Public Knowledge LLC
Management Consultants

Report to:

Colorado Department of Health Care Policy and Financing

Colorado Eligibility Modernization Project – Eligibility and Enrollment Analysis and Modernization Report

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SECTION 1. Introduction

1.1. Colorado Eligibility Modernization Project Background

The Colorado Eligibility Modernization Project was initiated by the Colorado Department of Health Care Policy and Financing (the Department) with the objective of making Colorado's health care delivery system and access to programs more outcome-focused and client-centered. In addition, with the anticipated growth of applications for public health insurance programs, the Department wants to build operational capacity while containing long-term costs[1].

In order to modernize eligibility, the Department envisioned creating a single state-level entity for eligibility and enrollment processes for the Medicaid and Child Health Plan *Plus* (CHP+) programs. The February 15, 2008 budget request, "Building Blocks to 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 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 to leverage localized expertise for eligibility and enrollment practices.

1.2. Report Objectives

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 this report:

- 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 to make recommendations on how the Department should structure eligibility and enrollment processes.

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[1] According to the Kaiser Commission on Medicaid and the Uninsured, Medicaid enrollment rose 2.1% nationwide in a fiscal year 2008 survey. The Commission expects to see it rise even more to 3.5% in fiscal year 2009. www.kff.org/medicad.

- Gather available data on the costs and benefits of different modernization options for business process improvements in eligibility and enrollment.

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

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

1.3. Approach and Organization

1.3.1. Project Scope and Approach

Public Knowledge's analysis targeted eligibility and enrollment processes for Medicaid and CHP+ in the State of Colorado. Public Knowledge specifically focused on the eligibility processes for applications, redeterminations, and case maintenance. The analysis and identified modernization options are based on a review of representative eligibility sites but are not aimed at specific site's operations and policies. Instead, our analysis focused on efficient and effective processes for Colorado's Medicaid and CHP+ program as a whole.

In addition, while Public Knowledge did include operational findings associated with the Colorado Benefits Management System (CBMS), the focal point of the analysis was not the system, but instead, the eligibility and enrollment processes that are highly automated by CBMS. A review of CBMS from a technical or operational perspective is outside the scope of this report.

Public Knowledge's approach to the project was developed in close collaboration with the Department during the project planning phase. During this phase, stakeholders were identified, the project vision was confirmed with the Department, the project work plan was developed, eligibility sites were selected for visits, and status reporting and communication protocols were established.

Once the planning phase was completed, Public Knowledge gathered data and information to support the analysis. This included the following tasks:

- **Visited and reviewed selected eligibility sites:** Public Knowledge conducted site visits to ten county offices, as well as a Medical Assistance site and the CHP+ vendor, to gain an understanding of the eligibility sites' eligibility and enrollment processes, to identify the similarities and variations in how eligibility sites perform their functions, and to identify efficiencies and inefficiencies in current operations.

- **Conducted research into best practices:** Public Knowledge conducted research on best practices and lessons learned from other states and Colorado's eligibility and enrollment processes.

- **Reviewed responses to Request for Information (RFI):** Public Knowledge reviewed responses to a Request for Information (RFI) that the Department released to solicit ways to modernize eligibility and enrollment processes. For more details on the RFI responses, see Appendix A.

- **Identified and documented findings:** Based on the information gathered through various sources, including stakeholder interviews, eligibility site visits, and a review of RFI responses, Public Knowledge identified and documented the relevant findings associated with Medicaid and CHP+ eligibility and enrollment processes.

- **Identified modernization options:** Based on the findings above, Public Knowledge identified gaps in Colorado's eligibility and enrollment processes. As a result of this gap analysis, and in collaboration with Department representatives, Public Knowledge developed eligibility and enrollment modernization options for the Medicaid and CHP+ programs.

1.3.2. Project Guiding Principles

A group of stakeholder and partner representatives consisting of clients, client advocates, county representatives, and other eligibility experts was formed to provide feedback on the Department's plan to modernize the State's eligibility and enrollment processes. The group developed guiding principles listed below as a shared vision for an eligibility and enrollment model.

- Clients should receive their eligibility determination results timely and accurately.

- Clients should receive their benefits timely and accurately.

- Clients deserve predictability and consistency of results throughout Colorado.

- Coloradoans should expect that government programs are run efficiently and effectively.

- Colorado should streamline and simplify options to increase enrollment and retention.

- Clients should have a variety of self-service options available to learn about, apply for, enroll in and retain health insurance coverage including the option for face-to-face guidance.

- Document management, including imaging, storage and retrieval should meet minimum standards across the State.

- Clients deserve to be treated with dignity and respect.

- Clients should have the option of applying for public health insurance programs when they are applying for other human services programs.

- Technology should be harnessed to improve Medicaid and CHP+ enrollment and retention.

Public Knowledge utilized the guiding principles during the course of the evaluation for formulating the best practices, findings, and modernization options presented in this report.

1.3.3. Glossary of Terms

The following terms are commonly used throughout the report and are defined below.

Glossary of Terms	
Application Initiation (AI)	The initial data entry of basic applicant information (i.e. client name, address, family members) into CBMS.
Business Objects	The reporting module that organizes CBMS data into reports. Business Objectives was replaced with Cognos in November 2008.
Business Process	Start to finish steps that outline a procedure (i.e. Application Initiation process).
CBMS	The Colorado Benefit Management System, Colorado's automated client eligibility system used throughout the eligibility and enrollment process to determine eligibility status of applicants for both the Department's health care programs as well as the financial programs administered by the Colorado Department of Human Services.
DRA	The Deficit Reduction Act, a Bill passed by Congress in 2005 that included legislation affecting many aspects of the Medicaid program. The Act requires that original or certified copies of citizenship and identity documentation be provided by all program applicants when applying for Medicaid. The citizenship and identity documentation is not required for the CHP+ program.
Interactive Interview (II)	The data entry of pertinent applicant information (i.e. such as income, assets) in CBMS. An Interactive Interview (II) is typically done during an interview with the applicant either in-person or via telephone for financial programs administered by the Colorado Department of Human Services. Most applicants applying for health care programs submit paper applications to the local county departments of social/human services.
Interfaces of data exchanges	The ability to link data from two separate sources.
Internet Portal	A secured point of access via the Internet that allows eligibility technicians to connect to the Department's systems.
Model	Overarching eligibility processes, including organizational structure, systems and business processes.
Medical Assistance Programs	Includes Medicaid and CHP+ programs.
Open Source Systems	Typically developed in a public, collaborative manner, Open Source Systems permit users to freely redesign the system and redistribute it in its modified form.
System	Information Technology (IT) related systems used in eligibility models.
SCHIP	State Children's Health Insurance Program, which is equivalent to Colorado's Child Health Plan *Plus* program or CHP+. The Colorado SCHIP program is referred to in legislation as the Children's Basic Health Plan and marketed as the Child Health Plan *Plus* program or CHP+.
TANF	Temporary Assistance for Needy Families program, commonly known as welfare.
Web	World Wide Web. Used interchangeably with the term Internet.

1.3.4. Report Organization

The remainder of the report is organized as follows:

- Section 2: State Models – Best Practices and Lessons Learned
- Section 3: Evaluation of Administrative Practices
- Section 4: Conditions for Success
- Section 5: Recommendations

1.4. Summary of Findings

Based on reviews and analysis conducted from July through November 2008, Public Knowledge found the following:

1. The Department should institute the following modernization components statewide:

    - **Implement an electronic document management system (EDMS).**
    - **Implement a centrally-managed customer service center (CSC) to broaden client access.**
    - **Expand the involvement of community-based organizations (CBOs) in the eligibility and enrollment process.**
    - **Develop web-based services for clients and CBOs.**
    - **Replace paper documentation with electronic client data where possible.**

    In reviewing these modernization components with stakeholders and Department leaders during the project, Public Knowledge found widespread agreement that such components are needed in Colorado. The Department currently operates with a decentralized eligibility and enrollment model that does not uniformly support these components.

2. The recommended modernization steps require a much higher degree of centralization than is currently supported by the Department. There is inadequate infrastructure or expertise extant within the Department, either in the eligibility sites or at the central office, for the centralization of components that have been identified. The expertise will need to be developed in-house or acquired through outsourcing.

The evidence for determining whether to implement centralized services using in-house resources or outsourcing to a vendor is varied in its veracity and not conclusive. However, the evidence does point to several factors in determining whether to outsource:

- The timeframe for implementing change using in-house resources is generally much longer than when using a vendor. For example, Utah has had many successes in modernizing using state staff but the timeframe described is about eight years with some changes still being implemented. Similar results may be obtained using contractors in a much shorter timeframe.

- In order to use in-house resources, the Department must be in a position to compete with private sector firms for the skilled resources needed for these efforts. Since the components being considered are not uniformly operational in Colorado eligibility sites, developing in-house capacity will require an investment in additional FTE's and infrastructure rather than simply moving decentralized resources to a centralized locale. Some eligibility sites have implemented an EDMS in a much smaller scale than what is required to implement on a statewide scale.

- Highly publicized examples of outsourced centralization efforts failing in the states of Indiana and Texas are not necessarily an indictment of outsourced services in general. Many aspects of health and human services programs have been successfully outsourced in Colorado and elsewhere. For example, medical claims processing and fiscal agent operations are routinely successfully outsourced, including in Colorado. The biggest factors for success seem to be a well-written contract with objective performance criteria, adequate state resources for monitoring the contractor, and a commitment to collaboration.

- Hard data for determining the return on investment or cost benefit to modernizing eligibility is difficult to pin down in a conclusive manner for outsourcing versus developing in-house capacity. However, cost benefits for each of the recommendations is presented in Section 5 using data that was made available during the project without regard to outsourcing. In addition to cost benefit data, Public Knowledge found in talking with other states is that the opportunity cost for not modernizing is significant. For example, state programs repeatedly cited significantly less turnover and an increase in job satisfaction among staff after modernization efforts. As another example, we found that modernized eligibility programs were more responsive to policy and legislative changes at both the federal and state level. Yet another example is an increase in the quality and accuracy of the disbursement of program benefits when eligibility and enrollment processes are modernized. Each of these examples comes with real savings that are nevertheless impossible to quantify beforehand or to generalize from another state's program.

In reviewing the successes and failures of other states, it is much too simplistic to frame the question as whether to adopt a centralized or decentralized approach to eligibility and enrollment. Instead, it is necessary to define the areas under consideration and to assess the current degree of centralization against the desired outcomes of a more centralized approach. We have included a matrix in Section 5 that attempts to highlight areas for consideration of a more centralized approach. Note that some eligibility and enrollment processes are still performed at the local level even in the most centralized programs.

The term "centralization" is commonly used when describing a modernized Medicaid and CHP+ model. It is clear from the best practice results that centralizing elements of the Medicaid and CHP+ model maximizes efficiency and effectiveness in eligibility and enrollment processes. It is Public Knowledge's belief that centralizing the recommended modernization options would provide eligibility sites with additional tools they need to help run a successful eligibility and enrollment model in Colorado. Whether or not the Department outsources eligibility functions depends on the factors described above. Additional detailed findings and recommendations for implementing the findings are found in the following sections of this report.

SECTION 2. State Models-Best Practices and Lessons Learned

2.1. Research Approach and Definitions

Public Knowledge researched several states for eligibility best practices and lessons learned. Nationwide trends were also considered based on discussions with the states, and participation at national eligibility conferences. Initial research efforts also included interviews with leaders from national organizations, such as the Center on Budget and Policy Priorities and the National Academy for State Health Policy. By gathering information at the national level, as well as enlisting feedback from Colorado stakeholders and partners, Public Knowledge was able to examine programs in other states that have recently changed their eligibility and enrollment model, implemented statewide systems, have a reputation for being innovative or have had significant issues with recent eligibility and enrollment processes.

A research template and interview protocol was developed early in the planning stage to promote consistent information gathering in the research phase. Public Knowledge interviewed Medicaid and State Child Health Insurance Program (SCHIP) leaders and managers from other states to gain an understanding of their eligibility and enrollment model, structure, use of technology and application, redetermination and case maintenance processes. Medicaid and SCHIP websites for several states were reviewed to gain an understanding of eligibility and enrollment practices as well as the automated tools that are available to applicants and existing clients.

Public Knowledge consultants visited Utah's Department of Workforce Services to observe their technology-driven eligibility and enrollment model that has been touted by some Medicaid and SCHIP leaders as a successful modernization effort. The site visit consisted of a day and a half of meetings, and interviews and job shadowing sessions in order to understand the innovations behind Utah's eligibility and enrollment model.

Site visits were held throughout Colorado at county eligibility and enrollment offices and contractor sites to gather best practices and office innovations within Colorado's current Medicaid and CHP+ programs.

In reviewing the research findings from the collected sources, it became clear that there is no perfect eligibility and enrollment model or system that resolves every challenge in Medicaid and CHP+ eligibility. The variation in demographics, priorities, and funding from state to state means that a model that fits one state may not be optimal for the same programs in another state. In addition, Public Knowledge recognizes that the existing eligibility and enrollment processes among the other states are dependent on their organizational structure and policies, and may not always fit Colorado's needs. To offset these variations, the best practices are presented as individual components of an "ideal" Medicaid eligibility and enrollment model. Rather than creating an all encompassing "Best Practice Eligibility and Enrollment Model," the state findings are broken down so that each component can be analyzed and implemented based on the level of improvement it would bring to Colorado.

For further details on the interview protocol and state responses, see Appendices B and C.

2.2. Lessons Learned from other States

In identifying best practices among states, it is important to recognize areas where states have struggled in implementing changes to eligibility and enrollment processes and models. The following information summarizes the key lessons learned from projects that unfortunately, were not successful.

- **"Big Bang" implementation approaches are risky:** The most frequently reported issue is states implementing too much, too soon. With any new project, the excitement and pressure to dramatically improve current conditions can often lead to a scope that is unreasonable for state resources to manage. Even with sufficient training, there is always a steep learning curve with new procedures and systems. Ideally, the least complicated procedures (such as updating existing information, redeterminations) should be implemented first, so that eligibility technicians can more easily grasp new concepts and system functionality.

- **Don't try to implement new systems or procedures without appropriate operational support:** There is no point in investing both time and money into implementing a new system or process if resources are not available to support it. For example, a customer service center (CSC) with sophisticated management software is of little value if there is not sufficient staff to support it. In result, clients are frustrated due to the lack of response and revert to in-person customer service, which is more costly to provide. Successful states considered their resources and capacity when setting the scope of their modernization efforts, and were realistic when placing new expectations on eligibility technicians.

- **Be cautious when piloting a new model by county:** Although the county pilot model has been successful for many states, there have been issues reported with case transfers between counties that are using the new model and counties that are not. It is crucial that workflows are clearly defined, so that if a case is transferred in or out, counties on both ends of the transfer understand each step in the procedure and successfully help the client with the transfer.

- **Make sure that the most up-to-date eligibility rules and policies are reflected in automated systems:** Medicaid and CHP+ rules and policies often change. Most states have a procedure in place to communicate such changes to staff, but some have failed to update those changes in their automated client eligibility systems and tools. As a result, eligibility technicians struggle with keeping the up-to-date information fresh in their minds while their systems reflect outdated rules and procedures. Conversely, sometimes changes are made in the system, but eligibility technicians are inadequately trained to use it. This can lead to an increase in error rates and eligibility technician frustration due to the added complications with the systems. States reported having an accessible program administrator and concrete change management process is vital for handling the continuously changing Medicaid and CHP+ rules and policies.

- **Be prepared to spend time and resources to monitor performance if any contractors are used:** Many states contract out a portion of their Medicaid and CHP+ eligibility and enrollment processes to a vendor. Frequently, outsourced operations were characterized by

a lack of state-defined performance measures, contract monitoring plans and resources to hold vendors accountable to contract requirements and state expectations. The more successful states have created full-time positions and even units to help monitor vendor performance. Although contracting out services can save time and money, the model can only be successful if the state dedicates the needed effort and resources into monitoring the vendor's performance.

2.3. Best Practices

Keeping in mind that there is no one model or system that could solve every challenge with Medicaid and CHP+ eligibility and enrollment, the best practices are organized into stand-alone components that the Department can adopt individually based on the likelihood of improving its Medicaid and CHP+ eligibility and enrollment processes. Listed in no particular order, the best practices are:

- Solicit **eligibility technician feedback** when designing eligibility and enrollment processes.
- Provide applicants with **online self-screening tools** to increase communication about medical assistance programs and application processes.
- Establish **customer service centers (CSCs)** to promote customer service and streamline the application process.
- Provide extensive **employee training** to promote uniform practice and consistent application of eligibility and enrollment processes.
- Implement new models in **phases**, starting with the least complicated procedures first.
- Allow applications, updates and eligibility redeterminations to be **processed by clients online** to reduce workload.
- Develop **reporting capabilities** that allow management to monitor performance and workloads down to the individual eligibility technician level.
- Implement **an electronic document management system (EDMS)**.
- Use a **uniform automated client eligibility system** to promote consistent practice.
- Create **interfaces** to other state and federal systems to ease data exchange and reduce manual labor efforts.
- Create a **web portal** that will allow eligibility technicians to access the automated client eligibility system and electronic file with more flexibility.

The next section will provide a more detailed analysis of each best practice.

2.3.1. Overall Eligibility and Enrollment Models

This section expands on each of the best practices with a focus on how states have implemented them to enhance their overall Medicaid and CHP+ eligibility and enrollment model. State examples are provided to support each finding.

- **Solicit eligibility technician feedback when designing eligibility and enrollment processes:** Feedback from eligibility technicians is crucial when developing and implementing a new eligibility and enrollment model. Eligibility technicians are key stakeholders since they are the ones relying on the model for their everyday work. Enlisting help early on in the project will also help win eligibility technicians' buy-in and increase the acceptance levels of major changes, and ultimately create a better product or process. Some states develop a committee consisting of a diverse group of staff to act as a steering committee for the duration of the project. This is the most direct way to enlist the experience and thinking of your most knowledgeable workers. Other stakeholders, such as clients and community-based organizations (CBOs), can also provide valuable input and guidance in implementing new models.

  <u>State Examples</u>

  Wisconsin: To promote eligibility technician feedback, Wisconsin developed a website during the implementation of their online application, ACCESS, for their eligibility technicians to submit opinions on the system's functionality and design. Since Wisconsin heavily relied on their community-based organizations for application assistance, the organizations were also involved in the feedback process. A stakeholder committee regularly collected the feedback and voted on suggestions to implement.

  New York: When designing their new online application module, New York had each county office team up with a prominent community advocate of their choice to work with during the design of the online application. The partnership allowed for a broader range of feedback for the online application, which ultimately led to greater satisfaction with the tool.

  Arizona: Client notifications and communication tools were an issue prior to Arizona's implementation of their automated client eligibility system. To address this issue, Arizona worked with local nursing home residents and community center members to design their new forms and notifications. Volunteers were given copies of the State's notification examples and asked for feedback. A test was also given to each participant to assess the effectiveness of the notification.

- **Provide clients with online self-screening tools to increase communication about medical assistance programs and processes:** Many states are implementing online self-screening and education tools for clients to use at their discretion. The combination of online tools can help potential clients' better gauge whether they will be eligible for benefits, as well as inform them about next steps in the application process. Though not everyone has access to the Internet, states have reported that online tools still reach a broad range of applicants and can provide applicants with added communication on medical assistance programs and processes. Like any system, the testing of the screening tools is crucial so that applicants are not deterred from applying for benefits.

  State Examples

  Wisconsin: Wisconsin built a comprehensive online application, complete with a self-screening tool. Applicants can easily go to the site and fill out a short survey that will ask basic information about their household, employment status and income. Once the survey is complete and the applicant is potentially eligible for benefits, the screening tool will guide the applicant through the next steps of the application process.

  Pennsylvania: Pennsylvania's COMPASS system provides self-screening for multiple programs, including Medicaid and SCHIP. The tool allows an applicant to input basic information and determine if they are potentially eligible for medical assistance.

  Tennessee: Tennessee provides an online self-screening tool for applicants interested in applying for both TennCare (the state's managed care program) and Tennessee Cover Kids (SCHIP or CHP+ in Colorado).

- **Establish customer service centers (CSCs) to promote customer service and streamline the eligibility and enrollment processes:** Customer service centers (CSCs) can be a valuable resource for clients by providing a flexible and easy way to receive answers to questions and guidance on the application process. By staffing CSCs with trained eligibility technicians, many of the basic procedures such as checking eligibility status, adding household members, or updating a change of address can be handled over the phone, thus, saving the client a trip to the office. Client calls and interruptions can easily consume an eligibility technician's day and greatly impact his or her ability to process applications. CSCs can alleviate the majority of client's questions and basic needs from the eligibility technicians, allowing more time to dedicate to case management activities.

  State Examples

  Utah: Utah has two centralized CSCs that serve over 125,000 individuals at any given time. The staff at the centers handles initial client inquiries, completes client updates and even conducts applicant interviews for programs such as Food Stamps. CSC staff has access to the automated client eligibility system and generate what they call "electronic alerts" to notify eligibility technicians if follow-up is needed on a case.

Larimer County, Colorado: Several eligibility sites in Colorado have implemented a CSC to provide better customer service and reduce the amount of client inquires to eligibility technicians. Larimer County staffs their CSC with trained eligibility technicians who can provide valuable answers and instructions to clients. The CSC eligibility technicians have access to CBMS to review cases as well as update client notes in the Case Comment fields. If the CSC eligibility technician is unable to meet the client's needs, a ticket is created in a Microsoft Access database and triaged to the client's eligibility technician for further follow-up. Larimer County estimates that the CSC addresses about 75 percent of all clients' questions, allowing eligibility technicians to focus more on application processing.

Washington State: Washington's Department of Social and Health Services operates a number of separate CSCs. The CSCs were first implemented in the 1990's on an experimental basis in some of the agency's regional offices. At first, the CSCs handled only client inquiries and a few basic eligibility functions such as updating client information in case files. Over time, they have evolved and now take on additional tasks such as processing eligibility for several types of assistance. The Department's Medical Assistance Administration (now the Health and Recovery Services Administration) contracted with a professional CSC manager to set up a CSC called "MEDS" that handles all aspects of the Medicaid eligibility processes for all medical-only cases.

