Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-09 Long Term Care Utilization Management

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

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	Total	$22,790,007	$0	$23,096,505	$1,030,568	$3,835,600
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,817,142	$0	$7,275,017	$257,644	$958,901
	CF	$2,403,997	$0	$1,765,609	($9,219)	($36,875)
	RF	$0	$0	$0	$0	$0
	FF	$13,568,868	$0	$14,055,879	$782,143	$2,913,574

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (A) General Administration - General Professional Services and Special Projects	Total	$7,200,237	$0	$7,975,237	($36,875)	($147,500)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,047,261	$0	$2,622,261	$0	$0
	CF	$1,527,500	$0	$1,227,500	($18,438)	($73,750)
	RF	$0	$0	$0	$0	$0
	FF	$3,625,476	$0	$4,125,476	($18,437)	($73,750)
01. Executive Director's Office, (E) Utilization and Quality Review Contracts - Professional Service Contracts	Total	$12,187,863	$0	$12,307,862	$905,203	$3,334,140
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,503,473	$0	$3,533,473	$217,084	$796,661
	CF	$461,089	$0	$461,089	$9,219	$36,875
	RF	$0	$0	$0	$0	$0
	FF	$8,223,301	$0	$8,313,300	$678,900	$2,500,604

	Total	**$3,401,907**	**$0**	**$2,813,406**	**$162,240**	**$648,960**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (F) Provider Audits and Services - Professional Audit Contracts	GF	$1,266,408	$0	$1,119,283	$40,560	$162,240
	CF	$415,408	$0	$77,020	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,720,091	$0	$1,617,103	$121,680	$486,720

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

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

Interagency Approval or Related Schedule 13s: None

Cost and FTE

- The Department requests $1,030,568 total funds, $257,644 General Fund, and $782,143 federal funds, in FY 2017-18, $3,835,600 total funds, $958,901 General Fund, and $2,913,574 federal funds in FY 2018-19 and ongoing to consolidate and acquire additional support for Long Term Care Utilization Management (LTC UM) functions which would assure the health, safety, and welfare of Medicaid members who are elderly or have disabilities and ensure sound stewardship of financial resources.

Current Program

- The Department spends over $1.4 billion annually on Long Term Care (LTC) services provided through Home and Community-Based Services (HCBS) waivers and through facilities such as nursing homes and intermediate care facilities for people with disabilities who need an institutional level of care.
- The Department operates multiple processes related to LTC UM internally and through various contracts. These processes ensure Department practices meet federal and state regulations, ensure funds are used efficiently and appropriately, and that clients' well-being is primary in all processes affecting them.

Problem or Opportunity

- The Department currently receives 50% Federal Financial Participation (FFP) for most LTC UM activities. These costs are eligible for a 75% FFP rate as allowed by 42 CFR § 433.15 if they are consolidated through a contract with a designated Quality Improvement Organization.
- Department staff and current contractors lack the resources and clinical expertise to adequately review and monitor utilization and the growing number of claims.

Consequences of Problem

- Without moving the LTC UM processes to a Quality Improvement Organization contractor, the Department will not be able to claim the enhanced FFP.
- Without clinically experienced staff the Department cannot ensure the health, safety and welfare of clients who require additional services and oversight to live in the community. There is also potential that without clinical experience, staff would be unable to properly investigate possible fraud in provider plans of care.
- The Department is unable to guarantee that adequate services are being provided in accordance with service plans, that services meet the federal definition for the benefit, or that costs are reasonable.

Proposed Solution

- The Department requests funding to contract with a Quality Improvement Organization (QIO) to perform LTC UM functions and to monitor health and welfare for LTC clients. Consolidation of these functions under the responsibility of a QIO would:
    - Allow faster responses to member issues;
    - Experienced QIO staff could ensure client wellbeing and an efficient allocation of funding according to individually assessed needs; and
    - Department staff could focus their efforts on contract oversight, analysis of the underlying root causes of recurring issues, strategic quality assurance activities and federal reporting.
- The QIO would monitor utilization of services provided in the HCBS waivers, prevent duplication of services between waivers and state plan services, ensure services align with the level of care needed by individuals and support the Department to meet federal waiver requirements.

Department Priority: ***R-9***
Request Detail: ***Long Term Care Utilization Management***

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Long Term Care Utilization Management	$1,030,568	$257,644

Problem or Opportunity:

Many of the Department's Long Term Care Utilization Management (LTC UM) activities are managed internally with non-clinical FTE or through contracts with service providers or case management agency staff. This process is de-consolidated and fragmented, leading to inefficient use of time and resources by Department staff and contractors which is impacting the Department's ability to provide for the health, safety, and welfare for clients enrolled in Medicaid long term services and supports. In addition, the Department is out of federal compliance in a number of different areas with respect to home and community-based services (HCBS) waiver requirements related to quality monitoring and improvement and financial review, including provider oversight and post payment review of claims. The Department's inability to remedy these issues puts the Department at the risk of loss of federal financial participation (FFP) and disallowances.

Utilization Management (UM) is the evaluation of the appropriateness and medical need of health care services and procedures according to evidence-based criteria or guidelines. Typically, UM addresses new clinical activities or inpatient admissions based on the analysis of a case, but may relate to ongoing provision of care, especially in an inpatient setting. UM describes proactive procedures, including discharge planning, concurrent planning, pre-certification, and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer or patient. An effective UM program is comprised of policies, processes and criteria which are all used to ensure the proper separation of duties and qualifications of UM staff, the frequency of reviews, and the balance of internal and external responsibilities. These policies, processes and criteria are also used for escalation processes to allow clients, caregivers or client advocates to challenge a point of care decision, and processes for evaluating inter-rater reliability amongst UM reviewers.

People who are elderly or have a disability accounted for 10.55% of the Department's overall caseload in FY 2014-15. Their total cost of care, including medical, mental health, and long term services and supports, represented 44.8% of the Department's total expenditure in FY 2014-15. Clients who require an institutional level of care because they need assistance with basic activities of daily living, such as bathing or eating,

require additional effort from the Department to ensure their health and safety is being met through services and supports necessary to live quality lives in the most appropriate setting possible. UM activities need to be completed to ensure client safety and wellbeing by making sure the services that are performed are in full compliance with all required rules and regulations, to improve the overall quality of work at both the Department and contracted agencies, and to identify and prevent fraud.

