

The Community Mental Health Medicaid Trust Fund: Background, Analyses, and Recommendations December 2005

The Department of Human Services and its Division of Mental Health (DHS/DMH) submits this paper in compliance with Section 18.4 of Public Act 093-0841, concerning the Community Mental Health Medicaid 718 Trust Fund. Specifically, the Act requires that: “The Department shall analyze the budgeting and programmatic impact of this funding allocation and report to the Governor and the General Assembly the results of this analysis and any recommendations for change, no later than December 31, 2005.” This paper incorporates some of the comments received on an earlier draft reviewed by a stakeholder subgroup of DHS/DMH’s System Restructuring Initiative (SRI) Finance Workgroup. The full Finance Workgroup and SRI Task Group will be asked to review this current paper at the same time it is submitted to the Governor and legislature.

Executive Summary

- From projections based on provider Medicaid billings through November 2005, the Department expects to have sufficient funds to complete advance grant payments to community mental health service providers on schedule through FY 2006.
- From these projections it is also anticipated that of the \$14 million loan advanced to the Trust Fund last year almost the entire amount (\$12.3 million) can be repaid in FY 2006, with the remaining amount payable in the following year per the statute’s provision permitting payoff over subsequent years.
- The projections further suggest that there will not be sufficient Medicaid billing to permit deposits in the General Fund, nor to the Trust Fund for expanding the community mental health system.
- Based on the above, the Department recommends that the Trust Fund be modified to clarify and enhance system incentives by:
 - 1) Changing the Trust Fund to receive only the funding over the total target of \$98 million (\$100 million after the desired change to accommodate the FY 2006 mental health Medicaid rate increase is approved).
 - 2) Make the incentive of additional funding more immediately attainable for FY 2007 to evaluate if it increases Medicaid billing.

The Significance of the Community Mental Health Medicaid Trust Fund

The Community Mental Health Medicaid Trust Fund was created through Public Act 92-0597 in June of 2002 as a means of funding payments by the Department of Human Services to community mental health providers. It has gone through significant changes over the past two years, becoming a critical resource for the state’s community mental health program. These

changes have generated interest in this analysis and any recommendations about how the fund might best fulfill this role.

Background on Medicaid Community Mental Health Services in Illinois before the Trust Fund

Initiation of Mental Health Medicaid in FY 1991

In order to evaluate the role of the Community Mental Health Medicaid Trust Fund it is necessary to understand how Medicaid¹ services for community mental health have been purchased. Practically speaking, the State of Illinois began to purchase Medicaid community mental health services in state fiscal year 1991. This Medicaid program involved distinct changes from the previous history of grant funding. Some of these changes pertained to provider qualifications and service requirements. Others concerned how the services were financed.

The most significant of the changes in financing was that providers were eligible to receive revenue in excess of normal, contracted grant amounts, depending upon the value of services provided which met the criteria for Medicaid. For example, if a provider had traditionally received a community mental health grant for \$500,000 per year and chose to bill \$200,000 under the Medicaid program for services provided with grant funding, the provider would continue to receive the full grant amount and also a portion (one-half) of the amount of accepted Medicaid-billed mental health services. This provider's total revenue from the Department of Human Services for mental health would be \$600,000 for the year: \$500,000 assured under a grant contract and \$100,000 earned by billing for services.

To receive this additional revenue, it was necessary for the provider to conform to Medicaid requirements for services, documentation, and billing. The understanding was that grant funded programs were already supporting treatment for indigent persons who were, or could be, Medicaid recipients, but the state did not have the detailed information necessary to support a claim for federal matching funds. Once providers supplied this information in the form of a bill, the state could claim appropriate federal matching funds. The federal Medicaid matching rate for Illinois is 50 percent. Therefore, the state determined that an additional payment equal to one-half of the value of the accepted Medicaid bills was the greatest commitment it could make without added financial risk of an increased demand for GRF.

Mental Health Medicaid Provider Incentives Increases Funding for the Community Mental Health System

The outcome of this change was not only that the mental health system could grow, but also that it could do so without increasing its commitment of state funds. Grant funding tends to be a rather static method of funding services. Without any direct association with consumer demand and need for services or any association with how providers have met this need, grant funding remains relatively unchanged over time, subject only to small increases (e.g., cost of living adjustments or initiatives) when possible. But the introduction of Medicaid into community

¹ It is important to point out that all subsequent references to "Medicaid" in this paper are intended to include not only Medicaid under Title XIX, but also the Illinois KidCare program under Title XXI.

mental health created a powerful incentive for growth that has totaled over \$532 million from FY 1991 through FY 2005. This is an average increase of nearly \$35.5 million per year, all of which was returned to the mental health system. More importantly, this was entirely offset by added federal matching revenue. It did not increase net state expenditures by one dollar.

