Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

S06- Access to Medicaid Covered Services
BA06-Access to Medicaid Covered Services

Dept. Approval By: Josh Block 1/4/16 — X — Supplemental FY 2015-16

Change Request FY 2016-17

Base Reduction FY 2016-17

OSPB Approval By: 1/4/16 — X — Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request Amount	FY 2016-17 Base Request	FY 2016-17 Budget Amendment	FY 2017-18 Continuation Amount
Total of All Line Items Impacted by Change Request	Total	$45,563,379	$267,859	$45,208,090	$505,986	$505,986
	FTE	388.0	0.0	391.0	3.0	3.0
	GF	$16,102,370	$133,930	$14,797,975	$252,994	$252,994
	CF	$4,885,629	$0	$4,929,903	$0	$0
	RF	$1,659,187	$0	$1,743,109	$0	$0
	FF	$22,916,193	$133,929	$21,732,406	$252,992	$252,992

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request Amount	FY 2016-17 Base Request	FY 2016-17 Budget Amendment	FY 2017-18 Continuation Amount
01. Executive Director's Office - Personal Services	Total	$28,299,126	$0	$28,894,861	$207,496	$207,496
	FTE	388.0	3.0	391.0	3.0	3.0
	GF	$9,898,385	$0	$10,049,433	$103,748	$103,748
	CF	$2,860,502	$0	$2,936,203	$0	$0
	RF	$1,501,543	$0	$1,564,801	$0	$0
	FF	$14,038,696	$0	$14,344,424	$103,748	$103,748
01. Executive Director's Office - Health, Life, and Dental	Total	$3,139,489	$0	$3,434,070	$23,781	$23,781
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,137,726	$0	$1,230,952	$11,891	$11,891
	CF	$277,707	$0	$337,577	$0	$0
	RF	$88,133	$0	$104,755	$0	$0
	FF	$1,635,923	$0	$1,760,786	$11,890	$11,890

01. Executive Director's Office - Short-term Disability	**Total**	**$61,246**	**$0**	**$55,072**	**$353**	**$353**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$22,736	$0	$20,569	$177	$177
	CF	$4,746	$0	$4,588	$0	$0
	RF	$1,457	$0	$1,393	$0	$0
	FF	$32,307	$0	$28,522	$176	$176
01. Executive Director's Office - Amortization Equalization Disbursement	**Total**	**$1,314,119**	**$0**	**$1,434,489**	**$8,924**	**$8,924**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$488,354	$0	$535,695	$4,462	$4,462
	CF	$101,814	$0	$119,586	$0	$0
	RF	$30,035	$0	$36,269	$0	$0
	FF	$693,916	$0	$742,939	$4,462	$4,462
01. Executive Director's Office - Supplemental Amortization Equalization Disbursement	**Total**	**$1,269,320**	**$0**	**$1,419,546**	**$8,832**	**$8,832**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$472,426	$0	$530,115	$4,416	$4,416
	CF	$98,344	$0	$118,340	$0	$0
	RF	$27,570	$0	$35,891	$0	$0
	FF	$670,980	$0	$735,200	$4,416	$4,416
01. Executive Director's Office - Operating Expenses	**Total**	**$2,128,109**	**$14,109**	**$2,004,697**	**$2,850**	**$2,850**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$965,356	$7,055	$917,251	$1,425	$1,425
	CF	$78,907	$0	$65,869	$0	$0
	RF	$10,449	$0	$10,449	$0	$0
	FF	$1,073,397	$7,054	$1,011,128	$1,425	$1,425
01. Executive Director's Office - General Professional Services and Special Projects	**Total**	**$9,351,970**	**$253,750**	**$7,965,355**	**$253,750**	**$253,750**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,117,387	$126,875	$2,431,211	$126,875	$126,875
	CF	$1,463,609	$0	$1,413,609	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,770,974	$126,875	$4,120,535	$126,875	$126,875

Letternote Text Revision Required? Yes ____ No X **If Yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and CORE Fund Number: FF: Title XIX (1000)

Reappropriated Funds Source, by Department and Line Item Name:
N/A

Approval by OIT? Yes ____ No ____ **Not Required:** X

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Cost and FTE

- The Department requests $267,859 total funds, including $133,930 General Fund for contracted actuarial services in FY 2015-16; and $505,986 total funds, including $252,994 General Fund for contracted actuarial services and 3.0 FTE in FY 2016-17. These resources would be used to meet the requirements of 42 CFR §§ 447.203(b), 447.204 and 447.205 "Methods for Assuring Access to Covered Medicaid Services" which is scheduled to go into effect on January 4, 2016.

