Governor Jared Polis
FY 2026-27 Funding Request

Kim Bimestefer, Executive Director
Department of Health Care Policy and Financing
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Department Priority: R-07
Driving Efficiencies in Benefit Service Delivery - Shared Services

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	$397,588,852	$16,626,704	$40,834,345
General Fund	$100,180,482	$1,503,264	$2,725,588
Cash Funds	$55,397,456	$1,560,567	$3,784,672
Reappropriated Funds	$17,713,083	$2,455,447	$7,950,874
Federal Funds	$224,297,831	$11,107,426	$26,373,211
FTE	795.6	3.0	3.0

Summary of Request

Problem or Opportunity
Forthcoming changes to federal programs supervised by the Department and the Colorado Department Human Services (DHS) increase concerns about the ability of Colorado's current county-administered model to meet the needs of the state's most vulnerable citizens. The supplemental component of this request is a result of an unforeseen contingency due to recent and forthcoming changes in federal regulation requiring the Department to implement some components of this request starting in FY 2025-26.

Proposed Solution
The Department, in collaboration with DHS, proposes to centralize - through a contract with one county - various administrative functions and optimize requirements and best practices across all counties. Both departments will partner to deliver solutions that provide relief to counties statewide that modernize current administration processes with an emphasis on increasing efficiency, reducing costs and creating sustainability.

Fiscal Impact of Solution
The Department requests $636,866 total funds, including $206,979 General Fund and 1.0 FTE in FY 2025-26, $16.6M total funds, including $1.5M GF and 3.0 FTE in FY 2026-27, and $40.8M total funds, including $2.7M General Fund and 3.0 FTE in FY 2027-28.

Requires Legislation	Colorado for All Impacts	Revenue Impacts	Impacts Another Department?	Statutory Authority
Yes	Positive	No	Yes Department of Human Services	25.5-1–115, C.R.S.

Background and Opportunity

When the federal government established the Medicaid program in 1965, each state was allowed to structure the program based on the state's needs, under the oversight and supervision of the single state agency (42 CFR Part 431.10). Based on the needs, the state could choose to administer eligibility and enrollment at the state-level (called state administration) or to delegate those functions to political subdivisions. At that time, Colorado elected to delegate eligibility and enrollment activities, and related functions, to the state's 64 counties, as administered by the 64 county departments of human services (42 CFR Part 431.11) Even with this delegation in place, the state itself, not the counties, is still accountable to the federal government for all activities under this supervision.

In Colorado, this is referenced as the state-supervised, county-administered system (county administration), which has been in place with minimal changes since the 1969 state implementation of Medicaid. The reasoning for this system being adopted by Colorado was for the eligibility and enrollment costs of federal programs, like Medicaid and the Supplemental Nutrition Assistance Program (SNAP), to be shared between counties and the state, with counties contributing a portion of those costs.

For context, more than 80% of states nationwide have centralized or regionalized functions for eligibility at the state-level, while the remainder are county-administered systems. However, even within those other county-administered systems, other states, such as Wisconsin and North Dakota, have either centralized certain eligibility and enrollment functions, or regionalized their county departments into groupings, to drive efficiencies. To date, Colorado has not centralized any county administered member eligibility functions beyond returned mail.

However, as Medicaid and other federal programs have evolved both nationally and within the state, the county administered system has struggled with meeting the expectations of both the federal and state government and with continually increasing costs to the General Fund. The current county administration system requires all counties to perform all eligibility and related administrative duties with disparate resources, salaries, staffing, etc. This is true regardless if a county has 500 people or 500,000 people. This potentially creates inequities as not all counties may have the local dollars necessary to draw down federal and state funds that would help them meet federal and state expectations, while providing all of the services an applicant or member is eligible to receive.

Additionally, the costs for the counties continue to grow. The General Assembly appropriated an additional $21 million in new HCPF county administration funding in the most recent legislative session. That increase in funding was based on the SB 22-235 Funding Model, where the General Assembly requested to understand the total amount of funding needed to administer medical assistance programs. Even with being funded at the level identified in the Funding Model, the county administered system continues to grow more costly year after year.

On April 11, 2025, within weeks of the General Assembly approving the $21 million in increased funding, the Colorado Human Services Directors Association (CHSDA) and Colorado Counties, INC (CCI) sent a letter to the Joint Budget Committee requesting an additional $56.3 million in funding to cover the current fiscal year, based on the current structure of the county administration program. That request did not account for the federal changes directed under H.R.1, the One Big Beautiful Bill Act.

Forthcoming changes to federal programs supervised by the Department and the Colorado Department Human Services (CDHS) increase concerns about the ability of Colorado's current county-administered model to meet the needs of the state's most vulnerable citizens.

Greatly increased/new work requirements, twice yearly renewals, and decreased funding are among some concerns for Colorado's important support programs such as Medicaid, Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). Additionally, a greater emphasis on Fraud, Waste and Abuse (FWA) by the federal government creates new challenges that would be difficult for the current system structure to address, demanding states (and counties) financially contribute more, creating General Fund pressure. These federal policy changes will increase the burden on counties that may already be struggling to meet state and federal requirements, growing staffing challenges, and strained budgets.

