Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-08 Medicaid Savings Initiatives**

Dept. Approval By: 11/1/17

OSPB Approval By:

___ Supplemental FY 2017-18

X Change Request FY 2018-19

___ Budget Amendment FY 2018-19

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,716,890,508**	**$0**	**$7,663,107,945**	**($1,391,380)**	**($4,136,489)**
	FTE	418.4	0.0	427.4	5.8	7.0
	GF	$2,121,723,743	$0	$2,107,446,252	($2,187,947)	($4,160,948)
	CF	$898,052,971	$0	$896,100,449	$2,862,240	$5,320,183
	RF	$72,715,206	$0	$72,916,331	$4,151	$847
	FF	$4,624,398,588	$0	$4,586,644,913	($2,069,824)	($5,296,571)

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
	Total	**$30,884,154**	**$0**	**$32,040,094**	**$392,224**	**$476,033**
	FTE	418.4	0.0	427.4	5.8	7.0
01. Executive Director's Office, (A) General Administration -- Personal Services	GF	$10,512,849	$0	$10,769,424	$180,175	$217,022
	CF	$2,985,184	$0	$3,045,883	$15,941	$20,994
	RF	$1,885,978	$0	$2,242,657	$0	$0
	FF	$15,500,143	$0	$15,982,130	$196,108	$238,017
	Total	**$3,637,126**	**$0**	**$4,639,956**	**$55,489**	**$55,489**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration -- Health, Life, and Dental	GF	$1,305,776	$0	$1,673,531	$25,013	$24,746
	CF	$344,132	$0	$297,330	$2,732	$2,999
	RF	$103,855	$0	$135,355	$0	$0
	FF	$1,883,363	$0	$2,533,740	$27,744	$27,744

01. Executive Director's Office, (A) General Administration -- Short-term Disability	**Total**	**$58,060**	**$0**	**$60,583**	**$667**	**$888**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,586	$0	$22,803	$306	$408
	CF	$4,802	$0	$3,381	$27	$36
	RF	$1,364	$0	$1,484	$0	$0
	FF	$30,308	$0	$32,915	$334	$444

01. Executive Director's Office, (A) General Administration -- Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,851,815**	**$17,574**	**$23,387**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$697,024	$8,074	$10,753
	CF	$133,634	$0	$103,331	$714	$941
	RF	$37,970	$0	$45,371	$0	$0
	FF	$843,045	$0	$1,006,089	$8,786	$11,693

01. Executive Director's Office, (A) General Administration -- Supplemental Amortization Equalization Disbursement	**Total**	**$1,615,047**	**$0**	**$1,851,815**	**$17,574**	**$23,387**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$600,398	$0	$697,024	$8,074	$10,753
	CF	$133,634	$0	$103,331	$714	$941
	RF	$37,970	$0	$45,371	$0	$0
	FF	$843,045	$0	$1,006,089	$8,786	$11,693

01. Executive Director's Office, (A) General Administration -- Operating Expenses	**Total**	**$2,162,529**	**$0**	**$2,082,684**	**$38,462**	**$6,650**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$961,889	$0	$948,995	$17,339	$2,966
	CF	$74,170	$0	$70,519	$1,894	$359
	RF	$26,219	$0	$13,297	$0	$0
	FF	$1,100,251	$0	$1,049,873	$19,229	$3,325

01. Executive Director's Office, (C) Information Technology Contracts and Projects -- MMIS Maintenance and Projects	**Total**	**$41,646,122**	**$0**	**$41,988,677**	**$57,456**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,955,404	$0	$5,979,906	$5,746	$0
	CF	$4,288,071	$0	$4,445,412	$0	$0
	RF	$11,808	$0	$6,618	$0	$0
	FF	$31,390,839	$0	$31,556,741	$51,710	$0

01. Executive Director's Office, (C) Information Technology Contracts and Projects -- Colorado Benefits Management Systems, Operating & Contracts	**Total**	**$23,549,140**	**$0**	**$23,549,140**	**$1,309,205**	**$280,969**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,219,684	$0	$5,183,715	$225,088	$60,613
	CF	$3,453,935	$0	$3,489,904	$115,539	$28,144
	RF	$57,566	$0	$57,566	$4,151	$847
	FF	$14,817,955	$0	$14,817,955	$964,427	$191,365

01. Executive Director's Office, (E) Utilization and Quality Review Contracts -- Professional Service Contracts	**Total**	**$13,824,436**	**$0**	**$16,087,495**	**$2,010,059**	**$2,003,849**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,017,493	$0	$4,597,070	$502,515	$500,963
	CF	$470,308	$0	$497,964	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$9,336,635	$0	$10,992,461	$1,507,544	$1,502,886

02. Medical Services Premiums -- Medical Services Premiums	**Total**	**$7,597,898,847**	**$0**	**$7,538,955,686**	**($5,290,090)**	**($7,007,141)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	($3,160,277)	($4,989,172)
	CF	$886,165,101	$0	$884,043,394	$2,724,679	$5,265,769
	RF	$70,552,476	$0	$70,368,612	$0	$0
	FF	$4,548,653,004	$0	$4,507,666,920	($4,854,492)	($7,283,738)

CF Letternote Text Revision Required?	Yes X	No ____	**If Yes, see schedule 4 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 a reduction of $1,391,380 total funds, including a reduction of $2,187,947 General Fund and an increase of 5.8 FTE in FY 2018-19, a reduction of $4,136,489 total funds, including a reduction of $4,160,948 General Fund and an increase of 7.0 FTE in FY 2019-20, and a reduction of $4,530,726 total funds, including a reduction of $4,593,450 General Fund an increase of 7.0 FTE in FY 2020-21 and future years to implement Medicaid program savings initiatives.

Current Program

- The Department has been appropriated over $9.9 billion in FY 2017-18 to provide services to 1.4 million eligible members; this represents the largest single agency budget for the State. Given the size of the Department's budget, initiatives that lead to reductions in cost are 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

- As part of the Department's focus on continual improvement to provide sound financial review, the Department has identified several opportunities for savings and efficiencies to provide more cost-effective care to Medicaid members; however, the Department does not have the spending authority to successfully implement these initiatives, therefore it cannot realize the savings that would be generated in its budget.

Consequences of Problem

- Although the Department has made incremental improvements within existing resources, it is unable to implement larger scale cost reduction strategies within existing resources because of the existing workload within the Department. These projects require dedicated personnel and changes to complex IT systems and cannot be absorbed within the Department's administrative budget.

Proposed Solution

- The Department requests funding to implement five separate initiatives that would lead to savings in the Medicaid program, including: increased utilization management; automation of public assistance reporting information system matching; increased trust unit recoveries; increased access to public transportation benefits; and, implementation of a parental fee for eligibility in the Children's Home and Community-Based Services waiver.

Department Priority:	***R-8***
Request Detail:	***Medicaid Savings Initiatives***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Medicaid Savings Initiatives	($1,391,380)	($2,187,947)

Problem or Opportunity:

The Department has been appropriated over $9.9 billion in FY 2017-18 to provide services to eligible members; this represents the largest single agency budget for the entire State. Given the size of the Department's budget, proper oversight is critical to ensuring that members are receiving the services that they need and that taxpayers are getting sufficient returns on the use of these funds. As part of the Department's focus on continual improvement to provide sound stewardship of financial resources, the Department has identified several opportunities for savings and efficiencies to provide cost effective care to Medicaid members; however, the Department does not have sufficient administrative resources to successfully implement these initiatives. Without the necessary administrative resources, the Department could not implement these changes as there may be unintended consequences for members.

Proposed Solution:

The Department requests a reduction of $1,391,380 total funds, including a reduction of $2,187,947 General Fund and an increase of 5.8 FTE in FY 2018-19 and a reduction of $4,136,489 total funds, including a reduction of $4,160,948 General Fund and an increase of 7.0 FTE in FY 2019-20, and a reduction of $4,530,726 total funds, including a reduction of $4,593,450 General Fund and an increase of 7.0 FTE in FY 2020-21 and future years to implement Medicaid program savings initiatives. The requested funding would be used to implement five separate initiatives including increased utilization management, automation of public assistance reporting information system matching, increased trust unit recoveries, increased access to public transportation benefits and implementation of a parental fee for eligibility in the Children's Home and Community-Based Services waiver.

Utilization Management

The Department requests a reduction of $725,295 total funds, including a reduction of $390,607 General Fund and an increase of 2.5 FTE in FY 2018-19, a reduction of $810,548 total funds, including a reduction of $413,210 General Fund and an increase of 3.0 FTE in FY 2019-20, and a reduction of $998,534 total funds including a reduction of $469,561 General Fund and an increase of 3.0 FTE in FY 2020-21 and ongoing to improve Medicaid utilization management, including implementing new prior authorization requirements on

several services and staff to support these changes. The Department has identified several service categories that would benefit from additional utilization management techniques. These services are at risk for over-utilization and, if managed more appropriately, could result in better health outcomes for Medicaid members and save the State money. The Department also needs additional resources to continue to support stakeholder-informed policy development processes, to continue to develop and refine cost-effective, evidence-based Medicaid policies.

New Prior Authorization Requirements

ColoradoPAR is the Medicaid utilization management (UM) program. A third-party vendor reviews prior authorization requests (PARs) to ensure items and services requested meet medical necessity guidelines and are within Medicaid's policies. The goals of the ColoradoPAR program are to: improve health outcomes of Medicaid members; decrease costs by eliminating duplicative and unnecessary services; and allow providers to easily track the status of their PARs using a web portal, rather than a paper process. To achieve these goals, providers request authorization for services before providing certain services. The ColoradoPAR vendor reviews the request to determine if services are medically necessary according to established criteria and guidelines.

The Department's ability to require prior authorizations for services is limited by both the amount of funding it has been appropriated for the ColoradoPAR vendor, and by the amount of internal resources the Department can devote to contract management and appeals. As such, the Department is unable to expand the current contract to implement PARs on additional services without additional funding. This has left a gap in oversight, where services which should have prior authorization requirements do not. Examples of services that have no prior authorization requirements include: elective surgeries; physical therapy, occupational therapy, and outpatient speech therapy; oxygen services; prosthetics and orthotics; adult long-term home health; and contact lenses. To ensure that the Department is not paying for unnecessary or duplicative services, the Department needs to expand the scope of the UM program to include review requirements for these, and potentially other services.

The Department is requesting funding to significantly expand the scope of the UM vendor contract to permit reviews of the services. Such an expansion cannot be absorbed by either the vendor, or Department staff. Prior authorizing additional services would significantly increase the number of requests handled by the Department's UM vendor, which would require the vendor to increase staffing commensurate with the expected increase in PARs. Further, the Department would need additional staff to manage the policy and to manage additional client appeal activities. New Department staff would be required for oversight of the UM contract deliverables specific to the services with new prior authorization requirements, quality assurance around PAR requirements and implementation, and provider education and outreach on the new process for these services. In addition, adding more PARs to benefits would result in a significant increase in denials and appeals. With every appeal the Department processes, staff are required to process the request in a timely manner, conduct conference calls with the client to explain the appeals process and answer questions, and coordinate with the UM vendor to schedule and review expert testimony.

Staff to Support Benefits Collaborative Process

The Department does not have the staff resources necessary to continue to support the Benefits Collaborative Process. The Department's work impacts over one million Coloradans, including members, providers, advocates, and family members; any changes in Medicaid policies require careful and skillful evaluation, development, and communication with stakeholders to ensure transparency and accountability. The Benefits Collaborative Process is the Department's formal public process for ensuring that Medicaid services are based on the best available clinical evidence. The Benefits Collaborative establishes evidence-based coverage policies that define the appropriate amount, scope, and duration of services as well as benefit limits; and promotes the health and functioning of Medicaid clients. Such policy is informed by: Department research into the amount, scope, and duration of services covered by Medicaid in other states, other Colorado health insurance providers, and Medicare; recently published evidenced-based reports and journal articles specific to the service or services in question; evidence-based and nationally recognized best practices; internal client utilization and health data; external data; and, information shared with the Department by stakeholders throughout the process.

The UM program enforces Department benefit limits and criteria for services requiring prior authorization, as well as determines the medical necessity of requests for services using clinical expertise and nationally-recognized criteria. The clinical expertise of the UM program staff and clinicians informs benefit and service policy content during the Benefits Collaborative policy development phases, while the UM program policy implementation is informed by policies developed during the Benefits Collaborative Process. For instance, the Department may establish through a Benefits Collaborative Process that a certain set of genetic tests are clinically utile only when certain medical factors exist, at which point the UM vendor may be asked to adopt or establish - using their clinical expertise and access to nationally recognized medical necessity criteria - certain prior authorization criteria for those specific tests.