Several distinct UM activities currently lack the resources to be completed at maximum effectiveness or currently suffer from conflicts of interest at the Department. One issue that has put strain on the Department's current UM activities is the increase in caseload experienced through a number of different factors. First, Colorado is experiencing population growth and the population of Coloradans who are elderly and/or who have a disability is also increasing. Additionally, the General Assembly has taken actions to increase enrollments or eliminate most waiting lists for the Home and Community-Based Services (HCBS) waivers. Enrollments need to be examined and reviewed to comply with key regulatory requirements from the Centers for Medicare and Medicaid Services (CMS) regarding monitoring.

With current resources, the Department is not able to keep up with the volume of work required to guarantee that adequate services are being provided in accordance with service plans, services are delivered as defined in the waivers or that providers are billing appropriately, which may lead to unnecessary General Fund expenditures as staff and contractors continue to struggle to manage LTC UM workload. Department staff are focused on reacting and responding to individual client issues and are not able to adequately focus their time on contract management and oversight, training and communication with Case Management Agencies (CMAs) and service providers, analysis of the underlying root causes of recurring issues, federal reporting and policy analysis. The reactive nature of the current organization of duties prevents staff from working on policy changes which would allow the Department to improve the services available to clients, continue to improve efficiency and ensure consistent high-quality care as the population of clients grows.

Additionally, because LTC UM activities are not being performed through an external Quality Improvement Organization contract, the Department is not able to secure an enhanced 75% federal financial participation (FFP) rate for administrative costs as allowed by 42 CFR § 433.15 or able to reap the benefits of consolidating work under one or a few vendors. A QIO is a group of health quality experts, clinicians, and consumers organized to improve the care delivered to individuals.[1] Administrative costs for QIO contracts are eligible to receive an enhanced FFP through the Medicaid and CMS relies on QIOs to improve the quality of health care for all Medicare and Medicaid beneficiaries.

The Department received some funding for UM activities through the FY 2014-15 R-13 "Funding for Utilization Review Services" budget request for Long Term Care Utilization Management services, however this funding is insufficient to cover the expanded scope of UM services being proposed in this request. The FY 2014-15 request provided increased funding to Single Entry Points (SEPs) to support the increased caseload to process Long Term Services and Supports (LTSS) applications and reviews, which resulted in faster decisions, elimination of the backlogs before individual's medical condition worsened and became costlier. This request also included a change to the FFP rate for services provided by SEPs that did not qualify

[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html

for the enhanced 75% FFP and included additional funding for the Department's QIO contract which included medical review for the Children's Extensive Supports waiver (HCBS-CES) and Pre-Admission Screening and Resident Review (PASSR). Outsourcing the HCBS-CES medical review and PASSR to a QIO has improved the review process greatly by providing clinical review of applications, an expedient review process and the expertise needed to represent the Department in appeals. Without additional funding, the Department would continue to struggle to meet federal and state regulations that are required for the services this request intends to improve.

Proposed Solution:

The Department requests $1,030,568 total funds, including $257,644 General Fund in FY 2017-18 and $3,835,600 total funds, including $958,901 General Fund in FY 2018-19 and ongoing in order to contract with a QIO to perform LTC UM functions. Outsourcing UM would place UM functions under the responsibility of professional experts in the area, which would allow faster responses to client issues, allow staff with expertise in the field to perform tasks that are currently being performed by Department staff, and would create an efficient use of funds as the Department would be able to claim an enhanced 75% FFP rate on these activities through 42 CFR § 433.15.

Additionally, moving UM activities to a QIO would enable staff to refocus their efforts on contract oversight, strategic quality assurance activities, federal reporting, analysis of the underlying root causes of recurring issues, policy changes, communication and training.

The Department assumes that the contract would be awarded April 1, 2018. The Department would utilize the Request for Proposals (RFP) process for vendor selection which includes writing the RFP, sending and receiving questions and responses from contractors, stakeholder engagement, contract negotiation and awarding the contract. The Department anticipates that the RFP process would take at least nine months from the time the Department would receive funding on July 1, 2017.

Each activity that would be consolidated under the QIO is detailed below, including the current problem and how the Department requests to resolve it.

<u>Home and Community Based Services Brain Injury Waiver Supportive Living Program Acuity Assessments</u>

The Department requests $14,985 total funds, $3,747 General Fund in FY 2017-18, $59,940 total funds, $14,985 General Fund in FY 2018-19 and ongoing to shift Home and Community Based Services Brain Injury Waiver Supportive Living Program (HCBS-BI SLP) acuity assessments used to determine provider rates to the QIO, helping to eliminate the current conflict of interest.

Clients enrolled in the HCBS-BI SLP program receive an acuity assessment to determine their level of need and develop their service plan. Currently, these assessments are administered by the same providers whose payment rates are affected by the outcome of the scores which results in a conflict of interest. In order to remove this conflict of interest the Department requests to move the acuity assessment activities to the QIO.

If the HCBS-BI SLP assessments were shifted to a QIO the conflict of interest would be mitigated and would allow the providers to focus solely on service delivery. This would allow the Department to ensure that clients' needs are met without the risk of conflict of interest.

Critical Incident Reporting and Monitoring

The Department requests $306,085 total funds, $76,522 General Fund in FY 2017-18, $1,224,340 total funds, $306,085 General Fund in FY 2018-19 and ongoing to utilize the QIO to validate critical incidents, conduct follow up work to ensure appropriate actions are taken, and close critical incidents once acceptable outcomes are achieved.

A "critical incident" is any actual or alleged event or situation that creates a significant risk of serious harm to the health or welfare of a client. Critical incident reporting (CIR) and monitoring focuses on the identification and follow-up to critical events or incidents (e.g., mistreatment, abuse, neglect and exploitation) that bring harm, or create the potential for harm, to an HCBS waiver client. As defined in CMS' HCBS waiver technical guide[2], an effective incident management system entails conducting oversight to make sure that applicable policies and procedures are being followed for the reporting of critical incidents or events and that necessary follow-up is being conducted on a timely basis. The Department is required to implement safeguards to prevent individuals from harm. A critical element of effective oversight is the operation of data systems that support the identification of trends and patterns in the occurrence of critical incidents or events in order to identify opportunities for improvement and thus support the development of strategies to reduce the occurrence of incidents in the future. The Department also has a responsibility to develop processes to prevent critical incidents from occurring.

