Schedule 13

Funding Request for the FY 2026-27 Budget Cycle

Health Care Policy and Financing

Request Title

S-09 Additional Resources for Federal Compliance
BA-09 Additional Resources for Federal Compliance

Dept. Approval By: _____ **X** **Supplemental FY 2025-26**

OSPB Approval By: _____ **X** **Budget Amendment FY 2026-27**

Summary Information	Fund	FY 2025-26 Initial Appropriation	FY 2025-26 Supplemental Request	FY 2026-27 Base Request	FY 2026-27 Budget Amendment	FY 2027-28 Continuation Request
Total of All Line Items Impacted by Change Request	**Total**	**$255,668,048**	**$173,016**	**$254,095,950**	**$3,401,414**	**$5,663,248**
	FTE	800.7	1.3	798.1	6.1	7.0
	GF	$72,928,582	$73,531	$72,636,253	$1,024,490	$1,460,375
	CF	$22,422,539	$12,978	$22,887,730	$176,218	$309,452
	RF	$3,338,005	$0	$3,373,942	$0	$0
	FF	$156,978,922	$86,507	$155,198,025	$2,200,706	$3,893,421

Line Item Information	Fund	FY 2025-26 Initial Appropriation	FY 2025-26 Supplemental Request	FY 2026-27 Base Request	FY 2026-27 Budget Amendment	FY 2027-28 Continuation Request
01. Executive Director's Office, (A) General Administration, (1) General Administration, Personal Services	**Total**	**$76,602,942**	**$108,040**	**$78,913,641**	**$527,269**	**$609,067**
	FTE	800.7	1.3	798.1	6.1	7.0
	GF	$29,477,201	$45,917	$30,293,903	$209,274	$237,905
	CF	$6,407,940	$8,104	$6,602,894	$54,361	$66,631
	RF	$3,155,881	$0	$3,211,037	$0	$0
	FF	$37,561,920	$54,019	$38,805,807	$263,634	$304,531
01. Executive Director's Office, (A) General Administration, (1) General Administration, Health, Life, and Dental	**Total**	**$12,823,330**	**$19,626**	**$16,840,982**	**$108,022**	**$124,365**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,434,254	$8,341	$6,493,890	$43,137	$48,858
	CF	$702,241	$1,472	$1,438,304	$10,874	$13,325
	RF	$0	$0	$0	$0	$0
	FF	$6,686,835	$9,813	$8,908,788	$54,011	$62,182
01. Executive Director's Office, (A) General Administration, (1) General Administration, Short-term Disability	**Total**	**$51,482**	**$152**	**$64,918**	**$698**	**$866**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$23,801	$64	$25,314	$277	$337
	CF	$427	$12	$5,360	$72	$96
	RF	$0	$0	$0	$0	$0
	FF	$27,254	$76	$34,244	$349	$433
01. Executive Director's Office, (A) General Administration, (1) General Administration, Paid Family and Medical Leave Insurance	**Total**	**$377,655**	**$432**	**$417,668**	**$2,098**	**$2,424**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$152,639	$184	$162,880	$833	$947
	CF	$27,098	$32	$34,480	$216	$265
	RF	$0	$0	$0	$0	$0
	FF	$197,918	$216	$220,308	$1,049	$1,212
01. Executive Director's Office, (A) General Administration, (1) General Administration, Unfunded Liability AED Payments	**Total**	**$7,918,630**	**$9,566**	**$9,281,509**	**$46,680**	**$53,924**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,391,947	$4,065	$3,619,548	$18,527	$21,062
	CF	$365,358	$718	$766,216	$4,813	$5,900
	RF	$0	$0	$0	$0	$0
	FF	$4,161,325	$4,783	$4,895,745	$23,340	$26,962

Line Item Information	Fund	FY 2025-26 Initial Appropriation	FY 2025-26 Supplemental Request	FY 2026-27 Base Request	FY 2026-27 Budget Amendment	FY 2027-28 Continuation Request
01. Executive Director's Office, (A) General Administration, (1) General Administration, Operating Expenses	**Total**	**$3,400,167**	**$28,984**	**$3,097,991**	**$75,438**	**$55,046**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,344,473	$12,318	$1,287,723	$26,624	$19,487
	CF	$296,462	$2,174	$257,147	$11,095	$8,036
	RF	$50,071	$0	$30,852	$0	$0
	FF	$1,709,161	$14,492	$1,522,269	$37,719	$27,523
01. Executive Director's Office, (A) General Administration, (1) General Administration, Leased Space	**Total**	**$3,700,205**	**$6,216**	**$3,700,205**	**$29,459**	**$32,556**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,482,562	$2,642	$1,482,562	$11,705	$12,789
	CF	$322,276	$466	$322,276	$3,025	$3,489
	RF	$38,849	$0	$38,849	$0	$0
	FF	$1,856,518	$3,108	$1,856,518	$14,729	$16,278
01. Executive Director's Office, (A) General Administration, (1) General Administration, General Professional Services and Special Projects	**Total**	**$45,936,358**	**$0**	**$40,397,469**	**$611,750**	**$503,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$16,663,486	$0	$14,707,769	$214,113	$213,550
	CF	$3,629,148	$0	$2,846,853	$91,762	$37,950
	RF	$81,000	$0	$81,000	$0	$0
	FF	$25,562,724	$0	$22,761,847	$305,875	$251,500
01. Executive Director's Office, (B) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects, MMIS Maintenance and Projects	**Total**	**$104,857,279**	**$0**	**$101,381,567**	**$2,000,000**	**$4,282,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$14,958,219	$0	$14,562,664	$500,000	$905,440
	CF	$10,671,589	$0	$10,614,200	$0	$173,760
	RF	$12,204	$0	$12,204	$0	$0
	FF	$79,215,267	$0	$76,192,499	$1,500,000	$3,202,800

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	None

Governor Jared Polis
FY 2026-27 Funding Request

Kim Bimestefer, Executive Director
Department of Health Care Policy & Financing
January 2, 2026

Department Priority: S-09, BA-09
Additional Resources For Federal Compliance

Summary of Funding Change for FY 2026-27

Fund Type	FY 2026-27 Base Request	FY 2026-27 Incremental Request	FY 2027-28 Incremental Request
Total Funds	$254,095,950	$3,401,414	$5,663,248
General Fund	$72,636,253	$1,024,490	$1,460,375
Cash Funds	$22,887,730	$176,218	$309,452
Reappropriated Funds	$3,373,942	$0	$0
Federal Funds	$155,198,025	$2,200,706	$3,893,421
FTE	798.1	6.1	7.0

Summary of Request

Problem or Opportunity:

The Department lacks spending authority to facilitate compliance with recent federal requirements pertaining to Health First Colorado, Colorado's Medicaid program. In recent years, the Centers for Medicare & Medicaid Services (CMS) published multiple final rules that address various aspects of the State's Medicaid program. The Department lacks the necessary resources to comply with the new federal regulations.

Proposed Solution:

The Department is requesting additional resources through a combination of FTE and contractor funding to ensure compliance with new federal regulations.

Fiscal Impact of Solution:

The Department requests $173k in total funds, including $73k General Fund, and 1.3 FTE in FY 2025-26; $3.4 million total funds including $1.0 million in General Fund, and 6.1 FTE in FY 2026-27; and 5.6 million total funds including $1.4 million General Fund, and 7.0 FTE in FY 2027-28 and ongoing.

Requires Legislation	Colorado for All Impacts	Revenue Impacts	Impacts Another Department?	Statutory Authority
No	Positive	No	No	25.5-5-102, C.R.S.

Background and Opportunity

Health First Colorado, Colorado's Medicaid program, is a public insurance program that provides health coverage to low-income families and individuals, including children, parents, pregnant women, seniors, and people with disabilities; it is funded jointly by the federal government and the State. Colorado operates Health First Colorado in accordance with federal guidelines including periodic updates issued by the Centers for Medicare & Medicaid Services (CMS) via a final rule. A CMS final rule sets out new or revised requirements and their effective date.

In recent months, CMS issued the following final rules affecting the administration of the program:

- CMS-2442-F – Ensuring Access to Medicaid Services
- CMS-2439-F – Medicaid and Children's Health Insurance Program Managed Care Access, Finance and Quality
- CMS-0057-F – CMS Interoperability and Prior Authorization Rule

Each final rule contains one or more provisions that drive a resource need for the Department. These provisions, also referred to as initiatives, are described in detail below.

