Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-07 Oversight of State Resources

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

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$6,866,975,675**	**$0**	**$6,802,474,032**	**$1,486,941**	**$1,979,221**
	FTE	400.3	0.0	400.6	13.2	14.0
	GF	$1,959,212,915	$0	$1,962,559,203	($1,658,036)	($1,534,694)
	CF	$711,296,978	$0	$684,014,029	$100,685	$70,716
	RF	$6,994,451	$0	$6,999,546	$0	$0
	FF	$4,189,471,331	$0	$4,148,901,254	$3,044,292	$3,443,199

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (A) General Administration - Personal Services	**Total**	**$29,707,221**	**$0**	**$29,797,905**	**$832,311**	**$881,836**
	FTE	400.3	0.0	400.6	13.2	14.0
	GF	$10,211,448	$0	$10,355,331	$415,282	$440,740
	CF	$2,994,337	$0	$2,952,905	$31,170	$31,170
	RF	$1,564,801	$0	$1,566,597	$0	$0
	FF	$14,936,635	$0	$14,923,072	$385,859	$409,926
01. Executive Director's Office, (A) General Administration - Health, Life, and Dental	**Total**	**$3,434,070**	**$0**	**$3,673,458**	**$103,052**	**$103,052**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,230,952	$0	$1,316,506	$46,079	$46,079
	CF	$337,577	$0	$349,778	$3,964	$3,964
	RF	$104,755	$0	$104,635	$0	$0
	FF	$1,760,786	$0	$1,902,539	$53,009	$53,009

01. Executive Director's Office, (A) General Administration - Short-term Disability	**Total**	**$55,072**	**$0**	**$57,991**	**$1,278**	**$1,360**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$20,569	$0	$21,560	$571	$611
	CF	$4,588	$0	$4,796	$53	$53
	RF	$1,393	$0	$1,365	$0	$0
	FF	$28,522	$0	$30,270	$654	$696
01. Executive Director's Office, (A) General Administration - Amortization Equalization Disbursement	**Total**	**$1,434,489**	**$0**	**$1,613,687**	**$33,679**	**$35,835**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$535,695	$0	$600,009	$14,997	$16,074
	CF	$119,586	$0	$133,459	$1,397	$1,397
	RF	$36,269	$0	$37,816	$0	$0
	FF	$742,939	$0	$842,403	$17,285	$18,364
01. Executive Director's Office, (A) General Administration - Supplemental Amortization Equalization Disbursement	**Total**	**$1,419,546**	**$0**	**$1,613,662**	**$33,679**	**$35,835**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$530,115	$0	$600,009	$14,997	$16,074
	CF	$118,340	$0	$133,459	$1,397	$1,397
	RF	$35,891	$0	$37,791	$0	$0
	FF	$735,200	$0	$842,403	$17,285	$18,364
01. Executive Director's Office, (A) General Administration - Operating Expenses	**Total**	**$2,058,538**	**$0**	**$2,035,574**	**$60,142**	**$13,112**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$930,699	$0	$923,963	$27,020	$5,856
	CF	$71,522	$0	$67,439	$2,827	$475
	RF	$10,449	$0	$10,449	$0	$0
	FF	$1,045,868	$0	$1,033,723	$30,295	$6,781
01. Executive Director's Office, (A) General Administration - General Professional Services and Special Projects	**Total**	**$7,200,237**	**$0**	**$7,975,237**	**$1,621,365**	**$1,469,748**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,047,261	$0	$2,622,261	$510,683	$434,874
	CF	$1,527,500	$0	$1,227,500	$300,000	$300,000
	RF	$0	$0	$0	$0	$0
	FF	$3,625,476	$0	$4,125,476	$810,682	$734,874

	Total	**$3,401,907**	**$0**	**$2,813,406**	**$204,000**	**$204,000**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (F) Provider Audits and Services - Professional Audit Contracts	GF	$1,266,408	$0	$1,119,283	$102,000	$102,000
	CF	$415,408	$0	$312,420	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,720,091	$0	$1,381,703	$102,000	$102,000
	Total	**$6,818,264,595**	**$0**	**$6,752,893,112**	**($1,402,565)**	**($765,557)**
	FTE	0.0	0.0	0.0	0.0	0.0
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	GF	$1,942,439,768	$0	$1,945,000,281	($2,789,665)	($2,597,002)
	CF	$705,708,120	$0	$678,832,273	($240,123)	($267,740)
	RF	$5,240,893	$0	$5,240,893	$0	$0
	FF	$4,164,875,814	$0	$4,123,819,665	$1,627,223	$2,099,185

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

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

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

Cost and FTE

- The Department requests $1,567,569 total funds, including a reduction of $1,577,408 General Fund, and 14.1 FTE in FY 2017-18, and $2,061,245 total funds, a reduction of $1,452,670 General Fund, and 15.0 FTE in FY 2018-19 ongoing to provide increased stewardship of State resources as required by outside compliance actions and recommended in industry best practices.

Current Program

- The Department manages a budget of approximately $9 billion for over 1.3 million Medicaid members. The Department is responsible for correctly processing medical claims, setting payment rates for services, working with stakeholder and providers to determine members benefit packages, improve member health outcomes and ensuring that all payments and members are eligible for programs under state and federal law.

Problem or Opportunity

- The Department has identified several operational issues and opportunities to improve oversight that it hopes to address in FY 2017-18 that fall into two categories: compliance actions and industry best practices. They range from verifying member assets to coordinating health services with the federal government. These issues are diverse and interconnected but have a common theme; not addressing these issues hinders the ability of the Department to be a sound financial steward of taxpayer resources.

Consequences of Problem

- If the Department does not address the compliance issues it risks being out of compliance with federal law and State Auditor recommendations. Being out of compliance with federal law may result in the withholding of federal funds.
- If the Department does not implement the best practices, it risks losing opportunities to capture cost savings from the proposed initiatives and increases the risk of mismanagement of state resources.

Proposed Solution

- The Department has identified nine initiatives that would increase the oversight of State resources.
- Of the initiatives, three are related to compliance with outside mandates, including: implementation of an asset verification program; an evaluation of the Department's Consumer Directed Care programs; and, proper maintenance of the Department's audit tracking database.
- The remaining initiatives are related to adhering to best practice to allow for proper oversight of the Department's program, including: hiring dedicated project management staff; performing annual audits of Community Mental Health Centers, increasing the Department's resources related to maintaining member and provider integrity; coordinating services for American Indians and Alaskan Natives; increasing the Department's resources related to the development and monitoring of the Hospital Provider Fee model; and, providing a dedicated benefit manager and updating provider rates for office administered drugs.

Department Priority:	***R-7***
Request Detail:	***Oversight of State Resources***

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Oversight of State Resources	$1,567,569	($1,577,408)

Problem or Opportunity:

The Department has been appropriated approximately $9 billion to provide services to eligible members; this represents the largest single agency budget for the entire State. Given the size of the Department's budget, proper oversight is critical to ensuring that members are receiving the services that they need and that taxpayers are getting sufficient returns on the use of these funds. As part of the Department's focus on continual improvement to provide sound financial review, the Department has identified several compliance and best practices issues that limit the Department's ability to provide necessary oversight over State resources. The Department has classified each issue as either a compliance or best practices initiative. Compliance initiatives are needed to comply with federal law or State Auditor recommendations; best practices initiatives are improvements that have been identified by internal staff that increase oversight of State resources, improve Department transparency, improve stakeholder relationships and provide cost effective care to Medicaid members. Each issue is described below, along with the proposed solution.

Proposed Solution:

The Department requests $1,567,569 in total funds, including a reduction of $1,577,408 in General Fund, and 14.1 FTE in FY 2017-18, $2,061,245 in total funds, a reduction of $1,452,670 General Fund and 15.0 FTE in FY 2018-19 and ongoing in order to provide adequate oversight resources for both contracted services and State FTE. The Department will use those resources to:

- Deploy an electronic asset verification program
- Evaluate the consumer directed care services offered by Medicaid
- Develop a robust audit tracking and reporting database
- Create a centralized Project Management Office
- Audit the cost reports of every Community Mental Health Center
- Increase the number of provider and member investigators
- Increase coordination of care between the federal Indian Health Services, Medicaid, the Office of Behavioral Health, and the Colorado Commission on Indian Affairs
- Provide necessary FTE and contract resources for the Hospital Provider Fee

- Hire a dedicated benefit manager for office administered drugs and raise the average rates for this class of drugs to 2.5% above average sale price.

Compliance Initiatives

Asset Verification Program

The Department requests $529,183 total funds including $264,592 General Fund in FY 2017-18 and $858,366 total funds, $429,183 General Fund in ongoing funding for an electronic asset verification contract in order to comply with federal regulations passed as part of the Federal Supplemental Appropriations Act of 2008. The Department also anticipates needing $100,000 total funds, $50,000 General Fund in supplemental funding in FY 2016-17 for this program. The Department asks for roll forward authority for this funding to provide flexibility for any possible delays in FY 2016-17.

The Federal Supplemental Appropriations Act modifies section 1940 of the Social Security Act and requires every state to create a Medicaid Asset Verification Program (AVP) that automatically and electronically verifies the liquid assets of aged, blind, and disabled applicants for Medicaid. Electronic Asset Verification Systems are already in place in several states and an AVP is used by the Social Security Administration for Social Security Insurance (SSI) benefits. Colorado's existing asset verification program requires Coloradans who apply for Medicaid due to age or a disability to list all assets on their application. This information must be provided in the initial application for Medicaid and during the redetermination process in order to qualify for Medicaid. Eligibility workers verify the listed assets from the application and members have ten business days to provide supporting documents for those assets in order to complete the application and redetermination process. If the member provides the documentation, the information is validated and updated within the Colorado Benefits Management System (CBMS) to determine eligibility. If the individual fails to provide the required asset documentation, they are denied enrollment into Medicaid.

In obtaining this information, counties are currently limited to paper sources provided by the applicant since banks do not accept signed Medicaid applications as authorization to obtain information. Additionally, obtaining this information can frequently pose a challenge for eligibility workers because members may not always understand the request or may not be able to provide a timely response to maintain eligibility.

Federal regulations previously required that Medicaid verify the assets through a credible electronic data source or through paper documentations such as bank statements, however, these requirements changed with passage of the Federal Supplemental Appropriations Act of 2008 which required an electronic verification system be in place. Although this mandate occurred in 2008 with targeted implementation date between 2009 and 2013, very few states have implemented an electronic AVP. Many states, like Colorado, encountered initial challenges in trying to establish policies and processes with financial institutions to meet this requirement. In addition, the Centers for Medicare and Medicaid Services (CMS) encouraged states to prioritize changes to state eligibility systems required under the Affordable Care Act over AVP implementation. In November 2015 the Department received a letter from the Centers for Medicare and Medicaid Services (CMS) requesting a work plan and timeline detailing how the State would fully implement an AVP. On December 31, 2015 the Department submitted a response to CMS that detailed the timeline for coming into compliance with section 1940, which included a planned request for funding from the Colorado General Assembly for FY 2017-18.