Beyond the federal challenges mentioned, the current county system already struggles with a structure that requires all counties to do all things, from eligibility, to quality assurance and client/member accuracy, errors, and fraud investigations, without sufficient funding support in place. There is concern of the ability of the General Fund to adequately support funding needs for all counties to meet federal and state requirements. And lastly, it can be challenging for the counties to come up with local funding to draw down federal and state dollars.

Proposed Solution and Anticipated Outcomes

The Department requests $636,866 total funds, including $206,979 General Fund and 1.0 FTE in FY 2025-26, and $16,626,704 total funds, including $1,503,264 General Funds and 3.0 FTE in FY 2026-27, and $40,834,345 total funds, including $2,725,588 General Fund and 3.0 FTE in FY 2027-28 to centralize - through a contract with one county - various administrative functions and optimize requirements and best practices across all counties. The Department, along with CDHS, will partner to deliver solutions that provide relief to counties statewide that modernize current administration processes with an emphasis on increasing efficiency, reducing costs and creating sustainability. It is critical that the State implement solutions that drive towards cost

avoidance and cost control, as the current county administered system model continues to see a need for more funding appropriated, with no end in sight.

The Department proposes to make changes to drive efficiencies and effectiveness, address county performance concerns, and address member and provider service experience inconsistencies within the current benefit service delivery system. Ultimately, success will be measured by a commitment to ensuring these efforts have positive outcomes for the millions of Coloradans in need, and are supported by best practices found in other county-administered systems and recommendations of the SB 22-235 report.

Specifically, the requested funding would allow the Department to implement four centralized shared services across all counties, including a Tier 1 Call Center, Medical Assistance Quality Assurance unit, Member Case Integrity unit, and Central Scanning unit. Shared services would support all counties in that specific function, alleviating the county departments of those duties, while still providing support to applicants and members and addressing federal compliance. These would help address disparities across counties and provide members with consistent services no matter which county they receive services in. Secondly, the Department requests to repurpose funding from its County Incentive Program, Colorado Medical Assistance Program (CMAP) and Eligibility Assistance Partner (EAP) Sites line items in order to use State funding more efficiently and to help offset the costs of the shared services model. Lastly, the funding would allow the Department to hire contractors to support the move to shared services, including project management support, change management and business process mapping vendors. These contractors would be essential in the planning and implementation of shared services and the move to maintenance and operations post-implementation.

Centralize Functions Across All Counties (Through a Contract with One County)

The Department proposes to centralize - through a contract with one county - certain eligibility and administrative functions across all 64 counties and Medical Assistance (MA)/ Eligibility Application Partner (EAP) sites and provide county support for compliance and call centers. To do this, the Department proposes the following initiatives.

<u>Tier 1 Call Center Shared Service</u>

Currently, the Big 11 counties each have their own formal call center, in which county call center agents utilize a county-provided system (funded with state and federal dollars) to take eligibility-related calls. Each of these counties uses its own call center system, causing challenges with interoperability and the integrity of data. The remaining 53 counties do not have formal call centers, and either eligibility technicians directly answer calls (pulling them away from processing work) or those calls are managed by front desk staff. The disparate experience across call center and non-call center counties creates potential inequities in service delivery and administration, which is expressly prohibited under Medicaid federal regulations (42 CFR Part 431.50 (b)(1)).

The Department requests $10,947,184 total funds, including $1,600,188 General Fund and 1.0 FTE in FY 2026-27 to create a statewide Tier 1 Call Center (T1 Call Center). The intent of the

T1 Call Center is to aggregate all county call center agents into one team that takes eligibility calls on behalf of all counties and all CBMS programs. The Department would contract with one best-in-class county to manage daily operations of the T1 Call Center, under supervision from the Department. The T1 Call Center would also leverage technology approved in the Department's FY 2025-26 R7 County Administration and CBMS Enhancements budget request by implementing an Interactive Voice Response (IVR) system that would automate the delivery of easy-to-access information to callers. When the IVR system cannot answer the question of a caller, the call would then flow into the T1 Call Center.

Additionally, counties would then be required to administer a Tier 2 Call Center (T2 Call Center). The T2 Call Center at the counties would be utilized when neither the IVR system nor the T1 Call Center can successfully resolve the caller's issue. T2 Call Centers would be staffed by existing county call center staff.

The T1 and T2 Call Centers would utilize the Department's existing call center system, creating efficiencies. The Department anticipates that the T1 Call Center will help mitigate any federal risk of non-compliance with call center wait times. During the Public Health Emergency (PHE), CMS took action against states with long call center wait times, arguing that those wait times presented barriers to accessing eligibility services in violation of federal regulation. With the pending implementation of Work Requirements, the Department anticipates county call volumes will be impacted and that individual counties will not have the resources to adequately handle those calls, therefore creating financial risk to the state.

To ensure that the T1 Call Center would be adequately staffed, the Department calculated the T1 Call Center FTE need based on the Erlang Calculator, using existing county self-reported data from the 11 county call centers reporting to the Department. The Erlang Calculator (also known as the Erlang C Formula) is a well-known, documented tool used by numerous call center operations to calculate the total number of agents needed based on available data, including call volume, average handle time and average speed to answer. As such, the Department determined a need for 291 T1 Call Center staff, including agents, supervisors, trainers and administrators.

