ATTACHMENT G

Colorado Department of Health Care Policy and Financing

Comprehensive Action Plan
Presented to the
Legislative Audit Committee and
Office of the State Auditor

May 15, 2009

COLORADO DEPARTMENT OF HEALTH CARE POLICY

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

May 15, 2009

Ms. Sally Symanski, State Auditor
Office of the State Auditor
Legislative Council Building
200 E. 14th Avenue
Denver, CO 80203

Dear Ms. Symanski:

Please find the Department of Health Care Policy and Financing's Corrective Action Plans regarding the February 2009 Single Statewide Audit Report.

If you have any questions or comments, please feel free to contact the Department's Client and Community Relations Deputy Director Sue Williamson at 303-866-2618 or sue.williamson@state.co.us.

Sincerely,

Joan Henneberry
Executive Director

JH:las

cc: Representative Dianne Primavera , Chair, Legislative Audit Committee
Senator David Schultheis, Vice-Chairman, Legislative Audit Committee
Senator Jim Isgar, Legislative Audit Committee
Representative James Kerr, Legislative Audit Committee
Representative Frank McNulty, Legislative Audit Committee
Representative Joe Miklosi, Legislative Audit Committee
Senator Shawn Mitchell, Legislative Audit Committee
Senator Lois Tochtrop, Legislative Audit Committee
Sally Symanski, State Auditor
HCPF Executive Director's Office
Sue Williamson, Deputy Director, Client and Community Relations Office
Jennifer Evans, Deputy Director, Administration and Operations Office
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Laurie Simon, HCPF Audit Coordinator

Overview

On March 17, 2009, the Department of Health Care Policy and Financing (the Department) appeared before the Legislative Audit Committee to respond to State of Colorado, Statewide Single Audit for the state fiscal year ending June 30, 2008. On March 23, 2009, the State of Colorado Office of the State Auditor (OSA) requested that the Department provide a comprehensive corrective action plan to address audit comments related to the Medicaid program, focusing in those areas where material weaknesses were identified. In the Statewide Single Audit for state fiscal year 2008, material weaknesses were identified in the following comments and recommendations:

- Recommendation 53 - Medicare Supplemental Insurance Benefits Program
- Recommendation 55 - Timely Termination of Benefits and CBMS System Problems
- Recommendation 56 - Case File Documentation
- Recommendation 57 - Controls Over Data Input
- Recommendation 59 - Income, Eligibility and Verification System Compliance
- Recommendation 60 - Medicaid Eligibility Quality Control (MEQC)
- Recommendation 62 - Subrecipient Audit Reports
- Recommendation 63 - Cash Controls
- Recommendation 64 - Provider Eligibility

Additionally, OSA requested that the corrective action plan include material weaknesses in both the Children's Basic Health Plan marketed as the Child Health Plan *Plus* (CHP+) and Medicaid as appropriate.

The Department's response outlines the various initiatives that the Department has underway to address these areas, the specific steps the Department is taking, the timeframe for completing the actions needed to address the problems, and how the Department will evaluate its efforts to ensure problems are addressed. Information is also provided about the eligibility testing and follow-up the Department is performing as part of the federal Improper Payments Information Act.

Medicare Supplemental Insurance Benefits Program

Overview

OSA reviewed the Medicare Supplementary Medical Insurance Benefits (SMIB) program which helps participants who are eligible for Medicaid and Medicare pay their Medicare Part B health insurance premiums. In Fiscal Year 2008, the Department reported to OSA and the Centers for Medicare and Medicaid Services (CMS) that it overstated and had been overpaid more than $8 million for State Fiscal Year 2004 through State Fiscal Year 2008 by the federal government for the SMIB program. OSA reviewed the SMIB program during their State Fiscal Year 2008 Statewide Single Audit and their test work found problems and control weaknesses with how the Department accounts for the program. The test work also found that the Department overstated its overpayment by $1.5 million. The Department actually received about $6.5 million in

had originally estimated with respect to the overpayment. The OSA concluded that the overpayment resulted primarily from a lack of knowledge of the SMIB program and a lack of internal controls over changes to the SMIB reports.

OSA recommended that the Department improve its internal controls over its SMIB Program to ensure that federal reporting and reimbursements are accurate and properly supported. The recommendation included documenting policies and procedures related to the SMIB program and requiring all staff involved with the SMIB program to attend training, ensuring that supervisors perform adequate reviews, and ensuring that adequate testing was performed on any system changes. In addition, the recommendation requested the Department to work with CMS to resolve amounts due to the federal government.

Initiatives and Evaluation

The Department agreed with OSA's recommendation for the SMIB program and is currently creating a Master Standard Operating Procedure that incorporates the program, budget and accounting sections step-by-step procedures. This Master Standard Operating Procedure will be used to train all staff involved with the SMIB program and to cross-train other Department staff. The Department expects to have the Master Standard Operating Procedure compiled by June 1, 2009 and Department staff trained during June 2009. The Department's program staff, who oversee the SMIB program, are working with the Claim Section to implement additional system changes for SMIB which will automate the reporting function. The Department still expects a implementation of these additional system changes in the spring of 2009.

In addition, The Department worked with the Centers for Medicare and Medicaid Services to resolve the outstanding balance of overdrawn federal funds and agreed upon an appropriate balance of $3,177,574.00. Based on the Department's agreement with the Centers for Medicare and Medicaid Services, a prior period adjustment in this amount was recorded on the CMS-64 for the quarter ended March 31, 2009.

Beginning July 1, 2009, the Department will evaluate the procedures and training and will work with OSA to follow-up with this audit recommendation.

Medicaid and CHP+ Eligibility

Administration

The State of Colorado is a state-supervised, county-administered system for the administration of medical assistance programs such as Medicaid and CHP+. While the Department is the single state agency responsible for the administration of the state's public health insurance programs, the local departments of social/human services in Colorado's 64 counties serve as the agents of the Department. Every county department of social/human services is structured in its own unique way based on available resources, size, and geography - no two counties organize their eligibility and enrollment activities in exactly the same way.

The legislature also granted the Department the authority to designate the private service contractor that administers CHP+, Denver Health and Hospitals, and other Medical Assistance

The legislature also granted the Department the authority to designate the private service contractor that administers CHP+, Denver Health and Hospitals, and other Medical Assistance (MA) sites as the Department determines necessary to accept medical assistance applications to determine eligibility for applicants. Peak Vista Community Health Center in El Paso County signed a contract with the Department in July 2008 to process medical applications as a MA site.

