Schedule 13
Change Request for FY 2009-10 Budget Request Cycle

Decision Item FY 2009-10 ☑	**Base Reduction Item FY 2009-10** ☐	**Supplemental FY 2008-09** ☐	**Budget Amendment FY 2009-10** ☐
Request Title:	Improved Eligibility and Enrollment Processing		
Department:	Health Care Policy and Financing	**Dept. Approval by:** John Bartholomew	**Date:** October 31, 2008
Priority Number:	DI-5	**OSPB Approval:**	**Date:** 10-24-08

	Fund	1 Prior-Year Actual FY 2007-08	2 Appropriation FY 2008-09	3 Supplemental Request FY 2008-09	4 Total Revised Request FY 2008-09	5 Base Request FY 2009-10	6 Decision/ Base Reduction FY 2009-10	7 November 1 Request FY 2009-10	8 Budget Amendment FY 2009-10	9 Total Revised Request FY 2009-10	10 Change from Base (Column 5) FY 2010-11
Total of All Line Items	**Total**	58,326,483	57,837,876	0	57,837,876	57,437,182	7,528,132	64,965,314	0	64,965,314	14,799,666
	FTE	243.8	272.7	0.0	272.7	276.0	2.8	278.8	0.0	278.8	3.0
	GF	18,468,209	18,299,062	0	18,299,062	17,934,018	3,591,238	21,525,256	0	21,525,256	8,870,580
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	9,286,510	0	9,286,510	9,269,973	0	9,269,973	0	9,269,973	(1,371,857)
	CFE/RF	10,959,772	1,570,778	0	1,570,778	1,578,285	0	1,578,285	0	1,578,285	0
	FF	28,898,502	28,681,526	0	28,681,526	28,654,906	3,936,894	32,591,800	0	32,591,800	7,300,943
(1) Executive Director's Office; (A) General Administration, Personal Services	**Total**	20,382,113	19,251,491	0	19,251,491	19,989,456	174,304	20,163,760	0	20,163,760	190,150
	FTE	243.8	272.7	0.0	272.7	276.0	2.8	278.8	0.0	278.8	3.0
	GF	8,523,018	7,994,379	0	7,994,379	8,121,243	83,070	8,204,313	0	8,204,313	90,622
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	731,501	0	731,501	786,800	0	786,800	0	786,800	0
	CFE/RF	2,219,695	1,557,401	0	1,557,401	1,564,984	0	1,564,984	0	1,564,984	0
	FF	9,639,400	8,968,210	0	8,968,210	9,516,429	91,234	9,607,663	0	9,607,663	99,528
(1) Executive Director's Office; (A) General Administration, Operating Expenses	**Total**	980,465	1,833,478	0	1,833,478	1,681,669	18,534	1,700,203	0	1,700,203	2,850
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	469,925	882,945	0	882,945	811,165	8,830	819,995	0	819,995	1,359
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	23,307	0	23,307	19,221	0	19,221	0	19,221	0
	CFE/RF	24,209	13,377	0	13,377	13,301	0	13,301	0	13,301	0
	FF	486,331	913,849	0	913,849	837,982	9,704	847,686	0	847,686	1,491
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	**Total**	0	2,443,584	0	2,443,584	1,625,334	100,000	1,725,334	0	1,725,334	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	1,099,292	0	1,099,292	752,667	47,854	800,521	0	800,521	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	62,500	0	62,500	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	1,281,792	0	1,281,792	872,667	52,146	924,813	0	924,813	0

Schedule 13
Change Request for FY 2009-10 Budget Request Cycle

Decision Item FY 2009-10 ☑			**Base Reduction Item FY 2009-10** ☐		**Supplemental FY 2008-09** ☐			**Budget Amendment FY 2009-10** ☐			
Request Title:	Improved Eligibility and Enrollment Processing										
Department:	Health Care Policy and Financing				**Dept. Approval by:**	John Bartholomew		**Date:**	October 31, 2008		
Priority Number:	DI-5				**OSPB Approval:**			**Date:**			
		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2007-08	Appropriation FY 2008-09	Supplemental Request FY 2008-09	Total Revised Request FY 2008-09	Base Request FY 2009-10	Decision/ Base Reduction FY 2009-10	November 1 Request FY 2009-10	Budget Amendment FY 2009-10	Total Revised Request FY 2009-10	Change from Base (Column 5) FY 2010-11
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	**Total**	0	153,600	0	153,600	0	7,741,136	7,741,136	0	7,741,136	22,572,998
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	73,503	0	73,503	0	3,704,405	3,704,405	0	3,704,405	10,801,970
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	80,097	0	80,097	0	4,036,731	4,036,731	0	4,036,731	11,771,028
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration	**Total**	31,449,101	27,203,133	0	27,203,133	27,203,133	(505,842)	26,697,291	0	26,697,291	(4,046,742)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	9,475,266	8,248,943	0	8,248,943	8,248,943	(252,921)	7,996,022	0	7,996,022	(2,023,371)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	5,452,981	0	5,452,981	5,452,981	0	5,452,981	0	5,452,981	0
	CFE/RF	6,249,284	0	0	0	0	0	0	0	0	0
	FF	15,724,551	13,501,209	0	13,501,209	13,501,209	(252,921)	13,248,288	0	13,248,288	(2,023,371)
(4) Indigent Care Program; Children's Basic Health Plan Administration	**Total**	5,514,804	6,952,590	0	6,952,590	6,937,590	0	6,937,590	0	6,937,590	(3,919,590)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	3,016,221	0	3,016,221	3,010,971	0	3,010,971	0	3,010,971	(1,371,857)
	CFE/RF	2,466,584	0	0	0	0	0	0	0	0	0
	FF	3,048,220	3,936,369	0	3,936,369	3,926,619	0	3,926,619	0	3,926,619	(2,547,733)
Non-Line Item Request:	None										
Letternote Revised Text:	None										
Cash or Federal Fund Name and COFRS Fund Number:	CFE: Fund 11G (Children's Basic Health Plan Trust Fund); FF: Title XIX and Title XXI										
Reappropriated Funds Source, by Department and Line Item Name:	Not Applicable										
Approval by OIT?	**Yes:** ☐	**No:** ☐	**N/A:** ☑								
Schedule 13s from Affected Departments:	Not Applicable										

CHANGE REQUEST for FY 2009-10 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	DI-5
Change Request Title:	Improved Eligibility and Enrollment Processing

SELECT ONE (click on box):

☒ Decision Item FY 2009-10
☐ Base Reduction Item FY 2009-10
☐ Supplemental Request FY 2008-09
☐ Budget Request Amendment FY 2009-10

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:
☒ Not a Supplemental or Budget Request Amendment
☐ An emergency
☐ A technical error which has a substantial effect on the operation of the program
☐ New data resulting in substantial changes in funding needs
☐ Unforeseen contingency such as a significant workload change

Short Summary of Request: The Department requests $7,528,132 total funds, $3,591,238 General Fund, and 2.8 FTE in FY 2009-10; and $14,799,666 total funds, $8,870,580 General Fund, and 3.0 FTE in FY 2010-11 for implementation and administration of an Eligibility Modernization Vendor model.

Background and Appropriation History: The Department is committed to ensuring that clients are healthier when they leave the Medicaid and Children's Basic Health Plan programs than when they entered. To that end, the Department is proposing a set of enhancements to administrative and program functions and interventions designed to maximize the health, functioning and self-sufficiency of Medicaid clients and providers. The primary goals of all four proposals in the Department's Budget Request for FY 2009-10 are to (1) provide a model that delivers seamless, integrated care to clients between different delivery systems, (2) maximize client health and satisfaction, and (3) achieve greater cost-effective care. The common thread underlying all of the proposals is making the health care delivery system, and access to programs, more outcomes-focused and client-centered. These enhancements and programmatic changes will lead to a more coordinated system based on shared

responsibility; where payers, providers, and clients each take appropriate responsibility for improving the health and health care for Colorado residents.

The Department's set of proposals are divided into four Change Requests:

- DI-5 Improved Eligibility and Enrollment Processing;
- DI-6 Medicaid Value-Based Care Coordination Initiative;
- BRI-1 Pharmacy Technical and Pricing Efficiencies; and,
- BRI-2 Medicaid Program Efficiencies.

The request in DI-5 would improve eligibility and enrollment processing by creating a single state-level entity to enhance and complement the current multiple county-level processes. This entity would streamline the navigation through the eligibility process of Medicaid and the Children's Basic Health Plan, create expedited eligibility and improve outreach and enrollment in both programs. In addition, the entity would modernize the current eligibility determination process by implementing an automated customer contact center and create an electronic document and workflow management system. This would provide a central repository for Medicaid and Children's Basic Health Plan applications and related documents. These changes would ensure easier, more reliable and timely eligibility and enrollment processes, making the program more efficient and effective and delivering important benefits to clients, providers and enrollment staff.