Critical Incident Reports are required to be filed by case managers every time a critical incident occurs, which are then sent to the Department to be reviewed. Roughly 277 critical incidents are reported each week. Of these, 71 are classified as "high" priorities, requiring additional effort and time to be managed. In some cases, the event requires the client to be relocated to a new living situation or safe environment or requires logistical planning in the event of a natural disaster such as a fire that has occurred.

Currently the process for review of critical incidents is deconsolidated and does not utilize a data system for tracking and monitoring which makes it more difficult for the Department to identifying trends and patterns. Review of critical incidents for waivers programs for people with intellectual or developmental disabilities are currently conducted by staff at the Colorado Department of Public Health and Environment (CDPHE) and critical incidents for the other eight waivers are managed and tracked by staff at the Department. The Department and CDPHE combined have a total of 1.0 permanent FTE and 1.0 temporary FTE devoted to critical incident reporting; however, this is an insufficient amount of resources to manage 277 critical incidents per week. As a result, staff are struggling to keep up with the growing volume of requests devoted to an important process that helps ensure that clients' safety and wellbeing is monitored and addressed. Current Department staff are also limited in the amount of oversight they are able to provide and are not able to focus their time on analysis of the underlying root causes of recurring issues, training, policy and rule changes in order to prevent future events from occurring.

By contracting with a QIO as a dedicated resource to manage critical incident reporting and the necessary follow up work, the Department would be able to achieve two important things. First, the Department staff who currently manage the CIR process would be able to focus on analysis of the underlying root causes of

[2] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf, Appendix G

recurring issues, cross checking data and working on proactive policy development to avoid critical incidents in the future. Second, the QIO would be able to dedicate more time to the critical incident management process, ensuring critical incidents are validated in a timely manner and follow up with affected parties (clients, caregivers, case management agencies, and providers) to ensure appropriate actions are taken quickly. Moving critical incident activities to the QIO would allow a streamlined and efficient process ensuring high quality review and would allow the Department to dedicate time to preventing critical incident in the future.

Over Cost Containment Reviews

The Department requests $39,100 total funds, $9,775 General Fund in FY 2017-18, $156,400 total funds, $39,100 General Fund in FY 2018-19 and ongoing funding to shift Over Cost Containment (OCC) reviews to the QIO vendor. This would allow the OCC reviews to be completed by professionals specializing in the area, which would ensure consistent quality, the reviews conducted were appropriate, and that decisions would adequately be able to be defended at appeal.

The Over Cost Containment (OCC) review process is intended to prevent the duplication of waiver and State Plan services, as well as to ensure that the average annual cost of care is less than the cost of providing the same services in an institutional setting. The Medicaid § 1915(c) waiver authority allows states to use a range of cost-containment strategies to meet federal cost neutrality requirements. The federal cost neutrality requirement is that average annual per participant waiver plus State Plan expenditure not exceed average per participant spending if services were provided in an institutional setting under the State Plan absent the waiver.

The OCC review is a process that involves the creation of a Prior Authorization Request (PAR) which is sent to the Department for review and either approved or denied when the average daily cost of combined HCBS and state plan services exceeds a certain threshold. The review process includes Long Term Home Health (LTHH) and HCBS waiver services. LTHH services are skilled or clinical in nature and typically drive the OCC review requirement. The QIO, as part of the OCC review process, is expected to closely examine and challenge when appropriate, provider-suggested services. The QIO would review the totality of the client's community-based service plan ensuring that only those services required to prevent institutionalization are authorized. Finally, the QIO would represent Department interests in all OCC appeals.

The Department currently lacks internal staff who have the clinical expertise to conduct appropriate reviews of clients and to defend subsequent decisions made at appeal. The staff currently performing OCC review for the Department do not have the proper qualifications to perform these reviews. As a result, the Department is unable to ensure that there is no duplication of services and that the costs of care is appropriate for clients. By shifting this process to the QIO, the Department could ensure that the staff reviewing OCC PARs would have the proper clinical experience and that the review process would ensure all the services were being utilized properly and that over expenditures of services were properly justified. The shifting of these activities to a QIO would ensure that the Department could better control costs and continue to meet federal waiver cost neutrality requirements. It would also allow current staff who are performing the reviews in addition to a regular workload to refocus efforts on regulatory reform, QIO oversight, waiver simplification, service

access improvements, etc. Additionally, staff would be able to provide higher-level direction and oversight of the vendor's work.

Nursing Facility Pay for Performance

The Department requests $0 total funds, and a decrease of $9,219 from the Nursing Facility Provider Fee Cash Fund in FY 2017-18. The Department requests $0 total funds, and a decrease of $36,875 from the Nursing Facility Provider Fee Cash Fund in FY 2018-19 and ongoing funding to shift the current contract for reviewing and scoring of completed Nursing Facility Pay for Performance applications, verifying implementation of approved applications, and developing recommendations from the current contractor to the QIO to allow the Department to receive the enhanced 75% FFP for the activity.

Annually, all nursing facility providers submit an application to the Department that provides evidence of the facility's performance in quality of care, quality of life and facility management. The Department currently has a contract with a vendor who reviews and scores all completed applications which includes reviewing supporting documentation offered through an informal appeal process when exercised, conducting site visits to verify implementation, and developing recommendations to the Department. The Department is able to make supplemental payments from the Nursing Facility Provider Fee to nursing facility providers that provide services that result in better care and higher quality of life for their residents pursuant to section 25.5-6-202(5), C.R.S. This Department, however, is currently receiving 50% FFP because the contract is not eligible for enhanced FFP since it is not consolidated with a QIO contract. Moving the nursing facility pay for performance review process to the QIO and expanding the requirements of the contract to include resident interviews to gauge person-centered and quality of life impacts would ensure the enhanced FFP and improve the care provided in the facilities by collecting and reporting on this type of data.

Because the Department has existing resources for this activity and because the FFP rate is being increased to 75%, this portion of the request results in a General Fund decrease to move these activities to the QIO.

Post Eligibility Treatment of Income/Incurred Medical Expenses Reviews

The Department requests $88,400 total funds, $22,100 General Fund in FY 2017-18, $353,600 total funds, $88,400 General Fund in FY 2018-19 and ongoing funding to shift Post Eligibility Treatment of Income-Incurred Medical Expenses (PETI-IME) reviews to the QIO.

