Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title	**S07- Compliance with Proposed Managed Care Regulations** **BA07-Compliance with Proposed Managed Care Regulations**
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	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**	**$57,445,363**	**$18,812**	**$56,887,218**	**$722,809**	**$722,809**
	FTE	388.0	0.0	391.0	4.0	4.0
	GF	$19,286,118	$9,406	$18,860,760	$361,405	$361,405
	CF	$5,346,718	$0	$5,456,861	$0	$0
	RF	$1,659,187	$0	$1,753,558	$0	$0
	FF	$31,153,340	$9,406	$30,816,039	$361,404	$361,404

Line Item Information	Fund	FY 2015-16 Initial Appropriation	FY 2015-16 Supplemental Request	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**	**$262,858**	**$262,858**
	FTE	388.0	4.0	391.0	4.0	4.0
	GF	$9,898,385	$0	$10,049,433	$131,429	$131,429
	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	$131,429	$131,429
01. Executive Director's Office - Health, Life, and Dental	**Total**	**$3,139,489**	**$0**	**$3,434,070**	**$31,709**	**$31,709**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,137,726	$0	$1,230,952	$15,855	$15,855
	CF	$277,707	$0	$337,577	$0	$0
	RF	$88,133	$0	$104,755	$0	$0
	FF	$1,635,923	$0	$1,760,786	$15,854	$15,854

01. Executive Director's Office - Short-term Disability	**Total**	**$61,246**	**$0**	**$55,072**	**$448**	**$448**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$22,736	$0	$20,569	$224	$224
	CF	$4,746	$0	$4,588	$0	$0
	RF	$1,457	$0	$1,393	$0	$0
	FF	$32,307	$0	$28,522	$224	$224
01. Executive Director's Office - Amortization Equalization Disbursement	**Total**	**$1,314,119**	**$0**	**$1,434,489**	**$11,306**	**$11,306**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$488,354	$0	$535,695	$5,653	$5,653
	CF	$101,814	$0	$119,586	$0	$0
	RF	$30,035	$0	$36,269	$0	$0
	FF	$693,916	$0	$742,939	$5,653	$5,653
01. Executive Director's Office - Supplemental Amortization Equalization Disbursement	**Total**	**$1,269,320**	**$0**	**$1,419,546**	**$11,188**	**$11,188**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$472,426	$0	$530,115	$5,594	$5,594
	CF	$98,344	$0	$118,340	$0	$0
	RF	$27,570	$0	$35,891	$0	$0
	FF	$670,980	$0	$735,200	$5,594	$5,594
01. Executive Director's Office - Operating Expenses	**Total**	**$2,128,109**	**$18,812**	**$2,004,697**	**$3,800**	**$3,800**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$965,356	$9,406	$917,251	$1,900	$1,900
	CF	$78,907	$0	$65,869	$0	$0
	RF	$10,449	$0	$10,449	$0	$0
	FF	$1,073,397	$9,406	$1,011,128	$1,900	$1,900
01. Executive Director's Office - General Professional Services and Special Projects	**Total**	**$9,351,970**	**$0**	**$7,965,355**	**$101,500**	**$101,500**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,117,387	$0	$2,431,211	$50,750	$50,750
	CF	$1,463,609	$0	$1,413,609	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,770,974	$0	$4,120,535	$50,750	$50,750
01. Executive Director's Office - Professional Service Contracts	**Total**	**$11,881,984**	**$0**	**$11,679,128**	**$300,000**	**$300,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,183,748	$0	$3,145,534	$150,000	$150,000
	CF	$461,089	$0	$461,089	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$8,237,147	$0	$8,072,505	$150,000	$150,000

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 $18,812 total funds, including $9,406 General Fund in FY 2015-16, and $722,809 total funds, including $361,404 General Fund in FY 2016-17 and ongoing in order to hire four FTE to lead and manage the rule overhaul, as proposed by the Centers for Medicare and Medicaid Services (CMS), to all of the Department's managed care plans and to expand the scope of its actuary and quality review contracts to assist the Department with implementation.

