Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-06 Value Based Payments

Dept. Approval By:

OSPB Approval By:

	Supplemental FY 2021-22
	Budget Amendment FY 2022-23
X	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$10,164,579,716**	**$0**	**$10,204,084,103**	**$22,850,574**	**$14,227,538**
	FTE	560.9	0.0	564.4	9.6	10.0
	GF	$2,452,055,865	$0	$2,652,765,151	$7,403,648	$4,671,497
	CF	$1,212,517,600	$0	$1,157,101,465	($7,197)	($105,315)
	RF	$85,662,348	$0	$90,712,286	$0	$0
	FF	$6,414,343,903	$0	$6,303,505,201	$15,454,123	$9,661,356

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$46,430,090**	**$0**	**$48,168,150**	**$727,980**	**$757,135**
	FTE	560.9	0.0	564.4	9.6	10.0
	GF	$17,965,940	$0	$18,939,543	$363,990	$378,567
	CF	$4,404,610	$0	$4,386,646	$0	$0
	RF	$1,892,340	$0	$1,835,728	$0	$0
	FF	$22,167,200	$0	$23,006,233	$363,990	$378,568
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$6,863,806**	**$0**	**$8,102,805**	**$135,440**	**$140,860**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,642,297	$0	$3,338,890	$67,720	$70,430
	CF	$556,742	$0	$563,126	$0	$0
	RF	$166,554	$0	$165,482	$0	$0
	FF	$3,498,213	$0	$4,035,307	$67,720	$70,430

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	**Total**	**$102,458**	**$0**	**$84,601**	**$1,037**	**$1,078**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$50,803	$0	$34,144	$518	$539
	CF	$9,763	$0	$5,638	$0	$0
	RF	$3,300	$0	$1,593	$0	$0
	FF	$38,592	$0	$43,226	$519	$539
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	**Total**	**$2,360,586**	**$0**	**$2,644,871**	**$32,398**	**$33,695**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$16,199	$16,847
	CF	$177,353	$0	$177,169	$0	$0
	RF	$52,920	$0	$49,788	$0	$0
	FF	$1,205,964	$0	$1,350,867	$16,199	$16,848

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$2,360,586**	**$0**	**$2,644,871**	**$32,398**	**$33,695**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$16,199	$16,848
	CF	$177,353	$0	$177,169	$0	$0
	RF	$52,920	$0	$49,788	$0	$0
	FF	$1,205,964	$0	$1,350,867	$16,199	$16,847
	Total	**$2,775,315**	**$0**	**$2,432,567**	**$79,500**	**$9,500**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,209,995	$0	$1,035,087	$39,750	$4,750
	CF	$251,588	$0	$212,239	$0	$0
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,300,435	$0	$1,171,944	$39,750	$4,750

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$2,790,748**	**$0**	**$2,947,131**	**$66,000**	**$66,000**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Leased Space	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,157,045	$0	$1,228,884	$33,000	$33,000
	CF	$238,330	$0	$236,234	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,395,373	$0	$1,482,013	$33,000	$33,000
	Total	**$20,770,683**	**$0**	**$20,374,867**	**$11,436,150**	**$8,187,350**
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,740,590	$0	$6,677,630	$5,718,075	$4,093,675
	CF	$3,257,637	$0	$3,155,524	$0	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$10,622,456	$0	$10,391,713	$5,718,075	$4,093,675

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - MMIS Maintenance and Projects	**Total**	**$93,728,681**	**$0**	**$85,899,269**	**$10,465,527**	**$8,551,638**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$16,660,075	$0	$12,944,857	$1,181,828	$1,395,211
	CF	$6,698,062	$0	$6,781,035	$0	$0
	RF	$12,204	$0	$12,204	$0	$0
	FF	$70,358,340	$0	$66,161,173	$9,283,699	$7,156,427
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$9,986,396,763**	**$0**	**$10,030,784,971**	**($125,856)**	**($3,553,413)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,403,780,422	$0	$2,606,432,022	($33,631)	($1,338,370)
	CF	$1,196,746,162	$0	$1,141,406,685	($7,197)	($105,315)
	RF	$83,318,813	$0	$88,434,406	$0	$0
	FF	$6,302,551,366	$0	$6,194,511,858	($85,028)	($2,109,728)

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-07 Utilization Management

Dept. Approval By: ____________________ ____ **Supplemental FY 2021-22**

OSPB Approval By: ____________________ ____ **Budget Amendment FY 2022-23**

X **Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$10,009,900,837**	**$0**	**$10,054,091,370**	**($3,011,223)**	**($2,999,155)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,410,583,442	$0	$2,613,132,975	($1,512,985)	($1,515,550)
	CF	$1,198,250,099	$0	$1,142,913,851	$116,559	$104,943
	RF	$83,318,813	$0	$88,434,406	$0	$0
	FF	$6,317,748,483	$0	$6,209,610,138	($1,614,797)	($1,588,548)

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (E) Utilization and Quality Review Contracts, (1) Utilization and Quality Review Contracts - Professional Service Contracts	**Total**	**$23,504,074**	**$0**	**$23,306,399**	**$3,650,175**	**$3,388,100**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,803,020	$0	$6,700,953	$398,837	$358,025
	CF	$1,503,937	$0	$1,507,166	$524,903	$470,442
	RF	$0	$0	$0	$0	$0
	FF	$15,197,117	$0	$15,098,280	$2,726,435	$2,559,633
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$9,986,396,763**	**$0**	**$10,030,784,971**	**($6,661,398)**	**($6,387,255)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,403,780,422	$0	$2,606,432,022	($1,911,822)	($1,873,575)
	CF	$1,196,746,162	$0	$1,141,406,685	($408,344)	($365,499)
	RF	$83,318,813	$0	$88,434,406	$0	$0
	FF	$6,302,551,366	$0	$6,194,511,858	($4,341,232)	($4,148,181)

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-08 County Administration, Oversight and Eligibility

Dept. Approval By:

OSPB Approval By:

	Supplemental FY 2021-22
	Budget Amendment FY 2022-23
X	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22		FY 2022-23		FY 2023-24
		Initial Appropriation	Supplemental Request	Base Request	Change Request	Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$11,329,373,255**	**$0**	**$11,412,109,575**	**($590,849)**	**($17,261,512)**
	FTE	560.9	0.0	564.4	5.9	6.0
	GF	$2,673,594,590	$0	$2,909,124,207	$461,138	($3,422,571)
	CF	$1,317,699,638	$0	$1,281,071,786	$1,936,919	$971,442
	RF	$85,650,144	$0	$90,700,082	$0	$0
	FF	$7,252,428,883	$0	$7,131,213,500	($2,988,906)	($14,810,383)

Line Item Information	Fund	FY 2021-22		FY 2022-23		FY 2023-24
		Initial Appropriation	Supplemental Request	Base Request	Change Request	Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$46,430,090**	**$0**	**$48,168,150**	**$443,822**	**$461,596**
	FTE	560.9	0.0	564.4	5.9	6.0
	GF	$17,965,940	$0	$18,939,543	$133,478	$138,824
	CF	$4,404,610	$0	$4,386,646	$88,433	$91,974
	RF	$1,892,340	$0	$1,835,728	$0	$0
	FF	$22,167,200	$0	$23,006,233	$221,911	$230,798
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$6,863,806**	**$0**	**$8,102,805**	**$84,516**	**$84,516**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,642,297	$0	$3,338,890	$25,418	$25,417
	CF	$556,742	$0	$563,126	$16,840	$16,841
	RF	$166,554	$0	$165,482	$0	$0
	FF	$3,498,213	$0	$4,035,307	$42,258	$42,258

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	**Total**	**$102,458**	**$0**	**$84,601**	**$631**	**$656**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$50,803	$0	$34,144	$190	$197
	CF	$9,763	$0	$5,638	$126	$131
	RF	$3,300	$0	$1,593	$0	$0
	FF	$38,592	$0	$43,226	$315	$328
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	**Total**	**$2,360,586**	**$0**	**$2,644,871**	**$19,750**	**$20,543**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$5,940	$6,178
	CF	$177,353	$0	$177,169	$3,935	$4,093
	RF	$52,920	$0	$49,788	$0	$0
	FF	$1,205,964	$0	$1,350,867	$9,875	$10,272

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$2,360,586**	**$0**	**$2,644,871**	**$19,750**	**$20,543**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$5,940	$6,179
	CF	$177,353	$0	$177,169	$3,935	$4,093
	RF	$52,920	$0	$49,788	$0	$0
	FF	$1,205,964	$0	$1,350,867	$9,875	$10,271
	Total	**$2,775,315**	**$0**	**$2,432,567**	**$61,680**	**$19,680**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,209,995	$0	$1,035,087	$18,550	$5,919
	CF	$251,588	$0	$212,239	$12,290	$3,921
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,300,435	$0	$1,171,944	$30,840	$9,840

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Leased Space	**Total**	**$2,790,748**	**$0**	**$2,947,131**	**$39,600**	**$39,600**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,157,045	$0	$1,228,884	$11,910	$11,910
	CF	$238,330	$0	$236,234	$7,890	$7,890
	RF	$0	$0	$0	$0	$0
	FF	$1,395,373	$0	$1,482,013	$19,800	$19,800
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	**Total**	**$20,770,683**	**$0**	**$20,374,867**	**$314,675**	**$119,900**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,740,590	$0	$6,677,630	$94,637	$36,060
	CF	$3,257,637	$0	$3,155,524	$62,700	$23,890
	RF	$150,000	$0	$150,000	$0	$0
	FF	$10,622,456	$0	$10,391,713	$157,338	$59,950

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (D) Eligibility Determinations and Client Services, (1) Eligibility Determinations and Client Services - County Administration	**Total**	**$104,194,924**	**$0**	**$91,775,122**	**$14,878,000**	**$14,878,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$16,014,288	$0	$13,615,517	$3,983,405	$3,983,405
	CF	$22,550,330	$0	$21,828,269	$2,662,929	$2,662,929
	RF	$0	$0	$0	$0	$0
	FF	$65,630,306	$0	$56,331,336	$8,231,666	$8,231,666
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$9,986,396,763**	**$0**	**$10,030,784,971**	**($13,511,279)**	**($27,022,558)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,403,780,422	$0	$2,606,432,022	($3,197,873)	($6,395,744)
	CF	$1,196,746,162	$0	$1,141,406,685	($697,720)	($1,395,442)
	RF	$83,318,813	$0	$88,434,406	$0	$0
	FF	$6,302,551,366	$0	$6,194,511,858	($9,615,686)	($19,231,372)

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$983,572,421**	**$0**	**$1,027,277,937**	**($2,255,022)**	**($4,510,044)**
03. Behavioral Health Community Programs, (A) Behavioral Health Community Programs, (1) Behavioral Health Community Programs - Behavioral Health Capitation Payments	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$201,125,147	$0	$233,987,626	($477,044)	($954,089)
	CF	$53,700,870	$0	$72,415,073	($127,413)	($254,825)
	RF	$0	$0	$0	$0	$0
	FF	$728,746,404	$0	$720,875,238	($1,650,565)	($3,301,130)
	Total	**$170,754,875**	**$0**	**$174,871,682**	**($686,972)**	**($1,373,944)**
05. Indigent Care Program, (A) Indigent Care Program, (1) Indigent Care Program - Children's Basic Health Plan Medical and Dental Costs	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,059,365	$0	$21,700,770	($143,413)	($286,827)
	CF	$35,628,900	$0	$36,508,014	($97,026)	($194,053)
	RF	$0	$0	$0	$0	$0
	FF	$114,066,610	$0	$116,662,898	($446,533)	($893,064)

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-09 Office of Community Living Program Enhancements

Dept. Approval By: ______________________ ____ **Supplemental FY 2021-22**

OSPB Approval By: ______________________ ____ **Budget Amendment FY 2022-23**

X **Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22		FY 2022-23		FY 2023-24
		Initial Appropriation	Supplemental Request	Base Request	Change Request	Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$10,802,403,570**	**$0**	**$10,870,376,272**	**$2,452,715**	**$2,443,390**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,734,007,135	$0	$3,001,907,689	$1,872,153	$1,867,490
	CF	$1,206,622,593	$0	$1,150,323,376	$0	$0
	RF	$83,318,813	$0	$88,434,406	$0	$0
	FF	$6,778,455,029	$0	$6,629,710,801	$580,562	$575,900

Line Item Information	Fund	FY 2021-22		FY 2022-23		FY 2023-24
		Initial Appropriation	Supplemental Request	Base Request	Change Request	Continuation
01. Executive Director's Office, (E) Utilization and Quality Review Contracts, (1) Utilization and Quality Review Contracts - Professional Service Contracts	**Total**	**$23,504,074**	**$0**	**$23,306,399**	**$540,000**	**$540,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,803,020	$0	$6,700,953	$270,000	$270,000
	CF	$1,503,937	$0	$1,507,166	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$15,197,117	$0	$15,098,280	$270,000	$270,000
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$9,986,396,763**	**$0**	**$10,030,784,971**	**($478,419)**	**($767,782)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,403,780,422	$0	$2,606,432,022	($239,210)	($383,891)
	CF	$1,196,746,162	$0	$1,141,406,685	$0	$0
	RF	$83,318,813	$0	$88,434,406	$0	$0
	FF	$6,302,551,366	$0	$6,194,511,858	($239,209)	($383,891)

Line Item Information	Fund	FY 2021-22		FY 2022-23		FY 2023-24
		Initial Appropriation	Supplemental Request	Base Request	Change Request	Continuation
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	**Total**	**$587,780,599**	**$0**	**$610,188,665**	**($11,738)**	**($23,477)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$235,212,336	$0	$286,747,344	($5,869)	($11,739)
	CF	$800,001	$0	$1,084,012	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$351,768,262	$0	$322,357,309	($5,869)	($11,738)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	**Total**	**$76,430,552**	**$0**	**$78,762,928**	**$14,924**	**$16,596**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$25,813,807	$0	$32,028,684	$7,462	$8,298
	CF	$4,967,873	$0	$4,982,582	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$45,648,872	$0	$41,751,662	$7,462	$8,298

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$9,328,155**	**$0**	**$9,327,943**	**$256,567**	**$513,134**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,964,700	$0	$4,381,321	$128,284	$256,567
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$5,363,455	$0	$4,946,622	$128,283	$256,567
	Total	**$98,633,608**	**$0**	**$98,994,248**	**$839,791**	**$873,329**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management for People with Disabilities	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$39,394,621	$0	$46,606,247	$419,896	$436,665
	CF	$1,313,030	$0	$1,342,931	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$57,925,957	$0	$51,045,070	$419,895	$436,664

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$7,679,672**	**$0**	**$7,308,510**	**$371,162**	**$371,162**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,308,510	$0	$7,308,510	$371,162	$371,162
	CF	$371,162	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
	Total	**$10,174,870**	**$0**	**$9,511,028**	**$636,731**	**$636,731**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$9,538,139	$0	$9,511,028	$636,731	$636,731
	CF	$636,731	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$2,475,277**	**$0**	**$2,191,580**	**$283,697**	**$283,697**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,191,580	$0	$2,191,580	$283,697	$283,697
	CF	$283,697	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-10 Provider Rate Adjustments

Dept. Approval By:

OSPB Approval By:

___	**Supplemental FY 2021-22**
___	**Budget Amendment FY 2022-23**
X	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$10,935,156,510**	**$0**	**$10,991,127,719**	**$104,434,828**	**$242,304,697**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,760,805,609	$0	$3,029,248,149	$41,327,629	$109,042,227
	CF	$1,228,706,761	$0	$1,171,682,268	$5,966,149	$6,561,230
	RF	$83,318,813	$0	$88,434,406	$0	$0
	FF	$6,862,325,327	$0	$6,701,762,896	$57,141,050	$126,701,240

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (D) Eligibility Determinations and Client Services, (1) Eligibility Determinations and Client Services - County Administration	**Total**	**$104,194,924**	**$0**	**$91,775,122**	**$440,463**	**$440,485**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$16,014,288	$0	$13,615,517	$62,953	$62,956
	CF	$22,550,330	$0	$21,828,269	$107,118	$107,123
	RF	$0	$0	$0	$0	$0
	FF	$65,630,306	$0	$56,331,336	$270,392	$270,406
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$9,986,396,763**	**$0**	**$10,030,888,504**	**$81,356,839**	**$160,084,596**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,403,780,422	$0	$2,606,498,055	$29,950,090	$68,096,136
	CF	$1,196,746,162	$0	$1,141,406,685	$5,815,962	$6,409,523
	RF	$83,318,813	$0	$88,434,406	$0	$0
	FF	$6,302,551,366	$0	$6,194,549,358	$45,590,787	$85,578,937

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$15,151,534**	**$0**	**$15,147,517**	**$68,318**	**$74,775**
03. Behavioral Health Community Programs, (A) Behavioral Health Community Programs, (1) Behavioral Health Community Programs - Behavioral Health Fee-for-Service Payments	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,923,821	$0	$2,927,199	$15,177	$16,612
	CF	$1,037,775	$0	$1,037,789	$4,457	$4,879
	RF	$0	$0	$0	$0	$0
	FF	$11,189,938	$0	$11,182,529	$48,684	$53,284
	Total	**$587,780,599**	**$0**	**$610,188,665**	**$17,608,299**	**$62,219,938**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$235,212,336	$0	$286,747,344	$8,799,018	$31,104,415
	CF	$800,001	$0	$1,084,012	$5,132	$5,556
	RF	$0	$0	$0	$0	$0
	FF	$351,768,262	$0	$322,357,309	$8,804,149	$31,109,967

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	**Total**	**$76,430,552**	**$0**	**$78,762,928**	**$3,631,427**	**$16,048,506**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$25,813,807	$0	$32,028,684	$1,788,794	$7,997,411
	CF	$4,967,873	$0	$4,982,582	$26,921	$26,844
	RF	$0	$0	$0	$0	$0
	FF	$45,648,872	$0	$41,751,662	$1,815,712	$8,024,251
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support Services	**Total**	**$36,844,096**	**$0**	**$36,965,214**	**$720,610**	**$2,788,661**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$14,596,925	$0	$17,366,204	$360,305	$1,394,332
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$22,247,171	$0	$19,599,010	$360,305	$1,394,329

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	**Total**	**$9,328,155**	**$0**	**$9,327,943**	**$57,953**	**$65,961**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,964,700	$0	$4,381,321	$28,977	$32,981
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$5,363,455	$0	$4,946,622	$28,976	$32,980
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management for People with Disabilities	**Total**	**$98,633,608**	**$0**	**$98,994,248**	**$455,531**	**$486,387**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$39,394,621	$0	$46,606,247	$226,927	$241,996
	CF	$1,313,030	$0	$1,342,931	$6,559	$7,305
	RF	$0	$0	$0	$0	$0
	FF	$57,925,957	$0	$51,045,070	$222,045	$237,086

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$7,679,672**	**$0**	**$7,308,510**	**$36,543**	**$36,543**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,308,510	$0	$7,308,510	$36,543	$36,543
	CF	$371,162	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
	Total	**$10,174,870**	**$0**	**$9,511,028**	**$47,555**	**$47,555**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$9,538,139	$0	$9,511,028	$47,555	$47,555
	CF	$636,731	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$2,475,277**	**$0**	**$2,191,580**	**$10,958**	**$10,958**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,191,580	$0	$2,191,580	$10,958	$10,958
	CF	$283,697	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
	Total	**$66,460**	**$0**	**$66,460**	**$332**	**$332**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Preventative Dental Hygiene	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$66,460	$0	$66,460	$332	$332
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-11 ACC/CHP+ Accountability

Dept. Approval By:

OSPB Approval By:

	Supplemental FY 2021-22
	Budget Amendment FY 2022-23
X	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$239,471,738**	**$0**	**$246,929,952**	**($1,048,141)**	**($1,055,452)**
	FTE	560.9	0.0	564.4	2.0	2.0
	GF	$45,934,143	$0	$48,411,412	($351,127)	($354,194)
	CF	$43,097,063	$0	$43,918,659	$0	$0
	RF	$2,181,331	$0	$2,115,676	$0	$0
	FF	$148,259,201	$0	$152,484,205	($697,014)	($701,258)

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$46,430,090**	**$0**	**$48,168,150**	**$140,724**	**$146,360**
	FTE	560.9	0.0	564.4	2.0	2.0
	GF	$17,965,940	$0	$18,939,543	$35,181	$36,590
	CF	$4,404,610	$0	$4,386,646	$24,627	$25,613
	RF	$1,892,340	$0	$1,835,728	$0	$0
	FF	$22,167,200	$0	$23,006,233	$80,916	$84,157
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$6,863,806**	**$0**	**$8,102,805**	**$27,630**	**$28,171**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,642,297	$0	$3,338,890	$6,773	$7,044
	CF	$556,742	$0	$563,126	$4,930	$4,930
	RF	$166,554	$0	$165,482	$0	$0
	FF	$3,498,213	$0	$4,035,307	$15,927	$16,197

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	**Total**	**$102,458**	**$0**	**$84,601**	**$200**	**$208**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$50,803	$0	$34,144	$50	$52
	CF	$9,763	$0	$5,638	$35	$36
	RF	$3,300	$0	$1,593	$0	$0
	FF	$38,592	$0	$43,226	$115	$120
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	**Total**	**$2,360,586**	**$0**	**$2,644,871**	**$6,262**	**$6,514**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$1,565	$1,628
	CF	$177,353	$0	$177,169	$1,096	$1,140
	RF	$52,920	$0	$49,788	$0	$0
	FF	$1,205,964	$0	$1,350,867	$3,601	$3,746

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	**Total**	**$2,360,586**	**$0**	**$2,644,871**	**$6,262**	**$6,514**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$1,565	$1,628
	CF	$177,353	$0	$177,169	$1,096	$1,140
	RF	$52,920	$0	$49,788	$0	$0
	FF	$1,205,964	$0	$1,350,867	$3,601	$3,746
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	**Total**	**$2,775,315**	**$0**	**$2,432,567**	**$15,900**	**$1,900**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,209,995	$0	$1,035,087	$3,975	$475
	CF	$251,588	$0	$212,239	$2,782	$332
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,300,435	$0	$1,171,944	$9,143	$1,093

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Leased Space	**Total**	**$2,790,748**	**$0**	**$2,947,131**	**$13,200**	**$13,200**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,157,045	$0	$1,228,884	$3,300	$3,300
	CF	$238,330	$0	$236,234	$2,310	$2,310
	RF	$0	$0	$0	$0	$0
	FF	$1,395,373	$0	$1,482,013	$7,590	$7,590
05. Indigent Care Program, (A) Indigent Care Program, (1) Indigent Care Program - Children's Basic Health Plan Administration	**Total**	**$5,033,274**	**$0**	**$5,033,274**	**($1,258,319)**	**($1,258,319)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$1,652,424	$0	$1,652,424	($440,412)	($440,412)
	RF	$0	$0	$0	$0	$0
	FF	$3,380,850	$0	$3,380,850	($817,907)	($817,907)

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$170,754,875**	**$0**	**$174,871,682**	**$0**	**$0**
05. Indigent Care Program, (A) Indigent Care Program, (1) Indigent Care Program - Children's Basic Health Plan Medical and Dental Costs	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,059,365	$0	$21,700,770	($403,536)	($404,911)
	CF	$35,628,900	$0	$36,508,014	$403,536	$404,911
	RF	$0	$0	$0	$0	$0
	FF	$114,066,610	$0	$116,662,898	$0	$0

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-12 Convert Contractor Resources to FTE

Dept. Approval By:

OSPB Approval By:

	Supplemental FY 2021-22
	Budget Amendment FY 2022-23
x	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$10,242,335,491**	**$0**	**$10,279,293,189**	**($339,518)**	**($597,425)**
	FTE	560.9	0.0	564.4	23.2	24.0
	GF	$2,471,948,063	$0	$2,670,535,829	($155,265)	($266,965)
	CF	$1,220,205,941	$0	$1,164,844,318	($60,722)	($62,982)
	RF	$85,663,985	$0	$90,713,940	$370,586	$360,214
	FF	$6,464,517,502	$0	$6,353,199,102	($494,117)	($627,692)

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$46,430,090**	**$0**	**$48,168,150**	**$1,746,305**	**$1,806,980**
	FTE	560.9	0.0	564.4	23.2	24.0
	GF	$17,965,940	$0	$18,939,543	$494,134	$513,923
	CF	$4,404,610	$0	$4,386,646	$54,473	$56,654
	RF	$1,892,340	$0	$1,835,728	$369,740	$379,915
	FF	$22,167,200	$0	$23,006,233	$827,958	$856,488
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$6,863,806**	**$0**	**$8,102,805**	**$326,675**	**$338,064**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,642,297	$0	$3,338,890	$92,168	$95,860
	CF	$556,742	$0	$563,126	$10,470	$10,889
	RF	$166,554	$0	$165,482	$66,155	$67,961
	FF	$3,498,213	$0	$4,035,307	$157,882	$163,354

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	**Total**	**$102,458**	**$0**	**$84,601**	**$2,485**	**$2,571**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$50,803	$0	$34,144	$700	$730
	CF	$9,763	$0	$5,638	$75	$77
	RF	$3,300	$0	$1,593	$526	$539
	FF	$38,592	$0	$43,226	$1,184	$1,225
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	**Total**	**$2,360,586**	**$0**	**$2,644,871**	**$77,717**	**$80,419**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$21,989	$22,869
	CF	$177,353	$0	$177,169	$2,423	$2,519
	RF	$52,920	$0	$49,788	$16,453	$16,907
	FF	$1,205,964	$0	$1,350,867	$36,852	$38,124

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$2,360,586**	**$0**	**$2,644,871**	**$77,717**	**$80,419**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$21,989	$22,869
	CF	$177,353	$0	$177,169	$2,423	$2,519
	RF	$52,920	$0	$49,788	$16,453	$16,907
	FF	$1,205,964	$0	$1,350,867	$36,852	$38,124
	Total	**$2,775,315**	**$0**	**$2,432,567**	**$200,400**	**$32,400**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,209,995	$0	$1,035,087	$58,901	$11,266
	CF	$251,588	$0	$212,239	$6,144	$735
	RF	$13,297	$0	$13,297	$38,357	$4,583
	FF	$1,300,435	$0	$1,171,944	$96,998	$15,816

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Leased Space	**Total**	**$2,790,748**	**$0**	**$2,947,131**	**$158,400**	**$158,400**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,157,045	$0	$1,228,884	$44,916	$44,916
	CF	$238,330	$0	$236,234	$5,101	$5,101
	RF	$0	$0	$0	$31,842	$31,842
	FF	$1,395,373	$0	$1,482,013	$76,541	$76,541
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	**Total**	**$20,770,683**	**$0**	**$20,374,867**	**($517,027)**	**($517,027)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,740,590	$0	$6,677,630	($318,089)	($318,089)
	CF	$3,257,637	$0	$3,155,524	$0	$0
	RF	$150,000	$0	$150,000	($69,000)	($69,000)
	FF	$10,622,456	$0	$10,391,713	($129,938)	($129,938)

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - MMIS Maintenance and Projects	**Total**	**$93,728,681**	**$0**	**$85,899,269**	**($473,471)**	**($473,471)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$16,660,075	$0	$12,944,857	($45,368)	($45,368)
	CF	$6,698,062	$0	$6,781,035	($33,313)	($33,313)
	RF	$12,204	$0	$12,204	$0	$0
	FF	$70,358,340	$0	$66,161,173	($394,790)	($394,790)
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - Colorado Benefits Management Systems, Operating & Contracts	**Total**	**$49,129,319**	**$0**	**$46,400,559**	**($295,116)**	**($293,077)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$11,230,398	$0	$9,038,072	($96,104)	($95,440)
	CF	$5,561,441	$0	$5,595,724	($51,356)	($51,001)
	RF	$1,637	$0	$1,654	$0	$0
	FF	$32,335,843	$0	$31,765,109	($147,656)	($146,636)

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (E) Utilization and Quality Review Contracts, (1) Utilization and Quality Review Contracts - Professional Service Contracts	**Total**	**$23,504,074**	**$0**	**$23,306,399**	**($535,000)**	**($715,000)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,803,020	$0	$6,700,953	($133,750)	($223,750)
	CF	$1,503,937	$0	$1,507,166	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$15,197,117	$0	$15,098,280	($401,250)	($491,250)
01. Executive Director's Office, (F) Provider Audits and Services, (1) Provider Audits and Services - Professional Audit Contracts	**Total**	**$5,122,382**	**$0**	**$5,502,128**	**($1,008,663)**	**($1,008,663)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,858,780	$0	$2,031,653	($296,751)	($296,751)
	CF	$622,963	$0	$639,963	($57,162)	($57,162)
	RF	$0	$0	$0	$0	$0
	FF	$2,640,639	$0	$2,830,512	($654,750)	($654,750)

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$9,986,396,763**	**$0**	**$10,030,784,971**	**($99,940)**	**($89,440)**
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,403,780,422	$0	$2,606,432,022	$0	$0
	CF	$1,196,746,162	$0	$1,141,406,685	$0	$0
	RF	$83,318,813	$0	$88,434,406	($99,940)	($89,440)
	FF	$6,302,551,366	$0	$6,194,511,858	$0	$0

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	Requires OIT Approval

Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-13 Compliance FTE

Dept. Approval By:

OSPB Approval By:

	Supplemental FY 2021-22
	Budget Amendment FY 2022-23
X	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$10,055,202,734**	**$0**	**$10,103,312,095**	**($4,678,266)**	**($4,719,512)**
	FTE	560.9	0.0	564.4	10.8	11.0
	GF	$2,430,513,980	$0	$2,635,174,317	($2,393,350)	($2,410,473)
	CF	$1,203,184,864	$0	$1,147,804,869	$108,434	$101,434
	RF	$85,500,144	$0	$90,550,083	$0	$0
	FF	$6,336,003,746	$0	$6,229,782,826	($2,393,350)	($2,410,473)

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$46,430,090**	**$0**	**$48,168,150**	**$779,816**	**$808,110**
	FTE	560.9	0.0	564.4	10.8	11.0
	GF	$17,965,940	$0	$18,939,543	$353,318	$367,465
	CF	$4,404,610	$0	$4,386,646	$73,180	$73,180
	RF	$1,892,340	$0	$1,835,729	$0	$0
	FF	$22,167,200	$0	$23,006,232	$353,318	$367,465
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$6,863,806**	**$0**	**$8,102,805**	**$154,946**	**$154,946**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,642,297	$0	$3,338,890	$70,430	$70,430
	CF	$556,742	$0	$563,126	$14,086	$14,086
	RF	$166,554	$0	$165,482	$0	$0
	FF	$3,498,213	$0	$4,035,307	$70,430	$70,430

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	**Total**	**$102,458**	**$0**	**$84,601**	**$1,112**	**$1,152**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$50,803	$0	$34,144	$504	$524
	CF	$9,763	$0	$5,638	$104	$104
	RF	$3,300	$0	$1,593	$0	$0
	FF	$38,592	$0	$43,226	$504	$524
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	**Total**	**$2,360,586**	**$0**	**$2,644,871**	**$34,705**	**$35,965**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$15,724	$16,354
	CF	$177,353	$0	$177,169	$3,257	$3,257
	RF	$52,920	$0	$49,788	$0	$0
	FF	$1,205,964	$0	$1,350,867	$15,724	$16,354

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$2,360,586**	**$0**	**$2,644,871**	**$34,705**	**$35,965**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$15,724	$16,354
	CF	$177,353	$0	$177,169	$3,257	$3,257
	RF	$52,920	$0	$49,788	$0	$0
	FF	$1,205,964	$0	$1,350,867	$15,724	$16,354
	Total	**$2,775,315**	**$0**	**$2,432,567**	**$87,450**	**$10,450**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,209,995	$0	$1,035,087	$39,750	$4,750
	CF	$251,588	$0	$212,239	$7,950	$950
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,300,435	$0	$1,171,944	$39,750	$4,750

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Leased Space	**Total**	**$2,790,748**	**$0**	**$2,947,131**	**$72,600**	**$72,600**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,157,045	$0	$1,228,884	$33,000	$33,000
	CF	$238,330	$0	$236,234	$6,600	$6,600
	RF	$0	$0	$0	$0	$0
	FF	$1,395,373	$0	$1,482,013	$33,000	$33,000
01. Executive Director's Office, (F) Provider Audits and Services, (1) Provider Audits and Services - Professional Audit Contracts	**Total**	**$5,122,382**	**$0**	**$5,502,128**	**$162,400**	**$167,300**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,858,780	$0	$2,031,653	$81,200	$83,650
	CF	$622,963	$0	$639,963	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,640,639	$0	$2,830,512	$81,200	$83,650

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$9,986,396,763**	**$0**	**$10,030,784,971**	**($6,006,000)**	**($6,006,000)**
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,403,780,422	$0	$2,606,432,022	($3,003,000)	($3,003,000)
	CF	$1,196,746,162	$0	$1,141,406,685	$0	$0
	RF	$83,318,813	$0	$88,434,406	$0	$0
	FF	$6,302,551,366	$0	$6,194,511,858	($3,003,000)	($3,003,000)

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-14 MMIS Funding Adjustment and Contractor Conversion

Dept. Approval By:

OSPB Approval By:

	Supplemental FY 2021-22
	Budget Amendment FY 2022-23
X	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$157,412,270**	**$0**	**$152,924,265**	**($56,079,142)**	**$1,066,405**
	FTE	560.9	0.0	564.4	12.5	13.0
	GF	$41,534,853	$0	$39,655,499	($10,347,479)	($1,050,633)
	CF	$12,513,801	$0	$12,539,256	($2,753,052)	$1,514,967
	RF	$2,193,535	$0	$2,127,880	$0	$0
	FF	$101,170,081	$0	$98,601,630	($42,978,611)	$602,071

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$46,430,090**	**$0**	**$48,168,150**	**$930,109**	**$967,357**
	FTE	560.9	0.0	564.4	12.5	13.0
	GF	$17,965,940	$0	$18,939,543	$144,260	$150,037
	CF	$4,404,610	$0	$4,386,646	$93,848	$97,607
	RF	$1,892,340	$0	$1,835,728	$0	$0
	FF	$22,167,200	$0	$23,006,233	$692,001	$719,713
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$6,863,806**	**$0**	**$8,102,805**	**$183,118**	**$183,118**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,642,297	$0	$3,338,890	$28,402	$28,401
	CF	$556,742	$0	$563,126	$18,477	$18,477
	RF	$166,554	$0	$165,482	$0	$0
	FF	$3,498,213	$0	$4,035,307	$136,239	$136,240

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	**Total**	**$102,458**	**$0**	**$84,601**	**$1,325**	**$1,375**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$50,803	$0	$34,144	$205	$213
	CF	$9,763	$0	$5,638	$134	$138
	RF	$3,300	$0	$1,593	$0	$0
	FF	$38,592	$0	$43,226	$986	$1,024
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	**Total**	**$2,360,586**	**$0**	**$2,644,871**	**$41,393**	**$43,053**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$6,420	$6,678
	CF	$177,353	$0	$177,169	$4,176	$4,344
	RF	$52,920	$0	$49,788	$0	$0
	FF	$1,205,964	$0	$1,350,867	$30,797	$32,031

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	**Total**	**$2,360,586**	**$0**	**$2,644,871**	**$41,393**	**$43,053**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$924,349	$0	$1,067,047	$6,420	$6,678
	CF	$177,353	$0	$177,169	$4,176	$4,344
	RF	$52,920	$0	$49,788	$0	$0
	FF	$1,205,964	$0	$1,350,867	$30,797	$32,031
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	**Total**	**$2,775,315**	**$0**	**$2,432,567**	**$103,350**	**$12,350**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,209,995	$0	$1,035,087	$16,030	$1,915
	CF	$251,588	$0	$212,239	$10,428	$1,246
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,300,435	$0	$1,171,944	$76,892	$9,189

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
	Total	**$2,790,748**	**$0**	**$2,947,131**	**$85,800**	**$85,800**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Leased Space	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,157,045	$0	$1,228,884	$13,308	$13,308
	CF	$238,330	$0	$236,234	$8,657	$8,657
	RF	$0	$0	$0	$0	$0
	FF	$1,395,373	$0	$1,482,013	$63,835	$63,835
	Total	**$93,728,681**	**$0**	**$85,899,269**	**($57,465,630)**	**($269,701)**
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - MMIS Maintenance and Projects	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$16,660,075	$0	$12,944,857	($10,562,524)	($1,257,863)
	CF	$6,698,062	$0	$6,781,035	($2,892,948)	$1,380,154
	RF	$12,204	$0	$12,204	$0	$0
	FF	$70,358,340	$0	$66,161,173	($44,010,158)	($391,992)

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-15 Restore APCD Scholarship Funds

Dept. Approval By:

OSPB Approval By:

___	**Supplemental FY 2021-22**
___	**Budget Amendment FY 2022-23**
X	**Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$3,795,498**	**$0**	**$3,795,498**	**$200,000**	**$200,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,962,231	$0	$2,962,231	$200,000	$200,000
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$833,267	$0	$833,267	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - All Payer Claims Database	**Total**	**$3,795,498**	**$0**	**$3,795,498**	**$200,000**	**$200,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,962,231	$0	$2,962,231	$200,000	$200,000
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$833,267	$0	$833,267	$0	$0

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-16 Urban Indian Health Organization State-Only Payments

Dept. Approval By: ______ Supplemental FY 2021-22

OSPB Approval By: ______ Budget Amendment FY 2022-23

X Change Request FY 2022-23

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$0**	**$0**	**$0**	**$48,025**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$48,025	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
06. Other Medical Services, (A) Other Medical Services, (1) Other Medical Services - State Only Payments to Urban Indian Health Organizations	**Total**	**$0**	**$0**	**$0**	**$48,025**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$48,025	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing

Funding Request for the FY 2022-23 Budget Cycle

Request Title

R-17 SBIRT Training Grant Program Reduction

Dept. Approval By: ______ ______ **Supplemental FY 2021-22**

OSPB Approval By: ______ ______ **Budget Amendment FY 2022-23**

X **Change Request FY 2022-23**

Summary Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$1,000,000**	**$0**	**$750,000**	**($250,000)**	**($250,000)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$1,000,000	$0	$750,000	($250,000)	($250,000)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2021-22 Initial Appropriation	FY 2021-22 Supplemental Request	FY 2022-23 Base Request	FY 2022-23 Change Request	FY 2023-24 Continuation
06. Other Medical Services, (A) Other Medical Services, (1) Other Medical Services - SBIRT Training Grant Program	**Total**	**$1,000,000**	**$0**	**$750,000**	**($250,000)**	**($250,000)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$1,000,000	$0	$750,000	($250,000)	($250,000)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-06
Request Detail: Value Based Payments

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$10,164,579,716	$22,850,574	$14,227,538
FTE	560.9	9.6	10.0
General Fund	$2,452,055,865	$7,403,648	$4,671,497
Cash Funds	$1,212,517,600	($7,197)	($105,315)
Reappropriated Funds	$85,662,348	$0	$0
Federal Funds	$6,414,343,903	$15,454,123	$9,661,356

Summary of Request

The department requests funding for the planning and implementation of three mandatory alternative payment models (APMs), including shared savings for pharmacy prescribers using the Prescriber Tool, a bundled payment methodology in maternity care, and partial capitation payments to primary care providers. Additionally, the department requests to establish Colorado Providers of Distinction programs for primary care, specialty care and hospital-based procedures. The department also requests $11,436,150 in roll-forward authority from FY 2022-23 to FY 2023-24, which will provide the department with flexibility to complete the development phase in FY 2023-24 if some of the work is delayed under the existing budget.

The primary care and maternity care APMs will be developed in partnership with the Division of Insurance (DOI) and the Department of Personnel and Administration (DPA) to establish an aligned approach to value-based payment across public and private payers in Colorado. This aligned approach will maximize the capacity of value-based payments to drive improved health outcomes and care quality while reducing health care costs and prioritize the reduction of health disparities to ensure all Coloradans have equitable access to high-quality primary and maternity care.

The total request represents an increase of less than 0.5% from the department's FY 2021-22 Long Bill total funds appropriation.

Current Program

Colorado's Medicaid program currently provides health care access to about 1.5 million people with a budget of $13.6 billion. The department spends most of its budget to pay providers that deliver services to Medicaid members. Most providers are paid on a fee-for-service basis, meaning the department pays for each incurred service based on a set rate.

In recent years, the General Assembly has authorized the department to establish alternative payment and delivery models within the Medicaid program. Key examples include H.B. 12-1281, which created a process for the department to implement payment reform pilot programs within the Accountable Care Collaborative, and H.B. 17-1353, which defined the Accountable Care Collaborative (ACC) in statute and authorized the department to implement performance-based payments for Medicaid providers. As a result of these and other initiatives, the department has enrolled nearly all members in a regional organization that helps members make sure they get the health care and services they need and is developing new payment methodologies that move away from traditional fee-for-service payments and towards payment structures that provide payments based on the provider's performance.

Further, the department continues to support providers in controlling costs and identifying unnecessary or duplicative care. In S.B. 18-266, the General Assembly provided the department resources to give information to providers participating in the ACC regarding the cost and quality of medical services provided by hospitals and other Medicaid providers, which resulted in the department rolling out the Prometheus Analytics tool to the seven Regional Accountable Entities (RAEs). This toolset enables providers to improve their referral patterns towards more cost-effective, higher-quality physicians and hospitals. In addition, S.B. 18-266 provided resources for the department to implement a prescriber tool that would provide information to prescribers about the department's drug cost information, preferred drug listing (PDL) information, Prior Authorization Requirements (PAR), and member-based risk factors based on diagnosis.

The department has also undertaken initiatives to move towards value-based payments by designing two alternative payment models (APMs) for primary care and a bundled payments methodology for perinatal care. The first APM model, APM 1, uses a modification of traditional fee-for-service (FFS) payments with incentive payments for meeting quality metrics, while the second model, APM 2, sends providers a monthly advance payment (known as a "partial capitation") for the services expected to be provided, to give more financial flexibility to primary care medical providers (PCMPs) that are more experienced in advanced primary care.

APM 1 pays qualifying PCMPs in the ACC higher payments for meeting selected structural or performance measures. APM 2 is currently voluntary.

The department implemented a maternity bundled payment program in November 2020 with the intention of improving maternal health in Colorado. However, the program is optional for provider participation and has limited funding, which means the department can only operate it on a small scale. Currently only three obstetrical care providers are participating in the program. The program covers all prenatal care, care related to labor and delivery, and postpartum care for the pregnant person only. Obstetrical care providers serve as the principal accountable provider because of their ability to influence the episode and influence clinical improvements in care for the parent and child. The department analyzes the total episode cost and reconciles this retrospectively with the obstetrical care provider and distributes any shared savings earned.

The department's maternity bundle is designed to improve outcomes for members and is piloting several innovative policies developed in partnership with stakeholders to improve health equity for pregnant people of color. The maternity bundle has a focus on improving outcomes for pregnant people who are experiencing mental health conditions and/or substance use disorders, and obstetrical providers are incentivized to implement enhanced screening practices and to follow through to ensure that the member utilized either mental health or substance use disorder treatment services. This program design is targeted to decrease the two leading causes of preventable maternal mortality in Colorado. The maternity bundle also focuses on health equity and improving the patient experience for people of color through targeted policy interventions. In the maternity bundle framework, the department will not pay shared savings to obstetrical providers who have a statistically significant difference in the total cost of care, or the number of services rendered, between the sub-group of people of color and white pregnant people. Obstetrical providers who participate in the maternity bundle are also required to complete a cultural competency training to ensure person-centered care is being provided. The department started a Maternity Advisory Committee (MAC) comprised of current or former Medicaid members who are people of color with lived experience receiving Medicaid maternity services. The group will advise the department on updates to the maternity bundled payment and review all data from the program.

Problem or Opportunity

Broadly speaking the fee-for-service model for health care in the United States has resulted in higher costs and unsatisfactory outcomes. The current fee-for-service system rewards providers by the volume of care they deliver. It does not promote quality care for patients or fiscal stability for providers. The financial pressures of the current system are a strain on the state

budget and the fee-for-service system is the driver in the cost growth of health care spending. The current fee-for-service system is also inequitable. Its problems disproportionately affect populations that historically have been treated unfairly in economic and legal structures. By moving Colorado Medicaid towards a system of value-based care the department can address these issues by tying provider payments to patient outcomes.

Pursuant to Section 25.5-4-401.2, C.R.S., prior to implementing performance-based payments, the department must submit to the Joint Budget Committee either evidence that the performance-based payments are designed to achieve budget savings or a budget request for costs associated with the performance-based payments. This request is intended to meet the requirement set in statute.

Creating Financial Stability in Primary Care

Providing high quality primary care is the foundation of a high-functioning health care system and is critical for achieving health care's quadruple aim (improving the patient experience, improving health care outcomes, reducing health care costs, and improving the doctor's experience).[1] Even before the COVID-19 pandemic the state of primary care in the United States was in decline. According to the National Academy of Sciences,[2] visits to primary care doctors nationally are declining and the workforce development pipeline is shrinking as doctors elect to specialize in more lucrative health care fields.

The COVID-19 pandemic has put further financial pressure on primary care providers. When the pandemic started many patients stopped visiting primary care providers due to fear of catching the virus, and primary care providers have lost significant revenue over the course of the pandemic. In a survey of 558 primary care physicians that was conducted in the early months of the pandemic, 6% of respondents reported their practices were "(possibly temporarily) closed" and 35% reported furloughing staff.[3] This pressure from the pandemic has exacerbated the challenging conditions primary care providers were facing from before the pandemic.

Poor Maternal Outcomes and Experience

According to the department's Maternity Report published in July 2021, Health First Colorado covers over 40% of births in the state of Colorado each year. As a state, Colorado ranks poorly in terms of preventable maternal mortality. According to the Colorado Maternal Mortality Review Committee Report published in July 2020, 76.6% of maternal deaths in Colorado are

---

[1] Implementing High Quality Primary Care: Rebuilding the Foundation of Health Care (2021)

[2] https://www.nationalacademies.org/news/2021/05/high-quality-primary-care-should-be-available-to-every-individual-in-the-u-s-says-new-report-payment-reform-telehealth-expansion-state-and-federal-policy-changes-recommended

[3] https://www.pcpcc.org/sites/default/files/news_files/C19%20Series%2012%20National%20Executive%20Summary%20with%20comments.pdf

preventable.[4] The leading causes of preventable maternal mortality are suicide within a year of giving birth followed closely by unintentional accidental overdose. Nationally, pregnant people who are black or American Indian/Alaskan Native experience worse outcomes than their white counterparts and have pregnancy-related mortality that are over three and two times higher than white pregnant people respectively.[5] People of color also consistently experience mistreatment in their maternity care, which impacts how they experience maternity care. People of color are more likely to experience being shouted at, scolded, threatened, ignored by their care provider, refused services, or receiving no responses for requests for help. According to an article in the Journal of Reproductive Health, 27.2% of people of color report experiencing mistreatment versus 18.7% of white pregnant people.[6]

There are disparities between white pregnant people and people of color within Colorado Medicaid as well. According to the department's maternity report, non-Hispanic Asian and non-Hispanic black members have the highest rates of pre-term birth at 13.1% and 12.2% of deliveries respectively. The report found that non-Hispanic black members have a disproportionately higher prevalence of hypertension or gestational hypertension, which significantly increases the risk of pre-term birth.

Adverse Selection Issues in Voluntary Models

Several of the department's initial efforts towards value-based payments have been implemented on a voluntary basis. There is growing evidence that voluntary APMs are not effective in achieving their goals. A study published in the New England Journal of Medicine[7] examined 54 different value-based payment models that have been used in Medicare. In the study, only five of the 54 models showed any savings and of those five models, four had mandatory provider participation. The authors describe the failure of the voluntary model as being due to the adverse selection problem in insurance markets. Most providers only participate in voluntary models on an ongoing basis if they believe it is in their economic interest to do so. Providers often drop out of voluntary models when they have substantial or sustained losses. As such, this creates a selection effect that results in higher payments on average while quality of care stays the same.

Identifying Providers that Deliver High Quality Care

The department currently has no way of knowing which providers are the highest performing in terms of cultural competency, patient experience, outcomes, and cost. This leads to Medicaid members having worse outcomes at an increased cost to the state by choosing

[4] https://drive.google.com/file/d/11sB0qnM1DmfCA-Z87el3KMHN6oBy5t2y/view
[5] https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/
[6] https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0729-2
[7] Smith B. CMS Innovation Center at 10 Years - Progress and Lessons Learned. N Engl J Med. 2021 Feb 25;384(8):759-764. doi: 10.1056/NEJMsb2031138. Epub 2021 Jan 13. PMID: 33440085.

lower-performing providers. Informing Medicaid members, providers, and the public with data that identifies where lower cost and higher performing providers are located, as well as advocating for and empowering members to seek out these providers, will help the department to control costs and to improve outcomes for the members that it serves. There is a need to identify higher performing and lower cost providers across primary care, specialty care, as well as at the facility level for hospital-based procedures.

Proposed Solution

The department requests $22,850,574 total funds including $7,403,648 General Fund in FY 2022-23 and $14,227,538 total funds, including $4,671,497 General Fund in FY 2023-24 to implement three mandatory APMs, and establish a Colorado Providers of Distinction program for providers that deliver high value, high quality services to members. The department also requests $11,436,150 in roll-forward authority from FY 2022-23 to FY 2023-24, which will provide the department with flexibility to complete the development phase in FY 2023-24 if some of the work is delayed under the existing budget. The primary care and maternity care APMs will be developed in partnership with the Division of Insurance (DOI) and Department of Personnel and Administration (DPA) to establish an aligned approach to value-based payment across public and private payers in Colorado. This aligned approach will maximize the capacity of value-based payments to drive improved health outcomes and care quality while reducing health care costs and prioritize the reduction of health disparities to ensure all Coloradans have equitable access to high-quality primary and maternity care.

Pharmacy Prescriber APM

The department requests to implement an APM that will require prescribers to have the Pharmacy Prescriber Tool enabled, with mandatory participation starting in FY 2022-23. The department will enroll all prescribers into a shared savings model to incentivize usage of the prescriber tool and lower spending on prescription drugs. The prescriber tool leads to better utilization management of drugs by connecting physicians to the department's PDL, which reflects current information on the most appropriate and cost-effective drugs. Prescribers earn shared savings as they increase their percentage of prescriptions of drugs that come from the PDL, or the lower cost option between multiple drugs on the PDL. The savings from using the tool will be shared with prescribers retrospectively on a quarterly basis. Prescribers will have to meet quality goals to earn shared savings to ensure that high-quality care is being provided.

The department is developing and preparing to implement the model within existing resources during FY 2021-22 and has hired a vendor to help engage prescribers, stakeholders, and Medicaid members in the design of the model. The department is hosting a series of small workgroups, webinars, and in-person stakeholder engagement meetings to design the model.

The vendor is providing expertise in pharmacy and helping the department to design the quality and financial model necessary to incentivize prescribers to use the tool. In order to support prescribers, the vendor is developing report cards to inform prescribers of performance in the model relative to their like peers. The department's actuary is developing the payment targets for prescribers to earn shared savings.

In FY 2022-23 the department requests resources for stakeholder engagement, actuarial payment development and shared savings calculations, and updates to the payment and quality model based on stakeholder feedback and learned experience operating the model. The department will hire a vendor to host public meetings including webinars and in-person meetings with prescribers, stakeholders, and Medicaid members to learn how the model has impacted care delivery around prescribing and any pain points in the model. The department will then work with a vendor to make updates to the payment and quality model based on stakeholder feedback received and any operational changes necessary. The department's actuary will then need to calculate shared savings on a quarterly basis and update the payment targets for the second full performance year of the program based on prescriber performance in the first year of the model.

In FY 2023-24 and each subsequent fiscal year, the department requests ongoing funds to continue a yearly stakeholder engagement process, develop payment targets with the department's actuary, and fund a professional formal evaluation of the program. The department will host an annual stakeholder engagement process with prescribers, stakeholder, and Medicaid members to develop changes to the financial model and quality model. The department will use the actuarial contract to calculate shared savings on a quarterly basis and to update the payment targets for prescribers. The funds for the professional evaluation will be used to do a mixed-method evaluation using both quantitative and qualitative methods to ensure that the APM is having the intended consequences of decreasing pharmacy expenditures and that outcomes and the patient experience are not being negatively impacted. The evaluation will allow the department to make updates to the program and to avoid or mitigate any unintended consequences of the APM.

Maternity Bundle APM

The department requests to expand the maternity bundled payments model to all obstetrical providers, with mandatory participation starting in FY 2023-24, and to expand the program to include costs and outcomes for the neonate. The neonate was not included in the initial program design due to actuarial and program complexity around neonatal intensive care unit costs and this request will support the addition of the neonate into the maternity bundle. Under a bundled payment methodology, the department sets a target budget for the entire maternity episode, including all services related to that condition. The budget will be based on historical average expenditure for the episode, with a targeted reduction to the costs

associated with avoidable clinical events for that episode. An example of an avoidable clinical event for a maternity episode will be a Cesarean delivery (C-section) for a low risk delivery or an avoidable hospitalization after the delivery for an infection. The budget set for a participating provider will include some target level of reduction in costs for these types of avoidable clinical events, incentivizing the provider to provide evidence-based treatment. This will result in costs avoided for the department in the short term as providers adapt changes to their treatment plans to achieve the predetermined budgets for the episodes.

The department will continue to pay providers based on submitted claims, but after the episode is completed the department will reconcile actual expenditures for each service to the budget. If expenditures were higher than the budget, the main care provider will owe the department 50% of the difference. If expenditures were lower than the budget, the department will share 50% of the savings with obstetrical care provider if all quality goals were met.

In FY 2022-23 the department requests funding to engage stakeholders, develop the budgets for obstetrical providers with the department's actuary, and hire a vendor to assist with project management and strategy development. The department will hire a vendor to engage obstetrical providers, stakeholders, and Medicaid members to determine updates to the program before it is made mandatory in FY 2023-24. This will require significant resources and project management since there are currently 242 providers who perform deliveries for Medicaid members, and it is important to engage with as many providers as possible. Therefore, the department is requesting funds to hire a project management vendor to support the launch of the mandatory maternity bundled payment. It is also important to ensure the maternity bundle episode definition and program design are sustainable long-term and support obstetrical providers enrolled in Medicaid. The requested funds are inclusive of a vendor to develop a long-term program strategy and clinical design, part of which is comprised of a strategy and clinical recommendations around the inclusion of the neonate and costs and outcomes associated with the baby.

In FY 2023-24 and each subsequent fiscal year, the department requests ongoing funds to continue a yearly stakeholder engagement process, develop payment targets with the department's actuary, and fund a professional formal evaluation of the program. The department will host an annual stakeholder engagement process with prescribers, stakeholder, and Medicaid members to develop changes to the financial model and quality model. The department will use the actuarial funds to calculate shared savings on a quarterly basis and to update the payment targets for obstetric providers. The funds for the professional evaluation will be used to do a mixed-method evaluation using both quantitative and qualitative methods to ensure that the APM is having the intended consequences of decreasing expenditures associated with a maternity episode and that outcomes and the patient experience are not

being negatively impacted. The evaluation will allow the department to make updates to the program and to avoid or mitigate any unintended consequences of the APM.

The request is also asking for funds for design, development, and implementation to support the development of a data sharing solution integrated with the Colorado Medicaid BIDM. This will be designed to integrate into provider electronic health records (EHRs) to supply obstetrical providers with up-to-date performance data against the budgets and performance against program quality metrics. The data sharing solution will also run individual episodes through an episode grouping algorithm which is designed to show avoidable clinical events so obstetrical providers can make evidence-based decisions at the point of care to improve outcomes for pregnant people and to ensure the neonate is born at a full-term and appropriate weight and avoids a high cost unnecessary neonatal intensive care unit (NICU) admission. The department also requests funding for ongoing maintenance and operations of the data sharing solution.

Prospective Partial Capitations to Primary Care Providers
The department requests to implement a prospective partial capitation APM for both adult and pediatric primary care. This request will make the APM 2 methodology mandatory for all primary care providers. APM 2 will launch with voluntary participation in January 2022 and the department requests that the Mandatory APM begin in FY 2024-25 for both adult and pediatric primary care. The department anticipates this payment arrangement will guarantee more consistent cash flow to providers as they face demand fluctuations. The payments will work as a partial capitation. In partial capitation models, physicians select the share of their revenue that they will like to come from the prospective payments and the rest will come from FFS. For example, a physician could elect to receive a partial capitation from the department that would account for 50% of their monthly revenue, and the other 50% of their revenue would come from payment of services rendered in that month. For adult patients, this APM will be constructed with quality metrics that will incentivize appropriately managing care for adults with chronic conditions, such as asthma, hypertension, and diabetes. The program will be set up such that providers can earn shared savings from reductions in the total cost of care on their patient panel. The department needs resources to develop an incentive program that is appropriate for providers overseeing the care of members who are children, such as focusing on well-child care visits. These programs will build upon the state's increased investment into high quality primary care that was made with the APM 1 program.

The department requests to expand the APM 2 in FY 2022-23 and FY 2023-24, which will require the department to engage stakeholders, develop the budgets for PCMPs with the department's actuary, and hire a vendor to assist with project management and strategy development. The department will hire a vendor to engage both adult and pediatric primary care doctors, stakeholders, and Medicaid members to determine updates to the program before it is made

mandatory in FY 2024-25. This will require significant resources and project management since there are 850 primary care providers enrolled in the program and it is important to engage with as many providers as possible. Therefore, the department requests funds to hire a project management vendor to support the launch of the mandatory APM 2 for adult and pediatric primary care doctors. It is also important to ensure long-term success of the program and to ensure the long-term financial viability of primary care doctors who support members enrolled in Medicaid. To do this the department also requests funds for a vendor to help with long-term program strategy and clinical design support to ensure the program supports doctors and does not increase administrative burden. The vendor will also provide clinical support with episode design for the top chronic conditions in Medicaid.

The department also requests ongoing funding past the program development year to continue a yearly stakeholder engagement process, develop payment targets with the department's actuary, and for funds for a professional formal evaluation of the program. The department will host an annual stakeholder engagement process with prescribers, stakeholder, and Medicaid members to develop changes to the financial model and quality model. The department will use the actuarial contract to calculate shared savings on a quarterly basis and to update the payment targets for prescribers. The funds for the professional evaluation will be used to do a mixed-method evaluation using both quantitative and qualitative methods to ensure that the APM is having the intended consequences of decreasing expenditures associated with chronic conditions and that outcomes and the patient experience are not being negatively impacted. The evaluation will allow the department to make updates to the program and to avoid or mitigate any unintended consequences of the APM.

The department also requests funds for design, development, and implementation to support the development of a data sharing solution integrated with the Colorado Medicaid BIDM. This will be designed to integrate into provider EHRs to supply providers with up-to-date performance data against the budgets and performance against program quality metrics. The data sharing solution will also run individual episodes through an episode grouping algorithm which is designed to show avoidable clinical events so providers can make evidence-based decisions at the point of care to improve outcomes for adult members with chronic conditions and pediatric members. The department also requests funding for ongoing maintenance and operations of the data sharing solution.

Colorado Providers of Distinction

The department requests to plan and implement separate Colorado Providers of Distinction programs in primary care, specialty care, and hospital-based procedures, starting in FY 2023-24. The Colorado Providers of Distinction programs identify health care providers that deliver high-value care and demonstrate better outcomes for Colorado patients and families. The programs will evaluate and report on health care outcomes and episode price for specific

conditions in primary care, specialty care, and hospital-based procedures to offer insights to providers and patients and promote referrals to the respective provider of distinction in their region.

The department will create three separate programs covering primary care medical providers, specialists, and surgeons and facilities for hospital-based procedures. Providers in these areas will have an opportunity to be included if they meet criteria. Those who do not meet criteria will be incentivized to keep costs down and improve outcomes by implementing evidence-based practices that will keep members healthy. These practices will lead to better quality of care for members and reduce the likelihood of Medicaid members developing complications and ending up in the hospital. As an example, a group of physicians in New Jersey implemented an enhanced recovery after surgery (ERAS) program which incorporated evidence-based, patient-centered practices to facilitate recovery and reduce patient's surgical stress. A study on the program found that mean length of hospital stay of those in the ERAS program was reduced by 18% compared to those who did not receive ERAS care and cost for those with ERAS were reduced[8].

In order to implement Providers of Distinction in primary care, specialty care, and for hospital based procedures the department needs to develop episode based analytics to identify the separate groups of Providers of Distinction, stakeholders need to be engaged from each group and analytics to alter member choice of provider, and the department needs support with strategy and clinical design of each of the three programs in FY 2022-23. The department also is seeking 90/10 funding to design and implement a solution which will integrate the Colorado Providers of Distinction analytics with the department's eConsult system to influence referrals between primary care and specialty care. The department will begin extensive stakeholder engagement in FY 2022-23. The stakeholder engagement for each project is extremely important to ensure that providers, stakeholders, and Medicaid members are engaged to ensure each category of Colorado Providers of Distinction promotes high-quality person-centered care. There are 850 PCMPs enrolled in the ACC, hundreds of specialists, and over 80 hospitals and each needs to be engaged to ensure that the program supports doctors and eases administrative burden and is clinically accurate. The department will need to develop episode-based analytics to identify Colorado Providers of Distinction in each of the three separate categories and the episodes will need to have a comprehensive risk adjustment methodology to ensure that providers do not only select healthy members to provide care for. To design the episodes of care and the financial and quality programs for each of the three categories of Colorado Providers of Distinction, the department will hire a vendor to provide

[8] Ari Sapin, Patrick Hilden, Luciana Cinicolo, Jenifer Stein, Amber Turner, Richard Pitera, Paul Yodicei, Prakash R. Paragi, Enhanced recovery after surgery for sleeve gastrectomies: improved patient outcomes, Surgery for Obesity and Related Diseases, 2021, ISSN 1550-7289, https://doi.org/10.1016/j.soard.2021.04.017.

strategic and clinical consulting support. This vendor will provide technical and clinical expertise to ensure that the methodology for each category is based on evidence and promotes high-quality person-centered care and is inclusive of all clinical elements for the various episodes. The vendor will also provide support to the design of the actual programs themselves and the relevant policies and provide recommendations on how to influence member behavior on choice of provider.

After the three separate programs are designed to support the launch of the program in FY 2023-24, the department will hire a vendor to link the episode-based analytics to the department's Find A Provider tool to provide our members with information about the quality of care of different providers, to identify Colorado providers of distinction, and to help members make informed decisions about their care. The department will also develop the analytics necessary to support primary care referrals to link the specialist Colorado Providers of Distinction with the eConsult platform under development by the department.

To support ongoing operations of the three separate Colorado Provider of Distinction Programs, the department is requesting funds for an annual stakeholder engagement process to support each of the separate programs, updates to the analytics episode based analytics platform and Find a Doctor tool, and updates to the eConsult-based analytics and a program evaluation of each of the three separate programs. The department will host an annual stakeholder engagement process for each of the three separate Colorado Provider of Distinction programs which will engage providers, stakeholders, and Medicaid members to ensure that the programs are having the intended impacts. The episode-based analytics and Find A Provider tool platforms will be updated based on the results of the stakeholder engagement process. The analytics to support primary care doctor referrals to specialists through eConsult will also require updates on an annual basis. The funds for the professional evaluation will be used to do a mixed-method evaluation of each separate program using both quantitative and qualitative methods to ensure that each separate program is having the intended consequences of decreasing expenditures associated with chronic conditions and that outcomes and the patient experience are not being negatively impacted. The evaluation will allow the department to make updates to the programs and to avoid or mitigate any unintended consequences of the programs.

Finally, due to the uncertain nature of the timeline to complete the design and development work of the APMs and Providers of Distinction as well as the tight labor market, the department is requesting $11,436,150 in roll-forward authority from FY 2022-23 to FY 2023-24. Roll-forward authority for the contractor funding will provide the department with flexibility to complete the development phase in FY 2023-24 if some of the work is delayed under the existing budget.

Evidence Continuum

This request aligns with Step 4 of the Evidence Continuum. Although there are some payment reform models in this request that are novel, there is literature on the success of value-based models that have been implemented in other states. The programs with the most evidence supporting their success are bundled payment methodologies, especially for maternity care, and models that focus on better management in primary care, especially among members with chronic conditions.

<table>
<tr><td>Theory of Change</td><td colspan="3">Value Based Models save money by reducing unnecessary procedures and ED visits, reducing the FFS incentive to bill a high volume of claims, and incentivizing prescribers to use cheaper, equivalent drugs. By focusing on quality metrics, and referring members to providers that demonstrate better outcomes, this program leads to higher quality of care for members.

By referring our members to high-performing Providers of Distinction the department will improve outcomes and the patient experience for Medicaid members and lower the amount being spent on medical premiums.</td></tr>
<tr><td>Program Objective</td><td colspan="3">Improve health equity and the quality of care, while reducing total cost of care.</td></tr>
<tr><td>Outputs Being Measured</td><td colspan="3">Quality of care and total cost of care through departmental claims</td></tr>
<tr><td>Outcomes Being Measured</td><td colspan="3">Improved health and less money spent on prescription drugs, maternity episodes, and chronic conditions.
Improved outcomes for Medicaid members served by Colorado Providers of Distinction and higher patient satisfaction.</td></tr>
<tr><td>Cost/Benefit Ratio</td><td colspan="3">The department anticipates savings from these value-based payments through prescribers prescribing less expensive drugs, better management of maternity care through bundled payments, and better management of chronic conditions and health episodes.</td></tr>
<tr><td>Evaluations</td><td>Pre-Post</td><td>Quasi-Experimental Design</td><td>Randomized Control Trial</td></tr>
<tr><td>Results of Evaluation</td><td>The state of Tennessee consistently reports savings from their Episodes of Care Program and Maternity bundled payment program. Tennessee estimates $45 million from the Episodes of Care Program and $10 million dollars for Perinatal Care in Calendar Year (CY) 2019.</td><td>A difference in differences study of the Arkansas Health Care Payment Improvement Initiative, a mandatory bundled payment methodology, comparing Arkansas to neighboring states before and after the policy was implemented. The study reports a 3.8% reduction in perinatal expenditure.</td><td></td></tr>
<tr><td>Continuum Level</td><td colspan="3">Step 4</td></tr>
</table>

Anticipated Outcomes

The department anticipates that the implementation of these APMs will result in an overall improvement in the health care delivery as the department takes steps to move away from the traditional FFS delivery system. The APMs will also help stabilize the primary care system in Colorado, which was adversely impacted by the COVID-19 pandemic by guaranteeing cash flow to primary care providers when they face dramatic fluctuations in demand. The department also anticipates savings as a result of these initiatives through prescribers prescribing less expensive drugs to members, better management of chronic conditions, and referring members to Colorado Providers of Distinction.

Implementation of the APMs and Colorado Providers of Distinction program will help meet the department's efforts in meeting the department's Wildly Important Goal (WIG) #1, "Medicaid Pharmacy Cost Control." The department is focused on decreasing Medicaid pharmacy expenses by implementing effective policy like the Prescription Drug Affordability Board electronic prescribing tools that empower providers to choose the most cost-effective drugs for their patients. It will also result in more effective provider reimbursement models including value-based payments.

In addition to the department's WIG above, this request will help the department meet the Health Cabinet WIG #2, "Create the operational infrastructure to promote value in health care and lower costs in the employer-sponsored insurance market by implementing utilization of non-fee-for-service payment and reimbursement structures in Colorado by June 30, 2022." The department is a major payer of health care services in Colorado.

