Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2019-20 Budget Cycle

Request Title

R-15 Operational Compliance and Program Oversight

Dept. Approval By: 11/1/18

OSPB Approval By:

	Supplemental FY 2018-19
	Budget Amendment FY 2019-20
X	Change Request FY 2019-20

Summary Information	Fund	FY 2018-19 Initial Appropriation	FY 2018-19 Supplemental Request	FY 2019-20 Base Request	FY 2019-20 Change Request	FY 2020-21 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,701,610,210**	**$0**	**$7,563,963,494**	**($780,722)**	**($2,049,942)**
	FTE	465.8	0.0	471.3	5.5	6.0
	GF	$2,137,804,003	$0	$2,093,118,399	$0	($324,839)
	CF	$945,678,767	$0	$942,857,141	$5,355	$43,036
	RF	$79,869,209	$0	$79,814,994	$0	$0
	FF	$4,538,258,231	$0	$4,448,172,960	($786,077)	($1,768,139)

Line Item Information	Fund	FY 2018-19 Initial Appropriation	FY 2018-19 Supplemental Request	FY 2019-20 Base Request	FY 2019-20 Change Request	FY 2020-21 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$34,785,923**	**$0**	**$36,413,166**	**$415,839**	**$455,094**
	FTE	465.8	0.0	471.3	5.5	6.0
	GF	$11,935,474	$0	$12,577,193	$178,362	$195,300
	CF	$3,129,300	$0	$3,273,826	$24,929	$27,192
	RF	$2,242,657	$0	$2,274,826	$0	$0
	FF	$17,478,492	$0	$18,287,321	$212,548	$232,602
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$4,647,883**	**$0**	**$4,655,713**	**$47,562**	**$47,562**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,575,324	$0	$1,651,283	$20,510	$20,510
	CF	$399,501	$0	$409,280	$2,758	$2,757
	RF	$135,355	$0	$123,276	$0	$0
	FF	$2,537,703	$0	$2,471,874	$24,294	$24,295

Line Item Information	Fund	FY 2018-19 Initial Appropriation	FY 2018-19 Supplemental Request	FY 2019-20 Base Request	FY 2019-20 Change Request	FY 2020-21 Continuation
	Total	**$60,727**	**$0**	**$66,035**	**$708**	**$772**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	GF	$21,043	$0	$24,054	$304	$331
	CF	$5,213	$0	$5,306	$42	$46
	RF	$1,484	$0	$1,522	$0	$0
	FF	$32,987	$0	$35,153	$362	$395
	Total	**$1,855,596**	**$0**	**$1,985,443**	**$18,587**	**$20,282**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$642,806	$0	$723,280	$7,973	$8,700
	CF	$159,439	$0	$159,516	$1,114	$1,215
	RF	$45,371	$0	$45,699	$0	$0
	FF	$1,007,980	$0	$1,056,948	$9,500	$10,367
	Total	**$1,855,596**	**$0**	**$1,985,443**	**$18,587**	**$20,282**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$642,806	$0	$723,280	$7,973	$8,700
	CF	$159,439	$0	$159,516	$1,114	$1,215
	RF	$45,371	$0	$45,699	$0	$0
	FF	$1,007,980	$0	$1,056,948	$9,500	$10,367
	Total	**$2,450,635**	**$0**	**$2,245,370**	**$48,918**	**$20,700**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$961,623	$0	$889,835	$22,126	$9,958
	CF	$239,823	$0	$210,072	$1,968	$329
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,235,892	$0	$1,132,166	$24,824	$10,413
	Total	**$20,291,689**	**$0**	**$21,753,943**	**$149,794**	**$149,794**
01. Executive Director's Office, (E) Utilization and Quality Review Contracts, (1) Utilization and Quality Review Contracts - Professional Service Contracts	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,246,451	$0	$5,513,119	$55,594	$55,594
	CF	$1,449,885	$0	$1,570,570	$16,531	$16,531
	RF	$0	$0	$0	$0	$0
	FF	$12,595,353	$0	$14,670,254	$77,669	$77,669

Line Item Information	Fund	FY 2018-19 Initial Appropriation	FY 2018-19 Supplemental Request	FY 2019-20 Base Request	FY 2019-20 Change Request	FY 2020-21 Continuation
01. Executive Director's Office, (F) Provider Audits and Services, (1) Provider Audits and Services - Professional Audit Contracts	**Total**	**$4,182,232**	**$0**	**$4,559,859**	**$251,499**	**$700,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,598,154	$0	$1,616,897	$115,375	$192,500
	CF	$423,472	$0	$583,585	$31,889	$143,732
	RF	$0	$0	$0	$0	$0
	FF	$2,160,606	$0	$2,359,377	$104,235	$363,768
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$7,631,479,929**	**$0**	**$7,490,298,522**	**($1,732,216)**	**($3,464,428)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,114,180,322	$0	$2,069,399,458	($408,217)	($816,432)
	CF	$939,712,695	$0	$936,485,470	($74,990)	($149,981)
	RF	$77,385,674	$0	$77,310,675	$0	$0
	FF	$4,500,201,238	$0	$4,407,102,919	($1,249,009)	($2,498,015)

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Cost and FTE

- The Department requests a reduction of $780,722 total funds, $0 General Fund and 5.5 FTE in FY 2019-20 and a reduction of $2,049,942 total funds, including a reduction of $324,839 General Fund and an increase of 6.0 FTE in FY 2020-21 and future years to provide increased stewardship of State resources through the implementation of operational compliance and program oversight measures.

Current Program

- As the administrator of Health First Colorado (Colorado's Medicaid program), the Department is responsible for processing medical claims for eligible members, setting appropriate payment rates for services, working with stakeholders and providers to determine members benefit packages, improve member health outcomes, and ensuring that all payments are made in compliance with state and federal regulations.
- Utilizing contracted vendors and FTE, the Department provides program management and oversight measures to assure members receive appropriate services and payments go to the appropriate entities.

Problem or Opportunity

- The Department does not have a comprehensive review process in place for the mission-critical system of client eligibility verification nor proper oversight measures of the service delivery and fiscal policy of programs that serve elderly and vulnerable populations. The Department is also out of compliance with federal guidance on monitoring the practices of its subrecipients, which are non-federal recipients of federal dollars distributed through a pass-through entity such as the Department.

Consequences of Problem

- If the Department does not implement these measures it risks losing opportunities to reduce fraud, waste and abuse, ensure that mission-critical systems are functioning properly, and allow eligible members to receive appropriate services at the appropriate rates.
- Without improvement, the Department risks non-compliance with federal regulations, potentially jeopardizing federal financial participation.

Proposed Solution

- The Department requests funding to implement program compliance and oversight measures for initiatives that would strengthen program oversight and its stewardship of State resources, including:
  - A comprehensive internal review of eligibility determinations, by dedicated FTE to manage end-to-end processes of identification and assessment of system errors, and implementation of corrective actions.
  - Dedicated FTE and one-time contract funding to provide operational and financial oversight of the Program for All-Inclusive Care for the Elderly (PACE).
  - An expanded scope of the existing Managed Care Organization audits that collect and review data used for rate setting and risk management.
  - Validation of critical rate-setting data submissions from providers within the Hospital Back-Up program.
  - Dedicated FTE for subrecipient monitoring of case management agencies including the Single-Entry Point entities.
  - Dedicated FTE to support and assist in the coordination and development of Department audit, compliance, and program integrity responsibilities.
  - Dedicated FTE to review claims for programs for people with Intellectual and Developmental Disabilities.

Department Priority: ***R-15***

Request Detail: ***Operational Compliance and Program Oversight***

Summary of Incremental Funding Change for FY 2019-20	Total Funds	General Fund
Operational Compliance and Program Oversight	($780,722)	$0

Problem or Opportunity:

The Department has been appropriated over $10.1 billion in FY 2018-19 to provide services to eligible members; this represents the largest single agency budget for the State. Given the size of the Department's budget, proper oversight is critical to ensuring that members are receiving the services that they need and that taxpayers are getting sufficient returns on the use of these funds. As part of the Department's focus on continual improvement to provide sound stewardship of financial resources, the Department has identified administrative opportunities to expand and strengthen operational compliance and program oversight. However, the Department does not have sufficient administrative resources to successfully implement these initiatives. Without the necessary administrative resources, the Department could not implement these changes without diverting resources from other areas. Aligned with the Department's focus on continual process improvement and organization efficiency and excellence, these opportunities would ensure the proper functionality of mission-critical operational systems and create a responsive and accountable framework that increases transparency and reduces potential conflicts of interest.

Proposed Solution:

The Department requests a reduction of $780,722 total funds, $0 General Fund, an increase of $5,355 cash funds, a reduction of $786,077 federal funds and 5.5 FTE in FY 2019-20; and a reduction of $2,049,942 total funds, including a reduction of $324,839 General Fund, an increase of $43,036 cash funds, and a reduction of $1,768,139 federal funds and 6.0 FTE in FY 2020-21 and future years to implement program compliance and oversight measures. The requested funding would fund the following activities:

- Perform comprehensive reviews of the Colorado Benefits Management System (CBMS) eligibility determinations and implement corrective actions based on findings
- Increase operational and financial oversight of the PACE program
- Expand the scope of the Managed Care Organization (MCO) financial reviews to conform with recent changes in the Medicaid delivery system
- Validate the Minimum Data Set (MDS) scores for the Hospital Back-Up (HBU) program

- Add dedicated FTE for subrecipient monitoring of Single Entry Point entities.
- Add dedicated FTE to support and assist in the coordination and development of Department audit, compliance, and program integrity responsibilities
- Add dedicated FTE to manage, investigate, and recover erroneously paid claims for Intellectual and Developmental Disability (IDD) services and/or refer suspected fraud to the Medicaid Fraud Control Unit (MFCU).

