Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-12 Work Number Verification

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,895,417,528**	**$0**	**$7,915,363,590**	**($22,577,733)**	**($46,239,666)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,285,686,174	$0	$2,294,366,911	($3,791,252)	($7,739,065)
	CF	$983,543,298	$0	$984,608,781	($1,436,052)	($2,923,121)
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	($17,350,429)	($35,577,480)

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (D) Eligibility Determinations and Client Services, (1) Eligibility Determinations and Client Services - Work Number Verification	**Total**	**$0**	**$0**	**$0**	**$1,531,649**	**$3,305,114**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$505,040	$1,089,815
	CF	$0	$0	$0	$252,569	$545,013
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$774,040	$1,670,286
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$7,895,417,528**	**$0**	**$7,915,363,590**	**($24,109,382)**	**($49,544,780)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,285,686,174	$0	$2,294,366,911	($4,296,292)	($8,828,880)
	CF	$983,543,298	$0	$984,608,781	($1,688,621)	($3,468,134)
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	($18,124,469)	($37,247,766)

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

Department Priority: R-12
Request Detail: Work Number Verification

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**($22,577,733)**	**($46,239,666)**
FTE	0.0	0.0	0.0
General Fund	$0	($3,791,252)	($7,739,065)
Cash Funds	$0	($1,436,052)	($2,923,122)
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	($17,350,429)	($35,577,480)

Summary of Request:

The Department requests a decrease of $22,577,733 total funds, including a decrease of $3,791,252 General Fund in FY 2020-21, and a decrease of $46,239,666 total funds, including a decrease of $7,739,065 General Fund in FY 2021-22, in order to implement a robust income verification process for Medicaid and CHP+ eligibility determinations based on real-time verifications. The Department's requested change to cash funds includes the Healthcare Affordability and Sustainability Fee cash fund. The Department is requesting to procure a contract with a vendor to obtain work number verification data and anticipates costs avoided from a reduction in Medicaid caseload. The Department would begin utilizing this data in the second half of FY 2020-21 and the savings would be ongoing, with FY 2021-22 seeing the full-year impact of the real-time income verification process. This request represents a decrease of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation.

Current Program:

The Department determines eligibility for Medicaid and Child Health Plan Plus (CHP+) members based on information about the member and the member's immediate family. The primary eligibility determinants are total gross household income compared to the Federal Poverty Level (FPL) and the household composition. To be determined eligible for Medicaid or CHP+, a member must meet the eligibility requirements of one of the eligibility categories as defined by the Department, following the guidelines set in the Social Security Act and Colorado state statute. Currently income is self-attested by individual members when they are initially determined or re-determined eligible for Medicaid or CHP+ with a requirement of post-eligibility verification through a valid electronic data source.

An individual is not required to provide documentation of income unless the self-attestation of income cannot be verified electronically, or the information verified electronically does not clear the reasonable compatibility process. Reasonable compatibility is a method of comparing applicants' self-attested income against income information from additional sources, such as information provided by the Colorado Department of Labor and Employment (CDLE) through the Income and Eligibility Verification System (IEVS) interface, as allowed by federal regulation[1]. Most employers in Colorado are required to report the wages of their employees to CDLE, and the IEVS interface is used to retrieve wage data from CDLE to verify wage information reported by their employer.

Reasonable compatibility is established if the income reported through IEVS is at or below the income limit for the program or if the individual attests to income below the applicable income standard, and the data source indicates income above the applicable standard, and the difference between the two is less than 10%. If income information provided by a member is determined to be not reasonably compatible with income obtained through IEVS, a notice about the discrepancy is sent to the member. The member will have a reasonable opportunity period to provide a reasonable explanation of the discrepancy or updated income verification. The Department is implementing a reasonable opportunity period of 30 days, effective at the beginning of FY 2020-21. If the discrepancy is not resolved during the reasonable opportunity period, the member's eligibility will be redetermined using the IEVS income and they may be terminated due to being over income. The purpose of the IEVS interface and the reasonable compatibility process is to correctly verify if the income eligibility requirements for Medicaid and CHP+ are met. In FY 2017-18, 236,474 members were sent a discrepancy notice from the reasonable compatibility process. Of those, 74,157 were subsequently disenrolled following their reasonable opportunity period.