The request in DI-6 for a Medicaid Value-Based Care Coordination Initiative would enable the Department to deliver high-quality, patient-centered, coordinated care to Medicaid clients across Colorado. To achieve this, the Department will undertake a statewide competitive procurement process for physical health services that emphasizes the importance of increasing the availability and services of medical homes for all clients. The Department intends to regionally procure services from Accountable Care Organizations that would operate as Administrative Services Organizations (ASOs) providing enhanced Primary Care Case Management services. The ASOs would be primarily responsible for establishing a coordinated care delivery system for all clients. The Department anticipates that payments to primary care physicians would be

supplemented with care coordination fees as well as outcomes-based performance incentives.

In addition to strengthening primary care services, the ASO would administer a comprehensive network of care coordination services. Care coordinators would be based in the community and help reinforce treatment plans, coordinate care between different providers, assist in care transitions between hospitals and community care, and importantly serve as a client advocate in navigating between physical health, behavioral health, waiver services, and long term care services as appropriate. The ASO would also deploy evidence-based medical management tools designed to promote patient safety and reduce unwarranted variation in care practices. The ASO contract would also be performance based with guarantees established around health outcomes, functional improvements, and self-sufficiency attainment. The Department anticipates that ASOs will incorporate an electronic health exchange that will greatly facilitate effective communication between clients, providers, and government agencies. Through such efforts, errors and duplication can be reduced. Clinical decision support tools as well as electronic registries will help improve outcomes at the point of care. This initiative aims to create a comprehensive, coordinated, outcomes focused care delivery system that optimizes the well being of Medicaid clients.

The Department's BRI-1, Pharmacy Technical and Pricing Efficiencies, requests a reduction in funds as a result of implementing an automated prior authorization system and changes to the reimbursement rates of drugs using a state maximum allowable cost structure. Automating prior authorizations would increase efficiency in managing current prior authorizations while decreasing the administrative burden on providers. The automated process would make it easier for providers to submit requests, it would be easier and faster for clients to obtain drugs with prior authorization restrictions, and provide savings within Medical Services Premiums.

The request in BRI-2, Medicaid Program efficiencies, would improve quality of service for clients through six initiatives:

- Medicaid Benefit Package Reform;

- Health Outcomes Measurement Initiative;
- Fluoride Varnish;
- Hospital Back Up Program Enhancements;
- Oxygen Durable Medical Equipment Administrator; and,
- Serious Reportable Events.

Through the Health Outcomes Measurement Initiative, the Department would directly survey Medicaid clients on a monthly basis regarding their health and functional status to measure effectiveness of the Medicaid program and find areas for improvement. In addition, the Department could analyze geographic indicators to identify and address health disparities between urban and rural areas; and analyze and compare the health and functional status of clients in different groups. Through the Hospital Back Up program, the Department would achieve cost savings and improvements to care by moving clients out of hospitals into more appropriate care settings. Potential cost savings would also be generated through the initiative for 1.0 FTE Oxygen Durable Medical Equipment Administrator. This FTE would help the Department contain oxygen related expenditures, which are the highest expenditure category within durable medical equipment, implement process improvements and introduce more technologically efficient oxygen delivery systems.

This package builds upon many recommendations from the Blue Ribbon Commission for Health Care Reform (commonly referred to as the 208 Commission). It draws upon successful Medicaid reform efforts in North Carolina, Indiana, Oklahoma, Arkansas, and New Hampshire. By awarding health care service contracts regionally, the Department anticipates community organizations coming together to serve their own community and be accountable for their performance. The regional model allows for a rough overlap with behavioral health organization regions allowing for more effective coordination of services between physical and behavioral health. Also, alignment with Children's Basic Health Plan regions will help create seamless care for children traversing between programs. A key goal of these initiatives is seamless care to the client between different delivery systems. The initiatives call for a holistic and systems approach to care delivery. The Department recognizes the varying needs of different populations served within

Medicaid and expects to set outcome measures that differ between TANF, SSI, waiver, and dual eligible populations. A key component of the model is comprehensively defining the Medicaid benefit so coverage, duration, amount, and scope are clearly articulated.

General Description of Request:

This request is for net total funds $7,528,132 in FY 2009-10 and net total funds $14,799,666 in FY 2010-11. The Department requests $7,741,136 total funds in FY 2009-10 and $22,532,998 total funds in FY 2010-11 for the (1) Executive Director's Office; (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project line for the implementation and administration of an Eligibility Modernization Vendor model. In addition, the Department requests $100,000 for the (1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects for a contractor to assess the impact of the implementation of the Eligibility Modernization Project on the Department of Human Services and other programs currently administered by the county departments of social/human services. Additionally, the Department requests $192,838 total funds in FY 2009-10 and $193,000 in FY 2010-11 for three additional FTE to maintain the Virtual Application Gateway software and to manage the contract with the Eligibility Modernization Vendor. These costs will be offset by a reduction in the (1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration line of $505,842 in FY 2009-10 and a reduction of $4,046,742 in FY 2010-11. An additional offset will be available in a reduction of $3,919,590 in FY 2010-11 in the (4) Indigent Care Program; Children's Basic Health Plan Administration line.

The Department's February 15, 2008 request titled "Building Blocks to Health Care Reform" (S-1A, BA-A1A) included funding to create a single state-level entity for eligibility and enrollment determination for the Medicaid and Children's Basic Health Plan programs. This entity was envisioned to enhance and complement the current multiple county-level processes that determine eligibility (the original "Centralized Eligibility Vendor" definition under the Department's February 15, 2008 "Building

Blocks to Health Care Reform" request now referred to as the "Eligibility Modernization Vendor"). As part of that request, the Department requested funding for an outside vendor with the requisite experience, skills and knowledge (the "RFP Vendor") to gather the requirements and draft the request for proposals for the Eligibility Modernization Vendor. Further, Colorado Benefits Management System enhancements were proposed. Both these items, the RFP Vendor and Colorado Benefits Management System enhancements, were funded. However, to allow more time for stakeholder input into the process, the funding to contract with an Eligibility Modernization Vendor was not appropriated. This request restates the need for funding to contract with a vendor to provide administrative responsibility and accountability over the eligibility and enrollment processes for the Department's health care programs.

The Department is committed to improving access to health care for low-income and uninsured Colorado residents, improving the quality of health care services our clients are receiving, and decreasing overall health care costs. Over the last two years, legislation was passed and funds appropriated supporting these goals. Specifically, Presumptive Eligibility for children, created in SB 07-211, was implemented in January of 2008 resulting in greater numbers of families applying for Medicaid and the Children's Basic Health Plan. In the Department's Supplemental and Budget Amendment Request, "Building Blocks to Health Care Reform," prioritized as S-1A and BA-A1A, submitted on February 15, 2008, and through SB 08-160 titled "Concerning Improvements to Health Care for Children" and signed into law by the Governor on June 3, 2008, the Department was appropriated additional funds to increase outreach efforts to enroll eligible children in public health insurance programs. In the Department's Building Blocks to Health Care Reform, S-1A and BA-A1A, submitted on February 15, 2008 and through SB 08-160, the Children's Basic Health Plan program was expanded to include children and prenatal clients up to 225% of the Federal Poverty Level. In SB 08-161 titled "Concerning Eligibility for Public Benefits, and Making an Appropriation Therefor", and signed by the Governor on June 3, 2008, verification of income through the Department of Labor and Employment's database was approved to streamline the

eligibility determination process. As a result of these initiatives, the Department anticipates that the number of applications submitted to counties and medical assistance sites will significantly increase over the coming years. The Department must assure that the appropriate infrastructure is in place to support the timely and accurate processing of applications while maintaining the highest level of customer service.

The counties and medical assistance sites have worked diligently to meet the current workload requirements related to the eligibility determination process. However, funding issues, staff attrition and problems associated with the implementation of the Colorado Benefits Management System in 2004, have hampered the ability of some counties to accommodate the Medicaid and Children's Basic Health Plan caseload. Several of the current issues that the Department needs to address were noted in the Statewide Single Audit for the fiscal year ended June 30, 2007. In that report, the Department needed to address several findings related to the eligibility determination process:

- Ensure that new Medicaid cases and redeterminations, as well as Children's Basic Health Plan applications, are processed within federal guidelines.
- Ensure that Medicaid eligibility is terminated in a timely manner when individuals are no longer eligible for the program.
- Ensure that case file documentation for the Medicaid program is adequate to support all eligibility determinations.
- Improve controls over Medicaid eligibility determinations and data entry by establishing reviews that compare case file data in Colorado Benefits Management System on an ongoing basis.
- Address electronic system data discrepancies within 45 days of receiving notification as required by federal regulations.
- Respond to findings that identify eligibility errors and that corrective action plans are adequate to address deficiencies identified.

