Department of Health Care Policy & Financing

FY 2022-23 Funding Request

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Governor

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ARPA Spending Plan for Home and Community Based Services

Summary of Funding Changes				
		Incremental Changes		
	FY 2021-22 Appropriation	**FY 2021-22 Request**	**FY 2022-23 Request**	**FY 2023-24 Request**
Total Funds	$757,686	$239,647,259	$208,891,050	$79,551,533
FTE	4.6	53.5	50.1	32.9
General Fund	$0	$0	$0	$0
Cash Funds	$378,843	$108,288,488	$132,115,304	$62,809,352
Reappropriated Funds	$0	$0	$0	$0
Federal Funds	$378,843	$131,358,771	$76,775,746	$16,742,181

Summary of Request

The Department submits this spending plan to implement initiatives to enhance, expand, and strengthen Home and Community-Based Services (HCBS) in Colorado over the next three years. Section 9817 of the American Rescue Plan Act (ARPA) provides enhanced federal funding for HCBS for one year and requires states to reinvest the enhanced funding back into those services. The Department submitted a proposed spending plan of reinvestments to the Centers for Medicare and Medicaid Services (CMS) and is waiting for final approval. The plan centers around projects that will supercharge existing initiatives, support the COVID-19 response and recovery, foster innovation and long-term transformative change, and increase quality and good fiscal stewardship.

This request fulfills the requirement in SB 21-286, “Distribute Federal Funds Home- & Community-Based Services,” to submit a proposed spending plan to the JBC as soon as practicable after receiving federal guidance on Section 9817. In total, it represents an increase of 4% of the Department’s FY 2021-22 Long Bill total funds appropriation.

Current Program

The American Rescue Plan Act was signed into law on March 11, 2021 and includes funding to support a wide range of infrastructure activities, programs, and services. Section 9817 of the Act increases the federal medical assistance percentage (FMAP) for Medicaid Home and Community-Based Services (HCBS) spending by 10 percentage points from April 1, 2021 through March 31, 2022. The bill specifies that states must use the enhanced funds to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen" Medicaid HCBS. The Department submitted a spending plan to outline the proposed uses of the enhanced funding to CMS on June 11, 2021.[1] CMS gave partial approval of the plan on July 23, 2021.

SB 21-286, "Distribute Federal Funds Home- & Community-Based Services," requires the Department to submit a spending plan to the Joint Budget Committee (JBC) specifying how the Department plans to use the enhanced funding. The Department cannot implement any of the proposed initiatives prior to JBC approval of the spending plan.

Home and Community-Based Services refers to all services eligible for the enhanced FMAP authorized in Section 9817, including:

- 1915(c) Home and Community-Based Waiver Programs
- Home Health Care, including Durable Medical Equipment
- Personal Care Services
- Self-Directed Personal Care Services
- Case Management
- School Based Services
- Rehabilitative Services, including Behavioral Health Services
- Private Duty Nursing
- Alternative Benefit Plans
- Program for All Inclusive Care for the Elderly (PACE)

These services encompass critical supports that help older adults, people with disabilities, and people with behavioral health needs to live and thrive in their communities. The Department's approach to identifying, prioritizing, and planning for the use of these funds has intentionally included a cross disability lens; therefore, this proposed spending plan is not population focused.

[1]https://hcpf.colorado.gov/sites/hcpf/files/CO%20State%20Spending%20Plan%20for%20Implementing%20Section%209817%20of%20ARPA%2C%20June%202021_Acc.pdf

Problem or Opportunity

To capitalize on this opportunity to truly transform the HCBS system, the Department identified four guiding principles to keep front of mind as the potential initiatives were imagined, reviewed, and considered:

From these guiding principles, the Department developed a list of priority initiatives reflecting stakeholder feedback, requirements from CMS, and priorities. These initiatives would provide immediate relief for the provider network, direct support to members and their families during the recovery phase following the pandemic and foster longer-term innovation and transformation to create an HCBS system of the future.

Proposed priority initiatives fall into the following categories:

- Strengthen the Workforce & Enhance Rural Sustainability
- Improve Crisis & Acute Services
- Improve Access to HCBS For Underserved Populations
- Support Post-COVID Recovery & HCBS Innovation
- Strengthen Case Management Redesign
- Invest in Tools & Technology
- Expand Emergency Preparedness
- Enhance Quality Outcomes

Proposed Solution

The Department requests authority to spend $528,089,842, including $282,646,726 from the Home- and Community-Based Services Improvement Fund, $20,566,418 from the ARPA Home- and Community-Based Services Account within the Healthcare Affordability and Sustainability

Fee cash fund, and $224,876,698 federal funds. This includes 53.5 term-limited FTE. The funding would be spread out over three fiscal years as shown in the table below.

Total	FY 2021-22	FY 2022-23	FY 2023-24
$528,089,842	$239,647,259	$208,891,050	$79,551,533

The Department is also requesting a statute change to allow the Department to spend the amount attributable to the Healthcare Affordability and Sustainability Fee as state-only funds. Most of the work proposed for initiatives impacting members financed through the cash fund is in state-only grant programs for behavioral health due to federal limitations on increasing behavioral health capitation rates.

Strengthen the Workforce & Enhanced Rural Sustainability

The direct care workforce is the backbone of the HCBS system. These frontline workers enable members to remain living safely in their homes and communities. Unfortunately, pre-COVID workforce shortages have been further exacerbated by the impacts of the pandemic as well as the increase in demand for HCBS services. Additionally, the state's direct care workforce has served on the frontline, risking their health and safety to ensure our members maintain theirs. The Department proposes a series of initiatives designed to strengthen the HCBS workforce.

Theory of Change	Investing in the direct care workforce will result in increased recruitment and retention of employees, which will in turn leads to ongoing and greater access to care for HCBS utilizers.
Program Objective	Increase hiring and improve retention rates and decrease vacancies within the direct care workforce.
Outputs Being Measured	Hire rates, turnover rates, member and provider feedback, and number of individuals trained.
Outcomes Being Measured	Ongoing and increased access to care for HCBS utilizers, particularly in rural areas and other care deserts, measured through provider network capacity and provider retention, and member satisfaction.
Cost/Benefit Ratio	The Department anticipates cost savings from these initiatives for several reasons. The high turnover within the field, as well as the significant vacancies, lead to clients going without needed care or receiving it from inconsistent caregivers, resulting in costly hospitalizations and institutionalization. The limited training required of these workers contributes to low quality care being delivered, also contributing to poor client outcomes and early institutionalization.
Evaluations	Pre-Post
Results of Evaluation	A recent economic analysis found that raising wages for direct care workers to a living wage would decrease turnover and increase the quality of care, while also dramatically speeding up local economic growth and simultaneously lowering costs to public programs, such as Medicaid (Weller, Almeida, Cohen & Stone, 2020).

	The State of Wyoming experienced a dramatic decrease in turnover rates of workers from an average of 52 to 32 percent after state funding was allocated to increase wages (Lynch, Fortune, Mikesell, & Walling, 2005; Sherard, 2002). San Francisco County nearly doubled the wages of home care workers over a 52-month period, and within that time, annual turnover decreased from 70 to 35 percent (Howes, 2005).
Continuum Level	Step 3

Increase Payments to Providers and Workers

The most direct way to provide assistance to the direct care workforce is to increase payments to providers and workers. The Department requests to distribute provider recovery payments with a required percentage to be paid to direct care workers and direct support professionals for the following providers and services:

- Personal Care
- Homemaker
- Participant-Directed Services (including skilled care under self-direction programs)
- Community-Based Residential Programs
- Case Management
- PACE
- Day Programs
- Non-Medical Transportation
- Supported Employment

The Department is developing a strategy to increase rates in the most effective way to support the workforce. The Department will provide more details on the short- and long-term plan for rate increases, including the amount to be passed through to workers. The plan may need to be adjusted over time as the pandemic continues to evolve in unexpected ways and based on pending federal legislation, which could alter the appropriate strategy for compensation. As part of its strategy, the Department is ensuring that as much of the increase as possible is provided in the first year to allow Colorado to fully maximize the 10% federal enhanced match.

The Department would need to hire one term-limited FTE who would be responsible for conducting financial compliance reviews to ensure providers pass through funding as required. The FTE would ensure providers submit required reporting and would follow up with non-responsive providers.

Direct Care Workforce Data Infrastructure

Under this project, the Department would expand the data infrastructure to better understand the current supply and demand for direct care workers and to track the impact of each investment strategy on recruitment, retention, and turnover. The Department would work with

contractors to develop two surveys for the direct care workforce. The first survey would be a staff stability survey for providers of long-term services and supports (LTSS) waiver services and would include data collection on the number of direct care workers (DCWs) providing care, turnover rates of DCWs, percentage of DCWs that are full-time or part-time, DCW vacancy rates, and hourly wages for all DCWs. The second survey would be for direct care workers rather than the employers to determine their satisfaction with compensation, benefits, career advancement, training, and their overall satisfaction with their employment. This survey would evaluate why there is a workforce crisis among direct care workers and what the Department can do to improve it. The surveys would be administered multiple times to supply comparative data. This project would fund the development of the surveys, data collection, and analysis. These surveys will assist in strengthening the data infrastructure in the short and long-term to better understand the workforce and evaluate the strategies outlined in this plan.

The Department requests to hire one partial term-limited FTE to manage the project, including developing the scope of work for the surveys, managing the contract and assisting with administration of the surveys. These surveys would be updated and used to establish all baseline data to inform direct care workforce efforts, recruitment and retention policies, and even skills-based career latticing.

Skill, Advancement, & Awareness for the Direct Care Workers

Colorado's direct care workforce is anticipated to grow by 40% between 2018 and 2028,[2] adding 116,000 new jobs due to both growth and separations. Yet, there are already significant shortages, anticipated only to get worse as the demand increases. Extensive research has also shown that a major barrier to recruitment into these positions is the lack of career advancement opportunities available; and poor training impacts both workers and clients.[3] 40% of direct care workers report that their initial training did not prepare them well for their job and these workers have consistently shared a need for greater initial and ongoing training. Poor training leads to higher risk for workplace injury, whereas high quality training improves client outcomes. Additionally, a high percentage of direct care workers report few to no career advancement opportunities directly contributing to turnover, which ranges from 40%-60% on average. Developing a standardized training coupled with a resource and job hub would support prospective workers with getting information they need for pursuing direct care jobs, obtaining the credential needed to provide high quality care, and obtaining a job.

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[2] Menne, H. L., Ejaz, F. K., Noelker, L. S., & Jones, J. A. (2007). Direct care workers' recommendations for training and continuing education. *Gerontology and Geriatrics Education, 28*(2), 91-108.

[3] Kemper, P., Heier, B., Barry, T., Brannon, D., Angelelli, J., Vasey, J., & Anderson-Knott, M. (2008). What do direct care workers say would improve their jobs? Differences across settings. *The Gerontologist, 48*(Special Issue I), 17-25.

The Department would need three FTE to manage the projects within the Skill, Advancement, and Awareness for the Direct Care Workers category. This includes contract management, stakeholder engagement, and project management support. In addition to these responsibilities, the FTE would have specific responsibilities associated with each of the projects. For the ‘Standardized Core Curriculum & Specialization’ project, the FTE would also assist with curricula development, oversight of the pilots, and assisting with training as needed. For the ‘Resource & Job Hub’ project, the FTE would assist with the design of the new website, including providing expertise to the needs and interests of interested or incumbent direct care workers. The FTE would provide oversight of the funds for the ‘Training Fund’ project and ensure accurate reporting and tracking of funds and training outcomes. For the ‘Career Pathways’ project, the FTE would work collaboratively with our sister agencies to develop new and build-out existing pathways. Finally, for the ‘Public Awareness Campaign’ project, the FTE would liaise with the Direct Care Workforce Collaborative and the marketing company to ensure the campaign is designed and executed in alignment with stakeholder recommendations.

Standardized Core Curriculum & Specialization

The Department would develop a standardized curriculum and training program for homemakers and personal care workers to establish quality standards, as well as increasing specialized qualifications tied to wage increases. The Department would work with a contractor to develop a homemaker and personal care worker curriculum to include modules on specialized topics, such as Alzheimer’s disease and related dementias and mental and behavioral health care and make the training available for free in-person through a train-the-trainer model and online. Initial work has been completed via the Training Advisory Committee per SB 19-238, “Improve Wages and Accountability Home Care Workers.”

These trainings would be developed using a ‘universal worker’ structure, designed for use by individuals working in a variety of settings and with different populations. The modules would be adaptable depending on the employer, client, and worker’s needs, the training certificate would be transferable across employers. Funding would support training development, creation and launch of the online training platform, and hosting statewide train-the-trainer sessions.

To complete this project, the Department would need a contractor to develop the core homemaker and personal care worker curriculum. The contractor would conduct stakeholder engagement on the curriculum, develop and pilot tests for the trainings, develop recommendations for provider incentive payments, and develop recommendations for the Department on long-term sustainability of the project. The Department would also need funding to evaluate the curriculum and pilot tests to ensure it is meeting the intended objectives and to launch the Learning Management System (LMS) platform.

Resource & Job Hub
The Department proposes to create a resource, job search, and employer matching hub for direct care workers to ease their entry into the job. This funding would support the development of a website for the direct care workforce where interested individuals could go to receive information and resources about direct care positions, access free training, and view job boards to quickly be placed in positions. The newly developed personal care/homemaker worker training would be accessible through this site, and individuals who completed the training would be entered into a database for easy tracking of certification.

Establish a Training Fund
Providing more training opportunities and incentives for workers to gain higher level skills would promote greater retention within the workforce. The Department proposes establishing a training fund with state-only funding targeted to high demand jobs and to support specialization and advancement opportunities for the HCBS workforce, including the behavioral health workforce. Funds could be distributed directly to the prospective or current worker, to the employer to provide the training to their employees, or to a training provider. Additionally, funds may be used to expand standard training provider resources or trainer availability where gaps exist. The trainings would include cultural competency elements for all populations served.

Career Pathways
The Department would establish income-based, affordable pathways for health professions to build career advancement opportunities for the workforce. The Department would provide resources through interagency agreements with the Colorado Community College System, the Department of Higher Education, and the Department of Labor and Employment to work on career development pathways for direct care workers.

Public Awareness Campaign
The Department proposes to launch a public awareness campaign about the value and importance of the direct care workforce. The campaign would garner workforce pride as well as greater respect and appreciation for these positions, which would ultimately help with recruiting and retaining individuals into the field. The Department would contract with an advertising agency to develop and launch the campaign.

Home Health Delegation
One way to expand the workforce in the home health field is to increase delegation to lower-skilled workers. For example, Registered Nurses (RNs) may delegate skilled tasks to a Certified Nurse Aide (CNA) that they otherwise would not be able to perform. An RN provides training to the CNA to perform the skilled task and the task is then delegated to them. The theory is that this would allow a CNA to practice to the top of their license and potentially increase their wages, leading to longer-term retention. The Department would contract with a vendor to

explore opportunities for further developing the home health workforce. This would include an environmental scan to identify care deserts, a survey to understand barriers and implementing solutions to increase delegation to this workforce, thereby enabling increased wages, retention, and recruitment. In addition, the Department would provide incentive payments using state-only funding to home health agencies that provide innovative models of care, such as increased delegation.

Workforce Compensation Research

Wages are not the only consideration in someone's decision to work in a certain field. The Department proposes to research innovative opportunities for increasing compensation for the HCBS workforce in other ways. The Department would hire a contractor to identify ways to provide child care for direct care workers; explore funding for shift differentials; and identify other practices that could better support low-income workers, such as hiring retention specialists or case managers within home care agencies whose job is to support the frontline workers.

Rural Sustainability and Investments

The Department would invest in three strategies to expand the provider network in rural communities by identifying gaps and potential opportunities for expansion. A care desert, also known as medical deserts, exist mostly in rural places and inner cities and lead to inequalities in health care. The federal government now designates nearly 80 percent of rural America as 'medically underserved.' About 20% of the U.S. population live in rural areas, but only 10% of doctors and other health care professionals operate in those regions, and that ratio is worsening each year.

The Department would need one FTE to manage the three projects within the Rural Sustainability and Investments category. This would include managing contracts and facilitating stakeholder engagement throughout the projects. For the 'Identify Care Gaps' project, the FTE would take the environmental scan completed by the contractor to conduct an in-depth analysis of rural areas and identify new innovative ways to increase provider capacity in these areas and ensure the model is sustainable. For the 'Develop Geographic Modifiers' project, the FTE would identify and move forward regulatory changes required to implement the new proposed modifiers. For the 'Shared Systems in Rural Communities' project, the FTE would oversee the contractors, manage the pilot, and monitor the evaluation. The FTE would also work on a long-term sustainability and implementation plan for the new models identified.

Identify Care Gaps

The Department first needs more data and analysis on where there are care deserts and potential solutions in those areas. The Department would hire a contractor to complete an environmental scan of Colorado's current HCBS provider network via a GIS heatmap; create a tool for the Department to update and track progress on a statewide level; identify gaps by

waiver, service, and provider type; find out which populations are the most impacted; and give recommendations for provider or service expansion and solutions in a final report.

Develop Geographic Modifiers

One way to help prevent a care desert is to pay providers differently by region to account for differences in cost structure, which would encourage more people to work in direct care professions in areas that are currently underpaid. The Department would hire a contractor to design rates by geographic region to account for the cost differential associated with different locations. Geographic modifiers are intended to improve the appropriateness of Medicaid rates to providers by accounting for the differences in prices for certain expenses, such as clinical and administrative staff salaries and benefits, rent, malpractice insurance, and other defined costs.

Shared Systems in Rural Communities

The workforce shortage is particularly concerning in rural areas. The Department proposes researching ways to partner with hospitals and rural health clinics to identify opportunities to share resources and/or more efficiently and creatively offer services in rural areas. The goal of this initiative is to increase access to services by setting up partnerships across hospitals, clinics, and HCBS providers to share certain resources between them. This could include using a coordinated pool of workers, training, personal protective equipment, or other resources. The Department, in partnership with the Office of eHealth Innovation, would contract with a vendor to identify areas that would benefit from this approach and recommendations on how to pursue and implement it. The contractor would develop a timeline, risk register, and a recommendation and plan to be piloted. The contractor would then help set up the pilot program by finding members and providers to test out the model. After the pilot is completed, the Department would contract with a vendor to evaluate the pilot by analyzing whether the desired outcomes were achieved, interviewing participants, and providing a final recommendation report to the Department.

Improve Crisis & Acute Services

Crisis situations can lead individuals who reside in the community to seek treatment or care in a hospital or institutional setting. Unfortunately, these emergency situations can often be the impetus for long-term placement in these settings. If preventive services were expanded, crisis response improved, and transitions strengthened, individuals may be able to, instead, return to their homes and communities. The Department proposes a series of initiatives to improve crisis and acute services.

Theory of Change	Providing timely access to a full continuum of care that is culturally competent and assists people where they are is vital to ensure clinically appropriate and cost-effective behavioral health treatment.
Program Objectives	To expand access to community-based crisis and transition care for the HCBS population. To increase access to culturally competent care.

Outputs Being Measured	Number of calls diverted from police to behavioral health responders. Stratification/Creation of performance metrics to ensure that behavioral health providers are adequately and appropriately serving members with disabilities.	
Outcomes Being Measured	Receipt of new benefit/services ("program reach") • Reduced use of inpatient and institutional care • Reduced readmissions to inpatient care. • Increased well-being. • Decreased total cost of care.	
Cost/Benefit Ratio	The Department predicts potential savings by ensuring high-risk patients are kept out of more expensive in-patient care, emergency department, or correctional facilities.	
Evaluations	Pre-Post	National Guidelines
Results of Evaluation	In Oregon, the CAHOOTS program mental health response teams save the city of Eugene an estimated $8.5 million per year. Annually, they divert 5-8% of police calls[4].	The Substance Abuse Mental Health Services Administration has outlined 3 essential services in the National Guidelines for Crisis Care. The third is "Crisis Receiving and Stabilization Facilities: Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services (over 24 hours) to all referrals in a home-like, non-hospital environment[5]."
Continuum Level	Step 3	

Behavioral Health Transition Support Grants to Prevent Institutionalization

Under this project, the Department would offer short-term grant funding for behavioral health crises and transition services to support higher acuity members moving from an institute or corrections to the community, specifically focusing on increasing capacity for community-based care. The Department would create grants for local communities, including providers, non-governmental organizations, and counties, to implement programs that are specific to their behavioral health capacity needs and geographic area. Grantees could request funding for implementation projects that improve service delivery options for crisis and transition programs or create pathways that improve care transitions. The focus will be on complex populations, with a history of institutionalization, and support step-down services specifically to help move individuals from inpatient to community settings. This grant would prioritize transition services that serve those that are disabled due to a mental health diagnosis.