Proposed Solution and Anticipated Outcomes

CMS-2442-F - Ensuring Access to Medicaid Services

Released April 22, 2024, this CMS final rule takes a comprehensive approach to improving access to care, quality and health outcomes, and better addressing health equity issues in the Medicaid program across fee-for-service (FFS), managed care delivery systems, and in home and community-based services (HCBS) programs. These improvements increase transparency and accountability, standardize data and monitoring, and create opportunities for States to promote active beneficiary engagement in their Medicaid programs, with the goal of improving access to care.

The rule has a particular focus on HCBS, including direct care worker compensation requirements, HCBS waitlists, grievance process development, critical incident reporting definitions and HCBS quality reporting. The final rule also seeks to increase transparency in payment rates.

Below are three provisions of the rule that are driving a need for additional Department resources.

Medicaid Advisory Committee & Beneficiary Advisory Council (MAC / BAC)

The Department is requesting 1.0 FTE ongoing, starting March 1, 2026, and $59,000 for FY 2026-27 and ongoing, for meeting facilitation costs, including member reimbursements, to ensure compliance with the below requirements:

42 CFR § 431.12, requires Health First Colorado to expand the scope of the state's Medical Care Advisory Committees for the purpose of advising the Department on their experience with the Medicaid program, matters of concern related to policy, development and the effective administration of the program. The Medicaid Advisory Committee (MAC) will advise states on an expanded range of issues. The new federal rule additionally requires States to establish a Beneficiary Advisory Council (BAC) composed of Medicaid beneficiaries, their families, and/or caregivers. Additional requirements:

- Establishes minimum requirements for MAC membership, including a requirement that 25% of the MAC members will be drawn from the BAC.
- Requires states to make information about the MAC and BAC activities publicly available including bylaws, meeting schedules, agendas, minutes, and membership lists.
- Requires states to make at least two MAC meetings per year open to the public. These meetings must include a public comment period.
- Requires states to provide staff to support the planning and execution of the MAC and BAC activities and ensure beneficiary participation.
- Requires states to create and publicly post an annual report summarizing MAC and BAC activities, their recommendations and the Department's responses to those recommendations.

42 CFR 431.12 (e) allows the Department to use an existing member group. This request proposes to leverage the Member Experience Advisory Council (MEAC) infrastructure and identifies the gaps and additional resources necessary to meet the minimum requirements of the new regulations. The current infrastructure includes the MEAC and the MEAC Alumni Group.

This request directly supports equity, diversity and inclusion by ensuring a diversity of member voices to impact Department decisions and ultimately improve the Department's health equity and access goals. The request would allow Department staff to:

- Support member preparation, education, and guidance through the BAC to participate in the MAC, as required by federal regulations, and provide the support needed for members to sit equally at the table.
- Support member recruitment efforts that ensure diversity in representation to include the underserved populations.
- Support inclusion through accessibility, reimbursements, incentives, interpretation, translation, and plain language communication.
- Support member participation outside of the meetings by aiding in issues that arise including but not limited to case management, care coordination and access to care challenges.

The FTE is a dedicated Outreach and Member Engagement Specialist with detailed job duties included in Appendix B. Funding is also necessary to facilitate the periodic meetings of both groups through member reimbursement of costs including travel, lodging, meals and childcare.

If this request is not approved, the Department would lack sufficient staffing and resources to support the additional and expanded administrative and fiscal requirements of the new regulation. The Department would be out of compliance with the federal regulation and subject to corrective actions and risk of federal financial participation. The Department would also be at risk of litigation from advocacy organizations who support the new regulations at 42 CFR 431.12.

Comparative Payment Rate Analysis & Disclosure, including Interested Parties Advisory Group (IPAG) Reporting

The Department is requesting 2.0 FTE and $121,000 in annual contractor funding in FY 2026-27 and ongoing, to facilitate compliance with the requirements below:

42 CFR § 447.203(b)(2), requires Health First Colorado to annually publish the comparative payment rate analysis for primary care services, obstetrical and gynecological services, and outpatient mental health and substance use disorder services.

42 CFR § 447.203(b)(3), requires Health First Colorado to annually publish the payment rate disclosure report for personal care, home health aide, homemaker and habilitation services.

42 CFR § 447.203(b)(6), requires Health First Colorado to establish the HCBS IPAG (Interested Parties Advisory Group) and publish recommendation reports every two years.

Effective July 1, 2026, Colorado Medicaid must publish the comparative payment rate analysis for the specified services and the payment rate disclosure report for four direct care services every year. It also must establish an Interested Parties Advisory Group to review the rates of four direct care services and publish a recommendation report to the Department every two years.

This request would drive more equitable outcomes for Health First Colorado members by standardizing rate data, increasing accountability and transparency, and promoting active stakeholder engagement.

Contractor funding would be used to conduct HCBS IPAG rate comparison analysis (personal care, home health aide, homemaker and habilitation services), the comparative payment rate analysis for primary care services, obstetrical and gynecological services, and outpatient mental health and substance use disorder services, and other ad-hoc analysis.

The two FTE include a rate analyst and a program administrator. The IPAG is an entirely new body and must be composed of direct care workers members, authorized representatives, and other members of the community. The program administrator would oversee the group so that they can advise and consult on FFS rates, HCBS payment adequacy data, and access to care metrics to ensure Medicaid rates are sufficient to ensure access to homemaker, home health, personal care, and habilitation services. The program administrator will create a transparent process to select

interested parties to serve on this committee. The process by which HCPF selects its advisory group members and convenes meetings must be made publicly available. The program administrator must ensure that the group has current and proposed payment rates with sufficient time to review and produce recommendations. The program administrator will create a report with the IPAG, every 2 years, that must be published on the state's website for state legislators and HHS to review recommendations. Detailed job duties are included in Appendix B.

If this request is not approved, the analysis for the access to care rule will have to be absorbed by existing Department staff. This process is time-consuming and complex and will detract from other critical Department work and/or the quality of the access to care analysis will be impacted.

Ensuring Access to HCBS Medicaid Services

The Department is requesting 2.0 FTE starting March 1, 2026 and $250,000 in contractor funding in FY 2026-27 and ongoing to facilitate compliance with the below requirements:

42 CFR § 441.302(a)(6), 42 CFR § 441.464(e), 42 CFR § 441.570(e), and 42 CFR § 441.745(a)(1)(v), require Health First Colorado to operate and maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. These rule changes require the Department to establish a new minimum definition of a critical incident and will add new reporting requirements for operating and maintaining an incident management system. While Colorado already has a statewide IT system for incident reporting for all HCBS waiver members, the rule increases requirements for reporting, investigation, information sharing, and incident management. The increase in the administrative burden to ensure compliance with all Access Rule requirements will dramatically increase the workload of Department staff. The state-level documentation, information sharing, and investigative responsibilities are expanding from four I/DD HCBS waivers to all 10 HCBS waivers. The approximate number of HCBS members in Colorado is almost 90,000 members versus the previous target population limited to the four waivers serving 19,000 members with only an intellectual or developmental disability.

42 CFR § 441.301(c)(7), § 441.464(d)(2)(v), § 441.555(b)(2)(iv), and § 441.745(a)(1)(iii) requires Health First Colorado to implement a grievance process for HCBS that are delivered through its Fee-for-Service (FFS) programs to help ensure that both the state of Colorado and providers are compliant with rules pertaining to person-centered planning rules and requirements. The Access Rule increases requirements that all HCBS waiver members have access to submit their grievances and complaints directly to the state, have their grievances formally reviewed, and have a resolution within strict timelines. Through special grant and ARPA funding, The Office of Community Living hired 4 contractors to begin a pilot to allow members to submit grievances directly to HCPF since September 2023. Throughout a 12-month period, the Office of Community Living received over 4,000 grievances. This position is critical to further develop the processes for the continued management, responses, and resolutions, and reporting to comply with requirements in the Access Rule.

The two FTE that the Department is requesting will perform tasks to help manage the overall implementation of CMS-2442-F, such as: incorporating changes to how the Department reports incidents; making improvements to the current grievance processes, and engaging with the

community and stakeholders on the changes required to comply with CMS-2442-F. Detailed job duties are included in Appendix B.

The contractor funding would be used to create an implementation strategy for CMS-2442-F across the Department.

CMS-2439-F – Medicaid and Children's Health Insurance Program Managed Care Access, Finance and Quality

Also released on April 22, 2024, this CMS final rule is considered a companion rule to CMS-2442-F and addresses topics specific to managed care delivery systems, including new requirements around medical loss ratio and rate transparency.