- **Provide extensive employee training to promote uniform practice and consistent application of eligibility rules and customer service:** Although new business models and systems can greatly assist staff in their daily work, eligibility technicians must be thoroughly trained in order to effectively apply the changes. The system training models that have proved most effective focus on training tasks rather than functionality. Eligibility technicians are more likely to identify with a familiar process (such as redeterminations or client updates) and can apply new information easier if training is focused on their job responsibilities rather than the system. States reported that training should prepare eligibility technicians for how their job roles will change with the implementation of a new system or model. Managers and supervisors will also need special focus since they are likely to receive questions from their eligibility technicians. In addition, states with effective training models have utilized incremental sessions for staff where eligibility technicians can refresh their skills and learn shortcuts to promote increased efficiency in their daily work.

State Examples

Nebraska: Eligibility technicians in Nebraska underwent a six-month training period prior to the release of their new automated client eligibility system. The system was rolled out by process (i.e. client updates, redeterminations, application processing), which correlated to a two-week training period for that particular process. The incremental training approach allowed eligibility technicians to master each process and decreased the learning curve associated with system changes. Eligibility technicians could easily relate to the processes being trained in each phase and better transition their skills into the new system.

Utah: Utah requires all eligibility technicians to undergo the same ten-week training course before being allowed to work in the system unsupervised. Like Nebraska, Utah developed a task-focused training model so that eligibility technicians could grasp the new content easier.

Florida: Although the State has training centers in each of their six regional offices, much of Florida's training is web-based to ensure uniformity. Workers are told at the time they are hired that keeping their job depends on their success in the training program, which takes about six weeks to complete. All work completed during the initial training period is reviewed for each eligibility technician. Intensive post-training reviews also occur in the form of case reviews and performance monitoring. Florida attributes it recent recognition as the state with "the most improved Food Stamp error reduction rate in the nation" in part to its implementation of the formal training program.

- **Implement new models in phases, starting with the least complicated procedures first:** As mentioned in the lessons learned section above, "Big Bang" rollouts can easily overwhelm eligibility technicians, and potentially lead to a catastrophic backlog of cases. States that had successful implementations rolled out their new model in phases, usually easing their eligibility technicians into the change by introducing the simplest processes first (i.e. starting with client updates or redeterminations before introducing application processing to eligibility technicians). By adopting the "slow and steady" theory to their implementation schedule, eligibility technicians were able to master each new process and grow more familiar with the system before the complicated procedures were introduced.

State Examples

Utah: Utah implemented their new eligibility model over a period of eight years. Each phase used the same design, testing and training methods to promote consistency in the model and practice.

Louisiana: Louisiana officials decided to bring their CSCs up carefully and slowly. They used only experienced eligibility technicians to staff the center and introduced the most basic tasks, such as client inquiries, first. Louisiana gradually expanded the complexity of their CSC responsibilities so that CSC staff can now conduct client updates, presumptive eligibility and redeterminations. The State reported that the expansion of responsibilities has greatly reduced application and enrollment processing times. Louisiana started with a vendor supplied CSC management system, but gradually modified it to meet their needs. The CSCs have handled approximately 800,000 calls since their implementation with very few reported problems.

2.3.2. Application Process and Performance Measures

The following best practices describe the components states have implemented to enhance their Medicaid and CHP+ application process and performance measures. State examples are included to support each finding.

- **Allow applications, updates and eligibility redeterminations to be processed by applicants or clients online to reduce workload:** Online applications provide an additional access point for applicants, as well as increase flexibility in the application process. States with online tools have reported that clients who submit an online application usually have a more complete application, allowing eligibility technicians to determine eligibility more quickly. Some states have implemented online redetermination processes as well, reducing the amount of data entry and case tracking for the eligibility technician. Online tools have further evolved and often include enhanced features, where clients can check their application status, benefit amounts and even request new Medicaid Identification cards online. Though not every applicant has access to a computer, states with online applications have creatively addressed the need by partnering with community-based organizations (CBOs) and public libraries, and setting up computer kiosks in eligibility sites. States with online applications report that about 25-50 percent of all applications are submitted online. For the list of states with online applications, see Appendix D.

  State Examples

  Wisconsin: Wisconsin has developed a nationally recognized online application tool, ACCESS. ACCESS is an Open Source system, meaning that the source code is free to the public. Many states, including New York and Pennsylvania, have used ACCESS as a basis for their online application. The system allows applicants and clients to screen for eligibility, apply online for programs, submit redeterminations, track their benefits, as well as update any personal information in their electronic file. Every online applicant or client creates a log-in and password that acts as their electronic signature for the application. Wisconsin reports that about 25-35 percent of all applications are submitted electronically, saving their eligibility technicians valuable time by decreasing their overall amount of data entry.

  Georgia: Georgia has also implemented an online Medicaid and SCHIP application and reports that approximately 50 percent of all applications are submitted electronically. This transition has greatly helped reduce the amount of time eligibility technicians spend organizing paper forms and entering applicant data into their automated client eligibility system.

  West Virginia: West Virginia created a website, called In-Roads, where individuals can apply for Medicaid and SCHIP as well as several other assistance programs. The site also includes a self-screening tool. After registering, an applicant can use the site to provide information the agency may need to conduct an eligibility review.

Pennsylvania: Anyone with Internet access can use Pennsylvania's online application and case maintenance system, COMPASS. Applicants and current clients can either apply for programs or renew benefits at any time of the day. All applicants and clients are assigned a user name and password, which ensures confidentiality once the application or renewal is received. The applicant or client can use his or her unique user identification/password to check on the status of his or her application or renewal after it is submitted. Additionally, the application or renewal can be suspended for up to 30 days in order to gather additional information.

- **Develop reporting capabilities that allow management to monitor performance and workload down to the individual eligibility technician level:** Individual workload reports are crucial for managing the overall performance of any department. Not only do individual workload reports help supervisors monitor eligibility technicians, they act as a tool for eligibility technicians when prioritizing work and help managers track overall trends in caseload performance. In addition, performance reports are a fundamental component in contractual agreements with vendors. States that have outsourced any part of eligibility process have defined specific metrics and have dedicated resources to monitoring the vendor's performance.

State Examples

Indiana: Due to extensive outsourcing, Indiana developed a series of detailed reports to help monitor vendor performance. The State also developed what they call Key Performance Indicators (KPIs), which act as performance metrics that help identify potential problem areas and measure the vendor's outcomes. An example of a KPI would be the average time it takes to process a Family Medical application. KPIs are monitored on an ongoing basis and communicated with the vendor. If the vendor is not compliant with the contract, penalties are applied.

Utah: Utah spent a large portion of their implementation developing performance metrics for both their eligibility technicians and their systems used in eligibility and enrollment processes. There are numerous measures present throughout the eligibility process; from the time the document is imaged to when the eligibility technician authorizes the case. Detailed reports were created to help monitor the series of metrics and better help measure the State's success more effectively.

2.3.3. Automated Systems

The following best practices describe the components states have implemented to enhance their automated systems. State examples are included to support each finding.

- **Implement an electronic document management system (EDMS):** One of the top tools used by states to improve efficiency is an integrated electronic document imaging and management system. Document imaging and management systems have advanced far beyond basic scanning functions. Many states now rely on EDMS for workload management and performance measures. With advanced barcoding technology, documents can be automatically catalogued and placed in a special queue to be processed by the appropriate eligibility technician. Newly scanned applications can be triaged to eligibility technicians for processing. Reports can easily be produced for managers and supervisors to help monitor caseloads down to the individual eligibility technician. States have also dramatically saved on overhead costs due to the decrease of paper storage needs.

  <u>**State Examples**</u>

  Utah: Utah currently runs a task-based eligibility model, where eligibility technicians are trained as generalists and cases are triaged to the next available eligibility technician rather than being divided by specific program. Utah has spent the past eight years developing a comprehensive document imaging and management system to help streamline their eligibility processes. It is important to note that Utah still uses their old automated client eligibility system and has only updated it to make it more efficient with document imaging. Therefore, a state does not necessarily need to invest in a new, automated client eligibility system in order to implement a sophisticated EDMS. Every document in Utah is scanned into the system at one of two imaging centers, which are strategically located close to US Postal Service hubs so that mail-in applications and documents can be intercepted and scanned before they reach the offices. All scanned documents are barcoded so that they can be easily associated with the correct case file. The scanned image is then triaged to a queue for it to be processed by the next available technician. Utah estimates a ten percent increase in their worker productivity due to the added technology and the instantaneous availability of documentation to workers.

  Arizona: Arizona has created an advanced EDMS primarily in-house. Every document is scanned and indexed 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 in the State.

  Louisiana: Louisiana converted all of its paper medical assistance case files to images in 2004, luckily before the devastation of Hurricane Katrina hit the State. After studying the document imaging methods used by other states, Louisiana decided to locate the imaging centers in each parish site so that the parishes had some control over the process. Although the work is divided among parishes, the state agency could easily move cases with the EDMS depending on each parish's workload. Louisiana also created an "overflow" unit where scanned files could be triaged if there was a backload of cases in any of the parish offices. Louisiana estimates that the costs of implementing an EDMS were recaptured by the

reduction in space needed to store paper files. More importantly, files are rarely lost and can be retrieved instantly. When hurricane Katrina struck four offices were totally destroyed, but not a single document was lost.

- **Use a uniform automated client eligibility system to promote consistent practice:** Access to the same automated tools is crucial for eligibility technicians. A centralized automated client eligibility system is essential to staff effectiveness. Colorado already has a working system, the Colorado Benefit Management System (CBMS), in place to help automate the eligibility process. Any enhancements to the Department's Information Technology (IT) resources should be implemented in a uniform and centralized manner.

  State Examples

  Arizona: Arizona has created an automated client eligibility system in-house. With having complete control over the design and development of the system, Arizona added educational tools and tool tips for their eligibility technicians to use while in the system. Also, user-friendly reports were created to help support managers and supervisors monitor job performance.

  Pennsylvania: Pennsylvania implemented its eligibility system, Client Information System, (CIS), in 1992. In 2001, the State modified its system to interface with their newly developed online application and screening tool. CIS consists of multiple databases and automatically populates applicant information from previously submitted applications, determines eligibility and benefits amounts for programs, produces client notices, generates benefits, maintains historical information, and fulfills state and federal reporting requirements. It supports workers in all facets of managing their caseload.

  Utah: As mentioned above, Utah has greatly advanced their eligibility and enrollment model by simply modifying their existing automated client eligibility system. They have a dedicated in-house IT staff that modifies their old system to meet the changing needs of eligibility technicians. This illustrates that states can modernize their eligibility and enrollment processes without investing in a new automated client eligibility system.

- **Create interfaces to other state systems to increase automated exchange and reduce manual labor efforts:** To reduce the amount of data entry required of their eligibility technicians, many states have created automatic interfaces to external systems with client data. Popular interfaces include links to Labor and Wage data, Vital Statistics, Internal Revenue, Social Security Administration and employment or training contractor systems. With the Deficit Reduction Act (DRA)'s recent mandate that requires originals or certified copies of identification and citizenship documentation with each application, real-time interfaces are even more crucial to the efficiency of application processing.

  State Examples

  Pennsylvania: Pennsylvania has created over 40 interfaces within their automated client eligibility system that automatically retrieve client information if available in external systems.

Eligibility technicians no longer need to manually search through systems or request client information for most of their client verification. This also helps the client by reducing the amount of effort and money that goes into collecting such documentation.

Utah: Similar to Pennsylvania, Utah has also built interfaces to many of the heavily used external systems. In addition, they have implemented a tool called E-find, which is commonly known as a "gopher" system. E-find acts as a search engine for client documentation. Eligibility technicians can enter client information into E-find, identify the needed client documentation by checking the appropriate box, and the E-find tool will search through all available external systems for the documentation. For example, an eligibility technician may need a birth certificate for a client. The technician enters the client information and marks that a birth certificate is needed. E-find will then search all external systems to try to find the client's birth certificate. This is a significant timesaving mechanism for eligibility technicians in regard to case research and verification collection.

- **Create a web portal that will allow eligibility technicians to access the automated client eligibility system and electronic file with more flexibility:** More and more eligibility systems are enabling eligibility technicians to conduct work functions over the Internet. Internet or web-based systems provide for more flexible access to the system, and typically require less hardware expenditures. With increasing staff turnover and growing facility costs, some states have transitioned their automated client eligibility systems online to help resolve such issues. Eligibility technicians can be located virtually anywhere that has access to the Internet. Some states have introduced virtual office incentives for eligibility technicians, and as a result, have seen a significant increase in employee satisfaction. In addition, states with virtual office employees have been able to reduce their facility needs and cut overall administration costs.

State Examples

Arizona: Arizona recently moved all eligibility related systems to the Internet. Due to the State's past struggle with staff turnover, Arizona saw the added system flexibility as a way to provide virtual office incentives to their top employees. Since the virtual office incentive implementation in 2006, Arizona has experienced a 13 percent drop in employee turnover and a significant increase in overall employee satisfaction. Due to the transition to virtual offices, Arizona was also able to close three large offices and downsize three others for a cost savings of around one million dollars.

Minnesota: Due to the flexible access of its web-based eligibility system, Minnesota was able to easily relocate a unit to an area dense with a skilled and affordable labor force. By providing computers and basic office supplies, the new unit was able to quickly transition onto the system with minimal costs to the State.

Utah: Utah provides eligibility technicians with a computer and portal to their web-based eligibility system for each virtual office. Since the implementation of virtual offices, the State estimates a ten percent increase in productivity among eligibility technicians.

SECTION 3. Evaluation of Administrative Practices

3.1. Evaluation Approach

In order to evaluate the current Medicaid and CHP+ administrative practices in Colorado, research was conducted at a statewide level and included an onsite review of current eligibility and enrollment processes in ten county offices that administer eligibility for these programs. The ten county sites represented both urban and rural areas serving diverse populations. As part of the site visits, Public Knowledge conducted interviews with county leaders and management, including directors, senior management, and supervisors. Public Knowledge also performed job shadowing with selected eligibility technicians to supplement our understanding of each selected county's eligibility and enrollment processes. Lastly, Public Knowledge developed process maps for each county's application, redetermination and case maintenance processes, as applicable. The process maps serve as a visual representation of how individual eligibility site's process applications and redeterminations and manage case maintenance. The process maps provide additional insight to variances in eligibility and enrollment processes among eligibility sites and efficiencies, or lack of efficiencies, of the processes. Summaries of the information obtained were shared in draft form with each county involved and modifications reflecting their input were made.

In addition to the ten county reviews, separate onsite reviews were conducted at: 1) a Denver Health Medical Assistance site (Denver Health contracts with the Department to offer enrollment services at 11 locations throughout the greater Denver area); and 2) the Denver site of the Department's CHP+ Eligibility and Enrollment (E&E) vendor, Affiliated Computer Services (ACS).

3.2. Summary of Statewide Eligibility Practices

Process mapping sessions were conducted with each county to gain insight into the eligibility and enrollment process for both Family Medical and Adult Medical Assistance programs. This includes the process steps involved in application processing, redetermination processing and case maintenance. The goal of the process mapping was to document a representative sample of eligibility and enrollment processes from around the state and to analyze the maps for commonalities as well as differences among the eligibility sites.

Although there are some differences in terms of eligibility technician responsibilities and tasks, the high-level eligibility processes are similar among the diverse eligibility sites. Sites that abandoned the traditional case-based business model and adopted a task-based eligibility model greatly differed from other sites due to the "team approach" to managing caseloads. For more information on each county, see the Eligibility Site Visit reports in Section 3.3.

The steps involved in the Medicaid and CHP+ eligibility and enrollment process were similar among the eligibility sites. The site receives an application by mail, fax or is delivered in person. From there, an eligibility technician is assigned to the Application Initiation process and enters basic applicant information into CBMS. Long-Term Care applications are usually triaged to a separate unit for processing. In addition, the Long-Term Care eligibility technician will refer the applicant for a functional assessment or verify that the functional assessment was already completed, which is

required for all Long-Term Care applicants. For Family Medical, Adult Medical and Long-Term Care Assistance, the eligibility technician will check for missing verification. If the application is missing verifications, a notification is sent alerting the applicant of the needed documents and the return deadline. Once all verifications are received, the eligibility technician continues to enter the applicant information in CBMS, reviews the eligibility results in the "wrap-up" screens and authorizes the case. A letter is sent to the applicant notifying him or her of their eligibility determination results. For a high-level process map of the Application Process, see Section 3.2.1.

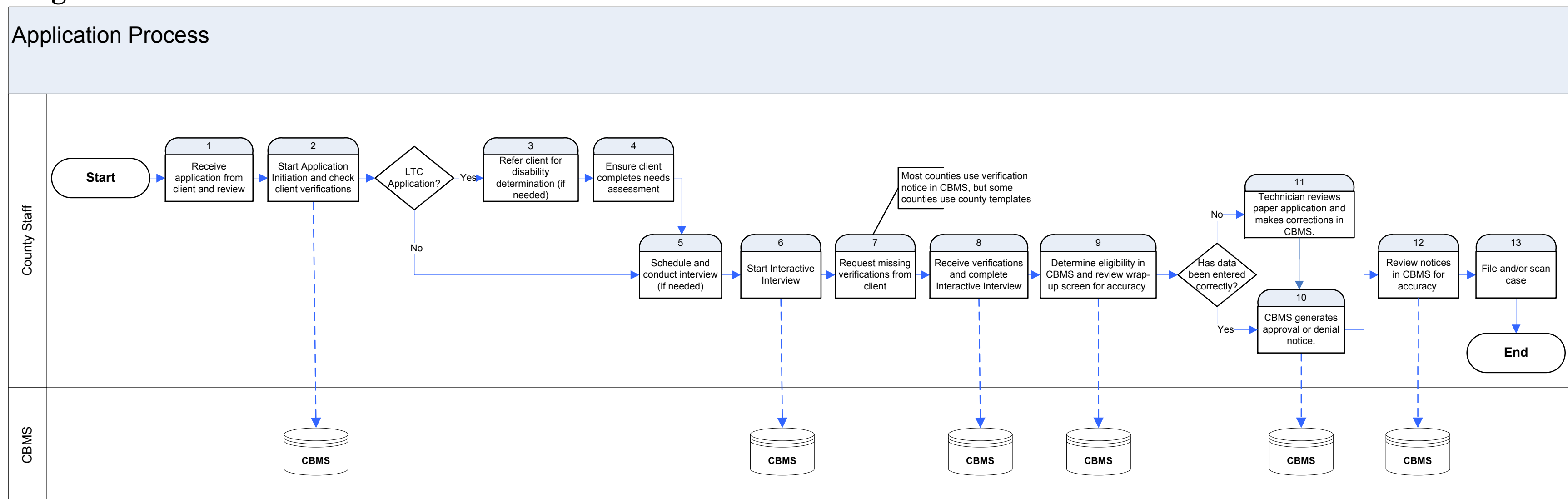
Eligibility sites also conduct similar steps when processing redeterminations. CBMS generates a redetermination packet, which is sent to the client two months in advance of the due date. The packet is reviewed by the client, changes are noted and returned to the office by either mail or in person. The eligibility technician begins research on the case, noting any verification and documentation that may be required to process the redetermination. The eligibility technician begins to enter the client information into CBMS. If verification is needed, a notification is sent alerting the client of the needed documents and the return deadline. Once all verifications are received, the eligibility technician continues to enter the client information in CBMS, reviews the eligibility results in the "wrap-up" screens and authorizes the case. A letter is sent to the client notifying him or her of their eligibility determination results. For a high-level process map of the Redetermination Process, see Section 3.2.2.

Case maintenance processes were also comparable among eligibility sites. The eligibility technician is notified of new client information from either the client or some other source. The eligibility technician begins research on the case, noting any documentation that may be required as a result of client changes. The eligibility technician begins to enter the updated information into CBMS. If verification is needed, a notification is sent alerting the client of the needed documents and the return deadline. Once all verifications are received, the eligibility technician continues to enter the client information into CBMS, reviews the eligibility results in the "wrap-up" screens and authorizes the case. A letter is sent to the client notifying him or her of their eligibility determination results. For a high-level process map of the Case Maintenance Process, see Section 3.2.3.

3.2.1. High-level Application Process Map

Diagram 3.2.1.1 below depicts a high-level process map of the Medicaid Application process, starting with receipt of the completed application by a county. There are many variations in how eligibility sites process applications, and the diagram below is an approximation of the high-level steps and the sequential order of steps. The diagram does not attempt to capture the actual detailed steps and tasks taken by each eligibility site for processing eligibility. Detailed process maps for the selected eligibility sites in which site visits were conducted can be found in the appendices.

