Exhibit A - Summary of Request

Calculation of Request						
FY 2017-18						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2017-18 Appropriation						
FY 2017-18 Long Bill Appropriation (SB 17-254)	$7,597,506,218	$1,168,754,401	$923,068,333	$886,211,720	$70,552,476	$4,548,919,288
SB 17-091 "Allow Medicaid Home Health Services in Community"	$2,211,530	$1,025,567	$0	$18,216	$0	$1,167,747
SB 17-256 "Hospital Provider Fee"	($528,200,000)	$0	$0	($264,100,000)	$0	($264,100,000)
SB 17-267 "Sustainability of Rural Colorado"	$526,381,099	($320,035)	$0	$264,035,165	$0	$262,665,969
FY 2017-18 Total Spending Authority	**$7,597,898,847**	**$1,169,459,933**	**$923,068,333**	**$886,165,101**	**$70,552,476**	**$4,548,653,004**
Total Projected FY 2017-18 Expenditure	$7,951,288,398	$1,223,360,074	$923,068,333	$877,237,108	$70,306,390	$4,857,316,493
FY 2017-18 Requested Change from Appropriation	**$353,389,551**	**$53,900,141**	**$0**	**($8,927,993)**	**($246,086)**	**$308,663,489**
Percent Change	4.65%	4.61%	0.00%	-1.01%	-0.35%	6.79%

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	$7,597,898,847	$1,169,459,933	$923,068,333	$886,165,101	$70,552,476	$4,548,653,004
Bill Annualizations						
Annualization of Long Bill FY 2017-18 (SB 17-254)	($50,391,426)	($15,511,493)	$0	($1,144,981)	($183,864)	($33,551,088)
SB 17-091 Annualization "Allow Medicaid Home Health Services in Community"	$277,910	$133,501	$0	$3,112	$0	$141,297
SB 17-267 Annualization "Sustainability of Rural Colorado"	($2,546,461)	($448,047)	$0	($90,770)	$0	($2,007,644)
HB 17-1353 Annualization "Implement Medicaid Delivery and Payment Initiatives"	($6,283,184)	$174,533	$0	($889,068)	$0	($5,568,649)
Total Annualizations	($58,943,161)	($15,651,506)	$0	($2,121,707)	($183,864)	($40,986,084)
FY 2018-19 Total Spending Authority	**$7,538,955,686**	**$1,153,808,427**	**$923,068,333**	**$884,043,394**	**$70,368,612**	**$4,507,666,920**
Total Projected FY 2018-19 Expenditure	$7,746,557,747	$1,211,985,491	$923,068,333	$919,747,809	$70,288,985	$4,621,467,129
FY 2018-19 Requested Change from Appropriation	**$207,602,061**	**$58,177,064**	**$0**	**$35,704,415**	**($79,627)**	**$113,800,209**
Percent Change	2.75%	5.04%	0.00%	4.04%	-0.11%	2.52%

Calculation of Request						
FY 2019-20						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2018-19 Appropriation Plus Special Bills	$7,538,955,686	$1,153,808,427	$923,068,333	$884,043,394	$70,368,612	$4,507,666,920
Bill Annualizations						
Annualization of Long Bill FY 2016-17 (HB 16-1405)	$6,360,483	$5,384,842	$0	($10,363)	($74,999)	$1,061,003
SB 17-091 Annualization "Allow Medicaid Home Health Services in Community"	$148,050	$69,867	$0	$4,032	$0	$74,151
SB 17-267 Annualization "Sustainability of Rural Colorado"	($436,536)	($76,809)	$0	($15,560)	$0	($344,167)
HB 17-1353 Annualization "Implement Medicaid Delivery and Payment Initiatives"	($105,710,550)	($36,134,788)	$0	($4,057,706)	$0	($65,518,056)
Total Annualizations	($99,638,553)	($30,756,888)	$0	($4,079,597)	($74,999)	($64,727,069)
FY 2019-20 Total Spending Authority	**$7,439,317,133**	**$1,123,051,539**	**$923,068,333**	**$879,963,797**	**$70,293,613**	**$4,442,939,851**
Total Projected FY 2019-20 Expenditures	$7,935,140,072	$1,325,258,155	$923,068,333	$936,628,797	$70,213,986	$4,679,970,801
FY 2019-20 Requested Change From Appropriation	**$495,822,939**	**$202,206,616**	**$0**	**$56,665,000**	**($79,627)**	**$237,030,950**
Percent Change	6.66%	18.01%	0.00%	6.44%	-0.11%	5.34%

Exhibit A - Summary of Request

Calculation of Fund Splits FY 2017-18							
Item	**Total Request**	**General Fund and General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP[3]**	**Notes**
Acute Care Services							
Base Acute	$2,425,395,044	$1,212,697,522	$0	$0	$1,212,697,522	50.00%	
Breast and Cervical Cancer Program	$1,995,464	$0	$698,412	$0	$1,297,052	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	$6,810,740	$0	$0	$0	$6,810,740	100.00%	
Affordable Care Act Drug Rebate Offset	($36,318,998)	$0	$0	$0	($36,318,998)	100.00%	
Affordable Care Act Preventive Services	$58,669,707	$28,748,156	$0	$0	$29,921,551	51.00%	
Non-Emergency Medical Transportation	$0	$80,522	$291	$0	($80,813)	N/A	CF: Breast and Cervical Cancer Prevention and Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$109,239,378	$13,108,725	$0	$0	$96,130,653	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$24,910,380	$2,989,246	$0	$0	$21,921,134	88.00%	
MAGI Parents/Caretakers to 133% FPL	$259,289,377	$0	$14,565,294	$0	$244,724,083	94.38%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Healthcare Affordability and Sustainability Fee Fund; NEMT services receive administrative match
MAGI Adults	$1,480,698,620	$0	$84,050,130	$0	$1,396,648,490	94.32%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Healthcare Affordability and Sustainability Fee Fund; NEMT services receive administrative match
Continuous Eligibility for Children	$45,497,120	$0	$22,748,560	$0	$22,748,560	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$48,681,734	$0	$25,849,726	$0	$22,832,008	Variable	CF: Healthcare Affordability and Sustainability Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$44,721,243	$0	$7,432,671	$0	$37,288,572	83.38%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$21,499,543	$0	$10,749,771	$0	$10,749,772	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Adult Dental Benefit Financing	$65,101,815	$0	$32,432,106	$0	$32,669,709	Variable	CF: Adult Dental Fund
HB 16-1408 Primary Care Rate Increase Financing	$10,575,826	$0	$5,287,913	$0	$5,287,913	50.00%	CF: Primary Care Provider Sustainability Fund
HB 16-1408 State Plan Autism Treatment	$2,522,286	$0	$1,261,143	$0	$1,261,143	50.00%	CF: Colorado Autism Treatment Fund
Acute Care Services Sub-Total	$4,582,038,176	$1,258,899,061	$205,076,017	$0	$3,118,063,098		
Community Based Long-Term Care Services							
Base Community Based Long-Term Care	$947,441,925	$473,720,962	$0	$0	$473,720,963	50.00%	
Children with Autism Waiver Services	$805,604	$0	$402,802	$0	$402,802	50.00%	CF: Colorado Autism Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$2,809,488	$337,139	$0	$0	$2,472,349	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$12,416	$1,490	$0	$0	$10,926	88.00%	
MAGI Parents/Caretakers to 133% FPL	$462,833	$0	$25,456	$0	$437,377	94.50%	Waivers Services Standard Match; Hospice/PDN/LTHH 95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Adults	$5,774,351	$0	$317,589	$0	$5,456,762	94.50%	Waivers Services Standard Match; Hospice/PDN/LTHH 95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Healthcare Affordability and Sustainability Fee Fund
Continuous Eligibility for Children	$116,339	$0	$58,169	$0	$58,170	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$7,757,596	$0	$4,119,239	$0	$3,638,357	Variable	CF: Healthcare Affordability and Sustainability Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$1,565,375	$0	$260,165	$0	$1,305,210	83.38%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$113,149	$0	$56,574	$0	$56,575	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Community Based Long-Term Care Services Sub-Total	$966,859,076	$474,059,591	$5,239,994	$0	$487,559,491		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$675,169,355	$337,584,677	$0	$0	$337,584,678	50.00%	
Class II Nursing Facilities	$4,069,927	$2,034,963	$0	$0	$2,034,964	50.00%	
PACE	$171,557,316	$85,778,658	$0	$0	$85,778,658	50.00%	
Supplemental Medicare Insurance Benefit (SMIB)	$183,627,842	$99,159,035	$0	$0	$84,468,807	46.00%	Approximately 13% of Total is State-Only & 5% is 100% FFP
Health Insurance Buy-In	$2,747,543	$1,373,771	$0	$0	$1,373,772	50.00%	
MAGI Parents/Caretakers to 133% FPL	$48,888	$0	$2,689	$0	$46,199	94.50%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Adults	$1,268,197	$0	$69,751	$0	$1,198,446	94.50%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Healthcare Affordability and Sustainability Fee Fund
Continuous Eligibility for Children	$0	$0	$0	$0	$0	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$88,852	$0	$47,180	$0	$41,672	Variable	CF: Healthcare Affordability and Sustainability Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$2,644,626	$0	$439,537	$0	$2,205,089	83.38%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$23,299	$0	$11,649	$0	$11,650	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Long-Term Care and Insurance Sub-Total	$1,041,245,845	$525,931,104	$570,806	$0	$514,743,935		

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	$34,808,240	$17,404,120	$0	$0	$17,404,120	50.00%	
Base Accountable Care Collaborative	$95,169,211	$47,584,605	$0	$0	$47,584,606	50.00%	
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"	$8,814,155	$1,057,699	$0	$0	$7,756,456	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$203,685	$24,442	$0	$0	$179,243	88.00%	
MAGI Parents/Caretakers to 133% FPL	$9,404,551	$0	$517,250	$0	$8,887,301	94.50%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Adults	$44,013,839	$0	$2,420,761	$0	$41,593,078	94.50%	95% FFP January 1, 2017; 94% FFP January 1, 2018; CF: Healthcare Affordability and Sustainability Fee Fund
Continuous Eligibility for Children	$6,893,756	$0	$3,446,878	$0	$3,446,878	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$615,634	$0	$326,898	$0	$288,736	Variable	CF: Healthcare Affordability and Sustainability Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$225,764	$0	$37,522	$0	$188,242	83.38%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$620,016	$0	$310,008	$0	$310,008	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Service Management Sub-Total	$202,054,577	$66,070,866	$7,702,180	$0	$128,281,531		
FY 2017-18 Estimate of Total Expenditures for Medical Services to Clients	**$6,792,197,674**	**$2,324,960,622**	**$218,588,997**	**$0**	**$4,248,648,055**		
Financing							
Upper Payment Limit Financing	$4,148,965	($4,226,991)	$4,148,965	$0	$4,226,991	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($22,510,946)	$49,366,109	$0	($26,855,163)	54.40%	CF: Department Recoveries
Denver Health Outstationing	$2,600,000	$910,000	$0	$0	$1,690,000	65.00%	
Healthcare Affordability and Sustainability Fee Supplemental Payments	$911,744,619	$0	$455,810,189	$0	$455,934,430	50.01%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Nursing Facility Supplemental Payments	$107,683,824	$0	$53,841,912	$0	$53,841,912	50.00%	CF: Medicaid Nursing Facility Provider Fee Cash Fund
Physician Supplemental Payments	$10,521,089	($553,975)	$5,535,317	$0	$5,539,747	Variable	CF: Certification of Public Expenditure
Hospital High Volume Inpatient Payment	$1,127,611	($59,373)	$593,255	$0	$593,729	Variable	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($67,518,800)	$67,518,800	$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	$6,141,995	($323,399)	$3,231,404	$0	$3,233,990	Variable	CF: Certification of Public Expenditure
University of Colorado School of Medicine Payment	$123,042,864	$0	$0	$61,275,346	$61,767,518	50.20%	RF: Department of Higher Education, Fee-for-service Contracts with State Institutions for Speciality Education Programs
Payment delays from implementation of interChange - Financing Impact	($8,920,243)	($57,115,527)	$0	$0	$48,195,284	N/A	
Cash Funds Financing[1]	$0	($27,133,204)	$18,102,160	$9,031,044	$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$1,159,090,724	($178,532,215)	$658,648,111	$70,306,390	$608,668,438		
Total Projected FY 2017-18 Expenditures[2]	**$7,951,288,398**	**$2,146,428,407**	**$877,237,108**	**$70,306,390**	**$4,857,316,493**		

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, $923,068,333 is General Fund Exempt.

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

Exhibit A - Summary of Request

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	$2,126,208,015	$1,063,104,007	$0	$0	$1,063,104,008	50.00%	
Breast and Cervical Cancer Program	$806,130	$0	$282,145	$0	$523,985	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	$6,818,232	$0	$0	$0	$6,818,232	100.00%	
Affordable Care Act Drug Rebate Offset	($42,008,078)	$0	$0	$0	($42,008,078)	100.00%	
Affordable Care Act Preventive Services	$60,545,571	$29,667,330	$0	$0	$30,878,241	51.00%	
Non-Emergency Medical Transportation	$0	$84,049	$160	$0	($84,209)	N/A	CF: Breast and Cervical Cancer Prevention and Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$102,926,563	$12,351,188	$0	$0	$90,575,375	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$23,350,581	$2,802,070	$0	$0	$20,548,511	88.00%	
MAGI Parents/Caretakers to 133% FPL	$244,204,797	$0	$16,193,701	$0	$228,011,096	93.37%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Healthcare Affordability and Sustainability Fee Fund; NEMT services receive administrative match
MAGI Adults	$1,364,029,407	$0	$91,307,857	$0	$1,272,721,550	93.31%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Healthcare Affordability and Sustainability Fee Fund; NEMT services receive administrative match
Continuous Eligibility for Children	$46,586,003	$0	$23,293,001	$0	$23,293,002	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$44,991,433	$0	$24,181,564	$0	$20,809,869	Variable	CF: Healthcare Affordability and Sustainability Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$46,020,771	$0	$7,993,808	$0	$38,026,963	82.63%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$24,607,330	$0	$12,303,665	$0	$12,303,665	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Adult Dental Benefit Financing	$68,411,606	$0	$34,085,705	$0	$34,325,901	Variable	CF: Adult Dental Fund
HB 16-1408 State Plan Autism Treatment	$3,937,837	$0	$1,968,918	$0	$1,968,919	50.00%	CF: Colorado Autism Treatment Fund
Acute Care Services Sub-Total	$4,134,928,356	$1,109,357,860	$211,610,524	$0	$2,813,959,972		
Community Based Long-Term Care Services							
Base Community Based Long-Term Care	$1,018,105,708	$509,052,854	$0	$0	$509,052,854	50.00%	
Children with Autism Waiver Services	$525,869	$0	$262,934	$0	$262,935	50.00%	CF: Colorado Autism Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$3,011,381	$361,366	$0	$0	$2,650,015	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$12,907	$1,549	$0	$0	$11,358	88.00%	
MAGI Parents/Caretakers to 133% FPL	$503,488	$0	$32,727	$0	$470,761	93.50%	Waivers receive standard match; 94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Adults	$6,182,805	$0	$401,882	$0	$5,780,923	93.50%	Waivers receive standard match; 94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Healthcare Affordability and Sustainability Fee Fund
Continuous Eligibility for Children	$123,059	$0	$61,529	$0	$61,530	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$8,405,574	$0	$4,517,747	$0	$3,887,827	Variable	CF: Healthcare Affordability and Sustainability Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$1,691,544	$0	$293,821	$0	$1,397,723	82.63%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$135,360	$0	$67,680	$0	$67,680	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Community Based Long-Term Care Sub-Total	$1,038,697,695	$509,415,769	$5,638,320	$0	$523,643,606		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$696,743,859	$348,371,929	$0	$0	$348,371,930	50.00%	
Class II Nursing Facilities	$4,339,105	$2,169,552	$0	$0	$2,169,553	50.00%	
PACE	$189,947,985	$94,973,992	$0	$0	$94,973,993	50.00%	
Supplemental Medicare Insurance Benefit (SMIB)	$198,595,486	$107,241,562	$0	$0	$91,353,924	46.00%	Approximately 13% of Total is State-Only & 5% is 100% FFP.
Health Insurance Buy-In	$3,480,440	$1,740,220	$0	$0	$1,740,220	50.00%	
MAGI Parents/Caretakers to 133% FPL	$61,928	$0	$4,025	$0	$57,903	93.50%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Adults	$1,225,412	$0	$79,652	$0	$1,145,760	93.50%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Healthcare Affordability and Sustainability Fee Fund
Continuous Eligibility for Children	$0	$0	$0	$0	$0	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$91,695	$0	$49,283	$0	$42,412	Variable	CF: Healthcare Affordability and Sustainability Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$2,822,921	$0	$490,341	$0	$2,332,580	82.63%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$28,037	$0	$14,018	$0	$14,019	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Long-Term Care and Insurance Sub-Total	$1,097,336,868	$554,497,255	$637,319	$0	$542,202,294		

Exhibit A - Summary of Request

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	$36,229,127	$18,114,563	$0	$0	$18,114,564	50.00%	
Base Accountable Care Collaborative	$115,056,978	$57,528,489	$0	$0	$57,528,489	50.00%	
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"	$11,078,707	$1,329,445	$0	$0	$9,749,262	88.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$376,328	$45,159	$0	$0	$331,169	88.00%	
MAGI Parents/Caretakers to 133% FPL	$14,426,477	$0	$937,721	$0	$13,488,756	93.50%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Adults	$57,196,925	$0	$3,717,800	$0	$53,479,125	93.50%	94% FFP January 1, 2018; 93% FFP January 1, 2019; CF: Healthcare Affordability and Sustainability Fee Fund
Continuous Eligibility for Children	$7,464,917	$0	$3,732,458	$0	$3,732,459	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$1,391,166	$0	$747,710	$0	$643,456	Variable	CF: Healthcare Affordability and Sustainability Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$229,895	$0	$39,933	$0	$189,962	82.63%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$758,202	$0	$379,101	$0	$379,101	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Service Management Sub-Total	$245,494,448	$77,017,656	$10,197,586	$0	$158,279,206		
FY 2018-19 Estimate of Total Expenditures for Medical Services to Clients	**$6,516,457,367**	**$2,250,288,540**	**$228,083,749**	**$0**	**$4,038,085,078**		
Financing							
Upper Payment Limit Financing	$4,332,197	($4,334,405)	$4,332,197	$0	$4,334,405	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($16,304,069)	$51,029,950	$0	($34,725,881)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$2,700,000	$945,000	$0	$0	$1,755,000	65.00%	
Healthcare Affordability and Sustainability Fee Supplemental Pa	$969,432,800	$0	$484,716,399	$0	$484,716,401	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Nursing Facility Supplemental Payments	$111,551,827	$0	$55,775,913	$0	$55,775,914	50.00%	CF: Medicaid Nursing Facility Provider Fee Cash Fund
Physician Supplemental Payments	$10,886,400	($572,969)	$5,729,684	$0	$5,729,685	Variable	CF: Certification of Public Expenditure
Hospital High Volume Inpatient Payment	$1,166,763	($61,409)	$614,086	$0	$614,086	Variable	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($67,518,800)	$67,518,800	$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	$6,355,256	($334,487)	$3,344,871	$0	$3,344,872	Variable	CF: Certification of Public Expenditure
University of Colorado School of Medicine Payment	$122,675,137	$0	$0	$61,337,568	$61,337,569	50.00%	RF: Department of Higher Education, Fee-for-service Contracts with State Institutions for Speciality Education Programs
Cash Funds Financing[1]	$0	($27,053,577)	$18,102,160	$8,951,417	$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$1,230,100,380	($115,234,716)	$691,664,060	$70,288,985	$583,382,051		
Total Projected FY 2018-19 Expenditures[2]	**$7,746,557,747**	**$2,135,053,824**	**$919,747,809**	**$70,288,985**	**$4,621,467,129**		

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, $923,068,333 is General Fund Exempt.

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

Exhibit A - Summary of Request

Calculation of Fund Splits
FY 2019-20

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP [3]	Notes
Acute Care Services							
Base Acute	$2,134,221,968	$1,067,110,984	$0	$0	$1,067,110,984	50.00%	
Breast and Cervical Cancer Program	$861,904	$0	$301,666	$0	$560,238	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
Family Planning	$14,278,751	$1,427,875	$0	$0	$12,850,876	90.00%	
Indian Health Service	$6,825,732	$0	$0	$0	$6,825,732	100.00%	
Affordable Care Act Drug Rebate Offset	($48,588,307)	$0	$0	$0	($48,588,307)	100.00%	
Affordable Care Act Preventive Services	$61,371,227	$30,071,901	$0	$0	$31,299,326	51.00%	
Non-Emergency Medical Transportation	$0	$86,956	$157	$0	($87,113)	N/A	CF: Breast and Cervical Cancer Prevention and Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$107,864,543	$31,550,379	$0	$0	$76,314,164	70.75%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$23,895,255	$6,989,362	$0	$0	$16,905,893	70.75%	
MAGI Parents/Caretakers to 133% FPL	$254,038,441	$0	$21,911,764	$0	$232,126,677	91.37%	93% FFP January 1, 2019; 90% FFP January 1, 2020; CF: Healthcare Affordability and Sustainability Fee Fund; NEMT services receive administrative match
MAGI Adults	$1,434,562,433	$0	$124,512,081	$0	$1,310,050,352	91.32%	93% FFP January 1, 2019; 90% FFP January 1, 2020; CF: Healthcare Affordability and Sustainability Fee Fund; NEMT services receive administrative match
Continuous Eligibility for Children	$47,353,153	$0	$23,676,576	$0	$23,676,577	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$44,314,854	$0	$24,026,736	$0	$20,288,118	Variable	CF: Healthcare Affordability and Sustainability Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$7,149,720	$0	$1,349,152	$0	$5,800,568	81.13%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$25,490,653	$0	$12,745,326	$0	$12,745,327	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Adult Dental Benefit Financing	$71,517,720	$0	$35,637,405	$0	$35,880,315	Variable	CF: Adult Dental Fund
HB 16-1408 State Plan Autism Treatment	$6,158,087	$0	$3,079,043	$0	$3,079,044	50.00%	CF: Colorado Autism Treatment Fund
Acute Care Services Sub-Total	$4,191,316,134	$1,137,237,457	$247,239,906	$0	$2,806,838,771		
Community Based Long-Term Care Services							
Base Community Based Long-Term Care	$1,102,318,044	$551,159,022	$0	$0	$551,159,022	50.00%	
Children with Autism Waiver Services	$0	$0	$0	$0	$0	50.00%	CF: Colorado Autism Treatment Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$3,279,911	$959,374	$0	$0	$2,320,537	70.75%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$12,873	$3,765	$0	$0	$9,108	70.75%	
MAGI Parents/Caretakers to 133% FPL	$545,692	$0	$46,384	$0	$499,308	91.50%	Waivers receive standard match; 93% FFP January 1, 2019; 90% FFP January 1, 2020; CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Adults	$8,410,714	$0	$714,911	$0	$7,695,803	91.50%	Waivers receive standard match; 93% FFP January 1, 2019; 90% FFP January 1, 2020; CF: Healthcare Affordability and Sustainability Fee Fund
Continuous Eligibility for Children	$123,600	$0	$61,800	$0	$61,800	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$9,193,610	$0	$4,984,614	$0	$4,208,996	Variable	CF: Healthcare Affordability and Sustainability Fee and Medicaid Buy-In Fund
Non-Newly Eligibles	$15,652	$0	$2,954	$0	$12,698	81.13%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$146,607	$0	$73,303	$0	$73,304	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Community Based Long-Term Care Sub-Total	$1,124,046,703	$552,122,161	$5,883,966	$0	$566,040,576		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$721,041,037	$360,520,518	$0	$0	$360,520,519	50.00%	
Class II Nursing Facilities	$4,339,105	$2,169,552	$0	$0	$2,169,553	50.00%	
PACE	$210,846,336	$105,423,168	$0	$0	$105,423,168	50.00%	
Supplemental Medicare Insurance Benefit (SMIB)	$210,194,472	$113,505,015	$0	$0	$96,689,457	46.00%	Approximately 13% of Total is State-Only & 5% is 100% FFP
Health Insurance Buy-In	$4,377,197	$2,188,598	$0	$0	$2,188,599	50.00%	
MAGI Parents/Caretakers to 133% FPL	$77,884	$0	$6,620	$0	$71,264	91.50%	93% FFP January 1, 2019; 90% FFP January 1, 2020; CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Adults	$4,198,074	$0	$356,836	$0	$3,841,238	91.50%	93% FFP January 1, 2019; 90% FFP January 1, 2020; CF: Healthcare Affordability and Sustainability Fee Fund
Continuous Eligibility for Children	$0	$0	$0	$0	$0	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$94,897	$0	$51,451	$0	$43,446	Variable	CF: Healthcare Affordability and Sustainability Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$9,968	$0	$1,881	$0	$8,087	81.13%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$30,591	$0	$15,295	$0	$15,296	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Long-Term Care and Insurance Sub-Total	$1,155,209,561	$583,806,851	$432,083	$0	$570,970,627		

Exhibit A - Summary of Request

Calculation of Fund Splits
FY 2019-20

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP [3]	Notes
Service Management							
Base Service Management	$44,000,905	$22,000,452	$0	$0	$22,000,453	50.00%	
Base Accountable Care Collaborative	$130,752,236	$65,376,118	$0	$0	$65,376,118	50.00%	
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"	$12,802,243	$3,744,656	$0	$0	$9,057,587	70.75%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$419,656	$122,749	$0	$0	$296,907	70.75%	
MAGI Parents/Caretakers to 133% FPL	$16,671,060	$0	$1,417,040	$0	$15,254,020	91.50%	93% FFP January 1, 2019; 90% FFP January 1, 2020; CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Adults	$64,549,197	$0	$5,486,682	$0	$59,062,515	91.50%	93% FFP January 1, 2019; 90% FFP January 1, 2020; CF: Healthcare Affordability and Sustainability Fee Fund
Continuous Eligibility for Children	$7,497,742	$0	$3,748,871	$0	$3,748,871	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Disabled Buy-In	$1,764,583	$0	$956,726	$0	$807,857	Variable	CF: Healthcare Affordability and Sustainability Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$391,497	$0	$73,875	$0	$317,622	81.13%	CF: Healthcare Affordability and Sustainability Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$814,202	$0	$407,101	$0	$407,101	50.00%	CF: Healthcare Affordability and Sustainability Fee Fund
Service Management Sub-Total	$280,949,047	$91,243,975	$12,733,158	$0	$176,971,914		
FY 2019-20 Estimate of Total Expenditures for Medical Services to Clients	**$6,751,521,445**	**$2,364,410,444**	**$266,289,113**	**$0**	**$4,120,821,888**		
Financing							
Upper Payment Limit Financing	$4,483,667	($4,483,666)	$4,483,667	$0	$4,483,666	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($16,854,767)	$52,753,573	$0	($35,898,806)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$2,800,000	$980,000	$0	$0	$1,820,000	65.00%	
Healthcare Affordability and Sustainability Fee Supplemental Pa	$915,341,286	$0	$457,670,643	$0	$457,670,643	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Nursing Facility Supplemental Payments	$115,558,769	$0	$57,779,384	$0	$57,779,385	50.00%	CF: Medicaid Nursing Facility Provider Fee Cash Fund
Physician Supplemental Payments	$14,126,735	($743,512)	$7,435,123	$0	$7,435,124	Variable	CF: Certification of Public Expenditure
Hospital High Volume Inpatient Payment	$1,207,250	($63,540)	$635,395	$0	$635,395	Variable	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($67,518,800)	$67,518,800	$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	$6,575,783	($346,094)	$3,460,939	$0	$3,460,938	Variable	CF: Certification of Public Expenditure
University of Colorado School of Medicine Payment	$122,525,137	$0	$0	$61,262,569	$61,262,568	50.00%	RF: Department of Higher Education, Fee-for-service Contracts with State Institutions for Speciality Education Programs
Cash Funds Financing[1]	$0	($27,053,577)	$18,102,160	$8,951,417	$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$1,183,618,627	($116,083,956)	$670,339,684	$70,213,986	$559,148,913		
Total Projected FY 2019-20 Expenditures[2]	**$7,935,140,072**	**$2,248,326,488**	**$936,628,797**	**$70,213,986**	**$4,679,970,801**		

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, $923,068,333 is General Fund Exempt.

(3) On January 1, 2020, the ACA expansion FMAP decreases from a 93% FMAP rate to 90% 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 Actuals	43,941	11,241	67,619	6,251	160,991	101,059	347,848	295	469,906	64,937	20,310	13,311	2,016	2,640	33,809	1,346,174
%C Change from FY 2015-16	3.63%	6.76%	-1.72%	0.55%	-1.44%	16.21%	8.58%	-8.39%	0.58%	9.14%	1.88%	-7.65%	14.61%	-0.34%	3.76%	3.79%
FY 2017-18 Projection	45,242	11,681	67,743	7,811	188,617	91,246	380,104	117	466,328	68,762	20,584	11,429	2,365	2,782	36,869	1,401,680
% Change from FY 2016-17	2.96%	3.91%	0.18%	24.96%	17.16%	-9.71%	9.27%	-60.34%	-0.76%	5.89%	1.35%	-14.14%	17.31%	5.38%	9.05%	4.12%
FY 2018-19 Projection	45,993	12,176	69,473	9,099	196,256	98,254	393,958	62	468,328	71,877	20,746	11,427	2,364	2,814	41,068	1,443,895
% Change from FY 2017-18	1.66%	4.24%	2.55%	16.49%	4.05%	7.68%	3.64%	-47.01%	0.43%	4.53%	0.79%	-0.02%	-0.04%	1.15%	11.39%	3.01%
FY 2019-20 Projection	46,770	12,712	71,706	10,368	201,516	102,381	401,763	61	470,392	74,443	20,929	11,425	2,364	2,846	45,746	1,475,422
% Change from FY 2018-19	1.69%	4.40%	3.21%	13.95%	2.68%	4.20%	1.98%	-1.61%	0.44%	3.57%	0.88%	-0.02%	0.00%	1.14%	11.39%	2.18%
FY 2017-18 Appropriation	44,144	11,659	69,085	7,414	192,463	80,982	389,466	253	479,307	69,199	20,456	14,131	1,803	2,551	37,354	1,420,267
Difference between the Total FY 2017-18 Projection and Appropriation	1,098	22	(1,342)	397	(3,846)	10,264	(9,362)	(136)	(12,979)	(437)	128	(2,702)	562	231	(485)	(18,587)

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	-	-	-	-	-	-	-	60	-	-	-	-	-	-	-	60
Total FY 2016-17 Adjustments	-	-	-	-	-	-	-	60	-	-	-	-	-	-	-	60
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	61	-	-	-	-	-	-	-	61
HB 16-1321 Medicaid Buy-In for SLS, SCI, and BI Waivers	-	-	(33)	38	-	-	-	-	-	-	-	-	-	-	-	5
Total FY 2017-18 Adjustments	-	-	(33)	38	-	-	-	61	-	-	-	-	-	-	-	66
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	61	-	-	-	-	-	-	-	61
HB 16-1321 Medicaid Buy-In for SLS, SCI, and BI Waivers	-	-	(35)	41	-	-	-	-	-	-	-	-	-	-	-	6
Total FY 2018-19 Adjustments	-	-	(35)	41	-	-	-	61	-	-	-	-	-	-	-	67
Breast and Cervical Cancer Program over 133% FPL	-	-	-	-	-	-	-	61	-	-	-	-	-	-	-	61
HB 16-1321 Medicaid Buy-In for SLS, SCI, and BI Waivers	-	-	(35)	41	-	-	-	-	-	-	-	-	-	-	-	6
Total FY 2019-20 Adjustments	-	-	(35)	41	-	-	-	61	-	-	-	-	-	-	-	67

Exhibit B - Medicaid Caseload

Prior to Adjustments - Not Official Department Request

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

Prior to Adjustments

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	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 Actuals	43,941	11,241	67,619	6,251	160,991	101,059	347,848	235	469,906	64,937	20,310	13,311	2,016	2,640	33,809	1,346,114
%C Change from FY 2015-16	3.63%	6.76%	-1.72%	0.55%	-1.44%	16.21%	8.58%	-14.55%	0.58%	9.14%	1.88%	-7.65%	14.61%	-0.34%	3.76%	3.79%
FY 2017-18 Projection	45,242	11,681	67,776	7,773	188,617	91,246	380,104	56	466,328	68,762	20,584	11,429	2,365	2,782	36,869	1,401,614
% Change from FY 2016-17	2.96%	3.91%	0.23%	24.35%	17.16%	-9.71%	9.27%	-76.17%	-0.76%	5.89%	1.35%	-14.14%	17.31%	5.38%	9.05%	4.12%
FY 2018-19 Projection	45,993	12,176	69,508	9,058	196,256	98,254	393,958	1	468,328	71,877	20,746	11,427	2,364	2,814	41,068	1,443,828
% Change from FY 2017-18	1.66%	4.24%	2.56%	16.53%	4.05%	7.68%	3.64%	-98.21%	0.43%	4.53%	0.79%	-0.02%	-0.04%	1.15%	11.39%	3.01%
FY 2019-20 Projection	46,770	12,712	71,741	10,327	201,516	102,381	401,763	0	470,392	74,443	20,929	11,425	2,364	2,846	45,746	1,475,355
% Change from FY 2018-19	1.69%	4.40%	3.21%	14.01%	2.68%	4.20%	1.98%	-100.00%	0.44%	3.57%	0.88%	-0.02%	0.00%	1.14%	11.39%	2.18%
FY 2017-18 Appropriation	44,144	11,659	69,085	7,414	192,463	80,982	389,466	253	479,307	69,199	20,456	14,131	1,803	2,551	37,354	1,420,267
Difference between the Total FY 2017-18 Projection and Appropriation	1,098	22	(1,309)	359	(3,846)	10,264	(9,362)	(197)	(12,979)	(437)	128	(2,702)	562	231	(485)	(18,653)

Exhibit B - Medicaid Caseload Forecast

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%**

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%**

Exhibit B - Medicaid Caseload Forecast

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%**

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%**

Exhibit B - Medicaid Caseload Forecast

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%**

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%**

MEDICAID CASELOAD FY 2016-17 without RETROACTIVITY

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	Monthly Growth	Monthly Growth Rate
July 2016	43,104	10,931	67,836	5,334	150,888	90,622	351,908	313	470,963	62,982	20,118	14,896	1,883	2,630	33,512	1,327,920	(3,057)	-0.23%
August 2016	43,374	11,011	67,906	5,452	150,673	91,044	359,971	310	471,980	63,715	20,203	14,911	1,872	2,634	33,636	1,338,692	10,772	0.81%
September 2016	43,633	11,039	68,043	5,598	151,271	90,010	356,125	311	471,754	64,431	20,296	14,401	1,797	2,571	33,623	1,334,903	(3,789)	-0.28%
October 2016	43,725	11,131	67,951	5,825	153,579	88,537	353,370	312	471,116	64,454	20,260	14,168	1,790	2,455	33,461	1,332,134	(2,769)	-0.21%
November 2016	43,913	11,233	67,914	5,918	155,687	90,158	358,986	306	473,863	61,650	20,306	13,876	1,738	2,434	33,416	1,341,398	9,264	0.70%
December 2016	43,481	11,181	66,509	6,114	157,155	90,730	362,193	303	472,054	62,524	20,296	13,608	1,736	2,430	33,390	1,343,704	2,306	0.17%
January 2017	43,888	11,405	68,174	6,267	158,234	87,555	362,098	295	469,992	64,732	20,297	13,527	1,816	2,526	33,173	1,343,979	275	0.02%
February 2017	43,649	11,363	67,879	6,382	158,909	86,966	361,837	285	467,770	64,616	20,235	12,860	1,765	2,406	33,167	1,340,089	(3,890)	-0.29%
March 2017	44,261	11,397	67,558	6,964	163,649	156,205	296,427	285	467,046	68,267	20,034	12,031	2,534	2,789	34,322	1,353,769	13,680	1.02%
April 2017	44,637	11,381	67,367	7,018	172,849	141,660	309,197	279	468,273	67,605	20,433	12,012	2,472	2,868	34,407	1,362,458	8,689	0.64%
May 2017	44,816	11,401	67,183	7,042	178,391	116,609	333,778	274	469,056	67,690	20,681	11,966	2,418	2,992	34,806	1,369,103	6,645	0.49%
June 2017	44,814	11,420	67,109	7,102	180,603	82,613	368,291	264	464,999	66,581	20,557	11,474	2,374	2,941	34,798	1,365,940	(3,163)	-0.23%
Year-to-Date Average	**43,941**	**11,241**	**67,619**	**6,251**	**160,991**	**101,059**	**347,848**	**295**	**469,906**	**64,937**	**20,310**	**13,311**	**2,016**	**2,640**	**33,809**	**1,346,174**	**2,914**	**0.22%**

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%	236.03%	-	-7.21%	4.81%	-	13.54%	5.86%	-	15.85%	17.65%	1.77%
FY 2011-12	$20,300.66	$16,955.03	$14,209.99	$8,877.60	$3,311.46	$2,423.80	$2,185.53	$17,216.60	$1,569.28	-	$3,783.82	$8,354.70	-	$15,148.44	$1,298.38	$4,717.85
% Change from FY 2010-11	-0.18%	-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	$24,168.32	$19,636.21	$16,194.70	$6,650.61	$3,029.23	$2,535.22	$3,785.54	$12,069.41	$1,869.77	$1,587.21	$4,278.39	$10,893.62	$9,738.80	$14,863.53	$1,221.39	$4,337.47
% Change from FY 2014-15	5.24%	4.81%	5.88%	-7.45%	0.46%	2.51%	-2.29%	-5.22%	3.42%	7.32%	2.03%	3.83%	3.02%	-0.20%	9.82%	0.44%
FY 2016-17	$26,602.84	$18,279.68	$15,829.81	$6,514.13	$2,639.59	$2,288.14	$3,388.68	$13,074.82	$1,756.87	$1,418.77	$3,973.33	$9,989.56	$7,696.84	$15,431.99	$1,211.04	$4,124.95
%C Change from FY 2015-16	10.07%	-6.91%	-2.25%	-2.05%	-12.86%	-9.75%	-10.48%	8.33%	-6.04%	-10.61%	-7.13%	-8.30%	-20.97%	3.82%	-0.85%	-4.90%
FY 2017-18 Projection	$27,668.77	$22,589.75	$18,952.27	$7,318.54	$3,214.49	$2,952.22	$4,160.38	$17,228.36	$2,131.73	$1,757.70	$4,775.51	$12,479.71	$10,631.14	$16,433.99	$1,347.28	$4,845.75
% Change from FY 2016-17	14.48%	15.04%	17.03%	10.04%	6.12%	16.45%	9.90%	42.74%	14.01%	10.74%	11.62%	14.56%	9.16%	10.57%	10.31%	11.72%
FY 2018-19 Projection	$27,714.32	$21,387.05	$17,933.97	$6,033.76	$2,841.36	$2,639.78	$3,756.40	$13,262.98	$1,971.90	$1,628.01	$4,525.58	$11,290.73	$10,042.22	$14,894.09	$1,309.89	$4,513.11
% Change from FY 2017-18	0.16%	-5.32%	-5.37%	-17.56%	-11.61%	-10.58%	-9.71%	-23.02%	-7.50%	-7.38%	-5.23%	-9.53%	-5.54%	-9.37%	-2.78%	-6.86%
FY 2019-20 Projection	$28,210.89	$21,473.82	$18,241.37	$5,342.33	$2,792.06	$2,651.91	$3,782.69	$14,412.56	$2,035.83	$1,664.99	$4,724.15	$11,652.04	$10,290.94	$15,227.25	$1,304.97	$4,575.99
% Change from FY 2018-19	1.79%	0.41%	1.71%	-11.46%	-1.74%	0.46%	0.70%	8.67%	3.24%	2.27%	4.39%	3.20%	2.48%	2.24%	-0.38%	1.39%

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	$24,168.32	$19,636.21	$16,194.70	$6,650.61	$3,029.23	$2,535.22	$3,785.54	$12,069.41	$1,869.77	$1,587.21	$4,278.39	$10,893.62	$9,738.80	$14,863.53	$1,221.39	$4,337.47
% Change from FY 2014-15	5.24%	4.81%	5.88%	-7.45%	0.46%	2.51%	-2.29%	-5.22%	3.42%	7.32%	2.03%	3.83%	3.02%	-0.20%	9.82%	0.44%
FY 2016-17	$26,602.84	$18,279.68	$15,829.81	$6,514.13	$2,639.59	$2,288.14	$3,388.68	$13,074.82	$1,756.87	$1,418.77	$3,973.33	$9,989.56	$7,696.84	$15,431.99	$1,211.04	$4,124.95
%C Change from FY 2015-16	10.07%	-6.91%	-2.25%	-2.05%	-12.86%	-9.75%	-10.48%	8.33%	-6.04%	-10.61%	-7.13%	-8.30%	-20.97%	3.82%	-0.85%	-4.90%
FY 2017-18 Projection	$27,668.77	$22,589.75	$18,952.27	$7,318.54	$3,214.49	$2,952.22	$4,160.38	$17,228.36	$2,131.73	$1,757.70	$4,775.51	$12,479.71	$10,631.14	$16,433.99	$1,347.28	$4,845.75
% Change from FY 2016-17	14.48%	15.04%	17.03%	10.04%	6.12%	16.45%	9.90%	42.74%	14.01%	10.74%	11.62%	14.56%	9.16%	10.57%	10.31%	11.72%
FY 2018-19 Projection	$27,714.32	$21,387.05	$17,933.97	$6,033.76	$2,841.36	$2,639.78	$3,756.40	$13,262.98	$1,971.90	$1,628.01	$4,525.58	$11,290.73	$10,042.22	$14,894.09	$1,309.89	$4,513.11
% Change from FY 2017-18	0.16%	-5.32%	-5.37%	-17.56%	-11.61%	-10.58%	-9.71%	-23.02%	-7.50%	-7.38%	-5.23%	-9.53%	-5.54%	-9.37%	-2.78%	-6.86%
FY 2019-20 Projection	$28,210.89	$21,473.82	$18,241.37	$5,342.33	$2,792.06	$2,651.91	$3,782.69	$14,412.56	$2,035.83	$1,664.99	$4,724.15	$11,652.04	$10,290.94	$15,227.25	$1,304.97	$4,575.99
% Change from FY 2018-19	1.79%	0.41%	1.71%	-11.46%	-1.74%	0.46%	0.70%	8.67%	3.24%	2.27%	4.39%	3.20%	2.48%	2.24%	-0.38%	1.39%

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 2017-18			FY 2018-19			FY 2019-20		
	Spending Authority	Request	Change	Base Spending Authority	Request	Change	Base Spending Authority	Request	Change
Cash Funds									
Certified Funds	$18,731,618	$13,508,941	($5,222,677)	$18,731,618	$14,020,838	($4,710,780)	$18,731,618	$16,015,124	($2,716,494)
Healthcare Affordability and Sustainability Fee Cash Fund	$644,890,063	$645,831,384	$941,321	$642,780,944	$687,144,679	$44,363,735	$638,719,530	$695,327,511	$56,607,981
Hospital Provider Fee Cash Fund	($40,540)	$0	$40,540	($40,540)	$0	$40,540	($40,540)	$0	$40,540
Medicaid Buy-In Fund	$4,870,633	$3,542,272	($1,328,361)	$4,872,919	$4,112,744	($760,175)	$4,872,919	$4,671,111	($201,808)
Tobacco Tax Cash Fund	$2,201,700	$2,201,700	$0	$2,201,700	$2,201,700	$0	$2,201,700	$2,201,700	$0
Health Care Expansion Fund	$67,518,800	$67,518,800	$0	$67,518,800	$67,518,800	$0	$67,518,800	$67,518,800	$0
Breast and Cervical Cancer Fund	$1,058,346	$698,703	($359,643)	$1,043,472	$282,305	($761,167)	$1,025,289	$301,823	($723,466)
Colorado Autism Treatment Fund	$7,149,477	$1,663,945	($5,485,532)	$7,149,477	$2,231,852	($4,917,625)	$7,149,477	$3,079,043	($4,070,434)
Nursing Facility Fund	$53,416,339	$53,841,912	$425,573	$53,416,339	$55,775,913	$2,359,574	$53,416,339	$57,779,384	$4,363,045
Tobacco Education Program Fund	$642,863	$642,863	$0	$642,863	$642,863	$0	$642,863	$642,863	$0
Department Recoveries Fund	$51,190,388	$49,366,109	($1,824,279)	$51,190,388	$51,029,950	($160,438)	$51,190,388	$52,753,573	$1,563,185
ICF-IID Provider Fee	$200,460	$200,460	$0	$200,460	$200,460	$0	$200,460	$200,460	$0
Adult Dental Fund	$33,001,621	$32,432,106	($569,515)	$33,001,621	$34,085,705	$1,084,084	$33,001,621	$35,637,405	$2,635,784
Transfer from Denver Health	$500,000	$500,000	$0	$500,000	$500,000	$0	$500,000	$500,000	$0
Primary Care Provider Sustainability Fund	$833,333	$5,287,913	$4,454,580	$833,333	$0	($833,333)	$833,333	$0	($833,333)
Total Cash Funds	**$886,165,101**	**$877,237,108**	**($8,927,993)**	**$884,043,394**	**$919,747,809**	**$35,704,415**	**$879,963,797**	**$936,628,797**	**$56,665,000**
Reappropriated Funds									
(6) Other Medical Services; (B) Old Age Pension State Medical Program	$9,031,044	$9,031,044	$0	$9,031,044	$8,951,417	($79,627)	$9,031,044	$8,951,417	($79,627)
Department of Higher Education, Fee-for-service Contracts with State Institutions for Speciality Education Programs	$61,521,432	$61,275,346	($246,086)	$61,337,568	$61,337,568	$0	$61,262,569	$61,262,569	$0
Total Reappropriated Funds	**$70,552,476**	**$70,306,390**	**($246,086)**	**$70,368,612**	**$70,288,985**	**($79,627)**	**$70,293,613**	**$70,213,986**	**($79,627)**

Note: Calculation of letternote changes for FY 2017-18 can be found on page ED-2. Request amounts shown above for FY 2017-18 and FY 2018-19 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 2017-18					
Spending Authority	**FY 2017-18 Long Bill Appropriation (SB 17-254)**	**SB 17-091 "Allow Medicaid Home Health Services in Community"**	**SB 17-256 "Hospital Provider Fee"**	**SB 17-267 "Sustainability of Rural Colorado"**	**Total**
Certified Funds	$18,731,618	$0	$0	$0	$18,731,618
Healthcare Affordability and Sustainability Fee Cash Fund	$0	$0	$0	$644,890,063	$644,890,063
Hospital Provider Fee Cash Fund	$644,896,151	$18,207	($264,100,000)	($380,854,898)	($40,540)
Medicaid Buy-In Fund	$4,870,633	$0	$0	$0	$4,870,633
Tobacco Tax Cash Fund	$2,201,700	$0	$0	$0	$2,201,700
Health Care Expansion Fund	$67,518,800	$0	$0	$0	$67,518,800
Breast and Cervical Cancer Fund	$1,058,337	$9	$0	$0	$1,058,346
Colorado Autism Treatment Fund	$7,149,477	$0	$0	$0	$7,149,477
Nursing Facility Fund	$53,416,339	$0	$0	$0	$53,416,339
Tobacco Education Program Fund	$642,863	$0	$0	$0	$642,863
Department Recoveries Fund	$51,190,388	$0	$0	$0	$51,190,388
ICF-IID Provider Fee	$200,460	$0	$0	$0	$200,460
Adult Dental Fund	$33,001,621	$0	$0	$0	$33,001,621
Transfer from Denver Health	$500,000	$0	$0	$0	$500,000
Primary Care Provider Sustainability Fund	$833,333	$0	$0	$0	$833,333
Total Cash Funds	**$886,211,720**	**$18,216**	**($264,100,000)**	**$264,035,165**	**$886,165,101**

Exhibit D - Cash Funds Report

Revised Totals for Letternotes and Appropriation Clauses
FY 2017-18

FY 2017-18 Request	FY 2017-18 Long Bill Appropriation (SB 17-254)	SB 17-091 "Allow Medicaid Home Health Services in Community"	SB 17-256 "Hospital Provider Fee"	SB 17-267 "Sustainability of Rural Colorado"	Total
Certified Funds	**$13,508,941**	$0	$0	$0	$13,508,941
Healthcare Affordability and Sustainability Fee Cash Fund	**$941,321**	$0	$0	$644,890,063	$645,831,384
Hospital Provider Fee Cash Fund	**$644,936,691**	$18,207	($264,100,000)	($380,854,898)	$0
Medicaid Buy-In Fund	**$3,542,272**	$0	$0	$0	$3,542,272
Tobacco Tax Cash Fund	$2,201,700	$0	$0	$0	$2,201,700
Health Care Expansion Fund	$67,518,800	$0	$0	$0	$67,518,800
Breast and Cervical Cancer Fund	**$698,694**	$9	$0	$0	$698,703
Colorado Autism Treatment Fund	**$1,663,945**	$0	$0	$0	$1,663,945
Nursing Facility Fund	**$53,841,912**	$0	$0	$0	$53,841,912
Tobacco Education Program Fund	$642,863	$0	$0	$0	$642,863
Department Recoveries Fund	**$49,366,109**	$0	$0	$0	$49,366,109
ICF-IID Provider Fee	$200,460	$0	$0	$0	$200,460
Adult Dental Fund	**$32,432,106**	$0	$0	$0	$32,432,106
Transfer from Denver Health	$500,000	$0	$0	$0	$500,000
Primary Care Provider Sustainability Fund	**$5,287,913**	$0	$0	$0	$5,287,913
Total Cash Funds	**$877,283,727**	**$18,216**	**($264,100,000)**	**$264,035,165**	**$877,237,108**

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 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	**$133,276,464**	**$106,670,688**	**$620,500,650**	**$48,681,734**	**$581,950,550**	**$259,289,377**	**$1,525,419,863**	**$1,995,464**	**$894,521,258**	**$109,239,378**	**$68,435,859**	**$141,418,313**	**$24,910,380**	**$45,719,372**	**$20,008,826**	**$4,582,038,176**
Community Based Long-Term Care																
Base CBLTC	$231,914,829	$59,076,607	$206,674,247	$3,572,365	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$501,238,048
Hospice	$41,928,023	$3,313,583	$5,918,861	$302,745	$432,071	$186,793	$4,180,601	$11,863	$146,976	$7,774	$5,366	$5,223	$12,416	$0	$0	$56,452,295
Private Duty Nursing & Long-Term Home Health	$82,699,835	$10,234,900	$240,020,926	$3,882,486	$644,093	$276,040	$3,159,125	$0	$38,721,636	$2,801,714	$26,697,307	$0	$0	$0	$30,671	$409,168,733
Subtotal CBLTC	**$356,542,687**	**$72,625,090**	**$452,614,034**	**$7,757,596**	**$1,076,164**	**$462,833**	**$7,339,726**	**$11,863**	**$38,868,612**	**$2,809,488**	**$26,702,673**	**$5,223**	**$12,416**	**$0**	**$30,671**	**$966,859,076**
Long-Term Care																
Class I Nursing Facilities	$504,591,560	$55,594,070	$114,745,827	$88,852	$288,759	$0	$3,868,823	$0	$0	$0	$57,671	$7,655	$0	$0	$0	$679,243,217
Class II Nursing Facilities	$1,429,310	$209,262	$2,431,355	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,069,927
PACE	$143,155,846	$18,596,201	$9,805,269	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$171,557,316
Subtotal Long-Term Care	**$649,176,716**	**$74,399,533**	**$126,982,451**	**$88,852**	**$288,759**	**$0**	**$3,868,823**	**$0**	**$0**	**$0**	**$57,671**	**$7,655**	**$0**	**$0**	**$0**	**$854,870,460**
Insurance																
Supplemental Medicare Insurance Benefit	$97,752,453	$5,742,481	$50,142,988	$0	$356,557	$0	$0	$0	$0	$0	$0	$0	$0	$0	$29,633,363	$183,627,842
Heath Insurance Buy-In	$19,555	$24,445	$2,395,544	$0	$29,333	$48,888	$44,000	$0	$171,111	$0	$0	$14,667	$0	$0	$0	$2,747,543
Subtotal Insurance	**$97,772,008**	**$5,766,926**	**$52,538,532**	**$0**	**$385,890**	**$48,888**	**$44,000**	**$0**	**$171,111**	**$0**	**$0**	**$14,667**	**$0**	**$0**	**$29,633,363**	**$186,375,385**
Service Management																
Single Entry Points	$10,308,486	$2,859,404	$21,631,959	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,799,849
Disease Management	$29,340	$26,368	$185,252	$21,313	$246,405	$172,623	$463,724	$0	$0	$0	$46,868	$77,665	$16,168	$0	$0	$1,285,726
ACC and PIHP Administration	$4,684,873	$1,522,804	$9,430,857	$615,634	$22,359,014	$9,404,551	$44,239,603	$8,391	$60,522,267	$8,814,155	$3,056,081	$1,107,087	$203,685	$0	$0	$165,969,002
Subtotal Service Management	**$15,022,699**	**$4,408,576**	**$31,248,068**	**$636,947**	**$22,605,419**	**$9,577,174**	**$44,703,327**	**$8,391**	**$60,522,267**	**$8,814,155**	**$3,102,949**	**$1,184,752**	**$219,853**	**$0**	**$0**	**$202,054,577**
Medical Services Total	**$1,251,790,574**	**$263,870,813**	**$1,283,883,735**	**$57,165,129**	**$606,306,782**	**$269,378,272**	**$1,581,375,739**	**$2,015,718**	**$994,083,248**	**$120,863,021**	**$98,299,152**	**$142,630,610**	**$25,142,649**	**$45,719,372**	**$49,672,860**	**$6,792,197,674**
Caseload	45,242	11,681	67,743	7,811	188,617	91,246	380,104	117	466,328	68,762	20,584	11,429	2,365	2,782	36,869	1,401,680
Medical Services Per Capita	$27,668.77	$22,589.75	$18,952.27	$7,318.54	$3,214.49	$2,952.22	$4,160.38	$17,228.36	$2,131.73	$1,757.70	$4,775.51	$12,479.71	$10,631.14	$16,433.99	$1,347.28	$4,845.75
Financing	$145,254,668	$32,720,756	$157,352,586	$9,251,740	$119,899,714	$49,126,488	$357,936,072	$301,455	$176,162,159	$14,981,618	$12,068,260	$54,994,029	$5,946,896	$23,094,283	$0	$1,159,090,724
Grand Total Medical Services Premiums	**$1,397,045,242**	**$296,591,569**	**$1,441,236,321**	**$66,416,869**	**$726,206,496**	**$318,504,760**	**$1,939,311,811**	**$2,317,173**	**$1,170,245,407**	**$135,844,639**	**$110,367,412**	**$197,624,639**	**$31,089,545**	**$68,813,655**	**$49,672,860**	**$7,951,288,398**
Total Per Capita	$30,879.39	$25,390.94	$21,275.06	$8,502.99	$3,850.16	$3,490.62	$5,102.06	$19,804.90	$2,509.49	$1,975.58	$5,361.81	$17,291.51	$13,145.68	$24,735.32	$1,347.28	$5,672.68

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	**$92,248,513**	**$93,364,540**	**$536,743,381**	**$44,991,433**	**$526,894,664**	**$244,204,797**	**$1,410,050,178**	**$806,130**	**$809,795,454**	**$102,926,563**	**$61,013,480**	**$127,194,488**	**$23,350,581**	**$41,911,969**	**$19,432,185**	**$4,134,928,356**
Community Based Long-Term Care																
Base CBLTC	$246,844,364	$63,156,504	$221,588,585	$3,849,904	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$535,439,357
Hospice	$43,061,459	$3,592,021	$6,312,569	$366,759	$467,534	$209,177	$4,506,118	$6,538	$153,505	$8,451	$5,624	$5,431	$12,907	$0	$0	$58,708,093
Private Duty Nursing & Long-Term Home Health	$91,262,406	$10,948,872	$259,573,006	$4,188,911	$686,727	$294,311	$3,368,231	$0	$41,837,324	$3,002,930	$29,354,826	$0	$0	$0	$32,701	$444,550,245
Subtotal CBLTC	**$381,168,229**	**$77,697,397**	**$487,474,160**	**$8,405,574**	**$1,154,261**	**$503,488**	**$7,874,349**	**$6,538**	**$41,990,829**	**$3,011,381**	**$29,360,450**	**$5,431**	**$12,907**	**$0**	**$32,701**	**$1,038,697,695**
Long-Term Care																
Class I Nursing Facilities	$520,734,665	$57,372,659	$118,416,824	$91,695	$297,997	$0	$3,992,596	$0	$0	$0	$59,516	$7,900	$0	$0	$0	$700,973,852
Class II Nursing Facilities	$1,523,842	$223,102	$2,592,161	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,339,105
PACE	$157,902,318	$20,804,517	$11,241,150	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$189,947,985
Subtotal Long-Term Care	**$680,160,825**	**$78,400,278**	**$132,250,135**	**$91,695**	**$297,997**	**$0**	**$3,992,596**	**$0**	**$0**	**$0**	**$59,516**	**$7,900**	**$0**	**$0**	**$0**	**$895,260,942**
Insurance																
Supplemental Medicare Insurance Benefit	$104,154,212	$6,248,980	$53,464,668	$0	$397,949	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,329,677	$198,595,486
Heath Insurance Buy-In	$24,771	$30,966	$3,034,547	$0	$37,157	$61,928	$55,737	$0	$216,754	$0	$0	$18,580	$0	$0	$0	$3,480,440
Subtotal Insurance	**$104,178,983**	**$6,279,946**	**$56,499,215**	**$0**	**$435,106**	**$61,928**	**$55,737**	**$0**	**$216,754**	**$0**	**$0**	**$18,580**	**$0**	**$0**	**$34,329,677**	**$202,075,926**
Service Management																
Single Entry Points	$10,733,975	$2,976,851	$22,524,832	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$36,235,658
Disease Management	$29,340	$26,368	$185,252	$21,313	$246,405	$172,623	$463,724	$0	$0	$0	$46,868	$77,665	$16,168	$0	$0	$1,285,726
ACC and PIHP Administration	$6,144,982	$1,663,383	$10,249,566	$1,391,166	$28,605,392	$14,426,477	$57,426,820	$9,637	$71,494,295	$11,078,707	$3,407,341	$1,715,138	$360,160	$0	$0	$207,973,064
Subtotal Service Management	**$16,908,297**	**$4,666,602**	**$32,959,650**	**$1,412,479**	**$28,851,797**	**$14,599,100**	**$57,890,544**	**$9,637**	**$71,494,295**	**$11,078,707**	**$3,454,209**	**$1,792,803**	**$376,328**	**$0**	**$0**	**$245,494,448**
Medical Services Total	**$1,274,664,847**	**$260,408,763**	**$1,245,926,541**	**$54,901,181**	**$557,633,825**	**$259,369,313**	**$1,479,863,404**	**$822,305**	**$923,497,332**	**$117,016,651**	**$93,887,655**	**$129,019,202**	**$23,739,816**	**$41,911,969**	**$53,794,563**	**$6,516,457,367**
Caseload	45,993	12,176	69,473	9,099	196,256	98,254	393,958	62	468,328	71,877	20,746	11,427	2,364	2,814	41,068	1,443,895
Medical Services Per Capita	$27,714.32	$21,387.05	$17,933.97	$6,033.76	$2,841.36	$2,639.78	$3,756.40	$13,262.98	$1,971.90	$1,628.01	$4,525.58	$11,290.73	$10,042.22	$14,894.09	$1,309.89	$4,513.11
Financing	$154,131,577	$34,688,831	$167,047,632	$9,840,803	$127,192,379	$52,156,256	$379,978,007	$369,030	$186,975,258	$15,868,295	$12,793,044	$58,306,758	$6,273,512	$24,478,998	$0	$1,230,100,380
Grand Total Medical Services Premiums	**$1,428,796,424**	**$295,097,594**	**$1,412,974,173**	**$64,741,984**	**$684,826,204**	**$311,525,569**	**$1,859,841,411**	**$1,191,335**	**$1,110,472,590**	**$132,884,946**	**$106,680,699**	**$187,325,960**	**$30,013,328**	**$66,390,967**	**$53,794,563**	**$7,746,557,747**
Total Per Capita	$31,065.52	$24,236.00	$20,338.46	$7,115.29	$3,489.45	$3,170.61	$4,720.91	$19,215.08	$2,371.14	$1,848.78	$5,142.23	$16,393.28	$12,695.99	$23,593.09	$1,309.89	$5,365.04

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2019-20	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	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	**$66,425,568**	**$93,979,639**	**$541,782,665**	**$44,314,854**	**$527,833,386**	**$254,038,441**	**$1,441,712,153**	**$861,904**	**$831,227,614**	**$107,864,543**	**$62,379,832**	**$131,088,398**	**$23,895,255**	**$43,336,747**	**$20,575,135**	**$4,191,316,134**
Community Based Long-Term Care																
Base CBLTC	$264,481,391	$67,765,311	$238,022,916	$4,097,524	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$574,367,142
Hospice	$44,164,513	$3,893,493	$6,764,519	$433,884	$498,415	$226,295	$4,771,049	$6,678	$160,075	$9,087	$5,890	$5,416	$12,873	$0	$0	$60,952,187
Private Duty Nursing & Long-Term Home Health	$101,380,884	$11,909,743	$284,394,922	$4,662,202	$745,259	$319,397	$3,655,317	$0	$45,821,949	$3,270,824	$32,531,390	$0	$0	$0	$35,487	$488,727,374
Subtotal CBLTC	**$410,026,788**	**$83,568,547**	**$529,182,357**	**$9,193,610**	**$1,243,674**	**$545,692**	**$8,426,366**	**$6,678**	**$45,982,024**	**$3,279,911**	**$32,537,280**	**$5,416**	**$12,873**	**$0**	**$35,487**	**$1,124,046,703**
Long-Term Care																
Class I Nursing Facilities	$538,919,159	$59,376,161	$122,552,040	$94,897	$308,403	$0	$4,132,021	$0	$0	$0	$61,594	$8,176	$0	$0	$0	$725,452,451
Class II Nursing Facilities	$1,523,842	$223,102	$2,592,161	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,339,105
PACE	$174,648,154	$23,572,860	$12,625,322	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$210,846,336
Subtotal Long-Term Care	**$715,091,155**	**$83,172,123**	**$137,769,523**	**$94,897**	**$308,403**	**$0**	**$4,132,021**	**$0**	**$0**	**$0**	**$61,594**	**$8,176**	**$0**	**$0**	**$0**	**$940,637,892**
Insurance																
Supplemental Medicare Insurance Benefit	$107,900,946	$6,647,481	$56,141,833	$0	$417,744	$0	$0	$0	$0	$0	$0	$0	$0	$0	$39,086,468	$210,194,472
Heath Insurance Buy-In	$31,154	$38,945	$3,816,417	$0	$46,730	$77,884	$70,098	$0	$272,602	$0	$0	$23,367	$0	$0	$0	$4,377,197
Subtotal Insurance	**$107,932,100**	**$6,686,426**	**$59,958,250**	**$0**	**$464,474**	**$77,884**	**$70,098**	**$0**	**$272,602**	**$0**	**$0**	**$23,367**	**$0**	**$0**	**$39,086,468**	**$214,571,669**
Service Management																
Single Entry Points	$13,035,016	$3,615,348	$27,356,125	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$44,006,489
Disease Management	$29,340	$26,368	$185,252	$21,313	$246,405	$172,623	$463,724	$0	$0	$0	$46,868	$77,665	$16,168	$0	$0	$1,285,726
ACC and PIHP Administration	$6,883,412	$1,926,757	$11,781,598	$1,764,583	$32,547,716	$16,671,060	$64,940,694	$10,584	$80,156,993	$12,802,243	$3,846,210	$1,921,494	$403,488	$0	$0	$235,656,832
Subtotal Service Management	**$19,947,768**	**$5,568,473**	**$39,322,975**	**$1,785,896**	**$32,794,121**	**$16,843,683**	**$65,404,418**	**$10,584**	**$80,156,993**	**$12,802,243**	**$3,893,078**	**$1,999,159**	**$419,656**	**$0**	**$0**	**$280,949,047**
Medical Services Total	**$1,319,423,379**	**$272,975,208**	**$1,308,015,770**	**$55,389,257**	**$562,644,058**	**$271,505,700**	**$1,519,745,056**	**$879,166**	**$957,639,233**	**$123,946,697**	**$98,871,784**	**$133,124,516**	**$24,327,784**	**$43,336,747**	**$59,697,090**	**$6,751,521,445**
Caseload	46,770	12,712	71,706	10,368	201,516	102,381	401,763	61	470,392	74,443	20,929	11,425	2,364	2,846	45,746	1,475,422
Medical Services Per Capita	$28,210.89	$21,473.82	$18,241.37	$5,342.33	$2,792.06	$2,651.91	$3,782.69	$14,412.56	$2,035.83	$1,664.99	$4,724.15	$11,652.04	$10,290.94	$15,227.25	$1,304.97	$4,575.99
Financing	$148,307,413	$33,378,045	$160,735,410	$9,468,949	$122,386,166	$50,185,430	$365,619,794	$355,086	$179,910,031	$15,268,680	$12,309,634	$56,103,523	$6,036,455	$23,554,011	$0	$1,183,618,627
Grand Total Medical Services Premiums	**$1,467,730,792**	**$306,353,253**	**$1,468,751,180**	**$64,858,206**	**$685,030,224**	**$321,691,130**	**$1,885,364,850**	**$1,234,252**	**$1,137,549,264**	**$139,215,377**	**$111,181,418**	**$189,228,039**	**$30,364,239**	**$66,890,758**	**$59,697,090**	**$7,935,140,072**
Total Per Capita	$31,381.89	$24,099.53	$20,482.96	$6,255.61	$3,399.38	$3,142.10	$4,692.73	$20,233.64	$2,418.30	$1,870.09	$5,312.31	$16,562.63	$12,844.43	$23,503.43	$1,304.97	$5,378.22

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 2017)	Difference from November Request	Description of Difference from Long Bill Plus Special Bills to R-1	Department Source
Acute Care					
Base Acute Cost	$4,154,831,040	$4,089,360,915	($65,470,125)	Driven by caseload changes such as reduction in AND/AB, MAGI Adults, MAGI Kids, and MAGI Pregnant Adults	Exhibit F
Bottom Line Impacts			$0		
Annualization of Hepatitis C Criteria Change	$27,217,614	$27,217,614	$0		Exhibit F
Annualization of SB 17-091 Allow Medicaid Home Health Services in the Community	$687,809	$687,809	$0		Exhibit F
Annualization of Copay 5% of Income	$4,740,105	$4,740,105	$0		Exhibit F
SB 17-267 Sustainability of Rural Colorado - Increased Copays	($1,818,901)	($1,818,901)	$0		Exhibit F
Annualization of State Plan Autism Treatment	$16,170,122	$1,916,000	($14,254,122)	Updated based on FY 2016-17 utilization, which was much lower than forecasted	Exhibit F
Annualization of FY 2011-12 BA-9: Limit Physical and Occupational Therapy	($96,712)	($96,712)	$0		Exhibit F
2017 JBC Action: PT/OT Supplemental Footnote	$2,321,083	$1,353,965	($967,118)	Assuming 11/1/2017 implementation once CMS approves SPA	Exhibit F
HB 15-1309 "Protective Restorations by Dental Hygenists"	$22,659	$22,660	$1	Rounding	
FY 2012-13 R-6: "Dental Efficiency"	($1,704,632)	($1,704,632)	$0		
Annualization of FY 2014-15 R-10: "Primary Care Specialty Collaboration"	($152,257)	$0	$152,257	Delay in implementation	Exhibit F
SB 11-177: Annualization "Sunset Teen Pregnancy & Dropout Program"	($36,779)	($36,779)	$0		Exhibit F
SB 10-117 OTC MEDS	($62,406)	($62,406)	$0		Exhibit F
Annualization of SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	($1,737,180)	($1,737,180)	$0		Exhibit F
Repay Overcollection of Drug Rebates in FY 2016-17	$0	$55,971,293	$55,971,293	The Department overcollected drug rebates in FY 2016-17 due to a PBMS issue	Exhibit F
FY 2017-18 R-7 Oversight of State Resources - Physician Administered Drugs	($540,130)	($1,076,686)	($536,556)	Difference is due to the implementation date being moved forward from January 1, 2018 to July 1, 2017	Exhibit F
FY 2017-18 R-7 Oversight of State Resources - IHS Savings	$5,029,654	$2,514,827	($2,514,827)	Anticipates a slower ramp up of implementation of care coordination	Exhibit F
FY 2017-18 R-7 Oversight of State Resources - Client and Provider Investigations	($862,435)	($862,435)	$0		
Annualization of HB 16-1097 "PUC Permit for Medicaid Transportation Providers"	($234,492)	($234,492)	$0		Exhibit F
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($1,012,935)	($771,860)	$241,075	Difference is due to a decrease in the average savings per member	Exhibit F
Annualization of Estimated Impact of Increasing PACE Enrollment	($2,656,345)	($3,621,645)	($965,300)	Increasing enrollment expectations in PACE based on enrollment count in July 2017	Exhibit F
2017 JBC Action: Community Provider Rate Increases (1.402% Across the Board)	$33,462,253	$37,390,955	$3,928,702	The appropriation did not include physician services; non-1408 codes are eligible for increase	Exhibit F
2017 JBC Action: TRI - Transportation	$1,724,068	$3,308,326	$1,584,258	Cash funds and federal funds for transportation increases were not recalculated. Request is a true-up	Exhibit F
2017 JBC Action: TRI - Home Health	$662,030	$662,030	$0		Exhibit F
2017 JBC Action: Post-Partum Depression Screening	$90,423	$90,423	$0		Exhibit F
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase'"	($5,171,476)	($5,171,476)	$0		Exhibit F
Annualization of HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	($51,053,050)	($28,018,437)	$23,034,613	Lower utilization along with cash flow updates because of suspected payment delays	Exhibit F
Annualization of FY 2017-18 R-6 Delivery System and Payment Reform - EAPG Methodology	($23,160,443)	($7,720,148)	$15,440,295	This difference is due to the FY 2016-17 impact of this policy not being built into the base appropriation	Exhibit F
FY 2017-18 R-6 Delivery System and Payment Reform - Primary Care Increase Continuation	$54,085,240	$55,572,637	$1,487,397	This difference is due to updated calculations with FY 2016-17 data	Exhibit F
FY 2017-18 R-6 Delivery System and Payment Reform - Vaccine Stock Rates	($994,353)	($994,353)	$0		Exhibit F
Accountable Care Collaborative Savings	($17,180,454)	($13,984,461)	$3,195,993	Updated model with reduced enrollment expectations in FY 2017-18	
Expiration of ACC: Access KP Initiative	$0	($3,882,854)	($3,882,854)	Policy change; the Department decided to allow this initiative to expire after the February submission	Exhibit F
FY 2017-18 Legislative Action - Elective Circumcisions	$0	$427,039	$427,039	New policy based on legislative action in 2017 session	Exhibit F
Payment delays from implementation of interChange	$0	$372,597,035	$372,597,035	Payment for services rendered in FY 2016-17	Exhibit F
Total Acute Care	**$4,192,569,120**	**$4,582,038,176**	**$389,469,056**		
Community Based Long-Term Care					
Base CBLTC Cost	$946,938,086	$937,828,111	($9,109,975)	Decreased LTHH, PDN, and hospice utilization offset by a slight increase in waiver per capita costs	Exhibit G
Bottom Line Impacts					
Colorado Choice Transitions - CBLTC Impact	$1,198,196	$3,334,905	$2,136,709	Due to increased CCT forecast	Exhibit G
FY 2017-18 Non-Medical Transportation 7.01% Targeted Rate Increase(1)	$488,883	$418,921	($69,962)	Includes 8 months of implementation, difference is due to reforecast	Exhibit G
FY 2017-18 Homemaker and Personal Care $0.50 Hourly Rate Increase(1)	$13,229,924	$11,000,457	($2,229,467)	Includes 8 months of implementation, difference is due to reforecast	Exhibit G
FY 2017-18 Across the Board 1.402% Rate Increase(1)	$5,613,304	$5,794,753	$181,449	Includes 8 months of implementation, difference is due to reforecast	Exhibit G
interChange Payment Lag Adjustment	$0	$7,859,051	$7,859,051	Payment for services rendered in FY 2016-17	Exhibit G
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers - CBLTC Impact	($22,872)	($22,872)	$0		Exhibit G
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$6,356	$6,356	$0		
Colorado Choice Transitions	$701,212	$579,591	($121,621)	Due to slight decrease in enrollment of CCT forecast	Exhibit G
Telehealth Expenditure Adjustment	$2,334	$2,991	$657	Updated forecast	Exhibit G
Annualization of FY 2015-16 R-7 "Participant Directed Programs Expansion"	($1,431,855)	($835,249)	$596,606	Implementation delay	Exhibit G
SB 17-091 Allow Medicaid Home Health Services in the Community	$1,523,721	$1,523,721	$0		Exhibit G
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($552,638)	($566,963)	($14,325)	Updated forecast	Exhibit G
Savings from days incurred in FY 2015-16 and paid in FY 2016-17 under HB 13-1152	($57,756)	($64,697)	($6,941)	Updated forecast	
Total Community Based Long-Term Care	**$967,636,894**	**$966,859,076**	**($777,818)**		

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 2017)	Difference from November Request	Description of Difference from Long Bill Plus Special Bills to R-1	Department Source
Long-Term Care and Insurance					
Class I Nursing Facilities					
Base Class I Nursing Facility Cost	$677,084,363	$678,839,769	$1,755,406	Updated rates forecast	Exhibit H
Bottom Line Impacts					
Hospital Back Up Program	$10,312,685	$10,939,828	$627,143	Payments for services rendered in FY 2016-17	Exhibit H
Recoveries from Department Overpayment Review	($1,000,000)	($1,000,000)	$0		Exhibit H
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($9,182,057)	($9,536,380)	($354,323)	Flow through due to updated rates forecast based on FY 2016-17 actuals	Exhibit H
Total Class I Nursing Facilities	**$677,214,991**	**$679,243,217**	**$2,028,226**		
Class II Nursing Facilities					
Base Class II Nursing Facilities Cost	$4,176,936	$4,069,927	($107,009)	Decreased Cost Per-Client Expectations	Exhibit H
Bottom Line Impacts					
Total Class II Nursing Facilities	**$4,176,936**	**$4,069,927**	**($107,009)**		
Program of All Inclusive Care for the Elderly (PACE)					
Base PACE Cost	$167,703,403	$182,728,918	$15,025,515	Increased enrollment expectations tempered by decreasing aggregate rate	Exhibit H
Bottom Line Impacts					
FY 2016-17 Retroactive Payments	$0	$12,403,283	$12,403,283	Payment for services rendered in FY 2016-17	Exhibit H
interChange Rate Adjustments	$0	($11,171,602)	($11,171,602)	Correction for mass rates adjustments made by interChange in FY 2016-17	Exhibit H
Total Program of All-Inclusive Care for the Elderly	**$167,703,403**	**$171,557,316**	**$3,853,913**		
Supplemental Medicare Insurance Benefit (SMIB)					
Base SMIB Cost	$185,840,175	$191,817,243	$5,977,068	Difference is due to an increase in the anticipated premiums cost	Exhibit H
Bottom Line Impacts					
Accounting Reconciliation	$0	($8,189,401)	($8,189,401)	Accounting Reconciliation	
Total Supplemental Medicare Insurance Benefit	**$185,840,175**	**$183,627,842**	**($2,212,333)**		
Health Insurance Buy-In Program (HIBI)					
Base HIBI Cost	$1,913,179	$2,132,413	$219,234	Increase driven by increase in cost of administration and service costs per member	Exhibit H
Bottom Line Impacts					
SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$57,051	$251,902	$194,851	Difference is due to an increase in the cost of administration per member	Exhibit H
SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$413,734	$363,228	($50,506)	Lower enrollment than previously anticipated	Exhibit H
Total Health Insurance Buy-In Program	**$2,383,963**	**$2,747,543**	**$363,580**		
Total Long-Term Care and Insurance	**$1,037,319,468**	**$1,041,245,845**	**$3,926,377**		
Service Management					
Single Entry Points (SEP)					
Single Entry Points (SEP) Base	$34,298,607	$34,298,607	$0		Exhibit I
Bottom Line Impacts					
FY 2017-18 Across the Board 1.402% Rate Increase	$480,866	$501,242	$20,376	Revised forecast for rate increase impact, adjusted implementation date	
Total Single Entry Points	**$34,779,473**	**$34,799,849**	**$20,376**		
Disease Management					
Base Disease Management	$1,285,726	$1,285,726	$0		Exhibit I
Bottom Line Impacts					
Total Disease Management	**$1,285,726**	**$1,285,726**	**$0**		
Accountable Care Collaborative					
ACC Base	$157,062,635	$158,504,396	$1,441,761	Enrollment expectations decreased, but the expiration of Kaiser-Access HMO pushes enrollment to be positive	Exhibit I
Bottom Line Impacts					
FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees" Annualization	$7,114,550	$4,242,478	($2,872,072)	Adjusted for enrollment expectations and the absorption of this population into ACC at lower PMPM after December 2017	Exhibit I
Bottom Line Impacts: MMP True-Up to $20 PMPM for FY 2016-17	$0	$1,122,128	$1,122,128	Payment delay from FY 2016-17 (new information)	Exhibit I
FY 2017-18 R-11 "Vendor Transitions"	$2,100,000	$2,100,000	$0		Exhibit I
Total Accountable Care Collaborative	**$166,277,185**	**$165,969,002**	**($308,183)**		
Total Service Management	**$202,342,384**	**$202,054,577**	**($287,807)**		
Grand Total Services	**$6,399,867,866**	**$6,792,197,674**	**$392,329,808**		

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 2017)	Difference from November Request	Description of Difference from Long Bill Plus Special Bills to R-1	Department Source
Bottom Line Financing					
Upper Payment Limit Financing	$3,928,460	$4,148,965	$220,505	Updated forecast based on CPI	Exhibit K
Department Recoveries Adjustment	$0	$0	$0		Exhibit A
Denver Health Outstationing	$4,504,703	$2,600,000	($1,904,703)	Difference due to transition from CPE-based methodology to GF methodology	Exhibit A
Healthcare Affordability and Sustainability Fee Supplemental Payments	$930,440,830	$911,744,619	($18,696,211)	Updated provider fee model	Exhibit J
Nursing Facility Provider Fee Supplemental Payments	$106,832,678	$107,683,824	$851,146	Updated model	Exhibit H
Physician Supplemental Payments	$14,122,422	$10,521,089	($3,601,333)	Updated based on FY 2016-17 actuals which were lower than anticipated	Exhibit A
Hospital High Volume Inpatient Payment	$8,281,533	$1,127,611	($7,153,922)	Updated based on FY 2016-17 actuals which were lower than anticipated	Exhibit A
Health Care Expansion Fund Transfer Adjustment	$0	$0	$0		Exhibit A
Intergovernmental Transfer for Difficult to Discharge Clients	$1,000,000	$1,000,000	$0		Exhibit A
Denver Health Ambulance Payments	$5,877,491	$6,141,995	$264,504	Updated based on FY 2016-17 actuals	Exhibit A
University of Colorado School of Medicine Payment	$123,042,864	$123,042,864	$0		
Payment delays from implementation of interChange - Financing Impact	$0	($8,920,243)	($8,920,243)	Some interim FY 2016-17 payments for DIDD waivers are expected to move from MSP to various DIDD appropriations in FY 2017-18	Exhibit A
Cash Funds Financing	$0	$0	$0		
Total Bottom Line Financing	**$1,198,030,981**	**$1,159,090,724**	**($38,940,257)**		
Grand Total[2]	**$7,597,898,847**	**$7,951,288,398**	**$353,389,551**		
Total Acute Care	$4,192,569,120	$4,582,038,176	$389,469,056		
Total Community Based Long-Term Care	$967,636,894	$966,859,076	($777,818)		
Total Class I Nursing Facilities	$677,214,991	$679,243,217	$2,028,226		
Total Class II Nursing Facilities	$4,176,936	$4,069,927	($107,009)		
Total Program of All-Inclusive Care for the Elderly	$167,703,403	$171,557,316	$3,853,913		
Total Supplemental Medicare Insurance Benefit	$185,840,175	$183,627,842	($2,212,333)		
Total Health Insurance Buy-In Program	$2,383,963	$2,747,543	$363,580		
Total Single Entry Point	$34,779,473	$34,799,849	$20,376		
Total Disease Management	$1,285,726	$1,285,726	$0		
Total Prepaid Inpatient Health Plan Administration	$166,277,185	$165,969,002	($308,183)		
Total Bottom Line Financing	$1,198,030,981	$1,159,090,724	($38,940,257)		
Rounding Adjustment	$0	$0	$0		
Grand Total[2]	**$7,597,898,847**	**$7,951,288,398**	**$353,389,551**		

(1) These totals include the impact of the rate increases to CBLTC, LTHH, and PDN. LTHH and PDN expenditures are calculated using average cost per unit, which includes the effect of the rate increases, therefore expenditure impacts for LTHH and PDN are estimates.

(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 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 2017)	Difference	Description of Difference from Long Bill Plus Special Bills to R-1
Acute Care				
Base Acute Cost	$4,152,105,488	$4,218,370,512	$66,265,024	Increase in per capitas of Parents/Caretakers, MAGI Adults, and MAGI Kids tempered by decrease in caseload from MAGI Adults, MAGI Kids, and MAGI Pregnant Adults
Bottom Line Impacts				
Annualization of Hepatitis C Criteria Change	$27,217,614	$27,217,614	$0	
Annualization of SB 17-091 Allow Medicaid Home Health Services in the Community	$717,726	$717,726	$0	
Annualization of Copay 5% of Income	$4,740,105	$4,950,011	$209,906	Caseload increase between FY 2017-18 and FY 2018-19
SB 17-267 Sustainability of Rural Colorado - Increased Copays	($4,365,362)	($4,365,362)	$0	
Annualization of State Plan Autism Treatment	$16,170,122	$3,331,551	($12,838,571)	Flow through of update based on FY 2016-17 utilization, which was much lower than forecasted
Annualization of FY 2011-12 BA-9: Limit Physical and Occupational Therapy	($96,712)	($96,712)	$0	
2017 JBC Action: PT/OT Supplemental Footnote	$2,321,083	$1,198,999	($1,122,084)	
HB 15-1309 "Protective Restorations by Dental Hygenists"	$22,659	$22,660	$1	Rounding
FY 2012-13 R-6: "Dental Efficiency"	($1,704,632)	($1,792,001)	($87,369)	From a delay in implementation in FY 18
Annualization of FY 2014-15 R-10: "Primary Care Specialty Collaboration"	($152,257)	$0	$152,257	Delay in implementation
SB 11-177: Annualization "Sunset Teen Pregnancy & Dropout Program"	($36,779)	($36,779)	$0	
SB 10-117 OTC MEDS	($62,406)	$904,712	$967,118	Annualization for full year estimate
Annualization of SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	($1,737,180)	($2,036,306)	($299,126)	Increase in cost avoidance from dispensing fees due to increase in utilization
Repay Overcollection of Drug Rebates in FY 2016-17	$0	$0	$0	
FY 2017-18 R-7 Oversight of State Resources - Physician Administered Drugs	$959,313	$959,313	$0	
FY 2017-18 R-7 Oversight of State Resources - IHS Savings	$5,029,654	$2,514,827	($2,514,827)	Flow through
FY 2017-18 R-7 Oversight of State Resources - Client and Provider Investigations	($1,724,870)	($1,724,870)	$0	
Annualization of HB 16-1097 "PUC Permit for Medicaid Transportation Providers"	($234,492)	($234,492)	$0	
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($1,012,935)	($2,052,765)	($1,039,830)	Flow Through of Savings assumption
Annualization of Estimated Impact of Increasing PACE Enrollment	($2,656,345)	($6,747,363)	($4,091,018)	Flow through of increasing enrollment expectations in PACE based on July 2017 enrollment
2017 JBC Action: Community Provider Rate Increases (1.402% Across the Board)	$36,844,586	$42,369,935	$5,525,349	Flow through of appropriation not including physician services though non-1408 codes are eligible
2017 JBC Action: TRI - Transportation	$1,845,097	$3,765,709	$1,920,612	Cash funds and federal funds for transportation increases were not recalculated. Request is a true-up
2017 JBC Action: TRI - Home Health	$686,194	$686,194	$0	
2017 JBC Action: Post-Partum Depression Screening	$90,764	$90,764	$0	
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase'"	($5,171,476)	($5,171,476)	$0	
Annualization of HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	($51,053,050)	($41,856,337)	$9,196,713	Flow through
Annualization of FY 2017-18 R-6 Delivery System and Payment Reform - EAPG Methodology	($23,160,443)	($7,720,148)	$15,440,295	Flow through
FY 2017-18 R-6 Delivery System and Payment Reform - Primary Care Increase Continuation	$0	$2,416,202	$2,416,202	Flow through
FY 2017-18 R-6 Delivery System and Payment Reform - Vaccine Stock Rates	($1,022,420)	($1,022,420)	$0	
Annualization of Accountable Care Collaborative Savings	($65,588,942)	($98,263,505)	($32,674,563)	Increased enrollment expectation due to ACC Phase II, as estimates for FY 2017-18 are lower than previously anticipated
Expiration of ACC: Access KP Initiative	$0	($3,882,854)	($3,882,854)	Flow through
FY 2017-18 Legislative Action - Elective Circumcisions	$0	$465,861	$465,861	Flow through of new policy based on legislative action in 2017 session
Payment delays from implementation of interChange	$0	$0	$0	
Annualization of HB 17-1353 Implement Medicaid Delivery & Payment Initiatives - Primary Care Incentives	$58,062,151	$59,734,303	$1,672,152	This difference is due to updated calculations with FY 2016-17 data
Annualization of HB 17-1353 Implement Medicaid Delivery & Payment Initiatives - SUD/SPMI Savings through Integration of Care	($57,785,147)	($57,785,147)	$0	
Total Acute Care	**$4,089,247,108**	**$4,134,928,356**	**$45,681,248**	
Community Based Long-Term Care				
Base CBLTC Cost	$947,072,718	$1,007,648,888	$60,576,171	Increased utilization for HCBS waivers and baked in rate increase for LTHH and PDN
Bottom Line Impacts				
Colorado Choice Transitions - CBLTC Impact	$1,198,196	$6,668,251	$5,470,055	Due to increased CCT forecast
FY 2017-18 Non-Medical Transportation 7.01% Targeted Rate Increase[2]	$538,299	$628,381	$90,082	Includes 8 months of implementation, difference is due to reforecast
FY 2017-18 Homemaker and Personal Care $0.50 Hourly Rate Increase[2]	$14,567,192	$16,500,686	$1,933,494	Includes 8 months of implementation, difference is due to reforecast
FY 2017-18 Across the Board 1.402% Rate Increase[2]	$6,180,691	$8,692,128	$2,511,437	Includes 8 months of implementation, difference is due to reforecast
interChange Payment Lag Adjustment	$0	$0	$0	Adjustment only occurs in FY 2017-18
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers - CBLTC Impact	($22,872)	($23,752)	($880)	Re-estimated savings from one BI client switching to Buy-In
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$6,356	$11,953	$5,597	Re estimated cost of Buy-In Client
Colorado Choice Transitions	$701,212	$1,133,949	$432,737	Due to increased out year enrollment and per capita cost in CCT forecast
Telehealth Expenditure Adjustment	$2,334	$5,809	$3,475	Due to increased telehealth forecast
Annualization of FY 2015-16 R-7 "Participant Directed Programs Expansion"	($1,431,855)	($3,681,376)	($2,249,521)	Implementation Delay
SB 17-091 Allow Medicaid Home Health Services in the Community	$1,771,714	$1,771,714	$0	
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($552,638)	($589,434)	($36,796)	Flow through
Savings from days incurred in FY 2017-18 and paid in FY 2018-19 under HB 13-1152	($57,756)	($69,502)	($11,746)	Flow through
Total Community Based Long-Term Care	**$969,973,591**	**$1,038,697,695**	**$68,724,104**	

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

Item	Base Spending Authority [1]	R-1 Request (November 2017)	Difference	Description of Difference from Long Bill Plus Special Bills to R-1
Long-Term Care and Insurance				
Class I Nursing Facilities				
Base Class I Nursing Facility Cost	$677,084,363	$702,165,132	$25,080,769	Flow through of updated rates forecast based on FY 2016-17 actuals
Bottom Line Impacts				
Hospital Back Up Program	$10,312,685	$10,378,930	$66,245	Updated forecast based on slight increase in utilization in FY 2016-17
Recoveries from Department Overpayment Review	($1,000,000)	($1,035,900)	($35,900)	Updated forecast
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($9,182,057)	($10,534,310)	($1,352,253)	Flow through due to updated rates forecast based on FY 2016-17 actuals
Total Class I Nursing Facilities	**$677,214,991**	**$700,973,852**	**$23,758,861**	
Class II Nursing Facilities				
Base Class II Nursing Facilities	$4,176,936	$4,339,105	$162,169	Caseload Increase Expected as New Beds are Filled
Bottom Line Impacts				
Total Class II Nursing Facilities	**$4,176,936**	**$4,339,105**	**$162,169**	
Program of All Inclusive Care for the Elderly (PACE)				
Base PACE Cost	$167,703,403	$189,947,985	$22,244,582	Flow through of increased enrollment expectations tempered by decreasing rates
Bottom Line Impacts				
Total Program of All-Inclusive Care for the Elderly	**$167,703,403**	**$189,947,985**	**$22,244,582**	
Supplemental Medicare Insurance Benefit (SMIB)				
Base SMIB	$185,840,175	$198,595,486	$12,755,311	Flow through of anticipated increase to premiums
Bottom Line Impacts				
Total Supplemental Medicare Insurance Benefit	**$185,840,175**	**$198,595,486**	**$12,755,311**	
Health Insurance Buy-In Program (HIBI)				
Base HIBI Cost	$1,913,178	$2,564,921	$651,743	Flow through
Bottom Line Impacts				
SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$57,051	$110,945	$53,894	Flow through of increase to administrative costs
SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$413,734	$804,574	$390,840	Difference due to enrollment trend growth
Total Health Insurance Buy-In Program	**$2,383,963**	**$3,480,440**	**$1,096,477**	
Total Long-Term Care and Insurance	**$1,037,319,468**	**$1,097,336,868**	**$60,017,400**	
Service Management				
Single Entry Points (SEP)				
Single Entry Points (SEP) Base	$34,517,052	$35,734,416	$1,217,364	Updated model based on estimated waiver caseload growth
Bottom Line Impacts				
FY 2017-18 Across the Board 1.402% Rate Increase	$529,471	$501,242	($28,229)	Represents full integration of rate increase
Total Single Entry Points	**$35,046,523**	**$36,235,658**	**$1,189,135**	
Disease Management				
Base Disease Management	$1,285,726	$1,285,726	$0	
Bottom Line Impacts				
Total Disease Management	**$1,285,726**	**$1,285,726**	**$0**	
Accountable Care Collaborative and Prepaid Inpatient Health Plan Administration				
ACC Base	$199,205,470	$207,973,064	$8,767,594	Expectation of higher than previously anticipated increase in enrollment mitigated by updated information for perfromance payments, with a delay to account for calculation of performance (in line with pre-ACC Phase II processes)
Bottom Line Impacts				
FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees" Annualization	$7,114,550	$0	($7,114,550)	Flow through (this population is expected to be fully integrated into the ACC by this time)
Bottom Line Impacts: MMP True-Up to $20 PMPM for FY 2016-17	$0	$0	$0	
FY 2017-18 R-11 "Vendor Transitions"	$2,100,000	$0	($2,100,000)	This funding annualizes out in FY 2018-19
Total Accountable Care Collaborative and Prepaid Inpatient Health Plan Administration	**$208,420,020**	**$207,973,064**	**($446,956)**	
Total Service Management	**$244,752,269**	**$245,494,448**	**$742,179**	
Grand Total Services	**$6,341,292,436**	**$6,516,457,367**	**$175,164,931**	

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

Item	Base Spending Authority [1]	R-1 Request (November 2017)	Difference	Description of Difference from Long Bill Plus Special Bills to R-1
Bottom Line Financing				
Upper Payment Limit Financing	$3,928,460	$4,332,197	$403,737	Flow through of updated forecast based on CPI
Department Recoveries Adjustment	$0	$0	$0	
Denver Health Outstationing	$4,504,703	$2,700,000	($1,804,703)	Flow through of transition from CPE-based methodology to GF methodology
Healthcare Affordability and Sustainability Fee Supplemental Payments	$930,440,830	$969,432,800	$38,991,970	Flow through of updated provider fee model
Nursing Facility Provider Fee Supplemental Payments	$106,832,678	$111,551,827	$4,719,149	Updated forecast based on change in CPI
Physician Supplemental Payments	$14,122,422	$10,886,400	($3,236,022)	Flow through of update based on FY 2016-17 actuals which were lower than anticipated
Hospital High Volume Inpatient Payment	$8,281,533	$1,166,763	($7,114,770)	Flow through of update based on FY 2016-17 actuals which were lower than anticipated
Health Care Expansion Fund Transfer Adjustment	$0	$0	$0	
Intergovernmental Transfer for Difficult to Discharge Clients	$1,000,000	$1,000,000	$0	
Denver Health Ambulance Payments	$5,877,491	$6,355,256	$477,765	Flow through of update based on FY 2016-17 actuals
University of Colorado School of Medicine Payment	$122,675,137	$122,675,137	$0	
Payment delays from implementation of interChange - Financing Impact	$0	$0	$0	
Cash Funds Financing	$0	$0	$0	
Total Bottom Line Financing	**$1,197,663,254**	**$1,230,100,380**	**$32,437,126**	
Grand Total[3]	**$7,538,955,690**	**$7,746,557,747**	**$207,602,057**	
Total Acute Care	$4,089,247,108	$4,134,928,356	$45,681,248	
Total Community Based Long-Term Care	$969,973,591	$1,038,697,695	$68,724,104	
Total Class I Nursing Facilities	$677,214,991	$700,973,852	$23,758,861	
Total Class II Nursing Facilities	$4,176,936	$4,339,105	$162,169	
Total Program of All-Inclusive Care for the Elderly	$167,703,403	$189,947,985	$22,244,582	
Total Supplemental Medicare Insurance Benefit	$185,840,175	$198,595,486	$12,755,311	
Total Health Insurance Buy-In Program	$2,383,963	$3,480,440	$1,096,477	
Total Single Entry Point	$35,046,523	$36,235,658	$1,189,135	
Total Disease Management	$1,285,726	$1,285,726	$0	
Total Prepaid Inpatient Health Plan Administration	$208,420,020	$207,973,064	($446,956)	
Total Bottom Line Financing	$1,197,663,254	$1,230,100,380	$32,437,126	
Rounding Adjustment	$0	$0	$0	
Grand Total[3]	**$7,538,955,690**	**$7,746,557,747**	**$207,602,057**	

(1) The Department has not received a FY 2018-19 appropriation as of this Budget Request. No annualizations are included.

(2) These totals include the impact of the rate increases to CBLTC, LTHH, and PDN. LTHH and PDN expenditures are calculated using average cost per unit, which includes the effect of the rate increases, therefore expenditure impacts for LTHH and PDN are estimates.

(3) 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 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	$111,364,853	$86,107,634	$537,716,834	$35,297,880	$475,749,516	$211,345,770	$1,167,658,452	$3,847,398	$783,239,283	$85,468,099	$57,929,504	$155,773,423	$16,985,317	$39,369,481	$14,591,949	$3,782,445,393
FY 2016-17	$106,601,490	$78,424,902	$473,764,718	$33,743,433	$405,443,610	$220,060,762	$1,129,131,683	$3,826,373	$730,820,218	$81,093,133	$54,383,984	$131,729,736	$15,331,069	$40,583,893	$12,315,470	$3,517,254,474
Estimated FY 2017-18	$133,276,464	$106,670,688	$620,500,650	$48,681,734	$581,950,550	$259,289,377	$1,525,419,863	$1,995,464	$894,521,258	$109,239,378	$68,435,859	$141,418,313	$24,910,380	$45,719,372	$20,008,826	$4,582,038,176
Estimated FY 2018-19	$92,248,513	$93,364,540	$536,743,381	$44,991,433	$526,894,664	$244,204,797	$1,410,050,178	$806,130	$809,795,454	$102,926,563	$61,013,480	$127,194,488	$23,350,581	$41,911,969	$19,432,185	$4,134,928,356
Estimated FY 2019-20	$66,425,568	$93,979,639	$541,782,665	$44,314,854	$527,833,386	$254,038,441	$1,441,712,153	$861,904	$831,227,614	$107,864,543	$62,379,832	$131,088,398	$23,895,255	$43,336,747	$20,575,135	$4,191,316,134

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 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%	7.39%	63.37%	1.17%	23.45%	28.81%	-24.37%	7.36%	25.79%	2.00%	0.43%	3.55%	-2.83%	65.79%	13.54%
FY 2016-17	-4.28%	-8.92%	-11.89%	-4.40%	-14.78%	4.12%	-3.30%	-0.55%	-6.69%	-5.12%	-6.12%	-15.44%	-9.74%	3.08%	-15.60%	-7.01%
Estimated FY 2017-18	25.02%	36.02%	30.97%	44.27%	43.53%	17.83%	35.10%	-47.85%	22.40%	34.71%	25.84%	7.35%	62.48%	12.65%	62.47%	30.27%
Estimated FY 2018-19	-30.78%	-12.47%	-13.50%	-7.58%	-9.46%	-5.82%	-7.56%	-59.60%	-9.47%	-5.78%	-10.85%	-10.06%	-6.26%	-8.33%	-2.88%	-9.76%
Estimated FY 2019-20	-27.99%	0.66%	0.94%	-1.50%	0.18%	4.03%	2.25%	6.92%	2.65%	4.80%	2.24%	3.06%	2.33%	3.40%	5.88%	1.36%

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	$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	$2,626.34	$8,178.14	$7,815.65	$5,677.64	$2,912.60	$2,430.27	$3,644.67	$11,948.44	$1,676.48	$1,436.41	$2,905.92	$10,807.84	$9,656.23	$14,862.02	$447.81	$2,916.33
FY 2016-17	$2,426.01	$6,976.68	$7,006.38	$5,398.09	$2,518.42	$2,177.55	$3,246.05	$12,970.76	$1,555.25	$1,248.80	$2,677.69	$9,896.31	$7,604.70	$15,372.69	$364.27	$2,612.78
Estimated FY 2017-18	$2,945.86	$9,131.98	$9,159.63	$6,232.46	$3,085.36	$2,841.65	$4,013.16	$17,055.25	$1,918.22	$1,588.66	$3,324.71	$12,373.64	$10,532.93	$16,433.99	$542.70	$3,268.96
Estimated FY 2018-19	$2,005.71	$7,667.92	$7,725.93	$4,944.66	$2,684.73	$2,485.44	$3,579.19	$13,002.10	$1,729.12	$1,431.98	$2,940.98	$11,131.05	$9,877.57	$14,894.09	$473.17	$2,863.73
Estimated FY 2019-20	$1,420.26	$7,392.99	$7,555.61	$4,274.20	$2,619.31	$2,481.30	$3,588.46	$14,129.57	$1,767.10	$1,448.95	$2,980.55	$11,473.82	$10,107.98	$15,227.25	$449.77	$2,840.76

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 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%	0.14%	2.19%	-2.95%	-6.05%	2.43%	5.94%	2.52%	3.80%	2.96%	-0.15%	42.69%	1.65%
FY 2016-17	-7.63%	-14.69%	-10.35%	-4.92%	-13.53%	-10.40%	-10.94%	8.56%	-7.23%	-13.06%	-7.85%	-8.43%	-21.25%	3.44%	-18.66%	-10.41%
Estimated FY 2017-18	21.43%	30.89%	30.73%	15.46%	22.51%	30.50%	23.63%	31.49%	23.34%	27.21%	24.16%	25.03%	38.51%	6.90%	48.98%	25.11%
Estimated FY 2018-19	-31.91%	-16.03%	-15.65%	-20.66%	-12.98%	-12.54%	-10.81%	-23.76%	-9.86%	-9.86%	-11.54%	-10.04%	-6.22%	-9.37%	-12.81%	-12.40%
Estimated FY 2019-20	-29.19%	-3.59%	-2.20%	-13.56%	-2.44%	-0.17%	0.26%	8.67%	2.20%	1.19%	1.35%	3.08%	2.33%	2.24%	-4.95%	-0.80%

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 2016-17 Per Capita	$2,426.01	$6,976.68	$7,006.38	$5,398.09	$2,518.42	$2,177.55	$3,246.05	$12,970.76	$1,555.25	$1,248.80	$2,677.69	$9,896.31	$7,604.70	$15,372.69	$364.27	$2,612.78
Average of FY 2008-09 through FY 2013-14	0.55%	3.03%	0.71%	0.00%	0.00%	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 2009-10 through FY 2013-14	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 2010-11 through FY 2013-14	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 2011-12 through FY 2013-14	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 2009-10 through FY 2014-15	4.93%	2.70%	1.01%	0.19%	-2.85%	1.42%	23.26%	-8.04%	0.60%	-3.25%	0.46%	4.86%	3.29%	1.19%	10.93%	0.95%
Average of FY 2010-11 through FY 2014-15	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 2011-12 through FY 2014-15	8.67%	4.00%	3.14%	-22.38%	-2.83%	3.12%	-9.99%	-7.49%	3.21%	-5.41%	3.61%	6.39%	5.49%	-3.02%	17.96%	3.33%
Average of FY 2012-13 through FY 2014-15	10.87%	3.87%	1.78%	-23.07%	0.76%	2.77%	-0.25%	-12.99%	3.23%	-0.98%	1.34%	7.96%	8.79%	-2.13%	13.69%	3.10%
Average of FY 2010-11 through FY 2015-16	3.47%	-0.55%	-1.09%	-0.79%	-4.66%	-1.27%	21.07%	-4.95%	0.52%	-5.86%	-0.21%	3.83%	-0.96%	0.41%	7.99%	-0.17%
Average of FY 2011-12 through FY 2015-16	5.41%	-0.67%	-0.23%	-18.02%	-5.50%	-0.26%	-10.23%	-3.48%	0.60%	-7.33%	0.75%	2.69%	-1.20%	-1.40%	8.81%	-0.11%
Average of FY 2012-13 through FY 2015-16	6.25%	-2.32%	-2.27%	-17.02%	-4.01%	-1.62%	-3.81%	-5.80%	-0.26%	-5.01%	-1.72%	2.49%	-1.22%	-0.27%	2.90%	-1.40%
Average of FY 2013-14 through FY 2015-16	6.30%	-7.28%	-3.24%	-4.81%	-6.70%	-4.11%	-6.95%	1.26%	-2.40%	-3.56%	-2.67%	-2.32%	-9.15%	1.65%	12.02%	-4.38%

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
Estimated FY 2017-18 Base Per Capita	$2,655.60	$8,141.71	$8,062.22	$6,043.77	$2,798.80	$2,494.31	$3,587.16	$12,970.76	$1,707.95	$1,433.31	$2,931.09	$10,933.83	$9,749.10	$14,728.06	$499.15	$2,919.27
Estimated FY 2017-18 Eligibles	45,242	11,681	67,743	7,811	188,617	91,246	380,104	117	466,328	68,762	20,584	11,429	2,365	2,782	36,869	1,401,680
Estimated FY 2017-18 Base Expenditure	$120,144,655	$95,103,315	$546,158,969	$47,207,887	$527,901,260	$227,595,810	$1,363,495,404	$1,517,579	$796,464,217	$98,557,100	$60,333,557	$124,962,743	$23,056,622	$40,973,463	$18,403,161	$4,091,875,742
Bottom Line Impacts																
Annualization of Hepatitis C Criteria Change	$1,951,200	$2,244,929	$6,580,292	$303,266	$1,855,833	$2,960,178	$10,957,616	$3,815	$139,235	$0	$70,571	$150,679	$0	$0	$0	$27,217,614
Annualization of SB 17-091 Allow Medicaid Home Health Services in the Community	$119,889	$59,564	$283,256	$7,742	$27,312	$7,625	$110,652	$23	$46,585	$1,180	$18,465	$4,880	$636	$0	$0	$687,809
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
SB 17-267 Sustainability of Rural Colorado - Increased Copays	($15,211)	($54,961)	($390,990)	($27,200)	($342,166)	($146,249)	($838,584)	$0	$0	$0	$0	$0	$0	($3,535)	($5)	($1,818,901)
Annualization of State Plan Autism Treatment	$0	$0	$1,814,640	$0	$0	$0	$0	$0	$93,119	$0	$8,241	$0	$0	$0	$0	$1,916,000
Annualization of FY 2011-12 BA-9: Limit Physical and Occupational Therapy	($825)	($2,378)	($18,321)	($672)	($16,729)	($4,183)	($52,795)	($19)	$0	$0	($14)	($220)	$0	$0	($556)	($96,712)
2017 JBC Action: PT/OT Supplemental Footnote	$11,550	$33,292	$256,493	$9,408	$234,205	$58,562	$739,129	$266	$0	$0	$196	$3,080	$0	$0	$7,784	$1,353,965
Annualization of HB 15-1309 "Protective Restorations by Dental Hygenists"	$1,441	$484	$2,976	$280	$5,068	$2,472	$9,543	$0	$0	$0	$0	$359	$37	$0	$0	$22,660
FY 2012-13 R-6: "Dental Efficiency"	$0	$0	$0	$0	$0	$0	$0	$0	($1,403,311)	($236,199)	($65,122)	$0	$0	$0	$0	($1,704,632)
SB 11-177: Annualization "Sunset Teen Pregnancy & Dropout Program"	$0	$0	($192)	$0	$0	$0	$0	$0	($30,736)	($4,858)	($798)	($195)	$0	$0	$0	($36,779)
SB 10-117 OTC MEDS	($466)	($1,846)	($13,025)	($853)	($8,225)	($3,663)	($22,187)	($24)	($8,534)	($1,311)	($1,661)	($551)	($60)	$0	$0	($62,406)
Annualization of SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	($12,965)	($51,395)	($362,577)	($23,736)	($228,962)	($101,954)	($617,634)	($675)	($237,552)	($36,500)	($46,230)	($15,336)	($1,659)	($1)	($4)	($1,737,180)
Repay Overcollection of Drug Rebates in FY 2016-17	$417,737	$1,655,918	$11,682,097	$764,752	$7,377,081	$3,284,904	$19,899,966	$21,738	$7,653,835	$1,176,002	$1,489,522	$494,123	$53,448	$35	$135	$55,971,293
FY 2017-18 R-7 Oversight of State Resources - Physician Administered Drugs	($29,717)	($30,363)	($206,077)	($29,501)	($173,131)	($32,839)	($457,591)	($7,860)	($34,239)	($7,429)	($4,414)	($43,067)	($5,922)	($108)	($14,428)	($1,076,686)
FY 2017-18 R-7 Oversight of State Resources - Client and Provider Investigations	($25,110)	($20,078)	($116,844)	($9,164)	($109,511)	($48,798)	($287,031)	($375)	($168,392)	($20,564)	($12,889)	($26,619)	($4,689)	($8,606)	($3,765)	($862,435)
Annualization of HB 16-1097 "PUC Permit for Medicaid Transportation Providers"	($41,396)	($22,281)	($88,478)	($2,078)	($12,886)	($2,457)	($40,590)	($75)	($17,032)	($1,464)	($3,456)	($1,790)	($47)	$0	($462)	($234,492)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($12,317)	($46,880)	($146,022)	$0	($152,996)	($1,124)	($227,491)	$0	($163,834)	$0	$0	($21,196)	$0	$0	$0	($771,860)
Annualization of Estimated Impact of Increasing PACE Enrollment	($1,768,582)	($972,185)	($880,878)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($3,621,645)
2017 JBC Action: Community Provider Rate Increases (1.402% Across the Board)	$1,215,693	$818,863	$5,072,095	$340,949	$4,694,166	$2,082,596	$11,364,157	$43,129	$7,887,710	$844,349	$521,441	$1,683,009	$186,746	$463,167	$172,885	$37,390,955
2017 JBC Action: TRI - Transportation	$347,348	$207,445	$888,423	$24,319	$279,342	$67,649	$1,008,675	$713	$328,710	$27,610	$54,009	$57,372	$4,222	$7,840	$4,649	$3,308,326
2017 JBC Action: TRI - Home Health	$118,356	$60,830	$255,451	$7,586	$28,941	$8,108	$117,220	$25	$42,905	$906	$15,831	$5,193	$673	$5	$0	$662,030
2017 JBC Action: Post-Partum Depression Screening	$0	$0	$0	$0	$0	$0	$0	$0	$90,423	$0	$0	$0	$0	$0	$0	$90,423
Annualization of FY 2014-15 BA-10: "Continuation of '1202 Provider Rate Increase"	($22,715)	($70,194)	($379,154)	($22,821)	($709,481)	($282,333)	($1,507,960)	($2,804)	($1,775,494)	($181,325)	($82,189)	($104,829)	($11,499)	($18,674)	($4)	($5,171,476)
Annualization of HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	($239,959)	($283,728)	($1,855,660)	($170,807)	($3,298,610)	($493,538)	($7,849,893)	($14,463)	($11,374,987)	($1,132,927)	($574,237)	($494,722)	($67,190)	($38,040)	($129,676)	($28,018,437)
Annualization of FY 2017-18 R-6 Delivery System and Payment Reform - EAPG Methodology	($39,984)	($115,504)	($841,072)	($67,983)	($1,298,734)	($529,052)	($2,823,124)	($3,153)	($1,511,252)	($178,855)	($102,476)	($164,890)	($15,576)	($28,477)	($16)	($7,720,148)
FY 2017-18 R-6 Delivery System and Payment Reform - Primary Care Increase Continuation	$475,943	$562,755	$3,680,574	$338,783	$6,542,567	$978,899	$15,569,717	$28,687	$22,561,502	$2,247,083	$1,138,959	$981,248	$133,267	$75,450	$257,203	$55,572,637
FY 2017-18 R-6 Delivery System and Payment Reform - Vaccine Stock Rates	($5,551)	($14,019)	($96,365)	($8,587)	($131,972)	($57,579)	($290,785)	($617)	($278,820)	($26,112)	($19,350)	($51,280)	($5,931)	($7,374)	($11)	($994,353)
Annualization of Accountable Care Collaborative Savings	($789,693)	($781,456)	($1,499,176)	($3,532,507)	($4,055,093)	$931,905	($4,049,141)	$0	($109,105)	($99,158)	($41,771)	$73,294	($32,560)	$0	$0	($13,984,461)
Expiration of ACC: Access KP Initiative	($5,771)	($12,731)	($134,386)	($4,553)	($611,190)	($370,852)	($860,488)	$0	($1,519,484)	($278,675)	($52,867)	($27,637)	($4,220)	$0	$0	($3,882,854)
FY 2017-18 Legislative Action - Elective Circumcisions	$0	$0	$0	$0	$0	$0	$0	$0	$427,039	$0	$0	$0	$0	$0	$0	$427,039
Payment delays from implementation of interChange	$11,292,728	$8,307,868	$50,187,819	$3,574,579	$42,950,286	$23,311,930	$119,613,500	$405,343	$77,418,750	$8,590,525	$5,761,116	$13,954,665	$1,624,082	$4,299,216	$1,304,628	$372,597,035
Total Bottom Line Impacts[1]	$13,131,809	$11,567,373	$74,341,681	$1,473,847	$54,049,290	$31,693,567	$161,924,459	$477,885	$98,057,041	$10,682,278	$8,102,302	$16,455,570	$1,853,758	$4,745,909	$1,605,665	$490,162,434
Estimated FY 2017-18 Expenditure including Payment Delays from FY 2016-17 Service Dates and Overcollection of Drug Rebates	**$133,276,464**	**$106,670,688**	**$620,500,650**	**$48,681,734**	**$581,950,550**	**$259,289,377**	**$1,525,419,863**	**$1,995,464**	**$894,521,258**	**$109,239,378**	**$68,435,859**	**$141,418,313**	**$24,910,380**	**$45,719,372**	**$20,008,826**	**$4,582,038,176**
Estimated FY 2017-18 Per Capita including Payment Delay from FY 2016-17 Service Dates	$2,945.86	$9,131.98	$9,159.63	$6,232.46	$3,085.36	$2,841.65	$4,013.16	$17,055.25	$1,918.22	$1,588.66	$3,324.71	$12,373.64	$10,532.93	$16,433.99	$542.70	$3,268.96
% Change over FY 2016-17 Per Capita	21.43%	30.89%	30.73%	15.46%	22.51%	30.50%	23.63%	31.49%	23.34%	27.21%	24.16%	25.03%	38.51%	6.90%	48.98%	25.11%
Estimated FY 2017-18 Expenditure Excluding Payment Delays from FY 2016-17 and Overcollection of Drug Rebates	**$121,565,999**	**$96,706,902**	**$558,630,734**	**$44,342,403**	**$531,623,183**	**$232,692,543**	**$1,385,906,397**	**$1,568,383**	**$809,448,673**	**$99,472,851**	**$61,185,221**	**$126,969,525**	**$23,232,850**	**$41,420,121**	**$18,704,063**	**$4,153,469,848**
Estimated FY 2017-18 Per Capita excluding Payment Delay from FY 2016-17 Service Dates (placeholder per capita for calculation purposes only)	$2,687.02	$8,278.99	$8,246.32	$5,676.92	$2,818.53	$2,550.17	$3,646.12	$13,404.98	$1,735.79	$1,446.63	$2,972.47	$11,109.42	$9,823.62	$14,888.61	$507.31	$2,963.21
% Change over FY 2016-17 Per Capita	10.76%	18.67%	17.70%	5.17%	11.92%	17.11%	12.32%	3.35%	11.61%	15.84%	11.01%	12.26%	29.18%	-3.15%	39.27%	13.41%

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]	2.00%	1.00%	0.30%	1.00%	-2.00%	0.00%	0.00%	0.00%	0.50%	0.00%	0.82%	1.00%	1.00%	0.00%	1.83%	
Estimated FY 2018-19 Base Per Capita	$2,740.76	$8,361.78	$8,271.06	$5,733.69	$2,762.16	$2,550.17	$3,646.12	$13,404.98	$1,744.47	$1,446.63	$2,996.84	$11,220.51	$9,921.85	$14,888.61	$516.60	$2,965.92
Estimated FY 2018-19 Eligibles	45,993	12,176	69,473	9,099	196,256	98,254	393,958	62	468,328	71,877	20,746	11,427	2,364	2,814	41,068	1,443,895
Estimated FY 2018-19 Base Expenditure	$126,055,775	$101,813,033	$574,615,351	$52,170,845	$542,090,473	$250,564,403	$1,436,418,143	$831,109	$816,984,146	$103,979,425	$62,172,443	$128,216,768	$23,455,253	$41,896,549	$21,215,729	$4,282,479,445
Bottom Line Impacts																
Annualization of SB 17-091 Allow Medicaid Home Health Services in the Community	$5,215	$2,591	$12,321	$337	$1,188	$332	$4,813	$1	$2,026	$51	$803	$212	$27	$0	$0	$29,917
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 SB 17-267 Sustainability of Rural Colorado - Increased Copays	($21,295)	($76,945)	($547,387)	($38,079)	($479,032)	($204,748)	($1,174,019)	$0	$0	$0	$0	$0	$0	($4,949)	($7)	($2,546,461)
Annualization of State Plan Autism Treatment	$0	$0	$1,340,666	$0	$0	$0	$0	$0	$68,797	$0	$6,088	$0	$0	$0	$0	$1,415,551
Annualization of 2017 JBC Action: PT/OT Supplemental Footnote	$8,250	$23,780	$183,210	$6,720	$167,290	$41,830	$527,948	$190	$0	$0	$140	$2,200	$0	$0	$5,560	$967,118
Annualization of FY 2012-13 R-6: "Dental Efficiency"	$0	$0	$0	$0	$0	$0	$0	$0	($127,573)	($21,473)	($5,920)	$0	$0	$0	$0	($154,966)
Annualization of SB 10-117 OTC MEDS	($652)	($2,585)	($18,235)	($1,194)	($11,515)	($5,128)	($31,064)	($34)	($11,947)	($1,836)	($2,325)	($771)	($83)	$0	$0	($87,369)
Annualization of SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"	($2,233)	($8,850)	($62,432)	($4,087)	($39,425)	($17,555)	($106,351)	($116)	($40,904)	($6,285)	($7,960)	($2,641)	($286)	$0	($1)	($299,126)
Annualization of FY 2017-18 R-7 Oversight of State Resources - Physician Administered Drugs	$56,194	$57,415	$389,690	$55,786	$327,388	$62,098	$865,300	$14,863	$64,745	$14,048	$8,348	$81,440	$11,198	$204	$27,282	$2,035,999
Annualization of FY 2017-18 R-7 Oversight of State Resources - Client and Provider Investigations	($25,110)	($20,078)	($116,844)	($9,164)	($109,511)	($48,798)	($287,031)	($375)	($168,392)	($20,564)	($12,889)	($26,619)	($4,689)	($8,606)	($3,765)	($862,435)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($20,441)	($77,797)	($242,324)	$0	($253,898)	($1,865)	($377,523)	$0	($271,883)	$0	$0	($35,174)	$0	$0	$0	($1,280,905)
Annualization of Estimated Impact of Increasing PACE Enrollment	($1,577,696)	($887,174)	($660,848)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($3,125,718)
Annualization of 2017 JBC Action: Community Provider Rate Increases (1.402% Across the Board)	$161,882	$109,040	$675,400	$45,401	$625,075	$277,318	$1,513,251	$5,743	$1,050,328	$112,434	$69,435	$224,110	$24,867	$61,675	$23,021	$4,978,980
Annualization of 2017 JBC Action: TRI - Transportation	$48,021	$28,679	$122,826	$3,362	$38,620	$9,353	$139,451	$99	$45,445	$3,817	$7,467	$7,932	$584	$1,084	$643	$457,383
Annualization of 2017 JBC Action: TRI - Home Health	$4,320	$2,220	$9,324	$277	$1,056	$296	$4,278	$1	$1,566	$33	$578	$190	$25	$0	$0	$24,164
Annualization of 2017 JBC Action: Post-Partum Depression Screening	$0	$0	$0	$0	$0	$0	$0	$0	$341	$0	$0	$0	$0	$0	$0	$341
Annualization of HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"	($118,512)	($140,129)	($916,484)	($84,359)	($1,629,137)	($243,751)	($3,876,948)	($7,143)	($5,617,942)	($559,536)	($283,607)	($244,336)	($33,184)	($18,787)	($64,045)	($13,837,900)
Annualization of FY 2017-18 R-6 Delivery System and Payment Reform - Primary Care Increase Continuation	($455,250)	($538,288)	($3,520,549)	($324,053)	($6,258,108)	($936,338)	($14,892,774)	($27,439)	($21,580,567)	($2,149,383)	($1,089,440)	($938,585)	($127,472)	($72,169)	($246,020)	($53,156,435)
Annualization of FY 2017-18 R-6 Delivery System and Payment Reform - Vaccine Stock Rates	($157)	($396)	($2,720)	($242)	($3,726)	($1,625)	($8,208)	($17)	($7,871)	($737)	($546)	($1,447)	($167)	($208)	$0	($28,067)
Annualization of HB 17-1353 Implement Medicaid Delivery & Payment Initiatives - Primary Care Incentives	$511,585	$604,898	$3,956,201	$364,153	$7,032,520	$1,052,206	$16,735,687	$30,835	$24,251,064	$2,415,360	$1,224,253	$1,054,730	$143,247	$81,100	$276,464	$59,734,303
Annualization of HB 17-1353 Implement Medicaid Delivery & Payment Initiatives - SUD/SPMI Savings through Integration of Care	($3,415,535)	($1,394,062)	($8,025,399)	($379,022)	($11,674,057)	($3,777,861)	($20,260,764)	($41,773)	($4,273,206)	($682,380)	($1,057,131)	($922,500)	($54,311)	($24,146)	($1,803,000)	($57,785,147)
Annualization of Accountable Care Collaborative Savings	($28,974,270)	($6,135,038)	($30,477,913)	($6,815,365)	($2,983,861)	($2,568,619)	($5,252,928)	$0	($611,541)	($156,411)	($17,649)	($221,021)	($64,428)	$0	$0	($84,279,044)
Annualization of FY 2017-18 Legislative Action - Elective Circumcisions	$0	$0	$0	$0	$0	$0	$0	$0	$38,822	$0	$0	$0	$0	$0	$0	$38,822
Total Bottom Line Impacts[2]	($33,807,262)	($8,448,493)	($37,871,970)	($7,179,412)	($15,195,809)	($6,359,606)	($26,367,965)	($24,979)	($7,188,692)	($1,052,862)	($1,158,963)	($1,022,280)	($104,672)	$15,420	($1,783,544)	($147,551,089)
Estimated FY 2018-19 Expenditure	**$92,248,513**	**$93,364,540**	**$536,743,381**	**$44,991,433**	**$526,894,664**	**$244,204,797**	**$1,410,050,178**	**$806,130**	**$809,795,454**	**$102,926,563**	**$61,013,480**	**$127,194,488**	**$23,350,581**	**$41,911,969**	**$19,432,185**	**$4,134,928,356**
Estimated FY 2018-19 Per Capita	$2,005.71	$7,667.92	$7,725.93	$4,944.66	$2,684.73	$2,485.44	$3,579.19	$13,002.10	$1,729.12	$1,431.98	$2,940.98	$11,131.05	$9,877.57	$14,894.09	$473.17	$2,863.73
% Change over FY 2017-18 Per Capita	-31.91%	-16.03%	-15.65%	-20.66%	-12.98%	-12.54%	-10.81%	-23.76%	-9.86%	-9.86%	-11.54%	-10.04%	-6.22%	-9.37%	-12.81%	-12.40%

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

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
	Out Year Projection															
Percentage Selected to Modify Per Capita(3)	2.00%	1.00%	0.30%	1.00%	-2.00%	0.00%	0.00%	0.00%	0.50%	0.00%	0.82%	1.00%	1.00%	0.00%	1.83%	
Estimated FY 2019-20 Base Per Capita	$2,045.82	$7,744.60	$7,749.11	$4,994.11	$2,631.04	$2,485.44	$3,579.19	$13,002.10	$1,737.77	$1,431.98	$2,965.10	$11,242.36	$9,976.35	$14,894.09	$481.83	$2,865.32
Estimated FY 2019-20 Eligibles	46,770	12,712	71,706	10,368	201,516	102,381	401,763	61	470,392	74,443	20,929	11,425	2,364	2,846	45,746	1,475,422
Estimated FY 2019-20 Base Expenditure	$95,683,001	$98,449,355	$555,657,682	$51,778,932	$530,196,657	$254,461,833	$1,437,986,112	$793,128	$817,433,106	$106,600,887	$62,056,578	$128,443,963	$23,584,091	$42,388,580	$22,041,795	$4,227,555,700
Bottom Line Impacts																
Annualization of State Plan Autism Treatment	$0	$0	$2,102,795	$0	$0	$0	$0	$0	$107,906	$0	$9,549	$0	$0	$0	$0	$2,220,250
Annualization of FY 2017-18 R-7 Oversight of State Resources - Physician Administered Drugs	$64,673	$66,079	$448,491	$64,204	$376,789	$71,468	$995,867	$17,105	$74,514	$16,168	$9,607	$93,729	$12,888	$234	$31,399	$2,343,215
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($25,883)	($98,521)	($306,875)	$0	($321,532)	($2,363)	($478,087)	$0	($344,307)	$0	$0	($44,544)	$0	$0	$0	($1,622,112)
Annualization of Estimated Impact of Increasing PACE Enrollment	($1,672,423)	($1,047,320)	($593,191)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($3,312,934)
Annualization of FY 2017-18 R-6 Delivery System and Payment Reform - Primary Care Increase Continuation	($20,693)	($24,468)	($160,025)	($14,730)	($284,460)	($42,561)	($676,944)	($1,247)	($980,935)	($97,699)	($49,520)	($42,663)	($5,794)	($3,280)	($11,183)	($2,416,202)
Annualization of FY 2017-18 R-6 Delivery System and Payment Reform - Vaccine Stock Rates	($144)	($364)	($2,504)	($223)	($3,430)	($1,496)	($7,557)	($16)	($7,246)	($679)	($503)	($1,333)	($154)	($192)	$0	($25,841)
Annualization of HB 17-1353 Implement Medicaid Delivery & Payment Initiatives - Primary Care Incentives	$11,153	$13,186	$86,245	$7,939	$153,309	$22,938	$364,838	$672	$528,673	$52,655	$26,689	$22,993	$3,123	$1,768	$6,027	$1,302,208
Annualization of HB 17-1353 Implement Medicaid Delivery & Payment Initiatives - SUD/SPMI Savings through Integration of Care	($3,512,210)	($1,433,521)	($8,252,556)	($389,750)	($12,004,489)	($3,884,792)	($20,834,242)	($42,955)	($4,394,158)	($701,695)	($1,087,053)	($948,611)	($55,849)	($24,829)	($1,854,033)	($59,420,743)
Annualization of Accountable Care Collaborative Savings	($26,858,084)	($4,075,883)	($20,505,411)	($8,005,114)	($2,053,779)	($1,817,169)	($4,536,697)	$0	($574,343)	($120,314)	($19,205)	($290,572)	($63,442)	$0	$0	($68,920,013)
Additional week 53 pay period in FY 2019-20	$2,756,178	$2,131,096	$13,308,014	$873,596	$11,774,321	$5,230,583	$28,898,863	$95,217	$19,384,404	$2,115,220	$1,433,690	$3,855,436	$420,392	$974,466	$361,130	$93,612,606
Total Bottom Line Impacts(3)	($29,257,433)	($4,469,716)	($13,875,017)	($7,464,078)	($2,363,271)	($423,392)	$3,726,041	$68,776	$13,794,508	$1,263,656	$323,254	$2,644,435	$311,164	$948,167	($1,466,660)	($36,239,566)
Estimated FY 2019-20 Expenditure	**$66,425,568**	**$93,979,639**	**$541,782,665**	**$44,314,854**	**$527,833,386**	**$254,038,441**	**$1,441,712,153**	**$861,904**	**$831,227,614**	**$107,864,543**	**$62,379,832**	**$131,088,398**	**$23,895,255**	**$43,336,747**	**$20,575,135**	**$4,191,316,134**
Estimated FY 2019-20 Per Capita	$1,420.26	$7,392.99	$7,555.61	$4,274.20	$2,619.31	$2,481.30	$3,588.46	$14,129.57	$1,767.10	$1,448.95	$2,980.55	$11,473.82	$10,107.98	$15,227.25	$449.77	$2,840.76
% Change over FY 2018-19 Per Capita	-29.19%	-3.59%	-2.20%	-13.56%	-2.44%	-0.17%	0.26%	8.67%	2.20%	1.19%	1.35%	3.08%	2.33%	2.24%	-4.95%	-0.80%

(1) Percentage selected to modify Per Capita amounts for Estimated FY 2017-18:	**OAP-A**	Due to payment delays as a result of transitioning to the new payment system, the per capita reported in FY 2016-17 is artificially low and any trend applied to the FY 2016-17 per capita would need to be artificially high in order to return the FY 2017-18 base per capita to expected levels. As a result, the Department forecasted expenditures for this population using the most recently estimated base per capita from the S-1 request.	**MAGI Parents/ Caretakers 69% to 133% FPL**	Please see explanation for OAP-A	**Foster Care**	Please see explanation for OAP-A
	OAP-B	Please see explanation for OAP-A	**MAGI Adults**	Please see explanation for OAP-A	**MAGI Pregnant Adults**	Please see explanation for OAP-A
	AND/AB	Please see explanation for OAP-A	**BCCP**	Please see explanation for OAP-A	**SB 11-250 Eligible Pregnant Adults**	Please see explanation for OAP-A
	Disabled Buy-in	Please see explanation for OAP-A	**Eligible Children (AFDC-C/BC)**	Please see explanation for OAP-A	**Non-Citizens Emergency Services**	Please see explanation for OAP-A
	MAGI Parents/ Caretakers to 68% FPL	Please see explanation for OAP-A	**SB 11-008 Eligible Children**	Please see explanation for OAP-A	**Partial Dual Eligibles**	Please see explanation for OAP-A
(2) 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 population.	**MAGI Parents/ Caretakers 69% to 133% FPL**	The Department has selected a flat trend as per capita expenditure is showing very little growth halfway through FY 2016-17.	**Foster Care**	The Department anticipates per capita costs will stabilize after the shifting caseload mix from expansion (former foster care ages 21-26) put downward pressure on per capita.
	OAP-B	The Department anticipates the per capita of this population will continue to grow, but at a slower rate.	**MAGI Adults**	The Department has flattened the trend for this population as anticipated double digit caseload growth is expected to outpace increases in overall expenditure.	**MAGI Pregnant Adults**	The Department anticipates small positive growth.
	AND/AB	The Department has selected a small positive trend for this population as the Department believes year over year growth will continue at low levels. This population is primarily driven by prescription drugs and inpatient hospital expenditure.	**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 increased the trend for this population to account for higher than anticipated per capita in FY 2015-16 and the first half of FY 2016-17. The Department anticipates per capita expenditure will slow down, but continue to grow at a slower pace.	**Eligible Children (AFDC-C/BC)**	The Department anticipates costs will stabilize for this population and continue to grow year-over-year at a smaller rate.	**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 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 in anticipation of the per capita leveling out over time.	**Partial Dual Eligibles**	The Department has maintained the FY 2017-18 trend for this population to be in line with assumptions for lower co-insurance expenditure.
(3) Percentage selected to modify Per Capita amounts for Estimated FY 2019-20:	**OAP-A**	The Department has selected a positive trend to account for large increases in co-insurance expenditure for this population.	**MAGI Parents/ Caretakers 69% to 133% FPL**	The Department has selected a flat trend as per capita expenditure is showing very little growth halfway through FY 2016-17.	**Foster Care**	The Department anticipates per capita costs will stabilize after the shifting caseload mix from expansion (former foster care ages 21-26) put downward pressure on per capita.
	OAP-B	The Department anticipates the per capita of this population will continue to grow, but at a slower rate.	**MAGI Adults**	The Department has flattened the trend for this population as anticipated double digit caseload growth is expected to outpace increases in overall expenditure.	**MAGI Pregnant Adults**	The Department anticipates small positive growth.
	AND/AB	The Department has selected a small positive trend for this population as the Department believes year over year growth will continue at low levels. This population is primarily driven by prescription drugs and inpatient hospital expenditure.	**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 increased the trend for this population to account for higher than anticipated per capita in FY 2015-16 and the first half of FY 2016-17. The Department anticipates per capita expenditure will slow down, but continue to grow at a slower pace.	**Eligible Children (AFDC-C/BC)**	The Department anticipates costs will stabilize for this population and continue to grow year-over-year at a smaller rate.	**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 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 in anticipation of the per capita leveling out over time.	**Partial Dual Eligibles**	The Department has maintained the FY 2017-18 trend for this population to be in line with assumptions for lower co-insurance expenditure.

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

Breast and Cervical Cancer Program Costs

Fiscal Year	Total	Caseload	Per Capita [3]	Percent Change
FY 2011-12	$10,278,309	597	$17,216.60	
FY 2012-13	$9,560,072	623	$15,345.22	-6.99%
FY 2013-14	$8,880,091	559	$15,885.67	-7.11%
FY 2014-15	$5,093,675	400	$12,734.19	-42.64%
FY 2015-16	$3,886,349	322	$12,069.41	-23.70%
FY 2016-17	$3,857,073	295	$13,074.82	-0.75%
FY 2017-18 Estimate [2]	$1,995,464	117	$17,055.25	**30.44%**
FY 2018-19 Estimate [2]	$806,130	62	$13,002.10	**-23.76%**
FY 2019-20 Estimate [2]	$861,904	61	$14,129.57	**8.67%**

(1) Totals taken from the Department's monthly report to the Joint Budget Committee on the Health Care Policy and Financing
(2) The FY 2017-18 through FY 2019-20 totals are calculated on page EF-2 and include bottom line impacts. Base per capita trends have remained constant at FY 2016-17 levels. Caseload totals are taken from Exhibit B.
(3) Base per capita grwoth in FY 2017-18 through FY 2019-20 remains flat. All increases/decreases to per capita are the result of bottom line adjustments

Fiscal Year	Per Capita	Caseload	Total Funds	General Fund	Cash Funds [1]	Reappropriated Funds	Federal Funds	FFP
FY 2017-18 Estimate	$17,055.25	117	$1,995,464	$0	$698,412	$0	$1,297,052	65.00%
FY 2018-19 Estimate	$13,002.10	62	$806,130	$0	$282,145	$0	$523,985	65.00%
FY 2019-20 Estimate	$14,129.57	61	$861,904	$0	$301,666	$0	$560,238	65.00%

(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.

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 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	$62,115,472
FY 2016-17	$9,626,404	$3,310,233	$15,679,512	$0	$29,215,409	$0	$0	$0	$0	$0	$236,132	$2,163,344	$318,121	$0	$0	$60,549,155
Estimated FY 2017-18	$11,386,054	$4,049,686	$16,700,004	$0	$37,968,602	$0	$0	$0	$0	$0	$157,834	$2,021,676	$347,631	$0	$0	$72,631,487
Estimated FY 2018-19	$11,816,522	$4,312,496	$17,430,776	$0	$39,979,310	$0	$0	$0	$0	$0	$158,784	$2,066,916	$350,676	$0	$0	$76,115,480
Estimated FY 2019-20	$12,266,836	$4,599,583	$18,310,844	$0	$41,542,523	$0	$0	$0	$0	$0	$160,245	$2,113,168	$353,891	$0	$0	$79,347,090

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 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	100.00%	100.00%	100.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
FY 2014-15	315.83%	375.12%	281.56%	0.00%	252.15%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	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%	30.40%	8.92%	0.00%	0.00%	23.02%
FY 2016-17	-0.15%	0.73%	0.83%	0.00%	-5.75%	0.00%	0.00%	0.00%	0.00%	0.00%	49.49%	-3.31%	29.89%	0.00%	0.00%	-2.52%
Estimated FY 2017-18	18.28%	22.34%	6.51%	0.00%	29.96%	0.00%	0.00%	0.00%	0.00%	0.00%	-33.16%	-6.55%	9.28%	0.00%	0.00%	19.95%
Estimated FY 2018-19	3.78%	6.49%	4.38%	0.00%	5.30%	0.00%	0.00%	0.00%	0.00%	0.00%	0.60%	2.24%	0.88%	0.00%	0.00%	4.80%
Estimated FY 2019-20	3.81%	6.66%	5.05%	0.00%	3.91%	0.00%	0.00%	0.00%	0.00%	0.00%	0.92%	2.24%	0.92%	0.00%	0.00%	4.25%

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	$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	$48.33
FY 2014-15	$171.46	$243.16	$175.71	$0.00	$167.13	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$115.19	$128.56	$0.00	$0.00	$145.40
FY 2015-16	$227.36	$312.12	$226.02	$0.00	$189.77	$0.00	$0.00	$0.00	$0.00	$0.00	$87.75	$155.24	$139.23	$0.00	$0.00	$171.33
FY 2016-17	$219.08	$294.48	$231.88	$0.00	$181.47	$0.00	$0.00	$0.00	$0.00	$0.00	$141.57	$162.52	$157.80	$0.00	$0.00	$165.56
Estimated FY 2017-18	$251.67	$346.69	$246.52	$0.00	$201.30	$0.00	$0.00	$0.00	$0.00	$0.00	$99.08	$176.89	$146.99	$0.00	$0.00	$182.75
Estimated FY 2018-19	$256.92	$354.18	$250.90	$0.00	$203.71	$0.00	$0.00	$0.00	$0.00	$0.00	$99.99	$180.88	$148.34	$0.00	$0.00	$185.13
Estimated FY 2019-20	$262.28	$361.83	$255.36	$0.00	$206.15	$0.00	$0.00	$0.00	$0.00	$0.00	$100.91	$184.96	$149.70	$0.00	$0.00	$187.79

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 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	100.00%	100.00%	100.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
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%	200.85%
FY 2015-16	32.60%	28.36%	28.63%	0.00%	13.55%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	34.77%	8.30%	0.00%	0.00%	17.83%
FY 2016-17	-3.64%	-5.65%	2.59%	0.00%	-4.37%	0.00%	0.00%	0.00%	0.00%	0.00%	61.33%	4.69%	13.34%	0.00%	0.00%	-3.37%
Estimated FY 2017-18	14.88%	17.73%	6.31%	0.00%	10.93%	0.00%	0.00%	0.00%	0.00%	0.00%	-30.01%	8.84%	-6.85%	0.00%	0.00%	10.38%
Estimated FY 2018-19	2.09%	2.16%	1.78%	0.00%	1.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.92%	2.26%	0.92%	0.00%	0.00%	1.30%
Estimated FY 2019-20	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%	1.44%

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 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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2014-15	$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 2015-16	$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 2016-17	$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 2017-18	$921,580	$304,407	$1,509,314	$0	$4,558,873	$0	$0	$0	$0	$0	$23,576	$176,921	$35,002	$0	$0	$7,529,673
Estimated FY 2018-19	$927,679	$314,141	$1,532,574	$0	$4,696,406	$0	$0	$0	$0	$0	$23,264	$175,176	$34,633	$0	$0	$7,703,873
Estimated FY 2019-20	$933,997	$324,664	$1,566,059	$0	$4,773,914	$0	$0	$0	$0	$0	$23,026	$173,432	$34,278	$0	$0	$7,829,370

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 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	100.00%	100.00%	100.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
FY 2015-16	-15.06%	-9.56%	-12.24%	0.00%	11.33%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	-3.72%	40.93%	0.00%	0.00%	0.53%
FY 2016-17	-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 2017-18	0.32%	4.34%	-7.37%	0.00%	8.63%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.22%	-25.42%	26.45%	0.00%	0.00%	2.76%
Estimated FY 2018-19	0.66%	3.20%	1.54%	0.00%	3.02%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.32%	-0.99%	-1.05%	0.00%	0.00%	2.31%
Estimated FY 2019-20	0.68%	3.35%	2.18%	0.00%	1.65%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.02%	-1.00%	-1.03%	0.00%	0.00%	1.63%

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	$36.43	$43.77	$38.55	$0.00	$32.96	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$24.43	$15.95	$0.00	$0.00	$29.57
FY 2015-16	$30.51	$39.35	$32.72	$0.00	$36.32	$0.00	$0.00	$0.00	$0.00	$0.00	$22.53	$24.31	$22.35	$0.00	$0.00	$28.47
FY 2016-17	$20.91	$25.95	$24.10	$0.00	$26.07	$0.00	$0.00	$0.00	$0.00	$0.00	$15.74	$17.82	$13.73	$0.00	$0.00	$20.04
Estimated FY 2017-18	$20.37	$26.06	$22.28	$0.00	$24.17	$0.00	$0.00	$0.00	$0.00	$0.00	$14.80	$15.48	$14.80	$0.00	$0.00	$18.95
Estimated FY 2018-19	$20.17	$25.80	$22.06	$0.00	$23.93	$0.00	$0.00	$0.00	$0.00	$0.00	$14.65	$15.33	$14.65	$0.00	$0.00	$18.74
Estimated FY 2019-20	$19.97	$25.54	$21.84	$0.00	$23.69	$0.00	$0.00	$0.00	$0.00	$0.00	$14.50	$15.18	$14.50	$0.00	$0.00	$18.53

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 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	100.00%	100.00%	100.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
FY 2015-16	-16.25%	-10.10%	-15.12%	0.00%	10.19%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	-0.49%	40.13%	0.00%	0.00%	-3.72%
FY 2016-17	-31.47%	-34.05%	-26.34%	0.00%	-28.22%	0.00%	0.00%	0.00%	0.00%	0.00%	-30.14%	-26.70%	-38.57%	0.00%	0.00%	-29.61%
Estimated FY 2017-18	-2.58%	0.42%	-7.55%	0.00%	-7.29%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.97%	-13.13%	7.79%	0.00%	0.00%	-5.44%
Estimated FY 2018-19	-0.98%	-1.00%	-0.99%	0.00%	-0.99%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.01%	-0.97%	-1.01%	0.00%	0.00%	-1.11%
Estimated FY 2019-20	-0.99%	-1.01%	-1.00%	0.00%	-1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.02%	-0.98%	-1.02%	0.00%	0.00%	-1.12%

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 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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2014-15	$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 2015-16	$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 2016-17	$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 2017-18	$10,464,475	$3,745,279	$15,190,690	$0	$33,409,729	$0	$0	$0	$0	$0	$134,258	$1,844,755	$312,629	$0	$0	$65,101,815
Estimated FY 2018-19	$10,888,843	$3,998,355	$15,898,201	$0	$35,282,904	$0	$0	$0	$0	$0	$135,520	$1,891,740	$316,043	$0	$0	$68,411,606
Estimated FY 2019-20	$11,332,839	$4,274,918	$16,744,785	$0	$36,768,609	$0	$0	$0	$0	$0	$137,219	$1,939,737	$319,613	$0	$0	$71,517,720

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 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	100.00%	100.00%	100.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
FY 2015-16	2823.33%	2646.75%	1791.09%	0.00%	799.73%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	803.33%	1785.49%	0.00%	0.00%	1123.72%
FY 2016-17	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 2017-18	19.98%	25.07%	9.12%	0.00%	24.66%	0.00%	0.00%	0.00%	0.00%	0.00%	1.95%	-7.77%	43.92%	0.00%	0.00%	18.83%
Estimated FY 2018-19	4.06%	6.76%	4.66%	0.00%	5.61%	0.00%	0.00%	0.00%	0.00%	0.00%	0.94%	2.55%	1.09%	0.00%	0.00%	5.08%
Estimated FY 2019-20	4.08%	6.92%	5.33%	0.00%	4.21%	0.00%	0.00%	0.00%	0.00%	0.00%	1.25%	2.54%	1.13%	0.00%	0.00%	4.54%

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	$4.81	$7.41	$7.50	$0.00	$14.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$10.15	$5.63	$0.00	$0.00	$9.45
FY 2015-16	$138.57	$202.36	$137.24	$0.00	$129.11	$0.00	$0.00	$0.00	$0.00	$0.00	$46.38	$94.74	$105.48	$0.00	$0.00	$110.80
FY 2016-17	$198.49	$266.39	$205.87	$0.00	$166.48	$0.00	$0.00	$0.00	$0.00	$0.00	$78.95	$150.27	$107.75	$0.00	$0.00	$149.81
Estimated FY 2017-18	$231.30	$320.63	$224.24	$0.00	$177.13	$0.00	$0.00	$0.00	$0.00	$0.00	$84.28	$161.41	$132.19	$0.00	$0.00	$163.81
Estimated FY 2018-19	$236.75	$328.38	$228.84	$0.00	$179.78	$0.00	$0.00	$0.00	$0.00	$0.00	$85.34	$165.55	$133.69	$0.00	$0.00	$166.39
Estimated FY 2019-20	$242.31	$336.29	$233.52	$0.00	$182.46	$0.00	$0.00	$0.00	$0.00	$0.00	$86.41	$169.78	$135.20	$0.00	$0.00	$169.26

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 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	100.00%	100.00%	100.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
FY 2015-16	2780.87%	2630.90%	1729.87%	0.00%	790.41%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	833.40%	1773.53%	0.00%	0.00%	1072.49%
FY 2016-17	43.24%	31.64%	50.01%	0.00%	28.94%	0.00%	0.00%	0.00%	0.00%	0.00%	70.22%	58.61%	2.15%	0.00%	0.00%	35.21%
Estimated FY 2017-18	16.53%	20.36%	8.92%	0.00%	6.40%	0.00%	0.00%	0.00%	0.00%	0.00%	6.75%	7.41%	22.68%	0.00%	0.00%	9.35%
Estimated FY 2018-19	2.36%	2.42%	2.05%	0.00%	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	1.26%	2.56%	1.13%	0.00%	0.00%	1.57%
Estimated FY 2019-20	2.35%	2.41%	2.05%	0.00%	1.49%	0.00%	0.00%	0.00%	0.00%	0.00%	1.25%	2.56%	1.13%	0.00%	0.00%	1.72%

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	14.88%	17.73%	6.31%	0.00%	10.93%	0.00%	0.00%	0.00%	0.00%	0.00%	-30.01%	8.84%	-6.85%	0.00%	0.00%	
Estimated FY 2017-18 Total Dental Per Capita	$251.67	$346.69	$246.52	$0.00	$201.30	$0.00	$0.00	$0.00	$0.00	$0.00	$99.08	$176.89	$146.99	$0.00	$0.00	$220.52
Estimated FY 2017-18 Eligible Caseload	45,242	11,681	67,743	-	188,617	-	-	-	-	-	1,593	11,429	2,365	-	-	328,670
Estimated FY 2017-18 Total Dental Expenditure	**$11,386,054**	**$4,049,686**	**$16,700,004**	**$0**	**$37,968,602**	**$0**	**$0**	**$0**	**$0**	**$0**	**$157,834**	**$2,021,676**	**$347,631**	**$0**	**$0**	**$72,631,487**
Emergency and Co-Occurring Dental																
Emergency and Co-Occurring Dental Per Capita Trend Factor	-2.58%	0.42%	-7.55%	0.00%	-7.29%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.97%	-13.13%	7.79%	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	$14.80	$15.48	$14.80	$0.00	$0.00	$22.88
Estimated FY 2017-18 Eligible Caseload	45,242	11,681	67,743	-	188,617	-	-	-	-	-	1,593	11,429	2,365	-	-	328,670
Estimated FY 2017-18 Emergency and Co-Occurring Dental Expenditure	**$921,580**	**$304,407**	**$1,509,314**	**$0**	**$4,558,873**	**$0**	**$0**	**$0**	**$0**	**$0**	**$23,576**	**$176,921**	**$35,002**	**$0**	**$0**	**$7,529,673**
Bottom Line Impacts																
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Adult Dental Benefit																
Estimated FY 2017-18 Adult Dental Benefit Per Capita	$231.30	$320.63	$224.24	$0.00	$177.13	$0.00	$0.00	$0.00	$0.00	$0.00	$84.28	$161.41	$132.19	$0.00	$0.00	$198.08
Estimated FY 2017-18 Eligible Caseload	45,242	11,681	67,743	-	188,617	-	-	-	-	-	1,593	11,429	2,365	-	-	328,670
Estimated FY 2017-18 Adult Dental Benefit Expenditure	**$10,464,475**	**$3,745,279**	**$15,190,690**	**$0**	**$33,409,729**	**$0**	**$0**	**$0**	**$0**	**$0**	**$134,258**	**$1,844,755**	**$312,629**	**$0**	**$0**	**$65,101,815**

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	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%	
Estimated FY 2018-19 Total Dental Per Capita	$256.92	$354.18	$250.90	$0.00	$203.71	$0.00	$0.00	$0.00	$0.00	$0.00	$99.99	$180.88	$148.34	$0.00	$0.00	$224.35
Estimated FY 2018-19 Eligible Caseload	45,993	12,176	69,473	-	196,256	-	-	-	-	-	1,588	11,427	2,364	-	-	339,277
Estimated FY 2018-19 Total Dental Expenditure	**$11,816,522**	**$4,312,496**	**$17,430,776**	**$0**	**$39,979,310**	**$0**	**$0**	**$0**	**$0**	**$0**	**$158,784**	**$2,066,916**	**$350,676**	**$0**	**$0**	**$76,115,480**
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%	
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	$14.65	$15.33	$14.65	$0.00	$0.00	$22.71
Estimated FY 2018-19 Eligible Caseload	45,993	12,176	69,473	-	196,256	-	-	-	-	-	1,588	11,427	2,364	-	-	339,277
Estimated FY 2018-19 Emergency and Co-Occurring Dental Expenditure	**$927,679**	**$314,141**	**$1,532,574**	**$0**	**$4,696,406**	**$0**	**$0**	**$0**	**$0**	**$0**	**$23,264**	**$175,176**	**$34,633**	**$0**	**$0**	**$7,703,873**
Bottom Line Impacts																
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Adult Dental Benefit																
Estimated FY 2018-19 Adult Dental Benefit Per Capita	$236.75	$328.38	$228.84	$0.00	$179.78	$0.00	$0.00	$0.00	$0.00	$0.00	$85.34	$165.55	$133.69	$0.00	$0.00	$201.64
Estimated FY 2018-19 Eligible Caseload	45,993	12,176	69,473	-	196,256	-	-	-	-	-	1,588	11,427	2,364	-	-	339,277
Estimated FY 2018-19 Adult Dental Benefit Expenditure	**$10,888,843**	**$3,998,355**	**$15,898,201**	**$0**	**$35,282,904**	**$0**	**$0**	**$0**	**$0**	**$0**	**$135,520**	**$1,891,740**	**$316,043**	**$0**	**$0**	**$68,411,606**

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%	
Estimated FY 2019-20 Total Dental Per Capita	$262.28	$361.83	$255.36	$0.00	$206.15	$0.00	$0.00	$0.00	$0.00	$0.00	$100.91	$184.96	$149.70	$0.00	$0.00	$227.96
Estimated FY 2019-20 Eligible Caseload	46,770	12,712	71,706	-	201,516	-	-	-	-	-	1,588	11,425	2,364	-	-	348,081
Estimated FY 2019-20 Total Dental Expenditure	**$12,266,836**	**$4,599,583**	**$18,310,844**	**$0**	**$41,542,523**	**$0**	**$0**	**$0**	**$0**	**$0**	**$160,245**	**$2,113,168**	**$353,891**	**$0**	**$0**	**$79,347,090**
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%	
Estimated FY 2019-20 Emergency and Co-Occurring Dental Per Capita	$19.97	$25.54	$21.84	$0.00	$23.69	$0.00	$0.00	$0.00	$0.00	$0.00	$14.50	$15.18	$14.50	$0.00	$0.00	$22.49
Estimated FY 2019-20 Eligible Caseload	46,770	12,712	71,706	-	201,516	-	-	-	-	-	1,588	11,425	2,364	-	-	348,081
Estimated FY 2019-20 Emergency and Co-Occurring Dental Expenditure	**$933,997**	**$324,664**	**$1,566,059**	**$0**	**$4,773,914**	**$0**	**$0**	**$0**	**$0**	**$0**	**$23,026**	**$173,432**	**$34,278**	**$0**	**$0**	**$7,829,370**
Bottom Line Impacts																
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Adult Dental Benefit																
Estimated FY 2019-20 Adult Dental Benefit Per Capita	$242.31	$336.29	$233.52	$0.00	$182.46	$0.00	$0.00	$0.00	$0.00	$0.00	$86.41	$169.78	$135.20	$0.00	$0.00	$205.46
Estimated FY 2019-20 Eligible Caseload	46,770	12,712	71,706	-	201,516	-	-	-	-	-	1,588	11,425	2,364	-	-	348,081
Estimated FY 2019-20 Adult Dental Benefit Expenditure	**$11,332,839**	**$4,274,918**	**$16,744,785**	**$0**	**$36,768,609**	**$0**	**$0**	**$0**	**$0**	**$0**	**$137,219**	**$1,939,737**	**$319,613**	**$0**	**$0**	**$71,517,720**

Adult Dental Cash Fund - Fund Splits

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)	45,242	$231.30	50.00%	$10,464,475	$0	$5,232,237	$5,232,238
Disabled Adults 60 to 64 (OAP-B)	11,681	$320.63	50.00%	$3,745,279	$0	$1,872,639	$1,872,640
Disabled Individuals to 59 (AND/AB)	67,743	$224.24	50.00%	$15,190,690	$0	$7,595,345	$7,595,345
MAGI Parents/Caretakers to 68% FPL	188,617	$177.13	50.00%	$33,409,729	$0	$16,704,864	$16,704,865
Foster Care	1,593	$84.28	50.00%	$134,258	$0	$67,129	$67,129
MAGI Pregnant Adults	11,429	$161.41	50.00%	$1,844,755	$0	$922,377	$922,378
SB 11-250 Eligible Pregnant Adults	2,365	$132.19	88.00%	$312,629	$0	$37,515	$275,114
Total	**328,670**	**$198.08**		**$65,101,815**	**$0**	**$32,432,106**	**$32,669,709**

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)	45,993	$236.75	50.00%	$10,888,843	$0	$5,444,421	$5,444,422
Disabled Adults 60 to 64 (OAP-B)	12,176	$328.38	50.00%	$3,998,355	$0	$1,999,177	$1,999,178
Disabled Individuals to 59 (AND/AB)	69,473	$228.84	50.00%	$15,898,201	$0	$7,949,100	$7,949,101
MAGI Parents/Caretakers to 68% FPL	196,256	$179.78	50.00%	$35,282,904	$0	$17,641,452	$17,641,452
Foster Care	1,588	$85.34	50.00%	$135,520	$0	$67,760	$67,760
MAGI Pregnant Adults	11,427	$165.55	50.00%	$1,891,740	$0	$945,870	$945,870
SB 11-250 Eligible Pregnant Adults	2,364	$133.69	88.00%	$316,043	$0	$37,925	$278,118
Total	**339,277**	**$201.64**		**$68,411,606**	**$0**	**$34,085,705**	**$34,325,901**

FY 2019-20

Eligibility Category	Caseload	Per Capita	FMAP	Total Funds [1]	General Fund	Adult Dental Fund	Federal Funds
Adults 65 and Older (OAP-A)	46,770	$242.31	50.00%	$11,332,839	$0	$5,666,419	$5,666,420
Disabled Adults 60 to 64 (OAP-B)	12,712	$336.29	50.00%	$4,274,918	$0	$2,137,459	$2,137,459
Disabled Individuals to 59 (AND/AB)	71,706	$233.52	50.00%	$16,744,785	$0	$8,372,392	$8,372,393
MAGI Parents/Caretakers to 68% FPL	201,516	$182.46	50.00%	$36,768,609	$0	$18,384,304	$18,384,305
Foster Care	1,588	$86.41	50.00%	$137,219	$0	$68,609	$68,610
MAGI Pregnant Adults	11,425	$169.78	50.00%	$1,939,737	$0	$969,868	$969,869
SB 11-250 Eligible Pregnant Adults	2,364	$135.20	88.00%	$319,613	$0	$38,354	$281,259
Total	**348,081**	**$205.46**		**$71,517,720**	**$0**	**$35,637,405**	**$35,880,315**

(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 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
FY 2016-17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

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 2009-10 (DA)	8.77%	15.77%	3.90%	0.00%	18.24%	100.00%	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%	100.00%	11.81%	191.52%	100.00%	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%	100.00%	-0.87%	93.15%	100.00%	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%
FY 2016-17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

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 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
FY 2016-17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

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 2009-10 (DA)	6.29%	5.88%	0.17%	0.00%	-2.24%	100.00%	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%	100.00%	-2.70%	123.37%	100.00%	-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%	100.00%	-9.62%	70.59%	100.00%	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%
FY 2016-17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

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 2008-09	$427,196	$1,186,557	$16,817,326	$0	$2,671,434	$0	$0	$10,076	$2,588,065	$0	$6,666,050	$37,479	$0	$0	$0	$30,404,183
FY 2009-10 (DA)	$379,006	$1,120,504	$14,252,288	$0	$2,576,466	$40,378	$0	$18,852	$2,217,109	$0	$5,259,219	$37,180	$0	$0	$0	$25,901,002
FY 2010-11 (DA)	$295,341	$1,248,935	$15,118,898	$0	$2,663,327	$262,302	$0	$23,161	$2,119,367	$0	$4,727,463	$43,326	$0	$0	$0	$26,502,120
FY 2011-12	$173,417	$1,428,350	$15,494,576	$1,661	$2,783,929	$714,836	$27,068	$23,715	$2,274,478	$0	$4,406,588	$39,733	$0	$0	$0	$27,368,351
FY 2012-13	$116,829	$900,643	$10,235,026	$43,544	$1,970,856	$558,209	$836,074	$23,633	$1,989,011	$0	$3,071,116	$17,539	$0	$0	$0	$19,762,480
FY 2013-14	$123,908	$772,046	$8,910,861	$107,817	$2,418,764	$533,746	$2,829,675	$11,867	$2,231,910	$0	$2,443,530	$56,023	$0	$0	$0	$20,440,147
FY 2014-15	$195,244	$1,053,691	$12,759,604	$192,881	$4,402,199	$1,121,427	$10,121,714	$4,713	$3,171,657	$792,892	$3,035,873	$135,622	$7,864	$0	$0	$36,995,381
FY 2015-16	$138,118	$1,159,101	$14,304,051	$277,653	$4,851,168	$646,978	$14,031,379	$1,008	$3,534,979	$720,110	$2,754,019	$127,012	$6,647	$0	$0	$42,552,223
FY 2016-17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

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 2009-10 (DA)	-11.28%	-5.57%	-15.25%	0.00%	-3.55%	100.00%	0.00%	87.10%	-14.33%	0.00%	-21.10%	-0.80%	0.00%	0.00%	0.00%	-14.81%
FY 2010-11 (DA)	-22.07%	11.46%	6.08%	0.00%	3.37%	549.62%	0.00%	22.86%	-4.41%	0.00%	-10.11%	16.53%	0.00%	0.00%	0.00%	2.32%
FY 2011-12	-41.28%	14.37%	2.48%	100.00%	4.53%	172.52%	100.00%	2.39%	7.32%	0.00%	-6.79%	-8.29%	0.00%	0.00%	0.00%	3.27%
FY 2012-13	-32.63%	-36.95%	-33.94%	2521.55%	-29.21%	-21.91%	2988.79%	-0.35%	-12.55%	0.00%	-30.31%	-55.86%	0.00%	0.00%	0.00%	-27.79%
FY 2013-14	6.06%	-14.28%	-12.94%	147.60%	22.73%	-4.38%	238.45%	-49.79%	12.21%	0.00%	-20.44%	219.42%	0.00%	0.00%	0.00%	3.43%
FY 2014-15	57.57%	36.48%	43.19%	78.90%	82.00%	110.10%	257.70%	-60.28%	42.11%	100.00%	24.24%	142.08%	100.00%	0.00%	0.00%	80.99%
FY 2015-16	-29.26%	10.00%	12.10%	43.95%	10.20%	-42.31%	38.63%	-78.61%	11.46%	-9.18%	-9.28%	-6.35%	-15.48%	0.00%	0.00%	15.02%
FY 2016-17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

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 2008-09	$11.36	$184.05	$327.47	$0.00	$43.18	$0.00	$0.00	$31.79	$11.01	$0.00	$369.66	$5.37	$0.00	$0.00	$0.00	$69.60
FY 2009-10 (DA)	$9.85	$158.96	$267.58	$0.00	$34.43	$12.47	$0.00	$44.36	$8.04	$0.00	$286.12	$4.75	$0.00	$0.00	$0.00	$51.93
FY 2010-11 (DA)	$7.59	$160.80	$268.61	$0.00	$32.83	$9.66	$0.00	$43.62	$7.01	$0.00	$257.03	$5.51	$0.00	$0.00	$0.00	$47.26
FY 2011-12	$4.36	$170.39	$260.70	$31.94	$29.86	$20.16	$23.87	$39.72	$6.80	$0.00	$244.35	$5.21	$0.00	$0.00	$0.00	$44.15
FY 2012-13	$2.86	$99.51	$165.29	$49.04	$19.83	$13.44	$78.62	$37.93	$5.53	$0.00	$172.76	$2.19	$0.00	$0.00	$0.00	$28.94
FY 2013-14	$2.96	$78.36	$138.32	$42.12	$19.40	$11.34	$32.43	$21.23	$5.59	$0.00	$133.77	$4.26	$0.00	$0.00	$0.00	$23.74
FY 2014-15	$4.67	$100.68	$191.74	$53.18	$27.23	$15.58	$41.93	$11.78	$7.12	$15.82	$151.52	$9.10	$4.50	$0.00	$0.00	$31.86
FY 2015-16	$3.26	$110.09	$207.91	$44.66	$29.70	$7.44	$43.80	$3.13	$7.57	$12.10	$138.15	$8.81	$3.78	$0.00	$0.00	$32.81
FY 2016-17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

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 2009-10 (DA)	-13.29%	-13.63%	-18.29%	0.00%	-20.26%	100.00%	0.00%	39.54%	-26.98%	0.00%	-22.60%	-11.55%	0.00%	0.00%	0.00%	-25.39%
FY 2010-11 (DA)	-22.94%	1.16%	0.38%	0.00%	-4.65%	-22.53%	0.00%	-1.67%	-12.81%	0.00%	-10.17%	16.00%	0.00%	0.00%	0.00%	-8.99%
FY 2011-12	-42.56%	5.96%	-2.94%	100.00%	-9.05%	108.70%	100.00%	-8.94%	-3.00%	0.00%	-4.93%	-5.44%	0.00%	0.00%	0.00%	-6.58%
FY 2012-13	-34.40%	-41.60%	-36.60%	53.54%	-33.59%	-33.33%	229.37%	-4.51%	-18.68%	0.00%	-29.30%	-57.97%	0.00%	0.00%	0.00%	-34.45%
FY 2013-14	3.50%	-21.25%	-16.32%	-14.11%	-2.17%	-15.63%	-58.75%	-44.03%	1.08%	0.00%	-22.57%	94.52%	0.00%	0.00%	0.00%	-17.97%
FY 2014-15	57.77%	28.48%	38.62%	26.26%	40.36%	37.39%	29.29%	-44.51%	27.37%	100.00%	13.27%	113.62%	100.00%	0.00%	0.00%	34.20%
FY 2015-16	-30.19%	9.35%	8.43%	-16.02%	9.07%	-52.25%	4.46%	-73.43%	6.32%	-23.51%	-8.82%	-3.19%	-16.00%	0.00%	0.00%	2.98%
FY 2016-17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

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

(2) The Department cannot currently report totals for FY 2016-17 due to identification issues for these services in the reported data. The Department will update this data in the February 2018 budget submission.

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	$7,000,143	$9,556,025	$8,774,817	$6,069,395	$31,400,380	176.25%
FY 2017-18[1]	$8,879,645	$9,124,529	$8,862,466	$9,452,358	$36,318,998	15.66%
FY 2018-19[1]	$10,270,571	$10,553,814	$10,250,700	$10,932,993	$42,008,078	15.66%
FY 2019-20[1]	$11,879,373	$12,206,984	$11,856,390	$12,645,560	$48,588,307	15.66%

(1) The estimated growth rate for FY 2017-18, FY 2018-19, and FY 2019-20 is equal to the percent growth in prescription drug expenditures between FY 2015-16 and FY 2016-17.

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

Total Family Planning Expenditure						
Fiscal Year	Total Reported Expenditures (1)	General Fund	Cash Funds (2)	Federal Funds (90% FMAP)	Change	% Change
FY 2003-04	$5,369,643	$536,964	$0	$4,832,679	-	-
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	$794,847	$0	$7,153,622	($1,667,674)	-17.34%
FY 2013-14	$9,583,635	$939,460	$18,903	$8,625,272	$1,635,166	20.57%
FY 2014-15	$11,582,466	$1,138,955	$19,292	$10,424,219	$1,998,831	20.86%
FY 2015-16	$11,741,307	$1,144,971	$29,160	$10,567,176	$158,841	1.37%
FY 2016-17	($8,328,211)	($832,821)	$0	($7,495,390)	($20,069,518)	-170.93%
FY 2017-18 Estimate (3)	$13,419,892	$1,610,387	$0	$11,809,505	$21,748,103	14.30%
FY 2018-19 Estimate (3)	$14,202,272	$1,704,273	$0	$12,497,999	$782,380	5.83%
FY 2019-20 Estimate (3)	$15,030,264	$1,803,631	$0	$13,226,633	$827,992	5.83%

(1) FY 2016-17 actuals are currently understated as a result of an over payment of drug rebates.

(2) 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 of this program.

(3) Base expenditure before rebates was in line with prior forecast. As a result, the trend chosen in FY 2017-18 through FY 2019-20 is such to keep total expenditure estimates in line with the prior estimates. One the overpayment of drug rebates in rectified, the Department will reassess the appropriateness of the trends.

Total Family Planning Expenditure Fund Splits					
Fiscal Year	Total Reported Expenditures	General Fund	Cash Funds	Federal Funds	FMAP
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%
FY 2019-20 Estimate (3)	$14,278,751	$1,427,875	$0	$12,850,876	90.00%
	$751,513	$375,756	$0	$375,757	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 2002-03	$511,451	-	-
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 (DA)	$1,536,532	$2,205	0.14%
FY 2010-11 (DA)	$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	$4,281,827	$2,831,640	195.26%
FY 2015-16	$4,286,478	$4,651	0.11%
FY 2016-17	$3,571,625	($714,853)	-16.68%
FY 2017-18 Estimated Total	$6,810,740	$3,239,115	90.69%
FY 2018-19 Estimated Total	$6,818,232	$7,492	0.11%
FY 2019-20 Estimated Total	$6,825,732	$7,500	0.11%

1. Expenditure estimate includes anticipated savings to Acute Care from better coordination of services for clients eligible under Indian Health Services, which results in higher expenditure available for 100% federal match. That expenditure estimate is $2,514,827 in FY 2017-18.

2. The trend for FY 2017-18 incorporates a base trend of about 20% due to the high variation from year to year in expenditure.

3. The trend in FY 2018-19 and FY 2019-20 is the growth experienced in FY 2015-16. Once the care coordination takes places in FY 2017-18, the Department expects expenditure to stabilize.