Post Eligibility Treatment of Income (PETI) is the reduction of a resident payment to a nursing facility for the costs of care provided to an individual by the amount that remains after certain deductions are applied to reduce the individual's total income. After the PETI calculation has been completed and all deductions have been taken, the Medicaid eligible individuals are liable to pay the remaining amount to the institution. 42 CFR § 435.725 allows incurred medical expenses (IME) not paid by a third party to be deducted from an individual's income. In order to monitor Incurred Medical Expenses, all expenses in excess of $400 per calendar year must be prior authorized by the Department or its designee. The purpose of the prior authorization process is to verify the medical necessity of the services or supplies, to validate that the requested expense is not a benefit of the Medicaid program, and to determine if the expenses requested are a duplication of expenses previously prior authorized. This process is currently managed internally by the Department's PETI Administrator; however, the Department receives over 3,100 requests per year which is

too many requests for a single staff member with other responsibilities to verify timely that services were delivered and appropriate.

A QIO would verify that IMEs (e.g. hearing aids and glasses, dental) have been rendered in a timely manner. The QIO would also document justifications for all untimely rendered IME services to: ensure that state services were utilized first, followed by waiver services; and then that PETI was utilized for services not otherwise covered to ensure medical necessity reviews for all submitted PETI/IME; and prevent duplicate or unnecessary payments.

Shifting PETI/IME reviews to a QIO would allow the FTE currently responsible for this work to focus on contract management, provider training, provider enrollment due to change of ownership, license and certifications tracking and policy and rule updates. This is crucial to continued success in the management of Department resources as it would allow staff to look for opportunities to improve both current and future processes and strategize how to better serve clients.

Post Payment Review

The Department requests $133,875 total funds, $33,469 General Fund in FY 2017-18, $535,500 total funds, $133,875 General Fund in FY 2018-19 and ongoing funding to have the QIO conduct routine post payment review of HCBS claims to determine that services were rendered appropriately and were consistent with services that were billed.

Post payment review is a process that provides assurances of financial accountability for HCBS services, which may include documentation substantiating claims billed and paid by the Department's Medicaid Management Information System (MMIS). The Department is required to conduct post payment review to provide CMS with required assurances regarding financial accountability and programmatic oversight for HCBS waiver programs. In FY 2014-15 and FY 2015-16, the Department initiated two one-time contracts for post-payment review of claims in order to review the integrity of provider billings as required in the HCBS waiver agreement. However, the Department does not have sustainable ongoing funding to do this work to the level that it needs to be done which requires payment reviews of a statistically valid, random sampling of HCBS claims. The lack of funding has prevented the Department from monitoring that services were actually rendered appropriately and consistent with the services that were billed.

With the requested funding, the Department would move this activity to the QIO vendor. The vendor would conduct post payment review of a sampling of HCBS waiver claims to ensure services were billed timely and adequately delivered and in keeping with the frequency, scope and duration reflected on the PAR and documented on the service plan. They would also be responsible for identifying and preventing fraud, ensuring services provided match claims activities and that PAR amendments are made as necessary to align with client need. The vendor would be required to review whether required prior authorizations were obtained appropriately, whether service plans included the appropriate services, and that provider documentation supports the services billed. By ensuring that services are appropriate, are billed in a timely manner and are delivered in an adequate way, the QIO would help to guarantee clients are receiving the services they need, at the appropriate time and at the prices that make sense for what they received.

Home and Community-Based Services Prior Authorization Request Utilization Management

The Department requests $35,063 total funds, $8,766 General Fund in FY 2017-18, $351,645 total funds, $87,912 General Fund in FY 2018-19 and ongoing funding to enlist the QIO to develop criteria for third party development of Prior Authorization Requests (PARs) and to ensure this criterion is being applied equitably across the system.

Case managers develop HCBS PARs to authorize the use of services based on the needs identified in the ULTC 100.2 and available supporting services. There is not currently a comprehensive check to ensure that State Plan services are being used in lieu of waiver benefits where appropriate or that PAR criteria is being applied equitably across case management agencies. To help achieve uniformity between processes at all case management agencies the Department would contract with the QIO to recommend standard service limits across waivers for review and approval by the Department. Once the uniformity process is established the QIO scope of work would include developing standards for a third-party post PAR review to ensure accuracy and uniformity and define areas that need to be improved. Further, the vendor would establish processes to ensure State Plan benefits were being used appropriately and would periodically review for utilization trends across waivers and State Plan services. Creating review criteria and sampling PARs would help create consistency in reviews and ensure clients' needs are being met.

Quality Improvement Strategy

The Department requests $88,400 total funds, $22,100 General Fund in FY 2017-18, $353,600 total funds, $88,400 General Fund in FY 2018-19 and ongoing funding to shift oversight of the Quality Improvement Strategy (QIS) to the QIO.

The Department has received written instruction from CMS on June 27, 2016 that a plan of correction will be put into place for the Adult Comprehensive waiver (HCBS-DD) and the Supported Living Services (HCBS-SLS) waivers due to deficiencies in its Quality Improvement Strategy (QIS) remediation efforts. According to 42 CFR § 441.302 the QIS process requires the Department to research the reasons for variations in utilization of services, such as if a client's condition improves and the Single Entry Point is not notified until their next annual Continued Stay Review so no PAR adjustments are made. Staff are required to do a review in order to make adjustments for underutilization, which is done to ensure CMS compliance. In this case they may not need the services approved in the frequency, scope and duration originally authorized which would result in an underutilization of services. The role of the QIS reviewer is to determine whether the variation in utilization from cases like described above can be explained. To reduce the possibility of fraud, case managers are expected to reduce authorized service units when underutilization is verified. In instances in which overutilization is anticipated, an upward adjustment in authorized units may be justified. It is the QIS reviewer's responsibility to ensure that case management agencies adjust PAR units to match claims activity. In order to determine whether the variation is appropriate at statistically valid levels, this process entails issue discovery, solution development, implementation and follow-up, ensuring that issues identified through the QIS process are addressed accordingly and that future concerns are minimized as required by the federal rule.[3] This process involves the review of a large amount of data, causing it to be

[3]https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Technical-Guidance.pdf Appendix D p. 188

a manual and time intensive process which has led the Department to be delayed in these reviews as caseload continues to increase, and the Department staff devoted to this activity lack capacity.