Lessons learned from prior Department work transitioning members from long term care institutions with the Colorado Choice Transitions Program would inform the design of the grant program. Extensive stakeholder engagement would also inform program design. Providers could request funding for program improvements, infection control, staff training, best practice

[4] https://www.eugene-or.gov/DocumentCenter/View/56717/CAHOOTS-Program-Analysis
[5] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

implementation costs, regulatory compliance, and community integration. The grants would use state-only funding.

The Department would need to hire a consulting firm to establish criteria and serve as a fiscal intermediary to manage the grant program, including the application process and distribution of the grant funding. The Department would also need a partial FTE to manage the contracts and grant deliverables, meet with grantees for technical assistance and problem solving, and ensure grant outcomes are achieved. This position would also build relationships with Colorado hospitals and help design transition processes that align across communities. The FTE would also work across the project to Expand the Behavioral Health Safety Net.

<u>Expand Behavioral Health Mobile Crisis Teams</u>
The Department proposes to supercharge activities related to the mobile behavioral health crisis teams, which offer an alternative to police or Emergency Medical Services (EMS) transport for a person in a mental health or substance use disorder crisis. Currently in Colorado, there are differing practices, pilots, and approaches to behavioral health crisis calls. The Department is applying for separate funding through ARPA to develop and submit a waiver to CMS to authorize a universal mobile crisis benefit for Medicaid members. If approved, many of the current provisioners will need to come into compliance to build the new benefit and will need resources to do so.

The Department proposes to provide funding in the form of grants to support this effort. Grantees could utilize funding to start a program or to come into compliance by using funds for required training, increasing their capacity for 24/7 response, equipment purchases, and potential technology needs. Funds would also be available to create more culturally responsive mobile crisis services in Colorado.

Similar to the Transition grants, the Department needs a contractor for fiscal management of the grant and to ensure stakeholder needs are heard prior to structuring the grant. The Department would need an FTE to facilitate the stakeholder engagement process and manage the contract and funding process.

<u>Institute for Mental Disease (IMD) Exclusion, Risk Mitigation Policy</u>
As a compliment to the crisis service grant programs, the Department would explore the detailed policy and licensing requirements of different provision types that are federally prescribed when serving persons experiencing behavioral health crises. Colorado currently has a network of different facilities that can be used to assist a person in crises including Acute Treatment Units (ATU), Crisis Stabilization Units (CSU), emergency rooms, and when needed, traditional hospitalization. Both emergency rooms and hospitals come at higher costs, may lack behavioral health expertise, and may experience capacity issues to serve persons with medical needs when supporting persons in crises. To ensure the State's new model of care from crises

response to crises service delivery is successful, there needs to be compliance work completed with ATUs and CSUs. These units must not overstep federal compliance standards that would then deem them Institutes for Mental Disease (IMD), which precludes Medicaid funding, therein unable to serve and/or receive reimbursement for members who make up 70% of all calls to the statewide Crises Services hotline.

To mitigate this risk, the Department would hire a contractor to complete research and identify solutions for addressing IMD risk in these facilities. This would include a review of recent CMS guidance related to IMD to determine what actions can or should be taken to mitigate risk, including changing reimbursement policy, seeking a waiver, and/or working with other State entities to review licensing requirement reforms. The contractor would also evaluate current ATU/CSU providers to review their programming and campus structure to ensure they do not meet the federal definition of IMD. The contractor would generate a recommendations report on how to mitigate IMD risk as the state promotes the use of ATUs and CSUs in lieu of hospitalization or institutionalization, including the costs and benefits of the State seeking an 1115 waiver. If deemed necessary, the contractor would work with the Department to develop and draft the 1115 waiver, or any authority or policy changes determined appropriate.

The Department needs 1.5 FTE to manage this project. One FTE would be responsible for the fiscal process of identifying a contractor, managing the contractor, reviewing CMS guidance from a state perspective, and participating in the extensive stakeholder engagement. The partial FTE would be responsible for managing the internal Medicaid responsibilities based on the contractor's recommendation and would partner with other Departments responsible for the licensing and regulation of these facilities to promulgate rules. This FTE would be a single staff person working on updates to State Plan Amendments and waivers for this project as well as the Child/Youth Step Down Project. This would ensure that members at risk of institution are able to access appropriate crisis services that are not in conflict with federal requirements. If the contractor does not recommend any significant policy or process changes, the FTE would be reduced.

Improve Access to HCBS For Underserved Populations

The Department has identified several underserved populations in HCBS programs, including individuals with disabilities living on tribal lands, those who identify as Black, Indigenous, and People of Color (BIPOC), and individuals with behavioral health needs. As a state focused on meeting the needs of all Coloradans, ensuring access across all populations through disability and culturally competent, whole-person care is a key priority for the Department. Implementing the initiatives described below would improve access for underserved populations.

Theory of Change	Addressing behavioral health in Colorado requires concerted effort and resources to address populations who are and have been underserved by existing systems.		
Program Objectives	To improve the service care provision of diverse populations and historically underserved communities and their families.		
Outputs Being Measured	Increased number of materials available in Spanish. Shifting practices among providers and family members to culturally competent, whole person care. Increased availability and competence of intensive case management services for vulnerable and underserved populations.		
Outcomes Being Measured	Addressing wide health education and knowledge disparities. Creation of health equity plan to reduce disparities in HCBS population. Culturally competent care for people with disabilities. Receipt of housing support services for members with SMI who are unhoused. Reduced ED/hospitalizations for those receiving housing supports. Increased use of outpatient BH services and primary care for those receiving housing supports. Housing support capacity increased for members with SMI.		
Cost/Benefit Ratio	High intensity outpatient and wrap-around services result in reduced use of emergency services including ED and inpatient care, reduced arrests and jail time, and increased engagement with primary and wellness care.		
Evaluations	Randomized Controlled Trial	Meta-analysis, Cost effectiveness of High Intensity Outpatient Care	Financial Analysis of Investment in Behavioral Health
Results of Evaluation	An independent evaluation of the Denver Social Impact Bond Program (SIB) which funded supportive housing found: over 12 months, 74-91 percent of participants remained in the supportive housing programs studied, and shelter use decreased 61-98 percent. Quasi-experimental studies show 38-40 percent reductions in jail days as compared to comparison groups, and pre/post studies show 42-87 percent reductions in jail days post-housing interventions[6].	Assertive Community Treatment (ACT) services for individuals with disabilities due to severe mental illness are cost effective due to reduced use of higher costs inpatient[7] care and reduced homelessness[8]. Young people in Wraparound tend to have better outcomes than similar young people who don't receive Wraparound, across different areas of their lives including mental health, and functioning in their homes, schools and communities[9] and 82% moved to less restrictive, less costly environments[10].	The economic benefits of expanded diagnosis and treatment of depression has a return of investment (ROI) of $7 for every $1 invested. On average, substance abuse treatment costs $1,583 and is associated with a monetary benefit to society of $11,487, representing a greater than 7:1 ratio of benefits to costs, primarily because of reduced costs of crime and increased employment earnings[11].
Continuum Level	Step 5		

[6] https://pfs.urban.org/pfs-project-fact-sheets/content/denver-social-impact-bond-program
[7] https://link.springer.com/article/10.2165/00115677-200109030-00003
[8] https://pubmed.ncbi.nlm.nih.gov/17329462/
[9] https://link.springer.com/article/10.1007/s10567-009-0059-y
[10] https://nwi.pdx.edu/pdf/WrapROI.pdf
[11] https://www.nasmhpd.org/sites/default/files/Too%20Significant%20To%20Fail_0.pdf

Equity Improvement Projects

Equity Study

Individuals receiving Medicaid home and community-based services (HCBS) in Colorado are more likely to be white and English-speaking than the overall population and general Medicaid population. It is unclear what is driving the disparity or how to create more equity in HCBS. This project would aid in better understanding who receives HCBS in Colorado and what services they receive, where the gaps are, and target outreach to ensure HCBS services are provided to all Coloradans who are eligible. Management of this contract and subsequent work on how to best utilize this information and directly address equity would be shared with the Rural Sustainability and Investments work. The Department proposes the following items and procurement of a contractor to study this issue.

- Internal data analysis: Identify disparities in HCBS by analyzing enrollment and utilization data by race, ethnicity, language, and geography; develop a snapshot report that identifies disparities across the system to be presented to stakeholders in the community
- External stakeholder feedback and recommendations: Based on disparities identified, contract with a vendor to gather feedback from stakeholders and write up recommendations
- Implementation planning: Once recommendations are gathered, an internal team would put together an implementation plan to begin creating more equity in HCBS.

Buy-In Analysis

Many people with disabilities are interested in working. Health insurance coverage can have an important relationship to employment for people with disabilities. For example, persons with disabilities on Medicaid may be concerned that they will lose their Medicaid coverage if they enter or return to the workforce. Commercial or employer-based health insurance might not provide coverage for services and supports that enable people with disabilities to work and live independently such as personal assistance services. The purpose of the Medicaid Buy-In program is to allow persons with disabilities to purchase Medicaid coverage that helps enable them to work.

The Department requests funding to hire a contractor to research strategies to improve equity outcomes by analyzing the financial, population size, and demographic impacts of using less restrictive eligibility income and resource methodologies for individuals with disabilities. This project would also include targeted outreach to ensure individuals know about the buy-in program for members with disabilities who are working and how they are able to qualify and retain their assets.

Disability Cultural Competency Training for Behavioral Health Providers

Developing and requiring disability and cultural competency training would ensure better access to appropriate care for HCBS members. Under this project, the Department proposes to pay for a vendor to develop a disability-specific, culturally competent curriculum that includes the different types of disabilities and incorporates people's lived experiences to help providers understand diverse populations' perspectives. The training would include information, examples and skill-building activities on how best to serve the disability community. The training curriculum would be multi-modal such that it can be provided via webinars, online self-paced modules and/or in-person. A vendor contract must require the vendor to include closed captioning in all recorded webinars or online self-paced modules.

HCBS Training for Members & Families

In addition to providing training for providers, the Department proposes developing and making available culturally competent trainings and resources for members and their families to assist with navigating the HCBS system. This would include providing education and support to family caregivers. The training project would provide information to members to help them navigate through the different waivers, the services within each waiver, and explain members' right to choose between service providers. The Department would create training materials for all waivers. The training would be member-focused, person-centered and in plain language for ease of use. The Department would work with contractors to develop each of the training and associated materials.

Translation of Case Management Material

The Department does not currently have member-facing case management material translated into all necessary languages. The Department would hire a vendor to translate public facing case management materials, such as waiver charts, waiver flow charts, and other basic information about waivers and other long-term services and support programs, into multiple languages for members and caretakers to understand in their own language. This work would also take into consideration other accessibility needs such as hearing and vision impairments.

Expedite Behavioral Health Projects

Expand the Behavioral Health Safety Net

The Department has an opportunity with these funds to strengthen and expand the behavioral health safety net through provider training, workforce development, enhanced standards, high-intensity outpatient services, and value-based pay for performance models supporting whole-person care. The Department proposes doing this in partnership with the RAEs by building off the continued work of SB 19-222 “Individuals at Risk of Institutionalization.” Previous work over the last two years created a definition for high intensity outpatient services through a collaborative stakeholder engagement process.

The project would build upon and implement this definition through the following four projects:

- Conduct a gap analysis for high intensity outpatient services: The Department needs to assess the extent to which its current delivery system provides adequate high intensity outpatient services and to identify any needed improvements. The Department would hire a contractor to compare and analyze the new definition of high intensity outpatient services to the current capacity and service portfolio of the delivery system. This contractor would produce three critical analytic outputs: 1) determination of what current services meet the definition, 2) determination of what key services are not currently being delivered, and 3) determination of whether additional authority, state or federal, is needed to address the identified gaps.
- Develop training and technical assistance to build capacity with providers and health plans: Providers will need technical assistance and other support to improve their capacity to deliver high intensity outpatient services. Through partnership with the RAEs, the Department would hire a contractor to develop and provide technical assistance to providers and health plans to expand capacity within existing service networks through the addition of new providers and improved service and cultural competency of existing providers.
- Develop value-based payment framework and model that leverages Colorado's Health IT Roadmap initiatives and infrastructure for high intensity services and whole person care: Providers will also need alternative financing models that better support whole person care and reward improved outcomes. The Department would hire a contractor to create a new value-based reimbursement model in order to support the definition of high intensity outpatient services and to improve capacity of the service networks. The contractor would produce a model that outlines a payment framework and financial model that supports the State's safety net delivery framework. The model would include concrete tactics to bolster rates for high intensity and whole-person care, including addressing the social and economic barriers to health, and to reward the delivery system for improved outcomes and long-term value through novel performance incentives.
- Assess and review regulatory foundations for high intensity outpatient services: In order to build adequate networks for high intensity outpatient services and to financially support these networks, the Department, working with the Office of Behavioral Health, needs to review and align their credentialing and contracting policies with the safety net framework. The Department would hire a contractor to assess and revise critical regulations concerning high intensity outpatient services. This work would include policy analysis and stakeholder engagement regarding the standards, quality, and facilities that help evaluate and treat people who are at risk to harm themselves, harm others, or gravely disable due to serious mental illness. It would also include exploring provider credentialing to deliver high intensity outpatient services, and strategic alignment

between the forthcoming Behavioral Health Administration and the Department. The contractor would produce consolidated recommendations, including stakeholder feedback, ready for implementation regarding regulatory changes necessary to support high intensity outpatient services.

The Department requests two FTE to support this work. One FTE would be responsible for managing all contractors and any additional internal staff to ensure overall work products and milestones are met; liaise with stakeholders, internal staff, and additional State agencies on parallel projects; and represent the Department as subject matter expert as needed. This FTE will also provide subject matter expertise to the Behavioral Health Capacity grants. The other FTE would be a rates analyst responsible for managing the value-based payment contract and supporting development of updated payment methodology.

Wrap-Around Services, including Peer Supports, for Members with Complex Needs
The Department proposes to fund and develop a sustainability strategy for wrap-around services, including community-based peer support, for recipients of complex social service benefits such as housing vouchers and supportive housing services. This would be focused on individuals with serious mental illness and a history of homelessness and repeat hospitalizations. People who are unhoused with serious mental illness are at high risk for not receiving appropriate treatment which results in costly and avoidable emergency room visits and hospitalizations. They are also at high-risk for institutionalization.

The Department would implement a pilot program to provide supportive services, including peer supports, behavioral health services, and supportive housing services, for 500 Medicaid members. This initiative would be modeled on the social impact bond project in Denver and would target individuals who have serious mental illness and have a history of homelessness and emergency care. The Department would contract with entities to provide the supportive services; entities could include community mental health centers, housing providers, independent living centers, new peer support organizations, and RAEs. Participating members would also receive emergency housing vouchers from the Department of Local Affairs (DOLA), which has committed 500 vouchers to the pilot program. The Department has also been awarded a technical assistance program by the National Academy for State Health Policy about how to best integrate services across state agencies to expand housing options to their Medicaid members.

Over the pilot period, the Department would collaborate with DOLA and the Department of Human Services (CDHS) to build a sustainability model for these housing supports by identifying which services are billable as wraparound Medicaid benefits and which are fundable through CDHS. With the support of the NASHP technical assistance grant, the Department would conduct an analysis of funding mechanisms and payment models and develop recommendations on how to improve support models of care for individuals with extensive history of complex

social and behavioral health needs. The Department would hire a contractor to complete a formal evaluation for costs and benefits.

For providers, this would create options for them to expand their business models, increasing their solvency and the populations they are able to serve. It would build provider capacity, including housing service providers, and sustainability in rural areas where traditional models of long-term care are becoming more difficult to provide due to changing economic and population needs.

The Department would need two FTE to implement this project. One FTE would be responsible for implementing the pilot program. This would include working with teams across the Department, external stakeholders, federal partners, and other state agencies to design the program. They would be responsible for selecting a contractor to evaluate the program, creating metrics, and designing a benefit. This FTE would also provide similar administrative support to the Social Determinants of Health (SDOH). The second FTE would coordinate the operational side of managing the program including setting up online communications, supporting grant reporting for recipients, budgets, compliance site visits, and coordination of federal approval of the program.

Behavioral Health Capacity Grants

To finalize the suite of projects to expand the behavioral health safety net in Colorado, the Department proposes a final project focused on community identified service gaps that members experience when seeking behavioral health services. The Dept. proposes granting small funding infusions that focus on the following needs: rural behavioral health, tribal behavioral health, integrating care and treatment options in communities, substance use services, and filling other locally identified gaps in the care continuum (not already mentioned in BH grants around transitions and mobile response). There would be a technical assistance component for grantees provided through a learning collaborative model.

Funds would be distributed to smaller sub-awardees using evidenced-based practices. Awards would be prioritized to agencies mitigating care deserts or better serving the Colorado American Indian/Alaskan Native (AI/AN) population. This grant program would prioritize providers and programs that are improving their ability to serve individuals with disabilities on an HCBS waiver, who also have co-occurring behavioral health (SUD and MH) needs with a focus on lower acuity services and smaller community-based providers compared to the previously mentioned initiatives.

By offering a structured yet adaptable subgrant program, the Department can meet diverse needs of members and continue to improve and innovate access to care. Detailed subgrant requirements would be developed by the Department during the planning year in collaboration

with providers and Medicaid beneficiaries impacted by these policies. This project would utilize shared FTE resources listed within the Expanding the Behavioral Safety Net project.

FTE Support for Projects to Improve Access to HCBS for Underserved Populations
The Department would need one FTE to supervise the projects and FTE under this category of work. The FTE would manage the 4.5 line-level staff requested to complete these projects and ensure all projects stay on track and meet anticipated outcomes. Without this support, the Department would risk not being able to effectively implement these projects, including distributing the grant funding in a timely manner.

Support Post-COVID Recovery & HCBS Innovation
The COVID-19 pandemic has had a startling, disproportionate impact on individuals residing in congregate care settings. While the ARPA funding may not be used for nursing facilities, it may be used to transform community-based residential care settings. Reimagining Colorado's residential settings is required to support member health, safety, and overall well-being, as well as to create the long-term care system of the future. This future system ideally supports choice, offers the continuum of care, and is provided in the member's home or community of choice. The proposed initiatives would support collaboration with community partners to begin the work of transforming the residential care setting environment and method by which these partners provide services.