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	$2,136,954	$5,348,889	$36,858,336	$3,241,713	$50,076,939	$23,371,946	$114,151,218	$245,946	$108,185,897	$9,866,976	$7,495,898	$19,401,101	$2,364,616	$2,747,335	$13	$385,493,777
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	$72,086,173	$12,028,188	$3,410,937	$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	$18,973,251	$67,899,601	$24,718	$21,248,151	$2,370,469	$362,349	$7,489,226	$837,731	$0	$0	$201,126,880
Inpatient Hospitals	$9,766,881	$8,733,648	$46,570,133	$3,549,136	$28,612,925	$12,227,931	$136,457,298	$58,122	$58,961,825	$2,777,403	$3,171,644	$32,399,452	$3,821,630	$15,542,187	($3,558)	$362,646,657
Outpatient Hospitals	$1,538,202	$4,670,029	$32,487,919	$2,635,997	$50,836,607	$20,465,183	$104,658,035	$128,456	$59,573,003	$6,789,276	$3,976,801	$6,716,478	$632,154	$1,156,186	$1,904	$296,266,230
Lab & X-Ray	$247,435	$749,472	$4,900,093	$336,816	$12,905,701	$5,555,519	$22,606,208	$33,414	$6,212,964	$748,385	$858,945	$4,134,029	$464,387	$86,080	$133	$59,839,581
Durable Medical Equipment	$11,346,365	$3,862,034	$33,924,411	$892,301	$4,466,275	$1,827,405	$14,155,854	$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	$160,808,709	$199,546	$61,368,815	$9,540,470	$11,797,096	$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	$23,925,420	$2,080,039	$767,233	$4,461,111	$386,479	$171,639	($348)	$71,201,370
Co-Insurance (Title XVIII-Medicare)	$16,148,720	$2,858,586	$11,212,033	$1,315,483	$1,569,187	$17,658	$189,252	$162	$10,103	$1,139	$9,109	$48,488	$35	$258	$7,946,737	$41,326,950
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	($2)	$0	($16)	$4	$13	$1	$0	($1)	$0	($2)	$0	($1)	$1	($1)
Acute Home Health	$2,138,232	$1,205,313	$4,346,933	$130,774	$622,076	$167,049	$2,542,606	$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	$58,466,350	$45,279,303	$279,886,200	$18,319,297	$239,640,914	$111,899,748	$614,933,430	$2,027,660	$404,687,478	$43,609,243	$30,230,269	$79,278,718	$9,002,397	$19,775,917	$8,120,781	$1,965,157,705
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	$1,369.07	$4,240.30	$4,132.09	$3,463.33	$1,499.74	$1,231.74	$1,814.22	$6,558.47	$857.90	$718.31	$1,505.63	$5,415.15	$4,856.53	$7,433.16	$240.87	$1,486.86

Exhibit F - ACUTE CARE - Expenditure by Half-Year

FY 2016-17 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	$1,731,841	$4,896,508	$34,692,103	$2,931,546	$41,664,874	$20,697,745	$106,874,002	$137,519	$101,800,237	$10,143,060	$7,448,470	$19,247,540	$2,201,457	$2,728,177	$993	$357,196,072
Emergency Transportation	$854,277	$589,232	$2,756,743	$120,989	$1,162,478	$386,359	$5,593,214	$1,489	$1,543,796	$145,150	$211,097	$332,451	$21,995	$41,876	$310	$13,761,456
Non-emergency Medical Transportation	$1,853,700	$1,002,505	$3,798,845	$108,088	$492,505	$102,877	$2,240,998	$1,155	$740,134	$71,645	$125,265	$90,183	$3,866	$1,974	$0	$10,633,740
Dental Services	$5,184,765	$1,732,613	$10,528,124	$910,362	$16,842,094	$9,601,171	$36,189,970	$34,176	$75,886,232	$13,425,791	$3,531,679	$1,288,190	$140,862	$123	$2,847	$175,298,999
Family Planning	$149	$228	$38,662	$1,589	$808,834	$404,374	$1,314,106	$0	$400,148	$72,331	$53,237	$113,575	$12,367	$0	$0	$3,219,600
Health Maintenance Organizations	$5,155,249	$5,666,245	$32,562,844	$944,846	$28,776,255	$17,716,195	$71,830,470	$16,872	$21,611,718	$2,722,157	$406,762	$5,922,878	$682,172	$0	$0	$194,014,663
Inpatient Hospitals	$8,547,797	$7,652,386	$45,253,758	$4,295,043	$26,645,787	$11,350,671	$140,565,223	$103,508	$66,733,939	$2,824,966	$3,542,135	$26,846,774	$2,680,308	$14,182,177	($10,487)	$361,213,985
Outpatient Hospitals	$1,606,589	$4,618,903	$31,905,569	$2,831,866	$46,670,593	$22,408,224	$118,620,125	$110,990	$56,630,518	$6,494,559	$3,854,184	$6,905,845	$620,282	$1,112,373	($1,157)	$304,389,463
Lab & X-Ray	$262,971	$816,647	$5,140,194	$367,160	$12,575,188	$5,681,031	$24,709,260	$23,810	$6,532,169	$867,433	$832,575	$4,203,480	$477,379	$89,655	($48)	$62,578,904
Durable Medical Equipment	$11,685,187	$4,097,356	$35,554,014	$1,102,764	$4,472,344	$2,121,763	$16,130,335	$10,925	$13,091,318	$1,234,413	$2,984,999	$245,501	$14,950	$0	$208,533	$92,954,402
Prescription Drugs	$3,356,849	$13,756,972	$94,360,566	$6,442,481	$55,715,440	$26,583,061	$174,981,850	$170,287	$59,023,858	$10,155,318	$11,812,403	$4,671,421	$429,874	$2,964	$117	$461,463,461
Drug Rebate	($2,078,460)	($8,517,905)	($58,425,233)	($3,988,991)	($34,497,330)	($16,459,434)	($108,343,514)	($105,437)	($36,545,802)	($6,287,868)	($7,313,886)	($2,892,404)	($266,165)	($1,835)	($73)	($285,724,337)
Rural Health Centers	$22,424	$108,401	$550,757	$21,291	$1,281,884	$839,234	$2,404,923	$1,238	$3,851,346	$401,251	$168,382	$362,340	$24,029	$5,695	$0	$10,043,195
Federally Qualified Health Centers	$360,931	$759,296	$4,104,907	$175,843	$8,260,016	$4,627,668	$21,862,508	$17,261	$26,842,716	$2,666,826	$939,878	$4,788,606	$439,385	$227,245	$701	$76,073,787
Co-Insurance (Title XVIII-Medicare)	$11,976,655	$2,402,869	$8,416,066	$1,343,170	$1,088,577	$21,365	$160,898	$0	$2,745	$40	$4,712	$22,035	$34	$0	$6,284,081	$31,723,247
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$1,460,341	$0	$0	$0	$0	$0	$0	$0	$1,460,341
Administrative Service Organizations - Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Services	$37	$28	$211	$12	$130	$64	$382	$1	$233	$27	$22	$39	$4	$10	$3	$1,203
Acute Home Health	$2,789,175	$1,388,578	$6,046,234	$178,585	$536,790	$147,415	$2,612,010	$2,443	$1,106,782	$44,690	$337,895	$127,487	$10,451	$0	$0	$15,328,535
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$53,310,136	$40,970,862	$257,284,364	$17,786,644	$212,496,459	$106,229,783	$617,746,760	$1,986,578	$399,252,087	$44,981,789	$28,939,809	$72,275,941	$7,493,250	$18,390,434	$6,485,820	$1,885,630,716
Caseload	43,538	11,088	67,693	5,707	153,209	90,184	357,092	309	471,955	63,293	20,247	14,310	1,803	2,526	33,506	1,336,459
Half -Year Per Capita	$1,224.44	$3,695.17	$3,800.74	$3,116.73	$1,386.97	$1,177.93	$1,729.94	$6,425.59	$845.95	$710.70	$1,429.37	$5,050.73	$4,156.76	$7,281.42	$193.57	$1,410.92

FY 2016-17 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	$3,817,841	$4,654,676	$31,422,129	$3,655,994	$40,579,330	$25,458,988	$86,783,622	$527,765	$85,520,506	$10,814,679	$7,562,456	$14,010,743	$2,423,926	$2,906,168	$32,745	$320,171,568
Emergency Transportation	$1,084,106	$1,081,886	$5,314,021	$164,919	$3,493,028	$2,788,137	$14,624,086	$1,616	$3,162,735	$371,536	$613,467	$498,999	$37,856	$131,771	$991	$33,369,154
Non-emergency Medical Transportation	$4,444,030	$950,467	$3,662,841	$185,722	$854,608	$654,678	$3,130,103	$3,744	$1,041,768	$121,914	$157,917	$167,805	$2,051	$18,143	$11	$15,395,802
Dental Services	$5,059,673	$1,438,083	$8,627,156	$866,254	$19,329,814	$13,227,528	$38,384,966	$24,497	$61,512,592	$10,793,954	$2,808,025	$1,439,664	$261,180	($499)	($99,988)	$163,672,899
Family Planning	$762	$98	$13,808	$4,589	$412,486	$120,027	$449,948	$0	$183,725	$32,657	$17,562	$44,449	$4,838	$0	$0	$1,284,949
Health Maintenance Organizations	$5,312,214	$6,162,813	$34,755,359	$1,228,788	$34,849,283	$16,771,562	$80,087,781	$5,381	$24,238,865	$3,201,809	$385,076	$6,468,755	$993,424	($691)	($25,023)	$214,435,396
Inpatient Hospitals	$6,535,041	$9,939,330	$51,220,449	$3,880,691	$27,828,568	$19,273,381	$129,156,624	$122,836	$63,901,966	$3,557,740	$4,554,538	$23,019,246	$2,760,002	$18,707,195	($25)	$364,457,582
Outpatient Hospitals	$1,258,849	$4,269,457	$23,267,723	$958,866	$35,802,026	$23,552,771	$79,053,229	$359,865	$47,282,677	$4,949,531	$3,107,142	$5,699,678	$790,031	$304,019	$286	$230,656,150
Lab & X-Ray	$227,642	$717,061	$3,886,933	$383,880	$10,705,389	$5,767,453	$18,145,003	$49,808	$4,818,324	$1,421,697	$781,758	$3,209,857	$334,266	$66,008	$25,736	$50,540,815
Durable Medical Equipment	$10,481,809	$3,262,045	$28,199,154	$903,546	$4,528,752	$3,436,406	$13,710,825	$18,244	$11,927,111	$1,460,934	$2,659,924	$184,917	$12,872	$40	$51,750	$80,838,329
Prescription Drugs	$3,340,373	$14,430,546	$96,371,191	$7,373,891	$65,095,760	$44,895,083	$169,779,650	$180,275	$66,821,914	$18,722,476	$11,763,471	$4,193,918	$533,522	$39	$139,357	$503,641,466
Drug Rebate	($2,917,554)	($12,392,121)	($83,890,689)	($6,546,203)	($59,393,292)	($48,167,242)	($141,244,025)	($145,122)	($58,993,941)	($20,616,890)	($9,994,341)	($3,554,674)	($505,637)	$455	($193,255)	($448,554,531)
Rural Health Centers	$16,560	$83,191	$404,907	$17,706	$951,256	$639,450	$1,597,005	$2,161	$2,723,834	$423,123	$153,461	$167,755	$17,264	$2,464	$0	$7,200,137
Federally Qualified Health Centers	$394,582	$543,243	$2,862,521	$196,286	$6,876,481	$4,959,904	$15,330,420	$10,251	$16,563,431	$858,936	$616,726	$3,767,686	$163,557	$58,347	($2)	$53,202,369
Co-Insurance (Title XVIII-Medicare)	$10,900,635	$1,367,426	$5,227,531	$2,545,576	$588,998	$52,996	$199,830	$1,571	$39,599	$4,902	$2,460	$24,565	$1,260	$0	$5,897,067	$26,854,416
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$674,680	$0	$0	$0	$0	$0	$0	$0	$674,680
Administrative Service Organizations - Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Services	$0	$1	($1)	$0	$0	($1)	$1	$0	$0	$0	$1	($1)	$0	$0	$0	$0
Acute Home Health	$3,334,791	$945,838	$5,135,321	$136,284	$444,664	$399,858	$2,195,855	$2,223	$823,025	($7,654)	$254,532	$110,433	$7,407	$0	$0	$13,782,577
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$53,291,354	$37,454,040	$216,480,354	$15,956,789	$192,947,151	$113,830,979	$511,384,923	$1,839,795	$331,568,131	$36,111,344	$25,444,175	$59,453,795	$7,837,819	$22,193,459	$5,829,650	$1,631,623,758
Caseload	44,344	11,395	67,545	6,796	168,773	111,935	338,605	280	467,856	66,582	20,373	12,312	2,230	2,754	34,112	1,355,890
Half -Year Per Capita	$1,201.77	$3,287.03	$3,204.98	$2,348.03	$1,143.24	$1,016.94	$1,510.27	$6,562.88	$708.70	$542.36	$1,248.93	$4,829.06	$3,514.98	$8,059.60	$170.90	$1,203.36

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 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	$36,756,794	$184,903,859	$2,098,863	$352,648	$42,535	$1,716,796	$0	$1,008,304	$2,152	$157,427	$34,316	$0	$0	$888,293	$394,019,725
FY 2016-17	$215,180,559	$37,057,401	$185,020,240	$2,510,268	$333,517	$32,557	$1,404,076	$0	$742,570	$5,742	$82,643	$2,552	$0	$0	$545,091	$442,917,216
Estimated FY 2017-18	$231,914,829	$59,076,607	$206,674,247	$3,572,365	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$501,238,048
Estimated FY 2018-19	$246,844,364	$63,156,504	$221,588,585	$3,849,904	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$535,439,357
Estimated FY 2019-20	$264,481,391	$67,765,311	$238,022,916	$4,097,524	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$574,367,142

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 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%
FY 2016-17	29.58%	0.82%	0.06%	19.60%	-5.42%	-23.46%	-18.22%	0.00%	-26.35%	166.82%	-47.50%	-92.56%	0.00%	0.00%	-38.64%	12.41%
Estimated FY 2017-18	7.78%	59.42%	11.70%	42.31%	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%	13.17%
Estimated FY 2018-19	6.44%	6.91%	7.22%	7.77%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.82%
Estimated FY 2019-20	7.14%	7.30%	7.42%	6.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.27%

Per Capita Cost

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	$2,743.01	$2,574.91	$1,930.11	$0.00	$0.27	$0.00	$0.00	$0.00	$0.00	$0.00	$4.92	$0.00	$0.00	$0.00	$16.08	$501.95
FY 2009-10 (DA)	$2,830.44	$2,532.16	$1,976.62	$0.00	$0.26	$0.00	$0.00	$0.00	$0.00	$0.00	$5.72	$0.00	$0.00	$0.00	$12.22	$465.89
FY 2010-11 (DA)	$2,855.77	$2,602.11	$2,141.01	$0.00	$0.40	$0.45	$0.00	$0.00	$0.01	$0.00	$4.72	$0.00	$0.00	$0.00	$8.32	$449.65
FY 2011-12	$2,961.23	$2,775.62	$2,198.29	$0.00	$0.09	$0.58	$0.00	$0.00	$0.02	$0.00	$6.17	$0.00	$0.00	$0.00	$13.79	$438.75
FY 2012-13	$3,070.55	$2,743.25	$2,307.53	$53.54	$0.17	$0.96	$0.73	$0.00	$0.05	$0.00	$3.89	$0.00	$0.00	$0.00	$10.43	$429.71
FY 2013-14	$3,445.72	$3,020.51	$2,520.35	$301.46	$1.65	$0.64	$3.89	$0.00	$0.66	$0.00	$9.26	$0.00	$0.00	$0.00	$37.99	$393.70
FY 2014-15	$3,661.66	$3,161.94	$2,583.97	$436.65	$4.10	$1.51	$5.78	$0.00	$2.23	$0.02	$14.38	$1.96	$0.00	$0.43	$35.10	$313.65
FY 2015-16	$3,916.18	$3,491.01	$2,687.56	$337.60	$2.16	$0.49	$5.36	$0.00	$2.16	$0.04	$7.90	$2.38	$0.00	$0.00	$27.26	$303.80
FY 2016-17	$4,897.03	$3,296.63	$2,736.22	$401.58	$2.07	$0.32	$4.04	$0.00	$1.58	$0.09	$4.07	$0.19	$0.00	$0.00	$16.12	$329.02
Estimated FY 2017-18	$5,126.10	$5,057.50	$3,050.86	$457.35	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$357.60
Estimated FY 2018-19	$5,367.00	$5,186.97	$3,189.56	$423.11	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$370.83
Estimated FY 2019-20	$5,654.94	$5,330.81	$3,319.43	$395.21	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$389.29

Percent Change in Per Capita Cost

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	3.19%	-1.66%	2.41%	0.00%	-3.70%	0.00%	0.00%	0.00%	0.00%	0.00%	16.26%	0.00%	0.00%	0.00%	-24.00%	-7.18%
FY 2010-11 (DA)	0.89%	2.76%	8.32%	0.00%	53.85%	100.00%	0.00%	0.00%	100.00%	0.00%	-17.48%	0.00%	0.00%	0.00%	-31.91%	-3.49%
FY 2011-12	3.69%	6.67%	2.68%	0.00%	-77.50%	28.89%	0.00%	0.00%	100.00%	0.00%	30.72%	0.00%	0.00%	0.00%	65.75%	-2.42%
FY 2012-13	3.69%	-1.17%	4.97%	100.00%	88.89%	65.52%	100.00%	0.00%	150.00%	0.00%	-36.95%	0.00%	0.00%	0.00%	-24.37%	-2.06%
FY 2013-14	12.22%	10.11%	9.22%	463.06%	870.59%	-33.33%	432.88%	0.00%	1220.00%	0.00%	138.05%	0.00%	0.00%	0.00%	264.24%	-8.38%
FY 2014-15	6.27%	4.68%	2.52%	44.85%	148.48%	135.94%	48.59%	0.00%	237.88%	100.00%	55.29%	100.00%	0.00%	100.00%	-7.61%	-20.33%
FY 2015-16	6.95%	10.41%	4.01%	-22.68%	-47.32%	-67.55%	-7.27%	0.00%	-3.14%	100.00%	-45.06%	21.43%	0.00%	-100.00%	-22.34%	-3.14%
FY 2016-17	25.05%	-5.57%	1.81%	18.95%	-4.17%	-34.69%	-24.63%	0.00%	-26.85%	125.00%	-48.48%	-92.02%	0.00%	0.00%	-40.87%	8.30%
Estimated FY 2017-18	4.68%	53.41%	11.50%	13.89%	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%	8.69%
Estimated FY 2018-19	4.70%	2.56%	4.55%	-7.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.70%
Estimated FY 2019-20	5.37%	2.77%	4.07%	-6.59%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.98%

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

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	$220,909,537	$49,784,132	$129,350,201	$2,414,752	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$402,458,622
Community Mental Health Supports Waiver	$7,906,521	$7,084,764	$31,031,822	$403,915	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$46,427,022
Disabled Children's Waiver	$0	$0	$20,140,739	$174,713	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$20,315,452
Consumer Directed Attendant Support-State Plan	$1,455,578	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,455,578
Brain Injury Waiver	$1,173,632	$2,066,882	$21,171,358	$400,640	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$24,812,512
Children with Autism Waiver	$0	$0	$771,366	$34,238	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$805,604
Children with Life Limiting Illness Waiver	$0	$0	$960,539	$13,243	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$973,782
Spinal Cord Injury Adult Waiver	$469,561	$140,829	$3,248,222	$130,864	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,989,476
Estimated FY 2017-18 Total Expenditure	$231,914,829	$59,076,607	$206,674,247	$3,572,365	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$501,238,048

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	$236,116,586	$53,211,189	$138,254,456	$2,580,979	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$430,163,210
Community Mental Health Supports Waiver	$8,503,113	$7,619,349	$33,373,346	$434,393	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$49,930,201
Disabled Children's Waiver	$0	$0	$22,475,961	$194,970	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$22,670,931
Consumer Directed Attendant Support-State Plan	$448,035	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$448,035
Brain Injury Waiver	$1,227,174	$2,161,176	$22,101,354	$454,782	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,944,486
Children with Autism Waiver	$0	$0	$503,520	$22,349	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$525,869
Children with Life Limiting Illness Waiver	$0	$0	$1,073,547	$14,802	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,088,349
Spinal Cord Injury Adult Waiver	$549,456	$164,790	$3,806,401	$147,629	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,668,276
Estimated FY 2018-19 Total Expenditure	$246,844,364	$63,156,504	$221,588,585	$3,849,904	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$535,439,357

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	$253,358,100	$57,096,733	$148,349,960	$2,769,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$461,574,238
Community Mental Health Supports Waiver	$9,184,851	$8,230,230	$36,049,054	$469,220	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$53,933,355
Disabled Children's Waiver	$0	$0	$25,301,291	$219,479	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,520,770
Consumer Directed Attendant Support-State Plan	$89,607	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$89,607
Brain Injury Waiver	$1,289,267	$2,270,526	$23,224,527	$472,898	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$27,257,218
Children with Autism Waiver	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Children with Life Limiting Illness Waiver	$0	$0	$1,220,947	$16,834	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,237,781
Spinal Cord Injury Adult Waiver	$559,566	$167,822	$3,877,137	$149,648	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,754,173
Estimated FY 2019-20 Total Expenditure	$264,481,391	$67,765,311	$238,022,916	$4,097,524	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$574,367,142

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)	$190,796,655	$23,040,615	$1,841,013	$3,516,917	$11,596,421	$1,594,734	$0	$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
FY 2016-17	$364,380,354	$38,195,913	$16,895,299	($1,224,402)	$20,667,950	$566,699	$717,215	$2,718,188	$442,917,216
Estimated FY 2017-18	$402,458,622	$46,427,022	$20,315,452	$1,455,578	$24,812,512	$805,604	$973,782	$3,989,476	$501,238,048
Estimated FY 2018-19	$430,163,210	$49,930,201	$22,670,931	$448,035	$25,944,486	$525,869	$1,088,349	$4,668,276	$535,439,357
Estimated FY 2019-20	$461,574,238	$53,933,355	$25,520,770	$89,607	$27,257,218	$0	$1,237,781	$4,754,173	$574,367,142

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)	7.73%	0.36%	5.34%	-14.76%	-3.59%	23.25%	0.00%	0.00%	5.99%
FY 2010-11 (DA)	9.58%	6.71%	2.51%	-15.80%	5.06%	-16.69%	100.00%	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%
FY 2016-17	13.40%	6.93%	34.53%	-158.81%	7.87%	1.46%	11.54%	37.67%	12.41%
Estimated FY 2017-18	10.45%	21.55%	20.24%	-218.88%	20.05%	42.16%	35.77%	46.77%	13.17%
Estimated FY 2018-19	6.88%	7.55%	11.59%	-69.22%	4.56%	-34.72%	11.77%	17.01%	6.82%
Estimated FY 2019-20	7.30%	8.02%	12.57%	-80.00%	5.06%	-100.00%	13.73%	1.84%	7.27%

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	14,192	1,907	931	N/A	214	57	N/A	0	17,309
FY 2009-10 (DA)	15,085	2,017	933	42	209	61	32	0	18,379
FY 2010-11 (DA)	15,920	2,131	971	39	203	53	65	0	19,382
FY 2011-12	17,198	2,287	915	36	210	43	79	0	20,768
FY 2012-13	18,432	2,524	964	33	225	36	90	N/A	22,311
FY 2013-14	19,415	2,642	938	31	239	34	88	51	23,438
FY 2014-15	19,795	2,719	965	N/A	273	34	81	53	23,947
FY 2015-16	20,567	2,835	1,065	N/A	319	N/A	107	49	24,994
FY 2016-17	19,885	2,788	1,136	N/A	303	N/A	126	63	24,351
Estimated FY 2017-18	21,989	3,264	1,406	17	364	36	148	90	27,314
Estimated FY 2018-19	22,619	3,409	1,535	5	376	18	163	104	28,229
Estimated FY 2019-20	23,282	3,560	1,676	1	388	0	181	104	29,192

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)	6.29%	5.77%	0.21%	N/A	-2.34%	N/A	N/A	0.00%	6.18%
FY 2010-11 (DA)	5.54%	5.65%	4.07%	100.00%	-2.87%	N/A	N/A	0.00%	5.46%
FY 2011-12	8.03%	7.32%	-5.77%	-7.69%	3.45%	-18.87%	21.54%	0.00%	7.15%
FY 2012-13	7.18%	10.36%	5.36%	-8.33%	7.14%	-16.28%	13.92%	100.00%	7.43%
FY 2013-14	5.33%	4.68%	-2.70%	N/A	6.22%	-5.56%	-2.22%	N/A	5.05%
FY 2014-15	1.96%	2.91%	2.88%	N/A	14.23%	0.00%	-7.95%	N/A	2.17%
FY 2015-16	3.90%	4.27%	10.36%	N/A	16.85%	N/A	32.10%	N/A	4.37%
FY 2016-17	-3.32%	-1.66%	6.67%	N/A	-5.02%	N/A	17.76%	N/A	-2.57%
Estimated FY 2017-18	10.58%	17.07%	23.77%	N/A	20.13%	N/A	17.46%	42.86%	12.17%
Estimated FY 2018-19	2.87%	4.44%	9.17%	-70.59%	3.30%	-50.00%	10.14%	15.56%	3.35%
Estimated FY 2019-20	2.93%	4.43%	9.19%	-80.00%	3.19%	-100.00%	11.04%	0.00%	3.41%

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	$12,479.12	$12,039.26	$1,877.21	N/A	$56,206.71	$22,700.57	N/A	$0.00	$12,667.31
FY 2009-10 (DA)	$12,648.10	$11,423.21	$1,973.22	$83,736.12	$55,485.27	$26,143.19	$0.00	$0.00	$12,644.12
FY 2010-11 (DA)	$13,132.96	$11,538.03	$1,943.56	$75,929.72	$60,014.37	$25,067.50	$1,834.96	$0.00	$13,009.16
FY 2011-12	$13,123.72	$11,339.86	$3,420.84	$96,157.86	$59,938.72	$23,776.44	$2,163.42	$0.00	$13,097.47
FY 2012-13	$13,182.26	$11,216.09	$5,550.19	$80,665.97	$57,109.70	$24,595.11	$2,301.46	N/A	$13,154.59
FY 2013-14	$14,404.27	$12,081.46	$8,637.29	$75,201.19	$59,347.60	$22,479.47	$2,518.55	$34,775.92	$14,461.76
FY 2014-15	$15,011.43	$12,500.70	$11,307.78	N/A	$60,986.48	$20,884.06	$5,847.83	$33,190.04	$15,209.31
FY 2015-16	$15,623.15	$12,600.20	$11,791.99	N/A	$60,064.41	N/A	$6,009.25	$40,294.37	$15,764.57
FY 2016-17	$18,324.38	$13,700.11	$14,872.62	N/A	$68,211.06	N/A	$5,692.18	$43,145.84	$18,188.87
Estimated FY 2017-18	$18,302.73	$14,223.97	$14,449.11	$85,622.24	$68,166.24	$22,377.89	$6,579.61	$44,327.51	$18,350.96
Estimated FY 2018-19	$19,017.78	$14,646.58	$14,769.34	$89,607.00	$69,001.29	$29,214.94	$6,676.99	$44,887.27	$18,967.71
Estimated FY 2019-20	$19,825.37	$15,149.82	$15,227.19	$89,607.00	$70,250.56	$0.00	$6,838.57	$45,713.20	$19,675.50

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)	1.35%	-5.12%	5.11%	N/A	-1.28%	N/A	N/A	0.00%	-0.18%
FY 2010-11 (DA)	3.83%	1.01%	-1.50%	N/A	8.16%	N/A	N/A	0.00%	2.89%
FY 2011-12	-0.07%	-1.72%	76.01%	26.64%	-0.13%	N/A	17.90%	0.00%	0.68%
FY 2012-13	0.45%	-1.09%	62.25%	-16.11%	-4.72%	3.44%	6.38%	100.00%	0.44%
FY 2013-14	9.27%	7.72%	55.62%	N/A	3.92%	-8.60%	9.43%	N/A	9.94%
FY 2014-15	4.22%	3.47%	30.92%	N/A	2.76%	-7.10%	132.19%	N/A	5.17%
FY 2015-16	4.08%	0.80%	4.28%	N/A	-1.51%	N/A	2.76%	N/A	3.65%
FY 2016-17	17.29%	8.73%	26.12%	N/A	13.56%	N/A	-5.28%	N/A	15.38%
Estimated FY 2017-18	-0.12%	3.82%	-2.85%	N/A	-0.07%	N/A	15.59%	2.74%	0.89%
Estimated FY 2018-19	3.91%	2.97%	2.22%	4.65%	1.23%	30.55%	1.48%	1.26%	3.36%
Estimated FY 2019-20	4.25%	3.44%	3.10%	0.00%	1.81%	-100.00%	2.42%	1.84%	3.73%

(1) Presented information regarding the enrolled clients in each waiver is derived from the average number of monthly paid claims for the waiver. Due to known data issues, the Department is using values from the FY 2017-18 S-1 Request as FY 2016-17 enrollment.
(2) N/A - Data cannot be displayed due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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 [4]	Brain Injury Waiver	Children with Autism Waiver[4]	Children with Life Limiting Illness Waiver[4]	Spinal Cord Injury Adult Waiver[4]	TOTAL
FY 2016-17 Estimated Enrollment [1]	21,382	3,062	1,240	N/A	330	N/A	135	70	26,273
Enrollment Trend Selected[2]	2.93%	6.60%	13.39%	N/A	10.15%	N/A	9.63%	0.00%	5.12%
FY 2017-18 Estimated Enrollment	**22,009**	**3,264**	**1,406**	**25**	**363**	**36**	**148**	**70**	27,321
Bottom Line Impacts									
FY 2015-16 R-7: "Participant Directed Programs Expansion"	0	0	0	(8)	0	0	0	0	(8)
SB 15-011: "Pilot Program Spinal Cord Injury Alternative Medicine"	(20)	0	0	0	0	0	0	20	0
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	0	0	0	0	1	0	0	0	1
Total Bottom Line Impacts	**(20)**	**0**	**0**	**(8)**	**1**	**0**	**0**	**20**	**(7)**
FY 2017-18 Estimated Enrollment	**21,989**	**3,264**	**1,406**	**17**	**364**	**36**	**148**	**90**	**27,314**
FY 2016-17 Cost Per Enrollee	$16,942.58	$13,323.95	$12,792.41	N/A	$65,082.34	N/A	$6,301.99	$42,811.43	$18,188.87
Percentage Selected to Modify Per Enrollee[3]	4.15%	3.35%	10.93%	N/A	1.72%	N/A	2.42%	1.84%	3.91%
FY 2017-18 Estimated Cost Per Enrollee	**$17,645.70**	**$13,770.30**	**$14,190.62**	**$83,278.28**	**$66,201.76**	**$22,066.78**	**$6,454.50**	**$43,599.16**	**$18,350.96**
Estimated FY 2017-18 Base Expenditure	**$388,011,298**	**$44,946,259**	**$19,952,012**	**$1,415,731**	**$24,097,441**	**$794,404**	**$955,266**	**$3,923,924**	**$484,096,335**
Bottom Line Impacts									
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$0	$0	$0	$0	($22,872)	$0	$0	$0	($22,872)
Colorado Choice Transitions	$2,871,094	$300,960	$0	$0	$162,851	$0	$0	$0	$3,334,905
FY 2017-18 Non-Medical Transportation 7.01% Targeted Rate Increase	$342,835	$63,718	$0	$0	$11,735	$0	$0	$633	$418,921
FY 2017-18 Homemaker and Personal Care $0.50 Hourly Rate Increase	$4,020,441	$197,345	$0	$34,928	$40,169	$0	$0	$22,569	$4,315,452
FY 2017-18 Across the Board 1.402% Rate Increase	$769,890	$202,459	$111,620	$4,919	$138,985	$0	$5,623	$2,759	$1,236,255
interChange Payment Lag Adjustment	$6,443,064	$716,281	$251,820	$0	$384,203	$11,200	$12,893	$39,591	$7,859,051
Total Bottom Line Impacts	**$14,447,324**	**$1,480,763**	**$363,440**	**$39,847**	**$715,071**	**$11,200**	**$18,516**	**$65,552**	**$17,141,712**
Estimated FY 2017-18 Expenditure	**$402,458,622**	**$46,427,022**	**$20,315,452**	**$1,455,578**	**$24,812,512**	**$805,604**	**$973,782**	**$3,989,476**	**$501,238,048**
Estimated FY 2017-18 Per Enrollee	$18,302.73	$14,223.97	$14,449.11	$85,622.24	$68,166.24	$22,377.89	$6,579.61	$44,327.51	$18,350.96
% Change over FY 2016-17 Per Enrollee	8.03%	6.75%	12.95%	N/A	4.74%	N/A	4.41%	3.54%	0.89%

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 2017-18 Average HCBS Waiver Enrollment	21,989	3,264	1,406	17	364	36	148	90	27,314
Enrollment Trend Selected[2]	2.93%	4.44%	9.17%	0.00%	3.23%	0.00%	10.14%	0.00%	3.46%
FY 2018-19 Estimated Enrollment	**22,633**	**3,409**	**1,535**	**17**	**376**	**36**	**163**	**90**	28,259
Bottom Line Impacts							70		
FY 2015-16 R-7: "Participant Directed Programs Expansion"	0	0	0	(12)	0	0	0	0	(12)
SB 15-011: "Pilot Program Spinal Cord Injury Alternative Medicine"	(14)	0	0	0	0	0	0	14	0
Children with Autism Waiver Sunset	0	0	0	0	0	(18)	0	0	(18)
Total Bottom Line Impacts	**(14)**	**0**	**0**	**(12)**	**0**	**(18)**	**0**	**14**	**(30)**
FY 2018-19 Estimated Enrollment	**22,619**	**3,409**	**1,535**	**5**	**376**	**18**	**163**	**104**	**28,229**
FY 2017-18 Cost per Enrollee	$18,302.73	$14,223.97	$14,449.11	$85,622.24	$68,166.24	$22,377.89	$6,579.61	$44,327.51	$18,350.96
Percentage Selected to Modify Per Enrollee[3]	4.15%	3.35%	3.10%	0.00%	1.72%	0.00%	2.42%	1.84%	3.90%
FY 2018-19 Estimated Cost Per Enrollee	**$19,062.29**	**$14,700.47**	**$14,897.03**	**$85,622.24**	**$69,338.70**	**$22,377.89**	**$6,738.84**	**$45,143.14**	**$18,967.71**
Estimated FY 2018-19 Base Expenditure	**$431,169,938**	**$50,113,902**	**$22,866,941**	**$428,111**	**$26,071,351**	**$402,802**	**$1,098,431**	**$4,694,887**	**$536,846,363**
Bottom Line Impacts									
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$0	$0	$0	$0	($880)	$0	$0	$0	($880)
Colorado Choice Transitions	$2,869,751	$300,820	$0	$0	$162,775	$0	$0	$0	$3,333,346
FY 2017-18 Non-Medical Transportation 7.01% Targeted Rate Increase	$171,418	$31,859	$0	$0	$5,867	$0	$0	$316	$209,460
FY 2017-18 Homemaker and Personal Care $0.50 Hourly Rate Increase	$2,010,221	$98,672	$0	$17,464	$20,084	$0	$0	$11,285	$2,157,726
FY 2017-18 Across the Board 1.402% Rate Increase	$384,945	$101,229	$55,810	$2,460	$69,492	$0	$2,811	$1,379	$618,126
Children with Autism Waiver Run out	$0	$0	$0	$0	$0	$134,267	$0	$0	$134,267
interChange Payment Lag Adjustment	($6,443,064)	($716,281)	($251,820)	$0	($384,203)	($11,200)	($12,893)	($39,591)	($7,859,051)
Total Bottom Line Impacts	**($1,006,728)**	**($183,701)**	**($196,010)**	**$19,924**	**($126,865)**	**$123,067**	**($10,082)**	**($26,611)**	**($1,407,006)**
Estimated FY 2018-19 Total Expenditure	**$430,163,210**	**$49,930,201**	**$22,670,931**	**$448,035**	**$25,944,486**	**$525,869**	**$1,088,349**	**$4,668,276**	**$535,439,357**
Estimated FY 2018-19 Per Enrollee	$19,017.78	$14,646.58	$14,769.34	$89,607.00	$69,001.29	$0.00	$6,676.99	$44,887.27	$18,967.71
% Change over FY 2017-18 Per Enrollee	3.91%	2.97%	2.22%	4.65%	1.23%	-100.00%	1.48%	1.26%	3.36%

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 2018-19 Average HCBS Waiver Enrollment	22,619	3,409	1,535	5	376	18	163	104	28,229
Enrollment Trend Selected[2]	2.93%	4.44%	9.17%	0.00%	3.23%	0.00%	11.04%	0.00%	3.46%
FY 2019-20 Estimated Enrollment	**23,282**	**3,560**	**1,676**	**5**	**388**	**0**	**181**	**104**	29,196
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 2019-20 Estimated Enrollment	**23,282**	**3,560**	**1,676**	**1**	**388**	**0**	**181**	**104**	**29,192**
Estimated FY 2018-19 Cost per Enrollee	$19,017.78	$14,646.58	$14,769.34	$89,607.00	$69,001.29	$0.00	$6,676.99	$44,887.27	$18,967.71
Percentage Selected to Modify Per Enrollee[3]	4.15%	3.35%	3.10%	0.00%	1.72%	0.00%	2.42%	1.84%	3.90%
FY 2019-20 Estimated Cost Per Enrollee	**$19,807.02**	**$15,137.24**	**$15,227.19**	**$89,607.00**	**$70,188.11**	**$0.00**	**$6,838.57**	**$45,713.20**	**$19,675.50**
Estimated FY 2019-20 Base Expenditure	**$461,147,040**	**$53,888,574**	**$25,520,770**	**$89,607**	**$27,232,987**	**$0**	**$1,237,781**	**$4,754,173**	**$573,870,932**
Bottom Line Impacts									
Colorado Choice Transitions	$427,198	$44,781	$0	$0	$24,231	$0	$0	$0	$496,210
Total Bottom Line Impacts	**$427,198**	**$44,781**	**$0**	**$0**	**$24,231**	**$0**	**$0**	**$0**	**$496,210**
Estimated FY 2019-20 Total Expenditure	**$461,574,238**	**$53,933,355**	**$25,520,770**	**$89,607**	**$27,257,218**	**$0**	**$1,237,781**	**$4,754,173**	**$574,367,142**
Estimated FY 2019-20 Per Enrollee	$19,825.37	$15,149.82	$15,227.19	$89,607.00	$70,250.56	$0.00	$6,838.57	$45,713.20	$19,675.50
% Change over FY 2018-19 Per Enrollee	4.25%	3.44%	3.10%	0.00%	1.81%	0.00%	2.42%	1.84%	3.73%

Definitions: HCBS: Home- and Community-Based Services

(1) Presented information regarding the enrolled clients in each waiver is derived from the average number of monthly paid claims for the waiver. Due to known data issues, the Department is using values from the FY 2017-18 S-1 Request as FY 2016-17 enrollment.

	Waiver	Percentages	Waiver	Percentages	Waiver	Percentages
(2) Percentage selected to modify enrollment for FY 2017-18 through FY 2019-20	Elderly, Blind and Disabled Waiver	2.93%, 2.93%, 2.93%	Consumer Directed Attendant Support-State Plan	N/A, N/A, N/A	Children with Life Limiting Illness Waiver	10.14%, 11.04%, 11.04%
	Community Mental Health Supports Waiver	4.44%, 4.44%, 4.44%	Brain Injury Waiver	3.23%, 3.23%, 3.23%	Spinal Cord Injury Adult Waiver	0.00%, 0.00%, 0.00%
	Disabled Children's Waiver	9.17%, 9.17%, 9.17%	Children with Autism Waiver	N/A, N/A, N/A		
(3) Percentage selected to modify per enrollee costs for FY 2017-18 through FY 2019-20	Elderly, Blind and Disabled Waiver	4.15%, 4.15%, 4.15%	Consumer Directed Attendant Support-State Plan	N/A, 0.00%, 0.00%	Children with Life Limiting Illness Waiver	2.42%, 2.42%, 2.42%
	Community Mental Health Supports Waiver	3.35%, 3.35%, 3.35%	Brain Injury Waiver	1.72%, 1.72%, 1.72%	Spinal Cord Injury Adult Waiver	1.84%, 1.84%, 1.84%
	Disabled Children's Waiver	10.93%, 3.10%, 3.10%	Children with Autism Waiver	N/A, N/A, N/A		

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

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

FY 2015-16 July - December CORE 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 CORE 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	$65,985,377	$1,116,947	$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	$2,561,913	$12,614,830	$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	$6,068,194	$9,024	$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	$469,699	$7,812	$1,302	$165	$5,117	$0	$64	$0	$516	$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	$19,061,697	$94,627,641	$1,198,443	$193,091	$23,452	$889,554	$0	$479,736	$1,383	$82,218	$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

FY 2016-17 July - December CORE 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	$87,300,379	$16,962,573	$68,978,227	$1,154,334	$237,051	$21,206	$820,984	$0	$21,663	$0	$53,046	$2,552	$0	$0	$334,329	$175,886,344
HCBS - Mental Illness	$3,234,032	$2,673,943	$13,062,242	$50,086	$10,695	$0	$114,245	$0	$0	$0	$8,181	$0	$0	$0	$79,681	$19,233,105
HCBS - Disabled Children	$0	$0	$7,192,996	$38,925	$0	$0	$0	$0	$502,686	$2,422	$475	$0	$0	$0	$0	$7,737,504
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	$303,521	$58,974	$239,819	$4,014	$824	$74	$2,854	$0	$75	$0	$184	$9	$0	$0	$1,162	$611,510
HCBS - Brain Injury	$447,254	$997,491	$8,192,375	$9,893	$1,619	$0	$9,468	$0	$0	$0	$0	$0	$0	$0	$21,124	$9,679,224
HCBS - Children with Autism	$0	$0	$219,026	$3,784	$0	$0	$0	$0	$47,445	$1,446	$448	$0	$0	$0	$0	$272,149
HCBS - Pediatric Hospice	$0	$0	$327,761	$780	$0	$0	$0	$0	$21,738	$1,107	$5,428	$0	$0	$0	$0	$356,814
HCBS - Spinal Cord Injury	$174,899	$27,332	$1,195,123	$11,564	$0	$0	$32,897	$0	$0	$0	$0	$0	$0	$0	$0	$1,441,815
Total	$91,460,085	$20,720,313	$99,407,569	$1,273,380	$250,189	$21,280	$980,448	$0	$593,607	$4,975	$67,762	$2,561	$0	$0	$436,296	$215,218,465
Caseload	43,538	11,088	67,693	5,707	153,209	90,184	357,092	309	471,955	63,293	20,247	14,310	1,803	2,526	33,506	1,336,459
Half -Year Per Capita	$2,100.68	$1,868.77	$1,468.50	$223.13	$1.63	$0.24	$2.75	$0.00	$1.26	$0.08	$3.35	$0.18	$0.00	$0.00	$13.02	$161.04

FY 2016-17 January - June CORE 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	$112,381,662	$14,033,617	$60,388,671	$1,177,315	$72,529	$11,176	$325,733	$0	$665	$0	$13,480	$0	$0	$0	$89,162	$188,494,010
HCBS - Mental Illness	$8,201,096	$1,776,096	$8,863,803	$62,896	$11,654	$175	$31,947	$0	$0	$0	($1)	$0	$0	$0	$15,142	$18,962,808
HCBS - Disabled Children	$0	$0	$9,019,731	$1,297	$0	$0	$0	$0	$135,267	$800	$700	$0	$0	$0	$0	$9,157,795
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	($1,201,560)	($106,711)	($510,519)	($11,940)	($824)	($74)	($2,854)	$0	($75)	$0	($184)	($9)	$0	$0	($1,162)	($1,835,912)
HCBS - Brain Injury	$3,926,227	$622,421	$6,378,978	$1,638	($31)	$0	$53,840	$0	$0	$0	$0	$0	$0	$0	$5,653	$10,988,726
HCBS - Children with Autism	$0	$0	$284,658	$3,710	$0	$0	$0	$0	$6,225	($33)	($10)	$0	$0	$0	$0	$294,550
HCBS - Pediatric Hospice	$0	$0	$352,435	$189	$0	$0	$0	$0	$6,881	$0	$896	$0	$0	$0	$0	$360,401
HCBS - Spinal Cord Injury	$413,049	$11,665	$834,914	$1,783	$0	$0	$14,962	$0	$0	$0	$0	$0	$0	$0	$0	$1,276,373
Total	$123,720,474	$16,337,088	$85,612,671	$1,236,888	$83,328	$11,277	$423,628	$0	$148,963	$767	$14,881	($9)	$0	$0	$108,795	$227,698,751
Caseload	44,344	11,395	67,545	6,796	168,773	111,935	338,605	280	467,856	66,582	20,373	12,312	2,230	2,754	34,112	1,355,890
Half -Year Per Capita	$2,790.01	$1,433.77	$1,267.49	$182.01	$0.49	$0.10	$1.25	$0.00	$0.32	$0.01	$0.73	($0.00)	$0.00	$0.00	$3.19	$167.93

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	$2,646,578	$602,061	$49,469,896	$559,463	$0	$0	$40,514	$0	$7,627,484	$192,885	$11,470,454	$0	$0	$0	$0	$72,609,335
FY 2016-17	$32,421,076	$380,219	$38,445,725	$526,916	$0	$0	$0	$0	$5,795,549	$168,244	$9,341,763	$0	$0	$0	$0	$87,079,492
Estimated FY 2017-18	$38,134,699	$450,813	$45,235,006	$624,991	$0	$0	$0	$0	$6,823,672	$194,669	$10,993,694	$0	$0	$0	$0	$102,457,544
Estimated FY 2018-19	$43,747,452	$517,165	$51,892,800	$716,979	$0	$0	$0	$0	$7,827,997	$223,321	$12,611,772	$0	$0	$0	$0	$117,537,486
Estimated FY 2019-20	$49,816,069	$588,906	$59,091,334	$816,437	$0	$0	$0	$0	$8,913,891	$254,300	$14,361,269	$0	$0	$0	$0	$133,842,206

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%	100.00%	20.10%	0.00%	0.00%	0.00%	0.00%	0.00%	19.72%	0.00%	-4.81%	0.00%	0.00%	0.00%	0.00%	13.97%
FY 2012-13	29.00%	312.36%	17.48%	100.00%	0.00%	0.00%	0.00%	0.00%	77.64%	100.00%	8.10%	0.00%	0.00%	0.00%	0.00%	18.31%
FY 2013-14	28.58%	31.89%	45.21%	1419.54%	0.00%	0.00%	100.00%	0.00%	215.51%	-93.11%	21.44%	0.00%	0.00%	0.00%	100.00%	44.26%
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%
FY 2016-17	1125.02%	-36.85%	-22.28%	-5.82%	0.00%	0.00%	-100.00%	0.00%	-24.02%	-12.77%	-18.56%	0.00%	0.00%	0.00%	0.00%	19.93%
Estimated FY 2017-18	17.62%	18.57%	17.66%	18.61%	0.00%	0.00%	0.00%	0.00%	17.74%	15.71%	17.68%	0.00%	0.00%	0.00%	0.00%	17.66%
Estimated FY 2018-19	14.72%	14.72%	14.72%	14.72%	0.00%	0.00%	0.00%	0.00%	14.72%	14.72%	14.72%	0.00%	0.00%	0.00%	0.00%	14.72%
Estimated FY 2019-20	13.87%	13.87%	13.87%	13.87%	0.00%	0.00%	0.00%	0.00%	13.87%	13.87%	13.87%	0.00%	0.00%	0.00%	0.00%	13.87%

Private Duty Nursing Per Capita Costs 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	$19.27	$28.98	$286.79	$0.00	$0.00	$0.00	$0.00	$0.00	$1.07	$0.00	$302.81	$0.00	$0.00	$0.00	$0.00	$48.88
FY 2009-10 (DA)	$26.90	$34.12	$284.19	$0.00	$0.00	$0.00	$0.00	$0.00	$2.19	$0.00	$361.73	$0.00	$0.00	$0.00	$0.00	$47.45
FY 2010-11 (DA)	$33.91	$0.00	$306.51	$0.00	$0.00	$0.00	$0.00	$0.00	$1.66	$0.00	$448.60	$0.00	$0.00	$0.00	$0.00	$48.73
FY 2011-12	$46.12	$16.12	$348.63	$0.00	$0.00	$0.00	$0.00	$0.00	$1.80	$0.00	$435.52	$0.00	$0.00	$0.00	$0.00	$50.24
FY 2012-13	$57.91	$61.55	$393.12	$20.81	$0.00	$0.00	$0.00	$0.00	$2.97	$0.70	$477.59	$0.00	$0.00	$0.00	$0.00	$53.95
FY 2013-14	$72.66	$74.57	$548.64	$109.68	$0.00	$0.00	$0.50	$0.00	$8.45	$0.02	$564.43	$0.00	$0.00	$0.00	$1.10	$61.74
FY 2014-15	$50.46	$42.17	$595.19	$82.83	$0.00	$0.00	$0.17	$0.00	$16.64	$0.54	$576.64	$0.00	$0.00	$0.00	$0.00	$52.96
FY 2015-16	$62.41	$57.18	$719.04	$89.99	$0.00	$0.00	$0.13	$0.00	$16.33	$3.24	$575.39	$0.00	$0.00	$0.00	$0.00	$55.98
FY 2016-17	$737.83	$33.82	$568.56	$84.29	$0.00	$0.00	$0.00	$0.00	$12.33	$2.59	$459.96	$0.00	$0.00	$0.00	$0.00	$64.69
Estimated FY 2017-18	$842.90	$38.59	$667.74	$80.01	$0.00	$0.00	$0.00	$0.00	$14.63	$2.83	$534.09	$0.00	$0.00	$0.00	$0.00	$73.10
Estimated FY 2018-19	$951.18	$42.47	$746.95	$78.80	$0.00	$0.00	$0.00	$0.00	$16.71	$3.11	$607.91	$0.00	$0.00	$0.00	$0.00	$81.40
Estimated FY 2019-20	$1,065.13	$46.33	$824.08	$78.75	$0.00	$0.00	$0.00	$0.00	$18.95	$3.42	$686.19	$0.00	$0.00	$0.00	$0.00	$90.71

Private Duty Nursing Per Capita Cost 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)	39.60%	17.74%	-0.91%	0.00%	0.00%	0.00%	0.00%	0.00%	104.67%	0.00%	19.46%	0.00%	0.00%	0.00%	0.00%	-2.93%
FY 2010-11 (DA)	26.06%	-100.00%	7.85%	0.00%	0.00%	0.00%	0.00%	0.00%	-24.20%	0.00%	24.02%	0.00%	0.00%	0.00%	0.00%	2.70%
FY 2011-12	36.01%	100.00%	13.74%	0.00%	0.00%	0.00%	0.00%	0.00%	8.43%	0.00%	-2.92%	0.00%	0.00%	0.00%	0.00%	3.10%
FY 2012-13	25.56%	281.82%	12.76%	100.00%	0.00%	0.00%	0.00%	0.00%	65.00%	100.00%	9.66%	0.00%	0.00%	0.00%	0.00%	7.38%
FY 2013-14	25.47%	21.15%	39.56%	427.05%	0.00%	0.00%	100.00%	0.00%	184.51%	-97.14%	18.18%	0.00%	0.00%	0.00%	100.00%	14.44%
FY 2014-15	-30.55%	-43.45%	8.48%	-24.48%	0.00%	0.00%	-66.00%	0.00%	96.92%	2600.00%	2.16%	0.00%	0.00%	0.00%	-100.00%	-14.22%
FY 2015-16	23.68%	35.59%	20.81%	8.64%	0.00%	0.00%	-23.53%	0.00%	-1.86%	500.00%	-0.22%	0.00%	0.00%	0.00%	0.00%	5.70%
FY 2016-17	1082.23%	-40.85%	-20.93%	-6.33%	0.00%	0.00%	-100.00%	0.00%	-24.49%	-20.06%	-20.06%	0.00%	0.00%	0.00%	0.00%	15.56%
Estimated FY 2017-18	14.24%	14.10%	17.44%	-5.08%	0.00%	0.00%	0.00%	0.00%	18.65%	9.27%	16.12%	0.00%	0.00%	0.00%	0.00%	13.00%
Estimated FY 2018-19	12.85%	10.05%	11.86%	-1.51%	0.00%	0.00%	0.00%	0.00%	14.22%	9.89%	13.82%	0.00%	0.00%	0.00%	0.00%	11.35%
Estimated FY 2019-20	11.98%	9.09%	10.33%	-0.06%	0.00%	0.00%	0.00%	0.00%	13.41%	9.97%	12.88%	0.00%	0.00%	0.00%	0.00%	11.44%

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
FY 2016-17	$61,237,565	$15,504,682	$9,655,256	$86,397,502
Estimated FY 2017-18	$72,522,542	$18,583,811	$11,351,191	$102,457,544
Estimated FY 2018-19	$83,946,378	$20,546,453	$13,044,655	$117,537,486
Estimated FY 2019-20	$96,208,208	$22,732,346	$14,901,652	$133,842,206

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%	18.99%
FY 2016-17	20.79%	16.74%	11.88%	18.59%
Estimated FY 2017-18	18.43%	19.86%	17.56%	18.59%
Estimated FY 2018-19	15.75%	10.56%	14.92%	14.72%
Estimated FY 2019-20	14.61%	10.64%	14.24%	13.87%

Private Duty Nursing (PDN) Average Utilizers Per Month Per Service Per Fiscal Year[2]

PRIVATE DUTY NURSING	Registered Nursing (RN)	Licensed Practical Nursing (LPN)	Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN[1][3]	TOTAL[4]
FY 2008-09	110	85	N/A	150
FY 2009-10 (DA)	124	87	N/A	164
FY 2010-11 (DA)	147	101	33	187
FY 2011-12	183	116	33	221
FY 2012-13	223	126	51	268
FY 2013-14	315	181	57	369
FY 2014-15	398	225	66	458
FY 2015-16	416	240	68	504
FY 2016-17	474	258	72	569
Estimated FY 2017-18	543	279	83	645
Estimated FY 2018-19	623	301	94	731
Estimated FY 2019-20	714	325	106	828

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][3]	TOTAL[4]
FY 2009-10 (DA)	12.73%	2.35%	N/A	9.35%
FY 2010-11 (DA)	18.55%	16.09%	N/A	14.10%
FY 2011-12	24.49%	14.85%	N/A	18.38%
FY 2012-13	21.86%	8.62%	54.55%	21.30%
FY 2013-14	41.26%	43.65%	11.76%	37.41%
FY 2014-15	26.35%	24.31%	15.79%	24.40%
FY 2015-16	4.52%	6.67%	3.03%	9.98%
FY 2016-17	13.99%	7.67%	5.59%	12.83%
Estimated FY 2017-18	14.51%	7.97%	15.60%	13.39%
Estimated FY 2018-19	14.73%	7.89%	13.25%	13.33%
Estimated FY 2019-20	14.61%	7.97%	12.77%	13.27%

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)(3)]	TOTAL
FY 2008-09	$112,158.52	$65,424.24	N/A	$142,660
FY 2009-10 (DA)	$113,406.10	$66,865.00	N/A	$144,602
FY 2010-11 (DA)	$109,059.50	$68,880.42	N/A	$146,324
FY 2011-12	$108,218.51	$61,125.97	$128,774.30	$140,871
FY 2012-13	$108,171.03	$58,297.23	$105,477.84	$137,403
FY 2013-14	$113,030.22	$58,666.31	$121,610.21	$144,247
FY 2014-15	$103,415.23	$53,738.22	$124,979.08	$134,155
FY 2015-16	$121,868.88	$55,340.77	$126,913.22	$144,019
FY 2016-17	$129,138.69	$60,002.64	$134,474.32	$151,885
Estimated FY 2017-18	$133,559.01	$66,608.64	$136,761.34	$158,849
Estimated FY 2018-19	$134,745.39	$68,260.64	$138,772.93	$160,790
Estimated FY 2019-20	$134,745.39	$69,945.68	$140,581.62	$161,645

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)(3)]	TOTAL
FY 2009-10 (DA)	1.11%	2.20%	N/A	1.36%
FY 2010-11 (DA)	-3.83%	3.01%	N/A	1.19%
FY 2011-12	-0.77%	-11.26%	N/A	-3.73%
FY 2012-13	-0.04%	-4.63%	-18.09%	-2.46%
FY 2013-14	4.49%	0.63%	15.29%	4.98%
FY 2014-15	-8.51%	-8.40%	2.77%	-7.00%
FY 2015-16	17.84%	2.98%	1.55%	7.35%
FY 2016-17	5.97%	8.42%	5.96%	5.46%
Estimated FY 2017-18	3.42%	11.01%	1.70%	4.58%
Estimated FY 2018-19	0.89%	2.48%	1.47%	1.22%
Estimated FY 2019-20	0.00%	2.47%	1.30%	0.53%

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	2,661	2,186	3,727
FY 2009-10 (DA)	2,875	2,231	4,990
FY 2010-11 (DA)	2,952	2,316	4,172
FY 2011-12	3,001	2,519	4,622
FY 2012-13	2,943	2,202	4,470
FY 2013-14	2,953	2,118	3,657
FY 2014-15	2,853	1,969	4,212
FY 2015-16	2,553	1,773	4,340
FY 2016-17	2,901	1,968	4,411
Estimated FY 2017-18	2,927	2,016	4,501
Estimated FY 2018-19	2,953	2,066	4,593
Estimated FY 2019-20	2,953	2,117	4,686

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)	8.04%	2.06%	33.88%
FY 2010-11 (DA)	2.68%	3.81%	-16.39%
FY 2011-12	1.66%	8.77%	10.79%
FY 2012-13	-1.93%	-12.58%	-3.29%
FY 2013-14	0.34%	-3.81%	-18.19%
FY 2014-15	-3.39%	-7.03%	15.18%
FY 2015-16	-10.52%	-9.95%	3.04%
FY 2016-17	13.63%	10.99%	1.64%
Estimated FY 2017-18	0.90%	2.45%	2.04%
Estimated FY 2018-19	0.89%	2.48%	2.04%
Estimated FY 2019-20	0.00%	2.47%	2.02%

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 2016-17 Average Paid Utilizers Per Month[5]	474	258	72	569
Utilizer Trend Selected[6]	14.57%	8.00%	6.43%	13.47%
FY 2017-18 Estimated Average Paid Utilizers Per Month	543	279	76	645
Bottom Line Impacts				
Total Bottom Line Impacts	**0**	**0**	**0**	**0**
FY 2017-18 Estimated Average Paid Utilizers Per Month	**543**	**279**	**76**	**645**
FY 2016-17 Average Paid Units Per Utilizer Per Year[5]	2,901	1,968	4,411	
Percentage Selected to Modify Per Client Utilization[7]	0.90%	2.47%	2.03%	
FY 2017-18 Estimated Average Paid Units Per Utilizer	**2,927**	**2,016**	**4,501**	
FY 2016-17 Average Paid Rate Per Unit	$44.85	$30.81	$28.60	
Unit Average Paid Rate Trend Selected	1.75%	7.23%	2.03%	
FY 2017-18 Average Paid Rate Per Unit	**$45.63**	**$33.04**	**$29.18**	
Estimated FY 2017-18 Base Expenditure	**$72,522,542**	**$18,583,811**	**$11,351,191**	**$102,457,544**
Bottom Line Impacts				
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**
Estimated FY 2017-18 Expenditure	**$72,522,542**	**$18,583,811**	**$11,351,191**	**$102,457,544**
Estimated FY 2017-18 Per Utilizer Cost	$133,559.01	$66,608.64	$149,357.78	$158,848.91
% Change Over FY 2016-17 Per Utilizer Cost	3.42%	11.01%	11.07%	4.58%

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 2017-18 Estimated Average Paid Utilizers Per Month	543	279	76	645
Utilizer Trend Selected[6]	14.66%	8.00%	5.39%	13.26%
FY 2018-19 Estimated Average Paid Utilizers Per Month	623	301	80	731
Bottom Line Impacts				
Total Bottom Line Impacts	**0**	**0**	**0**	**0**
FY 2018-19 Estimated Average Paid Utilizers Per Month	**623**	**301**	**80**	**731**
FY 2017-18 Average Paid Units Per Utilizer Per Year	2,927	2,016	4,501	
Percentage Selected to Modify Per Client Utilization[7]	0.90%	2.47%	2.03%	
FY 2018-19 Estimated Average Paid Units Per Utilizer	**2,953**	**2,066**	**4,593**	
FY 2017-18 Average Paid Rate Per Unit	$45.63	$33.04	$29.18	
Adjustment to Increase Average Paid Rate to Actual Rate	0.00%	0.00%	0.00%	
FY 2018-19 Estimated Average Paid Rate Per Unit	**$45.63**	**$33.04**	**$29.18**	
Estimated FY 2018-19 Base Expenditure	**$83,946,378**	**$20,546,453**	**$13,044,655**	**$117,537,486**
Bottom Line Impacts				
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**
Estimated FY 2018-19 Expenditure	**$83,946,378**	**$20,546,453**	**$13,044,655**	**$117,537,486**
Estimated FY 2018-19 Per Utilizer Cost	$134,745.39	$68,260.64	$163,058.19	$160,789.99
% Change Over FY 2017-18 Per Utilizer Cost	0.89%	2.48%	9.17%	1.22%

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 2018-19 Estimated Average Paid Utilizers Per Month	623	301	80	731
Utilizer Trend Selected[6]	14.66%	8.00%	5.39%	13.26%
FY 2019-20 Estimated Average Paid Utilizers Per Month	714	325	84	828
Bottom Line Impacts				
Total Bottom Line Impacts	**0**	**0**	**0**	**0**
FY 2019-20 Estimated Average Paid Utilizers Per Month	**714**	**325**	**84**	**828**
FY 2018-19 Average Paid Units Per Utilizer Per Year	2,953	2,066	4,593	
Percentage Selected to Modify Per Client Utilization[7]	0.00%	2.47%	2.03%	
FY 2019-20 Estimated Average Paid Units Per Client	**2,953**	**2,117**	**4,686**	
FY 2018-19 Average Paid Rate Per Unit	$45.63	$33.04	$29.18	
Unit Paid Rate Trend Selected	0.00%	0.00%	0.00%	
FY 2019-20 Estimated Average Paid Rate Per Unit	**$45.63**	**$33.04**	**$29.18**	
Estimated FY 2019-20 Base Expenditure	**$96,208,208**	**$22,732,346**	**$14,901,652**	**$133,842,206**
Bottom Line Impacts				
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**
Estimated FY 2019-20 Expenditure	**$96,208,208**	**$22,732,346**	**$14,901,652**	**$133,842,206**
Estimated FY 2019-20 Per Utilizer Cost	$134,745.39	$69,945.68	$177,400.62	$161,645.18
% Change Over FY 2018-19 Per Utilizer Cost	0.00%	2.47%	8.80%	0.53%

(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) 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.
(3) N/A - Rows cannot be displayed due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
(4) Since clients can access multiple services, the total average utilizers per month does not reflect the sum of the services but rather the total average utilizers per month for PDN as a benefit.
(5) Due to data irregularities in the months of March and April of 2017 this average estimate is an average based on the 10 months from FY 2016-17 that were not affected by data irregularities.

(6) Percentages Selected to Modify Utilizers for FY 2017-18 through FY 2019-20	RN	14.57%, 14.66%, 14.66%
	LPN	8.00%, 8.00%, 8.00%
	Blended & Group	6.43%, 5.39%, 5.39%
	Total PDN Utilizers	13.47%, 13.26%, 13.26%
(7) Percentages Selected to Modifier Units Per Utilizer for FY 2017-18 through FY 2019-20	RN	0.90%, 0.90%, 0.00%
	LPN	2.47%, 2.47%, 2.47%
	Blended & Group	2.03%, 2.03%, 2.03%

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
FY 2016-17	$39,750,102	$8,739,054	$173,793,283	$2,904,097	$583,453	$242,459	$2,827,143	$0	$28,451,344	$2,333,066	$14,000,869	$13,497	$1,036	$0	$0	$273,639,403
Estimated FY 2017-18	$44,565,136	$9,784,087	$194,785,920	$3,257,495	$644,093	$276,040	$3,159,125	$0	$31,897,964	$2,607,045	$15,703,613	$0	$0	$0	$30,671	$306,711,189
Estimated FY 2018-19	$47,514,954	$10,431,707	$207,680,206	$3,471,932	$686,727	$294,311	$3,368,231	$0	$34,009,327	$2,779,609	$16,743,054	$0	$0	$0	$32,701	$327,012,759
Estimated FY 2019-20	$51,564,815	$11,320,837	$225,303,588	$3,845,765	$745,259	$319,397	$3,655,317	$0	$36,908,058	$3,016,524	$18,170,121	$0	$0	$0	$35,487	$354,885,168

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%	100.00%	0.00%	541.32%	9.87%	0.00%	0.41%	100.00%	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%	100.00%	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%	100.00%	191.19%	116.79%	100.00%	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%
FY 2016-17	25.60%	-0.84%	10.57%	29.80%	24.64%	606.49%	41.23%	0.00%	24.75%	95.16%	7.32%	46.29%	100.00%	0.00%	0.00%	14.28%
Estimated FY 2017-18	12.11%	11.96%	12.08%	12.17%	10.39%	13.85%	11.74%	0.00%	12.11%	11.74%	12.16%	-100.00%	-100.00%	0.00%	100.00%	12.09%
Estimated FY 2018-19	6.62%	6.62%	6.62%	6.58%	6.62%	6.62%	6.62%	0.00%	6.62%	6.62%	6.62%	0.00%	0.00%	0.00%	6.62%	6.62%
Estimated FY 2019-20	8.52%	8.52%	8.49%	10.77%	8.52%	8.52%	8.52%	0.00%	8.52%	8.52%	8.52%	0.00%	0.00%	0.00%	8.52%	8.52%

Long-Term Home Health Per Capita Costs 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	$467.98	$689.35	$1,766.83	$0.00	$0.48	$0.00	$0.00	$13.73	$11.02	$0.00	$530.70	$0.00	$0.00	$0.00	$6.81	$286.36
FY 2009-10 (DA)	$473.36	$641.28	$1,902.62	$0.00	$0.59	$0.00	$0.00	$0.39	$11.38	$0.00	$557.91	$0.00	$0.00	$0.00	$6.15	$275.89
FY 2010-11 (DA)	$485.35	$686.66	$1,944.73	$0.00	$0.69	$0.28	$0.00	$2.02	$11.40	$0.00	$559.82	$0.02	$0.00	$0.00	$5.29	$263.18
FY 2011-12	$484.19	$711.02	$1,884.88	$0.00	$0.76	$0.60	$0.00	$0.34	$10.82	$0.00	$562.84	$0.05	$0.00	$0.00	$6.80	$243.92
FY 2012-13	$524.19	$780.36	$1,865.80	$415.25	$1.52	$0.12	$0.00	$1.35	$10.03	$0.00	$585.30	$0.21	$0.00	$0.00	$4.43	$232.26
FY 2013-14	$627.49	$815.07	$2,023.62	$514.38	$1.89	$0.40	$1.98	$4.38	$19.61	$9.64	$645.59	$0.09	$0.00	$0.00	$10.82	$216.64
FY 2014-15	$678.57	$870.86	$2,094.57	$536.53	$1.92	$0.97	$5.53	$0.00	$41.25	$14.48	$643.30	$0.46	$0.00	$0.00	$0.99	$183.07
FY 2015-16	$746.34	$837.06	$2,284.55	$359.88	$2.87	$0.39	$6.25	$0.00	$48.82	$20.09	$654.39	$0.64	$0.00	$0.00	$0.00	$184.61
FY 2016-17	$904.62	$777.43	$2,570.18	$464.58	$3.62	$2.40	$8.13	$0.00	$60.55	$35.93	$689.36	$1.01	$0.51	$0.00	$0.00	$203.27
Estimated FY 2017-18	$985.04	$837.61	$2,875.37	$417.04	$3.41	$3.03	$8.31	$0.00	$68.40	$37.91	$762.90	$0.00	$0.00	$0.00	$0.83	$218.82
Estimated FY 2018-19	$1,033.09	$856.74	$2,989.37	$381.57	$3.50	$3.00	$8.55	$0.00	$72.62	$38.67	$807.05	$0.00	$0.00	$0.00	$0.80	$226.48
Estimated FY 2019-20	$1,102.52	$890.56	$3,142.05	$370.93	$3.70	$3.12	$9.10	$0.00	$78.46	$40.52	$868.18	$0.00	$0.00	$0.00	$0.78	$240.53

Long-Term Home Health Per Capita Cost 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)	1.15%	-6.97%	7.69%	0.00%	22.92%	0.00%	0.00%	-97.16%	3.27%	0.00%	5.13%	0.00%	0.00%	0.00%	-9.69%	-3.66%
FY 2010-11 (DA)	2.53%	7.08%	2.21%	0.00%	16.95%	100.00%	0.00%	417.95%	0.18%	0.00%	0.34%	100.00%	0.00%	0.00%	-13.98%	-4.61%
FY 2011-12	-0.24%	3.55%	-3.08%	0.00%	10.14%	114.29%	0.00%	-83.17%	-5.09%	0.00%	0.54%	150.00%	0.00%	0.00%	28.54%	-7.32%
FY 2012-13	8.26%	9.75%	-1.01%	100.00%	100.00%	-80.00%	0.00%	297.06%	-7.30%	0.00%	3.99%	320.00%	0.00%	0.00%	-34.85%	-4.78%
FY 2013-14	19.71%	4.45%	8.46%	23.87%	24.34%	233.33%	100.00%	224.44%	95.51%	100.00%	10.30%	-57.14%	0.00%	0.00%	144.24%	-6.73%
FY 2014-15	8.14%	6.84%	3.51%	4.31%	1.59%	142.50%	179.29%	-100.00%	110.35%	50.21%	-0.35%	411.11%	0.00%	0.00%	-90.85%	-15.50%
FY 2015-16	9.99%	-3.88%	9.07%	-32.92%	49.48%	-59.79%	13.02%	0.00%	18.35%	38.74%	1.72%	39.13%	0.00%	0.00%	-100.00%	0.84%
FY 2016-17	21.21%	-7.12%	12.50%	29.09%	26.13%	515.38%	30.08%	0.00%	24.03%	78.85%	5.34%	57.81%	100.00%	0.00%	0.00%	10.11%
Estimated FY 2017-18	8.89%	7.74%	11.87%	-10.23%	-5.80%	26.25%	2.21%	0.00%	12.96%	5.51%	10.67%	-100.00%	-100.00%	0.00%	100.00%	7.65%
Estimated FY 2018-19	4.88%	2.28%	3.96%	-8.51%	2.64%	-0.99%	2.89%	0.00%	6.17%	2.00%	5.79%	0.00%	0.00%	0.00%	-3.61%	3.50%
Estimated FY 2019-20	6.72%	3.95%	5.11%	-2.79%	5.71%	4.00%	6.43%	0.00%	8.04%	4.78%	7.57%	0.00%	0.00%	0.00%	-2.50%	6.20%

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

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Telehealth[1]	Total
FY 2008-09	$3,338,322	$3,556,304	$3,153,526	$21,204,523	$58,782,570	$29,613,522	$3,727,926	$1,706,805	$0	$125,083,498
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	$73,088,478	$37,825,587	$5,154,767	$2,767,782	$516	$151,221,421
FY 2012-13	$3,971,740	$3,817,229	$3,511,343	$22,312,471	$77,554,316	$37,883,991	$6,436,658	$3,134,580	$8,204	$158,630,532
FY 2013-14	$5,478,336	$5,769,444	$5,772,910	$30,601,689	$89,319,042	$41,228,516	$6,162,682	$2,167,316	$15,260	$186,515,195
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	$10,558,321	$35,763,694	$115,697,949	$50,321,320	$8,713,140	$3,056,070	$6,742	$239,436,289
FY 2016-17	$8,294,295	$10,260,684	$14,162,396	$37,403,516	$131,321,353	$56,124,355	$9,172,852	$3,298,755	$6,742	$270,044,948
Estimated FY 2017-18	$9,840,503	$12,829,315	$18,160,896	$42,099,816	$145,863,915	$64,285,993	$9,898,009	$3,723,009	$9,733	$306,711,189
Estimated FY 2018-19	$10,719,474	$14,753,712	$20,150,108	$42,700,838	$154,545,323	$70,000,582	$10,084,098	$4,046,073	$12,551	$327,012,759
Estimated FY 2019-20	$11,677,750	$16,967,398	$22,363,361	$44,413,330	$166,779,858	$77,628,706	$10,547,155	$4,492,359	$15,251	$354,885,168

LTHH Percent Change in Cost Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Telehealth	Total
FY 2009-10 (DA)	2.11%	-2.48%	2.29%	2.76%	11.50%	16.12%	3.49%	13.43%	0.00%	10.02%
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%
FY 2016-17	17.11%	24.57%	34.13%	4.59%	13.50%	11.53%	5.28%	7.94%	0.00%	12.78%
Estimated FY 2017-18	18.64%	25.03%	28.23%	12.56%	11.07%	14.54%	7.91%	12.86%	44.36%	13.58%
Estimated FY 2018-19	8.93%	15.00%	10.95%	1.43%	5.95%	8.89%	1.88%	8.68%	28.95%	6.62%
Estimated FY 2019-20	8.94%	15.00%	10.98%	4.01%	7.92%	10.90%	4.59%	11.03%	21.51%	8.52%

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

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total[3]
FY 2008-09	526	606	484	2,348	2,395	1,566	183	96	4,769
FY 2009-10 (DA)	555	618	514	2,300	2,593	1,748	197	100	4,952
FY 2010-11 (DA)	556	630	538	2,457	2,802	1,899	214	117	5,309
FY 2011-12	596	637	530	2,558	2,938	2,009	271	137	5,586
FY 2012-13	655	691	556	2,723	3,093	2,132	368	152	5,933
FY 2013-14	913	1,015	899	3,092	3,324	2,285	339	116	6,862
FY 2014-15	1,080	1,249	1,352	3,235	3,644	2,581	393	142	7,693
FY 2015-16	1,176	1,451	1,616	3,317	3,869	2,734	414	155	8,290
FY 2016-17	1,366	1,774	2,192	3,372	4,201	3,023	426	174	9,290
Estimated FY 2017-18	1,489	2,040	2,675	3,450	4,419	3,284	443	188	9,941
Estimated FY 2018-19	1,622	2,346	2,968	3,528	4,648	3,569	459	205	10,579
Estimated FY 2019-20	1,767	2,698	3,294	3,607	4,889	3,878	476	223	11,258

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[3]
FY 2009-10 (DA)	5.51%	1.98%	6.20%	-2.04%	8.27%	11.62%	7.65%	4.17%	3.84%
FY 2010-11 (DA)	0.18%	1.94%	4.67%	6.83%	8.06%	8.64%	8.63%	17.00%	7.20%
FY 2011-12	7.19%	1.11%	-1.49%	4.11%	4.85%	5.79%	26.64%	17.09%	5.22%
FY 2012-13	9.90%	8.48%	4.91%	6.45%	5.28%	6.12%	35.79%	10.95%	6.21%
FY 2013-14	39.39%	46.89%	61.69%	13.55%	7.47%	7.18%	-7.88%	-23.68%	15.65%
FY 2014-15	18.29%	23.05%	50.39%	4.62%	9.63%	12.95%	15.93%	22.41%	12.11%
FY 2015-16	8.89%	16.17%	19.53%	2.53%	6.17%	5.93%	5.34%	9.15%	7.76%
FY 2016-17	16.16%	22.26%	35.64%	1.66%	8.58%	10.57%	2.90%	12.26%	12.06%
Estimated FY 2017-18	9.00%	14.99%	22.03%	2.31%	5.19%	8.63%	3.99%	8.05%	7.01%
Estimated FY 2018-19	8.93%	15.00%	10.95%	2.26%	5.18%	8.68%	3.61%	9.04%	6.42%
Estimated FY 2019-20	8.94%	15.00%	10.98%	2.24%	5.19%	8.66%	3.70%	8.78%	6.42%

LTHH Cost Per Utilizer Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2008-09	$6,346.62	$5,868.49	$6,515.55	$9,030.89	$24,543.87	$18,910.30	$20,371.18	$17,779.22	$26,226.62
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	$27,787.28
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	$27,798.44
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	$27,071.50
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	$26,736.23
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	$27,182.53
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	$27,633.18
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	$28,882.25
FY 2016-17	$6,071.96	$5,783.93	$6,460.95	$11,092.38	$31,259.55	$18,565.78	$21,532.52	$18,958.36	$29,069.39
Estimated FY 2017-18	$6,608.80	$6,288.88	$6,789.12	$12,202.85	$33,008.35	$19,575.52	$22,343.14	$19,803.24	$30,853.15
Estimated FY 2018-19	$6,608.80	$6,288.88	$6,789.12	$12,103.41	$33,249.85	$19,613.50	$21,969.71	$19,736.94	$30,911.50
Estimated FY 2019-20	$6,608.80	$6,288.88	$6,789.12	$12,313.09	$34,113.29	$20,017.72	$22,157.89	$20,145.11	$31,522.93

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

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day	Total
FY 2009-10 (DA)	-3.22%	-4.38%	-3.68%	4.90%	2.98%	4.03%	-3.87%	8.89%	5.95%
FY 2010-11 (DA)	2.16%	-2.41%	2.58%	-4.36%	0.56%	-0.55%	0.63%	2.71%	0.04%
FY 2011-12	-3.03%	-1.24%	-1.11%	-5.34%	-2.13%	-3.76%	-3.47%	1.60%	-2.62%
FY 2012-13	-0.35%	2.13%	-0.80%	-4.46%	0.79%	-5.62%	-8.05%	2.08%	-1.24%
FY 2013-14	-1.04%	2.90%	1.68%	20.78%	7.17%	1.54%	3.93%	-9.40%	1.67%
FY 2014-15	-0.84%	-0.35%	2.62%	3.49%	1.93%	0.38%	7.77%	4.03%	1.66%
FY 2015-16	1.21%	0.22%	-0.86%	5.27%	9.18%	1.62%	7.42%	1.44%	4.52%
FY 2016-17	0.82%	1.89%	-1.11%	2.88%	4.53%	0.87%	2.31%	-3.85%	0.65%
Estimated FY 2017-18	8.84%	8.73%	5.08%	10.01%	5.59%	5.44%	3.76%	4.46%	6.14%
Estimated FY 2018-19	0.00%	0.00%	0.00%	-0.81%	0.73%	0.19%	-1.67%	-0.33%	0.19%
Estimated FY 2019-20	0.00%	0.00%	0.00%	1.73%	2.60%	2.06%	0.86%	2.07%	1.98%

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

LTHH Units Per Utilizer Per Service Per Fiscal Year

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day
FY 2008-09	61	56	57	91	710	1,829	294	366
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
FY 2016-17	55	52	52	109	864	1,724	301	377
Estimated FY 2017-18	55	52	52	110	880	1,746	301	381
Estimated FY 2018-19	55	52	52	111	896	1,768	301	386
Estimated FY 2019-20	55	52	52	112	912	1,791	301	391

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

LONG-TERM HOME HEALTH	Physical Therapy (for 0-21 years LTHH)	Occupational Therapy (for 0-21 years LTHH)	Speech and Language Therapy (for 0-21 years LTHH)	Registered Nursing/Licensed Practical Nurse	Home Health Aid Basic	Home Health Aid Extended	Registered Nursing Brief First Visit of Day	Registered Nursing Brief Second or More Visit of Day
FY 2009-10 (DA)	-1.64%	-5.36%	-1.75%	5.49%	1.97%	2.68%	-3.40%	9.02%
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%
FY 2016-17	1.85%	1.96%	-3.70%	4.81%	6.27%	2.68%	3.44%	-3.08%
Estimated FY 2017-18	0.00%	0.00%	0.00%	0.92%	1.85%	1.28%	0.00%	1.06%
Estimated FY 2018-19	0.00%	0.00%	0.00%	0.91%	1.82%	1.26%	0.00%	1.31%
Estimated FY 2019-20	0.00%	0.00%	0.00%	0.90%	1.79%	1.30%	0.00%	1.30%

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	Telehealth	Total
FY 2016-17 Average Utilizers Per Month[4]	1,366	1,774	2,192	3,372	4,201	3,023	426	174	N/A	9,290
Utilizer Trend Selected[5]	8.98%	15.02%	22.04%	2.30%	5.18%	8.65%	4.10%	8.00%	N/A	7.02%
FY 2017-18 Estimated Average Utilizers Per Month	1,489	2,040	2,675	3,450	4,419	3,284	443	188	N/A	9,941
Bottom Line Impacts										
Total Bottom Line Impacts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**N/A**	**0**
FY 2017-18 Estimated Average Utilizers Per Month	**1,489**	**2,040**	**2,675**	**3,450**	**4,419**	**3,284**	**443**	**188**	**N/A**	**9,941**
FY 2016-17 Average Units Per Utilizer Per Year[4]	55	52	52	109	864	1,724	301	377	N/A	
Percentage Selected to Modify Units Per Utilizer[6]	0.00%	0.00%	0.00%	0.95%	1.82%	1.29%	0.00%	1.07%	N/A	
FY 2017-18 Estimated Average Units Per Utilizer	**55**	**52**	**52**	**110**	**880**	**1,746**	**301**	**381**	**N/A**	
FY 2016-17 Average Paid Rate Per Unit	$111.22	$111.86	$121.68	$103.21	$36.80	$10.80	$72.36	$50.63	N/A	
Unit Average Paid Rate Trend Selected	8.04%	8.12%	7.30%	6.45%	1.58%	3.40%	1.66%	1.70%	N/A	
FY 2017-18 Average Paid Rate Per Unit	**$120.16**	**$120.94**	**$130.56**	**$109.86**	**$37.38**	**$11.17**	**$73.56**	**$51.49**	**N/A**	
Estimated FY 2017-18 Base Expenditure	**$9,840,503**	**$12,829,315**	**$18,160,896**	**$41,691,870**	**$145,360,354**	**$64,047,261**	**$9,808,711**	**$3,688,126**	**$6,742**	**$305,433,778**
Bottom Line Impacts										
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$0	$0	$0	$1,005	$3,517	$1,499	$247	$88	$0	$6,356
Colorado Choice Transitions	$0	$0	$0	$91,344	$320,688	$137,073	$22,430	$8,056	$0	$579,591
Telehealth Expenditure Adjustment[7]	$0	$0	$0	$0	$0	$0	$0	$0	$2,991	$2,991
Annualization of FY 2015-16 R-7 "Participant Directed Programs Expansion"	$0	$0	$0	($131,635)	($462,143)	($197,536)	($32,324)	($11,610)	$0	($835,249)
SB 17-091 Allow Medicaid Home Health Services in the Community	$0	$0	$0	$447,232	$641,500	$297,696	$98,945	$38,348	$0	$1,523,721
Total Bottom Line Impacts	$0	$0	$0	$407,946	$503,561	$238,732	$89,298	$34,883	$2,991	$1,277,411
Estimated FY 2017-18 Expenditure	**$9,840,503**	**$12,829,315**	**$18,160,896**	**$42,099,816**	**$145,863,915**	**$64,285,993**	**$9,898,009**	**$3,723,009**	**$9,733**	**$306,711,189**
Estimated FY 2017-18 Per Utilizer Cost	$6,608.80	$6,288.88	$6,789.12	$12,202.85	$33,008.35	$19,575.52	$22,343.14	$19,803.24	N/A	$30,853.15
% Change Over FY 2016-17 Per Utilizer Cost	8.84%	8.73%	5.08%	10.01%	5.59%	5.44%	3.76%	4.46%	N/A	6.14%

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	Telehealth	Total
FY 2017-18 Estimated Average Utilizers Per Month	1,489	2,040	2,675	3,450	4,419	3,284	443	188	N/A	9,941
Utilizer Trend Selected[5]	8.91%	15.02%	10.97%	2.25%	5.18%	8.67%	3.72%	8.99%	N/A	6.42%
FY 2018-19 Estimated Average Utilizers Per Month	1,622	2,346	2,968	3,528	4,648	3,569	459	205	N/A	10,579
Bottom Line Impacts										
Total Bottom Line Impacts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**N/A**	**0**
FY 2018-19 Estimated Average Utilizers Per Month	**1,622**	**2,346**	**2,968**	**3,528**	**4,648**	**3,569**	**459**	**205**	**N/A**	**10,579**
FY 2017-18 Average Units Per Utilizer Per Year	55	52	52	110	880	1,746	301	381	N/A	
Percentage Selected to Modify Units Per Utilizer[6]	0.00%	0.00%	0.00%	0.94%	1.82%	1.29%	0.00%	1.32%	N/A	
FY 2018-19 Estimated Average Units Per Utilizer	**55**	**52**	**52**	**111**	**896**	**1,768**	**301**	**386**	**N/A**	
FY 2017-18 Average Paid Rate Per Unit	$120.16	$120.94	$130.56	$109.86	$37.38	$11.17	$73.56	$51.49	N/A	
Adjustment to Increase Average Paid Rate to Actual Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	
FY 2018-19 Average Paid Rate Per Unit	**$120.16**	**$120.94**	**$130.56**	**$109.86**	**$37.38**	**$11.17**	**$73.56**	**$51.49**	**N/A**	
Estimated FY 2018-19 Base Expenditure	**$10,719,474**	**$14,753,712**	**$20,150,108**	**$43,022,055**	**$155,673,047**	**$70,482,611**	**$10,162,976**	**$4,074,404**	**$9,733**	**$329,048,120**
Bottom Line Impacts										
HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$0	$0	$0	$882	$3,097	$1,324	$217	$78	$0	$5,597
Colorado Choice Transitions	$0	$0	$0	$87,367	$306,726	$131,106	$21,454	$7,706	$0	$554,358
Telehealth Expenditure Adjustment[7]	$0	$0	$0	$0	$0	$0	$0	$0	$2,818	$2,818
Annualization of FY 2015-16 R#7 "Participant Directed Programs Expansion"	$0	$0	$0	($448,550)	($1,574,762)	($673,109)	($110,145)	($39,561)	$0	($2,846,127)
SB 17-091 Allow Medicaid Home Health Services in the Community	$0	$0	$0	$39,084	$137,215	$58,650	$9,597	$3,447	$0	$247,993
Total Bottom Line Impacts	$0	$0	$0	($321,217)	($1,127,724)	($482,029)	($78,878)	($28,331)	$2,818	($2,035,361)
Estimated FY 2018-19 Expenditure	**$10,719,474**	**$14,753,712**	**$20,150,108**	**$42,700,838**	**$154,545,323**	**$70,000,582**	**$10,084,098**	**$4,046,073**	**$12,551**	**$327,012,759**
Estimated FY 2018-19 Per Utilizer Cost	$6,608.80	$6,288.88	$6,789.12	$12,103.41	$33,249.85	$19,613.50	$21,969.71	$19,736.94	N/A	$30,911.50
% Change Over FY 2017-18 Per Utilizer Cost	0.00%	0.00%	0.00%	-0.81%	0.73%	0.19%	-1.67%	-0.33%	N/A	0.19%

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**	**Telehealth**	**Total**
FY 2018-19 Estimated Average Utilizers Per Month	1,622	2,346	2,968	3,528	4,648	3,569	459	205	N/A	10,579
Utilizer Trend Selected[5]	8.91%	15.02%	10.97%	2.25%	5.18%	8.67%	3.72%	8.99%	N/A	6.42%
FY 2019-20 Estimated Average Utilizers Per Month	1,767	2,698	3,294	3,607	4,889	3,878	476	223	N/A	11,258
Bottom Line Impacts										
Total Bottom Line Impacts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**N/A**	**0**
FY 2019-20 Estimated Average Utilizers Per Month	**1,767**	**2,698**	**3,294**	**3,607**	**4,889**	**3,878**	**476**	**223**	**N/A**	**11,258**
FY 2018-19 Average Units Per Utilizer Per Year	55	52	52	111	896	1,768	301	386	N/A	
Percentage Selected to Modify Units Per Utilizer[6]	0.00%	0.00%	0.00%	0.94%	1.82%	1.29%	0.00%	1.32%	N/A	
FY 2019-20 Estimated Average Units Per Utilizer	**55**	**52**	**52**	**112**	**912**	**1,791**	**301**	**391**	**N/A**	
FY 2018-19 Average Paid Rate Per Unit	$120.16	$120.94	$130.56	$109.86	$37.38	$11.17	$73.56	$51.49	N/A	
Unit Paid Rate Trend Selected	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	
FY 2019-20 Average Paid Rate Per Unit	**$120.16**	**$120.94**	**$130.56**	**$109.86**	**$37.38**	**$11.17**	**$73.56**	**$51.49**	**N/A**	
Estimated FY 2019-20 Base Expenditure	**$11,677,750**	**$16,967,398**	**$22,363,361**	**$44,381,682**	**$166,668,748**	**$77,581,213**	**$10,539,383**	**$4,489,568**	**$12,551**	**$354,681,654**
Bottom Line Impacts										
Colorado Choice Transitions	$0	$0	$0	$13,236	$46,467	$19,862	$3,250	$1,167	$0	$83,982
Telehealth Expenditure Adjustment[7]	$0	$0	$0	$0	$0	$0	$0	$0	$2,700	$2,700
SB 17-091 Allow Medicaid Home Health Services in the Community	$0	$0	$0	$18,413	$64,643	$27,631	$4,521	$1,624	$0	$116,832
Total Bottom Line Impacts	$0	$0	$0	$31,648	$111,110	$47,493	$7,772	$2,791	$2,700	$203,514
Estimated FY 2019-20 Expenditure	**$11,677,750**	**$16,967,398**	**$22,363,361**	**$44,413,330**	**$166,779,858**	**$77,628,706**	**$10,547,155**	**$4,492,359**	**$15,251**	**$354,885,168**
Estimated FY 2019-20 Per Utilizer Cost	$6,608.80	$6,288.88	$6,789.12	$12,313.09	$34,113.29	$20,017.72	$22,157.89	$20,145.11	N/A	$31,522.93
% Change Over FY 2018-19 Per Utilizer Cost	0.00%	0.00%	0.00%	1.73%	2.60%	2.06%	0.86%	2.07%	N/A	1.98%

(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 does not reflect the sum of the services but rather the total Average Utilizers Per Month for LTHH as a benefit.

(4) Due to data irregularities in the months of March and April of 2017 this average estimate is an average based on the 10 months from FY 2016-17 that were not affected by data irregularities.

(5) Percentages Selected to Modify Utilizers for FY 2017-18 through FY 2019-20	Physical Therapy (for 0-21 years LTHH)	8.98%, 8.91%, 8.91%	Registered Nursing/Licensed Practical Nurse	2.30%, 2.25%, 2.25%	Registered Nursing Brief First Visit of Day	4.10%, 3.72%, 3.72%
	Occupational Therapy (for 0-21 years LTHH)	15.02%, 15.02%, 15.02%	Home Health Aid Basic	5.18%, 5.18%, 5.18%	Registered Nursing Brief Second or More Visit of Day	8.00%, 8.99%, 8.99%
	Speech and Language Therapy (for 0-21 years LTHH)	22.04%, 10.97%, 10.97%	Home Health Aid Extended	8.65%, 8.67%, 8.67%		
(6) Percentages Selected to Modify Units Per Utilizer for FY 2017-18 through FY 2019-20	Physical Therapy (for 0-21 years LTHH)	0.00%, 0.00%, 0.00%	Registered Nursing/Licensed Practical Nurse	0.95%, 0.94%, 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	1.82%, 1.82%, 1.82%	Registered Nursing Brief Second or More Visit of Day	1.07%, 1.32%, 1.32%
	Speech and Language Therapy (for 0-21 years LTHH)	0.00%, 0.00%, 0.00%	Home Health Aid Extended	1.29%, 1.29%, 1.29%		

(7) Due to small cell sizes that prevent the Telehealth forecast from using the same methodology as the other LTHH services, expenditure for Telehealth is adjusted via bottom line impact. See (1) for more information.

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

FY 2017-18 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	84	15	69		84 expected - 17.84% are expected to be enrolled on Division of Intellectual and Developmental Disabilities (DIDD) waivers under CCT
B	Estimated Demonstration Service Per Enrollee Annual Cost	$10,716	$4,858	$11,989		
C	**Estimated Demonstration Service Total Cost**	**$900,111**	**$72,870**	**$827,241**	**Row A * Row B**	**Demonstration expenses for all clients are paid in the Medical Services Premiums (MSP) line.**
D	Estimated Qualified Service Per Enrollee Annual Cost	$28,986	$65,807	$20,981		All expenditure has an effect on MSP, even clients enrolled on DIDD waivers while in CCT
E	**Estimated Qualified Service Total Cost**	**$2,434,794**	**$987,105**	**$1,447,689**	**Row A * Row D**	**DIDD Waiver Expenditure hits Long Bill Group 5 after 365 days in CCT program for DIDD clients**
F	Estimated Long-Term Home Health Per Enrollee Annual Cost	$6,900	$96	$8,379		
G	**Estimated Long-Term Home Health Total Cost**	**$579,591**	**$1,440**	**$578,151**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$3,914,496**	**$1,061,415**	**$2,853,081**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$833,727**	**$264,994**	**$568,733**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions (1)	325	42	283		Cumulative, 96% of new transitions are expected to complete transitioning
K	Estimated HCBS Service Per Enrollee Annual Cost	$25,445	$73,259	$18,351		New waiver expenditure for clients successfully transitioned into an HCBS waiver - This effects both MSP and DIDD
L	**Estimated Non CCT HCBS Service Costs Total (MSP)**	**$5,194,790**	**$0**	**$5,194,790**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DIDD)**	**$3,076,894**	**$3,076,894**	**$0**	**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per Full-Time Equivalent (FTE) Annual Cost		($68,507)	($68,507)		All from Exhibit H
O	**Estimated Nursing Facility Total Cost Avoided - For Informational Purposes Only**	**($27,065,687)**	**($2,945,795)**	**($24,119,892)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from skilled nursing facilities**
P	**Total Cost Avoidance - For Informational Purposes Only**	**($27,065,687)**	**($2,945,795)**	**($24,119,892)**	**Row O**	
Q	**Estimated Total Budget Impact - For Informational Purposes Only**	**($14,879,507)**	**$1,192,514**	**($16,072,021)**	**Row H + Row L + Row M + Row P**	
R	**CBLTC Bottom Line Adjustment**	**$3,334,905**	**$1,059,975**	**$2,274,930**	**Row C + Row E**	**Bottom Line Impact in CBLTC**
S	**DIDD Bottom Line Adjustment**	**$3,076,894**	**$3,076,894**	**N/A**	**Row M**	**Bottom Line Impact in DIDD**
T	**LTHH Bottom Line Adjustment**	**$579,591**	**$1,440**	**$578,151**	**Row G**	**Bottom Line Impact in LTHH**
U	*Estimated Rebalancing Fund Balance*	*$2,588,613*	*$264,994*	*$568,733*	*Row I + FY 2017-18 Row W*	*Off budget balance - non appropriated line item*

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

Exhibit G - COMMUNITY BASED LONG-TERM CARE - COLORADO CHOICE TRANSITIONS
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	80	14	66		80 expected - 17.84% are expected to be enrolled on Division of Intellectual and Developmental Disabilities (DIDD) waivers under CCT
B	Estimated Demonstration Service Per Enrollee Annual Cost	$11,981	$4,858	$13,492		
C	**Estimated Demonstration Service Total Cost**	**$958,484**	**$68,012**	**$890,472**	**Row A * Row B**	**Demonstration expenses for all clients are paid in the Medical Services Premiums (MSP) line.**
D	Estimated Qualified Service Per Enrollee Annual Cost	$29,686	$68,092	$21,539		All expenditure has an effect on MSP, even clients enrolled on DIDD waivers while in CCT
E	**Estimated Qualified Service Total Cost**	**$2,374,862**	**$953,288**	**$1,421,574**	**Row A * Row D**	**DIDD Waiver Expenditure hits Long Bill Group 5 after 365 days in CCT program for DIDD clients**
F	Estimated Long-Term Home Health Per Enrollee Annual Cost	$6,929.48	$96.00	$8,379.00		
G	**Estimated Long-Term Home Health Total Cost**	**$554,358**	**$1,344**	**$553,014**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$3,887,704**	**$1,022,644**	**$2,865,060**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$833,337**	**$255,325**	**$578,012**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions [1]	406	53	353		Cumulative, 96% of new transitions are expected to complete transitioning
K	Estimated HCBS Service Per Enrollee Annual Cost	$25,916	$72,159	$18,968		New waiver expenditure for clients successfully transitioned into an HCBS waiver - This effects both MSP and DIDD
L	**Estimated Non CCT HCBS Service Costs Total (MSP)**	**$6,690,291**	**$0**	**$6,690,291**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DIDD)**	**$3,824,412**	**$3,824,412**	**$0**	**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per FTE Annual Cost		($70,562)	($70,562)		All from Exhibit H
O	**Estimated Nursing Facility Total Cost Avoided - For Informational Purposes Only**	**($33,073,727)**	**($3,528,090)**	**($29,545,637)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from skilled nursing facilities**
P	**Total Cost Avoidance - For Informational Purposes Only**	**($33,073,727)**	**($3,528,090)**	**($29,545,637)**	**Row O**	
Q	**Estimated Total Budget Impact - For Informational Purposes Only**	**($18,671,320)**	**$1,318,966**	**($19,990,286)**	**Row H + Row L + Row M + Row P**	
R	**CBLTC Bottom Line Adjustment**	**$3,333,346**	**$1,021,300**	**$2,312,046**	**Row C + Row E**	**Bottom Line Impact in CBLTC**
S	**DIDD Bottom Line Adjustment**	**$3,824,412**	**$3,824,412**	**N/A**	**Row M**	**Bottom Line Impact in DIDD**
T	**LTHH Bottom Line Adjustment**	**$554,358**	**$1,344**	**$553,014**	**Row G**	**Bottom Line Impact in LTHH**
U	*Estimated Rebalancing Fund Balance*	*$3,421,950*	*$255,325*	*$578,012*	*Row I + FY 2017-18 Row W*	*Off budget balance - non appropriated line item*

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

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

FY 2019-20 Colorado Choice Transitions Budget Impact[2]						
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	12	2	10		12 expected - 17.84% are expected to be enrolled on Division of Intellectual and Developmental Disabilities (DIDD) waivers under CCT
B	Estimated Demonstration Service Per Enrollee Annual Cost	$12,053	$4,858	$13,492		
C	**Estimated Demonstration Service Total Cost**	**$144,636**	**$9,716**	**$134,920**	**Row A * Row B**	**Demonstration expenses for all clients are paid in the Medical Services Premiums (MSP) line.**
D	Estimated Qualified Service Per Enrollee Annual Cost	$29,298	$68,092	$21,539		All expenditure has an effect on MSP, even clients enrolled on DIDD waivers while in CCT
E	**Estimated Qualified Service Total Cost**	**$351,574**	**$136,184**	**$215,390**	**Row A * Row D**	**DIDD Waiver Expenditure hits Long Bill Group 5 after 365 days in CCT program for DIDD clients**
F	Estimated Long-Term Home Health Per Enrollee Annual Cost	$6,999	$96	$8,379		
G	**Estimated Long-Term Home Health Total Cost**	**$83,982**	**$192**	**$83,790**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$580,192**	**$146,092**	**$434,100**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$124,053**	**$36,475**	**$87,578**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions [1]	483	62	421		Cumulative, 96% of new transitions are expected to complete transitioning
K	Estimated HCBS Service Per Enrollee Annual Cost	$26,419	$72,159	$19,676		New waiver expenditure for clients successfully transitioned into an HCBS waiver - This effects both MSP and DIDD
L	**Estimated Non CCT HCBS Service Costs Total (MSP)**	**$8,273,941**	**$0**	**$8,273,941**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DIDD)**	**$4,473,840**	**$4,473,840**	**$0**	**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per FTE Annual Cost		($72,679)	($72,679)		All from Exhibit H
O	**Estimated Nursing Facility Total Cost Avoided - For Informational Purposes Only**	**($34,778,259)**	**($3,488,582)**	**($31,289,677)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from skilled nursing facilities**
P	**Total Cost Avoidance - For Informational Purposes Only**	**($34,778,259)**	**($3,488,582)**	**($31,289,677)**	**Row O**	
Q	**Estimated Total Budget Impact - For Informational Purposes Only**	**($21,450,286)**	**$1,131,350**	**($22,581,636)**	**Row H + Row L + Row M + Row P**	
R	**CBLTC Bottom Line Adjustment**	**$496,210**	**$145,900**	**$350,310**	**Row C + Row E**	**Bottom Line Impact in CBLTC**
S	**DIDD Bottom Line Adjustment**	**$4,473,840**	**$4,473,840**	**N/A**	**Row M**	**Bottom Line Impact in DIDD**
T	**LTHH Bottom Line Adjustment**	**$83,982**	**$192**	**$83,790**	**Row G**	**Bottom Line Impact in LTHH**
U	*Estimated Rebalancing Fund Balance*	*$3,546,003*	*$36,475*	*$87,578*	*Row I + FY 2017-18 Row W*	*Off budget balance - non appropriated line item*

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

(2) The CCT Grant expires after December 31st 2020

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HOSPICE

Hospice Calculations for FY 2017-18, FY 2018-19, FY 2019-20

FY 2017-18 Calculation

Nursing Facility Room and Board		
Service Expenditure:	Core Components	Reference
Estimate of FY 2017-18 Per Diem Rate	$179.30	Footnote 1
Estimate of Patient Days	236,604	Footnote 2
Total Estimated Costs for FY 2017-18 Days of Service	$42,423,097	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	89.08%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$37,790,495	
Estimated Expenditure for FY 2016-17 Dates of Service	$4,249,829	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2017-18 Prior to Adjustments	**$42,040,324**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2016-17 and paid in FY 2017-18 under HB 13-1152	($64,697)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($566,963)	Footnote 6
Total Bottom Line Adjustments:	**($631,660)**	
Total Estimated Nursing Facility Room and Board FY 2017-18 Total Fund Expenditure	**$41,408,664**	
Percentage Change in Core Component Expenditure Over Prior Year	10.63%	

Hospice Services		
Service Expenditure:	Core Components	Reference
Hospice Routine Home Care	$12,285,800	Footnote 7
Hospice General Inpatient	$2,395,655	Footnote 7
Other Services	$222,870	Footnote 7
Estimated Hospice Services Expenditure in FY 2017-18 Prior to Adjustments	**$14,904,325**	
Bottom Line Adjustments:		
FY 2017-18 1.402% Across the Board Rate Increase	$139,306	See narrative
Total Bottom Line Adjustments:	**$139,306**	
Total Estimated Hospice Services FY 2017-18 Total Fund Expenditure	**$15,043,631**	
Percentage Change in Expenditure Over Prior Year	4.11%	
Total Estimated FY 2017-18 Expenditure	**$56,452,295**	

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	$184.68	Footnote 1
Estimate of Patient Days	238,877	Footnote 2
Total Estimated Costs for FY 2018-19 Days of Service	$44,115,804	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	89.08%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$39,298,358	
Estimated Expenditure for FY 2017-18 Dates of Service	$4,632,602	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2018-19 Prior to Adjustments	**$43,930,960**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2017-18 and paid in FY 2018-19 under HB 13-1152	($69,502)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($589,434)	Footnote 6
Total Bottom Line Adjustments:	**($658,936)**	
Total Estimated Nursing Facility Room and Board FY 2018-19 Total Fund Expenditure	**$43,272,024**	
Percentage Change in Core Component Expenditure Over Prior Year	4.50%	
Hospice Services		
Service Expenditure:	**Core Components**	**Reference**
Hospice Routine Home Care	$12,656,556	Footnote 7
Hospice General Inpatient	$2,486,990	Footnote 7
Other Services	$222,870	Footnote 7
Estimated Hospice Services Expenditure in FY 2018-19 Prior to Adjustments	**$15,366,416**	
Bottom Line Adjustments:		
FY 2017-18 1.402% Across the Board Rate Increase	$69,653	See narrative
Total Bottom Line Adjustments:	**$69,653**	
Total Estimated Hospice Services FY 2018-19 Total Fund Expenditure	**$15,436,069**	
Percentage Change in Expenditure Over Prior Year	2.61%	
Total Estimated FY 2018-19 Expenditure	**$58,708,093**	

Exhibit G - COMMUNITY BASED LONG-TERM CARE - HOSPICE

FY 2019-20 Calculation		
Nursing Facility Room and Board		
Service Expenditure:	**Core Components**	**Reference**
Estimate of FY 2019-20 Per Diem Rate	$190.22	Footnote 1
Estimate of Patient Days	241,831	Footnote 2
Total Estimated Costs for FY 2019-20 Days of Service	$46,001,093	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	89.08%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$40,977,774	
Estimated Expenditure for FY 2018-19 Dates of Service	$4,817,446	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2019-20 Prior to Adjustments	**$45,795,220**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2018-19 and paid in FY 2019-20 under HB 13-1152	($72,255)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($613,956)	Footnote 6
Total Bottom Line Adjustments:	**($686,211)**	
Total Estimated Nursing Facility Room and Board FY 2019-20 Total Fund Expenditure	**$45,109,009**	
Percentage Change in Core Component Expenditure Over Prior Year	4.25%	
Hospice Services		
Service Expenditure:	**Core Components**	**Reference**
Hospice Routine Home Care	$13,038,501	Footnote 7
Hospice General Inpatient	$2,581,807	Footnote 7
Other Services	$222,870	Footnote 7
Estimated Hospice Services Expenditure in FY 2019-20 Prior to Adjustments	**$15,843,178**	
Bottom Line Adjustments:		
Total Bottom Line Adjustments:	**$0**	
Total Estimated Hospice Services FY 2019-20 Total Fund Expenditure	**$15,843,178**	
Percentage Change in Expenditure Over Prior Year	2.64%	
Total Estimated FY 2019-20 Expenditure	**$60,952,187**	

Hospice Nursing Facility Room and Board FY 2017-18 , FY 2018-19 and FY 2019-20 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 2017-18, FY 2018-19, and FY 2019-20 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 2017-18, FY 2018-19, and FY 2019-20 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 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	$163.39	3.00%	1.50%	$165.88	3.40%
FY 2016-17	$171.47	3.00%	1.50%	$174.08	4.94%
Estimated FY 2017-18	$176.61	3.00%	1.50%	$179.30	3.00%
Estimated FY 2018-19	$181.91	3.00%	1.50%	$184.68	3.00%
Estimated FY 2019-20	$187.37	3.00%	1.50%	$190.22	3.00%

(2) The Department estimated patient days based on FY 2015-16 actuals. These trends were dampened in FY 2018-19 and FY 2019-20 with the assumption that patient days would level off.

Fiscal Year	Patient Days	Percentage Change	Full Time Equivalent	Percentage Change
FY 2008-09	234,364	-	642	-
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	226,999	3.35%	620	2.99%
FY 2016-17	226,967	-0.01%	622	0.32%
Estimated FY 2017-18	236,604	4.25%	648	4.18%
Estimated FY 2018-19	238,877	0.96%	654	0.93%
Estimated FY 2019-20	241,831	1.24%	661	1.07%

(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 2017 has 11 more months to pay during FY 2017-18 (from August 2017 to June 2018), while a claim incurred in May 2018 only has one additional month to pay during FY 2017-18 (June 2018). Thus, more claims from May 2018 will pay in FY 2018-19 than claims from July 2017. 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	99.99%
August	10	99.97%
September	9	99.91%
October	8	99.89%
November	7	99.68%
December	6	99.36%
January	5	98.88%
February	4	98.21%
March	3	96.50%
April	2	92.76%
May	1	83.85%
June	0	0.00%
Average		89.08%

(5) As calculated in the table below, the estimated FY 2017-18 expenditure for core components with FY 2016-17 dates of service is the estimated FY 2016-17 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 2016-17	Source
IBNR Factor	89.08%	Footnote (4)
Estimated Patient Days from previous fiscal year	226,967	Footnote (2)
Estimated Per Diem Rate for Core Components for previous fiscal year	$171.47	Footnote (1)
Estimated claims expenditure for core components from previous fiscal year to be paid in the current fiscal year	$4,249,829	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 2017-18, FY 2018-19, and FY 2019-20 are accounted for here.

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%	$174.08	$171.47	($2.61)
Estimated FY 2016-17 Patient Days				226,999
Estimated FY 2016-17 Days Paid in FY 2016-17				202,211
Total FY 2016-17 Impact				**($527,771)**
Estimated FY 2016-17 Days Paid in FY 2017-18				24,788
FY 2017-18 Impact from Carryover from FY 2016-17				($64,697)
Estimated FY 2017-18 Rates	1.50%	$179.30	$176.61	($2.69)
Estimated FY 2017-18 Patient Days				236,604
Estimated FY 2017-18 Days Paid in FY 2017-18				210,767
FY 2017-18 Impact from FY 2017-18				($566,963)
Total FY 2017-18 Impact				**($631,660)**
Estimated FY 2017-18 Days Paid in FY 2018-19				25,837
FY 2018-19 Impact from Carryover from FY 2017-18				($69,502)
Estimated FY 2018-19 Rates	1.50%	$184.68	$181.91	($2.77)
Estimated FY 2018-19 Patient Days				238,877
Estimated FY 2018-19 Days Paid in FY 2018-19				212,792
FY 2018-19 Impact from FY 2018-19				($589,434)
Total FY 2018-19 Impact				**($658,936)**
Estimated FY 2018-19 Days Paid in FY 2019-20				26,085
FY 2019-20 Impact from Carryover from FY 2018-19				($72,255)
Estimated FY 2019-20 Rates	1.50%	$190.22	$187.37	($2.85)
Estimated FY 2019-20 Patient Days				241,831
Estimated FY 2019-20 Days Paid in FY 2019-20				215,423
FY 2019-20 Impact from FY 2019-20				($613,956)
Total FY 2019-20 Impact				**($686,211)**

(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 2017-18, FY 2018-19, and FY 2019-20. FY 2017-18 HRHC patient days are estimated by trending forward updated FY 2016-17 patient days by 2.0%, while FY 2018-19 and FY 2019-20 patient days are estimated by trending forward the previous year's patient days estimate by 1.0%. HRHC rates are estimated by trending forward rates in the second half of FY 2015-16 by averages of previous CMS rate increases. Hospice general inpatient expenditure estimates are produced by assuming similar utilization and a 3.81% increase in aggregate rates in FY 2018-19 and FY 2019-20. Estimates for the remaining service categories are based on FY 2016-17 actuals of $193,083.

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 2008-09	$31,767,623	$2,005,681	$5,941,976	$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
FY 2016-17	$40,464,888	$3,047,499	$5,646,291	$231,548	$352,449	$197,716	$3,656,340	$28,585	$141,542	$7,016	$5,060	$5,814	$10,115	$156,497	$0	$53,951,360
Estimated FY 2017-18	$41,928,023	$3,313,583	$5,918,861	$302,745	$432,071	$186,793	$4,180,601	$11,863	$146,976	$7,774	$5,366	$5,223	$12,416	$0	$0	$56,452,295
Estimated FY 2018-19	$43,061,459	$3,592,021	$6,312,569	$366,759	$467,534	$209,177	$4,506,118	$6,538	$153,505	$8,451	$5,624	$5,431	$12,907	$0	$0	$58,708,093
Estimated FY 2019-20	$44,164,513	$3,893,493	$6,764,519	$433,884	$498,415	$226,295	$4,771,049	$6,678	$160,075	$9,087	$5,890	$5,416	$12,873	$0	$0	$60,952,187

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 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%	100.00%	-88.94%	9.36%
FY 2010-11 (DA)	-11.14%	-30.50%	12.65%	0.00%	12.10%	100.00%	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%	100.00%	-50.07%	71.80%	100.00%	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%	100.00%	34.78%	100.00%	100.00%	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%	100.00%	0.00%	7.86%
FY 2016-17	9.34%	-16.33%	-13.60%	-15.40%	22.00%	122.53%	8.57%	61.60%	1.34%	100.00%	359.17%	100.00%	100.00%	5921.43%	0.00%	5.03%
Estimated FY 2017-18	3.62%	8.73%	4.83%	30.75%	22.59%	-5.52%	14.34%	-58.50%	3.84%	10.80%	6.05%	-10.17%	22.75%	-100.00%	0.00%	4.64%
Estimated FY 2018-19	2.70%	8.40%	6.65%	21.14%	8.21%	11.98%	7.79%	-44.89%	4.44%	8.71%	4.81%	3.98%	3.95%	0.00%	0.00%	4.00%
Estimated FY 2019-20	2.56%	8.39%	7.16%	18.30%	6.61%	8.18%	5.88%	2.14%	4.28%	7.53%	4.73%	-0.28%	-0.26%	0.00%	0.00%	3.82%

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	$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
FY 2016-17	$920.89	$271.11	$83.50	$37.04	$2.19	$1.96	$10.51	$96.90	$0.30	$0.11	$0.25	$0.44	$5.02	$59.28	$0.00	$40.08
Estimated FY 2017-18	$926.75	$283.67	$87.37	$38.76	$2.29	$2.05	$11.00	$101.39	$0.32	$0.11	$0.26	$0.46	$5.25	$0.00	$0.00	$40.27
Estimated FY 2018-19	$936.26	$295.01	$90.86	$40.31	$2.38	$2.13	$11.44	$105.45	$0.33	$0.12	$0.27	$0.48	$5.46	$0.00	$0.00	$40.66
Estimated FY 2019-20	$944.29	$306.28	$94.34	$41.85	$2.47	$2.21	$11.88	$109.48	$0.34	$0.12	$0.28	$0.47	$5.45	$0.00	$0.00	$41.31

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 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%	100.00%	-89.65%	-4.24%
FY 2010-11 (DA)	-12.13%	-36.93%	6.60%	0.00%	3.68%	100.00%	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%	100.00%	-56.74%	31.94%	100.00%	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%	100.00%	21.62%	100.00%	100.00%	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%	100.00%	0.00%	-3.44%
FY 2016-17	5.51%	-21.63%	-12.10%	-15.86%	23.73%	92.16%	0.00%	76.41%	0.00%	100.00%	316.67%	100.00%	100.00%	5948.98%	0.00%	1.21%
Estimated FY 2017-18	0.64%	4.63%	4.63%	4.64%	4.57%	4.59%	4.66%	4.63%	6.67%	0.00%	4.00%	4.55%	4.58%	-100.00%	0.00%	0.47%
Estimated FY 2018-19	1.03%	4.00%	3.99%	4.00%	3.93%	3.90%	4.00%	4.00%	3.13%	9.09%	3.85%	4.35%	4.00%	0.00%	0.00%	0.97%
Estimated FY 2019-20	0.86%	3.82%	3.83%	3.82%	3.78%	3.76%	3.85%	3.82%	3.03%	0.00%	3.70%	-2.08%	-0.18%	0.00%	0.00%	1.60%

Exhibit H - LONG-TERM CARE AND INSURANCE
Summary

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	$504,591,560	$55,594,070	$114,745,827	$88,852	$288,759	$0	$3,868,823	$0	$0	$0	$57,671	$7,655	$0	$0	$0	$679,243,217
Class II Nursing Facilities	$1,429,310	$209,262	$2,431,355	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,069,927
Program for All-Inclusive Care for the Elderly	$143,155,846	$18,596,201	$9,805,269	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$171,557,316
Subtotal Long-Term Care	**$649,176,716**	**$74,399,533**	**$126,982,451**	**$88,852**	**$288,759**	**$0**	**$3,868,823**	**$0**	**$0**	**$0**	**$57,671**	**$7,655**	**$0**	**$0**	**$0**	**$854,870,460**
Supplemental Medicare Insurance Benefit	$97,752,453	$5,742,481	$50,142,988	$0	$356,557	$0	$0	$0	$0	$0	$0	$0	$0	$0	$29,633,363	$183,627,842
Health Insurance Buy-In	$19,555	$24,445	$2,395,544	$0	$29,333	$48,888	$44,000	$0	$171,111	$0	$0	$14,667	$0	$0	$0	$2,747,543
Subtotal Insurance	**$97,772,008**	**$5,766,926**	**$52,538,532**	**$0**	**$385,890**	**$48,888**	**$44,000**	**$0**	**$171,111**	**$0**	**$0**	**$14,667**	**$0**	**$0**	**$29,633,363**	**$186,375,385**
Total Long-Term Care and Insurance	**$746,948,724**	**$80,166,459**	**$179,520,983**	**$88,852**	**$674,649**	**$48,888**	**$3,912,823**	**$0**	**$171,111**	**$0**	**$57,671**	**$22,322**	**$0**	**$0**	**$29,633,363**	**$1,041,245,845**
Class I Nursing Facility Supplemental Payments	$79,995,423	$8,813,606	$18,191,230	$14,086	$45,778	$0	$613,344	$0	$0	$0	$9,143	$1,214	$0	$0	$0	$107,683,824
Total Long-Term Care and Insurance Including Financing	**$826,944,147**	**$88,980,065**	**$197,712,213**	**$102,938**	**$720,427**	**$48,888**	**$4,526,167**	**$0**	**$171,111**	**$0**	**$66,814**	**$23,536**	**$0**	**$0**	**$29,633,363**	**$1,148,929,669**

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	$520,734,665	$57,372,659	$118,416,824	$91,695	$297,997	$0	$3,992,596	$0	$0	$0	$59,516	$7,900	$0	$0	$0	$700,973,852
Class II Nursing Facilities	$1,523,842	$223,102	$2,592,161	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,339,105
Program for All-Inclusive Care for the Elderly	$157,902,318	$20,804,517	$11,241,150	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$189,947,985
Subtotal Long-Term Care	**$680,160,825**	**$78,400,278**	**$132,250,135**	**$91,695**	**$297,997**	**$0**	**$3,992,596**	**$0**	**$0**	**$0**	**$59,516**	**$7,900**	**$0**	**$0**	**$0**	**$895,260,942**
Supplemental Medicare Insurance Benefit	$104,154,212	$6,248,980	$53,464,668	$0	$397,949	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,329,677	$198,595,486
Health Insurance Buy-In	$24,771	$30,966	$3,034,547	$0	$37,157	$61,928	$55,737	$0	$216,754	$0	$0	$18,580	$0	$0	$0	$3,480,440
Subtotal Insurance	**$104,178,983**	**$6,279,946**	**$56,499,215**	**$0**	**$435,106**	**$61,928**	**$55,737**	**$0**	**$216,754**	**$0**	**$0**	**$18,580**	**$0**	**$0**	**$34,329,677**	**$202,075,926**
Total Long-Term Care and Insurance	**$784,339,808**	**$84,680,224**	**$188,749,350**	**$91,695**	**$733,103**	**$61,928**	**$4,048,333**	**$0**	**$216,754**	**$0**	**$59,516**	**$26,480**	**$0**	**$0**	**$34,329,677**	**$1,097,336,868**
Class I Nursing Facility Supplemental Payments	$82,868,859	$9,130,191	$18,844,659	$14,592	$47,423	$0	$635,375	$0	$0	$0	$9,471	$1,257	$0	$0	$0	$111,551,827
Total Long-Term Care and Insurance Including Financing	**$867,208,667**	**$93,810,415**	**$207,594,009**	**$106,287**	**$780,526**	**$61,928**	**$4,683,708**	**$0**	**$216,754**	**$0**	**$68,987**	**$27,737**	**$0**	**$0**	**$34,329,677**	**$1,208,888,695**

FY 2019-20 Long-Term Care and Insurance Request

FY 2019-20	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	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	$538,919,159	$59,376,161	$122,552,040	$94,897	$308,403	$0	$4,132,021	$0	$0	$0	$61,594	$8,176	$0	$0	$0	$725,452,451
Class II Nursing Facilities	$1,523,842	$223,102	$2,592,161	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,339,105
Program for All-Inclusive Care for the Elderly	$174,648,154	$23,572,860	$12,625,322	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$210,846,336
Subtotal Long-Term Care	**$715,091,155**	**$83,172,123**	**$137,769,523**	**$94,897**	**$308,403**	**$0**	**$4,132,021**	**$0**	**$0**	**$0**	**$61,594**	**$8,176**	**$0**	**$0**	**$0**	**$940,637,892**
Supplemental Medicare Insurance Benefit	$107,900,946	$6,647,481	$56,141,833	$0	$417,744	$0	$0	$0	$0	$0	$0	$0	$0	$0	$39,086,468	$210,194,472
Health Insurance Buy-In	$31,154	$38,945	$3,816,417	$0	$46,730	$77,884	$70,098	$0	$272,602	$0	$0	$23,367	$0	$0	$0	$4,377,197
Subtotal Insurance	**$107,932,100**	**$6,686,426**	**$59,958,250**	**$0**	**$464,474**	**$77,884**	**$70,098**	**$0**	**$272,602**	**$0**	**$0**	**$23,367**	**$0**	**$0**	**$39,086,468**	**$214,571,669**
Total Long-Term Care and Insurance	**$823,023,255**	**$89,858,549**	**$197,727,773**	**$94,897**	**$772,877**	**$77,884**	**$4,202,119**	**$0**	**$272,602**	**$0**	**$61,594**	**$31,543**	**$0**	**$0**	**$39,086,468**	**$1,155,209,561**
Class I Nursing Facility Supplemental Payments	$85,845,510	$9,458,147	$19,521,559	$15,116	$49,126	$0	$658,198	$0	$0	$0	$9,811	$1,302	$0	$0	$0	$115,558,769
Total Long-Term Care and Insurance Including Financing	**$908,868,765**	**$99,316,696**	**$217,249,332**	**$110,013**	**$822,003**	**$77,884**	**$4,860,317**	**$0**	**$272,602**	**$0**	**$71,405**	**$32,845**	**$0**	**$0**	**$39,086,468**	**$1,270,768,330**

Class I Nursing Home Calculations for FY 2017-18, FY 2018-19 and FY 2019-20

FY 2017-18 Calculation

Service Expenditure:	Core Components	Reference
Estimate of FY 2017-18 Total Fund Portion of Per Diem Rate	$223.45	Footnote 1
Estimate of FY 2017-18 Patient Payment (per day)	($35.76)	Footnote 1
Estimated FY 2017-18 Medicaid Reimbursement (per day)	**$187.69**	
Estimate of Patient Days (without Hospital Back Up)	3,629,986	Footnote 2
Total Estimated Costs for FY 2017-18 Days of Service	$681,312,072	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	93.16%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$634,710,326	
Estimated Expenditure for FY 2016-17 Dates of Service	$44,129,443	Footnote 5
Estimated Expenditure in FY 2017-18 Prior to Adjustments	**$678,839,769**	
Bottom Line Adjustments:		
Hospital Back Up Program	$10,939,828	Footnote 6
Recoveries from Department Overpayment Review	($1,000,000)	Footnote 7
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($9,536,380)	Footnote 8
Total Bottom Line Adjustments:	**$403,448**	
Total Estimated FY 2017-18 Total Fund Expenditure	**$679,243,217**	
Percentage Change in Core Component Expenditure Over Prior Year	4.62%	
Supplemental Payments from Nursing Facility Provider Fund:		
Prior Year Rate Reconciliation	$56,481,416	Page EH-9
Cognitive Performance Scale	$800,883	Page EH-9
PASRR - Resident	$3,241,125	Page EH-9
PASRR - Facility	$980,887	Page EH-9
Medicaid Supplemental Payment	$39,544,234	Page EH-9
Pay for Performance	$6,635,279	Page EH-9
Total Estimated Supplemental Payments	**$107,683,824**	
Total Estimated FY 2017-18 Expenditure	**$786,927,041**	

Class I Nursing Home Calculations for FY 2017-18, FY 2018-19 and FY 2019-20

FY 2018-19 Calculation

Service Expenditure:	Core Components	Reference
Estimate of FY 2018-19 Total Fund Portion of Per Diem Rate	$229.71	Footnote 1
Estimate of FY 2018-19 Patient Payment (per day)	($36.39)	Footnote 1
Estimated FY 2018-19 Medicaid Reimbursement (per day)	**$193.32**	
Estimate of Patient Days (without Hospital Back Up)	3,640,059	Footnote 2
Total Estimated Costs for FY 2018-19 Days of Service	$703,696,206	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	93.16%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$655,563,386	
Estimated Expenditure for FY 2017-18 Dates of Service	$46,601,746	Footnote 5
Estimated Expenditure in FY 2018-19 Prior to Adjustments	**$702,165,132**	
Bottom Line Adjustments:		
Hospital Back Up Program	$10,378,930	Footnote 6
Recoveries from Department Overpayment Review	($1,035,900)	Footnote 7
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($10,534,310)	Footnote 8
Total Bottom Line Adjustments:	**($1,191,280)**	
Total Estimated FY 2018-19 Expenditure	**$700,973,852**	
Percentage Change in Core Component Expenditure Over Prior Year	3.20%	
Supplemental Payments from Nursing Facility Provider Fund:		
Prior Year Rate Reconciliation	$58,510,229	Page EH-9
Cognitive Performance Scale	$829,651	Page EH-9
PASRR - Resident	$3,357,546	Page EH-9
PASRR - Facility	$1,016,120	Page EH-9
Medicaid Supplemental Payment	$40,964,663	Page EH-9
Pay for Performance	$6,873,618	Page EH-9
Total Estimated Supplemental Payments	**$111,551,827**	
Total Estimated FY 2018-19 Expenditure	**$812,525,679**	

Class I Nursing Home Calculations for FY 2017-18, FY 2018-19 and FY 2019-20

FY 2019-20 Calculation

Service Expenditure:	Core Components	Reference
Estimate of FY 2019-20 Total Fund Portion of Per Diem Rate	$235.51	Footnote 1
Estimate of FY 2019-20 Patient Payment (per day)	($36.39)	Footnote 1
Estimated FY 2019-20 Medicaid Reimbursement (per day)	**$199.12**	
Estimate of Patient Days (without Hospital Back Up)	3,660,000	Footnote 2
Total Estimated Costs for FY 2019-20 Days of Service	$728,779,200	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	93.16%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$678,930,703	
Estimated Expenditure for FY 2018-19 Dates of Service	$48,132,820	Footnote 5
Estimated Expenditure in FY 2019-20 Prior to Adjustments	**$727,063,523**	
Bottom Line Adjustments:		
Hospital Back Up Program	$10,378,930	Footnote 6
Recoveries from Department Overpayment Review	($1,073,089)	Footnote 7
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($10,916,913)	Footnote 8
Total Bottom Line Adjustments:	**($1,611,072)**	
Total Estimated FY 2019-20 Expenditure	**$725,452,451**	
Percentage Change in Core Component Expenditure Over Prior Year	3.49%	
Supplemental Payments from Nursing Facility Provider Fund:		
Prior Year Rate Reconciliation	$60,611,915	Page EH-9
Cognitive Performance Scale	$859,452	Page EH-9
PASRR - Resident	$3,478,149	Page EH-9
PASRR - Facility	$1,052,620	Page EH-9
Medicaid Supplemental Payment	$42,436,114	Page EH-9
Pay for Performance	$7,120,519	Page EH-9
Total Estimated Supplemental Payments	**$115,558,769**	
Total Estimated FY 2019-20 Expenditure	**$841,011,220**	

Class I Nursing Home Calculations for FY 2017-18 , FY 2018-19 and FY 2019-20 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 2008-09 through FY 2019-20. 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 2008-09	$190.34	$33.10	$157.24	0.00%	$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	$201.53	$36.17	$165.36	1.50%	$204.60
FY 2015-16	$207.72	$35.43	$172.29	1.50%	$210.88
FY 2016-17	$214.72	$35.23	$179.49	1.50%	$217.99
Estimated FY 2017-18	$220.63	$35.76	$184.87	1.50%	$223.45
Estimated FY 2018-19	$226.81	$36.39	$190.42	1.50%	$229.71
Estimated FY 2019-20	$232.52	$36.39	$196.13	1.50%	$235.51

(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. For FY 2017-18 and FY 2018-19, the Department assumed the same number of patient days from the February 2017 request; for FY 2019-20, the Department applied a trend of 0.28% to assumed FY 2018-19 patient days. These trends were chosen with the assumption that patient days would level out over the next three fiscal years.

Fiscal Year	Patient Days	Percentage Change	Full Time Equivalent Clients	Percentage Change
FY 2008-09	3,427,547	-	9,391	-
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	3,487,254	0.99%	9,554	0.98%
FY 2015-16	3,570,320	2.38%	9,755	2.10%
FY 2016-17	3,594,447	0.68%	9,848	0.95%
Estimated FY 2017-18	3,629,986	0.99%	9,945	0.98%
Estimated FY 2018-19	3,640,059	0.28%	9,973	0.28%
Estimated FY 2019-20	3,660,000	0.55%	10,000	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 2017 has 11 more months to pay during FY 2017-18 (from August 2017 to June 2018), while a claim incurred in May 2018 only has one additional month to pay during FY 2017-18 (June 2018). Thus, more claims from May 2018 will pay in FY 2018-19 than claims from July 2017. 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	99.91%
August	10	99.87%
September	9	99.83%
October	8	99.77%
November	7	99.66%
December	6	99.48%
January	5	99.16%
February	4	98.64%
March	3	97.53%
April	2	95.12%
May	1	90.86%
June	0	38.07%
Average		93.16%

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 2017-18 expenditure for core components with FY 2016-17 dates of service is the estimated FY 2016-17 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 2016-17	Source
IBNR Factor	93.16%	Footnote (4)
Estimated Patient Days from previous fiscal year	3,594,447	Footnote (2)
Estimated Per Diem Rate for Core Components for previous fiscal year	$214.72	Footnote (1)
Less: Estimated Patient Payment Rate for previous fiscal year	$35.23	Footnote (1)
Estimated claims expenditure for core components from previous fiscal year to be paid in the current fiscal year	$44,129,443	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 and growth in the average per diem in FY 2016-17, the Department adjusted its estimate up for FY 2017-18. The FY 2017-18 estimate also includes approximately half a million dollars to account for retroactive payments for FY 2016-17 dates of service outside of typical IBNR claims observed for this service. Estimates for FY 2018-19 and FY 2019-20 were made with the assumption that client enrollment and the average per diem would stay at FY 2017-18 levels.

Fiscal Year	Hospital Back Up	Percent Difference
FY 2008-09	$6,920,964	-
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%
FY 2016-17	$9,225,021	7.05%
Estimated FY 2017-18	$10,939,828	18.59%
Estimated FY 2018-19	$10,378,930	-5.13%
Estimated FY 2019-20	$10,378,930	0.00%

(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 the most recent fiscal years, 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 2011-12	$2,063,191	-
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%
FY 2016-17	$885,647	27.36%
Estimated FY 2017-18	$1,000,000	12.91%
Estimated FY 2018-19	$1,035,900	3.59%
Estimated FY 2019-20	$1,073,089	3.59%

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

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

HB 13-1152	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
Estimated FY 2017-18 Rates	1.50%	$223.45	$220.63	($2.82)
Estimated FY 2017-18 Patient Days				3,629,986
Estimated FY 2017-18 Days Paid in FY 2017-18				3,381,695
Total FY 2017-18 Impact				**($9,536,380)**
Estimated FY 2017-18 Days Paid in FY 2018-19				248,291
FY 2018-19 Impact from Carryover from FY 2017-18				($700,181)
Estimated FY 2018-19 Rates	1.50%	$229.71	$226.81	($2.90)
Estimated FY 2018-19 Patient Days				3,640,059
Estimated FY 2018-19 Days Paid in FY 2018-19				3,391,079
FY 2018-19 Impact from FY 2018-19				($9,834,129)
Total FY 2018-19 Impact				**($10,534,310)**
Estimated FY 2018-19 Days Paid in FY 2019-20				248,980
FY 2019-20 Impact from Carryover from FY 2018-19				($722,042)
Estimated FY 2019-20 Rates	1.50%	$235.51	$232.52	($2.99)
Estimated FY 2019-20 Patient Days				3,660,000
Estimated FY 2019-20 Days Paid in FY 2019-20				3,409,656
FY 2019-20 Impact from FY 2019-20				($10,194,871)
Total FY 2019-20 Impact				**($10,916,913)**

(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[1]	Prior Year Rate Reconciliation [2]	Rate Cut Backfill	Cognitive Performance Scale	PASRR - Resident[3]	PASRR - Facility[3]	Medicaid Supplemental Payment	Pay for Performance	Total Effective Add-on/ Supplemental
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**
FY 2016-17	$13.98	$2.14	$0	$56,292,128	$0	$645,904	$2,820,102	$1,039,725	$36,647,929	$5,682,521	**$103,128,309**
Projected FY 2017-18	$14.39	$2.69	$0	$56,481,416	$0	$800,883	$3,241,125	$980,887	$39,544,234	$6,635,279	**$107,683,824**
Projected FY 2018-19	$14.81	$2.77	$0	$58,510,229	$0	$829,651	$3,357,546	$1,016,120	$40,964,663	$6,873,618	**$111,551,827**
Projected FY 2019-20	$15.34	$2.87	$0	$60,611,915	$0	$859,452	$3,478,149	$1,052,620	$42,436,114	$7,120,519	**$115,558,769**

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 2011-12	62.07%	62.39%	-9.90%	-19.74%	0.00%	893.45%	1295.07%	1199.05%	66.90%	259.98%	**17.21%**
FY 2012-13	2.59%	2.6%	-20.69%	46.79%	0.00%	9.85%	6.97%	-31.24%	3.56%	57.90%	**-3.39%**
FY 2013-14	2.29%	2.1%	16.24%	-26.46%	0.00%	-28.84%	-5.73%	55.81%	5.74%	-9.10%	**5.39%**
FY 2014-15	2.62%	2.5%	13.56%	-24.44%	0.00%	21.64%	-32.60%	-17.74%	1.76%	11.24%	**4.98%**
FY 2015-16	2.56%	2.5%	-37.53%	523.89%	0.00%	9.56%	25.67%	50.04%	4.15%	1.93%	**8.43%**
FY 2016-17	2.49%	2.4%	-100.00%	109.60%	0.00%	-23.18%	19.07%	22.66%	6.63%	-17.41%	**2.54%**
Projected FY 2017-18	2.93%	25.7%	0.00%	0.34%	0.00%	23.99%	14.93%	-5.66%	7.90%	16.77%	**4.42%**
Projected FY 2018-19	2.92%	3.0%	0.00%	3.59%	0.00%	3.59%	3.59%	3.59%	3.59%	3.59%	**3.59%**
Projected FY 2019-20	3.58%	3.6%	0.00%	3.59%	0.00%	3.59%	3.59%	3.59%	3.59%	3.59%	**3.59%**

(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) Totals of Prior Year Rate Reconciliation in FY 2016-17 and after include acuity adjustments, rate true-ups, and prior year rate true-up payments.
(3) 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 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
FY 2016-17	$492,617,483	$50,923,191	$100,809,620	$177,065	$217,731	$315,596	$4,098,376	$0	$70,792	$1,184	$27,882	$3,702	$0	$0	$0	$649,262,622
Estimated FY 2017-18	$504,591,560	$55,594,070	$114,745,827	$88,852	$288,759	$0	$3,868,823	$0	$0	$0	$57,671	$7,655	$0	$0	$0	$679,243,217
Estimated FY 2018-19	$520,734,665	$57,372,659	$118,416,824	$91,695	$297,997	$0	$3,992,596	$0	$0	$0	$59,516	$7,900	$0	$0	$0	$700,973,852
Estimated FY 2019-20	$538,919,159	$59,376,161	$122,552,040	$94,897	$308,403	$0	$4,132,021	$0	$0	$0	$61,594	$8,176	$0	$0	$0	$725,452,451

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 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%	100.00%	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%	100.00%	100.00%	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%	100.00%	345.79%	0.00%	0.00%	0.00%	100.00%	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%
FY 2016-17	4.42%	5.86%	5.04%	-4.79%	29.62%	1949.86%	18.52%	0.00%	100.00%	100.00%	446.38%	100.00%	0.00%	0.00%	-100.00%	4.77%
Estimated FY 2017-18	2.43%	9.17%	13.82%	-49.82%	32.62%	-100.00%	-5.60%	0.00%	-100.00%	-100.00%	106.84%	106.78%	0.00%	0.00%	0.00%	4.62%
Estimated FY 2018-19	3.20%	3.20%	3.20%	3.20%	3.20%	0.00%	3.20%	0.00%	0.00%	0.00%	3.20%	3.20%	0.00%	0.00%	0.00%	3.20%
Estimated FY 2019-20	3.49%	3.49%	3.49%	3.49%	3.49%	0.00%	3.49%	0.00%	0.00%	0.00%	3.49%	3.49%	0.00%	0.00%	0.00%	3.49%

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	$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
FY 2016-17	$11,210.88	$4,530.13	$1,490.85	$28.33	$1.35	$3.12	$11.78	$0.00	$0.15	$0.02	$1.37	$0.28	$0.00	$0.00	$0.00	$482.30
Estimated FY 2017-18	$11,153.17	$4,759.36	$1,693.84	$11.38	$1.53	$0.00	$10.18	$0.00	$0.00	$0.00	$2.80	$0.67	$0.00	$0.00	$0.00	$484.59
Estimated FY 2018-19	$11,322.04	$4,711.95	$1,704.50	$10.08	$1.52	$0.00	$10.13	$0.00	$0.00	$0.00	$2.87	$0.69	$0.00	$0.00	$0.00	$485.47
Estimated FY 2019-20	$11,522.75	$4,670.87	$1,709.09	$9.15	$1.53	$0.00	$10.28	$0.00	$0.00	$0.00	$2.94	$0.72	$0.00	$0.00	$0.00	$491.69

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 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%
FY 2016-17	0.77%	-0.85%	6.88%	-5.28%	31.07%	1633.33%	9.18%	0.00%	100.00%	100.00%	426.92%	100.00%	0.00%	0.00%	-100.00%	0.95%
Estimated FY 2017-18	-0.51%	5.06%	13.62%	-59.83%	13.33%	-100.00%	-13.58%	0.00%	-100.00%	-100.00%	104.38%	139.29%	0.00%	0.00%	0.00%	0.47%
Estimated FY 2018-19	1.51%	-1.00%	0.63%	-11.42%	-0.65%	0.00%	-0.49%	0.00%	0.00%	0.00%	2.50%	2.99%	0.00%	0.00%	0.00%	0.18%
Estimated FY 2019-20	1.77%	-0.87%	0.27%	-9.23%	0.66%	0.00%	1.48%	0.00%	0.00%	0.00%	2.44%	4.35%	0.00%	0.00%	0.00%	1.28%

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 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)	($84,406)	$729,155	$2,518,446	$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
FY 2016-17	$1,361,188	$199,288	$2,315,475	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,875,951
Estimated FY 2017-18	$1,429,310	$209,262	$2,431,355	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,069,927
Estimated FY 2018-19	$1,523,842	$223,102	$2,592,161	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,339,105
Estimated FY 2019-20	$1,523,842	$223,102	$2,592,161	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,339,105

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 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)	119.54%	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%
FY 2016-17	242.86%	-39.21%	-30.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-4.12%
Estimated FY 2017-18	5.00%	5.00%	5.00%	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%
Estimated FY 2018-19	6.61%	6.61%	6.61%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.61%
Estimated FY 2019-20	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

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	$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
FY 2016-17	$30.98	$17.73	$34.24	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.88
Estimated FY 2017-18	$31.59	$17.91	$35.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.90
Estimated FY 2018-19	$33.13	$18.32	$37.31	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.01
Estimated FY 2019-20	$32.58	$17.55	$36.15	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.94

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
Percent Change in Per Capita Cost																
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%
FY 2016-17	230.98%	-43.06%	-28.99%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-7.69%
Estimated FY 2017-18	1.97%	1.02%	4.82%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.69%
Estimated FY 2018-19	4.87%	2.29%	3.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.79%
Estimated FY 2019-20	-1.66%	-4.20%	-3.11%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.33%
Current Year Projection																
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 2016-17 Expenditure	$1,361,188	$199,288	$2,315,475	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,875,951
Percentage Selected to Modify Expenditure[(1)]	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Estimated FY 2017-18 Base Expenditure	$1,429,310	$209,262	$2,431,355	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,069,927
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	**$1,429,310**	**$209,262**	**$2,431,355**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,069,927**
Estimated FY 2017-18 Per Capita	$31.59	$17.91	$35.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.90
% Change over FY 2016-17 Per Capita	1.97%	1.02%	4.82%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.69%
Request Year Projection																
Estimated FY 2017-18 Expenditure	$1,429,310	$209,262	$2,431,355	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,069,927
Percentage Selected to Modify Expenditure[(1)]	6.61%	6.61%	6.61%	6.61%	6.61%	6.61%	6.61%	6.61%	6.61%	6.61%	6.61%	6.61%	6.61%	6.61%	6.61%	6.61%
Estimated FY 2018-19 Base Expenditure	$1,523,842	$223,102	$2,592,161	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,339,105
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	**$1,523,842**	**$223,102**	**$2,592,161**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,339,105**
Estimated FY 2018-19 Per Capita	$33.13	$18.32	$37.31	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.01
% Change over FY 2017-18 Per Capita	4.87%	2.29%	3.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.79%
Out Year Projection																
Estimated FY 2018-19 Expenditure	$1,523,842	$223,102	$2,592,161	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,339,105
Percentage Selected to Modify Expenditure[(1)]	0.00%	0.00%	0.00%	0.00%	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 2019-20 Base Expenditure	$1,523,842	$223,102	$2,592,161	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,339,105
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 2019-20 Total Expenditure	**$1,523,842**	**$223,102**	**$2,592,161**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,339,105**
Estimated FY 2019-20 Per Capita	$32.58	$17.55	$36.15	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.94
% Change over FY 2018-19 Per Capita	-1.66%	-4.20%	-3.11%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.33%

(1) The percentages selected to trend expenditure for FY 2017-18 is 5.00%, FY 2018-19 is 6.61%, and FY 2019-20 is 0.00%. The trend has been set to match expected increases in class II nursing facility cost.

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 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)	$61,924,560	$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
FY 2016-17	$128,240,295	$16,912,508	$8,496,888	$0	($15,917)	$0	($97,888)	$0	$0	$0	$0	$0	$0	$0	($824,674)	$152,711,212
Estimated FY 2017-18	$143,155,846	$18,596,201	$9,805,269	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$171,557,316
Estimated FY 2018-19	$157,902,318	$20,804,517	$11,241,150	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$189,947,985
Estimated FY 2019-20	$174,648,154	$23,572,860	$12,625,322	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$210,846,336

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 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%
FY 2016-17	17.82%	23.61%	31.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.37%
Estimated FY 2017-18	11.63%	9.96%	15.40%	0.00%	-100.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	12.34%
Estimated FY 2018-19	10.30%	11.88%	14.64%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.72%
Estimated FY 2019-20	10.61%	13.31%	12.31%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.00%

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	$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
FY 2016-17	$2,918.47	$1,504.54	$125.66	$0.00	($0.10)	$0.00	($0.28)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($24.39)	$113.44
Estimated FY 2017-18	$3,164.22	$1,592.00	$144.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$122.39
Estimated FY 2018-19	$3,433.18	$1,708.65	$161.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$131.55
Estimated FY 2019-20	$3,734.19	$1,854.38	$176.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$142.91

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 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%
FY 2016-17	13.69%	15.78%	33.38%	0.00%	100.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	14.04%
Estimated FY 2017-18	8.42%	5.81%	15.18%	0.00%	-100.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	7.89%
Estimated FY 2018-19	8.50%	7.33%	11.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.48%
Estimated FY 2019-20	8.77%	8.53%	8.81%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.64%

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
FY 2016-17	2,537	353	180	0	0	0	0	0	0	0	0	0	0	0	0	3,070
Estimated FY 2017-18	3,183	440	232	0	0	0	0	0	0	0	0	0	0	0	0	3,855
Estimated FY 2018-19	3,536	496	268	0	0	0	0	0	0	0	0	0	0	0	0	4,300
Estimated FY 2019-20	3,911	562	301	0	0	0	0	0	0	0	0	0	0	0	0	4,774
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%
FY 2016-17	1.08%	5.06%	14.65%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.23%
Estimated FY 2017-18	25.46%	24.65%	28.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	25.57%
Estimated FY 2018-19	11.09%	12.73%	15.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.54%
Estimated FY 2019-20	10.61%	13.31%	12.31%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.02%
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
FY 2016-17	$50,548.01	$47,910.79	$47,204.93	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$49,743.07
Estimated FY 2017-18	$44,655.63	$41,944.59	$41,944.59	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$44,183.04
Estimated FY 2018-19	$44,655.63	$41,944.59	$41,944.59	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$44,173.95
Estimated FY 2019-20	$44,655.63	$41,944.59	$41,944.59	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$44,165.55
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%
FY 2016-17	16.56%	17.66%	14.34%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.79%
Estimated FY 2017-18	-11.66%	-12.45%	-11.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-11.18%
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%	-0.02%
Estimated FY 2019-20	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.02%

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 2016-17 Average Monthly Paid Enrollment	2,537	353	180	-	-	-	-	-	-	-	-	-	-	-	-	3,070
Trend Factor[5]	25.46%	24.65%	28.89%	-	-	-	-	-	-	-	-	-	-	-	-	25.57%
Estimated FY 2017-18 Monthly Paid Enrollment	3,183	440	232	-	-	-	-	-	-	-	-	-	-	-	-	3,855
FY 2017-18 Estimated Cost Per Enrollee	$44,655.63	$41,944.59	$41,944.59	-	-	-	-	-	-	-	-	-	-	-	-	$44,183.04
Bottom Line Impacts																
FY 2016-17 Retroactive Payments	$10,241,154	$1,415,680	$746,449	-	-	-	-	-	-	-	-	-	-	-	-	$12,403,283
interChange Rate Adjustments	($9,224,178)	($1,275,099)	($672,325)	-	-	-	-	-	-	-	-	-	-	-	-	($11,171,602)
Total Bottom Line Impacts	$1,016,976	$140,581	$74,124	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,231,681
Estimated FY 2017-18 Expenditure	**$143,155,846**	**$18,596,201**	**$9,805,269**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$171,557,316**
Estimated FY 2017-18 Per Capita	$3,164.22	$1,592.00	$144.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$122.39
% Change over FY 2016-17 Per Capita	8.42%	5.81%	15.18%	0.00%	-100.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	7.89%

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 2017-18 Monthly Paid Enrollment	3,183	440	232	-	-	-	-	-	-	-	-	-	-	-	-	3,855
Trend Factor[5]	11.09%	12.73%	15.52%	-	-	-	-	-	-	-	-	-	-	-	-	11.54%
Estimated FY 2018-19 Monthly Paid Enrollment	3,536	496	268	-	-	-	-	-	-	-	-	-	-	-	-	4,300
FY 2018-19 Estimated Cost Per Enrollee	$44,655.63	$41,944.59	$41,944.59	-	-	-	-	-	-	-	-	-	-	-	-	$44,173.95
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	**$157,902,318**	**$20,804,517**	**$11,241,150**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$189,947,985**
Estimated FY 2018-19 Per Capita	$3,433.18	$1,708.65	$161.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$131.55
% Change over FY 2017-18 Per Capita	8.50%	7.33%	11.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.48%

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 2018-19 Monthly Paid Enrollment	3,536	496	268	-	-	-	-	-	-	-	-	-	-	-	-	4,300
Trend Factor[5]	10.61%	13.31%	12.31%	-	-	-	-	-	-	-	-	-	-	-	-	11.02%
Estimated FY 2019-20 Monthly Paid Enrollment	3,911	562	301	-	-	-	-	-	-	-	-	-	-	-	-	4,774
FY 2019-20 Estimated Cost Per Enrollee	$44,655.63	$41,944.59	$41,944.59	-	-	-	-	-	-	-	-	-	-	-	-	$44,165.55
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 2019-20 Expenditure	**$174,648,154**	**$23,572,860**	**$12,625,322**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$210,846,336**
Estimated FY 2019-20 Per Capita	$3,734.19	$1,854.38	$176.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$142.91
% Change over FY 2018-19 Per Capita	8.77%	8.53%	8.81%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.64%

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 2017-18, FY 2018-19, and FY 2019-20 are a weighted average of FY 2017-18 rates by forecasted FY 2017-18 provider distribution and FY 2016-17 third-party-liability status.

(4) Estimated costs per enrollee in this exhibit do not represent future rates in FY 2018-19 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 2017-18, FY 2018-19, and FY 2019-20 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 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
FY 2016-17	$99,587,634	$5,807,375	$52,202,417	$0	$326,524	$0	$0	$0	$0	$0	$0	$0	$0	$0	$28,817,019	$186,740,969
Estimated FY 2017-18	$97,752,453	$5,742,481	$50,142,988	$0	$356,557	$0	$0	$0	$0	$0	$0	$0	$0	$0	$29,633,363	$183,627,842
Estimated FY 2018-19	$104,154,212	$6,248,980	$53,464,668	$0	$397,949	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,329,677	$198,595,486
Estimated FY 2019-20	$107,900,946	$6,647,481	$56,141,833	$0	$417,744	$0	$0	$0	$0	$0	$0	$0	$0	$0	$39,086,468	$210,194,472

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 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%	100.00%	-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%
FY 2016-17	19.38%	19.38%	19.38%	0.00%	19.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	19.38%	19.38%
Estimated FY 2017-18	-1.84%	-1.12%	-3.95%	0.00%	9.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.83%	-1.67%
Estimated FY 2018-19	6.55%	8.82%	6.62%	0.00%	11.61%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.85%	8.15%
Estimated FY 2019-20	3.60%	6.38%	5.01%	0.00%	4.97%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.86%	5.84%

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	$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
FY 2016-17	$2,266.39	$516.62	$772.01	$0.00	$2.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$852.35	$138.72
Estimated FY 2017-18	$2,160.66	$491.61	$740.19	$0.00	$1.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$803.75	$131.01
Estimated FY 2018-19	$2,264.57	$513.22	$769.57	$0.00	$2.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$835.92	$137.54
Estimated FY 2019-20	$2,307.05	$522.93	$782.94	$0.00	$2.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$854.42	$142.46

Percent Change in Per Capita Cost

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
FY 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%	100.00%	-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%
FY 2016-17	15.20%	11.81%	21.46%	0.00%	21.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.05%	15.02%
Estimated FY 2017-18	-4.67%	-4.84%	-4.12%	0.00%	-6.90%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.70%	-5.56%
Estimated FY 2018-19	4.81%	4.40%	3.97%	0.00%	7.41%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.00%	4.98%
Estimated FY 2019-20	1.88%	1.89%	1.74%	0.00%	1.97%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.21%	3.58%

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 2016-17 Expenditure	**$99,587,634**	**$5,807,375**	**$52,202,417**	**$0**	**$326,524**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$28,817,019**	**$186,740,969**
FY 2016-17 First Half Expenditure	$45,274,647	$2,640,156	$23,732,324	$0	$148,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,100,827	$84,896,399
FY 2016-17 Second Half Expenditure	$54,312,987	$3,167,219	$28,470,093	$0	$178,079	$0	$0	$0	$0	$0	$0	$0	$0	$0	$15,716,192	$101,844,570
Estimated FY 2017-18 First Half Caseload Trend	1.48%	1.96%	0.09%	12.48%	8.58%	-4.86%	4.64%	-30.17%	-0.38%	2.95%	0.68%	-7.07%	8.66%	2.69%	4.53%	2.06%
Accounting Reconciliation	($4,367,349)	($254,679)	($2,289,302)	$0	($14,319)	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1,263,751.20)	($8,189,401)
Estimated FY 2017-18 First Half Expenditure	$50,684,833	$2,969,626	$26,204,353	$0	$177,810	$0	$0	$0	$0	$0	$0	$0	$0	$0	$15,107,136	$95,143,758
Estimated FY 2017-18 Second Half Caseload Trend	1.48%	1.95%	0.09%	12.48%	8.58%	-4.85%	4.63%	-30.17%	-0.38%	2.94%	0.67%	-7.07%	8.65%	2.69%	4.52%	2.06%
Estimated Increase in Medicare Part B Premium (Effective January 1, 2018)[1]	0.00%	0.00%	0.00%	0.00%	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 Second Half Expenditure	$51,434,969	$3,027,534	$26,227,937	$0	$193,066	$0	$0	$0	$0	$0	$0	$0	$0	$0	$15,789,979	$96,673,485
Total Bottom Line Impacts	**($4,367,349)**	**($254,679)**	**($2,289,302)**	**$0**	**($14,319)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**($1,263,751)**	**($8,189,401)**
Estimated FY 2017-18 Total Expenditure(2)	**$97,752,453**	**$5,742,481**	**$50,142,988**	**$0**	**$356,557**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$29,633,363**	**$183,627,842**
Estimated FY 2017-18 Per Capita	$2,160.66	$491.61	$740.19	$0.00	$1.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$803.75	$131.01
% Change over FY 2016-17 Per Capita	-4.67%	-4.84%	-4.12%	0.00%	-6.90%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.70%	-5.56%
Request Year Projection																
Estimated FY 2017-18 Expenditure	$97,752,453	$5,742,481	$50,142,988	$0	$356,557	$0	$0	$0	$0	$0	$0	$0	$0	$0	$29,633,363	$183,627,842
Estimated FY 2017-18 First Half Expenditure	$50,684,833	$2,969,626	$26,204,353	$0	$177,810	$0	$0	$0	$0	$0	$0	$0	$0	$0	$15,107,136	$95,143,758
Estimated FY 2017-18 Second Half Expenditure	$51,434,969	$3,027,534	$26,227,937	$0	$193,066	$0	$0	$0	$0	$0	$0	$0	$0	$0	$15,789,979	$96,673,485
Estimated FY 2018-19 First Half Caseload Trend	0.83%	2.12%	1.28%	8.25%	2.03%	3.84%	1.82%	-23.51%	0.22%	2.27%	0.40%	-0.01%	-0.02%	0.58%	5.70%	1.51%
Estimated FY 2018-19 First Half Expenditure	$51,861,879	$3,091,718	$26,563,655	$0	$196,985	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,690,008	$98,404,245
Estimated FY 2018-19 Second Half Caseload Trend	0.83%	2.12%	1.27%	8.24%	2.02%	3.84%	1.82%	-23.50%	0.21%	2.26%	0.39%	-0.01%	-0.02%	0.57%	5.69%	1.50%
Estimated Increase in Medicare Part B Premium (Effective January 1, 2019)[1]	0.00%	0.00%	0.00%	0.00%	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 Second Half Expenditure	$52,292,333	$3,157,262	$26,901,013	$0	$200,964	$0	$0	$0	$0	$0	$0	$0	$0	$0	$17,639,669	$100,191,241
Estimated FY 2018-19 Total Expenditure(2)	**$104,154,212**	**$6,248,980**	**$53,464,668**	**$0**	**$397,949**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$34,329,677**	**$198,595,486**
Estimated FY 2018-19 Per Capita	$2,264.57	$513.22	$769.57	$0.00	$2.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$835.92	$137.54
% Change over FY 2017-18 Per Capita	4.81%	4.40%	3.97%	0.00%	7.41%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.00%	4.98%
Out Year Projection																
Estimated FY 2018-19 Expenditure	$104,154,212	$6,248,980	$53,464,668	$0	$397,949	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,329,677	$198,595,486
Estimated FY 2018-19 First Half Expenditure	$51,861,879	$3,091,718	$26,563,655	$0	$196,985	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,690,008	$98,404,245
Estimated FY 2018-19 Second Half Expenditure	$52,292,333	$3,157,262	$26,901,013	$0	$200,964	$0	$0	$0	$0	$0	$0	$0	$0	$0	$17,639,669	$100,191,241
Estimated FY 2019-20 First Half Caseload Trend	0.85%	2.20%	1.61%	6.98%	1.34%	2.10%	0.99%	-0.81%	0.22%	1.79%	0.44%	-0.01%	0.00%	0.57%	5.70%	1.09%
Estimated FY 2019-20 First Half Expenditure	$52,736,818	$3,226,722	$27,334,119	$0	$203,657	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,645,130	$102,146,446
Estimated FY 2019-20 Second Half Caseload Trend	0.84%	2.20%	1.60%	6.97%	1.34%	2.10%	0.99%	-0.80%	0.22%	1.78%	0.44%	-0.01%	0.00%	0.57%	5.69%	1.09%
Estimated Increase in Medicare Part B Premium (Effective January 1, 2020)[1]	3.73%	3.73%	3.73%	3.73%	3.73%	3.73%	3.73%	3.73%	3.73%	3.73%	3.73%	3.73%	3.73%	3.73%	3.73%	3.73%
Estimated FY 2019-20 Second Half Expenditure	$55,164,128	$3,420,759	$28,807,714	$0	$214,087	$0	$0	$0	$0	$0	$0	$0	$0	$0	$20,441,338	$108,048,026
Estimated FY 2019-20 Total Expenditure(2)	**$107,900,946**	**$6,647,481**	**$56,141,833**	**$0**	**$417,744**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$39,086,468**	**$210,194,472**
Estimated FY 2019-20 Per Capita	$2,307.05	$522.93	$782.94	$0.00	$2.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$854.42	$142.46
% Change over Estimated FY 2018-19 Per Capita	1.88%	1.89%	1.74%	0.00%	1.97%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.21%	3.58%

[1] The Part B premium is $134.00 effective January 1, 2017. The Department projects that the premium will be $134.00 in CY 2018 and CY 2019, and projects the premium will be $139.00 in CY 2020 based on the 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, dated July 13th, 2017.