- 251 FTE - Call Center Agents (Administrator III): these agents would be responsible for directly answering calls that are unable to be answered by the IVR system and would have direct interaction with applicants and members.
- 20 FTE - Call Center Supervisors (Administrator IV): to appropriately supervise the 251 Call Center Agents FTE, the Department assumes the need for approximately 20 supervisors, which is slightly higher than the industry standard of 15 agents per supervisor. The complexity of cases that will come to the T1 Call Center will require additional supervisor support to manage.
- 20 FTE - Call Center Administration/ Managers (Administrator V): in addition to supervisors, the T1 Call Center needs appropriate staffing to conduct quality assurance activities, manage internal call center operations and appoint a leadership team to manage the T1 Call Center shared service.

The Department assumes that the average handle time (AHT) would be 15 minutes and the average speed of answer (ASA) would be 5 minutes or less. Activities include accepting applications, renewals and case changes over the phone, in addition to answering member or applicant questions about their case. Frequent questions coming into county call centers include calls around redetermination dates, whether documents submitted by the caller were received by the county, how much and what type of benefits the caller is receiving, and customer service or discrimination complaints regarding the county and other eligibility-related calls. The Department anticipates that the majority of these types of calls will be handled by the T1 Call Center, reducing the volume of calls that go directly to counties to their T2 Call Center.

The Department requests that this funding is appropriated to a new line item called 'Tier 1 Call Center Shared Service' in section (1) Executive Director's Office, (C) Eligibility Determinations and Client Services of its Long Bill.

Additionally, the Department requests funding for four MCC Call Center Management of System contractors in order to support the systems operations of the T1 Call Center system, which uses the Department's existing call center system. Because new users will be added into the Department's existing system, new Salesforce and administrative support contractors will be needed for systems access requests, user provisioning, systems updates, technical buildouts, maintenance and operations, project coordination and tracking and providing call center technical support to the T1 Call Center county.

Lastly, The Department requests 1.0 state FTE, which would act as a contract administrator and policy specialist for the T1 Call Center, helping manage daily operations. This position would start in FY 2025-26 to lead the contract and procurement efforts to implement this shared service, which will begin in FY 2026-27.

Medical Assistance Quality Assurance Shared Service

Currently, the Department mandates that all counties have a Quality Assurance/Quality Control Plan (Plan) in place. This Plan requires counties to conduct quality assurance activities within each county. The Plan sets minimum requirements for what should be reviewed for eligibility determination quality and how often and how many reviews should occur. However, each county is allowed to use its own technology system to track its case reviews, and while some counties have sophisticated databases, many utilize Excel spreadsheets or other, less-sophisticated tracking mechanisms. Additionally, none of the counties' case reviews align with the federal Payment Error Rate Measurement Program (PERM), which is what determines the state disallowance amount for error rates above 3%. Because of the disparate systems and how differently each county approaches its quality reviews, the federal and state dollars spent on these activities are inefficiently and ineffectively utilized. None of these activities in their current form would help the State avoid PERM disallowances, which could result in hundreds of millions of dollars of federal recoveries.

Therefore, the Department requests $1,502,705 total funds, including $476,881 General Fund and 1.0 FTE to create a centralized Medical Assistance Quality Assurance (MAQA) shared

service. This shared service would be for Medicaid programs only. The intent of this shared service is to aggregate county QA functions into one team that then uses the Department's QA process and system to produce a statistically significant statewide sample size for QA. This data is then used for standard oversight purposes.

By aggregating QA functions into one team that utilizes the Department's process and system, this shared service helps address the federal risk associated with the changes to the federal PERM and the allowable 3% error rate. The Department's current challenge is that it can only review around 1,200 cases annually within its existing resources. With the proposed QA structure, approximately 12,000 cases would be reviewed annually, all input into one QA tracking system (Onspring).

The Department calculated the MAQA unit staffing need based on the Department's member caseload, and how many monthly reviews are needed in order to get a statistically significant sample size. As such, the Department determined a need for 33 QA unit staff, including reviewers, supervisors and administrators.

- 20 FTE - Quality Assurance Reviewers (Administrator III): these reviewers would be responsible for conducting quality assurance reviews per the Department's existing process, using the existing quality assurance tracking system.
- 10 FTE - Quality Assurance Unit Supervisors, Trainers and Quality Liaisons (Administrator IV): to appropriately train and supervise the 20 reviewers, the Department assumes the need for 6 trainers and supervisors. Additionally 4 FTE will act as Quality Liaisons to counties, providing support to address errors in eligibility determination.
- 3 FTE - Quality Assurance Unit Administration/ Managers (Administrator V): in addition to supervisors, the MAQA unit needs appropriate staffing to conduct quality assurance activities, manage operations, and appoint a leadership team to manage the shared service.

The Department requests that this funding is appropriated to a new line item called 'Medical Assistance Quality Assurance Shared Service' in section (1) Executive Director's Office, (C) Eligibility Determinations and Client Services of its Long Bill.