Eligibility Determination Reviews

The Department requests a reduction of $1,528,973 total funds, including a reduction of $335,896 General Fund, and 0.9 FTE in FY 2019-20; and, a reduction of $2,670,274 total funds, including a reduction of $596,279 General Fund, and an increase of 1.0 FTE in FY 2020-21 and ongoing to implement a process to ensure that the system-generated eligibility determinations are correct and adhere to policy and rules. The verification process would include a contracted vendor performing sample case reviews of eligibility determination and the subsequent coordination between Department and system vendor to address any system vulnerabilities and gaps identified by the reviews.

The Department's eligibility system, the Colorado Benefits Management System (CBMS), is a mission-critical system that directly contributed to the processing and adjudicating of more than $6.2 billion in payments in FY 2017-18. Determining member eligibility is the gateway into Medicaid benefits and needs to be accurate. Due to the fast pace of policy changes, and the implementation of other major programs such as the Accountable Care Collaborative Phase II, the Department, in conjunction with the Governor's Office of Information Technology, makes frequent updates to CBMS. Additionally, the system is undergoing transformations to upgrade the storage of information and improve numerous screens used to determine eligibility. With constant and frequent changes to these systems, the Department believes an ongoing annual contract is necessary to ensure these systems are operating accurately.

The Department requests contractor funding to assist in the verification process by performing reviews on a sample of CBMS eligibility determinations and assisting the Department in promptly addressing errors and vulnerabilities. The Department would utilize the contractor's audit results to address findings and vulnerabilities with corrective actions and changes in system processes and operations. Due to the complexities surrounding Medicaid eligibility this contract would be highly technical in nature and would require that the Department hire an auditing firm that possesses experience and expertise in Medicaid eligibility, federal and state health care policy, and complex system integration. Eligibility audits is a time-consuming process that requires obtaining client records from county partners, review of eligibility documentation, and review of numerous fields and screens in CBMS. Systems audits require assessments to ensure that rules and edits are programmed correctly, federal and state rules are applied accurately, claims are processed and paid properly, and systems are interacting with one another precisely.

The requested FTE would be responsible for managing the vendor, including establishing the scope of work, conducting negotiations, performing contract administration functions, monitoring all contract deliverables, and reporting the vendor's audit performance. This includes overseeing logistics surrounding access and training of Department systems and applications, facilitating communication between the vendor and Department staff, and ensuring the vendor has accurate policy and systems information.

Additionally, the FTE would be tasked with addressing the audit vendor's findings and work with Department staff to develop corrective actions, improvement plans, and systems changes to remedy found errors and vulnerabilities. The FTE would ensure that discovered deficiencies are addressed promptly, and corrective actions are in place with appropriate timelines for resolution based on priority and magnitude of issue. Responsibilities of this FTE include communicating review findings to Department staff, assisting in the creation and implementation of solutions, monitoring, documenting and reporting the Department's efforts and progress. Because the vendor would be conducting reviews on an ongoing basis, the FTE would likely be monitoring several improvement-plans at the same time with some plans likely having long term timelines that require continual involvement.

The Department's request is partially offset in FY 2019-20 by available funding from a prior year appropriation, FY 2007-08 S-5 "Revised Federal Rule for Payment Error Rate Measurement (PERM) Program." The Department receives this funding once every three years. Funding for the PERM program is no longer needed due to the Centers for Medicare and Medicaid Services (CMS) assuming full responsibility, including all costs, of administering the PERM program and its audits. However, because this funding is appropriated to the Department on a cyclical basis corresponding to the "every third year" occurrence of the PERM audits, this funding is only available to offset the FY 2019-20 contractor funding as it is scheduled to be annualized out of the Department's base budget in FY 2020-21.

The Department expects that implementation of this annual eligibility review process would achieve savings as members incorrectly deemed eligible are identified and removed from the program. As part of the State of Colorado Statewide Single Audit[1] for FY 2016-17, the Office of the State Auditor (OSA) performed audit work to review the Department's internal controls over all aspects of the eligibility determination process for Medicaid. In seven of the 40 case files tested, the OSA identified at least one error in the eligibility process which likely contributed incorrectly granting full Medicaid eligibility for three persons. The Department's methodology for determining the expected savings is described in the Assumptions and Calculations section of this document and in Tables 12.1 and 12.2 in Appendix B.

Program of All-Inclusive Care for the Elderly (PACE) Administration

The Department requests $231,744 total funds, including $115,872 General Fund and 0.9 FTE in FY 2019-20 and $94,154 total funds, including $47,076 General Fund and 1.0 FTE in FY 2020-21 to strengthen the administration and oversight of the PACE program. Of the FY 2019-20 total funds, $140,000, including $70,000 General Fund, would be one-time funding for a vendor contract to perform a risk assessment report of the program and develop a risk reserve fund calculation tool.

The Program of All-Inclusive Care for the Elderly (PACE) is operated by Health First Colorado (Colorado's Medicaid Program) and Medicare. The PACE program provides comprehensive medical and social services to certain frail individuals 55 years of age and older. The overarching goal of PACE is to help individuals live and stay in their homes and communities through comprehensive care coordination. Additional goals of PACE are:

[1]https://leg.colorado.gov/sites/default/files/documents/audits/1701f_statewide_single_audit_fiscal_year_ended_june_30_2017.pdf

- To maximize the independence, dignity, and respect of PACE members
- To help make PACE members more independent and improve their quality of life
- To provide coordinated quality health care to PACE members
- To help support and keep PACE members together with their family.

Qualifying individuals must meet the following criteria:

- Age of 55 years or older
- Meet nursing facility level of care as determined by a Single-Entry Point agency
- Live in the service area of the PACE organization
- Able to live in a community without risking the individual's health or safety.

PACE enrollees receive all their health services through a PACE organization. PACE organizations have one or more physical centers that provide an array of primarily long-term care services in an adult day health center setting, supplemented with in-home and referral services as necessary. These services are varied and include the full scope of services provided by Medicare and Medicaid and range from primary care, physical therapy, hospital care, prescription drugs and emergency services to optometry, dental services, nutritional counseling, meals, and more.

PACE services are financed by combined Medicare and Medicaid prospective monthly capitation payments. PACE organizations assume full financial risk for enrollees' care and must accept the capitation payment as payment in full for Medicaid participants and may not bill, charge, collect or receive any other form of payment from the State or from, or on behalf of the participant, except in very limited cases.

Colorado's PACE program consists of four PACE Organizations that operate ten PACE centers for approximately 3,600 PACE enrollees residing in the following twelve counties: Adams, Arapahoe, Boulder, Broomfield, Delta, Denver, El Paso, Jefferson, Larimer, Montrose, Pueblo and Weld. The Department projects total expenditure for the PACE program to be more than $217 million in FY 2019-20, but has only one full-time staff member dedicated to PACE and lacks the resources to appropriately administer the program. Limited resources prevent adequate onsite reviews and surveys, implementation of performance and quality review plans, collection of encounter data for use in the development of performance-based metrics, tracking and monitoring of corrective action plans and extensive communication with internal and external stakeholders. Additionally, the lack of resources prevents the Department from actively addressing the findings and recommendations found in a recent review of the program[2] ("PACE Review") submitted to the Department by the Division of Health Care Policy and Research at the University of Colorado's Anschutz Medical Campus.

One of the three significant findings in the PACE Review was the need to strengthen the administration of the State's PACE program as Colorado's administrative resources fell far below PACE programs of

[2] Review of the Colorado Program for All-Inclusive Care for the Elderly (PACE) Program: Summary Report, submitted July 9, 2018, The Division of Health Care Policy and Research School of Medicine, University of Colorado Anschutz Medical Campus, R. Mark Gritz, PhD, Carter Sevick, MS

comparable size in other states. As an example, the state of Virginia has four full-time and two part-time staff in its PACE office whose program serves 1,500 enrollees, and North Carolina has five full-time staff for its PACE program of 2,000 members. Additional FTE would bring Colorado's staff to a comparable level consistent with other states and allow the implementation of oversight measures listed above as well as addressing the two other significant findings in the PACE Review which are *Care Transitions Following Disenrollment in PACE* and *Improving the PACE Enrollment Process*.

At this time, the Department does not have sufficient resources to properly administer the PACE program and is prioritizing a request for one compliance specialist FTE for FY 2019-20, with future FTE for PACE administration needs to be considered and determined according to program growth and workload.

Compliance Specialist

The Department has insufficient resources for effective oversight of PACE program operations and is overly reliant on federal auditing practices for revealing program vulnerabilities. Historically, to ensure adherence to federal regulations, the Centers for Medicare and Medicaid Services (CMS), in collaboration with the State, conducted bi-annual onsite audits of PACE providers and program centers. Recently however, CMS began limiting their auditing practices of the PACE program and eliminating time spent onsite, reducing program elements being audited, and acting independently without State collaboration. CMS continues to perform a bi-annual audit but no longer engages the State to work together in identifying compliance issues and developing corrective action plans. Further, the State can no longer effectively rely on CMS findings as regulatory gaps now exist due to CMS eliminating important elements from their audit protocol such as reviews of: contracted services, participant rights, appeal rights under Medicaid, enrollment processes, voluntary and involuntary disenrollments, and physical environment reviews. Since PACE organizations rely heavily on providing services within their own facility, insufficient or infrequent onsite reviews could negatively affect the health, safety, and welfare of Medicaid members as fewer corrective measures are identified. Further, any corrective action plan developed by CMS only requires an agreement to the plan of correction and does not stipulate ongoing monitoring to ensure full compliance.

