



Department of Health Care Policy and Financing
Department Description
FY 2013-14 Budget Request

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II. BACKGROUND INFORMATION

The Department of Health Care Policy and Financing (the Department) receives federal funding as the single state agency responsible for administering the Medicaid program (Title XIX) and the Child Health Insurance Program (Title XXI), known as the Children's Basic Health Plan. In addition to these programs, the Department administers the Colorado Indigent Care Program, the Old Age Pension State Medical Program, the Primary Care Fund, as well as the Home- and Community-Based Services Medicaid waivers. The Department also provides health care policy leadership for the state's Executive Branch. Most of the Department's programs are funded in part by the federal Centers for Medicare and Medicaid Services. The Medicaid program receives approximately 50% of its funding from the federal government and the Children's Basic Health Plan is approximately 65% federally funded.

Executive Director's Office

Susan Birch was appointed Executive Director of the Department effective January 18, 2011. The Executive Director has organized the Department to allow for greater focus on key program and operational areas. Areas of responsibility for the Executive Director include general governance and financial accountability for the Department, communication with partners within and outside of state government, and research and development for current and future refinement of Department operations and programs.

The State Medical Services Board was created by the Legislature effective July 1, 1994. The Board consists of 11 members appointed by the Governor and confirmed by the Senate. The members are persons who have knowledge of medical assistance programs, experience with the delivery of health care, and experience or expertise in caring for medically underserved children. The Board has the authority to adopt rules governing the Colorado Medicaid program and the Children's Basic Health Plan that are in compliance with state and federal regulations.

The Office of Community Living was created in July 2012 pursuant to an Executive Order by the Governor to meet the growing need for long-term services and supports by aging adults and people with disabilities. The goal of the Office of Community Living is to provide strategic direction on the redesign of all aspects of the long-term services and supports delivery system, including service models, payment structures, and data systems to create efficient and person-centered community-based care.

Health Programs Office

The Health Programs Office designs, implements, and administers Medicaid, Children's Basic Health Plan (CHP+), and the Long-Term Care Medicaid Programs. The office aims to improve the health status of all clients, achieve efficiencies in scarce health care resource utilization, and promote effective partnerships with providers and contractors to achieve improved health and functioning of

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clients. The office recognizes the diversity of geography, age, culture, ethnicity, psychosocial needs, income, and health among its clients and aims to deliver high-quality client-centered services. The office is comprised of the Health Programs Services and Supports Division and the Long-Term Services and Supports Division.

Health Programs Services and Supports Division

The Health Programs Services and Supports Division is responsible for the administration and performance of Medicaid fee-for-service and managed-care services and programs, as well as CHP+. The division also seeks to maximize the health, functioning, and self-sufficiency of all Medicaid and CHP+ clients affordably. The services and programs include both physical health and behavioral health benefits. The division is responsible for provider outreach, policy development, contract management, operations management, and overall Medicaid and CHP+ program performance.

Long-Term Services and Supports Division

The Long Term Care Services and Supports Division oversees Medicaid-funded community-based services and nursing facilities. The division has a particular focus on affordably maximizing the health, functioning, and self-sufficiency of clients in long-term care, institutional, or community settings. The clients utilizing these services have complex health care needs, requiring coordinated and high-quality services. Community-based services are those services provided in clients' homes as an alternative to placement in a nursing facility or other institutional setting. These community-based services provide support for clients to remain at home and in the community, allowing for individual choice. This division oversees all Medicaid Home- and Community-Based Services waiver programs (HCBS) and skilled services such as home health care, private duty nursing, and hospice care that are available through the Medicaid State Plan. The division is also responsible for managing consumer-directed attendant support services which allow qualifying individual clients to direct their own in-home care.

Administration and Innovation Office

The Administration and Innovation (A&I) Office aims to create a culture of innovation and engagement throughout the Department's workforce. This office includes the Strategy Section, Workforce Development Section, and Human Resources (HR) Section. The A&I Office also represents the Department in human resources collaboration efforts with the Department of Public Health and Environment (DPHE) and the Department of Human Services (DHS).

Strategy Section

The Strategy Section develops and enriches the Department's strategic management process. Its goal is to create understanding, value, and line-of-sight from individual staff roles to attainment of the Department's vision, mission, and goals. The Strategy Section guides the Department through the annual strategic-management process, from formulation activities to implementation and

evaluation. It collaborates with staff across the Department to achieve integration of various initiatives, including health reform, and develops strategies to leverage resources. Overall, this Section provides structure and cohesion for implementing and prioritizing projects that align with the Department's strategic direction. The Strategy Section has three areas of focus: Research and Planning, Innovation and Grants, and Process Improvement.

Workforce Development Section

The purpose of the Workforce Development Section is to sustain and improve the Department's ability to achieve its on-going mission and capacity to innovate. The Workforce Development Section will develop and implement a plan to integrate its talent-management processes to ensure that the A&I Office is effectively developing, managing, and improving programs to improve quality of the Department's workforce. The section is responsible for strategic human resources planning including the acquisition of software to support on-going and future human resources programs. The Workforce Development Section will participate in the evaluation of human resources functions that can be included in the scope of human resources collaboration with the Department of Public Health and Environment (DPHE) and the Department of Human Services (DHS).

Human Resources Section

The Human Resources Section provides the full range of human resource services to all employees of the Department. This is a decentralized personnel function, which includes:

- Recruitment
- Testing and selection
- Classification
- Salary administration
- Rules interpretation
- Dispute resolution
- Personnel performance management
- Annual compensation/benefits
- Employee/manager counseling
- Corrective and disciplinary actions
- Workforce turnover/retention analysis
- Maintaining personnel records

This section also provides guidance, counseling, and technical assistance to Department managers and staff on the application of the State personnel system. The Human Resources Section has assumed responsibility of the reception area and has been delegated the security function for the Department. The Human Resources Section is responsible for all functions necessary to properly classify

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Department staff positions and to fill those positions in accordance with the State constitution and the State personnel rules and procedures. The Human Resources Section is responsible for training all Department staff on Executive Orders such as sexual harassment, violence in the workplace, and maintaining a respectful workplace.

The Human Resources Section also oversees the building Reception Unit, which provides identification badges to all department visitors, to ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) in accordance with the State Procurement rules the Department's supply purchases are made.

Audits and Compliance Division

The Audits and Compliance Division consists of the Program Integrity Section and the Internal Audits Section. These sections ensure compliance with state and federal law, as well as identifying and recovering any improper Medicaid payments.

Program Integrity

The Program Integrity section monitors and improves provider accountability for the Medicaid program. The section identifies fraud, potentially excessive and/or improper utilization, and improper billing of the Medicaid program by providers. If aberrancies are identified, staff then investigate, classify, and recover payments and/or refer the providers to legal authorities for possible prosecution when appropriate. Administrative, civil, and/or criminal sanctions may also be pursued by the Department in coordination with the Attorney General's Medicaid Fraud Control Unit or the U.S. Attorney's office.

Internal Audits Section

The Internal Audits section exists to ensure that the Department maintains compliance with federal and state rules, laws, and regulations. The section has several different functions that assist with this, including the Medicaid Eligibility Quality Control Unit, County Audits, Payment Error Rate Measurement (PERM) Program, Internal Audits/Review, and Department Audit Coordination.

Finance Office

The Finance Office consists of the Budget Division, the Controller Division, the Rates and Analysis Division, and the Safety Net Programs Section. The Finance Office also houses the Provider Operations Division, which includes the Claims Systems and Operations Division and the Purchasing and Contracting Services Section.

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Budget Division

The Budget Division's key responsibilities are to project, construct, present, monitor, and manage the Department's budget. In addition, the Budget Division presents and defends the Department's budgetary needs to the Executive and Legislative authorities. The division prepares each phase of the budget request process, including deliverables such as statistical forecasting of caseload and premiums, requests for additional funding, and recommendations for reduced funding. This division also monitors caseload and expenditures throughout the fiscal year and ensures expenditures meet legal requirements while still coinciding with the Department's objectives. The Budget Division also tracks relevant legislation as it moves through the General Assembly and prepares fiscal impact statements for proposed legislation and ballot initiatives that may affect the Department. This division is also responsible for federal reporting as well as coordinating with other State agencies on budgetary issues that affect multiple departments.

The Budget Division is also tasked with working closely with the Centers for Medicare and Medicaid Services to ensure that the Department is maximizing federal Medicaid revenue. In addition, the Division strives to maximize available federal funding for hospital and clinic providers who participate in Medicaid and the Colorado Indigent Care Program.

The Budget Division includes the Financing and Indigent Care Unit, the Medical Premiums Unit, and the Personal Services and Other Agencies Unit.

Controller Division

The Controller Division oversees the accounting functions of the Department. The division ensures the proper recording and reporting of revenues and that expenditures in the Department are in compliance with generally accepted accounting principles and state and federal rules and regulations. All positions are responsible for monitoring the accurate reporting of assigned appropriations and working with Budget and Program personnel to resolve issues.

The Operations Unit is responsible for the proper recording of cash receipts, accounts receivable, accounts payable, and payroll. This includes processing and depositing checks and other receipts and properly recording this information in the State's financial records system, monitoring receivable balance sheet accounts and adjusting vendor accounts to properly account for amounts owed the State's Medicaid program, processing manual payments to vendors in the State's financial records system, and processing the Department's monthly and bi-weekly personnel payments through the State's central payroll system.

The Financial Reporting and Grants Unit is responsible for all accounting activities for the Children's Basic Health Plan, the Department of Human Services and County Administration Program, and Cash Management. Each accountant responds to the accounting needs of their Program, and the Cash Management Accountant manages the State and Federal Cash as well as the reporting of private grants and non-Medicaid Federal grants.

The Medicaid and Other Programs Unit is primarily responsible for all accounting entries and issues related to the Medical Services Premiums and Medicaid Mental Health Long Bill Groups, the Hospital Provider Fee, the Nursing Home Provider Fee, and Tobacco Taxes. Additional duties include recording the Departmental budget in the Colorado Financial Reporting System and performing and reconciling all entries related to the enhanced federal medical assistance percentage provided by the American Recovery and Reinvestment Act of 2009 (ARRA).

Rates and Analysis Division

The Rates Section of the Rates and Analysis Division develops rate-setting methodology and implements managed care rates for health maintenance organizations, behavioral health organizations, and the Program of All Inclusive Care for the Elderly providers. The section also monitors and updates rates paid for home and community-based services. In addition, this section is responsible for rate analysis and operations for hospitals, federally qualified health centers, and rural health clinics. It is the responsibility of this section to make sure that rates comply with all applicable state statutes and federal regulations.

The Department recognizes the critical need for professional, efficient, consistent, and appropriate analysis of its statistical information, and as such, has a Data Analysis Section. The section establishes standards for appropriate analytical methodologies for use in making strategic and fiscally responsible decisions. The focus of this section is to address the difficult and complex data analysis needs of both internal and external customers. This section extracts data for research, policy formation, report writing, forecasting, and rate setting for the Department's programs.

Safety Net Programs Section

The Safety Net Programs Section administers several programs that provide funding to hospitals and clinics that serve uninsured and underinsured individuals, and provide coverage for individuals not eligible for Medicaid or the Children's Basic Health Plan. The Colorado Indigent Care Program distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado citizens, migrant workers, and legal immigrants with limited financial resources.

The Safety Net Programs section is also responsible for all modeling of provider fees utilized within the Department. Currently, these include the Nursing Facility Provider Fee and the Hospital Provider Fee. The Safety Net Programs section develops fee models, works with external stakeholders, advisory boards and providers, coordinates the approval of the fee models with the Medical Services Board, and submits State Plan Amendments to the federal Centers for Medicare and Medicaid Services for approval of these fee models.

Provider Operations Division

The Provider Operations Division is composed of the Purchasing and Contracting Services Section and the Claims Systems and Operations Division, which is made up of the Fiscal Operations Section, the Program Management Unit, and the Claims System Section.

The Purchasing and Contracting Services Section provides support for all aspects of procurement for the Department and ensures compliance with state procurement statutes and rules. The section also reviews departmental contracts for compliance with state rules, regulations, and contracting standards and processes.

Within the Claims Systems and Operations Division, the Fiscal Agent Operations Section manages the Department's Information Technology (IT) contracts and agreements, monitors IT vendors for contractual compliance, and provides IT vendor operational oversight. The section drafts and negotiates contracts and monitors contract performance as well as federal oversight of IT contracts. The primary IT contract that the section manages and monitors is the Medicaid Management Information System (MMIS) contract, which is a multi-year, multi-million-dollar contract. The section also works with the Budget Division to provide estimates for building in modifications to the system to reflect changes needed to implement legislation or shifts in policy direction. The Fiscal Agent Operations Section also provides oversight of all operational aspects of the MMIS contract, and is responsible for addressing escalated billing and provider enrollment issues that require state approval.

The Program Management Unit (PMU) assists in developing and implementing large projects such as the MMIS procurement and ICD-10 implementation. Additionally, the PMU acts as a bridge between multiple departments to reduce inefficiencies and timeframes for approvals and increases the lines of communication for smaller projects or for projects that do not have legislative approval. The PMU fills gaps that may exist between the Department's fiscal agent, Departmental business analysts, and the various departments that are required to act together to complete projects in a timely manner. The PMU provides project management services for Claims and Operations Division projects, consolidated reporting of Claims and Operations Division projects, support division activities through strategic planning and develop methodologies and training for stakeholders on the methods and processes utilized in functional areas.

The Claims Systems Section ensures timely and accurate Medicaid and Children's Basic Health Plan claims processing and reporting. The section is responsible for directing the systems maintenance and enhancement of the MMIS by working closely with the systems staff of the fiscal agent, ACS Government Solutions. The section works with Department policy staff to gather requirements for the maintenance or enhancement of the MMIS by developing requirement documentation, reviewing and approving detail system design approaches, ensuring appropriate testing of changes, and by reviewing and approving all test outputs. Further, this section proposes IT

solutions to program staff and implement those solutions to support Department policies. The section works with policy staff at the Department and its sister agencies as well as programmers and business analysts at the fiscal agent to ensure the MMIS accurately pays for approved services to eligible clients by enrolled providers.

Clinical Services Office

The new Clinical Services Office provides clinical expertise across the Department. This Office focuses on preventing the onset of disease and helping the Department's clients to manage chronic diseases in such a way that their health improves. Staff in the Office advise clinically on medical services provided by the Medicaid agency, assist in policy development, program planning, quality improvement, provide clinical input on member and provider grievances and appeals, and act as liaisons with the provider community and other State agencies as needed. This Office includes Pharmacy, Strategic Projects and the Quality and Health Improvement units.

Pharmacy Section

The Pharmacy Section oversees access to medications for Medicaid clients, including the fee-for-service and dual-eligible (Medicare and Medicaid) populations. The section ensures that medications are used in a clinically appropriate and cost-effective manner through the Preferred Drug List Program and by performing drug-utilization analysis, with input from the Drug Utilization Review Board. The section aims to improve health care quality by addressing under-utilization, over-utilization, and inappropriate utilization of pharmaceuticals. This section administers the Rx Review Program (drug therapy counseling sessions for Medicaid clients). The section collects federal and supplemental drug rebates from pharmaceutical manufacturers. The section also ensures that pharmacy benefits are provided in compliance with federal and state statutes and regulations. Finally, the section provides pharmacy benefits information and assistance to clients, pharmacies, and prescribers to facilitate clients' access to their medications.

Quality and Health Improvement Unit

The Quality and Health Improvement Unit is responsible for directing, conducting, and coordinating performance-improvement activities for the care and services Medicaid and Children's Basic Health Plan clients receive. The unit works across programs, offices, and divisions to promote effectiveness and efficiency initiatives that support the Department's mission. Specific functions of the unit include process and outcome measurement and improvement, managing the external quality review of physical and behavioral managed care contractors and fee-for-service providers, monitoring managed care plan contract compliance, overseeing external review organization administration of satisfaction surveys to clients enrolled in Medicaid managed care and the Children's Basic Health Plan, development of long-term care quality tools and interagency quality collaborations, and development and implementation of quality strategies and consulting to program managers regarding performance measurement and improvement.

Policy and Communications Office

The Policy and Communications Office was created in September 2012, and includes the Director of Government Affairs, Legislative Liaison, Legislative Analyst, the Public Information Officer and other communications staff, the Policy and Federal Rules professionals, and the State Board Coordinator. The Office bears responsibility for management of the functions associated with government affairs and communication and media relations. The Policy and Communications Office is responsible for providing leadership and advice to the Department to optimize internal and external communication and enhance internal and external relations. The staff represents the Department before a wide variety of external stakeholders, including but not limited to policy makers, county partners, advocates/stakeholders, and the press. Staff are responsible for working with Department managers on high-profile matters to make certain they are handled in a manner that is most beneficial to the citizens of Colorado and to the Department. The Office bears responsibility for developing a broad-scale communications plan, proactively addressing both internal and external audiences' needs. The Policy and Communications Office is responsible for crafting messages to policy makers, clients, and stakeholders that are accurate and that reflect the overall mission and accomplishments of the Department and programs. The Office creates the Department's legislative agenda and advocates for successful passage of Department initiatives, and creates and maintains positive relationships with all legislators and regularly communicates with legislators about the Department's initiatives.

Client Services, Eligibility, and Enrollment Office

The Client Services, Eligibility, and Enrollment Office includes a diverse set of functions that promote the Department's mission of improving access to high-quality and cost-effective health care to Coloradans. Many of the activities focus on ensuring that those applying for State health care programs have the support and information they need to make the process as easy as possible. Once enrolled in a program, several activities support the client's continued retention if they remain eligible and promote access to health care services in appropriate settings. Many of the activities focus on ensuring that external partners, providers, stakeholders, and community-based organizations have opportunities to provide input regarding the implementation of programs and major initiatives of the Department. To this end, the Client Services, Eligibility, and Enrollment Office identifies ways to improve communication to further the goals of transparency and accountability.

Eligibility Division

The Eligibility Division exists to ensure access to Medicaid for eligible families, children, the elderly, and persons with disabilities. This section defines program eligibility through policy development and training to counties and other agencies. The section also provides policy expertise on Medicaid eligibility for all categories for the rules-based eligibility computer system, serving as a liaison to the Colorado Benefits Management System, managed by the Office of Information Technology.

Client Services Division

The Client Services Division provides a high level of communication and assistance to all clients who contact the Department. The section acts as a major focal point for callers who require assistance with questions about eligibility and program information and who need help in navigating a complex health care system. This section also includes the Program and Policy Training Unit, which produces and conducts trainings for a wide variety of internal and external customers regarding the Department's policies and initiatives.

Community Partnerships Office

The Community Partnerships Office builds and manages community partnerships and relationships and assists with aligning the Department's strategy and activities with statewide and national health reform initiatives. The Office includes the Legal Division and coordinates relationships between the Department and partners of the Department, including advocacy organizations, providers, and other units of government.

Legal Division

The Legal Division is responsible for handling privacy and Health Insurance Portability and Accountability Act (HIPAA) training and compliance. The Division also acts as records custodian and coordinates Colorado Open Records Act requests. Other responsibilities of the Division include managing and coordinating external data requests through the Department's data review board, managing the Department's privacy database, managing the Department's State Plan and drafting amendments to the State Plan, providing assistance in drafting rules, coordinating the Department's relationship with the Attorney General's office, providing analysis and guidance to Department personnel on various regulatory and legal issues, and monitoring the impacts of federal health care reform.

The Legal Division includes the Benefits Coordination section, whose mission is to ensure Medicaid is the payer of last resort, extending public purchasing power by pursuing third-party payment of medical costs for Medicaid-eligible persons. The Benefits Coordination Section pursues responsible payment sources to recover costs for medical care paid for by Medicaid. The sources the Benefits Coordination Section pursues include trusts, estate recoveries, and recovery of any payments for clients who were discovered to be ineligible for Medicaid retroactively. In FY 2011-12, the Benefits Coordination Section collected \$45.1 million in recoveries from trusts, estate recoveries, and recovery of any payments for clients who were discovered to be ineligible for Medicaid retroactively. This was an increase of 11.4% over the FY 2010-11 recoveries.

III. PRIOR-YEAR LEGISLATION

The following is a summary of major legislation enacted in 2012 that affects Department policies and procedures.

HB 12-1054 (Fields, Boyd) Simplify Procurement for HCPF Providers

This bill simplifies the procurement process by exempting the Department and health care providers from certain state fiscal-rule requirements concerning standard state contracts and commitment vouchers when the Department has regulatory authority over the program and when the provider has already signed a provider agreement.

HB 12-1202 (Levy, Lambert) Allow HCPF Appropriations for Quitline Matching Funds

This bill authorizes the General Assembly to appropriate moneys from the Tobacco Education Programs Fund to the Department in order to allow the Department to obtain federal matching funds for the Colorado Quitline program.

HB 12-1246 (Becker, Hodge) Reverse Payday Shift State Employees Paid Bi-Weekly

This bill reverses the payday shift enacted by Senate Bill 03-197 for state employees who are paid on a bi-weekly basis so that such employees will be paid in June in accordance with their regular two-week payment schedule.

HB 12-1281 (Young and Gerou, Steadman and Roberts) Medicaid Payment Reform Pilot

This bill creates the Medicaid Payment Reform and Innovation Pilot Program within the structure of the existing coordinated care system to foster the use of new payment projects. The Department is directed to create a process for interested contractors to submit payment projects for consideration under the pilot program.

HB 12-1288 (Murray, Bacon) Administration of IT Projects in State Government

This bill requires the Office of Information Technology (OIT) to develop a comprehensive risk-assessment that will be applied to every new information technology (IT) project to assess risk levels related to the project and determine whether the project should be classified as a major IT project. The bill also requires OIT to establish project budgets for projects of all sizes, including major IT projects.

SB 12-023 (Boyd, Summers, and Kerr A.) Improve Eligible Persons Access to PACE Program

This bill allows providers for the Program of All-inclusive Care for the Elderly (PACE) to contract with an enrollment broker to include the PACE program in its marketing materials to eligible long-term care clients.

SB 12-060 (Roberts, Gerou) Improve Medicaid Fraud Prosecution

This bill allows counties to keep the state share of any funds recovered from client fraud. It also requires the Attorney General to prepare annual reports on client and provider fraud, respectively.

SB 12-074 (Aguilar, Gardner B.) Consumer-Directed Care Designee Service Provider

This bill allows a guardian to also be a client's direct service provider under the Consumer Directed Attendant Support Services (CDASS) program.

SB 12-127 (Newell, Summers) Medicaid Health Homes Long-Term Care Providers

This bill requires, to the extent permitted under federal law, the Department to include providers of long-term care services and supports as health homes or as part of health homes in the Medicaid program.

SB 12-128 (Roberts, Summers) Alternative Care Facility Reimbursement Pilot

This bill allows the Department to create an enhanced reimbursement program in which an alternative care facility will receive a temporary increase in the Medicaid per-diem reimbursement rate for a client discharged from a nursing facility.

SB 12-159 (Hudak, Kerr J.) Evaluation Children with Autism Waiver

This bill clarifies the frequency and content of evaluations for children receiving Medicaid Home and Community-Based Services (HCBS) through the Children with Autism (CWA) waiver program. The Department is directed to annually review the fund balance of the Colorado Autism Treatment Fund to determine whether additional eligible children may be enrolled in the program. The bill also prioritizes getting children who are determined to have an imminent need for services on the waiver first if approved by the Centers for Medicare and Medicaid Services (CMS).