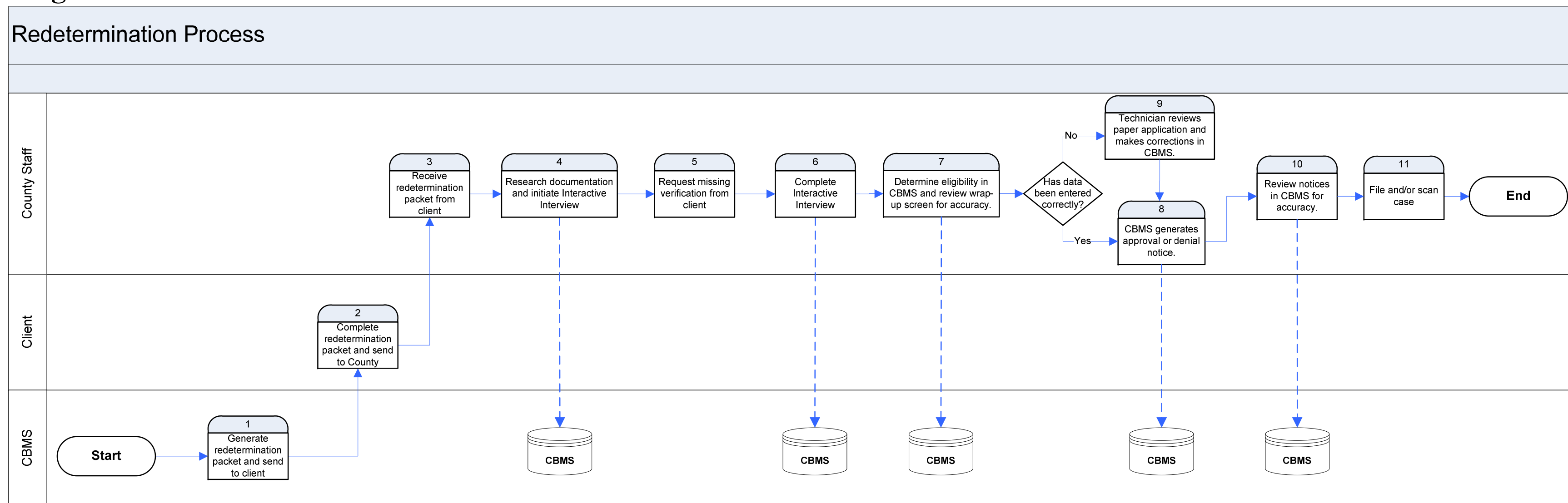
Diagram 3.2.1.1



3.2.2. High-level Redetermination Process Map

Diagram 3.2.2.1 below depicts a high-level process map of the Medicaid Redetermination process, starting with the automated generation of the redetermination packet by CBMS. There are many variations in how eligibility sites process redeterminations, and the diagram below is an approximation of the high-level steps and the sequential order of steps. The diagram does not attempt to capture the actual detailed steps and tasks taken by each eligibility site for processing redeterminations. Detailed process maps for the selected eligibility sites in which site visits were conducted can be found in the appendices.

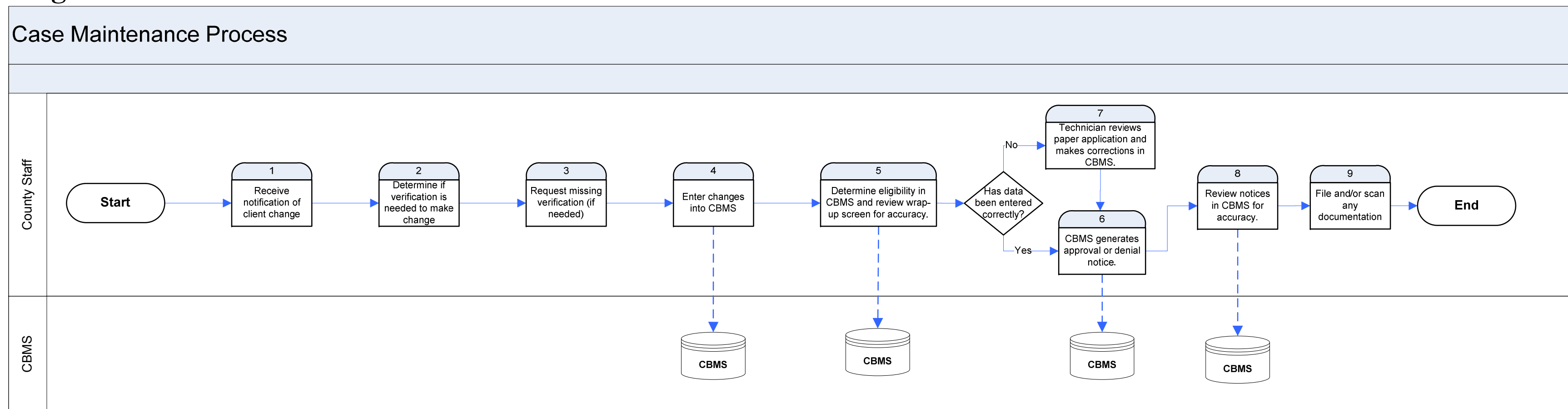
Diagram 3.2.2.1



3.2.3. High-level Case Maintenance Process Map

Diagram 3.2.3.1 below depicts a high-level process map of the Medicaid case maintenance process, starting with receipt of a client's change by the county. There are many variations in how eligibility sites perform case maintenance, and the diagram below is an approximation of the high-level steps and the sequential order of steps. The diagram does not attempt to capture the actual detailed steps and tasks taken by each eligibility site for performing case maintenance. Detailed process maps for the selected eligibility sites in which site visits were conducted can be found in the appendices.

Diagram 3.2.3.1



3.3. Site-Level Eligibility and Enrollment Processes (Select Sites)

Public Knowledge conducted site visits to gain an understanding of how eligibility sites performed eligibility and enrollment processes, to identify the similarities and variations among the sites, and to identify efficiencies and inefficiencies in current eligibility and enrollment processes. Ten counties were selected for visits as well as a Medical Assistance site and the CHP+ vendor. The representative sample included eligibility sites that varied considerably in terms of size and demographics of the eligible population, approach to administering eligibility, and other organizational considerations. The objective of each visit was to document the process flows for their medical eligibility, as well as analyze any innovations or challenges that stood out in the eligibility site. The site visits are summarized below by site and outline each eligibility site's basic information, Medicaid and CHP+ eligibility procedures, as well as any innovations or current challenges that stood out in the site. For details on the site visit agenda and interview guides, see Appendix E.

The following lists the eligibility sites visited during the review of Colorado's eligibility and enrollment practices:

- Adams County
- Arapahoe County
- Delta County
- El Paso County
- Gilpin County
- Fremont County
- Jefferson County
- Larimer County
- Mesa County
- Prowers County
- Denver Health Medical Assistance Site
- ACS, CHP+ Eligibility and Enrollment Vendor Site

3.3.1. Adams County

County Overview

The following table provides a basic profile of Adams County Department of Social Services as well as the surrounding demographics of the County.

Table: Adams County Department of Social Services Profile

Adams County Department of Social Services *Director: Dr. Donald Cassata*	
Demographic Information (United States Census Bureau)	
City:	Commerce City, CO
County population:	414,338 (2006 estimate)
% Poverty:	10.8% (2004 estimate)
% Foreign Born:	12.5% (2000 estimate)
Unique Medicaid Clients (Colorado Department of Health Care Policy and Financing, 2008):	47,045 (as of 9/30/08)
Department Information	
Total number of employees:	• Family Self-Sufficiency and Adult Services: 188.5 • Children and Family Services: 194 • Financial Services: 41 • Administrative Support: 7
Community-Based Organizations in Medicaid:	• Tri-County Health (Medicaid Eligibility site) • Salud Family Health Centers • Clinica Family Health Services • University of Colorado Hospital

Current Eligibility and Enrollment Processes

Adams County has worked to streamline eligibility procedures for their technicians, as well as speed up the application processing time for clients. Adams County Department of Social Services has divided their eligibility technicians into two general units for Medicaid purposes; a Family Medical Assistance unit and an Adult Medical Assistance unit. Although there are some specialties within the units, the majority of technicians act as generalists and can assist their clients with most of their program needs. Because of this blend of technical skills, Adams County reports little or no backlog with their high number of Medicaid applications and cases.

Adams County has one satellite office located in Aurora, Colorado. There are approximately 20 eligibility technicians staffed to assist in application processing. About 2000 Family Medical Assistance and other assistance program cases are processed in the satellite office each year. Adam's County also partners with three local clinics and the University of Colorado Hospital that determines eligibility and then transfers the case to the county for maintenance. The remaining new

cases for Adams County are either mailed into the office (either office), or delivered by walk-in applicants. All applicants interviewed at either office are screened for Family Medical, CHP+ and other benefit programs. Family Medical Assistance applications are received at the front desk, which is staffed with trained clerical workers that log each application into TRAC (an in-house customized software system that tracks applications through eligibility determination) and assigns the case to the lead eligibility technician. The clerical staff begins the Application Initiation (AI) process in CBMS and triages the application to the lead eligibility technician. Once the lead eligibility technician receives the case, it is alpha sorted and assigned to the appropriate technician.

The eligibility technician receives the new case and begins to fill out the 794 form, which acts as a cover sheet for the client file. The remaining application information is entered into CBMS. If the applicant is missing verification, CBMS will generate a notice alerting the applicant that he or she have ten calendar days (with the exception of the DRA documentation which allows for 14 calendar days) to return the needed verification. The eligibility technician will update the file in TRAC with a pending verification status. Once all verifications have been received, the eligibility technician continues to enter the applicant information into CBMS, runs eligibility and authorizes the case. The eligibility technician reviews the notices for accuracy of eligibility determination results and deletes any unnecessary notices. CBMS then generates the notice alerting the applicant of his or her eligibility determination results. The eligibility technician will then update the case status in TRAC and file the case.

The process for Adult Medical Assistance applications differs slightly from Family Medical Assistance. All applications are received at the front desk, and are logged into a homegrown tracking tool (different from TRAC) that is used to monitor the status of the case. A specialized AI technician receives the application, begins the AI process, and reviews the application for completeness. The AI technician will then assign the case to an eligibility technician via CBMS and update the log with the case status. File labels are generated at the front desk, which notifies the clerical worker to create a new file for the case. The new case is then triaged to an eligibility technician.

The receiving eligibility technician will review the case file for completeness. Necessary referrals are sent to vendors to schedule a functional assessment with the applicant. The eligibility technician conducts an Interactive Interview (II) over the phone with the applicants and simultaneously enters the application information into CBMS. If the applicant is missing verification, the eligibility technician will send a notification to the applicant alerting him or her that they have ten days (with the exception of DRA documentation which allows for 70 days) to return the needed verifications. Once all verifications and functional assessments are received, the eligibility technician continues to enter the remaining information into CBMS and runs eligibility. The eligibility technician reviews CBMS for accuracy and then authorizes the case. CBMS generates a letter to the applicant alerting him or her of the eligibility determination results. The case is then updated in the tracking system and filed.

For further details, see the Business Process Maps for Adams County attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions Adams County has implemented to increase efficiency or improve customer service.

Organizational Structure

Trained eligibility technicians on multiple programs: With the exception of a few trained specialists for 1634 Breast and Cervical Cancer, Emergency Medicaid cases and Community Waiver programs, the majority of eligibility technicians are trained on more than one program. In most cases, the client is able to work directly with one eligibility technician for all their benefit needs and concerns.

Dedicate specialized technicians to all case transfers: Due to the added complexity and time case transfers add to the workload, Adams County has created a specialized technician role to handle all case transfers. This role provides expertise in a complicated process as well as takes the burdensome process from the eligibility technician's duties.

Eligibility and Enrollment Processes

Conduct Interactive Interviews (II) with clients: All eligibility technicians are trained to conduct Interactive Interviews (II) with applicants in CBMS. This tool allows for information to be entered while the applicant is with the eligibility technician or on the phone, and can help the technician better communicate the complicated verification needs to the applicant and move cases to authorization more quickly.

Technology

Obtained a management reporting system and case tracking system: Adams County developed a management reporting system, called SCOPE, to better help their managers and supervisors monitor performance and workload. SCOPE breaks down the caseload to the individual eligibility technician level and is distributed to technicians to help them prioritize work. The Family Medical unit also utilizes a case tracking system called TRAC. All cases are entered into TRAC and updated as the status or location of the case changes. This allows eligibility technicians to gain a quick overview of where the case is in the process.

Created an in-house Quality Assurance unit: Due to their heavy focus on quality assurance, Adams County has created their own Quality Assurance unit to provide onsite system assistance within the office. The CBMS Technical Lead eligibility technician allows for a quicker resolution of system issues and greater staff support.

Purchased Q-Matic and set up a drop-off box in the lobby: Adams County has invested in Q-Matic technology to help create a streamlined client flow in their office. When applicants come in, they are assigned a number, which is then assigned to a clerical worker who "checks-in" the application and documentation. A drop box is also located inside of the lobby, which offers a convenient option for returning needed documentation.

Utilizes the full reporting capacity in Business Objects: In addition to the benefits described above, a specialized Quality Assurance Analyst has helped Adams County create a series of reports in Business Objects (the reporting module reports CBMS data) that can be used to monitor performance down to the individual technician. By fully utilizing the reporting capabilities within CBMS, Adams County is able to better monitor caseloads and job performance within their department.

Provides a dual monitor system to eligibility technicians: To help streamline the eligibility process, Adams County provides two monitors to each eligibility technician. This allows technicians to access and easily view additional external systems while processing the application in CBMS.

Community-Based Organizations

Developed an additional Medicaid Eligibility site with a new Community Based Organization: Adams County has recently partnered with Tri-County Health to implement a new Income Maintenance Specialist for Family Medicaid at their facility in Northglenn. One halftime employee is trained by the County to process Family Medical eligibility for any applicant who submits a complete application at the clinic. In addition, Adams County employs full-time Family Medical intake technicians at Salud Family Health Centers and Clinica Family Health Services clinics as well as a full-time Adult/Family Medical technician serving Adams, Arapahoe, and Denver Counties at University Hospital. Once eligibility is determined, all cases are transferred to the correct county for maintenance. As a result of this partnership, applicants are receiving approval faster, which in turn, allows applicants to receive benefits quicker. Within three months of starting this partnership, 100 percent of applications have been approved within one week of receiving a completed application.

Employee Training

Developing a strong, in-house training model: To help address staff training needs and reduce turnover, Adams County has developed an in-house training program. New hires are required to complete classroom training and job shadowing with 100 percent case checking completed by supervisors for a period of time designated by the supervisor. During this training period, CBMS is set up so that new eligibility technicians cannot authorize cases. A training room has been built with ten computers so all training is done in-house. Adams County expects that the new training model will streamline the hiring process and reduce the gaps in staff training and turnover.

Current Challenges

The following section outlines some of the challenges Adams County faces in their daily operations.

Eligibility and Enrollment Processes

Transfers between counties are inconsistent with the policy: Despite the mandated policy, Adams County reported that other counties often fail to update redeterminations before transferring a case to the County. In these cases, Adams County is then forced to send the case back.

Citizenship and identity requirements are burdensome: To provide better customer service and reduce the amount of travel required of their applicants, Adams County promotes mail-in applications for the Family and Adult Medical Assistance program. However, the Deficit Reduction

Act (DRA) mandates that original or certified proof of citizenship and identity be supplied with each application. Applicants usually have to make the trip to the office to provide these documentations despite the mail-in process. On top of the added time and travel, many applicants have to obtain original or certified documents, which takes money and additional processing time for the clients. Adams County has requested access to Vital Statistics data to alleviate applicants from the burdensome process of providing the certified documentation, but even that will serve only applicants born in Colorado.

Technology

Some Business Objects reports are insufficient: Adams County would like to see better reporting options for redetermination and pending cases, including the number of days and average duration of overdue redeterminations or pending cases. Currently eligibility technicians are calculating the data manually from other reports. Adams County would also like to see improved CBMS functionality, including reduced number of screens, elimination of unneeded or redundant fields, and increased functionality to eliminate workaround or manual processes.

3.3.2. Arapahoe County

County Overview

The following table provides a basic profile of the Arapahoe County Department of Human Services as well as the general demographics of the County.

Table: Arapahoe Department of Human Services County Profile

Arapahoe County Department of Human Services *Director: Cheryl Ternes*	
Demographic Information (United States Census Bureau)	
City:	Aurora, CO
County population:	537,197 (estimated 2006)
% Poverty:	8.2% (estimated 2004)
% Foreign Born:	11.0% (estimated 2000)
Unique Medicaid Cases (Colorado Department of Health Care Policy and Financing, 2008):	43,889 (as of 9/30/08)
Department Information	
Total number of employees:	• Department of Human Services: 451
Community-Based Organizations in Medicaid:	• Adams, Arapahoe School District • Tri-County Health Department • Plans to participate in a joint project with Adams and Denver Counties to station a eligibility technician at University of Colorado Hospital

Current Medicaid Eligibility and Enrollment Processes

The Arapahoe County Department of Human Services has two locations: one in Aurora and one in Littleton. The office in Aurora provides both Family Medical Assistance and CHP+ services, Food Stamps and the Colorado Works program to individuals and families. The Aurora office also contains a customer service center that answers client inquiries and performs some basic eligibility functions. The office in Littleton contains the Long-Term Care unit, and a specialized unit that processes all Family Medicaid-only applications and redeterminations, Adult Medical Assistance, Family Medical Assistance/Food Stamps, Family Medical/CHP+ applications.

The positions involved in Medicaid and CHP+ eligibility determination in Arapahoe County include clerical worker that specialize in application intake and Application Initiation (AI) in CBMS. Eligibility technicians handle the remaining steps in the eligibility process. Supervisors review cases before finalizing benefits for all new eligibility technicians for approximately a year, and each unit is

also supported by one or more lead eligibility technicians that assist the supervisors with various duties. Monthly case reviews are also conducted for each seasoned eligibility technician, which are used to help monitor performance.

Arapahoe County is able to provide same-day interviews for applicants applying for Family Medical Assistance along with other programs that require an interview. More information about this is included in the Innovations section of this report.

About a year ago, the Long-Term Care eligibility unit in Littleton was separated from the unit responsible for eligibility for adult cash programs due to the complexity of the Medicaid Long- Term Care eligibility rules. Two eligibility technicians serve the 13 nursing home facilities in the county. The casework is assigned to the eligibility technician by facility rather than by alpha-caseload to better serve the facilities. This has resulted in improved communications with the facilities. It has also helped drive standardization by ensuring clients and facilities are getting consistent answers and therefore are less frustrated.

Five eligibility technicians handle the Long-Term Care and Home and Community Based Services Waiver cases. Each of the eligibility technicians also handle applications for waiver programs, including programs covering the aged, blind and disabled persons with developmental disabilities, those who are mentally ill, and disabled children.

Arapahoe County images case file documents that need to be archived, although the imaging system does have a workflow management or management-reporting component. Any eligibility technician in the office can access the imaged documentation, which is organized by the household case number. Most case documentation is still kept in paper files that are held either at the technician's desk (pending applications) or, for ongoing cases, in case files located throughout the office.

County managers believe the chief factors that affect the workload associated with Medicaid and CHP+ eligibility include changes in policy and the increasing need in their community driven both by the current economic conditions and aging population.

For further details, see the Business Process Maps for Arapahoe County attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions Arapahoe County has implemented to increase efficiency or improve customer service.

Eligibility and Enrollment Processes

Offers same-day appointments: Medicaid-only applications do not require an interview, but if the applicant is also seeking services for another program that requires an interview, the applicant is offered an appointment the same day they hand in their paper application. Applicants who drop off their applications in the morning are given a specific appointment time during the day to return for their interview. They are also given a list of documents they need to bring with them, including the citizenship and verification requirements. This practice has shortened application-processing timeframes and has increased client satisfaction.

Organizational Structure

Developed a customer service center (CSC): Arapahoe County has established a customer service center (CSC) that answers client questions and takes limited action on Medicaid cases. Eleven eligibility technicians handle approximately 21,000 calls per month. CSC staff add needy newborns, request replacement Medicaid Identification Cards, act on address changes, troubleshoot issues, answer basic questions about case actions, provide general information and conduct provider eligibility verification.

Stationed out Medicaid Program Specialists: Arapahoe County has established agreements with several community partners to provide Medicaid eligibility services onsite. There are full time eligibility technicians stationed at the Tri-County Health Department and the public school. The office is currently working on a partnership with the Denver Health Medical Assistance site.

Employee Training

Developed integrated training model for new staff: Arapahoe County's Community Support Services Division employs two full time trainers. The Aurora office has a well-designed training room where eligibility technicians have access to computer terminals to practice. Their trainers assist in developing courses for eligibility technicians, including web-based training, and have actively participated with eligibility supervisors in the development of a Quality Improvement Plan which addresses the leading causes of errors found during Medicaid Quality Control reviews.

Current Challenges

The following section outlines some of the challenges Arapahoe County faces in its daily operations.

Organizational Structure

High turnover of staff: Like many counties, Arapahoe County has experienced significant turnover in eligibility technicians. Eligibility technicians currently carry combined Medicaid and Food Stamp (MA/FS) caseloads of 1,200. Eligibility technicians in the Long-Term Care unit currently carry caseloads of around 500. Office managers characterize their vacancy rate as a "staffing emergency", and at the time of the site visit, were in the process of hiring ten temporary staff to float and help fill vacancies. The managers believe a more reasonable caseload level is 700 MA/FS cases per eligibility technician.

Difficulty with recruiting new staff: Supervisors in Arapahoe County report that recruiting, training, and retaining new staff are some of their biggest challenges. They report when they recruit, it is hard to retain new staff because of the pressure of the job, the unusual combination of skills needed (analytical, computer, and people skills) and the relatively low wages. The average tenure of staff is 18 months. To make matters worse, when staff leave the caseload redistribution burdens the eligibility technicians that stay.

Coordination with CHP+ customer service center (CSC): Arapahoe County reports difficulty with coordination between Family Medical Assistance and CHP+ cases, especially in combined households. This coordination is made more confusing since the County completes CHP+

applications for families, and then transfers the case to Affiliated Computer Services (ACS) for case maintenance. At this point, the ownership of CHP+ cases is no longer with counties and this needs to be reiterated to clients.

Eligibility and Enrollment Processes

Lack of automation in procedures affects efficiency: There is a relatively large backlog in this office, mainly due to the high staff vacancy rate and the workload being "eligibility technician" dependent. Although some imaging of the case file is being done to help with document retrieval, the system cannot be used to manage work. In addition, Arapahoe County reported that CBMS also does not have the necessary tools to assist supervisors and managers in managing the workloads.

Citizenship and identity requirements are burdensome: Deficit Reduction Act (DRA) verification requirements cannot be requested through CBMS, burdening the eligibility technicians with extra work when having to manually create requests. This is of particular concern for supervisors because a recent audit noted the office has a weakness related to documenting DRA information in CBMS.

Technology

Issues with CBMS response time and accessibility: Arapahoe County reported daily issues with slow processing times in CBMS, especially between 12:00 PM to 3:00 PM. They also reported that the CBMS portal is frequently unavailable in the mornings. Also, since Arapahoe County has been focused on their backlog of cases, they are relying on weekend overtime to catch up. CBMS isn't available on Saturdays until 8:00 AM and Sundays at noon, which limits overtime possibilities.