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

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

Cash Based Actuals

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
FY 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
FY 2016-17	$15,177	$18,972	$1,859,221	$0	$22,766	$37,943	$34,149	$0	$132,802	$0	$0	$11,383	$0	$0	$0	$2,132,413
Estimated FY 2017-18	$19,555	$24,445	$2,395,544	$0	$29,333	$48,888	$44,000	$0	$171,111	$0	$0	$14,667	$0	$0	$0	$2,747,543
Estimated FY 2018-19	$24,771	$30,966	$3,034,547	$0	$37,157	$61,928	$55,737	$0	$216,754	$0	$0	$18,580	$0	$0	$0	$3,480,440
Estimated FY 2019-20	$31,154	$38,945	$3,816,417	$0	$46,730	$77,884	$70,098	$0	$272,602	$0	$0	$23,367	$0	$0	$0	$4,377,197

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 2009-10 (DA)	-2106.78%	160.41%	8.33%	0.00%	-36.49%	0.00%	0.00%	0.00%	-31.68%	0.00%	100.00%	-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%	100.00%	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%	100.00%	0.00%	0.00%	0.00%	0.27%
FY 2014-15	-23.46%	-45.33%	-9.41%	0.00%	-48.98%	100.00%	100.00%	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%
FY 2016-17	32.13%	32.14%	32.14%	0.00%	32.15%	32.14%	32.15%	0.00%	32.14%	0.00%	0.00%	32.15%	0.00%	0.00%	0.00%	32.14%
Estimated FY 2017-18	28.85%	28.85%	28.85%	0.00%	28.85%	28.85%	28.85%	0.00%	28.85%	0.00%	0.00%	28.85%	0.00%	0.00%	0.00%	28.85%
Estimated FY 2018-19	26.67%	26.68%	26.67%	0.00%	26.67%	26.67%	26.68%	0.00%	26.67%	0.00%	0.00%	26.68%	0.00%	0.00%	0.00%	26.67%
Estimated FY 2019-20	25.77%	25.77%	25.77%	0.00%	25.76%	25.77%	25.77%	0.00%	25.77%	0.00%	0.00%	25.76%	0.00%	0.00%	0.00%	25.77%

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	$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
FY 2016-17	$0.35	$1.69	$27.50	$0.00	$0.14	$0.38	$0.10	$0.00	$0.28	$0.00	$0.00	$0.86	$0.00	$0.00	$0.00	$1.58
Estimated FY 2017-18	$0.43	$2.09	$35.36	$0.00	$0.16	$0.54	$0.12	$0.00	$0.37	$0.00	$0.00	$1.28	$0.00	$0.00	$0.00	$1.96
Estimated FY 2018-19	$0.54	$2.54	$43.68	$0.00	$0.19	$0.63	$0.14	$0.00	$0.46	$0.00	$0.00	$1.63	$0.00	$0.00	$0.00	$2.41
Estimated FY 2019-20	$0.67	$3.06	$53.22	$0.00	$0.23	$0.76	$0.17	$0.00	$0.58	$0.00	$0.00	$2.05	$0.00	$0.00	$0.00	$2.97

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 2009-10 (DA)	100.00%	136.00%	4.42%	0.00%	-50.00%	0.00%	0.00%	0.00%	-42.86%	0.00%	100.00%	-100.00%	0.00%	0.00%	0.00%	-5.56%
FY 2010-11 (DA)	-44.44%	-93.22%	-2.25%	0.00%	50.00%	0.00%	0.00%	0.00%	-75.00%	0.00%	500.00%	0.00%	0.00%	0.00%	0.00%	-9.31%
FY 2011-12	0.00%	887.50%	3.57%	0.00%	66.67%	0.00%	0.00%	0.00%	300.00%	0.00%	100.00%	100.00%	0.00%	0.00%	0.00%	1.08%
FY 2012-13	40.00%	-77.22%	15.10%	0.00%	-30.00%	0.00%	0.00%	0.00%	-75.00%	0.00%	-41.67%	-100.00%	0.00%	0.00%	0.00%	6.42%
FY 2013-14	300.00%	1061.11%	-13.16%	0.00%	200.00%	0.00%	0.00%	0.00%	1400.00%	0.00%	1600.00%	100.00%	0.00%	0.00%	0.00%	-20.10%
FY 2014-15	-25.00%	-48.80%	-12.29%	0.00%	-61.90%	100.00%	100.00%	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%
FY 2016-17	29.63%	24.26%	34.47%	0.00%	27.27%	15.15%	25.00%	0.00%	27.27%	0.00%	0.00%	43.33%	0.00%	0.00%	0.00%	27.42%
Estimated FY 2017-18	22.86%	23.67%	28.58%	0.00%	14.29%	42.11%	20.00%	0.00%	32.14%	0.00%	0.00%	48.84%	0.00%	0.00%	0.00%	24.05%
Estimated FY 2018-19	25.58%	21.53%	23.53%	0.00%	18.75%	16.67%	16.67%	0.00%	24.32%	0.00%	0.00%	27.34%	0.00%	0.00%	0.00%	22.96%
Estimated FY 2019-20	24.07%	20.47%	21.84%	0.00%	21.05%	20.63%	21.43%	0.00%	26.09%	0.00%	0.00%	25.77%	0.00%	0.00%	0.00%	23.24%

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 2016-17 Expenditure	$15,177	$18,972	$1,859,221	$0	$22,766	$37,943	$34,149	$0	$132,802	$0	$0	$11,383	$0	$0	$0	$2,132,413
Average of FY 2010-11 through FY 2014-15	58.78%	382.46%	2.70%	0.00%	74.87%	20.00%	20.00%	0.00%	396.88%	0.00%	387.67%	15.31%	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%	25.00%	25.00%	0.00%	516.63%	0.00%	383.52%	19.13%	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%	33.33%	33.33%	0.00%	507.82%	0.00%	474.72%	-7.82%	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%	50.00%	50.00%	0.00%	797.76%	0.00%	732.75%	38.27%	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%	25.56%	25.56%	0.00%	418.86%	0.00%	306.81%	20.86%	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%	31.95%	31.95%	0.00%	387.81%	0.00%	356.04%	1.08%	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%	42.59%	42.59%	0.00%	541.10%	0.00%	488.50%	34.77%	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%	63.89%	63.89%	0.00%	28.90%	0.00%	-50.00%	2.16%	0.00%	0.00%	0.00%	10.14%
Average of FY 2012-13 through FY 2016-17	77.77%	219.99%	12.15%	0.00%	56.80%	31.98%	31.99%	0.00%	316.68%	0.00%	284.83%	7.29%	0.00%	0.00%	0.00%	14.03%
Average of FY 2013-14 through FY 2016-17	90.22%	293.86%	10.21%	0.00%	79.28%	39.98%	39.98%	0.00%	413.86%	0.00%	366.37%	34.12%	0.00%	0.00%	0.00%	13.17%
Average of FY 2014-15 through FY 2016-17	12.15%	4.86%	16.84%	0.00%	3.65%	53.31%	53.31%	0.00%	29.98%	0.00%	-33.33%	12.16%	0.00%	0.00%	0.00%	17.47%
Average of FY 2015-16 through FY 2016-17	29.96%	29.96%	29.96%	0.00%	29.97%	29.96%	29.97%	0.00%	29.96%	0.00%	0.00%	29.97%	0.00%	0.00%	0.00%	29.96%
Current Year Projection																
FY 2016-17 Expenditure	$15,177	$18,972	$1,859,221	$0	$22,766	$37,943	$34,149	$0	$132,802	$0	$0	$11,383	$0	$0	$0	$2,132,413
Estimated Incremental Expenditure for FY 2017-18																
SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$1,793	$2,241	$219,630	$0	$2,689	$4,482	$4,034	$0	$15,688	$0	$0	$1,345	$0	$0	$0	$251,902
SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$2,585	$3,232	$316,693	$0	$3,878	$6,463	$5,817	$0	$22,621	$0	$0	$1,939	$0	$0	$0	$363,228
Total Incremental Expenditure	$4,378	$5,473	$536,323	$0	$6,567	$10,945	$9,851	$0	$38,309	$0	$0	$3,284	$0	$0	$0	$615,130
Estimated FY 2017-18 Total Expenditure	**$19,555**	**$24,445**	**$2,395,544**	**$0**	**$29,333**	**$48,888**	**$44,000**	**$0**	**$171,111**	**$0**	**$0**	**$14,667**	**$0**	**$0**	**$0**	**$2,747,543**
Estimated FY 2017-18 Per Capita	$0.43	$2.09	$35.36	$0.00	$0.16	$0.54	$0.12	$0.00	$0.37	$0.00	$0.00	$1.28	$0.00	$0.00	$0.00	$1.96
% Change over FY 2016-17 Per Capita	22.86%	23.67%	28.58%	0.00%	14.29%	42.11%	20.00%	0.00%	32.14%	0.00%	0.00%	48.84%	0.00%	0.00%	0.00%	24.05%
Request Year Projection																
Estimated FY 2017-18 Expenditure	$19,555	$24,445	$2,395,544	$0	$29,333	$48,888	$44,000	$0	$171,111	$0	$0	$14,667	$0	$0	$0	$2,747,543
Estimated Incremental Expenditure for FY 2018-19																
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$926	$1,158	$113,448	$0	$1,389	$2,315	$2,084	$0	$8,103	$0	$0	$695	$0	$0	$0	$130,118
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$4,290	$5,363	$525,555	$0	$6,435	$10,725	$9,653	$0	$37,540	$0	$0	$3,218	$0	$0	$0	$602,779
Total Incremental Expenditure	$5,216	$6,521	$639,003	$0	$7,824	$13,040	$11,737	$0	$45,643	$0	$0	$3,913	$0	$0	$0	$732,897
Estimated FY 2018-19 Total Expenditure	**$24,771**	**$30,966**	**$3,034,547**	**$0**	**$37,157**	**$61,928**	**$55,737**	**$0**	**$216,754**	**$0**	**$0**	**$18,580**	**$0**	**$0**	**$0**	**$3,480,440**
Estimated FY 2018-19 Per Capita	$0.54	$2.54	$43.68	$0.00	$0.19	$0.63	$0.14	$0.00	$0.46	$0.00	$0.00	$1.63	$0.00	$0.00	$0.00	$2.41
% Change over FY 2017-18 Per Capita	25.58%	21.53%	23.53%	0.00%	18.75%	16.67%	16.67%	0.00%	24.32%	0.00%	0.00%	27.34%	0.00%	0.00%	0.00%	22.96%
Out Year Projection																
Estimated FY 2018-19 Expenditure	$24,771	$30,966	$3,034,547	$0	$37,157	$61,928	$55,737	$0	$216,754	$0	$0	$18,580	$0	$0	$0	$3,480,440
Estimated Incremental Expenditure for FY 2019-20																
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$951	$1,187	$116,318	$0	$1,424	$2,374	$2,136	$0	$8,308	$0	$0	$712	$0	$0	$0	$133,410
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$5,432	$6,792	$665,552	$0	$8,149	$13,582	$12,225	$0	$47,540	$0	$0	$4,075	$0	$0	$0	$763,347
Total Incremental Expenditure	$6,383	$7,979	$781,870	$0	$9,573	$15,956	$14,361	$0	$55,848	$0	$0	$4,787	$0	$0	$0	$896,757
Estimated FY 2019-20 Total Expenditure	**$31,154**	**$38,945**	**$3,816,417**	**$0**	**$46,730**	**$77,884**	**$70,098**	**$0**	**$272,602**	**$0**	**$0**	**$23,367**	**$0**	**$0**	**$0**	**$4,377,197**
Estimated FY 2019-20 Per Capita	$0.67	$3.06	$53.22	$0.00	$0.23	$0.76	$0.17	$0.00	$0.58	$0.00	$0.00	$2.05	$0.00	$0.00	$0.00	$2.97
% Change over FY 2018-19 Per Capita	24.07%	20.47%	21.84%	0.00%	21.05%	20.63%	21.43%	0.00%	26.09%	0.00%	0.00%	25.77%	0.00%	0.00%	0.00%	23.24%

Exhibit I - SERVICE MANAGEMENT
Summary

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	$10,308,486	$2,859,404	$21,631,959	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,799,849
Disease Management	$29,340	$26,368	$185,252	$21,313	$246,405	$172,623	$463,724	$0	$0	$0	$46,868	$77,665	$16,168	$0	$0	$1,285,726
Accountable Care Collaborative	$4,684,873	$1,522,804	$9,430,857	$615,634	$22,359,014	$9,404,551	$44,239,603	$8,391	$60,522,267	$8,814,155	$3,056,081	$1,107,087	$203,685	$0	$0	$165,969,002
Prepaid Inpatient Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Service Management	**$15,022,699**	**$4,408,576**	**$31,248,068**	**$636,947**	**$22,605,419**	**$9,577,174**	**$44,703,327**	**$8,391**	**$60,522,267**	**$8,814,155**	**$3,102,949**	**$1,184,752**	**$219,853**	**$0**	**$0**	**$202,054,577**

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	$10,733,975	$2,976,851	$22,524,832	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$36,235,658
Disease Management	$29,340	$26,368	$185,252	$21,313	$246,405	$172,623	$463,724	$0	$0	$0	$46,868	$77,665	$16,168	$0	$0	$1,285,726
Accountable Care Collaborative	$6,144,982	$1,663,383	$10,249,566	$1,391,166	$28,605,392	$14,426,477	$57,426,820	$9,637	$71,494,295	$11,078,707	$3,407,341	$1,715,138	$360,160	$0	$0	$207,973,064
Prepaid Inpatient Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Service Management	**$16,908,297**	**$4,666,602**	**$32,959,650**	**$1,412,479**	**$28,851,797**	**$14,599,100**	**$57,890,544**	**$9,637**	**$71,494,295**	**$11,078,707**	**$3,454,209**	**$1,792,803**	**$376,328**	**$0**	**$0**	**$245,494,448**

FY 2019-20 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	$13,035,016	$3,615,348	$27,356,125	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$44,006,489
Disease Management	$29,340	$26,368	$185,252	$21,313	$246,405	$172,623	$463,724	$0	$0	$0	$46,868	$77,665	$16,168	$0	$0	$1,285,726
Accountable Care Collaborative	$6,883,412	$1,926,757	$11,781,598	$1,764,583	$32,547,716	$16,671,060	$64,940,694	$10,584	$80,156,993	$12,802,243	$3,846,210	$1,921,494	$403,488	$0	$0	$235,656,832
Prepaid Inpatient Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Service Management	**$19,947,768**	**$5,568,473**	**$39,322,975**	**$1,785,896**	**$32,794,121**	**$16,843,683**	**$65,404,418**	**$10,584**	**$80,156,993**	**$12,802,243**	**$3,893,078**	**$1,999,159**	**$419,656**	**$0**	**$0**	**$280,949,047**

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	$11,356,086	$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
FY 2016-17	$8,784,331	$2,598,679	$18,717,289	$215,488	$36,556	$3,848	$221,260	$0	$237,934	$10,903	$182,138	$1,283	$0	$0	$79,525	$31,089,234
Estimated FY 2017-18	$10,308,486	$2,859,404	$21,631,959	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,799,849
Estimated FY 2018-19	$10,733,975	$2,976,851	$22,524,832	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$36,235,658
Estimated FY 2019-20	$13,035,016	$3,615,348	$27,356,125	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$44,006,489

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%	-18.31%	0.00%	0.00%	0.00%	-3.25%	0.00%	17.28%	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%
FY 2016-17	0.30%	3.84%	1.15%	7.35%	27.05%	-4.16%	28.67%	0.00%	-69.81%	16.39%	-18.50%	91.78%	0.00%	0.00%	-12.61%	-0.62%
Estimated FY 2017-18	17.35%	10.03%	15.57%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%	11.94%
Estimated FY 2018-19	4.13%	4.11%	4.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.13%
Estimated FY 2019-20	21.44%	21.45%	21.45%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	21.45%

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
FY 2016-17	$199.91	$231.18	$276.81	$34.47	$0.23	$0.04	$0.64	$0.00	$0.51	$0.17	$8.97	$0.10	$0.00	$0.00	$2.35	$23.09
Estimated FY 2017-18	$227.85	$244.79	$319.32	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$24.83
Estimated FY 2018-19	$233.38	$244.49	$324.22	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$25.10
Estimated FY 2019-20	$278.70	$284.40	$381.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$29.83

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%	100.00%	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%	100.00%	-66.67%	250.00%	0.00%	100.00%	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%	100.00%	-51.09%	-27.68%	0.00%	-15.35%	100.00%	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%	100.00%	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%
FY 2016-17	-3.21%	-2.73%	2.92%	6.75%	27.78%	-20.00%	18.52%	0.00%	-69.82%	6.25%	-19.98%	100.00%	0.00%	0.00%	-15.77%	-4.27%
Estimated FY 2017-18	13.98%	5.89%	15.36%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%	7.54%
Estimated FY 2018-19	2.43%	-0.12%	1.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.09%
Estimated FY 2019-20	19.42%	16.32%	17.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.84%

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 2017-18 Base Contracts	$10,160,007	$2,818,218	$21,320,382	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,298,607
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 2017-18 Base Expenditure	$10,160,007	$2,818,218	$21,320,382	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,298,607
Bottom Line Impacts																
FY 2017-18 Across the Board 1.402% Rate Increase	$148,479	$41,186	$311,577	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$501,242
Total Bottom Line Impacts	$148,479	$41,186	$311,577	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$501,242
Estimated FY 2017-18 Total Expenditure	**$10,308,486**	**$2,859,404**	**$21,631,959**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$34,799,849**
Estimated FY 2017-18 Per Capita	$227.85	$244.79	$319.32	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$24.83
% Change over FY 2016-17 Per Capita	13.98%	2.99%	18.72%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.94%

Request 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 2018-19 Base Contracts	$10,308,486	$2,859,404	$21,631,959	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$34,799,849
Estimated Increase in HCBS Enrollment[(1)(2)]	3.36%	3.34%	3.36%	2.72%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.35%
Estimated FY 2018-19 Base Expenditure	$10,654,851	$2,954,908	$22,358,793	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,968,552
Bottom Line Impacts																
SB 16-192 Single Assessment Tool	$79,124	$21,943	$166,039	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$267,106
Total Bottom Line Impacts	$79,124	$21,943	$166,039	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$267,106
Estimated FY 2018-19 Total Expenditure	**$10,733,975**	**$2,976,851**	**$22,524,832**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$36,235,658**
Estimated FY 2018-19 Per Capita	$233.38	$244.49	$324.22	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$25.10
% Change over FY 2017-18 Per Capita	2.43%	-0.12%	1.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.09%

Out 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 2019-20 Base Contracts	$10,733,975	$2,976,851	$22,524,832	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$36,235,658
Estimated Increase in HCBS Enrollment[(1)(2)]	3.40%	3.41%	3.41%	3.70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.41%
Estimated FY 2019-20 Per Capita	$11,098,930	$3,078,362	$23,292,929	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$37,470,221
Bottom Line Impacts																
SB 16-192 Single Assessment Tool	$1,936,086	$536,986	$4,063,196	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,536,268
Total Bottom Line Impacts	$1,936,086	$536,986	$4,063,196	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,536,268
Estimated FY 2019-20 Total Expenditure	**$13,035,016**	**$3,615,348**	**$27,356,125**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$44,006,489**
Estimated FY 2019-20 Per Capita	$278.70	$284.40	$381.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$29.83
% Change over FY 2018-19 Per Capita	19.42%	16.32%	17.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.84%

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 2017-18 expenditure is the amount of the base contracts in place with the SEPs; to trend expenditure for FY 2018-19 and FY 2019-20, 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
FY 2016-17	$21,390	$19,223	$135,054	$15,538	$179,636	$125,847	$338,068	$0	$0	$0	$34,168	$56,620	$11,787	$0	$0	$937,331
Estimated FY 2017-18	$29,340	$26,368	$185,252	$21,313	$246,405	$172,623	$463,724	$0	$0	$0	$46,868	$77,665	$16,168	$0	$0	$1,285,726
Estimated FY 2018-19	$29,340	$26,368	$185,252	$21,313	$246,405	$172,623	$463,724	$0	$0	$0	$46,868	$77,665	$16,168	$0	$0	$1,285,726
Estimated FY 2019-20	$29,340	$26,368	$185,252	$21,313	$246,405	$172,623	$463,724	$0	$0	$0	$46,868	$77,665	$16,168	$0	$0	$1,285,726

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%
FY 2016-17	384.27%	72.33%	76.12%	127.40%	71.06%	174.67%	46.11%	0.00%	0.00%	0.00%	121.91%	38.76%	149.78%	0.00%	0.00%	72.87%
Estimated FY 2017-18	37.17%	37.17%	37.17%	37.17%	37.17%	37.17%	37.17%	0.00%	0.00%	0.00%	37.17%	37.17%	37.17%	0.00%	0.00%	37.17%
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%
Estimated FY 2019-20	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

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
FY 2016-17	$0.49	$1.71	$2.00	$2.49	$1.12	$1.25	$0.97	$0.00	$0.00	$0.00	$1.68	$4.25	$5.85	$0.00	$0.00	$0.70
Estimated FY 2017-18	$0.65	$2.26	$2.73	$2.73	$1.31	$1.89	$1.22	$0.00	$0.00	$0.00	$2.28	$6.80	$6.84	$0.00	$0.00	$0.92
Estimated FY 2018-19	$0.64	$2.17	$2.67	$2.34	$1.26	$1.76	$1.18	$0.00	$0.00	$0.00	$2.26	$6.80	$6.84	$0.00	$0.00	$0.89
Estimated FY 2019-20	$0.63	$2.07	$2.58	$2.06	$1.22	$1.69	$1.15	$0.00	$0.00	$0.00	$2.24	$6.80	$6.84	$0.00	$0.00	$0.87

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%	100.00%	100.00%	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%
FY 2016-17	390.00%	61.32%	80.18%	126.36%	75.00%	135.85%	34.72%	0.00%	0.00%	0.00%	118.18%	50.18%	118.28%	0.00%	0.00%	66.67%
Estimated FY 2017-18	32.65%	32.16%	36.50%	9.64%	16.96%	51.20%	25.77%	0.00%	0.00%	0.00%	35.71%	60.00%	16.92%	0.00%	0.00%	31.43%
Estimated FY 2018-19	-1.54%	-3.98%	-2.20%	-14.29%	-3.82%	-6.88%	-3.28%	0.00%	0.00%	0.00%	-0.88%	0.00%	0.00%	0.00%	0.00%	-3.26%
Estimated FY 2019-20	-1.56%	-4.61%	-3.37%	-11.97%	-3.17%	-3.98%	-2.54%	0.00%	0.00%	0.00%	-0.88%	0.00%	0.00%	0.00%	0.00%	-2.25%

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 2017-18 Projection																
Estimated FY 2017-18 Base Per Capita	$0.65	$2.26	$2.73	$2.73	$1.31	$1.89	$1.22	$0.00	$0.00	$0.00	$2.28	$6.80	$6.84	$0.00	$0.00	$0.92
Estimated FY 2017-18 Eligibles	45,242	11,681	67,743	7,811	188,617	91,246	380,104	117	466,328	68,762	20,584	11,429	2,365	2,782	36,869	1,401,680
Estimated FY 2017-18 Base Expenditure	**$29,340**	**$26,368**	**$185,252**	**$21,313**	**$246,405**	**$172,623**	**$463,724**	**$0**	**$0**	**$0**	**$46,868**	**$77,665**	**$16,168**	**$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 2017-18 Total Expenditure	**$29,340**	**$26,368**	**$185,252**	**$21,313**	**$246,405**	**$172,623**	**$463,724**	**$0**	**$0**	**$0**	**$46,868**	**$77,665**	**$16,168**	**$0**	**$0**	**$1,285,726**
Estimated FY 2017-18 Per Capita	$0.65	$2.26	$2.73	$2.73	$1.31	$1.89	$1.22	$0.00	$0.00	$0.00	$2.28	$6.80	$6.84	$0.00	$0.00	$0.92
% Change over FY 2016-17 Per Capita	32.65%	32.16%	36.50%	9.64%	16.96%	51.20%	25.77%	0.00%	0.00%	0.00%	35.71%	60.00%	16.92%	0.00%	0.00%	31.43%
FY 2018-19 Projection																
Estimated FY 2018-19 Base Per Capita	$0.64	$2.17	$2.67	$2.34	$1.26	$1.76	$1.18	$0.00	$0.00	$0.00	$2.26	$6.80	$6.84	$0.00	$0.00	$0.89
Estimated FY 2018-19 Eligibles	45,993	12,176	69,473	9,099	196,256	98,254	393,958	62	468,328	71,877	20,746	11,427	2,364	2,814	41,068	1,443,895
Estimated FY 2018-19 Base Expenditure	**$29,340**	**$26,368**	**$185,252**	**$21,313**	**$246,405**	**$172,623**	**$463,724**	**$0**	**$0**	**$0**	**$46,868**	**$77,665**	**$16,168**	**$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 2018-19 Total Expenditure	**$29,340**	**$26,368**	**$185,252**	**$21,313**	**$246,405**	**$172,623**	**$463,724**	**$0**	**$0**	**$0**	**$46,868**	**$77,665**	**$16,168**	**$0**	**$0**	**$1,285,726**
Estimated FY 2018-19 Per Capita	$0.64	$2.17	$2.67	$2.34	$1.26	$1.76	$1.18	$0.00	$0.00	$0.00	$2.26	$6.80	$6.84	$0.00	$0.00	$0.89
% Change over FY 2017-18 Per Capita	-1.54%	-3.98%	-2.20%	-14.29%	-3.82%	-6.88%	-3.28%	0.00%	0.00%	0.00%	-0.88%	0.00%	0.00%	0.00%	0.00%	-3.26%
FY 2019-20 Projection																
Estimated FY 2019-20 Base Per Capita	$0.63	$2.07	$2.58	$2.06	$1.22	$1.69	$1.15	$0.00	$0.00	$0.00	$2.24	$6.80	$6.84	$0.00	$0.00	$0.87
Estimated FY 2019-20 Eligibles	46,770	12,712	71,706	10,368	201,516	102,381	401,763	61	470,392	74,443	20,929	11,425	2,364	2,846	45,746	1,475,422
Estimated FY 2019-20 Base Expenditure	**$29,340**	**$26,368**	**$185,252**	**$21,313**	**$246,405**	**$172,623**	**$463,724**	**$0**	**$0**	**$0**	**$46,868**	**$77,665**	**$16,168**	**$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 2019-20 Total Expenditure	**$29,340**	**$26,368**	**$185,252**	**$21,313**	**$246,405**	**$172,623**	**$463,724**	**$0**	**$0**	**$0**	**$46,868**	**$77,665**	**$16,168**	**$0**	**$0**	**$1,285,726**
Estimated FY 2019-20 Per Capita	$0.63	$2.07	$2.58	$2.06	$1.22	$1.69	$1.15	$0.00	$0.00	$0.00	$2.24	$6.80	$6.84	$0.00	$0.00	$0.87
% Change over FY 2018-19 Per Capita	-1.56%	-4.61%	-3.37%	-11.97%	-3.17%	-3.98%	-2.54%	0.00%	0.00%	0.00%	-0.88%	0.00%	0.00%	0.00%	0.00%	-2.25%

Exhibit I - SERVICE MANAGEMENT - ACCOUNTABLE CARE COLLABORATIVE

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 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	$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	$7,402,114	$468,572	$17,348,602	$8,867,761	$34,091,686	$21,262	$57,830,606	$7,572,596	$2,441,963	$1,142,668	$140,520	$1,411	$84,513	$140,949,203
FY 2016-17	$2,914,538	$1,131,754	$7,654,416	$394,525	$17,469,934	$10,220,432	$37,096,754	$2,115	$59,169,454	$8,511,080	$2,639,850	$1,146,380	$162,819	$61	$9,566	$148,523,678
Estimated FY 2017-18	$4,684,873	$1,522,804	$9,430,857	$615,634	$22,359,014	$9,404,551	$44,239,603	$8,391	$60,522,267	$8,814,155	$3,056,081	$1,107,087	$203,685	$0	$0	$165,969,002
Estimated FY 2018-19	$6,144,982	$1,663,383	$10,249,566	$1,391,166	$28,605,392	$14,426,477	$57,426,820	$9,637	$71,494,295	$11,078,707	$3,407,341	$1,715,138	$360,160	$0	$0	$207,973,064
Estimated FY 2019-20	$6,883,412	$1,926,757	$11,781,598	$1,764,583	$32,547,716	$16,671,060	$64,940,694	$10,584	$80,156,993	$12,802,243	$3,846,210	$1,921,494	$403,488	$0	$0	$235,656,832

Percent Change in Cash Based Actuals

ACCOUNTABLE CARE COLLABORATIVE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	-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	12.09%	147.26%	250.23%	1701.28%	630.97%	687.24%	100.00%	0.00%	178.25%	100.00%	326.19%	279.70%	100.00%	100.00%	100.00%	313.09%
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%
FY 2016-17	14.88%	13.41%	3.41%	-15.80%	0.70%	15.25%	8.81%	-90.05%	2.32%	12.39%	8.10%	0.32%	15.87%	-95.68%	-88.68%	5.37%
Estimated FY 2017-18	60.74%	34.55%	23.21%	56.04%	27.99%	-7.98%	19.25%	296.74%	2.29%	3.56%	15.77%	-3.43%	25.10%	-100.00%	-100.00%	11.75%
Estimated FY 2018-19	31.17%	9.23%	8.68%	125.97%	27.94%	53.40%	29.81%	14.85%	18.13%	25.69%	11.49%	54.92%	76.82%	0.00%	0.00%	25.31%
Estimated FY 2019-20	12.02%	15.83%	14.95%	26.84%	13.78%	15.56%	13.08%	9.83%	12.12%	15.56%	12.88%	12.03%	12.03%	0.00%	0.00%	13.31%

Per Capita Cost

ACCOUNTABLE CARE COLLABORATIVE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	$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	$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
FY 2016-17	$66.33	$100.68	$113.20	$63.11	$108.51	$101.13	$106.65	$7.17	$125.92	$131.07	$129.98	$86.12	$80.76	$0.02	$0.28	$110.33
Estimated FY 2017-18	$103.55	$130.37	$139.22	$78.82	$118.54	$103.07	$116.39	$71.72	$129.78	$128.18	$148.47	$96.87	$86.12	$0.00	$0.00	$118.41
Estimated FY 2018-19	$133.61	$136.61	$147.53	$152.89	$145.76	$146.83	$145.77	$155.44	$152.66	$154.13	$164.24	$150.10	$152.35	$0.00	$0.00	$144.04
Estimated FY 2019-20	$147.18	$151.57	$164.30	$170.20	$161.51	$162.83	$161.64	$173.51	$170.40	$171.97	$183.77	$168.18	$170.68	$0.00	$0.00	$159.72

Percent Change in Per Capita Cost

ACCOUNTABLE CARE COLLABORATIVE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	-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	9.12%	128.98%	236.13%	5.47%	585.79%	572.15%	100.00%	0.00%	158.86%	100.00%	332.37%	261.16%	100.00%	100.00%	100.00%	275.03%
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%
FY 2016-17	10.86%	6.22%	5.21%	-16.27%	2.17%	-0.82%	0.23%	-89.14%	1.73%	2.99%	6.11%	8.63%	1.09%	-96.23%	-89.19%	1.53%
Estimated FY 2017-18	56.11%	29.49%	22.99%	24.89%	9.24%	1.92%	9.13%	900.28%	3.07%	-2.20%	14.23%	12.48%	6.64%	-100.00%	-100.00%	7.32%
Estimated FY 2018-19	29.03%	4.79%	5.97%	93.97%	22.96%	42.46%	25.24%	116.73%	17.63%	20.24%	10.62%	54.95%	76.90%	0.00%	0.00%	21.65%
Estimated FY 2019-20	10.16%	10.95%	11.37%	11.32%	10.81%	10.90%	10.89%	11.63%	11.62%	11.57%	11.89%	12.05%	12.03%	0.00%	0.00%	10.89%

Exhibit I - SERVICE MANAGEMENT - ACCOUNTABLE CARE COLLABORATIVE

Current Year Projection

ACCOUNTABLE CARE COLLABORATIVE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RCCOs in the ACC	$1,837,630	$768,566	$5,215,572	$466,392	$16,780,425	$7,152,503	$33,645,917	$6,382	$44,743,851	$6,703,579	$2,258,378	$815,926	$154,912	$0	$0	$120,550,033
ACC: Medicare-Medicaid Program (RCCOs in the ACC)	$1,473,968	$323,871	$1,592,612	$1,610	$197,965	$88	$332	$0	$1,585	$0	$959	$2,330	$0	$0	$0	$3,595,320
Estimated Expenditure for PCMPs in the ACC	$578,565	$241,978	$1,642,087	$146,840	$5,283,204	$2,251,917	$10,593,190	$2,009	$14,087,300	$2,110,576	$711,035	$256,889	$48,773	$0	$0	$37,954,363
ACC: Medicare-Medicaid Program (PCMPs in the ACC)	$265,314	$58,297	$286,670	$290	$35,634	$16	$60	$0	$285	$0	$173	$419	$0	$0	$0	$647,158
Bottom Line Impacts: MMP True-Up to $20 PMPM for FY 2016-17	$460,038	$101,083	$497,067	$502	$61,786	$27	$104	$0	$495	$0	$299	$727	$0	$0	$0	$1,122,128
FY 2017-18 R-11 "Vendor Transitions"	$69,358	$29,009	$196,849	$0	$0	$0	$0	$0	$1,688,751	$0	$85,237	$30,796	$0	$0	$0	$2,100,000
Estimated FY 2017-18 Total Expenditure	$4,684,873	$1,522,804	$9,430,857	$615,634	$22,359,014	$9,404,551	$44,239,603	$8,391	$60,522,267	$8,814,155	$3,056,081	$1,107,087	$203,685	$0	$0	$165,969,002
Estimated FY 2017-18 Per Capita Cost	$103.55	$130.37	$139.22	$78.82	$118.54	$103.07	$116.39	$71.72	$129.78	$128.18	$148.47	$96.87	$86.12	$0.00	$0.00	$118.41

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	$6,144,982	$1,663,383	$10,249,566	$1,391,166	$28,605,392	$14,426,477	$57,426,820	$9,637	$71,494,295	$11,078,707	$3,407,341	$1,715,138	$360,160	$0	$0	$207,973,064
ACC: Medicare-Medicaid Program (RCCOs in the ACC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for PCMPs in the ACC	$0	$0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0	$0	$0	$0	$0
ACC: Medicare-Medicaid Program (PCMPs in the ACC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for SDAC in the ACC	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2018-19 Total Expenditure	$6,144,982	$1,663,383	$10,249,566	$1,391,166	$28,605,392	$14,426,477	$57,426,820	$9,637	$71,494,295	$11,078,707	$3,407,341	$1,715,138	$360,160	$0	$0	$207,973,064
Estimated FY 2018-19 Per Capita Cost	$133.61	$136.61	$147.53	$152.89	$145.76	$146.83	$145.77	$155.44	$152.66	$154.13	$164.24	$150.10	$152.35	$0.00	$0.00	$144.04

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	$6,883,412	$1,926,757	$11,781,598	$1,764,583	$32,547,716	$16,671,060	$64,940,694	$10,584	80,156,993	$12,802,243	$3,846,210	$1,921,494	$403,488	$0	$0	$235,656,832
ACC: Medicare-Medicaid Program (RCCOs in the ACC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for PCMPs in the ACC	$0	$0	$0	$0	$0	$0	$0	$0	-	$0	$0	$0	$0	$0	$0	$0
ACC: Medicare-Medicaid Program (PCMPs in the ACC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for SDAC in the ACC	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2019-20 Total Expenditure	$6,883,412	$1,926,757	$11,781,598	$1,764,583	$32,547,716	$16,671,060	$64,940,694	$10,584	$80,156,993	$12,802,243	$3,846,210	$1,921,494	$403,488	$0	$0	$235,656,832
Estimated FY 2019-20 Per Capita Cost	$147.18	$151.57	$164.30	$170.20	$161.51	$162.83	$161.64	$173.51	$170.40	$171.97	$183.77	$168.18	$170.68	$0.00	$0.00	$159.72

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 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	$107,268,716	$30,705,487	$2,975,000	$140,949,203
FY 2016-17	$111,937,658	$34,336,020	$2,250,000	$148,523,678
Estimated FY 2017-18	$127,367,481	$38,601,521	$0	$165,969,002
Estimated FY 2018-19	$207,973,064	$0	$0	$207,973,064
Estimated FY 2019-20	$235,656,832	$0	$0	$235,656,832
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 2009-10 (DA)	0.00%	0.00%	0.00%	0.00%
FY 2010-11 (DA)	0.00%	0.00%	0.00%	0.00%
FY 2011-12	0.00%	0.00%	0.00%	0.00%
FY 2012-13	100.00%	100.00%	100.00%	100.00%
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	34.98%	43.35%	-2.76%	35.59%
FY 2016-17	4.35%	11.82%	-24.37%	5.37%
Estimated FY 2017-18	13.78%	12.42%	-100.00%	11.75%
Estimated FY 2018-19	63.29%	-100.00%	0.00%	25.31%
Estimated FY 2019-20	13.31%	0.00%	0.00%	13.31%
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 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
FY 2016-17	937,858	730,618	937,858	937,858
Estimated FY 2017-18	1,015,002	790,716	-	1,015,002
Estimated FY 2018-19	1,252,792	-	-	1,252,792
Estimated FY 2019-20	1,268,797	-	-	1,268,797
Annual Percent Change in Enrollment				
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%
FY 2016-17	0.64%	3.32%	0.64%	0.64%
Estimated FY 2017-18	8.23%	8.23%	-100.00%	8.23%
Estimated FY 2018-19	23.43%	-100.00%	0.00%	23.43%
Estimated FY 2019-20	1.28%	0.00%	0.00%	1.28%

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 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	$115.11	$43.42	$3.19	$151.25
FY 2016-17	$119.35	$47.00	$2.40	$158.36
Estimated FY 2017-18	$125.48	$48.82	$0.00	$163.52
Estimated FY 2018-19	$166.01	$0.00	$0.00	$166.01
Estimated FY 2019-20	$185.73	$0.00	$0.00	$185.73

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 2013-14	-4.93%	4.85%	-49.41%	155.32%
FY 2014-15	-9.06%	2.83%	-37.19%	-8.16%
FY 2015-16	8.88%	11.59%	-21.62%	9.38%
FY 2016-17	3.68%	8.25%	-24.76%	4.70%
Estimated FY 2017-18	5.14%	3.87%	-100.00%	3.26%
Estimated FY 2018-19	32.30%	-100.00%	0.00%	1.52%
Estimated FY 2019-20	11.88%	0.00%	0.00%	11.88%

Current Year Projection

ACCOUNTABLE CARE COLLABORATIVE	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
Estimated FY 2017-18 Enrollment	1,015,002	790,716	N/A	1,015,002
FY 2017-18 PMPM Administration Fee	$9.90	$4.00	N/A	
Number of Months Paid	12	12	N/A	
Estimated FY 2017-18 Base Expenditure	$120,550,033	$37,954,363	$0	$158,504,396
FY 2014-15 BA-12: "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	$3,595,320	$647,158	$0	$4,242,478
Bottom Line Impacts: MMP True-Up to $20 PMPM for FY 2016-17	$1,122,128	$0	$0	$1,122,128
FY 2017-18 R-11 "Vendor Transitions"	$2,100,000			
Total Bottom Line Impacts	$6,817,448	$647,158	$0	$7,464,606
Estimated FY 2017-18 Total Expenditure	**$127,367,481**	**$38,601,521**	**$0**	**$165,969,002**
Estimated FY 2017-18 Cost Per Enrollee	$125.48	$48.82	$0.00	$163.52
% Change over FY 2016-17 Cost Per Enrollee	5.14%	3.87%	-100.00%	3.26%

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 2018-19 Enrollment	1,252,792	-	N/A	1,252,792
FY 2018-19 PMPM Administration Fee	$13.83	$0.00	N/A	
Number of Months Paid	12	12	N/A	
Estimated FY 2018-19 Base Expenditure	$207,973,064	$0	$0	$207,973,064
Total Bottom Line Impacts	$0	$0	$0	$0
Estimated FY 2018-19 Total Expenditure	**$207,973,064**	**$0**	**$0**	**$207,973,064**
Estimated FY 2018-19 Cost Per Enrollee	$166.01	$0.00	$0.00	$166.01
% Change over FY 2017-18 Cost Per Enrollee	32.30%	-100.00%	0.00%	1.52%

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 2019-20 Enrollment	1,268,797	-	N/A	1,268,797
FY 2019-20 PMPM Administration Fee	$15.48	$0.00	N/A	
Number of Months Paid	12	12	N/A	
Estimated FY 2019-20 Base Expenditure	$235,656,832	$0	$0	$235,656,832
Total Bottom Line Impacts	$0	$0	$0	$0
Estimated FY 2019-20 Total Expenditure	**$235,656,832**	**$0**	**$0**	**$235,656,832**
Estimated FY 2019-20 Cost Per Enrollee	$185.73	$0.00	$0.00	$185.73
% Change over FY 2018-19 Cost Per Enrollee	11.88%	0.00%	0.00%	11.88%

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 2007-08	$366,151	$74,505	$536,817	$0	$496,755	$0	$0	$0	$1,873,683	$0	$176,254	$85,306	$0	$0	$0	$3,609,472
FY 2008-09	$352,841	$75,159	$520,646	$0	$626,486	$0	$0	$0	$2,101,664	$0	$184,279	$74,059	$0	$0	$0	$3,935,134
FY 2009-10 (DA)	$331,989	$116,999	$938,116	$0	$713,502	$0	$0	$0	$2,715,378	$0	$208,304	$87,465	$0	$0	$0	$5,111,753
FY 2010-11 (DA)	$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
FY 2015-16	$10	$3	$27	$2	$31	$11	$9	$0	$18	$0	$2	$7	$1	$0	$0	$121

Percent Change in Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	-3.64%	0.88%	-3.01%	0.00%	26.12%	0.00%	0.00%	0.00%	12.17%	0.00%	4.55%	-13.18%	0.00%	0.00%	0.00%	9.02%
FY 2009-10 (DA)	-5.91%	55.67%	80.18%	0.00%	13.89%	0.00%	0.00%	0.00%	29.20%	0.00%	13.04%	18.10%	0.00%	0.00%	0.00%	29.90%
FY 2010-11 (DA)	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%
FY 2015-16	-99.99%	-99.99%	-99.99%	-99.99%	-99.99%	-99.99%	-100.00%	0.00%	-100.00%	-100.00%	-100.00%	-99.99%	-99.99%	0.00%	-100.00%	-99.99%

Per Capita Cost

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$10.09	$12.12	$10.75	$0.00	$9.29	$0.00	$0.00	$0.00	$9.18	$0.00	$10.28	$13.57	$0.00	$0.00	$0.00	$9.21
FY 2008-09	$9.38	$11.66	$10.14	$0.00	$10.13	$0.00	$0.00	$0.00	$8.94	$0.00	$10.22	$10.62	$0.00	$0.00	$0.00	$9.01
FY 2009-10 (DA)	$8.63	$16.60	$17.61	$0.00	$9.53	$0.00	$0.00	$0.00	$9.85	$0.00	$11.33	$11.17	$0.00	$0.00	$0.00	$10.25
FY 2010-11 (DA)	$10.57	$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
FY 2015-16	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Percent Change in Per Capita Cost

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens- Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	-7.04%	-3.80%	-5.67%	0.00%	9.04%	0.00%	0.00%	0.00%	-2.61%	0.00%	-0.58%	-21.74%	0.00%	0.00%	0.00%	-2.17%
FY 2009-10 (DA)	-8.00%	42.37%	73.67%	0.00%	-5.92%	0.00%	0.00%	0.00%	10.18%	0.00%	10.86%	5.18%	0.00%	0.00%	0.00%	13.76%
FY 2010-11 (DA)	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%
FY 2015-16	-100.00%	-100.00%	-100.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	-100.00%

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 2007-08	$3,609,472	$0	$0	$0	$3,609,472
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
FY 2015-16	$121	$0	$0	$0	$121

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%	9.02%
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%
FY 2015-16	-99.99%	0.00%	0.00%	0.00%	-99.99%

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 2007-08	11,955	-	-	-	11,955
FY 2008-09	13,051	-	-	-	13,051
FY 2009-10 (DA)	16,123	2,186	275	24	18,608
FY 2010-11 (DA)	19,045	1,826	544	112	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
FY 2015-16	-	-	-	-	-

Annual Percent Change in Enrollment

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	TOTAL
FY 2008-09	9.17%	0.00%	0.00%	0.00%	9.17%
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%
FY 2015-16	-100.00%	0.00%	0.00%	0.00%	-100.00%

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 2007-08	$301.92	$0.00	$0.00	$0.00	$301.92
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
FY 2015-16	$0.00	$0.00	$0.00	$0.00	$0.00

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 2008-09	-0.13%	0.00%	0.00%	0.00%	-0.13%
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%
FY 2015-16	-100.00%	0.00%	0.00%	0.00%	-100.00%

(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 - Healthcare Affordability and Sustainability Fee Cash Funded Populations and Supplemental Payments

Cash Funded Expansion Populations
Source of Funding

FY 2017-18 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Healthcare Affordability and Sustainability Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
Medicaid Expansion Clients							
MAGI Parents/Caretakers 69% to 133% FPL	91,246	$269,205,649	$0	$15,110,689	$0	$254,094,960	94.39%
Buy-In for Individuals with Disabilities	7,811	$57,143,816	$0	$26,800,771	$3,542,272	$26,800,773	46.90%
MAGI Adults	377,575	$1,531,755,007	$0	$86,858,231	$0	$1,444,896,776	94.33%
Non-Newly Eligibles	2,529	$49,157,008	$0	$8,169,895	$0	$40,987,113	83.38%
MAGI Parents/Caretakers 60% to 68% FPL	8,955	$22,256,007	$0	$11,128,002	$0	$11,128,005	50.00%
Continuous Eligibility for Children	39,706	$52,507,215	$0	$26,253,607	$0	$26,253,608	50.00%
Subtotal of Medicaid Expansion Clients		$1,982,024,702	$0	$174,321,195	$3,542,272	$1,804,161,235	
Supplemental Payments							
Inpatient Hospital Rates		$473,551,235	$0	$236,743,295	$0	$236,807,940	50.01%
Outpatient Hospital Rates		$349,869,074	$0	$174,910,657	$0	$174,958,417	50.01%
Hospital Quality Incentive Payment		$88,324,310	$0	$44,156,237	$0	$44,168,073	50.01%
Subtotal of Supplemental Payments		$911,744,619	$0	$455,810,189	$0	$455,934,430	
Cash Fund Financing		$0	($15,700,000)	$15,700,000	$0	$0	
Total		**$2,893,769,321**	**($15,700,000)**	**$645,831,384**	**$3,542,272**	**$2,260,095,665**	

FY 2018-19 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Healthcare Affordability and Sustainability Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
Medicaid Expansion Clients							
MAGI Parents/Caretakers 69% to 133% FPL	98,254	$259,196,690	$0	$17,168,174	$0	$242,028,516	93.38%
Buy-in for Individuals with Disabilities	9,099	$54,879,868	$0	$25,383,560	$4,112,744	$25,383,564	46.25%
MAGI Adults	391,365	$1,428,634,549	$0	$95,507,191	$0	$1,333,127,358	93.31%
Non-Newly Eligibles	2,593	$50,765,131	$0	$8,817,903	$0	$41,947,228	82.63%
MAGI Parents/Caretakers 60% to 68% FPL	9,318	$25,528,929	$0	$12,764,464	$0	$12,764,465	50.00%
Continuous Eligibility for Children	40,480	$54,173,979	$0	$27,086,988	$0	$27,086,991	50.00%
Subtotal of Medicaid Expansion Clients		$1,873,179,146	$0	$186,728,280	$4,112,744	$1,682,338,122	
Supplemental Payments							
Inpatient Hospital Rates		$506,727,863	$0	$253,363,931	$0	$253,363,932	50.00%
Outpatient Hospital Rates		$374,380,627	$0	$187,190,313	$0	$187,190,314	50.00%
Hospital Quality Incentive Payment		$88,324,310	$0	$44,162,155	$0	$44,162,155	50.00%
Subtotal of Supplemental Payments		$969,432,800	$0	$484,716,399	$0	$484,716,401	
Cash Fund Financing		$0	($15,700,000)	$15,700,000	$0	$0	
Total		**$2,842,611,946**	**($15,700,000)**	**$687,144,679**	**$4,112,744**	**$2,167,054,523**	

FY 2019-20 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Healthcare Affordability and Sustainability Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
Medicaid Expansion Clients							
MAGI Parents/Caretakers 69% to 133% FPL	102,381	$271,333,077	$0	$23,381,808	$0	$247,951,269	91.38%
Buy-in for Individuals with Disabilities	10,368	$55,367,944	$0	$25,348,416	$4,671,111	$25,348,417	45.78%
MAGI Adults	399,119	$1,511,720,418	$0	$131,070,510	$0	$1,380,649,908	91.33%
Non-Newly Eligibles	2,644	$7,566,837	$0	$1,427,862	$0	$6,138,975	81.13%
MAGI Parents/Caretakers 60% to 68% FPL	9,568	$26,482,053	$0	$13,241,025	$0	$13,241,028	50.00%
Continuous Eligibility for Children	40,658	$54,974,495	$0	$27,487,247	$0	$27,487,248	50.00%
Subtotal of Medicaid Expansion Clients		$1,927,444,824	$0	$221,956,868	$4,671,111	$1,700,816,845	
Supplemental Payments							
Inpatient Hospital Rates		$475,619,688	$0	$237,809,844	$0	$237,809,844	50.00%
Outpatient Hospital Rates		$351,397,288	$0	$175,698,644	$0	$175,698,644	50.00%
Hospital Quality Incentive Payment		$88,324,310	$0	$44,162,155	$0	$44,162,155	50.00%
Subtotal of Supplemental Payments		$915,341,286	$0	$457,670,643	$0	$457,670,643	
Cash Fund Financing		$0	($15,700,000)	$15,700,000	$0	$0	
Total		**$2,842,786,110**	**($15,700,000)**	**$695,327,511**	**$4,671,111**	**$2,158,487,488**	

Exhibit J - Healthcare Affordability and Sustainability Fee Cash Funded Populations and Supplemental Payments

Healthcare Affordability and Sustainability 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	Healthcare Affordability and Sustainability Fee	Medicaid Buy-in Fund	Federal Funds
Acute Care		$2,841.65	$259,289,377	$0	$14,565,294	$0	$244,724,083
Community-Based Long-Term Care		$5.07	$462,833	$0	$25,456	$0	$437,377
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.54	$48,888	$0	$2,689	$0	$46,199
Service Management		$103.07	$9,404,551	$0	$517,250	$0	$8,887,301
Total	**91,246**	**$2,950.33**	**$269,205,649**	**$0**	**$15,110,689**	**$0**	**$254,094,960**

Buy-In for Individuals with Disabilities

	Caseload	Per Capita	Total Funds [2]	General Fund	Healthcare Affordability and Sustainability Fee	Medicaid Buy-in Fund	Federal Funds
Acute Care		$6,232.46	$48,681,734	$0	$22,832,007	$3,017,719	$22,832,008
Community-Based Long-Term Care		$993.16	$7,757,596	$0	$3,638,356	$480,883	$3,638,357
Long-Term Care		$11.38	$88,852	$0	$41,672	$5,508	$41,672
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$78.82	$615,634	$0	$288,736	$38,162	$288,736
Total	**7,811**	**$7,315.81**	**$57,143,816**	**$0**	**$26,800,771**	**$3,542,272**	**$26,800,773**

MAGI Adults[1]

	Caseload	Per Capita	Total Funds [2]	General Fund	Healthcare Affordability and Sustainability Fee	Medicaid Buy-in Fund	Federal Funds[1]
Acute Care		$3,921.60	$1,480,698,620	$0	$84,050,130	$0	$1,396,648,490
Community-Based Long-Term Care		$15.29	$5,774,351	$0	$317,589	$0	$5,456,762
Long-Term Care		$3.24	$1,224,197	$0	$67,331	$0	$1,156,866
Insurance		$0.12	$44,000	$0	$2,420	$0	$41,580
Service Management		$116.57	$44,013,839	$0	$2,420,761	$0	$41,593,078
Total	**377,575**	**$4,056.82**	**$1,531,755,007**	**$0**	**$86,858,231**	**$0**	**$1,444,896,776**

Non-Newly Eligibles

	Caseload	Per Capita	Total Funds [2]	General Fund	Healthcare Affordability and Sustainability Fee	Medicaid Buy-in Fund	Federal Funds
Acute Care		$17,683.37	$44,721,243	$0	$7,432,671	$0	$37,288,572
Community-Based Long-Term Care		$618.97	$1,565,375	$0	$260,165	$0	$1,305,210
Long-Term Care		$1,045.72	$2,644,626	$0	$439,537	$0	$2,205,089
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$89.27	$225,764	$0	$37,522	$0	$188,242
Total	**2,529**	**$19,437.33**	**$49,157,008**	**$0**	**$8,169,895**	**$0**	**$40,987,113**

MAGI Parents/Caretakers 60% to 68% FPL

	Caseload	Per Capita	Total Funds [2]	General Fund	Healthcare Affordability and Sustainability Fee	Medicaid Buy-in Fund	Federal Funds
Acute Care		$3,085.36	$21,499,543	$0	$10,749,771	$0	$10,749,772
Community-Based Long-Term Care		$5.71	$113,149	$0	$56,574	$0	$56,575
Long-Term Care		$1.53	$23,299	$0	$11,649	$0	$11,650
Insurance		$2.05	$0	$0	$0	$0	$0
Service Management		$119.85	$620,016	$0	$310,008	$0	$310,008
Total	**8,955**	**$3,214.50**	**$22,256,007**	**$0**	**$11,128,002**	**$0**	**$11,128,005**

Continuous Eligibility for Children

	Caseload	Per Capita	Total Funds [2]	General Fund	Healthcare Affordability and Sustainability Fee	Medicaid Buy-in Fund	Federal Funds
Acute Care		$1,145.85	$45,497,120	$0	$22,748,560	$0	$22,748,560
Community-Based Long-Term Care		$2.93	$116,339	$0	$58,169	$0	$58,170
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$173.62	$6,893,756	$0	$3,446,878	$0	$3,446,878
Total	**39,706**	**$1,322.40**	**$52,507,215**	**$0**	**$26,253,607**	**$0**	**$26,253,608**

FY 2017-18 Summary

	Caseload	Per Capita	Total Funds [2]	General Fund	Healthcare Affordability and Sustainability Fee	Medicaid Buy-in Fund	Federal Funds
Total	**527,822**	**$3,755.10**	**$1,982,024,702**	**$0**	**$174,321,195**	**$3,542,272**	**$1,804,161,235**

(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.

Healthcare Affordability and Sustainability 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**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,485.44	$244,204,797	$0	$16,193,701	$0	$228,011,096
Community-Based Long-Term Care		$5.12	$503,488	$0	$32,727	$0	$470,761
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.63	$61,928	$0	$4,025	$0	$57,903
Service Management		$146.83	$14,426,477	$0	$937,721	$0	$13,488,756
Total	**98,254**	**$2,638.03**	**$259,196,690**	**$0**	**$17,168,174**	**$0**	**$242,028,516**
Buy-In for Individuals with Disabilities							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$4,944.66	$44,991,433	$0	$20,809,868	$3,371,696	$20,809,869
Community-Based Long-Term Care		$923.79	$8,405,574	$0	$3,887,826	$629,921	$3,887,827
Long-Term Care		$10.08	$91,695	$0	$42,411	$6,872	$42,412
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$152.89	$1,391,166	$0	$643,455	$104,255	$643,456
Total	**9,099**	**$6,031.42**	**$54,879,868**	**$0**	**$25,383,560**	**$4,112,744**	**$25,383,564**
MAGI Adults[1]							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds[1]**
Acute Care		$3,485.31	$1,364,029,407	$0	$91,307,857	$0	$1,272,721,550
Community-Based Long-Term Care		$15.80	$6,182,805	$0	$401,882	$0	$5,780,923
Long-Term Care		$2.99	$1,169,675	$0	$76,029	$0	$1,093,646
Insurance		$0.14	$55,737	$0	$3,623	$0	$52,114
Service Management		$146.15	$57,196,925	$0	$3,717,800	$0	$53,479,125
Total	**391,365**	**$3,650.39**	**$1,428,634,549**	**$0**	**$95,507,191**	**$0**	**$1,333,127,358**
Non-Newly Eligibles							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$17,748.08	$46,020,771	$0	$7,993,808	$0	$38,026,963
Community-Based Long-Term Care		$652.35	$1,691,544	$0	$293,821	$0	$1,397,723
Long-Term Care		$1,088.67	$2,822,921	$0	$490,341	$0	$2,332,580
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$88.66	$229,895	$0	$39,933	$0	$189,962
Total	**2,593**	**$19,577.76**	**$50,765,131**	**$0**	**$8,817,903**	**$0**	**$41,947,228**
MAGI Parents/Caretakers 60% to 68% FPL							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,684.73	$24,607,330	$0	$12,303,665	$0	$12,303,665
Community-Based Long-Term Care		$5.88	$135,360	$0	$67,680	$0	$67,680
Long-Term Care		$1.52	$28,037	$0	$14,018	$0	$14,019
Insurance		$2.22	$0	$0	$0	$0	$0
Service Management		$147.01	$758,202	$0	$379,101	$0	$379,101
Total	**9,318**	**$2,841.36**	**$25,528,929**	**$0**	**$12,764,464**	**$0**	**$12,764,465**
Continuous Eligibility for Children							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$1,150.84	$46,586,003	$0	$23,293,001	$0	$23,293,002
Community-Based Long-Term Care		$3.04	$123,059	$0	$61,529	$0	$61,530
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$184.41	$7,464,917	$0	$3,732,458	$0	$3,732,459
Total	**40,480**	**$1,338.29**	**$54,173,979**	**$0**	**$27,086,988**	**$0**	**$27,086,991**
FY 2018-19 Summary							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**551,109**	**$3,398.93**	**$1,873,179,146**	**$0**	**$186,728,280**	**$4,112,744**	**$1,682,338,122**

(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 J - Healthcare Affordability and Sustainability Fee Cash Funded Populations and Supplemental Payments

Healthcare Affordability and Sustainability Fee - Fund Splits and Service Category Impacts by Expansion Population
FY 2019-20

MAGI Parents/Caretakers 69% to 133% FPL[1]							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,481.30	$254,038,441	$0	$21,911,764	$0	$232,126,677
Community-Based Long-Term Care		$5.33	$545,692	$0	$46,384	$0	$499,308
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.76	$77,884	$0	$6,620	$0	$71,264
Service Management		$162.83	$16,671,060	$0	$1,417,040	$0	$15,254,020
Total	**102,381**	**$2,650.23**	**$271,333,077**	**$0**	**$23,381,808**	**$0**	**$247,951,269**
Buy-In for Individuals with Disabilities							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$4,274.20	$44,314,854	$0	$20,288,118	$3,738,618	$20,288,118
Community-Based Long-Term Care		$886.73	$9,193,610	$0	$4,208,996	$775,618	$4,208,996
Long-Term Care		$9.15	$94,897	$0	$43,445	$8,006	$43,446
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$170.20	$1,764,583	$0	$807,857	$148,869	$807,857
Total	**10,368**	**$5,340.27**	**$55,367,944**	**$0**	**$25,348,416**	**$4,671,111**	**$25,348,417**
MAGI Adults[1]							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds[1]**
Acute Care		$3,594.32	$1,434,562,433	$0	$124,512,081	$0	$1,310,050,352
Community-Based Long-Term Care		$21.07	$8,410,714	$0	$714,911	$0	$7,695,803
Long-Term Care		$10.34	$4,127,976	$0	$350,878	$0	$3,777,098
Insurance		$0.18	$70,098	$0	$5,958	$0	$64,140
Service Management		$161.73	$64,549,197	$0	$5,486,682	$0	$59,062,515
Total	**399,119**	**$3,787.64**	**$1,511,720,418**	**$0**	**$131,070,510**	**$0**	**$1,380,649,908**
Non-Newly Eligibles							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,704.13	$7,149,720	$0	$1,349,152	$0	$5,800,568
Community-Based Long-Term Care		$5.92	$15,652	$0	$2,954	$0	$12,698
Long-Term Care		$1.53	$4,045	$0	$763	$0	$3,282
Insurance		$2.24	$5,923	$0	$1,118	$0	$4,805
Service Management		$148.07	$391,497	$0	$73,875	$0	$317,622
Total	**2,644**	**$2,861.89**	**$7,566,837**	**$0**	**$1,427,862**	**$0**	**$6,138,975**
MAGI Parents/Caretakers 60% to 68% FPL							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,619.31	$25,490,653	$0	$12,745,326	$0	$12,745,327
Community-Based Long-Term Care		$6.17	$146,607	$0	$73,303	$0	$73,304
Long-Term Care		$1.53	$30,591	$0	$15,295	$0	$15,296
Insurance		$2.30	$0	$0	$0	$0	$0
Service Management		$162.74	$814,202	$0	$407,101	$0	$407,101
Total	**9,568**	**$2,792.05**	**$26,482,053**	**$0**	**$13,241,025**	**$0**	**$13,241,028**
Continuous Eligibility for Children							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$1,164.67	$47,353,153	$0	$23,676,576	$0	$23,676,577
Community-Based Long-Term Care		$3.04	$123,600	$0	$61,800	$0	$61,800
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$184.41	$7,497,742	$0	$3,748,871	$0	$3,748,871
Total	**40,658**	**$1,352.12**	**$54,974,495**	**$0**	**$27,487,247**	**$0**	**$27,487,248**
FY 2019-20 Summary							
	Caseload	**Per Capita**	**Total Funds [2]**	**General Fund**	**Healthcare Affordability and Sustainability Fee**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**564,738**	**$3,412.99**	**$1,927,444,824**	**$0**	**$221,956,868**	**$4,671,111**	**$1,700,816,845**

(1) The matching federal funds for this population will decrease from 93% to 90% 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 2017-18**	**FY 2018-19**	**FY 2019-20**
Total Funds	$3,517,162	$3,678,209	$3,806,985
General Fund	($3,594,682)	($3,680,416)	($3,806,984)
Cash Funds	$3,517,162	$3,678,209	$3,806,985
Federal Funds	$3,594,682	$3,680,416	$3,806,984
Home Health UPL			
Total Funds	$631,803	$653,988	$676,682
General Fund	($632,309)	($653,989)	($676,682)
Cash Funds	$631,803	$653,988	$676,682
Federal Funds	$632,309	$653,989	$676,682
Total Upper Payment Limit Financing			
Total Funds	$4,148,965	$4,332,197	$4,483,667
General Fund	($4,226,991)	($4,334,405)	($4,483,666)
Cash Funds	$4,148,965	$4,332,197	$4,483,667
Federal Funds	$4,226,991	$4,334,405	$4,483,666

Nursing Facilities Upper Payment Limit Calculation
Estimate Based on Calendar Year 2016 Actual Upper Payment Limit

State Nursing Facilities		
Provider Name	**Upper Payment Limit (Amount Remaining after Medicaid Payment)**	**Certified Uncompensated Cost**
Colorado St. Veterans - Fitzsimmons	$1,677,054	$1,907,380
Colorado St. Veterans - Florence	$934,351	$1,860,551
Colorado St. Veterans - Homelake	$1,199	$742,072
Colorado St. Veterans - Rifle	$884,780	$1,141,077
Colorado St. Veterans - Walsenburg	$289,764	$359,121
State Nursing Facilities Total	**$3,787,148**	**$6,010,202**
Government Nursing Facilities		
Arkansas Valley	$499,218	$1,289,403
Bent County Healthcare Center	($592,795)	($451,219)
Cheyenne Manor	$385,895	$382,822
Cripple Creek Rehabilitation & Wellness Center	($96,380)	($152,243)
E. Dene Moore Care Center	$1,439,227	$1,396,085
Gunnison Valley Health Senior Care	($151,496)	$182,540
Lincoln Community Hospital & Nursing Home	$703,788	$456,079
Prospect Park Living Center	$229,000	$259,848
Sedgwick County Hospital & Nursing Home	($150,263)	($196,328)
Southeast Colorado Hospital & LTC Center	$250,410	$216,747
Walbridge Memorial Convalescent Wing	$587,292	$1,214,986
Walsh Healthcare Center	$69,624	$291,491
Washington County Nursing Home	($87,329)	($229,795)
Government Nursing Facilities Total	**$3,086,191**	**$4,660,414**

Exhibit K - Upper Payment Limit Financing

Supplemental Medicaid Nursing Facilities Payment	
Estimated CY 2015 Upper Payment Limit	$7,111,844
Estimated CY 2016 Upper Payment Limit	$7,358,625
Estimated CY 2017 Upper Payment Limit	$7,613,969
Supplemental Medicaid Nursing Facility Payment FY 2017-18	
Total Funds	$3,517,162
General Fund (offset by Federal Funds)	($3,594,682)
Cash Funds	$3,517,162
Federal Funds	$3,594,682
Supplemental Medicaid Nursing Facility Payment FY 2018-19	
Total Funds	$3,678,209
General Fund (offset by Federal Funds)	($3,680,416)
Cash Funds	$3,678,209
Federal Funds	$3,680,416
Supplemental Medicaid Nursing Facility Payment FY 2019-20	
Total Funds	$3,806,985
General Fund (offset by Federal Funds)	($3,806,984)
Cash Funds	$3,806,985
Federal Funds	$3,806,984
CY 2016 Inflation Factor (1)	**3.47%**

(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	$218,996
Delta Montrose Home Health Services	$224,334
Estes Park Home Health	$393,123
Grand County Nursing Service	$60,489
Kit Carson County Home Health	$79,191
Lincoln Community Home Health	$39,158
Pioneers Hospital Home Health	$21,783
Prowers Home Health	$38,992
Southeast Colorado Hospital Home Health	$32,999
Yuma District Home Health Care	$112,653
Home Health Total	**$1,221,718**

Exhibit K - Upper Payment Limit Financing

Supplemental Medicaid Home Health Payment	
CY 2017 Upper Payment Limit	$1,264,112
CY 2018 Upper Payment Limit	$1,307,977
CY 2019 Upper Payment Limit	$1,353,364
Supplemental Medicaid Home Health Payment FY 2017-18	
Total Funds	$631,803
General Fund	($632,309)
Cash Funds	$631,803
Federal Funds	$632,309
Supplemental Medicaid Home Health Payment FY 2018-19	
Total Funds	$653,988
General Fund	($653,989)
Cash Funds	$653,988
Federal Funds	$653,989
Supplemental Medicaid Home Health Payment FY 2019-20	
Total Funds	$676,682
General Fund	($676,682)
Cash Funds	$676,682
Federal Funds	$676,682
CY 2016 Inflation Factor [1]	**3.47%**
(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 2014 for FY 2015-16 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	44,704	163,327	27.37%
Non State Owned Public			
Arkansas Valley Regional Medical Center	1,248	4,529	27.56%
Aspen Valley Hospital	297	2,449	12.13%
Delta County Memorial Hospital	1,305	5,846	22.32%
Denver Health Medical Center	73,910	114,508	64.55%
East Morgan County Hospital	183	1,200	15.25%
Estes Park Medical Center	121	1,066	11.35%
Grand River Medical Center	230	1,269	18.12%
Gunnison Valley Hospital	371	1,566	23.69%
Heart of the Rockies Regional Medical Center	867	3,708	23.38%
Kremmling Memorial Hospital	35	279	12.54%
Melissa Memorial Hospital	56	406	13.79%
Memorial Hospital	32,344	107,063	30.21%
The Memorial Hospital	1,158	2,636	43.93%
Montrose Memorial Hospital	1,881	11,298	16.65%
North Colorado Medical Center	14,998	46,770	32.07%
Poudre Valley Hospital	9,982	57,395	17.39%
Prowers Medical Center	894	2,019	44.28%
Sedgwick County Memorial Hospital	53	377	14.06%
Southeast Colorado Hospital	69	513	13.45%
Southwest Memorial Hospital	1,380	3,959	34.86%
Spanish Peaks Regional Health Center	110	585	18.80%
St. Vincent General Hospital District	46	200	23.00%
Wray Community District Hospital	245	1,081	22.66%
Yuma District Hospital	84	561	14.97%

Exhibit K - Upper Payment Limit Financing

Medicaid Eligible Inpatient Days from the Cost Report ending in Calendar Year 2014 for FY 2015-16 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	784	2,772	28.28%
Boulder Community Hospital	6,595	35,246	18.71%
Centura Health - St. Thomas More Hospital	1,574	6,063	25.96%
Children's Hospital Colorado	49,177	90,291	54.47%
Colorado Plains Medical Center	1,494	7,679	19.46%
Community Hospital	492	5,464	9.00%
Conejos County Hospital	38	251	15.14%
Family Health West Hospital	113	1,003	11.27%
Longmont United Hospital	6,667	28,653	23.27%
McKee Medical Center	3,751	13,299	28.21%
Medical Center of the Rockies	5,575	43,738	12.75%
Mercy Medical Center	3,479	14,861	23.41%
Mount San Rafael Hospital	594	2,300	25.83%
National Jewish Health	115	186	61.83%
Parkview Medical Center	18,875	80,841	23.35%
Centura Health - Penrose -St. Francis Health Services	17,460	96,889	18.02%
Pikes Peak Regional Hospital	311	1,462	21.27%
Platte Valley Medical Center	4,210	11,182	37.65%
Rio Grande Hospital	273	1,213	22.51%
San Luis Valley Regional Medical Center	2,354	5,387	43.70%
Centura Health - St. Mary-Corwin Medical Center	6,836	26,076	26.22%
St. Mary's Hospital and Medical Center	18,192	62,630	29.05%
Sterling Regional Medical Center	927	3,670	25.26%
Valley View Hospital	6,075	10,728	56.63%
Yampa Valley Medical Center	941	4,221	22.29%
Note: Figures from Cost Report Year End (CRYE) 2014.			

Exhibit L - Recoveries

Department Recovery Revenue											
Recovery Category	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**Estimated FY 2017-18**	**Estimated FY 2018-19**	**Estimated FY 2019-20**
Estate Recoveries[1]	$3,682,865	$3,006,302	$2,993,722	$4,679,459	$5,283,510	$6,969,380	$5,526,967	$6,261,038	$6,481,029	$6,645,728	$6,818,343
Income Trust and Repayments[1]	$3,217,373	$4,021,065	$4,202,267	$3,976,905	$3,467,692	$4,074,355	$6,716,046	$6,090,938	$6,304,953	$6,465,177	$6,633,102
Third Party Health Insurance	$14,857,476	$17,714,457	$19,834,962	$27,406,316	$21,063,474	$26,598,141	$28,691,812	$31,434,219	$32,538,710	$33,365,599	$34,232,230
Third Party Casualty	$3,917,944	$4,664,590	$6,983,907	$5,660,459	$7,093,986	$8,809,174	$8,457,430	$7,341,535	$7,599,492	$7,792,614	$7,995,018
Credit Balance Audits[2]	$0	$0	$0	$0	$0	$0	$0	$0	$500,000	$1,000,000	$1,500,000
Total Recoveries Including Bottom Line Impacts[3]	**$25,675,658**	**$29,406,414**	**$34,014,858**	**$41,723,139**	**$36,908,662**	**$46,451,050**	**$49,392,255**	**$51,127,730**	**$53,424,184**	**$55,269,118**	**$57,178,693**

(1) Historical Estate and Income Trust recoveries have been restated to reflect changes in accounting classifications.
(2) Credit Balance and Audits is a new line procured in the 2017 contract.
(3) 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

Contingency and Contractor Payments											
Recovery Category	**Contingency Amount[5]**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**Estimated FY 2017-18**	**Estimated FY 2018-19**	**Estimated FY 2019-20**
Estate Recoveries	12.00%	$315,662	$314,341	$491,343	$554,769	$801,479	$635,601	$720,019	$777,723	$797,487	$818,201
Income Trust and Repayments[4]	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Third Party Health Insurance	7.50%	$1,045,153	$1,170,263	$1,616,973	$1,242,745	$1,835,272	$1,979,735	$2,168,961	$2,440,403	$2,502,420	$2,567,417
Third Party Casualty	10.00%	$391,826	$586,648	$475,479	$595,895	$828,062	$794,998	$690,104	$759,949	$779,261	$799,502
Credit Balance Audits	16.00%	$0	$0	$0	$0	$0	$0	$0	$80,000	$160,000	$240,000
Total		**$1,752,641**	**$2,071,252**	**$2,583,795**	**$2,393,409**	**$3,464,813**	**$3,410,334**	**$3,579,084**	**$4,058,075**	**$4,239,168**	**$4,425,120**

(4) Income Trust and Repayments are processed by Department staff. No contingency fee is paid.
(5) The Department's recovery contract was reprocured for the beginning of FY 2017. 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 2017-18	$0	($22,510,946)	$49,366,109	($26,855,163)	54.40%
FY 2018-19	$0	($16,304,069)	$51,029,950	($34,725,881)	68.05%
FY 2019-20	$0	($16,854,767)	$52,753,573	($35,898,806)	68.05%

Recovery Trend for FY 2016-17 to FY 2017-18	3.51%
Recovery Trend for FY 2017-18 to FY 2018-19	3.51%
Recovery Trend for FY 2018-19 to FY 2019-20	3.51%

Exhibit M

FY 2016-17 Actuals	Cash-based Actuals														
	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	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	$5,549,682	$9,551,184	$66,114,232	$6,587,540	$82,244,204	$46,156,733	$193,657,624	$665,284	$187,320,743	$20,957,739	$15,010,926	$33,258,283	$4,625,383	$5,634,345	$33,738	$677,367,640
Emergency Transportation	$1,938,383	$1,671,118	$8,070,764	$285,908	$4,655,506	$3,174,496	$20,217,300	$3,105	$4,706,531	$516,686	$824,564	$831,450	$59,851	$173,647	$1,301	$47,130,610
Non-emergency Medical Transportation	$6,297,730	$1,952,972	$7,461,686	$293,810	$1,347,113	$757,555	$5,371,101	$4,899	$1,781,902	$193,559	$283,182	$257,988	$5,917	$20,117	$11	$26,029,542
Dental Services	$10,244,438	$3,170,696	$19,155,280	$1,776,616	$36,171,908	$22,828,699	$74,574,936	$58,673	$137,398,824	$24,219,745	$6,339,704	$2,727,854	$402,042	($376)	($97,141)	$338,971,898
Family Planning	$911	$326	$52,470	$6,178	$1,221,320	$524,401	$1,764,054	$0	$583,873	$104,988	$70,799	$158,024	$17,205	$0	$0	$4,504,549
Health Maintenance Organizations	$10,467,463	$11,829,058	$67,318,203	$2,173,634	$63,625,538	$34,487,757	$151,918,251	$22,253	$45,850,583	$5,923,966	$791,838	$12,391,633	$1,675,596	($691)	($25,023)	$408,450,059
Inpatient Hospitals	$15,082,838	$17,591,716	$96,474,207	$8,175,734	$54,474,355	$30,624,052	$269,721,847	$226,344	$130,635,905	$6,382,706	$8,096,673	$49,866,020	$5,440,310	$32,889,372	($10,512)	$725,671,567
Outpatient Hospitals	$2,865,438	$8,888,360	$55,173,292	$3,790,732	$82,472,619	$45,960,995	$197,673,354	$470,855	$103,913,195	$11,444,090	$6,961,326	$12,605,523	$1,410,313	$1,416,392	($871)	$535,045,613
Lab & X-Ray	$490,613	$1,533,708	$9,027,127	$751,040	$23,280,577	$11,448,484	$42,854,263	$73,618	$11,350,493	$2,289,130	$1,614,333	$7,413,337	$811,645	$155,663	$25,688	$113,119,719
Durable Medical Equipment	$22,166,996	$7,359,401	$63,753,168	$2,006,310	$9,001,096	$5,558,169	$29,841,160	$29,169	$25,018,429	$2,695,347	$5,644,923	$430,418	$27,822	$40	$260,283	$173,792,731
Prescription Drugs	$6,697,222	$28,187,518	$190,731,757	$13,816,372	$120,811,200	$71,478,144	$344,761,500	$350,562	$125,845,772	$28,877,794	$23,575,874	$8,865,339	$963,396	$3,003	$139,474	$965,104,927
Drug Rebate	($4,996,014)	($20,910,026)	($142,315,922)	($10,535,194)	($93,890,622)	($64,626,676)	($249,587,539)	($250,559)	($95,539,743)	($26,904,758)	($17,308,227)	($6,447,078)	($771,802)	($1,380)	($193,328)	($734,278,868)
Rural Health Centers	$38,984	$191,592	$955,664	$38,997	$2,233,140	$1,478,684	$4,001,928	$3,399	$6,575,180	$824,374	$321,843	$530,095	$41,293	$8,159	$0	$17,243,332
Federally Qualified Health Centers	$755,513	$1,302,539	$6,967,428	$372,129	$15,136,497	$9,587,572	$37,192,928	$27,512	$43,406,147	$3,525,762	$1,556,604	$8,556,292	$602,942	$285,592	$699	$129,276,156
Co-Insurance (Title XVIII-Medicare)	$22,877,290	$3,770,295	$13,643,597	$3,888,746	$1,677,575	$74,361	$360,728	$1,571	$42,344	$4,942	$7,172	$46,600	$1,294	$0	$12,181,148	$58,577,663
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$2,135,021	$0	$0	$0	$0	$0	$0	$0	$2,135,021
Prepaid Inpatient Health Plan Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Services	$37	$29	$210	$12	$130	$63	$383	$1	$233	$27	$23	$38	$4	$10	$3	$1,203
Acute Home Health	$6,123,966	$2,334,416	$11,181,555	$314,869	$981,454	$547,273	$4,807,865	$4,666	$1,929,807	$37,036	$592,427	$237,920	$17,858	$0	$0	$29,111,112
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$106,601,490**	**$78,424,902**	**$473,764,718**	**$33,743,433**	**$405,443,610**	**$220,060,762**	**$1,129,131,683**	**$3,826,373**	**$730,820,218**	**$81,093,133**	**$54,383,984**	**$131,729,736**	**$15,331,069**	**$40,583,893**	**$12,315,470**	**$3,517,254,474**
Community Based Long Term Care																
HCBS - Elderly, Blind, and Disabled	$199,682,041	$30,996,190	$129,366,898	$2,331,649	$309,580	$32,382	$1,146,717	$0	$22,328	$0	$66,526	$2,552	$0	$0	$423,491	$364,380,354
HCBS - Community Mental Health Services	$11,435,128	$4,450,039	$21,926,045	$112,982	$22,349	$175	$146,192	$0	$0	$0	$8,180	$0	$0	$0	$94,823	$38,195,913
HCBS - Children's HCBS	$0	$0	$16,212,727	$40,222	$0	$0	$0	$0	$637,953	$3,222	$1,175	$0	$0	$0	$0	$16,895,299
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	($898,039)	($47,737)	($270,700)	($7,926)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1,224,402)
HCBS - Brain Injury	$4,373,481	$1,619,912	$14,571,353	$11,531	$1,588	$0	$63,308	$0	$0	$0	$0	$0	$0	$0	$26,777	$20,667,950
HCBS - Children with Autism	$0	$0	$503,684	$7,494	$0	$0	$0	$0	$53,670	$1,413	$438	$0	$0	$0	$0	$566,699
HCBS - Children with Life Limiting Illness	$0	$0	$680,196	$969	$0	$0	$0	$0	$28,619	$1,107	$6,324	$0	$0	$0	$0	$717,215
HCBS - Spinal Cord Injury	$587,948	$38,997	$2,030,037	$13,347	$0	$0	$47,859	$0	$0	$0	$0	$0	$0	$0	$0	$2,718,188
CCT - Services	$995,060	$221,824	$1,534,970	$969	$0	$0	$34,524	$0	$0	$0	$0	$0	$0	$0	$2,110	$2,789,457
Private Duty Nursing	$32,421,076	$380,219	$38,445,725	$526,916	$0	$0	$0	$0	$5,795,549	$168,244	$9,341,763	$0	$0	$0	$0	$87,079,492
Long Term Home Health	$39,750,102	$8,739,054	$173,793,283	$2,904,097	$583,453	$242,459	$2,827,143	$0	$28,451,344	$2,333,066	$14,000,869	$13,497	$1,036	$0	$0	$273,639,403
Hospice	$40,464,888	$3,047,499	$5,646,291	$231,548	$352,449	$197,716	$3,656,340	$28,585	$141,542	$7,016	$5,060	$5,814	$10,115	$156,497	$0	$53,951,360
Subtotal Community Based Long Term Care	**$328,811,685**	**$49,445,997**	**$404,440,509**	**$6,173,798**	**$1,269,419**	**$472,732**	**$7,922,083**	**$28,585**	**$35,131,005**	**$2,514,068**	**$23,430,335**	**$21,863**	**$11,151**	**$156,497**	**$547,201**	**$860,376,928**
Long Term Care																
Class I Nursing Facilities	$492,617,483	$50,923,191	$100,809,620	$177,065	$217,731	$315,596	$4,098,376	$0	$70,792	$1,184	$27,882	$3,702	$0	$0	$0	$649,262,622
Class II Nursing Facilities	$1,361,188	$199,288	$2,315,475	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,875,951
Program of All-Inclusive Care for the Elderly	$128,240,295	$16,912,508	$8,496,888	$0	($15,917)	$0	($97,888)	$0	$0	$0	$0	$0	$0	$0	($824,674)	$152,711,212
Subtotal Long Term Care	**$622,218,966**	**$68,034,987**	**$111,621,983**	**$177,065**	**$201,814**	**$315,596**	**$4,000,488**	**$0**	**$70,792**	**$1,184**	**$27,882**	**$3,702**	**$0**	**$0**	**($824,674)**	**$805,849,785**
Insurance																
Supplemental Medicare Insurance Benefit	$99,587,634	$5,807,375	$52,202,417	$0	$326,524	$0	$0	$0	$0	$0	$0	$0	$0	$0	$28,817,019	$186,740,969
Health Insurance Buy-In Program	$15,177	$18,972	$1,859,221	$0	$22,766	$37,943	$34,149	$0	$132,802	$0	$0	$11,383	$0	$0	$0	$2,132,413
Subtotal Insurance	**$99,602,811**	**$5,826,347**	**$54,061,638**	**$0**	**$349,290**	**$37,943**	**$34,149**	**$0**	**$132,802**	**$0**	**$0**	**$11,383**	**$0**	**$0**	**$28,817,019**	**$188,873,382**
Service Management																
Single Entry Points	$8,784,331	$2,598,679	$18,717,289	$215,488	$36,556	$3,848	$221,260	$0	$237,934	$10,903	$182,138	$1,283	$0	$0	$79,525	$31,089,234
Disease Management	$21,390	$19,223	$135,054	$15,538	$179,636	$125,847	$338,068	$0	$0	$0	$34,168	$56,620	$11,787	$0	$0	$937,331
Prepaid Inpatient Health Plan Administration	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accountable Care Collaborative	$2,914,538	$1,131,754	$7,654,416	$394,525	$17,469,934	$10,220,432	$37,096,754	$2,115	$59,169,454	$8,511,080	$2,639,850	$1,146,380	$162,819	$61	$9,566	$148,523,678
Subtotal Service Management	**$11,720,259**	**$3,749,656**	**$26,506,759**	**$625,551**	**$17,686,126**	**$10,350,127**	**$37,656,082**	**$2,115**	**$59,407,388**	**$8,521,983**	**$2,856,156**	**$1,204,283**	**$174,606**	**$61**	**$89,091**	**$180,550,243**
Total Services	**$1,168,955,211**	**$205,481,889**	**$1,070,395,607**	**$40,719,847**	**$424,950,259**	**$231,237,160**	**$1,178,744,485**	**$3,857,073**	**$825,562,205**	**$92,130,368**	**$80,698,357**	**$132,970,967**	**$15,516,826**	**$40,740,451**	**$40,944,107**	**$5,552,904,812**
Financing & Supplemental Payments																
Upper Payment Limit Financing	$1,276,887	$177,064	$849,451	$20,244	$235,541	$122,358	$599,300	$1,010	$362,463	$37,843	$54,052	$35,317	$3,634	$4,706	($3)	$3,779,867
Hospital Supplemental Payments	$9,105,389	$13,973,028	$79,650,597	$6,110,922	$73,939,425	$42,366,499	$244,965,150	$405,247	$123,940,469	$9,655,632	$7,998,268	$32,077,626	$3,588,845	$17,537,986	($5,423)	$665,309,660
Nursing Facility Supplemental Payments	$78,230,759	$8,092,802	$16,025,981	$28,006	$34,626	$49,649	$650,126	$0	$11,131	$186	$4,452	$591	$0	$0	$0	$103,128,309
Physician Supplemental Payments	$103,283	$93,080	$653,879	$75,172	$869,408	$608,430	$1,638,394	$14,515	$1,725,163	$252,308	$165,332	$274,446	$57,003	$59,713	$1,076	$6,591,202
Outstationing Payments	$27,949	$83,895	$557,659	$51,767	$819,659	$392,055	$2,099,393	$2,134	$1,024,346	$117,799	$69,011	$120,235	$11,104	$19,851	($16)	$5,396,841
Accounting Adjustments	($1,303,739)	($244,827)	($1,257,452)	($63,911)	($618,666)	($437,066)	($1,542,272)	($4,350)	($869,298)	($141,049)	($102,329)	($150,969)	($21,825)	($59,345)	($14,835)	($6,831,933)
Subtotal Financing & Supplemental Payments	**$87,440,528**	**$22,175,042**	**$96,480,115**	**$6,222,200**	**$75,279,993**	**$43,101,925**	**$248,410,091**	**$418,556**	**$126,194,274**	**$9,922,719**	**$8,188,786**	**$32,357,246**	**$3,638,761**	**$17,562,911**	**($19,201)**	**$777,373,946**
Grand Total	**$1,256,395,739**	**$227,656,931**	**$1,166,875,722**	**$46,942,047**	**$500,230,252**	**$274,339,085**	**$1,427,154,576**	**$4,275,629**	**$951,756,479**	**$102,053,087**	**$88,887,143**	**$165,328,213**	**$19,155,587**	**$58,303,362**	**$40,924,906**	**$6,330,278,758**

Notes:

FY 2016-17 actuals are from data accessed in CORE on August 15, 2017.

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	$4,170,472	$10,532,475	$72,397,988	$6,450,995	$99,149,751	$43,258,830	$218,464,600	$463,550	$209,475,242	$19,617,514	$14,537,430	$38,525,890	$4,455,839	$5,540,117	$7,963	$747,048,656
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	$145,712,015	$24,525,543	$6,761,894	$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	$37,727,860	$123,878,453	$56,900	$40,884,782	$4,527,312	$591,464	$13,626,398	$1,435,071	$0	$0	$384,880,337
Inpatient Hospitals	$18,292,743	$16,639,326	$90,696,089	$6,764,992	$55,111,577	$22,910,109	$259,637,386	$78,035	$114,338,331	$5,179,888	$6,221,158	$64,923,374	$7,254,791	$31,036,448	$10,073	$699,094,320
Outpatient Hospitals	$3,014,976	$8,709,595	$63,421,210	$5,126,306	$97,931,288	$39,893,296	$212,878,197	$237,732	$113,956,211	$13,486,633	$7,727,226	$12,433,542	$1,174,484	$2,147,336	$1,211	$582,139,243
Lab & X-Ray	$481,231	$1,477,195	$9,692,110	$668,754	$25,701,856	$10,428,774	$42,882,704	$62,936	$11,724,610	$1,436,375	$1,670,621	$8,417,120	$922,946	$166,570	$43	$115,733,845
Durable Medical Equipment	$22,258,858	$7,902,572	$65,941,979	$1,834,863	$8,583,859	$3,223,250	$25,945,820	$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	$296,662,439	$324,059	$114,100,963	$17,531,462	$22,205,327	$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	$49,814,305	$4,453,883	$1,641,318	$9,148,673	$781,507	$344,754	$299	$145,816,160
Co-Insurance (Title XVIII-Medicare)	$29,610,286	$5,273,218	$21,041,966	$2,322,116	$2,942,588	$35,047	$360,398	$3,170	$19,711	$2,212	$20,505	$78,939	$54	$1,304	$14,301,153	$76,012,667
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	$680	$38	$465	$206	$1,154	$4	$750	$83	$72	$140	$15	$35	$13	$3,875
Acute Home Health	$5,040,801	$2,590,755	$10,879,696	$323,098	$1,232,589	$345,330	$4,992,413	$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	**$111,364,853**	**$86,107,634**	**$537,716,834**	**$35,297,880**	**$475,749,516**	**$211,345,770**	**$1,167,658,452**	**$3,847,398**	**$783,239,283**	**$85,468,099**	**$57,929,504**	**$155,773,423**	**$16,985,317**	**$39,369,481**	**$14,591,949**	**$3,782,445,393**
Community Based Long Term Care																
HCBS - Elderly, Blind, and Disabled	$158,254,237	$29,645,404	$128,736,747	$1,941,856	$337,114	$42,261	$1,422,526	$0	$29,685	$0	$140,367	$34,095	$0	$0	$736,932	$321,321,224
HCBS - Community Mental Health Services	$5,680,834	$4,844,841	$24,777,537	$92,735	$12,366	$0	$182,561	$0	$0	$0	$7,251	$0	$0	$0	$123,436	$35,721,561
HCBS - Children's HCBS	$0	$0	$11,624,351	$30,787	$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	$834,133	$12,582	$2,184	$274	$9,217	$0	$192	$0	$909	$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 - Children with Life Limiting Illness	$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	$2,646,578	$602,061	$49,469,896	$559,463	$0	$0	$40,514	$0	$7,627,484	$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	**$237,702,380**	**$50,137,270**	**$399,587,865**	**$5,186,822**	**$1,109,635**	**$165,702**	**$7,150,313**	**$17,689**	**$31,582,678**	**$1,390,480**	**$24,674,344**	**$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	$7,402,114	$468,572	$17,348,602	$8,867,761	$34,091,686	$21,262	$57,830,606	$7,572,596	$2,441,963	$1,142,668	$140,520	$1,411	$84,513	$140,949,203
Subtotal Service Management	**$11,299,481**	**$3,511,546**	**$25,983,158**	**$676,141**	**$17,482,419**	**$8,917,605**	**$34,495,043**	**$21,262**	**$58,618,840**	**$7,581,964**	**$2,680,846**	**$1,184,149**	**$145,240**	**$1,411**	**$175,512**	**$172,774,617**
Total Services	**$1,024,809,272**	**$206,749,698**	**$1,114,195,074**	**$41,346,813**	**$494,800,304**	**$220,473,187**	**$1,212,787,707**	**$3,886,349**	**$873,541,299**	**$94,440,543**	**$85,289,797**	**$157,009,728**	**$17,130,557**	**$39,373,491**	**$39,798,892**	**$5,625,632,711**
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	$1,261,349	$149,280	$85,530	$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**	**$200,803,495**	**$16,800,418**	**$12,394,932**	**$65,175,290**	**$7,094,608**	**$27,431,418**	**$7,004**	**$1,213,503,759**
Grand Total	**$1,120,115,780**	**$236,325,255**	**$1,262,962,468**	**$51,661,112**	**$630,016,796**	**$275,992,247**	**$1,621,597,144**	**$4,174,196**	**$1,074,344,794**	**$111,240,961**	**$97,684,729**	**$222,185,018**	**$24,225,165**	**$66,804,909**	**$39,805,896**	**$6,839,136,470**

Notes:

FY 2015-16 actuals are from data accessed in CORE on January 31, 2017.

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 - Community Mental Health Services	$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 - Children's HCBS	$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 - Children with Life Limiting Illness	$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

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
	Cash-based Actuals															
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 - Community Mental Health Services	$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 - Children's HCBS	$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 - Children with Life Limiting Illness	$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	$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.

Exhibit M

	Cash-based Actuals															
FY 2012-13	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	COFRS TOTAL
Acute Care																
Physician Services & EPSDT	$3,733,246	$7,649,554	$55,946,660	$2,017,690	$65,332,114	$18,077,268	$9,578,088	$0	$113,235,322	$2,820,853	$9,766,797	$16,755,632	$750,233	$5,679,532	$1,154	$311,344,143
Emergency Transportation	$124,218	$323,127	$2,163,425	$32,160	$1,485,643	$369,950	$641,885	$0	$1,637,796	$26,420	$187,373	$167,195	$8,312	$106,156	$0	$7,273,660
Non-emergency Medical Transportation	$2,046,589	$978,360	$4,716,005	$41,726	$433,180	$97,299	$194,838	$0	$914,535	$3,640	$102,262	$47,670	$334	$188	$129	$9,576,755
Dental Services	$1,392,227	$396,231	$5,433,896	$53,656	$5,859,871	$1,742,902	$662,572	$0	$92,806,672	$2,680,354	$5,018,241	$309,878	$16,150	$13,185	$203	$116,386,038
Family Planning	$30	$103	$22,595	$693	$263,357	$91,428	$11,356	$0	$192,173	$7,719	$77,522	$30,742	$1,502	$0	$0	$699,220
Health Maintenance Organizations	$5,627,161	$7,554,375	$40,140,958	$244,617	$23,044,932	$8,493,510	$0	$0	$38,756,103	$544,994	$785,911	$1,295,209	$43,813	$0	$0	$126,531,583
Inpatient Hospitals	$15,837,813	$18,086,253	$113,024,520	$3,818,807	$68,007,485	$13,393,053	$15,941,298	$0	$85,415,409	$2,638,015	$5,291,669	$28,564,111	$1,274,916	$35,472,048	$19,522	$406,784,919
Outpatient Hospitals	$3,353,219	$7,133,724	$57,838,186	$2,506,283	$71,204,056	$22,620,079	$14,655,972	$0	$85,203,477	$2,151,345	$5,978,631	$6,306,950	$276,268	$1,919,513	$302	$281,148,005
Lab & X-Ray	$488,758	$1,018,642	$7,339,265	$205,214	$16,311,375	$4,656,054	$1,995,854	$0	$7,258,518	$467,903	$1,468,092	$4,130,559	$161,187	$151,951	$13	$45,653,385
Durable Medical Equipment	$19,066,652	$6,220,600	$54,238,022	$369,556	$4,767,095	$1,520,743	$1,349,129	$0	$10,732,598	$160,536	$4,520,423	$142,596	$6,366	$3,137	$28,801	$103,126,254
Prescription Drugs	$6,719,553	$18,246,448	$126,656,626	$2,095,797	$58,302,300	$21,010,283	$12,450,869	$0	$65,383,399	$2,300,381	$18,488,514	$2,447,209	$102,473	$0	$262	$334,204,114
Drug Rebate	($3,599,458)	($9,774,062)	($67,846,065)	($1,122,654)	($31,230,752)	($11,254,563)	($6,669,548)	$0	($35,023,879)	($1,232,243)	($9,903,729)	($1,310,895)	($54,892)	$0	($140)	($179,022,880)
Rural Health Centers	$68,840	$302,964	$1,310,864	$32,728	$2,371,639	$886,068	$187,860	$0	$6,447,858	$122,104	$296,822	$294,754	$14,997	$7,574	$521	$12,345,593
Federally Qualified Health Centers	$944,509	$1,199,727	$8,478,727	$140,279	$16,982,037	$4,871,971	$4,036,338	$0	$54,024,086	$1,245,246	$1,894,311	$5,363,217	$207,877	$402,879	$0	$99,791,204
Co-Insurance (Title XVIII-Medicare)	$17,569,039	$3,024,606	$12,446,112	$274,031	$537,695	$888,995	$8,564	$0	$13,711	$1,394	$3,037	$34,811	$375	$112	$6,036,730	$40,839,212
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$9,559,144	$0	$0	$0	$0	$0	$0	$0	$9,559,144
Prepaid Inpatient Health Plan Services	$1,059,766	$1,577,317	$9,663,961	$647,691	$12,557,982	$4,456,972	$0	$0	$21,163,282	$158,949	$1,869,895	$4,464,891	$34,808	$0	$0	$57,655,514
Other Medical Services	$752	$599	$4,562	$92	$2,518	$741	$467	$72	$4,354	$0	$486	$517	$0	$327	$45	$15,532
Acute Home Health	$4,372,425	$1,944,403	$9,888,976	$79,789	$600,900	$172,799	$224,892	($840)	$555,960	$47,028	$669,278	$44,098	$1,587	$0	$124,081	$18,725,376
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,075,000	$0	$0	$0	$3,075,000
Subtotal of Acute Care	**$78,805,339**	**$65,882,971**	**$441,467,295**	**$11,438,155**	**$316,833,427**	**$92,095,552**	**$55,270,434**	**$9,558,376**	**$548,721,374**	**$14,144,638**	**$46,515,535**	**$72,164,144**	**$2,846,306**	**$43,756,602**	**$6,211,623**	**$1,805,711,771**
Community Based Long-Term Care																
HCBS - Elderly, Blind, and Disabled	$119,755,823	$19,994,030	$102,379,886	$47,026	$14,857	$39,338	$5,289	$0	$0	$0	$57,950	$0	$0	$0	$200,361	$242,494,560
HCBS - Community Mental Health Services	$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 - Children's HCBS	$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 - Children with Life Limiting Illness	$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	$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**

Exhibit M

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
	Cash-based Actuals													
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 - Community Mental Health Services	$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 - Children's HCBS	$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 - Children with Life Limiting Illness	$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	$0	$0
Private Duty Nursing	$1,832,636	$135,105	$20,720,340	$0	$0	$0	$0	$0	$601,939	$7,854,133	$0	$0	$0	$31,144,153
Long Term Home Health	$19,241,801	$5,960,470	$112,026,204	$0	$70,804	$21,256	$0	$205	$3,621,831	$10,150,245	$374	$0	$128,231	$151,221,421
Hospice	$32,103,872	$2,846,601	$6,969,248	$15,185	$114,106	$67,245	$4,370	$0	$116,333	$1,215	$1,787	$0	$86,846	$42,326,808
Subtotal Community Based Long-Term Care	**$170,857,494**	**$32,210,227**	**$270,368,664**	**$15,185**	**$193,458**	**$109,012**	**$4,370**	**$205**	**$4,347,507**	**$18,116,947**	**$2,161**	**$0**	**$475,338**	**$496,700,568**
Long-Term Care														
Class I Nursing Facilities	$411,201,009	$33,559,826	$76,088,316	$0	$0	$0	$0	$0	$0	$0	$0	$0	$395,618	$521,244,769
Class II Nursing Facilities	$0	$583,751	$1,915,323	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,499,074
Program of All-Inclusive Care for the Elderly	$73,671,387	$8,052,921	$3,756,277	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$85,480,585
Subtotal Long-Term Care	**$484,872,396**	**$42,196,498**	**$81,759,916**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$395,618**	**$609,224,428**
Insurance														
Supplemental Medicare Insurance Benefit	$63,201,668	$3,688,256	$33,153,682	$46,299	$207,374	$0	$0	$0	$0	$0	$0	$0	$18,301,648	$118,598,927
Health Insurance Buy-In Program	$2,162	$6,655	$1,122,186	$0	$9,727	$0	$0	$0	$12,996	$2,223	$3,358	$0	$0	$1,159,307
Subtotal Insurance	**$63,203,830**	**$3,694,911**	**$34,275,868**	**$46,299**	**$217,101**	**$0**	**$0**	**$0**	**$12,996**	**$2,223**	**$3,358**	**$0**	**$18,301,648**	**$119,758,234**
Service Management														
Single Entry Points	$11,748,349	$2,505,790	$10,910,528	$0	$5,343	$1,263	$0	$0	$1,749	$8,355	$0	$0	$45,369	$25,226,746
Disease Management	$51,573	$36,611	$303,654	$218	$164,545	$45,358	$1,307	$5,612	$280,261	$32,412	$34,593	$22,913	$2,955	$982,012
Prepaid Inpatient Health Plan Administration	$514,348	$183,069	$1,118,391	$1,094	$1,332,529	$526,053	$0	$0	$4,776,807	$325,880	$113,177	$0	$0	$8,891,348
Accountable Care Collaborative	$345,078	$256,950	$2,052,795	$377	$5,690,110	$2,269,608	$79,568	$0	$6,360,605	$576,072	$275,408	$107	$1,155	$17,907,833
Subtotal Service Management	**$12,659,348**	**$2,982,420**	**$14,385,368**	**$1,689**	**$7,192,527**	**$2,842,282**	**$80,875**	**$5,612**	**$11,419,422**	**$942,719**	**$423,178**	**$23,020**	**$49,479**	**$53,007,939**
Total Services	**$806,748,259**	**$142,133,983**	**$844,556,448**	**$461,635**	**$308,707,284**	**$85,950,215**	**$2,478,395**	**$10,278,309**	**$525,133,494**	**$68,237,438**	**$63,746,325**	**$41,961,185**	**$24,501,793**	**$2,924,894,763**
Financing and Supplemental Payments														
Upper Payment Limit Financing	$3,006,644	$328,259	$1,725,903	$520	$457,096	$139,126	$4,034	$0	$547,701	$114,617	$38,935	$10,444	$3,886	$6,377,165
Hospital Supplemental Payments	$17,049,970	$22,262,870	$172,465,286	$258,926	$131,847,819	$33,793,401	$1,509,784	$0	$154,850,875	$11,052,910	$33,244,021	$36,231,786	($13,389)	$614,554,259
Nursing Facility Supplemental Payments	$68,465,150	$5,587,726	$12,668,738	$0	$0	$0	$0	$0	$0	$0	$0	$0	$65,871	$86,787,485
Physician Supplemental Payments	$60,715	$123,502	$943,247	$1,136	$1,112,553	$290,538	$4,421	$0	$1,879,459	$178,573	$289,020	$101,452	$66	$4,984,682
Outstationing Payments	$18,395	$39,101	$328,574	$459	$399,437	$121,637	$3,552	$0	$456,997	$35,862	$33,998	$9,203	$0	$1,447,215
Accounting Adjustments	$763,823	$147,724	$878,727	$451	$337,808	$94,928	$2,831	$9,629	$556,699	$78,990	$65,448	$43,897	$6,238	$2,987,193
Subtotal Financing and Supplemental Payments	**$89,364,697**	**$28,489,182**	**$189,010,475**	**$261,492**	**$134,154,713**	**$34,439,630**	**$1,524,622**	**$9,629**	**$158,291,731**	**$11,460,952**	**$33,671,422**	**$36,396,782**	**$62,672**	**$717,137,999**
Grand Total	**$896,112,956**	**$170,623,165**	**$1,033,566,923**	**$723,127**	**$442,861,997**	**$120,389,845**	**$4,003,017**	**$10,287,938**	**$683,425,225**	**$79,698,390**	**$97,417,747**	**$78,357,967**	**$24,564,465**	**$3,642,032,762**

Exhibit M

FY 2010-11	Cash-based Actuals											
	Adults 65 and Older (OAP-A)	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens- Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,269,992	$6,951,129	$52,819,492	$61,394,491	$12,531,062	$0	$108,898,551	$10,934,900	$18,198,453	$6,592,130	$1,842	$282,592,042
Emergency Transportation	$135,881	$262,494	$2,067,024	$1,347,570	$236,352	$0	$1,665,110	$236,484	$196,837	$88,493	$5	$6,236,250
Non-emergency Medical Transportation	$2,248,810	$1,043,480	$5,199,711	$500,754	$72,340	$0	$1,156,790	$195,450	$48,109	$3,420	$243	$10,469,107
Dental Services	$980,947	$296,165	$5,001,213	$5,332,025	$1,211,640	$0	$89,583,233	$5,780,945	$379,656	$4,838	$30	$108,570,692
Family Planning	$0	$16	$12,731	$193,371	$60,160	$0	$120,830	$38,845	$15,461	$0	$0	$441,414
Health Maintenance Organizations	$6,832,995	$6,431,178	$38,459,466	$21,704,093	$6,456,182	$0	$35,589,978	$823,759	$1,190,805	$0	$0	$117,488,456
Inpatient Hospitals	$13,928,315	$14,401,355	$109,555,356	$64,961,507	$10,000,540	$0	$83,895,044	$6,584,854	$30,244,597	$38,292,048	($1,668)	$371,861,948
Outpatient Hospitals	$3,159,881	$5,575,085	$50,038,984	$57,298,855	$14,717,844	$0	$73,155,361	$6,071,798	$6,013,521	$1,460,551	$1,031	$217,492,911
Lab & X-Ray	$558,717	$853,427	$6,862,072	$13,332,748	$2,936,506	$0	$7,589,083	$1,757,292	$3,807,140	$164,351	$784	$37,862,120
Durable Medical Equipment	$19,960,510	$4,911,081	$48,169,450	$3,505,807	$797,869	$0	$8,735,551	$4,353,214	$180,213	$5	$14,245	$90,627,945
Prescription Drugs	$8,014,198	$16,245,119	$119,835,487	$46,135,231	$11,840,965	$0	$56,157,222	$20,762,963	$2,287,737	$23	$4	$281,278,949
Drug Rebate	($3,615,910)	($7,329,604)	($54,068,344)	($20,815,666)	($5,342,502)	$0	($25,337,470)	($9,368,002)	($1,032,200)	($10)	($2)	($126,909,710)
Rural Health Centers	$53,270	$206,418	$1,122,812	$1,871,661	$557,927	$0	$5,357,537	$698,495	$285,879	$33,931	$75	$10,188,005
Federally Qualified Health Centers	$916,375	$1,051,613	$7,588,335	$15,885,638	$3,802,322	$0	$53,308,981	$2,132,545	$5,192,824	$427,890	$0	$90,306,523
Co-Insurance (Title XVIII-Medicare)	$16,505,219	$2,494,667	$11,474,583	$349,523	$446,438	$0	$43,461	$31,683	$56,279	$44	$4,985,517	$36,387,414
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$10,106,643	$0	$0	$0	$0	$0	$10,106,643
Prepaid Inpatient Health Plan Services	$2,221,510	$2,361,149	$19,107,158	$10,370,751	$2,076,156	$0	$9,365,354	$2,583,913	$2,763,503	$0	$0	$50,849,494
Other Medical Services	$770	$518	$4,450	$2,275	$509	$78	$4,077	$555	$525	$361	$40	$14,158
Acute Home Health	$5,093,934	$2,031,276	$11,832,652	$537,458	$126,179	$0	$712,181	$1,112,785	$48,496	$0	$145,260	$21,640,221
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$81,265,414**	**$57,786,566**	**$435,082,632**	**$283,908,092**	**$62,528,489**	**$10,106,721**	**$510,000,874**	**$54,732,478**	**$69,877,835**	**$47,068,075**	**$5,147,406**	**$1,617,504,582**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$107,968,359	$16,811,191	$87,178,266	$19,464	$11,962	$0	$0	$72,439	$0	$0	$134,462	$212,196,143
HCBS - Community Mental Health Services	$3,642,260	$2,685,012	$18,587,745	$9,419	$0	$0	$0	$14,257	$0	$0	$8,097	$24,946,790
HCBS - Children's HCBS	$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 - Children with Life Limiting Illness	$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**

Exhibit M

FY 2010-11 Adjusted Totals for June 2010 Payment Delay	Cash-based Actuals											
	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	MAGI Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	COFRS TOTAL
Acute Care												
Physician Services & EPSDT	$4,130,718	$6,703,561	$51,097,852	$59,291,660	$12,375,689	$0	$105,296,010	$10,585,051	$17,581,872	$6,320,750	$1,842	$273,385,004
Emergency Transportation	$132,219	$249,128	$1,981,657	$1,308,793	$234,529	$0	$1,614,807	$227,759	$191,791	$83,441	$5	$6,024,129
Non-emergency Medical Transportation	$2,229,276	$1,030,710	$5,146,701	$497,276	$72,195	$0	$1,144,272	$191,775	$47,503	$3,420	$243	$10,363,372
Dental Services	$955,956	$287,848	$4,837,630	$5,162,280	$1,188,067	$0	$86,467,469	$5,552,511	$362,348	$4,838	$30	$104,818,977
Family Planning	$0	$16	$12,280	$185,275	$59,388	$0	$117,776	$38,636	$15,103	$0	$0	$428,473
Health Maintenance Organizations	$6,832,995	$6,431,178	$38,459,477	$21,704,066	$6,456,182	$0	$35,589,961	$823,759	$1,190,805	$0	$0	$117,488,424
Inpatient Hospitals	$13,226,398	$13,708,601	$104,724,510	$62,699,943	$9,835,760	$0	$80,955,351	$6,191,811	$29,151,219	$36,914,043	$3,263	$357,410,899
Outpatient Hospitals	$3,056,720	$5,426,119	$48,146,249	$55,076,726	$14,489,888	$0	$70,566,037	$5,827,169	$5,797,920	$1,403,889	$510	$209,791,226
Lab & X-Ray	$536,134	$822,885	$6,615,373	$12,854,214	$2,895,486	$0	$7,328,814	$1,689,199	$3,680,612	$157,642	$784	$36,581,144
Durable Medical Equipment	$19,273,723	$4,734,880	$46,704,499	$3,394,827	$780,295	$0	$8,456,548	$4,218,566	$167,275	$5	$14,696	$87,745,314
Prescription Drugs	$7,696,196	$15,713,437	$116,023,969	$44,475,389	$11,693,984	$0	$54,593,080	$20,062,946	$2,210,846	$23	$4	$272,469,874
Drug Rebate	($3,615,910)	($7,329,604)	($54,068,344)	($20,815,666)	($5,342,502)	$0	($25,337,470)	($9,368,002)	($1,032,200)	($10)	($2)	($126,909,710)
Rural Health Centers	$51,237	$201,149	$1,081,153	$1,802,214	$549,705	$0	$5,208,165	$685,199	$277,916	$30,833	$75	$9,887,646
Federally Qualified Health Centers	$877,183	$1,014,344	$7,353,061	$15,328,948	$3,746,392	$0	$51,735,998	$2,065,438	$4,996,706	$411,997	$0	$87,530,066
Co-Insurance (Title XVIII-Medicare)	$15,904,615	$2,389,850	$11,036,287	$332,809	$438,294	$0	$42,211	$30,661	$55,401	$44	$4,813,375	$35,043,547
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$9,817,118	$0	$0	$0	$0	$0	$9,817,118
Prepaid Inpatient Health Plan Services	$2,221,510	$2,361,149	$19,107,158	$10,370,751	$2,076,156	$0	$9,365,354	$2,583,913	$2,763,503	$0	$0	$50,849,494
Other Medical Services	$770	$518	$4,450	$2,275	$509	$78	$4,077	$555	$525	$361	$40	$14,158
Acute Home Health	$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 - Community Mental Health Services	$3,587,367	$2,652,010	$18,317,043	$9,419	$0	$0	$0	$13,599	$0	$0	$8,097	$24,587,535
HCBS - Children's HCBS	$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 - Children with Life Limiting Illness	$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

FY 2009-10	Cash-based Actuals											
	Adults 65 and Older (OAP-A)	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens- Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,504,959	$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 - Community Mental Health Services	$3,418,565	$2,358,037	$16,839,277	$80	$0	$0	$0	$22,942	$0	$0	$42,459	$22,681,360
HCBS - Children's HCBS	$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 - Children with Life Limiting Illness	$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 - Community Mental Health Services	$3,473,458	$2,391,039	$17,109,979	$80	$0	$0	$0	$23,600	$0	$0	$42,459	$23,040,615
HCBS - Children's HCBS	$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 - Children with Life Limiting Illness	$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 - Community Mental Health Services	$3,588,896	$2,137,938	$17,180,010	$1,005	$0	$0	$0	$6,584	$0	$0	$44,433	$22,958,866
HCBS - Children's HCBS	$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 - Children with Life Limiting Illness	$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 N - Expenditure History by Service Category

ACUTE CARE	FY 2016-17	Percent Change from Prior	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
Physician Services & EPSDT	$677,367,640	-9.33%	$747,048,656	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
Emergency Transportation	$47,130,610	48.98%	$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
Non-Emergency Medical Transportation	$26,029,542	40.91%	$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
Dental Services	$338,971,898	2.87%	$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
Family Planning	$4,504,549	73.60%	$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
Health Maintenance Organizations	$408,450,059	6.12%	$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
Inpatient Hospitals	$725,671,567	3.80%	$699,094,320	4.39%	$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
Outpatient Hospitals	$535,045,613	-8.09%	$582,139,243	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
Lab & X-Ray	$113,119,719	-2.26%	$115,733,845	22.51%	$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
Durable Medical Equipment	$173,792,731	4.01%	$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
Prescription Drugs	$965,104,927	15.66%	$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
Drug Rebate	($734,278,868)	79.58%	($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)
Rural Health Centers	$17,243,332	-16.80%	$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
Federally Qualified Health Centers	$129,276,156	-11.34%	$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
Co-Insurance (Title XVIII-Medicare)	$58,577,663	-22.94%	$76,012,667	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
Breast and Cervical Cancer Treatment Program	$2,135,021	-17.60%	$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
Prepaid Inpatient Health Plan Services	$0	0.00%	$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
Other Medical Services	$1,203	-68.95%	$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
Acute Home Health	$29,111,112	3.25%	$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
Presumptive Eligibility	$0	0.00%	$0	0.00%	$0	0.00%	$0	-100.00%	$3,075,000	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Subtotal of Acute Care	**$3,517,254,474**	**-7.01%**	**$3,782,445,393**	**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**
COMMUNITY BASED LONG-TERM CARE																	
HCBS - Elderly, Blind, and Disabled	$364,380,354	13.40%	$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
HCBS - Mental Illness	$38,195,913	6.93%	$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
HCBS - Disabled Children	$16,895,299	34.53%	$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
HCBS - Persons Living with AIDS	$0	0.00%	$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
HCBS - Consumer Directed Attendant Support	($1,224,402)	-158.81%	$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
HCBS - Brain Injury	$20,667,950	7.87%	$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
HCBS - Children with Autism	$566,699	1.46%	$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
HCBS - Pediatric Hospice	$717,215	11.54%	$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
HCBS - Spinal Cord Injury	$2,718,188	37.67%	$1,974,424	12.24%	$1,759,072	-0.82%	$1,773,572	602.38%	$252,509	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
CCT - Services	$2,789,457	26.31%	$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
Private Duty Nursing	$87,079,492	19.93%	$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
Long Term Home Health	$273,639,403	14.28%	$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	12.53%	$134,184,938	7.28%	$125,083,498
Hospice	$53,951,360	5.03%	$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
Subtotal of Community Based Long-Term Care	**$860,376,928**	**13.26%**	**$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**
LONG-TERM CARE AND INSURANCE																	
Class I Nursing Facilities	$649,262,622	4.77%	$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
Class II Nursing Facilities	$3,875,951	-4.12%	$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
Program of All-Inclusive Care for the Elderly	$152,711,212	18.37%	$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
Supplemental Medicare Insurance Benefit	$186,740,969	19.38%	$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
Health Insurance Buy-In Program	$2,132,413	32.14%	$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
Subtotal of Long-Term Care and Insurance	**$994,723,167**	**9.22%**	**$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**
SERVICE MANAGEMENT																	
Single Entry Points	$31,089,234	-0.62%	$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
Disease Management	$937,331	72.87%	$542,225	-45.13%	$988,242	87.54%	$526,953	-44.94%	$957,110	-2.54%	$982,012	100.00%	$0	-100.00%	$71,616	-97.52%	$2,882,271
Prepaid Inpatient Health Plan Administration	$0	0.00%	$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
Accountable Care Collaborative	$148,523,678	5.37%	$140,949,203	35.59%	$103,950,766	51.60%	$68,570,330	86.69%	$36,728,931	105.10%	$17,907,833	1917.99%	$887,411	100.00%	$0	0.00%	$0
Subtotal Service Management	$180,550,243	**4.50%**	$172,774,617	**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
Total Services	**$5,552,904,812**	**-1.29%**	**$5,625,632,711**	**12.18%**	**$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**
FINANCING AND SUPPLEMENTAL PAYMENTS																	
Upper Payment Limit Financing	$3,779,867	7.82%	$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
Hospital Supplemental Payments	$665,309,660	-38.67%	$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	100.00%	$0
Nursing Facility Supplemental Payments	$103,128,309	2.56%	$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	100.00%	$0
Physician Supplemental Payments	$6,591,202	-65.97%	$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	100.00%	$0
Outstationing Payments	$5,396,841	-16.24%	$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	100.00%	$0
Accounting Adjustments	($6,831,933)	531.07%	($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
Subtotal Financing and Supplemental Payments	**$777,373,946**	**-35.94%**	**$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**
Grand Total	**$6,330,278,758**	**-7.44%**	**$6,839,136,470**	**19.37%**	**$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**

Notes:

(1) FY 2016-17 actuals are from data accessed in CORE on August 15, 2017.

Exhibit N - Expenditure History by Service Category - Delay Adjusted

ACUTE CARE	FY 2016-17	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	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
Physician Services & EPSDT	$677,367,640	-9.33%	$747,048,656	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
Emergency Transportation	$47,130,610	48.98%	$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
Non-emergency Medical Transportation	$26,029,542	40.91%	$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
Dental Services	$338,971,898	2.87%	$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
Family Planning	$4,504,549	73.60%	$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
Health Maintenance Organizations	$408,450,059	6.12%	$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
Inpatient Hospitals	$725,671,567	3.80%	$699,094,320	4.39%	$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
Outpatient Hospitals	$535,045,613	-8.09%	$582,139,243	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
Lab & X-Ray	$113,119,719	-2.26%	$115,733,845	22.51%	$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
Durable Medical Equipment	$173,792,731	4.01%	$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
Prescription Drugs	$965,104,927	15.66%	$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
Drug Rebate	($734,278,868)	79.58%	($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)
Rural Health Centers	$17,243,332	-16.80%	$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
Federally Qualified Health Centers	$129,276,156	-11.34%	$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
Co-Insurance (Title XVIII-Medicare)	$58,577,663	-22.94%	$76,012,667	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
Breast and Cervical Cancer Treatment Program	$2,135,021	-17.60%	$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
Prepaid Inpatient Health Plan Services	$0	-100.00%	$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
Other Medical Services	$1,203	-68.95%	$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
Acute Home Health	$29,111,112	3.25%	$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
Presumptive Eligibility	$0	0.00%	$0	0.00%	$0	0.00%	$0	-100.00%	$3,075,000	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Subtotal of Acute Care	**$3,517,254,474**	**-7.01%**	**$3,782,445,393**	**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**
COMMUNITY BASED LONG-TERM CARE																	
HCBS - Elderly, Blind, and Disabled	$364,380,354	13.40%	$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
HCBS - Mental Illness	$38,195,913	6.93%	$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
HCBS - Disabled Children	$16,895,299	34.53%	$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
HCBS - Persons Living with AIDS	$0	0.00%	$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
HCBS - Consumer Directed Attendant Support	($1,224,402)	-158.81%	$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
HCBS - Brain Injury	$20,667,950	7.87%	$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
HCBS - Children with Autism	$566,699	1.46%	$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
HCBS - Pediatric Hospice	$717,215	11.54%	$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
HCBS - Spinal Cord Injury	$2,718,188	37.67%	$1,974,424	12.24%	$1,759,072	-0.82%	$1,773,572	602.38%	$252,509	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
CCT - Services	$2,789,457	26.31%	$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
Private Duty Nursing	$87,079,492	19.93%	$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
Long Term Home Health	$273,639,403	14.28%	$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
Hospice	$53,951,360	5.03%	$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
Subtotal Community Based Long-Term Care	**$860,376,928**	**13.26%**	**$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**
LONG-TERM CARE AND INSURANCE																	
Class I Nursing Facilities	$649,262,622	4.77%	$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
Class II Nursing Facilities	$3,875,951	-4.12%	$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
Program of All-Inclusive Care for the Elderly	$152,711,212	18.37%	$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
Supplemental Medicare Insurance Benefit	$186,740,969	19.38%	$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
Health Insurance Buy-In Program	$2,132,413	32.14%	$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
Subtotal Long-Term Care and Insurance	**$994,723,167**	**9.22%**	**$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**
SERVICE MANAGEMENT																	
Single Entry Points	$31,089,234	-0.62%	$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
Disease Management	$937,331	72.87%	$542,225	-45.13%	$988,242	87.54%	$526,953	-44.94%	$957,110	-2.54%	$982,012	100.00%	$0	-100.00%	$71,616	-97.52%	$2,882,271
Prepaid Inpatient Health Plan Administration	$0	-100.00%	$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
Accountable Care Collaborative	$148,523,678	5.37%	$140,949,203	35.59%	$103,950,766	51.60%	$68,570,330	86.69%	$36,728,931	105.10%	$17,907,833	1917.99%	$887,411	100.00%	$0	0.00%	$0
Subtotal Service Management	$180,550,243	**4.50%**	$172,774,617	**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
Total Services	**$5,552,904,812**	**-1.29%**	**$5,625,632,711**	**12.18%**	**$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**
FINANCING AND SUPPLEMENTAL PAYMENTS																	
Upper Payment Limit Financing	$3,779,867	7.82%	$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
Hospital Supplemental Payments	$665,309,660	-38.67%	$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	100.00%	$0
Nursing Facility Supplemental Payments	$103,128,309	2.56%	$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	100.00%	$0
Physician Supplemental Payments	$6,591,202	-65.97%	$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	100.00%	$0
Outstationing Payments	$5,396,841	-16.24%	$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	100.00%	$0
Accounting Adjustments	($6,831,933)	531.07%	($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
Subtotal Financing and Supplemental Payments	**$777,373,946**	**-35.94%**	**$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**
Grand Total	**$6,330,278,758**	**-7.44%**	**$6,839,136,470**	**19.37%**	**$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**

Notes:

(1) FY 2016-17 actuals are from data accessed in CORE on August 15, 2017.

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

Exhibit O - Appropriations and Expenditures

Final FY 2016-17 Funding Splits						
	Total Funds	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
HB 16-1405 FY 2016-17 Long Bill Appropriation	**$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)
SB 17-162 FY 2016-17 Supplemental Bill FY17	$126,254,607	$24,497,845	$0	$1,650,193	$3,861,816	$96,244,753
HB 17-254 FY 2016-17 Long Bill Add-on	($150,381,550)	$13,064,496	($43,633,333)	($8,451,937)	$0	($111,360,776)
Appropriations Totals	$6,794,137,652	$1,106,167,109	$830,201,667	$698,906,376	$9,102,709	$4,149,759,791
Final Expenditures	$6,330,278,758	$1,031,173,860	$830,201,667	$689,469,057	$9,504,132	$3,769,930,042
Remaining Balance	**$463,858,894**	**$74,993,249**	**$0**	**$9,437,319**	**($401,423)**	**$379,829,749**

Notes:

1. Totals reflect final CORE close as of August 15, 2017; 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 2016-17 Final Actuals			
Aid Category	**Caseload**	**Per Capita**	**Total**
Adults 65 and Older (OAP-A)	42,403	$29,629.88	$1,256,395,739
Disabled Adults 60 to 64 (OAP-B)	10,529	$21,621.89	$227,656,931
Disabled Individuals to 59 (AND/AB)	68,800	$16,960.40	$1,166,875,722
Disabled Buy-In	6,217	$7,550.59	$46,942,047
MAGI Parents/Caretakers to 68% FPL	163,342	$3,062.47	$500,230,252
MAGI Parents/Caretakers 69% to 133% FPL	86,964	$3,154.63	$274,339,085
MAGI Adults	320,374	$4,454.65	$1,427,154,576
Breast & Cervical Cancer Program	322	$13,278.35	$4,275,629
Eligible Children (AFDC-C/BC)	467,193	$2,037.18	$951,756,479
SB 11-008 Eligible Children	59,501	$1,715.15	$102,053,087
Foster Care	19,935	$4,458.85	$88,887,143
MAGI Pregnant Adults	14,413	$11,470.77	$165,328,213
SB 11-250 Eligible Pregnant Adults	1,759	$10,890.04	$19,155,587
Non-Citizens- Emergency Services	2,649	$22,009.57	$58,303,362
Partial Dual Eligibles	32,585	$1,255.94	$40,924,906
TOTAL	**1,296,986**	**TF**	**$6,330,278,758**
Total Funds include upper payment limit financing and supplemental payments and other Medicaid financing. Totals reflect final CORE close as of August 15, 2017 and do not include post-closing entries past this date. Totals may not match due to rounding.		**GF**	$1,031,173,860
		GFE	$830,201,667
		CF	$689,469,057
		RF	$9,504,132
		FF	$3,769,930,042

Exhibit O - Comparison of Budget Requests and Appropriations

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	$3,987,579,115	0.23%	$3,972,138,820	$3,529,242,517	-11.49%
Community Based Long-Term Care	$865,308,210	$856,322,485	-1.04%	$856,322,485	$843,234,384	$871,286,072	1.75%	$871,286,072	$860,376,928	-1.25%
Long-Term Care	$873,310,814	$916,648,706	4.96%	$916,648,706	$900,607,611	$910,684,364	-0.65%	$910,684,364	$908,978,094	-0.19%
Insurance	$164,392,778	$177,900,591	8.22%	$177,900,591	$194,635,458	$181,114,529	1.81%	$181,114,529	$188,873,382	4.28%
Service Management	$196,705,139	$205,109,626	4.27%	$205,109,626	$201,757,707	$183,998,925	-10.29%	$183,998,925	$180,550,243	-1.87%
Financing	$685,603,507	$683,967,918	-0.24%	$683,967,918	$667,241,731	$674,914,942	-1.32%	$674,914,942	$662,257,594	-1.88%
Total	$6,603,727,556	$6,762,714,402	2.41%	$6,818,264,595	$6,959,959,497	$6,809,577,947	-0.13%	$6,794,137,652	$6,330,278,758	-7.04%
Class I Nursing Facilities	$711,374,044	$755,586,890	6.22%	$755,586,890	$748,845,636	$756,736,893	0.15%	$756,736,893	$752,390,931	-0.57%

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	$4,147,131,805	-3.51%	$4,225,255,857	$4,595,159,265		8.75%			
Community Based Long-Term Care	$904,192,231	$947,398,644	4.78%	$969,015,200	$966,859,076		-0.22%			
Long-Term Care	$944,164,243	$955,928,008	1.25%	$955,928,008	$962,554,284		0.69%			
Insurance	$203,563,555	$188,224,138	-7.54%	$188,224,138	$186,375,385		-0.98%			
Service Management	$213,338,551	$199,761,518	-6.36%	$202,344,761	$202,054,577		-0.14%			
Financing	$550,848,541	$559,528,314	1.58%	$1,072,571,178	$1,038,285,811		-3.20%			
Total	$7,114,289,396	$6,997,972,427	-1.63%	$7,613,339,142	$7,951,288,398		4.44%			
Class I Nursing Facilities	$774,956,824	$784,047,669	1.17%	$784,047,669	$786,927,041		0.37%			

FY 2018-19 Comparison of Requests and Appropriations

FY 2018-19	November 1, 2017	February 15, 2018	% Change	FY 2018-19 Long Bill and Special Bills Appropriation	November 1, 2018	February 15, 2019	% Change over Appropriation	FY 2018-19 Final Appropriation	FY 2018-19 Actuals	% Change over Feb.
Acute Care	$4,148,514,756									
Community Based Long-Term Care	$1,038,697,695									
Long-Term Care	$1,006,812,769									
Insurance	$202,075,926									
Service Management	$245,494,448									
Financing	$1,104,962,153									
Total	$7,746,557,747									
Class I Nursing Facilities	$812,525,679									

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 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	$1,120,115,780	$236,325,255	$1,262,962,468	$51,661,112	$630,016,796	$275,992,247	$1,621,597,144	$4,174,196	$1,074,344,794	$111,240,961	$97,684,729	$222,185,018	$24,225,165	$66,804,909	$39,805,896	$6,839,136,470
FY 2016-17	$1,256,395,739	$227,656,931	$1,166,875,722	$46,942,047	$500,230,252	$274,339,085	$1,427,154,576	$4,275,629	$951,756,479	$102,053,087	$88,887,143	$165,328,213	$19,155,587	$58,303,362	$40,924,906	$6,330,278,758

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 2001-02	$1,536,804,691						
FY 2002-03	$1,651,670,874	7.47%	$114,866,182				
FY 2003-04	$1,868,750,230	13.14%	$217,079,357	10.31%			
FY 2004-05	$1,920,541,525	2.77%	$51,791,295	7.80%	-24.37%	7.80%	
FY 2005-06	$1,996,264,308	3.94%	$75,722,783	6.83%	-12.36%	6.62%	-15.10%
FY 2006-07	$2,061,396,809	3.26%	$65,132,501	6.12%	-10.45%	3.33%	-49.76%
FY 2007-08	$2,239,096,405	8.62%	$177,699,596	6.54%	6.81%	5.28%	58.62%
FY 2008-09	$2,526,991,443	12.86%	$287,895,038	7.44%	13.82%	8.25%	56.33%
FY 2009-10 (DA)	$2,948,044,702	16.66%	$421,053,259	8.59%	15.50%	12.71%	54.16%
FY 2010-11 (DA)	$3,325,395,184	12.80%	$377,350,482	9.06%	5.44%	14.11%	10.96%
FY 2011-12	$3,642,032,762	9.52%	$316,637,578	9.11%	0.51%	12.99%	-7.88%
FY 2012-13	$3,937,400,734	8.11%	$295,367,972	9.02%	-0.99%	10.14%	-21.94%
FY 2013-14	$4,618,770,200	17.31%	$681,369,466	9.71%	7.66%	11.65%	14.80%
FY 2014-15	$5,729,193,793	24.04%	$1,110,423,593	10.81%	11.36%	16.49%	41.56%
FY 2015-16	$6,839,136,470	19.37%	$1,109,942,677	11.42%	5.66%	20.24%	22.77%
FY 2016-17	$6,330,278,758	-7.44%	($508,857,712)	10.16%	-11.01%	11.99%	-40.75%

	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 2017-18 Projection	$7,951,288,398	25.61%	$1,621,009,640	$6,973,629,272	-12.30%	$7,089,376,582	-10.84%
FY 2018-19 Projection	$7,746,557,747	-2.57%	($204,730,651)	$8,759,383,218	13.07%	$8,904,770,220	14.95%
FY 2019-20 Projection	$7,935,140,072	2.43%	$188,582,325	$8,533,845,652	7.54%	$8,675,489,213	9.33%
FY 2017-18 Appropriation	$7,597,898,847						
Difference Between FY 2017-18 Projections and FY 2017-18 Appropriation	$353,389,551	4.65%		($624,269,575)	-8.22%	($508,522,265)	-6.69%
Difference Between FY 2018-19 Projections and FY 2017-18 Appropriation	$148,658,900	1.96%		$1,161,484,371	15.29%	$1,306,871,373	17.20%
Difference Between FY 2019-20 Projections and FY 2017-18 Appropriation	$337,241,225	4.44%		$935,946,805	12.32%	$1,077,590,366	14.18%

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	$6,839,136,470	19.37%	1,296,986	11.69%
FY 2016-17	$6,330,278,758	-7.44%	1,346,174	3.79%
FY 2017-18 Projection	$7,951,288,398	25.61%	1,401,680	4.12%
FY 2018-19 Projection	$7,746,557,747	-2.57%	1,443,895	3.01%
FY 2019-20 Projection	$7,935,140,072	2.43%	1,475,422	2.18%

(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 2019-20 Projection	Percent Change from Prior Year	FY 2018-19 Projection	Percent Change from Prior Year	FY 2017-18 Projection	Percent Change from Prior Year	FY 2016-17	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	$4,059,556,336	1.27%	$4,008,651,212	-9.88%	$4,447,888,418	30.02%	$3,420,830,272	-7.04%	$3,679,991,977	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	$1,120,753,919	8.21%	$1,035,673,407	7.43%	$964,037,172	12.38%	$857,851,709	13.14%	$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	$1,155,209,561	5.27%	$1,097,336,868	5.39%	$1,041,245,845	4.68%	$994,721,983	9.22%	$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	$267,727,148	14.39%	$234,039,413	21.25%	$193,020,569	12.32%	$171,853,654	4.12%	$165,047,413	22.97%	$134,218,911	32.13%	$101,584,215	44.28%	$70,409,603	32.83%	$53,007,939
Total Services	**$6,603,246,964**	**3.57%**	**$6,375,700,900**	**-4.07%**	**$6,646,192,004**	**22.05%**	**$5,445,257,618**	**-1.25%**	**$5,514,061,611**	**11.98%**	**$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	$1,162,313,492	-3.78%	$1,207,958,573	6.13%	$1,138,162,210	49.01%	$763,812,466	-35.79%	$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	**$7,765,560,456**	**2.40%**	**$7,583,659,473**	**-2.58%**	**$7,784,354,214**	**25.37%**	**$6,209,070,084**	**-7.38%**	**$6,703,670,344**	**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	$684,752,948	3.43%	$662,033,353	24.29%	$532,665,432	-9.28%	$587,130,447	-0.36%	$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	$9,272,377	3.75%	$8,936,945	2.87%	$8,687,578	14.09%	$7,614,874	-3.04%	$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	**$694,025,325**	**3.44%**	**$670,970,298**	**23.94%**	**$541,353,010**	**-8.98%**	**$594,745,321**	**-0.39%**	**$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	$572,485,267	5.23%	$544,009,622	3.73%	$524,449,757	15.82%	$452,810,203	6.13%	$426,671,562	8.09%	$394,730,397	13.32%	$348,330,959	100.00%	$0	0.00%	$0
Medicare Modernization Act	$164,976,430	7.24%	$153,834,714	4.91%	$146,635,899	12.39%	$130,472,767	14.44%	$114,014,333	5.78%	$107,786,301	1.32%	$106,376,992	4.48%	$101,817,855	8.80%	$93,582,494
Public School Health Services[(1)]	$99,599,702	0.00%	$99,599,702	7.07%	$93,022,977	12.28%	$82,845,907	17.72%	$70,374,889	32.36%	$53,167,635	22.24%	$43,494,624	-5.33%	$45,945,267	12.81%	$40,726,548
Total Other Medicaid Services Expenditure	**$837,061,399**	**4.97%**	**$797,444,038**	**4.36%**	**$764,108,633**	**14.71%**	**$666,128,877**	**9.01%**	**$611,060,784**	**9.97%**	**$555,684,333**	**11.54%**	**$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	11.26%	$5,864,156	-10.12%	$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	$6,832,172	0.00%	$6,832,172	0.00%	$6,832,172	5.97%	$6,447,127	-10.17%	$7,176,700	18.07%	$6,078,316	-2.08%	$6,207,423	18.97%	$5,217,447	9.71%	$4,755,641
High Risk Pregnant Women Program	$1,622,430	0.00%	$1,622,430	0.00%	$1,622,430	42.22%	$1,140,814	55.11%	$735,467	-24.16%	$969,806	-14.78%	$1,138,015	8.15%	$1,052,271	-6.57%	$1,126,309
Regional Centers	$44,134,533	0.00%	$44,134,533	-0.23%	$44,234,533	-32.69%	$65,719,538	35.26%	$48,586,422	22.92%	$39,525,715	-27.24%	$54,324,467	-1.63%	$55,222,864	8.09%	$51,089,926
Division of Youth Corrections Medicaid Funding	$1,127,424	0.00%	$1,127,424	0.00%	$1,127,424	22.34%	$921,535	-30.61%	$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)	$125,356	0.00%	$125,356	0.00%	$125,356	18471.26%	$675	-91.70%	$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	0.00%	$0	-100.00%	$325,077,613	-0.54%	$326,845,621
Total DHS - Medicaid Funded Expenditure	**$60,366,479**	**0.00%**	**$60,366,479**	**-0.17%**	**$60,466,479**	**-24.51%**	**$80,093,845**	**24.45%**	**$64,359,347**	**17.66%**	**$54,698,059**	**-23.25%**	**$71,263,238**	**-82.03%**	**$396,499,883**	**0.02%**	**$396,411,131**
Total Title XIX Services Expenditure	**$9,357,013,659**	**2.68%**	**$9,112,440,288**	**-0.41%**	**$9,150,282,336**	**21.20%**	**$7,550,038,127**	**-5.34%**	**$7,976,192,725**	**17.32%**	**$6,798,458,971**	**22.51%**	**$5,549,163,941**	**16.34%**	**$4,769,594,327**	**7.23%**	**$4,448,151,967**
Title XXI																	
CHP+ Children	$197,968,939	6.56%	$185,789,070	7.55%	$172,750,294	19.42%	$144,662,042	26.32%	$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	$142,645,111	5.61%	$135,068,769	-1.79%	$137,531,404	26.93%	$108,355,384	0.22%	$108,121,884	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	$15,268,680	-3.78%	$15,868,295	5.92%	$14,981,618	50.98%	$9,922,719	-40.94%	$16,800,418	103.64%	$8,250,157	9.97%	$7,502,364	127426.16%	$5,883	100.00%	$0
CHP+ Prenatal	$9,710,001	0.00%	$9,709,967	0.30%	$9,680,522	15.23%	$8,400,884	-28.24%	$11,706,851	204.23%	$3,848,028	-67.96%	$12,009,028	-43.97%	$21,433,958	0.11%	$21,411,076
Medicaid SB 11-250 Eligible Pregnant Adults Services	$25,218,364	2.39%	$24,630,169	-5.22%	$25,986,591	60.56%	$16,185,181	-8.31%	$17,652,473	2.60%	$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	$6,036,455	-3.78%	$6,273,512	5.49%	$5,946,896	63.43%	$3,638,761	-48.71%	$7,094,608	82.94%	$3,878,118	15.19%	$3,366,711	354664.07%	$949	100.00%	$0
Total Title XXI Services Expenditure	**$396,847,550**	**5.17%**	**$377,339,782**	**2.85%**	**$366,877,325**	**26.00%**	**$291,164,971**	**5.53%**	**$275,899,181**	**10.64%**	**$249,375,399**	**2.60%**	**$243,054,810**	**16.01%**	**$209,512,114**	**14.83%**	**$182,454,123**
Total Services Expenditure	**$9,753,861,209**	**2.78%**	**$9,489,780,070**	**-0.29%**	**$9,517,159,661**	**21.37%**	**$7,841,203,098**	**-4.98%**	**$8,252,091,906**	**17.09%**	**$7,047,834,370**	**21.68%**	**$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 2017-18, and the annualization from FY 2016-17 S-14/BA-13 "Public School Health Services Funding Adjustment" without the administrative costs, in FY 2018-19. This value is held constant in FY 2019-20.

(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 2017-18 and beyond for Child Welfare Services, and the FY 2017-18 appropriation constant for the other services, for the purpose of this exhibit. This does not represent an actual request by the Department.

Notes:

1. FY 2016-17 expenditure shows data as of August 15, 2017.

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**	**TOTAL Title XIX and Title XXI**
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	$6,678.50
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	$6,719.35
% 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%	0.61%
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	$6,768.04
% Change from FY 2009-10 (DA)	4.25%	5.01%	5.87%	-	3.94%	147.68%	-	-12.52%	1.67%	-1.97%	3.63%	16.77%	16.32%	-0.32%	-2.40%	23.46%	1.16%	0.72%
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	$6,650.37
% 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%	-1.74%
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	$6,530.49
% Change from FY 2011-12	1.01%	-1.04%	-2.54%	45.18%	-0.53%	-5.04%	162.01%	-10.86%	2.33%	-2.45%	5.36%	4.02%	-4.54%	-1.43%	-0.77%	19.84%	-0.43%	-1.80%
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	$6,272.27
% 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%	-3.95%
FY 2014-15	$26,218.37	$29,388.86	$24,541.44	$11,388.13	$3,879.45	$3,307.18	$5,451.68	$14,284.32	$2,376.03	$7,802.89	$13,309.05	$20,899.24	$2,226.78	$6,128.36	$2,162.03	$10,234.22	$2,347.11	$5,797.86
% Change from FY 2013-14	5.42%	5.24%	-1.36%	-35.92%	-5.96%	0.32%	-12.08%	-12.62%	1.36%	3.62%	1.26%	-15.06%	-10.99%	-7.83%	-14.18%	-14.73%	-14.14%	-7.56%
FY 2015-16	$27,736.43	$31,067.89	$26,397.95	$10,645.90	$4,206.74	$3,801.46	$5,715.44	$13,363.23	$2,616.64	$7,441.27	$15,738.50	$25,261.16	$2,237.84	$6,454.66	$2,166.10	$15,020.16	$2,442.26	$6,118.58
% Change from FY 2014-15	5.79%	5.71%	7.56%	-6.52%	8.44%	14.95%	4.84%	-6.45%	10.13%	-4.63%	18.25%	20.87%	0.50%	5.32%	0.19%	46.76%	4.05%	5.53%
FY 2016-17	$30,056.05	$29,284.00	$26,178.44	$9,969.30	$3,496.08	$3,074.28	$4,719.48	$14,783.60	$2,360.28	$6,468.84	$12,815.83	$22,133.11	$2,325.67	$5,902.06	$2,035.11	$10,323.64	$2,206.87	$5,556.58
%C Change from FY 2015-16	8.36%	-5.74%	-0.83%	-6.36%	-16.89%	-19.13%	-17.43%	10.63%	-9.80%	-13.07%	-18.57%	-12.38%	3.92%	-8.56%	-6.05%	-31.27%	-9.64%	-9.19%
FY 2017-18 Projection	$32,398.05	$34,821.22	$30,641.70	$10,786.98	$4,191.17	$3,675.03	$5,676.58	$20,176.45	$2,827.04	$7,278.08	$17,740.31	$24,787.05	$2,495.39	$6,877.05	$2,283.41	$13,307.97	$2,520.23	$6,447.39
% Change from FY 2016-17	7.79%	18.91%	17.05%	8.20%	19.88%	19.54%	20.28%	36.48%	19.78%	12.51%	38.42%	11.99%	7.30%	16.52%	5.42%	-11.40%	3.19%	5.37%
FY 2018-19 Projection	$32,687.33	$34,042.40	$30,216.14	$9,351.75	$3,938.07	$3,363.16	$5,326.40	$19,606.24	$2,763.74	$7,452.70	$16,950.04	$23,646.75	$2,390.33	$6,653.10	$2,258.51	$12,992.21	$2,478.94	$6,235.60
% Change from FY 2017-18	0.89%	-2.24%	-1.39%	-13.31%	-6.04%	-8.49%	-6.17%	-2.83%	-2.24%	2.40%	-4.45%	-4.60%	-4.21%	-3.26%	-1.09%	-2.37%	-1.64%	-3.28%
FY 2019-20 Projection	$33,076.47	$34,000.43	$30,507.46	$8,442.76	$3,856.69	$3,334.75	$5,298.43	$20,624.48	$2,815.07	$7,644.52	$17,127.19	$23,560.32	$2,344.00	$6,690.20	$2,300.34	$13,104.55	$2,514.32	$6,266.74
% Change from FY 2018-19	1.19%	-0.12%	0.96%	-9.72%	-2.07%	-0.84%	-0.53%	5.19%	1.86%	2.57%	1.05%	-0.37%	-1.94%	0.56%	1.85%	0.86%	1.43%	0.50%

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

Total Title XIX and Title XXI Caseload																		
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**	**TOTAL Title XIX and Title XXI**
FY 2008-09	37,619	6,447	51,355	-	61,874	-	-	317	235,129	18,033	6,976	3,987	15,075	436,812	61,582	1,665	63,247	500,059
FY 2009-10 (DA)	38,487	7,049	53,264	-	74,839	3,238	-	425	275,672	18,381	7,830	3,693	15,919	498,797	68,725	1,561	70,286	569,083
% 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%	11.60%	-6.25%	11.13%	13.80%
FY 2010-11 (DA)	38,921	7,767	56,285	-	81,114	27,167	-	531	302,410	18,393	7,868	3,213	17,090	560,759	67,267	1,742	69,009	629,768
% Change from FY 2009-10 (DA)	1.13%	10.19%	5.67%	-	8.38%	7.39	-	24.94%	9.70%	0.07%	0.49%	-13.00%	7.36%	12.42%	-2.12%	11.60%	-1.82%	10.66%
FY 2011-12	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	74,266	2,064	76,330	696,293
% Change from FY 2010-11 (DA)	2.10%	7.93%	5.59%	-	14.93%	0.31	-	12.43%	10.66%	-1.95%	-3.02%	-13.79%	10.42%	10.56%	10.40%	18.48%	10.61%	10.56%
FY 2012-13	40,827	9,051	61,920	888	99,392	41,545	10,634	623	359,843	17,777	8,024	2,684	21,206	674,414	86,071	1,955	88,026	762,440
% Change from FY 2011-12	2.74%	7.97%	4.18%	16.08	6.62%	17.16%	8.38	4.36%	7.53%	-1.43%	5.16%	-3.10%	12.37%	8.78%	15.90%	-5.28%	15.32%	9.50%
FY 2013-14	41,836	9,853	64,424	2,560	124,680	47,082	87,243	559	399,032	18,267	13,160	2,481	23,378	834,555	86,899	2,010	88,909	923,464
% Change from FY 2012-13	2.47%	8.86%	4.04%	1.88	25.44%	13.33%	7.20	-10.27%	10.89%	2.76%	64.01%	-7.56%	10.24%	23.75%	0.96%	2.81%	1.00%	21.12%
FY 2014-15	41,817	10,466	66,548	3,627	161,682	71,989	241,392	400	445,723	20,036	14,897	2,722	28,045	1,109,344	103,812	2,436	106,248	1,215,592
% Change from FY 2013-14	-0.05%	6.22%	3.30%	41.68%	29.68%	52.90%	176.69%	-28.44%	11.70%	9.68%	13.20%	9.71%	19.96%	32.93%	19.46%	21.19%	19.50%	31.63%
FY 2015-16	42,403	10,529	68,800	6,217	163,342	86,964	320,374	322	467,193	19,935	14,413	2,649	32,585	1,235,726	110,542	2,427	112,969	1,348,695
% Change from FY 2014-15	1.40%	0.60%	3.38%	71.41%	1.03%	20.80%	32.72%	-19.50%	4.82%	-0.50%	-3.25%	-2.68%	16.19%	11.39%	6.48%	-0.37%	6.33%	10.95%
FY 2016-17	43,941	11,241	67,619	6,251	160,991	101,059	347,848	295	469,906	20,310	13,311	2,640	33,809	1,279,221	129,202	2,734	131,936	1,411,157
%C Change from FY 2015-16	3.63%	6.76%	-1.72%	0.55%	-1.44%	16.21%	8.58%	-8.39%	0.58%	1.88%	-7.65%	-0.34%	3.76%	3.52%	16.88%	12.65%	16.79%	4.63%
FY 2017-18 Projection	45,242	11,681	67,743	7,811	188,617	91,246	380,104	117	466,328	20,584	11,429	2,782	36,869	1,330,553	142,446	3,127	145,573	1,476,126
% Change from FY 2016-17	2.96%	3.91%	0.18%	24.96%	17.16%	-9.71%	9.27%	-60.34%	-0.76%	1.35%	-14.14%	5.38%	9.05%	4.01%	10.25%	14.37%	10.34%	4.60%
FY 2018-19 Projection	45,993	12,176	69,473	9,099	196,256	98,254	393,958	62	468,328	20,746	11,427	2,814	41,068	1,369,654	149,092	3,126	152,218	1,521,872
% Change from FY 2017-18	1.66%	4.24%	2.55%	16.49%	4.05%	7.68%	3.64%	-47.01%	0.43%	0.79%	-0.02%	1.15%	11.39%	2.94%	4.67%	-0.03%	4.56%	3.10%
FY 2019-20 Projection	46,770	12,712	71,706	10,368	201,516	102,381	401,763	61	470,392	20,929	11,425	2,846	45,746	1,398,615	154,709	3,126	157,835	1,556,450
% Change from FY 2018-19	1.69%	4.40%	3.21%	13.95%	2.68%	4.20%	1.98%	-1.61%	0.44%	0.88%	-0.02%	1.14%	11.39%	2.11%	3.77%	0.00%	3.69%	2.27%

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

Total Title XIX and Title XXI Services Expenditure - 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	TOTAL Title XIX and Title XXI
FY 2008-09	$835,830,181	$172,047,121	$1,143,928,356	-	$256,482,156	-	-	$7,130,026	$490,904,684	$143,713,091	$63,867,448	$59,283,547	$35,768,774	$3,208,955,385	$112,599,454	$18,086,904	$130,686,358	$3,339,641,743
FY 2009-10 (DA)	$858,516,481	$189,852,084	$1,258,440,011	-	$353,112,221	$4,338,281	-	$9,104,713	$624,812,980	$145,573,963	$94,742,361	$74,354,502	$32,525,491	$3,645,373,087	$162,471,143	$16,023,878	$178,495,021	$3,823,868,108
% Change from FY 2008-09	2.71%	10.35%	10.01%	-	37.68%	-	-	27.70%	27.28%	1.29%	48.34%	25.42%	-9.07%	13.60%	44.29%	-11.41%	36.58%	14.50%
FY 2010-11 (DA)	$905,061,646	$219,666,847	$1,407,886,873	-	$397,803,042	$90,150,840	-	$9,951,651	$696,872,022	$142,804,448	$98,655,350	$75,541,133	$40,617,790	$4,085,011,642	$155,207,326	$22,076,574	$177,283,900	$4,262,295,542
% Change from FY 2009-10 (DA)	5.42%	15.70%	11.88%	-	12.66%	19.78	-	9.30%	11.53%	-1.90%	4.13%	1.60%	24.88%	12.06%	-4.47%	37.77%	-0.68%	11.47%
FY 2011-12	$951,391,884	$240,385,809	$1,505,687,844	$815,229	$471,200,755	$130,883,250	$4,107,493	$10,446,012	$772,442,447	$135,820,496	$100,358,906	$78,357,967	$46,253,876	$4,448,151,967	$161,043,047	$21,411,076	$182,454,123	$4,630,606,090
% Change from FY 2010-11 (DA)	5.12%	9.43%	6.95%	-	18.45%	45.18%	-	4.97%	10.84%	-4.89%	1.73%	3.73%	13.88%	8.89%	3.76%	-3.01%	2.92%	8.64%
FY 2012-13	$987,332,911	$256,854,618	$1,528,817,822	$20,211,918	$499,709,620	$145,612,885	$100,921,107	$9,717,456	$850,014,003	$130,610,718	$111,193,487	$78,979,079	$49,618,703	$4,769,594,327	$185,208,220	$24,303,894	$209,512,114	$4,979,106,441
% Change from FY 2011-12	3.78%	6.85%	1.54%	23.79	6.05%	11.25%	23.57	-6.97%	10.04%	-3.84%	10.80%	0.79%	7.27%	7.23%	15.01%	13.51%	14.83%	7.53%
FY 2013-14	$1,040,493,808	$275,152,406	$1,602,925,611	$45,497,017	$514,360,906	$155,218,145	$540,946,584	$9,138,450	$935,391,104	$137,552,573	$172,960,861	$61,044,575	$58,481,901	$5,549,163,941	$218,929,855	$24,124,955	$243,054,810	$5,792,218,751
% Change from FY 2012-13	5.38%	7.12%	4.85%	125.10%	2.93%	6.60%	436.01%	-5.96%	10.04%	5.31%	55.55%	-22.71%	17.86%	16.34%	18.21%	-0.74%	16.01%	16.33%
FY 2014-15	$1,096,373,378	$307,583,810	$1,633,183,749	$41,304,758	$627,236,436	$238,080,635	$1,315,991,551	$5,713,729	$1,059,049,630	$156,338,745	$198,264,891	$56,887,739	$62,449,921	$6,798,458,971	$224,444,844	$24,930,555	$249,375,399	$7,047,834,370
% Change from FY 2013-14	5.37%	11.79%	1.89%	-9.21%	21.94%	53.38%	143.28%	-37.48%	13.22%	13.66%	14.63%	-6.81%	6.79%	22.51%	2.52%	3.34%	2.60%	21.68%
FY 2015-16	$1,176,107,999	$327,113,844	$1,816,179,019	$66,185,584	$687,137,933	$330,589,855	$1,831,079,961	$4,302,959	$1,222,478,141	$148,341,703	$226,838,949	$66,916,803	$72,919,976	$7,976,192,725	$239,445,249	$36,453,932	$275,899,181	$8,252,091,906
% Change from FY 2014-15	7.27%	6.35%	11.20%	60.24%	9.55%	38.86%	39.14%	-24.69%	15.43%	-5.12%	14.41%	17.63%	16.77%	17.32%	6.68%	46.22%	10.64%	17.09%
FY 2016-17	$1,320,692,845	$329,181,459	$1,770,159,672	$62,318,120	$562,837,522	$310,683,424	$1,641,661,443	$4,361,161	$1,109,109,005	$131,382,160	$170,591,471	$58,431,409	$78,628,436	$7,550,038,127	$262,940,145	$28,224,826	$291,164,971	$7,841,203,098
%C Change from FY 2015-16	12.29%	0.63%	-2.53%	-5.84%	-18.09%	-6.02%	-10.34%	1.35%	-9.27%	-11.43%	-24.80%	-12.68%	7.83%	-5.34%	9.81%	-22.57%	5.53%	-4.98%
FY 2017-18 Projection	$1,465,752,629	$406,746,661	$2,075,760,626	$84,257,082	$790,526,362	$335,331,817	$2,157,690,479	$2,360,645	$1,318,329,888	$149,812,050	$202,754,058	$68,957,564	$92,002,475	$9,150,282,336	$325,263,316	$41,614,009	$366,877,325	$9,517,159,661
% Change from FY 2016-17	10.98%	23.56%	17.26%	35.20%	40.45%	7.93%	31.43%	-45.87%	18.86%	14.03%	18.85%	18.01%	17.01%	21.20%	23.70%	47.44%	26.00%	21.37%
FY 2018-19 Projection	$1,503,388,340	$414,500,285	$2,099,206,017	$85,091,607	$772,869,637	$330,444,066	$2,098,376,023	$1,215,587	$1,294,338,941	$154,613,675	$193,688,127	$66,541,941	$98,166,042	$9,112,440,288	$336,726,134	$40,613,648	$377,339,782	$9,489,780,070
% Change from FY 2017-18	2.57%	1.91%	1.13%	0.99%	-2.23%	-1.46%	-2.75%	-48.51%	-1.82%	3.21%	-4.47%	-3.50%	6.70%	-0.41%	3.52%	-2.40%	2.85%	-0.29%
FY 2019-20 Projection	$1,546,986,625	$432,213,414	$2,187,567,664	$87,534,574	$777,184,451	$341,415,092	$2,128,714,280	$1,258,093	$1,324,187,623	$159,992,194	$195,678,188	$67,052,667	$107,228,794	$9,357,013,659	$355,882,730	$40,964,820	$396,847,550	$9,753,861,209
% Change from FY 2018-19	2.90%	4.27%	4.21%	2.87%	0.56%	3.32%	1.45%	3.50%	2.31%	3.48%	1.03%	0.77%	9.23%	2.68%	5.69%	0.86%	5.17%	2.78%

Notes:

1. See Page EQ-1 for a list of services that are included in the calculations for expenditure and per capita costs for Title XIX and Title XXI services.
2. See Narrative for a description of events that alter trends.
3. The expenditure and 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	(Colorado Average Per Capita)^2	(U.S. Average Per Capita)^2	CO APC^2/ U.S. APC^2	*0.45	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	4,338,831	$34,140.15	-	-	-	-	-	-	-	-	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	4,444,513	$35,097.70	-	-	-	-	-	-	-	-	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	4,504,709	$34,890.80	$34,709.55	$31,319.06	$1,204,752,861.20	$980,883,519.28	122.82%	55.27%	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	4,555,084	$35,206.64	$35,065.05	$32,015.61	$1,229,557,731.50	$1,024,999,283.67	119.96%	53.98%	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	4,608,811	$36,407.20	$35,501.55	$32,940.95	$1,260,360,052.40	$1,085,106,186.90	116.15%	52.27%	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	4,662,534	$38,410.41	$36,674.75	$34,304.09	$1,345,037,287.56	$1,176,770,590.73	114.30%	51.44%	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	4,745,660	$40,492.08	$38,436.56	$36,121.34	$1,477,369,144.63	$1,304,751,203.40	113.23%	50.95%	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	4,821,784	$42,107.85	$40,336.78	$37,956.48	$1,627,055,820.77	$1,440,694,373.99	112.94%	50.82%	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	4,901,938	$43,522.00	$42,040.64	$39,682.28	$1,767,415,411.61	$1,574,683,346.00	112.24%	50.51%	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	4,976,853	$41,469.06	$42,366.30	$40,093.02	$1,794,903,375.69	$1,607,450,252.72	111.66%	50.25%	50.00%	65.00%	2009-10	50.00%	65.00%	50.00%	65.00%
2010	$12,459,613,000,000	309,348,193	$40,276.99	$211,419,677,000	5,050,289	$41,862.89	$42,284.65	$40,244.92	$1,787,991,625.62	$1,619,653,585.81	110.39%	49.68%	50.32%	65.22%	2010-11	50.00%	65.00%	50.00%	65.00%
2011	$13,233,436,000,000	311,663,358	$42,460.67	$227,052,222,000	5,120,193	$44,344.47	$42,558.81	$40,704.56	$1,811,252,308.62	$1,656,861,204.79	109.32%	49.19%	50.81%	65.57%	2011-12	50.00%	65.00%	50.00%	65.00%
2012	$13,915,100,000,000	313,998,379	$44,315.83	$234,006,000,000	5,193,097	$45,060.97	$43,756.11	$42,351.16	$1,914,597,162.33	$1,793,620,753.35	106.74%	48.03%	51.97%	66.38%	2012-13	50.00%	65.00%	50.00%	65.00%
2013	$14,073,700,000,000	316,204,908	$44,508.16	$246,648,000,000	5,272,677	$46,778.51	$45,394.65	$43,761.55	$2,060,674,248.62	$1,915,073,258.40	107.60%	48.42%	51.58%	66.11%	2013-14	50.00%	65.00%	50.00%	65.00%
2014	$14,809,700,000,000	318,563,456	$46,489.01	$266,535,000,000	5,356,626	$49,758.00	$47,199.16	$45,104.33	$2,227,760,704.71	$2,034,400,584.75	109.50%	49.28%	50.72%	65.50%	2014-15	51.01%	65.71%	50.76%	65.53%
2015	$15,458,500,000,000	320,896,618	$48,172.84	$277,732,000,000	5,456,584	$50,898.51	$49,145.01	$46,390.00	$2,415,232,007.90	$2,152,032,100.00	112.23%	50.50%	50.00%	65.00%	2015-16	50.72%	65.50%	50.79%	65.55%
2016	$16,011,600,000,000	323,127,513	$49,551.96	$287,620,000,000	5,555,751	$51,769.78	$50,808.76	$48,071.27	$2,581,530,092.74	$2,310,846,999.41	111.71%	50.27%	50.00%	65.00%	2016-17	50.02%	65.01%	50.20%	65.13%
2017	$16,732,000,000,000	326,626,000	$51,226.79	$302,864,000,000	5,655,405	$53,553.01	$52,073.77	$49,650.53	$2,711,677,522.01	$2,465,175,129.28	110.00%	49.50%	50.50%	65.35%	2017-18	50.00%	65.00%	**50.00%**	**65.00%**
2018	$17,719,000,000,000	329,256,000	$53,815.27	$321,945,000,000	5,751,727	$55,973.62	$53,765.47	$51,531.34	$2,890,725,764.32	$2,655,479,002.20	108.86%	48.99%	51.01%	65.71%	2018-19	50.00%	65.00%	**50.00%**	**65.00%**
2019	$18,729,000,000,000	331,884,000	$56,432.37	$341,583,000,000	5,848,903	$58,401.21	$55,975.95	$53,824.81	$3,133,306,978.40	$2,897,110,171.54	108.15%	48.67%	51.33%	65.93%	2019-20	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 2019-20 estimated FMAP is calculated based on forecasts of Personal Income from www.leg.state.co.us and Population from www.census.gov and demography.dola.colorado.gov. Current estimates suggest a FFY 2019-20 FMAP of 50.50%, with an average SFY 2019-20 FMAP of 50.38%. Because this time period is so far out, the Department has chosen to assume the 50.00% FMAP will continue in FY 2019-20, and will update this assumption as more data becomes available.

TABLE OF CONTENTS
Exhibits for the Medical Services Premiums Budget Request

Exhibit	Description
Exhibit A	Calculation of Request; Calculation of Fund Splits
Exhibit B	Medicaid Caseload Forecast
Exhibit C	History and Projections of Per Capita Costs
Exhibit D	Cash Funds Report
Exhibit E	Summary of Total Requested Expenditure by Service Group; Comparison of Request to Long Bill Appropriation and Special Bills
Exhibit F	Acute Care; Breast and Cervical Cancer Program Per Capita Detail; Adult Dental Cash Fund-Eligible Dental Services; Antipsychotic Drug Expenditure and Pharmacy Enhanced Rebates; Family Planning Enhanced Match Calculation; Indian Health Services
Exhibit G	Community Based Long-Term Care; Half-Year Expenditure Split; Private Duty Nursing; Long-Term Home Health; Colorado Choice Transitions; Hospice Request and Footnotes
Exhibit H	Long-Term Care and Insurance Summary; Class I Nursing Facilities Request, Footnotes, and Supplemental Payments; Class II Nursing Facilities; Program for All-Inclusive Care for the Elderly (PACE); Supplemental Medicare Insurance Benefit (SMIB); Health Insurance Buy-In (HIBI)
Exhibit I	Service Management - Summary; Single Entry Points; Disease Management; Accountable Care Collaborative; Prepaid Inpatient Health Plan Administration
Exhibit J	Healthcare Affordability and Sustainability Fee Financing
Exhibit K	Upper Payment Limit Financing
Exhibit L	Department Recoveries
Exhibit M	Expenditure History by Aid Category and Service Category
Exhibit N	Expenditure History by Service Category
Exhibit O	Comparison of Budget Requests; Appropriations and Expenditure for Prior Years
Exhibit P	Global Reasonableness; Expenditure and Caseload History (Reference Only)
Exhibit Q	Total Cost of Care Title XIX and Title XXI; Total Title XIX and Title XXI Services Per Capita Costs
Exhibit R	Federal Medical Assistance Percentage (FMAP) Estimate

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 2017-18 Behavioral Health Capitation Appropriation						
FY 2017-18 Long Bill Appropriation (SB 17-254)	$616,836,053	$172,509,947	$0	$25,816,287	$0	$418,509,819
FY 2017-18 Total Behavioral Heath Capitation Spending Authority	**$616,836,053**	**$172,509,947**	**$0**	**$25,816,287**	**$0**	**$418,509,819**
Projected Total FY 2017-18 Behavioral Health Capitation Expenditure	**$549,903,817**	**$173,277,148**	**$0**	**$25,128,452**	**$0**	**$351,498,217**
FY 2017-18 Behavioral Health Capitation Estimated Change from Appropriation	**($66,932,236)**	**$767,201**	**$0**	**($687,835)**	**$0**	**($67,011,602)**
Percent Change from Spending Authority	-10.85%	0.44%	0.00%	-2.66%	0.00%	-16.01%
FY 2017-18 Behavioral Health Fee-for-Service						
FY 2017-18 Behavioral Health Fee-For-Service Appropriation						
FY 2017-18 Long Bill Appropriation (SB 17-254)	$8,961,518	$1,936,255	$0	$374,248	$0	$6,651,015
FY 2017-18 Total Behavioral Heath Fee-For-Service Spending Authority	**$8,961,518**	**$1,936,255**	**$0**	**$374,248**	**$0**	**$6,651,015**
Projected Total FY 2017-18 Behavioral Health Fee-for-Service Expenditure	**$8,961,518**	**$1,958,482**	**$0**	**$368,299**	**$0**	**$6,634,737**
Total FY 2017-18 Behavioral Health Fee-For-Service Change from Appropriation	**$0**	**$22,227**	**$0**	**($5,949)**	**$0**	**($16,278)**
Percent Change from Spending Authority	0.00%	1.15%	0.00%	-1.59%	0.00%	-0.24%
FY 2017-18 Medicaid Behavioral Health Programs						
FY 2017-18 Total Spending Authority	**$625,797,571**	**$174,446,202**	**$0**	**$26,190,535**	**$0**	**$425,160,834**
Total Projected FY 2017-18 Expenditures	$558,865,335	$175,235,630	$0	$25,496,751	$0	$358,132,954
FY 2017-18 Estimated Change from Appropriation	**($66,932,236)**	**$789,428**	**$0**	**($693,784)**	**$0**	**($67,027,880)**
Percent Change from Spending Authority	-10.70%	0.45%	0.00%	-2.65%	0.00%	-15.77%

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	**$616,836,053**	**$172,509,947**	**$0**	**$25,816,287**	**$0**	**$418,509,819**
Bill Annualizations	$25,305,729	$6,923,088	$0	$881,388	$0	$17,501,253
FY 2018-19 Behavioral Health Capitation Base Amount	**$642,141,782**	**$179,433,035**	**$0**	**$26,697,675**	**$0**	**$436,011,072**
Projected Total FY 2018-19 Behavioral Health Capitation Expenditure	**$680,689,768**	**$187,100,392**	**$0**	**$31,827,726**	**$0**	**$461,761,650**
Total FY 2018-19 Behavioral Health Capitation Request	**$38,547,986**	**$7,667,357**	**$0**	**$5,130,051**	**$0**	**$25,750,578**
Percent Change from FY 2018-19 Behavioral Health Capitation Base	6.00%	4.27%	0.00%	19.22%	0.00%	5.91%
Percent Change from FY 2017-18 Estimated Behavioral Health Capitation Expenditure	23.78%	7.98%	0.00%	26.66%	0.00%	31.37%
FY 2018-19 Behavioral Health Fee-for-Service						
FY 2017-18 Behavioral Health Fee-For-Service Appropriation Plus Special Bills	**$8,961,518**	**$1,936,255**	**$0**	**$374,248**	**$0**	**$6,651,015**
Bill Annualizations	$11,566	$2,499	$0	$483	$0	$8,584
FY 2018-19 Behavioral Health Fee-For-Service Base Amount	**$8,973,084**	**$1,938,754**	**$0**	**$374,731**	**$0**	**$6,659,599**
Projected Total FY 2018-19 Behavioral Health Fee-for-Service Expenditure	**$9,223,001**	**$1,985,317**	**$0**	**$431,495**	**$0**	**$6,806,189**
Total FY 2018-19 Behavioral Health Fee-For-Service Request	**$249,917**	**$46,563**	**$0**	**$56,764**	**$0**	**$146,590**
Percent Change from FY 2018-19 Behavioral Health Fee-For-Service Base	2.79%	2.40%	0.00%	15.15%	0.00%	2.20%
Percent Change from FY 2017-18 Estimated Behavioral Health Fee-For-Service Expenditure	2.92%	1.37%	0.00%	17.16%	0.00%	2.58%
FY 2018-19 Medicaid Behavioral Health Programs						
FY 2018-19 Base Amount	**$651,114,866**	**$181,371,789**	**$0**	**$27,072,406**	**$0**	**$442,670,671**
Total Projected FY 2018-19 Expenditure	$689,912,769	$189,085,709	$0	$32,259,221	$0	$468,567,839
Total FY 2018-19 Request	**$38,797,903**	**$7,713,920**	**$0**	**$5,186,815**	**$0**	**$25,897,168**
Percent Change from Spending Authority	5.96%	4.25%	0.00%	19.16%	0.00%	5.85%

Exhibit AA - Calculation of Current Total Long Bill Group Impact						
FY 2019-20 Behavioral Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2018-19 Behavioral Health Capitation Appropriation Plus Special Bills	**$642,141,782**	**$179,433,035**	**$0**	**$26,697,675**	**$0**	**$436,011,072**
Bill Annualizations	$1,008,708	$181,364	$0	($47,806)	$0	$875,150
FY 2019-20 Behavioral Health Capitation Base Amount	**$643,150,490**	**$179,614,399**	**$0**	**$26,649,869**	**$0**	**$436,886,222**
Projected Total FY 2019-20 Behavioral Health Capitation Expenditure	**$704,045,905**	**$196,231,176**	**$0**	**$38,993,089**	**$0**	**$468,821,639.56**
Total FY 2019-20 Behavioral Health Capitation Continuation Amount	**$60,895,415**	**$16,616,777**	**$0**	**$12,343,220**	**$0**	**$31,935,418**
Percent Change from FY 2019-20 Behavioral Health Capitation Base	9.47%	9.25%	0.00%	46.32%	0.00%	7.31%
Percent Change from FY 2018-19 Estimated Behavioral Health Capitation Expenditure	3.43%	4.88%	0.00%	22.51%	0.00%	1.53%
FY 2019-20 Behavioral Health Fee-for-Service						
FY 2018-19 Behavioral Health Fee-For-Service Appropriation Plus Special Bills	**$8,973,084**	**$1,938,754**	**$0**	**$374,731**	**$0**	**$6,659,599**
FY 2019-20 Behavioral Health Fee-For-Service Base Amount	**$8,973,084**	**$1,938,754**	**$0**	**$374,731**	**$0**	**$6,659,599**
Projected Total FY 2019-20 Behavioral Health Fee-for-Service Expenditure	**$9,568,414**	**$2,147,022**	**$0**	**$541,030**	**$0**	**$6,880,362**
Total FY 2019-20 Behavioral Health Fee-For-Service Continuation Amount	**$595,330**	**$208,268**	**$0**	**$166,299**	**$0**	**$220,763**
Percent Change from FY 2018-19 Behavioral Health Fee-For-Service Base	6.63%	10.74%	0.00%	44.38%	0.00%	3.31%
Percent Change from FY 2018-19 Estimated Behavioral Health Fee-For-Service Expenditure	3.75%	8.15%	0.00%	25.38%	0.00%	1.09%
FY 2019-20 Medicaid Behavioral Health Programs						
FY 2019-20 Base Amount	**$652,123,574**	**$181,553,153**	**$0**	**$27,024,600**	**$0**	**$443,545,821**
Total Projected FY 2019-20 Expenditure	$713,614,319	$198,378,198	$0	$39,534,119	$0	$475,702,002
Total FY 2019-20 Continuation Amount	**$61,490,745**	**$16,825,045**	**$0**	**$12,509,519**	**$0**	**$32,156,181**
Percent Change from Spending Authority	9.43%	9.27%	0.00%	46.29%	0.00%	7.25%

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	$339,427,661	$169,713,830	$0	$0	$169,713,831	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$41,524	$0	$14,533	$0	$26,991	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$3,171,115	$0	$1,585,557	$0	$1,585,558	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$228,113,791	$0	$12,546,259	$0	$215,567,532	94.50%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Non Newly Eligible	$1,419,501	$0	$235,921	$0	$1,183,580	83.38%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$12,636,523	$0	$6,318,261	$0	$6,318,262	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Continuous Eligibility for Children	$9,470,552	$0	$4,735,276	$0	$4,735,276	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$16,400,899	$1,968,108	$0	$0	$14,432,791	88.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$837,486	$100,498	$0	$0	$736,988	88.00%	General Fund
Estimated FY 2017-18 Capitation Expenditure Before Adjustments	**$611,519,052**	**$171,782,436**	**$25,435,807**	**$0**	**$414,300,809**		
Date of Death Retractions	($1,472,996)	($736,498)	$0	$0	($736,498)	50.00%	General Fund
Risk Corridor Reconciliation [2]	($48,266,117)	$0	$0	$0	($48,266,117)	100.00%	Federal Funds
Expansion Adult Payment Rate BLI [3]	($17,786,031)	$0	$0	$0	($17,786,031)	100.00%	Federal Funds
Adjustment for Clients Placed in Incorrect Eligibility Types [4]	($1,848,939)	($357,455)	($552,408)	$0	($939,076)	50.79%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Health Insurance Provider Fee Payment[5]	$5,891,487	$1,654,984	$245,053	$0	$3,991,450	67.75%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Transitional Medicaid Eligibility Payment[6]	$1,867,361	$933,681	$0	$0.00	$933,681	50.00%	General Fund
Estimated FY 2017-18 Capitation Expenditure	**$549,903,817**	**$173,277,148**	**$25,128,452**	**$0**	**$351,498,217**		
Behavioral Health Fee-for-Service Traditional Clients	$3,851,219	$1,925,609	$0	$0	$1,925,610	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$1,948	$0	$682	$0	$1,266	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$76,565	$0	$38,282	$0	$38,283	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$4,585,420	$0	$252,198	$0	$4,333,222	94.50%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Non Newly Eligible	$27,187	$0	$4,518	$0	$22,669	83.38%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$38,430	$0	$19,215	$0	$19,215	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Continuous Eligibility for Children	$106,809	$0	$53,404	$0	$53,405	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$267,484	$32,098	$0	$0	$235,386	88.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$6,456	$775	$0	$0	$5,681	88.00%	General Fund
Estimated FY 2017-18 Fee-for-Service Payments	**$8,961,518**	**$1,958,482**	**$368,299**	**$0**	**$6,634,737**		
Final Estimated FY 2017-18 Medicaid Behavioral Health Community Programs Expenditure	**$558,865,335**	**$175,235,630**	**$25,496,751**	**$0**	**$358,132,954**		

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

[2] The reconciliation amount is made up of $4,546,673 for the Expansion Parent Risk Corridor for dates of service in FY 2015-16 and $43,719,444 for the MAGI Adult risk corridor for dates of service 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 was corrected with the implementation of the interChange in March 2017. 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 the eligible children 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.

[5] Due to ACA mandates the Health Insurance Provider Fee (HIPF) must be paid for all for profit BHO. The amounts reflect the total impact to Behavioral Health for the FY 2017-18.

[6] A system issue caused some clients to be incorrectly identified as Expansion Parents when previously they would have been placed on the Transitional Medicaid program prior to being considered eligible for being an expansion parent. As a result, the Department underpaid on those clients and will be paying out the remainder of the owed amount to BHO.

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	$356,618,303	$178,309,151	$0	$0	$178,309,152	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$23,220	$0	$8,127	$0	$15,093	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$3,484,000	$0	$1,742,000	$0	$1,742,000	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$250,046,651	$0	$16,253,032	$0	$233,793,619	93.50%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Non Newly Eligible	$1,535,923	$0	$266,790	$0	$1,269,133	82.63%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$14,924,681	$0	$7,462,340	$0	$7,462,341	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Continuous Eligibility for Children	$10,009,203	$0	$5,004,601	$0	$5,004,602	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$17,772,516	$2,132,702	$0	$0	$15,639,814	88.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$883,899	$106,068	$0	$0	$777,831	88.00%	General Fund
Estimated FY 2018-19 Capitation Expenditure Before Adjustments	**$655,298,396**	**$180,547,921**	**$30,736,890**	**$0**	**$444,013,585**		
Date of Death Retractions	($1,325,697)	($662,848)	$0	$0	($662,849)	50.00%	General Fund
HB 17-1353 Behavioral Health Organization Incentive Payments	$26,717,069	$7,215,319	$1,090,836	$0	$18,410,914	68.91%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Estimated FY 2018-19 Capitation Expenditure	**$680,689,768**	**$187,100,392**	**$31,827,726**	**$0**	**$461,761,650**		
Behavioral Health Fee-for-Service Traditional Clients	$3,901,983	$1,950,991	$0	$0	$1,950,992	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$1,032	$0	$361	$0	$671	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$79,669	$0	$39,834	$0	$39,835	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$4,774,100	$0	$310,316	$0	$4,463,784	93.50%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Non Newly Eligible	$27,875	$0	$4,842	$0	$23,033	82.63%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$44,767	$0	$22,383	$0	$22,384	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Continuous Eligibility for Children	$107,519	$0	$53,759	$0	$53,760	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$279,602	$33,552	$0	$0	$246,050	88.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$6,454	$774	$0	$0	$5,680	88.00%	General Fund
Estimated FY 2018-19 Fee-for-Service Payments	**$9,223,001**	**$1,985,317**	**$431,495**	**$0**	**$6,806,189**		
Final Estimated FY 2018-19 Medicaid Behavioral Health Community Programs Expenditure	**$689,912,769**	**$189,085,709**	**$32,259,221**	**$0**	**$468,567,839**		

[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 2019-20 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	$363,956,179	$181,978,089	$0	$0	$181,978,090	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$22,825	$0	$7,989	$0	$14,836	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$3,578,392	$0	$1,789,196	$0	$1,789,196	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$255,528,269	$0	$21,719,903	$0	$233,808,366	91.50%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Non Newly Eligible	$1,566,873	$0	$295,669	$0	$1,271,204	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$17,015,895	$0	$8,507,947	$0	$8,507,948	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Continuous Eligibility for Children	$10,054,219	$0	$5,027,109	$0	$5,027,110	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$18,408,831	$5,384,583	$0	$0	$13,024,248	70.75%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$884,126	$258,607	$0	$0	$625,519	70.75%	General Fund
Estimated FY 2019-20 Capitation Expenditure Before Adjustments	**$671,015,609**	**$187,621,279**	**$37,347,813**	**$0**	**$446,046,517**		
Date of Death Retractions	($1,193,127)	($596,563)	$0	$0	($596,564)	50.00%	General Fund
HB 17-1353 Behavioral Health Organization Incentive Payments	$28,131,120	$7,503,004	$1,306,187	$0	$19,321,929	68.69%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Health Insurance Provider Payment	$6,092,303	$1,703,456	$339,089	$0	$4,049,758	66.47%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Estimated FY 2019-20 Capitation Expenditure	**$704,045,905**	**$196,231,176**	**$38,993,089**	**$0**	**$468,821,640**		
Behavioral Health Fee-for-Service Traditional Clients	$4,120,863	$2,060,431	$0	$0	$2,060,432	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$1,016	$0	$356	$0	$660	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$81,806	$0	$40,903	$0	$40,903	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: MAGI Parents and Caretakers 69% - 133% FPL and MAGI Adults	$4,881,267	$0	$414,908	$0	$4,466,359	91.50%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Non Newly Eligible	$28,423	$0	$5,363	$0	$23,060	81.13%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$51,011	$0	$25,505	$0	$25,506	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
Continuous Eligibility for Children	$107,991	$0	$53,995	$0	$53,996	50.00%	CF: Healthcare Affordability and Sustainability Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$289,583	$84,703	$0	$0	$204,880	70.75%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$6,454	$1,888	$0	$0	$4,566	70.75%	General Fund
Estimated FY 2019-20 Fee-for-Service Payments	**$9,568,414**	**$2,147,022**	**$541,030**	**$0**	**$6,880,362**		
Final Estimated FY 2019-20 Medicaid Behavioral Health Community Programs Expenditure	**$713,614,319**	**$198,378,198**	**$39,534,119**	**$0**	**$475,702,002**		

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

Cash Funds Report									
Cash Fund	FY 2017-18			FY 2018-19			FY 2019-20		
	Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change
Behavioral Health Capitations									
Healthcare Affordability and Sustainability Fee Cash Fund	$25,785,121	$25,113,919	($671,202)	$26,666,421	$31,819,599	$5,153,178	$26,618,404	$38,985,100	$12,366,696
Breast and Cervical Cancer Prevention and Treatment Fund	$31,166	$14,533	($16,633)	$31,254	$8,127	($23,127)	$31,465	$7,989	($23,476)
Behavioral Health Capitations Total Cash Funds	**$25,816,287**	**$25,128,452**	**($687,835)**	**$26,697,675**	**$31,827,726**	**$5,130,051**	**$26,649,869**	**$38,993,089**	**$12,343,220**
Behavioral Health Fee-for-Service									
Healthcare Affordability and Sustainability Fee Cash Fund	$373,007	$367,617	($5,390)	$373,490	$431,134	$57,644	$373,490	$540,674	$167,184
Breast and Cervical Cancer Prevention and Treatment Fund	$1,241	$682	($559)	$1,241	$361	($880)	$1,241	$356	($885)
Behavioral Health Fee-for-Service Total Cash Funds	**$374,248**	**$368,299**	**($5,949)**	**$374,731**	**$431,495**	**$56,764**	**$374,731**	**$541,030**	**$166,299**

Exhibit CC - Medicaid Behavioral Health Community Programs Expenditure Summary
Actuals, Appropriations and Estimates Prior to Recoupments

ITEM	FY 2016-17 Actual		FY 2017-18 Appropriated		FY 2017-18 Estimate		FY 2017-18 Change from Appropriation		FY 2018-19 Estimate		FY 2018-19 Change from FY 2017-18 Estimate		FY 2018-19 Change from FY 2017-18 Appropriation		FY 2019-20 Estimate		FY 2019-20 Change from FY 2018-19 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)	43,941	$9,477,756	44,144	$9,624,246	45,242	$10,235,970	1,098	$611,724	45,993	$10,870,527	751	$634,557	1,849	$1,246,281	46,770	$11,055,786	777	$185,259
Disabled Individuals	85,111	$143,806,626	88,158	$151,525,713	87,235	$141,790,571	(923)	($9,735,142)	90,748	$149,446,616	3,513	$7,656,045	2,590	($2,079,097)	94,786	$156,099,241	4,038	$6,652,625
Low Income Adults	176,318	$61,419,604	208,397	$74,012,336	202,411	$71,712,736	(5,986)	($2,299,600)	210,047	$78,568,612	7,636	$6,855,876	1,650	$4,556,276	215,305	$80,552,027	5,258	$1,983,415
Expansion Parents & Caretakers	101,059	$37,181,688	80,982	$15,920,385	91,246	$16,195,730	10,264	$275,345	98,254	$18,237,436	7,008	$2,041,706	17,272	$2,317,051	102,381	$19,013,312	4,127	$775,876
MAGI Adults	347,848	$231,214,142	389,466	$256,487,935	380,104	$213,835,278	(9,362)	($42,652,657)	393,958	$233,793,083	13,854	$19,957,805	4,492	($22,694,852)	401,763	$238,484,980	7,805	$4,691,897
Eligible Children	534,843	$128,130,152	548,506	$133,470,884	535,090	$127,646,403	(13,416)	($5,824,481)	540,205	$133,589,216	5,115	$5,942,813	(8,301)	$118,332	544,835	$134,745,843	4,630	$1,156,627
Foster Care	20,310	$30,612,237	20,456	$31,708,667	20,584	$30,060,840	128	($1,647,827)	20,746	$30,769,686	162	$708,846	290	($938,981)	20,929	$31,041,595	183	$271,909
Breast and Cervical Cancer Program	295	$84,817	253	$89,900	117	$41,524	(136)	($48,376)	62	$23,220	(55)	($18,304)	(191)	($66,680)	61	$22,825	(1)	($395)
Sub-total Behavioral Health Capitation Payments	**1,309,725**	**$641,927,022**	**1,380,362**	**$672,840,066**	**1,362,029**	**$611,519,052**	**(18,333)**	**($61,321,014)**	**1,400,013**	**$655,298,396**	**37,984**	**$43,779,344**	**19,651**	**($17,541,670)**	**1,426,830**	**$671,015,609**	**26,817**	**$15,717,213**
Date of Death Retractions		($1,472,996)		($885,913)		($1,472,996)		($587,083)		($1,325,697)		$147,299		($439,784)		($1,193,127)		$132,570
Risk Corridor Reconciliation		($17,524,964)		$0		($48,266,117)		($48,266,117)		$0		$48,266,117		$0		$0		$0
Expansion Parent Payment Rate Reconciliation		($19,040,337)		($25,333,333)		($17,786,031)		$7,547,302		$0		$17,786,031		$25,333,333		$0		$0
Adjustment for Clients Placed in Incorrect Eligibility Types		$0		($3,067,698)		($1,848,939)		$1,218,759		$0		$1,848,939		$3,067,698		$0		$0
FY 2017-18 R-6 "Delivery System and Payment Reform" - Rate Savings		$0		($26,717,069)		$0		$26,717,069		$0		$0		$26,717,069		$0		$0
HB 17-1353 "Implement Medicaid Delivery and Payment Incentives" - Incentive Payments		$0		$0		$0		$0		$26,717,069		$26,717,069		$26,717,069		$28,131,120		$1,414,051
Health Insurance Provider Fee Payment		$0		$0		$5,891,487		$5,891,487		$0		($5,891,487)		$0		$6,092,303		($5,891,487)
Transitional Medicaid Eligibility Payment		$0		$0		$1,867,361		$1,867,361		$0		($1,867,361)		$0		$0		($1,867,361)
Total Behavioral Health Capitation Payments	**1,309,725**	**$603,888,725**	**1,380,362**	**$616,836,053**	**1,362,029**	**$549,903,817**	**(18,333)**	**($66,932,236)**	**1,400,013**	**$680,689,768**	**37,984**	**$130,785,951**	**19,651**	**$63,853,715**	**1,426,830**	**$704,045,905**	**26,817**	**$23,356,137**
Incremental Percent Change							-1.33%	-10.85%			2.79%	23.78%	1.42%	10.35%			1.92%	3.43%
Behavioral Health Fee-for Service Payments																		
Inpatient Services		$380,126		$439,551		$439,551		$0		$451,809		$12,258		$12,258		$469,318		$17,509
Outpatient Services		$7,349,403		$8,498,335		$8,498,335		$0		$8,735,335		$237,000		$237,000		$9,073,864		$338,529
Physician Services		$20,437		$23,632		$23,632		$0		$24,291		$659		$659		$25,232		$941
Total Behavioral Health Fee-for-Service Payments		**$7,749,966**		**$8,961,518**		**$8,961,518**		**$0**		**$9,211,435**		**$249,917**		**$249,917**		**$9,568,414**		**$356,979**
Total Behavioral Health Community Programs		**$611,638,691**		**$625,797,571**		**$558,865,335**		**($66,932,236)**		**$689,901,203**		**$131,035,868**		**$64,103,632**		**$713,614,319**		**$23,713,116**
Incremental Percent Change								-10.70%				23.45%		10.24%				3.44%

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 2007-08 Actuals	36,284	56,079	59,761	-	-	204,022	17,141	270	373,557
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 Actuals	43,941	85,111	176,318	101,059	347,848	534,843	20,310	295	1,309,725
% Change from FY 2015-16	3.63%	-0.51%	-1.78%	16.21%	8.58%	1.55%	1.88%	-8.39%	3.80%
FY 2017-18 Projections	45,242	87,235	202,411	91,246	380,104	535,090	20,584	117	1,362,029
% Change from FY 2016-17	6.70%	1.97%	12.75%	5.00%	19.00%	2.00%	3.00%	-64.00%	3.99%
FY 2018-19 Projections	45,993	90,748	210,047	98,254	393,958	540,205	20,746	62	1,400,013
% Change from FY 2017-18	1.66%	4.03%	3.77%	7.68%	3.64%	0.96%	0.79%	-47.00%	2.79%
FY 2019-20 Projections	46,770	94,786	215,305	102,381	401,763	544,835	20,929	61	1,426,830
% Change from FY 2018-19	1.69%	4.45%	2.50%	4.20%	1.98%	0.86%	0.88%	-2.00%	1.92%
FY 2017-18 Appropriation	44,144	88,158	208,397	80,982	389,466	548,506	20,456	253	1,380,362
Difference between the FY 2017-18 Appropriation and the FY 2017-18 Projection	1,098	(923)	(5,986)	10,264	(9,362)	(13,416)	128	(136)	(18,333)

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 2007-08 Actuals	36,284	6,146	49,933	-	53,473	6,288	-	-	-	204,022	-	17,141	270	373,557
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 Actuals	43,941	11,241	67,619	6,251	160,991	13,311	2,016	101,059	347,848	469,906	64,937	20,310	295	1,309,725
% Change from FY 2015-16	3.63%	6.76%	-1.72%	0.55%	-1.44%	-7.65%	14.61%	16.21%	8.58%	0.58%	9.14%	1.88%	-8.39%	3.80%
FY 2017-18 Projections	45,242	11,681	67,743	7,811	188,617	11,429	2,365	91,246	380,104	466,328	68,762	20,584	117	1,362,029
% Change from	2.96%	3.91%	0.18%	24.96%	17.16%	-14.14%	17.31%	-9.71%	9.27%	-0.76%	5.89%	1.35%	-60.34%	3.99%
FY 2018-19 Projections	45,993	12,176	69,473	9,099	196,256	11,427	2,364	98,254	393,958	468,328	71,877	20,746	62	1,400,013
% Change from FY 2017-18	1.66%	4.24%	2.55%	16.49%	4.05%	-0.02%	-0.04%	7.68%	3.64%	0.43%	4.53%	0.79%	-47.01%	2.79%
FY 2019-20 Projections	46,770	12,712	71,706	10,368	201,516	11,425	2,364	102,381	401,763	470,392	74,443	20,929	61	1,426,830
% Change from FY 2018-19	1.69%	4.40%	3.21%	13.95%	2.68%	-0.02%	0.00%	4.20%	1.98%	0.44%	3.57%	0.88%	-1.61%	1.92%
FY 2017-18 Appropriation	44,144	11,659	69,085	7,414	192,463	14,131	1,803	80,982	389,466	479,307	69,199	20,456	253	1,380,362
Difference between the FY 2017-18 Appropriation and the FY 2017-18 Projection	1,098	22	(1,342)	397	(3,846)	(2,702)	562	10,264	(9,362)	(12,979)	(437)	128	(136)	(18,333)

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 2008-09	2.53%	8.19%	1.75%	-	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 Actuals	$204.81	$1,618.89	$334.45	$353.29	$603.51	$230.06	$1,446.41	$273.29	$461.08
% Change from FY 2015-16	15.75%	9.51%	11.09%	-43.21%	-5.68%	2.07%	-22.66%	-29.17%	-3.56%
FY 2017-18 Projections	$221.62	$1,617.79	$354.12	$177.38	$561.29	$238.52	$1,458.12	$340.31	$447.90
% Change from FY 2016-17	25.25%	9.44%	17.62%	-71.49%	-12.28%	5.82%	-22.03%	-11.81%	-2.86%
FY 2018-19 Projections	$232.25	$1,640.26	$373.90	$185.52	$592.33	$247.26	$1,481.13	$349.73	$467.12
% Change from FY 2017-18	4.80%	1.39%	5.59%	4.59%	3.67%	3.67%	1.58%	2.77%	4.29%
FY 2019-20 Projections	$232.76	$1,641.19	$374.00	$185.63	$592.61	$247.29	$1,481.37	$351.51	$469.45
% Change from FY 2018-19	0.22%	0.06%	0.03%	0.06%	0.05%	0.01%	0.02%	$0.01	0.50%

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
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 Actuals	$204.81	$1,594.24	$1,622.37	$1,625.52	$337.50	$298.26	$329.80	$353.29	$603.51	$227.60	$247.83	$1,446.41	$273.29	$461.08
% Change from FY 2015-16	15.75%	11.01%	10.29%	-0.24%	10.82%	13.58%	12.17%	-43.21%	-5.68%	1.02%	9.62%	-22.66%	-29.17%	-3.56%
FY 2017-18 Projections	$221.62	$1,617.79	$1,617.79	$1,617.79	$354.12	$354.12	$354.12	$177.38	$561.29	$238.52	$238.52	$1,458.12	$340.31	$447.90
% Change from FY 2016-17	25.25%	12.65%	9.97%	-0.72%	16.28%	34.85%	20.44%	-71.49%	-12.28%	5.87%	5.50%	-22.03%	-11.81%	-2.86%
FY 2018-19 Projections	$232.25	$1,640.26	$1,640.26	$1,640.26	$373.90	$373.90	$373.90	$185.52	$592.33	$247.26	$247.26	$1,481.13	$349.73	$467.12
% Change from FY 2017-18	4.80%	1.39%	1.39%	1.39%	5.59%	5.59%	5.59%	4.59%	5.53%	3.67%	3.67%	1.58%	2.77%	4.29%
FY 2019-20 Projections	$232.76	$1,641.19	$1,641.19	$1,641.19	$374.00	$374.00	$374.00	$185.63	$592.61	$247.29	$247.29	$1,481.37	$351.51	$469.45
% Change from FY 2018-19	0.22%	0.06%	0.06%	0.06%	0.03%	0.03%	0.03%	0.06%	0.05%	0.01%	0.01%	0.02%	0.51%	0.50%

Exhibit DD - Medicaid Behavioral 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 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%**
FY 2016-17	Capitations	$8,999,674	$137,785,026	$58,968,966	$35,703,386	$209,929,370	$123,045,127	$29,376,555	$80,621	$603,888,725
	Fee-for-Service									
	Inpatient Services	$31,244	$120,848	$9,033	$5,368	$107,847	$86,132	$19,653	$0	$380,126
	Outpatient Services	$15,718	$550,742	$1,423,199	$634,520	$3,154,639	$1,428,144	$137,585	$4,855	$7,349,403
	Physician Services	$0	$1,240	$4,962	$1,064	$10,463	$1,402	$1,250	$56	$20,437
	Sub-Total Fee-for-Service	$46,962	$672,830	$1,437,194	$640,953	$3,272,950	$1,515,679	$158,488	$4,911	$7,749,966
	Total FY 2016-17 Expenditures	**$9,046,637**	**$138,457,856**	**$60,406,160**	**$36,344,339**	**$213,202,320**	**$124,560,806**	**$29,535,043**	**$85,532**	**$611,638,691**
	% Change from FY 2015-16	**17.27%**	**8.66%**	**8.86%**	**-33.43%**	**2.31%**	**3.71%**	**-21.15%**	**-33.57%**	**0.05%**

[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 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%**
FY 2016-17	Capitations	$8,999,674	$17,920,858	$109,703,026	$10,161,142	$54,333,943	$3,970,150	$664,873	$35,703,386	$209,929,370	$106,951,722	$16,093,405	$29,376,555	$80,621	$603,888,725
	Fee-for-Service														
	Inpatient Services	$31,244	$12,197	$108,652	$0	$9,033	$0	$0	$5,368	$107,847	$86,132	$0	$19,653	$0	$380,126
	Outpatient Services	$15,718	$54,312	$496,430	$0	$1,351,952	$68,106	$3,142	$634,520	$3,154,639	$1,297,910	$130,235	$137,585	$4,855	$7,349,403
	Physician Services	$0	$1,240	$0	$0	$1,552	$3,070	$340	$1,064	$10,463	$26	$1,376	$1,250	$56	$20,437
	Sub-Total Fee-for-Service	$46,962	$67,749	$605,082	$0	$1,362,536	$71,176	$3,482	$640,953	$3,272,950	$1,384,068	$131,611	$158,488	$4,911	$7,749,966
	Total FY 2016-17 Expenditures	**$9,046,637**	**$17,988,607**	**$110,308,108**	**$10,161,142**	**$55,696,479**	**$4,041,326**	**$668,355**	**$36,344,339**	**$213,202,320**	**$108,335,790**	**$16,225,016**	**$29,535,043**	**$85,532**	**$611,638,691**
	% Change from FY 2015-16	**17.27%**	**17.69%**	**8.17%**	**0.00%**	**8.95%**	**5.07%**	**28.06%**	**-33.43%**	**2.31%**	**1.79%**	**18.59%**	**-21.15%**	**-33.57%**	**0.05%**

[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 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
Weighted Capitation Rate	$18.86	$135.45	$29.54	$14.67	$46.88	$19.88	$121.70	$29.54	
Estimated Monthly Caseload (1)	45,242	87,235	202,411	91,246	380,104	535,090	20,584	117	1,362,029
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	
Total Estimated Costs for FY 2017-18 Q1 and Q2 Capitated Payments	$10,239,169	$141,791,769	$71,750,651	$16,062,946	$213,831,306	$127,651,070	$30,060,874	$41,474	$611,429,259
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	99.65%	99.80%	99.67%	99.35%	99.62%	99.76%	99.89%	99.88%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$10,203,332	$141,508,185	$71,513,874	$15,958,537	$213,018,747	$127,344,707	$30,027,807	$41,424	$609,616,613
Estimated Expenditures for Prior Period Dates of Service	$32,638	$282,386	$198,862	$237,193	$816,531	$301,696	$33,033	$100	$1,902,439
Total Estimated Expenditures in FY 2017-18 Before Adjustments	**$10,235,970**	**$141,790,571**	**$71,712,736**	**$16,195,730**	**$213,835,278**	**$127,646,403**	**$30,060,840**	**$41,524**	**$611,519,052**
Estimated Date of Death Retractions	($209,638)	($663,050)	($35,614)	($10,842)	($486,874)	($18,396)	($46,874)	($1,708)	($1,472,996)
Risk Corridor Reconciliation	$0	$0	$0	($4,546,673)	($43,719,444)	$0	$0	$0	($48,266,117)
Expansion Parents Rate Reconciliation	$0	$0	$0	($17,786,031)	$0	$0	$0	$0	($17,786,031)
Adjustment for Clients Placed in Incorrect Eligibility Types	$0	($1,848,939)	$0	$0	$0	$0	$0	$0	($1,848,939)
Health Insurance Provider Fee Payment	$74,157	$1,236,770	$527,425	$527,873	$2,001,905	$1,158,211	$363,925	$1,221	$5,891,487
Transitional Medicaid Eligibility Payment	$0	$0	$1,867,361	$0	$0	$0	$0	$0	$1,867,361
Total Estimated FY 2017-18 Expenditures Including Adjustments	**$10,100,489**	**$140,515,352**	**$74,071,908**	**($5,619,943)**	**$171,630,865**	**$128,786,218**	**$30,377,891**	**$41,037**	**$549,903,817**
Estimated FY 2017-18 Adjusted Per Capita Expenditure	**$221.62**	**$1,617.79**	**$354.12**	**$177.38**	**$561.29**	**$238.52**	**$1,458.12**	**$340.31**	**$447.90**

[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	$19.70	$137.25	$31.18	$15.48	$49.47	$20.61	$123.60	$31.18	
Estimated Monthly Caseload (1)	45,993	90,748	210,047	98,254	393,958	540,205	20,746	62	1,400,013
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	
Total Estimated Costs for FY 2018-19 Capitated Payments	$10,872,745	$149,461,956	$78,591,186	$18,251,663	$233,869,227	$133,603,501	$30,770,467	$23,198	$655,443,943
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	99.65%	99.80%	99.67%	99.35%	99.62%	99.76%	99.89%	99.88%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$10,834,690	$149,163,032	$78,331,835	$18,133,027	$232,980,524	$133,282,853	$30,736,619	$23,170	$653,485,750
Estimated Expenditures for Prior Period Dates of Service	$35,837	$283,584	$236,777	$104,409	$812,559	$306,363	$33,067	$50	$1,812,646
Total Estimated Expenditures in FY 2018-19	**$10,870,527**	**$149,446,616**	**$78,568,612**	**$18,237,436**	**$233,793,083**	**$133,589,216**	**$30,769,686**	**$23,220**	**$655,298,396**
Estimated Date of Death Retractions	($188,674)	($596,745)	($32,053)	($9,758)	($438,187)	($16,556)	($42,187)	($1,537)	($1,325,697)
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
Estimated Incentive Payment	$336,290	$5,608,581	$2,391,800	$2,393,829	$9,078,360	$5,252,324	$1,650,350	$5,535	$26,717,069
Health Insurance Provider Fee Payment	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Estimated FY 2018-19 Expenditures Including Adjustments	**$11,018,143**	**$154,458,452**	**$80,928,359**	**$20,621,507**	**$242,433,256**	**$138,824,984**	**$32,377,849**	**$27,218**	**$680,689,768**
Estimated FY 2018-19 Adjusted Per Capita Expenditure	**$232.25**	**$1,640.26**	**$373.90**	**$185.52**	**$592.33**	**$247.26**	**$1,481.13**	**$349.73**	**$467.12**

[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 2019-20

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	$19.70	$137.25	$31.18	$15.48	$49.47	$20.61	$123.60	$31.18	
Estimated Monthly Caseload [1]	46,770	94,786	215,305	102,381	401,763	544,835	20,929	61	1,426,830
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	
Total Estimated Costs for FY 2019-20 Capitated Payments	$11,056,428	$156,112,542	$80,558,519	$19,018,295	$238,502,587	$134,748,592	$31,041,893	$22,824	$671,061,680
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	99.65%	99.80%	99.67%	99.35%	99.62%	99.76%	99.89%	99.88%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$11,017,731	$155,800,317	$80,292,676	$18,894,676	$237,596,277	$134,425,195	$31,007,747	$22,797	$669,057,416
Estimated Expenditures for Prior Period Dates of Service	$38,055	$298,924	$259,351	$118,636	$888,703	$320,648	$33,848	$28	$1,958,193
Total Estimated Expenditures in FY 2019-20	**$11,055,786**	**$156,099,241**	**$80,552,027**	**$19,013,312**	**$238,484,980**	**$134,745,843**	**$31,041,595**	**$22,825**	**$671,015,609**
Estimated Date of Death Retractions	($169,807)	($537,071)	($28,848)	($8,782)	($394,368)	($14,900)	($37,968)	($1,383)	($1,193,127)
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
Estimated Incentive Payment	$354,089	$5,905,426	$2,518,391	$2,520,526	$9,558,849	$5,530,313	$1,737,698	$5,828	$28,131,120
Health Insurance Provider Fee Payment	$76,685	$1,278,926	$545,403	$545,866	$2,070,141	$1,197,689	$376,330	$1,263	$6,092,303
Total Estimated FY 2019-20 Expenditures Including Adjustments	**$11,316,753**	**$162,746,522**	**$83,586,973**	**$22,070,922**	**$249,719,602**	**$141,458,945**	**$33,117,655**	**$28,533**	**$704,045,905**
Estimated FY 2019-20 Adjusted Per Capita Expenditure	**$232.76**	**$1,641.19**	**$374.00**	**$185.63**	**$592.61**	**$247.29**	**$1,481.37**	**$351.51**	**$469.45**

[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 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	0.35%	-	-
Incurred in FY 2017-18	99.65%	0.35%	-
Incurred in FY 2018-19	-	99.65%	0.35%
Incurred in FY 2019-20	-	-	99.65%

Incurred But Not Reported (IBNR) Estimate for Disabled Individuals

	Paid in FY 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	0.20%	-	-
Incurred in FY 2017-18	99.80%	0.20%	-
Incurred in FY 2018-19	-	99.80%	0.20%
Incurred in FY 2019-20	-	-	99.80%

Incurred But Not Reported (IBNR) Estimate for Low Income Adults

	Paid in FY 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	0.33%	-	-
Incurred in FY 2017-18	99.67%	0.33%	-
Incurred in FY 2018-19	-	99.67%	0.33%
Incurred in FY 2019-20	-	-	99.67%

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

	Paid in FY 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	0.65%	-	-
Incurred in FY 2017-18	99.35%	0.65%	-
Incurred in FY 2018-19	-	99.35%	0.65%
Incurred in FY 2019-20	-	-	99.35%

Exhibit EE - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for MAGI Adults

	Paid in FY 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	0.38%	-	-
Incurred in FY 2017-18	99.62%	0.38%	-
Incurred in FY 2018-19	-	99.62%	0.38%
Incurred in FY 2019-20	-	-	99.62%

Incurred But Not Reported (IBNR) Estimate for Eligible Children

	Paid in FY 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	0.24%	-	-
Incurred in FY 2017-18	99.76%	0.24%	-
Incurred in FY 2018-19	-	99.76%	0.24%
Incurred in FY 2019-20	-	-	99.76%

Incurred But Not Reported (IBNR) Estimate for Foster Care

	Paid in FY 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	0.11%	-	-
Incurred in FY 2017-18	99.89%	0.11%	-
Incurred in FY 2018-19	-	99.89%	0.11%
Incurred in FY 2019-20	-	-	99.89%

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

	Paid in FY 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	0.12%	-	-
Incurred in FY 2017-18	99.88%	0.12%	-
Incurred in FY 2018-19	-	99.88%	0.12%
Incurred in FY 2019-20	-	-	99.88%

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period			
Incurred But Not Reported (IBNR) Estimate for Adults 65 and Older			
	Paid in FY 2017-18	**Paid in FY 2018-19**	**Paid in FY 2019-20**
Incurred in all other previous periods	$32,638	-	-
Incurred in FY 2017-18	$10,203,332	$35,837	-
Incurred in FY 2018-19	-	$10,834,690	$38,055
Incurred in FY 2019-20	-	-	$11,017,731
Total Paid in Current Period	$10,203,332	$10,834,690	$11,017,731
Total IBNR Amount	$32,638	$35,837	$38,055
Total Paid for All Incurred Dates	$10,235,970	$10,870,527	$11,055,786
Incurred But Not Reported (IBNR) Estimate for Disabled Individuals			
	Paid in FY 2017-18	**Paid in FY 2018-19**	**Paid in FY 2019-20**
Incurred in all other previous periods	$282,386	-	-
Incurred in FY 2017-18	$141,508,185	$283,584	-
Incurred in FY 2018-19	-	$149,163,032	$298,924
Incurred in FY 2019-20	-	-	$155,800,317
Total Paid in Current Period	$141,508,185	$149,163,032	$155,800,317
Total IBNR Amount	$282,386	$283,584	$298,924
Total Paid for All Incurred Dates	$141,790,571	$149,446,616	$156,099,241
Incurred But Not Reported (IBNR) Estimate for Low Income Adults			
	Paid in FY 2017-18	**Paid in FY 2018-19**	**Paid in FY 2019-20**
Incurred in all other previous periods	$198,862	-	-
Incurred in FY 2017-18	$71,513,874	$236,777	-
Incurred in FY 2018-19	-	$78,331,835	$259,351
Incurred in FY 2019-20	-	-	$80,292,676
Total Paid in Current Period	$71,513,874	$78,331,835	$80,292,676
Total IBNR Amount	$198,862	$236,777	$259,351
Total Paid for All Incurred Dates	$71,712,736	$78,568,612	$80,552,027
Incurred But Not Reported (IBNR) Estimate for Expansion Parents and Caretakers			
	Paid in FY 2017-18	**Paid in FY 2018-19**	**Paid in FY 2019-20**
Incurred in all other previous periods	$237,193	-	-
Incurred in FY 2017-18	$15,958,537	$104,409	-
Incurred in FY 2018-19	-	$18,133,027	$118,636
Incurred in FY 2019-20	-	-	$18,894,676
Total Paid in Current Period	$15,958,537	$18,133,027	$18,894,676
Total IBNR Amount	$237,193	$104,409	$118,636
Total Paid for All Incurred Dates	$16,195,730	$18,237,436	$19,013,312

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for MAGI Adults

	Paid in FY 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	$816,531	-	-
Incurred in FY 2017-18	$213,018,747	$812,559	-
Incurred in FY 2018-19	-	$232,980,524	$888,703
Incurred in FY 2019-20	-	-	$237,596,277
Total Paid in Current Period	$213,018,747	$232,980,524	$237,596,277
Total IBNR Amount	$816,531	$812,559	$888,703
Total Paid for All Incurred Dates	$213,835,278	$233,793,083	$238,484,980

Incurred But Not Reported (IBNR) Estimate for Eligible Children

	Paid in FY 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	$301,696	-	-
Incurred in FY 2017-18	$127,344,707	$306,363	-
Incurred in FY 2018-19	-	$133,282,853	$320,648
Incurred in FY 2019-20	-	-	$134,425,195
Total Paid in Current Period	$127,344,707	$133,282,853	$134,425,195
Total IBNR Amount	$301,696	$306,363	$320,648
Total Paid for All Incurred Dates	$127,646,403	$133,589,216	$134,745,843

Incurred But Not Reported (IBNR) Estimate for Foster Care

	Paid in FY 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	$33,033	-	-
Incurred in FY 2017-18	$30,027,807	$33,067	-
Incurred in FY 2018-19	-	$30,736,619	$33,848
Incurred in FY 2019-20	-	-	$31,007,747
Total Paid in Current Period	$30,027,807	$30,736,619	$31,007,747
Total IBNR Amount	$33,033	$33,067	$33,848
Total Paid for All Incurred Dates	$30,060,840	$30,769,686	$31,041,595

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

	Paid in FY 2017-18	Paid in FY 2018-19	Paid in FY 2019-20
Incurred in all other previous periods	$100	-	-
Incurred in FY 2017-18	$41,424	$50	-
Incurred in FY 2018-19	-	$23,170	$28
Incurred in FY 2019-20	-	-	$22,797
Total Paid in Current Period	$41,424	$23,170	$22,797
Total IBNR Amount	$100	$50	$28
Total Paid for All Incurred Dates	$41,524	$23,220	$22,825

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 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	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	Estimated Average Monthly Claims	41,288	86,385	180,508	88,030	324,563	532,162	20,056
	Average Caseload	42,403	85,546	179,514	86,964	320,374	526,694	19,935
	Claims as a Percentage of Caseload	97.37%	100.98%	100.55%	101.23%	101.31%	101.04%	100.61%
FY 2016-17	Estimated Average Monthly Claims	41,287	85,235	176,117	93,335	356,738	536,098	20,278
	Average Caseload	43,941	85,111	176,318	101,059	347,848	534,843	20,310
	Claims as a Percentage of Caseload	93.96%	100.15%	99.89%	92.36%	102.56%	100.23%	99.84%
Weighted Average Claims as a Percentage of Caseload [3]		97.37%	100.98%	100.55%	101.23%	101.31%	101.04%	100.61%
Retroactivity Adjustment Factor [3]		-2.63%	0.98%	0.55%	1.23%	1.31%	1.04%	0.61%

[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] Retroactivity adjustments are based off the estimated average months claims from FY 2015-16 S-2 due to inadequate runout in FY 2016-17.