With the compliance specialist FTE, the Department can implement operational compliance initiatives to ensure that members are receiving the services that they need, that providers are correctly billing the Department for those services, that providers are correctly enrolling and disenrolling members, and that the Department continues to effectively incentivize member well-being. By developing an annual operations audit process, including site visits, the Department can ensure the health, safety, and welfare of Medicaid members through corrective action plans reviewed on an annual basis that increase quality of care and resolve issues related to care delivery.

As highlighted in the PACE Review, a priority of this FTE would facilitate an appropriate disenrollment process and simplify the enrollment process of PACE participants. The FTE would develop and implement policies to prevent gaps in services immediately following PACE disenrollment including new policy measures that increase accountability of both the PACE Organizations/Centers and the Single Entry Point (SEP) agencies, and the development of quality measures for transitions of care. The FTE would simplify and shorten the PACE enrollment process by improving communication standards and creating education materials such as step-by-step guidebooks for prospective enrollees.

The FTE would monitor the fiscal soundness of PACE organizations and their related entities, including their compliance with a risk reserve fund requirement. With one-time contractor funding of $140,000, the Department would hire an audit firm with health care experience to establish a baseline of the existing financial condition, including an applicable risk assessment, of each PACE organization. The funding would also provide the Department with a tool that would appropriately calculate the amount potentially required for each PACE organization's risk reserve fund. State regulation requires PACE organizations to maintain reserves, however the reserves are not clearly defined; therefore, this information would be critical in developing sound fiscal policy of PACE. The financial information would also assist with the assessment of a PACE organization's financial viability in the event the organization requests to expand its service area.

If this request is approved, the Department anticipates increased quality of care and improved service delivery to PACE members. Establishing a risk reserve fund policy would likely ensure the continuing operation of the PACE program as the expected growth in older adults drives membership and expansion upward. The approval of this request would free up the Department's PACE program manager to prepare for future program expansion in a responsible and measured manner. A strategic plan anticipating program expansion would be developed and include a comprehensive analysis of program viability and sustainability for additional regions of the State and a Request for Application (RFA) process.

Managed Care Organization Financial Reviews

The Department requests $85,794 total funds, including $23,594 General Fund in FY 2019-20 and ongoing to expand the Department's existing Managed Care Organization (MCO) financial review contract to align with recent changes in Medicaid's health care delivery system environment.

The Department does not have the resources to fund additional financial reviews nor expand the existing scope to include adequate review and analysis of the myriad sub-contracting arrangements of the MCO entities. Beginning in FY 2018-19, with the launch of the Department's Accountable Care Collaborative Phase II, the number of managed care entities has increased from seven to nine including Behavioral Health Capitation contracts with the seven Regional Accountable Entities (RAEs) and the two Health Maintenance Organizations (HMOs). Additionally, the new set of behavioral health contractors presents a more varied and complex array of financial arrangements. For instance, one behavioral health contractor is owned by the same parent company that contracts as the HMO in the region. In other regions the behavioral health contractor is partially owned by the Community Mental Health Center (CMHC) which also has a contractual agreement with the local RAE. Because of the added size and complexity of the program, additional reviews are necessary to properly assess and quantify the financial risk faced by the State through its managed care agreements.

The current MCO financial review contract provides the Department with the following deliverables: an annual audit report of seven MCOs; a risk assessment report; and a priority recommendations report. The requested funding would allow the Department to expand the contract so that audit reports for all nine entities are completed and to allow more comprehensive analysis of the financial arrangements of these entities and their related contractual agreements. This analysis would provide the Department with a more comprehensive understanding of the final allocation of Medicaid dollars as it pertains to client services versus entity administration, or overhead. This information is critical for the Department to properly assess cost of care,

more accurately set rates within the MCO contracts and proactively address any potential underfunding of entities that may ultimately result in access-to-care and/or quality of care issues.

Hospital Back-Up Program Data Validation

The Department requests $64,000 total funds, including $32,000 in General Fund in FY 2019-20 and ongoing to validate the Minimum Data Set (MDS) scores that are used in rate-setting methodology for the Hospital Back-Up (HBU) program.

The HBU program supports qualified skilled nursing facilities in providing hospital-level care to clients who are ventilator dependent, have complex wounds, or have other medically complex needs. The HBU program serves as a placement for individuals who need to be discharged from a hospital but require a higher level of skilled nursing care than is currently available in any other clinically appropriate setting. The HBU program provides treatment to only the highest acuity patients whom often are dependent on life support systems such as mechanical ventilators.

The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified skilled nursing facilities (SNFs). The MDS assessment provides the foundation upon which a resident's individual care plan is formulated and are completed for all residents in SNFs regardless of source of payment for the individual resident. The assessments are required for residents upon admission to the nursing facility and occur periodically when the patient experiences a change in condition or on discharge. MDS information is transmitted electronically by nursing homes to the national MDS database at the Center for Medicare and Medicaid Services (CMS).

The MDS scores are the main components of the rate-setting methodology for HBU services therefore the accuracy of the scores is paramount to ensure appropriate rate-setting. Currently, the Department does not have the resources to validate Minimum Data Set (MDS) scores; instead, the MDS scores are self-reported by the skilled nursing facilities upon the completion of an MDS assessment. Because the MDS scores are self-reported by the provider and are the main component of the rate-setting methodology an independent MDS score validation is necessary to ensure appropriate rate-setting and eliminate conflict of interest concerns.

The Department has done extensive stakeholder outreach with HBU providers and received support for the MDS reimbursement methodology for MDS data validation from the Hospital Back-Up Operational Process Improvement Workgroup which was developed to build on improvement recommendations identified by the University of Colorado's research of the HBU program. Stakeholders are aware that MDS scores would be validated for all patients enrolled in the HBU program.

With the requested funding, the Department would receive independent validation of the MDS scores of HBU program residents which would ensure an accurate rate-setting methodology while eliminating the conflict of interest that exists between providers and the rate-setting process. The Department expects to contract with an experienced health care consulting firm which staffs experienced, nationwide experts on MDS scoring measures who can provide independent validation of the submitted scores and ensure their

accuracy and reasonableness. Additionally, the consulting firm would assist the Department in determining how the MDS scores affect the rate-setting methodology and collaborate in stakeholder outreach.

Subrecipient Monitoring of Single Entry Point Entities

The Department requests $183,225 total funds, including $91,613 in General Fund 1.8 FTE in FY 2019-20 and $188,076 total funds, including $94,039 General Fund and 2.0 FTE in FY 2020-21 and ongoing to implement subrecipient monitoring practices of Single Entry Point (SEP) entities.

The Department does not have the resources to comply with federally-mandated subrecipient monitoring requirements. Subrecipient monitoring is a compliance requirement for any non-federal recipient of federal assistance that passes that assistance to another recipient. The Department, considered a "pass-through entity" in federal regulations, is responsible for monitoring the federal assistance activities of the SEPs, or "subrecipients," according to Subpart D of the uniform guidance[3] which details the pass-through entity's responsibility for subrecipient monitoring and management.

The responsibilities of the pass-through entity begin with ensuring that every subaward is clearly identified to the subrecipient as a subaward and that the subrecipient agreement includes appropriate financial award identification data and mandatory terms and conditions set forth in 2 C.F.R. § 200.331. The financial data includes information such as the amount of federal funds obligated, performance period start and end dates, and federal award identification information. The terms and conditions include all requirements imposed by the pass-through entity on the subrecipient so that the federal award is used in accordance with federal regulations and the terms and conditions of the federal award. Further terms and conditions include any requirement that the pass-through entity imposes on the subrecipient for the pass-through entity to meet its own responsibility to the federal awarding agency including identification of any required financial and performance reports. Finally, the agreement must include an indirect cost rate and language granting the pass-through entity access to the records and financial statements of the subrecipient.

Upon execution of the subrecipient agreement the pass-through entity is required to perform the following:

- Assess the risk of noncompliance on the part of the subrecipient at the outset of the relationship and at least annually afterward
- Use that risk assessment to inform a plan for regular monitoring of the subrecipient's compliance
- Follow through on any findings revealed in monitoring, both by remedying the immediate situation and implementing controls that prevent future noncompliance

Though both entities are equally responsible for the federal funds received it is the Department, as the pass-through entity, that holds the responsibility of assuring compliance with federal laws and regulations.

[3] Office of Management and Budget ("OMB") issued the "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Final Rule (Uniform Guidance) on December 26, 2013", which is also referred to as OMB "Super Circular" or "Omni Circular" and is codified at 2 CFR Part 200. The Super Circular streamlines requirements from the preceding OMB Circulars applicable to the administration, use, and audit of federal grant funds by non-profit organizations, state, local and tribal governments, and colleges and universities.

Subrecipient monitoring may consist of site visits, regular contact and meetings, interviews, examinations of records and financial data, as well as requiring that the subrecipient be subject to an annual audit.

The Department contracts with twenty-four (24) SEPs to provide case management for individuals with disabilities who have long term care needs. A Single-Entry Point (SEP) is a single-access or entry-point agency within a local area where certain Medicaid-eligible clients and potential clients can obtain information on and be screened for long-term services and supports (LTSS). These agencies conduct functional assessments, make referrals to appropriate programs, complete functional eligibility determinations for LTSS and provide case management. A SEP may be a private or nonprofit organization or a county or multicounty agency.

SEPs serve the elderly, persons with disabilities, persons with mental health needs, persons living with AIDS, persons with brain and spinal cord injuries, children with a life-limiting illness and children with a physical disability. SEPs support access to LTSS through Medicaid programs for Home and Community-Based Services (HCBS) and services provided by nursing facilities. Specific HCBS programs require SEPs to coordinate services to clients in the least restrictive setting possible with the goal of keeping them in their homes and communities as an alternate to nursing facility placement.

