Table 4.1 Community Mental Health Centers (CMHC) Fund Splits							
Row	**Fiscal Year**	**Total Funds**	**General Fund**	**Cash Fund**	**Federal Funds**	**FFP Rate**	**Source/Calculation**
A	FY 2017-18 and Ongoing	$204,000	$102,000	$0	$102,000	50.00%	Table 4.2 Row C

Table 4.2 - Breakdown of Community Mental Health Centers (CMHC) Audit Costs			
Row	**Item**	**FY 2015-16**	**Comments/Calculation**
A	Cost for CMHC Cost Report Review	$12,000	Based on Department contract for existing Behavior Health Organization audits
B	Number of CMHCs in Colorado	17	Based on Number of CMHCs
C	**Total Cost for Review**	**$204,000**	**Row A * Row B**

Table 5.1 Consumer Directed Care Evaluation Fund Splits						
Row	**Fiscal Year**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP Rate**	**Source/Calculation**
A	2017-18	$422,000	$211,000	$211,000	50.00%	Table 5.2 Row F

Table 5.2 Consumer Directed Care Evaluation Costs			
Row	**Item**	**FY 2017-18**	**Source**
A	Survey Design and Sampling Methodology	$45,000	Department estimate based on similar work in the past
B	Survey Execution	$72,000	1,800 Client surveys X $40 each
C	Data Analysis of Entire Consumer Directed Attendant Support Services and In-Home Support Services Populations	$200,000	Department estimate based on similar work in the past
D	Data Analysis of Surveyed Populations	$120,000	Estimate based on previous audit of 4,200 HCBS waiver claims
E	Stakeholder and Department Meetings	$30,000	Department Estimate
F	**Total**	**$422,000**	**Row A + Row B + Row C + Row D + Row E**

Table 6.1 Asset Verification Program Fund Splits						
Row	**Fiscal Year**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP Rate**	**Source/Calculation**
A	2016-17	$100,000	$50,000	$50,000	50.00%	Table 6.2 Row E
B	2017-18	$529,183	$264,592	$264,591	50.00%	Table 6.2 Row E
C	2018-19 and Ongoing	$858,366	$429,183	$429,183	50.00%	Table 6.2 Row E

Table 6.2 Asset Verification Program Implementation and Ongoing Costs					
Row	**Item**	**FY 2016-17**	**FY 2017-18**	**Ongoing Costs**	**Notes**
A	Project Planning	$14,400	$0	$0	Based on estimate from Oklahoma Health Care Authority
B	Integration with State Systems	$59,680	$100,000	$0	Based on estimate from Oklahoma Health Care Authority and OIT input
C	Financial Institution Enrollment and Management	$25,920	$0	$0	Based on estimate from Oklahoma Health Care Authority
D	Verification Costs	$0	$429,183	$858,366	Verification costs assumes a January 2018 start date
E	Total Cost	$100,000	$529,183	$858,366	Row A + Row B + Row C + Row D

Table 7.1 Hospital Provider Contractor Fund Splits							
Row	**Fiscal Year**	**Total Funds**	**General Fund**	**Hospital Provider Fee**	**Federal Funds**	**FFP Rate**	**Source/Calculation**
Hospital Quality Incentive Payment (HQIP)							
A	2016-17 and Ongoing	$100,000	$0	$50,000	$50,000	50.00%	Table 7.3 Row D
Delivery Service Reform Incentive Payments (DSRIP)							
B	2017-18 and Ongoing	$500,000	$0	$250,000	$250,000	50.00%	Table 7.2 Row D

Table 7.2 Delivery Service Reform Incentive Payments (DSRIP) Cost Estimates			
Row	**Item**	**FY 2017-18**	**Source**
A	Valuation and Scoring of Projects	$150,000	Department estimate based on previous requests for proposals
B	Payment Methodology Development and Support	$125,000	Department estimate based on previous requests for proposals
C	Program Evaluation and CMS Support	$225,000	Department estimate based on previous requests for proposals
D	**Total**	**$500,000**	**Row A + Row B + Row C**

Table 7.3 Hospital Quality Incentive Payment (HQIP) Cost Estimates			
Row	**Item**	**FY 2017-18**	**Source**
A	Data Analysis	$50,000	Department estimate based on Existing Contract
B	Meetings with Department Staff and Stakeholders	$30,000	Department estimate based on Existing Contract
C	Data Infrastructure and Collection	$20,000	Department estimate based on Existing Contract
D	**Total**	**$100,000**	**Row A + Row B + Row C**

Table 8.1 Audit Database Fund Splits						
Row	**Fiscal Year**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP Rate**	**Source/Calculation**
A	FY 2017-18	$70,182	$35,091	$35,091	50%	Table 8.2 Row H
B	FY 2018-19 and Ongoing	$11,382	$5,691	$5,691	50%	Table 8.2 Row H

Table 8.2 - Calculation of Audit Database Funding				
Row	**Item**	**FY 2017-18**	**FY 2018-19 and ongoing**	**Source**
A	Project Kickoff and Requirements Gathering	$8,000	$0	OIT Estimate
B	Configure and Load Existing Data	$20,000	$0	OIT Estimate
C	Security Setup	$800	$0	OIT Estimate
D	Configure Automation	$12,000	$0	OIT Estimate
E	Production Deployment	$10,000	$0	OIT Estimate
F	Testing	$8,000	$0	OIT Estimate
G	Licenses	$11,382	$11,382	OIT Estimate
H	**Total**	**$70,182**	**$11,382**	**Sum (Row A: Row G)**

Table 9.1 Estimated State Share Cost Savings in FY 2017-18 and FY 2018-19					
Row	**Item**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes**
A	Costs for FY 2014-15	$23,814,394	$1,333,878	$45,799,932	Table 9.2 Row Q
B	Estimated percentage of services that could be coordinated with Indian Health Services (IHS) and be eligible for 100% Federal Medical Assistance Percentage (FMAP)	10.00%	10.00%	N/A	Department Estimate
C	Estimated shift in costs	($2,381,439)	($133,388)	$2,514,827	

Table 9.2 Client Expenses in FY 2014-15 by Eligibility Group and Funding Source, Net Indian Health Services								
Row	**Group**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**FMAP Rate[1]**	**State Funding Source**	**Notes**
A	Adults 65 and Older (OAP-A)	$2,631,759	$1,315,616	$0	$1,316,143	Standard (50%)	General Fund	
B	Breast & Cervical Cancer Program	$1,245	$0	$436	$809	Enhanced (65%)	BCCP Cash Fund	
C	Disabled Adults 60 to 64 (OAP-B)	$1,739,311	$869,482	$0	$869,829	Standard	General Fund	
D	Disabled Buy-In Adults	$224,407	$0	$112,181	$112,226	Standard	Hospital Provider Fee, Disabled Buy-in Fund	Calculation assumes Hospital Provider Fee
E	Disabled Buy-In Children	$41,093	$0	$20,542	$20,551	Standard	Hospital Provider Fee, Disabled Buy-in Fund	Calculation assumes Hospital Provider Fee
F	Disabled Individuals to 59 (AND/AB)	$14,329,783	$7,163,459	$0	$7,166,324	Standard	General Fund	
G	Foster Care	$1,128,918	$564,346	$0	$564,572	Standard	General Fund	
H	MAGI Parents/ Caretakers 69% to 133% FPL	$3,366,751	$0	$185,171	$3,181,580	Expansion (94.50%)	Hospital Provider Fee	
I	MAGI Adults	$18,464,517	$0	$1,015,548	$17,448,969	Expansion (94.50%)	Hospital Provider Fee	
J	Eligible Children (AFDC-C/BC)	$15,347,976	$7,672,453	$0	$7,675,523	Standard	General Fund, Hospital Provider Fee	Calculation Assumes 50% GF/ 50% FF
K	MAGI Pregnant Adults	$2,678,566	$1,339,015	$0	$1,339,551	Standard	General Fund	
L	MAGI Parents/ Caretakers to 68% FPL	$9,284,881	$4,641,512	$0	$4,643,369	Standard	General Fund, Hospital Provider Fee	Calculation Assumes 50% GF/ 50% FF
M	Non-Citizens- Emergency Services	$10,890	$5,444	$0	$5,446	Standard	General Fund	
N	Partial Dual Eligibles	$103,433	$51,706	$0	$51,727	Standard	General Fund	
O	SB 11-008 Eligible Children	$1,361,402	$163,368	$0	$1,198,034	Enhanced+ (88%)	General Fund, Hospital Provider Fee	Calculation Assumes 22% GF/ 88% FF
P	SB 11-250 Eligible Pregnant Adults	$233,272	$27,993	$0	$205,279	Enhanced+	General Fund	
Q	Total	$70,948,204	$23,814,394	$1,333,878	$45,799,932			Sum (Row A to Row P)

[1] FMAP rates reflect expected rates for State Fiscal Year 2017-18, not the rates applicable to State Fiscal Year 2014-15

Table 9.3 American Indian and Alaskan Native Medicaid Client Expenses in FY 2014-15			
Row	**Item**	**Expenses**	**Source/ Calculation**
A	Total American Indian and Alaskan Native Medicaid Client Expenses	$73,199,224	MMIS Data for self-identified American Indian and Alaskan Native clients
B	Subset of Services Offered at Indian Health Services Facility	$2,251,020	MMIS Data where the provider is an Indian Health Services facility claims are 100% federally funded
C	Claims Eligible for increased Federal Funding	$70,948,204	Row A - Row B

Table 10.1 Estimated Cost Savings in FY 2017-18 and Ongoing						
Row	**Item**	**Total Funds**	**General Fund***	**Cash Funds***	**Federal Funds***	**Notes**
	FY 2017-18					
A	Estimated Cost Avoidance	($579,450)	($170,740)	($21,498)	($387,212)	Table 10.2 Row H
B	Estimated Rate Impact	$39,320	$11,586	$1,459	$26,275	Table 10.4 Row H
C	**Total**	**($540,130)**	**($159,154)**	**($20,039)**	**($360,937)**	**Row A + Row B**
	FY 2018-19					
D	Estimated Cost Avoidance	($1,205,488)	($355,098)	($49,057)	($801,333)	Table 10.2 Row J
E	Estimated Rate Impact	$2,164,801	$637,679	$88,097	$1,439,025	Table 10.4 Row H
F	**Total**	**$959,313**	**$282,581**	**$39,040**	**$637,692**	**Row D + Row E**
	FY 2019-20					
G	Estimated Cost Avoidance	($1,242,979)	($366,141)	($54,938)	($821,900)	Table 10.2 Row L
H	Estimated Rate Impact	$4,545,507	$1,338,958	$200,904	$3,005,645	Table 10.4 Row H
I	**Total**	**$3,302,528**	**$972,817**	**$145,966**	**$2,183,745**	**Row G + Row H**
*Funds splits determined using relative % from FY 2016-17 R-1 Exhibit M for Physician Services, adjusted for caseload changes. Cash fund source assumed to be Hospital Provider Fee						

Table 10.2 Costs Avoidance Calculation			
Row	**Item**	**Total Funds**	**Source**
A	Amount Reimbursed for Office Administered Drugs	$1,826,782	FY 2014-15 MMIS Data See narrative for description of the query parameters
B	Amount Charged to Medicaid for Visit to Higher Level of Care Facility	$2,733,239	FY 2014-15 MMIS Data See narrative for description of the query parameters
C	Costs Avoided	($906,457)	Row A-Row B
D	Caseload Trend Factor to FY 2015-16	11.69%	FY 2016-17 R-1 Request (15-16 caseload increase)
E	Caseload Trend Factor to FY 2016-17	9.09%	FY 2016-17 R-1 Request (16-17 caseload trend)
F	Caseload Trend Factor to FY 2017-18	4.93%	FY 2016-17 R-1 Request (17-18 caseload trend)
G	Effective Start Day (Percent of Fiscal year)	50%	Assumes January 1st Start Date
H	Estimated FY 2017-18 Cost Avoidance	($579,450)	Row C * (1+ Row D) * (1+ Row E) * (1+ Row F) * Row G
I	Trend Factor to FY 2018-19	4.02%	FY 2016-17 R-1 Request (18-19 caseload trend)
J	FY 2018-19 Cost Avoidance	($1,205,488)	Row H * 2 * (1+Row I)
K	Trend Factor to FY 2019-20	3.11%	FY 2016-17 R-1 Request (18-19 caseload trend)
L	Estimated FY 2019-20 Cost Avoidance	($1,242,979)	Row J * (1+ Row K)

Table 10.3 Calculation of Using Average Sales Price Plus 2.5% Pricing for Office Administered Drugs					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Source**
A	Claims Priced at FY 2015-16 Medicaid Rates	$54,779,689	$56,484,216	$58,241,781	Actuarial analysis, trended forward by projected caseload growth
B	Claims Priced Using July 2015 Average Sales Price Plus 2.5%	$50,892,462	$52,476,034	$54,108,880	Actuarial analysis, trended forward by projected caseload growth
C	Drug Price Inflation Factor	3.83%	3.83%	3.83%	Three-year weighted average increase of Average Sales Price rates
D	Adjusted Claims Priced Using Average Sales Price	$54,865,478	$58,739,408	$62,886,867	FY 2017-18: Row B * (1 + Row C)^2 FY 2018-19: Row B * (1 + Row C)^3 FY 2019-20: Row B * (1 + Row C)^4
E	Incremental Difference	$85,789	$2,255,192	$4,645,086	Row D - Row A
F	Expenditure for Current Year Claims, Adjusted for Implementation Date and Cash Flow	$39,320	$2,161,226	$4,451,541	FY 2017-18: Row E * 5.5/12; Assumed implementation date of January 1, 2018 FY 2018-19: Row E * 11.5/12
G	Expenditure for Prior Year Claims	$0	$3,575	$93,966	Previous Year Row E * .5/12
H	**Total Impact**	**$39,320**	**$2,164,801**	**$4,545,507**	**Row F + Row G**

Table 11.1 Estimated Savings Per Integrity FTE				
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**Notes**
A	Recovery Amount	($2,644,801)	($2,644,801)	Average amount of provider integrity recoveries obtained over the last 3 fiscal years
B	Average Number of FTE	9.2	9.2	FY 2015-16 Average position count
C	Average Amount Recovered Per FTE	($287,478)	($287,478)	
D	Average Monthly Amount Recovered Per FTE	($23,957)	($23,957)	(Row C) / 12
E	Number of Requested FTE	6	6	
F	Number of Months After Training Ramp Up	6	12	Assumes 6 months of training
G	**Total Additional Amount Recovered**	**($862,435)**	**($1,724,870)**	**Row D * Row E * Row F**
H	General Fund	($249,072)	($498,144)	Assumes General Fund savings are consistent with the percent of General Fund expenditures in Medical Services Premiums in FY 2017-18
I	Cash Funds	($86,696)	($173,392)	Assumes cash fund savings are consistent with the percent of cash fund expenditures in Medical Services Premiums FY 2017-18
J	Federal Funds	($526,667)	($1,053,334)	Assumes federal fund savings are consistent with the percent of federal fund expenditures in Medical Services Premiums FY 2017-18

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-08 MMIS Operations

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___	Supplemental FY 2016-17
X	Change Request FY 2017-18
___	Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$124,932,128**	**$0**	**$99,029,028**	**$23,524,339**	**$5,707,012**
	FTE	400.3	0.0	400.6	1.8	2.0
	GF	$30,873,352	$0	$29,192,219	($566,430)	($1,641,310)
	CF	$8,940,225	$0	$7,882,030	$2,953,578	$2,253,604
	RF	$2,046,908	$0	$2,052,003	($275,978)	($281,168)
	FF	$83,071,643	$0	$59,902,776	$21,413,169	$5,375,886

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (A) General Administration - Personal Services	**Total**	**$29,707,221**	**$0**	**$29,797,905**	**$97,098**	**$107,886**
	FTE	400.3	0.0	400.6	1.8	2.0
	GF	$10,211,448	$0	$10,355,331	$24,275	$26,972
	CF	$2,994,337	$0	$2,952,905	$0	$0
	RF	$1,564,801	$0	$1,566,597	$0	$0
	FF	$14,936,635	$0	$14,923,072	$72,823	$80,914
01. Executive Director's Office, (A) General Administration - Health, Life, and Dental	**Total**	**$3,434,070**	**$0**	**$3,673,458**	**$15,854**	**$15,854**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,230,952	$0	$1,316,506	$3,964	$3,964
	CF	$337,577	$0	$349,778	$0	$0
	RF	$104,755	$0	$104,635	$0	$0
	FF	$1,760,786	$0	$1,902,539	$11,890	$11,890

01. Executive Director's Office, (A) General Administration - Short-term Disability	**Total**	**$55,072**	**$0**	**$57,991**	**$165**	**$184**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$20,569	$0	$21,560	$42	$46
	CF	$4,588	$0	$4,796	$0	$0
	RF	$1,393	$0	$1,365	$0	$0
	FF	$28,522	$0	$30,270	$123	$138
01. Executive Director's Office, (A) General Administration - Amortization Equalization Disbursement	**Total**	**$1,434,489**	**$0**	**$1,613,687**	**$4,350**	**$4,834**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$535,695	$0	$600,009	$1,088	$1,209
	CF	$119,586	$0	$133,459	$0	$0
	RF	$36,269	$0	$37,816	$0	$0
	FF	$742,939	$0	$842,403	$3,262	$3,625
01. Executive Director's Office, (A) General Administration - Supplemental Amortization Equalization Disbursement	**Total**	**$1,419,546**	**$0**	**$1,613,662**	**$4,350**	**$4,834**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$530,115	$0	$600,009	$1,088	$1,209
	CF	$118,340	$0	$133,459	$0	$0
	RF	$35,891	$0	$37,791	$0	$0
	FF	$735,200	$0	$842,403	$3,262	$3,625
01. Executive Director's Office, (A) General Administration - Operating Expenses	**Total**	**$2,058,538**	**$0**	**$2,035,574**	**$11,306**	**$1,900**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$930,699	$0	$923,963	$2,827	$475
	CF	$71,522	$0	$67,439	$0	$0
	RF	$10,449	$0	$10,449	$0	$0
	FF	$1,045,868	$0	$1,033,723	$8,479	$1,425
01. Executive Director's Office, (A) General Administration - Payments to OIT	**Total**	**$4,703,675**	**$0**	**$4,482,659**	**$325,000**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,974,295	$0	$1,881,535	$162,500	$0
	CF	$377,545	$0	$359,797	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,351,835	$0	$2,241,327	$162,500	$0

01. Executive Director's Office, (A) General Administration - General Professional Services and Special Projects	**Total**	**$7,200,237**	**$0**	**$7,755,477**	**($750,000)**	**($750,000)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,047,261	$0	$2,512,381	($187,500)	($187,500)
	CF	$1,527,500	$0	$1,227,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,625,476	$0	$4,015,596	($562,500)	($562,500)
01. Executive Director's Office, (C) Information Technology Contracts and Projects - MMIS Maintenance and Projects	**Total**	**$35,564,820**	**$0**	**$35,440,753**	**$5,501,405**	**$6,553,488**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,211,028	$0	$7,384,952	($1,526,183)	($1,405,046)
	CF	$2,226,262	$0	$2,191,808	$2,078,236	$2,253,604
	RF	$293,350	$0	$293,350	($281,542)	($281,168)
	FF	$25,834,180	$0	$25,570,643	$5,230,894	$5,986,098
01. Executive Director's Office, (C) Information Technology Contracts and Projects - MMIS Reprocurement Contracts	**Total**	**$26,916,597**	**$0**	**$0**	**$18,546,779**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,615,317	$0	$0	$1,034,108	$0
	CF	$701,879	$0	$0	$875,342	$0
	RF	$0	$0	$0	$5,564	$0
	FF	$23,599,401	$0	$0	$16,631,765	$0
01. Executive Director's Office, (C) Information Technology Contracts and Projects - Fraud Detection Software Contract	**Total**	**$250,000**	**$0**	**$250,000**	**($135,000)**	**($135,000)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$62,500	$0	$62,500	($34,155)	($34,155)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$187,500	$0	$187,500	($100,845)	($100,845)
01. Executive Director's Office, (E) Utilization and Quality Review Contracts - Professional Service Contracts	**Total**	**$12,187,863**	**$0**	**$12,307,862**	**($96,968)**	**($96,968)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,503,473	$0	$3,533,473	($48,484)	($48,484)
	CF	$461,089	$0	$461,089	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$8,223,301	$0	$8,313,300	($48,484)	($48,484)

CF Letternote Text Revision Required?	Yes	X	No		**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes	X	No	
FF Letternote Text Revision Required?	Yes		No	X
Requires Legislation?	Yes		No	X

Type of Request? Department of Health Care Policy and Financing Prioritized Request

Interagency Approval or Related Schedule 13s: OIT

Cost and FTE

- The Department requests a reduction of $1,495,480 total funds, including a reduction of $32,549 General Fund and 0.0 FTE in FY 2016-17; an increase of $23,524,339 total funds, including a reduction of $566,430 General Fund and an increase of 1.8 FTE in FY 2017-18; an increase of $5,707,012 total funds, including a reduction of $1,641,310 General Fund and an increase of 2.0 FTE in FY 2018-19; and, an increase of $5,707,012 total funds, including a reduction of $1,656,576 General Fund and an increase 2.0 FTE in FY 2019-20 and ongoing to address operational funding issues with the Medicaid Management Information System (MMIS).

Current Program

- The MMIS is an automated health care claims processing system and includes Fiscal Agent contracted services used to process and pay approximately $9 billion in Colorado Medicaid health care claims. The Department is implementing a new state of the art MMIS system beginning March 1, 2017.

Problem or Opportunity

- Funding is needed to address changes in funding needs for the various MMIS vendors resulting from the postponement of the new MMIS launch date, originally scheduled to begin October 31, 2016, to March 1, 2017. Funding adjustments, largely federal funds, are needed to adequately maintain current functionality until the new MMIS is able to successfully assume those functions.
- Funding adjustments between the MMIS budget lines and non-MMIS budget lines are needed to assure funding is appropriately aligned with the expenditures, including redistribution of funding out of balance with current FFP rates and caseload distributions.
- Two time-limited contract management positions are scheduled to end in FY 2016-17. Staff resources in FY 2017-18 forward are needed to manage vendor negotiations for the three main MMIS vendors, provide oversight of deliverables, and assure successful implementation of new policies, federal regulations and state laws through automated system solutions.
- The Department does not have sufficient funding to provide notifications to clients to assure that Medicaid co-pays incurred by all individuals in a Medicaid household do not exceed an aggregate limit of five percent of the family's income to be implemented with the launch of the new MMIS system.

Consequences of the Problem

- Without adequate state funding for the new MMIS maintenance and operations and Fiscal Agent services, the Department would be unable to meet claims-processing, analytical, and reporting needs and be unable to utilize available technology and analytical services that would achieve better health care and reduce costs.
- Without sufficient contract management resources, federal funds are at risk due to insufficient oversight of vendor resources, non-compliance with federal and state laws and regulation, and project delays.

Proposed Solution

- The Department requests additional funding, largely federal funds, for the new MMIS to ensure claims processing continues without interruption; transition of the new MMIS system from the development phase to the operational phase; align distribution of funding with current FFP rates; support data analytics; comply with federal requirements regarding co-pay notifications and provide for sufficient contract management resources.

Department Priority	***R-8***
Request Detail	***Medicaid Management Information System Operations Adjustment***

Summary of Incremental Funding Change for FY 2016-17	**Total Funds**	**General Fund**
MMIS Operations Adjustment	($1,495,480)	($32,549)

Summary of Incremental Funding Change for FY 2017-18	**Total Funds**	**General Fund**
MMIS Operations Adjustment	$23,524,339	($566,430)

Problem or Opportunity:

The Department does not have sufficient resources to address issues affecting the funding for the Medicaid Management Information System (MMIS). The Colorado Medicaid Management Innovation and Transformation (COMMIT) Project is the reprocurement project for the operations, maintenance, and development of systems enhancements of the new MMIS. The new MMIS consists of three systems including the Colorado interChange, supporting the core MMIS functions and Fiscal Agent Services; the Business Intelligence and Data Management (BIDM) system, which will provide data analytics services; and the Pharmacy Benefit Management System (PBMS), which will provide Pharmacy management services. The overall goal is to replace the legacy MMIS and existing Fiscal Agent services with a service delivery model that is both flexible and adaptable, which will provide easy access to data and comprehensive reporting. The funding issues related to the current and new MMIS include funding needs resulting from the postponement of the launch date of the new MMIS, redistribution of line item funding due to caseload and federal match rate adjustments, additional costs for transitioning the new MMIS from the design and development phase to the operational phase, need for additional contract management staffing and additional mailings to comply with federal requirements to notify clients when they have reached their co-pay limits.

Postponement of the New MMIS Launch

The new MMIS was originally scheduled to launch beginning October 31, 2016, but the launch has been postponed by four months to March 1, 2017. The Department is committed to minimizing disruptions to providers and members; in October 2016, the Department determined that a full launch on the original Go Live date could result in severe disruptions to services. A premature launch of the system could result in delayed or incorrect payments for services, risk of federal sanctions due to non-compliance with

requirements, public backlash, lawsuits over unpaid claims and sky-rocketing spending to repair the deficiencies in the system and from over-paid claims.

The Department is committed to assuring that the implementation of the new system does not negatively impact Medicaid members and providers. Before the release of this functionality, testing and rigorous evaluation for readiness is being performed and closely monitored to ensure the highest quality standard is met before delivering the system. The Department gathered information through user acceptance testing (UAT) and feedback from staff, providers and vendors. After a thorough evaluation of the system readiness for implementation, the Department determined that the provider enrollment and revalidation process had not been completed and therefore the system and Fiscal Agent services were not ready to assume the required operational responsibilities. The Department will continue testing of the new system and provider revalidation. The current MMIS will remain fully functioning until the new system is implemented.

There are several factors that led to the need for a postponement until March 1, 2017.

- Out of approximately 50,000 providers, over 8,000 providers and billing agents had not yet completed the provider enrollment and revalidation process, which is federally required for all providers. Providers must complete this process to receive payment. Approximately 2,500 providers per month complete enrollment, therefore, a four month postponement should be sufficient time to complete the enrollment and revalidation of all providers.
- UAT had only occurred for high priority test cases. A postponed implementation will allow more time to thoroughly test all aspects of the system, and make corrections and improvements prior to the implementation.
- Many providers had not received training. The postponement will allow providers time become familiar with the many differences in business processes between the current system and the new MMIS.
- Claims processing functionality differs between the two systems. Additional testing is needed so that claims processed through the new system are correct and pay similar to the current system.
- More time was needed for external testing of compatibility with provider systems to exchange information with the new MMIS.
- The postponement provides more time for the Department to ensure that the new MMIS will be deemed fully operational from the implementation date after the CMS system certification process is complete. Federal MMIS Certification is a process by which the Centers for Medicare and Medicaid Services (CMS) validates that the system is designed to support the efficient and effective management of the Medicaid Program and that the State is in compliance with requirements set forth in applicable laws and regulations, as well as CMS guidance, manuals, and State Medicaid Director letters. This ensures the Department is able to meet conditions to obtain federal funding at an enhanced 75% FFP rate for operational activities, pursuant to 42 CFR § 433.117. Otherwise, federal reimbursement would only be available at the 50% FFP rate until the date the system can be deemed certified.

The Department is negotiating new terms for the current and new vendors to address the current costs due to the postponement. There are cost increases and changes in the balance of funding across the funding sources

based on the ability to attribute enhanced federal matching rates for certain costs. Now that the system will be entering the operational phase, the Department is needing funding adjustments ongoing to account for changes in business needs and match rates that are not manageable within framework of the existing appropriations.

BUS Operational Support

Continued business analyst and developer resources are needed to support the operations of the Benefits Utilization System (BUS) in FY 2017-18. The funding obtained for additional BUS support through the FY 2014-15 S-8, FY 2015-16 BA-8 Legacy Systems and Technology Support request ends in FY 2016-17. The BUS is a database application maintained by the Governor's Office of Information Technology (OIT) used to input and store client assessments that determine eligibility for Long Term Services and Supports (LTSS) programs. The BUS is also used to create and update LTSS client service plans that document client needs and are subsequently used to determine authorization of Medicaid payments. Service plans must be updated timely to ensure a client's authorized services match his or her changing needs. Finally, BUS data is used to fulfill federal reporting requirements of the Centers for Medicare and Medicaid Services (CMS) to maintain ongoing federal funding for the Department's home and community based services (HCBS) waivers. The Versatile Interoperable Technology Advancing Lives System (VITAL) system was scheduled to replace the BUS on November 1, 2016. As the Department is in the process of rolling out a new replacement MMIS, the VITAL system is a part of the MMIS anticipated to replace the operations of the BUS. However, due to a postponement in the implementation of the new MMIS, the full implementation of the VITAL system is expected to be moved until sometime late in FY 2017-18 to allow for sufficient user training and acceptance. Additionally, the Department is required to maintain information included in the BUS after the system is decommissioned for federal auditing purposes. The information must be properly secured to comply with federal security requirements, but currently does not meet the federal standard.

Operational Funding True-up

The Department is seeking to make adjustments to true-up funding of the MMIS for the operational phase of the system.

MMIS Maintenance and Projects True-Up

The Department's request includes an adjustments to the MMIS Maintenance and Projects line from FY 2016-17 through FY 2019-20 due to changes in FFP rates, caseload trends, and proportionate distribution among cash funds. If the share of funding among the various funding sources is not adjusted, the imbalance in funds could result in the Department not having sufficient funding to fully utilize the total funds appropriated in the line item. The "M" headnote that applies to the three MMIS line items further adds to the inflexibility in use of the funding and potential difficulties in funding expenditures.

The Children's Health Plan *Plus* (CHP+) program FFP rate has increased from 65% FFP, which is the rate on which the current funding is based, to a blended rate of 88.13% FFP in FY 2016-17, and 88% in FY 2017-18, FY 2018-19 and FY 2019-20. The Hospital Provider Fee (HPF) population is a much larger share of the caseload than proportionately represented in the appropriations supporting the MMIS reprocurement and new operating systems. Caseload and expenditures for the Old Age Pension Health and Medical Care Program, otherwise known as the OAP State Only (OAP-SO) Medical Care Program, have decreased significantly

primarily resulting from new provisions of SB 13-200, which expand Medicaid eligibility to clients previously eligible for OAP-SO. The MMIS budget lines have not been adjusted to correspond with this shift in OAP-SO caseload and costs. As a result the current amount of OAP Health and Medical Cash Funds in the MMIS budget lines is over represented in the appropriations.

Other Line Item Adjustments:
The new MMIS will assume functions that were previously done through other vendors for Nursing Facility Prior Authorization Requests (PARs), Electronic Surveillance Utilization Review System (ESURS), SmartPA - Automated Prior Authorizations. Funding for the statewide data analytics contractor has already been adjusted in the Department's FY 2016-17 R-1 Medical Services Premiums request. The Department's needs related to these functions is addressed through the overall operational funding true-up of the MMIS Maintenance and Projects line.

MMIS Reprocurement Line Items True-up
For the MMIS Reprocurement Contracted Staff line item, the FY 2016-17 total funds need is overstated; conversely, for the MMIS Reprocurement Contracts line item, the FY 2016-17 total funds need is understated. For the MMIS Reprocurement Contract Staff line item, the reason for the imbalance is that a significant portion of expenses for contracted staff, originally approved by CMS at a 90% FFP match rate, were changed by CMS to a 50% FFP match rate, resulting in more General Fund need and less federal fund need. The Department elected to partially forgo utilization of contract staff to stay within the General Fund appropriations, however, this has left the Department unable to expend a large amount of total funds, mostly federal funds to support the needs of the MMIS reprocurement functions through contract staff. Given the issues with the federal match and the current status of reprocurement related needs, the further funding of contract staff is no longer the optimal means of supporting the MMIS reprocurement needs.

For the MMIS Reprocurement Contracts line item, the reason for the imbalance is that expenses for Commercial Off The Shelf (COTS) software products, which receive a 75% FFP match rate, are lower than expected, while expenses for general system implementation, which receive a 90% FFP match rate, are higher than expected, resulting in overall less General Fund need and more federal funds need. As the Department is moving from the reprocurement and development phase to the operational phase of the new system, additional funding needs have become apparent that were not sufficiently included in the original funding request to support the current development needs.

After reassessment of the needs of both MMIS Reprocurement line items together, the Department has determined funding needs have shifted related to the purposes of the two lines with FY 2016-17, and some costs are shifting from FY 2016-17 to FY 2017-18 due to the postponement. Without adjustments to these two line items, the funding is not representative of the true needs associated with each line item purpose and not accurately represented within the two fiscal years.

MMIS Contract Management FTE
The Department currently has two time-limited contract management positions funded under the MMIS Reprocurement Contracted Staff line item. The positions were established in 2013 to support the COMMIT Project. The COMMIT Project is taking the Department from one contractor providing fiscal agent services and MMIS for claims processing to three contractors to provide fiscal agent services, claims processing,

pharmacy benefit management and business intelligence/data management. Contract monitoring is an essential part of the contracting process. Monitoring should ensure that contractors comply with the contract terms, performance expectations are achieved, and any problems are identified and resolved. The number of contracts and complexity of the contractual oversight requirements of the new MMIS system has significantly increased. The Department is not able to ensure effective and efficient management of the MMIS contracts without additional staff resources. Two permanent staff are needed to deal with the increases in contract activity, contractor management, complexity of contractual requirements, and impact of new regulatory requirements on an ongoing basis. Without two additional FTE to effectively manage contractual obligations of the three contractors responsible for the ongoing maintenance and operations of the new MMIS system, the success of system implementation on ongoing operations is at risk. The Department needs to assure that sufficient contract management resources are available for proper oversight of vendor resources to avoid contract errors, project delays, federal fiscal penalties and disallowances, and to assure accountability of the vendors for their contractual responsibilities.

Co-Pay Limit Notifications

The legacy MMIS does not have the capability to notify clients and providers when the maximum aggregate co-pay limit has been reached. Section 42 CFR § 447.56 sets limitations on premiums and cost sharing. Medicaid co-pays incurred by all individuals in a Medicaid household must not exceed an aggregate limit of five percent of the family's income on either a monthly or quarterly basis, at the State's option. Colorado has selected monthly. Additionally, the Department must provide the following information to beneficiaries at the time of enrollment and at the time any change to cost sharing and premiums:

- Groups who are subject to premiums and cost sharing
- Amounts of co-pays
- Mechanisms for making payment of co-pays
- Consequence of not paying the co-pay
- List of hospitals, if any, that charge co-pays for non-emergency use of the emergency department, and,
- List of preferred drugs subject to the lower cost sharing.

States must make this information publically available as well. Providers will verify information at the point of service whether the patient has a co-payment. This can be accomplished through automated services through the new MMIS or through the Department's Fiscal Agent provider call center accessible to all Medicaid providers.

Proposed Solution:

The Department requests a reduction of $1,495,480 total funds, including a reduction of $32,549 General Fund and 0.0 FTE in FY 2016-17; an increase of $23,524,339 total funds, including a reduction of $566,430 General Fund and an increase of 1.8 FTE in FY 2017-18; $5,707,012 total funds, including a reduction of $1,641,310 General Fund and an increase of 2.0 FTE in FY 2018-19; and, $5,707,012 total funds, including a reduction of $1,656,576 General Fund and increase 2.0 FTE in FY 2019-20 and ongoing to address operational funding issues with the MMIS.

Postponement of the New MMIS Launch

Government technology implementation projects have high rates of failure because the requirements tend to be complex and new to organizations, with far-reaching business implications and the ability to impact a variety of stakeholders. MMIS projects are large, complex, lengthy, expensive, and often political in nature. Numerous state Medicaid MMIS implementation projects have suffered highly visible failures and states have spent millions of dollars more to correct initial errors. The Department's postponement of the implementation of Colorado's new MMIS is essential to ensure a successful launch of the system. It is vital that the Department take the additional time to address the provider enrollment and revalidation process and continue testing the new system. This will allow the Department to avoid the risks and enormous cost increases experienced in other states.

It is critical that staff and providers are confident that an appropriate testing process has been completed and that results of the testing process are truly indicative of the system's performance in a production environment. The additional four months will allow the Department to further collaborate with its provider community to embrace and realize the benefits of the new system. The postponement provides providers more time to complete the enrollment and revalidation process, to receive comprehensive training, and prepare for the associated changes in their business processes. The request will adjust funding to achieve all the objectives of the MMIS operational needs including funding needs resulting from the postponement in implementation. The fiscal impact of this change is included in the Operation Funding True-up section below.

<u>BUS Operational Support</u>

The Department requests $325,000 total funds, including $162,500 General Fund in FY 2017-18 to continue staff support of the BUS consistent with the funding currently appropriated in FY 2016-17 through the Payments to OIT line item. The Department is not anticipating the need for staff support in FY 2018-19. Department is seeking a cost effective means of providing support through time-limited staff resources. Based on OIT estimates, the funding would support one full-time ColdFusion Developer, one full-time Database Administrator, and one half-time Business Analyst to oversee the continued work of the BUS application and prepare for the transition to VITAL, plus $4,205 for hardware and software licenses as needed. These resources would keep the BUS application operating and allow for continued development and security remediation. Since the BUS application must be extended due to the postponement of VITAL full implementation to allow for sufficient user training and acceptance, using time-limited staff is more cost effective than using contract staff to maintain the system until the VITAL system is fully operational.

Operational Funding True-up

The Department requests to adjust the appropriations to provide better representation of federal matching funds based on current needs and federal approvals. Revisiting the makeup of the costs and appropriations provides an opportunity to assure appropriate and efficient use of state and federal funds and make sure that the new system is adequately funded. This request for the operational true-up of costs involves several components including funding redistribution of the three MMIS lines and several other line items with MMIS related funding to address current needs.

MMIS Maintenance and Projects Line True-up

The request associated with true-up of funds in the MMIS Maintenance and Projects line is an increase of $1,716,274 total funds, including an increase of $1,267,940 General Fund in FY 2016-17; $5,501,405 total funds, including a decrease of $1,526,183 General Fund in FY 2017-18; $6,556,488 total funds, including a reduction of $1,405,046 General Fund in FY 2018-19; $6,553,488 total funds, including a reduction of $1,420,312 General Fund in FY 2019-20 and ongoing. The increase in total funds is largely federal funds.

The Children's Health Plan *Plus* (CHP+) will be adjusted to a blended rate of 88.13% FFP in FY 2016-17, and 88% rate in FY 2017-18 and ongoing. The Department adjustment for state share of costs to match CHP+ federal funds would be with Children's Basic Health Plan (CBHP) Trust funds and Hospital Provider Fee cash fund. The caseload for clients funded under Title XXI is forecasted to be 8.81% of the total caseload in FY 2017-18; 8.75% in FY 2018-19; and 8.72% in FY 2019-20 which includes the CHP+ caseload and the Medicaid caseload funded under Title XXI. Adjustments to Title XXI proportionate share of costs will be done in FY 2017-18 forward to allow time for approval of changes to cost allocation methodologies with CMS. The Department is proposing to align funding from the HPF cash fund for FY 2017-18 through FY 2019-20 with the proportionate share of costs based on the HPF caseload trends. However, because the HPF model has been finalized and approved for FY 2016-17, the Department is not proposing any changes to the current amount of HPF cash funds in the FY 2016-17 appropriation.

Other Line Item Adjustments:

The Department requests a reduction of $981,968 total funds, including a reduction of $270,139 General Fund in FY 2017-18 and ongoing that is included in other non-MMIS line items for the Nursing Facility Prior Authorization Requests (PARs), the Electronic Surveillance Utilization Review System (ESURS), and the SmartPA (Automated Prior Authorizations) as those functions are included in the new MMIS, and therefore, the costs are included in the overall funding projections for the MMIS Maintenance and Projections line item in this request. As such the source of funding for these three specific operations in the existing line items is no longer needed.

These items include reductions of:

- $96,968 (50% General Fund) for Nursing Facility Prior Authorization Requests (PARs) from the Professional Services Contracts line item.
- $135,000 (25% General Fund) Electronic Surveillance Utilization Review System (ESURS) from the Fraud Detection Software Contract line item.
- $750,000 (25% General Fund) SmartPA - Automated Prior Authorizations - from the General Professional Services Special Projects line item.

Funding has already been reduced for the Statewide Data Analytics Contract (SDAC) from the Medical Services Premiums line item by $2,000,000 (50% General Fund) in FY 2016-17 and by $3,000,000 (50% General Fund) in FY 2017-18 and ongoing through the FY 2016-17 R-1 Medical Services Premiums request.

MMIS Reprocurement Line Item True-up

The Department requests a decrease of $4,675,328 total funds, including a decrease of $60,222 General Fund for FY 2016-17 to the MMIS Reprocurement Contracted Staff line item. The line item is eliminated in FY 2017-18.

The Department request an increase of $1,463,374 total funds, including a decrease of $1,240,267 General Fund to the MMIS Reprocurement Contracts line item for FY 2016-17; and funding in FY 2017-18 of $18,546,779 total funds, including $1,034,108 General Fund.

Taking the two line items together, this represents a net decrease of $3,211,754 total funds, including a net decrease of $1,300,489 General Fund for FY 2016-17; and an increase of $18,546,779 total funds, including $1,034,108 General Fund in FY 2017-18. The FY 2017-18 increase is largely federal funds at $16,631,765 due to the 90% FFP available for the costs associated with the MMIS Reprocurement Contracts line. The requested adjustment would true-up the reprocurement line items with actual need, accounting for the change in federal match rate from 90% to 50% for contracted staff in the MMIS Reprocurement Contracted Staff line item and COTS software products at the 75% FFP rate and greater need for general system implementation at the 90% FFP rate in the MMIS Reprocurement Contracts line item. This requested adjustment would also true-up both line items to the new FY 2016-17 and FY 2017-18 CHP federal match rates.

MMIS Contract Management FTE

The Department is requesting $133,123 total funds, including $33,284 General Fund and $99,839 federal funds, and 1.8 FTE in FY 2017-18, and $135,492 total funds, including $33,875 General Fund and $101,617 federal funds, and 2.0 FTE in FY 2018-19 and ongoing at the 75% FFP rate for the Personal Services costs and 50% FFP for associated Operating Expenses for contract management of the MMIS contracts. The Department currently has two time-limited contract management positions funded under the MMIS Reprocurement line item. Replacing these time-limited positions with permanent FTE is an important step in assuring that implementation and ongoing operations and management of the new MMIS. These staff would be required to maintain a unique level of knowledge and expertise in policy, systems, and operations that is needed to manage these contracts. The positions would serve as the point of contact for the Department on contractual matters and act as contractual liaison between Department staff and the vendors, ensuring timely handling of issues. With implementation of a new operating systems comes a certain amount of risk. These positions would have an instrumental role in mitigating deficits that might occur with implementation of the new system so that full certification of the new MMIS could occur within the earliest possible timeframe.

The current contract management staff resources are not sufficient to assume the increased responsibilities of the three main vendor contracts associated with the new MMIS. The positions would be responsible for managing the ongoing procurement processes related to the contracts, including contract modifications, development of solicitations, scopes of work, deliverables, performance measures and desired outcomes. These positions would also be responsible for monitoring the contractor progress and performance to ensure goods and services conform to the contract requirements; identifying potential problems and solutions or mitigations; reviewing invoices and authorizing payments consistent with the contract terms; arranging for contractor access to state facilities, equipment, data, staff, materials and information, as applicable; establishing reporting requirements; maintaining appropriate records; and participating in audits.

Co-Pay Limit Notifications

The Department requests $368,992 total funds, including $179,119 General Fund (including an adjustment of $69,241 to hold hospital provider fee cash funds at the current level), increase of $1,103 cash funds, increase of $111 reappropriated funds, and increase of $188,659 federal funds in FY 2016-17; $553,488 total funds, including an increase of $152,292 General Fund, $105,207 cash funds, $166 reappropriated funds, and $295,286 federal funds in FY 2017-18; and $553,488 total funds, including an increase of $150,958 General Fund, $107,050 cash funds, $166 reappropriated funds, and $295,314 federal funds in FY 2018-19; $553,488 total funds, including $150,278 General Fund, $107,714 cash funds, $166 reappropriated funds, and $295,330 federal funds in FY 2019-20 and ongoing. These amounts are included in the MMIS Maintenance and Projects Line True-up calculations. To provide client notices, the new MMIS, will utilize a systematic process to trigger both electronic and paper correspondence to Medicaid clients at enrollment when they have a co-pay, and when they have reached the five percent threshold for the month. The Department is required to comply with these requirements with the implementation of the new MMIS.

Anticipated Outcomes:

The funding to support operations of the new MMIS aligns with the Department's Performance Plan strategy to maximize use of the health information technology and data analytics, aligning these efforts with the broader health care system. The new MMIS system will advance the Department's analytic and business intelligence capabilities through a business intelligence and data management (BIDM) vendor, and include a pharmacy benefit management system (PBMS) providing claims processing, drug utilization review, and other pharmacy benefit management functionality. The Colorado interChange will improve our ability to process and pay medical claims, BIDM will enhance the Department's analytic and business intelligence capabilities, and PBMS will enable point of sale pharmacy claims processing, drug utilization review, and other functions. Capabilities of the new Colorado interChange system include a web-based member portal that can be accessed from a computer or mobile device. The portal advances the Department's strategy of increasing member engagement and health literacy by allowing members to easily keep their information up to date, find a doctor, and access important health information from their phone or computer.