The Department needs an additional full-time staff person to support this effort and requests 1.0 FTE to serve as a Stakeholder Relations Policy Development Specialist, who will facilitate Benefits Collaborative processes, as well as other policy-related stakeholder engagement. This will ameliorate delays due to existing staff capacity and ensure timely and comprehensive formal stakeholder-informed evidence-based policy development. This work has not only increased in depth and complexity, but the scope of requests for formal stakeholder engagement has expanded beyond fee-for-service benefits to other critical areas, including home and community based waiver programs; specific conditions, such as chronic back pain; and finance-related topics, such as copayments, payment methodologies, and rate setting.

Benefits Collaborative processes that are delayed or unrealized because of a lack of staff capacity negatively impact the Department's ability to efficiently adjust benefit and program policies in a timely, evidence-based, and stakeholder-informed manner. The Department's review of benefits cannot occur as quickly as it could with additional resources, therefore preventing the Department from future cost savings that would likely result from additional benefits going through the process. Without additional staff, new policies will be implemented with limited research, review, and external stakeholder input, which may lead to higher risks and higher costs.

Automate Public Assistance Reporting Information System Interstate Match

The Department requests a reduction of $1,015,263 total funds, including a reduction of $312,615 General Fund and an increase of 1.7 FTE in FY 2018-19 and a reduction of $2,890,033 total funds, including a reduction of $754,226 General Fund and an increase of 2.0 FTE in FY 2019-20 and future years to streamline and automate the Public Assistance Reporting Information System (PARIS) interstate match process, and provide internal resources to improve the process to prevent inappropriate expenditures.

The PARIS interstate match file identifies Colorado Medicaid enrollees who are also enrolled in another state's Medicaid program. This information is currently available to county departments and Department staff and counties are reimbursed for costs related to researching and resolving any matches within their county as part of their responsibility for case maintenance of Medicaid eligibility. In 2010, the Department automated the receipt of the PARIS Interstate Match into the Colorado Benefits Management System (CBMS) as a required condition of receipt of enhanced federal funding for systems, as outlined in 42 U.S.C. 1396b(r)(3). Additionally, section 25.5-4-209(4), C.R.S. requires the Department to access PARIS and to ensure that duplicate benefits are not being paid to persons identified.

With the passage of SB 10-167, "Medicaid False Claims Act," the Department received additional funding to increase county administration allocations for the 11 largest counties to encourage them to research and investigate potential cases of clients with eligibility in multiple states and take appropriate action on the cases to ensure duplicate benefits are not being paid. However, the amount of funding is not adequate to allocate to all counties and has not proven to be sufficient to encourage counties to prioritize the PARIS work. The Department also hired an FTE who is responsible for oversight and monitoring of the county administered PARIS interstate match process. Even with these steps to increase the number of PARIS matches that get resolved, the volume of individuals on the PARIS interstate match continues to rise and the manual, time-intensive process currently in place is not sufficient to address the volume of cases on the PARIS interstate match. This, in turn, leads to increased expenditures: although an individual living in another state may not be receiving services in Colorado, the Department would still make monthly capitation payments to providers such as the Regional Accountable Entities in the Accountable Care Collaborative and the Department's Dental Administrative Service Organization when a client is eligible for the program. Therefore, it is in the State's best interest to aggressively end open eligibility spans when the client is not living in Colorado.

Due to the large volume of individuals identified on the Colorado PARIS interstate match, which totaled 37,183 individuals in February 2017, or 2.6 percent of Medicaid caseload, an automated solution is necessary to keep up with the volume of matches. Not all the matches represent overexpenditure for Colorado because a portion of these individuals live in Colorado after having moved here from another state. Although the Department has implemented systematic processes for identifying PARIS matches and has ongoing communications with county departments and provides dedicated funding to the counties with the largest PARIS workload, the list is still too large for individual counties to fully manage.

The Department requests funding to implement system automation in CBMS to identify individuals on the PARIS interstate match who do not have corresponding eligibility end dates and generate a letter to the individual requiring them to verify their Colorado residency within a specified timeframe. If the individual does not verify residency, they would receive a notice of termination of eligibility for not responding to the

request for contact. This process would also identify individuals at initial application and re-determination who appear on the PARIS list so that appropriate action can be taken.

In addition to one- time funding for system automation, the Department requests funding for 1.7 FTE in FY 2018-19 who would continue ongoing to serve as PARIS investigators to research individual cases and coordinate with county departments and other states' PARIS contacts on matches that are not addressed through system automation. The requested staff would also coordinate with other states to close eligibility spans in those states when individuals are eligible in Colorado. This would help ensure that individuals with expenditures in Colorado are removed from the match list, which would reduce the likelihood that an individual living in Colorado has eligibility terminated inappropriately. This requires communication with Medicaid Departments in other states and close coordination with county departments. This work is time intensive and requires detailed tracking and follow up. The Department cannot successfully track the large volume of individuals on the match list without additional staff who would be responsible for reviewing the quarterly file and ensuring that cases are updated timely as appropriate.

Although the automation would reduce some manual work currently required by counties, the case maintenance by county departments would continue to be a critical part of the PARIS process. Because of this, the Department is not requesting any reduction to its County Administration appropriation. The Department would reallocate the existing PARIS county allocations into the general County Administration allocations and discontinue the policy of allocating separate PARIS funding to only certain counties. Currently and continuing with the system automation, county departments are responsible for initial and ongoing case maintenance of Medicaid eligibility which would still be necessary for a successful PARIS automation process.

Trust Unit Recoveries

The Department requests $151,426 total funds, including a reduction of $1,323,461 General Fund and an increase of 1.7 FTE in FY 2018-19 and $167,263 total funds, including a reduction of $1,595,380 General Fund and an increase of 2.0 FTE in FY 2019-20 and future years to increase staffing to review trust compliance issues and identify additional recoveries that the Department is currently unable to respond to due to limited staff resources.

Many individuals who qualify for Medicaid are required to contribute to the cost of their care. Section 25.5-4-209(1), C.R.S. requires that any recipient receiving benefits who receives any supplemental income, including trusts, shall apply this income to the cost of the benefits rendered. In many cases, this contribution occurs after the individual dies, when the Department recovers a portion of the cost of care through the recovery of assets, such as a from a trust.

With increased caseload and the aging of Colorado's population, the Department needs more resources to ensure compliance with state and federal laws. The Department currently has 1.0 dedicated FTE responsible for ensuring compliance related to income or assets in a trust. This position reviews trusts for applicants and enrolled members and advises, initiates, and recovers monies and handles any legal proceedings related to the assets in the trust. Within the parameters set forth by federal and state law, this position also analyzes, evaluates, and approves trusts and resources for Medicaid eligibility to determine the effect upon Medicaid

financial eligibility. The position requires extensive contact with the county departments, clients, and their representatives at time of eligibility determination and ongoing as situations change. As a result of the increasing caseload and the required work to coordinate benefits, the lack of staff resources focusing on this effort limits the amount of revenue the Department can recover for clients who have assets in a trust. Due to the increasing caseload and as financial situations of members constantly change, the Department is currently unable to respond to all leads and referrals related to assets in a trust that it receives from county departments, the Attorney General's Medicaid Fraud and Control Unit, and other referral sources. This limits the Department's ability to recover assets from trust due to lack of staff resources. Recoveries generally involve a legal proceeding which takes time and the Department cannot increase the value of recoveries without additional resources to research and respond to referrals and to actively pursue these assets.

To enhance the Department's ability to recover assets, the Department requests 2.0 FTE as Trust Recovery Specialists. These FTE would be generally responsible for reviewing compliance issues, seeking trust recoveries, monitoring court filings, and processing claims for recoveries. By dedicating additional resources to trust recoveries, the Department estimates that it would be able to increase the amount of funding recovered from trusts by over $3.3 million total funds per year by FY 2019-20. Detailed job descriptions for the requested FTE can be found in Appendix A.

Public Transportation Benefits for Non-Emergent Medical Transportation and Non-Medical Transportation

The Department requests a reduction of $565,951 total funds including a reduction of $282,976 General Fund in FY 2018-19, and a reduction of $810,700 total funds including a reduction of $405,350 General Fund in FY 2019-20 and future years to account for savings from discounted fares in the Non-Emergent Medical Transportation (NEMT) benefit, and to implement a public transportation benefit in the Non-Medical Transportation (NMT) program.

Medicaid members have access to a NEMT benefit to allow transportation to and from covered non-emergency medical appointments or services, and is only available when a member has no other means of transportation. Types of transportation available vary by location and may include trips in both private vehicles and public transportation. The Department has an opportunity to reduce the amount it spends on public transportation by taking advantage of a Regional Transportation District (RTD) program that would allow the Department to pay half price for bus passes for members through Medicaid's NEMT service.

Because of the available discount, the Department also sees an opportunity to decrease Non-Medical Transportation (NMT) expenditure in the Home and Community Based Services (HCBS) adult waivers by expanding NMT to include RTD bus passes. Non-Medical Transportation is a service offered to members eligible for home and community based services (HCBS) programs that provides transportation which enables members to gain personal physical access to non-medical community services and resources. The current NMT options are limited to trips via taxi, mobility vans, and wheelchair vans. NMT utilization is capped at two trips per week for all services except those that transport clients to and from adult day facilities. Approximately 15 percent of the HCBS long term services and supports (LTSS) adult waiver members utilize the NMT benefit.

The addition of a public transportation option as part of the NMT benefit is highly desired by the stakeholder community because expanding NMT would increase member independence. Additionally, by adding another NMT provider, members would be able to exercise provider choice. Right now, members wanting to utilize NMT services are sometimes at the will of very few transportation companies. Some areas have very few providers or very few providers willing to offer transportation to members. In these situations, sometimes the only willing provider is a larger taxi company which increases service costs and leads to excessive wait times.

The Department estimates approximate savings of $216,378 each year by receiving a 50 percent discount from RTD on bus fares currently offered through the NEMT program. Discounted tickets would be available for NEMT members who are seniors, individuals with disabilities, or students. There are ten different service options for NEMT and the 50 percent discount would apply to RTD transportation options which include: access-a-ride, local trips, monthly local pass, regional trips, and monthly regional passes.

To achieve the estimated savings, the Department is proposing to expand the NMT service to include public transportation. Public transportation is already a NMT service option for the HCBS Adult Comprehensive (HCBS-DD) waiver. Public transportation bus rides would be available in the following eight RTD service counties: Boulder, Broomfield, Denver, Jefferson, Adams, Arapahoe, Douglas, and Weld. The Department is proposing to provide the following RTD bus pass options to qualifying members: local tickets, local five-day pass books, monthly local passes, regional tickets, regional five-day pass books, and monthly regional passes. Expanding NMT would increase independence by allowing the members to travel around the community without relying upon a single provider or transportation option.

Parental Fee for Enrollment in Children's Home and Community Based Services Waiver

The Department requests $763,703 total funds, including $121,712 General Fund in FY 2018-19, $207,529 total funds, including a reduction of $992,765 General Fund in FY 2019-20, and $1,278 total funds, including a reduction of $1,368,934 General Fund in FY 2020-21 and ongoing to implement a parental fee into the Children's Home and Community Based Services (CHCBS) program. The fee would be collected based on the household's total income and would be a monthly premium, like the current process in the Buy-In Program for Children with Disabilities.

An inequity currently exists when providing Medicaid services to children with disabilities whose families have household income or resources that exclude them from traditional Medicaid eligibility. Families can access State Plan services either through the Children's Home and Community Based Services (CHCBS) program (if the child meets level of care requirements and targeting criteria of that waiver) or the Medicaid Buy-In Program for Children with Disabilities. Families with a child at risk of nursing facility or hospital placement can access State Plan services at no additional cost through eligibility in an HCBS program; however, other, potentially lower income, families must pay a monthly premium through the Children's Buy-In Program to access State Plan services if the child does not meet waiver eligibility criteria.[1]

[1] The Health First Colorado Buy-In Program for Children with Disabilities (Children's Buy-In) is a Family Medical Assistance program that provides Medicaid benefits for children who are under age 19, have a qualifying disability, and whose adjusted family income is at or below 300percent of the Federal Poverty Level (FPL). Eligible families receive Health First Colorado benefits for their child with a disability by paying a monthly premium on a sliding scale based on their adjusted income.