Because the SEPs receive a subaward from the Department to carry out a portion of a Federal award, a Federal assistance relationship is created between a pass-through entity and subrecipient. Additional characteristics that support the SEPs classification as subrecipients are found in their scope of work, including:

- Holds responsibility for programmatic decision-making
- Measures performance in relation to whether objectives of a federal program are met
- Determines who is eligible to receive what federal assistance
- In accordance with its agreement, uses the federal funds to carry out a program for a public purpose specified in authorizing statute, as opposed to providing goods or services for the benefit of the pass-through entity

As subrecipients of the Department's Title XIX Medicaid grant funding, the SEPs were paid over $31 million in FY 2017-18. The Department, with one existing staff member performing the duties of contract manager over all 24 individual SEP agreements, lacks the necessary resources to appropriately and effectively manage and monitor these agreements. The existing contract manager performs basic oversight and contract renewal tasks to assure member services are continuously provided however lacks the time for in-depth analysis of SEP operations and contract design. The Department believes each SEP agreement should include language, requirements and conditions designed specifically for the SEP entity, or subrecipient, and should take in consideration relevant variables of both fiscal and operational application including risk assessment, geographic region and demographics, Department expectations, and oversight and transparency stipulations. To allow the Department to effectively manage the SEP program significant additional resources are needed.

The Department is seeking 2.0 FTE to perform tasks that support and ensure compliance with federal subrecipient monitoring requirements[4] of the SEP entities. To successfully implement and sustain appropriate submonitoring practices of the SEPs the Department would hire a contract manager for contractual and financial policy oversight and a compliance specialist for operational compliance of the SEPs. The operational compliance FTE would bring SEP oversight resources to a similar level as the oversight of the Community Centered Boards (CCBs) which provide services of similar scope to a separate population. The contractual and financial policy FTE is necessary due to the increased workload of the existing SEP contract manager in response to the increasing complexity of SEP financing arrangements and the heightened standards of federal compliance. The FTEs would coordinate their tasks and objectives to produce a comprehensive plan of administration and oversight of all 24 SEP entities. Further descriptions supporting the FTE request are found below. For a breakout of the hourly requirements associated with the specific tasks expected of these FTEs please see Tables 9.1 and 9.2 in Appendix B of this request.

Financial Policy

The Department's request includes one FTE as a contract manager for contractual and financial policy oversight. Adhering to federally-required stipulations and guidelines, the FTE would be responsible for developing and implementing an annual risk assessment, developing a comprehensive financial and quality monitoring plan, developing and implementing an internal tracking tool for all monitoring activities across the Department's Office of Community Living, and revising required contract exhibits with annual subaward letters. Because SEPs are paid through administrative case management contracts (rather than targeted case management through the State Plan) oversight of the SEP financials is critical to ensure allowable expenditures are appropriately charged and classified.

This position, together with the existing SEP contract manager, would be responsible for direct management of the contracts and ensure that the SEPs financial information is reviewed in an order determined by the annual risk assessment. The FTE would also track all Single Audits[5] of initiated by the larger SEPs and ensure attestations are received from the SEPs that do not require a Single Audit. Single Audits are federally-required examinations of any entity that expends $750,000 or more of Federal assistance received for its operations. All documents and audit findings are to be comprehensively reviewed to proceed accordingly with potential issuance of recommendations and/or corrective measures.

Effective July 1, 2018, the Centers for Medicare and Medicaid Services (CMS) requires a confidence level of 95% with a 5% margin of error for quality and financial reviews. Currently, the Department spends approximately $90,000 for a vendor to perform desk-reviews of the SEPs. The increased oversight requirements from CMS would drive a substantial workload increase and rather than seek increased contractor funding the Department seeks the resources to perform the extensive reviews internally with dedicated FTE. Table 9 in Appendix B details the expected workload of the FTE.

[4] 2 CFR §200.331 Requirements for pass-through entities, 2 CFR §200.300 Statutory and National Policy Requirements through 2 CFR §200.309 Period of performance, and Subpart F – Audit Requirements.

[5] The Single Audit, under the OMB Uniform Guidance, is a rigorous, organization-wide audit or examination of an entity that expends $750,000 or more of federal assistance received for its operations. Usually performed annually, the Single Audit's objective is to provide assurance to the US federal government as to the management and use of such funds.

Operational Compliance

The Department's request includes one FTE as a compliance specialist for the operational compliance of the SEPs. This FTE would be responsible for implementing operational and programmatic oversight measures for subrecipient practices of the SEPs. The FTE would be responsible for developing and maintaining a Performance & Quality (PQ) Review Plan and Monitoring Tool, completing PQ desk reviews and PQ onsite reviews. Additional tasks would include the development of management reports, development of corrective action plans (CAPs), and potential follow-up activities with the SEPs including CAP monitoring and technical assistance.

The request for one FTE for operational compliance of the SEPs is based on the Department's existing operational compliance activities of the Community Centered Boards (CCBs). The twenty CCBs behave similarly in scope and practice to SEPs in their duties of assisting persons with Intellectual and Developmental Disability (IDD) and the Department's operational compliance requirements of CCBs are also similar[6]. Though the Department has two dedicated FTE that perform these duties for the CCBs the Department believes one FTE is sufficient for the SEPs because of the expected extensive collaboration with the SEP contract managers on all program components.

This request supplements the Department's FY 2017-18 R-9 "Long Term Care Utilization Management" budget request, which was approved by the General Assembly; the Department was appropriated $162,240 General Fund for operation audits of the CCBs and SEPs for FY 2018-19 and ongoing. The Centers for Medicare and Medicaid Services (CMS) did not permit 75% federal financial participation for all activities, and as a result, the Department has less funding available than expected for these activities. Despite the reduction of available total funds, the Department managed to implement most initiatives of the request including the operational audit activities of the CCBs. If the current request for two FTE is approved, it would allow the Department to complete the implementation of its oversight measures of the CCBs and SEPs, become compliant with federal guidance, and ensure the continual improvement of service delivery and care to some of its most vulnerable members. Approval of this request would also allow the Department to redesign the annual SEP contracts with language and requirements that better align with Department goals and other variables such as the regions served by the SEP entities.

Program Integrity

The Department requests $91,744 total funds, including $26,945 in General Fund and 0.9 FTE in FY 2019-20 and $94,154 total funds, including $27,654 in General Fund and 1.0 FTE in FY 2020-21 and ongoing to add a compliance specialist.

The Department has insufficient audit personnel to manage and coordinate the numerous audit activities of current and expected audits. The Department is currently subjected to fifteen high-activity audits for which there are two employees (one full-time and one half-time position) performing the liaison and response coordination duties. Because each audit can have up to five auditors asking questions, and each auditor may submit dozens of questions throughout the audit process, the extensive tracking and coordination efforts for

[6] Because CCBs are financed on a fee-for-service basis they are not subjected to federal subrecipient requirements, and as such, the financial oversight of the CCBs are part of larger Department utilization and quality review contracts

each question requires an immense amount of time and effort. Every audit request that is generated needs to be reviewed and analyzed, distributed to proper staff, logged, followed-up on, reviewed for quality assurance (QA), routed through a multi-level clearance procedure, submitted to the auditor, and stored/saved for future reference. Further, each question or audit request may have up to six or seven subparts, or follow-up questions, related to the original request which requires another layer of tracking and coordination. As an example, the 2017 State Auditor's Single Statewide Audit had 117 original requests and 47 subparts.

With CMS announcing on June 26, 2018, its new Program Integrity Strategy, including the addition of several new audits to be performed by the federal government, the Department has exceeded its capacity to handle any increase in the number audits and is requesting additional resources for the additional workload.

Claims Reviewer for Programs for People with Intellectual and Developmental Disabilities

The Department requests $91,744 total funds, including $45,872 General Fund and 0.9 FTE in FY 2019-20 and $94,154 including $47,077 General Fund and 1.0 FTE in FY 2020-21 and ongoing to manage, investigate, and recover erroneously paid claims for IDD services and/or refer suspected fraud to the Medicaid Fraud Control Unit (MFCU). This includes investigating referrals from the Colorado Department of Public Health and Environment (CDPHE), referrals from internal staff within the Department, referrals from case management agencies, and self-disclosures from service providers.

Currently, there are approximately 500 IDD service providers and CCBs who provide services to individuals with IDD. Under the waiver agreement with CMS, the Department is responsible for quarterly analysis using the federal Surveillance and Utilization Review Subsystem[7] (SURS). This process examines claims data across provider agencies to identify potential trends or outliers and informs potential recoupment efforts. Currently, the Department does not have identified FTE dedicated to research known issues and referrals, conduct SURS analysis, address compliance issues, or recoup funds for the IDD services.

If the request is approved, the Department would be responsible for ensuring appropriate application of the existing recoveries statute (section 25.5-4-301, C.R.S.), applying the statute to all IDD service providers and CCBs, established regulations, and enforce all requirements in cases of non-compliance. This position may result in the recovery of funds erroneously paid to IDD service providers; if so, the Department would request adjustments to its appropriation through the regular budget process. This position is necessary because currently the Department does not conduct regular investigations or reviews of IDD waivers or services.

Anticipated Outcomes:

Approving this request would ensure the Department has sufficient funding and FTE to effectively administer and support its programs. Aligned with the Department's strategic policy initiative of operational excellence of compliant, efficient, and effective business practices, the initiatives within this request also represent a direct implementation of Departmental core values, especially continuous improvement, transparency and accountability.