Among Medicaid programs that have an active or developing episode-based payment system, including Arkansas, Connecticut, Ohio, Oklahoma, New York, and Tennessee, all of them offer or require the methodology to be used for maternity services. Data is available for Arkansas and Tennessee's programs. Based on preliminary data, Arkansas has seen a 3.8% drop in perinatal episode expenditure and Tennessee has seen a 7.7% drop[9]. In the Tennessee Episodes of Care programs that is similar to Providers of Distinction, they reduced expenditures by $45 million per year.[10]

---

[9] https://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf;
(Harvard School of Medicine, 2018) Effects of Episode-Based Payment on Health Care Spending and Utilization: Evidence from Perinatal Care in Arkansas,
https://scholar.harvard.edu/files/ccarroll/files/carroll_etal_ebp_2018.pdf

[10] https://www.tn.gov/content/dam/tn/tenncare/documents2/EpisodesOfCare2019PerformancePeriodResults.pdf

If this request is not funded, the state risks continuing to pay for health care services through a system that rewards the volume of services billed over the value provided and that does not necessarily lead to better health outcomes for members.

Assumptions and Calculations

Alternative Payment Models
The department assumes that each APM will be comprised of components similar to those that the department will need to develop and operate.

Stakeholder Outreach and Engagement
The department requests funding to hire a contractor to facilitate stakeholder outreach efforts. Because the department is requesting that these APMs have mandatory participation, a key component of making sure each APM is successful is input from stakeholders. The work hours performed by the contractor in the first year is the equivalent of 1.5 FTE working the entire year. The work the contractor will be performing for each of the APMs and the Colorado Providers of Distinction is similar in scope to the stakeholder outreach work the department estimated as part of S.B. 19-195 at approximately $100,000. Senate Bill 19-195 required the department to conduct significant stakeholder outreach with many different entities involved in the child welfare system. The work around APMs will also require significant outreach to all prescribers, obstetrical providers, and PCMPs enrolled in the Medicaid program. Stakeholder engagement funding will be needed for all the APMs to engage providers in conversations on development of the programs and considering feedback and concerns. Stakeholders will recommend changes and updates to the APM measure set, measure points, and measure goals. This stakeholder engagement process will also include public listening sessions, ad hoc workgroup meetings, requests for written feedback, meetings with providers, and review with the ACC Program Improvement Advisory Committee (PIAC). This feedback is invaluable in creating a program that functions for all parties engaged in the APMs.

Actuarial Contractor
Each APM will need actuarial analysis to build actuarially-sound rates for the APMs and/or to calculate reimbursement of shared savings. For the three APMs, the 3,850 work hours performed by the contractor will be equivalent to two FTE working for the entire year in the first year. The estimates are also similar when scaled by provider type to the actuarial funding estimated for the FY 2019-20 R-7 “Primary Care Alternative Payment Models” request for calculating partial capitations for the voluntary APM 2 model. In this prior request, the department assumed $175,000 in actuarial funding for a voluntary program. The current request will affect more providers as a mandatory program. The department assumes that the

actuary contracts will require ongoing funding as the rates and savings reconciliations will need to be updated annually.

Prescriber Tool

For the Pharmacy prescriber APM the department will need a contracted actuary to be responsible for developing the process by which savings are identified and rewarded to prescribers. The actuary will develop a benchmark on which prescriber performance is measured. The department anticipates that the benchmark will be the percentage of prescriptions that come from the PDL, in a selected benchmark year. As a prescriber increases their percentage of prescriptions from the PDL relative to the benchmark year, the prescriber will earn shared savings with the department. The actuary will be responsible for estimating the amount of shared savings each prescriber will earn.

Maternity Bundled Payments

The Maternity bundled payments APM will need to be expanded to all obstetrical care providers. Currently, actuarial rate development is being performed by the department's actuary contractor for a very small number of obstetrical care providers. The department plans to expand the program to become mandatory for all state obstetrical care providers, which will entail the development of provider specific rates, meaning that the number of rates the contract will need to develop will also increase. Accomplishing this will require more work hours that cannot be supported in the department's current budget.

Primary Care Partial Capitations

An actuarial contractor will also be required for the prospective payment to APMs. The actuary will assist the department in calculating practice-specific PMPM payments for all primary care providers statewide. The actuary will also be instrumental in developing the cost-sharing payments that primary care providers will earn as they meet the quality metrics surrounding managing patients with chronic conditions and well-child visits.

Program Development and Project Management

The department will need contractors to assist in building and maintaining each of the APMs. The department believes there is value in this work being performed by a contractor who works with multiple state programs and has specialized experience in creating and managing APMs. The work hours that will be performed by the contractor in the first year are equivalent to that of 6.0 FTE. The estimates are similar to what the department was appropriated in S.B. 16-192, which provided funding for the department to research, design, and implement a new needs assessment tool for persons receiving long-term services and supports. The department was appropriated $800,000 for a contractor to develop the tool and $410,000 to run a pilot program to ensure the tool functions properly. The estimates in the current request are larger as the contractor will be developing multiple programs and assisting the department in management

beyond a pilot program. The work will focus around the best way to develop the program as well as how to improve it as the program begins operating. The APMs rely on cost and quality metrics as performance measures that will be used to reward providers with savings. The department will need to identify the metrics that will be used to compare providers and programs in order to know which ones have earned shared savings. In addition, each APM will rely on real-time data sharing to provide actionable information on program performance for each participating provider. The department anticipates that the department, the provider, and the contractor will all require access. The contractor will also assist with evaluating programs in other states to find out their lessons learned, as well as keeping track of CMS initiatives in Medicare to design better value-based methods. Starting in FY 2023-24, the department will seek programmatic evaluation which will also require assistance in design and direction.

Systems Costs

Systems costs will also be required to develop and maintain the APMs. The systems costs will be focused around expanding the department's ability to gather and analyze data for each of the APM's quality metrics and to get the data into a dashboard that all providers, the department, and contractors can access and update in real time. The systems changes will be similar in scope to systems changes that were estimated by the department through previous requests to build the prescriber tool. The department was appropriated $500,000 for the prescriber tool systems costs in S.B. 18-266 and was appropriated an additional $1,799,357 in the FY 2020-21 R-7 "Pharmacy Pricing and Technology" request. The functionality of the systems changes will be similar to the prescriber tool work as the department will need to connect at the individual provider level for this program to work as intended. The costs are scaled up from R-7 as there are four separate initiatives. The department assumes that some costs in the first year will be eligible for 90% FFP as they are related to design, development, and implementation. In subsequent years when the analytic systems and tools are built, the department assumes it could claim 75% FFP for ongoing maintenance and operations. The department will need to submit an advanced planning document (APD) to the CMS to claim the enhanced FFP.

Prescriber Tool

Several systems updates will be necessary to operationalize the Pharmacy Prescriber APM. The department will need to ensure that each prescriber has access to the prescriber tool and be able to measure how often prescribers are accessing the tool. The department will also need to track drugs prescribed from the PDL and their share of total drug prescriptions for each prescriber. Finally, the department will need data on the incentive payments in order to assess their effectiveness.

Maternity Bundle
Due to the complexity of this request, the department's existing provider-facing portal was not designed to provide cost and quality performance data for value-based payments. A new portal that has the ability to process and analyze rolling claim data to provide performance reporting and data analytics to participating providers is needed to fulfill the data sharing function of the program. The data portal will give the providers as well as the department a deep and thorough understanding of providers' performance on episode cost and service quality, and provide timely and actionable information for providers to adjust their practice behavior to reduce episode cost and improve service quality in order to achieve gain-sharing. The portal will require specific data analytic ability as well as deep understanding of the design and operation of episode of care. In addition, the department has a long-term goal of including electronic health record (EHR) data from providers into the data sharing function, which requires an upgrade to the data sharing function.

Evaluation
The department requests funds to evaluate each of the three mandatory APMs. The department believes there is value in hiring an independent evaluation expert to evaluate the model using a mixed-methods quantitative and qualitative approach to ensure that each model is having the intended outcomes. The contractor will use the department's administrative claims data to ensure the model is improving outcomes and the quality of care for Medicaid members and lowering costs from the baseline spending targets. The contractor will also perform qualitative evaluations of the models with providers to ensure that the model is not increasing administrative burden. The contractor will also evaluate members' patient experience to ensure the mandatory APM is not impacting the person-centeredness of care received.

The department based the estimate of hiring a contractor to evaluate the models on the contractor costs requested in the FY 2019-20 R-7 "Primary Care Alternative Payment Models" request. In this prior request, the department estimated approximately $200,000 would be needed to submit an 1115 waiver to CMS. Part of the 1115 waiver application is designing a plan to evaluate the waiver. The department assumes this task will be similar in nature to evaluating the APMs. The requested funding in this current request is greater due to the greater resource need associated with carrying out an evaluation.

Colorado Providers of Distinction
Stakeholder Outreach and Engagement
The department requests funding to hire a contractor to facilitate stakeholder outreach efforts for both primary care and specialty care. The contractor will engage providers in conversations on development of the program and taking into account feedback and concerns. This stakeholder engagement process will also include public listening sessions, ad hoc workgroup

meetings, request for written feedback, meetings with providers, and review with the ACC Program Advisory Committee (PIAC). This feedback is invaluable in creating a program that functions for all parties engaged in the Colorado Providers of Distinction programs.

Strategy Design Consulting

The department will need more consulting resources to develop the Colorado Providers of Distinction program. The work will focus around the best way to develop the program as well as how to improve it as the program begins operating. The program will consist of providers that are the most effective at meeting quality metrics and reducing costs. Some of the funding for this contract will be used to identify the performance metrics which the department will use to evaluate performance. Additionally, the contractor will be responsible for keeping track of and evaluating similar programs in other states for their lessons learned. The contractor will also keep track of CMS initiatives in Medicare to design better value-based methods. Eventually after the programs are in place, the department will need resources to evaluate these programs and the contractors will help set up evaluation metrics.

The Colorado Providers of Distinction program will also require contractor funding to gather the analytics necessary to identify them. This funding will be used to determine which practices meet criteria for being a Colorado Provider of Distinction and measure how their patients fare in comparison to the general Medicaid population through using EHR records and other measures.

Evaluation

The department requests funds to evaluate the Colorado Providers of Distinction program. The department believes there is value in hiring an independent evaluation expert to evaluate the model using a mixed-methods quantitative and qualitative approach to ensure that each Colorado Provider of Distinction program in primary care, specialty care, and hospital-based episodes is having the intended outcomes. The contractor will use the department's administrative claims data to ensure the model is improving outcomes and the quality of care for Medicaid members and lowering costs from the baseline spending targets. The contractor will also perform qualitative evaluations of the models with providers to ensure that the model is not increasing administrative burden. The contractor will also evaluate members' patient experience to ensure the mandatory APM is not impacting the person-centeredness of care received.

Administrative Resources

APM Financial Rates Analysts

To support the APMs, the department requests two FTE at the Financial Rate Analyst IV classification. These positions manage the design, implementation, and operations of the three mandatory APMs. This includes drafting and overseeing the stakeholder engagement, strategy,

evaluation, and actuarial APM contracts for the primary care models for adult and pediatric patients, the maternity bundle, and the prescriber tool shared savings program. These positions will be responsible for amending contracts, enacting options for additional scopes of work when necessary, and following the state's procurement rules and guidelines to support the department's business needs with the rates vendor.

These positions will also be responsible for designing complex financial rate methodologies for each of the three mandatory APMs. This entails complex financial modeling and data analysis to ensure the provider payments are sufficient for each of the programs. These positions will ensure the per-member per-month payments and incentives remain within budget and that the department pays the appropriate level of incentive to encourage behavior change and performance. The financial model will need to be designed for the initial program year and will need on-going updates on an annual basis with the department's actuarial contractor. The positions will manage the financial model updates each year as well as the actuarial contractor. The positions will also ensure that the financial and quality models are compliant with all federal regulations and manage the State Plan Amendment process for each of the three mandatory APMs for both implementation and on-going updates for operations.

Stakeholder engagement is a vital part of designing an alternative payment model to ensure the model supports providers, but also does not have any unintended consequences for Medicaid members. It takes an enormous amount of stakeholder engagement for a mandatory APM due to the large number of providers impacted by each program. There are 850 primary care medical providers between adult and pediatric patients in the ACC and approximately 242 obstetrical providers in Colorado Medicaid, and there will be 6,115 prescribers who have the prescriber tool enabled in their EHR. The positions will present complex financial and model information with the stakeholder engagement contractors to gather input on the model's design before program implementation for each of the three mandatory APMs. This will require managing a very large group of stakeholders with divergent viewpoints for each model and requires a high level of technical understanding and communications skills. The positions will also manage the stakeholder engagement for updates to each of the three APMs on an annual basis and will present performance results of the model to stakeholders to help gather feedback for updates to the model design for each of the three models.

Colorado Providers of Distinction Financial Rates Analysts

The department requests two FTE at the Financial Rate Analyst IV classification to support the Colorado Providers of Distinction program. These positions will manage the design, implementation, and operations of the Colorado Providers of Distinction program for primary care, specialists, and hospital-based procedures. This includes overseeing the Colorado Providers of Distinction contracts for stakeholder engagement, strategic design consulting, and program evaluations. These positions will be responsible for amending contracts, enacting

options for additional scopes of work when necessary, and following the state's procurement rules and guidelines to support the department's business needs with the rates vendor.

The positions will also lead the design of complex rate methodologies for Colorado Providers of Distinction in primary care, specialty care, and hospital-based procedural episodes. This entails complex financial modeling and data analysis to ensure the provider payments are sufficient for each of the programs. These positions will ensure the payments and incentives remain within budget and that the department pays the appropriate level of incentive to encourage behavior change and performance. The financial model will need to be designed for the initial program year and will need on-going updates on an annual basis with the department's actuarial contractor. The positions will manage the financial model updates each year as well as the actuarial contractor. The positions will also ensure that the financial and quality models are compliant with all federal regulations, manage the state plan amendment process, and manage on-going updates for operations.

The positions will also assist with stakeholder engagement with participating providers. Stakeholder engagement is a vital part of designing an alternative payment model to ensure the model supports providers, but also does not have any unintended consequences for Medicaid members. It takes an enormous amount of stakeholder engagement for a mandatory APM due to the large number of providers impacted by each program. There are 850 primary care medical providers between adult and pediatric patients in the ACC, there are hundreds of specialist practices enrolled in Medicaid, and more than 80 hospitals. The positions will present complex financial and model information with the stakeholder engagement contractors to gather input on the model's design before program implementation for each of the three mandatory APMs. This will require managing a very large group of stakeholders with divergent viewpoints for each model and requires a high level of technical understanding and communications skills. The positions will also manage the stakeholder engagement for updates to each of the three APMs on an annual basis and will present performance results of the model to stakeholders to help gather feedback for updates to the model design for each of the three models.

APM Program Administrators

The department requests two FTE at the Administrator IV classification. These FTE will assist in selecting and implementing quality measures in the various APMs and working with various APM stakeholders to assist in identifying areas of focus for measure selection using standardized measures. They will be responsible for ensuring reporting is feasible and appropriate codes are billable to accurately capture data for the measure. All measures will need to be assessed for alignment with state and federal priorities. These positions will develop department goals based on national benchmarks and department and Governor priorities, such as the CMS Core Measure Set. These positions will work with the Stakeholder Engagement Contractor to ensure

reporting of all performance measures are accurately and appropriately reported back to the providers/RAEs through the Data Analytics Portal for ongoing monitoring of performance at the provider level. In addition, these positions will work with the APM analysts to identify the most effective way to use measurement for payment and for collecting data for automation of payment calculation. Finally, these positions will also conduct annual evaluations of performance for changing measures and identify focus areas for improvement.

Colorado Providers of Distinction Program Administrator

The department requests one FTE at Administrator IV to support the Colorado Providers of Distinction program. The FTE will assist in research around potential metrics that will be used to identify Colorado Providers of Distinction to ensure that the department is using evidence-based, clinically relevant, and appropriate measures. The ideal candidate would have clinical knowledge. This position will also ensure the alignment of the Colorado Providers of Distinction with the overarching departmental quality structure.

RAE Alignment

The department requests two FTE at Program Administrator IV to focus on coordination and alignment with the RAEs.

One FTE will be the ACC APM Stakeholder Engagement Specialist whose primary task will be to collaborate with the APM Stakeholder Engagement Contractor and the APM staff to ensure appropriate engagement of RAEs and PCMPs. This position will also conduct and support additional stakeholder engagement and change management activities with RAEs and PCMPs to ensure effective incorporation of the APMs into the ACC. The position will design and evolve administrative payment processes to support the APMs and Colorado Providers of Distinction program and identify resources PCMPs require to be successful, as well as explore ways to incorporate into RAE practice transformation efforts.

The second FTE will be the ACC APM Design and Evaluation Specialist. They will serve as a liaison and collaborate with internal staff and the RAEs regarding the design of the APMs and establishing performance targets. In addition they will be responsible for providing ongoing oversight and evaluation of the RAEs regarding their support and implementation of APMs and the Colorado Providers of Distinction program, such as updating the documentation requirements of RAEs and their contracts as needed as well as federal authorities as necessary to support ACC implementation of APMs and Colorado Providers of Distinction.

Analytic Tools

The department requests one FTE at Statistical Analyst III to assist with using the analytic tools that will be developed.

This position will be the department subject matter expert on Performance Measurement for HCPF's Value Based Payment programs. This position will be responsible for managing the performance measure development process of the APMs and Colorado Providers of Distinction. This will include collaborating with the department's contractors, making key decisions on which measures are the most appropriate given the goals of the APMs and Colorado Providers of Distinction as well as data availability, designing statistically sound measure methodology, overseeing measure calculation, reviewing results, and aligning measurement throughout the department. This position will communicate performance measurement decisions and explain measure methodology to stakeholders both internally and externally. This position will have specialized knowledge in quality measurement and perform other related duties such as validating sampling frames and analyzing survey data.

Costs Avoided

The APMs will incentivize providers to make cost-effective decisions with quality of care in mind which will lead to better management of members' health and help them avoid complications. Once the APMs are implemented and the Colorado Providers of Distinction program is established, the department will be able to direct members to the providers that will give them the most value; as a result, the department anticipates that there will be costs avoided as best practices are identified and implemented.

Prescriber Tool

The department assumes some savings from creating a mandatory APM that incentivizes use of the prescriber tool through a shared savings model. The department calculated savings based on the number of prescribers expected to have the tool enabled by the beginning of FY 2022-23 and an assumed 2.0% of the average net pharmacy reimbursement per provider. The number of prescribers is expected to increase in FY 2023-24 and FY 2024-25 as more prescribers start using the tool. This savings figure is incremental to the amount previously estimated as part of rolling out the prescriber tool which had funding appropriated through S.B. 18-266 and later increased in the department's FY 2020-21 R-7 “Pharmacy Pricing and Technology” request. The department expects additional savings due to the shared savings from APM incentivizing prescribers to participate in the program and will share up to 25% of savings with prescribers.

The department also calculated costs associated with paying out savings that were previously assumed to accrue only to the department in S.B. 18-266 and subsequent budget actions. The department also assumes 25% of these savings will be paid to prescribers.

Maternity Bundle

The department assumes that it will spend less on episodes of care through a bundled payment methodology, because the budgets for the episodes will be set with a targeted reduction to expenditure on potentially avoidable complications (PACs) and the providers will be

incentivized to reduce costs incurred by members on PACs during the episode in the short term. The department estimated savings for participating providers based on the CY 2019 total expenditure spent on prenatal care and delivery costs for the mother and newborn, as calculated by the PROMETHEUS Analytics tool, and assuming that Colorado will experience similar savings to other states that have implemented Maternity Bundled Payment APMs. Tennessee estimated a 6.6% reduction in CY 2019 in the cost of a maternity episode due to their Episodes of Care program and maternity bundled payments. The department assumed a savings percentage of half that amount at 3.3% in order to remain conservative in its savings estimate.

Primary Care and Specialty Care Management

The department assumes that it will spend less on primary care and specialty care as the Primary Care APMs will lead to better management of members with chronic conditions. The department estimated savings for providers based on the CY 2019 total expenditure spent on certain episodes of care related to chronic diseases and other health issues, such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, and low back pain. The department estimate that it will save 5% on these costs is based on Tennessee's experience from their Episodes of Care program in managing these chronic conditions. The savings percentage was dampened to account for the time it will take to ramp up the programs.

Colorado Providers of Distinction

The department assumes it will spend less on certain hospital-based episodes of care once the Colorado Providers of Distinction program is implemented and more members select these providers for their care. The department estimated savings for providers based on the CY 2019 total expenditures spent on certain hospital procedures such as colonoscopies and joint replacements. The department estimates that it will save 7.4% on these costs based on Tennessee's savings experience from their Episodes of Care program in managing care during and after some of these common hospital procedures. The savings percentage was dampened to account for the time it will take to ramp up the programs.

Table 1.1
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$727,980	9.6	$363,990	$0	$0	$363,990	50.00%	Table 2.1 APM and Colorado Providers of Distinction support
B	(1) Executive Director's Office; (A) Health, Life, and Dental	$135,440	0.0	$67,720	$0	$0	$67,720	50.00%	Table 6 Health, Life, and Dental
C	(1) Executive Director's Office; (A) Short-term Disability	$1,037	0.0	$518	$0	$0	$519	50.00%	Table 6 Short-term Disability
D	(1) Executive Director's Office; (A) S.B. 04-257 Amortization Equalization Disbursement	$32,398	0.0	$16,199	$0	$0	$16,199	50.00%	Table 6, Amortization Equalization Disbursement
E	(1) Executive Director's Office; (A) S.B. 06-235 Supplemental Amortization Equalization Disbursement	$32,398	0.0	$16,199	$0	$0	$16,199	50.00%	Table 6, Supplemental Amortization Equalization Disbursement
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$79,500	0.0	$39,750	$0	$0	$39,750	50.00%	Table 6 Operating Expenses
G	(1) Executive Director's Office; (A) General Administration; Leased Space	$66,000	0.0	$33,000	$0	$0	$33,000	50.00%	Table 6 Leased Space
H	(1) Executive Director's Office; (A) General Administration; General Professional Services and Special Projects[1]	$11,436,150	0.0	$5,718,075	$0	$0	$5,718,075	50.00%	Table 2.1 Stakeholder Engagement, Program Development, Actuarial Rate Setting, Program Development and Consulting
I	(1) Executive Director's Office; (C) IT Contracts and Projects, MMIS Maintenance and Projects	$10,465,527	0.0	$1,181,828	$0	$0	$9,283,699	90.00%	Table 2.1 Analytical Tools and System Costs
J	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($125,856)	0.0	($33,631)	($7,197)	$0	($85,028)	67.56%	Table 2.1 Costs Avoided
K	**Total Request**	**$22,850,574**	**9.6**	**$7,403,648**	**($7,197)**	**$0**	**$15,454,123**		Sum of Rows A thru G

Notes:
(1) The Department requests $11,436,150 in roll forward authority from FY 2022-23 to FY 2023-24, which would provide the Department with flexibility to complete the development phase in FY 2023-24 if some of the work is delayed under the existing budget.

Table 1.2
Summary by Line Item
FY 2023-24

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$757,135	10.0	$378,567	$0	$0	$378,568	50.00%	Table 2.2 APM and Colorado Providers of Distinction support
B	(1) Executive Director's Office; (A) Health, Life, and Dental	$140,860	0.0	$70,430	$0	$0	$70,430	50.00%	Table 6 Health, Life, and Dental
C	(1) Executive Director's Office; (A) Short-term Disability	$1,078	0.0	$539	$0	$0	$539	50.00%	Table 6 Short-term Disability
D	(1) Executive Director's Office; (A) S.B. 04-257 Amortization Equalization Disbursement	$33,695	0.0	$16,847	$0	$0	$16,848	50.00%	Table 6, Amortization Equalization Disbursement
E	(1) Executive Director's Office; (A) S.B. 06-235 Supplemental Amortization Equalization Disbursement	$33,695	0.0	$16,848	$0	$0	$16,847	50.00%	Table 6, Supplemental Amortization Equalization Disbursement
C	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$9,500	0.0	$4,750	$0	$0	$4,750	50.00%	Table 6 Operating Expenses
D	(1) Executive Director's Office; (A) General Administration; Leased Space	$66,000	0.0	$33,000	$0	$0	$33,000	50.00%	Table 6 Leased Space
E	(1) Executive Director's Office; (A) General Administration; General Professional Services and Special Projects	$8,187,350	0.0	$4,093,675	$0	$0	$4,093,675	50.00%	Table 2.2 Stakeholder Engagement, Program Development, Actuarial Rate Setting, Program Development and Consulting
F	(1) Executive Director's Office; (C) IT Contracts and Projects, MMIS Maintenance and Projects	$8,551,638	0.0	$1,395,211	$0	$0	$7,156,427	83.68%	Table 2.2 Analytical Tools and System Costs
G	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($3,553,413)	0.0	($1,338,370)	($105,315)	$0	($2,109,728)	59.37%	Table 2.2 Costs Avoided
H	**Total Request**	**$14,227,538**	**10.0**	**$4,671,497**	**($105,315)**	**$0**	**$9,661,356**		Sum of Rows A thru G

Table 1.2
Summary by Line Item
FY 2024-25 and Ongoing

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$757,135	10.0	$378,567	$0	$0	$378,568	50.00%	Table 2.3 APM and Colorado Providers of Distinction support
B	(1) Executive Director's Office; (A) Health, Life, and Dental	$140,860	0.0	$70,430	$0	$0	$70,430	50.00%	Table 6 Health, Life, and Dental
C	(1) Executive Director's Office; (A) Short-term Disability	$1,078	0.0	$539	$0	$0	$539	50.00%	Table 6 Short-term Disability
D	(1) Executive Director's Office; (A) S.B. 04-257 Amortization Equalization Disbursement	$33,695	0.0	$16,848	$0	$0	$16,848	50.00%	Table 6, Amortization Equalization Disbursement
E	(1) Executive Director's Office; (A) S.B. 06-235 Supplemental Amortization Equalization Disbursement	$33,695	0.0	$16,848	$0	$0	$16,848	50.00%	Table 6, Supplemental Amortization Equalization Disbursement
C	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$9,500	0.0	$4,750	$0	$0	$4,750	50.00%	Table 6 Operating Expenses
D	(1) Executive Director's Office; (A) General Administration; Leased Space	$66,000	0.0	$33,000	$0	$0	$33,000	50.00%	Table 6 Leased Space
E	(1) Executive Director's Office; (A) General Administration; General Professional Services and Special Projects	$3,306,470	0.0	$1,653,235	$0	$0	$1,653,235	50.00%	Table 2.3 Stakeholder Engagement, Program Development, Actuarial Rate Setting, Program Development and Consulting
F	(1) Executive Director's Office; (C) IT Contracts and Projects, MMIS Maintenance and Projects	$6,740,703	0.0	$1,685,177	$0	$0	$5,055,526	75.00%	Table 2.3 Analytical Tools and System Costs
G	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($11,981,553)	0.0	($4,393,396)	($203,434)	$0	($7,384,723)	61.63%	Table 2.3 Costs Avoided
H	**Total Request**	**($892,418)**	**10.0**	**($534,004)**	**($203,434)**	**$0**	**($154,980)**		Sum of Rows A thru G

Table 2.1
Summary by Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
	Pharmacy Prescriber APM								
A	Stakeholder Engagement	$98,500	0.0	$49,250	$0	$0	$49,250	50.00%	Table 3.1 Row A
B	Actuarial Contractor For Savings Reimbursement	$95,400	0.0	$47,700	$0	$0	$47,700	50.00%	Table 3.1 Row B
C	Program Development Consulting	$151,500	0.0	$75,750	$0	$0	$75,750	50.00%	Table 3.1 Row C
D	Analytical Tools & Systems Costs	$901,839	0.0	$225,460	$0	$0	$676,379	75.00%	Table 3.1 Row E
E	Costs Avoided	($125,856)	0.0	($33,631)	($7,197)	$0	($85,028)	67.56%	Table 4.1 Row A
F	Total of Pharmacy Prescriber APM	$1,121,383	0.0	$364,529	($7,197)	$0	$764,051		Sum Row A - Row E
	Maternity Bundle APM								
G	Stakeholder Engagement	$246,250	0.0	$123,125	$0	$0	$123,125	50.00%	Table 3.2 Row A
H	Actuarial Rate Development	$148,400	0.0	$74,200	$0	$0	$74,200	50.00%	Table 3.2 Row B
I	Project Management	$249,750	0.0	$124,875	$0	$0	$124,875	50.00%	Table 3.2 Row C
J	Program Development Consulting	$494,900	0.0	$247,450	$0	$0	$247,450	50.00%	Table 3.2 Row D
K	Analytical Tools & Systems Costs	$4,614,060	0.0	$461,406	$0	$0	$4,152,654	90.00%	Table 3.2 Row F
L	Total of Maternity Bundle APM	$5,753,360	0.0	$1,031,056	$0	$0	$4,722,304		Sum Row G - Row K
	Primary Care Adults APM								
M	Stakeholder Engagement	$98,500	0.0	$49,250	$0	$0	$49,250	50.00%	Table 3.3 Row A
N	Actuarial Rate Development	$381,600	0.0	$190,800	$0	$0	$190,800	50.00%	Table 3.3 Row B
O	Project Management	$249,750	0.0	$124,875	$0	$0	$124,875	50.00%	Table 3.3 Row C
P	Program Development Consulting	$494,900	0.0	$247,450	$0	$0	$247,450	50.00%	Table 3.3 Row D
Q	Analytical Tools & Systems Costs	$1,349,263	0.0	$134,926	$0	$0	$1,214,337	90.00%	Table 3.3 Row F
R	Total of Primary Care Adults APM	$2,574,013	0.0	$747,301	$0	$0	$1,826,712		Sum Row M - Row Q
	Primary Care Pediatrics APM								
S	Stakeholder Engagement	$98,500	0.0	$49,250	$0	$0	$49,250	50.00%	Table 3.4 Row A
T	Actuarial Rate Development	$190,800	0.0	$95,400	$0	$0	$95,400	50.00%	Table 3.4 Row B
U	Project Management	$249,750	0.0	$124,875	$0	$0	$124,875	50.00%	Table 3.4 Row C
V	Program Development Consulting	$494,900	0.0	$247,450	$0	$0	$247,450	50.00%	Table 3.4 Row D
W	Analytical Tools & Systems Costs	$1,349,263	0.0	$134,926	$0	$0	$1,214,337	90.00%	Table 3.4 Row F
X	Total of Primary Care Pediatrics APM	$2,383,213	0.0	$651,901	$0	$0	$1,731,312		Sum Row S - Row W
	Colorado Providers of Distinction								
Y	Analytics	$3,912,750	0.0	$1,956,375	$0	$0	$1,956,375	50.00%	Table 3.5 Row A
Z	Stakeholder Engagement	$295,500	0.0	$147,750	$0	$0	$147,750	50.00%	Table 3.5 Row B
AA	Strategy/Design Consulting	$3,484,500	0.0	$1,742,250	$0	$0	$1,742,250	50.00%	Table 3.5 Row C
BB	Systems Costs	$2,251,102	0.0	$225,110	$0	$0	$2,025,992	90.00%	Table 3.5 Row F
CC	Total of Colorado Providers of Distinction	$9,943,852	0.00	$4,071,485	$0	$0	$5,872,367		Sum Row Y - Row BB
	APM and CPD Support								
DD	APM and Colorado Providers of Distinction Financial Rates Analysts	$299,132	3.8	$149,566	$0	$0	$149,566	50.00%	Table 6.1 - Personal Services
EE	Analytic Tools Statistical Analyst	$77,038	0.96	$38,519	$0	$0	$38,519	50.00%	Table 6.1 - Personal Services
FF	APM and Colorado Providers of Distinction Program Administrators	$211,086	2.9	$105,543	$0	$0	$105,543	50.00%	Table 6.1 - Personal Services
GG	RAE Alignment Program Administrators	$140,724	1.9	$70,362	$0	$0	$70,362	50.00%	Table 6.1 - Personal Services
HH	Total of APM Support	$727,980	9.6	$363,990	$0	$0	$363,990		Sum Row DD - Row GG
	Support FTE Costs								
II	FTE Centrally Appropriated Cost	$201,273	0.0	$100,636	$0	$0	$100,637	50.00%	Table 6.1 - Centrally Appropriated Costs
JJ	FTE Operating Costs	$79,500	0.0	$39,750	$0	$0	$39,750	50.00%	Table 6.1 - Operating Expenses
KK	FTE Leased Space	$66,000	0.0	$33,000	$0	$0	$33,000	50.00%	Table 6.1 - Leased Space
LL	Total of Support FTE Costs	$346,773	0.0	$173,386	$0	$0	$173,387		Sum Row II - Row KK
MM	**Total Request**	**$22,850,574**	**9.6**	**$7,403,648**	**($7,197)**	**$0**	**$15,454,123**		

Notes:
(1) The Department requests $11,436,150 in roll forward authority on items associated with the General Professional Services and Special Projects appropriation from FY 2022-23 to FY 2023-24. This would provide the Department with flexibility to complete the development phase in FY 2023-24 if some of the work is delayed under the existing budget.

Table 2.2
Summary by Initiative
FY 2023-24

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
	Pharmacy Prescriber APM								
A	Stakeholder Engagement	$101,500	0.0	$50,750	$0	$0	$50,750	50.00%	Table 3.1 Row A
B	Actuarial Rate Development	$98,100	0.0	$49,050	$0	$0	$49,050	50.00%	Table 3.1 Row B
C	Evaluation	$249,600	0.0	$124,800	$0	$0	$124,800	50.00%	Table 3.1 Row C
D	Analytical Tools & Systems Costs	$898,281	0.0	$224,570	$0	$0	$673,711	75.00%	Table 3.1 Row E
E	Costs Avoided	($603,366)	0.0	($161,235)	($34,501)	$0	($407,630)	67.56%	Table 4.1 Row B
F	Total of Pharmacy Prescriber APM	$744,115	0.0	$287,935	($34,501)	$0	$490,681		Sum Row A - Row E
	Maternity Bundle APM								
G	Stakeholder Engagement	$101,500	0.0	$50,750	$0	$0	$50,750	50.00%	Table 3.2 Row A
H	Actuarial Rate Development	$141,700	0.0	$70,850	$0	$0	$70,850	50.00%	Table 3.2 Row B
I	Program Development Consulting	$249,600	0.0	$124,800	$0	$0	$124,800	50.00%	Table 3.2 Row C
J	Analytical Tools & Systems Costs	$1,351,015	0.0	$337,754	$0	$0	$1,013,261	75.00%	Table 3.2 Row F
K	Costs Avoided	($1,646,207)	0.0	($791,583)	$0	$0	($854,624)	51.91%	Table 5.1 Row B
L	Total of Maternity Bundle APM	$197,608	0.0	($207,429)	$0	$0	$405,037		Sum Row G - Row K
	Primary Care Adults APM								
M	Stakeholder Engagement	$101,500	0.0	$50,750	$0	$0	$50,750	50.00%	Table 3.3 Row A
N	Actuarial Rate Development	$392,400	0.0	$196,200	$0	$0	$196,200	50.00%	Table 3.3 Row B
O	Project Management	$248,300	0.0	$124,150	$0	$0	$124,150	50.00%	Table 3.3 Row C
P	Program Development Consulting	$499,200	0.0	$249,600	$0	$0	$249,600	50.00%	Table 3.3 Row D
Q	Analytical Tools & Systems Costs	$2,702,030	0.0	$270,203	$0	$0	$2,431,827	90.00%	Table 3.4 Row F
R	Total of Primary Care Adults APM	$3,943,430	0.0	$890,903	$0	$0	$3,052,527		Sum Row M - Row Q
	Primary Care Pediatrics APM								
S	Stakeholder Engagement	$101,500	0.0	$50,750	$0	$0	$50,750	50.00%	Table 3.4 Row A
T	Actuarial Rate Development	$283,400	0.0	$141,700	$0	$0	$141,700	50.00%	Table 3.4 Row B
U	Project Management	$248,300	0.0	$124,150	$0	$0	$124,150	50.00%	Table 3.4 Row C
V	Program Development Consulting	$499,200	0.0	$249,600	$0	$0	$249,600	50.00%	Table 3.4 Row D
W	Analytical Tools & Systems Costs	$2,249,296	0.0	$224,929	$0	$0	$2,024,367	90.00%	Table 3.3 Row F
X	Total of Primary Care Pediatrics APM	$3,381,696	0.0	$791,129	$0	$0	$2,590,567		Sum Row S - Row W
	Colorado Providers of Distinction								
Y	Analytics	$2,320,650	0.0	$1,160,325	$0	$0	$1,160,325	50.00%	Table 3.5 Row A
Z	Stakeholder Engagement	$304,500	0.0	$152,250	$0	$0	$152,250	50.00%	Table 3.5 Row B
AA	Strategy/Design Consulting	$2,246,400	0.0	$1,123,200	$0	$0	$1,123,200	50.00%	Table 3.5 Row C
BB	Analytical Tools & Systems Costs	$1,351,015	0.0	$337,754	$0	$0	$1,013,261	75.00%	Table 3.5 Row F
CC	Total of Colorado Providers of Distinction	$6,222,565	0.0	$2,773,529	$0	$0	$3,449,036		Sum Row Y - Row BB
	APM and CPD Support								
DD	APM and Colorado Providers of Distinction Financial Rates Analysts	$311,112	4.0	$155,556	$0	$0	$155,556	50.00%	Table 6.1 - Personal Services
EE	Analytic Tools Statistical Analyst	$80,123	1.0	$40,061	$0	$0	$40,062	50.00%	Table 6.1 - Personal Services
FF	APM and Colorado Providers of Distinction Program Administrators	$219,540	3.0	$109,770	$0	$0	$109,770	50.00%	Table 6.1 - Personal Services
GG	RAE Alignment Program Administrators	$146,360	2.0	$73,180	$0	$0	$73,180	50.00%	Table 6.1 - Personal Services
HH	Total of APM Support	$757,135	10.0	$378,567	$0	$0	$378,568		Sum Row DD - Row GG
	Support FTE Costs								
II	FTE Centrally Appropriated Cost	$209,328	0.0	$104,664	$0	$0	$104,664	50.00%	Table 6.1 - Centrally Appropriated Costs
JJ	FTE Operating Costs	$9,500	0.0	$4,750	$0	$0	$4,750	50.00%	Table 6.1 - Operating Expenses
KK	FTE Leased Space	$66,000	0.0	$33,000	$0	$0	$33,000	50.00%	Table 6.1 - Leased Space
LL	Total of Support FTE Costs	$284,828	0.0	$142,414	$0	$0	$142,414		Sum Row II - Row KK
	Savings from Primary Care APMs and CPD								
MM	Total Estimated Savings	($1,303,840)	0.0	($385,552)	($70,814)	$0	($847,474)	65.00%	Table 5.1 Row D
NN	**Total Request**	**$14,227,538**	**10.0**	**$4,671,497**	**($105,315)**	**$0**	**$9,661,356**		

Table 2.3
Summary by Initiative
FY 2024-25 and Ongoing

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
	Pharmacy Prescriber APM								
A	Stakeholder Engagement	$101,500	0.0	$50,750	$0	$0	$50,750	50.00%	Table 3.1 Row A
B	Actuarial Rate Development	$98,100	0.0	$49,050	$0	$0	$49,050	50.00%	Table 3.1 Row B
C	Evaluation	$249,600	0.0	$124,800	$0	$0	$124,800	50.00%	Table 3.1 Row C
D	Analytical Tools & Systems Costs	$898,281	0.0	$224,570	$0	$0	$673,711	75.00%	Table 3.1 Row E
E	Costs Avoided	($1,080,876)	0.0	($288,837)	($61,806)	$0	($730,233)	67.56%	Table 4.1 Row C
F	Total of Pharmacy Prescriber APM	$266,605	0.0	$160,333	($61,806)	$0	$168,078		Sum Row A - Row E
	Maternity Bundle APM								
G	Stakeholder Engagement	$99,470	0.0	$49,735	$0	$0	$49,735	50.00%	Table 3.2 Row A
H	Actuarial Rate Development	$98,100	0.0	$49,050	$0	$0	$49,050	50.00%	Table 3.2 Row B
I	Evaluation	$249,600	0.0	$124,800	$0	$0	$124,800	50.00%	Table 3.2 Row D
I	Analytical Tools & Systems Costs	$1,351,015	0.0	$337,754	$0	$0	$1,013,261	75.00%	Table 3.2 Row F
J	Costs Avoided	($3,292,413)	0.0	($1,583,166)	$0	$0	($1,709,247)	51.91%	Table 5.1 Row F
K	Total of Maternity Bundle APM	($1,494,228)	0.0	($1,021,827)	$0	$0	($472,401)		Sum Row G - Row J
	Primary Care Adults APM								
L	Stakeholder Engagement	$101,500	0.0	$50,750	$0	$0	$50,750	50.00%	Table 3.3 Row A
M	Actuarial Rate Development	$98,100	0.0	$49,050	$0	$0	$49,050	50.00%	Table 3.3 Row B
N	Program Development Consulting	$249,600	0.0	$124,800	$0	$0	$124,800	50.00%	Table 3.3 Row D
O	Analytical Tools & Systems Costs	$2,249,296	0.0	$562,324	$0	$0	$1,686,972	75.00%	Table 3.3 Row F
P	Total of Primary Care Adults APM	$2,698,496	0.0	$786,924	$0	$0	$1,911,572		Sum Row L - Row O
	Primary Care Pediatrics APM								
Q	Stakeholder Engagement	$101,500	0.0	$50,750	$0	$0	$50,750	50.00%	Table 3.4 Row A
R	Actuarial Rate Development	$98,100	0.0	$49,050	$0	$0	$49,050	50.00%	Table 3.4 Row B
S	Program Development Consulting	$249,600	0.0	$124,800	$0	$0	$124,800	50.00%	Table 3.4 Row D
T	Analytical Tools & Systems Costs	$1,121,055	0.0	$280,264	$0	$0	$840,791	75.00%	Table 3.4 Row F
U	Total of Primary Care Pediatrics APM	$1,570,255	0.0	$504,864	$0	$0	$1,065,391		Sum Row Q - Row T
	Colorado Providers of Distinction								
V	Analytics	$458,400	0.0	$229,200	$0	$0	$229,200	50.00%	Table 3.5 Row A
W	Stakeholder Engagement	$304,500	0.0	$152,250	$0	$0	$152,250	50.00%	Table 3.5 Row B
X	Evaluation	$748,800	0.0	$374,400	$0	$0	$374,400	50.00%	Table 3.5 Row D
Y	Analytical Tools & Systems Costs	$1,121,055	0.0	$280,264	$0	$0	$840,791	75.00%	Table 3.5 Row F
Z	Total of Colorado Providers of Distinction	$2,632,755	0.0	$1,036,114	$0	$0	$1,596,641		Sum Row V - Row Y
	APM and CPD Support								
AA	APM and Colorado Providers of Distinction Financial Rates Analysts	$311,112	4.0	$155,556	$0	$0	$155,556	50.00%	Table 6.1 - Personal Services
BB	Analytic Tools Statistical Analyst	$80,123	1.0	$40,061	$0	$0	$40,062	50.00%	Table 6.1 - Personal Services
CC	APM and Colorado Providers of Distinction Program Administrators	$219,540	3.0	$109,770	$0	$0	$109,770	50.00%	Table 6.1 - Personal Services
DD	RAE Alignment Program Administrators	$146,360	2.0	$73,180	$0	$0	$73,180	50.00%	Table 6.1 - Personal Services
EE	Total of APM Support	$757,135	10.0	$378,567	$0	$0	$378,568		Sum Row AA - Row DD
	Support FTE Costs								
FF	FTE Centrally Appropriated Cost	$209,328	0.0	$104,664	$0	$0	$104,664	50.00%	Table 6.1 - Centrally Appropriated Costs
GG	FTE Operating Costs	$9,500	0.0	$4,750	$0	$0	$4,750	50.00%	Table 6.1 - Operating Expenses
HH	FTE Leased Space	$66,000	0.0	$33,000	$0	$0	$33,000	50.00%	Table 6.1 - Leased Space
II	Total of Support FTE Costs	$284,828	0.0	$142,414	$0	$0	$142,414		Sum Row FF - Row HH
	Savings from Primary Care APMs and CPD								
JJ	Total Estimated Savings	($7,608,264)	0.0	($2,521,393)	($141,628)	$0	($4,945,243)	65.00%	Table 5.1 Row G + Row H
KK	**Total Request**	**($892,418)**	**10.0**	**($534,004)**	**($203,434)**	**$0**	**($154,980)**		

3.1 Pharmacy Prescriber APM											
Row	Item	FY 2022-23			FY 2023-24			FY 2024-25			
		Total	Rate	Hours	Total	Rate	Hours	Total	Rate	Hours	
A	Stakeholder Engagement	$98,500	$197	500	$101,500	$203	500	$101,500	$203	500	
B	Acturial Rate Development	$95,400	$212	450	$98,100	$218	450	$98,100	$218	450	
C	Program Development Consulting	$151,500	$202	750	$0	$208	0	$0	$208	0	
D	Evaluation	$0	$202	0	$249,600	$208	1,200	$249,600	$208	1,200	
E	Analytical Tools & Systems Costs	$901,839	$140	6,450	$898,281	$144	6,250	$898,281	$144	6,250	

3.2 Maternity Bundle										
Row	Item	FY 2022-23			FY 2023-24			FY 2024-25		
		Total	Rate	Hours	Total	Rate	Hours	Total	Rate	Hours
A	Stakeholder Engagement	$246,250	$197	1,250	$101,500	$203	500	$99,470	$203	490
B	Acturial Rate Development	$148,400	$212	700	$141,700	$218	650	$98,100	$218	450
C	Project Management	$249,750	$185	1,350	$0	$191	0	$0	$191	0
D	Program Development Consulting	$494,900	$202	2,450	$249,600	$208	1,200	$0	$208	0
E	Evaluation	$0	$202	0	$0	$208	0	$249,600	$208	1,200
F	Analytical Tools & Systems Costs	$4,614,060	$140	33,000	$1,351,015	$144	9,400	$1,351,015	$144	9,400

3.3 Primary Care - Adult										
Row	Item	FY 2022-23			FY 2023-24			FY 2024-25		
		Total	Rate	Hours	Total	Rate	Hours	Total	Rate	Hours
A	Stakeholder Engagement	$98,500	$197	500	$101,500	$203	500	$101,500	$203	500
B	Acturial Rate Development	$381,600	$212	1,800	$392,400	$218	1,800	$98,100	$218	450
C	Project Management	$249,750	$185	1,350	$248,300	$191	1,300	$0	$191	0
D	Program Development Consulting	$494,900	$202	2,450	$499,200	$208	2,400	$249,600	$208	1,200
E	Evaluation	$0	$202	0	$0	$208	0	$0	$208	0
F	Analytical Tools & Systems Costs	$1,349,263	$140	9,650	$2,702,030	$144	18,800	$2,249,296	$144	15,650

3.4 Primary Care - Pediatric										
Row	Item	FY 2022-23			FY 2023-24			FY 2024-25		
		Total	Rate	Hours	Total	Rate	Hours	Total	Rate	Hours
A	Stakeholder Engagement	$98,500	$197	500	$101,500	$203	500	$101,500	$203	500
B	Acturial Rate Development	$190,800	$212	900	$283,400	$218	1,300	$98,100	$218	450
C	Project Management	$249,750	$185	1,350	$248,300	$191	1,300	$0	$191	0
D	Program Development Consulting	$494,900	$202	2,450	$499,200	$208	2,400	$249,600	$208	1,200
E	Evaluation	$0	$202	0	$0	$208	0	$0	$208	0
F	Analytical Tools & Systems Costs	$1,349,263	$140	9,650	$2,249,296	$144	15,650	$1,121,055	$144	7,800

3.5 Colorado Providers of Distinction										
Row	Item	FY 2022-23			FY 2023-24			FY 2024-25		
		Total	Rate	Hours	Total	Rate	Hours	Total	Rate	Hours
A	Analytics	$3,912,750	$185	7,050	$2,320,650	$191	4,050	$458,400	$191	800
B	Stakeholder Engagement	$295,500	$197	500	$304,500	$203	500	$304,500	$203	500
C	Strategy/Design Consulting	$3,484,500	$202	5,750	$2,246,400	$208	3,600	$0	$208	0
D	Evaluation	$0	$202	0	$0	$208	0	$748,800	$208	1,200
E	Systems Costs	$2,251,102	$140	16,100	$1,351,015	$144	9,400	$1,121,055	$144	7,800

Table 4.1 Incremental Savings Associated with Prescriber Tool by Fund						
Row	**Item**	**Total Fund**	**General Fund**	**Cash Fund**	**Federal Funds**	**Comment**
A	FY 2022-23 Prescriber Tool Savings	($125,856)	($33,631)	($7,197)	($85,028)	Table 4.2 Row C
B	FY 2023-24 Prescriber Tool Savings	($603,366)	($161,235)	($34,501)	($407,630)	Table 4.2 Row C
C	FY 2024-25 Prescriber Tool Savings	($1,080,876)	($288,837)	($61,806)	($730,233)	Table 4.2 Row C

Table 4.2 Total Savings Associated with the Prescriber Tool					
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Comment**
A	Prescribers with tool Enabled	6,115	8,115	10,115	FY 2022-23 is a WIG goal; Assuming 2k in growth YOY
B	Average Reimbursed Per Prescriber Net Rebates	$15,917	$15,917	$15,917	$389,311,561 spent in FY 2019-20 / 24,459 prescribers
C	Incremental Savings Percentage	2.00%	2.00%	2.00%	Department Assumption
D	Savings Per Prescriber	$318.34	$318.34	$318.34	Row D * Row E
E	Incremental Savings as a result of implementing Shared Savings Program	($1,946,649)	($2,583,329)	($3,220,009)	Row C * Row F * -1
F	Original Savings from Prescriber Tool	($5,336,522)	($5,336,522)	($5,336,522)	From SB 18-266 Appropriation
G	Total Savings of Prescriber Tool and APM	($7,283,171)	($7,919,851)	($8,556,531)	Row E + Row F
H	Percentage of Year Program is in Effect	100%	100%	100%	Mandatory Participation in Shared Savings Prescriber Tool APM on July 1, 2022.
I	**Annual Savings**	**($7,283,171)**	**($7,919,851)**	**($8,556,531)**	**Row G * Row H**
J	Shared Savings Percentage	25%	25%	25%	Assumed savings percentage
K	Incentive Payments to Prescribers	$1,820,793	$1,979,963	$2,139,133	Row I * Row J

Table 4.3 Incremental Savings Associated with Prescriber Tool APM					
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Comment**
A	Original Savings from Prescriber Tool	($5,336,522)	($5,336,522)	($5,336,522)	Table 4.2 Row F
B	Net Savings from Prescriber Tool and APM	($5,462,378)	($5,939,888)	($6,417,398)	Table 4.2 Row I + Row K
C	**Incremental Savings from APM**	**($125,856)**	**($603,366)**	**($1,080,876)**	**Row B - Row A**

Table 5.1 Estimated Savings to Department from Value-Based Payment & Colorado Providers of Distinction by Fiscal Year					
Row	**Item**	**Total Funds**	**General Fund**	**Cash Fund**	**Federal Funds**
A	**FY 2023-24 Net Savings to the Department**	**($2,950,047)**	**($1,177,135)**	**($70,814)**	**($1,702,098)**
B	*Maternity Bundle*	*($1,646,207)*	*($791,583)*	*$0*	*($854,624)*
C	*Primary Care APMs*	*$0*	*$0*	*$0*	*$0*
D	*Colorado Providers of Distinction*	*($1,303,840)*	*($385,552)*	*($70,814)*	*($847,474)*
E	**FY 2024-25 Net Savings to the Department**	**($10,900,677)**	**($4,104,559)**	**($141,628)**	**($6,654,490)**
F	*Maternity Bundle*	*($3,292,413)*	*($1,583,166)*	*$0*	*($1,709,247)*
G	*Primary Care APMs*	*($5,000,584)*	*($1,750,289)*	*$0*	*($3,250,295)*
H	*Colorado Providers of Distinction*	*($2,607,680)*	*($771,104)*	*($141,628)*	*($1,694,948)*

Table 5.2 Estimated Total Savings from Value-Based Payment & Colorado Providers of Distinction by Fiscal Year					
Row	**Item**	**Net Savings to the Department**	**Total Savings**	**Incentive Payment to Providers**	**Shared Savings Percentage with Providers**
A	FY 2023-24 Savings	**($2,950,047)**	($4,596,254)	$1,646,207	
B	*Maternity Bundle*	***($1,646,207)***	*($3,292,414)*	*$1,646,207*	*50%*
C	*Primary Care APMs*	***$0***	*$0*	*$0*	*50%*
D	*Colorado Providers of Distinction*	***($1,303,840)***	*($1,303,840)*	*$0*	*0%*
E	FY 2024-25 Savings	**($10,900,677)**	($19,193,675)	$8,292,998	
F	*Maternity Bundle*	***($3,292,413)***	*($6,584,827)*	*$3,292,414*	*50%*
G	*Primary Care APMs*	***($5,000,584)***	*($10,001,168)*	*$5,000,584*	*50%*
H	*Colorado Providers of Distinction*	***($2,607,680)***	*($2,607,680)*	*$0*	*0%*

Table 5.3 Estimated Savings from Value-Based Payment & Colorado Providers of Distinction Programs					
Row	**Item**	**Savings from Maternity Bundle**	**Savings from Primary Care APMs**	**Savings from Colorado Providers of Distinction**	**Description**
A	Costs Associated with Health Episodes	$199,540,210	$400,046,717	$35,238,914	Health First Colorado's costs in CY 2019
B	Assumed Savings Percentage	3.3%	5.0%	7.4%	Based on Tennessee's experience from Episodes of Care Program in CY 2019.
C	**Estimated Savings from Full Year of Program Implementation**	**($6,584,827)**	**($20,002,336)**	**($2,607,680)**	**Row A * Row B * -1**
D	Assumed Ramp-Up Percentage	50%	0%	50%	Program needs time in first year to be fully operational
E	Percentage of FY 2023-24 Program is in Effect	100%	0%	100%	CPD program and Mandatory Participation in Maternity Bundle APM start July 1, 2023.
F	**Estimated FY 2023-24 Savings**	**($3,292,414)**	**$0**	**($1,303,840)**	**Row C * Row D * Row E**
G	Assumed Ramp-Up Percentage	100%	50%	100%	Program needs time in first year to be fully operational
H	Percentage of FY 2024-25 Program is in Effect	100%	100%	100%	Primary Care APM Mandatory Participation starts July 1, 2024
I	**Estimated FY 2024-25 Savings**	**($6,584,827)**	**($10,001,168)**	**($2,607,680)**	**Row C * Row G * Row H**

Table 6.1
FTE Calculations

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund Source**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
RATE/FINANCIAL ANLYST III	1.0	July	General Fund	$74,783	$77,778	$77,778	
RATE/FINANCIAL ANLYST III	1.0	July	General Fund	$74,783	$77,778	$77,778	
RATE/FINANCIAL ANLYST III	1.0	July	General Fund	$74,783	$77,778	$77,778	
RATE/FINANCIAL ANLYST III	1.0	July	General Fund	$74,783	$77,778	$77,778	
ADMINISTRATOR IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
ADMINISTRATOR IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
ADMINISTRATOR IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
STATISTICAL ANALYST III	1.0	July	General Fund	$77,038	$80,123	$80,123	
ADMINISTRATOR IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
ADMINISTRATOR IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
Total Personal Services (Salary, PERA, Medicare)	**10.0**			**$727,980**	**$757,135**	**$757,135**	

Centrally Appropriated Costs							
Cost Center	**FTE Year 1**	**FTE Year 2+**	**Cost or Percentage**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Health, Life, Dental	10.0	10.0	$14,086	$135,440	$140,860	$140,860	
Short-Term Disability	-	-	0.16%	$1,037	$1,078	$1,078	
Amortization Equalization Disbursement	-	-	5.00%	$32,398	$33,695	$33,695	
Supplemental Amortization Equalization Disbursement	-	-	5.00%	$32,398	$33,695	$33,695	
Centrally Appropriated Costs Total				**$201,273**	**$209,328**	**$209,328**	

Operating Expenses							
Ongoing Costs	**FTE Year 1**	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Supplies	10.0	10.0	$500	$5,000	$5,000	$5,000	
Telephone	10.0	10.0	$450	$4,500	$4,500	$4,500	
Other	10.0	10.0	$0	$0	$0	$0	
Subtotal				*$9,500*	*$9,500*	*$9,500*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	10.0		$5,000	$50,000	$0	$0	
Computer	10.0		$2,000	$20,000	$0	$0	
Other	10.0		$0	$0	$0	$0	
Subtotal				*$70,000*	*$0*	*$0*	
Total Operating				**$79,500**	**$9,500**	**$9,500**	

Leased Space							
	FTE Year 1	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	10.0	10.0	$6,600	**$66,000**	**$66,000**	**$66,000**	

FY 2022-23 Value Based Payments Timeline

	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26
Pharmacy Prescriber APM					
Pharmacy Prescriber Tool Implemented July 1, 2020	X	X	X	X	X
Mandatory Pharmacy APM Implemented July 1, 2022		X	X	X	X
Stakeholder Engagement		X	X	X	X
Actuary Contracts		X	X	X	X
Program Development Consulting		X			
Evaluation of Pharmacy APM			X	X	X
Maternity Bundle					
Voluntary Maternity Bundle APM Nov 1, 2020	X	X			
Mandatory Maternity Bundle APM July 1, 2023			X	X	X
Stakeholder Engagement		X	X	X	X
Actuary Contracts		X	X	X	X
Program Development Consulting		X	X		
Evaluation Maternity APM				X	X
Project Management		X			
Primary Care APMs					
Voluntary Primary Care APM Adults (APM 2) January 1,2022		X	X		
Mandatory APM Primary Care Adult July 1, 2024				X	X
Voluntary Primary Care Pediatrics APM			X		
Mandatory Primary Care Pediatrics APM July 1, 2024				X	X
Stakeholder Engagement		X	X	X	X
Actuary Contracts		X	X	X	X
Program Development consulting		X	X	X	
Evaluation Primary Care APMs					X
Project Management		X	X	X	
Colorado Providers of Distinction					
Colorado Providers of Distinction Program July 1,2023			X	X	X
Analytics		X	X	X	X
Strategy/Design Consulting		X	X		
Colorado Provider of Distinction Program Evaluation				X	X

Department of Health Care Policy & Financing

FY 2022-23 Funding Request

November 1, 2021

Jared Polis
Governor

Kim Bimestefer
Executive Director

Department Priority: R-07
Request Detail: Utilization Management

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$10,009,900,837	($3,011,223)	($2,999,155)
FTE	0.0	0.0	0.0
General Fund	$2,410,583,442	($1,512,985)	($1,515,550)
Cash Funds	$1,198,250,099	$116,559	$104,943
Reappropriated Funds	$83,318,813	$0	$0
Federal Funds	$6,317,748,483	($1,614,797)	($1,588,548)

Summary of Request

The Department of Health Care Policy & Financing requests funding to expand and strengthen utilization management (UM) measures in Colorado's Medicaid program. The funding will be used to compensate the department's UM vendor for expanding medical necessity reviews for outpatient medical services and physician administered drugs (PADs) newly-identified as high-risk for fraud, overutilization, or not routinely considered medically necessary. This funding will also be utilized to modernize the department's UM program by expanding and improving data sharing and reporting capabilities to help identify potential health inequities and disparities within the PAR program.

Additionally, the department is requesting funding to modernize the Nurse Advice Line (NAL) with state-of-the-art technologies to facilitate increased member usage and the application of cost-effective interventions and services in real-time. Additional modernization components include robust data collection and establishing interconnectivity between department partners and systems for communicating recommendations of treatment for health and wellness and disease management programs, including behavioral health resources. This component will utilize existing appropriations for the programs and will only be implemented if federal matching funds are received. This request represents a decrease of less than 0.5% from the department's FY 2021-22 Long Bill total funds appropriation.

Current Program

Among the department's strategies for achieving better health outcomes and controlling costs is utilization management (UM). UM is broadly defined as the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services. Department initiatives such as ColoradoPAR and Nurse Advice Line are essential UM components.

Utilization Management Program
The department's UM program promotes quality, cost-effective health care delivery and member well-being while ensuring appropriate utilization of services. The UM program, also referred to as ColoradoPAR, utilizes prior authorization requests (PARs) or pre-approval of select services, benefits, equipment, and supplies for the fee-for-service (FFS) population. ColoradoPAR is administered by a nationally-accredited, federally-designated quality improvement organization (QIO)[1], which employs licensed clinical reviewers (e.g., nurses, pharmacists, and physicians) to evaluate each PAR for medical necessity or medical appropriateness, and compliance with established rules, regulations, and policy.

To ensure certain services meet medical necessity guidelines and are within Medicaid's policies, the department's UM vendor performs medical necessity reviews, including PARs and retrospective reviews, inpatient hospital admission and continued stay reviews, and prior authorizations of select physician administered drugs (PADs). The goals of the ColoradoPAR program are to improve the health outcomes of Medicaid members and serve as a cost containment measure that ensures appropriate utilization and eliminates duplicative and unnecessary services while allowing providers to easily track the status of their PARs through a web portal.

As part of the FY 2018-19 R-10 "Drug Cost Containment Initiatives" request, the department requested and received funding to implement an initial PAD prior authorization program that incorporates approximately two dozen PADs into the ColoradoPAR program. Incorporating PADs into the ColoradoPAR program allows for tracking of member claims through both the medical and pharmacy benefits systems to prevent duplicate or similar services. Pharmacy claims are paid through the Pharmacy Benefit Management System (PBMS), while physician administered drugs, considered a medical benefit, are paid through the interChange[2] system. Since the two systems do not compare utilization, a member may receive treatment for the same diagnosis through both the outpatient pharmacy and physician settings. The UM program prevents

[1] The QIO Program, one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries, is an integral part of the U.S. Department of Health and Human (HHS) Services' National Quality Strategy for providing better care and better health at lower cost

[2] The department's Medicaid Management Information System for processing fee-for-service, medical benefit claims

duplication of treatment. Implementation of this initial PAD PAR program is in its final stage and expected to launch by January 1, 2022.

Nurse Advice Line

Another critical component of the department's overarching strategy of utilization management is the Nurse Advice Line (NAL). The NAL is a free 24-hour phone line, available 365 days a year, whose primary purpose is to triage callers to the right level of care through use of evidence-based triage guidelines. Secondary purposes of the NAL include helping members with questions about managing medical conditions and connecting members to providers, community resources, and Regional Accountable Entity (RAE) care coordinators.

The department, together with its contracted vendor, administers a Nurse Advice Line Contact Center. The center is currently operated by shared health information aides, registered nurses (RNs), and health information aides (HIAs) and uses the nationally recognized Schmitt-Thompson Nurse Telephone Triage Guidelines[3].

When a Medicaid member calls the NAL, they reach a health information aide who identifies the reason for the call, gathers demographics and assists with non-symptomatic inquiries (such as community resource information). Licensed RNs trained extensively on guidelines and protocols assist callers with medical questions and evaluate symptoms utilizing their nursing expertise as well as pediatric and adult clinical decision support tools to triage callers to the right level of care at the right time. RNs provide resources and education materials to callers via secure email as appropriate. With the primary goal of telephone triage to direct a member toward the most appropriate level-of-care setting, a call may result in keeping members out of the emergency room when they should seek a lower level of care, or in the event that a member is unaware of the urgency of their condition, warrant a higher level of care.

Prior to the start of FY 2020-21, the Centers for Medicare and Medicaid Services (CMS) informed the department that the NAL did not qualify for federal funds. Subsequently, the department has held multiple discussions with CMS to defend the position that a match of at least 50% is appropriate and federally allowable under section 1903(a)(7) of the Social Security Act for activities "as found necessary… for the proper and efficient administration of the state plan." Although CMS' current contention remains that NAL services are not allowable as a Medicaid cost, the department continues to aggressively advocate for reconsideration as industry studies consistently show the cost containment benefits of a NAL. More recent discussions with CMS reflect a significant softening of their stance and the department is now anticipating federal fund approval sometime in FY 2021-22.

[3] www.stcc-triage.com

In the department's FY 2021-22 R-7 "Nurse Advice Line budget" request, additional General Fund money was appropriated to the department to maintain the NAL at the current level of operation. Contingent on federal approval of a 50% match, the department will be able to refinance some of the General Fund with both cash and federal funds.

Problem or Opportunity

The department has identified opportunities to strengthen its UM program, including expanding ColoradoPAR reviews and modernization initiatives for both ColoradoPAR and the NAL.

Medical Necessity Reviews

The department lacks funding to expand the medical necessity review requirement for newly-identified services that are susceptible to fraud, overutilization, or otherwise not routinely considered medically necessary. The ColoradoPAR program is limited by the amount of funding appropriated and is unable to close critical gaps in oversight and cost containment. Examples of services that have no prior authorization requirements include physical therapy/occupational therapy (PT/OT) services, orthopedic surgeries, and vascular procedures and surgeries.

Physician Administered Drugs PARs

Drug costs continue to increase year-over-year, putting pressure on the state's financial resources. In FY 2020-21 the department paid $137,674,788 providers for the physician administered drug benefit, a 32% increase from FY 2017-18. The department lacks funding to expand the PAR requirement for newly-identified PADs as well as for drugs in the developmental pipeline. The lack of a PAR requirement for PADs often results in a provider not considering cheaper drugs of similar clinical effectiveness, leaving the department to pay for drugs that are not necessarily the best, nor most cost-effective treatment.

Drugs in the developmental pipeline include specialty medications on the FDA expedited approval pathway.[4] These drugs require confirmatory clinical trials to maintain its approval status due to the limited evidence on which the initial approval is based. Among these drugs include gene therapies that are expected to cost over $1 million per dose. The department does not have sufficient funding to implement prior authorization policies for newly approved high-cost, limited clinical efficacy medications. Furthermore, with over 800 drugs in development for diseases that disproportionately affect racial and ethnic communities, the department has an opportunity to expand the PAR program to include additional PADs that, in addition to addressing medical necessity and ensuring the safety of its members, will assist the department in identifying health inequities and disparities.

[4] https://www.macpac.gov/wp-content/uploads/2020/10/Addressing-High-Cost-Drugs-and-Pipeline-Analysis.pdf

ColoradoPAR Program Modernization

The department has identified an opportunity to implement new measures towards developing and maintaining a modern ColoradoPAR program. The program has not been assessed to determine if changes are necessary as a result of evolving industry 'best practices' and department and state of Colorado priorities. There is an opportunity to implement annual reviews of the ColoradoPAR program to assess the requirements and process for medical necessity reviews as well as to explore options to decrease administrative and provider burden. An opportunity also exists to greatly improve the coordination and collaboration between the department's partners, such as the RAEs and Case Management Agencies (CMAs), to address member's needs for care coordination identified during the review process. Finally, the department is required to further comply with CMS' Interoperability and Patient Access Rule as additional requirements were published in December 2020.[5] The department lacks one-time funding for expert consultation towards understanding and implementing this complex rule.

Nurse Advice Line Modernization

The department lacks the funding to effectively modernize the NAL. With CMS determination that the program does not qualify for federal matching funds, modernization efforts have stalled. The department sees an opportunity to greatly enhance its overall utilization management strategy with a modernized, innovative NAL.

The department's NAL lacks current industry 'best practices' standards including enhanced communication, second level triage, real-time interventions and services, and technological advancements. With widespread internet accessibility and smartphone usage, an opportunity exists for the department to reassess the vision of NAL. The department believes that member utilization of the NAL has stagnated due in part to the absence of alternate communication options to the telephone call, such as texts, email, web chat, and video chat. Additional concerns are the limited data collection and analysis of NAL caller data, inability to share actionable caller data with RAE providers, and the lack of integration between the NAL and other technological entities such as the PEAK Health App and the department's website.