Sources of Funding for Community Mental Health Services through FY 2002

This development in Medicaid mental health services meant that provider revenue came from two sources and on two different schedules of payment. One was traditional, relatively constant grant funding. Grant funds were appropriated from general revenue funds and were distributed to each provider on a monthly basis as 1/12 of the provider's annual contract amount. The second source was the amount earned from services billed, which was dynamic and highly variable among the provider community. The funds earned by provider billing were available through another general revenue fund appropriation and were distributed only after Medicaid bills were adjudicated (processed by the Departments of Human Services and Healthcare and Family Services). This permitted the Department to maintain historical consistency for grant funding and easily monitor the growth in expenditures for Medicaid-billed services. It is important to keep in mind, as was mentioned above, that all payments from the Medicaid appropriation would be fully offset by increases in federal revenue, regardless of the rate of growth.

It was apparent that this growth in payments to providers for Medicaid services was vigorous, averaging 33 percent per year between FY 1992 and FY 2002. This required periodic increases in the appropriated amount for Medicaid, but these requests were always approved because it was clear that any increase would be offset, dollar for dollar, with additional federal matching revenue. This structure for funding community mental health services remained unchanged from FY 1991 through FY 2001.

Initiation of the Community Mental Health Medicaid Trust Fund in FY 2002

In FY 2002, while the basis for grant-in-aid and Medicaid payments remained the same, the sources of funding changed significantly. Medicaid billing increased more than expected from the previous fiscal year and the Department of Human Services (DHS) increased mental health rates for the first time in over ten years. These developments warranted an increase in the Medicaid appropriation for mental health by over \$14 million before the end of the fiscal year. Normally, this need would be met with a supplemental appropriation. In FY 2002, however, the Governor's Office decided it would be more expedient to create a special fund, the Community Mental Health Medicaid Trust Fund. Such a fund was created by statute, and sufficient funds were deposited to cover the rate increase and growth in Medicaid billing for FY 2002. In this first application, the Trust Fund added to the existing Medicaid appropriation in much the same way as a supplemental appropriation.

Replacement of the Medicaid Appropriation with the Medicaid Trust Fund in FY 2003

This new fund had more dramatic implications for FY 2003 under PA092-0597. While the appropriation and advance payment procedures for grant funding remained unchanged, the

Medicaid appropriation for community mental health services was eliminated entirely, leaving the Trust Fund as the only resource for these payments. Most significant was the fact that no deposit was made into the fund to cover the spending needs for the fiscal year, as had been done for FY 2002. Instead, resources for the Trust Fund were to come from deposits based upon federal matching revenue attributed to Medicaid community mental health services. Under the terms of the statute, at the beginning of each fiscal year, the Trust Fund would have a balance of zero. As mental health Medicaid bills were processed and the state received federal matching funds, an amount equal to these federal revenues was to be deposited into the Trust Fund, making payments to providers possible.

To accommodate the spending needs for FY 2003 and growth in subsequent years, the Trust Fund was defined with a high limit on the “spending authority”: \$95 million per year, well above the \$62 million expected to be paid for Medicaid services in FY 2003. With this high spending limit and because payments from the fund did not have to be made in advance, like grant funding, this change had no apparent impact on provider revenues. This function of the Community Mental Health Medicaid Trust Fund remained the same through FY 2003 and FY 2004.

Changes in the Transition to Fee-For-Service in FY 2005

In FY 2005, the role of the Community Mental Health Medicaid Trust Fund changed once again, due partly to a statute (PA 093-0841) and partly to new policies in the Department of Human Services. As part of the Governor’s priority of fiscal responsibility, the Department identified initiatives to maximize revenues on existing state spending. Due to new policies adopted in FY 2005 there was an expectation that additional community based mental health services would be claimed for Medicaid, thus increasing federal revenues. In order for the new federal revenues to benefit the state’s fiscal condition, a statutory change to the Community Mental Health Medicaid Trust Fund was required. The important statutory change was a restriction in the deposits to be made into the fund. In previous fiscal years 100 percent of federal matching revenue associated with Medicaid mental health services was deposited into the fund, assuring that the fund would always have sufficient resources to make provider payments. Under PA 093-0841, however, the deposits to the fund were limited to 73.7 percent of the federal matching revenue, with the balance (26.3 percent) deposited into the general revenue fund and unavailable for payments to community mental health providers until the target GRF deposit accumulated to \$25 million, after which subsequent deposits would be evenly split between additional GRF deposits and deposit in the Trust Fund for distribution to the community mental health system.