[7] https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-surs.pdf

Further, approval of this request would put measures in place to ensure that Department's members have their medical needs met and that each member's well-being and quality of life are appropriately considered. The increase in compliance and oversight funding would also assure that providers are correctly billing the Department for member services and that member benefits are correctly-priced, both of which would reduce fraud, waste and abuse within the Medicaid program.

Assumptions and Calculations:

Where applicable, notable assumptions for each calculation have been shown in the 'Proposed Solution' section of this document The Department has included two appendices that detail the calculations used to determine the fiscal impact for each initiative and includes:

- Appendix A - List of FTE proposed including the applicable initiative, FTE position title, position type, number of FTE requested and description of position tasks.
- Appendix B – Tables include Summary by Line Item table, Summary by Initiative table, FTE cost calculation table, cost estimate detail tables with corresponding assumptions for each of the vendor contracts to be funded by this request, detailed FTE tables listing expected hourly workload for the PACE Oversight, Subrecipient Monitoring of SEPs, and Claims Reviewer for Programs for People with IDD initiatives, and the expected travel expenses for the site visits of the SEPs.
- Tables 12.1 and 12.2 show the calculations supporting the savings expected from the implementation of the client eligibility determinations review. The Department uses the Modified Adjusted Gross Income (MAGI) populations in the methodology as these populations are believed to be more susceptible to eligibility determination errors due to the relative newness of their specific income determination criteria. Although the OSA found at least one person incorrectly deemed eligible in the 40-case sample within the Colorado Statewide Single Audit, the Department assumes a more conservative figure in determining expected savings. By applying a 0.11% (approximately one in every thousand persons) as its Percentage Effect on Caseload, shown in Row A of both tables, the Department arrives at a realistic savings expectation.

Appendix A: FTE Descriptions

Position Name	Position Classification	Number of FTE	Description of Duties
Eligibility Adjudications Reviews			
Compliance Investigator	Compliance Specialist IV	1	The FTE would negotiate, implement, monitor, and manage this contract, including developing contract scopes of work, negotiating terms with vendors, approving contractor personnel and work plans, performing all contract administration functions, monitoring and reviewing deliverables, processing invoices for payment, and ensuring adequate funds are available and budgeted for contracted work. The position would also serve as an audit liaison between the vendor and Department staff to conduct all activities related to the contract, including coordinating logistics surrounding systems access and building data samples and datasets for ongoing audit projects, communicating audit needs between both parties, and ensuring all necessary data and policy information is gathered to conduct accurate and comprehensive audits. The position would be responsible for reporting audit results and vendor performance to Department management, as well as communicating audit errors, deficiencies, and risks to the project manager.
PACE Administration			
Compliance Investigator	Compliance Specialist IV	1	The FTE would provide internal review and recommendations on the efficiency of the necessary activities to ensure compliance with federal and state regulations, as well as contract requirements for the PACE program. Duties would include the examination of the business processes, polices, and procedures involved in the enrollment and disenrollment, voluntary and involuntary, of Medicaid members in the PACE program. The FTE would perform yearly onsite audits to nine PACE centers to monitor the health, safety and welfare of Medicaid members. These duties would involve the review of the physical environment and contracted providers for compliance to federal and state regulations. The FTE would develop, negotiate, and monitor corrective action plans for performance-based measures to increase health, safety and welfare of Colorado Medicaid members. Additionally, the FTE would ensure effective and appropriate transitions of care for members immediately following PACE disenrollment. Moreover, the FTE would provide technical assistance to counties, single-entry points (SEP), Ombudsman and Adult Protective Services (APS) regarding the PACE program. These duties would include review of PACE onboarding through the SEP, regulatory guidance for the counties and APS, and coordinating with the Ombudsman on complex cases.

Position Name	Position Classification	Number of FTE	Description of Duties
Subrecipient Monitoring of SEPs			
Compliance Specialist	Compliance Specialist IV	1	The FTE would assist with managing and implementing case management performance monitoring for subrecipient practices of Single Entry Points (SEP). The position requested would be responsible for developing and maintaining a Performance & Quality (PQ) Review Plan and Monitoring Tool, PQ Desk Reviews, Onsite Reviews, development of reports and Corrective Action Plans (CAPs) from Desk/Onsite Reviews, tracking and monitoring of CAPs, and technical assistance.
Administrator	Administrator III	1	The FTE would be responsible for direct management of the SEP contracts and would ensure that the SEPs are reviewed in an order determined by the annual risk assessment. This position is necessary to review all Single Audits of the SEPs and ensure attestations from SEPs that do not require a Single Audit. Single Audits are federally-required examinations of any entity that expends $750,000 or more of federal assistance received for its operations. This position tracks all Single Audits, reviews all findings, and issues management decisions if findings are related to the SEP program. Based on the results of the risk assessment, financial reviews, and Single Audit findings, this position would conduct additional desk and onsite reviews as necessary and provide technical assistance to SEPs
Program Integrity			
Auditor	Compliance Specialist IV	1	The FTE would perform the following duties: Assign audit requests to the appropriate subject matter experts (SMEs). Establish internal due dates that include provisions for quality assurance (QA) and clearance. Monitor and track due dates daily and follow-up with staff on responses and clearance to ensure items are submitted by the auditors' due dates. Compile Department responses for each audit request, including working with three or four areas within the Department to develop a cohesive response. Because of the range and complexity of a request many questions require subject matter experts from several areas within the Department to develop a comprehensive response. Conduct extensive QA as responses are received from SMEs quickly comprehending certain Medicaid programs and initiate back and forth communication with the various SMEs to ensure responses are accurate, understandable and cover what the auditor is asking for. Ensure duplicate audit requests don't get sent to staff. Retrieve and store responses and supporting documents before uploading to an external agencies' secure websites. Follow-up with staff regularly on status of implementing corrective action plans. Reconfiguring and updating the external audit database as needed. Update the database daily to keep it current with status updates and other audit activities. Obtain,

Position Name	Position Classification	Number of FTE	Description of Duties
			review and submit system access forms on behalf of various external auditors. Provide formal and informal training to staff of various levels and sometime auditors on the external audit process. Coordinate the Department response to the state auditor's Legislative Audit Committee meetings which is where the Department officially outlines the details of its corrective action plans for each audit finding.
Claims Reviewer for Programs for People with Intellectual and Developmental Disabilities			
Compliance Specialist	Compliance Specialist IV	1	The FTE would be responsible for reviews of claims submitted for the Department's home- and community-based services (HCBS) programs for people with intellectual and developmental disabilities (IDD). Job duties would include drafting and implementing specific rules and related stakeholder engagement; establish requirements for supporting documentation from IDD service providers and case management agencies; developing processes, protocols, templates, and standards related to referrals, self-disclosures, investigation process, and SURS analysis; investigation of all referrals and self-disclosures including claims research, case management documentation research, outreach to providers, case management agencies, person receiving services or family, Program Integrity or the Medicaid Fraud Control Unit, and/or Adult Protective Services, requesting and review documentation from service providers to substantiate claims; determining overpayments and initiating and tracking recoveries.

Table 1.1 - Summary By Line Item
FY 2019-20

Row	FY 2019-20	Total Funds	FTE	General Fund	Cash Funds[(1)]	Federal Funds	FFP	Source
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$415,839	5.5	$178,362	$24,929	$212,548	51%	Table 3, Personal Services, PERA & Medicare
B	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$47,562	0.0	$20,510	$2,758	$24,294	51%	Table 3, Health, Life and Dental
C	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$708	0.0	$304	$42	$362	51%	Table 3, STD
D	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$18,587	0.0	$7,973	$1,114	$9,500	51%	Table 3, AED
E	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$18,587	0.0	$7,973	$1,114	$9,500	51%	Table 3, SAED
F	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$48,918	0.0	$22,126	$1,968	$24,824	51%	Table 3, Operating Expenses
G	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$149,794	0.0	$55,594	$16,531	$77,669	52%	Table 2.1, Row L + Table 2.1, Row N
H	(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$251,499	0.0	$115,375	$31,889	$104,235	41%	Table 2.1, Row E + Table 2.1, Row J
I	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($1,732,216)	0.0	($408,217)	($74,990)	($1,249,009)	72%	Table 2.1, Row F
J	**Total Request**	**($780,722)**	**5.5**	**$0**	**$5,355**	**($786,077)**	**NA**	**Sum of Rows A through I**

'(1) Cash funds consist of $86,358 from the Colorado Healthcare Affordability & Sustainability Fee Cash Fund, and reduction of $81,003 from the Children's Basic Health Plan Trust

Table 1.2 - Summary By Line Item
FY 2020-21 and Ongoing

Row	FY 2020-21	Total Funds	FTE	General Fund	Cash Funds[(1)]	Federal Funds	FFP	Source
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$455,094	6.0	$195,300	$27,192	$232,602	51%	Table 3, Personal Services, PERA & Medicare
B	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$47,562	0.0	$20,510	$2,757	$24,295	51%	Table 3, Health, Life and Dental
C	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$772	0.0	$331	$46	$395	51%	Table 3, STD
D	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$20,282	0.0	$8,700	$1,215	$10,367	51%	Table 3, AED
E	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$20,282	0.0	$8,700	$1,215	$10,367	51%	Table 3, SAED
F	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$20,700	0.0	$9,958	$329	$10,413	50%	Table 3, Operating Expenses
G	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$149,794	0.0	$55,594	$16,531	$77,669	52%	Table 2.2, Row K + Table 2.2, Row M
H	(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$700,000	0.0	$192,500	$143,732	$363,768	52%	Table 2.2, Row E
I	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($3,464,428)	0.0	($816,432)	($149,981)	($2,498,015)	72%	Table 2.2, Row F
J	**Total Request**	**($2,049,942)**	**6.0**	**($324,839)**	**$43,036**	**($1,768,139)**	**NA**	**Sum of Rows A through I**