Proposed Solution

The department requests a decrease of $3,011,223 total funds, including a decrease of $1,512,985 of General Fund in FY 2022-23, and a decrease of $2,999,155 total funds, including a decrease of $1,515,550 of General Fund in FY 2023-24. The decrease in funding is contingent on the department's receiving an appropriation to strengthen, expand and modernize several components of its UM program.

[5] CMS 9115-F fact sheet | https://www.cms.gov/newsroom/fact-sheets/reducing-provider-and-patient-burden-improving-prior-authorization-processes-and-promoting-patients

Medical Necessity Reviews

The department requests funding to expand the scope of the UM vendor contract to include medical necessity reviews of select vascular and orthopedic procedures and surgeries. Since the expansion will significantly increase the number of reviews submitted to the department's UM vendor, the requested funding will allow the vendor to increase staffing, including additional clinical specialists, to manage the application of the medical necessity criteria and process the expected increase of new PARs.

If this request is not funded the department will be unable to prevent potential overutilization or inappropriate utilization of certain benefits nor ensure that the RAEs and CMAs are notified of members that require additional care coordination and follow-up care. Consequently, the department's advancements towards equitable, fair application of medical necessity reviews and utilization of FFS benefits will be hindered.

Physician Administered Drugs PARs

The department requests funding for the PAD PAR program to develop and implement appropriate prior authorization policies to address newly-approved, high-cost medications, as well as ensure medical necessity and safety for Medicaid members. The department will receive guidance from the State's Drug Utilization Review (DUR) Board, incorporate stakeholder input, and work with the UM vendor to develop clinical criteria for prior authorization for these PADs.

In developing prior authorization policies, the department will use existing prior authorization processes in place for the pharmacy benefit to ensure the health and safety of its members. These processes include working with the Medical Services Board, the Pharmacy and Therapeutics (P&T) Committee, and the DUR Board to put drugs on the Preferred Drug List (PDL) and to determine prior authorization criteria for nonpreferred drugs and drugs with special prescribing guidelines. Before requiring prior authorization on a drug, the department will carefully evaluate with stakeholders to consider whether there are appropriate substitutes in place, particularly for drugs used by more vulnerable patients such as those receiving specialty drugs for cancer treatment.

If this request is not funded the department will be unable to prevent inappropriate or over-utilization of numerous PADs, as well as the inability to control utilization on newly-approved high cost PADs.

ColoradoPAR Program Modernization

As the ColoradoPAR and PAD programs expand, it is imperative to modernize the program as well. The department requests funding to contract with vendors on five modernization initiatives:

- Add a scope of work that includes data sharing and care coordination services with the RAEs and CMAs;

- Identify triggers for at-risk populations to allow for quick identification and referrals to RAE and CMA programs to ensure appropriate follow up care;
- Modernize data and systems between the department and the UM vendor for improved data analytics and data sharing between the UM Program, RAEs, and CMAs. This will include reporting that identifies potential inequities of provider submissions as defined by the department's equity, diversity, and inclusion (EDI) team. It will also enable equitable care coordination for certain at-risk and underserved communities;
- Complete an annual review and analysis of the current ColoradoPAR Program using industry experts to make recommendations on modifications to the PAR program to identify potential health inequities and disparities, improve data sharing and care coordination, and to increase cost efficiency and efficacy and cost savings; and
- Assess the CMS Interoperability Rule which requires industry expertise to evaluate readiness to implement and to help estimate a potential need for future resources.

If this request is not funded, the department will miss an opportunity to systematically assess and modernize the ColoradoPAR program towards identifying areas that contribute to health disparities and inequities. The department will also miss an opportunity to further efforts of improving care coordination and follow-up care communication between the RAEs and CMAs.

Nurse Advice Line Modernization

The department requests funding contingent on federal approval of a 50% federal match for NAL services. The department is engaged in ongoing and productive dialogue with CMS and estimates that formal CMS approval would occur before July 1, 2022. This portion of the request does not require new General Fund appropriations. If CMS approves a federal match, the department will use the existing appropriations as the state share for the program and draw additional federal funds to finance the modernization and expansion of the program.

Modernizing the NAL up to current industry standard, includes the following:

- Activate specialized phone lines targeted to special populations such as medically complex foster children, pregnant members, and members who are lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ);
- Enable specific drug protocols where a triage nurse can provide a member a prescription for a subset of medical conditions when they meet specific inclusion and exclusion criteria;
- Implement second level triage by an emergency medicine physician including tele-triage for visual assessment if necessary;
- Provide enhanced data analysis regarding populations and trends, allowing additional targeted phone lines, programs or communication;
- Provide real-time reporting and caller data sharing with Primary Care Medical Providers (PCMPs) and RAEs; and

- Expand communication opportunities by integrating secure video chat, web chat, text, and email as well as the PEAK Health application portal.

If this request is not funded the NAL will languish as a telephone-only system and miss an opportunity to increase accessibility and effectiveness via internet and smartphone usage.

Evidence-Based Continuum

The request aligns with Step 2 of the Evidence Continuum as analysis of the data will assist the department towards identification of critical outputs. Analysis of the oversight data will compel targeted department intervention to ensure consistent provider behavior and uniform application of Medicaid policies. Analysis of the NAL data will reveal real-time insights into member conditions and demographics including any developing health trends.

Theory of Change	Expand and strength utilization management measures		
Program Objective	Achieve better health outcomes and control costs through third-party evaluation of the medical necessity, appropriateness, and efficiency of health care services		
Outputs Being Measured	Medical necessity reviews, including PARs, and their approval/denial rate. NAL caller data including initial caller intent and final disposition of call		
Outcomes Being Measured	N/A		
Cost/Benefit Ratio	2.2 (5.8 General Fund-only) Calculated by using figures from Table 1.1 of appendix A with savings as the numerator and cost the denominator		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	N/A	N/A	N/A
Continuum Level	Step 2		

Anticipated Outcomes

If this request is approved the department will strengthen its UM program by increasing oversight of the appropriateness and efficiency in the delivery of health care services resulting in better health outcomes for members and cost reductions for the department's programs.

Medical Necessity Reviews

Approving this request will ensure the department has sufficient funding to improve utilization management of certain Medicaid services that industry standards suggest are susceptible to overutilization and inappropriate utilization.

Vascular procedures often require follow-up care and monitoring of high-risk populations. The medical necessity review process will allow the department to be involved in the member's potential need for increased care coordination among the department's key partners.

Adding medical necessity reviews for orthopedic procedures and surgeries will provide a critical level of oversight of these procedures due to their elective nature and the risk of overuse. Many orthopedic procedures first require that more conservative measures are trialed, including physical therapy and pain management. A review for medical necessity will ensure those steps had been appropriately taken before a surgery is performed.

Physician Administered Drugs PARs

Funding this request will allow the department to better manage the PAD benefit. By expanding its UM program with additional PARs, the department expects less inappropriate drug usage and better promotion of high-value drugs. Also, as a cost containment measure, this request supports the department's commitment to its Wildly Important Goal of Medicaid Pharmacy Cost Control.

As a cost containment measure, the department projects cost savings by assuming that implementing additional PARs on PADs will result in a 7.0% decrease in utilization of the drugs targeted for prior authorization policies. The department selected this percentage as a conservative estimate based on previous research on the effects of prior authorization on drug utilization.[6]

The department based its cost savings calculations on FY 2019-20 claims of a preliminary set of PADs. The drugs targeted in these calculations do not represent the department's final decisions on which drugs to prior authorize. The department will work with stakeholders, such as through the Pharmaceutical and Therapeutics committee, Drug Utilization Review Board, and Medical Services Board before making any determinations.

ColoradoPAR Program Modernization

Funding this request will allow the department to ensure that Medicaid members are receiving medically-appropriate services and benefits equitably and are being referred to the RAEs and CMAs to ensure care coordination. The funding will also allow the department to hire a vendor for periodic assessments and analysis to help decrease health disparities and identify more efficient and effective application of utilization management techniques.

Nurse Advice Line Modernization

Subject to the receipt of federal funds, approval of this request will allow the department to fully implement a nurse advice line with industry-wide, 'best practice' functionality leveraging

[6] Maine's prior authorization policy is associated with decreases in the use of nonpreferred drugs and a $3.40 per patient decrease in medication costs for patients with bipolar illness (Zhang et al, 2009). Michigan and Indiana's prior authorization programs on lipid-lowering medications for dual-eligible enrollees is associated with a reduction of $24,548 in prescription expenditures in Michigan and $16,070 in Indiana (Lu et al, 2011).

technology and advanced communication techniques. The implementation, which includes a member outreach and provider education component, is expected to expand NAL access and utilization among members.

The increase in utilization of the NAL is one of two main factors driving the department's expectation of cost savings. The other main factor is the implementation of second-level, or medical doctor, triage. Medical doctor triage is performed on the member by an emergency medicine physician through verbal communication, or visual assessment via tele-triage when applicable, and follows the expanded use of evidence-based triage guidelines that direct members to the appropriate level of care for their acute medical issues. Because calls escalated to second-level triage are likely from members whose original intent-of-care is either urgent care or emergency department care, any final disposition resulting in a downgrade of care will result in increased savings.

The department also expects to strengthen the NAL program as an evidenced-based program. As an example, with the NAL program collecting large amounts of data, the RN Informatics Specialist will be tasked with compiling this data to create meaningful analyses from which the department can make data-driven decisions to optimize the program including new targeted outreach efforts or additional member-support measures. Additionally, an effective NAL is a critical touchpoint of customer service that serves the department as a progressive and efficient business practice striving to direct members toward the right care at the right place at the right time.

A robust UM program and an enhanced, modern NAL aligns with and supports four of the department's six strategic pillars established to focus the department on achieving its most important goals:

- Medicaid Cost Control — Ensure the right services for the right people at the right price;
- Care Access — Improve member access to affordable, high-quality care;
- Member Health — Improve member health outcomes and reduce health disparities; and
- Operational Excellence and Customer Service — Provide excellent service to members, providers, and partners; compliant, efficient, effective person- and family-centered practices.

Assumptions and Calculations

Detailed assumptions and calculations are provided in Appendix A.

Medical Necessity Reviews

Table series 3 shows the estimated costs and projected savings associated with expanding the medical necessity review requirements for specific FFS medical benefits. The department

assumes a 75% FFP as medical necessity review and PARs qualify for the enhanced administrative match under federal regulation 42 CFR § 433.15(b)(6)(i).

Projected savings are calculated by estimating the number of denied requests and multiplying by the corresponding reimbursement rate. To estimate the rate of denied requests, the department used a combination of nationally available data on prior authorization requests and denials and the department's Medicaid Management Information System (MMIS) data for services that currently require a PAR. The department's current statistics on denial rates for existing services found that about seven percent of services were denied. Based on a report from the Office of Inspector General (OIG) on Medicare plans,[7] the aggregate denial rate of medical necessity review was approximately eight percent. The department believes that the seven percent figure represents a realistic projection as the specific targeted services are considered susceptible to inappropriate and overutilization. The department has also incorporated an assumption that the number of PAR requests will remain constant in the near future as any program growth will be offset by providers becoming more familiar with the requirements for these services and reducing the number of overall claims submitted. The department expects a seven percent denial rate in the first year followed by lower denial rates in subsequent years due to provider behavior adapting to the new oversight measures. However, to capture the effective savings from this phenomenon, the department maintains the seven percent denial for the out-years.

Physician Administered Drugs PARs

Table series 4 shows the estimated costs and projected savings associated with expanding the PAR requirement program for additional PADs.

The department assumes that expanding the PAD requirement on physician administered drugs will result in a 7.0 percent decrease in utilization of these drugs. The department selected this percentage based on previous research on the effects of prior authorization on drug utilization.[8] The findings of prior authorization literature are varied, and the results are often specific to a particular class of drugs or for certain programs. There are frequently other, concurrent policy implementations taking place during the research period which makes it difficult to attribute a change to prior authorization policies. The effectiveness of a prior authorization program also depends on if there are available substitutes. Another limitation is that drug rebate amounts are confidential, and the drug expenditures used in these studies represent expenditure before rebates are applied. As such, the research findings do not necessarily reflect the net effect of a policy change.

[7] https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf

[8] See footnote 6

Nurse Advice Line Modernization

Table series 6 shows the estimated cost to modernize the NAL and the corresponding projected savings. The department assumes 50% federal financial participation.

Table 6.6 shows the incremental savings amount for FY 2022-23. To arrive at this figure, the baseline savings of the existing NAL program was first calculated, followed by the projected savings from the modernization project. The difference between the two figures represents the incremental savings.

To calculate the projected savings, the department assumes that approximately 37% of the RN-triaged calls will be escalated to second level, or medical doctor triage. The department believes that implementation of medical doctor triage protocols will produce increased savings because calls escalated to second-level triage are likely from members whose original intent-of-care is either urgent care or emergency department care, and therefore any final disposition resulting in a downgrade of care will result in increased savings. This disposition could represent a 'one-level' downgrade (e.g., from an emergency room visit to an urgent care visit), up to a 'four-level' downgrade (e.g., from an emergency room visit to homecare).[9] The department assumes 54% of medical doctor triaged calls will result in a downgrade of care. The assumptions rely on data sourced from the department's NAL vendor who operates a separate medical assistance hotline and assisted the department with modeling the projected savings.

[9] The final disposition could also result in an upgrade (e.g., from urgent care to emergent care) that initially offsets any savings calculation, however, upgrades often have downstream effects of savings due to the initial appropriate care treatment. Consideration of upgrades are omitted from the savings calculation.

Table 1.1
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds[1]	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts; Professional Services Contracts	$3,650,175	0.0	$398,837	$524,903	$2,726,435	NA	Table 2.1, Row A + Table 2.1, Row D + Table 2.1, Row G + Table 2.1 Row H
B	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($6,661,398)	0.0	($1,911,822)	($408,344)	($4,341,232)	NA	Table 2.1, Row B + Table 2.1, Row E + Table 2.1, Row I
C	**Total Request**	**($3,011,223)**	**0.0**	**($1,512,985)**	**$116,559**	**($1,614,797)**	**NA**	**Row A + Row B**

[1]Cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 1.2
Summary by Line Item
FY 2023-24

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds[1]	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts; Professional Services Contracts	$3,388,100	0.0	$358,025	$470,442	$2,559,633	NA	Table 2.2, Row A + Table 2.2, Row D + Table 2.2, Row G + Table 2.2 Row H
B	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($6,387,255)	0.0	($1,873,575)	($365,499)	($4,148,181)	NA	Table 2.2, Row B + Table 2.2, Row E + Table 2.2, Row I
C	**Total Request**	**($2,999,155)**	**0.0**	**($1,515,550)**	**$104,943**	**($1,588,548)**	**NA**	**Row A + Row B**

[1]Cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 1.3
Summary by Line Item
FY 2024-25

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds[1]	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts; Professional Services Contracts	$3,457,448	0.0	$358,025	$505,116	$2,594,307	NA	Table 2.3, Row A + Table 2.3, Row D + Table 2.3, Row G + Table 2.3 Row H
B	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($6,553,903)	0.0	($1,901,499)	($406,139)	($4,246,265)	NA	Table 2.3, Row B + Table 2.3, Row E + Table 2.3, Row I
C	**Total Request**	**($3,096,455)**	**0.0**	**($1,543,474)**	**$98,977**	**($1,651,958)**	**NA**	**Row A + Row B**

[1]Cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 2.1
Summary by Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Federal Funds	FFP Rate	Notes/Calculations
Expansion of Medical Necessity Reviews								
A	Estimated Cost	$1,291,279	0.0	$217,419	$105,401	$968,459	75.00%	Table 3.1, Row D
B	Projected Savings	($3,717,698)	0.0	($1,066,980)	($227,895)	($2,422,823)	65.17%	Table 3.4, Rows C, D & E [FY 2022-23]
C	**Subtotal**	**($2,426,419)**	**0.0**	**($849,561)**	**($122,494)**	**($1,454,364)**	**59.94%**	**Row A + Row B**
Expansion of Prior Authorization Request (PAR) Requirement - Physician Administered Drugs (PAD)								
D	Estimated Cost	$540,000	0.0	$69,078	$65,922	$405,000	75.00%	Table 4.1, Row C
E	Projected Savings	($1,272,262)	0.0	($365,139)	($77,990)	($829,133)	65.17%	Table 4.2, Rows K, L & M [FY 2022-23]
F	**Subtotal**	**($732,262)**	**0.0**	**($296,061)**	**($12,068)**	**($424,133)**	**blend**	**Row D + Row E**
ColoradoPAR Program Modernization								
G	Estimated Cost	**$333,600**	**0.0**	**$112,340**	**$54,460**	**$166,800**	**50.00%**	**Table 5.1, Row D [FY 2022-23]**
Nurse Advice Line Modernization								
H	Estimated Cost	$1,485,296	0.0	$0	$299,120	$1,186,176	NA	Table 6.1, Row E
I	Projected Savings	($1,671,438)	0.0	($479,703)	($102,459)	($1,089,276)	65.17%	Table 6.6, Rows G, H & I
J	**Subtotal**	**($186,142)**	**0.0**	**($479,703)**	**$196,661**	**$96,900**	**blend**	**Row H + Row I**
K	**Total Request**	**($3,011,223)**	**0.0**	**($1,512,985)**	**$116,559**	**($1,614,797)**	**blend**	**Row C + Row F + Row G + Row J**

[1]Cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 2.2
Summary by Initiative
FY 2023-24

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Federal Funds	FFP Rate	Notes/Calculations
Expansion of Medical Necessity Reviews								
A	Estimated Cost	$1,291,278	0.0	$217,421	$105,400	$968,457	75.00%	Table 3.2, Row D
B	Projected Savings	($3,717,698)	0.0	($1,066,981)	($227,894)	($2,422,823)	65.17%	Table 3.4, Rows C, D & E [FY 2023-24]
C	**Subtotal**	**($2,426,420)**	**0.0**	**($849,560)**	**($122,494)**	**($1,454,366)**	**blend**	**Row A + Row B**
Expansion of Prior Authorization Request (PAR) Requirement - Physician Administered Drugs (PAD)								
D	Estimated Cost	$540,000	0.0	$69,078	$65,922	$405,000	75.00%	Table 4.1, Row C
E	Projected Savings	($1,327,350)	0.0	($380,950)	($81,366)	($865,034)	65.17%	Table 4.2, Rows K, L & M [FY 2023-24]
F	**Subtotal**	**($787,350)**	**0.0**	**($311,872)**	**($15,444)**	**($460,034)**	**blend**	**Row D + Row E**
ColoradoPAR Program Modernization								
G	Estimated Cost	$212,400	0.0	$71,526	$34,674	$106,200	**50.00%**	Table 5.1, Row D [FY 2023-24 and ongoing]
Nurse Advice Line Modernization								
H	Estimated Cost	$1,485,296	0.0	$0	$299,120	$1,186,176	NA	Table 6.2, Row E
I	Projected Savings	($1,483,081)	0.0	($425,644)	($90,913)	($966,524)	65.17%	Table 6.7, Rows G, H & I
J	**Subtotal**	**$2,215**	**0.0**	**($425,644)**	**$208,207**	**$219,652**	**blend**	**Row G + Row H**
K	**Total Request**	**($2,999,155)**	**0.0**	**($1,515,550)**	**$104,943**	**($1,588,548)**	**blend**	**Row C + Row F + Row G + Row J**

[1]Cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 2.3
Summary by Initiative
FY 2024-25

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Federal Funds	FFP Rate	Notes/Calculations
Expansion of Medical Necessity Reviews								
A	Estimated Cost	$1,291,278	0.0	$217,421	$105,400	$968,457	75.00%	Table 3.3, Row D
B	Projected Savings	($3,717,698)	0.0	($1,066,980)	($227,895)	($2,422,823)	65.17%	Table 3.4, Rows C, D & E [FY 2024-25]
C	**Subtotal**	**($2,426,420)**	**0.0**	**($849,559)**	**($122,495)**	**($1,454,366)**	**blend**	**Row A + Row B**
Expansion of Prior Authorization Request (PAR) Requirement - Physician Administered Drugs (PAD)								
D	Estimated Cost	$540,000	0.0	$69,078	$65,922	$405,000	75.00%	Table 4.1, Row C
E	Projected Savings	($1,384,828)	0.0	($397,446)	($84,890)	($902,492)	65.17%	Table 4.2, Rows K, L & M [FY 2024-25]
F	**Subtotal**	**($844,828)**	**0.0**	**($328,368)**	**($18,968)**	**($497,492)**	**blend**	**Row D + Row E**
ColoradoPAR Program Modernization								
G	Estimated Cost	$212,400	0.0	$71,526	$34,674	$106,200	**50.00%**	Table 5.1, Row D [FY 2023-24 and ongoing]
Nurse Advice Line Modernization								
H	Estimated Cost	$1,485,296	0.0	$0	$299,120	$1,186,176	NA	Table 6.3, Row E
I	Projected Savings	($1,522,903)	0.0	($437,073)	($93,354)	($992,476)	65.17%	Table 6.8, Rows G, H & I
J	**Subtotal**	**($37,607)**	**0.0**	**($437,073)**	**$205,766**	**$193,700**	**blend**	**Row G + Row H**
K	**Total Request**	**($3,096,455)**	**0.0**	**($1,543,474)**	**$98,977**	**($1,651,958)**	**blend**	**Row C + Row F + Row G + Row J**

[1]Cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 3.1 - Expansion of Medical Necessity Reviews Summary of Costs FY 2022-23							
Row	**Description**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**FFP Rate**	**Source**
A	Physical Therapy/Occupational Therapy	$816,517	$137,482	$66,648	$612,387	75.00%	Table 3.5, Row C [Total Cost]
B	Orthopedic Surgeries	$207,841	$34,996	$16,965	$155,880	75.00%	Table 3.5, Row F [Total Cost]
C	Vascular Procedures/Surgeries	$266,920	$44,943	$21,787	$200,190	75.00%	Table 3.5, Row I [Total Cost]
D	**Total Cost**	**$1,291,278**	**$217,421**	**$105,400**	**$968,457**	**NA**	**Row A + Row B + Row C**

[1]Cash Funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 3.2 - Expansion of Medical Necessity Reviews Summary of Costs FY 2023-24							
Row	**Description**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**FFP Rate**	**Source**
A	Physical Therapy/Occupational Therapy	$816,517	$137,482	$66,648	$612,387	75.00%	Table 3.6, Row C [Total Cost]
B	Orthopedic Surgeries	$207,841	$34,996	$16,965	$155,880	75.00%	Table 3.6, Row F [Total Cost]
C	Vascular Procedures/Surgeries	$266,920	$44,943	$21,787	$200,190	75.00%	Table 3.6, Row I [Total Cost]
D	**Total Cost**	**$1,291,278**	**$217,421**	**$105,400**	**$968,457**	**NA**	**Row A + Row B + Row C**

[1]Cash Funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 3.3 - Expansion of Medical Necessity Reviews Summary of Costs FY 2024-25							
Row	**Description**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**FFP Rate**	**Source**
A	Physical Therapy/Occupational Therapy	$816,517	$137,482	$66,648	$612,387	75.00%	Table 3.7, Row C [Total Cost]
B	Orthopedic Surgeries	$207,841	$34,996	$16,965	$155,880	75.00%	Table 3.7, Row F [Total Cost]
C	Vascular Procedures/Surgeries	$266,920	$44,943	$21,787	$200,190	75.00%	Table 3.7, Row I [Total Cost]
D	**Total Cost**	**$1,291,278**	**$217,421**	**$105,400**	**$968,457**	**NA**	**Row A + Row B + Row C**

[1]Cash Funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 3.4 - Expansion of Medical Necessity Reviews Projected Savings					
Row	**Description**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Source**
A	**Projected Savings - Total Funds**	**($3,717,698)**	**($3,717,698)**	**($3,717,698)**	**Table 3.8a, Row E plus Table 3.8b, Row E plus Table 3.8c, Row E**
B	Federal Medical Assistance Percentage	65.17%	65.17%	65.17%	Department's expected blended FMAP
C	General Fund Savings	($1,066,980)	($1,066,981)	($1,066,980)	Row C - Row F - Row G
D	Cash Fund Savings	($227,895)	($227,894)	($227,895)	Healthcare Affordability and Sustainability Fee Cash Fund
E	Federal Funds Savings	($2,422,823)	($2,422,823)	($2,422,823)	Row C * Row D

Table 3.5 - Expansion of Prior Authorization Request (PAR) Requirement Medical Necessity Reviews - Cost FY 2022-23					
Row	**Description**	**# of Reviews**	**Cost Per Review[(1)]**	**Total Cost**	**Source**
Physical Therapy/Occupational Therapy					
A	PAR - Automated Review	27,409	$3.03	$83,050	Table 3.9, Row A [FY 2022-23]; Allocation is
B	PAR - Manual Review	32,891	$22.30	$733,467	based on historical claims
C	**Subtotal**	**60,300**	**$13.54**	**$816,517**	**Row A + Row B**
Orthopedic Surgeries					
D	PAR - Automated Review	4,364	$3.03	$13,222	Table 3.9, Row B [FY 2022-23]; Allocation is
E	PAR - Manual Review	8,727	$22.30	$194,620	based on historical claims
F	**Subtotal**	**13,091**	**$15.88**	**$207,841**	**Row D + Row E**
Vascular Procedures/Surgeries					
G	PAR - Automated Review	4,595	$3.03	$13,922	Table 3.9, Row C [FY 2022-23]; Allocation is
H	PAR - Manual Review	11,345	$22.30	$252,998	based on historical claims
I	**Subtotal**	**15,940**	**$16.75**	**$266,920**	**Row G + Row H**
J	**Grand Total**			**$1,291,278**	**Row C + Row F + Row I**

[(1)] Based on cost structure from Department's current UM vendor contract

Table 3.6 - Expansion of Prior Authorization Request (PAR) Requirement Medical Necessity Reviews - Cost FY 2023-24					
Row	**Description**	**# of Reviews**	**Cost Per Review[(1)]**	**Total Cost**	**Source**
Physical Therapy/Occupational Therapy					
A	PAR - Automated Review	27,409	$3.03	$83,050	Table 3.9, Row A [FY 2023-24]; Allocation is
B	PAR - Manual Review	32,891	$22.30	$733,467	based on historical claims
C	**Subtotal**	60,300	**$13.54**	**$816,517**	**Row A + Row B**
Orthopedic Surgeries					
D	PAR - Automated Review	4,364	$3.03	$13,222	Table 3.9, Row B [FY 2023-24]; Allocation is
E	PAR - Manual Review	8,727	$22.30	$194,620	based on historical claims
F	**Subtotal**	13,091	**$15.88**	**$207,841**	**Row D + Row E**
Vascular Procedures/Surgeries					
G	PAR - Automated Review	4,595	$3.03	$13,922	Table 3.9, Row C [FY 2023-24]; Allocation is
H	PAR - Manual Review	11,345	$22.30	$252,998	based on historical claims
I	**Subtotal**	15,940	**$16.75**	**$266,920**	**Row G + Row H**
J	**Grand Total**			**$1,291,278**	**Row C + Row F + Row I**

[(1)] Based on cost structure from Department's current UM vendor contract

Table 3.7 - Expansion of Prior Authorization Request (PAR) Requirement Medical Necessity Reviews - Cost FY 2024-25					
Row	**Description**	**# of Reviews**	**Cost Per Review[1]**	**Total Cost**	**Source**
Physical Therapy/Occupational Therapy					
A	PAR - Automated Review	27,409	$3.03	$83,050	Table 3.9, Row A [FY 2024-25]; Allocation is based on historical claims
B	PAR - Manual Review	32,891	$22.30	$733,467	
C	**Subtotal**	60,300	**$13.54**	**$816,517**	**Row A + Row B**
Orthopedic Surgeries					
D	PAR - Automated Review	4,364	$3.03	$13,222	Table 3.9, Row B [FY 2024-25]; Allocation is based on historical claims
E	PAR - Manual Review	8,727	$22.30	$194,620	
F	**Subtotal**	13,091	**$15.88**	**$207,841**	**Row D + Row E**
Vascular Procedures/Surgeries					
G	PAR - Automated Review	4,595	$3.03	$13,922	Table 3.9, Row C [FY 2024-25]; Allocation is based on historical claims
H	PAR - Manual Review	11,345	$22.30	$252,998	
I	**Subtotal**	15,940	**$16.75**	**$266,920**	**Row G + Row H**
J	**Grand Total**			**$1,291,278**	**Row C + Row F + Row I**

[1] Based on cost structure from Department's current UM vendor contract

Table 3.8a: Physical Therapy/Occupational Therapy Savings Estimate					
Row	Description	FY 2022-23	FY 2023-24	FY 2024-25	Source
A	Estimated PAR Requests	60,300	60,300	60,300	Table 3.9; Row A
B	Estimated Percent Decrease in Utilization	7.00%	7.00%	7.00%	Estimate based on Department data on PAR denials
C	**Estimated Decrease to PARs**	**4,221**	**4,221**	**4,221**	**Row A * Row B**
D	Savings Per Unit	($362.20)	($362.20)	($362.20)	Table 3.10; Row A
E	**Total Savings**	**($1,528,847)**	**($1,528,847)**	**($1,528,847)**	**Row C * Row D**

Table 3.8b - Orthopedic Surgeries Savings Estimate					
Row	Description	FY 2022-23	FY 2023-24	FY 2024-25	Source
A	Estimated PAR Requests	13,091	13,091	13,091	Table 3.9; Row B
B	Estimated Percent Decrease in Utilization	7.00%	7.00%	7.00%	Estimate based on Department data on PAR denials
C	**Estimated Decrease to PARs**	**917**	**917**	**917**	**Row A * Row B**
D	Savings Per Unit	($940.16)	($940.16)	($940.16)	Table 3.10; Row B
E	**Total Savings**	**($862,127)**	**($862,127)**	**($862,127)**	**Row C * Row D**

Table 3.8c - Vascular Procedures/Surgeries Savings Estimate					
Row	Description	FY 2022-23	FY 2023-24	FY 2024-25	Source
A	Estimated PAR Requests	15,940	15,940	15,940	Table 3.9; Row C
B	Estimated Percent Decrease in Utilization	7.00%	7.00%	7.00%	Estimate based on Department data on PAR denials
C	**Estimated Decrease to PARs**	**1,116**	**1,116**	**1,116**	**Row A * Row B**
D	Savings Per Unit	($1,188.82)	($1,188.82)	($1,188.82)	Table 3.10; Row C
E	**Total Savings**	**($1,326,724)**	**($1,326,724)**	**($1,326,724)**	**Row C * Row D**

Table 3.9 - Expansion of Medical Necessity Reviews Estimated Number of Reviews						
Row	**Description**	Most Recent Data	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Source**
	Expected Growth Rate		*-2.31%*	*0.00%*	*0.00%*	*Feb 2021 Caseload Forecast; held constant for FY24 & FY25*
A	Physical Therapy/Occupational Therapy	61,725	60,300	60,300	60,300	Department claims data from CY 2020
B	Orthopedic Surgeries	13,401	13,091	13,091	13,091	Department claims data from CY 2020
C	Vascular Procedures & Surgeries	16,317	15,940	15,940	15,940	Department claims data from CY 2020

Table 3.10 - Expansion of Medical Necessity Reviews Average Cost Per Unit of Service						
Row	**Description**	Most Recent Data	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Source**
	Expected Growth Rate		*0.00%*	*0.00%*	*0.00%*	*Expected to remain constant*
A	Physical Therapy/Occupational Therapy	$362.20	$362.20	$362.20	$362.20	Department claims data from CY 2020
B	Orthopedic Surgeries	$940.16	$940.16	$940.16	$940.16	Department claims data from CY 2020
C	Vascular Procedures & Surgeries	$1,188.82	$1,188.82	$1,188.82	$1,188.82	Department claims data from CY 2020

Table 4.1 - Expansion of Prior Authorization Request (PAR) Requirement Physician Administered Drugs (PADs) Incremental Request							
Row	**Description**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**FFP Rate**	**Source**
A	Funding Needed for Comprehensive PAD PAR Program	$1,071,307	$201,905	$65,922	$803,480	75.00%	Proposal from Department's Utilization Management Vendor
B	Funding Available from FY 2018-19 R-10 "Drug Cost Containment Initiatives"	$531,307	$132,827	$0	$398,480	75.00%	FY 2018-19 R-10 Drug Cost Containment Initiatives
C	**Incremental Request**	**$540,000**	**$69,078**	**$65,922**	**$405,000**	**NA**	**Row A - Row B**

[1]Cash Funds are from the Healthcare Affordability and Sustainability Fee Cash Fund

Table 4.2 - Expansion of Prior Authorization Request (PAR) Requirement Physician Administered Drugs (PADs) Projected Savings					
Row	**Description**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Source**
A	Total Claims of Targeted PADs	10,716	10,716	10,716	CY 2019 MMIS Claims Data
B	Utilization Growth Trend	12.92%	12.92%	12.92%	FY 2021-22 S-1 Medical Services Premiums Exhibit B-1 Caseload; held constant for FY 2023-24 & FY 2024-25
C	**Estimated Claims**	**12,101**	**12,101**	**12,101**	**Row A * (1 + Row B)**
D	Estimated Percentage Decrease in Utilization	-7.00%	-7.00%	-7.00%	Assumption based on research on effects of prior authorization on utilization
E	**Estimated Claims Avoided**	**(847)**	**(847)**	**(847)**	**Row C * Row D**
F	CY 2019 Weighted Average of Claims of Targeted PADs	$1,439.74	$1,439.74	$1,439.74	Table 5.1; Weighted Average based on CY 2019 claims
G	Drug Price Inflation Factor	**4.33%**	8.85%	13.56%	Three-year weighted average increase of Average Sales Price rates
H	**CY 2019 Weighted Average of Claims of Targeted PADs**	**$1,502.08**	**$1,567.12**	**$1,634.98**	**Row F * (1 + Row G)**
I	**Projected Savings (Cost Avoidance)**	**($1,272,262)**	**($1,327,350)**	**($1,384,828)**	**Row E * Row H**
J	Federal Medical Assistance Percentage	65.17%	65.17%	65.17%	Department's expected blended FMAP
K	General Fund Savings	($365,139)	($380,950)	($397,446)	Row I - Row L - Row M
L	Cash Fund Savings	($77,990)	($81,366)	($84,890)	Healthcare Affordability and Sustainability Fee Cash Fund
M	Federal Funds Savings	($829,133)	($865,034)	($902,492)	Row I * Row J

Table 4.3: Physician Administered Drugs (PADs) Data For Preliminary Set of Targeted Drugs			
Row	**Description**	**Amount**	**Comments**
A	Total Expenditure	$15,428,228	CY 2019 MMIS Claims Data
B	Total Claims	10,716	CY 2019 MMIS Claims Data
C	Distinct Utilizers	3,064	CY 2019 MMIS Claims Data
D	Average Cost Per Claim	$1,439.74	Row A / Row B
E	Average Cost Per Utilizer	$5,035.32	Row A / Row C

Table 5.1 - ColoradoPAR Program Modernization Cost of Vendor Contracts					
Row	**Description**	**Calculation**	**FY 2022-23**	**FY 2023-24 and ongoing**	**Notes**
A	Annual Analysis of ColoradoPAR Program	600 hours at $202/hour	$121,200	$121,200	An annual analysis of the ColoradoPAR program to identify areas for improvement/modification addressing health inequities and disparities
B	Data Sharing Integration	480 hours at $190/hour	$91,200	$91,200	Implementation and maintenance of data sharing platform between Regional Accountable Entities (RAEs), Case Management Agencies (CMAs) and Department's Utilization Management (UM) vendor
C	CMS Rule Consultant	600 hours at $202/hour	$121,200	NA	One-time funding for technical assistance in interpreting and determining steps for compliance with CMS proposed rule concerning reducing provider and patient burden by improving prior authorization processes, and promoting patients’ electronic access to health information (CMS-9123-P)
D	**Total**		**$333,600**	**$212,400**	**Row A + Row B + Row C**

Table 6.1 - Nurse Advice Line Modernization
Incremental Request
FY 2022-23

Row	Description	Total Funds	General Fund	Cash Funds	Federal Funds	FFP Rate[1]	Source
A	Cost of Program Modernization	$2,372,352	$798,890	$387,286	$1,186,176	50.00%	Table 6.4a, Row A
B	Available Funding	$1,168,166	$1,080,000	$88,166	$0	NA	Current Department Spending Plan
C	**Subtotal**	**$1,204,186**	**($281,110)**	**$299,120**	**$1,186,176**	**NA**	**Row A - Row B**
D	Hold General Fund for Potential Future Budget Action	$281,110	$281,110	$0	$0	NA	Contingent on CMS Approval of Federal Matching Funds
E	**Incremental Request**	**$1,485,296**	**$0**	**$299,120**	**$1,186,176**	**NA**	**Row C + Row D**

[1] Assumes CMS approval of 50% federal financial participation

Table 6.2 - Nurse Advice Line Modernization
Incremental Request
FY 2023-24

Row	Description	Total Funds	General Fund	Cash Funds	Federal Funds	FFP Rate[1]	Source
A	Cost of Program Modernization	$2,372,352	$798,890	$387,286	$1,186,176	50.00%	Table 6.4a, Row B
B	Available Funding	$1,168,166	$1,080,000	$88,166	$0	NA	Department Spending Plan
C	**Subtotal**	**$1,204,186**	**($281,110)**	**$299,120**	**$1,186,176**	**NA**	**Row A - Row B**
D	Hold General Fund for Potential Future Budget Action	$281,110	$281,110	$0	$0	NA	Contingent on CMS Approval of Federal Matching Funds
E	**Incremental Request**	**$1,485,296**	**$0**	**$299,120**	**$1,186,176**	**NA**	**Row C + Row D**

[1] Assumes CMS approval of 50% federal financial participation

Table 6.3 - Nurse Advice Line Modernization
Incremental Request
FY 2024-25

Row	Description	Total Funds	General Fund	Cash Funds	Federal Funds	FFP Rate[1]	Source
A	Cost of Program Modernization	$2,372,352	$798,890	$387,286	$1,186,176	50.00%	Table 6.4a, Row C
B	Available Funding	$1,168,166	$1,080,000	$88,166	$0	NA	Department Spending Plan
C	**Subtotal**	**$1,204,186**	**($281,110)**	**$299,120**	**$1,186,176**	**NA**	**Row A - Row B**
D	Hold General Fund for Potential Future Budget Action	$281,110	$281,110	$0	$0	NA	Contingent on CMS Approval of Federal Matching Funds
E	**Incremental Request**	**$1,485,296**	**$0**	**$299,120**	**$1,186,176**	**NA**	**Row C + Row D**

[1] Assumes CMS approval of 50% federal financial participation

Table 6.4a - Nurse Advice Line Modernization Cost of Program Modernization			
Row	**Year**	**Amount**	**Source**
A	FY 2022-23	$2,372,352	Table 6.4B, Row M
B	FY 2023-24	$2,372,352	
C	FY 2024-25	$2,372,352	

Table 6.4b - Nurse Advice Line Modernization Breakdown of Costs				
Row	**Description**	**Monthly Amount**	**Annual Amount (Maximum)**	**Source**
Monthly Operations				
A	Nurse Advice Line Core Operations	$106,696	$1,280,352	Proposal from Department's Nurse Advice Line Operator
B	Additional Cost For Exceeding 3,000 Calls Per Month	$12,000	$144,000	
C	MDNL Second Level Triage w/Drug Protocols	$18,875	$226,500	
D	MDNL Teletriage Program	$625	$7,500	
E	Omni-Channel Services	$12,000	$144,000	
F	**Subtotal - Monthly Operations**		**$1,802,352**	**Sum of Row A through Row E**
Other Services - Annual				
G	Marketing & Outreach	N/A	$250,000	Proposal from Department's Nurse Advice Line Operator
H	Data Exchange System (Connection to RAE Database; accessible PCMP Database)	N/A	$60,000	
I	Omni-Channel Services Operations and Maintenance	N/A	$150,000	
J	Special Population Individual Phone Line Maintenance	N/A	$10,000	
K	**Subtotal - Other Services**		**$470,000**	**Sum of Row G through Row J**
L	RN Informatics Specialist/Reporting - $250/hour	400 hours	$100,000	Proposal from Department's Nurse Advice Line Operator
M	**Grand Total**		**$2,372,352**	**Row F + Row K + Row L**

Table 6.5 - Nurse Advice Line Modernization Glossary of Services		
Row	**Services**	**Description**
A	Teletriage	The use of communications and information technology that helps diagnose and direct noncritical cases to the next step in a person's care journey.
B	MDNL	Second level triage completed by board certified emergency medicine physicians.
C	Separate Phone Lines	Specific phone lines for targeted populations or sub-populations or conditions, e.g., medically complex foster children, pregnancy or pre-natal with tailored advice.
D	Data Exchange System	Information technology infrastructure required for the data exchange between Department and NAL vendor; e.g., allowing Department to provide member and provider files to vendor, or allowing the vendor to provide utilization and reporting directly to the Department (note: under the current contract, data is provided by the Department's UM vendor, not the Department).
E	RN Informatics Specialist	An additional NAL-CC team member who functions as the NAL Manager/Program lead and subject matter expert responsible for Health First Colorado NAL Program oversight. They complete all monthly, quarterly and annual reporting in addition to ongoing data analysis. Specific tasks include identifying subpopulation specific trends, evaluating clinical operations, and improving data exchange and decision making.
F	Business Liaison / Marketing & Outreach	An additional NAL-CC team member tasked with marketing initiatives including working directly with RAEs, PCMPs and FQHCs to develop relationships and collaborate with RN Informatics Specialist on data sharing with these providers and to carry out effective targeted marketing to identified subpopulations.
G	Provider Training	Coordinating with Primary Care Medical Providers and Regional Accountable Entities so they may provide appropriate care coordination to members including directing members to use the NAL, receiving and using reports from the NAL for their specific members, and moving members to care coordination programs as appropriate based on their triage situation and
H	Omni-Channel Services	In an omnichannel contact center, all communication channels (such as phone, SMS, online video chat, and email) are connected and integrated to provide a seamless customer experience.

Table 6.6 - Nurse Advice Line Modernization
Savings Calculation
FY 2022-23

Row	Description	Baseline Savings[1]	Savings Projection	Incremental Savings	Source
A	# of RN Triaged Calls	18,574	45,211		Baseline Savings figure is actual quantity from FY 2019-20; Savings Projection is projected quantity to reach 3% utilization goal
B	Medicaid Caseload	1,220,997	1,507,411		Department forecast exhibits, February 2021
C	% Utilization of NAL	1.52%	3.00%		Row A / Row B
D	Average Savings Per Triaged Call	$27.36	$48.21		Table 6.9, Row C and Table 6.10, Row G
E	**Total Annual Savings**	$508,185	$2,179,622	**$1,671,438**	**Row A * Row D**
F	Federal Medical Assistance Percentage			65.17%	Department's expected blended FMAP
G	General Fund Savings			$479,703	Row E - Row H - Row I
H	Cash Fund Savings			$102,459	Health Care Affordability & Sustainability Cash Fund
I	Federal Funds Savings			$1,089,276	Row E * Row F

[1] Data is from 2019 analysis provided to the Department by the NAL vendor

Table 6.7 - Nurse Advice Line Modernization
Savings Calculation
FY 2023-24

Row	Description	Baseline Savings Calculation[1]	Savings Projection Calculation	Incremental Savings	Source
A	# of RN Triaged Calls	18,574	41,304		Baseline Savings figure is actual quantity from FY 2019-20; Savings Projection is projected quantity to reach 3% utilization goal
B	Medicaid Caseload	1,220,997	1,376,792		Department forecast exhibits, February 2021
C	% Utilization of NAL	1.52%	3.00%		Row A / Row B
D	Average Savings Per Triaged Call	$27.36	$48.21		Table 6.9, Row C and Table 6.10, Row G
E	**Total Annual Savings**	$508,185	$1,991,266	**$1,483,081**	**Row A * Row D**
F	Federal Medical Assistance Percentage			65.17%	Blended FMAP across populations
G	General Fund Savings			$425,644	Row E - Row H - Row I
H	Cash Fund Savings			$90,913	Health Care Affordability & Sustainability Cash Fund
I	Federal Funds Savings			$966,524	Row E * Row F

[1] Data is sourced from analysis provided to the Department by the NAL vendor

Table 6.8 - Nurse Advice Line Modernization
Savings Calculation
FY 2024-25

Row	Description	Baseline Savings Calculation[1]	Savings Projection Calculation	Incremental Savings	Source
A	# of RN Triaged Calls	18,574	42,130		Baseline Savings figure is actual quantity from FY 2019-20; Savings Projection is projected quantity to reach 3% utilization goal
B	Medicaid Caseload	1,220,997	1,404,328		Department forecast exhibits, February 2021
C	% Utilization of NAL	1.52%	3.00%		Row A / Row B
D	Average Savings Per Triaged Call	$27.36	$48.21		Table 6.9, Row C and Table 6.10, Row G
E	**Total Annual Savings**	$508,185	$2,031,087	**$1,522,903**	**Row A * Row D**
F	Federal Medical Assistance Percentage			65.17%	Blended FMAP across populations
G	General Fund Savings			$437,073	Row E - Row H - Row I
H	Cash Fund Savings			$93,354	Health Care Affordability & Sustainability Cash Fund
I	Federal Funds Savings			$992,476	Row E * Row F

[1] Data is sourced from analysis provided to the Department by the NAL vendor

Table 6.9 Nurse Advice Line Modernization
Average Savings Per Caller
Baseline

Row	Description	Amount	Source
A	# of RN Triaged Callers	18,574	Analysis Completed by NAL vendor using 2019 Data
B	Total Savings	$508,116	
C	**Baseline Savings Per Caller**	**$27.36**	**Row B / Row A**

Table 6.10 Nurse Advice Line Modernization
Average Savings Per Caller
Projected

Row	Description	Amount	Source
A	Baseline Savings Per Caller	$27.36	Table 6.9, Row C
B	Projected % of Similar Calls After Modernization	63.06%	Analysis Completed by NAL vendor using 2019 Data
C	**Subtotal**	**$17.25**	**Row A * Row B**
D	Projected Savings Per Caller Submitted for Second-Level Triage	$ 83.82	Analysis Completed by NAL Vendor using 2019 Data
E	Projected % of Second-Level Triage	36.94%	
F	**Subtotal**	**$30.96**	**Row D * Row E**
G	**Average Projected Savings Per Caller**	**$48.21**	**Row C + Row F**

Department Priority: R-08
Request Detail: County Administration, Oversight and Accountability

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	**FY 2022-23 Request**	**FY 2023-24 Request**
Total Funds	$11,329,373,255	($590,849)	($17,261,512)
FTE	560.9	5.9	6.0
General Fund	$2,673,594,590	$461,138	($3,422,571)
Cash Funds	$1,317,699,638	$1,936,919	$971,442
Reappropriated Funds	$85,650,144	$0	$0
Federal Funds	$7,252,428,883	($2,988,906)	($14,810,383)

Summary of Request

The Department of Health Care Policy & Financing (HCPF or department) requests funding to rectify some of the state's annual funding deficit of its county administration appropriation, increase funding for pay-for-performance through the County Incentives Program allocation, hire additional staff to provide proper fiscal and programmatic oversight of county administrative-related activities, and reduce the amount of time it takes to conduct on-site compliance reviews of all 64 counties. In addition, the request includes additional department resources for addressing quality and audit findings as reported in numerous Office of State Auditor (OSA) audits. The staffing requested will provide the department with resources to address its OSA error rate, identify erroneous enrollment, and prevent avoidable costs by assuring only those truly eligible are enrolled in the Medical Assistance Program.

This request represents less than a 0.5% increase from the department's FY 2021-22 Long Bill total funds appropriation.

Current Program

The department's county administration appropriation provides federal and state reimbursement to 64 county departments of human/social services for costs associated with performing Medicaid, Children's Basic Health Plan (CHP), Long-Term Services and Supports (LTSS) and Old Age Pension (OAP) State Medicaid Program eligibility determinations, program integrity and appeals. The annual appropriation is allocated across all 64 counties to determine each county's portion of the funding.

Additionally, to help offset local county share costs, the department's County Incentives Program provides an incentive payment structure to counties that supports pay-for-performance. The program provides meaningful fiscal relief for county costs when performance benchmarks are met by providing an offset to the county local contribution.

Per Section 25.5-1-114 C.R.S. (2021), the department is required to conduct adequate oversight of its counties and the local administration of the Medical Assistance Program. Additionally, per 45 CFR § 75.303(a), the department, as a recipient of federal funds, must establish and maintain effective internal controls over its federal awards that provide reasonable assurance that the department is managing its federal grants in compliance with federal statutes, regulations, and the award terms and conditions.

In order to meet its oversight requirements, the department's Eligibility Quality Assurance (QA) Program conducts 120 monthly case reviews for all counties and eligibility sites. During these quality assurance reviews, the department monitors the accuracy and timeliness of eligibility determinations for Medical Assistance. In addition to reviewing county-caused errors, the Eligibility QA Program also reviews state guidance and systems to ensure compliance with federal and state requirements. These reviews produce data that allows the department to address potential audit findings or compliance issues prior to the discovery of errors in external audits.

The department also conducts Management Evaluation (ME) reviews, which includes on-site compliance and member experience reviews of all 64 counties and eligibility sites, and occur over a three-year review cycle. To meet the three-year review cycle, department staff must travel to at least two counties or eligibility sites monthly, resulting in 24 annual reviews. Unlike eligibility QA reviews, ME reviews do not review case-specific information, but rather focus on the county's operations. These reviews ensure member access to eligibility determinations, program integrity activities, and compliance with non-discrimination laws, accessibility and civil rights, and aspects of federal and state requirements for Medical Assistance.

Problem or Opportunity

The department's County Administration Program is underfunded and lacks the resources to provide proper fiscal policy monitoring and compliance oversight of the program and ensure that accountability and quality assurance efforts are sufficiently met. As a result, the department's error rate from the Single Statewide Audit (SSWA) reports conducted by the Office of State Auditor (OSA) continues on an upward trajectory, approaching 30%, as reported by the OSA reports[1].

The 2019 and 2020 SSWA reports conducted by the OSA extrapolated error rates and issues with eligibility determination, quality, and accuracy. For 32 of the 125 Medicaid beneficiaries' case files that were tested (26 percent), the OSA identified at least one error within each case file. In total, the OSA identified 43 errors within the 32 case files. In 16 of 25 CHP+ beneficiaries' case files tested (64 percent), the OSA identified at least one error. Based on the sample size, the OSA estimated the projected Medicaid questioned costs resulting from payments made on behalf of ineligible beneficiaries in the population between July 1, 2019, and February 29, 2020, to be about $165.6 million and, with 90 percent confidence, to be at least $41.1 million but not more than $290.0 million. The projected questioned costs amount of $165.6 million is based on a statistical calculation that does not correlate to specific payments to providers or to over-expenditures of the state's General Fund or federal funds. However, this calculation indicates that if auditors tested the entire population, there is a 90 percent likelihood of finding the true amount of questioned costs to be between $41.1 million and $290.0 million, and the amount would most likely be close to $165.6 million in erroneous payments. There is a 5 percent chance that the true amount of questioned costs is less than $41.1 million, and a 5 percent chance the true amount is over $290.0 million.[2]

The SSWA audits a small sample (125 Medicaid cases and 25 CHP+ cases) from across all 64 counties. Because of this, the department is unable to provide any county specific findings, hindering its ability to address issues at the county level. While the department's Oversight and Accountability (O&A) Program is designed to focus on the county level to find and address issues before they become audit findings, current resources only allow for 120 case reviews per month, across 64 counties and 12 medical assistance sites with a caseload of nearly 1.5 million Coloradans. The QA sample size across all eligibility sites results in a monthly review of only one case per month for some sites. In comparison, the Supplemental Nutrition Assistance Program (SNAP) conducts a nearly identical number of monthly case reviews for a significantly smaller

[1] 2019 Statewide Single Audit; 2020 Statewide Single Audit

[2] Though the department generally disagrees with the auditor's questioned costs and the projection of those questions costs calculations, these figures highlight the errors the department does need to address through increased county monitoring. Further, since these figures are published in public reports, they bring attention to the eligibility errors, which may cause CMS and the Office of the Inspector General (OIG) to perform similar audits. The OIG has the authority to perform similar extrapolations like the OSA, and based on those extrapolations the OIG can recover funds from the department. The department's raised concerns to the Legislative Audit Committee concerning the auditor's sampling, stratification, and costs used to generate the projected questioned costs; however, these concerns may not be taken into consideration in future OIG audits.

population size served, with over 517,000 Coloradans enrolled in SNAP. With limited staff to perform case reviews, and a smaller QA sample size in comparison to the population served, the department is not able to conduct quality reviews for all sites on a monthly basis, which contributes to increased OSA error rates.

Additionally, the department lacks resources to address and resolve the myriad of audit and QA findings to prevent possible disallowances resulting from high error rates. Though issues and errors are identified through quality assurance reviews and external audits, there are not enough policy and systems resources to issue appropriate guidance where it may be missing, address policy errors in current guidance, identify and prioritize system fixes to prevent and address errors, write and implement systems requirements and coordinate with counties and vendors to address the issues identified. Without the appropriate resources dedicated to policy and systems audit and QA findings, the department would build a backlog of errors, which could result in recurring errors in future audits, potentially causing the state to pay millions of dollars to the federal government as a result of inaccurate eligibility determinations.

Other department efforts in providing oversight of counties include on-site Management Evaluation reviews of all 64 counties on a three-year review cycle as part of the O&A Program. On-site compliance reviews conduct macro-level analyses of county compliance, such as non-discrimination or accuracy results, compared to QA reviews, which are micro-level analyses of actions taken on a particular case. On-site reviews are the only verifiable methodology to ensure county compliance across all their operations, but the program review timeline is significantly extended due to the lack of department staffing. Current staffing capacity limits the department to reviewing counties on a three-year cycle, and the significant workload completed by department staff may be negated if, for instance, a new county director is hired and modifies business processes, creating new compliance opportunities to be addressed. In this example, it would take another three years for the department to address those compliance opportunities, because of the longer cycle. Management Evaluation reviews are also conducted by SNAP and other CDHS programs; the SNAP ME Review Program estimates that reviews are conducted by 3.0 FTE, with 16-18 annual reviews conducted, indicating the department's current staffing level for the ME Review Program is under resourced in comparison to other state programs.

Eligibility determination audit findings are also related to the state's annual funding deficit for County Administration costs. Since FY 2015-16, the department has exhausted all state funding available in the county administration appropriation that pays for county-related costs. As a result, counties collectively have had to invest an average of $4.5 million annually of local funds to cover the state funding shortfall. When counties use more local funds than what is in their annual budgeted allocation, local funding must be diverted from county funds that support other programs, such as clerks and recorders, district attorneys and sheriffs, or from the county social services fund that supports other public assistance programs. Every dollar of county funds that must be used to cover the shortfall in the county administration appropriation diverts funding

away from other county priorities, such as roads and bridges and community support. Additionally, the state has the statutory responsibility to sufficiently fund the state's share of costs associated with proper and efficient county administration of the Medical Assistance Program.

The current county administration allocation methodology is determined through a complex formula that was originally developed by a county workload study in 2009. The allocation methodology includes workload-related data points but does not include external elements such as poverty rate or population data. The methodology is driven solely on activity minutes related to the overall workload, which is then used to determine each county's percentage of funding, which creates inequities between the large metropolitan counties and smaller or more rural counties.

The department has no FTE fully dedicated to supporting county administration financing. department staff associated with county oversight and relationships split time between fiscal oversight and stakeholder relations, and the department lacks staffing resources to adequately provide fiscal policy monitoring and compliance oversight of county spending, such as county budgets, county merit-based staffing levels, reviews of county contracts paid for with county administration funding, strategic plans for county administration expenditures, review of county costs to ensure eligibility for federal reimbursement and ensuring county fiscal benchmarks are met. Due to lack of staffing, the department does not consistently monitor county staffing levels or county budgets, which can cause underinvestment in county operations such as customer service, and long-term services and supports (LTSS) eligibility determinations, which are crucial to a positive member experience and applicants attempting to access services.

Proposed Solution

The department requests a reduction of $590,849 total funds, including an increase of $461,138 General Fund and 5.9 FTE in FY 2022-23, and a reduction of $17,261,512 total funds, including a decrease of $3,422,571 General Fund and increase of 6.0 FTE and in FY 2023-24 and ongoing to pay more of the state's share for county administration costs, increase funding for pay-for-performance through the County Incentives Program allocation, to hire additional staff and resources to provide proper fiscal and programmatic oversight of county administrative-related activities. With the requested resources, the department would increase county management evaluation reviews, county and eligibility site quality assurance case reviews, increase the support the department provides to counties to address audit findings, implement robust eligibility systems monitoring, and implement system fixes and builds, such as adding new data monitoring requirements, required data entry fields or revised system processes to identify potential errors, and reduce the probability of future audit findings.

The requested FTE would address error rates at the county- and state-level through a continuous improvement cycle, which is required per S.B. 16-190. Specifically, quality assurance staff would produce data to identify potential errors caused by both counties and the state. County administration staff would ensure the appropriate county funding is available and that the necessary county staff are hired and performance targets and benchmarks for counties are in place and met. Management evaluation reviewers would conduct on-site reviews to address county-caused QA errors and gather feedback from counties for improvement. Policy and systems staff would identify new policy guidance and system fixes to prevent errors going forward. To close the cycle, QA reviewers would be able to capture whether errors are repeating going forward. Each of these FTE are responsible for a portion of the continuous improvement cycle, and would assist the department in reducing its high OSA error rate and county compliance issues and in doing so, the department expects that these efforts would provide the State with cost savings to its Medicaid and CHP+ programs by capturing inaccurate enrollments.

If the request is not funded, the department would continue to see increased OSA audit findings and its error rate may reach, if not exceed, 30%. This alone had the potential for federal disallowances of hundreds of millions of dollars, due to ineligible individuals enrolled in the department's programs. Without the requested FTE, the continuous improvement cycle would continue to have gaps, such as the risk of identifying a compliance issue or potential audit finding without the necessary resources to fix, remedy or address the issue or finding. Additionally, if the state funding shortfall of county administration funding is not made whole, counties would continue to use their general funds to cover the shortfall, which would divert funding away from other county priorities.

County Administration Base Funding and Incentive Payments

The department requests an increase in funding in the county administration budget so that county-related costs can be reimbursed at the correct match rates and fund sources. The department also requests an increase in funding for the County Incentives Program in order to provide county local share offset for counties that are meeting their benchmarks. This funding does not reimburse counties for standard duties that would be paid from the county administration appropriation. Rather, it encourages counties to meet "stretch" goals and objectives that go beyond their regular operations, and provides fiscal relief to counties that meet the incentives by offsetting county local share costs. With the requested funding, the department would establish new performance benchmarks related to customer service, quality assurance, and LTSS.

To provide oversight to the county administration program, the department requests 1.0 FTE to implement a new fiscal policy monitoring and compliance program for county administration funding, expenditures, and staffing to ensure county operations meet minimum federal and state standards. The FTE would provide oversight and county support to improve county customer service, quality assurance and LTSS. Additionally, the department requests 1.0 FTE to support

the current County Incentives Program, and oversee the contracts and deliverables resulting from existing and any new performance benchmarks the department would establish. Detailed job descriptions can be found in the Assumptions and Calculations section of this request.

The department also requests funding to contract with a vendor to develop a new county administration allocation methodology that better supports the smaller and more rural counties, which would be created in consultation with all counties and the department of Human Services. The contractor would manage county stakeholder outreach, conduct policy analysis and research and propose a new allocation. The department would require the contractor's proposal to include research on wages, ability of the county to self-fund, poverty rates and other external factors that impact the ability of the county to support its human/social services department. The department would also have the vendor propose methodologies to differentiate targeted funding for county functions such as customer service and LTSS. These factors would be included in the new allocation model or factored into a recommendation for future action. The contractor would also provide an annual update of the allocation model and continued recommendations for improvement of the allocation methodology.

County Administration Program Oversight

The department requests administrative resources to improve its oversight of the eligibility determination process that is administered by the counties. In total, the department requests 4.0 FTE dedicated to quality assurance, management evaluation reviews, and addressing audit findings. These resources are described below, and detailed job descriptions can be found in the Assumptions and Calculations section of this request.

The department requests 1.0 FTE dedicated to the department's Quality Assurance Program, which would allow the department to increase the amount of QA reviews conducted monthly for all counties and eligibility sites. Increasing the amount of state-produced QA reviews would get the department closer to a statistically significant monthly QA sample size and provide the necessary quality and accuracy data to counties, sites and the department. Having the ability to pinpoint errors at a county level increases the ability to get to the root causes of the errors.

The department requests 2.0 FTE to support the department's Eligibility Site Accountability and Oversight Program. 1.0 FTE would address policy audits and findings by providing additional support and supervision of existing staff, updating guidance, issuing memos, manuals and letters and providing policy support for audit system builds. All of these policy activities are crucial in ensuring accurate responses to findings. 1.0 FTE would address system audits and findings by designing and implementing systems builds and changes, while using data mining and monitoring to proactively unearth systems issues. This FTE would be responsible for finding and addressing potential issues across the entire system, complementing the work being accomplished at the county and individual level.

The department requests 1.0 FTE to perform Management Evaluation reviews of all counties and eligibility sites to reduce the amount of time taken to conduct a review from a three-year cycle to closer to a two-year cycle. This would ensure the department meets federal and state requirements to conduct oversight of effective county operations for the purposes of Medical Assistance. Currently, the department has numerous audit findings and deficiencies relating to the lack of internal controls over counties, which results from an inconsistent monitoring plan and the lack of consistent oversight of all 64 counties.

Currently, the Eligibility QA Program utilizes manual forms and processes to document errors and findings and communicate with counties and eligibility sites. This significantly increases the amount of time spent maintaining and operating the overall quality assurance process while reducing the amount of time spent on quality reviews. The department requests funding to implement a more modern documentation and data collection process, through competitive bid or by exploring county-implemented solutions, to automate the QA review process and increase efficiencies when working with counties and sites. In addition to the one-time cost to implement a technology solution, the department expects an ongoing cost for maintaining and updating the QA review system used for QA documentation.

Evidence-Based Continuum

The department believes that this type of data collection and outreach is on Step 2 of the Evidence Continuum, "Identify Outputs." Performing management evaluation reviews, quality assurance reviews and having staff available to address audit findings would enable the department to address compliance issues at all counties and eligibility sites. As future OSA SSWA audits are performed, the department could monitor its error rate and would be able to measure whether the error rate has been reduced.

Theory of Change	Performing increased management evaluation reviews, quality assurance reviews, and address audit findings of counties and eligibility sites to identify issues and errors.		
Program Objective	Reduce error rates and findings, increase member satisfaction and applicant experience.		
Outputs Being Measured	Various outputs, including a decrease in audit findings and a reduced OSA error rate.		
Outcomes Being Measured	None.		
Cost/Benefit Ratio	Cost savings by identifying members that are likely ineligible to be on Medicaid and save the state money by disenrolling those members.		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	N/A	N/A	N/A
Continuum Level	Step 2		

Anticipated Outcomes

The department anticipates that approval of the request would reduce the amount of OSA findings and bring down the error rate of 26% from the 2019 OSA audit. The department would have the resources to address county-level audit findings and work with the counties to implement changes so the errors can be fixed, while also addressing policy and systems findings, through data mining and systems monitoring, to positively impact high OSA error rates. Data mining occurs when a potential error, audit finding, or issue is identified by eligibility determination system monitoring. If a potential error is identified, the department would pull data on the overall impact to applications and/or caseload. This helps determine if the potential error is a small or large impact and whether it may result in a change in eligibility status for applicants and members. In turn, the department expects that it would be able to identify members that are likely ineligible to be on Medicaid and save the state money by disenrolling those members.

By moving toward a two-year management review cycle of all the counties, the department anticipates increased compliance for county operations and a focus on areas that impact equity, diversity and inclusion, such as non-discrimination, language services and accessibility for applicants and members. With a focus on EDI compliance, the two-year management evaluation review cycle would ensure all counties have processes that allow for redress if an applicant or member feels their civil rights were violated. The reduced cycle would also ensure that counties have appropriate processes in place to support at-risk and marginalized populations in accordance with federal and state law.

By increasing the frequency of reviews, the department can better ensure counties are providing appropriate access and services. Current reviews conducted by the program have found that counties and eligibility sites have been cited by the department, on average, with between five to seven compliance findings, best practices and recommendations. Spread across all counties and sites, the department estimates that there are hundreds of unidentified and unresolved compliance issues that can cause a risk to federal funding, while causing applicant frustration and member complaints. Adding additional FTE to conduct reviews would allow the department to increase compliance reviews at counties, address county errors, and put in place structures and systems to prevent similar errors.

Additionally, funding the request would ensure the department can reimburse county costs accurately and prevent the counties from using other streams of funding to cover Medical Assistance over-expenditures. Approving the request would also allow the department to improve county administration outcomes more effectively by tying new incentive funding to three types

of county functions: customer service, quality assurance and long-term services and supports. The department expects increased member satisfaction and applicant experience through additional funding, new performance benchmarks, and increased staff for monitoring, with the long-term goals of reducing call center ASA to five minutes or less and increasing LTSS eligibility determination timeliness to 95%.

Funding this request supports one of the Governor's wildly important goals (WIGs):

- WIG #2 – Eligibility Technology Support: This request supports the WIG by investing in county resources supporting complex and timely activities that cannot be completed through system automation – such as LTSS cases, verifying accuracy and quality or receiving and managing customer service calls.

This request supports two of the department's strategic pillars that were established to ensure customer-focused performance management.

- Medicaid Cost Control — Ensure the right services for the right people at the right price
- Operational Excellence & Customer Service — Improve service to members, care providers, and partners, and create compliant, efficient, and effective business practices that are person- and family-centered.

Assumptions and Calculations

See Appendix A for detailed calculations.

County Administration Funding

County administration costs are split between the federal, state and county governments and the funding in this request assumes the same allocation methodology. Funds requested for the County Incentives Program are requested at 20% of the total requested county administration funding increase, consistent with the maximum amount that counties can provide in local match. Incentive funding is funded entirely with General Fund.

Cost Savings

Statistical sampling results from the 2020 OSA SSWA audit findings, with the audit review period occurring in the period prior to, and ending at the beginning of, the COVID-19 pandemic, found that the department has an upper limit of 278,429 likely ineligible beneficiaries, a point estimate of 169,026 likely ineligible beneficiaries, and a lower limit of 59,622 likely ineligible beneficiaries. Based on the department's February 2021 FY 2022-23, projected total enrollment of 1,224,820 members, and using the lower limit of likely ineligible beneficiaries, the department utilizes the OSA assumption that 4% of enrollment is likely ineligible beneficiaries. However, as indicated on the most recent 2020 SSWA, 25% of the 4% error rate resulted from the department's claims payment system; as a result, the true eligibility determination error rate is likely a maximum of 3%. Although the department is using OSA results for the purposes of the request,

some of the audit results remain in dispute. However, they do highlight the errors the department does need to address through increased county monitoring.