IV. HOT ISSUES

Customer Focus

Customer focus includes all activities and initiatives that improve health outcomes, client experience, and lower per capita costs. For years, both the public and private sectors in Colorado have been working toward the Triple Aim: achieving better care, better health, and lower cost, while keeping people and patients at the center of reform efforts. The Department acknowledges the current cost trajectory of health care is unsustainable, and the Department is working to make Coloradans healthier while getting the most value for every health care dollar spent. Colorado already has the framework for health system transformation in place, including an All-Payer Claims Database, Medicaid's Accountable Care Collaborative, and new initiatives like the Comprehensive Primary Care Initiative. The Department's State Health Care Innovation Plan touches on several innovative initiatives and broadly outlines a plan to build upon what is working to further reform Colorado's health care delivery and payment systems to achieve more value for every health care dollar spent.

Many collaborative payment and delivery system reform efforts are already underway among State agencies, providers, health plans, private payers, and stakeholders representing clients and families. Colorado has a unique culture that allows for innovations in health care at the local, regional, and State level. That collaboration must continue and grow in order to transform the health system. Many of the strategies in the State Health Care Innovation Plan include building upon the successes of previous and ongoing initiatives, while supporting innovations at the local levels to meet the health care needs of Colorado's diverse population and improving statewide infrastructure as the backbone of a transformed health system.

Accountable Care Collaborative

The Accountable Care Collaborative (ACC) Program is designed to transform the Medicaid Program into an integrated system of better care for all its members and to lower costs for the State of Colorado. The program is an innovative approach that neither returns to the fully capitated managed-care program of the 1990s, nor does it promulgate regular fee-for-service without counterbalancing adverse incentives.

The Department has outlined four goals to guide its efforts moving forward with the ACC Program. The program will:

- ensure access to a focal point of care or medical home;
- coordinate medical care and non-medical care;
- improve member and provider experiences; and
- provide the necessary data to support these goals.

The ACC Program is both a short-term solution to improving care and reducing costs, as well as a long-term investment in better health futures and savings for the Colorado population. The program design includes an immediate focus on reduction of specific key performance indicators that measure member utilization of services. In addition, better coordination of care will enhance client engagement, as well as prevention and wellness promotion. This increased focus on proactively managing care is expected to result in better health and reduced costs across the lifespan of current members. Reduced costs are achieved through the reduction of avoidable, duplicative, variable, and inappropriate use of health care resources.

The three core components of the ACC Program include the:

- Regional Care Collaborative Organizations (RCCOs), to ensure cost and quality outcomes for their Medicaid members;
- Primary Care Medical Providers (PCMPs), to serve as the focal point of care for each member; and
- Statewide Data and Analytics Contractor (SDAC), which provides actionable data at both the population and client level.

The State is geographically distributed into seven regions, each with a single RCCO. Each client is a member of the RCCO, based on residence in that region, and each client should have a designated PCMP. The SDAC provides an online dashboard of client data to each RCCO and all participating PCMPs to help manage their clients in the program.

The ACC Program currently has over 128,000 Medicaid clients enrolled, and approximately 135 Primary Care Medical Providers (PCMPs) are participating in the program, which includes 1,700 rendering providers. Program performance is currently being measured by tracking hospital readmissions, emergency room utilization, and high-cost imaging services. Additional measures are being developed to more broadly examine the program's impact.

The ACC Program is the platform through which the Department will implement future reform efforts, including:

- State Demonstration to Integrate Care for Dual Eligible Individuals (for individuals dually eligible for both Medicare and Medicaid);
- Comprehensive Primary Care Initiative (a federally funded initiative through the Center for Medicare & Medicaid Innovation to support enhanced primary care);
- ACC Payment Reform Initiative (H.B. 12-1281); and
- Behavioral health integration efforts.

The Department will submit a formal report to the legislature, to include initial program results on utilization and cost containment on November 1, 2012.

Long-Term Services and Supports Redesign

- **Colorado Choice Transitions**

Colorado Choice Transitions (CCT) is Colorado's Money Follows the Person (MFP) Rebalancing Demonstration program. The Department of Health Care Policy and Financing (the Department) was awarded \$22 million over five years from the Centers of Medicare and Medicaid Services (CMS). CCT has two primary goals for Coloradans: 1) transition Medicaid clients out of long-term care facilities into community living using traditional waiver services and enhanced home- and community-based services, or demonstration services, and 2) to support efforts to reform the long-term care delivery system for people of all ages with long-term care needs using rebalancing funds created through an enhanced federal match.

The Long-Term Services and Supports Division oversees Medicaid-funded community-based services and nursing facilities. The division has a particular focus on affordably maximizing the health, functioning, and self-sufficiency of clients in long-term care, institutional, and/or community settings. The clients utilizing these services have complex health care needs, requiring coordinated and high-quality services. Community-based services are those services provided in clients' homes as an alternative to placement in a nursing facility or other institutional setting. These community-based services provide support for clients to remain at home and in the community, allowing for individual choice. This division oversees all Medicaid Home- and Community-Based Services waiver programs (HCBS). The division is also responsible for managing consumer-directed attendant support services which allow qualifying individual clients to direct their own in-home care.

Colorado has 12 waiver programs serving a variety of populations. In 2008, Colorado ranked fifth among states in the proportion of Medicaid Community Based Long-Term Care (CBLTC) spending for persons with developmental disabilities and tenth among states in the proportion of Medicaid CBLTC spending for aged or disabled.

Colorado Choice Transitions (CCT) is a federal grant opportunity to build and improve the infrastructure supporting Home- and Community-Based Services (HCBS) for people of all ages with LTC needs. The program is designed to provide enhanced transition services to clients currently living in nursing and other long-term care facilities in order to transition and sustain them in the community for up to 365 days. Medicaid-eligible clients residing in long-term care facilities for 90 days or more and are willing to move to CCT qualified housing are eligible for the program and can receive CCT services. The Department anticipates 100 clients per year will transition and receive services in a community setting.

With the ability to provide additional services through the grant program, the Department intends to improve clients' quality of life and realize savings as clients move from long-term care facilities. Colorado's LTC system will become more person-centered, navigable, and integrated, making it easier to coordinate between agencies, providers, consumers and families, so that the elderly and adults with disabilities have greater access to home and community services and can continue to successfully transition into the community.

- **Long-term Care Advisory Committee**

In September 2011 the Long-term Care Advisory Committee (LTCAC) was reconstituted by Sue Birch, Executive Director of the Department of Health Care Policy and Financing (the Department), to be the primary planning and implementation channel for long-term services and supports (LTSS) redesign. The LTCAC was reconstituted to include members from all segments of the LTSS system to begin crafting a roadmap for the redesign of the LTSS system. Beginning in November 2011 and continuing through April 2012, both Sue Birch and Reggie Bicha, Executive Director of the Department of Human Services (DHS), led a series of community forums and meetings to gather stakeholder input on streamlining the administration of the two departments to reduce duplicate efforts with regard to rules, planning, and other administrative functions.

By April 2012, the LTCAC had conducted a strategic planning session, which included review and consideration of the recommendations found in Senate Bill 05-173 (2005), House Bill 07-1374 (2007), and the Olmstead Report (2010). The strategic planning session resulted in the identification of four strategic priorities and the development of four subcommittees of stakeholders and staff to work on those priorities. These four strategic priorities are Medicaid Entry and Eligibility, Waiver Modernization, Care Coordination, and Consumer Direction. Each of these subcommittees is discussed below.

- Medicaid Entry and Eligibility: The Centers for Medicare and Medicaid Services (CMS) through the Affordable Care Act has incentivized states to create more efficient, person-centered single entry point systems. While Colorado is not eligible for these incentives, it can use the manual created by CMS that outlines best practices for assessment and service planning processes, expectations for conflict-free case management and a suggested framework for entry point design. The entry point design work is based on the Aging and Disability Resource Center (ADRC) initiative that CMS and the Administration on Community Living have been promoting nationally over the last decade. The intent of this initiative is to streamline access to long-term services and supports regardless of payer. The ADRC initiative has generated multiple documents on best practices by state, and defines the functions of an entry point system.

- Waiver Modernization: To improve how Colorado serves clients and reduces the overall administrative burden and inefficiencies by having 12 Home- and Community-Based Services waivers, the Department is examining how HCBS waivers can be modernized by consolidating the number of waivers at the same time that the choice of services is expanded. As part of this process, the Department will be examining how it can create efficiencies in assessment and service planning processes and improve the allocation of services so that clients only receive the services they need when they need them. This specific work will be informed by the CMS manual mentioned earlier, which discusses best practices in assessment and service planning processes. It also lists all of the tools currently in use to assess the functional capacity of clients. The Department is in the process of securing a contractor who will research other states to examine lessons learned and the success of the consolidation efforts. In addition, the Department is in close contact with CMS to discuss the tools, timing and any technical assistance resources they may be able to provide as new waivers are submitted for federal approval.
- Care Coordination: Wisconsin and Massachusetts have generally been considered leaders in care coordination/case management for HCBS clients and particularly for individuals who are dual eligible for Medicare and Medicaid (i.e. ‘the Duals’). The AARP Policy Institute has published several reports on best practices in case management, which can be used as reference material as the case management infrastructure is redesigned. The Department has convened a workgroup examining care coordination to map the various entities doing case management/care coordination in the state for the Medicaid population. Based on this analysis, the Department will be working to identify areas where certain functions can be consolidated and areas to create more efficient hand-offs. The LTCAC will use this information to develop recommendations for a standard set of activities for care coordination.
- Consumer Direction: Both departments are committed to improving the client’s experience when contact is necessary with government systems. This means that services are developed to provide the right services at the right time in the right amount. One strategy for getting the right services at the right time is to maximize consumer choice and direction in the provision of services. The Department is currently engaged in a number of projects related to consumer direction, such as the development of the Community First Choice Council, the Participant Director Policy and Procedures Committee and now the Consumer Direction subcommittee of the LTCAC. These groups will be working closely together to expand consumer directed options in all aspects of the LTSS system.

- **Community-First Choice**

As part of the Affordable Care Act (ACA), the Community-First Choice (CFC) option allows states the option to provide person-centered home- and community-based attendant services and supports under the Medicaid State Plan, which is an agreement between the State and federal government that defines each state’s Medicaid program. CFC is intended to

provide home- and community-based attendant services and supports for elderly individuals and people living with disabilities.

Currently, the Department is creating a Community-First Choice Council (CFC Council) to explore possible implementation of a CFC program in Colorado. The CFC Council will have 20 members, consisting of ten people either with disabilities or elderly and their representatives, six state staff with expertise on Medicaid infrastructure, and four at-large members.

The Department has grant funding designated to help the CFC Council conduct a thorough analysis of the cost and programmatic structure of CFC in order to develop potentially viable options for the State.

Office of Community Living

The Office of Community Living was created in July 2012 pursuant to an Executive Order by the Governor to meet the growing need for long-term services and supports by aging adults and people with disabilities. By 2021, the number of Colorado adults 65 and older is expected to increase by 54 percent. The Office of Community Living will align services and supports so individuals and their families will not have to navigate a complicated or fragmented system.

The goal of the Office of Community Living is to provide strategic direction on the redesign of all aspects of the long-term services and supports delivery system, including service models, payment structures, and data systems to create efficient and person-centered community-based care. Through the Office of Community Living, the Department aims to:

- provide services in a timely manner with respect and dignity;
- strengthen consumer choice in service provision;
- incorporate best practices in service delivery;
- encourage integrated home- and community-based service delivery;
- involve stakeholders in planning and processes; and
- incorporate supportive housing.

State agencies and divisions will work collaboratively with the Office of Community Living. Such agencies and divisions include but are not limited to:

- Department of Local Affairs;
- Division of Housing;
- Department of Transportation;

- Department of Public Health and Environment; and
- Department of Human Services.

As part of the redesign process, an advisory group will consider and recommend changes to the long-term services and supports delivery system. The advisory group will meet regularly through September 2014. The advisory group will work closely with the Long-Term Care Advisory Committee, the Colorado Commission on Aging, and other planning groups to carry out this work and build on previous discussions and recommendations.

Integration of Behavioral Health

Colorado is divided into five mental health service areas. In each area, a Behavioral Health Organization (BHO) arranges for or provides medically necessary mental health services for Medicaid clients. The Department is beginning its process to rebid behavioral health services for 2014, which provides an opportunity to continue greater integration of care and to align systems of care.

Some Regional Care Collaborative Organizations (RCCOs) in the Accountable Care Collaborative (ACC) are already partnering with BHOs to better serve clients with behavioral health needs. Activities such as co-location between providers, limited data sharing, and client-focused collaboration are some of the innovative ways employed to address the needs of Medicaid clients. Colorado's State Health Care Innovation Plan will further advance the department's efforts to integrate physical and behavioral health services..

Planning for behavioral health integration efforts is already underway for individuals eligible for both Medicare and Medicaid and long-term care populations in Colorado. A newly-created Office of Community Living, the Dual Eligible Demonstration Project, and the Colorado provider group participating in the Centers for Medicare and Medicaid Services' Pioneer Accountable Care Organization all have processes to support integration of behavioral and physical health for Coloradans.

Health, Wellness, and Prevention

The Department's commitment to improving the health and wellness of Colorado Medicaid clients and communities extends from infant development to adult aging. Two years ago, the Department of began working on the Healthy Living Initiatives, addressing issues of health promotion and disease prevention for the Medicaid and Children's Basic Health Plan (CHP+) populations. In this, the Department identified four priority areas for health promotion: oral health, behavioral health (with a

focus on depression), nutrition and fitness (with a focus on obesity), and tobacco cessation. The top ten innovations are as follows:

- Medicaid has improved and expanded the tobacco cessation benefit for adults who want to quit.
- Federal matching funds now provide support to the Colorado QuitLine for Medicaid clients.
- Medicaid now offers annual depression screening for youth ages 11 to 20 years.
- The Oral Health Tool Kit outlines preventive oral health services available to children in the primary care setting.
- The Obesity Tool Kit outlines guidance for billing and reimbursement on addressing obesity in primary care through an extended visit with Body Mass Index (BMI) screening.
- The Healthy Living leadership team collaborates extensively with prevention partners statewide.
- The Healthy Living website provides information on trends in population health and outlines performance indicators for tracking changes in the health of individuals served by the Medicaid program.
- The Demographic Profile of Medicaid Clients provides information on Medicaid participants in Colorado in terms of income level, geographic distribution, age, gender, and ethnicity, which informs population health planning.
- An emphasis has been placed on evidence-based prevention programming for Medicaid clients, including chronic disease self-management classes and early-childhood nurse home-visitation through the Nurse Family Partnership program.
- An improved and expanded client engagement process has begun at the Department in order to more effectively involve clients and families in their own health, as well as engage clients as advisors to the Department.

Payment Reform

The Department is developing a broader vision for payment reform within the ACC Program and integration across the various delivery systems and will have a robust stakeholder process as this larger vision is developed. In this, the Department will support the design and testing of innovative, transformational health programs that generate savings and improve care, with an emphasis on multi-payer payment and service delivery models as well as build upon the ACC framework to integrate behavioral health and substance abuse into the ACC model.

- **Gainsharing**

The Department's FY 2012-13 approved "Medicaid Fee-for-Service Reform" budget request (R-5) included three separate gainsharing initiatives: Behavioral Health Organization (BHO) gainsharing, Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) gainsharing, and Accountable Care Collaborative (ACC) gainsharing. In this

request, BHO gainsharing was designed to measure and share savings with BHOs associated with reducing psychotropic drug utilization. FQHC and RHC gainsharing proposed sharing savings associated with reducing costs for specific hospital and pharmaceutical metrics. ACC gainsharing was less defined and only specified that savings above and beyond the administrative costs of the ACC program would be shared between the Department, the Regional Care Collaborative Organizations (RCCOs), and the Care Medical Providers (PCMPs).

Through a collaborative stakeholder process following the approval of this budget request, the Department is working with stakeholders to evaluate the feasibility of combining BHO and FQHC/RHC gainsharing into the ACC program. That is, only costs associated with clients enrolled in the ACC would be measured for the purposes of sharing savings. Furthermore, instead of specific metrics, savings would be measured on a total cost of care basis, along with quality metrics to ensure that care is not compromised. Aligning all three gainsharing initiatives has several benefits to the Department and to stakeholders. This would support the Department's ACC program and its future, leverage existing infrastructure and resources of the ACC program and the Statewide Data and Analytics Contractor (SDAC) vendor, encourage the integration of physical and behavioral health care, combine delivery system reform with payment reform, and simplify and streamline the Department's several payment reform initiatives.

Discussions with stakeholders to determine an equitable distribution of savings between the RCCOs and the providers, including FQHCs, RHCs, PCMPs, and the BHOs are ongoing, and will result in a draft methodology during the month of November.

- **ACC Pay-For-Performance Incentives**

Beginning in July 2012, the Department is withholding one dollar of the per-member per-month (PMPM) capitation being paid to the Accountable Care Collaborative (ACC) Regional Care Collaborative Organizations (RCCOs) and Primary Care Medical Providers (PCMPs) for a pay-for-performance incentive plan. This pay-for-performance incentive plan was in the Request for Proposals for the RCCOs, which went through a lengthy stakeholder process. The RCCOs and PCMPs may recover this dollar if certain thresholds are achieved as measured by the three Key Performance Indicators (KPIs):

1. Hospital All-Cause Thirty (30) Day Readmissions;
2. Emergency Room (ER) Visits; and
3. High Cost Imaging Services.

Each KPI calculation is based on service utilization by the population enrolled in the ACC. Performance will be measured as a percentage point improvement from the base period. To account for regional variation, each RCCO will be compared to the performance of its region during the base year. Improvement is measured by subtracting the program year-to-date performance from the regionally adjusted base year performance. There are two levels of performance achievement:

1. Level 1 savings indicate a 1-5% reduction in a particular KPI from the base period; and
2. Level 2 savings indicate a greater than 5% reduction in a particular KPI relative to the base period.

A reduction greater than 5% for each KPI results in a PMPM incentive payment of \$0.33, for a total incentive payment of one dollar if all three KPIs meet the Level 1 savings. Similarly, a reduction between 1-5% for each KPI results in a PMPM incentive payment equal to 66% of \$0.33, or \$0.22. Incentive payments for each member are calculated based on performance of the region in which the member lives. PCMPs that have enrolled members from multiple regions could receive varying incentive payments based on the regional performance of their members' regions.

- **HB 12-1281 Payment Reform Pilots**

The Department is preparing to begin implementing a payment reform pilot authorized by HB 12-1281, which permits the Department to accept proposals for innovative payment reforms that will demonstrate new ways of paying for improved client outcomes while reducing costs. The first step in this process was to publish an invitation for pilot project abstracts. Interested parties were required to work directly with the Accountable Care Collaborative's (ACC) Regional Care Collaborative Organizations (RCCOs) on the abstract and subsequent payment reform proposals. Abstracts were received and reviewed by Department staff in September 2012.

The Department is currently developing a formal process for requesting, receiving, evaluating, and selecting proposals. Evaluation criteria will be based partly on the ideas submitted in the abstracts as well as on alignment with Department goals and technical feasibility. Opportunities for stakeholder input are being offered through the Department's ACC Payment Reform Subcommittee, and public comment on the proposal criteria will be solicited before the criteria are finalized.

Proposals selection(s) will be made by June 2013.

Hospital Provider Fee

On April 21, 2009, Governor Ritter signed Colorado House Bill 09-1293 “Health Care Affordability Act” into law. The Colorado Hospital Association, the Department of Health Care Policy and Financing (“the Department”), and the Governor's Office worked together for nearly one year to develop House Bill 09-1293, which passed both the House and the Senate with more than 40 co-sponsors and bipartisan support. Once fully implemented, the legislation will provide health care coverage for uninsured Coloradans, reduce uncompensated care costs, and benefit the state as a whole.

The bill requires the Department to assess and collect a provider fee from all licensed or certified hospital providers, including providers that do not serve Medicaid clients. By partnering with hospitals, the Colorado Health Care Affordability Act (CHCAA) will allow Colorado to generate additional funding through a hospital provider fee and draw down federal Medicaid matching funds for the purposes of increasing reimbursement to hospitals for providing medical care, increasing the number of persons covered by public medical assistance, and paying the administrative costs of the Department in administering the hospital provider fee. Providing a payer source for more low-income and uninsured populations, who may otherwise be cared for in emergency departments, and increasing reimbursement to Colorado hospitals participating in publicly funded health insurance programs will reduce the cost shift of uncompensated care to other payers.

The Department successfully launched three Medicaid expansion populations within the last year: the Buy-In Program for Working Adults with Disabilities in March 2012, the Adults without Dependent Children program in May 2012, and the Buy-In Program for Disabled Children in July 2012. While the Adults without Dependent Children (AwDC) program currently covers only individuals with income up to 10% of the federal poverty level with an enrollment cap of 10,000 clients, the Department will continually monitor and analyze the costs of the existing clients around December 2012 to recommend whether more individuals can be covered under the Section 1115 Medicaid Demonstration Waiver. This is contingent upon the costs of the current caseload as well as the ability to generate additional provider fee revenue under the FFY 2012-13 hospital provider fee model, if necessary.

As of September 30, 2012, the approximate caseloads for the expansion populations funded under the hospital provider fee are:

- 39,700 Medicaid Parents, of which 17,900 were newly eligible for Medicaid;
- 15,300 CHP+ children, of which 9,100 were newly eligible for CHP+;
- 490 CHP+ pregnant women, of which 450 were newly eligible for CHP+;
- 10,000 Adults without Dependent Children, of which 8,000 were newly eligible for public assistance; and

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- 540 Disabled Individuals in the Working Adults and Children’s Buy-in. Of the 440 Working Adults, 190 were previously enrolled in regular Medicaid and now have gainful employment⁴.

In FY 2011-12, the Department collected approximately \$584 million in fees from hospitals which, with federal matching funds, funded health coverage expansions, supplemental payments to hospitals, the Department’s administrative expenses, and General Fund relief per SB 10-169. The following table outlines the Hospital Provider Fee expenditures beginning in FY 2009-10:

Payment Type	FY 2009-10	FY 2010-11	FY 2011-12
Supplemental Hospital Payments	\$590,238,707	\$745,237,426	\$896,654,478
Department Administration	\$2,938,743	\$5,743,900	\$15,824,778
Expansion Populations	\$3,241,896	\$90,099,056	\$134,338,939
General Fund Offset	\$46,329,410	\$61,343,993	\$65,700,000
Total Expenditures	\$642,748,756	\$902,424,375	\$1,112,518,195

Through this financing mechanism, Colorado was able to draw down and distribute \$528 million in additional federal dollars in FY 2011-12. The net gain to hospitals in federal fiscal year 2011-12 from supplemental payments was an estimated \$122.5 million. These net gains represent the reduction in uncompensated costs incurred by hospitals.

CHCAA reduces the need for hospital providers to shift uncompensated care costs to private payers by providing higher reimbursement for patients covered by public health care programs and reducing the number of uninsured Coloradans. By raising the rates paid to hospital providers, the need to shift costs is reduced. CHCAA increases reimbursement paid for inpatient and outpatient care for Medicaid clients as well as rates paid for the Colorado Indigent Care Program (CICP). Fewer uninsured Coloradans leads to lower uncompensated costs by creating a funding source for these clients. In the first year, the hospital provider fee increased eligibility for parents of Medicaid covered children and children and pregnant women covered by CHP+.

CHCAA was implemented following federal approval in April 2010; therefore, changes to cost to payment ratios due to CHCAA are captured with the CY 2010 data. The following table and graph display the difference between total payments and total costs on a per patient basis for Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other payer groups.

⁴ For the purposes of this analysis, “newly eligible for public assistance” and “previously enrolled in Medicaid” are measured relative to enrollment in October 2007.