Shifting this process to a QIO would ensure the QIS process is completed accurately, efficiently and in accordance with federal standards as populations in need of long term services and supports continues to grow. Additionally, it would allow current staff to work with the vendor to dive deeper into the root problems of critical incidents, over- and under-utilization, quality and design programs and measure to prevent them from occurring in the future. A QIO vendor would be better equipped to handle the volume of data from the QIS process that is received and manually processed as they would have clinically-trained staff who are able to evaluate medical records and make clinical determinations, something the Department is currently unable to do.

Case Management Agency Operational Audits

The Department requests $162,240 total funds, $40,560 General Fund in FY 2017-18, $648,960 total funds, $162,240 General Fund in FY 2018-19 and ongoing funding to contract with the QIO to perform desk and onsite operational audits of Single Entry Points (SEPs) and Community Centered Boards (CCBs). While there are similarities across the QIS reviews and Operational Audits as to the performance of review of operations and service quality, each type of review is necessary for different reasons. The QIS provides assurances to CMS on a four year cycle of a "point in time snapshot" of the quality of service delivery, but the operational audits ensure compliance with Department regulations. These audits occur on different time cycles, and work in unique ways to support operational transparency, client safety, and sound stewardship of resources. They are not interchangeable and cannot be substituted for one another.

Community Centered Boards (CCB), Single Entry Points (SEP), and private case management agencies are the Case Management Agencies (CMAs) contracted to determine functional eligibility for individuals applying for or enrolled in Medicaid institutional and HCBS waivers. The Department does not currently have the resources to complete operational audits of these agencies. The vendor would conduct site-based operational audits in accordance with federal HCBS waiver requirements to ensure agencies were following state and federal rules and procedures regarding hiring, oversight, reporting, training, etc. The vendor would also be utilized to expand the sample size to reach a 95% confidence interval with 5% variable percentage required by 42 CFR § 431.60. There are currently 47 CMAs, including 24 SEPs, 20 CCBs and 3 private case management agencies.

Pursuant to section 42 CFR § 431.60, the Department is federally required to conduct on-site audits of all CMAs on a rotating four-year cycle to ensure they meet all operational requirements. On-site audits involve reviews for CMA compliance with federal and state statutes and regulations, HCBS waiver assurances, contract requirements, Department guidance and agency policies and procedures. Auditors follow specific protocols to include formal notice, record requests, entrance/exit interviews, preliminary findings reports, final findings reports, corrective action reviews and final corrective action acceptance. Visits may require an on-site presence of one or more staff and may last from four hours to four days depending on the number of clients served by the CMA. Auditors review CMA organizational structure, approaches to case assignments, hiring practices to include minimum qualifications, leadership changes, training plans, complaint logs and mitigations, intake processes and financial eligibility verification processes. Client record audits include, but

are not limited to, reviews for the assurance of client involvement in provider selection, goal identification and service plan development. Auditors review individual records to ensure that necessary services were provided in accordance with the frequency, scope and duration documented in the service plan and that variances identified are justified and properly documented. Protocols are reviewed for how each agency interacts with the medical and other providers rendering client care. Agency procedures for reviewing home health PARs and managing negotiations are reviewed as are each agency's approach to local resource development expansion efforts.

Audits of this nature require significant time to complete, especially given the need to reach a 95% confidence level. Estimates from the Colorado Department of Public Health and Environment for the time required to survey IDD provider agencies of the same size as Community Centered Board case management arms require 10 working days and five working days for each Intermediate Care Facility for Individuals with Intellectual Disabilities. Although the surveys performed by CDPHE are focused on provider agencies, the level of detail, scrutiny, and level of operational and client-level review is very similar, requiring many hours of staff time. These reviews allow for the assurance that all agency operations, from policies and procedures down to the delivery of case management services to members, supports operational excellence and the overall health, safety, and welfare of members.

A discussion on the process for each type of agency audit is discussed below.

CCB Agency Operational Audits

The Department requests $81,120 total funds, $20,280 General Fund in FY 2017-18, $324,480 total funds, $81,120 General Fund in FY 2018-19 and ongoing funding to contract with the QIO to perform desk and onsite operational audits of Community Centered Boards (CCBs).

The Department has developed a process for conducting quality and performance reviews of CCBs on an ongoing, three-year cycle. This work includes a review of policies and procedures, a records review for individuals who are receiving waiver services through the HCBS-Persons with Developmental Disabilities (DD), HCBS-Supported Living Services (SLS) and HCBS-Children's Extensive Supports Services (CES) programs, a review of agency-wide practices, and a review of case management personnel qualifications. There are approximately 11,000 individuals enrolled in the HCBS-DD, HCBS-SLS, and HCBS-CES waivers. The Department currently has the resources to sample a limited number of case files for individuals enrolled in the waivers as part of these reviews on a three-year cycle. For the individuals being reviewed, the sample is currently set at 10 individuals per CCB to examine the Intellectual and Developmental Disability (I/DD) determination, rights notifications, individual planning, monitoring, incident management, suspension of rights, and contractual CCB requirements. The first CCB is scheduled to be reviewed in July 2016. Through the contractor, the Department would be able to achieve a representative sample of all individuals receiving services by waiver and by CCB. This would allow the Department to better monitor the administrative functions of our CCBs and comply with best practices for sampling within its waivers. The Department cannot perform this requirement effectively with the current resources available.

SEP Operational Audits

The Department requests $81,120 total funds, $20,280 General Fund in FY 2017-18, $324,480 total funds, $81,120 General Fund in FY 2018-19 and ongoing funding to contract with the QIO to perform desk and onsite operational audits of Single Entry Points (SEPs).

SEP Operational Audits are similar in nature to the CCB audits, but have important distinct differences from the CCB audits. Currently, on-site operational audits do not occur which has put the Department out of compliance with CMS requirements. CMS has identified the compliance issue within each waiver as part of waiver amendment reviews and has stated the Department will be at risk for FFP if it does not appropriately monitor all CMAs. Specifically, CMS has cited validating the program review tool responses and on-site reviews as significant areas of concern. Each year the Department is required to report on all of its performance measures in annual federal reporting. Part of the data is collected by having CMAs fill out a "program review tool". This tool looks at a number and percent of waiver participants in a representative sample to provide a redetermination of eligibility, to confirm the ULTC 100.2 assessment tool was applied appropriately, and that the Professional Medical Information Page (PMIP) was completed and signed by a licensed medical professional. The tool also includes a number of measures to ensure client service plans meet their personal goals and there is coordination between CMAs and other providers and that the client has been informed of their choice between the various services available to them. Having the SEP complete the program review tool represents a conflict of interest because to determine their level of need and develop their service plan, currently, these assessments are administered by the same providers whose payment rates are affected by the outcome of the scores which results in a conflict of interest. Currently, one FTE at the Department does all of the quality reporting and remediation for the program review tool and does not have the capacity to complete on site audits to eliminate the conflict of interest.