Problem or Opportunity:

The income verification process does not operate in real time. Employers are only required to report their employment data to CDLE quarterly; therefore, the updates that the Colorado Benefits Management System (CBMS) receives from the IEVS interface affect the Medicaid caseload after these quarterly updates are received and the member's reasonable opportunity period has ended. This means that there is at least a four-

[1] 42 CFR § 435.952(C)

month period during which certain individuals are enrolled in Medicaid who are later found to be ineligible, as their income is over the allowable threshold. Due to the current delayed income verification process, the Department is paying for services incurred by members who are later determined to be ineligible.

In addition, the current reasonable compatibility process creates additional workload for eligibility workers and confusion for members. Eligibility workers must update cases that are reported to them after an income discrepancy notice has been issued with either the explanation of the discrepancy or the new income verification. Members who receive notices experience a great deal of confusion about what it means for them and what to do next. Implementing an income verification upon the initial application or redetermination would significantly minimize the amount of work needed to follow up on IEVS verifications and would result in a streamlined process for members.

Proposed Solution:

The Department requests a net decrease of $22,577,733 total funds, including a net decrease of $3,791,252 General Fund. This request represents a decrease of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation. The Department also requests a net decrease of $46,239,666 total funds, including a net decrease of $7,739,065 General Fund in FY 2021-22 and future years in order to implement a real-time income verification process for eligibility determinations. The requested savings would come from preventing members who are later determined to be over the income threshold for Medicaid or CHP+ from being enrolled in the first place.

To implement the real-time verification process, the Department would contract with a vendor that can provide income verification data in real-time as the member is being determined eligible for medical assistance through CBMS. The Department would be able to access two different hubs of employer-reported data – one hub is maintained by the Centers for Medicare and Medicaid Services (CMS), which the Department can access at zero cost. The second hub contains a more complete dataset of employment records and would be available to the Department at a cost.

The CMS hub only contains information requested of the vendor by CMS. CMS requests the data with various fields that serve as filters to narrow down the data to be relevant to its purposes. If there is information about an employer that does not match CMS' filters, that record will not be included in the CMS data hub. For example, CMS requires Federal Employment Identification Number (FEIN) to be collected in their database hub. This dataset may not have FEIN for every employer record included in the dataset, as the dataset existed before CMS required this field. Any employment record in the complete database operated by the vendor that does not include FEIN will not be in the data hub operated by CMS, and the Department would need to pay the vendor to obtain real-time income information regarding any member who works for that employer. There are some employment records that do not exist even in this more robust dataset, such as for smaller, rural employers. The Department would need to continue to use CDLE data from the IEVS interface for those employers.

The Department proposes using the two databases together, along with the current IEVS interface, to properly identify eligibility in a "waterfall" approach. The Department would configure CBMS to search member employment records through the CMS data hub first; any employment records that do not match to that database would be searched against the vendor's dataset. If the employment record does not exist in either the CMS data hub or the vendor's dataset, the Department would use the current IEVS income verification process to verify income after the member is determined eligible. This waterfall approach would ensure the Department verifies income in the least costly, most efficient manner for each member.

The Department estimates that the overall effect of these real-time income determinations would be to reduce the number of members who are later determined to be ineligible for Medicaid. The Department estimates that these members are on Medicaid or CHP+ for at least four months before they are disenrolled through the reasonable compatibility process. Real-time income verification would dampen the Medicaid caseload as these members would never be determined eligible for Medicaid in the first place. The Department estimates the costs avoided as a result of these members not enrolling in Medicaid to be $24,109,382 total funds in FY 2020-21 and $49,544,780 total funds in FY 2021-22.

If this request is not approved the reasonable compatibility process would continue to have a significant built-in delay, with members enrolling into Medicaid and CHP+ only to be later determined ineligible.

Anticipated Outcomes:

The Department anticipates the work number verification system would put downward pressure on caseload growth, particularly for the MAGI Parents and Adults eligibility categories, which are income-sensitive populations. It would prevent Medicaid and CHP+ members from enrolling who are later found to be ineligible due to income and save money for the State. In addition, the work number verification system would reduce the administrative burden on county workers who are required to resolve all of the discrepancies through the current reasonable compatibility process and simplify the eligibility determination process for members. These outcomes align with the Department's Performance Plan long-range goals of enhancing the community experience of individuals and families, reducing the cost of health care in Colorado, and operational excellence.