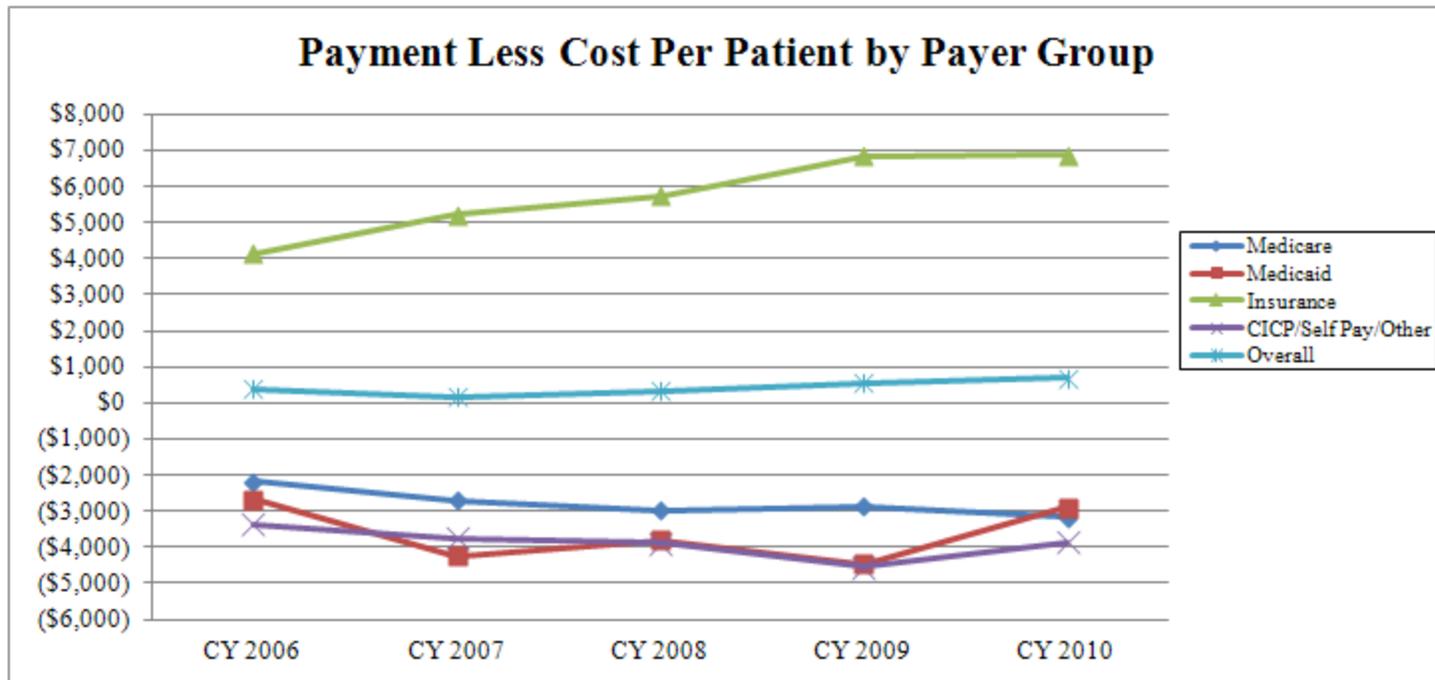
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Negative values indicate that costs exceed payments. This is the case for Medicare, Medicaid, and the CICP/Self Pay/Other payer groups and indicates hospitals are undercompensated for care provided to these clients.

Positive values indicate that payments exceed costs. This is the case for the private sector insurance group, where there is overcompensation relative to costs. This is the essence of cost shift as publicly insured and uninsured care is paid under cost and private payers pay more to cover those costs.

The data show that following the implementation of the CHCAA in July 2009, overcompensation by the private sector insurance was flat in CY 2010 – increasing less than 1% over CY 2009. The average rate of growth of private sector overcompensation was more than 18% per year for the previous three years. At the same time, the undercompensation for the Medicaid and CICP/Self Pay/Other payer groups sharply decreased in CY 2010.

Payment Less Cost Per Patient by Payer Group					
	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010
Medicare	(\$2,172)	(\$2,691)	(\$2,969)	(\$2,872)	(\$3,166)
Medicaid	(\$2,682)	(\$4,239)	(\$3,807)	(\$4,468)	(\$2,906)
Private Sector Insurance	\$4,148	\$5,221	\$5,749	\$6,838	\$6,881
CICP/Self Pay/Other	(\$3,370)	(\$3,754)	(\$3,874)	(\$4,561)	(\$3,848)
Overall	\$377	\$182	\$328	\$551	\$690



The Taxpayer’s Bill of Rights (TABOR) – Article X, Section 20 of the Colorado Constitution – limits the State’s revenue growth to the sum of inflation plus population growth in the previous calendar year. Under the provisions of TABOR, revenue collected above the TABOR limit must be returned to taxpayers, unless voters decide the State can retain the revenue. In November 2005, voters approved Referendum C, which set a new cap on revenue starting in FY 2010-11. According to the Office of State Planning and Budgeting September 2012 economic forecast, TABOR revenue is projected to be about \$1 billion below the Referendum C cap through FY 2014-15. Because the Hospital Provider Fee is cash fund revenue subject to TABOR, the Department monitors the increase in the forecasted fee collection in this light and provides updated projections of fee revenue to the Office of State Planning and Budgeting and Legislative Council for inclusion in economic forecasts that are updated quarterly. While the amount of provider fee needed to fund expansion populations will decrease if the State receives the ACA enhanced federal financial participation for a partial expansion, which thus reduces the amount of TABOR revenue collected, the State is still awaiting federal guidance on this issue.

As the expansion populations are implemented and continue to grow, the Department will have to closely monitor the costs of these newly eligible populations to ensure that adequate fee revenue can be collected within federal limitations. The provisions of CHCAA leave Colorado well-positioned to implement the Affordable Care Act of 2010 (ACA). With the expansion of Medicaid parents to 100% FPL and the phased-in implementation of the AwDC program, Colorado will be better prepared if the State opts to expand eligibility to 133% FPL for all individuals. In addition, ACA has numerous provisions that are anticipated to reduce the level of uncompensated care, decrease the rate of growth in health care costs, and improve health outcomes of individuals, all of which are goals of the Department in implementing CHCAA. If the State receives the enhanced federal financial participation available through ACA for a partial expansion beginning in January 2014 for expansion populations included in CHCAA (see Hot Issue below), the additional federal funds will help ensure the viability of the Hospital Provider Fee.

Under the original fiscal note for HB 09-1293, the Department expected to implement Continuous Eligibility for Medicaid children in the spring of 2012. The Department is delaying the implementation of Continuous Eligibility to allow the Department to further analyze the fiscal impact and the effect of federal health reform on this population.

Affordable Care Act

The passage of the Affordable Care Act (ACA) provides unprecedented opportunities to increase the value spent on health care, create a culture supporting healthy living and wellness, and expand access to affordable care. Signed into law on March 23, 2010, the ACA seeks to improve the quality of health of all Americans by providing increased options, more ownership over health decisions, and lowering costs, while ensuring more accountability and transparency from insurance companies. Beginning immediately and continuing through 2014, a myriad of changes to existing policies and implementation of new ones will result in the most comprehensive health reform effort in history. The ACA is wide-ranging in its attempt to achieve greater health outcomes and complex in its approach. Among the provisions of the ACA are:

- Coverage requirements: Require most U.S. citizens and legal residents to have health insurance, and require employers with more than 50 employees to offer health coverage by 2014 to avoid penalties.
- Expansion and reform of public programs:
 - Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% of the federal poverty level (FPL) based on modified adjusted gross income (as, under current law, undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges. To finance coverage for the newly eligible (those who were not previously eligible for at least benchmark equivalent coverage, those who were eligible for a capped program but were not enrolled, or those

- who were enrolled in state-funded programs), states will receive 100% federal medical assistance percentage (FMAP) for 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% for 2020 and subsequent years.
- Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019, and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Provide states with the option to provide CHIP coverage to children of State employees who are eligible for health benefits if certain conditions are met. Beginning in FFY 2015, states will receive a 23 percentage-point increase in the CHIP FMAP.
 - Increase Medicaid payments in fee-for-service and managed care for primary-care services provided by primary care doctors (family medicine, general internal medicine, or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014; States will receive 100% FMAP for the increased payment rates.
 - Creation of new State Plan options to permit Medicaid enrollees with chronic conditions to designate a provider as a health home, with 90% FMAP for two years for home health-related services, including care management, care coordination, and health promotion; and provide states that offer Medicaid coverage of and remove cost-sharing for recommended preventive services and immunizations with a one percentage-point increase in the FMAP for these services.
 - Creation of new demonstration projects, including those to pay bundled payments for episodes of care that include hospitalizations; to make global capitated payments to safety net hospital systems; to allow pediatric medical providers organized as accountable care organizations to share in cost-savings; and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition.
 - Long-term care improvements, including extending the Medicaid Money Follows the Person Rebalancing Demonstration program; providing states with new options for offering home- and community-based services (HCBS) through a Medicaid State Plan rather than through a waiver, including a provision to all full Medicaid benefits to individuals receiving HCBS; establishing the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care with a six percentage-point increase in the FMAP for reimbursable expenses in the program.
 - Reduce Medicaid disproportionate share hospital (DSH) allotments in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for 1115 waivers.
 - Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
 - Health insurance exchanges: Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133-400% FPL and create separate Exchanges through which small businesses can purchase coverage. All plans sold in the health insurance exchange must include the state-selected essential health benefits.

- Insurance market reform: Provide dependent coverage for children up to age 26 for all individual and group policies; prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage, and prohibit insurers from rescinding coverage except in cases of fraud; prohibit pre-existing condition exclusions for children; beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage; and require guarantee issue and renewability and allow rating variation based only on age, premium rating area, family composition, and tobacco use in the individual and the small group market and the Exchange.
- Other provisions: Promote health and wellness programs through grants to small employers; permit employers to offer employees rewards for participating in a wellness program and meeting certain health-related standards; establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program); and promoting the health workforce supply through increased Graduate Medical Education (GME) training positions, State grants to providers in medically underserved areas, and scholarships, loan-repayment programs and retention grants.

On the last day of the 2011-2012 Term, the United States Supreme Court issued its long-anticipated opinion about the ACA. In a case known as *National Federation of Independent Business v. Sebelius*, the Court agreed to consider the constitutionality of two major provisions of the ACA: the individual mandate and the Medicaid expansion. A majority of the Court upheld the individual mandate, and, while the Court found the Medicaid expansion unconstitutionally coercive of states because states did not have adequate notice to voluntarily consent and the Secretary could potentially withhold all of a state's existing federal Medicaid funds for non-compliance, a majority of the Court found that this issue was appropriately remedied by circumscribing the Secretary's enforcement authority, thus leaving the Medicaid expansion intact in the ACA but in effect making the expansion to 133% FPL optional.

The Department is in the process of developing a fiscal analysis of the impact of increasing Medicaid eligibility to 133% FPL. This analysis is extremely complex due to the interaction of many provisions of the ACA, including the individual mandate, the transition to the use of modified adjusted gross income (MAGI) to determine eligibility for public programs and the Exchange, the optional enrollment of newly eligible Medicaid enrollees in a benchmark benefit offering the State's essential health benefits, and the interplay between the provisions of the Colorado Health Care Affordability Act (CHCAA, see above) and the ACA. In the development of this analysis, the Department is collaborating with many entities – including the Governor's Office, the Colorado Health Institute, and the Colorado Center on Law and Policy – to ensure all assumptions included in the analysis are thoroughly vetted and reasonable. In addition, the Department is awaiting federal guidance, particularly related to the applicability of the enhanced FMAP for partial Medicaid expansions (e.g., to 100% FPL). Under the ACA, Colorado was slated to receive the enhanced FMAP for the Medicaid Parents from 61-100% FPL and the Adults without

Dependent Children to 100% FPL populations beginning in 2014, as these expansions were implemented after the passage of the ACA.

On September 28, 2012, Colorado submitted its recommendation for an Essential Health Benefits (EHB) Benchmark plan. The selection process was facilitated jointly by the Governor's Office, the Division of Insurance, and the Colorado Health Benefit Exchange, and the benefits in the benchmark plan will be used as a template for Colorado insurance carriers to use when designing EHB-compliant benefit plans in 2014 and 2015. Colorado selected its largest small group plan, which is offered by Kaiser Permanente. The Department is currently working with the Governor's Office and Kaiser Permanente to complete a comparison of the benchmark plan to the existing Medicaid benefit package and to estimate the cost of applying the benchmark plan to newly eligible Medicaid enrollees. In addition, the Department will evaluate the cost-effectiveness of purchasing health insurance through the Exchange for optional Medicaid populations, specifically enrollees in the Breast and Cervical Cancer Treatment program and pregnant women with income above 133% FPL, rather than offering Medicaid coverage. This requires a comparison of health benefits offered to ensure enrollees receive necessary services, an analysis of the cost of such enrollees under the EHB, and a comparison of the federal fund under Medicaid to the premium and cost-sharing credits available under the Exchange.

Information Technology

Medicaid Eligibility and Enrollment Modernization Project

On December 30, 2011 the Department received approval of a Planning Advanced Planning Document from the Centers for Medicare and Medicaid Services (CMS) to secure staff and consulting resources to research, analyze, and plan the Department's implementation of the Affordable Care Act (ACA) and collaboration with Colorado's Health Benefit Exchange (COHBE). In addition, the Department used the funding to examine options to modify and utilize as necessary the Colorado Benefits Management System (CBMS) to meet the CMS Seven Standards and Conditions and to comport with the ACA.

In June 2012, the Department submitted an Implementation Advanced Planning Document (IAPD) to CMS to obtain enhanced federal funding to modernize the Department's eligibility system and processes to facilitate efficient, effective, and elegant enrollment into medical assistance programs through an integrated system and to ensure seamless and minimal interoperability with COHBE. This funding will be used to implement necessary changes to CBMS to comport with the ACA and to ensure that the system meets the CMS Seven Standards and Conditions, which exist to "foster better collaboration with states, reduce unnecessary paperwork, and focus attention on the key elements of success for modern and flexible systems development and employment."

The Department is collaborating closely and partnering with the Governor's Office, Office of Information Technology (OIT), Department of Human Services (DHS), Colorado Counties, COHBE, Department of Education (CDE), and Department of Public Health and Environment (CDPHE) to provide an eligibility and enrollment process which works for Coloradans. In developing this Implementation Advanced Planning Document (IAPD), the Department worked in collaboration with its partners and stakeholders.

The Department adopts the national vision for health care reform to provide consumers and users with a World Class Experience of real-time online eligibility determination and has developed a comprehensive vision and coherent phased strategy to leverage federal, state and other funding, as it becomes available, to improve systems and business processes across multiple programs and agencies. Implementation of this strategy will streamline assistance processes, decrease ongoing administrative costs, and greatly enhance client service and satisfaction.

The Department received conditional approval of this IAPD in August 2012, along with written instruction from CMS to proceed with the initiation of the project.

MMIS Reprourement

The Medicaid Management Information System (MMIS) is the hardware, software, and business process workflows designed to meet the criteria for a "mechanized claim processing and information retrieval system" required by federal law to participate in the Medicaid program. The MMIS's core function is to adjudicate and process the Department's medical claims and capitations for payment; it also provides other important functions including provider enrollment and management, certain client management functions, and analytics and reporting. Since the MMIS electronically processes approximately 97% of the Department's claims, its capabilities and limitations play a pivotal role in how the Department administers the Medicaid program.

The current MMIS and Fiscal Agent services contract has been with Affiliated Computer Services, Inc. (ACS), now Xerox, since December 1998. During this period, the MMIS and Fiscal Agent services contract was competitively bid and reprocured once, in which the incumbent vendor won the bid. The current contract's operational phase began in July 2007, using the same MMIS software as the prior contract, and it expires June 30, 2015, at which time it will be an eight-year-old contract. After eight years, CMS has historically required the MMIS and Fiscal Agent services contract to be competitively bid and reprocured; therefore, the Department must reprocure the MMIS and Fiscal Agent services by the end of the current contract to satisfy federal requirements and maintain enhanced federal matching rate for Design, Development, and Implementation (DDI)

and operational costs. Before the current vendor, Blue Cross Blue Shield was the MMIS and Fiscal Agent services vendor for 12 years, using the same MMIS currently utilized by the Department.

The current MMIS is highly outdated, as it is over 20 years old (with some components being over 30 years old) and is based on a 1970s general mainframe design. Several of these components were modern when first designed (e.g., the MMIS is accessible by Department users through a Windows interface), but most interactions with outside parties (including providers) are now performed through outdated and difficult-to-configure processes. While the current MMIS is sufficient to process a high volume of claims, it lacks the enhanced capabilities of modern solutions. For example, modern MMIS solutions allow for system changes through configurable technology rather than long and costly programming efforts, allow for more effective web-based interfaces rather than mainframe file exchanges, and allow for alternative health benefit packages and provider reimbursement methodologies. Since the MMIS is central to administering the Medicaid program, the manual processes and workarounds that the Department has developed around these limitations create significant operating inefficiencies and restrictions to policy changes.

To best meet the federal requirements to competitively bid and reprocur the MMIS and Fiscal Agent services contract and to address the substantial difficulties, inefficiencies, and risks posed by the current MMIS, the Department is requesting funding in this budget submission to acquire a new, modern replacement MMIS. This proposed solution consists of a competitive bid and procurement for the MMIS and Fiscal Agent services to meet federal reprocurement deadlines, and replacing the current MMIS software with a modern MMIS, transferred and modified for use in Colorado, to address the current and future needs of the Department.

Health Information Technology

The Department has led innovations and adoption of Health Information Technology (HIT) for many years and has invested significantly in strategies to maintain its place in the forefront, putting technology and information systems to work to support a transformed health care system that provides better value and higher quality care.

Without comprehensive payment reform and financial incentives to provider better quality, more efficient care, health care providers have been slow to make significant investments in HIT. Although national standards are in place for electronic health records (EHRs), including vocabulary, content, and transport standards, many EHRs may not fully meet Meaningful Use standards. Additionally, every version of a particular EHR can be developed, implemented, and utilized by providers differently, causing difficulty and expense in custom interfaces and development where standards should provide for

scalability. This custom work requires intensive work with EHR vendor staff as well as additional costs to health care providers.

To incentivize health care providers and organizations to adopt and utilize HIT, the Department will continue to develop reformed payment strategies and structures that reward investment in providing better value and higher quality care. The Department will also pursue direct health plan support of HIT efforts; particularly HIE, in keeping with the understanding that savings achieved through better value care often accrue to the payer instead of the provider or consumer.

Enhanced Department Operations: People and Processes

The Department is currently implementing initiatives and processes to enhance operations and maximize Department resources, both human and capital. As part of this, the Department is undergoing an iterative revitalization process allowing the Department to make changes to enable the improvement of processes and functions. The Department is now in Phase III of its Revitalization Process. Based on feedback from a staff survey, input from the Department’s Executive Committee, and observations made by the Executive Director, the Department added the following offices: Clinical Services; Administration and Innovation; Policy and Communications; and Community Partnerships.

LEAN

In June and August 2012, the Department began two LEAN process improvement plans using LEAN coaching and training resources available from the Governor’s Office of State Planning and Budgeting. The June project focused on reducing the time to hire new employees and the August project focused on streamlining the service plan development process for Long Term Care waivers. These projects are described as follows:

Reduce Time to Hire

Key objectives of the “Reduce Time to Hire” project are to:

1. Streamline the hiring process to reduce the number of internal approvals, hand-offs; and days to hire
2. Improve the quality of hire (select ‘best-fit’ candidates), and collaboration between hiring managers and human resources
3. Fully utilize the capabilities of existing electronic systems (NEOGOV, SharePoint) to reduce the amount of paper and transactional processes

The result of the “Reduce Time to Hire” project was a process improvement plan to achieve an effective, fair, fast and user-friendly hiring process based on the following operational definitions: It will be effective by reducing the number of days to fill a vacancy and increasing the likelihood of hiring the top candidates; it will be fair by maintaining compliance with State rules; it will be *fast* by eliminating duplicative and non-value added steps; and it will be user-friendly by creating partnerships between human resource analysts and hiring managers.

The “Reduce Time to Hire” process improvement plan estimates implementation will achieve the following measurable improvements in FY 2012-13:

- A reduction in the number of hand-offs of hiring documents from 65 to 13.
- A reduction in the number of approvals to hire new staff from 36 to 7.
- A reduction in the average total time to hire from 142 business days to 65 business days.

LTC Waivers: Service Plan Development Process

An effort to LEAN the Department’s Long-Term Care (LTC) service plan development process was undertaken in August 2012. The purpose was to streamline the process and decrease variability between and across waivers and case management agencies with the goal of improving quality and consistency of services available to all Medicaid clients. Targeted outcomes of the “LTC Waivers” LEAN project are:

- Developing a uniform standardized case management review process that can be communicated to providers and improve initial case reviews
- Reducing the number of judgments against the Department
- Improving client and case manager experience with the Department

The result of the “LTC Waivers” project was a process improvement plan to provide clients a fair, transparent and uniform case management review process that accommodates client’s individual needs, and to take advantage of available technology to deliver an improved customer experience, move to electronic process and achieve a green “paperless” process. The Department will equip staff and case management agencies with the guidelines, training, tools and technology necessary to improve efficiency and the overall customer experience.

The “LTC Waivers” process improvement plan estimates its implementation will achieve the following measurable improvements in FY 2012-13:

- Reduce the number of faxes and paper used (by moving to an electronic process)
- Move home health case management reviews to a third-party vendor

- Move adult case management reviews greater than \$250/day to a third-party vendor

The Department's Strategy Section produces a monthly newsletter providing updates on all active and upcoming LEAN projects and soliciting suggestions for new projects.

Hiring and Retaining Staff

Like other employers, the Department has also had to adapt to a new, 21st century workforce. This workforce is mobile, and does not typically stay within State employment for more than a few years. This creates an acute problem for the Department, because the sheer complexity of the Medicaid program and its regulations mean that employees take a full year to train to be effective at an operational level, and several years to fully train to be effective at a policy or strategic level. The Department has experienced turnover rates higher than the state average, and the Department expects the turnover rate to increase with an improving economy.

Within the Administration and Innovation Office, the Department has created the Workforce Development Section. This Section will develop and implement a plan to integrate its talent-management processes to ensure that the Office is effectively developing, managing, and improving programs to improve quality of the Department's workforce. The section is responsible for strategic human resources planning including the acquisition of software to support on-going and future human resources programs. The Department believes that providing the opportunity for staff to develop their professional skills in their current positions not only benefits the Department through a stronger workforce, but also encourages internal promotional opportunities for staff that allow the Department to retain institutional knowledge and experience.

In addition to these changes currently being implemented, the Department is also requesting funding to hire additional employees to enable the Department to meet its objectives and restore core functionality as the administrator of the State's medical assistance programs and authority on health care. The Department's inadequate FTE level is impairing its ability to execute its mission to improve health care access and outcomes for the people it serves while demonstrating sound stewardship of financial resources. As discussed in FY 2013-14 R-6 "Additional FTE to Restore Functionality," the Department is committed to improving external relations, providing timelier responses, and presenting more information with better data. This agency wide request will support senior Department staff, enabling timely, better informed interactions with stakeholders, legislators, and other partners.

V. WORKLOAD REPORTS

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS[®])⁵ is a nationally recognized survey that measures client satisfaction within a given health plan and may be used to compare satisfaction across health plans. The goal of the CAHPS surveys is to effectively and efficiently obtain client information.

The Department requires Medicaid physical health plans to conduct client-satisfaction surveys to ascertain whether clients are satisfied with their care, as well as to ascertain differences among clients enrolled in Medicaid managed care, the Primary Care Physician Program, and Medicaid fee-for-service. As part of a comprehensive quality-improvement effort, the Department required physical health plans to conduct the CAHPS 4.0H Survey of Adults and 4.0H Survey of Children with Medicaid clients that had been continuously enrolled in a managed care plan for at least five of the last six months of calendar year 2010. The survey period for this questionnaire was July through December 2010, and the data was collected between February and May 2011. National averages for 2010 (the most recent comparative data available) are included.