Postponement of the New MMIS Launch

The Department is striving to ensure that the implementation team maintains a strategic approach to keep the COMMIT project moving toward established objectives, including deploying business process improvements, achieving system certification and meeting regulatory requirements. Employing these strategies will lead to a higher probability of implementation success. While implementation of a new MMIS is a significant undertaking because of the nature of the projects and requirements, the implementation is expected to be successful with the right mitigation strategies including planning, leadership, system validation, project monitoring and metrics, business process transformation, and risk management. The funding changes will help position the state as a leader in the administration of Medicaid programs with the most advanced and effective tools available to benefit its citizens.

Operational Funding True-up, and Co-Pay Notifications

The request seeks to align distribution of funding with current FFP rates, support data analytics, and to comply with federal requirements regarding co-pay notifications, which aligns with the Operational Excellence goal in the Department's Performance Plan to promote compliance with federal and state laws

and regulations. This request further aligns with the Department's strategy to expand the use of value-based purchasing methods by utilizing data analytics tools to correlate high quality with low cost to inform selection of services and providers. The funding adjustments to align appropriations with changes in federal FFP rates, caseload trends, effective use of cash funds, and identification of true funding needs promotes financial stewardship.

MMIS Contract Management FTE

This request aligns with the Department's strategy to improve efficiency of business processes by supporting this strategy focus on efficient and effective administration of the Medicaid programs, including IT infrastructure. Systematically and efficiently managing the MMIS contracts through the entire contract life cycle is vital for maximizing operational and financial performance and minimizing risk. Having full-time staff will allow these staff to establish relationships with the contractors, become knowledgeable of the contracts and learn the contracting and contractor payment processes utilized by the Department. The Department would have close oversight and management of contractors' performance which would result in compliance with the work requirements ensuring the Department receives all goods and/or services that the contractors are required to provide and a monitoring of expenditures. In addition, the Department would have staff that are knowledgeable of contractor management and Department processes which would increase operational effectiveness related to the various responsibilities of a contract manager.

Assumptions and Calculations:

Detailed calculations of the request are provided in the attached appendix. A summary of the incremental request by fiscal year and by line item is shown in tables 1.1a through 1.1d, by the specific cash funds and reappropriated funds in tables 1.2a through 1.2d, and by the components of this request in tables 2a through 2d.

Some of the system costs are shifted between line items and between fiscal year FY 2016-17 and FY 2017-18 and are included in the calculations for each of the MMIS line items. Details of the Operational Funding True-up are shown in tables 3.1a through 3.4d. As the new MMIS enters its operational phase, the MMIS operational appropriation is needing funding adjustments to align to the new system and its ongoing operational expenses with current federal FFP rates, to make technical corrections in the funding for caseload related adjustments, and to address federal regulatory requirements that result in funding impacts. Additionally, changes in funding needs that have resulted from the postponement of the implementation of the system are included in these calculations.

Table 3.1a through 3.1d provides the true-up of funding for the MMIS Maintenance and Projects line item, including adjustments needed to extend the use of the legacy MMIS system and including the cost of the mailing related to federal co-pay requirements. The breakout in expenditures by the components of the system in total funds and by FFP method is provided in table 3.2. The specific breakout of costs of the Co-Pay Limit Notifications are provided in table 3.3. The FY 2016-17 impact is only for 4 months because the implementation of this requirement will align with the rollout of the new MMIS. The FY 2017-18 impact is for the full 12 months. The Department assumes that the requirement will not be applied retroactively. The co-pay is limited to 5% of the client's adjusted income. When the client's share of cost has reached the co-pay limit, a notice will be mailed to the client. Additionally, the Department assumes that the mailing cost

of the notice would be $0.46 based on contractor quote. The average mailings for clients that are at the five percent co-pay maximum is 100,269 based on FY 2015-16 data. Tables 3.4a through 3.4d provides the various fund split percentages for all funding sources for FY 2016-17 through FY 2019-20.

The Department is also seeking to make adjustment between the MMIS Reprocurement line items because funding in both of the lines are not representative of the true needs. A large amount for federal funds remains in the MMIS Reprocurement Contract Staff line item due to CMS corrections to staffing FFP rates that did not qualify for the 90% enhanced match. The Department will implement some components that are not federally required to certify the system during the post go-live phase of the new MMIS system. Therefore, some of the costs for design and development in the MMIS reprocurement lines are shifted into FY 2017-18 in this request. Tables 4.1a through 4.1c shows the changes funding need to accommodate changes in the MMIS Reprocurement Contract Staff and MMIS Reprocurement Contracts lines to address current funding needs. The Department is seeking to include a large amount of federal funds to get the best use of enhanced match rates for the design and development of the system. Tables 4.2 and Table 5 if the FTE calculator for the two contract management FTE included in this request. The Department assumes that the contract management staff would be at the Contract Administrator III classification level, which is consistent with other contract management positions with similar responsibilities. Table 6 includes the other line item costs that are being reduced for functions that will be addressed through the new MMIS. Table 7 provides the detailed calculations for the estimated BUS cost needed for the transition to VITAL.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

Portions of this request require supplemental funding in FY 2016-17 and qualify as such by meeting the criteria of an unforeseen contingency.

The MMIS implementation was postponed for reasons that were not reasonably foreseeable by the Department. The Operational Funding True-up, and Co-Pay limit notifications portions of this request were unforeseen contingencies and as such each need specific funding adjustments for FY 2016-17. These adjustments would assure that the development, implementation, maintenance, and ongoing operation of the new MMIS will be successful.

Table 1.1a: FY 2016-17 Request Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	**Total FY 2016-17 Request**	**($1,495,480)**	**0.0**	**($32,549)**	**($537,805)**	**($269,394)**	**($655,732)**	Sum Rows B through D
B	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$1,716,274	0.0	$1,267,940	($306,876)	($279,984)	$1,035,194	Table 1.2a Row B
C	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Reprocurement Contracted Staff	($4,675,328)	0.0	($60,222)	($37,064)	$915	($4,578,957)	Table 1.2a Row C
D	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Reprocurement Contracts	$1,463,574	0.0	($1,240,267)	($193,865)	$9,675	$2,888,031	Table 1.2a Row D

Table 1.1b: FY 2017-18 Request Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	**Total FY 2017-18 Request**	**$23,524,339**	**1.8**	**($566,430)**	**$2,953,578**	**($275,978)**	**$21,413,169**	Sum Rows B through M
B	(1) Executive Director's Office; (A) General Administration, Personal Services	$97,098	1.8	$24,275	$0	$0	$72,823	Table 1.2b Row B
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$3,964	$0	$0	$11,890	Table 1.2b Row C
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$165	0.0	$42	$0	$0	$123	Table 1.2b Row D
E	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$4,350	0.0	$1,088	$0	$0	$3,262	Table 1.2b Row E
F	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$4,350	0.0	$1,088	$0	$0	$3,262	Table 1.2b Row F
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$11,306	0.0	$2,827	$0	$0	$8,479	Table 1.2b Row G
H	(1) Executive Director's Office; (A) General Administration, Payments to OIT	$325,000	0.0	$162,500	$0	$0	$162,500	Table 1.2b Row H
I	(1) Executive Director's Office; (A) General Administration, General Professional Services	($750,000)	0.0	($187,500)	$0	$0	($562,500)	Table 1.2b Row I
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$5,501,405	0.0	($1,526,183)	$2,078,236	($281,542)	$5,230,894	Table 1.2b Row J
K	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Reprocurement Contracts	$18,546,779	0.0	$1,034,108	$875,342	$5,564	$16,631,765	Table 1.2b Row K
L	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Fraud Detection Software Contract	($135,000)	0.0	($34,155)	$0	$0	($100,845)	Table 1.2b Row L
M	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	($96,968)	0.0	($48,484)	$0	$0	($48,484)	Table 1.2b Row M

Table 1.1c: FY 2018-19 Request Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	**Total FY 2018-19 Request**	**$5,707,012**	**2.0**	**($1,641,310)**	**$2,253,604**	**($281,168)**	**$5,375,886**	Sum Rows B through K
B	(1) Executive Director's Office; (A) General Administration, Personal Services	$107,886	2.0	$26,972	$0	$0	$80,914	Table 1.2c Row B
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$3,964	$0	$0	$11,890	Table 1.2c Row C
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$184	0.0	$46	$0	$0	$138	Table 1.2c Row D
E	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$4,834	0.0	$1,209	$0	$0	$3,625	Table 1.2c Row E
F	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$4,834	0.0	$1,209	$0	$0	$3,625	Table 1.2c Row F
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$1,900	0.0	$475	$0	$0	$1,425	Table 1.2c Row G
H	(1) Executive Director's Office; (A) General Administration, General Professional Services	($750,000)	0.0	($187,500)	$0	$0	($562,500)	Table 1.2c Row H
I	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$6,553,488	0.0	($1,405,046)	$2,253,604	($281,168)	$5,986,098	Table 1.2c Row I
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Fraud Detection Software Contract	($135,000)	0.0	($34,155)	$0	$0	($100,845)	Table 1.2c Row J
K	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	($96,968)	0.0	($48,484)	$0	$0	($48,484)	Table 1.2c Row K

Table 1.1d: FY 2019-20 and Ongoing Request Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	**Total FY 2019-20 and Ongoing Request**	**$5,707,012**	**2.0**	**($1,656,576)**	**$2,286,321**	**($281,146)**	**$5,358,413**	Sum Rows B through K
B	(1) Executive Director's Office; (A) General Administration, Personal Services	$107,886	2.0	$26,972	$0	$0	$80,914	Table 1.2d Row B
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$3,964	$0	$0	$11,890	Table 1.2d Row C
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$184	0.0	$46	$0	$0	$138	Table 1.2d Row D
E	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$4,834	0.0	$1,209	$0	$0	$3,625	Table 1.2d Row E
F	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$4,834	0.0	$1,209	$0	$0	$3,625	Table 1.2d Row F
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$1,900	0.0	$475	$0	$0	$1,425	Table 1.2d Row G
H	(1) Executive Director's Office; (A) General Administration, General Professional Services	($750,000)	0.0	($187,500)	$0	$0	($562,500)	Table 1.2d Row H
I	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$6,553,488	0.0	($1,420,312)	$2,286,321	($281,146)	$5,968,625	Table 1.2d Row I
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Fraud Detection Software Contract	($135,000)	0.0	($34,155)	$0	$0	($100,845)	Table 1.2d Row J
K	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	($96,968)	0.0	($48,484)	$0	$0	($48,484)	Table 1.2d Row K

Table 1.2a: FY 2016-17 Request Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds				Reappropriated Funds		Federal Funds	Source
					Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund		
A	**Total FY 2016-17 Request**	**($1,495,480)**	**0.0**	**($32,549)**	**($537,790)**	**$1,870**	**($1,885)**	**$0**	**($195,369)**	**($74,025)**	**($655,732)**	Sum Rows B through D
B	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$1,716,274	0.0	$1,267,940	($304,991)	$0	($1,885)	$0	($195,369)	($84,615)	$1,035,194	Table 2a Row A
C	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Reprocurement Contracted Staff	($4,675,328)	0.0	($60,222)	($37,064)	$0	$0	$0	$0	$915	($4,578,957)	Table 2a Row B
D	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Reprocurement Contracts	$1,463,574	0.0	($1,240,267)	($195,735)	$1,870	$0	$0	$0	$9,675	$2,888,031	Table 2a Row C

Table 1.2b: FY 2017-18 Request Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds				Reappropriated Funds		Federal Funds	Source
					Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund		
A	**Total FY 2017-18 Request**	**$23,524,339**	**1.8**	**($566,430)**	**$224,955**	**$2,730,508**	**($1,885)**	**$0**	**($195,369)**	**($80,609)**	**$21,413,169**	Sum Rows B through M
B	(1) Executive Director's Office; (A) General Administration, Personal Services	$97,098	1.8	$24,275	$0	$0	$0	$0	$0	$0	$72,823	Table 5 Salary, PERA and Medicare
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$3,964	$0	$0	$0	$0	$0	$0	$11,890	Table 5 Health-Life-Dental
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$165	0.0	$42	$0	$0	$0	$0	$0	$0	$123	Table 5 Short Term Disability
E	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$4,350	0.0	$1,088	$0	$0	$0	$0	$0	$0	$3,262	Table 5 AED
F	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$4,350	0.0	$1,088	$0	$0	$0	$0	$0	$0	$3,262	Table 5 SAED
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$11,306	0.0	$2,827	$0	$0	$0	$0	$0	$0	$8,479	Table 5 Operating Expenses
H	(1) Executive Director's Office; (A) General Administration, Payments to OIT	$325,000	0.0	$162,500	$0	$0	$0	$0	$0	$0	$162,500	Table 2b Row E
I	(1) Executive Director's Office; (A) General Administration, General Professional Services	($750,000)	0.0	($187,500)	$0	$0	$0	$0	$0	$0	($562,500)	Table 6 Row A
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$5,501,405	0.0	($1,526,183)	$58,219	$2,021,902	($1,885)	$0	($195,369)	($86,173)	$5,230,894	Table 2b Row A
K	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Reprocurement Contracts	$18,546,779	0.0	$1,034,108	$166,736	$708,606	$0	$0	$0	$5,564	$16,631,765	Table 2b Row B
L	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Fraud Detection Software Contract	($135,000)	0.0	($34,155)	$0	$0	$0	$0	$0	$0	($100,845)	Table 6 Row B
M	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	($96,968)	0.0	($48,484)	$0	$0	$0	$0	$0	$0	($48,484)	Table 6 Row C

Table 1.2c: FY 2018-19 Request Summary by Line Item												
Row	Line Item	Total Funds	FTE	General Fund	Cash Funds				Reappropriated Funds		Federal Funds	Source
					Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund		
A	**Total FY 2018-19 Request**	**$5,707,012**	**2.0**	**($1,641,310)**	**$70,650**	**$2,184,839**	**($1,885)**	**$0**	**($195,369)**	**($85,799)**	**$5,375,886**	Sum Rows B through K
B	(1) Executive Director's Office; (A) General Administration, Personal Services	$107,886	2.0	$26,972	$0	$0	$0	$0	$0	$0	$80,914	Table 5 Salary, PERA and Medicare
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$3,964	$0	$0	$0	$0	$0	$0	$11,890	Table 5 Health-Life-Dental
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$184	0.0	$46	$0	$0	$0	$0	$0	$0	$138	Table 5 Short Term Disability
E	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$4,834	0.0	$1,209	$0	$0	$0	$0	$0	$0	$3,625	Table 5 AED
F	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$4,834	0.0	$1,209	$0	$0	$0	$0	$0	$0	$3,625	Table 5 SAED
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$1,900	0.0	$475	$0	$0	$0	$0	$0	$0	$1,425	Table 5 Operating Expenses
H	(1) Executive Director's Office; (A) General Administration, General Professional Services	($750,000)	0.0	($187,500)	$0	$0	$0	$0	$0	$0	($562,500)	Table 6 Row A
I	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$6,553,488	0.0	($1,405,046)	$70,650	$2,184,839	($1,885)	$0	($195,369)	($85,799)	$5,986,098	Table 2c Row A
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Fraud Detection Software Contract	($135,000)	0.0	($34,155)	$0	$0	$0	$0	$0	$0	($100,845)	Table 6 Row B
K	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	($96,968)	0.0	($48,484)	$0	$0	$0	$0	$0	$0	($48,484)	Table 6 Row C

Table 1.2d: FY 2019-20 and Ongoing Request Summary by Line Item												
					Cash Funds				Reappropriated Funds			
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Children's Basic Health Plan Trust**	**Hospital Provider Fee Cash Fund**	**Colorado Autism Treatment Fund**	**Department of Health Care Policy and Financing Cash Fund**	**Public School Health Services**	**Old Age Pension Health and Medical Care Fund**	**Federal Funds**	**Source**
A	**Total FY 2019-20 and Ongoing Request**	**$5,707,012**	**2.0**	**($1,656,576)**	**$71,733**	**$2,216,473**	**($1,885)**	**$0**	**($195,369)**	**($85,777)**	**$5,358,413**	Sum Rows B through K
B	(1) Executive Director's Office; (A) General Administration, Personal Services	$107,886	2.0	$26,972	$0	$0	$0	$0	$0	$0	$80,914	Table 5 Salary, PERA and Medicare
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$3,964	$0	$0	$0	$0	$0	$0	$11,890	Table 5 Health-Life-Dental
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$184	0.0	$46	$0	$0	$0	$0	$0	$0	$138	Table 5 Short Term Disability
E	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$4,834	0.0	$1,209	$0	$0	$0	$0	$0	$0	$3,625	Table 5 AED
F	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$4,834	0.0	$1,209	$0	$0	$0	$0	$0	$0	$3,625	Table 5 SAED
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$1,900	0.0	$475	$0	$0	$0	$0	$0	$0	$1,425	Table 5 Operating Expenses
H	(1) Executive Director's Office; (A) General Administration, General Professional Services	($750,000)	0.0	($187,500)	$0	$0	$0	$0	$0	$0	($562,500)	Table 6 Row A
I	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$6,553,488	0.0	($1,420,312)	$71,733	$2,216,473	($1,885)	$0	($195,369)	($85,777)	$5,968,625	Table 2d Row A
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Fraud Detection Software Contract	($135,000)	0.0	($34,155)	$0	$0	$0	$0	$0	$0	($100,845)	Table 6 Row B
K	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	($96,968)	0.0	($48,484)	$0	$0	$0	$0	$0	$0	($48,484)	Table 6 Row C

Table 2a: FY 2016-17 Request Summary by Component

Row	Component	Total Funds	General Fund	Cash Funds				Reappropriated Funds		Federal Funds	Source
				Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund		
A	MMIS Maintenance and Projects True-Up	$1,716,274	$1,267,940	($304,991)	$0	($1,885)	$0	($195,369)	($84,615)	$1,035,194	Table 3.1a Row N
B	MMIS Reprocurement Contracted Staff True-Up	($4,675,328)	($60,222)	($37,064)	$0	$0	$0	$0	$915	($4,578,957)	Table 4.1a Row L
C	MMIS Reprocurement Contracts True-Up	$1,463,574	($1,240,267)	($195,735)	$1,870	$0	$0	$0	$9,675	$2,888,031	Table 4.1b Row L
D	**Total FY 2016-17 Request**	**($1,495,480)**	**($32,549)**	**($537,790)**	**$1,870**	**($1,885)**	**$0**	**($195,369)**	**($74,025)**	**($655,732)**	Sum Rows A through C

Table 2b: FY 2017-18 Request Summary by Component

Row	Component	Total Funds	General Fund	Cash Funds				Reappropriated Funds		Federal Funds	Source
				Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund		
A	MMIS Maintenance and Projects True-Up	$5,501,405	($1,526,183)	$58,219	$2,021,902	($1,885)	$0	($195,369)	($86,173)	$5,230,894	Table 3.1b Row I
B	MMIS Reprocurement Contracts True-Up	$18,546,779	$1,034,108	$166,736	$708,606	$0	$0	$0	$5,564	$16,631,765	Table 4.1c Row G
C	Contract Administrator III FTE	$133,123	$33,284	$0	$0	$0	$0	$0	$0	$99,839	Sum Table 1.2b Rows B through G
D	Adjustment of Other Line Items	($981,968)	($270,139)	$0	$0	$0	$0	$0	$0	($711,829)	Sum Table 1.2b Rows I, L, and M
E	Maintain BUS Support at OIT	$325,000	$162,500	$0	$0	$0	$0	$0	$0	$162,500	Table 7 Row E
F	**Total FY 2017-18 Request**	**$23,524,339**	**($566,430)**	**$224,955**	**$2,730,508**	**($1,885)**	**$0**	**($195,369)**	**($80,609)**	**$21,413,169**	Sum Rows A through E

Table 2c: FY 2018-19 Request Summary by Component

Row	Component	Total Funds	General Fund	Cash Funds				Reappropriated Funds		Federal Funds	Source
				Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund		
A	MMIS Maintenance and Projects True-Up	$6,553,488	($1,405,046)	$70,650	$2,184,839	($1,885)	$0	($195,369)	($85,799)	$5,986,098	Table 3.1c Row I
B	Contract Administrator III FTE	$135,492	$33,875	$0	$0	$0	$0	$0	$0	$101,617	Sum Table 1.2c Rows B through G
C	Adjustment of Other Line Items	($981,968)	($270,139)	$0	$0	$0	$0	$0	$0	($711,829)	Sum Table 1.2c Rows H, J, and K
D	**Total FY 2018-19 Request**	**$5,707,012**	**($1,641,310)**	**$70,650**	**$2,184,839**	**($1,885)**	**$0**	**($195,369)**	**($85,799)**	**$5,375,886**	Sum Rows A through C

Table 2d: FY 2019-20 and Ongoing Request Summary by Component

Row	Component	Total Funds	General Fund	Cash Funds				Reappropriated Funds		Federal Funds	Source
				Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund		
A	MMIS Maintenance and Projects True-Up	$6,553,488	($1,420,312)	$71,733	$2,216,473	($1,885)	$0	($195,369)	($85,777)	$5,968,625	Table 3.1d Row I
B	Contract Administrator III FTE	$135,492	$33,875	$0	$0	$0	$0	$0	$0	$101,617	Sum Table 1.2d Rows B through G
C	Adjustment of Other Line Items	($981,968)	($270,139)	$0	$0	$0	$0	$0	$0	($711,829)	Sum Table 1.2d Rows H, J, and K
D	**Total FY 2019-20 and Ongoing Request**	**$5,707,012**	**($1,656,576)**	**$71,733**	**$2,216,473**	**($1,885)**	**$0**	**($195,369)**	**($85,777)**	**$5,358,413**	Sum Rows A through C

Table 3.1a: FY 2016-17 MMIS Maintenance and Projects True-Up

Row	Item	Total Funds	General Fund	Cash Funds				Reappropriated Funds		Federal Funds	Calculated FFP	Source
				Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund			
FY 2016-17 Spending Authority												
A	FY 2016-17 Long Bill Plus Special Bills	$35,564,820	$7,211,028	$304,991	$1,800,106	$1,885	$119,280	$195,369	$97,981	$25,834,180	72.64%	HB 16-1405 Long Bill Appropriation Plus Special Bills
B	FY 2015-16 Roll-Forward Funding	$8,634,941	$1,044,676	$254,560	$333,564	$0	$515,775	$0	$0	$6,486,366	75.12%	CORE Final FY 2015-16 Unexpended Funds
C	**Total Spending Authority**	**$44,199,761**	**$8,255,704**	**$559,551**	**$2,133,670**	**$1,885**	**$635,055**	**$195,369**	**$97,981**	**$32,320,546**	**73.12%**	Sum Rows A and B
FY 2016-17 Estimated Expenditures												
D	75/25 MMIS Operations	$41,248,691	$6,141,518	$123,334	$3,881,914	$0	$0	$0	$12,375	$31,089,550	75.37%	Table 3.2 Row M, Fund Splits from Table 3.4a Row H
E	50/50 MMIS Operations	$3,303,832	$983,815	$9,878	$619,964	$0	$0	$0	$991	$1,689,184	51.13%	Table 3.2 Row Y, Fund Splits from Table 3.4a Row L
F	Provider Enrollment Screenings	$635,055	$0	$0	$0	$0	$635,055	$0	$0	$0	0.00%	Table 3.2 Row AA
G	ACC-Medicare/Medicaid Program Quality Metrics	$306,082	$0	$0	$0	$0	$0	$0	$0	$306,082	100.00%	Table 3.2 Row AB
H	Special Bills Projects	$301,027	$12,850	$0	$17,253	$0	$0	$0	$0	$270,924	90.00%	Table 3.2 Row AC
I	**Total Estimated Expenditures**	**$45,794,687**	**$7,138,183**	**$133,212**	**$4,519,131**	**$0**	**$635,055**	**$0**	**$13,366**	**$33,355,740**	**72.84%**	Sum Rows D through H
Technical Adjustments												
J	Hospital Provider Fee Adjustment	$0	$2,385,461	$0	($2,385,461)	$0	$0	$0	$0	$0	N/A	No additional HPF Cash Fund is requested because the HPF funding model has been determined for FY 2016-17
K	Roll Forward Reversion	$121,348	$0	$121,348	$0	$0	$0	$0	$0	$0	N/A	Row B - Row I CBHP funds only (A partial reversion of roll forward funds is requested because roll forward amounts cannot be decreased through the budget process)
L	**Total Technical Adjustments**	**$121,348**	**$2,385,461**	**$121,348**	**($2,385,461)**	**$0**	**$0**	**$0**	**$0**	**$0**	**N/A**	Sum Rows J and K
M	**Total Estimated Final Expenditure**	**$45,916,035**	**$9,523,644**	**$254,560**	**$2,133,670**	**$0**	**$635,055**	**$0**	**$13,366**	**$33,355,740**	**72.65%**	Sum Rows I and L
N	**TOTAL FY 2016-17 REQUEST**	**$1,716,274**	**$1,267,940**	**($304,991)**	**$0**	**($1,885)**	**$0**	**($195,369)**	**($84,615)**	**$1,035,194**	**N/A**	Row M - Row C
O	**FY 2016-17 Revised Appropriation**	**$37,281,094**	**$8,478,968**	**$0**	**$1,800,106**	**$0**	**$119,280**	**$0**	**$13,366**	**$26,869,374**	**N/A**	Sum Rows A and N

Table 3.1b: FY 2017-18 MMIS Maintenance and Projects True-Up

Row	Item	Total Funds	General Fund	Cash Funds				Reappropriated Funds		Federal Funds	Calculated FFP	Source
				Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund			
FY 2017-18 Spending Authority												
A	FY 2017-18 Base Request	$35,440,753	$7,384,952	$295,606	$1,772,374	$1,885	$121,943	$195,369	$97,981	$25,570,643	72.15%	November 1, 2016 Submission (includes Special Blls)
B	**Total Estimated Spending Authority**	**$35,440,753**	**$7,384,952**	**$295,606**	**$1,772,374**	**$1,885**	**$121,943**	**$195,369**	**$97,981**	**$25,570,643**	**72.15%**	Row A
FY 2017-18 Estimated Expenditures												
C	75/25 MMIS Operations	$38,261,767	$5,264,054	$343,973	$3,514,343	$0	$0	$0	$11,479	$29,127,918	76.13%	Table 3.2 Row M, Fund Splits from Table 3.4b Row H
D	50/50 MMIS Operations	$1,095,855	$301,525	$9,852	$199,511	$0	$0	$0	$329	$584,638	53.35%	Table 3.2 Row Y, Fund Splits from Table 3.4b Row L
E	Provider Enrollment Screenings	$121,943	$0	$0	$0	$0	$121,943	$0	$0	$0	0.00%	Table 3.2 Row AA
F	ACC-Medicare/Medicaid Program Quality Metrics	$270,080	$0	$0	$0	$0	$0	$0	$0	$270,080	100.00%	Table 3.2 Row AB
G	Special Bill Projects (various FFP rates)	$1,192,513	$293,190	$0	$80,422	$0	$0	$0	$0	$818,901	68.67%	Table 3.2 Row AC
H	**Total Estimated Expenditures**	**$40,942,158**	**$5,858,769**	**$353,825**	**$3,794,276**	**$0**	**$121,943**	**$0**	**$11,808**	**$30,801,537**	**75.23%**	Sum Rows C through G
I	**TOTAL FY 2017-18 REQUEST**	**$5,501,405**	**($1,526,183)**	**$58,219**	**$2,021,902**	**($1,885)**	**$0**	**($195,369)**	**($86,173)**	**$5,230,894**	**N/A**	Row H - Row B
J	**FY 2017-18 Revised Appropriation**	**$40,942,158**	**$5,858,769**	**$353,825**	**$3,794,276**	**$0**	**$121,943**	**$0**	**$11,808**	**$30,801,537**	**N/A**	Sum Rows B and I

Table 3.1c: FY 2018-19 MMIS Maintenance and Projects True-Up												
				Cash Funds				Reappropriated Funds				
Row	Item	Total Funds	General Fund	Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund	Federal Funds	Calculated FFP	Source
FY 2018-19 Spending Authority												
A	FY 2018-19 Base Request	$35,078,715	$7,348,842	$295,606	$1,773,666	$1,885	$121,943	$195,369	$97,981	$25,243,423	71.96%	FY 2018-19 Continuation Request, including Special Bills
B	**Total Estimated Spending Authority**	**$35,078,715**	**$7,348,842**	**$295,606**	**$1,773,666**	**$1,885**	**$121,943**	**$195,369**	**$97,981**	**$25,243,423**	**71.96%**	Row A
FY 2018-19 Estimated Expenditures												
C	75/25 MMIS Operations	$39,508,930	$5,387,833	$356,371	$3,674,726	$0	$0	$0	$11,853	$30,078,147	76.13%	Table 3.2 Row M, Fund Splits from Table 3.4c Row H
D	50/50 MMIS Operations	$1,095,855	$298,883	$9,885	$202,065	$0	$0	$0	$329	$584,693	53.35%	Table 3.2 Row Y, Fund Splits from Table 3.4c Row L
E	Provider Enrollment Screenings	$121,943	$0	$0	$0	$0	$121,943	$0	$0	$0	0.00%	Table 3.2 Row AA
F	ACC-Medicare/Medicaid Program Quality Metrics	$75,000	$0	$0	$0	$0	$0	$0	$0	$75,000	100.00%	Table 3.2 Row AB
G	Special Bills Projects	$830,475	$257,080	$0	$81,714	$0	$0	$0	$0	$491,681	59.20%	Table 3.2 Row AC
H	**Total Estimated Expenditures**	**$41,632,203**	**$5,943,796**	**$366,256**	**$3,958,505**	**$0**	**$121,943**	**$0**	**$12,182**	**$31,229,521**	**75.01%**	Sum Rows C through G
I	**TOTAL FY 2018-19 REQUEST**	**$6,553,488**	**($1,405,046)**	**$70,650**	**$2,184,839**	**($1,885)**	**$0**	**($195,369)**	**($85,799)**	**$5,986,098**	**N/A**	Row H - Row B
J	**FY 2018-19 Revised Appropriation**	**$41,632,203**	**$5,943,796**	**$366,256**	**$3,958,505**	**$0**	**$121,943**	**$0**	**$12,182**	**$31,229,521**	**N/A**	Sum Rows B and I

Table 3.1d: FY 2019-20 and Ongoing MMIS Maintenance and Projects True-Up												
				Cash Funds				Reappropriated Funds				
Row	Item	Total Funds	General Fund	Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund	Federal Funds	Calculated FFP	Source
Estimated FY 2019-20 Spending Authority												
A	FY 2019-20 Base Request	$35,078,715	$7,348,842	$295,606	$1,773,666	$1,885	$121,943	$195,369	$97,981	$25,243,423	71.96%	FY 2019-20 Continuation Request, including Special Bills
B	**Total Estimated Spending Authority**	**$35,078,715**	**$7,348,842**	**$295,606**	**$1,773,666**	**$1,885**	**$121,943**	**$195,369**	**$97,981**	**$25,243,423**	**71.96%**	Row A
FY 2019-20 Estimated Expenditures												
C	75/25 MMIS Operations	$39,583,930	$5,373,914	$357,443	$3,705,056	$0	$0	$0	$11,875	$30,135,642	76.13%	Table 3.2 Row M, Fund Splits from Table 3.4d Row H
D	50/50 MMIS Operations	$1,095,855	$297,536	$9,896	$203,369	$0	$0	$0	$329	$584,725	53.36%	Table 3.2 Row Y, Fund Splits from Table 3.4d Row L
E	Provider Enrollment Screenings	$121,943	$0	$0	$0	$0	$121,943	$0	$0	$0	0.00%	Table 3.2 Row AA
F	ACC-Medicare/Medicaid Program Quality Metrics	$0	$0	$0	$0	$0	$0	$0	$0	$0	100.00%	Table 3.2 Row AB
G	Special Bills Projects	$830,475	$257,080	$0	$81,714	$0	$0	$0	$0	$491,681	59.20%	Table 3.2 Row AC
H	**Total Estimated Expenditures**	**$41,632,203**	**$5,928,530**	**$367,339**	**$3,990,139**	**$0**	**$121,943**	**$0**	**$12,204**	**$31,212,048**	**74.97%**	Sum Rows C through G
I	**TOTAL FY 2019-20 AND ONGOING REQUEST**	**$6,553,488**	**($1,420,312)**	**$71,733**	**$2,216,473**	**($1,885)**	**$0**	**($195,369)**	**($85,777)**	**$5,968,625**	**N/A**	Row H - Row B
J	**FY 2019-20 Revised Appropriation**	**$41,632,203**	**$5,928,530**	**$367,339**	**$3,990,139**	**$0**	**$121,943**	**$0**	**$12,204**	**$31,212,048**	**N/A**	Sum Rows B and I

Table 3.2: MMIS Maintenance and Projects
FY 2016-17 through FY 2019-20 Estimated Expenditures

Row	Item	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	Source
75/25 MMIS Operations						
Legacy System						
A	Legacy MMIS - Base Operations	$21,146,210	$0	$0	$0	Provider Original Contract and 4 Month Negotiated Extension Funding
B	Legacy MMIS - Close-Out Operations	$5,028,714	$0	$0	$0	Provider Original Contract and 4 Month Negotiated Extension Funding
C	Legacy MMIS - Provider Reenrollment	$525,128	$0	$0	$0	Provider Original Contract and 4 Month Negotiated Extension Funding
D	Legacy Web Portal - Base Operations	$184,860	$0	$0	$0	Provider Original Contract and 4 Month Negotiated Extension Funding
E	Legacy Web Portal - Close-Out Operations	$46,215	$0	$0	$0	Provider Original Contract and 4 Month Negotiated Extension Funding
F	**Subtotal**	**$26,931,127**	**$0**	**$0**	**$0**	Sum Rows A through D
New System						
G	interChange - Base Operations	$9,430,407	$18,898,508	$24,726,180	$24,801,180	Provider Original Contract and 4 Month Negotiated Extension Funding
I	PBMS - Base Operations	$1,000,000	$3,162,500	$3,000,000	$3,000,000	Provider Original Contract and 4 Month Negotiated Extension Funding
J	BIDM - Base Operations	$3,887,157	$16,200,759	$11,782,750	$11,782,750	Provider Original Contract and 4 Month Negotiated Extension Funding
L	**Subtotal**	**$14,317,564**	**$38,261,767**	**$39,508,930**	**$39,583,930**	Sum Rows G through J
M	**Total 75/25 MMIS Operations**	**$41,248,691**	**$38,261,767**	**$39,508,930**	**$39,583,930**	Sum Rows F and L
50/50 MMIS Operations						
Legacy System						
N	Legacy MMIS - Base Postage	$534,211	$0	$0	$0	Provider Original Contract and 4 Month Negotiated Extension Funding
O	Legacy MMIS - Close-Out Postage	$127,039	$0	$0	$0	Provider Original Contract and 4 Month Negotiated Extension Funding
P	Legacy MMIS - Base PARs	$896,794	$0	$0	$0	Provider Original Contract and 4 Month Negotiated Extension Funding
Q	Legacy MMIS - Close-Out PARs	$213,264	$0	$0	$0	Provider Original Contract and 4 Month Negotiated Extension Funding
R	**Subtotal**	**$1,771,308**	**$0**	**$0**	**$0**	Sum Rows N through Q
New System						
S	interChange - Base Postage	$231,184	$462,367	$462,367	$462,367	Provider Original Contract and 4 Month Negotiated Extension Funding
T	interChange - Overlap Operations with Legacy MMIS	$328,000	$0	$0	$0	Provider Original Contract and 4 Month Negotiated Extension Funding
U	PBMS - Base Postage	$26,668	$80,000	$80,000	$80,000	Project Estimate
V	PBMS - Overlap Operations with Legacy MMIS	$762,176	$0	$0	$0	Provider Original Contract and 4 Month Negotiated Extension Funding
W	Co-Pay Notifications	$184,496	$553,488	$553,488	$553,488	Table 3.3 Row G and Row I
X	**Subtotal**	**$1,532,524**	**$1,095,855**	**$1,095,855**	**$1,095,855**	Sum Rows S through W
Y	**Total 50/50 MMIS Operations**	**$3,303,832**	**$1,095,855**	**$1,095,855**	**$1,095,855**	Sum Rows R and X
Other MMIS Operations						
New System						
AA	Provider Enrollment Screenings (Cash Funds Only)	$635,055	$121,943	$121,943	$121,943	FY 2015-16 S-9, BA-9 "Provider Enrollment Fee Collection"
AB	ACC-Medicare/Medicaid Program Quality Metrics (FF Only)	$306,082	$270,080	$75,000	$0	FY 2015-16 S-10, BA-10 "ACC-MMP Grant Funding True Up"
AC	Special Bill Projects (various FFP rates)	$301,027	$1,192,513	$830,475	$830,475	HB 16-1277, HB 16-1321, SB 16-077, SB 16-120, SB 16-192
AD	**Total Other MMIS Operations**	**$1,242,164**	**$1,584,536**	**$1,027,418**	**$952,418**	Sum Rows AA through AC
AE	**Total Estimated Expenditures**	**$45,794,687**	**$40,942,158**	**$41,632,203**	**$41,632,203**	Sum Rows M, Y, and AD

Table 3.3: Co-Pay Notifications Calculations			
Row	**Item**	**Amount**	**Source**
Estimate of Mailings Due to Clients Within 5% of Co-Pay Limit			
A	Average Number of Clients at 5% Co-Pay Limit per Month	100,269	MMIS Client Data
B	Number of Mailings Required per Client Upon Reaching Co-Pay Limit	1	Notice mailed to client
C	Average Number of Mailings per Month Due to Clients Reaching Co-Pay Limit	100,269	Row A * Row B
D	Mean Postage Rate (Presorted, First-Class, 1 oz.)	$0.46	Contractor Quote
E	Average Monthly Mailing Cost	$46,124	Row C * Row D
F	FY 2016-17 Annual Number of Months Impacted	4	Based on March 1, 2017 system implementation.
G	**Estimated FY 2016-17 Mailing Cost**	**$184,496**	Row E * Row F
H	Number of months of impact in FY 2017-18 and Annually Ongoing	12	Annual Months Impact
I	**Estimated FY 2017-18 and Ongoing Mailing Costs**	**$553,488**	Row E * Row H

Table 3.4a: FY 2016-17 MMIS Fund Splits											
				Cash Funds				Reappropriated Funds			
Row	Program	Total Funds	General Fund	Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund	Federal Funds	FFP
90/10 MMIS Development											
A	Title XIX (Medicaid) Program Share	96.971%	5.956%	0.000%	3.742%	0.000%	0.000%	0.000%	0.000%	87.273%	90.000%
B	Title XXI (CHIP) Program Share	2.999%	0.000%	0.299%	0.057%	0.000%	0.000%	0.000%	0.000%	2.643%	88.130%
C	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
D	**Total Percentage to each Fund Source**	**100.000%**	**5.956%**	**0.299%**	**3.799%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**89.916%**	
75/25 MMIS Operations or Development											
E	Title XIX (Medicaid) Program Share	96.971%	14.889%	0.000%	9.354%	0.000%	0.000%	0.000%	0.000%	72.728%	75.000%
F	Title XXI (CHIP) Program Share	2.999%	0.000%	0.299%	0.057%	0.000%	0.000%	0.000%	0.000%	2.643%	88.130%
G	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
H	**Total Percentage to each Fund Source**	**100.000%**	**14.889%**	**0.299%**	**9.411%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**75.371%**	
50/50 MMIS Operations or Development											
I	Title XIX (Medicaid) Program Share	96.971%	29.778%	0.000%	18.708%	0.000%	0.000%	0.000%	0.000%	48.485%	50.000%
J	Title XXI (CHIP) Program Share	2.999%	0.000%	0.299%	0.057%	0.000%	0.000%	0.000%	0.000%	2.643%	88.130%
K	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
L	**Total Percentage to each Fund Source**	**100.000%**	**29.778%**	**0.899%**	**18.765%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**51.128%**	

Table 3.4b: FY 2017-18 MMIS Fund Splits											
				Cash Funds				Reappropriated Funds			
Row	Program	Total Funds	General Fund	Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund	Federal Funds	FFP
90/10 MMIS Development											
A	Title XIX (Medicaid) Program Share	91.113%	5.503%	0.000%	3.609%	0.000%	0.000%	0.000%	0.000%	82.001%	90.000%
B	Title XXI (CHIP) Program Share	8.857%	0.000%	0.899%	0.164%	0.000%	0.000%	0.000%	0.000%	7.794%	88.000%
C	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
D	**Total Percentage to each Fund Source**	**100.000%**	**5.503%**	**0.899%**	**3.773%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**89.795%**	
75/25 MMIS Operations or Development											
E	Title XIX (Medicaid) Program Share	91.113%	13.758%	0.000%	9.021%	0.000%	0.000%	0.000%	0.000%	68.334%	75.000%
F	Title XXI (CHIP) Program Share	8.857%	0.000%	0.899%	0.164%	0.000%	0.000%	0.000%	0.000%	7.794%	88.000%
G	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
H	**Total Percentage to each Fund Source**	**100.000%**	**13.758%**	**0.899%**	**9.185%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**76.128%**	
50/50 MMIS Operations or Development											
I	Title XIX (Medicaid) Program Share	91.113%	27.515%	0.000%	18.042%	0.000%	0.000%	0.000%	0.000%	45.556%	50.000%
J	Title XXI (CHIP) Program Share	8.857%	0.000%	0.899%	0.164%	0.000%	0.000%	0.000%	0.000%	7.794%	88.000%
K	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
L	**Total Percentage to each Fund Source**	**100.000%**	**27.515%**	**0.899%**	**18.206%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**53.350%**	

Table 3.4c: FY 2018-19 MMIS Fund Splits											
Row	Program	Total Funds	General Fund	Cash Funds				Reappropriated Funds		Federal Funds	FFP
				Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund		
90/10 MMIS Development											
A	Title XIX (Medicaid) Program Share	91.099%	5.455%	0.000%	3.655%	0.000%	0.000%	0.000%	0.000%	81.989%	90.000%
B	Title XXI (CHIP) Program Share	8.871%	0.000%	0.902%	0.163%	0.000%	0.000%	0.000%	0.000%	7.806%	88.000%
C	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
D	**Total Percentage to each Fund Source**	**100.000%**	**5.455%**	**0.902%**	**3.818%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**89.795%**	
75/25 MMIS Operations or Development											
E	Title XIX (Medicaid) Program Share	91.099%	13.637%	0.000%	9.138%	0.000%	0.000%	0.000%	0.000%	68.324%	75.000%
F	Title XXI (CHIP) Program Share	8.871%	0.000%	0.902%	0.163%	0.000%	0.000%	0.000%	0.000%	7.806%	88.000%
G	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
H	**Total Percentage to each Fund Source**	**100.000%**	**13.637%**	**0.902%**	**9.301%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**76.130%**	
50/50 MMIS Operations or Development											
I	Title XIX (Medicaid) Program Share	91.099%	27.274%	0.000%	18.276%	0.000%	0.000%	0.000%	0.000%	45.549%	50.000%
J	Title XXI (CHIP) Program Share	8.871%	0.000%	0.902%	0.163%	0.000%	0.000%	0.000%	0.000%	7.806%	88.000%
K	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
L	**Total Percentage to each Fund Source**	**100.000%**	**27.274%**	**0.902%**	**18.439%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**53.355%**	

Table 3.4d: FY 2019-20 MMIS Fund Splits											
Row	Program	Total Funds	General Fund	Cash Funds				Reappropriated Funds		Federal Funds	FFP
				Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Colorado Autism Treatment Fund	Department of Health Care Policy and Financing Cash Fund	Public School Health Services	Old Age Pension Health and Medical Care Fund		
90/10 MMIS Development											
A	Title XIX (Medicaid) Program Share	91.092%	5.431%	0.000%	3.679%	0.000%	0.000%	0.000%	0.000%	81.982%	90.000%
B	Title XXI (CHIP) Program Share	8.878%	0.000%	0.903%	0.163%	0.000%	0.000%	0.000%	0.000%	7.812%	88.000%
C	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
D	**Total Percentage to each Fund Source**	**100.000%**	**5.431%**	**0.903%**	**3.842%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**89.794%**	
75/25 MMIS Operations or Development											
E	Title XIX (Medicaid) Program Share	91.092%	13.576%	0.000%	9.197%	0.000%	0.000%	0.000%	0.000%	68.319%	75.000%
F	Title XXI (CHIP) Program Share	8.878%	0.000%	0.903%	0.163%	0.000%	0.000%	0.000%	0.000%	7.812%	88.000%
G	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
H	**Total Percentage to each Fund Source**	**100.000%**	**13.576%**	**0.903%**	**9.360%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**76.131%**	
50/50 MMIS Operations or Development											
I	Title XIX (Medicaid) Program Share	91.092%	27.151%	0.000%	18.395%	0.000%	0.000%	0.000%	0.000%	45.546%	50.000%
J	Title XXI (CHIP) Program Share	8.878%	0.000%	0.903%	0.163%	0.000%	0.000%	0.000%	0.000%	7.812%	88.000%
K	OAP State-Only Program Share	0.030%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.030%	0.000%	0.000%
L	**Total Percentage to each Fund Source**	**100.000%**	**27.151%**	**0.903%**	**18.558%**	**0.000%**	**0.000%**	**0.000%**	**0.030%**	**53.358%**	