'(1) Cash funds consist of $12,096 from the Colorado Healthcare Affordability & Sustainability Fee Cash Fund, and $30,940 from the Children's Basic Health Plan Trust

Table 2.1 - Summary by Initiative
FY 2019-20

Row	Item	Total Funds	FTE	General Fund	Cash Funds[(1)]	Federal Funds	FFP	Source
Eligibility Determination Reviews								
A	FTE Costs	$91,744	0.9	$26,946	$15,962	$48,836	53%	Sum of Rows B, C, and D
B	*FTE Costs - Salary, PERA & Medicare*	*$71,638*	-	*$21,040*	*$12,463*	*$38,135*	53%	*Table 3- FTE Calculations - Position 1*
C	*FTE Costs - AED, SAED, STD and HLD*	*$14,453*	-	*$4,246*	*$2,514*	*$7,693*	53%	
D	*FTE Operating Expenses*	*$5,653*	-	*$1,660*	*$985*	*$3,008*	53%	
E	Contractor Costs	$111,499	-	$45,375	$31,889	$34,235	31%	Table 4.1, Row H
F	Expected Savings	($1,732,216)	-	($408,217)	($74,990)	($1,249,009)	72%	Table 12.1 Row F through Row J [Total Column]
G	**Subtotal**	**($1,528,973)**	**0.9**	**($335,896)**	**($27,139)**	**($1,165,938)**	**76.3%**	**Row A + Row E + Row F**
Program of All-Inclusive Care for the Elderly (PACE) Administration								
H	FTE Costs	$91,744	0.9	$45,872	$0	$45,872	50%	Sum of H, I, and J
I	*FTE Costs - Salary, PERA & Medicare*	*$71,638*	-	*$35,820*	*$0*	*$35,818*	50%	*Table 3- FTE Calculations - Position 2*
J	*FTE Costs - AED, SAED, STD and HLD*	*$14,453*	-	*$7,226*	*$0*	*$7,227*	50%	
K	*FTE Operating Expenses*	*$5,653*	-	*$2,826*	*$0*	*$2,827*	50%	
L	Contractor Costs	$140,000	-	$70,000	$0	$70,000	50%	Table 5, Row C
M	**Subtotal**	**$231,744**	**0.9**	**$115,872**	**$0**	**$115,872**	**50%**	**Row H + Row L**
Managed Care Organizations (MCOs) Financial Reviews								
N	Contractor Costs	$85,794	-	$23,594	$16,531	$45,669	53%	Table 6, Row G
Hospital Back-Up (HBU) Program								
O	Contractor Costs	$64,000	-	$32,000	$0	$32,000	50%	Table 7, Row C
Subrecipient Monitoring of Single Entry Point (SEP) Entities								
P	FTE Costs	$168,225	1.8	$84,113	$0	$84,112	50%	Sum of U, V, and W
Q	*FTE Costs - Salary, PERA & Medicare*	*$129,287*	-	*$64,643*	*$0*	*$64,644*	50%	*Table 3- FTE Calculations - Positions 3 and 4*
R	*FTE Costs - AED, SAED, STD and HLD*	*$27,632*	-	*$13,817*	*$0*	*$13,815*	50%	
S	*FTE Operating Expenses*	*$11,306*	-	*$5,653*	*$0*	*$5,653*	50%	
T	Travel Costs	$15,000	-	$7,500	$0	$7,500	50%	Table 11, Row D
U	**Subtotal**	**$183,225**	**1.8**	**$91,613**	**$0**	**$91,612**	**50%**	**Row P + Row T**
Program Integrity (PI)								
V	FTE Costs	$91,744	0.9	$26,945	$15,963	$48,836	53%	Sum of U, V, and W
W	*FTE Costs - Salary, PERA & Medicare*	*$71,638*	-	*$21,040*	*$12,466*	*$38,132*	53%	*Table 3- FTE Calculations - Position 5*
X	*FTE Costs - AED, SAED, STD and HLD*	*$14,453*	-	*$4,245*	*$2,514*	*$7,694*	53%	
Y	*FTE Operating Expenses*	*$5,653*	-	*$1,660*	*$983*	*$3,010*	53%	
Z	**Subtotal**	**$91,744**	**0.9**	**$26,945**	**$15,963**	**$48,836**	**53%**	**Row V**
Claims Reviewers for Programs for People with Intellectual and Developmental Disabilities (IDD)								
AA	FTE Costs	$91,744	0.9	$45,872	$0	$45,872	50%	Sum of Z, AA, and AB
AB	*FTE Costs - Salary, PERA & Medicare*	*$71,638*	-	*$35,819*	*$0*	*$35,819*	50%	*Table 3- FTE Calculations - Position 6*
AC	*FTE Costs - AED, SAED, STD and HLD*	*$14,453*	-	*$7,226*	*$0*	*$7,227*	50%	
AD	*FTE Operating Expenses*	*$5,653*	-	*$2,827*	*$0*	*$2,826*	50%	
AE	**Subtotal**	**$91,744**	**0.9**	**$45,872**	**$0**	**$45,872**	**50%**	**Row AA**
AF	**Total**	**($780,722)**	**5.5**	**$0**	**$5,355**	**($786,077)**	**NA**	**Row G + Row M + Row N + Row O + Row U + Row Z + Row AE**

(1) Cash funds consist of $86,358 from the Colorado Healthcare Affordability & Sustainability Fee Cash Fund, and reduction of $81,003 from the Children's Basic Health Plan Trust

Table 2.2 - Summary by Initiative
FY 2020-21

Row	Item	Total Funds	FTE	General Fund	Cash Funds[(1)]	Federal Funds	FFP	Source
Eligibility Determination Reviews								
A	FTE Costs	$94,154	1.0	$27,653	$16,377	$50,124	53%	Sum of Rows B, C, and D
B	*FTE Costs - Salary, PERA & Medicare*	*$78,156*	-	*$22,954*	*$13,597*	*$41,605*	53%	*Table 3 - FTE Calculations Position 1*
C	*FTE Costs - AED, SAED, STD and HLD*	*$15,048*	-	*$4,420*	*$2,615*	*$8,013*	53%	
D	*FTE Operating Expenses*	*$950*	-	*$279*	*$165*	*$506*	53%	
E	Contractor Costs	$700,000	-	$192,500	$143,732	$363,768	52%	Table 4.1, Row H
F	Expected Savings	($3,464,428)	-	($816,432)	($149,981)	($2,498,015)	72%	Table 12.2 Row F through Row J [Total Column]
G	**Subtotal**	**($2,670,274)**	**1.0**	**($596,279)**	**$10,128**	**($2,084,123)**	**78.05%**	**Row A + Row E + Row F**
Program of All-Inclusive Care for the Elderly (PACE) Administration								
H	FTE Costs	$94,154	1.0	$47,076	$0	$47,078	50%	Sum of H, I, and J
I	*FTE Costs - Salary, PERA & Medicare*	*$78,156*	-	*$39,078*	*$0*	*$39,078*	50%	*Table 3 - FTE Calculations Position 2*
J	*FTE Costs - AED, SAED, STD and HLD*	*$15,048*	-	*$7,523*	*$0*	*$7,525*	50%	
K	*FTE Operating Expenses*	*$950*	-	*$475*	*$0*	*$475*	50%	
L	Contractor Costs	$0	-	$0	$0	$0	NA	NA
M	**Subtotal**	**$94,154**	**1.0**	**$47,076**	**$0**	**$47,078**	**50%**	**Row H + Row L**
Managed Care Organizations (MCOs) Financial Reviews								
N	Contractor Costs	$85,794	-	$23,594	$16,531	$45,669	53%	Table 6, Row G
Hospital Back-Up (HBU) Program								
O	Contractor Costs	$64,000	-	$32,000	$0	$32,000	50%	Table 7, Row C
Subrecipient Monitoring of Single Entry Point (SEP) Entities								
P	FTE Costs	$173,076	2.0	$86,539	$0	$86,537	50%	Sum of U, V, and W
Q	*FTE Costs - Salary, PERA & Medicare*	*$142,470*	-	*$71,235*	*$0*	*$71,235*	50%	*Table 3- FTE Calculations - Positions 3 and 4*
R	*FTE Costs - AED, SAED, STD and HLD*	*$28,706*	-	*$14,354*	*$0*	*$14,352*	50%	
S	*FTE Operating Expenses*	*$1,900*	-	*$950*	*$0*	*$950*	50%	
T	Travel Costs	$15,000	-	$7,500	$0	$7,500	50%	Table 11, Row D
U	**Subtotal**	**$188,076**	**2.0**	**$94,039**	**$0**	**$94,037**	**50%**	**Row P + Row T**
Program Integrity (PI)								
V	FTE Costs	$94,154	1.0	$27,654	$16,377	$50,123	53%	Sum of U, V, and W
W	*FTE Costs - Salary, PERA & Medicare*	*$78,156*	-	*$22,955*	*$13,595*	*$41,606*	53%	*Table 3- FTE Calculations - Position 5*
X	*FTE Costs - AED, SAED, STD and HLD*	*$15,048*	-	*$4,420*	*$2,618*	*$8,010*	53%	
Y	*FTE Operating Expenses*	*$950*	-	*$279*	*$164*	*$507*	53%	
Z	**Subtotal**	**$94,154**	**1.0**	**$27,654**	**$16,377**	**$50,123**	**53%**	**Row U**
Claims Reviewers for Programs for People with Intellectual and Developmental Disabilities (IDD)								
AA	FTE Costs	$94,154	1.0	$47,077	$0	$47,077	50%	Sum of Z, AA, and AB
AB	*FTE Costs - Salary, PERA & Medicare*	*$78,156*	-	*$39,078*	*$0*	*$39,078*	50%	*Table 3- FTE Calculations - Positions 6*
AC	*FTE Costs - AED, SAED, STD and HLD*	*$15,048*	-	*$7,524*	*$0*	*$7,524*	50%	
AD	*FTE Operating Expenses*	*$950*	-	*$475*	*$0*	*$475*	50%	
AE	**Subtotal**	**$94,154**	**1.0**	**$47,077**	**$0**	**$47,077**	**50%**	**Row Z**
AF	**Total**	**($2,049,942)**	**6.0**	**($324,839)**	**$43,036**	**($1,768,139)**	**NA**	**Row G + Row M + Row N + Row O + Row U + Row Z + Row AE**