A minimum of 100 responses to each measure are required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Health Services Advisory Group, the contracted External Quality Review Organization that calculates CAHPS, has advised that plan ratings should not be compared to national averages. Using a national average would not be practicable due to its statistical sensitivity in comparison to plan results. It is equally impractical to use a statewide average, which is calculated by the National Committee for Quality Assurance, because plan results have case-mix differences factored into the numbers, while the statewide average does not factor in case-mix differences.

⁵ CAHPS is a registered trademark of the Agency for Health Care Research and Quality.

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FY 2011-12 CAHPS Results				
	Fee-For-Service	Primary Care Physician Program	Denver Health Medical Plan	Rocky Mountain Health Plan
Adult Medicaid				
Global Ratings				
Rating of Health Plan	★	★★★	★★★	★★★★★
Rating of All Health Care	★★	★★★★★	★★	★★★
Rating of Personal Doctor	★★	★★★★★	★★★★★	★★★
Rating of Specialist Seen Most Often	★★★	★★★★★	★	★★★★★
Composite Measures				
Getting Needed Care	★★★	★★★★★	★	★★★★★
Getting Care Quickly	★★	★★★★★	★	★★★★★
How Well Doctors Communicate	★★★	★★★	★★★★★	★★★★★
Customer Service	NA	NA	NA	NA
Shared Decision Making	★★	★★★★★	★★	★★★★★
★★★★★90th Percentile or Above ★★★★★75th-89th Percentiles ★★★50th-74th Percentiles				
★★25th-49th Percentiles ★Below 25th Percentile NA Not Applicable				
	Fee-For-Service	Primary Care Physician Program	Denver Health MP	Rocky Mountain Health Plan
Child Medicaid				
Global Ratings				
Rating of Health Plan	★	★★★	★★★★★	★★★
Rating of All Health Care	★	★★★★★	★★★	★★
Rating of Personal Doctor	★★★★★	★★★★★	★★★★★	★★★
Rating of Specialist Seen Most Often	★★	NA	NA	NA
Composite Measures				
Getting Needed Care	★★★	★★★	★	★★★★★
Getting Care Quickly	★★	★★★★★	★	★★★★★
How Well Doctors Communicate	★★★	★★★★★	★★	★★★
Customer Service	NA	NA	★★	NA
Shared Decision Making	★★	★★★★★	★★★	★★★★★
★★★★★80th Percentile or Above ★★★★★60th-79th Percentiles ★★★40th-59th Percentiles				
★★20th-39th Percentiles ★Below 20th Percentile NA Not Applicable				

Health Effectiveness Data and Information Set (HEDIS)

The Health Effectiveness Data and Information Set (HEDIS®)⁶ is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans. The performance measures address many significant health care issues such as access to care, effectiveness of care, and use of services. Each year, different HEDIS measures are selected that relate to quality initiatives outlined in the State Quality Improvement Work Plan. Since different measures are selected annually, variations may occur in data presentation and reported level of detail.

The Department requires Medicaid health plans to report HEDIS measure rates each year. The Department uses this information to track the health plans' performance in providing care and services to Medicaid clients and to identify and prioritize improvement efforts. As part of a comprehensive quality initiative, the Department required health plans to report rates on HEDIS measures for adults and children. The data presented in the following tables shows performance rates on measures ranging from child immunization rates to antibiotic utilization. The 2012 rates reflect services provided January 1, 2011, through December 31, 2011.

HEDIS Measure	Rocky Mountain Health Plan	Denver Health	Primary Care Physician Program (PCPP)	Fee-for-Service (FFS)	HMO Weighted Average ¹	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average ²	2011 HEDIS National Medicaid Average
Childhood Immunization Status (H) (Percent of children with immunization)								
Combination 2	78.2%	84.2%	76.6%	70.6%	82.3%	70.7%	72.0%	74.1%
Combination 3	76.2%	83.7%	76.1%	66.7%	81.3%	66.9%	68.5%	69.9%
Combination 4	12.7%	51.6%	53.3%	27.5%	39.4%	28.1%	29.4%	31.6%
Combination 5	63.4%	70.3%	58.3%	49.1%	68.2%	49.4%	51.5%	47.2%
Combination 6	52.1%	73.2%	38.3%	42.1%	66.6%	42.0%	44.8%	36.4%
Combination 7	11.3%	45.3%	41.2%	20.7%	34.6%	21.2%	22.7%	23.8%
Combination 8	9.0%	47.0%	27.8%	17.8%	35.1%	18.0%	19.9%	19.0%
Combination 9	44.9%	62.0%	31.2%	33.1%	56.7%	33.0%	35.7%	27.8%
Combination 10	8.1%	41.1%	22.6%	13.4%	30.8%	13.6%	15.5%	15.2%
4 Diphtheria, Tetanus, Pertussis	85.4%	84.7%	79.5%	75.9%	84.9%	76.0%	77.0%	80.2%
3 Polio Virus immunizations	94.7%	93.4%	94.2%	88.8%	93.8%	88.9%	89.5%	90.8%
1 Measles, Mumps, and Rubella	92.4%	92.5%	93.2%	87.8%	92.4%	88.0%	88.5%	90.6%

⁶ HEDIS is a registered trademark of the National Committee for Quality Assurance.

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HEDIS Measure	Rocky Mountain Health Plan	Denver Health	Primary Care Physician Program (PCPP)	Fee-for-Service (FFS)	HMO Weighted Average ¹	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average ²	2011 HEDIS National Medicaid Average
3 Haemophilus Influenza Type b	95.8%	93.2%	94.2%	91.2%	94.0%	91.3%	91.6%	90.3%
3 Hepatitis B immunizations	91.4%	94.2%	93.7%	89.1%	93.3%	89.2%	89.6%	90.1%
1 VZV (Chicken Pox) vaccine	91.2%	92.2%	93.7%	86.6%	91.9%	86.8%	87.4%	90.0%
4 Pneumococcal Conjugate	86.3%	85.6%	88.7%	77.6%	85.9%	77.9%	78.8%	79.4%
2 Hepatitis A	13.2%	52.8%	55.6%	32.4%	40.4%	32.9%	33.7%	36.5%
Required Number of Rotavirus	73.4%	72.7%	64.6%	61.3%	72.9%	61.4%	62.7%	57.6%
2 Influenza	55.6%	79.1%	43.6%	49.9%	71.7%	49.7%	52.2%	43.6%
Immunizations for Adolescents (A)³ (Percent of children with immunization)								
Combination 1	47.9%	82.3%	64.2%	52.5%	71.6%	53.1%	55.2%	52.2%
1 Meningococcal	50.7%	83.1%	66.7%	54.1%	73.0%	54.7%	56.8%	56.3%
1 Tdap/Td	83.6%	84.2%	80.5%	73.9%	84.0%	74.3%	75.4%	67.8%
Percent of Children with Well-Child Visits in the First 15 Months of Life (H) (fewer visits indicates better performance)								
0 visits	0.2%	1.0%	1.1%	2.2%	0.7%	2.2%	2.1%	2.2%
6 or more	82.6%	51.3%	61.4%	62.5%	62.7%	62.5%	62.5%	60.2%
Percent of Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (A)³								
Percent of Adolescents Receiving a Well-Care Visit (H)	42.8%	51.1%	47.9%	38.9%	48.4%	39.3%	40.3%	48.1%
Percent of Children/Adolescents Receiving Weight Assessment and Counseling for Nutrition and Physical Activity (H)								
BMI Assessment - 3-11 Years	73.4%	84.6%	58.7%	44.6%	80.9%	45.0%	49.2%	37.5%
Nutrition Counseling - 3-11 Years	65.1%	80.3%	63.2%	52.7%	75.3%	53.1%	55.6%	47.4%
Physical Activity Counseling - 3-11 Yrs	55.6%	57.1%	55.8%	37.8%	56.6%	38.4%	40.5%	35.6%
BMI Assessment - 12-17 Years	65.6%	87.0%	49.3%	50.4%	79.5%	50.4%	53.6%	36.8%
Nutrition Counseling - 12-17 Years	57.8%	80.4%	40.1%	47.0%	72.6%	46.7%	49.5%	41.3%
Physical Activity Counseling - 12-17 Yr	59.4%	76.1%	42.3%	47.0%	70.3%	46.8%	49.4%	38.5%
BMI Assessment - Total	71.1%	85.2%	55.5%	46.2%	80.4%	46.6%	50.5%	37.3%
Nutrition Counseling - Total	63.0%	80.3%	55.2%	51.1%	74.5%	51.3%	53.9%	45.6%
Physical Activity Counseling - Total	56.7%	61.3%	51.1%	40.4%	59.8%	40.8%	43.0%	36.7%
Annual Dental Visit								
Total	NB	NB	70.7%	65.7%	NB	65.9%	65.9%	47.8%
Ages 2 to 3 Years	NB	NB	56.4%	55.9%	NB	55.9%	55.9%	30.8%
Ages 4 to 6 Years	NB	NB	72.5%	70.4%	NB	70.4%	70.4%	54.3%

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HEDIS Measure	Rocky Mountain Health Plan	Denver Health	Primary Care Physician Program (PCPP)	Fee-for-Service (FFS)	HMO Weighted Average ¹	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average ²	2011 HEDIS National Medicaid Average
Ages 7 to 10 Years	NB	NB	80.7%	73.5%	NB	73.8%	73.8%	58.5%
Ages 11 to 14 Years	NB	NB	73.5%	67.7%	NB	68.0%	68.0%	53.2%
Ages 15 to 18 Years	NB	NB	63.8%	59.0%	NB	59.3%	59.3%	44.9%
Ages 19 to 21 Years	NB	NB	39.9%	36.1%	NB	36.2%	36.2%	33.2%
Prenatal and Postpartum Care (H)								
Percent receiving timely prenatal care	97.0%	83.5%	80.3%	76.2%	90.1%	76.2%	77.5%	83.7%
Percent receiving timely postpartum care	77.4%	59.6%	69.6%	60.3%	68.4%	60.5%	61.3%	64.4%
Percent of Children and Adolescents' Accessing Primary Care Practitioner								
Ages 12 to 24 Months	98.5%	95.0%	97.0%	95.4%	96.1%	95.4%	95.5%	96.1%
Ages 25 Months to 6 Years	89.0%	81.2%	85.8%	84.4%	83.6%	84.5%	84.4%	88.3%
Ages 7 to 11 Years	92.1%	84.0%	90.2%	86.6%	86.2%	86.7%	86.6%	90.2%
Ages 12 to 19 Years	91.6%	85.2%	90.0%	86.3%	87.2%	86.5%	86.5%	88.1%
Percent of Adults Accessing Preventive Care								
Total	89.8%	73.5%	83.9%	78.1%	78.9%	78.4%	78.5%	83.0%
Ages 20 to 44 Years	86.9%	71.1%	81.7%	77.6%	76.9%	77.8%	77.7%	81.2%
Ages 45 to 64 Years	91.5%	78.0%	86.0%	81.3%	81.8%	81.6%	81.6%	86.0%
Ages 65 Years and Older	96.4%	72.6%	84.5%	75.8%	80.1%	76.5%	76.8%	83.7%
Use of Appropriate Medications for People With Asthma								
Total	86.6%	81.6%	90.6%	89.7%	83.3%	89.8%	89.2%	88.4% ⁴
Ages 5-11 Years	96.4%	96.3%	90.2%	92.1%	96.4%	92.0%	92.3%	91.8%
Ages 12-18 Years	84.4%	89.4%	91.5%	89.3%	87.5%	89.5%	89.3%	—
Ages 19-50 Years	82.5%	67.2%	88.1%	84.9%	72.6%	85.1%	84.0%	—
Ages 51 to 64 Years	NA	50.8%	93.2%	92.3%	54.8%	92.4%	89.1%	—
Comprehensive Diabetes Care (H)								
HbA1c Testing	92.2%	84.9%	65.7%	66.4%	87.2%	66.4%	68.8%	82.0%
HbA1c Poor Control (>9.0%)*	19.2%	37.7%	63.7%	65.0%	32.0%	64.9%	61.0%	44.0%
HbA1c Control (<8.0%)	72.2%	46.7%	32.6%	30.9%	54.7%	31.0%	33.8%	46.9%
Eye Exam	60.8%	56.2%	45.7%	40.6%	57.6%	41.0%	43.0%	53.1%
LDL-C Screening	74.6%	75.4%	56.4%	57.2%	75.2%	57.1%	59.3%	74.7%
LDL-C Level <100 mg/dL	47.7%	54.0%	25.3%	19.5%	52.1%	19.9%	23.7%	34.6%
Medical Attention for Nephropathy	75.9%	79.3%	68.1%	73.0%	78.2%	72.6%	73.3%	77.7%
Blood Pressure Cont. <140/80 mm Hg	61.5%	55.5%	27.7%	30.9%	57.4%	30.6%	33.8%	38.7%
Blood Pressure Cont. <140/90 mm Hg	79.9%	71.0%	40.9%	46.5%	73.8%	46.0%	49.3%	60.4%

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HEDIS Measure	Rocky Mountain Health Plan	Denver Health	Primary Care Physician Program (PCPP)	Fee-for-Service (FFS)	HMO Weighted Average ¹	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average ²	2011 HEDIS National Medicaid Average
Percent of Clients With Low Back Pain Who Did Not Have an Imaging Study within 28 Days of Diagnosis	74.0%	80.0%	74.7%	73.4%	77.6%	73.5%	73.8%	75.5%
Percent of Clients on Persistent Medications Receiving Annual Monitoring								
Total	85.0%	86.0%	71.9%	83.5%	85.8%	82.4%	83.1%	83.9%
ACE inhibitors or ARBs	86.1%	90.1%	76.0%	86.7%	89.3%	85.9%	86.6%	86.0%
Anticonvulsants	74.9%	61.0%	62.2%	67.3%	65.6%	66.5%	66.4%	67.7%
Digoxin	NA	NA	NA	91.5%	91.9%	89.2%	89.7%	89.7%
Diuretics	89.9%	88.8%	76.6%	86.8%	89.0%	85.9%	86.6%	85.5%
Percent of Clients with COPD Exacerbations Receiving Appropriate Pharmacotherapy Management								
Bronchodilator	43.4%	65.9%	72.2%	64.7%	55.1%	65.3%	62.7%	82.1%
Systemic Corticosteroid	28.9%	56.1%	61.1%	47.4%	43.0%	48.5%	47.1%	65.3%
Percent of Women Receiving Chlamydia Screening								
Total	45.4%	67.8%	26.1%	55.9%	58.5%	55.1%	55.4%	57.5%
Ages 16 to 20 Years	42.3%	67.8%	29.9%	52.9%	58.1%	52.1%	52.7%	54.6%
Ages 21 to 24 Years	48.2%	67.8%	21.1%	58.6%	59.0%	57.7%	57.8%	62.3%
Percent of Adults Receiving BMI Assessment (H)	69.9%	84.9%	50.9%	52.1%	79.8%	52.0%	55.2%	42.2%
Inpatient Utilization								
Discharges/1,000 Member Months (Total Inpatient)	10.6	10.9	10.2	10.8	10.8	10.8	10.8	8.1
Days/1,000 Member Months (Total Inpatient)	31.1	36.4	51.5	48.8	34.8	48.9	47.3	29.8
Average Length of Stay (Total Inpatient)	2.9	3.4	5.0	4.5	3.2	4.5	4.4	3.6
Number of Ambulatory Care Visits/1,000 Member Months								
Outpatient Visits	436.6	289.6	379.5	346.6	334.3	348.0	346.5	357.2
ED Visits	62.9	40.5	55.5	60.4	47.3	60.2	58.7	62.0

Demographics and Expenditures

Demographic statistics provide valuable insight on the demand for medical care within each region. More populated areas tend to have a greater demand for medical care. Therefore, a region that is more populated is likely to have higher medical expenditures and caseloads. Likewise, as Colorado's population increases, the demand for medical care will also increase. The Department is reporting county-level data from the 2006-2010 American Community Survey conducted by the United States Census Bureau as well as 2012 demographic forecasts from the Colorado Department of Local Affairs (DOLA).

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

Medicaid

Using the Department's decision support system database, FY 2011-12 Medicaid data was collected for the following statistics and reported in the following table for the State by county:

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

Please note monthly expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System (COFRS). The decision support system extracts data on a different time span and from a different source (i.e., Medicaid Management Information System – MMIS) than COFRS. In addition, Medicaid expenditures reported include those for Medical Services Premiums, Medicaid Mental Health, and certain claims-based costs for Medicaid-funded programs administered by the Department of Human Services. Therefore, total expenditures presented in this document will not reconcile with the actual medical services expenditures reported in Exhibit M in the November 1, 2012 FY 2013-14 Budget Request.

Children's Basic Health Plan

Using FY 2011-12 expenditures and caseload data for the Children's Basic Health Plan (CHP+), the Department compiled the following data and reported it by county in the following table:

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

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

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

Please note all data included in prior Budget Submissions were aggregated at the Health Insurance Portability and Accountability Act (HIPAA) region level. HIPAA requires the Department release client information in a larger aggregation in order to maintain client confidentiality and anonymity in smaller counties. To do this, 20 “HIPAA Regions” were developed for the provision of Department information. However, beginning with the FY 2011-12 Budget Submission, the Department began reporting data at the county level and suppressed data for small counties. For data at the HIPAA-region level, please contact the Department’s Budget Division at 303-866-6077.

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

Colorado's Demographics, Medicaid, CHP+, and CICP – A Statewide View	
Characteristics	Colorado
<i>Demographic Characteristics</i>	
Population (2012) ¹	5,196,177
Population (2006-10) ²	4,887,061
Percent of Population 16+ in Labor Force (2006-10) ²	69.81%
Percent of Population 5+ Where Non-English is Spoken at Home (2006-10) ²	16.79%
Percent of Households with Income Below the Poverty Level in Past 12 Months (2006-10) ²	8.60%
Percent of Female-Headed Households (2006-10) ²	9.88%
<i>Medicaid Characteristics (FY 2011-12)</i>	
Average Number of Medicaid Clients per Month	619,963
Percent of Population Who are Medicaid Clients	11.93%
Medicaid Expenditures	\$3,478,430,739
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>	
Average Number of CHP+ Clients per Month ³	76,190
Percent of Population Who are CHP+ Clients	1.47%
CHP+ Expenditures	\$181,892,331
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>	
Unduplicated Client Count	225,906
Number of CICP Providers ⁴	197
CICP Expenditures	\$325,584,046

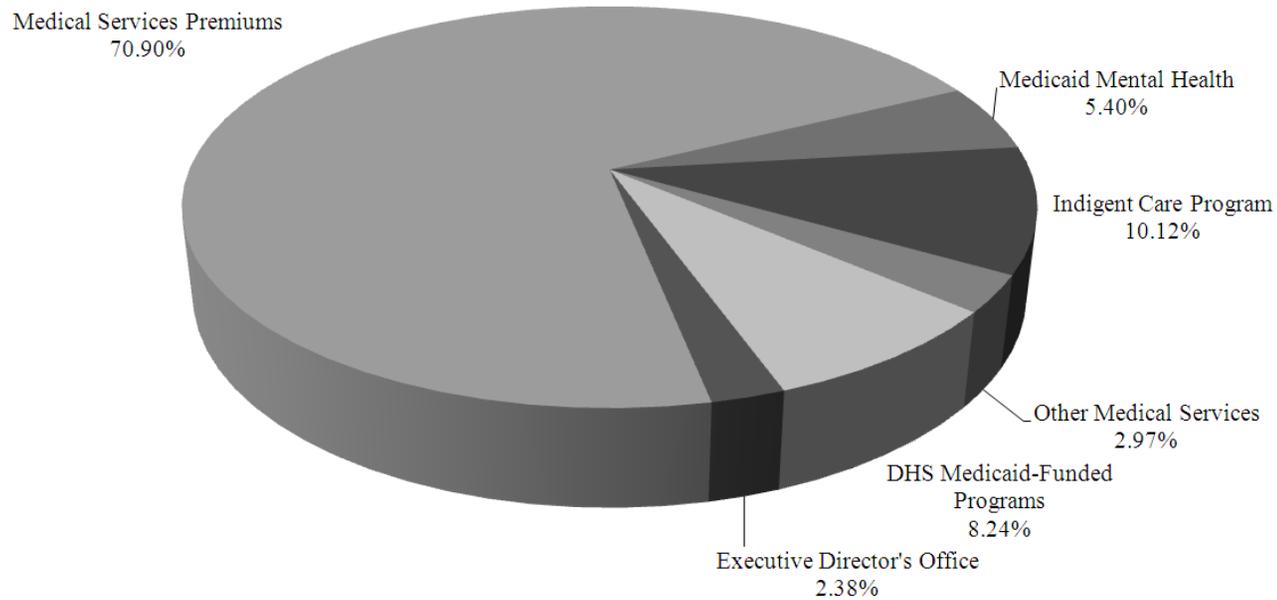
1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

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

FY 2011-12 Expenditures



Source: November 1, 2012 FY 2013-14 Budget Request, Schedule 2.

Medicaid and the Children’s Basic Health Plan

The following table provides insight on the variations of Medicaid and the Children’s Basic Health Plan (CHP+) usage across Colorado counties. Some important caveats must be mentioned concerning the Medicaid and CHP+ data presented in the county table. Overall, Medicaid and CHP+ expenditure figures by county will not equal the year-to-date FY 2011-12 appropriated or actual amounts. This is due to several factors:

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

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

Forecast,” as data reported here exclude enrollees in the CHP+ at Work program. Expenditures for the CHP+ at Work Program have been excluded from the data reported here.

2. County Medicaid expenditures represent actual fiscal year totals for Medical Services Premiums, Medicaid Mental Health, and certain claims-based costs for Medicaid-funded programs administered by the Department of Human Services.
3. Expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System (COFRS), whereas the Decision Support System database extracts its data from the Medicaid Management Information System (MMIS). Therefore, total Medicaid and CHP+ expenditures presented in the table below will not reconcile with the numbers for actual medical services reported in the June 2012 Premiums, Caseload, and Expenditure Report to the Joint Budget Committee. Some Medicaid expenditures are not linked to an eligibility type or to a unique client identification number for the following reasons:
 - a. These expenditures are financial transaction payments made to individual providers, health maintenance organizations, and service organizations, such as cost settlements or lump sum payments; and
 - b. Clients had no recorded eligibility type, gender, and/or county code.
4. Expenditures for drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments are not included in expenditure amounts by region since they are not processed in the MMIS.
5. Data has been suppressed for select counties with smaller populations per the Department’s threshold rule to comply with HIPAA regulations.