There were eight different categories of findings on the OSA report: Payments after Eligibility has Ended; Ineligible for Program; Income Issues; Missing Redetermination; Buy-In Premiums Not Assessed; Inappropriate Change to Eligibility; Missing Case Documentation; and, Data Entry Errors. The department anticipates that the additional resources for county funding, management evaluation reviews, quality assurance reviews, addressing audit findings, eligibility systems reports and tools that can indicate potential errors, and data analysis that determines true impact to drive improvements, could capture up to four out of the eight categories of findings in the OSA report, with the goal of proactively identifying 25% of the total ineligible population directly, with the remaining population captured over time as system improvements roll out. Assuming that the department can capture 25% of issues, the 3% of ineligibly enrolled beneficiaries would drop by 0.75%, by disenrolling those members who are truly ineligible for the program. This process would be applied specifically to Modified Adjusted Gross Income (MAGI) and Children's Basic Health Plan (CHP+) populations, minimizing the impact to highly vulnerable populations such as people receiving long-term services and supports. Identifying members that are enrolled but ineligible for services would provide the state savings as the department would budget for services costs based on more accurate trends and statistics. The department assumes a half year ramp up before it would begin to see any savings from member disenrollment to allow for hiring and training of the requested resources.

The department estimates that disenrollment across MAGI and CHP+ populations would result in savings in both Medicaid and CHP+. Caseload is based on FY 2022-23 projections, which assumes that the COVID-19 locked-in populations would be disenrolled by FY 2021-22. Fund splits have been calculated according to each type of population. The department also assumes that there would be a ramp up in the first year, and that it would start to see savings after hiring and training the requested FTE.

FTE

The staff the department has requested are summarized below. The department has factored in additional travel costs for the 1.0 FTE related to management evaluation reviews. Staff would travel throughout the state to perform reviews of counties and eligibility sites and would be reimbursed for travel-related costs. The department expects that staff would average around one trip per week, with two trips per month requiring overnight travel. The department assumes all FTE will start July 1, 2022 and would be full-time, permanent positions. For the requested fund splits, the department assumes a federal match rate of 50% for standard Medicaid administrative costs and a combination of General Fund and Healthcare Affordability and Sustainability Fee cash fund for the state fund sources.

Position Name	Position Classification	Number of FTE	Description
County Administration Funding and Oversight			
County Administration Supervisor	Administrator V	1.0	This FTE would design, implement and administer a new county administration fiscal policy monitoring and compliance program through strategic and tactical plans, systems, processes, guidelines, rules, and standards that are aligned with federal and state standards and align with the department's Wildly Important Goals. This FTE would monitor county administration funding, county staffing levels and operational compliance, issue fiscal policy guidance, address annual funding allocations, build and leverage relationships with county staff, leadership, and directors and issue recommendations for robust fiscal and programmatic oversight of counties. The FTE would review expenditures to ensure they are classified within the appropriate county administration funding streams, review annual county human services budgets, monitor merit-based employee compliance by the counties, act as a fiscal compliance point-of-contact and assist the counties with tying expenditures to service functions (customer service, quality assurance and LTSS), review county administrative requirements for federal and state compliance, and conduct general fiscal compliance work with the counties.
County Incentives Program Administrator	Administrator IV	1.0	This FTE would oversee the incentive program funding, contracts and deliverables resulting from existing benchmarks and any new performance benchmarks the department would establish. This position would help create contract performance benchmarks around county customer service and call center wait times and new/revised contracts, helping to achieve a lower ASA wait time and increasing timeliness of

			LTSS determinations and redeterminations, while addressing county quality and accuracy concerns.
Management Evaluation Reviews			
Management Evaluation Reviewer	Compliance Specialist IV	1.0	This FTE would perform on-site compliance reviews of all counties and eligibility sites. The FTE would travel to all 64 counties and 11+ MA Sites to verify: compliance with eligibility determination processes; non-discrimination, civil rights and accessibility policies at sites; program integrity programmatic activities; and additional federal and state regulations compliance checks. Positions would interpret policy, issue programmatic guidance for the ME Review Program, create and issue compliance and outcome reports, track and monitor outstanding compliance issues, and issue recommendations to internal staff to proactively address compliance opportunities.
Eligibility Oversight and Accountability			
Eligibility Policy Unit Supervisor	Policy Advisor V	1.0	This FTE would serve as a supervisor and exists to support and assign the resources allocated to the work unit. This is accomplished through personnel management, oversight of day-to-day operations, work planning and implementation, and management reporting. The FTE would provide department management with regular updates on eligibility issues and explain their impact on clients and the department's budget. In the course of the work, this position would also address policy audits and findings by updating guidance, issuing memos, manuals and letters, and providing policy support for system builds.

Eligibility Systems Analyst	Analyst IV	1.0	This position would provide eligibility systems analyst and operations assistance for Medical Assistance Programs to the department's Eligibility Site Accountability and Oversight Program. The position serves as an Eligibility Systems Representative/Point of Contact for all meetings and requests as they relate to the department's Eligibility Site Accountability and Oversight Program. The FTE would monitor Medical Assistance Eligibility Systems functionality and identify potential system issues, training opportunities, and system enhancements as it relates to the department's Eligibility Site Accountability and Oversight initiative. The position may serve as a project lead from project initiation through implementation for Medical Assistance CBMS and PEAK system enhancements/modifications as it relates to the department's Eligibility Site Accountability and Oversight initiative.
Eligibility Quality Assurance Reviewer	Compliance Specialist III	1.0	This position would be responsible for performing QA Reviews on Medical Assistance cases to support the calculation of an accuracy rate for eligibility determinations at a county level.

Table 1.1
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$443,822	5.9	$133,478	$88,433	$0	$221,911	50.00%	Tables FTE and Operating
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$84,516	0.0	$25,418	$16,840	$0	$42,258	50.00%	Tables FTE and Operating
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$631.00	0.0	$190	$126	$0	$315	50.00%	Tables FTE and Operating
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$19,750	0.0	$5,940	$3,935	$0	$9,875	50.00%	Tables FTE and Operating
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$19,750	0.0	$5,940	$3,935	$0	$9,875	50.00%	Tables FTE and Operating
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$61,680	0.0	$18,550	$12,290	$0	$30,840	50.00%	Tables FTE and Operating + Table 5 Row I
G	(1) Executive Director's Office, (A) General Administration, Leased Space	$39,600	0.0	$11,910	$7,890	$0	$19,800	50.00%	Tables FTE and Operating
H	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$314,675	0.0	$94,637	$62,700	$0	$157,338	50.00%	Table 4.1 Row G + Table 7.1 Row C
I	(1) Executive Director's Office, (D) Eligibility Determinations and Client Services, County Administration	$14,878,000	0.0	$3,983,405	$2,662,929	$0	$8,231,666	Blended	Table 2.1 Row A + Row H
J	(2) Medical Services Premiums, Medical and Long Term Care Services for Medicaid Eligible Individuals	($13,511,279)	0.0	($3,197,873)	($697,720)	$0	($9,615,686)	Blended	Table 6.1 Row F
K	(3) Behavioral Health Community Programs, Behavioral Health Capitation Payments	($2,255,022)	0.0	($477,044)	($127,413)	$0	($1,650,565)	Blended	Table 6.1 Row O
L	(5) Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs	($686,972)	0.0	($143,413)	($97,026)	$0	($446,533)	Blended	Table 6.1 Row U
M	**Total Request**	**($590,849)**	**5.9**	**$461,138**	**$1,936,919**	**$0**	**($2,988,906)**	**NA**	Sum of Rows A thru L

Table 1.2
Summary by Line Item
FY 2023-24 and Ongoing

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$461,596	6.0	$138,824	$91,974	$0	$230,798	50.00%	Tables FTE and Operating
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$84,516	0.0	$25,417	$16,841	$0	$42,258	50.00%	Tables FTE and Operating
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$656	0.0	$197	$131	$0	$328	50.00%	Tables FTE and Operating
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$20,543	0.0	$6,178	$4,093	$0	$10,272	50.00%	Tables FTE and Operating
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$20,543	0.0	$6,179	$4,093	$0	$10,271	50.00%	Tables FTE and Operating
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$19,680	0.0	$5,919	$3,921	$0	$9,840	50.00%	Tables FTE and Operating + Table 5 Row I
G	(1) Executive Director's Office, (A) General Administration, Leased Space	$39,600	0.0	$11,910	$7,890	$0	$19,800	50.00%	Tables FTE and Operating
H	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$119,900	0.0	$36,060	$23,890	$0	$59,950	50.00%	Table 4.2 Row G + Table 7.2 Row C
I	(1) Executive Director's Office, (D) Eligibility Determinations and Client Services, County Administration	$14,878,000	0.0	$3,983,405	$2,662,929	$0	$8,231,666	Blended	Table 2.2 Row A + Row H
J	(2) Medical Services Premiums, Medical and Long Term Care Services for Medicaid Eligible Individuals	($27,022,558)	0.0	($6,395,744)	($1,395,442)	$0	($19,231,372)	Blended	Table 6.2 Row F
K	(3) Behavioral Health Community Programs, Behavioral Health Capitation Payments	($4,510,044)	0.0	($954,089)	($254,825)	$0	($3,301,130)	Blended	Table 6.2 Row O
L	(5) Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs	($1,373,944)	0.0	($286,827)	($194,053)	$0	($893,064)	Blended	Table 6.2 Row U
M	**Total Request**	**($17,261,512)**	**6.0**	**($3,422,571)**	**$971,442**	**$0**	**($14,810,383)**	**NA**	Sum of Rows A thru L

Table 2.1
Summary by Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
County Administration Funding and Oversight									
A	County Administration Funding Shortfall	$12,398,333	0.0	$1,503,738	$2,662,929	$0	$8,231,666	NA	Sum: A.1 + A.2
A.1	*Enhanced*	$8,130,000	0.0	$733,523	$1,298,977	$0	$6,097,500	75.00%	Table 3 Row A
A.2	*Non-enhanced*	$4,268,333	0.0	$770,215	$1,363,952	$0	$2,134,166	50.00%	Table 3 Row B
B	Allocation Methodology Contractor	$252,925	0.0	$76,067	$50,396	$0	$126,462	50.00%	Table 4.1 Row G
C	FTE Costs	$124,641	1.0	$37,486	$24,835	$0	$62,320	50.00%	Sum Row D through Row F
D	*FTE Salary, PERA, Medicare*	$88,044	1.0	$26,479	$17,543	$0	$44,022	50.00%	Table 8.1 FTE and Operating
E	*FTE AED, SAED, STD and HLD*	$22,047	0.0	$6,631	$4,393	$0	$11,023	50.00%	Table 8.1 FTE and Operating
F	*FTE Operating Expenses and Leased Space*	$14,550	0.0	$4,376	$2,899	$0	$7,275	50.00%	Table 8.1 FTE and Operating
G	**Subtotal**	**$12,775,899**	**1.0**	**$1,617,291**	**$2,738,160**	**$0**	**$8,420,448**	**NA**	**Sum Row A + Row B + Row C**
County Incentive Program									
H	Increase Program by 20% of Funding Requested for County Administration	$2,479,667	0.0	$2,479,667	$0	$0	$0	0.00%	Total Funds in Row A * 20%
I	FTE Costs	$105,360	1.0	$31,687	$20,993	$0	$52,680	50.00%	Sum Row J through Row L
J	*FTE Salary, PERA, Medicare*	$70,362	1.0	$21,161	$14,020	$0	$35,181	50.00%	Table 8.2 FTE and Operating
K	*FTE AED, SAED, STD and HLD*	$20,448	0.0	$6,150	$4,074	$0	$10,224	50.00%	Table 8.2 FTE and Operating
L	*FTE Operating Expenses and Leased Space*	$14,550	0.0	$4,376	$2,899	$0	$7,275	50.00%	Table 8.2 FTE and Operating
M	**Subtotal**	**$2,585,027**	**1.0**	**$2,511,354**	**$20,993**	**$0**	**$52,680**	**NA**	**Sum Row H + Row I**
Management Evaluation Reviews									
N	FTE Costs	$119,340	1.0	$35,891	$23,779	$0	$59,670	50.00%	Sum Row O through Row R
O	*FTE Salary, PERA, Medicare*	$70,362	1.0	$21,161	$14,020	$0	$35,181	50.00%	Table 8.3 FTE and Operating
P	*FTE AED, SAED, STD and HLD*	$20,448	0.0	$6,150	$4,074	$0	$10,224	50.00%	Table 8.3 FTE and Operating
Q	*FTE Operating Expenses and Leased Space*	$14,550	0.0	$4,376	$2,899	$0	$7,275	50.00%	Table 8.3 FTE and Operating
R	*Travel*	$13,980	0.0	$4,204	$2,786	$0	$6,990	50.00%	Table 5 Row I
S	**Subtotal**	**$119,340**	**1.0**	**$35,891**	**$23,779**	**$0**	**$59,670**	**NA**	**Sum Row N**
Quality Assurance									
T	FTE Costs	$90,407	1.0	$27,190	$18,014	$0	$45,203	50.00%	Sum Row U through Row X
U	*FTE Salary, PERA, Medicare*	$56,648	1.0	$17,037	$11,287	$0	$28,324	50.00%	Table 8.4 FTE and Operating
V	*FTE AED, SAED, STD and HLD*	$19,209	0.0	$5,777	$3,828	$0	$9,604	50.00%	Table 8.4 FTE and Operating
W	*FTE Operating Expenses and Leased Space*	$14,550	0.0	$4,376	$2,899	$0	$7,275	50.00%	Table 8.4 FTE and Operating
X	Eligibility Quality Assurance Program Review Documentation System	$61,750	0.0	$18,571	$12,304	$0	$30,875	50.00%	Table 7.1 Row C
Y	**Subtotal**	**$152,157**	**1.0**	**$45,761**	**$30,318**	**$0**	**$76,078**	**NA**	**Row T + Row X**
Audits and Findings									
Z	FTE Costs	$230,001	1.9	$69,172	$45,828	$0	$115,001	50.00%	Sum Row AA through Row AC
AA	*FTE Salary, PERA, Medicare*	$158,406	1.9	$47,640	$31,563	$0	$79,203	50.00%	Table 8.5 FTE and Operating
AB	*FTE AED, SAED, STD and HLD*	$42,495	0.0	$12,780	$8,467	$0	$21,248	50.00%	Table 8.5 FTE and Operating
AC	*FTE Operating Expenses and Leased Space*	$29,100	0.0	$8,752	$5,798	$0	$14,550	50.00%	Table 8.5 FTE and Operating
AD	**Subtotal**	**$230,001**	**1.9**	**$69,172**	**$45,828**	**$0**	**$115,001**	**NA**	**Sum Row Z**
Caseload Reduction									
AE	Savings from Disenrolling Members	($16,453,273)	0.0	($3,818,331)	($922,159)	$0	($11,712,783)	NA	Table 6.1 Row V
AF	**Total Request**	**($590,849)**	**5.9**	**$461,138**	**$1,936,919**	**$0**	**($2,988,906)**	**NA**	**Row G + Row M + Row S + Row Y + Row AD + Row AE**

Table 2.2
Summary by Initiative
FY 2023-24 and Ongoing

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
County Administration Funding									
A	County Administration Funding Shortfall	$12,398,333	0.0	$1,503,738	$2,662,929	$0	$8,231,666	NA	Sum: A.1 + A.2
A.1	*Enhanced*	$8,130,000	0.0	$733,523	$1,298,977	$0	$6,097,500	75.00%	Table 3 Row A
A.2	*Non-enhanced*	$4,268,333	0.0	$770,215	$1,363,952	$0	$2,134,166	50.00%	Table 3 Row B
B	Allocation Methodology Contractor	$100,400	0.0	$30,195	$20,005	$0	$50,200	50.00%	Table 4.2 Row G
C	FTE Costs	$121,486	1.0	$36,537	$24,206	$0	$60,743	50.00%	Sum Row D through Row F
D	*FTE Salary, PERA, Medicare*	$91,570	1.0	$27,539	$18,246	$0	$45,785	50.00%	Table 8.1 FTE and Operating
E	*FTE AED, SAED, STD and HLD*	$22,366	0.0	$6,727	$4,456	$0	$11,183	50.00%	Table 8.1 FTE and Operating
F	*FTE Operating Expenses and Leased Space*	$7,550	0.0	$2,271	$1,504	$0	$3,775	50.00%	Table 8.1 FTE and Operating
G	**Subtotal**	**$12,620,219**	**1.0**	**$1,570,470**	**$2,707,140**	**$0**	**$8,342,609**	**NA**	**Sum Row A + Row B + Row C**
County Incentive Program									
H	Increase Program by 20% of Funding Requested for County Administration	$2,479,667	0.0	$2,479,667	$0	$0	$0	0.00%	Total Funds in Row A * 20.0%
I	FTE Costs	$101,434	1.0	$30,507	$20,210	$0	$50,717	50.00%	Sum Row J through Row L
J	*FTE Salary, PERA, Medicare*	$73,180	1.0	$22,009	$14,581	$0	$36,590	50.00%	Table 8.2 FTE and Operating
K	*FTE AED, SAED, STD and HLD*	$20,704	0.0	$6,227	$4,125	$0	$10,352	50.00%	Table 8.2 FTE and Operating
L	*FTE Operating Expenses and Leased Space*	$7,550	0.0	$2,271	$1,504	$0	$3,775	50.00%	Table 8.2 FTE and Operating
M	**Subtotal**	**$2,581,101**	**1.0**	**$2,510,174**	**$20,210**	**$0**	**$50,717**	**NA**	**Sum Row H + Row I**
Management Evaluation Reviews									
N	FTE Costs	$115,414	1.0	$34,711	$22,996	$0	$57,707	50.00%	Sum Row O through Row R
O	*FTE Salary, PERA, Medicare*	$73,180	1.0	$22,009	$14,581	$0	$36,590	50.00%	Table 8.3 FTE and Operating
P	*FTE AED, SAED, STD and HLD*	$20,704	0.0	$6,227	$4,125	$0	$10,352	50.00%	Table 8.3 FTE and Operating
Q	*FTE Operating Expenses and Leased Space*	$7,550	0.0	$2,271	$1,504	$0	$3,775	50.00%	Table 8.3 FTE and Operating
R	*Travel*	$13,980	0.0	$4,204	$2,786	$0	$6,990	50.00%	Table 5 Row I
S	**Subtotal**	**$115,414**	**1.0**	**$34,711**	**$22,996**	**$0**	**$57,707**	**NA**	**Sum Row N**
Quality Assurance									
T	FTE Costs	$85,880	1.0	$25,829	$17,111	$0	$42,940	50.00%	Sum Row U through Row X
U	*FTE Salary, PERA, Medicare*	$58,916	1.0	$17,719	$11,739	$0	$29,458	50.00%	Table 8.4 FTE and Operating
V	*FTE AED, SAED, STD and HLD*	$19,414	0.0	$5,839	$3,868	$0	$9,707	50.00%	Table 8.4 FTE and Operating
W	*FTE Operating Expenses and Leased Space*	$7,550	0.0	$2,271	$1,504	$0	$3,775	50.00%	Table 8.4 FTE and Operating
X	Eligibility Quality Assurance Program Review Documentation System	$19,500	0.0	$5,865	$3,885	$0	$9,750	50.00%	Table 7.2 Row C
Y	**Subtotal**	**$105,380**	**1.0**	**$31,694**	**$20,996**	**$0**	**$52,690**	**NA**	**Row T + Row X**
Audits and Findings									
Z	FTE Costs	$222,920	2.0	$67,042	$44,418	$0	$111,460	50.00%	Sum Row AA through Row AC
AA	*FTE Salary, PERA, Medicare*	$164,750	2.0	$49,548	$32,827	$0	$82,375	50.00%	Table 8.5 FTE and Operating
AB	*FTE AED, SAED, STD and HLD*	$43,070	0.0	$12,953	$8,582	$0	$21,535	50.00%	Table 8.5 FTE and Operating
AC	*FTE Operating Expenses and Leased Space*	$15,100	0.0	$4,541	$3,009	$0	$7,550	50.00%	Table 8.5 FTE and Operating
AD	**Subtotal**	**$222,920**	**2.0**	**$67,042**	**$44,418**	**$0**	**$111,460**	**NA**	**Sum Row Z**
Caseload Reduction									
AE	Savings from Disenrolling Members	($32,906,546)	0.0	($7,636,662)	($1,844,318)	$0	($23,425,566)	NA	Table 6.2 Row V
AF	**Total Request**	**($17,261,512)**	**6.0**	**($3,422,571)**	**$971,442**	**$0**	**($14,810,383)**	**NA**	**Row G + Row M + Row S + Row Y + Row AD + Row AE**

Table 3.1 County Administration Funding Shortfall									
Row	**Label**	**FFP**	**Total Funds**	**State Funds**	**General Fund**	**Healthcare Affordability and Sustainability Fee Cash Fund**	**Local Funds**	**Federal Funds**	**Notes/Calculations**
A	Total Allocations-Enhanced	75%	$8,130,000	$1,219,500	$733,523	$485,977	$813,000	$6,097,500	State Funds/Local Funds = Row C* Percent of State/Local Share Enhanced
B	Total Allocations-Non-Enhanced	50%	$4,268,333	$1,280,500	$770,215	$510,285	$853,667	$2,134,166	State Funds/Local Funds = Row C - Row A
C	**Total Allocations**		**$12,398,333**	**$2,500,000**	**$1,503,738**	**$996,262**	**$1,666,667**	**$8,231,666**	**Total: Row A + Row B**

Table 4.1- Contractor Funding for County Allocation FY 2022-23			
Row	**Description**	**Value**	**Source**
Stakeholder Engagement & Policy Development			
A	Expected Number of Hours	175	Department Estimate
B	Hourly Rate	$291	Department Standard Costs
C	**Subtotal**	**$50,925**	**Row A * Row B**
Allocation Methodology			
D	Expected Number of Hours	1,000	Department Estimate
E	Hourly Rate	$202	Average of costs in category on preferred vendor list [Analytics, Evaluation, Research]
F	**Subtotal**	**$202,000**	**Row D * Row E**
G	**Grand Total**	**$252,925**	**Row C + Row F**

Table 4.2 - Contractor Funding for County Allocation FY 2023-24 and Ongoing			
Row	**Description**	**Value**	**Source**
Stakeholder Engagement & Policy Development			
A	Expected Number of Hours	40	Department Estimate
B	Hourly Rate	$300	Department Standard Costs
C	**Subtotal**	**$12,000**	**Row A * Row B**
Allocation Methodology			
D	Expected Number of Hours	425	Department Estimate
E	Hourly Rate	$208	Average of costs in category on preferred vendor list [Analytics, Evaluation, Research]
F	**Subtotal**	**$88,400**	**Row D * Row E**
G	**Grand Total**	**$100,400**	**Row C + Row F**

Table 5- FTE Travel Costs FY 2022-23 and Ongoing			
Row	**Description**	**Value**	**Source**
Travel for Management Evaluation Reviews			
A	Expected Number of In-State Trips Per Year	52	Department Estimate (one trip per week time 1.0 FTE)
B	Average Distance in Miles	300	Department Estimate
C	Total Mileage	15,600	Row A * Row B
D	Reimbursement Rate	$0.55	State of Colorado Published Rate
E	**Subtotal Mileage**	**$8,580**	**Row C * Row D**
F	Overnight Trips	12	Department Estimate (two trips per month * 1.0 FTE)
G	Per Diem for Hotel, Meals & Incidentals	$450	Estimate based on current reimbursement rates for a two night, three day trip
H	**Subtotal Overnight Trips**	**$5,400**	**Row F * Row G**
I	**Total**	**$13,980**	**Row E + Row H**

Table 6.1: FY 2022-23 Estimated Caseload Reductions and Cost Savings by Population

Row	Item	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69 133% FPL	MAGI Adults	MAGI Eligible Children	SB 11-008 Eligible Children	Children 0-205% (Medical and Dental)	Children 206-260% (Medical and Dental)	Prenatal 0-205%	Prenatal 206-260%	TOTAL	Notes/Calculations
A	Estimated Percentage Effect on Caseload	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	Based on State of Colorado Statewide Single Audit - Fiscal Year Ended June 30, 2020, estimate 3% total ineligible individuals and Department requested FTE resolving 25% of issues = 0.75% total disenrollment
Medical Services Premiums												
B	Total Caseload	188,511	79,420	400,760	419,425	66,117					1,154,233	From the FY 21-22 S-1A "Medical Services Premiums" Request, Exhibit B (FY 22-23 projected caseload)
C	Estimated Affected Caseload	1,414	596	3,006	3,146	496					8,657	Row A * Row B
D	Per Capita Costs	$3,246.34	$2,890.58	$4,069.81	$2,402.07	$1,859.76					NA	From the FY 21-22 S-1A "Medical Services Premiums" Request, Exhibit C (FY 22-23 projected per Capita costs)
E	Portion of Year Affected	50.00%	50.00%	50.00%	50.00%	50.00%					50.00%	Half year impact
F	Subtotal: Savings	$2,294,890	$860,887	$6,116,314	$3,778,081	$461,107	N/A				$13,511,279	Row C * Row D * Row E
G	Federal Medical Assistance Percentage	50.00%	90.00%	90.00%	50.00%	65.00%					NA	Federal Financial Participation Rate
H	General Fund Impact	$1,147,445	$0	$0	$1,889,040	$161,387					$3,197,872	For General-Funded Populations, Row F - Row J, otherwise $0
I	CHASE Cash Fund Impact	$0	$86,089	$611,631	$0	$0					$697,720	For CHASE-Funded Populations, Row F - Row J, otherwise $0
J	Federal Funds Impact	$1,147,445	$774,798	$5,504,683	$1,889,041	$299,720					$9,615,687	Row F * Row G
Behavioral Health Capitation												
K	Total Caseload	188,511	79,420	400,760	419,425	66,117					1,154,233	From the FY 21-22 S-2A "Bnehavioral Health" Request, Exhibit DD (FY22-23 Behavioral Health Capitation projected caseload)
L	Estimated Affected Caseload	1,414	596	3,006	3,146	496					8,657	Row A * Row K
M	Per Capita Costs	$459.30	$304.46	$787.47	$360.40	$360.40					NA	From the FY 21-22 S-2A "Bnehavioral Health" Request, Exhibit DD (FY22-23 projected Behavioral Health Capitation per Capita costs)
N	Portion of Year Affected	50.00%	50.00%	50.00%	50.00%	50.00%	N/A				50.00%	Half year impact
O	Subtotal: Savings	$324,687	$90,676	$1,183,449	$566,853	$89,357					$2,255,022	Row L * Row M * Row N
P	Federal Medical Assistance Percentage	50.00%	90.00%	90.00%	50.00%	65.00%					NA	Federal Financial Participation Rate
Q	General Fund Impact	$162,343	$0	$0	$283,426	$31,275					$477,044	For General-Funded Populations, Row O - Row S, otherwise $0
R	CHASE Cash Fund Impact	$0	$9,068	$118,345	$0	$0					$127,413	For CHASE-Funded Populations, Row O - Row S, otherwise $0
S	Federal Funds Impact	$162,344	$81,608	$1,065,104	$283,427	$58,082					$1,650,565	Row O * Row P
CHP+												
Q	Total Caseload						41,890	27,875	325	497	70,587	From the FY 21-22 S-3 "Children's Basic Health Plan" Request, Exhibit C4 (avg FY22-23 projected caseload)
R	Estimated Affected Caseload						314	209	2	4	529	Row A * Row Q
S	Per Capita Costs			N/A			$2,512	$2,432	$12,447	$12,344	NA	From the FY 21-22 S-3 "Children's Basic Health Plan" Request, Exhibit C4 (avg FY22-23 projected per Capita costs)
T	Portion of Year Affected						50.00%	50.00%	50.00%	50.00%	50.00%	Half year impact
U	Subtotal: Savings						$394,583	$254,212	$15,170	$23,007	$686,972	Row R * Row S * Row T
V	Total Savings	$2,619,577	$951,563	$7,299,763	$4,344,934	$550,464	$394,583	$254,212	$15,170	$23,007	$16,453,273	Row F + Row O + Row U
W	Federal Medical Assistance Percentage	50.00%	90.00%	90.00%	50.00%	65.00%	65.00%	65.00%	65.00%	65.00%	NA	Federal Financial Participation Rate
X	General Fund Impact	$1,309,789	$0	$0	$2,172,467	$192,662	$138,104	$0	$5,309	$0	$3,818,331	For General-Funded Populations, Row V - Row Z, otherwise $0
Y	CHASE Cash Fund Impact	$0	$95,156	$729,976	$0	$0	$0	$88,974	$0	$8,052	$922,159	For CHASE-Funded Populations, Row V - Row Z, otherwise $0
Z	Federal Funds Impact	$1,309,789	$856,407	$6,569,787	$2,172,467	$357,802	$256,479	$165,238	$9,861	$14,955	$11,712,784	Row V * Row W

Table 6.2: FY 2023-24 Estimated Caseload Reductions and Cost Savings by Population

Row	Item	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69 133% FPL	MAGI Adults	MAGI Eligible Children	SB 11-008 Eligible Children	Children 0-205% (Medical and Dental)	Children 206-260% (Medical and Dental)	Prenatal 0-205%	Prenatal 206-260%	TOTAL	Notes/Calculations
A	Estimated Percentage Effect on Caseload	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	Based on State of Colorado Statewide Single Audit - Fiscal Year Ended June 30, 2020, estimate 3% total ineligible individuals and Department requested FTE resolving 25% of issues = 0.75% total disenrollment
Medical Services Premiums												
B	Total Caseload	188,511	79,420	400,760	419,425	66,117					1,154,233	From the FY 21-22 S-1A "Medical Services Premiums" Request, Exhibit B (FY 22-23 projected caseload)
C	Estimated Affected Caseload	1,414	596	3,006	3,146	496					8,657	Row A * Row B
D	Per Capita Costs	$3,246.34	$2,890.58	$4,069.81	$2,402.07	$1,859.76					NA	From the FY 21-22 S-1A "Medical Services Premiums" Request, Exhibit C (FY 22-23 projected per Capita costs)
E	Portion of Year Affected	100.00%	100.00%	100.00%	100.00%	100.00%					100.00%	Half year impact
F	Subtotal: Savings	$4,589,781	$1,721,774	$12,232,628	$7,556,162	$922,213	N/A				$27,022,558	Row C * Row D * Row E
G	Federal Medical Assistance Percentage	50.00%	90.00%	90.00%	50.00%	65.00%					NA	Federal Financial Participation Rate
H	General Fund Impact	$2,294,890	$0	$0	$3,778,081	$322,775					$6,395,746	For General-Funded Populations, Row F - Row J, otherwise $0
I	CHASE Cash Fund Impact	$0	$172,177	$1,223,263	$0	$0					$1,395,440	For CHASE-Funded Populations, Row F - Row J, otherwise $0
J	Federal Funds Impact	$2,294,891	$1,549,597	$11,009,365	$3,778,081	$599,438					$19,231,372	Row F * Row G
Behavioral Health Capitation												
K	Total Caseload	188,511	79,420	400,760	419,425	66,117					1,154,233	From the FY 21-22 S-2A "Bnehavioral Health" Request, Exhibit DD (FY22-23 Behavioral Health Capitation projected caseload)
L	Estimated Affected Caseload	1,414	596	3,006	3,146	496					8,657	Row A * Row K
M	Per Capita Costs	$459.30	$304.46	$787.47	$360.40	$360.40					NA	From the FY 21-22 S-2A "Bnehavioral Health" Request, Exhibit DD (FY22-23 projected Behavioral Health Capitation per Capita costs)
N	Portion of Year Affected	100.00%	100.00%	100.00%	100.00%	100.00%	N/A				100.00%	Half year impact
O	Subtotal: Savings	$649,373	$181,352	$2,366,899	$1,133,706	$178,714					$4,510,044	Row L * Row M * Row N
P	Federal Medical Assistance Percentage	50.00%	90.00%	90.00%	50.00%	65.00%					NA	Federal Financial Participation Rate
Q	General Fund Impact	$324,686	$0	$0	$566,853	$62,550					$954,089	For General-Funded Populations, Row O - Row S, otherwise $0
R	CHASE Cash Fund Impact	$0	$18,135	$236,690	$0	$0					$254,825	For CHASE-Funded Populations, Row O - Row S, otherwise $0
S	Federal Funds Impact	$324,687	$163,217	$2,130,209	$566,853	$116,164					$3,301,130	Row O * Row P
CHP+												
Q	Total Caseload						41,890	27,875	325	497	70,587	From the FY 21-22 S-3 "Children's Basic Health Plan" Request, Exhibit C4 (avg FY22-23 projected caseload)
R	Estimated Affected Caseload						314	209	2	4	529	Row A * Row Q
S	Per Capita Costs			N/A			$2,512	$2,432	$12,447	$12,344	NA	From the FY 21-22 S-3 "Children's Basic Health Plan" Request, Exhibit C4 (avg FY22-23 projected per Capita costs)
T	Portion of Year Affected						100.00%	100.00%	100.00%	100.00%	100.00%	Half year impact
U	Subtotal: Savings						$789,167	$508,423	$30,340	$46,014	$1,373,944	Row R * Row S * Row T
V	Total Savings	$5,239,154	$1,903,126	$14,599,527	$8,689,868	$1,100,927	$789,167	$508,423	$30,340	$46,014	$32,906,546	Row F + Row O + Row U
W	Federal Medical Assistance Percentage	50.00%	90.00%	90.00%	50.00%	65.00%	65.00%	65.00%	65.00%	65.00%	NA	Federal Financial Participation Rate
X	General Fund Impact	$2,619,577	$0	$0	$4,344,934	$385,324	$276,208	$0	$10,619	$0	$7,636,662	For General-Funded Populations, Row V - Row Z, otherwise $0
Y	CHASE Cash Fund Impact	$0	$190,313	$1,459,953	$0	$0	$0	$177,948	$0	$16,105	$1,844,318	For CHASE-Funded Populations, Row V - Row Z, otherwise $0
Z	Federal Funds Impact	$2,619,577	$1,712,813	$13,139,574	$4,344,934	$715,603	$512,959	$330,475	$19,721	$29,909	$23,425,565	Row V * Row W

Table 7.1- Contractor Funding for Eligibility Quality Assurance Program Review System FY 2022-23			
Row	Description	Value	Source
Development Costs			
A	Expected Number of Hours	325	Department Estimate
B	Hourly Rate	$190	Department Standard Costs for Technology
C	Total	$61,750	Row A * Row B

Table 7.2 - Contractor Funding for for Eligibility Quality Assurance Program Technology Improvements FY 2023-24 and Ongoing			
Row	Description	Value	Source
Ongoing Costs			
A	Expected Number of Hours	100	Department Estimate
B	Hourly Rate	$195	Department Standard Costs for Technology
C	Total	$19,500	Row A * Row B

Table 8.1
County Administration FTE Calculations

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund Source**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
ADMINISTRATOR V	1.0	July	General Fund	$88,044	$91,570	$91,570	
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$88,044**	**$91,570**	**$91,570**	
Centrally Appropriated Costs							
Cost Center	**FTE Year 1**	**FTE Year 2+**	**Cost or Percentage**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Health, Life, Dental	1.0	1.0	$14,086	$14,086	$14,086	$14,086	
Short-Term Disability	-	-	0.16%	$125	$130	$130	
Amortization Equalization Disbusement	-	-	5.00%	$3,918	$4,075	$4,075	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$3,918	$4,075	$4,075	
Centrally Appropriated Costs Total				**$22,047**	**$22,366**	**$22,366**	
Operating Expenses							
Ongoing Costs	**FTE Year 1**	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Supplies	1.0	1.0	$500	$500	$500	$500	
Telephone	1.0	1.0	$450	$450	$450	$450	
Other	1.0	1.0	$0	$0	$0	$0	
Subtotal				*$950*	*$950*	*$950*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	
Other	1.0		$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	
Total Operating				**$7,950**	**$950**	**$950**	
Leased Space							
	FTE Year 1	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	1.0	1.0	$6,600	**$6,600**	**$6,600**	**$6,600**	

Table 8.2
County Incentives Program FTE Calculations

Personal Services

Position Classification	**FTE**	**Start Month**	**State Fund Source**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
ADMINISTRATOR IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$70,362**	**$73,180**	**$73,180**	

Centrally Appropriated Costs

Cost Center	**FTE Year 1**	**FTE Year 2+**	**Cost or Percentage**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Health, Life, Dental	1.0	1.0	$14,086	$14,086	$14,086	$14,086	
Short-Term Disability	-	-	0.16%	$100	$104	$104	
Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Centrally Appropriated Costs Total				**$20,448**	**$20,704**	**$20,704**	

Operating Expenses

Ongoing Costs	**FTE Year 1**	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Supplies	1.0	1.0	$500	$500	$500	$500	
Telephone	1.0	1.0	$450	$450	$450	$450	
Other	1.0	1.0	$0	$0	$0	$0	
Subtotal				*$950*	*$950*	*$950*	

One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	
Other	1.0		$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	
Total Operating				**$7,950**	**$950**	**$950**	

Leased Space

	FTE Year 1	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	1.0	1.0	$6,600	**$6,600**	**$6,600**	**$6,600**	

Table 8.3
Management Evaluations FTE Calculations

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund Source**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
COMPLIANCE SPECIALIST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$70,362**	**$73,180**	**$73,180**	

Centrally Appropriated Costs							
Cost Center	**FTE Year 1**	**FTE Year 2+**	**Cost or Percentage**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Health, Life, Dental	1.0	1.0	$14,086	$14,086	$14,086	$14,086	
Short-Term Disability	-	-	0.16%	$100	$104	$104	
Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Centrally Appropriated Costs Total				**$20,448**	**$20,704**	**$20,704**	

Operating Expenses							
Ongoing Costs	**FTE Year 1**	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Supplies	1.0	1.0	$500	$500	$500	$500	
Telephone	1.0	1.0	$450	$450	$450	$450	
Other	1.0	1.0	$0	$0	$0	$0	
Subtotal				*$950*	*$950*	*$950*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	
Other	1.0		$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	
Total Operating				**$7,950**	**$950**	**$950**	

Leased Space							
	FTE Year 1	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	1.0	1.0	$6,600	**$6,600**	**$6,600**	**$6,600**	

Table 8.4
Quality Assurance FTE Calculations

Personal Services

Position Classification	FTE	Start Month	State Fund Source	FY 2022-23	FY 2023-24	FY 2024-25	Notes
COMPLIANCE SPECIALIST III	1.0	July	General Fund	$56,648	$58,916	$58,916	
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$56,648**	**$58,916**	**$58,916**	

Centrally Appropriated Costs

Cost Center	FTE Year 1	FTE Year 2+	Cost or Percentage	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Health, Life, Dental	1.0	1.0	$14,086	$14,086	$14,086	$14,086	
Short-Term Disability	-	-	0.16%	$81	$84	$84	
Amortization Equalization Disbusement	-	-	5.00%	$2,521	$2,622	$2,622	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$2,521	$2,622	$2,622	
Centrally Appropriated Costs Total				**$19,209**	**$19,414**	**$19,414**	

Operating Expenses

Ongoing Costs	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Supplies	1.0	1.0	$500	$500	$500	$500	
Telephone	1.0	1.0	$450	$450	$450	$450	
Other	1.0	1.0	$0	$0	$0	$0	
Subtotal				*$950*	*$950*	*$950*	

One-Time Costs (Capital Outlay)	FTE		Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Furniture	1.0		$5,000	$5,000	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	
Other	1.0		$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	
Total Operating				**$7,950**	**$950**	**$950**	

Leased Space

	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Leased Space	1.0	1.0	$6,600	**$6,600**	**$6,600**	**$6,600**	

Department Priority: R-09
Request Detail: Office of Community Living Program Enhancements

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$10,802,403,570	$2,452,715	$2,443,390
FTE	0.0	0.0	0.0
General Fund	$2,734,007,135	$1,872,153	$1,867,490
Cash Funds	$1,206,622,593	$0	$0
Reappropriated Funds	$83,318,813	$0	$0
Federal Funds	$6,778,455,029	$580,562	$575,900

Summary of Request

The Department of Health Care Policy & Financing requests funding to increase rates and expand benefits for services offered through the Home and Community-Based Services (HCBS) waivers, increase provider bed capacity, and create additional opportunities for care in the community. Specifically, the department requests funding to: expand the current Home Delivered Meals (HDM) service offered in HCBS waivers; increase the rate for the Transitional Living Program (TLP); create a negotiated rate for the Supported Living Program (SLP); align the rates for several long-term care case management activities; align service limits and rates between the Children's Habilitation Residential Program (CHRP) waiver and other HCBS waivers; and maintain the current funding and enrollment levels of the state-only programs for people with intellectual and developmental disabilities. These changes would create parity in reimbursement rates and utilization limits for services, expand access to community-based services, and reduce unnecessary institutional care.

The total request represents an increase of less than 0.5% from the department's FY 2021-22 Long Bill total funds appropriation.

Current Program

The Office of Community Living manages programs for children and adults with disabilities. This includes oversight of the department's ten Home and Community-Based Services (HCBS) programs. Each HCBS program is an extra set of Health First Colorado benefits that a member could qualify for in certain cases. These benefits help members remain in their home and community. In addition to managing Health First Colorado programs, the Office of Community Living monitors, trains, and provides technical assistance to case management agencies and stakeholders. The department currently manages six HCBS waivers for members without intellectual or developmental disabilities (IDD): Elderly, Blind, and Disabled (EBD), Community Mental Health Supports (CMHS), Children's Home and Community-Based Services (CHCBS), Brain Injury (BI), Children with Life Limiting Illness (CLLI), and Spinal Cord Injury (SCI) waivers. In FY 2021-22, average monthly enrollment for these waivers is projected to be 33,827 members. For FY 2021-22, the department was appropriated almost $800 million for these six waivers.

The department also manages four HCBS waiver programs for people with intellectual or developmental disabilities (IDD): Adult Comprehensive Services (HCBS-DD), Supported Living Services (HCBS-SLS), Children's Extensive Services (HCBS-CES), and Children's Habilitation Residential Program (HCBS-CHRP). These programs provide services such as residential care, day habilitation services and behavioral services, as well as case management, and are delivered through a variety of approved providers. In FY 2021-22, average monthly enrollment for the DD, SLS, CES, and CHRP waivers is projected to be 14,891 members. For FY 2021-22, the department was appropriated approximately $675 million for these waivers.

Problem or Opportunity

There are three problems this request aims to address: maintaining current levels of access for HCBS services, equalizing rates and service limitations for comparable services, and establishing rates that encourage community care over institutional care.

Home Delivered Meals Service

The department currently manages six Home and Community-Based Service (HCBS) waivers that offer home delivered meals as a benefit.[1] The HDM benefit includes nutritional counseling, planning, preparation, and the delivery of meals. 385 members used the service in FY 2020-21 and the total expenditure was just over $1 million. However, eligibility for the service is limited to members who are either transitioning from an institutional setting to a home and

[1] These waivers include: Elderly, Blind, and Disabled (EBD), Community Mental Health Supports (CMHS), Brain Injury (BI), Spinal Cord Injury (SCI), Developmental Disabilities (DD), and Supported Living Services (SLS)

community-based setting, transitioning from a more restrictive community setting to a less restrictive community setting, or experiencing a change in life circumstance. The department has identified an opportunity to improve the health and welfare for Medicaid members by making the current home-delivered meal benefit available to members for 30 days after they have been discharged from a hospital. Studies have shown that home-delivered meal programs that are available for members after leaving a hospital have been successful in reducing the number of hospital readmissions for those members and also in improving their health outcomes.[2] Allowing this service to be used by HCBS members leaving a hospital will reduce hospital readmissions and allow members to experience better outcomes while receiving care in a less-restrictive setting.

Rates for High Acuity Brain Injury Waiver Members

The Transitional Living Program (TLP) is a benefit only available through the Brain Injury (BI) waiver and offers intensive services in an assisted living setting for recently injured people with brain injuries. The service is designed to help members transition back into the community post-injury, usually from the hospital. The residential program is only available within 18 months after the first brain injury or three months after the second brain injury with a hospital stay. Utilization is generally limited to six months. Although demand is higher, there are only between two and four utilizers of this service each year due to provider capacity issues. The program has proven extremely successful in reducing hospital readmissions – since the beginning of the program in 2014 only one TLP utilizer has been readmitted to the hospital.

The Supported Living Program (SLP) is a benefit only available through the BI waiver and is a specialized assisted living service for people with brain injuries. Services offered through SLP include 24-hour oversight, assessment, training and supervision of self-care, medication management, behavioral management, and cognitive supports.

The current rate structures for TLP and SLP prevent some members from being able to discharge from a hospital and move into a community setting. At this point in time, the TLP has five different tiers of rates and the SLP has six different tiers of rates. Currently, the highest rates are insufficient to provide services for certain members and have led to providers restricting the number of beds they hold open for HCBS members. By increasing rates for high-acuity BI members, the department will create opportunities for members to receive care in the community versus a more restrictive and costly setting. Increasing rates for TLP and SLP will incentivize care in the community and capitalize on opportunities that have been shown to lead to better member outcomes.

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5620506/

Services and Supports for Children with Complex Needs

CHRP provides services and supports for children and youth who have an intellectual or developmental disability and very high needs. Often, a member's high needs put them in need of out-of-home placement. Services provided through CHRP help members learn and maintain the skills needed to live in their communities. The department's FY 2018-19 R-12 "Transfer Children's Residential Habilitation Program Waiver" request transferred administration of CHRP from Colorado Department of Human Services (CDHS) to the Department of Health Care Policy and Financing. Part of this change, among other things, included eliminating the requirement that children or youth seeking enrollment in CHRP be in the foster care system. The department believes this led to more appropriate residential placements, including the family home when suitable. As a result of the eligibility changes for CHRP, enrollment has grown substantially over the past several years. In FY 2020-21, enrollment in CHRP grew by 69.8%. Because CHRP is currently the only waiver that offers out-of-home placement for children with developmental disabilities, the growth in enrollment over FY 2019-20 and FY 2020-21 indicates that the expansion of the waiver through the FY 2018-19 R-12 request continues to be effective in targeting children and youth with a developmental disability who have very high needs and require an out-of-home placement. At the time of this request, there are 163 members authorized for services through CHRP.

Members enrolled in CHRP have access to respite care, which provides temporary relief for the member's primary caregiver. Respite care may be provided in the community, in the private residence of the respite care provider, or in the member's home. Members enrolled in CHRP are limited to 28 days, or 1,120 15-minute units, of respite care per service plan year. Members enrolled in the Children's Extensive Support Services (CES) waiver can also access respite care. CES members, however, are able to access a maximum of 30 days and an additional 1,880 15-minute units per service plan year. Members on CES who meet their respite unit limit can request additional care through an exceptions process with the department. There is currently no exceptions process for members on CHRP who meet their respite unit limit. Additionally, members enrolled in CES can access group respite, which is paid at the same rate as individual respite. Group respite is not currently offered for members enrolled in CHRP.

Members enrolled in CHRP can access residential supports if they require out-of-home placement. The out-of-home residential services offered on CHRP are dependent on an individual member's needs and include foster home, group home, and Residential Child Care Facilities (RCCF). Host home residential care is currently not offered through CHRP. Although many residential service providers offer both foster home and host home care to members enrolled in an HCBS waiver, the reimbursement rates for these services are not the same. Currently, the rate for foster homes is lower than that of host homes across all support levels.

Children and youth who receive services on CHRP have very high needs that often require extensive care and out-of-home placement. Right now, children on CHRP are unable to access the same amount of respite care as children on the CES waiver even though the need for that service is comparable between the two populations. In addition, the department currently reimburses residential habilitation providers more if they serve members on the Developmental Disabilities (DD) waiver compared to CHRP clients. By eliminating these disparities, the department will ensure that members currently being served are not being prevented from accessing critically important care and that there is capacity for vital services, such as residential care, as enrollment in the waiver increases.

Case Management Quality Performance Initiatives

There are currently 49 Case Management Agencies (CMAs), which include 24 Single Entry Points (SEPs), 20 Community Centered Boards (CCBs), and five private agencies that provide case management and administrative functions such as intake, functional eligibility determinations, and appeals for members who need long term services and supports. Case management provides members with the needed services and supports to facilitate members living in the community setting of their choice. Members who are enrolled in an HCBS waiver receive case management for comprehensive ongoing benefit coordination, monitoring of service delivery, and oversight of member health and welfare. Case management includes facilitating a member's enrollment in a program that meets their level of care requirements, locating, coordinating, and monitoring needed HCBS waiver services, and coordinating with non-waiver resources, including medical, social, and educational resources. Case managers are vital in guaranteeing that waiver services are being provided effectively and equitably. The majority of case management is provided through CCBs and SEP agencies. CCBs provide all case management services for members enrolled in an Intellectual and Developmental Disabilities (IDD) waiver. SEPs provide case management services for members enrolled in all other HCBS waivers. In FY 2021-22, average monthly caseload for SEPs and CCBs is projected to be 31,932 and 15,023, respectively. For FY 2021-22, the department was appropriated $98,633,608 for case management services.

Currently, case management rates vary across several case management activities between SEPs and CCBs. House Bill 21-1187, "Long-term Services and Support Case Management Redesign," updated case management statutes to require the department to establish a redesigned case management system with "Case Management Agencies" replacing current SEPs and CCBs. Eventually, the two agencies will need to be paid the same rate as CCBs and SEPs will no longer exist and all case management will be conducted by a CMA for all waiver programs, which is slated to occur in 2024. This request will align several rates between SEPs and CCBs and will be the first step in this process of redesigning the case management system,

which will begin to bring alignment of rates bringing the department closer to a conflict-free case management system.

Funding for State General Fund Programs

The department's FY 2019-20 R-16, "Employment First Initiatives and State Programs for People with IDD" request provided funding from the Intellectual and Developmental Disabilities Services Cash Fund (IDD Cash Fund) for state-only programs. This included funding to enroll all members on the State Supported Living Services (state-only SLS) waitlist and to enroll 272 members from Family Support Services Program (FSSP) waitlist. The statutory authorization for the IDD Cash Fund is currently set to expire following FY 2021-22.

The state-only funded programs State Supported Living Services (State SLS) program and Family Support Services Program (FSSP) provide non-residential services to adults and children with intellectual and developmental disabilities (IDD) in need of support and who often do not necessarily qualify for Medicaid. State-only SLS is a state-only program that provides services and supports to qualified individuals so they can remain in their homes and communities with minimal impact to their community and social supports. Examples of services provided through state-only SLS include prevocational services, job coaching and development, respite, specialized habilitation, and supported community connections. Members enrolled in state-only SLS also receive ongoing case management activities, which include intakes and referrals, assessment service plan development, monitoring, and waiting list management. State-only SLS enrollment averaged 609 members per month in FY 2020-21.

FSSP provides financial support for families who have children with developmental disabilities or delays with costs that are beyond those normally experienced by other families. The primary purpose of FSSP is to keep families together in the family home. In order to qualify, a family must have an eligible child living at home or be interested in facilitating a child's return to the home. Examples of services offered through FSSP include medical and dental expenses, additional insurance expenses, respite care and childcare, special equipment, home or vehicle modifications or repairs, family counseling and support groups, recreation and leisure needs, transportation, and homemaker services. FSSP enrollment averaged 4,659 members per month in FY 2020-21.

Following the expiration of the IDD Cash Fund after FY 2021-22, current programs that are partially funded using IDD Cash Fund will lose funding if a new source is not secured. Money from the FY 2019-20 R-16 "Employment First Initiatives and State Programs for People with IDD" request was used to eliminate the waitlist for state-only SLS and enroll 272 people from the FSSP waitlist. Demand for both state-only SLS and FSSP remains very high. At the time of this request, the waitlist for FSSP is 713 individuals. To maintain the current enrollment in these programs and to make certain that individuals and families continue to receive important

direct services and case management resources, funding for these programs will need to be maintained using the General Fund.

Proposed Solution

The department requests $2,452,715 total funds, including $1,872,153 General Fund in FY 2022-23, $2,443,390 total funds, including $1,867,490 General Fund in FY 2023-24, and $1,765,740 total funds including, $1,528,665 General Fund in FY 2024-25 and ongoing in order to increase rates and expand benefits for services offered through the Home and Community-Based Services (HCBS) waivers, increase provider bed capacity, and create additional opportunities for care in the community.

Home Delivered Meal Expansion
The department requests to expand the home delivered meals benefit that is offered on the Elderly, Blind and Disabled (EBD), Community Mental Health Supports (CMHS), Brain Injury (BI), Spinal Cord Injury (SCI), Developmental Disabilities (DD), and Supported Living Services (SLS) waivers. The home delivered meal service includes nutritional counseling, meal planning and preparation, and meal delivery for waiver members who demonstrate an inability to prepare their own meals or who have limited access to nutritious meals. Funding will be used to make this enhanced benefit available to members who have been discharged from a hospital for up to 30 days post-discharge and will be limited to two meals per day.

The department believes that the expansion of this benefit will result in long-term cost savings from avoided hospital readmissions. A study published by the National Institutes of Health[3] evaluated the impacts of a nutrition-focused quality improvement program for malnourished patients that have been hospitalized and found that nutritional interventions diminished the negative effects of malnutrition and improved patient health outcomes. The nutritional support also reduced the per-patient health care costs from patients by avoiding 30-day readmissions and reducing the length of hospital stay.

The HDM benefit is currently only available once for members transitioning from an institutional setting to a home and community-based setting. If this request is not approved, HCBS waiver members who are at a high-risk for malnutrition will continue to be at risk for hospital readmissions post-discharge, which is a far more expensive care setting compared to services offered through the HCBS waivers.

This request aligns with on Step 4 of the Office of State Planning and Budgeting (OSPB) Evidence Continuum due to the volume and rigor of studies conducted that evaluate the

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5620506/

positive health outcomes of home delivered meals. The department plans to evaluate the effectiveness of this benefit by comparing the hospital readmissions before and after this benefit is implemented.

Rates for High Acuity Brain Injury Waivers

The department requests an increase in funding to modify rates for the Transitional Living program (TLP) and create a negotiated rate for high-acuity utilizers of the Supported Living Program (SLP). These changes will increase access to care for high-acuity members on the Brain Injury (BI) waiver, giving them the chance to receive care within the community as opposed to within a hospital setting that is more expensive and restrictive. Additionally, with an accurate reimbursement rate, the department believes more providers will be willing to provide this service, which will improve capacity and access to care for members transitioning back into the community after sustaining a brain injury. The department is aware of members with an acquired brain injury who stay longer than necessary in hospitals due to the lack of TLP beds. A negotiated rate for SLP will allow providers the flexibility to increase staffing and offer services specific to members' needs in order to provide appropriate care.

If this request is not approved, members who require residential services on the BI waiver will continue to face difficulties in finding providers and accessing care, which will lead to members spending more time in hospital settings creating overall higher costs. At this time, due to low reimbursement rates, TLP is limited to only a handful of members each year. Additionally, members' health outcomes could suffer if the member is discharged to the home instead of into a TLP if the member's family does not have the resources to properly care for the member. If a negotiated rate for SLP is not approved, members could end up requiring an emergency enrollment onto the DD waiver or be admitted to the hospital, which are more expensive alternatives that may not as closely meet their level of care requirements. In FY 2021-22, the per capita cost of DD is projected to be $77,361, while the per capita cost of BI is projected to be $64,457.

The department believes this request is on Step 3 "Assess Outcomes" of OSPB's Evidence Continuum because the department could conduct a pre- and post-intervention evaluation using total cost of care in a hospital versus community setting for these members. The department is able to identify members in hospitals that could be discharged earlier if beds were available on these services.

Services and Supports for Children with Complex Needs

The department requests an increase in funding to align unit limits and reimbursement rates with similar services provided through other HCBS waivers. Specifically, the department would like to align rates and unit limits for respite services between the CES and CHRP waivers and to

increase CHRP reimbursement rates for foster home and group home care to align with the rates paid for host home and group residential care on the DD waiver.

If these requests are not approved, members on CHRP who reach their unit limit for respite services could be forced to enroll in CES in order to access the necessary care, which may not as closely fit their level-of-care requirements. Failing to align the rate of foster home on the CHRP waiver with the rate of host home services on the DD waiver will continue to discourage residential providers from offering placements to members on CHRP, which may create capacity issues as CHRP enrollment continues to grow and more members require residential support.

The department believes this request is on Step 2, "Identify Outputs" of OSPB's Evidence Continuum. The department has developed a conceptual link between allowing flexibility for services and supports on CHRP and a decrease in the number of emergency enrollments onto CES. The department collects data on the utilization of services and supports for members enrolled in an HCBS waiver.

Case Management Quality Performance Initiatives

The department requests an increase in funding to improve quality case management and create parity in several rates paid to SEPs and CCBs for case management activities. The department is requesting to align rates for the following services: case management training, appeals, and ongoing monitoring. The department views creating parity in the rates mentioned above as progress towards the goal of improving the quality of case management while implementing case management redesign. Additionally, this funding will be used to implement an annual survey to measure the performance and quality of service provided to members by SEP and CCB case managers. The performance data received from these surveys will be used to develop case management agency annual performance scorecards to better maintain case management expectations and ensure member satisfaction with case management services.

If this request is not approved, there will continue to be disparities in the rates for case management activities that are paid to SEPs and CCBs and will impact the department's implementation of quality case management across the state. Likewise, this creation of parity constitutes the first step in addressing the differences between case management agencies who perform the same administrative activities. Providing high quality and individualized services, which is needed to ensure that members are receiving the most appropriate care that fits their needs while guaranteeing that waiver services are being provided efficiently, effectively, and equitably among all members, is paramount. Further, denying this request will hinder the department's ability to create parity in the rates among case management agencies and create a quality case management system.

The department believes this request is on Step 2, "Identify Outputs" of OSPB's Evidence Continuum. The department has developed a conceptual link between creating parity in the rates paid to case management agencies and a decrease in the average caseload per case manager which will drive higher quality case management. The department will also be able to collect data on performance indicators and member satisfaction if this request is approved.

Funding for State General Fund Programs

The department requests ongoing funding to maintain the current enrollment of state-only programs. If this request is not approved, the state-only programs will not have adequate funding to continue to support the members who are currently enrolled beyond the expiration of the IDD Cash Fund following FY 2021-22. Denying this request will prevent individuals currently waiting to receive support from the FSSP from becoming enrolled in the program and will result in further increases to the FSSP waitlist.

The department believes this request is on Step 2, "Identify Outputs" of OSPB's Evidence Continuum because the department is able to use program data to evaluate progress. With the permanent funding, the department could calculate how many waitlist enrollments were able to remain on the program instead of being disenrolled when the current temporary funding expires.

Evidence Continuum

As identified in the text above, the department believes that different components of this request are at different steps of the evidence continuum.

Theory of Change	This request will create parity in unequal rates and service limitations for related services, establish rates that encourage community care over institutional care, and maintain current levels of access to HCBS services.		
Program Objective	Create parity in reimbursement rates for services, expand access to community-based services, and reduce unnecessary institutional care.		
Outputs Being Measured	Hospital readmission rates, number of malnutrition diagnoses among HCBS waiver members, and case manager caseload sizes.		
Outcomes Being Measured	Hospital readmission rates for members enrolled on an HCBS waiver, emergency enrollments in HCBS waivers, and member satisfaction with case management services.		
Cost/Benefit Ratio	N/A		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	Decreased hospital readmission rates, emergency enrollments between waivers, and the average caseload size per case manager.	N/A	N/A

Continuum Level	Home Delivered Meals Expansion – Step 4 Rates for High Acuity Brain Injury Waivers – Step 3 Services and Supports for Children with Complex Needs – Step 2 Case Management Quality Performance Initiatives – Step 2 Funding for state General Fund Programs- Step 2

Anticipated Outcomes

The department anticipates that funding the initiatives presented in this request will improve member health by meeting existing gaps in care and by expanding current services to accommodate the growing population receiving services through the HCBS waivers. By decreasing the disparity between the services available and the services needed by higher-needs members on the HCBS waivers, the department could improve access to appropriate levels of care for members who are currently being prevented from accessing critically important care by currently imposed limits. Allowing members to receive additional services within their current program will minimize the impact to their community and social supports by allowing them to continue within their current program and will prevent the jeopardization of their health, safety, and wellbeing caused by a deficiency in care. The expansion of services, including home delivered meals, will ensure that members returning from the hospital to their community have the tools necessary to maintain their health.

To evaluate the effectiveness of the expansion of the home delivered meals benefit and the rate increases to SLP and TLP, the department will examine the readmission rate for HCBS members into hospitals. Expansion of these services is expected to decrease the readmission rate, and an observed decrease in the number of hospital readmissions will indicate that HCBS waiver members are not suffering from malnutrition or other health related conditions resulting from inadequate access to care that will otherwise result in their readmission to a hospital.

To evaluate the effectiveness of the implementation of the program changes to CHRP, the department will examine the number of members transitioning from CHRP to CES. An observed decrease in the number of transitions would indicate that the increase to services on CHRP are providing higher-needs members with a more appropriate amount of care and that the gap between the services they need and the services they receive has closed.

To evaluate the effectiveness in the rate changes to case management services, the department will analyze performance data from case management agencies. Data collected from the annual performance surveys, which is included in this request, will provide the department with metrics on member satisfaction with their case management services.

Completion of the rate alignment will move the department one step closer to aligning SEP and CCB operation in pursuit of a conflict-free case management system.

The outcomes in these requests align with the department's Performance Plan long-range goals of improving member health outcomes, improving member access to affordable and high-quality care, providing excellent service to members, and ensuring the right services for the right people at the right price, which are strategic pillars 1, 2, 3, and 4, respectively. HDM has been proven to improve member health by reducing hospital readmissions caused by malnutrition. Increasing rates for TLP and SLP will ensure that members get the right service by increasing access to community-based services when appropriate. Creating parity in case management rates will improve the quality of case management services received by members. Establishing permanent funding for state-only programs will ensure current enrollees could remain on the programs.

Assumptions and Calculations

Home Delivered Meals Expansion

The department calculated the total cost to expand the home delivered meals benefit by starting with the average number of waiver members that were admitted into a hospital for at least one night in FY 2019-20 and FY 2020-21. The department applied an uptake percentage modeled after utilization of the current service. HDM will be limited to two meals per day. The cost of the service will be the number of expected utilizers multiplied by two meals a day for 30 days multiplied by the current rate. A detailed calculation can be found in Tables 3.1 through 3.3 of the Appendix.

Estimated savings from the policy are in the form of a reduction in hospital readmissions within 30 days of discharge. The 2018 study, "From Hospital to Home: Why Nutrition Counts," showed that post-discharge nutrition-focused transition programs reduced hospital readmissions by 29 percent.[4] The department assumes 29% of readmitted hospitals stays within 30 days of discharge will be avoided with this service expansion in the first year of implementation. The department increased this reduction assumption to 41% by FY 2023-24, which is the average of a 29% decline and a 52% decline in hospital readmission cited in two studies.[5] Detailed calculations can be found in Tables 3.1 and 3.2 in Appendix A.

---

[4] https://www.healthaffairs.org/do/10.1377/hblog20200117.329745/full/

[5]https://static1.squarespace.com/static/580a7cb9e3df2806e84bb687/t/6061413fa8a5bd1a2314da3a/1616986432130/FIMC_MTM_Policy_Recommendations.pdf

Expanding the HDM benefit will require extensive rule promulgation, policy development, and stakeholder engagement. Therefore, expected implementation for that service will be January 1, 2023.

Rates for High Acuity Brain Injury Waiver Members

The department estimated the savings associated with the rate change for TLP by taking the difference in costs of serving six members on the TLP at the higher estimated rate and the average annual cost of those same members receiving care within an inpatient hospital setting. The department estimates that the higher SLP rate will be set to a level that is approximately 20% above the tier 6 rate for SLP on the BI waiver. In order to estimate utilization, the department used data from level 7 utilizers of DD residential services. On average, these members use residential services 277 days a year. The department prorated this amount by 50% in the first year to account for an implementation date of January 1, 2023. If the negotiated rate for SLP is not approved, these members will continue to receive care in a higher cost setting. The department believes if a new rate isn't established that members will either end up in the hospital or on the DD waiver through an emergency enrollment. The department used average annual costs for level 7 DD members as a proxy for the higher-cost alternatives in order to estimate potential savings.

The department estimated the savings associated with the rate change for TLP by taking the difference in costs of serving six members on the TLP at the higher estimated rate and the average annual cost of those same members receiving care within an inpatient hospital setting. The department estimates that the higher SLP rate will be set to a level that is approximately 20% above the tier 6 rate for SLP on the BI waiver. In order to estimate utilization, the department used data from level 7 utilizers of DD residential services. On average, these members use residential services 277 days a year. The department prorated this amount by 50% in the first year to account for an implementation date of January 1, 2023. If the negotiated rate for SLP is not approved, these members will continue to receive care in a higher cost setting. The department believes most of these members could qualify for the DD waiver through an emergency enrollment, therefore cost savings will occur if this policy is approved because the level 7 negotiated SLP rate is less than the average cost of a level 7 member on the DD waiver.

The department estimates that savings will offset the cost of creating a negotiated rate for SLP and increasing the rate for TLP on the BI waiver. Savings are expected because greater access to SLP and TLP will reduce the number of days a member stays in the hospital or other more expensive settings. There are several current cases the department is aware of where members are being served in a hospital solely because there are no beds available on TLP or SLP.

See table 5.1 in the Appendix for a more detailed calculation.

Case Management Quality Performance Initiatives

The department estimated the total impact of aligning the rates paid to SEPs and CCBs for the following case management activities: case management training, appeals, and ongoing monitoring. The department assumes that the final aligned rate for each specified case management activity will be the higher of the currently established SEP or CCB rate. To arrive at the total estimated cost, the department multiplied the incremental rate change for each activity by the expected utilization of the service. Expected utilization of the service was forecasted using FY 2020-21 actuals and then applying the projected HCBS waiver enrollment trends for FY 2021-22 and beyond.

Based on the department's current contract for National Core Indicator surveys, the department assumes that 12,000 surveys at an estimated cost of $45 per survey will be needed to adequately sample all case management agencies to measure the performance and quality of service provided to members by SEP and CCB case managers.

Aligning case management rates will require a contract amendment for both SEPs and CCBs and could be implemented July 1, 2022.

Services and Supports for Children with Complex Needs

To estimate the cost of aligning CHRP respite limits with CES respite limits, the department examined the number of members on CHRP who are currently using greater than 90% of their authorized amount of respite services. The department assumes that only members who utilize close to their authorized limit will choose to receive additional units if available. The department assumes that given the opportunity, these high utilizers will choose to access the full amount of the additional respite care that will be available to them. As such, the department has estimated the total impact of allowing high-utilizing members on CHRP to increase their respite utilization that of CES members.

To estimate the cost of aligning the rate for respite on CHRP with the rate for respite on CES and the rate of foster home on CHRP with the rate for residential services on DD, the department reviewed FY 2020-21 claims data to estimate the current utilization for these services. To arrive at the total estimated costs, the department multiplied the incremental rate increase for respite, foster home, and DD residential services by the expected utilization of the service, which was based on FY 2020-21 actuals.

The department assumes that waiver amendments will be required to implement these changes and that amendment approval from the Centers for Medicare & Medicaid Services (CMS) will be received in time for an implementation date of January 1, 2023.

Funding for State General Fund Programs

As part of the department's FY 2021-22 Long Bill Appropriation, $1,291,590 was appropriated from the IDD Cash Fund to partially fund state-only programs. The department assumes that the same amount of General Fund will be needed to backfill the existing funding after the IDD Cash Fund expires following FY 2021-22. This funding will be permanent and will maintain current enrollments in state-only programs. The permanent funding will not be used to expand current services or authorize additional enrollments from the FSSP waitlist enrollments beyond naturally occurring churn.