Current Program

- The Department currently has several contracts with multiple entities to provide managed care services to Medicaid and Child Health Plan Plus (CHP+) clients.
- Managed care programs are administered under separate federal regulations, which were last significantly revised in 2002.

Problem or Opportunity

- CMS issued proposed rules in June 2015 for a significant overhaul to regulations pertaining to managed care programs. Although these regulations are not yet final, the Department expects that CMS will only provide 60 days from the notice of final rule making before the regulations are effective.
- Due to the scope of the proposed changes, the Department would be unable to absorb the workload required to implement the regulations with existing resources.

Consequences of Problem

- If the Department is unable to implement the new regulations by the required timeframe, the Department risks being out of federal compliance for its managed care programs, jeopardizing federal financial participation for managed care services. In FY 2014-15, the Department paid nearly $1 billion for managed care contracts.
- If additional resources are not appropriated, the Department may be unable to take the necessary steps once the regulation is finalized that must be taken to implement any rule changes by the required timeframes.

Proposed Solution

- The Department requests to hire 4.0 FTE by June 1, 2016 in order to interpret and implement all new proposed changes to managed care rules. The new staff would be tasked with understanding the complexities of the proposed rules so that implementation would be seamless and bring the Department into compliance upon the required effective date.
- The Department also requests funding to expand the scope of its actuary and quality review contracts to assist the Department with implementing the proposed changes.

Department Priority:	***S-7, BA-7***
Request Detail:	***Compliance with Proposed Federal Managed Care Regulations***

Summary of Incremental Funding Change for FY 2015-16	**Total Funds**	**General Fund**
Compliance with Proposed Federal Managed Care Regulations	$18,812	$9,406

Summary of Incremental Funding Change for FY 2016-17 and Ongoing	**Total Funds**	**General Fund**
Compliance with Proposed Federal Managed Care Regulations	$722,809	$361,405

Problem or Opportunity:

On June 1, 2015, the Centers for Medicare and Medicaid Services (CMS) issued a proposal to modernize Medicaid and Children's Health Insurance Program (CHIP) managed care regulations to update the programs' rules and strengthen the delivery of quality care for beneficiaries. The goal of the modernization is to better align managed care rules with other sources of health insurance coverage. This proposal significantly overhauls managed care regulations, and the Department does not have the resources to properly understand, implement, and monitor the extensive changes needed to come into compliance with the regulations without reducing oversight of other programs.

The changes significantly expand the scope of the state's quality strategy, with new standards for measurement and public input. There are new standards and requirements around rate-setting and data management and reporting, which would drive considerable work for some of the Department's external vendors. Programmatically, the proposed rule adds additional requirements for contractual and operational standards, which will need to be the sole focus of dedicated FTE.

The effective date has yet to be announced, but the Department expects that once the final rule is announced, compliance would need to be achieved within 60 days, as has been the case with other regulations[1]. At this time, CMS has not offered official guidance on whether all changes would need to be implemented

[1] Including the final regulations for "Methods for Assuring Access to Covered Medicaid Services". See 80 FR 67575 (http://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf).

immediately or if states will be able to adopt the rules over time. Given the scope of the changes, the Department must begin working on implementing them as soon as possible in order to be able to come into compliance when required.

These proposed rules represent a significant change to 42 CFR Parts 431, 433, 438, 440, 457, and 495, which directly impacts the Department's managed care contracts, as outlined in the Federal Register, Volume 80; Number 104[2]. Some of the major changes that would need to be implemented under the proposed rules are described in detail below. The Department cannot implement the extensive changes within existing resources.