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Adams	Alamosa	Arapahoe	Archuleta
<i>Demographic Characteristics</i>				
Population (2012) ¹	460,846	15,899	590,675	12,908
Percent of Colorado Population (2012) ²	8.87%	0.31%	11.37%	0.25%
Population (2006-10) ²	425,330	15,293	552,860	12,136
Percent of Colorado Population (2006-10) ²	8.70%	0.31%	11.31%	0.25%
Percent of Population 16+ in Labor Force (2006-10) ²	71.90%	62.19%	72.15%	60.02%
Percent of Homes Where Non-English is Spoken (2006-10) ²	27.24%	25.76%	21.71%	7.55%
Percent of Population Living Below the Poverty Level (2006-10) ²	11.20%	16.20%	9.00%	4.70%
Percent of Female-Headed Households (2006-10) ²	12.22%	21.63%	19.87%	10.33%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	72,070	4,081	67,251	1,441
Percent of Population Who are Medicaid Clients	15.64%	25.67%	11.39%	11.16%
Medicaid Expenditures	\$355,628,840	\$22,092,081	\$380,669,078	\$6,533,463
Percent of Total Medicaid Expenditures	10.22%	0.64%	10.94%	0.19%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	10,016	432	8,926	286
Percent of Population Who are CHP+ Clients	2.17%	2.72%	1.51%	2.21%
CHP+ Expenditures	\$23,457,170	\$1,001,782	\$21,625,830	\$709,705
Percent of Total CHP+ Expenditures	12.90%	0.55%	11.89%	0.39%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	19,038	8,666	14,379	0
Number of CICP Providers ⁴	9	6	10	0
CICP Expenditures	\$43,503,362	\$3,702,953	\$7,799,726	\$0
Percent of Total CICP Expenditures	13.36%	1.14%	2.40%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

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

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Baca	Bent	Boulder	Broomfield
<i>Demographic Characteristics</i>				
Population (2012) ¹	3,786	6,563	300,823	58,999
Percent of Colorado Population (2012) ²	0.07%	0.13%	5.79%	1.14%
Population (2006-10) ²	3,833	6,125	290,177	52,872
Percent of Colorado Population (2006-10) ²	0.08%	0.13%	5.94%	1.08%
Percent of Population 16+ in Labor Force (2006-10) ²	59.71%	41.49%	69.56%	74.50%
Percent of Homes Where Non-English is Spoken (2006-10) ²	4.65%	18.80%	16.18%	12.44%
Percent of Population Living Below the Poverty Level (2006-10) ²	11.10%	13.40%	6.50%	3.90%
Percent of Female-Headed Households (2006-10) ²	7.91%	28.42%	12.50%	14.82%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	632	1,095	23,490	3,045
Percent of Population Who are Medicaid Clients	16.69%	16.69%	7.81%	5.16%
Medicaid Expenditures	\$5,483,404	\$7,207,020	\$138,568,322	\$22,372,632
Percent of Total Medicaid Expenditures	0.16%	0.21%	3.98%	0.64%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	104	104	3,124	618
Percent of Population Who are CHP+ Clients	2.76%	1.58%	1.04%	1.05%
CHP+ Expenditures	\$249,829	\$238,835	\$7,458,691	\$1,408,281
Percent of Total CHP+ Expenditures	0.14%	0.13%	4.10%	0.77%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	225	0	11,660	0
Number of CICP Providers ⁴	1	0	6	0
CICP Expenditures	\$217,120	\$0	\$14,700,968	\$0
Percent of Total CICP Expenditures	0.07%	0.00%	4.52%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

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

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Chaffee	Cheyenne	Clear Creek	Conejos
<i>Demographic Characteristics</i>				
Population (2012) ¹	18,426	1,861	9,294	8,476
Percent of Colorado Population (2012) ²	0.35%	0.04%	0.18%	0.16%
Population (2006-10) ²	17,540	2,194	9,088	8,220
Percent of Colorado Population (2006-10) ²	0.36%	0.04%	0.19%	0.17%
Percent of Population 16+ in Labor Force (2006-10) ²	56.39%	65.46%	75.17%	59.20%
Percent of Homes Where Non-English is Spoken (2006-10) ²	6.30%	7.41%	3.95%	39.57%
Percent of Population Living Below the Poverty Level (2006-10) ²	8.80%	6.50%	4.20%	16.00%
Percent of Female-Headed Households (2006-10) ²	11.83%	4.83%	11.17%	19.10%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	1,749	240	676	2,165
Percent of Population Who are Medicaid Clients	9.49%	12.90%	7.27%	25.54%
Medicaid Expenditures	\$10,398,652	\$1,328,203	\$3,263,453	\$11,187,291
Percent of Total Medicaid Expenditures	0.30%	0.04%	0.09%	0.32%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	417	51	91	376
Percent of Population Who are CHP+ Clients	2.26%	2.72%	0.98%	4.44%
CHP+ Expenditures	\$981,671	\$124,251	\$219,964	\$875,498
Percent of Total CHP+ Expenditures	0.54%	0.07%	0.12%	0.48%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	607	0	0	324
Number of CICP Providers ⁴	3	0	0	4
CICP Expenditures	\$869,921	\$0	\$0	\$393,282
Percent of Total CICP Expenditures	0.27%	0.00%	0.00%	0.12%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

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

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Costilla	Crowley	Custer	Delta
<i>Demographic Characteristics</i>				
Population (2012) ¹	3,604	6,026	4,470	32,739
Percent of Colorado Population (2012) ²	0.07%	0.12%	0.09%	0.63%
Population (2006-10) ²	3,536	5,897	3,899	30,533
Percent of Colorado Population (2006-10) ²	0.07%	0.12%	0.08%	0.62%
Percent of Population 16+ in Labor Force (2006-10) ²	49.00%	30.92%	54.88%	57.35%
Percent of Homes Where Non-English is Spoken (2006-10) ²	52.75%	13.69%	1.27%	11.11%
Percent of Population Living Below the Poverty Level (2006-10) ²	20.40%	17.00%	11.70%	9.80%
Percent of Female-Headed Households (2006-10) ²	11.83%	14.19%	11.14%	12.51%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	1,084	928	425	4,445
Percent of Population Who are Medicaid Clients	30.07%	15.40%	9.51%	13.58%
Medicaid Expenditures	\$4,796,673	\$5,173,435	\$1,218,198	\$20,345,163
Percent of Total Medicaid Expenditures	0.14%	0.15%	0.04%	0.58%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	85	61	61	635
Percent of Population Who are CHP+ Clients	2.36%	1.01%	1.36%	1.94%
CHP+ Expenditures	\$197,485	\$138,427	\$153,144	\$1,507,740
Percent of Total CHP+ Expenditures	0.11%	0.08%	0.08%	0.83%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	0	0	119	369
Number of CICP Providers ⁴	1	0	1	1
CICP Expenditures	\$0	\$0	\$18,932	\$2,275,526
Percent of Total CICP Expenditures	0.00%	0.00%	0.01%	0.70%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

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

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Denver	Dolores	Douglas	Eagle
<i>Demographic Characteristics</i>				
Population (2012) ¹	622,148	2,140	297,485	56,145
Percent of Colorado Population (2012) ²	11.97%	0.04%	5.73%	1.08%
Population (2006-10) ²	578,087	2,027	273,440	50,793
Percent of Colorado Population (2006-10) ²	11.83%	0.04%	5.60%	1.04%
Percent of Population 16+ in Labor Force (2006-10) ²	70.48%	61.50%	76.46%	82.09%
Percent of Homes Where Non-English is Spoken (2006-10) ²	27.72%	3.48%	9.09%	30.70%
Percent of Population Living Below the Poverty Level (2006-10) ²	14.80%	10.70%	1.90%	5.80%
Percent of Female-Headed Households (2006-10) ²	16.02%	8.89%	10.58%	13.66%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	107,003	236	9,777	3,106
Percent of Population Who are Medicaid Clients	17.20%	11.03%	3.29%	5.53%
Medicaid Expenditures	\$575,631,372	\$851,005	\$60,456,276	\$9,936,129
Percent of Total Medicaid Expenditures	16.55%	0.02%	1.74%	0.29%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	9,404	63	1,850	598
Percent of Population Who are CHP+ Clients	1.51%	2.94%	0.62%	1.07%
CHP+ Expenditures	\$22,248,989	\$150,801	\$4,394,185	\$1,376,383
Percent of Total CHP+ Expenditures	12.23%	0.08%	2.42%	0.76%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	46,334	1,029	0	0
Number of CICP Providers ⁴	15	1	0	0
CICP Expenditures	\$98,598,071	\$86,962	\$0	\$0
Percent of Total CICP Expenditures	30.28%	0.03%	0.00%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

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

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Elbert	El Paso	Fremont	Garfield
<i>Demographic Characteristics</i>				
Population (2012) ¹	24,124	642,538	48,266	59,192
Percent of Colorado Population (2012) ²	0.46%	12.37%	0.93%	1.14%
Population (2006-10) ²	22,712	599,988	46,941	54,761
Percent of Colorado Population (2006-10) ²	0.46%	12.28%	0.96%	1.12%
Percent of Population 16+ in Labor Force (2006-10) ²	73.02%	70.23%	37.62%	76.06%
Percent of Homes Where Non-English is Spoken (2006-10) ²	4.66%	11.55%	14.34%	24.73%
Percent of Population Living Below the Poverty Level (2006-10) ²	2.30%	8.10%	9.80%	6.60%
Percent of Female-Headed Households (2006-10) ²	9.44%	18.21%	11.52%	13.83%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	1,379	74,490	7,018	6,702
Percent of Population Who are Medicaid Clients	5.72%	11.59%	14.54%	11.32%
Medicaid Expenditures	\$7,396,176	\$412,005,388	\$48,047,524	\$35,106,353
Percent of Total Medicaid Expenditures	0.21%	11.84%	1.38%	1.01%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	207	7,437	632	1,177
Percent of Population Who are CHP+ Clients	0.86%	1.16%	1.31%	1.99%
CHP+ Expenditures	\$471,111	\$18,205,659	\$1,470,328	\$2,830,717
Percent of Total CHP+ Expenditures	0.26%	10.01%	0.81%	1.56%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	0	34,689	2,399	3,083
Number of CICP Providers ⁴	0	22	2	6
CICP Expenditures	\$0	\$41,219,396	\$2,963,981	\$3,997,402
Percent of Total CICP Expenditures	0.00%	12.66%	0.91%	1.23%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

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

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Gilpin	Grand	Gunnison	Hinsdale
<i>Demographic Characteristics</i>				
Population (2012) ¹	5,654	15,576	15,596	866
Percent of Colorado Population (2012) ²	0.11%	0.30%	0.30%	0.02%
Population (2006-10) ²	5,126	14,526	15,136	489
Percent of Colorado Population (2006-10) ²	0.10%	0.30%	0.31%	0.01%
Percent of Population 16+ in Labor Force (2006-10) ²	76.15%	75.52%	74.91%	57.34%
Percent of Homes Where Non-English is Spoken (2006-10) ²	6.76%	9.45%	10.02%	13.22%
Percent of Population Living Below the Poverty Level (2006-10) ²	7.10%	5.10%	1.60%	6.50%
Percent of Female-Headed Households (2006-10) ²	11.15%	10.51%	5.52%	3.53%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	404	853	1,110	62
Percent of Population Who are Medicaid Clients	7.15%	5.48%	7.12%	7.16%
Medicaid Expenditures	\$2,058,114	\$3,825,133	\$5,512,607	\$138,792
Percent of Total Medicaid Expenditures	0.06%	0.11%	0.16%	0.00%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	58	252	261	N/A
Percent of Population Who are CHP+ Clients	1.03%	1.61%	1.67%	2.14%
CHP+ Expenditures	\$149,625	\$647,411	\$617,700	\$55,305
Percent of Total CHP+ Expenditures	0.08%	0.36%	0.34%	0.03%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	0	94	206	0
Number of CICP Providers ⁴	1	4	1	0
CICP Expenditures	\$0	\$89,042	\$98,559	\$0
Percent of Total CICP Expenditures	0.00%	0.03%	0.03%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

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

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Huerfano	Jackson	Jefferson	Kiowa
<i>Demographic Characteristics</i>				
Population (2012) ¹	6,800	1,455	539,973	1,416
Percent of Colorado Population (2012) ²	0.13%	0.03%	10.39%	0.03%
Population (2006-10) ²	6,948	1,464	528,614	1,643
Percent of Colorado Population (2006-10) ²	0.14%	0.03%	10.82%	0.03%
Percent of Population 16+ in Labor Force (2006-10) ²	49.13%	68.90%	70.97%	64.84%
Percent of Homes Where Non-English is Spoken (2006-10) ²	18.39%	4.21%	10.77%	2.69%
Percent of Population Living Below the Poverty Level (2006-10) ²	20.20%	13.50%	5.60%	10.20%
Percent of Female-Headed Households (2006-10) ²	13.79%	13.04%	16.02%	18.98%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	1,602	150	44,343	196
Percent of Population Who are Medicaid Clients	23.56%	10.31%	8.21%	13.84%
Medicaid Expenditures	\$10,714,083	\$552,206	\$341,906,619	\$1,401,074
Percent of Total Medicaid Expenditures	0.31%	0.02%	9.83%	0.04%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	101	40	5,920	43
Percent of Population Who are CHP+ Clients	1.48%	2.76%	1.10%	3.04%
CHP+ Expenditures	\$231,480	\$95,003	\$14,434,776	\$101,030
Percent of Total CHP+ Expenditures	0.13%	0.05%	7.94%	0.06%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	87	0	0	0
Number of CICP Providers ⁴	2	1	9	0
CICP Expenditures	\$543,980	\$0	\$0	\$0
Percent of Total CICP Expenditures	0.17%	0.00%	0.00%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

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

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Kit Carson	Lake	La Plata	Larimer
<i>Demographic Characteristics</i>				
Population (2012) ¹	8,480	7,733	53,474	308,439
Percent of Colorado Population (2012) ²	0.16%	0.15%	1.03%	5.94%
Population (2006-10) ²	8,156	7,039	50,149	291,162
Percent of Colorado Population (2006-10) ²	0.17%	0.14%	1.03%	5.96%
Percent of Population 16+ in Labor Force (2006-10) ²	64.36%	74.34%	70.71%	69.76%
Percent of Homes Where Non-English is Spoken (2006-10) ²	14.87%	29.90%	9.85%	8.66%
Percent of Population Living Below the Poverty Level (2006-10) ²	6.20%	18.60%	5.70%	6.90%
Percent of Female-Headed Households (2006-10) ²	15.28%	18.09%	14.16%	12.86%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	1,041	1,016	4,833	28,842
Percent of Population Who are Medicaid Clients	12.28%	13.14%	9.04%	9.35%
Medicaid Expenditures	\$5,606,319	\$4,093,480	\$23,504,618	\$163,180,057
Percent of Total Medicaid Expenditures	0.16%	0.12%	0.68%	4.69%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	281	165	938	3,985
Percent of Population Who are CHP+ Clients	3.31%	2.14%	1.75%	1.29%
CHP+ Expenditures	\$651,105	\$380,187	\$2,334,636	\$9,681,513
Percent of Total CHP+ Expenditures	0.36%	0.21%	1.28%	5.32%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	0	N/A	396	15,352
Number of CICP Providers ⁴	1	1	1	9
CICP Expenditures	\$0	\$134,561	\$2,685,569	\$27,673,827
Percent of Total CICP Expenditures	0.00%	0.04%	0.82%	8.50%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

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FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Las Animas	Lincoln	Logan	Mesa
<i>Demographic Characteristics</i>				
Population (2012) ¹	16,095	5,590	23,050	151,539
Percent of Colorado Population (2012) ²	0.31%	0.11%	0.44%	2.92%
Population (2006-10) ²	15,675	5,476	22,278	142,284
Percent of Colorado Population (2006-10) ²	0.32%	0.11%	0.46%	2.91%
Percent of Population 16+ in Labor Force (2006-10) ²	56.92%	53.68%	63.38%	65.05%
Percent of Homes Where Non-English is Spoken (2006-10) ²	14.90%	8.23%	9.11%	9.07%
Percent of Population Living Below the Poverty Level (2006-10) ²	13.00%	8.30%	10.40%	7.90%
Percent of Female-Headed Households (2006-10) ²	13.35%	10.73%	23.80%	14.42%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	3,058	669	2,823	21,300
Percent of Population Who are Medicaid Clients	19.00%	11.97%	12.25%	14.06%
Medicaid Expenditures	\$25,383,229	\$3,789,223	\$18,624,123	\$111,079,805
Percent of Total Medicaid Expenditures	0.73%	0.11%	0.54%	3.19%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	268	75	372	2,789
Percent of Population Who are CHP+ Clients	1.67%	1.34%	1.61%	1.84%
CHP+ Expenditures	\$635,602	\$200,297	\$850,322	\$6,875,198
Percent of Total CHP+ Expenditures	0.35%	0.11%	0.47%	3.78%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	1,393	1,317	955	6,419
Number of CICP Providers ⁴	3	1	2	6
CICP Expenditures	\$951,685	\$184,743	\$2,465,130	\$8,065,976
Percent of Total CICP Expenditures	0.29%	0.06%	0.76%	2.48%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

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FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Mineral	Moffat	Montezuma	Montrose
<i>Demographic Characteristics</i>				
Population (2012) ¹	748	14,329	26,439	43,546
Percent of Colorado Population (2012) ²	0.01%	0.28%	0.51%	0.84%
Population (2006-10) ²	1,020	13,519	25,279	40,266
Percent of Colorado Population (2006-10) ²	0.02%	0.28%	0.52%	0.82%
Percent of Population 16+ in Labor Force (2006-10) ²	55.70%	71.97%	64.74%	63.62%
Percent of Homes Where Non-English is Spoken (2006-10) ²	3.43%	11.01%	13.43%	13.64%
Percent of Population Living Below the Poverty Level (2006-10) ²	2.60%	10.80%	14.20%	8.10%
Percent of Female-Headed Households (2006-10) ²	0.45%	17.01%	20.11%	15.26%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	53	1,915	4,524	7,052
Percent of Population Who are Medicaid Clients	7.09%	13.36%	17.11%	16.19%
Medicaid Expenditures	\$233,554	\$9,747,204	\$25,319,497	\$30,249,965
Percent of Total Medicaid Expenditures	0.01%	0.28%	0.73%	0.87%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	N/A	292	674	1,267
Percent of Population Who are CHP+ Clients	0.95%	2.04%	2.55%	2.91%
CHP+ Expenditures	\$24,640	\$717,323	\$1,585,189	\$2,958,564
Percent of Total CHP+ Expenditures	0.01%	0.39%	0.87%	1.63%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	0	634	284	1,790
Number of CICP Providers ⁴	0	3	7	3
CICP Expenditures	\$0	\$919,094	\$778,018	\$3,237,425
Percent of Total CICP Expenditures	0.00%	0.28%	0.24%	0.99%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

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FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Morgan	Otero	Ouray	Park
<i>Demographic Characteristics</i>				
Population (2012) ¹	28,625	19,123	4,748	17,185
Percent of Colorado Population (2012) ²	0.55%	0.37%	0.09%	0.33%
Population (2006-10) ²	27,911	18,830	4,319	16,286
Percent of Colorado Population (2006-10) ²	0.57%	0.39%	0.09%	0.33%
Percent of Population 16+ in Labor Force (2006-10) ²	66.66%	55.98%	65.56%	68.69%
Percent of Homes Where Non-English is Spoken (2006-10) ²	25.87%	19.26%	6.60%	4.44%
Percent of Population Living Below the Poverty Level (2006-10) ²	12.80%	16.00%	5.00%	4.20%
Percent of Female-Headed Households (2006-10) ²	19.97%	21.68%	5.52%	9.56%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	4,729	4,790	353	1,162
Percent of Population Who are Medicaid Clients	16.52%	25.05%	7.44%	6.76%
Medicaid Expenditures	\$26,101,186	\$29,241,205	\$1,085,293	\$5,015,301
Percent of Total Medicaid Expenditures	0.75%	0.84%	0.03%	0.14%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	607	393	98	217
Percent of Population Who are CHP+ Clients	2.12%	2.05%	2.07%	1.26%
CHP+ Expenditures	\$1,427,619	\$909,083	\$224,079	\$497,432
Percent of Total CHP+ Expenditures	0.78%	0.50%	0.12%	0.27%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	2,143	1,195	0	0
Number of CICP Providers ⁴	3	3	0	0
CICP Expenditures	\$1,812,461	\$1,741,291	\$0	\$0
Percent of Total CICP Expenditures	0.56%	0.53%	0.00%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

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

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Phillips	Pitkin	Prowers	Pueblo
<i>Demographic Characteristics</i>				
Population (2012) ¹	4,473	17,932	12,707	163,590
Percent of Colorado Population (2012) ²	0.09%	0.35%	0.24%	3.15%
Population (2006-10) ²	4,394	16,389	12,734	156,244
Percent of Colorado Population (2006-10) ²	0.09%	0.34%	0.26%	3.20%
Percent of Population 16+ in Labor Force (2006-10) ²	64.84%	77.25%	66.62%	59.60%
Percent of Homes Where Non-English is Spoken (2006-10) ²	16.08%	16.23%	24.64%	14.09%
Percent of Population Living Below the Poverty Level (2006-10) ²	3.70%	4.80%	18.70%	13.60%
Percent of Female-Headed Households (2006-10) ²	10.55%	5.96%	21.12%	22.03%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	567	346	3,057	35,509
Percent of Population Who are Medicaid Clients	12.68%	1.93%	24.06%	21.71%
Medicaid Expenditures	\$3,069,606	\$1,487,436	\$16,593,361	\$224,960,476
Percent of Total Medicaid Expenditures	0.09%	0.04%	0.48%	6.47%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	104	77	397	2,530
Percent of Population Who are CHP+ Clients	2.32%	0.43%	3.12%	1.55%
CHP+ Expenditures	\$236,264	\$174,761	\$883,279	\$5,948,516
Percent of Total CHP+ Expenditures	0.13%	0.10%	0.49%	3.27%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	131	222	2,087	14,766
Number of CICP Providers ⁴	2	2	6	12
CICP Expenditures	\$124,230	\$1,057,289	\$2,075,841	\$26,318,891
Percent of Total CICP Expenditures	0.04%	0.32%	0.64%	8.08%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

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

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Rio Blanco	Rio Grande	Routt	Saguache
<i>Demographic Characteristics</i>				
Population (2012) ¹	7,206	12,216	24,030	6,132
Percent of Colorado Population (2012) ²	0.14%	0.24%	0.46%	0.12%
Population (2006-10) ²	6,494	11,926	22,924	6,161
Percent of Colorado Population (2006-10) ²	0.13%	0.24%	0.47%	0.13%
Percent of Population 16+ in Labor Force (2006-10) ²	66.90%	54.02%	78.63%	64.03%
Percent of Homes Where Non-English is Spoken (2006-10) ²	8.22%	26.92%	6.05%	35.78%
Percent of Population Living Below the Poverty Level (2006-10) ²	1.60%	10.30%	4.70%	20.20%
Percent of Female-Headed Households (2006-10) ²	11.14%	14.90%	9.56%	15.61%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	744	2,944	1,430	1,432
Percent of Population Who are Medicaid Clients	10.33%	24.10%	5.95%	23.35%
Medicaid Expenditures	\$3,331,965	\$15,259,822	\$8,435,120	\$5,460,516
Percent of Total Medicaid Expenditures	0.10%	0.44%	0.24%	0.16%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	103	420	460	171
Percent of Population Who are CHP+ Clients	1.43%	3.43%	1.91%	2.79%
CHP+ Expenditures	\$234,137	\$989,560	\$1,069,048	\$396,406
Percent of Total CHP+ Expenditures	0.13%	0.54%	0.59%	0.22%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	0	448	554	0
Number of CICP Providers ⁴	0	5	1	0
CICP Expenditures	\$0	\$220,292	\$1,490,453	\$0
Percent of Total CICP Expenditures	0.00%	0.07%	0.46%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

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FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	San Juan	San Miguel	Sedgwick	Summit
<i>Demographic Characteristics</i>				
Population (2012) ¹	735	7,899	2,448	29,387
Percent of Colorado Population (2012) ²	0.01%	0.15%	0.05%	0.57%
Population (2006-10) ²	752	7,299	2,412	27,105
Percent of Colorado Population (2006-10) ²	0.02%	0.15%	0.05%	0.55%
Percent of Population 16+ in Labor Force (2006-10) ²	82.10%	85.47%	56.03%	83.44%
Percent of Homes Where Non-English is Spoken (2006-10) ²	4.58%	10.62%	7.33%	15.28%
Percent of Population Living Below the Poverty Level (2006-10) ²	0.00%	7.00%	8.80%	3.10%
Percent of Female-Headed Households (2006-10) ²	10.46%	11.86%	9.24%	7.57%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	86	548	370	1,517
Percent of Population Who are Medicaid Clients	11.70%	6.94%	15.11%	5.16%
Medicaid Expenditures	\$218,101	\$1,104,681	\$2,982,619	\$5,454,617
Percent of Total Medicaid Expenditures	0.01%	0.03%	0.09%	0.16%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	N/A	111	56	394
Percent of Population Who are CHP+ Clients	2.87%	1.41%	2.28%	1.34%
CHP+ Expenditures	\$44,841	\$268,529	\$118,926	\$940,733
Percent of Total CHP+ Expenditures	0.02%	0.15%	0.07%	0.52%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	0	287	209	0
Number of CICP Providers ⁴	0	1	2	1
CICP Expenditures	\$0	\$134,407	\$83,963	\$0
Percent of Total CICP Expenditures	0.00%	0.04%	0.03%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