Further, with the anticipated growth of application submissions for public health insurance programs, the Department must identify operational strategies to build capacity while not increasing the growth rate in related costs over the long run. One approach focuses on creating a single point of responsibility and accountability for eligibility and enrollment functions. By leveraging existing technology together with implementing business process improvements, centralization of the eligibility and enrollment functions will make the administration of the public health insurance programs more effective and efficient, regardless of geography. The Department believes there are a number of increased efficiencies and economies of scale to be gained by centralizing certain eligibility and enrollment activities and processes. The Department plans to achieve this goal by contracting with an "Eligibility Modernization Vendor."

The Department's February 15, 2008 "Building Blocks to Health Care Reform" request, S-1A and BA-A1A, contained many conceptual elements of what a new eligibility model might include. However, the Department is seeking input from a variety of sources to help determine what eligibility and enrollment activities are best performed in a centralized way and those activities that are best performed locally. For example, the county departments of social/human services serve as a vital resource and provide an entry point to an array of financial and supportive services for many low-income clients. Alternatively, the scanning and imaging of paper documentation and the maintenance of case file documentation might best be performed in a centralized way. As such, the Department's approach to finding a new model for helping clients gain access to health care includes contracting with a vendor to serve as the single point of accountability and responsibility for eligibility processes while supporting certain eligibility and enrollment activities to be performed at the local level. It is the goal of the Department to leverage technology and to implement business process improvements so that as caseloads increase, the total annual cost remains the same. Most importantly, the Department wants to implement a business model that meets the needs of the client. There should be no "wrong door" with respect to how and when clients apply for health care coverage.

The application should then be processed as quickly as possible so that eligible clients can receive appropriate health care services.

To better refine the Department's vision and to understand the options available, the Department began the Colorado Eligibility Modernization Project. Under this project, important steps have been initiated. Bailit Health Purchasing, a national health care consulting firm, is assisting the Department by facilitating meetings with stakeholders, providing technical assistance on a request for information and providing feedback on the activities of the RFP Vendor.

The group of stakeholder representatives, which includes clients, client advocates, county representatives and other eligibility experts has been meeting on a monthly basis since June 5, 2008. The charter of the group was to solicit stakeholder feedback regarding the Department's plan to centralize certain eligibility and enrollment processes for all public health insurance programs. For these meetings the Department and stakeholders have developed a shared vision for an eligibility delivery system which includes the following guiding principles:

- Clients should receive their eligibility status timely and accurately.
- Clients should receive their benefits timely and accurately.
- Clients deserve predictability and consistency of results throughout Colorado.
- Coloradans should expect that government programs are run efficiently and effectively.
- Colorado should streamline and simplify options to increase enrollment and retention.
- Clients should have a variety of self-service options available to learn about, apply for, enroll in, and retain health insurance coverage including the option for face-to-face guidance.

- Document management, including imaging, storage and retrieval should meet minimum standards across the state.
- Clients deserve to be treated with dignity and respect.
- Clients should have the option of applying for public health insurance programs when they are applying for other human services programs.
- Technology should be harnessed to improve Medicaid and Children's Basic Health Plan enrollment and retention.

On August 13, 2008, the Department issued a request for information to experienced vendors, stakeholders and interested parties to obtain recommendations regarding processes and best practices to organize and implement a new eligibility process for Medicaid and the Children's Basic Health Plan. Bailit Health Purchasing and the group of stakeholder representatives reviewed the request for information. Under the request for information, the following objectives were established with regard to exploring options to eligibility modernization:

- Reduce or eliminate the dependence on paper applications and supporting documents to create efficiencies and to make it easier for families to apply for Medicaid and the Children's Basic Health Plan. This will result in shorter processing times, a reduction in physical storage space, and the improvement of security of the application process. Further, this process will permit the Department to back-up application and documentation records in case of a disaster and provide a centralized record that can be easily accessed for auditing purposes.
- Expedite the time required to process an application. As a result of ongoing monitoring of the multiple county-level process, the Department is aware that many of the applications for Medicaid and the Children's Basic Health Plan are not currently processed within the federal guidelines (45 days for Medicaid applications, with an additional 45 days when a disability determination is necessary). The Department wishes to expedite enrollment and significantly reduce the time required

to process an application. Under this objective, the Department requires that there be multiple customer-friendly mechanisms to enroll (face-to-face at a health care provider's location, by telephone, by mail and online), that can meet the needs, skills, and abilities of the client. Further, by expediting applications, the Department hopes to increase the number of individuals who maintain enrollment in Medicaid and the Children's Basic Health Plan.

- Enhance the customer service capabilities of the Department and assure access to information and assistance. The Department anticipates that under the Eligibility Modernization Vendor model, a vendor would also help manage customer service calls for the Department including calls concerning Medicaid eligibility and enrollment. A customer call center would provide a single entry point for customers seeking information on the Department's health care programs and provide assistance regarding eligibility and enrollment activities.

It should be noted that even though this request for information seeks information on best practices to organize and implement eligibility modernization for Medicaid and the Children's Basic Health Plan, it is expected that local county departments of social/human services will remain a point of contact for many clients. Until the best practices for administering eligibility and enrollment functions have been identified, any change in the level of involvement that county departments of social/human services will have in eligibility and enrollment functions is indeterminate. Further, the Department is exploring a variety of self-service options that might be available for clients applying for Medicaid and the Children's Basic Health Plan outside of the county departments of social/human services.

Responses to the request for information were submitted September 10, 2008. The Department reviewed the responses to the request for information and then invited a subset of respondents to present oral responses to the Department. Further, responses to the request for information and oral presentations were reviewed by Bailit Health Purchasing and Public Knowledge, LLC, the RFP Vendor selected by the Department.

The contract awarded to Public Knowledge was funded through the Department's February 15, 2008 request for an outside vendor with the requisite experience, skills and knowledge to gather the requirements and draft the request for proposals for the Eligibility Modernization Vendor. In summary, the scope-of-work for the Public Knowledge contract is as follows:

- The contract awarded to Public Knowledge was funded through the Department's February 15, 2008 request for an outside vendor with the requisite experience, skills and knowledge to gather the requirements and draft the request for proposals for the Eligibility Modernization Vendor. In summary, the scope-of-work for the Public Knowledge contract is as follows: Public Knowledge will be required to provide the Department with best practices for administering eligibility and enrollment functions, including, but not limited to existing programmatic delivery models, client enrollment access points, application intake, ongoing case maintenance, fraud and abuse monitoring, and recoveries for the Department's public health insurance programs, focusing on Medicaid and the Children's Basic Health Plan marketed as the Child Health Plan *Plus* (CHP+). Further, Public Knowledge will be expected to conduct a comprehensive business process analysis, with accompanying cost benefit and return on investment analyses, to improve the efficiency and quality for determining eligibility and enrollment operations for Medicaid and the Children's Basic Health Plan.
- Based on Public Knowledge's comprehensive business process analysis, with accompanying cost benefit and return on investment analyses, Public Knowledge will develop a request for proposals for a vendor to manage the business processes for eligibility and enrollment for both the Medicaid and Children's Basic Health Plan programs.

Public Knowledge's study on best practices for administering eligibility and enrollment functions, including technical requirements and cost benefit for redesign is expected by

November 17, 2008. Following the release of that report, the Department will consult with the group of stakeholder representatives to decide which elements should be included in the request for proposals for a vendor to manage the business processes for eligibility and enrollment. The final report will also include further details on the cost for a vendor to provide the Department with a single point of administrative responsibility and accountability for eligibility processes that would include options to enhance and complement eligibility and enrollment activities performed at a local level.

At this time, the Department does not have the study on best practices for administering eligibility and enrollment functions from Public Knowledge, so this request serves as a placeholder until more information becomes available. As with any project of this magnitude, the Department will provide information on the costs through the budget process, including budget amendments and future supplemental requests. Further, the Department will provide the General Assembly any additional information, including the study on best practices for administering eligibility and enrollment functions from Public Knowledge to assist in the completion of the appropriation. Since the Department believes that it is important to dedicate funding to this project so a vendor can begin work on January 1, 2010, it is important that funding be appropriated in FY 2009-10. As such, the cost estimate presented in this request largely mirrors that in the Department's February 15, 2008 request, "Building Blocks to Health Care Reform," S-1A, BA-A1A. Preliminary discussions with Bailit Health Purchasing have affirmed that the Department's total cost estimate is reasonable, even if the pricing of each component is not necessarily accurate.

The Department does not have a comprehensive list of the components that must be introduced under an Eligibility Modernization Vendor. However, the following elements, as presented under the original request, remain consistent with the Department's overall goals. To manage all of the eligibility and enrollment activities for Medicaid and Children's Basic Health Plan and significantly reduce the time to process and determine eligibility, the Department expects that three critical systems would be

implemented as part of the new business model: an Electronic Document Management System, a Workflow Process Management System and a Customer Contact Center. These systems are described below.

Electronic Document Management System

The Electronic Document Management System would provide a central repository for Medicaid and Children's Basic Health Plan applications and related documents. The document management system would change workflows through the current county model as well as how operational processes are performed. Rather than requiring county locations to store hard copies of case files, all documents would be electronically scanned and stored in a central location. This would significantly increase the ability to retrieve records for eligibility determinations, customer service activities, as well as serve to increase the ability to audit case files.