Assumptions and Calculations:

The Department estimates that this request would lead to a net savings of $22,577,733 in FY 2020-21 and a net savings of $46,239,666 in FY 2021-22 and onward. The net savings for both fiscal years is based on the combined estimate impact of the cost of contracting with a vendor to access the work number verification dataset and the savings to the Department from a reduction in caseload due to preventing certain members from enrolling in Medicaid and CHP+.

The Department would pay the vendor directly each time the eligibility system checks the complete, paid database to verify a member's income. Because the vendors collect wage information from only larger employers, the Department anticipates that the IEVS interface would still assist the Department with eligibility determinations; however, the volume of IEVS interface determinations is expected to decrease.

To arrive at the estimated costs, the Department used the number of newly determined cases and the number of re-determined cases for most recent months to get an approximate monthly average of the number of cases that would be checked against the work number verification system for Medicaid and CHP+ determinations. This monthly average is then applied to the share of cases that would be checked against the complete dataset held by the vendor, rather than the free CMS hub, to get the estimated number of cases that the Department would need to pay for in any given month. The share of cases in the complete dataset is based on the percentage of applicants matched to employer records within the Supplemental Nutrition Assistance Program (SNAP), which currently has a similar work number verification contract with a vendor. The Department assumes that this will be comparable to the percentage of Medicaid applicants who would be matched to employer records in the dataset. The Department assumes that the number of cases determined each month would grow proportionally to caseload growth and applies the caseload growth percentage to average affected monthly cases for FY 2021-22.

The Department received an estimated cost from a vendor of the cost per verification in the dataset. The total estimated paid verifications are then multiplied by this verification cost to obtain the total cost to the Department to use the work number verification dataset. The vendor-estimated rate increased from FY 2019-20 to FY 2020-21, and the Department assumes the rate will grow by the same percentage between FY 2020-21 and FY 2021-22 and has built that growth into the estimate.

The Department is assuming that all the necessary preparatory work would be completed before January 1, 2021, and real-time income verification process would begin on that day. Thus, the total cost for FY 2020-21 is divided in half to match the implementation timeline. The Department assumes the preparatory work would include building an interface between CBMS and the vendor database and CMS hub, which can be accomplished through existing CBMS pool hours, procuring the contract, and modifying the State Plan and Department rules to incorporate real-time income verification.

The Department estimates the cost savings by first determining the number of members whose Medicaid span was terminated because of the IEVS interface in FY 2017-18. These members were identified as members who received an IEVS discrepancy notice and no longer had an active Medicaid span after their reasonable opportunity period. The Department trended this forward by projected caseload growth to estimate the number of members who would be disenrolled due to the reasonable compatibility process in FY 2020-21 and FY 2021-22. The Department identified the expenditure these members incurred during their reasonable opportunity period using claims data from the Medicaid Management Information System (MMIS) to calculate a per member per month (PMPM) cost for impacted members. This PMPM is then multiplied by four months, which is the minimum estimated time they would otherwise be enrolled on Medicaid, and the estimated number of affected members to obtain the estimated costs avoided from preventing these members from enrolling in the first place.

All calculations are detailed in the Appendix.

Table 1.1 FY 2020-21 Work Number Verification Request Summary by Line Item								
Row	**Item**	**Total Funds**	**FTE**	**General Funds**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	**Total Request**	**($22,577,733)**	**0.0**	**($3,791,252)**	**($1,436,052)**	**$0**	**($17,350,429)**	**Row B + Row C**
B	Verification	$1,531,649	0.0	$505,040	$252,569	$0	$774,040	Table 2.1, Row A
C	(2) Medical Services Premiums	($24,109,382)	0.0	($4,296,292)	($1,688,621)	$0	($18,124,469)	Table 2.1, Row B

Table 1.2 FY 2021-22 Work Number Verification Request Summary by Line Item								
Row	**Item**	**Total Funds**	**FTE**	**General Funds**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	**Total Request**	**($46,239,666)**	**0.0**	**($7,739,065)**	**($2,923,122)**	**$0**	**($35,577,480)**	**Row B + Row C**
B	Verification	$3,305,114	0.0	$1,089,815	$545,013	$0	$1,670,286	Table 2.2, Row A
C	(2) Medical Services Premiums	($49,544,780)	0.0	($8,828,880)	($3,468,135)	$0	($37,247,766)	Table 2.2, Row B