Theory of Change	Investing in innovative ways to support HCBS members and providers recover from the pandemic will lead to long term sustainable solutions that will prove to help members live and age where and how they want.
Program Objective	To create short term COVID recovery programs for both members and providers and long-term sustainable models of care to accommodate the growing aging population and those wishing to remain in community-based settings indefinitely.
Outputs Being Measured	Provider sustainability will be a key measurement for the success of the recovery programs.
Outcomes Being Measured	Access to residential services for all members that supports choice and the continuum of care.
Cost/Benefit Ratio	The Department anticipates cost savings from these initiatives for a number of reasons. The pandemic had significant impacts to members and HCBS provider. Without recovery efforts many of those providers will end of closing their doors, resulting in costly hospitalizations and institutionalization for members that can no longer receive necessary care in the community. Additionally, providing new innovative ways for members to receive residential services will allow more members to receive needed residential supports in a more cost-effective way than a hospital or other institutional setting.
Evaluations	Pre-Post
Results of Evaluation	In "Evaluating California's Assisted Living Waiver Program" Chen, Chen, Jordan, Lim, Lou, and Segal have found in recent surveys that seniors prefer to receive care in a home or community-based settings rather than in an institution. Researchers at Johns Hopkins

	found that while in-home care remains the care preference of many older people, close to one-third chose assisted living as their preferred care option. States throughout the country are developing innovative and transformative HCBS programs. Approximately 16 states have developed and implemented rate methodologies that are based on acuity and more accurately reflect the needs of the individual. In “The Impact of Respite Programming on Caregiver Resilience in Dementia Care: A Qualitative Examination of Family Caregiver Perspectives,” Emily Roberts, PhD, and Kristopher Struckmeyer, MS, identified, “the importance of caregiver respite as one factor in sustained resilience over the continuum of care for family members caring for an individual with dementia.” Additionally, Cooke, Smith and Brenner found, “Respite care was viewed by parents as a vital resource to assist in the management of their child with an ASD, however, access to respite services is a significant challenge, and parents are prepared to go to extreme lengths to obtain appropriate respite services for their children,” in their article, “Parents’ experiences of accessing respite care for children with Autism Spectrum Disorder (ASD) at the acute and primary care interface: a systematic review.” In "Housing Design and Community Care: How Home Modifications Reduce Care Needs of Older People and People with Disability," Phillippa Carnemolla and Catherine Bridge's paper analyzed, "...self-reported care data from 157 Australian community care recipients (average age: 72 years) who had received home modifications within the past 6 months. A before/after comparison of care provided revealed that home modifications reduced hours of care provided by 42% per week. More detailed analysis revealed that the positive association of home modifications with care reduction is stronger with informal care (46% reduction) followed by formal care (16% reduction). These results suggest the role that home modifications, and housing design in general, play in reducing care needs in a community setting." Wisconsin created a pilot to understand how incentive-based payments impact on Competitive Integrated Employment (CIE) outcomes. The Wisconsin pilot consisted of 3,288 individuals: 25 months after the start of the pilot there was a 35% growth in the number of people employed in CIE. 6 years after the start of the pilot there was a 70.6% growth in the number of people in CIE.
Continuum Level	Step 3

Innovative Models of Care

Residential Innovation

Under this project, the Department would develop and pilot continuum models of care that incent the creation of financially viable small residential programs that are person-centered, with a focus on rural communities. This would be accomplished through two initiatives.

- Models of Care Analysis: Contract with a vendor to conduct an analysis of funding mechanisms and feasibility on how to improve transitions of care for people transitioning from nursing facilities and other institutional settings and potential new models of care

for investment and innovation. Vendor would produce a final report of recommendations for the Department to pursue for implementation, transition, and/or pilot.

- Pilot Program: Contract with a vendor to develop a pilot of an intentional community planned specifically to build a residential neighborhood that combines natural/community supports, modified residential homes, and existing services across systems to support older adults to live as they would like to in a safe, supportive community environment. The planned community would be inclusive of people living there who are older and aging adults as well as other community members who choose to live there.

The Department would need one FTE to implement these projects. The FTE would develop and manage the contracts and facilitate stakeholder engagement. Further, this FTE would also work on the 'New Systems of Care' project.

Promote Single Occupancy
This project would focus on supporting assisted living facilities and group homes in creating more single occupancy rooms, which would help prevent spread of diseases and promote greater independence among residents. The Department would contract with a vendor to research current practice and what it would take for these providers to offer more single occupancy rooms. The Department would offer incentive payments with state-only funding for providers to convert more space to single occupancy rooms. The FTE at the Department directing this work and managing the contract would be shared among the 'Residential Innovation' and 'New Systems of Care' work.

Child/Youth Step-down Options Program and Provider Recruitment
The Department proposes to focus on those areas in which there are currently gaps in services and treatment programs for children and youth. These include members with Autism Spectrum Disorder, intellectual and developmental disabilities, and other dual diagnoses. The Department would work with several providers to develop a viable step-down treatment program including location, licensing and payment options. The focus would be to create models of care that are financially viable and person-centered, with a focus on those children and youth who are sent out of state for services. This project would also look at creation or expansion of a step-down service between hospitals and a short-term residential placement. Building these programs would expand the provider network for children in the Children's Habilitation Residential Program (CHRP) waiver by allowing for a full continuum of payment options to fit the members' and providers' needs.

The Department would need 1.5 FTE to implement this project. The FTE would be responsible for working with providers to build up programs and step-down services and providing funding where allowable to support those efforts. This includes:

- Building relationships with in-state and out-of-state providers to identify opportunities to expand service capacity
- Working closely with over a dozen existing multi-stakeholder groups
- Reviewing evidence and engaging in program design to service the youth HCBS population
- Review the existing facility licensing and policies, gaps in the policies, and create an implementation plan to include policy changes, outcomes, evaluation and monitoring, and member engagement.

The partial FTE would support the compliance, state regulation, and federal waivers/state plan amendments needed. This position would also support the IMD risk mitigation project with similar duties. This includes mandatory stakeholder engagement, responding to public comments, writing and promulgating rule, engaging with CMS on the request, working internally to update all relevant rates and contracts, and creating online materials to educate stakeholders on the changes.

Alternative Care Facility Tiered Rates & Benefit

The Department currently pays one per diem rate for all members served in an Alternative Care Facility (ACF), regardless of the level of setting. The Department proposes hiring a contractor to develop a tiered rate methodology for setting levels, with an emphasis on secured settings, for the ACF benefit. The funding would provide insight on how the Department could create multiple level settings for the ACF program that would limit placement into a skilled nursing facility. The contractor would analyze other states that utilize a tiered rate for HCBS residential services and how each state assesses a member for the appropriate tier. The contractor would provide recommendations related to services incorporated at each level to limit nursing facility placement and analyze whether Colorado's assessment tools would be sufficient to determine an appropriate tier. If a new assessment tool is required, the contractor would develop an assessment tool to be used by case management agencies for ACF placement.

The Department would need one FTE to manage the contract and facilitate stakeholder engagement for the tiered rates. Additionally, this FTE would lead development of the new tiered rate benefit, run a pilot for this work, update all of the associated regulations, and work to gain CMS approval.

Pilot CAPABLE

The Department proposes piloting and evaluating the innovative Community Aging in Place - Advancing Better Living for Elders (CAPABLE) program to support HCBS members to remain at home. CAPABLE is an evidence-based initiative program developed by Johns Hopkins School of Nursing. It pairs older adults with a care team to help them age in place, including a nurse, occupational therapist, and a handy worker. The Department would pilot the CAPABLE program

in three to four locations across the State with the goal of enrolling 400 people. Though the program has been rigorously evaluated, the Department wants to ensure it results in the same outcomes, including cost savings, when implemented with a diverse group of members, including individuals of younger ages and those living in rural communities. This would include state-only funding for the pilot sites for the care team. The Department would also contract with a vendor to evaluate the success of the pilot in achieving improved client outcomes. This work would be shared with the ACF tiered rates and benefits position.

Supported Employment Pilot Extension

The Department received funding in FY 2019-20 R-16, "Employment First Initiatives and State Programs for People with IDD," to conduct a supported employment pilot program to incentivize outcomes where people achieve and maintain employment. Funding for this project is expiring on June 30, 2022. The Department proposes extending and expanding the current pilot program to allow for increased participation, additional data collection, and to determine if expanding incentive-based payments for supported employment services within the waivers is cost effective and produces positive outcomes. To do this, the Department would need an additional two years of funding for the grant funding and one term-limited FTE currently responsible for administering the project, plus one-time funding for the evaluation contractor.

New Systems of Care

The Department has an opportunity to identify and pilot innovative systems of care that recognize and leverage the needs and capabilities of various populations. Under this project, the Department would study successful initiatives implemented by other states and nations while also developing pilot programs that:

- Leverage creative solutions to provide low/no cost childcare to home and personal care workers, which helps address low wage concerns by expanding "total compensation"
- Pair older adults with college students who need affordable housing
- Create college credits and increase the workforce by employing college students to provide respite, homemaker, and personal care services to our growing older adult population, as well as the general HCBS population.

The Department would create a grant program with state-only funding to support innovative models of care. The Department would use a contractor to do an environmental scan of evidence-based practices that could be used and to create an innovative model to address "total compensation" for direct support professionals. A contractor would engage with stakeholders to develop the grant program whereby agencies could apply for funding to implement innovative initiatives.

Respite Rate Enhancement & Grants

Expanding respite services was one of the most frequently cited items by stakeholders for consideration in the ARPA spending plan. Respite services provide temporary relief for the members' primary caregiver. This is necessary to support to caregivers and helps prevent members going to institutional settings.

Respite Grant Program

The Department proposes creating a grant program for increased access to respite for caregivers/families of members. The Department would hire a contractor to identify the landscape of respite availability across Colorado. The contractor would create a report identifying the gaps in respite care availability. Based on this report, the contractor would develop a framework for a state-only grant program. Grant recipients could include parents, grandparents, or child caregivers of aging parents or family, and could be expanded to include other members of a household that are not usually afforded respite but could also benefit from respite.

Respite Rate Enhancement

The Department would provide a temporary targeted rate increase to incentivize additional respite providers to serve HCBS members and children, with a focus on home-based services. The rate increase would also apply to respite services provided under DHS' crisis services program. In addition, the Department would hire a contractor to identify innovative ways that can be taken to incentivize respite provision. The contractor would meet with providers and other Colorado respite programs to gather information about barriers for enrollment and service provision.

Home Modification Budget Enhancements

One way to help members continue to live in their homes is by funding specific modifications, adaptations, and improvements to their existing home setting. The Department proposes providing additional funding above the current service limitations for home modifications. This could be a set amount available and accessible by all members who have access to this benefit through their waiver. The Department would also need funding as part of an interagency agreement with DOLA to review the expanded home modification requests.

Hospital Community Investment Requirements

Under this project, the Department would research and develop recommendations for how to leverage hospital community investment requirements to support transformative efforts within their communities. The Department would develop minimum guidelines for community benefit spending and reporting values to hold hospitals accountable to meet community needs as determined by the community itself and align with statewide health priorities. These guidelines should allow for more consistent reporting and determination of what is a community health need as well as better evaluate the impact of community benefit programs. The Department

would need to hire a contractor to assist with project kickoff, facilitate stakeholder engagement, and develop processes and guidelines including methodology for minimum community benefit spending.

Community First Choice

Community First Choice (CFC) was established by the Affordable Care Act in 2010 and allows the Department to offer attendant care services on a state-wide basis to eligible members, instead of only those who meet criteria for a 1915(c) waiver. The Department would use funding to cover the administrative costs associated with the development and implementation of CFC, including system costs, stakeholder engagement, FTE, and a new Wellness and Education Benefit. The goal is to implement CFC by January 1, 2025. Once implemented, the state would qualify for a 6% ongoing federal enhanced match on certain HCBS services.

To develop and implement CFC, the Department would need the following:

- 5.0 FTE: The Department needs a program manager to oversee implementation and facilitate stakeholder engagement; a project manager to coordinate implementation and ensure the project stays on track; a policy advisor to develop standardized service definitions, implement rule revisions, and assist with benefit management; a business analyst to identify and implement system changes; and a policy advisor to manage contract for wellness benefit, develop materials for mailing, and to work with CMS for waiver approval.
- System changes: System changes would be required to add the existing HCBS benefits into the State Plan which necessitates changes to the provider subsystem, financial subsystem, prior authorization subsystem, the prior authorization system, provider subsystem, and care and case management product. Once these edits are made, there would need to be ongoing testing to ensure the changes made were accurate and operating correctly. Ongoing maintenance would be needed every time a change, such as a rate increase, is made to the benefits that would then be included in the state plan. The Department would need contractor staff hours and resources to make edits in its claims, eligibility, and case management systems.
- Stakeholder Engagement: The Department would need contractor funding to conduct stakeholder engagement related to CFC design and implementation. This contractor would manage all internal and external stakeholder participation surrounding CFC.

Strengthen Case Management Redesign

The transformation of Colorado's case management system is underway, requiring a complete reorganization of a decades-old system. Colorado is the second fastest growing state for older adults, which is driving increased demand for HCBS services. As the case management system adapts and transforms in preparation, growing pains could be better addressed if case management agencies were better prepared. To assist with expected organizational and system

changes, the Department proposes providing capacity-building funds, change management expertise, trainings on best practices and evolving systems support for agencies, members, and their families, as described in the initiatives below.

Theory of Change	Quality case management and coordination of care across the continuum of programs and services improves Medicaid member outcomes by building capacity; clarifying roles and identifying best practices in case management and coordination of care across system; improving training; and improving access, members would experience better outcomes and receive the right care at the right time, with reduced gaps in services/care, reduced duplication of services/care, and better ability to navigate the redesigned system.
Program Objective	Bolster case management delivery to provide members with effective case management and care coordination leading to improved member outcomes. Facilitate the transition and prepare LTSS case management service delivery for the required Federal and State changes implemented through case management redesign.
Outputs Being Measured	Quality of care and total cost of care through Departmental claims; case management training completion and evaluation of competency scoring; eligibility determination timelines.
Outcomes Being Measured	Improved outcomes for members with complex needs; improved member experience navigating the system; decreased length of time for eligibility determination and enrollment; improved quality of case management service delivery.
Cost/Benefit Ratio	The Department anticipates savings from these capacity building and streamlining measures as a result of better management of members' complex needs, faster access to needed services and improved delivery of quality and consistent case management services.
Evaluations	Pre-Post
Results of Evaluation	A structured literature review of twenty-nine studies mostly concerned with case management for frail older people, and others focused on people with multiple chronic diseases, high-cost patients, or those at high risk of hospital admissions. Three issues were identified as key to the coherent and sustainable implementation of case management for people with long-term conditions: fidelity to the core elements of case management; size of caseload; and case-management practice, incorporating matters relating to the continuity of care, the intensity and breadth of involvement, and control over resources.
Continuum Level	Step 3

Case Management Capacity Building

The Department proposes funding a contractor to support case management redesign efforts in the community. The contractor would develop a framework to support the change management requirements to ensure successful transition from the current system to implementation of a redesign that mitigates the negative impact on members. The contractor would work with Case Management Agencies (CMAs), local area organizations, and stakeholders to plan and prepare for Case Management Redesign (CMRD). In addition, the contractor would provide support to CMAs to implement CMRD policy changes, transition, legal and corporate structures, change

management, strategic and organizational planning, capacity and ensuring member have access to a CMA. As part of this effort, the contractor would develop infrastructure for a learning collaborative so that CMAs have access to individual resources relevant to their change management needs.

Improve and Expedite Long-Term Care Eligibility Processes

Under this project, the Department would work with stakeholders to identify solutions to barriers to long term care eligibility, both from a physical eligibility and financial eligibility perspective. CMS has stated that as part of ARPA they will consider approving new eligibility policies and or procedures, such as implementing expedited eligibility for HCBS or streamlined application and enrollment processes. These changes would require stakeholder engagement, submission to CMS for approval, and rule changes. Any changes would result in the need for system enhancements as well as training to counties, Medical Assistance sites, and case managers on eligibility requirements for waiver programs and other long-term care programs.

The Department would need one FTE to research and determine appropriate solutions for expedited eligibility processes and manage projects. In addition, the Department would need funding for any system changes that result from that research.

Improve Case and Care Management Practices

Members would benefit from better collaboration and coordination of care across their continuum of care needs and from being informed consumers of their care. To accomplish this, the Department proposes evaluating case management rates to ensure they are appropriate for the activities expected of CMAs and researching best practices among case managements.

Case Management Rates

The Department transitioned to a new rate structure for case management agencies in FY 2020-21. The Department proposes hiring a contractor to evaluate and identify best practice approaches for rate methodology in case management and then develop a proposed rate structure for these activities and services, including identifying options for tiered rates for supporting members with complex care needs. Contractor would also work in coordination with the Department to facilitate stakeholder engagement on methodology.

Case Management Best Practices

Person-centered case management and care coordination requires adapting outreach strategies and support services to the needs of the population and of individuals, which may be different depending on the disability. The Department would research national best practices and develop and pilot these practices through models of care coordination that meet the unique needs of a variety of member profiles such as complex care coordination for those with dual or poly diagnoses. The Department would hire a contractor to assist the Department with developing a training plan, including developing appropriate materials, for case management

and RAE staff on their various roles and responsibilities, collaborative roles between the systems, and effective care collaboration across the continuum of care, especially for members with complex needs. It would also include outreach and member materials to build awareness of the roles and responsibilities of the CMAs and RAEs. The contractor would develop infrastructure for a learning collaborative development and facilitation.

The Department will need two FTE to complete this initiative. The FTE would be responsible for project and contract management, including pilots of care coordination models, research, developing and facilitating the trainings and community of practice to the case management agencies and the RAEs. The FTE would also be responsible for the ensuring operational implementation and evaluation of these new case management agency and RAE care coordination programs inclusive of target member identification, intervention development, outreach design and program measurement.

Case Management Agency Training Program

The Department proposes developing and implementing comprehensive training for case management agencies to improve quality and consistency statewide. A contractor would develop a robust training program for CMAs for all waiver programs and services, as well as behavioral health services, State Plan benefits, benefits counseling and CFC. All of the trainings will be incorporated into a Learning Management System allowing the Department to assign and monitor training completion. The contractor would also update all existing training materials for content updates and upload them to LMS software to establish competency-based performance requirements of case managers.

The Department would need funding to hire a contractor to develop the training as this will include approximately 50 different trainings. The Department would need one FTE to manage the contract and their design and development team to ensure adherence to the training and develop and maintain the training materials.

Invest in Tools & Technology

The HCBS system is complex with several technology systems and an enormous data infrastructure. To adequately prepare for the future, these systems need continual maintenance and updates. The tools and technologies the Department uses not only impact the Department's administrative functions, but each is integral to providers' ability to perform their contractual obligations and to provide care to members. In addition, technological advancement is necessary to support our members and their families who rely on Department systems to access services, seek resources, and gauge provider quality. This work would be done in partnership with the Office of eHealth Innovation. The Department proposes a package of investments to elevate its current suite of tools and technology and to develop new and emerging systems that would enable the Department to prepare for the future.

Theory of Change	Investing in technological improvements allows members to more easily access care and helps remove administrative burden on providers
Program Objective	Make improvements across systems, including member-facing systems, to allow for more streamlined access to care
Outputs Being Measured	Expedited eligibility processing for LTSS members; greater utilization of member-facing search tools and systems; upgraded systems for LTSS providers
Outcomes Being Measured	Members and providers reporting greater ease of access to Medicaid systems; improvements in access-to-care measures
Cost/Benefit Ratio	Short-term investments through ARPA funds would provide long-lasting benefit to members and providers by connecting them more efficiently
Evaluations	Pre-Post
Results of Evaluation	In a presentation on interoperability in HCBS,[12] CMS notes that fractured eligibility and payment systems lead to disconnects in outcomes; it provides several examples of states and agencies that used enhanced technology systems to provide better care to HCBS members
Continuum Level	Level 3

Home Health/PDN Acuity Tool

Home Health

Unlike the pediatric Long-Term Home Health (LTHH) benefit, the adult LTHH benefit does not have an associated valid and reliable acuity tool to help determine the appropriate level of care and time spent with each member. An adult LTHH acuity tool would help streamline the adult portion of the home health benefit and ultimately provide long-term savings to the State by providing an additional basis with which to determine appropriate service needs for members. The Department received funding to implement a LTHH acuity tool in FY 2019-20 through R-9, “Long Term Home Health/Private Duty Nursing Acuity Tool.” The Department used this funding to conduct an environmental scan in FY 2020-21 of other state approaches but was unable to identify an appropriate tool, concluding that the Department must build one from the ground up. There was not adequate funding to build and implement a tool with the funding from that request.

The Department proposes hiring a contractor to create, pilot, and validate an LTHH acuity tool for the adult population that is specifically tailored to Colorado home health policies. The contractor would conduct both a policy and systems crosswalk of the proposed variables required for the LTHH acuity tool with the long-term services and supports (LTSS) assessment tool that determines nursing facility and/or hospital level of care for members seeking LTSS services. This would help determine opportunities for alignment of the tools to ensure that as members’ needs change they do not have barriers to accessing other State Plan or waiver

[12] https://www.healthit.gov/sites/default/files/2018-12/AdvancingInteropinHCBS.pdf

benefits, nor is there duplication of services. The long-term vision is to integrate this tool as a module or option connected with the HCBS assessment tool.