The Electronic Document Management System is a computer system (or set of computer programs) used to track and store electronic documents and/or images of paper documents. Document management systems commonly provide storage, versioning, security, as well as indexing and retrieval capabilities. Many document management systems integrate document management directly into other applications, so that users may retrieve existing documents directly from the document management system repository, make changes, and save the changed document back to the repository as a new version, all without leaving the application. Images of paper documents are created using scanners or multifunction printers. Optical character recognition software is often used, whether integrated into the hardware or as stand-alone software, in order to convert digital images into machine readable text. Simple retrieval of individual documents can be supported by allowing the user to specify the unique document identifier. More flexible methods of retrieval allow the user to specify partial search terms involving the document identifier and/or parts of the expected data file.

Workflow Process Management System

The Workflow Process Management System is an electronic document routing system that enables users to process work more efficiently, faster, and more accurately than with traditional paper processing. This system is beneficial whenever successive points of input or action are required in order to complete a task, process, or procedure. From

processing applications to approving expense reports to managing remittance processing, workflow streamlines collaboration and accelerates the completion of critical business tasks. With workflow process management systems, users or integrators define and configure document states, rules, actions, and lifecycles with a Windows interface. Upon configuration, workflow instantly routes documents through the business process as each increment of user or system work is completed within a queue. Once applications are imaged, the applications and related documents are routed to the appropriate work queues for follow-up and completion. Managers can then track the status of pended applications and use the system to monitor the performance of the staff and the timely processing of applications.

Customer Contact Center

A Customer Contact Center would provide a single entry point for customers seeking information on the Department's health care programs and to provide assistance for eligibility and enrollment activities. A Customer Contact Center is a central point which all customer contacts are managed. The Customer Contact Center typically includes one or more call centers but may include other types of customer contact as well, including website inquiries, and the collection of information from customers. Further, the Customer Contact Center would have the ability to handle a considerable volume of calls at the same time, to screen calls and forward calls to someone qualified to handle them, and to log calls. If the call is related to Medicaid or Children's Basic Health Plan policy or other issues not relating to the activities of eligibility and enrollment, the call would be directed to the Department's current Customer Service Section or other appropriate contact. The Department expects that the Customer Contact Center would utilize software, which will be linked to the Electronic Document Management System and would allow contact information to be routed to appropriate people, contacts to be tracked, and data to be gathered.

The Department assumes that a client phone call into the Customer Contact Center would typically be a one-time event such that the client would not receive a message stating someone will call them back. Instead, the client's question or issue is resolved during

that single phone call. The Customer Contact Center would be expected to escalate the call while the client was on the phone, similar to private industry support call centers. Further, the Customer Contact Center would provide, through the phone and internet, the client the ability to check their enrollment, status of application, inquire about missing documents, find provider locations, and receive general information without directly speaking to a technician.

Eligibility Modernization Vendor

Upon award of the contract on January 1, 2010 the Eligibility Modernization Vendor would begin the process to transition and manage the eligibility and enrollment activities for Medicaid under the new model, covering a single large county. The transition would involve collecting and converting all case files into a centralized electronic document management system. In addition, the vendor would become responsible for managing all customer service calls for the Department and for those calls concerning Medicaid eligibility and enrollment for the county in transition. Once the process was completed for the first county, the Department expects the vendor would be capable of implementing a consistent transition plan to convert 20% of the Medicaid caseload within the remainder of the fiscal year. During FY 2010-11 Medicaid eligibility and enrollment activities for 60% of the Medicaid caseload would be converted to the Eligibility Modernization Vendor, while 100% of Medicaid cases would be covered by June 30, 2012. This timetable assumes the implementation of the model in which all eligibility and enrollment activities are performed by the Eligibility Modernization Vendor. However, based on the recommendations of the group of stakeholder representatives, the vendors participating in the request for information process and the best practices study conducted by Public Knowledge LLC, the final business model may be modified. For example, the Eligibility Modernization Vendor might subcontract with counties to perform certain eligibility and enrollment activities.

The vendor would assume the operations of the Children's Basic Health Plan eligibility, enrollment and member services on July 1, 2010. These tasks include receiving applications, processing mail, processing applications, adding applicant data to the

Colorado Benefits Management System, confirming enrollment or disenrollment of members, providing other case maintenance tasks in the Colorado Benefits Management System, maintaining the program's toll-free lines, providing customer service, carrying out the program's financial administration, handling manual Managed Care Organizations enrollments, re-determining eligibility, and coordinating the program's non-medical appeal process. Further, the vendor would coordinate customer service activities with the State's health care provider network and dental vendor for the Children's Basic Health Plan.

The vendor would be required to develop and implement a thorough and consistent training plan so all employees are trained on statewide rules. Department staff would remain responsible for training the vendor's staff on general policy and operations, but the vendor would be responsible for ongoing training of new employees and annual refresher courses. This centralized approach to eligibility training would promote consistency with respect to day-to-day operations and allow for greater customer service and satisfaction. Historical data suggests that clients enrolled in public health insurance programs are a mobile population that often move to different counties. Because the 64 counties manage their eligibility processes in a variety of ways, clients often become frustrated and confused in their attempts to navigate the different requirements across counties. This results in a fragmented delivery system of care and creates continuity of care issues for clients.

The Department envisions that the Eligibility Modernization Vendor may have a central processing unit, with an incoming mail center linked to the centralized electronic document management system. This unit would scan and input all applications and documents mailed, faxed or electronically transmitted by or on behalf of clients. Once the application and documents were electronically processed through the Colorado Benefits Management System, the case would be forwarded to either a unit that specialized in Family Medical (including the Children's Basic Health Plan) or Adult Medical. These units would be responsible for determining eligibility and contacting clients when necessary. It is expected that technicians will specialize in one of these two areas since Family Medical focuses more on case management, whereas Adult Medical

involves more upfront work to collect resource and asset information from the client and then coordinate with the Single Entry Points, Community Centered Boards, Consultative Examinations, Ltd and the Social Security Agency.

The Department expects that an immediate efficiency can be achieved through a triage of incoming applications in order to distribute the workload by complexity of the application. Through this approach, standard applications (complete application for simple family units with employment) can be processed more quickly. The workload for complex applications (self-employed, three generational, or immigrant families) can be distributed to more experienced eligibility and enrollment representatives to support a more timely process. The Department's goal would be to establish a process that would eliminate the need for clients to have a face-to-face interview with a technician and if not, eliminate or significantly reduce the need for clients to contact the eligibility technician by phone. Further, the Family Medicaid and Adult Medicaid units would be responsible for addressing client phone calls and facilitating problem resolution for all eligibility and enrollment questions and issues.

As stated before, the Department does not have an official cost estimate or study on best practices for administering eligibility and enrollment functions from Public Knowledge, LLC at this time, so this request serves as a placeholder until more information becomes available. As with any project of this magnitude, the Department will provide information on the costs through the budget process, including budget amendments and future supplemental requests. Since the Department believes that it is important to dedicate funding to this project so a vendor can begin work on January 1, 2010, it is important that funding be appropriated in FY 2009-10. Preliminary discussions with Bailit Health Purchasing have affirmed that the Department's total cost estimate is reasonable, even if the pricing of each component is not necessarily accurate.

The estimated total cost for the Eligibility Modernization Vendor is $7,933,974 in FY 2009-10 and $22,765,998 in FY 2010-11. These figures include a phase-in during FY 2009-10 as the new vendor would not assume the full workload of the processing Medicaid eligibility until FY 2011-12. Even though the new vendor is only responsible

for 20% of the Medicaid caseload FY 2009-10, there is a significant amount of infrastructure that must be built to transition from the current county-based model to the new eligibility modernization model. As such, the budget for FY 2009-10 is based on 50% of the Customer Contact Center annual costs and an additional $1,000,000 for general start-up activities.

The full implemented cost figures for the Eligibility Modernization Vendor in FY 2011-12 of $31,718,270 include the cost of the Electronic Document Management System and Workflow Process Management System at $3,500,000 for both, a Customer Contact Center at an additional $3,500,000, the need for eligibility and enrollment personnel at $17,925,140 to process applications, $1,470,000 in vendor leased space, $763,000 in staffing operating costs, $397,540 in additional postage cost and $50,000 for the Virtual Application Gateway (see below). The Department assumes that the costs would be consistent over the remaining period of the contract from FY 2012-13 to FY 2013-14. These figures also include the new vendor assuming the operations of the Children's Basic Health Plan eligibility, enrollment, and member services; based on the contract period, the total cost for FY 2009-10 is estimated to be $3,919,590 total funds. These totals are shown in Table 9.