Current Program

- Under SB 15-228 "Medicaid Provider Rate Review," the Department is required to submit an annual report that reviews different provider rates on a five year schedule. This annual report includes an analysis of access, service, quality and utilization.
- SB 15-228 established an advisory committee composed of representatives from various stakeholder groups to assist the Department and Joint Budget Committee in approving a rate review schedule, reviewing the annual reports prepared by the Department, conducting public meetings to comment on the annual report, reviewing proposals for provider rates to be reviewed or adjusted, approving out-of-cycle rate reviews, and providing any other needed assistance.
- In order to meet the requirements of SB 15-228, the Department was appropriated 4.0 FTE and $250,000 for actuarial costs.

Problem or Opportunity

- The final rules for "Methods for Assuring Access to Covered Medicaid Services" were issued by the Centers for Medicare and Medicaid Services (CMS) on November 2, 2015 with an effective date of January 4, 2015. This rule requires the Department to develop a robust access monitoring review plan and create a process to evaluate any proposals to reduce or restructure Medicaid payment rates on how they may impact access, and which must involve beneficiaries, providers and other stakeholders. The first access monitoring report is due to CMS on July 1, 2016.
- These additional federal requirements put pressure on existing resources. The Department must provide CMS with five specific provider rate reviews on a three-year cycle, information on beneficiary access and demographics by geographic area, and additional analyses on access to a service whenever the Department submits a State Plan Amendment to reduce or restructure payment.
- In order to implement the Department's proposed R-12 "Medicaid Provider Rate Reductions" in the November 1, 2015 budget request, along with the expected expiration of the temporary primary care provider rate increases, the Department would need to provide an analysis of how these rate reductions impact access to care in the report due to CMS by July 1, 2016.

Consequences of Problem

- If this request is not approved, the Department would attempt to comply with the CMS-issued rules using existing limited resources. If the Department is unable to meet all requirements of the rule, the Department would not be able to implement provider rate reductions as requested, and risks losing federal funding.

Proposed Solution

In order to fully comply with the CMS-issued rules, the Department requests funds for contracted actuarial services and 3.0 FTE.

Department Priority:	***S-6, BA-6***
Request Detail:	***Access to Medicaid Covered Services***

Summary of Incremental Funding Change for FY 2015-16	**Total Funds**	**General Fund**
Access to Care Final Rule and Managed Care Final Rule	$267,859	$133,930

Summary of Incremental Funding Change for FY 2016-17	**Total Funds**	**General Fund**
Access to Care Final Rule and Managed Care Final Rule	$505,986	$252,994

Problem or Opportunity:

The Department needs additional resources in order to comply with new federal regulations, "Methods for Assuring Access to Covered Medicaid Services," issued by the Centers for Medicare and Medicaid Services (CMS) on November 2, 2015. The CMS-issued rules require states to: develop a robust access monitoring review plan; create a process involving beneficiaries, providers, and other stakeholders to evaluate any proposals to reduce or restructure Medicaid payment rates on how they may impact access; and meet specific public notice requirements to inform stakeholders of changes in statewide methods and standards for setting payment rates. Certain requirements of the CMS-issued rules overlap with the scope of SB 15-228 "Medicaid Provider Rate Review," but many are beyond the scope of the bill.