Members would benefit from an acuity tool with validated reliability that would accurately forecast the medically necessary amount of home health services that also considers their holistic HCBS needs to make sure they access the right service and the right time. Providers would benefit from an acuity tool that would assist them when assessing a member's needs and facilitate decision making as to the medically necessary amount of services that a member requires. The contractor would provide recommendations to the Department on how other states ensure oversight and mitigate any conflict of interest for who assesses and approves the amount, scope and duration of services to comply with all federal rules.

The Department would utilize an FTE to manage the contract, provide state policy information, engage stakeholders, and determine next steps regarding systems builds. This FTE would also be responsible for supporting all other Home Health Projects, such as the Home Health Delegation Project and the value-based payments Home Health project.

Private Duty Nursing (PDN)

The Private Duty Nursing Benefit currently utilizes a pilot acuity tool that was created in 2004 to help determine the appropriate medically necessary level of care and associated nursing hours for members. This tool could better assess and determine medically necessary services between pediatric and adult members. Development of separate adult and pediatric PDN acuity tools would help streamline the PDN benefit and ultimately provide long-term savings to the State by providing a more accurate basis with which to determine appropriate medically necessary service needs for members. The Department received funding to implement a PDN acuity tool in FY 2019-20 through R-9, "Long Term Home Health/Private Duty Nursing Acuity Tool." The Department hired a contractor in FY 2020-21 to review several tools identified during an environmental scan with this funding. None of the identified LTHH or PDN tools can be used "as is", the Department's only option is to create its own tool by incorporating features of these identified tools.

The Department proposes hiring a contractor to create, pilot, and validate both a pediatric PDN acuity tool and an adult PDN acuity tool that are specifically tailored to Colorado PDN and LTHH policies. Members would benefit from acuity tools with validated reliability that would accurately forecast the medically necessary amount of PDN services. Providers would benefit from an acuity tool that would assist them when assessing a member's needs and facilitate decision making as to the medically necessary amount of services that a member requires.

Once the vendor-created acuity tool is developed, the Department would integrate the developed tool as a module within the Care and Case Management System. The utilization management vendor would either access the CCM tool directly or through a workflow that

would allow them to perform the necessary medical necessity prior authorization determinations for PDN and LTHH benefits. Specialty Search in Provider Specialty Tool

HCBS providers struggle to identify which specialty they qualify for and which one to select when using the MMIS online enrollment module. As a result, providers either spend a lot of time researching provider specialties on the Department's website or select specialties in the MMIS for which they are not qualified or do not wish to enroll for. The result is a lot of wasteful back and forth between providers and the MMIS vendor, and often, providers and the Department.

The Department proposes to hire a contractor to develop an optional "specialty finder" tool that would, through a series of questions, help providers identify which specialty or specialties they would like to enroll in, as well as the HCBS population they would like to serve. The tool would also provide guidance on other enrollment requirements that may be necessary to enroll and point to non-HCBS provider types they may be eligible for. The contractor would write the algorithm for the tool. Once developed, the algorithm would be integrated into the Department's website. This tool would allow providers to quickly understand which specialties they are eligible for, understand the steps necessary to enroll, and cut down on questions to MMIS staff and staff across the Department and the Department of Public Health and Environment.

Member Facing Provider Finder Tool Improvement

The Department administers a "Find A Doctor" provider search tool on the Department's website[13] that identifies health care providers based on certain search criteria selected by the user. The Department is currently working to add additional functionality to the tool, including the ability to search by practitioner location, practitioner associations, and provider specialties.

Under this project, the Department would add the critical criteria of "Cultural Competency" to the search tool. Cultural competence in health care is broadly defined as the ability of providers and organizations to understand and integrate these factors into the delivery and structure of the health care system. The goal of culturally competent health care services is to provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background, English proficiency or literacy. Through this project, the Department would add cultural competence search criteria to the tool. This could include criteria such as: woman or minority owned/operated, cultural and ethnic subgroups, etc.

Digital Transformation Projects

HCBS Provider Electronic Health Record System Upgrades

Many HCBS providers either do not have an electronic means to communicate, analyze or share information, or have systems that are either outdated and too expensive to upgrade. The

[13] https://www.colorado.gov/pacific/hcpf/find-doctor

Department proposes using funding to invest in upgrading, implementing, and enhancing electronic health record systems for HCBS providers through a grant program administered by the Office of eHealth Innovation. This would allow them to better coordinate care, access real-time information through health information exchanges and other interoperable systems, and to purchase any necessary tools or equipment for virtual services.

Member Tech Literacy

Like HCBS providers, many HCBS-enrolled members could benefit from greater access to electronic systems. Under this project, the Department would work with a contractor to develop an application and a program for members that would provide a one-year digital literacy training. This would improve their ability to access benefits virtually and more broadly improve their wellbeing.

HCBS Provider Digital Transformation

The purpose of this project is to provide funding to home and community-based providers to digitally transform their care delivery. Funding would include investments in upgrading or implementing electronic health record systems to be able to better coordinate care, access real-time information through health information exchanges, and the purchase of tools necessary for the delivery of virtual services. This project would leverage lessons and processes from the Department's Electronic Health Record incentive program and the Office of eHealth Innovation's telemedicine projects, with a focus on inclusive and equitable approaches and solutions. These funds would be provided through a competitive grant program that is aligned with other developing efforts, such as HB 21-1289, "Funding for Broadband Deployment."

Innovative Tech Integration

Technology changes rapidly, including in the health care field. The Department proposes exploring innovative technology that would improve diagnoses, services access, health outcomes, and program delivery for medical, behavioral, and HCBS services provided to HCBS members. The Department would hire a contractor to research potential innovative models for diagnoses, access, outcomes, and delivery. The contractor would also evaluate whether those technologies would work in Colorado practices. The contractor would provide recommendations, including implementation steps, for pursuing these forms of technology.

Care & Case Management System Investments

The Department proposes funding investments in system changes, software, and hardware to support the new care and case management system. These initiatives would support data sharing in ways that support person-centered, timely provision of care, improving the member experience. The Department proposes funding investments in system changes, software, and hardware to support the new care and case management system. These initiatives would support data sharing in ways that support person-centered, timely provision of care, improving

the member experience. The Department would need three FTE to implement the multiple aspects of this project for benefits, case management, systems and operations.

One FTE would be responsible for gathering benefit and related system requirements for the enhancements for the CCM Tool. These enhancements are features or functionality that were not identified as of the point of contract execution related to the CCM Tool. The portion of time that this staff would spend on this work is needed in addition to the current staffing pattern because this work falls outside of the work assigned to existing staff regarding the CCM Tool. Existing staff are assigned with work related to bringing the new system up while closing down the legacy systems, with work extending to testing, business process re-engineering, document review, and eventually, technical assistance and Go Live Support. There are not adequate resources at this time to address needed enhancements to the current system still under construction. This FTE would also provide support for other technology projects, such as coordinating staff across the Department and the Governor's Office of eHealth Innovation regarding the Member Data Sharing project to enhance care coordination. Staff would support contract execution related to the "Provider Specialty Finder" project, and work related to securing Case Management Agency access to CORHIO.

The Department requests two FTE to coordinate and manage the additional workload of research, planning, design, development, testing and implementing of complex system changes specifically related to the impact on program and policy changes for case managers. These FTE would provide subject matter expertise for system enhancement requirements, policy decisions, testing, stakeholder engagement, technical assistance and release of enhancements. These positions coordinate and facilitate the day-to-day program and technology coordination, change management and CMA processes that relate to the CCM system enhancements. Functions include system quality control, formulation or execution of management and operational policy guidance related to CM activities and services.

Device Costs
The Department proposes providing one-time funding for CMAs to purchase laptops or other mobile devices compatible with the new case management IT solution, the Care and Case Management (CCM) system. These devices would be used to support agencies in utilizing the new CCM system to perform case management functions during their regular business operations. Case managers would have the IT technology necessary to leverage the capabilities of the new CCM tool, including accessing the log notes offline, perform assessments in the home, or upload assessments with the latest technology. Members would be able to be assessed quickly in their homes and provide signatures in real time.

System Costs
Funding would also be used to implement policy change requirements and enhancements that were not captured with the implementation of the CCM system. For example, the CCM system

does not include remote signature capability of support plans by all stakeholders; this has been identified as an opportunity for future enhancements. Another potential enhancement is to allow providers to upload incident reports directly to the member record for the case manager to review and identify whether a critical incident occurred. This is highly encouraged by CMS to ensure incidents are tracked, mitigated, and trended prior to becoming a critical incident. Further, the Department proposes creating bidirectional data feeds between providers and the CCM, building on existing statewide data sharing strategies in development or in place regarding EHRs.

The Department also proposes creating a regional advisory board to support improvements to provider IT sophistication and interoperability, to include the development of data dictionaries of key elements needed by providers.

Updates to SalesForce Database

Under this technology project, the Department would hire a contractor to implement a system to centralize complaints, issues, grievance, clinical documentation and quality care complaints. This would include updates to the Salesforce system to allow for clinical review tracking, time tracking for staff as well as tracking for creative solutions and complex solution calls allowing for tracking of diagnosis, services and length of time it takes to locate a solution for the cases. There is no single existing system that allows staff to track these issues; it currently happens in many different databases that do not communicate with each other.

Member Data Sharing

Because of the CMS Interoperability Rule, which is a part of the 21st Century Cures Act, the Department received funding through its FY 2021-22 R-9 “Patient Access and Interoperability Rule Compliance” decision item to develop an agreed upon, consensus-based approach regarding compliance with the Interoperability Rule. Compliance is based on the creation of an open framework that will allow data to be stored, shared, and pulled into consumer-chosen, consumer-facing applications, vetted through a federally mandated review process.

The Department requests funding to integrate key data points from the CCM tool into a data set that meets federal technical requirements. This data could include member assessments, case management log notes, and critical incidents. The data would be available for members to access through consumer-facing applications or other Electronic Health Record (EHR) applications, leveraging recommendations from the Testing and Experience and Functional Tools (TEFT) Grant, in consultation with the Governor’s Office of eHealth Innovation. The implemented solution would be a way for members to access data collected by and maintained in the CCM tool, as well as information about qualified providers as maintained in the BIDM, and could include functionality like secure, in-app texting/reminders that could occur between Health First Colorado members and their care team or teams. The Department would design a Long-Term Services and Supports-focused application or other point of access. Any solution

would need to include functionality that is compliant with the Americans with Disabilities (ADA) Act.

Members would be able to access their CCM-related data through the application of their choice, using a device of their choosing. Members would have a seamless experience with their CCM-related health data, irrespective of payer or provider or originating IT source, and be able to access that information using technology of their choosing. This solution builds on existing work done statewide to provide access to health care data.

Centers of Excellence in Pain Management
Many HCBS members deal with chronic pain and are unsure how to navigate the system to providers that are best equipped to help them manage their pain and thrive. The Department proposes piloting a program in which a contractor team consisting of a nurse practitioner and a licensed clinical social worker would assess the needs of chronic pain patients for mental health or substance use disorder treatment. The team would coordinate appropriate referrals to mental health, SUD, or chronic pain treatment providers primarily via telemedicine using best practices for appropriate pain management. This team would also coordinate with RAEs to offer training and support to further expand the program and meet the needs of all members seeking treatment for chronic pain.

In addition to contracting with the pain management team (nurse practitioner, licensed clinical social worker, EHR and telemedicine) the Department would need one FTE to implement this project. The FTE would manage the vendor contract and coordinate the referral process from the team to the appropriate pain or behavioral health providers.

Systems Infrastructure for Social Determinants of Health
The Department, in partnership with the Office of eHealth Innovation, is proposing to expand the infrastructure for a Social Health Information Exchange (SHIE) which provides case management agencies and health care providers with real-time connections resources like food, energy assistance, well-ness programs, and more. This would be part of a broader social health information exchange ecosystem being developed by the Office of eHealth Innovation. The Department would need funding to implement the system design to link RAEs and CMAs to the SHIE. In addition, the Department proposes to distribute funding in the form of state-only community grants to help connect small non-clinical agencies that specialize in and serve the HCBS population to the health information exchange and access the functionality. The Department would build upon lessons learned from the recent build of the prescriber tool that connects providers to information that helps inform real-time decisions needed to best help members.

The Department would need one FTE to manage community engagement and strong coordination with the Office of eHealth Innovation where much of the work will occur. The FTE

would facilitate community outreach with organizations for which the Department does not have a well-established communication and engagement process. The engagement specialist would travel to community meetings, manage small groups of identified community leads and build a new network for project communication. Together, the Department and OeHI would design a Request for Proposal to ensure small community-based organizations across the state can connect to the new system.

Data Sharing Expansion

The Department is proposing several initiatives to expand data sharing across entities, including State agencies, to improve member service by ensuring case managers and care coordinators have the information they need to best serve members.

Connect CMAs to CORHIO

The Department proposes to connect the Case Management Agencies (CMAs) to the Colorado State Health Information Exchange (CORHIO) to obtain hospital admission data in real-time. While Admission, Discharge, and Transfer (ADT) data from hospitals is transmitted from the BIDM to the CCM system, there is a significant lag, which prevents it from being actionable. This project would entail purchasing a license for one user at each CMA to access ADT information via CORHIO.

Case managers would benefit from knowing when members have been hospitalized, alerting them to possible changes in functional needs and services and supports, as well as possible critical incidents. Case managers would be able to better coordinate care and participate in discharge planning with access to this information.

Data Sharing with the State Unit on Aging

The Department suspects that many LTSS older adult members are receiving services through their local community, including the Area Agencies on Aging. These individuals may not be accessing the care that they need and are eligible for through Medicaid. Understanding who these individuals are and what services they are relying on from community-based organizations would help the Department to better target services. Additionally, if the Department can improve access to Medicaid services for these individuals, it would free up resources for older adults who are not eligible for Medicaid LTSS.

In this project, the Department would work with the Office of Aging and Adult Services within CDHS to conduct a system mapping of program and IT systems to determine a mechanism to share data and information across offices. The goal would be to implement a technology solution to access the Area Agencies on Aging data to identify and better track Medicaid LTSS members who are receiving services. Current efforts are underway through Colorado’s Health IT Roadmap led by the Office of eHealth Innovation to accelerate the sharing of information

and establish infrastructure, governance, and policy that enable the broader health IT ecosystem and State agencies to support care delivery and quality measurement.

Interface with Trails

The Department proposes implementing system changes to connect Trails, the State's child welfare system, with the MMIS to allow counties to improve quality and reduce duplicate cases. This would improve the eligibility determination process for LTSS utilizers. The interface would allow county staff to determine if a child who is going to be entered in Trails already has an open case in another system. This may be accomplished by building a warehouse, an interface, or allowing Trails and the MMIS to communicate in real time.

Eligibility Systems Improvements

The Department proposes to improve eligibility systems to hasten application processing, improve determination accuracy, and provide real-time provider eligibility status insights. To do this, the Department would hire a contractor to support streamlining eligibility processing for HCBS members. This would include system enhancements, policy requirements, modifications and training to address barriers to long-term care eligibility. Part of the project would be to create a bidirectional interface between CBMS and the CCM. This project would require funding to identify valuable enhancements, make systems, and train case managers on the new functionality.

These changes would further automate the exchange of information between case managers and county technicians and eliminate the need to maintain a third system acting as a go-between for the entities, increasing operational efficiency and improving the member experience.

FTE Support for Technology Projects

The Department requests four FTE to manage all technology projects. This includes coordinating and managing initial systems change planning and design across both CBMS and MMIS, as well as other Department systems. The FTE requested would ensure policy requirements are translated into system requirements within the allotted timeline of each project. One of the biggest risks of implementing multiple system projects in addition to current project workload is that the requirements will result in system defects and will not be completed within the project timelines. These business analysts would understand the policy and the system and are integral to achieving the project timelines for policy and systems teams, as these resources not only write the requirements, but test the system to ensure the system is functioning as intended and fixing any issues in the test environment. Without these additional resources, the timelines cannot be met.

Expand Emergency Preparedness

The pandemic has illustrated how crisis preparation and a swift response can dramatically change the outcome in the wake of an emergency. Individuals with disabilities, who live in the community, may not have the support or resources needed to be adequately prepared for an emergency, putting them at increased risk when a crisis arises. Building the capacity for both emergency preparedness and rapid response in the face of disasters, such as fires, floods, or a pandemic, will ensure Coloradans living with disabilities are protected. The Department proposes the initiatives described below to support future emergency preparedness.

Theory of Change	Individuals who face elevated risks in times of emergency, such as older adults and those with disabilities, have better outcomes and less mortality when concrete and robust emergency response plans and supplies are in place. Additionally, in times of non-emergency, having plans and supplies in place increases overall well-being by reducing anxiety and stress related to the increased potential for negative outcomes that may result from not having a plan or supplies.
Program Objective	Mitigate increased risk of mortality and negative health outcomes through robust planning and resource allocation for supplies.
Outputs Being Measured	Number of emergency preparedness and response plans in place, supplies provided.
Outcomes Being Measured	Reduced injury and mortality for older members and members with disabilities in the event of a disaster
Cost/Benefit Ratio	The Department anticipates cost savings from the expansion of emergency preparedness through reduced emergency-related care provided to members as a result of having the supplies and plans in place prior to an emergency arising.
Evaluations	Pre-Post
Results of Evaluation	In the United States, people with disabilities are 2 to 4 times more likely to die or sustain a critical injury during a disaster than people without disabilities.[14] The UN reports that "persons with disabilities are more likely to be left behind or abandoned during evacuation in disasters and conflicts due to a lack of preparation and planning, as well as inaccessible facilities and services and transportation systems. … Disruption to physical, social, economic, and environmental networks and support systems affect persons with disabilities much more than the general population. There is also a potential for discrimination on the basis of disability when resources are scarce. Furthermore, the needs of persons with disabilities continue to be excluded over the more long-term recovery and reconstruction efforts, thus missing another opportunity to ensure that cities are accessible and inclusively resilient to future disasters."[15]

[14] https://www.americanprogress.org/issues/disability/reports/2018/09/24/458467/serving-hardest-hit/

[15] https://www.un.org/development/desa/disabilities/issues/disability-inclusive-disaster-risk-reduction-and-emergency-situations.html

Continuum Level	Step 2

<u>Emergency Response Plans</u>
One initiative to support future emergency preparedness is developing provider emergency preparedness and response plans. These would be resources that outline how providers will assist members with preparedness, and in the event of an emergency, how they will provide direct support. The Department would hire a contractor to research national standards for emergency preparedness for various provider types. Based on that research, the contractor would develop tools and resources for providers in developing emergency preparedness and response plans.

<u>Member Emergency Preparedness</u>
In addition to providing resources for providers, the Department would assist members with disabilities and those with mental health needs who live independently in the community to be prepared for potential emergencies by providing resources, supplies, or education. The Department would hire a vendor to develop and execute a strategic plan to prepare members with disabilities, including behavioral health, for emergencies. The plan would address educational efforts, individual emergency plan development, and the distribution of resources and supplies, such as generators.

Enhance Quality Outcomes
A primary responsibility of the Department is ensuring the health, wellness, and safety of its members. As such, the Department must implement quality standards and maintain strict oversight of provider agencies. The Department proposes a series of projects to develop quality frameworks and oversight requirements, resulting in anticipated cost savings, provider accountability, and improved quality outcomes.

Theory of Change	Programmatic and Provider oversight with a focus performance enhancement will lead to members receiving higher quality services and higher performing providers.
Program Objective	To evaluate the performance of our contracted vendors to ensure oversight of agency performance and facilitate improved member outcomes
Outputs Being Measured	Survey of members on their satisfaction of services, ability to access services and supports Provider performance metrics
Outcomes Being Measured	Survey of members on their satisfaction of services, ability to access services- yearly analysis to determine whether impacts/outcomes are increasing, maintaining status or declining
Cost/Benefit Ratio	The Department anticipates increased performance from providers based on pay for performance incentives and published performance metrics that can impact whether a member selects to work with that provider.
Evaluations	Pre-Post Quasi-Experimental Design

Results of Evaluation	The Long-Term Services and Supports (LTSS) State Scorecard is a compilation of state data and analysis to showcases measures of state performance for creating a high-quality system of care in order to drive progress toward improvement in services for older adults and people with physical disabilities, and their family caregivers. The Scorecard provides comparable state data in order to benchmark performance, measure progress, and identify areas for improvement. Colorado's state rankings can be found on the Colorado specific page for the Long-Term Services and Supports State Scorecard website.[16] Colorado's Fact Sheet and the 2020 Report,[17] which is a compilation of all state data can be found on the Long-Term Services and Supports State Scorecard website.[18] Please note that data collection for the Scorecard was collected in 2019. Therefore, measures included in the 2020 Scorecard show the comprehensive system performance before the COVID-19 outbreak began.
Continuum Level	Step 3

Provider Score Cards

To support quality performance, the Department would establish metrics and develop public-facing provider scorecards. Scorecards can be used to identify at-risk providers for more intense follow up and to help consumers and their families make choices about their care. Providers with continuously low scores could face additional corrective action.