County Administration

The following explains the County Administration offset to the cost for the Eligibility Modernization Vendor. For many low-income clients, the county departments of social/human services serve as a vital resource and provide an entry point to an array of financial and supportive services. The Department funds these activities through its County Administration line item. The Department's approach to finding a new model for helping clients gain access to health care includes a vendor to provide the Department with a single point of administrative responsibility and accountability for eligibility processes. Other elements can be implemented, such as leveraging technology to assist the county departments of social/human services to increase efficiencies. Therefore, the Department expects that county departments of social/human services will continue to have a role in the eligibility and enrollment process.

Under an Eligibility Modernization Vendor model, the Department would continue to transfer to the counties the federal match received for any county costs incurred by the counties as a result of Medicaid eligibility activities. Similar to the Outstationing and Medical Assistance enrollment activities performed at the Denver Health Medical Center, such activities performed by the county departments of social/human services will remain eligible for a federal match. Using the random moment sampling process, the Department can document the actual costs at a county department of social/human services.

In 2007, the Colorado Workload Study Project was conducted by Deloitte Development, LLC in order to determine the level of funding needed by the counties to cover their costs related to county administration activities. Based on the FY 2007-08 cash payments to counties for Medicaid eligibility activities and the related costs as reported in the Colorado Financial Reporting System (which includes the FY 2007-08 Long Bill appropriation and a transfer of General Fund from the Department of Human Services), the Department reimbursed county departments of social/human services at 70% of their total cost as determined by the Workload Study. The cash payments included only the General Fund and federal fund pieces in order to accurately measure how much the Department contributed. These cash payments do not include the 20% local share provided by the counties. Since the Workload Study was conducted in FY 2006-07, the Department inflated the costs to estimate FY 2007-08 costs as well as costs in subsequent years by using both the growth in caseload (Medicaid and Children's Basic Health Plan) and the Consumer Price Index for Urban Wage Earners and Clerical Workers.[1]

Once the Eligibility Modernization Vendor model has been fully implemented, costs at all county departments of social/human services are expected to decrease on average 50% overall as the workload is moved to an Eligibility Modernization Vendor; however, this decrease is not known and will vary by county. To estimate this decrease in cost, the

[1] The Department assumed growth in caseload using total forecasted caseload for both Medicaid and the Children's Basic Health Plan from the Department's November 3, 2008 Budget Request. For each of the fiscal years, the Department used the Consumer Price Index for Urban Wage Earners and Clerical Workers of 4.3% (March 2007 and 2008).

Department used key cost drivers for Medical Application assistance identified in the Workload Study and estimated the amount by which these activities would decrease under the new eligibility model. Table 2 defines the key cost drivers for county administration activities and Table 3 summarizes the Department's calculations for estimating the average 50% drop in costs for the counties.

In Table 3, based on the new Eligibility Modernization Vendor model, the Department anticipates each of the cost drivers would be reduced by the indicated percentages due to workload shifting from the counties to the Eligibility Modernization Vendor. As shown in Table 3, the current estimated total of county costs based on the Workload Study of $44,082,868 in FY 2010-11 is reduced to $22,084,195 through this shift of duties. This results in a 50% reduction in total cost.

Due to the complicated nature of transitioning populations to a new model, the Department will need to analyze the actual cost reduction at the county departments of social/human services as the workload is moved to an Eligibility Modernization Vendor. Since the Department believes that it is important to dedicate funding to this project so a vendor can begin work on January 1, 2010, a reasonable reduction in county administration costs is included under this request. The reduction of costs at the county departments of social/human services will be better understood once the Eligibility Modernization Vendor assumes responsibility for Medicaid eligibility in one county which is expected to occur by March 31, 2010.

To maintain the cash payment to the county departments of social/human services at 70% of their cost under the new model, the Department estimates 20% of the total funding necessary would be General Fund in the amount of $4,416,839 (please see Tables 4 and 5 for calculations). The Department assumes federal funds in the amount of $11,042,098 would continue to make up 50% of the total funds. Currently, counties provide a local share of 20% of the total cost for county administration activities. The Department anticipates that the county share would need to increase under this new model in order to draw down the required federal funds. In addition to the cash funds currently provided by counties as the local share, the Department would use certification of public

expenditures in order to draw additional federal matching funds. Since the activities are performed by a public entity, the Department can use certification of public expenditures to increase the county share to 30% of the total costs to obtain the necessary federal funds. By using certification of public expenditures to increase the county share of total costs, the current cash contribution from the counties would not need to be increased under the new model.

Due to the decrease in costs and the reduction of General Fund needed for county administration activities, there will be $5,058,427 of General Fund remaining in the County Administration line item that could be transferred to offset some of the costs for the Eligibility Modernization Vendor. In FY 2009-10, the Department anticipates 20% of Medicaid caseload would be moved to the new Eligibility Modernization Vendor model; therefore, in FY 2009-10, the Department estimates that 5% percent of the $5,058,427 total General Fund (annualized amount as Eligibility Modernization Vendor starts January 1, 2010 and 20% of Medicaid caseload is covered under the new model by June 30, 2010) would be used as an offset for the new model. That percentage grows accordingly to 40% of the $5,058,427 General Fund in FY 2010-11 and to 80% of the $5,058,427 General Fund in FY 2011-12 to correspond with the annual average percentage of Medicaid caseload to be served each year. Assuming no additional funding is appropriated to the counties department of social/human services for Medicaid eligibility activities, $4,416,839 in General Fund remains in the County Administration line item appropriation in FY 2009-10, FY 2010-11, FY 2011-12 and ongoing.

In FY 2007-08, the Department paid a total of $9,475,266 in General Fund for County Administration (this amount includes the Department's FY 2007-08 Long Bill appropriation and a transfer of General Fund from the Department of Human Services). Pursuant to 24-75-106, C.R.S. (2008), the Department has unlimited transfer authority with the Department of Human Services for the County Administration line item; therefore, the actual cash payments made to counties can exceed the total appropriation in the Long Bill. In FY 2009-10, the Department estimates $22,084,195 in total funds would be necessary for County Administration under the new model. Of this total, the amount of General Fund remaining in the County Administration line item under the new

model would be $9,222,345 since only 5% of the $5,058,427 General Fund is used as an offset. This is because in FY 2009-10, the Eligibility Modernization Vendor would serve 20% of the caseload and as a result only a fraction of the counties would see a 50% reduction in total costs. In FY 2010-11, the General Fund remaining in the County Administration line item would be $7,451,895 since 40% of the $5,058,427 General Fund is used as an offset. In FY 2011-12, the General Fund remaining in the County Administration line item would be $5,428,524 since 80% of the $5,058,427 General Fund is used as an offset and counties should have on average, a 50% reduction in total cost (please see Tables 4 and 5 for calculations).

As stated before, the Department cannot provide an official cost estimate or the study on best practices for administering eligibility and enrollment functions from Public Knowledge, LLC at this time, so the amount of General Fund in County Administration that can be used to offset the costs of the Eligibility Modernization Vendor serves as a placeholder until more information becomes available.

Further, any impact on the county administration costs within the Department of Human Services' line items would be measured once the Eligibility Modernization Vendor begins work on Medicaid eligibility for one county. Currently the Departments use a federally approved Random Moment Time Sample methodology in order to appropriately allocate costs across the different programs that the county departments of social/human services administer for both departments. Due to removing many of the Medicaid activities from the county level, there may be a cost shift to other programs that the counties administer requiring additional state resources. While the Department anticipates there will be efficiencies and savings from moving to the Eligibility Modernization Vendor model, there may be some additional costs to the Department of Human Services' County Administration line item from the change in Medicaid activity levels at the county departments. The Departments would hire a contractor to assess the magnitude of the changes needed to the current Random Moment Time Sample process as well as identify any potential cost shifts. The Department estimates the cost for this contractor would be $100,000 in FY 2009-10. Once these issues have been better

identified, the Departments would address these issues through the normal budget process, including budget amendments and future supplemental requests.

Virtual Application Gateway

In an effort to help streamline the application process and provide alternate locations for clients to apply for Medicaid and Children's Basic Health Plan through the mail-in application process, the Department proposes to develop a Virtual Application Gateway. This gateway would be similar to the presumptive eligibility determination system for children and pregnant women that was developed in the Colorado Benefits Management System. The complete application for Medicaid and Children's Basic Health Plan could be completed electronically and submitted to a vendor through the Colorado Benefits Management System. Further, the system could be used to provide updated information or to process redeterminations. The Virtual Application Gateway would be primarily used by hospitals, community health centers and other health care providers. The Department would require that only providers or users certified and trained by the Department could participate in the eligibility application process by assisting clients to electronically apply for coverage and manually process signature pages and income verification.

Under the current process, providers who assist clients with facilitated enrollment and presumptive eligibility must submit a hard copy of the Medical Assistance Application to a county department of human/social services for final approval. This process can require multiple mailings and phone calls to verify that the application is complete and that the county department of human/social services has begun processing the application. Under this proposal applicants seeking care in their facilities, providers would have the ability to enter applicant data, check for prior eligibility, obtain applicant signatures on all necessary forms and forward income verification data to a vendor. This represents an additional processing workload for providers. However, many providers have already indicated that they are open to absorbing the increased workload, staffing and additional processing costs in order to facilitate a properly completed application and to obtain a more timely determination for eligibility.