The Department currently does not have enough resources to comply with the CMS-issued rules and needs additional FTE and funds for actuarial services to meet these federal requirements by July 1, 2016 and on an ongoing basis. The rules are effective on January 4, 2016 and the first access monitoring review plan is due to CMS on July 1, 2016. In addition, the Department would need to prepare access plans for all applicable rates as part of the SPAs to reduce rates by July 1, 2016 if R-12 "Medicaid Provider Rate Reductions" is approved. The Department notes that in this timeline, it must also make the access monitoring review plan and the impact assessment for implementation of the FY 2016-17 R-12 "Medicaid Provider Rate Reductions" and the expected expiration of the temporary primary care provider rate increases available for public review and comment for a period of no less than 30 days prior to submission to CMS, further condensing the time available to produce the first deliverables.

Background of New Regulations and SB 15-228

"Methods for Assuring Access to Covered Medicaid Services"

The objective of "Methods for Assuring Access to Covered Medicaid Services" is to ensure that states meet the access requirement of Section 1902(a)(30)(A) in the Social Security Act in a manner that is based on standard processes, methods and procedures. This section instructs states to make provider payments that are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available to the general population in the geographic area." Historically, CMS has had difficulty determining whether states have met this access requirement because of different and inconsistent procedures from state to state. The Department's successful implementation of these rules is critical not only for the sake of federal compliance, but also supports the Department's mission of improving health care access and outcomes of its clients.

SB 15-228 "Medicaid Provider Rate Review"

SB 15-228 established a process of conducting regular rate reviews of services funded by the Department and contains some overlap with the CMS-issued rules. The Department was appropriated resources as part of SB 15-228, including 4.0 FTE and $250,000 for actuarial services. With those resources, the Department is required to furnish annual provider rate review reports that compare Medicaid reimbursement rates to those of Medicare and private insurance on a five-year schedule[1] with the first report due on May 1, 2016; subsequent reports are due on May 1 of each year. This annual report includes an analysis of access, service, quality and utilization. SB 15-228 also established an advisory committee that consists of representatives from beneficiary, provider and stakeholder groups to assist the Department and Joint Budget Committee in approving a rate review schedule, reviewing the annual reports prepared by the Department, conducting public meetings to comment on the annual report, reviewing proposals for provider rates to be reviewed or adjusted, approving out-of-cycle rate reviews, and providing any other needed assistance. After taking into account the advisory committee's feedback on the provider rate review report, the Department must submit to the Joint Budget Committee a recommendation report on all of the provider rates reviewed by November 1st of each year.

Differences between New Regulations and SB 15-228

The new federal regulations and SB 15-228 overlap in their requirements for the Department to evaluate Medicaid payment rates against those of benchmarks such as Medicare and private health insurance. However, the requirements of the federal regulations and the access monitoring review plan involve the following components that are absent from or are more extensive than SB 15-228. The Department cannot absorb the additional work associated with these requirements with existing resources.

Beneficiary Access by Geographic Area

Paragraph 447.203(b) requires the State's annual report to describe the characteristics of the beneficiary population, particularly the access needs within geographic areas; determine based on the analysis the extent to which beneficiary needs are met; describe changes in beneficiary utilization by geographic area; and report

[1] "Medicaid Provider Rate Review Schedule." *Department of Health Care Policy and Financing.* https://www.colorado.gov/pacific/sites/default/files/Medicaid%20Provider%20Rate%20Review%20Schedule%20FINAL%20October%202015.pdf

provider and beneficiary feedback mechanisms. These beneficiary analyses are outside the scope of SB 15-228.

Three-Year Provider Rate Review Cycle

Paragraph 447.203(b)(5) requires the Department to review specific provider rates on a different cycle from SB 15-228. Separate data analyses must be conducted every three years for five recurring services types: primary care services, physician specialist services, behavioral health services, pre- and post-natal obstetric services, and home health services. The provider rate reviews under these two regulations would not necessarily overlap under the current Medicaid Provider Rate Annual Review Schedule[2] proposed by the Department and the SB 15-228 advisory committee, particularly as the CMS-mandated rate reviews are required more frequently on a three-year timeline. Furthermore, SB 15-228 did not require analyses of behavioral health, pre- and post-natal obstetric services and certain physician specialist services. The new rules require a much broader scope of rate reviews to be completed in a more condensed timeframe.