State Comprehensive Quality Strategy

42 CFR §§ 431.502-504 "State Comprehensive Quality Strategy" creates new requirements around developing and maintaining a comprehensive quality strategy for all of the Department's programs. The Department's current quality strategy does not adequately meet the needs of the new rules. Current rule requires a written strategy for assessing and improving care for services offered through a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), and Prepaid Ambulatory Health Plans (PAHPs). The proposed rule extends this to a comprehensive quality strategy for all state Medicaid programs, including all managed care and fee-for-service programs.[3] This change represents a significant increase to the Department's workload. Incorporating the current quality strategies for MCOs and PIHPs into a comprehensive strategy would take extensive planning and developing to meet CMS requirements.

The proposed rule establishes parameters the Department must follow when developing a comprehensive quality strategy. The quality strategy must include goals and objectives for continuous quality improvement, which must be measureable. Specific metrics and performance targets that the Department plans to use must link back to the goals and objectives mentioned above. These metrics must be published annually on the Department's website. The Department must obtain public input on the development of a quality strategy, and must include input from the State Medical Care Advisory Committee and tribes (through tribal consultation).

42 CFR § 438.334 "Availability of Services, Assurances of Adequate Capacity and Services, and Network Adequacy Standards" details some of the requirements of the rating system used in the comprehensive quality strategy and specifies that it must be implemented and maintained annually. This is a new federal requirement.

Actuarially Sound Capitation Rates for Medicaid Managed Care Programs

42 CFR § 438.400 "Actuarially Sound Capitation Rates for Medicaid Managed Care Programs" develops a framework for rate-setting and establishes standards for the development of capitation rates. Each capitation rate must be actuarially sound. Currently, the Department sets rates for many of its managed care contracts within an actuarially sound rate range rather than certifying individual rates. For example, in the Department's nearly $670 million behavioral health contract, the actuary certifies rates within a specific range rather than an exact rate. With the new regulations, an actuarially certified rate would be required for

[2] Ibid.
[3] 42 CFR 431, subpart I.

each rating cohort for each behavioral health organization (BHO) as opposed to a wider range of rates from which the Department can choose. The analysis currently required is not as extensive as would be needed if individual rates needed to be certified.

Encounter Data and Health Information Systems
42 CFR § 438.500 "Encounter Data and Health Information Systems" details new standards for submission and maintenance of encounters submitted by managed care plans for enrollees. All managed care encounter data would need to be audited for accuracy, completeness, and timeliness. The proposed rule specifically states that "federal matching payments would not be available for states that do not meet the established data submission benchmarks for accuracy, completeness, and timeliness". As a result of these changes, Department staff would need to amend all of the current managed care contracts for these audit provisions and routinely monitor them to ensure they remain in federal compliance. In current rule, encounter data submissions are not required to meet these standards.

Medical Loss Ratio
42 CFR § 438.800 "Medical Loss Ratio" establishes a standard Medical Loss Ratio (MLR) among all managed care entities and outlines the methodology for calculating it. Prior rule did not require managed care contracts to maintain a specific MLR. The Department would need to incorporate the newly defined MLR in its managed care contracts and ensure it is consistently applied among the managed care entities. This additional requirement will drive work for both the program management specialists and the Department's actuary. The program staff will need to monitor the contracts to ensure the defined MLR is achieved, and if not, work with appropriate entities to plan on how to achieve compliance. The Department's actuary would need to validate the MLR and incorporate it into future rate setting cycles, adding a new element to the Department's rate setting process. Failure to monitor and meet the minimum requirements would jeopardize the Department's ability to receive federal funds for its managed care programs.

Additional Requirements in the Proposed Rules
The requirements outlined above are intended to describe the nature of the changes for specific examples, but do not represent the full scope of changes that will drive additional work for the Department. Many of the additional requirements are outlined below.