As a result of having similar programs with different eligibility criteria, the Department has observed that families of children with disabilities with lower income may be contributing more than families with higher income, in certain cases. The Department believes this inequity is unfair to Medicaid members. By implementing the parental fees, the Department could correct this policy and create an opportunity for General Fund offsetting dollars.

The Department requests spending authority to implement monthly premiums in the CHCBS program. Implementation would require significant systems changes and modifications, and the Department estimates that fee collection would begin in November 2019. The Department has developed, through working with stakeholders, three potential fee collection models with varying number of tiers based on household income. This request utilizes these three models to estimate revenue; however, the Department would only finalize a rate model if the request is approved, after input from legislative and other stakeholders.

If this request is not approved, the inequity between Children's Buy-In and the CHCBS waiver would continue. Families over 300 percent FPL would be able to access Medicaid services at no additional cost through use of the waiver while families between 134 percent and 300 percent FPL would be required to pay a monthly premium to access services.

Anticipated Outcomes:

Utilization Management

Approving this request would ensure the Department has sufficient funding and FTE to offer more oversight and management for certain Medicaid services that industry standards suggest are susceptible to over utilization and to continue public policy development processes. This request addresses several of the Department's FY 2016-17 Performance Plan's primary goals of ensuring sound stewardship of financial resources, and address the Department's specific strategy, to 'Implement cost containment initiatives', as it would allow the Department to better manage appropriate utilization of Medicaid services while reducing costs to the State. Approval of this request would put measures in place to ensure the Department's members have their needs met appropriately and that funds are correctly spent. Additionally, approval of this request would help to ensure robust management of Medicaid benefits by providing staff resources to effect changes in Medicaid policies.

Automate Public Assistance Reporting Information System Interstate Match

Automating the verification of residency process for individuals on the PARIS interstate match would lead to a more timely eligibility re-determination and termination, when applicable, which would save the State money by eliminating capitation payments for members who do not reside in Colorado. Additional savings may be had in the future by reducing fraud or other abuse by closing eligibility spans for members who are not eligible. This request aligns with several strategies in the Department's FY 2016-17 performance plan including 'Implement cost containment initiatives', 'Improve Efficiency of Business Processes', 'Promote rigorous compliance with federal and state laws and regulations, fiscal rules and internal operating procedures', and 'Support counties and medical assistance sites with technical assistance for processing eligibility applications accurately and efficiently.'

Trust Unit Recoveries
Increasing the number of staff focusing on trust unit recoveries would provide additional internal resources to research and respond to referrals and process recoveries related to trusts. This would ensure compliance with state and federal laws and aligns with several strategies in the Department's performance plan including 'Implement cost containment initiatives,' 'Improve efficiency of business processes,' 'Promote rigorous compliance with federal and state laws and regulations' and 'Support counties and medical assistance sites with technical assistance for processing eligibility applications accurately and efficiently.'

Public Transportation Benefits for Non-Emergent Medical Transportation and Non-Medical Transportation
Modifying the existing NMT service to include public transportation would help the Department achieve the Community Living Advisory Group recommendation of connecting individuals to vital health and social services by providing an effective transportation system that can help individuals preserve and improve their independence and decrease the likelihood of institutionalization. Adding public transportation as an NMT option for individuals receiving home and community-based services could improve feelings of inclusion and connectedness to the community as well as increasing member choice and access to services. Implementing discount passes into the NEMT service would reduce expenditure without compromising participant access or service experience. The expanded service options align with strategies in the Department's FY 2016-17 Performance Plan including 'Expand network of providers serving Medicaid' and 'Make Long-Term Services and Supports easier to access and navigate'.

Parental Fee for Enrollment in Children's Home and Community Based Services Waiver
The proposed change represents a shift away from an unequal policy and would even the playing field for families with children with disabilities who need Medicaid services. This request is aligned with stakeholder feedback and shows how the Department is adapting and responding to the needs of this population. This request links directly to the Department's Performance Plan strategies to 'Instill a person- and family-centered approach to strengthen employee engagement, client experience, client engagement, and culture change.'

Assumptions and Calculations:

Utilization Management
The Department estimated the impact of adding prior authorization requirements to additional benefits based on historical utilization data for each of the services. The Department used the most recent period of complete data to calculate the expected number of new PARs for each respective benefit. The Department also used the same period's utilization and expenditure data to estimate the cost per utilizer, which the Department would expect to save from each denied request. In future years, the Department leaves the cost per utilizer constant. The Department has accounted for growth in the number of projected prior authorization requests by trending the most recent utilization data by overall caseload growth in the projected fiscal years from the Department's February 2017 forecast.

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 3.14 percent of services were denied. Based on private insurance in Vermont, statistics show that about 6 percent of prior authorization requests were denied, with about 50 percent of those appealed and overturned. These are for services that have had PAR requirements in place for several years. Therefore, the Department assumes that Vermont's data is more appropriate to use for year one of implementation and assumes the denial rate would trend down to historical Department levels in the following years. The Department has also incorporated an assumption that as providers are more familiar with requirements for these services and what is permissible, the number of overall claims submitted will also decrease. Therefore, the Department has chosen to leave the denial rate constant in all years. This assumes a higher denial rate with similar claims volume in year one and lower denial rates and claims volume in future years. The Department has chosen this method because it is likely that there would be a greater number of initial denials from new requirements, but over time, denials would trend to levels consistent with the Department's current denial rate while overall claim volume will also trend down.

As mentioned above, the Department must amend its Utilization Management contract to include the additional services. There are three cost components that would need funding. All contractor estimates are based on estimates from the current vendor. The first component is the estimated cost per PAR for the vendor to manage the benefits, which the Department assumes would cost $22.75 per PAR. Costs per PAR can vary greatly between physical health services and pharmacy services, as can be seen in the FY 2018-19 R-10 "Drug Cost Containment Initiatives" request. There are varying levels of work regarding each PAR request, with some requests considered standard and some more complex. In physical health PARs mentioned in this request, all are treated as standard requests at $22.75 per PAR. In the Departments FY 2018-19 R-10 "Drug Cost Containment Initiatives" request some PAR requests are considered complex and costs can vary from $42 per PAR to upwards of $80 for complex PARs. Second, the vendor would need to make changes within their system to manage the capacity increases. The Department estimates that this one-time IT cost would be $75,000, based on information provided by the vendor. The third component is for flexible prior authorization funding. The flexible funding adds a twenty-five percent increase to the administrative contract managing the requests to allow for flexibility in designing the new PAR policies. Current estimates are based on a preliminary set of codes developed by the Department. The Department would work with relevant stakeholders to develop a final set of codes to implement that would deliver the best return on investment to both the members and the Department. The flexible funding accounts for the potential increase in prior authorization requests resulting from the final codes selected. Additional savings resulting from the final codes selected will be accounted for through the normal budget process.

The Department would implement the PARs on these new services on January 1, 2019, which would provide adequate time for all required contract amendments, State Plan Amendments, and rule changes to be completed. If the request is approved, the Department would hire the new FTE on September 1, 2018 to begin work on managing the various components.

Approval of the Stakeholder Relations Policy Development Specialist would allow for additional benefits to be reviewed through the Benefits Collaborative Process to align with best practices and evidence-based research. In turn, this may generate long term savings due to more robust management of Medicaid benefits. However, the Department is still in the process of evaluating policy changes previously implemented and

therefore has not estimated the savings in its budget and would utilize the budget process to update associated savings.

The Department currently has 1.0 FTE who is the Stakeholder Relations Specialist and this position also serves as a Unit Manager. This FTE manages staff who are responsible for regulatory compliance, rule-writing, and State Plan Amendments, as well as the Medicaid Provider Rate Review process established in SB 15-228 and the compliance activities required under federal Access to Covered Medicaid Services regulations. The rate review and access initiatives are relatively new and the scope of work required for effective and meaningful stakeholder engagement on these projects, while effectively managing and mentoring staff, has become unmanageable. Without an additional FTE, the Department would be forced to make difficult decisions that would be detrimental to program management and would prevent it from being able to evaluate, develop, revise, and implement evidence-based policies in a manner that meets timeliness and quality standards. Additionally, it would prevent the Department from making changes based on best practices and stakeholder expectations, such as slowing progress on the Benefits Collaborative Process or re-prioritizing job duties for projects that are equally as important.

Detailed job descriptions for the requested FTE can be found in Appendix A. Detailed calculations can be found in Appendix B.

Automate Public Assistance Reporting Information System Matching

The Department estimates that of the total 37,177 individuals who match on Colorado's PARIS interstate match February 2017 report, that 20,717 would be terminated due to system automation and the remaining 16,466 individuals reside in Colorado and need to have their eligibility in another state updated. The Department calculated the client number by taking the number of individuals on the PARIS interstate match who match for two or more quarters in a row and do not have a corresponding eligibility end date in CBMS. Then, this list was compared with claims data. The clients who have fee for service (FFS) claims after the date of the match are assumed to reside in Colorado. For the remaining clients who have no FFS claims, the Department assumes these clients no longer reside in Colorado and that the automation process will terminate eligibility. The Department assumes that the PARIS match list will grow by the same growth rate as Medicaid caseload based on the Department's caseload statistics, which may represent a conservative estimate as historically the list has grown at a higher rate than caseload. Although most enrollees who reside in Colorado would have at least one FFS claim in a year, the Department estimates that 19.78 percent of clients who are continuously enrolled do not utilize any FFS claims in a year based on MMIS data, and has adjusted the calculations accordingly in an effort not to overestimate the number of individuals who would be terminated due to automation.

The Department assumes there are two types of capitation savings that would be realized due to eligibility termination. These are payments to Regional Accountable Entities and the Department's Dental Administrative Service Organization. Although the Department pays capitation payments to other types of providers, such as the payments to behavioral health organizations and managed care plans, the Department has not estimated savings for those payment types. Individuals who do not reside in Colorado and do not incur fee-for-service costs have the effect of artificially lowering the monthly capitation rates for these providers. These rates would be adjusted prospectively to incorporate the expected decrease in caseload

through the annual rate adjustment process, resulting in no expected change in aggregate payments to these providers.

The Department assumes the modifications to CBMS would be eligible for 75 percent enhanced FFP and be completed by September 30, 2018. Therefore, the Department assumes the first batch of PARIS letters to verify residency would be system generated and mailed by October 31, 2018. For those who did not verify Colorado residency, the first round of individuals who receive notices of termination of eligibility due to the automation would occur by November 30, 2019. The Department assumes it would need to submit an Advanced Planning Document (APD) update to Centers for Medicare and Medicaid Services (CMS) to request approval of enhanced FFP and that could be completed by July 1, 2018. If the Department does not receive approval for enhanced FFP, it would utilize the budget process to request a change in funding. Additionally, the Department estimates that the automation process would increase CBMS printing and mailing costs totaling 34,000 additional pages per quarter at $0.54 per page and has included these costs in the request. There may also be future decreases in printing and mailing costs for individuals who are terminated due to the automation; for example, a decrease in the number of annual redetermination packets that would be printed and mailed for the individuals that would be terminated. If this occurs, these decreases would be accounted for in the annual CBMS base request.

The Department assumes the 1.7 FTE would be hired September 1, 2018 and these costs would be eligible for 50 percent federal financial participation (FFP). The Department currently has 1.0 FTE who is responsible for oversight of Colorado's PARIS program. This is not a sufficient level of internal staff to properly and timely monitor the PARIS process as much of this FTE's time is currently spent researching individual cases which prevents them focusing on improving and monitoring of county PARIS processes. If this request is approved, many of the job duties would continue while other duties would shift upon hiring of the additional FTE requested and once automation is implemented. This FTE would continue to be the PARIS policy expert working with Department systems teams to design, develop and implement system automation and developing training for eligibility sites and customer service representatives, including county departments. The position would be responsible for implementing procedures to ensure the changes in process do not adversely impact Medicaid clients who remain Colorado residents, which would include troubleshooting any issues that arise due to automation. This FTE would also be responsible for training and overseeing work of the new staff. This employee's PARIS job duties would shift from primarily communicating with county departments on PARIS allocations, cases, reviewing county quarterly reports and individual case resolution to a program oversight role as the PARIS team lead. In addition to the interstate match, the current staff would continue to be the main contact on the other two PARIS files which are U.S. Department of Veterans Affairs (VA) and Federal file.

The Department assumes the state share of administrative costs for this request would be allocated between General Fund and Healthcare Affordability and Sustainability Fee Cash Fund.

Detailed job descriptions for the requested FTE can be found in Appendix A. Detailed calculations can be found in Appendix B.