Provider Rates for Services Receiving Access Complaints

The Department must conduct separate data analyses for services for which the Department or CMS has received a significantly higher volume of access complaints, or any services that are subject to a proposed provider rate review or restructuring.

Assessment of Access to Care with State Plan Amendment

Prior to submitting a State Plan Amendment (SPA), the Department must consider data and analysis performed as part of the access monitoring review plan, input from stakeholders on access to affected services as a result of the rate change, and maintain a record of the volume of input and the nature of the feedback received. When the Department decides to submit a SPA to restructure or reduce a rate, it must also include with the SPA an assessment of how access to care would be affected, analysis of feedback from stakeholders, and the most recent access review monitoring plan for the affected services. Furthermore, the Department must annually monitor that access to the service associated with that particular rate is sufficient for at least three years following the new rate's effective date.

The Department requested a 1% across-the-board rate reduction in FY 2016-17 R-12, "Medicaid Provider Rate Reductions," which would be effective July 1, 2016 if approved. Based on the new rules, the Department would need the access to care assessments completed and submitted to CMS with the rate reduction SPAs prior to July 1. Otherwise, the Department assumes that CMS would deny the SPAs and the Department would be unable to implement the reductions. Since the rate reductions would be applied across the board, the Department would need to complete the assessment for all provider rates. The assessment would need to be completed by mid-May in order to allow for enough time to present the information to the public as part of the public noticing requirements.

Addressing Access Questions and Remediation of Inadequate Access to Care

Under paragraph 447.203(b)(8), the State must submit a corrective plan within 90 days of identifying access issues, and specific steps and timelines to address the issues. The remediation of deficiencies should be

[2] Ibid

within 12 months. The Department currently does not have a procedure on such a timeline to address access issues.

Proposed Solution:

The Department requests $267,859 total funds, including $133,930 General Fund in FY 2015-16 and $505,986 total funds, including $252,994 General Fund and 3.0 FTE in FY 2016-17 in order to comply with the final rule for "Methods for Assuring Access to Covered Medicaid Services" issued by CMS that will go into effect on January 4, 2016. These resources would be used in collaboration with the ongoing efforts of the FTE allocated under SB 15-228. The requested funding would be used to hire: 1.0 FTE to manage beneficiary and provider input processes and analysis, and to work in collaboration with the Rate Review Stakeholder Relations Specialist hired under SB 15-228; 1.0 FTE to assist with the rate benchmarking analysis outside the scope of SB 15-228; and 1.0 FTE to develop more robust methodologies to measure access to care. In addition, the request includes funding to increase the scope of the Department's actuary contract to assist the Department in performing the extensive analyses required under the new federal regulation.

Anticipated Outcomes:

If this request is approved, the Department would be able to commit resources to implementing the CMS-issued rules. This would enable the Department to comply with the CMS-issued rules more quickly, submit sufficient analyses for approval on any SPAs related to rate reductions or methodology changes, such as for the 1% across-the-board reductions requested in FY 2016-17 R-12 "Medicaid Provider Rate Reductions," and the expiration of the temporary primary care physician rate increases, and prevent a risk of losing federal funding for Medicaid programs.

Much of "Methods for Assuring Access to Covered Medicaid Services" also aligns with the Department's goals of improving health outcomes, client experience and lower per capita costs, sustaining effective external relationships, enhancing efficiency and effectiveness through process improvement, and ensuring the sound stewardship of financial resources.

Assumptions and Calculations:

The requirements of the federal regulations are above and beyond those of SB 15-228 and necessitate additional resources. Among those requirements include: creating and updating the access monitoring plan that includes an analysis of the five services requested by CMS by geographic region; analyses and remediation plans for services receiving a high number of access complaints; and continued three-year monitoring of access for any services that experience a reduction in payment rates. The requested resources would be utilized in conjunction with existing resources, including those allocated under SB 15-228, to the fullest extent possible.