Additionally, the Department requests 1.0 state FTE, which would act as the contract administrator and policy specialist for the MAQA shared service, helping manage daily operations. This position would start in FY 2025-26 to lead the contract and procurement efforts to implement this shared service, which will begin in FY 2026-27.

The Department requests funding for one contractor to manage the state's county compliance database, Onspring, where quality assurance reviews will be completed. The contractor will act as a system administrator, to be used by both the Quality Assurance and Member Case Integrity shared services. For both the Quality Assurance unit and Member Case Integrity unit, this system administrator will build system functionality, dashboards and reporting and documentation tracking aligned with existing processes. The contractor will support county accountability efforts based on QA results. Additionally, the contractor will support member fraud mitigation efforts by producing data and reports that highlight areas of recurring fraud.

Lastly, the Department requests $125,000 total funds in FY 2026-27 in order to build out the State's existing county compliance database, Onspring, for the MAQA Shared Service to conduct quality assurance reviews within the system. Ongoing funding of $62,500 total funds starting in FY 2027-28 would be used for annual license costs, system builds and maintenance and operations.

Member Case Integrity Shared Service

Currently, each county is delegated the responsibility to conduct fraud investigations for MA Program eligibility. The challenge, however, is that there is not a specific appropriation for this function, so counties must choose between adequately funding eligibility processing staff, funding fraud investigations, or finding what the county considers the appropriate balance between the two important tasks. From a practical perspective, this results in the majority of counties not conducting fraud investigations at all. According to county self-report data through FY 2023-24, less than 20 counties actually reported having an active fraud investigation.

During a fraud investigation, if the county is able to recoup money from a member either administratively or through a criminal prosecution, those dollars go towards repaying the federal and state governments for the cost of benefits inappropriately received. If this occurs, current state statute allows the county that conducted the fraud investigation in which the member received services that they were ineligible for to keep those state dollars as an incentive. In the current county-administered funding model, how actively each county pursues member fraud varies widely, with some smaller, but urban, counties reporting more fraud investigations than larger counties with significantly higher caseloads.

As a result, differences in how MA member fraud investigations are administered by each county produces disparate experiences for members and inequities in which members are held accountable for their actions. For instance, a member who may be gaining eligibility fraudulently may have to pay back the costs of their benefits in one county that conducts fraud investigations, but not another county that does not. Essentially, whether a member is held accountable for fraudulently gaining eligibility is dependent on which county they live in, and if that county allocates funding to fraud investigations.

Therefore, the Department requests $4,438,381 total funds, including $867,853 General Fund and 1.0 FTE to create a centralized Member Case Integrity unit. The intent of this shared service is to aggregate member fraud investigators into one statewide, county-administered team that provides services to all counties and works with all judicial districts. This would create consistency and equity in which fraud investigations are pursued, as individual counties currently set those limits. This would also standardize the fraud investigation process and centralize fraud investigation documentation into one state system, Onspring, as mentioned in the MAQA shared service.

The federal administration's focus on fraud, waste and abuse in the Medicaid program creates risk for the state because member fraud investigations are delegated to the 64 counties, but only about 15-20 counties actually pursue fraud, or have active fraud investigations, at any given time. By aggregating the member fraud resources into one team, in one county, the

Department will be able to better direct member fraud investigations and monitor those for consistency, equity and compliance with federal requirements.

The Department calculated the Member Case Integrity unit staffing need based on county self-report data through fraud data collection that was statutorily mandated through FY 2023-24 in SB 24-135. Additionally, the Department leveraged data from counties that completed their state-mandated county compliance reviews, which occur once every three year cycle. Data was pulled from the 2022-2024 compliance review cycle.

As such, the Department determined a need for 55 Member Case Integrity unit staff, including fraud investigators, supervisors, judicial district liaisons, training staff, and administrators/ managers. Counties reported 2,094 active fraud investigations during FY 2023-24. Compared to the Department's total enrolled population of nearly 1.3 million, the current process only reviews 0.16% of the total enrolled population for fraud. Through the Member Case Integrity unit staffing model, the Department assumes a ramp up to approximately 7,500 active fraud investigations per year, or nearly 0.57% of the total enrolled population. This amount is over triple the current rate and better accounts for the federal administration's focus on fraud, waste and abuse. The staffing model assumes each fraud investigator would have an annual caseload of approximately 188 cases.

Due to the typically high level of effort involved in investigating fraud, the Department assumes that once state-mandated standardized procedures are in place, the fraud investigators in the unit would be better leveraged and may be able to manage more cases than the existing process. With state-mandated standardized procedures, the Department can ensure that fraud practices are applied equitably and that there is a secondary review by the Department on fraud determinations made by the unit.

- 40 FTE - Fraud Investigators (Administrator III): these investigators would be responsible for conducting fraud investigations based on referrals received from the new fraud referral process in the eligibility determination system; in addition, these FTEs would be responsible for administrative and criminal recoupments, working with court systems to pursue prosecutions for fraud, and to manage the tax intercept program.
- 10 FTE - Member Case Integrity Unit Trainers, Judicial Liaisons and Supervisors (Administrator IV): to appropriately supervise the 40 investigators, the Department assumes the need for 6 supervisors. Additionally, 4 FTE would also be judicial liaisons and training staff. These are needed in order to train fraud investigators on minimum state standards and liaisons to judicial districts to support criminal prosecutions, when necessary.
- 5 FTE - Member Case Integrity Unit Administration/ Managers (Administrator V): in addition to supervisors, the Member Case Integrity unit needs appropriate staffing to conduct quality assurance activities, manage operations, and appoint a leadership team to manage the shared service.