Trust Recoveries

The Department assumes the FTE would be hired September 1, 2018 and that recoveries could begin to be realized on that date and that these costs would be eligible for 50 percent FFP. The Department assumes that the state share of cost for this request would be General Fund because expansion populations funded with Healthcare Affordability and Sustainability Fee Cash Funds are not subject to asset tests and therefore are not impacted by trust recoveries.

The Department assumes that adding additional staffing would increase the amount of trust recoveries because the new FTE would be able to follow up and research additional referrals received from trust officers, county departments, or other sources. The Department has calculated the increased recoveries by taking the amount of income trust recoveries from the FY 2016-17 S-1 "Medical Services Premiums Request" and estimating the amount of recoveries per current FTE. Assuming decreasing marginal returns, the Department estimates that the new FTE would be able to bring in 50 percent of the recoveries that the two current FTE have generated. Therefore, each FTE would increase the annual amount of recoveries by $1,679,012, totaling to $3,358,023 on an annual basis and the estimate for FY 2018-19 has been adjusted based on the FTE start date. The Department would update this estimate based on actuals through the budget process. The Department assumes the recovery revenue is not considered TABOR revenue because it is a reimbursement of prior expenditures and not a fee or tax.

The Department assumes 50 percent FFP split between General Fund and federal funds for the increased recoveries for this initiative because all the populations subject to trust requirements are non-expansion populations therefore there would be no enhanced match or other cash fund sources impacted.

Detailed job descriptions for the requested FTE can be found in Appendix A. Detailed calculations can be found in Appendix B.

Public Transportation Benefits for Non-Emergent Medical Transportation and Non-Medical Transportation

Non-Emergent Medical Transportation

The Department currently contracts with a broker to manage NEMT trips and distribute RTD passes. The Department used data from the NEMT broker for the period March 2015 through May 2017 to estimate savings from the proposed 50 percent discount. The monthly data includes total NEMT trips and total number of trips taken on each of the RTD options (access-a-ride, fixed, monthly local, regional, and monthly regional). The Department used these values to predict monthly RTD rides, percentage of NEMT trips taken on RTD options, and yearly expenditure with and without the 50 percent discount. The discount would be available to Medicaid members who are seniors, individuals with disabilities, or students. In FY 2015-16, this eligible population was responsible for 65 percent of NEMT expenditure. Therefore, the Department estimated that 65 percent of all NEMT RTD bus trips would be eligible for the 50 percent discount.

Due to reclassification of RTD routes and fares in January 2016, the Department employed data from January 2016 through December 2016 to approximate how many NEMT trips would have been taken on each of RTD's new route categories listed above.

To implement the new policy, the Department assumes the NEMT broker would determine which NEMT clients are eligible to receive the discount passes. Due to this increase in administrative work, the Department assumes, based on conversations with its vendor, that the broker would need to hire an additional two positions to administer passes for NEMT and NMT members which would total $120,000 annually with $10,000 startup costs in the first year. Approximately $35,000 would also need to be added to the broker's annual contract for postage costs associated with the new passes. All changes to the broker's contract and operations would be completed by July 1, 2018.

Non-Medical Transportation

The Department assumes a public transportation option would produce a shift in utilization to public transportation from clients using taxis, mobility vans, or mobility vans to and from an adult day facility. The available RTD options would be: access-a-ride, local trips, five-day local pass book, monthly local pass, regional trips, five-day regional pass book, and a monthly regional pass. The Department assumes clients utilizing either of the wheelchair van transportation options would not shift their utilization.

To estimate this policy's impact on NMT expenditure, the Department analyzed claims data from FY 2015-16 to predict potential public transportation utilization by waiver clients. First, the Department collected the total number of one-way trips for the following NMT services: taxi, mobility van, and mobility van to and from adult day facilities. The Department then estimated how many of the current NMT units may shift to RTD public transportation units if the service were to be expanded. The Department assumed that 13 percent of current NMT units would switch to the newly available RTD option, as approximately 13 percent of NEMT trips since March 2015 have been taken on one of the available RTD options. NEMT is an appropriate proxy because it also serves members who are of the same eligibility category as NMT waiver clients. In addition, utilization of public transportation in waivers for Individuals with Development Disabilities (IDD) is much higher than both NEMT and NMT. Therefore, the Department believes NEMT utilization is the most accurate of the available ways to estimate future RTD utilization.

There is potential for increased utilization in the NMT services once the transportation options are expanded. The Department sees two ways that this could happen: if waiver clients who are not using NMT services currently see the available RTD options and decide to begin utilizing NMT or if current NMT clients begin to use more of their allotted units as the number of service options expands. This is uncertain, and if utilization increases occur, the Department would account for any changes via the regular budget process. NMT utilization would need to increase by over 11 percent to breakeven and offset the estimated savings.

The Department would need to submit a waiver amendment to the Centers for Medicaid and Medicare (CMS) to expand the options for NMT. The amendment would be for a modification of an existing service and would include new policies and regulations regarding the modified service. The Department estimates this work could be completed by September 1, 2018 and that the program would begin in October 2018.

Detailed calculations for both NEMT and NMT components can be found in Appendix B.

Parental Fee for Enrollment in Children's Home and Community Based Services Waiver

The Department previously worked with CHCBS stakeholders to design three potential sliding scale parental fee models. If the request is approved, the Department would analyze the options and select the most

appropriate one. For purposes of this request, however, the Department has selected one of the three models to use in estimating potential revenue. The model used for this request represents the lowest revenue estimate out of the three developed by the CHCBS workgroup.

The model has six tiers based on the household's Federal Poverty Level (FPL). The Department does not collect parental income information for CHCBS waiver members so the Department used the 2016 American Community Survey (ACS) as a proxy. The Department compiled a list of the zip codes for each of the 1,125 children enrolled on the CHCBS waiver during FY 2014-15. The 2015 median household income for each zip code, as collected by the 2016 ACS, was then applied to each member and was used as a proxy for the child's household income. Once the household income was applied, the Department distributed the children into the correct tier of the model developed by the workgroup. Because this work was several years out of date, the Department then applied this FPL distribution to average monthly caseload for FY 2016-17 for a more accurate estimate. The FPL bounds of the tiers and distribution of children within each tier is displayed in the below table.

Example Fee FPL Tiers, Client Distribution, and Monthly Premium			
Tier	**FPL**	**Clients**	**Premium**
1	0-275%	216	N/A
2	275-400%	602	2.5%
3	401-525%	419	3.0%
4	526-650%	162	4.0%
5	561-899%	0	5.0%
6	900% and above	0	6.0%
Total		1,399	

Based on the tier distribution, the Department then estimated the potential monthly premium amounts which correspond to the percentage of median household income that would be collected. Taking the estimated income of each child multiplied by the appropriate premium, the Department estimated each child's potential monthly premium amount.

Introducing a monthly premium to the CHCBS waiver may cause some families to decide not to enroll their children in the waiver. Many of these children use Medicaid services as a secondary insurance option and a monthly premium might represent too great a cost to pursue waiver enrollment. Another potential caseload change would be for the family to try and pursue a different waiver if the child meets eligibility criteria of that waiver to avoid the fee. It is possible that this policy change would lead to a drop in CHCBS waiver enrollment and an increase in, for example, the Children with Life Limiting Illness (CLLI) waiver. These effects are difficult to predict, and it is unclear if such movement would occur. As a result, the Department has not included any estimate for changes in service cost or caseload; should such adjustments be necessary, the Department would account for any changes via the regular budget process.

Collection of the fees would follow the business and system processes that are in place for the Medicaid Buy-In Program for Children with Disabilities by utilizing the eligibility and enrollment vendor, Denver Health,

to process any manual payments or adjustments. Due to the relatively small number of additional monthly premiums that would be collected and existing contract amounts, the Department assumes it could absorb administration of the additional premiums within existing appropriations. The Department would use the Program and Eligibility Application Kit (PEAK) and the Colorado Benefits Management System (CBMS) to assess parental income, determine the amount of monthly premiums each family would be responsible for, and collect payments. System changes would also include necessary modifications to collect data for federal reporting and Department data analysis and reporting.

Implementation Assumptions

Development and selection of the fee model would need to be completed before any system changes begin. The Department assumes that this work would be completed by Department staff by November 30, 2018. Upon completion of this work, system changes would begin to both CBMS and MMIS.

Implementing a parental fee into the CHCBS waiver would require a rule change and waiver amendment. If the request is approved, the Department assumes it could begin work on both tasks in June 2018. To implement the rule change, the Department would need to promulgate rules to the Medical Services Board (MSB). Given the timing of necessary steps, the Department assumes that the earliest the policy changes could be effective would be September 1, 2019, when necessary system changes are to be completed. The Department assumes that it would submit the waiver amendment and estimates an approval by September 1, 2019.

The Department is requesting funding in FY 2018-19 and FY 2019-20 to implement the necessary system changes for fee collection. The Department estimates that these changes would begin December 1, 2018, take nine months to complete, and revenue would start to be collected one month from the implementation date. Therefore, the Department is assuming that premium letters would be generated and mailed on September 1, 2019 and revenue from these fees would start being collected October 1, 2019. Creating necessary system infrastructure for fee collection is estimated to require seven months of work in FY 2018-19 and two months in FY 2019-20.

The Department would need to submit the necessary Implementation Advanced Planning Document (IAPD) to ensure federal matching funds for system changes associated with this project. The Department assumes all work related to the IAPD would occur during FY 2018-19. Delays in approval could delay implementation timelines for the parental fee. In the event of delayed implementation, the Department would address any needed funding changes through the normal budget process.

The Department assumes the fee collection process would be like the process for monthly premium collection for the Medicaid Buy-In Programs for people with disabilities, including the ability to pay online, by mail or in person at a Denver location. The Department contracts with the Colorado Medical Assistance Program (CMAP) eligibility and enrollment vendor who is responsible for collection of monthly premiums for the Children's Buy-In program and any manual payments or adjustments. This request would collect monthly

premiums from an estimated 1,183 clients each year[2]. The Department assumes it could cover increased costs to the CMAP contract for administration of the monthly premium process within existing appropriations.

The parental fee collection would be considered non-exempt revenue and the Department assumes it would be counted as Taxpayer's Bill of Rights (TABOR) revenue. The funds would be used to offset General Fund and federal funds expenditures and would be deposited into the Health Care Policy and Financing Cash Fund authorized in section 25.5-1-109, C.R.S. Fees applied to service costs are not eligible for a federal match and the Department has calculated fund splits in the request accordingly.

[2] This figure is the average monthly waiver clients during FY 2016-17 not including those families who are estimated to be below 275percent FPL. The number does not represent total enrollment on the waiver during FY 2016-17.

Appendix A: FTE Descriptions

Position Name	Position Classification	Number of FTE	Description
Utilization Management Contract Manager	Administrator IV	1.0	The FTE would be responsible for the additional scope of work under the current utilization management vendor's contract related to adding prior authorization requirements on additional benefits. The staff would have a unique technical expertise that is critical to the overall success of the Department. This position will have direct influence over the decision-making process. The Department and its vendor currently process about 20,000 requests per month for four large and six small benefits with 2.0 FTE. Adding an additional six benefits to the UM will increase the prior authorization requests by about 5,500 per month, which current staff cannot absorb. This position would assist with overseeing the UM contract deliverables and quality assurance assessments specific to the new benefits. Staff would also provide outreach and education to providers on the new services requiring PARs. The position would serve as a liaison between the UM vendor and Department staff on systems testing to ensure successful interoperability between the PAR portal and the interChange.
Client Appeals Representative	Administrator IV	1.0	The FTE would serve as an appeals representative for the new services that would require a PAR. The staff would have a unique technical expertise that is critical to the overall success of the Department. This position will have direct influence over the decision-making process. This position would ensure appeal requests are processed in a timely manner. The position would also coordinate with the UM vendor to schedule and review their expert testimony and cause for denial. The staff would assemble, prepare, and submit all medical documentation relating to the appeal as well as submit needed requests for dismissals, continuances, and exceptions. The Department currently has one FTE that handles appeals related to prior authorized services. Based on the current benefits requiring a prior authorization, this staff has worked about 400 appeals per year. With the number of PARs expected to increase by about one quarter and a higher initial denial rate, the Department expects the number of appeals to increase significantly.