The QIO vendor would conduct desk and on-site reviews on a three-year cycle, reviewing one third of the SEPs each year. These audits would be waiver specific and include a representative sample. Additionally, the contractor would review a sample of all program review tools submitted by the CMAs to validate their responses for QIS reporting, in an effort to alleviate CMS concerns about these specific areas and eliminate the conflict of interest that currently exists. This would also help to ensure that the Department would be appropriately monitoring all CMAs and ensure FFP is not lost.

<u>Home and Community Based Services Children's Extensive Support Targeting Criteria Review</u>

The Department requests $169,701 total funds, $42,426 General Fund in FY 2017-18 and $180,735 total funds, $45,184 General Fund in FY 2018-19 and ongoing to allocate additional funding for the QIO to review HCBS-Children's Extensive Support (HCBS-CES) waiver applications. The Department currently contracts this work to a QIO, however caseload and application volume has increased so that the current contract amount is not sufficient to complete the volume of work. This work of the QIO to review applications benefits the Department and the children/families receiving services by providing clinicians to make the determination of eligibility, an expedient review process and the expertise needed to represent the Department in appeals.

Currently the Department's acute care utilization management contractor reviews applications for the CES waiver to determine if children meet targeting criteria for the HCBS-CES waiver. The contractor has

estimated that they will need an increase in funding to continue performing this duty as the average monthly reviews has gone up from 150 to 235 as a result of the elimination of the waiting list for the HCBS-CES waiver. Funding was not included for this increase when the policy passed and as a result this request would add the funding needed to allow the contractor to continue with their work at the increased average monthly reviews amount.

Anticipated Outcomes:

One of the Department's Performance Plan's primary goals of "ensuring sound stewardship of financial resources" would be met by this request, as it would allow financial resources to be allocated more efficiently and reduce conflicts of interest where applicable. Approval of this request would put measures in place to ensure the Department's long term care clients have their needs met appropriately by ensuring federal and state utilization management regulations are adhered to. This would also effectively increase the quality of services being delivered by allowing a QIO who is an expert in the field to monitor and make recommendations for changes that the Department could implement. Consolidation of these services may also reduce the per capita cost of health care in Colorado in the long run, as the QIO would monitor utilization of services provided in the State Plan and HCBS waivers ensuring individuals receive the right services at the right time, and help the Department to meet federal waiver assurances. Finally, funding of this request would allow the Department to more efficiently allocate the General Fund by utilizing the enhanced FFP.

Assumptions and Calculations:

The Department assumes that the administrative activities outsourced through the contract with the QIO would qualify for 75% enhanced FFP as allowed by 42 CFR § 433.15. In order to gain federal approval of the enhanced match, the Department would be required to gain approval from CMS through the Department's Cost Allocation Plan describing the activities included in the QIO contract. If the Department does not receive approval for certain activities it would utilize the budget process to adjust funding requested at a revised FFP rate.

State procurement rules would require the Department to select the vendor through the Request for Proposal (RFP) process and the Department assumes that the vendor selection could be completed by April 1, 2018.

Tables 3.1 through 3.4 in the appendix details the assumptions for each of the estimates based upon number of units or hours required to complete the tasks. The Department assumes that these estimates are accurate based on its knowledge of volume and available data, however as some of the activities are new and as caseload continues to rise, the Department would use the budget process to adjust any of the estimates as necessary.

The Department assumes that the rate of $85.00, which is the ad hoc rate in its current acute care utilization management contract, the vendor responsible for UM activities for State Plan services, is a reasonable hourly rate for most of the activities being outsourced to a QIO vendor for LTC UM activities.

For detailed assumptions for each portion of the Department's requested contract please see below.

Brain Injury Waiver Supportive Living Program (BI SLP) Acuity Assessments

The Department assumes that 400 Supportive Living Program assessments would be required on an annual basis as the number of expected enrollments in FY 2016-17 is 200 and each assessment needs to be performed twice annually, each assessment takes 5 hours according to pre-procurement research and as a result an assumed 5 hours would be required totaling 2,000 hours annually for assessments.

The Department assumes that an hourly rate of $29.97 would be reasonable to have a QIO conduct BI SLP Acuity Assessments, based on an average of the current rates for Registered Nurses and Non-Registered Nurses to conduct BI SLP Acuity Assessments. The Department believes this estimated rate to be appropriate, as not all the assessments would require a nurse, but the average rate would balance out for assessments that do require a nurse's assessment.

Critical Incident Reporting (CIR) and Monitoring

The Department assumes that the QIO would need 60 minutes per incident to manage critical incidents to complete the tasks associated with critical incident reporting and monitoring. This information is based on pre-procurement market research. The total volume of critical incidents is currently 277 per week or 14,404 critical incidents per year.

Over Cost Containment Reviews

The Department assumes the contractor would complete 920 OCC reviews totaling 1,840 hours of work annually, which assumes an average time of 2 hours to complete each review. This estimate is based on results from pre-procurement market research and the workload that Department staff currently perform.

Nursing Facility Pay for Performance

The Department assumes the current total amount of the nursing facility pay for performance contract of $147,500 would not change due to the change in vendor and that this funding would be moved from (1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects to (1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts. The Department assumes that due to the shift to a QIO contractor that the match rate would be adjusted from 50% to 75% FFP and that any freed up General Fund from the enhanced FFP rate would be utilized to fund other portions of this request.

Post Eligibility Treatment of Income/Incurred Medical Expenses Reviews

The Department assumes that the current annual volume of 3,100 PETI/IME reviews would be an accurate estimate of ongoing workload, due to the estimated 3,100 annual PETI/IME requests that the Department receives, and that this activity would require 6,940 hours annually, or 2.2 hours per review.