Table 4.1a: FY 2016-17 MMIS Reprocurement Contracted Staff True-Up									
Row	Item	Total Funds	General Fund	Cash Funds		Reappropriated Fund	Federal Funds	Calculated FFP	Source
				Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Old Age Pension Health and Medical Care Fund			
FY 2016-17 Spending Authority									
A	FY 2016-17 Long Bill Appropriation	$5,145,018	$431,304	$37,064	$97,693	$0	$4,578,957	89.00%	HB 16-1405 Long Bill
B	FY 2015-16 Roll Forward	$4,109,035	$111,124	$34,561	$0	$0	$3,963,350	96.45%	CORE Final FY 2015-16 Unexpended Funds
C	**Total Spending Authority**	**$9,254,053**	**$542,428**	**$71,625**	**$97,693**	**$0**	**$8,542,307**	**92.31%**	Sum Rows A and B
FY 2016-17 Estimated Expenditures									
D	90/10 MMIS Development	$2,304,964	$137,284	$6,892	$87,566	$691	$2,072,531	89.92%	Table 4.2a Row E, Fund Splits from Table 3.5a Row D
E	75/25 MMIS Development	$29,160	$4,342	$87	$2,744	$9	$21,978	75.37%	Table 4.2a Row G, Fund Splits from Table 3.5a Row H
F	50/50 MMIS Development	$716,814	$213,453	$2,143	$134,510	$215	$366,493	51.13%	Table 4.2a Row K, Fund Splits from Table 3.5a Row L
G	**Total Estimated Expenditures**	**$3,050,938**	**$355,079**	**$9,122**	**$224,820**	**$915**	**$2,461,002**	**80.66%**	Sum Rows D through F
Technical Adjustments									
H	Hospital Provider Fee Adjustment	$0	$127,127	$0	($127,127)	$0	$0	N/A	No additional HPF Cash Fund is requested because the HPF funding model has been determined for FY 2016-17
I	Roll Forward Reversion	$1,527,787	$0	$25,439	$0	$0	$1,502,348	N/A	A partial reversion of roll forward funds is requested because roll forward amounts cannot be decreased through the budget process
J	**Total Technical Adjustments**	**$1,527,787**	**$127,127**	**$25,439**	**($127,127)**	**$0**	**$1,502,348**	**N/A**	Sum Rows H and I
K	**Total Estimated Final Expenditure**	**$4,578,725**	**$482,206**	**$34,561**	**$97,693**	**$915**	**$3,963,350**	**86.56%**	Sum Rows G and J
L	**TOTAL FY 2016-17 REQUEST**	**($4,675,328)**	**($60,222)**	**($37,064)**	**$0**	**$915**	**($4,578,957)**	**N/A**	Row K - Row C
M	**FY 2016-17 Revised Appropriation**	**$469,690**	**$371,082**	**$0**	**$97,693**	**$915**	**$0**	**0.00%**	Sum Rows A and L

Table 4.1b: FY 2016-17 MMIS Reprocurement Contracts True-Up									
				Cash Funds		Reappropriated Fund			
Row	Item	Total Funds	General Fund	Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Old Age Pension Health and Medical Care Fund	Federal Funds	Calculated FFP	Source
FY 2016-17 Spending Authority									
A	FY 2016-17 Long Bill Appropriation	$26,916,597	$2,615,317	$195,765	$506,114	$0	$23,599,401	87.68%	HB 16-1405 Long Bill
B	Roll Forward from FY 2015-16	$3,987,574	$1,256,111	$214,026	$199,533	$0	$2,317,904	58.13%	CORE Final FY 2015-16 Unexpended Funds
C	**Total Spending Authority**	**$30,904,171**	**$3,871,428**	**$409,791**	**$705,647**	**$0**	**$25,917,305**	**83.86%**	Sum Rows A and B
Estimated FY 2016-17 Expenditures									
D	90/10 MMIS Development	$30,942,015	$1,842,906	$92,517	$1,175,487	$9,283	$27,821,822	89.92%	Table 4.2b Row G, Fund Splits from Table 3.5a Row D
E	75/25 MMIS Development	$1,298,136	$193,279	$3,881	$122,168	$389	$978,419	75.37%	Table 4.2b Row M, Fund Splits from Table 3.5a Row H
F	50/50 MMIS Development	$9,966	$2,968	$30	$1,870	$3	$5,095	51.12%	Table 4.2b Row O, Fund Splits from Table 3.5a Row L
G	**Total Estimated Expenditures**	**$32,250,117**	**$2,039,153**	**$96,428**	**$1,299,525**	**$9,675**	**$28,805,336**	**89.32%**	Sum Rows D through F
Technical Adjustments									
H	Hospital Provider Fee Adjustment	$0	$592,008	$0	($592,008)	$0	$0	N/A	No additional HPF Cash Fund is requested because the HPF funding model has been determined for FY 2016-17
I	Roll Forward Reversion	$117,628	$0	$117,628	$0	$0	$0	N/A	A partial reversion of roll forward funds is requested because roll forward amounts cannot be decreased through the budget process
J	**Total Technical Adjustments**	**$117,628**	**$592,008**	**$117,628**	**($592,008)**	**$0**	**$0**	**N/A**	Sum Rows H and I
K	**Total Estimated Final Expenditure**	**$32,367,745**	**$2,631,161**	**$214,056**	**$707,517**	**$9,675**	**$28,805,336**	**88.99%**	Sum Rows G and J
L	**TOTAL FY 2016-17 REQUEST**	**$1,463,574**	**($1,240,267)**	**($195,735)**	**$1,870**	**$9,675**	**$2,888,031**	**N/A**	Row K - Row C
M	**FY 2016-17 Revised Appropriation**	**$28,380,171**	**$1,375,050**	**$30**	**$507,984**	**$9,675**	**$26,487,432**	**93.33%**	Sum Rows A and L

Table 4.1c: FY 2017-18 MMIS Reprocurement Contracts True-Up									
				Cash Funds		Reappropriated Fund			
Row	Item	Total Funds	General Fund	Children's Basic Health Plan Trust	Hospital Provider Fee Cash Fund	Old Age Pension Health and Medical Care Fund	Federal Funds	Calculated FFP	Source
FY 2017-18 Spending Authority									
A	FY 2017-18 Base Request	$0	$0	$0	$0	$0	$0	N/A	November 1, 2016 Submission
B	**Total Spending Authority**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**N/A**	Row A
Estimated FY 2017-18 Expenditures									
C	90/10 MMIS Development	$18,383,499	$1,011,644	$165,268	$693,609	$5,515	$16,507,463	89.80%	Table 4.2b Row G, Fund Splits from Table 3.5b Row D
D	75/25 MMIS Development	$163,280	$22,464	$1,468	$14,997	$49	$124,302	76.13%	Table 4.2b Row M, Fund Splits from Table 3.5b Row H
E	50/50 MMIS Development	$0	$0	$0	$0	$0	$0	N/A	Table 4.2b Row O, Fund Splits from Table 3.5b Row L
F	**Total Estimated Expenditures**	**$18,546,779**	**$1,034,108**	**$166,736**	**$708,606**	**$5,564**	**$16,631,765**	**89.67%**	Sum Rows C through E
G	**TOTAL FY 2017-18 REQUEST**	**$18,546,779**	**$1,034,108**	**$166,736**	**$708,606**	**$5,564**	**$16,631,765**	**N/A**	Row F - Row B
H	**FY 2017-18 Revised Appropriation**	**$18,546,779**	**$1,034,108**	**$166,736**	**$708,606**	**$5,564**	**$16,631,765**	**89.67%**	Sum Rows A and G

Table 4.2a: MMIS Reprocurement Contracted Staff FY 2016-17 and FY 2017-18 Estimated Expenditures				
Row	**Item**	**FY 2016-17**	**FY 2017-18**	**Source**
90/10 MMIS Development				
A	Compri Technical Staff	$1,787,642	$0	Provider Contract
B	Term-limited Technical Staff	$382,824	$0	Estimated Remaining Costs Based on FY 2016-17 Budget
C	Leased Space	$114,498	$0	Estimated Remaining Costs Based on FY 2016-17 Budget
D	Conferences	$20,000	$0	Estimated Remaining Costs Based on FY 2016-17 Budget
E	**Total 90/10 MMIS Development**	**$2,304,964**	**$0**	Sum Rows A through D
75/25 MMIS Development				
F	Clarity Licenses	$29,160	$0	Estimated Remaining Costs Based on FY 2016-17 Budget
G	**Total 75/25 MMIS Operations**	**$29,160**	**$0**	Row F
50/50 MMIS Development				
H	Compri Program Staff	$514,518	$0	Provider Contract
I	Term-limited Program Staff	$179,796	$0	Estimated Remaining Costs Based on FY 2016-17 Budget
J	Training	$22,500	$0	Estimated Remaining Costs Based on FY 2016-17 Budget
K	**Total 50/50 MMIS Operations**	**$716,814**	**$0**	Sum Rows H through J
L	**Total Estimated Expenditures**	**$3,050,938**	**$0**	Sum Rows E, G, and K

Table 4.2b: MMIS Reprocurement Contracts FY 2016-17 and FY 2017-18 Estimated Expenditures				
Row	**Item**	**FY 2016-17**	**FY 2017-18**	**Source**
90/10 MMIS Development				
A	interChange Development	$23,405,662	$14,101,180	FY 2016-17 and FY 2017-18 Provider Contract
B	BIDM Development	$3,251,891	$4,282,319	FY 2016-17 and FY 2017-18 Provider Contract
C	PBMS Development	$3,197,044	$0	Provider Contract
D	Independent Verification and Validation	$990,000	$0	Provider Contract
E	First Databank Implementation	$52,418	$0	Provider Contract
F	OIT Data Transfer CBMS to BIDM	$45,000	$0	Project Estimate
G	**Total 90/10 MMIS Development**	**$30,942,015**	**$18,383,499**	Sum Rows A through F
75/25 MMIS Development				
H	interChange COTS Software	$1,053,024	$0	Provider Contract
I	BIDM COTS Software	$23,333	$0	FY 2016-17 and FY 2017-18 Provider Contract
J	PBMS COTS Software	$22,731	$0	Provider Contract
K	Certification Reports	$39,750	$0	Provider Estimate
L	First Databank Licenses	$159,298	$163,280	FY 2016-17 and FY 2017-18 Provider Contract
M	**Total 75/25 MMIS Development**	**$1,298,136**	**$163,280**	Sum Rows H through L
50/50 MMIS Development				
N	interChange Development	$9,966	$0	Provider Contract
O	**Total 50/50 MMIS Development**	**$9,966**	**$0**	Row N
P	**Total Estimated Expenditures**	**$32,250,117**	**$18,546,779**	Sum Rows G, M, and O

Table 5 - Contract Administrator FTE Calculation

FTE Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- New full-time General Fund positions are reflected in Year 1 as 0.9166 FTE to account for the pay-date shift. This applies to personal services costs only; operating costs are not subject to the pay-date shift.

Expenditure Detail		Year 1 FY 2017-18		Year 2 FY 2018-19	
Personal Services:					
Classification Title	Monthly	FTE		FTE	
Contract Administrator III	$4,028	1.8	$87,005	2.0	$96,672
PERA			$8,831		$9,812
AED			$4,350		$4,834
SAED			$4,350		$4,834
Medicare			$1,262		$1,402
STD			$165		$184
Health-Life-Dental			$15,854		$15,854
Subtotal Position 1, #.# FTE		**1.8**	**$121,817**	**2.0**	**$133,592**
Classification Title	Monthly	FTE		FTE	
		-	$0	-	$0
PERA			$0		$0
AED			$0		$0
SAED			$0		$0
Medicare			$0		$0
STD			$0		$0
Health-Life-Dental			$0		$0
Subtotal Position 2, #.# FTE		**-**	**$0**	**-**	**$0**
Subtotal Personal Services		1.8	**$121,817**	2.0	**$133,592**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	2.0	$1,000	2.0	$1,000
Telephone Expenses	$450	2.0	$900	2.0	$900
PC, One-Time	$1,230	2.0	$2,460		
Office Furniture, One-Time	$3,473	2.0	$6,946		
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$11,306**		**$1,900**
TOTAL REQUEST		1.8	**$133,123**	2.0	**$135,492**
	General Fund:		*$33,284*		*$33,875*
	Cash funds:		*$0*		*$0*
	Reappropriated Funds:		*$0*		*$0*
	Federal Funds:		*$99,839*		*$101,617*

	FY 2017-18	FY 2018-19
PERA	10.15%	10.15%
AED	5.00%	5.00%
SAED	5.00%	5.00%
Medicare	1.45%	1.45%
STD	0.19%	0.19%
Health-Life-Dental	$7,927.19	$7,927.19

Table 6: FY 2017-18 and Ongoing Request to Adjust Other Line Items							
Row	**Line Item**	**Purpose**	**Total Funds**	**General Fund**	**Federal Funds**	**Calculated FFP**	**Source**
A	(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Smart (Automated) Prior Authorizations	($750,000)	($187,500)	($562,500)	75.00%	HB 16-1405 FY 2016-17 Spending Authority
B	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Fraud Detection Software Contract	Electronic Surveillance Utilization Review	($135,000)	($34,155)	($100,845)	74.70%	HB 16-1405 FY 2016-17 Spending Authority
C	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	Nursing Facility Prior Authorization Reviews	($96,968)	($48,484)	($48,484)	50.00%	HB 16-1405 FY 2016-17 Spending Authority
D	**Total FY 2017-18 and Ongoing Request**		**($981,968)**	**($270,139)**	**($711,829)**	**72.49%**	Sum Rows A through C

Table 7: FY 2017-18 Request to Maintain BUS Support at OIT							
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Federal Funds**	**FFP**	**Source**
A	Business Analyst Contractor (0.5 FTE)	$62,941	0.0	$31,471	$31,470		Continuation of FY 2014-15 S-8, FY 2015-16 BA-8 Legacy Systems and Technology Support Funding Using Time-Limited Staff Support
B	Database Administrator (1.0 FTE)	$113,253	0.0	$56,626	$56,627		
C	Cold Fusion Developer Contractor (1.0 FTE)	$144,601	0.0	$72,301	$72,300		
D	Hardware/Software Licenses	$4,205	0.0	$2,102	$2,103		
E	**Total FY 2017-18 Request**	**$325,000**	**0.0**	**$162,500**	**$162,500**	**50.00%**	Row A + Row B

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-09 Long Term Care Utilization Management

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	Total	$22,790,007	$0	$23,096,505	$1,030,568	$3,835,600
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,817,142	$0	$7,275,017	$257,644	$958,901
	CF	$2,403,997	$0	$1,765,609	($9,219)	($36,875)
	RF	$0	$0	$0	$0	$0
	FF	$13,568,868	$0	$14,055,879	$782,143	$2,913,574

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (A) General Administration - General Professional Services and Special Projects	Total	$7,200,237	$0	$7,975,237	($36,875)	($147,500)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,047,261	$0	$2,622,261	$0	$0
	CF	$1,527,500	$0	$1,227,500	($18,438)	($73,750)
	RF	$0	$0	$0	$0	$0
	FF	$3,625,476	$0	$4,125,476	($18,437)	($73,750)
01. Executive Director's Office, (E) Utilization and Quality Review Contracts - Professional Service Contracts	Total	$12,187,863	$0	$12,307,862	$905,203	$3,334,140
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,503,473	$0	$3,533,473	$217,084	$796,661
	CF	$461,089	$0	$461,089	$9,219	$36,875
	RF	$0	$0	$0	$0	$0
	FF	$8,223,301	$0	$8,313,300	$678,900	$2,500,604

	Total	**$3,401,907**	**$0**	**$2,813,406**	**$162,240**	**$648,960**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (F) Provider Audits and Services - Professional Audit Contracts	GF	$1,266,408	$0	$1,119,283	$40,560	$162,240
	CF	$415,408	$0	$77,020	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,720,091	$0	$1,617,103	$121,680	$486,720

CF Letternote Text Revision Required?	Yes	X	No		**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes		No	X	
FF Letternote Text Revision Required?	Yes		No	X	
Requires Legislation?	Yes		No	X	

Type of Request? Department of Health Care Policy and Financing Prioritized Request

Interagency Approval or Related Schedule 13s: None

Cost and FTE

- The Department requests $1,030,568 total funds, $257,644 General Fund, and $782,143 federal funds, in FY 2017-18, $3,835,600 total funds, $958,901 General Fund, and $2,913,574 federal funds in FY 2018-19 and ongoing to consolidate and acquire additional support for Long Term Care Utilization Management (LTC UM) functions which would assure the health, safety, and welfare of Medicaid members who are elderly or have disabilities and ensure sound stewardship of financial resources.

Current Program

- The Department spends over $1.4 billion annually on Long Term Care (LTC) services provided through Home and Community-Based Services (HCBS) waivers and through facilities such as nursing homes and intermediate care facilities for people with disabilities who need an institutional level of care.
- The Department operates multiple processes related to LTC UM internally and through various contracts. These processes ensure Department practices meet federal and state regulations, ensure funds are used efficiently and appropriately, and that clients' well-being is primary in all processes affecting them.

Problem or Opportunity

- The Department currently receives 50% Federal Financial Participation (FFP) for most LTC UM activities. These costs are eligible for a 75% FFP rate as allowed by 42 CFR § 433.15 if they are consolidated through a contract with a designated Quality Improvement Organization.
- Department staff and current contractors lack the resources and clinical expertise to adequately review and monitor utilization and the growing number of claims.

Consequences of Problem

- Without moving the LTC UM processes to a Quality Improvement Organization contractor, the Department will not be able to claim the enhanced FFP.
- Without clinically experienced staff the Department cannot ensure the health, safety and welfare of clients who require additional services and oversight to live in the community. There is also potential that without clinical experience, staff would be unable to properly investigate possible fraud in provider plans of care.
- The Department is unable to guarantee that adequate services are being provided in accordance with service plans, that services meet the federal definition for the benefit, or that costs are reasonable.

Proposed Solution

- The Department requests funding to contract with a Quality Improvement Organization (QIO) to perform LTC UM functions and to monitor health and welfare for LTC clients. Consolidation of these functions under the responsibility of a QIO would:
    - Allow faster responses to member issues;
    - Experienced QIO staff could ensure client wellbeing and an efficient allocation of funding according to individually assessed needs; and
    - Department staff could focus their efforts on contract oversight, analysis of the underlying root causes of recurring issues, strategic quality assurance activities and federal reporting.
- The QIO would monitor utilization of services provided in the HCBS waivers, prevent duplication of services between waivers and state plan services, ensure services align with the level of care needed by individuals and support the Department to meet federal waiver requirements.

Department Priority: ***R-9***
Request Detail: ***Long Term Care Utilization Management***

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Long Term Care Utilization Management	$1,030,568	$257,644

Problem or Opportunity:

Many of the Department's Long Term Care Utilization Management (LTC UM) activities are managed internally with non-clinical FTE or through contracts with service providers or case management agency staff. This process is de-consolidated and fragmented, leading to inefficient use of time and resources by Department staff and contractors which is impacting the Department's ability to provide for the health, safety, and welfare for clients enrolled in Medicaid long term services and supports. In addition, the Department is out of federal compliance in a number of different areas with respect to home and community-based services (HCBS) waiver requirements related to quality monitoring and improvement and financial review, including provider oversight and post payment review of claims. The Department's inability to remedy these issues puts the Department at the risk of loss of federal financial participation (FFP) and disallowances.

Utilization Management (UM) is the evaluation of the appropriateness and medical need of health care services and procedures according to evidence-based criteria or guidelines. Typically, UM addresses new clinical activities or inpatient admissions based on the analysis of a case, but may relate to ongoing provision of care, especially in an inpatient setting. UM describes proactive procedures, including discharge planning, concurrent planning, pre-certification, and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer or patient. An effective UM program is comprised of policies, processes and criteria which are all used to ensure the proper separation of duties and qualifications of UM staff, the frequency of reviews, and the balance of internal and external responsibilities. These policies, processes and criteria are also used for escalation processes to allow clients, caregivers or client advocates to challenge a point of care decision, and processes for evaluating inter-rater reliability amongst UM reviewers.

People who are elderly or have a disability accounted for 10.55% of the Department's overall caseload in FY 2014-15. Their total cost of care, including medical, mental health, and long term services and supports, represented 44.8% of the Department's total expenditure in FY 2014-15. Clients who require an institutional level of care because they need assistance with basic activities of daily living, such as bathing or eating,

require additional effort from the Department to ensure their health and safety is being met through services and supports necessary to live quality lives in the most appropriate setting possible. UM activities need to be completed to ensure client safety and wellbeing by making sure the services that are performed are in full compliance with all required rules and regulations, to improve the overall quality of work at both the Department and contracted agencies, and to identify and prevent fraud.

Several distinct UM activities currently lack the resources to be completed at maximum effectiveness or currently suffer from conflicts of interest at the Department. One issue that has put strain on the Department's current UM activities is the increase in caseload experienced through a number of different factors. First, Colorado is experiencing population growth and the population of Coloradans who are elderly and/or who have a disability is also increasing. Additionally, the General Assembly has taken actions to increase enrollments or eliminate most waiting lists for the Home and Community-Based Services (HCBS) waivers. Enrollments need to be examined and reviewed to comply with key regulatory requirements from the Centers for Medicare and Medicaid Services (CMS) regarding monitoring.

With current resources, the Department is not able to keep up with the volume of work required to guarantee that adequate services are being provided in accordance with service plans, services are delivered as defined in the waivers or that providers are billing appropriately, which may lead to unnecessary General Fund expenditures as staff and contractors continue to struggle to manage LTC UM workload. Department staff are focused on reacting and responding to individual client issues and are not able to adequately focus their time on contract management and oversight, training and communication with Case Management Agencies (CMAs) and service providers, analysis of the underlying root causes of recurring issues, federal reporting and policy analysis. The reactive nature of the current organization of duties prevents staff from working on policy changes which would allow the Department to improve the services available to clients, continue to improve efficiency and ensure consistent high-quality care as the population of clients grows.

Additionally, because LTC UM activities are not being performed through an external Quality Improvement Organization contract, the Department is not able to secure an enhanced 75% federal financial participation (FFP) rate for administrative costs as allowed by 42 CFR § 433.15 or able to reap the benefits of consolidating work under one or a few vendors. A QIO is a group of health quality experts, clinicians, and consumers organized to improve the care delivered to individuals.[1] Administrative costs for QIO contracts are eligible to receive an enhanced FFP through the Medicaid and CMS relies on QIOs to improve the quality of health care for all Medicare and Medicaid beneficiaries.

The Department received some funding for UM activities through the FY 2014-15 R-13 "Funding for Utilization Review Services" budget request for Long Term Care Utilization Management services, however this funding is insufficient to cover the expanded scope of UM services being proposed in this request. The FY 2014-15 request provided increased funding to Single Entry Points (SEPs) to support the increased caseload to process Long Term Services and Supports (LTSS) applications and reviews, which resulted in faster decisions, elimination of the backlogs before individual's medical condition worsened and became costlier. This request also included a change to the FFP rate for services provided by SEPs that did not qualify

[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html

for the enhanced 75% FFP and included additional funding for the Department's QIO contract which included medical review for the Children's Extensive Supports waiver (HCBS-CES) and Pre-Admission Screening and Resident Review (PASSR). Outsourcing the HCBS-CES medical review and PASSR to a QIO has improved the review process greatly by providing clinical review of applications, an expedient review process and the expertise needed to represent the Department in appeals. Without additional funding, the Department would continue to struggle to meet federal and state regulations that are required for the services this request intends to improve.

Proposed Solution:

The Department requests $1,030,568 total funds, including $257,644 General Fund in FY 2017-18 and $3,835,600 total funds, including $958,901 General Fund in FY 2018-19 and ongoing in order to contract with a QIO to perform LTC UM functions. Outsourcing UM would place UM functions under the responsibility of professional experts in the area, which would allow faster responses to client issues, allow staff with expertise in the field to perform tasks that are currently being performed by Department staff, and would create an efficient use of funds as the Department would be able to claim an enhanced 75% FFP rate on these activities through 42 CFR § 433.15.

Additionally, moving UM activities to a QIO would enable staff to refocus their efforts on contract oversight, strategic quality assurance activities, federal reporting, analysis of the underlying root causes of recurring issues, policy changes, communication and training.

The Department assumes that the contract would be awarded April 1, 2018. The Department would utilize the Request for Proposals (RFP) process for vendor selection which includes writing the RFP, sending and receiving questions and responses from contractors, stakeholder engagement, contract negotiation and awarding the contract. The Department anticipates that the RFP process would take at least nine months from the time the Department would receive funding on July 1, 2017.

Each activity that would be consolidated under the QIO is detailed below, including the current problem and how the Department requests to resolve it.

<u>Home and Community Based Services Brain Injury Waiver Supportive Living Program Acuity Assessments</u>

The Department requests $14,985 total funds, $3,747 General Fund in FY 2017-18, $59,940 total funds, $14,985 General Fund in FY 2018-19 and ongoing to shift Home and Community Based Services Brain Injury Waiver Supportive Living Program (HCBS-BI SLP) acuity assessments used to determine provider rates to the QIO, helping to eliminate the current conflict of interest.

Clients enrolled in the HCBS-BI SLP program receive an acuity assessment to determine their level of need and develop their service plan. Currently, these assessments are administered by the same providers whose payment rates are affected by the outcome of the scores which results in a conflict of interest. In order to remove this conflict of interest the Department requests to move the acuity assessment activities to the QIO.

If the HCBS-BI SLP assessments were shifted to a QIO the conflict of interest would be mitigated and would allow the providers to focus solely on service delivery. This would allow the Department to ensure that clients' needs are met without the risk of conflict of interest.

Critical Incident Reporting and Monitoring

The Department requests $306,085 total funds, $76,522 General Fund in FY 2017-18, $1,224,340 total funds, $306,085 General Fund in FY 2018-19 and ongoing to utilize the QIO to validate critical incidents, conduct follow up work to ensure appropriate actions are taken, and close critical incidents once acceptable outcomes are achieved.

A "critical incident" is any actual or alleged event or situation that creates a significant risk of serious harm to the health or welfare of a client. Critical incident reporting (CIR) and monitoring focuses on the identification and follow-up to critical events or incidents (e.g., mistreatment, abuse, neglect and exploitation) that bring harm, or create the potential for harm, to an HCBS waiver client. As defined in CMS' HCBS waiver technical guide[2], an effective incident management system entails conducting oversight to make sure that applicable policies and procedures are being followed for the reporting of critical incidents or events and that necessary follow-up is being conducted on a timely basis. The Department is required to implement safeguards to prevent individuals from harm. A critical element of effective oversight is the operation of data systems that support the identification of trends and patterns in the occurrence of critical incidents or events in order to identify opportunities for improvement and thus support the development of strategies to reduce the occurrence of incidents in the future. The Department also has a responsibility to develop processes to prevent critical incidents from occurring.

Critical Incident Reports are required to be filed by case managers every time a critical incident occurs, which are then sent to the Department to be reviewed. Roughly 277 critical incidents are reported each week. Of these, 71 are classified as "high" priorities, requiring additional effort and time to be managed. In some cases, the event requires the client to be relocated to a new living situation or safe environment or requires logistical planning in the event of a natural disaster such as a fire that has occurred.

Currently the process for review of critical incidents is deconsolidated and does not utilize a data system for tracking and monitoring which makes it more difficult for the Department to identifying trends and patterns. Review of critical incidents for waivers programs for people with intellectual or developmental disabilities are currently conducted by staff at the Colorado Department of Public Health and Environment (CDPHE) and critical incidents for the other eight waivers are managed and tracked by staff at the Department. The Department and CDPHE combined have a total of 1.0 permanent FTE and 1.0 temporary FTE devoted to critical incident reporting; however, this is an insufficient amount of resources to manage 277 critical incidents per week. As a result, staff are struggling to keep up with the growing volume of requests devoted to an important process that helps ensure that clients' safety and wellbeing is monitored and addressed. Current Department staff are also limited in the amount of oversight they are able to provide and are not able to focus their time on analysis of the underlying root causes of recurring issues, training, policy and rule changes in order to prevent future events from occurring.

By contracting with a QIO as a dedicated resource to manage critical incident reporting and the necessary follow up work, the Department would be able to achieve two important things. First, the Department staff who currently manage the CIR process would be able to focus on analysis of the underlying root causes of

[2] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf, Appendix G

recurring issues, cross checking data and working on proactive policy development to avoid critical incidents in the future. Second, the QIO would be able to dedicate more time to the critical incident management process, ensuring critical incidents are validated in a timely manner and follow up with affected parties (clients, caregivers, case management agencies, and providers) to ensure appropriate actions are taken quickly. Moving critical incident activities to the QIO would allow a streamlined and efficient process ensuring high quality review and would allow the Department to dedicate time to preventing critical incident in the future.

Over Cost Containment Reviews

The Department requests $39,100 total funds, $9,775 General Fund in FY 2017-18, $156,400 total funds, $39,100 General Fund in FY 2018-19 and ongoing funding to shift Over Cost Containment (OCC) reviews to the QIO vendor. This would allow the OCC reviews to be completed by professionals specializing in the area, which would ensure consistent quality, the reviews conducted were appropriate, and that decisions would adequately be able to be defended at appeal.

The Over Cost Containment (OCC) review process is intended to prevent the duplication of waiver and State Plan services, as well as to ensure that the average annual cost of care is less than the cost of providing the same services in an institutional setting. The Medicaid § 1915(c) waiver authority allows states to use a range of cost-containment strategies to meet federal cost neutrality requirements. The federal cost neutrality requirement is that average annual per participant waiver plus State Plan expenditure not exceed average per participant spending if services were provided in an institutional setting under the State Plan absent the waiver.

The OCC review is a process that involves the creation of a Prior Authorization Request (PAR) which is sent to the Department for review and either approved or denied when the average daily cost of combined HCBS and state plan services exceeds a certain threshold. The review process includes Long Term Home Health (LTHH) and HCBS waiver services. LTHH services are skilled or clinical in nature and typically drive the OCC review requirement. The QIO, as part of the OCC review process, is expected to closely examine and challenge when appropriate, provider-suggested services. The QIO would review the totality of the client's community-based service plan ensuring that only those services required to prevent institutionalization are authorized. Finally, the QIO would represent Department interests in all OCC appeals.

The Department currently lacks internal staff who have the clinical expertise to conduct appropriate reviews of clients and to defend subsequent decisions made at appeal. The staff currently performing OCC review for the Department do not have the proper qualifications to perform these reviews. As a result, the Department is unable to ensure that there is no duplication of services and that the costs of care is appropriate for clients. By shifting this process to the QIO, the Department could ensure that the staff reviewing OCC PARs would have the proper clinical experience and that the review process would ensure all the services were being utilized properly and that over expenditures of services were properly justified. The shifting of these activities to a QIO would ensure that the Department could better control costs and continue to meet federal waiver cost neutrality requirements. It would also allow current staff who are performing the reviews in addition to a regular workload to refocus efforts on regulatory reform, QIO oversight, waiver simplification, service

access improvements, etc. Additionally, staff would be able to provide higher-level direction and oversight of the vendor's work.

Nursing Facility Pay for Performance

The Department requests $0 total funds, and a decrease of $9,219 from the Nursing Facility Provider Fee Cash Fund in FY 2017-18. The Department requests $0 total funds, and a decrease of $36,875 from the Nursing Facility Provider Fee Cash Fund in FY 2018-19 and ongoing funding to shift the current contract for reviewing and scoring of completed Nursing Facility Pay for Performance applications, verifying implementation of approved applications, and developing recommendations from the current contractor to the QIO to allow the Department to receive the enhanced 75% FFP for the activity.

Annually, all nursing facility providers submit an application to the Department that provides evidence of the facility's performance in quality of care, quality of life and facility management. The Department currently has a contract with a vendor who reviews and scores all completed applications which includes reviewing supporting documentation offered through an informal appeal process when exercised, conducting site visits to verify implementation, and developing recommendations to the Department. The Department is able to make supplemental payments from the Nursing Facility Provider Fee to nursing facility providers that provide services that result in better care and higher quality of life for their residents pursuant to section 25.5-6-202(5), C.R.S. This Department, however, is currently receiving 50% FFP because the contract is not eligible for enhanced FFP since it is not consolidated with a QIO contract. Moving the nursing facility pay for performance review process to the QIO and expanding the requirements of the contract to include resident interviews to gauge person-centered and quality of life impacts would ensure the enhanced FFP and improve the care provided in the facilities by collecting and reporting on this type of data.

Because the Department has existing resources for this activity and because the FFP rate is being increased to 75%, this portion of the request results in a General Fund decrease to move these activities to the QIO.

Post Eligibility Treatment of Income/Incurred Medical Expenses Reviews

The Department requests $88,400 total funds, $22,100 General Fund in FY 2017-18, $353,600 total funds, $88,400 General Fund in FY 2018-19 and ongoing funding to shift Post Eligibility Treatment of Income-Incurred Medical Expenses (PETI-IME) reviews to the QIO.

Post Eligibility Treatment of Income (PETI) is the reduction of a resident payment to a nursing facility for the costs of care provided to an individual by the amount that remains after certain deductions are applied to reduce the individual's total income. After the PETI calculation has been completed and all deductions have been taken, the Medicaid eligible individuals are liable to pay the remaining amount to the institution. 42 CFR § 435.725 allows incurred medical expenses (IME) not paid by a third party to be deducted from an individual's income. In order to monitor Incurred Medical Expenses, all expenses in excess of $400 per calendar year must be prior authorized by the Department or its designee. The purpose of the prior authorization process is to verify the medical necessity of the services or supplies, to validate that the requested expense is not a benefit of the Medicaid program, and to determine if the expenses requested are a duplication of expenses previously prior authorized. This process is currently managed internally by the Department's PETI Administrator; however, the Department receives over 3,100 requests per year which is

too many requests for a single staff member with other responsibilities to verify timely that services were delivered and appropriate.

A QIO would verify that IMEs (e.g. hearing aids and glasses, dental) have been rendered in a timely manner. The QIO would also document justifications for all untimely rendered IME services to: ensure that state services were utilized first, followed by waiver services; and then that PETI was utilized for services not otherwise covered to ensure medical necessity reviews for all submitted PETI/IME; and prevent duplicate or unnecessary payments.

Shifting PETI/IME reviews to a QIO would allow the FTE currently responsible for this work to focus on contract management, provider training, provider enrollment due to change of ownership, license and certifications tracking and policy and rule updates. This is crucial to continued success in the management of Department resources as it would allow staff to look for opportunities to improve both current and future processes and strategize how to better serve clients.

Post Payment Review

The Department requests $133,875 total funds, $33,469 General Fund in FY 2017-18, $535,500 total funds, $133,875 General Fund in FY 2018-19 and ongoing funding to have the QIO conduct routine post payment review of HCBS claims to determine that services were rendered appropriately and were consistent with services that were billed.

Post payment review is a process that provides assurances of financial accountability for HCBS services, which may include documentation substantiating claims billed and paid by the Department's Medicaid Management Information System (MMIS). The Department is required to conduct post payment review to provide CMS with required assurances regarding financial accountability and programmatic oversight for HCBS waiver programs. In FY 2014-15 and FY 2015-16, the Department initiated two one-time contracts for post-payment review of claims in order to review the integrity of provider billings as required in the HCBS waiver agreement. However, the Department does not have sustainable ongoing funding to do this work to the level that it needs to be done which requires payment reviews of a statistically valid, random sampling of HCBS claims. The lack of funding has prevented the Department from monitoring that services were actually rendered appropriately and consistent with the services that were billed.

With the requested funding, the Department would move this activity to the QIO vendor. The vendor would conduct post payment review of a sampling of HCBS waiver claims to ensure services were billed timely and adequately delivered and in keeping with the frequency, scope and duration reflected on the PAR and documented on the service plan. They would also be responsible for identifying and preventing fraud, ensuring services provided match claims activities and that PAR amendments are made as necessary to align with client need. The vendor would be required to review whether required prior authorizations were obtained appropriately, whether service plans included the appropriate services, and that provider documentation supports the services billed. By ensuring that services are appropriate, are billed in a timely manner and are delivered in an adequate way, the QIO would help to guarantee clients are receiving the services they need, at the appropriate time and at the prices that make sense for what they received.

Home and Community-Based Services Prior Authorization Request Utilization Management

The Department requests $35,063 total funds, $8,766 General Fund in FY 2017-18, $351,645 total funds, $87,912 General Fund in FY 2018-19 and ongoing funding to enlist the QIO to develop criteria for third party development of Prior Authorization Requests (PARs) and to ensure this criterion is being applied equitably across the system.

Case managers develop HCBS PARs to authorize the use of services based on the needs identified in the ULTC 100.2 and available supporting services. There is not currently a comprehensive check to ensure that State Plan services are being used in lieu of waiver benefits where appropriate or that PAR criteria is being applied equitably across case management agencies. To help achieve uniformity between processes at all case management agencies the Department would contract with the QIO to recommend standard service limits across waivers for review and approval by the Department. Once the uniformity process is established the QIO scope of work would include developing standards for a third-party post PAR review to ensure accuracy and uniformity and define areas that need to be improved. Further, the vendor would establish processes to ensure State Plan benefits were being used appropriately and would periodically review for utilization trends across waivers and State Plan services. Creating review criteria and sampling PARs would help create consistency in reviews and ensure clients' needs are being met.

Quality Improvement Strategy

The Department requests $88,400 total funds, $22,100 General Fund in FY 2017-18, $353,600 total funds, $88,400 General Fund in FY 2018-19 and ongoing funding to shift oversight of the Quality Improvement Strategy (QIS) to the QIO.

The Department has received written instruction from CMS on June 27, 2016 that a plan of correction will be put into place for the Adult Comprehensive waiver (HCBS-DD) and the Supported Living Services (HCBS-SLS) waivers due to deficiencies in its Quality Improvement Strategy (QIS) remediation efforts. According to 42 CFR § 441.302 the QIS process requires the Department to research the reasons for variations in utilization of services, such as if a client's condition improves and the Single Entry Point is not notified until their next annual Continued Stay Review so no PAR adjustments are made. Staff are required to do a review in order to make adjustments for underutilization, which is done to ensure CMS compliance. In this case they may not need the services approved in the frequency, scope and duration originally authorized which would result in an underutilization of services. The role of the QIS reviewer is to determine whether the variation in utilization from cases like described above can be explained. To reduce the possibility of fraud, case managers are expected to reduce authorized service units when underutilization is verified. In instances in which overutilization is anticipated, an upward adjustment in authorized units may be justified. It is the QIS reviewer's responsibility to ensure that case management agencies adjust PAR units to match claims activity. In order to determine whether the variation is appropriate at statistically valid levels, this process entails issue discovery, solution development, implementation and follow-up, ensuring that issues identified through the QIS process are addressed accordingly and that future concerns are minimized as required by the federal rule.[3] This process involves the review of a large amount of data, causing it to be

[3]https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Technical-Guidance.pdf Appendix D p. 188

a manual and time intensive process which has led the Department to be delayed in these reviews as caseload continues to increase, and the Department staff devoted to this activity lack capacity.

Shifting this process to a QIO would ensure the QIS process is completed accurately, efficiently and in accordance with federal standards as populations in need of long term services and supports continues to grow. Additionally, it would allow current staff to work with the vendor to dive deeper into the root problems of critical incidents, over- and under-utilization, quality and design programs and measure to prevent them from occurring in the future. A QIO vendor would be better equipped to handle the volume of data from the QIS process that is received and manually processed as they would have clinically-trained staff who are able to evaluate medical records and make clinical determinations, something the Department is currently unable to do.

Case Management Agency Operational Audits

The Department requests $162,240 total funds, $40,560 General Fund in FY 2017-18, $648,960 total funds, $162,240 General Fund in FY 2018-19 and ongoing funding to contract with the QIO to perform desk and onsite operational audits of Single Entry Points (SEPs) and Community Centered Boards (CCBs). While there are similarities across the QIS reviews and Operational Audits as to the performance of review of operations and service quality, each type of review is necessary for different reasons. The QIS provides assurances to CMS on a four year cycle of a "point in time snapshot" of the quality of service delivery, but the operational audits ensure compliance with Department regulations. These audits occur on different time cycles, and work in unique ways to support operational transparency, client safety, and sound stewardship of resources. They are not interchangeable and cannot be substituted for one another.

Community Centered Boards (CCB), Single Entry Points (SEP), and private case management agencies are the Case Management Agencies (CMAs) contracted to determine functional eligibility for individuals applying for or enrolled in Medicaid institutional and HCBS waivers. The Department does not currently have the resources to complete operational audits of these agencies. The vendor would conduct site-based operational audits in accordance with federal HCBS waiver requirements to ensure agencies were following state and federal rules and procedures regarding hiring, oversight, reporting, training, etc. The vendor would also be utilized to expand the sample size to reach a 95% confidence interval with 5% variable percentage required by 42 CFR § 431.60. There are currently 47 CMAs, including 24 SEPs, 20 CCBs and 3 private case management agencies.

Pursuant to section 42 CFR § 431.60, the Department is federally required to conduct on-site audits of all CMAs on a rotating four-year cycle to ensure they meet all operational requirements. On-site audits involve reviews for CMA compliance with federal and state statutes and regulations, HCBS waiver assurances, contract requirements, Department guidance and agency policies and procedures. Auditors follow specific protocols to include formal notice, record requests, entrance/exit interviews, preliminary findings reports, final findings reports, corrective action reviews and final corrective action acceptance. Visits may require an on-site presence of one or more staff and may last from four hours to four days depending on the number of clients served by the CMA. Auditors review CMA organizational structure, approaches to case assignments, hiring practices to include minimum qualifications, leadership changes, training plans, complaint logs and mitigations, intake processes and financial eligibility verification processes. Client record audits include, but

are not limited to, reviews for the assurance of client involvement in provider selection, goal identification and service plan development. Auditors review individual records to ensure that necessary services were provided in accordance with the frequency, scope and duration documented in the service plan and that variances identified are justified and properly documented. Protocols are reviewed for how each agency interacts with the medical and other providers rendering client care. Agency procedures for reviewing home health PARs and managing negotiations are reviewed as are each agency's approach to local resource development expansion efforts.

Audits of this nature require significant time to complete, especially given the need to reach a 95% confidence level. Estimates from the Colorado Department of Public Health and Environment for the time required to survey IDD provider agencies of the same size as Community Centered Board case management arms require 10 working days and five working days for each Intermediate Care Facility for Individuals with Intellectual Disabilities. Although the surveys performed by CDPHE are focused on provider agencies, the level of detail, scrutiny, and level of operational and client-level review is very similar, requiring many hours of staff time. These reviews allow for the assurance that all agency operations, from policies and procedures down to the delivery of case management services to members, supports operational excellence and the overall health, safety, and welfare of members.

A discussion on the process for each type of agency audit is discussed below.

CCB Agency Operational Audits

The Department requests $81,120 total funds, $20,280 General Fund in FY 2017-18, $324,480 total funds, $81,120 General Fund in FY 2018-19 and ongoing funding to contract with the QIO to perform desk and onsite operational audits of Community Centered Boards (CCBs).

The Department has developed a process for conducting quality and performance reviews of CCBs on an ongoing, three-year cycle. This work includes a review of policies and procedures, a records review for individuals who are receiving waiver services through the HCBS-Persons with Developmental Disabilities (DD), HCBS-Supported Living Services (SLS) and HCBS-Children's Extensive Supports Services (CES) programs, a review of agency-wide practices, and a review of case management personnel qualifications. There are approximately 11,000 individuals enrolled in the HCBS-DD, HCBS-SLS, and HCBS-CES waivers. The Department currently has the resources to sample a limited number of case files for individuals enrolled in the waivers as part of these reviews on a three-year cycle. For the individuals being reviewed, the sample is currently set at 10 individuals per CCB to examine the Intellectual and Developmental Disability (I/DD) determination, rights notifications, individual planning, monitoring, incident management, suspension of rights, and contractual CCB requirements. The first CCB is scheduled to be reviewed in July 2016. Through the contractor, the Department would be able to achieve a representative sample of all individuals receiving services by waiver and by CCB. This would allow the Department to better monitor the administrative functions of our CCBs and comply with best practices for sampling within its waivers. The Department cannot perform this requirement effectively with the current resources available.

SEP Operational Audits

The Department requests $81,120 total funds, $20,280 General Fund in FY 2017-18, $324,480 total funds, $81,120 General Fund in FY 2018-19 and ongoing funding to contract with the QIO to perform desk and onsite operational audits of Single Entry Points (SEPs).