Position Name	Position Classification	Number of FTE	Description
Stakeholder Relations Specialist	Administrator V	1.0	The FTE would serve as the coordinator for the stakeholder processes required for policy development and changes, including changes in federal and state law, such as changes to copayments, payment methodologies and services. This also includes managing the Benefits Collaborative Process, which includes ensuring research and draft benefit policies are evidence-based and guided by best practices and planning, project management, stakeholder communication, and leading, and/or facilitating public meetings. The FTE would develop productive working relationships and collaborate with groups and individuals to constructively address disagreements and policy challenges. The FTE would identify and establish metrics to monitor policy changes, track and monitor related utilization and expenditure, and identify ways to enforce policy changes through claims system edits or prior authorization request requirements/criteria. This position would recommend best practices, identify and address benefit or policy gaps, solicit and respond to provider, client, and stakeholders in benefit coverage policy development, and assesses current and future benefit coverage policies. The position would ensure that leadership is informed on status of all projects and identify potential risks to progress.
PARIS Investigators	Program Assistant II	2.0	These FTE would provide additional internal resources to investigate PARIS matches not addressed by CBMS systems changes. The system changes would not address the cases where individuals have recently become enrolled in Colorado Medicaid, but remain enrolled in another state. To address the PARIS matches caused by open eligibility spans in other states, the Department requests additional FTE to verify matches and work with the other states to ensure that individuals do not show up on future reports. The positions would be required to run reports against the matched data as well as PARIS data in CBMS. The positions would be responsible for contacting other states with the purpose of determining the correct state for eligibility and terminating eligibility in the other state. These FTE would also work closely with county personnel to troubleshoot individuals that are terminated in error by CBMS utilizing the automated methodology to ensure that clients are not adversely impacted by the automated process. Positions would be responsible for duties

Position Name	Position Classification	Number of FTE	Description
			assigned by the program coordinator such as assisting the counties with questions and data needs.
Trust Unit Recovery Specialists	Administrator IV	2.0	These positions would be responsible for reviewing compliance issues, seeking trust recoveries, monitoring court filings, and processing claims for recoveries. These FTE would communicate with contractors including county departments related to trust resources for Medicaid clients. the position would provide decisions concerning Medicaid trusts, resources, and transfers without fair consideration to county staff, clients, and client representatives. The positions would work on projects in this subject matter area at the direction of the Trust and Recovery Officers. These positions recommend and support decisions related to trusts, resources, and transfers without fair consideration for the eligibility of persons applying for benefits from the state Medicaid program. These positions would review accounting documents from trustees and advises, initiates, and recovers monies on behalf of Medicaid upon the client's death or closure of the trust. Any legal proceedings such as administrative appeals, judicial reviews stemming from such trusts, resources, and transfers without fair consideration may be handled by this position. Within the parameters set forth by federal and state law, these positions may also analyze, evaluate, and approve trusts and resources to determine the effect upon applicant/recipient Medicaid financial eligibility.

Table 1.1 FY 2018-19 R-8 Medicaid Savings Initiatives Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$392,224	5.8	$180,175	$15,941	$0	$196,108	Table 8.1- FTE Row A
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$55,489	0.0	$25,013	$2,732	$0	$27,744	Table 8.1- FTE Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$667	0.0	$306	$27	$0	$334	Table 8.1- FTE Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$17,574	0.0	$8,074	$714	$0	$8,786	Table 8.1- FTE Row D
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$17,574	0.0	$8,074	$714	$0	$8,786	Table 8.1- FTE Row E
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$38,462	0.0	$17,339	$1,894	$0	$19,229	Table 8.1- FTE Row F
G	(1) Executive Director's Office, (C) Information Technology Contractors and Projects, Medicaid Management Information System Maintenance and Projects	$57,456	0.0	$5,746	$0	$0	$51,710	Table 2.1 Row R
H	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$1,309,205	0.0	$225,088	$115,539	$4,151	$964,427	Table 2.1 (Row F + Row G + Row Q + Row S)
I	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$2,010,059	0.0	$502,515	$0	$0	$1,507,544	Table 2.1 Row B
J	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($5,290,090)	0.0	($3,160,277)	$2,724,679	$0	($4,854,492)	Table 2.4 Row H
K	**Total Request**	**($1,391,380)**	**5.8**	**($2,187,947)**	**$2,862,240**	**$4,151**	**($2,069,824)**	**Row A + Row B + Row C + Row D + Row E + Row F + Row G + Row H + Row I + Row J**

Table 1.2 R-8 FY 2018-19 Medicaid Savings Initiatives Cash Fund Breakout								
Row	**Line Item**	**Healthcare Affordability and Sustainability Fee Cash Fund**	**Adult Dental Cash Fund**	**Breast and Cervical Cancer Program Cash Fund**	**CHP+ Trust Fund**	**HCPF Cash Fund**	**Recovery Cash Funds**	**Total**
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$15,941	$0	$0	$0	$0	$0	$15,941
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$2,732	$0	$0	$0	$0	$0	$2,732
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$27	$0	$0	$0	$0	$0	$27
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$714	$0	$0	$0	$0	$0	$714
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$714	$0	$0	$0	$0	$0	$714
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$1,894	$0	$0	$0	$0	$0	$1,894
G	(1) Executive Director's Office, (C) Information Technology Contractors and Projects, Medicaid Management Information System Maintenance and Projects	$0	$0	$0	$0	$0	$0	$0
H	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$115,282	$0	$0	$257	$0	$0	$115,539
I	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$0	$0	$0	$0	$0	$0	$0
J	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($66,056)	($7,541)	($77)	$0	$0	$2,798,353	$2,724,679
K	**Total Cash Fund Request**	**$71,248**	**($7,541)**	**($77)**	**$257**	**$0**	**$2,798,353**	**$2,862,240**

Table 1.3 FY 2019-20 R-8 Medicaid Savings Initiatives Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$476,033	7.0	$217,022	$20,994	$0	$238,017	Table 8.2 FTE Row A
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$55,489	0.0	$24,746	$2,999	$0	$27,744	Table 8.2 FTE Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$888	0.0	$408	$36	$0	$444	Table 8.2 FTE Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693	Table 8.2 FTE Row D
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693	Table 8.2 FTE Row E
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$6,650	0.0	$2,966	$359	$0	$3,325	Table 8.2 FTE Row F
G	(1) Executive Director's Office, (C) Information Technology Contractors and Projects, Medicaid Management Information System Maintenance and Projects	$0	0.0	$0	$0	$0	$0	Table 2.2 Row R
H	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$280,969	0.0	$60,613	$28,144	$847	$191,365	Table 2.2 (Row F + Row G + Row Q + Row S)
I	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$2,003,849	0.0	$500,963	$0	$0	$1,502,886	Table 2.2 Row B
J	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($7,007,141)	0.0	($4,989,172)	$5,265,769	$0	($7,283,738)	Table 2.5 Row H
K	**Total Request**	**($4,136,489)**	**7.0**	**($4,160,948)**	**$5,320,183**	**$847**	**($5,296,571)**	**Row A + Row B + Row C + Row D + Row E + Row F + Row G + Row H + Row I + Row J**

Table 1.4 R-8 FY 2019-20 Medicaid Savings Initiatives Cash Fund Breakout								
Row	**Line Item**	**Healthcare Affordability and Sustainability Fee Cash Fund**	**Adult Dental Cash Fund**	**Breast and Cervical Cancer Program Cash Fund**	**CHP+ Trust Fund**	**Medicaid Buy-In**	**Recovery Cash Funds**	**Total Cash Funds**
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$20,994	$0	$0	$0	$0	$0	$20,994
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$2,999	$0	$0	$0	$0	$0	$2,999
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$36	$0	$0	$0	$0	$0	$36
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$941	$0	$0	$0	$0	$0	$941
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$941	$0	$0	$0	$0	$0	$941
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$359	$0	$0	$0	$0	$0	$359
G	(1) Executive Director's Office, (C) Information Technology Contractors and Projects, Medicaid Management Information System Maintenance and Projects	$0	$0	$0	$0	$0	$0	$0
H	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$28,096	$0	$0	$48	$0	$0	$28,144
I	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$0	$0	$0	$0	$0	$0	$0
J	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($132,808)	($13,399)	($137)	$0	$2,054,090	$3,358,023	$5,265,769
K	**Total Cash Fund Request**	**($78,442)**	**($13,399)**	**($137)**	**$48**	**$2,054,090**	**$3,358,023**	**$5,320,183**

Table 1.5 FY 2020-21 R-8 Medicaid Savings Initiatives Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$476,033	7.0	$217,022	$20,994	$0	$238,017	Table 8.2 FTE Row A
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$55,489	0.0	$24,746	$2,999	$0	$27,744	Table 8.2 FTE Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$888	0.0	$408	$36	$0	$444	Table 8.2 FTE Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693	Table 8.2 FTE Row D
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693	Table 8.2 FTE Row E
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$6,650	0.0	$2,966	$359	$0	$3,325	Table 4.1 FTE Row F
G	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$74,718	0.0	$26,809	$10,423	$187	$37,299	Table 2.3 (Row F + Row G + Row Q + Row S)
H	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$1,919,048	0.0	$479,763	$0	$0	$1,439,285	Table 2.3 Row B
I	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($7,110,325)	0.0	($5,366,670)	$5,949,910	$0	($7,693,565)	Table 2.6 Row H
J	**Total Request**	**($4,530,726)**	**7.0**	**($4,593,450)**	**$5,986,603**	**$187**	**($5,924,065)**	**Row A + Row B + Row C + Row D + Row E + Row F + Row G + Row H + Row I**

Table 1.6 FY 2020-21 Medicaid Savings Initiatives Cash Fund Breakout								
Row	**Line Item**	**Healthcare Affordability and Sustainability Fee Cash Fund**	**Adult Dental Cash Fund**	**Breast and Cervical Cancer Program Cash Fund**	**CHP+ Trust Fund**	**Medicaid Buy-In**	**Recovery Cash Funds**	**Total Cash Funds**
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$20,994	$0	$0	$0	$0	$0	$20,994
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$2,999	$0	$0	$0	$0	$0	$2,999
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$36	$0	$0	$0	$0	$0	$36
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$941	$0	$0	$0	$0	$0	$941
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$941	$0	$0	$0	$0	$0	$941
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$359	$0	$0	$0	$0	$0	$359
G	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$10,416	$0	$0	$7	$0	$0	$10,423
H	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$0	$0	$0	$0	$0	$0	$0
I	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($133,364)	($13,399)	($137)	$0	$2,738,787	$3,358,023	$5,949,910
J	**Total Request**	**($96,678)**	**($13,399)**	**($137)**	**$7**	**$2,738,787**	**$3,358,023**	**$5,986,603**

Table 2.1 FY 2018-19 R-8 Medicaid Savings Initiatives Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP or FMAP	Source/Calculation
A	PAR- FTE Costs	$242,788	2.5	$121,399	$0	$0	$121,389	50%	Table 8.1- FTE
B	PAR- Contractor Costs	$2,010,059	0.0	$502,515	$0	$0	$1,507,544	75%	Table 3.1 Row A
C	PAR- Estimated Service Savings	($2,978,142)	0.0	($1,014,521)	($16,033)	$0	($1,947,588)	varies	Table 3.3 Row A
D	**PAR Total Request**	**($725,295)**	**2.5**	**($390,607)**	**($16,033)**	**$0**	**($318,655)**		Row A + Row B + Row C
E	PARIS- FTE costs	$127,776	1.7	$41,866	$22,022	$0	$63,888	50%	Table 8.1- FTE
F	PARIS- CBMS Changes	$547,878	0.0	$89,359	$47,118	$1,753	$409,648	75%	Table 4.2 Row A, Fund split using HCPF-Only RMS Calculator
G	PARIS- CBMS Print and Mailing Costs	$55,080	0.0	$19,763	$7,684	$138	$27,496	50%	Table 4.3 Row A, Fund split using HCPF-Only RMS Calculator
H	PARIS- Estimated Savings Capitation Payments	($1,745,997)	0.0	($463,603)	($57,641)	$0	($1,224,753)	varies	Table 4.1 Row I
I	**Automate PARIS Interstate Match Total Request**	**($1,015,263)**	**1.7**	**($312,615)**	**$19,183**	**$1,891**	**($723,722)**		Row E + Row F + Row G + Row H
J	Trust Unit Recoveries- FTE costs	$151,426	1.7	$75,716	$0	$0	$75,710	50%	Table 8.1- FTE
K	Trust Unit Recoveries- Estimated Revenue	$0	0.0	($1,399,177)	$2,798,353	$0	($1,399,176)	50%	Table 5.1 Row I
L	**Trust Unit Recoveries Total Request**	**$151,426**	**1.7**	**($1,323,461)**	**$2,798,353**	**$0**	**($1,323,466)**		Row J + Row K
M	Public Transportation Benefits- NEMT Savings	($216,378)	0.0	($108,189)	$0	$0	($108,189)	50%	Table 6.1 Row P
N	Public Transportation Benefits-NMT Savings	($499,573)	0.0	($249,787)	$0	$0	($249,786)	50%	Table 6.4 Row C
O	Public Transportation Benefits-Cost for Vendor/Provider	$150,000	0.0	$75,000	$0	$0	$75,000	50%	Estimate from NEMT broker for Bus Pass Coordinator and administration of additional passes
P	**Public Transportation Benefits Total Request**	**($565,951)**	**0.0**	**($282,976)**	**$0**	**$0**	**($282,975)**		Row M + Row N + Row O
Q	Parental Fee- CBMS Changes	$706,247	0.0	$115,966	$60,737	$2,260	$527,284	75%	Table 7.3 Row C
R	Parental Fee- MMIS Changes	$57,456	0.0	$5,746	$0	$0	$51,710	90%	Table 7.3 Row K
S	Parental Fee - CBMS Printing and Mailing	$0	0.0	$0	$0	$0	$0	53%	N/A
T	Parental Fee- Estimated Fee Collection	$0	0.0	$0	$0	$0	$0	0%	N/A
U	Parental Fee - Fee Collection Offset	$0	0.0	$0	$0	$0	$0	50%	N/A
V	**Parental Fee for Enrollment in Children's Home and Community Based Services Waiver Total Request**	**$763,703**	**0.0**	**$121,712**	**$60,737**	**$2,260**	**$578,994**		Row Q + Row R + Row S + Row T + Row U
W	**Total Request**	**($1,391,380)**	**5.8**	**($2,187,948)**	**$2,862,240**	**$4,151**	**($2,069,824)**		Row D + Row I + Row L + Row P + Row V