CBMS functionality doesn't support Medicaid: Supervisors believe Medicaid is still the most problematic program in CBMS. They reported that Medicaid eligibility spans are still not correct for many clients, and they do not have the supervisory authority to override incorrect eligibility determinations. In addition, ticklers and alerts in CBMS are cumbersome. There are too many to be useful, so eligibility technicians use a paper system to track applications and redeterminations (pending drawers). Finally, every 5615 form for nursing home care must be manually completed since CBMS calculations are not accurate.

Management reports in CBMS are not sufficient: Managers and supervisors in Arapahoe County reported problems with CBMS reports. They also noted they have not received sufficient training to feel comfortable pulling reports from CBMS. Managers and supervisors would like more summary reports to help manage the workload. They would also like a new redetermination report to better help anticipate future workload, a report on redetermination disqualifications (terminations), reports on newborns, and one for client age milestones (one, six, 16, and 18 years olds) to help them anticipate when action needs to be taken. In addition, they would like new reports to help monitor application processing times. Supervisors noted that they understand that ticklers and alerts were meant to replace reports, but they find them unusable due to the volume.

3.3.3. Delta County

County Overview

The following table provides a basic profile of the Delta County Department of Health and Human Service as well as the surrounding demographics of the County.

Table: Delta County Department of Health and Human Services Profile

Delta County Department of Health and Human Services *Director: Chuck Lemoine, Deputy Director: Bonnie Koehler*	
Demographic Information (United States Census Bureau)	
City:	Delta, CO
County population:	30,401 (2006 estimate)
% Poverty:	12.5% (2004 estimate)
% Foreign Born:	4.2% (2000 estimate)
Unique Medicaid Clients (Colorado Department of Health Care Policy and Financing, 2008)**:**	3,318 (as of 9/30/08)
Department Information	
Total number of employees:	• Administration/Common Support: 5 • Children's Services: 10 • Health Services: 13 • Self Sufficiency: 31
Community-Based Organizations in Medicaid:	• Hilltop • Delta Memorial Hospital • Local nursing homes • A Family Resource Center (will open soon in a former middle school in Delta)

Current Eligibility and Enrollment Processes

Delta County maintains two offices that handle Medicaid and CHP+ eligibility. Most of the seven eligibility technicians are stationed in the Delta office, but two are stationed in the North Fork Annex, located about 20 miles away. One North Fork eligibility technician exclusively handles all Long-Term Care cases, while the other processes a full range of cases at the site. The North Fork Annex also houses the Single Entry Point (SEP) case managers who perform the functional assessments required for Long-Term Care services.

The only major difference in eligibility determination processes employed between the two offices is that the Delta office uses a separate eligibility technician to handle intake. The eligibility technicians located in North Fork handle the entire process, from intake to case maintenance.

At the Delta office, both Family and Adult Medical Assistance applications are received at the front desk. The intake eligibility technician, who is located at the front desk, receives all applications and begins the Application Initiation (AI) process in CBMS. Once AI is complete, the case is sorted alphabetically and triaged to the appropriate ongoing eligibility technician. If the application is missing any documentation, CBMS generates a notification to the applicant alerting him or her that documentation is missing. Once all documentation is returned, the ongoing eligibility technician continues to process the application in CBMS and runs eligibility. Before the eligibility technician authorizes the case, he or she reviews the "wrap-up" screens in CBMS for accuracy. If errors are found, the eligibility technician reviews the client data and re-runs eligibility. Once all errors are addressed, the eligibility technician authorizes the case and reviews the notices for accuracy. CBMS generates a notification to the applicant alerting him or her of the eligibility determination results. The case is then filed away.

Although the Long-Term Care application process is similar, the eligibility technician usually receives a referral from a nursing home or other long-term care provider. At that point, the eligibility technician notifies the SEP unit of the new potential client. The eligibility technician sends an application form to the individual or his or her care provider. When the application is returned to the office, copies of the first two pages are faxed to the SEP unit. The SEP unit schedules a functional assessment with the applicant usually within a week. If the potential client is a new applicant, the eligibility technician conducts an interview to review the application. If the applicant is missing verification, CBMS generates a notification alerting him or her of the needed documentation. Once all documentation is collected, the eligibility technician must wait for the SEP assessment. When the SEP assessment is returned, the eligibility technician continues to enter the information in CBMS and run eligibility. The "wrap-up" screens are reviewed for errors. If errors are found, the eligibility technician reviews the data in CBMS and makes any necessary corrections. Once the errors are resolved, the eligibility technician re-runs eligibility and authorizes the case. CBMS generates a notification to the applicant alerting him or her of the eligibility determination results.

For further details, please see the Business Process Maps for Delta County attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions Delta County has implemented to increase efficiency or improve customer service.

Eligibility and Enrollment Processes

Created a specialized intake eligibility technician in the Delta Office: The Delta office used to utilize a clerical worker at the front desk, but found that stationing an intake eligibility technician has increased efficiency in the application process by alleviating ongoing technicians of the AI step. The intake eligibility technician can also handle most inquiries, which allows the ongoing eligibility technicians more time to process cases.

Technology

Implemented a document imaging system: Delta County has made a strong effort to scan all eligibility-related documents into a document imaging system. Two clerical workers, augmented at times by community volunteers, are responsible for all document imaging. A cover sheet is created for all associated documents, and the clerk manually assigns a file name. The documents are then scanned into their system, Paperport, which stores the associated documents by the case number. Eligibility technicians have immediate access to the files from their computer, and can call up virtually any document that has been scanned. The document imaging system has also cleared a large amount of office space that was once occupied by file cabinets.

Current Challenges

The following section outlines some of the challenges Delta County faces in their daily operations.

Technology

Issues with CBMS report data: Delta County reported several issues with CBMS reports. For example, many cases have multiple household applicants who are eligible for more than one program but are reported by CBMS as separate individuals under each program. Delta County feels that CBMS needs to provide the capability to merge all household applicants into one case. Delta County also expressed a need for CBMS to provide information on cases receiving Health Maintenance Organization (HMO) services.

Slow response time in CBMS: "System crashes" reportedly occur on almost a monthly basis. In addition, CBMS response time can be very slow throughout the day, which delays the application processing time.

CBMS generates an unnecessary amount of client notifications: For Medical programs, Delta County reported that CBMS generates an excessive amount of notifications. To make matters worse, the notifications often have conflicting and confusing statements that are confusing to clients. In result, clients call the office with inquires and complaints. Eligibility technicians need to spend additional time deleting the inappropriate notifications in the application process, as well as addressing their client's concerns when notifications are accidentally are sent out.

Community-Based Organizations

Insufficient communication with CHP+ vendor: Virtually everyone interviewed in Delta County reported issues in the communication with the CHP+ program vendor. Most of the complaints were related to the CHP+ customer service center (CSC). Clients will call with questions and never receive an answer from a CHP+ worker. The clients then call Delta County for help, but technicians are usually unable to assist since they too are unable to get adequate information about their client's case from the CHP+ CSC.

3.3.4. El Paso County

County Overview

The following table provides a basic profile of the El Paso County Department of Human Services as well as the general demographics of the County.

Table: El Paso County Department of Human Services Profile

El Paso County Department of Human Services *Director: Barbara Drake, Deputy Director: Rick Bengtsson*	
Demographic Information (United Census Bureau)	
City:	Colorado Springs, CO
County population:	576,884 (estimated 2006)
% Poverty:	10.3% (estimated 2004)
% Foreign Born:	6.4% (estimated 2000)
Unique Medicaid Clients (Colorado Department of Health Care Policy and Financing, 2008)**:**	50,037 (as of 9/30/08)
Department Information	
Total number of employees:	• Office of Economic Assistance and Adult Services (included temporary staff): 112 • Office of Employment and Family Support (including temporary staff and contractors): 54
Community-Based Organizations in Medicaid:	• Peak Vista Community Health Centers (Medical Assistance Site) • Rocky Mountain Health Care Services • The Resource Exchange • Nurses Therapy Services • Memorial Hospital • Penrose Hospital

Current Medicaid Eligibility and Enrollment Processes

El Paso's Department of Human Services has spent the past year reengineering their Family Medicaid and CHP+ intake processes to more efficiently address the backlog of cases still present from the CBMS implementation. El Paso has divided their Medicaid work into three main units: Intake Family Medicaid, Ongoing Family Medicaid and Adult Medical Assistance. El Paso has recently shifted their Intake unit to a task-focused model, adopting a team approach to the unit's caseload.

El Paso reports that the majority of Family Medical Assistance applications are received by mail. Adult Medical Assistance applications also come in through mail but can also be delivered by the

applicant, email or fax. Once the application is received, clerical workers route it to the appropriate unit. If the application is for Family-Medical only, it will be routed to the Intake Unit. If the application includes other programs (i.e. Food Stamps, Colorado Works), it is routed to the Ongoing Family Medical unit. If an Adult Medical Assistance application is received by mail, it is routed to the Adult Services unit where an Application Initiation (AI) eligibility technician will begin the AI process.

When the Intake unit receives an application, it is first logged into a centralized tracking spreadsheet. Clerical workers create a case file, which is then placed in a central pending file bank and sorted by date of application. Each morning, the Intake unit meets to divide up the cases for that date. Once an intake eligibility technician receives a new case, he or she begins the AI process and verifies that all documentation has been collected. If the case is missing verification, CBMS will generate a notification to the applicant explaining that he or she have ten calendar days (with the exception of DRA documentation which is 14 days) to return the missing documentation. Once all needed verifications are collected, the eligibility technician continues to enter the application in CBMS. The eligibility technician determines eligibility in CBMS and authorizes the case. CBMS will then generate a notice to the applicant alerting him or her of the eligibility determination results. The eligibility technician enters the case into a Transfer Tracking Log to be transferred to the Ongoing unit and routes the case to a Central File Bank for storage.

If the application is for Adult Medical Assistance, a specified AI eligibility technician conducts the AI process. The AI eligibility technician reviews the case for documentation, and in most cases, sends a Verification Checklist to the applicant explaining the verification needed to continue the application process. CBMS will then generates a notification to the applicant explaining that he or she has ten days (with the exception of the DRA documentation which allows for 70 calendar days) to return the needed documentation. Once all documentation is received, the AI eligibility technician completes the AI process in CBMS and assigns the case to an intake eligibility technician. An interview may be requested depending on the case. The intake eligibility technician conducts the interview, if necessary, completes the eligibility determination process in CBMS and authorizes the case. A notification will be sent to the applicant alerting him or her of the eligibility determination results. All denied cases are routed to the Records Room for storage while all approved cases are transferred to the Ongoing unit.

Applications for Long-Term Care services are handled somewhat differently. If a Long-Term Care application is received, an AI eligibility technician conducts an interview with the applicant to determine if he or she will be eligible for the programs. If so, the applicant is provided with the necessary applications, as well as instructions on needed documentation and next steps. The Single Entry Point (SEP) is contacted and a functional assessment is then scheduled with the applicant. Once the application is returned to the unit, it is assigned to an intake eligibility technician who begins researching the case and gathering the needed documentation. If the applicant is missing documentation, a manual letter is sent to the client alerting him or her of any additional verification that is needed. Once all documentation is received and the functional assessment is returned, the eligibility technician continues to enter the application information in CBMS. The eligibility technician runs eligibility and authorizes the case. CBMS will generate a notification to the applicant alerting him or her of the eligibility determination results. The case is then passed to a supervisor for review and transferred to the Ongoing unit for maintenance.

For further details, see the Business Process Maps for El Paso County attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions El Paso County has implemented to increase efficiency or improve customer service.

Eligibility and Enrollment Processes

Organized Family Medicaid work by tasks, not caseload: The El Paso Department of Human Services recently shifted from the traditional case-focused workflow and centralized all new Family Medicaid cases into one "pool," creating a team approach to the unit's caseload. Each morning, the staff meets to divide the cases, which are organized by the date received. The unit works as a team until all applications under that date are processed. The new task-based model has not only helped increase application processing efficiency, but has helped the unit meet all compliance requirements (eligibility determined within 45 calendar days after filing) for the past five months. On top of the clear benefits in application processing, the team approach has added to the Incoming Family Med unit's overall morale.

Technology

Implemented a new customer service center (CSC): El Paso County implemented an interactive customer service center (CSC) to handle many of their client's questions and concerns. The CSC has one central phone line, and is equipped with four phones. The CSC was originally staffed with trained eligibility technicians, but recently had to switch to clerical workers due to staffing issues. The clerical staff has view-only access to CBMS so that they can better assist clients and help triage issues to the appropriate technician. Although the CSC lacks sophisticated software and sufficient staff support, it currently handles approximately 25 percent of all client questions, allowing eligibility technicians more time to process applications.

Community-Based Organizations

Developed an additional Medicaid Eligibility site with a new Community Based Organization: El Paso County has recently partnered with Peak Vista Community Health Centers (Peak Vista) that implemented a new Intake Unit for Family Medicaid. Peak Vista staff will be trained by the county to perform all Intake tasks in CBMS. Once eligibility is determined, all cases will be transferred to El Paso County. Peak Vista staff carries a small caseload (typically one to three applications a day), but have helped by alleviating some of the county eligibility technician's work. El Paso County believes that this relationship will significantly reduce El Paso County's caseload in the future once Peak Vista grows more familiar with the eligibility process.

Employee Training

Developing a strong, in-house training model: To help address gaps in staffing, El Paso County is developing an in-house training unit. New staff will complete one of three training tracks, including a mandatory overview of all programs administered by the County. The goal of the training unit is to create "floaters" in which newly trained staff can easily be placed into areas with the greatest need. El Paso County expects that the new training model will streamline the hiring process and reduce the gaps in staffing.

Current Challenges

The following section outlines some of the challenges El Paso County faces in their daily operations.

Organizational Structure

High turnover of staff has led to an increased backlog of cases: Like many counties, El Paso County has experienced significant turnover of eligibility technicians. El Paso County Department of Human Services estimates that the turnover ranges from 40-50 percent each year, and that the average eligibility technician stays for about two to three years. Although El Paso has recently increased their staff by 51 FTEs, the high turnover and loss of knowledge has significantly added to the County's backlog in cases. El Paso County believes part of the problem may be insufficient compensation for the corresponding amount of work.

Eligibility and Enrollment Processes

Citizenship and identity requirements are burdensome: It is difficult to obtain certified copies of citizenship and identity for many clients, which usually causes a delay in the application processing.

Redetermination dates do not correlate among the programs: El Paso reiterated that the redetermination dates among the various programs the Department administers do not correlate. The multiple redetermination dates cause added strain on the eligibility technicians' efficiency and time management due to the multiple dates of redetermination.

Missing documentation in transfer cases causes extra work for eligibility technicians: Particularly in Long-Term Care transfer cases, the receiving eligibility technician typically only has the case information in CBMS to review, and does not receive the needed hard copies of verification. The eligibility technician will then have to call the county and attempt to obtain the missing documentation for the case. This manual process causes hours of added time for the receiving eligibility technician.

Technology

Challenges with CBMS continue to affect application processing efficiency: El Paso stressed that the data entry process in CBMS is not streamlined with the eligibility policy, resulting in many additional screens and fields for eligibility technicians to work through in CBMS. The inefficient data entry process negatively impacts both clients and eligibility technicians.

3.3.5. Fremont County

County Overview

The following table provides a basic profile of the Fremont County Department of Human Services as well as the general demographics of the County.

Table: Fremont County Department of Human Services Profile

Fremont County Department of Human Services *Director: Steven Clifton, Deputy Director: Richard Cozzette*	
Demographic Information (United States Census Bureau)	
City:	Canon City CO
County population:	48,010 (2006 estimate)
% Poverty:	14.2% (2004 estimate)
% Foreign Born:	1.5% (2000 estimate)
Unique Medicaid Cases (Colorado Department of Health Care Policy and Financing, 2008)**:**	5,199 (as of 9/30/2008)
Department Information	
Total number of employees:	• Department of Human Services: 98 • Medicaid Eligibility Technicians: 13
Community-Based Organizations in Medicaid:	• Public Health Nursing Unit • Pediatrics Associates • River Valley Pediatrics • Button Family Practice • St. Thomas More Hospital • EPSDT Coordinator • Local Nursing Homes

Current Medicaid Eligibility and Enrollment Processes

Since Fremont County was one of the pilot sites for CBMS, the County implemented several changes prior to the CBMS rollout in 2004. Fremont County spent approximately two years preparing for the CBMS go-live in order to make the transition seamless to both staff and clients. In result, Fremont County has simplified the application process by creating a single point of entry for all applications.

The majority of applications are hand-delivered to the front desk. The front desk triages the application to the Application Initiation (AI) unit for processing. Depending on the program(s) the applicant is applying for, an interview may be scheduled. Once the initial data is entered into CBMS, the application is sorted by alpha and triaged to the appropriate eligibility technician. If the application is requesting multiple programs, it is assigned by the following criteria: Family Medical

and CHP+/Food Stamps or Family Medical and CHP+/Food Stamps/TANF applications are assigned to TANF technicians, all Adult Medical related applications are assigned to an Adult eligibility technician, and any Adult Medical/Family Medical and CHP+/Food Stamps/TANF applications are assigned to a "combo" eligibility technician.

Once the eligibility technician receives the case, he or she will review the new application for needed documentation. For Adult Medical Assistance applications, the eligibility technician refers the applicant for a functional assessment. If verification is missing from the application, CBMS generates a notification explaining that the applicant has ten days (with the exception of DRA documentation which allows for 70 calendar days) to return the necessary documentation. Once the documentation and necessary functional assessment results are received, the eligibility technician continues to enter the application in CBMS, runs eligibility and authorizes the case. The eligibility technician reviews the correspondence list in CBMS for accuracy and, if needed, delete any unnecessary notifications from being sent to the client. CBMS then generates a notice alerting the applicant of the eligibility determination results.

For further details, see the Business Process Maps for Fremont County attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions Fremont County has implemented to increase efficiency or improve customer service.

Organizational Structure

Hire former clients as technicians: Fremont County has had great success with hiring former clients as technicians due to their personal involvement and familiarity of the programs. Fremont County also functions as a Work Experience Program site for Colorado Work's participants, and receives many clients as temporary staff within the Department throughout the year. This allows for an easy transition from the temporary role into a permanent position. In result, Fremont County has experienced success in retaining staff, as well as employee satisfaction. It is estimated that the average eligibility technician has been with the County for ten to twelve years.

Eligibility and Enrollment Processes

Created a single entry point for their clients: Fremont County has streamlined the application process by creating a single entry point for their applicants. Every applicant is assigned to a single eligibility technician, which makes both the application process, as well as ongoing procedures easier for both the applicant and eligibility technician. The applicant has direct access to the eligibility technician, and can easily access them with any issues or concerns. Fremont County believes that by reducing the amount of case shuffling between staff, there are fewer errors among eligibility technicians. In addition, there is less confusion in the application process and better customer service provided to the applicant.

Technology

Staffs a CBMS Specialist onsite: As the result of being a pilot site for CBMS, Fremont County recognized early that a CBMS Specialist was needed onsite to assist staff with the transition. The CBMS Specialist is the direct point of contact for all CBMS related questions from staff, as well as a point of contact for the State when communicating system changes or updates. The Specialist formats a weekly email summarizing all CBMS updates for the staff. A centralized CBMS bulletin board is also updated with any CBMS related notifications or issues. The streamlined communication model with CBMS promotes consistency in system practice, as well as provides the eligibility technicians with added support in CBMS.

Utilizes the full reporting capacity in CBMS: In addition to the benefits described above, the CBMS Specialist has helped Fremont County create a series of reports in Business Objects that can be used to monitor performance down to the individual eligibility technician. By fully utilizing CBMS data to report, Fremont County is able to better monitor caseloads and job performance within their department.

Community-Based Organizations

Developed a pathway of communication for community advocates: Although community advocates are not directly involved in the eligibility process, Fremont County has created a form to help aid communication between the County and community sites. Community advocates can fax in new information about the client, birth announcements, as well as questions about a client's Medicaid status. This communication has not only helped eligibility technicians receive new client information more quickly, but has also increased community advocate's satisfaction by opening a direct line of communication between the two sites.

Current Challenges

The following section outlines some of the challenges Fremont County faces in their daily operations.

Eligibility and Enrollment Processes

Citizenship and identity requirements are burdensome: Due to the added cost and time on applicants, Fremont County is concerned about the difficult process of obtaining certified copies of citizenship and identity. Fremont County recommends that an interface to Vital Statistic data be developed so that information can automatically be pulled, saving valuable time for applicants as well as eligibility technicians.

Missing documentation in transfer cases causes extra work for technicians: When pending cases are transferred to the county, the receiving eligibility technician typically only has the case information in CBMS to review, and lacks the needed hard copies of verification. The eligibility technician will then have to call the county and attempt to track down the missing documentation for the case. This manual process causes hours of added time for the receiving eligibility technician.

Technology

CBMS generates an excessive amount of client notifications: Fremont County reported that the amount of client correspondents that CBMS produces for Medical clients is excessive and confusing. Clients can receive multiple conflicting notifications for both Medicaid and CHP+ programs throughout the year. To prevent additional client confusion, eligibility technicians need to manually delete the unnecessary notifications in CBMS. This process is time consuming and detracts from the eligibility technician's application processing time.

3.3.6. Gilpin County

County Overview

The following table provides a basic profile of Gilpin County Department of Human Services as well as the surrounding demographics of the County.

Table: Gilpin County Department of Human Services Profile

Gilpin County Department of Human Services *Director: Betty Donovan*	
Demographic Information (United States Census Bureau)	
City:	Black Hawk, CO
County population:	5,042 (2006 estimate)
% Poverty:	5.6% (2004 estimate)
% Foreign Born:	3.4% (2000 estimate)
Unique Medicaid Cases (Colorado Department of Health Care Policy and Financing, 2008)**:**	210 (as of 9/30/08)
Department Information	
Total number of employees:	• Department of Human Services: 12
Community-Based Organizations in Medicaid:	• Non-emergent Medicaid transportation (NEMT) • Mountain Family (helps complete PE apps) • Senior Program (Volunteers of America)

Current Medicaid Eligibility and Enrollment Processes

Gilpin County Department of Human Services has spent the past year reorganizing their Medicaid and CHP+ eligibility caseloads in order to work more efficiently and provide an increased level of customer service. Gilpin County is currently staffed with twelve employees, four of which are dedicated to the Medical Assistance programs. The staff includes a Human Services Director, an eligibility technician, a Medicaid case manager, and a front desk office assistant. Since there is no supervisor level, eligibility technicians make all decisions for approvals through a waiver specific to the County. In the past year, the staffing level has remained the same but Gilpin County has made changes in the way eligibility technicians manage their caseload. Prior to this year, Gilpin County had one eligibility technician responsible for all Medical Assistance cases. Now the caseloads are divided into Children's Programs/Medical Assistance and Adult Programs/Medical Assistance, which are managed by two eligibility technicians. This split in caseload allows the eligibility technicians to put more focus on customer service and ensures that clients are getting all the services they are qualified to receive.