The Department requests that this funding is appropriated to a new line item called 'Member Case Integrity Shared Service' in section (1) Executive Director's Office, (C) Eligibility Determinations and Client Services of its Long Bill.

Additionally, the Department requests 1.0 state FTE. This position would be a contract administrator that would manage daily operations of the shared service. This position would start in FY 2025-26 to lead the contract and procurement efforts to implement this shared service, which will begin in FY 2026-27.

The Department also requests funding for one policy advisor contractor, that would set policy requirements for the shared service and provide state support for the tax intercept program. The contractor would leverage existing fraud, waste and abuse best practices within the state and others to set policy around member fraud. Setting policy includes initiating and completing rulemaking, conducting stakeholder engagement, producing policy and operational memos and coordinating federal policy guidance internally and with counties. This position would also manage and support the tax intercept program that will be implemented with the Member Case Integrity shared service.

Additionally, the Department requests $125,000 total funds in FY 2026-27 in order to build out the state's existing county compliance database, Onspring. This funding is specific to support the system build out for the Member Case Integrity shared service, which will centralize member fraud documentation. Ongoing funding of $62,500 total funds starting in FY 2027-28 would be used for annual license costs, system builds and maintenance and operations.

Lastly, the Department requests funding for CBMS Design, Development, and Implementation (DDI) hours in FY 2026-27 in order to build out three new functions. The first project would create functionality in CBMS that will allow a CBMS technician to submit a fraud referral. This would replace the current manual process that occurs separately in all counties to identify potential cases of fraud. This is also necessary for statewide tracking of fraud referrals to the newly proposed shared fraud investigation services across the state. This would ensure that any person working on eligibility determinations is able to alert the state to a suspected fraud situation for follow up and investigation. The second project will implement PEAK functionality to allow MA members to make payments for fraud recoupment via PEAK and Apps. There is currently no functionality for this, and members must set up a payment plan, and make payments directly to each individual county for cases where fraud recoupments have been ordered. This is a necessary solution for the transition from each county individually handling their local fraud cases, to the cases being handled through a shared service across the entire state. This would also allow an easier and more efficient method for members to make fraud payments across the entire State universally. The third project would implement tax intercept functionality in CBMS for MA programs. This would allow for the possibility of tax intercept as a means to collect on fraud cases. This functionality has previously never existed within the Medicaid program and is a necessary operation in order to facilitate additional recoupment methods that have been previously unavailable to the state.

Recent federal guidance is focusing on fraud investigation, prevention, and reporting and recoupment for MA programs. These three CBMS functions are necessary to help the Department's systems better align with federal expectation and also provide the Member Case Integrity unit with the adequate IT system resources across the entire process of fraud

recoupment from initially identifying potential fraud situations through the collection of fraud payments and monies owed.

Document Management Shared Service

Currently, each county has the responsibility of receiving documents from applicants and members through all modalities required by the federal and state government. This means that each county receives documents through the physical mail, faxes, emails, and any documents dropped off in-person at the county office. Because of the sheer volume of documentation that is required for eligibility determination, each county has had to utilize their existing resources to build operational processes that route documents so they can be scanned and indexed into an electronic document management system and then routed to the appropriate worker based on skill and experience. However, because of the disparate resources available to counties, especially if the county does not have the local share to fully utilize federal and state dollars, this duty may often fall on either front desk staff or the eligibility technician themselves. Larger counties have built teams around document management, but not all counties have this capability. Document management itself is often cited in two major areas of concern: the amount of complaints the state receives around documents that were submitted and the county could not account for, and the amount of audit findings the state receives for the exact same issue.

Therefore, the Department requests $1,823,658 total funds, including $267,545 General Fund in FY 2026-27 to create a centralized Document Scanning unit. The intent of this centralized service is to consolidate all document scanning, indexing and intelligent character recognition work to be done for all counties and all modalities except online submissions through PEAK (the state's online application platform) and documents that are physically dropped off at the county office by an applicant or member. Documents dropped off physically to the county office would remain the responsibility of that county to scan and index into the state's document management system.

The Department calculated the Document Scanning unit staffing need based on an estimated 12,000 pages per day that will need scanning and indexing. This number is based on current Electronic Document Management System (EDMS) and ARPA document management numbers, which is roughly 6,000 pages per day, in which each scanning technician can scan and index 750 pages per day. However, EDMS does not account for several of the larger counties, which currently have their own scanning systems. So, the Department estimated around double the number of current EDMS daily pages per day.

The Document Management technicians will be the ones scanning and indexing. Indexing takes up more time from the technicians because they have to make sure the scanned documents get attached to the correct case. The QA Analyst staff requested are critical, especially at the start up, to ensure that all documents are readable and are attached to the correct case, that there are no missing documents, etc. A detailed list of the staff requested can be found in Table 9.1 of the Appendix.