In June 2016, the Department was informed by CMS that Colorado was one of several states that has failed to make a good faith effort to implement the AVP requirement. CMS warned that without prompt action CMS would institute a corrective action plan. To avoid this corrective action plan, the Department must implement the program by December 2017. This notification has moved up the Department's original implementation date and timeline from March 2018 to December 2017. In order to meet the December 2017 deadline, the Department needs to award a contract in April 2017 and has prepared an estimate of $100,000 in FY 2016-17 costs related to this contract. Without funding, the Department will be put on a corrective action plan from CMS as well as other possible consequences such as the reduction of Federal Financial Participation (FFP).

The Department requests funding to hire a contractor to provide automatic electronic asset verification services for Medicaid programs that require an asset test. This vendor would have agreements with financial services institutions to be able to electronically confirm liquid assets, held by the applicant, in financial institutions (checking & savings accounts, certificates of deposits, etc.). Applicant information would be provided to the vendor, through CBMS, for new applications and during the redetermination process. The Department has reviewed proposal that were submitted for other states' AVP program have used that information to estimate the cost of implementing a program in Colorado. These estimates are detailed in Table 6.2 and 6.3. This estimate is a services-only estimate and does not include the cost of Colorado system changes. The required system changes will be absorbed using existing CBMS pool hours and therefore does not require additional funding.

In addition to the benefit of being in compliance with federal law, an electronic AVP would reduce the number of paper records that need to be submitted for Medicaid programs that have an asset test. The Department predicts efficiency improvements with an AVP with liquid asset verification since the AVP minimizes the need for paper documentation and allows for real-time information during eligibility determination. One state that recently implemented an AVP found that the program cut down the number of instances of members needing to submit paper document. If a member did not have any other assets, the Department estimates that the time needed to process an application could decrease by approximately 20 days using an AVP. This decrease in application time would allow members with simpler finances to start receiving services closer to the date of application and help eligibility sites meet the federally required 90 day determination timeline for non-MAGI (Modified Adjusted Gross Income) populations.

Consumer Directed Care Evaluation

The Department requests $422,000 total funds, including $211,000 General Fund in FY 2017-18 in order to hire an independent contractor to complete an analysis of Consumer Directed Services like Consumer-Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS) programs. The requested analysis would serve as the Department's response to a May 2015 audit from the Office of the State Auditor which recommended the Department look at the benefits, health outcomes achieved, and costs of CDASS compared to other service delivery options. A comprehensive analysis that includes both CDASS and IHSS would allow the Department to better understand cost drivers, member outcomes and possible areas for program improvement.

CDASS gives Home and Community Based Services (HCBS) waiver members the ability to direct and manage the attendants who provide personal care, homemaker and health maintenance services, rather than working through an agency. The following Home and Community Based Services (HCBS) waivers offer, or are in the process of offering, CDASS: Brain Injury (HCBS-BI), Spinal Cord Injury (HCBS-SCI), Elderly, Blind and Disabled (HCBS-EBD), Community Mental Health Supports (HCBS-CMHS), and Supported Living Services (HCBS-SLS). CDASS allows members to hire attendants who they may already know and who have been trained to provide the services, but who may not be licensed to provide skilled services through a home health agency. These services allow members to have more control over managing their services which can be especially beneficial to members in rural areas that may live far from a home care agency. Additionally, access to CDASS could improve a member's quality of life by empowering them to select, train, and manage the attendants of their choice and to have more control in scheduling their services.

In-Home Support Services (IHSS) also allows members to receive health maintenance, homemaker and personal care services in the community through attendants that the member choses. The significant difference in program is that IHSS attendants work through home health agencies to provide care rather than directly for the member. The member exercises employer authority but does not have budget authority under IHSS. These services are currently offered in the Spinal Cord Injury (HCBS-SCI), Elderly, Blind and Disabled (HCBS-EBD) and the Children's Home and Community Based Services (HCBS-CHBS) waivers.

In May 2015, the Office of the State Auditor recommended that "…the Department of Health Care Policy and Financing conduct a comprehensive analysis of the Consumer-Directed Attendant Support Services Program, including the benefits, health outcomes achieved, and costs compared to other service delivery options". However, the Department has neither the resources nor the expertise to conduct this analysis internally. Because expansion of the program to the HCBS-SLS waiver is currently pending approval from the Centers for Medicare and Medicaid Services (CMS), it is especially important that the Department fully understand the benefits, drawbacks, and changes in health outcomes offered by the program. An independent contractor could objectively show how the CDASS and IHSS programs could continue to serve the unmet needs of waiver members in a financially responsible manner.

The Department is requesting funding to hire a contractor to perform the following tasks:

- Develop an appropriate methodology to select a representative sample of survey participants.
- Create a survey instrument and survey methodology.
- Conduct cost analysis of CDASS and IHSS programs versus other agency based care.
- Perform data analysis examining costs of different service delivery methods.
- Combine survey results with claims data to gather a sense of financial and health outcomes associated with CDASS and IHSS participation.
- Provide the Department with monthly status updates.
- Present information and deliverables to CDASS and IHSS stakeholder groups.
- Design the analysis so that the study is comparable to other CDASS and IHSS analyses which have been performed by other states.

The Department envisions that the contractor would be able to quantify the impact CDASS and IHSS programs have had in health status or outcomes, quality of life of the members, member independence, and service satisfaction vs other care options. The Department also wants to quantify these benefits given the direct costs currently associated with CDASS and IHSS. The Department hopes to use the findings of this analysis to help direct future decisions on integrating Consumer Direct Services into other Medicaid benefits, such as respite services.

Audit Database

The Department requests $70,182 total funds, $35,091 General Fund in FY 2017-18 to correct, transition and modernize the Department's Audit Database. The Department also requests $11,382 total funds, $5,691 General Fund in ongoing funding to maintain software licenses.

The Department's Audit Database documents audit findings and the Department's mitigation efforts. The Department cannot effectively or efficiently fulfill the Office of the State Auditor's (OSA's) requirement to track the status of audit findings and recommendations because the reporting functionality of the Audit Database is partially inoperative. This occurred because part of the reporting functionality was unable to be preserved when the Department transitioned the underlying software from Microsoft Access to Microsoft SharePoint at the beginning of FY 2014-15. The transition to Microsoft SharePoint was necessary because the database had outgrown the storage limitations of Microsoft Access. The Department had previously requested funding for the Database in 2015-16 S-8, BA-8 "Legacy Systems and Technology Support" but JBC staff did not recommend the funding, instead recommending that the Department work with Governor's Office of Information Technology (OIT) to use existing operating funding to fix the database. In response, the Department has included the project as part of the Health Information Technology (HIT) projects list that the Department works on with OIT to prioritize IT projects. The project was given a low prioritization score due to unsecured funding, limited state wide impact of the project and the relative importance of other existing projects already in the queue. The project has also changed from a Microsoft SharePoint platform to a Salesforce platform based on feedback from OIT; this has resulted in a change in the cost estimate when compared to the database proposed in S-8, BA-8. The Department's goal is that with dedicated, secured funding, the database would move up in prioritization and become operational early in FY 2017-18. The Department anticipates that these expenses would have a startup cost of $70,182 and have ongoing costs of $11,382. See Table 10.2 for a breakdown of the costs.

Best Practices Initiatives

Project Management Staff

The Department requests $202,436 total funds, including $88,578 General Fund in FY 2017-18 and ongoing for 3.0 project management positions. These positions would provide necessary project management services for the Department as it continues to manage large and medium scale projects like Accountable Care Collaborate (ACC) Phase II. Additionally, project management resources will allow the department to better align with Centers Medicare and Medicaid Services (CMS) Medicaid Enterprise Life Cycle (MECL) and Medicaid Information Technology Architecture (MITA) frameworks.

Project management techniques helps organizations carry out projects on time, on budget, and with minimal disruption to the rest of the work of the organization. Many of the Department's projects involve large-scale

planning that affects every Office in the Department multiple program areas within the Department. When the Department implements programmatic changes in Medicaid, CHP+, or Office of Community Living these projects may mean dealing with multiple divisions within the Department like budget, accounting, human resources, communications, and systems. Accredited and trained project managers are skilled in project management techniques specific to dealing with organizing and managing these one-time projects. They can create plans to manage interdependence and address resource conflict. Organizations that use project management to monitor and control processes and schedules can more effectively complete their projects on time and on budget.

MECL and MITA are frameworks that have been created by CMS that fosters a project management mindset with an integrated business, information and technological approach to building management systems that are member-based and capable of sharing information across organizational silos based upon nationally recognized standards. MITA is most clearly visible in how CMS governs IT projects and associated business process need to be set up in order to receive enhanced federal funding that is typically associated with Medicaid technology projects like the Medicaid Management Information System (MMIS). This framework governs how states interact with CMS through the implementation, development, maintenance and operations stages of a technology system's life. While the focus on MECL and MITA are IT systems driven, CMS views MITA as a framework that applies to all of the Department's Medicaid business processes that interact with these system and impacts policy, financial operations and process design.

An example of a project that has MITA implications is Accountable Care Collaborate (ACC) re-procurement. For this project, the project manager is not overseeing an information technology project, but is responsible for assuring work on the design, drafting, and implementation of the solicitation is on time and work is done appropriately. Specifically the project manager is tasked to:

- Maintain the project work plan, timeline(s), action items lists, daily task lists, and issue log using project management software.
- Develop a reporting mechanism and reports in order to track and communicate the status, risks and accomplishments to Department leadership, staff, and external stakeholders.
- Monitor and verify milestones and completion dates contained in any staffer's project management.
- Assign work, monitor progress, and renegotiate problem resolution, so that each stage of the ACC re-procurement and implementation is completed on time.
- Assure that Department staff are not independently duplicating effort on tasks, but are working in a unified manner.
- Coordinate all work groups writing sections of the solicitation and shall coordinate with the Department's Purchasing and Contracting Services Section to assure the proposed drafts are drafted and reviewed for inclusion in the final solicitation.
- Present to senior leadership, updating it on project status and issues.
- Provide recommendations and guidance in addressing stakeholder concerns, from identification through resolution.
- Assist in monitoring budgets related to the work plan.

Because the Department did not have accredited, trained, and dedicated project management resources available, the Department will pay more than $200,000 per fiscal year for a project manager on this project. In addition, the Department continues to ask for resources through individual budget requests to manage the transition of vendors when large contracts are transitioned to another vendor. The Department believes that with additional resources and a central Project Management Office (PMO), the Department would not have needed the contracted project management resources and that future vendor transitions would require less additional resources.