The Department expects that the Virtual Application Gateway would have a logical sequencing that would guide the worker through a series of questions to obtain the necessary data to process eligibility in an automated fashion. Questions, for which the answer was not known, could generate an easy-to-understand, comprehensive request for verification that detailed necessary information needed for each household member. By using a "logic tree", only appropriate and necessary questions would be asked. Information would be gathered once, at a single point of contact. In addition, this would aid workers by removing the necessity for the worker to remember which, if any, additional questions should be asked in specific circumstances.

The Department anticipates that the development of the Virtual Application Gateway would have similar technical requirements to the development of presumptive eligibility. Based on the total cost to implement presumptive eligibility for children and pregnant women in the Colorado Benefits Management System, the Department estimates that the development and programming time, additional user licenses, and hardware would cost $900,000 in total funds for implementation. Since the project would not begin until a Eligibility Modernization Vendor was selected, the Department has allocated 20% of the costs, or $180,000 in FY 2009-10 and the remainder of the costs, $720,000, in FY 2010-11. The estimated annual cost of ongoing maintenance of $50,000 is expected in FY 2011-12.

Personnel Support

Currently the work associated with the selection of the RFP Vendor, Public Knowledge, LLC, as well as the convening of the group of stakeholder representatives and the drafting of the request for information process have been absorbed by existing Department staff. Managing the Public Knowledge contract, the stakeholders group, the request for information process, the request for proposals for the Eligibility Modernization Vendor, and managing the transition to the new model over several fiscal years will require additional resources that the Department did not request in the Department's February 15, 2008 request, S-1A and BA-A1A, "Building Blocks to Health

Care Reform." To move the project forward, Department has assigned various duties to different staff, which has fragmented responsibilities and creates a situation where numerous staff attend the same meetings. In the long run, due to the magnitude of this program, the Department will need several contract managers and other staff who have dedicated oversight and various other responsibilities related to the Eligibility Modernization Vendor. Starting in FY 2009-10, the Department believes that there needs to be a single project manager whose sole responsibility is the coordination of the various contracts and monitoring of the vendors' performance. Further, this individual will be responsible for delivering and monitoring timelines, product deliverables, and transition to the new model. Having a dedicated employee to manage this project and transition will alleviate the need to assign these duties to other staff who already maintain a heavy workload and will provide more continuity and stability as the Department transitions to a new model. As such, the Department is requesting a 1.0 FTE at the General Professional IV level to serve as project manager. In addition, the Department envisions that the Department's current staff, such as those who administer the Children's Basic Health Plan eligibility and enrollment contract and those who work with county department of human services and medical assistance sites, would be reassigned to provide adequate oversight of the Eligibility Modernization Vendor.

Additionally, as eligibility processes are modernized, the Department will realign staff in its Colorado Benefits Management System section. However, starting in FY 2009-10 the Department will need additional FTE. The oversight of the realignment of the Colorado Benefits Management System and the development and maintenance of the Virtual Application Gateway would require technical assistance in the form of two additional FTE at the General Professional IV level. These FTE would implement technology changes and enhancements, trouble-shoot technological problems, and provide solutions for system adjustments as needed. Processes performed by the 2.0 FTE would include but are not limited to the following:

- Monitor software performance and operations to ensure performance as designed.
- Monitor operations of the system to assure that it meets all design parameters, all expected reports are accurate and produced according to established schedules.

- Maintain system documentation by ensuring it is updated, complete, and accurate to reflect the system.
- Maintain a good understanding of the decision support system to provide ad-hoc information when called upon; coordinate creation of ad-hoc and production decision support system reports with end-users and Department reporting staff.
- Schedule and conduct evaluation of the Colorado Benefits Management System design documentation; approve or disapprove, or initiate modifications of the design and other interfaces with it. Failure to accurately assess impacts to designs can create significant rework or wasted effort incurring extra expenditures by the Department.
- Review all Colorado Benefits Management System changes to determine impacts on new approach to eligibility, the Virtual Application Gateway, and Department rules and policies.
- Follow defined Department change management processes.
- Coordinate with other staff, including vendor information technology staff, a variety of Department policy staff, and other Department information technology personnel to develop solutions to policy changes.
- Prepare project reporting and timely statistics on development progress.
- Use Department defined project management processes to control system changes through requirements, design, development, testing, and implementation phases.
- Develop test scenarios and approve test results for movement of changes into production environment.
- Develop required changes to the application and the decision tables to solve changing business needs.
- Work with Departmental policy staff who are responsible for the Medicaid program and the Children's Basic Health Plan to assure all eligibility rules and regulations are handled timely and accurately.

- Coordinate teams to develop both system and operational solutions to new policies and rules.
- Work with the Department of Human Services staff and the federal Centers for Medicare and Medicaid Services staff to maintain a certified eligibility determination system.

Consequences if Not Funded:

The Department would be unable to build capacity and modernize the current eligibility determination process by not implementing an automated customer contact center and create an electronic document and workflow management system. This would hinder the Department's efforts in future health care reform and expansion. Without a single state-level entity responsible for eligibility determinations, the Department would be less likely able to create an outcomes-focused and client-centered system. Without a single entity responsible for eligibility determinations, the Department would not be able to leverage its efforts to expedite the application process with enhanced customer service access to information and assistance, but would, instead, continue with the current less effective and less efficient processes.

The Department is committed to improving cost-efficiency, quality, and access to health care, and taking a realistic, building-block approach to making progress toward covering more of the uninsured. As the Department finds efficiencies in the system, cuts waste and brings more transparency to the system, it can reinvest those savings toward coverage and access. The Department views each of the steps outlined in this Change Request as critical in order to prepare for broader health care reform in the State of Colorado. Under the current structure for eligibility and the provision of services, the Department will not be able to keep pace with large shifts in enrollment and the expansion of benefits. Failure to fund analysis and support of eligibility systems infrastructure is likely to result in a destabilized system environment that will significantly reduce the Department's ability to meet its state and federal obligations to determine eligibility for health care programs. The administrative and systems barriers to enrollment must be addressed before the Department can expand coverage for children and families; to increase eligibility but then continue to make it difficult for families to enroll their children and for those children to get health care is counter-productive.

Calculations for Request:

Table 1: Summary of Request

Summary of Request FY 2009-10	Total Funds	General Fund	Federal Funds	FTE
Total Request	$7,528,132	$3,591,238	$3,936,894	2.8
(1) Executive Director's Office; (A) General Administration, Personal Services	$174,304	$83,070	$91,234	2.8
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$18,534	$8,830	$9,704	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Contracts	$100,000	$47,854	$52,146	0.0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	$7,741,136	$3,704,405	$4,036,731	0.0
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration	($505,842)	($252,921)	($252,921)	0.0

Table 1: Summary of Request (continued)

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Total Request	$14,799,666	$8,870,580	($1,371,857)	$7,300,943	3.0
(1) Executive Director's Office; (A) General Administration, Personal Services	$190,150	$90,622	$0	$99,528	3.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$2,850	$1,359	$0	$1,491	0.0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	$22,572,998	$10,801,970	$0	$11,771,028	0.0
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration	($4,046,742)	($2,023,371)	$0	($2,023,371)	0.0
(4) Indigent Care Program; Children's Basic Health Plan Administration	($3,919,590)	$0	($1,371,857)	($2,547,733)	0.0

Table 2: County Administration Key Cost Drivers

Key Cost Driver	**Activities/Processes Included**
Intake	Failed intake after application initiation or interactive interview; completed intake
Case Related Activities	Change in circumstances as reported by the client, alerts management, case reviews, seeking/receiving assistance
Client Communications and Information	Communications and Information
Administrative Activities (Non-case Related)	Administrative support activities; reports management; breaks; training; meetings; materials development; non-activity (case) specific reading (e.g. read regulations, policy and rules)
Eligibility Recertification (RRRs) and Periodic Reporting	Completed periodic reporting; discontinued or completed recertification, reverification, redetermination (RRR)
Management Activities	Personnel management; counseling; office operations
Claims	Investigation; claims research; establishment; recovery
Other	Electronic benefits transfer issuance; inter-county transfers; appeals and hearings; referrals; travel; Adult Protective Services activities

Table 3: Calculation of New Cost Levels

Key Cost Driver	Percentage of Total Medicaid Administration Costs	Total Level of Cost (inflated to FY 2010-11)	Estimated Reduction in Cost	New Cost Levels
Case Related Activities	29.62%	$13,057,346	50%	$6,528,673
Client Communications and Information	22.74%	$10,024,444	50%	$5,012,222
Intake	20.42%	$9,001,722	30%	$6,301,205
Eligibility Recertification (RRRs) and Periodic Reporting	13.29%	$5,858,613	80%	$1,171,723
Administrative Activities (Non-Case Related)	9.59%	$4,227,547	50%	$2,113,774
Management Activities	3.22%	$1,419,468	50%	$709,734
Other	1.12%	$493,728	50%	$246,864
Total		**$44,082,868**		**$22,084,195**