Table 1.1
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Personal Services Contracts	$540,000	0.0	$270,000	$0	$0	$270,000	50.00%	Table 2.1, Row J
B	(2) Medical Services Premiums	($478,419)	0.0	($239,210)	$0	$0	($239,209)	50.00%	Table 2.1, Sum of Rows A and G
C	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Adult Supported Living Services	$14,924	0.0	$7,462	$0	$0	$7,462	50.00%	Table 2.1, Row D
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State-only Programs, Family Support Services	$371,162	0.0	$371,162	$0	$0	$0	0.00%	Table 2.1, Row O
E	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Adult Comprehensive Services	($11,738)	0.0	($5,869)	$0	$0	($5,869)	50.00%	Table 2.1, Row C
F	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Children's Habilitation Residential Program	$256,567	0.0	$128,284	$0	$0	$128,283	50.00%	Table 2.1, Row N
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State-only Programs, State Supported Living Services	$636,731	0.0	$636,731	$0	$0	$0	0.00%	Table 2.1, Row P
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State-only Programs, State Supported Living Services Case Management	$283,697	0.0	$283,697	$0	$0	$0	0.00%	Table 2.1, Row Q
I	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Case Management for People with Disabilities	$839,791	0.0	$419,896	$0	$0	$419,895	50.00%	Table 2.1, Row I
J	**Total Request**	**$2,452,715**	**0.0**	**$1,872,153**	**$0**	**$0**	**$580,562**		**Sum of Rows A through I**

Table 1.2
Summary by Line Item
FY 2023-24

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Personal Services Contracts	$540,000	0.0	$270,000	$0	$0	$270,000	50.00%	Table 2.2, Row J
B	(2) Medical Services Premiums	($767,782)	0.0	($383,891)	$0	$0	($383,891)	50.00%	Table 2.2, Sum of Rows A and G
C	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Adult Supported Living Services	$16,596	0.0	$8,298	$0	$0	$8,298	50.00%	Table 2.2, Row D
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State-only Programs, Family Support Services	$371,162	0.0	$371,162	$0	$0	$0	0.00%	Table 2.2, Row O
E	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Adult Comprehensive Services	($23,477)	0.0	($11,739)	$0	$0	($11,738)	50.00%	Table 2.2, Row C
F	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Children's Habilitation Residential Program	$513,134	0.0	$256,567	$0	$0	$256,567	50.00%	Table 2.2, Row N
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State-only Programs, State Supported Living Services	$636,731	0.0	$636,731	$0	$0	$0	0.00%	Table 2.2, Row P
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State-only Programs, State Supported Living Services Case Management	$283,697	0.0	$283,697	$0	$0	$0	0.00%	Table 2.2, Row Q
I	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Case Management for People with Disabilities	$873,329	0.0	$436,665	$0	$0	$436,664	50.00%	Table 2.2, Row I
J	**Total Request**	**$2,443,390**	**0.0**	**$1,867,490**	**$0**	**$0**	**$575,900**		**Sum of Rows A through I**

Table 1.3
Summary by Line Item
FY 2024-25

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Personal Services Contracts	$540,000	0.0	$270,000	$0	$0	$270,000	50.00%	Table 2.3, Row J
B	(2) Medical Services Premiums	($1,403,228)	0.0	($701,614)	$0	$0	($701,614)	50.00%	Table 2.3, Sum of Rows A and G
C	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Adult Supported Living Services	$3,344	0.0	$1,672	$0	$0	$1,672	50.00%	Table 2.3, Row D
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State-only Programs, Family Support Services	$371,162	0.0	$371,162	$0	$0	$0	0.00%	Table 2.3, Row O
E	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Adult Comprehensive Services	($87,340)	0.0	($43,670)	$0	$0	($43,670)	50.00%	Table 2.3, Row C
F	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Children's Habilitation Residential Program	$513,134	0.0	$256,567	$0	$0	$256,567	50.00%	Table 2.3, Row N
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State-only Programs, State Supported Living Services	$636,731	0.0	$636,731	$0	$0	$0	0.00%	Table 2.3, Row P
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State-only Programs, State Supported Living Services Case Management	$283,697	0.0	$283,697	$0	$0	$0	0.00%	Table 2.3, Row Q
I	(4) Office of Community Living (A) Division of Intellectual and Development Disabilities (2) Medicaid Programs, Case Management for People with Disabilities	$908,240	0.0	$454,120	$0	$0	$454,120	50.00%	Table 2.3, Row I
J	**Total Request**	**$1,765,740**	**0.0**	**$1,528,665**	**$0**	**$0**	**$237,075**		**Sum of Rows A through I**

Table 2.1
Summary by Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Home Delivered Meal Service Expansion									
A	HDM Expansion Impact- Non-IDD HCBS Waivers	($262,785)	0.0	($131,393)	$0	$0	($131,392)	50.00%	Table 3.1, Row O
B	HDM Expansion Impact - HCBS-DD	($11,738)	0.0	($5,869)	$0	$0	($5,869)	50.00%	Table 3.1, Row O
C	HDM Expansion Impact - HCBS-SLS	$14,924	0.0	$7,462	$0	$0	$7,462	50.00%	Table 3.1, Row O
D	**Home Delivered Meal Service Expansion Total**	**($259,599)**	**0.0**	**($129,800)**	**$0**	**$0**	**($129,799)**	**50.00%**	**Sum of Rows A through C**
Rates for High Acuity Brain Injury Waiver Members									
E	TLP Change in Rate Methodology	$48,525	0.0	$24,263	$0	$0	$24,262	50.00%	Table 4.1, Row H
F	SLP Newly Negotiated Rate	($264,159)	0.0	($132,080)	$0	$0	($132,079)	50.00%	Table 5.1, Row H
G	**Rates for High Acuity Brain Injury Waiver Members Total**	**($215,634)**	**0.0**	**($107,817)**	**$0**	**$0**	**($107,817)**	**50.00%**	**Sum of Rows E and F**
Case Management Quality Performance Initiatives									
H	Case Management Activity Rate Alignment	$839,791	0.0	$419,896	$0	$0	$419,895	50.00%	Table 6.1, Row H
I	Case Management Performance Evaluation Survey	$540,000	0.0	$270,000	$0	$0	$270,000	50.00%	Table 6.5, Row C
J	**Case Management Quality Performance Initiatives Total**	**$1,379,791**	**0.0**	**$689,896**	**$0**	**$0**	**$689,895**	**50.00%**	**Sum of Rows H and I**
Services & Supports for Children with Complex Needs									
K	Aligning CHRP Respite Limit with CES Respite Limit	$33,756	0.0	$16,878	$0	$0	$16,878	50.00%	Table 7.1, Row D
L	Aligning Respite and Residential Services Rates	$222,811	0.0	$111,406	$0	$0	$111,405	50.00%	Table 7.4, Row E
M	**Services & Supports for Children with Complex Needs Total**	**$256,567**	**0.0**	**$128,284**	**$0**	**$0**	**$128,283**	**50.00%**	**Sum of Rows K and L**
Funding for State General Fund Programs									
N	Maintaining Funding for Family Support Services Program	$371,162	0.0	$371,162	$0	$0	$0	0.00%	Table 8.1, Row A
O	Maintaining Funding for State Supported Living Services	$636,731	0.0	$636,731	$0	$0	$0	0.00%	Table 8.1, Row B
P	Maintaining Funding for State Supported Living Services Case Management	$283,697	0.0	$283,697	$0	$0	$0	0.00%	Table 8.1, Row C
Q	**Funding for State General Fund Programs Total**	**$1,291,590**	**0.0**	**$1,291,590**	**$0**	**$0**	**$0**	**0.00%**	**Sum of Rows N through P**
R	**Total Request**	**$2,452,715**	**0.0**	**$1,872,153**	**$0**	**$0**	**$580,562**		**Sum of Rows D, G, J, M, and Q**

Table 2.2
Summary by Initiative
FY 2023-24

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Home Delivered Meal Service Expansion									
A	HDM Expansion Impact- Non-IDD HCBS Waivers	($527,389)	0.0	($263,695)	$0	$0	($263,694)	50.00%	Table 3.2, Row O
B	HDM Expansion Impact - HCBS-DD	($23,477)	0.0	($11,739)	$0	$0	($11,738)	50.00%	Table 3.2, Row O
C	HDM Expansion Impact - HCBS-SLS	$16,596	0.0	$8,298	$0	$0	$8,298	50.00%	Table 3.2, Row O
D	**Home Delivered Meal Service Expansion Total**	**($534,270)**	**0.0**	**($267,136)**	**$0**	**$0**	**($267,134)**	**50.00%**	**Sum of Rows A through C**
Rates for High Acuity Brain Injury Waiver Members									
E	TLP Change in Rate Methodology	$48,525	0.0	$24,263	$0	$0	$24,262	50.00%	Table 4.1, Row H
F	SLP Newly Negotiated Rate	($288,918)	0.0	($144,459)	$0	$0	($144,459)	50.00%	Table 5.1, Row H
G	**Rates for High Acuity Brain Injury Waiver Members Total**	**($240,393)**	**0.0**	**($120,196)**	**$0**	**$0**	**($120,197)**	**50.00%**	**Sum of Rows E and F**
Case Management Quality Performance Initiatives									
H	Case Management Activity Rate Alignment	$873,329	0.0	$436,665	$0	$0	$436,664	50.00%	Table 6.2, Row H
I	Case Management Performance Evaluation Survey	$540,000	0.0	$270,000	$0	$0	$270,000	50.00%	Table 6.5, Row C
J	**Case Management Quality Performance Initiatives Total**	**$1,413,329**	**0.0**	**$706,665**	**$0**	**$0**	**$706,664**	**50.00%**	**Sum of Rows H and I**
Services & Supports for Children with Complex Needs									
K	Aligning CHRP Respite Limit with CES Respite Limit	$67,512	0.0	$33,756	$0	$0	$33,756	50.00%	Table 7.1, Row D
L	Aligning Respite and Residential Services Rates	$445,622	0.0	$222,811	$0	$0	$222,811	50.00%	Table 7.4, Row E
M	**Services & Supports for Children with Complex Needs Total**	**$513,134**	**0.0**	**$256,567**	**$0**	**$0**	**$256,567**	**50.00%**	**Sum of Rows K and L**
Funding for State General Fund Programs									
N	Maintaining Funding for Family Support Services Program	$371,162	0.0	$371,162	$0	$0	$0	0.00%	Table 8.1, Row A
O	Maintaining Funding for State Supported Living Services	$636,731	0.0	$636,731	$0	$0	$0	0.00%	Table 8.1, Row B
P	Maintaining Funding for State Supported Living Services Case Management	$283,697	0.0	$283,697	$0	$0	$0	0.00%	Table 8.1, Row C
Q	**Funding for State General Fund Programs Total**	**$1,291,590**	**0.0**	**$1,291,590**	**$0**	**$0**	**$0**	**0.00%**	**Sum of Rows N through P**
R	**Total Request**	**$2,443,390**	**0.0**	**$1,867,490**	**$0**	**$0**	**$575,900**		**Sum of Rows D, G, J, M, and Q**

Table 2.3
Summary by Initiative
FY 2024-25

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Home Delivered Meal Service Expansion									
A	HDM Expansion Impact- Non-IDD HCBS Waivers	($1,047,269)	0.0	($523,635)	$0	$0	($523,634)	50.00%	Table 3.3, Row P
B	HDM Expansion Impact - HCBS-DD	($87,340)	0.0	($43,670)	$0	$0	($43,670)	50.00%	Table 3.3, Row P
C	HDM Expansion Impact - HCBS-SLS	$3,344	0.0	$1,672	$0	$0	$1,672	50.00%	Table 3.3, Row P
D	**Home Delivered Meal Service Expansion Total**	**($1,131,265)**	**0.0**	**($565,633)**	**$0**	**$0**	**($565,632)**	**50.00%**	**Sum of Rows A through C**
Rates for High Acuity Brain Injury Waiver Members									
E	TLP Change in Rate Methodology	$48,525	0.0	$24,263	$0	$0	$24,262	50.00%	Table 4.1, Row H
F	SLP Newly Negotiated Rate	($404,484)	0.0	($202,242)	$0	$0	($202,242)	50.00%	Table 5.1, Row H
G	**Rates for High Acuity Brain Injury Waiver Members Total**	**($355,959)**	**0.0**	**($177,979)**	**$0**	**$0**	**($177,980)**	**50.00%**	**Sum of Rows E and F**
Case Management Quality Performance Initiatives									
H	Case Management Activity Rate Alignment	$908,240	0.0	$454,120	$0	$0	$454,120	50.00%	Table 6.3, Row H
I	Case Management Performance Evaluation Survey	$540,000	0.0	$270,000	$0	$0	$270,000	50.00%	Table 6.5, Row C
J	**Case Management Quality Performance Initiatives Total**	**$1,448,240**	**0.0**	**$724,120**	**$0**	**$0**	**$724,120**	**50.00%**	**Sum of Rows H and I**
Services & Supports for Children with Complex Needs									
K	Aligning CHRP Respite Limit with CES Respite Limit	$67,512	0.0	$33,756	$0	$0	$33,756	50.00%	Table 7.1, Row D
L	Aligning Respite and Residential Services Rates	$445,622	0.0	$222,811	$0	$0	$222,811	50.00%	Table 7.4, Row E
M	**Services & Supports for Children with Complex Needs Total**	**$513,134**	**0.0**	**$256,567**	**$0**	**$0**	**$256,567**	**50.00%**	**Sum of Rows K and L**
Funding for State General Fund Programs									
N	Maintaining Funding for Family Support Services Program	$371,162	0.0	$371,162	$0	$0	$0	0.00%	Table 8.1, Row A
O	Maintaining Funding for State Supported Living Services	$636,731	0.0	$636,731	$0	$0	$0	0.00%	Table 8.1, Row B
P	Maintaining Funding for State Supported Living Services Case Management	$283,697	0.0	$283,697	$0	$0	$0	0.00%	Table 8.1, Row C
Q	**Funding for State General Fund Programs Total**	**$1,291,590**	**0.0**	**$1,291,590**	**$0**	**$0**	**$0**	**0.00%**	**Sum of Rows N through P**
R	**Total Request**	**$1,765,740**	**0.0**	**$1,528,665**	**$0**	**$0**	**$237,075**		**Sum of Rows D, G, J, M, and Q**

Table 3.1: FY 2022-23 Home Delivered Meal (HDM) Benefit Expansion

Row	Item	Elderly, Blind, and Disabled (EBD) Waiver	Community Mental Health Supports (CMHS) Waiver Supports	Brain Injury (BI) Waiver	Spinal Cord Injury (SCI) Waiver	Developmental Disabilities (DD) Waiver	Supported Living Services (SLS) Waiver	Total	Source/Calculation
Estimated Cost of HDM Benefit Expansion									
A	Number of HCBS members admitted to the hospital	595	59	9	7	92	50	812	2 year average (FY 2019-20 and FY 2020-21) number of hospital admissions for HCBS members divided by two to adjust for half year implementation
B	Estimated uptake percentage	80.27%	80.27%	80.27%	80.27%	80.27%	80.27%	80.27%	Current uptake rate of HDM service
C	Expected number of utilizers	478	47	7	6	74	40	652	Row A * Row B
D	Estimated days	30	30	30	30	30	30	N/A	Average of the range of 15 days and 6 months (180 days) cited in studies [1]
E	Total number of days	14,340	1,410	210	180	2,220	1,200	19,560	Row C * Row D
F	Meals per day	2	2	2	2	2	2	N/A	Expanded benefit is limited to only 2 meals per day
G	Total number of meals per day	28,680	2,820	420	360	4,440	2,400	39,120	Row E * Row F
H	Cost per meal	$11.74	$11.74	$11.74	$11.74	$11.74	$11.74	$11.74	FY 2021-22 rate for HDM
I	**Total Cost of HDM Benefit Expansion**	**$336,703**	**$33,107**	**$4,931**	**$4,226**	**$52,126**	**$28,176**	**$459,269**	**Row G * Row H**
Savings from Reduced Hospital Admissions									
J	Number of hospital readmission within 30 days for HCBS members	177	21	2	1	18	5	224	Average 3 year data from FY 2018-19, FY 2019-20 and FY 2020-21 divided by two to adjust for half year implementation
K	Estimated percentage reduction to hospital readmission rate	29.00%	29.00%	29.00%	29.00%	29.00%	29.00%	N/A	29% reduction in hospital admissions due to HDM based on study[1]
L	Estimated number of avoided hospital stays	51	6	1	0	5	1	64	Row J * Row K
M	Average cost per admission	$11,136.35	$10,507.75	$10,751.17	$11,163.23	$12,772.75	$13,252.00	69,583	Average cost of hospital stay in FY 2019-20 for HCBS waiver members
N	**Savings from Reduced Hospital Admissions**	**($567,954)**	**($63,047)**	**($10,751)**	**$0**	**($63,864)**	**($13,252)**	**($718,868)**	**Row M * Row L * -1**
O	**Total Estimated Impact**	**($231,251)**	**($29,940)**	**($5,820)**	**$4,226**	**($11,738)**	**$14,924**	**($259,599)**	Row I + Row N

(1) https://www.healthaffairs.org/do/10.1377/hblog20200117.329745/full/

Table 3.2: FY 2023-24 Home Delivered Meal (HDM) Benefit Expansion

Row	Item	Elderly, Blind, and Disabled (EBD) Waiver	Community Mental Health Supports (CMHS) Waiver Supports	Brain Injury (BI) Waiver	Spinal Cord Injury (SCI) Waiver	Developmental Disabilities (DD) Waiver	Supported Living Services (SLS) Waiver	Total	Source/Calculation
Estimated Cost of HDM Benefit Expansion									
A	Number of HCBS members admitted to the hospital	1,189	118	18	14	184	100	1,623	2 year average (FY 2019-20 and FY 2020-21) number of hospital admissions for HCBS members
B	Estimated uptake percentage	80.27%	80.27%	80.27%	80.27%	80.27%	80.27%	80.27%	Current uptake rate of HDM service
C	Expected number of utilizers	954	95	14	11	148	80	1,302	Row A * Row B
D	Estimated days	30	30	30	30	30	30	N/A	Average of the range of 15 days and 6 months (180 days) cited in studies [1]
E	Total number of days	28,620	2,850	420	330	4,440	2,400	39,060	Row C * Row D
F	Meals per day	2	2	2	2	2	2	N/A	Expanded benefit is limited to only 2 meals per day
G	Total number of meals per day	57,240	5,700	840	660	8,880	4,800	78,120	Row E * Row F
H	Cost per meal	$11.74	$11.74	$11.74	$11.74	$11.74	$11.74	$11.74	FY 2021-22 rate for HDM
I	**Total Cost of HDM Benefit Expansion**	**$671,998**	**$66,918**	**$9,862**	**$7,748**	**$104,251**	**$56,352**	**$917,129**	**Row G * Row H**
Savings from Reduced Hospital Admissions									
J	Number of hospital readmission within 30 days for HCBS members	353	42	4	2	36	10	447	Average 3 year data from FY 2018-19, FY 2019-20 and FY 2020-21
K	Estimated percentage reduction to hospital readmission rate	29.00%	29.00%	29.00%	29.00%	29.00%	29.00%	N/A	29% reduction in hospital admissions due to HDM based on study[1]
L	Estimated number of avoided hospital stays	102	12	1	1	10	3	129	Row J * Row K
M	Average cost per admission	$11,136.35	$10,507.75	$10,751.17	$11,163.23	$12,772.75	$13,252.00	N/A	Average cost of hospital stay in FY 2019-20 for HCBS waiver members
N	**Savings from reduced hospital admissions**	**($1,135,908)**	**($126,093)**	**($10,751)**	**($11,163)**	**($127,728)**	**($39,756)**	**($1,451,399)**	**Row M * Row L * -1**
O	**Total Estimated Impact**	**($463,910)**	**($59,175)**	**($889)**	**($3,415)**	**($23,477)**	**$16,596**	**($534,270)**	**Row I + Row N**

(1) https://www.healthaffairs.org/do/10.1377/hblog20200117.329745/full/

Table 3.3: FY 2024-25 Home Delivered Meal (HDM) Benefit Expansion

Row	Item	Elderly, Blind, and Disabled (EBD) Waiver	Community Mental Health Supports (CMHS) Waiver Supports	Brain Injury (BI) Waiver	Spinal Cord Injury (SCI) Waiver	Developmental Disabilities (DD) Waiver	Supported Living Services (SLS) Waiver	Total	Source/Calculation
Estimated Cost of HDM Benefit Expansion									
A	Number of HCBS members admitted to the hospital	1,189	118	18	14	184	100	1,623	2 year average (FY 2019-20 and FY 2020-21) number of hospital admissions for HCBS members
B	Estimated uptake percentage	80.27%	80.27%	80.27%	80.27%	80.27%	80.27%		Current uptake rate of HDM service
C	Expected number of utilizers	954	95	14	11	148	80	1,302	Row A * Row B
D	Estimated days	30	30	30	30	30	30	N/A	Average of the range of 15 days and 6 months (180 days) cited in studies [1]
E	Total number of days	28,620	2,850	420	330	4,440	2,400	39,060	Row C * Row D
F	Meals per day	2	2	2	2	2	2	N/A	Expanded benefit is limited to only 2 meals per day
G	Total number of meals per day	57,240	5,700	840	660	8,880	4,800	78,120	Row E * Row F
H	Cost per meal	$11.74	$11.74	$11.74	$11.74	$11.74	$11.74	N/A	FY 2021-22 rate for HDM
I	**Total Cost of HDM Benefit Expansion**	**$671,998**	**$66,918**	**$9,862**	**$7,748**	**$104,251**	**$56,352**	**$917,129**	**Row G * Row H**
Savings from Reduced Hospital Admissions									
J	Number of hospital readmission within 30 days for HCBS members	353	42	4	2	36	10	447	Average 3 year data from FY 2018-19, FY 2019-20 and FY 2020-21
K	Estimated percentage reduction to hospital readmission rate	40.50%	40.50%	40.50%	40.50%	40.50%	40.50%	N/A	Average of 29% and 52% reduction in hospital admissions from HDM cited in on studies[1],[2]
L	Estimated number of avoided hospital stays	143	17	2	1	15	4	182	Row J * Row K
M	Average cost per admission	$11,136.35	$10,507.75	$10,751.17	$11,163.23	$12,772.75	$13,252.00	N/A	Average cost of hospital stay in FY 2019-20 for HCBS waiver members
N	**Savings from Reduced Hospital Admissions**	**($1,592,498)**	**($178,632)**	**($21,502)**	**($11,163)**	**($191,591)**	**($53,008)**	**($2,048,394)**	**Row M * Row L * -1**
O	**Total Estimated Impact**	**($920,500)**	**($111,714)**	**($11,640)**	**($3,415)**	**($87,340)**	**$3,344**	**($1,131,265)**	**Row I + Row N**

(1) https://www.healthaffairs.org/do/10.1377/hblog20200117.329745/full/
(2) https://static1.squarespace.com/static/580a7cb9e3df2806e84bb687/t/6061413fa8a5bd1a2314da3a/1616986432130/FIMC_MTM_Policy_Recommendations.pdf

Table 4.1: Estimated Cost to Increase the Rate for Transitional Living Program (TLP)

Row	Item	FY 2022-23	FY 2023-24	FY 2024-25	Source/Calculation
Estimated Cost of TLP Rate Increase					
A	Maximum Number of Patients	6	6	6	Number of members served by TLP provider every year
B	Estimated Utilization in Days	180	180	180	Service is limited to 6 months at about 30 days per month
C	Current Average Daily Rate for TLP	$463.58	$463.58	$463.58	Department fee schedule
D	New Proposed Daily Rate	$656.47	$656.47	$656.47	Department estimated rate
E	Difference	$192.89	$192.89	$192.89	Row D - Row C
F	**Total Cost of TLP Rate Increase**	**$208,321**	**$208,321**	**$208,321**	**Row A * Row B * Row E**
Estimated Savings from TLP Rate Increase					
G	Average Per Utilizer Inpatient Cost	$159,796	$159,796	$159,796	Department actuals (measured before members joined TLP)
H	**Total Impact**	**$48,525**	**$48,525**	**$48,525**	**Row F - Row G**

Table 5.1: Estimated Cost to Create a Negotiated Rate for Supported Living Program (SLP) Service					
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Source/Calculation**
Estimated Cost of SLP Level 7 Rate					
A	Number of Utilizers	2	5	7	Estimated number of utilizers based on provider capacity
B	Estimated Negotiated SLP Daily Rate	$538.38	$538.38	$538.38	New estimated negotiated SLP daily rate
C	Estimated Number of Days	139	277	277	Average number days in residential habilitation services for Level 7 Individual with Intellectual Disabilities (IDD) members prorated for implementation in year 1
D	**Estimated Cost of Level 7 SLP Utilization**	**$149,670**	**$745,656**	**$1,043,919**	**Row A * Row C * Row D**
Estimated Savings from SLP Level 7 Rate					
E	Average Cost Per Client for Alternative Care	$206,914.70	$206,914.70	$206,914.70	Estimated using DD Level Y Residential Habilitation Annual Costs
F	Estimated Cost of Alternative Care	$413,829	$1,034,574	$1,448,403	Row A * Row F
G	**Total Impact**	**($264,159)**	**($288,918)**	**($404,484)**	**Row E - Row G**

Table 6.1: FY 2022-23 Estimated Impact of Aligning Single Entry Point (SEP) and Community-Centered Board (CCB) Rates for Case Management Activities							
Row	Item	Training Deliverable	Creation of the Packet (Appeal)	Attendance at Appeal Hearing	Monitoring	Total	Source/Calculation
A	Proposed Rate	$605.39	$496.08	$458.16	$97.74	N/A	Proposed aligned rate
B	Current CCB Rate	$602.79	$343.02	$458.16	$97.74	N/A	Current CCB rate
C	Difference Between Proposed Rate and Current CCB Rate	$2.60	$153.06	$0.00	$0.00	N/A	Row B - Row A
D	Current SEP Rate	$605.39	$496.08	$281.65	$83.45	N/A	Current SEP rate
E	Difference Between Proposed Rate and Current SEP Rate	$0.00	$0.00	$176.51	$14.29	N/A	Row D - Row A
F	Estimated CCB Utilization	40	16	5	48,905	48,966	Table 6.4, Row A
G	Estimated SEP Utilization	48	49	74	57,675	57,846	Table 6.4, Row B
H	**Impact**	**$104**	**$2,449**	**$13,062**	**$824,176**	**$839,791**	**(Row C * Row F) + (Row E * Row G)**

Table 6.2: FY 2023-24 Estimated Impact of Aligning Single Entry Point (SEP) and Community-Centered Board (CCB) Rates for Case Management Activities							
Row	Item	Training Deliverable	Creation of the Packet (Appeal)	Attendance at Appeal Hearing	Monitoring	Total	Source/Calculation
A	Proposed Rate	$605.39	$496.08	$458.16	$97.74	N/A	Proposed aligned rate
B	Current CCB Rate	$602.79	$343.02	$458.16	$97.74	N/A	Current CCB rate
C	Difference Between Proposed Rate and Current CCB Rate	$2.60	$153.06	$0.00	$0.00	N/A	Row B - Row A
D	Current SEP Rate	$605.39	$496.08	$281.65	$83.45	N/A	Current SEP rate
E	Difference Between Proposed Rate and Current SEP Rate	$0.00	$0.00	$176.51	$14.29	N/A	Row D - Row A
F	Estimated CCB Utilization	40	16	5	50,895	50,956	Table 6.4, Row D
G	Estimated SEP Utilization	48	49	74	60,022	60,193	Table 6.4, Row E
H	**Impact**	**$104**	**$2,449**	**$13,062**	**$857,714**	**$873,329**	**(Row C * Row F) + (Row E * Row G)**

Table 6.3: FY 2024-25 Estimated Impact of Aligning Single Entry Point (SEP) and Community-Centered Board (CCB) Rates for Case Management Activities							
Row	Item	Training Deliverable	Creation of the Packet (Appeal)	Attendance at Appeal Hearing	Monitoring	Total	Source/Calculation
A	Proposed Rate	$605.39	$496.08	$458.16	$97.74	N/A	Proposed aligned rate
B	Current CCB Rate	$602.79	$343.02	$458.16	$97.74	N/A	Current CCB rate
C	Difference Between Proposed Rate and Current CCB Rate	$2.60	$153.06	$0.00	$0.00	N/A	Row B - Row A
D	Current SEP Rate	$605.39	$496.08	$281.65	$83.45	N/A	Current SEP rate
E	Difference Between Proposed Rate and Current SEP Rate	$0.00	$0.00	$176.51	$14.29	N/A	Row D - Row A
F	Estimated CCB Utilization	40	16	5	52,966	53,027	Table 6.4, Row G
G	Estimated SEP Utilization	48	49	74	62,465	62,636	Table 6.4, Row H
H	**Impact**	**$104**	**$2,449**	**$13,062**	**$892,625**	**$908,240**	**(Row C * Row F) + (Row E * Row G)**

Table 6.4: Estimated Case Management Utilization by Activity							
Row	Item	Training Deliverable	Creation of the Packet (Appeal)	Attendance at Appeal Hearing	Monitoring	Total	Source/Calculation
A	Estimated FY 2022-23 CCB Utilization	40	16	5	48,905	48,966	Estimated utilization of activity
B	Estimated FY 2022-23 SEP Utilization	48	49	74	57,675	57,846	Estimated utilization of activity
C	FY 2023-24 Trend	0.00%	0.00%	0.00%	4.07%	N/A	FY 2021-22 S-5 request
D	Estimated FY 2023-24 CCB Utilization	40	16	5	50,895	50,956	Row A * (1 + Row C)
E	Estimated FY 2023-24 SEP Utilization	48	49	74	60,022	60,193	Row B * (1 + Row C)
F	FY 2024-25 Trend	0.00%	0.00%	0.00%	4.07%	N/A	FY 2021-22 S-5 request
G	Estimated FY 2024-25 CCB Utilization	40	16	5	52,966	53,027	Row D * (1 + Row F)
H	Estimated FY 2024-25 SEP Utilization	48	49	74	62,465	62,636	Row E * (1 + Row F)

Table 6.5: Case Management Quality Performance Surveys			
Row	Item	Amount	Source/Calculation
A	Number of Surveys	12,000	Estimated number of surveys needed to adequately sample all case management agencies
B	Cost per Survey	$45.00	Estimated rate for a 15 minute survey based on similar work
C	**Total Annual Impact**	**$540,000**	**Row A * Row B**

Table 7.1: Total Estimated Impact of Aligning Respite Unit Limits on the Children's Residential Habilitation Program (HCBS-CHRP) Waiver with the Children's Extensive Supports (HCBS-CES) Waiver					
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Source/Calculation**
A	Impact of Aligning Respite-Individual Limit with HCBS-CES	$65,198	$65,198	$65,198	Table 7.2, Row E
B	Impact of Aligning Respite-Day Limit with HCBS-CES	$2,314	$2,314	$2,314	Table 7.3, Row E
C	Implementation Adjustment	50%	100%	100%	Implementation 1/1/2023
D	**Total Estimated Annual Impact**	**$33,756**	**$67,512**	**$67,512**	**(Row A + Row B) * Row C**

Table 7.2: Respite-Individual, 15 Minute Unit Limit Alignment with HCBS-CES					
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Source/Calculation**
A	Estimated Number of Respite-Individual High Utilizers on HCBS-CHRP	6	6	6	FY 2020-21 actuals
B	Increase in Units from Aligning Unit Limit With HCBS-CES	1,880	1,880	1,880	Respite-individual unit limit on HCBS-CES waiver in addition to allowable day units
C	Estimated Number of Respite-Individual Units	11,280	11,280	11,280	Row A * Row B
D	Respite-Individual Rate on HCBS-CES	$5.78	$5.78	$5.78	Department fee schedule
E	**Total Estimated Impact of Aligning Respite-Individual Unit Limit**	**$65,198**	**$65,198**	**$65,198**	**Row C * Row D**

Table 7.3: Respite-Day/Group Unit Limit Alignment with HCBS-CES					
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Source/Calculation**
A	Estimated Number of Respite-Day High Utilizers on HCBS-CHRP	5	5	5	FY 2020-21 actuals
B	Increase in Units from Aligning Unit Limit With HCBS-CES	2	2	2	Incremental increase in respite-day unit limit to align with HCBS-CES respite-day unit limit
C	Number of Additional Respite-Day Units	10	10	10	Row A * Row B
D	Respite-Day Rate on HCBS-CES	$231.36	$231.36	$231.36	Department fee schedule
E	**Total Estimated Impact of Aligning Respite-Day Unit Limit**	**$2,314**	**$2,314**	**$2,314**	**Row C * Row D**

Table 7.4: Summary of HCBS-CHRP Unit and Rate Alignment Initiatives					
Row	Item	FY 2022-23	FY 2023-24	FY 2024-25	Source/Calculation
A	Impact of Aligning Foster Home Rates	$304,729	$304,729	$304,729	Table 7.5, Row E
B	Impact of Aligning Group Home Rates	$137,128	$137,128	$137,128	Table 7.7, Row E
C	Impact of Aligning Respite Rates	$3,765	$3,765	$3,765	Table 7.9, Row E
D	Partial Year Implementation	50%	100%	100%	Implementation 1/1/2023
E	**Total Estimated Annual Impact**	**$222,811**	**$445,622**	**$445,622**	**(Row A + Row C) * Row D**

Table 7.5: Estimated Impact from Aligning Foster Home Rates on HCBS-CHRP with Individual Residential Services and Supports/Host Home (IRSS/HH) Rates									
Row	Item	Foster Home Level 1	Foster Home Level 2	Foster Home Level 3	Foster Home Level 4	Foster Home Level 5	Foster Home Level 6	Total	Source/Calculation
A	Current Rate	$57.50	$92.50	$113.51	$138.22	$158.79	$199.60	N/A	Department fee schedule
B	Proposed Rate	$67.28	$108.71	$132.82	$161.73	$185.83	$233.57	N/A	Rate for IRSS/HH on Developmental Disabilities waiver on Department fee schedule
C	**Difference**	**$9.78**	**$16.21**	**$19.31**	**$23.51**	**$27.04**	**$33.97**	**N/A**	**Row B - Row A**
D	Estimated Utilization	23	740	4,617	229	6,942	302	12,853	Table 7.6, Row C
E	**Total Estimated Impact**	**$225**	**$11,995**	**$89,154**	**$5,384**	**$187,712**	**$10,259**	**$304,729**	**Row C * Row D**

Table 7.6: Foster Home Utilization for Members on HCBS-CHRP									
Row	Item	Foster Home Level 1	Foster Home Level 2	Foster Home Level 3	Foster Home Level 4	Foster Home Level 5	Foster Home Level 6	Total	Source/Calculation
A	Estimated Utilizers	1	5	19	1	26	1	53	FY 2020-21 actuals & projected utilization
B	Estimated Units Per Utilizer	23	148	243	229	267	302	1,212	FY 2020-21 actuals & projected utilization
C	**Total Estimated Units**	**23**	**740**	**4,617**	**229**	**6,942**	**302**	**12,853**	**Row A * Row B**

Table 7.7: Estimated Impact from Aligning Group Home Rates on HCBS-CHRP with Group Residential Services and Supports (GRSS) Rates									
Row	Item	Group Home Level 1	Group Home Level 2	Group Home Level 3	Group Home Level 4	Group Home Level 5	Group Home Level 6	Total	Source/Calculation
A	Current Rate	$84.32	$111.00	$130.76	$154.46	$170.64	$201.22	N/A	Department fee schedule
B	Proposed Rate	$119.74	$144.23	$163.20	$186.20	$203.95	$236.90	N/A	Rate for GRSS on Developmental Disabilities waiver on Department fee schedule
C	**Difference**	**$35.42**	**$33.23**	**$32.44**	**$31.74**	**$33.31**	**$35.68**	**N/A**	**Row B - Row A**
D	Estimated Utilization	1,568	125	1,050	71	716	484	4,014	Table 7.8, Row C
E	**Total Estimated Impact**	**$55,539**	**$4,154**	**$34,062**	**$2,254**	**$23,850**	**$17,269**	**$137,128**	**Row C * Row D**

Table 7.8: Group Home Utilization for Members on HCBS-CHRP									
Row	Item	Group Home Level 1	Group Home Level 2	Group Home Level 3	Group Home Level 4	Group Home Level 5	Group Home Level 6	Total	Source/Calculation
A	Estimated Utilizers	16	1	7	1	4	4	33	FY 2020-21 actuals & projected utilization
B	Estimated Units Per Utilizer	98	125	150	71	179	121	744	FY 2020-21 actuals & projected utilization
C	**Total Estimated Units**	**1,568**	**125**	**1,050**	**71**	**716**	**484**	**4,014**	**Row A * Row B**

Table 7.9: Estimated Impact from Aligning HCBS-CHRP Respite Rates with HCBS-CES Respite Rates					
Row	Item	Respite - Individual 15 Minute	Respite - Individual Day/Group	Total	Source/Calculation
A	Current Rate	$5.48	$216.87	N/A	Department fee schedule
B	Proposed Rate	$5.78	$231.36	N/A	Rate for respite on HCBS-CES waiver
C	**Difference**	**$0.30**	**$14.49**	**N/A**	**Row B - Row A**
D	Estimated Utilization	2,118	216	2,334	Table 7.10, Row C
E	**Total Estimated Impact**	**$635**	**$3,130**	**$3,765**	**Row C * Row D**

Table 7.10: Respite Utilization for Members on HCBS-CHRP Waiver					
Row	Item	Respite - Individual, 15 Minute	Respite - Individual Day/Group	Total	Source/Calculation
A	Estimated Utilizers	6	18	24	FY 2020-21 actuals
B	Estimated Units Per Utilizer	353	12	365	FY 2020-21 actuals
C	**Total Estimated Units**	**2,118**	**216**	**2,334**	**Row A * Row B**

Table 8.1: Funding to Maintain State General Fund Programs									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Source/Calculation**
A	Maintain Funding for Family Support Services Program	$371,162	0.0	$371,162	$0	$0	$0	0.00%	FY 2021-22 Long Bill Appropriation
B	Maintain Funding for State Supported Living Services	$636,731	0.0	$636,731	$0	$0	$0	0.00%	FY 2021-22 Long Bill Appropriation
C	Maintain Funding for State Supported Living Services Case Management	$283,697	0.0	$283,697	$0	$0	$0	0.00%	FY 2021-22 Long Bill Appropriation
D	**Total to Maintain Funding of State General Fund Programs**	**$1,291,590**	**0.0**	**$1,291,590**	**$0**	**$0**	**$0**	**0.00%**	**Sum of Rows A through C**

Department Priority: R-10
Request Detail: Provider Rate Adjustments

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$11,329,373,255	$104,434,828	$242,304,697
FTE	560.9	0.0	0.0
General Fund	$2,673,594,590	$41,327,629	$109,042,227
Cash Funds	$1,317,699,638	$5,966,149	$6,561,230
Reappropriated Funds	$85,650,144	$0	$0
Federal Funds	$7,252,428,883	$57,141,050	$126,701,240

Summary of Request

The Department of Health Care Policy & Financing requests funding to adjust member contributions for copayments and personal needs allowances, target specific services for rate adjustments, including certain rates related to home and community-based services (HCBS), and provide an across-the-board rate adjustment to all providers not receiving a targeted rate adjustment. The department's proposed targeted adjustments include rate increases for home and community-based services (HCBS) with a wage pass-through component, massage therapist rates, and the department's recommendations through the annual rate review process. This request represents an increase of 0.92% from the department's FY 2021-22 Long Bill total funds appropriation.

Current Program

Provider Rate Adjustments

Colorado's Medicaid program currently provides health care access to about 1.5 million people with a budget of $13.6 billion. Most providers are paid on a fee-for-service basis, meaning the department pays for each incurred service based on a set rate. Pursuant to Section 25.5-4-401.5, C.R.S., the department is required to periodically perform reviews of provider rates under the Colorado Medical Assistance Act. Section 25.5-4-401.5, C.R.S. also established the Medicaid Provider Rate Review Advisory Committee (MPRRAC) to assist in the review of provider reimbursement rates. For the most part, rate increases for providers are subject to annual appropriation by the General Assembly.

Home and Community Based Waiver Services

Home and Community-Based Service (HCBS) waiver members can receive care in their home or community with services such as personal care and homemaker. Other services, such as care provided in alternative care facilities, provide residential supports in a community-based setting. These types of services allow individuals to receive essential care and remain in a community setting. The need for Colorado's direct care workforce is anticipated to grow by 40.00% between 2018 and 2028. There are currently significant shortages in the workforce, and the shortages are anticipated to get worse as demand for direct care services increases.

The department submitted a spending plan to implement initiatives to enhance, expand, and strengthen Home and Community-Based Services (HCBS) in Colorado over the next three years. Section 9817 of the American Rescue Plan Act (ARPA) provides enhanced federal funding for HCBS for one year and requires states to reinvest the enhanced funding back into those services. The department's proposed plan was approved by the Centers for Medicare and Medicaid Services (CMS) and the Joint Budget Committee (JBC) in September 2021. As part of that plan, the department is increasing rates for certain HCBS services with a required wage passthrough for providers to pay at least $15 per hour base wage for frontline staff providing direct hands-on care. The increases under the spending plan will be effective from January 1, 2022 through April 15, 2023. The services targeted for this increase include:

- Adult Day;
- Alternative Care Facility;
- Consumer-Directed Attendant Support Services (CDASS);
- Community Connector;
- Day Habilitation;
- Homemaker;
- In-Home Support Services (IHSS);
- Mentorship;
- Personal Care;

- Prevocational Services;
- Residential Habilitation;
- Respite Care;
- Supported Community Connections; and
- Supportive Living Program.

Member Contributions

Copayments

The department requires copayments on several services including non-emergent outpatient hospital services, physician services, telemedicine services, rural health clinic services, pharmacy, optometry services, podiatry services, durable medical equipment, laboratory services, and radiology services. Copayments vary in costs for patients based on the services rendered and the income of the members. Federal law prohibits copayments to exceed 5.00% of the total income of a member of Medicaid. Appendix A summarizes the current copayments for existing services alongside the proposed changes.

Personal Needs Allowance

Currently only Medicaid members on the Brain Injury (BI), Community Mental Health Supports (CMHS), and Elderly Blind and Disabled (EBD) waivers in an Alternative Care Facility (ACF) and Supportive Living Program (SLP) are obligated to pay a cost share of their services. Personal Needs Allowances (PNA) vary from $84.00 to a maximum of $152.00 for Medicaid members on the BI, CMHS, and EBD waivers living in an ACF or SLP. Members may not have more than $152.00 in PNA, regardless of their income. PNAs are used by members to purchase a variety of items such as non-covered medical items, clothing, toiletries, entertainment, technology, snacks, and other items.

Problem or Opportunity

Provider Rate Adjustments

Investing in adequate provider rates and aligning payment with high-value services are critical components in ensuring members have sufficient access to care, that quality outcomes are achieved, and that services provided are cost effective. The department has an opportunity to address provider rates in a variety of service categories, including rates that may be currently set below reasonable benchmarks. The department requests to address these areas through a series of provider rate adjustments.

Non-Emergent Medical Transportation

On average, Non-Emergent Medical Transportation (NEMT) rates for services are estimated at 37.51% of the benchmark with individual rates for EMT services falling between 27.06% and

134.51% of the benchmark.[1] Providers indicate that rates are too low to ensure provider retention and appropriate access to high value services. The current department recommendation is to bring rates up to 80.00% of the benchmark and monitor the rates in the future.

Emergency Medical Transportation

On average, Emergency Medical Transportation (EMT) rates for services are estimated to be 40.92% of the benchmark with individual rates for EMT services falling between 29.44% and 99.51% of the benchmark.[1] EMT rates are among the lowest for service grouping reviewed through the Medicaid Provider Rate review process. The current department recommendation is to bring rates up to 80.00% of the benchmark.

Non-Medical Transportation

On average, Non-Medical Transportation (NMT) rates for services are estimated to be 86.98% of the benchmark with individual rates for EMT services falling between 56.21% and 265.80% of the benchmark.[1] The current department recommendation is to investigate rate disparities for NMT services across waivers for improving rate equity.

Speech Therapy

On average, Speech Therapy (ST) rates for services are estimated to be 73.51% of the benchmark with individual rates for EMT services falling between 16.82% and 107.20% of the benchmark.[2] Providers indicated that speech therapy rates are insufficient to offer competitive wages, retain specialized providers, and cover overhead costs. The current department recommendation is rebalancing Speech Therapy rates that were identified below 80.00% of the benchmark, and above 100.00%.

Home and Community Based Waiver Services

The rate increases and corresponding wage passthrough approved through the department's HCBS ARPA spending plan will expire on April 15, 2023 due to the limited available funding under the plan.[3] If the department does not maintain the higher rates, the providers will not be able to continue to pay $15 per hour base wage to direct care workers, resulting in a wage reduction. This will further exacerbate the capacity concerns within the direct care workforce.

[1] https://hcpf.colorado.gov/sites/hcpf/files/2021MPRRAR_websiteversion_mainreport_June2021.pdf

[2] https://hcpf.colorado.gov/sites/hcpf/files/HCPF%202020%20MPRR%20Recommendation%20Report_final_nov6.2020.pdf

[3] https://hcpf.colorado.gov/arpa

Member Contributions

Copayments

The department's current copayment policy is outdated and has not been materially revised since 1994. Since then, research on the effects on copayments has changed significantly and there is better understanding of how copayments encourage and discourage utilization.

Personal Needs Allowance

The current PNA monthly maximum amount is insufficient for monthly expenses incurred by members. The department receives numerous calls from members reporting that they have insufficient funds for basic needs, such as toiletries, clothing, or new eyeglasses. The department anticipates that raising the monthly maximum PNA will increase the funding available to members and correspondingly increase the financial stability and quality of life of members residing in these residential settings.

Proposed Solution

The department requests $104,434,828 total funds and $41,327,629 general fund in FY 2022-23 and $242,304,697 total funds and $109,042,227 general fund in FY 2023-24 and ongoing to provide an across-the-board provider rate increase of 0.5%, make changes to member contributions, make various targeted rate adjustments, and provide a permanent rate increase to HCBS.

Provider Rate Adjustments

Across-the Board Rate Adjustment

The department requests to implement an across-the-board (ATB) provider rate increase of 0.5% for most services that are not addressed in the other components of this request. In aggregate, the increases will help address adequacy of payments and support providers who are subject to rising labor, utility, and capital costs, and other inflationary pressure.

Durable Medical Equipment Rebalancing

The department requests to increase rates for certain services that were below 80% of the Medicare benchmark rate to the 80% level and to decrease rates for certain services that were above 100% of the benchmark rate to the 100% level. Overall, this will result in a net increase to expenditure for DME services. The MPRRAC and stakeholders noted their support of this department recommendation.[4]

[4] https://www.colorado.gov/pacific/hcpf/medicaid-provider-rate-review-advisory-committee

Massage Therapy Rates

The department requests to increase massage therapy rates for the SCI waiver and the CLLI waiver to be equal to the current massage therapy rate for the Supportive Living Services (SLS) waiver. This will improve equity for providers and members between various waivers.

Home and Community Based Services Rate Increase

The department requests to maintain the higher rates for certain HCBS services as implemented through the department's HCBS spending plan to support the direct care workforce. The department will continue to require a wage passthrough to ensure workers receive at least $15 per hour base wage. Maintaining these rates will allow the department to further support the financial stability of workers in the personal care industry in Colorado and ensure that patients have an adequate provider network to meet their needs.

Non-Emergent Medical Transportation Rate Increase

The department requests to increase rates of services that were below 60.8% of the benchmark rates up to 60.8% of the benchmark rates. This request moves the department closer to the department's recommendation of increasing rates to 80.00% of the benchmark.

Emergency Medical Transportation Rate Increase

The department requests to increase rates of services that were below 50.0% of the benchmark rates up to 50.0% of the benchmark rates. The MPRRAC noted that current rates may not be sufficient to provide high value services. This request moves the department closer to the department's recommendation of increasing rates to 80.00% of the benchmark.

Non-Medical Transportation Rate Increase

The department requests to increase rates of services that were below 70.0% of the benchmark rates up to 70.0% of the benchmark rates. This request moves the department closer to the department's recommendation of creating equity for non-medical transportation services across each of the department's waivers by closing the differences in rates.

Speech Therapy Rate Increase

The department requests to increase rates of services that were below 70.0% of the benchmark rates up to 70.0% of the benchmark rates. This request moves the department closer to the department's recommendation of increasing rates for Speech Therapy services to 80.00% of the benchmark.

Member Contributions

The department requests to adjust member copayments to discourage improper use of emergency services. The department will increase copayments on non-emergent emergency services to the federal maximum. The department will increase hospital outpatient emergency room copayments for non-emergent care from $6 to $8, the maximum amount permitted in federal regulations.

Increase Personal Needs Allowance Maximum

The department requests to increase the PNA maximum from $152.00 per month to $383.33 per month and reimburse providers the difference in the member contribution. The department will reimburse the difference in member contributions to keep the total payment for alternative care constant while decreasing the total cost members will pay. Increasing the PNA maximum will allow members to keep more money to pay for various items like clothing, toiletries, and non-standard medical items like eyeglasses, which will improve members' quality of life and financial stability.

Theory of Change	Investing in adequate provider rates and aligning payment with high-value services are critical components in ensuring members have sufficient access to care, that quality outcomes are achieved, and that services provided are cost-effective.		
Program Objective	The objective of adjusting provider rate changes is to increase access to care and to ensure adequate reimbursement of services for providers.		
Outputs Being Measured	Quality of care, utilization of services, member feedback, and provider feedback.		
Outcomes Being Measured	Member health, member feedback, access to services, adequacy of rates, provider network capacity, provider retention, positive member experience and increased satisfaction.		
Cost/Benefit Ratio	N/A		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	Evaluation of utilization of services, provider rates, and provider network size.	N/A	N/A
Continuum Level	Step 3		

Anticipated Outcomes

Provider Rate Adjustments

The department anticipates that changing rates based on the recommendations made through the rate review process will lead to better access to care and adequate provider payments compared to benchmarks.

Implementing a provider rate increase will reduce the financial strain and risk to member access that stagnant provider rates represent. Additionally, targeted rate changes to specific services will more appropriately align incentives, encouraging positive outcomes for members and allowing the department to pay for value rather than volume of services.

In addition, the department anticipates that increasing the rates for massage therapy services rendered to SCI Waiver members and CLLI Waiver members will increase provider capacity.

The department anticipates that maintaining the rate increases to HCBS direct care services will ensure providers pay at least $15 per hour to workers. This will support a more competitive labor market in the workforce, increasing the number of workers willing to provide home and community-based services and thus increasing access for all waiver members.

Member Contributions

The department anticipates that increasing copayments on non-emergent use of Emergency Department services will decrease inappropriate utilization of emergency services.

The department anticipates that by increasing the PNA for waiver members that members will experience an increase in their quality of life and financial stability through being able to afford essential items such as clothing and non-standard medical care.

Wildly Important Goals & Departmental Priorities

Funding this request strongly supports one of the Governor's Wildly Important Goals (WIGs):

- WIG #1 – Access to Care and Customer Service: The department expects that providing increases to home- and community-based rates will increase access to care and improve customer service in the home and community setting by increasing provider capacity. Additionally, the department anticipates that providing direct care workers with training and support will increase customer service satisfaction as providers will be better prepared to serve members. Furthermore, targeted rate adjustments are aimed to increase access to care for members by ensuring that providers are being reimbursed at an adequate rate.

The request also supports two of the department's five strategic pillars that were established to ensure customer-focused performance management.

- Operational Excellence & Customer Service — Provide excellent service to members, providers, and partners; compliant, efficient, effective person- and family-centered practices; and
- Care Access – Improve member access to affordable, high quality care.

Assumptions and Calculations

See Appendix A for detailed calculations.

Provider Rate Adjustments

Across-the Board Rate Adjustment

Estimates are based on the department's FY 2021-22 budget and prior year actuals. Although these rate increases will affect most Medicaid providers, a number of providers will be exempted from rate increases or receive different rate increases. These distinctions include:

- A portion of expenditure related to non-medical emergency transportation services is not eligible for an increase due to services rendered under a fixed price contract;
- Dental administrative payments are ineligible for rate increases because the contract was competitively procured, with payment rates agreed upon during the procurement;
- Reimbursements to pharmacies are not eligible for the rate increase. Pharmaceutical reimbursement has transitioned to a methodology that reflects the actual costs of purchasing and dispensing medications. Further, pharmaceutical reimbursement is unique in that the reimbursement methodology is directly tied to a moving price statistic that increases reimbursement as provider costs increase;
- Rates for rural health clinics (RHCs) are based on actual cost or the Medicare upper payment limit. RHCs have previously not been subject to rate decreases or increases due to the unique manner in which these rates are calculated;
- Rates for Federally Qualified Health Centers will be ineligible due to recent increases bringing reimbursement for this provider type to the upper limit of allowed amount under the current reimbursement methodology;
- Physical health managed care programs, including risk-based health maintenance organizations such as the providers for the Program of All-Inclusive Care for the Elderly (PACE), are negotiated within the parameters of their respective rate setting methodology and may not be impacted by rate increases depending on the outcome of rate negotiations
- Risk-based physical health managed care programs for Medicaid and the Child Health Plan Plus (CHP+) and regional accountable entities (RAEs)[5] will not receive direct rate increases as part of this change request. Rates are set in accordance with federal regulation and actuarial standards, which do not generally permit general provider rate increases. The department notes, however, that RAE and CHP+ rates generally increase in response to provider cost, and rates for Medicaid managed care organizations will increase indirectly based on increases applied to fee-for-service rates; and

[5] The Department assumes an across-the-board increase would still apply to the administrative per member per month payment for care coordination.

- Services receiving targeted rate adjustments will not be eligible for the additional across-the-board rate increase.

Targeted Rate Adjustments

For most services, the department assumes that the requested rate adjustments will be effective July 1, 2022. This aligns with the department's recent experience with receiving approval from the Centers for Medicare and Medicaid Services (CMS) for new rates in the department's State Plan and loading the new rates into the Medicaid Management Information System (MMIS). The department estimates that there will be an average one-month delay between the date in which a service occurs and the payment for that service. Therefore, the department assumes eleven out of twelve months of the impact of the rate increases will be realized in FY 2022-23, and a full-year impact will be realized in FY 2023-24.

Durable Medical Equipment Rebalancing

The department compared rates for DME services to appropriate benchmark rates and estimated the department's reimbursement rates compared to the benchmark as a percentage. For DME services below 80.00% of the benchmark rates will be brought up to 80.00% of the benchmark and for DME services above 100.00% of the benchmark rates will be brought down to 100.00% of the benchmark. The department estimated the cost by calculating the difference between the current rates and the proposed rates at either 80% or 100% of the benchmark and multiplied that difference by annual utilization.

Massage Therapy Rates

The estimated massage therapy rate increase is based on the proposed rate increase multiplied by the average annual utilization of massage therapy services on the SCI and the CLLI Waiver.

Home and Community Based Rate Increase

The department estimated Home- and Community-Based rate increases by projecting expenditure by services receiving the proposed rate increase and calculating the increase in payments based on the variable percentage increase by service.

Non-Emergent Medical Transportation

The department compared rates for NEMT services to appropriate benchmark rates and estimated the department's reimbursement rates compared to the benchmark as a percentage. For NEMT services below 60.80% of the benchmark rates will be brought up to 60.80% of the benchmark. The department estimated the cost by calculating the difference between the current rates and the proposed rates at 60.80% of the benchmark and multiplied that difference by annual utilization.

Emergent Medical Transportation

The department compared rates for EMT services to appropriate benchmark rates and estimated the department's reimbursement rates compared to the benchmark as a percentage. For EMT

services below 50.00% of the benchmark rates will be brought up to 50.00% of the benchmark. The department estimated the cost by calculating the difference between the current rates and the proposed rates at 50.00% of the benchmark and multiplied that difference by annual utilization.

Non-Medical Transportation
The department compared rates for NMT services to appropriate benchmark rates and estimated the department's reimbursement rates compared to the benchmark as a percentage. For NMT services below 70.00% of the benchmark rates will be brought up to 70.00% of the benchmark. The department estimated the cost by calculating the difference between the current rates and the proposed rates at 70.00% of the benchmark and multiplied that difference by annual utilization.

Speech Therapy Services
The department compared rates for Speech Therapy services to appropriate benchmark rates and estimated the department's reimbursement rates compared to the benchmark as a percentage. For NMT services below 70.00% of the benchmark rates will be brought up to 70.00% of the benchmark. The department estimated the cost by calculating the difference between the current rates and the proposed rates at 70.00% of the benchmark and multiplied that difference by annual utilization.

Changes to Member Contributions
The department estimates the change in copayment costs based on the average copayments paid in FY 2018-19, the number of copayments made in FY 2018-19, and the proposed changes in copayments. The department trended the copayments paid in FY 2018-19 by the average caseload growth of populations eligible to pay copayments under Medicaid policy. The department used FY 2018-19 data, as opposed to more current data, as FY 2019-20 and FY 2020-21 data is skewed by changes occurring during the COVID-19 pandemic; the department has adjusted the calculation based on the expected change in caseload between FY 2018-19 and FY 2022-23. The department assumes that the requested copayment adjustments will be effective July 1, 2022. This aligns with the department's recent experience with receiving approval from the Centers for Medicare and Medicaid Services (CMS) for new rates in the department's State Plan and loading the new rates into the Medicaid Management Information System (MMIS). The department estimates that there will be an average one-month delay between the date in which a service occurs and the payment for that service. Therefore, the department assumes eleven out of twelve months of the impact of the copayment increases will be realized in FY 2022-23, and a full-year impact will be realized in FY 2023-24.

Changes to Personal Needs Allowance Maximum
The department estimates the changes in PNAs based on the number of members currently receiving the maximum PNA and the proposed change to the allowance. The increase in costs to

the department is associated with reimbursing the difference in the ACF rate between the current and proposed PNA maximum which was previously paid by the member. The department assumes that the requested PNA maximum adjustments will be effective July 1, 2022. This aligns with the department's recent experience with receiving approval from the Centers for Medicare and Medicaid Services (CMS) for new rates in the department's Waiver and loading the new rates into the Medicaid Management Information System (MMIS). The department estimates that there will be an average one-month delay between the date in which a service occurs and the payment for that service. Therefore, the department assumes eleven out of twelve months of the impact of the copayment increases will be realized in FY 2022-23, and a full-year impact will be realized in FY 2023-24.