In addition, the legislature established a demonstration project that authorizes qualified personnel in three public schools to operate as a MA site and make eligibility determinations for medical benefits for Medicaid and CHP+. The three public schools participating in the demonstration program are located in Jefferson, Arapahoe, and Pueblo counties.

Initiatives

The following initiatives are part of the Department's ongoing comprehensive plan to improve the overall functioning of the Medicaid and CHP+ eligibility and enrollment processes. The Department believes it is important to demonstrate that its approach to strengthening the eligibility and enrollment processes cannot be isolated to the areas identified in the Single Statewide Audit. Thorough, thoughtful and sustainable strategies must be developed and implemented to address the fundamental root causes of an eligibility and enrollment process that is fragmented and inefficient. A crosswalk at the end of this section captures the current initiatives that are underway that specifically relate to the eligibility recommendations related to timely terminations, case file maintenance, quality control and the Eligibility, Income and Verification System (IEVS).

The Colorado Eligibility Modernization Project

As the single state agency responsible for the administration of Medicaid and CHP+, the Department is required to design an approach to Medicaid and CHP+ eligibility that is fair, accurate, timely, efficient, and consistent and that adheres to state and federal rules and regulations. The fiscal integrity of public health insurance programs depends on the ability of the eligibility processes to assure that those who are enrolled into health coverage are those who should be enrolled or retained in coverage when it is time to re-determine eligibility. If the state's public health insurance programs are to serve all those they are intended to serve, the process must be easy to use and not discouraging to applicants.

However, significant challenges exist within the current administrative structure of the eligibility and enrollment process. As mentioned, 64 counties have 64 different models for organizing their eligibility and enrollment activities. This leads to inconsistent and unpredictable results for applicants and clients. Not all counties have sufficient resources to handle the current caseload or increases in caseload. While staffing has remained stable during the economic recession, counties have historically experienced considerable staff turnover. The Department also lacks sufficient resources to properly train and monitor the timeliness and accuracy of applications as well as the high quality of customer service that we expect. Under the current model, the Department is unable to achieve savings and efficiencies through economies of scale. For example, several counties have or are planning on acquiring their own scanning technology

capability, but the technology cannot be leveraged across the state without great expense and effort. OSA findings over the past several years in the areas of case file documentation maintenance, the timeliness of processing applications and the accuracy of the data entry support the Department's opinion that the current eligibility and enrollment administrative infrastructure must be revamped.

As part of Governor Ritter's "Building Blocks for Health Care Reform," the Department launched the Colorado Eligibility Modernization Project in the spring of 2008. With the increased caseload and rising costs of health care, it makes sense to identify the ways that a person's eligibility determination can be made quickly and increase the likelihood that the person will seek health care services in the most appropriate settings. The goal of the eligibility modernization project is to find the best ways to enroll and retain children and families in our public health insurance programs while providing excellent customer service with faster application processing times.

Many other states are considering or implementing reforms to modernize their eligibility models. The models differ greatly, but include utilizing new technologies and procedures such as online applications, call centers, and document imaging, as well as looking at the ways to improve the current business processes. For example, Arizona created an advanced Electronic Document Management System (EDMS) which scans and indexes every document to the proper location, resulting in a paperless eligibility and enrollment process. The transition to the flexible document imaging workflow is linked to a 13 percent decrease in staff turnover. Utah runs a task-based eligibility model, where technicians are trained as generalists and cases are triaged to the next available eligibility technician rather than being divided by specific program which has increased both worker productivity and worker satisfaction. States also vary on how they have organized their eligibility activities as part of their eligibility modernization efforts. Many states include an array of both centralized and decentralized services as part of their models, while other states centralize the vast majority of their services.

In order to modernize eligibility, the Department envisioned creating a single state-level entity for eligibility and enrollment processes for the Medicaid and CHP+ programs. The February 15, 2008 budget request, "Building Blocks for Health Care Reform" included funding to create a single state-level entity for eligibility and enrollment processes for the Medicaid and CHP+ programs. The funding to create such an entity was not approved. However, the Department did receive funding to conduct an assessment of the current administration of eligibility and enrollment, to present modernization options, and to gather requirements and draft the request for proposals for services to modernize the current eligibility and enrollment model. Public Knowledge, LLC was selected as the vendor to perform these tasks.

As more information became available during the project, it became apparent that the practical application of modernizing access to health care would include an array of centralized and decentralized services. Some services might be centralized, and some might best be delivered in decentralized operations, but with modernized tools and processes. Both models for eligibility and enrollment are being considered as part of this analysis, which takes into account the eligibility sites' accessibility to potential and existing clients and the ability to leverage localized expertise for eligibility and enrollment practices.

The Department contracted with Public Knowledge, LLC in August of 2008 to complete the following objectives for the Colorado Eligibility Modernization Project through delivery of a final report in December of 2008:

- Evaluate the current administration of eligibility determination and enrollment processes for Medicaid and CHP+ on a statewide and eligibility site level and recommend business process improvements.

- Provide established best practices and lessons learned from other states and make recommendations on how the Department should structure eligibility and enrollment processes.

- Gather available data on the costs and benefits of different eligibility and enrollment modernization options.

- Identify technical requirements for business process modernization including an analysis of planned improvements and enhancements.

- Document improvements and enhancements for the eligibility and enrollment modernization including a draft schedule.

Based on eligibility site visits in Colorado, the study of best practices and lessons learned from other states, as well as internal knowledge and experience, Public Knowledge rendered their findings. To a great extent, Public Knowledge's findings mirror the findings of OSA with respect to the deficiencies identified for the Medicaid and CHP+ eligibility and enrollment process:

- The overall model utilized in Colorado is outdated and does not fit current workload and demographic trends.

- The current model is confusing to many clients and hinders access to programs.

- The current model fosters inconsistencies in the timing and manner in which eligibility determinations are made.

- The current model lacks accountability.

- No consistent training program exists for Medicaid, particularly for new eligibility technicians.

- The eligibility model is hindered by a reliance on paper documentation, limiting organizational options for managing the workload.

- The Colorado Benefits Management System (CBMS) does not fully support Medicaid and CHP+ eligibilitywith intuitive data entry requirements for eligibility technicians.