The Department currently has two project management units in the Department's Health Information Office (HIO) which provide necessary project management services in accordance with CMS MECL, MITA framework and industry best practices; one unit is focused on eligibility projects and cross functional projects, with the other unit primarily being focused on the Department's Colorado Medicaid Management Innovation and Transformation (COMMIT) Project. The goal of the COMMIT Project is to redefine systems and business processes for the Medical Assistance program by procuring technical and business services to replace the legacy MMIS model with a service delivery model and modern system. The Department's COMMIT-focused project management unit currently has a team of six project management professionals (ranging from program assistants to certified project managers) who are responsible for ensuring that project is in compliance with the MECL framework, which is a requirement for CMS certification of the MMIS, in order to ensure continuing enhanced funding for MMIS development and operations. Furthermore, future changes or enhancement to the MMIS system will require adherence to these frameworks. This includes new additions and modifications to the MMIS that are the result of new programs or benefits proposed by the Department or included in legislation proposed by the General Assembly.

The Department has already seen the benefits of including the services of project management staff in these technology based projects and in private and federal grants, which has resulted in better coordination between different areas of the Department as those areas satisfy the terms and expectations of these projects. Based on this experience, the Department is proposing merging these two units into a central PMO and supplementing the number of project managers as part of this request. The Department expects similar efficiency improvements from a dedicated PMO as it implements the ACC Phase II, the State Innovation Model (SIM), HCBS waiver consolidation, implementation of Community Living Advisory Group recommendations and other large scale and medium scale projects that broadly affect the Department.

CMS has further emphasized the importance of project management by granting 90% federal financial participation (FFP) for project management positions used in the Design, Development and Implementation (DDI) and 75% FFP for Maintenance and Operations funding related to the MMIS. Currently four of the six project management positions in the COMMIT focused project management unit are dependent on 90% FFP and would need to be eliminated when that funding expires in June 2017. The Department currently would only be able to hire temporary employees to fill these job duties when the enhanced funding from DDI expires without an additional appropriation from the General Assembly. This would represent a sizeable amount of knowledge drain from the Department which would take years to rebuild, especially knowledge related to MECL and MITA frameworks. The Department believes that due to the need to adapt to new systems, new health benefits, eligibility changes, new programs, new state processes and new federal mandates that the Department would benefit from an increase in the use of project management principals provided by trained

project managers. The Department expects that given Department's strategic policies, of providing innovative delivery systems, implementing value based payments and adapting new health technologies, dedicated project managers are key to ensuring that the Department is able to successfully accomplish these goals, on time and within budgets. Because these positions have a large overlap with MITA, which is an enterprise-wide initiative for the improvement of Medicaid management, the Department believes that their responsibilities could be structured so that the positions would be eligible to receive some 75% FFP from CMS but still provide project management value to other non-system based areas of the Department, such as the Office of Community Living, Finance Office and the Health Programs Office. In order to claim the 75% FFP rate the Department would need these positions to time track and the Department has included Clarity time tracking licenses as part of the request. The Department assumes that 25% of the PMO's time will be spent on MMIS projects that qualify for 75% FFP and 75% would be on activities that are eligible 50% FFP, resulting in a blended rate of 56.25%. The Department's FTE cost estimate can be found in Table 2.1. For further detail on position descriptions see Appendix A below.

Community Mental Health Centers Audits

The Department requests ongoing funding of $204,000 in total funds, $102,000 General Fund in FY 2017-18 and ongoing to support yearly audits of cost reports for all 17 Community Mental Health Centers (CMHCs) in Colorado in order to ensure correct capitations payments are made to the Behavioral Health Organization (BHO), who manage the Department's community behavioral health services.

Community behavioral health services provide comprehensive mental health and substance use disorder services to all Colorado Medicaid members. A member is assigned to a BHO based on where the member lives. The BHO arranges for the member to get medically necessary behavioral health services, like therapy or medications. The Department funds behavioral health services through capitation payments to BHOs who provide care coordination and are responsible for paying for the member care provided by the CMHCs and other behavioral health providers. The BHO capitation payments are largely based on costs incurred and reported by the CMHCs in their yearly cost reports, as the CMHC provide a majority of the mental health and substance use disorder services to all Colorado Medicaid members. Recent results from an audit of the four largest CMHCs found $12 million of incorrectly reported costs that flow directly into the BHO rate calculation. These incorrectly reported costs artificially increase the amount of the BHO capitation payment by inflating the true and allowable costs experienced by the CMHC, who received cost based sub capitation rates from the BHO.

Currently the Department is using audit funding approved in the Department's FY 2015-16 "R-15 Managed Care Organization Audits" request to audit four to eight CMHCs each year. This request also included funding for conducting a thorough review of current managed care contract language to identify weaknesses, providing guidance to the Department with implementing medical loss ratios across all managed care plans, using selected algorithms on claims data of one or more managed care plans to identify outlier populations that could be at risk of overpayment and testing identified outlier populations to ensure compliance with regulations for allowable medical expenses. Based on the results of the audit the Department believes it is in the State's best interest to audit every CMHC's cost report on a yearly basis. However, there are not enough existing resources to pay for the increase in CMHC audits and still provide the other services that were included in the Department's 2015-16 request.

Other providers are also paid rates based on costs such as Federal Qualified Health Centers (FQHC) and Rural Health Centers (RHC). All FQHC's financial cost reports are audited on a yearly basis. Without an in-depth analysis to ensure the reported charges are both reasonable and allowable, the Department risks over payment for services provided to Medicaid members under BHO contracts. These overpayments may put the Department at risk for disallowance of federal funds by the Centers for Medicare and Medicaid Services (CMS).

The Department requests funding to hire an auditor to conduct a thorough financial review of all CMHC cost reports, on an annual basis, to ensure that all capitation payments represent the true cost of delivering services. The Department has prepared an estimate in table 6.2.

At a minimum the auditor would need to review cost reports submitted by the CMHCs and would be responsible for:

- Determining allowable costs per the Mental Health Accounting and Auditing Guidelines.
- Evaluating the allocation of costs between the relative value unit (RVU) and the non-relative value unit cost centers.
- Proposing adjustments to the cost report and send proposed adjustments to the CMHCs for review.
- Reviewing the CMHCs response(s) to propose adjustments and make modification to cost reports, as necessary.

After reviewing the cost reports, the auditor would provide an adjusted cost report to the Department. The adjusted cost report would then be used by the Department's Payment Reform Division to calculate the new BHO capitation rates, which are then sent to CMS for approval.

Though the Department cannot guarantee savings would result from audit findings, savings could result from avoidance of future overpayments in BHO capitations. Ensuring proper payment for services aligns with the Department's performance plan by ensuring sound stewardship of financial resources and are consistent with other best practices used by the Department for other cost-based providers.

Member and Provider Investigators

The Department requests a reduction of $391,760 total funds, including a reduction of $13,732 General Fund, including an increase of 5.5 FTE in FY 2017-18 and a reduction of $1,247,003 total funds, a reduction of $259,211 General Fund and an increase of 6.0 FTE in FY 2018-19 and ongoing to target provider recoveries and to assist outside parties with member investigations. This request includes $470,675 total funds for new FTE and $862,435 total funds in cost savings in FY 2017-18.

In recent years, the programs administered by the Department have grown dramatically in scope and complexity as Medicaid caseload continues to grow. In 2007-08 the Department had 391,962 members and expenses of $3.5 billion; in FY 2016-17 the Department expects 1.3 million members and has a budget of $9.1 billion. This growth increases the potential for waste, and abuse of the payment system. The Department does not have enough resources to keep pace in monitoring provider compliance within that system. Benefit Managers monitor the utilization of services offered by the Department and, among other things, refers suspicious activity to the Department's Program Integrity section. The Program Integrity section searches

for and identifies potential improper claims from providers, investigates the cases, and recovers payments. The section works closely with the Attorney General's Medicaid Fraud Control Unit and the U.S. Attorney's Office on cases in which sanctions are pursued against providers. Staff in these positions must have a high level of expertise in program rules and requirements in order to make a determination on whether an overpayment was made. As these programs become more complex, the Department needs resources who can become subject matter experts on individual programs to effectively monitor payments and ensure they are made in compliance with all rules and policies. Currently, any new programs are assigned to staff who already have a full-time workload and are unable to complete reviews as frequently as needed.

In addition, the Department does not have any dedicated resources to monitor member integrity issues, which have primarily been administered by the counties. SB 12-060 "Improving Medicaid Fraud Prosecution" directed that state share of all claims that are determined to be fraudulently obtained are retained by the counties that investigate the claims. However, if the claim is determined to be a recovery (i.e. the claim does not meet the fraud threshold) then the state share is returned to the Department and is used to offset the Medical Services Premium service expenditure line. The Department has collaborated with county investigators, law enforcement agencies, US Drug Enforcement Agency, District Attorneys, Attorney General, and US Assistant Attorney on cases but does not have dedicated staff to assist these agencies with their investigations. Currently internal audit staff are diverted from their Department compliance roles to assist these investigators, who are backfilled with sub-recipient monitoring staff. In addition, counties have traditionally not pursued cases that cross multiple county lines, deal with opioids or durable medical equipment as they are considerably more complicated to investigate, especially with the limited resources counties have to investigate cases. The Department believes that having dedicated resources assigned to these areas would benefit Colorado's Medicaid Program by removing members that are abusing the Medicaid program by obtaining benefits that they do not either qualify for or need. For further detail on position descriptions see Appendix A below. The Department's FTE cost estimate can be found in Table 2.1

With additional resources, these sections would be able to assign staff to specific program areas in which they can become subject matter experts on the rules and policies. Staff would have the capacity to perform regular reviews on providers and members, which would lead to a higher rate of identification of cases to investigate. This would lead to an increase in recoveries over time, on a pace more consistent with the increase in services and claims. The Department has prepared an estimate of the increase in cost savings in Table 11.1. For this analysis, the Department assumes that new integrity positions would have similar level of cost savings seen with existing program integrity staff. The Department assumes that the member integrity cost savings would primarily be avoided in future costs from ineligible members rather than member recoupments; this is due to the member integrity positions primarily being focused on assisting outside investigators.

Indian Health Services (IHS) Coordination

The Department requests $322,508 total funds, including $2,139,555 in General Fund savings for 3.67 FTE in FY 2017-18 and $328,096 total funds, including a savings of $2,135,367 General fund and 4.0 FTE to better address American Indian/Alaska Native health, with a focus on eligible Medicaid members, and to better coordinate services with IHS facilities to obtain federal funding at a higher match rate than currently being received. Two of the requested FTE would be charged with implementing a coordination program

between the Accountable Care Collaborative (ACC), Indian Health Services (IHS) and tribal governments and two FTE would focus on outreach and assistance with eligible members and stakeholders. One of the outreach FTE would a part of the Department's budget but operate through a Memorandum of Understanding (MOU) in the Lieutenant Governor's Office, in the Colorado Commission of Indian Affairs (CCIA) and the other would be an FTE at the Department of Human Services, Office of Behavioral Health.