Table 1.1 Summary by Line Item FY 2022-23									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Notes/Calculations**
A	(1) Executive Directors Office, (D) Eligibility Determination and Client Services, County Administration	$440,463	0.0	$62,953	$107,118	$0	$270,392	50.00%	Table 3.1 Row B
B	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$81,356,839	0.0	$29,950,090	$5,815,962	$0	$45,590,787	N/A	Table 2.1 Row B + Table 2.1 Row C + Table 2.1 Row F + Table 2.1 Row H + Table 2.1 Row I + Table 3.1 Row G + Table 4.8 Row A
C	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	$68,318	0.0	$15,177	$4,457	$0	$48,684	N/A	Table 3.1 Row I
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	$17,608,299	0.0	$8,799,018	$5,132	$0	$8,804,149	50.00%	Table 2.1 Row G + Table 3.1 Row K + Table 4.5 Row C
E	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	$3,631,427	0.0	$1,788,794	$26,921	$0	$1,815,712	50.00%	Table 3.1 Row M + Table 4.5 Row B
F	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support Services	$720,610	0.0	$360,305	$0	$0	$360,305	50.00%	Table 3.1 Row O + Table 4.5 Row D
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	$57,953	0.0	$28,977	$0	$0	$28,976	50.00%	Table 3.1 Row Q + Table 4.5 Row E
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Eligibility Determination and Waiting List Management	$0	0.0	$0	$0	$0	$0	0.00%	Table 3.1 Row CC
I	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management	$455,531	0.0	$226,927	$6,559	$0	$222,045	48.74%	Table 3.1 Row S
J	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	$36,543	0.0	$36,543	$0	$0	$0	0.00%	Table 3.1 Row Y
K	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	$47,555	0.0	$47,555	$0	$0	$0	0.00%	Table 3.1 Row U
L	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	$10,958	0.0	$10,958	$0	$0	$0	0.00%	Table 3.1 Row W
M	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Preventive Dental Hygiene	$332	0.0	$332	$0	$0	$0	0.00%	Table 3.1 Row AA
N	**Total Request**	**$104,434,828**	**$0**	**$41,327,629**	**$5,966,149**	**$0**	**$57,141,050**	**N/A**	Sum of Rows A thru M

Table 1.2 Summary by Line Item FY 2023-24									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Notes/Calculations**
A	(1) Executive Directors Office, (D) Eligibility Determination and Client Services, County Administration	$440,485	0.0	$62,956	$107,123	$0	$270,406	50.00%	Table 3.2 Row B
B	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	$160,084,596	0.0	$68,096,136	$6,409,523	$0	$85,578,937	N/A	Table 2.2 Row B + Table 2.2 Row C + Table 2.2 Row F + Table 2.2 Row H + Table 2.2 Row I + Table 3.2 Row G + Table 4.9 Row A
C	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	$74,775	0.0	$16,612	$4,879	$0	$53,284	N/A	Table 3.2 Row I
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	$62,219,938	0.0	$31,104,415	$5,556	$0	$31,109,967	50.00%	Table 2.2 Row G + Table 3.2 Row K + Table 4.6 Row C
E	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	$16,048,506	0.0	$7,997,411	$26,844	$0	$8,024,251	50.00%	Table 3.2 Row M + Table 4.6 Row B
F	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support Services	$2,788,661	0.0	$1,394,332	$0	$0	$1,394,329	50.00%	Table 3.2 Row O + Table 4.6 Row D
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	$65,961	0.0	$32,981	$0	$0	$32,980	50.00%	Table 3.2 Row Q + Table 4.6 Row E
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Eligibility Determination and Waiting List Management	$0	0.0	$0	$0	$0	$0	0.00%	Table 3.2 Row CC
I	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management	$486,387	0.0	$241,996	$7,305	$0	$237,086	48.74%	Table 3.2 Row S
J	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	$36,543	0.0	$36,543	$0	$0	$0	0.00%	Table 3.2 Row Y
K	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	$47,555	0.0	$47,555	$0	$0	$0	0.00%	Table 3.2 Row U
L	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	$10,958	0.0	$10,958	$0	$0	$0	0.00%	Table 3.2 Row W
M	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Preventive Dental Hygiene	$332	0.0	$332	$0	$0	$0	0.00%	Table 3.2 Row AA
N	**Total Request**	**$242,304,697**	**0.0**	**###########**	**$6,561,230**	**$0**	**$126,701,240**	**N/A**	Sum of Rows A thru M

Table 2.1
Summary by Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Across the Board Rate Adjustment									
A	Across the Board Rate Increase	$32,230,602	0.0	$11,432,806	$1,499,074	$0	$19,298,722	NA	Table 3.1 Row DD
Targeted Rate Adjustments									
B	DME Rebalancing Rate Increase	$1,596,720	0.0	$798,360	$0	$0	$798,360	50.00%	Table 4.1 Row E
C	Massage Therapy Rate Increase	$27,293	0.0	$13,647	$0	$0	$13,646	50.00%	Table 4.2 Row F
D	HCBS Rate Increase	$33,373,436	0.0	$16,686,725	$0	$0	$16,686,711	50.00%	Table 4.3 Row L
E	NEMT Rate Increas	$22,816,821	0.0	$7,393,642	$4,014,769	$0	$11,408,410	50.00%	Table 4.3 Row E
F	EMT Rate Increase	$8,298,520	0.0	$1,948,546	$453,943	$0	$5,896,031	NA	Table 4.4 Row E
G	NMT Rate Increase	$3,046,513	0.0	$1,523,256	$0	$0	$1,523,257	50.00%	Table 4.5 Row E
H	Speech Therapy Rate Increase	$1,134,728	0.0	$567,364	$0	$0	$567,364	50.00%	Table 4.6 Row E
Changes to Member Contributions									
I	Changes to Copayments	($26,920)	0.0	($5,275)	($1,637)	$0	($20,008)	NA	Table 5.1 Row G
J	Personal Needs Allowance Maximum Increase	$1,937,115	0.0	$968,558	$0	$0	$968,557	50.00%	Table 5.2 Row G
K	**Total Request**	**$104,434,828**	**0.0**	**$41,327,629**	**$5,966,149**	**$0**	**$57,141,050**		**Sum of Rows A thru J**

Table 2.2
Summary by Initiative
FY 2023-24

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Across the Board Rate Adjustment									
A	Across the Board Rate Increase	$35,910,856	0.0	$12,896,464	$1,487,057	$0	$21,527,335	NA	Table 3.2 Row DD
Targeted Rate Adjustments									
B	DME Rebalancing Rate Increase	$1,729,780	0.0	$864,890	$0	$0	$864,890	50.00%	Table 4.1 Row E
C	Massage Therapy Rate Increase	$65,503	0.0	$32,752	$0	$0	$32,751	50.00%	Table 4.2 Row F
D	HCBS Rate Increase	$159,841,194	0.0	$79,920,605	$0	$0	$79,920,589	50.00%	Table 4.3 Row L
E	NEMT Rate Increas	$25,917,365	0.0	$8,398,353	$4,560,330	$0	$12,958,682	50.00%	Table 4.3 Row E
F	EMT Rate Increase	$9,426,193	0.0	$2,213,331	$515,629	$0	$6,697,233	NA	Table 4.4 Row E
G	NMT Rate Increase	$3,505,174	0.0	$1,752,587	$0	$0	$1,752,587	50.00%	Table 4.5 Row E
H	Speech Therapy Rate Increase	$1,288,924	0.0	$644,462	$0	$0	$644,462	50.00%	Table 4.6 Row E
mber Contributions									
I	Changes to Copayments	($29,368)	0.0	($5,755)	($1,786)	$0	($21,827)	NA	Table 5.1 Row G
J									
K	**Total Request**	**$242,304,697**	**0.0**	**$109,042,227**	**$6,561,230**	**$0**	**$126,701,240**		**Sum of Rows A thru J**

Table 3.1: FY 2022-23 - Amounts Eligible for 0.50% Rate Change by Funding Source (November Forecasted Budget)

Row	Long Bill Group	Total Funds	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds
	(1) Executive Director's Office					
A	(D) Eligibility Determination and Clients	$88,092,552	$12,590,592	$21,423,565	$0	$54,078,395
B	**Impact of 0.50% Rate Change**	**$440,463**	**$62,953**	**$107,118**	**$0**	**$270,392**
(1) Amount of cash by cash fund: Healthcare Affordability & Sustainability Fee: $25,541; Local Funds: $81,577						
	(2) Medical Services Premiums	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
C	Acute Care	$3,905,914,375	$1,112,214,894	$237,718,125	$0	$2,555,981,356
D	Community Based Long Term Care	$1,376,045,413	$673,548,035	$10,084,612	$0	$692,412,766
E	Service Management	$239,528,627	$70,774,398	$21,974,710	$0	$146,779,519
F	**Total Medical Services Premiums**	**$5,521,488,415**	**$1,856,537,327**	**$269,777,447**	**$0**	**$3,395,173,641**
G	**Impact of 0.50% Rate Change**	**$27,607,442**	**$9,282,686**	**$1,348,887**	**$0**	**$16,975,869**
(1) Amount of cash by cash fund: Healthcare Affordability & Sustainability Fee: $1,228,026; Breast and Cervical Cancer Prevention and Treatment Fund: $4,334; Adult Dental Cash Fund: $116,527						
	(3) Behavioral Health Community Programs	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
H	Behavioral Health Fee-for-Service	$13,663,493	$3,035,410	$891,445	$0	$9,736,638
I	**Impact of 0.50% Rate Change**	**$68,318**	**$15,177**	**$4,457**	**$0**	**$48,684**
(1) Amount of cash by cash fund: Healthcare Affordability & Sustainability Fee: $4,457						

Row	(4) Office of Community Living	Total Funds	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds
	(4) Office of Community Living					
J	Adult Comprehensive Services	$594,848,512	$296,397,837	$1,026,418	$0	$297,424,257
K	**Impact of 0.50% Rate Change**	**$2,974,243**	**$1,481,989**	**$5,132**	**$0**	**$1,487,122**
L	Adult Supported Living Services	$70,886,493	$30,058,970	$5,384,277	$0	$35,443,246
M	**Impact of 0.50% Rate Change**	**$354,432**	**$150,294**	**$26,921**	**$0**	**$177,217**
N	Children's Extensive Support Services	$35,729,322	$17,864,661	$0	$0	$17,864,661
O	**Impact of 0.50% Rate Change**	**$178,647**	**$89,323**	**$0**	**$0**	**$89,324**
P	Children's Habitation/Rehabilitation Program	$11,227,674	$5,613,837	$0	$0	$5,613,837
Q	**Impact of 0.50% Rate Change**	**$56,138**	**$28,069**	**$0**	**$0**	**$28,069**
R	Case Management	$91,106,164	$45,385,424	$1,311,719	$0	$44,409,021
S	**Impact of 0.50% Rate Change**	**$455,531**	**$226,927**	**$6,559**	**$0**	**$222,045**
T	State Supported Living Services	$9,511,028	$9,511,028	$0	$0	$0
U	**Impact of 0.50% Rate Change**	**$47,555**	**$47,555**	**$0**	**$0**	**$0**
V	State Supported Living Services Case Management	$2,191,580	$2,191,580	$0	$0	$0
W	**Impact of 0.50% Rate Change**	**$10,958**	**$10,958**	**$0**	**$0**	**$0**
X	Family Support Services	$7,308,510	$7,308,510	$0	$0	$0
Y	**Impact of 0.50% Rate Change**	**$36,543**	**$36,543**	**$0**	**$0**	**$0**
Z	Preventive Dental Hygiene	$66,460	$66,460	$0	$0	$0
AA	**Impact of 0.50% Rate Change**	**$332**	**$332**	**$0**	**$0**	**$0**
BB	Eligibility Determination and Waitlist Management	$0	$0	$0	$0	$0
CC	**Impact of 0.50% Rate Change**	**$0**	**$0**	**$0**	**$0**	**$0**
DD	**Total Impact**	**$32,230,602**	**$11,432,806**	**$1,499,074**	**$0**	**$19,298,722**

(1) Amount of cash by cash fund:
Healthcare Affordability & Sustainability Fee: $38,612

Table 3.2: FY 2023-24 - Amounts Eligible for 0.50% Rate Change by Funding Source (November Forecasted Budget)

Row	Long Bill Group	Total Funds	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds
	(1) Executive Director's Office					
A	(D) Eligibility Determination and Clients	$88,097,005	$12,590,592	$21,423,565	$0	$54,082,848
B	**Impact of 0.50% Rate Change**	**$440,485**	**$62,956**	**$107,123**	**$0**	**$270,406**
(1) Amount of cash by cash fund: Healthcare Affordability & Sustainability Fee: $25,542; Local Funds: $81,581						
	(2) Medical Services Premiums	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
C	Acute Care	$4,383,514,231	$1,275,879,429	$233,955,770	$0	$2,873,679,032
D	Community Based Long Term Care	$1,590,369,266	$778,128,939	$12,516,484	$0	$799,723,843
E	Service Management	$224,847,562	$66,357,339	$20,597,791	$0	$137,892,432
F	**Total Medical Services Premiums**	**$6,198,731,059**	**$2,120,365,707**	**$267,070,045**	**$0**	**$3,811,295,307**
G	**Impact of 0.50% Rate Change**	**$30,993,655**	**$10,601,829**	**$1,335,350**	**$0**	**$19,056,476**
(1) Amount of cash by cash fund: Healthcare Affordability & Sustainability Fee: $1,209,634; Breast and Cervical Cancer Prevention and Treatment Fund: $4,454; Adult Dental Cash Fund: $121,262						
	(3) Behavioral Health Community Programs	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
H	Behavioral Health Fee-for-Service	$14,954,985	$3,322,321	$975,706	$0	$10,656,958
I	**Impact of 0.50% Rate Change**	**$74,775**	**$16,612**	**$4,879**	**$0**	**$53,284**
(1) Amount of cash by cash fund: Healthcare Affordability & Sustainability Fee: $4,879						

Row	(4) Office of Community Living	Total Funds	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds
	(4) Office of Community Living					
J	Adult Comprehensive Services	$643,307,268	$320,542,437	$1,111,196	$0	$321,653,635
K	**Impact of 0.50% Rate Change**	**$3,216,536**	**$1,602,712**	**$5,556**	**$0**	**$1,608,268**
L	Adult Supported Living Services	$70,683,759	$29,973,002	$5,368,878	$0	$35,341,879
M	**Impact of 0.50% Rate Change**	**$353,419**	**$149,865**	**$26,844**	**$0**	**$176,710**
N	Children's Extensive Support Services	$38,588,789	$19,294,395	$0	$0	$19,294,394
O	**Impact of 0.50% Rate Change**	**$192,944**	**$96,472**	**$0**	**$0**	**$96,472**
P	Children's Habitation/Rehabilitation Program	$11,453,498	$5,726,749	$0	$0	$5,726,749
Q	**Impact of 0.50% Rate Change**	**$57,267**	**$28,634**	**$0**	**$0**	**$28,633**
R	Case Management	$97,277,315	$48,399,268	$1,460,945	$0	$47,417,102
S	**Impact of 0.50% Rate Change**	**$486,387**	**$241,996**	**$7,305**	**$0**	**$237,086**
T	State Supported Living Services	$9,511,028	$9,511,028	$0	$0	$0
U	**Impact of 0.50% Rate Change**	**$47,555**	**$47,555**	**$0**	**$0**	**$0**
V	State Supported Living Services Case Management	$2,191,580	$2,191,580	$0	**$0**	**$0**
W	**Impact of 0.50% Rate Change**	**$10,958**	**$10,958**	**$0**	**$0**	**$0**
X	Family Support Services	$7,308,510	$7,308,510	$0	$0	$0
Y	**Impact of 0.50% Rate Change**	**$36,543**	**$36,543**	**$0**	**$0**	**$0**
Z	Preventive Dental Hygiene	$66,460	$66,460	$0	$0	$0
AA	**Impact of 0.50% Rate Change**	**$332**	**$332**	**$0**	**$0**	**$0**
BB	Eligibility Determination and Waitlist Management	$0	$0	$0	$0	$0
CC	**Impact of 0.50% Rate Change**	**$0**	**$0**	**$0**	**$0**	**$0**
DD	**Total Impact**	**$35,910,856**	**$12,896,464**	**$1,487,057**	**$0**	**$21,527,335**

(1) Amount of cash by cash fund:
Healthcare Affordability & Sustainability Fee: $39,705

Table 4.1 Repricing Durable Medical Equipment Rates to 80-100% Benchmark				
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**Notes/Calculations**
A	Durable Medical Equipment Expenditure	$19,658,763	$19,658,763	
B	Repriced to 80-100% of Benchmark	$21,388,543	$21,388,543	Repriced Expenditure
C	**Incremental Difference**	**$1,729,780**	**$1,729,780**	**Row B - Row A**
D	Percentage of the Year Affected	92.31%	100.00%	First year is reduced due to cash accounting
E	**Estimated Impact of Aligning Benchmarks**	**$1,596,720**	**$1,729,780**	**Row C - Row D**

Table 4.2 Aligning Massage Therapy Rates Across Waivers				
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**Source/Calculation**
A	Current Massage Therapy Rate	$14.20	$14.20	SCI and CLLI Waiver Rate
B	Proposed Massage Therapy Rate	$19.10	$19.10	SLS Waiver Rate
C	Difference	$4.90	$4.90	Row B - Row A
D	Average Annual Paid Units	13,368	13,368	
E	Estimated Percentage of the Year Effected	41.67%	100.00%	Implementation January 1, 2023
F	**Total Impact**	**$27,293**	**$65,503**	**Row C * Row D * Row E**

Table 4.3 Repricing Non-Emergent Medical Transportation to 60.80% of the Benchmark				
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**Notes/Calculations**
A	Estimated NEMT Expenditure	$31,806,102	$33,349,094	CY 2019 data trended forward
B	Repriced to 60.80% of the Benchmark	$56,524,325	$59,266,459	Repriced Expenditure
C	**Incremental Difference**	**$24,718,223**	**$25,917,365**	**Row B - Row A**
D	Percentage of the Year Affected	92.31%	100.00%	First year is reduced due to cash accounting
E	**Estimated Impact of Aligning Benchmarks**	**$22,816,821**	**$25,917,365**	**Row C * Row D**

Table 4.4 Repricing Emergency Medical Transportation to 50.00% of the Benchmark				
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**Notes/Calculations**
A	Estimated EMT Expenditure	$31,136,236	$32,646,731	CY 2019 data trended forward
B	Repriced to 50.00% of the Benchmark	$40,126,299	$42,072,924	Repriced Expenditure
C	**Incremental Difference**	**$8,990,063**	**$9,426,193**	**Row B - Row A**
D	Percentage of the Year Affected	92.31%	100.00%	First year is reduced due to cash accounting
E	**Estimated Impact of Aligning Benchmarks**	**$8,298,520**	**$9,426,193**	**Row C * Row D**

Table 4.5 Repricing HCBS Non-Medical Transportation to 70.00% of the Benchmark				
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**Notes/Calculations**
A	Estimated NMT Expenditure	$39,764,735	$42,232,096	CY 2019 data trended forward
B	Repriced to 70.00% of the Benchmark	$43,065,124	$45,737,271	Repriced Expenditure
C	**Incremental Difference**	**$3,300,389**	**$3,505,174**	**Row B - Row A**
D	Percentage of the Year Affected	92.31%	100.00%	First year is reduced due to cash accounting
E	**Estimated Impact of Aligning Benchmarks**	**$3,046,513**	**$3,505,174**	**Row C * Row D**

Table 4.6 Repricing Speech Therapy to 70.00% of the Benchmark				
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**Notes/Calculations**
A	Estimated Speech Therapy Expenditure	$24,265,250	$25,442,416	CY 2019 data trended forward
B	Repriced to 70.00% of the Benchmark	$25,494,538	$26,731,341	Repriced Expenditure
C	**Incremental Difference**	**$1,229,289**	**$1,288,924**	**Row B - Row A**
D	Percentage of the Year Affected	92.31%	100.00%	First year is reduced due to cash accounting
E	**Estimated Impact of Aligning Benchmarks**	**$1,134,728**	**$1,288,924**	**Row C * Row D**

Table 4.7 Projected Costs of Increasing Rates to Reflect $15/Hour Minimum Wage						
Service	Waiver	Projected FY 2021-22 Expenditure				
Timeline			4/16/23 - 6/30/23		7/1/23 - 6/30/24	
Increase Type			Wage Pass Through		Wage Pass Through	
Adult Day Services	SCI, EBD, CMHS, BI	$24,999,805	24.21%	$1,263,699	24.21%	$6,052,453
Alternative Care Facility	EBD, CMHS	$81,453,386	33.75%	$5,739,778	33.75%	$27,490,518
Community Connector	CES, CHRP	$6,949,910	6.95%	$100,850	6.95%	$483,019
Consumer Directed Attendant Support Services (CDASS) - Denver	SCI, EBD, CMHS, BI, SLS	$10,823,520	0.95%	$21,378	0.95%	$102,390
Consumer Directed Attendant Support Services (CDASS) - Outside Denver	SCI, EBD, CMHS, BI, SLS	$167,782,418	12.63%	$4,424,478	12.63%	$21,190,919
Day Habilitation	SLS, DD	$134,682,908	14.29%	$4,018,435	14.29%	$19,246,188
Homemaker - Denver	SCI, CES, EBD, CMHS, BI, SLS	$7,163,249	0.00%	$0	0.00%	$0
Homemaker - Outside Denver	SCI, CES, EBD, CMHS, BI, SLS	$40,244,087	11.99%	$1,007,473	11.99%	$4,825,266
In-Home Support Services - Denver	SCI, CHCBS, EBD	$36,546,397	3.92%	$299,118	3.92%	$1,432,619
In-Home Support Services - Outside Denver	SCI, CHCBS, EBD	$178,812,451	9.71%	$3,625,177	9.71%	$17,362,689
Mentorship	SLS	$1,780,637	5.81%	$21,600	5.81%	$103,455
Non Medical Transportation	SCI, EBD, CMHS, BI, SLS, DD	$48,695,683	0.00%	$0	0.00%	$0
Personal Care - Denver	EBD, SCI, BI, CMHS, SLS	$59,612,194	0.00%	$0	0.00%	$0
Personal Care - Outside Denver	EBD, SCI, BI, CMHS, SLS	$131,759,216	11.99%	$3,298,469	11.99%	$15,797,930
Prevocational Services	SLS, DD	$4,430,145	18.62%	$172,230	18.62%	$824,893
Residential Habilitation - Denver	DD	$29,616,528	0.00%	$0	0.00%	$0
Residential Habilitation - Outside Denver	DD	$422,544,201	9.01%	$7,948,939	9.01%	$38,071,233
Respite Care	CES, SCI, EBD, CMHS, BI, SLS, CHRP, CLLI	$24,172,167	11.24%	$567,276	11.24%	$2,716,952
Supported Community Connections	CHRP, SLS	$10,039,609	0.00%	$0	0.00%	$0
Supported Living Programs	BI	$26,861,524	6.00%	$336,507	6.00%	$1,611,691
Supported Employment	SLS, DD	$36,283,776	6.97%	$528,029	6.97%	$2,528,979
Total				**$33,373,436**		**$159,841,194**

Table 5.1 Total Savings from Increasing Non-Emergent Use of Emergency Department Copayments				
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**Notes/Calculations**
A	Proposed Copayment	$8.00	$8.00	
B	Current Copayment	$6.00	$6.00	
C	Proposed Increase in Copayments	$2.00	$2.00	Row A - Row B
D	FY 2018-19 Copayments Paid	11,218	11,218	
E	Estimated Caseload Growth	30.89%	30.89%	Projected Growth from FY 2018-19 to FY 2022-23
F	Payment Period Adjustment	91.67%	100.00%	Projected Implementation July 1, 2023
G	**Total Annual Estimated Savings for Copayment Increases**	**($26,920)**	**($29,368)**	**Row C * Row D * Row E * Row F * -1**

Table 5.2 Total Increased Cost of Increasing Personal Needs Allowance				
Row	**Item**	**FY 2022-23**	**FY 2023-24**	**Notes/Calculations**
A	Proposed Personal Needs Allowance Maximum	$383.33	$383.33	
B	Current Personal Needs Allowance Maximum	$152.00	$152.00	
C	Proposed Change in Personal Needs Allowance	$231.33	$231.33	Row A - Row B
D	Number of Members Currently Paying Maximum	1,981	1,981	Number of Members Currently at PNA maximum
E	Estimated Percentage Increase in Personal Needs Maximum	84.54%	84.54%	Based on the percentage of expenditure projected to go to the proposed maximum based on current member income
F	Payment Period Adjustment	41.67%	100.00%	Projected Implementation January 1, 2023
G	**Total Annual Estimated Increase in Costs for Personal Needs Allowances**	**$1,937,115**	**$4,649,076**	**Row C * Row D * Row E * Row F * 12**

Department of Health Care Policy & Financing

FY 2022-23 Funding Request

November 1, 2021

Jared Polis
Governor

Kim Bimestefer
Executive Director

Department Priority: R-11
Request Detail: ACC CHP+ Accountability

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$239,471,738	($1,048,141)	($1,055,452)
FTE	560.9	2.0	2.0
General Fund	$45,934,143	($351,127)	($354,194)
Cash Funds	$43,097,063	$0	$0
Reappropriated Funds	$2,181,331	$0	$0
Federal Funds	$148,259,201	($697,014)	($701,258)

Summary of Request

The Department of Health Care Policy & Financing requests 2.0 FTE for the Accountable Care Collaborative (ACC) and Child Health Plan *Plus* (CHP+) programs to improve the process of care for clients enrolled in these programs. The goal of this request is to expand state-level oversight and accountability within the ACC and CHP+. The current staffing pattern is designed to ensure basic minimum compliance. To realize meaningful improvements in the quality of care and to drive equity in health outcomes, additional staff are required. This request will lead to meaningful improvements in the procurement process for the ACC Phase III. The department has identified quality and compliance issues within the ACC and CHP+ programs. By investing in the operational capacity of the department, the outcomes experienced by members in these programs can be analyzed and improved. This request is offset by reducing the Children's Basic Health Plan Administration line item by 25 percent. In aggregate, this results in a budget-negative request. This request represents a decrease of less than 0.5% from the department's FY 2020-21 Long Bill total funds appropriation.

Current Program

The department is committed to creating a high-performing, cost-effective Medicaid system that delivers quality services and improves the health of Coloradans. To achieve this, the department has implemented the second phase of the Accountable Care Collaborative (ACC), wherein the department contracts with seven Regional Accountable Entities (RAEs) to provide high-quality, cost-effective, coordinated care to clients across the state. The department utilizes incentive payments to RAEs to drive improved health outcomes for members.

The ACC is the primary physical and behavioral health care delivery system for over 1.4 million Colorado Medicaid members. The ACC is an intentionally iterative process. Phase I began in 2011, with the primary goal of ensuring that all members had access to coordinated primary care. Starting in 2015, the department began developing plans for the second phase of the ACC, which took effect July 1, 2018. Phase II eliminated the Regional Care Collaborative Organizations (RCCOs) and the Behavioral Health Organizations (BHOs), which had been responsible for providing primary and behavioral health care, respectively. These organizations were replaced by RAEs, which are intended to consolidate the administrative functions of RCCOs and BHOs. The primary goal of Phase II has been to realize greater care coordination for members and cost savings for the state.

ACC Phase III will begin on July 1, 2025. The department is required to competitively reprocure the RAE contracts; July 1, 2025 represents the maximum-allowed contract time-period of seven years; after this point, state statute requires that the department reprocure the RAE contracts. The department has begun the process of strategic planning, policy research and development, in preparation for the formal procurement and stakeholder engagement processes.

Current staffing patterns allocate one Program Specialist per RAE region. This enables the department to monitor basic minimum compliance with certain RAE responsibilities. It does not enable the department to build data-driven, equity-focused, proactive partnerships with the RAEs, which have the potential to drive significant improvements to the process and outcomes of care for members.

The Child Health Plan *Plus* (CHP+) is public low-cost health insurance for certain children and pregnant women. Congress established the Children’s Health Insurance Program in 1997, CHIP (now CHP+), covers children and pregnant persons from low-income families who earn too much to qualify for Medicaid. Like Medicaid, CHP+ functions as a state and federal partnership. The current federal match rate for CHP+ is 65%. Unlike Medicaid, CHP+ functions like a traditional health insurance plan in that it charges enrollees premiums and out-of-pocket costs

for services. To receive care, members are enrolled into a Managed Care Organization (MCO) that should be designed to meet their health care needs. As of June 2021, approximately 58,000 children and women were covered by CHP+ in Colorado. Enrollment in CHP+ has been artificially dampened by the requirements associated with the Public Health Emergency (PHE), which require state agencies to continue health care coverage for all medical assistance programs regardless of changes to eligibility status. Members who would have otherwise churned from Medicaid to CHP+ have remained in Medicaid for the duration of the PHE. Therefore, the department expects an increase in CHP+ enrollment upon termination of the PHE.

Current department staffing patterns allocate 3.0 FTE to oversee the six managed care plans offered under CHP+. One FTE is a manager. This staffing pattern is sufficient to ensure basic minimum compliance, field complaints, and carry out annual parity reporting. This staffing pattern is not sufficient to carry out any clinical work within the department or to fully dedicate any staff to performance management of CHP+ managed care plans.

Problem or Opportunity

The department has identified administrative opportunities to expand and strengthen operational compliance, program oversight, and accountability. The department does not have sufficient administrative resources to successfully implement quality and compliance improvements to the ACC and CHP+ programs without diverting resources from other areas. By realizing these opportunities for improvement, the department can create a more responsive, accountable framework of care for members.

Accountable Care Collaborative

The department has begun the process of strategic planning, policy research and development in preparation for the formal procurement process and stakeholder engagement associated with ACC Phase III. This request will provide critical support leading up to and throughout the procurement process. A key goal of the ACC Phase III is increased accountability and transparency around progress towards RAE performance metrics; however, current staffing patterns are insufficient to perform detailed analysis and enforcement of RAE performance metrics. The ACC Phase III procurement process will adhere to the following timeline:

- Spring 2023: publishing a concept paper to guide the formal procurement and stakeholder engagement process;
- Fall 2023: publishing a draft Request for Proposals (RFP);
- Spring 2024: posting official RFP;

- Fall 2024: executing contracts to allow a minimum of six months for vendor transition activities.

More broadly, there is an opportunity to improve the process and outcomes of care for members by expanding the operational capacity of the department to become a more proactive partner in monitoring RAE performance measures. The department has collected data showing that many RAEs are underperforming in key measures:

During the COVID-19 pandemic, suicide and self-inflicted injury became a more common reason for admission to the emergency department than in the previous year. There were approximately 2,600 pediatric emergency department visits for suicide and self-inflicted injury in calendar year 2020. For children in foster care, suicide and self-inflicted injury is the number one reason for an emergency department visit. More than ten percent of all emergency department visits for foster care children are for suicide and self-inflicted injury.

Low-cost behavioral health service utilization is also trending down across all RAEs for the 2020 calendar year. This represents a decline in members' utilization of preventative and therapeutic behavioral health services, which often leads to increased utilization of higher-cost service utilization in the long term. This decrease in behavorial health care service utilization could also be linked to the increase in suicide and self-inflicted injury.

Behavioral health utilization for individuals experiencing unstable housing is also trending down. This trend is especially concerning given the overall increase in the number of individuals who identify as living in unstable conditions.

Child Health Plan *Plus*

Similarly, there is a need for more active management within the CHP+ program, to ensure both that timely resolution to inaccurate payments and enrollments is achieved and that a minimally acceptable set of clinical programs are offered to members. This requires increased centralized oversight from the department.

Evidentiary findings from department data collection demonstrate program compliance issues stemming from slow resolution, reconciliation, and inaccurate payments. While the department has existing mechanisms in place to recoup inaccurate payments, and correct for enrollment and eligibility mismatch, the processes are very slow.

There is also evidence of Colorado's underperformance in many CMS Core Measures.[1] This data is mandated to be reported and publicly posted starting in 2024. In all the following measures, Colorado is in the tenth decile of performance:

- Childhood Asthma;
- Childhood Immunizations;
- Immunizations for Adolescents;
- Adolescent Well Care Visits;
- Well Visits 3-6 Years;[2]
- Well Visits in the first 15 months of Life (six visits);
- Prenatal and Postpartum Care;[3] and
- Postpartum Care.

Lastly, the CHP+ program's related program regulations are in need of updates to ensure compliance. There are significant penalties for noncompliance, yet the department lacks adequate dedicated resources to ensure compliance across all of its plans. Failing to meet compliance standards jeopardizes the federal match for the program, and the department could face financial penalties of $1 million in deferrals per deliverable.

By increasing the operational capacity of CHP+ within the department, there is opportunity for greater accountability, cost-effectiveness, and transparency in the health care programs and services utilized by members. Increasing the department's operational capacity will also allow for a more effective ACC Phase III procurement process by strengthening the department's ability to capitalize on data-driven performance measures.

Proposed Solution

The department requests a reduction of $1,048,141 total funds, including a reduction of $351,127 General Fund and an increase of 2.0 FTE in FY 2022-23; and a reduction of $1,055,452 total funds, including a reduction of $354,194 General Fund, and an increase of 2.0 FTE in FY 2023-24 to provide increased stewardship of state resources through the implementation of operational compliance and program oversight measures. This request is offset by reducing the Children's Basic Health Plan Administration line item by 25 percent. In aggregate, this results in

[1]https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures

[2] Well Visit measures changed in 2020 to align more with bright futures and are not comparable to the 2019 Medicaid 90th percentile.

[3] There are known issues with the data behind the Prenatal and Postpartum Care measure due to not being able to capture visit dates in the global bill.

a budget-negative request. This request to add dedicated FTE will provide for the following activities: Addressing operational capacity and oversight deficiencies in both the ACC and CHP+ programs; ensuring compliance, quality, and accountability within both the ACC and CHP+ programs; and assisting in the planning, development, and implementation of the ACC Phase III.

Accountable Care Collaborative

The department requests 1.0 FTE to perform quality and compliance oversight of RAEs and to implement an equity, quality, and accountability focused strategy to improve member health and shape the ACC Phase III.

ACC Quality and Accountability

The department's request includes one FTE to directly address the state's poor performance in critical core measures. This FTE will be an Accountability Analyst, and specific duties of the position will include: developing a strategy for enhanced quality and accountability in RAE contract compliance monitoring, assisting in the development of system changes to reflect the new Behavioral Health Administration structure, assisting in the strategy and stakeholder engagement efforts associated with ACC Phase III, assisting in behavioral health policy development related to ACC Phase III, providing operational support for statewide Behavioral Health efforts including additional and ongoing support for operationalizing the substance use disorder (SUD) benefit and the supported housing and supported employment benefits, developing better integration of peer support services, and working with OBH and the RAEs to incentivize and create capacity for intensive community-based services.

Child Health Plan *Plus*

The department requests to add 1.0 FTE to more strategically advance managed care performance in CHP+. This position will serve as the CHP+ Quality and Program Integrity Specialist, and specific duties will include implementing a quality and outcomes focused strategy to improve member health and reduce costs to the state to improve outcomes and mitigate compliance risk for the department by enforcing program improvement through evidence driven performance metrics. This will involve the development of data-driven quality metrics, strategies and interventions to improve member health, and reestablishing and maintaining CHP+ program compliance with federal and state rules and regulations. This position will also assist in CHP+ parity reporting, addressing benefit deviations within CHP+ program and its rule, and maintaining compliance with the CHP+ 1115 waiver special terms and conditions (STC), thereby mitigating risk for the department. This position will also lead CHP+ program evaluation efforts and develop strategies for outcome improvement and manage utilization and program performance through enforcement and performance metrics.

Financing

The entirety of this request is offset by reducing the Children's Basic Health Plan Administration line item by 25 percent. The department has unused funding that is appropriated for administration of CHP+. Each year, a significant portion of this funding reverts. This funding cannot be used for personal services because the line item has no FTE authority. The department requests to reallocate the funding in this line item to Personal Services, to allow for the hiring of permanent staff. In aggregate, this results in a budget-negative request.

Consequences if not Funded

If this request is not approved, the department will be left with inadequate resources to effectively monitor the compliance and improvement of its programs. Failure to remain in compliance with federal requirements could result in the disallowance of federal funds and financial penalties, directly impacting the state General Fund. The department has attempted to maintain the workload within existing resources, but it has become increasingly apparent that these programs cannot be effectively managed and improved within existing resources.

Evidence-Based Continuum

The department believes that the ACC and CHP+ programs are on Step 3 of the OSPB Evidence-based continuum, "Assess Outputs." The department collects and evaluates data on whether the program objectives are being achieved, as measured by CMS Core Measures. The theory of change within the request posits that improving the quality and accountability of the programs offered through the ACC and CHP+ will have a positive effect on the health outcomes experienced by members enrolled in these programs. The outputs to be measured to gauge the success of this proposed intervention include CMS Core Measures, long-term savings on high-cost health care services, short-term utilization of low-cost behavioral health care services, the number and type of inaccurate payments, and the number and type of financial penalties incurred by the department. The department believes the cost/benefit ratio of this proposed intervention to be budget-negative. Not only is the request budget-negative, but the resource offset being proposed is likely to avoid significant future costs by minimizing the department's risk of exposure to federal financial penalties, and by increasing the utilization of low-cost, short-term services in order to avoid the use of long-term, high-cost services. To measure the impact of this intervention, the department will carry out a Pre-Post Evaluation to compare the state's performance in CMS Core Measures.

Theory of Change	Increasing the quality and accountability of programs offered through the ACC and CHP+ will improve member health outcomes as measured by CMS Core Measures. [4]		
Program Objective	To improve member outcomes by increasing the equity, quality, and accountability of program offerings in the ACC and CHP+.		
Outputs Being Measured	Long-term savings on high-cost healthcare services, short-term utilization of low-cost behavioral health care services, inaccurate payments, and potential financial penalties imposed by the federal government.		
Outcomes Being Measured	CMS Core Measures		
Cost/Benefit Ratio	The cost of the status quo will likely be higher than the cost of this budget request. This high cost will most likely be expressed as increases to high-cost health care service utilization.		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Potential Evaluation	Beginning in 2024, states' data submissions of CMS Core Measure results will be publicly posted and held to a minimum standard. Evaluation will occur through direct comparison of Colorado's CMS Core Measure performance before and after the policy interventions in this request.		
Continuum Level	Step 3		

Anticipated Outcomes

Accountable Care Collaborative

This request will enable the department to increase the level of coordination and accountability for RAEs. Specifically, the department will focus new effort on the utilization patterns of low-cost behavioral health services and strategies for improving the state's performance in CMS Core Measures. This request will allow the department to focus targeted efforts on transitions of care by developing sustainable alternative services that will help members to effectively step down from the Colorado Mental Health Institutes (CMHIs) and that can provide a new level of services to support members in the community, preventing CMHI admission.

[4] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures

This request will also improve data integrity by expediting the process to change specifications in the department's claims processing system to more accurately identify behavioral health providers and behavioral health care service utilization patterns. This request will also expedite the process of working with the RAEs to create more standard data definitions, which will lead to increased accuracy in network reporting. This request will also empower the department to ensure that Phase III of the ACC includes the requisite performance and accountability metrics to ensure that equitable health access and outcomes are achieved.

Child Health Plan *Plus*

By investing in centralized oversight of CHP+ managed care plans, the department will be able to better monitor outcomes for members and ensure program compliance in a way that is not currently possible. This will entail increased data collection, research, and policy interventions designed to improve member outcomes and the low-scoring percentages in many CMS Core Measures. The department will be able to better monitor the minimally acceptable clinical offerings of MCOs within CHP+. The department anticipates that members will become more likely to receive core services, such as timely well visits and prenatal care, and that health outcomes will also improve. This may lead to future, longer-term reductions in service costs.

Connection to Department Performance Plan

This request contributes directly to the Pillars in the department's Performance Plan of Member Health, Care Access, and Operational Excellence. The resources requested drive compliant, efficient, effective business practices that are person- and family-centered. This will enable greater equity in health outcomes by improving members' access to providers. The initiatives within the request also represent a direct implementation of the department's mission of improving equity, access and outcomes through continuous improvement, transparency, and accountability.

Assumptions and Calculations

Where applicable, notable assumptions and sources have been footnoted. Detailed calculations used to determine the fiscal impact for each initiative are included in the appendix. This request is offset by a cash fund reduction in the Children's Basic Health Plan Administration line item. The cash fund reduction is then applied to the Children's Basic Health Plan Medical and Dental line item, which reduces the need for General Fund appropriations in the Children's Basic Health Plan Medical and Dental line item, caused by the insolvency of the Children's Basic Health Plan Trust cash fund.

Table 1.1
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$140,724	2.0	$35,181	$24,627	$0	$80,916	57.50%	Table 4-5 Personal Services
B	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, Health Life Dental	$27,630	0.0	$6,773	$4,930	$0	$15,927	57.64%	Table 4-5 Centrally Appropriated Costs
C	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, Short-Term Disability	$200	0.0	$50	$35	$0	$115	57.50%	Table 4-5 Centrally Appropriated Costs
D	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, AED	$6,262	0.0	$1,565	$1,096	$0	$3,601	57.51%	Table 4-5 Centrally Appropriated Costs
E	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, SAED	$6,262	0.0	$1,565	$1,096	$0	$3,601	57.51%	Table 4-5 Centrally Appropriated Costs
F	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$15,900	0.0	$3,975	$2,782	$0	$9,143	57.50%	Table 4-5 Operating Expenses
G	(1) Executive Director's Office; (A) General Administration, Leased Space	$13,200	0.0	$3,300	$2,310	$0	$7,590	57.50%	Table 4-5 Leased Space
H	(5) Indigent Care Program, Children's Basic Health Plan Administration	($1,258,319)	0.0	$0	($440,412)	$0	($817,907)	65.00%	Table 3.1
I	(5) Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs	$0	0.0	($403,536)	$403,536	$0	$0	65.00%	See narrative
J	**Total Request**	**($1,048,141)**	**2.0**	**($351,127)**	**$0**	**$0**	**($697,014)**		Sum of Rows A thru I

Table 1.2
Summary by Line Item
FY 2023-24

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$146,360	2.0	$36,590	$25,613	$0	$84,157	57.50%	Table 4-5 Personal Services
B	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, Health Life Dental	$28,171	0.0	$7,044	$4,930	$0	$16,197	57.50%	Table 4-5 Centrally Appropriated Costs
C	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, Short-Term Disability	$208	0.0	$52	$36	$0	$120	57.69%	Table 4-5 Centrally Appropriated Costs
D	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, AED	$6,514	0.0	$1,628	$1,140	$0	$3,746	57.51%	Table 4-5 Centrally Appropriated Costs
E	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, SAED	$6,514	0.0	$1,628	$1,140	$0	$3,746	57.51%	Table 4-5 Centrally Appropriated Costs
F	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$1,900	0.0	$475	$332	$0	$1,093	57.53%	Table 4-5 Operating Expenses
G	(1) Executive Director's Office; (A) General Administration, Leased Space	$13,200	0.0	$3,300	$2,310	$0	$7,590	57.50%	Table 4-5 Leased Space
H	(5) Indigent Care Program, Children's Basic Health Plan Administration	($1,258,319)	0.0	$0	($440,412)	$0	($817,907)	65.00%	Table 3.1
I	(5) Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs	$0	0.0	($404,911)	$404,911	$0	$0	65.00%	See narrative
J	**Total Request**	**($1,055,452)**	**2.0**	**($354,194)**	**$0**	**$0**	**($701,258)**		Sum of Rows A thru I

Table 1.2
Summary by Line Item
FY 2024-25 and Ongoing

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$146,360	2.0	$36,590	$25,613	$0	$84,157	57.50%	Table 4-5 Personal Services
B	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, Health Life Dental	$28,171	0.0	$7,044	$4,930	$0	$16,197	57.50%	Table 4-5 Centrally Appropriated Costs
C	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, Short-Term Disability	$208	0.0	$52	$36	$0	$120	57.69%	Table 4-5 Centrally Appropriated Costs
D	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, AED	$6,514	0.0	$1,628	$1,140	$0	$3,746	57.51%	Table 4-5 Centrally Appropriated Costs
E	(1) Executive Director's Office; (A) General Administration, Centrally Appropriated Costs, SAED	$6,514	0.0	$1,628	$1,140	$0	$3,746	57.51%	Table 4-5 Centrally Appropriated Costs
F	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$1,900	0.0	$475	$332	$0	$1,093	57.53%	Table 4-5 Operating Expenses
G	(1) Executive Director's Office; (A) General Administration, Leased Space	$13,200	0.0	$3,300	$2,310	$0	$7,590	57.50%	Table 4-5 Leased Space
H	(5) Indigent Care Program, Children's Basic Health Plan Administration	($1,258,319)	0.0	$0	($440,412)	$0	($817,907)	65.00%	Table 3.1
I	(5) Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs	$0	0.0	($404,911)	$404,911	$0	$0	65.00%	See narrative
J	**Total Request**	**($1,055,452)**	**2.0**	**($354,194)**	**$0**	**$0**	**($701,258)**		Sum of Rows A thru I

Table 2.1
Summary by Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	**Administrative Resources**								
B	Additional ACC FTE	$104,818	1.0	$52,409	$0	$0	$52,409	50.00%	See Table 4
C	Additional CHP+ FTE	$105,360	1.0	$0	$36,876	$0	$68,484	65.00%	See Table 5
D	*Subtotal*	*$210,178*	*2.0*	*$52,409*	*$36,876*	*$0*	*$120,893*		Row B + Row C
E									
F	**Financing**								
G	Reduction to CHP+ Administration Line	($1,258,319)	0.0	$0	($440,412)	$0	($817,907)	65.00%	See Table 3.1
H	Fund Split Adjustment to CHP+ Services Line	$0	0.0	($403,536)	$403,536	$0	$0	N/A	See Narrative
I	*Subtotal*	*($1,258,319)*	*0.0*	*($403,536)*	*($36,876)*	*$0*	*($817,907)*		Row G + Row H
J	**Total Request**	**($1,048,141)**	**2.0**	**($351,127)**	**$0**	**$0**	**($697,014)**		Row D + Row I

Table 2.2
Summary by Initiative
FY 2023-24

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	**Administrative Resources**								
B	Additional ACC FTE	$101,434	1.0	$50,717	$0	$0	$50,717	50.00%	See Table 4
C	Additional CHP+ FTE	$101,434	1.0	$0	$35,501	$0	$65,932	65.00%	See Table 5
D	*Subtotal*	*$202,868*	*2.0*	*$50,717*	*$35,501*	*$0*	*$116,649*		Row B + Row C
E									
F	**Financing**								
G	Reduction to CHP+ Administration Line	($1,258,319)	0.0	$0	($440,412)	$0	($817,907)	65.00%	See Table 3.1
H	Fund Split Adjustment to CHP+ Services Line	$0	0.0	($404,911)	$404,911	$0	$0	N/A	See Narrative
I	*Subtotal*	($1,258,319)	0.0	($404,911)	($35,501)	$0	($817,907)		Row G + Row H
J	**Total Request**	**($1,055,452)**	**2.0**	**($354,194)**	**$0**	**$0**	**($701,258)**		Row D + Row I

Table 2.3
Summary by Initiative
FY 2024-25 and Ongoing

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	**Administrative Resources**								
B	Additional ACC FTE	$101,434	1.0	$50,717	$0	$0	$50,717	50.00%	See Table 4
C	Additional CHP+ FTE	$101,434	1.0	$0	$35,501	$0	$65,932	65.00%	See Table 5
D	*Subtotal*	*$202,868*	*2.0*	*$50,717*	*$35,501*	*$0*	*$116,649*		Row B + Row C
E									
F	**Financing**								
G	Reduction to CHP+ Administration Line	($1,258,319)	0.0	$0	($440,412)	$0	($817,907)	65.00%	See Table 3.1
H	Fund Split Adjustment to CHP+ Services Line	$0	0.0	($404,911)	$404,911	$0	$0	N/A	See Narrative
I	*Subtotal*	*($1,258,319)*	*0.0*	*($404,911)*	*($35,501)*	*$0*	*($817,907)*		Row G + Row H
J	**Total Request**	**($1,055,452)**	**2.0**	**($354,194)**	**$0**	**$0**	**($701,258)**		Row D + Row I

Table 3.1
Estimated Impact of Reducing CHP+ Administration Line

Item	Total Funds	Cash Funds	Reappropriated Funds	Federal Funds
Current CHP+ Administration Line Item	$5,033,274	$1,761,646	$0	$3,271,628
Percentage Reduction	25%	25%	25%	25%
Total Requested Reduction	**($1,258,319)**	**($440,412)**	**$0**	**($817,907)**

Note: CHP+ FFP is 65%

Table 4
FTE Calculations

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund Source**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
ANALYST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	ACC Accountabilty Analyst
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$70,362**	**$73,180**	**$73,180**	

Centrally Appropriated Costs							
Cost Center	**FTE Year 1**	**FTE Year 2+**	**Cost or Percentage**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Health, Life, Dental	1.0	1.0	$14,086	$13,544	$14,086	$14,086	
Short-Term Disability	-	-	0.16%	$100	$104	$104	
Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Centrally Appropriated Costs Total				**$19,906**	**$20,704**	**$20,704**	

Operating Expenses							
Ongoing Costs	**FTE Year 1**	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Supplies	1.0	1.0	$500	$500	$500	$500	
Telephone	1.0	1.0	$450	$450	$450	$450	
Other	1.0	1.0	$0	$0	$0	$0	
Subtotal				*$950*	*$950*	*$950*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	
Other	1.0		$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	
Total Operating				**$7,950**	**$950**	**$950**	

Leased Space							
	FTE Year 1	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	1.0	1.0	$6,600	**$6,600**	**$6,600**	**$6,600**	

Table 5
FTE Calculations

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund Source**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
ANALYST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	CHP+ Accountabilty Analyst
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$70,362**	**$73,180**	**$73,180**	

Centrally Appropriated Costs							
Cost Center	**FTE Year 1**	**FTE Year 2+**	**Cost or Percentage**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Health, Life, Dental	1.0	1.0	$14,086	$14,086	$14,086	$14,086	
Short-Term Disability	-	-	0.16%	$100	$104	$104	
Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Centrally Appropriated Costs Total				**$20,448**	**$20,704**	**$20,704**	

Operating Expenses							
Ongoing Costs	**FTE Year 1**	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Supplies	1.0	1.0	$500	$500	$500	$500	
Telephone	1.0	1.0	$450	$450	$450	$450	
Other	1.0	1.0	$0	$0	$0	$0	
Subtotal				*$950*	*$950*	*$950*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	
Other	1.0		$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	
Total Operating				**$7,950**	**$950**	**$950**	

Leased Space							
	FTE Year 1	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	1.0	1.0	$6,600	**$6,600**	**$6,600**	**$6,600**	

Department Priority: R-12
Request Detail: Convert Contractor Resources to FTE

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	**FY 2022-23 Request**	**FY 2023-24 Request**
Total Funds	$10,242,335,491	($339,518)	($597,425)
FTE	560.9	23.2	24.0
General Fund	$2,471,948,063	($155,265)	($266,965)
Cash Funds	$1,220,205,941	($60,722)	($62,982)
Reappropriated Funds	$85,663,985	$370,586	$360,214
Federal Funds	$6,464,517,502	($494,117)	($627,692)

Summary of Request

The Department of Health Care Policy & Financing requests to build internal efficiencies, develop institutional knowledge, and adequately support multiple administrative duties. This will be done by repurposing funding appropriated to the department for contractor resources to instead hire state FTE to perform the duties, which is a more efficient and cost-effective solution and provides benefits such as retaining institutional knowledge and the ability to quickly refocus staff with changing priorities. Additionally, this request will supplement existing FTE to support administrative duties that are not adequately supported. This request is similar to the department's FY 2020-21 BA-11 and FY 2021-22 R-10, both named "Convert Contractor Resources to FTE," which also repurposed funding from contractor resources to hire FTE.

Cash funds included in this request are from the Healthcare Affordability and Sustainability Fee Cash Fund, the Children's Basic Health Plan Trust, and the Primary Care Fund. This request represents less than a 0.5% decrease to the department's budget.

Current Program

The department is responsible for fulfilling many critical administrative functions as the single state agency responsible for administration of the Medicaid program and the Children's Health Insurance Program. Since these programs are jointly funded with the federal government, department administration must meet requirements defined at both the state and federal level. The department is also responsible for the administration of several other statewide health care programs and for providing health care policy guidance and leadership to the executive branch, legislative branch, and other stakeholders in the state. Administrative duties include policy and data analysis, case management, financial audits, eligibility determination, information system development and maintenance, benefit utilization review, and much more. The department fulfills these administrative duties with a combination of contractor resources and state FTE resources depending on available funding, state and federal requirements, and appropriateness of a contractor versus state FTE solution.

Problem or Opportunity

The department has identified an opportunity to enhance several administrative functions by repurposing funding already appropriated for contractor resources and hiring FTE to perform these duties instead. The department has also identified administrative functions which lack adequate ongoing support and cannot be absorbed within existing resources.

While the appropriated contractor resources will allow the department to make progress in these areas, the department could make more progress and provide more ongoing support by using the funding for in-house staffing resources. This could be done with no additional General Fund and will build ongoing in-house expertise and institutional knowledge, therefore accomplishing more of the department's, Governor's, and General Assembly's goals.

Outside vendors are a less cost-effective way to meet the department's goals for these administrative duties. If the department were to continue using contractor resources, then each contractor would require oversight and management by department staff, which must be absorbed by existing staff in most cases. Contractor work typically is more expensive than FTE costs for equivalent work. The state frequently pays hourly rates to vendors that exceed the amount that would be paid for equivalent work by state FTE. In the past, the department has experienced difficulty in maintaining continuity of knowledge and processes when the work is transitioned between vendors. Subject matter knowledge is not always preserved during the transition process. The transition period between vendors generally results in delays in completion of deliverables as one vendor closes out and the other vendor ramps up to take on contractual responsibilities which would not occur with state FTE.

Proposed Solution

The department requests a reduction of $339,518 total funds, including a reduction of $155,265 General Fund and an increase of 23.2 FTE in FY 2022-23; and a reduction of $597,425 total funds, including a reduction of $266,965 General Fund, and an increase of 24.0 FTE in FY 2023-24 and ongoing to build internal efficiencies, develop institutional knowledge, and adequately support multiple administrative duties while realizing savings in total funds, General Fund, cash funds, and federal funds. The department requests to move funding that has already been appropriated for contractor resources to its personal services-related line items which will permit the hiring of additional staff. Cash funds are from the Healthcare Affordability and Sustainability Fee Cash Fund, the Children's Basic Health Plan Trust, and the Primary Care Fund. Reappropriated funds are from the Department of Higher Education (CDHE), Department of Human Services (CDHS), and Department of Public Health and Environment (CDPHE).

Long-Term Care Utilization Management

The department contracts with its Long-Term Care Utilization Management vendor to evaluate Home- and Community-Based Services (HCBS) 1915(c) waiver administration by the department's 47 case management agencies. The vendor performs Quality Improvement Strategies, which is required by the Centers for Medicare and Medicaid Services (CMS), to determine if member assessments and service plans across all HCBS waiver programs are being completed within the department's HCBS waiver agreements with CMS. Additionally, the vendor performs Performance and Quality Reviews to similarly evaluate the program, but on an agency-specific basis to identify specific performance successes and areas of improvement for each case management agency.

This request will eliminate contractor funding for Quality Improvement Services and Performance and Quality Reviews and add four FTE to the department to perform these functions instead, including one Program Manager, one Administrator, and two Compliance Specialists. The Program Manager will serve as a supervisor and be responsible for developing and monitoring review policies, review procedures, and CMS performance agreements. The Administrator will develop and administer trainings tailored to individual Case Management Agencies based on agency performance scores to continuously improve agency performance and monitor corrective action plans. The Compliance Specialists will develop agency review procedures and materials and conduct ongoing agency reviews of service plan development, assessment, developmental disability determination, monitoring, and revision and reassessment to ensure compliance with contract requirements and regulations. This request includes travel costs for the compliance specialists to conduct on-site agency reviews.

HCBS Waiver Claims Post-Payment Review

Until recently, the department contracted with a vendor to perform Post-Payment Reviews for all HCBS waiver programs. These reviews address CMS requirements to conduct claims sampling, data analysis, and review provider-submitted medical records for at least 5,000 HCBS waiver program claims per state fiscal year. In FY 2020-21, the department chose not to renew the contract and instead shifted the work in-house to two term-limited FTE to save money and improve the quality and accuracy of the reviews. The department does not have a permanent appropriation for these FTE but is able to temporarily absorb their cost in the department's Personal Services and FTE-related line items.

This request will eliminate contractor funding to perform the reviews and add two FTE to the department on a permanent basis to perform these functions instead, both Compliance Specialists. These FTE will be responsible for performing all post-payment review functions, including monitoring and auditing HCBS waiver provider billing and analyzing claims data and medical records to determine if providers used correct medical codes and diagnoses on claims. When an overpayment due to the department is found, these positions will issue a notice to the provider to recoup the overpayment. Additionally, these FTE will identify billing patterns that appear to be fraudulent, and in the event that fraud, waste, or abuse is suspected, will refer it to external parties such as the Attorney General's Office and the Medicaid Fraud Control Unit and assist with the preliminary investigation as needed. These FTE will also respond to any requests for information regarding addressing CMS requirements within the waiver applications.

Primary Care Fund and Colorado Indigent Care Program Reviews

The department currently contracts with a vendor to review Primary Care Fund and Colorado Indigent Care Program (CICP) applicant agencies, comprising approximately 50 hospitals and 32 community clinics. Reviews consist of both desk and on-site reviews of patient files such as financial eligibility, billing data, and processes and procedures to ensure program compliance with state and federal regulations. Additionally, H.B. 21-1198 establishes a new health care system financial assistance program for hospitals and provides additional contractor funding to the department to perform reviews of applicant agencies, which the department expects to be many of the same providers participating in CICP.

This request will eliminate contractor funding for both reviews along with new contractor funding for reviews in H.B. 21-1198 and add four FTE to the department to perform these functions instead, all Administrators. These FTE will develop and implement a program compliance and review process for Primary Care Fund and CICP applicant agencies, as well as applicant agencies under the new health care system financial assistance program for hospitals established by H.B. 21-1198. These FTE will conduct desk reviews and some on-site reviews of patient files including financial eligibility, program billing data, and processes and procedures to ensure program compliance with state statute and state and federal regulations. These FTE will also develop and implement an appeal process for providers, determine when corrective actions are required,

and conduct exit conferences with providers to review final determinations and discuss the appeal process.

Alternative Pay Model Rate Setting
To support the department's efforts to shift from paying for volume to paying for value, the department contracts with an actuarial vendor to assist with the department's Alternative Pay Model (APM) initiative. The vendor provides rate-setting services for the department's value-based payment programs. This includes preparation of base data, data analysis, evaluation of member utilization and churn, and assessment of risk and cost trends to determine appropriate rates for the department's value-based payment programs.

This request will reduce contractor funding for actuaries used in the value-based payment rate-setting process and add one new FTE to the department to perform some of this work instead, a Rate/Financial Analyst. This request will not eliminate the contractor funding entirely because actuarial work is still required in the rate-setting process; however, some of the work done by contracted actuaries does not require an actuary and this work will be performed by the requested FTE. This FTE will be responsible for preparing base data used in the rate-setting process, and analyzing member leakage, churn, and utilization patterns for the services included in the value-based payment being set. This FTE will specifically focus on the current scope of the maternity bundled value-based payment and the department's APM 2 initiative and will not be involved in the requested expansion of value-based payments in the department's FY 2022-23 R-6 "Value Based Payments" request.

Program Eligibility and Application Kit Outreach and Colorado Benefits Management System
The department, CDHS, and CDPHE jointly fund a contract managed by the Governor's Office of Information Technology (OIT) to provide Program Eligibility and Application Kit (PEAK) Outreach. The vendor enhances PEAK by researching user pain-points experienced by the public and front-line workers, developing and coordinating system improvements, and ensuring compliance with regulations and industry standards. Additionally, the department, CDHS, and CDPHE jointly fund a PEAK Product Manager and a Colorado Benefits Management System (CBMS) Deputy Product Owner, who oversee the development of these systems by interfacing with multiple stakeholders, determining system requirements, and monitoring implementation processes.

This request will eliminate contractor funding for PEAK Outreach and add four new FTE to the department to perform this function instead, including one Administrator, two Analysts, and one Project Manager. The Administrator will serve as the product owner for PEAK and lead expert for the Salesforce Marketing Cloud and optimizing the user experience within PEAK, leading efforts such as modernizing PEAK so that more of it is functional on mobile devices as more Coloradans apply for benefits online and use cell phones to do so. The Analysts will serve as Business Analysts and lead projects for CBMS-related and PEAK system enhancements and modifications, collaboratively working with multiple departments and stakeholders to research

user pain points, recommend enhancements, and ensure compliance with state and federal regulations, ultimately creating efficiencies such as reducing call center volume as the functionality and ease-of-use of PEAK increases. The Project Manager will manage all system enhancements by providing business needs assessments, managing project timelines, and collaborating with budget and accounting offices to identify costs, schedules, and resources for project initiatives.

Additionally, this request will repurpose funding from the department's CBMS Operating and Contract Expenses line item to the department's personal services-related line items to add two permanent FTE to the department for PEAK and CBMS oversight, both Program Managers. These positions will be the PEAK Product Manager and CBMS Deputy Product Owner and will be department FTE, but will be funded jointly by the department, CDHS, and CDPHE to serve all stakeholders in the CBMS and PEAK systems. These positions will oversee the development of their respective systems by coordinating with the multiple departments and other stakeholders, determining system priorities, translating priorities into system requirements, interfacing with contractors, monitoring implementation processes, and facilitating system training and documentation. The CBMS Deputy Product Owner will report to the CBMS Product Owner, which is a position at CDHS.

Independent Verification and Validation

The department contracts with a vendor to perform Independent Verification and Validation (IV&V) of system changes and implementations within the Medicaid Enterprise, which consists of four primary services including the department's Medicaid Management Information System (MMIS) and Fiscal Agent Services, Business Intelligence and Data Management (BIDM) services, the Pharmacy Benefit Management System (PBMS), and CBMS. Until recently, CMS required IV&V for monitoring and reviewing in-progress system implementations as well as final certification. However, new CMS guidance in 2020 eliminates the IV&V final certification requirements in favor of Outcome-Based Certification methods, which focus on evaluation of how well the system is meeting expected business outcomes.

This request will reduce contractor funding to perform IV&V and instead add two new FTE to the department to perform Outcome-Based Certification work, both Project Managers. This request will not eliminate the contractor funding entirely because even with the recent changes to CMS IV&V requirements, IV&V is still required in certain cases, such as monitoring and reviewing certain projects and reporting the results to CMS. However, since IV&V is no longer required for a project's certification in favor of Outcome-Based Certification methods, the department requires less IV&V contract work and more Project Management expertise since the success of certification is now the full responsibility of project management under this new framework. The requested Project Managers will develop outcomes and measures to use in the Outcome-Based Certification of a project, obtain CMS approval on the certification approach, meet with CMS to develop the certification intake forms, provide oversight of vendors and other

stakeholders throughout the evidence gathering and demonstration phases of the certification, ensure the certification evidence is complete and properly documented, and conduct operational readiness and final certification reviews with CMS.

MMIS Training

The department contracts with its MMIS and Fiscal Agent Services vendor to provide training to providers and department staff on using the MMIS. The vendor offers regular training to providers on basic billing procedures, provider portal usage, the basics of Medicaid programs, and training customized to each provider type including billing procedures for the types of claims they submit. The vendor also offers providers and department staff training as needed for any system changes that alter system functionality or entail program and policy updates. The vendor provides written training materials, user-guides, reference materials, and system documentation.

This request will eliminate contractor funding to perform MMIS Training and add two new FTE to the department to perform this function instead, both Administrators. These FTE will develop, deliver, and facilitate MMIS training courses for both providers and department staff. Provider trainings will be offered on a monthly basis for basic billing procedures, provider web portal usage, an introduction to Medicaid programs, and provider-specific training for the 86 different provider types and their associated claim types. These FTE will provide the training through live webinars and answer questions from providers at each training. These FTE will also provide training to department staff for technical user operation of the MMIS and provide training to both providers and department staff on system changes, new functionality, and program and policy updates. These FTE will maintain all system documentation for the provider web portal and provide guides and reference materials for billing procedures.

University of Colorado School of Medicine Physician Supplemental Payments

During the 2021 legislative session, the Joint Budget Committee (JBC) appropriated two FTE to the department to help oversee the University of Colorado School of Medicine (CUSOM) Physician Supplemental Payment program; however, it was unclear if these FTE were permanent.[1] Additionally, the department currently contracts with a vendor to calculate and report a federally-required Upper Payment Limit for CUSOM Physician Supplemental Payments.

This request will make permanent the two FTE appropriated by the JBC and eliminate the Upper Payment Limit contractor funding to add one new FTE to perform this function instead. The requested FTE include one Administrator, one Rate/Financial Analyst, and one Statistical Analyst. The requested Statistical Analyst and Administrator will make permanent the two FTE approved by the JBC and will be responsible for calculating CUSOM performance metrics, validating CUSOM data, measuring provider enrollment and member access, holding CUSOM accountable to department goals, supporting community collaboration efforts and access to care

[1] https://leg.colorado.gov/sites/default/files/cb6-03-24-21.pdf

work, and providing program-level support such as meeting and site visit coordination, reporting, and deliverable-tracking. The requested Rate/Financial analyst will perform functions currently performed by a vendor and this request will eliminate the contract funding for the FTE to perform the functions instead; these functions include calculating and reporting the federally required CUSOM Upper Payment Limit according to the department's State Plan and federal regulations, identifying and validating specific providers and other professionals eligible for participation, analyzing claims data, obtaining payer data including commercial charge and payment data, calculating the total allowable payment at the average commercial rate, and preparing the required documentation for CMS.

The department cannot absorb the administrative workload performed by the two FTE appropriated by the JBC within current FTE resources, as current resources dedicated to CUSOM Physician Supplemental Payments include only one Rate/Financial Analyst and 0.25 Accountant to oversee more than $150 million in annual payments.[2] This is the second-largest of the 18 supplemental payments to various providers made by the department, exceeded only by the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) supplemental payment, which has six dedicated staff plus additional support staff. Although the total annual CHASE supplemental is considerably larger than the current annual CUSOM supplemental, a minimum number of FTE are required to properly administer such large, complex supplemental payment programs and economies of scale are realized as the total dollar amount increases. The department expects CUSOM Physician Supplemental Payments to continue at least at their current level on an ongoing basis, requiring ongoing administrative support.

The requested FTE will not require any additional General Fund since the state source of funds will be reappropriated funding from CUSOM, matched with federal funds at a 50% federal match rate. Additionally, the reappropriated funding requested for these FTE will be offset by a reduction in reappropriated funding from the department's Medical and Long-Term Care Services for Medicaid Eligible Individuals line item. The CUSOM physician supplemental payment is financed through General Fund reappropriated from the Department of Higher Education to the department's Medical and Long-Term Care Services for Medicaid Eligible Individuals line item, with federal matching funds. However, a portion of the funds are reappropriated to administrative line items in the department to fund actual administrative costs of administering this payment mechanism. Thus, the requested increase in administrative costs for the requested FTE will shift reappropriated funds to administrative needs without causing an overall increase in reappropriated funds.

---

2 https://hcpf.colorado.gov/sites/hcpf/files/HCPF%2C%20CU%20LRFI%20%234%20Anschutz%20Medical%20Campus%20Funds.pdf

Consequences If Not Funded

If this request is not approved, the department will be unable to realize the benefits of converting the contracted administrative functions included in this request to FTE. These benefits include greater efficiency, greater line of sight into the work, better ability to rapidly adjust to changes in priorities, and the building of institutional knowledge and best practices. In addition, the department will continue to utilize contracts to fulfill these administrative functions, which are a less efficient method due to contracted staff typically costing more than state FTE and the additional state oversight role required for contracts. This oversight includes reviewing contractor work, taking corrective actions or financial adjustments, and procurement processes such as solicitations, annual contract renewals, negotiations, and invoice processing.

Additionally, if this request is not approved, the department will have inadequate resources to fulfill its administrative duties for CUSOM Physician Supplemental Payments. If additional resources are not permanently approved for CUSOM Physician Supplemental Payments, then CUSOM will continue to receive additional funding through supplemental payments while the department will be unable to ensure accountability to provider enrollment, member access, and other goals.

Evidence-Based Continuum

The department considers this request as aligning with Step 2 on the Office of State Planning and Budget (OSPB) continuum of evidence, as most of the initiatives included in this request include clear program objectives and the collection of evidence, analysis of data, or other form of testing to assess if program objectives are being met. Additionally, if deficiencies are found, most of the initiatives included in this request include some type of corrective action so that program objectives are better met such as corrective action plans, additional training, recouping payments, or system redesigns.

Theory of Change	Define clear program objectives and collect and analyze evidence and data or otherwise test program outputs to assess if program objectives are being met. Implement various corrective actions if not.		
Program Objective	Various program objectives, defined in advance.		
Outputs Being Measured	Various outputs including claims data, member data, user feedback, system functionality, and financial statements.		
Outcomes Being Measured	N/A		
Cost/Benefit Ratio	Benefits include greater efficiency, greater line of sight into work, better ability to rapidly adjust to changes in priorities, and building institutional knowledge and best practices, for no additional General Fund cost.		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	N/A	N/A	N/A
Continuum Level	Step 2		

Anticipated Outcomes

The department seeks to improve all areas of operations associated with the administrative functions included in this request. The department anticipates that approving this request will provide great return to the state by developing efficiencies and institutional knowledge on complex subject matter while realizing savings in total funds, General Fund, cash funds, and federal funds. The department anticipates this request will enhance administrative functions by using state FTE that can be more responsive to department priorities and more ingrained in the department culture and operations. The department anticipates a reduction in redundant overhead work required by administrative contracts including reviewing vendor work, implementing corrective action plans, determining financial adjustments to contracts, length solicitations, annual contract renewals processes, and invoice processing and payment. Additionally, the department anticipates approving this request will provide the administrative resources needed to adequately support CUSOM Physician Supplemental Payments and hold CUSOM accountable to supplemental payment performance goals.

If approved, this request will directly support the department's Pillars, the Governor's Wildly Important Goals (WIGs), and the Health Cabinet's WIGs described in the FY 2021-22 Department Performance Plan.[3] Specifically, this request will support:

[3] https://hcpf.colorado.gov/sites/hcpf/files/HCPF%202021-2022%20Performance%20Plan.pdf

- The Operational Excellence and Customer Service, and Medicaid Cost Control pillars by realizing the operational efficiencies and other benefits of converting identified contracted administrative functions to department FTE, by supporting various utilization and payment review functions, and by supporting APM rate setting efforts;
- The Member Health pillar through CUSOM Physician Supplemental Payments by tracking member access by race/ethnicity, urban/rural/frontier, and Regional Accountable Entity (RAE) region to improve member health outcomes and reduce disparities in care;
- The Care Access pillar through Long-Term Utilization Management and CUSOM Physician Supplemental Payments by holding partner organizations accountable to member access goals;
- The Governor's Eligibility Technology Support WIG by supporting PEAK Outreach and CBMS FTE and providing support for Outcome Based Certification of eligibility and related systems; and
- The Health Cabinet's WIG to utilize non-fee-for-service reimbursement structures by supporting APM rate setting efforts.

Assumptions and Calculations

Detailed calculations for this request are included in the attached appendix. The department made the following assumptions.

For the requested FTE, the department assumes all FTE included in this request will start July 1, 2022 and will be full-time, permanent positions as shown in table 3 of the appendix. For the Long-Term Care Utilization Management Compliance Specialist FTE, the department assumes monthly travel costs for case management agency site visits based on monthly travel costs of similar positions currently at the department, as shown in table 4 of the appendix.

For the requested contractor reductions, the department assumes all current funding for each contract will be eliminated and replaced with FTE to perform the duties instead, resulting in the contractor reductions shown in tables 5.1 and 5.2 of the appendix. For APM Rate Setting and IV&V, the department will not eliminate all contract funding because the vendors are still required to perform the function to some degree and the FTE will only partially replace vendor functions. For APM Rate setting, the department assumes the contractor funding will be reduced by 325 hours per year at a rate of $375 per hour and for IV&V, the department assumes the contractor funding will be reduced by 2,080 hours per year (one full-time position) at a rate of $145 per hour.

For the requested CUSOM Physician Supplemental Payments FTE, the department assumes the reappropriated funds for these FTE will be offset by a reduction to the Medical and Long-Term Care Services for Medicaid Eligible Individuals line item, as shown in Tables 7.1 and 7.2.

For the requested fund splits, the department assumes a federal match rate of 50% for standard Medicaid administrative costs and General Fund for the state fund source, with the following exceptions.

- For Long-Term Care Utilization Management and HCBS Waiver Claims Post Payment Review, the current contracts are eligible for an enhanced 75% federal match; however, the department assumes the requested FTE will only be eligible for the standard 50% federal match. Although this will result in the loss of some federal matching funds, the department believes the conversion will still be beneficial due to the General Fund savings it will generate and the operational efficiencies and other benefits of converting contractor functions to department FTE.
- For Primary Care Fund and CICP reviews, the current Primary Care Fund review contract is funded with 100% Primary Care Fund and the current CICP review contract and HB21-1198 funding is 100% General Fund; however, the department assumes the requested FTE will utilize General Fund and be eligible for the standard 50% federal match since the CICP audits include hospital audits and since S.B. 21-212 allows the Primary Care Fund to draw federal match.
- For PEAK Outreach and CBMS, the department assumes contractor funding will be reduced from the department's CBMS Operating and Contract Expenses line item and that reappropriated funding from the department, CDHS, and CDPHE to OIT will be reduced using standard CBMS fund splits as shown in table 6 of the appendix; for the requested FTE, the department assumes that funding will follow standard CBMS fund splits and include reappropriated funding from CDHS and CDPHE.
- For IV&V and MMIS Training, the department assumes both current contractor funding and requested FTE will utilize standard Medicaid Enterprise fund splits and be eligible for enhanced 75% and 90% federal match rates for maintenance and development work related to a certified MMIS.