- Eligibility sites use inconsistent methods for tracking case status and workloads.

- Medicaid and CHP+ review periods are not aligned with redetermination periods for other types of assistance programs, causing duplicate work for both eligibility technicians and clients that enter data into CBMS.

Before implementing any new tools or changes to the Medicaid and CHP+ eligibility and enrollment model, Public Knowledge recommended that the Department strengthen certain core elements of the current model. Again, many of the following "conditions for success" are consistent with several of the recommendations of the OSA:

1. Enhance the Colorado Benefits Management System (CBMS) to maximize eligibility and enrollment efficiency.

2. Solidify a Quality Management Plan to promote consistency in eligibility and enrollment processes and strengthen program integrity.

3. Develop a comprehensive training program that will provide greater support and deliver a uniform message.

4. Create a detailed communication strategy to encourage collaboration between Departments, county partners, Medical Assistance sites and community-based organizations (CBOs).

5. Realign the redetermination dates among the programs to streamline tasks.

Based on the analysis of Colorado's current eligibility and enrollment model, visits to eligibility sites, states' best practices, and feedback from county partners and stakeholders, Public Knowledge recommended the following modernization options:

- Implement an electronic document management system (EDMS) to begin the transition to a paperless eligibility and enrollment business model.

- Implement a centrally-managed customer service center (CSC) to broaden applicant and client access.

- Expand the involvement of community-based organizations (CBOs) in the eligibility and enrollment process.

- Develop web-based services for applicants, clients and CBOs.

- Replace paper documentation with electronic client data where possible.

The Department has begun implementing many of the "conditions for success" as described in subsequent sections. With respect to the recommendations for eligibility modernization, Public

Knowledge is moving forward with gathering the requirements regarding the Eligibility and Enrollment for the Medical Assistance Programs Request for Proposal (RFP). The first phase of the RFP will focus on the scope of work for the CHP+ eligibility and enrollment vendor. It is the Department's goal to incorporate some of the components of eligibility modernization into the RFP such as the customer service center and an EDMS that will scan and image documents as well as help manage the workflow for eligibility workers. The implementation of an EDMS will address many of the case file maintenance findings identified in the Single Statewide Audit by storing documents electronically and making the electronic images available across the state to all eligibility sites. The Department anticipates the new scope of work for the CHP+ eligibility and enrollment vendor will begin July 1, 2010. Depending on the availability of funding, it is the Department's intent to implement Public Knowledge's recommendations for eligibility modernization to all of the expansions of public health insurance programs administered by the Department.

Medical Eligibility Quality Improvement Plan

The Department recently implemented the Medical Eligibility Quality Improvement Plan (MEQIP) as the framework to communicate the Department's vision, objectives and strategies to improve the Medicaid and CHP+ eligibility determination process. Representatives from the counties, MA sites and Department comprise the Medical Eligibility Quality Improvement Committee (MEQIC) which was created to assist and advise the Department in implementing the MEQIP. The Department recognizes that eligibility sites have experienced increased caseload volumes throughout the state as a result of the economic downturn and appreciate the workload issues connected with implementing a new initiative. While this initiative is not meant to impose additional workload burdens to eligibility sites, it is the Department's responsibility to ensure that eligibility processing standards be developed, implemented and monitored.

To date, the Department has received 26 Medical Assistance Quality Improvement Plans from eligibility sites. The Department conducted technical assistance conference calls with eligibility sites in April to offer support in completing and submitting the Quality Improvement Plans. The remaining plans are due to the Department by May 1, 2009. The Department anticipates the MEQIP process will be ongoing.

Every month, eligibility sites are required to randomly select four cases per eligibility technician to review with respect to data entry, timely processing of applications, and case file maintenance. Specific to case file maintenance, county departments of social/human services and MA sites must review cases for documentation that supports their eligibility determinations. Findings are to be submitted to the Department on a quarterly basis. The review of the cases will help inform decisions about the need for additional training and technical assistance to the eligibility sites.

Colorado Benefits Management System (CBMS) Improvements

Web Portal Online Application

The "Web Portal" project will provide one-stop shopping for applicants/clients to screen and apply for benefits as well as check benefits, report changes and renew benefits online. The implementation timeline for the Web Portal project is 9 months with an estimated project start date of May 19, 2009. The Department received funding in its state fiscal year 2008-09 budget

to begin work on this initiative and has been appropriated funding in its 2009-10 budget to complete this project.

Intelligent Data Entry

The Department and the Department of Human Services are also working with the new CBMS vendor, Deloitte Consulting LLP, to begin work on some substantial improvements to CBMS for both the financial and medical programs. The "Intelligent Data Entry" project will streamline screens and make other front-end improvements that will make it easier for the end users to enter data into CBMS. The CBMS Change Request 2044 will remove over 150 redundant data entry fields on more than 75 CBMS data entry windows, which will reduce the amount of time CBMS users spend entering client application data into the system. The Intelligent Data Entry project will also serve to help address the cross-program contention issues between the financial and medical programs within CBMS. The Intelligent Data Entry project is expected to take approximately 12 months to implement with an estimated project start date of May 19, 2009. The Department received funding in its state fiscal year 2008-09 budget to begin work on this initiative and has been appropriated funding in its 2009-10 budget to complete this project.

Income, Eligibility Verification System (IEVS)

Changes and additions to CBMS were implemented on December 13, 2008, to eliminate inconsistent processing of the Income, Eligibility, and Verification System (IEVS) discrepancy records. The changes and additions will provide an effective tracking method for the IEVS discrepancy record processing. This will also minimize the number of IEVS discrepancy records by automating the Colorado Department of Labor and Employment Unemployment Insurance Benefits file update into interactive interview windows. Training on how to process these discrepancies within the 45 days will be done throughout the spring of 2009.

Additionally, SB 08-161 permits a simplified verification process with respect to income for both initial eligibility determinations and for re-determinations. For initial processing of applications and eligibility determination performed by county departments of social/human services, medical assistance sites, and the CHP+ eligibility and enrollment vendor, the income can be verified through IEVS. Because of the transition of the CBMS operations and maintenance vendor from EDS to Deloitte, the Department was required to postpone implementation of this legislation until after the transition was complete on April 15, 2009. The Department has identified the implementation of this legislation as a high priority for 2009 and has not yet determined a new implementation date.