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FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Teller	Washington	Weld	Yuma
<i>Demographic Characteristics</i>				
Population (2012) ¹	23,934	4,885	264,528	10,164
Percent of Colorado Population (2012) ²	0.46%	0.09%	5.09%	0.20%
Population (2006-10) ²	22,821	4,773	242,860	9,896
Percent of Colorado Population (2006-10) ²	0.47%	0.10%	4.97%	0.20%
Percent of Population 16+ in Labor Force (2006-10) ²	66.83%	66.48%	69.65%	65.44%
Percent of Homes Where Non-English is Spoken (2006-10) ²	5.32%	6.21%	18.88%	15.50%
Percent of Population Living Below the Poverty Level (2006-10) ²	5.40%	12.20%	9.80%	6.00%
Percent of Female-Headed Households (2006-10) ²	13.27%	9.56%	15.81%	9.79%
<i>Medicaid Characteristics (FY 2011-12)</i>				
Average Number of Medicaid Clients per Month	2,230	539	35,737	1,499
Percent of Population Who are Medicaid Clients	9.32%	11.03%	13.51%	14.75%
Medicaid Expenditures	\$11,077,550	\$3,376,230	\$172,679,426	\$8,880,394
Percent of Total Medicaid Expenditures	0.32%	0.10%	4.96%	0.26%
<i>Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)</i>				
Average Number of CHP+ Clients per Month ³	327	119	4,797	233
Percent of Population Who are CHP+ Clients	1.37%	2.43%	1.81%	2.29%
CHP+ Expenditures	\$742,823	\$278,097	\$11,265,236	\$519,582
Percent of Total CHP+ Expenditures	0.41%	0.15%	6.19%	0.29%
<i>Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)</i>				
Unduplicated Client Count	435	0	30,900	652
Number of CICP Providers ⁴	2	1	9	4
CICP Expenditures	\$376,585	\$0	\$21,326,707	\$646,425
Percent of Total CICP Expenditures	0.12%	0.00%	6.55%	0.20%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

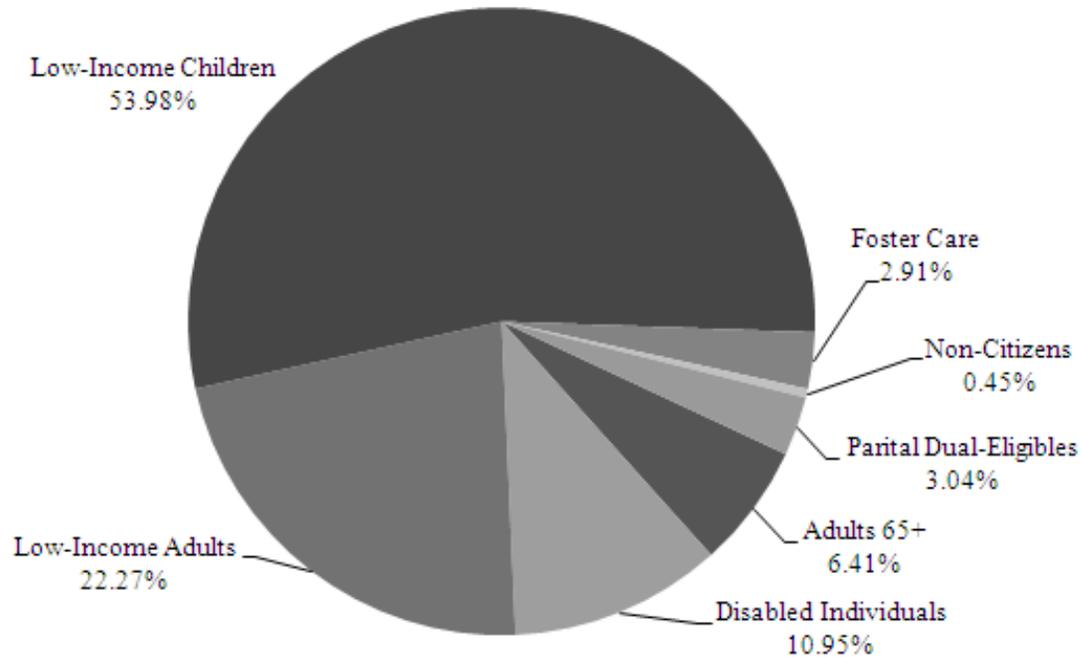
3) CHP+ caseload does not include "CHP+ at Work" clients

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

Medicaid Caseload

Medicaid caseload trends are influenced by a number of factors including: population trends, in-State migration, age of the population, length of stay, economic conditions, and State and federal policy changes. Projecting annual caseload is complicated by the fact that each of these factors can contribute to categorical changes, some of which may be contradictory. For example, the State may enact legislation that removes clients from a Medicaid category who are aged 65 and older, while the population of adults aged 65 and older is increasing. The chart below shows Medicaid caseload by category as a percentage of the overall caseload for FY 2011-12.⁷

FY 2011-12 Caseload



⁷ Source: November 1, 2012 FY 2013-14 Budget Request, Exhibit B, “Medicaid Caseload Forecast”

A. Clients

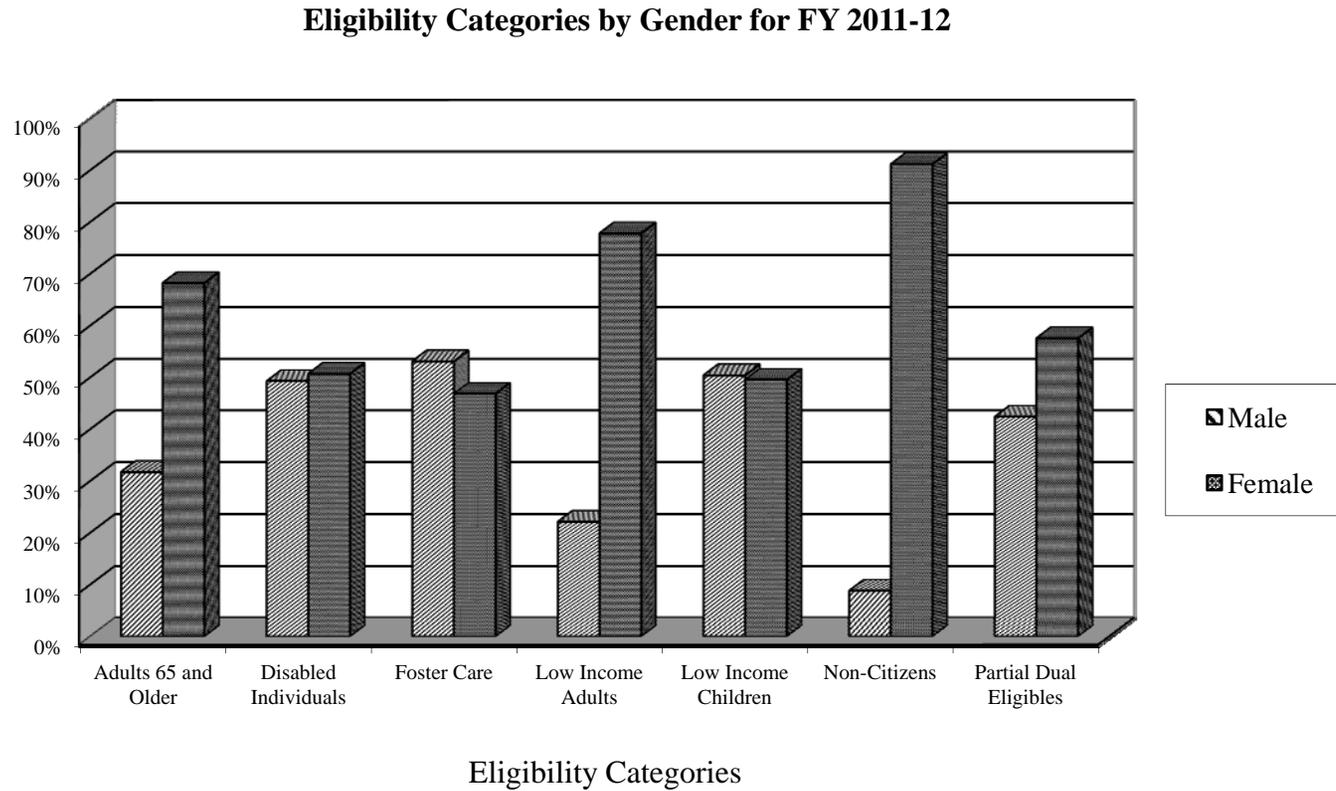
A1. 2012 Federal Poverty Levels

The table below reports the federal poverty levels for all states except Hawaii and Alaska from the Department of Health and Human Services. For family units of more than eight members, add \$3,960 for each additional family member.

Federal Poverty Guidelines for Annual Income									
Family Size	100%	120%	133%	150%	175%	185%	190%	200%	250%
1	\$11,170	\$13,404	\$14,893	\$16,755	\$19,548	\$20,665	\$21,223	\$22,340	\$27,925
2	\$15,130	\$18,156	\$20,173	\$22,695	\$26,478	\$27,991	\$28,747	\$30,260	\$37,825
3	\$19,090	\$22,908	\$25,453	\$28,635	\$33,408	\$35,317	\$36,271	\$38,180	\$47,725
4	\$23,050	\$27,660	\$30,733	\$34,575	\$40,338	\$42,643	\$43,795	\$46,100	\$57,625
5	\$27,010	\$32,412	\$36,013	\$40,515	\$47,268	\$49,969	\$51,319	\$54,020	\$67,525
6	\$30,970	\$37,164	\$41,293	\$46,455	\$54,198	\$57,295	\$58,843	\$61,940	\$77,425
7	\$34,930	\$41,916	\$46,573	\$52,395	\$61,128	\$64,621	\$66,367	\$69,860	\$87,325
8	\$38,890	\$46,668	\$51,853	\$58,335	\$68,058	\$71,947	\$73,891	\$77,780	\$97,225

Source: Federal Register, Vol. 77, No. 17, Thursday, January 26, 2012, Notices, page 4035

A2. Eligibility Categories by Gender for FY 2011-12⁸



⁸ Source: The Department’s decision support system (MMIS-DSS)

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

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

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

4) Percent based on member months in each category.

A3. Medicaid Enrollment by Type of Managed Care Provider

The following table shows the breakdown by client count for FY 2007-08 through FY 2011-12 for clients enrolled in health maintenance organizations, prepaid inpatient health plan, Primary Care Physician Program, and unassigned fee-for-service. Health maintenance organizations, prepaid inpatient health plan and Primary Care Physician Program enrollment figures were subtracted from total caseload numbers (without retroactivity) to calculate the fee-for-service enrollment figures, and as a result may cause the fee-for-service counts to be underrepresented.⁹

Average Medicaid Enrollment for FY 2007-08 through FY 2011-12					
Membership Category	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
HMOs and Prepaid Inpatient Health Plans	36,701	54,510	61,047	66,477	70,351
Primary Care Physician Program	25,875	22,717	23,240	23,380	23,264
Fee-for-Service	325,492	359,585	413,902	470,865	526,349
TOTAL	388,068	436,812	498,189	560,722	619,964

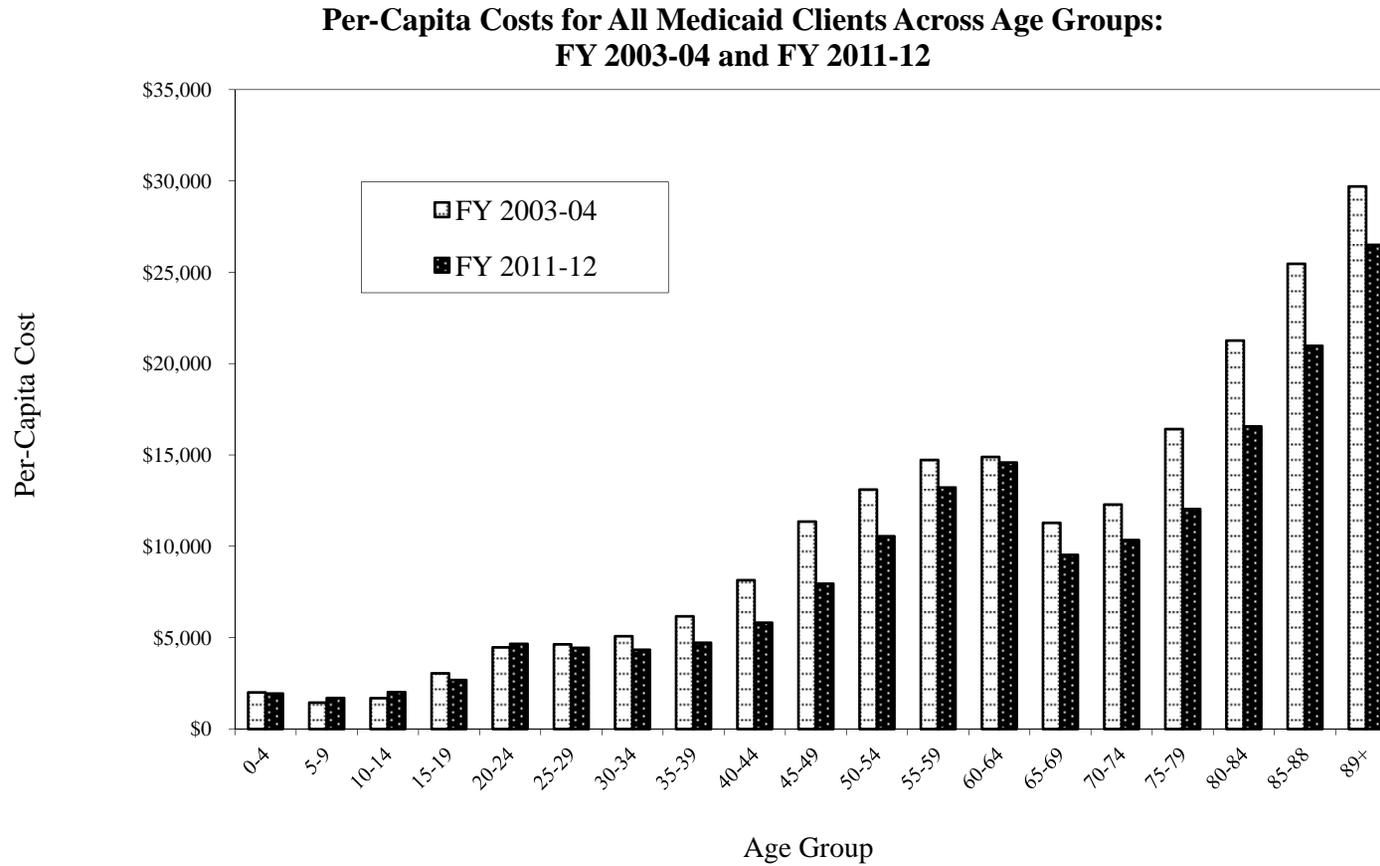
⁹ Department of Health Care Policy and Financing June 2012 Premiums, Caseload, and Expenditures Report (JBC Monthly Report).

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

Note: The Department developed a new caseload report in FY 2007-08 that it believes measures caseload more accurately. Because of the differences between the methodologies used in the original and new caseload reports, the Department restated historical Medicaid caseload through FY 2002-03. The numbers above through FY 2007-08 are based on the old methodologies and will not match restated caseload totals because the Department does not have a methodology for restating caseload by provider type.

B. Services

B1. Paid Medical Services Per-Capita Costs (from all claims) Across Age Groups¹⁰



¹⁰ Source: Medicaid paid claims. Financial transactions and other accounting adjustments are not included in the expenditures by age group.

B2. FY 2011-12 Services by County

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

Acute Care, including:

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

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

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

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

B4. FY 2011-12 Deliveries

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

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

Low Birthweight, Preterm, and Neonatal Intensive Care Unit

Neonatal Intensive Care Unit

B5. FY 2011-12 Top Tens

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

Inpatient Hospital

Outpatient Hospital

Federal Qualified Health Centers (FQHCs)

Rural Health Centers

Physician and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

Dental

Laboratory

Durable Medical Equipment and Supplies

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

The following should be noted:

- Clients with no county designation are not included.
- The Department's decision support system (MMIS-DSS), extracts data on a different time span and from a different source (i.e., the Medicaid Management Information System, or MMIS) than the Colorado Financial Reporting System. This decision support system contains a full extract of all county level data in the MMIS.
- The Department administers the following Home- and Community-Based Services waivers: Elderly, Blind and Disabled; Persons with Mental Illness; Persons Living with AIDS; Persons with Brain Injury; Children's; Children with Autism; Pediatric Hospice Waiver; and Spinal Cord Injury (effective July 2012).
- The Department of Human Services administers the following Home- and Community-Based Services waivers: Developmentally Disabled; Supported Living Services; Children's Extensive Support; and Children's Habilitation Residential Program.

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- The inpatient diagnosis related groups (DRGs) were categorized to improve the interpretation and evaluation of services (tables B5a and B5b). Research and reasonableness were used to determine the DRG categories. The naming of DRG categories was completed through consultation of the ICD-10 (International Classification of Diseases). There is a group called Non-Specific Symptoms, Disorders or Procedures which was created to minimize the number of DRG categories. Since the DRG descriptions were sometimes referring to diseases and sometimes to procedures, the term 'Disorders or Procedures' was often included in the names of categories, or groups.
- The tables exhibit the top 10 client counts, top 10 service utilizations, and top 10 expenditures by types of commonly used medical services. It should be noted that sometimes the ranking of top client counts and service utilizations are the same, but the expenditures rankings differ.
- The outpatient diagnosis groupings are based on the first three digits of the ICD-9 codes.
- For the top 10 prescription drug tables, the number of prescriptions filled was used instead of the number of prescriptions because it provides better insight on the frequency of pharmacy Medicaid payments. In addition, claims where the payment was zero were excluded from the analysis.
- The totals at the bottom of each of the top-10 tables reflect the sum of unique client count/count of services/expenditures for the top-10 groupings only. These sums should not be mistaken for the totals of clients, services and expenditures for a type of medical service.

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B2a: FY 2011-12 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	FQHCs	Physician and EPSDT	Pharmacy Prescriptions	Inpatient Hospital	Outpatient Hospital
Adams	23,982	57,652	44,331	6,095	33,366
Alamosa	2,905	2,925	2,853	312	1,797
Arapahoe	10,513	56,086	41,745	5,742	31,115
Archuleta	*	993	886	97	616
Baca	70	364	379	48	248
Bent	634	727	834	78	532
Boulder	9,744	17,042	13,763	1,866	10,044
Broomfield	746	2,546	1,957	258	1,401
Chaffee	42	1,257	1,122	130	737
Cheyenne	33	141	160	*	109
Clear Creek	171	526	456	52	246
Conejos	1,080	1,450	1,615	167	952
Costilla	659	543	623	56	350
Crowley	288	640	679	66	423
Custer	*	257	247	*	123
Delta	*	2,077	1,331	138	937
Denver	30,638	53,569	40,699	6,734	30,614
Dolores	106	184	161	*	99
Douglas	394	8,951	6,905	859	4,200
Eagle	301	2,970	1,819	356	1,105
Elbert	363	1,073	987	126	580
El Paso	30,997	57,413	49,651	5,853	37,208
Fremont	464	5,060	5,015	453	3,333
Garfield	2,483	4,870	4,121	601	3,008
Gilpin	173	315	274	*	158
Grand	*	786	592	76	372
Gunnison	*	981	640	88	453
Hinsdale	*	35	*	*	*
Huerfano	85	1,103	981	98	696
Jackson	*	97	85	*	50
Jefferson	6,815	35,687	28,130	3,398	18,883
Kiowa	55	101	149	*	76
Kit Carson	208	755	706	85	457
Lake	*	1,036	738	95	568
La Plata	67	4,256	3,086	358	2,231

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B2a: FY 2011-12 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	FQHCs	Physician and EPSDT	Pharmacy Prescriptions	Inpatient Hospital	Outpatient Hospital
Larimer	8,102	23,835	19,311	2,198	12,638
Las Animas	110	2,159	2,097	201	1,609
Lincoln	388	459	497	50	284
Logan	963	1,957	2,042	232	1,432
Mesa	59	7,930	4,916	465	3,216
Mineral	*	47	*	*	*
Moffat	524	1,590	1,331	138	906
Montezuma	377	3,413	3,006	319	2,103
Montrose	149	2,556	1,556	183	1,069
Morgan	1,680	3,656	3,248	423	2,322
Otero	2,091	3,724	3,380	385	2,425
Ouray	*	173	92	*	52
Park	72	983	777	90	371
Phillips	100	334	354	38	282
Pitkin	128	231	194	36	122
Prowers	1,774	2,190	2,316	224	1,520
Pueblo	9,750	28,774	25,116	2,565	18,112
Rio Blanco	*	374	381	32	265
Rio Grande	1,741	2,004	2,005	185	1,251
Routt	63	1,373	984	97	593
Saguache	1,029	900	873	104	564
San Juan	*	87	*	*	*
San Miguel	175	255	181	*	77
Sedgwick	44	247	260	*	173
Summit	*	1,524	900	178	490
Teller	1,146	1,654	1,537	138	1,168
Washington	88	349	345	34	206
Weld	15,434	29,468	23,836	3,021	16,514
Yuma	169	1,183	980	129	681
Suppressed Counties	169	-	93	190	74
STATEWIDE	166,987	434,057	350,327	45,606	251,864