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	MAGI Adults	Eligible Children	Foster Care
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	$55.52	$19.20	$215.41
	Claims as a Percentage of Capitation	99.46%	99.70%	99.97%	99.97%	100.00%	99.88%	99.93%
FY 2015-16	Weighted Claims-Based Rate	$16.38	$130.05	$26.65	$54.64	$56.17	$19.84	$165.32
	Weighted Capitation Rate	$16.21	$129.81	$26.87	$19.44	$56.56	$19.96	$166.71
	Claims as a Percentage of Capitation	101.07%	100.18%	99.18%	281.06%	99.32%	99.38%	99.16%
FY 2016-17	Weighted Claims-Based Rate	$18.32	$137.78	$28.44	$32.37	$50.00	$19.50	$123.21
	Weighted Capitation Rate	$18.53	$139.16	$29.06	$15.83	$52.98	$19.65	$124.82
	Claims as a Percentage of Capitation	98.87%	99.00%	97.87%	204.47%	94.38%	99.22%	98.71%
Average Claims as a Percentage of Capitation [4]		99.46%	99.70%	99.97%	99.97%	100.00%	99.88%	99.93%
Partial Month Adjustment Multiplier		-0.54%	-0.30%	-0.03%	-0.03%	0.00%	-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 2014-15. 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. The Department is investigating why FY 2015-16 has significant variations from historical trends.

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 2008-09 Actuals [3]	**$13.37**	**$121.31**	**$18.18**	**$0.00**	**$0.00**	**$14.34**	**$251.88**	**$39.96**
FY 2009-10 Actuals [3]	**$13.40**	**$131.64**	**$19.33**	**$19.33**	**$0.00**	**$14.71**	**$220.67**	**$38.18**
% Change from FY 2008-09	0.22%	8.52%	6.33%	-	-	2.58%	-12.39%	-4.46%
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%	-2.38%
FY 2011-12 Actuals	**$13.89**	**$140.82**	**$21.69**	**$21.69**	**$100.85**	**$16.33**	**$179.30**	**$36.46**
% Change from FY 2010-11	0.73%	1.21%	3.58%	3.58%	-	5.97%	-8.23%	-2.17%
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%	0.76%
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**	**$129.81**	**$26.87**	**$19.44**	**$56.56**	**$19.96**	**$166.71**	**$39.84**
% Change from FY 2014-15	13.99%	-11.59%	3.47%	-25.26%	1.85%	3.96%	-22.61%	-2.46%
FY 2016-17 Actuals	**$18.53**	**$139.17**	**$29.06**	**$15.83**	**$52.98**	**$19.65**	**$124.82**	**$38.84**
% Change from FY 2015-16	14.31%	7.21%	8.15%	-18.57%	-6.33%	-1.55%	-25.13%	-2.52%
FY 2017-18 Estimated Weighted Average Rate	**$19.48**	**$134.54**	**$29.39**	**$14.50**	**$46.27**	**$19.70**	**$121.05**	**$37.08**
% Change from FY 2016-17	5.13%	-3.33%	1.14%	-8.40%	-12.67%	0.25%	-3.02%	-4.52%
FY 2018-19 Estimated Weighted Average Rate	**$20.34**	**$136.32**	**$31.02**	**$15.30**	**$48.83**	**$20.42**	**$122.94**	**$38.67**
% Change from FY 2017-18	4.41%	1.32%	5.55%	5.52%	5.53%	3.65%	1.56%	4.29%
FY 2019-20 Estimated Weighted Average Rate	**$21.24**	**$138.12**	**$32.74**	**$16.15**	**$51.53**	**$21.16**	**$124.86**	**$43.75**
% Change from FY 2018-19	4.42%	1.32%	5.54%	5.56%	5.53%	3.62%	1.56%	13.14%

[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. Adults 65 and older make up a percentage of all client claims, and each BHO services some subset of the total number of claims for Adults 65 and older).

[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, reflect 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 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	-	-	275,672	18,381	475,947
Percentage of Total Caseload	8.09%	12.67%	17.46%	-	-	57.92%	3.86%	100.00%
FY 2009-10 Average Weighted Capitation Rate	$13.40	$131.64	$19.33	$19.33	-	$14.71	$220.67	$38.18
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	-	334,633	18,034	597,188
Percentage of Total Caseload	6.65%	11.36%	16.99%	5.94%	-	56.03%	3.02%	100.00%
FY 2011-12 Average Weighted Capitation Rate	$13.89	$140.82	$21.69	$21.69	$100.85	$16.33	$179.30	$36.46
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	$129.81	$26.87	$19.44	$56.56	$19.96	$166.71	$39.84
FY 2016-17 Average Caseload	43,941	85,111	176,613	101,059	347,848	534,843	20,310	1,309,725
Percentage of Total Caseload	3.35%	6.50%	13.48%	7.72%	26.56%	40.84%	1.55%	100.00%
FY 2016-17 Average Weighted Capitation Rate	$18.53	$139.17	$29.06	$15.83	$52.98	$19.65	$124.82	$38.84
FY 2017-18 Average Estimated Caseload	45,242	87,235	202,528	91,246	380,104	535,090	20,584	1,362,029
Percentage of Total Caseload	3.32%	6.40%	14.87%	6.70%	27.91%	39.29%	1.51%	100.00%
FY 2017-18 Average Weighted Capitation Rate	$19.48	$134.54	$29.39	$14.50	$46.27	$19.70	$121.05	$37.08
FY 2018-19 Average Estimated Caseload	45,993	90,748	210,109	98,254	393,958	540,205	20,746	1,400,013
Percentage of Total Caseload	3.29%	6.48%	15.01%	7.02%	28.14%	38.59%	1.48%	100.00%
FY 2018-19 Average Weighted Capitation Rate	$20.34	$136.32	$31.02	$15.30	$48.83	$20.42	$122.94	$38.67
FY 2019-20 Average Estimated Caseload	46,770	94,786	215,366	102,381	401,763	544,835	20,929	1,426,830
Percentage of Total Caseload	3.28%	6.64%	15.09%	7.18%	28.16%	38.18%	1.47%	100.00%
FY 2019-20 Average Weighted Capitation Rate	$21.24	$138.12	$32.74	$16.15	$51.53	$21.16	$124.86	$40.39

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 2017-18 Rate							
Weighted Capitation Point Estimate	**$19.48**	**$134.54**	**$29.39**	**$14.50**	**$46.27**	**$19.70**	**$121.05**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.63%	0.98%	0.55%	1.23%	1.31%	1.04%	0.61%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.54%	-0.30%	-0.03%	-0.03%	0.00%	-0.12%	-0.07%
Final Adjustment Factor [2]	**-3.16%**	**0.68%**	**0.52%**	**1.20%**	**1.31%**	**0.92%**	**0.54%**
FY 2017-18 Final Estimated Paid Rate [3]	**$18.86**	**$135.45**	**$29.54**	**$14.67**	**$46.88**	**$19.88**	**$121.70**
FY 2018-19 Estimated Rate							
Weighted Capitation Point Estimate	**$20.34**	**$136.32**	**$31.02**	**$15.30**	**$48.83**	**$20.42**	**$122.94**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.63%	0.98%	0.55%	1.23%	1.31%	1.04%	0.61%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.54%	-0.30%	-0.03%	-0.03%	0.00%	-0.12%	-0.07%
Final Adjustment Factor [2]	**-3.16%**	**0.68%**	**0.52%**	**1.20%**	**1.31%**	**0.92%**	**0.54%**
FY 2018-19 Final Estimated Rate [3]	**$19.70**	**$137.25**	**$31.18**	**$15.48**	**$49.47**	**$20.61**	**$123.60**
FY 2019-20 Estimated Rate							
Weighted Capitation Point Estimate	**$21.24**	**$138.12**	**$32.74**	**$16.15**	**$51.53**	**$21.16**	**$124.86**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.63%	0.98%	0.55%	1.23%	1.31%	1.04%	0.61%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.54%	-0.30%	-0.03%	-0.03%	0.00%	-0.12%	-0.07%
Final Adjustment Factor [2]	**-3.16%**	**0.68%**	**0.52%**	**1.20%**	**1.31%**	**0.92%**	**0.54%**
FY 2019-20 Final Estimated Rate [3]	**$19.70**	**$137.25**	**$31.18**	**$15.48**	**$49.47**	**$20.61**	**$123.60**

[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 eligible 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 2018-19 & FY 2019-20

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 Actual Rate	$18.53	$139.17	$29.06	$15.83	$52.98	$19.65	$124.82
FY 2017-18 Estimated Average Rate	$19.48	$134.54	$29.39	$14.50	$46.27	$19.70	$121.05
% Growth from FY 2016-17 to FY 2017-18 Rate	5.13%	-3.33%	1.14%	-8.40%	-12.67%	0.25%	-3.02%
Selected Trend Models							
Average Growth Model	$20.34	$136.32	$31.01	$14.26	$41.16	$20.42	$112.57
% Difference from FY 2017-18	4.41%	1.32%	5.53%	-1.67%	-11.05%	3.64%	-7.01%
Two Period Moving Average Model	$19.01	$136.85	$29.23	$15.17	$49.63	$19.68	$122.94
% Difference from FY 2017-18	-2.44%	1.71%	-0.56%	4.59%	7.25%	-0.13%	1.56%
Exponential Growth Model	$18.29	$181.11	$35.09	$24.05	$37.76	$21.96	$133.18
% Difference from FY 2017-18	-6.12%	34.61%	19.41%	65.88%	-18.40%	11.46%	10.02%
Linear Growth Model	$17.94	$164.67	$31.20	$23.03	$28.88	$21.00	$126.23
% Difference from FY 2017-18	-7.92%	22.39%	6.17%	58.81%	-37.59%	6.59%	4.28%
CY 2017 Forecast Minimum	$17.94	$136.32	$29.23	$14.26	$28.88	$19.68	$112.57
CY 2017 Forecast Maximum	$20.34	$181.11	$35.09	$24.05	$49.63	$21.96	$133.18
% change from FY 2017-18 Rate to Selected FY 2018-19 Capitation Rate [2]	4.41%	1.32%	5.53%	5.53%	5.53%	3.64%	1.56%
FY 2018-19 Forecast Point Estimate	**$20.34**	**$136.32**	**$31.02**	**$15.30**	**$48.83**	**$20.42**	**$122.94**
% change from FY 2018-19 Rate to Selected FY 2019-20 Capitation Rate [3]	4.41%	1.32%	5.53%	5.53%	5.53%	3.64%	1.56%
FY 2019-20 Forecast Point Estimate	**$21.24**	**$138.12**	**$32.74**	**$16.15**	**$51.53**	**$21.16**	**$124.86**

[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 eligible was not performed.

[2] Percentage selected to modify capitation rates for FY 2018-19	Population	Trend
	Adults 65 and Older (OAP-A)	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.
	Disabled Individuals	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.
	Low Income Adults	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.

[2] Percentage selected to modify capitation rates for FY 2018-19	Population	Trend
	MAGI Adults/ Expansion Parents & Caretakers	Trend is equal to Low Income Adults.
	Eligible Children	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.
	Foster Care	The trend selection is based on the two-year moving average.

[3] Percentage selected to modify capitation rates for FY 2019-20	Population	Trend
	Adults 65 and Older (OAP-A)	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.
	Disabled Individuals	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.
	Low Income Adults	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.

[3] Percentage selected to modify capitation rates for FY 2019-20	Population	Trend
	MAGI Adults/ Expansion Parents & Caretakers	Trend is equal to Low Income Adults.
	Eligible Children	Trend is equal to the Average Growth from FY 2009-10 to FY 2017-18.
	Foster Care	The trend selection is based on the two-year moving average.

Exhibit II - Reconciliations

Total Reconciliations by Fiscal Year

	FY 2015-16 Actuals	FY 2016-17 Actuals	FY 2017-18 Estimate	FY 2018-19 Estimate	FY 2019-20 Estimate
Estimated Reconciliation for FY 2014-15[1]	$0	($17,524,964)	$0	$0	$0
Estimated Reconciliation for FY 2015-16[2]	$0	$0	($50,115,056)	$0	$0
Estimated Reconciliation for FY 2016-17[3]	$0	($3,541,687)	($11,895,446)	$0	$0
Estimated Reconciliation for FY 2017-18	$0	$0	$0	$0	$0
Estimated Reconciliation for FY 2018-19[4]	$0	$0	$0	$0	$6,092,303
Net Impact of Estimated Reconciliations	$0	($21,066,651)	($62,010,502)	$0	$6,092,303

[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 $4,546,673 for the expansion parent risk corridor for dates of service in FY 2015-16, $43,719,444 for the MAGI Adult risk corridor for dates of service in FY 2015-16, and $1,848,939 for an eligibility issue that occurred in FY 2015-16 where Children were being incorrectly identified as Disabled.

[3] This reconciliation amount is made up of $17,786,031 for a parent rate reconciliation with dates of service in FY 2016-17, $1,867,361 that are being paid back to BHOs for Transitional Medicaid eligibility issues that incorrectly identified people as Expansion Parents and Caretakers when they should have been placed on Transitional Medicaid, and $12,376,983 that are being given back to BHOs for an issue that occurred in FY 2016-17 that caused MAGI Adults and Expansion Parents to be incorrectly identified. The FY 2017-18 estimates are made up of a parent rate reconciliation of $17,786,933 for incorrectly identifying Expansion Parents as MAGI Adults, and $5,891,487 paid back to the BHO's for the Health Insurance Provider Fee.

[4] This reconciliation amount is made up of $6,092,303 paid back to the BHOs for the health insurance provider fee for services that will have occurred in FY 2018-19.

Reconciliation Fund Splits

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Estimated Reconciliation for FY 2017-18	($62,010,502)	($357,455)	($552,408)	$0	($61,100,639)
Estimated Reconciliation for FY 2018-19	$0	$0	$0	$0	$0
Estimated Reconciliation for FY 2019-20	$6,092,303	$0	$0	$0	$6,092,303

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**
Healthcare Affordability and Sustainability Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	8,955	$354.12	$3,171,115	$0	$1,585,557	$0	$1,585,558	50.00%
MAGI Parents and Caretakers 69% - 133% FPL	91,246	$177.38	$16,184,888	$0	$890,169	$0	$15,294,719	94.50%
MAGI Adults	377,575	$561.29	$211,928,903	$0	$11,656,090	$0	$200,272,813	94.50%
Non Newly Eligible	2,529	$561.29	$1,419,501	$0	$235,921	$0	$1,183,580	83.38%
Buy-In for Disabled Individuals	7,811	$1,617.79	$12,636,523	$0	$6,318,261	$0	$6,318,262	50.00%
Continuous Eligibility Financing	39,706	$238.52	$9,470,552	$0	$4,735,276	$0	$4,735,276	50.00%
Total from Healthcare Affordability and Sustainability Fee Fund	-	-	**$254,811,482**	**$0**	**$25,421,274**	**$0**	**$229,390,208**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	68,762	$238.52	$16,400,899	$1,968,108	$0	$0	$14,432,791	88.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	2,365	$354.12	$837,486	$100,498	$0	$0	$736,988	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**
Healthcare Affordability and Sustainability Fee Cash Fund:								
Magi Parents and Caretakers 60% - 68% FPL	8,955	$8.55	$76,565	$0	$38,282	$0	$38,283	50.00%
MAGI Parents and Caretakers 69% - 133% FPL	91,246	$5.77	$526,489	$0	$28,957	$0	$497,532	94.50%
MAGI Adults	377,575	$10.75	$4,058,931	$0	$223,241	$0	$3,835,690	94.50%
Non Newly Eligible	2,529	$10.75	$27,187	$0	$4,518	$0	$22,669	83.38%
Buy-In for Disabled Individuals	7,811	$4.92	$38,430	$0	$19,215	$0	$19,215	50.00%
Continuous Eligibility Financing	39,706	$2.69	$106,809	$0	$53,404	$0	$53,405	50.00%
Total from Healthcare Affordability and Sustainability Fee Fund	-	-	**$4,834,411**	**$0**	**$367,617**	**$0**	**$4,466,794**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	68,762	$3.89	$267,484	$32,098	$0	$0	$235,386	88.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	2,365	$2.73	$6,456	$775	$0	$0	$5,681	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**
Healthcare Affordability and Sustainability Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	9,318	$373.90	$3,484,000	$0	$1,742,000	$0	$1,742,000	50.00%
MAGI Parents and Caretakers 69% - 133% FPL	98,254	$185.52	$18,227,678	$0	$1,184,799	$0	$17,042,879	93.50%
MAGI Adults	391,365	$592.33	$231,818,973	$0	$15,068,233	$0	$216,750,740	93.50%
Non Newly Eligible	2,593	$592.33	$1,535,923	$0	$266,790	$0	$1,269,133	82.63%
Buy-In for Disabled Individuals	9,099	$1,640.26	$14,924,681	$0	$7,462,340	$0	$7,462,341	50.00%
Continuous Eligibility for Children	40,480	$247.26	$10,009,203	$0	$5,004,601	$0	$5,004,602	50.00%
Total from Healthcare Affordability and Sustainability Fee Fund	**-**	**-**	**$280,000,458**	**$0**	**$30,728,763**	**$0**	**$249,271,695**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	71,877	$247.26	$17,772,516	$2,132,702	$0	$0	$15,639,814	88.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	2,364	$373.90	$883,899	$106,068	$0	$0	$777,831	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**
Healthcare Affordability and Sustainability Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	9,318	$8.55	$79,669	$0	$39,834	$0	$39,835	50.00%
MAGI Parents and Caretakers 69% - 133% FPL	98,254	$5.77	$566,926	$0	$36,850	$0	$530,076	93.50%
MAGI Adults	391,365	$10.75	$4,207,174	$0	$273,466	$0	$3,933,708	93.50%
Non Newly Eligible	2,593	$10.75	$27,875	$0	$4,842	$0	$23,033	82.63%
Buy-In for Disabled Individuals	9,099	$4.92	$44,767	$0	$22,383	$0	$22,384	50.00%
Continuous Eligibility Financing	40,480	$2.66	$107,519	$0	$53,759	$0	$53,760	50.00%
Total from Healthcare Affordability and Sustainability Fee Fund	**-**	**-**	**$5,033,930**	**$0**	**$431,134**	**$0**	**$4,602,796**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	71,877	$3.89	$279,602	$33,552	$0	$0	$246,050	88.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	2,364	$2.73	$6,454	$774	$0	$0	$5,680	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 2019-20 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**
Healthcare Affordability and Sustainability Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	9,568	$374.00	$3,578,392	$0	$1,789,196	$0	$1,789,196	50.00%
MAGI Parents and Caretakers 69% - 133% FPL	102,381	$185.63	$19,004,530	$0	$1,615,385	$0	$17,389,145	91.50%
MAGI Adults	399,119	$592.61	$236,523,739	$0	$20,104,518	$0	$216,419,221	91.50%
Non Newly Eligible	2,644	$592.61	$1,566,873	$0	$295,669	$0	$1,271,204	81.13%
Buy-In for Disabled Individuals	10,368	$1,641.19	$17,015,895	$0	$8,507,947	$0	$8,507,948	50.00%
Continuous Eligibility Financing	40,658	$247.29	$10,054,219	$0	$5,027,109	$0	$5,027,110	50.00%
Total from Healthcare Affordability and Sustainability Fee Fund	**-**	**-**	**$287,743,648**	**$0**	**$37,339,824**	**$0**	**$250,403,824**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	74,443	$247.29	$18,408,831	$5,384,583	$0	$0	$13,024,248	70.75%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	2,364	$374.00	$884,126	$258,607	$0	$0	$625,519	70.75%

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**
Healthcare Affordability and Sustainability Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	9,568	$8.55	$81,806	$0	$40,903	$0	$40,903	50.00%
MAGI Parents and Caretakers 69% - 133% FPL	102,381	$5.77	$590,738	$0	$50,213	$0	$540,525	91.50%
MAGI Adults	399,119	$10.75	$4,290,529	$0	$364,694	$0	$3,925,835	91.50%
Non Newly Eligible	2,644	$10.75	$28,423	$0	$5,363	$0	$23,060	81.13%
Buy-In for Disabled Individuals	10,368	$4.92	$51,011	$0	$25,505	$0	$25,506	50.00%
Continuous Eligibility Financing	40,658	$2.66	$107,991	$0	$53,995	$0	$53,996	50.00%
Total from Healthcare Affordability and Sustainability Fee Fund	**-**	**-**	**$5,150,498**	**$0**	**$540,673**	**$0**	**$4,609,825**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	74,443	$3.89	$289,583	$84,703	$0	$0	$204,880	70.75%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	2,364	$2.73	$6,454	$1,888	$0	$0	$4,566	70.75%

[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 2017-18 Calculation

Components	FY 2016-17 Actual	FY 2017-18 Appropriation	Estimated Change in Total Behavioral Health Caseload			FY 2017-18 Estimate	FY 2017-18 Change from Appropriation
			FY 2016-17 Average Monthly Caseload	FY 2017-18 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$380,126	$439,551	1,309,725	1,362,029	3.99%	$439,551	$0
Outpatient Services	$7,349,403	$8,498,335	1,309,725	1,362,029	3.99%	$8,498,335	$0
Physician Services	$20,437	$23,632	1,309,725	1,362,029	3.99%	$23,632	$0
Total After Prior Year Adjustments	**$7,749,966**	$8,961,518				**$8,961,518**	**$0**

FY 2018-19 Calculation

Components	FY 2017-18 Estimate [1]	Estimated Change in Total Behavioral Health Caseload			FY 2018-19 Estimate	FY 2018-19 Change from FY 2017-18 Estimate
		FY 2017-18 Average Monthly Caseload	FY 2018-19 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$439,551	1,362,029	1,400,013	2.79%	$452,376	$12,825
Outpatient Services	$8,498,335	1,362,029	1,400,013	2.79%	$8,746,303	$247,968
Physician Services	$23,632	1,362,029	1,400,013	2.79%	$24,322	$690
Total After Prior Year Adjustments	**$8,961,518**				**$9,223,001**	**$261,483**

[1] The FY 2017-18 estimates are the base for the FY 2018-19 estimates.

FY 2019-20 Calculation

Components	FY 2018-19 Estimate [2]	Estimated Change in Total Behavioral Health Caseload			FY 2019-20 Estimate [3]	FY 2019-20 Change from FY 2018-19 Estimate
		FY 2018-19 Average Monthly Caseload	FY 2019-20 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$451,809	1,400,013	1,426,830	1.92%	$469,318	$17,509
Outpatient Services	$8,735,335	1,400,013	1,426,830	1.92%	$9,073,864	$338,529
Physician Services	$24,291	1,400,013	1,426,830	1.92%	$25,232	$941
Total After Prior Year Adjustments	**$9,211,435**				**$9,568,414**	**$356,979**

[2] The FY 2018-19 estimates are the base for the FY 2019-20 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 Actual	$611,638,691	0.05%	$333,184	$611,472,100	2.87%	$600,143,340	11.83%
FY 2017-18 Appropriation vs. FY 2016-17 Actual	$616,836,053	0.85%	$5,197,362	$604,316,519	21.02%	$567,699,152	-5.41%
FY 2017-18 Estimate vs. FY 2016-17 Actual	$549,903,817	-10.09%	($61,734,874)	$580,771,254	16.30%	$590,949,339	-1.53%
FY 2017-18 Estimate vs. FY 2017-18 Appropriation	$549,903,817	-10.85%	($66,932,236)	$580,771,254	-3.90%	$590,949,339	4.10%
FY 2018-19 Estimate vs. FY 2017-18 Appropriation	$680,689,768	10.35%	$63,853,715	$648,762,911	7.35%	$619,591,168	9.14%
FY 2018-19 Estimate vs. FY 2017-18 Estimate	$680,689,768	23.78%	$130,785,951	$615,296,793	5.94%	$602,693,136	1.99%
FY 2019-20 Estimate vs. FY 2017-18 Appropriation	$704,045,905	14.14%	$87,209,852	$660,440,979	9.29%	$667,190,575	17.53%
FY 2019-20 Estimate vs. FY 2017-18 Estimate	$704,045,905	3.43%	$23,356,137	$692,367,837	12.53%	$644,879,830	7.00%

[1] This analysis compares the percent change between Behavioral Health Capitation Payments Reported in Exhibit DD. Other Medicaid Behavioral Health Payments have been excluded.

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title	**R-02 Behavioral Health Programs**

Dept. Approval By: 11/1/17

OSPB Approval By:

- [ ] Supplemental FY 2017-18
- [x] Change Request FY 2018-19
- [ ] Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$625,797,571**	**$0**	**$651,114,866**	**$38,797,903**	**$61,490,745**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$174,446,202	$0	$181,371,789	$7,713,920	$16,825,045
	CF	$26,190,535	$0	$27,072,406	$5,186,815	$12,509,519
	RF	$0	$0	$0	$0	$0
	FF	$425,160,834	$0	$442,670,671	$25,897,168	$32,156,181

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
03. Behavioral Health Community Programs -- Behavioral Health Capitation Payments	**Total**	**$616,836,053**	**$0**	**$642,141,782**	**$38,547,986**	**$60,895,415**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$172,509,947	$0	$179,433,035	$7,667,357	$16,616,777
	CF	$25,816,287	$0	$26,697,675	$5,130,051	$12,343,220
	RF	$0	$0	$0	$0	$0
	FF	$418,509,819	$0	$436,011,072	$25,750,578	$31,935,418
03. Behavioral Health Community Programs -- Behavioral Health Fee-for-Service Payments	**Total**	**$8,961,518**	**$0**	**$8,973,084**	**$249,917**	**$595,330**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,936,255	$0	$1,938,754	$46,563	$208,268
	CF	$374,248	$0	$374,731	$56,764	$166,299
	RF	$0	$0	$0	$0	$0
	FF	$6,651,015	$0	$6,659,599	$146,590	$220,763

CF Letternote Text Revision Required?	Yes __X__ No ____	**If Yes, see schedule 4 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	

Department of Health Care Policy and Financing
Behavioral Health Community Programs

FY 2017-18, FY 2018-19, and FY 2019-20 Budget Request

November 2017

TABLE OF CONTENTS

BEHAVIORAL HEALTH COMMUNITY PROGRAMS ***2***
History and Background Information 2
Program Administration........ 3
Medicaid Anti-Psychotic Pharmaceuticals 4
BEHAVIORAL HEALTH CAPITATION PAYMENTS AND MEDICAID BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS ***5***
Exhibit AA - Calculation of Current Total Long Bill Group Impact 8
Exhibit BB - Calculation of Fund Splits 8
Exhibit CC - Behavioral Health Community Programs Summary 11
Exhibit DD - Behavioral Health Caseload, Per Capita, and Expenditure History 11
Exhibit EE - Estimate and Request by Eligibility Category 12
Incurred-but-not-Reported Estimates........ 13
Exhibit FF - Behavioral Health Retroactivity Adjustment and Partial Month Adjustment Multiplier 14
Retroactivity Adjustment Multiplier........ 14
Partial Month Adjustment Multiplier........ 14
Exhibit GG - Behavioral Health Capitation Rate Trends and Forecasts 15
Exhibit HH - Forecast Model Comparisons 16
Final Forecasts 16
Capitation Trend Models 16
Exhibit II - MAGI ADULTS RECONCILIATION........ 19
Exhibit JJ – Alternative financing populations 20
Exhibit KK - Medicaid Behavioral Health Fee-for-Service Payments 22
Exhibit LL - Global Reasonableness Test for Behavioral Health Capitation Payments 24

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 went 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:

- HB 17-1353, "Implement Medicaid Delivery & Payment Initiatives", authorized the Department to implement performance-based payments for medical providers. The payments are designed to incentivize BHOs to achieve performance based goals regarding improving health outcomes, coordinating care, and containing costs. The bill also implemented the integration of behavioral health and physical health services under the new Regional Accountability Entity (RAE). Starting in July 2018, the Department will be working with the new RAEs instead of the BHOs. Although care will be integrated between behavioral health and physical health services under one entity, the Department will still pay actuarially sound capitation rates for behavioral health services, therefore there will be no changes to the forecasting methodology.

- For the most recent rate setting cycle for rates effective July 1, 2017 to June 30, 2018, the Department experienced a significant drop in a few eligibility categories for most BHOs. This decrease in capitations was anticipated and requested in the Department's FY 2017-18 R-6 "Delivery and Payment Reform." The Department decreased capitation rates to comply with new federal manage care regulations, which require rates to be set to an actuarially determined point rather than negotiated upon within an actuarially set range. In most cases the actuarially set point was lower than the rate that was negotiated within the actuarially sound range. New rates will be set for FY 2018-19, 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 2017-18 S-2A and FY 2018-19 R-2

FY 2017-18

- Major changes in the caseload and rate forecasts for a few eligibility categories contribute to about a $62.4 million decrease.
  - MAGI Adults rate forecast decreased by $8.02 or 14.6%
  - Foster Care rate forecast decreased by $7.48 or 5.79%
  - Children rates forecast decreased by $.40 or 2.0%
  - Individuals with Disabilities rates forecast decreased by $7.80 or 5.5%
  - Eligible Children caseload forecast decreased by 160,992 or 2.5% member months
  - MAGI Adult caseload forecast decreased by 112,344 or 2.4% member months
  - Low-income Adults caseload forecast decreased by 71,832 or 2.9% member months
- The Department estimates that it will recoup $48.3 million for the MAGI Adult and Expansion Parent risk corridor reconciliations for services that occurred in FY 2016-17. The prior forecast did not include the impact of this reconciliation.
- The Department updated its estimate of payments made to the BHOs because of a system overpayment issue. Due to system limitations in the old MMIS, eligibility categories were incorrectly assigned for a subset of the population. Expansion parents were being incorrectly classified as MAGI Adults which leads to paying about $30.00 more per member per month than the contracted amount for that population. The Department projects recouping $17.8 million in FY 2017-18 in the current forecast versus $25.3 million in the prior forecast. See Exhibit II for more detail.

- The Department estimates that it will pay $1.9 million dollars for an eligibility issue that caused clients that should have been placed onto transitional Medicaid, which is a subset of low income adults, to be classified as Expansion Parents and Caretakers instead. This resulted in the Department paying a lower capitation rate for these clients than would have been paid if they were classified correctly as low income adults. This lead to BHOs being paid approximately $7.00 to $13.00 less per member per month than the contracted amount for that population. The issue impacted capitations paid in FY 2015-16 and FY 2016-17.
- The Department estimates that it will pay $5.9 million for the Health Insurance Provider Fee (HIPF) to Foothills Behavioral Health Partners (FBHP) and Colorado Health Partnerships (CHP) for services that occurred in FY 2016-17 due to an ACA mandate that charges a fee to covered entities that provide health insurance, based on the amount of revenue that the provider earns. The ACA mandates that the HIPF be paid for based upon the insurer's market share. This mandate excludes insurers that have a certain percentage of revenue that is publicly funded and provides other exclusions based on the amount of premiums taken into an account[1].
- The Department paid additional capitation payments for children that were incorrectly classified as Individuals with Disabilities, resulting in about a $1.8 million overpayment. These payments will be recouped in FY 2017-18. Please see Exhibit II and the caseload narrative for additional information on this issue.

<u>FY 2018-19</u>

- The changes in caseload, rates, and the IBNR factor for FY 2018-19 from the S-2A to the R-2 are primarily the result of flow through of the caseload and rate forecast changes in FY 2017-18.
- 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 a risk corridor is no longer required to develop actuarially certified rates.

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.

[1] https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010

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 BHOs 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 2017-18 the federal match is 50.00%. Payments for members in the Breast and Cervical Cancer Program receive an enhanced federal match rate, which in FY 2017-18 is 65.00% and is described separately below. Capitation expenditures are split between traditional members and expansion members. Expansion members are funded from Healthcare Affordability and Sustainability 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 2017-18 Match Rate	FY 2018-19 Match Rate	FY 2019-20 Match Rate
Standard Medicaid	50.00%	50.00%	50.00%
Former CHP+ Children	88.00%	88.00%	70.75%
Former CHP+ Prenatal	88.00%	88.00%	70.75%
Expansion Adults	94.50%	93.50%	91.50%
BCCP	65.00%	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 2017-18 the federal match is 50.00%. 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 35.00% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund and 65.00% federal funds in FY 2017-18. 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 Healthcare Affordability and Sustainability 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 Healthcare Affordability and Sustainability Fee cash fund. Starting in FY 2011-12, additional expansion populations also received funding through the Healthcare Affordability and Sustainability 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 2017-18. 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

The former CHP+ populations that transferred to Medicaid with SB 11-008 (Eligible Children) and SB 11-250 (Eligible Pregnant Adults) receives the enhanced CHP+ FMAP of approximately 65.00%, with an additional 23 percentage point FMAP increase through September 30, 2019; the enhanced FMAP is expected to be 88.00% in FY 2017-18 and FY 2018-19, and 70.75% in FY 2019-20. The FMAP in FY 2019-20 is an estimated match rate that includes the 88.0% enhanced match rate for July 1, 2019 to September 30, 2019 and the standard match rate of 65.0% for October 1, 2019 to June 30, 2020.

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 Healthcare Affordability and Sustainability 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 2017-18 is 88.38%. 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 2017-18 will by 94.50%, 93.50% in FY 2018-19, and 91.50% in FY 2019-20.

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. 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.

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. 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.

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 forecasted rate is 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.

The claims-based rate is also adjusted 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 2018-19 Trend	FY 2019-20 Trend
Adults 65 and Older (OAP-A)	4.41%	4.41%
	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.
Individuals with disabilities Through 64 (AND/AB, OAP-B)	1.32%	1.32%
	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.
Low Income Adults / Expansion Parents & Caretakers	5.53%	5.53%
	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.	Trend is equal to the average growth from FY 2009-10 to FY 2017-18.
MAGI Adults	5.53%	5.53%
	Trend is equal to Low Income Adults.	Trend is equal to Low Income Adults.
Eligible Children (AFDC-C/BC)	3.64%	3.64%
	Trend is equal to the Average Growth from FY 2009-10 to FY 2017-18.	Trend is equal to the Average Growth from FY 2009-10 to FY 2017-18.
Foster Care	1.56%	1.56%
	The trend selection is based on the two-year moving average.	The trend selection is based on the two-year moving average.

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. The Department also changed its methodology for determining rates due to new 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 an actuarially certified rate range.

The new regulations lead to an overall reduction in rates since most capitation rates that were previously negotiated were higher than the rates that were set to an actuarially sound point. Based on current analysis of the behavioral health organizations cost data, the Department expects that 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 rates due to the uncertainty of the true cost of these populations. The risk corridors allow 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 FY 2015-16. The Department is estimating that it will recoup $48.3 million for FY 2015-16 in FY 2017-18. 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 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 is now able to correctly identify all populations and pay correctly so there will be no need to reconcile this in future years. The Department expects to make a recoupment with the BHOs of $1.8 million in FY 2017-18 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 also expects to make a payment to the BHOs of $1.9 million for an eligibility issue that caused some individuals to be placed in Expansion Parents and Caretakers when they should have been placed into the Transitional Medicaid program, which is a subset of the Low Income Adults population and has a higher rate than for Expansion Parents and Caretakers.

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.

Healthcare Affordability and Sustainability Fee Fund 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. In SB 17-267, The Hospital Provider Fee was changed to the Healthcare Affordability and Sustainability Fee Fund which provides for the costs of the following populations that impact the Behavioral Health budget:

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 HAS Fee Fund, effective July 1, 2017, in compliance with statute.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Low Income Adults in Exhibit DD to forecast the total costs for this population.

MAGI Parents/Caretakers 69% to 133% FPL

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. This expansion population receives 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 fell to 95%. On January 1, 2018, it falls to 94%, then on January 1, 2019,

it falls to 93%, and on January 1, 2020 it falls to 90%, where it will remain. Effective July 1, 2017, this population is financed with the HAS Fee for the State share of expenditure.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Expansion Parents & Caretakers in Exhibit DD to forecast the total costs for this population.

<u>MAGI Adults</u>

With the advent of SB 13-200, effective July 1, 2013, MAGI Adults are 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 fell to 95%. On January 1, 2018, it falls to 94%, and then to 93% on January 1, 2019 and 90% on January 1, 2020, where it will remain. Effective July 1, 2017, the State share of expenditure for this population is financed with the HAS Fee.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for MAGI Adults in Exhibit DD to forecast the total costs for this population.

<u>Non-Newly Eligible</u>

Medicaid expansion clients who were eligible for Medicaid prior to 2009 are not eligible for the enhanced expansion federal medical assistance percentage (FMAP) that began 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 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 the full enhanced expansion FMAP. Instead, with the approval of a resource proxy for the non-newly eligible, 75% of expenditure receives expansion FMAP while the remaining 25% receives the standard FMAP, funded from the HAS Fee Fund. The Department has incorporated the resource proxy in this request.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for MAGI Adults in Exhibit DD to forecast the total costs for this population.

<u>Buy-In for Disabled Individuals</u>

This expansion allows for individuals with disabilities with income up to 450% of the federal poverty level to pay premiums 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 caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Disabled Individuals in Exhibit DD to forecast the total costs for this population.

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 HAS Fee Cash Fund to fund the state share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives standard FMAP. Previously, the Department showed this adjustment in funding as a General Fund offset under Cash Funds Financing.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Eligible Children in Exhibit DD to forecast the total costs for this population.

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 Healthcare Affordability and Sustainability 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.

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.

Current Calculations

Due to payment delays from transitioning to the interChange payment system in March 2017, FY 2016-17 expenditure is artificially low and any trends applied to the FY 2016-17 expenditure would need to be artificially high to return fee-for-service costs to expected levels. To account for this, the current year's estimate is set equal to the FY 2017-18 appropriated amount. The request year estimate is the result of a forward trend of the appropriated amount 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 2017-18 appropriation is 0.85% higher than FY 2016-17 actual expenditures, primarily due to caseload growth. The FY 2017-18 estimate incorporates increased caseload projections along with various rate adjustments and reconciliations and therefore results in a 10.09% decrease from FY 2016-17 actual expenditures and an 10.85% decrease from the current appropriation. The FY 2018-19 estimate is built on the FY 2017-18 estimate and presents a 23.78% expenditure increase. This increase is primarily due to: 1) decrease in reconciliations from the risk corridor; 2) the addition of the rate incentive program; and 3) projected increases in capitation rates from FY 2017-18 to FY 2018-19. The FY 2018-19 request represents a 10.35% increase over the current FY 2017-18 appropriation. The FY 2019-20 Budget Request is built on the FY 2018-19 estimate and represents a 3.43% expenditure increase over the FY 2019-20 request and a 14.14% increase over the FY 2017-18 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 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 2017-18 Children's Basic Health Plan Capitation Appropriation						
FY 2017-18 Long Bill Appropriation (SB 17-254)	$179,773,700	$189,026	$432,590	$23,336,070	$0	$155,816,014
FY 2017-18 Total Children's Basic Heath Plan Capitation Spending Authority	**$179,773,700**	**$189,026**	**$432,590**	**$23,336,070**	**$0**	**$155,816,014**
Projected Total FY 2017-18 CBHP Capitation Expenditure	**$183,052,432**	**$189,955**	**$431,661**	**$23,303,965**	**$0**	**$159,126,851**
FY 2017-18 Children's Basic Health Plan Capitation Estimated Change from Appropriation	**$3,278,732**	**$929**	**($929)**	**($32,105)**	**$0**	**$3,310,837**
Percent Change from Spending Authority	1.82%	0.49%	-0.21%	-0.14%	0.00%	2.12%
FY 2017-18 CBHP External Admin						
FY 2017-18 CBHP External Admin Appropriation						
FY 2017-18 Long Bill Appropriation (SB 17-254)	$5,033,274	$0	$0	$603,993	$0	$4,429,281
FY 2017-18 Total CBHP External Admin Spending Authority	**$5,033,274**	**$0**	**$0**	**$603,993**	**$0**	**$4,429,281**
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 Change from Appropriation	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Percent Change from Spending Authority	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Exhibit C1 - Calculation of Current Total Long Bill Group Impact						
FY 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	**$179,773,700**	**$189,026**	**$432,590**	**$23,336,070**	**$0**	**$155,816,014**
Ammendment 35 Adjustment	$0	$11,992	($11,992)	$0	$0	$0
FY 2018-19 CBHP Capitation Base Amount	**$179,773,700**	**$201,018**	**$420,598**	**$23,336,070**	**$0**	**$155,816,014**
Projected Total FY 2018-19 CBHP Capitation Expenditure	**$195,499,037**	**$0**	**$0**	**$24,906,128**	**$0**	**$170,592,909**
Total FY 2018-19 CBHP Capitation Request	**$15,725,337**	**($201,018)**	**($420,598)**	**$1,570,058**	**$0**	**$14,776,895**
Percent Change from FY 2018-19 CBHP Capitation Base	8.75%	-100.00%	-100.00%	6.73%	0.00%	9.48%
Percent Change from FY 2017-18 Estimated CBHP Capitation Expenditure	6.80%	-100.00%	-100.00%	6.88%	0.00%	7.21%
FY 2018-19 CBHP External Admin						
FY 2017-18 CBHP External Admin Appropriation Plus Special Bills	**$5,033,274**	**$0**	**$0**	**$603,993**	**$0**	**$4,429,281**
FY 2018-19 CBHP External Admin Base Amount	**$5,033,274**	**$0**	**$0**	**$603,993**	**$0**	**$4,429,281**
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 Request	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Percent Change from FY 2018-19 CBHP External Admin Base	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Percent Change from FY 2017-18 Estimated CBHP External Admin Expenditure	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Exhibit C1 - Calculation of Current Total Long Bill Group Impact

FY 2019-20 Children's Basic Health Plan Capitation

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2018-19 CBHP Capitation Appropriation Plus Special Bills	**$179,773,700**	**$201,018**	**$420,598**	**$23,336,070**	**$0**	**$155,816,014**
FY 2019-20 CBHP Capitation Base Amount	**$179,773,700**	**$201,018**	**$420,598**	**$23,336,070**	**$0**	**$155,816,014**
Projected Total FY 2019-20 CBHP Capitation Expenditure	**$207,678,940**	**$12,212,227**	**$430,620**	**$49,298,011**	**$0**	**$145,738,082**
Total FY 2019-20 CBHP Capitation Continuation Amount	**$27,905,240**	**$12,011,209**	**$10,022**	**$25,961,941**	**$0**	**($10,077,932)**
Percent Change from FY 2019-20 CBHP Capitation Base	15.52%	5975.19%	2.38%	111.25%	0.00%	-6.47%
Percent Change from FY 2018-19 Estimated CBHP Capitation Expenditure	6.23%	0.00%	0.00%	97.94%	0.00%	-14.57%

FY 2019-20 CBHP External Admin

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2018-19 CBHP External Admin Appropriation Plus Special Bills	**$5,033,274**	**$0**	**$0**	**$603,993**	**$0**	**$4,429,281**
FY 2019-20 CBHP External Admin Base Amount	**$5,033,274**	**$0**	**$0**	**$603,993**	**$0**	**$4,429,281**
Projected Total FY 2019-20 CBHP External Admin Expenditure	**$5,033,274**	**$0**	**$0**	**$1,472,233**	**$0**	**$3,561,041**
Total FY 2019-20 CBHP External Admin Continuation Amount	**$0**	**$0**	**$0**	**$868,240**	**$0**	**($868,240)**
Percent Change from FY 2019-20 CBHP External Admin Base	0.00%	0.00%	0.00%	143.75%	0.00%	-19.60%
Percent Change from FY 2018-19 Estimated CBHP External Admin Expenditure	0.00%	0.00%	0.00%	143.75%	0.00%	-19.60%

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**
CBHP Expenditure to be matched	$180,825,967	$21,699,116	$0	$0	$159,126,851	88.00%
Enrollment Fees CBHP Trust Fund	$539,073	$0	$539,073	$0	$0	0.00%
Enrollment Fees Healthcare Affordability and Sustainability Fee Fund	$1,065,776	$0	$1,065,776	$0	$0	0.00%
Total CBHP Expenditure	**$182,430,816**	**$21,699,116**	**$1,604,849**	**$0**	**$159,126,851**	87.23%
Cash Fund Financing						
CBHP Trust Fund	$0	($13,903,500)	$13,903,500	$0	$0	NA
CO Immunization Fund	$0	($386,100)	$386,100	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Healthcare Affordability and Sustainability Fee Fund	$0	($7,409,515)	$7,409,515	$0	$0	NA
Estimated FY 2017-18 Capitation Expenditure	**$182,430,816**	**$0**	**$23,303,965**	**$0**	**$159,126,851**	87.23%
Disallowance Payments	$621,616	$621,616	$0	$0	$0	0.00%
Final Estimated FY 2017-18 Capitation Expenditure	**$183,052,432**	**$621,616**	**$23,303,965**	**$0**	**$159,126,851**	86.93%
CBHP Admin Payments	**$5,033,274**	**$0**	**$603,993**	**$0**	**$4,429,281**	88.00%
Final Estimated FY 2017-18 CBHP Expenditure	**$188,085,706**	**$621,616**	**$23,907,958**	**$0**	**$163,556,132**	86.96%

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**
CBHP Expenditure to be matched	$193,855,579	$23,262,670	$0	$0	$170,592,909	88.00%
Enrollment Fees CBHP Trust Fund	$552,020	$0	$552,020	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$1,091,438	$0	$1,091,438	$0	$0	0.00%
Total CBHP Expenditure	**$195,499,037**	**$23,262,670**	**$1,643,458**	**$0**	**$170,592,909**	87.26%
Cash Fund Financing						
CBHP Trust Fund	$0	($14,922,113)	$14,922,113	$0	$0	NA
CO Immunization Fund	$0	($379,763)	$379,763	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Healthcare Affordability and Sustainability Fee Fund	$0	($7,960,793)	$7,960,793	$0	$0	NA
Estimated FY 2018-19 Capitation Expenditure	**$195,499,037**	**$0**	**$24,906,128**	**$0**	**$170,592,909**	87.26%
Disallowance Payments	$0	$0	$0	$0	$0	0.00%
Estimated FY 2018-19 Capitation Expenditure	**$195,499,037**	**$0**	**$24,906,128**	**$0**	**$170,592,909**	87.26%
CBHP Admin Payments	**$5,033,274**	**$0**	**$603,993**	**$0**	**$4,429,281**	88.00%
Final Estimated FY 2018-19 CBHP Expenditure	**$200,532,311**	**$0**	**$25,510,121**	**$0**	**$175,022,190**	87.28%

Exhibit C2 - Calculation of Fund Splits

Calculation of Fund Splits - FY 2019-20 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	$205,990,222	$60,252,140	$0	$0	$145,738,082	70.75%
Enrollment Fees CBHP Trust Fund	$569,760	$0	$569,760	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$1,118,958	$0	$1,118,958	$0	$0	0.00%
Total CBHP Expenditure	**$207,678,940**	**$60,252,140**	**$1,688,718**	**$0**	**$145,738,082**	70.17%
Cash Fund Financing						
CBHP Trust Fund	$0	($26,711,975)	$26,711,975	$0	$0	NA
CO Immunization Fund	$0	($385,613)	$385,613	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Healthcare Affordability and Sustainability Fee Fund	$0	($20,511,704)	$20,511,704	$0	$0	NA
Estimated FY 2019-20 Capitation Expenditure	**$207,678,940**	**$12,642,847**	**$49,298,011**	**$0**	**$145,738,082**	**70.17%**
Disallowance Payments	$0	$0	$0	$0	$0	0.00%
Final Estimated FY 2019-20 Capitation Expenditure	**$207,678,940**	**$12,642,847**	**$49,298,011**	**$0**	**$145,738,082**	70.17%
CBHP Admin Payments	**$5,033,274**	**$0**	**$1,472,233**	**$0**	**$3,561,041**	70.75%
Final Estimated FY 2019-20 CBHP Expenditure	**$212,712,214**	**$12,642,847**	**$50,770,244**	**$0**	**$149,299,123**	70.19%

[1]Starting October 1, 2019, CBHP programs no longer receive an additional 23 percentage points on the federal match, which drops to 65.00%. The FY 2019-20 projected weighted match rate is 70.75%.

Exhibit C2 - Cash Funds Report for CBHP

Cash Funds Report for CBHP Capitation Payments

Cash Fund	FY 2017-18			FY 2018-19			FY 2019-20		
	Spending Authority	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**
Cash Funds									
CBHP Trust Fund[1]	$14,365,447	$14,442,573	$77,126	$14,365,447	$15,474,133	$1,108,686	$14,365,447	$27,281,735	$12,916,288
CO Immunization Fund	$365,625	$386,100	$20,475	$365,625	$379,763	$14,138	$365,625	$385,613	$19,988
Health Care Expansion Fund	$1	$1	$0	$1	$1	$0	$1	$1	$0
Healthcare Affordability and Sustainability Fee Fund	$8,604,997	$8,475,291	($129,706)	$8,604,997	$9,052,231	$447,234	$8,604,997	$21,630,662	$13,025,665
Department Recoveries	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Cash Funds	**$23,336,070**	**$23,303,965**	**($32,105)**	**$23,336,070**	**$24,906,128**	**$1,570,058**	**$23,336,070**	**$49,298,011**	**$25,961,941**

[1]Estimated revenues to the CBHP Trust Fund are based on the 2017 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 2017-18			FY 2018-19			FY 2019-20		
	Spending Authority	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**
Cash Funds									
CBHP Trust Fund[1]	$601,577	$601,577	$0	$601,577	$601,577	$0	$601,577	$1,466,344	$864,767
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
Healthcare Affordability and Sustainability Fee Fund`	$2,416	$2,416	$0	$2,416	$2,416	$0	$2,416	$5,889	$3,473
Total Cash Funds	**$603,993**	**$603,993**	**$0**	**$603,993**	**$603,993**	**$0**	**$603,993**	**$1,472,233**	**$868,240**

[1]Estimated revenues to the CBHP Trust Fund are based on the 2017 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**

Disallowances 12-001 CHIP, 12-003 CHIP, & 13-004 CHIP

Summary of Payments by Fiscal Year

Fiscal Year	Amount
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**

Exhibit C3 - Children's Basic Health Plan Programs Expenditure Summary
Actuals, Appropriations and Estimates Prior to Recoupments

ITEM	FY 2016-17 Actual		FY 2017-18 Appropriated		FY 2017-18 Estimate		FY 2017-18 Change from Appropriation		FY 2018-19 Estimate		FY 2018-19 Change from FY 2017-18 Estimate		FY 2018-19 Change from FY 2017-18 Appropriation		FY 2019-20 Estimate		FY 2019-20 Change from FY 2018-19 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	43,457	$82,286,298	46,934	$102,482,043	49,528	$104,309,837	2,594	$1,827,794	51,861	$111,914,144	2,333	$7,604,307	4,927	$9,432,101	54,055	$119,451,197	2,194	$7,537,053
Children 206%-260% FPL Medical	20,808	$42,139,085	22,077	$48,919,660	24,156	$50,991,482	2,079	$2,071,822	25,354	$55,183,422	1,198	$4,191,940	3,277	$6,263,762	26,211	$58,672,702	857	$3,489,280
Children to 205% FPL Dental	43,457	$9,843,938	46,934	$12,125,653	49,528	$11,791,460	2,594	($334,193)	51,861	$12,631,903	2,333	$840,443	4,927	$506,250	54,055	$13,461,653	2,194	$829,750
Children 206%-260% FPL Dental	20,808	$4,926,327	22,077	$5,318,556	24,156	$5,657,515	2,079	$338,959	25,354	$6,059,601	1,198	$402,086	3,277	$741,045	26,211	$6,383,387	857	$323,786
Prenatal to 205% FPL	225	$1,172,621	243	$3,181,007	275	$3,517,784	32	$336,777	275	$3,521,614	0	$3,830	32	$340,607	275	$3,521,648	0	$34
Prenatal 206%-260% FPL	493	$4,189,312	549	$7,125,165	487	$6,162,738	(62)	($962,427)	487	$6,188,353	0	$25,615	(62)	($936,812)	487	$6,188,353	0	$0
Bottom Line Impacts																		
FQHC Payments		*$907,641*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*
Department Recoveries		*$4,794,624*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*
Other Payments		*$301,124*		*$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*
Disallowance Payments		*$2,501,956*		*$621,616*		*$621,616*		*$0*		*$0*		*($621,616)*		*($621,616)*		*$0*		*$0*
Sub-total CBHP Program Expenditure	**64,983**	**$153,062,926**	**69,803**	**$179,773,700**	**74,446**	**$183,052,432**	**4,643**	**$3,278,732**	**77,977**	**$195,499,037**	**3,531**	**$12,446,605**	**8,174**	**$15,725,337**	**81,028**	**$207,678,940**	**3,051**	**$12,179,903**
Enrollment Fees		$1,272,538		$1,180,123		$1,604,849		$424,726		$1,643,458		$38,609		$463,335		$1,688,717		$45,259
Children to 200%		*$659,903*		*$306,109*		*$529,194*		*$223,085*		*$541,906*		*$12,711*		*$235,796*		*$559,409*		*$17,504*
Children 201%-205%		*$59,133*		*$6,501*		*$9,879*		*$3,378*		*$10,114*		*$236*		*$3,614*		*$10,350*		*$236*
Children 206%-260%		*$553,502*		*$867,513*		*$1,065,776*		*$198,264*		*$1,091,438*		*$25,661*		*$223,925*		*$1,118,958*		*$27,520*
Total CBHP Program Expenditure	**64,983**	**$153,062,926**	**69,803**	**$179,773,700**	**74,446**	**$183,052,432**	**4,643**	**$3,278,732**	**77,977**	**$195,499,037**	**3,531**	**$12,446,605**	**8,174**	**$15,725,337**	**81,028**	**$207,678,940**	**3,051**	**$12,179,903**
Incremental Percent Change							6.65%	1.82%			4.74%	6.80%	11.71%	8.75%			3.91%	6.23%
CBHP Admin Payments																		
External Admin		$2,251,214		$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		**$2,251,214**		**$5,033,274**		**$5,033,274**		**$0**		**$5,033,274**		**$0**		**$0**		**$5,033,274**		**$0**
Total CBHP Programs		**$155,314,140**		**$184,806,974**		**$188,085,706**		**$3,278,732**		**$200,532,311**		**$12,446,605**		**$15,725,337**		**$212,712,214**		**$12,179,903**
Incremental Percent Change								1.77%				6.62%		8.51%				6.07%

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 2009-10 Actuals	5,123	11,520	51,946	68,589	-	-	-	-	-	1,550	-	1,561	70,150
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%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.16%	0.00%	11.60%	-1.63%
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	2,869	8,383	25,785	37,036	1,349	3,680	11,639	16,668	53,704	227	460	687	54,391
% Change from FY 2013-14	-6.90%	-16.11%	-12.41%	-12.88%	2.26%	-16.57%	-12.57%	-12.47%	-12.75%	-49.67%	-8.37%	-27.91%	-12.98%
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	-4.61%	-4.27%	-6.23%	-5.66%	7.20%	-5.56%	-3.95%	-3.40%	-4.96%	-12.33%	1.96%	-2.77%	-4.93%
FY 2016-17 Actuals	3,114	9,705	30,638	43,457	1,695	4,556	14,557	20,808	64,265	225	493	718	64,983
% Change from FY 2015-16	13.81%	20.92%	26.71%	24.37%	17.25%	31.09%	30.22%	29.24%	25.91%	13.07%	5.12%	7.49%	25.67%
FY 2017-18 Projection	3,319	11,169	35,040	49,528	1,847	5,318	16,991	24,156	73,684	275	487	762	74,446
% Change from FY 2016-17	6.57%	15.09%	14.37%	13.97%	8.95%	16.72%	16.72%	16.09%	14.66%	22.22%	-1.22%	6.13%	14.56%
FY 2018-19 Projection	3,447	11,827	36,587	51,861	2,030	5,531	17,793	25,354	77,215	275	487	762	77,977
% Change from FY 2017-18	3.86%	5.89%	4.41%	4.71%	9.91%	4.01%	4.72%	4.96%	4.79%	0.00%	0.00%	0.00%	4.74%
FY 2019-20 Projection	3,579	12,243	38,233	54,055	2,198	5,669	18,344	26,211	80,266	275	487	762	81,028
% Change from FY 2018-19	3.83%	3.52%	4.50%	4.23%	8.28%	2.50%	3.10%	3.38%	3.95%	0.00%	0.00%	0.00%	3.91%
FY 2017-18 Appropriation	3,391	10,312	33,231	46,934	1,862	4,891	15,324	22,077	69,011	243	549	792	69,803
Difference between the FY 2017-18 Appropriation and Projection	(72)	857	1,809	2,594	(15)	427	1,667	2,079	4,673	32	(62)	(30)	4,643

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.

CBHP CASELOAD FY 2016-17 without RETROACTIVITY

FY 2016-17[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 2016	39,962	18,968	58,930	227	509	736	59,666	1,426	2.45%
August 2016	41,345	19,419	60,764	200	497	697	61,461	1,795	3.01%
September 2016	41,419	19,945	61,364	199	477	676	62,040	579	0.94%
October 2016	40,987	19,751	60,738	205	443	648	61,386	(654)	-1.05%
November 2016	40,451	19,205	59,656	202	464	666	60,322	(1,064)	-1.73%
December 2016	41,974	19,860	61,834	199	494	693	62,527	2,205	3.66%
January 2017	42,653	20,732	63,385	204	510	714	64,099	1,572	2.51%
February 2017	43,074	21,191	64,265	208	498	706	64,971	872	1.36%
March 2017	47,726	23,839	71,565	248	523	771	72,336	7,365	11.34%
April 2017	49,020	24,052	73,072	261	515	776	73,848	1,512	2.09%
May 2017	49,447	24,214	73,661	276	502	778	74,439	591	0.80%
June 2017	49,587	24,293	73,880	275	486	761	74,641	202	0.27%
Year-to-Date Average [2]	**43,970**	**21,289**	**65,260**	**225**	**493**	**719**	**65,978**	**1,367**	**2.14%**

[1] Caseload has been restated for Children above 200% FPL and Prenatal above 200% FPL between January 2014 and February 2017. 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. Beginning in March 2017, the Department is able to accuractly identify all clients by FPL so a distribution is no longer needed.

[2] Caseload Year-to-Date Average does not tie out to exhibit C4 - CBHP Caseload because the Department is experiencing issues related to the implementation of the interChange and believes that the caseload by month may be overstated.

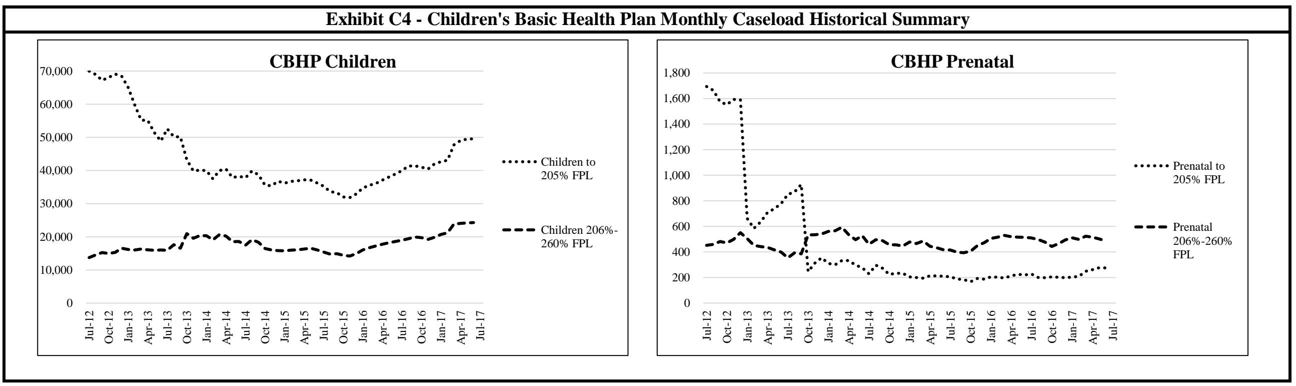


Exhibit C4 - Children's Basic Health Plan Monthly Caseload Historical Summary
CBHP Children
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
Jul-12
Oct-12
Jan-13
Apr-13
Jul-13
Oct-13
Jan-14
Apr-14
Jul-14
Oct-14
Jan-15
Apr-15
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Children to 205% FPL
Children 206%-260% FPL
CBHP Prenatal
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
Prenatal to 205% FPL
Prenatal 206%-260% FPL

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 2010-11 Actuals	$2,130.28	$2,439.89	$159.17	$148.60	$12,583.11	$13,159.54	$2,569.00
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	$2,230.43	$1,941.36	$227.61	$193.64	$16,784.57	$12,544.25	$2,504.14
% Change from FY 2013-14	-17.86%	-10.90%	-1.95%	-6.62%	18.43%	12.11%	-14.35%
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	-9.75%	2.70%	2.02%	14.59%	-28.29%	4.52%	-5.27%
FY 2016-17 Actuals	$1,957.98	$2,101.91	$238.73	$248.09	$5,656.79	$9,383.67	$2,312.30
% Change from FY 2015-16	-2.73%	5.43%	2.81%	11.81%	-53.00%	-28.43%	-2.52%
FY 2017-18 Projection	$2,106.08	$2,110.92	$238.08	$234.21	$12,791.94	$12,654.49	$2,450.51
% Change from FY 2016-17	7.56%	0.43%	-0.27%	-5.60%	126.13%	34.86%	5.98%
FY 2018-19 Projection	$2,157.96	$2,176.52	$243.57	$239.00	$12,805.87	$12,707.09	$2,507.14
% Change from FY 2017-18	2.46%	3.11%	2.31%	2.05%	0.11%	0.42%	2.31%
FY 2019-20 Projection	$2,209.81	$2,238.48	$249.04	$243.54	$12,805.99	$12,707.09	$2,563.05
% Change from FY 2018-19	2.40%	2.85%	2.24%	1.90%	0.00%	0.00%	2.23%

[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 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	$0	-		$12,414,377
	Total FY 2011-12 Expenditures	**$137,985,395**	**23,057,652**	**$17,014,352**	**4,396,724**		**$182,454,123**
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	**$125,304,779**	**$45,439,248**	**$6,391,873**	**$5,617,155**		**$182,753,054**
	% Change from FY 2012-13	**-10.17%**	**48.29%**	**-60.95%**	**10.93%**		**-4.60%**
FY 2014-15 Actuals	*Medical Per Capita*	$2,230.43	$1,941.36	$16,784.57	$12,544.25		
	Dental Per Capita	$227.61	$193.64	-	-		
	Caseload	37,036	16,668	227	460		54,391
	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)	-	$970,237	($5,429,661)
	Recoveries	($8,087,772)	($2,709,359)	($1,292,200)	($514,542)	$12,603,873	0
	Total FY 2014-15 Expenditures	**$83,190,418**	**$32,936,786**	**-$4,184,763**	**$5,255,812**	**$13,574,110**	**$130,772,362**
	% Change from FY 2013-14	**-33.61%**	**-27.51%**	**-165.47%**	**-6.43%**		**-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	-	-	$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%**		**-3.47%**
FY 2016-17 Actuals	*Medical Per Capita*	$1,957.98	$2,101.91	$5,656.79	$9,383.67		
	Dental Per Capita	$238.73	$248.09	-	-		
	Caseload	43,457	20,808	225	493		64,983
	Medical Expenditure	$85,087,185	$43,736,906	$1,272,778	$4,626,150		$134,723,019
	Dental Expenditure	$10,374,516	$5,162,311	-	-		$15,536,827
	Other Payments	$193,132	$107,992	-	-	$2,501,956	$2,803,080
	Recoveries	($2,673,527)	($1,584,102)	($100,157)	($436,838)	$4,794,624	-
	Total FY 2016-17 Expenditures	**$92,981,306**	**$47,423,107**	**$1,172,621**	**$4,189,312**	**$7,296,580**	**$153,062,926**
	% Change from FY 2015-16	**22.27%**	**38.07%**	**-48.78%**	**-29.23%**	**-4.37%**	**21.26%**

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 2017-18 Projection	*Medical Per Capita*	$2,106.08	$2,110.92	$12,791.94	$12,654.49		
	Dental Per Capita	$238.08	$234.21	-	-		
	Caseload	49,528	24,156	275	487		74,446
	Medical Expenditure	$104,309,837	$50,991,482	$3,517,784	$6,162,738		$164,981,841
	Dental Expenditure	$11,791,460	$5,657,515	-	-		$17,448,975
	Disallowance Repayment	-	-	-	-	$621,616	$621,616
	Recoveries	-	-	-	-		$0
	Total FY 2017-18 Expenditures	**$116,101,297**	**$56,648,997**	**$3,517,784**	**$6,162,738**	**$621,616**	**$183,052,432**
	% Change from FY 2016-17	**24.87%**	**19.45%**	**199.99%**	**47.11%**	**-91.48%**	**19.59%**
FY 2018-19 Projection	*Medical Per Capita*	$2,157.96	$2,176.52	$12,805.87	$12,707.09		
	Dental Per Capita	$243.57	$239.00	-	-		
	Caseload	51,861	25,354	275	487		77,977
	Medical Expenditure	$111,914,144	$55,183,422	$3,521,614	$6,188,353		$176,807,533
	Dental Expenditure	$12,631,903	$6,059,601	-	-		$18,691,504
	Disallowance Repayment	-	-	-	-	$0	$0
	Total FY 2018-19 Expenditures	**$124,546,047**	**$61,243,023**	**$3,521,614**	**$6,188,353**	**$0**	**$195,499,037**
	% Change from FY 2017-18	**7.27%**	**8.11%**	**0.11%**	**0.42%**	**-**	**6.80%**
FY 2019-20 Projection	*Medical Per Capita*	$2,209.81	$2,238.48	$12,805.99	$12,707.09		
	Dental Per Capita	$249.04	$243.54	-	-		
	Caseload	54,055	26,211	275	487		81,028
	Medical Expenditure	$119,451,197	$58,672,702	$3,521,648	$6,188,353		$187,833,900
	Dental Expenditure	$13,461,653	$6,383,387	-	-		$19,845,040
	Disallowance Repayment	-	-	-	-	$0	$0
	Total FY 2019-20 Expenditures	**$132,912,850**	**$65,056,089**	**$3,521,648**	**$6,188,353**	**$0**	**$207,678,940**
	% Change from FY 2018-19	**6.72%**	**6.23%**	**0.00%**	**0.00%**	**-**	**6.23%**

Exhibit C5 - Traditional Population Expenditures and Funding

FY 2017-18 Projected Expenditures				
	Children 0%-205% Medical	**Children 0%-205% Dental**	**Prenatal 0%-205%**	**Totals**
Caseload	49,528	49,528	275	49,803
Estimated Per Capita Cost	$2,106.08	$238.08	$12,791.94	$2,401.84
Total Estimated Expenditures FY 2017-18	**$104,309,837**	**$11,791,460**	**$3,517,784**	**$119,619,081**

FY 2018-19 Projected Expenditures				
	Children 0%-205% Medical	**Children 0%-205% Dental**	**Prenatal 0%-205%**	**Totals**
Caseload	51,861	51,861	275	52,136
Estimated Per Capita Cost	$2,157.96	$243.57	$12,805.87	$2,456.42
Total Estimated Expenditures FY 2018-19	**$111,914,144**	**$12,631,903**	**$3,521,614**	**$128,067,661**

FY 2019-20 Projected Expenditures				
	Children 0%-205% Medical	**Children 0%-205% Dental**	**Prenatal 0%-205%**	**Totals**
Caseload	54,055	54,055	275	54,330
Estimated Per Capita Cost	$2,209.81	$249.04	$12,805.99	$2,511.22
Total Estimated Expenditures FY 2019-20	**$119,451,197**	**$13,461,653**	**$3,521,648**	**$136,434,498**

Exhibit C5 - Traditional Population Expenditures and Funding

Cash Funds Forecast[1]

Row		FY 2014-15 Actuals	FY 2015-16 Actuals	FY 2016-17 Actuals	FY 2017-18 Forecast	FY 2018-19 Forecast	FY 2019-20 Forecast	Notes
A	CHP+ Trust Fund - 18% of settlement	$27,889,272	$27,459,195	$16,617,777	$14,256,000	$14,022,000	$14,238,000	2017 Tobacco MSA Payment Forecast and HB 16-1408[1]
B	**Total Trust Fund Expenditure**	**$26,062,316**	**$26,124,596**	**$14,611,213**	**$15,044,150**	**$16,075,710**	**$41,390,926**	Actuals: Reported in CORE Forecast: Exhibit C-2[2]
C	CHP Premiums	$24,562,287	$24,919,221	$14,163,658	$14,442,573	$15,474,133	$39,924,582	Actuals: Reported in CORE Forecast: Row B - Row D
D	CHP+ Admin	$1,500,029	$1,205,375	$447,555	$601,577	$601,577	$1,466,344	Actuals: Reported in CORE Forecast: Exhibit C1
E	% of Projection [3]	93.45%	95.14%	87.93%	105.53%	114.65%	290.71%	Row B / Row A
F	Immunizations - 2.5% of settlement	$1,177,918	$1,037,800	$2,189,338	$1,980,000	$1,947,500	$1,977,500	2017 Tobacco MSA Payment Forecast and HB 16-1408[1]
G	% Appropriated to CHP+	19.50%	19.50%	19.50%	19.50%	19.50%	19.50%	Percentage appropriated to CHP+
H	Projected Amount	$229,694	$202,371	$426,921	$386,100	$379,763	$385,613	Row F * Row G
I	**Total CO Immunization Fund Expenditure**	**$229,694**	**$202,371**	**$426,921**	**$386,100**	**$379,763**	**$385,613**	Actuals: Reported in CORE Forecast: Row H * Row J
J	% of Projection	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	Actuals: Row I / Row H Forecast: Rolling 3 year average

[1]https://leg.colorado.gov/sites/default/files/2017_tobacco_msa_payment_forecast_1192017.pdf
[2] Values in FY 2014-15 and FY 2015-16 are from the February 4, 2015 Tobacco Master Settlement and Amendment 35 Funding.
[3] The Department has an existing balance in the CHP+ Trust fund that, along with new MSA settlement monies, is sufficent to cover all expenditure through FY 2018-19. FY 2019-20 will require the use of General Fund as well as the Trust 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	$119,080,008	$14,289,601	$0	$0	$0	$0	$104,790,407	88.00%
Estimated Enrollment Fees	*$539,073*	*$0*	*$539,073*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$119,619,081**	**$14,289,601**	**$539,073**	**$0**	**$0**	**$0**	**$104,790,407**	87.60%
Offset From Cash Funds [3]	$0	($14,289,601)	$13,903,500	$386,100	$1	$0	$0	NA
Total Estimated Expenditures FY 2017-18	**$119,619,081**	**$0**	**$14,442,573**	**$386,100**	**$1**	**$0**	**$104,790,407**	87.60%
Offset from General Fund [3]	$0	*$0*	*$0*	$0	$0	$0	$0	NA
Total Estimated Expenditures FY 2017-18	**$119,619,081**	**$0**	**$14,442,573**	**$386,100**	**$1**	**$0**	**$104,790,407**	**87.60%**

[1]Forecasted above in Cash Funds Forecast Table, Row C
[2]Forecasted above in Cash Funds Forecast Table, Row I
[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	$127,515,641	$15,301,877	$0	$0	$0	$0	$112,213,764	88.00%
Estimated Enrollment Fees	*$552,020*	*$0*	*$552,020*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$128,067,661**	**$15,301,877**	**$552,020**	**$0**	**$0**	**$0**	**$112,213,764**	87.62%
Offset From Cash Funds [3]	*$0*	*($15,301,877)*	*$14,922,113*	*$379,763*	*$1*	*$0*	*$0*	NA
Total Estimated Expenditures FY 2018-19	**$128,067,661**	**$0**	**$15,474,133**	**$379,763**	**$1**	**$0**	**$112,213,764**	87.62%
Offset from General Fund [3]	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2018-19	**$128,067,661**	**$0**	**$15,474,133**	**$379,763**	**$1**	**$0**	**$112,213,764**	87.62%

[1]Forecasted above in Cash Funds Forecast Table, Row C
[2]Forecasted above in Cash Funds Forecast Table, Row I
[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 2019-20 - 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	$135,864,738	$39,740,436	$0	$0	$0	$0	$96,124,302	70.75%
Estimated Enrollment Fees	*$569,760*	*$0*	*$569,760*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$136,434,498**	**$39,740,436**	**$569,760**	**$0**	**$0**	**$0**	**$96,124,302**	70.45%
Offset From Cash Funds	*$0*	*($27,097,589)*	*$26,711,975*	*$385,613*	*$1*	*$0*	*$0*	NA
Total Estimated Expenditures FY 2019-20	**$136,434,498**	**$12,642,847**	**$27,281,735**	**$385,613**	**$1**	**$0**	**$96,124,302**	70.45%
Offset from General Fund	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2019-20	**$136,434,498**	**$12,642,847**	**$27,281,735**	**$385,613**	**$1**	**$0**	**$96,124,302**	70.45%

[1]Forecasted above in Cash Funds Forecast Table, Row C
[2]Forecasted above in Cash Funds Forecast Table, Row I

Exhibit C5 - Expansion Population Expenditures and Funding				
FY 2017-18 Projected Expenditures				
	Children 206%-260% Medical	**Children 206%-260% Dental**	**Prenatal 206%-260%**	**Totals**
Caseload	24,156	24,156	487	24,643
Estimated Per Capita Cost	$2,110.92	$234.21	$12,654.49	$2,548.87
Total Estimated Expenditures FY 2017-18	$50,991,482	$5,657,515	$6,162,738	$62,811,735
FY 2018-19 Projected Expenditures				
	Children 206%-260% Medical	**Children 206%-260% Dental**	**Prenatal 206%-260%**	**Totals**
Caseload	25,354	25,354	487	25,841
Estimated Per Capita Cost	$2,176.52	$239.00	$12,707.09	$2,609.47
Total Estimated Expenditures FY 2018-19	$55,183,422	$6,059,601	$6,188,353	$67,431,376
FY 2019-20 Projected Expenditures				
	Children 206%-260% Medical	**Children 206%-260% Dental**	**Prenatal 206%-260%**	**Totals**
Caseload	26,211	26,211	487	26,698
Estimated Per Capita Cost	$2,238.48	$243.54	$12,707.09	$2,668.53
Total Estimated Expenditures FY 2019-20	$58,672,702	$6,383,387	$6,188,353	$71,244,442

Exhibit C5 - Expansion Population Expenditures and Funding

FY 2017-18 - Calculation of Fund Splits

Item	Total Funds	General Fund	HAS Fee Cash Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$61,745,959	$0	$7,409,515	$0	$54,336,444	88.00%
Estimated Enrollment Fees	*$1,065,776*	*$0*	*$1,065,776*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2017-18	$62,811,735	$0	$8,475,291	$0	$54,336,444	86.51%

FY 2018-19 - Calculation of Fund Splits

Item	Total Funds	General Fund	HAS Fee Cash Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$66,339,938	$0	$7,960,793	$0	$58,379,145	88.00%
Estimated Enrollment Fees	*$1,091,438*	*$0*	*$1,091,438*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2018-19	$67,431,376	$0	$9,052,231	$0	$58,379,145	86.58%

FY 2019-20 - Calculation of Fund Splits

Item	Total Funds	General Fund	HAS Fee Cash Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$70,125,484	$0	$20,511,704	$0	$49,613,780	70.75%
Estimated Enrollment Fees	*$1,118,958*	*$0*	*$1,118,958*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2019-20	$71,244,442	$0	$21,630,662	$0	$49,613,780	69.64%

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 2011-12 Actuals	19,517	1,402	-	$620,097	$29.64
FY 2012-13 Actuals	22,168	1,614	15,575	$932,439	$23.69
% Change from FY 2011-12	13.58%	15.12%	-	50.37%	-20.08%
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 Actuals	24,808	2,223	20,808	$1,272,538	$26.60
% Change from FY 2015-16	22.56%	33.92%	29.24%	13.30%	-10.00%
FY 2017-18 Projection	23,304	1,986	19,595	$1,604,849	$35.75
% Change from FY 2016-17	-6.06%	-10.66%	-5.83%	26.11%	34.41%
FY 2018-19 Projection	23,865	2,037	20,067	$1,643,458	$35.75
% Change from FY 2017-18	2.41%	2.57%	2.41%	2.41%	-0.01%
FY 2019-20 Projection	24,636	2,088	20,573	$1,688,717	$35.70
% Change from FY 2018-19	3.23%	2.50%	2.52%	2.75%	-0.13%

(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 2017-18	Projected New Enrollees[1]	24,307	447	4,651	14,503	43,908
	Projected New Cases[2]	17,777	335	3,484	10,883	32,479
	Projected Average Fee[3]	$29.77	$29.49	$29.49	$88.49	$49.41
	Total Estimated Paid	$529,194	$9,879	$102,737	$963,040	$1,604,849
FY 2018-19	Projected New Enrollees[1]	24,892	458	4,763	14,852	44,965
	Projected New Cases[2]	18,204	343	3,568	11,145	33,260
	Projected Average Fee[3]	$29.77	$29.49	$29.49	$88.49	$49.41
	Total Estimated Paid	$541,906	$10,114	$105,214	$986,224	$1,643,458
FY 2019-20	Projected New Enrollees[1]	25,696	469	4,883	15,227	46,275
	Projected New Cases[2]	18,792	351	3,658	11,426	34,227
	Projected Average Fee[3]	$29.77	$29.49	$29.49	$88.49	$49.34
	Total Estimated Paid	$559,409	$10,350	$107,867	$1,011,090	$1,688,717

[1] This is the number of new enrollees in FY 2015-16 with the projected growth trend for FY 2017-18, FY 2018-19, and FY 2019-20.

[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 2015-16[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 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	$273.53	$144.70	$173.97	$277.89	$144.24	$171.62	$3.95	$16.52	$20.28	$3.83	$16.15	$19.98	$1,067.18	$1,058.94	$201.03
Estimated Monthly Caseload	3,319	11,169	35,040	1,847	5,318	16,991	3,319	11,169	35,040	1,847	5,318	16,991	275	487	74,446
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	$10,894,153	$19,393,852	$73,150,906	$6,159,154	$9,204,820	$34,991,945	$157,321	$2,214,143	$8,527,334	$84,888	$1,030,628	$4,073,762	$3,521,694	$6,188,445	$179,593,045
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service	98.48%	99.17%	99.30%	98.50%	99.17%	99.37%	99.55%	99.52%	99.61%	99.72%	99.58%	99.69%	98.17%	98.16%	99.18%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$10,728,562	$19,232,883	$72,638,850	$6,066,767	$9,128,420	$34,771,496	$156,613	$2,203,515	$8,494,077	$84,650	$1,026,299	$4,061,133	$3,457,247	$6,074,578	$178,125,090
Estimated Expenditure for Prior Period Dates of Service	$168,524	$112,572	$341,568	$63,415	$37,189	$108,744	$750	$7,148	$23,586	$175	$2,014	$6,281	$60,537	$88,160	$1,020,663
Total Estimated Expenditure in FY 2017-18	**$10,897,086**	**$19,345,455**	**$72,980,418**	**$6,130,182**	**$9,165,609**	**$34,880,240**	**$157,363**	**$2,210,663**	**$8,517,663**	**$84,825**	**$1,028,313**	**$4,067,414**	**$3,517,784**	**$6,162,738**	**$179,145,753**
Unadjusted Per Capitas in FY 2017-18	$3,283.24	$1,732.07	$2,082.77	$3,318.99	$1,723.51	$2,052.87	$47.41	$197.93	$243.08	$45.93	$193.36	$239.39	$12,791.94	$12,654.49	$2,406.39

	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	**$103,222,959**	**$50,176,031**	**$10,885,689**	**$5,180,552**	**$3,517,784**	**$6,162,738**	**$179,145,753**
Reconciliation Payments	$1,086,878	$815,451	$905,771	$476,963	$0	$0	$3,285,063
Total Estimated FY 2017-18 Expenditure Including Bottom Line Impacts	**$104,309,837**	**$50,991,482**	**$11,791,460**	**$5,657,515**	**$3,517,784**	**$6,162,738**	**$182,430,816**
Estimated Monthly Caseload	49,528	24,156	49,528	24,156	275	487	74,446
Final Estimated Per Capita	$2,106.08	$2,110.92	$238.08	$234.21	$12,791.94	$12,654.49	$2,450.51
Unadjusted Per Capita	$2,084.13	$2,077.17	$219.79	$214.46	$12,791.94	$12,654.49	$2,406.39

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	$281.76	$148.05	$177.99	$289.79	$148.53	$175.26	$4.02	$16.96	$20.71	$3.88	$16.58	$20.40	$1,067.19	$1,058.94	$205.27
Estimated Monthly Caseload	3,447	11,827	36,587	2,030	5,531	17,793	3,447	11,827	36,587	2,030	5,531	17,793	275	487	77,977
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	$11,654,721	$21,011,848	$78,145,442	$7,059,284	$9,858,233	$37,420,814	$166,283	$2,407,031	$9,092,601	$94,517	$1,100,448	$4,355,726	$3,521,727	$6,188,445	$192,077,120
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service	98.48%	99.17%	99.30%	98.50%	99.17%	99.37%	99.55%	99.52%	99.61%	99.72%	99.58%	99.69%	98.17%	98.16%	99.18%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$11,477,569	$20,837,450	$77,598,424	$6,953,395	$9,776,410	$37,185,063	$165,535	$2,395,477	$9,057,140	$94,252	$1,095,826	$4,342,223	$3,457,279	$6,074,578	$190,510,621
Estimated Expenditure for Prior Period Dates of Service	$165,293	$160,256	$510,846	$92,185	$76,561	$220,481	$705	$10,693	$33,161	$240	$4,338	$12,432	$64,335	$113,775	$1,465,301
Total Estimated Expenditure in FY 2018-19	**$11,642,862**	**$20,997,706**	**$78,109,270**	**$7,045,580**	**$9,852,971**	**$37,405,544**	**$166,240**	**$2,406,170**	**$9,090,301**	**$94,492**	**$1,100,164**	**$4,354,655**	**$3,521,614**	**$6,188,353**	**$191,975,922**
Unadjusted Per Capitas in FY 2018-19	$3,377.68	$1,775.40	$2,134.89	$3,470.73	$1,781.41	$2,102.26	$48.23	$203.45	$248.46	$46.55	$198.91	$244.74	$12,805.87	$12,707.09	$2,461.96

	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	**$110,749,838**	**$54,304,095**	**$11,662,711**	**$5,549,311**	**$3,521,614**	**$6,188,353**	**$191,975,922**
Reconciliation Payments	$1,164,306	$879,327	$969,192	$510,290	$0	$0	$3,523,115
Total Estimated FY 2018-19 Expenditure Including Bottom Line Impacts	**$111,914,144**	**$55,183,422**	**$12,631,903**	**$6,059,601**	**$3,521,614**	**$6,188,353**	**$195,499,037**
Estimated Monthly Caseload	51,861	25,354	51,861	25,354	275	487	77,977
Final Estimated Per Capita	$2,157.96	$2,176.52	$243.57	$239.00	$12,805.87	$12,707.09	$2,507.14
Unadjusted Per Capita	$2,135.51	$2,141.84	$224.88	$218.87	$12,805.87	$12,707.09	$2,461.96

Exhibit C6 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2019-20

FY 2019-20 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	$290.24	$151.48	$182.11	$302.20	$152.94	$178.96	$4.08	$17.41	$21.14	$3.94	$17.02	$20.83	$1,067.20	$1,058.94	$209.83
Estimated Monthly Caseload	3,579	12,243	38,233	2,198	5,669	18,344	3,579	12,243	38,233	2,198	5,669	18,344	275	487	81,028
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 2019-20 Capitated Payments	$12,465,228	$22,254,836	$83,551,340	$7,970,827	$10,404,202	$39,394,107	$175,228	$2,557,808	$9,698,947	$103,921	$1,157,837	$4,585,266	$3,521,760	$6,188,445	$204,029,752
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service	98.48%	99.17%	99.30%	98.50%	99.17%	99.37%	99.55%	99.52%	99.61%	99.72%	99.58%	99.69%	98.17%	98.16%	99.19%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$12,275,757	$22,070,121	$82,966,481	$7,851,265	$10,317,847	$39,145,924	$174,439	$2,545,531	$9,661,121	$103,630	$1,152,974	$4,571,052	$3,457,312	$6,074,578	$202,368,032
Estimated Expenditure for Prior Period Dates of Service	$176,833	$173,626	$545,725	$105,657	$81,995	$235,785	$745	$11,625	$35,359	$268	$4,632	$13,293	$64,336	$113,775	$1,563,654
Total Estimated Expenditure in FY 2019-20	**$12,452,590**	**$22,243,747**	**$83,512,206**	**$7,956,922**	**$10,399,842**	**$39,381,709**	**$175,184**	**$2,557,156**	**$9,696,480**	**$103,898**	**$1,157,606**	**$4,584,345**	**$3,521,648**	**$6,188,353**	**$203,931,686**
Unadjusted Per Capitas in FY 2019-20	$3,479.35	$1,816.85	$2,184.30	$3,620.07	$1,834.51	$2,146.84	$48.95	$208.87	$253.62	$47.27	$204.20	$249.91	$12,805.99	$12,707.09	$2,516.81

	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 2019-20	**$118,208,543**	**$57,738,473**	**$12,428,820**	**$5,845,849**	**$3,521,648**	**$6,188,353**	**$203,931,686**
Reconciliation Payments	$1,242,654	$934,229	$1,032,833	$537,538	$0	$0	$3,747,254
Total Estimated FY 2019-20 Expenditure Including Bottom Line Impacts	**$119,451,197**	**$58,672,702**	**$13,461,653**	**$6,383,387**	**$3,521,648**	**$6,188,353**	**$207,678,940**
Estimated Monthly Caseload	54,055	26,211	54,055	26,211	275	487	81,028
Final Estimated Per Capita	$2,209.81	$2,238.48	$249.04	$243.54	$12,805.99	$12,707.09	$2,563.05
Unadjusted Per Capita	$2,186.82	$2,202.83	$229.93	$223.03	$12,805.99	$12,707.09	$2,516.81

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	98.48%	99.17%	99.30%	98.50%	99.17%	99.37%	99.55%	99.52%	99.61%	99.72%	99.58%	99.69%	98.17%	98.16%	99.14%
Estimated Percent of Claims Paid in Prior Period	1.52%	0.83%	0.70%	1.50%	0.83%	0.63%	0.45%	0.48%	0.39%	0.28%	0.42%	0.31%	1.83%	1.84%	0.86%
FY 2017-18 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	1.52%	0.83%	0.70%	1.50%	0.83%	0.63%	0.45%	0.48%	0.39%	0.28%	0.42%	0.31%	1.83%	1.84%	0.86%
Estimated Expenditure for Prior Period Dates of Service	$168,524	$112,572	$341,568	$63,415	$37,189	$108,744	$750	$7,148	$23,586	$175	$2,014	$6,281	$60,537	$88,160	$1,020,663
FY 2018-19 Estimated Expenditure for Prior Period Dates of Service															
Estimated Expenditure for Claims Incurred in Prior Period	$10,894,153	$19,393,852	$73,150,906	$6,159,154	$9,204,820	$34,991,945	$157,321	$2,214,143	$8,527,334	$84,888	$1,030,628	$4,073,762	$3,521,694	$6,188,445	$179,593,045
Estimated Percent of Prior Period Claims Paid in Current Period	1.52%	0.83%	0.70%	1.50%	0.83%	0.63%	0.45%	0.48%	0.39%	0.28%	0.42%	0.31%	1.83%	1.84%	0.82%
Estimated Expenditure for Prior Period Dates of Service	$165,293	$160,256	$510,846	$92,185	$76,561	$220,481	$705	$10,693	$33,161	$240	$4,338	$12,432	$64,335	$113,775	$1,465,301
FY 2019-20 Estimated Expenditure for Prior Period Dates of Service															
Estimated Expenditure for Claims Incurred in Prior Period	$11,654,721	$21,011,848	$78,145,442	$7,059,284	$9,858,233	$37,420,814	$166,283	$2,407,031	$9,092,601	$94,517	$1,100,448	$4,355,726	$3,521,727	$6,188,445	$192,077,120
Estimated Percent of Prior Period Claims Paid in Current Period	1.52%	0.83%	0.70%	1.50%	0.83%	0.63%	0.45%	0.48%	0.39%	0.28%	0.42%	0.31%	1.83%	1.84%	0.81%
Estimated Expenditure for Prior Period Dates of Service	$176,833	$173,626	$545,725	$105,657	$81,995	$235,785	$745	$11,625	$35,359	$268	$4,632	$13,293	$64,336	$113,775	$1,563,654

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 2016-17 Actuals	Reconciliation Payments[1]	$874,970	$625,995	$778,560	$402,922	$0	$0	$2,682,447
	FQHC Payments[2]	$657,938	$249,703	$0	$0	$0	$0	$907,641
	HIPF Payments[3]	$147,568	$84,415	$45,564	$23,576	$0	$0	$301,124
	Total Bottom Line Adjustments for FY 2016-17	**$1,532,908**	**$875,698**	**$778,560**	**$402,922**	**$0**	**$0**	**$3,590,088**
FY 2017-18 Projections	Reconciliation Payments[1]	$1,086,878	$815,451	$905,771	$476,963	$0	$0	$3,285,063
	FQHC Payments[2]	$0	$0	$0	$0	$0	$0	$0
	HIPF Payments[3]	$0	$0	$0	$0	$0	$0	$0
	Total Bottom Line Adjustments for FY 2017-18	**$1,086,878**	**$815,451**	**$905,771**	**$476,963**	**$0**	**$0**	**$3,285,063**
FY 2018-19 Projections	Reconciliation Payments[1]	$1,164,306	$879,327	$969,192	$510,290	$0	$0	$3,523,115
	FQHC Payments[2]	$0	$0	$0	$0	$0	$0	$0
	HIPF Payments[3]	$0	$0	$0	$0	$0	$0	$0
	Total Bottom Line Adjustments for FY 2018-19	**$1,164,306**	**$879,327**	**$969,192**	**$510,290**	**$0**	**$0**	**$3,523,115**
FY 2019-20 Projections	Reconciliation Payments[1]	$1,242,654	$934,229	$1,032,833	$537,538	$0	$0	$3,747,254
	FQHC Payments[2]	$0	$0	$0	$0	$0	$0	$0
	HIPF Payments[3]	$0	$0	$0	$0	$0	$0	$0
	Total Bottom Line Adjustments for FY 2019-20	**$1,242,654**	**$934,229**	**$1,032,833**	**$537,538**	**$0**	**$0**	**$3,747,254**

[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 reconciliation payment any longer.

[3] Adjustment accounts for the provider fee that for profit insurers are required to pay as a result of the Affordable Care Act.

Exhibit C7 - Bottom Line Impact Calculations

Projected Reconciliation Payments Calculations

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
Actual FY 2016-17 Reconciliation Payments	$874,970	$625,995	$778,560	$402,922	$0	$0	$2,682,447
FY 2017-18 Projected Rate Inflation Exhibit C9	8.99%	12.21%	2.08%	1.97%	0.05%	0.00%	6.68%
Estimated Reconciliations After Rate Inflation	$953,644	$702,436	$794,738	$410,860	$0	$0	$2,861,678
FY 2017-18 Projected Base Caseload Growth Exhibit C4	13.97%	16.09%	13.97%	16.09%	22.22%	-1.22%	14.79%
Final Estimated FY 2017-18 Reconciliations	**$1,086,878**	**$815,451**	**$905,771**	**$476,963**	**$0**	**$0**	**$3,285,063**

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	$1,086,878	$815,451	$905,771	$476,963	$0	$0	$3,285,063
FY 2018-19 Projected Rate Inflation Exhibit C9	2.30%	2.74%	2.19%	1.93%	0.00%	0.00%	2.33%
Estimated Reconciliations After Rate Inflation	$1,111,929	$837,778	$925,592	$486,178	$0.00	$0.00	$3,361,477
FY 2018-19 Projected Base Caseload Growth Exhibit C4	4.71%	4.96%	4.71%	4.96%	0.00%	0.00%	4.81%
Final Estimated FY 2018-19 Reconciliations	**$1,164,306**	**$879,327**	**$969,192**	**$510,290**	**$0**	**$0**	**$3,523,115**

Estimated FY 2019-20 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 2018-19 Projected Reconciliation Payments	$1,164,306	$879,327	$969,192	$510,290	$0	$0	$3,523,115
FY 2019-20 Projected Rate Inflation Exhibit C9	2.40%	2.77%	2.24%	1.90%	0.00%	0.00%	2.37%
Estimated Reconciliations After Rate Inflation	$1,192,217	$903,683	$990,912	$519,963	$0.00	$0.00	$3,606,775
FY 2019-20 Projected Base Caseload Growth Exhibit C4	4.23%	3.38%	4.23%	3.38%	0.00%	0.00%	3.89%
Final Estimated FY 2019-20 Reconciliations	**$1,242,654**	**$934,229**	**$1,032,833**	**$537,538**	**$0**	**$0**	**$3,747,254**

Exhibit C8 - Children's Basic Health Plan Retroactivity Adjustment[1]

		Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal 0%-205%	Prenatal 206%-260%
		Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18		
FY 2009-10	Average Monthly Claims	5,931	12,158	51,911	0	0	0	4,763	10,346	45,695	0	0	0	1,563	0
	Average Caseload	5,123	11,520	51,946	0	0	0	5,123	11,520	51,946	0	0	0	1,550	0
	Claims as a Percentage of Caseload	115.77%	105.53%	99.93%	0.00%	0.00%	0.00%	92.97%	89.81%	87.97%	0.00%	0.00%	0.00%	100.85%	0.00%
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	2,869	8,383	25,785	1,349	3,680	11,639	2,869	8,383	25,785	1,349	3,680	11,639	227	460
	Claims as a Percentage of Caseload	127.71%	114.90%	112.31%	102.38%	95.67%	94.78%	106.95%	102.45%	100.67%	82.36%	84.04%	83.18%	132.20%	94.57%
FY 2015-16	Average Monthly Claims	3,547	9,713	29,044	1,425	3,204	10,154	2,959	8,530	25,803	1,175	2,814	8,968	290	439
	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	129.64%	121.03%	120.12%	98.55%	92.20%	90.83%	108.14%	106.29%	106.72%	81.27%	80.98%	80.22%	145.73%	93.69%
FY 2016-17	Average Monthly Claims	2,644	7,437	23,026	1,035	2,572	8,103	2,385	6,915	21,487	911	2,372	7,539	196	295
	Average Caseload	3,114	9,705	30,638	1,695	4,556	14,557	3,114	9,705	30,638	1,695	4,556	14,557	225	493
	Claims as a Percentage of Caseload	84.89%	76.63%	75.16%	61.06%	56.45%	55.66%	76.59%	71.25%	70.13%	53.74%	52.07%	51.79%	87.26%	59.77%
Weighted Average Claims as a Percentage of Caseload[2]		118.89%	112.32%	110.86%	118.89%	112.32%	110.86%	98.85%	98.64%	98.34%	98.85%	98.64%	98.34%	109.19%	109.19%
Retroactivity Adjustment Factor		18.89%	12.32%	10.86%	18.89%	12.32%	10.86%	-1.15%	-1.36%	-1.66%	-1.15%	-1.36%	-1.66%	9.19%	9.19%

[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 2015-16 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 2015-16 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 2015-16 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 2009-10	Weighted Claims-Based Rate	$306.23	$107.47	$138.74	$440.63	$106.41	$138.74	$14.81	$14.81	$14.81	$14.64	$14.64	$14.64	$827.81	$827.08
	Weighted Capitation Rate	$306.62	$111.70	$138.79	$396.96	$105.89	$135.97	$14.81	$14.81	$14.81	$14.81	$14.81	$14.81	$821.12	$821.35
	Claims as a Percentage of Capitation	99.87%	96.21%	99.96%	111.00%	100.49%	102.04%	100.00%	100.00%	100.00%	98.85%	98.85%	98.85%	100.81%	100.70%
FY 2010-11	Weighted Claims-Based Rate	$392.40	$110.87	$137.53	$415.80	$107.46	$137.53	$4.59	$12.41	$15.98	$4.56	$12.17	$15.63	$1,184.98	$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	$0.00
	Claims as a Percentage of Capitation	101.85%	100.01%	101.29%	102.50%	100.68%	104.86%	179.30%	103.68%	98.28%	179.53%	104.28%	98.74%	108.30%	0.00%
FY 2011-12	Weighted Claims-Based Rate	$397.04	$122.31	$0.00	$382.70	$119.61	$143.98	$2.82	$13.87	$16.85	$2.79	$13.52	$16.43	$1,147.26	$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%	0.00%	98.00%	98.94%	101.03%	100.36%	99.86%	99.88%	99.29%	97.76%	97.86%	99.98%	100.00%
FY 2012-13	Weighted Claims-Based Rate	$301.19	$121.06	$139.61	$289.34	$119.37	$139.61	$3.20	$14.02	$18.10	$3.18	$13.65	$17.66	$934.60	$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%	102.76%	99.69%	99.93%	99.94%	100.00%	100.00%	99.94%	99.99%	100.00%
FY 2013-14	Weighted Claims-Based Rate	$285.21	$122.68	$141.23	$283.04	$120.84	$141.23	$3.17	$13.29	$16.82	$3.17	$12.97	$16.79	$981.83	$970.08
	Weighted Capitation Rate	$285.23	$122.59	$140.98	$283.15	$120.84	$143.41	$3.35	$13.99	$17.78	$3.35	$13.65	$17.67	$980.64	$970.08
	Claims as a Percentage of Capitation	99.99%	100.07%	100.18%	99.96%	100.00%	98.48%	94.63%	95.00%	94.60%	94.63%	95.02%	95.02%	100.12%	100.00%
FY 2014-15	Weighted Claims-Based Rate	$282.07	$123.55	$145.47	$281.56	$121.50	$145.47	$4.51	$14.81	$19.84	$4.48	$14.37	$19.45	$978.40	$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%	96.83%	95.35%	94.94%	94.97%	95.52%	94.98%	95.02%	99.82%	99.98%
FY 2015-16	Weighted Claims-Based Rate	$240.47	$117.20	$139.96	$238.13	$114.60	$139.96	$5.22	$15.41	$20.62	$5.06	$15.05	$20.25	$976.98	$969.78
	Weighted Capitation Rate	$240.75	$117.42	$140.20	$238.13	$114.60	$137.03	$5.51	$16.25	$21.74	$5.33	$15.84	$21.32	$980.47	$970.08
	Claims as a Percentage of Capitation	99.88%	99.81%	99.83%	100.00%	100.00%	102.14%	94.74%	94.83%	94.85%	94.93%	95.01%	94.98%	99.64%	99.97%
FY 2016-17	Weighted Claims-Based Rate	$222.11	$122.16	$157.55	$225.35	$121.79	$157.55	$3.96	$17.00	$20.96	$3.85	$16.61	$20.57	$976.48	$969.62
	Weighted Capitation Rate	$220.54	$123.35	$160.50	$224.32	$122.93	$161.11	$4.35	$18.71	$22.65	$2.97	$17.07	$21.95	$980.48	$970.08
	Claims as a Percentage of Capitation	100.71%	99.04%	98.16%	100.46%	99.07%	97.79%	91.03%	90.86%	92.54%	129.63%	97.31%	93.71%	99.59%	99.95%
Average Claims as a Percentage of Capitation[2]		99.88%	99.81%	99.83%	99.92%	99.07%	97.79%	94.74%	94.83%	94.85%	94.93%	95.01%	94.98%	99.64%	99.97%
Claims Distribution Adjustment Multiplier		-0.12%	-0.19%	-0.17%	-0.08%	-0.93%	-2.21%	-5.26%	-5.17%	-5.15%	-5.07%	-4.99%	-5.02%	-0.36%	-0.03%

[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% - Age 0-18, FY 2015-16; Children Medical 206% TO 260% - Age 0-1, FY 2014-15; Ages 2-18, FY 2016-17
	Children Dental	Children Dental to 205% - FY 2015-16; Children Dental 206%-260% - FY 2015-16
	Prenatal	Prenatal to 205% - FY 2015-16; Prenatal 206%-260% - FY 2015-16

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 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
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	$285.23	$122.59	$140.98	$283.15	$120.84	$143.41	$3.35	$13.99	$17.78	$3.35	$13.65	$17.67	$980.64	$970.08
% Change	*-5.32%*	*1.20%*	*0.96%*	*-2.14%*	*1.23%*	*5.56%*	*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	*-0.95%*	*0.86%*	*3.00%*	*-0.48%*	*0.53%*	*4.76%*	*41.19%*	*11.51%*	*17.49%*	*40.00%*	*10.84%*	*15.85%*	*-0.05%*	*0.00%*
FY 2015-16 Actuals	$240.75	$117.42	$140.20	$238.13	$114.60	$137.03	$5.51	$16.25	$21.74	$5.33	$15.84	$21.32	$980.47	$970.08
% Change	*-14.79%*	*-5.04%*	*-3.45%*	*-15.49%*	*-5.66%*	*-8.79%*	*16.49%*	*4.17%*	*4.07%*	*13.65%*	*4.69%*	*4.15%*	*0.03%*	*0.00%*
FY 2016-17 Actuals	$220.54	$123.35	$160.50	$224.32	$122.93	$161.11	$4.35	$18.71	$22.65	$2.97	$17.07	$21.95	$980.48	$970.08
% Change	*-8.39%*	*5.05%*	*14.48%*	*-5.80%*	*7.27%*	*17.57%*	*-21.05%*	*15.14%*	*4.19%*	*-44.28%*	*7.77%*	*2.95%*	*0.00%*	*0.00%*
FY 2017-18 Estimated Rate	$230.34	$129.07	$157.20	$233.93	$129.62	$158.31	$4.22	$17.66	$21.74	$4.08	$17.23	$21.39	$980.86	$970.08
% Change	*4.44%*	*4.64%*	*-2.06%*	*4.28%*	*5.44%*	*-1.74%*	*-2.99%*	*-5.61%*	*-4.02%*	*37.37%*	*0.94%*	*-2.55%*	*0.04%*	*0.00%*
FY 2018-19 Estimated Rate	$237.27	$132.06	$160.83	$243.95	$133.47	$161.66	$4.29	$18.13	$22.20	$4.14	$17.69	$21.84	$980.87	$970.08
% Change	*3.01%*	*2.32%*	*2.31%*	*4.28%*	*2.97%*	*2.12%*	*1.66%*	*2.66%*	*2.12%*	*1.47%*	*2.67%*	*2.10%*	*0.00%*	*0.00%*
FY 2019-20 Estimated Rate	$244.41	$135.12	$164.55	$254.40	$137.44	$165.08	$4.36	$18.61	$22.66	$4.20	$18.16	$22.30	$980.88	$970.08
% Change	*3.01%*	*2.32%*	*2.31%*	*4.28%*	*2.97%*	*2.12%*	*1.63%*	*2.65%*	*2.07%*	*1.45%*	*2.66%*	*2.11%*	*0.00%*	*0.00%*

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 2009-10 Actuals	$146.77	$153.84	$14.81	$0.00	$821.12	$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%*	*0.00%*	*33.25%*	*0.00%*
FY 2011-12 Actuals	$162.49	$161.35	$15.33	$14.79	$1,147.48	$1,138.60
% Change	*9.02%*	*4.42%*	*5.07%*	*10.46%*	*4.87%*	*4.52%*
FY 2012-13 Actuals	$149.77	$146.06	$16.13	$15.50	$934.90	$912.11
% Change	*-7.83%*	*-9.48%*	*5.22%*	*4.80%*	*-18.53%*	*-19.89%*
FY 2013-14 Actuals	$147.19	$147.83	$15.84	$15.75	$981.44	$970.08
% Change	*-1.72%*	*1.21%*	*-1.80%*	*1.61%*	*4.98%*	*6.36%*
FY 2014-15 Actuals	$151.22	$154.78	$18.45	$18.02	$980.09	$970.08
% Change	*2.74%*	*4.70%*	*16.48%*	*14.41%*	*-0.14%*	*0.00%*
FY 2015-16 Actuals	$150.98	$154.53	$18.44	$18.01	$980.15	$970.08
% Change	*-0.16%*	*-0.16%*	*-0.05%*	*-0.06%*	*0.01%*	*0.00%*
FY 2016-17 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 2017-18 Estimated Rate	$155.76	$157.78	$19.65	$19.15	$980.86	$970.08
% Change	*8.99%*	*12.21%*	*2.08%*	*1.97%*	*0.05%*	*0.00%*
FY 2018-19 Estimated Rate	$159.35	$162.10	$20.08	$19.52	$980.87	$970.08
% Change	*2.30%*	*2.74%*	*2.19%*	*1.93%*	*0.00%*	*0.00%*
FY 2019-20 Estimated Rate	$163.17	$166.59	$20.53	$19.89	$980.88	$970.08
% Change	*2.40%*	*2.77%*	*2.24%*	*1.90%*	*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 2017-18 Estimated Rate	$230.34	$129.07	$157.20	$233.93	$129.62	$158.31	$4.22	$17.66	$21.74	$4.08	$17.23	$21.39	$980.86	$970.08
Retroactivity Adjustment Multiplier (Exhibit C8)	18.89%	12.32%	10.86%	18.89%	12.32%	10.86%	-1.15%	-1.36%	-1.66%	-1.15%	-1.36%	-1.66%	9.19%	9.19%
Claims Distribution Adjustment Multiplier (Exhibit C8)	-0.12%	-0.19%	-0.17%	-0.08%	-0.93%	-2.21%	-5.26%	-5.17%	-5.15%	-5.07%	-4.99%	-5.02%	-0.36%	-0.03%
Final Adjustment Factor	18.75%	12.11%	10.67%	18.79%	11.28%	8.41%	-6.35%	-6.46%	-6.72%	-6.16%	-6.28%	-6.60%	8.80%	9.16%
FY 2017-18 Final Estimated Rate	$273.53	$144.70	$173.97	$277.89	$144.24	$171.62	$3.95	$16.52	$20.28	$3.83	$16.15	$19.98	$1,067.18	$1,058.94

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	$237.27	$132.06	$160.83	$243.95	$133.47	$161.66	$4.29	$18.13	$22.20	$4.14	$17.69	$21.84	$980.87	$970.08
Retroactivity Adjustment Multiplier (Exhibit C8)	18.89%	12.32%	10.86%	18.89%	12.32%	10.86%	-1.15%	-1.36%	-1.66%	-1.15%	-1.36%	-1.66%	9.19%	9.19%
Claims Distribution Adjustment Multiplier (Exhibit C8)	-0.12%	-0.19%	-0.17%	-0.08%	-0.93%	-2.21%	-5.26%	-5.17%	-5.15%	-5.07%	-4.99%	-5.02%	-0.36%	-0.03%
Final Adjustment Factor	18.75%	12.11%	10.67%	18.79%	11.28%	8.41%	-6.35%	-6.46%	-6.72%	-6.16%	-6.28%	-6.60%	8.80%	9.16%
FY 2018-19 Final Estimated Rate	$281.76	$148.05	$177.99	$289.79	$148.53	$175.26	$4.02	$16.96	$20.71	$3.88	$16.58	$20.40	$1,067.19	$1,058.94

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 2019-20 Estimated Rate	$244.41	$135.12	$164.55	$254.40	$137.44	$165.08	$4.36	$18.61	$22.66	$4.20	$18.16	$22.30	$980.88	$970.08
Retroactivity Adjustment Multiplier (Exhibit C8)	18.89%	12.32%	10.86%	18.89%	12.32%	10.86%	-1.15%	-1.36%	-1.66%	-1.15%	-1.36%	-1.66%	9.19%	9.19%
Claims Distribution Adjustment Multiplier (Exhibit C8)	-0.12%	-0.19%	-0.17%	-0.08%	-0.93%	-2.21%	-5.26%	-5.17%	-5.15%	-5.07%	-4.99%	-5.02%	-0.36%	-0.03%
Final Adjustment Factor	18.75%	12.11%	10.67%	18.79%	11.28%	8.41%	-6.35%	-6.46%	-6.72%	-6.16%	-6.28%	-6.60%	8.80%	9.16%
FY 2019-20 Final Estimated Rate	$290.24	$151.48	$182.11	$302.20	$152.94	$178.96	$4.08	$17.41	$21.14	$3.94	$17.02	$20.83	$1,067.20	$1,058.94

Exhibit C10 - Forecast Model Comparisons - Capitation Trend Models

Capitation Rate Forecast Model for FY 2017-18

Model	Children's Medical 0%-205%			Children's Medical 206%-260%			Children's Dental 0%-205%			Children's Dental 206%-260%			Prenatal 0%-205%	Prenatal 206%-260%
	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18	Ages 0-1	Ages 2-5	Ages 6-18		
FY 2015-16 Full Year Average Rate	$240.75	$117.42	$140.20	$238.13	$114.60	$137.03	$5.51	$16.25	$21.74	$5.33	$15.84	$21.32	$980.47	$970.08
FY 2016-17 Full Year Average Rate	$220.54	$123.35	$160.50	$224.32	$122.93	$161.11	$4.35	$18.71	$22.65	$2.97	$17.07	$21.95	$980.48	$970.08
FY 2017-18 Estimated Average Rate	$230.34	$129.07	$157.20	$233.93	$129.62	$158.31	$4.22	$17.66	$21.74	$4.08	$17.23	$21.39	$980.86	$970.08
Recent Growth Rates														
% Growth from FY 2015-16 to FY 2016-17 Rate	-8.39%	5.05%	14.48%	-5.80%	7.27%	17.57%	-21.05%	15.14%	4.19%	-44.28%	7.77%	2.95%	0.00%	0.00%
% Growth from FY 2016-17 to FY 2017-18 Rate	4.44%	4.64%	-2.06%	4.28%	5.44%	-1.74%	-2.99%	-5.61%	-4.02%	37.37%	0.94%	-2.55%	0.04%	0.00%
Selected Trend Models														
Average Growth Model	$237.27	$132.06	$160.83	$217.47	$133.47	$161.66	$4.13	$18.13	$22.75	$4.52	$17.89	$22.30	$996.32	$984.42
% Difference from FY 2017-18 Rate	3.01%	2.32%	2.31%	-7.04%	2.97%	2.12%	-2.13%	2.66%	4.65%	10.78%	3.83%	4.25%	1.58%	1.48%
% Difference from FY 2018-19 Rate	3.01%	2.32%	2.31%	-7.04%	2.97%	2.12%	-2.18%	2.65%	4.66%	10.84%	3.80%	4.26%	1.58%	1.48%
Two Period Moving Average Model	$225.44	$126.21	$158.85	$229.13	$126.28	$159.71	$4.29	$18.19	$22.20	$3.53	$17.15	$21.67	$980.67	$970.08
% Difference from FY 2017-18 Rate	-2.13%	-2.22%	1.05%	-2.05%	-2.58%	0.88%	1.54%	2.97%	2.09%	-13.60%	-0.46%	1.31%	-0.02%	0.00%
% Difference from FY 2018-19 Rate	1.09%	1.13%	-0.52%	1.05%	1.32%	-0.44%	-0.76%	-1.44%	-1.03%	7.87%	0.23%	-0.65%	0.01%	0.00%
Exponential Growth Model	$237.79	$128.70	$160.70	$197.49	$129.59	$159.36	$5.61	$19.51	$24.27	$4.71	$18.47	$23.74	$1,026.16	$1,008.71
% Difference from FY 2017-18 Rate	3.24%	-0.29%	2.23%	-15.58%	-0.02%	0.66%	32.95%	10.50%	11.63%	15.38%	7.21%	11.00%	4.62%	3.98%
% Difference from FY 2018-19 Rate	-2.93%	1.37%	2.29%	-7.85%	1.92%	2.10%	9.53%	5.83%	5.15%	6.74%	5.29%	5.07%	1.01%	0.85%
Linear Growth Model	$199.73	$128.46	$156.69	$179.16	$129.13	$159.17	$5.32	$19.13	$23.93	$4.66	$18.14	$23.37	$1,022.69	$1,006.17
% Difference from FY 2017-18 Rate	-13.29%	-0.47%	-0.33%	-23.41%	-0.38%	0.55%	26.09%	8.33%	10.09%	14.13%	5.30%	9.24%	4.26%	3.72%
% Difference from FY 2018-19 Rate	-9.57%	1.26%	1.49%	-14.03%	1.72%	1.91%	6.17%	4.49%	4.14%	4.95%	4.15%	4.03%	0.85%	0.72%

	Children's Medical 0%-205% Ages 0-1	Ages 2-5	Ages 6-18	Children's Medical 206%-260% Ages 0-1	Ages 2-5	Ages 6-18	Children's Dental 0%-205% Ages 0-1	Ages 2-5	Ages 6-18	Children's Dental 206%-260% Ages 0-1	Ages 2-5	Ages 6-18	Prenatal 0%-205%	Prenatal 206%-260%
% change from FY 2017-18 Rate to Selected FY 2018-19 Capitation Rate [1]	3.01%	2.32%	2.31%	4.28%	2.97%	2.12%	1.54%	2.66%	2.09%	1.54%	2.66%	2.09%	0.00%	0.00%
FY 2018-19 Forecast Point Estimate	**$237.27**	**$132.06**	**$160.83**	**$243.95**	**$133.47**	**$161.66**	**$4.29**	**$18.13**	**$22.20**	**$4.14**	**$17.69**	**$21.84**	**$980.87**	**$970.08**
% change from FY 2018-19 Rate to Selected FY 2019-20 Capitation Rate [1]	3.01%	2.32%	2.31%	4.28%	2.97%	2.12%	1.54%	2.65%	2.09%	1.54%	2.65%	2.09%	0.00%	0.00%
FY 2019-20 Forecast Point Estimate	**$244.41**	**$135.12**	**$164.55**	**$254.40**	**$137.44**	**$165.08**	**$4.36**	**$18.61**	**$22.66**	**$4.20**	**$18.16**	**$22.30**	**$980.88**	**$970.08**

[1] Selected trends are described below.

Children Medical	FY 2018-19	Children 0%-205%: Average Growth Model Children 206%-260%: Ages 0-1 - Growth From FY 2016-17 to FY 2017-18; Ages 2-5 - Average Growth Model
	FY 2019-20	Children 0%-205%: Average Growth Model Children 206%-260%: Ages 0-1 - Growth From FY 2016-17 to FY 2017-18; Ages 2-5 - Average Growth Model
Children Dental	FY 2018-19	Children 0%-205%: Ages 0-1 - Two Period Moving Average Model; Ages 2-5 - Average Growth Model; Ages 6-18 - Two Period Moving Average Model Children 206%-260%: Ages 0-1 - Two Period Moving Average Model; Ages 2-5 - Average Growth Model; Ages 6-18 - Two Period Moving Average Model
	FY 2019-20	Children 0%-205%: Ages 0-1 - Two Period Moving Average Model; Ages 2-5 - Average Growth Model; Ages 6-18 - Two Period Moving Average Model Children 206%-260%: Ages 0-1 - Two Period Moving Average Model; Ages 2-5 - Average Growth Model; Ages 6-18 - Two Period Moving Average Model
Prenatal	FY 2018-19	Prenatal 0%-205%: No Growth Prenatal 206%-260%: No Growth
	FY 2019-20	Prenatal 0%-205%: No Growth Prenatal 206%-260%: No Growth

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title	**R-03 CHP+**

Dept. Approval By: ____________ 11/1/17

OSPB Approval By: ____________

___ **Supplemental FY 2017-18**

X **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$179,773,700**	**$0**	**$179,773,700**	**$15,725,337**	**$27,905,240**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$621,616	$0	$621,616	($621,616)	$12,021,231
	CF	$23,336,070	$0	$23,336,070	$1,570,058	$25,961,941
	RF	$0	$0	$0	$0	$0
	FF	$155,816,014	$0	$155,816,014	$14,776,895	($10,077,932)

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
05. Indigent Care Program -- Children's Basic Health Plan Medical and Dental Costs	**Total**	**$179,773,700**	**$0**	**$179,773,700**	**$15,725,337**	**$27,905,240**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$621,616	$0	$621,616	($621,616)	$12,021,231
	CF	$23,336,070	$0	$23,336,070	$1,570,058	$25,961,941
	RF	$0	$0	$0	$0	$0
	FF	$155,816,014	$0	$155,816,014	$14,776,895	($10,077,932)

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 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

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

FY 2017-18, FY 2018-19, and FY 2019-20 Budget Request

November 2017

TABLE OF CONTENTS

CHILDREN'S BASIC HEALTH PLAN ***1***
Points of Interest 1
History and Background Information 2
CBHP CAPITATION PAYMENTS ***2***
Exhibit C1 - Calculation of Current Total Long Bill Group Impact 4
Exhibit C2 - Calculation of Fund Splits 5
Exhibit C3 - Children's Basic Health Plan Summary 5
Exhibit C4 - CBHP Caseload 5
Exhibit C5 - Children's Basic Health Plan Funding Sources 7
Exhibit C6 - Estimate and Request by Eligibility Category 8
Incurred-but-not-Reported Estimates 9
Exhibit C7 - Children's Basic Health Plan Bottom Line Impacts to Expenditure 10
Exhibit C8 - CBHP Retroactivity Adjustment and Claims Distribution Adjustment Multiplier 10
Retroactivity Adjustment Multiplier 11
Claims Distribution Adjustment Multiplier 11
Exhibit C9 - CBHP Capitation Rate Trends and Forecasts 11
Exhibit C10 - Forecast Model Comparisons 13
Final Forecasts 13
Capitation Trend Models 13
CBHP CASELOAD ***20***
Children's Basic Health Plan Caseload Forecast 22

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 October 1, 2017, federal funding for the CHP+ program is expired and there is no current appropriation beyond that. For this request, the Department assumes that the program would be reauthorized, but if it is not reauthorized at the federal level, the Department expects it can fund the program through January 2018.
- Through the Affordable Care Act (ACA) the federal participation for this program was enhanced by 23%, through September 30, 2019, at which point it would revert to 65%.
- With the passage of the ACA and the enhanced federal financial participation, the Department has been able to pay for the state's share of costs entirely with cash funds. With the expiration of the 23% enhanced match in FY 2019-20, the Department anticipates that it will need to start funding a portion of the expenses with General Fund. This is due to the exhaustion of the CHP+ Trust fund, which will take place sometime in FY 2019-20. Absent the 23 percent enhanced match, the Department will likely require General Fund in future years as well.
- In the 2017 legislative session, SB 17-267 "Sustainability of Rural Colorado" was passed and creates the Colorado Healthcare Affordability and Sustainability Enterprise within the Department to manage the Healthcare Affordability and Sustainability (HAS) Fee, which replaces the Hospital Provider Fee assess under current law. Beginning in FY 2017-18, the state share of the populations with FPL greater than 205% will be paid with the HAS Fee.
- Beginning 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 Healthcare Affordability and Sustainability (HAS) fee fund. With the implementation of the interChange, the Department is now able to identify discrete FPLs for CHP+ members. Between January 2014 and March 2017, the Department used a distribution of clients over 200% FPL prior to January 2014 to assign clients with that particular income rating code to the appropriate cohorts.
- In FY 2013-14, a budget amendment was passed to expand dental services in CHP+ to bring the program into compliance with the CHIPRA Legislation of 2009. This has initially resulted in a substantial increase in rates for dental services beginning in FY 2014-15 due to the uncertainty of what actual costs would be, but has since declined and appears to be leveling off in FY 2017-18.
- 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. The final payment was made in Quarter 1 of FY 2017-18. 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.

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 beginning in FY 2014-15.

Effective July 1, 2010, the Department implemented a new reimbursement schedule for inpatient hospital payments and effective October 31, 2016 implemented a new reimbursement schedule for outpatient hospital payments. The Department is now using the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and the Colorado Medicaid Enhanced Ambulatory Patient Groups (EAPGs) for outpatient services.

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%-156%, 157%-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.

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. 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 the Healthcare Affordability and Sustainability Fee Fund (SB 17-267).

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 average for the State Fiscal Year 2017-18 was 88.00%. The projected FMAP for FY 2018-19 is 88.00% and with the expiration of the enhanced 23 percentage point bump, the projected FMAP for FY 2019-20 is 70.75%. With the 23 percentage point increase, the Department forecasts that the CBHP Trust Fund will be sufficient for the State share of CHP+ expenditures through FY 2018-19. The total amount attributed to the General Fund in FY 2017-18 is due to the disallowance payments, discussed above. Beginning in FY 2019-20, the Department expects that it will need to begin funding the program with a combination of General Fund and CHP+ Trust Fund for members to 205% FPL. The Department is also expecting to recover payments in FY 2017-18 for prior year dates of service, but is unsure of the magnitude at this time. 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-3.20 of this narrative.

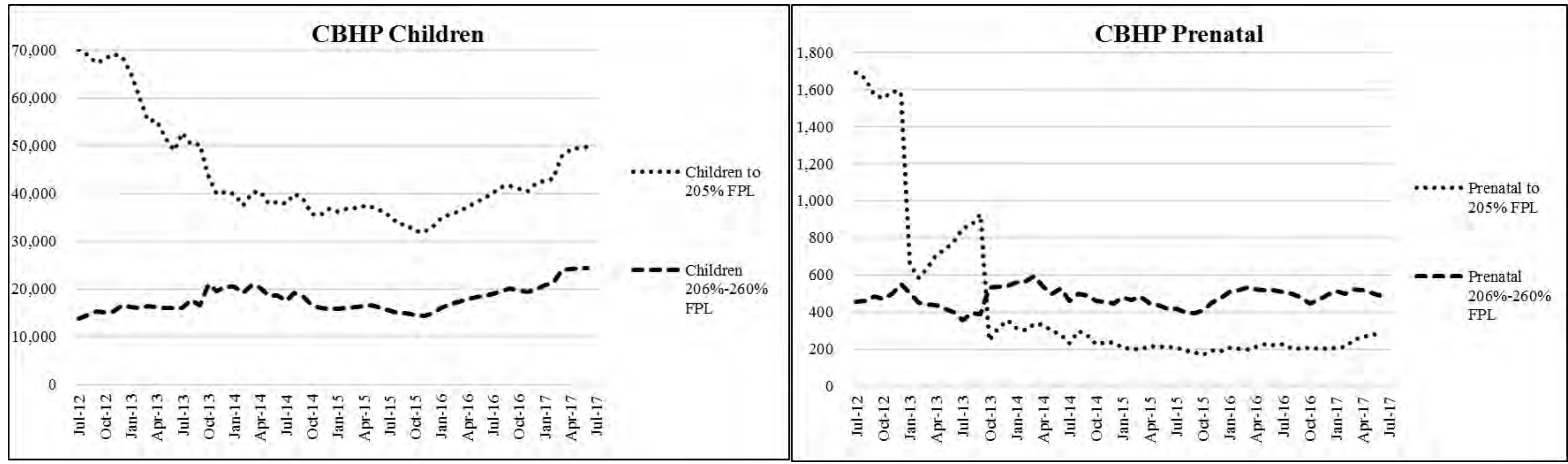
Children's Basic Health Plan Caseload by Fiscal Year

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.

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.

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 (January 2014 – June 2017) seem to have continued with moderate growth.



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. Calculations are described in exhibits C6 through C10.

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. 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 2017 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.

As described above for exhibit C2, the CHP+ Federal Match increased by 23 percentage points in October 2015 and remains in effect until September 30, 2019. With 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, through September 30, 2019. This results in $0 General Fund expenditure for capitation payments. Beginning October 1, 2019, when the enhanced federal match rate reverts back to a projected

65%, the Department expects General Fund will be needed for this population as there will no longer be enough revenue in the CHP+ Trust Fund to support expenditures.

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 Healthcare Affordability and Sustainability 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.

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 exhibit C6..

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 were 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 paid $907,641 for FQHC/RHC reconciliations, but does not expect to pay or recoup any funds thereafter.

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. Exhibit C8 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 in Exhibit C8, 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 in Exhibit C8.

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%-156%, 157%-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 2016-17, and the projected weighted rates through FY 2019-20.

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 2016-17 Actuals	**$142.91**	**$140.61**	**$19.25**	**$18.78**	**$980.40**	**$970.08**	**$170.24**
FY 2017-18 Estimated Rate	**$155.76**	**$157.78**	**$19.65**	**$19.15**	**$980.86**	**$970.08**	**$184.08**
% Change from FY 2016-17	8.99%	12.21%	2.08%	1.97%	0.05%	0.00%	8.13%
FY 2018-19 Estimated Rate	**$159.35**	**$162.10**	**$20.08**	**$19.52**	**$980.87**	**$970.08**	**$187.91**
% Change from FY 2017-18	2.30%	2.74%	2.19%	1.93%	0.00%	0.00%	2.08%
FY 2019-20 Estimated Rate	**$163.17**	**$166.59**	**$20.53**	**$19.89**	**$980.88**	**$970.08**	**$192.03**
% Change from FY 2018-19	2.40%	2.77%	2.24%	1.90%	0.00%	0.00%	2.20%

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. Exhibit C10 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.

Exhibit C10 also presents, a series of forecast models each eligibility category. From the models or from historical changes, a point estimate is selected as an input. 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

Exhibit C10 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 in Exhibit C10 (see below).

The forecasted rate is then adjusted by the claims distribution adjustment multiplier, calculated in Exhibit C8. 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, 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

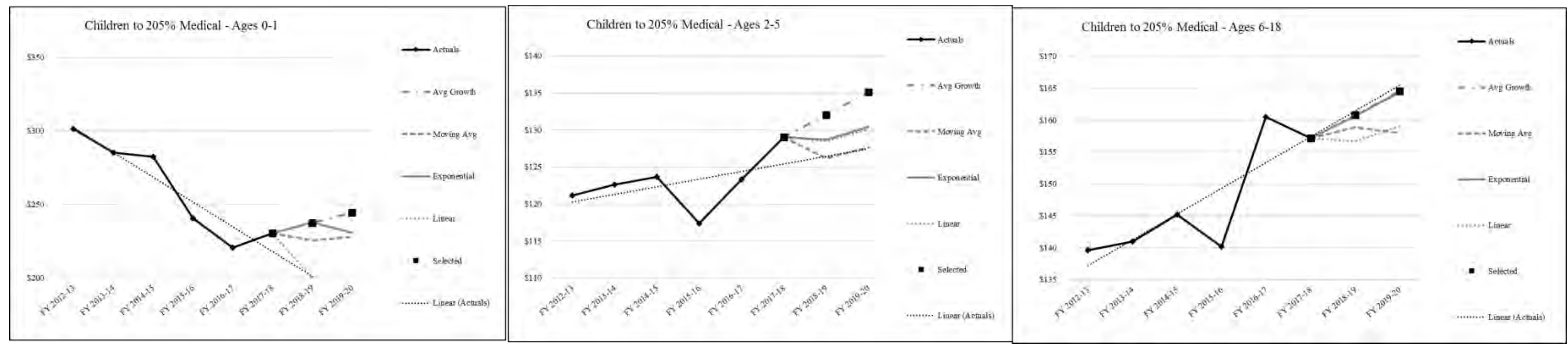
The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented in Exhibit C10.

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.

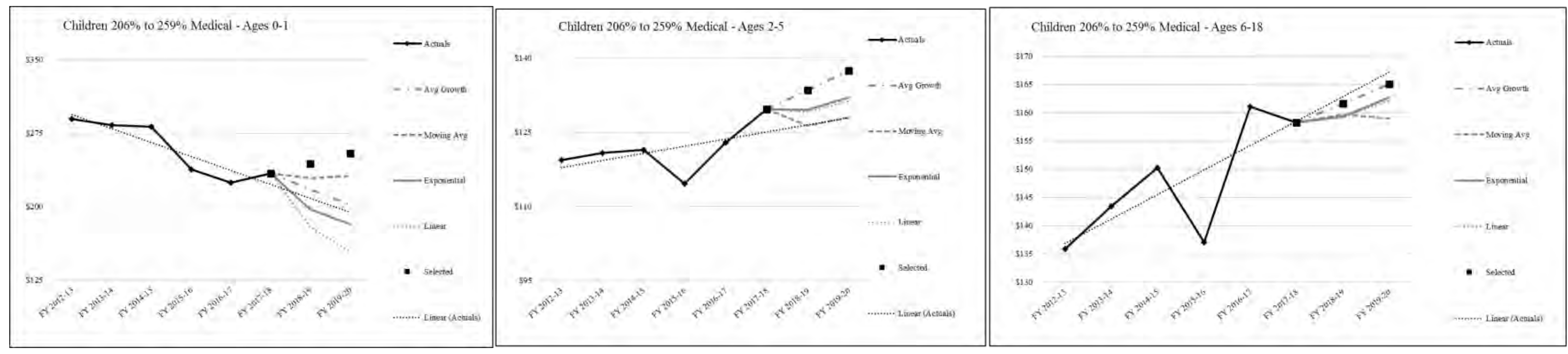
The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

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.

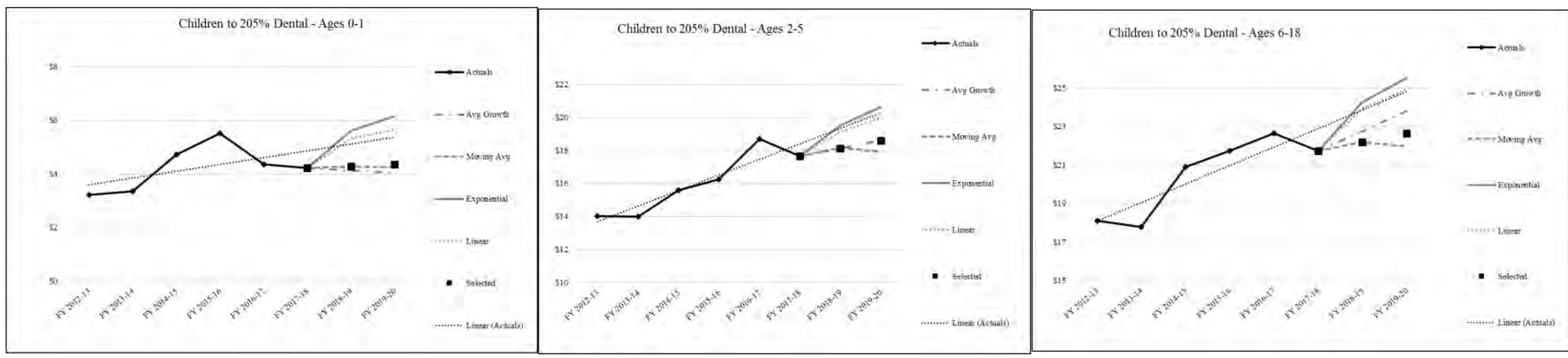
Rate Trends for Children Medical to 205% FPL			
Aid Category	**FY 2018-19 Trend Selection**	**FY 2019-20 Trend Selection**	**Justification**
Children to 205% FPL Medical Ages 0-1	**3.01%** Average Growth Model	**3.01%** Average Growth Model	Rates for FY 2017-18 grew by about 4.4% and the Department expects similar but slower growth into the future.
Children to 205% FPL Medical Ages 2-5	**2.32%** Average Growth Model	**2.32%** Average Growth Model	Rates for FY 2017-18 grew by about 4.6% and the Department expects similar but slower growth into the future.
Children to 205% FPL Medical Ages 6-18	**2.31%** Average Growth Model	**2.31%** Average Growth Model	Rates for this group decreased about 2.1% in FY 2017-18, but the Department expects that trend to reverse and experience some growth in the future.



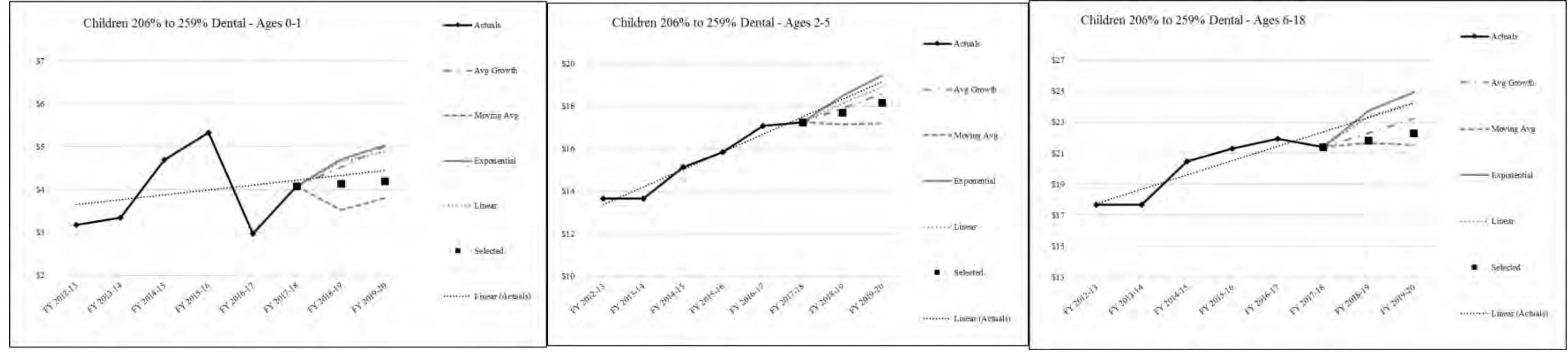
Rate Trends for Children Medical 206% to 260% FPL			
Aid Category	**FY 2018-19 Trend Selection**	**FY 2019-20 Trend Selection**	**Justification**
Children 206% to 260% FPL Medical Ages 0-1	**4.28%**	**4.28%**	Rates increased in FY 2017-18 and the Department expects rates to continue to increase at a moderate pace.
	Growth from FY 2016-17 to FY 2017-18	Growth from FY 2016-17 to FY 2017-18	
Children 206% to 260% FPL Medical Ages 2-5	**2.97%**	**2.97%**	Rates increased about 5.4% in FY 2017-18 after increasing more than 7.2% in FY 2016-17. The Department expects moderate growth for this cohort.
	Average Growth Model	Average Growth Model	
Children 206% to 260% FPL Medical Ages 6-18	**2.12%**	**2.12%**	Rates decreased about 1.7% in FY 2017-18 after increasing over 17.5% in FY 2016-17. The Department expects moderate growth for this cohort.
	Average Growth Model	Average Growth Model	



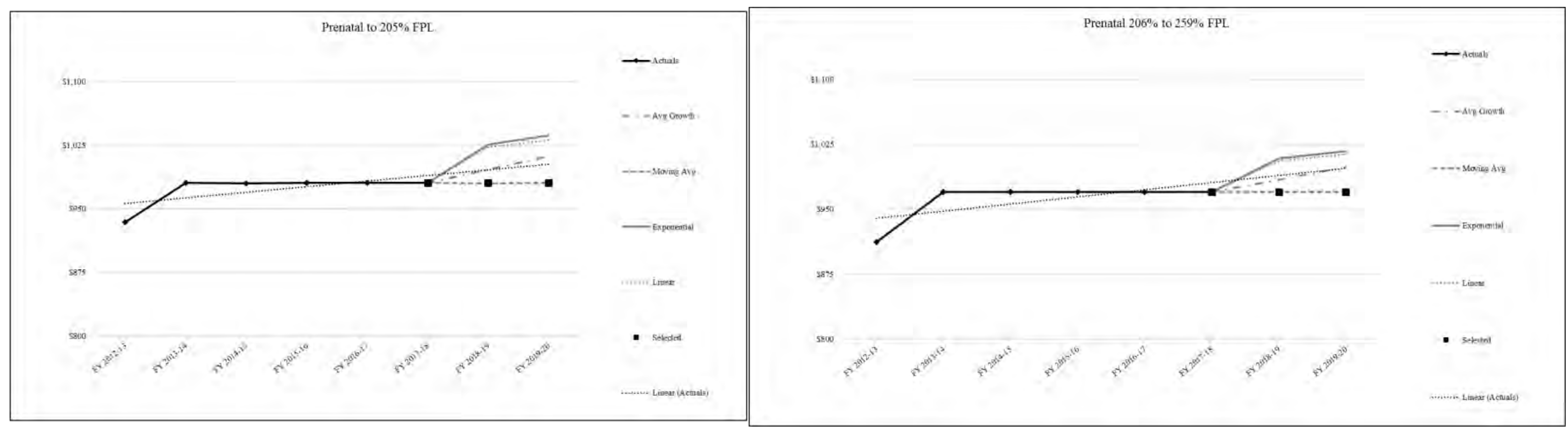
Rate Trends for Children Dental to 205% FPL			
Aid Category	**FY 2018-19 Trend Selection**	**FY 2019-20 Trend Selection**	**Justification**
Children to 205% FPL Dental Ages 0-1	**1.54%**	**1.54%**	Rates for this cohort declined slightly in FY 2017-18 after a significant decline in FY 2016-17. This is due to the unknowns when setting rates due to the expansion of the dental benefits and rates appear to be settling in. The Department uses a small positive trend.
	Two Period Moving Average Model	Two Period Moving Average Model	
Children to 205% FPL Dental Ages 2-5	**2.66%**	**2.65%**	Rates for this cohort declined slightly in FY 2017-18 after a significant decline in FY 2016-17. This is due to the unknowns when setting rates due to the expansion of the dental benefits and rates appear to be settling in. The Department uses a small positive trend.
	Average Growth Model	Average Growth Model	
Children to 205% FPL Dental Ages 6-18	**2.09%**	**2.09%**	Rates for this cohort declined slightly in FY 2017-18 after a significant decline in FY 2016-17. This is due to the unknowns when setting rates due to the expansion of the dental benefits and rates appear to be settling in. The Department uses a small positive trend.
	Two Period Moving Average Model	Two Period Moving Average Model	



Rate Trends for Children Dental 206% to 260% FPL			
Aid Category	**FY 2018-19 Trend Selection**	**FY 2019-20 Trend Selection**	**Justification**
Children 206% to 260% FPL Dental Ages 0-1	**1.54%**	**1.54%**	Rates trend similarly for dental regardless of FPL and the Department has chosen to stick with the trends for the Children 0-205% FPL.
	Trend from 0-205% FPL Ages 0-1	Trend from 0-205% FPL Ages 0-1	
Children 206% to 260% FPL Dental Ages 2-5	**2.66%**	**2.65%**	Rates trend similarly for dental regardless of FPL and the Department has chosen to stick with the trends for the Children 0-205% FPL.
	Trend from 0-205% FPL Ages 2-5	Trend from 0-205% FPL Ages 2-5	
Children 206% to 260% FPL Dental Ages 6-18	**2.09%**	**2.09%**	Rates trend similarly for dental regardless of FPL and the Department has chosen to stick with the trends for the Children 0-205% FPL.
	Trend from 0-205% FPL Ages 6-18	Trend from 0-205% FPL Ages 6-18	



Rate Trends for Prenatal			
Aid Category	**FY 2018-19 Trend Selection**	**FY 2019-20 Trend Selection**	**Justification**
Prenatal to 205% FPL	**0.00%**	**0.00%**	Medical Advance rates have remained unchanged from FY 2013-14 and the Department expects this to continue in the future. Prenatal client expenditure is paid at cost, through a prepayment and reconciliation. As a result, the prepayment capitation rates are not expected to change.
	No Growth	No Growth	
Prenatal 206%-260% FPL	**0.00%**	**0.00%**	Medical Advance rates have remained unchanged from FY 2013-14 and the Department expects this to continue in the future. Prenatal client expenditure is paid at cost, through a prepayment and reconciliation. As a result, the prepayment capitation rates are not expected to change.
	No Growth	No Growth	



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 2015-16 (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 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	16.56	15.12	7.81	7.27
	% > 12 Mo's	68.77%	58.39%	5.54%	3.69%
FY 2015-16	Avg. LOS Mo's	16.30	15.89	8.75	8.08
	% > 12 Mo's	81.51%	78.49%	12.72%	9.30%

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 2017. CBHP caseload increased significantly in FY 2016-17 and coincides with the implementation of the interChange. A large percentage of the growth experienced are for members that are not tied to an HMO. For the purpose of forecasting caseload, the Department has chosen to forecast based on those clients that are actively tied to an HMO because that appears to be the best representation of actual enrollment and expenditure. As a result, caseload figures in the exhibits may not tie directly to those mentioned below for forecasting. 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: $\log(y) = c + trend + \varepsilon$
- Difference Stationary: $differenced(\log(y)) = c + \varepsilon$

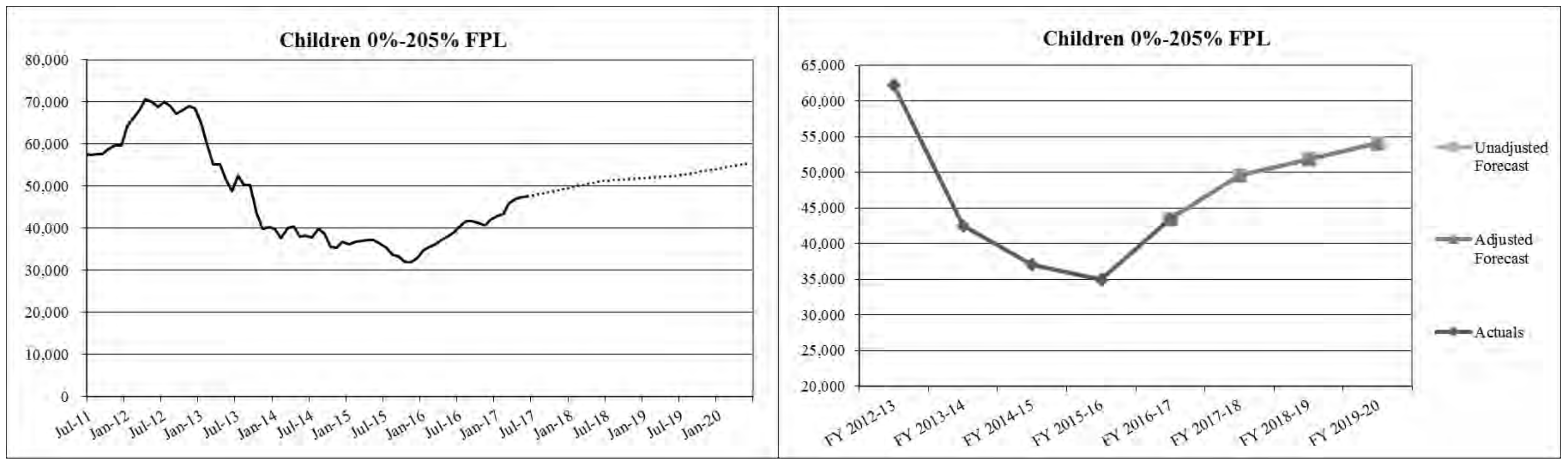
Model Selection

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%-156%, 157%-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)



- Monthly caseload for June 2017 for CHP+ Children 0%-205% FPL was 47,513, which was higher than what was forecasted in the February 2017 forecast by 302. If caseload for this group remained at this level for FY 2017-18 caseload would grow by roughly 9.3% from year to year. The Department does expect some growth in FY 2017-18 beyond the baseline, projecting the final FY 2017-18 average monthly caseload of 49,528, or an increase of 13.97% over FY 2016-17. The Department expects moderate caseload growth in FY 2018-19 and FY 2019-20 as a result of the improving economy and slowing growth in Medicaid caseload for children.

- 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.

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

	Actuals	Monthly Change	% Change
Jun-15	36,287	-	-
Jul-15	35,269	(1,018)	-2.81%
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%
Jul-16	40,444	1,506	3.87%
Aug-16	41,602	1,158	2.86%
Sep-16	41,643	41	0.10%
Oct-16	41,197	(446)	-1.07%
Nov-16	40,572	(625)	-1.52%
Dec-16	42,020	1,448	3.57%
Jan-17	42,841	821	1.95%
Feb-17	43,232	391	0.91%
Mar-17	45,992	2,760	6.38%
Apr-17	46,985	993	2.16%
May-17	47,439	454	0.97%
Jun-17	47,513	74	0.16%

February 2017 Forecast	
Forecasted June 2017 Level	47,211

Base trend from June 2017 level			
FY 2017-18	47,513	9.33%	4,056

	Caseload	% Change	Level Change
FY 2009-10	68,589		
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	37,036	-12.88%	(5,475)
FY 2015-16	34,940	-5.66%	(2,096)
FY 2016-17	43,457	24.38%	8,517
FY 2017-18	49,528	13.97%	6,071
FY 2018-19	51,861	4.71%	2,333
FY 2019-20	54,055	4.23%	2,194

HB 09-1353 Adjustment	
FY 2016-17	-
FY 2017-18	-
FY 2018-19	-
FY 2019-20	-

November 2017 Projections After Adjustments			
FY 2016-17	43,457	24.38%	8,517
FY 2017-18	49,528	13.97%	6,071
FY 2018-19	51,861	4.71%	2,333
FY 2019-20	54,055	4.23%	2,194

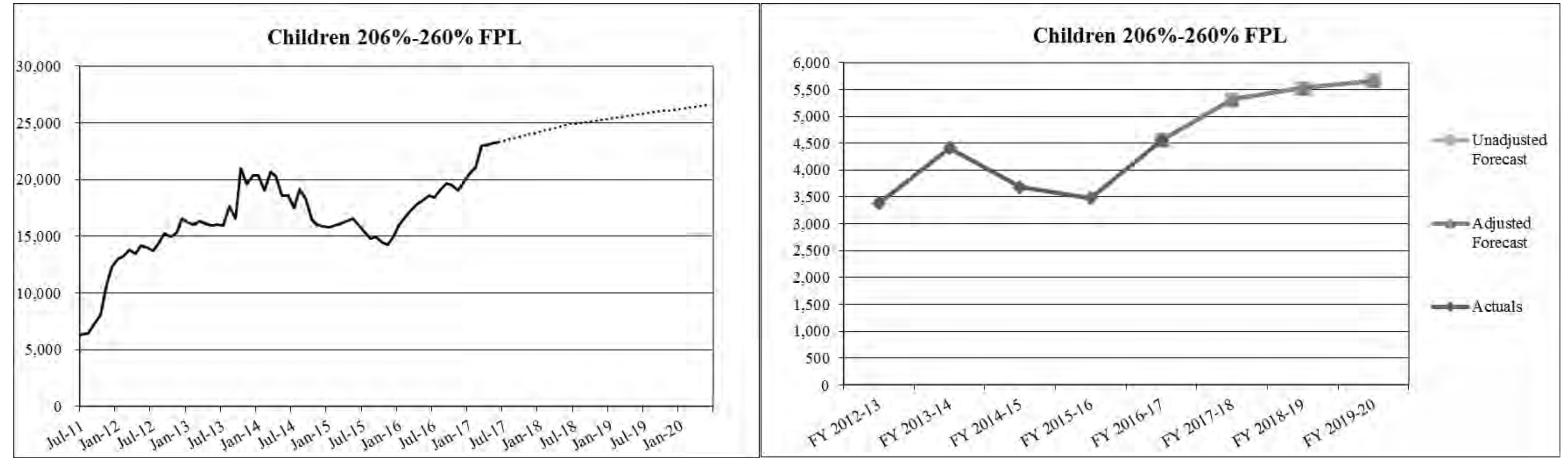
Actuals	Monthly Change	% Change
6-month average	916	2.09%
12-month average	715	1.70%
18-month average	811	2.08%
24-month average	468	1.17%

February 2017 Projection Before Adjustments			
FY 2016-17	42,029	20.29%	7,089
FY 2017-18	45,908	9.23%	3,879
FY 2018-19	49,347	7.49%	3,439

HB 09-1353 Adjustment	
FY 2016-17	991
FY 2017-18	1,026
FY 2018-19	1,050

February 2017 Projection After Adjustments			
FY 2016-17	43,020	23.13%	8,080
FY 2017-18	46,934	9.10%	3,914
FY 2018-19	50,397	7.38%	3,463

Monthly Average Growth Comparisons		
February 2017 Forecast	689	1.63%
FY 2016-17 Actuals	715	1.70%
FY 2016-17 1st Half	514	1.30%
FY 2016-17 2nd Half	916	2.09%
FY 2017-18 Forecast	310	0.63%
February 2017 Forecast	(43)	-0.09%
FY 2018-19 Forecast	97	0.19%
February 2017 Forecast	569	1.14%



- Monthly caseload for June 2017 for CHP+ Children 206%-260% FPL was 23,302, which was higher than what was forecasted in the February 2017 forecast by 1,252. If caseload for this group remained at this level for FY 2017-18 caseload would grow by roughly 11.99%. from year to year. The Department does expect some growth in FY 2017-18 beyond the baseline, projecting the final FY 2017-18 average monthly caseload of 24,156, or an increase of 16.09% over FY 2016-17. The Department expects moderate caseload growth in FY 2018-19 and FY 2019-20 as a result of the improving economy and slowing growth in Medicaid caseload for children.

- 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.

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

	Actuals	Monthly Change	% Change
Jun-15	16,005	-	-
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%
Jul-16	18,452	(116)	-0.62%
Aug-16	19,132	680	3.69%
Sep-16	19,693	561	2.93%
Oct-16	19,508	(185)	-0.94%
Nov-16	19,056	(452)	-2.32%
Dec-16	19,783	727	3.82%
Jan-17	20,529	746	3.77%
Feb-17	21,011	482	2.35%
Mar-17	22,957	1,946	9.26%
Apr-17	23,066	109	0.47%
May-17	23,209	143	0.62%
Jun-17	23,302	93	0.40%

February 2017 Forecast	
Forecasted June 2017 Level	22,050

Base trend from June 2017 level			
FY 2017-18	23,302	11.99%	2,494

	Caseload	% Change	Level Change
FY 2011-12	11,049		
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	20,808	29.24%	4,708
FY 2017-18	24,156	16.09%	3,348
FY 2018-19	25,354	4.96%	1,198
FY 2019-20	26,211	3.38%	857

HB 09-1353 Adjustment	
FY 2016-17	-
FY 2017-18	-
FY 2018-19	-
FY 2019-20	-

November 2017 Projections After Adjustments			
FY 2016-17	20,808	29.24%	4,708
FY 2017-18	24,156	16.09%	3,348
FY 2018-19	25,354	4.96%	1,198
FY 2019-20	26,211	3.38%	857

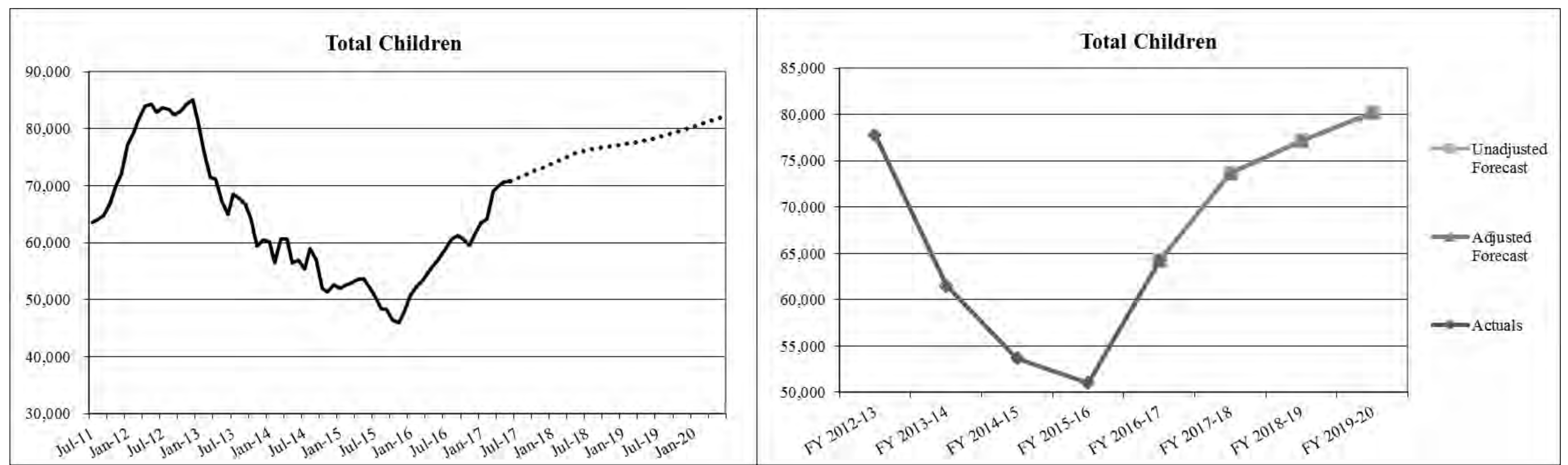
Actuals	Monthly Change	% Change
6-month average	587	2.81%
12-month average	395	1.95%
18-month average	466	2.55%
24-month average	304	1.63%

February 2017 Projection Before Adjustments			
FY 2016-17	19,607	21.78%	3,507
FY 2017-18	21,548	9.90%	1,941
FY 2018-19	22,824	5.92%	1,276

HB 09-1353 Adjustment	
FY 2016-17	502
FY 2017-18	529
FY 2018-19	542
	542

February 2017 Projection After Adjustments			
FY 2016-17	20,109	24.90%	4,009
FY 2017-18	22,077	9.79%	1,968
FY 2018-19	23,366	5.84%	1,289

Monthly Average Growth Comparisons		
February 2017 Forecast	227	1.16%
FY 2016-17 Actuals	395	1.95%
FY 2016-17 1st Half	203	1.09%
FY 2016-17 2nd Half	587	2.81%
FY 2017-18 Forecast	131	0.55%
February 2017 Forecast	63	0.29%
FY 2018-19 Forecast	73	0.29%
February 2017 Forecast	240	1.03%



- Monthly caseload for June 2017 for CHP+ Children 0%-260% FPL was 70,815, which was higher than what was forecasted in the February 2017 forecast by 2,295. If caseload for this group remained at this level for FY 2017-18 caseload would grow by roughly 10.19%. from year to year. The Department does expect some growth in FY 2017-18 beyond the baseline, projecting the final FY 2017-18 average monthly caseload of 73,684, or an increase of 14.66% over FY 2016-17. The Department expects moderate caseload growth in FY 2018-19 and FY 2019-20 as a result of the improving economy and slowing growth in Medicaid caseload for children.

Total Children: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-15	52,292	-	-
Jul-15	50,651	(1,641)	-3.14%
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%
Jul-16	58,896	1,390	2.42%
Aug-16	60,734	1,838	3.12%
Sep-16	61,336	602	0.99%
Oct-16	60,705	(631)	-1.03%
Nov-16	59,628	(1,077)	-1.77%
Dec-16	61,803	2,175	3.65%
Jan-17	63,370	1,567	2.54%
Feb-17	64,243	873	1.38%
Mar-17	68,949	4,706	7.33%
Apr-17	70,051	1,102	1.60%
May-17	70,648	597	0.85%
Jun-17	70,815	167	0.24%

February 2017 Forecast	
Forecasted June 2017 Level	68,520

Base trend from June 2017 level			
FY 2017-18	70,815	10.19%	6,550

	Caseload	% Change	Level Change
FY 2009-10	68,725		
FY 2010-11	67,267	-2.12%	(1,458)
FY 2011-12	74,266	10.40%	6,999
FY 2012-13	77,835	4.81%	3,569
FY 2013-14	61,554	-20.92%	(16,281)
FY 2014-15	53,704	-12.75%	(7,850)
FY 2015-16	51,040	-4.96%	(2,664)
FY 2016-17	64,265	25.91%	13,225
FY 2017-18	73,684	14.66%	9,419
FY 2018-19	77,215	4.79%	3,531
FY 2019-20	80,266	3.95%	3,051

HB 09-1353 Adjustment	
FY 2016-17	-
FY 2017-18	0
FY 2018-19	0
FY 2019-20	0

November 2017 Projections After Adjustments			
FY 2016-17	64,265	25.91%	13,225
FY 2017-18	73,684	14.66%	9,419
FY 2018-19	77,215	4.79%	3,531
FY 2019-20	80,266	3.95%	3,051

Actuals	Monthly Change	% Change
6-month average	1,502	2.32%
12-month average	1,109	1.77%
18-month average	1,277	2.23%
24-month average	772	1.31%

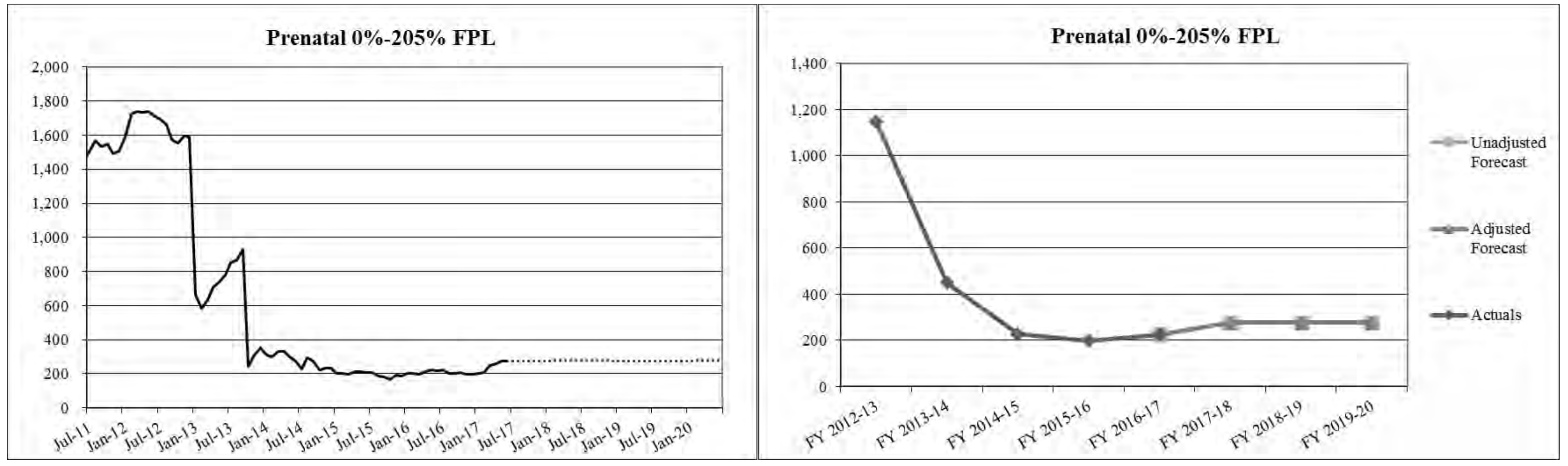
February 2017 Projection Before Adjustments			
FY 2016-17	61,636	20.76%	10,596
FY 2017-18	67,456	9.44%	5,820
FY 2018-19	72,171	6.99%	4,715

HB 09-1353 Adjustment	
FY 2016-17	1,555
FY 2017-18	1,592
FY 2018-19	542

February 2017 Projection After Adjustments			
FY 2016-17	63,191	17.67%	9,487
FY 2017-18	69,048	9.27%	5,857
FY 2018-19	72,713	5.31%	3,665

Monthly Average Growth Comparisons		
February 2017 Forecast	916	1.48%
FY 2016-17 Actuals	1,109	1.77%
FY 2016-17 1st Half	1,109	1.23%
FY 2016-17 2nd Half	1,502	2.32%
FY 2017-18 Forecast	441	0.60%
February 2017 Forecast	21	0.03%
FY 2018-19 Forecast	170	0.22%
February 2017 Forecast	809	1.11%

Prenatal Caseload Projections (Exhibit C4)



- Monthly caseload for June 2017 for CHP+ Prenatal 0%-205% FPL was 275, which was lower than what was forecasted in the February 2017 forecast by 68 clients. If caseload for this group remained at this level for FY 2017-18 caseload would grow by roughly 22.22%. from year to year. The Department does expect minimal additional growth in FY 2017-18 beyond the baseline, projecting the final FY 2017-18 average monthly caseload of 277, or an increase of 23.11% over FY 2016-17. The Department expects caseload in FY 2018-19 and FY 2019-20 to remain flat.