For quality strategy, the proposed rule includes the addition of a fourth mandatory external quality review (EQR) activity to validate MCO and PIHP network adequacy during the preceding 12 months. This activity would need to be conducted for each MCO and PIHP[4]. Another change is the expansion of technical reporting requirements, including a requirement for the EQR technical report to include performance information related to mandatory activities and related recommendations, where previously just validation was required. The annual technical reports are due no later than April 30th of each year and must address data collected in the previous 15 months[5]. State assessments for performance must now include primary care case management (PCCM) entities and must be included in the comprehensive quality strategy, and contracts

[4] 42 CFR § 438.358(b)(4), 80 FR 31281
[5] 42 CFR § 438.364(a) and (b), 80 FR 31282-31283

with PCCMs must be submitted to CMS[6]. States must review and approve managed care plans once every three years using stringent standards similar to those used by accrediting organizations[7].

The rule also includes new standards around client and provider materials. The state will be required to operate a website with an updated list of documents, all of which must be ADA compliant, which include but are not limited to provider directories, member handbooks, appeal and grievance notices, and other notices critical to obtaining services[8]. There are new minimum standards to enrollee handbooks and provider directories, all of which must be updated and maintained by the Department.

The Department will also be charged with a number of new requirements relating to program integrity. All ordering and referring physicians must be enrolled as participating providers leading to additional screening, which includes PCCMs and PCCM entities[9]. The Department will be required to review ownership and control disclosures submitted by MCOs, PIHPs, and PCCM entities and any subcontractors and conduct federal database checks to determine exclusion status[10]. The Department will also be required to receive and investigate information from whistleblowers[11].

Proposed Solution:

The Department requests $18,812 total funds in FY 2015-16 and $722,809 total funds and 4.0 FTE in FY 2016-17 and ongoing in order to understand, implement, and monitor the new managed care regulations and how they impact all of the Department's managed care contracts when the proposed rule becomes final. This funding would be used to hire: 2.0 FTE to assist with policy coordination and implementation as well as support for contract writing and amending, and reviewing all materials to ensure they meet the new standards; 1.0 FTE to assist with auditing and oversight of the managed care plans for compliance with the new regulations and detection of fraud, waste, and abuse; and 1.0 FTE to assist with changes in quality measure alignment and quality vendor oversight. The Department would hire the staff June 1, 2016 due to the significance of the changes and to ensure the Department is in compliance as soon as the rule is effective. In addition, this request includes funding to increase the scope of the Department's actuary contract due to the additional requirements for actuarial certification of rates and for the external quality review contracts to assist with the extensive quality oversight proposed in the rules and additional reporting requirements on managed care plans.

The Department's request is itemized by fiscal year and fund source in tables 1.1 through 1.3.

Anticipated Outcomes:

If this request is approved, the Department would be able to commit resources to understanding and planning for implementation of the significant changes required in the proposed managed care regulations, including additional oversight and actuarial certifications. Once this proposal becomes final rule, the FTE would be

[6] 42 CFR 438.340(e), 80 FR 31280, 438.350 and 438.358, 80 FR 31257
[7] 42 CFR 438.310(b)(2) and 438.332(a), 80 FR 31278-31280
[8] 42 CFR 438.10, 80 FR 31263-31265
[9] 42 CFR 438.608(b), 80 FR 31287
[10] 42 CFR 438.602(c), 80 FR 31286
[11] 42 CFR 438.602(f), 80 FR 31286

tasked with monitoring and managing the contracts to ensure the Department remains in compliance and that all requirements are met. These resources would enable the Department to make certain all requirements are sufficiently fulfilled. Timely implementation is key so the Department does not risk federal financial participation on expenditure on any of the Department's managed care contracts.

This request links to the Department's Performance Plan goals of improving member experience while reducing growth rate of costs. The Department must be prepared to implement all rule changes once they become final. As a result, the Department must have a comprehensive understanding of what is required to be in federal compliance. Not being prepared to operate within the new rules may ultimately lead to a declining member experience if members are unable to receive adequate services or experience a delay in receiving necessary services. The Department's General Fund costs would increase if CMS disallowed expenditure on the managed care contracts due to noncompliance with the rule.