The Department would work with a contractor to create provider and CMA scorecards and to add the scorecards to the provider search tool. The contractor would include applicable performance measures to include in the scorecard. The Department would develop metrics and a weighting algorithm with provider input. Providers should understand metrics and underlying data sources and believe that scores accurately and meaningfully represent care quality. Provider input and buy-in can help the Department develop a better methodology, promote higher quality data collection, and encourage providers to improve performance based on findings.

In addition to the contractor funding, the Department would need a partial FTE to manage and coordinate the project, including maintaining the scorecard system after the contractor has completed development.

Provider Oversight

The Department operates ten waivers to provide Home and Community-Based Services (HCBS) to our members. To do this, the Department contracts with the Colorado Department of Public Health and Environment (CDPHE) to certify providers, demonstrating they meet state and

[16] https://www.longtermscorecard.org/databystate/state?state=CO
[17] http://www.longtermscorecard.org/~/media/Microsite/Files/2020/LTSS%202020%20Reference%20Edition%20PDF%20923.pdf
[18] https://www.longtermscorecard.org/

federal requirements regarding the safety and well-being of consumers. The certification process involves an initial survey when the provider enrolls in Medicaid and unannounced re-certification surveys periodically thereafter, in most cases every three years. Through onsite visits conducted every three years, surveyors capture comprehensive information on: policies and procedures; consumer experience and satisfaction with services; staff perspectives on care quality; alignment between care plans and service delivery; and, in the case of residential settings, facility safety and cleanliness.

The Department has identified challenges with the certification processes. For one, surveys are not standardized across the various provider types. In addition, the complexity of the process and workload have made it challenging to certify providers every three years, as required. Finally, The Department does not have the tools necessary to analyze information on certification outcomes and hold providers to higher standards of quality of care.

The Department proposes to hire a contractor to help the Department finalize and implement work started in 2016 to address these challenges and to streamline the CDPHE oversight and application process. Specifically, the contractor would do the following:

- Confirm prior decision points made on where the process could be simplified, or unnecessary steps could be eliminated entirely with the goal of reducing the time it takes a provider to become enrolled.
- Implement a 3-tier system for all waiver services based on risk for fraud and abuse
- Facilitate and support break-out cross-Department groups in making necessary changes
- Provide support to streamline and align the certification processes across survey types
- Make recommendations to improve data collection and sharing, so data is actionable
- Create an action plan and timeline to implement recommendations from 2016 such as:
    - Allow deeming based on accreditation,
    - Streamline and align current survey certification processes,
    - Emphasize Quality Management Programs,
    - Enhance remediation strategies, and
    - Create a comprehensive picture of provider quality
- Create recommendations to more fully integrate the surveying and provider enrollment processes across CDPHE, HCPF, and its vendors, such as:
    - An electronic workflow that would allow a warm handoff from CDPHE to HCPF for enrollment to bill for services once survey work is completed
    - Creation of an identification/tracking method for the shared tracking of providers across the two agencies

The Department would need funding for the contractor, as well as for system changes to the MMIS to incorporate the recommendations and a partial FTE to manage the contract and system changes.

Pay-for-Performance
The Department currently pays for most services under a fee-for-service methodology, which rewards for volume of services rather than the quality of the care provided. The Department proposes shifting to pay-for-performance programs within a few program areas. To accomplish these projects, the Department would need one FTE to complete financial analyses for each of the pay-for-performance programs, including designing complex financial rate methodologies. This entails complex financial modeling and data analysis to ensure the provider payments are sufficient for each of the programs. The position would also ensure that the financial and quality models are compliant with all federal regulations.

Pay-for-Performance for HCBS Waivers
The Department would hire a contractor to develop a pay-for-performance rate methodology for the HCBS Residential programs. The contractor would work with various states that use pay for performance to identify key performance indicators to accomplish policy directives such as ensuring proper placement and care planning. The contractor would provide the Department recommendations on performance benchmarks, bonus pay amounts, and per diems. The Department would need a partial FTE to manage and coordinate the project, including performing stakeholder engagement.

Pay-for-Performance for PACE
Hire a contractor to identify key performance measures to incorporate into a pay-for-performance methodology within the PACE capitation payments. The contractor would identify the percentage for each performance measure, develop monitoring processes and reporting requirements, and develop an appeal process and contractual language. The Department would need an FTE to manage and coordinate the project, including performing stakeholder engagement.

Pay-for-Performance for Home Health
Hire a contractor to develop a pay-for-performance methodology for Long Term Home Health services. The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that accelerates the shift from paying for home health services based on volume, to a system that incentivizes value and quality. The proposed change addresses challenges facing Americans with Medicare who receive health care at home. The proposed rule also outlines nationwide expansion of the Home Health Value-Based Purchasing (HHVBP) Model to incentivize quality of care improvements without denying or limiting coverage or provision of Medicare benefits for all Medicare consumers, and updates to payment rates and policies. The contractor would develop methodologies and models to select the best value-based payment options. The Department would utilize the FTE listed under the Home Health and PDN Acuity to coordinate activities and manage the contract, identify policy goals, and draft regulations.

PACE Licensure

Within the PACE program, the Department would develop quality standards by establishing a PACE licensure type to ensure appropriate oversight and compliance. The Department would hire a contractor to establish a PACE audit structure including fee cost, resource needs, timeline, survey elements, corrective action plan templates, reporting requirements, valid sample size, appeal process, performance measures, and interview questions. The Department would also hire a contractor to develop a system to record and capture incident reviews, complaints, survey results, and reports. The Department would need an FTE to manage the contracts, facilitate stakeholder engagement, create reporting requirements, and identify key performance goals for the PACE organizations.

Quality

The Department is implementing an eConsult system to connect primary care providers with specialists in FY 2021-22. The Department proposes hiring a contractor to research whether it is feasible to expand the eConsult program to include a broader array of specialists, such as providers that have expertise and good outcomes working with individuals with disabilities. This funding request may be revisited pending CMS feedback regarding the Department's overall eConsult design.

CMS Quality Metrics

The Department proposes to routinely stratify CMS quality metrics by disability and SMI status. To accomplish this, the Department would invest in data repositories that enable more robust insights into gaps in care as well as the providers and services with positive outcomes, supports, and programs for individuals receiving HCBS. The Department would share this data with the RAEs and CMAs to help them connect members with the highest-performing providers. The Department would use the funding for systems investments to create clear data linkages necessary for dashboards to be operational.

Waiver Quality Expansion

To better understand where there are quality gaps in the HCBS waiver programs, the Department proposes to expand waiver quality surveys and metrics. This would provide insights into member experience, member satisfaction, and whether members received care that they reported needing. The Department would utilize the data to recommend changes to waiver programs.

The Department would hire a contractor to research and recommend the most appropriate member surveys to determine member experience, health outcomes, satisfaction, and quality outcome analysis measures. The contractor would design and/or procure the surveys and implement member outreach, engagement, and survey completion. The Department would also need two FTE for this project. One FTE would manage the survey development and perform data analysis on the outcomes of the surveys. The second FTE would be responsible for

stakeholder engagement, assisting with training, and developing program improvement plans for providers seeking to improve on the surveys.

Department of Corrections Partnership

The Department has engaged with Colorado Department of Corrections to address behavioral health services engagement as individuals are released from prison. This is captured in a cross-Department WIG. This project would work to expand post-release supports to members who are entering or may have already entered back into the community. The Department would hire one FTE responsible for the following action items:

- Identification of best practices when working with justice involved members
- Collaborate with justice systems at each level (released from incarceration, parole and probation) to share best practices,
- Identify most prevalent needs from these members and work with stakeholders to implement best practices when addressing them
- Work with state and local government and community-based organizations to identify solutions, develop meaningful metrics and build lasting support systems for individuals involved with the justice system.
- Partner with the Regional Accountability Entities to create member-reported information about the need for criminal-justice specific care coordination. Provide training materials and education to RAEs.
- Identify data system opportunities to monitor member enrollments in multiple systems and develop strategies to ensure data system connections are in place to improve coordination activities.

Quality Measures and Benefits Training

To ensure the best use of services potentially available to the HCBS population, the Department would develop training on quality performance measures with a focus on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit metrics. The team would use an analysis of EPSDT exceptions to illuminate current gaps in the HCBS program. The analysis and created training would include specific learning objective on how and when to use EPSDT exceptions and how and when to use HCBS services. To the extent this analysis exposes policy gaps, this information would be used to inform policy and program adjustments. These trainings would also be used to assist the state to meet the federal requirement of an intersection of EPSDT and waiver services as outlined in the CMS Part V Manual.

To complete this project, the Department would need to hire a contractor to provide a standard, adult learning training on EPSDT benefit and performance metrics. The final product would be posted on Department websites. The training is expected to be 4-6 separate training modules.

Additional Administrative Resources

Implementing this spending plan is a significant undertaking. The Department is requesting resources to implement each project but will also need resources to provide the administrative support for the projects overall. Department anticipates hiring 50+ term limited FTE, as well as executing many new or significantly amended contracts through the spending plan. The Department needs staff to draft position descriptions, recruit term-limited employees, and lead RFP development, as well as ensuring accurate coding and reporting to CMS and the JBC. The Department proposes to hire the positions described below as administrative resources for the spending plan work. The Department is also requesting funding for contractors to evaluate the projects pursued under this plan to guide future programmatic changes.

Function	FTE Request	Justification
Human Resources	1.0 FTE	Position would manage hiring, onboarding, and additional support for an inflated headcount; this includes employee relations, FMLA, Leave, Benefits, learning & development.
Procurement	2.0 FTE	Positions would be responsible for drafting up to 45 new solicitations, contracts and purchase orders to meet contracting needs resulting from these projects.
Accounting	2.0 FTE	One position would create and maintain coding infrastructure across both the iC and CORE systems, which would allow for tracking on the Department's approved spending plan and to ensure proper reporting; reconcile the quarterly spending plan to the CMS-64; and serve as the Division expert on ARPA reporting for OSC and Audit purposes. One position would process payments and reconciliations; provide reporting and oversight of budgetary lines; and process adjustments and necessary accounting entries related to ARPA funding.
Disability Funding Committee Coordinator and Policy Liaison	0.5 FTE	This position would provide insight and coordination regarding the impact of ARPA on disabled members, support cross-coordination across state agencies, and aid in outreach and collaboration with key stakeholders.
Data Analyst	1.0 FTE	This position would provide analytical support across all projects. This includes pulling claims data, visualizing the data, and interpreting the data to provide insights and help project managers draw conclusions.

Program Assistants	2.0 FTE	These positions would provide administrative support for all the projects, including coordinating the hiring and onboarding processes for new FTE; preparing receiving reports for contractor deliverables; setting up and organizing schedules for stakeholder and internal meetings; preparing documentation for meetings, attending, and taking minutes; and tracking progress as needed on certain key projects.
Total	**8.5**	

Anticipated Outcomes

The Department anticipates that the short-term funding provided through this spending plan would result in long-lasting changes to the HCBS system. It would provide much-needed funding to direct care workers and providers, which would encourage greater retention and increased access to care. It would target investments to innovative ways to provide more person-centered care, which the Department can leverage to determine the most appropriate long-term solutions. The spending plan would result in technological improvements to streamline communication between HCBS providers, members, and departments. It would also allow the Department to develop many trainings and quality tools that would result in more appropriate and cost-effective services for members.

Assumptions and Calculations

Appendix A contains detailed calculations for each of the initiatives. Below are high-level descriptions of how the Department calculated each type of initiative.

- FTE Costs: The Department calculated the costs for each FTE by project separately. Most positions are assumed to begin on October 1, 2021 and last through the duration of the project (through March 31, 2024).
- Contractor Costs: The Department estimated costs based on projects of similar scope, then evaluated the number of hours for each contract and multiplied it by the standard hourly rate for that type of contractor to ensure reasonability.

The Department assumes that any costs that could be covered through the state plan or waiver authority would be eligible for Federal Medicaid Assistance Percentage (FMAP), which includes a 6.2% bump through December 31, 2021 and an additional 10% bump through March 31, 2022. The Department assumes that any costs that could be covered as Medicaid administrative costs would be eligible for 50% federal financial participation. All other costs are assumed to be covered with state-only funds; this is primarily for grant programs that are not covered under current Medicaid authority.

Supplemental, 1331 Supplemental or Budget Amendment Criteria

This request meets supplemental criteria as it is required by State statute. Section 25.5-6-1804 (SB 21-286) was signed into law on June 30, 2021 and requires that: "As soon as practicable after receiving federal guidance, the state department shall submit a proposed spending plan for the expenditures pursuant to this part 18 [Colorado Medical Assistance Program Requirements for Disbursement of Federal Funds Under the Federal 'American Rescue Plan Act of 2021'] to the Joint Budget Committee for the committee's rejection or approval."

CMS released guidance on Section 9817 of the American Rescue Plan Act on May 13, 2021, which did not provide enough time for the Department to outreach stakeholders and develop a spending plan prior to the finalization of the FY 2021-22 Long Bill. This request fulfills the requirement in SB 21-286 to submit a proposed spending plan to the JBC as soon as practicable after receiving federal guidance. The Department is prohibited from spending money from the Home- and Community-Based Services Improvement fund until the Joint Budget Committee approves the spending plan.

Table 1.1
FY 2021-22 Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$2,520,553	49.5	$0	$1,260,277	$0	$1,260,276	50.00%
B	(1) Executive Director's Office, (A) General Administration, Centrally Appropriated Costs	$572,731	0.0	$0	$286,365	$0	$286,366	50.00%
C	*Health, Life, Dental*	*$344,789*	*0.0*	*$0*	*$172,394*	*$0*	*$172,395*	*50.00%*
D	*Short-Term Disability*	*$3,589*	*0.0*	*$0*	*$1,794*	*$0*	*$1,795*	*50.01%*
E	*Amortization Equalization Disbusement*	*$112,177*	*0.0*	*$0*	*$56,088*	*$0*	*$56,089*	*50.00%*
F	*Supplemental Amortization Equalization Disbusement*	*$112,177*	*0.0*	*$0*	*$56,088*	*$0*	*$56,089*	*50.00%*
G	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$272,967	0.0	$0	$136,484	$0	$136,483	50.00%
H	(1) Executive Director's Office, (A) General Administration, Leased Space	$226,601	0.0	$0	$113,300	$0	$113,301	50.00%
I	(1) Executive Director's Office, (A) General Administration, General Professional Services	$30,560,714	0.0	$0	$15,280,357	$0	$15,280,357	50.00%
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information Systems Maintenance and Projects	$10,707,693	0.0	$0	$5,353,846	$0	$5,353,847	50.00%
K	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$94,018,907	0.0	$0	$37,533,114	$0	$56,485,793	60.08%
L	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	$67,262,159	0.0	$0	$26,851,602	$0	$40,410,557	60.08%
M	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	$12,118,673	0.0	$0	$4,837,873	$0	$7,280,800	60.08%
N	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support	$5,425,413	0.0	$0	$2,165,869	$0	$3,259,544	60.08%
O	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	$4,369	0.0	$0	$1,744	$0	$2,625	60.08%
P	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management	$2,695,503	0.0	$0	$1,206,681	$0	$1,488,822	55.23%
Q	(6) Other Medical Services - NEW LINE ITEM	$13,260,976	4.0	$0	$13,260,976	$0	$0	0.00%
Row	**Total**	**$239,647,259**	**53.5**	**$0**	**$108,288,488**	**$0**	**$131,358,771**	

Table 1.2
FY 2022-23 Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$3,383,177	46.1	$0	$1,691,589	$0	$1,691,588	50.00%
B	(1) Executive Director's Office, (A) General Administration, Centrally Appropriated Costs	$769,133	0.0	$0	$384,567	$0	$384,566	50.00%
C	*Health, Life, Dental*	*$463,189*	*0.0*	*$0*	*$231,594*	*$0*	*$231,595*	*50.00%*
D	*Short-Term Disability*	*$4,814*	*0.0*	*$0*	*$2,407*	*$0*	*$2,407*	*50.00%*
E	*Amortization Equalization Disbusement*	*$150,565*	*0.0*	*$0*	*$75,282*	*$0*	*$75,283*	*50.00%*
F	*Supplemental Amortization Equalization Disbusement*	*$150,565*	*0.0*	*$0*	*$75,282*	*$0*	*$75,283*	*50.00%*
G	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$43,822	0.0	$0	$21,911	$0	$21,911	50.00%
H	(1) Executive Director's Office, (A) General Administration, Leased Space	$304,425	0.0	$0	$152,212	$0	$152,213	50.00%
I	(1) Executive Director's Office, (A) General Administration, General Professional Services	$43,507,317	0.0	$0	$21,753,658	$0	$21,753,659	50.00%
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information Systems Maintenance and Projects	$14,170,604	0.0	$0	$7,085,302	$0	$7,085,302	50.00%
K	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$51,898,062	0.0	$0	$25,949,031	$0	$25,949,031	50.00%
L	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	$29,551,763	0.0	$0	$14,775,881	$0	$14,775,882	50.00%
M	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	$4,791,035	0.0	$0	$2,395,519	$0	$2,395,516	50.00%
N	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support	$932,606	0.0	$0	$466,303	$0	$466,303	50.00%
O	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	$667	0.0	$0	$333	$0	$334	50.07%
P	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management	$4,198,881	0.0	$0	$2,099,440	$0	$2,099,441	
Q	(6) Other Medical Services - NEW LINE ITEM	$55,339,558	4.0	$0	$55,339,558	$0	$0	0.00%
R	**Total**	**$208,891,050**	**50.1**	**$0**	**$132,115,304**	**$0**	**$76,775,746**	

Table 1.3
FY 2023-24 Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$2,392,529	28.9	$0	$1,196,264	$0	$1,196,265	50.00%
B	(1) Executive Director's Office, (A) General Administration, Centrally Appropriated Costs	$537,087	0.0	$0	$268,543	$0	$268,544	50.00%
C	*Health, Life, Dental*	*$320,716*	*0.0*	*$0*	*$160,358*	*$0*	*$160,358*	*50.00%*
D	*Short-Term Disability*	*$3,405*	*0.0*	*$0*	*$1,702*	*$0*	*$1,703*	*50.01%*
E	*Amortization Equalization Disbusement*	*$106,483*	*0.0*	*$0*	*$53,241*	*$0*	*$53,242*	*50.00%*
F	*Supplemental Amortization Equalization Disbusement*	*$106,483*	*0.0*	*$0*	*$53,241*	*$0*	*$53,242*	*50.00%*
G	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$30,356	0.0	$0	$15,178	$0	$15,178	50.00%
H	(1) Executive Director's Office, (A) General Administration, Leased Space	$210,788	0.0	$0	$105,394	$0	$105,394	50.00%
I	(1) Executive Director's Office, (A) General Administration, General Professional Services	$18,780,684	0.0	$0	$9,390,342	$0	$9,390,342	50.00%
J	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information Systems Maintenance and Projects	$9,866,250	0.0	$0	$4,933,125	$0	$4,933,125	50.00%
K	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$1,666,667	0.0	$0	$833,334	$0	$833,333	50.00%
L	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	$0	0.0	$0	$0	$0	$0	
M	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	$0	0.0	$0	$0	$0	$0	
N	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support	$0	0.0	$0	$0	$0	$0	
O	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	$0	0.0	$0	$0	$0	$0	
P	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management	$0	0.0	$0	$0	$0	$0	
Q	(6) Other Medical Services - NEW LINE ITEM	$46,067,172	4.0	$0	$46,067,172	$0	$0	0.00%
R	**Total**	**$79,551,533**	**32.9**	**$0**	**$62,809,352**	**$0**	**$16,742,181**	