SEP Operational Audits are similar in nature to the CCB audits, but have important distinct differences from the CCB audits. Currently, on-site operational audits do not occur which has put the Department out of compliance with CMS requirements. CMS has identified the compliance issue within each waiver as part of waiver amendment reviews and has stated the Department will be at risk for FFP if it does not appropriately monitor all CMAs. Specifically, CMS has cited validating the program review tool responses and on-site reviews as significant areas of concern. Each year the Department is required to report on all of its performance measures in annual federal reporting. Part of the data is collected by having CMAs fill out a "program review tool". This tool looks at a number and percent of waiver participants in a representative sample to provide a redetermination of eligibility, to confirm the ULTC 100.2 assessment tool was applied appropriately, and that the Professional Medical Information Page (PMIP) was completed and signed by a licensed medical professional. The tool also includes a number of measures to ensure client service plans meet their personal goals and there is coordination between CMAs and other providers and that the client has been informed of their choice between the various services available to them. Having the SEP complete the program review tool represents a conflict of interest because to determine their level of need and develop their service plan, currently, these assessments are administered by the same providers whose payment rates are affected by the outcome of the scores which results in a conflict of interest. Currently, one FTE at the Department does all of the quality reporting and remediation for the program review tool and does not have the capacity to complete on site audits to eliminate the conflict of interest.

The QIO vendor would conduct desk and on-site reviews on a three-year cycle, reviewing one third of the SEPs each year. These audits would be waiver specific and include a representative sample. Additionally, the contractor would review a sample of all program review tools submitted by the CMAs to validate their responses for QIS reporting, in an effort to alleviate CMS concerns about these specific areas and eliminate the conflict of interest that currently exists. This would also help to ensure that the Department would be appropriately monitoring all CMAs and ensure FFP is not lost.

<u>Home and Community Based Services Children's Extensive Support Targeting Criteria Review</u>

The Department requests $169,701 total funds, $42,426 General Fund in FY 2017-18 and $180,735 total funds, $45,184 General Fund in FY 2018-19 and ongoing to allocate additional funding for the QIO to review HCBS-Children's Extensive Support (HCBS-CES) waiver applications. The Department currently contracts this work to a QIO, however caseload and application volume has increased so that the current contract amount is not sufficient to complete the volume of work. This work of the QIO to review applications benefits the Department and the children/families receiving services by providing clinicians to make the determination of eligibility, an expedient review process and the expertise needed to represent the Department in appeals.

Currently the Department's acute care utilization management contractor reviews applications for the CES waiver to determine if children meet targeting criteria for the HCBS-CES waiver. The contractor has

estimated that they will need an increase in funding to continue performing this duty as the average monthly reviews has gone up from 150 to 235 as a result of the elimination of the waiting list for the HCBS-CES waiver. Funding was not included for this increase when the policy passed and as a result this request would add the funding needed to allow the contractor to continue with their work at the increased average monthly reviews amount.

Anticipated Outcomes:

One of the Department's Performance Plan's primary goals of "ensuring sound stewardship of financial resources" would be met by this request, as it would allow financial resources to be allocated more efficiently and reduce conflicts of interest where applicable. Approval of this request would put measures in place to ensure the Department's long term care clients have their needs met appropriately by ensuring federal and state utilization management regulations are adhered to. This would also effectively increase the quality of services being delivered by allowing a QIO who is an expert in the field to monitor and make recommendations for changes that the Department could implement. Consolidation of these services may also reduce the per capita cost of health care in Colorado in the long run, as the QIO would monitor utilization of services provided in the State Plan and HCBS waivers ensuring individuals receive the right services at the right time, and help the Department to meet federal waiver assurances. Finally, funding of this request would allow the Department to more efficiently allocate the General Fund by utilizing the enhanced FFP.

Assumptions and Calculations:

The Department assumes that the administrative activities outsourced through the contract with the QIO would qualify for 75% enhanced FFP as allowed by 42 CFR § 433.15. In order to gain federal approval of the enhanced match, the Department would be required to gain approval from CMS through the Department's Cost Allocation Plan describing the activities included in the QIO contract. If the Department does not receive approval for certain activities it would utilize the budget process to adjust funding requested at a revised FFP rate.

State procurement rules would require the Department to select the vendor through the Request for Proposal (RFP) process and the Department assumes that the vendor selection could be completed by April 1, 2018.

Tables 3.1 through 3.4 in the appendix details the assumptions for each of the estimates based upon number of units or hours required to complete the tasks. The Department assumes that these estimates are accurate based on its knowledge of volume and available data, however as some of the activities are new and as caseload continues to rise, the Department would use the budget process to adjust any of the estimates as necessary.

The Department assumes that the rate of $85.00, which is the ad hoc rate in its current acute care utilization management contract, the vendor responsible for UM activities for State Plan services, is a reasonable hourly rate for most of the activities being outsourced to a QIO vendor for LTC UM activities.

For detailed assumptions for each portion of the Department's requested contract please see below.

Brain Injury Waiver Supportive Living Program (BI SLP) Acuity Assessments

The Department assumes that 400 Supportive Living Program assessments would be required on an annual basis as the number of expected enrollments in FY 2016-17 is 200 and each assessment needs to be performed twice annually, each assessment takes 5 hours according to pre-procurement research and as a result an assumed 5 hours would be required totaling 2,000 hours annually for assessments.

The Department assumes that an hourly rate of $29.97 would be reasonable to have a QIO conduct BI SLP Acuity Assessments, based on an average of the current rates for Registered Nurses and Non-Registered Nurses to conduct BI SLP Acuity Assessments. The Department believes this estimated rate to be appropriate, as not all the assessments would require a nurse, but the average rate would balance out for assessments that do require a nurse's assessment.

Critical Incident Reporting (CIR) and Monitoring

The Department assumes that the QIO would need 60 minutes per incident to manage critical incidents to complete the tasks associated with critical incident reporting and monitoring. This information is based on pre-procurement market research. The total volume of critical incidents is currently 277 per week or 14,404 critical incidents per year.

Over Cost Containment Reviews

The Department assumes the contractor would complete 920 OCC reviews totaling 1,840 hours of work annually, which assumes an average time of 2 hours to complete each review. This estimate is based on results from pre-procurement market research and the workload that Department staff currently perform.

Nursing Facility Pay for Performance

The Department assumes the current total amount of the nursing facility pay for performance contract of $147,500 would not change due to the change in vendor and that this funding would be moved from (1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects to (1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts. The Department assumes that due to the shift to a QIO contractor that the match rate would be adjusted from 50% to 75% FFP and that any freed up General Fund from the enhanced FFP rate would be utilized to fund other portions of this request.

Post Eligibility Treatment of Income/Incurred Medical Expenses Reviews

The Department assumes that the current annual volume of 3,100 PETI/IME reviews would be an accurate estimate of ongoing workload, due to the estimated 3,100 annual PETI/IME requests that the Department receives, and that this activity would require 6,940 hours annually, or 2.2 hours per review.

Post Payment Review

The Department estimates that it would be required to perform 4,200 reviews in order to achieve a statistically significant sample size for post payment review of claims. At 1.5 hours per review, this this would require 6,300 hours annually. The vendor would be required to conduct post payment reviews on a representative sample (randomly selected) of claims in its waiver agreements with CMS related to the Financial Integrity Assurance.

Home and Community-Based Services Prior Authorization Request Utilization Management

The Department estimates that 150 hours will be needed to develop criteria for third party development of Prior Authorization Requests (PARs) in the first year of the contract. There are 11 waivers in total, leading to a total hour requirement of 1,650.

The Department assumes that in the second year of the contract and ongoing, to ensure this criterion is being applied equitably across the system, the QIO would need to create review criteria and 10% of HCBS clients PARs would need to be sampled to ensure accuracy resulting in 4,137 hours annually.

Quality Improvement Strategy

The Department assumes that the rate of $78.00, which is based on the rate the Office of the State Auditor uses for state agencies, would be a reasonable rate for these activities.

Case Management Agency Operational Audits

The Department assumes that the rate of $78.00, which is based on the rate the Office of the State Auditor uses for state agencies, would be a reasonable rate for these activities.

Home and Community-Based Services Children's Extensive Support Targeting Criteria Review

The Department believes that the current contract amount for the Children's Extensive Supports (HCBS-CES) waiver medical review would not be an accurate assessment of cost for this new contract in FY 2017-18 an onward. This contract is no longer an accurate assessment of cost, due to the increasing caseload leading to an increased cost for the vendor to handle. In table 3.3, the Department estimates that it would require $169,701 in FY 2017-18 and $180,735 in FY 2018-19, based on the existing cost per enrolled individual and the estimates caseload. In FY 2017-18 and FY 2018-19 the projected increase in caseload from the FY 2016-17 S-5 was used to determine the increased funding needed.

Table 1.1 FY 2017-18 Long Term Care Utilization Review and Utilization Management Summary by Line Item								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	**Total Request**	**$1,030,568**	**0.0**	**$257,644**	**($9,219)**	**$0**	**$782,143**	**Row B + Row C + Row D**
B	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	($36,875)	0.0	$0	($18,438)	$0	($18,437)	Table 2.3 Row A
C	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$905,203	0.0	$217,084	$9,219	$0	$678,900	Table 2.1 Row B + Row C + Row D + Row E + Row F + Row G + Row H + Row I + Row L
D	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$162,240	$0	$40,560	$0	$0	$121,680	Table 2.1 Row J + Row K

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 1.2 FY 2018-19 Long Term Care Utilization Review and Utilization Management Summary by Line Item								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	**Total Request**	**$3,835,600**	**0.0**	**$958,901**	**($36,875)**	**$0**	**$2,913,574**	**Row B + Row C + Row D**
B	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	($147,500)	$0	$0	($73,750)	$0	($73,750)	Table 2.4 Row A
C	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$3,334,140	$0	$796,661	$36,875	$0	$2,500,604	Table 2.1 Row B + Row C + Row D + Row E + Row F + Row G + Row H + Row I + Row L
D	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$648,960	$0	$162,240	$0	$0	$486,720	Table 2.1 Row J + Row K

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 2.1 FY 2017-18 Long Term Care Utilization Review and Utilization Management Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	**Total Request**	**$1,067,443**	**0.0**	**$257,644**	**$9,219**	**$0**	**$800,580**	**75%**	**Sum of Rows B to M**
B	Brain Injury Supported Living Program Assessments	$14,985	0.0	$3,747	$0	$0	$11,238	75%	Table 3.1 Row A
C	Critical Incidents	$306,085	0.0	$76,522	$0	$0	$229,563	75%	Table 3.1 Row B
D	Over Cost Containment	$39,100	0.0	$9,775	$0	$0	$29,325	75%	Table 3.1 Row C
E	Nursing Facility Pay for Performance	$36,875	0.0	$0	$9,219	$0	$27,656	75%	Table 3.1 Row D
F	Post Eligibility Treatment of Income Incurred Medical Expenses (PETI/IME) Review	$88,400	0.0	$22,100	$0	$0	$66,300	75%	Table 3.1 Row E
G	Post Payment Review	$133,875	0.0	$33,469	$0	$0	$100,406	75%	Table 3.1 Row F
H	Home and Community-Based Services Prior Authorization Request Utilization Management	$35,063	0.0	$8,766	$0	$0	$26,297	75%	Table 3.1 Row G
I	Quality Improvement Strategy	$81,120	0.0	$20,280	$0	$0	$60,840	75%	Table 3.1 Row H
J	Community Centered Board Operational Audits	$81,120	0.0	$20,280	$0	$0	$60,840	75%	Table 3.1 Row I
K	Single Entry Point Operational Audits	$81,120	0.0	$20,280	$0	$0	$60,840	75%	Table 3.1 Row J
L	Home and Community Based Services Children's Extensive Support Services Targeting Criteria Review	$169,700	0.0	$42,425	$0	$0	$127,275	75%	Table 3.1 Row K Estimated new contract in addition to current contract amount. See narrative for further detail of cost estimate

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 2.2 FY 2018-19 Long Term Care Utilization Review and Utilization Management Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	**Total Request**	**$3,983,100**	**0.0**	**$958,901**	**$36,875**	**$0**	**$2,987,324**	**75%**	**Sum of Rows B to M**
B	Brain Injury Supported Living Program Assessments	$59,940	0.0	$14,985	$0	$0	$44,955	75%	Table 3.2 Row A
C	Critical Incidents	$1,224,340	0.0	$306,085	$0	$0	$918,255	75%	Table 3.2 Row B
D	Over Cost Containment	$156,400	0.0	$39,100	$0	$0	$117,300	75%	Table 3.2 Row C
E	Nursing Facility Pay for Performance	$147,500	0.0	$0	$36,875	$0	$110,625	75%	Table 3.2 Row D
F	Post Eligibility Treatment of Income Incurred Medical Expenses (PETI/IME) Review	$353,600	0.0	$88,400	$0	$0	$265,200	75%	Table 3.2 Row E
G	Post Payment Review	$535,500	0.0	$133,875	$0	$0	$401,625	75%	Table 3.2 Row F
H	Home and Community-Based Services Prior Authorization Request Utilization Management	$351,645	0.0	$87,912	$0	$0	$263,733	75%	Table 3.2 Row G
I	Quality Improvement Strategy	$324,480	0.0	$81,120	$0	$0	$243,360	75%	Table 3.2 Row H
J	Community Centered Board Operational Audits	$324,480	0.0	$81,120	$0	$0	$243,360	75%	Table 3.2 Row I
K	Single Entry Point Operational Audits	$324,480	0.0	$81,120	$0	$0	$243,360	75%	Table 3.2 Row J
L	Home and Community Based Services Children's Extensive Support Services Targeting Criteria Review	$180,735.0	0.0	$45,184	$0	$0	$135,551	75%	Table 3.2 Row K

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 2.3 FY 2017-18 Long Term Care Utilization Review and Utilization Management Current Contract Adjustments

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	Adjustment for Current Contract- Nursing Facility Pay for Performance	($36,875)	0.0	$0	($18,438)	$0	($18,437)	50%	Amount of current contract

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 2.4 FY 2018-19 Long Term Care Utilization Review and Utilization Management Current Contract Adjustments

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	Adjustment for Current Contract- Nursing Facility Pay for Performance	($147,500)	0.0	$0	($73,750)	$0	($73,750)	50%	Amount of current contract

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 3.1 FY 2017-18 Long Term Care Utilization Review and Utilization Management Estimated Contract Costs						
Row	**Activity Name**	**Hourly Rate**	**Estimated Annual Units/Hours**	**Estimated Annual Cost**	**Cost Adjusted for April 1, 2018 Implementation Date**	**Notes**
A	Brain Injury Supported Living Program Assessments	$29.97	2,000	$59,940	$14,985	Rate from similar contract, estimate of assessments based on current Brain Injury Supported Living Program population multiplied by 2 to account for biannual assessments
B	Critical Incident Reporting	$85.00	14,404	$1,224,340	$306,085	Hours estimate from 1 hour per Critical Incident Report, 277 Critical Incident Reports per week, rate is based on similar contract
C	Over Cost Containment Reviews	$85.00	1,840	$156,400	$39,100	Hours estimate from pre-procurement market research, rate from similar contract
D	Nursing Facility Pay for Performance	N/A	N/A	$147,500	$36,875	Current contract cost
E	Post Eligibility Treatment of Income Incurred Medical Expenses (PETI/IME) Review	$85.00	4,160	$353,600	$88,400	Hours estimate from pre-procurement market research, rate from similar contract
F	Post Payment Review	$85.00	6,300	$535,500	$133,875	Hours estimate from pre-procurement market research, rate from similar contract
G	Home and Community-Based Services Prior Authorization Request Utilization Management	$85.00	1,650	$140,250	$35,063	Estimated 150 hours needed per waiver annually 11 waivers total, rate from similar contract
H	Quality Improvement Strategy	$78.00	4,160	$324,480	$81,120	Hours estimate and cost based on pre-procurement market research
I	Community Centered Board Operational Audits	$78.00	4,160	$324,480	$81,120	Hours estimate and cost based on pre-procurement market research
J	Single Entry Point Operational Audits	$78.00	4,160	$324,480	$81,120	Hours estimate and cost based on pre-procurement market research
K	Home and Community Based Services Children's Extensive Support Services Targeting Criteria Review	N/A	N/A	$169,700	N/A	Estimated new contract in addition to current contract amount. See narrative for further detail of cost estimate
L	**Total**	**N/A**	**N/A**	**$3,760,670**	**$897,743**	

Table 3.2 FY 2018-19 Long Term Care Utilization Review and Utilization Management Estimated Contract Costs					
Row	**Activity Name**	**Hourly Rate**	**Estimated Annual Units/Hours**	**Estimated Annual Cost**	**Notes**
A	Brain Injury Supported Living Program Assessments	$29.97	2,000	$59,940	Rate from similar contract, estimate of assessments based on current Brain Injury Supported Living Program population multiplied by 2 to account for biannual assessments
B	Critical Incident Reporting	$85.00	14,404	$1,224,340	Hours estimate from 1 hour per Critical Incident Report, 277 Critical Incident Reports per week, rate is based on similar contract
C	Over Cost Containment Reviews	$85.00	1,840	$156,400	Hours estimate from pre-procurement market research, rate is based on similar contract
D	Nursing Facility Pay for Performance	N/A	N/A	$147,500	Current contract cost
E	Post Eligibility Treatment of Income Incurred Medical Expenses (PETI/IME) Review	$85.00	4,160	$353,600	Hours estimate from pre-procurement market research, rate is based on similar contract
F	Post Payment Review	$85.00	6,300	$535,500	Hours estimate from pre-procurement market research, rate is based on similar contract
G	Home and Community-Based Services Prior Authorization Request Utilization Management	$85.00	4,137	$351,645	10% of HCBS clients, rate is based on similar contract
H	Quality Improvement Strategy	$78.00	4,160	$324,480	Hours estimate and cost based on pre-procurement market research
I	Community Centered Board Operational Audits	$78.00	4,160	$324,480	Hours estimate and cost based on pre-procurement market research
J	Single Entry Point Operational Audits	$78.00	4,160	$324,480	Hours estimate and cost based on pre-procurement market research
K	Home and Community Based Services Children's Extensive Support Services Targeting Criteria Review	N/A	N/A	$180,735	Estimated new contract in addition to current contract amount. See narrative for further detail of cost estimate
L	**Total**	**N/A**	**N/A**	**$3,983,100**	

Table 3.3 Adjusted Children's Extensive Support Services Total Contract Cost Per Year

Row	Costs	FY 2017-18	FY 2018-19	Notes
A	Cost Per Enrolled	$167.19	$167.19	Cost Per Enrolled Table 3.4 Row A
B	Estimated Total Enrolled	1,643	1,709	FY 2016-17 R-5
C	Estimated Annual Cost	$274,700	$285,735	Row A * Row B
D	Existing Funding	$105,000	$105,000	Current Available Funding
E	Additional Funding Needed	$169,700	$180,735	Row C - Row D

Table 3.4 Children's Extensive Support Services Cost Per Enrolled Calculation

Row	FY 2016-17 Estimated Total Enrolled	FY 2016-17 Contract Amount + Additional Funding Needed	Estimated Cost Per Enrolled	Notes
A	1,579	$264,000	$167.19	Contract / Total Enrolled

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-10 Regional Center Task Force Recommendation Implementation

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	Total	$78,298,019	$0	$78,828,540	$922,801	$450,890
	FTE	35.5	0.0	35.5	1.8	2.0
	GF	$27,709,858	$0	$28,067,689	$224,066	$225,445
	CF	$2,992,684	$0	$3,053,047	$0	$0
	RF	$1,316,658	$0	$1,321,536	$0	$0
	FF	$46,278,819	$0	$46,386,268	$698,735	$225,445

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (A) General Administration - Health, Life, and Dental	Total	$3,434,070	$0	$3,673,458	$15,854	$15,854
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,230,952	$0	$1,316,506	$7,927	$7,927
	CF	$337,577	$0	$349,778	$0	$0
	RF	$104,755	$0	$104,635	$0	$0
	FF	$1,760,786	$0	$1,902,539	$7,927	$7,927
01. Executive Director's Office, (A) General Administration - Short-term Disability	Total	$55,072	$0	$57,991	$234	$254
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$20,569	$0	$21,560	$117	$127
	CF	$4,588	$0	$4,796	$0	$0
	RF	$1,393	$0	$1,365	$0	$0
	FF	$28,522	$0	$30,270	$117	$127

01. Executive Director's Office, (A) General Administration - Amortization Equalization Disbursement	**Total**	**$1,434,489**	**$0**	**$1,613,687**	**$6,144**	**$6,702**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$535,695	$0	$600,009	$3,072	$3,351
	CF	$119,586	$0	$133,459	$0	$0
	RF	$36,269	$0	$37,816	$0	$0
	FF	$742,939	$0	$842,403	$3,072	$3,351
01. Executive Director's Office, (A) General Administration - Supplemental Amortization Equalization Disbursement	**Total**	**$1,419,546**	**$0**	**$1,613,662**	**$6,144**	**$6,702**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$530,115	$0	$600,009	$3,072	$3,351
	CF	$118,340	$0	$133,459	$0	$0
	RF	$35,891	$0	$37,791	$0	$0
	FF	$735,200	$0	$842,403	$3,072	$3,351
01. Executive Director's Office, (C) Information Technology Contracts and Projects - MMIS Maintenance and Projects	**Total**	**$35,564,820**	**$0**	**$35,440,753**	**$593,300**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,211,028	$0	$7,384,952	$59,330	$0
	CF	$2,226,262	$0	$2,191,808	$0	$0
	RF	$293,350	$0	$293,350	$0	$0
	FF	$25,834,180	$0	$25,570,643	$533,970	$0
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Administrative Costs - Personal Services	**Total**	**$3,063,982**	**$0**	**$3,096,155**	**$137,128**	**$149,590**
	FTE	35.5	0.0	35.5	1.8	2.0
	GF	$1,431,598	$0	$1,439,296	$68,564	$74,795
	CF	$182,080	$0	$187,556	$0	$0
	RF	$75,000	$0	$76,579	$0	$0
	FF	$1,375,304	$0	$1,392,724	$68,564	$74,795
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Administrative Costs - Operating Expenses	**Total**	**$1,070,539**	**$0**	**$1,065,836**	**$11,148**	**$1,900**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$144,899	$0	$144,899	$5,574	$950
	CF	$4,251	$0	$1,900	$0	$0
	RF	$770,000	$0	$770,000	$0	$0
	FF	$151,389	$0	$149,037	$5,574	$950

	Total	**$32,255,501**	**$0**	**$32,266,998**	**$152,849**	**$269,888**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs - Case Management	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$16,605,002	$0	$16,560,458	$76,410	$134,944
	CF	$0	$0	$50,291	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$15,650,499	$0	$15,656,249	$76,439	$134,944

CF Letternote Text Revision Required?	Yes	No	X	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes	No	X	
FF Letternote Text Revision Required?	Yes	No	X	
Requires Legislation?	Yes	No	X	
Type of Request?	Department of Health Care Policy and Financing Prioritized Request			
Interagency Approval or Related Schedule 13s: None				

Cost and FTE

- The Department requests $922,801 total funds, $224,066 General Fund and 1.8 FTE in FY 2017-18, $450,890 total funds, $225,455 General Fund and 2.0 FTE in FY 2018-19, $464,107 total funds, $232,054 General Fund and 2.0 FTE in FY 2019-20 to expand Intensive Case Management (ICM) services to clients transitioning out of an Intermediate Care Facility (ICF) or Regional Center waiver settings while they still live in the ICF or Regional Center setting and to hire two ongoing FTE to project manage the Regional Center Task Force (RCTF) recommendations and to oversee Department activities pertaining to ICFs.

Current Program

- Clients transitioning out of an ICF, who are not enrolled in the Colorado Choice Transitions (CCT) program, are not eligible to receive case management services until they have stopped receiving ICF services. Clients receiving Home and Community Based Services Adult Comprehensive Waiver (HCBS-DD) services from a Regional Center have their case management services capped at 240 units (60 hours) per-year.
- Currently, the Department does not have staff solely dedicated to the implementation of the RCTF recommendations or ICF oversight. These tasks are being divided amongst existing staff.

Problem or Opportunity

- Clients who are transitioning out of ICFs do not qualify for case management services while living in an ICF, meaning that case managers do not have adequate time to assess the transitioning client's needs and preferences pre-transition. Additionally, once a client has transitioned, case managers are limited to 240 units of case management for the year, which makes it difficult to ensure a stable and successful transition. While clients on the HCBS-DD waiver who receive services from a Regional Center have access to case management, the amount available is inadequate to ensure that a client's needs are met during the transition.
- There is an opportunity to improve coordination between departments, ICFs, clients, and stakeholders during the implementation of the RCTF recommendations and regarding ongoing ICF operations by hiring dedicated staff to serve as project managers and reference points in these areas.

Consequences of the Problem

- ICF clients do not have access to case management services, such as assessments of needs and service coordination, until they transition from the ICF. HCBS-DD clients receiving services from a Regional Center have limited case management services per-year, which includes case management while transitioning. These limitations may lead to inadequate post transition support.
- There is no single reference point for RCTF recommendation implementation, leaving the Department vulnerable to implementation delays due to lack of coordination. ICF knowledge is stratified within the Department, limiting the Department's ability to swiftly react to ICF structural and policy changes.

Proposed Solution

- The Department proposes expanding ICM eligibility to clients living in ICFs or clients on the HCBS-DD waiver receiving services from a Regional Center for up to one year after their transition begins. This would ensure that each transitioning client's needs are fully assessed and that a service package is created for the client prior to leaving the ICF, to help the client seamlessly transition to the community.
- The Department requests 1.0 FTE to project manage the RCTF recommendations and 1.0 FTE to oversee ongoing ICF operations.

Department Priority:	***R-10***
Request Detail:	***Regional Center Task Force Recommendation Implementation***

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Regional Center Task Force Recomendation Implementation	$922,801	$224,066

Problem or Opportunity:

The Department is currently unable to offer comprehensive case management services to clients transitioning out of Intermediate Care Facilities (ICF) or Regional Center-waiver settings to the community. ICF clients are currently ineligible to receive Targeted Case Management (TCM) services in tandem with ICF services, giving case managers inadequate time to prepare for the client's transition to the community. TCM is currently only available to clients receiving home and community based services (HCBS) who do not reside in institutional settings such as ICFs. HCBS clients enrolled on the Adult Comprehensive waiver (HCBS-DD) receiving services from Regional Centers have access to case management; however, the cap on the service is too restrictive to ensure that case managers have time to fully assess the clients' needs and coordinate with providers to ensure a successful transition. Additionally, the Department has insufficient staff resources to facilitate implementation of the recommendations from the Regional Center Task Force (RCTF), and to effectively oversee the ongoing operations of ICFs. There are currently no specific staff available to manage these complicated systems.

In December 2015, the RCTF, created by HB 14-1338 "Regional Centers Task Force and Utilization Study", published its final recommendations.[1] The recommendations include expansive and comprehensive steps needed to improve Regional Center operations, increase and/or shift funding and eliminate barriers to accessing services so that community providers can effectively serve people with the highest level of needs while insuring optimal client outcomes in terms of choice and service options. As stated in the recommendations, "[the recommendations] represent an ambitious multi-year commitment that would require collaboration between the legislature, various state agencies, community providers, medical professionals, families, advocates, and a host of others".

A summary of the ten RCTF recommendations are as follows:

[1] The Regional Center Task Force Final Recommendations can be found online at this address: http://regionalcentersforum.weebly.com/uploads/2/4/8/8/24880735/hb14-1338_regional_centers_task_force_final_report_12-23-15.pdf

1. Leverage Medicaid waiver redesign efforts already underway pursuant to the requirements of HB 15-1318 “Consolidate Intellectual and Developmental Disabilities Waivers” and explore additional alternatives.
2. Fully include services for individuals with Intellectual and Developmental Disabilities (I/DD) in the capitated mental health system by basing access and reimbursement of services on the presentation of behavioral symptoms, not diagnoses, and require Behavioral Health Organizations to actively recruit and develop provider networks.
3. Develop guidelines, training, and clinical tools for medical, behavioral and mental health providers to deliver effective services for persons with I/DD.
4. Enhance the transition planning process to include additional person-centered elements and improve outcome tracking.
5. Identify, authorize and fund an entity (or entities) to coordinate service delivery for those individuals with I/DD who receive services from multiple systems of care to optimize on-going access to services and provide support during emergencies, transitions and crises.
6. Create contractual agreements with community-based providers across the state that include a no reject/ no eject clause and have the Regional Centers serve as a safety net provider as necessary.
7. Formalize the role of Regional Centers and certain community providers as a statewide crisis stabilization system for individuals with I/DD and certain community providers as a statewide crisis stabilization system for individuals with I/DD and/or co-occurring serious and persistent conditions.
8. Conduct an accurate cost analysis of both community and Regional Center Home and Community Based Services (HCBS) beds related to compliance with the 2014 Centers for Medicare and Medicaid Services (CMS) Final Rule to guide future decisions on the number and location of state-operated HCBS waiver beds. In addition, provide funding and support needed to successfully transition residents, who desire to transition and are deemed ready to transition, to community placements and consolidate these beds as successes allow.
9. Once no-reject/no-eject contracts with community providers are established, implement a fully-funded transition process to place residents, who desire to transition and are deemed ready to transition, in the community, and over time reduce the number of state-run ICF beds as successes allow.
10. Establish an ongoing monitoring, assessment, and reporting structure to ensure that recommendations are implemented and evaluated for impact.

Since the publication of the RCTF recommendations the Department has been meeting monthly with the Colorado Department of Human Services (CDHS) and the Colorado Department of Public Health and Environment (CDPHE) to coordinate implementation of the recommendations. Additionally, the Department hired a contractor to develop an implementation plan for the recommendations which consists of eighty-seven separate major action steps required to implement the recommendations. These tasks have been assigned to individual Department and CDHS staff; however, there is currently no project manager overseeing the combined implementation of the tasks which could cause a lack of coordination, oversight, and synergy as the tasks move forward at the various agencies.

Transition Services

Of the tasks identified as necessary to implement the vision of the RCTF, the Department has identified several that can be accomplished faster and with less resources than the others. One of these is closing the case management gap for clients transitioning from an ICF or Regional Center to the community by leveraging Intensive Case Management (ICM) services similar to that offered under the Colorado Choice Transitions (CCT) program.[2] This task aligns with both recommendation 1 and 4.

TCM and ICM are case management services provided to people with I/DD that include but are not limited to:

- Performance of comprehensive assessments of needs and periodic reassessments of individual needs to determine the need for any medical, educational, social or other services;
- Development and periodic revision of a client care plan;
- Locating, coordinating, and monitoring needed developmental disabilities services;
- Coordinating with other non-developmental disabilities funded services to ensure non-duplication of services; and
- Monitoring the effective and efficient provision of services across multiple funding sources.

TCM is a State Plan service that has a general application to monitoring and coordinating services and resources for HCBS recipients. It is not specific to transition services. In order to successfully transition out of an institution, constant, direct attention is required by case managers to manage transition elements. As a result, the Department created a different benefit in the Colorado Choice Transitions program known as "intensive case management". Although the activities performed by case managers under the TCM and ICM benefits are very similar, the ICM benefit is specific to transition services and reimbursed at a higher rate and in a greater amount in order to emphasize those services that are related to assisting clients transition to a community setting. By having a dedicated benefit for transition services, the Department has been able to successfully transition 166 clients from institutions since the inception of the CCT program through June 30, 2016, something that would not have been possible under the TCM benefit.

The lack of comprehensive transition case management services lends to client and guardian reticence to begin the transition process. Addressing this problem is in line with RCTF recommendation 1.B.4.b. which suggests that the Department "Utilize an intensive case management model and rate to ensure robust service coordination and engagement during and after the transition".

[2] Colorado Choice Transitions is a program authorized under the federal Money Follows the Person initiative, meant to assist clients residing in qualified institutions with exploring their community-based options for long term supports and services; facilitate the transition of clients to a community setting so long as the right services and supports can be arranged in the community to ensure the health, welfare and safety of the client; and provide enhanced services and supports through willing and qualified providers. For more information on CCT, please see the Department's website: https://www.colorado.gov/pacific/hcpf/colorado-choice-transitionshttps://www.colorado.gov/pacific/hcpf/colorado-choice-transitionshttps://www.colorado.gov/pacific/hcpf/colorado-choice-transitionshttps://www.colorado.gov/pacific/hcpf/colorado-choice-transitions

Regional Center Task Force Recommendation Oversight and Coordination

The expansion of case management services to transitioning clients is one of eighty-seven separate major action steps that the Department, along with CDHS and CDPHE, have identified as necessary to fully implement the RCTF recommendations. Full implementation of the RCTF recommendations require a multi-year interdepartmental effort. Time frames and expected resources needed for individual tasks vary, but they all require careful oversight and tracking to ensure that they are completed efficiently and synergistically with other tasks. There is currently a lack of centralized project management for this implementation process. Individual staff members have been assigned tasks, but without a central reference point there is a risk that cohesion may suffer as the project moves forward.

SB 16-178 "Grand Junction Regional Center Campus" directs CDHS, within the parameters of certain guiding principles related to relocating individuals receiving services on the campus to home-like settings of their choosing, to vacate the Grand Junction Regional Center campus no later than July 1, 2018. The publication of the RCTF recommendations and the passage of SB 16-178 signal a period of change in the role of community providers as well as Regional Centers. The Regional Centers, as provided for in the RCTF recommendations, will formalize and improve their safety net and crisis stabilization functions. Therefore it is imperative to have well managed transitions as individuals enter and exit the Regional Centers more rapidly than current process. During this period and beyond, the Department may face difficulties in the absence of a dedicated FTE for ICF coordination. While new ICFs are created and as others close, there is currently no staff to act as the Department's subject matter expert on ICF policy and regulation, or to engage in activities including analysis of new ICF applications and client tracking. Without a dedicated FTE these functions would continue to be absorbed by existing staff on top of their assigned duties, or would not be performed.

The lack of staff related to RCTF recommendation implementation and ICF coordination present a significant obstacle in the Department's efforts to facilitate lasting transitions from ICF and Regional Center settings to the community. Case managers cannot provide case management services to clients living in an ICF. Because of this, clients and guardians who choose to attempt the transition process may find themselves or their loved ones have not been ideally matched with services upon transition. The lack of case management may lead transitioned clients to return to an ICF or Regional Center setting, and may also lead to client and guardian resistance to attempt a transition in the first place. The lack of dedicated RCTF and ICF staff limit the Department's ability to identify and address issues such as this during implementation of the RCTF recommendations and beyond.

Proposed Solution:

The Department requests $922,801 total funds, $224,066 General Fund and 1.8 FTE in FY 2017-18, $450,890 total funds, $225,455 General Fund and 2.0 FTE in FY 2018-19, $464,107 total funds, $232,054 General Fund and 2.0 FTE in FY 2019-20 to expand ICM services to clients who are transitioning out of an ICF or Regional Center waiver setting, and to hire two ongoing FTE: one to oversee Department activities pertaining to ICFs and one to serve as a project manager for the implementation of the RCTF recommendations.

If this request is approved, transitioning clients would have access to case management services for up to a one year transition phase and case managers would be allowed to be reimbursed for services rendered to clients in ICF or Regional Center waiver settings during this time period, regardless of whether the transition

is successful. The Department would not impose a predefined limitation on the number of service hours available under the ICM benefit. This would allow case managers to provide services to clients who may be less likely to transition than others, which would reduce one of the barriers to transition for all ICF and Regional Center clients equally, not just the most likely to transition.

A State Plan Amendment (SPA) would be required to allow for the expanded ICM services and allow for this service to be offered to clients residing in an ICF setting. The SPA would require approval from the Centers for Medicare and Medicaid Services (CMS). Also, in order to offer the proposed case management services the Department would need to modify the Colorado Code of Regulations (CCR) to allow for case management to be offered pre-transition to transitioning clients. The Department expects these processes to take three months, contingent on CMS' responsiveness.

Clients would be directly impacted through greater support from case managers both before and after a transition takes place. Case managers would have more time to vet provider options pre-transition, increasing the prevalence of client choice in providers during the transition process. The provider would also have more time to prepare for the unique needs of the client whom they would be serving. Clients and providers would have more time to identify common interests, which would help them to build a successful professional relationship prior to the client's transition. Ultimately the client would experience a more seamless transition from ICF and Regional Center providers to community providers in a way that better meets the client's needs in regards to provider choice and service package.

The Department anticipates that these outcomes would make clients feel more comfortable and successful in their new community setting. This would reduce the number of readmissions for transitioned clients and demonstrate the possibility of successful transitions to clients and guardians who may be interested in the idea of a community transition but had previously refused due to concerns over provider coordination.

The Department would evaluate the efficacy of case management expansion using a number of different qualitative and quantitative measures. The Department would reference data from the Department of Human Services C-Stat report regarding the number of Regional Center transitions and the number of pending transitions.[3] The Department would compare eligibility data and claims data to the number of transitions to determine the impact of service expansion. Quality of life surveys carried out by case managers would be considered to determine the impact of the program on client wellbeing.

To address the gap in centralized ICF knowledge that currently exists in the Department, the Department requests funding for an ICF coordinator. The ICF coordinator would serve as the Departments subject matter expert for ICF policy, process new ICF applications, and track ICF client and staff activities for accuracy and efficacy. This FTE would serve as a reference point for all projects impacting ICFs, and as such the ICF coordinator would likely play a role in both the implementation of expanded ICM as well as RCTF recommendation implementation. The FTE would also serve as an external liaison for ICF operations related to the Department, and may perform or assign various ad-hoc projects as needed.

[3] https://sites.google.com/a/state.co.us/performance-management/what-is-c-stat

To successfully implement the RCTF recommendations the Department requests funding for a RCTF recommendation project manager. This FTE would communicate with the various staff and stakeholders involved in implementing the tasks required for the RCTF recommendations to be actualized. This FTE would become familiar with the long term goals of the recommendations, develop a long-term implementation plan in line with current efforts, assign tasks to staff, track task implementation progress, and assist staff in addressing any obstacles when they arise. Consolidating the responsibility of overseeing the implementation of the recommendations under one FTE would expedite implementation by improving staff coordination across agencies and improve outcomes through closer monitoring. Additionally, the administrative burden of task tracking and coordination currently on all staff currently working on the recommendations would be reduced, allowing for them to spend more time on their other assigned duties.

Anticipated Outcomes:

By adding additional case management services for clients transitioning out of ICFs and Regional Center waivers the Department anticipates that case managers would have more time to assess, refer, and monitor clients during their transition period while coordinating with providers and arranging an optimal community settings for the clients unique needs. This community setting would be immediately available to the client upon transition to avoid gaps in service. The addition of this service is anticipated to incentivize more clients and their guardians to consider a transition and as such is expected to increase the volume of transitions from ICFs and Regional Center waivers to the community. Furthermore, with more time spent on specifying the optimal community setting for each client, client and guardian satisfaction with the client's post transition setting is expected to increase as measured by a quality of life survey.

By hiring staff dedicated to ICF oversight the Department expects to be able to complete projects involving ICFs and solve problems that arise surrounding ICFs faster and more effectively. The Department would also be able to begin more detailed tracking of client movements within the ICF and Regional Center communities, their service packages and costs, and staff activities and costs to identify potential areas of improvement. The coordinator would address the current ICF knowledge stratification that exists within the Department by acting as the sole ICF reference point, while simultaneously freeing up existing staff to focus on their other assigned duties.

By hiring staff focused on implementation of the RCTF recommendations the Department expects to identify and avoid potential roadblocks to implementation early enough to avoid them or minimize their impact. The Department expects that staff involved in implementation would experience an environment of enhanced coordination and support. The Department anticipates that in the presence of a project manager the RCTF recommendations would be implemented faster, in greater alliance with the intent of the recommendations, and in the most effective way to ensure positive client experience in the changing Regional Center environment.

Assumptions and Calculations:

The Department assumes that clients on the HCBS-DD waiver receiving services from Regional Centers and ICF clients transitioning to the community would most likely transition to the HCBS-DD waiver due to their intensive needs. Because CCT is a program offered specifically to clients transitioning out of institutional settings such as ICFs, the Department expects clients utilizing this proposed case management expansion

would utilize the service at a similar rate as CCT clients transitioning to the HCBS-DD waiver. The Department also assumes that the same rate would be used as the current rate for ICM.

ICM services are reimbursed at a greater rate than TCM services. The Department would pay for ICM services at the current ICM rate under the CCT program. The ICM benefit would be used, in line with RCTF recommendation 1, to support case managers who serve ICF and Regional Center waiver clients who often have above average acuity and more intensive needs. The Department would have the ability to approve services above the current 240 unit case management cap to ensure that services are rendered as needed during the transition. Previous experience with CCT clients has shown that clients have used 404 ICM units per-year on average during their transitions, significantly more than the 240 unit cap that currently exists for TCM. Given the goal of facilitating successful community transitions, the Department believes that using the current ICM rate, with the ability to surpass the current TCM unit cap, is the best solution to support case managers while they provide as much case management as is necessary to achieve an optimal client outcome.

The Department assumes that ICM would replace TCM services that clients on the HCBS-DD waiver are eligible for, during the transition period as multiple case management services would be redundant. This creates a small offset to costs for clients transferring from the Regional Center waiver, as well as for ICF clients after they enter the community. This cost offset is due to clients using less TCM as they substitute ICM for TCM. The Department estimates that a transitioning ICF client would spend, on average, three months of the transition living in the ICF, based on previous transitions data. The Department assumes that all clients utilizing ICM would use the service for a year based on the historic utilization of CCT clients transitioning to the HCBS-DD waiver. Clients transitioning out of an ICF setting would then have, on average, nine months in a community setting in which they are still eligible for ICM. Clients would not utilize TCM during these months, indicating nine months of TCM cost avoidance for these clients on average.

The Department assumes that adding ICM services would incentivize a certain number of clients to transition as clients and guardians become aware that a barrier to transition has been addressed. The Department also assumes that beds made free as a result of clients transitioning to the community would be filled by clients currently waiting to enter ICFs or the Regional Center waiver based on CDHS feedback regarding clients waiting to enter the Regional Centers. Because transitions would be offset by admissions, the Department expects that any savings that would result from increased transitions from ICFs to the community would be offset by the costs of additional clients entering the facility.

The Department assumes that systems changes would be necessary to implement the case management expansion portion of this request. The Department has received a scope of work statement and cost estimate for these updates from its fiscal agent. These changes would include modifications to the Department's VITAL system ensure that needed eligibility data is recorded and synced with the InterChange system, create and establish business rules for Benefit Plans and claims processing, assign clients to the appropriate benefit plans, create a benefit plan hierarchy, ensure provider types exist to accommodate the provider services, create and establish reporting processes, and ensure that prior authorization functionality would accommodate new processes required for new benefit plans.

The Department expects to be able to begin offering case management to transitioning clients on October 1, 2017. This implementation date was selected to give the Department adequate time to complete the necessary systems changes, rule changes, and State Plan Amendment.

The Department assumes that both the RCTF Project Manager and the ICF Coordinator FTE would be hired at the Administrator IV level with a targeted start date of July 1, 2017, and would be ongoing.