IHS is the federal agency within the Department of Health and Human Services that provides services to American Indians and Alaskan Natives directly through its hospitals, health centers, and health stations, as well as indirectly by coordinating with tribe-administered health care facilities and contract health services (CHS), which are provided by non-IHS/tribal facilities. CHS is not an entitlement program; an IHS referral to a non-IHS/tribal facility does not imply the care will be paid for by IHS. If IHS is requested to pay, then a patient must meet residency requirements, notification requirements, medical priority, and use of alternative resources as defined by IHS. American Indian/Alaska Native Medicaid member costs are 100% federally funded when those members receive their services from an IHS facility. Traditionally if these members are served at a non-IHS facility, their claims are processed using the standard federal match rates under Medicaid.

In a letter dated February 26, 2016, CMS issued guidance to state Medicaid agencies clarifying that American Indian/Alaska native Medicaid members' claims could receive 100% federal funding if those services were coordinated through IHS, even if the services were not provided at an IHS facility.[1] This guidance provides additional financial incentives for the State to increase the coordination of care provided in the ACC to American Indian/Alaska Native Medicaid members served by IHS. CMS has not fully defined what coordination means and what level of coordination would be sufficient to claim 100% federal funding for these services, but has stated that they intent to issue additional guidance materials.

The Department and the Colorado Commission of Indian Affairs recently produced a study that looked at "key statewide and county specific data points and stakeholder comments regarding Medicaid enrollment, tribal enrollment, health care needs, cost changes, and care coordination." The report focused on issues affecting the Denver Indian Health and Family Services, Inc. (DIHFS) in the City & County of Denver, the Southern Ute Indian Tribe (SUIT) in La Plata County, and the Ute Mountain Ute Tribe (UMUT) in Montezuma County. The report identified major access to care issues in both urban and rural settings, including issues with eligible tribal members having to travel long distances to visit an IHS/tribal clinic or hospital. The report also identified areas where coordination and information sharing between IHS/Tribal facilities and outside providers were underperforming, which resulted in members either foregoing care or having to pay out-of-pocket costs that would have been covered by IHS in other situations. Based on the interview with the three tribal facilities, the report recommends "that HCPF gather deeper and more accurate information on tribal enrollment and affiliation, health care needs, cost changes, and care coordination along with tribal participation in the newly developed [Regional Accountable Entities] contracts."

The Department proposes creating four new positions to address the recommendations of the report and to coordinate health care issues between tribal members and the State; two positions would be at the Department working on coordinating services between IHS/Tribal and Medicaid providers, one position would be in the

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf

Lieutenant Governor's Office, in the Colorado Commission of Indian Affairs who would lead this cross functional health team and the final position would be at the Department of Human Services, Office of Behavioral Health, who would be responsible for providing training and technical assistance to behavioral health providers in delivering culturally responsive treatment to American Indian and Alaskan Native people seeking care throughout the state. The Department's position would help facilitate the coordination between IHS and tribal members as well as coordination with the Regional Collaborative Care Organizations (RCCOs) that provide for the coordination and integration of care within the ACC framework. These positions would also be responsible for developing the policies and procedures for documenting coordination with IHS and gaining the necessary federal approval for 100% federal funding. The other FTE based outside of the Department would focus on outreach and assistance with eligible members and stakeholders. Based on the lessons gained from the report done with CCIA, there is a major information gap between the services that are provided by State programs and eligible tribal populations. This request would create a cross agency group, with a diverse knowledge base, that would be able to address the unique health and wellness issues that affect American Indian/Alaska Native populations in Colorado. For further detail on position descriptions see Appendix A below.

Funding this request would improve care coordination and ensure that American Indian/Alaska Native Medicaid members access the care they need at appropriate times, free up IHS/Tribal funding for non-Medicaid eligible tribal members and would result in savings for the State. In FY 2014-15 the Department spent $73.2 million on self-identified American Indian/Alaska Natives, but only $2.3 million of total expenditure qualified for 100% federal funding; if the State is able to coordinate 10% of the remaining care offered at non-IHS facilities, making the expenses eligible for 100% federal funding, the Department estimates it would result in approximately $2.38 million General Fund savings. The Department's FTE cost estimate can be found in Table 2.1. The Department's estimated savings can be found in Table 9.1, 9.2 and 9.3 and is based on FY 2014-15 expenses paid by the Department for self-identified American Indian/Alaska Natives.

Hospital Provider Fee Model Resources

The Department requests $681,612 total funds, including $340,808 Hospital Provider Fee in FY 2017-18 and $676,909 total funds, including $338,456 Hospital Provider Fee in FY 2018-19 and ongoing funding to hire 1.0 FTE and provide ongoing contractor funding to provide oversight, development and review of the Hospital Provider Fee Model, with a major focus on the new Hospital Quality Incentive Payments (HQIP) and Delivery Service Reform Incentive payments (DSRIP). Additionally, the Department requests $100,000 in dedicated ongoing funding for HQIP data analysis starting in FY 2016-17.

The Colorado Health Care Affordability Act, HB 09-1293, created several Medicaid populations in Colorado (MAGI Adults, MAGI Parents/Caretakers above 60% FPL, continuous eligibility for eligible children, and the Buy-In Program for Working Adults and Children with Disabilities), a hospital supplemental payment program, and administration related to supporting the populations and supplemental payment program are funded with the Hospital Provider Fee. Colorado then expanded Medicaid under the Affordable Care Act (ACA) in SB 13-200, which further expanded eligibility of Hospital Provider Fee funded populations. The current Hospital Provider Fee (HPF) model involves $670 million in assessed fees, and supports $1.1 billion in direct supplemental payments to hospitals.

Responsibility for the preparation development, maintenance and modifications to the model rests with two financial analysts. Due to the sheer volume of data, the number of disparate sources of data, and the calculations and estimations required by the model, the current level of staffing and contractor resources is inadequate to ensure the timely development of a model that has been adequately reviewed. The 2015-16 hospital provider fee was approved by the Oversight and Advisory Board in February 2016 and by CMS in July 2016, with a retroactive effective date of October 2015. Approval of the model months after the effective date results in the need for substantial retroactive reconciling adjustments to both the fees charged and direct supplemental payments made to hospitals. This lack of resources has also contributed to a perceived lack of the transparency for the Hospital Provider Fee model. This lack of transparency was brought up by several members of the General Assembly during the last legislative session, during the debate on HB 16-1420, which would have turned the Hospital Provider Fee into a TABOR-exempt entity. Since high level staff are tasked with preparing the model and actively managing contracts, they are less available to provide educational outreach to outside parties.

Given the limited number of staff, it is difficult to provide the necessary time to both fully develop the model and provide the necessary outreach and assistance required for such a large program. These lack of resources have also caused delays in model approval, have caused uncertainty in the state budget, and have resulted in the need for large reconciliation payments to be made every year once the model is approved by the Centers for Medicare and Medicaid Services (CMS). In addition, the Hospital Provider Fee model has received $8 million in disallowances from CMS that have had to be paid by the participating hospitals that have resulted from errors in the model.

The Department has also proposed new supplemental payments that are tied to incentivizing quality and efficient care, consistent with other initiatives persued by the Department to better utilize financial resources and improve health outcome for members. The Colorado Health Care Affordability Act established performance-based hospital quality incentive payments to those hospitals that provide services that improve health care outcomes for their patients. Each year, HQIP funding in total equals up to 7% of the total hospital reimbursements made in the prior year. A hospital's HQIP funding is based upon its scoring on nationally recognized performance metrics, which are consistent with federal quality standards. Determining hospitals' HQIP scores involves data gathering from disparate sources, calculations and analysis. Currently the Department has $50,000 per year available for a contractor to gather and validate data from hospitals and other sources, calculate HQIP performance scores and payments, manage hospital communications and appeals of HQIP scoring results. This vendor must also have expertise to identify and develop the quality metrics and scoring methodology selected each year. The current amount of funding is inadequate to secure a vendor who can perform these functions satisfactorily, resulting in HQIP scoring errors and re-work by Department staff. The Department requests $100,000 in FY 2016-17 and ongoing funding to secure a more qualified vendor for HQIP scoring.

The Department is also pursuing transformation of the current provider fee-financed hospital payments to Delivery System Reform Incentive Payments (DSRIP) under the authority of a Section 1115 demonstration waiver. The DSRIP waiver will focus on improving population health across targeted communities through the development of the significant infrastructure, delivery system integration, and care interventions needed to allow the state's hospitals to join the ongoing improvements in care efforts already underway throughout

the state's Accountable Care Collaborative (ACC) and other initiatives. The Department needs ongoing funding for consultants to develop the Section 1115 demonstration waiver application, gather and document stakeholder input, respond to stakeholder feedback, assist in negotiating waiver terms and conditions with CMS, develop hospital guidance documents, conduct valuation and scoring of hospitals' DSRIP projects, evaluate hospital program performance, determine hospital scoring and payments, and assist with program evaluation and reporting to CMS. These payments need full and ongoing analysis to ensure the desired outcomes are achieved. Currently, the Department is funding the analysis and development of these payment with funds that were appropriated to the Department in FY 2014-15 in S-10, BA-10 "Provider Fee Analytics" causing the Department to not be able to fund some of the projects that were included as part of that request.

The Department requests one additional financial analyst to provide the necessary staffing needed to successfully run the Hospital provider Fee Model and programs. For further detail on position descriptions see Appendix A below. The Department's FTE cost estimate can be found in Table 2.1. Additionally, the Department requests $100,000 in dedicated ongoing funding for HQIP data analysis and $500,000 in ongoing funding for development and analysis of Delivery Service Reform Incentive Payments. These additional funds would ensure that all projects proposed in the S-10, BA-10 would be fully funded and the new supplemental payments would have the necessary contractual support to provide hospitals incentives to provide quality and efficient care.

Office Administered Drug Management

The Department requests a reduction of $472,592 total funds, $125,382 General Fund and 0.9 FTE in FY 2017-18 and an increase of $1,027,059 total funds, $316,456 General Fund in 2018-19 and ongoing in order to update the pricing for office administered drugs on a periodic basis consistent with pricing for other drugs, for 1.0 FTE to act as benefits manager for the office administered drugs services, and to account for savings associated with reduced hospital visits as a result of better availability of office administered drugs. The Department also proposes raising reimbursement rates for office administered drugs, on average, to 2.5% over the average sales price (ASP). This request assumes $67,538 total funds in FTE expenses and $540,130 total funds in net cost savings between rate increases and cost avoidance in FY 2017-18.

When a patient is administered a drug at a physician's office, the Department reimburses the provider for the drugs administered. The rate at which the physician are reimbursed are static, listed in the Department's fee schedule and are not currently adjusted to reflect average acquisition costs, like the pharmacy drug benefits offered by Medicaid. After the rates are set, they remain unchanged year-over-year, even as the costs of the office to administer drugs changes, as drugs enter or leave the market. Upon review of current rates, many rates were found to be below the average sales price and some are above the average retail price. The static nature of the payment list can result in a large variance between what a provider pays to purchase the drug and what price Medicaid reimburses the physician. This price disparity can result in providers administering drugs that are less effective for the patient (such as a once-a-day oral anti-psychotic versus an injected anti-psychotic that last for 30 days) or providers not administering the drug in their office but advising members to receive the drug at a hospital, who are reimbursed for the cost of the drug and are allowed to charge an additional facility fee to Medicaid.