- 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.

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

	Actuals	Monthly Change	% Change
Jun-15	210	-	-
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%
Jul-16	224	4	1.82%
Aug-16	203	(21)	-9.38%
Sep-16	205	2	0.99%
Oct-16	210	5	2.44%
Nov-16	199	(11)	-5.24%
Dec-16	196	(3)	-1.51%
Jan-17	202	6	3.06%
Feb-17	206	4	1.98%
Mar-17	248	42	20.39%
Apr-17	261	13	5.24%
May-17	276	15	5.75%
Jun-17	275	(1)	-0.36%

February 2017 Forecast	
Forecasted June 2017 Level	343

Base trend from June 2017 level			
FY 2017-18	275	22.22%	50

	Caseload	% Change	Level Change
FY 2009-10	1,550		
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	225	13.07%	26
FY 2017-18	277	23.11%	52
FY 2018-19	277	0.00%	0
FY 2019-20	277	0.00%	0

HB 09-1353 Adjustment	
FY 2016-17	-
FY 2017-18	-
FY 2018-19	-
FY 2019-20	-

November 2017 Projections After Adjustments			
FY 2016-17	225	13.07%	26
FY 2017-18	277	23.11%	52
FY 2018-19	277	0.00%	-
FY 2019-20	277	0.00%	-

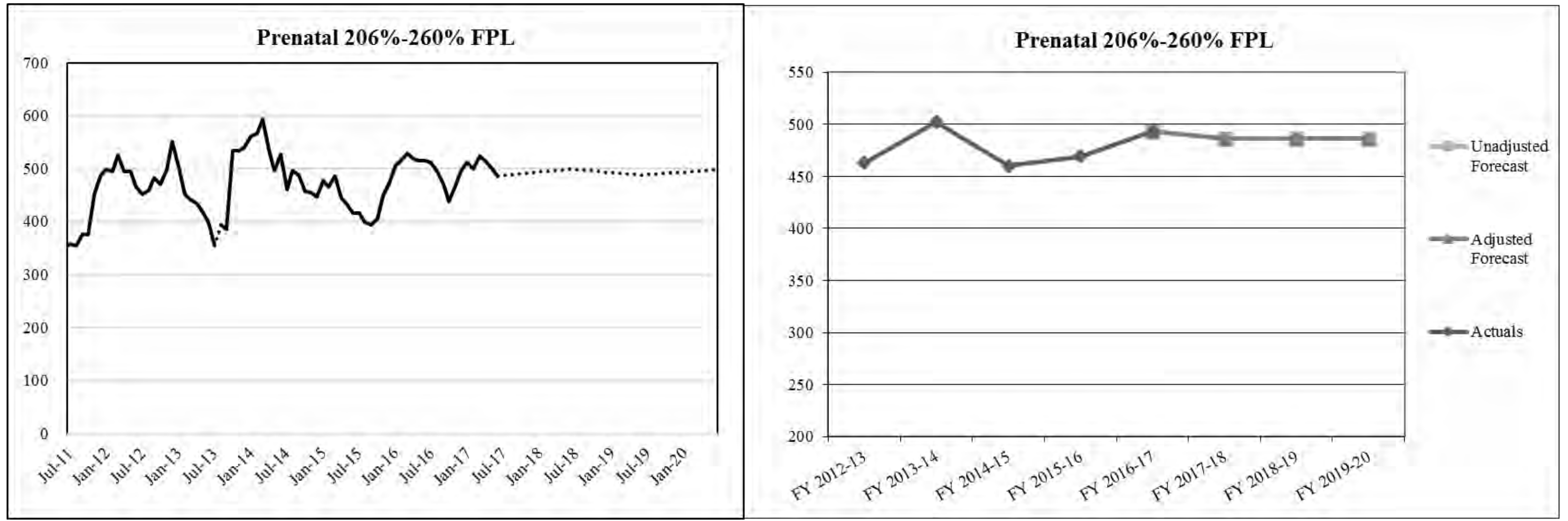
Actuals	Monthly Change	% Change
6-month average	13	6.01%
12-month average	5	2.10%
18-month average	5	2.36%
24-month average	3	1.36%

February 2017 Projection Before Adjustments			
FY 2016-17	209	5.03%	10
FY 2017-18	209	0.00%	0
FY 2018-19	209	0.00%	0

HB 09-1353 Adjustment	
FY 2016-17	35
FY 2017-18	34
FY 2018-19	34

February 2017 Projection After Adjustments			
FY 2016-17	244	5.03%	45
FY 2017-18	243	0.00%	(1)
FY 2018-19	243	0.00%	0

Monthly Average Growth Comparisons		
February 2017 Forecast	10	0
FY 2016-17 Actuals	5	2.10%
FY 2016-17 1st Half	(4)	-1.81%
FY 2016-17 2nd Half	13	6.01%
FY 2017-18 Forecast	0	0.11%
February 2017 Forecast	(13)	(0)
FY 2018-19 Forecast	(0)	-0.09%
February 2017 Forecast	13	0



- Monthly caseload for June 2017 for CHP+ Prenatal 206%-260% FPL was 486, which was lower than what was forecasted in the February 2017 forecast by 93 clients. If caseload for this group remained at this level for FY 2017-18 caseload would grow by roughly -1.42%. from year to year. The Department does expect caseload to remain constant in FY 2017-18, projecting the final FY 2017-18 average monthly caseload of 486. The Department expects caseload in FY 2018-19 and FY 2019-20 to remain flat.

- 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.

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

	Actuals	Monthly Change	% Change
Jun-15	416	-	-
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%
Jul-16	512	(2)	-0.39%
Aug-16	494	(18)	-3.52%
Sep-16	471	(23)	-4.66%
Oct-16	438	(33)	-7.01%
Nov-16	467	29	6.62%
Dec-16	497	30	6.42%
Jan-17	512	15	3.02%
Feb-17	500	(12)	-2.34%
Mar-17	523	23	4.60%
Apr-17	515	(8)	-1.53%
May-17	502	(13)	-2.52%
Jun-17	486	(16)	-3.19%

February 2017 Forecast	
Forecasted June 2017 Level	579

Base trend from June 2017 level			
FY 2017-18	486	0.00%	0

	Caseload	% Change	Level Change
FY 2010-11	272		
FY 2011-12	448		
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	493	5.12%	24
FY 2017-18	486	-1.42%	(7)
FY 2018-19	486	0.00%	0
FY 2019-20	486	0.00%	0

HB 09-1353 Adjustment	
FY 2016-17	0
FY 2017-18	0
FY 2018-19	0
FY 2019-20	0

November 2017 Projections After Adjustments			
FY 2016-17	493	5.12%	24
FY 2017-18	486	-1.42%	(7)
FY 2018-19	486	0.00%	-
FY 2019-20	486	0.00%	-

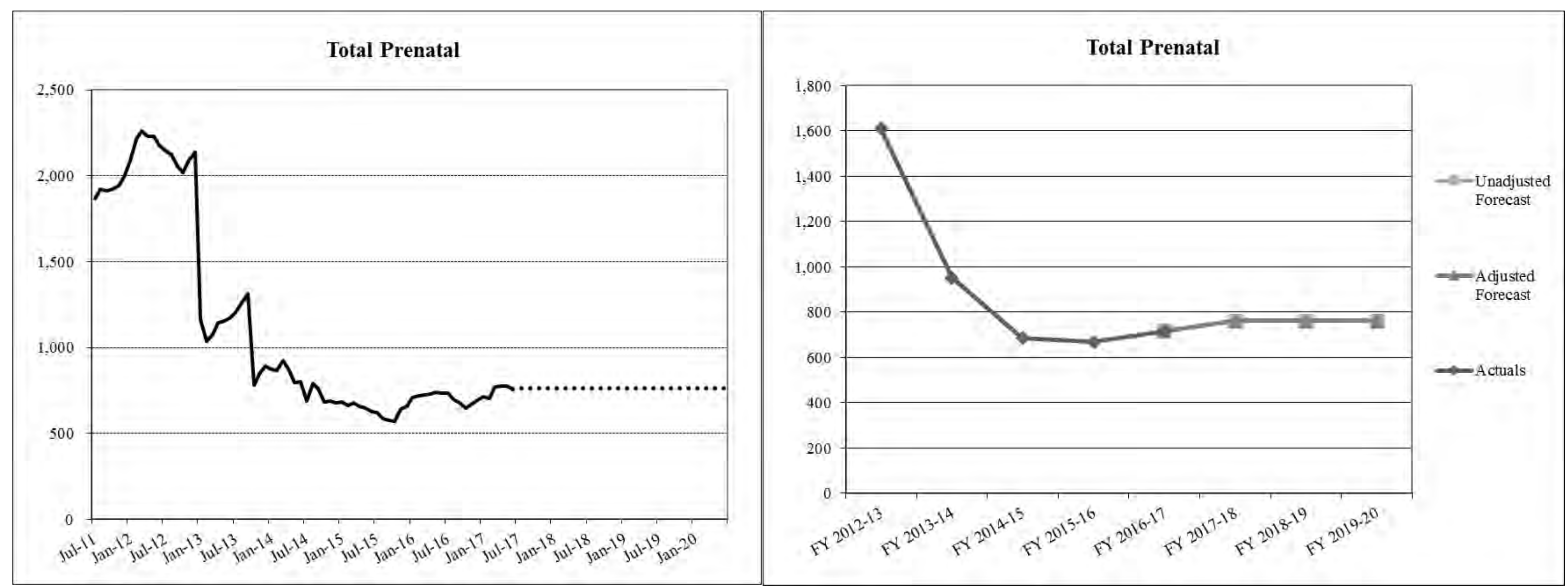
Actuals	Monthly Change	% Change
6-month average	(2)	-0.33%
12-month average	(2)	-0.37%
18-month average	1	0.24%
24-month average	3	0.74%

February 2017 Projection Before Adjustments			
FY 2016-17	488	4.05%	19
FY 2017-18	488	0.00%	0
FY 2018-19	488	0.00%	0

HB 09-1353 Adjustment	
FY 2016-17	61
FY 2017-18	61
FY 2018-19	61

February 2017 Projection After Adjustments			
FY 2016-17	549	17.06%	80
FY 2017-18	549	0.00%	0
FY 2018-19	549	0.00%	0

Monthly Average Growth Comparisons		
February 2017 Forecast	5	0.99%
FY 2016-17 Actuals	(2)	-0.37%
FY 2016-17 1st Half	(3)	-0.42%
FY 2016-17 2nd Half	(2)	-0.33%
FY 2017-18 Forecast	0	0.00%
February 2017 Forecast	(5)	-0.82%
FY 2018-19 Forecast	(0)	0.00%
FY 2017-18 Forecast	4	0.71%



Monthly caseload for June 2017 for CHP+ Prenatal 0%-260% FPL was 761, which was lower than what was forecasted in the February 2017 forecast by 82 clients. If caseload for this group remained at this level for FY 2017-18 caseload would grow by roughly 5.99%. from year to year. The Department does expect minimal additional growth in FY 2017-18 beyond the baseline, projecting the final FY 2017-18 average monthly caseload of 762, or an increase of 6.27% over FY 2016-17. The Department expects caseload in FY 2018-19 and FY 2019-20 to remain flat.

Total Prenatal: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-15	626	-	-
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%
Jul-16	736	2	0.27%
Aug-16	697	(39)	-5.30%
Sep-16	676	(21)	-3.01%
Oct-16	648	(28)	-4.14%
Nov-16	666	18	2.78%
Dec-16	693	27	4.05%
Jan-17	714	21	3.03%
Feb-17	706	(8)	-1.12%
Mar-17	771	65	9.21%
Apr-17	776	5	0.65%
May-17	778	2	0.26%
Jun-17	761	(17)	-2.19%

February 2017 Forecast	
Forecasted June 2017 Level	843

Base trend from June 2017 level			
FY 2017-18	761	5.99%	43

	Caseload	% Change	Level Change
FY 2009-10	1,561		
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	718	7.49%	50
FY 2017-18	762	6.13%	44
FY 2018-19	762	0.00%	0
FY 2019-20	762	0.00%	0

HB 09-1353 Adjustment	
FY 2016-17	-
FY 2017-18	-
FY 2018-19	-
FY 2019-20	-

November 2017 Projections After Adjustments			
FY 2016-17	718	7.49%	50
FY 2017-18	762	6.27%	44
FY 2018-19	762	0.00%	-
FY 2019-20	762	0.00%	-

Actuals	Monthly Change	% Change
6-month average	11	1.64%
12-month average	2	0.37%
18-month average	6	0.87%
24-month average	6	0.90%

February 2017 Projection Before Adjustments			
FY 2016-17	697	4.34%	29
FY 2017-18	697	0.00%	0
FY 2018-19	697	0.00%	0

HB 09-1353 Adjustment	
FY 2016-17	96
FY 2017-18	95
FY 2018-19	95

February 2017 Projection After Adjustments			
FY 2016-17	793	9.58%	125
FY 2017-18	792	3.55%	(1)
FY 2018-19	792	0.00%	-

Monthly Average Growth Comparisons		
February 2017 Forecast	9	1.16%
FY 2016-17 Actuals	2	0.37%
FY 2016-17 1st Half	(7)	-0.89%
FY 2016-17 2nd Half	11	1.64%
FY 2017-18 Forecast	0	0.01%
February 2017 Forecast	(4)	-0.98%
FY 2018-19 Forecast	(0)	-0.02%
February 2017 Forecast	7	0.84%

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	Healthcare Affordability and Sustainability 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 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title	**R-01 Medical Services Premiums**

Dept. Approval By: 11/1/17

OSPB Approval By:

___ **Supplemental FY 2017-18**

X **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$7,597,898,847	$0	$7,538,955,686	$207,602,061	$495,822,939
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	$58,177,064	$202,206,616
	CF	$886,165,101	$0	$884,043,394	$35,704,415	$56,665,000
	RF	$70,552,476	$0	$70,368,612	($79,627)	($79,627)
	FF	$4,548,653,004	$0	$4,507,666,920	$113,800,209	$237,030,950

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
02. Medical Services Premiums -- Medical Services Premiums	Total	$7,597,898,847	$0	$7,538,955,686	$207,602,061	$495,822,939
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	$58,177,064	$202,206,616
	CF	$886,165,101	$0	$884,043,394	$35,704,415	$56,665,000
	RF	$70,552,476	$0	$70,368,612	($79,627)	($79,627)
	FF	$4,548,653,004	$0	$4,507,666,920	$113,800,209	$237,030,950

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 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

Department of Health Care Policy and Financing
Medical Services Premiums

FY 2017-18, FY 2018-19, and FY 2019-20 Budget Request

November 2017

TABLE OF CONTENTS

TABLE OF CONTENTS ..... *II*

MAJOR FORECAST CHANGES *1*

I. BACKGROUND *2*

II. MEDICAID CASELOAD *5*

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS *5*

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS *8*

Exhibit A - Calculation of Total Request and Fund Splits **8**
Summary of Request 8
Calculation of Fund Splits 11
Exhibit B - Medicaid Caseload Projection **19**
Exhibit C - History and Projections of Per capita Costs **19**
Exhibit D - Cash Funds Report **20**
Exhibit E - Summary of Premium Request By Service Group **20**
Summary of Total Requested Expenditure by Service Group 20
Comparison of November 2017 Request to FY 2017-18 Appropriation and FY 2018-19 Base Spending Authority 20
Exhibit F - Acute Care **20**
Calculation of Acute Care Expenditure 20
Breast and Cervical Cancer Program Per Capita Detail and Fund Splits 28
Adult Dental Cash Fund-eligible Per Capita Detail 28
Antipsychotic Drugs 29
Family Planning - Calculation of Enhanced Federal Match 30
Indian Health Service 30
Expenditure by Half-Year 31
Exhibit G - Community-Based Long-Term Care **31**
Calculation of Community-Based Long-Term Care Waiver Expenditure 32
Prior-Year Expenditure 33
Hospice 41
Private Duty Nursing 43
Long-Term Home Health 47

Colorado Choice Transitions 53
Exhibit H - Long-Term Care And Insurance Services 54
Summary of Long-Term Care and Insurance Request 54
Class I Nursing Facilities 54
Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category 62
Class II Nursing Facilities 62
Program of All-Inclusive Care for the Elderly (PACE) 63
Supplemental Medicare Insurance Benefit (SMIB) 65
Health Insurance Buy-In (HIBI) 67
Exhibit I - Service Management 68
Summary of Service Management 68
Single Entry Points 68
Disease Management 70
Accountable Care Collaborative 70
Prepaid Inpatient Health Plan Administration 73
Exhibit J - Healthcare Affordability and Sustainability Fee Funded Populations 73
Summary of Cash Funded Expansion Populations 73
Healthcare Affordability and Sustainability Fee Fund 73
Medicaid Buy-in Fund 75
Hospital Supplemental Payments 75
Cash Fund Financing 76
Exhibit K - Upper Payment Limit Financing 76
Exhibit L - Department Recoveries 77
Exhibit M - Cash-Based Actuals 77
Exhibit N - Expenditure History by Service Category 78
Exhibit O - Comparison Of Budget Requests And Appropriations 78
Exhibit P - Global Reasonableness 78
Exhibit Q - Title XIX and Title XXI Total Cost of Care 78
Exhibit R - Federal Medical Assistance Percentage (FMAP) 79

V. ADDITIONAL CALCULATION CONSIDERATIONS 80

New Legislation and Impacts from FY 2017-18 Budget Cycle Requests 80
Prior-Year Legislation, Impacts from Previous Budget Cycles, and Other Adjustments 82

MAJOR FORECAST CHANGES

- Acute Care – The current request is approximately $388.6 million over the February request in total funds. The $388.6 million increase consists of a $264.9 million increase in federal funds and an increase of $115.9 million General Fund compared to the February request. The increases are driven by a $427.5 million total funds increase ($344.5 million federal funds and $71.7 million General Fund) due to FY 2016-17 payments that have been delayed to FY 2017-18 in the new Medicaid Management Information System (MMIS) and an overpayment of drug rebates in FY 2016-17 that the Department anticipates will be recouped in FY 2017-18. The remaining difference between the requests is a decrease of $40 million total funds, consisting of a decrease of $27.4 million federal funds and a decrease of $9 million General Fund from the February request. The decreases in federal funds are primarily driven by changes in caseload expectations for the MAGI Adults population (a decrease of 9,362, or 2.4%), offset by an increase in caseload expectations for the MAGI Parents/Caretakers to 133% FPL population (of 10,264, or 12.7%), a reduction in estimated utilization of behavioral therapies for autism under the State Plan, and an increase in the Affordable Care Act Drug Rebate Offset, which refunds CMS 100% of rebate increases attributable to the Affordable Care Act's changes in rebate calculations. The decreases in General Fund are driven by changes in caseload expectations for the Disabled Individuals to 59 (AND/AB) population (a decrease of 1,342 or 2.0%), the MAGI Parents/Caretakers to 68% population (a decrease of 3,846 or 2.0%), the MAGI Eligible Children population (a decrease of 12,979 or 2.8%), and the MAGI Pregnant Adults population (a decrease of 2,702 or 23.6%), offset by an increase in the Adults 65 and Older (OAP-A) population (increase of 1,098 or 2.4%). The reduction in estimated utilization of behavioral therapies for autism under the State Plan also accounts for the decrease in requested General Fund.
- Community-Based Long-Term Care – The current request is approximately $777 thousand below the February request. The slight decrease is primarily due to a decrease in Private Duty Nursing (PDN) and Long-Term Home Health (LTHH) average monthly utilizers compared to the February expectations, which is leveled out by an increased in PDN and LTHH utilization and cost per client due to the rate increase. This decrease was dampened by an increase in utilization for PDN and LTHH and the targeted and across the board rate increases that occurred in PDN and LTHH. The forecast for LTSS waivers remained stable and close to the previous forecast with almost all the difference coming from the targeted and across the board rate increases.

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. The Department's request identifies, and in some cases amends, the fiscal impact of various State and federal policy 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.

2. 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 94.5% FMAP in FY 2017-18, a 93.5% FMAP in FY 2018-19, and a 91.5% FMAP in FY 2019-20 as the federal match for these populations falls from 95% to 94% in January 2018, 93% in January 2019, and 90% in January 2020. 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 through September 30, 2019; the enhanced FMAP is expected to be 88.0% in FY 2017-18 and FY 2018-19, and 70.75% in FY 2019-20.

3. 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 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.

4. The State's FMAP for Medicaid services will decrease from 50.02% to 50.00% beginning October 1, 2017. With the new FMAP of 50.00% beginning October 2017, FMAP for FY 2017-18 will be 50.02% for the first quarter and 50.00% for the latter three quarters, resulting in an effective FMAP of 50.00% 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 2018-19 and FY 2019-20, 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 50.00% Federal Financial Participation (FFP). 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.

5. 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 December 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 2016-17 actuals may change in the next request. The Department does not expect major changes to FY 2016-17 actuals. The FY 2016-17 actuals contained within this request reflect data for FY 2016-17 as of August 15, 2017.

6. The Department launched its new Medicaid Management Information System (MMIS), InterChange, on March 1, 2017. Some provider payments were delayed while the Department and providers navigated the new system. The Department estimates that approximately $381.7 million in payments were from FY 2016-17 to FY 2017-18.

7. In FY 2016-17, the Department overcollected approximately $56 million in drug rebates. The Department anticipates that FY 2017-18 drug rebate payments from manufacturers will be less to account for the overcollection in the previous fiscal year.

8. The Department provided descriptions of any federal sanctions or potential sanctions for state activities of which the Department is already aware in its hearing responses on December 14, 2016. The following items are new or have updated information since that submission.

    - 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. The Department appealed the decision and CMS filed a response to the appeal stating that it has not yet issued a final agency decision and therefore the DAB does not have jurisdiction. The Department did not contest that decision.

- 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 Department requested reconsideration of the disallowance with the Secretary of the U.S. Department of Health and Human Services and the request for reconsideration was denied. Following this denial, the Department returned the disallowed federal funds and the matter is now closed. Because the Department retains a portion of the federal funds drawn under this program for administrative expenses, the Department repaid the disallowed funds from its reserves with no impact to participating school districts or the General Fund.

- OIG performed an audit on the Department and issued a report entitled Colorado Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs. The audit identified physician-administered drug claims which had been billed without a National Drug Code (NDC) number. As a result, the Department did not invoice manufacturers for drug rebates on those claims. The Department agreed to work with CMS to determine and refund the unallowable portion of $8,137,597 in federal share for those claims. The Department worked with Magellan Medicaid Administration (Magellan) to identify the applicable NDC numbers when possible and invoice manufacturers for the related drug rebates. Because the applicable NDC number could not be identified for many of the claims, the Department worked with CMS to return $6,420,952 in FFP in FY 2016-17.

- As allowed under federal regulations, the Department reimburses hospital providers that help enroll eligible Coloradans into the Medicaid program, referred to as outstationed eligibility services or outstationing. Recently, the Centers for Medicare and Medicaid Services (CMS) raised questions about the Department's outstationing payments made to

hospitals over the last 5 years. The Department has suspended current payments while it works to address CMS's questions. No deferral or disallowance of federal funds has been received to date.

- In November 2016 OIG conducted an audit of Medicaid's Targeted Case Management (TCM) program. The objective of the audit was to determine whether the Department's Medicaid payments for TCM services were in accordance with Federal and State requirements. The audit period reviewed was from October 2013 to September 2015. In the Exit Conference held August 14, 2017, OIG informed the Department that there would be findings totaling approximately $44 million in overpayments of federal funds. OIG's audit report is expected to be released sometime in October 2017.

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 the caseload forecast is complete, 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 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 expenditure data 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 that 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:

- Healthcare Affordability and Sustainability 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 expenditure 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% and then ramped down each year until it returned to 50.00% beginning October 1, 2017. For more information about historic FMAP and FMAP changes, see Exhibit R.

Certain populations and services receive different FMAPs than the new standard 50.00% that begins October 2017, summarized in the table below. Clients who transitioned from CHP+ to Medicaid under SB 11-008 and SB 11-250 receive the CHP+ FMAP, which is approximately 65%. Section 2105(b) of the Social Security Act further modifies the enhanced FMAP for CHP+ clients, including clients who transitioned from CHP+ to Medicaid and are funded under Title XXI, by an additional 23 percentage points, effective October 1, 2015 through September 30, 2019. Therefore, FMAP for clients who transitioned from CHP+ to Medicaid receive 88.00% FMAP in FY 2017-18 and FY 2018-19, and 70.75% FMAP in FY 2019-20 when the additional 23 percentage points ends. Clients in the BCCP program also receive a 65% match. Since the FMAP decrease to 50% occurs at the start of the second quarter of FY 2017-18, the FMAP would be 50.02% for quarter one and 50% for the remainder of the year, resulting in a final FMAP of approximately 50% for FY 2017-18. This logic is applied to the populations receiving 65.01% for quarter one and 65% the remainder of the fiscal year, resulting in a final FMAP of 65% for FY 2017-18. The expansion populations, MAGI Parents/Caretakers 69% to 133% and MAGI Adults, receive a match of 95% beginning January 1, 2017, though this falls to 94% beginning January 1, 2018, resulting in a final FMAP of 94.50% for these populations for FY 2017-18. The match for this population falls again to 93% beginning January 1, 2019, resulting in a final FMAP of 93.50% for these populations for FY 2018-19, and falls to 90% beginning January 1, 2020, resulting in a final FMAP of 91.50% for FY 2019-20. 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 83.38%, 82.63%, and 81.13% for FY 2017-18, FY 2018-19, and FY 2019-20 respectively. The Disabled Buy-In population receives the standard match for expenditure net of patient premiums.

Calculation of expenditure by financing type can be found in Exhibit A and calculation of FMAP can be found in Exhibit R.

Population-Based FMAPs			
Fiscal Year	**FMAP**	**Population(s)**	**Comments**
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	HAS 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	HAS Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%
FY 2019-20	70.75%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.00%	Clients in the BCCP Program	Please see Exhibit F
	91.50%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	81.13%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.00%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	HAS Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%

Service-Based FMAPs			
Fiscal Year	**FMAP**	**Service**	**Comments**
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
FY 2019-20	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. However, the following programs are paid for using different funding mechanisms:

- Breast and Cervical Cancer Program: This program typically receives a 65.00% FMAP. 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 expenditure. 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). FMAP for these clients remains at the same level as if the clients had enrolled in Children's Basic Health Plan (CHP+) instead of Medicaid, or 65%. 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 2017-18, FY 2018-19, and FY 2019-20 is expected to be 88.00%, 88.00%, and 70.75% 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. 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 2017-18, FY 2018-19, and FY 2019-20 is expected to be 88.00%, 88.00%, and 70.75% respectively.

- MAGI Parents/Caretakers 69% to 133% FPL: This population began participation in Medicaid in FY 2009-10 and is funded with a combination of federal funds and HAS Fee. 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, with ramp down every year until it reaches 90% effective January 1, 2020. 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 HAS 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 with ramp down every year until it reaches 90% effective January 1, 2020. 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 HAS 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: HAS Fee, premiums paid by clients, and federal funds. While the program receives federal match on the HAS 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 HAS 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 HAS Fee, as required by statute. The Department can claim 75% of the expenditure 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 HAS 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 HAS 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 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 for FY 2016-17 only, at a lower rate than the original increase and for select primary care procedures. This accounts for the impact of claims runout for the rate increases that are paid for with the Primary Care Provider Sustainability Fund. 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 accounts 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 5.0% receives 100% FFP. These assumptions are held constant in FY 2017-18, 2018-19, and in FY 2019-20.

- 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.

- Upper Payment Limit Financing: Offsets General Fund as a bottom-line adjustment to total expenditure. 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 expenditure in excess of the current reimbursement methodology. Prior to FY 2017-18, these payments were made with certified public expenditure. Going forward, these payments are to be made with General Fund; however, the Department is currently pursuing approval of the new payment model from CMS and cannot change payment methods without that approval. The Department anticipates the State share of these payments to be fully General Funded with federal financial participation starting in FY 2017-18, dependent upon CMS approval. Recently, CMS raised questions about the Department's outstationing payments made to hospitals over the last five years. The Department has suspended current payments as it works to address CMS's questions. No deferral or disallowance of federal funds has been received to date. The FY 2017-18, FY 2018-19, and FY 2019-20 estimates each account for one calendar year of payments under the new methodology using random moment time study (RMTS) methods.

- Hospital Supplemental Payments: Hospital payments are increased for Medicaid hospital services through a total of five supplemental payments, three 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 payments is to increase hospital reimbursement payments for Medicaid inpatient and outpatient care, up to a maximum of the federal Upper Payment Limit (UPL), and to create hospital quality incentive payments that reward hospitals for enhanced quality, health outcomes and cost effectiveness.

- 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 2017-18, FY 2018-19, and FY 2019-20 totals are based on the total amounts Denver Health and Memorial Health Systems were able to certify in prior fiscal years.

- 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. It has not met the requirements to receive this supplemental payment in the last few fiscal years, however it did qualify in FY 2016-17. The Department assumes Memorial Hospital will continue to meet the criteria to receive this supplemental payment in the current year, request year and out year.

- 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. The FY 2017-18, FY 2018-19, and FY 2019-20 estimates are based on the Legislative Council's Amendment 35 revenue forecasts.

- 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 State Plan Amendment (SPA) associated with this program has been approved by CMS and the Department anticipates payments to begin in FY 2017-18.

- 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 2017-18, FY 2018-19, and FY 2019-20 totals are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.

- University of Colorado School of Medicine Payment: As one of the initiatives under SB 17-254, the Colorado Legislature approved a transfer of $61.9 million funds from the University of Colorado School of Medicine (UCSOM) to the Department beginning in FY 2017-18, in order to gain access to federal matching funds. The Department then would reimburse UCSOM approximately $123 million through a UPL payment for physician services.

- Payment Delays from Implementation of InterChange – Financing Impact: This adjustment consists of three different impacts, described below.

    - When the Department implemented the new Medicaid Management Information System (MMIS), InterChange, on March 1, 2017, some payments became difficult to identify and it was necessary to update the financial coding elements. For this reason, some services were paid at standard FMAP through interim payments to providers. When the claims associated with these services process through the financial system, they will process at the correct FMAP associated with the claims, depending on population and service criteria, and the interim payments will be backed out. Therefore, there will be an FMAP adjustment in FY 2017-18, when the standard FMAP interim payments are reversed and the claims are processed at a higher average FMAP, due to populations such as Medicaid expansion.

- The Department collected more drug rebates than anticipated in FY 2016-17, in part due to the overcollection issue described in the Background section. The drug rebates were collected at a higher FMAP percentage on average than acute services overall. Therefore, any reduction to drug rebates in FY 2017-18 that occur as a result of the overcollection in FY 2016-17 will impact federal funds at a higher rate than would otherwise be estimated as part of the acute care forecast.

- This item also contains interim payments for the Division of Intellectual and Developmental Disabilities (DIDD) waivers, which cannot currently be separately identified from Long-term Services and Supports (LTSS) waivers. When these claims appropriately process and the interim payment is reversed, the Department anticipates that approximately $9 million will move from Medical Services Premiums to the various DIDD appropriations under the Office of Community Living.

- 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 comes 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 2017-18, FY 2018-19, and FY 2019-20.

Cash and Reappropriated Funds	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Tobacco Tax Cash Fund (SB 11-210)	$2,201,700	$2,201,700	$2,201,700
Healthcare Affordability and Sustainability 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)	$9,031,044	$8,951,417	$8,951,417
Service Fee Fund (SB 13-167)	$200,460	$200,460	$200,460
Total	**$27,133,204**	**$27,053,577**	**$27,053,577**

Exhibit B - Medicaid Caseload Projection

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1997-98 through FY 2019-20. 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 2008-09 through FY 2016-17.

A description of the forecasting methodology for Medicaid caseload, including all adjustments, is 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, expenditure 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. This expenditure is 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. This expenditure is 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 2017 Request to FY 2017-18 Appropriation and FY 2018-19 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 2017 Budget Request to the Department's Long Bill plus Special Bills appropriation for FY 2017-18, as well as the November 2017 Budget Request and the Department's base spending authority for FY 2018-19. 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 expenditure 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 considering 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 Department used FY 2017-18 base per capita figures from the February 15, 2017 request instead of selecting trends to modify the FY 2016-17 per capita costs to calculate the FY 2017-18 base per capita costs. Due to payment delays as a result of transitioning to the interChange payment system, the per capita costs reported in FY 2016-17 are overall artificially low and any trends applied to the FY 2016-17 per capita costs would need to be artificially high to return the FY 2017-18 base per capita costs to expected levels. To account for the FY 2016-17 service payments that will be made in FY 2017-18, the Department incorporated a bottom line adjustment into the FY 2017-18 acute forecast; please refer to "Payment Delays from Implementation of interChange" in the section on bottom line adjustment for more detail. The FY 2018-19 and FY 2019-20 base per capita costs are estimated using the standard trend selection methodology used in previous requests. In order to remove the artificial inflation of the FY 2017-18 final per capita caused by the bottom line impact accounting for the additional payments that will be made in FY 2017-18, the Department calculated placeholder per capita figures that exclude the "Payment Delays from Implementation of interChange" and "Repay Overcollection of Drug Rebates in FY 2016-17" bottom line impacts. The selected FY 2018-19 trends are then applied to these placeholder per capita costs.

The table below describes the trend selections for FY 2017-18, FY 2018-19, and FY 2019-20. The Department held FY 2018-19 trends from the February 15, 2017 request constant into FY 2019-20. The Department determined it could not reasonably estimate updated trends based on incomplete payments in FY 2016-17.

The selected trend factors for FY 2017-18, FY 2018-19, and FY 2019-20 with the rationale for selection, are as follows:

Aid Category	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	FY 2019-20 Trend Selection	Justification
Adults 65 and Older (OAP-A)	No Trend	2.00%	2.00%	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)	No Trend	1.00%	1.00%	The Department anticipates the per capita of this population will continue to grow at a moderate rate.
Disabled Individuals to 59 (AND/AB)	No Trend	0.30%	0.30%	The Department has selected a small positive trend for this population as the Department believes year over year growth will continue at low levels. The trend is driven primarily by increases in prescription drugs and inpatient hospital costs.
Disabled Buy-in	No Trend	1.00%	1.00%	The positive trend for this population is primarily driven by prescription drugs and inpatient hospital expenditure.
MAGI Parents/ Caretakers to 68% FPL	No Trend	-2.00%	-2.00%	The Department has selected a downward trend as per capita increases 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.

Aid Category	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	FY 2019-20 Trend Selection	Justification
MAGI Parents/ Caretakers 69% to 133% FPL	No Trend	0.00%	0.00%	The Department has selected a flat trend as per capita growth is expected to level out.
MAGI Adults	No Trend	0.00%	0.00%	The Department has flattened the trend for this population as caseload growth continues to level off.
Breast and Cervical Cancer Program	No Trend	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)	No Trend	0.50%	0.50%	The Department anticipates costs will stabilize for this population and continue to grow year-over-year at a low rate.
SB 11-008 Eligible Children	No Trend	0.00%	0.00%	The Department has selected a flat trend in anticipation of the per capita leveling out over time as the population stabilizes.
Foster Care	No Trend	0.82%	0.82%	The Department anticipates per capita costs will stabilize as the shifting caseload mix from expansion (former foster care ages 21-26) puts downward pressure on per capita. The positive trend is driven by prescription drugs and physician services.

Aid Category	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	FY 2019-20 Trend Selection	Justification
MAGI Pregnant Adults	No Trend	1.00%	1.00%	The Department anticipates small positive growth for this population.
SB 11-250 Eligible Pregnant Adults	No Trend	1.00%	1.00%	The trend for this category is tied to MAGI Pregnant Adults, as the Department assumes similar utilization within these populations.
Non-Citizens	No Trend	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.
Partial Dual Eligibles	No Trend	1.83%	1.83%	The Department has maintained the per capita growth trend for this population over FY 2018-19 and FY 2019-20. 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:

- Annualization of 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.

- SB 17-091, Allow Medicaid Home Health Services in the Community, formerly referred to as 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 demonstrated compliance with this rule starting July 1, 2017 through SB 17-091 which removed language from statute stipulating a home health services must be received "in the home."
- Annualization of 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 legacy MMIS was unable to take the 5% cap into consideration, causing some clients to pay over the cap. The new interChange system, implemented March 1, 2017, will prevent clients from paying copays that exceed 5% of their household income, and as a result, the Department needs to reimburse providers for the full cost of the service without subtracting copay for these clients.
- SB 17-267 Sustainability of Rural Colorado – Increased Copays, accounts for the decrease in the Department's payment for services due to collection of greater copays. SB 17-267 stipulates copays for pharmacy must be at least double the average amount paid by recipients in state fiscal year FY 2015-16 and copays for hospital outpatient services must be at least double the amount required to be paid as specified in Department rules as of January 1, 2017, subject to federal law.
- Annualization of 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).
- Annualization of 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.
- 2017 JBC Action: PT/OT Supplemental Footnote, allows members to receive more than 48-units of physical therapy or occupational therapy services with prior authorization. The adjustment accounts for reimbursement of services beyond the 48-units.
- Annualization of 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.
- R-6 (FY 2012-13), Dental Efficiency, reduces expenditure through refinement of Department policy regarding provision of orthodontics. Payment structure and clinical qualifying criteria for authorization are being evaluated and revised.
- SB 11-177, Annualization of Sunset Teen Pregnancy and Dropout Program, removes the Teen Pregnancy and Dropout Program from Acute Care when the program sunset on September 1, 2016.
- 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 costlier visits to the emergency room or physicians for over-the-counter prescriptions.

- Annualization of 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 expenditure due to the avoided dispensing fees that are more frequent when a client receives drugs in smaller quantities.
- Repay Overcollection of Drug Rebates in FY 2016-17, accounts for adjustments to FY 2017-18 drug rebate collections due to voided pharmacy claims from the legacy system being billed to drug manufacturers in FY 2016-17. The Department anticipates that it will receive less in drug rebates in FY 2017-18.
- FY 2017-18 R-7 Oversight of State Resources – Physician Administered Drugs, incorporates the impact of changing the reimbursement rates of physician administered drugs to an average of 2.5% over the average sales price (ASP) and the cost avoidance associated with members no longer needing to receive this service at higher cost outpatient facilities. Due to more competitive reimbursement in the physician setting, the Department anticipates patients will be matched to more appropriate drugs and less physicians will advise members to receive drugs in a hospital setting. The Department was able to implement this methodology earlier than anticipated on July 1, 2017.
- FY 2017-18 R-7 Oversight of State Resources – Client and Provider Investigations, accounts for the expected increase in recoveries due to hiring dedicated staff in the Department's Program Integrity section to investigate client and provider fraud.
- Annualization of 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, thereby increasing access to transportation and producing savings through increased access to preventive services through NEMT.
- Annualization of SB 10-167, Colorado False Claims Act increases enrollment in the Health Insurance Buy-In (HIBI) program. As of May 2017, there were 681 enrollees in the program. The Department expects to increase enrollment by approximately 2% per month through FY 2017-18.
- Annualization of 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.
- 2017 JBC Action: Community Provider Rate Increases (1.402% Across the Board), incorporates the acute care impact of the 1.402% across the board rate increases approved during the 2017 legislative session. Though the Department was not officially appropriated an amount for physician services that are not associated with codes that received a rate increase through HB 16-1408, the adjustment includes an estimated impact for these services. The rate increases are effective July 1, 2017, with the exception of rate increases to services provided under HCBS waivers. Rate increases associated with HCBS waivers are effective October 1, 2017 and are accounted for in Exhibit G.

- 2017 JBC Action: Targeted Rate Increase – Transportation, accounts for a 7.01% targeted rate increase to transportation services, including emergency transportation, non-emergency transportation, and non-medical transportation offered under HCBS waivers. The rate increases are effective July 1, 2017, with the exception of rate increases to services provided under HCBS waivers. Rate increases associated with HCBS waivers are effective October 1, 2017 and are accounted for in Exhibit G.
- 2017 JBC Action: Targeted Rate Increase – Home Health, factors in targeted rate increases to acute home health services, including skilled nursing, physical therapy, occupational therapy, and speech therapy.
- 2017 JBC Action: Post-Partum Depression Screening, expands maternal depression screening to be billable three times in the first year postpartum under the child's Medicaid ID.
- Annualization of 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.
- Annualization of 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.
- Annualization of FY 2017-18 R-6 Delivery System and Payment Reform – EAPG Methodology, incorporates the impact of changing reimbursement methodologies for outpatient hospital. The Department adopted the Enhanced Ambulatory Patient Grouping (EAPG) system, a form of bundled payment, as of October 31, 2016.
- FY 2017-18 R-6 Delivery System and Payment Reform – Primary Care Increase Continuation, continues the primary provider rate increases approved in HB 16-1408.
- FY 2017-18 R-6 Delivery System and Payment Reform – Vaccine, accounts for a reduction to expenditure due to annually setting reimbursement rates for vaccine stock equal to the private sector cost based on the immunization list published by the Center for Disease Control and Prevention (CDC).
- HB 17-1353 Implement Medicaid Delivery & Payment Initiatives – Primary Care Incentives, incorporates the payment reform primary care incentives, which transitions the FY 2017-18 continuation of HB 16-1408's primary care rate increase into a primary care incentive payment tied to quality and performance metrics.
- HB 17-1353 Implement Medicaid Delivery & Payment Initiative – Substance Use Disorder (SUD) & Serious Persistent Mental Illness (SPMI) Savings through Integration of Care, accounts for estimated savings associated with integrating behavioral and physical health care, especially better care coordination for populations with substance use disorders and serious and persistent mental illnesses.
- Annualization of 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.
- Expiration of ACC Initiative: Kaiser-Access Health Maintenance Organization (HMO), moves expenditure related to clients enrolled in this HMO back to the regular ACC program with the expiration of this initiative. This has the effect of shifting expenditure from Acute Care to the ACC.

- FY 2017-18 Legislative Action – Elective Circumcisions, incorporates funding for elective circumcisions that was not previously appropriated through SB 17-254, Long Appropriations Bill.
- Payment Delays from Implementation of interChange, accounts for the Department's estimate of FY 2016-17 service payments in acute care that will need to be made in FY 2017-18 due to provider payment issues coinciding with implementation of the interChange. The Department estimates this amount to be $379 million.
- Additional Week 53 Pay Period in FY 2019-20, factors in an additional payment period in FY 2019-20. Payments are typically made on the Monday of each week and there are 53 Mondays in FY 2019-20.

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. All Breast and Cervical Cancer Program expenditure receives an enhanced federal match rate of approximately 65.00%. 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 was expanded to include ages 21 through 39, based on CDPHE's FY 2016-17 R-4 "Cervical Cancer Eligibility Expansion." This change did not have an impact of the anticipated magnitude, and the previous caseload adjustment for this policy change has now been removed as the policy change is incorporated into the trend.

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 Adult 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 the expenditure that will be funded by the Adult Dental Cash Fund.

The Department's February 2017 estimate for FY 2016-17 seemed consistent with actual expected expenditure, but reporting of expenditure may be artificially low due to the implementation of the interChange. As a result, the Department is using the estimate from the February request for FY 2017-18 and FY 2018-19, along with a similar trend in FY 2019-20.

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. This expenditure is 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. The Department cannot report totals for FY 2016-17 in the November 2017 request, due to identification issues for these services in the reporting layer of the new MMIS. The Department will update the actuals for FY 2016-17 in the February 2018 budget submission.

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 2016-17. The trend chosen to forecast rebates is based on the percent growth in prescription drugs between FY 2015-16 and FY 2016-17.

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 (CMS) for enhanced federal funds.

In FY 2016-17, the Department received more rebates attributed to Family Planning than it should have, as the result of a rebate payment error. As such, the Department's total expenditure is reported as a total net recovery, which is not an accurate reflection of actual expenditure. Therefore, the Department has kept the FY 2017-18 and FY 2018-19 estimates the same as in the February 2017 request, and has held the estimated FY 2018-19 growth constant in FY 2019-20.

Indian Health Service

In 1976, the Indian Health Care Improvement Act (PL 94-437) 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 American 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, but due to the implementation of the interChange, the FY 2016-17 data may be understated. Because of this, the Department has chosen to use estimates from the February 2017 request as a base in addition to the expected shift in expenditure from base acute care to Indian Health Services from better care coordination for this population, which will result in more expenditure claimed at the 100% federal match.

Expenditure by Half-Year

As an additional reasonability check, this section presents previous fiscal years' 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 per capita by six-month period can be quickly compared, and historic per capita costs may be referenced with page EF-1 of this request.

<u>EXHIBIT G - COMMUNITY-BASED LONG-TERM CARE</u>

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, the 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-LTSS waiver claims for an average of 24,994 clients per month. From July 2016 through the end of February 2017, the Department paid HCBS-LTSS waiver claims for an average of 26,089 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 HCBS waivers that are included in the Medical Services Premiums line item are administered under the Long-Term Services and Supports (LTSS) Division and referred to throughout this narrative as HCBS-LTSS waivers. The Persons Living with AIDS adult waiver is no longer active and clients were phased into the Elderly, Blind and Disabled waiver by the end of FY 2013-14. The waivers included in the Medical Services Premiums line item are:

- Elderly, Blind and Disabled Adult Waiver
- Community Mental Health Supports Adult Waiver[1]
- Disabled Children's Waiver
- Consumer Direct Attendant Support State Plan Waiver
- Brain Injury Adult Waiver
- Children with Autism Waiver

---

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

- Children with Life Limiting Illness Waiver[2]
- Spinal Cord Injury Adult Waiver[3]

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-LTSS 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 HCBS-LTSS 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 current 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-LTSS 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 that identified clients as being attributed to waivers. During FY 2014-15, the Department noticed that the enrollment was not trending with utilization and that clients reported as enrolled in some waivers were actually enrolled in other waivers based on their claims utilization. Thus, in FY 2015-16, the Department decided to depict waiver enrollment as the average number of clients per month with an active prior authorization (PAR) for services on each waiver since services under waivers cannot be rendered without an active PAR. Recent concerns with the consistency of the PAR data, however, has prompted the Department to return to using the steadier number of clients with paid claims per month measure for waiver enrollment for this forecast. While the Department works to identify and correct for the retroactive adjustment of PARs, the Department believes the number of paid claims is the most accurate depiction of waiver enrollment.

The selected enrollment and cost per enrollee trend factors for FY 2017-18, FY 2018-19, and FY 2019-20, with the rationale for selection, are below. In most cases, the Department kept the trends for both enrollment and cost per enrollee steady for each of the three years. In situations where trends differ each year, the variation is noted.

---

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

Prior-Year Expenditure

As an additional reasonability check, the Department has split historic actual expenditure into half-year increments to analyze the changing rates of expenditure over time.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Elderly, Blind and Disabled Waiver	FY 2017-18 through FY 2019-20: 2.93%	FY 2017-18 through FY 2019-20: 4.15%	Enrollment history is fairly steady, growing at an average of just under 5% each year. Recent growth has been slightly below historical averages, so the trend is lower and matches the previous forecast. Per enrollee cost history has grown at approximately 5% on average since FY 2008-09. Recent data has not shown a divergence from the previous forecast so the Department has maintained the previous forecast's trends.
Community Mental Health Supports Waiver (CMHS)	FY 2017-18: 6.60%, FY 2018-19 and FY 2019-20: 4.44%	FY 2017-18 through FY 2019-20: 3.35%	Enrollment growth is on a steady incline, growing at almost 6% per year. Growth in FY 2015-16 was just about 1% but growth in FY 2016-17 returned to historical behavior; therefore, the selected trend is similar to average historic annual growth. Recent per enrollee data has not changed since the last forecast, so the Department has kept the same trend, which is equal to the 4-year average growth rate.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Disabled Children's Waiver	FY 2017-18 through FY 2019-20: 13.39%, 9.17%, 9.17% respectively	FY 2017-18 through FY 2019-20: 10.93%, 3.10%, 3.10% respectively	Since the Department has made significant efforts to better manage clients waiting for enrollment, waiver enrollment has increased strongly since FY 2011-12. Recent enrollment has been higher than expected and growth has only slowed slightly. Growth in FY 2016-17 was over 15%, so the Department has applied the same enrollment trends from the previous forecast. 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. Growth of per enrollee costs has begun to slow slightly, and the Department has chosen a strong trend in FY 2017-18, but with lower growth for future years. Growth in future years is the same as the previous forecast.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Consumer Directed Attendant Support-State Plan	FY 2017-18 through FY 2019-20: 0.00%	FY 2017-18 through FY 2019-20: 0.00%	Additional enrollment in this program is currently prohibited. When CDASS becomes available on other 1915(c) waivers, members 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 many clients leaving for CDASS expansion under the Supported Living Services waiver, enrollment is expected to only be one client after FY 2019-20. The Department moved to a needs-based allocation plan in FY 2011-12 to align with the CDASS waiver benefit; interestingly, 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 was lower than previous estimates. The Department kept per enrollee costs at its current level for all years in the forecast. Reported per enrollee costs for FY 2016-17 were affected by billing issues related to the launch of the interChange system.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Brain Injury Waiver	FY 2017-18 through FY 2019-20: 10.15%, 3.23%, 3.23% respectively	FY 2017-18 through FY 2019-20: 3.70%, 1.72%, 1.72% respectively	Historically there has been slow and steady growth in BI enrollment. Growth increased rapidly in FY 2012-13 and has continued through the current year. Driven by an increase in providers and the number of beds available for the supported living program (SLP), the Department expects waiver enrollment to grow through the out-year. The trend for FY 2017-18 is the average of the previous two years of growth and future trends are the same as the previous forecast. Historic cost per enrollee growth has been just over 2.5% annually. FY 2016-17 saw greater growth in cost per enrollee than FY 2015-16, but still under predicted values. Therefore, the Department has kept the trends selected in the previous forecast.
Children with Autism Waiver	FY 2017-18 through FY 2018-19: 24.14%, 0%	FY 2017-18 through FY 2019-20: 0.00%	The waiver is set to expire December 31, 2018. The Department is currently working on a transition plan and, until finalized, has projected enrollment to continue through FY 2018-19. This is a temporary assumption that may be adjusted once the transition plan is approved by CMS. The Department used current waitlist data to forecast FY 2017-18 enrollment and added a bottom line enrollment adjustment to demonstrate the sunset of the waiver; therefore, there is no enrollment trend for FY 2019-20. Average cost per enrollee had been on a downward trend since FY 2009-10, but per enrollee cost grew over 26% in FY 2016-17. The Department does not anticipate utilization to change between now and the end of the waiver so it has chosen a flat trend.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Children with Life Limiting Illness Waiver	FY 2017-18 through FY 2019-20: 9.63%, 10.14%, 11.04% respectively	FY 2017-18 through FY 2019-20: 2.42%	Waiver programmatic changes have improved the program, resulting in large growth. After a slight downturn, enrollment growth returned to a high level and grew at just over 20% through the first eight months of FY 2016-17. Enrollment is expected to increase as more providers become aware of recent rate increases and programmatic changes that were fully implemented in FY 2015-16. The Department continues to see strong growth in enrollment for this waiver, which is reflected through higher growth trends than the previous forecast. Cost per enrollee growth has been sporadic but positive for most of the duration of the waiver. Programmatic changes have been fully implemented and the Department has selected a modest growth trend for future years.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Spinal Cord Injury Adult Waiver	FY 2017-18 through FY 2019-20: 0.00%	FY 2017-18 through FY 2019-20: 3.68%, 1.84%, 1.84% respectively	Senate Bill 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine" reauthorized 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 all years, the Department adjusts enrollment through the bottom line impact of Senate Bill 15-011 instead of through the enrollment growth trend. The trend in per enrollee 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 to allow more providers to enroll to better serve the SCI waiver population. The Department believes the previous forecast offers realistic growth for per enrollee cost and has decided to keep those trends.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-enrollee 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:

<u>Expenditure</u>

- 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 increased enrollment expectations which also increased the cumulative nursing facility cost avoidance from the February request.
- 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 2019-20 costs to CLTBC result from reassessing a sample of Long-Term Services and Supports (LTSS) 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 LTSS member 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), to be implemented no later than three months after receiving federal approval. The Department initially assumed it would be able to begin enrolling HCBS-SLS, HCBS-BI, and HCBS-SCI clients into the Buy-In program on July 1, 2017. However, this program was implemented March 1, 2017. In FY 2017-18 and beyond, there will be a mix of existing HCBS-BI and HCBS-SCI clients transitioning into the Buy-In program for the respective waivers.
- FY 2017-18 Non-Medical Transportation 7.01% Targeted Rate Increase: The Joint Budget Committee approved a 7.01% rate increase to Non-Medical Transportation providers, which is a service in the Elderly, Blind, and Disabled, Community Mental Health Supports, Brain Injury, and Spinal Cord Injury waivers. The rate increase is effective October 1, 2017.
- FY 2017-18 Homemaker and Personal Care $0.50 Hourly Rate Increase: The Joint Budget Committee approved these targeted rate increases effective October 1, 2017, to raise the hourly rate by $0.50 for all Homemaker and Personal Care services.

- FY 2017-18 Across the Board 1.402% Rate Increase: The Joint Budget Committee approved a 1.402% across the board rate increase, to be effective October 1, 2017 for the CBLTC waivers. The rate increase applies to all waiver services provided through CBLTC waivers.
- interChange Payment Lag Adjustment: The Department has included an expenditure bottom line impact to adjust for interim payments made after the launch of interChange. Due to billing issues, the Department issued interim payments to providers to assist providers when they were not able to get paid due to system issues. This bottom line impact occurs only in FY 2017-18 and represents estimated expenditure for claims affected by billing issues associated with the launch of interChange.
- Children with Autism Waiver Run out: The Children with Autism waiver is set to expire December 31, 2018. The bottom line impact accounts for two months of claims run out after the end of the waiver.

Hospice

Hospice expenditure for FY 2017-18, FY 2018-19, and FY 2019-20 is forecasted as the sum of two primary categories of services. The first – Nursing Facility Room and Board expenditure – is expenses incurred on a per-diem basis for clients receiving hospice services in a full-time capacity at a nursing facility. This expenditure represents approximately 70% of total hospice expenditure in FY 2016-17. 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 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 expenditure for hospice clients mirrors the Class I Nursing Facility forecast.

Hospice nursing facility room and board total expenditure estimates for a particular fiscal year are the product of forecasted patient days and forecasted room and board per diem, with additional bottom-line impact adjustments made for rate cuts applied to claims paid that were incurred in the previous fiscal year. 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 an autoregressive model with monthly control variables to estimate FY 2017-18 patient days; this removed 3,316 patient days to the fiscal year relative to the February 2017 forecast. The assumed growth rate for patient days in FY 2018-19 and FY 2019-20 remains at the February 2017 forecast level of 0.96%. This trend estimate assumes patient days will 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 roughly the same 3% per-year rate[4]. The Department assumed a slightly higher growth rate at 4.94% for FY 2017-18 based on FY 2016-17 actual rates. 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.

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 or three times per week, generally by nurses. In FY 2016-17, Hospice Routine Home Care expenditure was approximately $11.9 million and thus represented 78% 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 2016-17 by 1.50% for FY 7-18, FY 2018-19, and FY 2019-20; the trends were selected with the assumption that patient days would remain at about this level over time. The Hospice Routine Home Care per diem is forecasted by applying approximately a 1.80% trend to daily rates in FY 2016-17. This 1.80% trend was selected based on previous CMS hospice rate increases. Starting on January 1, 2016, the Department was instructed by CMS to implement a tiered rate system for Routine Home Care Services. [5] Patient days incurred in the first sixty days of service are billed a higher rate than days incurred beyond the sixty-day threshold.

The next-largest component of hospice services expenditure is Hospice General Inpatient Care. This expenditure is incurred for services provided to hospice patients at inpatient facilities under severe circumstances. In FY 2016-17, the Department paid approximately $2.3 million for Hospice General Inpatient Care. The Department estimated FY 2017-18, FY 2018-19, and FY 2019-20 service costs by forecasting its rates and patient days. Patient days are estimated to grow at a moderate rate of 2.46% based on actual patient days in FY 2016-17, and rates were estimated by applying a 1.32% trend (growth in rates between FY 2015-16 and FY 2016-17) to FY 2016-17 observed rates.

The remaining components of hospice services expenditure in total represent approximately $200,000 of expenditure based on FY 2016-17 actual expenditure. There is significant variation in these remaining services by fiscal year. The Department estimated in the February

[4] Because the distribution of patient days across facilities is likely different between class I nursing facility and hospice services, the aggregate rate for hospice might not grow at exactly 3% as outlined in statute.
[5] For more information, refer to: https://www.colorado.gov/pacific/sites/default/files/2016%20Hospice%20Rates%20and%20Rules.pdf

2017 request that full year expenditure would be approximately $222,870. This estimate is held constant in the current request for FY 2017-18, FY 2018-19, and FY 2019-20.

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 impact of a rate increase that affects Hospice services other than Nursing Facility Room and Board: the across the board rate increase, which increases the Hospice rate by 1.402%. 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 2016-17 Legislative Session, PDN LPN received a targeted rate increase to bring the rate up 7.24% to $33.04, while the remaining four services received the 1.4% across the board rate increases. The rate increases were implemented on October 1, 2017.

As PDN expenditure is the product of the units utilized per client, the number of utilizers, and the rate, and the Department expects rates to remain constant, expenditure forecasts for FY 2017-18, FY 2018-19, and FY 2019-20 are primarily based on unit per utilizer and utilizer forecasts for those fiscal years. The unit per utilizer and utilizer forecasts are separated into three pieces: RN; LPN; and grouped RN Group, LPN Group, and Blended Group.

The Department forecasts growth in FY 2017-18 at 21.59%, which is due to much higher than expected growth in average monthly enrollment and average units per utilizer. The trend is decreased in the request and out-years to 14.65% and 13.93% respectively, which is consistent with historical growth patterns. Additionally, the total client counts for PDN have been lowered in the historical actuals in addition to in the forecasted actuals to help better reflect the actual total client counts due to a more accurate methodology being employed in this forecast. This change in methodology involved moving from the sum off all unique client counts across all PDN services and instead using the unique client count for PDN as a whole. The sum of unique client count totals across the PDN services was not accurate because clients can utilize multiple services at once and as a result this sum was higher than the actual unique client total.

Private Duty Nursing Utilization Trends and Justification			
Service	**Average Month Utilizer Trend Selection**	**Units Per Client Trend Selection**	**Justification**
Registered Nursing (RN)	FY 2017-18 through FY 2019-20: 14.57%, 14.66%, and 14.66% respectively.	FY 2017-18 through FY 2019-20: 0.90%, 0.90%, and 0%, respectively.	RN average utilizers per month had grown in the double digits from FY 2008-09 to FY 2014-15. This growth slowed in FY 2015-16, when the annual average utilizers per month growth dropped to 4.52%, but increased again in FY 2016-17 with growth for the year of 20.79%. Average monthly growth has grown steadily recently and the Department chose to apply this monthly growth trend to historical claims data to produce estimates for this request. RN units per client have historically decreased; however, in FY 2016-17, there was growth of 13.63%. Based on these actuals, 2017-18 is expected to grow at 0.90% growth. The Department expects growth in units per client to remain positive and eventually flatten in FY 2019-20.

Private Duty Nursing Utilization Trends and Justification			
Service	**Average Month Utilizer Trend Selection**	**Units Per Client Trend Selection**	**Justification**
Licensed Practical Nursing (LPN)	FY 2017-18 through FY 2019-20: 8%.	FY 2017-18 through FY 2019-20: 2.47%.	LPN services drove about 17.95% of total expenditure in FY 2016-17. Similar to RN, LPN average utilizers per month have grown mostly in the double digits over time, with an average of 15.53% per year, reaching maximum growth in FY 2013-14 of 43.65%. In FY 2016-17, average utilizers per month yearly growth fell to 7.67%. Average monthly growth has grown steadily over time and the Department chose to apply a modified linear time trend to historical claims data over this time frame to produce estimates for FY 2017-18, FY 2018-19, and FY 2019-20. Average utilizers per month grew right around the Department's February expectations. Again, much like RN units per client, LPN units per client have historically decreased, with average yearly growth of -2.27%; however, in FY 2016-17 growth was positive again at 10.99%. Growth in units per clients in FY 2016-17 outpaced the February request's expectations. Therefore, the Department has slightly raised the expectations for the forecast years and has held growth in all years constant at 2.47%.

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 2017-18 through FY 2019-20: 6.43%, 5.39%, and 5.39%, respectively.	FY 2017-18 through FY 2019-20: 2.03%.	LPN-group, RN-group, and Blended RN/LPN are expected to drive about 11.18% of total expenditure in FY 2016-17 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 and FY 2016-17, the Department has chosen to forecast FY 2017-18, FY 2018-19, and FY 2019-20 linearly at 6.43%, 5.39%, and 5.39% This represents an increase over expectations in the November request. For the grouped and blended PDN services, units per client growth has been very positive over the last few years, but grew faster for blended services and for RN and LPN Groups in FY 2016-17. For this reason, the Department used weighted average yearly growth to forecast FY 2017-18, FY 2018-19, and FY 2019-20, which resulted in a constant growth rate of 2.03%.

Long-Term Home Health

Long-Term Home Health (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), and 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. LTHH rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change. During the FY 2016-17 Legislative Session, LTHH services received a 1.4% across the board rate increase as well as a 6% targeted rate increase for the RN/LPN service and the three therapy services. The rate increases were implemented on October 1, 2017.

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 low utilization, telehealth is forecasted by total expenditure.

Final expenditure estimates for FY 2017-18, FY 2018-19, and FY 2019-20 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 expenditure growth in FY 2017-18 as 12.09%, which is a decrease from February's expected growth of 16.74%. This decrease can largely be attributed to one primary factor, the monthly utilizers being less than expected based on the aggressive growth from the first half of FY 2016-17. The total expenditure is then decreased in the request year to growth of 6.62%, and increased to growth of 8.52% in the out year. This irregular growth is due to a higher initial growth in the first year of the request due to the rate increases and aggressive growth trends. Growth is then returned to a more standard level in the request year and out years. Total expenditure growth for FY 2017-18 is slightly higher than historic average yearly growth, due to the spike in average utilizers per month and average utilization per utilizer in FY 2016-17 as well as the rate increases. The trends were brought up as a result, which brought them more in line with historical average yearly growth. Additionally, the total client counts for LTHH have been lowered in the historical actuals in addition to in the forecasted actuals to reflect the actual total client counts due to a more accurate methodology being employed in this forecast. This change in methodology involved moving from the sum off all unique client counts across all LTHH services and instead using the unique client count for LTHH as a whole. The sum of unique client count totals across the LTHH services was not accurate because clients can utilize multiple services at once and as a result this sum was higher than the actual unique client total.

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 2017-18 through FY 2019-20: 5.18%. Home Health Aid Extended: FY 2017-18 through FY 2019-20: 8.65%, 8.67%, and 8.67% respectively.	Home Health Aid Basic: FY 2017-18 through FY 2019-20: 1.82%. Home Health Aid Extended: FY 2017-18 through FY 2019-20: 1.29%.	HHA Basic and HHA Extended account for the bulk of the total FY 2016-17 expenditure, at 69.41% of the total. Average utilizers per month for HHA Basic and Extended have steadily increased along a linear path since FY 2008-09. In FY 2016-17, both services continued to increase though this was lower than the February forecast for HHA Basic. The Department decreased enrollment trends for HHA Basic to compensate for the decrease in growth compared to the February request, and kept trends the same for HHA Extended as growth was around the expected levels. HHA Basic units per utilizer growth has been historically positive at 2.03% with more rapid growth recently. In FY 2016-17, units per client increased over the February expectations, so the forecast was brought up to 1.82%. HHA Extended units per utilizers increased in the second half of FY 2016-17, and came in higher than expected. Given that HHA Extended had higher growth in FY 2016-17, the Department brought the trend up to 1.29%.

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 2017-18 through FY 2019-20: 2.30%, 2.25%, and 2.25%, respectively.	FY 2017-18 through FY 2019-20: 0.95%, 0.94%, and 0.94%, respectively.	RN/LPN account for about 13.85% of FY 2016-17 LTHH total expenditure and have seen both average monthly utilizers and units per utilizer increase, on average, since FY 2008-09. Average monthly utilizers have grown linearly since FY 2012-13, with some slowing in the most recent year. Given the linear growth and recent slowing, the Department chose to use a reduced annual linear regression to forecast average monthly utilizers for FY 2017-18, FY 2018-19, and FY 2019-20, which results in an average of 2.25% growth per year. Units per utilizer have also grown over time, but have average growth of about 0.94% per year, which is what the Department used to forecast units per utilizer for FY 2017-18, FY 2018-19, and FY 2019-20. Growth in FY 2016-17 was in line with the February forecast's predictions.

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 2017-18 through FY 2019-20: 4.10%, 3.72%, and 3.72%, respectively. RN Brief Second or more: FY 2017-18 through FY 2019-20: 8.00%, 8.99%, and 8.99%, respectively.	RN Brief First of Day: FY 2017-18 through FY 2019-20: 0%. RN Brief Second or more: FY 2017-18 through FY 2019-20: 1.07%, 1.32%, and 1.32%, respectively	RN Brief First of Day and RN Brief Second or More account for 4.62% of the FY 2016-17 total expenditure and have averaged positive historical growth for both metrics in this table. For RN Brief First of Day, the Department chose a reduced linear regression to model growth, due to the slowing in the recent year. For the Second or more visit of the day, the Department expects average monthly client growth to stabilize at historic growth and used average annual growth to forecast this service. In FY 2016-17, both services came in at their predicted growth levels in the February forecast. Units per client growth for RN Brief First of Day is relatively flat over time, so the Department maintained 0% for all years in the forecast. The Second or More Visit of the day units per utilizer dipped slightly in FY 2016-17 but otherwise grew steadily since FY 2008-09, except FY 2013-14. The Department expects steady growth in FY 2017-18, FY 2018-19, and FY 2019-20. Both services were utilized at expected levels from the February forecast.

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 2017-18 through FY 2019-20: 8.98%, 8.91%, and 8.91%, respectively. Occupational Therapy: FY 2017-18 through FY 2019-20: 15.02%. Speech/Language Therapy: FY 2017-18 through FY 2019-20: 22.04%, 10.97%, and 10.97% respectively.	Physical Therapy: FY 2017-18 through FY 2019-20: 0.00%. Occupational Therapy: FY 2017-18 through FY 2019-20: 0.00%. Speech/Language Therapy: FY 2017-18 through FY 2019-20: 0.00%.	PT, OT, and S/LT account for 12.12% of LTHH expenditure in FY 2016-17, but, with large utilizer growth over the last few years as well as the targeted rate increases, that share is expected to continue to increase. In FY 2016-17, all three services met February expectations; however, growth was exceptionally high compared to historic growth. Due to this increase in growth, the Department selected annual average growth trends in line with the February forecast for all three services. All the services are expected to continue their rapid growth, around the most recent levels. In FY 2016-17, units per client utilization followed expectations, with only slight negative variations, so the Department selected a flat 0% trend for all three services in the forecast years.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior average monthly enrollment and utilization/cost per client trend factors, the Department adds total-dollar bottom-line impacts to 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 Long-Term Home Health:

Expenditure

- 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 initially assumed it would be able to begin enrolling HCBS-SLS, HCBS-BI, and HCBS-SCI clients into the Buy-In program on July 1, 2017. However, this was actually implemented on March 1, 2017. In FY 2017-18 and beyond, there will be a mix of existing HCBS-BI and HCBS-SCI clients transitioning into the Buy-In program for the respective waivers. These clients are expected to have a minimal impact for the LTHH services they are expected to utilize, which can be seen starting in FY 2017-18.
- 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 November request. This adjustment to LTHH captures the additional cost of LTHH services these CCT clients are expected to use.
- Telehealth Expenditure Adjustment: Due to small cell sizes that prevent the Telehealth forecast from using the same methodology as the other LTHH services, expenditure for Telehealth is adjusted via bottom line impact.
- FY 2015-16 R-7 "Participant Directed Programs Expansion": The Department's FY 2015-16 R-7 request expands access to Consumer Directed Attendant Support Services (CDASS) in the Supported Living Services (SLS) Home- and Community-Based Services (HCBS) waiver. The savings to LTHH are expected from the clients who currently utilize LTHH services in the SLS waiver, who would then shift into using CDASS services instead. Due to several implementation delays, this will not take effect until FY 2017-18.

- Like 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 a result of SB 17-091 "Allow Medicaid Home Health Services in the Community" and 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.

<u>Enrollment</u>
- N/A

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 (CBLTC). The grant allows the Department to provide transitional services to ease the movement from nursing facilities 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 facility to help them adapt to a 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 Centers for Medicare and Medicaid Services (CMS). The Colorado Choice Transitions (CCT) exhibit illustrates the total cost of the program by delineating the two types of services the Department offers through the program: demonstration services (new services offered through the program) and qualified services (existing waiver services and home health). These costs are reflected in Exhibits F and G as a bottom line impact. The exhibit then reports the estimated costs avoided due to transitioning clients from nursing facilities. Following the net impact of the program, the exhibit reports 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 anticipated that approximately 100 clients would transition per 365 days beginning in May 2013. Due to rate and rate methodology issues for Transition Coordination Agencies, enrollment has been lower than anticipated. The Department expects enrollment will be below 100 in FY 2017-18, FY 2018-19, and FY 2019-20, in line with February expectations, despite rate adjustments for Transition Coordination Agencies to ensure clients receive the services they need. After December 31, 2018, the CCT program will no longer be able to transition new clients due to the time-limit in the grant for transitions being reached, which can be seen in the CCT exhibit by the noticeable drop in expected average monthly enrolled clients. This leads to a decrease in overall CCT expenditure as well. After December 31, 2020, the CCT program will no longer continue in its current form as this is when the grant expires.

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 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 45.2% between FY 1999-00 and FY 2016-17. This is due to Department efforts 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 have continued to increase into FY 2016-17; 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 expenditure 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.

HB 13-1152 extended the 1.5% rate reduction of HB 10-1324, SB 11-125, and 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[6]:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2017-18.
- 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 2017-18. 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 2017-18 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2017-18.
- 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 2017-18.
- Of the estimated total reimbursement for claims incurred in FY 2017-18, only a portion of those claims will be paid in FY 2017-18. The remainder is assumed to be paid in FY 2018-19. The Department estimates that 93.16% of claims incurred in FY 2017-18 will also be paid during FY 2017-18. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2017-18.
- During FY 2017-18, the Department will also pay for some claims incurred during FY 2016-17 and prior years (“prior year claims”). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2016-17 to calculate an estimate of outstanding claims to be paid in FY 2017-18.
- The sum of the current year claims and the prior year claims is the estimated expenditure in FY 2017-18 prior to adjustments.

[6] For clarity, FY 2017-18 is used as an example. The estimates for FY 2018-19 and FY 2019-20 are based on the estimate for FY 2017-18, and follow the same methodology.

- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in Footnotes 6 and 7.
- Legislative impacts are added as bottom-line adjustments. For FY 2017-18, 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 2017-18 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 2017-18, FY 2018-19, and FY 2019-20 calculations for Class I Nursing Facilities:

- Expenditure for the Hospital Backup Program are included as bottom-line adjustments for FY 2017-18 through FY 2019-20. Please refer to Footnote 6 on page EH-7 for more detail. The estimate for FY 2017-18, FY 2018-19, and FY 2019-20 is calculated by multiplying the average per diem in FY 2016-17 by the anticipated number of client days in FY 2017-18. The estimate for FY 2017-18 also includes a bottom line adjustment of approximately half a million dollars to account for payment of services rendered in FY 2016-17. Although there is typically a drop off in payments by date of service in the most recent months due to the lack of claims runout, the Department observed less was paid in final months of FY 2016-17 relative to previous years.
- 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 2017-18, FY 2018-19, and FY 2019-20. 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 13-1152 extended the 1.5% nursing facility per diem rate cut of HB 12-1340 permanently, effective July 1, 2013.

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 2016-17 that will be paid in FY 2017-18 and the percentage of claims incurred in FY 2017-18 that will be paid in FY 2018-19 and subsequent years. The Department applies the same factor to the FY 2018-19 and FY 2019-20 estimates.

The Department uses the IBNR adjustment calculation for the November 2017 Request using paid claims data through June 2017. 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%
February 2017	93.17%
November 2017	93.16%

Patient Days Forecast[7]

The Department observed a 0.95% increase in normalized patient days as a result of new clients using the service in FY 2016-17. The estimated number of patient days in FY 2016-17 was within 0.43% of the patient days forecasted in the February 2017. As such, the

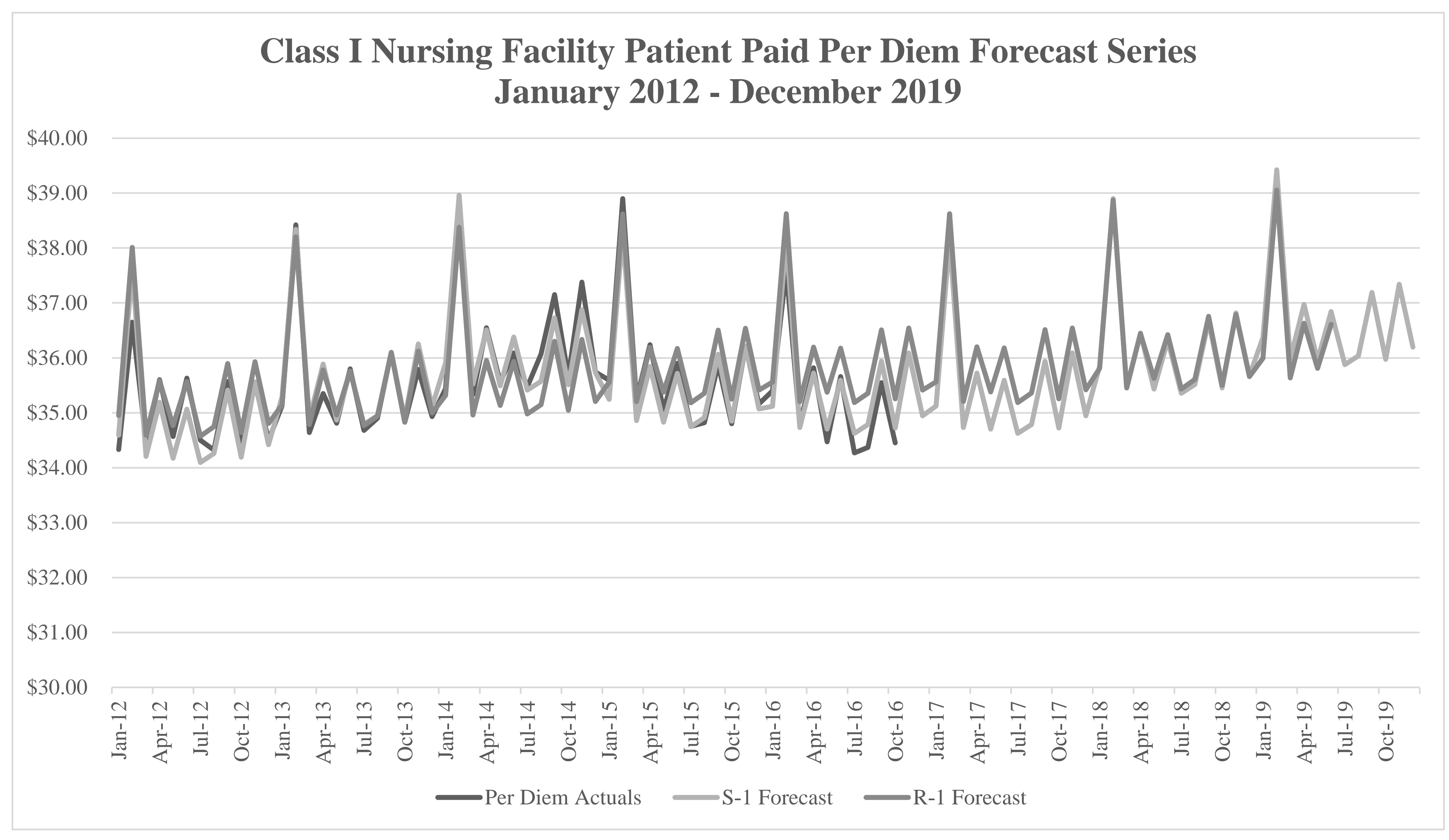
[7] In previous requests, the Department forecasted patient days by using an auto-regressive model using IBNR-adjusted days. This methodology introduced a large negative trend that seemed unlikely given the growth in patient days in FY 2016-17.

Department carried forward patient day estimates from the February 2017, with the assumption that patient days would keep growing, but level out in later fiscal years. The Department will continue to monitor this growth in patient days to determine whether it represents a change in the underlying trend and update the February 2018 Request accordingly.

Patient Payment Forecast Model

The Department utilizes a seasonally adjusted model that accounts 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.

Due to data mapping issues in the interChange, the Department was unable to reforecast patient payment in the November 2017 request and instead used the February 2017 forecast. The following graph and statistics are connected to the patient payment forecast in the February 2017 request.



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

Utilizing the F-statistic, an analysis of the model's overall statistical significance can be done. The patient payment model has a p-value of 0.00000 and is statistically significant at the 99% confidence level. The Adjusted R-squared for the model is 0.9736, suggesting 97.36% 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 July 1, 2017, Bethesda operates 5 facilities with a total of 27 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. Due to the opening of a new facility in July 2016, there was an increase in caseload over FY 2016-17. The Department anticipates this increase to continue in FY 2017-18 as

new beds are filled, leveling off in FY 2018-19 as facility capacity is reached. Should additional facilities open the Department will revise the caseload forecast accordingly.

Cost per-capita decreased over FY 2015-16 and FY 2016-17. The Department anticipates a slight decline in expenditure per-capita in FY 2017-18 as new clients enroll and expects expenditure per-capita to level off in FY 2018-19 and FY 2019-20. 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 amended once per year, generally on July 1 of each year.

Exhibit H6 contains two distinct summary measures by fiscal year: 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.

The Department has added a number of PACE providers over the last ten years. 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. Most recently, TRU Community Care opened in February 2017 and serves Boulder and Weld counties. One new facility, HopeWest, is expected to open in spring of 2018.

Expenditure estimates for PACE for FY 2017-18, FY 2018-19, and FY 2019-20 are the product of two pieces: projected enrollment and cost per enrollee. As is consistent with 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 two bottom line impacts to FY 2017-18: one is for retroactive payments made for services rendered in FY 2016-17, and the second adjusts the PACE forecasted budget for rate corrections that will occur in FY 2017-18. In March 2017, the interChange incorrectly adjusted all rates paid in the last 24 months to FY 2016-17 gross rates; the correction will change paid rates back to the correct rate of the proper fiscal year, net of patient payment. The Department is closely monitoring these systems issues going forward. To account for fluctuation due to the 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 steadily increasing, and as a result, the enrollment forecast in the November 2017 request has increased from the February 2017 request.

Per-enrollee costs for FY 2017-18 are determined by cross-walking the actual FY 2017-18 rates net of patient payment for PACE services with an eligibility-type distribution estimate derived from FY 2017-18 enrollment projections. As such, they only represent an estimate to the extent that eligibility type and provider distributions for FY 2017-18 are unknown. The rates were determined at the beginning of the fiscal year and are known for this forecast.

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. The Department anticipates the new UPL methodology will be completed in FY 2017-18.

Based on recent CMS guidance to calculate the PACE upper payment limit net of patient payment, forecasted rates for FY 2017-18, FY 2018-19, and FY 2019-20 are lower than rates of the most recent years, which were calculated using an upper payment limit that included patient payment. The Department expects PACE capitation rates to stay relatively flat in the next few fiscal years.

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

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

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:[9]

---

[8] 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.

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

History of Medicare Premiums

Calendar Year	Part A	% Change	Part B	% Change
2003	$316.00	-	$58.70	-
2004	$343.00	8.54%	$66.60	13.46%
2005	$375.00	9.33%	$78.20	17.42%
2006	$393.00	4.80%	$88.50	13.17%
2007	$410.00	4.33%	$93.50	5.65%
2008	$423.00	3.17%	$96.40	3.10%
2009	$443.00	4.73%	$96.40	0.00%
2010	$461.00	4.06%	$110.50	14.63%
2011	$450.00	-2.39%	$115.40	4.43%
2012	$451.00	0.22%	$99.90	-13.43%
2013	$441.00	-2.21%	$104.90	5.01%
2014	$426.00	-3.40%	$104.90	0.00%
2015	$407.00	-4.46%	$104.90	0.00%
2016	$411.00	0.98%	$123.70	17.92%
2017	$413.00	0.49%	$134.00	8.33%

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 2017-18, the Department inflates the actual expenditure in the second half of FY 2016-17 by half the estimated increase in caseload along with the anticipated growth in Medicare Part B Premiums. For the second half of FY 2017-18, the Department inflates the first half expenditure by half of the caseload growth along with the anticipated growth in Medicare Part B Premiums. The total estimated expenditure for FY 2017-18 is the sum of the first half actual expenditure and the second half estimated expenditure.

To forecast FY 2018-19, the Department first inflates the estimated expenditure from FY 2017-18 by half the estimated caseload trend for FY 2018-19, as reported in Exhibit B. This figure represents the approximate expenditure for the first half of FY 2018-19. Then, the Department inflates the estimated first half expenditure by half the estimated caseload trend for FY 2018-19 and the estimated increase

in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2018-19 is the sum of the first half and second half estimates. The forecast of FY 2019-20 expenditure utilizes the same methodology as the forecast of FY 2018-19. In this request, the Department assumes that the Medicare Part B premium will be $134.00 in CY 2018, $134.00 in CY 2019, and $139.00 in CY 2020.

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. 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.

Beginning with the November 2014 Request, the Department estimates 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.

- SB 10-167 "Medicaid Efficiency and Colorado False Claims Act" impacts the HIBI program in FY 2017-18 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 2017-18. The new contract increased the administration costs for per member per month rate starting in FY 2017-18. The new cost of administration is a tiered cost structure based off the total enrollment of the program. 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, HCBS-LTSS waivers, 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.

.

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.

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-LTSS waiver enrollment, as determined by average monthly enrollment. This figure is therefore consistent with the caseload growth of the HCBS-LTSS 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 2017-18, the Department's projection uses the total base contracts amount, which is the current amount allocated to SEPs in the FY 2017-18 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.

- FY 2017-18 Across the Board 1.402% Rate Increase: The Joint Budget Committee approved a 1.402% rate increase to be implemented 10/1/2017. The rate increase affects all waiver services and therefore is relevant to Single Entry Point agencies who are providers of waiver services.
- 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 2019-20 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.

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.

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. 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 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 2017 request aligns the Department’s projected expenditure with the reappropriated funds in DPHE’s budget that are funded by Medicaid.

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) and the Primary Care Medical Providers (PCMPs) are administrative fees that receive service FMAP and that are incorporated in the ACC exhibit.

The 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 982,000 by June 2017. 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 2016-17 include payments for the Statewide Data Analytic Contractor (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.

Based on program operation experience, the Department assumes that approximately 22% 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 year, 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 through FY 2017-18. The first, which began September 2014, is a $0.50 reduction in the base PMPM for RCCOs. A portion of these funds are 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 are only paid 65% of their PMPM for clients who have been unattributed to a PCMP for at least six consecutive months. These funds are spent in full 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.

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. While enrollment for adults, children, and pregnant women was lower in the first half of FY 2016-17 than anticipated, enrollment in the new Medicaid Management Information System (MMIS), interChange, which implemented on March 1, 2017 has been much higher, primarily due to a system issue where the new system initially disregarded prior opt-outs when passively enrolling clients into the ACC. The Department anticipates that this issue will be resolved in FY 2017-18, and therefore revised its estimates of the savings from the ACC to Acute Care in Exhibit F, to a level only marginally higher than was previously assumed. The SDAC contract was absorbed by the MMIS contractor in the middle of FY 2016-17, and has therefore been removed from this exhibit as the new contract is no longer under Medical Services Premiums.

The Department requested to initiate Phase II of the ACC in the FY 2017-18 R-6 “Delivery System and Payment Reforms” request, and it was approved in HB 17-1353 “Implement Medicaid Delivery & Payment Initiatives”. Phase II of the ACC includes mandatory enrollment of the Medicaid population into the ACC, which would only exclude clients enrolled in a managed care program such as a health maintenance organization or the Program of All-Inclusive Care for the Elderly (PACE) and the Non-Citizens-Emergency Services and Partial Dual Eligibles eligibility categories. The ACC Phase II also combines the RCCOs and Behavioral Health Organizations (BHOs) into a single entity called a Regional Accountable Entity (RAE). RAEs will be responsible for further integrating behavioral and physical health care to achieve improved outcomes and cost reduction. PMPM for the RAEs will be $15.50, with a portion of the PMPM pushed through from the RAEs to PCMPs. RAEs will receive capitated payments for managed Behavioral Health just as BHOs do currently.

The increased caseload expectations due to mandatory enrollment and the changes to PMPM under ACC Phase II have been built into the ACC forecast trends, based on anticipated enrollment in other managed care programs and caseload, for FY 2018-19 and beyond.

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 ACC 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.

The additional PMPM for the ACC:MMP will end on December 31, 2017, and the ACC:MMP will effectively be absorbed into the base ACC. For forecast purposes in the November 2017 request, RCCO and PCMP payments for the ACC:MMP population are separated out as bottom-line adjustments to maintain forecast consistency in FY 2017-18. In FY 2018-19 and beyond, the ACC:MMP will be fully absorbed into ACC Phase II and is no included as a separate bottom-line adjustment.

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 ACC:MMP, as detailed above. A one-time ACC:MMP-related bottom-line impact was added to FY 2017-18 to account for truing up the PMPM for this population for FY 2016-17 post-March 2017, as the additional payment up to $20 PMPM since the new MMIS went live will be paid in FY 2017-18.

The Department also added a one-time bottom-line impact for the FY 2017-18 R-11 "Vendor Transitions" to account for the transition from the current RCCOs to the new RAEs in FY 2017-18, as the July 1, 2018 implementation of ACC Phase II approaches.

The November 2016 request included a bottom-line impact to account for movement of clients from the PMPM-based ACC to the new Kaiser-Access health maintenance organization (HMO), a pilot payment reform initiative under HB 12-1281. This bottom-line impact was removed in the February 2017 forecast with the assumption that the shift of clients to Kaiser-Access was already accounted for in

the base FY 2016-17 ACC enrollment trends. On June 30, 2017, the Kaiser-Access HMO ended. The impact of this change is accounted for directly in the forecast of expected ACC enrollment in FY 2017-18, and not as a bottom-line impact.

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 - HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

These exhibits summarize the source of funding for the Health Care Affordability Act of 2009 cash-funded expansion populations. These estimates are incorporated into the Calculation of Fund Splits in Exhibit A.

Healthcare Affordability and Sustainability Fee Fund

HB 09-1293 originally established the Hospital Provider Fee Fund to provide for the costs of certain expansion populations on Medicaid, outlined below. SB 17-267 replaced the Hospital Provider Fee Fund with the Healthcare Affordability and Sustainability (HAS) Fee 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
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. This expansion population receives 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 fell to 95%. On January 1, 2018, it falls to 94%, then on January 1, 2019, it falls to 93%, and on January 1, 2020 it falls to 90%, where it will remain. Effective July 1, 2017, this population is financed with the HAS Fee for the State share of expenditure.

For caseload estimates and methodology, please see the Acute Care and caseload sections of this narrative.

MAGI Adults

With the advent of SB 13-200, effective July 1, 2013, MAGI Adults are 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 fell to 95%. On January 1, 2018, it falls to 94%, and then to 93% on January 1, 2019 and 90% on January 1, 2020, where it will remain. Effective July 1, 2017, the State share of expenditure for this population is financed with the HAS Fee. Clients in this category are not eligible to receive HCBS Waiver services; in cases where it appears that these clients have received waiver services, this expenditure receives 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 enhanced expansion federal medical assistance percentage (FMAP) that began 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 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 the full enhanced expansion FMAP. Instead, with the approval of a resource proxy for the non-newly eligibles, 75% of expenditure receives expansion FMAP while the remaining 25% receives the standard FMAP, funded from the HAS 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 HAS Fee Fund, effective July 1, 2017, 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 HAS Fee Cash Fund to fund the state share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives standard FMAP. 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 breaks 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 expenditure 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 individuals with disabilities with income up to 450% of the federal poverty level to pay premiums 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 premiums from the Medicaid Buy-in fund are applied first, and then the remaining expenditure is split at standard medical FMAP as federal funds and HAS Fee Cash Fund. For more information on the funding detail for this population, see Calculation of Fund Splits under Exhibit A.

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

Hospital Supplemental Payments

The Department increases hospital payments for Medicaid hospital services through a total of five supplemental payments, three 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 HAS 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. The HAS Fee replaced the Hospital Provider Fee effective July 1, 2017, under SB 17-267.

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 using certification of public expenditure.
- Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditure.

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 expenditure. These offsets started in FY 2001-02. Nursing facilities account for the larger portion of Upper Payment Limit funding. Home health has expenditure that is less by comparison and will experience little impact related to changes in reimbursement rates.

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 if 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 could utilize UPL financing for outpatient hospital services as well. However, FY 2010-11 was the last year the Department could 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 used 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. A new line of recoveries, Credit Balance and Audits, was added in the reprocured contract effective July 1, 2017.

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 2017-18. 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 9 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 expenditure by aid category from the estimated final expenditure by service categories. This is a necessary step because expenditure in the Colorado Operations Resource Engine (CORE) is 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. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditure 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.

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 December of the current fiscal year. This introduces a small degree of uncertainty regarding FY 2016-17 actuals that was not present previously. It is possible that the FY 2016-17 actuals may change in the next request. In addition, the Department is continuing to validate data as it is reported in the new Medicaid Management Information System (MMIS) reporting layer for FY 2016-17. This includes known issues with expenditure reported for certain service categories. The data presented in this request is based on information available as of August 15, 2017, and may be restated in future requests based on further analysis.

EXHIBIT N - EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2008-09 through FY 2016-17 final actual expenditure is 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 2016-17 final actual total expenditure for Medical Services Premiums, including fund splits, the remaining balance of the FY 2016-17 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 2016-17, FY 2017-18, and FY 2018-19 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 expenditure. The Cash Flow Pattern is one forecasting tool used to estimate final expenditure 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 expenditure.

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 includes 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 includes 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, the FY 2018-19 FMAP estimate is calculated using historic data from the BEA. This FMAP calculation 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 October 1, 2017. Therefore, FMAP for FY 2017-18 and past time periods 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 2019-20 FMAP estimate is based on data after calendar year 2016, 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.

The current estimate for FY 2019-20 calculates to 50.50% FMAP. However, because this value is based on estimates that are subject to change, and the time period is so far forward, the Department has chosen to maintain estimated FMAP at the standard 50.00% level in FY 2019-20. The Department will monitor this estimate and restate in a future request, as needed.

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 that 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 2017-18 Budget Cycle Requests

This section describes the impact from legislation passed during the 2017 Legislative Session, including impacts from the Department's FY 2017-18 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

Legislative Actions Approved as Part of SB 17-254, Long Appropriations Bill

The General Assembly approved a number of actions that were incorporated in SB 17-254, the Long Appropriations Bill. Among them were expanding post-partum depression screening for new mothers up to three visits in the first year after the child's birth; allowing exceptions to the 48-unit limit on physical and occupational therapy with prior authorization; targeted rate increases of 7.01% for transportation providers; targeted rate increases for home health and home care providers; and a 1.402% across-the-board provider rate increase for eligible services.

FY 2017-18 R-6: "Delivery System and Payment Reform"

The JBC approved a number of components in the Department's FY 2017-18 R-6 request, including: the Department's adoption of the Enhanced Ambulatory Patient Grouping (EAPG) system as of October 31, 2016; continuation of the primary care rate increases approved in HB 16-1408, but with General Fund state share; and changing the reimbursement methodology for vaccine stock so that vaccine stock rates are set annually based on the immunization list published by the Center for Disease Control and Prevention (CDC).

FY 2017-18 R-7: "Oversight of State Resources"

Through the Department's FY 2017-18 R-7 request, reimbursement rates of physician administered drugs were increased to an average of 2.5% over the average sales price (ASP). The Department also calculated a cost-avoidance estimate due to members no longer receiving these drugs at higher cost outpatient facilities. Due to more competitive reimbursement in the physician setting, the Department anticipates patients will be matched to more appropriate drugs and less physicians will advise members to receive drugs in a hospital setting. The Department was able to implement this methodology as of July 1, 2017.

FY 2017-18 R-11: "Vendor Transitions"

With the implementation of Phase II of the Accountable Care Collaborative (ACC) on July 1, 2018, the Department requested and the General Assembly appropriated transition funding for the transition from the current Regional Collaborative Care Organizations (RCCOs) to the Regional Accountable Entities (RAEs) in FY 2017-18, to prepare for any changes in vendors that might occur in July 2018 and to ensure a continuum of care for Medicaid clients enrolled in the ACC.

FY 2017-18 R-16: "University of Colorado School of Medicine Supplemental Payment"

In the 2017 legislative session, the General Assembly approved a transfer of $61.9 million from the University of Colorado School of Medicine (UCSOM) to the Department beginning in FY 2017-18 in order to gain access to federal matching funds. The Department would then reimburse UCSOM approximately $123.8 million through a UPL payment for physician services.

SB 17-091 "Allow Medicaid Home Health Services in the Community"

SB 17-091 expands the locations where clients can receive home health services. 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 adjustments in Exhibit F and Exhibit G account for an increase in utilization due to clients receiving additional home health services in the community. The Department demonstrated compliance with this rule as of July 1, 2017 through SB 17-091, which removes language from statute stipulating home health services must be received "in the home."

SB 17-256 "Hospital Reimbursement Rates"

SB 17-256 reduces the cash funds appropriation from the Hospital Provider Fee by $264,100,000 in FY 2017-18. This restriction was removed by SB 17-267 "Sustainability of Rural Colorado."

SB 17-267 "Sustainability of Rural Colorado"

SB 17-267 replaces the existing Hospital Provider Fee program with the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) as of July 1, 2017. Under CHASE, the Department can charge and collect the Healthcare Affordability and Sustainability (HAS) fee that functions similarly to the Hospital Provider Fee. The Department must also increase copays in pharmacy and outpatient services.

HB 17-1353 "Implement Medicaid Delivery & Payment Initiatives"

HB 17-1353 approved the payment reform and Accountable Care Collaborative (ACC) Phase II portions of the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" request, for FY 2018-19 and beyond. This includes increased estimates for ACC savings due to the integration of physical and behavioral health care, especially for clients with diagnoses of substance use disorder and/or serious and persistent mental illness, as well as movement from the continuation of the previous primary care rate increases to primary care incentive payments and other payment reform initiatives. Note that savings to the ACC due to increased enrollment under mandatory enrollment under Phase II are accounted for in the section labeled "ACC Savings," as this change was incorporated directly into the forecast model for the ACC.

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 necessary system edits are completed for pharmacists to enroll as providers.

ACC Savings

The Accountable Care Collaborative (ACC) 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 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 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. 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. The first six months of actual data for FY 2016-17 showed that enrollment in the ACC was slower than anticipated, though enrollment in the second half of FY 2016-17 ramped up, primarily driven by the implementation of the new Medicaid Management Information System (MMIS) and a system issue that disregarded previous opt-outs while passively enrolling clients into the ACC. While the Department estimates savings for the ACC, these estimates have been reduced in FY 2017-18 from the previous request.

The Department plans to launch Phase II of the ACC on July 1, 2018, which will entail mandatory enrollment of clients into the ACC. Because mandatory enrollment will only exclude clients enrolled in another managed care program, such as a health maintenance organization (HMO) or the Program of All-Inclusive Care for the Elderly (PACE), or clients in the Non-Citizens-Emergency Services or Partial Dual Eligibles population, Phase II of the ACC is expected to increase savings due to care coordination due to the additional clients enrolled in the program. However, in line with its original request, the FY 2017-18 R-6 "Delivery System and Payment Reform," the Department anticipates a 6-month delay from the start of Phase II before realizing savings due to enhanced care coordination. The increased savings to Acute Care for the ACC Phase II are included here only for savings as a result of increased enrollment due to mandatory enrollment. Expected savings due to the integration of physical and behavioral health care are accounted for under the impact of HB 17-1353 "Implement Medicaid Delivery & Payment Initiatives."

The chart below shows program expenditure and estimated savings for FY 2014-15 through FY 2019-20. RCCO/RAE administrative payments include the reductions attributable to the policy changes mentioned in Exhibit I. For more detailed information on the ACC program, refer to Exhibit I.

Accountable Care Collaborative Expenditure and Assumed Savings

Service Category		FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Program Administration (Exhibit I, PIHP)	**SDAC**	$3,059,475	$2,975,000	$2,250,000	$0	$0	$0
	RCCO/RAE	$79,471,841	$102,794,192	$107,512,884	$122,650,033	$207,973,063	$235,656,831
	PCMP	$21,419,450	$30,705,518	$33,304,987	$37,954,363	$0	$0
	Total Administration	**$103,950,766**	**$136,474,710**	**$143,067,871**	**$160,604,396**	**$207,973,063**	**$235,656,831**
Program Savings (Exhibit F, Acute)	**Incremental**	**($43,062,535)**	**($28,277,387)**	**($7,955,394)**	**($13,984,461)**	**($84,279,044)**	**($68,920,013)**

(1) Total savings is calculated using estimated savings per member from the 2016 Legislative Request for Information (LRFI) on the implementation of the ACC.
(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 changing some of the criteria in the MMIS to allow a broader range of providers to participate as lock-in providers. This program would generate savings by decreasing excessive use of medical services and thereby reducing the expenditure for medically unnecessary claims. The program criteria target the abuse of prescription medication, inappropriate use of emergency room and/or physician services. The expansion has been delayed due to a delay in the required system changes. 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.

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 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 expenditure due to increased PACE enrollment to Acute Care is $3,621,645 in FY 2017-18, $3,125,718 in FY 2018-19, and $3,312,934 in FY 2019-20.

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. The Department has been able to partially implement the components of SB 10-167, though full implementation is ongoing. The initiatives that impact the current budget are as follows:

<u>Health Insurance Buy-In Program Expansion</u>

The Department anticipates purchasing private health insurance coverage through the Health Insurance Buy-In (HIBI) Program for an additional 1,300 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 May 2017, there were 681 clients enrolled in HIBI. The Department assumes approximately 2% enrollment growth per month through FY 2019-20.

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 2016-17 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 2017-18through FY 2019-20.

FY 2017-18 through FY 2019-20 Total HIBI Impact from SB 10-167

Item	FY 2017-18	FY 2018-19	FY 2019-20
Provider Payment	$478,512	$608,630	$742,040
Premiums Payment	$2,247,474	$2,850,253	$3,613,600
Total Savings (Realized in Acute Care)	($4,775,883)	($6,056,788)	($7,678,900)
Incremental Savings for Bottom-Line Impact in Exhibit F	($771,860)	($1,280,905)	($1,622,112)
Total Impact	**($2,049,897)**	**($2,597,905)**	**($3,323,260)**

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 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 $14,879,507 total funds costs avoided in FY 2017-18, $18,671,320 costs avoided in FY 2018-19,

and $21,450,286 costs avoided in FY 2019-20 These figures do not include any expenditure from the rebalancing fund. Please see the narrative on CCT in Exhibit G for more detail.

FY 2012-13 R-6: "Medicaid Budget Reductions"

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 had not been implemented until recently, as described below.

- *Dental Efficiencies*: The Department clarified rules regarding eligibility for orthodontics and evaluated payment structure and methods. Effective July 1, 2017, the Department changed the payment structure for reimbursing orthodontia. The Department reimburses 80% of costs up front to providers and makes the remaining payments in four different installments at months 6, 12, 18, and with the final payment at de-banding.

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 anticipated implementation will begin on November 1, 2017.

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. In FY 2016-17, the Department removed the impact of the expansion but has kept a portion of the impact in FY 2017-18 and beyond to account for utilization of EPSDT services that are medically necessary.

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 expenditure 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 has adjusted both estimates based on FY 2016-17 actuals, and has adjusted the estimated FY 2017-18 impact of the rate increases in FY 2016-17 based on estimated claims run out and payment delays.

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 Brain 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 implemented the program into the Brain Injury Waiver and the Spinal Cord Injury Waiver on April 1, 2017. 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 2018-19 R-5, Office of Community Living Cost and Caseload Adjustments.

SB 16-192 "Assessment Tool Intellectual and Developmental Disabilities"

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. The tool must be used for adults and children including services for persons with intellectual and developmental disabilities. The bill requires the department to begin utilizing the tool as soon as practicable after selection and complete any client reassessments within 30 days of being requested by a member. Funds included in this request represent funding for the pilot program and all client reassessments.

Other Adjustments to the November 2017 Budget Request

- Payment Delays from Implementation of interChange, accounts for the Department's estimate of FY 2016-17 service payments that will need to be made in FY 2017-18 due to provider payment issues coinciding with implementation of the interChange. The Department estimates this amount to be $381.7 million.
- Repay Overcollection of Drug Rebates in FY 2016-17, accounts for adjustments to FY 2017-18 drug rebate collections due to voided pharmacy claims from the legacy system being billed to drug manufacturers in FY 2016-17. The Department anticipates that it will receive less in drug rebates in FY 2017-18.
- FY 2017-18 Legislative Action – Elective Circumcisions, incorporates funding for elective circumcisions that was not previously appropriated through SB 17-254, Long Appropriations Bill.

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title	**R-04 Medicare Modernization Act State Contribution**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ Supplemental FY 2017-18

X Change Request FY 2018-19

___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$148,950,319**	**$0**	**$148,950,319**	**$4,884,395**	**$16,026,111**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$148,950,319	$0	$148,950,319	$4,884,395	$16,026,111
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
06. Other Medical Services -- Medicare Modernization Act State Contribution Payment	**Total**	**$148,950,319**	**$0**	**$148,950,319**	**$4,884,395**	**$16,026,111**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$148,950,319	$0	$148,950,319	$4,884,395	$16,026,111
	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 schedule 4 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 a reduction of $2,314,420 General Fund for FY 2017-18; an increase of $4,884,395 General Fund for FY 2018-19; and an increase of $16,026,111 General Fund for FY 2019-20 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. This reimbursement to CMS is 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.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2018-19 Funding Request | November 1, 2017

Department Priority: ***R-4***
Request Detail: ***Medicare Modernization Act State Contribution Payment***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Medicare Modernization Act State Contribution Payment	$4,884,395	$4,884,395

Summary of Incremental Funding Change for FY 2019-20	Total Funds	General Fund
Medicare Modernization Act State Contribution Payment	$16,026,111	$16,026,111

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 2018-19, and FY 2019-20 are needed.

Proposed Solution:

The Department requests a decrease of $2,314,420 General Fund for FY 2017-18; an increase of $4,884,395 General Fund for FY 2018-19; and an increase of $16,026,111 General Fund for FY 2019-20 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 2017-18 Performance Plan is to promote "Operational Excellence: The Department is a model for compliant, efficient and effective business practices that are person-and-family-centered". 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 2017-18, FY 2018-19, and FY 2019-20 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 $146,635,899 for FY 2017-18; $153,834,714 for FY 2018-19; and $164,976,430 for FY 2019-20 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 D in table 3.1 and Q in tables 3.2, 3.3, and 3.4 of the appendix).

The total caseload and expenditure estimates for FY 2017-18, FY 2018-19, and FY 2019-20 are calculated in tables 2.1a, 2.2a, and 2.3a, respectively. The Department assumes the changes in dual-eligible caseload will follow a 2.48% growth trend determined by annualizing the monthly average growth over the past two years from July 2015 through June 2017. 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 0.21% 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, 3.3, and 3.4 of the appendix. The CY 2018 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 2017 NHE estimates in row F from the percentage of growth from 2016 NHE estimates in row C. The annual percentage increase (API) in average per capita aggregate Part D expenditures in row J for CY 2018 is provided in the "Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies"[1] issued by CMS on April 4, 2017. For CY 2019 and CY 2020, the Department uses the median of the last seven years of the annual percentage increase in average per capita Part D expenditures from CY 2011 to CY 2017 to project the percentage change in the rate (found in row J of tables 3.3 and 3.4). The final percentage change in the PMPM rate is calculated in row K of tables 3.2-3.4.

To calculate the CY 2018 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 2017: 50.02%
- FFY 2018: 50.00%
- FFY 2019: 50.00%
- FFY 2020: 50.00%

To determine the State's share of the PMPM for tables 3.2, 3.3, 3.4 (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).

Table 4.1 provides actual caseload history from FY 2006-07 through FY 2016-17 and caseload projections based on current trends for FY 2017-18 through FY 2018-20. 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 2017, and projected PMPM rates for CY 2018 to CY 2020.

---

[1] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf

Table 1.1
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	$148,950,319	$148,950,319	Long Bill Appropriation (SB 17-254)
B	Projected FY 2017-18 Expenditures	$146,635,899	$146,635,899	Table 2.1a Row O
C	**FY 2017-18 Estimated Change from Appropriation**	**($2,314,420)**	**($2,314,420)**	**Row B - Row A**

Table 1.2
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	$148,950,319	$148,950,319	Long Bill Appropriation (SB 17-254)
B	Projected FY 2018-19 Expenditures	$153,834,714	$153,834,714	Table 2.2a Row O
C	**FY 2018-19 Estimated Change from Appropriation**	**$4,884,395**	**$4,884,395**	**Row B - Row A**

Table 1.3
FY 2019-20 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 2019-20 Spending Authority	$148,950,319	$148,950,319	Long Bill Appropriation (SB 17-254)
B	Projected FY 2019-20 Expenditures	$164,976,430	$164,976,430	Table 2.3a Row O
C	**FY 2019-20 Estimated Change from Appropriation**	**$16,026,111**	**$16,026,111**	**Row B - Row A**

Table 2.1a
FY 2017-18 Projected Caseload and Expenditures

Row	Month	CY 2015	CY 2016	CY 2017	CY 2018	FY 2017-18 TOTAL
A	May 2017	131	734	75,881	0	76,746
B	June 2017	(75)	(67)	75,359	0	75,217
C	July 2017	(59)	85	75,942	0	75,968
D	August 2017	(49)	33	76,142	0	76,126
E	September 2017	(37)	(7)	76,331	0	76,287
F	October 2017	(24)	(40)	76,511	0	76,447
G	November 2017	(13)	(74)	76,693	0	76,606
H	December 2017	0	(94)	76,860	0	76,766
I	January 2018	0	(98)	2,690	74,336	76,928
J	February 2018	0	(98)	1,368	75,821	77,091
K	March 2018	0	(92)	755	76,583	77,246
L	April 2018	0	(83)	423	77,073	77,413
M	CY Client Total	(126)	199	614,955	303,813	918,841
N	CY PMPM Rate [1]	Varies [2]	Varies [2]	Varies [2]	$160.91	
O	**Expenditures [3]**	**($15,803)**	**$28,879**	**$97,736,273**	**$48,886,550**	**$146,635,899**

(1) PMPM rates in Row N are shown in Table 2.1b
(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 2.1b

Table 2.1b
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	1	$124.68	$125	Caseload Forecast * Actual Rate
B	Oct-Dec 2015	(127)	$125.42	($15,928)	Caseload Forecast * Actual Rate
C	**CY 2015 Total**	**(126)**		**($15,803)**	Row A + Row B
D	Jan-Sept 2016	(315)	$139.98	($44,094)	Caseload Forecast * Actual Rate
E	Oct-Dec 2016	514	$141.97	$72,973	Caseload Forecast * Actual Rate
F	**CY 2016 Total**	**199**		**$28,879**	Row D + Row E
G	Jan-Sept 2017	385,394	$158.91	$61,242,961	Caseload Forecast * Table 3.1 Row A
H	Oct-Dec 2017	229,561	$158.97	$36,493,312	Caseload Forecast * Table 3.1 Row D
I	**CY 2017 Total**	**614,955**		**$97,736,273**	Row G + Row H

Table 2.2a
FY 2018-19 Projected Caseload and Expenditures

Row	Month	CY 2016	CY 2017	CY 2018	CY 2019	FY 2018-19 TOTAL
A	May 2019	(78)	251	77,400	0	77,573
B	June 2019	(67)	156	77,652	0	77,741
C	July 2019	(61)	86	77,875	0	77,900
D	August 2019	(50)	34	78,078	0	78,062
E	September 2019	(38)	(8)	78,274	0	78,228
F	October 2019	(25)	(45)	78,461	0	78,391
G	November 2019	(13)	(74)	78,646	0	78,559
H	December 2019	0	(98)	78,818	0	78,720
I	January 2020	0	(103)	2,761	76,230	78,888
J	February 2020	0	(97)	1,398	77,752	79,053
K	March 2020	0	(96)	777	78,535	79,216
L	April 2020	0	(83)	434	79,036	79,387
M	CY Client Total	(332)	(77)	630,574	311,553	941,718
N	CY PMPM Rate (1)	Varies (2)	Varies (2)	$160.91	$168.28	
O	**Expenditures (3)**	**($46,886)**	**($12,201)**	**$101,465,662**	**$52,428,139**	**$153,834,714**

(1) PMPM Rates in Row N are shown in table 2.2b
(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 2.2b

Table 2.2b
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	(125)	$139.98	($17,498)	Caseload Forecast * Actual Rate
E	Oct - Dec 2016	(207)	$141.97	($29,388)	Caseload Forecast * Actual Rate
F	**CY 2016 Total**	**(332)**		**($46,886)**	Row D + Row E
G	Jan - Sept 2017	(660)	$158.91	($104,881)	Caseload Forecast * Table 3.1 Row A
H	Oct - Dec 2017	583	$158.97	$92,680	Caseload Forecast * Table 3.1 Row D
I	**CY 2017 Total**	**(77)**		**($12,201)**	Row G + Row H

Table 2.3a
FY 2019-20 Projected Caseload and Expenditures

Row	Month	CY 2017	CY 2018	CY 2019	CY 2020	FY 2019-20 TOTAL
A	May 2018	(82)	259	79,373	0	79,550
B	June 2018	(69)	157	79,630	0	79,718
C	July 2018	(63)	90	79,860	0	79,887
D	August 2018	(51)	35	80,069	0	80,053
E	September 2018	(39)	(8)	80,268	0	80,221
F	October 2018	(26)	(46)	80,458	0	80,386
G	November 2018	(13)	(76)	80,649	0	80,560
H	December 2018	0	(100)	80,827	0	80,727
I	January 2019	0	(106)	2,830	78,172	80,896
J	February 2019	0	(102)	1,434	79,733	81,065
K	March 2019	0	(97)	797	80,536	81,236
L	April 2019	0	(88)	446	81,051	81,409
M	CY Client Total	(343)	(82)	646,641	319,492	965,708
N	CY PMPM Rate (1)	Varies (2)	$160.91	$168.28	$175.99	
O	**Expenditures (3)**	**($54,519)**	**($13,195)**	**$108,816,747**	**$56,227,397**	**$164,976,430**

(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 2019-20 with CY 2016 and CY 2017 Rates

Row	Rate Period	Caseload Forecast	Rates	Total	Source
G	Jan - Sept 2017	(130)	$158.91	($20,658)	Caseload Forecast * Table 3.1 Row A
H	Oct - Dec 2017	(213)	$158.97	($33,861)	Caseload Forecast * Table 3.1 Row D
I	**CY 2017 Total**	**(343)**		**($54,519)**	Row G + Row H

Table 3.1
CY 2017 PMPM Rate Calculation

Row	Item		Source
A	CY 2017 PMPM Rate (January through September 2017 with 50.02% FMAP)	$158.91	Centers for Medicare and Medicaid Services (CMS) [1]
B	FFY 17 FMAP State Share Percentage	49.98%	FFY 17 FMAP is 50.02%
C	FFY 18 FMAP State Share Percentage	50.00%	The projected FFY 18 FMAP is 50%
D	**CY 2017 PMPM Rate (October through December 2017 with 50.00% FMAP)**	**$158.97**	Row A / Row B * Row C

(1) Centers for Medicare and Medicaid Services (CMS) State Medicaid Director Letter Calendar Year (CY) 2017 Jan - Sep Phased- down State Contribution Final Per-Capita Rates , Issued October 28, 2016

Table 3.2
Estimated CY 2018 PMPM Rate Calculation

Row	Item		Source
2016 NHE Estimates			
A	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Centers for Medicare and Medicaid Services (CMS) [1]
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Centers for Medicare and Medicaid Services (CMS) [1]
C	Percentage Growth	23.48%	(Row B ÷ Row A) - 1
Projected 2017 NHE Estimates			
D	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Department estimate
E	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
F	Percentage Growth	23.48%	(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	Annual percentage trend for July 2017	3.94%	Announcement Letter 2018 [2]
I	Prior Year Revisions of the Annual percentage trend	-2.62%	Announcement Letter 2018 [2]
J	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2018	1.22%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2018**	**1.22%**	Row G + Row J
L	CY 2017 PMPM Rate Prior to FMAP and Phasedown	$423.93	Actual
M	Projected CY 2018 PMPM Rate Prior to FMAP and Phasedown	$429.10	Row L × (1 + Row K)
N	FFY 18 FMAP State Share	50.00%	FFY 18 FMAP is 50%
O	Projected CY 2018 PMPM Rate Prior to Phasedown	$214.55	Row M × Row N
P	Ongoing Phasedown Percentage Rate	75.00%	Statutory rate : Sec. 1935. (C) (5) [42 U.S.C. 1396u-5]
Q	**Estimated CY 2018 PMPM Rate (January through December 2018 with 50.00% FMAP)**	**$160.91**	Row O × Row P

(1) Centers for Medicare and Medicaid Services (CMS) State Medicaid Director Letter Calendar Year (CY) 2017, 2011 thru 2017 NHE estimates; and
(2) Announcement of CY 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table VI-3.

Table 3.3
Estimated CY 2019 PMPM Rate Calculation

Row	Item		Source
	Projected 2017 NHE Estimates		
A	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Department estimate
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
C	Percentage Growth	23.48%	(Row B ÷ Row A) - 1
	Projected 2018 NHE Estimates		
D	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Department estimate
E	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
F	Percentage Growth	23.48%	(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	4.07%	Median Change from CY 2011 to CY 2017
I	Projected Prior Year Revisions of the Annual percentage trend	0.49%	Average Change from CY 2011 to CY 2017
J	Projected Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2018	4.58%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2018**	**4.58%**	Row G + Row H
L	CY 2018 PMPM Rate Prior to FMAP and Phasedown	$429.10	Table 3.2 Row M
M	Projected CY 2019 PMPM Rate Prior to FMAP and Phasedown	$448.75	Row L × (1 + Row K)
N	Projected FFY 19 FMAP State Share	50.00%	Estimated FFY 19 FMAP is 50%
O	Projected CY 2019 PMPM Rate Prior to Phasedown	$224.38	Row M × Row N
P	Ongoing Phasedown Percentage Rate	75.00%	Statutory rate : Sec. 1935. (C) (5) [42 U.S.C. 1396u-5]
Q	**Estimated CY 2019 PMPM Rate (January through December 2019 with 50.00% FMAP)**	**$168.28**	Row O × Row P

Source: Centers for Medicare and Medicaid Services (CMS), 2011 thru 2015 NHE estimates; and Announcements of CY 2012 through CY 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table V-3.

Table 3.4 Estimated CY 2020 PMPM Rate Calculation			
Row	**Item**		**Source**
Projected 2018 NHE Estimates			
A	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Department estimate
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
C	Percentage Growth	23.48%	(Row B ÷ Row A) - 1
Projected 2019 NHE Estimates			
D	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Department estimate
E	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
F	Percentage Growth	23.48%	(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	4.07%	Median Change from CY 2011 to CY 2017
I	Projected Prior Year Revisions of the Annual percentage trend	0.49%	Average Change from CY 2011 to CY 2017
J	Projected Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2018	4.58%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2018**	**4.58%**	Row G + Row H
L	CY 2019 PMPM Rate Prior to FMAP and Phasedown	$448.75	Table 3.2 Row M
M	Projected CY 2020 PMPM Rate Prior to FMAP and Phasedown	$469.31	Row L × (1 + Row K)
N	Projected FFY 20 FMAP State Share	50.00%	Estimated FFY 19 FMAP is 50%
O	Projected CY 2020 PMPM Rate Prior to Phasedown	$234.65	Row M × Row N
P	Ongoing Phasedown Percentage Rate	75.00%	Statutory rate : Sec. 1935. (C) (5) [42 U.S.C. 1396u-5]
Q	**Estimated CY 2020 PMPM Rate (January through December 2020 with 50.00% FMAP)**	**$175.99**	Row O × Row P

Source: Centers for Medicare and Medicaid Services (CMS), 2011 thru 2015 NHE estimates; and Announcements of CY 2012 through CY 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table V-3.

Table 4.1
Invoice Caseload History

Item	Total Member Months Caseload	Average Monthly Caseload
FY 2006-07	611,212	50,934
FY 2007-08	642,840	53,570
% Change from FY 2006-07	5.17%	5.18%
FY 2008-09	651,968	54,331
% Change from FY 2007-08	1.42%	1.42%
FY 2009-10	664,292	55,358
% Change from FY 2008-09	1.89%	1.89%
FY 2010-11	697,817	58,151
% Change from FY 2009-10	5.05%	5.05%
FY 2011-12	725,075	60,423
% Change from FY 2010-11	3.91%	3.91%
FY 2012-13	750,509	62,542
% Change from FY 2011-12	3.51%	3.51%
FY 2013-14	812,812	67,734
% Change from FY 2012-13	8.30%	8.30%
FY 2014-15	865,253	72,104
% 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	888,070	74,006
% Change from FY 2015-16	1.18%	1.18%
FY 2017-18 Projection	918,841	76,570
% Change from FY 2016-17	3.46%	3.46%
FY 2018-19 Projection	941,718	78,477
% Change from FY 2017-18 Projection	2.49%	3.46%
FY 2019-20 Projection	965,708	80,476
% Change from FY 2018-19 Projection	2.55%	2.49%

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	649,533	54,128
% Change from FY 2007-08	2.98%	2.98%
FY 2009-10	665,732	55,478
% Change from FY 2008-09	2.49%	2.49%
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	803,259	66,938
% Change from FY 2012-13	6.05%	6.05%
FY 2014-15	865,730	72,144
% Change from FY 2013-14	7.78%	7.78%
FY 2015-16	872,160	72,680
% Change from FY 2014-15	0.74%	0.74%
FY 2016-17	894,073	74,506
% Change from FY 2015-16	2.51%	2.51%
FY 2017-18 Projection	918,492	76,541
% Change from FY 2016-17	2.73%	2.73%
FY 2018-19 Projection	941,822	78,485
% Change from FY 2017-18 Projection	2.54%	2.54%
FY 2019-20 Projection	965,819	80,485
% Change from FY 2018-19 Projection	2.55%	2.55%

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	$158.91	50.02%	Table 3.1 Row Q
H	Oct-Dec 2017	$158.97	50.00%	Table 3.1 Row S
	CY 2018			
I	Estimated Jan-Dec 2018	$160.91	50.00%	Table 3.1 Row Q
	CY 2019			
J	Estimated Jan-Dec 2019	$168.28	50.00%	Table 3.2 Row Q
	CY 2020			
K	Estimated Jan-Dec 2019	$175.99	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	$158.91	$158.91	$158.91	$158.97	**$158.93**
% Change from CY 2016					13.13%
CY 2018 Projection	$160.91	$160.91	$160.91	$160.91	**$160.91**
% Change from CY 2017					1.25%
CY 2019 Projection	$168.28	$168.28	$168.28	$168.28	**$168.28**
% Change from CY 2018					4.58%
CY 2020 Projection	$175.99	$175.99	$175.99	$175.99	**$175.99**
% Change from CY 2019					4.58%

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-05 Office of Community Living Cost and Caseload**

Dept. Approval By: 11/1/17

OSPB Approval By:

___ **Supplemental FY 2017-18**

X **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$519,310,846	$0	$520,010,867	$38,735,903	$67,624,408
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$264,566,731	$0	$264,872,792	$19,254,462	$33,673,436
	CF	$162,074	$0	$206,044	$113,469	$138,750
	RF	$0	$0	$0	$0	$0
	FF	$254,582,041	$0	$254,932,031	$19,367,972	$33,812,222

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Adult Comprehensive Services	Total	$376,385,762	$0	$376,656,016	$30,890,545	$53,305,927
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$188,192,881	$0	$188,328,008	$15,445,271	$26,652,964
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$188,192,880	$0	$188,328,007	$15,445,274	$26,652,963

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Adult Supported Living Services						
	Total	**$79,102,446**	**$0**	**$79,268,043**	**$5,766,739**	**$9,454,815**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$43,432,794	$0	$43,479,346	$2,785,050	$4,611,482
	CF	$133,801	$0	$170,052	$98,315	$115,921
	RF	$0	$0	$0	$0	$0
	FF	$35,535,851	$0	$35,618,645	$2,883,374	$4,727,412

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Children's Extensive Support Services						
	Total	**$28,030,392**	**$0**	**$28,030,392**	**$794,228**	**$1,584,861**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$14,015,196	$0	$14,015,196	$397,114	$792,431
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$14,015,196	$0	$14,015,196	$397,114	$792,430

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Case Management						
	Total	**$35,792,246**	**$0**	**$36,056,416**	**$1,284,391**	**$3,278,805**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$18,925,860	$0	$19,050,242	$627,027	$1,616,559
	CF	$28,272	$0	$35,991	$15,154	$22,829
	RF	$0	$0	$0	$0	$0
	FF	$16,838,114	$0	$16,970,183	$642,210	$1,639,417

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 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 2017-18, the Department requests an increase of $20,627,930 total funds, including an increase of $5,137,659 General Fund an increase of $5,237,789 Intellectual and Developmental Disabilities Cash Funds, a decrease of $162,073 Hospital Provider Fee Cash Fund, and an increase of $100,294 Healthcare Affordability and Sustainability Fee Cash Fund. For FY 2018-19, the Department requests an increase of $38,735,903 total funds, including an increase of $19,254,462 General Fund, a decrease of $206,609 Hospital Provider Fee Cash Fund, and an increase of $320,078 Healthcare Affordability and Sustainability Fee Cash Fund. For FY 2019-20, the Department requests an increase of $67,624,408 total funds, including an increase of $33,673,435 General Fund, a decrease of $206,609 Hospital Provider Fee Cash Fund, and an increase of $345,359 Healthcare Affordability and Sustainability Fee Cash Fund. 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 over-expenditure in the current year without action because the Department estimates that some services rendered in the previous fiscal year will be paid in the current year due to delayed claims as a result of interChange implementation.
- 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 over-spend its appropriation, necessitating a request to use over-expenditure authority 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.
- Over-expending funds in the current, 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 2018-19	Total Funds	General Fund
Office of Communty Living Cost and Caseload Adjustments	$20,627,930	$5,137,659

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, 2017 Medicaid Funding Requested Waiting List Report, there are 2,853 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, costlier 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 2017-18, the Department requests an increase of $20,627,930 total funds, including an increase of $5,137,659 General Fund and an increase of $5,237,789 Intellectual and Developmental Disabilities Cash Funds. For FY 2017-18, the Department requests an increase of $38,735,903 total funds, including an increase of $19,254,462 General Fund. For FY 2018-19, the Department requests an increase of $67,624,408 total funds, including an increase $33,673,435 General 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 2017-18 it would serve: 5,672 people on the HCBS-DD waiver (including people in Regional Centers); 5,262 people on the HCBS-SLS waiver; and, 1,724 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 12,385 people on average per month in FY 2017-18, and 12,881 people on average per month in FY 2018-19, 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 2016 to 50.02%. 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 2017-18 will decrease to 50.00% and remain the same in FFY 2017-18 at 50.00%. For state fiscal years this translates to an FMAP of 50.00% in FY 2017-18 through FY 2019-20. FMAP forecasts can be found in exhibit R of the Department's FY 2017-18 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 November 1, 2017. The state portion of Buy-In expenditure will be paid for with Healthcare Affordability & Sustainability 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 estimated 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 2017-18 the Department was appropriated funding for 5,587 enrollments through HB 16-1405 "FY 2017-18 Long Appropriations Bill" which included a request to increase the HCBS-DD enrollment cap by 243 clients as bottom line adjustments. These bottom line adjustments were composed of 150 emergency enrollments, 46 foster care transitions 16 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 as requested in the Department's FY 2014-15 R-8 "Developmental Disabilities New Full Program Equivalents".

In FY 2017-18 the Department requests an additional 85 HCBS-DD enrollments, including an increase of 78 emergency enrollments, a reduction of 11 foster care transitions, an increase of 19 youth transitions from the HCBS-CES waiver and a reduction of 1 CCT transition to reach a maximum enrollment figure of 5,672 enrollments. In FY 2018-19 the Department requests an additional 328 enrollments, including 228 emergency enrollments, 35 foster care transitions, 51 youth transitions, and 14 CCT enrollments, to reach a maximum enrollment figure of 6,000.

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 2016-17. Between FY 2013-14 and FY 2016-17 the number of emergency enrollments authorized each month has been steadily increasing. The Department believes that this is the result of several compounding factors. In FY 2014-15 and FY 2015-16 the Department 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 2017, the Department estimates that 35 clients are likely to transition to HCBS-DD as foster care transitions in FY 2017-18, which represents a reduction of 11 clients from expected enrollment forecasted in the in the FY 2017-18 S-5. This estimate is based on lower than anticipated foster care transitions in FY 2016-17. Also, using updated data through June 2017, the Department anticipates that 51 youth will transition to the HCBS-DD waiver from the HCBS-CES waiver. This estimate is based on higher than anticipated HCBS-CES transitions in FY 2016-17.

Additionally, the Department is now predicting that 14 CCT clients will transition from institutions to the HCBS-DD waiver in FY 2017-18, which represents a reduction of 1 client from expected enrollment forecasted in the FY 2016-17 S-5. The Department has revised its CCT forecast downward based on lower than expected utilization of CCT services in FY 2016-17. 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.

The implementation of the Department's new Medicaid Management Information System (MMIS), interChange, has led to billing difficulties for providers including delayed payments and denied payments. These difficulties have created enough oddities in the data that the Department believes post-implementation data to be unreliable in several aspects. One of the aspects is the recording of prior authorizations (PAR) for HCBS waivers for individuals with IDD. The Department believes that PAR counts are artificially low post-implementation and do not accurately reflect the number of clients seeking authorizations. Because of this the Department has elected to hold constant the FPE conversion factor from the previous FY 2017-18 S-5 forecast without updating data to include post-implementation data, as this conversion factor is a function of PARs.

For each waiver and TCM, the selected FPE conversion factor is the average of the FPE conversion factor from the previous year and the conversion factor seen in the first six months in FY 2016-17. 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, adjusted for the first six months of FY 2016-17 actuals, is a good prediction of utilization in the coming years.

The HCBS-CES and HCBS-SLS waivers have experienced 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 FY 2016-17 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 that approaches a natural rate. All clients on the HCBS-CES waiting list were enrolled, or left the waiting list for another reason, in FY 2016-17 so the Department anticipates that the natural conversion factor will be reached and remain constant in the current, request, and out years. 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 waiver specific methods, discussed below; these enrollments are then 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 2016-17 and FY 2017-18 maximum enrollment levels.

Maximum Assumed 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 a number of members equal to the appropriated enrollment amount will be authorized for services for each year in this request. The Department does not believe that all authorized enrollments in a fiscal year will be receiving services by the end of the fiscal year. This is due to the sometimes lengthy process of matching the unique needs of a client and their family to a provider whom is willing to serve the client. Clients authorized towards the end of the fiscal year may not become enrolled until the following fiscal year. Therefore, to calculate average monthly enrollment in the HCBS-DD waiver, the maximum authorized enrollment is adjusted downwards based on the ratio of authorized to enrolled clients on the HCBS-DD waiver in FY 2015-16. The Department did not update the ratio for FY 2016-17 data due to reliability concerns with post-interChange implementation data. The calculation of FY 2016-17 Maximum Assumed Enrollment is shown in table 1.1.

Table 1.1 – Calculation of HCBS-DD Maximum Assumed Enrollment					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes**
A	Requested Maximum HCBS-DD Enrollment	5,627	6,000	6,316	Appendix A - Exhibit D.1
B	FY 2015-16 Ratio of Enrollments Authorized HCBS-DD Enrollments to Enrolled with a Prior Authorization (PAR)	98.04%	98.04%	98.04%	Actuals
C	**FY 2016-17 Maximum Assumed HCBS-DD Enrollment**	**5,413**	**5,882**	**6,192**	**Row A * Row B**

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.

Maximum assumed enrollment for the HCBS-SLS waiver is based on linear enrollment projections from over the period spanning January, 2016 through December, 2016. The Department assumes that growth in this waiver will continue at a decreasing rate as pending clients are enrolled. Once all pending clients are enrolled.

All members previously on the HCBS-CES waitlist have been authorized and enrolled in the waiver the first half of FY 2016-17. The Department expects enrollment in this waiver to slow because of this, and has slowed its enrollment expectations for the current, request, and out years. The Department did not update enrollment trends from the FY 2017-18 S-5 forecast due to reliability concerns with post-interChange implementation data.

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.

Due to reliability concerns with post-interChange implementation data the Department held constant the cost per-FPE forecast from the FY 2017-18 S-5 and adjusted this value for new bottom line adjustments.

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 for the anticipated across the board rate increase, and targeted rate increase to transportation services, approved by the General Assembly and included in SB 17-254 FY 2017-18 Long Appropriations Bill. The across the board rate increase was for 1.402% to be implemented on July 1, 2017 and the targeted rate increase to transportation was 7.01% to be implemented October 1, 2017 pending CMS approval.

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 July, 2017 to November, 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 2017-18 with full utilization expected to be reached in November, 2018.

Once CDASS is available on the HCBS-SLS waiver, the waiver will have all services offered by the 1915(i) waiver along with additional services and supports. Because of this, the Department expects all 1915(i) clients will transition to the HCBS-SLS waiver once CDASS is available. An additional bottom line impact was added to account for the expected influx of clients currently on the HCBS-1915(i) waiver to the HCBS-SLS when CDASS is approved by CMS. Due to higher than average utilization of consumer directed services amongst this population, these clients are expected to increase the aggregate cost per-client on the HCBS-SLS waiver as they transition.

To account for billing irregularities resulting from implementation of the interChange system, the Department has added a one-time bottom line impact to cost per-FPE in FY 2017-18. This bottom line impact accounts for payments that the Department expects to pay on pending claims from FY 2016-17 that could not be paid due to systems issues. To account for long payment processing times experienced after interChange implementation the Department has extended the time limit for submitting a claim to 240 days. The Department anticipates that a large number of claims that would have normally been paid in FY 2016-17 will be paid for in FY 2017-18. To calculate this amount the Department assumes that the difference between the Department's FY 2016-17 expenditure projections in each waiver and the actual expenditure in each waiver will be paid in FY 2017-18 in addition to normal expenditure. This bottom line adjustment is annualized out in FY 2018-19.

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.

SB 16-192 "Assessment Tool Intellectual & Developmental Disabilities" requires the Department to design and implement a new assessment tool for individuals receiving long-term services and supports, including services for persons with intellectual and developmental disabilities. This entails the re-assessment of everyone receiving these services in FY 2019-20. A row has been added to the QA/UR/SIS forecast table in this fiscal year to account for increased 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 A1.1 - Calculation of Request

FY 2017-18

Item	Total Request	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Adult Comprehensive Services (HCBS-DD)					
Total Request	$391,065,217	$190,294,818	$5,237,790	$0	$195,532,609
Adjusted Spending Authority	$376,385,762	$188,192,881	$1	$0	$188,192,880
Incremental Request	$14,679,455	$2,101,937	$5,237,789	$0	$7,339,729
Adult Supported Living Services (HCBS-SLS)					
Total Request	$80,283,909	$44,078,957	$78,369	$0	$36,126,583
Adjusted Spending Authority	$79,102,446	$43,432,794	$133,801	$0	$35,535,851
Incremental Request	$1,181,463	$646,163	($55,432)	$0	$590,732
Children's Extensive Support Services (HCBS-CES)					
Total Request	$28,754,289	$14,377,144	$0	$0	$14,377,145
Adjusted Spending Authority	$28,030,392	$14,015,196	$0	$0	$14,015,196
Incremental Request	$723,897	$361,948	$0	$0	$361,949
Case Management					
Total Request	$39,825,462	$20,948,830	$21,925	$0	$18,854,707
Adjusted Spending Authority	$35,782,347	$18,920,925	$28,272	$0	$16,833,150
Incremental Request	$4,043,115	$2,027,905	($6,347)	$0	$2,021,557
Family Support Services					
Total Request	$7,058,033	$7,058,033	$0	$0	$0
Adjusted Spending Authority	$7,058,033	$7,058,033	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Preventive Dental Hygiene					
Total Request	$64,199	$64,199	$0	$0	$0
Adjusted Spending Authority	$64,199	$64,199	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,164,947	$3,143,726	$0	$0	$21,221
Adjusted Spending Authority	$3,164,947	$3,144,020	$0	$0	$20,927
Incremental Request	$0	($294)	$0	$0	$294
Office of Community Living Total					
Total Request	$550,216,056	$279,965,707	$5,338,084	$0	$264,912,265
Adjusted Spending Authority	$529,588,126	$274,828,048	$162,074	$0	$254,598,004
Incremental Request	**$20,627,930**	**$5,137,659**	**$5,176,010**	**$0**	**$10,314,261**

Table A1.2 - Calculation of Request					
FY 2018-19					
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Adult Comprehensive Services (HCBS-DD)					
Total Request	$408,102,965	$204,051,481	$1	$0	$204,051,483
Adjusted Spending Authority	$377,212,420	$188,606,210	$1	$0	$188,606,209
Incremental Request	$30,890,545	$15,445,271	$0	$0	$15,445,274
Adult Supported Living Services (HCBS-SLS)					
Total Request	$85,335,596	$46,414,237	$268,933	$0	$38,652,426
Adjusted Spending Authority	$79,568,857	$43,629,187	$170,618	$0	$35,769,052
Incremental Request	$5,766,739	$2,785,050	$98,315	$0	$2,883,374
Children's Extensive Support Services (HCBS-CES)					
Total Request	$28,824,620	$14,412,310	$0	$0	$14,412,310
Adjusted Spending Authority	$28,030,392	$14,015,196	$0	$0	$14,015,196
Incremental Request	$794,228	$397,114	$0	$0	$397,114
Case Management					
Total Request	$37,330,908	$19,672,334	$51,145	$0	$17,607,429
Adjusted Spending Authority	$36,046,517	$19,045,307	$35,991	$0	$16,965,219
Incremental Request	$1,284,391	$627,027	$15,154	$0	$642,210
Family Support Services					
Total Request	$7,058,033	$7,058,033	$0	$0	$0
Adjusted Spending Authority	$7,058,033	$7,058,033	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Preventive Dental Hygiene					
Total Request	$64,199	$64,199	$0	$0	$0
Adjusted Spending Authority	$64,199	$64,199	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,164,947	$3,144,020	$0	$0	$20,927
Adjusted Spending Authority	$3,164,947	$3,144,020	$0	$0	$20,927
Incremental Request	$0	$0	$0	$0	$0
Office of Community Living Total					
Total Request	$569,881,268	$294,816,614	$320,079	$0	$274,744,575
Adjusted Spending Authority	$531,145,365	$275,562,152	$206,610	$0	$255,376,603
Incremental Request	**$38,735,903**	**$19,254,462**	**$113,469**	**$0**	**$19,367,972**

Table A1.3 - Calculation of Request					
FY 2019-20					
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Adult Comprehensive Services (HCBS-DD)					
Total Request	$430,518,347	$215,259,174	$1	$0	$215,259,172
Adjusted Spending Authority	$377,212,420	$188,606,210	$1	$0	$188,606,209
Incremental Request	$53,305,927	$26,652,964	$0	$0	$26,652,963
Adult Supported Living Services (HCBS-SLS)					
Total Request	$89,023,672	$48,240,669	$286,539	$0	$40,496,464
Adjusted Spending Authority	$79,568,857	$43,629,187	$170,618	$0	$35,769,052
Incremental Request	$9,454,815	$4,611,482	$115,921	$0	$4,727,412
Children's Extensive Support Services (HCBS-CES)					
Total Request	$29,615,253	$14,807,627	$0	$0	$14,807,626
Adjusted Spending Authority	$28,030,392	$14,015,196	$0	$0	$14,015,196
Incremental Request	$1,584,861	$792,431	$0	$0	$792,430
Case Management					
Total Request	$42,723,858	$22,361,134	$58,820	$0	$20,303,904
Adjusted Spending Authority	$39,445,053	$20,744,575	$35,991	$0	$18,664,487
Incremental Request	$3,278,805	$1,616,559	$22,829	$0	$1,639,417
Family Support Services					
Total Request	$7,058,033	$7,058,033	$0	$0	$0
Adjusted Spending Authority	$7,058,033	$7,058,033	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Preventive Dental Hygiene					
Total Request	$64,199	$64,199	$0	$0	$0
Adjusted Spending Authority	$64,199	$64,199	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,164,947	$3,144,020	$0	$0	$20,927
Adjusted Spending Authority	$3,164,947	$3,144,020	$0	$0	$20,927
Incremental Request	$0	$0	$0	$0	$0
Office of Community Living Total					
Total Request	$602,168,309	$310,934,856	$345,360	$0	$290,888,093
Adjusted Spending Authority	$534,543,901	$277,261,420	$206,610	$0	$257,075,871
Incremental Request	**$67,624,408**	**$33,673,436**	**$138,750**	**$0**	**$33,812,222**

Table A.2 - 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)]	$391,065,217	$195,532,607	$1	$195,532,609	50.00%	Table B.1 Row K
Cash Fund Financing[(2)]	$0	($5,237,789)	$5,237,789	$0		FY 2016-17 Reversion to Intellectual and Developmental Disabilites Cash Fund
Subtotal	$391,065,217	$190,294,818	$5,237,790	$195,532,609	50.00%	
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services	$72,096,428	$36,048,214	$0	$36,048,214	50.00%	Table B.1 Row K
Medicaid Services (Buy-In)[(3)]	$156,738	$0	$78,369	$78,369	50.00%	Table B.1 Row K
State Only Services	$8,030,743	$8,030,743	$0	$0	0.00%	Table G.1 Row N
Subtotal	$80,283,909	$44,078,957	$78,369	$36,126,583		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$28,754,289	$14,377,144	$0	$14,377,145	50.00%	Table B.1 Row K
Case Management						
Medicaid Services	$32,342,770	$16,171,385	$0	$16,171,385	50.00%	Table B.1 Row K
Medicaid Services (Buy-In)[(3)]	$34,315	$0	$17,158	$17,157	50.00%	Table B.1 Row K
State Only Services	$2,116,047	$2,116,047	$0	$0	0.00%	Table G.1 Row AB
Quality Assurance, Utilization Review, Support Intensity Scale	$5,322,797	$2,661,398	$0	$2,661,399	50.00%	Table F.1 Row J
Quality Assurance, Utilization Review, Support Intensity Scale (Buy-In)[(3)]	$9,533	$0	$4,767	$4,766	50.00%	Table F.2 Row J
Subtotal	$39,825,462	$20,948,830	$21,925	$18,854,707		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,136,653	$3,136,653	$0	$0	0.00%	Table G.1 Row AM
PASRR	$28,294	$7,073	$0	$21,221	75.00%	Table G.1 Row AL
Subtotal	$3,164,947	$3,143,726	$0	$21,221		
Other Programs						
Family Support Services	$7,058,033	$7,058,033	$0	$0	0.00%	Table G.1 Row AE
Preventive Dental Hygiene	$64,199	$64,199	$0	$0	0.00%	Table G.1 Row AH
Subtotal	$7,122,232	$7,122,232	$0	$0		
Grand Total	**$550,216,056**	**$279,965,707**	**$5,338,084**	**$264,912,265**		

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 Healthcare Affordability & Sustainability 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.3 - 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]	$408,102,965	$204,051,481	$1	$204,051,483	50.00%	Table B.1 Row L
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services (Standard)	$76,766,987	$38,383,494	$0	$38,383,493	50.00%	Table B.1 Row L
Medicaid Services (Buy-In)[2]	$537,866	$0	$268,933	$268,933	50.00%	Table B.1 Row L
State Only Services	$8,030,743	$8,030,743	$0	$0	0.00%	Table G.2 Row H
Subtotal	$85,335,596	$46,414,237	$268,933	$38,652,426		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$28,824,620	$14,412,310	$0	$14,412,310	50.00%	Table B.1 Row L
Case Management						
Medicaid Services (Standard)	$29,689,661	$14,844,831	$0	$14,844,830	50.00%	Table B.1 Row L
Medicaid Services (Buy-In)[2]	$87,523	$0	$43,762	$43,761	50.00%	Table B.1 Row L
State Only Services	$2,116,047	$2,116,047	$0	$0	0.00%	Table G.2 Row S
Quality Assurance, Utilization Review, Support Intensity Scale (Standard)	$5,422,911	$2,711,456	$0	$2,711,455	50.00%	Table F.2 Row J
Quality Assurance, Utilization Review, Support Intensity Scale (Buy-In)[2]	$14,766	$0	$7,383	$7,383	50.00%	Table F.2 Row J
Subtotal	$37,330,908	$19,672,334	$51,145	$17,607,429		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,136,653	$3,136,653	$0	$0	0.00%	Table G.2 Row AA
PASRR	$28,294	$7,367	$0	$20,927	75.00%	Table G.2 Row Z
Subtotal	$3,164,947	$3,144,020	$0	$20,927		
Other Programs						
Family Support Services	$7,058,033	$7,058,033	$0	$0	0.00%	Table G.2 Row U
Preventive Dental Hygiene	$64,199	$64,199	$0	$0	0.00%	Table G.2 Row W
Subtotal	$7,122,232	$7,122,232	$0	$0		
Grand Total	**$569,881,268**	**$294,816,614**	**$320,079**	**$274,744,575**		

Definitions: FFP: Federal financial participation rate

(1) Cash funds from the Health Care Expansion Fund

(2) Cash funds from the Healthcare Affordability & Sustainability 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 2019-20

Item	Total Request	General Fund	Cash Funds	Federal Funds	FFP	Source
Adult Comprehensive Services (HCBS-DD)						
Subtotal(1)	$430,518,347	$215,259,174	$1	$215,259,172	50.00%	Table B.1 Row M
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services (Standard)	$80,419,852	$40,209,926	$0	$40,209,926	50.00%	Table B.1 Row M
Medicaid Services (Buy-In)(2)	$573,077	$0	$286,539	$286,538	50.00%	Table B.1 Row M
State Only Services	$8,030,743	$8,030,743	$0	$0	0.00%	Table G.3 Row F
Subtotal	$89,023,672	$48,240,669	$286,539	$40,496,464		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$29,615,253	$14,807,627	$0	$14,807,626	50.00%	Table B.1 Row M
Case Management						
Medicaid Services (Standard)	$31,266,265	$15,633,133	$0	$15,633,132	50.00%	Table B.1 Row M
Medicaid Services (Buy-In)(2)	$92,473	$0	$46,237	$46,236	50.00%	Table B.1 Row M
State Only Services	$2,116,047	$2,116,047	$0	$0	0.00%	Table G.3 Row M
Quality Assurance, Utilization Review, Support Intensity Scale (Standard)	$9,223,908	$4,611,954	$0	$4,611,954	50.00%	Table F.3 Row L
Quality Assurance, Utilization Review, Support Intensity Scale (Buy-In)(2)	$25,165	$0	$12,583	$12,582	50.00%	Table F.3 Row L
Subtotal	$42,723,858	$22,361,134	$58,820	$20,303,904		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,136,653	$3,136,653	$0	$0	0.00%	Table G.3 Row U
PASRR	$28,294	$7,367	$0	$20,927	75.00%	Table G.3 Row T
Subtotal	$3,164,947	$3,144,020	$0	$20,927		
Other Programs						
Family Support Services	$7,058,033	$7,058,033	$0	$0	0.00%	Table G.3 Row N
Preventive Dental Hygiene	$64,199	$64,199	$0	$0	0.00%	Table G.3 Row Q
Subtotal	$7,122,232	$7,122,232	$0	$0		
Grand Total	**$602,168,309**	**$310,934,856**	**$345,360**	**$290,888,093**		

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 2017-18**			**FY 2018-19**			**FY 2019-20**		
	Base 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	$5,237,789	$5,237,789	$0	$0	$0	$0	$0	$0
Hospital Provider Fee Cash Fund	$162,073	$0	($162,073)	$206,609	$0	($206,609)	$206,609	$0	($206,609)
Healthcare Affordability & Sustainability Fee Cash Fund	$0	$100,294	$100,294	$0	$320,078	$320,078	$0	$345,359	$345,359
Total Cash Funds	**$162,074**	**$5,338,084**	**$5,176,010**	**$206,610**	**$320,079**	**$113,469**	**$206,610**	**$345,360**	**$138,750**

Table B.1 - Division for Intellectual and Developmental Disabilities (DIDD) Total Program Expenditure and Forecast								
Row	**Fiscal Year**	**HCBS - Waiver for Persons with Developmental Disabilities (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - 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	FY 2016-17	$347,057,913	$58,395,990	$0	$25,113,943	$22,242,358	$0	$452,810,203
K	Estimated FY 2017-18	$391,065,217	$72,096,428	$156,738	$28,754,289	$32,342,770	$34,315	$524,449,757
L	Estimated FY 2018-19	$408,102,965	$76,766,987	$537,866	$28,824,620	$29,689,661	$87,523	$544,009,622
M	Estimated FY 2019-20	$430,518,347	$80,419,852	$573,077	$29,615,253	$31,266,265	$92,473	$572,485,267

Table B.12- 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	FY 2016-17	5.10%	9.61%	0.00%	19.17%	0.63%	0.00%	6.13%
K	Estimated FY 2017-18	12.68%	23.46%	100.00%	14.50%	45.41%	100.00%	15.82%
L	Estimated FY 2018-19	4.36%	6.48%	243.16%	0.24%	-8.20%	155.06%	3.73%
M	Estimated FY 2019-20	5.49%	4.76%	6.55%	2.74%	5.31%	5.66%	5.23%

Table C.1 - 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	Adjusted Appropriation	$376,385,762	$71,071,703	$28,030,392	$28,438,382	$503,926,239	See Footnote (1)
B	Projected FPE	5,338.09	4,703.50	1,566.52	10,392.42	N/A	Table D.3.3, Row E
C	Projected Per FPE Expenditure	$73,259.39	$15,361.57	$18,355.52	$3,115.45	N/A	Table E.1, Row I.
D	Total Projected Expenditure	$391,065,217	$72,253,166	$28,754,289	$32,377,085	$524,449,757	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**$14,679,455**	**$1,181,463**	**$723,897**	**$3,938,703**	**$20,523,518**	**Row D - Row A**

Table C.2 - 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 2018-19 Base Request	$377,212,420	$71,538,114	$28,030,392	$36,046,517	$512,827,443	See Footnote (1)
B	Projected FPE	5,655.63	4,902.47	1,610.70	10,826.10	N/A	Table D.3.4, Row E. See Footnote (2)
C	Projected Per FPE Expenditure	$72,158.71	$15,768.55	$17,895.71	$2,750.50	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	$408,102,965	$77,304,854	$28,824,620	$29,777,184	$544,009,623	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**$30,890,545**	**$5,766,740**	**$794,228**	**($6,269,333)**	**$31,182,180**	**Row D - Row A**

Table C.3 - FY 2019-20 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 2019-20 Base Request	$377,212,420	$71,538,114	$28,030,392	$39,445,053	$516,225,979	See Footnote (1)
B	Projected FPE	5,966.27	5,056.93	1,654.88	11,367.36	N/A	Table D.3.5, Row E. See Footnote (2)
C	Projected Per FPE Expenditure	$72,158.71	$15,902.90	$15,769.88	$17,895.71	N/A	Table E.1 Row K.
D	Total Projected Expenditure	$430,518,347	$80,419,852	$26,097,259	$203,426,978	$740,462,436	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**$53,305,927**	**$8,881,738**	**($1,933,133)**	**$163,981,925**	**$224,236,457**	**Row D - Row A**

(1) All appropriation amounts above are for Medicaid funded individuals only and do not include state-only funded individuals, clients served at regional centers, 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 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	5,343
B	Base Trend Increase	0.00%
C	Initial Estimated FY 2017-18 Enrollment	5,343
	Bottom Line Adjustments	
D	Colorado Choice Transitions (CCT)	15
E	Emergency Enrollments	228
F	Foster Care Transitions	35
G	Youth Transitions	51
H	Total Bottom Line Adjustments	329
I	**Estimated FY 2017-18 Maximum Enrollment**	**5,672**

Table D.1.2 - 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	5,672
B	Base Trend Increase	0.00%
C	Initial Estimated FY 2018-19 Enrollment	5,672
	Bottom Line Adjustments	
D	Colorado Choice Transitions (CCT)	14
E	Emergency Enrollments	228
F	Foster Care Transitions	35
G	Youth Transitions	51
H	Total Bottom Line Adjustments	328
I	**Estimated FY 2018-19 Maximum Enrollment**	**6,000**

Table D.1.3 - FY 2019-20 HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) Maximum Enrollment Forecast

Row	Item	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)
A	Estimated FY 2018-19 Maximum Enrollment	6,000
B	Base Trend Increase	0.00%
C	Initial Estimated FY 2019-20 Enrollment	6,000
	Bottom Line Adjustments	
D	Colorado Choice Transitions (CCT)	2
E	Emergency Enrollments	228
F	Foster Care Transitions	35
G	Youth Transitions	51
H	Total Bottom Line Adjustments	316
I	**Estimated FY 2019-20 Maximum Enrollment**	**6,316**

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	2,287	0	291	6,165	0
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	2,369	0	328	6,420	0
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	2,625	0	325	6,049	0
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	2,848	0	358	7,045	0
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	2,860	0	338	6,578	0
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	3,021	0	347	6,760	0
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	3,015	0	498	6,795	0
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	3,381	0	836	7,812	0
X		FPE as a Percentage of Average Monthly Enrollment	98.55%	91.92%	N/A	86.10%	82.60%	N/A
Y	FY 2015-16	Average Monthly Enrollment	4,903	4,311	0	1,373	10,704	0
Z		FPE	4,832	3,896	0	1,200	8,994	0
AA		FPE as a Percentage of Average Monthly Enrollment	98.55%	90.37%	N/A	87.40%	84.02%	N/A
AB	FY 2016-17	Average Monthly Enrollment	5,077	4,637	0	1,602	11,316	0
AC		FPE	4,917	4,095	0	1,378	8,940	0
AD		FPE as a Percentage of Average Monthly Enrollment	96.86%	88.30%	N/A	86.06%	79.00%	N/A
AE		**FY 2017-18 Selected FPE Conversion Factor(1)**	**98.62%**	**90.85%**	**90.85%**	**92.04%**	**84.05%**	**84.05%**
AF		**FY 2018-19 and FY 2019-20 Selected FPE Conversion Factor(1)**	**98.62%**	**90.85%**	**90.85%**	**92.04%**	**84.05%**	**84.05%**

(1) The selected FPE Conversion Factor for all waivers and TCM is the FY 2015-16 conversion factor. Due to currently unreliable interChange data the Department elected to hold its conversion factor constant from the previous forecast.

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	FY 2016-17	5,077	4,637	0	1,602	11,427	0
K	Estimated FY 2017-18	5,413	5,139	20	1,702	12,385	20
L	Estimated FY 2018-19	5,735	5,358	38	1,750	12,843	38
M	Estimated FY 2018-20	6,050	5,566	40	1,798	13,525	40

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	3.55%	7.56%	0.00%	16.68%	6.75%	0.00%
K	Estimated FY 2017-18	6.62%	10.83%	100.00%	6.24%	8.38%	100.00%
L	Estimated FY 2018-19	5.95%	4.26%	90.00%	2.82%	3.70%	90.00%

Table D.3.3 - 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	FY 2016-17 Year-End Enrollment; June 2017	5,071	4,606	0	1,604	11,392	0	
	Bottom Line Adjustments							See narrative
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	342	550	0	98	990	0	See narrative
C	Adjustments from HB-16-1321: Medicaid Buy-In Certain Medicaid Waivers	0	(17)	20	0	(17)	20	See narrative
D	Total Bottom Line Adjustments	342	533	0	98	973	0	Row B + Row C
E	Final Estimated FY 2017-18 Average Monthly Enrollment Under Current Policy	5,413	5,139	20	1,702	12,365	20	Row A + Row D
F	**Final Estimated FY 2017-18 Average Monthly Enrollment**	**5,413**	**5,139**	**20**	**1,702**	**12,365**	**20**	**Row A + Row E**
G	FPE Adjustment Factor	98.62%	90.85%	90.85%	92.04%	84.05%	84.05%	Table D.2, Row AE
H	**Estimated FY 2017-18 FPE**	**5,338.09**	**4,668.98**	**18.17**	**1,566.52**	**10,392.42**	**16.81**	**Row C * Row D**

Table D.3.4 - Calculation of FY 2018-19 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)

Row	FY 2018-19	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	5,561	5,262	0	1,724	12,657	0	
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	174	129	0	26	330	0	See narrative
C	Adjustments from HB-16-1321: Medicaid Buy-In Certain Medicaid Waivers	0	(33)	38	0	(33)	38	See narrative
D	Total Bottom Line Adjustments	174	96	38	26	297	38	Row B
E	Final Estimated FY 2018-19 Average Monthly Enrollment Under Current Policy	5,735	5,358	38	1,750	**297**	38	Row A + Row B
F	**Final Estimated FY 2018-19 Average Monthly Enrollment**	**5,735**	**5,358**	**38**	**1,750**	**12,843**	**38**	**Row A + Row B**
G	FPE Adjustment Factor	98.62%	90.85%	90.85%	92.04%	84.05%	84.05%	Table D.2, Row AF
H	**Estimated FY 2017-18 FPE**	**5,655.63**	**4,867.95**	**34.52**	**1,610.70**	**10,794.16**	**31.94**	**Row C * Row D**

Table D.3.5 - Calculation of FY 2019-20 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)

Row	FY 2019-20	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	5,882	5,494	0	1,772	13,259	0	
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	168	107	0	26	301	0	See narrative
C	Adjustments from HB-16-1321: Medicaid Buy-In Certain Medicaid Waivers	0	(35)	40	0	(35)	40	See narrative
D	Total Bottom Line Adjustments	168	72	0	26	266	0	Row B
E	Final Estimated FY 2017-18 Average Monthly Enrollment Under Current Policy	6,050	5,566	40	1,798	13,525	40	Row A + Row B
F	**Final Estimated FY 2017-18 Average Monthly Enrollment**	**6,050**	**5,566**	**40**	**1,798**	**13,525**	**40**	**Row A + Row B**
G	FPE Adjustment Factor	98.62%	90.85%	90.85%	92.04%	84.05%	84.05%	Table D.2, Row AF
H	**Estimated FY 2017-18 FPE**	**5,966.27**	**5,056.93**	**36.34**	**1,654.88**	**11,367.36**	**33.62**	**Row C * Row D**

Table D.4.1 - HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers

Row	Fiscal Year	Average Monthly Enrollment	Total Cost	Per Utilizer Cost	Percent Change in Enrollment	Percent Change in Total Cost	Percent Change in Per-Utilizer Cost
A	FY 2007-08	120	$19,814,222	$165,119			
B	FY 2008-09	129	$26,028,730	$201,773	7.50%	31.36%	22.20%
C	FY 2009-10	118	$28,360,034	$240,339	-8.53%	8.96%	19.11%
D	FY 2010-11	122	$24,142,015	$197,885	3.39%	-14.87%	-17.66%
E	FY 2011-12	122	$25,276,720	$207,186	0.00%	4.70%	4.70%
F	FY 2012-13	135	$24,167,096	$179,016	10.66%	-4.39%	-13.60%
G	FY 2013-14	127	$22,225,364	$175,003	-5.93%	-8.03%	-2.24%
H	FY 2014-15	124	$21,454,023	$173,016	-2.36%	-3.47%	-1.14%
I	FY 2015-16	116	$19,900,398	$171,186	-6.25%	-7.24%	-1.06%
J	FY 2016-17(1)	111	$19,175,157	$172,749	-4.52%	-3.64%	0.91%

(1) Through February 2017. Regional Center payments were manually processed after the implementation of interChange and caseload data is currently not available for these months.

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	FY 2016-17	$70,579.68	$14,261.48	$0.00	$18,220.51	$2,545.76	$0.00
K	Estimated FY 2017-18	$73,259.39	$15,441.58	$8,626.21	$18,355.52	$3,112.15	$2,041.35
L	Estimated FY 2018-19	$72,158.71	$15,769.88	$15,581.30	$17,895.71	$2,750.53	$2,740.23
M	Estimated FY 2019-20	$72,158.71	$15,902.90	$15,769.88	$17,895.71	$2,750.53	$2,750.53

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	FY 2016-17	3.28%	4.29%	0.00%	3.75%	3.59%	0.00%
K	Estimated FY 2017-18	3.80%	8.27%	100.00%	0.74%	22.25%	100.00%
L	Estimated FY 2018-19	-1.50%	2.13%	80.63%	-2.51%	-11.62%	34.24%
M	Estimated FY 2019-20	0.00%	0.84%	1.21%	0.00%	0.00%	0.38%

Table E.3 - 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 S-5 (FPE) Expenditure Forecast	$70,013.99	$14,324.02	$0.00	$17,646.05	$2,687.14	$0.00	Table E.3 Row E, Buy-In Set Equal to Respective Non-Buy-In Service
B	Base Trend	1.49%	0.00%	0.00%	0.00%	0.00%	0.00%	
C	Estimated Base FY 2017-18 Per FPE Expenditure	$71,054.50	$14,324.02	$0.00	$17,646.05	$2,687.14	$0.00	Row A * (1 + Row B)
	Rate Adjustments [1]							
D		1.42%	1.68%	1.68%	1.29%	1.29%	1.29%	FY 2017-18 Rate Increase
E	Estimated Base FY 2017-18 Per FPE after Rate Adjustments	$72,063.47	$14,564.66	$8,496.05	$17,873.68	$2,721.80	$2,041.35	Row A * (1 + Row B). Buy-In programs adjusted for expected 11/1/2017 implementation date.
	Bottom Line Adjustments							
F	Annualization of FY 2015-16 R-7 "Participant Directed Programs Expansion" [1]	$0.00	$173.54	$130.16	$0.00	$0.00	$0.00	Adjusted for delayed start date.
G	Annualization of costs associated with transitioning individuals on the 1915(i) Waiver to HCBS-SLS CDASS	$0.00	$48.90	$0.00	$0.00	$0.00	$0.00	Additional cost of high CDASS utilization 1915(i) transitions
H	InterChange Payment Lag Adjustment	$1,195.92	$654.48	$0.00	$481.84	$375.65	$0.00	Providers have unpaid claims held over from FY 2016-17 due to technical issues with interChange implementation. These clients are expected to bill in FY 2017-18.
I	Annualization of FY 2018-19 R-10 Regional Center Task Force Recommendation Implementation	$0.00	$0.00	$0.00	$0.00	$14.71	$0.00	Addition of Intensive Case Management for clients transitioning out of institutional settings.
J	**Total Estimated FY 2017-18 Per FPE Expenditure**	**$73,259.39**	**$15,441.58**	**$8,626.21**	**$18,355.52**	**$3,112.15**	**$2,041.35**	**Sum of Row E Through I**

(1) The Department expects to begin offering Consumer Directed Attendant Support Services (CDASS) to clients on the HCBS-SLS waiver by November 1, 2017. The Department assumes that participation in the program will ramp-up at a uniform rate over FY 2017-18 and reach full enrollment by June 1, 2018 at 12.65% of the HCBS-SLS waiver population, with each SLS-CDASS client costing an additional $7,467.00 in waiver services above non-CDASS HCBS-SLS clients.

Table E.4 - 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	$73,259.39	$15,441.58	$15,441.58	$18,355.52	$3,112.15	$3,112.15	Table E.4 Row E. Buy-in Increased to match corresponding non-buy in service.
	Rate Adjustments (1)							
B		0.13%	0.15%	0.15%	0.12%	0.12%	0.12%	Annualization of FY 2017-18 Rate Increase
C	Estimated Base FY 2018-19 Per FPE after Rate Adjustments	$73,354.63	$15,464.74	$15,464.74	$18,377.55	$3,115.88	$3,115.88	Row C * (1 + Row D).
	Bottom Line Adjustments							
D	Annualization of FY 2015-16 R-7 "Participant Directed Programs Expansion"(1)	$0.00	$771.04	$771.04	$0.00	$0.00	$0.00	Adjusted for delayed start date.
E	Annualization of costs associated with transitioning individuals on the 1915(i) Waiver to HCBS-SLS CDASS	$0.00	$188.58	$0.00	$0.00	$0.00	$0.00	Additional cost of high CDASS utilization 1915(i) transitions
F	Annualization of InterChange Payment Lag Adjustment	($1,195.92)	($654.48)	($654.48)	($481.84)	($375.65)	($375.65)	
G	Annualization of FY 2018-19 R-10 Regional Center Task Force Recommendation Implementation	$0.00	$0.00	$0.00	$0.00	$10.30	$0.00	Addition of Intensive Case Management for clients transitioning out of institutional settings.
H	**Total Estimated FY 2018-19 Per FPE Expenditure**	**$72,158.71**	**$15,769.88**	**$15,581.30**	**$17,895.71**	**$2,750.53**	**$2,740.23**	**Row E + Row F + Row G**

(1) The Department expects to begin offering Consumer Directed Attendant Support Services (CDASS) to clients on the HCBS-SLS waiver by November 1, 2017. The Department assumes that participation in the program will ramp-up at a uniform rate over FY 2017-18 and reach full enrollment by June 1, 2018 at 12.65% of the HCBS-SLS waiver population, with each SLS-CDASS client costing an additional $7467.00 in waiver services above non-CDASS HCBS-SLS clients.

Table E.5 - Calculation of FY 2019-20 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 2018-19 Per Full Program Equivalent (FPE) Expenditure	$72,158.71	$15,769.88	$15,769.88	$17,895.71	$2,750.53	$2,750.53	Table E.4 Row E. Buy-in Increased to match corresponding non-buy in service.
B	Base Trend	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	Based on Analysis of Individual Service Trends
C	Estimated Base FY 2017-18 Per FPE Expenditure	$72,158.71	$15,769.88	$15,769.88	$17,895.71	$2,750.53	$2,750.53	Row A * (1 + Row B)
	Rate Adjustments							
D		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
E	Estimated Base FY 2019-20 Per FPE after Rate Adjustments	$72,158.71	$15,769.88	$15,769.88	$17,895.71	$2,750.53	$2,750.53	Row C * (1 + Row D).
	Bottom Line Adjustments (1)							
F	Annualization of costs associated with transitioning individuals on the 1915(i) Waiver to HCBS-SLS CDASS	$0.00	$133.02	$0.00	$0.00	$0.00	$0.00	Additional cost of high CDASS utilization 1915(i) transitions
G	**Total Estimated FY 2019-20 Per FPE Expenditure**	**$72,158.71**	**$15,902.90**	**$15,769.88**	**$17,895.71**	**$2,750.53**	**$2,750.53**	**Row E + Row F + Row G**

(1) The Department expects to begin offering Consumer Directed Attendant Support Services (CDASS) to clients on the HCBS-SLS waiver by November 1, 2017. The Department assumes that participation in the program will ramp-up at a uniform rate over FY 2017-18 and reach full enrollment by June 1, 2018 at 12.65% of the HCBS-SLS waiver population, with each SLS-CDASS client costing an additional $7467.00 in waiver services above non-CDASS HCBS-SLS clients.