Table 2.1
Summary by Initiative

Row	Project Area	Total Funds Impact	FTE	SFY 2021-22	SFY 2022-23	SFY 2023-24	Source/Calculation
A	Strengthen the Workforce & Enhance Rural Sustainability	$280,030,726	5.8	$175,575,026	$97,422,096	$7,033,604	Table 4.1
B	Improve Crisis & Acute Services	$17,220,077	3.0	$658,780	$9,192,169	$7,369,129	Table 5.1
C	Improve Access to HCBS for Underserved Populations	$56,525,872	5.5	$6,924,288	$25,650,174	$23,951,410	Table 6.1
D	Support Post-COVID Recovery and HCBS Innovation	$63,399,639	9.5	$20,445,105	$27,769,936	$15,184,598	Table 7.1
E	Strengthen Case Management Redesign	$10,675,745	4.0	$3,669,922	$4,125,314	$2,880,509	Table 8.1
F	Invest in Tools & Technology	$78,608,869	10.0	$25,656,462	$34,381,484	$18,570,923	Table 9.1
G	Expand Emergency Preparedness	$8,471,750	-	$4,248,375	$4,223,375	$0	Table 10
H	Enhance Quality Outcomes	$6,481,726	7.3	$1,833,171	$3,032,615	$1,615,941	Table 11.1
I	Department Administrative Overhead	$8,949,321	13.5	$1,393,817	$3,851,986	$3,703,519	Table 12.1
J	**Total Cost**	**$530,363,726**	**58.5**	**$240,404,945**	**$209,649,149**	**$80,309,631**	

Table 2.2
Summary by Fund Source

Row	Item	Total Funds Impact	FTE	SFY 2021-22	SFY 2022-23	SFY 2023-24	Source/Calculation
A	***Total Admin Cost***	***$142,427,189***	***54.5***	***$46,914,821***	***$62,936,576***	***$32,575,792***	***Sum of all admin expenses***
B	ARPA Cash Fund	$71,213,594		$23,457,410	$31,468,288	$16,287,896	Row A - Row C
C	Federal Funds	$71,213,595		$23,457,411	$31,468,288	$16,287,896	Row A * Row D
D	FMAP	50.00%		50.00%	50.00%	50.00%	Assume standard match
E	***Services Total Impact***	***$273,268,829***	***0.0***	***$180,229,148***	***$91,373,014***	***$1,666,667***	***Sum of all service expenses***
F	ARPA Cash Fund	$118,468,785		$71,948,945	$45,686,507	$833,333	Row E - Row G
G	Federal Funds	$154,800,044		$108,280,203	$45,686,507	$833,334	Row E * Row H
H	FMAP	56.65%		60.08%	50.00%	50.00%	Assume FMAP effective for time period
I	***State Only Impact***	***$114,667,706***	***4.0***	***$13,260,976***	***$55,339,558***	***$46,067,172***	***Sum of all state-only expenses***
J	ARPA Cash Fund	$114,667,706		$13,260,976	$55,339,558	$46,067,172	Row I - Row K
K	Federal Funds	$0		$0	$0	$0	Row I * Row L
L	FMAP	0.00%		0.00%	0.00%	0.00%	No FMAP for state-only costs
M	**Total Funds**	**$530,363,724**	**58.5**	**$240,404,945**	**$209,649,148**	**$80,309,631**	**Row A + Row E + Row I**
N	**Total ARPA Cash Fund**	**$304,350,085**		**$108,667,331**	**$132,494,353**	**$63,188,401**	**Row B + Row F + Row J**
O	**Total Federal Funds**	**$226,013,639**		**$131,737,614**	**$77,154,795**	**$17,121,230**	**Row C + Row G + Row K**
P	Total Funds - Appropriated through SB 21-286	$2,273,882	5.0	$757,686	$758,098	$758,098	SB 21-286
Q	ARPA Cash Fund - Appropriated through SB 21-286	$1,136,941		$378,843	$379,049	$379,049	SB 21-286
R	Federal Funds - Appropriated through SB 21-286	$1,136,941		$378,843	$379,049	$379,049	SB 21-286
S	**Incremental Total Funds**	**$528,089,842**	**53.5**	**$239,647,259**	**$208,891,050**	**$79,551,533**	**Row M - Row P**
T	**Incremental Cash Funds**	**$303,213,144**		**$108,288,488**	**$132,115,304**	**$62,809,352**	**Row N - Row Q**
U	**Incremental Federal Funds**	**$224,876,698**		**$131,358,771**	**$76,775,746**	**$16,742,181**	**Row O - Row R**

Table 3.1
SFY 2020-21 Calculation of Savings

Item	HCBS Waivers	Home Health (including DME)	Targeted Case Management	PACE	State Plan Pediatric Personal Care	Private Duty Nursing	Rehabilitative Services[1]	Total
FY 2020-21 Estimated Total Expenditure	$1,350,652,327	$606,833,638	$24,336,203	$241,399,635	$2,216,800	$110,036,191	$697,494,280	$3,032,969,074
% of Year Eligible for Enhanced Rate	25.00%	25.00%	25.00%	25.00%	25.00%	25.00%	25.00%	25.00%
Eligible FY 2020-21 Expenditure	$337,663,082	$151,708,410	$6,084,051	$60,349,909	$554,200	$27,509,048	$174,373,570	$758,242,270
State Share Savings	**($33,766,308)**	**($15,170,841)**	**($608,405)**	**($6,034,991)**	**($55,420)**	**($2,750,905)**	**($13,254,938)**	**($71,641,808)**
Reinvestment of State Funds	**$33,766,308**	**$15,170,841**	**$608,405**	**$6,034,991**	**$55,420**	**$2,750,905**	**$13,254,938**	**$71,641,808**

Table 3.2
SFY 2021-22 Calculation of Savings

Item	HCBS Waivers	Home Health (including DME)	Targeted Case Management	PACE	State Plan Pediatric Personal Care	Private Duty Nursing	Rehabilitative Services[1]	Total
FY 2021-22 Estimated Total Expenditure	$1,478,213,175	$628,322,748	$25,821,765	$267,082,914	$3,729,273	$118,516,055	$788,683,471	$3,310,369,401
% of Year Eligible for Enhanced Rate	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%
Eligible FY 2021-22 Expenditure	$1,108,659,881	$471,242,061	$19,366,324	$200,312,186	$2,796,955	$88,887,041	$591,512,603	$2,482,777,051
State Share Savings	**($110,865,988)**	**($47,124,206)**	**($1,936,632)**	**($20,031,219)**	**($279,696)**	**($8,888,704)**	**($43,604,483)**	**($232,730,928)**
Reinvestment of State Funds	**$110,865,988**	**$47,124,206**	**$1,936,632**	**$20,031,219**	**$279,696**	**$8,888,704**	**$43,604,483**	**$232,730,928**

Table 3.3
Calculation of Savings - Total Across Fiscal Years

Item	HCBS Waivers	Home Health (including DME)	Targeted Case Management	PACE	State Plan Pediatric Personal Care	Private Duty Nursing	Rehabilitative Services[1]	Total
Total Eligible Expenditure - April 2021 - March 2022	$1,446,322,963	$622,950,471	$25,450,375	$260,662,095	$3,351,155	$116,396,089	$765,886,173	$3,241,019,321
State Share Savings	**($144,632,296)**	**($62,295,047)**	**($2,545,037)**	**($26,066,210)**	**($335,116)**	**($11,639,609)**	**($56,859,421)**	**($304,372,736)**
Reinvestment of State Funds	**$144,632,296**	**$62,295,047**	**$2,545,037**	**$26,066,210**	**$335,116**	**$11,639,609**	**$56,859,421**	**$304,372,736**

[1] State share savings for rehabilitative services is equal to less than 10% due to the share of the expenditure attributable to the ACA expansion population, which will receive a 5% bump rather than a 10% bump.

Table 4.1 Workforce and Rural Sustainability

Row	Item	Total Funds	FTE Count	FY 2021-22	FY 2022-23	FY 2023-24	Admin/Service	Source/Calculation
	Increase Payments to Providers and Workers							
A	Rate Increase to Services Provided by Direct Care Workers	$262,335,191	0.0	$173,184,399	$89,150,792	$0	Service	Detailed plan forthcoming
B	FTE	$248,728	1.0	$78,294	$97,390	$73,044	Admin	One FTE to conduct financial compliance reviews
C	**Total Cost**	**$262,583,919**	**1.0**	**$173,262,693**	**$89,248,182**	**$73,044**		
	Direct Care Workforce Data Infrastructure							
D	Contractor Cost	$1,000,000	0.0	$500,000	$500,000	$0	Admin	One-time costs to create two surveys; ongoing costs to administer; costs for evaluation of all workforce projects
E	FTE	$157,384	0.8	$49,972	$61,379	$46,033	Admin	Partial FTE to manage contracts across the workforce projects
F	**Total Cost**	**$1,157,384**	**0.8**	**$549,972**	**$561,379**	**$46,033**		
	Skill, Advancement, & Awareness for the Direct Care Workers							
	FTE	$335,721	1.0	$104,392	$132,188	$99,142	Admin	One supervisor FTE to manage staff and projects within this bucket
	Standardized Core Curriculum & Specialization							
G	Curriculum Develop and Pilot Contractor	$1,125,000	0.0	$375,000	$375,000	$375,000	Admin	$375,000 for system development and the creation of the curriculum
H	Evaluation Contractor	$150,000	0.0	$50,000	$50,000	$50,000	Admin	$50,000/year to develop and execute the evaluation of all developed curricula
I	LMS	$750,000	0.0	$250,000	$250,000	$250,000	Admin	$200,000/year for onging costs to maintain and run the LMS, $50,000/year to manage the website 'hub'
J	FTE	$124,361	0.5	$39,147	$48,694	$36,521	Admin	Partial FTE to oversee the contracts
	Resource & Job Hub						Admin	
K	Website Development	$750,000	0.0	$250,000	$250,000	$250,000	Admin	$200,000/year for onging costs to maintain and run the website, $50,000/year to manage the website 'hub'
	Establish a Training Fund							
L	Training Funding	$7,000,000	0.0	$0	$3,500,000	$3,500,000	State-Only	Includes paying for contractor to act as fiscal intermediary
M	Incentives to Providers to Upskill	$2,000,000	0.0	$0	$1,000,000	$1,000,000	State-Only	Incentive program for workers to upskill
N	FTE	$222,628	1.0	$52,195	$97,390	$73,044	State-Only	1 FTE to manage the program
	Career Pathways							
O	Interagency Agreements	$429,643	0.0	$0	$245,509	$184,134	Admin	3 term limited FTEs at CDLE, Community College System, and DORA
P	FTE	$71,606	0.5	$0	$40,918	$30,688	Admin	Partial FTE to manage contracts
	Public Awareness Campaign							
Q	Contractor Cost	$432,000	0.0	$0	$216,000	$216,000	Admin	Hire advertising agency to develop + launch public awareness campaign; costs based on Health First Colorado campaign costs
R	**Total Cost**	**$13,390,959**	**3.0**	**$1,120,733**	**$6,205,699**	**$6,064,527**		
	Home Health Delegation							
S	Incentives for New Models of Care	$1,200,000	0.0	$0	$600,000	$600,000	State-Only	Incentive program for home health agencies
T	Contractor Cost	$150,000	0.0	$75,000	$75,000	$0	Admin	Contractor to investigate
U	**Total Cost**	**$1,350,000**	**0.0**	**$75,000**	**$675,000**	**$600,000**		
	Workforce Compensation Research							
V	Contractor Cost	$50,000	0.0	$0	$50,000	$0	Admin	Pay contractor to look at compensation rates for these workers - include case managers
W	**Total Cost**	**$50,000**	**0.0**	**$0**	**$50,000**	**$0**		
	Rural Sustainability and Investments							
	Identify Care Gaps							
X	Contractor Cost	$650,000	0.0	$500,000	$150,000	$0	Admin	Contractor to complete an environmental scan of Colorado's current HCBS/Medicaid provider network
Y	FTE	$148,464	1.0	$66,628	$81,836	$0	Admin	One FTE to manage rural sustainability and investment projects
	Develop Geographic Modifiers							
Z	Contractor Cost	$250,000	0.0	$0	$250,000	$0	Admin	Contractor to explore strategies by identifying regions and the associated rates by geographic region to account for the cost differential associated with different locations
	Shared Systems in Rural Communities							
AA	Contractor Cost	$450,000	0.0	$0	$200,000	$250,000	Admin	Contractor to explore strategies for partnering with hospitals and rural health clinics to create shared workforce skill sets, systems of care, and other administrative efficiencies
AB	**Total Cost**	**$1,498,464**	**1.0**	**$566,628**	**$681,836**	**$250,000**		

Table 4.1 Workforce and Rural Sustainability								
Row	Item	Total Funds	FTE Count	FY 2021-22	FY 2022-23	FY 2023-24	Admin/Service	Source/Calculation
AC	**Total Cost for Workforce & Rural Sustainability Projects**	**$280,030,726**	**5.8**	**$175,575,026**	**$97,422,096**	**$7,033,604**		
AD	Admin Costs	$7,272,906	4.8	$2,338,432	$3,073,914	$1,860,560	Admin	Sum of admin initiatives
AE	Services Costs	$262,335,191	0.0	$173,184,399	$89,150,792	$0	Services	Sum of service iniatives
AF	State-Only Costs	$10,422,628	1.0	$52,195	$5,197,390	$5,173,044	State-Only	Sum of state-only iniatives

Table 4.2
FTE Calculations - Workforce and Rural Sustainability

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
COMPLIANCE SPECIALIST IV	1.0	October		$54,885	$73,180	$54,885	Increase Payments to Providers and Workers
CONTRACT ADMINISTRATOR III	0.8	October		$33,141	$44,187	$33,140	Direct Care Workforce Data Infrastructure
ADMINISTRATOR IV	0.5	October		$27,442	$36,590	$27,443	Standardized Core Curriculum & Specialization
ADMINISTRATOR III	3.0			$0	$176,749	$132,562	Career Pathways. Not included in FTE count; IA positions
CONTRACT ADMINISTRATOR III	0.5			$0	$29,458	$22,094	Career Pathways
ADMINISTRATOR IV	1.0	January		$36,590	$73,180	$54,885	Establish a Training Fund
PROGRAM MANAGEMENT III	1.0	October		$78,819	$105,092	$78,819	Skill, Advancement, & Awareness for the Direct Care
ADMINISTRATOR III	1.0	October		$44,187	$58,916	$0	Rural Sustainability and Investments
Total Personal Services (Salary, PERA, Medicare)	**5.8**			**$275,064**	**$597,352**	**$403,827**	

Centrally Appropriated Costs							
Cost Center	**FTE**	**FTE**	**Cost or**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Health, Life, Dental	3.7	5.8	$10,042	$37,032	$87,868	$58,369	
Short-Term Disability	-	-	0.16%	$392	$851	$574	
Amortization Equalization Disbusement	-	-	5.00%	$12,242	$26,585	$17,973	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$12,242	$26,585	$17,973	
Centrally Appropriated Costs Total				**$61,907**	**$141,889**	**$94,889**	

Operating Expenses							
Ongoing Costs	**FTE**	**FTE**	**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Supplies	3.7	5.8	$500	$1,844	$4,375	$2,907	
Telephone	3.7	5.8	$450	$1,661	$3,938	$2,618	
Other	3.7	5.8	$0	$0	$0	$0	
Subtotal				*$3,505*	*$8,313*	*$5,525*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Furniture	5.8		$5,000	$18,438	$0	$0	
Computer	5.8		$2,000	$7,375	$0	$0	
Other	5.8		$0	$0	$0	$0	
Subtotal				*$25,813*	*$0*	*$0*	
Total Operating				**$29,318**	**$8,313**	**$5,525**	

Leased Space							
	FTE	**FTE**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	3.7	5.8	$6,600	**$24,338**	**$57,750**	**$38,363**	

Table 5.1 Improve Crisis and Acute Services to Keep People in Their Communities

Row	Item	Total	FTE Count	FY 2021-22	FY 2022-23	FY 2023-24	Admin/Service	Source/Calculation
	Behavioral Health Transition Support Grants to Prevent Institutionalization							
A	Contractor Cost	$150,000	0.0	$150,000	$0	$0	State-Only	Contractor for planning and to complete RFP
B	Grant Funding	$14,000,000	0.0	$0	$7,000,000	$7,000,000	State-Only	Grants to RAE regions ($2 million per region)
C	FTE	$124,361	0.5	$39,146	$48,694	$36,521	State-Only	Partial FTE to manage grant program
D	**Total Costs**	**$14,274,361**	**0.5**	**$189,146**	**$7,048,694**	**$7,036,521**		
	Expand Behavioral Health Mobile Crisis Teams							
E	Grant Funding	$1,750,000	0.0	$0	$1,750,000	$0	State-Only	Grants to RAE regions for readiness
F	Contractor Cost	$150,000	0.0	$150,000	$0	$0	Admin	Training contractor for RAEs and providers
G	FTE	$222,628	1.0	$52,195	$97,390	$73,044	State-Only	1 FTE to manage program
H	**Total Costs**	**$2,122,628**	**1.0**	**$202,195**	**$1,847,390**	**$73,044**		
	IMD Risk Mitigation							
I	Contractor Cost	$450,000	0.0	$150,000	$150,000	$150,000	Admin	Contractor funding to help with waiver application and budget neutrality
J	FTE	$373,088	1.5	$117,439	$146,085	$109,564	Admin	1.5 FTE to submit waiver and coordinate implementation
K	**Total Cost for IMD 1115 Waiver**	**$823,088**	**1.5**	**$267,439**	**$296,085**	**$259,564**		
L	**Total Cost for Behavioral Health Projects**	**$17,220,077**	**3.0**	**$658,780**	**$9,192,169**	**$7,369,129**		
M	Admin Costs	$973,088	1.5	$417,439	$296,085	$259,564	Admin	Sum of admin initiatives
N	State-Only Costs	$16,246,989	1.5	$241,341	$8,896,084	$7,109,564	State-Only	Sum of state-only initiatives

Table 5.2
FTE Calculations - Improve Crisis and Acute Services to Keep People in Their Communities

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
GRANTS SPECIALIST IV	0.5	October		$27,442	$36,590	$27,443	Behavioral Health Transition Support Grants
POLICY ADVISOR IV	1.0	January		$36,590	$73,180	$54,885	Expand Behavioral Health Crisis Teams
POLICY ADVISOR IV	1.5	October		$82,328	$109,771	$82,328	IMD Risk Mitigation
Total Personal Services (Salary, PERA, Medicare)	**3.0**			**$146,360**	**$219,541**	**$164,656**	

Centrally Appropriated Costs							
Cost Center	**FTE**	**FTE**	**Cost or**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Health, Life, Dental	2.0	3.0	$10,042	$20,084	$30,126	$22,595	
Short-Term Disability	-	-	0.16%	$208	$312	$234	
Amortization Equalization Disbusement	-	-	5.00%	$6,513	$9,770	$7,328	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$6,513	$9,770	$7,328	
Centrally Appropriated Costs Total				**$33,319**	**$49,978**	**$37,485**	

Operating Expenses							
Ongoing Costs	**FTE**	**FTE**	**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Supplies	2.0	3.0	$500	$1,001	$1,500	$1,126	
Telephone	2.0	3.0	$450	$900	$1,350	$1,013	
Other	2.0	3.0	$0	$0	$0	$0	
Subtotal				*$1,901*	*$2,850*	*$2,139*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Furniture	3.0		$5,000	$10,000	$0	$0	
Computer	3.0		$2,000	$4,000	$0	$0	
Other	3.0		$0	$0	$0	$0	
Subtotal				*$14,000*	*$0*	*$0*	
Total Operating				**$15,901**	**$2,850**	**$2,139**	

Leased Space							
	FTE	**FTE**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	2.0	3.0	$6,600	**$13,200**	**$19,800**	**$14,850**	