Along with staffing, the Department would also invest in high capacity scanners along with two flatbed scanners, which require annual maintenance. It is imperative that the Document Scanning unit have the proper resources in order to be as efficient and effective as possible. The Department assumes that the scanner purchases are one-time while the maintenance costs are annual.

To help offset the cost of this shared service, the Department proposes to repurpose existing funding currently appropriated for the Eligibility Overflow Processing Center. The Department determined that this function may no longer be necessary with the coming implementation of the Joint Agency Interoperability (JAI) program's Unified County System (UCS), which is supported by the Joint Technology Committee. The UCS project implements a single, statewide document and workload management system for all counties. The implementation of the UCS was a recommendation to improve administration and gain efficiencies, as documented in the SB 22-235 report to the General Assembly. The function of scanning documents into the UCS would be performed by a variety of existing county staff, many doing multiple duties as generalists, without this request for shared services. The UCS is already funded by the General Assembly, but only for the system, implementation, and maintenance and operations. The UCS funding does not include county staff to perform the scanning function. With the UCS and the Document Scanning unit, all documents received by all counties can be scanned in a central location to be routed anywhere throughout the state, except those physically dropped off at a county. The Department assumes that the UCS will allow for shared work amongst counties, minimizing the need for overflow processing. As shared work becomes more common, along with implementation of the shared services, the need for the Eligibility Overflow Processing Center decreases, and thus the Department proposes to reallocate the funding to the centralized Document Scanning unit shared service.

The Department requests that this funding is appropriated to a new line item called 'Document Management Shared Service' in section (1) Executive Director's Office, (C) Eligibility Determinations and Client Services of its Long Bill.

Reallocate Current Streams of Funding

To support the initiatives of the shared services, the Department proposes to better leverage existing appropriations to drive the standardization and centralization of specific scopes of work.

<u>County Incentives Program</u>

The County Incentives Program utilizes a General Fund only appropriation to build performance-based contracts with each county. These contracts set performance standards and deliverables for counties to meet. In return, the county 'earns' General Fund as an offset to their local share. While the Department continues to believe performance-based contracts are critical to county accountability, there is an opportunity to better leverage the General Fund dollars appropriated to the county administration program. As such, the Department requests to decrease the County Incentive Program by $2,000,000 total funds/ General fund in FY

2026-27 and by $6,224,384 total funds/ General Fund in FY 2027-28 and ongoing and use this to offset some of the costs that will be incurred by the shared services initiatives.

Colorado Medical Assistance Program (CMAP)

With the implementation of the T1 Call Center shared service, the Department requests to reduce its budget for CMAP by approximately 10%, or $795,946, which is entirely funded through the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE). CMAP currently operates a call center that supports members of the Child Health Plan Plus (CHP+) program. However, counties are responsible for the eligibility determination of CHP+ members; therefore, the T1 Call Center will begin to take over those services. Based on CMAP's reporting, the 10% reduction is in line with the total volume of their calls that relate to CHP+. As such, the Department requests to decrease the CMAP Program by $238,784 total funds in FY 2026-27 and by $795,946 total funds in FY 2027-28 and ongoing and use this funding to offset some of the costs that will be incurred by the shared services initiatives. Of the 10% reduction of funding of CMAP, the Department assumes a 30% reduction in FY 2026-27 and 100% reduction of funding in FY 2027-28.

Eligibility Application Partner (EAP) Sites

EAP Sites can assist an applicant with completing an application for Medical Assistance. Once the case is determined, the county becomes responsible for ongoing case maintenance.

Currently, the Department receives an appropriation to support this service at EAP sites, however, not all EAP sites are funded, as some receive reimbursement while others do not. While these partners play an important role in providing application assistance, the support service of an EAP Site is not mandated by federal regulation, and the Department proposes to move all EAP Sites to being unfunded/ not receiving reimbursement, so as to correct the current inequity, and use this savings to help offset some of the costs that will be incurred by the shared services initiatives. This also aligns with federal compliance that directly limits who can determine eligibility to only merit-based, governmental employees, in which all EAP Sites do not meet this qualification.

Department Contractor Resources

The Department requests $394,850 total funds in FY 2025-26 and $1,184,553 total funds in FY 2026-27 for term limited contractor funding for nine contractor positions which would support implementation of the shared services. These positions would start in FY 2025-26 to lead the project planning and procurement efforts to select counties to implement the shared services, which will begin in FY 2026-27.

- One project manager lead will provide state-level implementation support across all of the shared services. This lead will coordinate the remaining project managers and other support contractors.

- One project manager for MAQA and Member Case Integrity shared services will provide implementation support to the two counties selected to contract for these services, which will be HCPF only services.
- One project manager for T1 Call Center and Central Scanning shared services will provide implementation support, in coordination with CDHS, to the two counties selected to contract for these services.
- Two change management managers will lead change management efforts to support the implementation of shared services. Specifically, these positions will be essential in supporting counties and county staff in the transition to shared services.
- Four business process mapping managers will produce process maps and document best practices across all of the duties that are transitioning to shared services, so that business process and practices done by various counties are integrated into the shared services processes.