Table 1.1 - Request Components by Line Item FY 2017-18

Row	Item	Total Funds	FTE	General Fund	Federal Funds	Federal Match Rate	Source
A	Total Request	$922,801	1.8	$224,066	$698,735		Sum of Row B through Row I
B	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$7,927	$7,927	50.00%	Table 3.1
C	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$234	0.0	$117	$117	50.00%	Table 3.1
D	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$6,144	0.0	$3,072	$3,072	50.00%	Table 3.1
E	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$6,144	0.0	$3,072	$3,072	50.00%	Table 3.1
F	(1) Executive Director's Office; (C) Medicaid Management Information System Maintenance and Projects	$593,300	0.0	$59,330	$533,970	90.00%	Table 4.1 Row F
G	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; Personal Services	$137,128	1.8	$68,564	$68,564	50.00%	Table 3.1
H	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; Operating Expenses	$11,148	0.0	$5,574	$5,574	50.00%	Table 3.1
I	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; Case Management	$152,849	0.0	$76,410	$76,439	50.01%	Table 2.1 Row E

Table 1.2 - Request Components by Line Item FY 2018-19

Row	Item	Total Funds	FTE	General Fund	Federal Funds	Federal Match Rate	Source
A	Total Request	$450,890	2.0	$225,445	$225,445		Sum of Row B through Row H
B	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$7,927	$7,927	50.00%	Table 3.1
C	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$254	0.0	$127	$127	50.00%	Table 3.1
D	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$6,702	0.0	$3,351	$3,351	50.00%	Table 3.1
E	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$6,702	0.0	$3,351	$3,351	50.00%	Table 3.1
F	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; Personal Services	$149,590	2.0	$74,795	$74,795	50.00%	Table 3.1
G	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; Operating Expenses	$1,900	0.0	$950	$950	50.00%	Table 3.1
H	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; Case Management	$269,888	0.0	$134,944	$134,944	50.00%	Table 2.1 Row E

Table 1.3 - Request Components by Line Item FY 2019-20

Row	Item	Total Funds	FTE	General Fund	Federal Funds	Federal Match Rate	Source
A	Total Request	$464,107	2.0	$232,054	$232,053		Sum of Row B through Row H
B	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$15,854	0.0	$7,927	$7,927	50.00%	Table 3.1
C	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$254	0.0	$127	$127	50.00%	Table 3.1
D	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$6,702	0.0	$3,351	$3,351	50.00%	Table 3.1
E	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$6,702	0.0	$3,351	$3,351	50.00%	Table 3.1
F	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; Personal Services	$149,590	2.0	$74,795	$74,795	50.00%	Table 3.1
G	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; Operating Expenses	$1,900	0.0	$950	$950	50.00%	Table 3.1
H	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; Case Management	$283,105	0.0	$141,553	$141,552	50.00%	Table 2.1 Row E

Table 2.1 - Total Cost of Expanding Intensive Case Management to Clients Transitioning from Regional Centers and Private Intermediate Care Facilities

Row	Item	FY 2017-18	FY 2018-19	FY 2019-20	Notes
A	Expected Number of Intermediate Care Facility (ICF) and Regional Center (RC) Waiver Clients Transitioning to the Community	31	42	44	Table 2.2 Row J
B	Projected Cost Per-Client of Expanded Intensive Case Management Services	$6,393.96	$8,525.28	$8,525.28	Table 2.3 Row F
C	Gross Expected Cost of Intensive Case Management Expansion	$198,213	$358,062	$375,112	Row A * Row B
D	Expected Cost Avoidance from Targeted Case Management (TCM) Reduction	($45,364)	($88,174)	($92,007)	Table 2.5 Row K
E	**Net Expected Cost of Intensive Case Management Expansion**	**$152,849**	**$269,888**	**$283,105**	**Row C + Row D**

Table 2.2 - Expected Caseload Utilizing Expanded Case Management by Current Residence					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes**
A	Expected Transitions from Intermediate Care Facility (ICF) Settings	36	36	36	Based on historic transitions per-year.
B	Expected Fraction of ICF Transitions Eligible for Case Management Expansion	90.00%	90.00%	90.00%	Historic fraction of ICF transition clients who would have been eligible for expanded Intensive Case Management.(1)
C	Expected Transitions from ICF who would be Eligible for Case Management Expansion	24	32	32	Row A * Row B, Adjusted for October 1, 2017 start date.
D	Expected Colorado Choice Transitions (CCT) Clients from ICFs	2	2	0	On average, two client per-year who transitioned from an ICF setting have used CCT. The CCT program expires on December 31, 2018. Adjusted for October 1, 2017 start date.
F	**Expected Transitions from an ICF Setting Using Expanded Intensive Case Management**	**22**	**30**	**32**	**Row C - Row D**
G	Expected Transitions from Regional Center (RC) Waiver Setting	18	18	18	Based on historic transitions per-year.
H	Expected Fraction of RC Waiver Transitions Eligible for Case Management Expansion	68.75%	68.75%	68.75%	Historic fraction of RC waiver transition clients who would have been eligible for expanded Intensive Case Management.(1)
I	**Expected Transitions From Regional Center Waiver Eligible for Expanded Intensive Case Management**	**9**	**12**	**12**	Row G * Row H, Adjusted for October 1, 2017 start date.
J	**Expected Total Transitions Qualifying for Expanded Intensive Case Management**	**31**	**42**	**44**	**Row F + Row I**

(1) Examples of transitions that would not qualify for case management include transitions to the client's family home, skilled nursing facilities, mental health institutes, jail, or transitions from RC waiver to an ICF.

Table 2.3 - Cost Per-Client of Expanding Case Management Services to Transitioning Clients					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes**
A	Average ICM Units Utilized Per-Year by Colorado Choice Transitions (CCT) Clients Transitioning to HCBS-DD Waiver	404	404	404	Actuals
B	Average ICM Units Utilized Per-Month by CCT Clients Transitioning to HCBS-DD Waiver	33.67	33.67	33.67	Row A / 12
C	Cost Per-Unit	$21.10	$21.10	$21.10	FY 2015-16 rate
D	Average Cost Per-Client Per-Month	$710.44	$710.44	$710.44	Row B * Row C
E	Expected Average Months of Expanded Intensive Case Management Utilization Per-Client	9	12	12	Average ICM utilization length for CCT clients transitioning to the HCBS-DD waiver. Adjusted for October 1, 2017 Start Date
F	**Average Expanded Intensive Case Management Cost Per-Client Per Year**	**$6,393.96**	**$8,525.28**	**$8,525.28**	**Row D * Row E**

Table 2.4 - Cost Avoidance Per-Client for Clients Substituting Expanded Case Management for Targeted Case Management (TCM)					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes**
A	TCM Units Used by Regional Center (RC) Waiver Clients Per-Year	161	161	161	Historic utilization per-year for RC waiver clients.
B	TCM Units Used by RC Waiver Clients Per-Month	13.42	13.42	13.42	Row A / 12
C	TCM Cost Per-Unit	$15.87	$15.87	$15.87	TCM rate in FY 2015-16
D	**Expected TCM Cost Avoidance Per-Month Per-Client**	**($212.98)**	**($212.98)**	**($212.98)**	**Row B * Row C**

Table 2.5 - Estimated Cost Avoidance from Substituting Expanded Intensive Case Management for Targeted Case Management (TCM) During Regional Center Waiver Client					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes**
A	Average TCM Cost Avoidance Per-Client Per-Month	($212.98)	($212.98)	($212.98)	Table 2.4 Row D
B	Expected Average Months of Expanded Intensive Case Management Utilization	9	12	12	Table 2.3 Row E
C	Estimated Cost Avoidance Per-Client for Clients Transitioning from Regional Center (RC) Waiver	($1,916.82)	($2,555.76)	($2,555.76)	Row A * Row B
D	Estimated Number of RC Waiver Clients Transitioning to the Community	9	12	12	Table 2.2 Row I
E	**TCM Cost Avoidance From Clients Transitioning from RC Waiver Substituting Expanded Intensive Case Management for TCM**	**($17,251)**	**($30,669)**	**($30,669)**	**Row C * Row D**
F	Expected Average Months of Intermediate Care Facility (ICF) Transition Where Client is Receiving ICF Services	3	3	3	Department estimate based on previous transitions. See narrative for further detail.
G	Expected Average Months of ICF Transition Where Client is Receiving Waiver Services	6	9	9	Row B - Row F
H	Estimated Cost Avoidance/Client for Clients Transitioning from an ICF	($1,277.88)	($1,916.82)	($1,916.82)	Row A * Row G
I	Estimated Number of ICF Clients Transitioning to the Community	22	30	32	Table 2.2 Row F
J	**TCM Cost Avoidance from Clients Transitioning from ICF Substituting Expanded Intensive Case Management for TCM**	**($28,113)**	**($57,505)**	**($61,338)**	**Row H * Row I**
K	**Total TCM Cost Avoidance**	**($45,364)**	**($88,174)**	**($92,007)**	**Row E + Row J**

Table 3.1 FTE Costs						
Expenditure Detail			FY 2017-18 (Request Year)		FY 2018-19 (Out-year)	
Personal Services:						
Classification Title	Monthly	FTE		FTE		
Administrator IV	$5,585	0.92	$61,437	1.0	$67,020	
PERA			$6,236		$6,803	
AED			$3,072		$3,351	
SAED			$3,072		$3,351	
Medicare			$891		$972	
STD			$117		$127	
Health-Life-Dental			$7,927		$7,927	
Subtotal Position 1, 1.0 FTE		**0.9**	**$82,752**	**1.0**	**$89,551**	
Classification Title	Monthly	FTE		FTE		
Administrator IV	$5,585	0.92	$61,437	1.0	$67,020	
PERA			$6,236		$6,803	
AED			$3,072		$3,351	
SAED			$3,072		$3,351	
Medicare			$891		$972	
STD			$117		$127	
Health-Life-Dental			$7,927		$7,927	
Subtotal Position 2, 1.0 FTE		**0.9**	**$82,752**	**1.0**	**$89,551**	
Subtotal Personal Services		1.8	**$165,504**	2.0	**$179,102**	
Operating Expenses:						
		FTE		FTE		
Regular FTE Operating	$500	1.8	$917	2.0	$1,000	
Telephone Expenses	$450	1.8	$825	2.0	$900	
PC, One-Time	$1,230	2.0	$2,460			
Office Furniture, One-Time	$3,473	2.0	$6,946			
Other						
Other						
Other						
Other						
Subtotal Operating Expenses			**$11,148**		**$1,900**	
TOTAL REQUEST		1.8	**$176,652**	2.0	**$181,002**	
	General Fund:		*$88,326*		*$90,501*	
	Cash funds:					
	Reappropriated Funds:					
	Federal Funds:		*$88,326*		*$90,501*	

Table 4.1 FY 2017-18 Cost to Update Vital and InterChange Systems to Allow for Case Management Expansion					
Row	**Item**	**Hours**	**Hourly Rate**	**Total Cost**	**Notes**
A	Project Manager	250	$150.29	$37,573	Based on Hewlett Packard Estimate
B	Business Analyst	250	$124.76	$31,190	Based on Hewlett Packard Estimate
C	Customization	2,850	$135.34	$385,719	Based on Hewlett Packard Estimate
D	Technical Writer	40	$76.90	$3,076	Based on Hewlett Packard Estimate
E	Testing and Validation	1,402	$96.82	$135,742	Based on Hewlett Packard Estimate
F	Total	4,792		$593,300	Sum of Row A through E

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-11 Vendor Transitions

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	Total	$6,853,876,662	$0	$6,788,779,370	$2,598,458	$0
	FTE	400.3	0.0	400.6	0.0	0.0
	GF	$1,955,207,891	$0	$1,957,977,876	$929,629	$0
	CF	$709,039,078	$0	$682,114,901	$369,600	$0
	RF	$6,805,694	$0	$6,806,592	$0	$0
	FF	$4,182,823,999	$0	$4,141,880,001	$1,299,229	$0

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (A) General Administration - Personal Services	Total	$29,707,221	$0	$29,750,823	$26,448	$0
	FTE	400.3	0.0	400.6	0.0	0.0
	GF	$10,211,448	$0	$10,339,935	$13,224	$0
	CF	$2,994,337	$0	$2,946,007	$0	$0
	RF	$1,564,801	$0	$1,565,699	$0	$0
	FF	$14,936,635	$0	$14,899,182	$13,224	$0
01. Executive Director's Office, (D) Eligibility Determinations and Client Services - Customer Outreach	Total	$5,904,846	$0	$6,135,435	$472,010	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,556,675	$0	$2,637,660	$236,005	$0
	CF	$336,621	$0	$336,621	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,011,550	$0	$3,161,154	$236,005	$0

	Total	**$6,818,264,595**	**$0**	**$6,752,893,112**	**$2,100,000**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	GF	$1,942,439,768	$0	$1,945,000,281	$680,400	$0
	CF	$705,708,120	$0	$678,832,273	$369,600	$0
	RF	$5,240,893	$0	$5,240,893	$0	$0
	FF	$4,164,875,814	$0	$4,123,819,665	$1,050,000	$0

CF Letternote Text Revision Required?	Yes X	No ____	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes ____	No X	
FF Letternote Text Revision Required?	Yes ____	No X	
Requires Legislation?	Yes ____	No X	
Type of Request?	Department of Health Care Policy and Financing Prioritized Request		
Interagency Approval or Related Schedule 13s: None			

Cost and FTE

- The Department requests $2,598,458 total funds, including $929,629 General Fund, $369,600 cash funds, and $1,299,229 federal funds in FY 2017-18 for vendor transition costs due to the required reprocurement of contractor-delivered services, including contracts for the Accountable Care Collaborative, the enrollment broker, and the Medicaid managed care ombudsman services.

Current Program

- The Accountable Care Collaborative (ACC) Program promotes improved health for members by delivering care in an increasing seamless way. It is easier for members and providers to navigate and makes smarter use of every dollar spent. The program has demonstrated a net return on investment while simultaneously improving health outcomes. Seven Regional Care Collaborative Organizations (RCCOs) provide management of primary care medical providers for Medicaid.
- Five regional Behavioral Health Organizations (BHOs) are managed care entities that provide comprehensive behavioral health services to Medicaid members in Colorado.
- The enrollment broker, an independent facilitator, conducts a variety of activities to assist eligible Medicaid clients choose available health plan options and providers, as well as providing notices required by the Centers for Medicare and Medicaid Services (CMS).
- The Medicaid managed care Ombudsman provides advocacy and assistance to members who are experiencing difficulty with their health plans.

Problem or Opportunity

- The Department lacks sufficient resources to carry out key functions to successfully transition services to new vendors due to the reprocurement of the ACC providers, the enrollment broker, and the Medicaid managed care ombudsman contracts. Services could be seriously delayed or disrupted without significant coordinated efforts to transition administrative duties from one vendor to another.

Consequences of the Problem

- If this request is not approved, members may experience delayed or absent services, longer processing periods, or be forced to resubmit data, leading to poorer outcomes and higher costs. In some cases, it may violate federal law (e.g. 42 CFR § 438.206) if covered services are not available and accessible to enrollees.

Proposed Solution

- The Department requests one-time funding to allow for transitional overlap between vendors to avoid negative impacts on enrollment and service delivery for Medicaid enrollees. The Department will return the funding if it is determined that is not needed for the transition.
- Vendors would be required to submit a transition plan as part of the competitive bidding process.
- The incoming vendors would be able to transition into the contractual obligations with assistance from the outgoing vendors, with minimal or no impact on members and service delivery.

Department Priority: ***R-11***
Request Detail: ***Vendor Transitions***

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Vendor Transitions	$2,598,458	$929,629

Problem or Opportunity:

The Department does not have sufficient resources to successfully transition vendor services resulting from the reprocurement of the contracts for the Accountable Care Collaborative (ACC), the enrollment broker, and the Medicaid managed care ombudsman programs to assure that the vendor transition does not negatively affect enrollment and service delivery for Medicaid members. It has been the Department's recent experience that failing to provide a transition period has resulted in disruption of services and additional expenses incurred by the State. One example of a transition that did not include transition funding was the Department's non-emergent medical transportation broker in January 2013. As a result, individuals enrolled in Medicaid were unable to arrange for transportation, creating a barrier to access health care services. A seamless transition between vendors is critical to ensure services to Medicaid members are not affected. As such, the Department anticipates transition funding is needed to ensure service delivery is not impacted.

Accountable Care Collaborative Phase II

In 2009, the General Assembly approved a budget action authorizing the Medicaid Value-Based Care Coordination Initiative, now known as the Accountable Care Collaborative (ACC) Program. Contracts for the Regional Care Collaborative Organizations (RCCOs), which are central to the ongoing operations of the program, are set to expire June 30, 2018. The Department is committed to creating a high-performing health care delivery system that is cost-effective, delivers quality services, and improves member health; the current bifurcated system of care results in lack of responsibility for whole person care.

The new procurement of the ACC vendor contracts presents an important opportunity to make significant improvements in the Medicaid delivery system by increasing accountability for whole-person care. The Department will implement an integrated approach to the management of both physical and behavioral health services. In the ACC Phase II, the Department will no longer have separate systems responsible for physical health and behavioral health. As of July 1, 2018, one entity in each of seven regions, the Regional Accountability Entity (RAE), will be responsible for duties currently performed by the RCCOs and BHOs in their region. This major system change is a complex undertaking which will require the RAE to provide administrative oversight of the delivery of physical health services, pay for and deliver behavioral health

services under a capitated payment, and ensure coordination of whole-person care for members. The RAE contract will shape the future of the Medicaid delivery system in Colorado; therefore, a successful reprocurement incorporating program elements that improve member experience and drive future quality outcomes and cost efficiencies in the Medicaid program is critically important. However, the Department lacks sufficient resources to carry out key functions that would ensure a successful procurement process that moves the ACC program forward. Specifically, the Department has identified that additional resources are needed to support the vendor transition. Member services are at risk of being seriously delayed or disrupted without significant coordinated efforts to transition administrative duties from one vendor system to the other. An overlap in contract periods between the RCCO/BHO vendors and the RAE vendors will afford the new vendors the opportunity to establish, test, and implement essential administrative functions to support the new system of care while the current vendors provide a critical safety net of services to assure that no gap or disruption in services to members is experienced. Without additional support through the vendor transition process, progress already achieved under the ACC and BHO program could be jeopardized, both in terms of cost efficiencies and member outcomes.

Enrollment Broker Contract

The enrollment broker is an independent facilitator that serves as a link between the managed care delivery system and Medicaid enrollees. Enrollment broker services include member outreach and education; developing, translating, producing and sending informational and enrollment materials; processing member enrollments and disenrollments; operating a customer contact center; maintaining systems and system interfaces; and reporting on activities. The contract reprocurement would occur in FY 2016-17, with a new contract becoming effective January 1, 2018 and operations beginning March 1, 2018.

Much of the enrollment broker's work is dependent upon the new Medicaid Management Information System (MMIS), which would include extracting information on a regular basis to build lists of eligible Medicaid enrollees and maintaining a database. The new contractor would need time to build, implement, and test an interface that would communicate with the Department's MMIS before beginning operations. The new MMIS would provide access to a larger quantity of data and analytics; streamline processes to make the Department more efficient; and reduce the potential for fraud, waste, and abuse. Therefore, establishing the interface with the new system is a vital step in the transition and is anticipated to benefit the work done by the enrollment broker to a much greater degree than the current system.

Medicaid Managed Care Ombudsman

The Ombudsman for Medicaid managed care assists BHO and RCCO members with a grievance, appeal or other issue related to their mental and medical health care. The Ombudsman is independent from all of the health care plans. When a person has a problem or concern, the Ombudsman works with both the person and the provider to find a solution that works for everyone; responds to and resolves complaints; and makes referrals to other agencies, such as state health insurance programs, assistant programs, and programs providing legal aid. The contract would be reprocured during FY 2016-17, with a new contract effective July 1, 2017 and operations beginning September 1, 2017. It is important for the current vendor to complete the work they started with current issues where possible, while the new vendor trains and takes on new cases to effectively transition the responsibilities of the Ombudsman. However, there are not sufficient funds within

the current appropriation for a two-month overlap of contracts of the incumbent and new vendor to facilitate a smooth transition.

Poor handling of vendor transitions could have severe consequences, such as major disruptions for members and providers. Without sufficient transition funding, the Department cannot assure a seamless transition between vendors, which is critical to ensure services to Medicaid members are not negatively affected. As such, the Department anticipates transition funding is needed to ensure service delivery is not impacted.

Proposed Solution:

The Department requests one-time funding for $2,598,458 total funds, comprised of $929,629 General Fund, $369,600 cash funds, and $1,299,229 federal funds in FY 2017-18 for costs associated with the vendor transitions due to contract reprocurement of the ACC, enrollment broker, and Medicaid managed care ombudsman program.

As a best practice to maintain a seamless transition for Medicaid members, the Department would need to overlap contract periods, as the outgoing vendor closes out its work and the incoming vendor ramps up. The overlap in vendor contracts would aid the current and incoming vendors in completing key transition functions before the new vendor begins service provision, so that members do not experience disruptions in care. Transition planning would be a factor in the Request for Proposals (RFPs) for new vendors and would be included in the contracts as applicable. The Department experienced recent success with similar transition funding awarded for the transition of the northeast BHO region. Funding was provided for the BHO transition tasks related to customer service and outreach. The Department did not experience any significant issues related to the BHO transition and attributes much of the success to the proactive approach taken with the approved funding.

If the request is not approved, delays and disruptions in services could lead to poorer and unacceptable outcomes for members and higher costs for the State. Specifically, the vendors may not have the financial capacity to complete key tasks associated with the transition process prior to the handoff of responsibility for service provision. A seamless transition of the programs between vendors would be improbable should the Department not be able to provide for an overlapping transition period due to lack of funding.

Accountable Care Collaborative Phase II

The vendor transition functions that will occur during the transition period include knowledge transfer between vendors; establishing infrastructure for data collection and exchanges, billing and reimbursement; testing of system compatibility; demonstration of adherence to security protocols; hiring and training new staff; development and distribution of materials; member and provider notifications and education; and setup of provider agreements and networks.

All prospective vendors will be required to submit a transition plan in their proposal addressing their specific need. The vendor proposals will include their estimated administrative costs related to the transition activities they anticipate performing. The new vendor will be responsible for leading, coordinating, and implementing the transition plan, with assistance from the Department. The goal is for the new vendor to demonstrate to

the Department, prior to handover of service provision, that operations are ready to begin and services can be rendered.

Enrollment Broker

While the new vendor prepares for operations between January 1, 2018 and February 28, 2018, the outgoing vendor would continue providing outreach and education; developing, translating, producing and sending informational and enrollment materials; processing member enrollments and disenrollments; operating a customer contact center; maintaining systems and system interfaces; and reporting on activities. The new vendor would receive transfer information from the current vendor; develop, implement, and test the infrastructure for data collection and exchanges with the MMIS; test system compatibilities against the MMIS for encounter submissions and enrollment and disenrollment capabilities; test system capabilities with e-mail, instant messaging, and texting platforms; coordinate systems for billing and reimbursement purposes; set up facilities and a customer contact center; hire and train new staff; create a business continuity plan; create a communications plan; demonstrate adherence to security protocols and HIPAA compliance; develop policies and procedures for all systems and functions necessary to administer the contract effectively and that align with state requirements; and, develop, design and produce member materials. Allowing for the completion of these activities prior to service provision is critical before the incoming vendor begins full operations approximately March 1, 2018.

Medicaid Managed Care Ombudsman

The Department anticipates the transition between the new vendor and the outgoing vendor to be complete between July 1, 2017 and August 31, 2017. The process would be gradual with the new vendor taking on more of the workload in a systematic progression. There would be a great amount of knowledge transfer during this period as the incumbent vendor transitions functions of the Ombudsman to the new vendor. The outgoing vendor would complete work current issues while the new vendor trains and takes on the new cases. The new vendor would begin full operations September 1, 2017.

Anticipated Outcomes:

The request is in line with the Department's mission of improving health care access and outcomes for the people served by the Department while demonstrating sound stewardship of financial resources. By mitigating disruptions in services between outgoing and incoming vendors, the Department is ensuring those who are eligible for Medicaid have access to needed services, which ultimately leads to better health outcomes and reduced medical costs.

The Department's intent is to ensure the readiness of the new vendors to assume responsibilities of the three programs included in the request through a coordinated vendor transition period. If the request were funded, the incoming vendors would be able to transition into their contractual obligations with assistance from the Department and in cooperation and collaboration with the outgoing vendor. This would allow for optimal health care and outcomes for the members to be maintained during the transition period. Providing resources for early preparation, adequate education and training, and proper testing of new systems while the current vendors are continuing services would mitigate potential problems during the transition.

Diminishing interruptions between outgoing BHO and RCCO vendors and the incoming RAE vendors will minimize the delays and disruption in services that Medicaid members may experience, leading to greater health outcomes.

Assumptions and Calculations:

Detailed calculations for this request are included in the attached addendum. The total incremental request of $2,598,458 is shown on table 1.1.

The Department assumes that funding is needed to facilitate an effective and efficient transition between vendors resulting from the reprocurement of contracts for the ACC Phase II, enrollment broker, and Medicaid managed care ombudsman contracts. The funding is critical to assure that new vendors are able to be fully operational when handoff and acceptance of the program occurs. The Department will return any funding that is not needed for the transition due to the reprocurement of these contracts. A summary of the incremental request by line item is found on table 1.1 and by component on tables 2.1, 2.2 and 2.3.

Accountable Care Collaborative Phase II Transition

The incremental request of $2,100,000 ($680,400 General Fund) for this component is shown on table 2.3. The Department assumes that the new RAE vendors will need a five-month transition period because of the complexity of the transition from the current bifurcated physical and behavioral health care system with the BHOs and RCCOs to an integrated system under the new RAEs. The Department has determined that there will be seven regions and one RAE per region under the ACC Phase II integration. The Department has estimated that an average of $300,000 per RAE may be needed in FY 2017-18 to effectively transition to the new RAE system (see table 3). In FY 2013-14, the Department was awarded $200,000 per BHO for transition tasks, which proved instrumental to the success of setting up necessary infrastructure in order to become a fully functioning BHO by the contract start-up date. The Department is anticipating that transition functions will be much more complex with the integration of the RCCO and BHO contracts into one RAE contract per region. Therefore, the Department is estimating that the $300,000 per region proposed in this request would adequately support this complex transition. The vendors will be required, as part of the request for proposals process, to identify the resources they need to adequately assume service delivery responsibilities. The percentage of the Hospital Provider Fee Cash Funds attributed to this request is based on the Department's FY 2017-18 caseload projections.

Enrollment Broker Transition

The incremental request of $472,010 ($236,005 General Fund) for this component is shown on table 2.2. The Department assumes that the new enrollment broker vendor would need a two-month period to complete startup activities needed for a smooth transition. Using the FY 2016-17 contract expenditure estimates for base operating functions, the Department has determined in table 4, the average monthly cost and multiplied this amount by two months to estimate the costs of maintaining the current vendor an additional two months until handover and acceptance of the program by the new vendor at the end of the transition period could be achieved. The vendors will be required, as part of the request for proposals process, to identify the resources they need to adequately assume service delivery responsibilities.

Medicaid Managed Care Ombudsman Transition

The incremental request of $26,448 ($13,224 General Fund) for this component, shown on table 2.1. The Department assumes that the new Medicaid managed care ombudsman vendor would need a two-month transition period. The Department proposes to extend the current vendors' contract an additional two months so that the current vendor could continue service provision during this transition period. In table 5, the Department has determined the average monthly cost by using FY 2016-17 projected monthly expenditures multiplied by two months to determine the total cost of maintaining the current vendor an additional two months in FY 2017-18 until the new vendor is prepared to fully assume responsibilities of the program.

Table 1.1
FY 2017-18 Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funding	Federal Funds	Source
(1) Executive Director's Office; (A) General Administration; Personal Services									
A	FY 2017-18 Base Request	$29,750,823	400.6	$10,339,935	$0	$2,946,007	$1,565,699	$14,899,182	Nov. 1, 2016 Base Request
B	FY 2017-18 Estimated Expenditures	$29,777,271	0.0	$10,353,159	$0	$2,946,007	$1,565,699	$14,912,406	Row A + Table 2.1 Row A
C	**Incremental Change**	**$26,448**	**400.6**	**$13,224**	**$0**	**$0**	**$0**	**$13,224**	**Row B - Row A**
(1) Executive Director's Office; (D) Eligibility Determination and Client Services; Customer Outreach									
D	FY 2017-18 Base Request	$6,135,435	0.0	$2,637,660	$0	$336,621	$0	$3,161,154	Nov. 1, 2016 Base Request
E	Projected FY 2017-18 Expenditures	$6,607,445	0.0	$2,873,665	$0	$336,621	$0	$3,397,159	Row A + Table 2.2 Row A
F	**Incremental Change**	**$472,010**	**0.0**	**$236,005**	**$0**	**$0**	**$0**	**$236,005**	**Row E - Row D**
(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals									
G	FY 2017-18 Base Request	$6,752,893,112	0.0	$1,945,000,281	$0	$678,832,273	$5,240,893	$4,123,819,665	Nov. 1, 2016 Base Request
H	Projected FY 2017-18 Expenditures	$6,754,993,112	0.0	$1,945,680,681	$0	$679,201,873	$5,240,893	$4,124,869,665	Row A + Table 2.3 Row A
I	**Incremental Change**	**$2,100,000**	**0.0**	**$680,400**	**$0**	**$369,600**	**$0**	**$1,050,000**	**Row H - Row G**
J	**Total Incremental Request**	**$2,598,458**	**400.6**	**$929,629**	**$0**	**$369,600**	**$0**	**$1,299,229**	**Row C + Row F + Row I**

Table 1.2
FY 2017-18 Cash Funds Summary of Request

				FY 2017-18		
Row	**Line Item**	**Cash Fund**	**FTE**	**Spending Authority**	**Total Estimated Funding Need**	**Incremental Request**
A	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	Hospital Provider Fee Cash Fund	0.0	$0	$369,600	$369,600
B	**Total Cash Funds**		**0.0**	**$0**	**$369,600**	**$369,600**

Table 2.1 Summary by Component and Fund Split
FY 2017-18 Ombudsman Vendor Transition

Row	Description	Total Funds	FTE	General Fund	Cash Fund	Federal Funds	FFP	Source
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$26,448	0.0	$13,224	$0	$13,224	50.00%	Table 5 Row D

Table 2.2 Summary by Component and Fund Split
FY 2017-18 Enrollment Broker Vendor Transition

Row	Description	Total Funds	FTE	General Fund	Cash Fund	Federal Funds	FFP	Source
A	(1) Executive Director's Office; (D) Eligibility Determination and Client Services; Customer Outreach	$472,010	0.0	$236,005	$0	$236,005	50.00%	Table 4 Row D

Table 2.3 Summary by Component and Fund Split
FY 2017-18 ACC Phase II Vendor Transition

Row	Description	Total Funds	FTE	General Fund	Hospital Provider Fee Cash Fund(1)	Federal Funds	FFP	Source
A	(2) Medical Services Premiums	$2,100,000	0.0	$680,400	$369,600	$1,050,000	50.00%	Table 3 Row C

(1) The amount of Hospital Provider Fee Cash Funds is determined based on the R-1 caseload percentage share of HPF populations.

Table 3 Accountable Care Collaborative Phase II Vendor Transition Cost			
Row	**Item**	**Amount**	**Source/Calculation**
A	Number of RAE	7	The Department will contract with one RAE per each of the seven Regions under the ACC Phase 2.0.
B	Average Estimated Cost Per RAE	$300,000	Department Estimate
C	**Total Estimated Transition Cost**	**$2,100,000**	**Row A * Row B**

Table 4 Enrollment Broker Vendor Transition Cost			
Row	**Description**	**Amount**	**Source/Calculation**
A	Estimated Annual Base Operating Costs	$2,832,060	Based on FY 2016-17 Base Operating Expenses
B	Average Monthly Cost	$236,005	Row A / 12
C	Number of Transition Months	2	Department Estimate
D	**Total Estimated Transition Cost**	**$472,010**	**Row B * Row C**

Table 5 Ombudsman Vendor Transition Cost			
Row	**Item**	**Amount**	**Source/Calculation**
A	FY 2016-17 Ombudsman Base Costs	$158,688	FY 2016-17 Estimated Costs
B	Average Monthly Cost	$13,224	Row A / 12
C	Number of Transition Months	2	Department Estimate
D	**Total Estimated Transition Cost**	**$26,448**	**Row B * Row C**

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-12 LPHA Partnerships

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$0**	**$0**	**$0**	**$711,000**	**$711,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$355,500	$355,500
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$355,500	$355,500

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
	Total	**$0**	**$0**	**$0**	**$711,000**	**$711,000**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (B) Transfers to/from Other Departments - Local Public Health Agencies, Transfer to CDPHE	GF	$0	$0	$0	$355,500	$355,500
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$355,500	$355,500

CF Letternote Text Revision Required?	Yes ___	No X	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes ___	No X	
FF Letternote Text Revision Required?	Yes ___	No X	
Requires Legislation?	Yes ___	No X	

Type of Request? Department of Health Care Policy and Financing Prioritized Request

Interagency Approval or Related Schedule 13s: Department of Public Health and Environment

Cost and FTE

- The department requests $1,066,500 total funds, including $0 General Fund in FY 2017-18 and future years in order to fund the Local Public Health Agency (LPHA) & Regional Care Collaborative Organization (RCCO) partnership initiative. These partnerships intend to bridge the gap between medical and public health systems.
- This request would increase funding available for LPHAs by $355,500 through an increase in federal funds by repurposing existing General Fund appropriations.

Current Program

- LPHAs are responsible for a multitude of public health activities. Those that are related to population-based health efforts that intersect with the RCCOs' work include: disease prevention, investigation, and control; maternal and child health prevention and education; injury prevention and education; and clinical services.
- RCCOs are responsible for the care coordination of Medicaid members enrolled in the Accountable Care Collaborative (ACC), including connecting members to non-medical needs.
- Currently LPHA-RCCO collaborations form on a voluntary and underfunded basis. There is a fair amount of fragmented and duplicative work being done to identify members in need of different direct health and population-based health services, and to coordinate services for members.

Problem or Opportunity

- RCCOs and LPHAs have indicated they want to work more collaboratively with each other to address health outcomes of the common Medicaid population they serve through their respective programs.
- The state dollars that the LPHAs currently spend on services provided to Medicaid-eligible Coloradans qualify for a federal match. These existing state dollars would need to be appropriated to the Department to earn the match, as it is the single state agency administering Medicaid.
- Introducing a financial incentive through offering new federally matched funds could help encourage more LPHA-RCCO partnerships, reducing fragmentation and duplication of efforts and sparking innovation in creating population-based health programs that would specifically target Medicaid members.

Consequences of the Problem

- The State is not maximizing the amount of money that is eligible for a federal match for these programs. Some of these programs are at risk of being cut back or ending due to expiring grant funding.
- Without additional funding, these organizations would continue to operate largely in isolation without the capability to share data systems and resources to coordinate and build upon their respective public health outreach efforts, ensuring duplicative and fragmented work would continue to occur.

Proposed Solution

- The Department requests a transfer of $355,500 General Fund in FY 2017-18 and future years to draw down an additional $355,500 in federal funds. These funds would be reappropriated to the Department of Public Health and Environment (CDPHE) as reappropriated funds. CDPHE would lower its General Fund request by $355,500 so that no new State dollars are allocated to LPHAs.
- In FY 2017-18, this federally enhanced funding would be used to hire community health workers to help Medicaid members navigate between the medical and public health systems, and to provide LPHAs with access to their RCCOs' data systems.

Department Priority: R-12
Request Detail: Local Public Health Agency Partnerships

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Local Public Health Agency Partnerships	$1,066,500	$0

Problem or Opportunity:

This request seeks to reduce the fragmentation between medical and public health systems by joining the population-based health[1] work performed by the Local Public Health Agencies (LPHAs)[2] and Regional Care Collaborative Organizations (RCCOs) through a common funding mechanism. RCCOs and LPHAs have indicated they want to work more collaboratively with each other to address health outcomes of the common Medicaid population they are serving through their respective programs. The departments have identified four collaboration partnerships that seek to reduce the fragmentation between the two health systems through sharing data systems and using community health workers to help members understand and navigate between different services. The departments have a chance to fund these collaboration efforts, without requesting additional state funds, through using the existing state dollars the LPHAs spend on Medicaid members to draw down a federal match. Not using this available financing mechanism would mean the four partnerships would have insufficient resources to implement innovative coordination efforts between the medical and public health systems. If this request is not approved, the State would miss an opportunity for receiving additional federal funding for Medicaid members who benefit significantly from the work done by local public health programs.

The Department views these partnerships as an opportunity to integrate LPHAs into the framework of the Accountable Care Collaborative (ACC). The Accountable Care Collaborative (ACC) program promotes improved health for members by delivering care in an increasingly seamless way. It is easier for members

[1] Population-based health concentrates on integrating health systems and emphasizes health promotion, disease prevention, and interventions that focus on upstream factors, and underlying causes of poor health behaviors, such as physical inactivity, behavioral risk factors, and lack of preventative care and poor nutrition. Results of population-based health efforts are measured by a population or group's health outcomes. <https://www.academyhealth.org/files/AH2013pophealth.pdf>

[2] LPHAs are responsible for a multitude of public health activities. Those that are related to population-based health efforts include: disease prevention, investigation, and control; maternal and child health prevention and education; injury prevention and education; and clinical services. Examples of LPHA programs include: teen pregnancy assistance and teen pregnancy prevention; women, infant, and children (WIC) programs; nurse family partnerships; and diabetes assistance and prevention.

and providers to navigate and it makes smarter use of every dollar spent. The ACC is made up of seven Regional Care Collaborative Organizations (RCCOs)[3], which are responsible for connecting members to Medicaid providers and helping members find community and social services in their area, many of them administered through the public health system through the LPHAs. By formalizing partnerships between RCCOs and LPHAs focusing on population health and community outreach, the Department could improve access to various public health programs, such as diabetes management or teen pregnancy prevention, which would have a long term impact on member health care outcomes. The departments, LPHAs and RCCOs have been working together for the last two years to identify and improve areas of collaboration between LPHAs and RCCOs. The options for collaboration fall into three categories:

- Disease prevention, education, and referrals;
- Data and information sharing; and
- Prevention and population health promotion.

The departments identified four separate collaborations that could be funded through Medicaid dollars, and have based this request on those programs. The current collaborations include work by the Mesa County Health Department, the San Juan Basin Health Department (SJBH), Northwest Colorado Health, and Boulder County Public Health (BCPH). Mesa County, SJBH, and Northwest would work with RCCO 1, Rocky Mountain Health Plans (RMHP), and BCPH would work with RCCO 6, Colorado Community Health Alliance (CCHA). Using the additional funds, these collaborations would set up data sharing systems to properly identify members in need of services and contract with community health workers to coordinate members' care within the two organizational structures. LPHAs do not currently have the capacity or resources to gain access to the RCCOs' data systems, nor to devote to these care coordination efforts.

The ability to provide financial support would help encourage meaningful and effective LPHA-RCCO partnerships, allow the two entities to formally align health goals and metrics, and spark innovation in creating population-based health programs that would specifically target Medicaid members. Medicaid members oftentimes have few resources to acquire meaningful health education, potentially resulting in poor health outcomes. LPHAs and RCCOs would have the ability to combine their knowledge and resources to address the health of Medicaid members from both a direct health perspective and a population-based health one.

For example, two efforts that combine direct health and population-based health are the GENESIS and GENESISTERS programs[4] run by Boulder County Public Health (BCPH) in the RCCO 6 region. In the partnership proposed for these programs, the RCCO would be involved in coordinating care within the medical neighborhood, including connecting the member with a primary care physician, an obstetrician, and other providers who would be able to assist the member with the medical needs of her pregnancy. The LPHA

[3] Beginning July 1, 2018, the Department will transition RCCOs to "Regional Accountable Entities" (RAEs). See the Department's November 1, 2016 budget request R-6 "Delivery System and Payment Reform" for more information about the Department's Accountable Care Collaborative Phase II initiative. Although this request uses terminology from the existing ACC program, the Department would fully integrate the proposed programs in this request with the ACC Phase II program redesign.

[4] GENESIS aims to provide pregnant teens with community assistance, and GENESISTER targets pregnancy prevention efforts towards the sisters of pregnant teens. Boulder County has more information on these programs on its website: http://www.bouldercounty.org/family/pregnancy/pages/genesisservices.aspx.

program GENESIS would then be involved in coordinating resources to make sure the member succeeds in the non-medical aspects of her life that are just as influential in determining her health outcomes. Examples of services offered by the Boulder GENESIS program include:

- Providing transportation to medical appointments,
- Assisting with re-entry into school or GED programs,
- Linking the mother to job training programs,
- Providing access to healthy and affordable food, and
- Offering counseling and support.

BCPH would use the requested funding to support sharing member information with RCCO 6, as well as making sure the members are enrolled in RCCO 6 and know how to access RCCO and county services. The ability to cross-refer members to these medical and non-medical services in a coordinated manner demonstrates a more person-centered approach to health care that is in line with the mission of the ACC.

The LPHA-RCCO collaboration partnerships also mean more steady streams of funding for LPHA programs. Programs such as GENESIS and GENESISTERS are at risk of ending or being cut back due to insufficient or expiring grant funding. GENESIS and GENESISTERS recently had a Robert Wood Johnson Foundation yearly grant of $125,000 expire, an amount that accounted for roughly half of the programs' yearly budget. Under the LPHA-RCCO collaboration initiative, these programs would be effectively incorporated into the ACC with the blended state and federal funding.

Proposed Solution:

The Department requests $711,000 total funds, including a budget neutral transfer of $355,500 General Fund in FY 2017-18 and future years from the Department of Public Health and Environment in order to fund LPHA-RCCO collaborations. This request also includes a corresponding reduction to the Department of Public Health and Environment's (CDPHE) General Fund request by $355,500 and an increase in reappropriated funds of $711,000 in each year. The requested General Fund would be used to draw down a federal match, and then the full amount would be reappropriated to CDPHE. CDPHE would be tasked with disbursing this money to the LPHAs that are a part of the collaboration initiatives, as part of its ongoing administration of its programs. Finally, to ensure that CDPHE can continue to provide the full amount of state funding to the LPHAs regardless of how much federal funding is received, the Department requests that the General Assembly appropriate the funding without an "M" headnote restriction.

Going forward, the funding for the LPHA-RCCO program would vary by year, depending on which programs request funding. If additional programs are identified in the future, the departments would use the regular budget process to request adjustments to spending authority. Each individual program would be required to have a LPHA-RCCO collaborative component and the LPHA and RCCO must sign a memorandum of understanding (MOU) agreeing to that collaboration. Although it would be possible to pass the federally matched funding back to the LPHAs without a collaboration requirement, the departments believe these funds should be leveraged to encourage stronger partnerships and coordination efforts between LPHAs and RCCOs, particularly as it has been established as a goal by both entities.

The consequences of not funding this request are that the State would not maximize the amount of money that is eligible for a federal match and RCCOs and LPHAs care coordination efforts might continue to operate in underfunded silos. There are many programs and efforts run by the LPHAs that intersect with the work of the RCCOs and are eligible for a federal match, but are currently funded solely with state funds. The LPHAs identified in this initial solicitation currently do not have the capacity to fully help Medicaid members navigate between the medical and public health systems, nor do they have the resources to access their RCCOs' data systems. Without these resources, the LPHAs are less able to effectively coordinate care, potentially leading to poorer health outcomes for Medicaid members who oftentimes lack the knowledge and resources to go through the medical and public health systems on their own.

Differences from FY 2015-16 R-11 "Public Health and Medicaid Alignment" Request

As part of the FY 2015-16 budget cycle, the Department requested funding under R-11 "Public Health and Medicaid Alignment" to coordinate and encourage LPHA-RCCO collaborations. The Joint Budget Committee did not approve the request. During Figure Setting, the committee's staff based its recommendation to deny the request in part because it did not understand why these collaborations could not be accomplished within existing resources. The current request is different in two ways:

First, there is no requested increase in State funds. The departments would use General Fund that is already appropriated to CDPHE and used by the LPHAs on Medicaid members to draw down a federal match. Total funds would increase by the corresponding amount of federal funds earned through the federal financial participation, and the inclusion of reappropriated funds in CDHPE's appropriations.

Second, the funding would be used on LPHA-RCCO partnership programs that have already identified a plan for collaboration. In order for the LPHAs to request this funding, the LPHAs were required to work with their RCCO, to outline areas of collaboration, and the departments, to determine how much of their General Fund allocation they would need for these areas of collaboration.

Anticipated Outcomes:

The funding of this request would mean that LPHAs and RCCOs would have more resources to coordinate health care and align direct health services with population-based health services. Specifically, for the collaborations in FY 2017-18, these additional resources would be used to facilitate data sharing[5] and support community health workers in coordinating resources between the two health systems. Sharing data means less duplicative work performed by the LPHAs and RCCOs in identifying members in need of specific direct-health and population-based health services. The coordination of these two health systems should lead to a higher volume of low-cost interventions and preventive care, and less use of higher cost services such as the emergency department. These partnerships align with the Department's performance goals of being more person-centered, improving the efficiency and effectiveness of the care-coordination process, and the partnerships represent a creative solution that employs both the strengths of the LPHAs and RCCOs.

[5] RCCO 1, Rocky Mountain Health Plans (RMHP), intends to allow access to its Essette data system to LPHAs participating in this pilot. RCCO 6, Colorado Community Health Alliance (CCHA), also plans on exchanging member information with their LPHA, Boulder County Public Health (BCPH).

The health care industry is undergoing a transformation with more value being placed in low-cost preventive measures, health interventions, and integrated delivery systems. Initiatives such as the ACC and Comprehensive Primary Care (CPC) program encourage patients to be involved with their health and empowers them to seek early preventive care. Population-based health programs recognize that social determinants of health are just as important as direct-health to a person's wellbeing. The LPHA-RCCO partnership programs are another piece of this shift of creating a culture of health and wellness.

Assumptions and Calculations:

Funding and Payment Mechanisms

In order to draw down a federal Medicaid match for these programs, the Department must develop a defensible way to tie the funding for these programs to services provided to Medicaid members. This would require working with the LPHAs to establish an allocation methodology of their funding. The LPHAs would identify the percentage of their current funding from CDPHE that would be spent on the proposed initiatives. The LPHAs would also identify the population served by each initiative, and the percentage of that population that is enrolled in Medicaid, in order to calculate the percentage of the funding eligible for Medicaid federal financial participation. As the single state agency administering Medicaid, the funding would need to be appropriated to HCPF in order to receive the federal match. The funding would be paid as reappropriated funds to CDPHE, which would then use the funding to pay the LPHAs for the costs incurred by Medicaid members participating in the approved collaboration initiatives. This financing methodology is dependent on approval from the Centers for Medicare and Medicaid Services (CMS).

The following table shows the funds requested by each department.

Table 1: FY 2017-18 Funds Requested by Department for Local Public Health Agency Partnerships

Department	Total Funds	General Fund	Reappropriated Funds*	Federal Funds
Health Care Policy and Financing	$711,000	$355,500	$0	$355,500
Public Health and Environment	$355,500	($355,500)	$711,000	$0
Total Requested Funds	**$1,066,500**	**$0**	**$711,000**	**$355,500**

* The departments note that through CDPHE reappropriating funds from HCPF, these funds are being double-counted. The funding mechanism is necessary so that both agencies have the proper spending authority.