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

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B2b: FY 2011-12 Expenditures for Selected Acute Care Service Categories by County					
County	FQHCs	Physician and EPSDT	Pharmacy Prescriptions	Inpatient Hospital	Outpatient Hospital
Adams	\$13,135,864	\$37,506,986	\$33,055,309	\$42,759,654	\$32,847,067
Alamosa	\$1,867,627	\$1,620,436	\$2,134,850	\$1,696,642	\$1,258,635
Arapahoe	\$5,351,985	\$36,097,624	\$35,141,813	\$42,455,331	\$29,915,687
Archuleta	*	\$520,289	\$372,581	\$759,346	\$527,752
Baca	\$26,110	\$154,738	\$465,204	\$277,228	\$208,330
Bent	\$343,073	\$360,479	\$1,193,950	\$587,414	\$338,992
Boulder	\$5,133,034	\$10,806,195	\$12,561,666	\$12,993,531	\$8,829,156
Broomfield	\$379,154	\$1,633,073	\$2,150,083	\$1,872,634	\$1,559,957
Chaffee	\$12,147	\$869,123	\$1,096,270	\$963,477	\$769,588
Cheyenne	\$8,589	\$57,080	\$167,104	*	\$89,264
Clear Creek	\$88,385	\$376,350	\$497,208	\$469,918	\$304,910
Conejos	\$565,335	\$775,013	\$1,142,660	\$916,692	\$978,171
Costilla	\$420,823	\$310,506	\$608,333	\$371,877	\$393,504
Crowley	\$125,132	\$354,688	\$826,255	\$510,965	\$279,980
Custer	*	\$116,793	\$127,379	*	\$121,489
Delta	*	\$689,416	\$627,872	\$706,159	\$650,957
Denver	\$16,422,290	\$34,305,624	\$31,542,843	\$61,950,282	\$30,711,566
Dolores	\$50,121	\$76,169	\$74,233	*	\$77,474
Douglas	\$160,257	\$6,332,724	\$7,182,475	\$5,503,272	\$4,354,217
Eagle	\$181,201	\$1,527,427	\$1,233,537	\$2,532,185	\$1,183,493
Elbert	\$156,720	\$888,983	\$972,112	\$1,220,358	\$733,640
El Paso	\$19,069,987	\$38,749,611	\$46,433,056	\$35,082,105	\$31,342,136
Fremont	\$204,033	\$3,093,829	\$5,328,145	\$3,151,023	\$2,506,396
Garfield	\$1,406,730	\$2,337,008	\$2,622,637	\$3,833,451	\$3,170,662
Gilpin	\$84,903	\$289,364	\$383,608	*	\$171,010
Grand	*	\$442,607	\$714,042	\$487,169	\$636,630
Gunnison	*	\$546,697	\$270,751	\$829,149	\$422,797
Hinsdale	*	\$10,374	*	*	*
Huerfano	\$81,308	\$649,666	\$1,518,725	\$521,060	\$608,652
Jackson	*	\$60,978	\$101,722	*	\$83,269
Jefferson	\$3,624,947	\$25,458,789	\$29,944,175	\$25,047,172	\$20,047,820
Kiowa	\$26,071	\$40,403	\$199,389	*	\$96,534
Kit Carson	\$70,265	\$339,046	\$483,908	\$547,579	\$556,723
Lake	*	\$542,355	\$577,831	\$684,996	\$546,983
La Plata	\$22,421	\$2,634,531	\$2,154,716	\$2,693,531	\$1,813,705

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B2b: FY 2011-12 Expenditures for Selected Acute Care Service Categories by County					
County	FQHCs	Physician and EPSDT	Pharmacy Prescriptions	Inpatient Hospital	Outpatient Hospital
Larimer	\$3,795,876	\$14,779,530	\$18,924,097	\$14,684,287	\$11,318,150
Las Animas	\$54,770	\$1,343,924	\$1,981,457	\$1,605,756	\$1,551,985
Lincoln	\$197,439	\$255,387	\$430,113	\$298,589	\$309,222
Logan	\$580,416	\$947,177	\$1,981,109	\$1,655,478	\$1,137,469
Mesa	\$16,666	\$2,817,438	\$1,906,733	\$3,670,507	\$2,839,795
Mineral	*	\$21,068	*	*	*
Moffat	\$232,717	\$861,058	\$926,472	\$1,023,612	\$1,255,348
Montezuma	\$123,032	\$1,685,256	\$2,435,859	\$2,264,260	\$1,771,407
Montrose	\$47,740	\$827,923	\$524,354	\$1,134,533	\$814,446
Morgan	\$934,559	\$1,901,574	\$2,476,709	\$2,657,247	\$2,339,576
Otero	\$1,074,473	\$1,824,893	\$3,345,363	\$2,589,678	\$1,570,633
Ouray	*	\$43,879	\$78,685	*	\$25,613
Park	\$36,708	\$607,709	\$864,033	\$712,706	\$507,166
Phillips	\$45,031	\$130,379	\$275,854	\$242,139	\$255,160
Pitkin	\$82,571	\$100,213	\$118,526	\$174,032	\$145,184
Prowers	\$920,061	\$795,919	\$1,797,534	\$1,606,526	\$1,242,638
Pueblo	\$6,821,946	\$19,549,258	\$28,044,261	\$17,543,178	\$16,228,713
Rio Blanco	*	\$122,416	\$255,079	\$131,905	\$345,617
Rio Grande	\$1,030,049	\$1,036,409	\$1,573,970	\$1,239,176	\$968,989
Routt	\$26,561	\$725,899	\$1,064,086	\$682,589	\$701,720
Saguache	\$631,907	\$469,851	\$621,858	\$786,346	\$424,587
San Juan	*	\$30,430	*	*	*
San Miguel	\$76,112	\$97,517	\$133,573	*	\$76,845
Sedgwick	\$15,935	\$81,049	\$293,395	*	\$174,813
Summit	*	\$998,906	\$881,030	\$1,408,641	\$453,866
Teller	\$642,537	\$869,246	\$1,703,926	\$908,580	\$841,700
Washington	\$36,985	\$153,542	\$304,531	\$409,845	\$227,434
Weld	\$8,333,836	\$17,970,446	\$20,423,733	\$20,353,480	\$14,857,023
Yuma	\$61,528	\$550,824	\$966,066	\$935,031	\$1,033,713
Suppressed Counties	\$68,430	\$0	\$138,678	\$1,196,313	\$70,498
STATEWIDE	\$94,906,395	\$282,174,095	\$318,377,525	\$331,338,635	\$241,626,458

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

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B2c: FY 2011-12 Average Cost Per Client for Selected Acute Care Service Categories by County						
County	FQHCs	Physician and EPSDT	Pharmacy Prescriptions	Inpatient Hospital	Outpatient Hospital	
Adams	\$548	\$651	\$746	\$7,016	\$984	
Alamosa	\$643	\$554	\$748	\$5,438	\$700	
Arapahoe	\$509	\$644	\$842	\$7,394	\$961	
Archuleta	\$605	\$524	\$421	\$7,828	\$857	
Baca	\$373	\$425	\$1,227	\$5,776	\$840	
Bent	\$541	\$496	\$1,432	\$7,531	\$637	
Boulder	\$527	\$634	\$913	\$6,963	\$879	
Broomfield	\$508	\$641	\$1,099	\$7,258	\$1,113	
Chaffee	\$289	\$691	\$977	\$7,411	\$1,044	
Cheyenne	\$260	\$405	\$1,044	\$8,451	\$819	
Clear Creek	\$517	\$715	\$1,090	\$9,037	\$1,239	
Conejos	\$523	\$534	\$708	\$5,489	\$1,027	
Costilla	\$639	\$572	\$976	\$6,641	\$1,124	
Crowley	\$434	\$554	\$1,217	\$7,742	\$662	
Custer	\$459	\$454	\$516	\$7,638	\$988	
Delta	\$444	\$332	\$472	\$5,117	\$695	
Denver	\$536	\$640	\$775	\$9,200	\$1,003	
Dolores	\$473	\$414	\$461	\$3,080	\$783	
Douglas	\$407	\$707	\$1,040	\$6,407	\$1,037	
Eagle	\$602	\$514	\$678	\$7,113	\$1,071	
Elbert	\$432	\$829	\$985	\$9,685	\$1,265	
El Paso	\$615	\$675	\$935	\$5,994	\$842	
Fremont	\$440	\$611	\$1,062	\$6,956	\$752	
Garfield	\$567	\$480	\$636	\$6,378	\$1,054	
Gilpin	\$491	\$919	\$1,400	\$8,686	\$1,082	
Grand	\$470	\$563	\$1,206	\$6,410	\$1,711	
Gunnison	\$410	\$557	\$423	\$9,422	\$933	
Hinsdale	*	\$296	\$1,170	\$3,648	\$488	
Huerfano	\$957	\$589	\$1,548	\$5,317	\$874	
Jackson	\$160	\$629	\$1,197	\$10,826	\$1,665	
Jefferson	\$532	\$713	\$1,064	\$7,371	\$1,062	
Kiowa	\$474	\$400	\$1,338	\$4,146	\$1,270	
Kit Carson	\$338	\$449	\$685	\$6,442	\$1,218	
Lake	\$217	\$524	\$783	\$7,210	\$963	
La Plata	\$335	\$619	\$698	\$7,524	\$813	

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B2c: FY 2011-12 Average Cost Per Client for Selected Acute Care Service Categories by County						
County	FQHCs	Physician and EPSDT	Pharmacy Prescriptions	Inpatient Hospital	Outpatient Hospital	
Larimer	\$469	\$620	\$980	\$6,681	\$896	
Las Animas	\$498	\$622	\$945	\$7,989	\$965	
Lincoln	\$509	\$556	\$865	\$5,972	\$1,089	
Logan	\$603	\$484	\$970	\$7,136	\$794	
Mesa	\$282	\$355	\$388	\$7,894	\$883	
Mineral	\$492	\$448	\$1,599	\$2,787	\$1,420	
Moffat	\$444	\$542	\$696	\$7,417	\$1,386	
Montezuma	\$326	\$494	\$810	\$7,098	\$842	
Montrose	\$320	\$324	\$337	\$6,200	\$762	
Morgan	\$556	\$520	\$763	\$6,282	\$1,008	
Otero	\$514	\$490	\$990	\$6,726	\$648	
Ouray	\$294	\$254	\$855	\$4,907	\$493	
Park	\$510	\$618	\$1,112	\$7,919	\$1,367	
Phillips	\$450	\$390	\$779	\$6,372	\$905	
Pitkin	\$645	\$434	\$611	\$4,834	\$1,190	
Prowers	\$519	\$363	\$776	\$7,172	\$818	
Pueblo	\$700	\$679	\$1,117	\$6,839	\$896	
Rio Blanco	\$316	\$327	\$669	\$4,122	\$1,304	
Rio Grande	\$592	\$517	\$785	\$6,698	\$775	
Routt	\$422	\$529	\$1,081	\$7,037	\$1,183	
Saguache	\$614	\$522	\$712	\$7,561	\$753	
San Juan	\$209	\$350	\$1,576	\$4,027	\$831	
San Miguel	\$435	\$382	\$738	\$4,680	\$998	
Sedgwick	\$362	\$328	\$1,128	\$4,893	\$1,010	
Summit	\$454	\$655	\$979	\$7,914	\$926	
Teller	\$561	\$526	\$1,109	\$6,584	\$721	
Washington	\$420	\$440	\$883	\$12,054	\$1,104	
Weld	\$540	\$610	\$857	\$6,737	\$900	
Yuma	\$364	\$466	\$986	\$7,248	\$1,518	
STATEWIDE	\$568	\$650	\$909	\$7,265	\$959	

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

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B3a: FY 2011-12 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	HCBS Waivers Administered by HCPF	HCBS Waivers Administered by DHS	Program of All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and II)
Adams	1,888	789	433	1,127	1,238
Alamosa	422	56	0	160	117
Arapahoe	2,772	1,094	441	1,155	1,267
Archuleta	106	*	0	*	57
Baca	81	*	0	*	77
Bent	94	*	0	42	53
Boulder	1,279	472	*	543	688
Broomfield	208	76	*	82	160
Chaffee	131	46	0	59	74
Cheyenne	*	*	0	*	*
Clear Creek	73	*	*	*	0
Conejos	198	*	0	68	62
Costilla	178	*	0	57	*
Crowley	112	*	0	*	41
Custer	*	0	0	*	*
Delta	308	59	119	131	130
Denver	4,323	778	817	1,528	1,966
Dolores	*	0	0	*	*
Douglas	582	187	*	217	194
Eagle	51	*	0	*	*
Elbert	55	*	*	*	*
El Paso	2,760	943	176	1,629	1,460
Fremont	580	111	0	178	395
Garfield	331	106	0	34	206
Gilpin	50	*	0	*	0
Grand	60	*	0	*	*
Gunnison	60	*	0	*	41
Hinsdale	*	0	0	*	0
Huerfano	161	37	0	38	80
Jackson	*	0	0		*
Jefferson	2,303	976	176	988	1,607
Kiowa	*	0	0	*	*
Kit Carson	51	*	0	*	34
Lake	*	*	0	*	*
La Plata	371	59	0	93	108

FY 2013-14 BUDGET REQUEST: DEPARTMENT DESCRIPTION

B3a: FY 2011-12 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	HCBS Waivers Administered by HCPF	HCBS Waivers Administered by DHS	Program of All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and II)
Larimer	1,523	497	*	776	919
Las Animas	538	69	0	43	121
Lincoln	71	*	0	*	*
Logan	221	88	0	40	113
Mesa	1,639	406	*	324	511
Mineral	*	*	0	0	*
Moffat	96	31	0	*	51
Montezuma	424	36	0	136	175
Montrose	338	117	157	120	173
Morgan	298	53	*	82	213
Otero	437	82	0	152	192
Ouray	*	*	0	*	*
Park	47	*	0	*	*
Phillips	43	*	0	*	38
Pitkin	36	0	0	*	*
Prowers	218	47	0	49	97
Pueblo	1,971	586	155	1,187	782
Rio Blanco	53	*	0	*	41
Rio Grande	195	*	0	88	129
Routt	53	35	0	*	46
Saguache	155	*	0	57	*
San Juan	*	0	0	*	*
San Miguel	*	*	0	*	*
Sedgwick	35	*	0	0	*
Summit	35	*	*	*	*
Teller	133	*	0	52	52
Washington	39	*	*	*	41
Weld	1,501	391	*	779	652
Yuma	167	*	0	*	89
Suppressed Counties	150	244	*	339	176
STATEWIDE	30,004	8,471	2,489	12,353	14,666

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

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B3b: FY 2011-12 Expenditures for Selected Long-Term Care Categories by County					
County	HCBS Waivers Administered by HCPF	HCBS Waivers Administered by DHS	Program of All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and II)
Adams	\$15,372,414	\$28,550,819	\$13,185,866	\$15,197,416	\$44,776,585
Alamosa	\$2,294,041	\$2,569,939	\$0	\$358,990	\$3,744,529
Arapahoe	\$27,611,404	\$44,327,228	\$12,821,396	\$17,791,045	\$48,041,457
Archuleta	\$980,079	*	\$0	*	\$1,894,264
Baca	\$212,411	*	\$0	*	\$3,025,000
Bent	\$368,286	*	\$0	\$214,072	\$1,760,711
Boulder	\$10,020,929	\$18,103,700	*	\$6,507,721	\$24,345,568
Broomfield	\$1,823,972	\$2,503,571	*	\$1,240,223	\$4,778,364
Chaffee	\$578,235	\$1,539,830	\$0	\$447,987	\$2,103,175
Cheyenne	*	*	\$0	*	*
Clear Creek	\$368,042	*	*	*	\$0
Conejos	\$1,236,248	*	\$0	\$142,995	\$2,761,906
Costilla	\$1,201,425	*	\$0	\$152,279	\$33,742
Crowley	\$508,849	*	\$0	*	\$1,113,966
Custer	*	\$0	\$0	*	*
Delta	\$2,550,423	\$1,783,318	\$3,777,772	\$1,172,596	\$4,121,606
Denver	\$49,154,356	\$23,529,789	\$25,741,178	\$17,843,672	\$74,121,037
Dolores	*	\$0	\$0	*	*
Douglas	\$5,542,229	\$5,387,567	*	\$4,019,606	\$7,501,511
Eagle	\$392,981	*	\$0	*	*
Elbert	\$442,460	*	*	*	*
El Paso	\$28,542,015	\$33,583,501	\$5,356,278	\$37,764,844	\$53,879,410
Fremont	\$4,465,310	\$4,851,800	\$0	\$1,917,363	\$13,120,809
Garfield	\$1,797,937	\$5,015,977	\$0	\$183,095	\$8,440,932
Gilpin	\$294,313	*	\$0	*	\$0
Grand	\$412,371	*	\$0	*	*
Gunnison	\$514,296	*	\$0	*	\$1,658,161
Hinsdale	*	\$0	\$0	*	
Huerfano	\$1,449,802	\$1,182,705	\$0	\$96,110	\$2,447,752
Jackson	*	\$0	\$0	\$0	*
Jefferson	\$22,384,672	\$35,905,438	\$15,031,819	\$16,723,152	\$63,561,834
Kiowa	\$82,349	\$0	\$0	*	*
Kit Carson	\$384,258	*	\$0	*	\$1,026,145
Lake	*	*	\$0	*	*
La Plata	\$3,177,935	\$2,061,220	\$0	\$680,402	\$3,598,144

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B3b: FY 2011-12 Expenditures for Selected Long-Term Care Categories by County					
County	HCBS Waivers Administered by HCPF	HCBS Waivers Administered by DHS	Program of All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and II)
Larimer	\$8,792,935	\$20,638,372	*	\$7,734,491	\$30,918,598
Las Animas	\$6,721,239	\$2,081,817	\$0	\$219,714	\$4,846,606
Lincoln	\$502,445	*	\$0	*	*
Logan	\$1,448,113	\$3,924,617	\$0	\$407,809	\$3,176,954
Mesa	\$18,654,377	\$27,958,958	*	\$2,902,481	\$16,692,932
Mineral	*	*	\$0		*
Moffat	\$441,373	\$1,446,889	\$0	*	\$1,730,546
Montezuma	\$3,956,357	\$1,119,449	\$0	\$1,170,166	\$5,081,170
Montrose	\$2,285,649	\$4,296,717	\$5,117,834	\$1,761,419	\$6,227,225
Morgan	\$1,810,580	\$1,738,693	*	\$226,446	\$7,103,966
Otero	\$2,051,900	\$3,825,093	\$0	\$1,888,184	\$5,856,125
Ouray	*	*	\$0	*	*
Park	\$258,180	*	\$0	*	*
Phillips	\$255,606	*	\$0	*	\$1,116,725
Pitkin	\$525,160	\$0	\$0	*	*
Prowers	\$916,875	\$1,673,670	\$0	\$163,182	\$3,546,768
Pueblo	\$14,980,543	\$32,513,767	\$4,069,538	\$17,752,330	\$24,891,800
Rio Blanco	\$212,122	*	\$0	*	\$1,517,130
Rio Grande	\$984,328	*	\$0	\$265,567	\$4,259,317
Routt	\$176,169	\$1,419,549	\$0	*	\$2,360,355
Saguache	\$884,799	*	\$0	\$115,094	*
San Juan	*	\$0	\$0	*	*
San Miguel	*	*	\$0	*	*
Sedgwick	\$254,692	*	\$0		*
Summit	\$254,441	*	*	*	*
Teller	\$1,105,185	*	\$0	\$820,797	\$1,311,021
Washington	\$115,084	*	*	*	\$1,076,613
Weld	\$12,026,235	\$15,199,613	*	\$8,171,569	\$21,636,596
Yuma	\$931,709	\$176,540	\$0	*	\$2,533,005
Suppressed Counties	\$843,196	\$6,513,447	\$261,082	\$1,697,392	\$5,282,857
STATEWIDE	\$265,553,329	\$335,423,591	\$85,366,242	\$167,779,141	\$523,022,914

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

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B3c: FY 2011-12 Average Cost Per Client for Selected Long-Term Care Categories by County					
County	HCBS Waivers Administered by HCPF	HCBS Waivers Administered by DHS	Program of All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and II)
Adams	\$8,142	\$36,186	\$30,452	\$13,485	\$36,168
Alamosa	\$5,436	\$45,892	\$0	\$2,244	\$32,005
Arapahoe	\$9,961	\$40,518	\$29,073	\$15,404	\$37,917
Archuleta	\$9,246	\$15,204	\$0	\$5,811	\$33,233
Baca	\$2,622	\$17,890	\$0	\$23,115	\$39,286
Bent	\$3,918	\$40,378	\$0	\$5,097	\$33,221
Boulder	\$7,835	\$38,355	\$19,136	\$11,985	\$35,386
Broomfield	\$8,769	\$32,942	\$22,615	\$15,125	\$29,865
Chaffee	\$4,414	\$33,475	\$0	\$7,593	\$28,421
Cheyenne	\$1,623	\$5,013	\$0	\$3,025	\$41,317
Clear Creek	\$5,042	\$12,752	\$6,958	\$8,606	\$0
Conejos	\$6,244	\$12,308	\$0	\$2,103	\$44,547
Costilla	\$6,750	\$13,744	\$0	\$2,672	\$6,748
Crowley	\$4,543	\$26,863	\$0	\$4,950	\$27,170
Custer	\$6,254	\$0	\$0	\$7,290	\$3,065
Delta	\$8,281	\$30,226	\$31,746	\$8,951	\$31,705
Denver	\$11,370	\$30,244	\$31,507	\$11,678	\$37,701
Dolores	\$16,921	\$0	\$0	\$3,042	\$54,029
Douglas	\$9,523	\$28,811	\$19,136	\$18,524	\$38,668
Eagle	\$7,706	\$20,914	\$0	\$1,400	\$15,871
Elbert	\$8,045	\$15,416	\$3,479	\$15,210	\$37,722
El Paso	\$10,341	\$35,613	\$30,433	\$23,183	\$36,904
Fremont	\$7,699	\$43,710	\$0	\$10,772	\$33,217
Garfield	\$5,432	\$47,321	\$0	\$5,385	\$40,975
Gilpin	\$5,886	\$11,354	\$0	\$7,122	\$0
Grand	\$6,873	\$13,980	\$0	\$2,034	\$25,506
Gunnison	\$8,572	\$25,760	\$0	\$3,129	\$40,443
Hinsdale	\$1,431	\$0	\$0	\$960	\$0
Huerfano	\$9,005	\$31,965	\$0	\$2,529	\$30,597
Jackson	\$530	\$0	\$0	\$0	\$10,911
Jefferson	\$9,720	\$36,788	\$85,408	\$16,926	\$39,553
Kiowa	\$3,580	\$0	\$0	\$2,638	\$27,750
Kit Carson	\$7,534	\$39,771	\$0	\$649	\$30,181
Lake	\$3,751	\$7,726	\$0	\$2,853	\$32,711
La Plata	\$8,566	\$34,936	\$0	\$7,316	\$33,316

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B3c: FY 2011-12 Average Cost Per Client for Selected Long-Term Care Categories by County					
County	HCBS Waivers Administered by HCPF	HCBS Waivers Administered by DHS	Program of All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and II)
Larimer	\$5,773	\$41,526	\$3,479	\$9,967	\$33,644
Las Animas	\$12,493	\$30,171	\$0	\$5,110	\$40,055
Lincoln	\$7,077	\$45,029	\$0	\$11,787	\$41,199
Logan	\$6,553	\$44,598	\$0	\$10,195	\$28,115
Mesa	\$11,382	\$68,864	\$41,751	\$8,958	\$32,667
Mineral	\$383	\$13,776	\$0	\$0	\$36,804
Moffat	\$4,598	\$46,674	\$0	\$3,599	\$33,932
Montezuma	\$9,331	\$31,096	\$0	\$8,604	\$29,035
Montrose	\$6,762	\$36,724	\$32,598	\$14,678	\$35,996
Morgan	\$6,076	\$32,806	\$11,772	\$2,762	\$33,352
Otero	\$4,695	\$46,647	\$0	\$12,422	\$30,501
Ouray	\$8,495	\$10,469	\$0	\$11,870	\$28,602
Park	\$5,493	\$39,782	\$0	\$9,488	\$0
Phillips	\$5,944	\$11,515	\$0	\$16,074	\$29,387
Pitkin	\$14,588	\$0	\$0	\$243	\$8,765
Prowers	\$4,206	\$35,610	\$0	\$3,330	\$36,565
Pueblo	\$7,600	\$55,484	\$26,255	\$14,956	\$31,831
Rio Blanco	\$4,002	\$6,150	\$0	\$1,224	\$37,003
Rio Grande	\$5,048	\$42,346	\$0	\$3,018	\$33,018
Routt	\$3,324	\$40,559	\$0	\$2,125	\$51,312
Saguache	\$5,708	\$53,702	\$0	\$2,019	\$10,422
San Juan	\$1,624	\$0	\$0	\$187	\$3,264
San Miguel	\$12,655	\$5,946	\$0	\$7,933	\$18,635
Sedgwick	\$7,277	\$52,131	\$0	\$0	\$28,511
Summit	\$7,270	\$31,960	\$9,244	\$2,231	\$24,346
Teller	\$8,310	\$20,968	\$0	\$15,785	\$25,212
Washington	\$2,951	\$40,162	\$13,917	\$1,321	\$26,259
Weld	\$8,012	\$38,874	\$26,094	\$10,490	\$33,185
Yuma	\$5,579	\$17,654	\$0	\$1,702	\$28,461
STATEWIDE	\$6,793	\$31,005	\$25,003	\$7,621	\$30,936

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

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B3d: HCBS Waiver Programs Administered by the Department of Health Care Policy and Financing (HCPF)								
Fiscal Year	Elderly Blind and Disabled; and Consumer Directed Care for the Elderly*	Children's Home and Community-Based Services	Persons with Brain Injury	Persons with Mental Illness	Persons Living with AIDS	Children with Autism	Pediatric Hospice	Total HCPF
FY 2006-07	17,019	1,254	306	2,160	62	17	0	20,553
FY 2007-08	17,627	1,360	264	2,312	71	73	0	21,522
FY 2008-09	18,618	1,334	264	2,489	71	89	42	22,756
FY 2009-10	19,848	1,314	253	2,641	67	113	84	24,163
FY 2010-11	20,890	1,285	249	2,786	60	108	120	25,118
FY 2011-12	22,385	1,179	255	2,966	57	99	151	26,901

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

B3e: HCBS Waiver Programs Administered by Department of Human Services (DHS)					
Fiscal Year	Children's Habilitation Residential Program	Supported Living Services	Developmentally Disabled	Children's Extensive Support	Total DHS
FY 2006-07	165	2,982	4,112	381	7,521
FY 2007-08	149	3,057	4,207	430	7,692
FY 2008-09	156	3,285	4,379	423	8,053
FY 2009-10	165	3,270	4,482	431	8,223
FY 2010-11	150	3,235	4,395	422	8,114
FY 2011-12	120	3,307	4,371	399	8,136

Unduplicated client counts represent the number of unique clients who received a service in each category only.