Below is a provision of the rule that is driving a need for additional Department resources.

Managed Care Rates

The Department is requesting $240,000 in contractor funding in FY 2026-27 to facilitate compliance with the below requirements.

42 CFR § 438.207(b), § 438.6, § 438.7, § 438.3, § 438.8, § 438.74, § 438.16, § 438.3, and § 438.608 require managed care plans to report any identified or recovered overpayments to states within 30 calendar days. These rules also require states to annually submit Medical Loss Ratio (MLR) reports for each Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP) under contract with Health First Colorado. MLR is a tool for CMS and states to use to assess that Medicaid managed care capitation funds are appropriately set and spent on claims and quality improvement activities rather than administrative expenses.

These MLRs must contain actual expenditures and revenues for state directed payments. Also, these rules provide additional flexibility to allow incentive payment contracts between healthcare plans and providers to be based on a percentage of a verifiable dollar amount or specific dollar amount.

These regulations also impact In-Lieu of Services (ILOS), specifying that ILOSs can be used as immediate or longer-term substitutes for a covered service or setting under the state plan, or when the ILOSs can be expected to reduce or prevent the future need for such service or setting to better support Health Related Social Needs (HRSNs). These rules require that an ILOS be considered approvable as a service or setting through the Medicaid state plan or a Medicaid section 1915(c) waiver and requires the state to develop a transition plan to arrange for state plan services and settings to be provided timely if an ILOS will be terminated.

The contractor would help conduct annual reviews of the managed care claims payment analysis, conduct calculations related to the Average Commercial Rate (ACR) and provide support to calculate State Directed Payment (SDP) cost percentage. The SDP is calculated by dividing the part of total capitation payments that are attributed to SDPs by the total amount of capitation payments made. The FTE will also review work related to the MLR and will help support the monitoring, calculation, and evaluation of the ILOS cost percentage, which is the annual amount calculated specific to each managed care program that includes an ILOS.

The Department requests $240K in contractor funding to pay an actuary for actuarial analysis for the average commercial rates and average commercial rates.

If this request is not approved, the Department would be out of compliance with the federal regulation and subject to corrective actions and risk of losing federal financial participation.

Managed Care Access & Quality Rating System (QRS) Standards

The Department is requesting 1.0 FTE starting March, 2026 and $2,000,000 in contractor funding in FY 2026-27 to facilitate compliance with the below requirements.

42 CFR § 438.68(e), § 457.1218, § 438.10(h), § 438.68(f), § 438.66, § 438.207(f), § 438.515, § 457.1240(d), and § 438.340 require states to conduct annual enrollee experience surveys and to set appointment time standards for certain services, including outpatient mental health and substance use disorder services, adult and pediatric primary care, adult and pediatric obstetrics and gynecology.

These rules also require the state to use independent "secret shoppers" surveys to validate managed care plans' compliance with appointment wait time standards and to conduct annual enrollee experience surveys for each managed care plan. The state must conduct an analysis comparing managed care plan payment rates for homemaker services, home health aide services, personal care services, and habilitation services for fee-for-service (FFS) rates for the same services. These rules also mandate the state to establish a Medicaid Quality Rating System (QRS) which would include quality measures and requirements for the state to publicly post QRS data to allow members to compare managed care plans. .

The requested FTE will include be a program administrator IV position to manage the implementation of the QRS, oversee the contract for the secret shopper surveys, and monitor new activities and processes related to appointment wait time standards for both the Regional Accountable Entities (RAEs) and Managed Care Organizations (MCOs).

Contractor funding will be required in FY 2026-27 to expand the scope of the External Quality Review Organization (EQRO) contract for the secret shopper survey and the development and validation of QRS.

If this request is not approved, Health First Colorado will not be able to comply with the federal regulations as the External Quality and Review Organization (EQRO) will not have the resources to complete the new federally required activities. Managed Care Entities (MCEs) could be forced to direct funding away from member services to ensure they have the administrative resources to comply with federal requirements, which could ultimately result in decreased quality of care and member experience.

CMS-0057-F – CMS Interoperability and Prior Authorization Rule

Released on September 10, 2024, this CMS final rule emphasizes the need to improve health information exchange to achieve appropriate and necessary access to health records for

patients, healthcare providers, and payers. This final rule also focuses on efforts to improve prior authorization processes through policies and technology and to help ensure that patients remain at the center of their own care.

The rule enhances certain policies from the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) and adds several new provisions to facilitate increased data sharing and to reduce overall payer, healthcare provider, and patient burden through improvements to prior authorization practices and data exchange practices.

Through the provisions in this final rule, state Medicaid and Children's Health Insurance Program (CHIP) Fee-for-Service (FFS) programs, Medicaid managed care plans, and CHIP managed care entities (collectively "impacted payers") are required to implement and maintain certain application programming interfaces (APIs) to improve the electronic exchange of health care data, as well as to streamline prior authorization processes. Broadly defined as a software intermediary comprised of rules and protocols that allow software applications to communicate with each other, a properly designed API allows an entity to extract and share data within and across other entities. The new API will improve patient, provider, and payer access to interoperable patient data and reduce the burden of prior authorization processes.

Impacted payers are required to implement certain provisions of the rule by January 1, 2026. However, in response to stakeholder comments on the proposed rule, impacted payers have until primarily January 1, 2027, to meet the application programming interface (API) requirements in this final rule.

Interoperability & Prior Authorization Requests (PARs)

The Department is requesting 0.3 FTE, starting March 2027, and $51k total funds, including $18k General Fund in FY 2026-27, and 1.0 FTE and $2.4 million total funds, including $452k General Fund, in systems changes & staff training funding in FY 2027-28 and ongoing, to facilitate compliance with the below requirements:

To improve the electronic exchange of health care data, as well as to streamline prior authorization processes, the following four APIs must be implemented and maintained by the Department:

- **Patient Access API** – the Department is required to add information about prior authorizations (excluding those for drugs) to the data available via the Patient Access API. In addition to giving patients access to more of their data, this will help patients understand their payer's prior authorization process and its impact on their care. This requirement must be implemented by January 1, 2027.
- **Provider Access API** - To facilitate care coordination and support movement toward value-based payment models, the Department is required to implement and maintain a Provider Access API to share patient data with in-network providers with whom the patient has a treatment relationship. The following data is required to be made available via the Provider Access API: individual claims and encounter data (without provider remittances and enrollee cost-sharing information) and specified prior authorization

information (excluding those for drugs). Additionally, an attribution process must be maintained to associate patients with in-network or enrolled providers with whom they have a treatment relationship and to allow patients to opt out of having their data available to providers under these requirements. The Department must provide plain language information to patients about the benefits of API data exchange with their providers and their ability to opt out. These requirements must be implemented by January 1, 2027.

- **Payer-to-Payer API** - To support care continuity, the Department must implement and maintain a Payer-to-Payer API to make available claims and encounter data (excluding provider remittances and enrollee cost-sharing information) and information about certain prior authorizations (excluding those for drugs). The Department is only required to share patient data with a date of service within five years of the request for data. This will help improve care continuity when a patient changes payers and ensure that patients have continued access to the most relevant data in their records. An opt-in process for patients to provide permission under these requirements must be maintained. The Department is required to provide plain-language educational resources to patients that explain the benefits of the Payer-to-Payer API data exchange and their ability to opt in. These requirements must be implemented by January 1, 2027.
- **Prior Authorization API** – The Department is required to implement and maintain a Prior Authorization API that is populated with its list of covered items and services, can identify documentation requirements for prior authorization approval, and supports a prior authorization request and response. These Prior Authorization APIs must also communicate whether the payer approves the prior authorization request (and the date or circumstance under which the authorization ends), denies the prior authorization request (and a specific reason for the denial), or requests more information. This requirement must be implemented beginning January 1, 2027.

To further improve the prior authorization process, additional requirements are stipulated:

- **Prior Authorization Decision Timeframes:** The Department is required to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests. Standard or non-urgent requests must now be completed within seven calendar days instead of ten business days.
- **Provider Notice, Including Denial Reason**: Beginning in 2026, the Department must provide a specific reason for denied prior authorization decisions, regardless of the method used to send the prior authorization request with decisions communicated via portal, fax, email, mail, or phone. As with all policies in this final rule, this provision does not apply to prior authorization decisions for drugs. The requirement is intended to both facilitate better communication and transparency between payers, providers, and patients, as well as improve providers' ability to resubmit the prior authorization request, if necessary.
- **Prior Authorization Metrics**: The Department is required to publicly report certain prior authorization metrics annually by posting them on their website. These operational or process-related prior authorization policies are being finalized with a compliance date

starting January 1, 2026, and the initial set of metrics must be reported by March 31, 2026.