Gilpin does not carry a backlog of cases; all medical cases are processed as soon as they receive the necessary verifications. Application processing time is typically two weeks for most cases. There is also one satellite office in the Gold Mountain Village Apartments where the two eligibility technicians travel twice a month to assist applicants in the application process. An additional satellite office will open soon in Rollinsville (North County – unincorporated Gilpin County). According to Gilpin County, some Medical Assistance applications arrive by mail but the majority of applicants (70 percent) come into the office for assistance. The front desk is staffed with an office assistant who begins the Application Initiation process and occasionally helps applicants complete an application. The office assistant date stamps the application, checks for signatures, and triages the applications to the appropriate eligibility technician. If the application is requesting Adult Medical Assistance, it is triaged to the adult service eligibility technician. All others are triaged to the Family Medical eligibility technician.

Once the eligibility technician receives the case, he or she reviews the new application for needed verification. If verifications are missing from the application, the eligibility technician provides a written, county-created request for verification checklist highlighting the missing documents the applicant needs to provide. This checklist is provided either in person, emailed, or mailed to the client. Once the verification is received, the eligibility technician continues to enter the application in CBMS, runs eligibility and authorizes the case. The eligibility technician reviews the correspondence list in CBMS for accuracy and, if needed, deletes any unnecessary notifications from being sent to the applicant. CBMS then generates a notice alerting the applicant of their eligibility determination results.

For further details, see the Business Process Maps for Gilpin County attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions Gilpin County has implemented to increase efficiency or improve customer service.

Organizational Structure

Organized work by program expertise: The eligibility technicians are generalists but the caseload has been distributed between two technicians. This allows the eligibility technicians to focus more focus on the client and customer service, reducing the errors, and ensuring that clients are getting all the services they are qualified to receive. The new approach to distributing the caseload has also enhanced the working environment and has promoted teamwork among eligibility technicians.

Eligibility and Enrollment Processes

Created a single entry point for their clients: Gilpin County has streamlined the application process by creating a single entry point for their clients. Every applicant is assigned to a single eligibility technician, who makes both the application process, as well as ongoing procedures easier for both the client and eligibility technician. The applicant has direct access to the eligibility technician, and can easily access the eligibility technician with any issues or concerns. Gilpin County believes that by reducing the amount of case shuffling between staff, there are fewer errors among eligibility technicians. In addition, there is less confusion in the application process and better customer service provided to the client.

Eligibility technicians make approvals: Due to the small size of Gilpin County, the County does not have a supervisor, so a waiver was created to allow eligibility technicians to conduct approvals. This has resulted in faster processing times and no backlog of cases. All cases are processed under the 45 calendar day required time frame.

Emphasized customer service and employee morale: Gilpin County takes pride in their customer service and concern for their clients. Since Gilpin County is small, clients have a familiarity with the eligibility technicians and the technicians have built trust with the clients by proactively reaching out to the clients. The County Food Bank is located in the Gilpin County Department of Human Services office and is accessible five days a week during the department's business hours whereas most banks are only open for two days. Gilpin County has also created a separate room for children to play, watch DVDs, etc. while the parent is in the office to seek services. Gilpin County also has emergency assistance money that is county-funded and used to provide assistance to clients in the community. In addition, grant money is used to provide homeless clients the identification that they need. A staff appreciation budget is also in place and employees are able to paint a wall in their office a color of their choice, which increases employee morale and staff retention.

Technology

Utilize CBMS for the Interactive Interview (II): The eligibility technicians use CBMS for the majority of the process. CBMS has drastically decreased the amount of paperwork in the paper files in Gilpin County.

Current Challenges

The following section outlines some of the challenges Gilpin County faces in their daily operations.

Organizational Structure

Difficulty with recruiting: The remote nature of Gilpin County makes it difficult to recruit qualified staff. Recently staff retention has been high and there has not been a need to recruit but Gilpin County cited this as an issue that they foresee in the future.

Eligibility and Enrollment Processes

Citizenship and identity requirements are burdensome: To provide better customer service and reduce the amount of travel required of their clients, the County promotes mail-in applications for the Family Medical program. However, with the new Deficit Reduction Act (DRA) mandates for certified proof of citizenship and identity for each applicant, so applicants often have to make the trip to the office despite the mail-in process. On top of the added time and travel, many applicants have to obtain original certified documents, which take money and additional processing time for applicants.

3.3.7. Jefferson County

County Overview

The following table provides a basic profile of the Jefferson County Department of Human Services as well as the general demographics of the County.

Table: Jefferson County Department of Human Services Profile

Jefferson County Department of Human Services ***Director: Cheryl Ternes***	
Demographic Information (United States Census Bureau)	
City:	Golden, CO
County population:	526,994 (estimated 2006)
% Poverty:	7.1% (estimated 2004)
% Foreign Born:	5.4% (estimated 2000)
Unique Medicaid Cases (Colorado Department of Health Care Policy and Financing, 2008)**:**	28,994 (as of 9/30/2008)
Department Information	
Total number of employees:	• Economic and Medical Assistance Services (EMAS): 80 • Long-Term Care: 30
Community-Based Organizations in Medicaid:	• JeffCo Action Center • Jefferson Center for Community Health • Jefferson County Mental Health • Mountain Resource Center (serving the Conifer/Evergreen area) • Arvada Food Bank • Colorado Homeless and Family Tree • Jefferson County Schools (pilot program)

Current Medicaid Eligibility and Enrollment Processes

In Jefferson County, two divisions provide Medicaid services. The Economic and Medical Assistance Services (EMAS) division administers the Family Medical (FM), Temporary Assistance for Needy Families (TANF), and Food Stamp (FS) Programs. The Aging and Adult Services (AAS) division administers the Adult Medicaid and Long-Term Care programs and also acts as the Single Entry Point (SEP) provider in the county. The positions involved in Medicaid eligibility include eligibility technicians, clerical workers, leads, supervisors, and community work experience (CWEP) clients from the TANF program.

In recent years, Jefferson County has changed their business processes to specialize in some of the eligibility functions. Intake for Adult and Long-Term Care programs is specialized in AAS. Jefferson County also specialized the Colorado Works intake unit. In addition, managers created a specialized Medical-only intake team that processes all mail-in applications. The unit has doubled in size in the past year; there is now one lead, four eligibility technicians and two clerical workers. There is also a general intake unit that focuses on the initial application process. Eligibility technicians in the intake unit work as either interviewers or processors and perform data input and authorization. A separate ongoing unit also maintains eligibility for combined (FS/FM) and medical-only cases (about 15 percent are medical-only).

Although the ongoing unit has alpha caseload, the eligibility technicians work as a team. On most teams, two eligibility technicians work current cases and three program specialists work the backlog of redeterminations. The unit supervisor also plans to specialize two staff people to request missing verification. The caseload size is approximately 700 FS/FM cases per eligibility technician.

Clerical workers support each unit involved in Medicaid eligibility. Four clerical specialists positions support general intake by creating and maintaining files, doing Application Initiation (AI) in CBMS, and making and generating appointments notices is necessary. They also work the customer service center (CSC) and can re-issue Medicaid Identification cards. The Ongoing unit has one administrative specialist that maintains files and can add a needy newborn to an existing case. The Medical-only unit has a clerical worker who enters all new applications into an Excel database used for tracking, and completes the AI process in CBMS.

In order to monitor workload, managers in EMAS use a processing log that identifies work completed by staff in the previous week. The CBMS information is pulled from Business Objects and then manipulated by county data analysts. Jefferson County administrative specialists also maintain an Excel spreadsheet when they initiate an application so supervisors can monitor the 48-hour AI processing standard.

Since 2005, Jefferson County occasionally uses a contractor called Integrated Document Solutions (IDS) to process backlogs of applications for Medicaid. County staff completes the AI process within 48 hours then sends to IDS to complete data entry. If verification is required, the case is pended and sent back to the County to be monitored and worked. IDS complete approximately 100 cases per week (50 FS and 50 Medicaid). Their work may be extended to redeterminations in the future.

For further details, see the Business Process Maps for Jefferson County attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions Jefferson County has implemented to increase efficiency or improve customer service.

Organizational Structure

Utilized a pool of temporary staff to fill in Jefferson County Department of Human Services vacancies: Jefferson County reported issues with obtaining staff within a specified period of time.

In response, Jefferson County created what they call a "temp pool" that they can use to fill vacancies while they search for a permanent hire. This has helped fill in staffing gaps that can often lead to a backlog of cases.

Eligibility and Enrollment Processes

Developed a customer service center (CSC): Jefferson County currently staffs a customer service center (CSC) to handle client questions and basic customer service needs, such as reissuing Medicaid Identification cards. All calls go into a centralized queue for the next available eligibility technician to answer. CSC staff has access to CBMS for basic troubleshooting assistance and case comments. If the CSC is unable to assist a client, a ticket is created in an Access database and is directed to the client's eligibility technician. Jefferson County would like to increase the capacity of their CSC and are currently examining staffing models to accommodate the potential changes.

Created an internal quality assurance team: A huge asset to Jefferson County's overall performance is the standard quality assurance team within the County. Instead of burdening the supervisors with the six case reviews a month, Jefferson County has created four full time positions that are dedicated to quality reviews. Not only has this taken the effort off of supervisor's plates, but it has also enforced quality within Jefferson County's Department of Human Services.

Intake is specialized: To streamline the caseload, Jefferson County has created specialized intake units for their Medicaid programs. One unit conducts client interviews, one processes only Medical mail-in applications, while another works on the backlog. Each unit provides expertise and can easily focus on their role in the eligibility process.

Increased focus on Long-Term Care clientele: Studies conducted by Jefferson County estimate that the Long-Term Care clientele will grow from 15 to 26 percent of their Medical cases within the next twenty years. Jefferson County recognizes that the elderly and disabled have different needs, so are starting to implement changes that will better accommodate the population. For example, Jefferson County has utilized aging studies and findings to better design their buildings and services to meet the physical and emotional needs of their elderly population.

Technology

Created a performance monitoring tool: To supplement the lack of user-friendly performance monitoring tools in CBMS, an Excel tool was created to enable supervisors to gauge the workload more effectively. Data from the previous week is pulled from CBMS and manipulated by county analysts to display individual performance and workloads more accurately.

Piloting Document Imaging: Adult Protective Services (APS) and Single Entry Point (SEP) cases are transitioning to a document management system called LiveLink, which acts as a supplement to CBMS. Jefferson County will start scanning all adult documentation by November 2008. LiveLink has already proved to be extremely helpful since all client documentation is instantly accessible to eligibility technicians. The shift to document imaging has also significantly cut down the file storage needs.

Employee Training

Staffs an in-house training team: Jefferson County has been coined the "Training County." Jefferson County has placed extreme emphasis on training, and has collaborated with other counties as well as State trainers to create a training group within Colorado. Jefferson County currently staffs a training team consisting of three trainers. Trainers review all policy changes, communicate new information to staff and update training curriculum as needed. The current curriculum consists of two weeks of training, which includes CBMS, application processing procedures and Medicaid policy. Every eligibility technician is tested, and scores are pooled to help trainers identify areas of additional training needs.

Community-Based Organizations

Created strong community-based organizations (CBOs) within the county: Jefferson County has worked with many community-based organizations (CBOs) to set up onsite application assistance for clients within Jefferson County. With CBOs helping clients through the process, the applications are often completed upon submittal to the County. As a result, applications are processed faster and clients receive benefits more quickly.

Current Challenges

The following section outlines some of the challenges Jefferson County faces in their daily operations.

Organizational Structure

Difficulty with retaining new staff: The largest challenge reported by Jefferson County is their inability to retain staff. Insufficient wages and a high level of job availability are the two main reasons Jefferson County believes eligibility technicians leave. In result, the vacancies lead to an increase in case backlog.

Eligibility and Enrollment Processes

Incomplete applications from Presumptive Eligibility (PE) sites cause added work: Jefferson County reported that they are not receiving a sufficient level of application information from their PE sites. In addition, some applications are delivered months after the applicant submitted it to the PE site. This forces additional work onto eligibility technicians as well and leads to frustrated clients.

Citizenship and identity requirements are burdensome: Due to the added cost and time on applicants, Jefferson County is concerned about the difficult process of obtaining certified copies of citizenship and identity. Jefferson County recommended an interface to Vital Statistic data be developed so that information can automatically be pulled, saving valuable time for clients as well as eligibility technicians.

Missing documentation in transfer cases causes extra work for eligibility technicians: When pending cases are transferred to Jefferson County, the receiving technician typically only has the case information in CBMS to review, and lacks the needed hard copies of verification. The eligibility technician will then have to call the county and attempt to track down the missing documentation for the case. This manual process causes hours of added time for the receiving technician, as well as delays benefits for the client.

Technology

CBMS functionality doesn't fully support Medicaid needs: Jefferson County reported multiple issues with CBMS functionality. The largest complaint was that CBMS is not consistent with calculations, which forces eligibility technicians to have to manually check the system for accuracy. It was also reported that the screens and data requirements in CBMS are not streamlined with the current Medicaid eligibility process.

CBMS generates an excessive amount of client notifications: Jefferson County Department of Human Services reported that the amount of client correspondence that CBMS produces for Medical clients is excessive and confusing. Clients can receive multiple conflicting notifications for both Medicaid and CHP+ programs throughout the year. To prevent additional client confusion, eligibility technicians need to manually delete the unnecessary notifications in CBMS. This process is time consuming and detracts from the eligibility technician's application processing time.

Management reports in Business Objects are not sufficient: Jefferson County would like to see more effective reporting options for managers and supervisors, including performance monitoring and workload summary reports. Jefferson County expressed that reports have to be more flexible and user-friendly at the manager level.

3.3.8. Larimer County

County Overview

The following table provides a basic profile of the Larimer County Department of Human Services as well as the general demographics of the County.

Table: Larimer County Department of Human Services Profile

Larimer County Department of Human Services *Director: Ginny Riley, Deputy Director: Glen Rathgerber*	
Demographic Information (United States Census Bureau)	
City:	Fort Collins, CO
County population:	281, 565 (estimated 2007)
% Poverty:	13% (estimated 2006)
% Foreign Born:	4.3% (estimated 2000)
Unique Medicaid Cases (Colorado Department of Health Care Policy and Financing, 2008)**:**	18,194 (as of 9/30/08)
Department Information	
Total number of employees:	• Accounting and Business Operations Divisions: 29 • Benefits Planning Division: 90 • Adult and Child Support Services Division: 72 • Children, Youth and Family Division: 172
Community-Based Organizations in Medicaid:	• Larimer County School District, including the Head Start program • Loveland Memorial Hospital • Salud Family Health Centers • Pathways against Poverty • Loveland Community Centers • Larimer County Nursing Homes • Larimer County Funeral Homes

Current Medicaid Eligibility and Enrollment Processes

Larimer County Department of Human Services has spent the past two years reengineering their eligibility processes in order to work more efficiently and accommodate an increasing volume of work. Their business flow is a task-based model with an emphasis on front-end customer service. Note: The Long-Term Care unit is a separate unit within the division.

Larimer County reports most Medical Assistance applications arrive by mail. There are also a few satellite locations in Loveland and Estes Park that will assist clients in the application process and

deliver the completed applications to the Larimer County Department of Human Service's front desk. The front desk is staffed with clerical workers who begin the Application Initiation (AI) process and triage the applications to the appropriate department specialists (specialized clerical worker). The department specialists review the AI information in CBMS and create a paper file and cover sheet for the eligibility technicians. A case number is assigned before the application is passed to the eligibility technician.

The majority of Larimer County eligibility technicians are generalists, meaning that the case is assigned to a general queue for the next available eligibility technician to accept. However, if the new case is a Family Medical-only application, a clerical worker assigns it to a specified Family Medicaid eligibility technician and files the case in a designated file drawer. All Long-Term Care applications are directed to the Long-Term Care unit for processing.

The cases are typically worked according to the weekly Pending List report (sorted by oldest to newest), but can be expedited per supervisor request. Once the Family Medical eligibility technician accepts a case, he or she will review the application and perform any outstanding research that needs to be conducted. The Long-Term Care unit performs similar actions but may conduct an interview if requested by the applicant. Completed applications are processed and authorized, and a Notice of Action letter is generated from CBMS and sent to the applicant alerting him or her of the eligibility determination results. All cases are sent to the Records Department to be imaged into the system.

Incomplete applications are entered into CBMS and marked as "N," not complete. CBMS issues an automatic verification request to the applicant, giving the client ten calendar days (with the exception of DRA documentation that allows 14 calendar days for Family Medical applications and 70 calendar days for Adult Medical) to return the needed verification. Once the verifications are received, the eligibility technician continues to process and authorize the case in CBMS. The applicant then receives a Notice of Action letter alerting him or her of the eligibility determination results.

For further details, see the Business Process Maps for Larimer County attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions Larimer County has implemented to increase efficiency or improve customer service.

Organizational Structure

Applied LEAN methodology to business model: Due to their increasing caseloads and high percentage of turnover in eligibility technicians within the department, Larimer County has adopted certain LEAN principles in their organization, particularly the concept of deployable resources. Larimer County trains the majority of their eligibility technicians to be generalists, meaning that cases can be assigned to eligibility technicians based on need rather than program. Because eligibility technicians can be moved to fill in staffing gaps, Larimer County is less likely to develop a backlog when there are vacancies. This model has greatly helped decrease the average application processing time, as well reduced some of the burnout factor in staff.

Organized work by task, not caseload: Due to the change in resource organization, Larimer County was able to shift their workflow management from a caseload-driven model to a task-based model. Although there was some resistance from eligibility technicians, the change has helped reduce Larimer County's backlog since cases are triaged by priority and date rather than alpha caseload. The new approach to the caseload has also enhanced the working environment and promotes teamwork among eligibility technicians.

Technology

Implemented a new customer service center (CSC): Larimer County implemented an interactive customer service center (CSC) to handle many of their client's questions and concerns. The CSC is staffed with trained eligibility technicians, who are knowledgeable in the application process and program requirements. CSC eligibility technicians are equipped with CBMS access so they can pull up the electronic file, update case notes, and triage cases to technicians. The CSC has been operating with inadequate call management software and phone system, but is in the process of acquiring the software and hardware they need. Even so, the CSC resolves approximately 75 percent of clients' questions, allowing technicians to focus their attention of processing cases.

Employee Training

Developed a strong, in-house training model: To allow for more control over employee training, Larimer County recently developed an in-house training unit. The training unit is staffed with trainers, including one CBMS specialist. The goal of the training unit is to prepare eligibility technicians for the generalist role so that the newly trained staff can easily be placed in the areas with the greatest need.

Focused training material on tasks: Rather than focusing their CBMS training on areas of system functionality, Larimer County has shifted their focus to training tasks. With task-based system training, staff can apply the new information more easily since they are usually more familiar with their daily procedures than they are with system functionality. This model has helped ease staff into applying new system procedures and CBMS functionality into their daily work.

Current Challenges

The following section outlines some of the challenges Larimer County faces in their daily operations.

Organizational Structure

High turnover of staff: Like many counties, Larimer County has experienced significant turnover of eligibility technicians. Although a large portion of the turnover was the result of staff promotions, the Larimer County is still working to fill the vacant roles. Larimer County believes part of the problem may be insufficient compensation for the corresponding amount of work.

Eligibility and Enrollment Processes

Citizenship and identity requirements are burdensome: To provide better customer service and reduce the amount of travel required of their clients, the Larimer County promotes mail-in applications for the Family Medical program. However, with the Deficit Reduction Act (DRA) mandates that applicants provide original or certified proof of citizenship and identity with each

application. Consequently, applicants usually have to make the trip to the office despite the mail-in process. On top of the added time and travel, many applicants have to obtain original certified documents, which take money and additional processing time for the applicants. Larimer County has requested access to Vital Statistics data to alleviate applicants from the burdensome process of providing the certified documentation, but even that will serve only applicants born in Colorado.

72-hour window lag time between CBMS and the Medicaid Management Information System (MMIS): Larimer County reports that there is a 72-hour lag time in the interface between CBMS and the MMIS system, the system providers use to verify eligibility. This means if a client needs same-day medical services, Larimer County must obtain a letter issued from the Department promising payment before some providers will provide same-day service. They report providers in their county require the letter to be issued by the State.

Employee Training

Computer based training is outdated: Larimer County communicated that the State-provided CBMS training is outdated and ineffective. There have been numerous amounts of system functionality and reports that have been "accidentally discovered" by staff that were never included in the Department's CBMS training. A robust, centralized CBMS curriculum should be provided by the Department and include system shortcuts, case studies of complex case situations, provider relations training (i.e., nursing homes), as well as proper application of 5615 forms and trust process for Adult Medical Assistance applicants.

3.3.9. Mesa County

County Overview

The following table provides a basic profile of the Mesa County Department of Human Services as well as the general demographics of the County.