This request supports various pillars of the Department's performance plan, such as member health, care access, and operational excellence and customer service. The Department believes that by centralizing various county administered services, quality of care will be more standardized and there will be less disparities between services provided in each county. The T1 Call Center will allow the counties to provide excellent service to members in an effective and efficient manner.

Supporting Evidence and Evidence Designation

The Department assumes that an Evidence Designation is not applicable to this request because the request does not meet the statutory definition for a program or practice. To be considered a program or practice, the request must have specific outcomes, a target population, and defined and replicable elements. This request is centralizing current county administered services in order to standardize and make services more equitable across the state.

The Department does expect that the request will improve the county-administered system, address new federal compliance obligations, and improve the Medicaid member experience overall. The need to reform the county-administered system to meet these new compliance obligations is evident by the challenges presented by H.R. 1, which was signed into law on July 4, 2025. This request supports the following objectives through the propose shared services:

- The T1 Call Center unit will help address new requirements relating to twice-a-year renewals and work requirements for Medicaid Expansion populations.
- The Quality Assurance unit will ensure an adequate sample size for quality assurance reviews is obtained, so county-based errors can be addressed prior to federal audits, specifically the Payment Error Rate Measurement (PERM) audit, helping to prevent potential federal disallowances. PERM audit good faith waivers, which delay/prevent disallowances, will end in Federal Fiscal Year 2030 (begins October 2029), setting greater risk for the state.

- The Central Scanning unit will also help address the PERM good faith waiver termination by implementing a centralized team to manage documents submitted by applicants and members. Lost case file documentation is a frequent, reoccurring finding in federal audits, increasing the risk associated with PERM findings.
- The Member Case Integrity unit will help ensure federal compliance and equity in member fraud investigations while addressing the current federal administration's emphasis on fraud, waste and abuse in the Medicaid program. The unit will ensure fraud investigations are completed throughout the state, as opposed to the current piecemeal model.
- By better leveraging existing appropriations, where possible, the Department also aims to fulfill its mission of being a sound steward of taxpayer resources.

These objectives all focus around a more positive Medicaid member experience, allowing for better customer service, and minimal benefit and service interruption. Many components of the request are focused on centralizing eligibility and administrative functions across all counties, which will help reduce the level of county eligibility worker manual intervention, and free up that time for them to focus on more complex cases and other more meaningful interaction.

Promoting Colorado for All

This request aligns with the Governor's priority to build a Colorado for All and has a positive impact on in-need populations. Medicaid, CHP+, and long-term care (LTC) members and public assistance program clients all rely on county staff support for a variety of eligibility application, renewal, and appeals services. Inconsistencies across counties can create confusion, and any delay or impact to coverage can result in devastating impacts to a member.

By centralizing and streamlining several administrative functions, county staff will be able to focus on member support with less administrative burden.

Ultimately, all Medicaid members, including highly vulnerable LTC members, will benefit by receiving additional support from counties and consistency of services from anywhere in the state.

Assumptions and Calculations

Detailed calculations can be found in Appendix A.

The Department assumes that all federal match is specific to Medicaid's share of the cost.

Where appropriate, the Department has leveraged the Colorado Healthcare Affordability & Sustainability Fee Cash Fund, making up 35.00% of the state match.

Where applicable, shared services costs will be covered through a shared cost allocation model between the Department and CDHS, where costs are roughly based on current statistics: 80% Medicaid, 20% DHS. These percentages mirror the current cost allocation of CBMS. Of the CDHS costs, 89% are SNAP, which would have a 31.25% federal match in FY 2026-27 and 25% federal match in FY 2027-28 and ongoing; the remaining 11% would be federal TANF (7%) and Adult

Financial (4%) funds. DHS will submit the corresponding non-prioritized funding request for their component.

Implementation Timeline

Recent changes passed in H.R.1 for work requirements and six month Medicaid renewal requirements for the Affordable Care Act (ACA) expansion population have propelled the Department and CDHS to collaborate to redesign service delivery, support counties, and ensure federal performance criteria are met in order to ensure a continuous safety net and avoid federal penalties. This request forms one piece of the solution. In order to allow for sufficient ramp up time as the Department addresses these federal changes, this request includes funding in FY 2025-26. This will provide the Department resources to hire contractors and state FTE such as contract managers and systems administrators to begin implementation. This will include procurement planning, drafting of contracts and statements of work, conducting evaluation of existing county processes that will transition to shared services, and providing rapid change management support to counties and county staff as transitions occur. Then, in FY 2026-27 the Department assumes 30% implementation of all four shared services and full implementation starting in FY 2027-28.

Tier 1 Call Center Shared Service

The Department assumes that both the Department of Human Services and the Department would utilize the T1 Call Center, and therefore the costs would be shared between both departments. The T1 Call Center costs assume staffing and operating costs for 291 staff. Additionally, the Department assumes various licensing costs per agent for Five9 licenses and Salesforce licenses. The Department estimates an annual cost of $2,532 per Salesforce license.

The Department assumes that this shared service will be 30% implemented in FY 2026-27 and fully implemented in FY 2027-28. The Department assumes a 75% FFP for Tier 1 Call Center staffing and licensing costs.