In addition, the Department of Human Services revised grant-in-aid contracts with community providers as part of the transition to fee-for-service to offer providers the security of advance payments to maintain their cash flow. For this strategy to work, it was necessary to advance all provider revenue, not just grant funding as had been done in the past. Since each provider’s revenue from the Department for community mental health services came from two sources (grants and Medicaid) in the past, those sources had to be combined in a single annual contract amount, to be paid in 1/12 monthly payments.

Even though the two sources of provider revenue for mental health services became one in FY 2005, the Department still needed to depend upon both the grant appropriation and the Community Mental Health Medicaid Trust Fund to make these payments. While the Trust Fund still depended upon deposits from federal matching funds, it was no longer disbursed as Medicaid payments alone. It became a critical resource for fulfilling the Department's contractual obligation for all community mental health services: Medicaid and non-Medicaid.

Even if the providers had increased their Medicaid billing significantly in the beginning of the year, the diversion from the Trust Fund would have made it impossible to complete the advance payment for the last month in the fiscal year due to cash flow. The last advance would have been due before all the needed revenue was deposited into the Trust Fund. Circumstances made the best-case scenario less positive. There were delays in implementing Rule 132 changes, with agreements to give providers a period to phase in the changes. The Departments of Human Services and Healthcare and Family Services had made several critical system changes in the processing of Medicaid bills as part of the transition to fee-for-service. Providers had to make changes to their own computer systems to accommodate the Rule 132 and system changes. While necessary for the transition, these changes had the immediate effect of slowing Medicaid billing and the state's claiming of federal matching funds. This meant that deposits to the Trust Fund would be delayed, further restricting the ability of the Department of Human Services to advance funds to providers.

Table 1 (attached) illustrates the anticipated problem for the Department of Human Services to complete its mental health contract payments in FY 2005. The table presents, on a monthly basis, total Medicaid billing (column F) and deposits to the Trust Fund (column H) along with the Department's total contract obligation (column C) and planned payments to meet the obligation from the general revenue appropriation (column D) and the Trust Fund (column H). This shows that because of the diversion of deposits to the Trust Fund and delayed Medicaid billing, the Department would have had a growing deficit in the Trust Fund balance (column I), making it unable to complete the payment in May 2005.

Remedying the Cash Flow Problem for FY 2005

Anticipating this problem as early as November of 2004, the Department took actions to remedy the problem. These actions included a) intensive technical assistance with the provider community to assist them in submitting bills and correcting billing rejections, b) changing the projected payment schedule to manage the cash flow problem by expending more of the general revenue appropriation earlier and deferring payments from the Trust Fund until later in the fiscal year, and c) facilitating HFS speed up of deposits into the Trust Fund. It became clear, however, that these actions would not be sufficient. As a result, the Department proposed legislation that would terminate the diversion to the general fund of 26.3 percent of federal matching funds associated with community mental health services. Instead the first \$73 million would be deposited in the Trust Fund to satisfy provider contracts. In addition, the legislation authorized a loan to the Trust Fund of \$14 million to replenish the Trust Fund for diversions, which had already occurred earlier in the fiscal year (see the \$14 million balance in April in column J of Table 1).

These proposed legislative changes were passed as PA 094-0058. These measures were sufficient to provide the Department of Human Services with the funds required to complete all contract payments within the fiscal year (although the payment, which normally would have been made in May, was delayed until June).

It is important to note that another provision of PA 094-0058 was that after the amount to be paid out of the Trust Fund for obligated contract amounts (\$73 million) had been transacted, an amount equal to any additional federal matching funds obtained during the twelve months of FY 2005 up to \$25 million was to be deposited into the general revenue fund. As Table 1 illustrates, the full \$73 million of deposits to the Trust Fund needed to complete payments on the obligated contracts was not attained (see column G on Table 1). Thus, no deposits were made to the general revenue fund and no additional federal revenue was available for deposit in the Trust Fund for distribution to the community mental health system.