Much of the initial work can be absorbed within existing Department resources initially, however, a Data Analytics & Reporting Specialist, is necessary starting in FY 2026-27 to process and maintain the necessary metrics to meet the reporting requirements.

In addition to the FTE. Contracted staff are necessary to complete tasks driven by the requirements. These include a Project Manager and an API Maintenance & Support Specialist. Specific job duties for each position are included in table 9.2 in the appendix.

The systems funding requested is allocated to the following scopes of work:

- **API Development and System Integration**
    - **Patient, Provider, and Payer-to-Payer APIs:** These APIs need to be developed to facilitate the required data exchange. This includes custom development, integration with existing systems (such as the Department's claim processing system and eligibility system), and testing to ensure compliance.
    - **Prior Authorization API:** Development to streamline the prior authorization process, including automated approvals, real-time data exchange, and integration with vendors.
    - **System Enhancements:** Additional updates and optimization of existing systems.
- **Vendor Contracting and Management**
    - **Vendor Services**: Services from existing Department vendors (such as utilization management vendors and Rocky Mountain Health Plans) will be needed for specific program integration, such as the HCBS waivers and RAE programs and include data migration, compliance testing, and reporting.
    - **Consulting Services**: Engage consulting partners for project management, API implementation, and technical support.
- **Compliance, Security, and Training**
    - **Compliance and Security Audits**: Security testing, audits, and compliance assessments are required to meet CMS standards and ensure the privacy and protection of patient data.
    - **Staff Training**: Training for Department staff on the new systems, API usage, and compliance requirements. This will involve creating training materials, workshops, and ongoing support.
- **Data Reporting and Monitoring**
    - **Analytics and Reporting Tools**: Development and maintenance of dashboards for tracking API usage, compliance metrics, and vendor performance.
    - **Ongoing Monitoring and Maintenance**: Routine API maintenance, monitoring, and system updates to align with regulatory changes and enhancements.

If this request is not approved the Department would not meet the CMS interoperability and prior authorization deadlines, leading to non-compliance with federal regulations. This could

result in penalties, reduced efficiency, and delayed patient and provider access to necessary health information.

Supporting Evidence and Evidence Designation

The Department assumes that an Evidence Designation is not applicable to this request because the request is entirely administrative and does not meet the statutory definition for a program or practice.

Promoting Colorado for All

The Department has identified this request as equity-positive given there are several initiatives supporting federal regulations intended to promote equity amongst Medicaid members. The Interoperability & Prior Authorization Requests (PARs) promotes equity by giving members of all backgrounds better access to information about their health. Improving access and transferability of member health records for both the member, and their trusted health professionals, throughout State health systems, especially with the process of PARs and potential appeals/grievances, promotes transparency and allows each member to participate more fully in managing their health care.

The Medicaid Advisory Committee & Beneficiary Advisory Council initiative strongly promotes equity as it increases and diversifies member voices into the Department's decision-making process. The Department's health equity goals are supported as follows:

Equity: By providing appropriate accommodation and staff to support BAC members with preparation, education, and guidance, the opportunity for BAC members to participate and contribute to the MAC is greatly increased. This directly addresses equity by providing the supports needed to allow members to sit equally at the table.

Diversity: By providing staff and contractor support to support the member recruitment efforts diversity in representation is ensured. Members represent the un/underserved populations that Medicaid intends to serve.

Inclusion: By providing reimbursement funding and available supporting staff, inclusion is accomplished through appropriate incentives, accessibility measures, interpretation/translation services, and plain language communication.

Assumptions and Calculations

For detailed calculations, please see Appendix A.The FTE calculations were derived using the standard FTE calculation table, found in table series (3), and assumes a 50% FFP for all initiatives.

Contractor funding for consultation, analytical work, and stakeholder engagement/meeting facilitation was determined using previous Department contracts of similar scope. The

Department assumes a 50% FFP for this contractor funding. Contractor funding for contracted staff within the Interoperability & Prior Authorization Requests initiative also uses prior contracts for determining the hourly rate and assumes ongoing FFP of 75% corresponding to the standard maintenance and operations (M&O) project phase.

Appendix B

Beneficiary Advisory Council (BAC)			
Position Title	**Classification**	**# of FTE**	**Job Duties**
Outreach and Member Engagement Specialist (BAC)	Liaison IV	1.0	The proposed FTE would create a single point of contact and accountability for Medicaid members, their family/caregivers who participate in the Beneficiary Advisory Council (BAC), and rotated participation on the MAC. Duties would include: ● Developing a process that will be published for recruiting members for the BAC, including creating the application, reviewing applications, conducting interviews, making recommendations for appointments, and training participants. ● Operationalizing BAC member onboarding and transitions. ● Creating, updating and maintaining BAC bylaws. ● Planning and organizing monthly meetings for BAC members, whether virtual, in person and hybrid per federal requirement. ● Facilitating meetings, ensuring appropriate technology and accommodations, such as Zoom, phone, and in person, accessibility and translation. ● Coordinating with staff across the department to bring topics before the BAC, ensuring agendas are established and published online at least 30 days prior to the meetings. ● Preparation for meetings and collecting actionable feedback from BAC members will include coordination with Department staff and BAC members before MAC meetings. Preparation will include the review and editing of materials before sharing with BAC members and meeting with Department staff to plan meetings, presentations and discussion. ● Preparing materials for BAC members before meetings such as agenda and policy documents, which includes accessibility, translation and plain language.

			• Collecting feedback from BAC via in-meeting discussions, in-meeting surveys, and after-meeting formats. • Raising feedback from BAC to Department staff and leadership. • Tracking progress on feedback incorporated into programs and projects. • Operationalizing BAC meetings, including facilitating meetings; accommodating BAC member needs before, during and after meetings; managing public comment during meetings. • Writing the scope of work, procuring the Contractor, and managing the performance for the report development • Contributing to the annual report required by CMS. • Coordinating with the MAC and other entities related to the required appointments to the MAC.

Comparative Payment Rate Analysis & Disclosure, including Interested Parties Advisory Group (IPAG) Reporting			
Position Title	**Classification**	**# of FTE**	**Job Duties**
TBD	Rate/Financial Analyst IV	1.0	The proposed FTE would improve current processes and strengthen the Department's ability to manage internal controls and processes and would support and respond to the compliance requirements outlined in 42 CFR § 447.203, additional federal scrutiny, regulation changes, and ongoing stakeholder engagement. Additional tasks include: • Collaborate with internal and external stakeholders to develop solid rate comparison methodologies and procedures for HCBS personal care, home health aide, homemaker and habitation services. • Conduct comprehensive access to care analysis for the four services reviewed by HCBS IPAG.

			• Complete the HCBS payment rate disclosure report for required direct care services annually and submit them to CMS. • Review the analysis deliverables from the actuary contractor, including the rate comparison analysis results for HCBS personal care, home health aide, homemaker and habitation services, and the annual comparative payment rate analysis for primary care services, obstetrical and gynecological services, and outpatient mental health and substance use disorder services. • Provide analytical and technical support to the stakeholder engagement meetings and participate in the report writing for HCBS IPAG's recommendations. • Engage and explain questions on analysis methodologies and data procedures with internal policy staff and external stakeholders.
TBD	Administrator IV	1.0	The proposed FTE would improve current processes and strengthen the Department's ability to manage internal controls and processes and would support and respond to the compliance requirements outlined in 42 CFR § 447.203, additional federal scrutiny, regulation changes, and ongoing stakeholder engagement. Additional tasks include: • Review internal policies, procedures and practices to ensure adherence to state and federal requirements especially 42 CFR § 447.203, adequate controls, and comprehensive procedures. Fulfill the CMS reporting requirements. • Collaborate with internal and external stakeholders, establish the HCBS IPAG (Interested Parties Advisory Group), and outreach to related stakeholders impacted by the reviewed services. • Organize and host recurring meetings with external stakeholders, including direct care workers, beneficiaries or their authorized representatives, and other interested parties impacted by the services rates.

			• Facilitate recommendation discussion from the HCBS IPAG members, write the recommendation report, and publish it to the public.