Federally matched reappropriated funds cannot be used on non-Medicaid individuals, services that are already funded by federal dollars, or clinical services that are already covered under a Medicaid billable code. The amount of funding provided to any LPHA is contingent on the availability of federal funds; however, if the Department is unable to draw down the full amount of federal funds, the departments anticipate that CDPHE would still provide the General Fund appropriation to the LPHAs, and the departments would revert unused reappropriated and federal funds spending authority.

Funds Requested by LPHA-RCCO Partnership

As part of the proposal process, the departments worked with the LPHAs to identify the amount of General Fund they would spend on their programs in FY 2017-18 and to estimate the percentage of their clients that

are Medicaid eligible. The product of these two quantities represents the General Fund share that would be used to earn the 50% federal funds match for administrative activities; the enhanced total funds are detailed in Table 2 by partnership. These calculations were made with the assumption that CMS would approve a cost allocation methodology.

Table 2: FY 2017-18 Funds Requested by LPHA-RCCO Partnership	
LPHA-RCCO Partnership	**Total Funds**
Northwest Colorado Health - Rocky Mountain Health Plans	$11,000
San Juan Basin Health Dept. - Rocky Mountain Health Plans	$72,000
Mesa County Health Dept. - Rocky Mountain Health Plans	$228,000
Boulder County Public Health - Colorado Community Health Alliance	$400,000
Total Requested Funds	**$711,000**

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-13 Quality of Care and Performance Improvement Projects

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$8,270,776**	**$0**	**$9,041,073**	**$639,237**	**$639,237**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,192,160	$0	$2,767,160	$280,869	$280,869
	CF	$1,531,751	$0	$1,229,400	$0	$0
	RF	$770,000	$0	$770,000	$0	$0
	FF	$3,776,865	$0	$4,274,513	$358,368	$358,368

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (A) General Administration - General Professional Services and Special Projects	**Total**	**$7,200,237**	**$0**	**$7,975,237**	**$708,339**	**$708,339**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,047,261	$0	$2,622,261	$315,420	$315,420
	CF	$1,527,500	$0	$1,227,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,625,476	$0	$4,125,476	$392,919	$392,919
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Administrative Costs - Operating Expenses	**Total**	**$1,070,539**	**$0**	**$1,065,836**	**($69,102)**	**($69,102)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$144,899	$0	$144,899	($34,551)	($34,551)
	CF	$4,251	$0	$1,900	$0	$0
	RF	$770,000	$0	$770,000	$0	$0
	FF	$151,389	$0	$149,037	($34,551)	($34,551)

CF Letternote Text Revision Required?	Yes	___	No	___ **If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes	___	No	___
FF Letternote Text Revision Required?	Yes	___	No	___
Requires Legislation?	Yes	X	No	___
Type of Request?	Department of Health Care Policy and Financing Prioritized Request			
Interagency Approval or Related Schedule 13s: None				

Cost and FTE

- The Department requests $639,237 total funds, including $280,869 General Fund and $358,368 federal funds in FY 2017-18 and ongoing to improve member quality of care through enhanced patient assessment and performance improvement processes.

Current Program

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a series of patient surveys that rate health care experience satisfaction related to various measures including the communication efforts of doctors and nurses, pain management during a health care visit, and end of life care and considerations.
- The National Core Indicators (NCI) is a voluntary effort for states to measure and track their own performance, compare results across states, and establish national benchmarks. The initiative is designed to assess the performance of the Department's programs and delivery systems and improve services for older adults and individuals with physical and developmental disabilities.
- A Performance Improvement Project (PIP) is a quality improvement requirement implemented by regional provider entities and validated by the Department's external quality review organization (EQRO).

Problem or Opportunity

- CAHPS surveys are performed at the provider network level, which only allows the Department to identify and align the results with a corresponding region of the state. The survey results do not provide sufficient detail for a direct and meaningful intervention to mitigate shortfalls within a specific practice.
- The Department lacks the funds necessary to expand NCI surveys in FY 2017-18 for aging or disabled adults (referred to as NCI-AD surveys), which are valued surveys used to improve quality of services and strategic use of funds. The current NCI-AD pilot program, entirely through a federal grant, ends in FY 2016-17.
- Current NCI funding for individuals with intellectual and developmental disabilities (referred to as NCI-IDD surveys) provides for only one survey, which limits ability to track performance and affect change.
- The Department could be required under new federal Medicaid managed care rules to validate up to 57 PIPs annually, however, the current available funding is only sufficient to conduct 31 PIPs.

Consequences of the Problem

- If the Department is unable to implement the CAHPS survey at the practice level, the ability for process improvement and in identifying and reducing the sources of patient frustration and dissatisfaction is limited.
- If the Department is unable to implement and expand the NCI-AD and NCI-IDD surveys on a statewide basis, critical data for assessment and process improvement to improve services for older adults and individuals with physical and developmental disabilities would be limited or unavailable.
- If additional resources are not provided, the Department may be unable to fund the validation of the PIPs, risking non-compliance with federal regulations and opportunities for process improvement measures implemented by the regional provider entities could be missed or delayed.

Proposed Solution

- The Department would be able to more effectively identify the sources of patient dissatisfaction by conducting annual CAHPS surveys at the practice level, and then work collaboratively with the specific practice to improve the shortfalls identified in the survey results.
- Implementation of 6 NCI surveys on a permanent, statewide basis would provide critical data by which policy and programmatic strategies could be based to improve services for older adults and individuals with physical or developmental disabilities.
- With the requested funding, the Department would be able to fund the 26 additional PIP validations to support the continual process improvement of the provider entities.

Department Priority:	***R-13***
Request Detail:	***Quality of Care & Performance Improvement Projects***

Summary of Incremental Funding Change for FY 2017-18 and Ongoing	Total Funds	General Fund
Quality of Care & Performance Improvement Projects	$639,237	$280,269

Problem or Opportunity:

The Department does not have sufficient funding in its Professional Contracts line item to fund changes needed to measure member experience by conducting the Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult and child surveys at the practice level, to implement and expand existing National Core Indicators surveys on a permanent, statewide basis, and to increase the number of Performance Improvement Projects (PIP).

Consumer Assessment of Healthcare Providers and Systems

The goal of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys is to provide performance feedback that is actionable and aid in improving overall member satisfaction. Through these surveys, health care experience satisfaction is rated using various measures including:

- Communication effectiveness of primary care physicians and specialists;
- Access to care, including appropriateness and timeliness of care; and
- Coordination of health care needs and integration of behavioral health treatment.

In addition, the surveys reflect whether prescription medication reconciliation, smoking cessation options, and neighborhood resource awareness were discussed or considered. The CAHPS surveys ask patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others. The surveys focus on matters that patients themselves say are important to them and for which patients are the best, and sometimes only source of information.

The CAHPS patient surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The surveys are conducted for physical health only, and are currently performed at the regional level. This allows the Department to identify and align the results with a corresponding region of the state but does not provide sufficient detail for a direct and meaningful intervention to mitigate identified

shortfalls at the individual provider level. Additionally, the current amount of CAHPS funding is only sufficient for annual sampling of either adults or children, but not both during a fiscal year.

Based on stakeholder feedback and an 8-month review of current practices in Colorado, the Health Impact on Lives: Health Improvement Subcommittee of the Program Improvement Advisory Committee (PIAC) recognized the limitation of administering the CAHPS survey statewide without attention to specific practices or primary care providers. The committee recommends that data from member satisfaction surveys be analyzed at both the individual provider and regional level to identify not only those providers offering exceptional care but also those providers who need improvement and the areas where interventions are needed.[1]

National Core Indicators

The Department seeks to expand its ability to identify shortcomings in services that could be corrected if known. Without the availability of the National Core Indicators (NCI), the long term services and supports (LTSS) and intellectual and developmental disabilities (IDD) landscape would be dramatically impacted by lack of quality assessment necessary to improve care to the most vulnerable populations who need it. Currently, the existing NCI surveys have provided information that could be used by the Department to gain this information, but this is limited by the relatively small scale by which this can be employed. The Department is in need of further improving its quality strategy, but the funding available for the NCI projects is not sufficient to realize this goal. The Department conducts face-to-face surveys with randomly selected individuals receiving services. In addition, families are randomly selected for a survey by mail. Data from these interviews and surveys are used to create state reports about individual outcomes; health, welfare, and rights; staff stability and competency; family outcomes and system performance. A national report is generated as well as a report for each state. The State report, based on the data collected through the interviews and surveys, is issued annually and are publically available. States can use the reports to track their own performance over time, to compare results across states, and to establish national benchmarks. The Department currently engages in two types of surveys, NCI surveys for aging or disabled adults (hereafter referred to as NCI-AD surveys) and NCI surveys for individuals with intellectual and developmental disabilities (hereafter referred to as NCI-IDD surveys).

National Core Indicators - Aging and Disabilities

The National Core Indicators - Aging and Disabilities (NCI-AD) is an initiative designed to support states' interest in assessing the performance of their programs and delivery systems to improve services for older adults and individuals with physical disabilities. NCI-AD is a collaborative effort between the National Association of States United for Aging and Disabilities (NASUAD) and the Human Services Research Institute (HSRI). NCI-AD's primary aim is to collect and maintain valid and reliable data that give states a broad view of how publicly-funded services impact the quality of life and outcomes of service to recipients.

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[1] The Department of Health Care Policy and Financing, Recommendation to the PIAC: Measuring Patient/Client Experience of Primary Care in ACC Phase II.
https://www.colorado.gov/pacific/sites/default/files/Final%20Recommendation%20from%20Health%20Improvement%20to%20the%20PIAC%20February%202016.pdf

Data for the project are gathered through annual in-person surveys administered to a sample of older adults and individuals with physical disabilities accessing publicly-funded services via skilled nursing facilities, Medicaid waivers, Medicaid state plans, and/or state-funded programs, as well as older adults served by Older Americans Act programs. The survey instrument includes a background survey, which gathers data about the consumer from agency records, and an in-person survey, which includes subjective satisfaction-related questions that can only be answered by the consumer, and objective questions that can be answered by the consumer, or if needed, their proxy.

After the data is collected, HSRI interprets data and provides a state-specific report that serves to support state efforts to strengthen Long Term Services and Supports (LTSS) policy, inform quality improvement activities, and compare their performance with national norms. All data is then published on the NCI website[2]. For FY 2015-16 Colorado was able to secure federal grant funding through U.S. Department of Health and Human Services, Administration for Community Living, to test the survey tool in the state and determine its long-term applicability and effectiveness. The survey was conducted to over 400 respondents across four populations:

- Home and Community Based Services waiver program populations Elderly, Blind and Disabled (HCBS-EBD) and Brain Injury (HCBS-BI),
- Older Americans Act (OAA) population; and
- Accountable Care Collaborative: Medicare-Medicaid (ACC_MMP) program population.

The survey consists of more than 100 items and is administered in-person by a trained interviewer, with proxy respondents if the person receiving services cannot answer questions or prefers proxy responses.

National Core Indicators – Intellectual and Developmental Disabilities

National Core Indicators specific to intellectual and developmental disabilities were developed by HSRI and the National Association of State Directors of Developmental Disabilities Services as a means for public agencies who provide intellectual and developmental disabilities services to measure and track their own performance. States that participate in NCI-IDD pool their resources and knowledge to create performance monitoring systems, identify common performance indicators, collaborate on data collection strategies, and share results.

Through existing funding in FY 2015-16 the Department was able to conduct one face-to-face survey to assess the programs for individuals with developmental disabilities, and included interviews of the waiver program populations, Developmental Disabilities (HCBS-DD) and Supported Living Services (HCBS-SLS), as well as for the State Supported Living Services (State SLS) program population. The Department seeks to further its use of the NCI-IDD surveys to expand on its ability to identity issues and successes for overall system improvement and improved member experience with the systems of care. The Department currently has $69,102 ($34,551 General Fund and $34,551 federal funds) of available funding in FY 2017-18 for the NCI-IDD project allowing for one face-to-face survey implementation for the programs for individuals with developmental disabilities. The Department lacks funding for additional interviews and flexibility of the survey structure for assessing IDD programs and for in-depth analysis of sub-populations.

[2] http://www.nationalcoreindicators.org/

Performance Improvement Project

A Performance Improvement Project (PIP) is a quality improvement requirement for all 19 regional provider entities that must first be validated by the Department's external quality review organization (EQRO). A PIP is a concentrated effort towards process improvement in the provider health care delivery system.

Following the validation process, the PIP is self-administered by each of the 19 regional provider entities listed below:

- Seven Regional Care Collaborative Organizations (RCCOs)[3]
- Five Behavioral Health Organizations (BHOs)
- Five Child Health Plan Plus (CHP+) program plans.
- Denver Health Medicaid Choice
- Rocky Mountain HMO

Typically, a PIP would direct the collection of sufficient data to clarify an issue or concern within the entity. A subsequent intervention is then designed and implemented to target improvements in the areas identified. Areas include both clinical and nonclinical areas and vary depending on the type of entity and the unique scope of services provided.

The Department needs funding for 57 PIP validations, but only 31 PIP validations are funded in FY 2017-18 and ongoing, which is insufficient to carry out the number of PIP validations necessary as indicted by Centers for Medicare and Medicaid Services (CMS). CMS issued final rules on May 6, 2016, intended to modernize the Medicaid managed care regulations including promoting quality of care and strengthening the efforts to reform the managed care delivery systems. Federal regulations at 42 CFR § 438.330(a)(2) states that "CMS may specify performance measures and PIPs which must be included in standard measures identified and PIPs required by the State" and 42 CFR §438.330(d) adds that the State must require managed care organizations to conduct performance improvement projects, including any performance improvement projects required by CMS that focus on both clinical and nonclinical areas. While the regulations are somewhat ambiguous in specifying a number of PIPs required annually, in the preamble of the May 6, 2016 final rule CMS states, "We assume that each MCO/PIHP will conduct at least 3 performance improvement projects." Therefore, the Department anticipates that three PIPs for each of the 12 managed care entities would be required annually resulting in a total of 36 PIP validations needed for the MCOs. Additionally, it is the Department's policy to apply the same level of quality standards to the seven fee-for-service RCCOs, therefore, 21 PIP validations in total annually would be needed for the RCCOs.

The Department received $60,000 in additional funding for PIPs from FY 2016-17 BA-7 "Compliance with Proposed Federal Managed Care Regulations" request, which was based on proposed Medicaid managed care rules. It was assumed that the timeline for implementing the additional PIPs would be on a bi-annual basis. In addition, that budget request only included additional funding for PIPs for the MCOs, however, the Department did not request funding for additional PIPs for RCCOs, as it is the Department's policy to hold

[3] Beginning July 1, 2018, the Department will transition RCCOs to "Regional Accountable Entities" (RAEs). See the Department's November 1, 2016 budget request R-6 "Delivery System and Payment Reform" for more information about the Department's Accountable Care Collaborative Phase II initiative. Although this request uses terminology from the existing ACC program, the Department would fully integrate the proposed programs in this request with the ACC Phase II program redesign.

the fee-for-service RCCOs to the same quality standards as the MCOs. The current funding only supports seven PIP validations for the RCCOs, which falls short of the 21 PIP validations needed for the Department to align with the federal policy for PIP validation for the MCOs.

Proposed Solution:

The Department requests $639,237 total funds, including $280,869 General Fund and $358,368 federal funds in FY 2017-18 and ongoing in order to improve quality of care through enhanced consumer assessment and performance improvement processes.

Consumer Assessment of Healthcare Providers and Systems

The Department requests $163,478 total funds, including $81,739 General Fund and $81,739 federal funds in FY 2017-18 and ongoing to conduct CAHPS surveys at the practice level which would enable the Department to identify sources of patient dissatisfaction and then work collaboratively with the specific practice to improve the areas identified in the survey results. The requested funding would permit the surveys to be conducted to both adults and children on an annual basis.

The Department would conduct the CAHPS surveys at the provider level beginning in FY 2017-18. Conducting the surveys at the provider level in advance of the ACC Phase II implementation would promote advanced understanding and experience of the methodology, protocols and challenges for surveying at such a granular level. The Department would include a broad sample of providers, including rural and urban provider groups and Federally Qualified Health Centers.

National Core Indicators

The Department requests $345,759 total funds, including $179,130 General Fund and $166,629 federal funds in FY 2017-18 and ongoing for the implementation of five additional NCI surveys (four NCI-AD surveys and 1 additional NCI-IDD survey) on a permanent statewide basis, and includes a funding adjustment to address cost increases for the existing NCI-IDD survey.

National Core Indicators - Aging and Disabilities

With the requested funding for four NCI-AD surveys, the Department intends to leverage lessons learned during the pilot to accomplish a full-production rollout of the NCI-AD as an outcome measure in its federally required Quality Improvement Strategy (QIS) in the HCBS-EBD waiver program. The HCBS-EBD waiver program is the Department's single biggest HCBS waiver in terms of the number of individuals using services. The Department expects that through the process of waiver simplification outlined in the recommendation of the Community Living Advisory Group (CLAG) that ultimately this would lead to the NCI-AD being used for QIS for all adult waivers.

The Department has been able to make interesting comparisons between other states under the pilot, however, the pilot sampling frame is inadequate for use in federally approved waiver quality monitoring. The Department intends to continue and enhance its surveys of members within the Department of Human Services administered Older Americans' Act programs, the HCBS-EBD waiver program, the Accountable Care Collaborative: Medicare-Medicaid program, and the HCBS-BI program. Further, this request would allow the Department the flexibility to structure surveys for a specific waiver program, for specific populations across several program, or for sub-populations within a specific program. For example, an

assessment of members with co-occurring diagnosis that includes behavioral health problems could be designed for a cross-section of programs and include the HCBS Community Mental Health Supports (CMHS) program, residents of skilled nursing facilities, and enrollees in the PACE program.

National Core Indicators – Intellectual and Developmental Disabilities

Expanding to two NCI-IDD surveys would increase the availability of system performance data would strengthen Colorado's ability to administer key long term support programs for individuals with intellectual disabilities. NCI-IDD has been instrumental in facilitating collaboration between state developmental disabilities (DD) agencies on the identification of service delivery trends, policy planning and development of mutual strategies to improve the well-being of those receiving services. Performance data on service outcomes, particularly those that are meaningful to people with disabilities, such as choice, relationships, community participation and employment, make it possible to determine the extent to which the values that underpin the Developmental Disabilities Assistance and Bill of Rights Act of 2000 and state laws are manifested in the lives of those served.

Performance Improvement Project

The Department requests $130,000 total funds, including $20,000 General Fund and $110,000 federal funds for FY 2017-18 and ongoing for 26 additional PIP validations, which would allow for validation of a total of 57 PIPs annually. The validation of the additional PIPs places the Department in compliance with new federal regulations, aligns quality standard processes for the RCCOs with the MCOs, and facilitates implementation of process improvement measures by regional provider entities.

Anticipated Outcomes:

This request links to the Department's Performance Plan and its specific strategic policy initiative of operational excellence. The transformation of the CAHPS survey program, by providing the Department with clear, actionable data sufficient for meaningful interventions, reflects the Department's core value of continuous improvement. This transformation, along with the additional implementation of PIPs required by federal statute, strengthens the Department as a model of compliant, efficient and effective business practices that are person- and family-centered.

Consumer Assessment of Healthcare Providers and Systems

Conducting the CAHPS surveys at the practice, clinic, or institution level would allow the Department to identify areas of dissatisfaction at the point of service and then provide the specific practice, clinic or institution with the concrete and personalized evidence needed to foster change in a more targeted and timely manner. Since the Accountable Care Collaborative launch in 2011, progress has largely been measured by whether Medicaid costs or the use of certain services have declined, such as emergency room visits or high-cost tests such as MRIs. The program has also reported on the use of services among Colorado enrollees with chronic diseases such as diabetes and hypertension. The CAHPS data complements these metrics by providing a baseline measurement for understanding the patient's experience of care. Ongoing annual CAHPS surveys would help the Department understand how patients perceive the quality of their care and whether their perceptions change over time.

National Core Indicators

National Core Indicators – Aging & Disabilities

The NCI-AD program brings an important value proposition to the field of aging and disability services through development of indicators and outcomes that assess quality of life, community integration, and person-centered services. The program would help address long-recognized gaps in assessing outcomes in LTSS service systems that go beyond measures of health and safety to address important social, community, and person-centered goals as well as quality of life.

The NCI-AD aligns with the Department's performance plan by promoting community living and striving toward the goal of an enhanced quality of life and community experience for individuals and families. The Department supports the National Quality Forum's Home and Community-Based Services (NQF-HCBS) quality measurement recommendations which state that measurement should be approached at three levels: at the level of the person receiving HCBS, at the level of service provision, and at the systems level. According to NQF, the NCI-AD most closely assesses the constructs defined within this type of measurement.[4]

The NCI-AD survey provides hard data on whether LTSS is improving the lives of members, as perceived directly and subjectively by the members receiving services. Whether people receiving services report that their lives are improved through their access to those services is possibly the most important measure of quality that HCPF could conceivably measure. However, the current QIS is comprised solely of process measures and contains no measure currently that addresses member experience of access to services. While maintaining non-subjective process measures in its waiver, QIS is an important part Department's quality monitoring, the addition of NCI-AD to QIS fills a large gap, and would be a large improvement in the accountability of HCPF to people in services.

The NCI-AD aligns with the Department's performance plan by promoting community living and striving toward the goal of an enhanced quality of life and community experience for individuals and families. The Department supports the National Quality Forum's Home and Community-Based Services (NQF-HCBS) quality measurement recommendations which state that measurement should be approached at three levels: at the level of the person receiving HCBS, at the level of service provision, and at the systems level. According to NQF, the NCI-AD most closely assesses the constructs defined within this type of measurement.

National Core Indicators – Intellectual and Developmental Disabilities

Expanded participation in the NCI program would improve the performance of the programs in the Division for Intellectual and Developmental Disabilities (DIDD) by utilizing nationally recognized standardized outcome measures to better measure and evaluate the performance and effectiveness of the developmental disabilities system in Colorado. The data obtained through this project would assist the Department in identifying service gaps or developmental disabilities systems issues, and support improvements to policy, processes and quality improvement efforts as well as federally required quality and evaluation activities for the Medicaid waiver programs. The NCI collaboration seeks to share information in a variety of formats to

[4]National Quality Forum, Measuring HCBS Quality. http://www.qualityforum.org/Measuring_HCBS_Quality.aspx

maximize the use of findings for quality improvement and policy change. Data from NCI are aggregated and used to support state efforts to strengthen long term care policy, inform the conduct of quality assurance activities, and compare performance with national norms. Additionally, NCI data have been used as the basis of data briefs on specific areas of interest such as employment, dual diagnosis, self-directed services, and autism spectrum disorders.

Performance Improvement Project

This component of the request aligns with the Department's FY 2016-17 Performance Plan strategy to support statewide efforts to improve population health by identifying problem areas of the provider network health care delivery system and intervening for targeted improvements. The validation of additional PIPs complies with federal regulation and furthers the Department's goal towards continuous quality improvement in line with the Department's mission and the Triple Aim component of person-centeredness toward better care-quality for its members.

The following is an example of how the PIP is used to promote improvements and improved outcomes regarding access to services. Data for a BHO showed that children and teens in their region had a much lower utilization rate of behavioral health services than other BHOs across the state. The BHO addressed this issue through a PIP. The PIP supported healthy living initiative goals of improved screening, diagnosis, referral and treatment for depression among adolescents. Goals of this PIP were to improve processes related to service access for the youth population and to increase treatment utilization, as demonstrated by an increase in overall penetration rates. This study topic addressed access to a broad range of mental health services including screening, referral, assessment and treatment. The provider convened an internal core task group and held a number of stakeholder to identify barriers to mental health access and potential interventions. In addition, parent focus groups were held.

Key interventions for this PIP included:

- Creation of a flyer for newly enrolled members about early warning signs that children may need mental health referrals and information about how to access mental health services
- Collaboration between crisis service agencies, the BHO and RCCO Primary Care Providers to refer youth to mental health services
- Reorganization within the BHO to provide immediate assistance to parents/children who need a mental health appointment or services.
- Quarterly articles in the agency newsletter, produced in English and Spanish, regarding importance of accessing MH services for children with the BHO contact number prominently displayed.
- The regional RCCO included BHO contact phone numbers in monthly online newsletters.

After interventions specified through the PIP were implemented there was a 26% increase in utilizers of behavioral health services between baseline and re-measurement, and because the implementation is built into the entities' business model, the Department expects the baseline to be re-established at a higher number.

Assumptions and Calculations:

Detailed calculations of this request are included in the attached appendix. Table 1 in the appendix lists the components of this request along with their respective dollar amounts. Table 2 shows the incremental request by component.

Consumer Assessment of Healthcare Providers and Systems

The Department estimates it would need a $163,478 incremental increase in total funds in FY 2017-18 and ongoing for the increased workload required for the enhance CAHPS survey operations. The total cost of conducting the CAHPS is $389,403, based on an estimate provided to the Department by its external quality review organization (EQRO) and consists of an annual sampling size of 13,200 children and 10,800 adults.

National Core Indicators

The Department is requesting $340,622 total funds to expand the NCI project. The total cost of the new NCI components is $409,724; however, the Department currently has funding for NCI-IDD in the Division of Intellectual Developmental Disabilities, Operating Expenses line item for $69,102 ($34,551 General Fund and $34,551 federal funds). This request proposes to consolidate this funding under the Professional Contracts line item for administrative efficiencies. Both the NCI-IDD and NCI-AD projects are managed under through a single unit in the Department. Additionally, the Department contracts with one vendor to administer both the NCI-IDD and NCI-AD projects, thus, consolidating funding in one line would facilitate more effective contract management and simplify administrative processes.

To obtain federal approval, it is necessary that HCBS-EBD, now only a subset of a statistically significant sample, have enough survey observations to be independently statistically significant at the 95% level with a 5% confidence interval. The recommended sample size is 411 face-to-face interviews for each survey. NCI-AD is useful for management oversight to continue to sample other populations in addition to HCBS-EBD, so that comparisons in quality can be made between and among different Departmental programs.

Table 6.2 shows the key components of the $235,500 NCI-AD project costs based on the current FY 2016-17 contract for the grant funded pilot project. The Department is proposing to contract with a vendor to conduct four surveys annually, including 411 face-to-face interviews for each survey at $125.00 per interview. The cost per survey is $51,375. Out of the funding for 1,644 (4 surveys x 411 interviews) NCI-AD interviews, the Department estimates that 100 members in the sample from the Older Americans Act population would not qualify for Medicaid, therefore, the cost of the interviews for this group would be supported with General Fund only, as shown in table 2, row C. Table 6.3 shows the key components of the NCI-IDD project costs of $143,025 and includes the cost of two surveys of 411 face-to-face interviews each at $137.50 per interview.

Performance Improvement Projects

The Department estimates, as shown in tables 3.1 in the appendix, it would need $130,000 total funds including $20,000 General Fund in FY 2017-18 and ongoing for 26 additional PIP validations to be performed by the Department's EQRO contractor. Table 7 shows the applicable federal financial participation (FFP) for the PIPs. An enhanced FFP of 75% is available for the validation of MCO PIPs and a FFP of 50% for the RCCO PIPs. Table 8 shows the approximate cost of a PIP validation at $5,000 and the maximum number of PIP validations on a yearly basis is 57 (three PIPS per each of the 19 provider network

entities). The Department currently has available funding for thirty-one PIPs, which falls short of the necessary funding needed to conduct 57 PIP validations on an annual basis.

Table 1.1 - Summary by Line Item FY 2017-18							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**Source**
A	**Total Request**	**$639,237**	**0.0**	**$280,869**	**$0**	**$358,368**	**Row B + Row C**
B	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$708,339	0.0	$315,420	$0	$392,919	Table 2, Row E + Table 3.3, Row B (see Row C below)
C	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities, (1) Adminstrative Costs, Operating Expenses	($69,102)	0.0	($34,551)	$0	($34,551)	Table 3.3, Row B * (-1); Transfer of funds for NCI-IDD to Professional Services line

Table 1.2 - Summary by Line Item FY 2018-19 and Ongoing							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**Source**
A	**Total Request**	**$639,237**	**0.0**	**$280,869**	**$0**	**$358,368**	**Row B + Row C**
B	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$708,339	0.0	$315,420	$0	$392,919	Table 2, Row E + Table 3.3, Row B (see Row C below)
C	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities, (1) Adminstrative Costs, Operating Expenses	($69,102)	0.0	($34,551)	$0	($34,551)	Table 3.3, Row B * (-1); Transfer of funds for NCI-IDD to Professional Services line

Table 2 - Summary of Request with Fund Splits FY 2017-18 and ongoing								
Row	**Description of Activity**	**Acronym**	**Total Funds**	**General Funds**	**Cash Funds**	**Federal Funds**	**FFP**	**Source**
A	Consumer Assessment of Healthcare Providers & Systems	CAHPS	$163,478	$81,739	$0	$81,739	50.00%	Table 3.1, Row A
B	National Core Indicators - Surveys - Medicaid Eligible	NCI-IDD NCI-AD	$333,259	$166,630	$0	$166,629	50.00%	Table 3.1 Row B, - Table 2, Row C
C	National Core Indicators - AD Non-Medicaid Older American's Act (OAA) Surveys	NCI-AD only	$12,500	$12,500	$0	$0	0.00%	Approximately 100 individuals of OAA population are not Medicaid eligible.
D	Performance Improvement Projects	PIPs	$130,000	$20,000	$0	$110,000	Blend	Table 7, Row E
E	**Total Request**		**$639,237**	**$280,869**	**$0**	**$358,368**	**Blend**	**Sum of Rows A through D**

Table 3.1 - Incremental Request FY 2017-18 and Ongoing				
Row	**Description of Activity**	**Acronym**	**Total**	**Notes**
A	Consumer Assessment of Healthcare Providers & Systems	CAHPS	$163,478	Table 3.2, Row A - Table 3.3, Row A
B	National Core Indicators - Surveys	NCI-IDD NCI-AD	$345,759	Table 3.2, Row B - Table 3.3, Row B
C	Performance Improvement Project	PIPs	$130,000	Table 3.2, Row C - Table 3.3, Row C
D	**Total Incremental Request**		**$639,237**	Row A + Row B + Row C

Table 3.2 - Total Estimated Cost of Program Implementation FY 2017-18 and Ongoing				
Row	**Description of Activity**	**Acronym**	**Total**	**Notes**
A	Consumer Assessment of Healthcare Providers & Systems	CAHPS	$389,403	Table 4, Row C
B	National Core Indicators - Surveys	NCI-IDD NCI-AD	$414,861	Table 5, Row E
C	Performance Improvement Project	PIPs	$285,000	Table 7, Row C
D	**Total Estimated Cost of Program Implementation**		**$1,089,264**	Row A + Row B + Row C

Table 3.3 - Total Base Funding Available FY 2017-18				
Row	**Description of Activity**	**Acronym**	**Total**	**Notes**
A	Consumer Assessment of Healthcare Providers & Systems	CAHPS	$225,925	Current program measures patient experience at the entity level. Also, funding is only sufficient for either adults or children on annual basis.
B	National Core Indicators - Surveys	NCI-IDD NCI-AD	$69,102	FY 2014-15 R-16 "New Operational and Membership Funds for the Division for Developmental Disabilities"
C	Performance Improvement Project	PIPs	$155,000	Existing funding for validations of one annual PIPs for each of the nineteen entities (DH, Rocky, RCCOs, BHOs, CHP+). Plus, additional funding for an additional 12 PIPs from FY 2016-17 S-7, BA-7 "Compliance with Proposed Federal Managed Care Regulations"
D	**Total Base Funding Available**		**$450,027**	Row A + Row B + Row C

Table 4 - Consumer Assessment of Healthcare Providers & Systems (CAHPS) Total Estimated Cost of Program Implementation FY 2017-18 and Ongoing				
Row	**Description**	**Sample Size**	**Cost**	**Notes**
A	CAHPS surveys and annual report - Children	13,200	$225,925	Actual cost of conducting the FY 2015-16 CAHPS surveys and annual report completed by the Department's external quality review organization (EQRO)
B	CAHPS surveys and annual report - Adults	10,800	$163,478	Estimate of additional costs for expanding sample size to include adults and to compile data at the provider/practice level; estimate provided by EQRO and submitted to the Department's Quality and Health Improvement
C	**Total**	**24,000**	**$389,403**	**Row A + Row B**

Table 5 - Summary of Costs - National Core Indicators (NCI) Survey Program FY 2017-18 and Ongoing			
Row	**Description**	**Amount**	**Notes**
A	Cost of NCI Surveys	$378,525	Table 6.1, Row C
B	NCI-IDD Annual Participation Fee	$15,000	Paid to National Association of State Directors of Developmental Disabilities Services (NASDDDS)
C	NCI-AD Annual Participation Fee	$15,000	Paid to National Association of States United for Aging and Disabilities (NASUAD)
D	Mailing of Pre-Notification Letter	$6,336	Letter sent to all potential participants by Integrated Document Solutions (IDS)
E	**Total Cost of NCI Survey Program**	**$414,861**	**SUM (Row A: Row D)**

Table 6.1 - Summary of Survey Costs - National Core Indicators (NCI) Surveys FY 2017-18 and Ongoing			
Row	**Description**	**Amount**	**Notes**
A	Total Cost of NCI-AD Surveys	$235,500	Table 6.2, Row I
B	Total Cost of NCI-IDD Surveys	$143,025	Table 6.3, Row I
C	**Total Cost of NCI Surveys**	**$378,525**	**Row A + Row B**

Table 6.2 - National Core Indicators-Aging & Disabilities (NCI-AD) Surveys FY 2017-18 and Ongoing			
Row	**Description**	**Amount**	**Notes**
A	Survey Sample Size	411	Statistical significant sample size
B	Cost Per Interview	$125.00	The Department's contract with NCI-IDD survey vendor in FY 2016-17.
C	**NCI-AD Base Survey Rate**	**$51,375**	**Row A * Row B**
D	Number of Annual NCI-AD Surveys	4	Number of surveys for target populations
E	**Subtotal Cost of Surveys**	**$205,500**	**Row C * Row D**
F	Interviewer Assignment List	$6,000	The Department's contract with NCI-AD survey vendor in FY 2016-17.
G	Interviewer Training	$9,000	
H	Survey Results Report & Final Data Report	$15,000	
I	**Total Cost of NCI-AD Surveys**	**$235,500**	**SUM (Row E:Row H)**

Table 6.3 - National Core Indicators-Intellectual and Developmental Disabilities (NCI-IDD) Surveys FY 2017-18 and Ongoing			
Row	**Description**	**Amount**	**Notes**
A	Survey Sample Size	411	Statistical significant sample size
B	Cost Per Interview	$137.50	The Department's contract with NCI-IDD survey vendor in FY 2016-17.
C	**NCI-IDD Base Survey Rate**	**$56,513**	**Row A * Row B**
D	Number of Annual NCI-IDD Surveys	2	Number of surveys for target populations
E	**Subtotal Cost of Surveys**	**$113,025**	**Row C * Row D**
F	Interviewer Assignment List	$6,000	The Department's contract with NCI-AD survey vendor in FY 2016-17.
G	Interviewer Training	$9,000	
H	Survey Results Report & Final Data Report	$15,000	
I	**Total Cost of NCI-IDD Surveys**	**$143,025**	**SUM (Row E:Row H)**

Table 7 - Performance Improvement Plans (PIPs) Incremental Request with Fund Splits for FY 2017-18 and ongoing							
Row	**Description**	**Total Funds**	**General Funds**	**Cash Funds**	**Federal Funds**	**FFP**	**Notes**
A	Managed Care Organization (MCO) PIP validations	$180,000	$45,000	$0	$135,000	75%	Table 8, Row A
B	Regional Care Collaborative Organization (RCCO) PIP validations	$105,000	$52,500	$0	$52,500	50%	Table 8, Row B
C	**Total Funding Needed**	**$285,000**	**$97,500**	**$0**	**$187,500**	**Blend**	**Row A + Row B**
D	Total Funding Currently Available	$155,000	$77,500	$0	$77,500	50%	Validation of one annual PIP for each of the nineteen plans (DH, Rocky, RCCOs, BHOs, CHP+ plans); plus additional funding of $60,000 from FY 2016-17 S-7 "Compliance with Proposed Federal Managed Care Regulations"
E	**Incremental Request with Fund Splits**	**$130,000**	**$20,000**	**$0**	**$110,000**	**Blend**	**Row C - Row D**

Table 8 - Performance Improvement Projects (PIPs) Incremental Request for FY 2017-18 and ongoing					
Row	**Description**	**Amount per PIP**	**# of PIPs**	**Total**	
A	Managed Care Organizations (MCOs)	$5,000	36	$180,000	Validation of three annual PIPs for each of the 12 MCOs (Denver Health HMO, Rocky Mountain HMO, BHOs, and CHP+ plans)
B	Regional Care Collaborative Organizations (RCCOs)	$5,000	21	$105,000	Validation of three annual PIPs for each of the 7 RCCOs
C	**Total Funding Needed**	**$5,000**	**57**	**$285,000**	**Row A + Row B**

Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-14 Federal Medical Assistance Percentage

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___	Supplemental FY 2016-17
X	Change Request FY 2017-18
___	Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$378,141,121**	**$0**	**$437,891,024**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$59,673,080	$253,832	$0
	CF	$156,939,380	$0	$156,939,380	$574,855	$0
	RF	$1,498,980	$0	$1,498,980	$6,020	$0
	FF	$219,702,761	$0	$219,779,584	($834,707)	$0

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (B) Transfers to/from Other Departments - Nurse Home Visitor Program, Transfer from CDHS	**Total**	**$3,010,000**	**$0**	**$3,010,000**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$1,498,980	$0	$1,498,980	$6,020	$0
	FF	$1,511,020	$0	$1,511,020	($6,020)	$0
05. Indigent Care Program - Safety Net Provider Payments	**Total**	**$311,296,186**	**$0**	**$311,296,186**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$155,073,238	$0	$155,073,238	$574,855	$0
	RF	$0	$0	$0	$0	$0
	FF	$156,222,948	$0	$156,222,948	($574,855)	$0

05. Indigent Care Program - Clinic Based Indigent Care	**Total**	**$6,119,760**	**$0**	**$6,119,760**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,047,640	$0	$3,047,640	$12,240	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,072,120	$0	$3,072,120	($12,240)	$0
05. Indigent Care Program - Pediatric Specialty Hospital	**Total**	**$13,455,012**	**$0**	**$13,455,012**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,700,596	$0	$6,700,596	$26,910	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$6,754,416	$0	$6,754,416	($26,910)	$0
06. Other Medical Services - Commission on Family Medicine Residency Training Programs	**Total**	**$7,597,298**	**$0**	**$7,597,298**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,786,304	$0	$3,786,304	$12,345	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,810,994	$0	$3,810,994	($12,345)	$0
06. Other Medical Services - Teaching Hospital -- Denver Health and Hospital Authority	**Total**	**$2,804,714**	**$0**	**$2,804,714**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,396,748	$0	$1,396,748	$5,609	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,407,966	$0	$1,407,966	($5,609)	$0
06. Other Medical Services - Teaching Hospital -- University of Colorado Hospital	**Total**	**$1,181,204**	**$0**	**$1,181,204**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$585,390	$0	$585,390	$5,212	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$595,814	$0	$595,814	($5,212)	$0
07. Department of Human Services Medicaid-Funded Programs, (B) Office of Information Technology Services - Medicaid - Other Office Of Information Technology Services Line Items	**Total**	**$647,220**	**$0**	**$647,220**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$322,316	$0	$322,316	$1,294	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$324,904	$0	$324,904	($1,294)	$0

07. Department of Human Services Medicaid-Funded Programs, (C) Office of Operations - Medicaid Funding - Office Of Operations - Medicaid Funding	**Total**	**$5,656,943**	**$0**	**$5,726,487**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,817,321	$0	$2,852,093	$11,151	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,839,622	$0	$2,874,394	($11,151)	$0
07. Department of Human Services Medicaid-Funded Programs, (D) Division of Child Welfare - Medicaid Funding - Child Welfare Services	**Total**	**$15,197,702**	**$0**	**$15,197,702**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,568,456	$0	$7,568,456	$30,395	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$7,629,246	$0	$7,629,246	($30,395)	$0
07. Department of Human Services Medicaid-Funded Programs, (E) Office of Early Childhood - Medicaid Funding - Div of Comm. and Family Support, Early Intervention Services	**Total**	**$6,563,353**	**$0**	**$6,563,353**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,268,550	$0	$3,268,550	$13,758	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,294,803	$0	$3,294,803	($13,758)	$0
07. Department of Human Services Medicaid-Funded Programs, (G) Behavioral Health Services - Medicaid Funding - Mental Health Treatment Services for Youth (H.B. 99-1116)	**Total**	**$123,624**	**$0**	**$123,624**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$61,565	$0	$61,565	$247	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$62,059	$0	$62,059	($247)	$0
07. Department of Human Services Medicaid-Funded Programs, (G) Behavioral Health Services - Medicaid Funding - High Risk Pregnant Women Program	**Total**	**$1,600,000**	**$0**	**$1,600,000**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$796,800	$0	$796,800	$3,200	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$803,200	$0	$803,200	($3,200)	$0

	Total	**$6,693,980**	**$0**	**$6,693,980**	**$0**	**$0**
07. Department of Human Services Medicaid-Funded Programs, (G) Behavioral Health Services - Medicaid Funding - Mental Health Institutes	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,333,602	$0	$3,333,602	$13,388	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,360,378	$0	$3,360,378	($13,388)	$0
	Total	**$53,235,691**	**$0**	**$53,319,797**	**$0**	**$0**
07. Department of Human Services Medicaid-Funded Programs, (H) Services for People with Disabilities - Medicaid Funding - Regional Centers	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$24,645,233	$0	$24,687,288	$106,471	$0
	CF	$1,866,142	$0	$1,866,142	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$26,724,316	$0	$26,766,367	($106,471)	$0
	Total	**$1,102,033**	**$0**	**$1,102,033**	**$0**	**$0**
07. Department of Human Services Medicaid-Funded Programs, (H) Services for People with Disabilities - Medicaid Funding - Regional Center Depreciation and Annual Adjustments	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$542,310	$0	$542,310	$8,707	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$559,723	$0	$559,723	($8,707)	$0
	Total	**$1,452,654**	**$0**	**$1,452,654**	**$0**	**$0**
07. Department of Human Services Medicaid-Funded Programs, (J) Division of Youth Corrections - Medicaid Funding - Division Of Youth Corrections - Medicaid Funding	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$723,422	$0	$723,422	$2,905	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$729,232	$0	$729,232	($2,905)	$0

CF Letternote Text Revision Required?	Yes X No ___	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes X No ___	
FF Letternote Text Revision Required?	Yes ___ No X	
Requires Legislation?	Yes ___ No X	
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	
Interagency Approval or Related Schedule 13s:	None	

Cost and FTE

- The Department requests an increase of $0 total funds, including an increase of $253,832 General Fund, $574,855 cash funds, $6,020 reappropriated funds, and a decrease of $834,707 in federal funds for FY 2017-18 to account for a decrease in the state's Federal Medical Assistance Percentage (FMAP).

Current Program

- Pursuant to Section 1905(b) of the Social Security Act, a state's FMAP is a function of the state's per capita personal income relative to national per capita personal incomes.
- FMAP is determined by the Secretary of Health and Human Services each year; historically, Colorado's FMAP has been 50%, with the exception of years when the FMAP was temporarily increased to combat the effects of recession and, most recently, FY 2014-15 through FY 2016-17 when the FMAP was increased because the State's per capita personal income was below the national average.

Problem or Opportunity

- The Department anticipates a decrease of 0.02% points to its FMAP, resulting in an FMAP of 50.00%, effective October 2017 through September 2018. This corresponds with a decrease in the state fiscal year FMAP from 50.20% in FY 2016-17 to 50.00% in FY 2017-18[1].
- The decrease in FMAP is not accounted for in several line items in the November 1, 2016 request. These line items are from the (1) Executive Director's Office, (5) Indigent Care Program, (6) Other Medical Services, and (7) Department of Human Services Medicaid-Funded Programs Long Bill groups.

Consequences of Problem

- The previously assumed FMAP of 50.20% for FY 2017-18 understates the need for General Fund, cash funds, and reappropriated funds, and additional state funding is necessary to continue providing services for Medicaid clients.

Proposed Solution

- The Department requests a decrease in the federal funds appropriation and an increase in General Fund, cash funds, and reappropriated funds for FY 2017-18 to account for the decreased FMAP.

[1] The FMAP by state fiscal year is calculated as one quarter of the previous federal fiscal year FMAP and three quarters of the current federal fiscal year FMAP. This is due to FMAP changes going into effect on the federal fiscal year on October 1, which is one quarter through the state fiscal year.

Department Priority:	***R-14***
Request Detail:	***Federal Medical Assistance Percentage***

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Federal Medical Assitance Percentage	$0	$253,832

Problem or Opportunity:

Currently, the Federal Medical Assistance Percentage (FMAP) is 50.02% for most Medicaid programs, with an average FMAP of 50.20% for FY 2016-17. Pursuant to section 1905(b) of the Social Security Act, a state's FMAP is a function of the state's per capita personal income relative to national per capita personal incomes. Each state's FMAP is evaluated annually and can range from 50.00% to 83.00%. Based on information from the Bureau of Economic Analysis, the Department estimates an FMAP of 50.00% for FY 2017-18.