B3f: Long-Term Care Programs Administered by Department of Health Care Policy and Financing					
Fiscal Year	Home Health	Program for All-Inclusive Care for the Elderly	Class I Nursing Facilities	Class II Nursing Facilities	Total Nursing Facilities (Classes I and II)
FY 2006-07	10,161	1,376	14,045	21	14,066
FY 2007-08	10,272	1,501	13,886	21	13,907
FY 2008-09	10,902	1,794	13,614	22	13,636
FY 2009-10	10,982	2,013	13,583	38	13,621
FY 2010-11	11,859	2,214	13,650	35	13,685
FY 2011-12	12,079	2,665	13,939	20	13,959

Source: Medicaid paid claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months (FY 2003-06) one and one-half months (FY 2006-07) after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Totals are not the sum of categories.

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B4a: FY 2011-12 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date			
County Name	Unique Deliveries	Total Payments	Average Payment
Adams	3,314	\$23,004,105	\$7,024
Alamosa	157	\$1,189,299	\$7,575
Arapahoe	2,948	\$21,273,608	\$7,303
Archuleta	70	\$466,847	\$6,669
Baca	*	*	\$6,818
Bent	36	\$265,480	\$7,374
Boulder	994	\$6,827,053	\$6,889
Broomfield	119	\$843,898	\$7,092
Chaffee	66	\$479,088	\$7,259
Cheyenne	*	*	\$8,589
Clear Creek	33	\$256,153	\$8,005
Conejos	81	\$632,188	\$7,805
Costilla	*	*	\$8,830
Crowley	*	*	\$7,276
Custer	*	*	\$6,703
Delta	63	\$306,865	\$4,871
Denver	3,920	\$25,309,125	\$7,495
Dolores	*	*	\$6,502
Douglas	389	\$2,720,235	\$7,011
Eagle	285	\$2,010,410	\$7,104
Elbert	47	\$334,483	\$7,117
El Paso	2,989	\$22,083,493	\$7,391
Fremont	219	\$1,663,850	\$7,597
Garfield	376	\$2,685,339	\$7,142
Gilpin	*	*	\$6,075
Grand	41	\$273,418	\$6,669
Gunnison	60	\$398,505	\$6,642
Hinsdale	*	*	\$5,898
Huerfano	45	\$373,099	\$8,291
Jackson	*	*	\$8,340
Jefferson	1,666	\$11,946,418	\$7,316
Kiowa	*	*	\$6,826
Kit Carson	48	\$403,295	\$8,402
Lake	46	\$293,703	\$6,385
La Plata	200	\$1,371,290	\$6,891

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B4a: FY 2011-12 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date			
County Name	Unique Deliveries	Total Payments	Average Payment
Larimer	1,174	\$7,469,752	\$6,363
Las Animas	92	\$692,123	\$7,523
Lincoln	*	*	\$7,238
Logan	122	\$1,147,918	\$9,409
Mesa	385	\$1,298,272	\$3,372
Mineral	*	*	\$5,155
Moffat	76	\$612,997	\$8,066
Montezuma	165	\$1,276,397	\$7,736
Montrose	98	\$453,328	\$4,626
Morgan	245	\$1,887,747	\$7,705
Otero	171	\$1,194,583	\$6,986
Ouray	*	*	\$5,104
Park	43	\$342,065	\$7,955
Phillips	35	\$244,688	\$6,991
Pitkin	30	\$165,541	\$5,518
Prowers	134	\$1,055,305	\$7,875
Pueblo	1,156	\$9,314,393	\$8,057
Rio Blanco	*	*	\$5,809
Rio Grande	82	\$629,529	\$7,677
Routt	62	\$439,103	\$7,082
Saguache	60	\$512,212	\$8,537
San Juan	*	*	\$9,471
San Miguel	*	*	\$5,316
Sedgwick	*	*	\$6,964
Summit	127	\$756,044	\$5,953
Teller	56	\$416,391	\$7,436
Washington	*	*	\$8,819
Weld	1,582	\$11,531,018	\$7,289
Yuma	75	\$460,127	\$6,135
Suppressed Counties	276	\$1,907,001	\$6,909
STATEWIDE	24,458	\$173,294,077	\$7,085
Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. *Denotes county included in "Suppressed Counties" category.			

B4b: FY 2011-12 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Delivery Type			
Vaginal or C-Section	Unique Deliveries	Total Payments	Average Payment
Caesarian	5,292	\$50,208,037	\$9,488
Vaginal	17,645	\$118,149,244	\$6,696
Unknown/No Delivery Information	1,521	\$4,936,797	\$3,246
Total	24,458	\$173,294,077	\$7,085

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

B4c: FY 2011-12 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Age on Delivery Date			
Age Group	Unique Deliveries	Total Payments	Average Payment
<=14	*	*	\$6,353
15-19	3,399	\$22,998,150	\$6,766
20	1,643	\$11,476,881	\$6,985
21-24	6,450	\$46,714,778	\$7,243
25-34	10,570	\$75,019,095	\$7,097
35+	2,357	\$16,848,884	\$7,148
Unknown	*	*	\$5,310
Total	24,458	\$173,294,077	\$7,085

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

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B4d: FY 2011-12 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's Eligibility Type on Delivery Date			
Eligibility Type	Unique Deliveries	Total Payments	Average Payment
Disabled Individuals to 59	281	\$3,448,999	\$12,274
Low-Income and Expansion Adults	9,001	\$70,763,237	\$7,862
Eligible Children	1,648	\$11,528,079	\$14,051
Foster Care	115	\$1,138,778	\$9,902
Baby Care Adults	8,435	\$61,302,396	\$14,662
Non-Citizens	4,964	\$25,055,507	\$5,047
Other Medicaid Eligibility Types	14	\$57,081	\$4,077
Total Medicaid	24,458	\$173,294,077	\$7,085

B4e: FY 2011-12 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit (NICU) Claims by Severity of Condition and Needy Newborn Status							
	Most Severe Classification*	Unique Clients	Unique Clients: Not Needy Newborn	Unique Clients: Needy Newborn	Total LBW / Preterm / NICU Payments	Payments: Not Needy Newborn	Payments: Needy Newborn
Low Birthweight Infants							
	Extremely Low BW (<1000 grams)	320	150	170	\$8,414,938	\$1,889,297	\$6,525,642
	Very Low BW (1000 - 1499 grams)	337	73	264	\$6,064,485	\$508,021	\$5,556,464
	Low BW (1500-2499 grams)	2,480	583	1,897	\$8,915,475	\$713,773	\$8,201,702
	All LBW Clients	3,137	806	2,331	\$23,394,899	\$3,111,090	\$20,283,809
Preterm Infants Not Classified as Low Birthweight							
	Very Preterm (<32 weeks gestation)	452	186	266	\$3,264,259	\$788,456	\$2,475,803
	Moderately Preterm (32 to 36 weeks gestation)	588	92	496	\$1,438,760	\$148,551	\$1,290,208
	All Preterm Infants not identified via LBW	1,040	278	762	\$4,703,019	\$937,007	\$3,766,011
Infants Treated in the NICU Not Due to LBW or Preterm							
	NICU - Other, Including Normal Birthweight	1,169	87	1,082	\$3,704,042	\$214,366	\$3,489,676
	TOTAL	5,346	1,171	4,175	\$31,801,960	\$4,262,464	\$27,539,496
<p>*Individuals assigned to classifications according to the most severe diagnosis code associated with his or her claims during the fiscal year. Source: Medicaid paid claims from MMIS-DSS. Notes: Data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent clients who received a service in each category only. Needy Newborns are infants born to mothers who had Medicaid eligibility at the time of the infant's birth. Needy Newborns are identified via Program Aid Code H2.</p>							

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B4f: FY 2011-12 Clients and Costs Associated with Neonatal Intensive Care Unit Claims		
DRG Description	Unique Clients with DRG*	NICU Payments
Neonates, Died or Transferred to Another	NR	\$86,391
Full-Term Neonate with Major Problems	682	\$3,253,256
Neonate with Other Significant Problems	1,217	\$2,612,038
Neonates < 1,000 grams	75	\$5,154,976
Neonates 1,000-1,499 grams	163	\$4,418,987
Neonates 1500-1,999 grams	345	\$4,248,044
Neonates > 2,000 grams with RDS	167	\$2,433,146
Neonates > 2,000 grams, Premature with Major Problems	281	\$1,779,902
Neonate, Low Birthweight Diagnosis, Over 28 Days	NR	\$164,404
TOTAL NICU Payments		\$24,151,144

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

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B5a: FY 2011-12 Top 10 Major Diagnostic Categories (Inpatient) Ranked by Expenditures					
Rank	MDC	Description	Expenditures	Unduplicated Client Count	Average Cost
1	14	Pregnancy, Childbirth and the Puerperium	\$82,291,762	22,722	\$3,622
2	4	Respiratory System	\$29,316,249	4,695	\$6,244
3	15	Conditions of Newborns	\$24,891,301	3,706	\$6,716
4		Pre-MDC Other	\$24,304,116	285	\$85,278
5	8	Musculoskeletal System and Connective tissue	\$23,653,518	2,201	\$10,747
6	5	Circulatory System	\$20,752,504	1,658	\$12,517
7	6	Digestive System	\$20,751,896	2,973	\$6,980
8	1	Nervous System	\$19,276,874	2,086	\$9,241
9	18	Infectious and Parasitic Diseases	\$15,197,658	1,456	\$10,438
10	11	Kidney and Urinary Tract	\$14,160,596	1,323	\$10,703
		Top Ten Totals	\$274,596,472	43,105	\$6,370

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

B5b: FY 2011-12 Top 10 Inpatient Hospital Diagnosis Related Groups Ranked by Expenditures					
Rank	DRG	Description	Expenditures	Unduplicated Client Count	Average Cost
1	373	Vaginal Delivery without Complicating Diagnoses	\$37,227,588	13,397	\$2,779
2	370	Cesarean Section with Complicating Diagnoses	\$15,009,580	2,137	\$7,024
3	541	Tracheotomy with Mechanical Ventilator with Major Operating Room Procedure	\$12,821,130	138	\$92,907
4	372	Vaginal Delivery with Complicating Diagnoses	\$11,056,240	2,941	\$3,759
5	371	Cesarean Sections without Complicating Diagnoses	\$10,170,819	2,923	\$3,480
6	898	Bronchitis and Asthma, Age <17 with Complicating Diagnoses	\$6,067,597	1,604	\$3,783
7	576	Septicemia without Mechanical Ventilator, 96+ hours, age >17	\$5,420,418	696	\$7,788
8	317	Admit for Renal Dialysis	\$5,406,453	55	\$98,299
9	542	Tracheotomy with Mechanical Ventilator without Major Operating Room Procedure	\$5,274,754	103	\$51,211
10	801	Neonates < 1,000 Grams	\$5,154,976	75	\$68,733
		Top Ten Totals	\$113,609,556	24,069	\$4,720

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

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B5c: FY 2011-12 Top 10 Outpatient Hospital Principal Diagnosis Categories Ranked by Expenditures					
Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count	Average Cost
1	789	Other Symptoms Involving Abdomen and Pelvis	\$14,086,817	20,571	\$685
2	786	Symptoms Involving Respiratory System and Other Chest Symptoms	\$8,933,898	17,115	\$522
3	521	Diseases of Hard Tissues of Teeth	\$8,329,336	5,525	\$1,508
4	780	General Symptoms	\$6,815,393	16,995	\$401
5	V58	Other and Unspecified Aftercare	\$5,613,078	3,816	\$1,471
6	474	Chronic Disease of Tonsils and Adenoids	\$4,258,330	2,724	\$1,563
7	784	Symptoms Involving Head and Neck	\$4,220,403	8,653	\$488
8	787	Symptoms Involving Digestive System	\$4,080,506	12,661	\$322
9	V57	Care Involving Use of Rehabilitation Procedures	\$3,903,030	12,227	\$319
10	585	Chronic Renal Failure	\$3,687,960	384	\$9,604
Top Ten Totals			\$63,928,752	100,671	\$635

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

B5d: FY 2011-12 Top 10 Outpatient Surgical Procedures Ranked by Expenditures					
Rank	Surgical Procedure Code	Description	Expenditures	Unduplicated Client Count	Average Cost
1	96.54	Dental Scaling, Polishing, and Debridement	\$769,352	310	\$2,482
2	28.3	Tonsillectomy with Adenoidectomy	\$764,293	290	\$2,635
3	99.29	Injection or Infusion of Other Therapeutic or Prophylactic Substance	\$555,892	623	\$892
4	23.09	Extraction of Other Tooth	\$551,777	237	\$2,328
5	89.17	Polysomnogram	\$482,255	357	\$1,351
6	23.41	Application of Crown	\$415,348	200	\$2,077
7	23.70	Root Canal, Not Otherwise Specified	\$385,965	156	\$2,474
8	37.23	Combined Right and Left Heart Cardiac Catheterization	\$352,928	35	\$10,084
9	93.54	Application of Splint	\$319,182	1,023	\$312
10	47.01	Laparoscopic Appendectomy	\$299,683	74	\$4,050
Top Ten Totals			\$4,896,674	3,305	\$1,482

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

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B5e: FY 2011-12 Top 10 Federally Qualified Health Center (FQHC) Principal Diagnosis Categories Ranked by Expenditures					
Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count	Average Cost
1	V20	Health Supervision of Infant or Child	\$16,264,177	62,472	\$260
2	V72	Special Investigations and Examinations*	\$14,280,016	46,836	\$305
3	V22	Normal Pregnancy	\$6,963,698	7,963	\$875
4	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	\$3,198,722	15,755	\$203
5	V04	Need For Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	\$1,755,215	11,826	\$148
6	724	Other and Unspecified Disorders of Back	\$1,608,457	5,559	\$289
7	V25	Encounter For Contraceptive Management	\$1,557,999	5,699	\$273
8	250	Diabetes Mellitus	\$1,543,493	3,878	\$398
9	382	Suppurative and Unspecified Otitis Media	\$1,489,810	6,834	\$218
10	780	General Symptoms	\$1,365,306	6,680	\$204
Top Ten Totals			\$50,026,894	173,502	\$288

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.
 *Diagnosis V72 - Special Investigations and Examinations - may include a substantial amount of dental claims.

B5f: FY 2011-12 Top 10 Rural Health Center (RHC) Principal Diagnosis Categories Ranked by Expenditures					
Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count	Average Cost
1	V20	Health Supervision of Infant or Child	\$1,034,093	5,616	\$184
2	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	\$443,582	2,716	\$163
3	V72	Special Investigations and Examinations*	\$372,604	962	\$387
4	382	Suppurative and Unspecified Otitis Media	\$348,257	1,937	\$180
5	462	Acute Pharyngitis	\$259,990	1,902	\$137
6	724	Other and Unspecified Disorders of Back	\$237,934	1,122	\$212
7	789	Other Symptoms Involving Abdomen and Pelvis	\$215,908	1,288	\$168
8	780	General Symptoms	\$210,374	1,459	\$144
9	V22	Normal Pregnancy	\$195,267	449	\$435
10	786	Symptoms Involving Respiratory System and Other Chest Symptoms	\$195,234	1,372	\$142
Top Ten Totals			\$3,513,241	18,823	\$187

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.
 *Diagnosis V72 - Special Investigations and Examinations - may include a substantial amount of dental claims.

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B5g: FY 2011-12 Top 10 Physician and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program Principal Diagnosis Categories, Ranked by Expenditures					
Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count	Average Cost
1	V20	Health Supervision of Infant or Child	\$17,737,263	113,212	\$157
2	315	Specific Delays in Development	\$10,048,656	5,965	\$1,685
3	650	Normal Delivery	\$8,424,846	11,657	\$723
4	367	Disorders of Refraction and Accommodation	\$7,943,280	56,529	\$141
5	V25	Encounter For Contraceptive Management	\$7,375,653	22,809	\$323
6	789	Other Symptoms Involving Abdomen and Pelvis	\$6,984,967	42,553	\$164
7	786	Symptoms Involving Respiratory System and Other Chest Symptoms	\$5,548,741	54,482	\$102
8	780	General Symptoms	\$5,344,007	43,302	\$123
9	784	Symptoms Involving Head and Neck	\$4,411,839	24,651	\$179
10	783	Symptoms Concerning Nutrition, Metabolism, and Development	\$3,681,774	10,417	\$353
Top Ten Totals			\$63,618,371	294,931	\$216

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

B5h: FY 2011-12 Top 10 Dental Procedures Ranked by Expenditures					
Rank	Procedure Code	Procedure Description	Expenditures	Unduplicated Client Count	Average Cost
1	D2930	Prefab Stainless Steel Crown Primary	\$7,210,156	24,252	\$297
2	D8090	Comprehensive Ortho Adult Dentition	\$6,137,243	2,095	\$2,929
3	D1120	Prophylaxis Child	\$5,860,170	153,032	\$38
4	D7140	Extraction Erupted Tooth/Exposed Root	\$4,180,383	30,712	\$136
5	D8080	Comprehensive Ortho Adolescent Dentition	\$3,879,493	1,465	\$2,648
6	D0120	Periodic Oral Evaluation	\$3,868,640	139,151	\$28
7	D2391	Resin Based Comp One Surface Posterior	\$3,553,932	31,985	\$111
8	D2392	Resin Based Comp Two Surfaces Posterior	\$3,373,961	24,153	\$140
9	D2150	Amalgam Two Surfaces Permanent	\$3,275,506	23,473	\$140
10	D7210	Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap	\$3,154,940	13,047	\$242
Top Ten Totals			\$44,494,423	443,365	\$100

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

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B5i: FY 2011-12 Top 10 Laboratory Procedures Ranked by Expenditures					
Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count	Average Cost
1	87491	Chlamydia Tracholmatis, DNA, Amplified Probe Technique	\$2,591,344	43,771	\$59
2	87591	Nisseria Gonorrhoea, DNA, Amplified Probe Technique	\$2,553,027	43,299	\$59
3	80101	Drug Screen, Single	\$1,900,936	9,932	\$191
4	85025	Complete Blood Count with Automated White Blood Cells Differential	\$1,489,179	89,248	\$17
5	80053	Comprehensive Metabolic Panel	\$1,437,014	64,675	\$22
6	84443	Thyroid Stimulus Hormone	\$1,187,061	44,677	\$27
7	83914	Mutation Identification by Enzymatic Ligation or Primer Extension	\$973,599	2,893	\$337
8	80050	General Health Panel	\$958,908	20,592	\$47
9	83901	Molecular Diagnostics; Amplification	\$832,408	2,891	\$288
10	87086	Urine Culture/Colony Count	\$771,758	52,609	\$15
Top Ten Totals			\$14,695,235	374,587	\$39

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

B5j: FY 2011-12 Top 10 Durable Medical Equipment and Supplies Procedures Ranked by Expenditures					
Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count	Average Cost
1	E1390	Oxygen Concentrator	\$13,336,632	13,196	\$1,011
2	E0442	Stationary Oxygen, Liquid	\$4,889,112	4,430	\$1,104
3	B4160	Enteral Formula for Pediatrics, Calorie Dense	\$4,024,481	1,362	\$2,955
4	B4161	Enteral Formula for Pediatrics, Hydrolyzed/Amino Acid	\$2,412,288	529	\$4,560
5	T4527	Adult Disposable Diaper, Large	\$2,214,788	3,180	\$696
6	B4035	Enteral Feed Supplement, Pump, per day	\$2,106,637	1,157	\$1,821
7	T4526	Adult Disposable Diaper, Medium	\$1,867,536	3,334	\$560
8	A4554	Disposable Underpads	\$1,842,403	7,217	\$255
9	T4535	Disposable Liner/Shield/Pad	\$1,708,673	5,075	\$337
10	E0441	Stationary Oxygen, Gas	\$1,613,984	1,812	\$891
Top Ten Totals			\$36,016,534	41,292	\$872

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

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B5k: FY 2011-12 Top 10 Prescription Drugs Ranked by Expenditures					
Rank	Drug Name	Therapeutic Class	Expenditures	Unduplicated Client Count	Average Cost
1	Abilify	Antipsychotics	\$18,401,495	5,597	\$3,288
2	Seroquel	Antipsychotics	\$14,251,278	5,059	\$2,817
3	Singulair	Leukotrene Receptor Antagonist	\$7,126,255	12,110	\$588
4	Synagis	Monoclonal Antibody (prevention/treatment of respiratory virus in infants)	\$6,386,937	607	\$10,522
5	Aciphex	Proton Pump Inhibitors	\$6,114,723	5,001	\$1,223
6	Norditropin	Anabolic Steroid	\$5,856,715	296	\$19,786
7	Advair	Beta-Adrenergics and Glucocort	\$5,447,010	6,743	\$808
8	Olanzapine	Antipsychotics	\$5,229,786	1,688	\$3,098
9	Oxycontin	Analgesics	\$4,878,634	1,179	\$4,138
10	Oxycodone	Analgesics	\$4,582,797	44,146	\$104
		Top Ten Total	\$78,275,629	82,426	\$950

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

B5l: FY 2011-12 Top 10 Prescription Drugs Ranked by Number of Prescriptions Filled					
Rank	Drug Name	Therapeutic Class	Total Prescriptions Filled	Expenditures	Average Cost
1	Oxycodone	Analgesic	147,566	\$4,582,797	\$31
2	Hydrocodone	Analgesic	145,419	\$2,057,681	\$14
3	Amoxicillin	Antibiotics	107,462	\$1,117,672	\$10
4	Lorazepam	Anti-anxiety Drugs	62,586	\$514,746	\$8
5	Azithromycin	Macrolides	59,587	\$1,643,667	\$28
6	Lisinopril	ACE Inhibitor	58,151	\$416,299	\$7
7	Proair	Beta-adrenergic agents	57,918	\$2,815,214	\$49
8	Clonazepam	Anti-Convulsants	57,472	\$496,935	\$9
9	Levothyroxine	Thyroid Hormone	56,498	\$519,886	\$9
10	Ibuprofen	NSAID	55,767	\$394,230	\$7
		Top Ten Total	808,426	\$14,559,127	\$18

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