Ensuring Access to HCBS Services			
Position Title	**Classification**	**# of FTE**	**Job Duties**
TBD	Administrator IV	1.0	The FTE would reside in (CMQPD) and oversee implementation and management of case management changes necessary to comply with Access Rule compliance. • Establish and implement short and long-range goals and objectives for the expansion of Access Rule compliance for all HCBS waivers. • Advisement of regulatory changes needed for Access Rule compliance. • Incident reporting IT system formation and development of new requirements. • Cross state agency collaboration and advisement of statutory and regulatory changes necessary to comply with Access Rule and CDHS rule requirements for Adult Protective Services. • Review and investigate critical incident reporting as necessary to ensure increased oversight, administrative review, and state level administrative review is effective to meet Access Rule compliance. • Establish and implement short and long-range goals and objectives to evaluate the effectiveness of increased oversight of critical incident reporting and investigations, including developing reporting metrics for HCPF and CMS.

TBD	Administrator IV	1.0	This FTE would work in the Benefits and Services Management Division (BSMD) to manage the overall implementation of the Access Rule. The Rule includes 12 distinct sections, with varying timelines, that will require an on-going FTE. ● This position will ensure that all of the sections are completed on time, within the required budget and will communicate with high level CMS officials requiring interpretation of federal regulation and law anticipated. ● This position will be responsible for the coordination with other offices regarding the new Managed Care rules. The position will need to be fluent in both regulations to ensure the implementation of the Access rule. ● Position will need to ensure consistent and complex policy analysis throughout the six-year period of implementation to meet all the rule requirements. ● This position will sit on numerous workgroups convened by CMS to develop Technical Assistance for the state. ● This position will communicate with CMS officials requiring interpretation of federal regulation and law anticipated. This will involve significant time demands and a keen understanding of both federal and state processes. ● There will be numerous changes to both the State Plan and Medicaid waivers. This FTE will be tasked with all amendments, coordination with multiple entities, and reporting back to CMS. ● This position will be responsible for changes to state rules and regulations as well as amending statutes associated with the Access Rule.

			• This position will be responsible for coordination and communicating with the community and stakeholders on changes necessary for the implementation of the rule. • This position will be required to coordinate with agencies outside of HCPF to ensure all requirements are met. These agencies include CDPHE, CDHS, CDLE, and the Governor's Office.

Interoperability & Prior Authorization Requests (PARs)			
Position Title	**Classification**	**# of FTE**	**Job Duties**
Data Analytics and Reporting Specialist	Statistical Analyst IV	1.0	One additional permanent Department staff is needed to support. • Develop the necessary reporting mechanisms, as required by CMS, to track and publicly report prior authorization metrics, such as approval rates, denials, and timeframes. • Ensure annual compliance with CMS's requirement to report on these metrics.

Managed Care Access and Quality Rating System			
Position Title	**Classification**	**# of FTE**	**Job Duties**
TBD	Program Administrator IV	1.0	Manage and oversee the quality strategy process, MAC QRS Implementation, MAC QRS annual evaluation and effectiveness review, and contract management for the new secret shopper survey.

Table 1.0
Summary by Line Item
FY 2025-26

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office (A) General Administration; Personal Services	$108,040	1.3	$45,917	$8,104	$0	$54,019	50.00%	FTE tables
B	(1) Executive Director's Office (A) General Administration; Health, Life, and Dental	$19,626	0.0	$8,341	$1,472	$0	$9,813	50.00%	FTE tables
C	(1) Executive Director's Office (A) General Administration; Short-term Disability	$152	0.0	$64	$12	$0	$76	50.00%	FTE tables
D	(1) Executive Director's Office (A) General Administration; Unfunded Liability AED Payments	$9,566	0.0	$4,065	$718	$0	$4,783	50.00%	FTE tables
E	(1) Executive Director's Office (A) General Administration; Paid Family and Medical Leave Insurance	$432	0.0	$184	$32	$0	$216	50.00%	FTE tables
F	(1) Executive Director's Office (A) General Administration; Operating Expenses	$28,984	0.0	$12,318	$2,174	$0	$14,492	50.00%	FTE tables
G	(1) Executive Director's Office (A) General Administration; Leased Space	$6,216	0.0	$2,642	$466	$0	$3,108	50.00%	FTE tables
H	**Total Request**	**$173,016**	**1.3**	**$73,531**	**$12,978**	**$0**	**$86,507**	**50.00%**	**Sum of Rows**

Table 1.1
Summary by Line Item
FY 2026-27

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office (A) General Administration; Personal Services	$527,269	6.1	$209,274	$54,361	$0	$263,634	50.00%	FTE tables
B	(1) Executive Director's Office (A) General Administration; Health, Life, and Dental	$108,022	0.0	$43,137	$10,874	$0	$54,011	50.00%	FTE tables
C	(1) Executive Director's Office (A) General Administration; Short-term Disability	$698	0.0	$277	$72	$0	$349	50.00%	FTE tables
D	(1) Executive Director's Office (A) General Administration; Unfunded Liability AED Payments	$46,680	0.0	$18,527	$4,813	$0	$23,340	50.00%	FTE tables
E	(1) Executive Director's Office (A) General Administration; Paid Family and Medical Leave Insurance	$2,098	0.0	$833	$216	$0	$1,049	50.00%	FTE tables
F	(1) Executive Director's Office (A) General Administration; Operating Expenses	$75,438	0.0	$26,624	$11,095	$0	$37,719	50.00%	FTE tables + Table 2.1, Row B
G	(1) Executive Director's Office (A) General Administration; Leased Space	$29,459	0.0	$11,705	$3,025	$0	$14,729	50.00%	FTE tables
H	(1) Executive Director's Office; (A) General Administration; General Professional Services	$611,750	0.0	$214,113	$91,762	$0	$305,875	50.00%	Table 2.1, Row E + Table 2.1, Row G + Table 2.1, Row J
I	(1) Executive Director's Office; (B) Information Technology Contracts and Projects; Medicaid Management Information Systems	$2,000,000	0.0	$500,000	$0	$0	$1,500,000	75.00%	Table 2.1, Row O
I	**Total Request**	**$3,401,414**	**6.1**	**$1,024,490**	**$176,218**	**$0**	**$2,200,706**	**64.70%**	**Sum of Rows**

Table 1.2
Summary by Line Item
FY 2027-28 and Ongoing

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office (A) General Administration; Personal Services	$609,067	7.0	$237,905	$66,631	$0	$304,531	50.00%	FTE tables
B	(1) Executive Director's Office (A) General Administration; Health, Life, and Dental	$124,365	0.0	$48,858	$13,325	$0	$62,182	50.00%	FTE tables
C	(1) Executive Director's Office (A) General Administration; Short-term Disability	$866	0.0	$337	$96	$0	$433	50.00%	FTE tables
D	(1) Executive Director's Office (A) General Administration; Unfunded Liability AED Payments	$53,924	0.0	$21,062	$5,900	$0	$26,962	50.00%	FTE tables
E	(1) Executive Director's Office (A) General Administration; Paid Family and Medical Leave Insurance	$2,424	0.0	$947	$265	$0	$1,212	50.00%	FTE tables
F	(1) Executive Director's Office (A) General Administration; Operating Expenses	$55,046	0.0	$19,487	$8,036	$0	$27,523	50.00%	FTE tables + Table 2.2, Row B
G	(1) Executive Director's Office (A) General Administration; Leased Space	$32,556	0.0	$12,789	$3,489	$0	$16,278	50.00%	FTE tables
H	(1) Executive Director's Office; (A) General Administration; General Professional Services	$503,000	0.0	$213,550	$37,950	$0	$251,500	50.00%	Table 2.2, Row F + Table 2.2, Row I
I	(1) Executive Director's Office; (B) Information Technology Contracts and Projects; Medicaid Management Information Systems	$4,282,000	0.0	$905,440	$173,760	$0	$3,202,800	74.80%	Table 2.2, Row L + Table 2.2 Row M
J	**Total Request**	**$5,663,248**	**7.0**	**$1,460,375**	**$309,452**	**$0**	**$3,893,421**	**68.75%**	**Sum of Rows**