<u>Additional Resources Needed to Comply with Regulations</u>

Actuarial Services

The Department assumes that it would need $253,750 total funds for FY 2015-16 to fund an additional 1,250 hours of actuarial services, at a rate of $203 per hour, to meet the requirements of the federal regulation on a condensed timeline. This estimate is based on the amount spent on actuarial services for a similar range of

work done in response to the FY 2015-16 Legislative Requests for Information #1. The actuary would assist the Department with creating the benchmarking tools that compare Medicaid rates to those of Medicare and private payers for five core services, which include primary care, physician specialist, behavioral health, pre- and post-natal obstetric, and home health services, as well as the provider categories that would be affected by the FY 2016-17 R-12 "Medicaid Provider Rate Reduction" request in order to submit the rate reduction SPAs in time for a July 1, 2016 effective date.

For FY 2016-17, the Department assumes that it would need $253,750 to fund 1,250 hours of actuarial services to meet the ongoing requirements of "Methods for Assuring Access to Covered Medicaid Services." The actuary would be responsible for updating the data used in benchmarking tools that compare Medicaid rates to those of Medicare and private payers for the services affected by the 1% "Medicaid Provider Rate Reduction" request, as well as any additional services that receive a large number of access complaints or are subject to a proposed rate reduction in future SPAs. The actuary would also assist in updating the data used in benchmarking tools for the access review plan, which is due to CMS every three years for the five core services.

The benchmarking exercise is an intense and complex process that requires comparing data from many sources including those of other public payers, such as other State Medicaid systems and Medicare, and those of private health insurers. Obtaining a vendor that has existing experience performing similar functions for the Department and other entities is necessary to complete the work in the timeframe required to achieve regulatory compliance, and would add significant value to the project. Part of the complex nature of the benchmarking exercise is due to the fact that utilization data lags behind current rate schedules (and sometimes rate methodologies); as such, the data must be repriced and transformed before the rates can even be compared. Oftentimes, the documentation of the other payment sources is not sufficient to determine if the rate structure is in fact similar to that of the Department, and therefore, research must be done on the data to ensure that the rates are comparable. Both of these functions are examples of how prior experience with several payment systems is beneficial. Lastly, the majority of the benchmarking exercise takes place during about a six-month time period; it is advantageous to hire an experienced contractor that can concentrate resources during this period, rather than to higher multiple temporary Department staff that would require training before being fully able to contribute due to the sophisticated data analysis required.

FTE

Additional FTE are needed to implement the requirements of the Access rules. These FTE would work collaboratively with the FTE appropriated under SB 15-228. The Department assumes that the FTE would be hired on June 1, 2016,[3] in order to start working on implementing the rule as soon as possible after the supplemental bill is signed. Until then, the Department is temporarily reassigning staff, including those allocated under SB 15-228, as well as hiring a temporary employee within existing resources to focus on complying with the federal regulations. The Department views this as an unsustainable arrangement and would need additional staff on an ongoing basis, particularly so that these temporarily reassigned staff may

[3] The Department notes that as a result of the pay-date shift, most of the costs associated with these FTE would begin in FY 2016-17.

refocus on their existing job functions, including fulfilling the requirements of SB 15-228. The requested FTE would be responsible for the activities listed below.

Client Access Specialist FTE

1.0 FTE would be hired at a General Professional IV level to manage beneficiary and provider input processes and analysis. This position would work collaboratively with program staff and benefit managers to develop and deploy access to care monitoring mechanisms; develop new processes tracking and trending customer service center and appeals data at the Department as well as at the county, Regional Care Collaborative Organization (RCCO) and Behavioral Health Organization (BHO) levels; manage processes to gather and analyze provider feedback; and develop methods, design strategies and standards for access monitoring in the case of remediation or corrective actions from the new federal regulation. The FTE would work jointly with the Rate Review Stakeholder Relations Specialist appropriated under SB 15-228 in soliciting beneficiary and provider feedback through the SB 15-228 advisory committee. This position would be involved in the ongoing access monitoring requirements including: incorporating beneficiary and provider input on access to care; coordinating with the Rate Benchmarking and Access Data Analysts to update the access monitoring review plan; and leading any remediation efforts if insufficient provider access is discovered.