Assumptions and Calculations:

The Department assumes that CMS will adopt all of the proposed rules and that the rules will be effective early in FY 2016-17. This is currently unknown as the Department cannot predict how long CMS will take to finalize the regulation. Because the consequences of being out of compliance are severe, it is appropriate to assume that final regulations would be published in the near future. The Department also assumes that it would be required to be in compliance with all rules on a short timeline after the rules are effective, based on the Department's experience with the recently-finalized rule around access to covered Medicaid services.[12] The Department assumes that staff would need to have a comprehensive understanding and be completely operational soon after the rules are finalized.

The Department assumes that it would need $101,500 total funds in FY 2016-17 and ongoing for 500 hours of additional actuarial services at $203 per hour to account for the increased scope of work the Department's contracted actuary would need to perform due to requirements for more granular rate certifications and the establishment of MLRs within all managed care contracts. As required by 42 CFR § 438.800, the Department would need actuarially sound capitation rates for each separate cohort within the population enrolled in the managed care plan, rather than actuarially sound rate ranges. The actuary would also need to validate the MLR and incorporate it into future rate setting cycles, adding a new element to the rate setting process

The Department assumes that it would need $300,000 total funds in FY 2016-17 and ongoing to fund an enhanced scope of work in the Department's external quality review organization (EQRO) contract, which would include assisting the Department with implementing additional quality oversight requirements. The regulations around quality oversight in the proposed rules are more robust for all entities including fee-for-service, required quality strategy and the development and standardization of a quality rating system for health plans. These key activities are beyond the current work of the Department's quality health improvement unit and existing EQRO activities. The performance measurement, framework for ranking plans, provider level data, and enhanced oversight of communications to clients drive the need for additional funding.

[12] 80 FR 67575

The requested funding for the EQRO contractor is based on projects of similar scope, in particular the readiness review completed for the Rocky Mountain Health Plan (RMHP) pilot program, as created under HB 12-1281 "Medicaid Payment Reform Pilot Program". The Department will be required to validate each MCO, PIHP, and PAHP on an ongoing basis, which is similar to the scope of work completed for the HB 12-1281 pilot program. Based on that experience, the Department assumes that the validations will cost $40,000 per entity. It is unknown how quickly the Department would need to validate these organizations, but the requested funding would allow the Department to validate six of the Department's 13 contracts per year, for an annual total of $240,000. There will also be requirements around performance improvement projects (PIPs). The Department assumes that each MCO, PIHP, and PAHP would be required to conduct at least three PIPs rather than the current requirement of one[13]. The cost for the EQRO contractor to validate each PIP is about $5,000 and the Department would require three PIPs per entity. Based on these estimates, the Department anticipates it could perform the additional two required PIPs for six entities each year for an annual total of $60,000.[14]

The Department assumes that the following FTE would be hired on June 1, 2016, which would provide time for all FTE to understand the requirements of the proposed rule and develop an implementation plan for how the Department would be in compliance when required by CMS. Due to the pay date shift, the Department assumes it would pay for one time operating costs for the new employees in FY 2015-16, and begin paying salary and other benefits for the FTE in FY 2016-17. The requested FTE would be responsible for the activities listed below.

Program Management Specialists

Two FTEs would be hired at the General Professional IV level as program management specialists. These positions would coordinate with CMS as requirements are finalized to ensure the Department has a complete understanding of the requirements and how to appropriately implement the changes. They would develop guidelines for implementation of the new proposed rule, coordinating with different sections across the Department. The employees in these positions would also serve as the leads on monitoring implementation. They would be charged with ensuring all of the contract requirements are met for all of the Department's managed care programs. Specifically, these employees would be responsible for amending the definition section in all of the current contracts, ensuring compliance with payment and accountability improvements for all contracts, and monitoring sub-contractual agreements for compliance.

