

Follow one person through the layers

Member worksheets · 1:25 – 2:00 p.m. · Use with the administrative partner fact sheets

The one rule. You are not solving this person's case. You are counting who touched it. The judgment about what to keep, restructure or remove comes later this afternoon. This exercise is the evidence you will use to make it.

The fact sheets in your packet describe the delivery system by function: one sheet per contractor, what it does, what it is paid, how it is measured. That is the right way to write that document, and it is the system as it sees itself.

These four worksheets show the same system from the other direction: what a person encounters moving through it. Take one. The third column has been filled in from the fact sheets so that your time goes to interrogating it rather than to looking things up. It is a starting point, not an answer — where it is wrong, that is a finding, and we want it marked.

How the 35 minutes run

- **1:25 – 1:30 Setup.** Pick up one journey.
- **1:30 – 1:40 On your own.** The third column is already filled in from the Department's fact sheets. Work down the steps and check it: correct anything that is wrong, add any entity that is missing, and strike any that does not belong. In the fourth column, mark whether that step had to happen at all.
- **1:40 – 1:55 At your table.** Compare. Where did a layer do something that genuinely had to be done, and where did it add a step? Answer the four questions at the foot of your sheet together.
- **1:55 – 2:00 Worksheets collected.** There is no report-back. Your sheets are synthesized and come back to you at 5:10 as the opening input to the removal test.

Where these journeys come from

Each is a composite, built from what Coloradans described in the public input closed on August 20th. None is a real individual's case, and none is drawn from documentation submitted to the Commission by a family. If a step looks wrong to you, say so because that is a useful finding in itself, and the pathways have been checked with the department.

Two layers are deliberately absent from all four journeys. Behavioral health and the BHASOs are covered on October 7; case management is covered on September 17. Neither is in front of you today.

The four journeys

- **A.** A family whose child moves from CHP+ to Medicaid mid-year.
- **B.** A working adult with a disability applying for the buy-in program.
- **C.** A member who needs specialty care without a primary care home.
- **D.** A member whose prescription is refused at the pharmacy counter.

JOURNEY A

A child moves from CHP+ to Medicaid

Household income drops mid-year. The child is eligible for Medicaid and no longer for CHP+. The care does not change; the coverage does. Layers crossed: county, eligibility system, CHP+ plan, regional accountable entity, fiscal agent.

Step	What happened	Which entity touched it — as described in the Department's fact sheets. Correct anything you find wrong.	Needed?
1	The family reports the income change to the county.	County human services department	Y / N
2	The county processes the change in the eligibility system.	County eligibility staff, working in the state eligibility system	Y / N
3	CHP+ coverage ends and Medicaid begins – but the effective dates do not line up, leaving a gap.	State eligibility system; CHP+ health plan (coverage ends); regional accountable entity (new assignment)	Y / N
4	At the next appointment, the pediatrician's office checks eligibility and sees no active coverage.	Provider office; fiscal agent / MMIS eligibility verification	Y / N
5	The visit goes ahead. The claim is submitted and denied.	Provider office; fiscal agent / MMIS claims processing	Y / N
6	The family receives a bill and starts calling to find out who can fix it.	Provider billing office; Member Contact Center; county; CHP+ plan or regional accountable entity	Y / N
7	Coverage is corrected and backdated. The claim has to be resubmitted.	County; state eligibility system; fiscal agent / MMIS reprocessing	Y / N

The four questions

1. How many separate entities touched this journey?

2. When it went wrong, which one was accountable?

3. Which one could this person reach?

4. Based on this journey, what is one thing you would want the Commission to examine further?

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JOURNEY B

An adult applies for the buy-in program

A working adult with a disability applies for Medicaid buy-in so they can keep working and keep coverage. Layers crossed: PEAK, county, state customer service, pharmacy benefit administrator, fiscal agent.

Step	What happened	Which entity touched it — as described in the Department’s fact sheets. Correct anything you find wrong.	Needed?
1	The application is submitted online.	PEAK (state online application)	Y / N
2	A request arrives for asset documentation that was already provided with the application.	County eligibility staff; state eligibility system	Y / N
3	The application sits. The online account shows no status the applicant can interpret.	PEAK; county eligibility staff	Y / N
4	They call the county and are told the state holds it. They call the state and are told the county holds it.	County eligibility staff; state Member Contact Center	Y / N
5	While waiting, they pay cash for maintenance prescriptions.	Pharmacy only. No Medicaid entity is engaged at this step — coverage is not active.	Y / N
6	The application is approved and coverage is backdated.	County eligibility staff; state eligibility system	Y / N
7	The pharmacy cannot reprocess the cash fills; the applicant seeks reimbursement separately.	Pharmacy; pharmacy benefit administrator; fiscal agent (reimbursement route)	Y / N

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JOURNEY C

A member needs specialty care without a primary care home

A member is assigned to a regional accountable entity but has never been attributed to a primary care provider. Of 992,177 members assigned to a RAE, 693,131 are attributed to a primary care medical provider. Layers crossed: regional accountable entity, member contact center, provider enrollment, utilization management vendor, fiscal agent and the MMIS.

Step	What happened	Which entity touched it — as described in the Department's fact sheets. Correct anything you find wrong.	Needed?
1	The member is assigned to a regional accountable entity based on where they live. They are not attributed to a primary care medical provider.	State enrollment and assignment process; regional accountable entity	Y / N
2	Needing care, the member uses Find a Doctor or calls the Member Contact Center to locate a provider accepting new patients.	Member Contact Center; regional accountable entity provider directory	Y / N
3	The member is seen, and is referred on to a specialist.	Primary care provider; regional accountable entity	Y / N
4	The specialist is not enrolled as a Medicaid provider. Enrollment has to be completed before a claim can be paid.	Provider enrollment (fiscal agent); HCPF provider services	Y / N
5	The service requires prior authorization. The request goes to the utilization management vendor.	Utilization management vendor	Y / N
6	The provider submits the claim through the MMIS. The fiscal agent applies payment methodologies and claims edits.	Fiscal agent / MMIS	Y / N
7	The claim is denied. The remittance advice goes to the provider. The member finds out when a bill arrives.	Fiscal agent / MMIS (remittance advice); provider billing office	Y / N
8	Whether a care coordinator becomes involved depends on whether this member is among those the RAE engaged – 99,993 unique members in FY 2025-26.	Regional accountable entity	Y / N

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JOURNEY D

A prescription is refused at the counter

A member arrives to collect a maintenance medication they have taken for two years. Layers crossed: pharmacy, pharmacy benefit administrator, prescriber, the department's drug list, fiscal agent.

Step	What happened	Which entity touched it — as described in the Department's fact sheets. Correct anything you find wrong.	Needed?
1	The pharmacy submits the claim. It is rejected — prior authorization is now required following a change to the drug list.	Pharmacy; pharmacy benefit administrator (point of sale); HCPF preferred drug list	Y / N
2	The pharmacist tells the member to contact the prescriber. No one tells the prescriber.	Pharmacy	Y / N
3	The member reaches the prescriber's office, which submits the prior authorization request.	Prescriber's office; pharmacy benefit administrator	Y / N
4	The request is reviewed and additional clinical documentation is asked for.	Pharmacy benefit administrator (clinical review)	Y / N
5	The member goes without the medication, or pays cash for a partial supply.	None. No Medicaid entity is engaged at this step.	Y / N
6	The prior authorization is approved.	Pharmacy benefit administrator	Y / N
7	The member returns to the pharmacy and the fill proceeds.	Pharmacy; pharmacy benefit administrator; fiscal agent	Y / N

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