Table: Mesa County Department of Human Services Profile

Mesa County Department of Human Services ***Director: Len Stewart, Deputy Director: Tracey Garcher***	
Demographic Information (United States Census Bureau)	
City:	Grand Junction, CO
County population:	134,189 (2006 estimate)
% Poverty:	10.8% (2004 estimate)
% Foreign Born:	3.0% (2000 estimate)
Unique Medicaid Clients (Colorado Department of Health Care Policy and Financing, 2008)**:**	14,032 (as of 9/30/08)
Department Information	
Total number of employees:	• Work Force Center: 41 • Self Sufficiency/Child Support Division: 68 • Child Welfare Services Division: 83 • Adult Service/Special Projects/Clerical Division: 44 • Assurance/Purchasing: 18 • 211 Infoline Resource and Referral: 4 • Child Care Resource and Referral; 1 • Mesa County IT Support: 3
Community-Based Organizations in Medicaid:	• Hilltop, a non-profit corporation which operates a program called B4 Babies and Beyond • Grand Junction School District • St. Mary's Hospital and Health Center • Grand Junction Housing Authority • The Benevolent Community Partnership • Mesa County Department of Health • Local nursing homes

Current Medicaid Eligibility and Enrollment Processes

Mesa County has two offices in Grand Junction. One is a Workforce Center and is staffed with a team of eligibility technicians that assist Mesa County Department of Human Services by conducting

occasional courtesy intake interviews for the Family Medical program as well as process all Family Medical cases associated with Colorado Works cases. All other Medical Assistance applications are sent to the Intake unit located at Mesa County's main building. Mesa County conducts intake for all application types, including Long-Term Care. Mesa County has established four units to administer ongoing eligibility tasks (redeterminations and case maintenance): An ongoing Family Medical unit, an Adult Services unit, a unit that handles Long-Term Care cases, and as mentioned above, the generalist unit in the Workforce Center that handles all Family/Adult Medical Assistance cases associated with the Colorado Works program.

Many applicants are referred to the Mesa County Department of Human Services through the B4 Babies and Beyond program operated by a non-profit organization called Hilltop, which specializes in delivering pre-and postnatal services to pregnant women and new mothers. B4 Babies eligibility technicians guide potential clients in the Medical Assistance application process, and help them gather the appropriate documentation required for the program. The added help from B4 Babies greatly speeds up the approval process and decreases the Intake unit's workload.

If the applicant delivers an application, the Intake eligibility technician conducts an interview and gathers all documentation from the applicant. If the application is received by mail, a clerical worker date stamps the application and assigns it to an Intake eligibility technician. The eligibility technician makes copies of any original documents and scans all client documentation into county's document imaging system after eligibility is determined. The Intake eligibility technician enters the application information into CBMS, and adds the new case into a county-developed log that is used to track the status of all applications. If additional documentation is needed from the applicant, CBMS generates a notification explaining that the applicant has ten calendar days (with the exception of Deficit Reduction Act (DRA) documentation which allows for 14 calendar days for Family Medical applicants and 70 calendar days for Adult Medical applicants) to return the missing documentation.

Once all necessary documentation is gathered, the Intake eligibility technician enters the remaining information into CBMS, runs eligibility and authorizes the case. CBMS generates a notification to the applicant alerting him or her of the eligibility determination results. If the case is approved, it is assigned alphabetically to either an Adult or Family eligibility technician in the Ongoing unit for case maintenance.

The process for Long-Term Care applicants differs slightly due to the required financial determination, as well as the functional assessment of the applicant's medical and long-term care needs. Since the assets and resource tests for Long-Term Care applicants can be quite complex, the application typically requires more time to process. Once all the documentation is gathered, the eligibility technician enters the application into CBMS, runs eligibility and authorizes the case. The case is then referred to an Adult Services case manager in the Single Entry Point (SEP) unit for a functional assessment. If the applicant is deemed functionally eligible, the case is referred to the Ongoing unit and assigned alphabetically to a Long-Term Care eligibility technician for case maintenance tasks.

For further details, see the Business Process Maps for Mesa County attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions Mesa County has implemented to increase efficiency or improve customer service.

Organizational Structure

Separated Intake and Ongoing Medicaid eligibility functions: Mesa County has developed a workflow model with separate Intake and Ongoing units that divide the application process. Eligibility technicians assigned to the Intake unit are generalists and work on all program applications, while Ongoing technicians specialize in certain programs. This model has helped streamline the application process for Mesa County and increased efficiency among eligibility technicians.

Eligibility and Enrollment Processes

Documenting Process Maps: Mesa County will undertake its own process mapping of all eligibility activities starting in October 2008. The Child Welfare Services just completed the process mapping for that unit, which resulted in some changes that increased the efficiency of the program. Their goal for mapping eligibility processes is to increase timeliness and accuracy in eligibility determinations.

Technology

Developed extensive ad-hoc reporting: Mesa County has developed numerous ad-hoc reports, most of which are derived from CBMS data. Mesa County is able to monitor caseloads and performance down to the individual eligibility technician.

Implemented a document imaging system: In 2002, Mesa County purchased an imaging system called SIRE (Scan, Index, Research and Edit) and recently contracted with Goodwill Industries to handle the imaging of all relevant documentation. Although the process is somewhat time consuming, images are associated with CBMS records by a face sheet called a TAG, which is completed for each document. The scanned documents are available for electronic retrieval within one to two weeks. Although the system takes initial effort from eligibility technicians, it saves a significant amount of time once the images become instantaneously available to eligibility technicians.

Community-Based Organizations

Partnered with Hilltop*:* Mesa County has forged numerous relationships within the community. The most significant relationship is with an organization called Hilltop. As previously mentioned, Hilltop operates a program called B4 Babies and Beyond. The program offers prenatal and early childhood development services to almost half of the pregnant women in Mesa County. Mesa county outstations a half-time eligibility technician at Hilltop's Grand Junction site and funds a portion of the Hilltop eligibility technician's salary. B4 Babies and Beyond works closely with applicants through the application process, and ensures that all the documentation is collected in order to expedite applications for Medicaid, CHP+ and other programs. In result, the time it takes

the technician to handle Medical Assistance applications is reduced, and allows young mothers quicker access to their pre and post-partum medical care. B4 Babies and Beyond also maintains a 24-hour 211 emergency line and addresses many of their clients' questions about the Medicaid and CHP+ programs.

Created communication lines with local pharmacists: Mesa County has agreed to alert local pharmacists when a person has qualified for Medicaid. In result, pharmacists are more willing to provide prescription drugs to applicants who have not yet received a medical identification card.

Employee Training

Coordinated training effort with Quality Assurance Unit: Mesa County staffs a Quality Assurance Team that handles fraud investigations and recoveries. The team regularly shares information with eligibility supervisors, who incorporate common error trends and lessons learned into future employee training.

Current Challenges

The following section outlines some of the challenges Mesa County faces in their daily operations.

Organizational Structure

Insufficient staffing levels: Supervisors indicated that until recently, when the Mesa County Commissioners authorized a pay increase for eligibility technicians, they had difficulty recruiting qualified individuals. Though the surface of the problem has been mitigated, supervisors indicated that they are still short staffed by about four to five technicians.

Eligibility and Enrollment Processes

Citizenship and identity requirements are burdensome: Managers and supervisors are concerned that the recent citizenship and identity requirements add a considerable amount of time in the application process. They recommend the Department develop an interface between CBMS and Vital Statistics to help automate the information sharing.

Insufficient response from CHP+ vendor: Considerable dissatisfaction was expressed about the CHP+ Eligibility and Enrollment (E&E) vendor. Supervisors claimed the CHP+ E&E vendor is prematurely closing applications. Clients then come to Mesa County's offices to complain, and there is little eligibility technicians can do to help since they also cannot generally reach the vendor's eligibility technicians.

Technology

Slow response time in CBMS: "System crashes" reportedly occur on almost a monthly basis. In addition, CBMS response time can be very slow throughout the day, which delays the application processing time.

Inconsistent technical assistance with CBMS: Supervisors stated that they often report CBMS problems, as well as issues with presumptive eligibility determinations, to the CBMS Helpdesk, and receive inconsistent levels of support depending on the Helpdesk eligibility technician.

3.3.10. Prowers County

County Overview

The following table provides a basic profile of the Prowers County Department of Social Services as well as the surrounding demographics of the County.

Table: Prowers County Department of Social Services Profile

Prowers County Department of Social Services *Director: Linda Fairbairn*	
Demographic Information (United States Census Bureau)	
City:	Lamar, Colorado
County Population:	13,766 (2006 estimate)
% Poverty:	17.4% (2004 estimate)
% Foreign Born:	10.6% (2000 estimate)
Unique Medicaid Cases (Colorado Department of Health Care Policy and Financing, 2008)**:**	2,459 (as of 9/30/08)
Department Information	
Total number of employees:	• Administrative Unit: 4 • Child Support and Income Maintenance Unit: 19 • Family and Children's Services: 11 • Welcome Home Child and Family Development Center: 22 • Systems Analyst Manager and Analyst Assistant: 2
Community-Based Organizations in Medicaid:	• Prowers County Department of Health • Veteran's Affairs Office • Law enforcement agencies • Lamar Community College • High Plains Community Health Center • The Board of Cooperative Education • Local medical care providers • The Tobacco Prevention Council

Current Eligibility and Enrollment Processes

With a devastating fire in 2005, on top of the implementation of CBMS, Prowers County has streamlined their eligibility processes to counteract the challenges of the past few years. Aside from the Adult Medical Assistance technicians, the majority of Prowers County eligibility technicians are

generalists and can assist the client with all of their service needs. As a result, Prowers County has created a single-entry point model for their clients, providing improved customer service and enhanced client-technician relationships within their department.

The front desk receives all applications either by mail or directly from their applicants. Almost half of their Medicaid applications are delivered from their presumptive eligibility partner sites, such as High Plains Community Health Center. A clerical worker at the front desk date stamps the application and check to see if the applicant is an existing client in CBMS. If not, a county household number is assigned. The application and any accompanying verification are entered in the CBMS Traffic Log, which is used to track the case throughout application processing. A case folder is either created for new applicants or pulled for returning clients. The case is passed to an Application Initiation (AI) clerk who begins the AI process in CBMS. Once the basic application information is entered, the AI clerk triages the case to the appropriate eligibility technician. Cases are assigned by a rotation formula that is tracked at the front desk.

The eligibility technician receives a case and begins to review the application for completeness. If the applicant is missing verification, a notification is generated from CBMS alerting the applicant that he or she has ten days (with the exception of Deficit Reduction Act (DRA) documentation which allows for 14 calendar days) to return the needed verification. Once all verifications are collected, the eligibility technician continues to enter the information into CBMS. The eligibility technician checks the "wrap-up" screens and CBMS calculations for accuracy. If errors are found, the eligibility technician reviews the case information in CBMS, fixes the necessary issues, and re-runs eligibility. If there are no errors, the eligibility technician authorizes the case. CBMS then generates a notification alerting the applicant of the eligibility determination results. The case is then filed at the eligibility technician's desk.

Many of the Long-Term Care applicants come to the office on referrals, typically from a medical provider or the County Health Department. In many cases, the County Health Department's Options nurse will schedule a functional assessment of the applicant before the submission of his or her application. If an assessment has not been ordered, the eligibility technician will initiate the assessment with either Options or Consultative Examinations Limited (CEL) at the time the application is received. Applications for Adult services differ slightly in the fact that the eligibility technician requests, to simplify the process, a face-to-face interview (if physically able) with either the applicant or a beneficiary. The eligibility technician conducts an interview with the applicant and enters the application information into CBMS. Since applicants usually lack the needed verification, the eligibility technician provides the applicant with a list of items needed for the application process. The applicant has ten days (with the exception of DRA documentation which allows for 70 calendar days) to return the verification. Once the verification and assessment results are collected, the eligibility technician continues to process the application in CBMS and reviews the "wrap-up" screens. The eligibility technician verifies CBMS results by completing a few manual calculations of the applicant's payments and community spousal figures. If errors are found, the eligibility technician reviews the information in CBMS, fixes the necessary issues and re-reviews the "wrap-up" screens. If there are no errors, the eligibility technician runs eligibility and authorizes the case. CBMS generates a notice to the applicant alerting him or her of the eligibility determination results.

For further details, see the Business Process Maps for Prowers County attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions Prowers County has implemented to increase efficiency or improve customer service.

Organizational Structure

Most eligibility technicians are trained as generalist: Although there are specified Adult Medical Assistance technicians, the bulk of Prowers County eligibility technicians are generalists and can assist their clients with all their service needs. This greatly reduces the amount of case shuffling within department and allows for a single contact for all the client's needs.

Eligibility and Enrollment Processes

Supervisors handle all case transfers: By having a skilled supervisor handle case transfers both in and out of Prowers County, complicated issues can generally be resolved more quickly and the incoming case can be easily assigned to an eligibility technician.

Created a "Walk-In Day" for clients: Prowers County has designated Tuesdays from 9:00 AM to 11:00 AM as "Walk-In Day." During that time, clients can come in without an appointment and speak to an eligibility technician regarding any questions or concerns. Since there are no other appointments during that time, eligibility technicians can dedicate those hours to their client and attempt to address all their needs during that time of the week. In result, the eligibility technicians generally have more time during the week to work on application processing.

Close relationship with the Department of Health speeds up the Long-Term Care application process: Prowers County Department of Health is located in the same building as Prowers County Department of Social Services. The Department of Public Health also employs the nurses who conduct functional assessments for individuals applying for Long-Term Care assistance. Since both departments work closely with one another, the Department of Public Health is able to initiate assessments almost immediately upon knowing that the individual will be applying. Many counties do not order an assessment until financial eligibility has been determined. By having the two steps occur simultaneously, the entire application process is shortened.

Technology

Extensive use of Business Object's reports: In Prowers County, the supervisor's use of Business Object's reports is extensive when compared to many counties. The reports can be used to monitor performance and workload down to the individual eligibility technician. Certain reports are also passed to all eligibility technicians to help prioritize their workload.

Community-Based Organizations

Built a working relationship with the Child Development Center: Prowers County also operates a Welcome Home Child and Family Development Center. This ensures a close working relationship between the Prowers County Department of Social Services and the unit in charge of

outreach to children with medical needs. The Welcome Center also coordinates closely with the local Head Start agency, which serves a clientele that largely served by Prowers County Department of Social Services.

Regular contact by the county director with community-based organizations: Once a month, Prowers County Department of Social Services and the Department of Public Health host a meeting with all community advocates. County commissioners also frequently attend. The group meetings promote a consistent message to all advocates, and allow important questions and decisions to be addressed in a team approach. A high percentage of medical providers in Prowers County are willing to accept Medicaid patients, partially as a result of this effort to keep the lines of communication open.

Employee Training

Over the shoulder assistance from a designated trainer: Prowers County has created an onsite training facility with a computer lab to support hands-on CBMS training. The trainer works closely with supervisors and staff to update the curriculum and communicate training points. The trainer also holds a two-hour training session every Wednesday to discuss unusual case situations and jointly develop solutions with the attending eligibility technicians and supervisors. The trainer also develops templates and cheat-sheets for technicians that outline policies and procedures.

Current Challenges

The following section outlines some of the challenges Prowers County faces in their daily operations.

Eligibility and Enrollment Processes

Reported numerous problems with CHP+ vendor: Prowers County reported that the CHP+ vendor does not generally return phone calls, leaving eligibility technicians with insufficient information to pass to their clients. It was also reported that CHP+ cases are sometimes closed without explanation, or the vendor makes unnecessary changes to the case in CBMS. The lack of communication in addition to the consistent case issues voiced by Prowers County causes frustration to both eligibility technicians and clients.

Problems with CBMS Helpdesk: Prowers County also voiced concern on past issues with the CBMS Helpdesk. It was reported that the Helpdesk sometimes closes tickets prematurely due to the pressure on eligibility technicians to have more completed actions. Although this occurred more often when CBMS was originally implemented, Prowers County continues to have issues with inconsistent levels of support from the Helpdesk.

Technology

CBMS generates an excessive amount of client notifications: Prowers County reported that the amount of client correspondents that CBMS produces for Medical clients is excessive and confusing. Clients can receive multiple conflicting notifications for both Medicaid and CHP+ programs throughout the year. To prevent additional client confusion, eligibility technicians need to manually delete the unnecessary notifications in CBMS. This process is time consuming and detracts from the eligibility technicians' application processing time.

Screens in CBMS are cumbersome: Prowers County reported that there are an inefficient number of screens in CBMS that are unavoidable when processing applications. It was recommended that the data entering process be streamlined with the application to reduce the time for eligibility technicians and clients.

Calculations in CBMS are sometimes inaccurate: Prowers County stated that many calculations, especially for Long-Term Care applicants, were inaccurate when calculating benefits or community spousal figures. In result, eligibility technicians need to manually check CBMS for accuracy for every case, causing added time to the application processing period.

Employee Training

Training for rural counties insufficient: Prowers County management was pleased with the training being offered by the Department, but would like to see more training delivered on-site, instead of asking staff drive to Denver for training. Prowers County has even offered to pay the Department trainer's travel costs since it is less expensive than sending several of their staff to Denver.

3.3.11. Medical Assistance Site

Department Overview

The following table provides a basic profile of Denver Health's Enrollment Services Department (Medical Assistance site) as well as general demographics of the County.

Table: Denver Health Department of Enrollment Services

Denver Health Department of Enrollment Services ***CFO: Peg Burnette, Director: Carol Lovseth***	
Demographic Information (United States Census Bureau)	
City:	Denver, CO
County population:	566,974 (2006 estimate)
% Poverty:	15.2% (2004 estimate)
% Foreign Born:	17.4% (2000 estimate)
Unique Medicaid Cases:	~55,000 cases a year
Department Information	
Total number of employees:	• Supervisor staff: 6 • Eligibility technicians: 37 • Clerical workers: 19 • Administrative Analyst: 2 • Training Specialist: 2
Community-Based Organizations in Medicaid:	Denver Health has 11 Enrollment Services locations throughout the Denver area.

Current Medicaid Eligibility and Enrollment Processes

Denver Health's Enrollment Services Department is a Medical Assistance (MA) site that assists clients through the application process for a range of programs, including Medicaid, CHP+, Colorado Indigent Care Program (CICP) and Denver Health's discount programs. Denver Health MA site is contracted with the Department and offers enrollment services at 11 locations throughout the greater Denver area. Each location processes Medicaid and CHP+ eligibility and then transfers the case to the appropriate county office for case maintenance. It is estimated that the Denver Health MA sites processes over 55,000 applications a year.

To receive an application at Denver Health, applicants typically schedule an appointment or drop in, depending on the location. At about half of the locations, the application is provided to the client by the front desk, which is staffed with clerical workers who are trained to assist the client through the initial application steps. The clerical worker reviews the application for missing documentation and alerts the applicant if additional verification is needed for the application process. For the smaller offices, the eligibility technicians are responsible for this step.

The applicant begins to complete the application while waiting to be escorted to an eligibility technician in order to continue the application process. If the applicant is applying for Adult Medical Assistance, the eligibility technician sends a referral to Consultative Examinations Limited (CEL), the State's Disability Determination vendor, or a Single Entry Point (SEP) to schedule a functional assessment with the applicant. The eligibility technician reviews the application and conducts an Interactive Interview (II) with the applicant in CBMS. If documentation is missing, the applicant can be granted presumptive eligibility if the applicant is pregnant or a child, but is given a list of verification that is still needed. The applicant has ten days (with the exception of the Deficit Reduction Act (DRA) documentation which allows for 14 calendar days for Family Medical applicants and 70 calendar days for Adult Medical applicants) to deliver the documentation to the eligibility technician. The eligibility technician enters all provided information into CBMS, runs eligibility and authorizes the case. Since eligibility is determined with the applicant present, the applicant is notified of the medical eligibility determination results at the end of the interview. If the applicant does not qualify for Medicaid or CHP+, the eligibility technician reviews other programs for which the applicant may qualify. The case is then transferred to the client's county of residence for ongoing maintenance.

For further details, see the Business Process Maps for Denver Health MA site attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions Denver Health MA site has implemented to increase efficiency or improve customer service.

Organizational Structure

Applied LEAN methodology to business model: The Denver Health MA site adopted LEAN methodology throughout their organization. Denver Health trains the majority of their eligibility technicians to be generalists, meaning that cases can be assigned to eligibility technician based on need rather than program. Because eligibility technicians can be moved to fill in staffing gaps, the Denver Health MA site is less likely to delay application processing when there are vacancies.

Eligibility and Enrollment Processes

Created a single entry point for clients: To ease confusion and increase the level of customer service for their clients, the Denver Health MA site has created a single entry point for their applicants. Each applicant is assigned to one eligibility technician who will guide him or her through the eligibility process. In result, eligibility technicians are able to build a stronger relationship with their clients and the client has a direct point of contact for any questions or concerns.

Conducts Interactive Interviews (II) with applicants, which result in same-day eligibility: The Denver Health MA site performs an interview for applicants (unless physically or mentally unable). Eligibility technicians conduct an Interactive Interview (II) with each applicant in CBMS. If all documentation is collected, the eligibility technician is able to communicate the applicant's eligibility determination results that same day. Depending on the status, the applicant could potentially leave the interview with medical benefits.

Developed standardized quality assurance practices: The Denver Health MA site has developed a robust Quality Assurance program to help monitor performance of eligibility technicians as well as the entire unit. A group of trainers, supervisors and analysts make up a review team and conduct at least three detailed case reviews per eligibility technician each month. The Denver Health MA site has developed a standardized list of criteria that is checked in each case review. The results of each review are entered into an Access database and reported on by eligibility technician. Results are also passed to supervisors, who evaluate the reviews with each eligibility technician. The goal error rate for performance reviews is 5.6 percent. If corrective action is needed, the supervisor works with the eligibility technician on any issues or concerns. This standardized quality assurance model is not only beneficial for the overall site, but also provides a detailed level of support and set of learning tools for each eligibility technician.

Technology

Utilizes Access databases to track individual performance levels: The Denver Health MA site created a tool called the Client Visit Data Entry Form in an Access database, which is completed after every case to help monitor performance. After each interview, the eligibility technician completes the form that outlines some basic information about the case. Managers and supervisors report on the average amount of applications processed per hour (the goal is 1.3). The report is used for individual performance reviews as well a tool to help managers determine if resources are needed at additional sites.

Employee Training

Developed a strong, in-house training model: To allow for more control over employee training, the Denver Health MA site developed an in-house training unit. The training unit is staffed with two trainers, who train everything from policy to CBMS. Trainers are actively involved in the Quality Assurance reviews and can easily incorporate error trends or reoccurring issues into their training curriculum.

Current Challenges

The following section outlines some of the challenges the Denver Health MA site faces in their daily operations.