Table 6.1 Improve Access to HCBS for Underserved Populations

Row	Item	Total	FTE Count	FY 2021-22	FY 2022-23	FY 2023-24	Admin/Service	Source/Calculation
	Equity Improvement Projects							
A	Access for People of Color	$150,000	0.0	$150,000	$0	$0	Admin	Contractor to outreach communities for conversations
B	Access for Workers with Disabilities	$250,000	0.0	$0	$250,000	$0	Admin	Eligibility analysis to try to optimize the income and asset (and other eligibility requirements) to ensure that people with disabilities can work
C	**Total Costs**	**$400,000**	**0.0**	**$150,000**	**$250,000**	**$0**		
	Disability Training for Providers							
D	Contractor Costs	$1,000,000	0.0	$250,000	$750,000	$0	Admin	Robust training with ability to enforce completion among providers
E	**Total Costs**	**$1,000,000**	**0.0**	**$250,000**	**$750,000**	**$0**		
	HCBS Training for Members & Families							
F	Working with People with Disabilities	$25,000	0.0	$0	$25,000	$0	Admin	Based on costs for previous webinar work
G	Office of Community Living 101	$150,000	0.0	$0	$150,000	$0	Admin	3rd party vendor to create training
H	Support for Family Caregivers	$228,966	0.0	$0	$162,966	$66,000	Admin	Invest in a structured, online assessment of needs and connects to resources; based on quote from vendor with increase for inflation
I	**Total Costs**	**$403,966**	**0.0**	**$0**	**$337,966**	**$66,000**		
	Translation of Case Management Material							
J	Contractor Costs	$375,000	0.0	$0	$325,000	$50,000	Admin	Costs to translate all materials into top 3-5 languages
K	**Total Costs**	**$375,000**	**0.0**	**$0**	**$325,000**	**$50,000**		
	Expedite Behavioral Health Projects							
L	Gap Analysis	$140,000	0.0	$140,000	$0	$0	Admin	Contractor funding to identify gaps and make recommendations
M	Value Based Payments	$300,000	0.0	$300,000	$0	$0	Admin	Modelling/actuarial work to figure out the best way to implement value based payments
N	Targeted provider recruitment, training, and stakeholder engagement	$3,000,000	0.0	$1,000,000	$1,000,000	$1,000,000	Admin	Work with local communities to identify providers that do not accept Medicaid; provide technical assistance and education on high-intensity outpatient services; train providers to expand expertise
O	Assess and Review Regulatory Foundations for High-Intensity BH Services	$3,000,000	0.0	$1,000,000	$1,000,000	$1,000,000	Admin	$1M for technical assistance each year
P	Capacity building for higher-intensity BH services (incentives to RAEs)	$24,000,000	0.0	$0	$12,000,000	$12,000,000	State-Only	Incentive payments to RAEs
Q	FTE	$578,125	2.0	$180,789	$227,048	$170,288	Admin	Two FTE to manage projects and provide rate analytics
R	**Total Costs**	**$31,018,125**	**2.0**	**$2,620,789**	**$14,227,048**	**$14,170,288**		
	Wrap-Around Services, including Peer Supports, for Complex Members							
S	Housing Wrap-Around Services	$15,000,000	0.0	$5,000,000	$5,000,000	$5,000,000	State-Only	500 members per year at $10,000 per member
T	Budget Impact Analysis	$750,000	0.0	$250,000	$250,000	$250,000	State-Only	Robust analysis to determine whether program is cost effective
U	Project Management and Training	$300,000	0.0	$100,000	$100,000	$100,000	State-Only	Contractor funding for project management
V	DOLA Offset	($1,750,000)	0.0	($1,750,000)	$0	$0	State-Only	DOLA can offset the costs using current funding
W	Peer Supports Grants	$2,700,000	0.0	$0	$1,350,000	$1,350,000	Admin	Grant program; 3 programs for $450k each
X	Evaluation Contractor	$360,000	0.0	$0	$180,000	$180,000	Admin	Evaluate the grant programs
Y	FTE	$508,699	2.0	$159,961	$199,278	$149,460	Admin	Two FTE to oversee project
Z	**Total Costs**	**$17,868,699**	**2.0**	**$3,759,961**	**$7,079,278**	**$7,029,460**		
	Behavioral Health Capacity Grants							
AA	Grant Program	$5,000,000	0.0	$0	$2,500,000	$2,500,000	State-Only	Includes tribal grants
AB	FTE	$124,361	0.5	$39,147	$48,694	$36,521	State-Only	Partial FTE to manage grant program
AC	**Total Costs**	**$5,124,361**	**0.5**	**$39,147**	**$2,548,694**	**$2,536,521**		
	FTE Support							
AD	FTE	$335,721	1.0	$104,392	$132,188	$99,142	Admin	One FTE to supervise projects and staff in this category of work
AE	**Total Costs**	**$335,721**	**1.0**	**$104,392**	**$132,188**	**$99,142**		
AF	**Total Cost for Underserved Populations Projects**	**$56,525,872**	**5.5**	**$6,924,288**	**$25,650,174**	**$23,951,410**		
AG	Admin Costs	$13,101,511	5.0	$3,285,141	$5,751,480	$4,064,890	Admin	Sum of admin initiatives
AH	State-Only Costs	$43,424,361	0.5	$3,639,147	$19,898,694	$19,886,521	State-Only	Sum of state-only initiatives

Table 6.2
FTE Calculations - Improve Access to HCBS for Underserved Populations

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
GRANTS SPECIALIST IV	0.5	October		$27,442	$36,590	$27,443	BH Capacity Grants
POLICY ADVISOR V	1.0	October		$68,677	$91,570	$68,678	Wrap-Around Services, including Peer Supports, for Complex Members
GRANTS SPECIALIST III	1.0	October		$44,187	$58,916	$44,187	Wrap-Around Services, including Peer Supports, for Complex Members
ADMINISTRATOR V	1.0	October		$68,677	$91,570	$68,678	Expedite Behavioral Health Projects
RATE/FINANCIAL ANLYST IV	1.0	October		$63,288	$84,384	$63,288	Expedite Behavioral Health Projects
PROGRAM MANAGEMENT III	1.0	October		$78,819	$105,092	$78,819	FTE Support
Total Personal Services (Salary, PERA, Medicare)	**5.5**			**$351,090**	**$468,122**	**$351,092**	

Centrally Appropriated Costs							
Cost Center	**FTE**	**FTE**	**Cost or**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Health, Life, Dental	4.1	5.5	$10,042	$41,426	$55,231	$41,423	
Short-Term Disability	-	-	0.16%	$500	$666	$500	
Amortization Equalization Disbusement	-	-	5.00%	$15,625	$20,832	$15,625	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$15,625	$20,832	$15,625	
Centrally Appropriated Costs Total				**$73,176**	**$97,561**	**$73,173**	

Operating Expenses							
Ongoing Costs	**FTE**	**FTE**	**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Supplies	4.1	5.5	$500	$2,063	$2,750	$2,063	
Telephone	4.1	5.5	$450	$1,859	$2,475	$1,859	
Other	4.1	5.5	$0	$0	$0	$0	
Subtotal				*$3,922*	*$5,225*	*$3,922*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Furniture	5.5		$5,000	$20,625	$0	$0	
Computer	5.5		$2,000	$8,250	$0	$0	
Other	5.5		$0	$0	$0	$0	
Subtotal				*$28,875*	*$0*	*$0*	
Total Operating				**$32,797**	**$5,225**	**$3,922**	

Leased Space							
	FTE	**FTE**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	4.1	5.5	$6,600	**$27,225**	**$36,300**	**$27,225**	

Table 7.1 Post-COVID Recovery and HCBS Innovation

Row	Item	Total	FTE Count	FY 2021-22	FY 2022-23	FY 2023-24	Admin/Service	Source/Calculation
	Innovative Models of Care							
	Residential Innovation							
A	Contractor Research	$125,000	0.0	$125,000	$0	$0	Admin	Models of care analysis
B	Neighborhood Community	$1,000,000	0.0	$0	$1,000,000	$0	Admin	Planned community pilot
C	FTE	$151,338	1.0	$78,294	$73,044	$0	Admin	One FTE to manage project
	Promote Single Occupancy							
D	Contractor Research	$150,000	0.0	$75,000	$75,000	$0	Admin	Contract with a vendor to conduct an analysis of funding mechanisms and feasibility
E	Grants to Providers and Communities	$20,000,000	0.0	$0	$10,000,000	$10,000,000	State-Only	Payments to support single occupancy
F	**Total Costs**	**$21,426,338**	**1.0**	**$278,294**	**$11,148,044**	**$10,000,000**		
	Child/Youth Step-down Options Program and Provider Recruitment							
G	Contractor Cost	$3,900,000	0.0	$2,400,000	$1,500,000	$0	Admin	$1 million for infrastructure costs to recruit provider; $1.4 million to build capacity. $1.5 million in second year for possible expansions
H	FTE	$373,088	1.5	$117,439	$146,085	$109,564	Admin	1.5 FTE to manage project
I	**Total Costs**	**$4,273,088**	**1.5**	**$2,517,439**	**$1,646,085**	**$109,564**		
	Tiered ACF Rates							
J	Contractor Cost	$200,000	0.0	$66,667	$133,333	$0	Admin	Contractor to inform how to define levels of care and what criteria to use to develop an assessment/consult on new assessment tool
K	FTE	$148,464	1.0	$66,628	$81,836	$0	Admin	One FTE to manage contract, pilot, and project
L	**Total Costs**	**$348,464**	**1.0**	**$133,295**	**$215,169**	**$0**		
	Pilot CAPABLE							
M	Pilot Funding	$3,000,000	0.0	$0	$1,500,000	$1,500,000	State-Only	Pilot program; includes funding for fiscal intermediary contracts
N	Contractor Costs	$150,000	0.0	$50,000	$50,000	$50,000	State-Only	Evaluation contract
O	**Total Costs**	**$3,150,000**	**0.0**	**$50,000**	**$1,550,000**	**$1,550,000**		
	Extending Supported Employment Pilot							
P	Grant Funding	$900,000	0.0	$0	$450,000	$450,000	State-Only	Extending state-only grant program
Q	Evaluation Contractor	$75,000	0.0	$0	$0	$75,000	State-Only	Contractor funding
R	FTE	$248,727	1.0	$78,293	$97,390	$73,044	State-Only	Extending current FTE
S	**Total Costs**	**$1,223,727**	**1.0**	**$78,293**	**$547,390**	**$598,044**		
	New Systems of Care							
T	Grant Funding	$15,000,000	0.0	$7,500,000	$7,500,000	$0	State-Only	Fund to develop and pilot new models- ex. housing for workers, daycare for worker's children + day program for members; includes contractor costs to administer
U	**Total Costs**	**$15,000,000**	**0.0**	**$7,500,000**	**$7,500,000**	**$0**		
V	***Enhancement in Respite Benefit***							
	Respite Grant Program							
W	Grant Funding	$1,500,000	0.0	$0	$750,000	$750,000	State-Only	Grant funding for Community Center Boards to distribute to families
X	Contractor funding	$75,000	0.0	$75,000	$0	$0	State-Only	Contractor to research respite and create grant framework
	Respite Rate Enhancement							
Y	Rate Increase	$5,933,638	0	$5,933,638	$0	$0	Service	25% rate enhancement for Medicaid respite waiver services
Z	State-Only Crisis Services	$625,000	0.0	$625,000	$0	$0	State-Only	25% rate enhancement for state-only respite crisis services
AA	Contractor funding	$75,000	0.0	$75,000	$0	$0	Admin	Stakeholder engagement, research, and report
AB	**Total Costs**	**$8,208,638**	**0.0**	**$6,708,638**	**$750,000**	**$750,000**		
	Enhanced Home Modification Benefit							
AC	Home Modification Enhancement	$5,000,000	0.0	$1,111,111	$2,222,222	$1,666,667	Service	Calculated as 500 members utilizing enhanced budget of $10,000; based on 1,000 utilizers in FY 2019-20 * 50% uptake rate; assume we begin paying claims in January 2022
AD	IA with DOLA to do Certifications	$167,172	0.0	$44,418	$81,836	$40,918	Admin	Review home modification requests; IA with DOLA
AE	**Total Costs**	**$5,167,172**	**0.0**	**$1,155,529**	**$2,304,058**	**$1,707,585**		
	Hospital Community Investment Requirements							
AF	Contractor Cost	$300,000	0.0	$300,000	$0	$0	Admin	Research and develop recommendations
AG	**Total Costs**	**$300,000**	**0.0**	**$300,000**	**$0**	**$0**		
	Community First Choice							

Table 7.1 Post-COVID Recovery and HCBS Innovation

Row	Item	Total	FTE Count	FY 2021-22	FY 2022-23	FY 2023-24	Admin/Service	Source/Calculation
AH	Personnel and Administrative Costs	$1,457,664	5.0	$465,924	$588,586	$403,155	Admin	Start up costs to include 5 FTE and stakeholder engagement
AI	IT Costs	$2,844,547	0.0	$1,257,693	$1,520,604	$66,250	Admin	Requires changes to MMIS, Aerial, and CBMS including contract to implement changes
AJ	**Total Costs**	**$4,302,212**	**5.0**	**$1,723,617**	**$2,109,190**	**$469,405**		
AK	**Total Cost for Innovation Projects**	**$63,399,639**	**9.5**	**$20,445,105**	**$27,769,936**	**$15,184,598**		
AL	Admin Costs	$10,892,274	8.5	$5,072,063	$5,200,324	$619,887	Admin	Sum of admin initiatives
AM	Services Costs	$10,933,638	0.0	$7,044,749	$2,222,222	$1,666,667	Services	Sum of service iniatives
AN	State-Only Costs	$41,573,727	1.0	$8,328,293	$20,347,390	$12,898,044	State-Only	Sum of state-only iniatives

Table 7.2
FTE Calculations - Post-COVID Recovery and HCBS Innovation

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
POLICY ADVISOR IV	1.0	October		$54,885	$54,885	$0	Innovative Models of Care
POLICY ADVISOR IV	1.5	October		$82,328	$109,771	$82,328	Child/Youth Step-down Options Program and Provider
CONTRACT ADMINISTRATOR III	1.0	October		$44,187	$58,916	$0	Tiered ACF Rates
POLICY ADVISOR IV	1.0	October		$54,885	$73,180	$54,885	Extending Supported Employment Pilot
ADMINISTRATOR III	1.0	January		$14,729	$58,916	$44,187	Enhanced Home Modification Benefit. Not included in FTE count; IA position
PROGRAM MANAGEMENT III	1.0	October		$78,819	$105,092	$78,819	CFC
PROGRAM MANAGEMENT I	1.0	October		$68,677	$91,570	$68,678	CFC
POLICY ADVISOR III	1.0	October		$44,187	$58,916	$44,187	CFC
ANALYST IV	1.0	October		$54,885	$73,180	$54,885	CFC
POLICY ADVISOR III	1.0	October		$44,187	$58,916	$44,187	CFC
Total Personal Services (Salary, PERA, Medicare)	**9.5**			**$486,884**	**$688,457**	**$472,156**	

Centrally Appropriated Costs							
Cost Center	**FTE**	**FTE**	**Cost or**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Health, Life, Dental	6.9	9.5	$10,042	$69,042	$95,399	$61,507	
Short-Term Disability	-	-	0.16%	$714	$980	$651	
Amortization Equalization Disbusement	-	-	5.00%	$22,324	$30,639	$20,359	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$22,324	$30,639	$20,359	
Centrally Appropriated Costs Total				**$114,404**	**$157,657**	**$102,876**	

Operating Expenses							
Ongoing Costs	**FTE**	**FTE**	**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Supplies	6.9	9.5	$500	$3,438	$4,750	$3,063	
Telephone	6.9	9.5	$450	$3,097	$4,275	$2,759	
Other	6.9	9.5	$0	$0	$0	$0	
Subtotal				*$6,535*	*$9,025*	*$5,822*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Furniture	9.5		$5,000	$34,375	$0	$0	
Computer	9.5		$2,000	$13,750	$0	$0	
Other	9.5		$0	$0	$0	$0	
Subtotal				*$48,125*	*$0*	*$0*	
Total Operating				**$54,660**	**$9,025**	**$5,822**	

Leased Space							
	FTE	**FTE**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	6.9	9.5	$6,600	**$45,375**	**$62,700**	**$40,425**	

Table 8.1 Case Management

Row	Item	Total Funds	FTE Count	FY 2021-22	FY 2022-23	FY 2023-24	Admin/Service	Notes/Calculations
	Case Management Capacity Building							
A	Contractor Costs	$4,300,000	0.0	$1,500,000	$1,400,000	$1,400,000	Admin	Contractor would support Department in change management
B	**Total Costs**	**$4,300,000**	**0.0**	**$1,500,000**	**$1,400,000**	**$1,400,000**		
	Improve and Expedite Long-Term Care Eligibility Processes							
C	System Costs	$2,000,000	0.0	$200,000	$900,000	$900,000	Admin	Updating system enhancements and removing outdated systems
D	FTE	$248,728	1.0	$78,294	$97,390	$73,044	Admin	One FTE to manage the projects
E	**Total Costs**	**$2,248,728**	**1.0**	**$278,294**	**$997,390**	**$973,044**		
	Improve Case/Care Management Practices							
F	Case Management Rates							
G	Contractor Costs	$400,000	0.0	$200,000	$200,000	$0	Admin	Contractor to develop new case management rates
	Case/ Care Management Best Practices (Roles and Responsibilities)							
H	Contractor Costs	$2,700,000	0.0	$1,300,000	$1,200,000	$200,000	Admin	First year would be to develop materials and then subsequent years would be for member outreach
I	FTE	$355,930	2.0	$66,628	$154,880	$134,422	Admin	Two FTE to support the change management projects
J	**Total Costs**	**$3,455,930**	**2.0**	**$1,566,628**	**$1,554,880**	**$334,422**		
	Case Management Agency Training							
K	Contractor Costs	$525,000	0.0	$325,000	$100,000	$100,000	Admin	Costs to update all existing training materials and systems
L	FTE	$146,088	1.0	$0	$73,044	$73,044	Admin	One FTE to manage contract
M	**Total Costs**	**$671,088**	**1.0**	**$325,000**	**$173,044**	**$173,044**		
N	**Total Cost for Case Management Projects**	**$10,675,745**	**4.0**	**$3,669,922**	**$4,125,314**	**$2,880,509**		

Table 8.2
FTE Calculations - Case Management

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
POLICY ADVISOR IV	1.0	October		$54,885	$73,180	$54,885	Improve and Expedite Long-Term Care Eligibility Processes
TRAINING SPECIALIST IV	1.0			$0	$54,885	$41,164	Case Management Agency Training
ADMINISTRATOR III	1.0	October		$44,187	$58,916	$44,187	Improve Case/Care Management Practices
TRAINING SPECIALIST IV	1.0			$0	$54,885	$41,164	Improve Case/Care Management Practices
Total Personal Services (Salary, PERA, Medicare)	**4.0**			**$99,072**	**$241,866**	**$181,400**	

Centrally Appropriated Costs							
Cost Center	**FTE**	**FTE**	**Cost or**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Health, Life, Dental	1.5	4.0	$10,042	$15,064	$35,148	$30,126	
Short-Term Disability	-	-	0.16%	$141	$344	$297	
Amortization Equalization Disbusement	-	-	5.00%	$4,410	$10,765	$9,296	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$4,410	$10,765	$9,296	
Centrally Appropriated Costs Total				**$24,024**	**$57,022**	**$49,015**	

Operating Expenses							
Ongoing Costs	**FTE**	**FTE**	**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Supplies	1.5	4.0	$500	$750	$1,750	$1,500	
Telephone	1.5	4.0	$450	$676	$1,576	$1,352	
Other	1.5	4.0	$0	$0	$0	$0	
Subtotal				*$1,426*	*$3,326*	*$2,852*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Furniture	4.0		$5,000	$7,500	$0	$0	
Computer	4.0		$2,000	$3,000	$0	$0	
Other	4.0		$0	$0	$0	$0	
Subtotal				*$10,500*	*$0*	*$0*	
Total Operating				**$11,926**	**$3,326**	**$2,852**	

Leased Space							
	FTE	**FTE**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	1.5	4.0	$6,600	**$9,900**	**$23,100**	**$19,800**	