(1) Cash funds consist of $12,096 from the Colorado Healthcare Affordability & Sustainability Fee Cash Fund, and $30,940 from the Children's Basic Health Plan Trust

Table 3: FTE Calculations

FTE Calculation Assumptions:

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

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

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

Expenditure Detail			FY 2019-20		FY 2020-21	
Personal Services:						
Classification Title	Monthly Salary	FTE		FTE		
Compliance Specialist IV	$5,823	0.9	$64,048	1.0	$69,876	
PERA			$6,661		$7,267	
AED			$3,202		$3,494	
SAED			$3,202		$3,494	
Medicare			$929		$1,013	
STD			$122		$133	
Health-Life-Dental			$7,927		$7,927	
Subtotal Position 1		**0.9**	**$86,091**	**1.0**	**$93,204**	
Classification Title	Monthly Salary	FTE		FTE		
Compliance Specialist IV	$5,823	0.9	$64,048	1.0	$69,876	
PERA			$6,661		$7,267	
AED			$3,202		$3,494	
SAED			$3,202		$3,494	
Medicare			$929		$1,013	
STD			$122		$133	
Health-Life-Dental			$7,927		$7,927	
Subtotal Position 2		**0.9**	**$86,091**	**1.0**	**$93,204**	
Classification Title	Monthly Salary	FTE		FTE		
Compliance Specialist IV	$5,823	0.9	$64,048	1.0	$69,876	
PERA			$6,661		$7,267	
AED			$3,202		$3,494	
SAED			$3,202		$3,494	
Medicare			$929		$1,013	
STD			$122		$133	
Health-Life-Dental			$7,927		$7,927	
Subtotal Position 3		**0.9**	**$86,091**	**1.0**	**$93,204**	
Classification Title	Monthly Salary	FTE		FTE		
Administrator III	$4,686	0.9	$51,542	1.0	$56,232	
PERA			$5,360		$7,267	
AED			$2,577		$2,812	
SAED			$2,577		$2,812	
Medicare			$747		$815	
STD			$98		$107	
Health-Life-Dental			$7,927		$7,927	
Subtotal Position 4		**0.9**	**$70,828**	**1.0**	**$77,972**	
Classification Title	Monthly Salary	FTE		FTE		
Compliance Specialist IV	$5,823	0.9	$64,048	1.0	$69,876	
PERA			$6,661		$7,267	
AED			$3,202		$3,494	
SAED			$3,202		$3,494	
Medicare			$929		$1,013	
STD			$122		$133	
Health-Life-Dental			$7,927		$7,927	
Subtotal Position 5		**0.9**	**$86,091**	**1.0**	**$93,204**	
Classification Title	Monthly Salary	FTE		FTE		
Compliance Specialist IV	$5,823	0.9	$64,048	1.0	$69,876	
PERA			$6,661		$7,267	
AED			$3,202		$3,494	
SAED			$3,202		$3,494	
Medicare			$929		$1,013	
STD			$122		$133	
Health-Life-Dental			$7,927		$7,927	
Subtotal Position 6		**0.9**	**$86,091**	**1.0**	**$93,204**	
Subtotal Personal Services		5.5	**$501,283**	6.0	**$543,992**	
Operating Expenses:						
		FTE		FTE		
Regular FTE Operating Expenses	$500	6.0	$3,000	6.0	$3,000	
Telephone Expenses	$450	6.0	$2,700	6.0	$2,700	
PC, One-Time	$1,230	6.0	$7,380	-		
Office Furniture, One-Time	$3,473	6.0	$20,838	-		
Other						
Other						
Other						
Other						
Subtotal Operating Expenses	$950	$5,653	**$33,918**		**$5,700**	
TOTAL REQUEST		5.5	**$535,201**	6.0	**$549,692**	
General Fund:			*$229,748*		*$235,999*	
Cash funds:			*$31,925*		*$32,754*	
Reappropriated Funds:			*$0*		*$0*	
Federal Funds:			*$273,528*		*$280,939*	

Table 4.1 - Eligibility Determination Review
FY 2019-20

Row	Description	Total Funds	General Fund	CHASE	CHP+ Trust	Federal Funds	Medicaid FFP	CHP+ FFP	Source
A	**Funding Requirement**	**$700,000**	**$192,500**	**$119,000**	**$15,877**	**$372,623**	**50%**	**79.38%**	**Row B + Row C + Row D**
B	General Fund	$385,000	$192,500	$0	$0	$192,500	50%	NA	Fund split allocations, including federal funds, correspond to current caseload estimates of expansion populations and CHP+ populations and their expected FFP rate. Table 4.3 provides estimate of contractor cost.
C	CHASE	$238,000	$0	$119,000	$0	$119,000	50%	NA	
D	CHP+	$77,000	$0	$0	$15,877	$61,123	NA	79.38%	
E	**Existing Funding**	**$588,501**	**$147,125**	**$0**	**$102,988**	**$338,388**	**50%**	**65%**	**Row F + Row G**
F	General Fund	$294,250	$147,125	$0	$0	$147,125	50%	NA	FY 2007-08 S-5 "Revised Federal Rule for Payment Error Rate Measurement (PERM) Program" approved funding to correspond to the cyclical nature of PERM audits which occur every three years.
G	CHP+	$294,251	$0	$0	$102,988	$191,263	NA	65%	
H	**Funding Requested**	**$111,499**	**$45,375**	**$119,000**	**($87,111)**	**$34,235**	**50%**	**Blend**	**Row A - Row E**

Table 4.2 - Eligibility Determination Reviews
FY 2020-21 And Ongoing

Row	Description	Total Funds	General Fund	CHASE	CHP+ Trust	Federal Funds	Medicaid FFP	CHP+ FFP	Source
A	**Funding Requirement**	**$700,000**	**$192,500**	**$119,000**	**$24,732**	**$363,768**	**50%**	**67.88%**	**Row B + Row C + Row D**
B	General Fund	$385,000	$192,500	$0	$0	$192,500	50%	NA	Fund split allocations, including federal funds, correspond to current caseload estimates of expansion populations and CHP+ populations and their expected FFP rate. Table 4.3 provides estimate of contractor cost.
C	CHASE	$238,000	$0	$119,000	$0	$119,000	50%	NA	
D	CHP+	$77,000	$0	$0	$24,732	$52,268	NA	67.88%	
E	**Existing Funding**	**$0**	**$0**	**$0**	**$0**	**$0**	**50%**	**65%**	**Row F + Row G**
F	General Fund	$0	$0	$0	$0	$0	50%	NA	FY 2007-08 S-5 "Revised Federal Rule for Payment Error Rate Measurement (PERM) Program" approved funding to correspond to the cyclical nature of PERM audits which occur every three years.
G	CHP+	$0	$0	$0	$0	$0	NA	65%	
H	**Funding Requested**	**$700,000**	**$192,500**	**$119,000**	**$24,732**	**$363,768**	**50%**	**Blend**	**Row A - Row E**

Table 4.3 - Eligibility Determination Reviews Vendor Contract Estimate FY 2019-20 and Ongoing							
Row	**Description**	**Average of Estimated Hours per Review**	**Hourly Rate**	**Cost per Review**	**# of Reviews**	**Extended Cost**	**Source/Assumptions**
Eligibility Determination Reviews - Colorado Benefits Management System (CBMS)							
A	Reviewing eligibility determinations will require an ongoing sampling of clients, which include selection of records, requests for those records from county office and partner sites, analysis against CBMS data, and verification against state and federal regulations. The vendor will also be tasked to evaluate the accuracy of CBMS eligibility data interfacing with other Department systems, including the Colorado interChange.	4.0	$175	$700.00	1,000	$700,000	The estimated contract cost is based on the Department's previous federally-conducted Payment Error Rate Measurement (PERM) program, where auditors performed as many as 500 reviews in a single audit cycle. Under the Department's review contract, the vendor will be expected to do approximately twice the number of reviews.
B	**Estimated Contract Cost**					**$700,000**	**Row A**

Table 5 - Program of All-Inclusive Care for the Elderly (PACE)
Estimated Cost of Vendor Contract
FY 2019-20

Row	Description	Estimated Hours	Hourly Rate	Units	Cost per Deliverable	Extended Cost	Source/Assumptions
A	Risk Assessment Report for current state of the PACE Program in the event of catastrophic episode	400	$175	1	$70,000	$70,000	Estimate based on existing contract of similar scope and requirements (Managed Care Organizations Financial Review).
B	Develop a tool to calculate the Risk Reserve Fund amount for the four PACE Organizations based on geographic location	100	$175	4	$17,500	$70,000	
C	**Total**					**$140,000**	Row A + Row B