Table 2.2 FY 2019-20 R-8 Medicaid Savings Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Fund	Reappropriated Funds	Federal Funds	FFP or FMAP	Source/Calculation
A	PAR- FTE Costs	$279,689	3.0	$139,845	$0	$0	$139,844	50%	Table 8.2- FTE
B	PAR- Contractor Costs	$2,003,849	0.0	$500,963	$0	$0	$1,502,886	75%	Table 3.1 Row B
C	PAR- Estimated Service Savings	($3,094,086)	0.0	($1,054,018)	($16,657)	$0	($2,023,411)	varies	Table 3.3 Row B
D	**PAR Total Request**	**($810,548)**	**3.0**	**($413,210)**	**($16,657)**	**$0**	**($380,681)**		Row A + Row B + Row C
E	PARIS- FTE costs	$138,882	2.0	$43,172	$26,270	$0	$69,440	50%	Table 8.2- FTE
F	PARIS- CBMS Changes	$0	0.0	$0	$0	$0	$0	0%	N/A
G	PARIS- CBMS Print and Mailing Costs	$73,440	0.0	$26,350	$10,245	$184	$36,661		Table 4.3 Row B, Fund split using HCPF-Only RMS Calculator
H	PARIS- Estimated Savings Capitation Payments	($3,102,355)	0.0	($823,748)	($129,687)	$0	($2,148,920)	varied	Table 4.1 Row I
I	**Automate PARIS Interstate Match Total Request**	**($2,890,033)**	**2.0**	**($754,226)**	**($93,172)**	**$184**	**($2,042,818)**		Row E + Row F + Row G + Row H
J	Trust Unit Recoveries- FTE costs	$167,263	2.0	$83,632	$0	$0	$83,632	50%	Table 8.2- FTE
K	Estimated Trust Recovery Revenue	$0	0.0	($1,679,011)	$3,358,023	$0	($1,679,012)	50%	Table 5.1 Row G
L	**Trust Unit Recoveries Total Request**	**$167,263**	**2.0**	**($1,595,380)**	**$3,358,023**	**$0**	**($1,595,381)**		Row J + Row K
M	Public Transportation Benefits- NEMT Savings	($216,378)	0.0	($108,189)	$0		($108,189)	50%	Table 6.1 Row P
N	Public Transportation Benefits-NMT Savings	($749,322)	0.0	($374,661)	$0		($374,661)	50%	Table 6.4 Row E
O	Public Transportation Benefits-Cost for Vendor/Provider	$155,000	0.0	$77,500	$0		$77,500	50%	Estimate from NEMT broker for Bus Pass Coordinator and administration of additional passes
P	**Public Transportation Benefits NMT and NEMT Total Request**	**($810,700)**	**0.0**	**($405,350)**	**$0**	**$0**	**($405,350)**		Row M + Row N + Row O
Q	Parental Fee- CBMS Changes	$206,570	0.0	$33,919	$17,765	$661	$154,225	75%	Table 7.3 Row C
R	Parental Fee- MMIS Changes	$0	0.0	$0	$0	$0	$0	90%	Table 7.3 Row K
S	Parental Fee - CBMS Printing and Mailing	$959	0.0	$344	$134	$2	$479	50%	Table 7.3 Row H
T	Parental Fee- Estimated Fee Collection	$0	0.0	($1,027,045)	$2,054,090	$0	($1,027,045)	50%	Table 7.2 Row C
U	**Implementing a Parental Fee for Enrollment in Children's Home and Community Based Services Waiver Total Request**	**$207,529**	**0.0**	**($992,782)**	**$2,071,989**	**$663**	**($872,341)**		Row Q + Row R + Row S + Row T
V	**Total Request**	**($4,136,489)**	**7.0**	**($4,160,948)**	**$5,320,183**	**$847**	**($5,296,571)**		Row D + Row I + Row L+ Row P + Row U

Table 2.3 FY 2020-21 R-8 Medicaid Savings Initiatives Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Fund	Reappropriated Funds	Federal Funds	FFP or FMAP	Source/Calculation
A	PAR- FTE Costs	$279,689	3.0	$139,845	$0	$0	$139,844		Table 8.2- FTE
B	PAR- Contractor Costs	$1,919,048	0.0	$479,763	$0	$0	$1,439,285		Table 3.1 Row C
C	PAR- Estimated Service Savings	($3,197,270)	0.0	($1,089,168)	($17,213)	$0	($2,090,889)		Table 3.3 Row C
D	**PAR Total Request**	**($998,534)**	**3.0**	**($469,561)**	**($17,213)**	**$0**	**($511,760)**		Row A + Row B + Row C
E	PARIS- FTE costs	$138,882	2.0	$43,172	$26,270	$0	$69,440	50%	Table 8.2- FTE
F	PARIS- CBMS Changes	$0	0.0	$0	$0	$0	$0	0%	N/A
G	PARIS- CBMS Print and Mailing Costs	$73,440	0.0	$26,350	$10,245	$184	$36,661	50%	Table 4.3 Row C, Fund split using HCPF-Only RMS Calculator
H	PARIS- Estimated Savings Capitation Payments	($3,102,355)	0.0	($823,748)	($129,687)	$0	($2,148,920)	varied	Table 4.1 Row I
I	**Automate PARIS Interstate Match Total Request**	**($2,890,033)**	**2.0**	**($754,226)**	**($93,172)**	**$184**	**($2,042,818)**		Row E + Row F + Row G + Row H
J	Trust Unit Recoveries- FTE costs	$167,263	2.0	$83,632	$0	$0	$83,632	50%	Table 8.2- FTE
K	Estimated Trust Recovery Revenue	$0	0.0	($1,679,011)	$3,358,023	$0	($1,679,012)	50%	Table 5.1 Row G
L	**Trust Unit Recoveries Total Request**	**$167,263**	**2.0**	**($1,595,380)**	**$3,358,023**	**$0**	**($1,595,381)**		Row J + Row K
M	Public Transportation Benefits- NEMT Savings	($216,378)	0.0	($108,189)	$0	$0	($108,189)	50%	Table 6.1 Row P
N	Public Transportation Benefits- NMT Savings	($749,322)	0.0	($374,661)	$0	$0	($374,661)	50%	Table 6.4 Row E
O	Public Transportation Benefits-Cost for Vendor/Provider	$155,000	0.0	$77,500	$0	$0	$77,500	50%	Estimate from NEMT broker for Bus Pass Coordinator and administration of additional passes
P	**Public Transportation Benefits NMT and NEMT Total Request**	**($810,700)**	**0.0**	**($405,350)**	**$0**	**$0**	**($405,350)**		Row M + Row N + Row O
Q	Parental Fee- CBMS Changes	$0	0.0	$0	$0	$0	$0	75%	N/A
R	Parental Fee- MMIS Changes	$0	0.0	$0	$0	$0	$0	90%	N/A
S	Parental Fee - CBMS Printing and Mailing	$1,278	0.0	$459	$178	$3	$638	53.05%	Table 7.3 Row H
T	Parental Fee- Estimated Fee Collection	$0	0.0	($1,369,393)	$2,738,787	$0	($1,369,394)	50%	Table 7.2 Row E
U	**Implementing a Parental Fee for Enrollment in Children's Home and Community Based Services Waiver Total Request**	**$1,278**	**0.0**	**($1,368,934)**	**$2,738,965**	**$3**	**($1,368,756)**		Row Q + Row R + Row S + Row T
V	**Total Request**	**($4,530,726)**	**7.0**	**($4,593,450)**	**$5,986,603**	**$187**	**($5,924,065)**		Row D + Row I + Row L + Row P + Row U

Table 2.4 FY 2018-19 R-8 Medicaid Program Savings Initiatives Medical Services Premiums Impacts								
Row	**Label**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	PAR- Estimated Savings	($2,978,142)	0.0	($1,014,521)	($16,033)	$0	($1,947,588)	Table 2.1 Row C
B	PARIS- Estimated Savings	($1,745,997)	0.0	($463,603)	($57,641)	$0	($1,224,753)	Table 2.1 Row H
C	Trust Unit Recoveries- Estimated Revenue	$0	0.0	($1,399,177)	$2,798,353	$0	($1,399,176)	Table 2.1 Row K
D	Discounted Bus Tickets- NEMT Savings	($216,378)	0.0	($108,189)	$0	$0	($108,189)	Table 2.1 Row M
E	Discounted Bus Tickets- NMT Savings	($499,573)	0.0	($249,787)	$0	$0	($249,786)	Table 2.1 Row N
F	Discounted Bus Tickets- Cost for Vendor/Provider	$150,000	0.0	$75,000	$0	$0	$75,000	Table 2.1 Row O
G	CHCBS Parental Fee	$0	0.0	$0	$0	$0	$0	Fee Collection begins 10/1/2019
H	**Total Medical Services Premiums Impact**	**($5,290,090)**	**0.0**	**($3,160,277)**	**$2,724,679**	**$0**	**($4,854,492)**	Row A + Row B + Row C + Row D + Row E + Row F + Row G

Table 2.5 FY 2019-20 R-8 Medicaid Program Savings Initiatives Medical Services Premiums Impacts								
Row	**Label**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	PAR- Estimated Savings	($3,094,086)	0.0	($1,054,018)	($16,657)	$0	($2,023,411)	Table 2.2 Row C
B	PARIS- Estimated Savings	($3,102,355)	0.0	($823,748)	($129,687)	$0	($2,148,920)	Table 2.2 Row H
C	Trust Unit Recoveries- Estimated Revenue	$0	0.0	($1,679,011)	$3,358,023	$0	($1,679,012)	Table 2.2 Row K
D	Discounted Bus Tickets- NEMT Savings	($216,378)	0.0	($108,189)	$0	$0	($108,189)	Table 2.2 Row M
E	Discounted Bus Tickets- NMT Savings	($749,322)	0.0	($374,661)	$0	$0	($374,661)	Table 2.2 Row N
F	Discounted Bus Tickets- Cost for Vendor/Provider	$155,000	0.0	$77,500	$0	$0	$77,500	Table 2.2 Row O
G	CHCBS Parental Fee	$0	0.0	($1,027,045)	$2,054,090	$0	($1,027,045)	Table 2.2 Row T
H	**Total Medical Services Premiums Impact**	**($7,007,141)**	**0.0**	**($4,989,172)**	**$5,265,769**	**$0**	**($7,283,738)**	Row A + Row B + Row C + Row D + Row E + Row F + Row G