The Department used claims data from FY 2014-15 to quantify the cost associated with members receiving an office administered drug at a higher cost facility. The Department identified all members who had received a noffice administered drug at outpatient facility within one week of visiting a physician's office and compared the list of drugs administered to the list of office administer drugs that have been identified by stakeholders as below acquisition cost. The result of that analysis is summarized in Tables 10.1 and 10.2 and represent the estimated cost savings associated with reducing the number of members who have to go to an outpatient setting to get their office administered drug.

The Department has also prepared an estimate of the expected costs associated with tying reimbursements for office administered drugs to 2.5% over the average sales price (ASP) of the drug class, which is essential to obtaining these savings. This analysis is detailed in Table 10.3. The Department proposes setting the rates for the total class of drugs to 2.5% over ASP requests flexibility to allow for incentive based pricing of some drugs over the 2.5% in order to incentives the use of those drugs; The Department would lower rates of other drugs to maintain an average rate of 2.5% over ASP. The Department believes that this incentive based pricing would allow for better, more cost effective treatment of members.

The requested position would be responsible for adjusting the Department's drug reimbursement fee schedule to incentivize physicians to provide cost efficient care that provides the best health outcomes to members. The position would also research the costs and benefits of a prior authorization program for physician administer drugs, update pharmacy and procedural codes for new and reformulated drugs codes, and prepare Medicaid State Plan Amendments for changes in physician administer drugs services. For further detail on position descriptions see Appendix A below. The Department's FTE cost estimate can be found in Table 2.1. The Department believes that having a benefits manager for office administered drugs would result in provider reimbursements that improve access to appropriate treatment, better track costs, create the ability to better incentivizes providers to provide cost effective care and a reduction in costs associated with members receiving office administered drugs in higher cost settings.

Anticipated Outcomes:

Approving this request would ensure the Department has sufficient funding and FTE to administer and support its programs. One of the Department's Performance Plan's primary goals of "ensuring sound stewardship of financial resources" would be met by this request, as it would allow financial resources to be allocated more efficiently. Approval of this request would put measures in place to ensure the Department's members have their needs met appropriately and that funds are correctly spent. Finally, The Department anticipates that several of these proposed changes will decrease the amount of General Fund needed by the Department and will ensure that Colorado obtains the maximum amount of federal funding that is available to the State.

In addition to the cost savings, the increase in oversight funding will ensure that the that members are receiving the services that they need, that providers are correctly billing the Department for those services, that benefits are correctly priced and that the Department continues to effectively incentive wellbeing. By demonstrating sound stewardship of financial resources, the Department is able to improve health care access and outcomes for the people it serves.

Assumptions and Calculations:

Where applicable, notable assumptions for each calculations have been shown in the 'Proposed Solution' section of this document. The Department has included an appendix that details the calculations used to determine the fiscal impact for each request and includes:

- A list of each FTE proposed including the applicable initiative, FTE position title, position type, number of FTE requested and description of position tasks.
- FTE cost calculation.
- Cost breakouts for contractor costs for CMHC audit, consumer directed services evaluation, AVP services, Hospital Provider Fee contracts and audit database.
- Estimated cost savings calculations for IHS services coordination, office administered drugs and provider/consumer fraud savings.

Appendix A: FTE Descriptions

Position Name	Position Classification	Number of FTE	Description
Member Investigators			
Member Integrity Investigator	Compliance Investigator II	**2.0**	The proposed positions would have two major focuses: assisting outside investigators and investigating complicated member integrity cases. These position would work closely with counties' investigators, Department eligibility and program staff, law enforcement, other state agencies and other external agencies investigating Medicaid members. They would provide Medicaid claims payment data to outside investigators or law enforcement, testify on behalf of the Department and represent the Department in external meetings. They would also provide training and technical guidance and support to Colorado's 64 counties with the goals of improving information sharing, implementing best practices and encouraging consistency in investigations across counties. The positions would also collect data from counties and produce the annual legislative report required by SB 12-060. Internally these positions would monitor and conduct assessment of tips and complaints received and determine appropriate actions, conduct investigation (especially cases that counties traditional do not pursue such as opioids, other controlled substances and durable medical equipment. Staff would prepare and refer these cases to law enforcement for prosecution.

Provider Investigators			
Nurse Reviewer	Compliance Specialist IV	1.0	The proposed position would be responsible for reviewing claims post-payment and conducting the preliminary investigations, preparing summary reports which are used as the basis for making a demand for repayment request. This position would also evaluate and respond to informal request for reconsiderations made by providers and would provide technical assistance in cases of fraud. The proposed position would focus on utilizing professional nursing education and experience in reviews of medical records to identify possible overpayments or possible fraud, such as private duty nursing or overlapping billings by providers which perform multiple roles for the Department, e.g. a provider who provides home health; home and community based services; early and periodic screening, diagnostic, and treatment; and transition coordination services.
Benefits Managers	Administrator III	1.0	The proposed position would be located in the Health Programs Office and would specialize in identifying utilization outliers that appear to be provider specific. This position would perform both facility and services analysis. Duties would include data analysis of claims data, investigations of outliers and referral to Program Integrity section for formal investigation of suspicious providers. This position would act as a liaisons with the Program Integrity section for all investigations that involve the Department's Health Programs Office.
Certified Billing Coding Specialist	Compliance Specialist IV	1.0	The proposed position would be responsible for reviewing claims post-payment and conducting the preliminary investigations. The position will focus on billing code issues and provide technical assistance on interpretation and application of billing codes to other reviewers and analysts. The position would have a medical background that would allow them to evaluate the appropriateness of the billing coding used by the providers.
Claims Reviewers	Compliance Specialist IV	1.0	The proposed position would be responsible for reviewing claims post-payment and conducting the preliminary investigations, preparing summary reports which are used as the basis for making a demand for repayment request. This position would also evaluate and respond to informal request for reconsiderations made by providers and would provide technical assistance in cases of fraud. This positions would focus on the Child Health Plan *Plus* program, full risk managed care, consumer directed attendant support services, other waiver services, dental and state plan personal care services.
	Total FTE	**4.0**	

Office Administered Drugs			
Benefits Manager	Administrator III	**1.0**	The proposed position would be responsible for management of the physician administered drug benefit. Duties would include data analysis of claims data, assessing the effectiveness of different value based reimbursement models, developing clinical criteria for utilization, and insuring these drugs and devices are being administered in the most cost effective place of service. The position would perform both facility and physician service analysis. In addition this position would be responsible for regularly monitoring and adjusting reimbursement for office administered drugs and devices.
Hospital Provider Fee Resources			
Financial Modeling Analyst	Rate/Financial Analyst II	**1.0**	The proposed position would assist with the development and modeling of the hospital provider fee, the related supplemental payments to hospitals and calculate federally-required Upper Payment Limit (UPL) and Disproportionate Share Hospital (DSH) limits. This position would assume a number of the fee, payment, and federal limit calculations that are currently being performed by the unit lead. The position would assist with the calculations of proposed alternate payment and calculation methodologies that may more effectively achieve the hospital provider fee program's goals. The additional analyst would reduce the risk of calculation errors and improve the timeliness of hospital provider fee model development by allowing for a more robust internal review process.

Project Management			
Project Manager	Project Manager I	1.0	The proposed position, which is an existing position moving from 90% federal funding to 56.25%, would act as consultants to provide strategy, create systems, processes, guidelines and rules related to project management practices. The positions would provide support to the Department's project team by coordinating activities, providing guidance on project management processes used for the project, and communication of project information to stakeholders. In conjunction with the project sponsor and other key project stakeholders, the position define, document, and establish the project scope of work, the project schedule, procurements, budget, risks, communication needs, and required resources. The position would also works with Office Division Directors to identify changes needed for improved performance and coordinates with policy staff to appropriately prioritize and implement needed systems, policy and operations changes. Finally, the position is responsible for ensuring current compliance and strategic planning to achieve required compliance with Medicaid Enterprise Life Cycle (MECL) and Medicaid Information Technology Architecture (MITA) frameworks, and for providing department-wide project management assistance.
Assistant Project Manager	Liaison II	1.0	The existing position, which are moving from 90% federal funding to 56.25%, manages compliance activities that include business needs assessment and system and operational solutions for timely and successful implementation and maintenance of compliance objectives. The position would manage processes to ensure that program, systems, and/or operations impacts are identified in advance to provide notification of change to stakeholders as well as gain appropriate federal and state approvals. The position would analyze complex vendor project plans and following defined project management principles, makes corrections as requested by Department management.
Program Assistance	Program Assistant II	1.0	This existing position, which is moving from 90% federal funding to 56.25%, is responsible for supporting communication for project activities among the project team, staff and others to optimize access and to ensure timely communication and facilitation of activities relating to projects. The position coordinates and produces presentations for division/section meetings, project meetings, stakeholder meetings, etc., communicates proficiently with a variety of policy and technical staff in written and verbal formats. The position also collaborates with budget and accounting staff and contract vendors to identify costs, schedule, and resources for project initiatives.
	Total FTE	**3.0**	

Indian Health Services Coordination			
Outreach Coordinator	Administrator IV	1.0	The proposed FTE would be a part of the Department's budget but would operate through a Memorandum of Understanding (MOU) with the Lieutenant Governor's Office, specifically the Colorado Commission of Indian Affairs (CCIA). The position would facilitate formal tribal consultations with the Southern Ute Indian Tribe (SUIT) and Ute Mountain Ute Tribe (UMUT) for the Department and work to improve government-to-government relations between the Department and the Tribes on health issues. The position would travel to and interface directly with tribal partners regarding implementation of State policies. The position would develop strong relationships with the SUIT and UMUT staff at multiple levels and coordinate with tribal council members, human services, public health, attorneys, public information officers, community partner organizations, staff of American Indian organizations such as the Denver Indian Family Resource Center, Denver Indian Health and Family Services to inform and engage tribal partners on eligibility and policy changes from the State.
Training and Technical Assistance Project Manager	Project Manager 1	1.0	The position will represent the Office of Behavioral Health on inter-agency efforts aimed at improving the health and wellness of American Indian and Alaskan Native. This will assure that the efforts of OBH to improve access and effectiveness of behavioral health services for this population are aligned with that of the Department of Healthcare Policy and Financing and their Regional Collaborative Care Organizations (RCCOs) and Behavioral Health Organizations (BHOs), as well as the Lieutenant Governor's Office and the Colorado Commission on Indian Affairs. This position will be knowledgeable about the two tribes in Colorado, the Southern Ute and the Ute Mountain Ute, and will offer liaison services between the Indian Health Medical Centers in Towaoc and Ignacio and the Tribal Health Medical Center in Denver and the behavioral health providers delivering care to shared members.
Coordination Specialists	Administrator IV	2.0	These proposed positions would be responsible for assisting the Regional Care Collaborative Organizations (RCCOs) in their efforts to coordinate services for American Indian and Alaska Native between Indian Health Services (IHS) and Non-IHS providers. These proposed positions would assist Department staff on the Colorado Commission of Indian Affairs and related subcommittees These positions would work with outreach staff to find and correct pain points in for American Indian and Alaska Native Medicaid members. This would include developing and distributing resource guides and aids that can assist tribal agencies and health facilities with Medicaid processes and services. The positions would identify and help the Department act on opportunities to maximized federal matching funds per new CMS guidance related to 100% match for services offered in non-IHS facilities.
	Total FTE	**4.00**	
Grand Total		**15.00**	