Table 6 - Managed Care Organizations (MCO)
Expanded Scope of Financial Reviews
FY 2019-20 and Ongoing

Row	Description	Estimated Hours	Hourly Rate	Units	Cost per Deliverable	Extended Cost	Source
A	Updated Risk Assessment Report	100	$175	1	$17,500	$17,500	Vendor proposal submitted to the Department on April 6, 2018.
B	Updated Annual Review Priority Recommendation	30	$175	1	$5,250	$5,250	
C	Updated Annual Review Plan	30	$175	1	$5,250	$5,250	
D	Annual Review of Reports	90	$175	9	$15,750	$141,750	
E	**Total**					**$169,750**	Row A to Row D
F	Existing Funding for Current Contract					$83,956	Department spending plan for Professional Audit Services line item
G	**Funding Requested**					**$85,794**	**Row E - Row F**

Table 7 - Hospital Back-Up Program Minimum Data Set (MDS) Score Verifications FY 2019-20 and Ongoing					
Row	**Description**	**# of HBU Certified Facilities**	**Cost per facility**	**Extended Cost**	**Source**
A	Facility-Wide Annual Review	4	$8,000	$32,000	Vendor proposal submitted to the Department on February 16, 2018.
B	Facility-Wide Second Review (approximately 6 months subsequent to Annual Review)	4	$8,000	$32,000	
C	**Funding Requested**			**$64,000**	Row A + Row B

Table 8 - Program of All-Inclusive Care for the Elderly (PACE) Oversight FTE Workload - Contract and Financial Policy		
Row	**Task**	**Estimated # of Hours (Annually)**
Develop and implement fiscal monitoring plans for the PACE Organizations		
A	Develop and implement contract provisions and a monitoring plan for the ongoing submission of encounter data	400
B	Annual review and revision of contracts	400
C	Develop contract deliverables in alignment with the Department and PACE Organization requirements for effective oversight of compliance investigators	400
D	Monitoring of enrollments for the effective processing of payments to the PACE Organizations and the coordination with Audits and Compliance for recoupment of overpayments	500
E	Track, monitor, and review deliverables by the PACE Organizations and develop recommendations for any breach of contract, or corrective action plan	320
F	Technical assistance	80
G	**Total Hours of Expected Workload**	**2,100**
H	Number of FTE Requested	1

Table 9.1 - Subrecipient Monitoring of Single Entry Point (SEP) Entities FTE Workload - Contract Manager		
Row	**Task**	**Estimated # of Hours (Annually)**
Develop and implement a fiscal monitoring plan for the SEP entities		
A	Perform an annual subrecipient risk assessment for 12 SEPs	80
B	Develop and implement a monitoring plan for financial and quality oversight of the 24 SEPs; develop and implement a monitoring tracking tool that includes financial and quality oversight from both Operations and Administrations Division (OAD) and the Case	320
C	Revise and assist contract manager in negotiating of contract and contract exhibits annually for 12 SEPs including all language as required by 2 CFR §200.331	504
D	Issue Catalogue of Federal Domestic Assistance (CFDA) letters to each SEP annually, notifying the agency of the federal award amount received each SEP Fiscal Year	96
E	Review and analysis of the financial reviews and Single Audits of the SEPs. Meet with SEPs to discuss results and resolve outstanding questions. Issue management decisions on all findings.	960
F	Technical assistance	100
G	**Total Hours of Expected Workload**	**2,060**
H	Number of FTE Requested	1

Table 9.2 - Subrecipient Monitoring of Single Entry Point (SEP) Entities FTE Workload - Operational Compliance		
Row	**Task**	**Estimated # of Hours (Annually)**
Develop and maintain a performance and quality review plan for the SEP entities		
A	Desk reviews of operational plans and guidelines of 24 SEPs	360
B	Conduct on-site reviews of SEPs	720
C	Develop and implement Performance & Quality Reports, reviewing results with SEPs, and issuing management decisions on all findings, including Corrective Action Plans (CAPs)	360
D	Tracking and monitoring CAPs for SEPs.	480
E	Technical assistance	200
F	**Total Hours of Expected Workload**	**2,120**
G	Number of FTE Requested	1
H	**Total Hours per FTE**	**2,120**

Table 10 - Claims Reviewers for Programs for People with Intellectual and Developmental Disabilities FTE Workload		
Row	**Task**	**Estimated # of Hours (Annually)**
A	Draft and implement specific IDD rules and engage in related stakeholder engagement	160
B	Establish requirements for supporting documentation from IDD service providers and CCBs	40
C	Develop processes, protocols, templates, and standards related to referrals, self-disclosures, investigation process, and SURS analysis	120
D	Accept, review, and investigation of all referrals and self-disclosures to include: claims research, case management documentation research, outreach to providers, case management agencies, person receiving services or family, Program Integrity or MFCU, and/or APS; request and review documentation from service providers to substantiate claims; determine if cases require referral to Program Integrity or MFCU; determine if an overpayment occurred and the amount to be recovered by the Department Recommend termination of provider agreements or contracts to program staff, if necessary	1,300
E	Issue review notification letters; Issue demand letters for any recoveries; respond to informal reconsiderations and/or appeals	312
F	Manage and track recoveries	52
G	Analysis of review findings to include trending reports	104
H	**Total Hours of Expected Workload**	**2,088**
I	Number of FTE Requested	1

Table 11 - Subrecipient Monitoring of Single Entry Point (SEP) Entities Travel Estimate for 2 FTEs			
Row	**Description**	**Amount**	**Source**
A	Car Rental / Mileage	$2,150	Estimates are based on existing travel schedules for two staff members overseeing Community Centered Boards (CCBs); 50 days of travel
B	Hotel	$10,000	
C	Meals / Incidentals	$2,850	
D	**Subtotal**	**$15,000**	**Row A + Row B + Row C**

Table 12.1: FY 2019-20 Estimated Caseload Reductions by Population								
Row	**Item**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69-133% FPL**	**MAGI Adults**	**MAGI Eligible Children**	**SB 11-008 Eligible Children**	**TOTAL**	**Notes/Calculations**
A	Estimated Percentage Effect on Caseload[(1)]	-0.11%	-0.11%	-0.11%	-0.11%	-0.11%	-0.11%	Based on State of Colorado Statewide Single Audit - Fiscal Year Ended June 30, 2017
B	Total Caseload	191,312	81,922	374,513	439,248	68,553	1,155,548	From the February 2018 S-1 "Medical Services Premiums" Request, Exhibit B
C	Estimated Affected Caseload	(207)	(88)	(404)	(474)	(74)	(1,247)	Row A * Row B
D	Per Capita Costs	$2,893.62	$2,826.77	$3,751.80	$2,082.35	$1,543.53	$2,778.55	From the February 2018 S-1 "Medical Services Premiums" Request, Exhibit C
E	Portion of Year Affected	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	Implementation date January 2020, half year impact
F	**Total Savings**	**($299,490)**	**($124,378)**	**($757,864)**	**($493,404)**	**($57,080)**	**($1,732,216)**	**Row C * Row D * Row E**
G	Federal Medical Assistance Percentage	50.00%	91.50%	91.50%	50.00%	79.38%	72.10%	Population-based, from the February 2018 S-1 "Medical Services Premiums" Request
H	General Fund Impact	($149,745)	$0	$0	($246,702)	($11,770)	($408,217)	For General-Funded Populations, Row F - Row J, otherwise $0
I	CHASE Cash Fund Impact	$0	($10,572)	($64,418)	$0	$0	($74,990)	For CHASE-Funded Populations, Row F - Row J, otherwise $0
J	Federal Funds Impact	($149,745)	($113,806)	($693,446)	($246,702)	($45,310)	($1,249,009)	Row F * Row G

(1)Actual decimal number used is -.0011

Table 12.2: FY 2020-21 Estimated Caseload Reductions by Population								
Row	**Item**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69-133% FPL**	**MAGI Adults**	**MAGI Eligible Children**	**SB 11-008 Eligible Children**	**TOTAL**	**Notes/Calculations**
A	Estimated Percentage Effect on Caseload	-0.11%	-0.11%	-0.11%	-0.11%	-0.11%	-0.11%	Based on State of Colorado Statewide Single Audit - Fiscal Year Ended June 30, 2017
B	Total Caseload	191,312	81,922	374,513	439,248	68,553	1,155,548	From the February 2018 S-1 "Medical Services Premiums" Request, Exhibit B
C	Estimated Affected Caseload	(207)	(88)	(404)	(474)	(74)	(1,247)	Row A * Row B
D	Per Capita Costs	$2,893.62	$2,826.77	$3,751.80	$2,082.35	$1,543.53	$5,557.08	From the February 2018 S-1 "Medical Services Premiums" Request, Exhibit C
E	Portion of Year Affected	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	Full year impact
F	**Total Savings**	**($598,979)**	**($248,756)**	**($1,515,727)**	**($986,807)**	**($114,159)**	**($3,464,428)**	**Row C * Row D * Row E**
G	Federal Medical Assistance Percentage	50.00%	91.50%	91.50%	50.00%	79.38%	72.10%	Population-based, from the February 2018 S-1 "Medical Services Premiums" Request
H	General Fund Impact	($299,489)	$0	$0	($493,403)	($23,540)	($816,432)	For General-Funded Populations, Row F - Row J, otherwise $0
I	CHASE Cash Fund Impact	$0	($21,144)	($128,837)	$0	$0	($149,981)	For CHASE-Funded Populations, Row F - Row J, otherwise $0
J	Federal Funds Impact	($299,490)	($227,612)	($1,386,890)	($493,404)	($90,619)	($2,498,015)	Row F * Row G