Table 2.6 FY 2020-21 R-8 Medicaid Program Savings Initiatives Medical Services Premiums Impacts								
Row	**Label**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	PAR- Estimated Savings	($3,197,270)	0.0	($1,089,168)	($17,213)	$0	($2,090,889)	Table 2.3 Row C
B	PARIS- Estimated Savings	($3,102,355)	0.0	($823,748)	($129,687)	$0	($2,148,920)	Table 2.3 Row H
C	Trust Unit Recoveries- Estimated Revenue	$0	0.0	($1,679,011)	$3,358,023	$0	($1,679,012)	Table 2.3 Row K
D	Discounted Bus Tickets- NEMT Savings	($216,378)	0.0	($108,189)	$0	$0	($108,189)	Table 2.3 Row M
E	Discounted Bus Tickets- NMT Savings	($749,322)	0.0	($374,661)	$0	$0	($374,661)	Table 2.3 Row N
F	Discounted Bus Tickets- Cost for Vendor/Provider	$155,000	0.0	$77,500	$0	$0	$77,500	Table 2.3 Row O
G	CHCBS Parental Fee	$0	0.0	($1,369,393)	$2,738,787	$0	($1,369,394)	Table 2.3 Row R + Row S
H	**Total Medical Services Premiums Impact**	**($7,110,325)**	**0.0**	**($5,366,670)**	**$5,949,910**	**$0**	**($7,693,565)**	Row A + Row B + Row C + Row D + Row E + Row F + Row G

Table 3.1: Estimated Cost of Utilization Management Contract by Fund Splits							
Row	Fiscal Year	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
A	FY 2018-19	$2,010,059	$502,515	$0	$0	$1,507,544	Table 3.2: Row N, FY 2018-19
B	FY 2019-20	$2,003,849	$500,963	$0	$0	$1,502,886	Table 3.2: Row N, FY 2019-20
C	FY 2020-21	$1,919,048	$479,763	$0	$0	$1,439,285	Table 3.2: Row N, FY 2020-21

Table 3.2: Estimated Costs to Utilization Management Contract					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated Additional PARs by Service Category				
B	Cosmetic Surgeries	1,162	1,204	1,247	Table 3.4a: Row A
C	Back Surgeries	2,095	2,170	2,248	Table 3.4b: Row A
D	Outpatient Speech Therapy	19,235	19,918	20,626	Table 3.4c: Row A
E	Oxygen	25,289	26,187	27,117	Table 3.4d: Row A
F	Prosthetics & Orthotics	6,821	7,064	7,315	Table 3.4e: Row A
G	Adult Long Term Home Health	5,117	5,299	Table 1.4 R-8 FY 2	Table 3.4f: Row A
H	Vision	8,327	8,623	8,930	Table 3.4g: Row A
I	**Total Additional PARs**	**68,046**	**70,465**	**67,483**	**Sum of Rows B - H**
J	Additional Contract Cost Per PAR	$22.75	$22.75	$22.75	Estimate from current UM vendor
K	**Total Cost of Additional PAR**	**$1,548,047**	**$1,603,079**	**$1,535,238**	**Row I * Row J**
L	Contractor IT Systems Cost	$75,000	$0	$0	Estimate from current UM Vendor on system capacity updates. One year cost.
M	Flexible Prior Authorization Request (PAR) Fundin	$387,012	$400,770	$383,810	25% increase in Row L to allow for flexibility in designing PAR policies
N	**Total Estimated Cost**	**$2,010,059**	**$2,003,849**	**$1,919,048**	**Row K + Row L + Row M**

Table 3.3: Utilization Management Estimated Savings by Fund Splits						
Row	Fiscal Year	Total Funds	General Fund	Cash Funds	Federal Funds	Source
A	FY 2018-19	($2,978,142)	($1,014,521)	($16,033)	($1,947,588)	Sum of Tables 3.4a-3.4g Row E, FY 2018-19
B	FY 2019-20	($3,094,086)	($1,054,018)	($16,657)	($2,023,411)	Sum of Tables 3.4a-3.4g: Row E, FY 2019-20
C	FY 2020-21	($3,197,270)	($1,089,168)	($17,213)	($2,090,889)	Sum of Tables 3.4a-3.4g: Row E, FY 2020-21

Table 3.4a: Utilization Management Savings Estimate - Cosmetic Surgeries					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	1,162	1,204	1,247	Table 3.5; Row B
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	37	38	40	Row A * Row B
D	Savings Per Unit	($443.62)	($443.62)	($443.62)	Table 3.6; Row B
E	**Total Savings**	**($16,414)**	**($16,858)**	**($17,745)**	**Row C * Row D**

Table 3.4b: Utilization Management Savings Estimate - Back Surgeries					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	2,095	2,170	2,248	Table 3.5; Row C
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	66	69	71	Row A * Row B
D	Savings Per Unit	($14,634.15)	($14,634.15)	($14,634.15)	Table 3.6; Row C
E	**Total Savings**	**($965,854)**	**($1,009,757)**	**($1,039,025)**	**Row C * Row D**

Table 3.4c: Utilization Management Savings Estimate - Outpatient Speech Therapy					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	19,235	19,918	20,626	Table 3.5; Row D
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	604	626	648	Row A * Row B
D	Savings Per Unit	($1,362.01)	($1,362.01)	($1,362.01)	Table 3.6; Row D
E	**Total Savings**	**($822,655)**	**($852,619)**	**($882,583)**	**Row C * Row D**

Table 3.4d: Utilization Management Savings Estimate - Oxygen					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	25,289	26,187	27,117	Table 3.5; Row E
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	795	823	852	Row A * Row B
D	Savings Per Unit	($1,068.31)	($1,068.31)	($1,068.31)	Table 3.6; Row E
E	**Total Savings**	**($849,307)**	**($879,220)**	**($910,201)**	**Row C * Row D**

Table 3.4e: Utilization Management Savings Estimate - Prosthetics & Orthotics					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	6,821	7,064	7,315	Table 3.5; Row F
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	215	222	230	Row A * Row B
D	Savings Per Unit	($364.45)	($364.45)	($364.45)	Table 3.6; Row F
E	**Total Savings**	**($78,357)**	**($80,908)**	**($83,824)**	**Row C * Row D**

Table 3.4f: Utilization Management Savings Estimate - Adult Long-Term Home Health					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	5,117	5,299	5,488	Table 3.5; Row G
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	161	167	173	Row A * Row B
D	Savings Per Unit	($1,407.99)	($1,407.99)	($1,407.99)	Table 3.6; Row G
E	**Total Savings**	**($226,687)**	**($235,135)**	**($243,583)**	**Row C * Row D**

Table 3.4g: Utilization Management Savings Estimate - Vision					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Estimated PAR Requests	8,327	8,623	8,930	Table 3.5; Row H
B	Estimated Percent Decrease in Utilization	3.14%	3.14%	3.14%	Based on Department data on PAR denials
C	Estimated Decrease to PARs	131	136	141	Row A * Row B
D	Savings Per Unit	($144.03)	($144.03)	($144.03)	Table 3.6; Row H
E	**Total Savings**	**($18,868)**	**($19,589)**	**($20,309)**	**Row C * Row D**

Table 3.5: Utilization Management Estimated Number of PARs by Fiscal Year						
Row	**Item**	**Most Recent Data**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
	PAR Growth Rate		13.50%	3.55%	3.55%	From Departments February 2017 Caseload Forecast
A	Units (New PAR Requests)					
B	Surgeries (Cosmetic)	1,023	1,162	1,204	1,247	Department data from CY 2016
C	Surgeries (Back)	1,845	2,095	2,170	2,248	Department data from FY 2016
D	Outpatient Speech Therapy	16,947	19,235	19,918	20,626	Department data from CY 2016
E	Oxygen	23,243	25,289	26,187	27,117	Department data from FY 2017, Q2
F	Prosthetics & Orthotics	6,009	6,821	7,064	7,315	Department data from CY 2016
G	Adult Long Term Home Health	4,508	5,117	5,299	5,488	Department data from CY 2016
H	Vision	7,336	8,327	8,623	8,930	Department data from CY 2016

Table 3.6: Utilization Management Savings Per Unit						
Row	**Item**	**Most Recent Data**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Notes/Source**
A	Savings Per Unit					
B	Surgeries (Cosmetic)	$443.62	$443.62	$443.62	$443.62	Estimated cost per unit based on CY 2016
C	Surgeries (Back)	$14,634.15	$14,634.15	$14,634.15	$14,634.15	Estimated cost per unit based on FY 2016
D	Outpatient Speech Therapy	$1,362.01	$1,362.01	$1,362.01	$1,362.01	Estimated cost per unit based on CY 2016
E	Oxygen	$1,068.31	$1,068.31	$1,068.31	$1,068.31	Estimated cost per unit based on FY 2017, Quarter 2
F	Prosthetics & Orthotics	$364.45	$364.45	$364.45	$364.45	Estimated cost per unit based on CY 2016
G	Adult Long Term Home Health	$1,407.99	$1,407.99	$1,407.99	$1,407.99	Estimated cost per unit based on CY 2016
H	Vision	$144.03	$144.03	$144.03	$144.03	Estimated cost per unit based on CY 2016

Table 4.1 Automate PARIS Interstate Match Estimated Savings				
Row	**Item**	**FY 2018-19**	**FY 2019-20 and ongoing**	**Source/Description**
A	Total Clients on Current PARIS List with Capitation Payments	23,736	23,736	Based on data from quarterly PARIS reports excluding certain clients, as described in the narrative
B	Percent of Clients with No Fee-For-Service Claims	19.78%	19.78%	Approximate percent of clients who are continuously enrolled and do not incur any fee-for-service claims in a year
C	Adjusted total clients	19,041	19,041	Row A - (Row A * Row B)
D	Estimated Growth in PARIS List	8.80%	12.77%	Cumulative caseload growth from FY 2016-17 in Department's February forecast for Medical Services
E	Estimated Number of Clients on PARIS List with Capitation Payments	20,717	21,473	Row C * (1 + Row D)
F	Dental Administrative Service Organization PMPM	$0.54	$0.54	Current contract rate
G	Accountable Care Collaborative PMPM	$11.50	$11.50	Rate specified in the ACC Phase II Request for Proposals
H	Number of Months of Implementation	7	12	Eligibility terminations would occur starting December 2018
I	**Total Estimated Costs Avoided**	**$1,745,997**	**$3,102,355**	**Row E * (Row F + Row G) * Row H**
J	General Fund	$463,603	$823,748	Row I - Row K - Row L
K	Cash Funds	$57,641	$129,687	Based on eligibility of clients in Row C
L	Federal Funds	$1,224,753	$2,148,920	Based on eligibility of clients in Row C

Table 4.2 Automate PARIS FY 2018-19 CBMS Estimate				
Row	**Contractor**	**Hourly Rate**	**Hours**	**FY 2018-19**
A	Deloitte-CBMS	$127	4,314	$547,878

Table 4.3 Automate PARIS CBMS Print and Mail Cost Estimate					
Row	**Fiscal Year**	**Quarterly Number of Pages**	**Number of Quarters**	**Cost Per Page**	**Total Estimated Cost**
A	FY 2018-19	34,000	3	0.54	$55,080
B	FY 2019-20	34,000	4	0.54	$73,440
C	FY 2020-21	34,000	4	0.54	$73,440

Table 5.1 Trust Unit Recoveries Estimated savings			
Row	**Item**	**Value**	**Notes/Calculations**
A	FY 2015-16 Income Trust and Repayments	$6,716,046	FY 2017-18 S-1, Exhibit L
B	Number of current FTE	2.0	Although 1.0 FTE is assigned as a Trust Recovery Specialist, other FTE such as the Trust Officer and other staff also spend part of their time working on Trust recoveries
C	Estimated value of recovery per FTE	$3,358,023	Row A / Row B
D	Assumption of new FTE recovery rate compared to current	50%	Adjustment made due to diminishing returns
E	Estimated annual recoveries per new FTE	$1,679,012	Row C * Row D
F	Number of new FTE	2.0	
G	**Estimated annual total increased recoveries**	**$3,358,023**	**Row E * Row F**
H	Number of months FTE would be employed in FY 2018-19	10	Start date September 1, 2018
I	**Adjusted estimated total recoveries in FY 2018-19**	**$2,798,353**	**Row G * (Row H/12)**