Case Cleansing

With the implementation of CBMS, a number of cases were transferred or converted from the legacy system, Client Oriented Information System (COIN), into CBMS. These cases were mandated by the courts to remain open until certain issues were addressed and the workers had an opportunity to review each case before authorizing the eligibility determination to be run in CBMS. Over the period of two years, the cases were reviewed and processed by the county departments of social/human services. As of September 2008, all cases that were mandated to remain open until appropriately processed have been reviewed and either approved or terminated.

Timely Terminations

In 2006, the Department's Business Analysis Section conducted an analysis of the time-limited programs. At that time, the list of clients was sent to respective county departments of social/human services to manually review and terminate cases appropriately.

In December of 2008, changes were implemented into CBMS to allow the system to take action on a case if the technician did not follow-up on an alert requiring eligibility to be rerun. These situations were mostly related to time-limited programs. The triggers were set, in most situations, to automatically run eligibility and authorization ten days after the technician was notified with an alert. Appropriate noticing is sent to the client when they are terminated or re-determined for a new program. In addition, the Department is in the process of conducting a Medicaid Eligibility Quality Control study that will review the timely termination of clients in the pregnancy aid category.

CBMS Alerts

For all CBMS trainings, the Department pays particular attention to the issue of system alerts. In feedback from eligibility workers, CBMS alerts are often identified as overly cumbersome. The theory behind alerts is to provide efficiency and individual ticklers generated by the system. CBMS alerts were designed to assist the worker in managing the caseload within CBMS. In trainings, the Department identifies those alerts that must be worked. However, when implementing changes into CBMS, the Department solicits feedback from the end-user on whether a proposed alert is necessary or useful to the eligibility technician. The expectation of the Department is that workers are responsible to review all case alerts and to take timely actions when applicable. Further enhancements to the alert generation process are being reviewed to eliminate unnecessary alerts and to reduce the number to those that require immediate action.

Exceeding Processing Guidelines (EPG) Business Improvement Process

The Department's Eligibility Section previously had an Exceeding Processing Guidelines (EPG) Unit of 5 FTE that exclusively monitored and assisted eligibility sites with the more problematic applications that appeared on the EPG report. The Unit provided weekly reports to the 64 counties and 3 MA sites and logged the reason for each application's processing delay. The Unit also provided technical assistance to technicians to troubleshoot and resolve issues in addition to the dedicated CBMS Help Desk support. The Department experienced only marginal improvements with respect to the timely processing of applications through this process.

In 2007, the EPG Unit developed and implemented an Access database where staff would upload the data from the EPG report. The Access database allows efficiencies for monitoring the 67 eligibility sites. Cases that appear on the EPG report one week frequently remain on the report the following week. To eliminate duplication of research on cases that appear on the report for multiple weeks, the Unit uploads the data every Monday morning, removes duplicates from the report and emails the revised report to each site. Each site then researches the cases received and reports back to the Unit by that Friday on the reasons why the case is pending. The Unit updates the records in the database to reflect the status of each case. This process dramatically reduced the amount of research the sites are required to conduct on the EPG cases, as they are no longer researching the same cases each week and can devote more time to resolving the actual reason for the delay.

During that time, the Unit also began offering regular conference calls with the eligibility sites that have the highest number of cases on the EPG report. Conference calls are held weekly, bi-weekly or monthly depending on the site's individual needs. The purpose of the conference call was to provide technical assistance and support specific to that site. The Department discovered that eligibility site supervisors did not always allow their technicians to contact the Department directly when assistance was needed. Consequently, the conference calls allowed for a more efficient use of everyone's time as sites were able to prepare for the calls in advance with a list of scenarios and questions for the Unit to provide guidance and direction.

In November of 2008, the Decision Support System was transitioned from Business Objects to Cognos. With this transition, the data became available in a print-only format. From November 2008 until March 2009, the Unit worked diligently with Information Systems (IS) staff to obtain the EPG report in a usable format. Currently, in order for the Unit to receive the report, IS staff must physically go to the new vendor's office to run the sequence query language (SQL) program weekly. While this is not the most efficient use of time, it is currently the best and only option that has been made available to the Department. As a result, the EPG report is not always sent to sites every Monday morning. The Unit is looking for additional ways to monitor the timeliness of application processing.

In 2009, the Unit began playing a larger role in the Medical Eligibility Quality Improvement Plan (MEQIP) and in developing training materials and user guides. The Unit has been reorganized from 5 FTE to 4 FTE, to allow the additional FTE to focus on CBMS operational issues with Adult Medical programs. The EPG Unit has been renamed the Monitoring and Quality Unit.

Monitoring and Quality Unit

The Department's Eligibility Monitoring and Quality Unit is the foundation for the majority of the improvement efforts currently performed by the Department. The Unit continues to be responsible for monitoring and disseminating the EPG report and also has responsibility for the following:

Medicaid Eligibility Quality Control (MEQC)

Although the MEQC Unit is part of the Audits Section, the Eligibility Monitoring and Quality Unit plays a key role in the MEQC process. The Unit provides:

- invaluable input into areas in which to conduct MEQC studies;
- technical expertise on difficult cases under review;
- research of rules, regulations and operational procedures;
- summary and recommendation to MEQC and Executive Management on how errors should be cited;
- ongoing monitoring of the corrective action plans resulting from MEQC findings;
- recommendations to Department management on identification and resolution of operational, system and policy conflicts as a result from MEQC findings; and
- technical expertise to sites on how to resolve identified issues.

The MEQC process as well as the PERM process are discussed in greater detail later in this section.

Medical Eligibility Quality Improvement Plan (MEQIP)

The Department's Monitoring and Quality Unit is directly responsible for the oversight of the MEQIP. The Unit provides technical assistance on the sites internal quality review processes, monitors and trends the results of the quality improvement activities. The Unit offered 5 technical conference calls to sites to provide guidance on expectations, to identify resources, documents and tools, and to provide technical assistance on the completion of the annual plan and quarterly reports. The Unit also responds to inquiries sent to a dedicated email address MEQIP@hcpf.state.co.us as well as provides over-the-phone assistance.

Training

The Unit provides enhanced and specialized technical training that is not comparable to any of the CBMS training offered through the Office of Information Technology. The training is provided upon request through over the phone support, on site or in a computer lab. The Unit also responds to email requests for assistance. The Unit spent over one full month conducting on-site training for a new MA site in preparation for their first operational day. The Unit also reviews eligibility training materials before they are presented by other Department eligibility staff to ensure that specific areas of concern identified through the various audit findings are adequately addressed.