Table 2.0
Summary by Initiative
FY 2025-26

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated	Federal Funds	FFP Rate	Notes/Calculations
Beneficiary Advisory Council (BAC)									
A	FTE	$43,254	0.3	$15,138	$6,489	$0	$21,627	50.00%	Table 3.1 (one FTE starting March 2026)
B	**Subtotal**	**$43,254**	**0.3**	**$15,138**	**$6,489**	**$0**	**$21,627**	**50.00%**	**Row A**
Ensuring Access To HCBS Medicaid Services									
C	FTE	$86,508	0.7	$43,254	$0	$0	$43,254	50.00%	Table 3.7 (three FTE starting March 2026)
D	**Subtotal**	**$86,508**	**0.7**	**$43,254**	**$0**	**$0**	**$43,254**	**NA**	**Row C**
Managed Care Access And QRS									
E	FTE	$43,254	0.3	$15,139	$6,489	$0	$21,626	50.00%	Table 3.8 (one FTE starting March 2026)
F	**Subtotal**	**$43,254**	**0.3**	**$15,139**	**$6,489**	**$0**	**$21,626**	**50.00%**	**Row E**
G	**Total Request**	**$173,016**	**1.3**	**$73,531**	**$12,978**	**$0**	**$86,507**	**50.00%**	**Sum of Subtotal Rows**

Table 2.1
Summary by Initiative
FY 2026-27

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated	Federal Funds	FFP Rate	Notes/Calculations
Beneficiary Advisory Council (BAC)									
A	FTE	$112,064	1.0	$39,223	$16,810	$0	$56,031	50.00%	Table 3.1
B	Meeting Expenses incl. Member	$49,902	-	$17,466	$7,485	$0	$24,951	50.00%	Table 4.1, Row C
C	**Subtotal**	**$161,966**	**1.0**	**$56,689**	**$24,295**	**$0**	**$80,982**	**50.00%**	**Row A + Row B + Row C**
Ensuring Access To HCBS Medicaid Services									
D	FTE	$226,641	2.0	$113,320	$0	$0	$113,321	50.00%	Table 3.7
E	Contractor Funding	$250,000	-	$87,500	$37,500	$0	$125,000	50.00%	Table 6.3, Row F
F	**Subtotal**	**$476,641**	**2.0**	**$200,820**	**$37,500**	**$0**	**$238,321**	**50.00%**	**Row J + Row K + Row L**
Managed Care Rates									
G	Contractor Funding	$240,750	-	$84,263	$36,112	$0	$120,375	50.00%	Table 7.1, Row M
H	**Subtotal**	**$240,750**	**-**	**$84,263**	**$36,112**	**$0**	**$120,375**	**50.00%**	**Row N + Row O**
Comparative Payment Rate Analysis & Disclosure, including Interested Parties Advisory Group (IPAG) Reporting									
I	FTE	$236,318	1.8	$82,710	$35,449	$0	$118,159	50.00%	Table 3.5
J	Contractor Funding	$121,000	-	$42,350	$18,150	$0	$60,500	50.00%	Table 8, Row C
K	**Subtotal**	**$357,318**	**1.8**	**$125,060**	**$53,599**	**$0**	**$178,659**	**50.00%**	**Row Q + Row R**
Interoperability & Prior Authorization Requests (PARs)									
L	FTE	$51,419	0.3	$17,996	$7,714	$0	$25,709	50.00%	Table 3.6
M	**Subtotal**	**$51,419**	**0.3**	**$17,996**	**$7,714**	**$0**	**$25,709**	**NA**	**Row T + Row U + Row V + Row W**
Managed Care Access And QRS									
N	FTE	$113,320	1.0	$39,662	$16,998	$0	$56,660	50.00%	Table 3.8
O	Contractor Funding	$2,000,000	0.0	$500,000	$0	$0	$1,500,000	75.00%	Table 10.1, Row A
P	**Subtotal**	**$2,113,320**	**1.0**	**$539,662**	**$16,998**	**$0**	**$1,556,660**	**73.66%**	**Row N + Row O**
Q	**Total Request**	**$3,401,414**	**6.1**	**$1,024,490**	**$176,218**	**$0**	**$2,200,706**	**64.70%**	**Sum of Subtotal Rows**

Table 2.2
Summary by Initiative
FY 2027-28 and Ongoing

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated	Federal Funds	FFP Rate	Notes/Calculations
Beneficiary Advisory Council (BAC)									
A	FTE	$113,328	1.0	$39,665	$17,000	$0	$56,663	50.00%	Table 3.1
B	Meeting Expenses incl. Member	$49,902	-	$17,466	$7,485	$0	$24,951	50.00%	Table 4.1, Row C
C	**Subtotal**	**$163,230**	**1.0**	**$57,131**	**$24,485**	**$0**	**$81,614**	**50.00%**	**Row A + Row B + Row C**
Ensuring Access To HCBS Medicaid Services									
D	FTE	$226,656	2.0	$113,328	$0	$0	$113,328	50.00%	Table 3.7
E	Contractor Funding	$250,000	-	$125,000	$0	$0	$125,000	90.00%	Table 6.4, Row F
E	**Subtotal**	**$476,656**	**2.0**	**$238,328**	**$0**	**$0**	**$238,328**	**50.00%**	**Row H**
Managed Care Rates									
F	Contractor Funding	$132,000	-	$46,200	$19,800	$0	$66,000	50.00%	Table 7.1, Row M
G	**Subtotal**	**$132,000**	**-**	**$46,200**	**$19,800**	**$0**	**$66,000**	**50.00%**	**Row M + Row N**
Comparative Payment Rate Analysis & Disclosure, including Interested Parties Advisory Group (IPAG) Reporting									
H	FTE	$240,856	2.0	$84,300	$36,129	$0	$120,427	50.00%	Table 3.5
I	Contractor Funding	$121,000	-	$42,350	$18,150	$0	$60,500	50.00%	Table 8, Row C
J	**Subtotal**	**$361,856**	**2.0**	**$126,650**	**$54,279**	**$0**	**$180,927**	**50.00%**	**Row P + Row Q**
Interoperability & Prior Authorization Requests (PARs)									
K	FTE	$134,178	1.0	$46,961	$20,128	$0	$67,089	50.00%	Table 3.6
L	Contracted Staff	$832,000	-	$145,600	$62,400	$0	$624,000	75.00%	Table 9.2
M	Systems Funding	$1,450,000	-	$259,840	$111,360	$0	$1,078,800	74.40%	Table 9.1, Row M [FY 2027-28]
N	**Subtotal**	**$2,416,178**	**1.0**	**$452,401**	**$193,888**	**$0**	**$1,769,889**	**NA**	**Row S + Row T**
Managed Care Access And QRS									
O	FTE	$113,328	1.0	$39,665	$17,000	$0	$56,663	50.00%	Table 3.8
P	Contractor Funding	$2,000,000		$500,000	$0	$0	$1,500,000	75.00%	Table 10.1, Row A
Q	**Subtotal**	**$2,113,328**	**1.0**	**$539,665**	**$17,000**	**$0**	**$1,556,663**	**73.66%**	**Row O + Row P**
R	**Total Request**	**$5,663,248**	**7.0**	**$1,460,375**	**$309,452**	**$0**	**$3,893,421**	**68.75%**	**Sum of Subtotal Rows**

Table 3.1
BAC FTE Calculations

Personal Services

Position Classification	FTE	Start Month	End Month	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
ADMINISTRATOR IV	1.0	Mar 2026	N/A	$27,010	$82,433	$82,433	$82,433	$82,433	$82,433	MAC / BAC
	0.0		N/A	$0	$0	$0	$0	$0	$0	MAC / BAC
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$27,010**	**$82,433**	**$82,433**	**$82,433**	**$82,433**	**$82,433**	

Centrally Appropriated Costs

Cost Center	FTE	FTE	Cost or	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Health, Life, Dental	0.0	0.0	Varies	$4,907	$16,512	$17,767	$17,767	$17,767	$17,767	
Short-Term Disability	-	-	Varies	$38	$109	$117	$117	$117	$117	
Unfunded Liability AED Payments	-	-	10.00%	$2,391	$7,298	$7,298	$7,298	$7,298	$7,298	
Paid Family and Medical Leave Insurance	-	-	0.45%	$108	$328	$328	$328	$328	$328	
Centrally Appropriated Costs Total				**$7,444**	**$24,247**	**$25,510**	**$25,510**	**$25,510**	**$25,510**	

Operating Expenses

Ongoing Costs	FTE	FTE	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Supplies	0.0	0.0	$500	$167	$500	$500	$500	$500	$500	
Telephone	0.0	0.0	$235	$79	$235	$235	$235	$235	$235	
Other	0.0	0.0	$0	$0	$0	$0	$0	$0	$0	
Subtotal				*$246*	*$735*	*$735*	*$735*	*$735*	*$735*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2025-26**	**FY 2026-27**	**FY 2027-28**	**FY 2028-29**	**FY 2029-30**	**FY 2030-31**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	$0	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	$0	$0	$0	
Other	1.0		$0	$0	$0	$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	*$0*	*$0*	*$0*	
Total Operating				**$7,246**	**$735**	**$735**	**$735**	**$735**	**$735**	