Table 4: Estimated County Administration Funding Under Eligibility Modernization Vendor Model

Row	Item	Amount	Comments
A	Estimated County Administration, Medical Assistance Costs Without Eligibility Modernization Vendor	$44,082,868	Costs as presented in the Colorado Workload Study Project, March 2007. The costs included activities related to Medicaid eligibility activities, and have been inflated using the growth in Medicaid and CBHP caseload and the Consumer Price Index for Urban Wage Earners and Clerical Workers.[2]
B	Estimated County Administration, Medical Assistance Costs With Eligibility Modernization Vendor	$22,084,195	Assumes an overall reduction of 50% in the costs included activities related to Medicaid eligibility activities.
C	Percent of County Administration Costs Covered by County Administration Payment (General Fund plus federal funds)	70%	Based on actual cash payments made to counties through the Colorado Financial Reporting System as compared to actual costs estimated in the Colorado Workload Study Project.
D	Estimated County Administration Payment (General Fund and Federal Funds)	$15,458,937	Row B * Row C. Based on the FY 2007-08 cash payments to counties for Medicaid eligibility activities, with 20% of General Fund FY 2007-08 remaining in the cash payments and 50% Federal Fund covering county administration costs.
E	Federal Funds for Remaining for County Administration Under New Model	$11,042,098	Row B * 0.5 (Assuming a 50% federal match on total costs), need this amount to maintain paying the counties 70% of cost.
F	FY 2007-08 Appropriation	$7,248,943	FY 2007-08 Long Bill, SB 07-239
G	General Fund Transfer from Department of Human Services for FY 2007-08	$2,226,323	Based on data from the Colorado Financial Reporting System (COFRS)
H	Total Level of General Fund for FY 2007-08	$9,475,266	Row F + Row G

[2] The Department assumed growth in caseload using total forecasted caseload for both Medicaid and the Children's Basic Health Plan from the Department's November 3, 2008 Budget Request. For each of the fiscal years, the Department used the Consumer Price Index for Urban Wage Earners and Clerical Workers of 4.3% (March 2007 and 2008).

Table 5: Estimated General Fund Remaining In County Administration Under Eligibility Modernization Vendor Model

Row	Item	FY 2009-10	FY 2010-11	FY 2011-12	Comments
A	Amount of General Fund Needed for County Administration Under the New Model	$4,416,839	$4,416,839	$4,416,839	Table 4 Row D - Table 4 Row E. To maintain the cash payment to the county departments of social/human services at 70% of estimated cost, General Fund accounts for 20% of the total. (Assumes funding level for County Administration remains the same).
B	Amount of General Fund Available to Shift For Eligibility Modernization Vendor	$5,058,427	$5,058,427	$5,058,427	Table 4 Row H - Row A. This General Fund amount can be transferred to offset some of the costs for the Centralized Administrative and Accountability Model for Eligibility and Enrollment Processes.
C	Percent of General Fund Shifted Eligible from County Administration to Offset Eligibility Modernization Vendor Cost	5%	40%	80%	Corresponds to annual average of caseload to be assumed by Eligibility Modernization Vendor. See narrative for assumptions.
D	General Fund Shifted Eligible from County Administration to Offset Eligibility Modernization Vendor Cost	$252,921	$2,023,371	$4,046,742	Row B * Row D
E	Total Amount to Offset (General Fund and Federal Funds)	$505,842	$4,046,742	$8,093,484	Row D * 2 (Assumes 50% federal match)
F	Total Amount of General Fund Remaining in County Administration Line Item	$9,222,345	$7,451,895	$5,428,524	Table 4 Row H - Row D

Table 6: OSPB Common Policy for FTE Requests

Fiscal Year(s) of Request		**FY 2009-10**	**FY 2010-11**
PERSONAL SERVICES	**Title:**	**General Professional IV**	
Number of PERSONS / class title		3	3
Number of months working in FY 08-09, FY 09-10 and FY 10-11		12	12
Number months paid in FY 08-09, FY 09-10 and FY 10-11[1]		11	12
Calculated FTE per classification		**2.8**	**3.0**
Annual base salary		$56,795	$56,795
Salary		$156,186	$170,385
PERA	**10.15%**	$15,853	$17,294
Medicare	**1.45%**	$2,265	$2,471
Subtotal Personal Services at Division Level		**$174,304**	**$190,150**
OPERATING EXPENSES			
Supplies @ $500/$500[2]	**$500**	$1,500	$1,500
Computer @ $900/$0	**$900**	$2,700	$0
Office Suite Software @ $330/$0	**$330**	$990	$0
Office Equipment @ $3,998/$0 (includes cubicle and chair)	**$3,998**	$11,994	$0
Telephone Base @ $450/$450[2]	**$450**	$1,350	$1,350
Other[3,4]			
Other[3,4]			
Other[3,4]			
Subtotal Operating Expenses		**$18,534**	**$2,850**
GRAND TOTAL ALL COSTS		**$192,838**	**$193,000**

Table 7: Fund Splits for FTE Personal Services and Operating Expenses

FY 2009-10	Program	Total Funds	General Fund	Federal Funds
Personal Services	Medicaid	$147,087	$73,544	$73,543
	Children's Basic Health Plan	$27,217	$9,526	$17,691
Subtotal		$174,304	$83,070	$91,234
Operating Expenses	Medicaid	$15,616	$7,808	$7,808
	Children's Basic Health Plan	$2,918	$1,022	$1,896
Subtotal		$18,534	$8,830	$9,704
Total		**$192,838**	**$91,900**	**$100,938**
FY 2010-11	**Program**	**Total Funds**	**General Fund**	**Federal Funds**
Personal Services	Medicaid	$160,459	$80,230	$80,229
	Children's Basic Health Plan	$29,691	$10,392	$19,299
Subtotal		$190,150	$90,622	$99,528
Operating Expenses	Medicaid	$2,401	$1,201	$1,200
	Children's Basic Health Plan	$449	$158	$291
Subtotal		$2,850	$1,359	$1,491
Total		**$193,000**	**$91,981**	**$101,019**

Table 8: Eligibility Modernization Fund Splits

FY 2009-10	Total Funds	General Fund	Cash Funds	Federal Funds
Costs				
Eligibility Modernization Vendor	$7,741,136	$3,704,405	$0	$4,036,731
FTE Costs	$192,838	$91,900	$0	$100,938
Contractor Costs	$100,000	$47,854	$0	$52,146
Offsets				
County Administration	($505,842)	($252,921)	$0	($252,921)
Total	**$7,528,132**	**$3,569,703**	**$0**	**$3,913,429**
FY 2010-11	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**
Costs				
Eligibility Modernization Vendor	$22,572,998	$10,801,970	$0	$11,771,028
FTE Costs	$193,000	$91,981	$0	$101,019
Offsets				$0
County Administration	($4,046,742)	($2,023,371)	$0	($2,023,371)
CBHP Administration (Eligibility Contract)	($3,919,590)	$0	($1,371,857)	($2,547,733)
Total	**$14,799,666**	**$8,870,580**	**($1,371,857)**	**$7,300,943**
FY 2011-12	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**
Costs				
Eligibility Modernization Vendor	$31,525,270	$15,085,946	$0	$16,439,324
FTE Costs	$193,000	$91,981	$0	$101,019
Offsets				
County Administration	($8,093,484)	($4,046,742)	$0	($4,046,742)
CBHP Administration (Eligibility Contract)	($3,919,590)	$0	($1,875,661)	($2,043,929)
Total	**$19,705,196**	**$11,131,185**	**($1,875,661)**	**$10,449,672**

* General Fund portion for Medicaid-related costs is 50% of the total. General Fund portion for CBHP-related costs is 35% of the total funds. The Department estimates that the total General Fund Share, based on a weighted average of Medicaid and CBHP costs, is 47.85% of the total.