The Department assumes a 50% FFP for the 1.0 state FTE requested to support the T1 Call Center. The Department assumes this FTE will be hired in March 2026.

The Department assumes the requested four contractors would be hired beginning in FY 2026-27, and would be funded continuously because the T1 Call Center would utilize HCPF's existing call center system as part of regular operations. The Department assumes it would contract at a rate of $62.06 per hour for a total of 2,080 hours per year. The Department estimates an annual cost of $2,532 per Salesforce license, which each contractor would require in order to access the Salesforce system that they would be managing. The Department assumes a 50% FFP for contractor costs.

Medical Assistance Quality Assurance Shared Service

The Department assumes that the MAQA unit would only review Medical Assistance cases, and therefore costs would be fully attributed to the Department. The MAQA unit costs assume staffing and operating costs for 33 staff.

The Department assumes that this shared service will be 30% implemented in FY 2026-27 and fully implemented in FY 2027-28. The Department assumes a 50% FFP for MAQA unit staffing costs and a 75% FFP for Onspring costs. The Department assumes a 50% FFP for the 1.0 state FTE and one OnSpring Systems Administrator contractor requested to support the MAQA unit. The Department assumes the FTE and contractor will be hired in March 2026.

Member Case Integrity Shared Service

The Department assumes that the Member Case Integrity unit would only perform investigations for the Medical Assistance Program and therefore costs would be fully attributed to the Department. The Member Case Integrity unit costs assume staffing and operating costs for 55 staff.

The Department assumes a 50% FFP for the 1.0 state FTE and one Member Case Integrity Policy Advisor contractor requested to support the Member Case Integrity unit. The Department assumes the FTE and contractor will be hired in March 2026.

The Department assumes that this shared service will be 30% implemented in FY 2026-27 and fully implemented in FY 2027-28. The Department assumes a 50% FFP for Member Case Integrity unit staffing costs and a 75% FFP for Onspring costs. The Department has worked with its current CBMS vendor, Deloitte, to get a cost estimate of the three projects to increase CBMS functionality. Negotiated rates with Deloitte for all CBMS programming costs are $132.08 in FY 2026-27. The Department assumes that CBMS DDI costs are eligible for 90% FFP. The CBMS DDI costs are one-time in FY 2026-27 and there are no ongoing costs associated with the projects.

Document Management Shared Service

The Department assumes that both CDHS and the Department would utilize the Document Scanning unit and therefore the costs would be shared between both departments. The Document Scanning unit costs assume staffing and operating costs for 51 staff.

The Department assumes that this shared service will be 30% implemented in FY 2026-27 and fully implemented in FY 2027-28. The Department assumes a 75% FFP for Document Scanning unit staffing costs.

The Department assumes a 30% funding reallocation from the Eligibility Overflow Processing Center line item in FY 2026-27 and 100% reallocation of the line item in FY 2027-28 and ongoing in order to use the funding to offset the cost of this shared service.

Department Contractor Resources

The Department assumes the requested nine contractors would be hired for 4 months in FY 2025-26 and would continue work until December 31, 2028. The Department assumes it would contract at a rate of $62.06 per hour for a total of 2,080 hours per year. The Department estimates an annual cost of $2,532 per Salesforce license, which each contractor would require in order to access the Salesforce system they would be managing. The Department assumes a 50% FFP for contractor costs.

Tier 1 Call Center

Position Name	Position Classification	No. of FTE	Descriptions
County Administration Call Center Manager	Administrator V	1.0	This position would be the Policy and Contract Manager for the Tier 1 Call Center, acting as the direct liaison and point of accountability between the Department and the county selected for the scope of work. Duties include procurement, contract management, reimbursement and fiscal administration, as well as setting policies, standardized business practices and ensuring contract compliance. Compliance includes taking formal state action for failure to comply with contract provisions, including corrective action and sanctions. This position will work under the existing contract the Department has with counties by adding a new scope of work to that contract.

Quality Assurance Unit

Position Name	Position Classification	No. of FTE	Descriptions
County Administration Quality Assurance Manager	Administrator V	1.0	This position would be the Policy and Contract Manager for the Quality Assurance unit, acting as the direct liaison and point of accountability between the Department and the county selected for the scope of work. Duties include procurement, contract management, reimbursement and fiscal administration, as well as setting policies, standardized business practices and ensuring contract compliance. Compliance includes taking formal state action for failure to comply with contract provisions, including corrective action and sanctions. This position will work under the existing contract the Department has with counties by adding a new scope of work to that contract.

Member Integrity Unit

Position Name	Position Classification	No. of FTE	Descriptions
County Administration Case Integrity Manager	Administrator V	1.0	This position would be the Contract Manager for the Member Case Integrity unit, acting as the direct liaison and point of accountability between the Department and the county selected for the scope of work. Duties include procurement, contract management, reimbursement and fiscal administration, as well as setting standardized business practices, ensuring contract compliance and reviewing the quality of work performed by the unit. Compliance includes taking formal state action for failure to comply with contract provisions, including corrective action and sanctions. This position will work under the existing contract the Department has with counties by adding a new scope of work to that contract.