1.0 Rate Benchmarking Analyst FTE

1.0 FTE would be hired at the Rate/Financial Analyst III level to assist with the rate benchmarking analysis required under the federal regulation. The regulation requires that Medicaid rates are compared against those of other public and private health insurance by geographic region. This position would be responsible for obtaining, compiling and validating the data to be used by the actuarial contractor; designing the rate methodology review necessary for benchmarking; coordinating with the actuarial contractor and reviewing the contractor's analysis; extrapolating the contractor's analysis to determine fiscal impact; and coordinating with the Client Access Specialist and Access Data Analyst in updating the access monitoring review plan. This position would be needed on an ongoing basis to perform the aforementioned tasks as the benchmarking exercise must be performed every three-years for the five CMS-requested services, as well as for any services subject to a proposed rate reduction.

1.0 Access Data Analyst FTE

1.0 FTE would be hired at the Statistical Analyst III level to develop a methodology around using data to monitor access to care, including measuring how beneficiary needs are being met and the availability of providers and care by geographic region. This analyst would use the designed methodology to analyze and predict the impact of proposed rate changes on access to care in conjunction with the Rate Benchmarking Analyst. Upon the adoption of any rate decreases, the Access Data Analyst would also be involved in monitoring access to care for affected services over the minimum three year period. The position would collaborate with the Client Access Specialist and Rate Benchmarking Analyst to update the access monitoring review plan every three years.

Existing Resources for Input Requirements

The Department assumes that some existing resources, including those from SB 15-228, could be employed for the beneficiary and provider input requirements of the CMS-issued rules. Under §447.203(b)(2), the Department must consider relevant provider and beneficiary input and information, including information obtained through the public rate-setting process, medical advisory committees established under 42 CFR

431.12, and other provider and beneficiary feedback mechanisms. Under §447.203(b)(7), the State must have ongoing mechanisms for beneficiary and provider input such as hotlines, surveys, ombudsman, or a process of review of grievances and appeals. It must respond to input with appropriate investigation, analysis and response, and maintain a record of input and the nature of the State's response. The Department assumes the advisory committee formed under SB 15-228 could serve as an ongoing mechanism for beneficiary and provider input. At this time, the advisory committee has agreed to meet on a bimonthly basis and stakeholder feedback is tracked during meetings. Additionally, the Department assumes it could review beneficiary and provider grievances and appeals through existing mechanisms such as the contracted ombudsman.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

This request is being made as a result of new information. The final rule for "Methods for Assuring Access to Covered Medicaid Services" was issued by CMS on November 2, 2015.

Access to Medicaid Covered Services

Table 1.1 - FY 2015-16 Estimated Costs

Row	Item	Total Funds	FTE	General Fund	Federal Funds	Source / Notes
A	Personal Services	$0	0.0	$0	$0	Table 2: FTE for Access to Medicaid Covered Services
B	Health, Life, and Dental	$0	0.0	$0	$0	Table 2: FTE for Access to Medicaid Covered Services
C	Amortization Equalization Disbursement	$0	0.0	$0	$0	Table 2: FTE for Access to Medicaid Covered Services
D	Supplemental Amortization Equalization Disbursement	$0	0.0	$0	$0	Table 2: FTE for Access to Medicaid Covered Services
E	Short Term Disability	$0	0.0	$0	$0	Table 2: FTE for Access to Medicaid Covered Services
F	Operating Expenses	$14,109	0.0	$7,055	$7,054	Table 2: FTE for Access to Medicaid Covered Services
G	Additional Actuarial Costs	$253,750	0.0	$126,875	$126,875	Based on prior contracts of similar scope. Assumed 1,250 hours billed at $203/hour.
H	**Total Costs**	**$267,859**	**0.0**	**$133,930**	**$133,929**	