Table 9: Summary of Eligibility Modernization Funding

Eligibility Modernization Vendor Model		**FY 2009-10**	**FY 2010-11**	**FY 2011-12**
Vendor Startup Costs		$1,000,000	$0	$0
Electronic Document Management		$700,000	$2,100,000	$3,500,000
Customer Contact Center		$1,750,000	$3,500,000	$3,500,000
Medicaid Eligibility and Enrollment Personnel		$3,585,028	$10,755,084	$17,925,140
CBHP Eligibility and Enrollment Personnel		$0	$3,919,590	$3,919,590
Personnel Operating		$152,600	$457,800	$763,000
Contractor Leased Space		$294,000	$882,000	$1,470,000
Increased Postage		$79,508	$238,524	$397,540
Virtual Application Gateway		$180,000	$720,000	$50,000
Personnel Support (3.0 FTE)		$192,838	$193,000	$193,000
Total		**$7,933,974**	**$22,765,998**	**$31,718,270**
Contract to Assess Impact to Other Programs Administered by the County Departments and Department of Human Services		$100,000	$0	$0
Offsets				
County Administration		($505,842)	($4,046,742)	($8,093,484)
CBHP Eligibility and Enrollment Personnel		$0	($3,919,590)	($3,919,590)
Total Offsets		**($505,842)**	**($7,966,332)**	**($12,013,074)**
Grand Total Eligibility Modernization		**$7,528,132**	**$14,825,985**	**$19,733,877**

Cash Funds Projections:

Cash Fund Name	Cash Fund Number	FY 2007-08 Expenditures	FY 2007-08 End of Year Cash Balance	FY 2008-09 End of Year Cash Balance Estimate *	FY 2009-10 End of Year Cash Balance Estimate *	FY 2010-11 End of Year Cash Balance Estimate *
Children's Basic Health Plan Trust	11G	$120,907,223	$9,231,077	$5,463,582	($21,746,716)	($28,734,729)

* Cash Balance Estimates do not incorporate the impact of any Change Requests.

Assumptions for Calculations: The division of costs between the Medicaid program and the Children's Basic Health Plan is based on a ratio of each program's forecasted caseload to the total forecasted caseload for both programs.

The Department assumes 50% federal financial participation for Medicaid funding. The Department also assumes 65% federal financial participation for the Children's Basic Health Plan contribution to the line items. The State share of the Children's Basic Health Plan funding has been assigned to General Fund rather than Cash Funds due to the limited funding available from the Children's Basic Health Plan Trust Fund.

The total funding needed for 3.0 FTE is based on the calculation spreadsheet provided by The Governor's Office of State Planning and Budget for all additions of FTE.

Bailit Health Purchasing, one of the consultants, has reviewed and confirmed the estimated costs for the start up and phase in of the Eligibility Modernization Center as shown in Table 1. Public Knowledge, LLC will review the costs again as they continue their assessment.

Impact on Other Government Agencies: The expenditures for this request would occur only within the Department of Health Care Policy and Financing; however, this request has unknown operational and potential fiscal impacts to the Department of Human Services. The Department of Health Care Policy and Financing is collaborating with the Department of Human Services to explore these unknown impacts and assist the Department of Human Services with any operational and

potential fiscal impacts this proposed change would bring. This request proposes to use a portion of the funding to hire a contractor to investigate how the Department of Human Services would be impacted from a fiscal perspective. The primary fiscal unknowns are regarding the effects on the current Random Moment Time Sampling process and potential impacts to the federal funding sources at the Department of Human Services.

Cost Benefit Analysis:

Cost	$7,528,132 in FY 2009-10, and $14,799,666 in FY 2010-11
Benefit	Builds support for increased capacity of future health care expansion for new programs.
Benefit	Insures support for expedited processing of online eligibility applications with less dependence on paper applications.
Benefit	Enlarges support for a more consumer friendly interface with Colorado citizens.
Benefit	Creates support for additional future technical efficiencies.
Benefit	Relieves heavy burden on county departments of human services/social services.

Implementation Schedule:

Main Task	Start	Complete
Develop request for proposals for a RFP Vendor	January 15, 2008	February 15, 2008
Release request for proposals for a RFP Vendor	February 21, 2008	April 22, 2008
Revised request for proposals for a RFP Vendor issued	March 26, 2008	April 22, 2008
Responses due from RFP Vendor	April 22, 2008	April 22, 2008
Award of RFP Vendor contract to Public Knowledge, LLC	May 13, 2008	May 13, 2008
Draft and negotiate RFP Vendor contract	May 14, 2008	June 30, 2008

Main Task	Start	Complete
Develop request for information for a Modernized Eligibility Administrative and Accountability Model for Eligibility and Enrollment Processes	May 15, 2008	August 12, 2008
Stakeholders group including clients, client advocates, county representatives and other eligibility experts was assembled	June 5, 2008	ongoing
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	July 3, 2008	July 3, 2008
RFP Vendor contract executed	August 1, 2008	June 30, 2009
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	August 7, 2008	August 7, 2008
Request for information for Eligibility Modernization Vendor released	August 13, 2008	September 10, 2008
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	September 4, 2008	September 4, 2008
Review request for information responses from RFP Vendor	September 11, 2008	October 15, 2008
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	October 2, 2008	October 2, 2008
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	November 6, 2008	October 6, 2008
Reports released November 28, 2008 – Review of business processes, including assessment of other states and best practice review.	November 28, 2008	November 28, 2008
Stakeholder input and review on request for proposals for Eligibility Modernization Vendor	December 1, 2008	January 31, 2009
Proposals due from Eligibility Modernization Vendor	December 2, 2008	December 2, 2008
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	December 4, 2008	December 4, 2008
Develop request for proposals for Eligibility Modernization Vendor	January 1, 2009	February 28, 2009

Main Task	Start	Complete
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	January 8, 2009	January 8, 2009
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	February 5, 2009	February 5, 2009
Release request for proposals for Eligibility Modernization Vendor	March 1, 2009	May 15, 2009
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	March 5, 2009	March 5, 2009
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	April 2, 2009	April 2, 2009
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	May 7, 2009	May 7, 2009
Review Responses from Eligibility Modernization Vendor RFP	May 15, 2009	June 30, 2009
Stakeholders group including clients, client advocates, county representatives and other eligibility experts monthly meeting	June 4, 2009	June 4, 2009
Intent to award Eligibility Modernization Vendor contract	July 1, 2009	July 1, 2009
Draft and negotiate Eligibility Modernization Vendor contract	July 15, 2009	September 30, 2009
Eligibility Modernization Vendor contract executed	October 1, 2009	December 31, 2014
Eligibility Vendor begin systems development (phone/call center, database/archive) and general start-up activities	October 1, 2009	December 31, 2009
Eligibility Modernization Vendor begins work Medicaid eligibility for one county	January 1, 2010	March 31, 2010
Eligibility Modernization Vendor begin Medicaid Eligibility transition for 20 percent of caseload	April 1, 2010	June 30, 2010
Eligibility Modernization Vendor begin CHP+ contract work	July 1, 2010	December 31, 2014
Eligibility Modernization Vendor begin Medicaid eligibility transition for 60 percent of caseload	July 1, 2010	June 30, 2011

Main Task	Start	Complete
Eligibility Modernization Vendor begin Medicaid eligibility transition for 100 percent of caseload	July 1, 2011	June 30, 2012
Eligibility Modernization Vendor continue Medicaid eligibility for 100 percent of caseload	July 1, 2012	December 31, 2014

Statutory and Federal Authority:

24-1-107, C.R.S. (2008) Internal organization of department – allocation and reallocation of powers, duties, and functions – limitations. *In order to promote economic and efficient administration and operation of a principal department and notwithstanding any other provisions of law, except as provided in section 24-1-105, the head of a principal department, with the approval of the governor, may establish, combine, or abolish divisions, sections, and units other than those specifically created by law and may allocate and reallocate powers, duties, and functions to divisions, sections and units under the principal department, but no substantive function vested by law in any officer, department, institution, or other agency within the principal department shall be removed from the jurisdiction of such officer, department, institution, or other agency under provisions of this section.*

25.5-1-104 (2) (4), C.R.S. (2008) Department of health care policy and financing created – executive director – powers, duties, and functions… (2) *The department of health care policy and financing shall consist of an executive director of the department of health care policy and financing, the medical services board, and such divisions, sections, and other units as shall be established by the executive director…* (4) *The department of health care policy and financing shall be responsible for the administration of functions and programs as set forth in this title.*

25.5-4-204 (1) (b), C.R.S. (2008) Automated medical assistance administration. *(1) The General Assembly hereby finds and declares that the agency responsible for the administration of the State's medical assistance program would be more effective in its ability to streamline administrative functions of program administrators and providers*

under the program through the implementation of an automated system that will provide for the following:…(b) On-line eligibility determinations.

25.5-4-206, C.R.S. (2008) Reimbursement to counties – costs of administration. *The State Department shall reimburse the county departments for costs of administration incurred by the counties under this article and articles 5 and 6…*

25.5-5-101 (1), C.R.S. (2008) Mandatory provisions – eligible groups. *(1) In order to participate in the Medicaid Program, the federal government requires the State to provide medical assistance to certain eligible groups…*

Performance Measures:

This request will help to provide more administrative resources in order to support nearly all of the Department's Performance Measures, including those that are aligned with the Governor's *The Colorado Promise*:

- Increase the number of clients served through targeted, integrated care management programs.
- Increase the number of children served through a dedicated medical home service delivery model.
- Increase the number of managed care options for clients enrolling in Medicaid.
- Increase the number of clients enrolled in viable managed care options.
- Improve access to and quality of Medicaid health care as demonstrated through improvements in Medicaid Health plan scores on Health Plan Employer Data Information Set (HEDIS) measures.