Table 9.1 Tools and Technology

Row	Item	Total Funds	FTE Count	FY 2021-22	FY 2022-23	FY 2023-24	Admin/Service	Source/Calculation
	Home Health/PDN Acuity Tool							
A	Contractor Cost for LTHH Tool Development	$2,459,504	0.0	$896,552	$1,412,952	$150,000	Admin	Based on costs for SB 16-192 Single Assessment Tool
B	Contractor Cost for PDN Tool Development	$2,459,504	0.0	$896,552	$1,412,952	$150,000	Admin	Based on costs for SB 16-192 Single Assessment Tool
C	System Costs to Connect to CCM Tool	$1,000,000	0.0	$0	$1,000,000	$0	Admin	Set aside depending on feasibility
D	FTE	$248,727	1.0	$78,293	$97,390	$73,044	Admin	One FTE to manage all home health/PDN projects
E	**Total Costs**	**$6,167,735**	**1.0**	**$1,871,397**	**$3,923,294**	**$373,044**		
	Specialty Search in Provider Specialty Tool							
F	Contractor Costs	$150,000	0.0	$0	$150,000	$0	Admin	Contractor to develop tool for providers to determine specialty
G	**Total Costs**	**$150,000**	**0.0**	**$0**	**$150,000**	**$0**		
	Member Facing Provider Finder Tool Improvement							
H	Contractor Costs	$150,000	0.0	$75,000	$75,000	$0	Admin	Two contracts to complete project
I	**Total Costs**	**$150,000**	**0.0**	**$75,000**	**$75,000**	**$0**		
	Digital Transformation Projects							
J	Integration and Innovation Support	$750,000	0.0	$250,000	$250,000	$250,000	Admin	OeHI technical support for technology projects
K	HCBS Provider Electronic Health Record System Upgrades	$6,000,000	0.0	$2,000,000	$2,000,000	$2,000,000	Admin	Upgrade electronic health record systems to ensure interoperability and better coordinate care
L	Member Tech Literacy	$500,000	0.0	$250,000	$250,000	$0	Admin	Technical assistance and member education on adopting virtual solutions and ensuring general tech literacy
M	HCBS Provider Digital Transformation	$15,000,000	0.0	$5,000,000	$5,000,000	$5,000,000	Admin	Provide digital transformation workflow technical assistance to incorporate virtual service delivery for HCBS providers
N	**Total Costs**	**$22,250,000**	**0.0**	**$7,500,000**	**$7,500,000**	**$7,250,000**		
	Innovative Tech Integration							
O	Contractor Costs	$150,000	0.0	$75,000	$75,000	$0	Admin	Research project to study innovative technology to determine feasibility, legality, etc.
P	**Total Costs**	**$150,000**	**0.0**	**$75,000**	**$75,000**	**$0**		
	Care & Case Management System Investments							
Q	System Costs	$13,800,000	0.0	$5,000,000	$4,400,000	$4,400,000	Admin	Contractor for enhancements needed to CCM
R	Device Costs	$1,295,876	0.0	$1,295,876	$0	$0	Admin	Capital purchase of laptops and tablets for case management agencies to perform assessments; 1,292 direct case management staff at a $1,003 per-user cost
S	FTE	$693,969	3.0	$182,671	$292,169	$219,129	Admin	2 FTE to support the additional workload that will accompany the various care and case management tool and assessment and support plan enhancement projects being implemented due to ARP; 1 FTE to assist in developing system requirements
T	**Total Costs**	**$15,789,845**	**3.0**	**$6,478,547**	**$4,692,169**	**$4,619,129**		
	Updates to SalesForce Database for CM/Quality/Clinical							
U	Contractor Costs	$500,000	0.0	$250,000	$250,000	$0	Admin	Contractor funding to centralize complaints, issues, grievance, clinical documentation and quality care complaint tracking
V	**Total Costs**	**$500,000**	**0.0**	**$250,000**	**$250,000**	**$0**		
	Member Portal							
W	Contractor Costs	$12,200,000	0.0	$3,200,000	$9,000,000	$0	Admin	Contractor to design and manage EHR program; funding for HCBS providers to develop certified EHR; contractor funding to adudit incentive program; funding for development of API to connect system to CCM
X	**Total Costs**	**$12,200,000**	**0.0**	**$3,200,000**	**$9,000,000**	**$0**		
	Centers for Excellence in Pain Management							
Y	Contractor Costs	$400,000	0.0	$200,000	$200,000	$0	Admin	Contractor costs for Nurse Practitioner and Licensed Clinical Social Worker
Z	FTE	$112,034	1.0	$51,015	$61,019	$0	Admin	One FTE to manage scheduling and referral coordination
AA	**Total Costs**	**$512,034**	**1.0**	**$251,015**	**$261,019**	**$0**		
	Systems Infrastructure for Social Determinants of Health							
AB	Contractor Costs for System Changes	$12,000,000	0.0	$4,000,000	$4,000,000	$4,000,000	Admin	Costs to expand access to the prescriber tool phase II, linking social determinants of health and care management support for people who receive HCBS
AC	Community Grants	$3,000,000	0.0	$1,000,000	$1,000,000	$1,000,000	State-Only	Grants for food banks and other community organizations

Table 9.1 Tools and Technology								
Row	**Item**	**Total Funds**	**FTE Count**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Admin/Service**	**Source/Calculation**
AD	FTE	$298,856	1.0	$93,333	$117,442	$88,082	Admin	One FTE to manage program
AE	**Total Costs**	**$15,298,856**	**1.0**	**$5,093,333**	**$5,117,442**	**$5,088,082**		
	Expand Data Sharing Across Entities							
AF	Improvements - System Communication	$2,000,000	0.0	$250,000	$1,750,000	$0	Admin	Systems changes to connect iC and Trails
AG	Data Sharing with SUA	$100,000	0.0	$0	$100,000	$0	Admin	Contractor to do mapping of two systems -identify members with State Unit on Aging and figuring out where there could be alignment
AH	Connect CMAs to CORHIO	$1,345,500	0.0	$299,000	$598,000	$448,500	Admin	Connect CMAs to CORHIO ADT data ($13,000 * 46 case management agencies, pro-rated by year)
AI	**Total Costs**	**$3,445,500**	**0.0**	**$549,000**	**$2,448,000**	**$448,500**		
	Eligibility Systems Improvements							
AJ	System Changes	$1,000,000	0.0	$0	$500,000	$500,000	Admin	Changes to improve eligibility determination for LTSS utilizers; assumes $1M in costs for MMIS/CBMS costs
AK	**Total Costs**	**$1,000,000**	**0.0**	**$0**	**$500,000**	**$500,000**		
	FTE Support							
AL	FTE	$994,898	4.0	$313,169	$389,560	$292,169	Admin	Four FTE as business analysts to manage and coordinate all technology projects
AM	**Total Costs**	**$994,898**	**4.0**	**$313,169**	**$389,560**	**$292,169**		
AN	**Total Cost for Technology Projects**	**$78,608,869**	**10.0**	**$25,656,462**	**$34,381,484**	**$18,570,923**		
AO	Admin Costs	$75,608,869	10.0	$24,656,462	$33,381,484	$17,570,923	Admin	Sum of admin initiatives
AP	State-Only Costs	$3,000,000	0.0	$1,000,000	$1,000,000	$1,000,000	State-Only	Sum of state-only initiatives

Table 9.2
FTE Calculations - Tools and Technology

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
ANALYST IV	3.0	December		$128,058	$219,540	$164,655	Care & Case Management System Investments
ADMIN ASSISTANT II	1.0	October		$29,869	$39,826	$0	Centers for Excellence in Pain Management
CONTRACT ADMINISTRATOR V	1.0	October		$68,677	$91,570	$68,678	Systems Infrastructure for Social Determinants of Health
ANALYST IV	4.0	October		$219,540	$292,721	$219,541	FTE over all technology projects
POLICY ADVISOR IV	1.0	October		$54,885	$73,180	$54,885	Home Health/PDN Acuity Tool
Total Personal Services (Salary, PERA, Medicare)	**10.0**			**$501,029**	**$716,837**	**$507,758**	

Centrally Appropriated Costs							
Cost Center	**FTE**	**FTE**	**Cost or**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Health, Life, Dental	7.0	10.0	$10,042	$70,294	$100,420	$67,784	
Short-Term Disability	-	-	0.16%	$714	$1,021	$723	
Amortization Equalization Disbusement	-	-	5.00%	$22,298	$31,901	$22,597	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$22,298	$31,901	$22,597	
Centrally Appropriated Costs Total				**$115,603**	**$165,243**	**$113,701**	

Operating Expenses							
Ongoing Costs	**FTE**	**FTE**	**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Supplies	7.0	10.0	$500	$3,500	$5,000	$3,375	
Telephone	7.0	10.0	$450	$3,151	$4,500	$3,039	
Other	7.0	10.0	$0	$0	$0	$0	
Subtotal				*$6,651*	*$9,500*	*$6,414*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Furniture	10.0		$5,000	$35,000	$0	$0	
Computer	10.0		$2,000	$14,000	$0	$0	
Other	10.0		$0	$0	$0	$0	
Subtotal				*$49,000*	*$0*	*$0*	
Total Operating				**$55,651**	**$9,500**	**$6,414**	

Leased Space							
	FTE	**FTE**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	7.0	10.0	$6,600	**$46,199**	**$66,000**	**$44,550**	

Table 10 Emergency Preparedness

Row	Item	Total	FTE Count	FY 2021-22	FY 2022-23	FY 2023-24	Admin/Service	Source/Calculation
	Emergency Response Plans							
A	Contractor Cost	$25,000	0.0	$25,000	$0	$0	Admin	Contractor to put together training for providers, members, and case management agencies on putting together an emergency plan
B	**Total Costs**	**$25,000**	**0.0**	**$25,000**	**$0**	**$0**		
	Member Emergency Preparedness							
C	Generators and Emergency Kits (likely through contractor)	$8,346,750	0.0	$4,173,375	$4,173,375	$0	Admin	$1,500 per member for generator plus other emergency kit resources *11,129 HCBS members using vent related DME or oxygen concentrators * 50% takeup rate
D	Delivery and Orientation/Setup Costs	$100,000	0.0	$50,000	$50,000	$0	Admin	
E	**Total Cost for Generators and Other Resources**	**$8,446,750**	**0.0**	**$4,223,375**	**$4,223,375**	**$0**		
F	**Total Cost for Emergency Preparedness Projects**	**$8,471,750**	**0.0**	**$4,248,375**	**$4,223,375**	**$0**		

Table 11.1 Quality Outcomes

Row	Item	Total	FTE Count	FY 2021-22	FY 2022-23	FY 2023-24	Admin/Service	Source/Calculation
	Provider Scorecards							
A	Contractor Cost	$50,000	0.0	$50,000	$0	$0	Admin	Contractor to provide recommendations on measures/data that can be collected across providers, with comparisons to other states
B	FTE	$26,889	0.3	$16,660	$10,229	$0	Admin	Partial FTE to manage and coordinate; upload data over time
C	**Total Cost for Provider Scorecards**	**$76,889**	**0.3**	**$66,660**	**$10,229**	**$0**		
	Provider Oversight							
D	Contractor Cost	$75,000	0.0	$37,500	$37,500	$0	Admin	Contractor to check decision points and implement certification program
E	System Changes	$225,000	0.0	$0	$225,000	$0	Admin	Website for providers to do online certification
F	FTE	$80,660	0.8	$49,972	$30,688	$0	Admin	Partial FTE to manage the contract
G	**Total Costs**	**$380,660**	**0.8**	**$87,472**	**$293,188**	**$0**		
	Pay for Performance							
H	FTE	$279,269	1.0	$87,456	$109,606	$82,207	Admin	One FTE to provide rate/financial analysis for all P4P projects
	P4P HCBS							
I	Contractor Cost	$100,000	0.0	$100,000	$0	$0	Admin	Contractors to look into how we would do P4P - what other states do and develop what performance metrics should be and how we would implement
J	FTE	$26,888	0.3	$16,659	$10,229	$0	Admin	Partial FTE to manage the project/contract
	P4P PACE							
K	Pay for Performance Contractor	$150,000	0.0	$0	$150,000	$0	Admin	Contractors to look into how we would do P4P - what other states do and develop what performance metrics should be and how we would implement
L	FTE	$230,300	1.0	$66,628	$81,836	$81,836	Admin	One FTE to implement project
	P4P LTHH							
M	Contractor Cost	$400,000	0.0	$400,000	$0	$0	Admin	$200k each for home health and PDN
N	**Total Costs**	**$1,186,457**	**2.3**	**$670,743**	**$351,671**	**$164,043**		
	PACE Licensure							
O	PACE Licensure	$200,000	0.0	$200,000	$0	$0	Admin	Contractor would provide framework for PACE licensure
P	PACE Audit Structure	$1,000,000	0.0	$0	$500,000	$500,000	Admin	System development for PACE auditing program and a contractor who would help develop quality metrics and benchmarks by researching what other states do
Q	FTE	$320,029	1.0	$99,684	$125,910	$94,435	Admin	One FTE to manage project
R	**Total Costs**	**$1,520,029**	**1.0**	**$299,684**	**$625,910**	**$594,435**		
	eConsult to Improve Quality							
S	Contractor Cost	$150,000	0.0	$0	$0	$150,000	Admin	Contractor to research feasibility of expanding eConsult scope
T	**Total Costs**	**$150,000**	**0.0**	**$0**	**$0**	**$150,000**		
	CMS Quality Metrics							
U	Contractor Cost	$1,000,000	0.0	$0	$500,000	$500,000	Admin	Platform for providers to do training on performance measures
V	**Total Costs**	**$1,000,000**	**0.0**	**$0**	**$500,000**	**$500,000**		
	Waiver Quality Expansion							
W	Contractor Cost	$750,000	0.0	$150,000	$600,000	$0	Admin	Contractor to develop surveys
X	FTE	$480,059	2.0	$139,193	$194,781	$146,085	Admin	Two FTE to manage project
Y	**Total Costs**	**$1,230,059**	**2.0**	**$289,193**	**$794,781**	**$146,085**		
	Department of Corrections Partnership							
Z	FTE	$187,632	1.0	$44,418	$81,836	$61,379	Admin	One FTE to identify opportunities to leverage HCBS programs and behavioral health supports to improve post-release access to care, reduce overdose rates, and reduce other morbidity, mortality and recidivism
AA	**Total Costs**	**$187,632**	**1.0**	**$44,418**	**$81,836**	**$61,379**		
	Quality Measures Training							
AB	Contractor Cost	$750,000	0.0	$375,000	$375,000	$0	Admin	Would need 4-5 modules at $150k module each
AC	**Total Costs**	**$750,000**	**0.0**	**$375,000**	**$375,000**	**$0**		
AD	**Total Cost for Quality Projects**	**$6,481,726**	**7.3**	**$1,833,171**	**$3,032,615**	**$1,615,941**		

Table 11.2
FTE Calculations - Quality Outcomes

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
CONTRACT ADMINISTRATOR III	0.3	October		$11,048	$7,364	$0	Provider Scorecards
CONTRACT ADMINISTRATOR III	0.8	October		$33,141	$22,093	$0	Provider Oversight
CONTRACT ADMINISTRATOR III	0.3	October		$11,048	$7,364	$0	Pay for Performance - HCBS
POLICY ADVISOR III	1.0	October		$44,187	$58,916	$44,187	Pay for Performance - PACE
RATE/FINANCIAL ANLYST IV	1.0	October		$63,288	$84,384	$63,288	Pay for Performance
PROJECT MANAGER III	1.0	October		$74,502	$99,335	$74,501	PACE Licensure
POLICY ADVISOR IV	2.0	November		$97,578	$146,361	$109,771	Quality - Waiver Quality Expansion
POLICY ADVISOR III	1.0	January		$29,458	$58,916	$44,187	Department of Corrections Partnership
Total Personal Services (Salary, PERA, Medicare)	**7.3**			**$364,250**	**$484,733**	**$335,934**	

Centrally Appropriated Costs							
Cost Center	**FTE**	**FTE**	**Cost or**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Health, Life, Dental	5.0	7.3	$10,042	$50,422	$66,528	$47,700	
Short-Term Disability	-	-	0.16%	$519	$688	$499	
Amortization Equalization Disbusement	-	-	5.00%	$16,211	$21,573	$15,607	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$16,211	$21,573	$15,607	
Centrally Appropriated Costs Total				**$83,363**	**$110,362**	**$79,413**	

Operating Expenses							
Ongoing Costs	**FTE**	**FTE**	**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Supplies	5.0	7.3	$500	$2,511	$3,314	$2,375	
Telephone	5.0	7.3	$450	$2,260	$2,981	$2,139	
Other	5.0	7.3	$0	$0	$0	$0	
Subtotal				*$4,771*	*$6,295*	*$4,514*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Furniture	7.3		$5,000	$25,106	$0	$0	
Computer	7.3		$2,000	$10,042	$0	$0	
Other	7.3		$0	$0	$0	$0	
Subtotal				*$35,148*	*$0*	*$0*	
Total Operating				**$39,919**	**$6,295**	**$4,514**	

Leased Space							
	FTE	**FTE**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	5.0	7.3	$6,600	**$33,139**	**$43,725**	**$31,350**	

Table 12.1 Overhead Costs								
Row	Item	Total	FTE Count	FY 2021-22	FY 2022-23	FY 2023-24	Admin/Service	Source/Calculation
	Department Administrative Overhead Costs							
A	Project Managers	$1,150,684	5.0	$383,286	$383,699	$383,699	Admin	SB 21-286; 5 FTE to manage and coordinate work
B	Administrative FTE	$1,675,437	8.5	$636,131	$593,887	$445,420	Admin	8.5 FTE to support work across the Department
C	Project Coordination Contract	$1,123,200	0.0	$374,400	$374,400	$374,400	Admin	SB 21-286; 2080 hours * $180 hourly rate for Project Management
D	Evaluation Contracts	$5,000,000	0.0	$0	$2,500,000	$2,500,000	Admin	Contractors to evaluate various programs
E	**Total Cost for Overhead**	**$8,949,321**	**13.5**	**$1,393,817**	**$3,851,986**	**$3,703,519**		

Table 12.2
FTE Calculations - Overhead Costs

Personal Services							
Position Classification	**FTE**	**Start Month**	**State Fund**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
HUMAN RESOURCES SPEC III	1.0	October		$44,187	$58,916	$44,187	Human Resources
PURCHASING AGENT IV	2.0	October		$109,771	$0	$0	Procurement
ACCOUNTANT III	1.0	October		$63,288	$84,384	$63,288	Accounting
ACCOUNTANT II	1.0	October		$44,187	$58,916	$44,187	Accounting
PROJECT MANAGER II	0.5	October		$34,338	$45,785	$34,339	Governor's Office
ANALYST IV	1.0	October		$54,885	$73,180	$54,885	Data Analysis
PROGRAM ASSISTANT II	2.0	October		$88,941	$118,588	$88,941	Program Assistants
Total Personal Services (Salary, PERA, Medicare)	**8.5**			**$439,597**	**$439,769**	**$329,827**	

Centrally Appropriated Costs							
Cost Center	**FTE**	**FTE**	**Cost or**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Health, Life, Dental	6.4	8.5	$10,042	$64,020	$65,273	$48,955	
Short-Term Disability	-	-	0.16%	$626	$626	$470	
Amortization Equalization Disbusement	-	-	5.00%	$19,564	$19,572	$14,680	
Supplemental Amortization Equalization Disbusement	-	-	5.00%	$19,564	$19,572	$14,680	
Centrally Appropriated Costs Total				**$103,775**	**$105,043**	**$78,785**	

Operating Expenses							
Ongoing Costs	**FTE**	**FTE**	**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Supplies	6.4	8.5	$500	$3,188	$3,250	$2,438	
Telephone	6.4	8.5	$450	$2,871	$2,925	$2,196	
Other	6.4	8.5	$0	$0	$0	$0	
Subtotal				*$6,059*	*$6,175*	*$4,634*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**Notes**
Furniture	8.5		$5,000	$31,875	$0	$0	
Computer	8.5		$2,000	$12,750	$0	$0	
Other	8.5		$0	$0	$0	$0	
Subtotal				*$44,625*	*$0*	*$0*	
Total Operating				**$50,684**	**$6,175**	**$4,634**	

Leased Space							
	FTE	**FTE**	**Cost**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**Notes**
Leased Space	6.4	8.5	$6,600	**$42,075**	**$42,900**	**$32,175**	