Leased Space

	FTE	FTE	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Leased Space	0.0	0.0	$4,650	**$1,554**	**$4,650**	**$4,650**	**$4,650**	**$4,650**	**$4,650**	

Table 3.5
IPAG FTE Calculations

Personal Services

Position Classification	FTE	Start Month	End Month	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
RATE/FINANCIAL ANLYST IV	1.0	Jul 2026	N/A	$0	$87,780	$95,414	$95,414	$95,414	$95,414	
ADMINISTRATOR IV	1.0	Jul 2026	N/A	$0	$75,838	$82,433	$82,433	$82,433	$82,433	
Total Personal Services (Salary, PERA, Medicare)	**2.0**			**$0**	**$163,618**	**$177,847**	**$177,847**	**$177,847**	**$177,847**	

Centrally Appropriated Costs

Cost Center	FTE	FTE	Cost or	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Health, Life, Dental	0.0	0.0	Varies	$0	$32,692	$35,534	$35,534	$35,534	$35,534	
Short-Term Disability	-	-	Varies	$0	$218	$252	$252	$252	$252	
Unfunded Liability AED Payments	-	-	10.00%	$0	$14,486	$15,745	$15,745	$15,745	$15,745	
Paid Family and Medical Leave Insurance	-	-	0.45%	$0	$652	$708	$708	$708	$708	
Centrally Appropriated Costs Total				**$0**	**$48,048**	**$52,239**	**$52,239**	**$52,239**	**$52,239**	

Operating Expenses

Ongoing Costs	FTE	FTE	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Supplies	0.0	0.0	$500	$0	$920	$1,000	$1,000	$1,000	$1,000	
Telephone	0.0	0.0	$235	$0	$432	$470	$470	$470	$470	
Other	0.0	0.0	$0	$0	$0	$0	$0	$0	$0	
Subtotal				*$0*	*$1,352*	*$1,470*	*$1,470*	*$1,470*	*$1,470*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2025-26**	**FY 2026-27**	**FY 2027-28**	**FY 2028-29**	**FY 2029-30**	**FY 2030-31**	**Notes**
Furniture	2.0		$5,000	$0	$10,000	$0	$0	$0	$0	
Computer	2.0		$2,000	$0	$4,000	$0	$0	$0	$0	
Other	2.0		$0	$0	$0	$0	$0	$0	$0	
Subtotal				*$0*	*$14,000*	*$0*	*$0*	*$0*	*$0*	
Total Operating				**$0**	**$15,352**	**$1,470**	**$1,470**	**$1,470**	**$1,470**	

Leased Space

	FTE	FTE	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Leased Space	0.0	0.0	$4,650	**$0**	**$9,300**	**$9,300**	**$9,300**	**$9,300**	**$9,300**	

Table 3.6
Interoperability FTE Calculations

Personal Services

Position Classification	FTE	Start Month	End Month	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
STATISTICAL ANALYST IV	1.0	Mar 2027		$0	$33,918	$101,492	$101,492	$101,492	$101,492	Data Analytics & Reporting Specialist
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$0**	**$33,918**	**$101,492**	**$101,492**	**$101,492**	**$101,492**	

Centrally Appropriated Costs

Cost Center	FTE	FTE	Cost or	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Health, Life, Dental	0.0	0.0	Varies	$0	$5,518	$17,767	$17,767	$17,767	$17,767	
Short-Term Disability	-	-	Varies	$0	$45	$144	$144	$144	$144	
Unfunded Liability AED Payments	-	-	10.00%	$0	$3,003	$8,986	$8,986	$8,986	$8,986	
Paid Family and Medical Leave Insurance	-	-	0.45%	$0	$135	$404	$404	$404	$404	
Centrally Appropriated Costs Total				**$0**	**$8,701**	**$27,301**	**$27,301**	**$27,301**	**$27,301**	

Operating Expenses

Ongoing Costs	FTE	FTE	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Supplies	0.0	0.0	$500	$0	$167	$500	$500	$500	$500	
Telephone	0.0	0.0	$235	$0	$79	$235	$235	$235	$235	
Other	0.0	0.0	$0	$0	$0	$0	$0	$0	$0	
Subtotal				*$0*	*$246*	*$735*	*$735*	*$735*	*$735*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2025-26**	**FY 2026-27**	**FY 2027-28**	**FY 2028-29**	**FY 2029-30**	**FY 2030-31**	**Notes**
Furniture	1.0		$5,000	$0	$5,000	$0	$0	$0	$0	
Computer	1.0		$2,000	$0	$2,000	$0	$0	$0	$0	
Other	1.0		$0	$0	$0	$0	$0	$0	$0	
Subtotal				*$0*	*$7,000*	*$0*	*$0*	*$0*	*$0*	
Total Operating				**$0**	**$7,246**	**$735**	**$735**	**$735**	**$735**	

Leased Space

	FTE	FTE	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Leased Space	0.0	0.0	$4,650	**$0**	**$1,554**	**$4,650**	**$4,650**	**$4,650**	**$4,650**	

Table 3.7
HCBS Access FTE Calculations

Personal Services

Position Classification	FTE	Start Month	End Month	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
ADMINISTRATOR IV	1.0	Mar 2026	N/A	$27,010	$82,433	$82,433	$82,433	$82,433	$82,433	in the BSMD to manage overall implementation of the Access Rule
ADMINISTRATOR IV	1.0	Mar 2026	N/A	$27,010	$82,433	$82,433	$82,433	$82,433	$82,433	CMQPD to manage and resolve and provide oversight of grievances.
Total Personal Services (Salary, PERA, Medicare)	**2.0**			**$54,020**	**$164,866**	**$164,866**	**$164,866**	**$164,866**	**$164,866**	

Centrally Appropriated Costs

Cost Center	FTE	FTE	Cost or	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Health, Life, Dental	0.0	0.0	Varies	$9,814	$35,534	$35,534	$35,534	$35,534	$35,534	
Short-Term Disability	-	-	Varies	$76	$218	$234	$234	$234	$234	
Unfunded Liability AED Payments	-	-	10.00%	$4,782	$14,596	$14,596	$14,596	$14,596	$14,596	
Paid Family and Medical Leave Insurance	-	-	0.45%	$216	$656	$656	$656	$656	$656	
Centrally Appropriated Costs Total				**$14,888**	**$51,004**	**$51,020**	**$51,020**	**$51,020**	**$51,020**	

Operating Expenses

Ongoing Costs	FTE	FTE	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Supplies	0.0	0.0	$500	$334	$1,000	$1,000	$1,000	$1,000	$1,000	
Telephone	0.0	0.0	$235	$158	$470	$470	$470	$470	$470	
Other	0.0	0.0	$0	$0	$0	$0	$0	$0	$0	
Subtotal				*$492*	*$1,470*	*$1,470*	*$1,470*	*$1,470*	*$1,470*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2025-26**	**FY 2026-27**	**FY 2027-28**	**FY 2028-29**	**FY 2029-30**	**FY 2030-31**	**Notes**
Furniture	2.0		$5,000	$10,000	$0	$0	$0	$0	$0	
Computer	2.0		$2,000	$4,000	$0	$0	$0	$0	$0	
Other	2.0		$0	$0	$0	$0	$0	$0	$0	
Subtotal				*$14,000*	*$0*	*$0*	*$0*	*$0*	*$0*	
Total Operating				**$14,492**	**$1,470**	**$1,470**	**$1,470**	**$1,470**	**$1,470**	

Leased Space

	FTE	FTE	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Leased Space	0.0	0.0	$4,650	**$3,108**	**$9,300**	**$9,300**	**$9,300**	**$9,300**	**$9,300**	

Table 3.8
Managed Care Access and QRS FTE Calculations

Personal Services

Position Classification	FTE	Start Month	End Month	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
ADMINISTRATOR IV	1.0	Mar 2026	N/A	$27,010	$82,433	$82,433	$82,433	$82,433	$82,433	
Total Personal Services (Salary, PERA, Medicare)	**1.0**			**$27,010**	**$82,433**	**$82,433**	**$82,433**	**$82,433**	**$82,433**	