Post Payment Review

The Department estimates that it would be required to perform 4,200 reviews in order to achieve a statistically significant sample size for post payment review of claims. At 1.5 hours per review, this this would require 6,300 hours annually. The vendor would be required to conduct post payment reviews on a representative sample (randomly selected) of claims in its waiver agreements with CMS related to the Financial Integrity Assurance.

Home and Community-Based Services Prior Authorization Request Utilization Management

The Department estimates that 150 hours will be needed to develop criteria for third party development of Prior Authorization Requests (PARs) in the first year of the contract. There are 11 waivers in total, leading to a total hour requirement of 1,650.

The Department assumes that in the second year of the contract and ongoing, to ensure this criterion is being applied equitably across the system, the QIO would need to create review criteria and 10% of HCBS clients PARs would need to be sampled to ensure accuracy resulting in 4,137 hours annually.

Quality Improvement Strategy

The Department assumes that the rate of $78.00, which is based on the rate the Office of the State Auditor uses for state agencies, would be a reasonable rate for these activities.

Case Management Agency Operational Audits

The Department assumes that the rate of $78.00, which is based on the rate the Office of the State Auditor uses for state agencies, would be a reasonable rate for these activities.

Home and Community-Based Services Children's Extensive Support Targeting Criteria Review

The Department believes that the current contract amount for the Children's Extensive Supports (HCBS-CES) waiver medical review would not be an accurate assessment of cost for this new contract in FY 2017-18 an onward. This contract is no longer an accurate assessment of cost, due to the increasing caseload leading to an increased cost for the vendor to handle. In table 3.3, the Department estimates that it would require $169,701 in FY 2017-18 and $180,735 in FY 2018-19, based on the existing cost per enrolled individual and the estimates caseload. In FY 2017-18 and FY 2018-19 the projected increase in caseload from the FY 2016-17 S-5 was used to determine the increased funding needed.

Table 1.1 FY 2017-18 Long Term Care Utilization Review and Utilization Management Summary by Line Item								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	**Total Request**	**$1,030,568**	**0.0**	**$257,644**	**($9,219)**	**$0**	**$782,143**	**Row B + Row C + Row D**
B	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	($36,875)	0.0	$0	($18,438)	$0	($18,437)	Table 2.3 Row A
C	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$905,203	0.0	$217,084	$9,219	$0	$678,900	Table 2.1 Row B + Row C + Row D + Row E + Row F + Row G + Row H + Row I + Row L
D	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$162,240	$0	$40,560	$0	$0	$121,680	Table 2.1 Row J + Row K

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 1.2 FY 2018-19 Long Term Care Utilization Review and Utilization Management Summary by Line Item								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	**Total Request**	**$3,835,600**	**0.0**	**$958,901**	**($36,875)**	**$0**	**$2,913,574**	**Row B + Row C + Row D**
B	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	($147,500)	$0	$0	($73,750)	$0	($73,750)	Table 2.4 Row A
C	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$3,334,140	$0	$796,661	$36,875	$0	$2,500,604	Table 2.1 Row B + Row C + Row D + Row E + Row F + Row G + Row H + Row I + Row L
D	(1) Executive Director's Office, (F) Provider Audits and Services, Professional Audit Contracts	$648,960	$0	$162,240	$0	$0	$486,720	Table 2.1 Row J + Row K

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 2.1 FY 2017-18 Long Term Care Utilization Review and Utilization Management Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	**Total Request**	**$1,067,443**	**0.0**	**$257,644**	**$9,219**	**$0**	**$800,580**	**75%**	**Sum of Rows B to M**
B	Brain Injury Supported Living Program Assessments	$14,985	0.0	$3,747	$0	$0	$11,238	75%	Table 3.1 Row A
C	Critical Incidents	$306,085	0.0	$76,522	$0	$0	$229,563	75%	Table 3.1 Row B
D	Over Cost Containment	$39,100	0.0	$9,775	$0	$0	$29,325	75%	Table 3.1 Row C
E	Nursing Facility Pay for Performance	$36,875	0.0	$0	$9,219	$0	$27,656	75%	Table 3.1 Row D
F	Post Eligibility Treatment of Income Incurred Medical Expenses (PETI/IME) Review	$88,400	0.0	$22,100	$0	$0	$66,300	75%	Table 3.1 Row E
G	Post Payment Review	$133,875	0.0	$33,469	$0	$0	$100,406	75%	Table 3.1 Row F
H	Home and Community-Based Services Prior Authorization Request Utilization Management	$35,063	0.0	$8,766	$0	$0	$26,297	75%	Table 3.1 Row G
I	Quality Improvement Strategy	$81,120	0.0	$20,280	$0	$0	$60,840	75%	Table 3.1 Row H
J	Community Centered Board Operational Audits	$81,120	0.0	$20,280	$0	$0	$60,840	75%	Table 3.1 Row I
K	Single Entry Point Operational Audits	$81,120	0.0	$20,280	$0	$0	$60,840	75%	Table 3.1 Row J
L	Home and Community Based Services Children's Extensive Support Services Targeting Criteria Review	$169,700	0.0	$42,425	$0	$0	$127,275	75%	Table 3.1 Row K Estimated new contract in addition to current contract amount. See narrative for further detail of cost estimate

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 2.2 FY 2018-19 Long Term Care Utilization Review and Utilization Management Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	**Total Request**	**$3,983,100**	**0.0**	**$958,901**	**$36,875**	**$0**	**$2,987,324**	**75%**	**Sum of Rows B to M**
B	Brain Injury Supported Living Program Assessments	$59,940	0.0	$14,985	$0	$0	$44,955	75%	Table 3.2 Row A
C	Critical Incidents	$1,224,340	0.0	$306,085	$0	$0	$918,255	75%	Table 3.2 Row B
D	Over Cost Containment	$156,400	0.0	$39,100	$0	$0	$117,300	75%	Table 3.2 Row C
E	Nursing Facility Pay for Performance	$147,500	0.0	$0	$36,875	$0	$110,625	75%	Table 3.2 Row D
F	Post Eligibility Treatment of Income Incurred Medical Expenses (PETI/IME) Review	$353,600	0.0	$88,400	$0	$0	$265,200	75%	Table 3.2 Row E
G	Post Payment Review	$535,500	0.0	$133,875	$0	$0	$401,625	75%	Table 3.2 Row F
H	Home and Community-Based Services Prior Authorization Request Utilization Management	$351,645	0.0	$87,912	$0	$0	$263,733	75%	Table 3.2 Row G
I	Quality Improvement Strategy	$324,480	0.0	$81,120	$0	$0	$243,360	75%	Table 3.2 Row H
J	Community Centered Board Operational Audits	$324,480	0.0	$81,120	$0	$0	$243,360	75%	Table 3.2 Row I
K	Single Entry Point Operational Audits	$324,480	0.0	$81,120	$0	$0	$243,360	75%	Table 3.2 Row J
L	Home and Community Based Services Children's Extensive Support Services Targeting Criteria Review	$180,735.0	0.0	$45,184	$0	$0	$135,551	75%	Table 3.2 Row K