Table 6.1 Public Transportation Benefits for NEMT and NMT Potential NEMT Savings by Type of RTD Trip					
Row	**Item**	**Current**	**With Discount**	**Savings**	**Notes**
A	Access-a-ride (average) round trip cost per client	$7.10	$3.55	$3.55	Average of local and regional access-a-ride
B	Estimated annual number of round trips	17,148	17,148	0	Predicted value based off monthly average from January 2016 through December 2016, due to reclassification from RTD
C	**Estimated Access-A-Ride Expenditure**	**$121,751**	**$60,875**	**($60,876)**	**Row A * Row B**
D	Fixed cost per client	$5.20	$2.60	$2.60	From RTD Fares Website
E	Number of Round Trips	17,460	17,460	0	Predicted value based off monthly average from January 2016 through December 2016, due to reclassification from RTD
F	**Estimated "Fixed" Expenditure**	**$90,792**	**$45,396**	**($45,396)**	**Row D * Row E**
G	Monthly Local Cost Per Client	$99.00	$49.50	$49.50	From RTD Fares Website
H	Number of Round Trips	2,112	2,112	0	Predicted value based off monthly average from January 2016 through December 2016, due to reclassification from RTD
I	**Estimated Local Expenditure**	**$209,088**	**$104,544**	**($104,544)**	**Row G * Row H**
J	Regional Cost Per Client	$9.00	$4.50	$4.50	From RTD Fares Website
K	Number of Round Trips	96	96	0	Predicted value based off monthly average from January 2016 through December 2016, due to reclassification from RTD
L	**Estimated Regional Expenditure**	**$864**	**$432**	**($432)**	**Row J * Row K**
M	Monthly Regional Cost Per Client	$171.00	$85.50	$85.50	From RTD Fares Website
N	Number of Round Trips	60	60	0	Predicted value based off monthly average from January 2016 through December 2016, due to reclassification from RTD
O	**Estimated Regional Monthly Expenditure**	**$10,260**	**$5,130**	**($5,130)**	**Row M * Row N**
P	**Total Estimated Cost/ (Savings)**	**$432,755**	**$216,377**	**($216,378)**	**Row C + Row F + Row I + Row L + Row O**

Table 6.2 Public Transportation Benefits for NEMT and NMT Round Trips by Type								
Row	**Item**	**Access-a-ride**	**Fixed (Local)**	**Monthly Local**	**Regional**	**Monthly Regional**	**Total**	**Notes/Calculations**
A	Total CY 2016 Average Monthly Round Trips	2,198	2,239	271	13	7	4,728	Veyo data: January 2016 through December 2016
B	Percentage of NEMT Trips	46.49%	47.36%	5.73%	0.27%	0.15%	100.00%	Row A / Row A Total
C	Percentage of Trips Eligible for Discount	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	Assumption from FY 2017-18 S-1 Data Percentage of NEMT expenditure attributable to eligible population (OAP-A, OAP-B, AND/AB, and Disabled Buy-In).
D	Estimated Eligible Trips Monthly Round Trips	1,429	1,455	176	8	5	3,073	Row A * Row C
E	Estimated Eligible Trips Annual Round Trips	17,148	17,460	2,112	96	60	36,876	Row C * 12

Table 6.3 Public Transportation Benefits for NEMT and NMT Current NEMT Cost per Round Trip		
Trip Type	**Cost Per Ticket**	**Cost Per Round Trip**
Access-a-ride (average)	$10.73	$10.73
Fixed	$5.20	$5.20
Monthly Local	$99.00	$4.95
Regional	$9.00	$9.00
Monthly Regional	$171.00	$24.43
Average Cost per NEMT RTD Round Trip		**$10.86**

Table 6.4 Public Transportation Benefits for NEMT and NMT Potential Savings for NMT Adjusted for Implementation			
Row	**Item**	**Total**	**Notes**
A	Annual Savings	($749,322)	Table 3.1 Row G
B	Percentage of FY 2018-19 With New Policy	66.67%	October 1, 2018 Implementation
C	**Estimated FY 2018-19 Savings**	**($499,573)**	**Row A * Row B**
D	Percentage of FY 2019-20 With New Policy	100.00%	Full Implementation
E	**Estimated FY 2019-20 and Ongoing Savings**	**($749,322)**	**Row A * Row D**

Table 6.5 Public Transportation Benefits for NEMT and NMT
Potential Savings of Each NMT Service

Row	Item	Taxi	Mobility Van	Mobility Van to and From Adult Day	Total	Notes
A	FY 2015-16 Eligible NMT Units	9,757	19,609	34,164	63,530	Table 6.7 Row C
B	Savings per Unit	($30.26)	($12.79)	($5.95)		Table 6.6 Row C
C	**Potential Savings**	**($295,247)**	**($250,799)**	**($203,276)**	**($749,322)**	**Row A * Row B**

Table 6.6 Public Transportation Benefits for NEMT and NMT
Potential Savings of Each NMT Service

Row	Item	Taxi	Mobility Van	Mobility Van to and From Adult Day	Notes
A	Average FY 2015-16 Cost per Unit	$32.98	$15.51	$8.67	Table 4.4 Row T
B	Discounted Average Cost of RTD One Way Trip	$2.72	$2.72	$2.72	Half of average NEMT RTD one way trip
C	**Potential Savings Per Unit**	**($30.26)**	**($12.79)**	**($5.95)**	**Row A - Row B**

Table 6.7 Public Transportation Benefits for NEMT and NMT
Estimated Eligible Unit per NMT Service

Row	Item	Taxi	Mobility Van	Mobility Van to and From Adult Day	Total	Notes
A	Total Number of Units/Year	75,053	150,835	262,802	488,690	Table 4.4 Row O
B	Percentage of Trips To Be Taken by RTD	13.00%	13.00%	13.00%	13.00%	Flexible Assumption, matches average percentage of NEMT RTD trips
C	**Number of Eligible Units for Discount**	**9,757**	**19,609**	**34,164**	**63,530**	**Row A * Row B**

Table 6.8 Public Transportation Benefits for NEMT and NMT
Average Unit Cost of NMT Service

Row	NMT Service	Taxi	Mobility Van	Mobility Van, To and From Adult Day	Notes
Annual Expenditure per NMT Service					
A	HCBS-SCI	$14,525	N/A	N/A	FY 2015-16 MMIS Claims Data
B	HCBS-BI	$164,642	$28,755	$5,341	FY 2015-16 MMIS Claims Data
C	HCBS-EBD	$1,792,832	$1,892,955	$2,402,292	FY 2015-16 MMIS Claims Data
D	HCBS-CMHS	$479,555	$227,543	$40,936	FY 2015-16 MMIS Claims Data
E	Total Expenditure	$2,451,554	$2,149,253	$2,448,569	Sum Rows A-D
Average Monthly Utilizers					
F	HCBS-SCI	3	N/A	N/A	FY 2015-16 MMIS Claims Data
G	HCBS-BI	17	9	4	FY 2015-16 MMIS Claims Data
H	HCBS-EBD	279	767	1,384	FY 2015-16 MMIS Claims Data
I	HCBS-CMHS	105	155	24	FY 2015-16 MMIS Claims Data
J	Total Clients	404	931	1,412	Sum of Row F through Row I
Total Number of Units per NMT Service					
K	HCBS-SCI	507	N/A	N/A	FY 2015-16 MMIS Claims Data
L	HCBS-BI	4,009	1,484	642	FY 2015-16 MMIS Claims Data
M	HCBS-EBD	53,990	131,484	257,260	FY 2015-16 MMIS Claims Data
N	HCBS-CMHS	16,547	17,867	4,900	FY 2015-16 MMIS Claims Data
O	Total Number of Units	75,053	150,835	262,802	Sum Row F-I
Cost per Unit Per NMT Service					
P	HCBS-SCI	$28.65	N/A	N/A	Row A divided by Row K
Q	HCBS-BI	$41.07	$19.38	$8.32	Row B divided by Row L
R	HCBS-EBD	$33.21	$14.40	$9.34	Row C divided by Row M
S	HCBS-CMHS	$28.98	$12.74	$8.35	Row D divided by Row N
T	Average Cost Per Unit	$32.98	$15.51	$8.67	Average of Rows P through S
Units Per Client Per NMT Service					
U	HCBS-SCI	169	N/A	N/A	Row K divided by Row F
V	HCBS-BI	236	165	161	Row L divided by Row G
W	HCBS-EBD	194	171	186	Row M divided by Row H
X	HCBS-CMHS	158	115	204	Row N divided by Row I
Y	Average Units per Client	189	150	184	Average of Rows U through X

Table 7.1 FY 2018-19 Implementing a Parental Fee into CHCBS Waiver Annual Fee Collection Estimate									
Row	**Item**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**	**Total**	**Notes**
A	Federal Poverty Level (FPL) Lower Limit	0%	276%	401%	526%	651%	900%		Determined in consulation with CHCBS workgroup
B	FPL Upper Limit	275%	400%	525%	650%	899%	N/A		Determined in consulation with CHCBS workgroup
C	Parental Fee	0.00%	2.50%	3.00%	4.00%	5.00%	6.00%		Determined in consulation with CHCBS workgroup
D	Median Household Income of FPL Group	$43,197	$63,303	$86,439	$107,936	$129,426	$210,517		Average median household income of zip codes belonging to each FPL tier
E	Average Yearly Parental Fee Amount	$0	$1,583	$2,593	$4,317	$6,471	$12,631		Row C * Row D
F	Caseload	216	602	419	162	0	0	1,399	FY 2016-17 average monthly CHCBS clients that live in zip codes that fall within designated FPL tier
G	**Potential Parental Fee**	**$0**	**$952,966**	**$1,086,467**	**$699,354**	**$0**	**$0**	**$2,738,787**	**Row E * Row F**

Table 7.2 FY 2018-19 Implementing a Parental Fee into CHCBS Waiver Annual Fee Collection Adjusted for Implementation Dates			
Row	**Item**	**Total**	**Notes**
A	Annual Fee Collection Estimate	$2,738,787	Table 7.1 Row G
B	Percentage of FY 2019-20 With Active Fee	75%	Fee implemented 10/1/2019
C	**Estimated FY 2019-20 Collection**	**$2,054,090**	**Row A * Row B**
D	Percentage of FY 2020-21 With Active Fee	100%	Full Implementation
E	**Estimated FY 2020-21 and ongoing collection**	**$2,738,787**	**Row A * Row D**

Table 7.3 FY 2018-19 Implementing a Parental Fee into CHCBS Waiver System Changes and Printing and Mailing Costs				
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
A	Deloitte - CBMS Hourly Rate	127	130	0
B	Deloitte- CBMS Hours	5,561	1,589	0
C	**Deloitte- CBMS Cost Estimate**	**$706,247**	**$206,570**	**$0**
D	Deloitte- CBMS Printing and Mailing Cost per Letter	$1.08	$1.08	$1.08
E	Monthly Letters	0	1,183	1,183
F	CBMS Annual Printing and Mailing Costs	$0	$1,278	$1,278
G	Percentage of Year with Active Mailing	0.00%	75.00%	100.00%
H	**CBMS Printing and Mailing Costs**	**$0**	**$959**	**$1,278**
I	DXC - MMIS Hourly Rate	$127.68	$130.46	$130.46
J	DXC- MMIS Hours	450	0	0
K	**DXC - MMIS Cost Estimate**	**$57,456**	**$0**	**$0**

Table 8.1 FTE Costs FY 2018-19							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Healthcare Affordability and Sustainability Fee Cash Funds**	**Reappropriated Funds**	**Federal Funds**
A	Personal Services	$392,224	5.8	$180,175	$15,941	$0	$196,108
B	Health, Life and Dental	$55,489	0.0	$25,013	$2,732	$0	$27,744
C	Short-term Disability	$667	0.0	$306	$27	$0	$334
D	SB 04-257 Amortization Equalization Disbursement	$17,574	0.0	$8,074	$714	$0	$8,786
E	SB 06-235 Supplemental Amortization Equalization Disbursement	$17,574	0.0	$8,074	$714	$0	$8,786
F	Operating Expenses	$38,462	0.0	$17,339	$1,894	$0	$19,229
G	**Total**	**$521,990**	**5.8**	**$238,981**	**$22,022**	**$0**	**$260,987**

Table 8.2 FTE Costs FY 2019-20							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
A	Personal Services	$476,033	7.0	$217,022	$20,994	$0	$238,017
B	Health, Life and Dental	$55,489	0.0	$24,746	$2,999	$0	$27,744
C	Short-term Disability	$888	0.0	$408	$36	$0	$444
D	SB 04-257 Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693
E	SB 06-235 Supplemental Amortization Equalization Disbursement	$23,387	0.0	$10,753	$941	$0	$11,693
F	Operating Expenses	$6,650	0.0	$2,966	$359	$0	$3,325
G	**Total**	**$585,834**	**7.0**	**$266,648**	**$26,270**	**$0**	**$292,916**