Table 1.0 Summary by Line Item					
FY 2016-17	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
Total Request	**$200,000**	**0.0**	**$50,000**	**$50,000**	**$100,000**
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$200,000	0.0	$50,000	$50,000	$100,000
[1] Cash Fund Portion is Hospital Provider Fee					

Table 1.1 Summary by Line Item					
FY 2017-18	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
Total Request	**$1,567,569**	**14.1**	**($1,577,408)**	**$100,685**	**$3,044,292**
(1) Executive Director's Office; (A) General Administration, Personal Services	$832,311	13.2	$415,282	$31,170	$385,859
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$103,052	0.0	$46,079	$3,964	$53,009
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$1,278	0.0	$571	$53	$654
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$33,679	0.0	$14,997	$1,397	$17,285
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$33,679	0.0	$14,997	$1,397	$17,285
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$60,142	0.0	$27,020	$2,827	$30,295
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$1,621,365	0.0	$510,683	$300,000	$810,682
(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$204,000	0.0	$102,000	$0	$102,000
(2) Medical Services Premiums; Medical Services Premiums	($1,402,565)	0.0	($2,789,665)	($240,123)	$1,627,223
DHS (8) Behavioral Health Services; (A) Community Behavioral Health Administration	$80,628	0.9	$80,628	$0	$0
[1] Cash Fund Portion is Hospital Provider Fee					

Table 1.2 Summary by Line Item					
FY 2018-19	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
Total Request	**$2,061,245**	**15.0**	**($1,452,670)**	**$70,716**	**$3,443,199**
(1) Executive Director's Office; (A) General Administration, Personal Services	$881,836	14.0	$440,740	$31,170	$409,926
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$103,052	0.0	$46,079	$3,964	$53,009
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$1,360	0.0	$611	$53	$696
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$35,835	0.0	$16,074	$1,397	$18,364
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$35,835	0.0	$16,074	$1,397	$18,364
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$13,112	0.0	$5,856	$475	$6,781
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$1,469,748	0.0	$434,874	$300,000	$734,874
(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$204,000	0.0	$102,000	$0	$102,000
(2) Medical Services Premiums; Medical Services Premiums	($765,557)	0.0	($2,597,002)	($267,740)	$2,099,185
DHS (8) Behavioral Health Services; (A) Community Behavioral Health Administration	$82,024	1.0	$82,024	$0	$0
[1] Cash Fund Portion is Hospital Provider Fee					

Table 2.0 Summary by Initiative FY 2016-17							
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**Source/Calculation**
A	**Electronic Asset Verification Program (AVP)**	**$100,000**	**0.0**	**$50,000**	**$0**	**$50,000**	**Row B**
B	Contractor Costs	$100,000	0.0	$50,000	$0	$50,000	Table 6.1
C	**Hospital Provider Fee Model Resources**	**$100,000**	**0.0**	**$0**	**$50,000**	**$50,000**	**Row D**
D	Contractor Costs	$100,000	0.0	$0	$50,000	$50,000	Table 7.1
E	**Total**	**$200,000**	**0.0**	**$50,000**	**$50,000**	**$100,000**	

Table 2.1 Summary by Initiative FY 2017-18							
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**Source/Calculation**
A	**Electronic Asset Verification Program (AVP)**	**$529,183**	**0.00**	**$264,592**	**$0**	**$264,591**	**Row B**
B	Contractor Costs	$529,183	0.00	$264,592	$0	$264,591	Table 6.1
C	**Consumer Directed Care Evaluation**	**$422,000**	**0.00**	**$211,000**	**$0**	**$211,000**	**Table 5.1**
D	**Audit Database**	**$70,182**	**0.00**	**$35,091**	**$0**	**$35,091**	**Table 8.1**
E	**Project Management Staff**	**$202,436**	**3.00**	**$88,578**	**$0**	**$113,858**	**Row F + Row G**
F	Extension of Existing FTE	$198,824	3.00	$86,997	$0	$111,827	Table 3.1, FTE Calculator Assumes 56.25% Federal Financial Participation (FFP)
G	FTE Operating Costs	$3,612	0.00	$1,581	$0	$2,031	Table 3.1, FTE Calculator Assumes 56.25% FFP
H	**Community Mental Health Center Audits**	**$204,000**	**0.00**	**$102,000**	**$0**	**$102,000**	**Table 4.1**
I	**Client and Provider Investigators**	**($391,760)**	**5.50**	**($13,732)**	**($86,696)**	**($291,332)**	**Row J + Row K +Row L +Row M**
J	Client FTE	$149,946	1.83	$74,975	$0	$74,971	Table 3.1, FTE Calculator
K	Provider FTE	$286,811	3.67	$143,406	$0	$143,405	Table 3.1, FTE Calculator
L	FTE Operating Costs	$33,918	0.00	$16,959	$0	$16,959	Table 3.1, FTE Calculator
M	Anticipated Cost Savings	($862,435)	0.00	($249,072)	($86,696)	($526,667)	Table 11.1
N	**Indian Health Services Coordination**	**$322,508**	**3.67**	**($2,139,555)**	**($133,388)**	**$2,595,451**	**Row O + Row P + Row Q + Row R + Row S**
O	Department FTE Costs	$149,946	1.83	$74,975	$0	$74,971	Table 3.1, FTE Calculator
P	FTE Operating Costs	$11,306	0.00	$5,653	$0	$5,653	Table 3.1, FTE Calculator
Q	Other Agency FTE	$149,950	1.83	$149,950	$0	$0	Table 3.1, FTE Calculator
R	FTE Operating Costs	$11,306	0.00	$11,306	$0	$0	Table 3.1, FTE Calculator
S	Anticipated Cost Savings	$0	0.00	($2,381,439)	($133,388)	$2,514,827	Table 9.1
T	**Hospital Provider Fee Model Resources**	**$681,612**	**1.00**	**$0**	**$340,808**	**$340,804**	**Row U + Row V+ Row W**
U	FTE Costs	$75,959	1.00	$0	$37,981	$37,978	Table 3.1, FTE Calculator
V	FTE Operating Costs	$5,653	0.00	$0	$2,827	$2,826	Table 3.1, FTE Calculator
W	Contractor Costs	$600,000	0.00	$0	$300,000	$300,000	Table 7.1
X	**Office Administered Drug Management**	**($472,592)**	**0.92**	**($125,382)**	**($20,039)**	**($327,171)**	**Row Y + Row Z + Row AA**
Y	FTE Costs	$61,885	0.92	$30,945	$0	$30,940	Table 3.1, FTE Calculator
Z	FTE Operating Costs	$5,653	0.00	$2,827	$0	$2,826	Table 3.1, FTE Calculator
AA	Cost Avoidance	($579,450)	0.00	($170,740)	($21,498)	($387,212)	Table 10.1
AB	Rate Impact	$39,320	0.00	$11,586	$1,459	$26,275	Table 10.1
AC	**Total**	**$1,567,569**	**14.1**	**($1,577,408)**	**$100,685**	**$3,044,292**	

Table 2.2 Summary by Initiative FY 2018-19 and Ongoing							
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Federal Funds**	**Source/Calculation**
A	**Electronic Asset Verification Program (AVP)**	**$858,366**	**0.00**	**$429,183**	**$0**	**$429,183**	**Row B**
B	Contractor Costs	$858,366	0.00	$429,183	$0	$429,183	Table 6.1
C	**Consumer Directed Care Evaluation**	**$0**	**0.00**	**$0**	**$0**	**$0**	**Table 5.1**
D	**Audit Database**	**$11,382**	**0.00**	**$5,691**	**$0**	**$5,691**	**Table 8.1**
E	**Project Management Staff**	**$202,436**	**3.00**	**$88,578**	**$0**	**$113,858**	**Row F + Row G**
F	Extension of Existing FTE	$198,824	3.00	$86,997	$0	$111,827	Table 3.1, FTE Calculator Assumes 56.25% Federal Financial Participation (FFP)
G	FTE Operating Costs	$3,612	0.00	$1,581	$0	$2,031	Table 3.1, FTE Calculator Assumes 56.25% FFP
H	**Community Mental Health Center Audits**	**$204,000**	**0.00**	**$102,000**	**$0**	**$102,000**	**Table 4.1**
I	**Client and Provider Investigators**	**($1,247,003)**	**6.00**	**($259,211)**	**($173,392)**	**($814,400)**	**Row J + Row K +Row L +Row M**
J	Client Fraud FTE	$162,148	2.00	$81,074	$0	$81,074	Table 3.1, FTE Calculator
K	Provider Fraud FTE	$310,019	4.00	$155,009	$0	$155,010	Table 3.1, FTE Calculator
L	FTE Operating Costs	$5,700	0.00	$2,850	$0	$2,850	Table 3.1, FTE Calculator
M	Anticipated Cost Savings	($1,724,870)	0.00	($498,144)	($173,392)	($1,053,334)	Table 11.1
N	**Indian Health Services Coordination**	**$328,096**	**4.00**	**($2,135,367)**	**($133,388)**	**$2,596,851**	**Row O + Row P + Row Q + Row R + Row S**
O	Department FTE Costs	$162,148	2.00	$81,074	$0	$81,074	Table 3.1, FTE Calculator
P	FTE Operating Costs	$1,900	0.00	$950	$0	$950	Table 3.1, FTE Calculator
Q	Other Agency FTE	$162,148	2.00	$162,148	$0	$0	Table 3.1, FTE Calculator
R	FTE Operating Costs	$1,900	0.00	$1,900	$0	$0	Table 3.1, FTE Calculator
S	Anticipated Cost Savings	$0	0.00	($2,381,439)	($133,388)	$2,514,827	Table 9.1
T	**Hospital Provider Fee Model Resources**	**$676,909**	**1.00**	**$0**	**$338,456**	**$338,453**	**Row U + Row V+ Row W**
U	FTE Costs	$75,959	1.00	$0	$37,981	$37,978	Table 3.1, FTE Calculator
V	FTE Operating Costs	$950	0.00	$0	$475	$475	Table 3.1, FTE Calculator
W	Contractor Costs	$600,000	0.00	$0	$300,000	$300,000	Table 7.1
X	**Office Administered Drug Management**	**$1,027,059**	**1.00**	**$316,456**	**$39,040**	**$671,563**	**Row Y + Row Z + Row AA**
Y	FTE Costs	$66,796	1.00	$33,400	$0	$33,396	Table 3.1, FTE Calculator
Z	FTE Operating Costs	$950	0.00	$475	$0	$475	Table 3.1, FTE Calculator
AA	Cost Avoidance	($1,205,488)	0.00	($355,098)	($49,057)	($801,333)	Table 10.1
AB	Rate Impact	$2,164,801	0.00	$637,679	$88,097	$1,439,025	Table 10.1
AC	**Total**	**$2,061,245**	**15.0**	**($1,452,670)**	**$70,716**	**$3,443,199**	

Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- New full-time General Fund positions are reflected in Year 1 as 0.9166 FTE to account for the pay-date shift. This applies to personal services costs only; operating costs are not subject to the pay-date shift.