Table F.1 - Division for Intellectual and Developmental Disabilities (DIDD) FY 2017-18 Quality Assurance, Utilization Review and Support Intensity Scale Service Forecast

Row	Service	Item	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities 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	5,413	111	5,139	20	1,702	12,385	Table D.3.1 Row K
B		Rate	$25.86	$25.86	$25.86	$25.86	$25.86		FY 2017-18 Rate
C		Estimated Total Expenditure	$1,679,762	$34,446	$1,594,734	$6,206	$528,165	$3,843,313	Row A * Row B * 12
D	**Utilization Review**	Estimated Total Average Monthly Enrollment	5,413	111	5,139	20	1,702	12,385	Table D.3.1 Row K
E		Rate	$82.44	$82.44	$82.44	$82.44	$82.44		FY 2017-18 Rate
F		Estimated Total Expenditure	$446,248	$9,151	$423,659	$1,649	$140,313	$1,021,020	Row D* Row E
G	**Support Intensity Scale**	Estimated New and Renewal Average Monthly Enrollment	846	11	1,116	7	0	1,980	Estimated June 2018 Enrollment - Estimated June 2017 Enrollment + 10% of Estimated June 2017 Enrollment
H		Rate	$236.35	$236.35	$236.35	$236.35	$0.00		FY 2017-18 Rate
I		Estimated Total Expenditure	$199,952	$2,600	$263,767	$1,678	$0	$467,997	Row G * Row H
J	**Estimated Total Expenditure**		**$2,325,962**	**$46,197**	**$2,282,160**	**$9,533**	**$668,478**	**$5,332,330**	**Row C + Row F + Row I**

Table F.2 - 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 Comprehensive Waiver (HCBS-DD) - Regional Centers**	**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	5,735	111	5,358	38	1,750	12,992	Table D.3.1 Row L
B		Rate	$25.51	$25.51	$25.51	$25.51	$25.51		FY 2017-18 Rate
C		Estimated Total Expenditure	$1,755,598	$33,979	$1,640,191	$11,633	$535,710	$3,977,111	Row A * Row B * 12
D	**Utilization Review**	Estimated Total Average Monthly Enrollment	5,735	111	5,358	38	1,750	12,992	Table D.3.1 Row L
E		Rate	$82.44	$82.44	$82.44	$82.44	$82.44		FY 2017-18 Rate
F		Estimated Total Expenditure	$472,793	$9,151	$441,714	$3,133	$144,270	$1,071,061	Row D* Row E
G	**Support Intensity Scale**	Estimated New and Renewal Average Monthly Enrollment	878	11	759	0	0	1,648	Estimated June 2019 Enrollment - Estimated June 2018 Enrollment + 10% of Estimated June 2018 Enrollment
H		Rate	$236.35	$236.35	$236.35	$236.35	$0.00		FY 2017-18 Rate
I		Estimated Total Expenditure	$207,515	$2,600	$179,390	$0	$0	$389,505	Row G * Row H
J	**Estimated Total Expenditure**		**$2,435,906**	**$45,730**	**$2,261,295**	**$14,766**	**$679,980**	**$5,437,677**	**Row C + Row F + Row I**

Table F.3 - Division for Intellectual and Developmental Disabilities (DIDD) FY 2019-20 Quality Assurance, Utilization Review and Support Intensity Scale Service Forecast										
Row	**Service**	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS) Buy-In**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**Family Support Services and State Only Supported Living Services**	**Total**	**Source/Calculation**
A	**Quality Assurance**	Estimated Total Average Monthly Enrollment	6,050	111	5,566	40	1,798	0	13,565	Table D.3.1 Row M
B		Rate	$25.86	$25.86	$25.86	$25.86	$25.86	$0.00		FY 2017-18 Rate
C		Estimated Total Expenditure	$1,877,436	$34,446	$1,727,241	$12,413	$557,955	$0	$4,209,491	Row A * Row B * 12
D	**Utilization Review**	Estimated Total Average Monthly Enrollment	6,050	111	5,566	40	1,798	0	13,565	Table D.3.1 Row M
E		Rate	$82.44	$82.44	$82.44	$82.44	$82.44	$0.00		FY 2017-18 Rate
F		Estimated Total Expenditure	$498,762	$9,151	$458,861	$3,298	$148,227	$0	$1,118,299	Row D* Row E
G	**Support Intensity Scale**	Estimated New and Renewal Average Monthly Enrollment	81	0	482	0	30	0	593	Estimated new clients up to August 1, 2017 Implementation of SB 16-192.
H		Estimated SB 16-192 Enrollment	6,050	111	5,566	40	1,798	4,261	17,826	Additional Enrollments From implementation of SB 16-192. See Narrative for further detail.
I		Total Enrollment	6,131	111	6,048	40	1,828	4,261	18,419	Row H + Row I
J		Rate	$236.35	$236.35	$236.35	$236.35	$0.00	$236.35	$236.35	FY 2017-18 Rate
K		Estimated Total Expenditure	$1,449,062	$26,235	$1,429,445	$9,454	$0	$1,007,087	$3,921,283	Row G * Row H
L	**Estimated Total Expenditure**		**$3,825,260**	**$69,832**	**$3,615,547**	**$25,165**	**$706,182**	**$1,007,087**	**$9,249,073**	**Row C + Row F + Row I**

Table G.1 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	$353,441,824	0.0	$176,014,027	$0	$1	$0	$177,427,796
B	Annualization of FY 2017-18 S-5 "IDD Cost and Caseload Adjustment" - FY 2017-18 Impact	$17,191,935	0.0	$9,302,852	$0	$0	$0	$7,889,083
C	1.40% Across the Board Rate Increase	$5,195,599	0.0	$2,597,800	$0	$0	$0	$2,597,799
D	Floor Long Bill Amendment - 7.01% Increase to Transportation Services	$556,404	0.0	$278,202	$0	$0	$0	$278,202
E	Total FY 2017-18 Spending Authority	$376,385,762	0.0	$188,192,881	$0	$1	$0	$188,192,880
	Adult Supported Living Services							
F	FY 2016-17 Final Spending Authority	$74,072,488	0.0	$38,522,702	$0	$4,701,000	$0	$30,848,786
G	HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$53,589	0.0	($207,615)	$0	$234,405	$0	$26,799
H	Annualization of FY 2015-16 R#7 "Participant Directed Programs Expansion"	$1,261,619	0.0	$630,683	$0	$0	$0	$630,936
I	Annualization of FY 2017-18 S-5 "IDD Cost and Caseload Adjustment" - FY 2017-18 Impact	$7,025,554	0.0	$3,738,824	$0	($103,012)	$0	$3,389,742
J	Annualization of JBC Action - Grant to SLS Providers	($4,701,000)	0.0	$0	$0	($4,701,000)	$0	$0
K	1.40% Across the Board Rate Increase	$1,089,382	0.0	$598,359	$0	$1,842	$0	$489,181
L	Floor Long Bill Amendment - 7.01% Increase to Transportation Services	$300,814	0.0	$149,841	$0	$566	$0	$150,407
M	Total FY 2017-18 Spending Authority	$79,102,446	0.0	$43,432,794	$0	$133,801	$0	$35,535,851
N	**SLS Services**	$71,071,703	0.0	$35,402,051	$0	$133,801	$0	$35,535,851
O	**SLS State-Only**	$8,030,743	0.0	$8,030,743	$0	$0	$0	$0
	Children's Extensive Support Services							
P	FY 2016-17 Final Spending Authority	$25,868,756	0.0	$12,882,640	$0	$0	$0	$12,986,116
Q	Annualization of FY 2017-18 S-5 "IDD Cost and Caseload Adjustment" - FY 2017-18 Impact	$1,774,134	0.0	$938,805	$0	$0	$0	$835,329
R	1.40% Across the Board Rate Increase	$387,502	0.0	$193,751	$0	$0	$0	$193,751
S	Total FY 2017-18 Spending Authority	$28,030,392	0.0	$14,015,196	$0	$0	$0	$14,015,196
	Case Management							
T	FY 2016-17 Final Spending Authority	$33,207,351	0.0	$17,647,593	$0	$0	$0	$15,559,758
U	HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$11,497	0.0	($44,544)	$0	$50,292	$0	$5,749
V	Annualization of FY 2017-18 S-5 "IDD Cost and Caseload Adjustment" - FY 2017-18 Impact	$1,925,745	0.0	$984,763	$0	($22,410)	$0	$963,392
W	R-10 Regional Center Task Force Recommendation Implementation	$142,950	0.0	$71,475	$0	$0	$0	$71,475
X	1.40% Across the Board Rate Increase	$494,804	0.0	$261,638	$0	$390	$0	$232,776
Y	Total FY 2017-18 Spending Authority	$35,782,347	0.0	$18,920,925	$0	$28,272	$0	$16,833,150
Z	**Targeted Case Management**	$28,438,382	0.0	$14,196,865	$0	$22,326	$0	$14,219,192
AA	**QA, UR and SIS**	$5,227,918	0.0	$2,608,013	$0	$5,946	$0	$2,613,958
AB	**Case Management - State Only**	$2,116,047	0.0	$2,116,047	$0	$0	$0	$0
	Family Support Services							
AC	FY 2016-17 Final Spending Authority	$6,960,460	0.0	$6,960,460	$0	$0	$0	$0
AD	1.40% Across the Board Rate Increase	$97,573	0.0	$97,573	$0	$0	$0	$0
AE	Total FY 2017-18 Spending Authority	$7,058,033	0.0	$7,058,033	$0	$0	$0	$0
	Preventive Dental Hygiene							
AF	FY 2016-17 Final Spending Authority	$63,311	0.0	$63,311	$0	$0	$0	$0
AG	1.40% Across the Board Rate Increase	$888	0.0	$888	$0	$0	$0	$0
AH	Total FY 2017-18 Spending Authority	$64,199	0.0	$64,199	$0	$0	$0	$0
	Eligibility Determination and Waitlist Management							
AI	FY 2016-17 Final Spending Authority	$3,121,194	0.0	$3,100,556	$0	$0	$0	$20,638
AJ	1.40% Across the Board Rate Increase	$43,753	0.0	$43,464	$0	$0	$0	$289
AK	Total FY 2017-18 Spending Authority	$3,164,947	0.0	$3,144,020	$0	$0	$0	$20,927
AL	**PASRR**	$28,294.15	0.0	$7,367	$0	$0	$0	$20,927
AM	**Medicaid Eligibility Determination**	$3,136,653	0.0	$3,136,653	$0	$0	$0	$0
AN	Total FY 2017-18 Spending Authority	$529,588,126	0.0	$274,828,048	$0	$162,074	$0	$254,598,004

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	$376,385,762	0.0	$188,192,881	$0	$1	$0	$188,192,880
B	Annualization of Floor Long Bill Amendment - 7.01% Increase to Transportation Services	$826,658	0.0	$413,329	$0	$0	$0	$413,329
C	Total FY 2018-19 Spending Authority	$377,212,420	0.0	$188,606,210	$0	$1	$0	$188,606,209
	Adult Supported Living Services							
D	FY 2017-18 Final Spending Authority	$79,102,446	0.0	$43,432,794	$0	$133,801	$0	$35,535,851
E	Annualization of HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$19,487	0.0	($26,227)	$0	$35,976	$0	$9,738
F	Annualization of Floor Long Bill Amendment - 7.01% Increase to Transportation Services	$446,924	0.0	$222,620	$0	$841	$0	$223,463
G	Total FY 2018-19 Spending Authority	$79,568,857	0.0	$43,629,187	$0	$170,618	$0	$35,769,052
H	**SLS Services**	$71,538,114	0.0	$35,598,444	$0	$170,618	$0	$35,769,052
I	**SLS State-Only**	$8,030,743	0.0	$8,030,743	$0	$0	$0	$0
	Children's Extensive Support Services							
J	FY 2017-18 Final Spending Authority	$28,030,392	0.0	$14,015,196	$0	$0	$0	$14,015,196
K	Total FY 2018-19 Spending Authority	$28,030,392	0.0	$14,015,196	$0	$0	$0	$14,015,196
	Case Management							
L	FY 2017-18 Final Spending Authority	$35,782,347	0.0	$18,920,925	$0	$28,272	$0	$16,833,150
M	Annualization of HB 16-1321 Medicaid Buy-In Certain Medicaid Waivers	$4,181	0.0	($5,627)	$0	$7,719	$0	$2,089
N	SB 16-192 Single Assessment	$142,950	0.0	$71,475	$0	$0	$0	$71,475
O	FY 2017-18 R-10 RCTF Reccomendation Implementation	$117,039	0.0	$58,534	$0	$0	$0	$58,505
P	Total FY 2018-19 Spending Authority	$36,046,517	0.0	$19,045,307	$0	$35,991	$0	$16,965,219
Q	**Targeted Case Management**	$28,702,552	0.0	$14,321,247	$0	$30,045	$0	$14,351,260
R	**QA, UR and SIS**	$5,227,918	0.0	$2,608,013	$0	$5,946	$0	$2,613,958
S	**Case Management - State Only**	$2,116,047	0.0	$2,116,047	$0	$0	$0	$0
	Family Support Services							
T	FY 2017-18 Final Spending Authority	$7,058,033	0.0	$7,058,033	$0	$0	$0	$0
U	Total FY 2018-19 Spending Authority	$7,058,033	0.0	$7,058,033	$0	$0	$0	$0
	Preventive Dental Hygiene							
V	FY 2017-18 Final Spending Authority	$64,199	0.0	$64,199	$0	$0	$0	$0
W	Total FY 2018-19 Spending Authority	$64,199	0.0	$64,199	$0	$0	$0	$0
	Eligibility Determination and Waitlist Management							
X	FY 2017-18 Final Spending Authority	$3,164,947	0.0	$3,144,020	$0	$0	$0	$20,927
Y	Total FY 2018-19 Spending Authority	$3,164,947	0.0	$3,144,020	$0	$0	$0	$20,927
Z	**PASRR**	$28,294	0.0	$7,367	$0	$0	$0	$20,927
AA	**Medicaid Eligibility Determination**	$3,136,653	0.0	$3,136,653	$0	$0	$0	$0
AB	Grand Total FY 2018-19 Spending Authority	$531,145,365	0.0	$275,562,152	$0	$206,610	$0	$255,376,603

Table G.3 FY 2019-20 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 2018-19 Final Spending Authority	$377,212,420	0.0	$188,606,210	$0	$1	$0	$188,606,209
B	Total FY 2019-20 Spending Authority	$377,212,420	0.0	$188,606,210	$0	$1	$0	$188,606,209
	Adult Supported Living Services							
C	FY 2018-19 Final Spending Authority	$79,568,857	0.0	$43,629,187	$0	$170,618	$0	$35,769,052
D	Total FY 2019-20 Spending Authority	$79,568,857	0.0	$43,629,187	$0	$170,618	$0	$35,769,052
E	**SLS Services**	$71,538,114	0.0	$35,598,444	$0	$170,618	$0	$35,769,052
F	**SLS State-Only**	$8,030,743	0.0	$8,030,743	$0	$0	$0	$0
	Children's Extensive Support Services							
G	FY 2018-19 Final Spending Authority	$28,030,392	0.0	$14,015,196	$0	$0	$0	$14,015,196
H	Total FY 2019-20 Spending Authority	$28,030,392	0.0	$14,015,196	$0	$0	$0	$14,015,196
	Case Management							
I	FY 2018-19 Final Spending Authority	$36,046,517	0.0	$19,045,307	$0	$35,991	$0	$16,965,219
J	SB 16-192 Single Assessment	$3,398,536	0.0	$1,699,268	$0	$0	$0	$1,699,268
K	**Targeted Case Management**	$39,445,053	0.0	$20,744,575	$0	$35,991	$0	$18,664,487
L	**QA, UR and SIS**	$8,626,453	0.0	$4,307,281	$0	$5,946	$0	$4,313,226
M	**Case Management - State Only**	$2,116,047	0.0	$2,116,047	$0	$0	$0	$0
	Family Support Services							
N	FY 2018-19 Final Spending Authority	$7,058,033	0.0	$7,058,033	$0	$0	$0	$0
O	Total FY 2019-20 Spending Authority	$7,058,033	0.0	$7,058,033	$0	$0	$0	$0
	Preventive Dental Hygiene							
P	FY 2018-19 Final Spending Authority	$64,199	0.0	$64,199	$0	$0	$0	$0
Q	Total FY 2019-20 Spending Authority	$64,199	0.0	$64,199	$0	$0	$0	$0
	Eligibility Determination and Waitlist Management							
R	FY 2018-19 Final Spending Authority	$3,164,947	0.0	$3,144,020	$0	$0	$0	$20,927
S	Total FY 2019-20 Spending Authority	$3,164,947	0.0	$3,144,020	$0	$0	$0	$20,927
T	**PASRR**	$28,294	0.0	$7,367	$0	$0	$0	$20,927
U	**Medicaid Eligibility Determination**	$3,136,653	0.0	$3,136,653	$0	$0	$0	$0
V	Grand Total FY 2019-20 Spending Authority	$534,543,901	0.0	$277,261,420	$0	$206,610	$0	$257,075,871

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title — **R-06 Electronic Visit Verification Implementation**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ Supplemental FY 2017-18

X Change Request FY 2018-19

___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$7,786,649,770	$0	$7,729,290,856	($777,203)	($6,443,371)
	FTE	418.4	0.0	427.4	7.8	8.0
	GF	$2,169,934,556	$0	$2,154,597,785	($1,200,233)	($3,889,331)
	CF	$894,262,529	$0	$892,391,462	$0	$0
	RF	$72,657,640	$0	$72,812,343	$0	$0
	FF	$4,649,795,045	$0	$4,609,489,266	$423,030	($2,554,040)

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- Personal Services	Total	$30,884,154	$0	$32,040,094	$490,846	$507,058
	FTE	418.4	0.0	427.4	7.8	8.0
	GF	$10,512,849	$0	$10,769,424	$112,053	$176,641
	CF	$2,985,184	$0	$3,045,883	$0	$0
	RF	$1,885,978	$0	$2,242,657	$0	$0
	FF	$15,500,143	$0	$15,982,130	$378,793	$330,417
01. Executive Director's Office, (A) General Administration -- Health, Life, and Dental	Total	$3,637,126	$0	$3,637,126	$63,416	$63,416
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,305,776	$0	$1,305,776	$14,233	$21,799
	CF	$344,132	$0	$344,132	$0	$0
	RF	$103,855	$0	$103,855	$0	$0
	FF	$1,883,363	$0	$1,883,363	$49,183	$41,617

01. Executive Director's Office, (A) General Administration -- Short-term Disability	**Total**	**$58,060**	**$0**	**$58,060**	**$714**	**$743**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,586	$0	$21,586	$154	$240
	CF	$4,802	$0	$4,802	$0	$0
	RF	$1,364	$0	$1,364	$0	$0
	FF	$30,308	$0	$30,308	$560	$503
01. Executive Director's Office, (A) General Administration -- Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,615,047**	**$18,779**	**$19,505**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$600,398	$4,056	$6,308
	CF	$133,634	$0	$133,634	$0	$0
	RF	$37,970	$0	$37,970	$0	$0
	FF	$843,045	$0	$843,045	$14,723	$13,197
01. Executive Director's Office, (A) General Administration -- Supplemental Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,615,047**	**$18,779**	**$19,505**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$600,398	$4,056	$6,308
	CF	$133,634	$0	$133,634	$0	$0
	RF	$37,970	$0	$37,970	$0	$0
	FF	$843,045	$0	$843,045	$14,723	$13,197
01. Executive Director's Office, (A) General Administration -- Operating Expenses	**Total**	**$2,162,529**	**$0**	**$2,082,684**	**$30,445**	**$7,600**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$961,889	$0	$948,995	$8,639	$2,613
	CF	$74,170	$0	$70,519	$0	$0
	RF	$26,219	$0	$13,297	$0	$0
	FF	$1,100,251	$0	$1,049,873	$21,806	$4,987
01. Executive Director's Office, (C) Information Technology Contracts and Projects -- MMIS Maintenance and Projects	**Total**	**$41,646,122**	**$0**	**$41,988,677**	**$2,217,813**	**$2,290,560**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,955,404	$0	$5,979,906	$465,574	$572,640
	CF	$4,288,071	$0	$4,445,412	$0	$0
	RF	$11,808	$0	$6,618	$0	$0
	FF	$31,390,839	$0	$31,556,741	$1,752,239	$1,717,920

Line Item	Fund					
02. Medical Services Premiums -- Medical Services Premiums	**Total**	**$7,597,898,847**	**$0**	**$7,538,955,686**	**($3,563,217)**	**($9,209,023)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	($1,781,609)	($4,604,512)
	CF	$886,165,101	$0	$884,043,394	$0	$0
	RF	$70,552,476	$0	$70,368,612	$0	$0
	FF	$4,548,653,004	$0	$4,507,666,920	($1,781,608)	($4,604,511)

Line Item	Fund					
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Adult Supported Living Services	**Total**	**$79,102,446**	**$0**	**$79,268,043**	**($47,164)**	**($124,080)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$43,432,794	$0	$43,479,346	($23,582)	($62,040)
	CF	$133,801	$0	$170,052	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$35,535,851	$0	$35,618,645	($23,582)	($62,040)

Line Item	Fund					
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Children's Extensive Support Services	**Total**	**$28,030,392**	**$0**	**$28,030,392**	**($7,614)**	**($18,655)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$14,015,196	$0	$14,015,196	($3,807)	($9,328)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$14,015,196	$0	$14,015,196	($3,807)	($9,327)

CF Letternote Text Revision Required? Yes ____ No X — **If Yes, see schedule 4 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 $420,959 total funds, including $42,096 General Fund and 0.8 FTE, in FY 2017-18 to hire staff to oversee systems implementation of an Electronic Visit Verification (EVV) system and to begin work with an EVV systems contractor. The Department requests rollforward authority for funds allocated to begin contractor work in the amount of $296,267 total funds.
- The Department requests a decrease of $777,203 total funds, including a decrease of $1,200,233 General Fund and an increase of 7.8 FTE, in FY 2018-19. This amount includes an increase of $2,840,792 total funds that would be used to pay for EVV system implementation and operations, and an offsetting savings estimate of $3,617,995 total funds.
- The Department requests a decrease of $6,443,371 total funds, including a decrease of $3,889,331 General Fund and an increase of 8.0 FTE, in FY 2019-20. This amount includes an increase of $2,908,387 total funds that would be used to pay for EVV system operations and an offsetting savings estimate of $9,351,758 total funds.
- Of the FTE requested, 4.0 FTE would be term-limited, with terms expiring June 30, 2021.

Current Program

- The state currently does not employ an EVV system. In FY 2015-16 the state spent $655,480,406 total funds on services that would be covered by EVV under the Department's proposed solution.

Problem or Opportunity

- The 21st Century Cures Act mandates that all states implement an EVV system for Personal Care services by January 1, 2019 and for Home Health services by January 1, 2023.
- Implementation of EVV for Personal Care and Home Health services could be expanded to additional attendant based services with minimal additional cost to the Department.
- The Department expects to see a cost savings from reduced billing, and improvements in data collection, for all services in which EVV is implemented.

Consequences of Problem

- If EVV is not implemented in Personal Care the state will see incremental reductions in federal Medicaid matching funds beginning in FY 2019-20 and compounding until EVV is implemented.
- If EVV is not implemented in other attendant based services, the Department will remain at risk of overbilling in these services.

Proposed Solution

- The Department requests funding to implement EVV for Personal Care Services by the January 1, 2019 deadline as mandated by the 21st Century Cures Act. The Department also requests to simultaneously implement EVV for Home Health Services, Homemaker services, Hospice, Private Duty Nursing, and Health Maintenance Activities. This process would involve contracting with an EVV systems vendor to create a Colorado-specific EVV system and provide provider trainings, working with current Medicaid Management Information System (MMIS) vendors to integrate EVV into the Department's collective system, and providing ongoing support to providers to facilitate EVV implementation and mitigate service and payment disruptions. The Department requests rollforward authority for funds allocated to begin contractor work in the amount of $296,267 total funds.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2018-19 Funding Request | November 1, 2017

Department Priority: ***R-6***
Request Detail: ***Electronic Visit Verification Implementation***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Electronic Visit Verification Implementation	($777,203)	($1,200,233)

Problem or Opportunity:

The Department does not currently operate an Electronic Visit Verification (EVV) system as required through H.R. 34 of the 114th Congress, also known as the 21st Century Cures Act, signed into law on December 13, 2016. This law mandates that all states implement an EVV system for Personal Care services by January 1, 2019 and for Home Health services by January 1, 2023.

An EVV system would require attendants to clock in and out when they begin and finish providing services using a combination of telephone and internet based resources. This reduces the risk of fraud due to improper self-reporting of time spent providing a service.

If the state does not meet the January 1, 2019 implementation deadline for EVV for Personal Care services the 21st Century Cures Act calls for the State's Federal Medical Assistance Percentage (FMAP) to be reduced by 0.25 percentage points in calendar years 2019 and 2020, 0.5 percentage points in calendar year 2021, 0.75 percentage points in calendar year 2022 and one percentage point in 2023 and each year afterwards. A corresponding penalty applies to states missing the January 1, 2023 deadline to implement EVV for Home Health services. These FMAP reductions would reduce the amount of federal funding received by the Department, increasing the cost for the State to maintain the same level of services for clients.[1]

An analysis of four states currently using EVV shows a savings potential of five to twelve percent per-service due to implementation of EVV.[2] Colorado currently relies on providers to bill the Department for services rendered based on an attendant's self-reported hours. This methodology leaves the State vulnerable to over-billing by providers who overstate the amount of time spent providing a service. States currently employing

[1] The 21st Century Cures Act allows for a one year delay in FMAP reduction if a state can show a good faith effort towards implementing EVV that has encountered unavoidable system delays. In the event of delayed implementation, the Department would request an abeyance of the FMAP reduction from CMS, and would document all delays in preparation for this contingency.
[2] Based on a review of Florida, Texas, Tennessee, and Oklahoma by Sandata – a provider of EVV systems and services.

EVV systems have seen savings from a reduction of units billed per-visit, as well as a reduction in the number of overall visits billed for services.

Proposed Solution:

The Department requests an increase of $420,959 total funds, including $42,096 General Fund and 0.8 FTE, in FY 2017-18 to hire staff to oversee systems implementation of an Electronic Visit Verification (EVV) system and to begin work with an EVV systems contractor. The Department requests rollforward authority for funds allocated to begin contractor work in the amount of $296,267 total funds.

The Department requests a decrease of $777,203 total funds, including a decrease of $1,200,233 General Fund and increase of 7.8 FTE, in FY 2018-19. This amount includes an increase of $2,840,792 total funds that would be used to pay for EVV system implementation and operations, and an offsetting savings estimate of $3,617,995 total funds.

The Department requests a decrease of $6,443,371 total funds, including a decrease of $3,889,331 General Fund and increase of 8.0 FTE, in FY 2019-20. This amount includes an increase of $2,908,387 total funds that would be used to pay for EVV system operations and an offsetting savings estimate of $9,351,758 total funds.

The Department requests funding to enter into an ongoing contract with an EVV systems vendor that would be responsible for tracking service data and reporting this data to the Department. The duty of the EVV vendor would be to deploy EVV systems across Colorado's Personal Care, Home Health, Hospice, Private Duty Nursing, and Consumer Directed Attendant Support Services Financial Management Service provider network. At a minimum, as mandated by the 21st Century Cures Act, the vendor would be required to collect data on the type of service being performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends. The Department's Medicaid Management Information System (MMIS) system would cross-reference this EVV data with claims data to verify the accuracy of each type of claim. This collection of data is referred to as a transaction when applied to a single check in or check out instance. The primary ongoing function of the EVV vendor would be to record, store, and transmit to the MMIS every EVV transaction that occurs in Colorado. The Department estimates that the EVV vendor will process approximately 1.25 million transactions per month based on contractor estimates. The EVV vendor would also be required to train providers on use of EVV and provide assistance for EVV systems in an ongoing capacity by operating a call center.

The Department requests that funds for the EVV and interChange contractor be allocated in FY 2017-18 and given rollforward authority into FY 2018-19. The Department believes that beginning work on an EVV system as early as possible will facilitate effective implementation by the federally mandated implementation deadline of January 1, 2019 and supplemental funding coupled with rollforward authority would aid in meeting this deadline.

The Department requests 8.0 FTE to aid in implementation and ongoing oversight of EVV. Of these FTE 4.0 are requested as permanent staff and 4.0 are requested as term limited positions through June 30, 2021. In FY 2015-16, the Department served approximately forty thousand unique individuals through the attendant

based services included in EVV under the Department's proposed solution. These clients are served through a network of providers that are diverse in size, location, operational structure, scope of services offered, and familiarity with EVV. The Department's goal is to implement a fully functional EVV system across this network by January 1, 2019. Assuming that the Department receives supplemental funding in April, this timeline leaves approximately 9 months for the Department to coordinate with an EVV vendor to design, disseminate, and train providers to use an EVV system. During this time, the Department would also need to oversee the integration of the newly designed EVV system with the current interChange system. In order to meet this deadline, and meet the goal of minimally disrupting provider operations and client quality of care, the Department is requesting significant FTE resources to form two teams that would oversee implementation from a systems perspective and a programmatic perspective focused on provider/client experience.

The systems team would include five FTE; a Project Manager (term limited), a Business Analyst (term limited), a Testing Analyst (term limited), an Operations Analyst, and a Data Analyst. Detailed descriptions the role of each FTE can be found in Appendix A. The Department's recent experience with the implementation of the interChange system has emphasized the need for comprehensive contractor oversight when implementing and maintaining systems that have provider and client impacts of large scope. These FTE combined would ensure that that contractors know and meet Department expectations in terms of functionality and timeline. These FTE would facilitate communication between contractors to ensure that systems bridges meet Department standards. These FTE would ensure that contractor work is meeting the needs of providers and clients during implementation and in an ongoing capacity.

The Programmatic team would include three FTE; two Policy Specialists and a Quality Assurance Specialist (term limited). Detailed descriptions of the role of each FTE can be found in Appendix A. These staff would focus on the impact of EVV on the provider and client experience. They would work with providers to ensure that new rules are understood, listen to provider concerns, and ensure that concerns are addressed during the systems implementation process in collaboration with the system team. These staff would engage in frequent stakeholder outreach during implementation to ease the impact of EVV on provider processes. After implementation, this team would act as the Department's liaison for providers impacted by EVV and would update state regulation, Federal program and policy agreements, and contracts as needed.

Without these two teams working in tandem, the Department risks a delayed or incomplete implementation of EVV. Delayed implementation would put the Department at risk of an FMAP reduction, requiring the state to appropriate additional General Fund dollars to maintain current levels of care. Incomplete implementation would degrade EVV functionality along with the provider and client EVV experience. Without staff to oversee systems implementation the Department would have less input during the design process, potentially leading to an extended and costly systems revision process once the system is operational. Such a process would disrupt provider operations, require frequent re-training, and reduce the usefulness of EVV data. Without staff to collaborate with providers on EVV policy provider and client preferences would be less likely to be integrated into the EVV system. Ultimately, understaffing the teams involved in EVV implementation would risk harming the client and provider experience by mandating the use of an unsupported system that was rapidly developed with minimal input from clients and providers and with little Department oversight.

The Department is also requesting funding to hold multiple targeted stakeholder trainings across the state during the first half of FY 2018-19. Staff from the Department and the EVV contractor would visit locations across the state to communicate directly with impacted providers to answer questions and hear concerns about the new system. These trainings would be supplemental to trainings provided by the EVV vendor. Given the expedited timeline of EVV implementation, the Department believes that additional trainings local to providers would facilitate the transition to EVV.

Anticipated Outcomes:

Under the Department's proposed solution, an EVV system that meets the requirements of the 21st Century Cures Act would be implemented by January 1, 2019. This would ensure that the Department meets the requirements of the Act and is not at risk to lose federal matching funds. Additionally, the Department expects to see savings immediately upon implementation of EVV due to reduced volume of units billed per-visit and reduced total visits for all services in which EVV is implemented.

The Department is committed to achieving its performance plan goals. Fraud mitigation through EVV aligns with the Department's long run performance plan goal of reducing the cost of health care in Colorado. EVV is supported by the Department's "Tools of Transformation" strategic policy initiative by using levers in the Departments control to maximize the use of value-based payment reform and emerging health technologies. EVV would help to ensure that the Department is paying attendants only for time spent providing services by leveraging modern technology.

The Department would begin stakeholder outreach in the fall of 2017 and begin to hire staff in the spring of 2017. These FTE, with assistance from current staff, would plan EVV implementation and draft the scope of work for the EVV systems contractor. The systems contractor would begin work in the spring of 2018 developing Colorado's EVV system and distributing provider training.

During the first half of FY 2018-19 the Department's interChange vendor would work with the EVV vendor to establish needed connectivity with the Department's current systems. Simultaneously the Department would draft and submit the necessary State Plan Amendment (SPA), Implementation Advance Planning Document (IAPD), Waiver Amendments, and rule changes. Without any unforeseen delays, the EVV system would be operational by the federally mandated deadline of January 1, 2019.

After implementation, the requested Department staff would monitor utilization of affected services. Systems staff would maintain lines of contact to EVV and interChange vendors to rectify any identified system faults. Staff would respond to provider concerns and suggest adaptations to the EVV system based on this feedback when needed. Staff would also maintain lines of communication with federal partners to ensure compliance with EVV regulation.

Assumptions and Calculations:

The Department anticipates that the work of an EVV contractor will fall under the scope of the Department's current contract with its interChange vendor, allowing the Department to forgo the Request for Proposal (RFP) process to expedite implementation and meet the January 1, 2019 implementation deadline.

This contractor would require one-time funding for provider system set-up, internal technical implementation, and provider training. The contractor would also require ongoing operations funding to process EVV transactions, as defined by a single check-in or check-out instance, as well as funding for maintenance of a provider support center and software upgrades.

For the EVV system to function it would need to be able to communicate with the Department's current claims systems. Contractor funding would be required to establish a bridge from the Department's interChange MMIS and the Colorado Benefits Management System (CBMS) to the EVV system to transfer client data and provider/agency data. This data is needed so the EVV system can recognize when an authorized provider is providing services to an eligible client. The EVV system would also need the capability to transfer transaction data to interChange. Additional systems modifications would be required to transfer EVV data from interChange to the Business Intelligence & Data Management system (BIDM), the Department's data analysis environment, to allow the Department to monitor the efficacy of EVV, provide reports, and conduct research.

The implementation of EVV is dependent on approval of a SPA and IAPD. Both of these approvals would be necessary to ensure that the State receives federal matching funds for this project. For a detailed project timeline please see the accompanying tables.

Once EVV is implemented the Department expects to see significant savings resulting from a decrease in the number of billed units for services utilizing EVV. To estimate the amount of savings the Department anticipates that EVV would result in a one percent reduction to the total dollar amount billed for services using EVV. This reduction would be both from fewer units billed per-visit and fewer overall visits billed. This assumption is based on feedback from states that currently use a form of EVV compiled in a study by Sandata, a provider of EVV Services. This study showed that Texas saw a five to seven percent savings in services in which EVV was implemented, Oklahoma saw a decrease of eight percent in billed visits per-month in services in which EVV was implemented, and Florida saw a savings of forty-six percent year-over year in Home Health post EVV implementation. Florida had been experiencing steady declines in Home Health expenditure in prior years, though forty-six was the largest decrease. Based on their research, Sandata estimated a five percent reduction in services covered by EVV in Colorado. Due to differences in the service package covered by EVV from other states and the unique provider and client network in Colorado, the department has chosen to estimate preliminary savings at one percent of the estimated total cost of services that would be provided under EVV. If actual savings differ from the estimates, the Department would account for the difference between estimated and actual savings through the regular budget process.

The estimated cost of procuring an ongoing EVV vendor was estimated based on feedback from Sandata, a provider of EVV system services. The estimated cost of connecting the EVV system to the interChange system was estimated based on feedback from the Department's current interChange vendor. See table 4.2 in the attached tables for a breakout of expected EVV vendor cost.

Please refer to the accompanying tables for more detail on cost estimates, savings estimates, and the EVV implementation timeline for further information.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

The supplemental component of this request is justified by new data requiring substantive changes in funding needs. The new data is in the form of a new federal law mandating the implementation of EVV in for Personal Care by January 1, 2019. This regulation creates an unforeseen contingency requiring a significant workload change. Implementation is expected to require a significant increase of workload for the Department and its contractors. In order to implement by the January 1, 2019 deadline, the Department is requesting supplemental funding to hire a staff in FY 2017-18 as well as to begin work with systems contractors.

Appendix A: FTE Descriptions

Position Name	Position Classification	Number of FTE	Description
Program and Policy Operations Staff			
Home and Community Based Services Policy Specialist	Administrator IV	1.0	The Policy Specialist would be responsible for ongoing oversight and administration of EVV system. The position would be responsible for tracking and maintaining compliance with all regulatory and statutory policy. The position would ensure coordination and collaboration with systems, providers, and pay sources. The position would work closely with inter- and intra-Departmental teams as well as external stakeholders to create, review, and update policy as needed. The position would coordinate with case management entities, as well as participant directed organizations, to provide guidance when necessary. This position would be the subject matter expert on EVV for all HCBS waiver services. This position would be responsible for the ongoing federal and state administration of policy and regulatory requirements.
Quality Assurance Specialist	Administrator III	1.0 (term limited through June 30, 2021)	The Quality Assurance Specialist would be responsible for ensuring compliance with all quality and performance requirements. The position would use data to understand potential areas of concern and highlight audit risks when appropriate. The EVV system will identify instances of potential fraud/waste/abuse by flagging claims that do not comply with EVV requirements. This position would review and investigate client and provider patterns of fraudulent activity for the purpose of making referrals to the Program Integrity division and recommendations on program improvement through rule revision.
Medicaid Provider Policy Specialist	Administrator IV	1.0	This position would formulate, plan, design, develop, evaluate, and resolve problems for the functions of the EVV system as it applies to the Home Health, Private Duty Nursing, and State Plan Personal Care Benefit areas. Managing these benefits would require the position to research and recommend best practices; identify and address benefit or policy gaps; respond to provider inquiries about EVV; and assess current and future EVV policies to meet the Department's expectations for a high level of efficiency, economy, and quality of care. This position would act as subject matter expert on programs not covered under an HCBS waiver.

Systems Implementation and Maintenance Staff			
Project Coordinator	Project Coordinator	1.0 (term limited through June 30, 2021)	The Project Coordinator would oversee the implementation of the EVV system. The Project Coordinator would work with providers to oversee the implementation of the EVV system. This position would coordinate EVV implementation while monitoring the effect on the overall MMIS system, coordinate recording of modifications for management control, and manage compliance of solutions with federal legislation or rules for the Department. This position would provide program and project management expertise to Department staff, business associates and contractors in developing appropriate business solutions for implementing federal mandates and Department initiatives. Mandates include MMIS changes under Health Insurance Portability and Accountability Act (HIPAA), Medicaid Information Technology Architecture (MITA), and other regulatory and/or strategic initiatives related Health IT/Health IE (Information Exchange).
Business Analyst	Analyst III	1.0 (term limited through June 30, 2021)	The EVV tool is a new system component that must be fully developed and integrated with the interChange MMIS. This requires a Business Analyst to work with the vendors in the requirements elicitation process. Due to the timeframe for completing initial Design, Development, and Implementation (DDI) of the EVV subsystem, allocation this FTE would be central to the project's success. The Department would need permanent, ongoing support from these FTE to ensure smooth integration between interChange system components as future enhancements are implemented, specifically to fully capture downstream subsystem requirement impacts. This requires specialized, ongoing knowledge of the business analysis on the technical functions and integration points of the EVV tool with the larger interChange system, as well as maintained awareness of potential federal and state regulation or rule changes that could affect daily EVV processes.
Testing Analyst	Analyst III	1.0 (term limited through June 30, 2021)	The Testing Analyst (TA) would validate that the scope of the developed EVV functionality fully meets Department business requirements. This position would work with the Policy Analysts to understand the requirements of the EVV system based on provider feedback and federal regulation. This position would identify systematic shortfalls before implementation and would

			work with other systems staff to remedy these issues. The position would ensure the functionality of ongoing system updates.
Operations Analyst	Analyst III	1.0	The Operations Analyst position would manage, analyze, and resolve escalated EVV transactions processed by the interChange to ensure ongoing EVV functionality. The Operations Analyst would review escalated claims and prior authorizations established by the EVV system. The Operations Analyst would regularly provide clarification and education to Fiscal Agent monitoring staff, public and private partners, and contractors when questions about EVV systems functionality arise. The position would follow up with written and verbal responses to resolve all issues that surface during the review of escalated transactions.
Data Analyst	Statistical Analyst III	1.0	The role of the Data Analyst would be to understand the structure of the EVV database, and to understand the EVV system's integration into the MMIS database management system, in order to provide reliable and useful ad-hoc reports. These ad-hoc reports would be used by other FTE on the EVV to monitor provider service delivery behavior and to prevent fraudulent billing. This position would be required to utilize business intelligence software to write complex queries to extract data from the EVV system directly or through the Department's business intelligence and data management system. The position would write code to manipulate data to provide actionable information to answer very specific questions around the operations and evaluation of the EVV system. The position would summarize the data into understandable reports and communicate findings to internal and external customers. The position would be required to work with the EVV contractor, auditors, federal and state agencies and produce reports out of the EVV to meet their requests.
Grand Total		**8.0**	

Table 1.1 - FY 2017-18 Electronic Visit Verification (EVV) Summary by Line Item									
Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP or FMAP	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$52,218	0.8	$5,222	$0	$0	$46,996	90.00%	Table 2.1 Row A
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$39,635	0.8	$3,963	$0	$0	$35,672	90.00%	Table 2.1 Row A
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$84	0.8	$8	$0	$0	$76	90.48%	Table 2.1 Row A
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$2,245	0.8	$225	$0	$0	$2,020	89.98%	Table 2.1 Row A
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$2,245	0.8	$225	$0	$0	$2,020	89.98%	Table 2.1 Row A
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$28,265	0.8	$2,826	$0	$0	$25,439	90.00%	Table 2.1 Row A
G	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information System Maintenance and Projects(1)	$296,267	0.0	$29,627	$0	$0	$266,640	90.00%	Table 2.1 Row B and C
H	**Total Estimate**	**$420,959**	**0.8**	**$42,096**	**$0**	**$0**	**$378,863**		

(1) The Department requests roll forward authority for $296,267 total funds requested for EVV systems contractors.

Table 1.2 - FY 2018-19 Electronic Visit Verification (EVV) Summary by Line Item									
Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP or FMAP	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$490,846	7.8	$112,053	$0	$0	$378,793	77.17%	Table 2.2 Row F
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$63,416	7.8	$14,233	$0	$0	$49,183	77.56%	Table 2.2 Row F
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$714	7.8	$154	$0	$0	$560	78.43%	Table 2.2 Row F
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$18,779	7.8	$4,056	$0	$0	$14,723	78.40%	Table 2.2 Row F
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$18,779	7.8	$4,056	$0	$0	$14,723	78.40%	Table 2.2 Row F
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$30,445	7.8	$8,639	$0	$0	$21,806	71.62%	Table 2.2 Row E and F
G	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information System Maintenance and Projects	$2,217,813	0.0	$465,574	$0	$0	$1,752,239	79.01%	Table 2.2 Row B, C, and D
H	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($3,563,217)	0.0	($1,781,609)	$0	$0	($1,781,608)	50.00%	Table 2.2 Row A
I	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs; Supported Living Services	($47,164)	0.0	($23,582)	$0	$0	($23,582)	50.00%	Table 2.2 Row A
J	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs; Children's Extensive Support Services	($7,614)	0.0	($3,807)	$0	$0	($3,807)	50.00%	Table 2.2 Row A
K	**Total Estimate**	**($777,203)**	**7.8**	**($1,200,233)**	**$0**	**$0**	**$423,030**		

Table 1.3 - FY 2019-20 Electronic Visit Verification (EVV) Summary by Line Item									
Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP or FMAP	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$507,058	8.0	$176,641	$0	$0	$330,417	65.16%	Table 2.3 Row C
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$63,416	8.0	$21,799	$0	$0	$41,617	65.63%	Table 2.3 Row C
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$743	8.0	$240	$0	$0	$503	67.70%	Table 2.3 Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$19,505	8.0	$6,308	$0	$0	$13,197	67.66%	Table 2.3 Row C
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$19,505	8.0	$6,308	$0	$0	$13,197	67.66%	Table 2.3 Row C
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$7,600	8.0	$2,613	$0	$0	$4,987	65.62%	Table 2.2 Row B
G	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information System Maintenance and Projects	$2,290,560	0.0	$572,640	$0	$0	$1,717,920	75.00%	Table 2.3 Row B
H	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($9,209,023)	0.0	($4,604,512)	$0	$0	($4,604,511)	50.00%	Table 2.3 Row A
I	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs; Supported Living Services	($124,080)	0.0	($62,040)	$0	$0	($62,040)	50.00%	Table 2.3 Row A
J	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs; Children's Extensive Support Services	($18,655)	0.0	($9,328)	$0	$0	($9,327)	50.00%	Table 2.3 Row A
K	**Total Estimate**	**($6,443,371)**	**8.0**	**($3,889,331)**	**$0**	**$0**	**($2,554,040)**		

Table 1.4 - FY 2020-21 Electronic Visit Verification (EVV) Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$507,058	8.0	$176,641	$0	$0	$330,417	65.16%	Table 2.4 Row C
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$63,416	8.0	$21,799	$0	$0	$41,617	65.63%	Table 2.4 Row D
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$743	8.0	$240	$0	$0	$503	67.70%	Table 2.4 Row (1) The Quality Assurance Specialist, Project Coordinator, Business Analyst, and Testing Analyst are requested as term limited through June 30, 2021.
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$19,505	8.0	$6,308	$0	$0	$13,197	67.66%	Table 2.4 Row
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$19,505	8.0	$6,308	$0	$0	$13,197	67.66%	Table 2.4 Row
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$7,600	8.0	$2,612	$0	$0	$4,988	65.62%	Table 2.2 Row
B	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information System Maintenance and Projects	$2,290,560	0.0	$572,640	$0	$0	$1,717,920	75.00%	Table 2.4 Row B
C	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($10,004,055)	0.0	($5,002,028)	$0	$0	($5,002,027)	50.00%	Table 2.4 Row A
D	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs; Supported Living Services	($137,104)	0.0	($68,552)	$0	$0	($68,552)	50.00%	Table 2.4 Row A
E	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs; Children's Extensive Support Services	($19,196)	0.0	($9,598)	$0	$0	($9,598)	50.00%	Table 2.4 Row A
F	**Total Estimate**	**($7,251,968)**	**8.0**	**($4,293,630)**	**$0**	**$0**	**($2,958,338)**		

Table 2.1 FY 2017-18 Electronic Visit Verification (EVV) Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP or FMAP	Notes/Calculations
A	EVV Operations Staff[1]	$124,692	0.8	$12,469	$0	$0	$112,223	90.00%	Funding for Project Coordinator, Business Analyst, two Policy Specialists, and one Quality Assurance Specialist
B	EVV Contractor Startup Costs[2]	$196,267	0.0	$19,627	$0	$0	$176,640	90.00%	Table 4.1 Row A
C	Construction of EVV Interfaces[2]	$100,000	0.0	$10,000	$0	$0	$90,000	90.00%	Table 4.1 Row B
D	**Total Estimate**	**$420,959**	**0.8**	**$42,096**	**$0**	**$0**	**$378,863**		

(1) The Quality Assurance Specialist, Project Coordinator, Business Analyst, and Testing Analyst are requested as term limited through June 30, 2021.
(2) The Department requests roll forward authority for $296,267 total funds requested for EVV systems contractors.

Table 2.2 FY 2018-19 Electronic Visit Verification (EVV) Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP or FMAP	Notes/Calculations
A	Savings from Reduced Billed Units in EVV Eligible Services	($3,617,995)	0.0	($1,808,998)	$0	$0	($1,808,997)	50.00%	Table 3.1 Row E
B	EVV Contractor Startup Costs	$392,533	0.0	$39,254	$0	$0	$353,279	90.00%	Table 4.2 Row A
C	EVV Contractor Ongoing Costs	$1,625,280	0.0	$406,320	$0	$0	$1,218,960	75.00%	Table 4.2 Row B + Table 4.2 Row D
D	Construction of EVV Interfaces	$200,000	0.0	$20,000	$0	$0	$180,000	90.00%	Table 4.1 Row B
E	Statewide Targeted Stakeholder Engagement	$8,736	0.0	$4,368	$0	$0	$4,368	50.00%	Table 5.1 Row E
F	EVV Operations Staff	$614,243	7.8	$138,823	$0	$0	$475,420	77.40%	Funding for Project Coordinator, Business Analyst, Tester, Operations Analyst, Data Analyst, Policy Specialist, and Quality Assurance Specialist
G	**Total Estimate**	**($777,203)**	**7.8**	**($1,200,233)**	**$0**	**$0**	**$423,030**		

Table 2.3 FY 2019-20 Electronic Visit Verification (EVV) Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Savings from Reduced Billed Units in EVV Eligible Services	($9,351,758)	0.0	($4,675,879)	$0	$0	($4,675,879)	50.00%	Table 3.1 Row E
B	EVV Contractor Ongoing Costs	$2,290,560	0.0	$572,640	$0	$0	$1,717,920	75.00%	Table 4.1 Row A
C	EVV Operations Staff	$617,827	8.0	$213,908	$0	$0	$403,919	65.38%	Funding for Project Coordinator, Business Analyst, Tester, Operations Analyst, Data Analyst, Policy Specialist, and Quality Assurance Specialist
D	**Total Estimate**	**($6,443,371)**	**8.0**	**($3,889,331)**	**$0**	**$0**	**($2,554,040)**		

(1) The Quality Assurance Specialist, Project Coordinator, Business Analyst, and Testing Analyst are requested as term limited through June 30, 2021.

Table 2.4 FY 2020-21 Electronic Visit Verification (EVV) Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Savings from Reduced Billed Units in EVV Eligible Services	($10,160,355)	0.0	($5,080,178)	$0	$0	($5,080,177)	50.00%	Table 3.1 Row E
B	EVV Contractor Ongoing Costs	$2,290,560	0.0	$572,640	$0	$0	$1,717,920	75.00%	Table 4.1 Row A
C	EVV Operations Staff	$617,827	8.0	$213,908	$0	$0	$403,919	50.00%	Funding for Project Coordinator, Business Analyst, Tester, Operations Analyst, Data Analyst, Policy Specialist, and Quality Assurance Specialist
D	**Total Estimate**	**($7,251,968)**	**8.0**	**($4,293,630)**	**$0**	**$0**	**($2,958,338)**		

Table 3.1 Expected Savings From Implementation of Electronic Visit Verification (EVV)					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes**
A	Total Expected Expenditure on EVV Eligible Services	$861,427,408	$935,175,771	$1,016,035,453	Expected expenditure on EVV eligible Personal Care and Home Health services[1]
B	Expected Percent Reduction in Expenditure on EVV Eligible Services	1.00%	1.00%	1.00%	Based on feedback from states currently utilizing EVV and an EVV systems provider
C	Percent of Year that EVV will be Effective	41.67%	100.00%	100.00%	Based on January 1, 2019 implementation, with a one month billing lag
D	Adjusted Expected Percent Reduction in Expenditure on EVV Eligible Services	0.42%	1.00%	1.00%	Row B * Row C
E	**Expected Savings Resulting from Implementation of EVV**	**$3,617,995**	**$9,351,758**	**$10,160,355**	**Row A * Row D**

(1) EVV eligible services include: Acute Home Health, Home and Community Based Services Children's Extensive Support Services Waiver (HCBS-CES) Basic Homemaker, HCBS-CES Enhanced Homemaker, HCBS-CES Personal Care, Home and Community Based Services Elderly, Blind, and Disabled Waiver (HCBS-EBD) Consumer Directed Services and Supports (CDASS), HCBS-EBD Homemaker, HCBS-EBD In Home Services and Supports (IHSS) Health Maintenance, HCBS-EBD IHSS Homemaker, HCBS-EBD IHSS Personal Care, HCBS-EBD IHSS Relative Personal Care, HCBS-EBD Personal Care, HCBS-EBD Relative Personal Care, Hospice, Children's Home and Community Based Services Waiver IHSS Health Maintenance, Long Term Home Health services, Private Duty Nursing services, Home and Community Based Services Spinal Cord Injury Waiver (HCBS-SCI) CDASS, HCBS-SCI Homemaker, HCBS-SCI IHSS Health Maintenance, HCBS-SCI IHSS Homemaker, HCBS-SCI IHSS Personal Care, HCBS-SCI Personal Care, HCBS-SCI Relative Personal Care, Home and Community Based Services Supported Living Services Waiver (HCBS-SLS) Basic Homemaker, HCBS-SLS Enhanced Homemaker, HCBS-SLS Personal Care, Program of All Inclusive Care for the Elderly (PACE) Home Health, PACE Personal Care.

Table 4.1 - Contractor Funding Required for Implementation, Operations, and Maintenance of Electronic Visit Verification (EVV) Systems						
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes**
A	EVV Vendor	$196,267	$2,021,773	$2,290,560	$2,290,560	Table 4.2 Row E
B	EVV Interfaces	$100,000	$200,000	$0	$0	Table 4.3 Row E Adjusted for April, 2018 Expected start Date
C	**Total**	**$296,267**	**$2,221,773**	**$2,290,560**	**$2,290,560**	**Row A + Row B**

Table 4.2 - Cost to Create and Maintain a Contracted Electronic Visit Verification (EVV) System						
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes**
A	Technical Implementation Fee	$196,267	$392,533	$0	$0	Table 4.4 Row G Adjusted for April, 2018 Expected Start Date
B	Transaction Fees	$0	$665,280	$1,330,560	$1,330,560	Table 4.5 Row E
C	Training Fees	$0	$3,960	$0	$0	Cost of 6 Contractor Led Webinars
D	Ongoing Services	$0	$960,000	$960,000	$960,000	Contractor estimate of cost to maintain a toll-free support line and provide ongoing software upgrades
E	**Total Cost**	**$196,267**	**$2,021,773**	**$2,290,560**	**$2,290,560**	**Row A + Row B + Row C + Row D**

Table 4.3 - Cost to Construct Electronic Visit Verification (EVV) Interfaces with HCPF Systems			
Row	**Item**	**Cost**	**Notes**
A	Client interface between interChange and EVV	$75,000	Table 4.7 Row G
B	Client interface between CBMS and EVV	$75,000	Table 4.7 Row G
C	Provider/Agency EVV interChange interface	$75,000	Table 4.7 Row G
D	Data extract export to BIDM	$75,000	Table 4.7 Row G
E	**Total EVV system interface costs**	**$300,000**	**Sum of Rows A through D**

Table 4.4 - Electronic Visit Verification (EVV) Technical Implementation Fee Breakdown					
Row	**Item**	**Cost Per-Hour**	**Hours Needed**	**Total Cost**	**Notes**
A	Configuration Staff	$125.00	1,000	$125,000	Based on Contractor Estimate
B	Customization Staff	$135.00	1,000	$135,000	Based on Contractor Estimate
C	Testing and Validation Staff	$100.00	1,000	$100,000	Based on Contractor Estimate
D	Business Analyst Staff	$125.00	400	$50,000	Based on Contractor Estimate
E	Technical Writing and Documentation Staff	$72.00	400	$28,800	Based on Contractor Estimate
F	Project Management Staff	$150.00	1,000	$150,000	Based on Contractor Estimate
G	**Total**			**$588,800**	**Sum of Rows A through F**

Table 4.5 - Electronic Visit Verification (EVV) Transaction Fees					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes**
A	Minimum Monthly Transaction Fee	$84,294	$84,294	$84,294	Contractor Quote
B	Cost of Transactions over Minimum	$26,586	$26,586	$26,586	Table 4.6 Row E
C	Total Monthly Transaction Costs	$110,880	$110,880	$110,880	Row A + Row B
D	Months in Year that EVV is Effective	6	12	12	Based on January 1, 2019 Implementation Date
E	**Total Annual Transaction Costs**	**$665,280**	**$1,330,560**	**$1,330,560**	**Row C * Row D**

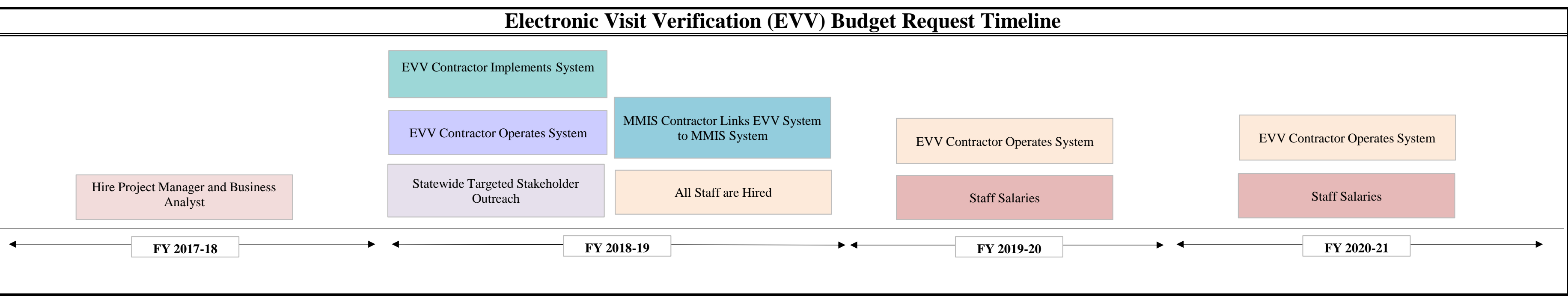
Table 4.6 - Cost of Electronic Visit Verification (EVV) Transaction Fees Above Minimum					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes**
A	Total Expected Monthly Transactions	1,232,000	1,232,000	1,232,000	Contractor Estimate
B	Included Transactions in Minimum Monthly Transaction Fee	936,600	936,600	936,600	Contractor Quote
C	Estimated Transactions over Minimum	295,400	295,400	295,400	Row A - Row B
D	Cost Per Transaction over Minimum	$0.09	$0.09	$0.09	Contractor Quote
E	Cost of Transactions over Minimum	$26,586	$26,586	$26,586	Row C * Row D

Table 4.7 - Electronic Visit Verification (EVV) Interface Implementation Cost					
Row	**Item**	**Cost Per-Hour**	**Hours Needed**	**Total Cost**	**Notes**
A	Configuration Staff	$125.00	200	$25,000	Based on Contractor Estimate
B	Customization Staff	$135.00	120	$16,200	Based on Contractor Estimate
C	Testing and Validation Staff	$100.00	80	$8,000	Based on Contractor Estimate
D	Business Analyst Staff	$125.00	80	$10,000	Based on Contractor Estimate
E	Technical Writing and Documentation Staff	$75.00	80	$6,000	Based on Contractor Estimate
F	Project Management Staff	$150.00	80	$12,000	Based on Contractor Estimate
G	Total Cost			$77,200	Sum of Rows A through F

Table 5.1 - Cost of Statewide Targeted Stakeholder Engagement			
Row	**Item**	**Value**	**Notes**
A	Number of Destinations	6	Including Grand Junction, Pueblo, Colorado Springs, Fort Collins, Durango, and Sterling
B	Number of Employees Traveling	4	Department Estimate of Needed Staff to Administer Outreach
C	Total Employee Trips	24	Row A * Row B
D	Cost Per-Employee Trip	$364	Including Hotels, Mileage, and Meals
E	**Total Cost**	**$8,736**	**Row C * Row D**

FY 2017-18 FTE Request					
Expenditure Detail			FY 2017-18		FY 2018-19
Personal Services:					
Classification Title	Monthly	FTE		FTE	
PROJECT COORDINATOR	$4,323	0.17	$8,646	1.0	$51,874
PERA			$878		$5,265
AED			$432		$2,594
SAED			$432		$2,594
Medicare			$125		$752
STD			$16		$99
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1, 1.0 FTE		**0.17**	**$18,456**	**1.0**	**$71,105**
Classification Title	Monthly	FTE		FTE	
ANALYST III	$4,117	0.17	$8,234	1.0	$49,404
PERA			$836		$5,015
AED			$412		$2,470
SAED			$412		$2,470
Medicare			$119		$716
STD			$16		$94
Health-Life-Dental			$7,927		$7,927
Subtotal Position 2, 1.0 FTE		**0.17**	**$17,956**	**1.0**	**$68,096**
Classification Title	Monthly	FTE		FTE	
ADMINISTRATOR IV	$5,371	0.17	$10,742	1.0	$64,449
PERA			$1,090		$6,542
AED			$537		$537
SAED			$537		$537
Medicare			$156		$156
STD			$20		$20
Health-Life-Dental			$7,927		$7,927
Subtotal Position 3 1.0 FTE		**0.2**	**$21,009**	**1.0**	**$80,168**
Classification Title	Monthly	FTE		FTE	
ADMINISTRATOR III	$4,323	0.17	$8,646	1.0	$51,874
PERA			$878		$5,265
AED			$432		$2,594
SAED			$432		$2,594
Medicare			$125		$752
STD			$16		$99
Health-Life-Dental			$7,927		$7,927
Subtotal Position 4, 1.0 FTE		**0.2**	**$18,456**	**1.0**	**$71,105**
Classification Title	Monthly	FTE		FTE	
ADMINISTRATOR IV	$5,371	0.17	$10,742	1.0	$64,449
PERA			$878		$5,265
AED			$432		$2,594
SAED			$432		$2,594
Medicare			$125		$752
STD			$16		$99
Health-Life-Dental			$7,927		$7,927
Subtotal Position 5, 1.0 FTE		**0.2**	**$20,552**	**1.0**	**$83,680**
Subtotal Personal Services		0.8	**$96,427**	5.0	**$374,154**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating Expenses	$500	5.0	$2,500	5.0	$2,500
Telephone Expenses	$450	5.0	$2,250	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			**$28,265**		**$4,750**
TOTAL REQUEST		0.8	**$124,692**	5.0	**$378,904**
	General Fund:		*$12,469.24*		*$96,033.67*
	Cash funds:				
	Reappropriated Funds:				
	Federal Funds:		*$112,223.16*		*$282,870.73*

FY 2018-19 FTE Request					
Expenditure Detail			FY 2018-19		FY 2019-20
Personal Services:					
Classification Title	Monthly	FTE		FTE	
ANALYST III	$4,323	0.9	$47,551	1.0	$51,874
PERA			$4,826		$5,265
AED			$2,378		$2,594
SAED			$2,378		$2,594
Medicare			$689		$752
STD			$90		$99
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1, 1.0 FTE		**0.9**	**$65,839**	**1.0**	**$71,105**
Classification Title	Monthly	FTE		FTE	
ANALYST III	$4,323	0.9	$47,551	1.0	$51,874
PERA			$4,826		$5,265
AED			$2,378		$2,594
SAED			$2,378		$2,594
Medicare			$689		$752
STD			$90		$99
Health-Life-Dental			$7,927		$7,927
Subtotal Position 2 1.0 FTE		**0.9**	**$65,839**	**1.0**	**$71,105**
Classification Title	Monthly	FTE		FTE	
STATISTICAL ANALYST III	$5,880	0.9	$64,680	1.0	$70,560
PERA			$6,565		$7,162
AED			$3,234		$3,528
SAED			$3,234		$3,528
Medicare			$938		$1,023
STD			$123		$134
Health-Life-Dental			$7,927		$7,927
Subtotal Position 3, 1.0 FTE		**0.9**	**$86,701**	**1.0**	**$93,862**
Subtotal Personal Services		2.8	**$218,380**	3.0	**$236,072**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating Expenses	$500	3.0	$1,500	3.0	$1,500
Telephone Expenses	$450	3.0	$1,350	3.0	$1,350
PC, One-Time	$1,230	3.0	$3,690	-	
Office Furniture, One-Time	$3,473	3.0	$10,419	-	
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$16,959**		**$2,850**
TOTAL REQUEST		2.8	**$235,339**	3.0	**$238,922**
	General Fund:		*$42,789*		*$59,731*
	Cash funds:				
	Reappropriated Funds:				
	Federal Funds:		*$192,550*		*$179,192*


Electronic Visit Verification (EVV) Budget Request Timeline
EVV Contractor Implements System
EVV Contractor Operates System
MMIS Contractor Links EVV System to MMIS System
EVV Contractor Operates System
EVV Contractor Operates System
Hire Project Manager and Business Analyst
Statewide Targeted Stakeholder Outreach
All Staff are Hired
Staff Salaries
Staff Salaries
FY 2017-18
FY 2018-19
FY 2019-20
FY 2020-21

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-07 HCBS Transition Services Continuation and Expansion**

Dept. Approval By: 11/1/17

OSPB Approval By:

__ Supplemental FY 2017-18

X Change Request FY 2018-19

__ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$8,065,315,343	$0	$8,013,182,644	($1,136,406)	($6,323,180)
	FTE	418.4	0.0	427.4	0.0	0.0
	GF	$2,303,685,062	$0	$2,291,052,957	($703,203)	($3,161,590)
	CF	$895,729,081	$0	$893,766,451	$0	$0
	RF	$72,807,640	$0	$72,962,343	$0	$0
	FF	$4,793,093,560	$0	$4,755,400,893	($433,203)	($3,161,590)

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- Personal Services	Total	$30,884,154	$0	$32,040,094	$0	$0
	FTE	418.4	0.0	427.4	0.0	0.0
	GF	$10,512,849	$0	$10,769,424	$0	$0
	CF	$2,985,184	$0	$3,045,883	$0	$0
	RF	$1,885,978	$0	$2,242,657	$0	$0
	FF	$15,500,143	$0	$15,982,130	$0	$0
01. Executive Director's Office, (A) General Administration -- Health, Life, and Dental	Total	$3,637,126	$0	$3,637,126	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,305,776	$0	$1,305,776	$0	$0
	CF	$344,132	$0	$344,132	$0	$0
	RF	$103,855	$0	$103,855	$0	$0
	FF	$1,883,363	$0	$1,883,363	$0	$0

01. Executive Director's Office, (A) General Administration -- Short-term Disability	**Total**	**$58,060**	**$0**	**$58,060**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,586	$0	$21,586	$0	$0
	CF	$4,802	$0	$4,802	$0	$0
	RF	$1,364	$0	$1,364	$0	$0
	FF	$30,308	$0	$30,308	$0	$0

01. Executive Director's Office, (A) General Administration -- Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,615,047**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$600,398	$0	$0
	CF	$133,634	$0	$133,634	$0	$0
	RF	$37,970	$0	$37,970	$0	$0
	FF	$843,045	$0	$843,045	$0	$0

01. Executive Director's Office, (A) General Administration -- Supplemental Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,615,047**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$600,398	$0	$0
	CF	$133,634	$0	$133,634	$0	$0
	RF	$37,970	$0	$37,970	$0	$0
	FF	$843,045	$0	$843,045	$0	$0

01. Executive Director's Office, (A) General Administration -- Operating Expenses	**Total**	**$2,162,529**	**$0**	**$2,082,684**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$961,889	$0	$948,995	$0	$0
	CF	$74,170	$0	$70,519	$0	$0
	RF	$26,219	$0	$13,297	$0	$0
	FF	$1,100,251	$0	$1,049,873	$0	$0

01. Executive Director's Office, (A) General Administration -- General Professional Services and Special Projects	**Total**	**$9,412,649**	**$0**	**$14,534,207**	**$561,244**	**$561,244**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,005,615	$0	$5,621,706	$280,622	$280,622
	CF	$1,600,352	$0	$1,545,040	$0	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$4,656,682	$0	$7,217,461	$280,622	$280,622

Line Item						
01. Executive Director's Office, (C) Information Technology Contracts and Projects -- MMIS Maintenance and Projects	**Total**	**$41,646,122**	**$0**	**$41,988,677**	**$337,500**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,955,404	$0	$5,979,906	$33,750	$0
	CF	$4,288,071	$0	$4,445,412	$0	$0
	RF	$11,808	$0	$6,618	$0	$0
	FF	$31,390,839	$0	$31,556,741	$303,750	$0
02. Medical Services Premiums -- Medical Services Premiums	**Total**	**$7,597,898,847**	**$0**	**$7,538,955,686**	**($2,381,760)**	**($7,648,416)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	($1,190,880)	($3,824,208)
	CF	$886,165,101	$0	$884,043,394	$0	$0
	RF	$70,552,476	$0	$70,368,612	$0	$0
	FF	$4,548,653,004	$0	$4,507,666,920	($1,190,880)	($3,824,208)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Adult Comprehensive Services	**Total**	**$376,385,762**	**$0**	**$376,656,016**	**$346,610**	**$763,992**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$188,192,881	$0	$188,328,008	$173,305	$381,996
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$188,192,880	$0	$188,328,007	$173,305	$381,996

CF Letternote Text Revision Required? Yes ___ No X **If Yes, see schedule 4 fund source detail.**

RF Letternote Text Revision Required? Yes ___ No X

FF Letternote Text Revision Required? Yes ___ No X

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 a reduction of $1,136,406 total funds, including $703,203 General Fund in FY 2018-19 and a reduction of $6,323,180 total funds, including $3,161,590 General Fund in FY 2019-20 to move services currently available under the Colorado Choice Transitions (CCT) program to the Home and Community Based Services (HCBS) waivers and to the Medicaid State Plan. In FY 2020-21 funding for 2.1 FTE would be required in addition to services funding and in FY 2021-22 and onward 5.0 FTE would be required to implement the transition services appropriately. The funding would also be used to increase options counseling availability for the Aging and Disability Resources for Colorado (ADRC).

Current Program

- The CCT grant program has been in operation since April 2013 providing services to aid clients transitioning from institutional living to living and remaining in the community where they receive the services they need more cost-effectively; these services include home delivered meals and several others.
- To determine if a Medicaid member is interested in transitioning to the community, they answer several different questions that are part of the Minimum Data Set (MDS) assessment. Depending on their answers to certain questions, these clients are then referred to the ADRC which is currently contracted at $319,302 per year to provide options counseling to discuss the clients' next steps and options for transitioning.

Problem or Opportunity

- The CCT grant expires on December 31, 2020. With the expiration of the grant, the Department has very limited resources within the HCBS waivers to assist clients interested in transitioning from institutions to the community. The Department has the opportunity to take lessons learned from CCT and develop a sustainable program to allow clients to continue to transition to the community.
- Colorado's current options counseling infrastructure cannot adequately address the high number of referrals it receives without additional supports from the State.

Consequences of Problem

`

- If the Department is unable to continue providing the services offered through the CCT grant program, clients who currently reside in Long Term Care (LTC) facilities who would prefer to move to the community would have very limited resources available to make these transitions happen, which could lead to a lower overall quality of life for these clients. Additionally, leaving clients without the ability to transition from facilities would lead to higher costs for the state over time.
- Both of these issues would be compounded if the ADRC network was unable to receive funding to increase options counseling availability as the current funding is leading to fewer transitions than expected.
- If the CCT grant program were to end without a replacement, the Department would risk being out of compliance with Olmstead requirements, which require the Department to allow individuals to receive care in the least restrictive setting possible.

Proposed Solution

- The Department requests 5.0 FTE beginning January 1, 2021 and funding to redesign and relocate some of the current CCT services into the HCBS waivers and the State Plan to make them available before the CCT grant program ends.
- Funding would be used to expand options counseling availability through the ADRC.
- Legislation would be needed to authorize services through the State Plan.

FY 2018-19 Funding Request | November 1, 2017

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-07
Request Detail: HCBS Transition Services Continuation and Expansion

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
HCBS Transition Services Continuation and Expansion	($1,136,406)	($703,203)

Problem or Opportunity:

The Colorado Choice Transitions (CCT) grant program, which provides services to clients residing in long-term care facilities to transfer to more cost-effective community settings to receive services, will no longer be able to transition new clients after December 31st, 2018, as the federal grant which authorizes the program requires sustainability for the transition service by that time. The Department has the opportunity to add the services that worked well during the CCT grant program to the State Plan and Home and Community Based Services (HCBS) waiver programs to allow clients to continue to transition to the community. Additionally, the regional Aging and Disability Resources for Colorado (ADRC) is unable to meet with some clients to discuss the different options for transitioning from a nursing facility due to the volume of clients requesting options counseling and limited resources. As a result, clients who wish to transition to the community are unable to be referred to a transition coordination agency to begin the process and ultimately transfer in a timely manner.

The CCT grant program was authorized to begin transitioning clients from long term care facilities to the community on April 1, 2011 and the Department was able to begin transitioning clients on April 1, 2013. The CCT grant program was authorized by Congress in section 6071 of the Deficit Reduction Act of 2005. The CCT grant program provides clients the opportunity to receive the services they need to live in the community through CCT to aid in the transition process. These additional CCT services help clients to become more independent and, as a result, incur a far lower cost to the state for clients to live in the community when compared to Long Term Care (LTC) facilities. The CCT services currently available through the grant include Community Transition Services (CTS), Home Delivered Meals (HDM), Peer Mentorship (PM), Independent Living Skills Training (ILST), Assistive Technology Extended (ATE), Caregiver Education (CE), Transitional Behavioral Health Supports (TBHS) and Intensive Case Management (ICM). Descriptions of the CCT services can be found in Appendix A. These services are provided during the transition process and throughout the first year of community living enabling clients to better adjust to their new living situation in communities.

Of the services listed above, ICM and CTS are the primary services clients utilize while beginning the transition process and continue being some of the most important services utilized to ensure transitions are successful. ICM and CTS are services that are provided by a Case Management Agency and Transition Coordination Agency and include things essential to move a client from a nursing facility and establish a community-based residence. The CTS service currently exists in the Home and Community Based Services (HCBS) Elderly, Blind, and Disabled (EBD) waiver; however, there is still a need for additional access to the services outside of just the EBD waiver which is what the CCT grant program currently addresses. The Department has also faced some financial challenges in implementing CTS as an HCBS service and a CCT service. These challenges include being unable to recruit or retain an adequate provider base to fully implement CTS to its potential because provider payments are not made until after a transition has been completed. This is an issue as providers are not compensated if the client did not successfully complete the transition, even when clients receive services from providers while they are exploring whether a transition is possible. Additionally, there is no reimbursement for transitions that do not happen regardless of how much work went into attempting to make the transition happen.

The CCT grant program has seen notable success since it began transferring clients in 2013 with 274 transitions completed. Among clients who have transitioned through CCT, only eighteen have been re-admitted to a nursing facility as of June 30th, 2017. The high retention rate of clients entering the community has translated into a significant improvement in the quality of life of clients who chose to transition to the community. For example, a recent quality of life survey was administered to clients living in institutions and the same survey was administered to clients that were transitioned from institutions to the communities. This survey showed that when the clients living in an institution were asked "Do you like where you live?" only 35 percent answered "Yes," whereas clients that were transitioned to a community when asked the same question answered "Yes" 79 percent of the time after living in the community for 11 months, and answered "Yes" 92 percent of the time upon living in the community for 24 months. In addition to increasing the quality of life for the clients who transitioned, the CCT grant program also demonstrates significant cost savings for the Department compared to serving these clients in a nursing facility.

December 31st, 2018 is the final day that new clients will be able to receive transition support through the CCT grant program. Clients that have transitioned by December 31st will be able to receive services through the CCT grant program to help them successfully complete their transition to the community setting for the next 365 days of enrollment, however no new transitions will be able to take place during this time without additional funding for transition services. This provides the Department with an opportunity to continue to provide transition services, by creating a sustainable transition service package through the State Plan and HCBS waiver programs instead of the CCT grant program. This would allow the Department to utilize what it has learned while running the CCT grant program, and would continue to allow clients to transition from long term care facilities in a permanent and sustainable way going forward. Additionally, the Department would have the opportunity to save on costs these clients would otherwise incur from receiving care in long term care facilities.

Additionally, December 31st, 2020 is the final day that the CCT grant program is allotted grant funding for administrative functions. After this date, funding would be required to pay for 5.0 FTE per fiscal year to allow the transition services to continue unhindered. There would be a need for 5.0 FTE in FY 2020-21,

however as only half of this fiscal year will be without grant funding, funding for only 2.1 FTE would be required. From FY 2021-22 and onward funding would be required to pay for the full 5.0 FTE required to administer the transition services.

If the transition services associated with the CCT grant program were to go away it would also jeopardize the Department's compliance with the United States Supreme Court's Olmstead decision. The Olmstead decision holds states accountable for providing community-based care whenever appropriate, rather than placing individuals with disabilities in institutional settings. Without transition services this would not be possible. If the Department is determined to be out of compliance with the Olmstead decision, it could face possible litigation, and violation of the Americans with Disabilities Act[1], the Rehabilitation Act of 1973[2], and the U.S. Supreme Court decision in Olmstead v. L.C., 527 U.S. 581 (1999).

In order to create a robust transition service package, there is also a need to increase options counseling availability for the Aging and Disability Resource Centers (ADRC) in Colorado in addition to integrating transition and community-based services. The Department currently offers options counseling through the regional ADRCs but is not able to meet the current demand. Options counseling assists clients in beginning the transition process to the community by providing an opportunity for clients in institutional placements to learn about community living options which includes the long-term services and supports available to them in the community. All clients residing in skilled nursing facilities are eligible for options counseling and are identified through the Minimum Data Set (MDS) Assessment, a mandated assessment administered to all nursing home residents that has questions used to determine whether a client would be interested in learning about living in the community. When residents express interest in moving to a more integrated community setting, they are supposed to be referred per federal regulation to their county-specific Local Contact Agency (LCA). These LCAs are the ADRCs and provide options counseling and can be found statewide. However, many clients that should be referred to their local LCA for options counseling are not because the ADRC network lacks the infrastructure and resources to meet the demand for providing options counseling in a timely fashion. Currently only about 24 percent of clients are able to receive options counseling after indicating that they are interested in transitioning to the community. Over the two most recent fiscal years 3,141 clients were interested in receiving options counseling, while only 761 clients were able to receive the service. The remaining 2,380 clients are waiting to receive options counseling when there is capacity.

Currently, options counseling is paid for through a contract with the ADRC network that totals to $319,302 annually. The Department previously submitted the FY 2014-15 R-9 "Medicaid Community Living Initiatives" budget request to increase funding for options counseling; however, the funding approved at that time is insufficient to meet the growing demand for options counseling. Colorado's current options counseling funding cannot adequately address the high number of referrals without additional resources. Funding for options counseling would need to increase to allow more transitions to take place and ensure that clients are able to receive the services they require in an environment that is best suited to their needs.

The Department had also previously requested for additional funds to help facilitate the transition process, however this previous request was targeted more at regional centers and as a result additional funding is still

[1] 42 U.S.C. §12132
[2] 29 U.S.C. § 794(a)

needed. Last year the Department received funding for its FY 2017-18 R-10 "Regional Task Force Recommendation Implementation" budget request that included the Intensive Case Management (ICM) service, for any client in a regional center setting. Additional funding is required to extend this service to clients residing in nursing facilities.

Proposed Solution:

The Department requests a reduction of $1,136,406 total funds, including $703,203 General Fund in FY 2018-19 and a reduction of $6,323,180 total funds, including $3,161,590 General Fund in FY 2019-20 to move several services currently available under the Colorado Choice Transitions (CCT) program to the Home and Community Based Services (HCBS) waiver programs and Medicaid State Plan. In FY 2020-21 funding for 2.1 FTE would be required in addition to services funding and in FY 2021-22 and onward 5.0 FTE would be required to implement the transition services appropriately. In order to fully implement these services into the Medicaid State Plan and waiver programs, the Department would be required to write a State Plan amendment, waiver amendments and legislation within the proposed timeline. The funding would also be used to increase options counseling availability for the Aging and Disability Resources for Colorado (ADRC) which helps long term care (LTC) facility clients learn about options for transitioning into living in the community, an option that might otherwise be unavailable to these clients.

In order to continue to transition clients from institutional settings to the community the Department proposes to extend Intensive Case Management (ICM) into the Medicaid State Plan. This service would be available to clients who are transitioning to the community and would only be available for one year after clients had begun to transition to the community. Systems changes would be necessary in order to implement these services. While the Department believes it can absorb some system changes within pool hours, others, specifically those associated with the Department's new case management system need funding to make the changes. The Department is in the process of designing and implementing the new case management system and would need to build the new services into the platform and transfer the information to interChange to pay claims.

Additionally, covering transition support through Medicaid State Plan authority would address some of the financing challenges the Department has experienced with implementing CTS as an HCBS service and a CCT demonstration service where providers could not be paid until after a transition occurred or not at all if the client was unable to leave the facility.

In addition to ICM, CCT has seven other services that assist with people successfully transitioning, living, and remaining in the community. Of these the Department request to move the following four services[3] into the adult HCBS waivers, the household set-up component of the Community Transition Services (CTS), Home Delivered Meals (HDM), Peer Mentorship (PM), and Independent Living Skills Training (ILST). These services would move into various HCBS waivers, including the Persons with Brain Injury (BI), Community Mental Health Supports (CMHS), Elderly, Blind, and Disabled (EBD), Supported Living Services (SLS), and Adult Comprehensive Services (DD) waivers. This service package represents a

[3] It is important to note that even with the transition services being requested to move forward with this request, there would still be a need for the ICM services that were added last year through the R-10 as these services are available to a different group of clients than the transition services in this request.

reduction of services currently available through CCT, however because the other services not included in this package had low utilization, no additional savings are expected. This service package has been selected because of the CCT services available these five are the most heavily utilized and are some of the most helpful CCT services for clients, as they are the most helpful to promoting independence among clients. The Department believes that by moving the services listed above into the waivers it would allow the Department to continue transitioning clients to the community successfully and without interruption. To move these services into the waivers, waiver amendments or waiver renewals would be required.

In addition to continuing transition services, the Department requests 5.0 FTE beginning in the second half of FY 2020-21 to continue to maintain the CCT grant programs services once they are moved into the Medicaid State Plan and HCBS waivers. These FTE are important to include going forward as they would allow the program to be implemented and maintained in the most efficient way possible by helping to coordinate with various local and state agencies to coordinate successful transitions. The FTE would also ensure that all resources dedicated to the transitions services were being utilized correctly and to their fullest potential, which would require specialized knowledge, as laid out below. Additionally, these FTE would be necessary as the tasks below would require too much additional time and resources from current FTE to reliably maintain going forward. These positions will be grant funded until December 31, 2020. The FTE titles and responsibilities can be found in Appendix A.

In addition to resources requested for transition services, the Department is requesting funding to increase options counseling resources by 76 percent for the ADRC. This increase would allow the Department to either contract with other vendors or expand the current ADRC network effectively increasing the available resources to allow for more availability of options counseling for those who would like to learn about transitioning into the community. Resources to further provide options counseling would setup the network to respond to the demand for options counseling and would lead to additional community transitions. These additional transitions would provide savings to the Department through the reduction of cost in providing services in the community versus more costly institutions, which can be seen in Appendix B, Table 3.

Anticipated Outcomes:

CCT is listed in the Department Performance Plan as a cost-containment initiative. It improves health for low-income and vulnerable Coloradans; enhances the quality of life and community experience of individuals and families; and reduces the cost of health care in Colorado. This would be expected to continue if transition services are able to continue. In addition, transition services would support choice, person-centeredness and compliance with the following two primary goals of Colorado's Community Living Plan:

- Proactively identifying individuals in institutional care who want to move to a community living option and ensuring successful transition through a person-centered planning approach; and
- Supporting successful transitions to community settings, ensuring a stable and secure living experience, and preventing re-institutionalization through the provision of responsive community-based services and supports.

Moreover, transition services would provide clients the opportunities to live in the most integrated setting possible and would assist the state in meeting its non-discrimination requirements under Section 504 and the

Americans with Disabilities Act. This act requires that “a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities" 28 CFR § 35.130(d).

The expected outcome of increasing ADRC options counseling is an increase in the number of clients receiving options counseling, as it would become more available to those who wanted to access it. This increase in options counseling would be expected to increase the number of clients transitioning out of institutions over time and would result in additional cost savings for the Department.

Together these initiatives would help the Department ensure that clients are receiving the most cost-effective care possible, while still ensuring that clients are able to access the care that best suits their needs.

Assumptions and Calculations:

Detailed information on calculations can be found in the attached appendix. However, there are a number of assumptions that went into the calculations that are noted below.

The Department assumes that the funding currently allotted to CCT through the Money Follows the Person (MFP) grant would continue to be used to pay for CCT FTE and administration until the funding is depleted or the expiration date of the funding on December 31st, 2020 is reached, whichever comes first.

The Department assumes there would be no gap in transition services. Once transitions stop through the CCT grant program, the Department would begin transitioning clients through the State Plan and offer the other well-utilized CCT services through HCBS waiver services. As with CCT, clients utilizing the State Plan transition service would have access to it for 180 days and the HCBS waiver services post transition and as long as they continue to meet HCBS eligibility thereafter. After that clients who successfully transitioned would have access to the State Plan and standard waiver services but would no longer have access to the CCT services.

The Department calculated the expected costs from transition services in future years by using current CCT service costs trended forward. This Department assumes that historical CCT data is a good proxy for future transition service costs that would result from CCT services moved over to the State Plan and HCBS waivers if this request were to be approved. Even though not all of the CCT services would be included, the services being excluded were under-utilized and did not contribute a significant amount to service costs.

The Department assumes that roughly 93 percent of clients transitioned each year using transition services would remain in the community after their transition based on current data from the CCT grant program. This current data shows that since the program began transitioning clients in April 2013 there have been 274 successful transitions and only 18 of these clients have gone back to living in long term care facilities after their transition.

The Department assumes that expanding the ICM service into the State Plan to provide transition services would require legislation and a State Plan amendment. In addition, the Department assumes that moving the CTS-household setup, HDM, PM, and ILST services into the waivers would require using the waiver amendment or waiver renewal process. The Department assumes it would take between six and twelve

months to implement these services into the State Plan and HCBS waivers from when funding would be received on July 1, 2018. This assumption is based on an estimate that the State Plan amendment for the transition service and the waiver amendment for the EBD, BI and CMHS waivers would be initiated on July 1, 2018, submitted on September 30, 2018 and implemented on January 1, 2019. For the Intellectual and Developmental Disability waivers, the Department assumes that the waiver renewal process would lead to an implementation date of July 1, 2019.

The Department assumes that while nursing facilities have the capacity for additional clients, regional centers operate close to capacity. Therefore, only nursing facility savings are being calculated from successful transitions, as regional centers fill up as soon as an opening in one appears. This is due to the regional centers having much less available housing and pent up demand. Therefore, the Department is only calculating costs avoided from nursing facilities, not regional centers. The Department assumes that only 75 percent of clients transitioning to the DD waiver using transition services will be coming from nursing facilities. The remaining 25 percent would come from regional centers based on historical data.

The Department assumes there would be a need for systems changes in order to expand the ICM and other transition services into the State Plan and HCBS waivers. These changes include limiting the services available to transitioning clients only and for one year. In order to implement these changes, the Department would draft and submit the necessary Implementation Advance Planning Document (IAPD) to ensure that the additional federal match rate for these systems changes costs would be received. These costs can be seen in Appendix B.

The Department assumes that 5.0 FTE would be required to ensure that transition services are integrated into the waivers and State Plan. This estimate of 5.0 FTE is the same as the current number of FTE allocated to the CCT grant program.

The Department assumes that with the increase in funding for the ADRC to increase options counseling availability that a 25 percent increase in transitions would result. Currently, not all clients that respond to the MDS questionnaire that they are interested in transitioning to the community are successfully referred to the ADRC for options counseling. The Department believes that with additional funding, the ADRC would be able to provide additional options counseling resulting in more transitions into the community. The number of additional transitions is uncertain; however, the Department believes a 76 percent increase in funding is reasonable which would result in a 25 percent increase in new clients, an average of 20 new clients per year. This increase of clients is not an exact 76% increase, due to the complexity of transitioning clients from long term care facilities and the resources needed to increase the number of monthly transitions, however the Department expects that a 25% increase in clients is reasonable and achievable with the increase in funding for options counseling.

The Department assumes that using the current ADRC contract and unmet demand for options counseling is an accurate proxy for the funding needed to increase availability of options counseling. The Department utilized the current contract with the ADRC, and multiplied the current yearly contract cost of $319,302 by the percentage of unmet demand for options counseling from the past two fiscal years to get the new expected yearly contract cost of $561,244. This percentage of unmet demand was determined with a calculation of the

residents who were waiting to receive options counseling divided by the total residents who were interested in options counseling, which was approximately 76 percent.

FTE Descriptions

Position Name	Position Classification	Number of FTE	Description
Entry Point Operations Manager	Program Management I	1.0	The Entry Point Operations Manager's primary responsibility is to supervise the various other staff members overseeing the transition services as they were moved into the waivers and State Plan, as well as providing oversight of all activities performed by the unit members and helping to lead the unit in making sure the transition services were being implemented as effectively as possible.
Data Analyst	Statistical Analyst III	1.0	The Data Analyst's primary responsibility is to download, manage, and manipulate data for the work related to transitions from an institutional setting using various types of complex software. The Data Analyst then takes this information and distills what is crucial for other staff to then incorporate into their duties.
Transition Administrator	Administrator IV	1.0	The Transition Administrator is primarily utilized to monitor the performance of transition coordination agencies, and identify possible barriers to transition. This FTE would also find solutions to the identified problems, and would help to facilitate transitions across several different systems.
Benefit Coordinator	Administrator III	1.0	The Benefit Coordinator helps to establish HCBS or State Plan benefits that would support community integration and successful transitions. In addition, they would monitor data and develop strategies to better understand what benefits could be added removed or changed to best serve the client's needs in transitioning and adjusting to the community.

Position Name	Position Classification	Number of FTE	Description
Community Liaison	Liaison III	1.0	The Community Liaison monitors the MDS Section Q referral process to ensure that clients were able to access options counseling and begin transitioning and were informed of community based options available to them. This FTE would also help provide technical assistance in outreach and marketing where applicable.

R-07 HCBS Transition Services Continuation and Expansion Appendix A: Current Colorado Choice Transitions Services

Current CCT Services	
Service Name	**Service Description**
Community Transition Services (CTS)	Services that are provided by a Transition Coordination Agency to assist individuals to transition from institutional care to community-based living arrangements and include resources essential to establish a community-based residence.
Home Delivered Meals (HDM)	A service that provides nutritious meals that are delivered to homebound clients who are unable to prepare their own meals and have limited or no outside assistance.
Peer Mentorship (PM)	Services that are provided by peers to promote self-advocacy and encourage community living among clients by instructing and advising clients on issues and topics related to community living, and modeling successful community living and problem-solving.
Independent Living Skills Training (ILST)	Skills training that is designed to improve or maintain a client's physical, emotional, and economic independence in the community with or without supports.
Assistive Technology Extended (ATE)	Devices, items, pieces of equipment, or product systems used to increase, maintain, or improve functional capabilities of clients and training in the use of the technology when the cost is not otherwise covered through the State Plan durable medical equipment benefit or home modification waiver benefit or available through other means.
Caregiver Education (CE)	Educational and coaching services that assist clients and family members to recruit other family members and friends to form an informal caregiver network to share caregiving responsibilities.

Current CCT Services	
Service Name	**Service Description**
Transitional Behavioral Health Supports (TBHS)	Services by a qualified paraprofessional to support a client during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's stability in the community
Intensive Case Management (ICM)	Services to assist clients in assessing needed home and community-based services, Medicaid State Plan services and non-Medicaid supports and services to support the clients' return to the community from placement in a qualified institution and to aid the client in their transition.

Table 1.1 FY 2018-19 Cost Savings Through Community Living Processes Summary by Line Item								
Line Item	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
(1) Executive Director's Office; (A) General Administration, Personal Services[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Short-term Disability[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Operating Expenses[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Directors Office; General Administration, General Professional Services and Special Projects	$561,244	0.0	$280,622	$0	$0	$280,622	50.00%	Table 2.1 Row G
(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information System Maintenance and Projects	$337,500	0.0	$33,750	$0	$0	$303,750	90.00%	Table 2.1 Row J
(2) Medical Services Premiums; Medical Services Premiums	($2,381,760)	0.0	($1,190,880)	$0	$0	($1,190,880)	50.00%	Sum Table 2.1 Rows B, D, F, H, & I
(4) Office Of Community Living; (A) Division Of Intellectual and Developmental Disabilities, Adult Comprehensive Services	$346,610	0.0	$173,305	$0	$0	$173,305	50.00%	Sum Table 2.1 Rows C & E
Total Estimate	**($1,136,406)**	**0.0**	**($703,203)**	**$0**	**$0**	**($433,203)**		

[1] This item is being paid for with grant funding which is an off budget funding source so the costs do not appear here

Table 1.2 FY 2019-20 Cost Savings Through Community Living Processes Summary by Line Item								
Line Item	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
(1) Executive Director's Office; (A) General Administration, Personal Services[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Short-term Disability[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Operating Expenses[1]	$0	0.0	$0	$0	$0	$0	50.00%	Table 7
(1) Executive Directors Office; General Administration, General Professional Services and Special Projects	$561,244	0.0	$280,622	$0	$0	$280,622	50.00%	Table 2.1 Row G
(2) Medical Services Premiums; Medical Services Premiums	($7,648,416)	0.0	($3,824,208)	$0	$0	($3,824,208)	50.00%	Sum Table 2.1 Rows B, D, F, H, & I
(4) Office Of Community Living; (A) Division Of Intellectual and Developmental Disabilities, Adult Comprehensive Services	$763,992	0.0	$381,996	$0	$0	$381,996	50.00%	Sum Table 2.1 Rows C & E
Total Estimate	**($6,323,180)**	**0.0**	**($3,161,590)**	**$0**	**$0**	**($3,161,590)**		
[1] This item is being paid for with grant funding which is an off budget funding source so the costs do not appear here								

Table 1.3 FY 2020-21 Cost Savings Through Community Living Processes Summary by Line Item								
Line Item	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
(1) Executive Director's Office; (A) General Administration, Personal Services[1]	$157,981	2.1	$78,991	$0	$0	$78,990	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental[1]	$39,635	0.0	$19,818	$0	$0	$19,817	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Short-term Disability[1]	$269	0.0	$135	$0	$0	$134	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement[1]	$7,080	0.0	$3,540	$0	$0	$3,540	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement[1]	$7,080	0.0	$3,540	$0	$0	$3,540	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Operating Expenses[1]	$28,265	0.0	$14,133	$0	$0	$14,132	50.00%	Table 7
(1) Executive Directors Office; General Administration, General Professional Services and Special Projects	$561,244	0.0	$280,622	$0	$0	$280,622	50.00%	Table 2.1 Row G
(2) Medical Services Premiums; Medical Services Premiums	($13,563,921)	0.0	($6,781,961)	$0	$0	($6,781,960)	50.00%	Sum Table 2.1 Rows B, D, F, H, & I
(4) Office Of Community Living; (A) Division Of Intellectual and Developmental Disabilities, Adult Comprehensive Services	$798,151	0.0	$399,076	$0	$0	$399,075	50.00%	Sum Table 2.1 Rows C & E
Total Estimate	**($11,964,216)**	**2.1**	**($5,982,106)**	**$0**	**$0**	**($5,982,110)**		

[1] This item is being partially paid for with grant funding which is an off budget funding source so the total costs do not appear here, only the portion being paid with State resources

Table 1.4 FY 2021-22 Cost Savings Through Community Living Processes Summary by Line Item								
Line Item	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
(1) Executive Director's Office; (A) General Administration, Personal Services[1]	$379,154	5.0	$189,577	$0	$0	$189,577	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental[1]	$39,635	0.0	$19,818	$0	$0	$19,817	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Short-term Disability[1]	$646	0.0	$323	$0	$0	$323	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement[1]	$16,987	0.0	$8,494	$0	$0	$8,493	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement[1]	$16,987	0.0	$8,494	$0	$0	$8,493	50.00%	Table 7
(1) Executive Director's Office; (A) General Administration, Operating Expenses[1]	$4,750	0.0	$2,375	$0	$0	$2,375	50.00%	Table 7
(1) Executive Directors Office; General Administration, General Professional Services and Special Projects	$561,244	0.0	$280,622	$0	$0	$280,622	50.00%	Table 2.1 Row G
(2) Medical Services Premiums; Medical Services Premiums	($19,051,409)	0.0	($9,525,705)	$0	$0	($9,525,704)	50.00%	Sum Table 2.1 Rows B, D, F, H, & I
(4) Office Of Community Living; (A) Division Of Intellectual and Developmental Disabilities, Adult Comprehensive Services	$834,300	0.0	$417,150	$0	$0	$417,150	50.00%	Sum Table 2.1 Rows C & E
Total Estimate	**($17,197,706)**	**5.0**	**($8,598,852)**	**$0**	**$0**	**($8,598,854)**		

Table 2.1 FY 2018-19 Cost Savings Through Community Living Processes Summary by Initiative						
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculations**
A	FTE Costs	$0	$0	$240,310	$458,159	Table 7.2 Row C
B	CCT LTSS Client Service Costs	$1,007,313	$2,023,164	$2,095,834	$2,171,735	Tables 3.1, 3.2, 3.3, and 3.4 Row F
C	CCT DD Client Service Costs	$269,585	$603,151	$630,119	$658,658	Tables 3.1, 3.2, 3.3, and 3.4 Row F
D	Cost Increase from New Enrollments due to New Funding for LTSS Client Service Costs	$244,197	$505,791	$523,958	$542,934	Tables 3.1, 3.2, 3.3, and 3.4 Row F
E	Cost Increase from New Enrollments due to New Funding for DD Client Service Costs	$77,025	$160,841	$168,032	$175,642	Tables 3.1, 3.2, 3.3, and 3.4 Row F
F	Current Options Counseling Contract Costs	($319,302)	($319,302)	($319,302)	($319,302)	Table 6.1 Row A * -1
G	New Options Counseling Contract Costs	$561,244	$561,244	$561,244	$561,244	Table 6.1 Row C
H	Nursing Facility Savings Offset	($2,623,558)	($7,879,093)	($12,674,020)	($17,130,481)	Tables 3.1, 3.2, 3.3, and 3.4 Row L (Excluding ADRC Savings)
I	Increase to Nursing Facility Savings from Increase in Enrollments due to New Funding	($690,410)	($1,978,976)	($3,190,391)	($4,316,295)	Tables 3.1, 3.2, 3.3, and 3.4 Row L (Excluding Current CCT Savings)
J	State Plan System Change Implementation Costs	$337,500	$0	$0	$0	Table 8.1 Row A
K	**Total Request**	**($1,136,406)**	**($6,323,180)**	**($11,964,216)**	**($17,197,706)**	**Sum of Rows A to J**

Table 3.3 FY 2020-21 Transition Services Budget Impact

Row	COLORADO CHOICE TRANSITIONS	Total	Existing DD Transitions Under Current Funding	DD Transitions Under New Funding	Existing LTSS Transitions Under Current Funding	LTSS Transitions Under New Funding	Calculation	Notes
A	Estimated Average Monthly Enrollment	99	15	4	64	16		Table 4.3 Row A, B, & C
B	Estimated Transition Services Per Enrollee Annual Cost	$25,692	$40,964	$40,964	$22,065	$22,065		Average Cost Per Client for Transition Services
C	**Estimated Transition Service Total Cost**	**$2,543,495**	**$614,467**	**$163,858**	**$1,412,136**	**$353,034**	**Row A * Row B**	**Estimated Total Transition Services Costs**
D	Estimated Long-Term Home Health Per Enrollee Annual Cost	$8,833	$1,043	$1,043	$10,683	$10,683		Average Cost Per Client for Long-Term Home Health Services
E	**Estimated Long-Term Home Health Total Cost**	**$874,448**	**$15,652**	**$4,174**	**$683,698**	**$170,924**	**Row A * Row D**	**Estimated Total LTHH Service Costs**
F	**Estimated Total Expenditures For Transition Services**	**$3,417,943**	**$630,119**	**$168,032**	**$2,095,834**	**$523,958**	**Row C + Row E**	**Total Expenditure for Transition Services**
G	Estimated Number of Completed Transitions (1)	135	20	5	88	22	(Table 3.2 Row A + Table 3.1 Row G) * 96%	96% Is the Completion Rate of Transitions Over The Life of the CCT Program, See Narrative for Additional Detail
H	Estimated HCBS Service Per Enrollee Annual Cost	$45,432	$70,014	$70,014	$39,653	$39,653		New Waiver Expenditure for Clients Successfully Transitioned Into An HCBS Waiver - This Effects Both LTSS and DD. Cost Per Client Trended forward from FY 2017-18 S-1
I	**Estimated Non-Transition Services HCBS Service Costs Total (LTSS)**	**$4,352,666**	**$0**	**$0**	**$3,488,983**	**$863,683**	**Row G * Row H**	**LTSS impact**
J	**Estimated Non-Transition Services HCBS Service Costs Total (DD)**	**$1,780,671**	**$1,399,427**	**$381,244**	**$0**	**$0**	**Row G * Row H**	**DD impact**
K	Estimated Nursing Facility Per Full-Time Equivalent (FTE) Annual Cost	(71,111)	($71,111)	($71,111)	($71,111)	($71,111)		Trended Forward From FY 2017-18 S-1 Exhibit G
L	**Estimated Nursing Facility Total Cost Avoided**	**($15,864,411)**	**($1,866,013)**	**($503,746)**	**($10,808,007)**	**($2,686,645)**	**(Row A + Row G) * Row K; DIDD: ((Row A + Row G) * 75%) * Row K**	**Only 75% of DD Clients Are Assumed To Be Transitioning From Nursing Facilities, See Narrative For Additional Detail**
M	**Total Cost Avoidance**	**($15,864,411)**	**($1,866,013)**	**($503,746)**	**($10,808,007)**	**($2,686,645)**	**Row L**	**Total Costs Avoided by Using Transition Services**
N	**Estimated Total Budget Impact**	**($6,313,131)**	**$163,533**	**$45,530**	**($5,223,190)**	**($1,299,004)**	**Row F + Row I + Row J + Row M**	**Total Transition Services Impact to State Budget**

Table 3.4 FY 2021-22 Transition Services Budget Impact

Row	COLORADO CHOICE TRANSITIONS	Total	Existing DD Transitions Under Current Funding	DD Transitions Under New Funding	Existing LTSS Transitions Under Current Funding	LTSS Transitions Under New Funding	Calculation	Notes
A	Estimated Average Monthly Enrollment	99	15	4	64	16		Table 4.4 Row A, B, & C
B	Estimated Transition Services Per Enrollee Annual Cost	$26,588	$42,904	$42,904	$22,713	$22,713		Average Cost Per Client for Transition Services
C	**Estimated Transition Service Total Cost**	**$2,632,212**	**$643,565**	**$171,617**	**$1,453,624**	**$363,406**	**Row A * Row B**	**Estimated Total Transition Services Costs**
D	Estimated Long-Term Home Health Per Enrollee Annual Cost	$9,260	$1,006	$1,006	$11,220	$11,220		Average Cost Per Client for Long-Term Home Health Services
E	**Estimated Long-Term Home Health Total Cost**	**$916,757**	**$15,093**	**$4,025**	**$718,111**	**$179,528**	**Row A * Row D**	**Estimated Total LTHH Service Costs**
F	**Estimated Total Expenditures For Transition Services**	**$3,548,969**	**$658,658**	**$175,642**	**$2,171,735**	**$542,934**	**Row C + Row E**	**Total Expenditure for Transition Services**
G	Estimated Number of Completed Transitions (1)	218	33	9	141	35	(Table 3.2 Row A + Table 3.1 Row G) * 96%	96% Is the Completion Rate of Transitions Over The Life of the CCT Program, See Narrative for Additional Detail
H	Estimated HCBS Service Per Enrollee Annual Cost	$46,596	$70,014	$70,014	$41,199	$41,199		New Waiver Expenditure for Clients Successfully Transitioned Into An HCBS Waiver - This Effects Both LTSS and DD. Cost Per Client Trended forward from FY 2017-18 S-1
I	**Estimated Non-Transition Services HCBS Service Costs Total (LTSS)**	**$7,266,490**	**$0**	**$0**	**$5,819,807**	**$1,446,683**	**Row G * Row H**	**LTSS impact**
J	**Estimated Non-Transition Services HCBS Service Costs Total (DD)**	**$2,891,341**	**$2,276,721**	**$614,620**	**$0**	**$0**	**Row G * Row H**	**DD impact**
K	Estimated Nursing Facility Per Full-Time Equivalent (FTE) Annual Cost	(71,111)	($71,111)	($71,111)	($71,111)	($71,111)		Trended Forward From FY 2017-18 S-1 Exhibit G
L	**Estimated Nursing Facility Total Cost Avoided**	**($21,446,776)**	**($2,534,292)**	**($681,520)**	**($14,596,189)**	**($3,634,775)**	**(Row A + Row G) * Row K; DIDD: ((Row A + Row G) * 75%) * Row K**	**Only 75% of DD Clients Are Assumed To Be Transitioning From Nursing Facilities, See Narrative For Additional Detail**
M	**Total Cost Avoidance**	**($21,446,776)**	**($2,534,292)**	**($681,520)**	**($14,596,189)**	**($3,634,775)**	**Row L**	**Total Costs Avoided by Using Transition Services**
N	**Estimated Total Budget Impact**	**($7,739,976)**	**$401,087**	**$108,742**	**($6,604,647)**	**($1,645,158)**	**Row F + Row I + Row J + Row M**	**Total Transition Services Impact to State Budget**

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

Table 3.1 FY 2018-19 Transition Services Budget Impact

Row	COLORADO CHOICE TRANSITIONS	Total	Existing DD Transitions Under Current Funding	DD Transitions Under New Funding	Existing LTSS Transitions Under Current Funding	LTSS Transitions Under New Funding	Calculation	Notes
A	Estimated Average Monthly Enrollment	50	7	2	33	8		Table 4.1 Row A, B, & C
B	Estimated Transition Services Per Enrollee Annual Cost	$23,820	$37,390	$37,390	$20,841	$20,841		Average Cost Per Client for Transition Services
C	**Estimated Transition Service Total Cost**	**$1,190,997**	**$261,729**	**$74,780**	**$687,759**	**$166,729**	**Row A * Row B**	**Estimated Total Transition Services Costs**
D	Estimated Long-Term Home Health Per Enrollee Annual Cost	$8,142	$1,122	$1,122	$9,683	$9,683		Average Cost Per Client for Long-Term Home Health Services
E	**Estimated Long-Term Home Health Total Cost**	**$407,123**	**$7,856**	**$2,245**	**$319,554**	**$77,468**	**Row A * Row D**	**Estimated Total LTHH Service Costs**
F	**Estimated Total Expenditures For Transition Services**	**$1,598,120**	**$269,585**	**$77,025**	**$1,007,313**	**$244,197**	**Row C + Row E**	**Total Expenditure for Transition Services**
G	Estimated Number of Completed Transitions (1)	0	0	0	0	0		None From New CTS Program in This Request in First Year
H	Estimated HCBS Service Per Enrollee Annual Cost	$53,373	$70,014	$70,014	$36,732	$36,732		New Waiver Expenditure for Clients Successfully Transitioned Into An HCBS Waiver - This Effects Both LTSS and DD. Cost Per Client from FY 2017-18 S-1
I	**Estimated Non-Transition Services HCBS Service Costs Total (LTSS)**	**$0**	**$0**	**$0**	**$0**	**$0**	**Row G * Row H**	**LTSS impact**
J	**Estimated Non-Transition Services HCBS Service Costs Total (DD)**	**$0**	**$0**	**$0**	**$0**	**$0**	**Row G * Row H**	**DD impact**
K	Estimated Nursing Facility Per Full-Time Equivalent (FTE) Annual Cost	(69,041)	($69,041)	($69,041)	($69,041)	($69,041)		From FY 2017-18 S-1 Exhibit G
L	**Estimated Nursing Facility Total Cost Avoided**	**($3,313,968)**	**($345,205)**	**($138,082)**	**($2,278,353)**	**($552,328)**	**(Row A + Row G) * Row K; DIDD: ((Row A + Row G) * 75%) * Row K**	**Only 75% of DD Clients Are Assumed To Be Transitioning From Nursing Facilities, See Narrative For Additional Detail**
M	**Total Cost Avoidance**	**($3,313,968)**	**($345,205)**	**($138,082)**	**($2,278,353)**	**($552,328)**	**Row L**	**Total Costs Avoided by Using Transition Services**
N	**Estimated Total Budget Impact**	**($1,715,848)**	**($75,620)**	**($61,057)**	**($1,271,040)**	**($308,131)**	**Row F + Row I + Row J + Row M**	**Total Transition Services Impact to State Budget**

Table 3.2 FY 2019-20 Transition Services Budget Impact

Row	COLORADO CHOICE TRANSITIONS	Total	Existing DD Transitions Under Current Funding	DD Transitions Under New Funding	Existing LTSS Transitions Under Current Funding	LTSS Transitions Under New Funding	Calculation	Notes
A	Estimated Average Monthly Enrollment	99	15	4	64	16		Table 4.2 Row A, B, & C
B	Estimated Transition Services Per Enrollee Annual Cost	$24,836	$39,128	$39,128	$21,441	$21,441		Average Cost Per Client for Transition Services
C	**Estimated Transition Service Total Cost**	**$2,458,718**	**$586,919**	**$156,512**	**$1,372,230**	**$343,057**	**Row A * Row B**	**Estimated Total Transition Services Costs**
D	Estimated Long-Term Home Health Per Enrollee Annual Cost	$8,427	$1,082	$1,082	$10,171	$10,171		Average Cost Per Client for Long-Term Home Health Services
E	**Estimated Long-Term Home Health Total Cost**	**$834,229**	**$16,232**	**$4,329**	**$650,934**	**$162,734**	**Row A * Row D**	**Estimated Total LTHH Service Costs**
F	**Estimated Total Expenditures For Transition Services**	**$3,292,947**	**$603,151**	**$160,841**	**$2,023,164**	**$505,791**	**Row C + Row E**	**Total Expenditure for Transition Services**
G	Estimated Number of Completed Transitions (1)	46	7	2	31	7	(Table 3.1 Row A + Table 3.1 Row G) * 96%	96% Is the Completion Rate of Transitions Over The Life of the CCT Program, See Narrative for Additional Detail
H	Estimated HCBS Service Per Enrollee Annual Cost	$44,347	$70,014	$70,014	$38,165	$38,165		New Waiver Expenditure for Clients Successfully Transitioned Into An HCBS Waiver - This Effects Both LTSS and DD. Cost Per Client Trended forward from FY 2017-18 S-1
I	**Estimated Non-Transition Services HCBS Service Costs Total (LTSS)**	**$1,454,294**	**$0**	**$0**	**$1,170,529**	**$283,765**	**Row G * Row H**	**LTSS impact**
J	**Estimated Non-Transition Services HCBS Service Costs Total (DD)**	**$585,647**	**$455,503**	**$130,144**	**$0**	**$0**	**Row G * Row H**	**DD impact**
K	Estimated Nursing Facility Per Full-Time Equivalent (FTE) Annual Cost	(71,111)	($71,111)	($71,111)	($71,111)	($71,111)		Trended Forward From FY 2017-18 S-1 Exhibit G
L	**Estimated Nursing Facility Total Cost Avoided**	**($9,858,069)**	**($1,146,978)**	**($312,470)**	**($6,732,115)**	**($1,666,506)**	**(Row A + Row G) * Row K; DIDD: ((Row A + Row G) * 75%) * Row K**	**Only 75% of DD Clients Are Assumed To Be Transitioning From Nursing Facilities, See Narrative For Additional Detail**
M	**Total Cost Avoidance**	**($9,858,069)**	**($1,146,978)**	**($312,470)**	**($6,732,115)**	**($1,666,506)**	**Row L**	**Total Costs Avoided by Using Transition Services**
N	**Estimated Total Budget Impact**	**($4,525,181)**	**($88,324)**	**($21,485)**	**($3,538,422)**	**($876,950)**	**Row F + Row I + Row J + Row M**	**Total Transition Services Impact to State Budget**

Table 4.1 FY 2018-19 Additional Aging and Disability Resource Center (ADRC) Enrollments by Waiver/Category					
Row	**Item**	**Developmental Disabilities (DD) Waivers**	**Long-Term Support Services (LTSS) Waivers**	**Total**	**Notes/Calculations**
A	Current Average Monthly Enrollment	7	33	40	Total: Table 5.1 Row A * .5 (Ramp Up Period) See Narrative for Explanation DD: Total * 18.63% See Narrative for Explanation LTSS: Total - DD Clients
B	New Average Monthly Clients Enrolled With Options Counseling Increase	2	8	10	Total: Table 5.1 Row D * .5 (Ramp Up Period) DD: Table 5.1 Row A * 18.63% LTSS: Table 5.1 Row A - DD Clients
C	New Total Average Monthly Enrollment	9	41	50	Row A + Row B

Table 4.2 FY 2019-20 Additional Aging and Disability Resource Center (ADRC) Enrollments by Waiver/Category					
Row	**Item**	**Developmental Disabilities (DD) Waivers**	**Long-Term Support Services (LTSS) Waivers**	**Total**	**Notes/Calculations**
A	Current Average Monthly Enrollment	15	64	79	Total: Table 5.1 Row A DD: Total * 18.63% See Narrative for Explanation LTSS: Total - DD Clients
B	New Average Monthly Clients Enrolled With Options Counseling Increase	4	16	20	Total: Table 5.1 Row D DD: Table 5.1 Row A * 18.63% LTSS: Table 5.1 Row A - DD Clients
C	New Total Average Monthly Enrollment	19	80	99	Row A + Row B

Tables 4.3 FY 2020-21 Additional Aging and Disability Resource Center (ADRC) Enrollments by Waiver/Category					
Row	**Item**	**Developmental Disabilities (DD) Waivers**	**Long-Term Support Services (LTSS) Waivers**	**Total**	**Notes/Calculations**
A	Current Average Monthly Enrollment	15	64	79	Total: Table 5.1 Row A DD: Total * 18.63% See Narrative for Explanation LTSS: Total - DD Clients
B	New Average Monthly Clients Enrolled With Options Counseling Increase	4	16	20	Total: Table 5.1 Row D DD: Table 5.1 Row A * 18.63% LTSS: Table 5.1 Row A - DD Clients
C	New Total Average Monthly Enrollment	19	80	99	Row A + Row B

Table 4.4 FY 2021-22 Additional Aging and Disability Resource Center (ADRC) Enrollments by Waiver/Category					
Row	**Item**	**Developmental Disabilities (DD) Waivers**	**Long-Term Support Services (LTSS) Waivers**	**Total**	**Notes/Calculations**
A	Current Average Monthly Enrollment	15	64	79	Total: Table 5.1 Row A DD: Total * 18.63% See Narrative for Explanation LTSS: Total - DD Clients
B	New Average Monthly Clients Enrolled With Options Counseling Increase	4	16	20	Total: Table 5.1 Row D DD: Table 5.1 Row A * 18.63% LTSS: Table 5.1 Row A - DD Clients
C	New Total Average Monthly Enrollment	19	80	99	Row A + Row B

Table 5.1 Average Monthly Transition Services Clients			
Row	**Item**	**FY 2018-19**	**Notes/Calculations**
A	Expected Average Monthly Transition Services Clients	79	Current Monthly Average from Departmental Data
B	Expected Increase From Aging and Disability Resource Center Options Counseling Increase	25%	Table 6.2 Row D * 33% See Description in Narrative
C	New Expected Average Monthly Transition Services Clients	99	Row A * (1 + Row B)
D	New Expected Clients From Options Counseling Increase	20	Row C - Row A

Table 6.1 Estimated Expenditures on Options Counseling

Row	Item	FY 2018-19	Notes
A	Existing Yearly Contract Value	$319,302	Current Contract Value
B	Increase in Options Counseling Funds Needed	76%	Table 6.2 Row D
C	New Total Estimated Yearly Contract Value	$561,244	Row A * (1 + Row B)
D	Net Increase in Yearly Contract Value	$241,942	Row C - Row A

Table 6.2 Estimated Nursing Facility Residents Options Counseling Unmet Demand

Row	Item	FY 2015-16 to FY 2016-17	Notes
A	Residents Served by Options Counseling FY 2015-16 to FY 2016-17	761	From ADRC
B	Residents Waiting to Receive Options Counseling FY 2015-16 to FY 2016-17	2,380	From ADRC, See Description In Narrative
C	Total Residents	3,141	Row A + Row B
D	**Total Unmet Demand for Options Counseling**	**76%**	**Row B / Row C**

Table 7.1 Total Yearly FTE Expenses

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 2020-21		FY 2021-22	
Personal Services:					
Classification Title	Monthly Salary	FTE		FTE	
PROGRAM MANAGEMENT I	$6,622	0.4	$33,110	1.0	$79,464
PERA			$3,361		$8,066
AED			$1,656		$3,973
SAED			$1,656		$3,973
Medicare			$480		$1,152
STD			$63		$151
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1, 1.0 FTE		**0.4**	**$48,253**	**1.0**	**$104,706**
Classification Title	Monthly Salary	FTE		FTE	
LIAISON III	$4,962	0.4	$24,810	1.0	$59,544
PERA			$2,518		$6,044
AED			$1,241		$2,977
SAED			$1,241		$2,977
Medicare			$360		$863
STD			$47		$113
Health-Life-Dental			$7,927		$7,927
Subtotal Position 2, 1.0 FTE		**0.4**	**$38,144**	**1.0**	**$80,445**
Classification Title	Monthly Salary	FTE		FTE	
STATISTICAL ANALYST III	$5,600	0.4	$28,000	1.0	$67,200
PERA			$2,842		$6,821
AED			$1,400		$3,360
SAED			$1,400		$3,360
Medicare			$406		$974
STD			$53		$128
Health-Life-Dental			$7,927		$7,927
Subtotal Position 3, 1.0 FTE		**0.4**	**$42,028**	**1.0**	**$89,770**
Classification Title	Monthly Salary	FTE		FTE	
ADMINISTRATOR III	$4,962	0.4	$24,810	1.0	$59,544
PERA			$2,518		$6,044
AED			$1,241		$2,977
SAED			$1,241		$2,977
Medicare			$360		$863
STD			$47		$113
Health-Life-Dental			$7,927		$7,927

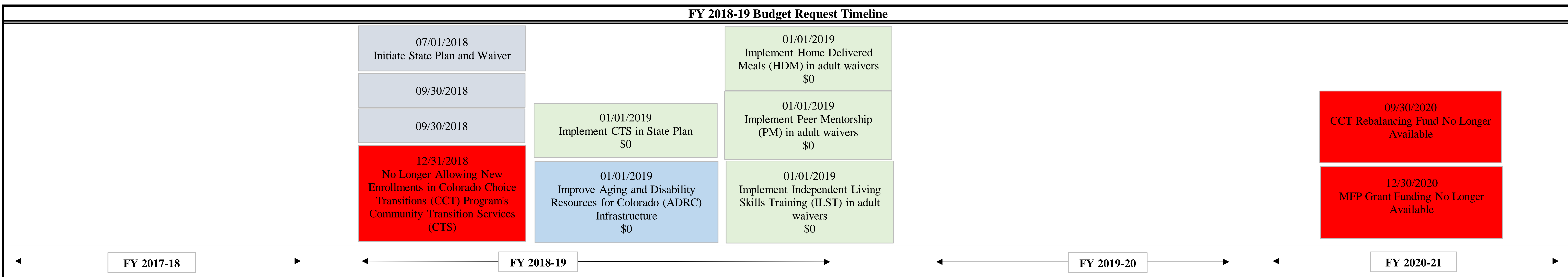
Subtotal Position 4, 1.0 FTE			**0.4**	**$38,144**	**1.0**	**$80,445**
Classification Title	Monthly Salary	FTE			FTE	
ADMINISTRATOR IV	$6,166	0.4		$30,830	1.0	$73,992
PERA				$3,129		$7,510
AED				$1,542		$3,700
SAED				$1,542		$3,700
Medicare				$447		$1,073
STD				$59		$141
Health-Life-Dental				$7,927		$7,927
Subtotal Position 5, 1.0 FTE			**0.4**	**$45,476**	**1.0**	**$98,043**
Subtotal Personal Services			2.1	**$212,045**	5.0	**$453,409**
Operating Expenses:						
		FTE			FTE	
Regular FTE Operating Expenses	$500	5.0		$2,500	5.0	$2,500
Telephone Expenses	$450	5.0		$2,250	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				**$28,265**		**$4,750**
TOTAL REQUEST			2.1	**$240,310**	5.0	**$458,159**
	General Fund:					
	Cash funds:					
	Reappropriated Funds:					
	Federal Funds:					

	FY 2020-21	FY 2021-22
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	$7,927

Table 7.2 Total Yearly FTE Budget Impact						
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculations**
A	New FTE Costs[1]	$458,159	$458,159	$458,159	$458,159	Table 7.1 Total Request FY 2021-22
B	Currently Budgeted FTE Costs[1]	($458,159)	($458,159)	($217,849)	$0	Money Follows the Person (MFP) Grant Funding, See Footnote
C	Total Yearly Budget Impact	$0	$0	$240,310	$458,159	Row A + Row B

[1] This item is being paid for with MFP grant funding; costs do not appear here until the grant runs out after December 31, 2020

Table 8.1 FY 2018-19 System Changes Contractor Costs				
Row	**Hours**	**Hourly Rate**	**Total Cost**	**Notes/Calculations**
A	2,500	$135	$337,500	Hours Estimate from Contractor for Similar System Changes Hourly Rate Based on Blended Rate for Duties Involved


FY 2018-19 Budget Request Timeline
07/01/2018
Initiate State Plan and Waiver
09/30/2018
09/30/2018
12/31/2018
No Longer Allowing New Enrollments in Colorado Choice Transitions (CCT) Program's Community Transition Services (CTS)
01/01/2019
Implement CTS in State Plan
$0
01/01/2019
Improve Aging and Disability Resources for Colorado (ADRC) Infrastructure
$0
01/01/2019
Implement Home Delivered Meals (HDM) in adult waivers
$0
01/01/2019
Implement Peer Mentorship (PM) in adult waivers
$0
01/01/2019
Implement Independent Living Skills Training (ILST) in adult waivers
$0
09/30/2020
CCT Rebalancing Fund No Longer Available
12/30/2020
MFP Grant Funding No Longer Available
FY 2017-18
FY 2018-19
FY 2019-20
FY 2020-21

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-08 Medicaid Savings Initiatives**

Dept. Approval By: 11/1/17

OSPB Approval By:

	Supplemental FY 2017-18
X	Change Request FY 2018-19
	Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,716,890,508**	**$0**	**$7,663,107,945**	**($1,391,380)**	**($4,136,489)**
	FTE	418.4	0.0	427.4	5.8	7.0
	GF	$2,121,723,743	$0	$2,107,446,252	($2,187,947)	($4,160,948)
	CF	$898,052,971	$0	$896,100,449	$2,862,240	$5,320,183
	RF	$72,715,206	$0	$72,916,331	$4,151	$847
	FF	$4,624,398,588	$0	$4,586,644,913	($2,069,824)	($5,296,571)

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- Personal Services	**Total**	**$30,884,154**	**$0**	**$32,040,094**	**$392,224**	**$476,033**
	FTE	418.4	0.0	427.4	5.8	7.0
	GF	$10,512,849	$0	$10,769,424	$180,175	$217,022
	CF	$2,985,184	$0	$3,045,883	$15,941	$20,994
	RF	$1,885,978	$0	$2,242,657	$0	$0
	FF	$15,500,143	$0	$15,982,130	$196,108	$238,017
01. Executive Director's Office, (A) General Administration -- Health, Life, and Dental	**Total**	**$3,637,126**	**$0**	**$4,639,956**	**$55,489**	**$55,489**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,305,776	$0	$1,673,531	$25,013	$24,746
	CF	$344,132	$0	$297,330	$2,732	$2,999
	RF	$103,855	$0	$135,355	$0	$0
	FF	$1,883,363	$0	$2,533,740	$27,744	$27,744

Line Item	Fund					
01. Executive Director's Office, (A) General Administration -- Short-term Disability	**Total**	**$58,060**	**$0**	**$60,583**	**$667**	**$888**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,586	$0	$22,803	$306	$408
	CF	$4,802	$0	$3,381	$27	$36
	RF	$1,364	$0	$1,484	$0	$0
	FF	$30,308	$0	$32,915	$334	$444

Line Item	Fund					
01. Executive Director's Office, (A) General Administration -- Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,851,815**	**$17,574**	**$23,387**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$697,024	$8,074	$10,753
	CF	$133,634	$0	$103,331	$714	$941
	RF	$37,970	$0	$45,371	$0	$0
	FF	$843,045	$0	$1,006,089	$8,786	$11,693

Line Item	Fund					
01. Executive Director's Office, (A) General Administration -- Supplemental Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,851,815**	**$17,574**	**$23,387**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$697,024	$8,074	$10,753
	CF	$133,634	$0	$103,331	$714	$941
	RF	$37,970	$0	$45,371	$0	$0
	FF	$843,045	$0	$1,006,089	$8,786	$11,693

Line Item	Fund					
01. Executive Director's Office, (A) General Administration -- Operating Expenses	**Total**	**$2,162,529**	**$0**	**$2,082,684**	**$38,462**	**$6,650**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$961,889	$0	$948,995	$17,339	$2,966
	CF	$74,170	$0	$70,519	$1,894	$359
	RF	$26,219	$0	$13,297	$0	$0
	FF	$1,100,251	$0	$1,049,873	$19,229	$3,325

Line Item	Fund					
01. Executive Director's Office, (C) Information Technology Contracts and Projects -- MMIS Maintenance and Projects	**Total**	**$41,646,122**	**$0**	**$41,988,677**	**$57,456**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,955,404	$0	$5,979,906	$5,746	$0
	CF	$4,288,071	$0	$4,445,412	$0	$0
	RF	$11,808	$0	$6,618	$0	$0
	FF	$31,390,839	$0	$31,556,741	$51,710	$0

01. Executive Director's Office, (C) Information Technology Contracts and Projects -- Colorado Benefits Management Systems, Operating & Contracts	**Total**	**$23,549,140**	**$0**	**$23,549,140**	**$1,309,205**	**$280,969**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,219,684	$0	$5,183,715	$225,088	$60,613
	CF	$3,453,935	$0	$3,489,904	$115,539	$28,144
	RF	$57,566	$0	$57,566	$4,151	$847
	FF	$14,817,955	$0	$14,817,955	$964,427	$191,365

01. Executive Director's Office, (E) Utilization and Quality Review Contracts -- Professional Service Contracts	**Total**	**$13,824,436**	**$0**	**$16,087,495**	**$2,010,059**	**$2,003,849**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,017,493	$0	$4,597,070	$502,515	$500,963
	CF	$470,308	$0	$497,964	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$9,336,635	$0	$10,992,461	$1,507,544	$1,502,886

02. Medical Services Premiums -- Medical Services Premiums	**Total**	**$7,597,898,847**	**$0**	**$7,538,955,686**	**($5,290,090)**	**($7,007,141)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	($3,160,277)	($4,989,172)
	CF	$886,165,101	$0	$884,043,394	$2,724,679	$5,265,769
	RF	$70,552,476	$0	$70,368,612	$0	$0
	FF	$4,548,653,004	$0	$4,507,666,920	($4,854,492)	($7,283,738)

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 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 a reduction of $1,391,380 total funds, including a reduction of $2,187,947 General Fund and an increase of 5.8 FTE in FY 2018-19, a reduction of $4,136,489 total funds, including a reduction of $4,160,948 General Fund and an increase of 7.0 FTE in FY 2019-20, and a reduction of $4,530,726 total funds, including a reduction of $4,593,450 General Fund an increase of 7.0 FTE in FY 2020-21 and future years to implement Medicaid program savings initiatives.

Current Program

- The Department has been appropriated over $9.9 billion in FY 2017-18 to provide services to 1.4 million eligible members; this represents the largest single agency budget for the State. Given the size of the Department's budget, initiatives that lead to reductions in cost are 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.

Problem or Opportunity

- As part of the Department's focus on continual improvement to provide sound financial review, the Department has identified several opportunities for savings and efficiencies to provide more cost-effective care to Medicaid members; however, the Department does not have the spending authority to successfully implement these initiatives, therefore it cannot realize the savings that would be generated in its budget.

Consequences of Problem

- Although the Department has made incremental improvements within existing resources, it is unable to implement larger scale cost reduction strategies within existing resources because of the existing workload within the Department. These projects require dedicated personnel and changes to complex IT systems and cannot be absorbed within the Department's administrative budget.

Proposed Solution

- The Department requests funding to implement five separate initiatives that would lead to savings in the Medicaid program, including: increased utilization management; automation of public assistance reporting information system matching; increased trust unit recoveries; increased access to public transportation benefits; and, implementation of a parental fee for eligibility in the Children's Home and Community-Based Services waiver.

Department Priority: ***R-8***
Request Detail: ***Medicaid Savings Initiatives***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Medicaid Savings Initiatives	($1,391,380)	($2,187,947)

Problem or Opportunity:

The Department has been appropriated over $9.9 billion in FY 2017-18 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 stewardship of financial resources, the Department has identified several opportunities for savings and efficiencies to provide cost effective care to Medicaid members; however, the Department does not have sufficient administrative resources to successfully implement these initiatives. Without the necessary administrative resources, the Department could not implement these changes as there may be unintended consequences for members.

Proposed Solution:

The Department requests a reduction of $1,391,380 total funds, including a reduction of $2,187,947 General Fund and an increase of 5.8 FTE in FY 2018-19 and a reduction of $4,136,489 total funds, including a reduction of $4,160,948 General Fund and an increase of 7.0 FTE in FY 2019-20, and a reduction of $4,530,726 total funds, including a reduction of $4,593,450 General Fund and an increase of 7.0 FTE in FY 2020-21 and future years to implement Medicaid program savings initiatives. The requested funding would be used to implement five separate initiatives including increased utilization management, automation of public assistance reporting information system matching, increased trust unit recoveries, increased access to public transportation benefits and implementation of a parental fee for eligibility in the Children's Home and Community-Based Services waiver.

Utilization Management

The Department requests a reduction of $725,295 total funds, including a reduction of $390,607 General Fund and an increase of 2.5 FTE in FY 2018-19, a reduction of $810,548 total funds, including a reduction of $413,210 General Fund and an increase of 3.0 FTE in FY 2019-20, and a reduction of $998,534 total funds including a reduction of $469,561 General Fund and an increase of 3.0 FTE in FY 2020-21 and ongoing to improve Medicaid utilization management, including implementing new prior authorization requirements on

several services and staff to support these changes. The Department has identified several service categories that would benefit from additional utilization management techniques. These services are at risk for over-utilization and, if managed more appropriately, could result in better health outcomes for Medicaid members and save the State money. The Department also needs additional resources to continue to support stakeholder-informed policy development processes, to continue to develop and refine cost-effective, evidence-based Medicaid policies.

New Prior Authorization Requirements

ColoradoPAR is the Medicaid utilization management (UM) program. A third-party vendor reviews prior authorization requests (PARs) to ensure items and services requested meet medical necessity guidelines and are within Medicaid's policies. The goals of the ColoradoPAR program are to: improve health outcomes of Medicaid members; decrease costs by eliminating duplicative and unnecessary services; and allow providers to easily track the status of their PARs using a web portal, rather than a paper process. To achieve these goals, providers request authorization for services before providing certain services. The ColoradoPAR vendor reviews the request to determine if services are medically necessary according to established criteria and guidelines.

The Department's ability to require prior authorizations for services is limited by both the amount of funding it has been appropriated for the ColoradoPAR vendor, and by the amount of internal resources the Department can devote to contract management and appeals. As such, the Department is unable to expand the current contract to implement PARs on additional services without additional funding. This has left a gap in oversight, where services which should have prior authorization requirements do not. Examples of services that have no prior authorization requirements include: elective surgeries; physical therapy, occupational therapy, and outpatient speech therapy; oxygen services; prosthetics and orthotics; adult long-term home health; and contact lenses. To ensure that the Department is not paying for unnecessary or duplicative services, the Department needs to expand the scope of the UM program to include review requirements for these, and potentially other services.

The Department is requesting funding to significantly expand the scope of the UM vendor contract to permit reviews of the services. Such an expansion cannot be absorbed by either the vendor, or Department staff. Prior authorizing additional services would significantly increase the number of requests handled by the Department's UM vendor, which would require the vendor to increase staffing commensurate with the expected increase in PARs. Further, the Department would need additional staff to manage the policy and to manage additional client appeal activities. New Department staff would be required for oversight of the UM contract deliverables specific to the services with new prior authorization requirements, quality assurance around PAR requirements and implementation, and provider education and outreach on the new process for these services. In addition, adding more PARs to benefits would result in a significant increase in denials and appeals. With every appeal the Department processes, staff are required to process the request in a timely manner, conduct conference calls with the client to explain the appeals process and answer questions, and coordinate with the UM vendor to schedule and review expert testimony.

Staff to Support Benefits Collaborative Process

The Department does not have the staff resources necessary to continue to support the Benefits Collaborative Process. The Department's work impacts over one million Coloradans, including members, providers, advocates, and family members; any changes in Medicaid policies require careful and skillful evaluation, development, and communication with stakeholders to ensure transparency and accountability. The Benefits Collaborative Process is the Department's formal public process for ensuring that Medicaid services are based on the best available clinical evidence. The Benefits Collaborative establishes evidence-based coverage policies that define the appropriate amount, scope, and duration of services as well as benefit limits; and promotes the health and functioning of Medicaid clients. Such policy is informed by: Department research into the amount, scope, and duration of services covered by Medicaid in other states, other Colorado health insurance providers, and Medicare; recently published evidenced-based reports and journal articles specific to the service or services in question; evidence-based and nationally recognized best practices; internal client utilization and health data; external data; and, information shared with the Department by stakeholders throughout the process.

The UM program enforces Department benefit limits and criteria for services requiring prior authorization, as well as determines the medical necessity of requests for services using clinical expertise and nationally-recognized criteria. The clinical expertise of the UM program staff and clinicians informs benefit and service policy content during the Benefits Collaborative policy development phases, while the UM program policy implementation is informed by policies developed during the Benefits Collaborative Process. For instance, the Department may establish through a Benefits Collaborative Process that a certain set of genetic tests are clinically utile only when certain medical factors exist, at which point the UM vendor may be asked to adopt or establish - using their clinical expertise and access to nationally recognized medical necessity criteria - certain prior authorization criteria for those specific tests.

The Department needs an additional full-time staff person to support this effort and requests 1.0 FTE to serve as a Stakeholder Relations Policy Development Specialist, who will facilitate Benefits Collaborative processes, as well as other policy-related stakeholder engagement. This will ameliorate delays due to existing staff capacity and ensure timely and comprehensive formal stakeholder-informed evidence-based policy development. This work has not only increased in depth and complexity, but the scope of requests for formal stakeholder engagement has expanded beyond fee-for-service benefits to other critical areas, including home and community based waiver programs; specific conditions, such as chronic back pain; and finance-related topics, such as copayments, payment methodologies, and rate setting.

Benefits Collaborative processes that are delayed or unrealized because of a lack of staff capacity negatively impact the Department's ability to efficiently adjust benefit and program policies in a timely, evidence-based, and stakeholder-informed manner. The Department's review of benefits cannot occur as quickly as it could with additional resources, therefore preventing the Department from future cost savings that would likely result from additional benefits going through the process. Without additional staff, new policies will be implemented with limited research, review, and external stakeholder input, which may lead to higher risks and higher costs.

Automate Public Assistance Reporting Information System Interstate Match

The Department requests a reduction of $1,015,263 total funds, including a reduction of $312,615 General Fund and an increase of 1.7 FTE in FY 2018-19 and a reduction of $2,890,033 total funds, including a reduction of $754,226 General Fund and an increase of 2.0 FTE in FY 2019-20 and future years to streamline and automate the Public Assistance Reporting Information System (PARIS) interstate match process, and provide internal resources to improve the process to prevent inappropriate expenditures.

The PARIS interstate match file identifies Colorado Medicaid enrollees who are also enrolled in another state's Medicaid program. This information is currently available to county departments and Department staff and counties are reimbursed for costs related to researching and resolving any matches within their county as part of their responsibility for case maintenance of Medicaid eligibility. In 2010, the Department automated the receipt of the PARIS Interstate Match into the Colorado Benefits Management System (CBMS) as a required condition of receipt of enhanced federal funding for systems, as outlined in 42 U.S.C. 1396b(r)(3). Additionally, section 25.5-4-209(4), C.R.S. requires the Department to access PARIS and to ensure that duplicate benefits are not being paid to persons identified.

With the passage of SB 10-167, "Medicaid False Claims Act," the Department received additional funding to increase county administration allocations for the 11 largest counties to encourage them to research and investigate potential cases of clients with eligibility in multiple states and take appropriate action on the cases to ensure duplicate benefits are not being paid. However, the amount of funding is not adequate to allocate to all counties and has not proven to be sufficient to encourage counties to prioritize the PARIS work. The Department also hired an FTE who is responsible for oversight and monitoring of the county administered PARIS interstate match process. Even with these steps to increase the number of PARIS matches that get resolved, the volume of individuals on the PARIS interstate match continues to rise and the manual, time-intensive process currently in place is not sufficient to address the volume of cases on the PARIS interstate match. This, in turn, leads to increased expenditures: although an individual living in another state may not be receiving services in Colorado, the Department would still make monthly capitation payments to providers such as the Regional Accountable Entities in the Accountable Care Collaborative and the Department's Dental Administrative Service Organization when a client is eligible for the program. Therefore, it is in the State's best interest to aggressively end open eligibility spans when the client is not living in Colorado.

Due to the large volume of individuals identified on the Colorado PARIS interstate match, which totaled 37,183 individuals in February 2017, or 2.6 percent of Medicaid caseload, an automated solution is necessary to keep up with the volume of matches. Not all the matches represent overexpenditure for Colorado because a portion of these individuals live in Colorado after having moved here from another state. Although the Department has implemented systematic processes for identifying PARIS matches and has ongoing communications with county departments and provides dedicated funding to the counties with the largest PARIS workload, the list is still too large for individual counties to fully manage.

The Department requests funding to implement system automation in CBMS to identify individuals on the PARIS interstate match who do not have corresponding eligibility end dates and generate a letter to the individual requiring them to verify their Colorado residency within a specified timeframe. If the individual does not verify residency, they would receive a notice of termination of eligibility for not responding to the

request for contact. This process would also identify individuals at initial application and re-determination who appear on the PARIS list so that appropriate action can be taken.

In addition to one- time funding for system automation, the Department requests funding for 1.7 FTE in FY 2018-19 who would continue ongoing to serve as PARIS investigators to research individual cases and coordinate with county departments and other states' PARIS contacts on matches that are not addressed through system automation. The requested staff would also coordinate with other states to close eligibility spans in those states when individuals are eligible in Colorado. This would help ensure that individuals with expenditures in Colorado are removed from the match list, which would reduce the likelihood that an individual living in Colorado has eligibility terminated inappropriately. This requires communication with Medicaid Departments in other states and close coordination with county departments. This work is time intensive and requires detailed tracking and follow up. The Department cannot successfully track the large volume of individuals on the match list without additional staff who would be responsible for reviewing the quarterly file and ensuring that cases are updated timely as appropriate.

Although the automation would reduce some manual work currently required by counties, the case maintenance by county departments would continue to be a critical part of the PARIS process. Because of this, the Department is not requesting any reduction to its County Administration appropriation. The Department would reallocate the existing PARIS county allocations into the general County Administration allocations and discontinue the policy of allocating separate PARIS funding to only certain counties. Currently and continuing with the system automation, county departments are responsible for initial and ongoing case maintenance of Medicaid eligibility which would still be necessary for a successful PARIS automation process.

Trust Unit Recoveries

The Department requests $151,426 total funds, including a reduction of $1,323,461 General Fund and an increase of 1.7 FTE in FY 2018-19 and $167,263 total funds, including a reduction of $1,595,380 General Fund and an increase of 2.0 FTE in FY 2019-20 and future years to increase staffing to review trust compliance issues and identify additional recoveries that the Department is currently unable to respond to due to limited staff resources.

Many individuals who qualify for Medicaid are required to contribute to the cost of their care. Section 25.5-4-209(1), C.R.S. requires that any recipient receiving benefits who receives any supplemental income, including trusts, shall apply this income to the cost of the benefits rendered. In many cases, this contribution occurs after the individual dies, when the Department recovers a portion of the cost of care through the recovery of assets, such as a from a trust.

With increased caseload and the aging of Colorado's population, the Department needs more resources to ensure compliance with state and federal laws. The Department currently has 1.0 dedicated FTE responsible for ensuring compliance related to income or assets in a trust. This position reviews trusts for applicants and enrolled members and advises, initiates, and recovers monies and handles any legal proceedings related to the assets in the trust. Within the parameters set forth by federal and state law, this position also analyzes, evaluates, and approves trusts and resources for Medicaid eligibility to determine the effect upon Medicaid

financial eligibility. The position requires extensive contact with the county departments, clients, and their representatives at time of eligibility determination and ongoing as situations change. As a result of the increasing caseload and the required work to coordinate benefits, the lack of staff resources focusing on this effort limits the amount of revenue the Department can recover for clients who have assets in a trust. Due to the increasing caseload and as financial situations of members constantly change, the Department is currently unable to respond to all leads and referrals related to assets in a trust that it receives from county departments, the Attorney General's Medicaid Fraud and Control Unit, and other referral sources. This limits the Department's ability to recover assets from trust due to lack of staff resources. Recoveries generally involve a legal proceeding which takes time and the Department cannot increase the value of recoveries without additional resources to research and respond to referrals and to actively pursue these assets.

To enhance the Department's ability to recover assets, the Department requests 2.0 FTE as Trust Recovery Specialists. These FTE would be generally responsible for reviewing compliance issues, seeking trust recoveries, monitoring court filings, and processing claims for recoveries. By dedicating additional resources to trust recoveries, the Department estimates that it would be able to increase the amount of funding recovered from trusts by over $3.3 million total funds per year by FY 2019-20. Detailed job descriptions for the requested FTE can be found in Appendix A.

Public Transportation Benefits for Non-Emergent Medical Transportation and Non-Medical Transportation

The Department requests a reduction of $565,951 total funds including a reduction of $282,976 General Fund in FY 2018-19, and a reduction of $810,700 total funds including a reduction of $405,350 General Fund in FY 2019-20 and future years to account for savings from discounted fares in the Non-Emergent Medical Transportation (NEMT) benefit, and to implement a public transportation benefit in the Non-Medical Transportation (NMT) program.

Medicaid members have access to a NEMT benefit to allow transportation to and from covered non-emergency medical appointments or services, and is only available when a member has no other means of transportation. Types of transportation available vary by location and may include trips in both private vehicles and public transportation. The Department has an opportunity to reduce the amount it spends on public transportation by taking advantage of a Regional Transportation District (RTD) program that would allow the Department to pay half price for bus passes for members through Medicaid's NEMT service.

Because of the available discount, the Department also sees an opportunity to decrease Non-Medical Transportation (NMT) expenditure in the Home and Community Based Services (HCBS) adult waivers by expanding NMT to include RTD bus passes. Non-Medical Transportation is a service offered to members eligible for home and community based services (HCBS) programs that provides transportation which enables members to gain personal physical access to non-medical community services and resources. The current NMT options are limited to trips via taxi, mobility vans, and wheelchair vans. NMT utilization is capped at two trips per week for all services except those that transport clients to and from adult day facilities. Approximately 15 percent of the HCBS long term services and supports (LTSS) adult waiver members utilize the NMT benefit.

The addition of a public transportation option as part of the NMT benefit is highly desired by the stakeholder community because expanding NMT would increase member independence. Additionally, by adding another NMT provider, members would be able to exercise provider choice. Right now, members wanting to utilize NMT services are sometimes at the will of very few transportation companies. Some areas have very few providers or very few providers willing to offer transportation to members. In these situations, sometimes the only willing provider is a larger taxi company which increases service costs and leads to excessive wait times.

The Department estimates approximate savings of $216,378 each year by receiving a 50 percent discount from RTD on bus fares currently offered through the NEMT program. Discounted tickets would be available for NEMT members who are seniors, individuals with disabilities, or students. There are ten different service options for NEMT and the 50 percent discount would apply to RTD transportation options which include: access-a-ride, local trips, monthly local pass, regional trips, and monthly regional passes.

To achieve the estimated savings, the Department is proposing to expand the NMT service to include public transportation. Public transportation is already a NMT service option for the HCBS Adult Comprehensive (HCBS-DD) waiver. Public transportation bus rides would be available in the following eight RTD service counties: Boulder, Broomfield, Denver, Jefferson, Adams, Arapahoe, Douglas, and Weld. The Department is proposing to provide the following RTD bus pass options to qualifying members: local tickets, local five-day pass books, monthly local passes, regional tickets, regional five-day pass books, and monthly regional passes. Expanding NMT would increase independence by allowing the members to travel around the community without relying upon a single provider or transportation option.

Parental Fee for Enrollment in Children's Home and Community Based Services Waiver

The Department requests $763,703 total funds, including $121,712 General Fund in FY 2018-19, $207,529 total funds, including a reduction of $992,765 General Fund in FY 2019-20, and $1,278 total funds, including a reduction of $1,368,934 General Fund in FY 2020-21 and ongoing to implement a parental fee into the Children's Home and Community Based Services (CHCBS) program. The fee would be collected based on the household's total income and would be a monthly premium, like the current process in the Buy-In Program for Children with Disabilities.

An inequity currently exists when providing Medicaid services to children with disabilities whose families have household income or resources that exclude them from traditional Medicaid eligibility. Families can access State Plan services either through the Children's Home and Community Based Services (CHCBS) program (if the child meets level of care requirements and targeting criteria of that waiver) or the Medicaid Buy-In Program for Children with Disabilities. Families with a child at risk of nursing facility or hospital placement can access State Plan services at no additional cost through eligibility in an HCBS program; however, other, potentially lower income, families must pay a monthly premium through the Children's Buy-In Program to access State Plan services if the child does not meet waiver eligibility criteria.[1]

---

[1] The Health First Colorado Buy-In Program for Children with Disabilities (Children's Buy-In) is a Family Medical Assistance program that provides Medicaid benefits for children who are under age 19, have a qualifying disability, and whose adjusted family income is at or below 300percent of the Federal Poverty Level (FPL). Eligible families receive Health First Colorado benefits for their child with a disability by paying a monthly premium on a sliding scale based on their adjusted income.

As a result of having similar programs with different eligibility criteria, the Department has observed that families of children with disabilities with lower income may be contributing more than families with higher income, in certain cases. The Department believes this inequity is unfair to Medicaid members. By implementing the parental fees, the Department could correct this policy and create an opportunity for General Fund offsetting dollars.

The Department requests spending authority to implement monthly premiums in the CHCBS program. Implementation would require significant systems changes and modifications, and the Department estimates that fee collection would begin in November 2019. The Department has developed, through working with stakeholders, three potential fee collection models with varying number of tiers based on household income. This request utilizes these three models to estimate revenue; however, the Department would only finalize a rate model if the request is approved, after input from legislative and other stakeholders.

If this request is not approved, the inequity between Children's Buy-In and the CHCBS waiver would continue. Families over 300 percent FPL would be able to access Medicaid services at no additional cost through use of the waiver while families between 134 percent and 300 percent FPL would be required to pay a monthly premium to access services.

Anticipated Outcomes:

Utilization Management

Approving this request would ensure the Department has sufficient funding and FTE to offer more oversight and management for certain Medicaid services that industry standards suggest are susceptible to over utilization and to continue public policy development processes. This request addresses several of the Department's FY 2016-17 Performance Plan's primary goals of ensuring sound stewardship of financial resources, and address the Department's specific strategy, to 'Implement cost containment initiatives', as it would allow the Department to better manage appropriate utilization of Medicaid services while reducing costs to the State. 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. Additionally, approval of this request would help to ensure robust management of Medicaid benefits by providing staff resources to effect changes in Medicaid policies.

Automate Public Assistance Reporting Information System Interstate Match

Automating the verification of residency process for individuals on the PARIS interstate match would lead to a more timely eligibility re-determination and termination, when applicable, which would save the State money by eliminating capitation payments for members who do not reside in Colorado. Additional savings may be had in the future by reducing fraud or other abuse by closing eligibility spans for members who are not eligible. This request aligns with several strategies in the Department's FY 2016-17 performance plan including 'Implement cost containment initiatives', 'Improve Efficiency of Business Processes', 'Promote rigorous compliance with federal and state laws and regulations, fiscal rules and internal operating procedures', and 'Support counties and medical assistance sites with technical assistance for processing eligibility applications accurately and efficiently.'

Trust Unit Recoveries

Increasing the number of staff focusing on trust unit recoveries would provide additional internal resources to research and respond to referrals and process recoveries related to trusts. This would ensure compliance with state and federal laws and aligns with several strategies in the Department's performance plan including 'Implement cost containment initiatives,' 'Improve efficiency of business processes,' 'Promote rigorous compliance with federal and state laws and regulations' and 'Support counties and medical assistance sites with technical assistance for processing eligibility applications accurately and efficiently.'

Public Transportation Benefits for Non-Emergent Medical Transportation and Non-Medical Transportation

Modifying the existing NMT service to include public transportation would help the Department achieve the Community Living Advisory Group recommendation of connecting individuals to vital health and social services by providing an effective transportation system that can help individuals preserve and improve their independence and decrease the likelihood of institutionalization. Adding public transportation as an NMT option for individuals receiving home and community-based services could improve feelings of inclusion and connectedness to the community as well as increasing member choice and access to services. Implementing discount passes into the NEMT service would reduce expenditure without compromising participant access or service experience. The expanded service options align with strategies in the Department's FY 2016-17 Performance Plan including 'Expand network of providers serving Medicaid' and 'Make Long-Term Services and Supports easier to access and navigate'.

Parental Fee for Enrollment in Children's Home and Community Based Services Waiver

The proposed change represents a shift away from an unequal policy and would even the playing field for families with children with disabilities who need Medicaid services. This request is aligned with stakeholder feedback and shows how the Department is adapting and responding to the needs of this population. This request links directly to the Department's Performance Plan strategies to 'Instill a person- and family-centered approach to strengthen employee engagement, client experience, client engagement, and culture change.'

Assumptions and Calculations:

Utilization Management

The Department estimated the impact of adding prior authorization requirements to additional benefits based on historical utilization data for each of the services. The Department used the most recent period of complete data to calculate the expected number of new PARs for each respective benefit. The Department also used the same period's utilization and expenditure data to estimate the cost per utilizer, which the Department would expect to save from each denied request. In future years, the Department leaves the cost per utilizer constant. The Department has accounted for growth in the number of projected prior authorization requests by trending the most recent utilization data by overall caseload growth in the projected fiscal years from the Department's February 2017 forecast.

To estimate the rate of denied requests, the Department used a combination of nationally available data on prior authorization requests and denials and the Department's Medicaid Management Information System (MMIS) data for services that currently require a PAR. The Department's current statistics on denial rates

for existing services found that about 3.14 percent of services were denied. Based on private insurance in Vermont, statistics show that about 6 percent of prior authorization requests were denied, with about 50 percent of those appealed and overturned. These are for services that have had PAR requirements in place for several years. Therefore, the Department assumes that Vermont's data is more appropriate to use for year one of implementation and assumes the denial rate would trend down to historical Department levels in the following years. The Department has also incorporated an assumption that as providers are more familiar with requirements for these services and what is permissible, the number of overall claims submitted will also decrease. Therefore, the Department has chosen to leave the denial rate constant in all years. This assumes a higher denial rate with similar claims volume in year one and lower denial rates and claims volume in future years. The Department has chosen this method because it is likely that there would be a greater number of initial denials from new requirements, but over time, denials would trend to levels consistent with the Department's current denial rate while overall claim volume will also trend down.

As mentioned above, the Department must amend its Utilization Management contract to include the additional services. There are three cost components that would need funding. All contractor estimates are based on estimates from the current vendor. The first component is the estimated cost per PAR for the vendor to manage the benefits, which the Department assumes would cost $22.75 per PAR. Costs per PAR can vary greatly between physical health services and pharmacy services, as can be seen in the FY 2018-19 R-10 "Drug Cost Containment Initiatives" request. There are varying levels of work regarding each PAR request, with some requests considered standard and some more complex. In physical health PARs mentioned in this request, all are treated as standard requests at $22.75 per PAR. In the Departments FY 2018-19 R-10 "Drug Cost Containment Initiatives" request some PAR requests are considered complex and costs can vary from $42 per PAR to upwards of $80 for complex PARs. Second, the vendor would need to make changes within their system to manage the capacity increases. The Department estimates that this one-time IT cost would be $75,000, based on information provided by the vendor. The third component is for flexible prior authorization funding. The flexible funding adds a twenty-five percent increase to the administrative contract managing the requests to allow for flexibility in designing the new PAR policies. Current estimates are based on a preliminary set of codes developed by the Department. The Department would work with relevant stakeholders to develop a final set of codes to implement that would deliver the best return on investment to both the members and the Department. The flexible funding accounts for the potential increase in prior authorization requests resulting from the final codes selected. Additional savings resulting from the final codes selected will be accounted for through the normal budget process.

The Department would implement the PARs on these new services on January 1, 2019, which would provide adequate time for all required contract amendments, State Plan Amendments, and rule changes to be completed. If the request is approved, the Department would hire the new FTE on September 1, 2018 to begin work on managing the various components.

Approval of the Stakeholder Relations Policy Development Specialist would allow for additional benefits to be reviewed through the Benefits Collaborative Process to align with best practices and evidence-based research. In turn, this may generate long term savings due to more robust management of Medicaid benefits. However, the Department is still in the process of evaluating policy changes previously implemented and

therefore has not estimated the savings in its budget and would utilize the budget process to update associated savings.

The Department currently has 1.0 FTE who is the Stakeholder Relations Specialist and this position also serves as a Unit Manager. This FTE manages staff who are responsible for regulatory compliance, rule-writing, and State Plan Amendments, as well as the Medicaid Provider Rate Review process established in SB 15-228 and the compliance activities required under federal Access to Covered Medicaid Services regulations. The rate review and access initiatives are relatively new and the scope of work required for effective and meaningful stakeholder engagement on these projects, while effectively managing and mentoring staff, has become unmanageable. Without an additional FTE, the Department would be forced to make difficult decisions that would be detrimental to program management and would prevent it from being able to evaluate, develop, revise, and implement evidence-based policies in a manner that meets timeliness and quality standards. Additionally, it would prevent the Department from making changes based on best practices and stakeholder expectations, such as slowing progress on the Benefits Collaborative Process or re-prioritizing job duties for projects that are equally as important.

Detailed job descriptions for the requested FTE can be found in Appendix A. Detailed calculations can be found in Appendix B.

Automate Public Assistance Reporting Information System Matching
The Department estimates that of the total 37,177 individuals who match on Colorado's PARIS interstate match February 2017 report, that 20,717 would be terminated due to system automation and the remaining 16,466 individuals reside in Colorado and need to have their eligibility in another state updated. The Department calculated the client number by taking the number of individuals on the PARIS interstate match who match for two or more quarters in a row and do not have a corresponding eligibility end date in CBMS. Then, this list was compared with claims data. The clients who have fee for service (FFS) claims after the date of the match are assumed to reside in Colorado. For the remaining clients who have no FFS claims, the Department assumes these clients no longer reside in Colorado and that the automation process will terminate eligibility. The Department assumes that the PARIS match list will grow by the same growth rate as Medicaid caseload based on the Department's caseload statistics, which may represent a conservative estimate as historically the list has grown at a higher rate than caseload. Although most enrollees who reside in Colorado would have at least one FFS claim in a year, the Department estimates that 19.78 percent of clients who are continuously enrolled do not utilize any FFS claims in a year based on MMIS data, and has adjusted the calculations accordingly in an effort not to overestimate the number of individuals who would be terminated due to automation.

The Department assumes there are two types of capitation savings that would be realized due to eligibility termination. These are payments to Regional Accountable Entities and the Department's Dental Administrative Service Organization. Although the Department pays capitation payments to other types of providers, such as the payments to behavioral health organizations and managed care plans, the Department has not estimated savings for those payment types. Individuals who do not reside in Colorado and do not incur fee-for-service costs have the effect of artificially lowering the monthly capitation rates for these providers. These rates would be adjusted prospectively to incorporate the expected decrease in caseload

through the annual rate adjustment process, resulting in no expected change in aggregate payments to these providers.

The Department assumes the modifications to CBMS would be eligible for 75 percent enhanced FFP and be completed by September 30, 2018. Therefore, the Department assumes the first batch of PARIS letters to verify residency would be system generated and mailed by October 31, 2018. For those who did not verify Colorado residency, the first round of individuals who receive notices of termination of eligibility due to the automation would occur by November 30, 2019. The Department assumes it would need to submit an Advanced Planning Document (APD) update to Centers for Medicare and Medicaid Services (CMS) to request approval of enhanced FFP and that could be completed by July 1, 2018. If the Department does not receive approval for enhanced FFP, it would utilize the budget process to request a change in funding. Additionally, the Department estimates that the automation process would increase CBMS printing and mailing costs totaling 34,000 additional pages per quarter at $0.54 per page and has included these costs in the request. There may also be future decreases in printing and mailing costs for individuals who are terminated due to the automation; for example, a decrease in the number of annual redetermination packets that would be printed and mailed for the individuals that would be terminated. If this occurs, these decreases would be accounted for in the annual CBMS base request.

The Department assumes the 1.7 FTE would be hired September 1, 2018 and these costs would be eligible for 50 percent federal financial participation (FFP). The Department currently has 1.0 FTE who is responsible for oversight of Colorado's PARIS program. This is not a sufficient level of internal staff to properly and timely monitor the PARIS process as much of this FTE's time is currently spent researching individual cases which prevents them focusing on improving and monitoring of county PARIS processes. If this request is approved, many of the job duties would continue while other duties would shift upon hiring of the additional FTE requested and once automation is implemented. This FTE would continue to be the PARIS policy expert working with Department systems teams to design, develop and implement system automation and developing training for eligibility sites and customer service representatives, including county departments. The position would be responsible for implementing procedures to ensure the changes in process do not adversely impact Medicaid clients who remain Colorado residents, which would include troubleshooting any issues that arise due to automation. This FTE would also be responsible for training and overseeing work of the new staff. This employee's PARIS job duties would shift from primarily communicating with county departments on PARIS allocations, cases, reviewing county quarterly reports and individual case resolution to a program oversight role as the PARIS team lead. In addition to the interstate match, the current staff would continue to be the main contact on the other two PARIS files which are U.S. Department of Veterans Affairs (VA) and Federal file.

The Department assumes the state share of administrative costs for this request would be allocated between General Fund and Healthcare Affordability and Sustainability Fee Cash Fund.

Detailed job descriptions for the requested FTE can be found in Appendix A. Detailed calculations can be found in Appendix B.

Trust Recoveries

The Department assumes the FTE would be hired September 1, 2018 and that recoveries could begin to be realized on that date and that these costs would be eligible for 50 percent FFP. The Department assumes that the state share of cost for this request would be General Fund because expansion populations funded with Healthcare Affordability and Sustainability Fee Cash Funds are not subject to asset tests and therefore are not impacted by trust recoveries.

The Department assumes that adding additional staffing would increase the amount of trust recoveries because the new FTE would be able to follow up and research additional referrals received from trust officers, county departments, or other sources. The Department has calculated the increased recoveries by taking the amount of income trust recoveries from the FY 2016-17 S-1 "Medical Services Premiums Request" and estimating the amount of recoveries per current FTE. Assuming decreasing marginal returns, the Department estimates that the new FTE would be able to bring in 50 percent of the recoveries that the two current FTE have generated. Therefore, each FTE would increase the annual amount of recoveries by $1,679,012, totaling to $3,358,023 on an annual basis and the estimate for FY 2018-19 has been adjusted based on the FTE start date. The Department would update this estimate based on actuals through the budget process. The Department assumes the recovery revenue is not considered TABOR revenue because it is a reimbursement of prior expenditures and not a fee or tax.

The Department assumes 50 percent FFP split between General Fund and federal funds for the increased recoveries for this initiative because all the populations subject to trust requirements are non-expansion populations therefore there would be no enhanced match or other cash fund sources impacted.

Detailed job descriptions for the requested FTE can be found in Appendix A. Detailed calculations can be found in Appendix B.

Public Transportation Benefits for Non-Emergent Medical Transportation and Non-Medical Transportation

Non-Emergent Medical Transportation

The Department currently contracts with a broker to manage NEMT trips and distribute RTD passes. The Department used data from the NEMT broker for the period March 2015 through May 2017 to estimate savings from the proposed 50 percent discount. The monthly data includes total NEMT trips and total number of trips taken on each of the RTD options (access-a-ride, fixed, monthly local, regional, and monthly regional). The Department used these values to predict monthly RTD rides, percentage of NEMT trips taken on RTD options, and yearly expenditure with and without the 50 percent discount. The discount would be available to Medicaid members who are seniors, individuals with disabilities, or students. In FY 2015-16, this eligible population was responsible for 65 percent of NEMT expenditure. Therefore, the Department estimated that 65 percent of all NEMT RTD bus trips would be eligible for the 50 percent discount.

Due to reclassification of RTD routes and fares in January 2016, the Department employed data from January 2016 through December 2016 to approximate how many NEMT trips would have been taken on each of RTD's new route categories listed above.

To implement the new policy, the Department assumes the NEMT broker would determine which NEMT clients are eligible to receive the discount passes. Due to this increase in administrative work, the Department assumes, based on conversations with its vendor, that the broker would need to hire an additional two positions to administer passes for NEMT and NMT members which would total $120,000 annually with $10,000 startup costs in the first year. Approximately $35,000 would also need to be added to the broker's annual contract for postage costs associated with the new passes. All changes to the broker's contract and operations would be completed by July 1, 2018.

Non-Medical Transportation
The Department assumes a public transportation option would produce a shift in utilization to public transportation from clients using taxis, mobility vans, or mobility vans to and from an adult day facility. The available RTD options would be: access-a-ride, local trips, five-day local pass book, monthly local pass, regional trips, five-day regional pass book, and a monthly regional pass. The Department assumes clients utilizing either of the wheelchair van transportation options would not shift their utilization.

To estimate this policy's impact on NMT expenditure, the Department analyzed claims data from FY 2015-16 to predict potential public transportation utilization by waiver clients. First, the Department collected the total number of one-way trips for the following NMT services: taxi, mobility van, and mobility van to and from adult day facilities. The Department then estimated how many of the current NMT units may shift to RTD public transportation units if the service were to be expanded. The Department assumed that 13 percent of current NMT units would switch to the newly available RTD option, as approximately 13 percent of NEMT trips since March 2015 have been taken on one of the available RTD options. NEMT is an appropriate proxy because it also serves members who are of the same eligibility category as NMT waiver clients. In addition, utilization of public transportation in waivers for Individuals with Development Disabilities (IDD) is much higher than both NEMT and NMT. Therefore, the Department believes NEMT utilization is the most accurate of the available ways to estimate future RTD utilization.

There is potential for increased utilization in the NMT services once the transportation options are expanded. The Department sees two ways that this could happen: if waiver clients who are not using NMT services currently see the available RTD options and decide to begin utilizing NMT or if current NMT clients begin to use more of their allotted units as the number of service options expands. This is uncertain, and if utilization increases occur, the Department would account for any changes via the regular budget process. NMT utilization would need to increase by over 11 percent to breakeven and offset the estimated savings.

The Department would need to submit a waiver amendment to the Centers for Medicaid and Medicare (CMS) to expand the options for NMT. The amendment would be for a modification of an existing service and would include new policies and regulations regarding the modified service. The Department estimates this work could be completed by September 1, 2018 and that the program would begin in October 2018.

Detailed calculations for both NEMT and NMT components can be found in Appendix B.

Parental Fee for Enrollment in Children's Home and Community Based Services Waiver
The Department previously worked with CHCBS stakeholders to design three potential sliding scale parental fee models. If the request is approved, the Department would analyze the options and select the most

appropriate one. For purposes of this request, however, the Department has selected one of the three models to use in estimating potential revenue. The model used for this request represents the lowest revenue estimate out of the three developed by the CHCBS workgroup.

The model has six tiers based on the household's Federal Poverty Level (FPL). The Department does not collect parental income information for CHCBS waiver members so the Department used the 2016 American Community Survey (ACS) as a proxy. The Department compiled a list of the zip codes for each of the 1,125 children enrolled on the CHCBS waiver during FY 2014-15. The 2015 median household income for each zip code, as collected by the 2016 ACS, was then applied to each member and was used as a proxy for the child's household income. Once the household income was applied, the Department distributed the children into the correct tier of the model developed by the workgroup. Because this work was several years out of date, the Department then applied this FPL distribution to average monthly caseload for FY 2016-17 for a more accurate estimate. The FPL bounds of the tiers and distribution of children within each tier is displayed in the below table.

Example Fee FPL Tiers, Client Distribution, and Monthly Premium			
Tier	**FPL**	**Clients**	**Premium**
1	0-275%	216	N/A
2	275-400%	602	2.5%
3	401-525%	419	3.0%
4	526-650%	162	4.0%
5	561-899%	0	5.0%
6	900% and above	0	6.0%
Total		1,399	

Based on the tier distribution, the Department then estimated the potential monthly premium amounts which correspond to the percentage of median household income that would be collected. Taking the estimated income of each child multiplied by the appropriate premium, the Department estimated each child's potential monthly premium amount.

Introducing a monthly premium to the CHCBS waiver may cause some families to decide not to enroll their children in the waiver. Many of these children use Medicaid services as a secondary insurance option and a monthly premium might represent too great a cost to pursue waiver enrollment. Another potential caseload change would be for the family to try and pursue a different waiver if the child meets eligibility criteria of that waiver to avoid the fee. It is possible that this policy change would lead to a drop in CHCBS waiver enrollment and an increase in, for example, the Children with Life Limiting Illness (CLLI) waiver. These effects are difficult to predict, and it is unclear if such movement would occur. As a result, the Department has not included any estimate for changes in service cost or caseload; should such adjustments be necessary, the Department would account for any changes via the regular budget process.

Collection of the fees would follow the business and system processes that are in place for the Medicaid Buy-In Program for Children with Disabilities by utilizing the eligibility and enrollment vendor, Denver Health,

to process any manual payments or adjustments. Due to the relatively small number of additional monthly premiums that would be collected and existing contract amounts, the Department assumes it could absorb administration of the additional premiums within existing appropriations. The Department would use the Program and Eligibility Application Kit (PEAK) and the Colorado Benefits Management System (CBMS) to assess parental income, determine the amount of monthly premiums each family would be responsible for, and collect payments. System changes would also include necessary modifications to collect data for federal reporting and Department data analysis and reporting.

Implementation Assumptions

Development and selection of the fee model would need to be completed before any system changes begin. The Department assumes that this work would be completed by Department staff by November 30, 2018. Upon completion of this work, system changes would begin to both CBMS and MMIS.

Implementing a parental fee into the CHCBS waiver would require a rule change and waiver amendment. If the request is approved, the Department assumes it could begin work on both tasks in June 2018. To implement the rule change, the Department would need to promulgate rules to the Medical Services Board (MSB). Given the timing of necessary steps, the Department assumes that the earliest the policy changes could be effective would be September 1, 2019, when necessary system changes are to be completed. The Department assumes that it would submit the waiver amendment and estimates an approval by September 1, 2019.

The Department is requesting funding in FY 2018-19 and FY 2019-20 to implement the necessary system changes for fee collection. The Department estimates that these changes would begin December 1, 2018, take nine months to complete, and revenue would start to be collected one month from the implementation date. Therefore, the Department is assuming that premium letters would be generated and mailed on September 1, 2019 and revenue from these fees would start being collected October 1, 2019. Creating necessary system infrastructure for fee collection is estimated to require seven months of work in FY 2018-19 and two months in FY 2019-20.

The Department would need to submit the necessary Implementation Advanced Planning Document (IAPD) to ensure federal matching funds for system changes associated with this project. The Department assumes all work related to the IAPD would occur during FY 2018-19. Delays in approval could delay implementation timelines for the parental fee. In the event of delayed implementation, the Department would address any needed funding changes through the normal budget process.

The Department assumes the fee collection process would be like the process for monthly premium collection for the Medicaid Buy-In Programs for people with disabilities, including the ability to pay online, by mail or in person at a Denver location. The Department contracts with the Colorado Medical Assistance Program (CMAP) eligibility and enrollment vendor who is responsible for collection of monthly premiums for the Children’s Buy-In program and any manual payments or adjustments. This request would collect monthly

premiums from an estimated 1,183 clients each year[2]. The Department assumes it could cover increased costs to the CMAP contract for administration of the monthly premium process within existing appropriations.

The parental fee collection would be considered non-exempt revenue and the Department assumes it would be counted as Taxpayer's Bill of Rights (TABOR) revenue. The funds would be used to offset General Fund and federal funds expenditures and would be deposited into the Health Care Policy and Financing Cash Fund authorized in section 25.5-1-109, C.R.S. Fees applied to service costs are not eligible for a federal match and the Department has calculated fund splits in the request accordingly.

[2] This figure is the average monthly waiver clients during FY 2016-17 not including those families who are estimated to be below 275percent FPL. The number does not represent total enrollment on the waiver during FY 2016-17.

Appendix A: FTE Descriptions

Position Name	Position Classification	Number of FTE	Description
Utilization Management Contract Manager	Administrator IV	1.0	The FTE would be responsible for the additional scope of work under the current utilization management vendor's contract related to adding prior authorization requirements on additional benefits. The staff would have a unique technical expertise that is critical to the overall success of the Department. This position will have direct influence over the decision-making process. The Department and its vendor currently process about 20,000 requests per month for four large and six small benefits with 2.0 FTE. Adding an additional six benefits to the UM will increase the prior authorization requests by about 5,500 per month, which current staff cannot absorb. This position would assist with overseeing the UM contract deliverables and quality assurance assessments specific to the new benefits. Staff would also provide outreach and education to providers on the new services requiring PARs. The position would serve as a liaison between the UM vendor and Department staff on systems testing to ensure successful interoperability between the PAR portal and the interChange.
Client Appeals Representative	Administrator IV	1.0	The FTE would serve as an appeals representative for the new services that would require a PAR. The staff would have a unique technical expertise that is critical to the overall success of the Department. This position will have direct influence over the decision-making process. This position would ensure appeal requests are processed in a timely manner. The position would also coordinate with the UM vendor to schedule and review their expert testimony and cause for denial. The staff would assemble, prepare, and submit all medical documentation relating to the appeal as well as submit needed requests for dismissals, continuances, and exceptions. The Department currently has one FTE that handles appeals related to prior authorized services. Based on the current benefits requiring a prior authorization, this staff has worked about 400 appeals per year. With the number of PARs expected to increase by about one quarter and a higher initial denial rate, the Department expects the number of appeals to increase significantly.

Position Name	Position Classification	Number of FTE	Description
Stakeholder Relations Specialist	Administrator V	1.0	The FTE would serve as the coordinator for the stakeholder processes required for policy development and changes, including changes in federal and state law, such as changes to copayments, payment methodologies and services. This also includes managing the Benefits Collaborative Process, which includes ensuring research and draft benefit policies are evidence-based and guided by best practices and planning, project management, stakeholder communication, and leading, and/or facilitating public meetings. The FTE would develop productive working relationships and collaborate with groups and individuals to constructively address disagreements and policy challenges. The FTE would identify and establish metrics to monitor policy changes, track and monitor related utilization and expenditure, and identify ways to enforce policy changes through claims system edits or prior authorization request requirements/criteria. This position would recommend best practices, identify and address benefit or policy gaps, solicit and respond to provider, client, and stakeholders in benefit coverage policy development, and assesses current and future benefit coverage policies. The position would ensure that leadership is informed on status of all projects and identify potential risks to progress.
PARIS Investigators	Program Assistant II	2.0	These FTE would provide additional internal resources to investigate PARIS matches not addressed by CBMS systems changes. The system changes would not address the cases where individuals have recently become enrolled in Colorado Medicaid, but remain enrolled in another state. To address the PARIS matches caused by open eligibility spans in other states, the Department requests additional FTE to verify matches and work with the other states to ensure that individuals do not show up on future reports. The positions would be required to run reports against the matched data as well as PARIS data in CBMS. The positions would be responsible for contacting other states with the purpose of determining the correct state for eligibility and terminating eligibility in the other state. These FTE would also work closely with county personnel to troubleshoot individuals that are terminated in error by CBMS utilizing the automated methodology to ensure that clients are not adversely impacted by the automated process. Positions would be responsible for duties

Position Name	Position Classification	Number of FTE	Description
			assigned by the program coordinator such as assisting the counties with questions and data needs.
Trust Unit Recovery Specialists	Administrator IV	2.0	These positions would be responsible for reviewing compliance issues, seeking trust recoveries, monitoring court filings, and processing claims for recoveries. These FTE would communicate with contractors including county departments related to trust resources for Medicaid clients. the position would provide decisions concerning Medicaid trusts, resources, and transfers without fair consideration to county staff, clients, and client representatives. The positions would work on projects in this subject matter area at the direction of the Trust and Recovery Officers. These positions recommend and support decisions related to trusts, resources, and transfers without fair consideration for the eligibility of persons applying for benefits from the state Medicaid program. These positions would review accounting documents from trustees and advises, initiates, and recovers monies on behalf of Medicaid upon the client's death or closure of the trust. Any legal proceedings such as administrative appeals, judicial reviews stemming from such trusts, resources, and transfers without fair consideration may be handled by this position. Within the parameters set forth by federal and state law, these positions may also analyze, evaluate, and approve trusts and resources to determine the effect upon applicant/recipient Medicaid financial eligibility.