Expectations for the Community Mental Health Medicaid Trust Fund in FY 2006

The legislative changes made for the Trust Fund in FY 2005 apply to FY 2006 (and subsequent fiscal years), with one important difference. That difference is that when sufficient deposits have been made into the Trust Fund to fully cover the contract obligations for community mental health services, amounts equal to any additional federal matching revenue deposited during the fiscal year will be used as follows: 1) the first \$14 million available in this manner will be applied to a repayment of the loan to the Trust Fund in FY 2005, 2) the next \$11 million available in this manner will be deposited into the general fund, and 3) all additional funds made available in this manner will be split, with 50 percent deposited into the general revenue fund, and 50 percent deposited into the Community Mental Health Medicaid Trust Fund for distribution to the mental health service system. These provisions address the need to complete payments on contract obligations, to repay the loan made in FY 2005, to contribute to the general fund, and to offer incentives for the community mental health provider system to reach the billing goals for Medicaid and reinvest a portion of the added federal revenue into the service system.

Attaining these objectives would be beneficial to all. But to accomplish them all in FY 2006 may not be possible. Table 2 illustrates how these provisions would operate under reasonable projections for Medicaid billing for mental health services in Illinois. Column C shows the obligated contract amounts for mental health services, and columns D and E present the payment schedule from both the legacy grant appropriation and the Trust Fund. Column F shows the Medicaid FFP, and column G the deposits in the Trust Fund, indicating sufficient deposits to pay and meet contractual payments from the fund by May 2006. All of the data in the table are actual through November and are projected for the rest of the fiscal year based upon historical patterns.

This table illustrates several important points. One is that with FY 2006 deposits into the fund based upon Medicaid services, the Department has sufficient funds to complete advance grant payments by May, consistent with a normal payment schedule. A second important point is that with these projections \$12.3 million will be available to repay the FY 2005 loan, leaving \$ 1.7 million to be repaid next fiscal year. Also, the table indicates that it is not likely that there will

be sufficient Medicaid bills processed in FY 2006 to make any deposits to the general revenue fund (column I). Of course, this means that it is also unlikely that available federal revenues will permit the deposit of an amount equal to 50 percent of federal revenue obtained after all of the other objectives have been attained. Medicaid billing during the fiscal year would have to increase by nearly 17 percent over these projections before that process could begin.

Table 2 shows that the cash flow problem that the Department of Human Services faced in FY 2005, before the remedial legislation, has been resolved under the terms of PA 094-0058. Under those provisions, the Department is reasonably assured of available funds to meet its contract obligations, barring any serious disruption in Medicaid billing. The table also indicates that most of the loan to the Trust Fund can be repaid in FY 2006, with certainty that the repayment will be complete in FY 2007. However, it is also clear that a substantial increase in annual Medicaid billing must occur before additional federal revenue is generated for the general revenue fund or system growth in the Trust Fund.

It is important to explain differences between Table 1 and Table 2 with respect to the amount of money needed in the Trust Fund to complete contract obligations. While this amount is shown as \$73 million in FY 2005, it is shown as \$75 million in FY 2006. These figures are different because of the effect of the 3 percent Cost of Living Adjustment in general revenue fund appropriations for mental health passed in the 94th general assembly. If the full 3 percent is to be awarded to community mental health providers it must apply to the payments not only from the general revenue fund appropriation, but also those from the Community Mental Health Medicaid Trust Fund. Due to an apparent oversight of the role of both of these funding sources this accommodation was not made when the Cost of Living Adjustment was passed. The Department of Human Services has requested that this change in the statute be made. The increase requested to the statutory language governing the Community Mental Health Medicaid Trust Fund in FY 2006 will be funded through increased federal revenue that will be garnered as a result of the Mental Health Medicaid rate increases as well as through increased Medicaid claiming on community-based mental health services that can occur as a result of the 3% Cost of Living Adjustment. If it is not done before the end of the fiscal year, the Department will end up with a deficit of \$2 million.

Options for Changes in the Role of the Community Mental Health Medicaid Trust Fund

Under the conditions of Section 18.4 in Public Act 093-0841, the Department of Human Services is offered the opportunity to recommend changes in the manner in which the Community Mental Health Medicaid Trust Fund operates. This analysis demonstrates that while the conditions of the Trust Fund presented serious potential problems in FY 2005, these cash flow problems have largely been resolved.