Eligibility and Enrollment Processes

Inconsistent training among counties results in inaccurate practices: The Denver Health MA site developed a rigid curriculum of training and consistent set of performance metrics for their staff in response to the contractual agreement with the Department. However, the Denver Health MA site expressed concern that the corresponding county eligibility technicians generally do not share the same level of training and accountability. As a result, case transfers between the sites have fostered numerous eligibility issues-the most prevalent one cited is that a county will contradict the eligibility status of a client coming from the Denver Health MA site. Not only is this frustrating for Denver Health eligibility technicians, but is also confusing and harmful for the client since it could result in a delay of benefits.

3.3.12. Affiliated Computer Services (ACS) CHP+ Eligibility and Enrollment Operations

Overview

The following table provides a basic profile of the Affiliated Computer Services (ACS).

Table: Affiliated Computer Services (ACS) Profile

ACS *VP of Western Region for Government services: Brett Jackovich, Account Manager: Michelle Santuae*	
Department Information	
City:	State-wide vendor for CHP+ Eligibility and Enrollment including a centralized call center, located in Denver, CO
Total number of employees:	• Account Manager: 1 • Customer Service Manager: 1 • Eligibility Enrollment Manager: 1 • Staff Members: 51
Community Partners:	• Community Health Centers • County Offices
Unique CHP+ cases:	60,000 (yearly estimate as of 2008)

Current Eligibility and Enrollment Processes

Affiliated Computer Service (ACS) is the vendor contracted with the Department to determine eligibility for CHP+, maintain the active CHP+ caseload, and manage a centralized customer service center (CSC) for the CHP+ program. ACS maintains two offices that house their staff. One office contains the Eligibility & Enrollment group (E&E), the Member Maintenance group and the Quality Assurance staff. The second office houses the customer service center and mailroom. When applications are received in the ACS office, it is unknown whether the applicants will qualify for the Family Medicaid program or the CHP+ program. In some cases some family members may qualify for the CHP+ program, while others may qualify for the Family Medicaid program.

Applications received by ACS are triaged through the mailroom for consistent handling. Each application received is entered in Colorado Rapid Application Tracking System (CRATS) before being routed to E&E. Basic information, including the date the application was received, is entered in CRATS. Once logged, the application is routed to E&E for entry in CBMS and eligibility determination. If the application is missing any documentation, a letter is generated and sent to the applicant alerting him or her that documentation is missing. Once all documentation is returned, the eligibility technician continues to process the application in CBMS and runs eligibility. Before the eligibility technician authorizes the case, he or she reviews the "wrap-up" screens in CBMS for accuracy. If errors are found, the technician reviews the applicant data and re-runs eligibility. Once

all errors are addressed, the eligibility technician reviews the notifications in CBMS and deletes any unnecessary notifications, if needed, before authorizing the case. CBMS generates a notification to the applicant alerting him or her of the eligibility determination results. The case is then filed in the case folder and sent to the file room. All steps along the way are documented in CRATS. Any case notes entered in CRATS are also entered in CBMS case notes for consistency. There is no interface between CRATS and CBMS.

Once eligibility has been established, the case is maintained by the Member Maintenance group (M&M). M&M handles expedites, terminations, aging reports, CBMS tickets, and all case maintenance. ACS also has a department onsite that handles Quality Assurance (QA) of all applications/cases, and a centralized customer service center where questions can be answered for applicants, clients, counties, and providers. Eligibility technicians are responsible for processing new applications, redeterminations, renewals, mail and verifications received from applicants.

For further details, please see the Business Process Maps for ACS attached in Appendix F.

Medicaid Eligibility and Enrollment Innovations

The following section outlines the creative solutions ACS has implemented to increase efficiency or improve customer service.

Eligibility and Enrollment Processes

Created the Member Maintenance Department: The Member Maintenance Department was established to handle expedites, terminations, aging reports, CBMS tickets, and all case maintenance. This allows the E&E group to focus on eligibility determinations. The Member Maintenance team also helps eligibility sites (e.g. counties, CBOs, MA sites) with CHP+ case research when needed.

Supervisors are on the floor with Eligibility & Enrollment and customer service center (CSC) staff: The supervisors for these two groups are on the floor in cubicles with E&E technicians and CSC staff, called Call Center Representatives (CCRs). This allows for a true "open door" policy for eligibility technicians. The supervisors are available and involved in the job training, and constant monitoring of the workload for eligibility technicians and representatives. Caseloads are monitored in E&E by reports, and by Avaya technology used in the CSC.

Technology

Implemented an application tracking system: CRATS was developed and implemented by ACS at the Department's request. This system allows eligibility technicians to track applications received, and additional information throughout the application process (i.e. verifications requested, received, etc.). This tool is relied upon heavily by the CSC when applicants call to request information on the status of their application. CRATS also allows ACS to track statistics on applications received.

Streamlined application processes: Over the past three years, much time has been spent determining the appropriate workload for eligibility technicians and the appropriate level of monitoring of this workload by the eligibility supervisor. ACS feels the current processes in place allows a manageable workload for eligibility technicians, creates known expectations for the technicians, and a streamlined process for determining eligibility.

Employee Training

Training innovations: Training for staff is a large area of focus for ACS. There is a two-week training program for new eligibility technicians. There is side-by-side training for new employees with current employees. They conduct some presentation training, scavenger hunts, and cross-departmental training. CCRs take a certification test at the end of their training program that they have to pass with a 90 percent or above. There are sixty questions on this test.

Current Challenges

The following section outlines some of the challenges ACS faces in their daily operations.

Technology

Issues with CBMS report data: ACS reported several issues with CBMS reports data in Business Objects. The primary issue encountered is that Business Object reports lump all CHP+ cases under one umbrella, even if eligibility has been determined by an eligibility site, rather than ACS. This gives a false picture of the ACS statistics.

Varying renewal dates for a single family in CBMS: In some cases there may be a family of three with varying renewal dates for each family member. These renewals must be worked and run eligibility individually, which can be time consuming for the eligibility technicians.

CBMS generates an unnecessary amount of client notifications: For Medical programs, ACS reported that CBMS generates an excessive amount of client notifications. To make matters worse, the notifications often have conflicting and confusing statements that generate a numerous amount of inquires and complaints from clients. Eligibility technicians need to spend additional time deleting the inappropriate notifications in the application process, as well as addressing their clients' concerns when notifications accidentally are sent out.

3.4. Statewide Findings

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 has categorized the findings into three overarching categories.

1. **Outdated eligibility and enrollment processes hinder client access to programs**
2. **Lack of centralized support impacts quality and accountability**
3. **Inadequate tools supporting eligibility lead to inefficiency**

Detailed findings within each area are presented in the following sections.

3.4.1. Outdated eligibility and enrollment processes hinder client access to programs

3.4.1.1. Finding #1

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

Traditional eligibility and enrollment models depend on the eligibility technician to handle every aspect of the eligibility process, from intake to case closure. The eligibility determination process nearly always involves a face-to face interview and occurs in a sequential fashion, with one step having to be completed before another could be undertaken.

In response to the rising number of application submissions and cases, states are forced to work smarter. The growing trend in modernized eligibility and enrollment models proves that the technician dependency and added client face-time impedes efficiency in application processing. Modern technological innovations now allow Medicaid and CHP+ eligibility related tasks to be divided among several eligibility technicians who specialize in different tasks (such as redeterminations or client updates). As a result, many aspects of the eligibility and enrollment model can occur simultaneously as opposed to sequentially. This team approach to the caseload speeds up the eligibility and enrollment process and increases efficiency in application processing. Since face-to-face contact is not needed for Medicaid and CHP+ applicants, many states do not offer interviews for clients, which frees up even more time for eligibility technicians to process applications.

Public Knowledge found significant differences in the way a caseload is processed at various eligibility sites. Although some counties have recently adopted the modernized task-based model, other counties still rely on their client/eligibility technician relationship to handle all aspects of eligibility and enrollment. At the majority of eligibility sites, applicants and clients had direct contact with their assigned eligibility technician. The eligibility technician handles every aspect of that applicant or client's case, which includes answering client inquires, processing applications, tracking verification and performing case maintenance. Technicians at many eligibility sites expressed concern over the amount of time each eligibility technician spends on tasks other than application processing.

There is also an excessive amount of "pending cases" at eligibility sites. Applicants are often missing needed verifications, which forces the eligibility technician to stop what they are doing and "pend" the case until the verification is delivered. This is especially true with Long-Term Care cases. The stop-and-start method of processing applications is inefficient, and negatively impacts the overall caseload and adds interruptions to the eligibility technician's day.

3.4.1.2. Finding #2

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

The eligibility sites Public Knowledge visited appeared to deliver inconsistent messaging of how applications could be submitted. Most eligibility sites promoted mail-in submittals, but due to the recent Deficit Reduction Act (DRA) requirements, clients are usually forced to deliver their certified citizenship and identity verifications to the office. Depending on the eligibility site, an interview might be conducted as well. Although there appeared to be multiple ways to submit an application, the different application processes across the State increases the level of complexity for the applicants.

The application process is further complicated if an applicant qualifies for multiple programs. Many eligibility sites have different units that process applications for Food Stamps or TANF, which can be confusing for the clients who often have to work with multiple eligibility technicians and submit multiple applications and verifications. This complexity is further illustrated with families that receive both Medicaid and CHP+ benefits. Eligibility sites determine eligibility for both Medicaid and CHP+, but the cases are maintained by the State's CHP+ Eligibility and Enrollment (E&E) vendor. Basic questions, changes or renewals are burdensome for these families since they have to work with two different entities on any concern or process. Several eligibility sites have confirmed that CHP+ case transfers between the counties and the vendor to be an issue for both applicants and clients. In some cases, the counties are the initial point of contact for CHP+ applicants. CHP+ cases can be initiated and pended by eligibility sites, awaiting additional documentation to complete the processing of eligibility. Once applications are determined eligible, the case is electronically transferred to the CHP+ E&E vendor for maintenance. Juggling CHP+ cases between eligibility sites and the centralized vendor is confusing to clients and impacts overall customer service.

Some programs in other states have implemented what they call a "no wrong door" policy regarding eligibility and enrollment processes. The policy increases flexibility in the application process by designing additional access points for the applicant (i.e. online applications, call centers, community-based organizations). Although it is in theory is being deployed at some Colorado eligibility sites, the complex application processes and verification requirements in place make complete implementation of "no wrong door" nearly impossible without streamlining those processes.

3.4.1.3. Finding #3

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

Although the implementation of the Colorado Benefits Management System (CBMS) has promoted consistency in the eligibility and enrollment processes, there are still significant differences among eligibility sites in the length of time required to process applications and maintain caseloads. Public Knowledge visited some sites that are in crisis mode and maintained a significant backlog of cases, while others are keeping up with the caseload and are easily meeting compliance standards. From a applicant perspective, he or she could submit their application to one site and maybe get benefits within the 45 given days or could travel 20 miles down the road to another eligibility site and receive benefits that same week. Although factors such as the amount of applications received and available resources differ among eligibility sites, the differences in the application processing period impacts both customer service and program integrity.

There is also some evidence from Public Knowledge's reviews that counties are applying policies inconsistently, resulting in potentially conflicting eligibility results for the same clients depending on the county. For example, an applicant would be deemed eligible for benefits at a Medical Assistance site but would later be denied by the county to which the case was transferred. Differences in training, performance monitoring and quality assurance could all influence the differences in eligibility determination.

3.4.2. Lack of centralized support impacts quality and accountability

The Department appears to lack the resources to provide the level of support eligibility sites need to effectively and consistently determine Medicaid and CHP+ eligibility. The following findings highlight specific areas that affect program integrity.

3.4.2.1. Finding #4

The current model lacks accountability.

Public Knowledge found no single document that clearly outlines the Department's expectations of eligibility sites. There is a lack of uniform performance measures and consistent monitoring at the State level. The majority of managers that were interviewed agreed that the time it takes to process an application and redetermination is the most important performance indicator, but had no benchmark to determine an appropriate metric. It was also reported that the reports and tools provided to help monitor performance were insufficient, and were inconsistently used among eligibility sites. Some sites were able to create detailed ad-hoc reports from Business Objects that provided a high-level overview of the site's caseload, as well as individual performance. In contrast, other eligibility sites did not even attempt to translate the reports since they were "not user friendly" or intuitive.

A lack of accountability was also apparent in the inconsistent quality assurance programs applied across the State. Eligibility sites reported that there is no centralized Quality Management Plan and that every site was expected to come up with its own set of quality assurance processes. The quality assurance measures are inconsistent among eligibility sites. One site has a documented Quality Management Plan that outlines expectations down to the individual level. The site has a dedicated Quality Assurance Team that conducts three case reviews per eligibility technician per month. A standard checklist of items is reviewed and the evaluation is shared with both the eligibility technician and their supervisor. Each eligibility technician had a goal of a 95% accuracy rate. If the rate is not achieved, a clear plan of corrective action is administered and monitored.

On the other hand, some eligibility sites have no formal quality assurance procedures for their Medicaid or CHP+ eligibility and enrollment processes. The only time a Medicaid or CHP+ case is reviewed is when the client is also on the Food Stamps program, which has a set of federally enforced quality assurance standards. If that combined application happens to be picked in the random Food Stamp sample, the eligibility site will also review the Medicaid or CHP+ eligibility for accuracy. This contrast in quality assurance processes further illustrates the lack of centralized support and accountability in the current eligibility and enrollment model.

3.4.2.2. Finding #5

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

We recognize that the Department has recently hired additional training resources, but the results are not yet evident in the eligibility sites. Although the State conducts some regional training, most Medicaid and CHP+ training for new eligibility technicians occurs at the local level and does not seem to be centrally coordinated.

Many sites reported that State-provided materials are too high-level and do not train "real-life" eligibility issues or difficult case scenarios. As a result, each eligibility site has augmented the training materials with its own curriculum and materials. Some eligibility sites have a comprehensive training plan with an in-house training team that uses a hands-on approach to provide training in policy, CBMS as well as case scenarios. Other sites relied on their supervisors to train new eligibility technicians, many of whom were carrying a heavy caseload and other responsibilities.

Eligibility sites recommended that a "train the trainer" model be implemented in Colorado so that the materials and message can be communicated top-down, while still allowing the eligibility sites some control over the training methods.

3.4.3. Inadequate tools supporting eligibility lead to inefficiency

3.4.3.1. Finding #6

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

Every eligibility site we visited relied heavily on paper documentation, impacting the eligibility technician's ability to efficiently complete the application process. The paper applications and paper copies of verifications are shuffled between clerical workers and eligibility technicians, and could only be viewed by one person at a time. Not only does this hinder efficiency in the application processing, it also increases the chance of losing paper files.
Further support for this finding became apparent during the site visit to Prowers County Department of Human Services. Two years ago, Prowers County had a fire that damaged a significant portion of their paper Medicaid files. Luckily very few of the files were destroyed, but due to the extensive smoke damage, Prowers County had to spend around $300,000 cleaning the paper files. They estimate that if the fire had destroyed the files, time and resources needed to replace the paper files would have been astronomical.

Although some eligibility sites have already implemented basic document imaging technology, the imaging systems lack the vital management technology that allows the scanned files to be easily triaged, tracked or sorted. Also, the existing imaging systems are not compatible with other eligibility sites' systems, which does not aid in case transfers. Imaging at most scanning sites is primarily done once a case has been completed, so documents are often not available to eligibility technicians during the determination process, further limiting productivity.

3.4.3.2. Finding #7

The Colorado Benefits Management System (CBMS) still does not fully support Medicaid and CHP+ eligibility.

The Department is currently evaluating CBMS and planning next steps with the system. However, since CBMS issues were among the top complains during our visits to eligibility sites, the issues that were identified are listed here for completeness.

Overall, the eligibility sites reported that CBMS is cumbersome to use. There are too many screens and too many data fields required to be filled out with cumbersome navigation capability. Many of the data fields call for client information that is not currently required in the medical assistance applications. The data input process in CBMS needs to be streamlined with the Medicaid and CHP+ applications to reduce the overall time it takes to process an application.

It was also reported that CBMS automatically generates client notices that are confusing to Medicaid and CHP+ applicants and clients. Therefore, eligibility technicians must manually check the notices for accuracy and delete any unnecessary notices in CBMS prior to being sent to the client. If the inappropriate client notices go out by mistake, the confused clients generally call their county eligibility technicians, deterring eligibility technicians from application processing.

The management reports were often described as not being user friendly. A number of managers are either unaware of current Business Object (reporting module for CBMS data) reports, or do not use them since they feel the data is unusable. Many sites have additional report requests, but are unable to properly extract any readable data with the limited ad-hoc reporting tool.

3.4.3.3. Finding #8

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

During the visits to the eligibility sites, Public Knowledge found a variety of methods for tracking cases as well as individual workloads. Some eligibility sites have invested in sophisticated case tracking systems, while others still rely on a paper log that has to be manually updated. The manual process limits any form of workload monitoring since it cannot produce reports for supervisors.

Some eligibility sites use Business Objects reports to help track cases and workload, but reported that data is not available in real time, limiting its usefulness to get an accurate view of the current caseload.

3.4.3.4. Finding #9

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.

Many low-income clients apply for and are eligible for multiple public assistance programs, such as Food Stamps. In addition, nearly all TANF recipients are also eligible for Medicaid. Each program requires a periodic redetermination of eligibility from the date the application was approved. In order to complete a redetermination all factors of eligibility must be re-verified (with the exception of DRA verifications which are only verified once), which is a time consuming process for both the eligibility technician and client. Unfortunately, in many cases, the redetermination dates for each program do not align despite the fact that the eligibility information needed is nearly the same for each redetermination. By not synchronizing redetermination dates, eligibility technicians are forced to repeat the same task several times through a given year. The process is also confusing and time consuming for clients since they must supply the same information for each program at different times during a given year.

SECTION 4. Conditions for Success

Before implementing any new tools or changes to the Medicaid and CHP+ eligibility and enrollment model, Public Knowledge recommends that the Department strengthen certain core elements of the current model. The Department should invest time and resources in the following tasks prior to implementing Public Knowledge's recommendations in Section 5:

1. **Enhance the Colorado Benefit 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.**

Finalizing these tasks is crucial to the success of future modernization efforts in Colorado. The Department recognizes the need for each task and has already put forth efforts to strengthen these core elements.

4.1. Enhance the Colorado Benefit Management System (CBMS) to maximize eligibility and enrollment efficiency

As mentioned in Finding #7 above, eligibility sites report that issues associated with the Colorado Benefit Management System (CBMS) are the top challenges sites face on a daily basis. Eligibility sites also stated that the system was cumbersome to use and greatly impacts overall efficiency in the eligibility and enrollment process.

Although system enhancements have been made since the implementation, there are still many reported issues that continue to frustrate eligibility sites. To address CBMS issues, the Department contracted with Electronic Data Systems (EDS) to conduct a technical assessment of CBMS and deliver a series of Realignment Alternatives that the Department could implement to improve the system and increase flexibility in serving clients.

The CBMS Realignment Project was established with the following objectives[2]:

- Create an environment that allows for data entry and eligibility determinations for medical assistance programs that will not adversely impact data entry and eligibility determinations

[2] Presented at the CBMS Realignment Committee, November 2008.

for financial assistance programs. Prevent cross program eligibility errors by not allowing Medicaid updates to change Department of Human Services (DHS) client/case data/eligibility results, and conversely.

- Simplify data entry and reduce processing time by making the CBMS front end more user-friendly. Require that users enter only the information necessary to determine eligibility for the specific program for which they are applying.

- Separate Reference Tables for each major program area allowing each program area the ability to modify and maintain these tables without impact to the other program area.

- Improve client communications by enabling each major program area to control all correspondence sent to clients, regardless of the source (i.e. Client Correspondence, Document Verification Noticing, or Redetermination, Recertification and Reassessment).

- Assure retention of unique client identification processes.

- Assure retention of current functionality of interfaces into and out of CBMS.

In addition to the objectives, the CBMS Realignment Project was conducted under the following constraints:

- Utilize existing hardware and software products.

- Minimize the purchase and on-going maintenance costs of hardware and software products.

- Minimize additional application maintenance costs associated with maintaining the new solution.

- Maintain the ability to share core data (i.e. client demographics) across all programs.

- Minimize the impact on system response time on certain automated processes.

- No adverse impact on current CBMS operations and maintenance project.

EDS's results of the CBMS Realignment Project produced two Alternatives. Alternative One supports the objective that allows both the Department and DHS to individually define application behavior that best meets their business needs. Alternative Two focuses on implementing the maximum number of objectives with minimal costs (Electronic Data Systems, 2008).

The Department recognizes the need to enhance CBMS and continues to work with DHS and the Office of Information Technology (OIT) to solidify the next steps from the CBMS Realignment Project. After careful analysis of Colorado's current Medicaid eligibility and enrollment model as well as modernization trends from around the country, Public Knowledge recommends that the Department continue to collaborate with DHS and OIT in all efforts related to CBMS. Instead of dividing CBMS by departments, a detailed communication plan and change management process should be developed that meets each party's needs.

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

The Department has already started to standardize a Quality Management Plan across the State. Finding #4 outlines detailed issues related to the inconsistent quality assurance processes among eligibility sites. To promote accountability and strengthen program integrity, the Department must develop a detailed Quality Management Plan for monitoring the quality of Medicaid and CHP+ eligibility determinations and ongoing case maintenance. The Quality Management Plan must communicate a case review process that includes standard application items to check, a minimum amount of cases to review each period, a defined corrective action plan when errors are found and a series of performance metrics (such as a goal error rate, sufficient time frames for processing applications, etc.) that the State can use to fairly measure quality among eligibility sites. Public Knowledge is designing a similar Quality Management Plan for Wyoming's Department of Health and has passed along contact information to the Department for additional technical assistance.

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

A strong training program is essential to the success of any organization. Finding #5 describes the issues with the Department's current training model. Although the Department does conduct training sessions and develop training materials, the eligibility sites reported that the training is outdated and does not address the "challenging eligibility scenarios" that eligibility technicians face on a daily basis. In result, many eligibility sites have created in-house training units to supplement the Department training. Although the eligibility sites stated that they prefer some control over their employee training, they recommended that the Department develop a more robust "train the trainer" model and enhance current training materials and methods to better support the eligibility sites. The Department is currently working to enhance their training model and develop a comprehensive curriculum for eligibility sites to follow.