Table 1.2 - FY 2016-17 Estimated Costs

Row	Item	Total Funds	FTE	General Fund	Federal Funds	Source / Notes
A	FTE Costs	$207,496	3.0	$103,748	$103,748	Table 2: FTE for Access to Medicaid Covered Services
B	Health, Life, and Dental	$23,781	0.0	$11,891	$11,890	Table 2: FTE for Access to Medicaid Covered Services
C	Amortization Equalization Disbursement	$8,924	0.0	$4,462	$4,462	Table 2: FTE for Access to Medicaid Covered Services
D	Supplemental Amortization Equalization Disbursement	$8,832	0.0	$4,416	$4,416	Table 2: FTE for Access to Medicaid Covered Services
E	Short Term Disability	$353	0.0	$177	$176	Table 2: FTE for Access to Medicaid Covered Services
F	Operating Expenses	$2,850	0.0	$1,425	$1,425	Table 2: FTE for Access to Medicaid Covered Services
G	Additional Actuarial Costs	$253,750	0.0	$126,875	$126,875	Based on prior contracts of similar scope. Assumed 1,250 hours billed at $203/hour.
H	**Total Costs**	**$505,986**	**3.0**	**$252,994**	**$252,992**	

Table 1.3 - FY 2017-18 Estimated Costs

Row	Item	Total Funds	FTE	General Fund	Federal Funds	Source / Notes
A	FTE Costs	$207,496	3.0	$103,748	$103,748	Table 1.2, Row A
B	Health, Life, and Dental	$23,781	0.0	$11,891	$11,890	Table 1.2, Row B
C	Amortization Equalization Disbursement	$8,924	0.0	$4,462	$4,462	Table 1.2, Row C
D	Supplemental Amortization Equalization Disbursement	$8,832	0.0	$4,416	$4,416	Table 1.2, Row D
E	Short Term Disability	$353	0.0	$177	$176	Table 1.2, Row E
F	Operating Expenses	$2,850	0.0	$1,425	$1,425	Table 1.2, Row F
G	Additional Actuarial Costs	$253,750	0.0	$126,875	$126,875	Based on prior contracts of similar scope. Assumed 1,250 hours billed at $203/hour.
H	**Total Costs**	**$505,986**	**3.0**	**$252,994**	**$252,992**	

FTE Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

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

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

Expenditure Detail		FY 2015-16		FY 2016-17	
Personal Services:					
Classification Title	Monthly	FTE		FTE	
STATISTICAL ANALYST III	$5,372	-	$0	1.0	$64,464
PERA			$0		$6,543
AED			$0		$3,094
SAED			$0		$3,062
Medicare			$0		$935
STD			$0		$122
Health-Life-Dental			$0		$7,927
Subtotal Position 1, 1.0 FTE		-	**$0**	**1.0**	**$86,147**
Classification Title	Monthly	FTE		FTE	
RATE/FINANCIAL ANLYST III	$5,215	-	$0	1.0	$62,580
PERA			$0		$6,352
AED			$0		$3,004
SAED			$0		$2,973
Medicare			$0		$907
STD			$0		$119
Health-Life-Dental			$0		$7,927
Subtotal Position 2, 1.0 FTE		-	**$0**	**1.0**	**$83,862**
Classification Title	Monthly	FTE		FTE	
GENERAL PROFESSIONAL IV	$4,907	-	$0	1.0	$58,884
PERA			$0		$5,977
AED			$0		$2,826
SAED			$0		$2,797
Medicare			$0		$854
STD			$0		$112
Health-Life-Dental			$0		$7,927
Subtotal Position 3, 1.0 FTE		-	**$0**	**1.0**	**$79,377**
Subtotal Personal Services		-	**$0**	3.0	**$249,386**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	0.0	$0	3.0	$1,500
Telephone Expenses	$450	0.0	$0	3.0	$1,350
PC, One-Time	$1,230	3.0	$3,690	-	
Office Furniture, One-Time	$3,473	3.0	$10,419	-	
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$14,109**		**$2,850**
TOTAL REQUEST		-	**$14,109**	3.0	**$252,236**
	General Fund:		*$7,055*		*$126,119*
	Cash funds:		*$0*		*$0*
	Reappropriated Funds:		*$0*		*$0*
	Federal Funds:		*$7,054*		*$126,117*