There may be other reasons to consider other changes for the Trust Fund, however. Since the Department of Human Services began to advance all provider revenue as grant payments providers have no economic incentive to attain or exceed billing targets. In the past (prior to FY 2005) providers earned additional revenue by billing, but in FY 2005 and FY 2006 there has been no requirement that the additional revenue be earned. It is guaranteed in regular monthly

payments, independent of provider billing performance. In retrospect, this may be a major contributor to the rate of growth in Medicaid billing for mental health services between FY 2004 and FY 2005 being the lowest of the past ten years.

It is possible to use the Community Mental Health Medicaid Trust Fund to restore some of this incentive. One option would be to allow more funds associated with increased federal revenue to be available for growth or expansion in the mental health service system and to link this growth to individual provider performance. This could be accomplished by increasing the proportion of funds deposited to the Trust Fund after the state's billing targets have been met. For example, instead of an amount equal to 50 percent of the additional revenue generated deposited into the Trust Fund, this could be 75 percent, with 25 percent deposited into the general fund. It could also be accomplished by making these deposits to the Trust Fund a higher priority than the other deposits to the general fund. At present, once the contractual obligations are met, then next \$25 million of federal matching revenue associated with mental health services is to repay the loan and be deposited into the general funds. Only after that amount has been reached may deposits to the Trust Fund resume. As this analysis indicates, it is likely that this may not occur until late FY 2008, too far in the future to influence provider-billing behavior now. If this requirement were eliminated, deposits to the general fund and the Trust Fund could start simultaneously, and earlier. It is possible, then, that providers would see additional funding available near the end of FY 2007. Deposits to the general revenue fund would occur, as well, but they would only be a portion of the additional revenue. Without some strong economic incentives for providers to bill, however, it may be several years before the system reaches the goals intended in Public Act 093-0841.

Recommendations

As explained above, the combined current contracting methodology and the Trust Fund structure has minimized the incentives for providers to increase Medicaid billing. To enhance the role of the Trust Fund in maximizing federal Medicaid revenues, the Department recommends the following changes for FY07.

- 1) **Change the Trust Fund to receive only the funding over the total target** of \$98 million (\$100 million after desired change to accommodate FY 2006 mental health Medicaid rate increase). This would mean that the funding currently being deposited into the Trust Fund prior to the loan repayment and General Revenue Fund (GRF) deposits would be appropriated to DHS/DMH from GRF and all the revenue up to the target would be deposited into the GRF. Structuring the Trust Fund in this fashion is similar to the new Developmental Disabilities Fund. The amount of deposits into the Trust Fund would then clearly be the enhancement funding that DHS/DMH could allocate consistent with priorities determined by the Department and the Division of Mental Health with the stakeholder and consultants' input.
- 2) **Make the incentive of additional funding more immediately attainable.** The developmental disability providers have demonstrated that a powerful incentive for effectively increasing Medicaid billing occurs when: (a) the goal is achievable in a reasonable amount of time, (b) the payment methodology is connected to billing, and (c)

when they have a role in determining the use of the enhancement funding. Given that it is unlikely that mental health providers will move to full advance and reconcile in FY 2007, DHS/DMH recommends for FY 2007 only that the 50% portion begin after the loan is paid off, rather than after the loan repayment and GRF target (currently \$25 million total) are both achieved. The effectiveness of this incentive in increasing Medicaid billings could then be evaluated for future policy making.

Table 1: The Problem in Meeting FY2005 Community Mental Health Payments and the 718 Trust Fund