Expenditure Detail		FY 2017-18			FY 2018-19	
	Monthly Salary	FTE			FTE	
Compliance Investigator II	$ 5,005	1.83		110,102	2.00	120,120
PERA				11,175		12,192
AED				5,505		6,006
SAED				5,505		6,006
Medicare				1,596		1,742
STD				209		228
Health-Life-Dental				15,854		15,854
Subtotal Position 1, 2.0 FTE		1.83	**$**	**149,946**	2.00	**$ 162,148**
	Monthly Salary	FTE			FTE	
Compliance Specialist IV	$ 5,005	2.75		165,153	3.00	180,180
PERA				16,763		18,288
AED				8,258		9,009
SAED				8,258		9,009
Medicare				2,395		2,613
STD				314		342
Health-Life-Dental				23,782		23,782
Subtotal Position 2, 3.0 FTE		2.75	**$**	**224,923**	3.00	**$ 243,223**
	Monthly Salary	FTE			FTE	
Administrator III	$ 4,028	1.83		88,610	2.00	96,672
PERA				8,994		9,812
AED				4,431		4,834
SAED				4,431		4,834
Medicare				1,285		1,402
STD				168		184
Health-Life-Dental				15,854		15,854
Subtotal Position 3, 2.0 FTE		1.83	**$**	**123,773**	2.00	**$ 133,592**

	Monthly Salary	FTE		FTE	
Rate/Financial Analyst II	$ 4,655	1.00	55,860	1.00	55,860
PERA			5,670		5,670
AED			2,793		2,793
SAED			2,793		2,793
Medicare			810		810
STD			106		106
Health-Life-Dental			7,927		7,927
Subtotal Position 4, 1.0 FTE		1.00	**$ 75,959**	1.00	**$ 75,959**
	Monthly Salary	FTE		FTE	
Administrator IV (Department)	$ 5,005	1.83	110,102	2.00	120,120
PERA			11,175		12,192
AED			5,505		6,006
SAED			5,505		6,006
Medicare			1,596		1,742
STD			209		228
Health-Life-Dental			15,854		15,854
Subtotal Position 5, 2.0 FTE		1.83	**$ 149,946**	2.00	**$ 162,148**
	Monthly Salary	FTE		FTE	
Administrator IV (Other Agencies via MOU)	$ 5,005	0.92	55,051	1.00	60,060
PERA			5,588		6,096
AED			2,753		3,003
SAED			2,753		3,003
Medicare			798		871
STD			105		114
Health-Life-Dental			7,927		7,927
Subtotal Position 6, 1.0 FTE		0.92	**$ 74,975**	1.00	**$ 81,074**
	Monthly Salary	FTE		FTE	
Project Manager I (Other Agencies)	$ 5,005	0.92	55,051	1.00	60,060
PERA			5,588		6,096
AED			2,753		3,003
SAED			2,753		3,003
Medicare			798		871
STD			105		114
Health-Life-Dental			7,927		7,927
Subtotal Position 7, 1.0 FTE		0.92	**$ 74,975**	1.00	**$ 81,074**

	Monthly Salary	FTE			FTE		
Project Manager (Existing FTE)	$ 5,005	1.00		60,060	1.00		60,060
PERA				6,096			6,096
AED				3,003			3,003
SAED				3,003			3,003
Medicare				871			871
STD				114			114
Health-Life-Dental				7,927			7,927
Subtotal Position 8, 1.0 FTE		1.00	**$**	**81,074**	1.00	**$**	**81,074**
	Monthly Salary	FTE			FTE		
Liaison II (Existing FTE)	$ 3,486	1.00		41,832	1.00		41,832
PERA				4,246			4,246
AED				2,092			2,092
SAED				2,092			2,092
Medicare				607			607
STD				79			79
Health-Life-Dental				7,927			7,927
Subtotal Position 9, 1.0 FTE		1.00	**$**	**58,875**	1.00	**$**	**58,875**
	Monthly Salary	FTE			FTE		
Program Assistant II (Existing FTE)	$ 3,486	1.00		41,832	1.00		41,832
PERA				4,246			4,246
AED				2,092			2,092
SAED				2,092			2,092
Medicare				607			607
STD				79			79
Health-Life-Dental				7,927			7,927
Subtotal Position 10, 1.0 FTE		1.00	**$**	**58,875**	1.00	**$**	**58,875**
New FTE Subtotal		11.08	**$**	**874,497**	12.00	**$**	**939,218**
Continued FTE Subtotal		3.00	**$**	**198,824**	3.00	**$**	**198,824**
Subtotal Personal Services		14.1	**$**	**1,073,321**	15.00	**$**	**1,138,042**
Operating Expenses							
Regular FTE Operating Expenses	500.00	15.00		7,500	15.00		7,500
Telephone Expenses	450.00	15.00		6,750	15.00		6,750
PC, One-Time	1,230.00	12.00		14,760	-		
Office Furniture, One-Time	3,473.00	12.00		41,676	-		
Clarity License	254.00	3.00		762	3.00		762
New FTE Subtotal		12.00		**67,836**	12.00		**11,400**
Continued FTE Subtotal		3.00		**3,612**	3.00		**3,612**
Subtotal Operating Expenses		15.00		**71,448**	15.00		**15,012**
TOTAL REQUEST		**14.1**	**$**	**1,144,769**	**15.00**	**$**	**1,153,054**
General Fund:			$	599,574		$	607,458
Cash funds:			$	40,808		$	38,456
Reappropriated Funds:				-			-
Federal Funds:			$	504,387		$	507,140

Table 4.1 Community Mental Health Centers (CMHC) Fund Splits							
Row	**Fiscal Year**	**Total Funds**	**General Fund**	**Cash Fund**	**Federal Funds**	**FFP Rate**	**Source/Calculation**
A	FY 2017-18 and Ongoing	$204,000	$102,000	$0	$102,000	50.00%	Table 4.2 Row C

Table 4.2 - Breakdown of Community Mental Health Centers (CMHC) Audit Costs			
Row	**Item**	**FY 2015-16**	**Comments/Calculation**
A	Cost for CMHC Cost Report Review	$12,000	Based on Department contract for existing Behavior Health Organization audits
B	Number of CMHCs in Colorado	17	Based on Number of CMHCs
C	**Total Cost for Review**	**$204,000**	**Row A * Row B**

Table 5.1 Consumer Directed Care Evaluation Fund Splits						
Row	**Fiscal Year**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP Rate**	**Source/Calculation**
A	2017-18	$422,000	$211,000	$211,000	50.00%	Table 5.2 Row F

Table 5.2 Consumer Directed Care Evaluation Costs			
Row	**Item**	**FY 2017-18**	**Source**
A	Survey Design and Sampling Methodology	$45,000	Department estimate based on similar work in the past
B	Survey Execution	$72,000	1,800 Client surveys X $40 each
C	Data Analysis of Entire Consumer Directed Attendant Support Services and In-Home Support Services Populations	$200,000	Department estimate based on similar work in the past
D	Data Analysis of Surveyed Populations	$120,000	Estimate based on previous audit of 4,200 HCBS waiver claims
E	Stakeholder and Department Meetings	$30,000	Department Estimate
F	**Total**	**$422,000**	**Row A + Row B + Row C + Row D + Row E**

Table 6.1 Asset Verification Program Fund Splits						
Row	**Fiscal Year**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP Rate**	**Source/Calculation**
A	2016-17	$100,000	$50,000	$50,000	50.00%	Table 6.2 Row E
B	2017-18	$529,183	$264,592	$264,591	50.00%	Table 6.2 Row E
C	2018-19 and Ongoing	$858,366	$429,183	$429,183	50.00%	Table 6.2 Row E

Table 6.2 Asset Verification Program Implementation and Ongoing Costs					
Row	**Item**	**FY 2016-17**	**FY 2017-18**	**Ongoing Costs**	**Notes**
A	Project Planning	$14,400	$0	$0	Based on estimate from Oklahoma Health Care Authority
B	Integration with State Systems	$59,680	$100,000	$0	Based on estimate from Oklahoma Health Care Authority and OIT input
C	Financial Institution Enrollment and Management	$25,920	$0	$0	Based on estimate from Oklahoma Health Care Authority
D	Verification Costs	$0	$429,183	$858,366	Verification costs assumes a January 2018 start date
E	Total Cost	$100,000	$529,183	$858,366	Row A + Row B + Row C + Row D

Table 7.1 Hospital Provider Contractor Fund Splits							
Row	**Fiscal Year**	**Total Funds**	**General Fund**	**Hospital Provider Fee**	**Federal Funds**	**FFP Rate**	**Source/Calculation**
Hospital Quality Incentive Payment (HQIP)							
A	2016-17 and Ongoing	$100,000	$0	$50,000	$50,000	50.00%	Table 7.3 Row D
Delivery Service Reform Incentive Payments (DSRIP)							
B	2017-18 and Ongoing	$500,000	$0	$250,000	$250,000	50.00%	Table 7.2 Row D

Table 7.2 Delivery Service Reform Incentive Payments (DSRIP) Cost Estimates			
Row	**Item**	**FY 2017-18**	**Source**
A	Valuation and Scoring of Projects	$150,000	Department estimate based on previous requests for proposals
B	Payment Methodology Development and Support	$125,000	Department estimate based on previous requests for proposals
C	Program Evaluation and CMS Support	$225,000	Department estimate based on previous requests for proposals
D	**Total**	**$500,000**	**Row A + Row B + Row C**

Table 7.3 Hospital Quality Incentive Payment (HQIP) Cost Estimates			
Row	**Item**	**FY 2017-18**	**Source**
A	Data Analysis	$50,000	Department estimate based on Existing Contract
B	Meetings with Department Staff and Stakeholders	$30,000	Department estimate based on Existing Contract
C	Data Infrastructure and Collection	$20,000	Department estimate based on Existing Contract
D	**Total**	**$100,000**	**Row A + Row B + Row C**