In FY 2013-14, the Department received notification from CMS of an increased FMAP for FFY 2014-15, primarily due to the income losses experienced in Colorado during the recession. According to income data released by the Bureau of Economic Analysis, Colorado experienced a larger per capita personal income decline in 2009 than the nation overall, and a smaller growth rate in 2010. This caused the gap between Colorado's per capita personal income and the national per capita personal income to shrink; although Colorado's per capita personal income had grown faster than the national average in 2011 and 2012, the declines from prior years triggered an increase in FMAP over 50.00% through FFY 2016-17. Because the formula to calculate the State's FMAP and eFMAP uses the average of the most recent three years of per capita income, the declines related to the recession are no longer a factor in the FMAP calculation.[2] Consequently, the State's FMAP is expected to remain at 50.00% in FFY 2017-18 and ongoing.

[2] The formula for FMAP is: $\text{FMAP}_{state} = 1 - \left[\left(\frac{Per\ Capita\ Income_{Colorado}{}^{2}}{Per\ Capita\ Income_{U.S.}{}^{2}}\right) \times 0.45\right]$. The per capita income statistics are the average of the most recent 3 years of data published by the Bureau of Economic Analysis

Per Capita Personal Income 2006-2015				
Year	**National**	**Percent Change**	**Colorado**	**Percent Change**
2006	$38,144		$40,709	
2007	$39,821	4.40%	$42,265	3.82%
2008	$41,082	3.17%	$43,631	3.23%
2009	$39,376	-4.15%	$41,508	-4.87%
2010	$40,277	2.29%	$41,877	0.89%
2011	$42,453	5.40%	$44,349	5.90%
2012	$44,266	4.27%	$46,402	4.63%
2013	$44,438	0.39%	$46,746	0.74%
2014	$46,049	3.63%	$48,869	4.54%
2015	$47,669	3.52%	$50,410	3.15%

Source: Bureau of Economic Analysis

Proposed Solution:

The Department requests an increase in State funding due to the decrease in FMAP to continue to provide services for Medicaid clients. This specific request only accounts for line items in which the new FMAP is not factored into the line item's respective November 1, 2016 request. The decreased Federal Medical Assistance Percentage (FMAP) request accounts for changes in FMAP for certain line items from the (1) Executive Director's Office, (5) Indigent Care Program, (6) Other Medical Services, (7) Department of Human Services Medicaid-Funded Programs. Line items from (2) Medical Services Premiums, (3) Behavioral Health Community Programs, (4) Office of Community, and Children's Basic Health Plan Medical and Dental Costs already fully account for the decrease in FMAP in their respective November 1, 2016 requests.

The Department requests an increase of $0 total funds, including an increase of $253,832 General Fund, $574,855 cash funds and $6,020 reappropriated funds and a decrease of $834,707 federal funds for FY 2017-18.

Anticipated Outcomes:

Additional funding is required for the Department to continue providing services to Medicaid clients.

Assumptions and Calculations:

The Department assumes that only medical assistance payments will be eligible for the increased FMAP; expenditure classified as administrative is ineligible. It is unclear how the relationship between Colorado's per capita personal income and national personal per capita income may change in the future. Therefore, the Department anticipates that it would use the regular budget process in subsequent years to account for any future changes to FMAP.

Please see the Appendix for detailed calculations.

Table 1: FY 2017-18 Incremental Request for Change in Federal Medical Assistance Percentage					
Line Item	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer from Department of Human Services for Nurse Home Visitor Program	$0	$0	$0	$6,020	($6,020)
(5) Indigent Care Program; Safety Net Provider Payments	$0	$0	$574,855	$0	($574,855)
(5) Indigent Care Program; Clinic Based Indigent Care	$0	$12,240	$0	$0	($12,240)
(5) Indigent Care Program; Pediatric Specialty Hospital	$0	$26,910	$0	$0	($26,910)
(6) Other Medical Services; Commission on Family Medicine Residency Training Programs	$0	$12,345	$0	$0	($12,345)
(6) Other Medical Services; State University Teaching Hospitals - Denver Health and Hospital Authority	$0	$5,609	$0	$0	($5,609)
(6) Other Medical Services; State University Teaching Hospitals - University of Colorado Hospital Authority	$0	$5,212	$0	$0	($5,212)
(7) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding	$0	$1,294	$0	$0	($1,294)
(7) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	$0	$11,151	$0	$0	($11,151)
(7) Department of Human Services Medicaid-Funded Programs; (D) Division of Child Welfare - Medicaid Funding, Child Welfare Services	$0	$30,395	$0	$0	($30,395)
(7) Department of Human Services Medicaid-Funded Programs; (E) Office of Early Childhood - Medicaid Funding; Division of Community and Family Support, Early Intervention Services	$0	$13,758	$0	$0	($13,758)
(7) Department of Human Services Medicaid-Funded Programs; (G) Behavioral Health Services - Medicaid Funding, Mental Health Treatment Services for Youth (H.B. 99-1116)	$0	$247	$0	$0	($247)
(7) Department of Human Services Medicaid-Funded Programs; (G) Behavioral Health Services - Medicaid Funding, High Risk Pregnant Women Program	$0	$3,200	$0	$0	($3,200)
(7) Department of Human Services Medicaid-Funded Programs; (G) Behavioral Health Services - Medicaid Funding, Mental Health Institutes	$0	$13,388	$0	$0	($13,388)
(7) Department of Human Services Medicaid-Funded Programs; (H) Services for People with Disabilities - Medicaid Funding, Regional Centers	$0	$106,471	$0	$0	($106,471)
(7) Department of Human Services Medicaid-Funded Programs; (H) Services for People with Disabilities - Medicaid Funding, Depreciation and Annual Adjustments	$0	$8,707	$0	$0	($8,707)
(7) Department of Human Services Medicaid-Funded Programs; (J) Division of Youth Corrections - Medicaid Funding	$0	$2,905	$0	$0	($2,905)
Total	**$0**	**$253,832**	**$574,855**	**$6,020**	**($834,707)**

[1] Cash funds source is the Hospital Provider Fee.

Table 2: FY 2017-18 Requested Spending Authority with Change in Federal Medical Assistance Percentage						
Line Item	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**FMAP**
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer from Department of Human Services for Nurse Home Visitor Program	$3,010,000	$0	$0	$1,505,000	$1,505,000	50.00%
(5) Indigent Care Program; Safety Net Provider Payments	$311,296,186	$0	$155,648,093	$0	$155,648,093	50.00%
(5) Indigent Care Program; Clinic Based Indigent Care	$6,119,760	$3,059,880	$0	$0	$3,059,880	50.00%
(5) Indigent Care Program; Pediatric Specialty Hospital	$13,455,012	$6,727,506	$0	$0	$6,727,506	50.00%
(6) Other Medical Services; Commission on Family Medicine Residency Training Programs	$7,597,298	$3,798,649	$0	$0	$3,798,649	50.00%
(6) Other Medical Services; State University Teaching Hospitals - Denver Health and Hospital Authority	$2,804,714	$1,402,357	$0	$0	$1,402,357	50.00%
(6) Other Medical Services; State University Teaching Hospitals - University of Colorado Hospital Authority	$1,181,204	$590,602	$0	$0	$590,602	50.00%
(7) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding	$647,220	$323,610	$0	$0	$323,610	50.00%
(7) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	$5,656,943	$2,828,472	$0	$0	$2,828,471	50.00%
(7) Department of Human Services Medicaid-Funded Programs; (D) Division of Child Welfare - Medicaid Funding, Child Welfare Services	$15,197,702	$7,598,851	$0	$0	$7,598,851	50.00%
(7) Department of Human Services Medicaid-Funded Programs; (E) Office of Early Childhood - Medicaid Funding; Division of Community and Family Support, Early Intervention Services	$6,958,957	$3,479,479	$0	$0	$3,479,478	50.00%
(7) Department of Human Services Medicaid-Funded Programs; (G) Behavioral Health Services - Medicaid Funding, Mental Health Treatment Services for Youth (H.B. 99-1116)	$123,624	$61,812	$0	$0	$61,812	50.00%
(7) Department of Human Services Medicaid-Funded Programs; (G) Behavioral Health Services - Medicaid Funding, High Risk Pregnant Women Program	$1,600,000	$800,000	$0	$0	$800,000	50.00%
(7) Department of Human Services Medicaid-Funded Programs; (G) Behavioral Health Services - Medicaid Funding, Mental Health Institutes	$6,693,980	$3,346,990	$0	$0	$3,346,990	50.00%
(7) Department of Human Services Medicaid-Funded Programs; (H) Services for People with Disabilities - Medicaid Funding, Regional Centers	$53,235,691	$24,751,704	$1,866,142	$0	$26,617,845	50.00%
(7) Department of Human Services Medicaid-Funded Programs; (H) Services for People with Disabilities - Medicaid Funding, Depreciation and Annual Adjustments	$1,102,033	$551,017	$0	$0	$551,016	50.00%
(7) Department of Human Services Medicaid-Funded Programs; (J) Division of Youth Corrections - Medicaid Funding	$1,452,654	$726,327	$0	$0	$726,327	50.00%
Total	**$454,242,851**	**$68,102,193**	**$157,514,235**	**$1,505,000**	**$227,121,423**	

[1] Cash funds source is the Hospital Provider Fee.

Table 3: FY 2017-18 Current Spending Authority by Line Item						
Line Item	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**FMAP**
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer from Department of Human Services for Nurse Home Visitor Program	$3,010,000	$0	$0	$1,498,980	$1,511,020	50.20%
(5) Indigent Care Program; Safety Net Provider Payments	$311,296,186	$0	$155,073,238	$0	$156,222,948	50.18%
(5) Indigent Care Program; Clinic Based Indigent Care	$6,119,760	$3,047,640	$0	$0	$3,072,120	50.20%
(5) Indigent Care Program; Pediatric Specialty Hospital	$13,455,012	$6,700,596	$0	$0	$6,754,416	50.20%
(6) Other Medical Services; Commission on Family Medicine Residency Training Programs	$7,597,298	$3,786,304	$0	$0	$3,810,994	50.16%
(6) Other Medical Services; State University Teaching Hospitals - Denver Health and Hospital Authority	$2,804,714	$1,396,748	$0	$0	$1,407,966	50.20%
(6) Other Medical Services; State University Teaching Hospitals - University of Colorado Hospital Authority	$1,181,204	$585,390	$0	$0	$595,814	50.44%
(7) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding	$647,220	$322,316	$0	$0	$324,904	50.20%
(7) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	$5,656,943	$2,817,321	$0	$0	$2,839,622	50.20%
(7) Department of Human Services Medicaid-Funded Programs; (D) Division of Child Welfare - Medicaid Funding, Child Welfare Services	$15,197,702	$7,568,456	$0	$0	$7,629,246	50.20%
(7) Department of Human Services Medicaid-Funded Programs; (E) Office of Early Childhood - Medicaid Funding; Division of Community and Family Support, Early Intervention Services	$6,958,957	$3,465,721	$0	$0	$3,493,236	50.20%
(7) Department of Human Services Medicaid-Funded Programs; (G) Behavioral Health Services - Medicaid Funding, Mental Health Treatment Services for Youth (H.B. 99-1116)	$123,624	$61,565	$0	$0	$62,059	50.20%
(7) Department of Human Services Medicaid-Funded Programs; (G) Behavioral Health Services - Medicaid Funding, High Risk Pregnant Women Program	$1,600,000	$796,800	$0	$0	$803,200	50.20%
(7) Department of Human Services Medicaid-Funded Programs; (G) Behavioral Health Services - Medicaid Funding, Mental Health Institutes	$6,693,980	$3,333,602	$0	$0	$3,360,378	50.20%
(7) Department of Human Services Medicaid-Funded Programs; (H) Services for People with Disabilities - Medicaid Funding, Regional Centers	$53,235,691	$24,645,233	$1,866,142	$0	$26,724,316	50.20%
(7) Department of Human Services Medicaid-Funded Programs; (H) Services for People with Disabilities - Medicaid Funding, Depreciation and Annual Adjustments	$1,102,033	$542,310	$0	$0	$559,723	50.79%
(7) Department of Human Services Medicaid-Funded Programs; (J) Division of Youth Corrections - Medicaid Funding	$1,452,654	$723,422	$0	$0	$729,232	50.20%
Total	**$454,242,851**	**$67,848,361**	**$156,939,380**	**$1,498,980**	**$227,956,130**	

[1] Cash funds source is the Hospital Provider Fee.

Cost and FTE

- The Department is providing an informational-only estimate for the cost of eliminating the Home and Community Based Services – Adult Comprehensive Waiver (HCBS-DD) waiting list. The Department estimates it would require $29,301,994 total funds, including $14,648,078 General Fund and 0.9 FTE in FY 2017-18 and $93,407,513 total funds, including $46,703,760 General Fund and 1.0 FTE in FY 2018-19, $160,697,025 total funds, $80,348,515 General Fund and 1.0 FTE in FY 2019-20, and $190,383,350 total funds, $95,191,678 General Fund and 1.0 FTE in FY 2020-21 to eliminate the enrollment cap for the HCBS-DD Waiver and eliminate the waitlist by July 1, 2020.

Current Program

- The HCBS-DD waiver provides services to adults with developmental disabilities who require access to support 24 hours a day to live safely in the community and who do not have the resources available to meet their needs through other means.
- The HCBS-DD waiver enables individuals with developmental disabilities who require access to support 24 hours a day to live in a non-institutional community setting and who would require a more restrictive and more expensive facility if not for the receipt of that support.

Problem or Opportunity

- As of September 2016, there are 2,310 people on the waiting list for HCBS–DD services.
- HB 14-1051 "Developmental Disability Services Strategic Plan" required the Department to develop a comprehensive strategic plan to enroll eligible persons with intellectual and developmental disabilities into home- and community-based services programs at the time those persons choose to enroll in the programs or need the services or supports. The bill required the Department to submit annual strategic plans that include specific recommendations and annual benchmarks for achieving the enrollment goal by July 1, 2020, including recommendations relating to increasing system capacity.
- The Department requested and received funding to eliminate the waiting lists for the Home and Community Based Services - Children's Extensive Support Waiver (HCBS-CES) and the Home and Community Based Services – Supported Living Services Waiver (HCBS-SLS). Elimination of the HCBS-DD waiting list would allow the Department to continue phasing-in enrollment of HCBS-DD waitlist to achieve the goal of providing access to all eligible individuals by July 1, 2020.

Consequences of the Problem

- The number of individuals waiting for services continues to increase each year. Without additional enrollments each year, people with intellectual and developmental disabilities are likely to access other less appropriate, more costly settings or become vulnerable to abuse, neglect or homelessness.
- The Department would not be able to begin phasing-in enrollment of thousands of individuals currently waiting for the HCBS-DD waiver in order to achieve the goal of providing access to all eligible individuals by July 1, 2020, as required by HB 14-1051.

Proposed Solution

- The Department is providing a cost estimate for eliminating the waiting list for the HCBS-DD waiver by July 1, 2020 by enrolling clients over a three year period starting in FY 2017-18. Eliminating the waiver cap would enable people to receive needed services to live safe and self-determined lives in their own homes and communities.

Department Priority: ***R-I-1 (Informational Only)***
Request Detail: ***Elimination of the HCBS-DD Waiting List***

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Elimination of the HCBS-DD Waiting List	$29,301,994	$14,648,078

Problem or Opportunity:

As of September 30, 2016, 2,310 people with developmental disabilities are waiting for needed services on the Home and Community Based Services – Adult Comprehensive Waiver (HCBS-DD) waiting list. Individuals waiting to receive services may experience deterioration in their medical or behavioral conditions, their caregivers may struggle to continue to provide supports, and their quality of life may suffer as a result of not being able to obtain the services they need. Providing services addresses all aspects of health, safety and quality of life for these individuals. The waiting list currently includes those requiring emergency enrollments as well as those transitioning out of institutional settings. Additionally, the list may include current Medicaid recipients being served in an alternative waiver that does not fully meet their needs, and may also include individuals being served in nursing facilities or hospitals that are not as cost-effective as the HCBS waivers.

The HCBS-DD program provides services to adults with developmental disabilities who require access to support to live safely in the community and who do not have the resources available to meet their needs. The HCBS-DD waiver provides access to 24-hour, seven days a week supervision through Residential Habilitation, Day Habilitation Services, Supported Employment, Behavior Services, and Non-Medical Transportation, as well as other services. The Residential Habilitation benefit ensures the health and safety of individuals while assisting in the acquisition, retention or improvement of skills to support individuals to live in the community. The Day Habilitation Services includes assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills. Budgetary limitations restrict Colorado's ability to serve all individuals who are eligible for and in need of the services and supports described above. Consequently, many individuals are placed on waiting lists which often results in receiving services and supports that are not best suited to their specific needs and preferences which puts them at risk for needing costly institutional care.

The existing waiting list provides limited opportunities for individuals in non-emergent situations to exit the waiting list and enroll in the HCBS-DD waiver. Each year, additional enrollments in the HCBS-DD waiver are needed to provide enrollments for emergency situations, individuals transitioning out of foster care, from

the youth waiver (HCBS-CES), individuals transitioning from an institution who do not qualify for or do not want Colorado Choice Transition (CCT) or CCT clients transitioning from an institutional setting. Otherwise, clients are added to the waiting list in hopes that someone leaves the waiver which may open up an enrollment for them. Without enrollments each year, people with intellectual and developmental disabilities are likely to transition to other less appropriate, more costly settings such as Intermediate Care Facilities at the state operated Regional Centers, private sector, or nursing facilities. Without waiver services, many individuals rely on family and friends to help provide needed support. If family and friends are no longer able to provide needed support or services, the individual may become vulnerable to abuse, neglect, or homelessness.

Additionally, the longer an individual has to wait for appropriate services, the more likely they are to have an emergency situation. While these situations can result in immediate waiver enrollment, the emergency may burden the individual, the individual's family or caretakers by experiencing a dire medical or living situation that may have been avoided if the individual had been receiving the appropriate level of care and services. These situations may also burden the Department because emergency enrollments inhibit the Department's ability to enroll non-emergent cases. Therefore, the waiting list keeps growing and individuals can be part of the waiting list for multiple years unless they have an emergency which results in an enrollment. In FY 2015-16 the Department received funding for 40 emergency enrollments but due to attrition was able to approve 183 emergency requests which took precedence over individuals on the waiting list. Emergency enrollments are reserved for individuals who meet certain criteria including but not limited to: homelessness, is a danger to others, or is a danger to self.

In addition, HB 14-1051 "Developmental Disability Services Strategic Plan" requires the Department to develop, in consultation with intellectual and developmental disability system stakeholders, a comprehensive strategic plan to meet the enrollment goal by July 1, 2020 to ensure that Coloradans with intellectual and developmental disabilities and their families will be able to access the services and supports they need and want at the time they need and want those services and supports. The Department submitted the first strategic plan in 2014 and provides annual updates to that plan with information on additional legislation and initiatives that support the legislative direction of HB 14-1051 "Developmental Disability Services Strategic Plan", implementation of the strategic plan, and information detailing the total number of persons with intellectual and development disabilities waiting for enrollment into a Medicaid or State funded program.

The most recent strategic plan was submitted on November 1, 2016 and showed that while the waiting list for the HCBS-DD waiver continued to grow, nearly 300 individuals were enrolled from the waiting list over the past year. The strategic plan describes four initiatives to improve waiver processes and provides status updates on deliverables that support the four initiatives. Additional funding would allow the Department to begin phasing-in enrollments of the thousands of individuals currently waiting for the HCBS-DD waiver in order to achieve the goal of providing access to all eligible individuals by July 1, 2020.

The Department has sufficient funding to enroll all clients currently waiting for the HCBS-SLS waiver. Significant progress has been made to enroll clients needing services immediately into the HCBS-SLS waiver and the Department expects that progress to continue. All enrollments have been authorized and the Community Centered Boards (CCBs) are currently working to get all eligible individuals enrolled. Eliminating the HCBS-SLS waiting list has provided many adults with intellectual and developmental

disabilities services, however, a number of them continue to wait on the HCBS-DD waiting list for services that would better meet their needs.

Proposed Solution:

The Department estimates eliminating the enrollment cap for the HCBS-DD waiver and eliminating the waiting list by July 1, 2020 would require $29,301,994 total funds, including $14,648,078 General Fund and 0.9 FTE in FY 2017-18 and $93,407,513 total funds, including $46,703,760 General Fund and 1.0 in FY 2018-19, $160,697,025 total funds, $80,348,515 General Fund and 1.0 FTE in FY 2019-20, and $190,383,350 total funds, $95,191,678 General Fund and 1.0 FTE in FY 2020-21. To eliminate the waiting list by the aforementioned deadline, the Department would need to provide approximately 1,033 new enrollments each year until the waiting list is eliminated by July 1, 2020. Funding would be ongoing and would require amendments to the HCBS-DD waiver to eliminate the enrollment cap.

Eliminating the HCBS-DD waiting list would address the Department's goal of serving the needs of individuals with intellectual or developmental disabilities in the least restrictive setting. Without additional funds, people with intellectual or developmental disabilities will wait for an enrollment to become available through attrition, which cannot keep up with demand, therefore growing the waiting list for HCBS-DD services. If individuals could come off the waitlist and could enroll in the waiver, they would start to receive the appropriate level of service for their individual needs and could avoid emergency situations which put their lives and wellbeing at risk. This support would enable Coloradans to reside in communities of their choosing and in the least restrictive settings possible and would lower individuals' risk of having to enter a more costly institutional setting.

In eliminating the waiting list there are a number of costs that would be incurred in order for individuals to be enrolled at a pace that would eliminate the waiting list by July 1, 2020. The Department currently contracts with CCBs to enroll and provide case management, Quality Assurance (QA), Utilization Review (UR) services and Supports Intensity Scale (SIS) assessments for HCBS-DD participants. These costs would need to be included for all newly enrolled clients receiving HCBS waiver services for adults with intellectual and development disabilities and are provided on a monthly, yearly, or periodic basis for members.

The Department pays QA monthly costs for each client related to performance of Quality Improvement Strategy (QIS) activities as well as the mechanisms for overall quality assurance and system improvement. Such activities include application of policies and procedures for the resolution of complaints and grievances, critical incident reporting and response, and the assessment and reporting of process and outcome performance measures. The Department pays UR costs on a monthly basis for each client. UR activities include the implementation of processes to ensure that waiver services have been authorized in conformance to waiver requirements and monitoring service utilization to ensure that the amount of services is within the levels authorized in the service plan. The Department performs a support level needs assessments for adults with intellectual and development disabilities. The assessment tool currently in use is the Supports Intensity Scale (SIS). This assessment tool may change, however, as an outcome of work underway for SB 16-192 "Assessment Tool Intellectual & Developmental Disabilities". This legislation requires the Department, with stakeholder input, to develop or select a needs assessment tool for all long-term services and supports on or before July 1, 2018. The selection process will determine whether the Department will continue to use the

SIS or a different tool if selected. The SIS assesses an individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The SIS also measures Exceptional Medical and Behavioral Support Needs. SIS costs are calculated by assuming that all new enrollments will receive an assessment as well as 10% of existing enrollments who will request additional assessments each year. The Department pays $13.88 per online assessment to contract with the American Association on Intellectual and Development Disabilities (AAIDD) to use the AAIDD SISOnline™ system.

In addition to funding needed for the CCBs, the Department estimates an additional 1.0 permanent FTE at the Administrator IV level would be required to oversee case management, waitlist coordination, and reporting. During the buy down of the HCBS-SLS and HCBS-CES waivers, the Department did not request additional FTE. Overall workload in the Department has increased as enrollments increased, including enrollment and waiting list management, case management training, SIS and support level training, critical incident management and reporting, complaints and investigations, quality and performance reviews, federal and evidentiary reporting, Prior Authorization Request (PAR) approvals, and technical assistance. Managing the waiting lists requires additional support in order to ensure clients are enrolled in the most efficient and effective way. As of September 30, 2016 the Department was serving approximately 5,000 individuals through the HCBS-DD waiver, with 2,310 currently on the waiting list for HCBS-DD waiver services. If waiting list elimination began, there would be an increase of over 50% in program enrollment by the year 2020. The Department estimates an additional FTE would be needed to support this increase in workload and new projects related to the overall increase in enrollments for all three waivers operated by the Division for Intellectual and Developmental Disabilities (DIDD).

This position would work as the staff authority on increasing the effectiveness and efficiency of the CCB enrollment process. Increased effectiveness and efficiency would ensure that individuals on the waiting list would be able to receive services in a timely manner after gaining authorization to enroll in the waiver. The FTE would review and update existing policies, procedures, and practices governing the enrollment process for all DIDD HCBS waivers and recommend process improvements. The position would identify areas of weakness by examining areas of statute, waiver, and/or regulation that needs to be revised to ensure timely enrollments occur in order to eliminate the waiting list by July 1, 2020. Additionally, the position would identify where the Department needs to provide training or updates to IT systems due to missing data. Another responsibility of the FTE would be to identify best practices that would inform regulation, case manager training, and business processes for case management agencies.

This position would provide technical assistance to CCBs as they process new enrollments and identify training needs and provide training statewide and CCB specific as needed. This position would act as the lead monitor for enrollment operations, identifying any enrollment issues that occur, and through desk and on-site reviews, would ensure that all individuals are provided a person centered planning process which includes free choice of qualified and willing providers. The position would review processes at case management agencies and identify through trend analysis the agencies that are taking longer than others to enroll individuals. The Department estimates this FTE would need to start July 1, 2017 for training purposes in anticipation of the implementation date of October 1, 2017. This would need to be a permanent position because additional enrollments represent ongoing workload as described above.

Anticipated Outcomes:

By funding enrollments for the number of individuals projected to be waiting and in need of services by July 1, 2020, individuals who currently are not able to access needed services would have access as their needs dictate.

With increased access, there is potential that fewer individuals on the waitlist would need emergency or more expensive alternative services because more individuals would be receiving the appropriate level of care and support in the community. This anticipated reduction in emergency enrollments would help mitigate the consequences to the individual and their caretakers or family. Having the ability to enroll from the waiting list in a timely manner could reduce the number of cases of individuals ending up in inappropriate or unfortunate circumstances because they are not receiving the services they need at the time that they need. Allowing more individuals on the waiting list authorization to enroll in the waiver gives clients the opportunity to choose between home and community based care or more restrictive entitlement care like an institution or a nursing home. The Department believes that clients will more often choose the home and community based care when given this choice, therefore keeping more clients out of more costly and restrictive institutions.

Assumptions and Calculations:

Based on FY 2015-16 and FY 2016-17 HCBS-DD waiting list data, the Department estimated waiting list numbers through the end of FY 2020-21 by calculating the number of average monthly waiting list additions. Using these estimates, the Department projected that 3,101 individuals would be waiting for HCBS-DD waiver services by June 30, 2020. In order to eliminate the waiting list by July 1, 2020, enrollment implementation is estimated to begin October 1, 2017 with approximately 846 enrollments occurring in the FY 2017-18 and just over 1,100 occurring in FY 2018-19 and FY 2019-20.

In order to eliminate the HCBS-DD waiting list, the Department would be required to amend its waiver application with the Centers for Medicare and Medicaid Services (CMS). This waiver amendment would take approximately 30 days for public comment and three months for CMS approval.

The Department estimates that approximately 846 clients would enroll within the first year of eliminating the waiver cap, assuming an October 1, 2017 implementation date. Approximately 1,100 enrollments from the waitlist would continue in FY 2018-19 and FY 2019-20 until the waiting list is eliminated by July 1, 2020. Because of the challenges faced when providing services to this many individuals, adjustments may need to be made in future budget processes in order to ensure provider capacity.

The Department assumes clients would enroll into the HCBS-DD waiver at a rate of approximately 94 enrollments each month which accounts for waiver attrition. The Department assumes there would be a lag between when an individual is authorized to join the waiver and when the individual begins receiving services because it takes time to find providers and to coordinate care after authorization and before enrollment. The Department assumes a linear monthly trend because the length of this lag is unique to the individual and there is no reliable trend showing a pattern for monthly enrollments. In order to capture the full cost of eliminating the waitlist, the Department has included projections through FY 2020-21 to incorporate an entire year's worth of service for each client. Inclusion of FY 2020-21 is necessary to capture the costs of clients who

would enroll in June 2020 and would only have one month's cost by the time the waitlist is eliminated on July 1, 2020. Additionally, this cost estimate only shows the impact of eliminating the HCBS-DD waiting list by July 1, 2020. It does not estimate the additional impact of continued enrollments once the waiting list is eliminated. Resources for these enrollments would need to occur during future budget processes to maintain elimination of the waiting list.

The Department assumes the new enrollments would be a mix of individuals receiving some type of Medicaid services and individuals not receiving any Medicaid services. May 2016 data showed approximately 81% of current HCBS-DD waitlist clients were receiving some sort of services either through other HCBS waivers or the state plan, with 19% of current waitlist individuals not receiving any type of medical service through the State. Approximately 70% of clients on the HCBS-DD waiting list are currently receiving HCBS-SLS services. Another 6% of waiting list clients are receiving services through the Home and Community Based Services – Elderly, Blind, and Disabled Waiver (HCBS-EBD) and the remaining 5% of the waiting list are receiving State Plan services only. The waiting list forecast was determined using May 2016 data because it was the most recent information and showed which services DD waiting list individuals received during the first ten months of FY 2015-16. Therefore, it was possible to see if individuals had received any type of services during the year, had switched between service types, or received services from the State's Medicaid program.

To estimate costs per enrollee the Department utilized existing rates and average costs for a number of services including QA, UR, SIS, the AAIDD contract, capacity building, and annual waiver service costs. With the passage of SB 16-192, the assessment tool selection process will determine whether the Department will continue to use the SIS or a different tool if selected. Because the implementation of a new needs assessments tool is unknown, the Department used existing SIS costs as a proxy for what might be needed after SB 16-192 is implemented. Because some individuals on the waiting list are already receiving services, the Department's estimate accounts for which services clients are currently receiving. Waiver costs are calculated using the difference between the estimated annual cost of the HCBS-DD waiver and estimated waiver costs of the current service the client was receiving in May 2016 (i.e. HCBS-SLS, HCBS-EBD, or State Plan). Therefore, the projected cost for clients not receiving any services would just be the estimated HCBS-DD waiver cost. The estimated annual cost for clients currently on HCBS-SLS is the difference between HCBS-DD annual cost and HCBS-SLS annual cost. These estimated costs were adapted from the FY 2016-17 S-5 Office of Community Living Cost and Caseload Adjustments request.

The Department estimates that eliminating the waiting list would require additional funding to go toward CCBs for capacity building for newly enrolled clients to ensure that once clients are authorized to enroll in the waiver, they would be able to receive the necessary services in a timely manner. Additionally, the CCBs require funds in order to recruit, hire and train additional staff necessary to enroll individuals and assist these individuals in accessing services. The CCBs provided information in FY 2014-15 when the HCBS-SLS waitlist was eliminated indicating the costs associated with these new staff to be $1,098 per enrollment. The Department adjusted this rate for inflation and therefore estimates CCBs would need $1,117 per individual on the HCBS-DD waiting list. The costs associated with additional staff includes an estimated 9% overhead for the CCBs. This per individual figure would be distributed during a client's enrollment year to the CCBs and does not include funding for the HCBS-DD service providers. The Department assumes this cost should

be applied to every enrollment, no matter which service they are currently receiving because they would be receiving a different set of services through the HCBS-DD waiver. Therefore, total cost for capacity building was estimated by multiplying $1,117 by the total number of new enrollments from the waitlist each year.

The Department estimates one additional FTE at an Administrator IV level would be necessary because the individual would be a staff authority on evaluating current practices, policies, and procedures surrounding the enrollment process for all DIDD HCBS waivers as well as other CCB actions like Request for Proposals (RFP) (the process to select a direct service agency). Additionally, the position would need to regularly make decisions at the process level and conduct data analysis to reach conclusions that result in work process development and improvement. This examination requires the application of known and established theory, principles, conceptual models, professional standards, and precedents in order to determine their relationship to the problem. The position would act as a consultant to the CCBs to review existing practices and would also provide technical assistance to the CCBs. This authority would directly influence management decisions within an agency. In order to execute the aforementioned tasks, the position is estimated to be at the Administrator IV level.

Table 1.1
Calculation of Fund Splits - FY 2017-18

Item	Total Funds	FTE	General Fund	Federal Funds	FMAP
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$7,927	0.9	$3,964	$3,963	50.00%
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$105	0	$53	$52	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$2,753	0	$1,377	$1,376	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$2,753	0	$1,377	$1,376	50.00%
(2) Medical Services Premiums	$602,480	0	$301,180	$301,300	50.01%
(4) Office of Community Living; (A); (1) Administrative Costs; Personal Services	$61,437	0	$30,719	$30,718	50.00%
(4) Office of Community Living; (A); (1) Administrative Costs; Operating Expenses	$5,573	0	$2,787	$2,786	50.00%
(4) Office of Community Living; (A); (1) Administrative Costs; Support Level Administration	$12,922	0	$6,460	$6,462	50.01%
(4) Office of Community Living; (2) Program Costs; Adult Comprehensive Services	$26,890,089	0	$13,442,355	$13,447,734	50.01%
(4) Office of Community Living; (2) Program Costs; Case Management	$770,973	0	$385,409	$385,564	50.01%
(4) Office of Community Living; (2) Program Costs; Eligibility Determination and Waiting List Management	$944,982	0	$472,397	$472,585	50.01%
Total Projected FY 2017-18 Expenditure	**$29,301,994**	**0.9**	**$14,648,078**	**$14,653,916**	

Table 1.2
Calculation of Fund Splits - FY 2018-19

Item	Total Funds	FTE	General Fund	Federal Funds	FMAP
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$7,927	1.0	$3,964	$3,963	50.00%
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$114	0.0	$57	$57	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$3,003	0.0	$1,502	$1,501	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$3,003	0.0	$1,502	$1,501	50.00%
(2) Medical Services Premiums	$16,964,349	0.0	$8,482,175	$8,482,174	50.00%
(4) Office of Community Living; (A); (1) Administrative Costs; Personal Services	$67,027	0.0	$33,514	$33,513	50.00%
(4) Office of Community Living; (A); (1) Administrative Costs; Operating Expenses	$950	0.0	$475	$475	50.00%
(4) Office of Community Living; (A); (1) Administrative Costs; Support Level Administration	$19,571	0.0	$9,786	$9,785	50.00%
(4) Office of Community Living; (2) Program Costs; Adult Comprehensive Services	$72,979,946	0.0	$36,489,973	$36,489,973	50.00%
(4) Office of Community Living; (2) Program Costs; Case Management	$2,101,647	0.0	$1,050,824	$1,050,823	50.00%
(4) Office of Community Living; (2) Program Costs; Eligibility Determination and Waiting List Management	$1,259,976	0.0	$629,988	$629,988	50.00%
Total Projected FY 2018-19 Expenditure	**$93,407,513**	**1.0**	**$46,703,760**	**$46,703,753**	

Table 1.3
Calculation of Fund Splits - FY 2019-20

Item	Total Funds	FTE	General Fund	Federal Funds	FMAP
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$7,927	1.0	$3,964	$3,963	50.00%
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$114	0.0	$57	$57	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$3,003	0.0	$1,502	$1,501	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$3,003	0.0	$1,502	$1,501	50.00%
(2) Medical Services Premiums	$3,480,782	0.0	$1,740,391	$1,740,391	50.00%
(4) Office of Community Living; (A); (1) Administrative Costs; Personal Services	$67,027	0.0	$33,514	$33,513	50.00%
(4) Office of Community Living; (A); (1) Administrative Costs; Operating Expenses	$950	0.0	$475	$475	50.00%
(4) Office of Community Living; (A); (1) Administrative Costs; Support Level Administration	$19,946	0.0	$9,973	$9,973	50.00%
(4) Office of Community Living; (2) Program Costs; Adult Comprehensive Services	$152,387,628	0.0	$76,193,814	$76,193,814	50.00%
(4) Office of Community Living; (2) Program Costs; Case Management	$3,467,786	0.0	$1,733,893	$1,733,893	50.00%
(4) Office of Community Living; (2) Program Costs; Eligibility Determination and Waiting List Management	$1,258,859	0.0	$629,430	$629,429	50.00%
Total Projected FY 2019-20 Expenditure	**$160,697,025**	**1.0**	**$80,348,515**	**$80,348,510**	

Table 1.4
Calculation of Fund Splits - FY 2020-21

Item	Total Funds	FTE	General Fund	Federal Funds	FMAP
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$7,927	1.0	$3,964	$3,963	50.00%
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$114	0.0	$57	$57	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$3,003	0.0	$1,502	$1,501	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$3,003	0.0	$1,502	$1,501	50.00%
(2) Medical Services Premiums	$4,167,153	0.0	$2,083,577	$2,083,576	50.00%
(4) Office of Community Living; (A); (1) Administrative Costs; Personal Services	$67,027	0.0	$33,514	$33,513	50.00%
(4) Office of Community Living; (A); (1) Administrative Costs; Operating Expenses	$950	0.0	$475	$475	50.00%
(4) Office of Community Living; (A); (1) Administrative Costs; Support Level Administration	$4,303	0.0	$2,152	$2,151	50.00%
(4) Office of Community Living; (2) Program Costs; Adult Comprehensive Services	$182,326,028	0.0	$91,163,014	$91,163,014	50.00%
(4) Office of Community Living; (2) Program Costs; Case Management	$3,803,842	0.0	$1,901,921	$1,901,921	50.00%
Total Projected FY 2020-21 Expenditure	**$190,383,350**	**1.0**	**$95,191,678**	**$95,191,672**	

Table 2.1
Summary by Initiative

Row	Item	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	Notes
A	FTE	$80,548	$82,024	$82,024	$82,024	FTE Estimated Costs Worksheet
B	Quality Assurance (QA)	$41,045	$131,367	$232,122	$276,484	Total Annual QA Cost by Service Type (Table 3.1.1 - Table 3.4.1 Row A)
C	Utilization Review (UR)	$132,698	$424,705	$750,445	$893,872	Total Annual UR Cost by Service Type (Table 3.1.1 - Table 3.4.1 Row B)
D	AAIDD Contract	$12,922	$19,571	$19,946	$4,303	Total Annual AAIDD Cost by Service Type (Table 4.3 Row F)
E	Supports Intensity Scale (SIS) Assessments	$217,007	$328,657	$334,950	$72,258	Total Annual SIS Cost by Service Type (Table 4.3 Row C)
F	Targeted Case Management (TCM)	$380,223	$1,216,918	$2,150,269	$2,561,229	Total Annual TCM by Service Type (Table 3.1.1 - Table 3.4.1 Row C)
G	Waiver Costs	$26,890,089	$72,979,947	$152,387,628	$182,326,028	Total Annual Waiver Cost by Service Type (Table 3.1.1 - Table 3.4.1 Row D)
H	State Plan Costs	$602,480	$16,964,349	$3,480,782	$4,167,153	Total Annual State Plan Cost by Service Type (Table 3.1.1 - Table 3.4.1 Row E)
I	Capacity Building	$944,982	$1,259,976	$1,258,859	$0	Table 5.1 Row J
J	**Total Cost**	**$29,301,994**	**$93,407,513**	**$160,697,025**	**$190,383,350**	**Sum Rows A through I**

Table 3.1.1
Estimated Cost by Initiative for FY 2017-18

Row	Service	Currently Receiving No Services		Currently On State Plan Only		Currently On Home and Community Based Services – Supported Living Services (HCBS-SLS) Waiver		Currently On Home and Community Based Services – Elderly, Blind, or Disabled (HCBS-EBD) Waiver		Total	Notes
		New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments		
A	Quality Assurance (QA)	$25,351	$0	$7,847	$0	$0	$0	$7,847	$0	$41,045	QA Annual Cost/Client (Table 8.1) Row A * Estimated Caseload (Table 3.1.2)
B	Utilization Review (UR)	$81,960	$0	$25,369	$0	$0	$0	$25,369	$0	$132,698	UR Annual Cost/Client (Table 8.1) Row B * Estimated Caseload (Table 3.1.2)
C	Targeted Case Management (TCM)	$234,843	$0	$72,690	$0	$0	$0	$72,690	$0	$380,223	TCM Annual Cost/Client (Table 8.1) Row C * Estimated Caseload (Table 3.1.2)
D	Waiver Costs	$5,956,590	$0	$1,843,706	$0	$17,677,129	$0	$1,412,664	$0	$26,890,089	Annual Waiver Cost/Client (Table 8.1) Row D * Estimated Caseload (Table 3.1.2)
E	State Plan Costs	$602,480	$0	$0	$0	$0	$0	$0	$0	$602,480	State Plan Annual Cost/Client (Table 8.1) Row E * Estimated Caseload (Table 3.1.2)
F	**Total Cost for New or Existing Enrollment**	**$6,901,224**	**$0**	**$1,949,612**	**$0**	**$17,677,129**	**$0**	**$1,518,570**	**$0**	**$28,046,535**	**Sum Row A through Row E**

Table 3.1.2
2017-18 Estimated Caseload

Current Service	Average Monthly New Enrollments	Total FPE Enrollments from Previous Fiscal Year	Source
No Services	84	0	Table 6.1 Row C for fiscal year 2017-18
State Plan	26	0	Table 6.1 Row F for fiscal year 2017-18
SLS	314	0	Table 6.1 Row I for fiscal year 2017-18
EBD	26	0	Table 6.1 Row L for fiscal year 2017-18

Table 3.2.1
Estimated Cost by Initiative for FY 2018-19

Row	Service	Currently Receiving No Services		Currently On State Plan Only		Currently on HCBS-SLS		Currently on HCBS-EBD		Total	Notes
		New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments		
A	Quality Assurance (QA)	$34,799	$47,986	$9,518	$12,374	$0	$0	$11,600	$15,090	$131,367	QA Annual Cost/Client (Table 8.1) Row A * Estimated Caseload (Table 3.2.2)
B	Utilization Review (UR)	$112,504	$155,139	$30,770	$40,005	$0	$0	$37,501	$48,786	$424,705	UR Annual Cost/Client (Table 8.1) Row B * Estimated Caseload (Table 3.2.2)
C	Targeted Case Management (TCM)	$322,360	$444,524	$88,167	$114,626	$0	$0	$107,453	$139,788	$1,216,918	TCM Annual Cost/Client (Table 8.1) Row C * Estimated Caseload (Table 3.2.2)
D	Waiver Costs	$8,176,376	$1,140,408	$2,236,274	$0	$23,801,044	$32,820,912	$2,088,271	$2,716,662	$72,979,947	Annual Waiver Cost/Client Table 8.1 Row E * Estimated Caseload (Table 3.2.2)
E	State Plan Costs	$827,001	$13,062,963	$0	$3,074,385	$0	$0	$0	$0	$16,964,349	State Plan Annual Cost/Client (Table 8.1) Row F * Estimated Caseload (Table 3.2.2)
F	**Total Cost for New or Existing Enrollment**	**$17,649,416**	**$26,125,994**	**$4,601,003**	**$6,148,772**	**$47,602,088**	**$65,641,824**	**$4,333,096**	**$5,636,987**	**$177,739,180**	**Sum Row A through Row E**

Table 3.2.2
2018-19 Estimated Caseload

Current Service	Average Monthly New Enrollments	Total FPE Enrollments from Previous Fiscal Year	Source
No Services	115	159	Table 6.1 Row A & Row B for fiscal year 2018-19
State Plan	32	41	Table 6.1 Row D & Row E for fiscal year 2018-19
SLS	423	583	Table 6.1 Row G Row H for fiscal year 2018-19
EBD	38	50	Table 6.1 Row J & Row K for fiscal year 2018-19

Table 3.3.1
Estimated Cost by Initiative for FY 2019-20

Row	Service	Currently Receiving No Services		Currently On State Plan Only		Currently on HCBS-SLS		Currently on HCBS-EBD		Total	Notes
		New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments		
A	Quality Assurance (QA)	$34,799	$111,666	$9,518	$29,149	$0	$0	$11,770	$35,220	$232,122	QA Annual Cost/Client (Table 8.1) Row A * Estimated Caseload (Table 3.3.2)
B	Utilization Review (UR)	$112,504	$361,016	$30,770	$94,237	$0	$0	$38,053	$113,865	$750,445	UR Annual Cost/Client (Table 8.1) Row B * Estimated Caseload (Table 3.3.2)
C	Targeted Case Management (TCM)	$322,360	$1,034,428	$88,167	$270,020	$0	$0	$109,034	$326,260	$2,150,269	TCM Annual Cost/Client (Table 8.1) Row C * Estimated Caseload (Table 3.3.2)
D	Waiver Costs	$8,176,376	$26,237,359	$2,236,274	$6,848,816	$23,801,044	$76,628,149	$2,118,996	$6,340,614	$152,387,628	Annual Waiver Cost/Client (Table 8.1) Row D * Estimated Caseload (Table 3.3.2)
E	State Plan Costs	$827,001	$2,653,781	$0	$0	$0	$0	$0	$0	$3,480,782	State Plan Annual Cost/Client (Table 8.1) Row E * Estimated Caseload (Table 3.3.2)
F	**Total Cost for New or Existing Enrollment**	**$9,473,040**	**$30,398,250**	**$2,364,729**	**$7,242,222**	**$23,801,044**	**$76,628,149**	**$2,277,853**	**$6,815,959**	**$159,001,246**	**Sum Row A through Row E**