The requested FTE would also update beneficiary protections, beneficiary support systems, and enrollment processes, both contractually and operationally. These positions would ensure contractual and operational compliance with quality of care standards, state monitoring standards, information standards, and choice of provider standards. They would ensure contractual and operations compliance with new regulatory requirements around the availability of services, assurances of adequate capacity and services, and network

[13] 42 CFR 438.330(d), 80 FR 31279; at 80 FR 31198, CMS states: "We assume that each MCO/PIHP will conduct at least 3 performance improvement projects, each PAHP will conduct at least 1 performance improvement project, and that each MCO/PIHP/PAHP will calculate at least 3 performance measures."

[14] The actual costs for a vendor to perform this work will not be known until the Department is able to negotiate contracts for the proposed scope of work. The Department would use the regular budget process to request adjustments if necessary.

adequacy standards. These positions would also ensure the Department's encounter data and health information systems are in compliance with the proposed rule.

The requested FTE would also be tasked with managing the required publishing of deliverables and materials on the Department's website, ensuring materials are Americans with Disabilities Act (ADA) compliant. A few examples of recurring deliverables that are required to be on the state's Medicaid website are as follows: the Department's defined quality metrics and performance standards, network adequacy standards, and quality performance reports, all of which must be maintained at least annually.

Quality and Health Improvement Specialist

One FTE at the General Professional IV level would be hired as a quality and health improvement specialist to oversee the creation of the state comprehensive quality strategy. As mentioned above, the state comprehensive quality strategy and required quality rating system is one of the most comprehensive changes to the regulations. This employee would draft and implement the written quality strategy, and develop the content required for the quality rating system. As part of the implementation, the employee would facilitate meetings to obtain public input on the development and revision of the quality strategy and rating system, evaluate the effectiveness of the strategy, and oversee the submission of the comprehensive quality strategy to CMS and online publication of the quality rating system annually. In addition, the employee would coordinate reviews and updates of the comprehensive quality strategy on an on-going basis as required by CMS.

Program Integrity Analyst

One FTE at the General Professional IV level would be hired as a program integrity analyst to assist with oversight of the managed care plans' compliance programs for fraud, waste and abuse oversight and detection. Since the publication of the current regulations on managed care in 2002, significant new legislative changes have been made to Medicaid program integrity operations. 42 CFR §§ 438.600, 438.602, 438.604, 438.606, 438.608 and 438.610 in the proposed regulation would strengthen the fiscal and programmatic integrity of Medicaid managed care programs. The requested program integrity analyst would review the plans' effort to combat fraud, waste and abuse, and coordinate fraud investigations and resulting suspensions of payments, including in response to information from whistleblowers, as required in the proposed rule. The analyst would also coordinate program integrity policy as implemented in the proposed rate setting regulations. As mentioned above, all ordering and referring physicians must be enrolled as participating providers, and the Department would need to complete screenings of MCOs, PIHPs, PCCMs and all network providers. In addition, the Department will be required to review ownership and control disclosures submitted by MCOs, PIHPs, PCCMs, and all network providers. The analyst would assist with issues arising from screening provider applications and ownership and control disclosures from the MCOs, PIHPs, PCCMs, and all network providers which might result in the denial of an application for cause or termination of a provider agreement for cause. This position requires a unique skillset that requires strategic analysis and judgment.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

The supplemental request is the result of an unforeseen contingency that results in a substantial change to workload. With the proposed rules change, the Department expects that it would need to implement changes

to managed care contracts quickly once the rules become final, which cannot be absorbed with existing resources.