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 2.3 FY 2017-18 Long Term Care Utilization Review and Utilization Management Current Contract Adjustments

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	Adjustment for Current Contract- Nursing Facility Pay for Performance	($36,875)	0.0	$0	($18,438)	$0	($18,437)	50%	Amount of current contract

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 2.4 FY 2018-19 Long Term Care Utilization Review and Utilization Management Current Contract Adjustments

Row	Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	Adjustment for Current Contract- Nursing Facility Pay for Performance	($147,500)	0.0	$0	($73,750)	$0	($73,750)	50%	Amount of current contract

[1] Cash Fund Portion is Nursing Facility Provider Fee Cash Fund (22X0)

Table 3.1 FY 2017-18 Long Term Care Utilization Review and Utilization Management Estimated Contract Costs						
Row	**Activity Name**	**Hourly Rate**	**Estimated Annual Units/Hours**	**Estimated Annual Cost**	**Cost Adjusted for April 1, 2018 Implementation Date**	**Notes**
A	Brain Injury Supported Living Program Assessments	$29.97	2,000	$59,940	$14,985	Rate from similar contract, estimate of assessments based on current Brain Injury Supported Living Program population multiplied by 2 to account for biannual assessments
B	Critical Incident Reporting	$85.00	14,404	$1,224,340	$306,085	Hours estimate from 1 hour per Critical Incident Report, 277 Critical Incident Reports per week, rate is based on similar contract
C	Over Cost Containment Reviews	$85.00	1,840	$156,400	$39,100	Hours estimate from pre-procurement market research, rate from similar contract
D	Nursing Facility Pay for Performance	N/A	N/A	$147,500	$36,875	Current contract cost
E	Post Eligibility Treatment of Income Incurred Medical Expenses (PETI/IME) Review	$85.00	4,160	$353,600	$88,400	Hours estimate from pre-procurement market research, rate from similar contract
F	Post Payment Review	$85.00	6,300	$535,500	$133,875	Hours estimate from pre-procurement market research, rate from similar contract
G	Home and Community-Based Services Prior Authorization Request Utilization Management	$85.00	1,650	$140,250	$35,063	Estimated 150 hours needed per waiver annually 11 waivers total, rate from similar contract
H	Quality Improvement Strategy	$78.00	4,160	$324,480	$81,120	Hours estimate and cost based on pre-procurement market research
I	Community Centered Board Operational Audits	$78.00	4,160	$324,480	$81,120	Hours estimate and cost based on pre-procurement market research
J	Single Entry Point Operational Audits	$78.00	4,160	$324,480	$81,120	Hours estimate and cost based on pre-procurement market research
K	Home and Community Based Services Children's Extensive Support Services Targeting Criteria Review	N/A	N/A	$169,700	N/A	Estimated new contract in addition to current contract amount. See narrative for further detail of cost estimate
L	**Total**	**N/A**	**N/A**	**$3,760,670**	**$897,743**	

Table 3.2 FY 2018-19 Long Term Care Utilization Review and Utilization Management Estimated Contract Costs					
Row	**Activity Name**	**Hourly Rate**	**Estimated Annual Units/Hours**	**Estimated Annual Cost**	**Notes**
A	Brain Injury Supported Living Program Assessments	$29.97	2,000	$59,940	Rate from similar contract, estimate of assessments based on current Brain Injury Supported Living Program population multiplied by 2 to account for biannual assessments
B	Critical Incident Reporting	$85.00	14,404	$1,224,340	Hours estimate from 1 hour per Critical Incident Report, 277 Critical Incident Reports per week, rate is based on similar contract
C	Over Cost Containment Reviews	$85.00	1,840	$156,400	Hours estimate from pre-procurement market research, rate is based on similar contract
D	Nursing Facility Pay for Performance	N/A	N/A	$147,500	Current contract cost
E	Post Eligibility Treatment of Income Incurred Medical Expenses (PETI/IME) Review	$85.00	4,160	$353,600	Hours estimate from pre-procurement market research, rate is based on similar contract
F	Post Payment Review	$85.00	6,300	$535,500	Hours estimate from pre-procurement market research, rate is based on similar contract
G	Home and Community-Based Services Prior Authorization Request Utilization Management	$85.00	4,137	$351,645	10% of HCBS clients, rate is based on similar contract
H	Quality Improvement Strategy	$78.00	4,160	$324,480	Hours estimate and cost based on pre-procurement market research
I	Community Centered Board Operational Audits	$78.00	4,160	$324,480	Hours estimate and cost based on pre-procurement market research
J	Single Entry Point Operational Audits	$78.00	4,160	$324,480	Hours estimate and cost based on pre-procurement market research
K	Home and Community Based Services Children's Extensive Support Services Targeting Criteria Review	N/A	N/A	$180,735	Estimated new contract in addition to current contract amount. See narrative for further detail of cost estimate
L	**Total**	**N/A**	**N/A**	**$3,983,100**	

Table 3.3 Adjusted Children's Extensive Support Services Total Contract Cost Per Year

Row	Costs	FY 2017-18	FY 2018-19	Notes
A	Cost Per Enrolled	$167.19	$167.19	Cost Per Enrolled Table 3.4 Row A
B	Estimated Total Enrolled	1,643	1,709	FY 2016-17 R-5
C	Estimated Annual Cost	$274,700	$285,735	Row A * Row B
D	Existing Funding	$105,000	$105,000	Current Available Funding
E	Additional Funding Needed	$169,700	$180,735	Row C - Row D

Table 3.4 Children's Extensive Support Services Cost Per Enrolled Calculation

Row	FY 2016-17 Estimated Total Enrolled	FY 2016-17 Contract Amount + Additional Funding Needed	Estimated Cost Per Enrolled	Notes
A	1,579	$264,000	$167.19	Contract / Total Enrolled