R-12 Convert Contractor Resources to FTE
Appendix A: Assumptions and Calculations

Table 1.1
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$1,746,305	23.2	$494,134	$54,473	$369,740	$827,958	47.41%	Table 3, Personal Services
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$326,675	0.0	$92,168	$10,470	$66,155	$157,882	48.33%	Table 3, Cost Center
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$2,485	0.0	$700	$75	$526	$1,184	47.65%	Table 3, Health, Life, Dental
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$77,717	0.0	$21,989	$2,423	$16,453	$36,852	47.42%	Table 3, Short-Term Disability
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization Disbursement	$77,717	0.0	$21,989	$2,423	$16,453	$36,852	47.42%	Table 3, Amortization Equalization Disbursement
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$200,400	0.0	$58,901	$6,144	$38,357	$96,998	48.40%	Sum of Table 3, Operating Expenses and Table 4, Row D
G	(1) Executive Director's Office; (A) General Administration; Leased Space	$158,400	0.0	$44,916	$5,101	$31,842	$76,541	48.32%	Table 3, Leased Space
H	(1) Executive Director's Office; (A) General Administration; General Professional Services and Special Projects	($517,027)	0.0	($318,089)	$0	($69,000)	($129,938)	25.13%	Table 5.1, Sum of Rows G, I, and Q
I	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; MMIS Maintenance and Projects	($473,471)	0.0	($45,368)	($33,313)	$0	($394,790)	83.38%	Table 5.1, Sum of Rows M and O
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; CBMS Operating and Contract Expenses	($295,116)	0.0	($96,104)	($51,356)	$0	($147,656)	50.03%	Table 5.1, Row K
K	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts; Professional Services Contracts	($535,000)	0.0	($133,750)	$0	$0	($401,250)	75.00%	Table 5.1, Row C
L	(1) Executive Director's Office; (F) Provider Audits and Services; Professional Audit Contracts	($1,008,663)	0.0	($296,751)	($57,162)	$0	($654,750)	64.91%	Table 5.1, Sum of Rows A, E, and F
M	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($99,940)	0.0	$0	$0	($99,940)	$0	0.00%	Table 7.1, Row D
N	**Total Request**	**($339,518)**	**23.2**	**($155,265)**	**($60,722)**	**$370,586**	**($494,117)**	**N/A**	**Sum of Rows A through M**

R-12 Convert Contractor Resources to FTE
Appendix A: Assumptions and Calculations

Table 1.2
Summary by Line Item
FY 2023-24 and Ongoing

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$1,806,980	24.0	$513,923	$56,654	$379,915	$856,488	47.40%	Table 3, Personal Services
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$338,064	0.0	$95,860	$10,889	$67,961	$163,354	48.32%	Table 3, Cost Center
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$2,571	0.0	$730	$77	$539	$1,225	47.65%	Table 3, Health, Life, Dental
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$80,419	0.0	$22,869	$2,519	$16,907	$38,124	47.41%	Table 3, Short-Term Disability
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization Disbursement	$80,419	0.0	$22,869	$2,519	$16,907	$38,124	47.41%	Table 3, Amortization Equalization Disbursement
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$32,400	0.0	$11,266	$735	$4,583	$15,816	48.81%	Sum of Table 3, Operating Expenses and Table 4, Row D
G	(1) Executive Director's Office; (A) General Administration; Leased Space	$158,400	0.0	$44,916	$5,101	$31,842	$76,541	48.32%	Table 3, Leased Space
H	(1) Executive Director's Office; (A) General Administration; General Professional Services and Special Projects	($517,027)	0.0	($318,089)	$0	($69,000)	($129,938)	25.13%	Table 5.2, Sum of Rows H, J, and R
I	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; MMIS Maintenance and Projects	($473,471)	0.0	($45,368)	($33,313)	$0	($394,790)	83.38%	Table 5.2, Sum of Rows N and P
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; CBMS Operating and Contract Expenses	($293,077)	0.0	($95,440)	($51,001)	$0	($146,636)	50.03%	Table 5.2, Row L
K	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts; Professional Services Contracts	($715,000)	0.0	($223,750)	$0	$0	($491,250)	68.71%	Table 5.2, Sum of Rows B and D
L	(1) Executive Director's Office; (F) Provider Audits and Services; Professional Audit Contracts	($1,008,663)	0.0	($296,751)	($57,162)	$0	($654,750)	64.91%	Table 5.2, Sum of Rows A, F, and G
M	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($89,440)	0.0	$0	$0	($89,440)	$0	0.00%	Table 7.2, Row D
N	**Total Request**	**($597,425)**	**24.0**	**($266,965)**	**($62,982)**	**$360,214**	**($627,692)**	**N/A**	**Sum of Rows A through M**

Table 2.1
Summary by Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Long-Term Care Utilization Management									
A	FTE Costs	$438,556	3.8	$219,275	$0	$0	$219,281	50.00%	Table 3
B	Travel Costs	$9,600	*0.0*	$4,800	$0	$0	$4,800	50.00%	Table 4, Row D
C	Contractor Cost Reductions	($873,000)	0.0	($218,250)	$0	$0	($654,750)	75.00%	Table 5.1, Row B
D	**Subtotal**	**($424,844)**	**3.8**	**$5,825**	**$0**	**$0**	**($430,669)**	**N/A**	**Sum of Rows A, B, and C**
HCBS Waiver Claims Post Payment Review									
E	FTE Costs	$209,639	1.9	$104,818	$0	$0	$104,821	50.00%	Table 3
F	Contractor Cost Reductions	($535,000)	0.0	($133,750)	$0	$0	($401,250)	75.00%	Table 5.1, Row D
G	**Subtotal**	**($325,361)**	**1.9**	**($28,932)**	**$0**	**$0**	**($296,429)**	**N/A**	**Sum of Rows E and F**
Primary Care Fund and CICP Reviews									
H	FTE Costs	$419,279	3.8	$209,638	$0	$0	$209,641	50.00%	Table 3
I	Contractor Cost Reductions	($392,815)	0.0	($335,653)	($57,162)	$0	$0	0.00%	Table 5.1, Row H
J	**Subtotal**	**$26,464**	**3.8**	**($126,015)**	**($57,162)**	**$0**	**$209,641**	**N/A**	**Sum of Rows H and I**
Alternative Pay Model Rate Setting									
K	FTE Costs	$116,567	1.0	$58,282	$0	$0	$58,285	50.00%	Table 3
L	Contractor Cost Reductions	($121,875)	0.0	($60,937)	$0	$0	($60,938)	50.00%	Table 5.1, Row J
M	**Subtotal**	**($5,308)**	**1.0**	**($2,655)**	**$0**	**$0**	**($2,653)**	**N/A**	**Sum of Rows K and L**
PEAK Outreach and CBMS									
N	FTE Costs	$668,805	5.8	$97,103	$51,874	$370,586	$149,242	22.31%	Table 3
O	Contractor Cost Reductions	($295,116)	0.0	($96,104)	($51,356)	$0	($147,656)	50.03%	Table 5.1, Row L
P	**Subtotal**	**$373,689**	**5.8**	**$999**	**$518**	**$370,586**	**$1,586**	**N/A**	**Sum of Rows N and O**
Independent Verification and Validation									
Q	FTE Costs	$209,639	1.9	$13,006	$11,101	$0	$185,532	88.50%	Table 3
R	Contractor Cost Reductions	($301,600)	0.0	($18,711)	($15,972)	$0	($266,917)	88.50%	Table 5.1, Row N
S	**Subtotal**	**($91,961)**	**1.9**	**($5,705)**	**($4,871)**	**$0**	**($81,385)**	**N/A**	**Sum of Rows Q and R**
MMIS Training									
T	FTE Costs	$179,728	1.9	$27,875	$18,134	$0	$133,719	74.40%	Table 3
U	Contractor Cost Reductions	($171,871)	0.0	($26,657)	($17,341)	$0	($127,873)	74.40%	Table 5.1, Row P
V	**Subtotal**	**$7,857**	**1.9**	**$1,218**	**$793**	**$0**	**$5,846**	**N/A**	**Sum of Rows T and U**
CUSOM Physician Supplemental Payments									
W	FTE Costs	$337,886	3.0	$0	$0	$168,940	$168,946	50.00%	Table 3
X	Contractor Cost Reductions	($138,000)	0.0	$0	$0	($69,000)	($69,000)	50.00%	Table 5.1, Row R
Y	Supplemental Payments Offset	($99,940)	0.0	$0	$0	($99,940)	$0	0.00%	Table 7.1, Row D
Z	**Subtotal**	**$99,946**	**3.0**	**$0**	**$0**	**$0**	**$99,946**	**N/A**	**Sum of Rows W through Y**
AA	**Total Request**	**($339,518)**	**23.2**	**($155,265)**	**($60,722)**	**$370,586**	**($494,117)**	**N/A**	**Sum of Rows A through Z**

R-12 Convert Contractor Resources to FTE
Appendix A: Assumptions and Calculations

Table 2.2 Summary by Initiative FY 2023-24 and Ongoing									
Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Long-Term Care Utilization Management									
A	FTE Costs	$425,789	4.0	$212,892	$0	$0	$212,897	50.00%	Table 3
B	Travel Costs	$9,600	*0.0*	$4,800	$0	$0	$4,800	50.00%	Table 4, Row D
C	Contractor Cost Reductions	($1,053,000)	0.0	($308,250)	$0	$0	($744,750)	70.73%	Table 5.2, Row C
D	**Subtotal**	**($617,611)**	**4.0**	**($90,558)**	**$0**	**$0**	**($527,053)**	**N/A**	**Sum of Rows A, B, and C**
HCBS Waiver Claims Post Payment Review									
E	FTE Costs	$202,869	2.0	$101,434	$0	$0	$101,435	50.00%	Table 3
F	Contractor Cost Reductions	($535,000)	0.0	($133,750)	$0	$0	($401,250)	75.00%	Table 5.2, Row E
G	**Subtotal**	**($332,131)**	**2.0**	**($32,316)**	**$0**	**$0**	**($299,815)**	**N/A**	**Sum of Rows E and F**
Primary Care Fund and CICP Reviews									
H	FTE Costs	$405,736	4.0	$202,866	$0	$0	$202,870	50.00%	Table 3
I	Contractor Cost Reductions	($392,815)	0.0	($335,653)	($57,162)	$0	$0	0.00%	Table 5.2, Row I
J	**Subtotal**	**$12,921**	**4.0**	**($132,787)**	**($57,162)**	**$0**	**$202,870**	**N/A**	**Sum of Rows H and I**
Alternative Pay Model Rate Setting									
K	FTE Costs	$113,650	1.0	$56,824	$0	$0	$56,826	50.00%	Table 3
L	Contractor Cost Reductions	($121,875)	0.0	($60,937)	$0	$0	($60,938)	50.00%	Table 5.2, Row K
M	**Subtotal**	**($8,225)**	**1.0**	**($4,113)**	**$0**	**$0**	**($4,112)**	**N/A**	**Sum of Rows K and L**
PEAK Outreach and CBMS									
N	FTE Costs	$650,093	6.0	$94,392	$50,421	$360,214	$145,066	22.31%	Table 3
O	Contractor Cost Reductions	($293,077)	0.0	($95,440)	($51,001)	$0	($146,636)	50.03%	Table 5.2, Row M
P	**Subtotal**	**$357,016**	**6.0**	**($1,048)**	**($580)**	**$360,214**	**($1,570)**	**N/A**	**Sum of Rows N and O**
Independent Verification and Validation									
Q	FTE Costs	$202,869	2.0	$12,586	$10,742	$0	$179,541	88.50%	Table 3
R	Contractor Cost Reductions	($301,600)	0.0	($18,711)	($15,972)	$0	($266,917)	88.50%	Table 5.2, Row O
S	**Subtotal**	**($98,731)**	**2.0**	**($6,125)**	**($5,230)**	**$0**	**($87,376)**	**N/A**	**Sum of Rows Q and R**
MMIS Training									
T	FTE Costs	$171,761	2.0	$26,639	$17,331	$0	$127,791	74.40%	Table 3
U	Contractor Cost Reductions	($171,871)	0.0	($26,657)	($17,341)	$0	($127,873)	74.40%	Table 5.2, Row Q
V	**Subtotal**	**($110)**	**2.0**	**($18)**	**($10)**	**$0**	**($82)**	**N/A**	**Sum of Rows T and U**
CUSOM Physician Supplemental Payments									
W	FTE Costs	$316,886	3.0	$0	$0	$158,440	$158,446	50.00%	Table 3
X	Contractor Cost Reductions	($138,000)	0.0	$0	$0	($69,000)	($69,000)	50.00%	Table 5.2, Row S
Y	Supplemental Payments Offset	($89,440)	0.0	$0	$0	($89,440)	$0	0.00%	Table 7.2, Row D
Z	**Subtotal**	**$89,446**	**3.0**	**$0**	**$0**	**$0**	**$89,446**	**N/A**	**Sum of Rows W through Y**
AA	**Total Request**	**($597,425)**	**24.0**	**($266,965)**	**($62,982)**	**$360,214**	**($627,692)**	**N/A**	**Sum of Rows A through Z**

R-12 Convert Contractor Resources to FTE
Appendix A: Assumptions and Calculations

Table 3
FTE Calculations

Personal Services

Position Classification	FTE	Start Month	State Fund Source	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Long-Term Care Utilization Management							
ADMINISTRATOR IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
COMPLIANCE SPECIALIST IV	2.0	July	General Fund	$140,726	$146,361	$146,361	
PROGRAM MANAGEMENT I	1.0	July	General Fund	$88,044	$91,570	$91,570	
HCBS Waiver Claims Post Payment Review							
COMPLIANCE SPECIALIST IV	2.0	July	General Fund	$140,726	$146,361	$146,361	
Primary Care Fund and CICP Reviews							
ADMINISTRATOR IV	4.0	July	General Fund	$281,451	$292,721	$292,721	
Alternative Pay Model Rate Setting							
RATE/FINANCIAL ANLYST IV	1.0	July	General Fund	$81,135	$84,384	$84,384	
PEAK Outreach and CBMS							
ADMINISTRATOR III	1.0	July	General Fund	$56,648	$58,916	$58,916	Multiple State Fund Sources
ANALYST IV	2.0	July	General Fund	$140,726	$146,361	$146,361	Multiple State Fund Sources
PROJECT MANAGER I	1.0	July	General Fund	$70,362	$73,180	$73,180	Multiple State Fund Sources
PROGRAM MANAGEMENT II	2.0	July	General Fund	$191,022	$198,671	$198,671	Multiple State Fund Sources
Independent Verification and Validation							
PROJECT MANAGER I	2.0	July	General Fund	$140,726	$146,361	$146,361	Multiple State Fund Sources
MMIS Training							
ADMINISTRATOR III	2.0	July	General Fund	$113,296	$117,833	$117,833	Multiple State Fund Sources
CUSOM Physician Supplemental Payments							
ADMINISTRATOR IV	1.0	July	Reappr Funds	$73,180	$73,180	$73,180	
RATE/FINANCIAL ANLYST III	1.0	July	Reappr Funds	$77,778	$77,778	$77,778	
STATISTICAL ANALYST III	1.0	July	Reappr Funds	$80,123	$80,123	$80,123	
Total Personal Services (Salary, PERA, Medicare)	**24.0**			**$1,746,305**	**$1,806,980**	**$1,806,980**	

Centrally Appropriated Costs

Cost Center	FTE Year 1	FTE Year 2+	Cost or Percentage	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Health, Life, Dental	24.0	24.0	$14,086	$326,675	$338,064	$338,064	
Short-Term Disability	-	-	0.16%	$2,485	$2,571	$2,571	
Amortization Equalization Disbursement	-	-	5.00%	$77,717	$80,419	$80,419	
Supplemental Amortization Equalization Disbursement	-	-	5.00%	$77,717	$80,419	$80,419	
Centrally Appropriated Costs Total				**$484,594**	**$501,473**	**$501,473**	

Operating Expenses

Ongoing Costs	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Supplies	24.0	24.0	$500	$12,000	$12,000	$12,000	
Telephone	24.0	24.0	$450	$10,800	$10,800	$10,800	
Other	24.0	24.0	$0	$0	$0	$0	
Subtotal				*$22,800*	*$22,800*	*$22,800*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	24.0		$5,000	$120,000	$0	$0	
Computer	24.0		$2,000	$48,000	$0	$0	
Other	24.0		$0	$0	$0	$0	
Subtotal				*$168,000*	*$0*	*$0*	
Total Operating				**$190,800**	**$22,800**	**$22,800**	

Leased Space

	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Leased Space	24.0	24.0	$6,600	**$158,400**	**$158,400**	**$158,400**	

Table 4 Travel Costs for Long-Term Care Utilization Management			
Row	**Item**	**Value**	**Notes/Calculations**
A	Average monthly travel cost per FTE	$400	Department estimate
B	Number of FTE	2.0	Table 3, Long Term Care Utilization Management, Compliance Specialist Positions
C	Months per year	12	Full year
D	**Total Cost**	**$9,600**	**Product of Rows A through C**

R-12 Convert Contractor Resources to FTE
Appendix A: Assumptions and Calculations

Table 5.1
Contractor Cost Reductions
FY 2022-23

Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Long-Term Care Utilization Management								
A	Performance Quality Reviews	($873,000)	($218,250)	$0	$0	($654,750)	75.00%	Eliminate contractor funding
B	**Subtotal**	**($873,000)**	**($218,250)**	**$0**	**$0**	**($654,750)**	**75.00%**	**Row A**
HCBS Waiver Claims Post Payment Review								
C	Post-Payment Reviews	($535,000)	($133,750)	$0	$0	($401,250)	75.00%	Eliminate contractor funding
D	**Subtotal**	**($535,000)**	**($133,750)**	**$0**	**$0**	**($401,250)**	**75.00%**	**Row C**
Primary Care Fund and CICP Reviews								
E	Primary Care Fund Reviews	($57,162)	$0	($57,162)	$0	$0	0.00%	Eliminate contractor funding
F	CICP Reviews	($78,501)	($78,501)	$0	$0	$0	0.00%	Eliminate contractor funding
G	Contractor Funding from HB21-1198	($257,152)	($257,152)	$0	$0	$0	0.00%	Eliminate contractor funding
H	**Subtotal**	**($392,815)**	**($335,653)**	**($57,162)**	**$0**	**$0**	**0.00%**	**Sum of Rows E through G**
Alternative Pay Model Rate Setting								
I	Actuarial Rate Setting	($121,875)	($60,937)	$0	$0	($60,938)	50.00%	Reduce contract by 325 hours at $375 per hour
J	**Subtotal**	**($121,875)**	**($60,937)**	**$0**	**$0**	**($60,938)**	**50.00%**	**Row I**
PEAK Outreach and CBMS								
K	PEAK Outreach and CBMS Management	($295,116)	($96,104)	($51,356)	$0	($147,656)	50.03%	Table 6.1, Row H
L	**Subtotal**	**($295,116)**	**($96,104)**	**($51,356)**	**$0**	**($147,656)**	**50.03%**	**Row K**
Independent Verification and Validation								
M	Independent Verification and Validation	($301,600)	($18,711)	($15,972)	$0	($266,917)	88.50%	Reduce contract by 2,080 hours at $145 per hour
N	**Subtotal**	**($301,600)**	**($18,711)**	**($15,972)**	**$0**	**($266,917)**	**88.50%**	**Row M**
MMIS Training								
O	MMIS Training	($171,871)	($26,657)	($17,341)	$0	($127,873)	74.40%	Eliminate contractor funding
P	**Subtotal**	**($171,871)**	**($26,657)**	**($17,341)**	**$0**	**($127,873)**	**74.40%**	**Row O**
CUSOM Physician Supplemental Payments								
Q	Upper Payment Limit Calculation	($138,000)	$0	$0	($69,000)	($69,000)	50.00%	Eliminate contractor funding
R	**Subtotal**	**($138,000)**	**$0**	**$0**	**($69,000)**	**($69,000)**	**50.00%**	**Row Q**
S	**Total Request**	**($2,829,277)**	**($890,062)**	**($141,831)**	**($69,000)**	**($1,728,384)**	**N/A**	**Sum of Rows A through R**

Table 5.2
Contractor Cost Reductions
FY 2023-24 and Ongoing

Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Long-Term Care Utilization Management								
A	Performance Quality Reviews	($873,000)	($218,250)	$0	$0	($654,750)	75.00%	Eliminate contractor funding
B	Quality Improvement Services	($180,000)	($90,000)	$0	$0	($90,000)	50.00%	Eliminate contractor funding
C	**Subtotal**	**($1,053,000)**	**($308,250)**	**$0**	**$0**	**($744,750)**	**70.73%**	**Row A**
HCBS Waiver Claims Post Payment Review								
D	Post-Payment Reviews	($535,000)	($133,750)	$0	$0	($401,250)	75.00%	Eliminate contractor funding
E	**Subtotal**	**($535,000)**	**($133,750)**	**$0**	**$0**	**($401,250)**	**75.00%**	**Row D**
Primary Care Fund and CICP Reviews								
F	Primary Care Fund Reviews	($57,162)	$0	($57,162)	$0	$0	0.00%	Eliminate contractor funding
G	CICP Reviews	($78,501)	($78,501)	$0	$0	$0	0.00%	Eliminate contractor funding
H	Contractor Funding from HB21-1198	($257,152)	($257,152)	$0	$0	$0	0.00%	Eliminate contractor funding
I	**Subtotal**	**($392,815)**	**($335,653)**	**($57,162)**	**$0**	**$0**	**0.00%**	**Sum of Rows F through H**
Alternative Pay Model Rate Setting								
J	Actuarial Rate Setting	($121,875)	($60,937)	$0	$0	($60,938)	50.00%	Reduce contract by 325 hours at $375 per hour
K	**Subtotal**	**($121,875)**	**($60,937)**	**$0**	**$0**	**($60,938)**	**50.00%**	**Row J**
PEAK Outreach and CBMS								
L	PEAK Outreach and CBMS Management	($293,077)	($95,440)	($51,001)	$0	($146,636)	50.03%	Table 6.2, Row H
M	**Subtotal**	**($293,077)**	**($95,440)**	**($51,001)**	**$0**	**($146,636)**	**50.03%**	**Row L**
Independent Verification and Validation								
N	Independent Verification and Validation	($301,600)	($18,711)	($15,972)	$0	($266,917)	88.50%	Reduce contract by 2,080 hours at $145 per hour
O	**Subtotal**	**($301,600)**	**($18,711)**	**($15,972)**	**$0**	**($266,917)**	**88.50%**	**Row N**
MMIS Training								
P	MMIS Training	($171,871)	($26,657)	($17,341)	$0	($127,873)	74.40%	Eliminate contractor funding
Q	**Subtotal**	**($171,871)**	**($26,657)**	**($17,341)**	**$0**	**($127,873)**	**74.40%**	**Row P**
CUSOM Physician Supplemental Payments								
R	Upper Payment Limit Calculation	($138,000)	$0	$0	($69,000)	($69,000)	50.00%	Eliminate contractor funding
S	**Subtotal**	**($138,000)**	**$0**	**$0**	**($69,000)**	**($69,000)**	**50.00%**	**Row R**
T	**Total Request**	**($3,007,238)**	**($979,398)**	**($141,476)**	**($69,000)**	**($1,817,364)**	**N/A**	**Sum of Rows A through S**

Table 6.1 PEAK Outreach and CBMS FY 2022-23			
Row	**Item**	**Value**	**Notes/Calculations**
A	PEAK Outreach Contract	$397,405	Current Contract Amount
B	PEAK Product Manager and CBMS Deputy Product Owner	$264,483	Table 3, PEAK Outreach and CBMS, Program Management Positions
C	**Total Cost**	**$661,888**	**Sum of Rows A and B**
D	HCPF Share Percentage	44.59%	March 2021 CBMS Statistics
E	CDHS Share Percentage	54.07%	March 2021 CBMS Statistics
F	CDPHE Share Percentage	1.34%	March 2021 CBMS Statistics
G	**Total of Department Shares**	**100.00%**	**Sum of Rows D through F**
H	HCPF Cost	$295,116	Row C * Row D
I	CDHS Cost	$357,902	Row C * Row E
J	CDPHE Cost	$8,870	Row C * Row F
K	**Total of Department Costs**	**$661,888**	**Sum of Rows H through J**

Table 6.2 PEAK Outreach and CBMS FY 2023-24 and Ongoing			
Row	**Item**	**Value**	**Notes/Calculations**
A	PEAK Outreach Contract	$397,405	Current Contract Amount
B	PEAK Product Manager and CBMS Deputy Product Owner	$259,910	Table 3, PEAK Outreach and CBMS, Program Management Positions
C	**Total Cost**	**$657,315**	**Sum of Rows A and B**
D	HCPF Share Percentage	44.59%	March 2021 CBMS Statistics
E	CDHS Share Percentage	54.07%	March 2021 CBMS Statistics
F	CDPHE Share Percentage	1.34%	March 2021 CBMS Statistics
G	**Total of Department Shares**	**100.00%**	**Sum of Rows D through F**
H	HCPF Cost	$293,077	Row C * Row D
I	CDHS Cost	$355,429	Row C * Row E
J	CDPHE Cost	$8,809	Row C * Row F
K	**Total of Department Costs**	**$657,315**	**Sum of Rows H through J**

Table 7.1
Calculation of CUSOM Physician Supplemental Payments Offset
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	Requested FTE Costs for CUSOM Physician Supplemental Payments	$337,886	3.0	$0	$0	$168,940	$168,946	50.00%	Table 3
B	Requested Contractor Cost Reductions for CUSOM Physician Supplemental Payments	($138,000)	0.0	$0	$0	($69,000)	($69,000)	50.00%	Table 5.1, Row R
C	**Subtotal**	**$199,886**	**3.0**	**$0**	**$0**	**$99,940**	**$99,946**	**50.00%**	**Sum of Rows A and B**
D	Requested Offset to CUSOM Physician Supplemental Payments	($99,940)	0.0	$0	$0	($99,940)	$0	0.00%	(-1) * Row C, Reappropriated Funds
E	**Total Request**	**$99,946**	**3.0**	**$0**	**$0**	**$0**	**$99,946**	**100.00%**	**Sum of Rows C and D**

Table 7.2
Calculation of CUSOM Physician Supplemental Payments Offset
FY 2023-24 and Ongoing

Row	Contractor Cost Reductions	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	Requested FTE Costs for CUSOM Physician Supplemental Payments	$316,886	3.0	$0	$0	$158,440	$158,446	50.00%	Table 3
B	Requested Contractor Cost Reductions for CUSOM Physician Supplemental Payments	($138,000)	0.0	$0	$0	($69,000)	($69,000)	50.00%	Table 5.2, Row S
C	**Subtotal**	**$178,886**	**3.0**	**$0**	**$0**	**$89,440**	**$89,446**	**50.00%**	**Sum of Rows A and B**
D	Requested Offset to CUSOM Physician Supplemental Payments	($89,440)	0.0	$0	$0	($89,440)	$0	0.00%	(-1) * Row C, Reappropriated Funds
E	**Total Request**	**$89,446**	**3.0**	**$0**	**$0**	**$0**	**$89,446**	**100.00%**	**Sum of Rows C and D**

Department Priority: R-13
Request Detail: Compliance FTE

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$10,055,202,734	($4,678,266)	($4,718,512)
FTE	560.9	10.8	11.0
General Fund	$2,430,513,980	($2,393,350)	($2,410,473)
Cash Funds	$1,203,184,864	$108,434	$101,434
Reappropriated Funds	$85,500,144	$0	$0
Federal Funds	$6,336,003,746	($2,393,350)	($2,410,473)

Summary of Request

The Department of Health Care Policy & Financing requests an increase in staffing, offset by savings, in order to provide increased stewardship of state resources through the implementation of operational compliance and program oversight measures. The department's proper oversight and accountability is critical to ensuring that members are receiving the services that they need and that taxpayers are getting sufficient returns on the use of these funds. As part of the department's focus on continual improvement to provide sound stewardship of financial resources and reporting requirements, the department has identified opportunities to expand and strengthen operational compliance and program oversight.

This represents an increase of less than 0.5% of the department's FY 2021-22 Long Bill total funds appropriation.

Current Program

As the administrator of Health First Colorado (Colorado's Medicaid program), the Child Health Plan *Plus* (CHP+), and other public health care programs for Coloradans who qualify, the department is responsible for ensuring that all programs remain compliant and that operational oversight measures are in place. The department is regulated by the Centers for Medicare & Medicaid Services (CMS) and per 45 CFR § 75.303(a), the department, as a recipient of federal funds, must establish and maintain effective internal controls over its federal grants in compliance with federal statutes, regulations, and the award terms and conditions.

Additionally, the Governor issued Executive Order D 2020-175 on the development of Equity, Diversity, and Inclusion (EDI) for the state of Colorado. The department is required to provide a report on program progress annually.

The department has been appropriated over $13.6 billion in FY 2021-22 to provide services to eligible members; this represents the largest single agency budget for the 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.

Problem or Opportunity

Given the size of the department's budget and the number of people served through its programs, proper oversight is critical to ensuring that members are receiving the services that they need, and that taxpayers' resources are spent wisely in support of the department's programs. As part of the department's focus on continual improvement to provide sound stewardship of financial resources, the department has identified administrative opportunities to expand and strengthen operational compliance and program oversight and accountability. When the department falls out of compliance with state and federal rules and regulations, it risks having to repay federal funds. All repayments to the federal government would be paid directly with General Fund dollars, therefore any General Fund dollar that must be used to repay federal funds, is taken away from another state priority.

Proposed Solution

The department requests a reduction of $4,678,266 total funds, including a reduction of $2,393,350 General Fund and an increase of 10.8 FTE in FY 2022-23; and a reduction of $4,719,512 total funds, including a reduction of $2,410,473 General Fund, and an increase of 12.0 FTE in FY 2023-24 to

provide increased stewardship of state resources through the implementation of operational compliance and program oversight measures.

The request to add dedicated FTE and contractor funding will provide for the following activities:

- Address operational compliance and oversight deficiencies across multiple programs;
- Ensure quality assurance and drive more accountability to the department's programs; and
- Comply with legislative and policy requirements.

Quality, Accountability and Oversight
The department requests three FTE to address gaps in quality assurance, accountability, compliance, and oversight within various programs in the department.

Quality
The department requests one FTE to fully develop the department's quality programs and initiatives with movement to evidence-based outcome measures. CMS has developed the Child and Adult Core Sets[1] of measures that the department is required to report on and currently does not have capacity. Specifically, the department is unable to accurately and timely report out on several core measures; including, Hospital Quality Improvement Payment, Hospital Transformation Program, Minimum Loss Ratio, CHP+, Dental, and Substance Abuse Disorder (SUD) Waiver. Failure to comply with CMS reporting requirements may result in a loss or reduction in federal funding. In addition, the department directs, conducts, and coordinates performance improvement activities supporting care and services delivered by Colorado Medicaid and CHP+. The Child and Adult Core Sets of health care quality measures are among the main federal quality measurement and improvement initiatives in Medicaid and Children's Health Insurance Program (CHIP).

There is evidence of Colorado's underperformance in many CMS Core Measures.[2] This data is mandated to be reported and publicly posted starting in 2024. Colorado is in the tenth decile of performance for: childhood asthma; childhood immunizations; immunizations for adolescents; adolescent well care visits; well visits 3-6 years; well visits in the first 15 months of life (six visits); and, prenatal and postpartum care. It is critical that the department dedicate resources to fully develop these quality programs and improve these results.

CMS is building on its Meaningful Measures 2.0[3] initiative by further shaping the entire ecosystem of quality measures that drive value-based care with fully digitalizing measures by 2025 instead of 2030 as originally planned. This will include addressing and adding measurement gaps, align

---

[1] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html
[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures
[3] Centers for Medicare & Medicaid Services, 2021 CMS Quality Conference: CMS Quality Measurement Action Plan, March 2021, Meaningful Measures 2.0: Moving from Measure Reduction to Modernization

measures across value-based programs and partners, and incorporating social and economic determinants measures. Beginning in FY 2024-25, the department is required to report on the core set of quality measures for children enrolled in Medicaid and CHIP and the core set of behavioral health measures for adults enrolled in Medicaid. The continued federal focus on quality reporting requires dedicated resources at the state level.

Accountability

The department requests one FTE Accountant in areas impacted by the OSA annual statewide financial audit. This FTE will be the subject matter expert over audit findings pertaining to the department's financial systems, with responsibilities associated with researching OSA audit requests, querying and reconciling data from the Business Intelligence & Data Management (BIDM) system and the Colorado Operations Resource Engine (CORE) and interpreting and respond to auditor questions related to federal and state reporting. This will also include OIG audits of the American Rescue Plan Act of 2021 (ARPA) program that are above what is already occurring with the OSA statewide financial audits.

CMS and the Office of the State Auditor (OSA) continually audit the department to ensure the Medicaid and CHP+ programs are in compliance with all federal and state requirements. For example, OSA uses the Single-wide State Audit to ensure the department is in compliance with state and federal requirements. Over the last few years, OSA has begun "data mining" and expanding their audits during the annual statewide financial audit throughout the department, and a department accountant spends about 25% of their time coordinating and delegating research requests and then complying the results to OSA. In addition, the department has been under an OIG Overpayment/Recovery Audit since September 2019 that is still ongoing, and the OSA Overpayment/Recovery test work has directly impacted the department's workload. This position will support the work associated with existing and future audits in identifying and tracking transactions in payroll, accounts payables, accounts receivable, and cash receipts transactions.

The department's review identified areas of the budget that are not funded at sufficient levels to meet operational oversight and audit compliance requirements and would be unable to implement these initiatives without diverting resources from other areas. The department is at a substantial financial risk as the OSA has begun extrapolating their findings to hundreds of millions of dollars and CMS is attempting to recover questionable costs identified in these audit reports. Without the necessary compliance resources, the department is at risk of falling out of federal compliance and losing federal financial participation (FFP).

Oversight

The department requests one FTE to absorb the increase in demands in departmental rules and CMS compliance requirements. The position will specialize in tracking and implementing rules, federal mandates, and rate changes for the department's programs. Delay in implementation of rules,

federal mandates, and rate changes through CMS may result in non-conformance of federal policy and potential reduction in federal funding.

As the department has experienced a significant uptick in workload as programs have expanded and adjusted to changing state and federal requirements and the demands of ensuring the department's rules and State Plan are in compliance have outpaced the current resources dedicated to this work. Any changes driven by CMS rules or state legislation that the department must implement needs to be accurately reflected in rule as well as the Medicaid State Plan. The new position will provide policy analysis on State Plan Amendments (SPA), rule changes, and any other federal or state legislative policy changes. Failure to remain current places the department at risk of loss of FFP.

Olmstead Compliance

The department requests one FTE to manage and oversee the implementation of the Colorado Community Living Plan[4], which is Colorado's Olmstead Plan. On June 22, 1999, the United States Supreme Court found in *Olmstead v. L.C.* that unnecessary segregation of individuals with disabilities in institutions is a form of discrimination based on disability. Referring to the Americans with Disabilities Act (ADA), the Olmstead decision holds states accountable for providing community-based care whenever appropriate, rather than placing individuals with disabilities in institutional settings. The Olmstead decision was reinforced on June 18, 2001, when President George W. Bush signed an Executive Order requiring states to provide community-based alternatives for individuals with disabilities in compliance with the terms of the Olmstead decision. While a good portion of the strategies outlined in the Colorado Community Living Plan exist in the department, it actually includes the work and commitment of several state agencies to fulfil the commitment of community living across the state. This plan was first developed in 2014 and then updated in 2018 and to comply with federal requirements; the state's Olmstead Plan must be updated regularly with ongoing input from impacted stakeholders. Coordination and communication across stakeholders and state agencies and timely implementation of the plan has proven to be a massive lift and can no longer be absorbed within current resources. States that have failed to meet Olmstead requirements have faced legal action by the Department of Justice.

PACE Oversight

The department requests one FTE to improve the PACE program in two ways. First, HCPF will develop a pay-for-performance framework that includes identifying and developing key performance metrics and revamp the PACE capitation rates. The pay-for-performance plan will utilize the current rate process to allow PACE providers to earn an additional percentage of the Upper Payment Limit (UPL) by meeting key performance goals such as decreasing hospitalization, decreasing disenrollment, increasing staffing ratios, etc. The staff will perform contract management, enrollment and disenrollment, monitoring quality of care, establishing key

[4] Colorado's Community Living Plan, July 30, 2014 Colorado Department of Health Care Policy and Financing, Colorado Department of Human Services, Colorado Department of Local Affairs, Office of the Governor Joint Endorsement

performance benchmarks, stakeholder engagement, and work with counties to align processes for the PACE program. Second, this position will be responsible for enhanced oversight and development of inspection and review structures to ensure the health, safety, and welfare of PACE members. The position will engage PACE members, community stakeholders, and PACE organizations to understand best practices to provide this structure. With this position the department can ensure the health, safety, and welfare of PACE participants by filling in the gaps in PACE oversight while ensuring continuous quality improvement. The department hopes to eliminate possible gaps in the following areas: physical environment review, disenrollment surveying and quality evaluations, performance benchmarks for programmatic comparison, incentivizing quality improvement and innovation, and complaint investigations.

Eligibility Appeals

The department requests one FTE to ensure eligibility appeals are processed consistently in a timely manner per H.B. 16-1277, "Concerning the Appeal Process for Medical Assistance Benefits," to address the OSA audit findings[5] and implement fixes to address error rates and issues with eligibility appeals processes. Through evaluating eligibility site processes, the outcome will provide an efficient and effective process to assist members in processing eligibility claims and reduce the department's appeals process and cycle times.

The department went through reviews of eligibility sites processes which demonstrated deficiencies with respect to the appeals process, which is evident in member complaints about the appeals process. The current staff was created in 2013 in preparation for the implementation of the Affordable Care Act. Over time the appeals have increased due to member caseload, and department resources have not adjusted accordingly. With the strengthening appeals process provided in H.B. 16-1277, the department resources are inadequate to comply with current legislation and are at risk of not capturing enhanced federal funds participation and thus will need to rely on state resources for eligibility appeals.

Recovery Audit Contract (RAC) Program

The department is requesting three FTE for program integrity review and fraud capture. Under 42 CFR § 455 Subpart F, all states are mandated to contract with a vendor to conduct post-payment claim audits on all programs. The department must have staff to work with the vendor on the identified overpayments in an effort to recover the improper payments. The RAC program runs several review projects on an ongoing basis, auditing multiple provider types including durable medical equipment providers, hospitals, laboratories, and physicians. The vendor has identified an opportunity to recover significantly more overpayments, but the department does not have the companion staff to work those cases. Additional resources will allow the department to focus

[5] State of Colorado, Office of the State Auditor, June 2021, Statewide Single Audit Fiscal Year Ended June 30, 2020, pages I-10, II-5

resources on working with the vendor to recover money that will otherwise remain with providers. The new staff have the potential to collect $6.0 million in the next state fiscal year in recoveries.

Nursing Facility Minimum Wage

The department is requesting one FTE and contractor resources to implement and administer the new supplemental payment program for nursing facilities introduced by H.B. 19-1210, "Prohibitions on a Local Government Establishing Minimum Wage Laws within its Jurisdiction," and comply with the bill's requirements. The department's fiscal note included administrative resources, but the final bill did not appropriate any administrative funding. The department cannot properly administer H.B. 19-1210 within existing resources and is unable to approve eligible nursing facilities, calculate and distribute appropriate supplemental payment amounts, and ensure payments are used in accordance with the bill. The FTE will be responsible for reviewing facility applications to determine eligibility, calculating payments to eligible facilities using reported wage data and available appropriations, communicating explanations of payment calculations to eligible facilities, distributing payments on a regularly established basis, and recovering any payments determined to be used improperly. The contractor resources will be used to audit the nursing facility supplemental payments to ensure they are used to increase compensation for facility employees up to the local minimum wage in accordance with the bill and referring any improperly used payments to the department for recovery.

CMP Compliance

The department is requesting one FTE to manage more appropriately the Civil Monetary Penalty (CMP) program with the Colorado Department of Public Health and Environment (CDPHE). A CMP is a monetary penalty imposed on nursing facilities by the CMS following survey findings in which a facility is found to be out of compliance with one or more participation requirements for Medicare or Medicaid. A portion of collected CMPs are returned by CMS to be reinvested in projects that benefit nursing facility residents, pursuant to 42 CFR § 488.433.

The department did not receive any resources through S.B. 21-128. The department and CDPHE coordinated an interim plan to temporarily fund the HCPF position until more permanent funding could be secured. This position will represent the department's priorities in the management of the CMP in determination of how the funds will be used, participation on the Nursing Home Innovations Grant Board established in S.B. 14-151, monitoring and measure of awarded grants for outcomes, and evaluation and analysis of concluded grants to determine viability for replication.

There is no General Fund impact for this position; funding will be from the Nursing Facility Penalty Cash Fund. This is permitted under S.B. 21-128, which allows up to ten percent of the total funding available from the cash fund to be appropriated for administration. Additional federal funding is not available for this position, as the cash fund is partially funded with federal funds collected from providers.

Evidence-Based Continuum

The department considers this request as aligning with Step 4 of the Office of State Planning and Budget (OSPB) continuum of evidence, as most of the initiatives included in this request clear program objectives and the collection of evidence, analysis of data, or other form of testing to assess if program objectives are being met. The initiatives included in this request include compliance corrective actions so that program objectives are met such as state and federal compliance, accountability, and oversight of audit requirements allowing the continuum of federal financial participation.

Theory of Change	Increasing the compliance functions of the department will maintain CMS, OSA, and other federal oversight and audit requirement allowing continuation of federal and state funding		
Program Objective	To allow the department to come into compliance with state and federal regulations and mandates[6]		
Outputs Being Measured	Number of audit and compliance requirements completed within federal and state guidelines and state singlewide audit		
Outcomes Being Measured	Number of audit findings and disallowances from CMS, OSA, and other federal and state oversight and audits [7]		
Cost/Benefit Ratio	The minimal increase in the departments compliance and audit functions will offset the disallowance of CMS federal funding and increase in state and federal funds for Medicaid and CHP+ programs.		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	Medicaid Recovery Audit contractors and OIG perform audits and investigations of fraud and abuse to promote efficiency and effectiveness and minimize loss of governmental programs as mandated by amended Public Law 95-452[8]		
Continuum Level	Step 4		

Anticipated Outcomes

[6] Colorado Newsline 'Not acceptable, whatsoever': Medicaid mismanagement draws lawmaker scrutiny, January 26, 2021, Moe Clark

[7] OSA Statewide Single Audit, Fiscal Year Ended June 30, 2020, Financial Audit State of Colorado

[8] AHIMA Practice Brief, November 2013, Understanding Governmental Audits (2013 update)

Approving this request will put measures in place to ensure that the department has funding and resources to effectively comply with state and federal oversight, accountability, and compliance reporting of Medicaid and CHP+ programs. This aligns with the department's performance plan pillar of operational excellence and customer service by: providing excellent customer service to members, providers, and partners; complaint, efficient, and effective person- and family-centered practices; the initiatives with this request also represent a direct implementation of departmental core values, especially continuous process improvement, oversight, transparency, accountability, and implement solutions identified in state and county audits to improve eligibility determination accuracy.

Assumptions and Calculations

Where applicable, notable assumptions for each calculation have been shown in the 'Proposed Solution' section of this document. The department has included detailed calculations used to determine the fiscal impact for each initiative in the appendix. Cash funds are from the Nursing Home Penalty Cash Fund. Reappropriated funds are from a transfer from the Department of Personnel and Administration which appropriates from the General Fund.

The department assumes all FTE included in this request will start July 1, 2022 and will be full-time, permanent positions. Recovery Audit Payments Savings will be contingent on the number of FTE appropriated to process the recovery actions. The Recovery Audit Payments Savings were calculated based on the estimated annual FTE hours assigned to recoveries times the hourly recovery rate. The recovery rate is calculated based on the annual total recoveries divided by the annual hours worked on recovery audits. The Contractor costs were calculated based on the number of facilities under $15 per hour statewide times the annual audit hours per facility times the department's standard contractor cost rates.

Table 1.1
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$779,816	10.8	$353,318	$73,180	$0	$353,318	45.31%	
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$154,946	0.0	$70,430	$14,086	$0	$70,430	45.45%	
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$1,112	0.0	$504	$104	$0	$504	45.32%	
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$34,705	0.0	$15,724	$3,257	$0	$15,724	45.31%	
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization Disbursement	$34,705	0.0	$15,724	$3,257	$0	$15,724	45.31%	
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$87,450	0.0	$39,750	$7,950	$0	$39,750	45.45%	
G	(1) Executive Director's Office; (A) General Administration; Leased Space	$72,600	0.0	$33,000	$6,600	$0	$33,000	45.45%	
H	(1) Executive Director's Office; (F) Provider Audits and Services; Professional Audit Contracts	$162,400	0.0	$81,200	$0	$0	$81,200	50.00%	
I	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($6,006,000)	0.0	($3,003,000)	$0	$0	($3,003,000)	50.00%	
J	Total Request	($4,678,266)	10.8	($2,393,350)	$108,434	$0	($2,393,350)	51.16%	Sum of Rows A thru I

Table 1.2
Summary by Line Item
FY 2023-24

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$808,110	11.0	$367,465	$73,180	$0	$367,465	41.42%	
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$154,946	0.0	$70,430	$14,086	$0	$70,430	41.67%	
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$1,152	0.0	$524	$104	$0	$524	41.44%	
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$35,965	0.0	$16,354	$3,257	$0	$16,354	41.42%	
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization Disbursement	$35,965	0.0	$16,354	$3,257	$0	$16,354	41.42%	
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$10,450	0.0	$4,750	$950	$0	$4,750	41.67%	
G	(1) Executive Director's Office; (A) General Administration; Leased Space	$72,600	0.0	$33,000	$6,600	$0	$33,000	41.67%	
H	(1) Executive Director's Office; (F) Provider Audits and Services; Professional Audit Contracts	$167,300	0.0	$83,650	$0	$0	$83,650	50.00%	
I	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($6,006,000)	0.0	($3,003,000)	$0	$0	($3,003,000)	50.00%	
J	**Total Request**	**($4,719,512)**	**11.0**	**($2,410,473)**	**$101,434**	**$0**	**($2,410,473)**	**51.07%**	Sum of Rows A thru I

Table 1.2 Summary by Line Item FY 2024-25 and Ongoing									
Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$808,110	11.0	$367,465	$73,180	$0	$367,465	41.42%	
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$154,946	0.0	$70,430	$14,086	$0	$70,430	41.67%	
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$1,152	0.0	$524	$104	$0	$524	41.44%	
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$35,965	0.0	$16,354	$3,257	$0	$16,354	41.42%	
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization Disbursement	$35,965	0.0	$16,354	$3,257	$0	$16,354	41.42%	
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$10,450	0.0	$4,750	$950	$0	$4,750	41.67%	
G	(1) Executive Director's Office; (A) General Administration; Leased Space	$72,600	0.0	$33,000	$6,600	$0	$33,000	41.67%	
H	(1) Executive Director's Office; (F) Provider Audits and Services; Professional Audit Contracts	$172,200	0.0	$86,100	$0	$0	$86,100	50.00%	
I	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($6,006,000)	0.0	($3,003,000)	$0	$0	($3,003,000)	50.00%	
J	**Total Request**	**($4,714,612)**	**11.0**	**($2,408,023)**	**$101,434**	**$0**	**($2,408,023)**	**51.08%**	Sum of Rows A thru I

Table 2.1
Summary by Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Quality, Accountability and Oversight									
A	FTE Costs	$340,300	2.9	$170,150	$0	$0	$170,150	50.00%	Table 5
Olmstead Compliance									
B	FTE Costs	$105,360	1.0	$52,680	$0	$0	$52,680	50.00%	Table 6
PACE Oversight									
C	FTE Costs	$105,360	1.0	$52,680	$0	$0	$52,680	50.00%	Table 7
Eligibility Appeals									
D	FTE Costs	$132,786	1.0	$66,393	$0	$0	$66,393	50.00%	Table 8
Recovery Audit Contract (RAC) Program									
E	FTE Costs	$262,910	2.9	$131,455	$0	$0	$131,455	50.00%	Table 9
F	Nursing Facility Contractor	$162,400	0.0	$81,200	$0	$0	$81,200	50.00%	Table 4
G	Audit Recoveries	($6,006,000)	0.0	($3,003,000)	$0	$0	($3,003,000)	50.00%	Table 3
Nursing Facility Minimum Wage									
H	FTE Costs	$110,184	1.0	$55,092	$0	$0	$55,092	50.00%	Table 10
CMP Compliance									
I	FTE Costs	$108,434	1.0	$0	$108,434	$0	$0	0.00%	Table 11
J	**Total Request**	**($4,678,266)**	**10.8**	**($2,393,350)**	**$108,434**	**$0**	**($2,393,350)**	**51.16%**	Sum of Rows A thru I

Table 2.2 Summary by Initiative FY 2023-24									
Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Quality, Accountability and Oversight									
A	FTE Costs	$329,486	3.0	$164,743	$0	$0	$164,743	50.00%	Table 5
Olmstead Compliance									
B	FTE Costs	$101,434	1.0	$50,717	$0	$0	$50,717	50.00%	Table 6
PACE Oversight									
C	FTE Costs	$101,434	1.0	$50,717	$0	$0	$50,717	50.00%	Table 7
Eligibility Appeals									
D	FTE Costs	$129,954	1.0	$64,977	$0	$0	$64,977	50.00%	Table 8
Recovery Audit Contract (RAC) Program									
E	FTE Costs	$248,998	3.0	$124,499	$0	$0	$124,499	50.00%	Table 9
F	Nursing Facility Contractor	$167,300	0.0	$83,650	$0	$0	$83,650	50.00%	Table 4
G	Audit Recoveries	($6,006,000)	0.0	($3,003,000)	$0	$0	($3,003,000)	50.00%	Table 3
Nursing Facility Minimum Wage									
H	FTE Costs	$106,448	1.0	$53,224	$0	$0	$53,224	50.00%	Table 10
CMP Compliance									
I	FTE Costs	$101,434	1.0	$0	$101,434	$0	$0	0.00%	Table 11
J	**Total Request**	**($4,719,512)**	**11.0**	**($2,410,473)**	**$101,434**	**$0**	**($2,410,473)**	**51.07%**	Sum of Rows A thru I

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Table 2.3 Summary by Initiative FY 2024-25 and Ongoing									
Quality, Accountability and Oversight									
A	FTE Costs	$329,486	3.0	$164,743	$0	$0	$164,743	50.00%	Table 5
Olmstead Compliance									
B	FTE Costs	$101,434	1.0	$50,717	$0	$0	$50,717	50.00%	Table 6
PACE Oversight									
C	FTE Costs	$101,434	1.0	$50,717	$0	$0	$50,717	50.00%	Table 7
Eligibility Appeals									
D	FTE Costs	$129,954	1.0	$64,977	$0	$0	$64,977	50.00%	Table 8
Recovery Audit Contract (RAC) Program									
E	FTE Costs	$248,998	3.0	$124,499	$0	$0	$124,499	50.00%	Table 9
F	Nursing Facility Contractor	$172,200	0.0	$86,100	$0	$0	$86,100	50.00%	Table 4
G	Audit Recoveries	($6,006,000)	0.0	($3,003,000)	$0	$0	($3,003,000)	50.00%	Table 3
Nursing Facility Minimum Wage									
H	FTE Costs	$106,448	1.0	$53,224	$0	$0	$53,224	50.00%	Table 10
CMP Compliance									
I	FTE Costs	$101,434	1.0	$0	$101,434	$0	$0	0.00%	Table 11
J	**Total Request**	**($4,714,612)**	**11.0**	**($2,408,023)**	**$101,434**	**$0**	**($2,408,023)**	**51.08%**	Sum of Rows A thru I

Table 3.1 Recovery Audit Payment Savings								
Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	FY 2022-23 Recovery Audit Payments	($6,006,000)	($3,003,000)	$0	$0	($3,003,000)	50.00%	Table 3.4 Row H
B	FY 2023-24 Recovery Audit Payments	($6,006,000)	($3,003,000)	$0	$0	($3,003,000)	50.00%	Table 3.4 Row H
C	FY 2024-25 and Ongoing Recovery Audit Payments	($6,006,000)	($3,003,000)	$0	$0	($3,003,000)	50.00%	Table 3.4 Row H

Table 3.2 Program Savings						
Row	Item	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	Notes/Calculations
A	Hours per Week	30	35	35	35	Average workload
B	Weeks per Year	50	50	50	50	Estimated work weeks
C	Annual Hours Worked	1500	1750	1750	1750	Row A * Row B
D	SFY20-21 Recoveries Realized	$1,715,838				Based on SFY20-21
E	Recoveries per Annual Hours	($1,144)				
F	Estimated Future Recoveries		($2,002,000)	($2,002,000)	($2,002,000)	Row C * Row E
G	Number of New FTE		3.00	3.00	3.00	FTE Requested
H	**Total Estimated Recoveries**		**($6,006,000)**	**($6,006,000)**	**($6,006,000)**	Row F * Row G

Table 4.1 Nursing Facility Minimum Wage Contractor Costs								
Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	FY 2022-23 Contractor Costs	$162,400	$81,200	$0	$0	$81,200	50.00%	Table 4.4 Row D
B	FY 2023-24 Contractor Costs	$167,300	$83,650	$0	$0	$83,650	50.00%	Table 4.4 Row D
C	FY 2024-25 and Ongoing Contractor Costs	$172,200	$86,100	$0	$0	$86,100	50.00%	Table 4.4 Row D

Table 4.2 Contractor Costs for Nursing Facility Minimum Wage					
Row	Item	FY 2022-23	FY 2023-24	FY 2024-25	Notes/Calculations
A	Number of Facilities under $15 per hour statewide	70	70	70	Department Estimate
B	Annual audit hours per Facility	10	10	10	Department Estimate
C	Hourly audit contractor rate	$232	$239	$246	HCPF Standard Cost Rates
D	**Total Cost**	**$162,400**	**$167,300**	**$172,200**	Row A * Row B * Row C

Table 5 - Quality, Accountability, and Oversight
FTE Calculations

Personal Services

Position Classification	FTE	Start Month	State Fund Source	FY 2022-23	FY 2023-24	FY 2024-25	Notes
ACCOUNTANT III	1.0	July	General Fund	$81,135	$84,384	$84,384	
POLICY ADVISOR III	1.0	July	General Fund	$56,648	$58,916	$58,916	
PROGRAM MANAGEMENT II	1.0	July	General Fund	$95,511	$99,335	$99,335	
Total Personal Services (Salary, PERA, Medicare)	**3.0**			**$233,294**	**$242,635**	**$242,635**	

Centrally Appropriated Costs

Cost Center	FTE Year 1	FTE Year 2+	Cost or Percentage	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Health, Life, Dental	3.0	3.0	$14,086	$42,258	$42,258	$42,258	
Short-Term Disability	-	-	0.16%	$333	$345	$345	
Amortization Equalization Disbusement	-	-	5.00%	$10,383	$10,798	$10,798	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$10,383	$10,798	$10,798	
Centrally Appropriated Costs Total				**$63,356**	**$64,199**	**$64,199**	

Operating Expenses

Ongoing Costs	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Supplies	3.0	3.0	$500	$1,500	$1,500	$1,500	
Telephone	3.0	3.0	$450	$1,350	$1,350	$1,350	
Other	3.0	3.0	$0	$0	$0	$0	
Subtotal				*$2,850*	*$2,850*	*$2,850*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	3.0		$5,000	$15,000	$0	$0	
Computer	3.0		$2,000	$6,000	$0	$0	
Other	3.0		$0	$0	$0	$0	
Subtotal				*$21,000*	*$0*	*$0*	
Total Operating				**$23,850**	**$2,850**	**$2,850**	

Leased Space

	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Leased Space	3.0	3.0	$6,600	$19,800	$19,800	$19,800	

Table 6 - Olmstead Compliance
FTE Calculations

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund Source**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
COMPLIANCE SPECIALIST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$70,362**	**$73,180**	**$73,180**	

Centrally Appropriated Costs							
Cost Center	**FTE Year 1**	**FTE Year 2+**	**Cost or Percentage**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Health, Life, Dental	1.0	1.0	$14,086	$14,086	$14,086	$14,086	
Short-Term Disability	-	-	0.16%	$100	$104	$104	
Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Centrally Appropriated Costs Total				**$20,448**	**$20,704**	**$20,704**	

Operating Expenses							
Ongoing Costs	**FTE Year 1**	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Supplies	1.0	1.0	$500	$500	$500	$500	
Telephone	1.0	1.0	$450	$450	$450	$450	
Other	1.0	1.0	$0	$0	$0	$0	
Subtotal				*$950*	*$950*	*$950*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	
Other	1.0		$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	
Total Operating				**$7,950**	**$950**	**$950**	

Leased Space							
	FTE Year 1	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	1.0	1.0	$6,600	$6,600	$6,600	$6,600	

Table 7 - PACE Oversight
FTE Calculations

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund Source**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
COMPLIANCE SPECIALIST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$70,362**	**$73,180**	**$73,180**	

Centrally Appropriated Costs							
Cost Center	**FTE Year 1**	**FTE Year 2+**	**Cost or Percentage**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Health, Life, Dental	1.0	1.0	$14,086	$14,086	$14,086	$14,086	
Short-Term Disability	-	-	0.16%	$100	$104	$104	
Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$3,131	$3,257	$3,257	
Centrally Appropriated Costs Total				**$20,448**	**$20,704**	**$20,704**	

Operating Expenses							
Ongoing Costs	**FTE Year 1**	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Supplies	1.0	1.0	$500	$500	$500	$500	
Telephone	1.0	1.0	$450	$450	$450	$450	
Other	1.0	1.0	$0	$0	$0	$0	
Subtotal				*$950*	*$950*	*$950*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	
Other	1.0		$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	
Total Operating				**$7,950**	**$950**	**$950**	

Leased Space							
	FTE Year 1	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	1.0	1.0	$6,600	**$6,600**	**$6,600**	**$6,600**	

Table 8 - Eligibility Appeals
FTE Calculations

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund Source**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
AUDITOR IV	1.0	July	General Fund	$95,512	$99,335	$99,335	
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$95,512**	**$99,335**	**$99,335**	

Centrally Appropriated Costs							
Cost Center	**FTE Year 1**	**FTE Year 2+**	**Cost or Percentage**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Health, Life, Dental	1.0	1.0	$14,086	$14,086	$14,086	$14,086	
Short-Term Disability	-	-	0.16%	$136	$141	$141	
Amortization Equalization Disbusement	-	-	5.00%	$4,251	$4,421	$4,421	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$4,251	$4,421	$4,421	
Centrally Appropriated Costs Total				**$22,724**	**$23,069**	**$23,069**	

Operating Expenses							
Ongoing Costs	**FTE Year 1**	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Supplies	1.0	1.0	$500	$500	$500	$500	
Telephone	1.0	1.0	$450	$450	$450	$450	
Other	1.0	1.0	$0	$0	$0	$0	
Subtotal				*$950*	*$950*	*$950*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	
Other	1.0		$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	
Total Operating				**$7,950**	**$950**	**$950**	

Leased Space							
	FTE Year 1	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	1.0	1.0	$6,600	$6,600	$6,600	$6,600	

Table 9 - Recovery Audit Contract (RAC) Program
FTE Calculations

Personal Services

Position Classification	FTE	Start Month	State Fund Source	FY 2022-23	FY 2023-24	FY 2024-25	Notes
COMPLIANCE SPECIALIST II	1.0	July	General Fund	$49,026	$50,989	$50,989	
COMPLIANCE SPECIALIST III	1.0	July	General Fund	$56,648	$58,916	$58,916	
CONTRACT ADMINISTRATOR III	1.0	July	General Fund	$56,648	$58,916	$58,916	
Total Personal Services (Salary, PERA, Medicare)	**3.0**			**$162,322**	**$168,821**	**$168,821**	

Centrally Appropriated Costs

Cost Center	FTE Year 1	FTE Year 2+	Cost or Percentage	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Health, Life, Dental	3.0	3.0	$14,086	$42,258	$42,258	$42,258	
Short-Term Disability	-	-	0.16%	$231	$241	$241	
Amortization Equalization Disbusement	-	-	5.00%	$7,224	$7,513	$7,513	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$7,224	$7,513	$7,513	
Centrally Appropriated Costs Total				**$56,938**	**$57,525**	**$57,525**	

Operating Expenses

Ongoing Costs	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Supplies	3.0	3.0	$500	$1,500	$1,500	$1,500	
Telephone	3.0	3.0	$450	$1,350	$1,350	$1,350	
Other	3.0	3.0	$0	$0	$0	$0	
Subtotal				*$2,850*	*$2,850*	*$2,850*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	3.0		$5,000	$15,000	$0	$0	
Computer	3.0		$2,000	$6,000	$0	$0	
Other	3.0		$0	$0	$0	$0	
Subtotal				*$21,000*	*$0*	*$0*	
Total Operating				**$23,850**	**$2,850**	**$2,850**	

Leased Space

	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Leased Space	3.0	3.0	$6,600	**$19,800**	**$19,800**	**$19,800**	

Table 10 - Nursing Facility Minimum Wage
FTE Calculations

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund Source**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
RATE/FINANCIAL ANLYST III	1.0	July	General Fund	$74,783	$77,778	$77,778	
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$74,783**	**$77,778**	**$77,778**	

Centrally Appropriated Costs							
Cost Center	**FTE Year 1**	**FTE Year 2+**	**Cost or Percentage**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Health, Life, Dental	1.0	1.0	$14,086	$14,086	$14,086	$14,086	
Short-Term Disability	-	-	0.16%	$107	$112	$112	
Amortization Equalization Disbusement	-	-	5.00%	$3,328	$3,461	$3,461	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$3,328	$3,461	$3,461	
Centrally Appropriated Costs Total				**$20,849**	**$21,120**	**$21,120**	

Operating Expenses							
Ongoing Costs	**FTE Year 1**	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Supplies	1.0	1.0	$500	$500	$500	$500	
Telephone	1.0	1.0	$450	$450	$450	$450	
Other	1.0	1.0	$0	$0	$0	$0	
Subtotal				*$950*	*$950*	*$950*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	
Other	1.0		$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	
Total Operating				**$7,950**	**$950**	**$950**	

Leased Space							
	FTE Year 1	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	1.0	1.0	$6,600	$6,600	$6,600	$6,600	

Table 11 - Civil Monetary Penalty (CMP) Compliance FTE Calculations

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund Source**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
ANALYST IV	1.0	July	Cash Funds	$73,180	$73,180	$73,180	
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$73,180**	**$73,180**	**$73,180**	

Centrally Appropriated Costs							
Cost Center	**FTE Year 1**	**FTE Year 2+**	**Cost or Percentage**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Health, Life, Dental	1.0	1.0	$14,086	$14,086	$14,086	$14,086	
Short-Term Disability	-	-	0.16%	$104	$104	$104	
Amortization Equalization Disbusement	-	-	5.00%	$3,257	$3,257	$3,257	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$3,257	$3,257	$3,257	
Centrally Appropriated Costs Total				**$20,704**	**$20,704**	**$20,704**	

Operating Expenses							
Ongoing Costs	**FTE Year 1**	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Supplies	1.0	1.0	$500	$500	$500	$500	
Telephone	1.0	1.0	$450	$450	$450	$450	
Other	1.0	1.0	$0	$0	$0	$0	
Subtotal				*$950*	*$950*	*$950*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	
Other	1.0		$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	
Total Operating				**$7,950**	**$950**	**$950**	

Leased Space							
	FTE Year 1	**FTE Year 2+**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	1.0	1.0	$6,600	$6,600	$6,600	$6,600	

Department of Health Care Policy & Financing

FY 2022-23 Funding Request

November 1, 2021

Jared Polis
Governor

Kim Bimestefer
Executive Director

Department Priority: R-14
Request Detail: MMIS Funding Adjustment and Contractor Conversion

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$157,412,270	($56,079,142)	$704,201
FTE	560.9	12.5	13.0
General Fund	$41,534,853	($10,347,479)	($1,106,811)
Cash Funds	$12,513,801	($2,753,052)	$1,478,419
Reappropriated Funds	$2,193,535	$0	$0
Federal Funds	$101,170,081	($42,978,611)	$332,593

Summary of Request

The Department of Health Care Policy & Financing requests to rebalance the Medicaid Management Information System Maintenance and Projects line item to accurately reflect current costs associated with operating the Medicaid Management Information Systems (MMIS) and current federal match rates. As part of this rebalancing, the department requests a one-time reduction to its FY 2022-23 appropriation, as funding from prior year appropriations remains available for FY 2022-23 operations.

In addition, the department requests to add staff to address gaps in operation and management for current and upcoming modular re-procurements. This request aims to build internal efficiencies, develop institutional knowledge, and adequately support multiple administrative duties. The administrative resources are fully funded with reductions to the MMIS appropriation. The reductions in vendor funding were made possible by the department's diligence in continuously managing costs. With the approval of this request, the department will be able to re-align the budget with current federal match policy and current project timelines.

This request represents a decrease of less than 0.5% from the department's FY 2021-22 Long Bill total funds appropriation.

Current Program

The Medicaid Enterprise currently consists of four primary services provided through separate contractors. These services include the Medicaid Management Information System (MMIS) or Colorado interChange, supporting the core MMIS functions (e.g., claims processing) and Fiscal Agent services; the Business Intelligence and Data Management (BIDM) system, which provides data analytics services; the Pharmacy Benefit Management System (PBMS), which provides pharmacy management services; and the Colorado Benefits Management System (CBMS), which provides eligibility determination services. Funding for all services outside of CBMS is funded through the MMIS appropriation. In accordance with Section 25.5-4-211 C.R.S. (2021) the funding appropriated for the MMIS is rolled forward at the end of each fiscal year if not expended.

The department received additional contract funding from the FY 2019-20 R-12, “Medicaid Enterprise Operations,” request to shore up funding shortfalls and prepare for CMS required modular procurements of Information Technology (IT) systems. The request added contract funding to support the department’s MMIS vendors to address three main components:

- Legislative Requirements on System Functionality;
- Improvements to Member and Provider Experience; and
- Planning for the future of MMIS.

Funding levels and associated federal match rates were based on several factors, including existing contracts of similar nature and collaboration with other states.

In the department’s FY 2019-20 R-12 “Medicaid Enterprise Operations” request, the department received contractor funding to perform Services Integration work for the Medicaid Enterprise. Services Integration ensures that the numerous modules provided by different vendors in the Medicaid Enterprise are fully integrated and interoperable, with accurate and consistent communication and flow of data between modules, well-designed modular system architecture and alignment with CMS requirements. Services Integration is increasingly important as CMS guidance trends away from large, single-system implementations in favor of smaller interoperable module implementations. The department contracts with vendors to implement the services for MMIS, BIDM, PBMS and CBMS. Due to regulations from the Centers for Medicare and Medicaid Services (CMS) around re-procurement or transition of vendors for these services, the department requires the re-procurement or a re-evaluation of vendors on a modular timeline. This requires that the department manage multiple procurements on different timelines which requires more administrative resources than the previous approach where all components were re-procured simultaneously.

Problem or Opportunity

The department has identified an opportunity to rebalance the MMIS appropriation to reflect current expectations and address staffing needs financed with funding that has already been appropriated for the MMIS related activities.

MMIS Appropriation Rebalance

The department has identified an opportunity to rebalance the MMIS line item and return funding that is beyond the department's needs. The department has created multiple efficiencies within the MMIS line that have reduced costs and shortened timelines for multiple projects; this includes leveraging better federal financial participation (FFP) match rates, combining several projects, negotiations with vendors for rate reductions, and collaborating with other states to get project scope and pricing insight. For example, the FFP rate on licenses increased, allowing for software licenses to be paid at 90% instead of 75% after the software was in production, which reduced the amount of General Fund being used. Additionally, the department negotiated contract reductions with its primary MMIS vendors that reduced hourly rates, license costs, travel costs, and location savings as staff transitioned to work remotely during the public health emergency (PHE). Also, the department has collaborated with other states' Medicaid programs to find out best business practices when in negotiations with vendors, providing better and more accurate estimates. Internally, the department regularly reviewed projects with vendors to identify whether projects can be combined or identify scope reductions and project implementation efficiencies. The department's efforts towards efficiency and responsible financial stewardship has led to the MMIS roll-forward growing year after year as cost reductions have been realized.

Administrative Resources

The department has identified a resource shortage in order to support modular procurements and identified efficiencies that can be achieved by using state FTE to do work previously done by contractors.

<u>Modular Re-Procurement</u>

The modular re-procurement model creates an increased workload for the department since there are multiple vendors and systems up for re-procurement on different timelines. The CMS requirements for modular re-procurement increased the workload of the department's contract managers and Advanced Planning Documents (APDs) team. Each of these contracts requires a dedicated resource to manage the multifaceted components to meet state and federal regulations as well as ensure vendors are collaborating with stakeholders to meet and implement the department's initiatives and project goals. The department does not have sufficient staffing to manage these contracts under the CMS modular re-procurement rules. Similarly, the department was managing ten APDs last year and now with the CMS requirement, the department is managing 23 APDs. Given the changes that CMS has imposed in the process, the department

anticipates that the number of APDs will remain at this high level and may increase in the future. With the increase in APDs being managed, expected future growth, and the increase in projects that the staff are managing; the department is unable to absorb the workload within existing resources.

Medicaid Enterprise Services Integration

Outside vendors are a less cost-effective way to meet the department's goals for these administrative duties. Dedicated FTE are necessary to manage the Medicaid Enterprise systematic benefit and policy rules from a federal and state regulatory compliance level. Over the last several years the department has learned that contractor staff are knowledgeable and skilled in implementing projects based on timelines and budget; however, they are not knowledgeable or invested in long-term programmatic policy rules and regulations regarding the Medicaid and CHP+ programs. The lack of long-term institutional knowledge has forced the department to provide additional staffing support to the contract staff to ensure continuity of Medicaid and CHP+ rules are on the forefront of every project.

If the department is to continue using contractor resources, then each contractor will require oversight and management by department staff. Additionally, contractor work is typically more expensive than FTE costs for equivalent work. The department frequently pays hourly rates to vendors that exceed the amount that would be paid for equivalent work by state FTE. In the past, the department has experienced difficulty in maintaining continuity of knowledge and processes when the work is transitioned between vendors. Subject matter knowledge is not always preserved during the transition process. The transition period between vendors generally results in delays in the completion of deliverables, as one vendor closes out and the other vendor ramps up to take on contractual responsibilities which would not occur with state FTE. While the appropriated contractor resources would allow the department to make progress in projects, the department could make more progress and provide more ongoing support by using the funding for in-house staffing resources. This could be done with no additional impact on the General Fund, and would build ongoing in-house expertise and institutional knowledge, therefore accomplishing more of the department's goals.