Table 8.1 Audit Database Fund Splits						
Row	**Fiscal Year**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP Rate**	**Source/Calculation**
A	FY 2017-18	$70,182	$35,091	$35,091	50%	Table 8.2 Row H
B	FY 2018-19 and Ongoing	$11,382	$5,691	$5,691	50%	Table 8.2 Row H

Table 8.2 - Calculation of Audit Database Funding				
Row	**Item**	**FY 2017-18**	**FY 2018-19 and ongoing**	**Source**
A	Project Kickoff and Requirements Gathering	$8,000	$0	OIT Estimate
B	Configure and Load Existing Data	$20,000	$0	OIT Estimate
C	Security Setup	$800	$0	OIT Estimate
D	Configure Automation	$12,000	$0	OIT Estimate
E	Production Deployment	$10,000	$0	OIT Estimate
F	Testing	$8,000	$0	OIT Estimate
G	Licenses	$11,382	$11,382	OIT Estimate
H	**Total**	**$70,182**	**$11,382**	**Sum (Row A: Row G)**

Table 9.1 Estimated State Share Cost Savings in FY 2017-18 and FY 2018-19					
Row	**Item**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes**
A	Costs for FY 2014-15	$23,814,394	$1,333,878	$45,799,932	Table 9.2 Row Q
B	Estimated percentage of services that could be coordinated with Indian Health Services (IHS) and be eligible for 100% Federal Medical Assistance Percentage (FMAP)	10.00%	10.00%	N/A	Department Estimate
C	Estimated shift in costs	($2,381,439)	($133,388)	$2,514,827	

Table 9.2 Client Expenses in FY 2014-15 by Eligibility Group and Funding Source, Net Indian Health Services								
Row	**Group**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**FMAP Rate[1]**	**State Funding Source**	**Notes**
A	Adults 65 and Older (OAP-A)	$2,631,759	$1,315,616	$0	$1,316,143	Standard (50%)	General Fund	
B	Breast & Cervical Cancer Program	$1,245	$0	$436	$809	Enhanced (65%)	BCCP Cash Fund	
C	Disabled Adults 60 to 64 (OAP-B)	$1,739,311	$869,482	$0	$869,829	Standard	General Fund	
D	Disabled Buy-In Adults	$224,407	$0	$112,181	$112,226	Standard	Hospital Provider Fee, Disabled Buy-in Fund	Calculation assumes Hospital Provider Fee
E	Disabled Buy-In Children	$41,093	$0	$20,542	$20,551	Standard	Hospital Provider Fee, Disabled Buy-in Fund	Calculation assumes Hospital Provider Fee
F	Disabled Individuals to 59 (AND/AB)	$14,329,783	$7,163,459	$0	$7,166,324	Standard	General Fund	
G	Foster Care	$1,128,918	$564,346	$0	$564,572	Standard	General Fund	
H	MAGI Parents/ Caretakers 69% to 133% FPL	$3,366,751	$0	$185,171	$3,181,580	Expansion (94.50%)	Hospital Provider Fee	
I	MAGI Adults	$18,464,517	$0	$1,015,548	$17,448,969	Expansion (94.50%)	Hospital Provider Fee	
J	Eligible Children (AFDC-C/BC)	$15,347,976	$7,672,453	$0	$7,675,523	Standard	General Fund, Hospital Provider Fee	Calculation Assumes 50% GF/ 50% FF
K	MAGI Pregnant Adults	$2,678,566	$1,339,015	$0	$1,339,551	Standard	General Fund	
L	MAGI Parents/ Caretakers to 68% FPL	$9,284,881	$4,641,512	$0	$4,643,369	Standard	General Fund, Hospital Provider Fee	Calculation Assumes 50% GF/ 50% FF
M	Non-Citizens- Emergency Services	$10,890	$5,444	$0	$5,446	Standard	General Fund	
N	Partial Dual Eligibles	$103,433	$51,706	$0	$51,727	Standard	General Fund	
O	SB 11-008 Eligible Children	$1,361,402	$163,368	$0	$1,198,034	Enhanced+ (88%)	General Fund, Hospital Provider Fee	Calculation Assumes 22% GF/ 88% FF
P	SB 11-250 Eligible Pregnant Adults	$233,272	$27,993	$0	$205,279	Enhanced+	General Fund	
Q	Total	$70,948,204	$23,814,394	$1,333,878	$45,799,932			Sum (Row A to Row P)

[1] FMAP rates reflect expected rates for State Fiscal Year 2017-18, not the rates applicable to State Fiscal Year 2014-15

Table 9.3 American Indian and Alaskan Native Medicaid Client Expenses in FY 2014-15			
Row	**Item**	**Expenses**	**Source/ Calculation**
A	Total American Indian and Alaskan Native Medicaid Client Expenses	$73,199,224	MMIS Data for self-identified American Indian and Alaskan Native clients
B	Subset of Services Offered at Indian Health Services Facility	$2,251,020	MMIS Data where the provider is an Indian Health Services facility claims are 100% federally funded
C	Claims Eligible for increased Federal Funding	$70,948,204	Row A - Row B

Table 10.1 Estimated Cost Savings in FY 2017-18 and Ongoing						
Row	**Item**	**Total Funds**	**General Fund***	**Cash Funds***	**Federal Funds***	**Notes**
	FY 2017-18					
A	Estimated Cost Avoidance	($579,450)	($170,740)	($21,498)	($387,212)	Table 10.2 Row H
B	Estimated Rate Impact	$39,320	$11,586	$1,459	$26,275	Table 10.4 Row H
C	**Total**	**($540,130)**	**($159,154)**	**($20,039)**	**($360,937)**	**Row A + Row B**
	FY 2018-19					
D	Estimated Cost Avoidance	($1,205,488)	($355,098)	($49,057)	($801,333)	Table 10.2 Row J
E	Estimated Rate Impact	$2,164,801	$637,679	$88,097	$1,439,025	Table 10.4 Row H
F	**Total**	**$959,313**	**$282,581**	**$39,040**	**$637,692**	**Row D + Row E**
	FY 2019-20					
G	Estimated Cost Avoidance	($1,242,979)	($366,141)	($54,938)	($821,900)	Table 10.2 Row L
H	Estimated Rate Impact	$4,545,507	$1,338,958	$200,904	$3,005,645	Table 10.4 Row H
I	**Total**	**$3,302,528**	**$972,817**	**$145,966**	**$2,183,745**	**Row G + Row H**
*Funds splits determined using relative % from FY 2016-17 R-1 Exhibit M for Physician Services, adjusted for caseload changes. Cash fund source assumed to be Hospital Provider Fee						

Table 10.2 Costs Avoidance Calculation			
Row	**Item**	**Total Funds**	**Source**
A	Amount Reimbursed for Office Administered Drugs	$1,826,782	FY 2014-15 MMIS Data See narrative for description of the query parameters
B	Amount Charged to Medicaid for Visit to Higher Level of Care Facility	$2,733,239	FY 2014-15 MMIS Data See narrative for description of the query parameters
C	Costs Avoided	($906,457)	Row A-Row B
D	Caseload Trend Factor to FY 2015-16	11.69%	FY 2016-17 R-1 Request (15-16 caseload increase)
E	Caseload Trend Factor to FY 2016-17	9.09%	FY 2016-17 R-1 Request (16-17 caseload trend)
F	Caseload Trend Factor to FY 2017-18	4.93%	FY 2016-17 R-1 Request (17-18 caseload trend)
G	Effective Start Day (Percent of Fiscal year)	50%	Assumes January 1st Start Date
H	Estimated FY 2017-18 Cost Avoidance	($579,450)	Row C * (1+ Row D) * (1+ Row E) * (1+ Row F) * Row G
I	Trend Factor to FY 2018-19	4.02%	FY 2016-17 R-1 Request (18-19 caseload trend)
J	FY 2018-19 Cost Avoidance	($1,205,488)	Row H * 2 * (1+Row I)
K	Trend Factor to FY 2019-20	3.11%	FY 2016-17 R-1 Request (18-19 caseload trend)
L	Estimated FY 2019-20 Cost Avoidance	($1,242,979)	Row J * (1+ Row K)

Table 10.3 Calculation of Using Average Sales Price Plus 2.5% Pricing for Office Administered Drugs					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Source**
A	Claims Priced at FY 2015-16 Medicaid Rates	$54,779,689	$56,484,216	$58,241,781	Actuarial analysis, trended forward by projected caseload growth
B	Claims Priced Using July 2015 Average Sales Price Plus 2.5%	$50,892,462	$52,476,034	$54,108,880	Actuarial analysis, trended forward by projected caseload growth
C	Drug Price Inflation Factor	3.83%	3.83%	3.83%	Three-year weighted average increase of Average Sales Price rates
D	Adjusted Claims Priced Using Average Sales Price	$54,865,478	$58,739,408	$62,886,867	FY 2017-18: Row B * (1 + Row C)^2 FY 2018-19: Row B * (1 + Row C)^3 FY 2019-20: Row B * (1 + Row C)^4
E	Incremental Difference	$85,789	$2,255,192	$4,645,086	Row D - Row A
F	Expenditure for Current Year Claims, Adjusted for Implementation Date and Cash Flow	$39,320	$2,161,226	$4,451,541	FY 2017-18: Row E * 5.5/12; Assumed implementation date of January 1, 2018 FY 2018-19: Row E * 11.5/12
G	Expenditure for Prior Year Claims	$0	$3,575	$93,966	Previous Year Row E * .5/12
H	**Total Impact**	**$39,320**	**$2,164,801**	**$4,545,507**	**Row F + Row G**

Table 11.1 Estimated Savings Per Integrity FTE				
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**Notes**
A	Recovery Amount	($2,644,801)	($2,644,801)	Average amount of provider integrity recoveries obtained over the last 3 fiscal years
B	Average Number of FTE	9.2	9.2	FY 2015-16 Average position count
C	Average Amount Recovered Per FTE	($287,478)	($287,478)	
D	Average Monthly Amount Recovered Per FTE	($23,957)	($23,957)	(Row C) / 12
E	Number of Requested FTE	6	6	
F	Number of Months After Training Ramp Up	6	12	Assumes 6 months of training
G	**Total Additional Amount Recovered**	**($862,435)**	**($1,724,870)**	**Row D * Row E * Row F**
H	General Fund	($249,072)	($498,144)	Assumes General Fund savings are consistent with the percent of General Fund expenditures in Medical Services Premiums in FY 2017-18
I	Cash Funds	($86,696)	($173,392)	Assumes cash fund savings are consistent with the percent of cash fund expenditures in Medical Services Premiums FY 2017-18
J	Federal Funds	($526,667)	($1,053,334)	Assumes federal fund savings are consistent with the percent of federal fund expenditures in Medical Services Premiums FY 2017-18