Audit Follow-up

The Unit monitors all of the audit findings, recommendations and activities in relation to the eligibility determination process to ensure that areas of concern are adequately addressed and that staff remains focused on the priority issues. At times, audit recommendations cannot be implemented as originally intended due to a variety of variables outside of the Unit's direct control, which may include but is not limited to budget/funding, political negotiations with the Department of Human Services on prioritization of CBMS changes, new legislation and federal guidance/priorities.

User Manuals and Guides

The Unit will play a critical role in the development of user manuals and guides, as discussed in more detail below.

Development of User Manuals

In 2008, the Department's Eligibility Section began drafting a project plan to develop and implement the use of User Manuals. The intent of the User Manual is to provide eligibility sites with an online, hands-on, searchable, and current desk reference that assists eligibility workers in the daily activities of processing applications and determining eligibility. The Department historically has provided this information through a variety of sources, including rules, agency letters, director letters, training handouts and CBMS references. The Department's goal is to provide one, simplified resource that makes the eligibility process easier. While the User Manuals will not replace rules or CBMS references, the Department hopes to eliminate the use of agency and director letters and training handouts for this purpose.

The Department plans on implementing the manuals in a phased approach. The manuals will be divided into sections based on program areas. Each section of the manual will follow the process of researching, drafting, feedback, revision, and implementation. The Section anticipates that User Manuals will remain fluid, meaning that they will be constantly under review and updated on a regular basis. The first manual to pilot this process is the Presumptive Eligibility Manual.

Training

The Department's Eligibility Section is responsible for training all of the eligibility sites on eligibility policy and operations. Throughout the years, the frequency and types of trainings made available to Medicaid and CHP+ eligibility workers have been dependent on the availability of funding for these activities. As part of the Department's state fiscal year 08-09 budget, funds were appropriated to create an external training unit with three dedicated FTE to develop training curriculum and coordinate external trainings with external stakeholders and partners. Because of the hiring freeze, the Department has only been able to hire one FTE to assist with training efforts. However, with just an additional resource, the Department has been able to bolster its efforts around training. In the spring of 2009, the Department is sponsoring seven regional mini-conferences for community stakeholders and county workers that will focus on a variety of eligibility related topics. The Department recently completes its first two mini-conferences in Fort Collins and Denver and the response was overwhelmingly positive by those who attended. This illustrates that when resources are available, the Department is able to offer valuable training to improve the understanding of our programs.

Additionally, the Department recently implemented technology that will dramatically improve the Department's responsibility for training eligibility sites. Approximately 2,300 CBMS users process Medical Assistance Applications statewide and there are an additional 500 individuals statewide who provide application assistance either through Certified Application Assistance Sites (CAAS), independent advocacy organizations, schools and community organizations statewide. In order to effectively announce, register and track our training efforts, the Department purchased an online registration service. This allows the Department to focus efforts on producing quality training and supporting materials and to focus less on coordinating logistics to train 2,300 CBMS users and 500 advocates and application assistance staff statewide. The registration service allows the Department to track, manage and report on our training efforts, site registration, attendance, and training evaluation feedback.

The Department then plans to correlate the eligibility worker's participation/attendance at trainings with their performance as part of the Medical Eligibility Quality Improvement initiative. The Department also plans to provide summary reports to eligibility site supervisors and management on their staff's attendance at available trainings.

Also under consideration by the Department is the development of online testing to evaluate any training attendee's proficiency in the subject matter taught. When the participant takes and passes the course with a certain level of proficiency, the Department will issue a certificate of completion. The Department also plans to make that information available to eligibility site managers and supervisors for individual performance evaluations. While the Office of Information Technology has a test development tool for CBMS workers, it does not have the

capacity to retain the scores and data in a database or data warehouse for use by Department staff.

Medicaid Eligibility Rule Rewrite

In 2007, the Eligibility Section's Policy Unit embarked on reviewing and redrafting the 200 pages of the existing Code of Colorado Regulations that govern Medicaid eligibility. Because of the exhaustive nature of this project, the Policy Unit recruited assistance from the Eligibility Sections Project Management Unit. The project entailed a meticulous process of reviewing and documenting in a lengthy crosswalk every agency letter for its applicability and rule for its relevant federal regulation or state statute. All rules were then reviewed for their current applicability. A working meeting was held to determine the best organization of each rule, and an overall structural organization to the rules was established and assigned to each member. The rules were drafted and another crosswalk was created to assist in locating old rule citations within the new rule structure and to provide a quick reference for rules that were deleted or substantially rewritten, clarified or reinterpreted.

The Unit then solicited feedback from the Department's stakeholders. Stakeholders included eligibility sites, advocacy organizations, clients, providers and other partners. All feedback was documented and incorporated where feasible. The rules were presented to the Medical Services Board in January 2008 and approved. The Unit's rule revisions have received letters of commendation, and have clarified previously ambiguous interpretations.

Application Overflow Process for Counties

The Department is offering additional resources to assist the county departments of social/human services with the increased number of applications submitted to the counties as a result of the current economic downturn. The Overflow Application Process for Counties will accommodate applications that have not yet been worked or entered into CBMS. The applications forwarded to the Department by the counties are distributed to one of the Department's MA sites for processing. The MA site has the responsibility for processing the case including: data entry accuracy, timely processing, and verification requests. Additionally, any MA site that processes applications is responsible for the determinations they authorized.

Once applications have been received and documented by the Department, counties receive a report identifying the list of the applications that were sent to the Department and the MA site to which they were forwarded. Applicants receive a letter from the Department informing them that their application has been received and forwarded on for processing. This letter also provides MA site contact information for any inquiries applicants may have.

Once eligibility has been determined, the MA site keeps all denials within their own caseload. All approvals are sent to the appropriate county via an "Inter County Transfer" through CBMS for ongoing case maintenance. The original applications and supporting documentation will not be transferred back to the originating county because the MA site is responsible for the processing of the application and authorization of the eligibility determination.

The Department has set up a UPS account to allow the counties to ship new applications for medical assistance to the Department at no cost to the eligibility sites.