Table 1.1 FY 2018-19 R-8 Medicaid Savings Initiatives Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$392,224	5.8	$180,175	$15,941	$0	$196,108	Table 8.1- FTE Row A
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$55,489	0.0	$25,013	$2,732	$0	$27,744	Table 8.1- FTE Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$667	0.0	$306	$27	$0	$334	Table 8.1- FTE Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$17,574	0.0	$8,074	$714	$0	$8,786	Table 8.1- FTE Row D
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$17,574	0.0	$8,074	$714	$0	$8,786	Table 8.1- FTE Row E
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$38,462	0.0	$17,339	$1,894	$0	$19,229	Table 8.1- FTE Row F
G	(1) Executive Director's Office, (C) Information Technology Contractors and Projects, Medicaid Management Information System Maintenance and Projects	$57,456	0.0	$5,746	$0	$0	$51,710	Table 2.1 Row R
H	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$1,309,205	0.0	$225,088	$115,539	$4,151	$964,427	Table 2.1 (Row F + Row G + Row Q + Row S)
I	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$2,010,059	0.0	$502,515	$0	$0	$1,507,544	Table 2.1 Row B
J	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($5,290,090)	0.0	($3,160,277)	$2,724,679	$0	($4,854,492)	Table 2.4 Row H
K	**Total Request**	**($1,391,380)**	**5.8**	**($2,187,947)**	**$2,862,240**	**$4,151**	**($2,069,824)**	**Row A + Row B + Row C + Row D + Row E + Row F + Row G + Row H + Row I + Row J**

Table 1.2 R-8 FY 2018-19 Medicaid Savings Initiatives Cash Fund Breakout								
Row	**Line Item**	**Healthcare Affordability and Sustainability Fee Cash Fund**	**Adult Dental Cash Fund**	**Breast and Cervical Cancer Program Cash Fund**	**CHP+ Trust Fund**	**HCPF Cash Fund**	**Recovery Cash Funds**	**Total**
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$15,941	$0	$0	$0	$0	$0	$15,941
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$2,732	$0	$0	$0	$0	$0	$2,732
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$27	$0	$0	$0	$0	$0	$27
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$714	$0	$0	$0	$0	$0	$714
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$714	$0	$0	$0	$0	$0	$714
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$1,894	$0	$0	$0	$0	$0	$1,894
G	(1) Executive Director's Office, (C) Information Technology Contractors and Projects, Medicaid Management Information System Maintenance and Projects	$0	$0	$0	$0	$0	$0	$0
H	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$115,282	$0	$0	$257	$0	$0	$115,539
I	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$0	$0	$0	$0	$0	$0	$0
J	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($66,056)	($7,541)	($77)	$0	$0	$2,798,353	$2,724,679
K	**Total Cash Fund Request**	**$71,248**	**($7,541)**	**($77)**	**$257**	**$0**	**$2,798,353**	**$2,862,240**

Table 1.3 FY 2019-20 R-8 Medicaid Savings Initiatives Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$476,033	7.0	$217,022	$20,994	$0	$238,017	Table 8.2 FTE Row A
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$55,489	0.0	$24,746	$2,999	$0	$27,744	Table 8.2 FTE Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$888	0.0	$408	$36	$0	$444	Table 8.2 FTE Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693	Table 8.2 FTE Row D
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693	Table 8.2 FTE Row E
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$6,650	0.0	$2,966	$359	$0	$3,325	Table 8.2 FTE Row F
G	(1) Executive Director's Office, (C) Information Technology Contractors and Projects, Medicaid Management Information System Maintenance and Projects	$0	0.0	$0	$0	$0	$0	Table 2.2 Row R
H	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$280,969	0.0	$60,613	$28,144	$847	$191,365	Table 2.2 (Row F + Row G + Row Q + Row S)
I	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$2,003,849	0.0	$500,963	$0	$0	$1,502,886	Table 2.2 Row B
J	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($7,007,141)	0.0	($4,989,172)	$5,265,769	$0	($7,283,738)	Table 2.5 Row H
K	**Total Request**	**($4,136,489)**	**7.0**	**($4,160,948)**	**$5,320,183**	**$847**	**($5,296,571)**	**Row A + Row B + Row C + Row D + Row E + Row F + Row G + Row H + Row I + Row J**

Table 1.4 R-8 FY 2019-20 Medicaid Savings Initiatives Cash Fund Breakout

Row	Line Item	Healthcare Affordability and Sustainability Fee Cash Fund	Adult Dental Cash Fund	Breast and Cervical Cancer Program Cash Fund	CHP+ Trust Fund	Medicaid Buy-In	Recovery Cash Funds	Total Cash Funds
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$20,994	$0	$0	$0	$0	$0	$20,994
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$2,999	$0	$0	$0	$0	$0	$2,999
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$36	$0	$0	$0	$0	$0	$36
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$941	$0	$0	$0	$0	$0	$941
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$941	$0	$0	$0	$0	$0	$941
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$359	$0	$0	$0	$0	$0	$359
G	(1) Executive Director's Office, (C) Information Technology Contractors and Projects, Medicaid Management Information System Maintenance and Projects	$0	$0	$0	$0	$0	$0	$0
H	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$28,096	$0	$0	$48	$0	$0	$28,144
I	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$0	$0	$0	$0	$0	$0	$0
J	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($132,808)	($13,399)	($137)	$0	$2,054,090	$3,358,023	$5,265,769
K	**Total Cash Fund Request**	**($78,442)**	**($13,399)**	**($137)**	**$48**	**$2,054,090**	**$3,358,023**	**$5,320,183**

Table 1.5 FY 2020-21 R-8 Medicaid Savings Initiatives Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$476,033	7.0	$217,022	$20,994	$0	$238,017	Table 8.2 FTE Row A
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$55,489	0.0	$24,746	$2,999	$0	$27,744	Table 8.2 FTE Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$888	0.0	$408	$36	$0	$444	Table 8.2 FTE Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693	Table 8.2 FTE Row D
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693	Table 8.2 FTE Row E
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$6,650	0.0	$2,966	$359	$0	$3,325	Table 4.1 FTE Row F
G	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$74,718	0.0	$26,809	$10,423	$187	$37,299	Table 2.3 (Row F + Row G + Row Q + Row S)
H	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$1,919,048	0.0	$479,763	$0	$0	$1,439,285	Table 2.3 Row B
I	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($7,110,325)	0.0	($5,366,670)	$5,949,910	$0	($7,693,565)	Table 2.6 Row H
J	**Total Request**	**($4,530,726)**	**7.0**	**($4,593,450)**	**$5,986,603**	**$187**	**($5,924,065)**	**Row A + Row B + Row C + Row D + Row E + Row F + Row G + Row H + Row I**

Table 1.6 FY 2020-21 Medicaid Savings Initiatives Cash Fund Breakout

Row	Line Item	Healthcare Affordability and Sustainability Fee Cash Fund	Adult Dental Cash Fund	Breast and Cervical Cancer Program Cash Fund	CHP+ Trust Fund	Medicaid Buy-In	Recovery Cash Funds	Total Cash Funds
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$20,994	$0	$0	$0	$0	$0	$20,994
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$2,999	$0	$0	$0	$0	$0	$2,999
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$36	$0	$0	$0	$0	$0	$36
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$941	$0	$0	$0	$0	$0	$941
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$941	$0	$0	$0	$0	$0	$941
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$359	$0	$0	$0	$0	$0	$359
G	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$10,416	$0	$0	$7	$0	$0	$10,423
H	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$0	$0	$0	$0	$0	$0	$0
I	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($133,364)	($13,399)	($137)	$0	$2,738,787	$3,358,023	$5,949,910
J	**Total Request**	**($96,678)**	**($13,399)**	**($137)**	**$7**	**$2,738,787**	**$3,358,023**	**$5,986,603**

Table 2.1 FY 2018-19 R-8 Medicaid Savings Initiatives Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Source/Calculation**
A	PAR- FTE Costs	$242,788	2.5	$121,399	$0	$0	$121,389	50%	Table 8.1- FTE
B	PAR- Contractor Costs	$2,010,059	0.0	$502,515	$0	$0	$1,507,544	75%	Table 3.1 Row A
C	PAR- Estimated Service Savings	($2,978,142)	0.0	($1,014,521)	($16,033)	$0	($1,947,588)	varies	Table 3.3 Row A
D	**PAR Total Request**	**($725,295)**	**2.5**	**($390,607)**	**($16,033)**	**$0**	**($318,655)**		Row A + Row B + Row C
E	PARIS- FTE costs	$127,776	1.7	$41,866	$22,022	$0	$63,888	50%	Table 8.1- FTE
F	PARIS- CBMS Changes	$547,878	0.0	$89,359	$47,118	$1,753	$409,648	75%	Table 4.2 Row A, Fund split using HCPF-Only RMS Calculator
G	PARIS- CBMS Print and Mailing Costs	$55,080	0.0	$19,763	$7,684	$138	$27,496	50%	Table 4.3 Row A, Fund split using HCPF-Only RMS Calculator
H	PARIS- Estimated Savings Capitation Payments	($1,745,997)	0.0	($463,603)	($57,641)	$0	($1,224,753)	varies	Table 4.1 Row I
I	**Automate PARIS Interstate Match Total Request**	**($1,015,263)**	**1.7**	**($312,615)**	**$19,183**	**$1,891**	**($723,722)**		Row E + Row F + Row G + Row H
J	Trust Unit Recoveries- FTE costs	$151,426	1.7	$75,716	$0	$0	$75,710	50%	Table 8.1- FTE
K	Trust Unit Recoveries- Estimated Revenue	$0	0.0	($1,399,177)	$2,798,353	$0	($1,399,176)	50%	Table 5.1 Row I
L	**Trust Unit Recoveries Total Request**	**$151,426**	**1.7**	**($1,323,461)**	**$2,798,353**	**$0**	**($1,323,466)**		Row J + Row K
M	Public Transportation Benefits- NEMT Savings	($216,378)	0.0	($108,189)	$0	$0	($108,189)	50%	Table 6.1 Row P
N	Public Transportation Benefits-NMT Savings	($499,573)	0.0	($249,787)	$0	$0	($249,786)	50%	Table 6.4 Row C
O	Public Transportation Benefits-Cost for Vendor/Provider	$150,000	0.0	$75,000	$0	$0	$75,000	50%	Estimate from NEMT broker for Bus Pass Coordinator and administration of additional passes
P	**Public Transportation Benefits Total Request**	**($565,951)**	**0.0**	**($282,976)**	**$0**	**$0**	**($282,975)**		Row M + Row N + Row O
Q	Parental Fee- CBMS Changes	$706,247	0.0	$115,966	$60,737	$2,260	$527,284	75%	Table 7.3 Row C
R	Parental Fee- MMIS Changes	$57,456	0.0	$5,746	$0	$0	$51,710	90%	Table 7.3 Row K
S	Parental Fee - CBMS Printing and Mailing	$0	0.0	$0	$0	$0	$0	53%	N/A
T	Parental Fee- Estimated Fee Collection	$0	0.0	$0	$0	$0	$0	0%	N/A
U	Parental Fee - Fee Collection Offset	$0	0.0	$0	$0	$0	$0	50%	N/A
V	**Parental Fee for Enrollment in Children's Home and Community Based Services Waiver Total Request**	**$763,703**	**0.0**	**$121,712**	**$60,737**	**$2,260**	**$578,994**		Row Q + Row R + Row S + Row T + Row U
W	**Total Request**	**($1,391,380)**	**5.8**	**($2,187,948)**	**$2,862,240**	**$4,151**	**($2,069,824)**		Row D + Row I + Row L + Row P + Row V

Table 2.2 FY 2019-20 R-8 Medicaid Savings Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Fund**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Source/Calculation**
A	PAR- FTE Costs	$279,689	3.0	$139,845	$0	$0	$139,844	50%	Table 8.2- FTE
B	PAR- Contractor Costs	$2,003,849	0.0	$500,963	$0	$0	$1,502,886	75%	Table 3.1 Row B
C	PAR- Estimated Service Savings	($3,094,086)	0.0	($1,054,018)	($16,657)	$0	($2,023,411)	varies	Table 3.3 Row B
D	**PAR Total Request**	**($810,548)**	**3.0**	**($413,210)**	**($16,657)**	**$0**	**($380,681)**		Row A + Row B + Row C
E	PARIS- FTE costs	$138,882	2.0	$43,172	$26,270	$0	$69,440	50%	Table 8.2- FTE
F	PARIS- CBMS Changes	$0	0.0	$0	$0	$0	$0	0%	N/A
G	PARIS- CBMS Print and Mailing Costs	$73,440	0.0	$26,350	$10,245	$184	$36,661		Table 4.3 Row B, Fund split using HCPF-Only RMS Calculator
H	PARIS- Estimated Savings Capitation Payments	($3,102,355)	0.0	($823,748)	($129,687)	$0	($2,148,920)	varied	Table 4.1 Row I
I	**Automate PARIS Interstate Match Total Request**	**($2,890,033)**	**2.0**	**($754,226)**	**($93,172)**	**$184**	**($2,042,818)**		Row E + Row F + Row G + Row H
J	Trust Unit Recoveries- FTE costs	$167,263	2.0	$83,632	$0	$0	$83,632	50%	Table 8.2- FTE
K	Estimated Trust Recovery Revenue	$0	0.0	($1,679,011)	$3,358,023	$0	($1,679,012)	50%	Table 5.1 Row G
L	**Trust Unit Recoveries Total Request**	**$167,263**	**2.0**	**($1,595,380)**	**$3,358,023**	**$0**	**($1,595,381)**		Row J + Row K
M	Public Transportation Benefits- NEMT Savings	($216,378)	0.0	($108,189)	$0		($108,189)	50%	Table 6.1 Row P
N	Public Transportation Benefits-NMT Savings	($749,322)	0.0	($374,661)	$0		($374,661)	50%	Table 6.4 Row E
O	Public Transportation Benefits-Cost for Vendor/Provider	$155,000	0.0	$77,500	$0		$77,500	50%	Estimate from NEMT broker for Bus Pass Coordinator and administration of additional passes
P	**Public Transportation Benefits NMT and NEMT Total Request**	**($810,700)**	**0.0**	**($405,350)**	**$0**	**$0**	**($405,350)**		Row M + Row N + Row O
Q	Parental Fee- CBMS Changes	$206,570	0.0	$33,919	$17,765	$661	$154,225	75%	Table 7.3 Row C
R	Parental Fee- MMIS Changes	$0	0.0	$0	$0	$0	$0	90%	Table 7.3 Row K
S	Parental Fee - CBMS Printing and Mailing	$959	0.0	$344	$134	$2	$479	50%	Table 7.3 Row H
T	Parental Fee- Estimated Fee Collection	$0	0.0	($1,027,045)	$2,054,090	$0	($1,027,045)	50%	Table 7.2 Row C
U	**Implementing a Parental Fee for Enrollment in Children's Home and Community Based Services Waiver Total Request**	**$207,529**	**0.0**	**($992,782)**	**$2,071,989**	**$663**	**($872,341)**		Row Q + Row R + Row S + Row T
V	**Total Request**	**($4,136,489)**	**7.0**	**($4,160,948)**	**$5,320,183**	**$847**	**($5,296,571)**		Row D + Row I + Row L+ Row P + Row U

Table 2.3 FY 2020-21 R-8 Medicaid Savings Initiatives Summary by Initiative										
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Fund**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Source/Calculation**
A	PAR- FTE Costs	$279,689	3.0	$139,845	$0	$0	$139,844		Table 8.2- FTE
B	PAR- Contractor Costs	$1,919,048	0.0	$479,763	$0	$0	$1,439,285		Table 3.1 Row C
C	PAR- Estimated Service Savings	($3,197,270)	0.0	($1,089,168)	($17,213)	$0	($2,090,889)		Table 3.3 Row C
D	**PAR Total Request**	**($998,534)**	**3.0**	**($469,561)**	**($17,213)**	**$0**	**($511,760)**		Row A + Row B + Row C
E	PARIS- FTE costs	$138,882	2.0	$43,172	$26,270	$0	$69,440	50%	Table 8.2- FTE
F	PARIS- CBMS Changes	$0	0.0	$0	$0	$0	$0	0%	N/A
G	PARIS- CBMS Print and Mailing Costs	$73,440	0.0	$26,350	$10,245	$184	$36,661	50%	Table 4.3 Row C, Fund split using HCPF-Only RMS Calculator
H	PARIS- Estimated Savings Capitation Payments	($3,102,355)	0.0	($823,748)	($129,687)	$0	($2,148,920)	varied	Table 4.1 Row I
I	**Automate PARIS Interstate Match Total Request**	**($2,890,033)**	**2.0**	**($754,226)**	**($93,172)**	**$184**	**($2,042,818)**		Row E + Row F + Row G + Row H
J	Trust Unit Recoveries- FTE costs	$167,263	2.0	$83,632	$0	$0	$83,632	50%	Table 8.2- FTE
K	Estimated Trust Recovery Revenue	$0	0.0	($1,679,011)	$3,358,023	$0	($1,679,012)	50%	Table 5.1 Row G
L	**Trust Unit Recoveries Total Request**	**$167,263**	**2.0**	**($1,595,380)**	**$3,358,023**	**$0**	**($1,595,381)**		Row J + Row K
M	Public Transportation Benefits- NEMT Savings	($216,378)	0.0	($108,189)	$0	$0	($108,189)	50%	Table 6.1 Row P
N	Public Transportation Benefits- NMT Savings	($749,322)	0.0	($374,661)	$0	$0	($374,661)	50%	Table 6.4 Row E
O	Public Transportation Benefits-Cost for Vendor/Provider	$155,000	0.0	$77,500	$0	$0	$77,500	50%	Estimate from NEMT broker for Bus Pass Coordinator and administration of additional passes
P	**Public Transportation Benefits NMT and NEMT Total Request**	**($810,700)**	**0.0**	**($405,350)**	**$0**	**$0**	**($405,350)**		Row M + Row N + Row O
Q	Parental Fee- CBMS Changes	$0	0.0	$0	$0	$0	$0	75%	N/A
R	Parental Fee- MMIS Changes	$0	0.0	$0	$0	$0	$0	90%	N/A
S	Parental Fee - CBMS Printing and Mailing	$1,278	0.0	$459	$178	$3	$638	53.05%	Table 7.3 Row H
T	Parental Fee- Estimated Fee Collection	$0	0.0	($1,369,393)	$2,738,787	$0	($1,369,394)	50%	Table 7.2 Row E
U	**Implementing a Parental Fee for Enrollment in Children's Home and Community Based Services Waiver Total Request**	**$1,278**	**0.0**	**($1,368,934)**	**$2,738,965**	**$3**	**($1,368,756)**		Row Q + Row R + Row S + Row T
V	**Total Request**	**($4,530,726)**	**7.0**	**($4,593,450)**	**$5,986,603**	**$187**	**($5,924,065)**		Row D + Row I + Row L + Row P + Row U

Table 2.4 FY 2018-19 R-8 Medicaid Program Savings Initiatives Medical Services Premiums Impacts								
Row	**Label**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	PAR- Estimated Savings	($2,978,142)	0.0	($1,014,521)	($16,033)	$0	($1,947,588)	Table 2.1 Row C
B	PARIS- Estimated Savings	($1,745,997)	0.0	($463,603)	($57,641)	$0	($1,224,753)	Table 2.1 Row H
C	Trust Unit Recoveries- Estimated Revenue	$0	0.0	($1,399,177)	$2,798,353	$0	($1,399,176)	Table 2.1 Row K
D	Discounted Bus Tickets- NEMT Savings	($216,378)	0.0	($108,189)	$0	$0	($108,189)	Table 2.1 Row M
E	Discounted Bus Tickets- NMT Savings	($499,573)	0.0	($249,787)	$0	$0	($249,786)	Table 2.1 Row N
F	Discounted Bus Tickets- Cost for Vendor/Provider	$150,000	0.0	$75,000	$0	$0	$75,000	Table 2.1 Row O
G	CHCBS Parental Fee	$0	0.0	$0	$0	$0	$0	Fee Collection begins 10/1/2019
H	**Total Medical Services Premiums Impact**	**($5,290,090)**	**0.0**	**($3,160,277)**	**$2,724,679**	**$0**	**($4,854,492)**	Row A + Row B + Row C + Row D + Row E + Row F + Row G

Table 2.5 FY 2019-20 R-8 Medicaid Program Savings Initiatives Medical Services Premiums Impacts								
Row	**Label**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	PAR- Estimated Savings	($3,094,086)	0.0	($1,054,018)	($16,657)	$0	($2,023,411)	Table 2.2 Row C
B	PARIS- Estimated Savings	($3,102,355)	0.0	($823,748)	($129,687)	$0	($2,148,920)	Table 2.2 Row H
C	Trust Unit Recoveries- Estimated Revenue	$0	0.0	($1,679,011)	$3,358,023	$0	($1,679,012)	Table 2.2 Row K
D	Discounted Bus Tickets- NEMT Savings	($216,378)	0.0	($108,189)	$0	$0	($108,189)	Table 2.2 Row M
E	Discounted Bus Tickets- NMT Savings	($749,322)	0.0	($374,661)	$0	$0	($374,661)	Table 2.2 Row N
F	Discounted Bus Tickets- Cost for Vendor/Provider	$155,000	0.0	$77,500	$0	$0	$77,500	Table 2.2 Row O
G	CHCBS Parental Fee	$0	0.0	($1,027,045)	$2,054,090	$0	($1,027,045)	Table 2.2 Row T
H	**Total Medical Services Premiums Impact**	**($7,007,141)**	**0.0**	**($4,989,172)**	**$5,265,769**	**$0**	**($7,283,738)**	Row A + Row B + Row C + Row D + Row E + Row F + Row G

Table 2.6 FY 2020-21 R-8 Medicaid Program Savings Initiatives Medical Services Premiums Impacts								
Row	**Label**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	PAR- Estimated Savings	($3,197,270)	0.0	($1,089,168)	($17,213)	$0	($2,090,889)	Table 2.3 Row C
B	PARIS- Estimated Savings	($3,102,355)	0.0	($823,748)	($129,687)	$0	($2,148,920)	Table 2.3 Row H
C	Trust Unit Recoveries- Estimated Revenue	$0	0.0	($1,679,011)	$3,358,023	$0	($1,679,012)	Table 2.3 Row K
D	Discounted Bus Tickets- NEMT Savings	($216,378)	0.0	($108,189)	$0	$0	($108,189)	Table 2.3 Row M
E	Discounted Bus Tickets- NMT Savings	($749,322)	0.0	($374,661)	$0	$0	($374,661)	Table 2.3 Row N
F	Discounted Bus Tickets- Cost for Vendor/Provider	$155,000	0.0	$77,500	$0	$0	$77,500	Table 2.3 Row O
G	CHCBS Parental Fee	$0	0.0	($1,369,393)	$2,738,787	$0	($1,369,394)	Table 2.3 Row R + Row S
H	**Total Medical Services Premiums Impact**	**($7,110,325)**	**0.0**	**($5,366,670)**	**$5,949,910**	**$0**	**($7,693,565)**	Row A + Row B + Row C + Row D + Row E + Row F + Row G

Table 3.1: Estimated Cost of Utilization Management Contract by Fund Splits							
Row	Fiscal Year	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
A	FY 2018-19	$2,010,059	$502,515	$0	$0	$1,507,544	Table 3.2: Row N, FY 2018-19
B	FY 2019-20	$2,003,849	$500,963	$0	$0	$1,502,886	Table 3.2: Row N, FY 2019-20
C	FY 2020-21	$1,919,048	$479,763	$0	$0	$1,439,285	Table 3.2: Row N, FY 2020-21

Table 3.2: Estimated Costs to Utilization Management Contract					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated Additional PARs by Service Category				
B	Cosmetic Surgeries	1,162	1,204	1,247	Table 3.4a: Row A
C	Back Surgeries	2,095	2,170	2,248	Table 3.4b: Row A
D	Outpatient Speech Therapy	19,235	19,918	20,626	Table 3.4c: Row A
E	Oxygen	25,289	26,187	27,117	Table 3.4d: Row A
F	Prosthetics & Orthotics	6,821	7,064	7,315	Table 3.4e: Row A
G	Adult Long Term Home Health	5,117	5,299	Table 1.4 R-8 FY 2	Table 3.4f: Row A
H	Vision	8,327	8,623	8,930	Table 3.4g: Row A
I	**Total Additional PARs**	**68,046**	**70,465**	**67,483**	**Sum of Rows B - H**
J	Additional Contract Cost Per PAR	$22.75	$22.75	$22.75	Estimate from current UM vendor
K	**Total Cost of Additional PAR**	**$1,548,047**	**$1,603,079**	**$1,535,238**	**Row I * Row J**
L	Contractor IT Systems Cost	$75,000	$0	$0	Estimate from current UM Vendor on system capacity updates. One year cost.
M	Flexible Prior Authorization Request (PAR) Fundin	$387,012	$400,770	$383,810	25% increase in Row L to allow for flexibility in designing PAR policies
N	**Total Estimated Cost**	**$2,010,059**	**$2,003,849**	**$1,919,048**	**Row K + Row L + Row M**

Table 3.3: Utilization Management Estimated Savings by Fund Splits						
Row	Fiscal Year	Total Funds	General Fund	Cash Funds	Federal Funds	Source
A	FY 2018-19	($2,978,142)	($1,014,521)	($16,033)	($1,947,588)	Sum of Tables 3.4a-3.4g Row E, FY 2018-19
B	FY 2019-20	($3,094,086)	($1,054,018)	($16,657)	($2,023,411)	Sum of Tables 3.4a-3.4g: Row E, FY 2019-20
C	FY 2020-21	($3,197,270)	($1,089,168)	($17,213)	($2,090,889)	Sum of Tables 3.4a-3.4g: Row E, FY 2020-21

Table 3.4a: Utilization Management Savings Estimate - Cosmetic Surgeries					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	1,162	1,204	1,247	Table 3.5; Row B
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	37	38	40	Row A * Row B
D	Savings Per Unit	($443.62)	($443.62)	($443.62)	Table 3.6; Row B
E	**Total Savings**	**($16,414)**	**($16,858)**	**($17,745)**	**Row C * Row D**

Table 3.4b: Utilization Management Savings Estimate - Back Surgeries					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	2,095	2,170	2,248	Table 3.5; Row C
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	66	69	71	Row A * Row B
D	Savings Per Unit	($14,634.15)	($14,634.15)	($14,634.15)	Table 3.6; Row C
E	**Total Savings**	**($965,854)**	**($1,009,757)**	**($1,039,025)**	**Row C * Row D**

Table 3.4c: Utilization Management Savings Estimate - Outpatient Speech Therapy					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	19,235	19,918	20,626	Table 3.5; Row D
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	604	626	648	Row A * Row B
D	Savings Per Unit	($1,362.01)	($1,362.01)	($1,362.01)	Table 3.6; Row D
E	**Total Savings**	**($822,655)**	**($852,619)**	**($882,583)**	**Row C * Row D**

Table 3.4d: Utilization Management Savings Estimate - Oxygen					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	25,289	26,187	27,117	Table 3.5; Row E
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	795	823	852	Row A * Row B
D	Savings Per Unit	($1,068.31)	($1,068.31)	($1,068.31)	Table 3.6; Row E
E	**Total Savings**	**($849,307)**	**($879,220)**	**($910,201)**	**Row C * Row D**

Table 3.4e: Utilization Management Savings Estimate - Prosthetics & Orthotics					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	6,821	7,064	7,315	Table 3.5; Row F
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	215	222	230	Row A * Row B
D	Savings Per Unit	($364.45)	($364.45)	($364.45)	Table 3.6; Row F
E	**Total Savings**	**($78,357)**	**($80,908)**	**($83,824)**	**Row C * Row D**

Table 3.4f: Utilization Management Savings Estimate - Adult Long-Term Home Health					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	5,117	5,299	5,488	Table 3.5; Row G
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	161	167	173	Row A * Row B
D	Savings Per Unit	($1,407.99)	($1,407.99)	($1,407.99)	Table 3.6; Row G
E	**Total Savings**	**($226,687)**	**($235,135)**	**($243,583)**	**Row C * Row D**

Table 3.4g: Utilization Management Savings Estimate - Vision					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	8,327	8,623	8,930	Table 3.5; Row H
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	131	136	141	Row A * Row B
D	Savings Per Unit	($144.03)	($144.03)	($144.03)	Table 3.6; Row H
E	**Total Savings**	**($18,868)**	**($19,589)**	**($20,309)**	**Row C * Row D**

Table 3.5: Utilization Management Estimated Number of PARs by Fiscal Year						
Row	**Item**	**Most Recent Data**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
	PAR Growth Rate		13.50%	3.55%	3.55%	From Departments February 2017 Caseload Forecast
A	Units (New PAR Requests)					
B	Surgeries (Cosmetic)	1,023	1,162	1,204	1,247	Department data from CY 2016
C	Surgeries (Back)	1,845	2,095	2,170	2,248	Department data from FY 2016
D	Outpatient Speech Therapy	16,947	19,235	19,918	20,626	Department data from CY 2016
E	Oxygen	23,243	25,289	26,187	27,117	Department data from FY 2017, Q2
F	Prosthetics & Orthotics	6,009	6,821	7,064	7,315	Department data from CY 2016
G	Adult Long Term Home Health	4,508	5,117	5,299	5,488	Department data from CY 2016
H	Vision	7,336	8,327	8,623	8,930	Department data from CY 2016

Table 3.6: Utilization Management Savings Per Unit						
Row	**Item**	**Most Recent Data**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Savings Per Unit					
B	Surgeries (Cosmetic)	$443.62	$443.62	$443.62	$443.62	Estimated cost per unit based on CY 2016
C	Surgeries (Back)	$14,634.15	$14,634.15	$14,634.15	$14,634.15	Estimated cost per unit based on FY 2016
D	Outpatient Speech Therapy	$1,362.01	$1,362.01	$1,362.01	$1,362.01	Estimated cost per unit based on CY 2016
E	Oxygen	$1,068.31	$1,068.31	$1,068.31	$1,068.31	Estimated cost per unit based on FY 2017, Quarter 2
F	Prosthetics & Orthotics	$364.45	$364.45	$364.45	$364.45	Estimated cost per unit based on CY 2016
G	Adult Long Term Home Health	$1,407.99	$1,407.99	$1,407.99	$1,407.99	Estimated cost per unit based on CY 2016
H	Vision	$144.03	$144.03	$144.03	$144.03	Estimated cost per unit based on CY 2016

Table 4.1 Automate PARIS Interstate Match Estimated Savings				
Row	**Item**	**FY 2018-19**	**FY 2019-20 and ongoing**	**Source/Description**
A	Total Clients on Current PARIS List with Capitation Payments	23,736	23,736	Based on data from quarterly PARIS reports excluding certain clients, as described in the narrative
B	Percent of Clients with No Fee-For-Service Claims	19.78%	19.78%	Approximate percent of clients who are continuously enrolled and do not incur any fee-for-service claims in a year
C	Adjusted total clients	19,041	19,041	Row A - (Row A * Row B)
D	Estimated Growth in PARIS List	8.80%	12.77%	Cumulative caseload growth from FY 2016-17 in Department's February forecast for Medical Services
E	Estimated Number of Clients on PARIS List with Capitation Payments	20,717	21,473	Row C * (1 + Row D)
F	Dental Administrative Service Organization PMPM	$0.54	$0.54	Current contract rate
G	Accountable Care Collaborative PMPM	$11.50	$11.50	Rate specified in the ACC Phase II Request for Proposals
H	Number of Months of Implementation	7	12	Eligibility terminations would occur starting December 2018
I	**Total Estimated Costs Avoided**	**$1,745,997**	**$3,102,355**	**Row E * (Row F + Row G) * Row H**
J	General Fund	$463,603	$823,748	Row I - Row K - Row L
K	Cash Funds	$57,641	$129,687	Based on eligibility of clients in Row C
L	Federal Funds	$1,224,753	$2,148,920	Based on eligibility of clients in Row C

Table 4.2 Automate PARIS FY 2018-19 CBMS Estimate				
Row	**Contractor**	**Hourly Rate**	**Hours**	**FY 2018-19**
A	Deloitte-CBMS	$127	4,314	$547,878

Table 4.3 Automate PARIS CBMS Print and Mail Cost Estimate					
Row	**Fiscal Year**	**Quarterly Number of Pages**	**Number of Quarters**	**Cost Per Page**	**Total Estimated Cost**
A	FY 2018-19	34,000	3	0.54	$55,080
B	FY 2019-20	34,000	4	0.54	$73,440
C	FY 2020-21	34,000	4	0.54	$73,440

Table 5.1 Trust Unit Recoveries Estimated savings			
Row	**Item**	**Value**	**Notes/Calculations**
A	FY 2015-16 Income Trust and Repayments	$6,716,046	FY 2017-18 S-1, Exhibit L
B	Number of current FTE	2.0	Although 1.0 FTE is assigned as a Trust Recovery Specialist, other FTE such as the Trust Officer and other staff also spend part of their time working on Trust recoveries
C	Estimated value of recovery per FTE	$3,358,023	Row A / Row B
D	Assumption of new FTE recovery rate compared to current	50%	Adjustment made due to diminishing returns
E	Estimated annual recoveries per new FTE	$1,679,012	Row C * Row D
F	Number of new FTE	2.0	
G	**Estimated annual total increased recoveries**	**$3,358,023**	**Row E * Row F**
H	Number of months FTE would be employed in FY 2018-19	10	Start date September 1, 2018
I	**Adjusted estimated total recoveries in FY 2018-19**	**$2,798,353**	**Row G * (Row H/12)**

Table 6.1 Public Transportation Benefits for NEMT and NMT Potential NEMT Savings by Type of RTD Trip					
Row	**Item**	**Current**	**With Discount**	**Savings**	**Notes**
A	Access-a-ride (average) round trip cost per client	$7.10	$3.55	$3.55	Average of local and regional access-a-ride
B	Estimated annual number of round trips	17,148	17,148	0	Predicted value based off monthly average from January 2016 through December 2016, due to reclassification from RTD
C	**Estimated Access-A-Ride Expenditure**	**$121,751**	**$60,875**	**($60,876)**	**Row A * Row B**
D	Fixed cost per client	$5.20	$2.60	$2.60	From RTD Fares Website
E	Number of Round Trips	17,460	17,460	0	Predicted value based off monthly average from January 2016 through December 2016, due to reclassification from RTD
F	**Estimated "Fixed" Expenditure**	**$90,792**	**$45,396**	**($45,396)**	**Row D * Row E**
G	Monthly Local Cost Per Client	$99.00	$49.50	$49.50	From RTD Fares Website
H	Number of Round Trips	2,112	2,112	0	Predicted value based off monthly average from January 2016 through December 2016, due to reclassification from RTD
I	**Estimated Local Expenditure**	**$209,088**	**$104,544**	**($104,544)**	**Row G * Row H**
J	Regional Cost Per Client	$9.00	$4.50	$4.50	From RTD Fares Website
K	Number of Round Trips	96	96	0	Predicted value based off monthly average from January 2016 through December 2016, due to reclassification from RTD
L	**Estimated Regional Expenditure**	**$864**	**$432**	**($432)**	**Row J * Row K**
M	Monthly Regional Cost Per Client	$171.00	$85.50	$85.50	From RTD Fares Website
N	Number of Round Trips	60	60	0	Predicted value based off monthly average from January 2016 through December 2016, due to reclassification from RTD
O	**Estimated Regional Monthly Expenditure**	**$10,260**	**$5,130**	**($5,130)**	**Row M * Row N**
P	**Total Estimated Cost/ (Savings)**	**$432,755**	**$216,377**	**($216,378)**	**Row C + Row F + Row I + Row L + Row O**

Table 6.2 Public Transportation Benefits for NEMT and NMT
Round Trips by Type

Row	Item	Access-a-ride	Fixed (Local)	Monthly Local	Regional	Monthly Regional	Total	Notes/Calculations
A	Total CY 2016 Average Monthly Round Trips	2,198	2,239	271	13	7	4,728	Veyo data: January 2016 through December 2016
B	Percentage of NEMT Trips	46.49%	47.36%	5.73%	0.27%	0.15%	100.00%	Row A / Row A Total
C	Percentage of Trips Eligible for Discount	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	Assumption from FY 2017-18 S-1 Data Percentage of NEMT expenditure attributable to eligible population (OAP-A, OAP-B, AND/AB, and Disabled Buy-In).
D	Estimated Eligible Trips Monthly Round Trips	1,429	1,455	176	8	5	3,073	Row A * Row C
E	Estimated Eligible Trips Annual Round Trips	17,148	17,460	2,112	96	60	36,876	Row C * 12

Table 6.3 Public Transportation Benefits for NEMT and NMT Current NEMT Cost per Round Trip		
Trip Type	**Cost Per Ticket**	**Cost Per Round Trip**
Access-a-ride (average)	$10.73	$10.73
Fixed	$5.20	$5.20
Monthly Local	$99.00	$4.95
Regional	$9.00	$9.00
Monthly Regional	$171.00	$24.43
Average Cost per NEMT RTD Round Trip		**$10.86**

Table 6.4 Public Transportation Benefits for NEMT and NMT Potential Savings for NMT Adjusted for Implementation			
Row	**Item**	**Total**	**Notes**
A	Annual Savings	($749,322)	Table 3.1 Row G
B	Percentage of FY 2018-19 With New Policy	66.67%	October 1, 2018 Implementation
C	**Estimated FY 2018-19 Savings**	**($499,573)**	**Row A * Row B**
D	Percentage of FY 2019-20 With New Policy	100.00%	Full Implementation
E	**Estimated FY 2019-20 and Ongoing Savings**	**($749,322)**	**Row A * Row D**

Table 6.5 Public Transportation Benefits for NEMT and NMT
Potential Savings of Each NMT Service

Row	Item	Taxi	Mobility Van	Mobility Van to and From Adult Day	Total	Notes
A	FY 2015-16 Eligible NMT Units	9,757	19,609	34,164	63,530	Table 6.7 Row C
B	Savings per Unit	($30.26)	($12.79)	($5.95)		Table 6.6 Row C
C	**Potential Savings**	**($295,247)**	**($250,799)**	**($203,276)**	**($749,322)**	**Row A * Row B**

Table 6.6 Public Transportation Benefits for NEMT and NMT
Potential Savings of Each NMT Service

Row	Item	Taxi	Mobility Van	Mobility Van to and From Adult Day	Notes
A	Average FY 2015-16 Cost per Unit	$32.98	$15.51	$8.67	Table 4.4 Row T
B	Discounted Average Cost of RTD One Way Trip	$2.72	$2.72	$2.72	Half of average NEMT RTD one way trip
C	**Potential Savings Per Unit**	**($30.26)**	**($12.79)**	**($5.95)**	**Row A - Row B**

Table 6.7 Public Transportation Benefits for NEMT and NMT
Estimated Eligible Unit per NMT Service

Row	Item	Taxi	Mobility Van	Mobility Van to and From Adult Day	Total	Notes
A	Total Number of Units/Year	75,053	150,835	262,802	488,690	Table 4.4 Row O
B	Percentage of Trips To Be Taken by RTD	13.00%	13.00%	13.00%	13.00%	Flexible Assumption, matches average percentage of NEMT RTD trips
C	**Number of Eligible Units for Discount**	**9,757**	**19,609**	**34,164**	**63,530**	**Row A * Row B**

Table 6.8 Public Transportation Benefits for NEMT and NMT
Average Unit Cost of NMT Service

Row	NMT Service	Taxi	Mobility Van	Mobility Van, To and From Adult Day	Notes
	Annual Expenditure per NMT Service				
A	HCBS-SCI	$14,525	N/A	N/A	FY 2015-16 MMIS Claims Data
B	HCBS-BI	$164,642	$28,755	$5,341	FY 2015-16 MMIS Claims Data
C	HCBS-EBD	$1,792,832	$1,892,955	$2,402,292	FY 2015-16 MMIS Claims Data
D	HCBS-CMHS	$479,555	$227,543	$40,936	FY 2015-16 MMIS Claims Data
E	Total Expenditure	$2,451,554	$2,149,253	$2,448,569	Sum Rows A-D
	Average Monthly Utilizers				
F	HCBS-SCI	3	N/A	N/A	FY 2015-16 MMIS Claims Data
G	HCBS-BI	17	9	4	FY 2015-16 MMIS Claims Data
H	HCBS-EBD	279	767	1,384	FY 2015-16 MMIS Claims Data
I	HCBS-CMHS	105	155	24	FY 2015-16 MMIS Claims Data
J	Total Clients	404	931	1,412	Sum of Row F through Row I
	Total Number of Units per NMT Service				
K	HCBS-SCI	507	N/A	N/A	FY 2015-16 MMIS Claims Data
L	HCBS-BI	4,009	1,484	642	FY 2015-16 MMIS Claims Data
M	HCBS-EBD	53,990	131,484	257,260	FY 2015-16 MMIS Claims Data
N	HCBS-CMHS	16,547	17,867	4,900	FY 2015-16 MMIS Claims Data
O	Total Number of Units	75,053	150,835	262,802	Sum Row F-I
	Cost per Unit Per NMT Service				
P	HCBS-SCI	$28.65	N/A	N/A	Row A divided by Row K
Q	HCBS-BI	$41.07	$19.38	$8.32	Row B divided by Row L
R	HCBS-EBD	$33.21	$14.40	$9.34	Row C divided by Row M
S	HCBS-CMHS	$28.98	$12.74	$8.35	Row D divided by Row N
T	Average Cost Per Unit	$32.98	$15.51	$8.67	Average of Rows P through S
	Units Per Client Per NMT Service				
U	HCBS-SCI	169	N/A	N/A	Row K divided by Row F
V	HCBS-BI	236	165	161	Row L divided by Row G
W	HCBS-EBD	194	171	186	Row M divided by Row H
X	HCBS-CMHS	158	115	204	Row N divided by Row I
Y	Average Units per Client	189	150	184	Average of Rows U through X

Table 7.1 FY 2018-19 Implementing a Parental Fee into CHCBS Waiver Annual Fee Collection Estimate									
Row	**Item**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**	**Total**	**Notes**
A	Federal Poverty Level (FPL) Lower Limit	0%	276%	401%	526%	651%	900%		Determined in consulation with CHCBS workgroup
B	FPL Upper Limit	275%	400%	525%	650%	899%	N/A		Determined in consulation with CHCBS workgroup
C	Parental Fee	0.00%	2.50%	3.00%	4.00%	5.00%	6.00%		Determined in consulation with CHCBS workgroup
D	Median Household Income of FPL Group	$43,197	$63,303	$86,439	$107,936	$129,426	$210,517		Average median household income of zip codes belonging to each FPL tier
E	Average Yearly Parental Fee Amount	$0	$1,583	$2,593	$4,317	$6,471	$12,631		Row C * Row D
F	Caseload	216	602	419	162	0	0	1,399	FY 2016-17 average monthly CHCBS clients that live in zip codes that fall within designated FPL tier
G	**Potential Parental Fee**	**$0**	**$952,966**	**$1,086,467**	**$699,354**	**$0**	**$0**	**$2,738,787**	**Row E * Row F**

Table 7.2 FY 2018-19 Implementing a Parental Fee into CHCBS Waiver Annual Fee Collection Adjusted for Implementation Dates			
Row	**Item**	**Total**	**Notes**
A	Annual Fee Collection Estimate	$2,738,787	Table 7.1 Row G
B	Percentage of FY 2019-20 With Active Fee	75%	Fee implemented 10/1/2019
C	**Estimated FY 2019-20 Collection**	**$2,054,090**	**Row A * Row B**
D	Percentage of FY 2020-21 With Active Fee	100%	Full Implementation
E	**Estimated FY 2020-21 and ongoing collection**	**$2,738,787**	**Row A * Row D**

Table 7.3 FY 2018-19 Implementing a Parental Fee into CHCBS Waiver System Changes and Printing and Mailing Costs				
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
A	Deloitte - CBMS Hourly Rate	127	130	0
B	Deloitte- CBMS Hours	5,561	1,589	0
C	**Deloitte- CBMS Cost Estimate**	**$706,247**	**$206,570**	**$0**
D	Deloitte- CBMS Printing and Mailing Cost per Letter	$1.08	$1.08	$1.08
E	Monthly Letters	0	1,183	1,183
F	CBMS Annual Printing and Mailing Costs	$0	$1,278	$1,278
G	Percentage of Year with Active Mailing	0.00%	75.00%	100.00%
H	**CBMS Printing and Mailing Costs**	**$0**	**$959**	**$1,278**
I	DXC - MMIS Hourly Rate	$127.68	$130.46	$130.46
J	DXC- MMIS Hours	450	0	0
K	**DXC - MMIS Cost Estimate**	**$57,456**	**$0**	**$0**

Table 8.1 FTE Costs FY 2018-19							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Healthcare Affordability and Sustainability Fee Cash Funds**	**Reappropriated Funds**	**Federal Funds**
A	Personal Services	$392,224	5.8	$180,175	$15,941	$0	$196,108
B	Health, Life and Dental	$55,489	0.0	$25,013	$2,732	$0	$27,744
C	Short-term Disability	$667	0.0	$306	$27	$0	$334
D	SB 04-257 Amortization Equalization Disbursement	$17,574	0.0	$8,074	$714	$0	$8,786
E	SB 06-235 Supplemental Amortization Equalization Disbursement	$17,574	0.0	$8,074	$714	$0	$8,786
F	Operating Expenses	$38,462	0.0	$17,339	$1,894	$0	$19,229
G	**Total**	**$521,990**	**5.8**	**$238,981**	**$22,022**	**$0**	**$260,987**

Table 8.2 FTE Costs FY 2019-20							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
A	Personal Services	$476,033	7.0	$217,022	$20,994	$0	$238,017
B	Health, Life and Dental	$55,489	0.0	$24,746	$2,999	$0	$27,744
C	Short-term Disability	$888	0.0	$408	$36	$0	$444
D	SB 04-257 Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693
E	SB 06-235 Supplemental Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693
F	Operating Expenses	$6,650	0.0	$2,966	$359	$0	$3,325
G	**Total**	**$585,834**	**7.0**	**$266,648**	**$26,270**	**$0**	**$292,916**

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-09 FY 2018-19 Provider Rate Adjustments**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ **Supplemental FY 2017-18**

_X_ **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$8,136,458,390**	**$0**	**$8,078,226,816**	**$27,826,226**	**$30,391,853**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,369,297,504	$0	$2,353,954,558	$10,274,899	$11,103,734
	CF	$886,701,423	$0	$884,624,169	$989,594	$1,013,831
	RF	$70,552,476	$0	$70,368,612	$0	$0
	FF	$4,809,906,987	$0	$4,769,279,477	$16,561,733	$18,274,288

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
02. Medical Services Premiums -- Medical Services Premiums	**Total**	**$7,597,898,847**	**$0**	**$7,538,955,686**	**$24,037,926**	**$26,265,792**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	$8,330,411	$8,989,091
	CF	$886,165,101	$0	$884,043,394	$985,050	$1,008,874
	RF	$70,552,476	$0	$70,368,612	$0	$0
	FF	$4,548,653,004	$0	$4,507,666,920	$14,722,465	$16,267,827
03. Behavioral Health Community Programs -- Behavioral Health Fee-for-Service Payments	**Total**	**$8,961,518**	**$0**	**$8,973,084**	**$59,938**	**$65,387**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,936,255	$0	$1,938,754	$13,099	$14,290
	CF	$374,248	$0	$374,731	$2,463	$2,687
	RF	$0	$0	$0	$0	$0
	FF	$6,651,015	$0	$6,659,599	$44,376	$48,410

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Adult Comprehensive Services	**Total**	**$376,385,762**	**$0**	**$376,656,016**	**$2,654,608**	**$2,895,936**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$188,192,881	$0	$188,328,008	$1,327,304	$1,447,968
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$188,192,880	$0	$188,328,007	$1,327,304	$1,447,968

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Adult Supported Living Services	**Total**	**$79,102,446**	**$0**	**$79,268,043**	**$554,245**	**$604,631**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$43,432,794	$0	$43,479,346	$301,470	$328,876
	CF	$133,801	$0	$170,052	$1,748	$1,907
	RF	$0	$0	$0	$0	$0
	FF	$35,535,851	$0	$35,618,645	$251,027	$273,848

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Children's Extensive Support Services	**Total**	**$28,030,392**	**$0**	**$28,030,392**	**$187,272**	**$204,296**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$14,015,196	$0	$14,015,196	$93,636	$102,148
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$14,015,196	$0	$14,015,196	$93,636	$102,148

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Case Management	**Total**	**$35,792,246**	**$0**	**$36,056,416**	**$259,306**	**$282,880**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$18,925,860	$0	$19,050,242	$136,196	$148,578
	CF	$28,272	$0	$35,991	$333	$363
	RF	$0	$0	$0	$0	$0
	FF	$16,838,114	$0	$16,970,183	$122,777	$133,939

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Family Support Services	**Total**	**$7,058,033**	**$0**	**$7,058,033**	**$50,038**	**$50,038**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,058,033	$0	$7,058,033	$50,038	$50,038
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Preventive Dental Hygiene	**Total**	**$64,199**	**$0**	**$64,199**	**$455**	**$455**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$64,199	$0	$64,199	$455	$455
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Eligibility Determination and Waiting List Management	**Total**	**$3,164,947**	**$0**	**$3,164,947**	**$22,438**	**$22,438**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,144,020	$0	$3,144,020	$22,290	$22,290
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$20,927	$0	$20,927	$148	$148

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 fund source detail.**

RF Letternote Text Revision Required? Yes ___ No X

FF Letternote Text Revision Required? Yes ___ No X

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 $27,826,226 total funds, including $10,274,899 General Fund in FY 2018-19 and $30,391,853 total funds, including $11,103,734 General Fund in FY 2019-20.

Current Program
• Colorado's Medicaid program currently provides health care access to more than 1,346,174 individuals and provides care to more than 9,848 full time equivalent clients in class I nursing facilities.
• Pursuant to SB 15-228, the Department is required to periodically perform reviews of provider rates under the Colorado Medical Assistance Act. SB 15-228 also established the Medicaid Provider Rate Review Advisory Committee to assist in the review of provider reimbursement rates.
• Nursing facility per diem rates are allowed to grow as a function of nursing facility costs, pursuant to the rate methodology outlined in section 25.5-6-202, C.R.S. Rates are statutorily limited to an aggregate annual growth rate of three percent pursuant to 25.5-6-202(9)(I), C.R.S.

Problem or Opportunity
• The Department has an opportunity to address inadequate provider rates in a variety of service categories as well as address provider rates which may be currently set above reasonable levels.

Consequences of Problem
• Reduced provider participation reduces clients' access to health care. Reduced access to health care can, in turn, result in poor client outcomes and subsequent higher costs for the State.
• Incentives for providers created by insufficient and/or inconsistent reimbursement can result in utilization of services that are inefficient, less effective, and more costly. As with access issues, there are negative impacts for client outcomes and fiscal impacts for the State.

Proposed Solution
• The Department proposes to adjust provider rates in three ways. First, the Department would provide an across-the-board rate increase of 0.77% to all providers not targeted by the other components. Second, the Department would implement a decrease to anesthesia rates and an increase to alternative care facility rates; and third, the Department would reduce the allowable growth factor on nursing facility per diem rates down to one percent in FY 2018-19 only. Beginning in FY 2019-20, the allowable growth factor would revert to three percent.
• In order to implement the nursing facility per diem policy change, a change in statute would be required because current law permits a three percent annual increase to rates.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: ***R-9***

Request Detail: ***Provider Rate Adjustments***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Provider Rate Adjustments	$27,826,226	$10,274,899

Problem or Opportunity:

Investing in adequate provider rates and aligning payment with high-value services are critical components in ensuring clients have sufficient access to care, that quality outcomes are achieved, and that services provided are cost effective.

The Department has an opportunity to address provider rates in a variety of service categories as well as address provider rates which may be currently set above reasonable levels or receive higher-than-average increases. The Department proposes to address these areas through a series of provider rate adjustments.

Proposed Solution:

The Department requests an increase of $27,826,226 total funds, including $10,274,899 General Fund in FY 2018-19 and $30,391,853 total funds, including $11,103,734 General Fund in FY 2019-20 to adjust provider rates across several service categories.

There are three components of rate adjustments the Department proposes to make. First, the Department proposes to implement several of the recommendations developed through the Department's rate review process; second, a 0.77% across-the-board (ATB) rate increase for most Medicaid providers; and third, the Department proposes to reduce the inflation factor on nursing facility per diem rates from 3% in current statute, to 1% in FY 2018-19 to align with other provider rate increases in the proposal. As part of the Department's rate review process, the Department may also rebalance and adjust rates or payment methodologies for physician services at a budget neutral benchmark.

Rate Review Process Recommendations

The Department proposes to implement several key recommendations from the 2017 Medicaid Provider Rate Review Recommendation Report, issued on November 1, 2017.[1] These recommendations are informed by results of the 2017 Medicaid Provider Rate Review Analysis Report[2], the Medicaid Provider Rate Review Advisory Committee's (MPRRAC) recommendations, the Department's rate setting process, and the research of the Department's subject matter experts.

Anesthesia Services

The Department requests a decrease of $9,728,911 total funds, $2,950,535 General Fund, to decrease anesthesia rates to 100% of the rate comparison benchmark—the 2016 Medicare conversion factor. The results of the 2017 PSA Analysis Report revealed that the Department's payments for anesthesia services varied when compared to the benchmark, but all payments were above 100% of the benchmark. This recommendation also aligns with the MPRRAC's recommendation to reduce anesthesia rates to 100% of the benchmark. With the reduction in rates, the Department would closely evaluate access to those services as required by 42 CFR § 447.203.

Alternative Care Facilities

The Department requests $15,684,482 total funds, $7,842,241 General Fund, to increase rates for Alternative Care Facilities (ACFs). With the requested funding, the Department would raise the current rate from $51.92 per day to $64.88 per day, an increase of 25.0%. This recommendation is informed by findings of the 2017 HCBS Analysis Report and the Department's rate setting process. This recommendation also supports the MPRRAC's recommendation for waiver services. The Department has received stakeholder feedback, specific to ACFs, that client access and provider retention issues may exist.

Physician Services

The Department would explore options to rebalance and adjust rates or payment methodologies for physician services at a budget neutral benchmark. Specifically, the Department would account for differences based on the place of service, using Medicare as a model. The Department would evaluate services that fall either below 80% or above 100% of the established benchmark, and identify services that would benefit from an immediate rate change. Any adjustments made would be budget neutral; the Department is not requesting for changes to physician rates beyond the across-the-board rate change discussed below.

---

[1] The 2017 Medicaid Provider Rate Review Recommendation Report can be found on the Department's Medicaid Provider Rate Review Advisory Committee's website. https://www.colorado.gov/pacific/hcpf/medicaid-provider-rate-review-advisory-committee

[2] The 2017 Medicaid Provider Rate Review Analysis Report was published in two parts: Physician Services, Surgery, and Anesthesia (2017 PSA Analysis Report) and HCBS Waivers (2017 HCBS Analysis Report)

- https://www.colorado.gov/pacific/sites/default/files/2017%20Medicaid%20Provider%20Rate%20Review%20Analysis%20Report%20-%20Physician%20Services%2C%20Surgery%2C%20and%20Anesthesia.pdf
- https://www.colorado.gov/pacific/sites/default/files/2017%20Medicaid%20Provider%20Rate%20Review%20Analysis%20Report%20-%20HCBS%20Waivers.pdf

Across-the-Board Provider Rate Increase
The Department requests $34,417,648 total funds, $11,656,690 General Fund to implement an across-the-board (ATB) provider rate increase of 0.77% for most services that are not addressed in the other components of this request. In aggregate, the increases would help address adequacy of payments.

Nursing Facility Per Diem Reduction
The Department requests a decrease of $12,546,993 total funds, $6,273,497 General Fund to reduce the allowable inflation factor on nursing facility per diem rates for FY 2018-19 from 3% to 1% to align with the overall Department's request of providing a nearly 1% ATB rate increase to other services not specifically targeted for additional increases. The reduction to the inflation factor would be a one-time reduction, reverting to 3% beginning in FY 2019-20.

This request would require a statute change. Section 25.5-6-202(9)(I), C.R.S (2017) requires that the General Fund share of the aggregate statewide average of the per diem rate net of patient payment be limited to an annual increase of three percent. In order for the Department to implement the request, the General Assembly must pass legislation to alter the allowable growth factor for rates from three percent annual increase in FY 2018-19 to the new limit; in this case, one percent.

Anticipated Outcomes:

Implementing a provider rate increase would reduce the financial strain and risk to client access that stagnant provider rates represent. Additionally, targeted rate changes to specific services would more appropriately align incentives, encouraging positive outcomes for clients and allowing the Department to pay for value rather than volume of services.

Providing adequate reimbursement to providers encourages participation in Medicaid and therefore increases client access, which aligns with the Department's Strategic Plan.

Assumptions and Calculations:

Across-the-Board Provider Rate Increase
Estimates are based on the Department's FY 2018-19 budget and prior year actuals. As the Department will be revising Medicaid caseload and per capita cost forecasts through future budget requests, adjustments to estimates may be necessary in the future.

Although these rate increases would affect most Medicaid providers, a number of providers would be exempted from rate increases or receive different rate increases. These distinctions include:

- A portion of expenditure related to non-medical emergency transportation services is not eligible for an increase due to services rendered under a fixed price contract.
- Dental administrative payments are ineligible for rate increases because the contract was competitively procured, with payment rates agreed upon during the procurement.
- Reimbursement to pharmacies are not eligible for the rate increase. Pharmaceutical reimbursement has transitioned to a methodology that reflects the actual costs of purchasing and dispensing medications. Further, pharmaceutical reimbursement is unique in that the reimbursement methodology is directly tied to a moving price statistic that increases reimbursement as provider costs increase.

- Rates for rural health clinics (RHCs) are based on actual cost or the Medicare upper payment limit. RHCs have previously not been subject to rate decreases or increases due to the unique manner in which these rates are calculated.
- Rates for Federally Qualified Health Centers would be ineligible due to recent increases bringing reimbursement for this provider type to the upper limit of allowed amount under the current reimbursement methodology.
- Class I and Class II nursing facility rates are determined in accordance with statutory guidelines which has the effect of increasing reimbursement to most providers each year, based on providers' cost. Therefore, the Department is not requesting funding to increase nursing facility rates. In addition, the Department would exempt hospice rates that are set in part as a function of nursing facility rates and in part as a result of federal requirements. Hospice rates that are not related to nursing facility rates are included in the Department's proposal.
- Physical health managed care programs, including risk-based health maintenance organizations such as the providers for the Program of All-Inclusive Care for the Elderly (PACE), are negotiated within the parameters of their respective rate setting methodology and may or may not be impacted by rate increases.
- Risk-based physical health managed care programs for Medicaid and the Child Health Plan *Plus* (CHP+) and behavioral health organizations (BHO) would not receive direct rate increases as part of this change request. Rates are set in accordance with federal regulation and actuarial standards, which do not generally permit general provider rate increases. The Department notes, however, that BHO and CHP+ rates generally increase in response to provider cost, and rates for Medicaid managed care organizations would increase indirectly based on increases applied to fee-for-service rates.

Nursing Facility Per Diem Reduction
To calculate the reduction from the change in policy, the Department used the forecasted patient days for nursing facility care and multiplied it by the forecasted per diem rate net of patient payment. In the Department's FY 2018-19 R-1 "Medical Services Premiums", the FY 2018-19 per diem rate was estimated by trending forward the FY 2017-18 estimated rate by three percent. To calculate the total expenditure for the new policy, the Department used the same methodology as in the R-1, but instead trended forward the estimated FY 2017-18 per diem rates by one percent for FY 2018-19 and three percent from FY 2018-19 to FY 2019-20.

The requested reduction to the inflation factor used to calculate FY 2018-19 nursing facility rates would be a one-time change, reducing the inflation factor from three to one percent in that year only. Beginning in FY 2019-20, the factor would revert to three percent. The change in policy to a one percent inflation factor in FY 2018-19 would result in a permanent downward level shift in nursing facility expenditure. As a result, the Department would still experience a reduction to expenditure in FY 2019-20 and beyond, even after the three percent growth limit is reinstated.

The Department would not be required to seek a state plan amendment (SPA) or pursue any changes to its rules to implement this request and therefore expects that the change would be implemented July 1, 2018. The Department does not anticipate the request would impact Nursing Facility Supplemental Payments.

Please see Appendix A for detailed calculations.

Table 1.1: FY 2018-19 Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$24,037,926	0.0	$8,330,411	$985,050	$0	$14,722,465	Table 3.1, Row F + Table 4.1, Row C + Table 5.1, Row G + Table 6.1, Row A
B	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	$59,938	0.0	$13,099	$2,463	$0	$44,376	Table 3.1, Row H
C	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Adult Comprehensive Services	$2,654,608	0.0	$1,327,304	$0	$0	$1,327,304	Table 3.1, Row J
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Adult Supported Living Services	$554,245	0.0	$301,470	$1,748	$0	$251,027	Table 3.1, Row L
E	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Children's Extensive Support Services	$187,272	0.0	$93,636	$0	$0	$93,636	Table 3.1, Row N
F	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	$241,598	0.0	$127,342	$333	$0	$113,923	Table 3.1, Row P
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Children's Habitation Rehabilitational Program	$17,708	0.0	$8,854	$0	$0	$8,854	Table 3.1, Row R
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Family Support Services	$50,038	0.0	$50,038	$0	$0	$0	Table 3.1, Row T
I	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Preventive Dental Hygiene	$455	0.0	$455	$0	$0	$0	Table 3.1, Row V
J	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Eligibility Determination and Waiting List Management	$22,438	0.0	$22,290	$0	$0	$148	Table 3.1, Row X
K	**Total Request**	**$27,826,226**	**0.0**	**$10,274,899**	**$989,594**	**$0**	**$16,561,733**	**Sum of Rows A - J**

Table 1.2: FY 2019-20 Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$26,265,792	0.0	$8,989,091	$1,008,874	$0	$16,267,827	Table 3.2, Row F + Table 4.2, Row C + Table 5.1, Row H + Table 6.1, Row B
B	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	$65,387	0.0	$14,290	$2,687	$0	$48,410	Table 3.2, Row H
C	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Adult Comprehensive Services	$2,895,936	0.0	$1,447,968	$0	$0	$1,447,968	Table 3.2, Row J
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Adult Supported Living Services	$604,631	0.0	$328,876	$1,907	$0	$273,848	Table 3.2, Row L
E	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Children's Extensive Support Services	$204,296	0.0	$102,148	$0	$0	$102,148	Table 3.2, Row N
F	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	$263,562	0.0	$138,919	$363	$0	$124,280	Table 3.2, Row P
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Children's Habitation Rehabilitational Program	$19,318	0.0	$9,659	$0	$0	$9,659	Table 3.2, Row R
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Family Support Services	$50,038	0.0	$50,038	$0	$0	$0	Table 3.2, Row T
I	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Preventive Dental Hygiene	$455	0.0	$455	$0	$0	$0	Table 3.2, Row V
J	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Eligibility Determination and Waiting List Management	$22,438	0.0	$22,290	$0	$0	$148	Table 3.2, Row X
K	**Total Request**	**$30,391,853**	**0.0**	**$11,103,734**	**$1,013,831**	**$0**	**$18,274,288**	**Sum of Rows A - J**

Table 2.1: FY 2018-19 Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	0.77% ATB Provider Rate Increase	$34,417,648	0.0	$11,656,690	$1,264,133	$0	$21,496,825	62.46%	From Table 3.1, Row Y
B	Alternative Care Facility Rate Increase	$15,684,482	0.0	$7,842,241	$0	$0	$7,842,241	50.00%	From Table 5.1, Row G
C	Nursing Facilities Per Diem Reduction	($12,546,993)	0.0	($6,273,497)	$0	$0	($6,273,496)	50.00%	From Table 4.1, Row C
D	Anesthesia Reduction	($9,728,911)	0.0	($2,950,535)	($274,539)	$0	($6,503,837)	66.85%	From Table 6.1, Row A
E	**Total Estimate**	**$27,826,226**	**0.0**	**$10,274,899**	**$989,594**	**$0**	**$16,561,733**	**59.52%**	**Sum of Rows A - D**

Table 2.2: FY 2019-20 Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	0.77% ATB Provider Rate Increase	$37,539,896	0.0	$12,709,773	$1,379,054	$0	$23,451,069	62.47%	From Table 3.2, Row Y
B	Alternative Care Facility Rate Increase	$17,110,344	0.0	$8,555,172	$0	$0	$8,555,172	50.00%	From Table 5.1, Row H
C	Nursing Facilities Per Diem Reduction	($13,912,015)	0.0	($6,956,008)	$0	$0	($6,956,007)	50.00%	From Table 4.2, Row C
D	Anesthesia Reduction	($10,346,372)	0.0	($3,205,203)	($365,223)	$0	($6,775,946)	65.49%	From Table 6.1, Row B
E	**Total Estimate**	**$30,391,853**	**0.0**	**$11,103,734**	**$1,013,831**	**$0**	**$18,274,288**	**60.13%**	**Sum of Rows A - D**

Table 3.1: FY 2018-19 - Amounts Eligible for Rate Increase by Funding Source (Includes Budget Actions Not Yet Approved)

Row	Long Bill Group	Total Funds	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds
	(2) Medical Services Premiums					
A	Acute Care	$3,395,585,368	$910,840,514	$173,906,358	$0	$2,310,838,496
B	Community Based Long Term Care	$918,731,739	$450,550,224	$5,004,030	$0	$463,177,485
C	Program for All-Inclusive Care for the Elderly	$0	$0	$0	$0	$0
D	Service Management	$36,235,658	$18,117,829	$0	$0	$18,117,829
E	**Total Medical Services Premiums**	**$4,350,552,765**	**$1,379,508,567**	**$178,910,388**	**$0**	**$2,792,133,810**
F	**Impact of 0.77% Rate Increase**	**$30,629,348**	**$9,712,202**	**$1,259,589**	**$0**	**$19,657,557**
	(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $1,017,628; Breast and Cervical Cancer Prevention and Treatment Fund: $1,986; Adult Dental Fund: $239,975					
	(3) Behavioral Health Community Programs	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
G	Behavioral Health Fee-for-Service	$8,513,539	$1,860,579	$349,888	$0	$6,303,072
H	**Impact of 0.77% Rate Increase**	**$59,938**	**$13,099**	**$2,463**	**$0**	**$44,376**
	(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $2,463					

Table 3.1: FY 2018-19 - Amounts Eligible for Rate Increase by Funding Source (Continued) (Includes Budget Actions Not Yet Approved)						
Row	**Long Bill Group**	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Reappropriated Funds**	**Federal Funds**
	(4) Office of Community Living					
I	Adult Comprehensive Services	$377,057,039	$188,528,518	$1	$0	$188,528,520
J	**Impact of 0.77% Rate Increase**	**$2,654,608**	**$1,327,304**	**$0**	**$0**	**$1,327,304**
K	Adult Supported Living Services	$78,724,155	$42,820,329	$248,246	$0	$35,655,580
L	**Impact of 0.77% Rate Increase**	**$554,245**	**$301,470**	**$1,748**	**$0**	**$251,027**
M	Children's Extensive Support Services	$26,599,728	$13,299,864	$0	$0	$13,299,864
N	**Impact of 0.77% Rate Increase**	**$187,272**	**$93,636**	**$0**	**$0**	**$93,636**
O	Case Management	$34,316,350	$18,087,603	$47,211	$0	$16,181,536
P	**Impact of 0.77% Rate Increase**	**$241,598**	**$127,342**	**$333**	**$0**	**$113,923**
	(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $2,081					

Table 3.1: FY 2018-19 - Amounts Eligible for Rate Increase by Funding Source (Continued)
(Includes Budget Actions Not Yet Approved)

Row	Long Bill Group	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Q	Children's Habitation/Rehabilitation Program	$2,515,319	$1,257,660	$0	$0	$1,257,659
R	**Impact of 0.77% Rate Increase**	**$17,708**	**$8,854**	**$0**	**$0**	**$8,854**
S	Family Support Services	$6,515,107	$6,515,107	$0	$0	$0
T	**Impact of 0.77% Rate Increase**	**$50,038**	**$50,038**	**$0**	**$0**	**$0**
U	Preventive Dental Hygiene	$59,261	$59,261	$0	$0	$0
V	**Impact of 0.77% Rate Increase**	**$455**	**$455**	**$0**	**$0**	**$0**
W	Eligibility Determination and Waitlist Management	$2,921,490	$2,902,172	$0	$0	$19,318
X	**Impact of 0.77% Rate Increase**	**$22,438**	**$22,290**	**$0**	**$0**	**$148**
Y	**Total Impact**	**$34,417,648**	**$11,656,690**	**$1,264,133**	**$0**	**$21,496,825**

Table 3.2: FY 2019-20 - Amounts Eligible for Rate Increase by Funding Source (Includes Budget Actions Not Yet Approved)

Row	Long Bill Group	Total Funds	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds
	(2) Medical Services Premiums					
A	Acute Care	$3,395,585,368	$910,840,514	$173,906,358	$0	$2,310,838,496
B	Community Based Long Term Care	$918,731,739	$450,550,224	$5,004,030	$0	$463,177,485
C	Program for All-Inclusive Care for the Elderly	$0	$0	$0	$0	$0
D	Service Management	$36,235,658	$18,117,829	$0	$0	$18,117,829
E	**Total Medical Services Premiums**	**$4,350,552,765**	**$1,379,508,567**	**$178,910,388**	**$0**	**$2,792,133,810**
F	**Impact of 0.77% Rate Increase**	**$33,413,835**	**$10,595,130**	**$1,374,097**	**$0**	**$21,444,608**
	(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $1,098,072; Breast and Cervical Cancer Prevention and Treatment Fund: $2,317; Adult Dental Fund: $273,708					
	(3) Behavioral Health Community Programs	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
G	Behavioral Health Fee-for-Service	$8,513,539	$1,860,579	$349,888	$0	$6,303,072
H	**Impact of 0.77% Rate Increase**	**$65,387**	**$14,290**	**$2,687**	**$0**	**$48,410**
	(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $2,687					

Table 3.2: FY 2019-20 - Amounts Eligible for Rate Increase by Funding Source (Continued) (Includes Budget Actions Not Yet Approved)						
Row	**Long Bill Group**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
	(4) Office of Community Living					
I	Adult Comprehensive Services	$377,057,039	$188,528,518	$1	$0	$188,528,520
J	**Impact of 0.77% Rate Increase**	**$2,895,936**	**$1,447,968**	**$0**	**$0**	**$1,447,968**
K	Adult Supported Living Services	$78,724,155	$42,820,329	$248,246	$0	$35,655,580
L	**Impact of 0.77% Rate Increase**	**$604,631**	**$328,876**	**$1,907**	**$0**	**$273,848**
M	Children's Extensive Support Services	$26,599,728	$13,299,864	$0	$0	$13,299,864
N	**Impact of 0.77% Rate Increase**	**$204,296**	**$102,148**	**$0**	**$0**	**$102,148**
O	Case Management	$34,316,350	$34,316,350	$34,316,350	$34,316,350	$34,316,350
P	**Impact of 0.77% Rate Increase**	**$263,562**	**$138,919**	**$363**	**$0**	**$124,280**
	(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $2,270					

Table 3.2: FY 2019-20 - Amounts Eligible for Rate Increase by Funding Source (Continued) (Includes Budget Actions Not Yet Approved)						
Row	**Long Bill Group**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
Q	Children's Habitation/Rehabilitation Program	$2,515,319	$1,257,660	$0	$0	$1,257,659
R	**Impact of 0.77% Rate Increase**	**$19,318**	**$9,659**	**$0**	**$0**	**$9,659**
S	Family Support Services	$6,515,107	$6,515,107	$0	$0	$0
T	**Impact of 0.77% Rate Increase**	**$50,038**	**$50,038**	**$0**	**$0**	**$0**
U	Preventive Dental Hygiene	$59,261	$59,261	$0	$0	$0
V	**Impact of 0.77% Rate Increase**	**$455**	**$455**	**$0**	**$0**	**$0**
W	Eligibility Determination and Waitlist Management	$2,921,490	$2,902,172	$0	$0	$19,318
X	**Impact of 0.77% Rate Increase**	**$22,438**	**$22,290**	**$0**	**$0**	**$148**
Y	**Total Impact**	**$37,539,896**	**$12,709,773**	**$1,379,054**	**$0**	**$23,451,069**

Table 4.1: FY 2018-19 Impact of Reducing Growth in Nursing Facility Rates							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	Estimated Expenditure with 3% Growth for FY 2018-19 Nursing Facility Rates	$700,973,852	$350,486,926	$0	$0	$350,486,926	FY 2018-19 R-1, "Medical Services Premiums" Exhibit H4 - LTC - Class I NF Actuals, FY 2018-19
B	Estimated Expenditure with 1% Growth for FY 2018-19 Nursing Facility Rates	$688,426,859	$344,213,429	$0	$0	$344,213,430	FY 2018-19 R-1 "Medical Services Premiums" model using a 1% growth factor.
C	**Difference**	**($12,546,993)**	**($6,273,497)**	**$0**	**$0**	**($6,273,496)**	**Row B - Row A**

Table 4.2: FY 2019-20 Impact of Reducing Growth in Nursing Facility Rates							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	Estimated Expenditure with 3% Growth for FY 2018-19 Nursing Facility Rates	$725,452,451	$362,726,226	$0	$0	$362,726,225	FY 2018-19 R-1, "Medical Services Premiums" Exhibit H4 - LTC - Class I NF Actuals, FY 2019-20
B	Estimated Expenditure with 1% Growth for FY 2018-19 Nursing Facility Rates	$711,540,436	$355,770,218	$0	$0	$355,770,218	Assumes growth rate reverts to 3% based on new FY 2018-19 forecasted rates.
C	**Difference**	**($13,912,015)**	**($6,956,008)**	**$0**	**$0**	**($6,956,007)**	**Row B - Row A**

Table 5.1: Estimated Increase in Alternative Care Facility Rates			
Row	**Item**	**Amount**	**Notes/Calculations**
A	Current Rate	$51.92	Per Day
B	Estimated Utilization	266.50	Days per Utilizer
C	Estimated Utilizers	4,955	Number of Utilizers
D	Estimated Expenditure Under Current Rate	$68,560,749	Row A * Row B * Row C
E	Proposed New Rate	$64.88	Proposed
F	Estimated Expenditure Under New Rate	$85,671,093	Row E * Row B * Row C
G	**FY 2018-19 Estimated Increase in Expenditure**	**$15,684,482**	**(Row F - Row D) * 11 / 12**
H	**FY 2019-20 Estimated Increase in Expenditure**	**$17,110,344**	**Row F - Row D**

Table 6.1: Estimated Impact by Fund Splits - Anesthesia Rates						
Row	**Fiscal Year**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
A	FY 2018-19(1)	($9,728,911)	($2,950,535)	($274,539)	$0	($6,503,837)
B	FY 2019-20(2)	($10,346,372)	($3,205,203)	($365,223)	$0	($6,775,946)

1. Cash fund breakout: Healthcare Affordability & Sustainability Fee: ($271,195), Breast and Cervical Cancer Prevention and Treatment Fund: ($3,344)
2. Cash fund breakout: Healthcare Affordability & Sustainability Fee: ($361,666), Breast and Cervical Cancer Prevention and Treatment Fund: ($3,557)

Table 6.2: Calculation of Using 100% of Medicare for Anesthesia Services				
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Claims Priced at FY 2015-16 Medicaid Rates	$42,239,414	$43,160,233	Actuarial analysis, trended forward by projected caseload growth
B	Claims Priced at 100% of the Medicare Rate	$32,087,507	$32,787,015	Actuarial analysis, trended forward by projected caseload growth
C	Incremental Difference	($10,151,907)	($10,373,218)	Row B - Row A
D	Expenditure for Current Year Claims, Adjusted for Implementation Date and Cash Flow	($9,728,911)	($9,941,001)	Row C * 11.5/12
E	Expenditure for Prior Year Claims	$0	($405,371)	Previous Year Row D * .5/12
F	**Total Impact**	**($9,728,911)**	**($10,346,372)**	**Row D + Row E**

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-10 Drug Cost Containment Initiatives**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ Supplemental FY 2017-18

X Change Request FY 2018-19

___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$7,662,782,054	$0	$7,611,566,065	$132,777	($1,512,798)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,105,506,778	$0	$2,093,075,442	($24,407)	($390,093)
	CF	$892,523,832	$0	$890,531,810	($39,129)	($102,816)
	RF	$70,714,284	$0	$70,525,230	$0	$0
	FF	$4,594,037,160	$0	$4,557,433,583	$196,313	($1,019,889)

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- General Professional Services and Special Projects	Total	$9,412,649	$0	$14,534,207	$300,500	$300,500
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,005,615	$0	$5,621,706	$150,250	$150,250
	CF	$1,600,352	$0	$1,545,040	$0	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$4,656,682	$0	$7,217,461	$150,250	$150,250
01. Executive Director's Office, (C) Information Technology Contracts and Projects -- MMIS Maintenance and Projects	Total	$41,646,122	$0	$41,988,677	$630,500	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,955,404	$0	$5,979,906	$63,050	$0
	CF	$4,288,071	$0	$4,445,412	$0	$0
	RF	$11,808	$0	$6,618	$0	$0
	FF	$31,390,839	$0	$31,556,741	$567,450	$0

01. Executive Director's Office, (E) Utilization and Quality Review Contracts -- Professional Service Contracts	**Total**	**$13,824,436**	**$0**	**$16,087,495**	**$282,297**	**$512,599**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,017,493	$0	$4,597,070	$70,574	$128,150
	CF	$470,308	$0	$497,964	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$9,336,635	$0	$10,992,461	$211,723	$384,449

02. Medical Services Premiums -- Medical Services Premiums	**Total**	**$7,597,898,847**	**$0**	**$7,538,955,686**	**($1,080,520)**	**($2,325,897)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	($308,281)	($668,493)
	CF	$886,165,101	$0	$884,043,394	($39,129)	($102,816)
	RF	$70,552,476	$0	$70,368,612	$0	$0
	FF	$4,548,653,004	$0	$4,507,666,920	($733,110)	($1,554,588)

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 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 $132,777 total funds, including a decrease of $24,407 General Fund in FY 2018-19 and a decrease of $1,512,798 total funds, including a decrease of $390,093 General Fund in FY 2019-20 to improve management of the pharmacy and physician administered drug benefits. This funding would be used to procure a utilization management vendor for physician administered drugs, administrative resources to set up alternative payment models for prescription drugs, and to account for anticipated savings from these initiatives.

Current Program

- The total funds spent on pharmacy and physician administered drug benefits totaled $834,402,471 ($425,522,785 net of rebates) and $53,185,751 respectively in FY 2015-16.
- Pharmacy claims are paid through the Pharmacy Benefit Management System (PBMS), while physician administered drugs are considered a medical benefit and are paid through the interChange system.
- Prior authorization is required on some drugs in the pharmacy benefit, including those non-preferred agents on the preferred drug list (PDL). There are currently no prior authorization restrictions on any physician administered drugs. The Department was appropriated an FTE to manage the physician administered drug benefit through the FY 2017-18 R-7 "Oversight of State Resources."
- Oversight of these benefits come from the Drug Utilization Review (DUR) Board, the Pharmacy and Therapeutics (P&T) Committee managing Preferred Drug List, and Medical Services Board.

Problem or Opportunity

- Prescription drug expenditures have grown significantly in the last few years due to the increasing number of specialty drugs in the market and increases in drug prices.
- Utilization management of the Physician Administered Drug benefit and participating in alternative payment models (APM) are new tools the Department can use to manage benefits and lessen pressure on the State's financial resources.

Consequences of Problem

- If the request is not approved, the Department would miss two opportunities to mitigate increasing drug costs. The Department would be unable to put prior authorizations on physician administered drugs and could not guarantee that these services are provided in the most cost-effective manner.
- Drug costs would likely increase more rapidly than they would have otherwise under containment policies.

Proposed Solution

- The utilization management vendor would be responsible for working in conjunction with the benefit manager in developing clinical criteria for prior authorization for physician administered drugs and processing prior authorization requests (PARs).
- The Department is in the initial phases of developing APMs to address the rising costs of specialty drugs. The Department expects to start engaging with manufacturers to participate in these APMs in 2018.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: ***R-10***
Request Detail: ***Drug Cost Containment Initiatives***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Drug Cost Containment Initiatives	$132,777	($24,407)

Problem or Opportunity:

Drug costs have consistently increased year over year, putting pressure on the State's limited financial resources. In FY 2015-16, the Department spent $834,402,471 on prescription drugs ($425,522,785 net of rebates), and $53,185,751 on physician administered drugs. The Department must come up with new strategies for containing drug costs, reducing inappropriate utilization, and holding manufacturers accountable for the health outcomes that are claimed for the drugs they produce.

A significant driver of this growth is the increase in high-cost specialty drugs[1] in the market. In FY 2015-16, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that high-cost specialty drugs made up 0.9 percent of Medicaid claims in 2014, but accounted for 32 percent of total Medicaid drug expenditures before rebates.[2] The Center for Evidence-based Policy estimates 110 new high-cost specialty drugs in the pipeline awaiting approval from the U.S. Food and Drug Administration (FDA). Medicaid agencies also tend to bear more of these specialty drug costs due to the nature of Medicaid members being on average in poorer health than those on private insurance.[3] Additionally, unlike private payers, Medicaid agencies cannot exclude many of these new drugs from coverage under the prescription drug regulations because they must cover all prescription drugs sold by a manufacturer that has a national rebate agreement with the Centers for Medicare and Medicaid Services (CMS).[4]

The regulatory and economic constraints faced by the Department means it must devise innovative and creative policies to achieve its goals of drug cost containment, while ensuring the health and safety of its members. In previous years, the Department has relied on using prior authorization policies, maintaining a

---

[1] The definition of a high cost specialty drug varies by organization. Common elements of these drugs include costs greater than $600 per prescription and treatment of a serious or life-threatening disease or condition.
[2] Medicaid and CHIP Payment and Access Commission (MACPAC) (2016). Medicaid spending for prescription drugs: Issue brief https://www.macpac.gov/publication/medicaid-spending-for-prescription-drugs/
[3] Oregon Health & Science University: Center for Evidence-based Policy (2016). State Medicaid Alternative Reimbursement and Purchasing Test for High-cost Drugs (SMART-D) Economic Analysis. http://smart-d.org/wp-content/uploads/2016/09/Pipeline-and-Economic_Final_Sept-9-2016.pdf
[4] 42 CFR § 447.502

preferred drug list (PDL), and using cost-based reimbursement methodologies. The Department is also exploring putting quantity limitations on certain drugs, better managing of unmanaged drug classes, and allowing more prescribed over-the-counter drugs to be reimbursed.

The two new cost containment strategies proposed by the Department in this request involve utilization management of the physician administered drug benefit and engaging in alternative payment models (APMs).

Physician Administered Drugs Benefit Management

The Department is currently in the process of restructuring the physician administered drug benefit[5] and requires additional resources for the next phase of updates. The next step in improved management of the benefit involves using a utilization management[6] vendor to implement and administer a prior authorization system.

As part of the FY 2017-18 R-7 "Oversight of State Resources", the Department requested to set rates of physician administered drugs to an average of 2.5 percent over the average sales price (ASP) by drug class. This structure allowed the Department flexibility to set some drug rates above 2.5 percent over ASP for incentive pricing, while lowering other rates. The Department was also appropriated an administrator FTE to manage the physician administered drugs benefit. The role of this position involves adjusting the Department's drug reimbursement fee schedule, updating pharmacy and procedural codes for new and reformulated drug codes, and developing clinical criteria for utilization.

Without a utilization management system, new or costlier drugs that are of similar clinical effectiveness to an existing drug can be billed to the Department without prior authorization. The Department would continue to spend funds on drugs that do not necessarily represent the best, nor most cost-effective treatment for a member.

Additionally, the Department does not currently have a way of tracking if a member has accessed duplicate or similar services through both the medical and pharmacy benefits. Pharmacy claims are paid through the Pharmacy Benefit Management System (PBMS), while physician administered drugs are considered a medical benefit and are paid through the interChange system. Because the two systems do not compare utilization, it is possible for a member to receive treatment for the same diagnosis through both the outpatient pharmacy and physician settings. A utilization management system would prevent duplication of treatment.

Alternative Payment Models (APMs)

The Department seeks to expand its use of value-based purchasing methods by tying more payments to quality or value within the pharmacy benefit. For pharmacy, these models are typically voluntary collaborations between a drug manufacturer and a Medicaid program, intended to hold manufacturers accountable for the outcomes they claim for their drugs, and help Medicaid programs control exorbitant drug costs. An alternative payment model (APM) is based on financial outcomes or health outcomes of the covered population. Financial-based APMs use financial caps or discounts through programs such as

---

[5] Injectable drugs, allergen extracts, infusion drugs and immunizations administered in a physician's office are considered physician administered drugs.

[6] Utilization Management is the evaluation of the appropriateness and medical need of health care services and procedures according to evidence-based criteria or guidelines.

supplemental rebates to ensure spending predictability, while health outcomes-based APMs tie the clinical outcomes of the patient population to drug payment.[7] APMs have been used in European markets for years with various levels of success in different countries. The most common APM used is the price-volume model. In this model, prices are attached to the utilization volume of a drug and the price per unit gradually decreases as there is more patient utilization. The second most common APM involves data collection requirements so that health outcomes can be measured at a later point in time or cost-savings expectations can be validated.[8]

The Department is investigating whether it would need to pursue a section 1115 Medicaid demonstration waiver in developing some of the APMs. An 1115 waiver would allow the Department to waive certain provisions of the Social Security Act, such as covering all drugs that have entered into the national rebate program with CMS. For a health-outcome based APM that might rely on exemption from covering Fast Track drugs or drugs with limited proven clinical efficacy, an 1115 waiver would likely be necessary. With these drugs, the Department would spend additional time in its reviews before allowing the drugs to be covered.

Proposed Solution:

The Department requests an increase of $132,777 total funds, including a decrease of $24,407 General Fund in FY 2018-19 and a decrease of $1,512,798 total funds, including a decrease of $390,093 General Fund in FY 2019-20 to procure a utilization management vendor for the physician administered drug benefit and for administrative resources to set up alternative payment models. This request also takes into account anticipated savings from a more robust utilization management program for physician administered drugs. These two initiatives represent new tools the Department can use to contain drug costs. The resources requested would provide additional mechanisms for more efficient administration of the pharmacy and physician administered drug benefits through utilization management and value-based purchasing initiatives.

If the request is not approved, the Department would miss an opportunity to mitigate increasing drug costs. The Department would be unable to put prior authorizations on physician administered drugs and could not guarantee that these services are provided in the most cost-effective manner. Drug costs would likely increase more rapidly than they would have otherwise under containment policies.

Procure Utilization Management Vendor for Physician Administered Drugs

The benefit manager appropriated under the FY 2017-18 R-7 “Oversight of State Resources” would work in conjunction with the utilization management vendor in developing clinical criteria for prior authorization for physician administered drugs. The vendor would process prior authorization requests (PARs) and send authorizations to the interChange to pay the claim.

In developing these prior authorization policies, the Department may use existing prior authorization processes in place for the pharmacy benefit to ensure the health and safety of its members. These processes include working with the Medical Services Board, the Pharmacy and Therapeutics (P&T) Committee to put drugs on the Preferred Drug List (PDL), and the Drug Utilization Review (DUR) Board to determine prior

---

[7] Please refer to footnote 3 for citation.

[8] Oregon Health & Science University: Center for Evidence-based Policy (2016). State Medicaid Alternative Reimbursement and Purchasing Test for High-cost Drugs (SMART-D) Alternate Payment Model Brief. http://smart-d.org/wp-content/uploads/2016/10/SMARTD_APM_Report_Final_Oct-21-2016.pdf

authorization criteria for nonpreferred drugs and drugs with special prescribing guidelines. Before requiring prior authorization on a drug, the Department would carefully evaluate with its stakeholders whether there were appropriate substitutes in place, particularly for drugs used by more vulnerable patients, such as those receiving specialty drugs for cancer treatment.

Designing Alternative Payment Models (APMs)

The Department is committed to tying health outcomes to reimbursement across the Medicaid program through alternative payment models (APMs) and is currently in the initial phases of developing alternative payment models for its pharmacy program. The Department expects to work on an APM implementation plan and target a preliminary selection of drugs and drug classes in fall of 2017 and start reaching out to manufacturers in spring of 2018. There is still uncertainty on which manufacturers the Department would work with, which drugs would be targeted, and the structure of the APM.

The Department is requesting administrative funding for an actuarial contractor and consultant to help develop and implement the APMs and 1115 Medicaid demonstration waiver. An actuary would assist with determining measurable health and financial outcomes for contracts with manufacturers, including compiling other data sources outside of Medicaid claims. It would model the impact of the proposed payment projects on expenditure and health outcomes in the design phase and analyze the actual impact of the APM contract once it is implemented. The actuary would also validate the selected payment methodologies, ensuring that they meet federal regulations. A consultant would provide support with determining whether an 1115 Medicaid demonstration waiver is needed to implement the APMs and guide the Department through the planning process of developing the waiver, performing stakeholder outreach, and working with CMS to ensure any preliminary concepts are defensible. The consultant would need to be experienced in the necessary steps for submitting an 1115 demonstration waiver, including negotiations with CMS, public outreach, and budget neutrality calculations.

Any corresponding savings from implementing the APMs would be accounted for in the Medical Services Premiums line item through the regular budget process once specific drugs are targeted and APM contracts are in place. Pursuant to HB 17-1353 "Implement Medicaid Delivery & Payment Initiatives," the Department would also submit to the Joint Budget Committee its APM plans, including demonstrating the new payment methodology is designed to achieve budget savings and an overview of the stakeholder engagement process used to develop the APM.

Anticipated Outcomes:

Funding this request would allow the Department to better manage the pharmacy and physician administered drug benefits through utilization management and alternative payment methodologies (APMs). These two new cost containment techniques represent the Department's commitment to its performance plan goals of maximizing the use of value-based payment reforms, including tying provider payments to quality and value and implementing cost containment initiatives; and operational excellence through improving the efficiency of business processes.

Through utilization management of physician administered drugs, the Department expects less inappropriate drug usage and better promotion of high-value drugs. Prior authorization and the PDL have historically been

successful tools in managing the pharmacy benefit. In the FY 2014-15 Pharmacy Utilization Plan[9], the Department estimated a cost avoidance of $10,434,380 in FY 2013-14 as a result of these two utilization control mechanisms.

Through developing APMs, the Department anticipates better health outcomes for clients and a better way of controlling drug costs for the State. If a drug's performance falls below expectations, the Department assumes it would collect more in supplemental rebates to offset the drug's cost.

Assumptions and Calculations:

Utilization Management Vendor

The Department would incur costs related to implementing a utilization management vendor, including costs to adapt the interChange to connect to vendor systems, and also savings from changes in utilization associated with increased prior authorizations. The Department based its cost calculations on the presumption that these changes could be implemented using vendors with existing contracts with the Department and a request for proposal (RFP) would not need to be issued. The Department anticipates vendors would be able to start on the project as soon as funding is received on July 1, 2018 and complete the systems changes by January 1, 2019.

Systems Costs Associated with Utilization Management Vendor and interChange

The utilization management vendor would be responsible for approving prior authorizations of physician administered drugs. Based on the preliminary list of drugs identified for prior authorization, the Department anticipates processing approximately 5,000 prior authorization requests per year. The Department also included an estimate for additional funding as prior authorization policies are developed. This flexible funding accounts for a 25% variation in PAR quantities from the estimate based on the preliminary targeted drug list.

The prior authorization costs estimates are based on one vendor's program where the cost per PAR varies based on the processing system the Department chooses. Under a standard prior authorization system with this vendor, every PAR transaction costs $42 to process; this means for a PAR that is denied and then appealed, two transactions would be counted. The standard type of prior authorization system would be used in the proposed PARs reflected in the FY 2018-19 R-8 "Assorted Medicaid Saving Initiatives" request with each PAR transaction costing $22.75. A complex PAR costs $83 to process, but under this system, no additional fees would be assessed regardless of the number of transactions associated with the PAR.[10] The complex PAR system is expected to save both time and financial resources because of the more thorough initial review. The Department would also have the option of using a blended system with both standard and complex PAR processing. The calculations in Table 4.1 assume the Department would use a blended system and correspondingly, a weighted average of $77.95 per PAR. These calculations also assume drugs that

---

[9] The Pharmacy Utilization Plan was an annual legislative report to the House Health and Human Services Committee and the Joint Budget Committee required by 25.5-5-506(3)(b), C.R.S. (2014). This requirement has been since repealed by HB 16-1081.
[10] Approximately 70 physician administered drugs are recommended to be processed under the complex prior authorization system and undergo an initial peer to peer review.

undergo the standard PAR would only be processed once. Drugs with average annual costs per utilizer that are below the cost of processing a PAR would not be targeted.

Depending on the vendor that is selected for the project, and the PAR processing system, it is possible that an interface would need to be built between the PBMS system and interChange system. This cost of building this interface is estimated to be $630,500 and require 4,850 project hours.

The Department assumes the cost of setting up the interface between the interChange and utilization management system is eligible for a 90 percent federal financial participation (FFP) rate as allowed by 42 CFR § 433.15(b)(3) for design, development, or installation of mechanized claims processing and information retrieval systems. For the components involving processing prior authorizations, the Department anticipates claiming 75 percent FFP under 42 CFR § 433.15(6)(i) for funds expended for the performance of medical and utilization review. In order to claim this enhanced funding, the Department would need to submit an advance planning document (APD) to CMS with implementation details.

Effect of Prior Authorization Policy on Utilization

The Department assumes that implementing a prior authorization system on physician administered drugs would result in a 7.0 percent decrease in utilization of drugs targeted for prior authorization policies. The Department selected this percentage as a conservative estimate based on previous research on the effects of prior authorization on drug utilization.

The findings of prior authorization literature are varied and the results are often only specific to a particular class of drugs or for certain programs.[11] There are frequently other policies taking place at the same time of the research period and this makes it difficult to attribute a change unambiguously to prior authorization policies. The effectiveness of a prior authorization program also depends upon if the class of drugs has other available substitutes. Another limitation is that rebate amounts are confidential and the drug expenditures used in these studies represent expenditure before rebates are applied. As such, the research findings do not necessarily reflect the net effect of a policy change.

The Department assumed that implementing prior authorization on physician administered drugs would result in a 7.0 percent decrease in utilization. This figure is roughly half of the 13.9 percent reduction in market share observed in West Virginia upon putting prior authorization criteria on second-generation antipsychotics (Law et al, 2009). In the West Virginia study, the researchers examined the effect of Medicaid prior authorization policies on utilization of second-generation antipsychotic agents. Specifically they looked at changes in nonpreferred medications in West Virginia and Texas in comparison with other states without similar prior authorization requirements. In West Virginia, implementing prior authorization policies was associated with a 13.9 percent reduction in the market share of nonpreferred drugs over two years.

[11] Maine's prior authorization policy is associated with decreases in the use of nonpreferred drugs and a $3.40 per patient decrease in medication costs for patients with bipolar illness (Zhang et al, 2009). Michigan and Indiana's prior authorization programs on lipid-lowering medications for dual-eligible enrollees is associated with a reduction of $24,548 in prescription expenditures in Michigan and $16,070 in Indiana (Lu et al, 2011). Fischer et al (2004) found prior authorization criteria for cyclooxygenase-2 inhibitors in Medicaid programs was associated with a spending reduction of $185 million annually.

Nonpreferred drug usage in Texas also decreased but this trend was not statistically significant.[12] Phillips (1997) evaluated the effect of prior authorization on drug utilization in Iowa's Medicaid program and found overall 17.1 percent of new and extension prior authorization requests were denied coverage and there was an associated net savings of $2.51 million to $3.83 million for antiarthritics, benzodiazepines, antiulcer, and antihistamines.[13] The Department assumed a lower percentage decrease in utilization than those that can be inferred from Law et al (2009) and Phillips (1997) to remain conservative in its savings estimates. Additionally, the Department assumes a portion of clients would switch to less expensive alternatives, thereby dampening any assumed decrease in drug utilization.

The Department based the cost avoidance calculations on FY 2015-16 claims of a preliminary set of physician administered drugs. The drugs targeted in these calculations do not represent the Department's final decisions on which drugs to prior authorize. The Department would continue to work with stakeholders, such as through the Pharmaceutical and Therapeutics committee, Drug Utilization Review Board, and Medical Services Board before making any determinations. These initiatives would not circumvent existing processes.

The Department assumes there would be no reduction in costs related to visits to the physician's office. Due to the nature of these targeted drugs, the drugs must be administered in a physician's office or another clinical setting. In addition to billing for the drug itself, providers can also bill for an administration fee or an infusion fee depending on how the drug is administered. The Department assumes that the billing for the administration or infusion fee would not change.

Alternative Payment Model (APM)
The Department assumes it would start negotiating APM contracts with manufacturers in spring of 2018 and any agreements would be effective in FY 2018-19. Any associated savings would also be reflected in the FY 2018-19 budget cycle. This timeline is subject to change based on the APMs that the Department chooses to pursue and whether they would need an 1115 demonstration waiver, which can take two years to develop and submit to CMS for approval. The Department would also need to evaluate whether statutory changes are needed to implement the APMs.

The Department estimates it would need $300,500 total funds in contractor funding on an ongoing basis to assist with measuring the health and financial outcomes of the APMs, including compiling any other necessary data outside of Medicaid claims, and planning an 1115 demonstration waiver. This figure is based on an estimate of 500 contract hours for the actuary at an average rate of $250 per hour based on previous actuarial contracts and 1,300 contract hours for the consultant at an average rate of $135 per hour based on contracts of similar scope.

Please see Appendix A for more detailed information on calculations.

---

[12] Law, M.R., Ross-Degnan, D., & Soumerai, S.B. (2008). Effect of prior authorization of second-generation antipsychotic agents on pharmacy utilization and reimbursements. Psychiatric Services, 59(5), 540-546.
[13] Phillips, C. (1997). Evaluating the operational performance and financial effects of a drug prior authorization program. Journal of Managed Care Pharmacy, 3(6), 699-706.

Table 1.1: FY 2018-19 Drug Cost Containment Initiatives by Line Item						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**Comments**
A	**Total Request**	**$132,777**	**($24,407)**	**($39,129)**	**$196,313**	**Sum of Rows B through E**
B	(1) Executive Director's Office, (A) General Professional Services and Special Projects	$300,500	$150,250	$0	$150,250	Row F of Table 2.1
C	(1) Executive Director's Office, (C) Medicaid Management Information System Maintenance and Projects	$630,500	$63,050	$0	$567,450	Row C of Table 2.1
D	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$282,297	$70,574	$0	$211,723	Row A + Row B of Table 2.1
E	(2) Medical Services Premiums	($1,080,520)	($308,281)	($39,129)	($733,110)	Row D of Table 2.1

Footnotes:
(1) Cash funds include decreases of $72 to the Breast and Cervical Cancer Prevention cash fund and $39,057 to the Healthcare Affordability and Sustainability Fee cash fund.

Table 1.2: FY 2019-20 Drug Cost Containment Initiatives by Line Item						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**Comments**
A	**Total Request**	**($1,512,798)**	**($390,093)**	**($102,816)**	**($1,019,889)**	**Sum of Rows B through D**
B	(1) Executive Director's Office, (A) General Professional Services and Special Projects	$300,500	$150,250	$0	$150,250	Row D of Table 2.2
C	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$512,599	$128,150	$0	$384,449	Row A of Table 2.2
D	(2) Medical Services Premiums	($2,325,897)	($668,493)	($102,816)	($1,554,588)	Row B of Table 2.2

Footnotes:
(1) Cash funds include decreases of $155 to the Breast and Cervical Cancer Prevention cash fund and $102,661 to the Healthcare Affordability and Sustainability Fee cash fund.

Table 1.3: FY 2020-21 Drug Cost Containment Initiatives by Line Item						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**Comments**
A	**Total Request**	**($1,671,380)**	**($438,128)**	**($125,656)**	**($1,107,596)**	**Sum of Rows B through D**
B	(1) Executive Director's Office, (A) General Professional Services and Special Projects	$300,500	$150,250	$0	$150,250	Row D of Table 2.3
C	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$531,307	$132,827	$0	$398,480	Row A of Table 2.3
D	(2) Medical Services Premiums	($2,503,187)	($721,205)	($125,656)	($1,656,326)	Row B of Table 2.3

Footnotes:
(1) Cash funds include decreases of $167 to the Breast and Cervical Cancer Prevention cash fund and $125,489 to the Colorado Healthcare Affordability and Sustainability Fee cash fund.

Table 2.1: FY 2018-19 Drug Cost Containment Initiatives

Row	Item	Total Funds	General Fund	Cash Funds[1]	Federal Funds	FFP	Comments
A	Cost of Processing Prior Authorization Requests	$247,297	$61,824	$0	$185,473	75.00%	Table 3.2
B	Implementation Costs of Utilization Management System	$35,000	$8,750	$0	$26,250	75.00%	Table 3.2
C	Developing Interface between interChange and UM System	$630,500	$63,050	$0	$567,450	90.00%	Table 3.2
D	Costs Avoided from Prior Authorization on Physician Administered Drugs (PADs)	($1,080,520)	($308,281)	($39,129)	($733,110)	67.85%	Table 3.1
E	**Utilization Management of Physician Administered Drugs Subtotal**	**($167,723)**	**($174,657)**	**($39,129)**	**$46,063**		**Sum of Rows A through D**
F	Alternative Payment Model (APM) Contractor Resources	$300,500	$150,250	$0	$150,250	50.00%	Table 6.1
G	**Total of Drug Cost Containment Initiatives**	**$132,777**	**($24,407)**	**($39,129)**	**$196,313**		**Row E + Row F**

Footnotes:
(1) Cash funds include decreases of $72 to the Breast and Cervical Cancer Prevention cash fund and $39,057 to the Healthcare Affordability and Sustainability Fee cash fund.

Table 2.2: FY 2019-20 Drug Cost Containment Initiatives

Row	Item	Total Funds	General Fund	Cash Funds[1]	Federal Funds	FFP	Comments
A	Cost of Processing Prior Authorization Requests (PARs)	$512,599	$128,150	$0	$384,449	75.00%	Table 3.2
B	Costs Avoided from Prior Authorization on Physician Administered Drugs (PADs)	($2,325,897)	($668,493)	($102,816)	($1,554,588)	66.84%	Table 3.1
C	**Utilization Management of Physician Administered Drugs Subtotal**	**($1,813,298)**	**($540,343)**	**($102,816)**	**($1,170,139)**		**Row A + Row B**
D	Alternative Payment Model (APM) Contractor Resources	$300,500	$150,250	$0	$150,250	50.00%	Table 6.1
E	**Total of Drug Cost Containment Initiatives**	**($1,512,798)**	**($390,093)**	**($102,816)**	**($1,019,889)**		**Row C + Row D**

Footnotes:
(1) Cash funds include decreases of $155 to the Breast and Cervical Cancer Prevention cash fund and $102,661 to the Healthcare Affordability and Sustainability Fee cash fund.

Table 2.3: FY 2020-21 Drug Cost Containment Initiatives

Row	Item	Total Funds	General Fund	Cash Funds[1]	Federal Funds	FFP	Comments
A	Cost of Processing Prior Authorization Requests (PARs)	$531,307	$132,827	$0	$398,480	75.00%	Table 3.2
B	Costs Avoided from Prior Authorization on Physician Administered Drugs (PADs)	($2,503,187)	($721,205)	($125,656)	($1,656,326)	66.17%	Table 3.1
C	**Utilization Management of Physician Administered Drugs Subtotal**	**($1,971,880)**	**($588,378)**	**($125,656)**	**($1,257,846)**		**Row A + Row B**
D	Alternative Payment Model (APM) Contractor Resources	$300,500	$150,250	$0	$150,250	50.00%	Table 6.1
E	**Total of Drug Cost Containment Initiatives**	**($1,671,380)**	**($438,128)**	**($125,656)**	**($1,107,596)**		**Row C + Row D**

Footnotes:
(1) Cash funds include decreases of $167 to the Breast and Cervical Cancer Prevention cash fund and $125,489 to the Healthcare Affordability and Sustainability Fee cash fund.

Table 3.1: Net Effect of Utilization Management (UM) of Physician Administered Drugs (PADs)					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Comments**
A	Utilization Management Systems Costs	$912,797	$512,599	$531,307	Row D of Table 3.2
B	Decreased Utilization from Prior Authorization Policies	($1,080,520)	($2,325,897)	($2,503,187)	Row K of Table 3.3
C	**Net Effect of PADs Utilization Management**	**($167,723)**	**($1,813,298)**	**($1,971,880)**	**Row A + Row B**

Table 3.2: Utilization Management (UM) Systems Changes					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Comments**
A	Processing Prior Authorization Requests	$247,297	$512,599	$531,307	Row H of Table 4.1
B	Implementation Costs of Utilization Management System	$35,000	$0	$0	Based on contractor estimate
C	Developing Interface between interChange and UM System	$630,500	$0	$0	Row C of Table 4.2
D	**Total**	**$912,797**	**$512,599**	**$531,307**	**Row A + Row B + Row C**

Table 3.3: Decreased Utilization of Physician Administered Drugs (PADs) as a result of Prior Authorization Policies					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Comments**
A	FY 2015-16 Total Units of Service of Targeted PADs	1,933,169	1,933,169	1,933,169	FY 2015-16 MMIS Claims Data
B	Utilization Trend from FY 2015-16	13.50%	17.64%	21.94%	FY 2017-18 S-1 Medical Services Premiums Exhibit B-1 Caseload Trends
C	Estimated Units of Service of Targeted PADs	2,194,178	2,274,266	2,357,276	Row A * (1 + Row B)
D	Estimated Percentage Decrease in Utilization	-7.00%	-7.00%	-7.00%	Assumption based on research on effects of prior authorization on utilization
E	Estimated Utilization avoided with Policy Change	-153,592	-159,199	-165,009	Row C * Row D
F	FY 2017-18 Weighted Average Price of Targeted PADs	$13.55	$13.55	$13.55	Table 5.1; Weighted Average based on FY 2015-16 units of service
G	Drug Price Inflation Factor from FY 2017-18	3.83%	7.81%	11.94%	Three-year weighted average increase of Average Sales Price rates
H	FY 2017-18 Weighted Average Price of Targeted PADs	$14.07	$14.61	$15.17	Row F * (1 + Row G)
I	Full Year Estimate of Costs Avoided	($2,161,039)	($2,325,897)	($2,503,187)	Row E * Row H
J	Portion of Year Policy is Effective	50.00%	100.00%	100.00%	Assume effective date of January 1, 2019
K	**Estimate of Costs Avoided by Fiscal Year**	**($1,080,520)**	**($2,325,897)**	**($2,503,187)**	**Row I * Row J**

Table 4.1: Cost of Prior Authorization on Physician Administered Drugs					
Row	**Items**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Comments**
A	FY 2015-16 Distinct Utilizers	4,472	4,472	4,472	Table 5.1; FY 2015-16 MMIS Claims Data of Preliminarily Targeted PADs
B	Utilization Trend from FY 2015-16	13.50%	17.64%	21.94%	FY 2017-18 S-1 Medical Services Premiums Exhibit B-1 Caseload Trends
C	Estimated Number of Prior Authorization Requests (PARs)	5,076	5,261	5,453	Row A * (1 + Row B)
D	Flexible Prior Authorization Request (PAR) Funding	6,345	6,576	6,816	25% increase in Row C to allow for flexibility in designing PA policies
E	Cost of Processing Complex PAR	$77.95	$77.95	$77.95	Table 5.1; weighted average based on preliminary set of codes targeted for PARs.
F	Full Year Cost Estimate of Prior Authorization	$494,593	$512,599	$531,307	Row D * Row E
G	Portion of Year Policy is Effective	50%	100%	100%	Assume effective date of January 1, 2019
H	**Estimate of Costs Avoided by Fiscal Year**	**$247,297**	**$512,599**	**$531,307**	**Row F * Row G**

Table 4.2: Estimated Cost of Developing Interface between interChange and UM System		
Row	**Items**	**FY 2018-19 Costs**
A	Blended Staff Rate	$130.00
B	Number of Project Hours	4,850
C	**Cost of Developing Interface**	**$630,500**

Table 5.1: Preliminary Set of Physician Administered Drugs (PADs) Targeted for Prior Authorization			
Row	**Item**		**Comments**
A	FY 2015-16 Expenditure of Preliminarily Targeted Drugs	$16,071,108	FY 2015-16 MMIS Claims Data
B	FY 2015-16 Units of Service of Preliminarily Targeted Drugs	1,933,169	FY 2015-16 MMIS Claims Data
C	FY 2015-16 Distinct Utilizers of Preliminarily Targeted Drugs	4,472	FY 2015-16 MMIS Claims Data
D	FY 2015-16 Average Cost Per Utilizer of Preliminarily Targeted Drugs	$3,593.72	Row A / Row C
E	July 2017 Average of ASP Pricing of Preliminarily Targeted Drugs	$13.55	Medicare Part B Drug Average Sales Price
F	Average Suggested Prior Authorization Request (PAR) Cost based on Drug Code	$77.95	Contractor Estimate: $42 for standard PAR and $83 for complex PAR

Table 6.1: Alternative Payment Model Contractor Resources

Row	Item	FY 2018-19	FY 2019-20	FY 2020-21	Comments
	Actuarial Analysis				
A	Contractor Rate	$250.00	$250.00	$250.00	Average actuarial contractor rate based on previous contracts
B	Number of Hours	500	500	500	Estimated number of hours based on previous contracts
C	Total Request for Actuarial Analysis	$125,000	$125,000	$125,000	Row A * Row B
	Consultant for 1115 Demonstration Waiver				
D	Contractor Rate	$135.00	$135.00	$135.00	Average consultant rate based on previous contracts
E	Number of Hours	1,300	1,300	1,300	Estimated number of hours based on previous contracts
F	Total Request for Consultant Hours	$175,500	$175,500	$175,500	Row D * Row E
G	**Total Request for Contractor Resources**	**$300,500**	**$300,500**	**$300,500**	**Row C + Row F**

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-11 Administrative Contracts Adjustments**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___	**Supplemental FY 2017-18**
X	**Change Request FY 2018-19**
___	**Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$23,237,085**	**$0**	**$30,621,702**	**$1,716,842**	**$470,651**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,023,108	$0	$10,218,776	$1,251,367	($23,870)
	CF	$2,070,660	$0	$2,043,004	$831,237	$831,237
	RF	$150,000	$0	$150,000	$0	$0
	FF	$13,993,317	$0	$18,209,922	($365,762)	($336,716)

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- General Professional Services and Special Projects	**Total**	**$9,412,649**	**$0**	**$14,534,207**	**$412,560**	**$470,651**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,005,615	$0	$5,621,706	$206,280	$235,325
	CF	$1,600,352	$0	$1,545,040	$0	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$4,656,682	$0	$7,217,461	$206,280	$235,326
01. Executive Director's Office, (E) Utilization and Quality Review Contracts -- Professional Service Contracts	**Total**	**$13,824,436**	**$0**	**$16,087,495**	**$1,304,282**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,017,493	$0	$4,597,070	$1,045,087	($259,195)
	CF	$470,308	$0	$497,964	$831,237	$831,237
	RF	$0	$0	$0	$0	$0
	FF	$9,336,635	$0	$10,992,461	($572,042)	($572,042)

CF Letternote Text Revision Required?	Yes X No ___	**If Yes, see schedule 4 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 $177,606 total funds, including $88,803 General Fund and $88,803 federal funds for FY 2017-18; $1,716,842 total funds, including $1,251,367 General Fund, $831,237 cash funds, and a reduction of $365,762 federal funds for FY 2018-19; and $470,651 total funds, including a reduction of $23,869 General Fund, and increase of $831,237 cash funds, and a reduction of $336,717 federal funds for FY 2019-20, and ongoing, for adjustments in administrative contract funding for compliance with federal requirements, and changes in federal financial participation rates and vendor rates.

Current Program

- Federal statute requires states to create a Medicaid Asset Verification Program (AVP) that automatically and electronically verifies the liquid assets of Medicaid applications who are aged, blind, and/or disabled, which in Colorado is scheduled to commence in January 2018.
- The Professional Services Contract line provides funding for Acute Care Utilization Review, Long Term Care Utilization Review, External Quality Review, and Drug Utilization Review.

Problem or Opportunity

- The Department underestimated the cost to perform asset verification reviews on all Medicaid applicants and members who are elderly, blind, and/or disabled. The Department originally estimated the cost based on a quote of $3.30 per review provided to another state; however, Colorado's current vendor has determined the cost will be $4.50 per review. The Department has also revised its estimate of the number of reviews needing conducted per year which resulted in a projected increase in costs.
- The funding for Professional Services Contracts line item is out of balance with the allowable federal financial participation rates, and Centers for Medicare and Medicaid Services (CMS) is seeking disallowance of claims made at enhanced match rates for the external quality review organization (EQRO) contract funded under this line.

Consequences of Problem

- Because the Department does not have enough funding for all asset verifications, the Department may not be able to fully comply with federal statute and regulations for verification of assets and could be subjected to corrective action or federal fiscal penalties.
- Without additional appropriations for the Professional Services Contracts line, the Department would be required to reduce the scope of utilization review and external quality review to compensate for shortfalls in federal financial participation and to repay the federal disallowance, leaving the Department without full and complete information necessary to assess appropriateness and quality of services.

Proposed Solution

- The Department requests funding to adjust asset verification cost estimates, to rebalance appropriations between fund sources in the Professional Services Contracts line item rates, and to prepare for disallowance of EQRO claims made at an enhanced match rate.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: ***R-11***

Request Detail: ***Administrative Contracts Adjustments***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Administrative Contracts Adjustments	$1,716,842	$1,251,367

Problem or Opportunity:

The Department has identified areas of the budget for administrative contracts than are not funded at sufficient levels to carry out the functions and responsibilities of the Department. The Department has insufficient funding to perform asset verification reviews for Medicaid applicants; the appropriation for Professional Services Contract line requires adjustments in both state and federal fund sources, which has created a shortfall in State matching funds needed to fully address utilization review and external quality reviews need; and, the Centers for Medicare and Medicaid Services is seeking disallowance of claims made at enhanced match rates for the external quality review organization contract funded under this line.

Asset Verification Program

The Department does not have sufficient appropriations related to performing asset verification reviews for certain Medicaid applicants. As a result, the Department may not be able to compensate its vendor for the required scope of work, which would cause the Department to be out of compliance with federal law related to asset verifications.

The Federal Supplemental Appropriations Act of 2008 modifies section 1940 of the Social Security Act to require every state to create a Medicaid Asset Verification Program (AVP) that automatically and electronically verifies the liquid assets of Medicaid applications who are aged, blind, and/or disabled. Asset verification information must be provided in the initial application for Medicaid and during the redetermination process to qualify for Medicaid. In its FY 2017-18 budget request R-7, “Oversight of State Resources” the Department requested funding for the expected costs of implementing an AVP. However, after a competitive procurement, the Department has found that the costs of implementing an AVP are higher than anticipated.

To estimate the costs of implementing an AVP in its original budget request, the Department used information provided from the Oklahoma Health Care Authority (OHCA), which administers Oklahoma’s Medicaid program. OHCA provided a quote of $3.30 for each review; however, results from the Department’s competitive procurement required payments of $4.50 per review. This is a 36.4% increase per review over

the original estimate. Additionally, the Department has revised its estimate for the number of applications requiring an asset verification review. The Department originally estimated the total number of reviews needing performed to be 130,056 in FY 2017-18 and 260,111 in FY 2018-19. With more current caseload and application data, and better understanding of functionality from the vendor, the Department has updated those figures to be 134,842 in FY 2017-18 (a 3.7% increase), 282,428 in FY 2018-19 (an 8.6% increase) and is including a projected increase to 295,337 in FY 2019-20. Based on both the higher cost per application and higher caseload estimates, there is not sufficient funding available to fully pay for the need of the AVP.

Professional Services Contracts Funding

The funding for Professional Services Contract line item is out of balance with the allowable federal financial participation rates of the current contracts funded under this line. The Department does not have sufficient flexibility within the appropriated line item to fund all contracts at the allowable federal financial participation (FFP) rates. Further, the Department has an opportunity to reduce overall General Fund expenditure by allocating cash fund revenue from the Healthcare Affordability and Sustainability (HAS) Fee Cash Fund to administration costs.

The change in FFP rates is the result of new managed care rules[1] relating to external quality reviews activities. Federal regulations at 42 CFR § 438, subpart E, set forth the parameters that states must follow when conducting an external quality review of its delivery systems including its managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). An external quality review is the analysis and evaluation by an external quality review organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors, furnish to Medicaid recipients. Though not all the activities stipulated in the contract with the EQRO are federally required, the activities are considered mission-critical by the Department to provide both qualitative and quantitative data used to improve overall health of the Medicaid population, improve client engagement in their overall health, and reduce unnecessary expenditures.

In a letter from the Centers for Medicare and Medicaid Services (CMS) dated October 26, 2015, CMS provided notice to the Department that activities or functions included in the Department's EQRO contract related to the Accountable Care Collaborative (ACC) Regional Care Collaborative Organizations (RCCOs) do not qualify for the 75% enhanced match authorized at 42 CFR § 438.370. The ACC is considered a primary care case management (PCCM) organization, and federal regulations do not permit usage of the enhanced match for PCCMs. In response to the letter, in January 2016, the Department submitted a supplemental budget request, S-12, BA-12, "External Quality Review Organization FFP Adjustment," which requested additional General Fund based on the expected determination of qualifying activities for the enhanced FFP. However, subsequent guidance from CMS through an information bulletin published on June 10, 2016[2] clarifies that under 42 CFR §§ 433.15 and 438.370, FFP is only available at the 50% matching rate for mandatory and optional EQR-related activities for PIHPs, PAHPs and affected PCCM entities as well as for production of the EQR technical report. This is a change from the previous regulations, under which the enhanced 75% match was available for EQR of PIHPs to the same extent as MCOs. States may, but are not required to,

---

[1] https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html

[2] https://www.medicaid.gov/federal-policy-guidance/downloads/cib061016.pdf

conduct EQR activities for Fee-for-Service (FFS) delivery systems. Federal financial participation for FFS quality activities continues to be available at the regular 50% administrative match. Based on this subsequence guidance from CMS, the Department has insufficient state funding to pay for the full scope of external quality reviews activities.

In addition to the change in federal funding, the Department has an opportunity to allocate additional cash funds to the appropriation. Specifically, funding from the HAS Fee Cash Fund currently comprises 7.7% of the total appropriation for the line item, but populations funded by the HAS Fee Cash Fund composed approximately 34.5% of total Medicaid caseload. As such, it is appropriate to increase the share of HAS Fee Cash Fund in the appropriation.

External Quality Review Organization Disallowance

Related to the CMS' determination that external quality review activities for RCCOs do not qualify for the enhanced federal match rate, CMS has issued deferral letters to the Department requesting reimbursement of federal funds claimed at enhanced 75% FFP claimed for related activities in the Department's EQRO contract over the period beginning April 1, 2014 and ending June 30, 2016. CMS' position is that these activities only qualify for 50% FFP. The Department is actively contesting CMS's decision via the standard appeals process; however, if the Department fails in that effort, there is not sufficient funding available to repay these funds to CMS.

Proposed Solution:

The Department requests $177,606 total funds, including $88,803 General Fund and $88,803 federal funds for FY 2017-18; $1,716, 842 total funds, including $1,251,367 General Fund, $831,237 cash funds, and a reduction of $365,762 federal funds for FY 2018-19; and $470,651 total funds, including a reduction of $23,869 General Fund, an increase of $831,237 cash funds, and a reduction of $336,717 federal funds for FY 2019-20, and ongoing , to adjust asset verification cost estimates, to rebalance the Professional Services Contracts line item to current FFP rates, and to prepare for disallowance of EQRO claims made at an enhanced match rate.

Asset Verification Program

The Department requests an additional $177,606 total funds, including $88,803 General Fund, for FY 2017-18; $412,560 total funds, including $206,280 General Fund, for FY 2018-19; and $470,651 total funds, including $235,326 General Fund, for FY 2019-20; to perform the appropriate number of asset verification reviews as mandated by the Federal Supplemental Appropriations Act of 2008.

Without proper funding, the Department would be unable to fully compensate the vendor for start-up costs associated with implementing the AVP, and would not have enough funding to pay for all the expected asset verifications required under federal law. In turn, this could lead to the Department being out of compliance with federal law, and the Department would be subject to disallowances of FFP for costs incurred by clients who have gained eligibility without complete asset verification.

Professional Services Contracts Funding

The Department requests $0 total funds, including a reduction of $259,195 General Fund, increase of $831,237 cash funds, and a reduction of $572,042 federal funds in FY 2018-19 and ongoing to rebalance the

available funding to the current allowable FFP rates for the Department's contracts funded through the Professional Services Contracts line. This request also includes a rebalancing of appropriations between the General Fund and the HAS Fee Cash Fund.

Without an adjustment to the funding sources, the Department would not have sufficient spending authority for its Professional Services Contracts line item. Without sufficient spending authority, the Department may be required to reduce scopes-of-work within certain contracts, or eliminate other contracts entirely. This could lead to the Department being out of compliance with federal law, and the Department would be subject to disallowances of FFP if federally required activities are not taking place.

External Quality Review Organization Disallowance
The Department requests $1,304,282 General Fund in FY 2018-19 to provide one-time spending authority for a potential disallowance of federal funds claimed at an enhanced 75% FFP for services within the EQRO contract that occurred during FY 2014-15 and FY 2015-16. CMS contends these costs only qualified for a 50% administrative FFP and has provided notice of deferral for the claims in question.

Without additional appropriations to repay the federal government, CMS would withhold payments from the Department's federal Medicaid grants. If this occurred, the Department would not have sufficient funding to pay for required external quality review activities, which could lead to the Department being out of compliance with federal law, and the Department would be subject to additional disallowances of FFP if federally required activities are not taking place.

Anticipated Outcomes:

Asset Verification Program
Approval of this request would ensure the Department can perform Asset Verification Program (AVP) reviews on all Medicaid applicants and members who are elderly, blind, and/or disabled, as required by federal statute. Should the Department be unable to complete all required AVP reviews, the State would be at risk of CMS restricting the amount of federal funding the State receives to administer Medicaid in the State of Colorado. 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 implementing a robust AVP may decrease the amount of General Fund needed by the Department if the Department finds clients who have assets that were previously unknown. This request aligns with the Department's strategies to "Promote rigorous compliance with compliance with federal and state laws and regulations, fiscal rules, and internal operating procedures" and to "Support counties and medical assistance sites with technical assistance for processing eligibility applications accurately and efficiently" by assuring that assets of clients and members are adequately assessed and benefits are appropriately authorized or denied.

Professional Services Contracts Funding
Approval of this request would allow the Department to adequately contract for mission critical services that assist the Department in the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services. The request addresses the Department initiatives to decrease inappropriate utilization of benefits, improve provider satisfaction and ease, and promote continuity of member care, and

to ensure provider payments are tied to quality or value through innovative payment methods. Enforcing proper use of benefits and identifying potential areas for improvement and fiscal stewardship are critical to managing benefit utilization which promotes the Department strategy to "Ensure robust management of Medicaid benefits".

External Quality Review Organization Disallowance

Approval of this request would ensure that the Department has sufficient funding to continue external quality review activities if the Department is unsuccessful in defending its position that the claims at the enhanced match rate were allowable. This request aligns with the Department's Performance Plan strategy to 'Promote rigorous compliance with federal and state laws and regulations, fiscal rules, and internal operating procedures' by ensuring the Department has adequate appropriations to comply with federal regulations.

Assumptions and Calculations:

Detailed calculations for this request are included on the attached appendix.

Asset Verification Program

The Department is using more current application and redetermination data and information provided by the vendor on cost per asset verification review to calculate the new amounts needed. The current vendor has determined the cost would be $4.50 per review. The Department's implementation of this project was delayed until January 2018, which is shifting expenditures into FY 2017-18. Therefore, the supplemental cost impact is included within this decision item for a complete representation of the need. Calculations are included in tables 3.1 through 3.4.

Professional Services Contracts Funding

The rebalance of funding requested is based on the FFP rates for services and activities for current FY 2017-18 contracts. The Department has adjusted fund splits between the General Fund and the HAS Fee cash fund based on current caseload statistics. The Department's calculations are shown in tables 4.1 through 4.4.

External Quality Review Organization Disallowance

The potential disallowance is based on actual amounts provided to the Department in letters of deferral from CMS, which are shown on table 5.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

Asset Verification

The Department received new data resulting in substantive changes in funding needs. The Department competitively procured the vendor for the AVP, which resulted in higher costs than were expected at the time of the original budget request. This new information was not available at the time the original request was made, and substantially changes the level of funding needed to meet the federal requirement.

Table 1.1 FY 2017-18 Administrative Contracts Adjustments Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services	$177,606	0.0	$88,803	$0	$0	$88,803	50.00%	Table 3.1 Row A
B	**Total Request**	**$177,606**	**0.0**	**$88,803**	**$0**	**$0**	**$88,803**	**50.00%**	Row A

Table 1.2 FY 2018-19 Administrative Contracts Adjustments Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds1**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services	$412,560	0.0	$206,280	$0	$0	$206,280	50.00%	Table 3.1 Row B
B	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$1,304,282	0.0	$1,045,087	$831,237	$0	($572,042)	NA	Table 4.1 Row E
C	**Total Request**	**$1,716,842**	**0.0**	**$1,251,367**	**$831,237**	**$0**	**($365,762)**	**NA**	Row A + Row B

Table 1.3 FY 2019-20 and Ongoing - Administrative Contracts Adjustments Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services	$470,651	0.0	$235,326	$0	$0	$235,325	50.00%	Table 3.1 Row C
B	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$0	0.0	($259,195)	$831,237	$0	($572,042)	NA	Table 4.1 Row E
C	**Total Request**	**$470,651**	**0.0**	**($23,869)**	**$831,237**	**$0**	**($336,717)**	**NA**	Row A + Row B

Table 1.4 - Cash Funds Detail								
			FY 2018-19			FY 2019-20		
Row	Line Item	Fund Source	FY 2017-18 LB Appropriation	Incremental Request	Revised Total	FY 2017-18 LB Appropriation	Incremental Request	Revised Total
	EDO (E) Utilization and Quality Review Contracts;							
A	Professional Services Contract	Healthcare Affordability and Sustainability Fee Cash Fund	$372,339	$831,237	**$1,203,576**	$372,339	$831,237	**$1,203,576**
B		Medicaid Nursing Facility Cash Fund	$9,219	$0	**$9,219**	$9,219	$0	**$9,219**
C		Adult Dental Fund	$88,750	$0	**$88,750**	$88,750	$0	**$88,750**
D	**Section Total**		**$470,308**	**$831,237**	**$1,301,545**	**$470,308**	**$831,237**	**$1,301,545**

Table 2.1 FY 2017-18 Administrative Contracts Adjustments Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Asset Verification Program	$177,606	0.0	$88,803	$0	$0	$88,803	50.00%	Table 3.1 Row A
B	**Total Estimate**	**$177,606**	**0.0**	**$88,803**	**$0**	**$0**	**$88,803**	**NA**	Row A

Table 2.2 FY 2018-19 Administrative Contracts Adjustments Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Asset Verification Program	$412,560	0.0	$206,280	$0	$0	$206,280	50.00%	Table 3.1 Row B
B	Professional Services Contract Line Item FFP True-up	$0	0.0	($259,195)	$831,237	$0	($572,042)	NA	Table 4.1 Row E
C	External Quality Review Disallowance	$1,304,282	0.0	$1,304,282	$0	$0	$0	0.00%	Table 5 Row J
D	**Total Estimate**	**$1,716,842**	**0.0**	**$1,251,367**	**$831,237**	**$0**	**($365,762)**	**NA**	Sum Rows A thru C

Table 2.3 FY 2019-20 Administrative Contracts Adjustments Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Asset Verification Program	$470,651	0.0	$235,326	$0	$0	$235,325	50.00%	Table 3.1 Row C
B	Professional Services Contract Line Item FFP True-up	$0	0.0	($259,195)	$831,237	$0	($572,042)	NA	Table 4.1 Row E
C	**Total Estimate**	**$470,651**	**0.0**	**($23,869)**	**$831,237**	**$0**	**($336,717)**	**NA**	Sum Rows A thru B

Table 3.1 Summary of Incremental Request by Fund Splits Asset Verification Program (AVP)									
Row	**Fiscal Year**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Source**
A	FY 2017-18	$177,606	0.0	$88,803	$0	$0	$88,803	50.00%	Table 3.2 Row H
B	FY 2018-19	$412,560	0.0	$206,280	$0	$0	$206,280	50.00%	Table 3.3 Row G
C	FY 2019-20 and Ongoing	$470,651	0.0	$235,326	$0	$0	$235,325	50.00%	Table 3.4 Row G

Table 3.2 FY 2017-18 Asset Verification Program (AVP) Revised Cost Estimate			
Row	**Item**	**Amount**	**Source**
A	Original Estimated AVP Reviews Needing Conducted	130,056	FY 2017-18 R-7 Oversight of State Resources Request
B	Original Cost per Verification	$3.30	FY 2017-18 R-7 Oversight of State Resources Request
C	**Original Cost Estimate**	**$429,183**	Row A * Row B
D	Revised Projected FY 2017-18 Application Total	269,684	Estimated Elderly,Blind, Disabled Application Projections
E	**Projected Total Applications Requiring AVP Review**	**134,842**	Row D / 2 (six months only)
F	Revised Estimated Cost per Verification	$4.50	Vendor Estimate
G	**Revised Cost Estimate**	**$606,789**	Row E * Row F
I	**Incremental Request**	**$177,606**	Row G - Row C + Row H

Table 3.3 FY 2018-19 Asset Verification Program (AVP) Revised Cost Estimate			
Row	**Item**	**Amount**	**Source**
A	Original Estimated AVP Reviews Needing Conducted	260,111	FY 2017-18 R-7 Oversight of State Resources Request
B	Original Cost per Verification	$3.30	FY 2017-18 R-7 Oversight of State Resources Request
C	**Original Cost Estimate**	**$858,366**	Row A * Row B
D	Revised Projected Total Applications Requiring AVP Review	282,428	Estimated Elderly, Blind, Disabled Application Projections
E	Revised Estimated Cost per Verification	$4.50	Vendor Estimate
F	**Revised Cost Estimate**	**$1,270,926**	Row D * Row E
G	**Incremental Request**	**$412,560**	Row F - Row C

Table 3.4 FY 2019-20 Asset Verification Program (AVP) Revised Cost Estimate			
Row	**Item**	**Amount**	**Source**
A	Original Estimated AVP Reviews Needing Conducted	260,111	Table 3.2 Row A , FY 2017-18 R-7 Ongoing Request
B	Original Cost per Verification	$3.30	Table 3.2 Row B , FY 2017-18 R-7 Ongoing Request
C	**Original Cost Estimate**	**$858,366**	Row A * Row B
D	Revised Projected Total Applications Requiring AVP Review	295,337	Estimated Elderly,Blind, Disabled Application Projection
E	Revised Estimated Cost per Verification	$4.50	Vendor Estimate
F	**Revised Cost Estimate**	**$1,329,017**	Row D * Row E
G	**Incremental Request**	**$470,651**	Row F - Row C

Table 4.1 FY 2018-19 and Ongoing Summary of Incremental Request by Fund Source Professional Services Contracts Line Item FFP True-Up								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**	**Source**
A	FY 2018-19 Base Budget	$13,824,436	0.00	$4,017,493	$470,308	$9,336,635	67.54%	SB 17-254 Long Bill
B	Annualization of FY 2018-19 R-09 Long Term Utilization Management & FY 2016-17 BA-10 ACC MMP Grant Funding True-Up	$2,263,059	0.00	$579,577	$27,656	$1,655,826	73.17%	Base Request
C	**FY 2018-19 Continuation Budget**	**$16,087,495**	**0.00**	**$4,597,070**	**$497,964**	**$10,992,461**	**68.33%**	**Row A + Row B**
D	Revised Fund Split by Current FFP Rates	$16,087,495	0.00	$4,337,875	$1,329,201	$10,420,419	64.77%	
E	**Incremental Request**	**$0**	**0.00**	**($259,195)**	**$831,237**	**($572,042)**	**-3.56%**	Row B - Row A

Table 4.2 FY 2018-19 EDO (E); Professional Services Contracts Appropriation by Budget Component								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**	**Source**
A	**FY 2018-19 Spending Authority**	**$16,087,495**	**0.0**	**$4,597,070**	**$497,964**	**$10,992,461**	**68.33%**	**Sum of Rows B thru E**
B	Acute Care Utilization Review	$5,881,972	0.0	$1,154,590	$315,905	$4,411,477	75.00%	Breakout of Appropriation by Budget Components
C	Long-Term Care Utilization Review	$6,295,498	0.0	$2,034,488	$36,875	$4,224,135	67.10%	
D	External Quality Review	$3,263,246	0.0	$1,133,359	$118,013	$2,011,874	61.65%	
E	Drug Utilization Review	$646,779	0.0	$274,633	$27,171	$344,975	53.34%	

Table 4.3 FY 2018-19 Revised Fund Split of Budget Components by Current FFP Rates								
Row	**Budget Component**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**	**% of Component by Current FFP Rate**
A	**Acute Care Utilization Review**	**$5,881,972**	**0.0**	**$1,031,935**	**$542,816**	**$4,307,221**	**73.23%**	100.00%
B		$417,032	0.0	$136,641	$71,875	$208,516	50.00%	7.09%
C		$5,464,940	0.0	$895,294	$470,941	$4,098,705	75.00%	92.91%
D	**Long-Term Care Utilization Review**	**$6,295,498**	**0.0**	**$2,138,535**	**$36,875**	**$4,120,088**	**65.44%**	100.00%
E		$2,406,139	0.0	$1,188,976	$14,094	$1,203,069	50.00%	38.22%
F		$3,889,359	0.0	$949,559	$22,781	$2,917,019	75.00%	61.78%
G	**External Quality Review**	**$3,263,246**	**0.0**	**$955,487**	**$638,038**	**$1,669,721**	**51.17%**	100.00%
H		$3,110,852	0.0	$934,666	$620,760	$1,555,426	50.00%	95.33%
I		$152,394	0.0	$20,821	$17,278	$114,295	75.00%	4.67%
J	**Drug Utilization Review**	**$646,779**	**0.0**	**$211,918**	**$111,472**	**$323,389**	**50.00%**	100%
K		$646,779	0.0	$211,918	$111,472	$323,389	50.00%	100.00%
L		$0	0.0	$0	$0	$0	75.00%	0.00%
M	**Total**	**$16,087,495**	**0.0**	**$4,337,875**	**$1,329,201**	**$10,420,419**		Sum Rows A, D, G, and J

Table 4.4 FY 2018-19 EDO (E); Professional Services Contracts Variance								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**	**Source**
A	**FY 2018-19 Spending Authority**	**$0**	**0.0**	**($259,195)**	**$831,237**	**($572,042)**		Sum of Rows B thru E
B	Acute Care Utilization Review	$0		($122,655)	$226,911.00	($104,256)	-1.77%	Table 4.3 Row A - Table 4.2 Row B
C	Long-Term Care Utilization Review	$0		$104,047	$0	($104,047)	-1.66%	Table 4.3 Row D - Table 4.2 Row C
D	External Quality Review	$0		($177,872)	$520,025	($342,153)	**-10.48%**	Table 4.3 Row G - Table 4.2 Row D
E	Drug Utilization Review	$0		($62,715)	$84,301	($21,586)	**-3.34%**	Table 4.3 Row J - Table 4.2 Row E

Table 5 - Summary of CMS Deferral Notices External Quality Review Organization (EQRO)				
Row	**Description**	**Period Covered / Quarter ending**	**Amount**	**Source**
A	CO-2014-3-E-02-ADM	06/30/2014	$123,704	CMS Letter Dated: April 18, 2016
B	CO-2014-4-E-04-ADM	09/30/2014	$208,060	CMS Letter Dated: May 06, 2016
C	CO-2015-1-E-03-ADM	12/31/2014	$90,614	CMS Letter Dated: June 23, 2016
D	CO-2015-2-E-05-ADM	03/31/2015	$150,311	CMS Letter Dated: July 07, 2016
E	CO-2015-3-E-07-ADM	06/30/2015	$178,110	CMS Letter Dated: July 13, 2016
F	CO-2015-4-E-09-ADM	09/30/2015	$150,268	CMS Letter Dated: September 15, 2016
G	CO-2016-1-E-02-ADM	12/31/2015	$172,484	CMS Letter Dated: October 27, 2016
H	CO-2016-2-E-03-ADM	03/31/2016	$140,804	CMS Letter Dated: December 6, 2016
I	CO-2016-3-E-04--ADM	06/30/2016	$89,927	CMS Letter Dated: May 12, 2017
J	**Total**		**$1,304,282**	Sum (Row A:Row I)

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-12 Children's Habilitation Residential Program Transfer**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___	Supplemental FY 2017-18
X	Change Request FY 2018-19
___	Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$7,726,516,843	$0	$7,675,514,394	$210,455	$535,213
	FTE	418.4	0.0	427.4	1.8	2.0
	GF	$2,150,183,206	$0	$2,138,078,078	$105,230	$267,607
	CF	$891,469,281	$0	$889,248,200	$0	$0
	RF	$72,795,832	$0	$73,002,147	$0	$0
	FF	$4,612,068,524	$0	$4,575,185,969	$105,225	$267,606

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- Personal Services	Total	$30,884,154	$0	$32,040,094	$141,876	$156,309
	FTE	418.4	0.0	427.4	1.8	2.0
	GF	$10,512,849	$0	$10,769,424	$70,938	$78,154
	CF	$2,985,184	$0	$3,045,883	$0	$0
	RF	$1,885,978	$0	$2,242,657	$0	$0
	FF	$15,500,143	$0	$15,982,130	$70,938	$78,155
01. Executive Director's Office, (A) General Administration -- Health, Life, and Dental	Total	$3,637,126	$0	$4,639,956	$15,854	$15,854
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,305,776	$0	$1,673,531	$7,927	$7,927
	CF	$344,132	$0	$297,330	$0	$0
	RF	$103,855	$0	$135,355	$0	$0
	FF	$1,883,363	$0	$2,533,740	$7,927	$7,927

01. Executive Director's Office, (A) General Administration -- Short-term Disability	**Total**	**$58,060**	**$0**	**$60,583**	**$241**	**$266**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,586	$0	$22,803	$121	$133
	CF	$4,802	$0	$3,381	$0	$0
	RF	$1,364	$0	$1,484	$0	$0
	FF	$30,308	$0	$32,915	$120	$133

01. Executive Director's Office, (A) General Administration -- Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,851,815**	**$6,357**	**$7,003**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$697,024	$3,179	$3,502
	CF	$133,634	$0	$103,331	$0	$0
	RF	$37,970	$0	$45,371	$0	$0
	FF	$843,045	$0	$1,006,089	$3,178	$3,501

01. Executive Director's Office, (A) General Administration -- Supplemental Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,851,815**	**$6,357**	**$7,003**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$697,024	$3,179	$3,502
	CF	$133,634	$0	$103,331	$0	$0
	RF	$37,970	$0	$45,371	$0	$0
	FF	$843,045	$0	$1,006,089	$3,178	$3,501

01. Executive Director's Office, (A) General Administration -- Operating Expenses	**Total**	**$2,162,529**	**$0**	**$2,082,684**	**$10,270**	**$1,900**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$961,889	$0	$948,995	$5,135	$950
	CF	$74,170	$0	$70,519	$0	$0
	RF	$26,219	$0	$13,297	$0	$0
	FF	$1,100,251	$0	$1,049,873	$5,135	$950

01. Executive Director's Office, (A) General Administration -- General Professional Services and Special Projects	**Total**	**$9,412,649**	**$0**	**$14,534,207**	**$29,500**	**$29,500**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,005,615	$0	$5,621,706	$14,750	$14,750
	CF	$1,600,352	$0	$1,545,040	$0	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$4,656,682	$0	$7,217,461	$14,750	$14,750

02. Medical Services Premiums -- Medical Services Premiums	**Total**	**$7,597,898,847**	**$0**	**$7,538,955,686**	**$67,940**	**$67,940**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	$33,971	$33,970
	CF	$886,165,101	$0	$884,043,394	$0	$0
	RF	$70,552,476	$0	$70,368,612	$0	$0
	FF	$4,548,653,004	$0	$4,507,666,920	$33,969	$33,970

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Children's Extensive Support Services	**Total**	**$28,030,392**	**$0**	**$28,030,392**	**$2,515,319**	**$2,579,167**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$14,015,196	$0	$14,015,196	$1,257,660	$1,289,584
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$14,015,196	$0	$14,015,196	$1,257,659	$1,289,583

04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (1) Program Costs -- Case Management	**Total**	**$35,792,246**	**$0**	**$36,056,416**	**$0**	**$253,530**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$18,925,860	$0	$19,050,242	$0	$126,765
	CF	$28,272	$0	$35,991	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$16,838,114	$0	$16,970,183	$0	$126,765

07. Department of Human Services Medicaid-Funded Programs, (D) Division of Child Welfare - Medicaid Funding -- Child Welfare Services	**Total**	**$15,410,746**	**$0**	**$15,410,746**	**($2,583,259)**	**($2,583,259)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,705,373	$0	$7,705,373	($1,291,630)	($1,291,630)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$7,705,373	$0	$7,705,373	($1,291,629)	($1,291,629)

CF Letternote Text Revision Required? Yes ___ No _X_ **If Yes, see schedule 4 fund source detail.**

RF Letternote Text Revision Required? Yes ___ No _X_

FF Letternote Text Revision Required? Yes ___ No _X_

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 $210,455 total funds, including $105,230 General Fund and 1.8 FTE, in FY 2018-19, $535,213 total funds, including $267,607 General Fund and 2.0 FTE, in FY 2019-20, and $505,713 total funds, including $252,859 General Fund and 2.0 FTE, in FY 2020-21 to transfer the Home and Community Based Services Children's Habilitation Residential Program (HCBS-CHRP) from the Department of Human Services (CDHS) to the Department of Health Care Policy and Financing (HCPF), stakeholder outreach, to add transition services to the program, and to account for anticipated caseload increases in the waiver. Of the requested FTE, one position would be transferred from CDHS, and one position would be new.

Current Program

- HCBS-CHRP is a Medicaid-financed program that provides treatment and out of home services for foster children with intellectual and developmental disabilities (IDD).
- HCBS-CHRP is currently operated by CDHS Division of Child Welfare.

Problem or Opportunity

- Colorado needs a program/funding option to provide crisis stabilization and out of home services for children with intellectual and developmental disabilities who have complex behavioral supports needs.
- The CHRP waiver is the only out of home option for children with intellectual or developmental disabilities. For years, it has been used to try and address the need for crisis stabilization and out of home placement.
- As a component of the child welfare system, children on HCBS-CHRP must be in foster care. This precludes all children living in their family home from the waiver. When children with IDD exhibit complex and dangerous behaviors it becomes unsafe for the child to live at home, the family can either place the child in a hospital at a great cost to the state, send the child to a facility that provides residential services to children, or give up custody and place the child in foster care.
- The CHRP waiver is not fully utilized, in part because case workers do not have the specialization in intellectual and developmental disabilities (IDD) necessary to best facilitate access to HCBS-CHRP services.
- There is an opportunity to leverage HCPF's expertise in providing HCBS services to individuals with IDD to improve the structure of service delivery in HCBS-CHRP and ultimately improve client outcomes.

Consequences of Problem

- In its current form, HCBS-CHRP is not optimally serving the interests of I/DD individuals because families are required to surrender custody of their child to access HCBS-CHRP services.
- Children and youth on the waiver are paired with case workers who are not specialized in service coordination for children and youth with an IDD.

Proposed Solution

- The Department requests that the operations of the HCBS-CHRP waiver be transferred from the Department of Human Services to HCPF and to remove the foster care requirement from the waiver.
- The Department requests funding to implement transitional services as a waiver service to prevent out of home placement, where possible, and facilitate the return from out-of-home placement to the home.
- The Department requests to move HCBS-CHRP case management responsibilities from county case workers to Community Centered Boards (CCB) and Case Management Agencies (CMA).
- The Department requests funding for an additional FTE to fully develop and oversee the policy changes required to the HCBS-CHRP waiver to implement this request.

FY 2018-19 Funding Request | November 1, 2017

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: ***R-12***

Request Detail: ***Children's Habilitation Residential Program Transfer***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Children's Habilitation Residential Program Transfer	$210,455	$105,230

Problem or Opportunity:

The Home and Community Based Services Children's Habilitation Residential Program (HCBS-CHRP) waiver, was created to provide residential services for children and youth in foster care with an intellectual or developmental disability and very high needs. The behaviors exhibited by these children are so severe and dangerous they place themselves, their families and their communities in danger.

HCBS-CHRP is currently operated as part of the Child Welfare Services Program administered by the Department of Human Services (CDHS). Section 25.5-5-306, C.R.S. currently limits HCBS-CHRP eligibility to children who are "placed by the Department of Human Services or through county departments of social services in licensed or certified out-of- home placement facilities." This statute creates several problems that this request aims to remedy:

1. This language requires that child or youth be in the foster care system to receive services through HCBS-CHRP. This effectively prohibits access to HCBS-CHRP services for families who do not want to forfeit custody of their child, because State foster care rules require the natural family of a child to forfeit parental rights. Because of this, when families have a child who exhibits dangerous behaviors, and it becomes unsafe for the child to live at home, a family can either place the child in a hospital, send the child to a facility that provides residential services to children, or to give up custody and place the child in foster care in order to qualify the child for HCBS-CHRP services.

2. Service delivery coordination is currently administered by county child welfare case workers. These case workers are trained to support children who have experienced abusive or neglectful home situations but are not often trained to coordinate services for individuals with IDD. These case workers are many times less familiar and less connected with the IDD provider network than case managers who specialize in service coordination for all other HCBS waivers for individuals with IDD.

3. Service providers for the HCBS-CHRP waiver are limited to child welfare agencies making it difficult to leverage the existing network of IDD providers.

The HCBS-CHRP waiver provides services for youth with IDD within the child welfare system whose needs are high enough that they would be at risk of institutionalization without these services. The HCBS-CHRP waiver is the only out-of-home option for children with intellectual or developmental disabilities. For years, the waiver has been used to try and address the need for crisis stabilization and out of home placement outlined above. Historically, however, families who were not negligent or abusive felt forced to relinquish custody of their child to the child welfare system, so that their child could receive out of home support. This has led to a mismatch between the available resources and the need; counties performing case management for children in the child welfare program typically support children who have been abused or neglected, whereas the children enrolled in this waiver program have intellectual or developmental disabilities with behaviors that are so severe and dangerous they place themselves, their families, and their communities in danger.

Children meeting the risk of institutionalization criteria can exhibit severe behaviors, including violent actions that can make them unsafe for a family living at home, particularly as the child ages. The services covered by the HCBS-CHRP waiver can mitigate the severity of behavioral issues; however, as a part of the child welfare system, a family cannot access HCBS-CHRP services unless they surrender custody of their child. As an alternative, families have sent their child to a hospital during a behavioral crisis, often for an extended period. During a crisis – and often after repeated crises – families will take their child to the emergency room. With few options, families are sometimes left with no better option than to leave the child at the hospital until appropriate wrap-around services are available; however, because service options are limited, these children may spend months at the hospital until their families agree to take them home. If the child qualifies for Medicaid, these extended hospital stays occur at a significant cost to the state. Another alternative is to place the child in a facility that provides residential services for children. There are few of these facilities in Colorado and this has led to many families moving their children out of state, away from their families and communities maintain custody of their child while keeping the remainder of their family safe.

The Department and CDHS agree that it is not in the best interest of children and families to require that children enter the foster care system to receive HCBS-CHRP services. It is also an ineffective and inappropriate use of child welfare resources. Family involvement is beneficial to the development of children and the services offered through HCBS-CHRP should be available to all children who meet income and level of care eligibility requirements, whether with their family or outside of the home. The requirement that children enter foster care to receive HCBS-CHRP services harms families by forcing them to choose services for their child or custody of their child. This decision has forced some families to place their children in hospitals for extended periods of time and these stays can cost the state a significant amount of money if the child is Medicaid eligible. For these reasons, the foster care requirement does not benefit children, families, or the state.

The optimal place for waiver operation is with HCPF. As administrators of all other HCBS waivers, transfer of the program to the Department would open the opportunity to leverage the Department's waiver

administration expertise and lines of communication to providers and stakeholders in the IDD community. These resources would allow the Department to support the HCBS-CHRP administrator with waiver operations and identification of areas of potential improvement. The Department has already identified two possible improvements.

The Department sees an opportunity to improve service coordination by transferring of HCBS-CHRP case management from county child welfare case workers to IDD case managers at CCBs and CMAs. These case managers are specifically trained to coordinate services for individuals with an IDD and are better connected with the network of IDD providers than county child welfare case workers.

Removal of the foster care requirement would potentially allow for children currently living in foster care settings to return to their homes. This creates a potential problem as there are not services focused on setting transitions within the HCBS-CHRP waiver. The Department has identified an opportunity to facilitate these transitions with the addition of transition specific services to the waiver. These services would focus on the logistics of the physical move as well as service provider changes.

Proposed Solution:

The Department requests $210,455 total funds, including $105,230 General Fund and 1.8 FTE, in FY 2018-19, $535,213 total funds, including $267,607 General Fund and 2.0 FTE, in FY 2019-20, and $505,713 total funds, including $252,859 General Fund and 2.0 FTE, in FY 2020-21 to transfer the Home and Community Based Services Children's Habilitation Residential Program (HCBS-CHRP) from the Department of Human Services (CDHS) to the Department of Health Care Policy and Financing (HCPF), stakeholder outreach, to add transition services to the program, and to account for anticipated caseload increases in the waiver. Of the requested FTE, one position would be transferred from CDHS, and one position would be new. To move the waiver to HCPF, a legislative change is required to modify section 25.5-5-306, C.R.S. to allow for the waiver to be administered outside of the CDHS child welfare system.

The Department requests that the Joint Budget Committee sponsor legislation to modify section 25.5-5-306, C.R.S. to remove the statutory requirements requiring children to be placed in foster care prior to receiving services through HCBS-CHRP, and to transfer the program and its appropriations from CDHS to HCPF. The Department requests that the transfer of resources and appropriations be effective July 1, 2018, although the departments would maintain the existing infrastructure until the Centers for Medicare and Medicaid Services (CMS) approves a waiver amendment related to the changes. The departments would enact interagency agreements for FY 2018-19 to ensure that program operations would continue until CMS grants approval.

The Department requests funding for stakeholder engagement beginning on July 1, 2018 and continuing through June 30, 2020 to facilitate provider and client outreach and identification of clients in need of transitional services. Outreach would take place before case management moves, before new services are implemented, and before case management moves to CCBs and CMAs and after to ensure provider and client family concerns are being considered in the Department's actions.

The Department requests funding to transfer HCBS-CHRP case management services from child welfare case managers to CCBs and other case management agencies. The Department would transfer HCBS-CHRP

case management duties from the CDHS child welfare case workers to more specialized case managers at CCBs. This would allow children and families to access services coordination from case managers more familiar with the IDD system trained to interact with individuals who have an IDD. The Department would facilitate this change throughout FY 2018-19 with a targeted implementation date of July 1, 2019.

The Department requests funding to add transition services to the program to prevent out of home placements and in order to allow for children to leave hospitals and out-of-state placements to move back into their home. This initial phase can be the deciding factor for a successful transition by ensuring that a compatible provider is available to serve the client. Transition Services will facilitate a change in residential setting by assisting with logistics of the move out of a residential facility, hospital setting, or foster care setting back to the client's family home. The Department would facilitate this change throughout FY 2018-19 with a targeted implementation date of July 1, 2019.

One FTE currently oversees operations of the HCBS-CHRP waiver at CDHS. In order to effectively administer these structural changes to the HCBS-CHRP waiver, the Department requests that resources are allocated for an additional FTE to manage the policy amendments needed for the requested changes to the waiver. This position would be responsible for researching new provider requirements, managing provider recruitment, managing transition of current participant services to the new providers, and the transition to the new case management agencies. In an ongoing capacity, this position serves as the point of contact for stakeholders involved in crises stabilization of youth with an IDD. The position would work to identify procedural improvements to HCBS-CHRP service delivery that would reduce the number of out of home placements and time spent out of home by youth on the HCBS-CHRP waiver. The position would facilitate improvements to transition service provision and crises stabilization while considering feedback from families and providers. The position would monitor the provider network involved in crises stabilization and transition service to ensure that it is appropriately serving the target population.

If statute is not modified to move HCBS-CHRP from the child welfare system families will continue to face the difficult choice of accessing necessary services for their child through HCBS-CHRP or keeping their child in the family home, and a service gap will continue for high needs children living in their family home.

If HCBS-CHRP service coordination remains with county case workers, youth would continue to receive service coordination by individuals who are not highly trained in IDD resulting in sub-optimal service delivery. If waiver administration is not transferred to HCPF, the Department would be limited in its ability to implement waiver reforms, and the administration of the waivers would continue to be at two separate departments which is inefficient.

Anticipated Outcomes:

The Department anticipates that moving administration of HCBS-CHRP to HCPF, transferring case management responsibilities to CCBs and CMAs, and adding transition services would lead to better service outcomes for enrolled youth by improving service coordination which would lead to more appropriate residential placements, including the family home when suitable. Improved residential placements would lead to higher quality of life for youth and reduce the burden on children's hospitals to accommodate youth who cannot be discharged for safety reasons.

Outcomes would be measured through stakeholder outreach and feedback, the number of children returning home, as well as by the number of youth successfully accessing the services available on the waiver.

This proposal aligns with the Department's performance plan long-range goal of enhancing the quality of life and community experience of individuals and families by delivery systems innovation. The Department's proposed solution would ensure that Medicaid members can easily access and navigate needed and appropriate services and would make long-term services and supports easier to access and navigate.

Assumptions and Calculations:

If the request is approved the Department would begin drafting a waiver amendment to move the program in the spring of 2018. The targeted CMS approval date would be fall 2018. The Department would hire one additional staff person in July 2018 and this staff would research and modify provider qualifications to ensure provider availability for individuals on the HCBS-CHRP waiver. This FTE would also research and modify service definitions and eligibility requirements on the waiver to facilitate the addition of transitional services. The Department would transfer the existing HCBS-CHRP administration FTE position to HCPF once CMS approves the necessary waiver amendments. The Department would include the transfer of case management to CCBs and CMAs and the transition services in the waiver renewal that is due in July 2019. Case management would be transferred from case workers to CCB and CMA case managers in July 2019. Transition services would be implemented in July 2019. For further detail on the timeline associated with this request see the companion tables.

The Department assumes costs related to this request would be eligible for the standard 50 percent federal financial participation (FFP) as an HCBS waiver authorized by section 1915(c) of the Social Security Act.

To calculate the costs of transferring case management, the Department assumes that caseload would increase and return to a three-year average once the waiver moves to HCPF. The Department believes that implementing the proposed solution would reverse the current negative enrollment trend by making the waiver more appealing to families who would no longer be required to forfeit custody to access HCBS-CHRP services. The Department believes that some children currently in foster care will return home if the foster care requirement is removed, but the Department lacks adequate data to predict how many children would return home exactly. The Department assumes that half of HCBS-CHRP clients in foster care would transition back to their family home over the course of two years once the foster care requirement is removed and transition services are available. The Department would adjust for fewer or more transitions, once statute is modified and transition services are available, through the normal budget process.

Funding for HCBS-CHRP case administration by county departments is currently transferred to CDHS through HCPF in order to utilize Medicaid matching funds. Although the waiver transfer would reduce some work currently required by counties, the case maintenance by county departments would continue to be a critical part of HCBS-CHRP until case management is fully transitioned to the CCBs and CMAs. Because of this, the Department is not requesting to reduce the funding transfer to CDHS for HCBS-CHRP case administration.

The Department assumes that behavioral services covered by the HCBS-CHRP waiver would be provided under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) in FY 2018-19 and after.

The Department believes that there is potential for savings from reduced days paid for clients living in children's hospitals for extended periods of time and reduced high cost out of home placements, including out of state. Because clients in these settings have some of the most intensive needs, the time needed to complete their transitions may vary significantly. Because of this variance HCPF does not currently have enough information to estimate potential savings in this area, but would update its budget through the normal budget process should savings occur.

Additional information and calculations can be found in Appendix A.

Table 1.1 FY 2018-19 Children's Residential Habilitation Program Transfer Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$141,876	1.8	$70,938	$0	$0	$70,938	50.00%	Table 2.1 Row B
B	(1) Executive Director's Office, (A) General Administration, Health, Life and	$15,854	1.8	$7,927	$0	$0	$7,927	50.00%	Table 2.1 Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term	$241	1.8	$121	$0	$0	$120	50.00%	Table 2.1 Row B
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$6,357	1.8	$3,179	$0	$0	$3,178	50.00%	Table 2.1 Row B
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization	$6,357	1.8	$3,179	$0	$0	$3,178	50.00%	Table 2.1 Row B
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$10,270	1.8	$5,135	$0	$0	$5,135	50.00%	Table 2.1 Row B
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$29,500	0.0	$14,750	$0	$0	$14,750	50.00%	Table 2.1 Row C
H	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$67,940	0.0	$33,971	$0	$0	$33,969	50.00%	Table 3.1 Row C
I	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs; Children's Habilitation Residential	$2,515,319	0.0	$1,257,660	$0	$0	$1,257,659	50.00%	Table 3.1 Row D
J	(7) Department of Human Services Medicaid-Funded Programs; (D) Division of Child Welfare - Medicaid Funding; Child Welfare Services	($2,583,259)	0.0	($1,291,630)	$0	$0	($1,291,629)	50.00%	Inverse of Table 2.1 Row A
K	**Total Request**	**$210,455**	**1.8**	**$105,230**	**$0**	**$0**	**$105,225**	**50.00%**	

Table 1.2 FY 2019-20 Children's Residential Habilitation Program Transfer Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$156,309	2.0	$78,154	$0	$0	$78,155	50.00%	Table 2.2 Row B
B	(1) Executive Director's Office, (A) General Administration, Health, Life and	$15,854	2.0	$7,927	$0	$0	$7,927	50.00%	Table 2.2 Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term	$266	2.0	$133	$0	$0	$133	50.00%	Table 2.2 Row B
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$7,003	2.0	$3,502	$0	$0	$3,501	50.00%	Table 2.2 Row B
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization	$7,003	2.0	$3,502	$0	$0	$3,501	50.00%	Table 2.2 Row B
F	(1) Executive Director's Office, (A) General Administration, Operating	$1,900	2.0	$950	$0	$0	$950	50.00%	Table 2.2 Row B
H	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$29,500	0.0	$14,750	$0	$0	$14,750	50.00%	Table 2.2 Row F
I	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$67,940	0.0	$33,970	$0	$0	$33,970	50.00%	Table 3.1 Row C
J	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs; Targeted Case Management	$253,530	0.0	$126,765	$0	$0	$126,765	50.00%	Table 2.2 Row C and E
K	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs; Children's Habilitation Residential	$2,579,167	0.0	$1,289,584	$0	$0	$1,289,583	50.00%	Table 3.1 Row C + Table 2.2 Row D
L	(7) Department of Human Services Medicaid-Funded Programs; (D) Division of Child Welfare - Medicaid Funding; Child Welfare Services	($2,583,259)	0.0	($1,291,630)	$0	$0	($1,291,629)	50.00%	Inverse of Table 2.2 Row A
M	**Total Request**	**$535,213**	**2.0**	**$267,607**	**$0**	**$0**	**$267,606**	**50.00%**	

Table 1.3 FY 2020-21 Children's Residential Habilitation Program Transfer Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP or FMAP	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$156,309	2.0	$78,155	$0	$0	$78,154	50.00%	Table 2.3 Row B
B	(1) Executive Director's Office, (A) General Administration, Health, Life and	$15,854	2.0	$7,927	$0	$0	$7,927	50.00%	Table 2.3 Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term	$266	2.0	$133	$0	$0	$133	50.00%	Table 2.3 Row B
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$7,003	2.0	$3,502	$0	$0	$3,501	50.00%	Table 2.3 Row B
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization	$7,003	2.0	$3,502	$0	$0	$3,501	50.00%	Table 2.3 Row B
F	(1) Executive Director's Office, (A) General Administration, Operating	$1,900	2.0	$950	$0	$0	$950	50.00%	Table 2.3 Row B
G	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$67,940	0.0	$33,971	$0	$0	$33,969	50.00%	Table 3.1 Row C
H	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs; Targeted Case Management	$253,530	0.0	$126,765	$0	$0	$126,765	50.00%	Table 2.3 Row C and E
I	(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs; Children's Habilitation Residential	$2,579,168	0.0	$1,289,585	$0	$0	$1,289,583	50.00%	Table 3.1 Row C + Table 2.3 Row D
J	(7) Department of Human Services Medicaid-Funded Programs; (D) Division of Child Welfare - Medicaid Funding; Child Welfare Services	($2,583,259)	0.0	($1,291,630)	$0	$0	($1,291,629)	50.00%	Inverse of Table 2.3 Row A
K	**Total Request**	**$505,713**	**2.0**	**$252,859**	**$0**	**$0**	**$252,854**	**50.00%**	

Table 2.1 FY 2018-19 Children's Residential Habilitation Program Transfer Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Transfer Existing Service Costs(1)	$2,583,259	0.0	$1,291,630	$0	$0	$1,291,629	50.00%	Table 3.1 Row A
B	FTE	$180,955	1.8	$90,478	$0	$0	$90,477	50.00%	FTE Tables
C	Stakeholder Engagement	$29,500	0.0	$14,750	$0	$0	$14,750	50.00%	Table 6.1 Row A
D	**Total Estimate**	**$2,793,714**	**1.8**	**$1,396,858**	**$0**	**$0**	**$1,396,856**	**50.00%**	

(1) Existing service costs are already included in the budget as an interdepartmental transfer, and is therefore budget neutral. The total cost of HCBS-CHRP services is shown here while the net impact to the Departments budget is shown in the Summary by Line Item tab.

Table 2.2 FY 2019-20 Children's Residential Habilitation Program Transfer Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Transfer Existing Service Costs(1)	$2,583,259	0.0	$1,291,630	$0	$0	$1,291,629	50.00%	Table 3.1 Row A
B	FTE	$188,335	2.0	$94,168	$0	$0	$94,167	50.00%	FTE Tables
C	Transfer CHRP Case Management to CCBs and CMAs	$217,658	0.0	$108,829	$0	$0	$108,829	50.00%	Table 4.1 Row C
D	Creation of Transition Services	$63,848	0.0	$31,924	$0	$0	$31,924	50.00%	Table 5.1 Row C
E	Creation of Intensive Case Management	$35,872	0.0	$17,936	$0	$0	$17,936	50.00%	Table 5.1 Row E
F	Stakeholder Engagement	$29,500	0.0	$14,750	$0	$0	$14,750	50.00%	Table 6.1 Row A
G	**Total Estimate**	**$3,118,472**	**2.0**	**$1,559,237**	**$0**	**$0**	**$1,559,235**	**50.00%**	

(1) Existing service costs are already included in the budget as an interdepartmental transfer, and is therefore budget neutral. The total cost of HCBS-CHRP services is shown here while the net impact to the Departments budget is shown in the Summary by Line Item tab.

Table 2.3 FY 2020-21 Children's Residential Habilitation Program Transfer Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Transfer Existing Service Costs(1)	$2,583,259	0.0	$1,291,630	$0	$0	$1,291,629	50.00%	Table 3.1 Row A
B	FTE	$188,335	2.0	$94,168	$0	$0	$94,167	50.00%	FTE Tables
C	Transfer CHRP Case Management to CCBs	$217,658	0.0	$108,829	$0	$0	$108,829	50.00%	Table 4.1 Row C
D	Creation of Transition Services	$63,848	0.0	$31,924	$0	$0	$31,924	50.00%	Table 5.1 Row C
E	Creation of Intensive Case Management	$35,872	0.0	$17,936	$0	$0	$17,936	50.00%	Table 5.1 Row E
F	**Total Estimate**	**$3,088,972**	**2.0**	**$1,544,487**	**$0**	**$0**	**$1,544,485**	**50.00%**	

(1) Existing service costs are already included in the budget as an interdepartmental transfer, and is therefore budget neutral. The total cost of HCBS-CHRP services is shown here while the net impact to the Department's budget is shown in the Summary by Line Item tab.

Table 3.1 Expected Service Cost of Transferring Existing Children's Habilitation Residential Program waiver (CHRP) Services to the Department of Healthcare Policy and Financing (HCPF)

Row	Item	FY 2018-19	FY 2019-20	FY 2020-21	Notes
A	Cost of Transferring CHRP Services to HCPF	$2,583,259	$2,583,259	$2,583,259	Table 3.2 Row F and G
B	Fraction of Expenditure on Services Eligible for Early and Periodic Screening Diagnostic and Treatment (EPSDT)	2.63%	2.63%	2.63%	Based on FY 2015-16 Actuals - Behavioral Services are covered by EPSDT
C	EPSDT Expenditure Expected	$67,940	$67,940	$67,940	Row A * Row B
D	HCBS-CHRP Expenditure Expected	$2,515,319	$2,515,319	$2,515,319	Row A - Row C

Table 3.2 Expected CHRP Service Expenditure					
Row	**Item**	**Currency**	**Caseload**	**Cost Per-Capita**	**Notes**
A	FY 2013-14 Expenditure on CHRP Services	$2,871,745	92	$31,214.62	Actuals
B	FY 2014-15 Expenditure on CHRP Services	$2,793,542	82	$34,067.59	Actuals
C	FY 2015-16 Expenditure on CHRP Services	$2,084,490	68	$30,654.26	Actuals
D	FY 2016-17 Expected Expenditure on CHRP Services	$2,084,490	68	$30,654.26	Row C, assuming constant enrollment and expenditure from FY 2015-16
E	FY 2017-18 Expected Expenditure on CHRP Services	$2,084,490	68	$30,654.26	Row C, assuming constant enrollment and expenditure from FY 2015-16
F	FY 2018-19 Expected Expenditure on CHRP Services	$2,583,259	81	$31,892.09	Average of Rows A, B, and C. The Department anticipates that CHRP caseload will reverse its negative trend when the program is implemented.
G	FY 2019-20 Expected Expenditure on CHRP Services	$2,583,259	81	$31,892.09	Average of Rows A, B, and C

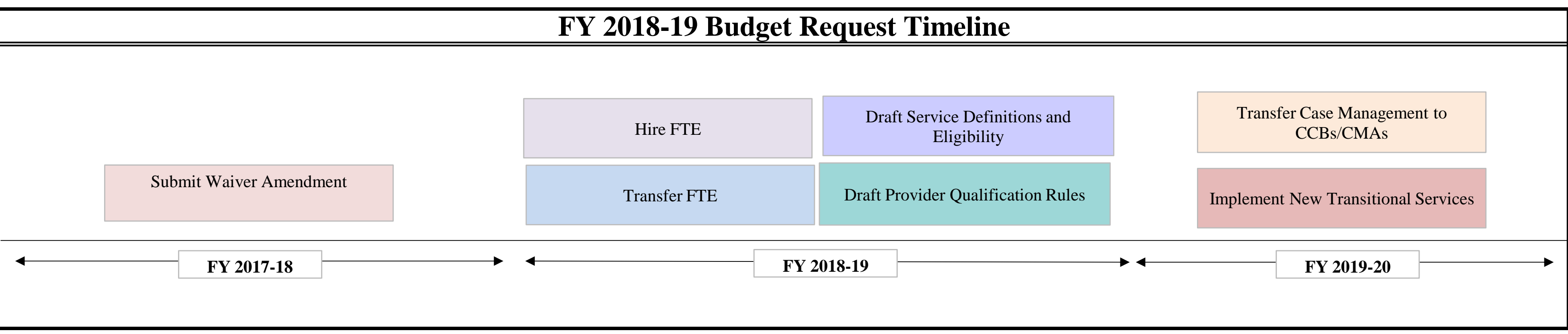
Table 4.1 - Expected Targeted Case Management Expenditure Resulting from Transferring CHRP Case Management from Counties to Community Centered Boards and Case Management Agencies					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes**
A	Expected CHRP Caseload Using Targeted Case Management	0	81	81	Table 3.2 Row G. Assuming case management is transitioned from county case workers to Targeted Case Management on July 1, 2019.
B	Expected Targeted Case Management Cost Per-Client	$2,687.14	$2,687.14	$2,687.14	FY 2017-18 S-5, Table B.1.1.
C	Expected Cost of CHRP Transitional Services	$0	$217,658	$217,658	Row A + Row B

Table 5.1 - Cost of CHRP Transitional Services and Intensive Case Management (ICM)					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes**
A	Expected CHRP Transitional Services and ICM Caseload	0	17	17	Table 3.2 Row G * .25%. Assuming that one quarter of clients living out of home will transfer home over the course of FY 2019-20 and FY 2020-21
B	Expected CHRP Transitional Services Cost Per-Client	$3,755.79	$3,755.79	$3,755.79	Table 5.2 Row A
C	Expected Cost of CHRP Transitional Services	$0	$63,848	$63,848	Row A * Row B
D	Expected CHRP ICM Cost Per-Client	$2,110.14	$2,110.14	$2,110.14	Table 5.2 Row B
E	Expected Cost of CHRP ICM	$0	$35,872	$35,872	Row A * Row D
F	Expected Cost of CHRP Transitional Services and ICM	$0	$99,720	$99,720	Row C + Row E

Table 5.2 - Expected CHRP Transitional Services Cost Per-Client			
Row	**Item**	**Value**	**Notes**
A	Cost Per-Client Per-Year of CTS	$ 3,755.79	FY 2015-16 Cost Per-Client of CTS Services for Colorado Choice Transitions Clients
B	Cost Per-Client Per-Year of ICM	$ 2,110.14	FY 2015-16 Cost Per-Client of ICM Services for Colorado Choice Transitions Clients
C	Cost Per-Client Per-Year of Transition Services	$ 5,865.93	Row A + Row B

Table 6.1 - Stakeholder Outreach					
Row	**Activity Name**	**Hourly Rate**	**Estimated Annual Units/Hours**	**Estimated Cost**	**Notes**
A	Stakeholder Engagement - Facilitation	$295.00	100	$29,500	Hourly Rate Based on Current Contract, Hours Estimate from Department Staff Based on Expected Workload

Expenditure Detail			FY 2018-19		FY 2019-20
Personal Services:					
Classification Title	Monthly	FTE		FTE	
ADMINISTRATOR IV	$6,301	0.9	$68,051	1.0	$75,612
PERA			$6,907		$7,675
AED			$3,403		$3,781
SAED			$3,403		$3,781
Medicare			$987		$1,096
STD			$129		$144
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1, 1.0 FTE		**0.9**	**$90,807**	**1.0**	**$100,016**
Classification Title	Monthly	FTE		FTE	
ADMINISTRATOR IV	$5,371	0.9	$59,078	1.0	$64,449
PERA			$5,996		$6,542
AED			$2,954		$3,222
SAED			$2,954		$3,222
Medicare			$857		$935
STD			$112		$122
Health-Life-Dental			$7,927		$7,927
Subtotal Position 2, 1.0 FTE		**0.9**	**$79,878**	**1.0**	**$86,419**
Subtotal Personal Services		1.8	**$170,685**	2.0	**$186,435**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	1.8	$908	2.0	$1,000
Telephone Expenses	$450	1.8	$818	2.0	$900
PC, One-Time	$1,230	1.8	$2,235	-	
Office Furniture, One-Time	$3,473	1.8	$6,309	-	
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$10,270**		**$1,900**
TOTAL REQUEST		1.8	**$180,955**	2.0	**$188,335**
	General Fund:		*$90,478*		*$94,168*
	Cash funds:				
	Reappropriated Funds:				
	Federal Funds:		*$90,477*		*$94,167*


FY 2018-19 Budget Request Timeline
Hire FTE
Draft Service Definitions and Eligibility
Transfer Case Management to CCBs/CMAs
Submit Waiver Amendment
Transfer FTE
Draft Provider Qualification Rules
Implement New Transitional Services
FY 2017-18
FY 2018-19
FY 2019-20

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title	**R-13 All-Payer Claims Database Funding**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ **Supplemental FY 2017-18**

X **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$39,971,963**	**$0**	**$42,526,947**	**$2,818,558**	**$2,826,570**
	FTE	418.4	0.0	427.4	1.8	2.0
	GF	$14,002,896	$0	$14,808,801	$1,684,280	$1,688,287
	CF	$3,675,556	$0	$3,623,775	$0	$0
	RF	$2,093,356	$0	$2,483,535	$0	$0
	FF	$20,200,155	$0	$21,610,836	$1,134,278	$1,138,283

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- Personal Services	**Total**	**$30,884,154**	**$0**	**$32,040,094**	**$175,386**	**$191,345**
	FTE	418.4	0.0	427.4	1.8	2.0
	GF	$10,512,849	$0	$10,769,424	$87,693	$95,673
	CF	$2,985,184	$0	$3,045,883	$0	$0
	RF	$1,885,978	$0	$2,242,657	$0	$0
	FF	$15,500,143	$0	$15,982,130	$87,693	$95,672
01. Executive Director's Office, (A) General Administration -- Health, Life, and Dental	**Total**	**$3,637,126**	**$0**	**$4,639,956**	**$15,854**	**$15,854**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,305,776	$0	$1,673,531	$7,927	$7,927
	CF	$344,132	$0	$297,330	$0	$0
	RF	$103,855	$0	$135,355	$0	$0
	FF	$1,883,363	$0	$2,533,740	$7,927	$7,927

01. Executive Director's Office, (A) General Administration -- Short-term Disability	**Total**	**$58,060**	**$0**	**$60,583**	**$298**	**$325**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,586	$0	$22,803	$149	$163
	CF	$4,802	$0	$3,381	$0	$0
	RF	$1,364	$0	$1,484	$0	$0
	FF	$30,308	$0	$32,915	$149	$162

01. Executive Director's Office, (A) General Administration -- Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,851,815**	**$7,857**	**$8,573**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$697,024	$3,929	$4,287
	CF	$133,634	$0	$103,331	$0	$0
	RF	$37,970	$0	$45,371	$0	$0
	FF	$843,045	$0	$1,006,089	$3,928	$4,286

01. Executive Director's Office, (A) General Administration -- Supplemental Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,851,815**	**$7,857**	**$8,573**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$697,024	$3,929	$4,287
	CF	$133,634	$0	$103,331	$0	$0
	RF	$37,970	$0	$45,371	$0	$0
	FF	$843,045	$0	$1,006,089	$3,928	$4,286

01. Executive Director's Office, (A) General Administration -- Operating Expenses	**Total**	**$2,162,529**	**$0**	**$2,082,684**	**$11,306**	**$1,900**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$961,889	$0	$948,995	$5,653	$950
	CF	$74,170	$0	$70,519	$0	$0
	RF	$26,219	$0	$13,297	$0	$0
	FF	$1,100,251	$0	$1,049,873	$5,653	$950

01. Executive Director's Office, (H) All Payer's Claims Database -- All Payer's Claims Database	**Total**	**$0**	**$0**	**$0**	**$2,600,000**	**$2,600,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$1,575,000	$1,575,000
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$1,025,000	$1,025,000

CF Letternote Text Revision Required?	Yes ___ No X	**If Yes, see schedule 4 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 $2,818,558 total funds, including $1,684,280 General Fund, $1,134,278 federal funds, and 1.8 FTE for FY 2018-19, and $2,826,570 total funds, including $1,688,287 General Fund, $1,138,283 federal funds, and 2.0 FTE for FY 2019-20 and ongoing to provide funding for the Medicaid share of claims within the All Payer Claims Database system (APCD), plus additional funding to support the end of grant funding for the APCD.
- The requested FTE would provide more Departmental oversight to the APCD contract and the advisory committee.

Current Program

- The APCD collects claims data from over 21 commercial health insurance companies and builds a more comprehensive picture of health care in Colorado. The APCD takes claims data and turns it into actionable information that provides insights about Coloradans' health, quality of care, utilization, outcomes and cost.
- The Center for Improving Value in Health Care (CIVHC) administers the APCD on behalf of the Department and works closely with an advisory committee to make sure the APCD meets statutory milestones.
- Currently the APCD is funded through grants and donations received directly by CIVHC. CIVHC received $3,800,000 in FY 2016-17 and FY 2017-18 to administer the APCD.

Problem or Opportunity

- A majority of the current grant funding received by CIVHC for the APCD is time limited and will sunset at the end of FY 2017-18, as the need for funding to maintain the APCD is increasing. The Department anticipates that it will cost $5,000,000 to maintain and administer the APCD in FY 2018-19 and ongoing. CIVHC projects to receive $2,400,000 from earned revenue through its administration of the APCD, and needs an additional $2,600,000 to continue operations.
- There is an opportunity to allocate a portion of APCD costs associated with Medicaid claims in the database to the Department. This would allow the Department to receive a federal match on state dollars to offset the needed funds to continue operations.