Operational Support

The current BIDM vendor has been unable to implement a tool that assists in tracking department recoveries of overpayments by the department. The current tool developed still leaves gaps and does not accommodate all the needed workflows of the department. There are currently no departmental staff to fill this gap, and without a dedicated business analyst to translate business workflow requirements to the vendor and to hold the vendor accountable to meeting requirements, the department is unable to fully utilize vendors to develop and maintain useful IT products. Additionally, the department is utilizing the BIDM vendor to assist in pulling the data required for the federal reporting. This knowledge and expertise are not internal and instead lies with a contractor. There is concern that with a new vendor, the department could lose this

institutional knowledge. This is necessary to provide support and ensure the accuracy and integrity of state and federal expenditure reporting. With the department ultimately responsible for what is reported to CMS, it is important that staff with an understanding of the department's programs are working with vendors when designing reporting functionality.

Proposed Solution

The department requests a reduction of $56,079,142 total funds, including a reduction of $10,347,479 General Fund, and an increase of 12.5 FTE in FY 2022-23; and, $704,201 total funds, including a reduction of $1,106,811 General Fund, and 13.0 FTE in FY 2023-24 in order to build internal efficiencies, develop institutional knowledge, and adequately support multiple administrative duties while realizing General Fund savings. The department will rebalance current funding to better align the existing funding to the current workload by returning unneeded funding and converting contractor resources to permanent staff.

As this request reflects administrative changes to the department's claims system and operations, it is not ranked on the Office of State Planning & Budgeting's Evidence-Based continuum.

MMIS Appropriation Rebalance

The department is seeking to rebalance the MMIS appropriation and then reduce funding in order to true-up the MMIS line. The department has assessed the current state of all MMIS projects and requirements and requests to reduce the appropriation accordingly with updated estimates. With the rebalancing, the department requests to return part of the FY 2022-23 appropriation and fund activities with a combination of funding rolled forward from FY 2021-22 and current year funding. Additionally, the department requests a permanent General Fund decrease in the MMIS appropriation ongoing.

The growth of the roll-forward is due to the inherent variability of IT project implementation and requires a periodic true-up of funding. The need to rebalance the MMIS budget is due to four main factors. First, several IT projects have come in under budget year after year. Second, the department negotiated with its contractors to reduce project costs, leading to savings. Third, the department has combined projects or used different solutions that were more efficient and associated project costs were lower than estimated. Fourth, the department has leveraged better FFP, thus reducing the General Fund impact. As a result of the factors listed above, the department has consistently underspent its appropriation for the MMIS, which has led to a significant amount of available funding from prior years. The department requests to return funding that is above the cost to run the MMIS, BIDM and PBMS system.

If this portion of the request is not funded, the department will continue to have funding unnecessarily accrue in its roll-forward beyond the needs of the program. This funding will be unable to be appropriated to other areas in the state with funding needs.

Administrative Resources

Services Integrator Contractor Conversation

The department requests a conversion of the Services Integrator contract funding to permanent state staff to better align the currently appropriated resources to the current workload. This request will reduce contractor funding for Services Integration work approved in the department's FY 2019-20 R-12 "Medicaid Enterprise Operations" request and replace the funding with five FTE at the department to perform these functions instead.

For these functions, the department requests four Analysts and one Project Manager. One of the Analysts will serve as Business Analysts and be responsible for defining technical requirements on Medicaid Enterprise enhancement projects and interfacing with contractors to ensure the department's business requirements are fulfilled. One of the Analysts will serve as the Modular Program Lead and be responsible for leading the department's services operations and other staff working on the Medicaid Enterprise along with coordinating and overseeing process adherence related to modular implementation activities. One of the Analysts will serve as a Quality Assurance Analyst and be responsible for coordinating all system testing efforts, providing process direction and assistance to department staff and monitoring contractor testing performance. One analyst will serve as Quality Assurance Testers and be responsible for the overall testing of integrated services, testing multiple modules across multiple services to ensure proper integration, and supporting all testing to ensure the service functions as designed before going into production. The requested Project Manager will be a designated unit lead and be responsible for overseeing the four analysts. Additionally, the position will be responsible for providing comprehensive program and project oversight of the planning and execution of modular service projects across the Medicaid Enterprise, including communication, organization change management, and risk management.

If this portion of the request is not funded, the department will still require all previously appropriated funding and continue to utilize a contractor to fulfill the Services Integrator role, which is out of alignment with the revised re-procurement process required by CMS. Having the department solely rely on contract resources does not put the department policy and practices as the first priority for these system changes. The department needs dedicated staff familiar with the Medicaid system to be able to fully translate policy into a system. Without these additional resources the department is not able to create systems that are meeting all the department needs. The department has concluded that components of the SI contract are completing work and building knowledge that will be better to bring in-house and add to the departmental knowledge base and skillset.

Modular Re-procurement Resources

The department requests eight FTE to fill operational and managerial needs of modular re-procurement to ensure that the department can meet its current functional needs, continue to improve its systems and meet CMS requirements. The current FTE resources are not sufficient to comply with and implement new CMS regulations and rules regarding modular re-procurement and reporting. The lack of resources bottlenecks spending and progress on department goals and projects. These resources will allow the department to address current bottlenecks in project spending and allow the department to administer and run the current MMIS systems. If this request is not approved, the department will have inadequate resources to fulfill its administrative duties for the administration of the MMIS. Currently, the department is unable to absorb or even start working on system changes due to changes in state and federal policy because of a lack of state resources available to manage and track projects. Without these resources the department is unable to take on any more work that will require system changes, creating a significant backlog. Failure to implement these projects may result in the department falling out of compliance with state and federal requirements, ultimately leading to the loss of federal funds.

Federal Advanced Planning Specialists

The department requests two FTE to supplement the current APD team. The current FTE are not sufficient to meet the increased responsibilities of the three main vendor contracts associated with the new modular re-procurement of the MMIS. These positions will be responsible for drafting and managing the APDs in order to secure enhanced federal funding for the department's IT projects. These positions will also perform detailed analysis, reconciliation and resolution of projects and utilization data for the APDs, billings and inventory review, and internal audit analysis associated with the APDs. The additional staff will allow the department to better manage the significant increase in the amount of APDs required to gain federal approval from CMS, which will lead to more timely and accurate submissions, less follow-up questions from CMS and quicker turnaround on securing advanced funding.

Electronic Visit Verification Business Analysts

The department requests two FTE to serve as business analysts to support the Electronic Visit Verification system. The department does not have sufficient resources to maintain and improve the current EVV system. The programmatic business needs for EVV continues to evolve as the program has been implemented and needs ongoing support for modifications, new program rules, and reporting capabilities for stakeholders. The department was originally appropriated time-limited resources for implementation and has no dedicated, ongoing support for this system, which is used by 2,000 providers. These additional FTE will backfill the term-limited staff and be responsible for implementing critical EVV system modifications. One position will be responsible for the analysis and elicitation of business requirements, identification of risk and mitigation plans, and evaluation of technical design specifications related to ongoing system changes necessary to ensure compliance with state and federal laws and alignment with department

policies. The other analyst will be responsible for ensuring User Acceptance Test (UAT) testing and System End to End testing is thoroughly accomplished with all contractors to ensure the EVV programmatic business needs are met. These positions will provide ongoing support for updating the MMIS, performing UAT testing, and leading integration work, allowing for proper and timely reporting. These positions are critical to meet federal and state initiatives related to EVV.

Contract Managers
The department requests two FTE to serve as contract managers for managing the increased contracts due to the shift towards modular re-procurement. The department does not have sufficient staffing to manage its MMIS Enterprise contracts driven by modular re-procurement requirements. The department manages multiple major system contracts which allows the department to engage with vendors to operate and administer Medicaid. Currently the department has fifteen complex contracts being managed by only three contract managers. These new positions will be responsible for managing the ongoing procurement processes related to the contracts, including contract modifications, development of solicitations, scopes of work, deliverables, performance metrics and desired outcomes. These positions will focus on the Medicaid Enterprise System Integration, Data & Alignment (MIDA) and Provider Management Module contract. They will be responsible for drafting agreements, monitoring contractor progress and performance to ensure goods and services conform to contract requirements; identifying potential problems and solutions or mitigations; reviewing invoices and authorizing payments consistent with the contract terms; arranging for contractor access to state facilities, equipment, data, staff, materials and information, as applicable; establishing reporting requirements; maintaining appropriate records; and participating in audits.

Program Integrity/Recovery Tracking Business Analyst
The department requests one FTE to provide continuous technical support for recovery tracking performed by the department. The department's vendor has been unable to fully implement a tool that assists in tracking department recoveries. The current tool developed still leaves gaps and does not accommodate all the needed workflows of the department. Existing processes are fragmented, and records are maintained over a slew of software products. Existing FTE are not systems experts and implementing new software infrastructure will take time away from their daily work of identifying and making recoveries. The department does not have sufficient staffing to gather technical requirements from SMEs and help execute and implement a new tool that comprehensively tracks the recoveries of overpayments for the department's current recoveries staff. Without this additional resource the department is not able to implement an effective recovery tracking tool. After the implementation of the new tool this FTE will continue to be a necessary resource as policy and department goals change. This position will ensure that this recovery tool is effective and in-line with the department's evolving needs. This FTE will provide technical support in implementing the recovery tracking tool. This position will be responsible for ensuring user experience meets industry standards and best practices are implemented. This

position will translate business workflow requirements to the vendor and hold the vendor accountable to meeting those requirements.

Federal Reporting Business Analyst

The department requests one FTE to serve as dedicated system development support for complying with mandatory federal expenditure reports. The federal reporting requirements are constantly changing as new federal laws and regulations are implemented. Each federal change requires technical changes to the reporting framework, such as when the federal medical assistance percentage (FMAP) changes, or when CMS requires that expenditure is reported differently. The department does not have dedicated internal support for this reporting and vendor resources have not been sufficient to monitor and respond to changes in federal policy. Further, because this knowledge and expertise are not within the department and is instead with a contractor, the department is concerned that it may lose critical institutional knowledge in the event of a vendor transition. This FTE will be responsible for maintaining the system that generates the quarterly expenditure report for CMS. This position will be responsible for keeping the system updated for programs/benefits, funding codes and federal matching percentages changes. This position will also primarily be responsible for supporting reporting changes through all stages of change management, from requirements for design to testing of the report on a quarterly basis. This position will work closely with the department's accounting and budget staff to ensure the accuracy and integrity of state and federal expenditure reporting by vendors.

Theory of Change	Not on the continuum - N/A		
Program Objective	Not on the continuum - N/A		
Outputs being measured	Not on the continuum - N/A		
Outcomes being measured	Not on the continuum - N/A		
Cost/Benefit ratio	N/A		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	N/A		

Continuum Level	N/A

Anticipated Outcomes

The department seeks to improve all areas of its system operations including the administrative functions included in this request. The department anticipates that approval of this request will provide significant return-on-investment to the state by developing efficiencies and institutional knowledge on complex subject matter while better utilizing existing funding and realizing savings.

The department anticipates that approval of this request will further the department's mission of improving health care access and outcomes for the people it serves while demonstrating sound financial stewardship of state resources. The funding in the request addresses critical administrative resource needs which if left unfunded, will negatively impact the department's ability to meet the needs of Health First Colorado members. The department anticipates this request will enhance administrative functions by using permanent staff which can be more responsive to department priorities and more ingrained in the department's culture and operations.

In addition, this request will free up state resources that are currently unnecessarily appropriated to the department. In doing so, the department will be able to fund the outcome of this request without additional appropriations, while making additional funding available to the General Assembly to appropriate for other programs.

This request aligns with the Operational Excellence pillar in the department Performance Plan to promote effective and efficient use of state resources, and also aligns with the department's strategy to improve efficiency of business processes by supporting efficient and effective administration of the Medicaid programs, including IT infrastructure. The department has more accurately identified the current funding needs to operate and maintain its system and seeks to promote sound financial stewardship with this request.

Assumptions and Calculations

Detailed calculations of the request are provided in the attached appendix A.

The department assumes that for FY 2022-23, the department will return part of the FY 2022-23 appropriation and fund activities with a combination of funding rolled forward from FY 2021-22 and current year funding. MMIS funding will return to its normal level for FY 2023-24 and ongoing and a full appropriation will be required. The department assumes that the activities to be

fulfilled through non-SI related FTE will have to be addressed, therefore if the conversion of FTE were not approved, the department will need additional contract funding.

The department has included $500,000 General Fund for transition costs. This funding will allow the department the transition between vendors on upcoming procurements should a new vendor be chosen. As the department re-procures larger contracts, additional transition funding may be necessary and will be requested through the normal budget process. The department assumed there will be a funding need related to transition activities after consulting with other states.

For the requested FTE, the department assumes all FTE included in this request will start July 1, 2022 and will be full-time, permanent positions. The department assumes that the FTE will be eligible for an average of 75% FFP. The department assumes that the majority of the work will be done at 75% FFP; some work may qualify for higher or lower federal match rates, and the department will account for any changes in federal funds via the regular budget process.

Table 1.1
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$930,109	12.5	$144,260	$93,848	$0	$692,001	74.40%	Table 5.1 and Table 6.1
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$183,118	0.0	$28,402	$18,477	$0	$136,239	74.40%	Table 5.1 and Table 6.1
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$1,325	0.0	$205	$134	$0	$986	74.42%	Table 5.1 and Table 6.1
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$41,393	0.0	$6,420	$4,176	$0	$30,797	74.40%	Table 5.1 and Table 6.1
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization Disbursement	$41,393	0.0	$6,420	$4,176	$0	$30,797	74.40%	Table 5.1 and Table 6.1
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$103,350	0.0	$16,030	$10,428	$0	$76,892	74.40%	Table 5.1 and Table 6.1
G	(1) Executive Director's Office; (A) General Administration; Leased Space	$85,800	0.0	$13,308	$8,657	$0	$63,835	74.40%	Table 5.1 and Table 6.1
H	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; MMIS Maintenance and Projects	($57,465,630)	0.0	($10,562,524)	($2,892,948)	$0	($44,010,158)	76.59%	Table 2.1: Row C + Row E + Row I
I	**Total Request**	**($56,079,142)**	**12.5**	**($10,347,479)**	**($2,753,052)**	**$0**	**($42,978,611)**	**N/A**	Sum of Rows A through H

Table 1.2
Summary by Line Item
FY 2023-24

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$967,357	13.0	$150,037	$97,607	$0	$719,713	74.40%	Table 5.1 and Table 6.1
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$183,118	0.0	$28,401	$18,477	$0	$136,240	74.40%	Table 5.1 and Table 6.1
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$1,375	0.0	$213	$138	$0	$1,024	74.47%	Table 5.1 and Table 6.1
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$43,053	0.0	$6,678	$4,344	$0	$32,031	74.40%	Table 5.1 and Table 6.1
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization Disbursement	$43,053	0.0	$6,678	$4,344	$0	$32,031	74.40%	Table 5.1 and Table 6.1
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$12,350	0.0	$1,915	$1,246	$0	$9,189	74.40%	Table 5.1 and Table 6.1
G	(1) Executive Director's Office; (A) General Administration; Leased Space	$85,800	0.0	$13,308	$8,657	$0	$63,835	74.40%	Table 5.1 and Table 6.1
H	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; MMIS Maintenance and Projects	($631,905)	0.0	($1,314,041)	$1,343,606	$0	($661,470)	104.68%	Table 2.2: Row C + Row E + Row I
I	**Total Request**	**$704,201**	**13.0**	**($1,106,811)**	**$1,478,419**	**$0**	**$332,593**	**N/A**	Sum of Rows A through H

Table 1.3
Summary by Line Item
FY 2024-25 and Ongoing

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$967,357	13.0	$150,037	$97,607	$0	$719,713	74.40%	Table 5.1 and Table 6.1
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$183,118	0.0	$28,401	$18,477	$0	$136,240	74.40%	Table 5.1 and Table 6.1
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$1,375	0.0	$213	$138	$0	$1,024	74.47%	Table 5.1 and Table 6.1
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$43,053	0.0	$6,678	$4,344	$0	$32,031	74.40%	Table 5.1 and Table 6.1
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization Disbursement	$43,053	0.0	$6,678	$4,344	$0	$32,031	74.40%	Table 5.1 and Table 6.1
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$12,350	0.0	$1,915	$1,246	$0	$9,189	74.40%	Table 5.1 and Table 6.1
G	(1) Executive Director's Office; (A) General Administration; Leased Space	$85,800	0.0	$13,308	$8,657	$0	$63,835	74.40%	Table 5.1 and Table 6.1
H	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; MMIS Maintenance and Projects	($1,186,014)	0.0	($1,258,580)	$1,360,542	$0	($1,287,976)	108.60%	Table 2.3: Row C + Row E + Row I
I	**Total Request**	**$150,092**	**13.0**	**($1,051,350)**	**$1,495,355**	**$0**	**($293,913)**	**N/A**	Sum of Rows A through H

Table 2.1
Summary by Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	*Roll Forward Adjustments*								
B	Reduction to MMIS Appropriation Due to Excess Rollforward Funding	($57,362,559)	0.0	($9,703,222)	($4,213,847)	$0	($43,445,490)	75.74%	Table 3.1 Row S
C	**Roll Forward Adjustments Subtotal**	**($57,362,559)**	**0.0**	**($9,703,222)**	**($4,213,847)**	**$0**	**($43,445,490)**	**75.74%**	**Row B**
D	*Base Funding Adjustments*								
E	Adjustment to MMIS Base Funding	$1,634,355	0.0	($589,827)	$1,496,206	$0	$727,976	44.54%	Table 3.1 Row R
F	Increase in FTE to Support Operations	$832,260	7.7	$129,084	$83,974	$0	$619,202	74.40%	Table 6.1
G	**Base Funding Subtotal**	**$2,466,615**	**7.7**	**($460,743)**	**$1,580,180**	**$0**	**$1,347,178**	**54.62%**	**Row E + Row F**
H	*Services Integrations Adjustments*								
I	Reduction to SI Contract	($1,737,426)	0.0	($269,475)	($175,307)	$0	($1,292,644)	74.40%	Table 4.1 Row E
J	Increase in FTE for SI Work	$554,228	4.8	$85,961	$55,922	$0	$412,345	74.40%	Table 5.1
K	**Services Integration Subtotal**	**($1,183,198)**	**4.8**	**($183,514)**	**($119,385)**	**$0**	**($880,299)**	**74.40%**	**Row I + Row J**
L	**Total Request**	**($56,079,142)**	**12.5**	**($10,347,479)**	**($2,753,052)**	**$0**	**($42,978,611)**	**N/A**	**Row C + Row G + Row K**

Table 2.2
Summary by Initiative
FY 2023-24

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	*Roll Forward Adjustments*								
B	Reduction to MMIS Appropriation Due to Excess Rollforward Funding	$0	0.0	$0	$0	$0	$0	N/A	N/A
C	**Roll Forward Adjustments Subtotal**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**N/A**	**Row B**
D	*Base Funding Adjustments*								
E	Adjustment to MMIS Base Funding	$1,105,521	0.0	($1,044,566)	$1,518,913	$0	$631,174	57.09%	Table 3.2 Row R
F	Increase in FTE to Support Operations	$800,416	8.0	$124,144	$80,762	$0	$595,510	74.40%	Table 6.1
G	**Base Funding Subtotal**	**$1,905,937**	**8.0**	**($920,422)**	**$1,599,675**	**$0**	**$1,226,684**	**64.36%**	**Row E + Row F**
H	*Services Integrations Adjustments*								
I	Reduction to SI Contract	($1,737,426)	0.0	($269,475)	($175,307)	$0	($1,292,644)	74.40%	Table 4.2 Row E
J	Increase in FTE for SI Work	$535,690	5.0	$83,086	$54,051	$0	$398,553	74.40%	Table 5.1
K	**Services Integration Subtotal**	**($1,201,736)**	**5.0**	**($186,389)**	**($121,256)**	**$0**	**($894,091)**	**74.40%**	**Row I + Row J**
L	**Total Request**	**$704,201**	**13.0**	**($1,106,811)**	**$1,478,419**	**$0**	**$332,593**	**N/A**	**Row C + Row G + Row K**

Table 2.3
Summary by Initiative
FY 2024-25 and Ongoing

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	*Roll Forward Adjustments*								
B	Reduction to MMIS Appropriation Due to Excess Rollforward Funding	$0	0.0	$0	$0	$0	$0	N/A	N/A
C	**Roll Forward Adjustments Subtotal**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**N/A**	**Row B**
D	*Base Funding Adjustments*								
E	Adjustment to MMIS Base Funding	$551,412	0.0	($989,105)	$1,535,849	$0	$4,668	0.85%	Table 3.3 Row R
F	Increase in FTE to Support Operations	$800,416	8.0	$124,144	$80,762	$0	$595,510	74.40%	Table 6.1
G	**Base Funding Subtotal**	**$1,351,828**	**8.0**	**($864,961)**	**$1,616,611**	**$0**	**$600,178**	**44.40%**	**Row E + Row F**
H	*Services Integrations Adjustments*								
I	Reduction to SI Contract	($1,737,426)	0.0	($269,475)	($175,307)	$0	($1,292,644)	74.40%	Table 4.3 Row E
J	Increase in FTE for SI Work	$535,690	5.0	$83,086	$54,051	$0	$398,553	74.40%	Table 5.1
K	**Services Integration Subtotal**	**($1,201,736)**	**5.0**	**($186,389)**	**($121,256)**	**$0**	**($894,091)**	**74.40%**	**Row I + Row J**
L	**Total Request**	**$150,092**	**13.0**	**($1,051,350)**	**$1,495,355**	**$0**	**($293,913)**	**N/A**	**Row C + Row G + Row K**

Table 3.1
MMIS Budget by Federal Match
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	**MMIS**	**$71,700,163**	**0.0**	**$9,520,581**	**$6,410,250**	**$0**	**$55,769,332**	**77.78%**	**Sum of Row B through D**
B	*Costs that Receive a 90% Federal Match*	$17,344,395	0.0	$1,076,046	$918,559	$0	$15,349,790	88.50%	MMIS Budget Build
C	*Costs that Receive a 75% Federal Match*	$54,265,768	0.0	$8,416,617	$5,475,419	$0	$40,373,732	74.40%	MMIS Budget Build
D	*Costs that Receive a 50% Federal Match*	$90,000	0.0	$27,918	$16,272	$0	$45,810	50.90%	MMIS Budget Build
E	**BIDM**	**$12,206,811**	**0.0**	**$2,315,726**	**$1,181,218**	**$0**	**$8,709,867**	**71.35%**	**Sum of Row F through I**
F	*Costs that Receive a 90% Federal Match*	$0	0.0	$0	$0	$0	$0	N/A	MMIS Budget Build
G	*Costs that Receive a 75% Federal Match*	$11,706,811	0.0	$1,815,726	$1,181,218	$0	$8,709,867	74.40%	MMIS Budget Build
H	*Costs that Receive a 50% Federal Match*	$0	0.0	$0	$0	$0	$0	N/A	MMIS Budget Build
I	*Costs that Receive No Federal Match*	$500,000	0.0	$500,000	$0	$0	$0	N/A	MMIS Budget Build
J	**PBMS**	**$3,626,650**	**0.0**	**$574,901**	**$372,321**	**$0**	**$2,679,428**	**73.88%**	**Sum of Row K through M**
K	*Costs that Receive a 90% Federal Match*	$0	0.0	$0	$0	$0	$0	N/A	MMIS Budget Build
L	*Costs that Receive a 75% Federal Match*	$3,546,650	0.0	$550,085	$357,857	$0	$2,638,708	74.40%	MMIS Budget Build
M	*Costs that Receive a 50% Federal Match*	$80,000	0.0	$24,816	$14,464	$0	$40,720	N/A	MMIS Budget Build
N	Provider Enrollment Fee Offset	$0	0.0	($54,285)	$314,685	$0	($260,400)	N/A	Table 7.1 Offset Calculator
O	Reappropriated Funds Offset	$0	0.0	($1,893)	($1,233)	$12,204	($9,078)	N/A	Table 7.2 Offset Calculator
P	**Estimated FY 2022-23 MMIS Expenditure**	**$87,533,624**	**0.0**	**$12,355,030**	**$8,277,241**	**$12,204**	**$66,889,149**	**76.42%**	**Row A + Row E + Row J + Row N + Row O**
Q	**Estimated FY 2022-23 Appropriation**	**$85,899,269**	**0.0**	**$12,944,857**	**$6,781,035**	**$12,204**	**$66,161,173**	**77.02%**	**Department Reconciliation Documents**
R	**Base Funding True-Up Request**	**$1,634,355**	**0.0**	**($589,827)**	**$1,496,206**	**$0**	**$727,976**	**44.54%**	**Row P - Row Q**
S	**Project FY 2022-23 Roll-Forward**	**$57,362,559**	**0.0**	**$9,703,222**	**$4,213,847**	**$0**	**$43,445,490**	**75.74%**	**Department Reconciliation Documents**
T	**Total MMIS True-Up Request**	**($55,728,204)**	**0.0**	**($10,293,049)**	**($2,717,641)**	**$0**	**($42,717,514)**	**76.65%**	**Row R - Row S**

Table 3.2
MMIS Budget by Federal Match
FY 2023-24

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	**MMIS**	**$70,975,748**	**0.0**	**$9,457,958**	**$6,362,773**	**$0**	**$55,155,017**	**77.71%**	**Sum of Row B through D**
B	*Costs that Receive a 90% Federal Match*	$16,812,353	0.0	$1,043,038	$890,382	$0	$14,878,933	88.50%	MMIS Budget Build
C	*Costs that Receive a 75% Federal Match*	$52,678,953	0.0	$8,170,504	$5,315,306	$0	$39,193,143	74.40%	MMIS Budget Build
D	*Costs that Receive a 50% Federal Match*	$1,484,442	0.0	$244,416	$157,085	$0	$1,082,941	72.95%	MMIS Budget Build
E	**BIDM**	**$12,402,392**	**0.0**	**$1,923,610**	**$1,251,402**	**$0**	**$9,227,380**	**74.40%**	**Sum of Row F through I**
F	*Costs that Receive a 90% Federal Match*	$0	0.0	$0	$0	$0	$0	N/A	MMIS Budget Build
G	*Costs that Receive a 75% Federal Match*	$12,402,392	0.0	$1,923,610	$1,251,402	$0	$9,227,380	74.40%	MMIS Budget Build
H	*Costs that Receive a 50% Federal Match*	$0	0.0	$0	$0	$0	$0	N/A	MMIS Budget Build
I	*Costs that Receive No Federal Match*	$0	0.0	$0	$0	$0	$0	N/A	MMIS Budget Build
J	**PBMS**	**$3,626,650**	**0.0**	**$574,901**	**$372,321**	**$0**	**$2,679,428**	**73.88%**	**Sum of Row K through M**
K	*Costs that Receive a 90% Federal Match*	$0	0.0	$0	$0	$0	$0	N/A	MMIS Budget Build
L	*Costs that Receive a 75% Federal Match*	$3,546,650	0.0	$550,085	$357,857	$0	$2,638,708	74.40%	MMIS Budget Build
M	*Costs that Receive a 50% Federal Match*	$80,000	0.0	$24,816	$14,464	$0	$40,720	50.90%	MMIS Budget Build
N	Provider Enrollment Fee Offset	$0	0.0	($54,285)	$314,685	$0	($260,400)	N/A	Table 7.1 Offset Calculator
O	Reappropriated Funds Offset	$0	0.0	($1,893)	($1,233)	$12,204	($9,078)	N/A	Table 7.2 Offset Calculator
P	**Estimated FY 2023-24 MMIS Expenditure**	**$87,004,790**	**0.0**	**$11,900,291**	**$8,299,948**	**$12,204**	**$66,792,347**	**76.77%**	**Row A + Row E + Row J + Row N + Row O**
Q	**Estimated FY 2023-24 Base Appropriation**	**$85,899,269**	**0.0**	**$12,944,857**	**$6,781,035**	**$12,204**	**$66,161,173**	**77.02%**	**Department Reconciliation Documents**
R	**Total MMIS True-Up Request**	**$1,105,521**	**0.0**	**($1,044,566)**	**$1,518,913**	**$0**	**$631,174**	**57.09%**	**Row P - Row Q**

Table 3.3
MMIS Budget by Federal Match
FY 2024-25 and Ongoing

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	**MMIS**	**$69,780,189**	**0.0**	**$9,413,931**	**$6,314,986**	**$0**	**$54,051,272**	**77.46%**	**Sum of Row B through D**
B	*Costs that Receive a 90% Federal Match*	$15,295,274	0.0	$948,919	$810,038	$0	$13,536,317	88.50%	MMIS Budget Build
C	*Costs that Receive a 75% Federal Match*	$52,999,025	0.0	$8,220,147	$5,347,602	$0	$39,431,276	74.40%	MMIS Budget Build
D	*Costs that Receive a 50% Federal Match*	$1,485,890	0.0	$244,865	$157,346	$0	$1,083,679	72.93%	MMIS Budget Build
E	**BIDM**	**$13,043,842**	**0.0**	**$2,023,098**	**$1,316,125**	**$0**	**$9,704,619**	**74.40%**	**Sum of Row F through I**
F	*Costs that Receive a 90% Federal Match*	$0	0.0	$0	$0	$0	$0	N/A	MMIS Budget Build
G	*Costs that Receive a 75% Federal Match*	$13,043,842	0.0	$2,023,098	$1,316,125	$0	$9,704,619	74.40%	MMIS Budget Build
H	*Costs that Receive a 50% Federal Match*	$0	0.0	$0	$0	$0	$0	N/A	MMIS Budget Build
I	*Costs that Receive No Federal Match*	$0	0.0	$0	$0	$0	$0	N/A	MMIS Budget Build
J	**PBMS**	**$3,626,650**	**0.0**	**$574,901**	**$372,321**	**$0**	**$2,679,428**	**73.88%**	**Sum of Row K through M**
K	*Costs that Receive a 90% Federal Match*	$0	0.0	$0	$0	$0	$0	N/A	MMIS Budget Build
L	*Costs that Receive a 75% Federal Match*	$3,546,650	0.0	$550,085	$357,857	$0	$2,638,708	74.40%	MMIS Budget Build
M	*Costs that Receive a 50% Federal Match*	$80,000	0.0	$24,816	$14,464	$0	$40,720	50.90%	MMIS Budget Build
N	Provider Enrollment Fee Offset	$0	0.0	($54,285)	$314,685	$0	($260,400)	N/A	Table 7.1 Offset Calculator
O	Reappropriated Funds Offset	$0	0.0	($1,893)	($1,233)	$12,204	($9,078)	N/A	Table 7.2 Offset Calculator
P	**Estimated FY 2024-25 MMIS Expenditure**	**$86,450,681**	**0.0**	**$11,955,752**	**$8,316,884**	**$12,204**	**$66,165,841**	**76.54%**	**Row A + Row E + Row J + Row N + Row O**
Q	**Estimated FY 2024-25 Base Appropriation**	**$85,899,269**	**0.0**	**$12,944,857**	**$6,781,035**	**$12,204**	**$66,161,173**	**77.02%**	**Department Reconciliation Documents**
R	**Total MMIS True-Up Request**	**$551,412**	**0.0**	**($989,105)**	**$1,535,849**	**$0**	**$4,668**	**0.85%**	**Row P - Row Q**

Table 4.1
Contractor Cost Reductions
FY 2022-23

Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Medicaid Enterprise Services Integration								
A	1 Business Analysts	($380,058)	($58,947)	($38,348)	$0	($282,763)	74.40%	Eliminate contractor funding
B	1 Modular Program Lead	($380,058)	($58,947)	($38,348)	$0	($282,763)	74.40%	Eliminate contractor funding
C	2 Quality Assurance Analyst/Tester	($651,540)	($101,054)	($65,741)	$0	($484,745)	74.40%	Eliminate contractor funding
D	1 Program Manager	($325,770)	($50,527)	($32,870)	$0	($242,373)	74.40%	Eliminate contractor funding
E	**Total Request**	**($1,737,426)**	**($269,475)**	**($175,307)**	**$0**	**($1,292,644)**	**N/A**	**Sum of Rows A through D**

Table 4.2
Contractor Cost Reductions
FY 2023-24

Row	Subtotal	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Medicaid Enterprise Services Integration								
A	1 Business Analysts	($380,058)	($58,947)	($38,348)	$0	($282,763)	74.40%	Eliminate contractor funding
B	1 Modular Program Lead	($380,058)	($58,947)	($38,348)	$0	($282,763)	74.40%	Eliminate contractor funding
C	2 Quality Assurance Analyst/Tester	($651,540)	($101,054)	($65,741)	$0	($484,745)	74.40%	Eliminate contractor funding
D	1 Program Manager	($325,770)	($50,527)	($32,870)	$0	($242,373)	74.40%	Eliminate contractor funding
E	**Total Request**	**($1,737,426)**	**($269,475)**	**($175,307)**	**$0**	**($1,292,644)**	**N/A**	**Sum of Rows A through D**

Table 4.3
Contractor Cost Reductions
FY 2024-25 and Ongoing

Row	Subtotal	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Medicaid Enterprise Services Integration								
A	1 Business Analysts	($380,058)	($58,947)	($38,348)	$0	($282,763)	74.40%	Eliminate contractor funding
B	1 Modular Program Lead	($380,058)	($58,947)	($38,348)	$0	($282,763)	74.40%	Eliminate contractor funding
C	2 Quality Assurance Analyst/Tester	($651,540)	($101,054)	($65,741)	$0	($484,745)	74.40%	Eliminate contractor funding
D	1 Program Manager	($325,770)	($50,527)	($32,870)	$0	($242,373)	74.40%	Eliminate contractor funding
E	**Total Request**	**($1,737,426)**	**($269,475)**	**($175,307)**	**$0**	**($1,292,644)**	**N/A**	**Sum of Rows A through D**

Table 5.1
FTE Calculations
Services Integration FTE

Personal Services

Position Classification	FTE	Start Month	State Fund Source	FY 2022-23	FY 2023-24	FY 2024-25	Notes
ANALYST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
ANALYST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
ANALYST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
ANALYST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
PROJECT MANAGER III	1.0	July	General Fund	$95,511	$99,335	$99,335	
Total Personal Services (Salary, PERA, Medicare)	**5.0**			**$376,959**	**$392,055**	**$392,055**	

Centrally Appropriated Costs

Cost Center	FTE Year 1	FTE Year 2+	Cost or Percentage	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Health, Life, Dental	5.0	5.0	$14,086	$70,430	$70,430	$70,430	
Short-Term Disability	-	-	0.16%	$537	$557	$557	
Amortization Equalization Disbursement	-	-	5.00%	$16,776	$17,449	$17,449	
Supplemental Amortization Equalization Disbursement	-	-	5.00%	$16,776	$17,449	$17,449	
Centrally Appropriated Costs Total				**$104,518**	**$105,885**	**$105,885**	

Operating Expenses

Ongoing Costs	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Supplies	5.0	5.0	$500	$2,500	$2,500	$2,500	
Telephone	5.0	5.0	$450	$2,250	$2,250	$2,250	
Other	5.0	5.0	$0	$0	$0	$0	
Subtotal				*$4,750*	*$4,750*	*$4,750*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	5.0		$5,000	$25,000	$0	$0	
Computer	5.0		$2,000	$10,000	$0	$0	
Other	5.0		$0	$0	$0	$0	
Subtotal				*$35,000*	*$0*	*$0*	
Total Operating				**$39,750**	**$4,750**	**$4,750**	

Leased Space

	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Leased Space	5.0	5.0	$6,600	**$33,000**	**$33,000**	**$33,000**	

Table 6.1
FTE Calculations
Operations FTE

Personal Services

Position Classification	FTE	Start Month	State Fund Source	FY 2022-23	FY 2023-24	FY 2024-25	Notes
PROJECT COORDINATOR	1.0	July	General Fund	$56,648	$58,916	$58,916	
PROJECT COORDINATOR	1.0	July	General Fund	$56,648	$58,916	$58,916	
CONTRACT ADMINISTRATOR V	1.0	July	General Fund	$88,044	$91,570	$91,570	
CONTRACT ADMINISTRATOR IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
ANALYST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
ANALYST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
ANALYST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
ANALYST IV	1.0	July	General Fund	$70,362	$73,180	$73,180	
Total Personal Services (Salary, PERA, Medicare)	**8.0**			**$553,150**	**$575,302**	**$575,302**	

Centrally Appropriated Costs

Cost Center	FTE Year 1	FTE Year 2+	Cost or Percentage	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Health, Life, Dental	8.0	8.0	$14,086	$112,688	$112,688	$112,688	
Short-Term Disability	-	-	0.16%	$788	$818	$818	
Amortization Equalization Disbursement	-	-	5.00%	$24,617	$25,604	$25,604	
Supplemental Amortization Equalization Disbursement	-	-	5.00%	$24,617	$25,604	$25,604	
Centrally Appropriated Costs Total				**$162,711**	**$164,714**	**$164,714**	

Operating Expenses

Ongoing Costs	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Supplies	8.0	8.0	$500	$4,000	$4,000	$4,000	
Telephone	8.0	8.0	$450	$3,600	$3,600	$3,600	
Other	8.0	8.0	$0	$0	$0	$0	
Subtotal				*$7,600*	*$7,600*	*$7,600*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Furniture	8.0		$5,000	$40,000	$0	$0	
Computer	8.0		$2,000	$16,000	$0	$0	
Other	8.0		$0	$0	$0	$0	
Subtotal				*$56,000*	*$0*	*$0*	
Total Operating				**$63,600**	**$7,600**	**$7,600**	

Leased Space

	FTE Year 1	FTE Year 2+	Cost	FY 2022-23	FY 2023-24	FY 2024-25	Notes
Leased Space	8.0	8.0	$6,600	**$52,800**	**$52,800**	**$52,800**	

Table 7.1
Provider Enrollment Fee Offset Calculator

Item $ Amount	$350,000.00	**Line %**	**Line $ Amount**	**FFP**	**State Fund Source**	**State $ Amount**	**Federal $ Amount**
		62.04%	$217,140.00	75.0%	Title XIX - General Fund	$54,285.00	$162,855.00
Title XIX - Medicaid	**94.00%**	31.96%	$111,860.00	75.0%	Title XIX - CHASE	$27,965.00	$83,895.00
General Fund	66.000%	0.00%	$0.00	65.0%	Title XXI - CHP+ Trust	$0.00	$0.00
CHASE	34.0%	6.00%	$21,000.00	65.0%	Title XXI - CHASE	$7,350.00	$13,650.00
			$350,000.00			**$89,600.00**	**$260,400.00**
Title XXI - CHP	**6.00000%**						
CBHP Trust	0.000%						
CHASE	100.000%						

Table 7.2
Reappropriated Funds Offset Calculator

Item $ Amount	$12,204.00	**Line %**	**Line $ Amount**	**FFP**	**State Fund Source**	**State $ Amount**	**Federal $ Amount**
		62.04%	$7,571.00	75.0%	Title XIX - General Fund	$1,893.00	$5,678.00
Title XIX - Medicaid	**94.00%**	31.96%	$3,901.00	75.0%	Title XIX - CHASE	$976.00	$2,925.00
General Fund	66.000%	0.00%	$0.00	65.0%	Title XXI - CHP+ Trust	$0.00	$0.00
CHASE	34.0%	6.00%	$732.00	65.0%	Title XXI - CHASE	$257.00	$475.00
			$12,204.00			**$3,126.00**	**$9,078.00**
Title XXI - CHP	**6.00000%**						
CBHP Trust	0.000%						
CHASE	100.000%						

Department of Health Care Policy & Financing

FY 2022-23 Funding Request

November 1, 2021

Jared Polis
Governor

Kim Bimestefer
Executive Director

Department Priority: R-15
Request Detail: Restore APCD Scholarship Funds

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$3,795,498	$200,000	$200,000
FTE	0.0	0.0	0.0
General Fund	$2,962,231	$200,000	$200,000
Cash Funds	$0	$0	$0
Reappropriated Funds	$0	$0	$0
Federal Funds	$833,267	$0	$0

Summary of Request

The Department of Health Care Policy & Financing (HCPF or department) requests to partially restore funding for the All-Payer Claims Database (APCD) Scholarship Program that was removed in FY 2020-21 by the Joint Budget Committee (JBC) as part of budget balancing reductions due to the COVID-19 economic downturn. This program will provide grants to state and local government entities, academics, researchers, nonprofit organizations, and others to help offset the cost of licensing data and reports from the APCD for health care research and partially restore an important funding stream that supports the operations and development of the APCD. The APCD is a comprehensive database of health care claims across all Colorado health insurance carriers and before funding was removed in FY 2020-21, the APCD Scholarship Program was instrumental in enabling researchers to access this data and provide valuable insights into improving health care and lowering health care costs for all Coloradans. As the economic situation improves, the department has an opportunity to resume the APCD Scholarship Program, which is more valuable than ever as the impact of COVID-19 on the health of Coloradans and the health care system at large is studied and as the state's health care infrastructure, payment, and delivery systems are rebuilt to better serve the needs of residents.

This request represents less than a 0.5 percent increase to the department's budget.

Current Program

The APCD is a comprehensive database of claims across all Colorado health insurance carriers, including Medicaid, Medicare, and commercial payers. The data collected includes diagnosis and service information and provides the most complete overall picture of health care and health care costs in Colorado. The APCD provides data and analytics to a variety of stakeholders including state and local government entities, academic institutions, researchers, health care providers, nonprofit health focused entities, employer groups, health technology companies, and more to support the triple aim of better health, better care, and lower costs. The APCD is administered by the not-for-profit Center for Improving Health Care (CIVHC) in close collaboration with the state and other stakeholders through various governance structures including the CIVHC Board of Directors, the CO APCD Advisory Committee, and the Data Release Review Committee.

The APCD Scholarship Program was a grant program that provided academics, nonprofits, state and local government entities, and others access to the APCD for research purposes. The grants helped participants by offsetting up to 80% of the cost of licensing data and reports from the APCD. The department administered the grants and the criteria for awarding grants was developed by the APCD Advisory Committee. Between FY 2017-18 and FY 2019-20, nearly $1.5 million in grant funds were awarded for 65 different research projects, with nearly half of the funding going to nonprofit entities and the remainder going to academics, researchers, governmental entities, and physician practices. Past scholarship fund projects include:

- Data critical in implementing effective Employer Purchasing Alliances including Peak Health Alliance to help address the high cost of care in rural areas of Colorado;
- A study of Cost Savings from Medically Tailored Meals for the Chronically Ill;
- A study of Emergency Department Utilization by the Colorado Children's Health Care Access Program;
- County-level health care cost analyses including Garfield, Lake, and Chafee counties;
- A study of the Incidence of Cancer Rates in the Rocky Flats Region;
- Multiple legislative requests to support bill discussions across aisles; and
- Many other research projects focused on improving health care and lowering costs.

Problem or Opportunity

Funding for the APCD Scholarship Program was removed by the JBC in FY 2020-21 as part of the budget balancing reductions due to the COVID-19 economic downturn.[1] Without this funding, the

[1] http://leg.colorado.gov/sites/default/files/hcpf_bal_fy20-21_05-04-20.pdf

department has been unable to provide grants to eligible organizations to offset the cost of licensing data and reports from the APCD for health care focused research. This has limited the ability of state and local government entities, legislators, academics, researchers, nonprofits and others to perform valuable research using the uniquely comprehensive data and analytics available in the APCD. Furthermore, since these grants ultimately fund APCD operations and development, this has negatively impacted investment into the APCD to ensure the success of this valuable resource for understanding health care in Colorado. As the state's economic situation improves, the department has an opportunity to restore funding for the APCD Scholarship Program and begin awarding grants again for health care research that supports better health, better care, and lower costs for all Coloradans.

Proposed Solution

The department requests an increase of $200,000 total funds, including $200,000 General Fund in FY 2022-23 and ongoing in order to partially restore funding removed in response to the COVID-19 economic downturn for the APCD Scholarship Program. This funding will be used to resume the APCD Scholarship Program and award grants to eligible participants to support research projects that support better health, better care, and lower costs of health care for all Coloradans. The grant funding will be used by participants to offset the costs of licensing data and reports from the APCD for use in their research, which will in turn provide funding to the APCD for continued investment in the quality and usefulness of APCD data and analytics. The APCD Scholarship Program has proven its value through prior research projects it has funded and the department anticipates it will be more valuable than ever in upcoming years as stakeholders in Colorado's health care system seek to understand the impact of COVID-19 on the health of Coloradans and the health care system at large, be better prepared for future outbreaks, and support re-building the state's health care infrastructure, payment, and delivery systems to better serve the needs of Coloradans.

If this request is not approved, the department will be unable to resume the APCD Scholarship Program and begin providing grants again to state and local government entities, academics, nonprofits, and others for research into improving health care and reducing costs for all Coloradans. Without these grants, it is likely that many potential research projects using APCD data will not be able to be done. In particular, removal of this program in FY 2020-21 has had a dramatic negative impact on the ability of nonprofit organizations to perform research projects using APCD data and reports, which previously made up the majority of projects funded by the program. Furthermore, the APCD Scholarship Program represents an important funding stream for the operation and development of the APCD, which had its state funding reduced by nearly 30% in FY 2020-21 from the COVID-19-related budget balancing reductions. Without the APCD Scholarship Program, the APCD will continue operating with reduced state funding and face

limitations in its ability to enhance the quality and the utility of the data collected in the APCD for state agencies, researchers, and others.

The department considers this request as aligning with Step 3 on the Office of State Planning and Budget (OSPB) continuum of evidence. This is because the APCD Scholarship Program has a clear program objective to enable access to APCD data and reports through grants that offset licensing costs. It also has a clear output measure in how many projects and how much grant money is awarded by the program each year, which has been tracked in prior years when the program was funded. This can be compared to FY 2020-21 when the program was not funded, which had a dramatic negative impact on the ability of nonprofits to access APCD data and perform research projects.

Theory of Change	Offsetting the cost for access to ACPD data will enable more research into Colorado's health care system and associated costs, supporting the triple aim of better health, better care, and lower costs.		
Program Objective	The program seeks to reduce licensing fees for APCD data and analytics by up to 80% for eligible researchers including state and local government entities, academics, nonprofits, and others.		
Outputs Being Measured	The number of research projects enabled by APCD Scholarship grants.		
Outcomes Being Measured	Research projects enabled by APCD Scholarships grants have been critical in fulfilling legislative requests to support bill discussions, addressing the high cost of care in rural areas, and improving health care and lowering costs statewide.		
Cost/Benefit Ratio	At a cost of $200,000 General Fund annually, the outcomes of research projects enabled by these grants has an incalculable positive impact on improving health care and lowering health care costs for Coloradans.		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	N/A	N/A	N/A
Continuum Level	Step 3		

Anticipated Outcomes

The department anticipates this request will allow for partial restoration of the APCD Scholarship funding removed in the FY 2020-21 budget balancing reductions by the JBC, allowing the department to resume awarding grants to eligible participants for projects using APCD data and reports. The department is not requesting full restoration of the funding in order to balance with other needs in the department's overall FY 2022-23 General Fund request as the state continues to recover from the COVID-19 economic downturn. The department anticipates that a partial restoration of funding will enable many valuable research projects that will otherwise not be

able to be done, and will continue with the success of past projects funded by the program that have been instrumental in supporting new policy discussions, implementing and evaluating current legislation, enhancing primary care, and improving health care and health care affordability across the state. Furthermore, the department anticipates this will partially restore an important funding stream for the APCD, which faced significant reductions in state funding due to the COVID-19-related budget balancing reductions in FY 2020-21 and help ensure the ongoing value and utility of the statewide health care data and analytics in the APCD.

If approved, this request will directly support the department's dillars described in the FY 2021-22 Department Performance Plan.[2] Most significantly, it will support the department's Affordability Leadership pillar to reduce the cost of health care in Colorado to save people money on health care. APCD data and analytics are foundational to comprehensively researching the cost of health care across all health insurance carriers in Colorado. Past APCD Scholarship Program projects have shown that enabling access to this data through the grant program fosters research, insights, and policy discussions that help improve health outcomes and reduce health care costs for all Coloradans.

Assumptions and Calculations

Detailed calculations for this request are included in the attached appendix.

The department assumes annual funding for the APCD Scholarship Program will be restored to 40% of its previous level of $500,000, before it was removed in the FY 2020-21 budget balancing reductions by the JBC. As shown in Table 3 in the attached appendix, this will be $200,000 annually composed entirely of General Fund.

[2] https://hcpf.colorado.gov/sites/hcpf/files/HCPF%202021-2022%20Performance%20Plan.pdf

R-15 Restore APCD Scholarship Funds
Appendix A: Assumptions and Calculations

Table 1.1
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; All-Payer Claims Database	$200,000	0.0	$200,000	$0	$0	$0	0.00%	Table 2.1, Row B
B	**Total Request**	**$200,000**	**0.0**	**$200,000**	**$0**	**$0**	**$0**		Row A

Table 1.2
Summary by Line Item
FY 2023-24 and Ongoing

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; All-Payer Claims Database	$200,000	0.0	$200,000	$0	$0	$0	0.00%	Table 2.2, Row B
B	**Total Request**	**$200,000**	**0.0**	**$200,000**	**$0**	**$0**	**$0**		Row A

R-15 Restore APCD Scholarship Funds

Appendix A: Assumptions and Calculations

Table 2.1 Summary by Initiative FY 2022-23									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Notes/Calculations**
A	APCD Scholarship Funding	$200,000	0.0	$200,000	$0	$0	$0	0.00%	Table 3, Row B
B	**Total Request**	**$200,000**	**0.0**	**$200,000**	**$0**	**$0**	**$0**		Row A

Table 2.2 Summary by Initiative FY 2023-24 and Ongoing									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Notes/Calculations**
A	APCD Scholarship Funding	$200,000	0.0	$200,000	$0	$0	$0	0.00%	Table 3, Row B
B	**Total Request**	**$200,000**	**0.0**	**$200,000**	**$0**	**$0**	**$0**		Row A

Table 3
Annual APCD Scholarship Funding

Row	Item	Amount	Notes/Calculations
A	Grants for APCD Access	$200,000	Partial restoration of APCD Scholarship Funding
B	**Total**	**$200,000**	**Row A**

Department Priority: R-16
Request Detail: Urban Indian Health Organization State-Only Payments

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$0	$48,025	$0
FTE	0.0	0.0	0.0
General Fund	$0	$48,025	$0
Cash Funds	$0	$0	$0
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$0	$0

Summary of Request

The Department of Health Care Policy & Financing (HCPF or department) requests funding to provide temporary state-only payments to Urban Indian Health Organizations that qualify for a time-limited 100% federal medical assistance percentage (FMAP) provided through Section 9815 of the American Rescue Plan Act of 2021 (ARPA). The amount of the state-only payments will be equivalent to the estimated General Fund savings realized by the state from the temporary enhanced FMAP. This request represents an increase of less than 0.5% from the department's FY 2021-22 Long Bill total funds appropriation.

Current Program

Urban Indian Health Organizations are non-profit community health centers that were established through Subtitle IV of the Indian Health Care Improvement Act. These facilities serve American Indian and Alaska Native (AI/AN) people with a variety of services, including primary care, dental care, behavioral health, disease prevention, and health insurance enrollment assistance. Individuals who are non-native or non-tribally enrolled can also receive care through Urban Indian Health Organizations. Nationally, there are 41 providers within the Urban Indian Health Organization network that serve approximately 150,000 clients annually.[1] In addition to Medicaid reimbursement for eligible services, Urban Indian Health Organizations receive funding through the Indian Health Service (IHS), an agency within the Department of Health and Human Services.[2]

In Colorado, there is only one provider that is classified as an Urban Indian Health Organization, Denver Indian Health and Family Services (DIHFS). DIHFS primarily serves the Denver Metropolitan area, including Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, and Weld Counties. In addition to traditional health care services, Urban Indian Health Organizations sponsors cultural activities to further engage with the AI/AN communities in Colorado.

Through Section 9815 of ARPA, states are eligible for a 100% federal medical assistance percentage (FMAP) for services received through an Urban Indian Health Organization or Native Hawaiian Health Care System. The enhanced federal matching funds are available for eight quarters beginning April 1, 2021 and ending March 31, 2023. The enhanced matching funds are available for services rendered to all Medicaid beneficiaries served at Urban Health Care Organizations, not only AI/AN members. There are no provisions within ARPA that require the savings associated with the FMAP increase to be reinvested in Urban Indian Health Organizations.

Section 1905(b) of the Social Security Act requires the federal government to match state expenditures for services received through an IHS facility by a Medicaid-eligible AI/AN at a 100% FMAP. However, services provided through Urban Indian Health Organizations do not qualify for the 100% match, and instead are matched at the state’s regular FMAP rate, regardless of a Medicaid member’s AI/AN status.

[1] https://www.dihfs.org/about-us.html
[2] https://www.uihi.org/urban-indian-health/about-urban-indian-health-organizations/

Problem or Opportunity

For many providers, including Urban Indian Health Organizations, third-party revenue and non-discretionary funding allows them to appropriate funding where there are gaps in both clinical operations and long-range strategic planning. A 2016 report[3] published by the Urban Indian Health Institute showed that nearly one in four AI/AN individuals under the age of 65 reported having no health insurance. This rate is roughly three times higher than the uninsured rate among non-Hispanic white individuals. AI/AN individuals who meet eligibility requirements are eligible for health coverage under Medicaid, Medicare, or the Children's Health Insurance Program (CHIP). However, for individuals who are ineligible for public assistance programs and who have no other form of medical insurance, Urban Indian Health Organizations often serve as safety-net clinics.[4] For Urban Indian Health Organizations, the procurement of third-party revenue, including grants and charitable contributions, is essential in addressing the gap in funding for clinical services and general operations, as well as to address the health disparities and inequities that impact the populations they serve.

Proposed Solution

The department requests $70,825 General Fund in FY 2021-22 and $48,025 General Fund in FY 2022-23 to provide temporary state-only payments to Urban Indian Health Organizations that qualify for the temporary 100% FMAP provided through ARPA. The state-only payments to Urban Indian Health Organizations will support their capacity in addressing operational funding gaps and health care disparities. Colorado will be among several states who intend to pass on the savings associated with the temporary enhanced FMAP to the Urban Indian Health Organizations directly.

If this request is approved, the amount of the state-only payments will be limited to the amount appropriated by the General Assembly. Additional state-only payments beyond the appropriation will require additional action by the General Assembly to approve. Because state-only payments using monies from the Healthcare Affordability and Sustainability Fee (HAS Fee) will require separate statutory authority, savings to the HAS Fee due to the enhanced FMAP will not be included in the state-only payments.

[3] https://www.uihi.org/urban-indian-health/urban-indian-health-organization-profiles/

[4] https://www.kff.org/wp-content/uploads/2001/10/6326urbanindianhealth.pdf

Evidence-Based Continuum

This request is in Step 1 on the evidence-based continuum scale.

Theory of Change	Providing temporary state-only payments to Urban Indian Health Organizations will assist them in providing necessary services to individuals and will aid their effort in addressing health care disparities among American Indian and Alaskan Native populations.		
Program Objective	To reduce health care disparities and address gaps in providers' clinical operations.		
Outputs Being Measured			
Outcomes Being Measured			
Cost/Benefit Ratio	N/A		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation	N/A	N/A	N/A
Continuum Level	Step 1		

Anticipated Outcomes

The department anticipates that by providing state-only payments to Urban Indian Health Organizations, these providers who offer essential services and support to AI/AN populations will have the financial means to address any current gaps in clinical operations and guarantee long-term sustainability. Further, providing these temporary state-only payments during the Public Health Emergency and subsequent recovery will help Urban Indian Health Organizations address the health care disparities and inequities that exist among AI/AN populations as a result of the COVID-19 pandemic. Throughout the pandemic, local providers have been essential in addressing disparate COVID-19 vaccination rates among under resourced communities. Ensuring local providers and community organizations have access to the resources necessary to continue in reducing health inequities has been the goal of the Governor and the State Vaccine Equity Outreach Team, which has worked to schedule more than 175 vaccine equity clinics across Colorado in partnership with community-based organizations, local public health agencies, and Tribes. DIHFS has been an exemplary example of vaccine equity outreach during this time.

The outcomes in this request align with the department's performance plan long-range goals of improving member health outcomes & reducing health disparities, and improving access to affordable, high-quality care. These goals are strategic pillars 1 and 2, respectively.

Assumptions and Calculations

See Appendix A for detailed calculations.

Using prior year actuals for services, the department estimated the total General Fund savings associated with the FMAP for services provided by Urban Indian Health Organizations rising from its current average to 100%. The General Fund savings realized through the enhanced FMAP will be made as state-only payments to eligible Urban Indian Organization providers. The state is eligible for the enhanced FMAP for services received through an Urban Indian Organization through March 31, 2023. Therefore, the state-only payments equivalent to the corresponding state savings from the enhanced FMAP will only be made in FY 2021-22 and part of FY 2022-23.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

The request meets supplemental criteria because of unforeseen circumstances arising from the passage of ARPA. ARPA was signed into law on March 11, 2021, towards the end of the Colorado legislative session and after the General Assembly finalized decisions on discretionary requests. Additionally, the department received information and clarification from the Centers for Medicare & Medicaid Services (CMS) in FY 2021-22 that the enhanced federal matching funds are available for all Medicaid beneficiaries served at Urban Indian Health Care Organizations.[5] This information was not previously available to the department and would have prevented the department from making accurate projections of state-only payments.

[5] https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-004.pdf

Table 1.1
Summary by Line Item
FY 2021-22

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(6) Other Medical Services - NEW LINE ITEM State-Only Payments to Urban Indian Health Organizations	$70,825	0.0	$70,825	$0	$0	$0	0.00%	Table 2.1, Row A
B	**Total Request**	**$70,825**	**0.0**	**$70,825**	**$0**	**$0**	**$0**	**0.00%**	Sum of Row A

Table 1.2
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(6) Other Medical Services - NEW LINE ITEM State-Only Payments to Urban Indian Health Organizations	$48,025	0.0	$48,025	$0	$0	$0	0.00%	Table 2.2, Row A
B	**Total Request**	**$48,025**	**0.0**	**$48,025**	**$0**	**$0**	**$0**	**0.00%**	Sum of Row A

Table 1.3
Summary by Line Item
FY 2023-24

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(6) Other Medical Services - NEW LINE ITEM State-Only Payments to Urban Indian Health Organizations	$0	0.0	$0	$0	$0	$0	0.00%	Table 2.3, Row A
B	**Total Request**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**0.00%**	Sum of Row A

Table 2.1
Summary by Initiative
FY 2021-22

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	State-Only Payments to Urban Indian Organizations	$70,825	0.0	$70,825	$0	$0	$0	0.00%	Table 3, Row I
B	**Total Request**	**$70,825**	**0.0**	**$70,825**	**$0**	**$0**	**$0**	**0.00%**	Sum of Row A

Table 2.2
Summary by Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	State-Only Payments to Urban Indian Organizations	$48,025	0.0	$48,025	$0	$0	$0	0.00%	Table 3, Row I
B	**Total Request**	**$48,025**	**0.0**	**$48,025**	**$0**	**$0**	**$0**	**0.00%**	Sum of Row A

Table 2.3
Summary by Initiative
FY 2023-24

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	State-Only Payments to Urban Indian Organizations	$0	0.0	$0	$0	$0	$0	0.00%	Table 3, Row I
B	**Total Request**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**0.00%**	Sum of Row A

Table 3: Estimated State-Only Payments to Urban Indian Organizations Due to Enhanced FMAP from American Rescue Plan Act (ARPA)					
Row	**Item**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Source/Calculation**
A	Estimated Qualifying Expenditure	$130,519	$130,519	$130,519	Based on prior actual expenditure for General Funded propulations
B	Estimated Blended FMAP Prior to Enhancement	53.99%	50.94%	50.94%	Estimated blended FMAP based on Department actuals
C	Enhanced FMAP Provided through ARPA	100.00%	100.00%	100.00%	Enhanced FMAP provided by ARPA for Urban Indian Organizations
D	Estimated State Share Prior to Enhanced FMAP	$60,052	$64,033	$64,033	Row A * (1 - Row B)
E	Estimated State Share with Enhanced FMAP	$0	$0	$0	Row A * (1- Row C)
F	Percent of Fiscal Year Eligible for Enhanced FMAP	100.00%	75.00%	0.00%	Eligible for eight quarters of enhanced FMAP beginning in FY 2020-21 Q4
G	Total Estimated State Savings from Enhanced FMAP	($60,052)	($48,025)	$0	(Row E - Row D) * Row F
H	Actual General Fund Savings from Enhanced FMAP Incurred in FY 2020-21	($10,773)	$0	$0	Actual savings for FY 2020-21 Q4
I	**Estimated State-Only Payments to Urban Indian Organizations**	**$70,825**	**$48,025**	**$0**	**(Row G + Row H) * -1**

Jared Polis
Governor

Kim Bimestefer
Executive Director

Department Priority: R-17
Request Detail: Screening, Brief Intervention, and Referral to Treatment Training Grant Program Reduction

Summary of Funding Change for FY 2022-23			
		Incremental Change	
	FY 2021-22 Appropriation	FY 2022-23 Request	FY 2023-24 Request
Total Funds	$1,000,000	($250,000)	($250,000)
FTE	0.0	0.0	0.0
General Fund	$0	$0	$0
Cash Funds	$1,000,000	($250,000)	($250,000)
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$0	$0

Summary of Request

The Department of Health Care Policy & Financing (HCPF or department) requests to reduce the Screening, Brief Intervention, and Referral to Treatment (SBIRT) program by $250,000 from the Marijuana Tax Cash Fund (MTCF). As part of budget balancing, the department needs to reduce funding to certain programs that use the Marijuana Tax Cash Fund (MTCF). The Governor's Office of State Planning and Budgeting's (OSPB) September forecast shows MCTF revenue at more than 20% below the adopted FY 2021-22 budget.

This request represents a decrease of less than 0.5% from the department's FY 2021-22 Long Bill total funds appropriation.

Current Program

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training Grant Program awards funding to organizations to train health professionals on providing services related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. In most years, this is a grant program with the Marijuana Tax Cash Fund (MTCF) as the entire source of funding and it does not receive a federal match. In FY 2021-22, the department received one-time funding of $250,000 from the Behavioral and Mental Health cash fund (BMH fund) as appropriated in S.B. 21-137, "Behavioral Health Recovery Act."

In FY 2010-11, legislation was passed which made SBIRT a covered benefit of the Colorado Medicaid program. In 2015-16 legislation was passed, and subsequently amended, which created the separate SBIRT Grant for the Department to administer. The department uses the grant funding to satisfy the statutory requirements from Section 25.5-5-208, C.R.S. including:

- Training for health professionals statewide that is evidence-based and that may be either in person or web based
- Consultation and technical assistance to providers, healthcare organizations, and stakeholders
- Outreach, communication, and education of providers and patients
- Coordination with primary care, mental health, integrated health care, and substance use prevention, treatment and recovery efforts, and
- Campaigning to increase public awareness of the risks related to alcohol, marijuana, tobacco, and drug use and to reduce the stigma of treatment.

Funding amounts have changed during the past few years as a result of funding decisions made by the General Assembly. Most recently in 2021-22 the General Assembly allocated an additional $250,000 in MTCF.

Appropriation History of Screening, Brief Intervention, and Referral to Treatment Training Grants Program	
State Fiscal Year	**Total Funding Amount**
2016-17	$750,000 MTCF
2017-18	$750,000 MTCF
2018-19	$1,675,000 MTCF
2019-20	$1,500,000 MTCF
2020-21	$500,000 MTCF
2021-22	$1,000,000.00 ($750,000 MTCF, $250,000 BMH fund)
2022-23 and ongoing	$750,000 MTCF

Problem or Opportunity

As part of budget balancing, the department needs to reduce funding to certain programs that use the Marijuana Tax Cash Fund (MTCF). The Governor's Office of State Planning and Budgeting's (OSPB) September forecast shows MCTF revenue at more than 20% below the adopted FY 2021-22 budget.

The department believes that it can operate the program effectively if it returns to the FY 2020-21 funding levels. Payments made under this line item are not based on specific outcomes and there has been no formal evaluation or return on investment calculated for these payments.

Proposed Solution

The department requests to reduce the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training Grant program by $250,000 cash funds, from the Marijuana Tax Cash Fund (MTCF). This reduction will help reduce the insolvency of the MTCF, while still allowing the department to provide training grants for these critical services.

Evidence-Based Continuum

This request aligns with Step 2 of the Evidence Continuum. The training grants associated with this program have not been subject to formal evaluation. Reducing the funding available for this program may reduce the number of new providers who are able to provide SBIRT services.

Theory of Change	The reduction to the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training Grant program will prevent the MTCF from being depleted		
Program Objective	SBIRT Training Grant Program awards funding to organizations to train health professionals on providing services related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse.		
Outputs Being Measured	Number of providers trained in the SBIRT process		
Outcomes Being Measured	Number of members being screened for substance use disorders and being referred to treatment		
Cost/Benefit Ratio	N/A		
Evaluations	Pre-Post	Quasi-Experimental Design	Randomized Control Trial
Results of Evaluation		The Colorado-specific training grants have not been subject to evaluation, however, SBIRT services have and there is compelling evidence that they result in savings and better health outcomes.[1] These results are expected to continue even with the training grant reduction.	
Continuum Level	Step 3		

Anticipated Outcomes

The outcome-priority for the department is having providers trained in the SBIRT process. If funding is reduced, the department will prioritize provider training over other allowable uses of this funding, such as outreach and public awareness campaigns. This reduction will not

[1] Melek, S. P., Creten, N., Davenport, S., & Matthews, K. (2016). (rep.). *SBIRT Analysis Financial impact for practices that implemented Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance use*. Denver, CO: Millman Inc.

affect the SBIRT services that the department provides. It only affects the funding available for training grants and other allowable purposes pursuant to Section 25.5-5-208, C.R.S.

Denying the request could result in services provided through the Marijuana Tax Cash Fund (MTCF) being abruptly stopped if the MTCF is depleted.

Assumptions and Calculations

Please refer to Appendix A for detailed calculations.

R-17 Screening , Brief Intervention, and Referral to Treatment Training Grant Program Reduction
Appendix A: Assumptions and Calculations

Table 1.1
Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(6) Other Medical Services, Screening, Brief Intervention, and Referral to Treatment Training Grant Program	($250,000)	0.0	$0	($250,000)	$0	$0		1/3 of current MTCF Appropriation
B	**Total Request**	**($250,000)**	**0.0**	**$0**	**($250,000)**	**$0**	**$0**		Row A

Table 1.2
Summary by Line Item
FY 2023-24

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(6) Other Medical Services, Screening, Brief Intervention, and Referral to Treatment Training Grant Program	($250,000)	0.0	$0	($250,000)	$0	$0		1/3 of current MTCF Appropriation
B	**Total Request**	**($250,000)**	**0.0**	**$0**	**($250,000)**	**$0**	**$0**		Row A

Table 1.2
Summary by Line Item
FY 2024-25 and Ongoing

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(6) Other Medical Services, Screening, Brief Intervention, and Referral to Treatment Training Grant Program	($250,000)	0.0	$0	($250,000)	$0	$0		1/3 of current MTCF Appropriation
B	**Total Request**	**($250,000)**	**0.0**	**$0**	**($250,000)**	**$0**	**$0**		Row A