Crosswalk of Eligibility Initiatives and OSA Recommendations

(✓) Medicaid (+) CHP+

Initiatives Addressing Recommendations	Recommendations			
	55 Timely Terminations and Alerts	56 Case File Documentation	57 Data Entry	59 IEVS
• Eligibility Modernization: Intelligent Data Entry Initiative (CBMS Front End Improvements) • Status: Phase One scheduled to begin June 1, 2009 with estimated completion date of December 2010 • Change Request 2044	✓+		✓+	
• Medical Eligibility Quality Improvement Plan (MEQIP) to promote consistency in eligibility and enrollment processes and strengthen program integrity • Status: MEQIP implemented in January 2009; 26 eligibility sites have completed plans; ongoing monitoring		✓+	✓+	
• Electronic Document Management System (transition to a paperless eligibility and enrollment process) • Status: Implementation Date of July 1, 2010 (CHP+) and July 1, 2011 for Medicaid Expansion Populations		✓+	✓+	
• Income, Eligibility and Verification System to eliminate inconsistent processing of IEVS discrepancy reports • Status: Completed on December 13, 2008				✓+
• Changes in CBMS to allow system to take action on case if technician did not follow-up on alert requiring eligibility to re-run so eligibility terminations would take place in	✓+			

Initiatives Addressing Recommendations	Recommendations			
	55 Timely Terminations and Alerts	56 Case File Documentation	57 Data Entry	59 IEVS
system • Status: Completed December				
• Monitoring and Quality Unit • Status: Ongoing	✓	✓	✓	✓
• Development of User Manuals • Status: Commencing May 2009 and then ongoing	✓	✓	✓	✓
• Training to eligibility technicians • Status: Ongoing (7 regional mini-conferences May and June of 2009)	✓+	✓+	✓+	✓+
• Medicaid Eligibility Rule Rewrite • Status: Medical Services Board adopted rules January 2009		✓		
• Application Overflow Processing for Counties		✓	✓	

Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC)

The Department currently conducts audits of eligibility determinations under the two federally mandated programs: (1) Payment Error Rate Measurement Program (PERM) and the Medicaid Eligibility Quality Control (MEQC) studies. Many states have asked for changes to the two programs because of the overlap in the requirements and the duplication of resources necessary to perform both activities.

Payment Error Rate Measurement Program (PERM)

The PERM program is required by the federal Centers for Medicare and Medicaid Services (CMS) to comply with the Improper Payments Information Act of 2002. The purpose of the program is to examine the accuracy of eligibility determinations and claims payment to ensure that the Department only pays for appropriate expenditures. States are divided and rotate every three years through a PERM cycle. Colorado is considered a" year-two" or federal fiscal year (FFY 2007) state. Colorado's first PERM review was conducted in FFY 2007. The next PERM cycle will begin in FFY 2010. Despite the delay in the release of federal regulations and policies, the Department was one of the few FFY 2007 states that completed the eligibility reviews on time per federal requirements. Under PERM, the Department was required to work with three federal contractors to conduct review of claims payments. This review included 520 Medicaid FFS claims, 272 Medicaid managed care claims, and 272 CHP+ managed care claims. In addition, the Department hired a contractor, Maximus Inc., to conduct the eligibility reviews of 1416 case files. The results of the PERM reviews are reported in the table below. It is important to note that Colorado's Medicaid error rate of 6.02 percent and SCHIP error rate of 6.12 percent are substantially below the national average error rates of 10.5 percent and 14.7 percent, respectively, of the other 16 states.

Colorado Medicaid Error Rates	Sample Size	Colorado Error Estimate	National Average Error Estimate
Overall	**1,296**	**6.02%**	**10.5%**
Fee-for-service claims	520	5.42%	8.9%
Managed care claims	272	0.11%	3.1%
Eligibility payment error rate with undetermined cases counted as errors	504	1.20%	2.9%

Colorado SCHIP Error Rates	Sample Size	Colorado Error Estimate	National Average Error Estimate
Overall	**776**	**6.12%**	**14.7%**
Fee-for-service claims	-	-	11.0%
Managed care claims	272	0.12%	0.1%
Eligibility payment error rate with undetermined cases counted as errors	504	6.01%	11.0%

Currently, the Department is completing the federally required PERM corrective action plan for any identified claims or eligibility errors. The Department is utilizing this information to improve administrative processes to further improve claims payment and the accuracy of eligibility determinations. The greatest contributing factor of claim errors was the inability to obtain the medical records from the providers. The greatest contributing factors of the eligibility error rate were inaccurate income calculations and the Deficit Reduction Act verifications.

The Department must return the federal share for any claims paid in error and recover the overpayment from the providers. The Department has sent out demand letters to providers regarding identified claims paid in error and the appropriate federal financial participation (FFP) amount was refunded to CMS within the 60-day timeframe.

Currently, CMS does not require the return of FFP for any errors identified with incorrect eligibility determinations.

Medicaid Eligibility Quality Control (MEQC)

The Department also conducts MEQC studies that are referred to as pilots. Pilot MEQC studies allow the Department to identify areas of concern and review the eligibility determinations for these issues. Pilots differ from traditional MEQC in that traditional MEQC will look at a broad sample of eligibility determinations. The advantage of the pilots is that the Department can investigate specific areas where the Department may have concerns and then make administrative changes to address deficiencies. Because pilots specifically investigate an area of concern, the error rate for the study may be increased. However, the probable increase in the error rate is offset by the ability to improve the accuracy and timeliness of eligibility determinations. After the Department completes an MEQC study, the Department distributes a final report that outlines the issues identified in the pilot and the steps that the Department is taking to eliminate or reduce the errors in the future. Additionally, the Department requires the eligibility sites to respond to the findings with an overall corrective action plan. The Department also requires the sites to respond to the individual case errors documenting the corrective action taken.

Due to the fact that the Department conducts pilots, the Department does not risk FFP for incorrect eligibility determinations based on guidance from CMS.

The Department has worked closely with CMS over the past several years to strengthen its MEQC studies and processes. CMS has acknowledged the notable improvement. In the 2007-08 Single Statewide Audit, OSA identified the following three areas of concern with respect to MEQC:

1. Ensuring the county departments of social/human services and medical assistance sites respond to findings and that the corrective action plans adequately address the deficiencies identified;

2. Performing recovery on any improper payments; and

3. Ensuring that the reporting requirements of the pilot programs were met.

All three of these recommendations have been addressed. As noted above, the Department continues to monitor all of the medical assistance sites to ensure that they respond to the findings on a case level and through the individual site corrective action plans. With respect to performing recovery on improper payments, the Department received an email from CMS confirming the Department's interpretation that recovery was not necessary is correct for MEQC eligibility errors . For Recommendation Number 3, the Department has met reporting requirements by appropriately asking CMS for an extension on any reporting requirements when it is determined that the requirement effort will extend beyond the initial estimated date according to CMS policies.