A	B	C			D	E	F	G	H	I	J
		FY2005 Funding Plan				FY2005 Actual Billing Activity ²					
Month	Year	Cumulative Community Based Mental Health Contract Obligations FY2005	Cumulative Contract Payment Supported by GRF Dollars	Cumulative Contract Payments Supported by 718 Trust Fund Dollars	Cumulative Medicaid Billing Actuals FY2005 ¹	Cumulative Total FFP Generated in FY2005 from Community Based MH Services	Cumulative Deposits to 718 Trust Fund Actuals FY2005 at 73.7% ³	718 Trust Fund Balance (without \$14M Loan) ⁴	Deposits to GRF at 26.3% of FFP Generated		
JUL	2004	\$57,992,515	\$57,992,515	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
AUG	2004	\$86,988,772	\$86,988,772	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
SEP	2004	\$115,985,029	\$115,985,029	\$0	\$6,397,806	\$3,198,903	\$2,357,592	\$2,357,592	\$841,311	\$1,227,985	
OCT	2004	\$144,981,286	\$144,981,286	\$0	\$9,338,288	\$4,669,144	\$3,441,159	\$3,441,159	\$2,287,915	\$2,287,915	
NOV	2004	\$173,977,544	\$173,977,544	\$0	\$17,398,590	\$8,699,295	\$6,411,380	\$6,411,380	\$6,131,862	\$6,131,862	
DEC	2004	\$202,973,801	\$202,973,801	\$0	\$46,630,130	\$23,315,065	\$17,183,203	\$17,183,203	\$7,649,458	\$7,649,458	
JAN	2005	\$231,970,058	\$217,310,058	\$14,660,000	\$58,170,780	\$29,085,390	\$21,435,932	\$6,775,932	\$9,585,490	\$9,585,490	
FEB	2005	\$260,966,315	\$231,646,315	\$29,320,000	\$72,893,460	\$36,446,730	\$26,861,240	-\$2,458,760	\$11,965,048	\$11,965,048	
MAR	2005	\$289,962,573	\$245,982,573	\$43,980,000	\$90,988,959	\$45,494,480	\$33,529,432	-\$10,450,568	\$14,040,914	\$14,040,914	
APR	2005	\$318,958,830	\$260,318,830	\$58,640,000	\$106,775,009	\$53,387,505	\$39,346,591	-\$19,293,409	\$16,226,965	\$16,226,965	
MAY	2005	\$347,955,087	\$274,655,087	\$73,300,000	\$123,398,974	\$61,699,487	\$45,472,522	-\$27,827,478	\$18,245,666	\$18,245,666	
JUN	2005				\$138,750,310	\$69,375,155	\$51,129,489				

Notes:

¹ Revenues received in early FY 2005 for FY 2004 services were largely used to satisfy the contractual obligation to pay the provider 50% of billing in FY 2004.

² Actual transactions are more complex than can be presented in this table; the data presented highlight the major problems and solutions.

³ In FY05, 73.7% of FFP generated from MH Medicaid claim was deposited into the 718 Trust Fund. Under PA94-0058, in place for FY06, the first \$73M in FFP is deposited into the 718 Trust Fund.

⁴ If PA94-0058 had been in place in FY05, the Department would not have had enough funds to pay the full contract obligations without the \$14M loan into the 718 Trust Fund.

Table 2: Meeting FY2006 Community Mental Health Payments and the 718 Trust Fund

A	B	C	D	E	F	G	H	I
Month	Year	Cumulative Community Based Mental Health Contract Obligations FY2006	Cumulative Contract Payment Supported by GRF Dollars	Cumulative Contract Payment Supported by 718 Trust Fund Dollars	Cumulative Medicaid FFP in FY06 ¹	FY06 Deposits to 718 Trust Fund, YTD ²	Loan Repayment Cumulative	Deposits to GRF, YTD
JUL	2005	\$62,328,297	\$62,328,297	\$0	\$7,195,734	\$7,195,734	\$0	\$0
AUG	2005	\$93,492,445	\$93,492,445	\$0	\$13,064,567	\$13,064,567	\$0	\$0
SEP	2005	\$124,656,593	\$124,656,593	\$0	\$20,668,638	\$20,668,638	\$0	\$0
OCT	2005	\$155,820,742	\$155,820,742	\$0	\$27,404,426	\$27,404,426	\$0	\$0
NOV	2005	\$186,984,890	\$186,984,890	\$0	\$34,735,002	\$34,735,002	\$0	\$0
DEC	2005	\$218,149,038	\$202,149,038	\$16,000,000	\$42,021,083	\$42,021,083	\$0	\$0
JAN	2006	\$249,313,187	\$217,313,187	\$32,000,000	\$49,332,447	\$49,332,447	\$0	\$0
FEB	2006	\$280,477,335	\$237,477,335	\$43,000,000	\$56,711,895	\$56,711,895	\$0	\$0
MAR	2006	\$311,641,483	\$257,641,483	\$54,000,000	\$64,186,061	\$64,186,061	\$0	\$0
APR	2006	\$342,805,632	\$277,805,632	\$65,000,000	\$71,771,894	\$71,771,894	\$0	\$0
MAY	2006	\$373,969,780	\$298,969,780	\$75,000,000	\$79,480,552	\$75,000,000	\$4,480,552	\$0
JUN	2006	\$0	\$0	\$0	\$87,319,734	\$75,000,000	\$12,319,734	\$0

Notes:

¹ Amounts in Column F reflect actual billings through November, and projections for December through June based on historical patterns.

² Shows increased deposits consistent with the Department’s request to fund the COLA.