Consequences of Problem

- If the Department does not provide additional funding to CIVHC to administer the APCD, it may be unable to use the APCD to identify ways to improve the cost efficiency and quality of clients' health care.
- Without additional funds, the APCD is at risk of discontinuing operations as current revenue for the APCD is not enough to sustain itself. Under section 25.5-1-204(11), C.R.S. (2017) if there is insufficient funding, the database shall cease to be operational and the data shall be destroyed or returned to its original source.

Proposed Solution

- The Department requests to hire two FTE to oversee the APCD contract and manage projects and funding for the administration of the APCD through CIVHC.
- By funding the APCD, the Department could continue to delegate the administration of the APCD through an outside entity and obtain actionable information regarding cost of care by service and location and continue its drive towards more cost-efficient value-based care.

COLORADO
Department of Health Care Policy & Financing
FY 2018-19 Funding Request | November 1, 2017

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: ***R-13***

Request Detail: ***All-Payer Claims Database Funding***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
All-Payer Claims Database Funding	$2,818,558	$1,684,280

Problem or Opportunity:

The All-Payer Claims Database (APCD) is at risk of discontinuing operations because the majority of the grant funding currently received by the Center for Improving Value in Health Care (CIVHC) to administer the APCD on behalf of the Department is time limited and sunsets at the end of FY 2017-18. While Medicaid claims make up a large portion of the database, the APCD does not receive funding from the Department for the Medicaid share, which is allowable under federal cost allocation rules. If the APCD is not funded adequately and cannot continue operations, the Department, Medicare, commercial health insurance, health care providers, and institutions that perform research would lose a valuable tool to identify opportunities for efficiency, measure access to health care, compare rates, and identify fraud, waste, and abuse by comparing claims data to other health insurance providers in Colorado. Colorado citizens would also lose access to the APCD website, which provides transparency to Coloradans about the cost and quality of health care[1].

The Department has an opportunity to allocate a portion of the costs to Medicaid to support the functions associated with Medicaid claims in the APCD, which would receive a federal match. There would be a portion of the costs that do not qualify for a federal match, which would need to be paid for with state-only funding in lieu of grant funds. With Medicaid money being allocated to the APCD, the Department needs additional resources to provide oversight of the APCD. Without these additional resources, the Department is at risk of not receiving approval of the Medicaid cost allocation plan, which is needed to receive federal funds, and of federal disallowance if the plan is not accurately followed.

Current Operations of the All-Payer Claims Database (APCD)

The APCD is a comprehensive claims database that includes claims from Medicaid, Medicare and over 21 commercial health insurance companies. The APCD is a secure database that complies with all federal privacy and anti-trust laws. Claims data includes information about location of service, cost of service,

[1] See "CO APCD" by Center for Improving Value in Health Care: http://www.civhc.org/CO-APCD-Website-Changes.aspx/

diagnosis, and type of service across all insurance providers. The claims database provides the most complete picture of health care in Colorado, and crucial information on the costs associated with it.

The APCD is authorized under section 25.5-1-204, C.R.S. (2017). The statute gives the Department's executive director the authority to appoint both the administrator of the APCD and the members of its advisory committee. In 2010, the executive director appointed CIVHC, a non-partisan, not-for-profit organization, to be the administrator of the APCD. The advisory committee was also established and is used to support the database in the reporting of health care data including cost, quality, efficiency information, public reporting of safety, and analysis of health care spending and utilization patterns.

CIVHC expects the cost of administering the program to increase in FY 2018-19 and ongoing to $5,000,000. Currently, through selling limited datasets and reports the APCD earns $2,400,000 annually. CIVHC also receives grant funding from grant making organizations, including the Colorado Health Foundation and the Colorado Health Trust, but the majority of that funding is time limited and will not be available after FY 2017-18. With the loss of certain grant funding there will be a gap of $2,600,000 between the cost of administering the APCD and anticipated revenue. While Medicaid is responsible for 41 percent covered lives in the database, no Medicaid funding is provided for its share of the database. The costs associated with the Medicaid data and functions would be eligible to receive a federal match. After allocating funds to Medicaid for the APCD, the Department anticipates there would still be unfunded costs remaining for the APCD, which could either be covered by grant funding if available or by General Fund.

Currently, the Department absorbs the workload associated with administering the APCD. Department staff develop and amend the contract with CIVHC, which follows State procurement rules, laws, and guidelines. Department staff also ensure the data submissions for the APCD are timely, comprehensive, and conform to modified data submission guidelines. The Department does not have sufficient resources to take a more active role in administering the APCD going forward, including making sure Medicaid costs are incorporated in the cost allocation plan and appropriately followed per CMS guidance and overseeing the advisory and stakeholder groups.

Proposed Solution:

The Department requests $2,818,558 total funds, including $1,684,279 General Fund and 1.8 FTE in FY 2018-19, and $2,826,570, including $1,688,287 General Fund and 2.0 FTE in FY 2019-20 and ongoing to fund the operations and oversight of the APCD. The requested funding would be used to pay for Medicaid's share of the administration of the APCD through CIVHC, plus additional funding to offset the loss of grant funding with state-only funds. One FTE would be responsible for providing more Department oversight and direction for the current APCD contract. The other FTE would be responsible for overseeing the advisory committee.

The requested funding would fund Medicaid's portion of the claims database, plus an additional state-only portion needed to keep the APCD operational. The resulting hybrid financing arrangement is similar to other states; for example, in Arkansas, the APCD receives funding from a combination of state and federal funds,

earned revenue, and grant funding[2]. The Department would still be required to pay for any ad hoc reports and special analysis needed from the APCD separately and would continue to administer the scholarship program for nonprofit and government entities to access and conduct research in the databases. Both are examples of earned revenue for the APCD. However, the Department would make arrangements through the contract with CIVHC for the APCD to provide routine data feeds to the Department and other states agencies, like the Division of Insurance, available at no additional cost.

The Department requests funding for a program manager who would be responsible for overseeing the administration of the APCD and jointly administering the advisory committee that is established in statute with CIVHC. The program manager would facilitate the advisory committee, communicate with CIVHC on behalf of the advisory committee, and would promote the Department's core values of transparency throughout APCD processes. This position would ensure ongoing participation among stakeholders and state agencies by ensuring the public is notified and allowed to participate in advisory group meetings. This position would also work with the APCD to ensure that Department data submissions to the APCD are timely, comprehensive, and conform to newly modified data submission guides, as well as to verify that any Medicare data released by the APCD to external organizations adheres to CMS' data use requirements[3]. The program manager would work with participating stakeholders on standards and practices for sharing information within the APCD and developing a process for electronically sharing Medicaid and Medicare data between the entities. This work would be done in collaboration with CIVHC and other state agencies as appropriate. This position would pursue appropriate grants and revenue sources to help offset the costs associated with the administration of the APCD. The Department is absorbing this work now, but would need a program manager to more actively administer the advisory committee for the APCD going forward.

The Department requests funding for a contract administrator to oversee the contracts for the APCD. This position would allow the Department to provide more insight and direction for the contract that provides the Medicaid funding to CIVHC, as the APCD administrator, on behalf of the Department. The contract administrator would be primarily responsible for developing and amending contracts following State procurement rules, laws, and guidelines to support the Department's business needs. The contract administrator would establish spending plans, track expenditures on the contracts, and maintain the cost allocation plan with CMS, as well as manage other correspondence sent to CMS to ensure that federal funds are available. The contract administrator would verify that CIVHC is comporting with its contractual obligations to administer the APCD on behalf of the Department and would assess CIVHC's performance in meeting the obligations of the APCD. The Department is currently absorbing the contract management work, but would need an additional resource to navigate the cost allocation process and ensure continual compliance with CMS to use the Medicaid funds.

If the Department does not provide funding and continues to rely on grant funding to support the APCD, the APCD would remain vulnerable to being underfunded. Pursuant to section 25.5-1-204(11), C.R.S. (2017), if

---

[2] *Ark. Code Ann. § 23-61-901 et. seq.*
[3] http://civhc.org/getmedia/c0c05b8f-f85e-45dd-b137-74a4c215ef36/Medicare-Data-FAQs.pdf.aspx/

there is insufficient funding the database shall cease to be operational and the data shall be destroyed or returned to its original source.

Anticipated Outcomes:

By appropriating funding to allow the APCD to continue operations, the State would avoid the loss of a key resource. The APCD benefits Medicare, Medicaid, and commercial insurance companies by providing robust data analysis across payers on cost of care and health outcomes. Colorado residents also would be able to continue using the APCD website to access that information. Data analysis from the APCD is a valuable tool that allows the Department to continue moving towards its long-range goals, as specified in the Department's FY 2017-18 Performance Plan, of improving health for low-income and vulnerable Coloradans and reducing the cost of health care in Colorado. Hiring two FTE dedicated to the APCD would allow the Department to become more involved with and provide additional oversight for the APCD's operations.

The APCD can and has provided information that allows the Department to compare its performance against Medicare and other commercial health care providers. Analyses from the APCD help with determining proper rates for services, identifying potential access to care issues, and seeking efficiencies in providing health care services. These benefits directly link to the Department's strategic initiatives of developing tools of transformation and delivery systems innovation. Clients would also continue to benefit from the APCD because it moves the Department towards more cost-efficient, value-based care and would create more transparency in the health care industry.

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 1.1 through 1.2. A summary of cost allocation determination and APCD funding calculations are shown in tables 2.1 through 2.3.

The Department assumes that it will cost $5,000,000 to administer the APCD in FY 2018-19 and ongoing based on CIVHC's estimated costs and the assumption that the APCD will continue to earn $2,400,000 in revenue in FY 2018-19 and ongoing based on the 2016 annual report from the APCD[4]. The Department assumes that $2,050,000 of the costs can be allocated to Medicaid and receive a federal match, based on the percentage of Medicaid covered lives within the APCD. The Department is actively working on submitting a cost allocation plan to CMS, and assumes that it would be approved by July 1, 2018. The Department would allocate costs based on the final metric that is approved by CMS through the plan. The Department assumes that $550,000 would be state-only funds used to backfill the remainder of the APCD's costs, which are not eligible for a federal match. The funding would be needed in FY 2018-19 and ongoing.

The Department assumes that the provisions specified in section 24-75-1305, C.R.S. (2017), which restrict the General Assembly from appropriating funding for a program "…previously funded through grant moneys and that has not received adequate grant moneys to support the program…" do not apply, because CIVHC is not a "state agency." Section 24-75-1301(1), C.R.S. (2017) defines "grant" to be "…any gift, grant, or

---

[4] See "CO APCD Annual Report 2016" by the Center for Improving Value in Health Care: http://civhc.org/getmedia/80881590-f979-41b2-89dd-cb2bdaeb5424/FINAL-2016-CO-APCD-Annual-Report-with-Bookmarks.pdf.aspx/

donation from a nongovernmental entity *to a state agency*…" (*emphasis* added). In this case, the previous grant funding was directly applied for and received by CIVHC. CIVHC is an independent non-profit organization, and is not a state agency as defined by 24-75-1301(2), C.R.S. (2017). Therefore, grant money received by CIVHC may not qualify as a "grant moneys" for the purposes of section 24-75-1305, C.R.S. (2017), and the prohibitions on appropriating and requesting funding in that section may not apply. However, the Department is cognizant that the APCD is a "function of state government," as used in sections 24-75-1305(1) and (2), C.R.S (2017). If the General Assembly determines that nongovernmental funding that CIVHC receives qualifies as a "grant" pursuant to section 24-75-1301(1), C.R.S. (2017) and the General Assembly may decide they need to authorize appropriations for the APCD via legislation instead of through the budget process.

The Department assumes both FTE would start on July 1, 2018.

Table 1.1 FY 2018-19 Funding for the All-Payer Claims Database Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$175,386	1.8	$87,693	$0	$0	$87,693	50.00%	Table 3 - Salary, PERA, and Medicare
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$15,854	0.0	$7,927	$0	$0	$7,927	50.00%	Table 3 - Health, Life, and Dental
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$298	0.0	$149	$0	$0	$149	50.00%	Table 3 - Short Term Disability
D	(1) Executive Director's Office, (A) General Administration, S.B 04-257 Amortization Equalization Disbursement	$7,857	0.0	$3,929	$0	$0	$3,928	50.00%	Table 3 - AED
E	(1) Executive Director's Office, (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$7,857	0.0	$3,929	$0	$0	$3,928	50.00%	Table 3 - SAED
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$11,306	0.0	$5,653	$0	$0	$5,653	50.00%	Table 3 - Operating Expenses
G	(1) Executive Director's Office, (H) All-Payers Claims Database	$2,600,000	0.0	$1,575,000	$0	$0	$1,025,000	39.42%	Table 2.1
H	**Total Estimate**	**$2,818,558**	**1.8**	**$1,684,280**	**$0**	**$0**	**$1,134,278**	**40.24%**	**Row A+B+C+D+E+F**

Table 1.2 FY 2019-20 Funding for the All-Payer Claims Database Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$191,345	2.0	$95,673	$0	$0	$95,672	50.00%	Table 3 - Salary, PERA, and Medicare
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$15,854	0.0	$7,927	$0	$0	$7,927	50.00%	Table 3 - Health, Life, and Dental
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$325	0.0	$163	$0	$0	$162	50.00%	Table 3 - Short Term Disability
D	(1) Executive Director's Office, (A) General Administration, S.B 04-257 Amortization Equalization Disbursement	$8,573	0.0	$4,287	$0	$0	$4,286	50.00%	Table 3 - AED
E	(1) Executive Director's Office, (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$8,573	0.0	$4,287	$0	$0	$4,286	50.00%	Table 3 - SAED
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$1,900	0.0	$950	$0	$0	$950	50.00%	Table 3 - Operating Expenses
G	(1) Executive Director's Office, (H) All-Payers Claims Database	$2,600,000	0.0	$1,575,000	$0	$0	$1,025,000	39.42%	Table 2.1
H	**Total Estimate**	**$2,826,570**	**2.0**	**$1,688,287**	**$0**	**$0**	**$1,138,283**	**40.27%**	**Row A+B+C+D+E+F**

Table 2.1 All-Payer Claims Database (APCD)
Source Breakdown of Requested Funding

Row	Item	FY 2018-19	FY 2019-20	FY 2020-21	Calculations/Assumptions
A	**Total Funding Needed**	**$2,600,000**	**$2,600,000**	**$2,600,000**	**Table 2.2 Row C**
B	General Fund	$1,575,000	$1,575,000	$1,600,000	Row E + Row H
C	Federal Funds	$1,025,000	$1,025,000	$1,000,000	Row F + Row I
D	**Total Title XIX Eligible Costs**	**$2,050,000**	**$2,050,000**	**$2,000,000**	**Table 2.3 Row C**
E	General Fund	$1,025,000	$1,025,000	$1,000,000	Row D - Row F
F	Federal Funds	$1,025,000	$1,025,000	$1,000,000	Row D * 50% Federal Match Rate
G	**Additional Funds Needed - General Fund**	**$550,000**	**$550,000**	**$600,000**	**Table 2.2 Row E**
H	General Fund	$550,000	$550,000	$600,000	Row G - Row I
I	Federal Funds	$0	$0	$0	Cost not eligible for Title XIX

Table 2.2 All-Payer Claims Database (APCD)
Estimated Funding Needed

Row	Item	FY 2018-19	FY 2019-20	FY 2020-21	Calculations/Assumptions
A	Cost of Administering APCD	$5,000,000	$5,000,000	$5,000,000	Table 2.3 Row A
B	Earned Revenue Available	$2,400,000	$2,400,000	$2,400,000	Based on annual report from the APCD; see narrative for details
C	**Total Funding Needed**	**$2,600,000**	**$2,600,000**	**$2,600,000**	**Row A - Row B**
D	Total Title XIX Eligible Costs	$2,050,000	$2,050,000	$2,000,000	Table 2.3 Row C
E	Additional Funds Needed - General Fund	$550,000	$550,000	$600,000	Row E - Row F

Table 2.3 All Payer Claims Database (APCD)
Estimated Title XIX Eligible Costs

Row	Item	FY 2018-19	FY 2019-20	FY 2020-21	Calculations/Assumptions
A	Cost of Administering APCD	$5,000,000	$5,000,000	$5,000,000	Based on annual cost report plus anticipated increases; see narrative for details
B	Medicaid Percentage of APCD claims	41.00%	41.00%	40.00%	Based on the percentage of Medicaid covered lives within the APCD
C	**Title XIX Eligible Costs**	**$2,050,000**	**$2,050,000**	**$2,000,000**	**Row A * Row B**

Table 3.1 FTE Calculations

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	
Contract Administrator VI	$6,943		0.9	$76,367	1.0	$83,316
Tab PERA				$7,751		$8,457
AED				$3,818		$4,166
SAED				$3,818		$4,166
Medicare				$1,107		$1,208
STD				$145		$158
Health-Life-Dental				$7,927		$7,927
Subtotal Position 1, 1.0 FTE			**0.9**	**$100,933**	**1.0**	**$109,398**
Classification Title	Monthly Salary		FTE		FTE	
Program Manager III	$7,345		0.9	$80,789	1.0	$88,140
PERA				$8,200		$8,946
AED				$4,039		$4,407
SAED				$4,039		$4,407
Medicare				$1,171		$1,278
STD				$153		$167
Health-Life-Dental				$7,927		$7,927
Subtotal Position 2, 1.0 FTE			**0.9**	**$106,318**	**1.0**	**$115,272**
Subtotal Personal Services			1.8	**$207,252**	2.0	**$224,670**
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	**$218,558**	2.0	**$226,570**
	General Fund:			*$109,278.78*		*$113,285*
	Cash funds:			*$0*		*$0*
	Reappropriated Funds:			*$0*		*$0*
	Federal Funds:			*$109,279*		*$113,285*

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-14 Safety Net Program Adjustments**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ **Supplemental FY 2017-18**

_X_ **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$50,104,108**	**$0**	**$50,870,574**	**$81,324**	**$138,361**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,321,733	$0	$7,583,286	$0	$0
	CF	$38,079,612	$0	$38,079,612	$81,324	$138,361
	RF	$0	$0	$0	$0	$0
	FF	$4,702,763	$0	$5,207,676	$0	$0

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (F) Provider Audits and Services -- Professional Audit Contracts	**Total**	**$3,254,646**	**$0**	**$4,021,112**	**$135,500**	**$203,860**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,299,343	$0	$1,560,896	$28,864	$40,187
	CF	$312,420	$0	$312,420	$106,636	$163,673
	RF	$0	$0	$0	$0	$0
	FF	$1,642,883	$0	$2,147,796	$0	$0
05. Indigent Care Program -- Clinic Based Indigent Care	**Total**	**$6,119,760**	**$0**	**$6,119,760**	**($28,864)**	**($40,187)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,059,880	$0	$3,059,880	($28,864)	($40,187)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,059,880	$0	$3,059,880	$0	$0

05. Indigent Care Program -- Primary Care Fund Program	**Total**	**$27,767,192**	**$0**	**$27,767,192**	**($53,160)**	**($53,160)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$27,767,192	$0	$27,767,192	($53,160)	($53,160)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

06. Other Medical Services -- Old Age Pension State Medical	**Total**	**$12,962,510**	**$0**	**$12,962,510**	**$27,848**	**$27,848**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,962,510	$0	$2,962,510	$0	$0
	CF	$10,000,000	$0	$10,000,000	$27,848	$27,848
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 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 $81,324 cash funds in FY 2018-19 and $138,361 cash funds in FY 2019-20 and ongoing to allow for increased oversight of the Department's safety net programs and allow additional available funding to be directed towards these programs, instead of going unused.
- The cash funds include the Department of Health Care Policy and Financing Cash Fund, the Primary Care Fund Cash Fund and the Healthcare Affordability and Sustainability Fee Cash Fund. This request has no General Fund impact.

Current Program

- The Colorado Dental Health Care Program for Low-Income Seniors ("Senior Dental Program") promotes the health and welfare of low-income seniors by providing access to patient-centered dental care.
- The Primary Care Fund Program provides grant funding to participating health care providers that make comprehensive, primary care services available to residents of Colorado regardless of their ability to pay.
- The Colorado Indigent Care Program facilitates payments to participating hospitals and clinics that serve the indigent population.

Problem or Opportunity

- The lack of sufficient spending authority prevents the Department from allocating surplus revenue from the Primary Care Fund to participating providers, and prevents the reallocation of recovery funds towards increased access to dental care for low-income seniors within the Senior Dental Program.
- The current audit processes within the Primary Care Fund and the Colorado Indigent Care Program lack sufficient funding for a thorough and meaningful audit structure.

Consequences of Problem

- If this request is not approved the availability of health care services could be reduced and fewer services would be provided to populations of needy patients.
- Risks of inaccurate payment distributions would remain and general program oversight would remain inadequate.

Proposed Solution

- The Department requests spending authority to expend the surplus funds available in the Primary Care Fund and increase funding towards participating providers for uncompensated care of primary care services to indigent patients.
- The Department requests increased spending authority to allow for the reallocation of Senior Dental Program recoveries and increase the access of dental services for low-income seniors.
- The Department requests funding for compliance audits of the Primary Care Fund Program and Colorado Indigent Care Programs and improve effectiveness and efficiencies of the programs.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: ***R-14***

Request Detail: ***Safety Net Program Adjustments***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Safety Net Program Adjustments	$81,324	$0

Problem or Opportunity:

The Department administers "safety net" programs which establish and allocate funding to qualified medical providers who serve the indigent population. As part of its efforts towards continual process improvement and organizational efficiency and excellence, the Department has identified opportunities within three programs, which would allow the Department to provide additional services to needy populations, increase grant funding for clinics who serve the indigent population, and increase oversight and accuracy within data collection and funding calculation processes.

Senior Dental Program Reallocation of Recoveries

The Department does not have spending authority to reallocate funds received from recoveries from providers of the Colorado Dental Health Care Program for Low-Income Seniors ("Senior Dental Program"). As a result, the Department has funds which could be allocated to providers in order to increase services, but cannot be because of a lack of spending authority.

The purpose of the Senior Dental Program is to promote the health and welfare of Colorado's low-income seniors by providing access to dental care to individuals age 60 and over who are not eligible for dental services under any other dental health care program. The Senior Dental Program provides grants to entities throughout the state that promote the health and welfare of Colorado's low-income seniors. These entities include local Area Agencies on Aging (AAA), public health agencies, Community Health Centers, private dental practices, and other community-based organizations who meet application criteria developed under the guidance of the Senior Dental Advisory Committee. A similar dental program for seniors that was administered by the Colorado Department of Public Health and Environment (CDPHE) was replaced by reorganizing the "Colorado Dental Care Act of 1977" and relocating the program with the Department. FY 2014-15 was the transition phase of the Colorado Dental Care Act of 1977 administered by the CDPHE to the Senior Dental Program administered by the Department. This transition consisted of defining grant criteria, establishing program rules and awarding grant monies to qualified grantees. Grants for the Senior Dental Program were issued by the Department on July 1, 2015 and qualified seniors could receive dental services on that date.

The Senior Dental Program is appropriated General Fund dollars as the sole source of funding. The administration of the program includes desk review audits of participating providers which may result in recoveries from providers of a portion of their prior year payments due to audit findings. Recovery funds are also obtained through the efforts of the Office of the Attorney General in relation to an ongoing case involving incorrectly billed dental procedures. All recoveries are deposited in the Department of Health Care Policy and Financing Cash Fund. These recoveries cannot be reallocated to qualified providers due to lack of spending authority; therefore, the funds are not available for use as originally intended to provide dental services to needy seniors. The Colorado Dental Board, which investigates complaints about the practice of dentistry and dental hygiene and disciplines those who violate the Board's rules, has communicated to the Department their desire that the recovered funds be available to be spent in accordance with the program's enacting legislation.

Primary Care Fund Program Spending Authority and Audits

The expenditures of the Primary Care Fund program are limited to the lower of the Long Bill appropriation or nineteen percent (19%) of the Amendment 35 tobacco tax ('tobacco tax") revenues[1], thus when revenue exceeds the amount appropriated, the Department does not have spending authority to allocate surplus revenue for primary care services. Additionally, the Primary Care Fund program has insufficient funding to implement a thorough and effective audit process.

Section 24-22-117(2)(b), C.R.S. provides for an allocation of moneys from Colorado's tax on cigarettes and tobacco products to health care providers that make comprehensive, primary care services available in an outpatient setting to residents of Colorado regardless of their ability to pay. The funds provide reimbursement to providers for otherwise uncompensated costs and charity care. The Primary Care Fund provides an allocation of moneys to health care providers that make basic health care services available in an outpatient setting to residents of Colorado who are considered medically indigent. Moneys are allocated based on the number of medically indigent patients served by one health care provider in an amount proportionate to the total number of medically indigent patients served by all health care providers who qualify for moneys from this fund. Funding can be used by providers to extend hours of operation, serve more patients, create diabetes management programs, comply with electronic health record regulations, and hire additional staff, etc.

The Primary Care Fund program is a State-only program which receives no federal funding. The appropriation for the Primary Care Fund is based on a forecast of annual tobacco tax collections and the forecasts can vary significantly for actual collections. In FY 2015-16, collections totaled $27,471,835, yet because the appropriation was set at $26,778,000, the Department was unable to fully expend available funds (a $693,835 gap between spending authority and available funding) on the participating Primary Care Fund program providers in a manner consistent with the intent of the legislation. Whenever the Primary Care Fund appropriation is lower than the actual tobacco tax collections, surplus revenue remains in the fund. The Department currently has no spending authority to allocate the surplus funds to participating providers so

---

[1] In 2004 Colorado voters approved Amendment 35, a tax increase on cigarettes and other tobacco products. The revenue was designated for health care services and tobacco education to improve the health of all Coloradans. For additional information see §24-22-117, C.R.S (2017)

that more primary care services could be provided in an outpatient setting to uninsured or medically indigent patients.

To ensure that allocated funds are being appropriately spent, the Department is appropriated $50,000 (as requested in the Department's FY 2015-16 budget request R-12 "Primary Care Fund Program.") The Department contracts with a vendor to perform audits of provider applications and the underlying data which are used to determine grant awards. The results of the audits have revealed multiple data validation issues such as not applying a sliding fee scale appropriately, not correctly identifying the medically indigent population, and not maintaining proper documentation for records used to complete the application from which they received state funds. The Department has determined that additional funding for adequate vendor payment is needed, as evidenced by a failed procurement, and an expanded audit scope is necessary to adequately verify the accuracy and validity of the data submitted.

The audited information is used to determine the provider's eligibility status to receive the funding as a qualified provider and the amount of payments they receive. Grant awards based on inaccurate data can adversely impact services to patients by qualified providers by reducing providers' respective share of the Primary Care Fund. If these payments are not accurately allocated to providers serving the target populations of uninsured or medically indigent patients, the availability and quality of these services could be reduced or compromised in a manner that would adversely affect the health outcomes of these patients.

Colorado Indigent Care Program Provider Audits

The current audit process of the Colorado Indigent Care Program (CICP) is inadequate. The program does not administer a standard, statewide audit, but requires CICP providers to self-administer an annual compliance audit of their CICP activities. This lack of uniformity of audit processes, including inconsistent interpretation of the program rules and requirements, increases risk of inaccurate application of the program's eligibility determination rules, increases risk of inaccurate reporting data, and is administratively burdensome for both the Department and the providers.

CICP, established in section 25.5-3-101, C.R.S., provides discounted health care services to low-income people and families. The CICP program offers a partial solution to the health care needs of the state's medically indigent citizens and does not provide a comprehensive benefits package. The program is not an insurance program, but rather a financial vehicle for providers to recoup some of their costs for providing medical services to the medically indigent who are not eligible for Medicaid or the Child Health Plan Plus (CHP+). The benefits offered under this program vary from provider to provider with minimum requirements set by the Department.

Based on compliance requirements prescribed in the CICP Provider Reference Manual, provider audits focus on operational and reporting activities and policies, including provider policy for determining an applicant's financial eligibility for the program with verification of appropriate documentation as proof of lawful presence in the country. The reporting aspects of the audits verify the accuracy of the data reported to the Department regarding aggregated CICP utilization and financial write-offs of the program. Currently, CICP providers conduct internal audits, except for a provider who receive $1,000,000 or more annually in CICP

funding, in which case, these providers are required to hire an independent auditor to perform the annual audit.

Beginning in FY 2014-15, the Department intensified its communications with CICP stakeholders with the intent of modernizing the CICP to allow for more efficient administration of the program, while maintaining the integrity of the program and a safety net for the low-income Coloradans who receive discounted health care services through qualified CICP providers. During FY 2016-17, the concept of a state-administered audit was discussed on several occasions in stakeholder forums and stakeholder workgroup sessions. Stakeholders were strongly supportive of a state-administered audit. Without a uniform audit that the Department oversees, it cannot be known with reasonable certainty that CICP rules and policies are accurately and consistently followed.

Proposed Solution:

The Department requests $81,324 cash funds in FY 2018-19 and $138,361 cash funds in FY 2019-20 and ongoing to provide additional spending authority for existing surplus cash fund and to improve oversight of the Department's safety net programs.

Senior Dental Program Reallocation of Recoveries

The Department is requesting $27,848 total funds in FY 2018-19, and ongoing, consisting entirely of cash funds from recoveries in the Health Care Policy and Financing Cash Fund, to increase spending authority and allow the Senior Dental Program to spend available funds from program recoveries. The additional spending authority would allow the Department to fully expend all available funding in a manner consistent with the program's legislative intent. If additional spending authority is not granted, it is possible that low-income seniors in need of dental services would not be provided such services due to provider capacity reaching its maximum.

Primary Care Fund Program Spending Authority and Audits

The Department requests budget-neutral appropriations that include a reduction of $53,160 in the Primary Care Fund Program line item and a corresponding increase of $53,160 in the Professional Audit Services line item to expand the program's existing audit processes for FY 2018-19, and ongoing. The Department also requests the ongoing authority to spend year-end surplus revenues that remain in the Primary Cary Fund. To accomplish this, the Department request the addition of an (I) headnote on the cash funds amount for the (5) Indigent Care Program; Primary Care Fund Program line item.

The additional $53,160 would result in a total of $103,160 available for program audits. This increase would allow for an expanded audit that would provide sufficient oversight and accountability standards to achieve better audit results and allow for a more accurate distribution of state tobacco tax revenues amongst all grantees. The implementation of the expanded audit is expected to begin October 1, 2018.

If the request is not approved, fewer services would be provided to populations of needy patients, risks of inaccurate Primary Care Fund program payment distributions would remain and general program oversight would continue to be inadequate.

Colorado Indigent Care Program Provider Audits

The Department requests $53,476 cash funds in FY 2018-19 and $110,513 total funds, including $138,361 cash funds, in FY 2019-20 and ongoing to administer an audit process to increase oversight of the program and ensure compliance of program rules and regulations. The cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund. The Department would use the requested funding for the development of a standard, consistent audit program and audit implementation.

Implementation of the audit program would eliminate the need for providers to finance external audits or devote staff resources to internal audits of their CICP program, and remove the annual burden on providers replacing it with a state-administered audit. Approximately one-third of the providers would be audited each year so that every provider is audited once every three years. The audits would also ensure uniformity in maintaining standards for the program so that client eligibility is determined appropriately and accurate utilization data is reported to the Department.

If the request is not approved, then the risks of improper application of program rules would remain unchanged and the procedural elements which can negatively impact a client's eligibility determination continue with inadequate oversight. Data reporting processes that are critical to the determination of program funding also remain unchecked while the audit burden on providers remains inconsistent and difficult for the Department to manage.

Anticipated Outcomes:

The request for additional program spending authority and audit funding addresses the Department's goal to improve the health of low-income and vulnerable Coloradans and furthers the Department's sound stewardship of financial resources.

Senior Dental Program Reallocation of Recoveries

Approving this request would ensure that the Department has sufficient spending authority to reallocate funds for Senior Dental Program services to improve the dental health of low-income seniors. The spending authority would increase the amount of funding available for the program each year, up to the amount of recoveries received during the year. The Department would use the funds to increase grants to providers who would offer dental services to low-income seniors. The recovery of funds addresses the Department's strategy to "Promote rigorous compliance with federal and state laws and regulations, fiscal rules and internal operating procedures" by minimizing inappropriate use and waste of resources. Additionally, the reinvestment of the funds recovered toward dental services furthering dental care to seniors in need aligns with the Department's strategic policy initiative to improve population health.

Primary Care Fund Program Spending Authority and Audits

Securing spending authority for the full amount of Primary Care Fund would assure that the grant payments to participating providers are maximized and that the full amount of tobacco tax collections are expended according to statute which aligns with the Departments strategy to "Support statewide efforts to improve population health." Expanding the compliance audit ensures that the grant awards are accurately targeted and increases availability of health care services to the medically indigent and uninsured. The compliance audit addresses the Department's strategy to "Promote rigorous compliance with federal and state laws and

regulations, fiscal rules and internal operating procedures." This request would allow the Department to ensure rigorous compliance by holding our business partners accountable, which enables the Department to minimize waste of resources resulting from fraud, waste and abuse.

Colorado Indigent Care Program Provider Audits

As part of the Department's strategy to "Implement cost containment initiatives," the CICP is being modernized by improving the program's ability to mitigate uncompensated health care costs that would otherwise drive up the cost of health care borne by payers such as private health insurance. This strategy focuses on reducing the growth rate of expenditures by implementing programs that lower per-capita costs while improving health outcomes and the experience of people served. Holding providers accountable and ensuring compliance with program rules enables the Department to increase oversight over the correct use of funds and the maximization of resources available. A state-administered audit would allow for a more accurate distribution of the program's fixed amount of funding among CICP providers and establish a redistribution policy upon determination of adverse audit results.

Assumptions and Calculations:

The Department has included an appendix that details the figures and calculations relevant to the request.

Senior Dental Program Reallocation of Recoveries

The Department periodically recovers funds for payments to grantees in the prior fiscal year due to routine program reviews and possible settlements involving the Colorado Office of Attorney General. The Department estimates that a maximum of one percent of grantee funding for services is at risk of being recovered which is $27,848 as calculated in table 3.1 of the appendix. In FY 2016-17, the Department received $10,878 in recoveries attributed to Senior Dental Program; the Department anticipates that this number will vary from year to year. The Department expects that one percent of additional spending authority would provide sufficient flexibility for future variances. Due to this uncertainty, the Department requests an (I) notation on the cash funds portion of the appropriation to allow expenditures up to the amount of the recoveries collected.

Primary Care Fund Program Spending Authority and Audits

The "(I)" notation may be applied to a cash funds figure when the amount is otherwise authorized by law to be spent by a department pursuant to a provision of state statute or state constitution which applies to this fund. The (I) notation would allow the full 19% of the Amendment 35 tobacco tax revenues, plus the accumulated interest income deposited into the fund, to be allocated for primary care services in an outpatient setting to uninsured or medically indigent patients.

The Department found that the $50,000 currently available for the audit of the Primary Care Fund Program is not sufficient to fully implement the audit as intended. The Department is requesting an additional $53,160, as shown in table 4, to be transferred from the Primary Care Fund line item to provide adequate funding for the audit based on feedback from vendors that provide audit services. This request is total funds neutral, as the Department would reduce the allocations to providers from the Primary Care Fund by the same amount.

Colorado Indigent Care Program Provider Audits

There are two groups of providers in CICP, a clinic group and a hospital group, with the number of clinics historically accounting for approximately 25% of the total number of program providers. Program funding for the two provider groups have separate funding sources; the Department's request draws funding from each funding source proportionally. The respective costs are determined via a methodology based on the number of expected audits within each group. Table 5.1 shows the hospital and clinic allocations for both years. The clinic portion of the audits is General Fund originally appropriated to the Client Based Indigent Care line item and the Hospital portion is new funding from the Healthcare Affordability and Sustainability Fee Cash Fund.

Because FY 2018-19 would be the first year of the audit, a partial implementation of the audit is planned. In October 2018, there would be a start-up period to allow for sufficient training and collaboration between the Department, the auditor and program stakeholders to develop an audit methodology conforming to the rules and guidelines of the CICP. The Department estimates that FY 2018-19 would have start-up costs to create the audit methodology. These figures are based on discussions with current Department vendors familiar with the program. Then, upon development of the audit methodology, the audit process for FY 2018-19 would comprise of one-third of the scope of the full implementation.

In FY 2019-20, the Department would fully implement the audit process. The allocation amounts from the provider groups for the full implementation cost are showed in table 5.1, row E. The costs are sourced proportionally from the two provider groups based on the number of providers in the group as a percentage of the total number of program providers. Details of the audit cost estimates are found in tables 5.2 and 5.3. The quantity of hours estimated for each of the components is based on recent Department audits of similar scope including the Disproportionate Share Hospitals (DSH) program, Primary Care Fund program, and Nursing Facility Provider Fee program. The hourly rates of the auditor classification are mid-range figures of similarly listed rates within the current Price Agreement List.

Table 1.1 - Summary by Line Item FY 2018-19						
Row	**Line Item**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**Source**
A	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$135,500	$28,864	$106,636	$0	Table 2.1, Row B 1 + Row C1 Table 1.3, Row A
B	(5) Indigent Care Program, Clinic Based Indigent Care	($28,864)	($28,864)	$0	$0	Table 2.1, Row C2
C	(5) Indigent Care Program, Primary Care Program	($53,160)	$0	($53,160)	$0	Table 1.3, Row B
D	(6) Other Medical Services, Old Age Pension State Medical Program	$27,848	$0	$27,848	$0	Table 1.3, Row C
E	**Total**	**$81,324**	**$0**	**$81,324**	**$0**	**Sum of Rows A Thru D**

[1] Cash Funds are detailed in Table 1.3

Table 1.2 - Summary by Line Item FY 2019-20						
Row	**Line Item**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**Source**
A	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$203,860	$40,187	$163,673	$0	Table 2.2, Row B1 + Row C1 Table 1.4, Row A
B	(5) Indigent Care Program, Clinic Based Indigent Care	($40,187)	($40,187)	$0	$0	Table 2.2, Row C2
C	(5) Indigent Care Program, Primary Care Program	($53,160)	$0	($53,160)	$0	Table 2.2, Row B2
D	(6) Other Medical Services, Old Age Pension State Medical Program	$27,848	$0	$27,848	$0	Table 1.4, Row C
E	**Total**	**$138,361**	**$0**	**$138,361**	**$0**	**Sum of Rows A Thru D**

[1] Cash Funds are detailed in Table 1.4

Table 1.3 - Cash Fund Breakout by Line Item FY 2018-19						
Row	**Line Item**	**HCPF Cash Fund**	**Primary Care Fund**	**HASF Cash Fund**	**Total Cash Funds**	**Source**
A	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$0	$53,160	$53,476	$106,636	Table 2.1, Row B1 & Table 2.1 Row C3
B	(5) Indigent Care Program, Primary Care Program	$0	($53,160)	$0	($53,160)	Table 2.1, Row B2
C	(6) Other Medical Services, Old Age Pension State Medical Program	$27,848	$0	$0	$27,848	Table 2.1, Row A1
D	**Total**	**$27,848**	**$0**	**$53,476**	**$81,324**	**Row A + Row B + Row C**

Table 1.4 - Cash Impact of Line Item FY 2019-20						
Row	**Line Item**	**HCPF Cash Fund**	**Primary Care Fund**	**HASF Cash Fund**	**Total Cash Funds**	**Source**
A	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$0	$53,160	$110,513	$163,673	Table 2.2, Row B1 & Table 2.2, Row C3
B	(5) Indigent Care Program, Primary Care Program	$0	($53,160)	$0	($53,160)	Table 2.2, Row B2
C	(6) Other Medical Services, Old Age Pension State Medical Program	$27,848	$0	$0	$27,848	Table 2.2, Row A1
D	**Total**	**$27,848**	**$0**	**$110,513**	**$138,361**	**Row A + Row B + Row C**

Table 2.1 Summary by Initiative FY 2018-19									
Row	**Line Item**	**Total Funds**	**General Fund**	**HCPF Cash Fund**	**Primary Care Fund**	**CHASE Cash Fund**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	**Senior Dental Program Reallocation of Recoveries**	**$27,848**	**$0**	**$27,848**	**$0**	**$0**	**$0**	**NA**	**Row A1**
A1	(6) Other Medical Services, Old Age Pension State Medical Program	$27,848	$0	$27,848	$0	$0	$0	NA	Table 3.1, Row C
B	**Primary Care Fund Spending Authority and Audit Funding**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**NA**	**Row B1 + Row B2**
B1	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$53,160	$0	$0	$53,160	$0	$0	NA	Table 4, Row N
B2	(5) Indigent Care Program, Primary Care Program	($53,160)	$0	$0	($53,160)	$0	$0	NA	Table 4, Row N * -1
C	**Colorado Indigent Care Program Audit Funding**	**$53,476**	**$0**	**$0**	**$0**	**$53,476**	**$0**	**NA**	**Row C1 + Row C2 + Row C3**
	Clinics								
C1	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$28,864	$28,864	$0	$0	$0	$0	NA	Table 5.1, Row D [Clinics]
C2	(5) Indigent Care Program, Clinic Based Indigent Care	($28,864)	($28,864)	$0	$0	$0	$0	NA	Table 5.1, Row D [Clinics] * -1
	Hospitals								
C3	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$53,476	$0	$0	$0	$53,476	$0	NA	Table 5.1, Row D [Hospitals]
D	**Total Request**	**$81,324**	**$0**	**$27,848**	**$0**	**$53,476**	**$0**	**NA**	**Row A + Row B + Row C**

Table 2.2 - Summary by Initiative FY 2019-20									
Row	**Line Item**	**Total Funds**	**General Fund**	**HCPF Cash Fund**	**Primary Care Fund**	**CHASE Cash Fund**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	**Senior Dental Program Reallocation of Recoveries**	**$27,848**	**$0**	**$27,848**	**$0**	**$0**	**$0**	**NA**	**Row A1**
A1	(6) Other Medical Services, Old Age Pension State Medical Program	$27,848	$0	$27,848	$0	$0	$0	NA	Table 3.1, Row C
B	**Primary Care Fund Spending Authority and Audit Funding**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**NA**	**Row B1 + Row B2**
B1	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$53,160	$0	$0	$53,160	$0	$0	NA	Table 4, Row N
B2	(5) Indigent Care Program, Primary Care Program	($53,160)	$0	$0	($53,160)	$0	$0	NA	Table 4, Row N * -1
C	**Colorado Indigent Care Program Audit Funding**	**$110,513**	**$0**	**$0**	**$0**	**$110,513**	**$0**	**NA**	**Row C1 + Row C2 + Row C3**
	Clinics								
C1	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$40,187	$40,187	$0	$0	$0	$0	NA	Table 5.1, Row D [Clinics]
C2	(5) Indigent Care Program, Clinic Based Indigent Care	($40,187)	($40,187)	$0	$0	$0	$0	NA	Table 5.1, Row D [Clinics] * -1
	Hospitals								
C3	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$110,513	$0	$0	$0	$110,513	$0	NA	Table 5.1, Row D [Hospitals]
D	**Total Request**	**$138,361**	**$0**	**$27,848**	**$0**	**$110,513**	**$0**	**NA**	**Row A + Row B + Row C**

Table 3.1 - Senior Dental Program Spending Authority Increase FY 2018-19			
Row	**Description**	**Amount**	**Source**
A	Grantee Funds for Services	$2,784,759	Estimated services costs based on FY 17 actuals
B	Percentage of Expected Recoveries	1%	The Department estimates that up to 1% of funds for services could be recovered on an annual basis.
C	**Spending Authority Increase**	**$27,848**	**Row A * Row B**

Table 3.2 - FY 2016-17 Senior Dental Program Recoveries		
Row	**Description**	**Amount**
A	Department Review Recoveries	$7,027
B	Attorney General Settlement	$3,851
C	**Total**	**$10,878**

Table 4 - Primary Care Fund Audit
Cost Estimate by Audit Component

Row	Audit Method & Reporting Requirements	# of Audits	# of Hours Per Audit	Number of Hours of Work by Auditor Classification		Description
A	Auditor Classification			Senior	Junior	
B	Entrance Conference			12	12	Based on information from recently procured audits.
C	Level I Desk Review Audit of Provider Application	14	40.0	-	560	Number of Audits multiplied by Number of Hours Per Audit
D	Level II Audit Review of Selected Provider Applications	7	16.0	112	-	Number of Audits multiplied by Number of Hours Per Audit
E	Draft Report of Audit Findings			24	76	Based on information from recently procured audits.
F	Exit Conference			8	12	
G	Final Report (Department's Responses Incorporated)			10	10	
H	Auditor Remains Available for Questions/Appeals			10	36	
I	**Total Auditor Hours**			**176**	**706.0**	**Sum of Row B through Row H**
J	Hourly Rate			$185.00	$100.00	Department's FY 2016-17 Price Agreement List.
K	**Subtotal of Audit Cost by Auditor Classification**			**$32,560**	**$70,600**	**Row I * Row J**
L	**Total Estimated Audit Cost**				**$103,160**	**Sum of Row K**
M	Less Funding from FY 2015-16 R-14 "Primary Care Fund Audit"				($50,000)	FY 2015-16 R-14 "Primary Care Fund Audit"
N	**Total Request**				**$53,160**	**Row L + Row M**

*The number of audit hours required per audit component and Senior and Junior auditor rates are based on various Department audits including the DSH audit and Nursing Facility audit, and the Department's FY 2016-17 Price Agreement List.

Table 5.1 - Colorado Indigent Care Program Audit Breakdown of Funding by Hospitals and Clinics					
Row	**Description**	**Total**	**Hospital**	**Clinics**	**Source**
A	Allocation percentage of costs between Hospitals and Clinics	100.00%	73.33%	26.67%	Based on quantity of CICP providers within each category
B	FY 2018-19 Start-up Costs[1]	$29,600	$14,800	$14,800	Costs shared equally as audit development is independent of quantity of providers within group
C	FY 2018-19 Audit Cost - Partial Implementation	$52,740	$38,676	$14,064	Table 5.2, Row S multiplied by allocation % in Row A
D	**FY 2018-19 Total Costs - Partial Implementation**	**$82,340**	**$53,476**	**$28,864**	**Row B + Row C**
E	**FY 2019-20 Total Costs - Full Implementation**	**$150,700**	**$110,513**	**$40,187**	**Table 5.3, Row S multiplied by allocation % in Row A**

[1] Auditor for development of audit methodology at expected cost of 160 hours @ $185/hour

Table 5.2 - Colorado Indigent Care Program Audit
Cost Estimate by Audit Component
FY 2018-19 - Partial Implementation (8 Audits)

Row	Audit Method & Reporting Requirements	# of Audits	# of Hours Per Audit	Number of Hours of Work by Auditor Classification		Description
A	Auditor Classification			**Senior**	**Junior**	
B	Entrance Conference			8	8	Based on information from recently procured audits.
	6 Hospital Audits					
C	Desk Review Audits of Client Application - Eligibility	6	24.0	-	144	Number of Provider Audits multiplied by Number of Hours Per Audit
D	Desk Review Audits of Provider Records - Billing	6	16.0	-	96	
E	Desk Review Audits of Provider - Programmatic	6	1.0	-	6	
	2 Clinic Audits					
F	Desk Review Audits of Client Application - Eligibility	2	24.0	-	48	
G	Desk Review Audits of Provider Records - Billing	2	16.0	-	32	
H	Desk Review Audits of Provider - Programmatic	2	1.0	-	2	
I	Level II Review of Selected Provider Applications	4	8.0	32	-	
J	Draft Report of Audit Findings			-	8	Based on information from recently procured audits.
K	Review Report of Audit Findings			8	-	
L	Exit Conference with Provider			8	8	
M	Present Final Report for each Provider Submitted to Department			8	8	
N	Summary Report of Audit Findings and Recommendations			8	12	
O	Auditor Remains Available for Questions/Appeals	12	1.0	12	-	
P	**Total Auditor Hours**			**84**	**372**	**Sum of Rows B through O**
Q	Hourly Rate			$185.00	$100.00	Department's FY 2016-17 Price Agreement List.
R	**Subtotal of Audit Cost by Auditor Type**			**$15,540**	**$37,200**	**Row P * Row Q**
S	**Total Estimated Audit Cost**				**$52,740**	**Sum of Row R**

*The number of audit hours required per audit component and Senior and Junior auditor rates are based on various Department audits including the DSH audit and Primary Care Fund audit, and the Department's FY 2016-17 Price Agreement List.

Table 5.3 - Colorado Indigent Care Program Audit
Cost Estimate by Audit Component
FY 2019-20 - Full Implementation (24 Audits)

Row	Audit Method & Reporting Requirements	# of Audits	# of Hours Per Audit	Number of Hours of Work by Auditor		Description
A	Auditor Classification			**Senior**	**Junior**	
B	Entrance Conference			16	16	Based on information from recently procured audits.
	18 Hospital Audits					
C	Desk Review Audits of Client Application - Eligibility	18	24.0	-	432	Number of Provider Audits multiplied by Number of Hours Per Audit
D	Desk Review Audits of Provider Records - Billing	18	16.0	-	288	
E	Desk Review Audits of Provider - Programmatic	18	1.0	-	18	
	6 Clinic Audits					
F	Desk Review Audits of Client Application - Eligibility	6	24.0	-	144	
G	Desk Review Audits of Provider Records - Billing	6	16.0	-	96	
H	Desk Review Audits of Provider - Programmatic	6	1.0	-	6	
I	Level II Review of Selected Provider Applications	12	8.0	96	-	
J	Draft Report of Audit Findings			-	40	Based on information from recently procured audits.
K	Review Report of Audit Findings			24	-	
L	Exit Conference with Provider			24	24	
M	Present Final Report for each Provider Submitted to Department			8	12	
N	Summary Report of Audit Findings and Recommendations			16	24	
O	Auditor Remains Available for Questions/Appeals	36	1.0	36	-	
P	**Total Auditor Hours**			**220**	**1,100**	**Sum of Rows B through O**
Q	Hourly Rate			$185.00	$100.00	Department's FY 2016-17 Price Agreement List.
R	**Subtotal of Audit Cost by Auditor Type**			**$40,700**	**$110,000**	**Row P * Row Q**
S	**Total Estimated Audit Cost**				**$150,700**	**Sum of Row R**

*The number of audit hours required per audit component and Senior and Junior auditor rates are based on various Department audits including the DSH audit and Primary Care Fund audit, and the Department's FY 2016-17 Price Agreement List.

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-15 CHASE Administrative Costs**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___	Supplemental FY 2017-18
X	Change Request FY 2018-19
___	Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$92,145,138	$0	$98,685,346	$1,192,262	$1,200,040
	FTE	418.4	0.0	427.4	10.1	10.0
	GF	$23,324,498	$0	$26,208,772	$0	$0
	CF	$9,760,599	$0	$9,919,676	$596,132	$600,022
	RF	$2,255,164	$0	$2,593,731	$0	$0
	FF	$56,804,877	$0	$59,963,167	$596,130	$600,018

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- Personal Services	Total	$30,884,154	$0	$32,040,094	$604,770	$659,798
	FTE	418.4	0.0	427.4	10.1	10.0
	GF	$10,512,849	$0	$10,769,424	$0	$0
	CF	$2,985,184	$0	$3,045,883	$302,385	$329,900
	RF	$1,885,978	$0	$2,242,657	$0	$0
	FF	$15,500,143	$0	$15,982,130	$302,385	$329,898
01. Executive Director's Office, (A) General Administration -- Health, Life, and Dental	Total	$3,637,126	$0	$3,637,126	$87,198	$87,198
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,305,776	$0	$1,305,776	$0	$0
	CF	$344,132	$0	$344,132	$43,599	$43,599
	RF	$103,855	$0	$103,855	$0	$0
	FF	$1,883,363	$0	$1,883,363	$43,599	$43,599

Line Item	Fund					
01. Executive Director's Office, (A) General Administration -- Short-term Disability	Total	**$58,060**	**$0**	**$58,060**	**$919**	**$1,003**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,586	$0	$21,586	$0	$0
	CF	$4,802	$0	$4,802	$460	$502
	RF	$1,364	$0	$1,364	$0	$0
	FF	$30,308	$0	$30,308	$459	$501

Line Item	Fund					
01. Executive Director's Office, (A) General Administration -- Amortization Equalization Disbursement	Total	**$1,615,047**	**$0**	**$1,615,047**	**$24,190**	**$26,390**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$600,398	$0	$0
	CF	$133,634	$0	$133,634	$12,095	$13,195
	RF	$37,970	$0	$37,970	$0	$0
	FF	$843,045	$0	$843,045	$12,095	$13,195

Line Item	Fund					
01. Executive Director's Office, (A) General Administration -- Supplemental Amortization Equalization Disbursement	Total	**$1,615,047**	**$0**	**$1,615,047**	**$24,190**	**$26,390**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$600,398	$0	$0
	CF	$133,634	$0	$133,634	$12,095	$13,195
	RF	$37,970	$0	$37,970	$0	$0
	FF	$843,045	$0	$843,045	$12,095	$13,195

Line Item	Fund					
01. Executive Director's Office, (A) General Administration -- Operating Expenses	Total	**$2,162,529**	**$0**	**$2,082,684**	**$62,184**	**$10,450**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$961,889	$0	$948,995	$0	$0
	CF	$74,170	$0	$70,519	$31,092	$5,225
	RF	$26,219	$0	$13,297	$0	$0
	FF	$1,100,251	$0	$1,049,873	$31,092	$5,225

Line Item	Fund					
01. Executive Director's Office, (A) General Administration -- Legal Services	Total	**$1,114,404**	**$0**	**$1,114,404**	**$123,811**	**$123,811**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$360,583	$0	$360,583	$0	$0
	CF	$196,620	$0	$196,620	$61,906	$61,906
	RF	$0	$0	$0	$0	$0
	FF	$557,201	$0	$557,201	$61,905	$61,905

01. Executive Director's Office, (A) General Administration -- General Professional Services and Special Projects	**Total**	**$9,412,649**	**$0**	**$14,534,207**	**$250,000**	**$250,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,005,615	$0	$5,621,706	$0	$0
	CF	$1,600,352	$0	$1,545,040	$125,000	$125,000
	RF	$150,000	$0	$150,000	$0	$0
	FF	$4,656,682	$0	$7,217,461	$125,000	$125,000

01. Executive Director's Office, (C) Information Technology Contracts and Projects -- MMIS Maintenance and Projects	**Total**	**$41,646,122**	**$0**	**$41,988,677**	**$15,000**	**$15,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,955,404	$0	$5,979,906	$0	$0
	CF	$4,288,071	$0	$4,445,412	$7,500	$7,500
	RF	$11,808	$0	$6,618	$0	$0
	FF	$31,390,839	$0	$31,556,741	$7,500	$7,500

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 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

- This request is for $1,192,262 total funds, including $596,132 cash funds, $596,130 federal funds, and 10.1 FTE in FY 2018-19; and $1,200,040 total funds, including $600,022 cash funds, $600,018 federal funds, and 11.0 FTE in FY 2019-20; and ongoing, to fund the increased workload for the administration of the Colorado Healthcare Affordability and Sustainability Enterprise. The cash funds are from the Healthcare Affordability and Sustainability Fee (HAS Fee) Cash Fund. This request has no General Fund impact.

Current Program

- SB 17-267 "Concerning the Sustainability of Rural Colorado" eliminates the Hospital Provider Fee program and creates the Colorado Healthcare Affordability and Sustainability Enterprise ("CHASE" or "Enterprise") as a government-owned enterprise within the Department, effective July 1, 2017.
- Section 25.5-4-402.4, C.R.S., establishes the HAS Fee to obtain federal financial participation to increase hospital reimbursement for care provided under Medicaid and the Colorado Indigent Care Program (CICP). Fee revenue also serves as the state share to fund health coverage for more than 440,000 Coloradans currently enrolled in Medicaid and the Children's Health Plan Plus (CHP+).
- Under oversight from the CHASE Board, the Enterprise is charged with implementing and administering the HAS Fee with administrative costs paid from the HAS Fee Cash Fund.

Problem or Opportunity

- Additional business services of the Enterprise that were not part of the purpose of the former Hospital Provider Fee program are outlined at section 25.5-4-402.4(4)(a)(IV), C.R.S. These include consulting with hospitals to improve cost efficiency, patient safety, and clinical effectiveness; advising on changes in federal and state laws; and providing coordinating services to adapt and transition to any new or modified Medicaid performance tracking and payment systems. The Enterprise is also tasked with monitoring and reporting on the impact of the HAS Fee on the overall health care market.
- The Enterprise has insufficient resources to support the administration of the HAS Fee and to perform its prescribed business functions. A workload increase attributed to additional business functions of the Enterprise, including advising and consulting with hospitals and ensuring the Enterprise is operated within the requirements of TABOR, cannot be absorbed within existing resources.
- Workload attributed to analytics related to the impact of the Enterprise on hospitals' financial viability and the Colorado health care market, and the development of value-based payments initiatives, including Delivery Services Reform Incentive Payments (DSRIP) is expected to increase.

Consequences of Problem

- If this request is not approved, the Enterprise would not be able to carry out all its business services, risks associated with improper administration of an enterprise increase, the inadequacy of current analysis would persist, and the Enterprise would be understaffed in performing duties essential for proper administration.

Proposed Solution

- This request is for staff to administer and provide business services in accordance with the relevant sections of SB 17-267, anticipated increases in legal costs, and contracting with health care consultants to produce informative reports and analytics on the impact of the Enterprise on the greater health care marketplace.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2018-19 Funding Request | November 1, 2017

Department Priority:	*R-15*
Request Detail:	*Colorado Healthcare Affordability and Sustainability Enterprise Administration Costs*

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Colorado Healthcare Affordability and Sustainability Enterprise Administration Costs	$1,192,262	$0

Problem or Opportunity:

The Colorado Healthcare Affordability and Sustainability Enterprise, hereafter referred to as the "Enterprise" or "CHASE", has insufficient funding for its administration. The proper and efficient administration of the Enterprise, in accordance with state fiscal rules, state statute, and the Colorado State Constitution, requires an increase in workload which cannot be absorbed within existing resources.

SB 17-267 "Concerning the Sustainability of Rural Colorado", signed into law on May 30, 2017, repealed the Hospital Provider Fee program and created the Enterprise to assess the Healthcare Affordability and Sustainability Fee (HAS Fee), effective July 1, 2017. The purposes of the fee are to increase hospital reimbursement for care provided under the Medicaid program and the Colorado Indigent Care Program (CICP), and to fund health coverage for more than 480,000 Coloradans currently enrolled in Medicaid and the Child Health Plan Plus (CHP+). To comply with both state law and the state's Medicaid State Plan agreement with the Centers for Medicare and Medicaid Services (CMS), the Enterprise must establish rules to assess fees on hospitals, ensure continuing health care coverage for these Medicaid and CHP+ members and make required payments to hospitals.

SB 17-267 outlines additional business services of the Enterprise that were not part of the purpose of the former Hospital Provider Fee program. These additional business services include: consulting with hospitals to help them improve cost efficiency, patient safety, and clinical effectiveness; advising hospitals regarding potential changes to federal and state laws and regulations governing Medicaid; providing coordinating services to hospitals to help them adapt and transition to any new or modified performance tracking and payment systems for the Medicaid program; and providing funding for a health care delivery system reform incentive payments (DSRIP) program.

SB 17-267 supports the shift of hospital payments to value-based payments by requiring the Enterprise to seek a federal waiver to fund, and in cooperation between the Department and hospitals, support the

implementation of a health care delivery system reform incentive payment (DSRIP) program no earlier than October 1, 2019. The DSRIP program aligns the shared goals of the State and the hospitals towards improvements in care coordination, the integration of physical and behavioral health services, chronic condition management, targeted population health, and the use of metrics and milestones to drive accountability through outcome-based measurement. Further, the DSRIP program will be designed to use evidence-based quality improvement methods with clear goals, activities and quality improvement metrics. Participating DSRIP hospitals will include both urban and rural hospitals, which benefit from CHASE funding.

Given the unique challenges facing critical access hospitals, rural hospitals and other small hospitals, the State intends to make special provisions for DSRIP program requirements and payments for those hospitals. A main objective under SB 17-267 was to provide for the stability of rural hospitals. Rural hospitals will be treated to different measures and expectations under the DSRIP. A key value of DSRIP will be finding innovative ways to improve the performance of the delivery system and drive quality. For these rural hospitals, it is important that the approach also involve innovative strategies that lead to stability and sustainability. These unique challenges and opportunities need to be addressed separately from the larger urban systems, and as such, requires a distinct track of stakeholder engagement and DSRIP program development.

To be able to implement a DSRIP waiver program in October 2019, the Department must embark on a robust program development and stakeholder engagement process. The Department needs dedicated hospital policy, quality, and communication staff to engage a variety of stakeholders across the state that includes hospitals as well as other key delivery system partners, such as Regional Accountability Entities (RAEs), Local Public Health Agencies (LPHAs), and Federally Qualified Health Centers (FQHCs).

The Enterprise is, and operates as, a government-owned business, or "enterprise", within the Department of Health Care Policy and Financing. An enterprise[1] is generally defined as a self-supporting, or largely self-supporting, government owned business that receives its revenue in return for the provision of goods or services. The increased workload necessary to ensure operational and reporting compliance, including maintaining separate and distinct financial records of the Enterprise and a new level of oversight, cannot be absorbed within existing resources. Funds are needed for a consultant to analyze and report on the impact of the HAS Fee on the overall health care market and consult with hospitals on impact of state and/or federal health care law or policy changes on hospitals.

Further, the Enterprise needs adequate legal services funding due to the existing[2] legal action against the hospital provider fee, as the plaintiffs have moved to amend their suit to include a challenge of the qualification of CHASE as an enterprise under TABOR. In existing litigation, plantiffs allege that the hospital provider fee is a tax and therefore subject to TABOR's requirement that a public vote be taken before it is levied or increased. Plaintiffs challenge the fee imposed in fiscal years 2011, 2012, and 2013 and seek a refund of all revenue collected, kept, or spent unconstitutionally, plus interest. The Department expects that

[1] Article X, Section 20 (2) (d) of the Colorado State Constitution
[2] Tabor Foundation v. HCPF, et al Case No: 2015CV32305

further litigation on the subject of whether CHASE qualifies an an enterprise under the Colorado constitution would drive the need for more legal services.

Finally, the Enterprise needs adequate resources to ensure transparent, timely and accurate communications to all stakeholders including State legislators, hospitals, and Colorado taxpayers regarding the goals and results of the Enterprise and the initiatives within SB 17-267, including health care delivery system reform incentive payments.

Proposed Solution:

The Department requests $1,192,262 total funds, including $596,132 cash funds, $596,130 federal funds, and 10.1 FTE in FY 2018-19; and $1,200,040 total funds, including $600,022 cash funds, $600,018 federal funds, and 11.0 FTE in FY 2019-20; and ongoing, to adequately administer the Colorado Healthcare Affordability and Sustainability Enterprise including the provision of the Enterprise's business services that were not part of the former Hospital Provider Fee program. The requested funding would be used to fund FTE throughout the Department necessary for the increased workload requirements of the Enterprise outlined in SB 17-267 and support the Enterprise's broad operations in its compliance with state and federal rules and regulations, including the Colorado State Constitution. The funding would also support a health care analytics contract, software licensing, and an expected increase in legal services. The cash funds are from the HAS Fee Cash Fund. This request has no General Fund impact.

With the requested funding, dedicated FTE would be developed to serve as subject matter experts in all essential areas needed to carry out duties for the effective administration of the Enterprise. Specifically, consulting and advising with hospitals requires dedicated policy, quality, and communications subject matter experts. Monitoring the impact on the health care market requires a dedicated analyst, analytical software, and contracted health care consultants. Ensuring the Enterprise operates in accordance with TABOR requires dedicated audit, accounting, and budget subject matter experts on the financial aspects of an enterprise. The staff would be accessible to address and resolve issues concerning the requirements and best practices for operating a government-run business. Existing resources cannot absorb the workload associated with the provision of these new services. Additional FTE are necessary to assume the duties of managing four existing vendor contracts, including a hospital data collection contract, a State Plan Amendment (SPA) development contract, a disproportionate share hospital (DSH) audit contract, and a hospital financial data analysis contract, as well as the duties in the management of the DSRIP project. The additional FTE would allow more senior and experienced staff to spend adequate time and energy on these business service requirements of the bill.

The Department has received notice of legal challenges to the qualification of CHASE as an enterprise under the State Constitution, necessitating $123,811 in additional legal services costs. With the requested funding, the Department, in conjunction with the Department of Law, would be able to retain outside counsel for the purposing of defending against the lawsuits, in order to allow the HAS fee to continue to be collected, continue making payments to hospitals, and continue funding the Medicaid populations supported by the HAS fee.

The requested contractor funding would provide $250,000 for contractor resources to carry out enterprise-related business services, including consulting with hospitals to improve cost efficiency, patient safety, and clinical effectiveness, advising hospitals regarding potential changes to federal and state laws and regulations governing Medicaid; providing coordinating services to hospitals to help them adapt and transition to any new or modified performance tracking and payment systems for the Medicaid program; and implementing and administering a delivery system reform incentive payments program to improve quality of hospital care.

If this request is not funded the Enterprise would be unable to fully provide the business services to hospitals nor develop and implement the DSRIP initiative as outlined in SB 17-267, thus risking the loss of an opportunity to collaborate and coordinate with hospitals and stakeholders on the transformation and modernization of health care delivery systems including the conversion of hospital payments to value-based payments. Enterprise staff would be unable to absorb the increased workload and the risks of Enterprise operations being non-complant with state and federal regulations would increase. The expected provision of analytics and reports on the impact of the HAS Fee and Enterprise initiatives would also be compromised if this request is not approved.

Anticipated Outcomes:

The approval of this request would ensure the Enterprise has sufficient funding and FTE to properly administer and support its operations. The Enterprise would be able to fulfill its business functions including advising and consulting with hospitals, analyzing the Enterprise's effect on the health care market, and implementing a new incentive payments program.

The proper administration of Enterprise operations aligns with two of the strategies found within the Department's Performance Plan. Specifically, this request exemplifies both the "improved efficiency of business process" strategy and the "rigorous compliance with federal and state laws and regulations, fiscal rules and internal operating procedures" strategy by facilitating accountability and transparency of Enterprise operations.

Implementation of the DSRIP program represents movement toward the strategy to "expand of the use of value-based purchasing methods" through use of evidence-based quality improvement methods and outcome-based measurement. The approval of this request would also allow the Enterprise and its contracted consultants to expand their analytics commitments and their focus to produce informative and relevant reports and analyses related to the Enterprise and its impact on the Colorado health care marketplace, which adheres to the Department's strategy of "maximizing use of health information technology and data analytic, aligning efforts with the broader health care system."

Assumptions and Calculations:

Detailed FTE descriptions in the following Appendix A and calculations of this request are included and the attached Appendix B.

The Department requests funding for 11 new staff positions, legal services, a contracted consultant and software licensing costs. Appendix A, table 1 includes FTE position names, classifications and description

of job duties of each of the FTE requested. These positions would provide essential roles for the effective management and administration of the Enterprise as subject matter experts.

Appendix B includes tables that summarize the requested funding. Table 1 shows the incremental request summarized by line item. Table 2 shows the summary of the components of the request. Calculation details are shown in table 3 and table 4.

Per section 25.5-4-402.4(4)(III), administration funding is limited to three percent (3%) of the expenditures of the Enterprise, based on a methodology approved by the Office of State Planning and Budgeting and Joint Budget Committee staff. Table 5 uses a totals funds methodology to show that with the approval of this request the projected administration funding percentage is 2.23%, which is a 0.03 percentage point increase overall from the total FY 2017-18 Hospital Provider Fee administration appropriations.

Appendix A: FTE Descriptions

Table 1 – FTE Summary			
Position Name	**Position Classification**	**Number of FTE**	**Description of Duties**
Auditor	Auditor III	1	The proposed FTE would provide internal review and recommendations on the efficiency of the necessary activities to prepare the CHASE collection and disbursement model. The examination of the business processes involved in the preparation and development of the HAS fee and hospital payments model including examining the results of the model and the process trail from input to output ensures that the resources are being managed efficiently and effectively.
Contract Manager	Contract Administrator III	1	This FTE would negotiate, implement, monitor, and manage Enterprise contracts, including developing contract scopes of work, negotiating terms with vendors, approving contractor personnel and work plans, processing invoices for payment, and ensuring adequate funds are available and budgeted for contracted work. The Enterprise contracts with consultants to review the Enterprise's calculations of the HAS Fee, provide advice and consultation on upper payment limit calculations to assure adherence to federal requirements, gather and validate data used in the fee-related calculations, and evaluate the fee's effect on the health care market. The additional provision of business services outline in SB 17-267 has created the need for a dedicated contract manager to assume the duties heretofore absorbed by other staff.

Table 1 – FTE Summary			
Position Name	**Position Classification**	**Number of FTE**	**Description of Duties**
Project Manager	Project Manager II	1	The proposed FTE would act as consultant to provide strategy, create systems, processes, guidelines and rules related to the Enterprise using project management best practices. The position would provide support to the Enterprise project team by coordinating the DSRIP programs, providing guidance on project management processes and communication of project information to stakeholders. The additional provision of business services outline in SB 17-267 has created the need for a dedicated project manager to assume the duties heretofore absorbed by other staff.
Budget Analyst	Budget Analyst III	1	The proposed FTE would provide budget services for the additional business services required of the Enterprise. This including the budget development and ensuing tracking and reporting of the expenditures of the DSRIP program, the consultant/analytics contract, and the expected increase in legal services expenditures. This FTE would also provide a level of oversight of the fiscal operations of the Enterprise and its compliance with state fiscal rules and state and federal law.

Table 1 – FTE Summary			
Position Name	**Position Classification**	**Number of FTE**	**Description of Duties**
Accountant	Accountant II	1	The proposed FTE would provide dedicated accounting and reporting services for the fiscal operations of the Enterprise that correspond to the new business services and initiatives outlined in SB 17-267. Additionally, as a separate government-run business, the Enterprise requires clear distinction in its fiscal operations from the Department. This FTE would support the Enterprise in all standard accounting services including accounts payable, accounts receivable, payroll and monthly and year-end reporting. This FTE would also provide a level of oversight of the fiscal operations of the Enterprise and its compliance with state fiscal rules and state and federal law.
Hospital Policy Administrator	Administrator III	1	The proposed FTE would provide the Enterprise with a dedicated hospital policy staff to develop hospital policy related to new or modified payment systems and/or changes in federal and state laws and regulations related to the Medicaid program. Additionally, this FTE would provide stakeholder engagement activities related to the development and implementation of the DSRIP program.
Hospital Quality Administrator	Administrator III	1	The proposed FTE would perform activities related to the DSRIP program including the development of hospital performance metrics to improve cost efficiency, patient safety, and clinical effectiveness. This position would be responsible for keeping up to date with trends in outcomes measurement, identifying national or professionally accepted standards, norms and benchmarks. In addition, the position would consult with the policy staff regarding data assessment and the use of collected data to improve outcomes.

Table 1 – FTE Summary			
Position Name	**Position Classification**	**Number of FTE**	**Description of Duties**
Community Health Needs Assessment Reporting Analyst	Administrator III	1	This proposed FTE would serve as the Department expert on Community Health Needs Assessments performed by certain tax-excempt hospitals required under section 26 U.S.C. § 501(r) of the Internal Revenue Code. This FTE would track and monitor reports submitted by hospitals in order to provide an interface between the community, the hospital, the Department of Public Health and Enviornment, and the Department.
Rates and Financial Analyst	Rate/Financial Analyst II	1	The proposed FTE would assist in calculating the HAS fee, hospital payments, and requisite upper payment limit and hospital-specific DSH Disproportionate Share Hospital (DSH) payment limits within federal regulatory parameters. These calculations involve compiling costs and data from hospitals, utilization and expenditure data from the Department's claims data warehouse, and other metrics. Calculating the fee and hospital payments involve ten (10) separate calculations. Additionally, changes to payment systems and the federal or state regulatory environment require close coordination with multiple sections within the Department. Currently, the Department relies on one Rate/Financial Analyst staff to perform these functions, which is inadequate given the workload and the expected workload from SB 17-267.

Table 1 – FTE Summary			
Position Name	**Position Classification**	**Number of FTE**	**Description of Duties**
Stakeholder Relations Specialist	Policy Advisor II	1	The proposed FTE would provide communication services for the Enterprise to further the collaborative and transparent process involving all stakeholders. This FTE would be responsible for providing timely and accurate communications to all stakeholders include State legislators, hospitals, and Colorado taxpayers regarding the goals and results of the Enterprise and the initiatives within SB 17-267, including health care delivery system reform incentive payments. The current workload has been absorbed by various Department staff in an ad hoc manner which has resulted in inconsistent and uncoordinated and untimely communications.
Procurement and Contracts Specialist	Purchasing Agent II	1	The proposed FTE would provide the Enterprise with the legal and administrative expertise related to the procurement and contracting of outside business services. These services include the following: approving procurement methodologies; preparing Purchase Orders (POs); drafting, reviewing and approving contracts; and issuing and awarding solicitations, such as Requests for Proposals (RFPs), Documented Quotes (DQs) and Invitation for Bids (IFBs). As a separate government-run business, the Enterprise requires clear distinction in its procurement documents from the Department. The Department does not have a dedicated FTE for procurement operations related to Enterprise activities. This FTE would support the Enterprise by drafting the necessary documentation in compliance with State statute, the State constitution, and state and federal procurement codes, rules, policies, procedures and guidelines.

Table 1.1 - Summary By Line Item
FY 2018-19

Row	FY 2018-19	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	Source
A	**Total Request**	**$1,192,262**	**10.1**	$0.00	**$596,132**	**$0.00**	**$596,130**	**Sum Rows B through J**
B	(1) Executive Director's Office; (A) General Administration, Personal Services	$604,770	10.1	$0.00	$302,385	$0.00	$302,385	Table 3, Personal Services, PERA & Medicare
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$87,198	0.0	$0.00	$43,599	$0.00	$43,599	Table 3, Health, Life and Dental
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$919	0.0	$0.00	$460	$0.00	$459	Table 3, STD
E	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$24,190	0.0	$0.00	$12,095	$0.00	$12,095	Table 3, AED
F	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$24,190	0.0	$0.00	$12,095	$0.00	$12,095	Table 3, SAED
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$62,184	0.0	$0.00	$31,092	$0.00	$31,092	Table 3, Operating Expenses
H	(1) Executive Director's Office; (A) General Administration, Legal Services	$123,811	0.0	$0.00	$61,906	$0.00	$61,905	Table 2.1, Row B
I	(1) Executive Director's Office; (A) General Administration, General Professional Services	$250,000	0.0	$0.00	$125,000	$0.00	$125,000	Table 2.1, Row C
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System, Maintenance and Projects	$15,000	0.0	$0.00	$7,500	$0.00	$7,500	Table 2.1, Row D

[1]Cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 1.2 - Summary By Line Item
FY 2019-20

Row	FY 2019-20	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	Source
A	**Total Request**	**$1,200,040**	**11.0**	**$0**	**$600,022**	**$0**	**$600,018**	**Sum Rows B thru J**
B	(1) Executive Director's Office; (A) General Administration, Personal Services	$659,798	11.0	$0	$329,900	$0	$329,898	Table 3, PS, PERA & Medicare
C	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$87,198	0.0	$0	$43,599	$0	$43,599	Table 3, Health, Life and Dental
D	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$1,003	0.0	$0	$502	$0	$501	Table 3, STD
E	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$26,390	0.0	$0	$13,195	$0	$13,195	Table 3, AED
F	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$26,390	0.0	$0	$13,195	$0	$13,195	Table 3, SAED
G	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$10,450	0.0	$0	$5,225	$0	$5,225	Table 3, Operating Expenses
H	(1) Executive Director's Office; (A) General Administration, Legal Services	$123,811	0.0	$0	$61,906	$0	$61,905	Table 2.2, Row B
I	(1) Executive Director's Office; (A) General Administration, General Professional Services	$250,000	0.0	$0	$125,000	$0	$125,000	Table 2.2, Row C
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System, Maintenance and Projects	$15,000	0.0	$0	$7,500	$0	$7,500	Table 2.2, Row D

[1]Cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 2.1 - Summary by Initiative FY 2018-19										
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	FTE for Administrative Workload	$803,451	10.1	$0	$401,726	$0	$401,725	50.00%	Table 3, Total Cost of FTE for FY 2018-19
B	Legal Costs	$123,811	0.0	$0	$61,906	$0	$61,905	50.00%	Table 4.1, Row C
C	Contractor Costs	$250,000	0.0	$0	$125,000	$0	$125,000	50.00%	Table 4.2, Row C
D	Software Licensing Costs	$15,000	0.0	$0	$7,500	$0	$7,500	50.00%	Table 4.3, Row C
E	**Total**	**$1,192,262**	**10.1**	**$0**	**$596,132**	**$0**	**$596,130**	**######**	**Sum of Row A through Row D**

[1]Cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 2.2 - Summary by Initiative FY 2019-20									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	FTE for Administrative Workload	$811,229	11.0	$0	$405,616	$0	$405,613	50.00%	Table 3, Total Cost of FTE for FY 2019-20
B	Legal Costs	$123,811	0.0	$0	$61,906	$0	$61,905	50.00%	Table 4.1, Row C
C	Contractor Costs	$250,000	0.0	$0	$125,000	$0	$125,000	50.00%	Table 4.2, Row C
D	Software Licensing Costs	$15,000	0.0	$0	$7,500	$0	$7,500	50.00%	Table 4.3, Row C
E	**Total**	**$1,200,040**	**11.0**	**$0**	**$600,022**	**$0**	**$600,018**	**######**	**Sum of Row A through Row D**

[1]Cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 3 - FTE Calculations

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	FTE		FTE	
AUDITOR III	$5,115	0.92	$56,261	1.00	$61,380
PERA			$5,710		$6,230
AED			$2,813		$3,069
SAED			$2,813		$3,069
Medicare			$816		$890
STD			$107		$117
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1		**0.92**	**$76,447**	**1.00**	**$82,682**
Classification Title	Monthly	FTE		FTE	
CONTRACT ADMINISTRATOR III	$4,117	0.92	$45,284	1.00	$49,404
PERA			$4,596		$5,015
AED			$2,264		$2,470
SAED			$2,264		$2,470
Medicare			$657		$716
STD			$86		$94
Health-Life-Dental			$7,927		$7,927
Subtotal Position 2		**0.92**	**$63,078**	**1.00**	**$68,096**
Classification Title	Monthly	FTE		FTE	
PROJECT MANAGER II	$6,400	0.92	$70,395	1.00	$76,800
PERA			$7,145		$7,795
AED			$3,520		$3,840
SAED			$3,520		$3,840
Medicare			$1,021		$1,114
STD			$134		$146
Health-Life-Dental			$7,927		$7,927
Subtotal Position 3		**0.92**	**$93,662**	**1.00**	**$101,462**

Expenditure Detail		FY 2018-19		FY 2019-20	
Personal Services:					
Classification Title	Monthly	FTE		FTE	
BUDGET & POLICY ANLST III	$5,898	0.92	$64,873	1.00	$70,776
PERA			$0		$0
AED			$0		$0
SAED			$0		$0
Medicare			$0		$0
STD			$0		$0
Health-Life-Dental			$7,927		$7,927
Subtotal Position 4		**0.92**	**$72,800**	**1.00**	**$78,703**
Classification Title	Monthly	FTE		FTE	
ACCOUNTANT II	$4,117	0.92	$45,284	1.00	$49,404
PERA			$4,596		$5,015
AED			$2,264		$2,470
SAED			$2,264		$2,470
Medicare			$657		$716
STD			$86		$94
Health-Life-Dental			$7,927		$7,927
Subtotal Position 5		**0.9**	**$63,078**	**1.00**	**$68,096**
Classification Title	Monthly	FTE		FTE	
ADMINISTRATOR III	$4,117	2.75	$135,851	3.00	$148,212
PERA			$13,789		$15,044
AED			$6,793		$7,411
SAED			$6,793		$7,411
Medicare			$1,970		$2,149
STD			$258		$282
Health-Life-Dental			$23,782		$23,782
Subtotal Position 6		**2.75**	**$189,236**	**3.00**	**$204,291**
Classification Title	Monthly	FTE		FTE	
RATE/FINANCIAL ANLYST II	$4,757	0.92	$52,323	1.00	$57,084
PERA			$5,311		$5,794
AED			$2,616		$2,854
SAED			$2,616		$2,854
Medicare			$759		$828
STD			$99		$108
Health-Life-Dental			$7,927		$7,927
Subtotal Position 7		**0.92**	**$71,651**	**1.00**	**$77,449**

Expenditure Detail			FY 2018-19		FY 2019-20
Personal Services:					
Classification Title	Monthly	FTE		FTE	
POLICY ADVISOR II	$3,563	0.92	$39,190	1.00	$42,756
PERA			$3,978		$4,340
AED			$1,960		$2,138
SAED			$1,960		$2,138
Medicare			$568		$620
STD			$74		$81
Health-Life-Dental			$7,927		$7,927
Subtotal Position 8		**0.92**	**$55,657**	**1.00**	**$60,000**
Classification Title	Monthly	FTE		FTE	
PURCHASING AGENT II	$3,563	0.92	$39,190	1.00	$42,756
PERA			$3,978		$4,340
AED			$1,960		$2,138
SAED			$1,960		$2,138
Medicare			$568		$620
STD			$74		$81
Health-Life-Dental			$7,927		$7,927
Subtotal Position 9		**0.92**	**$55,657**	**1.00**	**$60,000**
Subtotal Personal Services		10.08	**$741,266**	11.00	**$800,779**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating Expenses	$500	11.00	$5,500	11.00	$5,500
Telephone Expenses	$450	11.00	$4,950	11.00	$4,950
PC, One-Time	$1,230	11.00	$13,530	-	
Office Furniture, One-Time	$3,473	11.00	$38,203	-	
Subtotal Operating Expenses	$5,653		**$62,183**		**$10,450**
TOTAL REQUEST		10.08	**$803,449**	11.00	**$811,229**
	Cash funds:		*$401,725*		*$405,615*
	Federal Funds:		*$401,724*		*$405,614*

Table 4.1 - Estimated Costs of Legal Services FY 2018-19 and Ongoing			
Row	**Item**	**Amount**	**Source**
A	Existing Allocation of Legal Services to the Colorado Healthcare Affordability and Sustainability Enterprise	$247,622	SB 17-267 "Concerning the Sustainability of Rural Colorado"
B	Anticipated Percentage Increase of Legal Costs Due to Legal Action Against the Department	50%	Tabor Foundation v. HCPF, et al Case No: 2015CV32305
C	**Estimated Increase of Costs of Legal Services**	**$123,811**	**Row A * Row B**

Table 4.2 - Estimated Costs of Vendor Contract FY 2018-19 and Ongoing			
Row	**Item**	**Amount**	**Source**
A	Projected Number of Hours of Work for Vendor to Produce Deliverables	1,250	Based on prior consulting contract regarding Hospital Provider Fee analytics
B	Hourly Cost of Consultant	$200	Department's FY 2016-17 Price Agreement List
C	**Estimated Cost of Vendor Contract**	**$250,000**	**Row A * Row B**

Table 4.3 - Estimated Costs of Software Licenses FY 2018-19 and Ongoing			
Row	**Item**	**Amount**	**Source**
A	Software License Cost - Tableau Desktop	$2,500	Provided by the Information Technology (IT) Department
B	Number requested	6	Four licenses for members of Enterprise model development team; two licenses for hospital policy & communications staff
C	**Estimated Costs of Software Licenses**	**$15,000**	**Row A * Row B**

Table 5 - Analysis of the Administration Costs of the Enterprise					
Row	**Item**	**FY 2017-18**	**FY 2018-19 R-15 "CHASE Department Administrative Costs"**	**Total**	**Source**
A	Total Funds Projection for the Administration Expenditures of Enterprise	$76,206,091	$1,192,262	**$77,398,353**	FY 2017-18 Figure from Department Performance Budget Entry
B	Total Funds Projection for All Expenditures of Enterprise	$3,470,297,578	$1,192,262	**$3,471,489,840**	
C	**CHASE Admininstration %**	**2.20%**	**NA**	**2.23%**	**Row A / Row B**

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-16 CPE for Emergency Med Transportation Providers**

Dept. Approval By: 11/1/17

OSPB Approval By:

	Supplemental FY 2017-18
X	**Change Request FY 2018-19**
	Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$7,607,311,496	$0	$7,553,489,893	$18,807,725	$18,807,725
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,095,533,881	$0	$2,082,498,466	($620,560)	($620,560)
	CF	$887,765,453	$0	$885,588,434	$9,547,069	$9,547,069
	RF	$70,702,476	$0	$70,518,612	$0	$0
	FF	$4,553,309,686	$0	$4,514,884,381	$9,881,216	$9,881,216

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- General Professional Services and Special Projects	Total	$9,412,649	$0	$14,534,207	$668,294	$668,294
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,005,615	$0	$5,621,706	$334,147	$334,147
	CF	$1,600,352	$0	$1,545,040	$0	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$4,656,682	$0	$7,217,461	$334,147	$334,147
02. Medical Services Premiums -- Medical Services Premiums	Total	$7,597,898,847	$0	$7,538,955,686	$18,139,431	$18,139,431
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	($954,707)	($954,707)
	CF	$886,165,101	$0	$884,043,394	$9,547,069	$9,547,069
	RF	$70,552,476	$0	$70,368,612	$0	$0
	FF	$4,548,653,004	$0	$4,507,666,920	$9,547,069	$9,547,069

CF Letternote Text Revision Required?	Yes _X_ No ___	**If Yes, see schedule 4 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 $180,000 total funds, including $90,000 General Fund in FY 2017-18, and $18,807,725 total funds, including a decrease of $620,560 General Fund in FY 2018-19 and future years, to provide supplemental payments to emergency medical transportation providers and support the Department's costs of administering the supplemental payments.

Current Program

- Public Emergency Medical Transportation (EMT) services include emergency transportation to and from a hospital. EMT services are a mandatory Medicaid State Plan benefit offered to all Medicaid clients. Public ground EMT providers must transport a client to the hospital to be reimbursed. Public EMT providers must be owned or operated by an eligible governmental entity, to include the state, a city, county, city and county, fire protection district, special district, community services district, health care district, or a federally recognized Indian tribe.

Problem or Opportunity

- Public emergency medical transportation (EMT) providers incur significant uncompensated costs for services provided to Medicaid clients. The uncompensated expenditures cannot be claimed or reimbursed through Medicaid or any other program. The Department has an opportunity to partially offset the uncompensated costs through certification of public expenditures.

Consequences of Problem

- The Department would forgo the opportunity to reimburse the uncompensated costs of EMT providers through the use of certified public expenditure (CPE), and would miss out on the opportunity for General Fund savings similar to other CPE programs administered by the Department.

Proposed Solution

- EMT service providers eligible to participate in this program would receive supplemental reimbursement payments by completing a federally approved cost report form. The supplemental reimbursement payment is based on claiming federal financial participation on CPEs that have already been incurred by the public provider. To be eligible for reimbursement the CPE cannot be claimed at any other time to receive federal funds under Medicaid or any other program. The supplemental reimbursement amount is determined by the methodology approved by the Centers for Medicare and Medicaid Services (CMS).

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority:	***R-16***
Request Detail:	***Certification of Public Expenditure for Emergency Medical Transportation Providers***

Summary of Incremental Funding Change for FY 2018-19	**Total Funds**	**General Fund**
Certification of Public Expenditure for Emergency Medical Transportation Providers	$18,807,725	($620,560)

Problem or Opportunity:

Public emergency medical transportation (EMT) providers incur significant uncompensated costs for services provided to Medicaid clients. Because these providers receive public funds, the Department has an opportunity to obtain a federal match on expenditures made by public entities. In doing so, the Department can increase compensation for these providers, fund the necessary administrative contracts needed to obtain federal certification, and offset the Department's existing cost of administering the program.

Emergency medical transportation (EMT) services, also referred to as emergency medical services (EMS), include emergency transportation to and from a hospital. EMT services are a mandatory Medicaid State Plan benefit offered to all Colorado Medicaid clients, but EMT providers must transport a client to the hospital to be reimbursed. When the EMT service provider arrives onsite, they determine if the patient needs to be transported to the hospital for care or if treatment is able to be provided onsite. There is a financial disincentive for providers to treat the patient onsite because they are not reimbursed for the costs of going to the location of the patient. Therefore, there is financial incentive for the provider to determine that transportation to a hospital is needed, because they are reimbursed. This however would also result in the patient receiving higher-cost care that would be passed on to the State.

The Department's 2016 Medicaid Provider Rate Review Analysis Report[1] states that the EMT service payments are at 30.74% of benchmark rates and are significantly below Medicare and other states. The report concludes that payments are sufficient for client access, and provider payments were likely sufficient to allow for provider retention and client access for emergency medical transportation; however, they may not support appropriate reimbursement for high value services, as EMT service providers cannot refuse services to clients. Therefore, according to the report, it is difficult to evaluate whether EMT service rates support appropriate reimbursement for high-value services.

[1]https://www.colorado.gov/pacific/sites/default/files/2016%20Medicaid%20Provider%20Rate%20Review%20Analysis%20Report.pdf

The Department has an opportunity to provide supplemental payments to public emergency medical transportation providers for emergency medical transportation services provided to Medicaid clients. Pursuant to 42 CFR § 433.51, public funds may be considered as the State's share in claiming federal financial participation when the public funds are certified by the contributing public agency as representing expenditures eligible for federal financial participation.

EMT service providers eligible to participate in this program would receive supplemental reimbursement payments by completing a federally approved cost report form. The supplemental reimbursement payment is based on claiming federal financial participation on certified public expenditure (CPE) that have already been incurred by the public provider. To be eligible for reimbursement, the CPE cannot be claimed at any other time to receive federal funds under Medicaid or any other program. The supplemental reimbursement amount is determined by a methodology approved by Centers for Medicare and Medicaid Services (CMS).

The following requirements must be met for a publicly owned EMT service provider to be eligible for the program: the provider must provide services to Colorado Medicaid clients; must be enrolled as a Medicaid provider in Colorado; and, must be owned or operated by an eligible governmental entity, to include the state, a city, county, fire protection district, special district, community services district, health care district, or a federally recognized Indian tribe.

The Department estimates that the total amount of provider expenditure able to be certified in FY 2018-19 to be approximately $19 million, based on published annual budget data for public ground EMT providers. In addition to providing supplemental payments to providers, the Department would also be able to use some of the new federal revenue to offset the costs of administering the program.

Proposed Solution:

The Department requests one-time supplemental funding of $180,000 total funds, including $90,000 General Fund, in FY 2017-18 to contract for assistance with the development of a payment methodology, development of the State Plan Amendment, and to provide training and technical assistance to providers regarding federal requirements and billing procedures.

The Department requests $18,807,725 total funds, including a reduction of $620,560 General Fund, and increases of $9,547,069 cash funds and $9,881,216 federal funds in FY 2018-19, and ongoing, to provide supplemental payments to public emergency medical transportation providers for emergency medical transportation services provided to Medicaid clients, and for administration costs to support the program. The requested funding would allow for an overall increase of $9,547,069 federal funds, of which $8,592,362 would be given to providers as supplemental payments, $668,294 would be retained by the Department for contractor resources for direct administration, and $286,413 would be returned to the General Fund to offset the Department's other costs of administering the emergency medical transportation program.

Consistent with previously approved supplemental payment programs, including the Physician Supplemental Payments, the Department requests to retain 10% of the federal revenue generated by this program to offset state administration costs with the remaining federal revenue distributed to providers through a federally approved methodology. Of the 10% of total federal revenue withheld, a portion would be retained to procure

a vendor to assist with implementation and management of the program, and the remaining withheld funds would be returned to the General Fund to offset the Department's existing cost of managing its emergency transportation program. The vendor would assist the Department with the development of the initial State Plan Amendment and approval process including financial demonstration required by the Centers for Medicare and Medicaid Services (CMS) and stakeholder outreach. The retention of FFP must be disclosed in the State Plan Amendment process and approved by CMS.

If this request is not approved, public ground EMT providers would continue to be significantly undercompensated for their costs of providing emergency medical transportation and the Department would forgo an opportunity to access federally-allowable Medicaid funds without General Fund impact. Because EMT services must always be available and ambulances must be fully staffed and stocked at all times, sufficient funding is necessary to minimize the risks of reduction to members' access to emergency medical services or a deterioration in the quality of these services.

Anticipated Outcomes:

Implementation of a certified public expenditure program for public ground EMT providers would provide compensation for costs of this critical provider group and ensure that the Department's members have sufficient access to emergency medical services. If the request is approved, the Department would work with its selected vendor to establish a federally approved methodology via a State Plan Amendment to make supplemental payments to providers. The Department anticipates that the first payments to providers would be made before the end of calendar year 2018.

Consistent with other CPE-based supplemental payment programs within the Department, an amount equal to 10% of the federal revenue generated by the program and would initially be applied as General Fund savings in the Medical Services Premiums line. These savings would be partially offset by the ongoing costs associated with the program administration that would be funded in the General Professional Services line item. These costs include contracting with a vendor for the maintenance and administration of the cost-reporting and certification tool necessary to receive federal matching funds; to conduct stakeholder meetings and outreach; develop State Plan Amendments (SPAs), maintain the cost reporting system in compliance with federal requirements; train providers; perform Certified Public Expenditure calculations; and perform programmatic reviews of the public ground EMT providers' certified costs to ensure compliance with federal requirements.

This request aligns with the Department's Performance Plan strategies to "Ensure robust management of Medicaid benefits" and "Expand the network of providers servicing Medicaid" by providing better compensation to providers who have a limited ability to choose to stop rendering services. This request would allow for additional federal funds to flow to public entities, helping to strengthen the financial stability of public partners and ensure that Medicaid clients have access to federally required emergency transportation services. The Department's use of outside contractors with prior expertise in cost reporting and certification of public expenditure supports the Department's Performance Plan strategy to "Promote rigorous compliance with federal and state laws and regulations, fiscal rules, and internal operating procedures" by ensuring that all applicable federal rules are followed before the Department makes payments.

Assumptions and Calculations:

Detailed calculations for this request are provided in the attached appendix.

The Department estimates the total amount of provider CPE to be $19,094,138 in FY 2018-19; the Department holds this estimate constant for FY 2019-20 and future years. This figure is derived from published annual budget data for public ground EMT providers, adjusted to reflect the portions of the budget data specific to emergency medical transportation and the expected Medicaid caseload utilization percentage. Because the Department's calculations are based on budgeted amounts, the amount of expenditure available for certification may be smaller or larger than the Department's estimates; the Department would use the regular budget process to account for any observed difference.

Table group 1 contains summary information by Long Bill line item, including fund splits. Table group 2 contains summary information by initiative, including fund splits.

Table 3.1 calculates the estimated total federal revenue from certification of emergency medical transportation expenditure, the estimated amount of withholding permitted, and the estimated supplemental payments to providers.

Table 3.2 shows the Department's estimated FY 2017-18 need for contractor resources. The Department has based its request in FY 2017-18 based on a quote from a vendor familiar with the project, and would provide the Department with assistance in State Plan Amendment development and approval process including financial demonstration for CMS and stakeholder outreach.

Table 3.3 calculates the estimated need for contractor resources in FY 2018-19 and future years. The Department's estimate is based on the contractor resources needed for the Public School Health Services program, which has varied between 6% and 8% of total federal funds received in recent years. The Department believes that the Public School Health Services program is an appropriate proxy for the costs of this program, as it is also a program in which public expenditure is certified to draw additional federal funds, and the scope of work for the vendor would be similar.

Table 1.1
Summary by Line Item
FY 2017-18

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, General Professional Services	$180,000	0.0	$90,000	$0	$0	$90,000	Table 2.1, Row A
B	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$0	0.0	$0	$0	$0	$0	Table 2.1, Row B + Table 2.1, Row C
C	**Total Request**	**$180,000**	**0.0**	**$90,000**	**$0**	**$0**	**$90,000**	**Row A + Row B**

Table 1.2
Summary by Line Item
FY 2018-19

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, General Professional Services	$668,294	0.0	$334,147	$0	$0	$334,147	Table 2.2, Row A
B	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$18,139,431	0.0	($954,707)	$9,547,069	$0	$9,547,069	Table 2.2, Row B + Table 2.2, Row C
C	**Total Request**	**$18,807,725**	**0.0**	**($620,560)**	**$9,547,069**	**$0**	**$9,881,216**	**Row A + Row B**

[1] Cash funds are funds certified public expenditure (CPE)

Table 1.3
Summary by Line Item
FY 2019-20 and ongoing

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, General Professional Services	$668,294	0.0	$334,147	$0	$0	$334,147	Table 2.3, Row A
B	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$18,139,431	0.0	($954,707)	$9,547,069	$0	$9,547,069	Table 2.3, Row B + Table 2.3, Row C
C	**Total Request**	**$18,807,725**	**0.0**	**($620,560)**	**$9,547,069**	**$0**	**$9,881,216**	**Row A + Row B**

[1] Cash funds are funds certified public expenditure (CPE)

Table 2.1
Summary by Initiative
FY 2017-18

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP or FMAP	Notes/Calculations
A	Contractor Resources	$180,000	0.0	$90,000	$0	$0	$90,000	50.00%	Table 3.2, Row A
B	Emergency Medical Transportation CPE Supplemental Payments	$0	0.0	$0	$0	$0	$0	50.00%	N/A
C	General Fund Offset	$0	0.0	$0	$0	$0	$0	0.00%	N/A
D	**Total Estimate**	**$180,000**	**0.0**	**$90,000**	**$0**	**$0**	**$90,000**	**NA**	**Row (A + B + C)**

Table 2.2
Summary by Initiative
FY 2018-19

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	FFP or FMAP	Notes/Calculations
A	Contractor Resources	$668,294	0.0	$334,147	$0	$0	$334,147	50.00%	Table 3.3, Row C
B	Emergency Medical Transportation CPE Supplemental Payments	$19,094,138	0.0	$0	$9,547,069	$0	$9,547,069	50.00%	Table 3.1, Row A
C	General Fund Offset	($954,707)	0.0	($954,707)	$0	$0	$0	0.00%	Table 3.1, Row E * -1
D	**Total Estimate**	**$18,807,725**	**0.0**	**($620,560)**	**$9,547,069**	**$0**	**$9,881,216**	**NA**	**Row (A + B + C)**

[1] Cash funds are funds certified public expenditure (CPE)

Table 2.3
Summary by Initiative
FY 2019-20 and ongoing

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	FFP or FMAP	Notes/Calculations
A	Contractor Resources	$668,294	0.0	$334,147	$0	$0	$334,147	50.00%	Table 3.3, Row C
B	Emergency Medical Transportation CPE Supplemental Payments	$19,094,138	0.0	$0	$9,547,069	$0	$9,547,069	50.00%	Table 3.1, Row A
C	General Fund Offset	($954,707)	0.0	($954,707)	$0	$0	$0	0.00%	Table 3.1, Row E * -1
D	**Total Estimate**	**$18,807,725**	**0.0**	**($620,560)**	**$9,547,069**	**$0**	**$9,881,216**	**NA**	**Row (A + B + C)**

[1] Cash funds are funds certified public expenditure (CPE)

Table 3.1
Estimates of Emergency Medical Transportation CPE, Department Withhold and Supplemental Payment Amounts

Row	Description	Amount	Source
A	Certified Public Expenditure (CPE)	$19,094,138	Preliminary estimate provided by Department consultant
B	Federal Financial Participation Rate	50.00%	Federal Matching Assistance Percentage (FMAP)
C	**Federal Revenue**	**$9,547,069**	**Row A * Row B**
D	Percent of Withholding of Federal Revenue	10.00%	Standard Department withhold percentage applied to supplemental payments
E	**Total Amount of Withholding**	**$954,707**	**Row C * Row D**
F	**Supplemental Payments to Providers**	**$8,592,362**	**Row C - Row E**

Table 3.2
Estimate of Administrative Contract Amount
FY 2017-18

Row	Description	Amount	Source
A	One-time Request for Contractor Resources	$180,000	Vendor estimate provided to Department for contracted services that assist with State Plan Amendment development and approval process including financial demonstration for Centers of Medicare & Medicaid Services (CMS) and stakeholder outreach.

Table 3.3
Estimate of Administrative Contract Amount
FY 2018-19 and ongoing

Row	Description	Amount	Source
A	Estimate of Increased Federal Funds	$9,547,069	Table 3.1, Row C
B	Estimated Percentage of Administrative Withhold	7%	The percentage is comparable to the Department's Public School Health Services Program contract of similar scope that accounts for between 6% and 8% of total federal funds of the program. (see narrative for contract details)
C	**Ongoing Request for Contractor Resources**	**$668,294**	**Row A * Row B**

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title | **R-17 Single Assessment Tool Financing**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ **Supplemental FY 2017-18**

X **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,643,103,742**	**$0**	**$7,589,546,309**	**($6,112,924)**	**$408,475**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,114,459,741	$0	$2,101,548,708	($3,056,462)	$204,238
	CF	$887,793,725	$0	$885,624,425	$0	$0
	RF	$70,702,476	$0	$70,518,612	$0	$0
	FF	$4,570,147,800	$0	$4,531,854,564	($3,056,462)	$204,237

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- General Professional Services and Special Projects	**Total**	**$9,412,649**	**$0**	**$14,534,207**	**($5,702,924)**	**$5,213,258**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,005,615	$0	$5,621,706	($2,851,462)	$2,606,629
	CF	$1,600,352	$0	$1,545,040	$0	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$4,656,682	$0	$7,217,461	($2,851,462)	$2,606,629
02. Medical Services Premiums -- Medical Services Premiums	**Total**	**$7,597,898,847**	**$0**	**$7,538,955,686**	**($267,050)**	**($3,159,906)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	($133,525)	($1,579,953)
	CF	$886,165,101	$0	$884,043,394	$0	$0
	RF	$70,552,476	$0	$70,368,612	$0	$0
	FF	$4,548,653,004	$0	$4,507,666,920	($133,525)	($1,579,953)

	Total	**$35,792,246**	**$0**	**$36,056,416**	**($142,950)**	**($1,644,877)**
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	$18,925,860	$0	$19,050,242	($71,475)	($822,438)
	CF	$28,272	$0	$35,991	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$16,838,114	$0	$16,970,183	($71,475)	($822,439)

CF Letternote Text Revision Required? Yes ____ No X **If Yes, see schedule 4 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 to shift funding appropriated related to SB 16-192 "Assessment Tool Intellectual and Developmental Disabilities" between fiscal years for a net-zero General Fund impact. The shifting of funds would result in a request of:
  - FY 2017-18: A reduction of $830,699 total funds, including $526,944 General Fund and $303,755 federal funds; and
  - FY 2018-19: A reduction of $6,112,924 total funds, including $3,056,462 General Fund and $3,056,462 federal funds; and
  - FY 2019-20: An increase of $408,475 total funds, including $204,238 General Fund and $204,237 federal funds; and
  - FY 2020-21: An increase of $6,758,336 total funds, $3,379,168 General Fund, and $3,379,168 federal funds.
- The movement of funds would allow the Department to successfully develop and implement a single assessment tool for long-term services and supports (LTSS) clients in the Health First Colorado waiver programs, as required by the bill.

Current Program

- The Department currently uses more than 30 tools to conduct functional assessments for adults and children. The assessments are done to determine several things including: eligibility, level of care needs for home and community-based services (HCBS), financial planning, funding allocation, and rate setting.
- Funds were allocated through SB 16-192 "Assessment Tool Intellectual and Developmental Disabilities" to implement a single assessment tool for Individuals with Development Disabilities (IDD) and individuals utilizing long-term services and supports. The bill requires that the tool, to be used by adults and children, be selected on or before July 1, 2018. Once selected, the tool should be used to assess clients' needs as soon as practicable.

Problem or Opportunity

- As a result of updated timelines, recent contractor work, and receipt of additional grant funding, the Department requires the shifting of funds between fiscal years to complete the development and implementation of the single assessment tool required by SB 16-192.

Consequences of Problem

- Without the proper movement of funds, the Department would revert funds that are essential to the infrastructure of the tool and could delay implementation of the single assessment tool which is required to begin as soon as practicable after the tool selection deadline of July 1, 2018.

Proposed Solution

- The Department is requesting the reallocation of appropriated funds between fiscal years and roll forward authority for all contractor work in order to complete projects related to developing and implementing the new single assessment tool.

FY 2018-19 Funding Request | November 1, 2017

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: ***R-17***
Request Detail: ***Single Assessment Tool Financing***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Single Assessment Tool Financing	($6,112,924)	($3,056,462)

Problem or Opportunity:

The Department has identified a need to move spending authority related to the implementation of SB 16-192 "Assessment Tool Intellectual and Developmental Disabilities" between fiscal years. The bill identified needed spending of $21,522,162 total funds over five years to select and implement a single assessment tool for children and adults on all Home and Community Based Services (HCBS) waivers. Given recent contractor work and receipt of funding through a grant the Department has identified the need to update project timelines and shift funding between years.

SB 16-192 was signed into law on June 8, 2016 and requires the Department to select a new needs assessment tool for persons receiving long-term services and supports by July 1, 2018. The tool must be used for adults and children including services for persons with intellectual and developmental disabilities. The bill requires the Department to begin utilizing the tool as soon as practicable after the selection and complete any client reassessments within 30 days of being requested by a member.

Currently the Department uses over thirty tools to complete assessments for adults and children eligible for HCBS waivers. Two critical examples are the Supports Intensity Scale (SIS) and the ULTC 100.2. The SIS tool is used to identify support needs for clients receiving services in the HCBS Adult Comprehensive (HCBS-DD) waiver and the HCBS Supported Living Services Waiver (HCBS-SLS). The SIS is 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 ULTC 100.2 tool is used to assess the functional eligibility of clients looking to receive long-term services and supports. The Department was working with a contractor through a grant on developing a replacement for the ULTC 100.2 tool prior to the SB 16-192 being introduced in the General Assembly. After its passage, the Department began working to select and implement a single tool with the broader intention of replacing all current assessment tools for children and adults looking to receive long-term services and supports. In FY 2016-17 the Department continued to work with a contractor to select a functional assessment tool, including developing modules for assessing care planning needs and functional eligibility for adults and then adapting the modules for children. Since working with the contractor, the Department has been able to formalize

necessary elements and now has a better idea of the implementation timeline and cost estimates. Given this new information, the Department would need to shift funding between fiscal years in order to implement the new assessment tool in a timely and efficient way. The Department has selected a tool and conducted stakeholder outreach on the proposed timeline extension. The next steps for implementation include establishing system capabilities to automate the tool, executing a pilot study of the tool, and implementing any changes or improvements identified through the piloting process. In order to implement the single assessment tool the Department needs to access funding in different fiscal years than currently appropriated and needs to re-purpose funding for newly identified implementation processes.

The Department has obtained FY 2017-18 funding from the Testing Experience and Functional Assessment Tools (TEFT) in Community-Based Long Term Service and Supports (CB-LTSS) Grant. TEFT grant funds total $2,500,588 in FY 2017-18 and are to be used for salary payments, automation of the new tool, piloting processes, and the enhancement of personal health record development. The Department is using this funding to pay for some existing elements of the bill's implementation which frees up already appropriated SB 16-192 funds.

While working with a contractor the Department also identified other initiatives needed to implement the new assessment tool that funding from TEFT and SB 16-192 does not cover such as a level of care pilot study, additional funding for a continuing quality improvement contractor, and funds for a resource allocation contractor. The contractor and Department believe these additional efforts are critical to developing and implementing the tool as well as improving upon all aspects of the eligibility and assessment process. With freed up funding already appropriated to SB 16-192 activities the Department has the opportunity to repurpose these funds to improve the new assessment tools without requesting additional General Fund.

Proposed Solution:

The Department requests a reduction of $830,699 total funds, including $526,944 General Fund in FY 2017-18, a reduction of $6,112,924 total funds, including $3,056,462 General Fund in FY 2018-19, an increase of $408,475 total funds, including $204,238 General Fund in FY 2019-20 and an increase of $6,758,336 total funds including $3,379,168 General Fund in FY 2020-21. The net General Fund impact of shifting funds between the four years is $0 and the impact to federal funds is an increase of $223,188. Implementation of SB 16-192 requires several different contractors and many simultaneous efforts, and shifting funding between fiscal years along with roll forward authority for all contractor funding would allow the Department to successfully coordinate the different initiatives involved in implementation of the bill.

For a detailed breakdown of costs and timing, please see the implementation timeline in the attached appendix.

The Department is requesting to shift funds that were originally expected to be appropriated in the earlier years of implementation to the final years, FY 2019-20 and FY 2020-21. The Department has also secured additional funding from the TEFT grant that will serve to support efforts in FY 2018-19. The Department requests adjustments in funding related to the following projects:

- Rate and Algorithm Contractor: The Department was allocated $900,000 between FY 2017-18 and FY 2018-19 to hire a contractor to develop and test the algorithm and rates based on the new functional eligibility and needs assessment tool. $825,000 of the funding was appropriated for FY 2017-18 only and now the Department is requesting to split this funding evenly between FY 2018-19 and FY 2019-20. The Department is requesting to delay this contract until after the assessment tool pilot is completed, which will be in the spring or summer of 2018.
- Tool Development Contractor: Responsible for developing and selecting the tool and then adapting the tool based off stakeholder feedback. The contractor was appropriated $800,000 in FY 2017-18 alone but the Department is now requesting to push this funding into both FY 2017-18 and FY 2018-19 which would allow the contractor to implement changes or improvements that might be identified through the FY 2018-19 pilot.
- Client Reassessments: The Department was appropriated $11,164,860 for client reassessments once the new tool and modules are selected, piloted, and all case managers trained. The bill's fiscal note estimated that it would take just over one year to evaluate all existing and new members using the new tool. This request proposes splitting the appropriated funds evenly between FY 2019-20 and FY 2020-21 instead and slightly reduces this allocation by $84,706.
- Case Manager Training: All case managers and those involved in the pilot program would need to be trained on how to use the new functional and needs assessment tools or modules. After working with the tool development contractor in FY 2016-17, the Department has concluded that this funding would need to be split between FY 2019-20 and FY 2020-21. The Department slightly reduced this allocation and proposes to shift 70% of the $6,676,517 to training into FY 2019-20 and the remainder of funds to FY 2020-21.

Repurposed Funding

As the implementation planning process has begun, the Department has both secured additional funding and identified the opportunity to repurpose already appropriated funds. As part of this request, the Department would repurpose funding from the following project:

- Six-Month Pilot Program: The Department was appropriated $410,000 to administer a six-month pilot program of the new assessment tool during FY 2018-19. The six-month pilot, however, will be partially funded by the TEFT grant. Working with the tool development contractor, the Department is requesting to repurpose some of the original funding for several initiatives to strengthen tool implementation which are outlined in the section above.

Additional Initiatives

Through working with a contractor, the Department has identified new initiatives essential to the implementation of the bill and is requesting to use freed-up appropriated funds for these new projects:

- Resource Allocation Request for Proposal (RFP) Development: The Department would like to create more efficient and person-centered budgets or support levels for all individuals receiving long-term services and supports (LTSS). In order to do this a contractor would provide technical assistance in drafting an RFP for a contractor to develop algorithms and/or decision criteria and related business processes that would utilize new assessment items and align with the support planning process.

- Pediatric Personal Care Assessment Tool (PCAT) and the Pediatric Assessment Tool (PAT): To further reduce the number of assessment tools, the resource allocation contractor would examine the interplay between HCBS and State Plan assessment processes and determine if the PCAT could be built into the assessment tool or if the new assessment tool could provide information to inform the completion of the PCAT. Additionally, the contractor would examine the potential interplay between the new assessment tool and the PAT, which is used to determine the level of support from home health services a child may need. It is expected that information from the new assessment tool could inform the completion of the PAT.
- Hospital Level of Care Pilot: In order to come into compliance with the Centers for Medicare and Medicaid Services (CMS) technical guidance the Department would like to distinguish between nursing home level of care (LOC) and hospital LOC for relevant HCBS waivers. Currently LOC is determined retrospectively by looking at claims data and the new assessment process presents an opportunity to correct this policy and determine LOC on the front end. This would help to ensure individuals are receiving appropriate care and help identify accurate cost differences between the nursing home LOC and hospital LOC. The Department must clarify decision criteria used for hospital LOC by running additional pilot programs with the new assessment tool. An analysis of the assessment and claims data for clients would establish criteria based on characteristics of the population and be used to establish hospital LOC thresholds.
- Continuous Quality Improvement Contractor: The current appropriation includes $100,000 for an evaluation contractor. $150,000 of the newly available funds would be added to the evaluation contractor to sum to $250,000 to be used between FY 2018-19 and FY 2020-21. The evaluation contractor would work on continuous quality improvement (CQI) of the assessment process and ensure the adequate ongoing training of case managers. The additional funding would allow the evaluation work to be completed on an ongoing basis instead of one-time. Ongoing evaluation is necessary to track and monitor the implementation of the tool as it is rolled out and utilized by more case managers.

Due to the uncertain nature of contractor work, the Department is asking for roll forward authority for each of the four years. Implementation of the bill requires many contemporaneous efforts that overlap fiscal years and have varying completion timelines. It is likely that the Department could realize the need for roll forward authority on efforts after the General Assembly session or budget process has ended. Therefore, the Department is requesting roll forward authority for all spending related to implementation of SB 16-192. If the request is not approved, the Department would revert the unused appropriated funds each year and a timely implementation of the single assessment tool would be at risk.

Anticipated Outcomes:

This request allows the Department to continue important work being done to improve the way Health First Colorado members start to receive needed services and ensure that the Department stays on track to implement SB 16-192 within five years which is the allotted timeline from the original bill and corresponding fiscal note. This request aligns with the Department's FY 2016-17 Performance Plan strategic policy initiative of delivery systems innovation by reducing the number of assessment tools needed to evaluate member. This

would simplify the eligibility process and improve access to care, a primary focus of the Department's Performance Plan.

Assumptions and Calculations:

The Department has created cost tables and an updated project timeline detailing the various elements involved in the implementation of SB 16-192. Page 1 of the appendix shows two implementation timelines for SB 16-192. The first timeline was created using SB 16-192 and the other timeline illustrates the movement of implementation elements and additional funding described in this request. The other pages of the appendix contain budget summary tables of the proposed shifting of funds including the net General Fund impact of $0. Please refer to the attached appendix for further detail on how the Department is requesting to change the current appropriation.

Table 1.1.1 FY 2017-18 Single Assessment Tool Financing Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects[1]	($1,109,684)	0.0	($554,842)	$0	$0	($554,842)	50.00%	Table 1.2.1 Row G
B	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$278,985	0.0	$27,898	$0	$0	$251,087	90.00%	Table 1.2.1 Row H
C	**Total Request**	**($830,699)**	**0.0**	**($526,944)**	**$0**	**$0**	**($303,755)**		**Row A + Row B**

[1] The Department is requesting roll forward authority for all contractor funding in this request, which is contained within this Long Bill item during this year

Table 1.1.2 FY 2018-19 Single Assessment Tool Financing Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects[1]	($5,702,924)	0.0	($2,851,462)	$0	$0	($2,851,462)	50.00%	Table 1.2.2 Row I
B	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	($267,050)	0.0	($133,525)	$0	$0	($133,525)	50.00%	Table 1.2.2 Row J
C	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	($142,950)	0.0	($71,475)	$0	$0	($71,475)	50.00%	Table 1.2.2 Row K
D	**Total Request**	**($6,112,924)**	**0.0**	**($3,056,462)**	**$0**	**$0**	**($3,056,462)**		**Sum of Rows A through C**

[1] The Department is requesting roll forward authority for all contractor funding in this request, which is contained within this Long Bill item during this year

Table 1.1.3 FY 2019-20 Single Assessment Tool Financing Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects[1]	$5,213,258	0.0	$2,606,629	$0	$0	$2,606,629	50.00%	Table 1.2.3 Row I
B	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals[2]	($3,159,906)	0.0	($1,579,953)	$0	$0	($1,579,953)	50.00%	Table 1.2.3 Row J
C	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management[3]	($1,644,877)	0.0	($822,438)	$0	$0	($822,439)	50.00%	Table 1.2.3 Row K
D	**Total Request**	**$408,475**	**0.0**	**$204,238**	**$0**	**$0**	**$204,237**		**Sum of Rows A through C**

[1,2,3] The Department is requesting roll forward authority for contractor funding, case manager training, and client reassessments

Table 1.1.4 FY 2020-21 Single Assessment Tool Financing Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects[1]	$2,038,259	0.0	$1,019,129	$0	$0	$1,019,130	50.00%	Table 1.2.4 Row I
B	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals[2]	$3,104,799	0.0	$1,552,400	$0	$0	$1,552,399	50.00%	Table 1.2.4 Row J
C	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management[3]	$1,615,278	0.0	$807,639	$0	$0	$807,639	50.00%	Table 1.2.4 Row K
D	**Total Request**	**$6,758,336**	**0.0**	**$3,379,168**	**$0**	**$0**	**$3,379,168**		**Sum of Rows A through C**

[1,2,3] The Department is requesting roll forward authority for contractor funding, case manager training, and client reassessments

Table 1.2.1 Single Assessment Tool Financing FY 2017-18 Movement of State Appropriated Funds by Line Item						
Original Appropriation						
Row	**Element**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**	**Notes**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$1,675,000	$837,500	$837,500	50%	Table 2.1 Rows A + B + C
B	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$145,200	$14,520	$130,680	90%	Table 2.1 Row D
C	Total	$1,820,200	$852,020	$968,180		Row A + B
Requested Appropriation						
D	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$565,316	$282,658	$282,658	50%	Table 2.1 Rows F + G + I + J
E	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$424,185	$42,418	$381,767	90%	Table 2.1 Row H
F	Total	$989,501	$325,076	$664,425		Row D + Row E
Incremental Difference						
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	($1,109,684)	($554,842)	($554,842)	50%	Row D - Row A
H	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$278,985	$27,898	$251,087	90%	Row E - Row B
I	**Difference**	**($830,699)**	**($526,944)**	**($303,755)**		**Row G + Row H**

Table 1.2.2 Single Assessment Tool Financing FY 2018-19 Movement of State Appropriated Funds by Line Item						
Original Appropriation						
Row	**Element**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**	**Notes**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$7,075,000	$3,537,500	$3,537,500	50%	Table 2.2 Rows A + B + D + E
B	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	$267,050	$133,525	$133,525	50%	Medical Services Premiums (MSP) allocation for assessment tool pilot study - 65% of Table 2.2 Row C
C	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	$142,950	$71,475	$71,475	50%	Division of Intellectual and Developmental Disabilities (DIDD) allocation for assessment tool pilot study - 35% of Table 2.2 Row C
D	Total	$7,485,000	$3,742,500	$3,742,500		
Requested Appropriation						
E	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$1,372,076	$686,038	$686,038	50%	Table 2.2 Sum of Rows G through L
F	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	$0	$0	$0	50%	Part of assessment tool pilot now being paid by TEFT, funds originally allocated to project will be used for new initiatives within GPS line
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	$0	$0	$0	50%	Part of assessment tool pilot now being paid by TEFT, funds originally allocated to project will be used for new initiatives within GPS line
H	Total	$1,372,076	$686,038	$686,038		Sum of Rows E through G
Incremental Difference						
I	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	($5,702,924)	($2,851,462)	($2,851,462)	50%	Row E- Row A
J	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	($267,050)	($133,525)	($133,525)	50%	Row F- Row B
K	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	($142,950)	($71,475)	($71,475)	50%	Row G- Row C
L	**Difference**	**($6,112,924)**	**($3,056,462)**	**($3,056,462)**		**Sum of Rows I through K**

Table 1.2.3 Single Assessment Tool Financing
FY 2019-20 Movement of State Appropriated Funds by Line Item

Row	Element	Total Funds	General Fund	Federal Funds	FFP	Notes
Original Appropriation						
A	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$75,000	$37,500	$37,500	50%	Table 2.3 Rows A + B
B	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	$6,803,374	$3,401,687	$3,401,687	50%	MSP portion of client reassessments - 65% of Table 2.3 Row C
C	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	$3,541,486	$1,770,743	$1,770,743	50%	DIDD portion of client reassessments - 35% of Table 2.3 Row C
D	Total	$10,419,860	$5,209,930	$5,209,930		Sum of Rows A through C
Requested Appropriation						
E	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$5,288,258	$2,644,129	$2,644,129	50%	Table 2.3 Rows F + G + J + K
F	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	$3,643,468	$1,821,734	$1,821,734	50%	Table 2.3 Row H
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	$1,896,609	$948,305	$948,304	50%	Table 2.3 Row I
H	Total	$10,828,335	$5,414,168	$5,414,167	50%	Sum of Rows E through G
Incremental Difference						
I	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$5,213,258	$2,606,629	$2,606,629	50%	Row E- Row A
J	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	($3,159,906)	($1,579,953)	($1,579,953)	50%	Row F- Row B
K	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	($1,644,877)	($822,438)	($822,439)	50%	Row G- Row C
L	**Difference**	**$408,475**	**$204,238**	**$204,237**		**Sum of Rows I through K**

Table 1.2.4 Single Assessment Tool Financing
FY 2019-20 Movement of State Appropriated Funds by Line Item

Row	Element	Total Funds	General Fund	Federal Funds	FFP	Notes
Original Appropriation						
A	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$50,000	$25,000	$25,000	50%	Table 2.4 Row A
B	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	$538,669	$269,334	$269,335	50%	MSP portion of client reassessments - 65% of Table 2.3 Row C
C	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	$281,331	$140,666	$140,665	50%	DIDD portion of client reassessments - 35% of Table 2.3 Row C
D	Total	$870,000	$435,000	$435,000		Sum of Rows A through C
Requested Appropriation						
E	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$2,088,259	$1,044,129	$1,044,130	50%	Table 2.4 Sum of Rows D through F
F	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	$3,643,468	$1,821,734	$1,821,734	50%	Table 2.4 Row G
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	$1,896,609	$948,305	$948,304	50%	Table 2.4 Row H
H	Total	$7,628,336	$3,814,168	$3,814,168		Sum of Rows F through H
Incremental Difference						
I	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$2,038,259	$1,019,129	$1,019,130	50%	Row E - Row A
J	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	$3,104,799	$1,552,400	$1,552,399	50%	Row F - Row B
K	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	$1,615,278	$807,639	$807,639	50%	Row G - Row C
L	**Difference**	**$6,758,336**	**$3,379,168**	**$3,379,168**		**Sum of Rows I through K**

Table 2.1 Single Assessment Tool Financing FY 2017-18 Movement of State Appropriated Funds					
SB 16-192 Fiscal Note					
Row	**Element**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
A	Stakeholder Contractor	$50,000	$25,000	$25,000	50%
B	Tool Development Contractor	$800,000	$400,000	$400,000	50%
C	Rate and Algorithm Contractor	$825,000	$412,500	$412,500	50%
D	System Changes	$145,200	$14,520	$130,680	90%
E	Total	$1,820,200	$852,020	$968,180	
Budget Request					
F	Stakeholder Contractor	$50,000	$25,000	$25,000	50%
G	Tool Development Contractor	$448,276	$224,138	$224,138	50%
H	System Changes	$424,185	$42,418	$381,767	90%
I	Resource Allocation Request for Proposal (RFP)	$15,000	$7,500	$7,500	50%
J	Pediatric Personal Care Assessment Tool (PCAT)	$52,040	$26,020	$26,020	50%
K	Total	$989,501	$325,076	$664,425	
L	**Difference**	**($830,699)**	**($526,944)**	**($303,755)**	

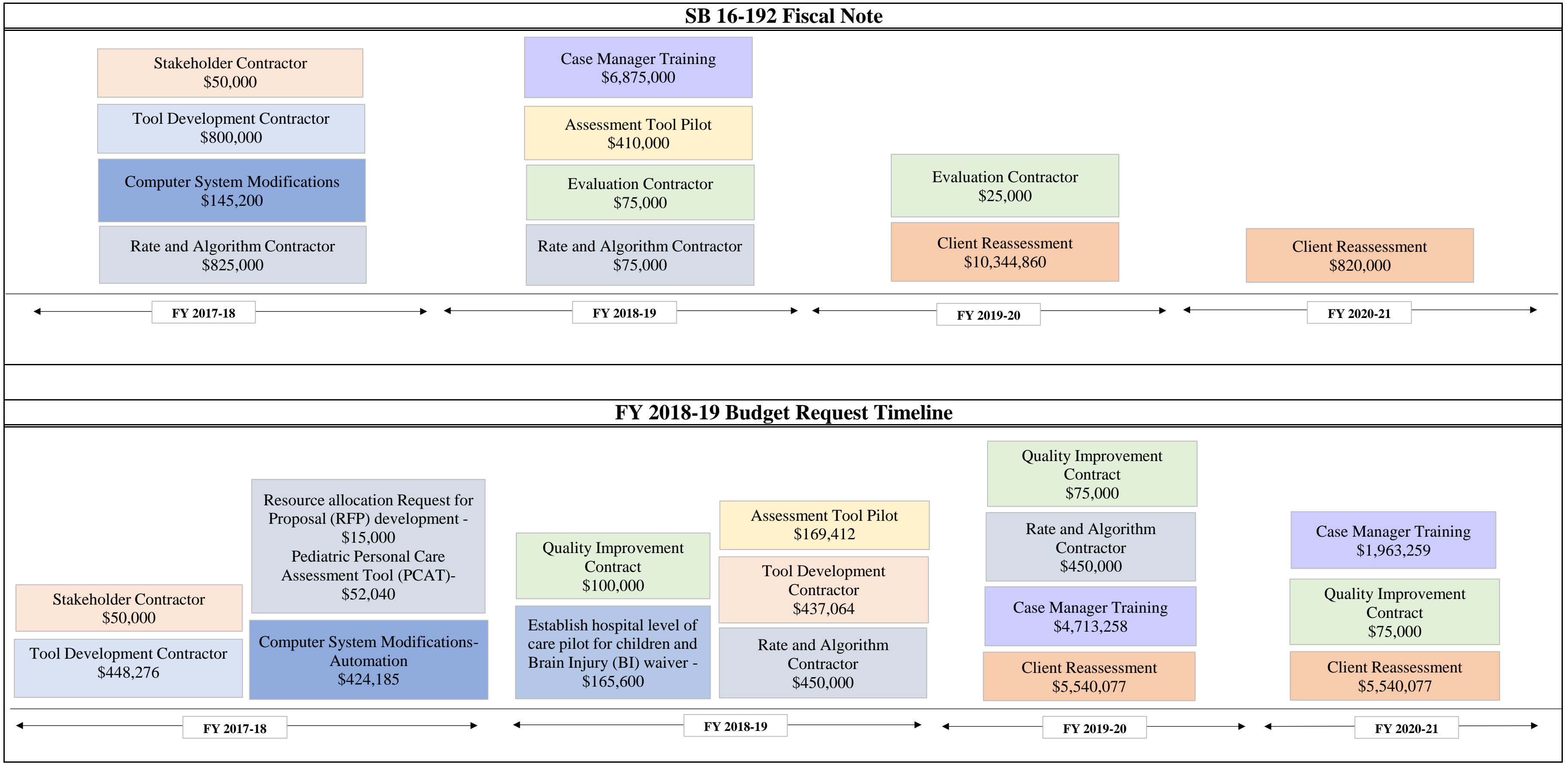
Table 2.2 Single Assessment Tool Financing FY 2018-19 Movement of State Appropriated Funds					
SB 16-192 Fiscal Note					
Row	**Element**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
A	Stakeholder Contractor	$50,000	$25,000	$25,000	50%
B	Rate and Algorithm Contractor	$75,000	$37,500	$37,500	50%
C	Assessment Tool Pilot	$410,000	$205,000	$205,000	50%
D	Evaluation Contractor	$75,000	$37,500	$37,500	50%
E	Case Manager Training	$6,875,000	$3,437,500	$3,437,500	50%
F	Total	$7,485,000	$3,742,500	$3,742,500	
Budget Request					
G	Stakeholder Contractor	$50,000	$25,000	$25,000	50%
H	Tool Development Contractor	$437,064	$218,532	$218,532	50%
I	Assessment Tool Pilot	$169,412	$84,706	$84,706	50%
J	Assessment Tool Pilot Repurpose Hospital Level of Care (LOC) Pilot	$165,600	$82,800	$82,800	50%
K	Evaluation Contractor - Continuous Quality Improvement (CQI)	$100,000	$50,000	$50,000	50%
L	Rate and Algorithm Contractor	$450,000	$225,000	$225,000	50%
M	Total	$1,372,076	$686,038	$686,038	
N	**Difference**	**($6,112,924)**	**($3,056,462)**	**($3,056,462)**	

Table 2.3 Single Assessment Tool Financing FY 2019-20 Movement of State Appropriated Funds					
SB 16-192 Fiscal Note					
Row	**Element**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
A	Stakeholder Contractor	$50,000	$25,000	$25,000	50%
B	Evaluation Contractor	$25,000	$12,500	$12,500	50%
C	Client Reassessments	$10,344,860	$5,172,430	$5,172,430	50%
D	Total	$10,419,860	$5,209,930	$5,209,930	
Budget Request					
F	Stakeholder Contractor	$50,000	$25,000	$25,000	50%
G	Case Manager Training	$4,713,258	$2,356,629	$2,356,629	50%
H	Medical Services Premiums (MSP) Client Reassessments	$3,643,468	$1,821,734	$1,821,734	50%
I	Division of Intellectual and Developmental Disabilities (DIDD) Client Reassessments	$1,896,609	$948,305	$948,304	50%
J	Evaluation Contractor (CQI)	$75,000	$37,500	$37,500	50%
K	Rate and Algorithm Contractor	$450,000	$225,000	$225,000	50%
L	Total	$10,828,335	$5,414,168	$5,414,167	
M	**Difference**	**$408,475**	**$204,238**	**$204,237**	

Table 2.4 Single Assessment Tool Financing FY 2020-21 Movement of State Appropriated Funds					
SB 16-192 Fiscal Note					
Row	**Element**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
A	Stakeholder Contractor	$50,000	$25,000	$25,000	50%
B	Client Reassessment	$820,000	$410,000	$410,000	50%
C	Total	$870,000	$435,000	$435,000	
Budget Request					
D	Stakeholder Contractor	$50,000	$25,000	$25,000	50%
E	Evaluation Contractor (CQI)	$75,000	$37,500	$37,500	50%
F	Case Manager Training	$1,963,259	$981,629	$981,630	50%
G	MSP Client Reassessments	$3,643,468	$1,821,734	$1,821,734	50%
H	DIDD Client Reassessments	$1,896,609	$948,305	$948,304	50%
I	Total	$7,628,336	$3,814,168	$3,814,168	
J	**Difference**	**$6,758,336**	**$3,379,168**	**$3,379,168**	

Table 2.5 Single Assessment Tool Financing Movement of State Appropriated Funds					
Row	**Element**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
A	SB 16-192 Fiscal Note	$20,595,060	$10,239,450	$10,355,610	50%
B	FY 2018-19 Budget Request	$20,818,248	$10,239,450	$10,578,798	50%
C	**Difference**	**$223,188**	**$0**	**$223,188**	

FY 2018-19 Single Assessment Tool Financing Implementation Timeline



Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-18 Cost Allocation Vendor Consolidation**

Dept. Approval By: 11/1/17

OSPB Approval By:

___ **Supplemental FY 2017-18**

X **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$12,667,295**	**$0**	**$18,555,319**	**$366,400**	**$373,728**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,304,958	$0	$7,182,602	$120,050	$122,451
	CF	$1,912,772	$0	$1,857,460	$63,150	$64,413
	RF	$150,000	$0	$150,000	$0	$0
	FF	$6,299,565	$0	$9,365,257	$183,200	$186,864

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- General Professional Services and Special Projects	**Total**	**$9,412,649**	**$0**	**$14,534,207**	**$340,780**	**$347,596**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,005,615	$0	$5,621,706	$111,656	$113,889
	CF	$1,600,352	$0	$1,545,040	$58,734	$59,909
	RF	$150,000	$0	$150,000	$0	$0
	FF	$4,656,682	$0	$7,217,461	$170,390	$173,798

	Total	**$3,254,646**	**$0**	**$4,021,112**	**$25,620**	**$26,132**
01. Executive Director's Office, (F) Provider Audits and Services -- Professional Audit Contracts	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,299,343	$0	$1,560,896	$8,394	$8,562
	CF	$312,420	$0	$312,420	$4,416	$4,504
	RF	$0	$0	$0	$0	$0
	FF	$1,642,883	$0	$2,147,796	$12,810	$13,066

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 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 $366,400 total funds, including $120,050 General Fund in FY 2018-19 and $373,728 total funds, including $122,451 General Fund in FY 2019-20 and $381,203 total funds, including $124,900 General Fund in FY 2020-21 and ongoing to procure a cost allocation vendor to assist the Department in compliance of federal cost allocation requirements and to ensure that costs are appropriately allocated between programs.

Current Program

- The Department is required to comply with federal requirements of cost allocation of administrative costs to ensure that costs are allocated appropriately to various federal programs and to ensure no duplication of payments. Compliance has become more difficult over time due to increased complexity of Department operations, increased caseload, enhanced match rates, and to date the Department has absorbed costs related to compliance within existing appropriations.
- An approved cost allocation methodology must be implemented and documented for all contracts to ensure that costs are allocated appropriately to federal programs to ensure each program is paying their share of costs. This process is time and labor intensive and requires national cost allocation expertise to provide proper guidance and training to state staff and contractors. The Department does not have sufficient staff resources to react and respond timely to CMS questions on cost allocation to gain and maintain federal approval.
- The Department currently has a contract for ongoing support of its public assistance cost allocation plan which is required to complete the quarterly calculations required by federal rules.

Problem or Opportunity

- Although the Department has spending authority for a vendor contract to support quarterly calculations for cost allocation methodologies for statewide costs, the Department does not have the staff or contractor resources necessary to implement and support the complex cost allocation methodologies required for federal approval for several of its vendor contracts. Because the Department does not have funding for this contract, the increased workload required for staff and existing contracts has become unmanageable and the Department needs additional resources to continue to support the complexity of its contracts.

Consequences of Problem

- Without proper support, the Department cannot ensure that all payments are allocated according to approved methodologies or respond timely to CMS concerns. Without the resources to support and track cost allocation approvals for all the Department's contracts, the Department is at increased risk for disallowance of federal funds.

Proposed Solution

- The Department requests to procure a cost allocation vendor to assist the Department in compliance of federal cost allocation requirements and to ensure that costs are appropriately allocated between programs.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority:	*R-18*
Request Detail:	*Cost Allocation Vendor Consolidation*

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Cost Allocation Vendor Consolidation	$366,400	$120,050

Problem or Opportunity:

Due to the increased complexity of the Department's contracts and increased scrutiny by Centers for Medicare and Medicaid Services (CMS), the Department is at risk for disallowance of federal funds without additional support for implementing and documenting methodologies in the Department's Public Assistance Cost Allocation Plan (PACAP). The Department's current appropriation for cost-allocation related work is insufficient, and the Department needs to increase the resources dedicated to cost-allocation activities to ensure compliance with federal regulations.

Federal law requires the PACAP to reference methodologies, claiming mechanisms, interagency agreements, and other relevant issues that will be used when claiming and appropriately allocating costs. Per 2 CFR § 200, costs must be supported by an allocation methodology that includes a narrative description of the procedures that the state agency will use in identifying and measuring costs. Federal and state requirements of administering Medical Assistance Programs require the use of vendor contracts to ensure that Coloradans can access the programs that they are eligible for in the communities in which they live.

The Department received ongoing funding of $45,000 total funds to support the allocation of Department overhead costs, through its FY 2014-15, S-15, BA-15 budget request "PACAP Contractor." This funding, however, is not sufficient to support cost allocation methodologies required by CMS for outside vendors. These vendors include the eligibility and enrollment vendor and medical assistance sites and recent updates to these contracts and requirements by CMS have required implementation of more complex cost allocation methodologies which require ongoing resources to support. Many of these vendors are public entities and have multiple lines of business with the Department, such as also being paid for hospital services or as clinics, which makes cost allocation more complex.

The Department is constantly modifying cost allocation methodology and documentation each time a new contract is issued or changed and federal compliance has become more complex over time. Certain administrative costs may be matched at higher federal financial participation (FFP) rates, but qualifying for enhanced FFP has increased the need for expert assistance and more complex cost allocation methodologies.

In FY 2016-17 and FY 2017-18, the Department has been required to modify or develop additional cost allocation methodologies on several of its contracts by CMS. To complete these updates, the Department has made several amendments to the existing PACAP contract to gain technical assistance from national cost allocation experts to assist with updates and documentation for several of its vendor contracts. To date, the administrative costs for these amendments has been absorbed within existing resources. The scope of work for these contracts includes multiple meetings with Department staff and contracted vendors to set up random moment time study (RMTS) activities or other tracking methods and processes, and to develop cost reporting, training and guidance to ensure that the Department can maintain an approved methodology to prevent disallowance of federal funds. The contractor also assists with documentation of the methodology in the PACAP and with CMS approval process, preparing calculations for payments based on cost reports provided by the contracted vendors, providing technical assistance and training contractors and Department staff.

Based on the Department's recent experiences, updates to cost allocation methodology and CMS approval can take 18 months or longer, requiring staff and contractor assistance to ensure compliance and approval from CMS, requiring ongoing communications and decisions to be negotiated and documented to ensure the staff and vendors are aware of the status and next steps required to gain approval. The Department has, to date, absorbed this additional workload within existing appropriations. Continuing contractor payments during the period of PACAP approval leads to additional risk of disallowance of federal funds, however the Department must continue certain contracts during approval process to ensure that clients can get the service they need. Additionally, CMS requires the Department to commit to auditing of these methodologies which cannot be absorbed within existing resources.

Proposed Solution:

The Department requests $366,400 total funds, including $120,050 General Fund in FY 2018-19, $373,728 total funds, including $122,451 General Fund in FY 2019-20 and $381,203 total funds, including $124,900 General Fund in FY 2020-21 and ongoing to procure a cost allocation vendor to assist the Department in compliance of federal cost allocation requirements for its vendor contracts. The request also includes funding to procure an audit contractor to audit several of the more complex vendor methodologies and payments once every three years as required in recent PACAP negotiations with CMS.

Procuring a contractor for technical assistance would allow the Department to implement a more streamlined and organized approach to cost allocation updates and provide additional resources to support the complexity of the Department's program operations. Having a combined contract would also allow the Department to more efficiently manage and track needs for training and the status of CMS submissions and approvals, and to be responsive to the needs of its vendors, agency partners and CMS.

Although each state's Medicaid program is unique, the Department believes that hiring a contractor with national experience in Medicaid allowable claiming methodologies would be beneficial as such a contractor could provide information including other state's experiences with approvals and to assist in researching the appropriate methodologies and the costs and benefits associated with allowable methodologies. The scope of work would also include documentation and ongoing support with cost allocation calculations when necessary.

If this request is not funded, the Department would continue to absorb workload within existing appropriations and would not have the expertise or support necessary to proactively manage the PACAP process, increasing the risk for deferral and disallowance on vendor payments. Additionally, without ongoing funding, the Department would not be able to maintain the complex methodologies that have been required and implemented for some its contractors and may need to consider reducing contract payments to vendors to cover these administrative costs, which may limit the level of service that members receive if contract payments are not sufficient.

Anticipated Outcomes:

The Department anticipates that if this budget request is approved that the Department would be at a lower risk for deferral and disallowance for issues related to cost allocation because it would have the support and expertise of the vendor to document and update cost allocation methodologies to ensure compliance with federal law. Streamlining and expediting the process for these PACAP approvals would decrease the potential disallowance risk.

This request aligns with strategies as outlined in the Department's FY 2016-17 Performance Plan including 'Improve efficiency of business processes,' 'Promote rigorous compliance with federal and state laws and regulations and 'Support counties and medical assistance sites with technical assistance for processing eligibility applications accurately and efficiently.'

Assumptions and Calculations:

The Department assumes the costs for the PACAP vendor would be eligible for 50% FFP. The Department assumes the costs would be allocated between General Fund and Healthcare Affordability and Sustainability Fee Cash Funds based on Medicaid caseload statistics.

The scope of work for the PACAP vendor would include ensuring the PACAP methodology describes how federal requirements[1] are met. This includes requirements that costs must be "proper and efficient" for the state's administration of its Medicaid state plan (section 1903(a)(7) of the Social Security Act), and that costs related to multiple programs must be allocated in accordance with the benefits received by each participating program (2 CFR § 200). This would be accomplished by developing a method to assign costs based on the relative benefit to the Medicaid program and the other government or non-government programs and ensuring that costs are supported by an allocation methodology that appears in the State's approved PACAP (42 CFR § 433.34). Contractor responsibilities would include ensuring that costs do not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns, that costs must not include the overhead costs of operating a provider facility and that costs must not duplicate payment for activities that are already being offered or should be provided by other entities, or paid through other programs. Additionally, the contractor would ensure that costs would not supplant funding obligations from other federal sources and that costs are supported by adequate source documentation.

The Department assumes that the PACAP vendor scope of work would also include the cost allocation work to determine allowable costs for Medicaid administration for the eligibility and enrollment vendor, Connect

[1] https://www.medicaid.gov/medicaid/financing-and-reimbursement/admin-claiming/index.html

for Health Colorado, and Denver Health Medical Assistance sites; and, that additional eligibility determination contracts, including the other Medical Assistance Sites would be added as required. There is a current need to update and document the methodology for these contracts to claim federal funding because the PACAP is currently unapproved and the Department has begun this work using existing appropriations. However, the Department cannot continue to absorb these costs and would benefit from having a consolidated vendor contract. The Department has calculated the costs for these scopes of work based on the current cost of the contracts and included a 2% annual increase each year to account for rises in costs. Additionally, the Department assumes that there would be an ongoing need for reviewing, updating and documenting cost allocation methodologies because of administering the Medicaid and CHP+ programs and there would be a need for technical assistance on additional administrative payments, Single Entry Points (SEP), Community Centered Boards (CCB), Aging and Disability Resource Centers (ADRC), and vendor costs for Health Insurance Exchange/Health Information Technology (HIE/HIT) initiatives. The Department would write the scope of work to include flexibility for the vendor to work on these and other programs as required as the need arises. The Department has calculated the cost for the technical assistance as detailed in Table 2.1 based on 600 hours of work per year at a rate of $210 per hour, assuming a 2% increase per year.

In addition to the PACAP contractor, in recent PACAP negotiations, CMS has added a requirement that the Department audit several of vendors that use complex cost allocation methodologies which involve RMTS once every three years to ensure the RMTS results are valid and that the costs documented by the contractors are allowable. The Department has three types of vendors which currently are subject to the audit requirements (the eligibility and enrollment vendor, Medical Assistance sites, and Connect for Health Colorado). Therefore, the Department assumes that it would need funding to audit one Medicaid vendor each year, and that each vendor would be audited every three years. The Department has calculated the cost of the audit at 122 hours per year at $210 per hour based on an estimate from a current vendor who specializes in this work. This audit would ensure the time study is performed correctly, the time study results are valid, the financial data submitted is true and correct, RMTS training requirements are met and that appropriate documentation is maintained to support the time study and the claim.

Table 1.1 FY 2018-19 Cost Allocation Vendor Consolidation Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Healthcare Affordability and Sustainability Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$340,780	0.0	$111,656	$58,734	$0	$170,390	Table 2.1 Row A
B	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$25,620	0.0	$8,394	$4,416	$0	$12,810	Table 2.1 Row B
C	**Total Request**	**$366,400**	**0.0**	**$120,050**	**$63,150**	**$0**	**$183,200**	Row A + Row B

Table 1.2 FY 2019-20 Cost Allocation Vendor Consolidation Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Healthcare Affordability and Sustainability Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$347,596	0.0	$113,889	$59,909	$0	$173,798	Table 2.2 Row A
B	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$26,132	0.0	$8,562	$4,504	$0	$13,066	Table 2.2 Row B
C	**Total Request**	**$373,728**	**0.0**	**$122,451**	**$64,413**	**$0**	**$186,864**	Row A + Row B

Table 1.3 FY 2020-21 Cost Allocation Vendor Consolidation Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Healthcare Affordability and Sustainability Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$354,548	0.0	$116,167	$61,107	$0	$177,274	Table 2.3 Row A
B	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$26,655	0.0	$8,733	$4,594	$0	$13,328	Table 2.3 Row B
C	**Total Request**	**$381,203**	**0.0**	**$124,900**	**$65,701**	**$0**	**$190,602**	Row A + Row B

Table 2.1 FY 2018-19 Cost Allocation Vendor Consolidation Summary by Initiative									
Row	**Program**	**Total Funds**	**FTE**	**General Fund**	**Healthcare Affordability and Sustainability Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	Cost Allocation Vendor Contract	$340,780	0.0	$111,656	$58,734	$0	$170,390	50%	Estimate based on current contract as described in narrative
B	Cost Allocation Audit Vendor Costs	$25,620	0.0	$8,394	$4,416	$0	$12,810	50%	Estimate described in narrative
C	**Total Request**	**$366,400**	**0.0**	**$120,050**	**$63,150**	**$0**	**$183,200**		Row A + Row B

Table 2.2 FY 2019-20 Cost Allocation Vendor Consolidation Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	Cost Allocation Vendor Contract	$347,596	0.0	$113,889	$59,909	$0	$173,798	50%	Estimate based on current contract as described in narrative.
B	Cost Allocation Audit Vendor Costs	$26,132	0.0	$8,562	$4,504	$0	$13,066		Estimate described in narrative
C	**Total Request**	**$373,728**	**0.0**	**$122,451**	**$64,413**	**$0**	**$186,864**		Row A + Row B

Table 2.3 FY 2020-21 Cost Allocation Vendor Consolidation Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	Cost Allocation Vendor Contract Total	$354,548	0.0	$116,167	$61,107	$0	$177,274	50%	Estimate based on current contract as described in narrative.
B	Cost Allocation Audit Vendor Costs	$26,655	0.0	$8,733	$4,594	$0	$13,328	50%	Estimate described in narrative
C	**Total Request**	**$381,203**	**0.0**	**$124,900**	**$65,701**	**$0**	**$190,602**		Row A + Row B

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title	**R-19 IDD Waiver Consolidation Administrative Funding**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ **Supplemental FY 2017-18**

X **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$9,412,649**	**$0**	**$14,534,207**	**$478,500**	**$177,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,005,615	$0	$5,621,706	$239,250	$88,500
	CF	$1,600,352	$0	$1,545,040	$0	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$4,656,682	$0	$7,217,461	$239,250	$88,500

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
	Total	**$9,412,649**	**$0**	**$14,534,207**	**$478,500**	**$177,000**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration -- General Professional Services and Special Projects	GF	$3,005,615	$0	$5,621,706	$239,250	$88,500
	CF	$1,600,352	$0	$1,545,040	$0	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$4,656,682	$0	$7,217,461	$239,250	$88,500

CF Letternote Text Revision Required? Yes ___ No X

RF Letternote Text Revision Required? Yes ___ No X

FF Letternote Text Revision Required? Yes ___ No X

If Yes, see schedule 4 fund source detail.

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

Cost and FTE

- The Department requests $478,500 total funds, including $239,250 General Fund in FY 2018-19 and $177,000 total funds, including $88,500 General Fund in FY 2019-20 for administrative resources needed to consolidate the Home and Community Based Services (HCBS) adult waivers for persons with Intellectual and Developmental Disabilities (IDD).

Current Program

- HB 15-1318 "Consolidate Intellectual and Developmental Disabilities Waivers" directed the Department to establish a redesigned waiver for persons with Intellectual and Developmental Disabilities effective July 1, 2016 or as soon as the Centers for Medicare and Medicaid Services (CMS) approves it.
- The Department received 3.0 FTE, along with funding for contractors and system changes to implement the bill.

Problem or Opportunity

- The Department was unable to implement the bill by July 1, 2016 due to obstacles that were discovered through the stakeholder process and additional research identified through contractor work that require resources and time to resolve.

Consequences of Problem

- Without funding to contract out the additional work needed, the Department would have to further extend the waiver submission date to CMS.
- Additionally, further delays mean that vulnerable clients in the Home and Community Based Services-Developmentally Disabled (HCBS-DD) and Home and Community Based Services-Supported Living Services (HCBS-SLS) waivers would have to wait longer to access additional services or service delivery modalities that would be made available through the redesigned waiver.

Proposed Solution

- The Department requests two years of contractor funding for stakeholder engagement, data analysis, CMS waiver application design and submission, and assistance with the design, development and implementation of a transition plan of the waiver, in order to continue to implement the requirements of HB 15-1318.

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2018-19 Funding Request | November 1, 2017

Department Priority: ***R-19***

Request Detail: ***IDD Waiver Consolidation Administrative Funding***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
IDD Waiver Consolidation Administrative Funding	$478,500	$239,250

Problem or Opportunity:

The Department is currently in the process of preparing to submit the Home and Community Based Services (HCBS) Consolidated Waiver amendment for Adults with Intellectual and Developmental Disabilities (IDD) to the Centers for Medicare and Medicaid Services (CMS) as required by HB 15-1318 "Consolidate Intellectual And Developmental Disabilities Waivers;" however, the Department has identified additional work needed to develop the redesigned waiver and required waiver application in a timely and thoughtful manner. The Department does not have any appropriations for this purpose in FY 2017-18 or FY 2018-19. The implementation of a consolidated waiver would impact over 10,000 clients with complex needs and the Department believes a thoughtful implementation of the consolidation is crucial to ensure clients continue to receive the care they need.

The General Assembly appropriated the Department $2,176,695 total funds and 3.0 FTE in FY 2015-16, with roll forward authority into FY 2016-17, for the consolidated waiver implementation process through HB 15-1318. This funding was appropriated to analyze the breadth of fiscal, operational, and programmatic impacts of a redesigned waiver and for FTE to monitor this work, guide facilitation with stakeholders and to move towards the goal of implementing the consolidated waiver by July 1, 2016. The Department was unable to meet this deadline. HB 15-1318 took effect August 5, 2015 which allowed for nine months to hire the FTE, conduct stakeholder outreach, draft the waiver, and obtain CMS approval. Historically, the Department has needed one year for stakeholder vetting and one year for CMS waiver application submission and approval as there are generally a number of questions and responses required to obtain federal approval.

Though not able to meet the timeline from the bill, the Department was able to make significant progress towards waiver development by utilizing appropriated resources towards;

- Hiring FTE to develop and manage a project plan for implementing the bill, working with stakeholders, managing contracts, etc.
- Establishing the Waiver Implementation Council (the Council) to advise on the design and implementation of the redesigned waiver.

- Conducting quarterly meetings with the Council.
- Developing drafts of the redesigned waiver's 12 service definitions, all of which have been reviewed by the Council.
- Performing impact analyses of the proposed waiver, including work toward developing quality measures, provider qualifications, streamlining provider monitoring processes, service utilization forecasts, norm-referenced service limits, and new data for determining rates.

Through this work a number of additional issues and considerations that require further analysis and stakeholder vetting were brought to light. For example, the Department hired a contractor to model different options on how the Residential Habilitation service could be implemented in a combined waiver. The contractor was able to provide some estimates but was not able to do a complete analysis as the Department was unable to provide information on how the Support Level in the HCBS-DD waiver and HCBS-SLS waiver would convert to the combined waiver within the timeframe the contractor funding was available. As a result the Department was not able to receive the full analysis needed to make a decision on how to include the service in the combined waiver. The development of the Support Levels is crucial to estimating the utilization impact of the Residential Habilitation and other services and would require the help of a new contractor to develop before further analysis can be done. While the Department does have FTE assigned to waiver consolidation, they do not have the expertise to conduct the in-depth analysis required. As such, contractors would be needed to assist the Department in aligning Support Levels and Service Plan Authorization Limits as well as estimating the cost of the consolidated waiver once policy decisions on the design of the waiver are complete.

Additionally, through stakeholder engagement and contractor work the Department has identified the need for training, developing, planning, and implementing a transition plan for gradually enrolling individuals into the redesigned waiver to help ensure the waiver redesign is performed efficiently.

Finally, as the Department and contractors continue to design and develop the consolidated waiver, stakeholder engagement and input is essential to ensure the waiver would continue to meet the needs of the clients impacted by the consolidation.

Proposed Solution:

The Department requests $478,500 total funds, including $239,250 General Fund in FY 2018-19 and $177,000 total funds, including $88,500 General Fund in FY 2019-20 to hire contractors to continue work related to redesigning the HCBS-DD and HCBS-SLS waivers and submit the waiver application to CMS for review by July 2019. The funding requested would be used to hire a contractor to assist with the additional work needed to complete the waiver redesign process, including: assisting the Department in aligning Support Levels and Service Plan Authorization Limits and estimating the cost of the consolidated waiver; training, developing, planning, and implementing a transition plan for gradually enrolling individuals into the redesigned waiver; collecting stakeholder engagement and input; and performing other activities needed to address the issues and considerations discovered through recent work.

The Department would utilize funding to hire contractors to assist in performing a variety of activities needed to consolidate the HCBS-DD and HCBS-SLS waivers. The first activity the contractors would assist the

Department with is building upon existing data analytics work including analyzing results from the work already completed through FY 2017-18 to then aligning Support Levels and Service Plan Authorization Limits in the redesigned HCBS waiver program as well as estimating the cost of the consolidated waiver once policy decisions on the design of the waiver were completed. This funding would also be used to study the utilization and potential limitations of Residential Habilitation.

Additionally, the Department would use funding for training, developing, planning and implementing a transition plan for gradually enrolling individuals in the redesigned waiver to help ensure the waiver redesign was performed efficiently. Training and development would consist of updating, matching, and coordinating the training content being written for the new combined waiver with what is written in the waiver sections of the CMS application. The contractor would also help to implement a transition plan to begin gradually enrolling individuals into the redesigned waiver. A gradual transition would be necessary to ensure that issues identified during the transition could be addressed and resolved before full implementation. This would ensure that clients are not adversely impacted and that the Department could carefully manage costs.

The Department would also use funding to perform statewide stakeholder engagement. The Department would hire a contractor to perform neutral third-party facilitation for ongoing stakeholder engagement work and input in the waiver redesign process as well as for an online stakeholder forum to allow for greater access and transparency to the process. The contractor would engage stakeholders statewide in order to gauge and monitor feedback on waiver redesign and ensure that stakeholders' feedback was utilized to address any concerns that arose in the waiver redesign process. Hiring a third-party to complete this work would allow the Department to provide programmatic expertise and fully participate in the design and development of the new waiver without also serving as the facilitator.

The final piece of these contracts would consist of ad hoc analysis. This ad hoc analysis would consist of many different activities, such as drafting content, dependent on the need arising.

If this request is not approved, the Department would be unable to consolidate the HCBS-DD and HCBS-SLS waivers due to the current lack of specific actuarial credentials and experience needed to complete the analysis required to implement a combined waiver. As a result the Department would be unable to complete the additional work needed to submit the redesigned waiver to CMS by June 30, 2019.

Anticipated Outcomes:

Approving this request would ensure that the Department has funding to continue the process to redesign the HCBS-DD and HCBS-SLS waiver programs. Additional funding would ensure that the Department does not have to further delay the waiver being submitted to CMS. This in turn would allow clients currently receiving services in the HCBS-DD and HCBS-SLS waivers, and enrollees who will join in the future, to access any new services and additions or changes to the waiver once it is finalized and submitted. This request would also help the Department meet its performance plan goal to "Make Long-Term Services and Supports easier to access and navigate" by simplifying processes, expanding services, and reducing administrative burden for the individuals the Department serves. Thoughtful development of the training materials needed for case managers and other administrators would ensure successful and compliant service provision through the transition period of the waiver and beyond.

Assumptions and Calculations:

The Department assumes that current contracts in place for other work being done by the Department that is similar to this request that includes data analysis, facilitation, waiver redesign work, ad-hoc work, and stakeholder engagement are an accurate proxy for the hourly rate of the costs for the work that would need to be done to successfully redesign the new waiver. This is assumed because the work would be similar to what is already outlined in the current contracts. These rates are then multiplied by the estimated hours required to complete the activities outlined above to get the final cost of each activity. These figures and calculations can be seen in Appendix A.

The Department assumes the funding would be split into multiple vendor contracts and that the contract start date would be July 1, 2018. The Department assumes that existing staff would continue to manage the vendor contracts, including preparing and negotiating contract amendments, directing work, reviewing deliverables and participating in stakeholder engagement, and this would be absorbed within existing resources.

The Department estimated the number of hours required to complete the requested work by utilizing similar contracts or work completed by the Department. The stakeholder engagement contract is estimated to include 600 hours of work which would include activities such as preparing for and planning meetings, creating presentations, project planning, and managing and moderating an online stakeholder forum, among many other activities. The data and actuarial analysis contract is estimated to include 450 hours of work which would include developing unit limitations for services, regression analysis, analyzing waitlist data, and the review and synthesis of information and data from FY 2016-17 among other activities. Finally, the CMS waiver application and submission contract is estimated to include 1,150 hours of work and would include activities such as developing a risk plan, designing a transition plan, developing training, and ad-hoc work among other activities.

Table 1.1 FY 2018-19 Waiver Consolidation Summary by Line Item								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	**Total Request**	**$478,500**	**0.0**	**$239,250**	**$0**	**$0**	**$239,250**	**Row B**
B	(1) Executive Director's Office, (A) General Administration, General Professional Services And Special Projects	$478,500	0.0	$239,250	$0	$0	$239,250	Table 2.1 Row A

Table 1.2 FY 2019-20 Waiver Consolidation Summary by Line Item								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	**Total Request**	**$177,000**	**0.0**	**$88,500**	**$0**	**$0**	**$88,500**	**Row B**
B	(1) Executive Director's Office, (A) General Administration, General Professional Services And Special Projects	$177,000	0.0	$88,500	$0	$0	$88,500	Table 2.2 Row A

Table 1.3 FY 2020-21 Waiver Consolidation Summary by Line Item								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	**Total Request**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**Row B**
B	(1) Executive Director's Office, (A) General Administration, General Professional Services And Special Projects	$0	0.0	$0	$0	$0	$0	Funding No Longer Needed After FY 2019-20

Table 2.1 Waiver Consolidation FY 2018-19 Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	**Total Request**	**$478,500**	**0.0**	**$239,250**	**$0**	**$0**	**$239,250**	**50%**	**Sum of Rows B to H**
B	Stakeholder Engagement - Facilitation	$88,500	0.0	$44,250	$0	$0	$44,250	50%	Table 3.1 Row A
C	Stakeholder Engagement - Online Forum Facilitation and Support	$59,000	0.0	$29,500	$0	$0	$29,500	50%	Table 3.1 Row B
D	Stakeholder Engagement - Statewide Stakeholder Engagement	$29,500	0.0	$14,750	$0	$0	$14,750	50%	Table 3.1 Row C
E	Data and Actuarial Analysis Contract - Support Level and Unit Limitation Analysis	$97,500	0.0	$48,750	$0	$0	$48,750	50%	Table 3.1 Row D
F	Data and Actuarial Analysis Contract - Combination and Analysis of Prior Work	$48,750	0.0	$24,375	$0	$0	$24,375	50%	Table 3.1 Row E
G	CMS Waiver Application and Submission - Training, Development, Planning Implementation of the Transition Plan	$121,500	0.0	$60,750	$0	$0	$60,750	50%	Table 3.1 Row F
H	CMS Waiver Application and Submission - Ad Hoc Analysis	$33,750	0.0	$16,875	$0	$0	$16,875	50%	Table 3.1 Row G

Table 2.2 Waiver Consolidation FY 2019-20 Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	**Total Request**	**$177,000**	**0.0**	**$88,500**	**$0**	**$0**	**$88,500**	**50%**	**Sum of Rows B to D**
B	Stakeholder Engagement - Facilitation	$88,500	0.0	$44,250	$0	$0	$44,250	50%	Table 3.2 Row A
C	Stakeholder Engagement - Online Forum Facilitation and Support	$59,000	0.0	$29,500	$0	$0	$29,500	50%	Table 3.2 Row B
D	Stakeholder Engagement - Statewide Stakeholder Engagement	$29,500	0.0	$14,750	$0	$0	$14,750	50%	Table 3.2 Row C

Table 3.1 FY 2018-19 Waiver Consolidation Estimated Contract Costs

Row	Activity Name	Hourly Rate	Estimated Annual Units/Hours	Estimated Cost	Notes
A	Stakeholder Engagement - Facilitation	$295.00	300	$88,500	Hourly Rate Based on Current Contract, Hours Estimate from Department Staff Based on Expected Workload
B	Stakeholder Engagement - Online Forum Facilitation and Support	$295.00	200	$59,000	Hourly Rate Based on Current Contract, Hours Estimate from Department Staff Based on Expected Workload
C	Stakeholder Engagement - Statewide Stakeholder Engagement	$295.00	100	$29,500	Hourly Rate Based on Current Contract, Hours Estimate from Department Staff Based on Expected Workload
D	Data and Actuarial Analysis Contract - Support Level and Unit Limitation Analysis	$325.00	300	$97,500	Hourly Rate Based on Current Contract, Hours Estimate from Department Staff Based on Expected Workload
E	Data and Actuarial Analysis Contract - Combination and Analysis of Prior Work	$325.00	150	$48,750	Hourly Rate Based on Current Contract, Hours Estimate from Department Staff Based on Expected Workload
F	CMS Waiver Application and Submission - Training, Development, Planning Implementation of the Transition Plan	$135.00	900	$121,500	Hourly Rate Based on Current Contract, Hours Estimate from Department Staff Based on Expected Workload
G	CMS Waiver Application and Submission - Ad Hoc Analysis	$135.00	250	$33,750	Hourly Rate Based on Current Contract, Hours Estimate from Department Staff Based on Expected Workload
H	**Total**	**N/A**	**2,200**	**$478,500**	Sum Rows A - G

Table 3.2 FY 2019-20 Waiver Consolidation Estimated Contract Costs

Row	Activity Name	Hourly Rate	Estimated Annual Units/Hours	Estimated Cost	Notes
A	Stakeholder Engagement - Facilitation	$295.00	300	$88,500	Hourly Rate Based on Current Contract, Hours Estimate from Department Staff Based on Expected Workload
B	Stakeholder Engagement - Online Forum Facilitation and Support	$295.00	200	$59,000	Hourly Rate Based on Current Contract, Hours Estimate from Department Staff Based on Expected Workload
C	Stakeholder Engagement - Statewide Stakeholder Engagement	$295.00	100	$29,500	Hourly Rate Based on Current Contract, Hours Estimate from Department Staff Based on Expected Workload
D	**Total**	**N/A**	**600**	**$177,000**	Sum Rows A - C

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **NPR-01 CBMS-PEAK Annual Funding Adjustment**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ Supplemental FY 2017-18

X Change Request FY 2018-19

___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$24,233,956	$0	$24,233,956	$5,530,865	$6,073,774
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,465,013	$0	$5,429,044	$1,248,935	$1,367,608
	CF	$3,549,856	$0	$3,585,825	$237,418	$306,861
	RF	$59,285	$0	$59,285	$34,399	$36,142
	FF	$15,159,802	$0	$15,159,802	$4,010,113	$4,363,163

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (C) Information Technology Contracts and Projects -- CBMS, Health Care and Economic Security Staff Dev. Center	Total	$684,816	$0	$684,816	$320,599	$320,599
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$245,329	$0	$245,329	$70,486	$70,486
	CF	$95,921	$0	$95,921	$88,843	$88,918
	RF	$1,719	$0	$1,719	$1,508	$1,508
	FF	$341,847	$0	$341,847	$159,762	$159,687

	Total	**$23,549,140**	**$0**	**$23,549,140**	**$5,210,266**	**$5,753,175**
01. Executive Director's Office, (C) Information Technology Contracts and Projects -- Colorado Benefits Management Systems, Operating & Contracts	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,219,684	$0	$5,183,715	$1,178,449	$1,297,122
	CF	$3,453,935	$0	$3,489,904	$148,575	$217,943
	RF	$57,566	$0	$57,566	$32,891	$34,634
	FF	$14,817,955	$0	$14,817,955	$3,850,351	$4,203,476

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 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 Non-Prioritized Request

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

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **NPR-02 Commission on Family Medicine**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ **Supplemental FY 2017-18**

X **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,747,298**	**$0**	**$7,897,298**	**$600,000**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,798,649	$0	$3,798,649	$300,000	$0
	CF	$0	$0	$0	$0	$0
	RF	$75,000	$0	$150,000	$0	$0
	FF	$3,873,649	$0	$3,948,649	$300,000	$0

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
06. Other Medical Services -- Commission on Family Medicine Residency Training Programs	**Total**	**$7,747,298**	**$0**	**$7,897,298**	**$600,000**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,798,649	$0	$3,798,649	$300,000	$0
	CF	$0	$0	$0	$0	$0
	RF	$75,000	$0	$150,000	$0	$0
	FF	$3,873,649	$0	$3,948,649	$300,000	$0

CF Letternote Text Revision Required? Yes ___ No X **If Yes, see schedule 4 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: Commission on Family Medicine (COFM)

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title NPR-05 FY 2018-19 OIT HCPF Security Request

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ Supplemental FY 2017-18
X Change Request FY 2018-19
___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$5,035,698	$0	$5,001,933	$194,302	$194,302
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,139,744	$0	$2,128,681	$63,663	$63,663
	CF	$378,109	$0	$372,290	$33,488	$33,488
	RF	$0	$0	$0	$0	$0
	FF	$2,517,845	$0	$2,500,962	$97,151	$97,151

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- Payments to OIT	Total	$5,035,698	$0	$5,001,933	$194,302	$194,302
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,139,744	$0	$2,128,681	$63,663	$63,663
	CF	$378,109	$0	$372,290	$33,488	$33,488
	RF	$0	$0	$0	$0	$0
	FF	$2,517,845	$0	$2,500,962	$97,151	$97,151

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 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: The Governor's Office of Information Technology

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title NPR-06 FY 2018-19 Payments to Risk Management Cybersecurity

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ Supplemental FY 2017-18

X Change Request FY 2018-19

___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$128,274	$0	$85,476	$3,766	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$64,137	$0	$42,738	$1,883	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$64,137	$0	$42,738	$1,883	$0

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- Payment to Risk Management and Property Funds	Total	$128,274	$0	$85,476	$3,766	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$64,137	$0	$42,738	$1,883	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$64,137	$0	$42,738	$1,883	$0

CF Letternote Text Revision Required? Yes ___ No X **If Yes, see schedule 4 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: Other

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title	**NPR-07 FY 2018-19 Microsoft ELA**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ Supplemental FY 2017-18

X Change Request FY 2018-19

___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$5,035,698	$0	$5,001,933	$144,261	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,139,744	$0	$2,128,681	$47,267	$0
	CF	$378,109	$0	$372,290	$24,864	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,517,845	$0	$2,500,962	$72,130	$0

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- Payments to OIT	Total	$5,035,698	$0	$5,001,933	$144,261	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,139,744	$0	$2,128,681	$47,267	$0
	CF	$378,109	$0	$372,290	$24,864	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,517,845	$0	$2,500,962	$72,130	$0

CF Letternote Text Revision Required? Yes X No ___ **If Yes, see schedule 4 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: Governor's Office of Information Technology

Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title	**NPR-08 FY 2018-19 DHS R-18 Restore Regional Center Funding**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ Supplemental FY 2017-18

X Change Request FY 2018-19

___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$44,234,533**	**$0**	**$44,234,533**	**$6,682,728**	**$6,682,728**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$20,228,364	$0	$20,228,364	$3,341,364	$3,341,364
	CF	$1,888,903	$0	$1,888,903	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$22,117,266	$3,470,380	$22,117,266	$3,341,364	$3,341,364

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
07. Department of Human Services Medicaid-Funded Programs, (H) Services for People with Disabilities - Medicaid Funding -- Regional Centers	**Total**	**$44,234,533**	**$6,940,760**	**$44,234,533**	**$6,682,728**	**$6,682,728**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$20,228,364	$3,470,380	$20,228,364	$3,341,364	$3,341,364
	CF	$1,888,903	$0	$1,888,903	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$22,117,266	$3,470,380	$22,117,266	$3,341,364	$3,341,364

CF Letternote Text Revision Required? Yes ___ No X — **If Yes, see schedule 4 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 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **NPR-09 FY 2018-19 DHS R-05b Community Based Intensive Reside**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ **Supplemental FY 2017-18**

X **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$6,832,172**	**$0**	**$6,832,172**	**($17,321)**	**($17,321)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,416,086	$0	$3,416,086	($8,661)	($8,661)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,416,086	$0	$3,416,086	($8,660)	($8,660)

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
	Total	**$6,832,172**	**$0**	**$6,832,172**	**($17,321)**	**($17,321)**
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	$3,416,086	$0	$3,416,086	($8,661)	($8,661)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,416,086	$0	$3,416,086	($8,660)	($8,660)

CF Letternote Text Revision Required? Yes ___ No X **If Yes, see schedule 4 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 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title	NPR-10 DHS Common Policy Adjustment with Medicaid

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ Supplemental FY 2017-18
X Change Request FY 2018-19
___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$9,213,968**	**$0**	**$9,188,906**	**$60,759**	**$64,957**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,606,985	$0	$4,594,455	$30,382	$32,482
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,606,983	$0	$4,594,451	$30,377	$32,475

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
07. Department of Human Services Medicaid-Funded Programs, (K) Other -- DHS Services Indirect Cost Assessment	**Total**	**$9,213,968**	**$0**	**$9,188,906**	**$60,759**	**$64,957**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,606,985	$0	$4,594,455	$30,382	$32,482
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,606,983	$0	$4,594,451	$30,377	$32,475

CF Letternote Text Revision Required? Yes ___ No X — **If Yes, see schedule 4 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 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title NPR-11 DHS 1% Provider Rate Increase

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ Supplemental FY 2017-18

X Change Request FY 2018-19

___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	Total	$24,941,315	$0	$24,941,315	$246,242	$246,242
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$12,470,659	$0	$12,470,659	$123,121	$123,121
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$12,470,656	$0	$12,470,656	$123,121	$123,121

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
07. Department of Human Services Medicaid-Funded Programs, (D) Division of Child Welfare - Medicaid Funding -- Child Welfare Services	Total	$15,410,746	$0	$15,410,746	$154,108	$154,108
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,705,373	$0	$7,705,373	$77,054	$77,054
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$7,705,373	$0	$7,705,373	$77,054	$77,054
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	$6,655,359	$0	$6,655,359	$66,554	$66,554
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,327,680	$0	$3,327,680	$33,277	$33,277
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,327,679	$0	$3,327,679	$33,277	$33,277

	Total	$125,356	$0	$125,356	$1,254	$1,254
07. Department of Human Services Medicaid-Funded Programs, (G) Behavioral Health Services - Medicaid Funding -- Mental Health Treatment Services for Youth (H.B. 99-1116)	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$62,678	$0	$62,678	$627	$627
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$62,678	$0	$62,678	$627	$627

	Total	$1,622,430	$0	$1,622,430	$16,224	$16,224
07. Department of Human Services Medicaid-Funded Programs, (G) Behavioral Health Services - Medicaid Funding -- High Risk Pregnant Women Program	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$811,215	$0	$811,215	$8,112	$8,112
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$811,215	$0	$811,215	$8,112	$8,112

	Total	$1,127,424	$0	$1,127,424	$8,102	$8,102
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	$563,713	$0	$563,713	$4,051	$4,051
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$563,711	$0	$563,711	$4,051	$4,051

CF Letternote Text Revision Required? Yes ____ No X — **If Yes, see schedule 4 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 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **NPR-12 CDPHE Total Compensation**

Dept. Approval By: [signature] 11/1/17

OSPB Approval By: [signature]

___ Supplemental FY 2017-18

X Change Request FY 2018-19

___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,944,099**	**$0**	**$7,636,495**	**$295,336**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,025,481	$0	$2,855,490	$121,066	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,918,618	$0	$4,781,005	$174,270	$0

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (B) Transfers to/from Other Departments -- Facility Survey and Certification, Transfer to CDPHE	**Total**	**$7,944,099**	**$0**	**$7,636,495**	**$295,336**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,025,481	$0	$2,855,490	$121,066	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,918,618	$0	$4,781,005	$174,270	$0

CF Letternote Text Revision Required? Yes ___ No X **If Yes, see schedule 4 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