Subrecipient Audit Reports

OSA identified areas in which the Department could improve subrecipient monitoring and made the following recommendations:

1. Implement written policies and procedures for subrecipient audit reports;

2. Conduct timely and appropriate follow-up on all audit findings; and

3. Require subrecipients with federal expenditures of $500,000 or more within the fiscal year to provide annual audit reports in accordance with the Office of Management and Budget (OMB) A-133 Circular.

In Fiscal Year 06-07, the Department took over the responsibility of monitoring the County Departments of Social and Human Services (Counties) for the Medical Assistance programs. Since that time and in accordance with federal regulations, the Department has issued management decision letters on all applicable county subrecipient reports. Although the Department was in compliance and followed the guidance in the OMB A-133 Circular, the Department wanted to have robust procedures. Prior to the completion of the State Fiscal Year 2007-08 Single Statewide Audit, the Department hired a consultant with specialized knowledge

in monitoring subrecipients to ensure that the Department had strong and comprehensive processes. During the course of the Singlewide State Audit, the Department developed draft written Subrecipient monitoring procedures and finalized these procedures in December 2008, thus implementing Recommendation Number 1.

In addition, the Department hired a consultant to review the Single Entry Point Agency's audit reports. The Department ultimately terminated the contractual relationship with the consultant due to lack of performance. The Department reviewed the portion of the work that was completed and discovered findings that could not be substantiated. All but nine of the most complex, substantiated findings have been resolved. The Department is working to resolve the remaining findings. The Department is committed to reviewing the audit reports timely.

Lastly, the Department is not clear that the agencies identified in the OSA report meet the subrecipient definition as outlined in the OMB A-133 Circular. The Department is seeking a legal opinion. This is expected to be completed in June 2009. If the legal opinion does identify the agencies as subrecipient, the Department will implement monitoring in accordance with all applicable federal and state, laws, regulation and guidance.

Cash Controls

OSA reviewed the Department's cash controls for reimbursements and recoveries it receives from different sources, such as estate, income trust and tort recoveries as well as drug rebates. In State Fiscal Year 2007-08, the Department recovered approximately $16.5 million from recovery programs and $55.2 million from drug rebates. During the State Fiscal Year 2007-08 Single Statewide Audit, OSA found that the Department should strengthen its internal controls over the checks it receives. Specifically, OSA recommended that the Department address deficiencies with cash intake and cash reconciliations, physical controls over cash, and the timeliness of check processing.

OSA also recommended that the Department improve its internal controls related to cash receipts. The recommendation included the development of written policies and procedures for receiving and depositing checks including stamping the date received on each check, developing a reconciliation process between checks received and amounts deposited with the State Treasury, and establishing additional procedures to track checks received. In addition, the recommendation addressed keeping checks received at the front desk secure, restricting access to the mail room and depositing checks in a timely manner, consistent with State requirements.

Initiatives and Evaluation

The Department agreed with OSA's recommendation and recognizes the importance of having strong internal cash controls. In order to address this recommendation, the Department is updating its current policies and procedures to address the deficiencies noted by OSA related to cash intake and reconciliations, physical controls over cash, and the timeliness of check processing and deposits. In order to address these deficiencies, the Department began date stamping each check it received on January 22, 2009 to assist it with determining the timeliness of its deposits and expects to implement a reconciliation process on May 11, 2009. Written policies and procedures have been created for handling and securing the checks received by the front desk and these policies and procedures have been included in the Master Standard

Operating Procedure for Cash Receipts. On May 1, 2009, the Department received approval from the Office of the State Controller for a Fiscal Rule Waiver from Fiscal Rule 6-1. The Department now has 45 days to deposit estate, income trust and tort recoveries from the date the recoveries are received by the Controller's Division.

Also, the Department began evaluating the reconciliation process after its implementation on May 11, 2009 and will work with OSA to ensure the reconciliation process strengthens the Department's current internal cash controls. In addition, the Department will be monitoring the timeliness of its deposits by periodically sampling cash receipts to determine if checks are being deposited in compliance with Fiscal Rule 6-1, or in the case of estate, income trust, and tort recoveries, these checks are being deposited in compliance with the Fiscal Rule Waiver granted by the Office of the State Controller.

Provider Eligibility

The Department is responsible for verifying that the providers who are providing services to Medicaid beneficiaries are licensed in accordance with federal, state and local laws and regulations.

While the Departments Medicaid Management Information System (MMIS) often correctly documents the current licensure of participating providers, the Department has identified a number of initiatives that will improve the percentage of providers which have current licensure recorded in MMIS (if they are required to be licensed) at any given time. An expired license date in MMIS or the lack of a license expiration date does not necessarily mean that a provider is not licensed to provide services, only that the provider's updated license expiration date may not have been recorded.

Provider licensure in the Colorado Medicaid Program begins with the provider enrollment process in which the provider is required to submit verification of current licensure, usually in the form of a copy of their paper license.

After initial enrollment, the Department must ensure that license renewal is captured in MMIS after the initial license has expired.

Colorado Practitioner Providers

For practitioner provider types, Colorado provider licensure updates are accomplished by a highly automated process with data provided directly from the Colorado Department of Regulatory Agencies (DORA).This automated functionality was completed in 2006. (See Appendix H, Customer Service Request (CSR) 1946

This current process is effective and relatively simple to execute, but is complicated by two factors:

1. **Grace Period:** The license expiration date of various practitioner provider types occur at different times of the year. For example, physician licensure expires on May 31 of every even year while licenses for physical therapists expire on October 31 every even year. More importantly, DORA allows for a 60-day grace period after the expiration of the

current licensure before the license is placed in a lapsed status. As an example, for Medical Doctor (MD), Doctor of Osteopathy (DO) and Physician Assistant (PA) licenses, DORA's Policy Number 20-10 states that 'During the 60-day grace period, licensees with an active license status shall have all of the rights and privileges afforded by an active medical license. No licenses shall be placed in a lapsed status until the grace period has expired.'