Centrally Appropriated Costs

Cost Center	FTE	FTE	Cost or	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Health, Life, Dental	0.0	0.0	Varies	$4,907	$17,767	$17,767	$17,767	$17,767	$17,767	
Short-Term Disability	-	-	Varies	$38	$109	$117	$117	$117	$117	
Unfunded Liability AED Payments	-	-	10.00%	$2,391	$7,298	$7,298	$7,298	$7,298	$7,298	
Paid Family and Medical Leave Insurance	-	-	0.45%	$108	$328	$328	$328	$328	$328	
Centrally Appropriated Costs Total				**$7,444**	**$25,502**	**$25,510**	**$25,510**	**$25,510**	**$25,510**	

Operating Expenses

Ongoing Costs	FTE	FTE	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Supplies	0.0	0.0	$500	$167	$500	$500	$500	$500	$500	
Telephone	0.0	0.0	$235	$79	$235	$235	$235	$235	$235	
Other	0.0	0.0	$0	$0	$0	$0	$0	$0	$0	
Subtotal				*$246*	*$735*	*$735*	*$735*	*$735*	*$735*	
One-Time Costs (Capital Outlay)	**FTE**		**Cost**	**FY 2025-26**	**FY 2026-27**	**FY 2027-28**	**FY 2028-29**	**FY 2029-30**	**FY 2030-31**	**Notes**
Furniture	1.0		$5,000	$5,000	$0	$0	$0	$0	$0	
Computer	1.0		$2,000	$2,000	$0	$0	$0	$0	$0	
Other	1.0		$0	$0	$0	$0	$0	$0	$0	
Subtotal				*$7,000*	*$0*	*$0*	*$0*	*$0*	*$0*	
Total Operating				**$7,246**	**$735**	**$735**	**$735**	**$735**	**$735**	

Leased Space

	FTE	FTE	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Leased Space	0.0	0.0	$4,650	**$1,554**	**$4,650**	**$4,650**	**$4,650**	**$4,650**	**$4,650**	

Table 4.1 - Beneficiary Advisory Council (BAC)			
Row	**Item**	**Total Funds**	**Source**
Benefits Advisory Council (BAC)			
A	Meeting operations &	$49,902	Includes ASL accommodations, travel, etc. for six meetings BAC
B	**Total**	**$49,902**	**Row A**

Table 6.1 - HCBS Access Final Rule FY 2026-27							
Row	**Item**	**Total Funds**	**GF**	**CF**	**FF**	**FMAP**	**Source**
Ensuring HCBS Access System Changes							
A	Creation of Application Programming Interface (API)	-	-	-	-	90.00%	
B	System Changes to the CCM	-	-	-	-	90.00%	
C	Mapping New Fields to BIDM	-	-	-	-	90.00%	
D	**System Changes Subtotal**	**-**	**-**	**-**	**-**		
Ensuring HCBS Access Contractor Funding							
E	Implementation Strategy of Access Rule	$250,000	$125,000	$0	$125,000	50.00%	
F	**Contractor Funding Subtotal**	**$250,000**	**$125,000**	**$0**	**$125,000**		
G	**Total Cost**	**$250,000**	$125,000	$0	$125,000		

Table 6.2 - HCBS Access Final Rule FY 2027-28 And On-Going							
Row	**Item**	**Total Funds**	**GF**	**CF**	**FF**	**FMAP**	**Source**
Ensuring HCBS Access System Changes							
A	Creation of Application Programming Interface (API)	-	-	-	-	90.00%	
B	System Changes to the CCM	-	-	-	-	90.00%	
C	Mapping New Fields to BIDM	-	-	-	-	90.00%	
D	**System Changes Subtotal**	**-**	**-**	**-**	**-**		
Ensuring HCBS Access Contractor Funding							
E	Implementation Strategy of Access Rule	$250,000	$125,000	$0	$125,000	50.00%	
F	**Contractor Funding Subtotal**	**$250,000**	**$125,000**	**$0**	**$125,000**		
G	**Total Cost**	**$250,000**	$125,000	$0	$125,000		

Table 7.1 Managed Care Rate Federal Compliance
Vendor Cost

Row	Item	FY 2026-27	FY 2027-28 & Ongoing	Notes/Source
Payment Analysis Design				
A	Actuary	$375	$0	Optumas Actuarial Rate
B	Hours	50	-	Estimated Hours Needed based on similar scope project
C	Analyst	$150	$0	Optumas Analyst Rate
D	Hours	180	0	Estimated Hours Needed based on similar scope project
E	**Subtotal**	**$45,750**	**$0**	**(Row A * Row B) + (Row C * Row D)**
ACR Calculation				
A	Actuary	$375	$375	Optumas Actuarial Rate
B	Hours	50	50	Estimated Hours Needed based on similar scope project
C	Analyst	$150	$150	Optumas Analyst Rate
D	Hours	180	180	Estimated Hours Needed based on similar scope project
E	**Subtotal**	**$45,750**	**$45,750**	**(Row A * Row B) + (Row C * Row D)**
MLR Template Update & Review				
A	Actuary	$375	$0	Optumas Actuarial Rate
B	Hours	80	-	Estimated Hours Needed based on similar scope project
C	Analyst	$150	$0	Optumas Analyst Rate
D	Hours	220	-	Estimated Hours Needed based on similar scope project
E	**Subtotal**	**$63,000**	**$0**	**(Row A * Row B) + (Row C * Row D)**
ILOS % Calculation				
A	Actuary	$375	$375	Optumas Actuarial Rate
B	Hours	120	120	Estimated Hours Needed based on similar scope project
C	Analyst	$150	$150	Optumas Analyst Rate
D	Hours	275	275	Estimated Hours Needed based on similar scope project
E	**Subtotal**	**$86,250**	**$86,250**	**(Row A * Row B) + (Row C * Row D)**
M	**Grand Total**	**$240,750**	**$132,000**	

Table 8.1 - Comparative Payment Rate Analysis & Disclosure, including Interested Parties Advisory Group (IPAG) Reporting Contractor Funding FY 2026-27 and Ongoing			
Row	**Item**	**Total Funds**	**Source**
Health Care Consultant			
A	Expected # of hours based on contracts of similar scope	550	Rate comparison & analysis
B	Rate	$220	Department rate sheet
C	**Total**	**$121,000**	**Row A * Row B**

Table 9.1 - Interoperability & Prior Authorization Requests (PAR) Final Rule Systems Funding					
Row	**Item**	Year 1 FY 2025-26	Year 2 FY 2026-27	**Two year total - DDI**	**Year 3 FY28 & ongoing - M&O**
		absorbed by current appropriation			
API Development and System Integration					
A	Patient, Provider, and Payer-to-Payer APIs	$1,000,000	$1,000,000	**$2,000,000**	-
B	Prior Authorization API	$500,000	$500,000	**$1,000,000**	-
C	Subtotal	$1,500,000	$1,500,000	**$3,000,000**	**-**
Vendor Contracting and Management					
D	Vendor Services	$500,000	$500,000	**$1,000,000**	-
E	Consulting Services	$400,000	$400,000	**$800,000**	-
F	Subtotal	$900,000	$900,000	**$1,800,000**	**-**
Compliance, Security, and Training					
G	Compliance and Security Audits	$250,000	$250,000	**$500,000**	-
H	Licensing	$0	$0	**$0**	$950,000
I	Staff Training	$100,000	$100,000	**$200,000**	$500,000
J	Subtotal	$350,000	$350,000	**$700,000**	**$1,450,000**
Data Reporting and Monitoring					
K	Analytics and Reporting Tools	$150,000	$150,000	**$300,000**	-
L	Subtotal	$150,000	$150,000	**$300,000**	**-**
M	**Total**	$2,900,000	$2,900,000	**$5,800,000**	**$1,450,000**

Table 9.2 - Interoperability & Prior Authorization Final Rule		
Row	**Item**	**FY 2027-28 & Ongoing**
Contracted FTE - Term Limited		
A	**Project Manager**	**$416,000**
	Oversee the entire project lifecycle, ensuring timelines, vendor management,	
B	**API Maintenance & Support**	**$416,000**
	Maintain and update the APIs as the project moves into the testing, integration,	
C	**Total**	**$832,000**

Table 10.1 - Managed Care Access & Quality Rating System (QRS) FY 26-27 through FY 27-28							
Row	**Item**	**Total Funds**	**GF**	**CF**	**FF**	**FMAP**	**Source**
A	Quality Rating System Development	$2,000,000	$500,000	$0	$1,500,000	75.00%	QRS Development
B	**Total Cost**	**$2,000,000**	$500,000	$0	$1,500,000	75.00%	