Table 2.1 FY 2020-21 Summary By Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Comments**
	Work Number Verification								
A	Contractor Cost for Verifications	$1,531,649	0.0	$505,040	$252,569	$0	$774,040	50.54%	Table 3.2, Row G
B	Costs Avoided from Lower Caseload	($24,109,382)	0.0	($4,296,292)	($1,688,621)	$0	($18,124,469)	75.18%	Table 3.1, Row J
C	**Total Impact in FY 2020-21**	**($22,577,733)**	**0.0**	**($3,791,252)**	**($1,436,052)**	**$0**	**($17,350,429)**	**76.85%**	**Row A + Row B**

Table 2.2 FY 2021-22 and Ongoing Summary By Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Comments**
	Work Number Verification								
A	Contractor Cost for Verifications	$3,305,114	0.0	$1,089,815	$545,013	$0	$1,670,286	50.54%	Table 3.2, Row G
B	Costs Avoided from Lower Caseload	($49,544,780)	0.0	($8,828,880)	($3,468,135)	$0	($37,247,766)	75.18%	Table 3.1, Row J
C	**Total Impact in FY 2021-22**	**($46,239,666)**	**0.0**	**($7,739,065)**	**($2,923,122)**	**$0**	**($35,577,480)**	**76.94%**	**Row A + Row B**

Table 3.1 Estimated Costs Avoided From Real Time Income Verification				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes**
A	Estimated Annual Number of Clients Terminated Through IEVS[(1)]	74,157	74,894	Identified as the Number of Clients whose Medicaid Spans were Terminated after receiving a letter from IEVS
B	Caseload Growth Factor	0.99%	2.75%	February Caseload Projections
C	Estimated Total Annual Number of Clients Terminated Through IEVS	74,894	76,954	Row A*(1+Row B)
D	Estimated PMPM Costs of IEVS Clients	$292.65	$292.65	Calculated as the Sum of Claims of clients in Row A divided by Row C divided by 12
E	Cost of Claims Over 4 Month Affected Period	$87,670,480	$90,081,418	Row D * Row C * 4 Months
F	Percent of Employers in Dataset	55.00%	55.00%	Vendor Estimate
G	**Costs Avoided**	**($48,218,764)**	**($49,544,780)**	**Row E * Row F * (-1)**
H	Implementation Date Adjustment	50.00%	100.00%	Assuming Start date January 1, 2021
I	**Total Costs Avoided**	**($24,109,382)**	**($49,544,780)**	**Row I* Row H**

[(1)]Income Eligibility Verification System (IEVS)

Table 3.2 Estimated Cost of Vendor Contract				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes**
A	Estimated Verifications- Medicaid	36,520	37,524	Table 3.3 Row G
B	Estimated Verification Rate	$6.66	$6.99	Vendor Estimate
C	Rate Adjustment	5.01%	5.01%	Vendor Estimate; Assuming the same growth rate for both years
D	Cost Per Verification	$6.99	$7.34	Row B * (1+Row C)
E	**FY 2020-21 Estimated Cost**	**$3,063,298**	**$3,305,114**	**Row A * Row D * 12**
F	Implementation Date Adjustment	50.00%	100.00%	Assuming Start date January 1, 2021
G	**Total Cost of Vendor Contract**	**$1,531,649**	**$3,305,114**	**Row E * Row F**

Tabel 3.3 Estimated Average Monthly Cases to be Verified				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes**
A	Newly Determined Cases	35,057	35,057	Average of Previous 4 months
B	Redetermined Cases	138,948	138,948	Average of Previous 4 months
C	Monthly Medicaid Cases	174,005	174,005	Row A + Row B
D	Caseload Growth	0.99%	2.75%	S-1 Caseload Forecast
E	**Total Monthly Medicaid Cases**	**174,005**	**178,790**	**Row D * (1 + Row D)**
F	Percent of Employers in Dataset	55.00%	55.00%	Vendor estimate
G	Paid Service Share of Cases	38.16%	38.16%	Estimated number covered by the free service
H	**Total Affected Medicaid Cases**	**36,520**	**37,524**	**Row E * Row F * Row G**