Table 1.1- FY 2015-16 Estimated Costs						
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Federal Funds**	**Source / Notes**
A	FTE Costs	$0	0.0	$0	$0	FTE Table, FY 2015-16
B	Health, Life, and Dental	$0	0.0	$0	$0	FTE Table, FY 2015-16
C	Amortization Equalization Disbursement	$0	0.0	$0	$0	FTE Table, FY 2015-16
D	Supplemental Amortization Equalization Disbursement	$0	0.0	$0	$0	FTE Table, FY 2015-16
E	Short Term Disability	$0	0.0	$0	$0	FTE Table, FY 2015-16
F	Operating Expenses	$18,812	0.0	$9,406	$9,406	FTE Table, FY 2015-16
G	Additional Actuarial Costs	$0	0.0	$0	$0	Not applicable
H	Additional Quality Review Costs	$0	0.0	$0	$0	Not applicable
I	**Total Costs**	**$18,812**	**0.0**	**$9,406**	**$9,406**	**Sum of Row A through Row H**

Table 1.2 - FY 2016-17 Estimated Costs						
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Federal Funds**	**Source / Notes**
A	FTE Costs	$262,858	4.0	$131,429	$131,429	FTE Table, FY 2016-17
B	Health, Life, and Dental	$31,709	0.0	$15,855	$15,854	FTE Table, FY 2016-17
C	Amortization Equalization Disbursement	$11,306	0.0	$5,653	$5,653	FTE Table, FY 2016-17
D	Supplemental Amortization Equalization Disbursement	$11,188	0.0	$5,594	$5,594	FTE Table, FY 2016-17
E	Short Term Disability	$448	0.0	$224	$224	FTE Table, FY 2016-17
F	Operating Expenses	$3,800	0.0	$1,900	$1,900	FTE Table, FY 2016-17
G	Additional Actuarial Costs	$101,500	0.0	$50,750	$50,750	Compliance with Proposed Federal Managed Care Regulations Narrative, Page 6
H	Additional Quality Review Costs	$300,000	0.0	$150,000	$150,000	Compliance with Proposed Federal Managed Care Regulations Narrative, Page 6/7
I	**Total Costs**	**$722,809**	**4.0**	**$361,405**	**$361,404**	**Sum of Row A through Row H**

Table 1.3 - FY 2017-18 Estimated Costs						
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Federal Funds**	**Source / Notes**
A	FTE Costs	$262,858	4.0	$131,429	$131,429	Table 1.2, Row A
B	Health, Life, and Dental	$31,709	0.0	$15,855	$15,854	Table 1.2, Row B
C	Amortization Equalization Disbursement	$11,306	0.0	$5,653	$5,653	Table 1.2, Row C
D	Supplemental Amortization Equalization Disbursement	$11,188	0.0	$5,594	$5,594	Table 1.2, Row D
E	Short Term Disability	$448	0.0	$224	$224	Table 1.2, Row E
F	Operating Expenses	$3,800	0.0	$1,900	$1,900	Table 1.2, Row F
G	Additional Actuarial Costs	$101,500	0.0	$50,750	$50,750	Table 1.2, Row G
H	Additional Quality Review Costs	$300,000	0.0	$150,000	$150,000	Table 1.2, Row H
I	**Total Costs**	**$722,809**	**4.0**	**$361,405**	**$361,404**	**Sum of Row A through Row H**

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	
General Profession IV	$4,907	-	$0	4.0	$235,536
PERA			$0		$23,907
AED			$0		$11,306
SAED			$0		$11,188
Medicare			$0		$3,415
STD			$0		$448
Health-Life-Dental			$0		$31,709
Subtotal Position 1, #.# FTE		**-**	**$0**	**4.0**	**$317,509**
Subtotal Personal Services		-	**$0**	4.0	**$317,509**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	0.0	$0	4.0	$2,000
Telephone Expenses	$450	0.0	$0	4.0	$1,800
PC, One-Time	$1,230	4.0	$4,920		
Office Furniture, One-Time	$3,473	4.0	$13,892		
Other					
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$18,812**		**$3,800**
TOTAL REQUEST		-	**$18,812**	4.0	**$321,309**
	General Fund:		*$9,406*		*$160,654*
	Cash funds:		*$0*		*$0*
	Reappropriated Funds:		*$0*		*$0*
	Federal Funds:		*$9,406*		*$160,655*