As a result of the grace period, provider licensure in MMIS was updated only 60 days after the expiration date for the provider type and immediately after the license expiration date for the provider type. This resulted in the percentage of unlicensed providers as recorded in MMIS appearing to be very high, despite the fact that they were legally able to practice during the grace period. As of April 8, 2009, nearly all physicians - whose licenses expired on May 31 of every odd year - had current licensure. In contrast, optometrists - whose licenses expire on March 31 - had a high percentage of expired licensure on April 8, 2009, despite the fact that they could continue to legally practice during their grace period.

Beginning in July 2009, the licensure update process will be executed twice for each provider type, once on the date of license expiration and once 60 days later as currently done to improve the percentage of current practitioner licensure as recorded in MMIS. This is expected to record a new license date for a large fraction of practitioners on the license expiration date and thus significantly increase the overall percentage of licensed providers recorded in MMIS.

2. **No Unique Identifier.** DORA does not collect a unique or semi-unique identifier as part of their licensing process that can be used by the Department. As a result, matching of DORA licensing to current providers of service to the Department is accomplished by matching names, addresses, etc. While a large fraction of providers can be systematically matched via these parameters, those that cannot must be researched individually - a process that is administratively complex and time consuming.

   The National Provider Identifier (NPI) is mandated by HIPAA rules to be the exclusive identifier of providers for health care services. If the NPI was used by DORA as part of their licensure process, matching their data with the Department's provider data could be simplified. The Department will contact DORA and the Colorado Department of Public Health and Environment (CDPHE) about using NPI as part of their licensing process. The Department will seek a response by the end of June of 2009. Possible dates for implementation of the improved matching process will depend on DORA and CDPHE resources.

Colorado Facility Providers

As automated processes have not been established for facility type providers, the percentage of Colorado facility providers who do not have a current license recorded in the Department's MMIS is relatively high in most cases as demonstrated in the table below.

Many of the facility provider types of this group are certified by CDPHE. CDPHE has a number of Web sites which allows the public to search for facility providers in a city or county. For example, the following web site provides a way to search for ambulatory surgical centers:

http://www.hfemsd1.dphe.state.co.us/hfd2003/homebase.aspx?Ftype=asc&Do=list

There is a good correspondence between the provider types available from the CDPHE web sites and the Department's facility provider types. Also, the data shown in all the CDPHE web sites has, for the most part, the same characteristics and the same format, implying that they are stored in a common database.

The Department has contacted CDPHE staff and is discussing the possibility of periodically receiving source licensure and certification data for these provider types. Since the number of providers in this group (other than for clinic) is relatively small, this data from CDPHE can be used to post current certification data in MMIS using a directly updated query monthly or quarterly as needed and with minimal administrative effort. Many details have yet to be defined. A commitment was made to implement an automated process in the Department's response to the 2008 OSA Single Statewide audit finding #64b., to be completed by December 2010, but it is likely that this process could be implemented in a less automated way earlier.

In the past, the Department has relied on Department staff who have had oversight responsibilities for these provider types to ensure they have current licensure. In most cases, the number of providers to monitor is relatively small. However, these staff may not have had the tools, processes and/or support to ensure that this monitoring was regularly done and reasonably efficient to execute. In addition to the above action, appropriate Department staff will be provided with a monthly report showing which of their provider type groups are not currently licensed, and a simplified process to allow them to update licensure for the provider types that they monitor. Facility providers which do not have current licensure on three consecutive reports to the Department staff responsible will be suspended until current licensure is provided.

Out of State Providers

There are much fewer out-of-state than in-state providers, but keeping their licensure data current is more problematic and administratively time consuming as the Department has less access to the much larger number of state licensing agencies or departments involved. As opposed to the largely automated process for in-state practitioners, all out-of-state licensure is validated by paper, usually a copy of the provider's license sent by the provider.

On a trial basis, for out-of-state hospitals, the Department will enter the hospital's license expiration date and the enrollment termination date. The Department will also enter an additional enrollment span beginning after the license termination date in which the provider is suspended. This will result in suspension of claims until the provider validates current licensure but minimizes the administrative impact of returning the provider to a full active enrollment state. The Department plans to implement this process by the end of June of 2009.

Some out-of-state providers - border providers and others that provide very specific services to the Colorado program - are as active as in-state providers and ensuring current licensure is

equally as important. These providers have significant incentive to keep their licensure current with the Department. If the trial program for out-of-state hospitals proves successful, it can next be applied to other out-of-state providers. The expansion of the out-of-state provider trial documented in the second step above will be implemented by December 2009, contingent upon the successful implementation of the above referenced step.

Lastly, as part of the monthly licensure status process used for in-state providers, letters can be sent to the most active out-of-state providers whose licenses are soon to expire. The Department plans to implement this process by the end of June 2009.

Progress and assessment of the effectiveness of the outlined initiatives will be monitored via monthly review of the provider licensure, in aggregate and by provider type.

Longer Term Initiatives

The Department understands that recent audits have called for automating the process of provider licensure updates in MMIS and agrees that this would be optimal and hopes to achieve this in the longer term. However, several factors make it imprudent to put significant effort into short term MMIS enhancements to support automated provider licensing updates:

- Implementation of the low cost corrective actions above will significantly reduce the number of providers who appear to have expired licensure in MMIS and can be done so with limited additional administrative effort.

- The Department has competing demands and other high priority areas with respect to making enhancements and changes into MMIS. Changes that are needed to comply with federal and state laws together with changes that could dramatically reduce administrative costs will be high priority areas for the Department's MMIS vendor and Department staff for several years.

- A CMS program to automate provider enrollment, the Unified Provider Enrollment Process (UPEP), could potentially include provider enrollment and licensing at a national level. However, the scope of this project has not been sufficiently defined to allow the Department to predict its impact on provider licensing work in Colorado.

- A complete replacement of the current MMIS system is now being considered by the Department. Until the timetable for this project is better understood, updates to the system will be limited to those with the most immediate financial and efficiency benefits.

Appendices

Appendix A: OSA Letter

Appendix B: Caseload Report

Appendix C: Link to Eligibility Modernization Report

Appendix D: Medical Eligibility Quality Improvement Plan (MEQIP)

Appendix E: Timely Processing Trend Analysis

Appendix F: Eligibility Trainings

Appendix G: PERM/MEQC Final Reports

Appendix H: Provider Licensing CSR