Table 3.3.2
2019-20 Estimated Caseload

Current Service	Average Monthly New Enrollments	Total FPE Enrollments from Previous Fiscal Year	Source
No Services	115	370	Table 6.1 Row A & Row B of fiscal year 2019-20
State Plan	32	97	Table 6.1 Row D & Row E of fiscal year 2019 - 20
SLS	423	1,361	Table 6.1 Row G & Row H of fiscal year 2019 - 20
EBD	39	117	Table 6.1 Row J & Row K of fiscal year 2019 - 20

Table 3.4.1
Estimated Cost by Initiative for FY 2020-21

Row	Service	Currently Receiving No Services		Currently On State Plan Only		Currently on HCBS-SLS		Currently on HCBS-EBD		Total	Notes
		New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments	New Enrollments	Existing Enrollments		
A	Quality Assurance (QA)	$0	$175,346	$0	$45,908	$0	$0	$0	$55,229	$276,484	QA Annual Cost/Client (Table 8.1) Row A * Estimated Caseload (Table 3.4.2)
B	Utilization Review (UR)	$0	$566,893	$0	$148,422	$0	$0	$0	$178,557	$893,872	UR Annual Cost/Client (Table 8.1) Row B * Estimated Caseload (Table 3.4.2)
C	Targeted Case Management (TCM)	$0	$1,624,331	$0	$425,276	$0	$0	$0	$511,622	$2,561,229	TCM Annual Cost/Client (Table 8.1) Row C * Estimated Caseload (Table 3.4.2)
D	Waiver Costs	$0	$41,199,744	$0	$10,786,754	$0	$120,396,549	$0	$9,942,981	$182,326,028	Annual Waiver Cost/Client (Table 8.1) Row D * Estimated Caseload (Table 3.4.2) "
E	State Plan Costs	$0	$4,167,153	$0	$0	$0	$0	$0	$0	$4,167,153	State Plan Annual Cost/Client (Table 8.1) Row E * Estimated Caseload (Table 3.4.2)
F	**Total Cost for New or Existing Enrollment**	**$0**	**$47,733,467**	**$0**	**$11,406,360**	**$0**	**$120,396,549**	**$0**	**$10,688,390**	**$190,224,766**	**Sum Row A through Row E**

Table 3.4.2
2020-21 Estimated Caseload

Current Service	Average Monthly New Enrollments	Total FPE Enrollments from Previous Fiscal Year	Source
No Services	0	581	Table 6.1 Row A & Row B of fiscal year 2020-21
State Plan	0	152	Table 6.1 Row D & Row E of fiscal year 2020-21
SLS	0	2139	Table 6.1 Row G & Row H of fiscal year 2020-21
EBD	0	183	Table 6.1 Row J & Row K of fiscal year 2020-21

Table 4.1
Estimated Supports Intensity Scale (SIS) Caseload

Row	Item	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	Notes/Calculations
A	Annual Enrollments from Waitlist	846	1,128	1,127	0	Number of Enrollments from waitlist per fiscal year (Table 9.1 Row C).
B	Percentage of Population Eligible for First Assessment	100.00%	100.00%	100.00%	100.00%	Assuming those currently on HCBS-SLS are not eligible for first assessment.
C	Estimated Number of First Assessments	846	1,128	1,127	0	Row A * B
D	Estimated Total Program Enrollment from Waitlist	846	2,820	3,101	3,101	Current fiscal year's enrollment from waitlist + Previous fiscal year's enrollment from waitlist.
E	Percentage of Population Eligible for Additional Assessment	10.00%	10.00%	10.00%	10.00%	Estimated percentage of population requesting additional assessment.
F	Estimated Number of Additional Assessments	85	282	310	310	Row D * Row E

Table 4.2
Supports Intensity Scale Cost per Enrollment

Row	Item	Cost	Source
A	SIS Assessment Cost	$233.09	FY 2016-17 S-5 Table F.3
B	AAIDD Contract Cost	$13.88	FY 2016-17 AAIDD Contract

Table 4.3
Estimated Supports Intensity Scale Costs

Row	Item	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	Notes/Calculations
A	SIS Cost of First Assessment	$197,194	$262,926	$262,692	$0	Table 4.1 Row C * Table 4.2 Row A
B	SIS Cost of Additional Assessments	$19,813	$65,731	$72,258	$72,258	Table 4.1 Row F * Table 4.2 Row A
C	**Total SIS Assessment Costs**	**$217,007**	**$328,657**	**$334,950**	**$72,258**	**Row A + Row B**
D	AAIDD Contract Costs of First Assessments	$11,742	$15,657	$15,643	$0	Table 4.1 Row C * Table 4.2 Row B
E	AAIDD Contract Costs of Additional Assessments	$1,180	$3,914	$4,303	$4,303	Table 4.1 Row F * Table 4.2 Row B
F	**Total AAIDD Contract Cost**	**$12,922**	**$19,571**	**$19,946**	**$4,303**	**Row D + Row E**

Table 5.1
Capacity Building Costs

Row	Item	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	Source/Calculation
A	Capacity Building Cost per Client	$1,117.00	$1,117.00	$1,117.00	$1,117.00	2014-15 Capacity Building Estimate - Adjusted for inflation. See narrative for further detail.
Currently Receiving No Services						
B	New Enrollments	161	214	214	0	Table 7.1 Total Annual Waitlist Additions per fiscal year.
C	Capacity Building Cost	$179,837	$239,395	$239,183	$0	Row A * Row B
Currently Receiving State Plan Services Only						
D	New Enrollments	42	56	56	0	Table 7.1 Total Annual Waitlist Additions per fiscal year.
E	Capacity Building Cost	$46,914	$62,999	$62,943	$0	Row A * Row D
Currently Receiving HCBS-SLS Services						
F	New Enrollments	592	790	789	0	Table 7.1 Total Annual Waitlist Additions per fiscal year.
G	Capacity Building Cost	$661,264	$881,983	$881,201	$0	Row A * Row F
Currently Receiving HCBS-EBD Services						
H	New Enrollments	51	68	68	0	Table 7.1 Total Annual Waitlist Additions per fiscal year.
I	Capacity Building Cost	$56,967	$75,599	$75,532	$0	Row A * Row H
J	**Total Capacity Building Expenditure**	**$944,982**	**$1,259,976**	**$1,258,859**	**$0**	**Row C + Row E + Row G + Row I**

Table 6.1
Annual FPE Enrollment Schedule by Current Service Type and Year

Row	Enrollment by Current Service	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	Source/Calculations
Currently Receiving No Services						
A	New FPE Enrollments Currently Receiving No Services	84	115	115	0	Estimated Average FPE from Table 7.1
B	Existing Cumulative FPE Enrollments Currently not Receiving Services	0	159	370	581	Total Annual FPE From Each Service Category Table 7.1
C	Total FPE Enrollments Currently not Receiving Services	84	274	485	581	Row A + Row B
Currently Receiving State Plan Services Only						
D	New FPE Enrollments Currently on State Plan	26	32	32	0	Estimated Average FPE from Table 7.1
E	Existing Cumulative FPE Enrollments Currently on State Plan	0	41	97	152	Total Annual FPE From Each Service Category from Table 7.1
F	Total FPE Enrollments Currently on State Plan	26	73	128	152	Row D + Row E
Currently on HCBS-SLS Waiver						
G	New FPE Enrollments From HCBS-SLS	314	423	423	0	Estimated Average FPE from Table 7.1
H	Existing Cumulative FPE Enrollments From HCBS-SLS	0	583	1,361	2,139	Total Annual FPE From Each Service Category from Table 7.1
I	Total FPE Enrollments From HCBS-SLS	314	1,006	1,784	2,139	Row G + Row H
Currently on HCBS-EBD Waiver						
J	New FPE Enrollments from HCBS-EBD	26	38	39	0	Estimated Average FPE from Table 7.1
K	Existing Cumulative FPE Enrollments from HCBS-EBD	0	50	117	183	Total Annual FPE From Each Service Category from Table 7.1
L	Total FPE Enrollments from HCBS-EBD	26	88	156	183	Row J + Row K

Table 7.1
Waitlist Additions by Current Service Type

Row	Item	Currently Receiving No Services	Currently Only Receiving State Plan Services	Currently On HCBS-SLS Waiver	Currently On HCBS-EBD Waiver	Total Waitlist Reductions	Source/Calculation
A	Proportion of HCBS-DD waitlist receiving services	19.00%	5.00%	70.00%	6.00%	100.00%	Assumption based on May 2016 HCBS-DD Waitlist Data.
B	FPE Adjustment Factor	98.55%	98.55%	98.55%	98.55%	98.55%	Estimated FY 2017-18 FPE Adjustment Factor from FY 2016-17 S-5.
	FY 2017-18						
C	Waitlist Reduction (Total Across All Service Categories)	846	846	846	846	846	Table 9.1 Row E
D	Total Annual Waitlist Additions from Each Service Category	161	42	592	51	846	Row A * Row C
E	**Total Annual FPE from Each Service Category**	**159**	**41**	**583**	**50**	**834**	**Row B * Row D**
F	Average Monthly Enrollment	85	26	319	26	456	Assumes a linear ramp up
G	**Estimated Average FPE**	**84**	**26**	**314**	**26**	**449**	**Row B * Row F**
	FY 2018-19						
H	Waitlist Reduction (Total Across All Service Categories)	1,128	1,128	1,128	1,128	1,128	Table 9.1 Row E
I	Total Annual Waitlist Additions from Each Service Category	214	56	790	68	1,128	Row A * Row H
J	**Total Annual FPE from Each Service Category**	**211**	**56**	**778**	**67**	**1,112**	**Row B * Row I**
K	Average Monthly Enrollment	117	32	429	39	617	Assumes a linear ramp up
L	**Estimated Average FPE**	**115**	**32**	**423**	**38**	**608**	**Row B * Row K**
	FY 2019-20						
M	Waitlist Reduction (Total Across All Service Categories)	1,127	1,127	1,127	1,127	1,127	Table 9.1 Row E
N	Total Annual Waitlist Additions from Each Service Category	214	56	789	68	1,127	Row A * Row M
O	**Total Annual FPE from Each Service Category**	**211**	**56**	**777**	**67**	**1,111**	**Row B * Row N**
P	Average Monthly Enrollment	117	32	429	39	617	Assumes a linear ramp up
Q	**Estimated Average FPE**	**115**	**32**	**423**	**38**	**608**	**Row B * Row P**

Table 8.1
Estimated Costs Per Enrollment

Row	Service	Currently Receiving No Services	Currently Only Receiving State Plan Services	Currently On HCBS-SLS Waiver	Currently On HCBS-EBD Waiver	Source/Calculation
A	Quality Assurance (QA)	$301.80	$301.80	$0	$301.80	FY 2016-17 S-5 Table F.3
B	Utilization Review (UR)	$975.72	$975.72	$0	$975.72	FY 2016-17 S-5 Table F.3
C	Targeted Case Management (TCM)	$2,795.75	$2,795.75	$0	$2,795.75	FY 2016-17 S-5 Table C.3
D	Waiver Costs	$70,911.78	$70,911.78	$56,296.59	$54,333.23	Difference between DD waiver annual cost/client and SLS/EBD waiver/State Plan annual cost/client (Sources: FY 2016-17 S-1 and S-5).
E	State Plan Costs	$7,172.38	$0	$0	$0	FY 2016-17 S-1
F	**Total Per Enrollee Costs**	**$82,157**	**$74,985**	**$56,297**	**$58,407**	**Sum of Row A through Row E**

Table 9.1
Waitlist Addition Schedule

Row	Item	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	Notes
A	Waitlist at Beginning of Fiscal Year	2,453	2,669	2,885	3,101	Assumes an annual trend of 18 waitlist additions per month. See narrative for further detail.
B	Estimated Annual Additions to Waitlist	216	216	216	216	Based on trend of 18 waitlist additions per month
C	Number of Months of Implementation	9	12	12	12	Assumes October 1, 2017 implementation date
D	Number of Monthly Enrollments Needed to Reduce Waitlist by FY 2020-21	94	94	94	0	Row A FY 2020-21 / Sum of Row C for FY 2017-18 through FY 2019-20
E	**Annual Waitlist Reduction**	**846**	**1,128**	**1,127**	**0**	**Row D* Row C**

Table 9.2
Waitlist Schedule

Row	Item	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	Source/Calculations
A	Waitlist at Start of Fiscal Year	2,453	1,823	911	0	FY 2017-18: Table 9.1 Row A FY 2018-19-FY 2021-21: Row D of previous fiscal year
B	Estimated Annual Additions to Waitlist	216	216	216	0	Based on trend of 18 waitlist additions per month
C	Annual Waitlist Reduction	846	1,128	1,127	0	Table 9.1 Row E
D	Waitlist at End of Fiscal Year	1,823	911	0	0	Row A + Row B - Row C

FTE Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- New full-time General Fund positions are reflected in Year 1 as 0.9166 FTE to account for the pay-date shift. This applies to personal services costs only; operating costs are not subject to the pay-date shift.

Expenditure Detail		FY 2017-18		FY 2018-19	
Personal Services:					
Classification Title	Monthly	FTE		FTE	
Position Title (Admin IV)	$5,005	0.9	$55,051	1.0	$60,060
PERA			$5,588		$6,096
AED			$2,753		$3,003
SAED			$2,753		$3,003
Medicare			$798		$871
STD			$105		$114
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1, #.# FTE		**0.9**	**$74,975**	**1.0**	**$81,074**
Subtotal Personal Services		0.9	**$74,975**	1.0	**$81,074**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	0.9	$458	1.0	$500
Telephone Expenses	$450	0.9	$412	1.0	$450
PC, One-Time	$1,230	1.0	$1,230		
Office Furniture, One-Time	$3,473	1.0	$3,473		
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$5,573**		**$950**
TOTAL REQUEST		0.9	**$80,548**	1.0	**$82,024**
	General Fund:		*$40,266*		*$41,004*
	Cash funds:				
	Reappropriated Funds:				
	Federal Funds:		*$40,282*		*$41,020*

Cost and FTE

- The Department estimates it would need $123,800,000 total funds, $61,900,000 reappropriated funds, $61,900,000 federal funds, and 3.0 FTE in FY 2017-18 and $123,800,000 total funds, $61,900,000 reappropriated funds and $61,900,000 federal funds and 6.0 FTE in FY 2018-19 and ongoing to increase reimbursement rates on physician professional services provided by physicians employed by University of Colorado School of Medicine (UCSOM).

Current Program

- Federal regulations allow for aggregate Medicaid payments to a group of facilities up to the amount of the upper payment limit (UPL). The UPL is a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles. The Department currently administers supplemental payments using UPL methodology, including payments to nursing facilities, hospitals, and home health providers and these payments are eligible for federal funding at the standard Federal Medical Assistance Percentage (FMAP) rate which is estimated to be 50% for FY 2017-18 and ongoing.
- UCSOM providers deliver primary care and specialty services, primarily at University of Colorado Hospital and Children's Hospital Colorado, to Colorado Medicaid clients, and claims data indicates that UCSOM providers had 537,002 encounters with Medicaid clients in FY 2015-16.
- Medicaid reimbursement rates for physician services are lower than rates based upon Medicare payment principles, including average commercial rates (ACR).

Problem or Opportunity

- Due to the lower than average reimbursement rates, most private sector physicians limit access to Medicaid patients. UCSOM physicians provide patient care to publicly financed patients, including Medicaid, TriCare and Medicare, and patient access is subsidized by commercially insured private payers. Because private physicians may limit the number of Medicaid patients they will accept, it is important that UCSOM physicians continue to provide and expand access to these critical services.
- HB 16-1408, "Cash Fund Allocations for Health Related Programs" authorized funding for specialty education programs to include care provided by UCSOM that are eligible for payment through Medicaid.

Consequences of Problem

- Without increased reimbursement, UCSOM may not be able to maintain and would not be able to expand access to these critical services to Medicaid clients, which could result in clients foregoing needed care.

Proposed Solution

- The Department estimates that it would need funding to implement UPL methodology to make supplemental payments for physician services provided by UCSOM faculty physicians. If approved, UCSOM would use the revenue from the supplemental physician payments to benefit the Medicaid program and details of the measurements would be outlined in a written agreement between the Department and UCSOM.
- Additionally, the Department estimates it would need administrative resources for 6.0 FTE and contractor funding necessary to administer the supplemental payment and funding for increases to family medicine residency training program to increase the number of family medicine residents at UCSOM.

Department Priority:	***R-I-2 (Informational Only)***
Request Detail:	***University of Colorado School of Medicine Supplemental Physician Payment***

Summary of Incremental Funding Change for FY 2017-18	**Total Funds**	**General Fund**
CU School of Medicine Supplemental Physician Payment	$123,800,000	$0

Problem or Opportunity:

The University of Colorado School of Medicine (UCSOM) faculty physicians deliver services to Medicaid patients, which includes 537,002 encounters with individuals eligible for Medicaid in FY 2015-16, comprising an essential source of the primary and specialty care for Colorado's Medicaid program. Because the UCSOM is publically financed, the Department has an opportunity to increase reimbursement using additional federal Medicaid funds, without incurring new General Fund or other state expenditure. In order to allow for increased reimbursement through the Medicaid program, the General Assembly included a provision in HB 16-1408[1], "Cash Fund Allocations for Health Related Programs" authorizing funding for specialty education programs to include care provided by UCSOM that are eligible for payment through Medicaid.

Section 1902(a)(30)(A) of the Social Security Act requires states to assure that payments made under Medicaid State Plans are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. To promote efficiency, economy, and quality of care, the Centers for Medicare and Medicaid Services (CMS) sets an upper bound, the Medicaid Upper Payment Limit (UPL), for how much states can pay providers under certain fee-for-service arrangements. The UPL is not a limit on payments to individual providers, but is intended to prevent Medicaid from paying more than Medicare would pay for the same services in aggregate. As a result, states may make—and receive federal matching dollars for—payments beyond those for services provided by any institution, as long as total Medicaid payments do not exceed the UPL for the specific group of institutions. Although there is not a federal regulation that establishes a UPL for non-institutional providers, CMS has

[1] Section 23-18-304(1) (c), C.R.S.

provided guidance that Medicare payment principles and average commercial rates for physician services may be used as upper limits[2].

The current Medicaid reimbursement rate for physician services provided by UCSOM faculty physicians is 60% lower than the Average Commercial Rate (ACR) payment, resulting in most private sector physicians limiting access to Medicaid patients. As a result, there is significant room under the UPL to allow for increased reimbursement; however, because Medicaid is a program jointly financed by the states and the federal government, Colorado must provide additional state funding in order to receive additional federal reimbursement. In 2016, HB 16-1408 changed State statute to allow for appropriations for specialty education services provided by the Health Sciences Center campus at the University of Colorado to be used for Medicaid reimbursement. As a result, the Department is now statutorily able to finance additional reimbursements for UCSOM faculty physicians under the UPL, although as of yet, the Department does not have an appropriation to allow for these payments.

Proposed Solution:

The Department estimates it would need $123,800,000 total funds, including $61,900,000 reappropriated funds, $61,900,000 federal funds, and 3.0 FTE in FY 2017-18 and $123,800,000 total funds, including $61,900,000 reappropriated funds, $61,900,000 federal funds and 6.0 FTE in FY 2018-19 and ongoing in order to implement and administer a supplemental payment to UCSOM. The funding would be used to: increase reimbursement to UCSOM through a UPL payment for physician services; provide administrative resources to the Department to administer the supplemental payments; administer the Care Transitions Intervention training program; manage a written agreement between the Department and UCSOM; and, include an increase to the Commission on Family Medicine Residency Training Program to increase the number of family medicine residents by one each year, beginning in FY 2017-18, to total three additional residents by FY 2019-20 and ongoing.

If approved, as a condition of receiving this additional reimbursement, UCSOM would use the revenue from the supplemental physician payment to benefit the Medicaid program as outlined in a written agreement between the Department and UCSOM.

If additional spending authority is not granted, the Department would be unable to provide this additional reimbursement to UCSOM and the Department would notify CMS that the approved State Plan Amendment (SPA) is not able to be implemented due to lack of state funding.

Anticipated Outcomes:

The Department anticipates that, if approved, additional reimbursement would result in expanded access to care for Medicaid clients. To achieve this, the Department would enter into a written agreement with the UCSOM that conditions payment on meeting the negotiated benchmarks. Although UPL payments are not required to be tied to specific policy objectives, CMS has indicated, as part of an oversight initiative that began in 2003, that State Plans must demonstrate a link between supplemental payments and general

[2] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/upl-instructions-qualified-practitioner-services-replacement-new.pdf

Medicaid purposes. The Department anticipates that the first year of payments would be used for UCSOM to build infrastructure and increase staffing to meet the requirements as outlined in the agreement. After an initial startup phase, the staffing and infrastructure would be in place in order to measure outcomes and determine whether or not UCSOM was achieving benchmarks as outlined in the agreement. As measurement occurs, payments could be withheld or the agreement could be modified according to performance.

After passage of HB 16-1408, the Department, the Department of Higher Education (CDHE), and UCSOM began working together with the assistance of a contractor hired by UCSOM to draft a Medicaid State Plan Amendment (SPA) to gain federal approval from CMS for a UPL payment methodology based upon ACR through the Medicaid Program. The SPA for the UCSOM supplemental physician payment was submitted to CMS on September 30, 2016 with a retroactive effective date of July 1, 2016. Once the SPA is approved and an interagency agreement is entered into by UCSOM and HCPF, the Colorado Department of Higher Education (CDHE) could then send funds designated for the UCSOM's Specialty Education Program (SEP) to the Department to draw down federal funding under the Medicaid program. However, because the exact timeline for SPA approval is unknowable, CDHE would require a revision to the existing footnote and letter note to give it flexibility in distributing the SEP funds to either the Department, if the SPA is approved, or to UCSOM, if the SPA is not approved in FY 2017-18. This proposed footnote change is included in the CDHE FY 2017-18 budget request.

If the General Assembly provides the identified spending authority, whether or not the SPA is approved, CDHE would send a portion of UCSOM's SEP contract to the Department to fund 1.0 FTE to administer the SPA process. If the SPA is approved in FY 2017-18, an additional amount from the SEP contract would be sent to HCPF for administrative resources to support the interagency agreement which includes funding additional 2.0 FTE, a contractor to assist with the UPL payment calculations and for the Colorado Commission on Family Medicine to fund an additional resident per year for the first three years, totaling to three additional residents in FY 2019-20 and ongoing.

Once the SPA is approved, and if funding is approved, the Department would use the estimated resources to hire staff and contractors to develop a process to determine and monitor the outcomes and enforce the agreed upon standards. The Department would be able to measure the program's success based on results of the outcome measurements as outlined in the written agreement between the Department and UCSOM. The Department would be able to measure changes in access to care by comparing claims and outcome data from periods prior to the increased reimbursement to periods after the reimbursement, and would continue to monitor access and outcomes on an ongoing basis in the future.

These outcomes link to the Department's FY 2016-17 performance plan, specifically Strategy #1A, "Ensure robust management of Medicaid benefits", by adding a new benefit manager for specialty care, and Strategy #1B, "Expand the network of providers serving Medicaid".

Assumptions and Calculations:

If a supplemental payment were approved, the Department estimates that UCSOM would receive $123,042,864 in total new Medicaid payments in FY 2017-18. However, because the State share would

come from existing UCSOM appropriations, the net increase in reimbursement to UCSOM would be $61,521,432, assuming the standard 50% FMAP rate.

To provide property authority for the departments, and to ensure the funding remains available to CDHE if CMS does not approve a SPA, the below footnote would need be included in the Long Bill for both Departments if the policy is moved forward.

> *Upon approval of the State Plan Amendment, the Department of Higher Education shall distribute the approved amount to the Department of Health Care Policy and Financing in FY 2017-18, pursuant to 23-18-304, (1)(c), C.R.S.*
>
> *If the State Plan Amendment is not approved in FY 2017-18 the Department of Higher Education shall distribute the funding for the administrative costs at the Department of Health Care Policy and Financing and the remainder to the University of Colorado.*

In addition, the below letternote would need to be added to the Long Bill for CDHE (4) College Opportunity Fund Program, (B) Fee-for-service Contracts with State Institutions, Fee-for-service Contracts with State Institutions for Specialty Education Programs.

> *Of this amount, $61,900,000 of the fee-for-service Contracts with State Institutions for Specialty Education Programs appropriation designated for the Governing Boards, Regents of the University of Colorado, may be provided as payments to the Department of Health Care Policy and Financing for administration of, and eligible payment for, health services provided by medical faculty of the health science center campus at the University of Colorado, pursuant 23-18-304, (1) (c), C.R.S.*

The Department submitted the SPA with supporting UPL calculation and documentation to CMS on September 30, 2016. If state and federal approval is received, supplemental payments would be made retroactive to July 1, 2016, as federal regulations allow for SPAs to be effective beginning the first day of the calendar quarter that the SPA was submitted. Based on its prior experience and discussions with CMS, the Department estimates that federal approval would take at least nine months. Therefore, the Department estimates that the SPA could be approved as soon as July 1, 2017, with the first supplemental payment occurring in FY 2017-18, and that the Department would continue to make payments using that methodology on an ongoing basis.

The Department assumes that, if appropriated, the supplemental payments for each year would be paid on a regular schedule, either annually or quarterly, in January of the subsequent year[3] because the Department has to allow time for the fiscal year end to close, and claims to run out before it would have the data necessary to calculate the payment. The Department assumes that the first supplemental payment, which would be based upon FY 2016-17 claims data, could be calculated and paid by February 1, 2018. The Department assumes that if the SPA took longer to approve then the first payment date would be adjusted accordingly.

[3] For example, supplemental payments for FY 2017-18 would be paid in January 2019.

The Department assumes that once the SPA was approved, it would enter into a written agreement with UCSOM outlining the terms and conditions of the supplemental payment and that this written agreement would be updated and negotiated annually. The agreement would describe proposed business process changes and outline the measurement and reporting processes.

The Department assumes that the reappropriated funds would exist on both the Department and the CDHE budget in order to allow CDHE to still have access to the reappropriated funds if the SPA is not approved. However the Department assumes that the funding for 1.0 FTE would be available to the Department beginning July 1, 2017 regardless of the SPA approval date as this FTE would be required to continue the work of the current contractor which includes working with CMS on federal approval.

The Department assumes that if the SPA is not approved, but funding was appropriated for this purpose, that it would utilize the budget process to update the funding estimate.

The Department assumes that supplemental payments would be made to UCSOM as a provider payment; as a result, UCSOM does not need an increase in reappropriated funding in the Long Bill. This methodology is consistent with how UCSOM facility providers are currently paid for Medicaid services.

Administrative Resources

Contingent upon CMS approval by July 1, 2017 and action by the General Assembly, the Department assumes that 3.0 FTE and contractor resources would be necessary in FY 2017-18 and that 6.0 FTE and contractor resources would be necessary in FY 2018-19 and ongoing to administer the supplemental payment and terms of the written agreement. Detailed FTE descriptions can be found at the end of this section. The Department assumes that 1.0 FTE would be hired July 1, 2017 regardless of CMS approval to continue the work that the contractor hired by Department of Higher Education is currently doing related to SPA approval. This FTE would also be responsible for calculation of the payments. The Department assumes the remaining FTE would be hired no sooner than January 1, 2018, pending SPA approval, to facilitate the functions related to the written agreement between the Departments and UCSOM. If SPA approval is delayed the Department assumes that the remaining 2.0 FTE hire date would also be delayed accordingly.

The Department's estimate includes contractor funding to create annual performance measure methodology and accountability standards, including audit and external quality review measures and to implement the care transitions intervention training program. These resources would begin once SPA approval occurred and would be necessary to continue the work started by the existing contractor and existing staff on the Medicaid State Plan Amendment (SPA), including providing supporting calculations and responding to questions from the Centers for Medicare and Medicaid Services (CMS), and for ongoing payment and upper payment limit calculations and support after federal approval is received. Additionally, the Department would require the staff and contractor resources for ongoing contract management and oversight. The Department assumes that the resources for the Commission on Family Medicine to hire new residents would also begin once the SPA was approved.

FTE Descriptions

Position	Job Class	Position Description
Financial Analyst	Rate/Financial Analyst	This 1.0 FTE would develop the payment methodology, draft the Medicaid State Plan Amendment (SPA), and respond to questions from the Centers for Medicare and Medicaid Services (CMS). Additionally, this position would provide calculations for ongoing payment and upper payment limit calculations and provide support after federal approval is received. The Department estimates that the SPA approval process would take a minimum of 9 months. This position would be hired July 1, 2017.
Physician Supplemental Payment Senior Data Analyst	Statistical Analyst	This 1.0 FTE would be responsible for creating and analyzing a set of metrics designed to monitor, evaluate and improve the Supplemental Physician Payment program. The position would work in collaboration with UCSOM, Department staff and relevant State agencies to create, implement and share program metrics and analytics. Specifically the position would review and analyze data related to (a) changes in Medicaid access to UPI physicians, particularly in rural areas; (b) uptake of UCSOM as a primary care medical home for the Medicaid population; (c) expansion in specialty access through workforce expansion; (d) uptake and impact of alternative delivery models such as telehealth; and (e) monitor the impact of loan forgiveness on access in rural areas (in alignment with existing loan forgiveness and repayment programs implemented by the State at the Colorado Department of Public Health and Environment). The position would be a staff authority on the data related to the Supplemental Physician Payment Program and will influence the direction and policy of the program through analytics.
Physician Supplemental Payment Staff	Administrator	This 1.0 FTE would be responsible for selecting and monitoring key domains for quality measurement including site audits, client experience of care survey data, performance improvement projects, developing the overall quality strategy for improving care, and reporting and analyzing a set of metrics designed to monitor, evaluate and improve the Supplemental Physician Payment program. The position would work in collaboration with UCSOM, Department analysts and executives, and relevant State agencies to create, implement and report program metrics, client experience of care, cost and quality outcomes, and site audit outcomes. Specifically the position would develop the measurement strategy to include regular

		site audits, provider incentive payments, implementation of performance improvement projects to improve key aspects of care for targeted Medicaid populations, improve business processes to support client engagement in medical homes, improve access to care for clients in rural areas, and evaluate the uptake and impact of alternative delivery models such as telehealth, medical homes, and specialty care on client outcomes. The position would be a staff authority on the health outcomes related to the Supplemental Physician Payment Program and would influence the direction and policy of the program.
Specialty Care Benefit Manager	Administrator	This 1.0 FTE would focus specifically on specialty care and allow for dedicated benefit management for specialty care providers and services provided by specialists. An area of ongoing focus for Medicaid is access to specialty care services for enrollees and management of access and costs of services provided by specialists. Benefit Management staff within the Department's Health Programs Office perform a number of critical roles to appropriately manage the health services available to Medicaid enrollees. These tasks include: monitoring and implementing policies and benefits structures that align with national best practices, researching and maintaining knowledge of state and federal Medicaid regulations, development of state rules and regulations, provider and billing enrollment support, client eligibility support, claims systems expertise, benefit utilization analysis and management, and rates and claims management. Currently, one FTE is dedicated to managing all physician services benefits including primary care, Federally Qualified Health Centers, Rural Health Centers, specialty care services, physician administered drugs and a number of other benefits.
Care Transitions Intervention Specialist	Training Specialist	This 1.0 FTE would be responsible for the Care Transitions Intervention (CTI) training program which would provide training to hospital discharge planners and community-based organizations. The staff would manage this portion of the agreement with UCSOM and facilitate recruitment of hospitals and community-based organizations to participate in CTI training. At present, discharge planning from hospitals uses various approaches to discharge patients from hospitals. In many cases where patients need long term services and support, the client is predominantly discharged to a nursing facility. UCSOM has developed a nationally recognized evidence-based intervention, CTI, and has established a training program that is available to agencies nationally.

Physician Supplemental Payment Budget Analyst	Budget Analyst	This 0.5 FTE Budget Analyst would be responsible for managing the budget line item, which includes monitoring, tracking and explaining encumbrances and expenditures. This would also include reappropriated funds from the Department of Higher Education and federal funds. The analyst would also be responsible for developing budget requests and amendments, and providing additional data analysis, as needed.
Physician Supplemental Payment Accountant	Accountant	This 0.5 FTE Accountant would establish and maintain the Physicians Supplemental Payments subsidiary ledger; monitor, analyze, and reconcile balances for assigned accounts; enter, review, submit, and research payments, transfers, and cash receipts in accordance with internal controls; enter correcting entries; and run reports to ensure that the recording of related accounting transactions are in accordance with GAAP, State fiscal rules, and Department rules, policies, and procedures. This position would also research and respond to questions regarding related transactions from providers, Department employees, and auditors.

Table 1.1 FY 2017-18 R-I-2 University of Colorado School of Medicine Supplemental Payment									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds (1)**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	**Total Estimate**	**$123,800,000**	**3.0**	**$0**	**$0**	**$61,900,000**	**$61,900,000**		**Sum of Row B through Row J**
B	(1) Executive Director's Office, (A) General Administration, Personal Services	$208,949	3.0	$0	$0	$104,475	$104,474	50.00%	Table 3 FTE Calculations
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$47,562	0.0	$0	$0	$23,781	$23,781	50.00%	Table 3 FTE Calculations
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$356	0.0	$0	$0	$178	$178	50.00%	Table 3 FTE Calculations
E	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$9,363	0.0	$0	$0	$4,682	$4,681	50.00%	Table 3 FTE Calculations
F	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$9,363	0.0	$0	$0	$4,682	$4,681	50.00%	Table 3 FTE Calculations
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$31,543	0.0	$0	$0	$15,770	$15,773	50.00%	Table 3 FTE Calculations
H	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$300,000	0.0	$0	$0	$150,000	$150,000	50.00%	Table 2.1 Row B
I	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$123,042,864	0.0	$0	$0	$61,521,432	$61,521,432	50.00%	Table 2.1 Row D
J	(6) Other Medical Services, Commission on Family Medicine Residency Training Programs	$150,000	0.0	$0	$0	$75,000	$75,000	50.00%	Table 2.1 Row C

(1) Funds Reappropriated from Department of Higher Education, (5) Governing Boards, (E) Board of Governors of the Colorado State University System. *Long Bill Footnote: Upon approval of the State Plan Amendment, the Department of Higher Education shall distribute the approved amount to the Department of Health Care Policy and Financing in FY 2017-18, pursuant to 23-18-304, (1)(c), C.R.S.*
If the State Plan Amendment is not approved in FY 2017-18 the Department of Higher Education shall distribute the funding for the administrative costs at the Department of Health Care Policy and Financing and the remainder to the University of Colorado.

Table 1.2 FY 2018-19 R-I-2 University of Colorado School of Medicine Supplemental Payment									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds (1)**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	**Total Estimate**	**$123,800,000**	**6.0**	**$0**	**$0**	**$61,900,000**	**$61,900,000**		Sum of Row B through Row J
B	(1) Executive Director's Office, (A) General Administration, Personal Services	$424,881	6.0	$0	$0	$212,441	$212,440	50.00%	Table 3 FTE Calculations
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$55,489	0.0	$0	$0	$27,745	$27,744	50.00%	Table 3 FTE Calculations
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$723	0.0	$0	$0	$362	$361	50.00%	Table 3 FTE Calculations
E	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$19,035	0.0	$0	$0	$9,518	$9,517	50.00%	Table 3 FTE Calculations
F	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$19,035	0.0	$0	$0	$9,518	$9,517	50.00%	Table 3 FTE Calculations
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$5,700	0.0	$0	$0	$2,848	$2,852	50.00%	Table 3 FTE Calculations
H	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$300,000	0.0	$0	$0	$150,000	$150,000	50.00%	Table 2.2 Row B
I	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$122,675,137	0.0	$0	$0	$61,337,568	$61,337,569	50.00%	Table 2.2 Row D
J	(6) Other Medical Services, Commission on Family Medicine Residency Training Programs	$300,000	0.0	$0	$0	$150,000	$150,000	50.00%	Table 2.2 Row C

(1) Funds Reappropriated from Department of Higher Education, (5) Governing Boards, (E) Board of Governors of the Colorado State University System. *Long Bill Footnote: Reappropriated Funds exist on both Department of Health Care Policy and Financing and Department of Higher Education budgets, however Department of Higher Education will not transfer funding beyond the 1.0 FTE at Department of Health Care Policy and Financing until the status of the State Plan Amendment is known.*

Table 1.3 FY 2019-20 R-I-2 University of Colorado School of Medicine Supplemental Payment									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds (1)**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	**Total Estimate**	**$123,800,000**	**6.0**	**$0**	**$0**	**$61,900,000**	**$61,900,000**		Sum of Row B through Row J
B	(1) Executive Director's Office, (A) General Administration, Personal Services	$424,881	6.0	$0	$0	$212,441	$212,440	50.00%	Table 3 FTE Calculations
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$55,489	0.0	$0	$0	$27,745	$27,744	50.00%	Table 3 FTE Calculations
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$723	0.0	$0	$0	$362	$361	50.00%	Table 3 FTE Calculations
E	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$19,035	0.0	$0	$0	$9,518	$9,517	50.00%	Table 3 FTE Calculations
F	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$19,035	0.0	$0	$0	$9,518	$9,517	50.00%	Table 3 FTE Calculations
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$5,700	0.0	$0	$0	$2,847	$2,853	50.00%	Table 3 FTE Calculations
H	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$300,000	0.0	$0	$0	$150,000	$150,000	50.00%	Table 2.3 Row B
I	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$122,525,137	0.0	$0	$0	$61,262,569	$61,262,568	50.00%	Table 2.3 Row D
J	(6) Other Medical Services, Commission on Family Medicine Residency Training Programs	$450,000	0.0	$0	$0	$225,000	$225,000	50.00%	Table 2.3 Row C

(1) Funds Reappropriated from Department of Higher Education, (5) Governing Boards, (E) Board of Governors of the Colorado State University System. *Long Bill Footnote: Reappropriated Funds exist on both Department of Health Care Policy and Financing and Department of Higher Education budgets, however Department of Higher Education will not transfer funding beyond the 1.0 FTE at Department of Health Care Policy and Financing until the status of the State Plan Amendment is known.*

Table 2.1 FY 2017-18 R-I-2 University of Colorado School of Medicine Supplemental Payment Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds (1)**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	FTE	$307,136	3.0	$0	$0	$153,568	$153,568	50.00%	Table 3 FTE Calculations
B	Contractor Resources	$300,000	0.0	$0	$0	$150,000	$150,000	50.00%	Estimate based upon similar consultant contract
C	Family Medicine Residency Training Program	$150,000	0.0	$0	$0	$75,000	$75,000	50.00%	1 resident, $150,000 per resident
D	Estimated Supplemental Payment	$123,042,864	0.0	$0	$0	$61,521,432	$61,521,432	50.00%	Row G - Row A - Row B- Row C
E	**Total Estimate**	**$123,800,000**	**3.0**	**$0**	**$0**	**$61,900,000**	**$61,900,000**		Reappropriated funds amount provided by CUSOM

(1) Amount of annual supplemental payment may vary each year due to UPL calculation. Amount of annual supplemental payment is known, Department of Higher Education would transfer reappropriated funds amount to HCPF and any remaining reappropriated funds would remain at Department of Higher Education.

Table 2.2 FY 2018-19 R-I-2 University of Colorado School of Medicine Supplemental Payment Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds (1)**	**Federal Funds**	**FFP or FMAP**	**Notes**
A	FTE	$524,863	6.0	$0	$0	$262,432	$262,431	50.00%	Table 3 FTE Calculations
B	Contractor Resources	$300,000	0.0	$0	$0	$150,000	$150,000	50.00%	Estimate based upon similar consultant contract
C	Family Medicine Residency Training Program	$300,000	0.0	$0	$0	$150,000	$150,000	50.00%	2 residents, $150,000 per resident
D	Estimated Supplemental Payment	$122,675,137	0.0	$0	$0	$61,337,568	$61,337,569	50.00%	Row G - Row A - Row B- Row C
E	**Total Estimate**	**$123,800,000**	**6.0**	**$0**	**$0**	**$61,900,000**	**$61,900,000**		Reappropriated funds amount provided by CUSOM

(1) Amount of annual supplemental payment may vary each year due to UPL calculation. Amount of annual supplemental payment is known, Department of Higher Education would transfer reappropriated funds amount to HCPF and any remaining reappropriated funds would remain at Department of Higher Education.

Table 2.3 FY 2019-20 R-I-2 University of Colorado School of Medicine Supplemental Payment Summary by Initiative (2)									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds (1)**	**Federal Funds**	**FFP or FMAP**	**Notes**
A	FTE	$524,863	6.0	$0	$0	$262,432	$262,431	50.00%	Table 3 FTE Calculations
B	Contractor Resources	$300,000	0.0	$0	$0	$150,000	$150,000	50.00%	Estimate based upon similar consultant contract
C	Family Medicine Residency Training Program	$450,000	0.0	$0	$0	$225,000	$225,000	50.00%	3 residents, $150,000 per resident
D	Estimated Supplemental Payment	$122,525,137	0.0	$0	$0	$61,262,568	$61,262,569	50.00%	Row G - Row A - Row B- Row C
E	**Total Estimate**	**$123,800,000**	**6.0**	**$0**	**$0**	**$61,900,000**	**$61,900,000**		Reappropriated funds amount provided by CUSOM

(1) Amount of annual supplemental payment may vary each year due to UPL calculation. Amount of annual supplemental payment is known, Department of Higher Education would transfer reappropriated funds amount to HCPF and any remaining reappropriated funds would remain at Department of Higher Education.
(2) This funding is intended to be ongoing for future years.

FTE Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- New full-time General Fund positions are reflected in Year 1 as 0.9166 FTE to account for the pay-date shift. This applies to personal services costs only; operating costs are not subject to the pay-date shift.

Expenditure Detail		FY 2017-18		FY 2018-19	
Personal Services:					
Classification Title	Monthly	FTE		FTE	
RATE/FINANCIAL ANLYST II	$4,655	0.92	$51,391.00	1.0	$55,860
PERA			$5,216		$5,670
AED			$2,570		$2,793
SAED			$2,570		$2,793
Medicare			$745		$810
STD			$98		$106
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1, 1.0 FTE		**0.92**	**$70,517**	**1.0**	**$75,959**
STATISTICAL ANALYST III	$5,479	0.42	$27,614	1.0	$65,748
PERA			$2,803		$6,673
AED			$1,381		$3,287
SAED			$1,381		$3,287
Medicare			$400		$953
STD			$52		$125
Health-Life-Dental			$7,927		$7,927
Subtotal Position 2, 1.0 FTE		**0.42**	**$41,558**	**1.0**	**$88,000**
ADMINISTRATOR IV	$5,005	0.83	$49,850	2.0	$120,120
PERA			$5,060		$12,192
AED			$2,493		$6,006
SAED			$2,493		$6,006
Medicare			$723		$1,742
STD			$95		$228
Health-Life-Dental			$7,927		$15,854
Subtotal Position 3, 2.0 FTE		**0.83**	**$68,641**	**2.0**	**$162,148**
TRAINING SPECIALIST IV	$5,005	0.42	$25,225	1.0	$60,060
PERA			$2,560		$6,096
AED			$1,261		$3,003
SAED			$1,261		$3,003
Medicare			$366		$871
STD			$48		$114
Health-Life-Dental			$7,927		$7,927
Subtotal Position 4, 1.0 FTE		**0.42**	**$38,648**	**1.0**	**$81,074**
ACCOUNTANT IV	$6,361	0.21	$16,030	0.5	$38,166
PERA			$1,627		$3,874
AED			$802		$1,908
SAED			$802		$1,908
Medicare			$232		$553
STD			$30		$73
Health-Life-Dental			$7,927		$7,927
Subtotal Position 5, 0.5 FTE		**0.21**	**$27,450**	**0.5**	**$54,409**
BUDGET & POLICY ANLST I	$6,794	0.21	$17,121	0.5	$40,764
PERA			$1,738		$4,138
AED			$856		$2,038
SAED			$856		$2,038
Medicare			$248		$591
STD			$33		$77
Health-Life-Dental			$7,927		$7,927
Subtotal Position 6, 1.0 FTE		**0.21**	**$28,779**	**0.5**	**$57,573**
Subtotal Personal Services		3.01	**$275,593**	6.0	**$519,163**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	3.5	$1,750	6.0	$3,000
Telephone Expenses	$450	3.5	$1,575	6.0	$2,700
PC, One-Time	$1,230	6.0	$7,380	-	
Office Furniture, One-Time	$3,473	6.0	$20,838	-	
Subtotal Operating Expenses			**$31,543**		**$5,700**
TOTAL REQUEST		3.01	**$307,136**	6.0	**$524,863**
	General Fund:		*$153,568*		*$262,432*
	Cash funds:		*$0*		*$0*
	Reappropriated Funds:		*$0*		*$0*
	Federal Funds:		*$153,568*		*$262,432*