4.4. Create a detailed communication strategy to encourage collaboration between the departments, county partners, Medical Assistance sites and community-based organizations

Colorado's current Medicaid and CHP+ eligibility and enrollment model is comprised of a web of relationships between State departments, county partners, Medical Assistance sites and community-based organizations (CBOs). In order to satisfy the needs of all parties, Public Knowledge recommends that the Department develop a detailed communication strategy to encourage knowledge sharing and collaboration in all modernization efforts. Each party has unique insight into the eligibility and enrollment model and can provide valuable feedback in the design of modernization elements.

4.5. Realign Redetermination dates to streamline tasks

All major public assistance programs (i.e. Food Stamps, Medicaid, TANF) require periodic redeterminations of eligibility. A redetermination consists of a comprehensive review of eligibility factors that may be subject to change. Most of the assistance programs' redeterminations require similar client information as well as verifications. In result, the client must submit the same information multiple times throughout the year for the eligibility technician to process. Not only is this time consuming for both the client and the eligibility technician, but inefficient since the same process must be repeated several times.

With a small amount of planning and interagency cooperation, many states have realigned the dates of redeterminations for clients on multiple assistance programs. Redetermination dates for one program can be adjusted so the initial Medicaid or CHP+ redetermination falls on the same date as, for instance, the next Food Stamp Program redetermination. In result, there is significant potential for time saving, postage and mailing costs, as well as an increase in efficiency for both clients and eligibility technicians.

Implementation of such realignment would require a cooperative effort with DHS as well as the development of joint policy instructions to the workers in both agencies. In addition, a CBMS management report may need to be developed to help track upcoming redetermination dates to better forecast workload.

SECTION 5. Modernization Recommendations

5.1. Current State of Modernization

Based on the analysis of Colorado's current eligibility and enrollment model, visits to eligibility sites, states' best practices, Options Analysis results[3] and feedback from county partners and stakeholders, Public Knowledge recommends the following modernization options:

- **Implement an electronic document management system (EDMS).**
- **Implement a centrally-managed customer service center (CSC) to broaden client access.**
- **Expand the involvement of community-based organizations (CBOs) in the eligibility and enrollment process.**
- **Develop web-based services for clients and CBOs.**
- **Replace paper documentation with electronic client data where possible.**

Each of these initiatives constitute a sizeable project to manage, so Public Knowledge recommends an implementation plan that carefully coordinates each ones' dependencies. Some of these initiatives, like involving CBOs more in the eligibility process, are relatively low-tech and simple to implement, so it may be a short-term strategy even though it is not the highest priority in terms of funding or staff resources.

The term "centralization" is commonly used when describing a modernized Medicaid and CHP+ model. It is clear from the best practice results that centralizing elements of the Medicaid and CHP+ model maximizes efficiency and effectiveness in eligibility and enrollment processes. It is important to note that a state can still maintain a county-administered model and successfully centralize certain eligibility and enrollment processes. For example, Louisiana runs a state-administered, parish-run Medicaid eligibility and enrollment model and has developed a successful balance of power between the State and the parishes. All of the eligibility tools, such as the automated client eligibility system, CSC and EDMS, are centrally administered to promote uniform practices. However, each parish chooses how to manage and use the tools provided by the State. By centralizing the key elements of their Medicaid and CHP+ model, Louisiana was able to empower their local parish offices and increase efficiency and effectiveness across the State. It is Public Knowledge's belief that centralizing the recommended modernization options would provide eligibility sites with the tools they need to help run a successful eligibility and enrollment model in Colorado.

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[3] The Department Leadership Team met on November 13, 2008 to participate in an Options Analysis, review Public Knowledge's recommendations, and to rank them in order of priority for implementation. For results of the Options Analysis, please see Appendix G.

Public Knowledge includes a suggested level of centralization for each of the five recommendations. However, in order to accurately evaluate centralization options for Colorado, the current model needs to be compared against states with modernized Medicaid and CHP+ processes. Public Knowledge has developed the following scale to examine the current state of centralization in Colorado, as well as propose a future state model for the State's Medicaid and CHP+ programs:

- **Level 1** represents the lowest level of centralization and signifies the decentralization of resources and processes, or a lack of or insufficient technology and automation in eligibility and enrollment processes.

- **Level 2** represents a lower level of centralization with a model that is largely decentralized but has some minor aspects of centralization. This level could also signify that a minimal level of technology and automation in eligibility and enrollment processes exists, but is not sufficient for the current needs.

- **Level 3** represents a hybrid model. The hybrid model reflects a mix between decentralized and centralized in eligibility and enrollment processes. Level 3 could also signify that some automation in eligibility and enrollment processes exists, but is in need of enhancements.

- **Level 4** represents a centralized eligibility and enrollment model that has certain aspects of the model carried out in regional organizations. This level could also signify that a sufficient level of technology and automation is in place for eligibility and enrollment processes. Note: centralization does not necessarily mean that tasks are physically located in one centralized area.

- **Level 5** represents the highest level of centralization of resources and processes. This level may also signify that technology and automation is heavily utilized in eligibility and enrollment processes. Note: centralization does not necessarily mean that tasks are physically located in one centralized area.

After a detailed analysis of Colorado's Medicaid and CHP+ eligibility and enrollment model, Public Knowledge has developed the following assessment of State's current state of centralization:

Table: Assessment of Colorado's Current Centralization Model

Assessment of Colorado's Current Centralization Model Less centralized ← → More centralized					
Option	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Implement a Statewide Electronic Document Imaging and Management System (EDMS)	Current State				
Implement a centrally-managed customer service center (CSC) to broaden client access			Current State		
Expand the involvement of community-based organizations (CBOs) in the eligibility and enrollment process			Current State		
Develop web-based services for clients and CBOs	Current State				
Replace paper documentation with electronic client data where possible	Current State				

Supporting Evidence

Implement an Electronic Data Management System (EDMS): Currently, only a few eligibility sites within Colorado have implemented any form of an EDMS. Each eligibility site procures, implements and maintains its own EDMS without any Department guidance or regulation. All images are restricted to the eligibly site and cannot be transferred among counties or accessed remotely. For example, El Paso County has implemented a basic scanning system that can be used to access and store Medicaid cases. However, the imaged documents can only be viewed by appropriate El Paso employees and cannot be transferred along with cases to other county departments. Jefferson County, on the other hand, is piloting a different EDMS that will store images of their Adult Protective Services (APS) and Single Entry Point (SEP) cases. This range of systems and scanning capabilities throughout Colorado reflects a process that is completely decentralized.

Implement a centrally-managed customer service center (CSC) to broaden client access: Colorado's current CSC model is a hybrid that has both decentralized and centralized elements, resulting in a Level 3 classification. Some eligibility sites throughout the State maintain a CSC, but the range of services offered in each CSC appears to differ from site to site. Larimer County, for example, staffs trained eligibility technicians in its CSC and is able to resolve approximately 75 percent of client inquiries. In contrast, El Paso County's CSC is staffed by clerical workers who are able to resolve 25 percent of client inquires. Unlike the EDMS model, the Department does operate a centralized CSC for the CHP+ program through their current vendor, Affiliated Computer Services (ACS). The centralized CSC handles all client inquiries for CHP+ cases.

Expand the involvement of community-based organizations (CBOs) in the eligibility and enrollment process: Similar to Colorado's CSC model, the Department currently maintains a hybrid model with their community-based organizations (CBOs). Many county partners have built strong relationships with local CBOs in their area and have greatly benefited from the assistance. The Department has also contracted with Denver Health and Hospital Authority to run a Medical Assistance (MA) site in the City and County of Denver. CBOs at both the centralized and decentralized level greatly benefit the overall eligibility and enrollment model.

Develop web-based services for clients and CBOs: Currently, there are no online applications or additional web-based services for applicants or clients at either a decentralized or centralized level. Although the Department does have a website, applicants can only print an application or learn where to apply. Therefore, this element of modernization was assigned a Level One status since it lacks the necessary online technology that best practice research shows is a great benefit to both clients and states.

Replace paper documentation with electronic client data where possible: As with its web-based services, Colorado currently lacks the electronic verification technology at both a centralized and decentralized level. Modernized states have developed automatic interfaces or web portals to external systems that assist in gathering needed client verifications. For example, an interface to Internal Revenue Services data could automatically pull income data for clients, eliminating the need for the client to bring in the paper documentation. Due to the current manual process of gathering client data, this area of modernization was assigned a Level One status.

5.2. Proposed Future State of Modernization

This section outlines the modernization recommendations as well as the proposed level of centralization for each recommendation. Public Knowledge recommends that the Department implement the following modernization options to reflect the centralization model below.

Table: Recommended Future Centralization Model

Recommended Future Centralization Model Less centralized ←→ More centralized					
Option	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Implement a Statewide Electronic Document Imaging and Management System					Future State
Implement a centrally-managed customer service center (CSC) to broaden client access					Future State
Expand the involvement of community-based organizations (CBOs) in the eligibility and enrollment process			Future State		
Develop web-based services for clients and CBOs					Future State
Replace paper documentation with electronic client data where possible					Future State

5.2.1. Implement an Electronic Document Management System (EDMS)

Implementing an EDMS in Colorado's eligibility and enrollment processes should be a high priority for the State because it would provide greater flexibility to the State's workflow and can produce significant gains in worker productivity. Although significant savings would be gained in paper storage and retrieval costs, even greater savings would occur by being able to better manage eligibility and enrollment workflows. The workflow management software in an EDMS supports processing eligibility work by task, which is a trend in eligibility and enrollment process improvements.

Modern EDMS are being used in several states, including Wisconsin, Utah, Washington, Louisiana and Florida. Some have been developed by in-house Information Technology (IT) resources, but can also be purchased from private vendors. Vendors typically supply not only the imaging equipment, but also the accompanying management hardware and software, as well as technical assistance to the user. The more advanced systems utilize barcodes and optical character recognition technology so that the system "recognizes" what type of document has been imaged, associates it with similar documents pertaining to the same case, and even assigns it a specified queue for processing.

Once images are scanned into the EDMS, the documents are available instantaneously to users at multiple locations. The increased flexibility of document access allows work to be easily distributed and tracked. The management software also provides enhanced reporting and the ability to reassign work to either cover vacancies or meet increasing demands for service. Because of this, states that have already implemented an EDMS experienced an increase in the timeliness and accuracy of application processing.

EDMS Considerations

With any new project, there are possible implementation issues, timeline delays, budget risks and organizational constraints that can affect the system's success. However, an EDMS is one of the most common components of modernized Medicaid and CHP+ eligibility and enrollment model. The technology is considered "low-risk" because it has been tested for years in other states and in other industries. In addition, performance standards and implementation guidelines have already been developed by other states with these systems. Although requirements will need to be defined so Colorado's EDMS provides the functionality necessary to support their eligibility and enrollment needs, there are models from other states and off-the-shelf products from vendors that could serve as a good starting place.

During the visits to eligibility sites, Public Knowledge found that the eligibility sites recognize the need for an EDMS. Some eligibility sites have already started using basic scanning technology and welcome the increased flexibility and efficiency that would come with an EDMS.

The added flexibility in document access would also aid clients when transferring between counties. A common concern expressed in our site visits was that transferring counties rarely included the needed case documentation with cases received by the county. In result, the worker is forced to track down the client's documents, or ask for replacements to be submitted by the client, thus delaying benefits.

In addition, if Colorado were to acquire a comprehensive EDMS that could store and manage not just Medicaid case information, but also include the other assistance programs, such as the Food Stamps, eligibility technicians could have access to documentation that is required by multiple programs. Since many of the eligibility requirements and policies are similar, it would be highly efficient to share the technology.

Benefits Compared to Costs

There will be up-front costs of purchasing, implementing and running the EDMS. Costs of such systems vary, but have been generally coming down while the technology, particularly optical character recognition, has been improving. Affiliated Computer Services (ACS) responded to the recent Request for Information (RFI) and proposed a comprehensive EDMS system in the price range of $22.4 to $31.3 million. This comprehensive approach includes costs associated with other modernization components, such as online applications. For more information on the RFI, see Appendix A for a summary.

States with a comprehensive EDMS have reported significant cost savings associated with file and paper storage, postage, paper supply purchases, copier and ink costs. To measure just one aspect of these potential savings, if each of Colorado's counties saved 120 square feet of space due to reduced file and paper storage needs, they could save a total of nearly $164,000 per year.[4]

Due to the flexibility in document access, some states have implemented virtual office incentives for their eligibility workers. Such states have been able to further downsize their facility needs. Arizona reported over a million dollars in facility savings.

EDMS Implementation Approach

Implementing an EDMS can be accomplished independently of other modernization initiatives. Freeing eligibility tasks from paper is almost a prerequisite to making the eligibility process more efficient. Of course even greater benefits can be gained from an EDMS when it is implemented in coordination with other modernization efforts like task-based workflows and centralized CSCs. But the technology related to EDMS is rapidly improving relative to costs, making it a cost effective place to start.

Many states have implemented their own EDMS and have used in-house IT resources to customize the document management and workflow software. Some states have contracted for the service as a part of a broader contract for eligibility and enrollment services. Others have purchased off-the-shelf systems from a vendor who has customized it for their agency. Either route has produced positive results in other states.

Another important factor in the successful implementation of an EDMS for Medicaid and CHP+ eligibility is the partnership with DHS's public assistance programs. Most of these are commonly associated with receipt of medical assistance. The most efficient implementation of EDMS would include the complete electronic file for a case, including documents related to the cash, food, and

[4] This calculation estimates a cost of $21 per square foot of office space.

medical programs clients may be participating in. This would allow eligibility technicians working with just the Medicaid component to view common documents gathered for another program like Food Stamps.

The majority of states are operating a centralized EDMS model. Although their EDMS is centrally-administered, some states manage the imaging and indexing in regional locations. In this model all paper documents are sent to regional sites located close to US Postal Service Center hubs so mail can be intercepted and scanned before it reaches the local offices. Documents can also be faxed and emailed to the regional sites, or couriered from service delivery sites, like eligibility sites. Documents are immediately converted to images and assigned to an office or worker to be reviewed and to take any necessary action on the case.

Examples

- ***Washington:*** Washington State has strategically located their regional imaging centers next to U.S. postal hubs. All mail-in applications or related documents are intercepted and scanned into their EDMS prior to the mail ever reaching the regional offices for processing. All documents are barcoded and triaged to the appropriate queue where it is processed by one of the six regional offices.

- ***Utah:*** Utah studied Washington State's EDMS model prior to implementing its own EDMS system. Utah has set up three "drop centers" throughout the State where mail-in applications and related documents are received and scanned into the system. The drop centers are also strategically placed next to U.S. postal hubs in order to maximize efficiency in the scanning process. Their barcoding system, Content Management, barcodes each document to aid in document management. Utah follows the task-based model and divides the caseload by task. Depending on the action needed (i.e. application processing, redetermination, update client information), the document is placed in the appropriate queue to be processed by the next available eligibility technician.

- ***Louisiana:*** Prior to Hurricane Katrina, Louisiana implemented a uniform EDMS to be used in each of their 64 parish offices. Similar to Colorado, eligibility for Medicaid and SCHIP (CHP+ in Colorado) programs are determined at the parish level despite being administered by the state. As a compromise to the parishes, Louisiana procured one EDMS system that each parish would use to manage all eligibility documents. Distributing the imaging responsibilities among the parishes has been successful for Louisiana since it promotes consistent practice while allowing each parish to have some control over the management of the scanned documents.

Public Knowledge recommends that the Department implement an EDMS that can be accessed from anywhere in the State. Centralizing the EDMS minimizes the amount of interfaces and hardware needed, as well as ensures that all documents can be easily transferred between sites. Implementing a single system would guarantee scanned images could be shared across the State and that a consistent level of quality assurance is applied to each image. Managers and supervisors at eligibility sites could easily manage incoming documents and triage tasks to available resources. By locating imaging centers next to regional postal hubs, paper documents could be intercepted and scanned before the paper reaches the local office, increasing the efficiency in application processing.

In contrast, a decentralized model would require the Department to purchase enough hardware for scanners to be located in every eligibility site or other point of service delivery, leaving quality assurance and temporary storage of paper documentation would be the responsibility of the local offices.

Whatever course the Department takes in procuring an EDMS, the new system should take into account that several Colorado counties already image some or all eligibility documents. A new statewide EDMS would need the ability to interface to existing systems. In addition, there will be an ongoing maintenance and enhancement effort that will need to be staffed by either in-house IT staff or a vendor. System and hardware upgrades are recommended every couple of years to maximize the capabilities of EDMS.

5.2.2. Implement a Centrally-Managed Customer Service Center (CSC) to Broaden Client Access

Many states use customer service centers (CSCs) to handle questions and basic Medicaid and SCHIP (CHP+ in Colorado) case actions such as change reporting. Some CSCs are even equipped to handle all aspects of the eligibility and enrollment process, including redeterminations and applications. CSCs are the first point of contact for client inquiries, and can help to triage the inquiries based on severity of the concern or complexity of the question.

Another important feature of CSC technology is an Interactive Voice Response (IVR) system that allows clients to access some information and take basic action on their case 24-hours a day through an automated system. Many states have mirrored their web-based services in their CSC's IVR systems. The use of this technology provides yet another option for clients to access programs and receive customer service, and is highly efficient as it requires little human intervention.

CSCs in other states are also being used to proactively obtain recertification information from clients over the phone, rather than waiting for the client to return a paper form. This process prevents some clients from having gaps in medical coverage because they did not fill out and submit a redetermination packet. States that have implemented this model, like Louisiana and Utah, report a higher retention of Medicaid enrollees and a reduction in the administrative costs associated with re-opening cases.

CSC Considerations

Call center technology and management is well defined and tested in eligibility and enrollment processes and in other industries. Many states have successfully implemented CSCs, including the CHP+ CSC in Colorado, and have developed guidelines and standards for customer service via the telephone. Regardless of who operates the CSC, performance standards will need to be set and monitored to ensure quality customer service.

One of the most important considerations for CSC implementation is how to staff an expanded CSC with highly trained eligibility technicians. If trained and experienced eligibility technicians are not staffing the CSC, the number of unresolved client inquires will likely increase and will need to be referred to someone else for resolution. In addition, without appropriate resources to manage the high volume of calls, high wait times could frustrate clients and deter clients from using the service in the future.

Many counties recognize the benefits of CSCs and welcome opportunities to alleviate their eligibility technicians from having to answer basic client inquires and processing common changes. Some counties have already implemented basic CSCs to reduce some of the burden and provide clients with better service. However, some county staff are concerned that certain populations of clients, like the elderly and disabled, will find it difficult to communicate over the telephone, and they feel that a CSC would detract from the client/eligibility technician relationship. Working closely with eligibility sites to establish performance standards for a centralized CSC may help alleviate some of their concerns.

Benefits Compared to Costs

Up-front costs associated with implementing a CSC include the appropriate software and hardware required to run a successful customer service center with an IVR option. Numerous call management software packages are available as off-the-shelf products and are decreasing in price. If a vendor were to provide the CSC services, their contract should include providing the necessary tools and infrastructure to operate the center.

Additional resources may be needed to staff the CSC. Based on the lessons learned from other states, Colorado should staff a CHP+ and Medicaid CSC with experienced or highly trained eligibility technicians. Louisiana, a state that has successfully implemented a CSC, decided to do this after carefully studying other states, including some with unsuccessful implementations. To attract top eligibility technicians, Louisiana offered a higher wage to their CSC staff. If a vendor were providing the service, the vendor's recruiting strategy would need to be carefully planned and coordinated so as not to create staffing issues for surrounding counties with experienced eligibility technicians who may be job candidates. In addition, depending on how the CSC is staffed, additional facility space may be required.

ACS reported in their RFI, that Virginia experienced a 20 percent reduction in the number of calls that required a live representative's assistance with the implementation of an IVR. According to costs calculated in Deloitte's workload study from the spring of 2007, a 20 percent reduction in eligibility workers time spent on client communications and processing changes in client circumstances would translate to a savings of $1.9 million per year of eligibility workers time.[5]

CSC Implementation Approach

One of the major advantages of implementing CSCs is they can be easily "scaled-up" as new services or programs are brought into the business process. Many states begin with a single CSC that handles all inquiries and triages issues to local eligibility technicians. As technology (like EDMS) improves, case documentation can be made available to anyone in the State, allowing the CSC to take on more responsibility for eligibility processing.

Public Knowledge believes that there is a logical fit between management and administration of CHP+ cases and the Medicaid Family Medical programs in Colorado, especially when the family is

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[5] $1.9 million is equal to 20 percent of the value of time estimated by Deloitte spent across all counties on two activities — h) Change in Circumstance Reported by the Client, and i) Client Communications and Information.[3] For a complete definition of these activities see Deloitte's study, entitled *Colorado Workload Study Final Report*, attached in Appendix H.

receiving only medical assistance. Public Knowledge recommends creating a CSC to service CHP+ and Family Medical-only cases, and then adding other types of cases over time- such as SSI-related Medicaid and the financial eligibility determinations for long-term care.

Other states have phased in services by establishing a single 800 number as a first-point-of contact for questions and change reporting in eligibility. As staff become more experienced with eligibility rules and confident in the technology, other tasks can be added like redetermination processing and application processing. Application processing through CSCs can be done more easily now that new federal regulations allow telephonic signatures on applications.

A more recent trend has been for states to allow CSC staff to telecommute from home. In Utah, some CSC staff work from their home. They answer questions and handle most aspects of the eligibility and enrollment processes. CSC staff receive the same training as eligibility technicians, most of which is provided via the Internet.

Examples

- ***Utah:*** Utah currently has two centralized CSCs that handle every aspect of the eligibility and enrollment process, including handling initial client inquires, completing client updates and even conducting client interviews for programs such as Food Stamps. The CSCs are staffed with trained eligibility technicians who are able to resolve a high percentage of issues or tasks called into the center. Due to the centralized model and flexible access to electronic case files, many of the CSC staff work out of their homes. This added incentive has been linked to an increase in productivity and employee satisfaction.

- ***Colorado:*** Several eligibility sites in Colorado have implemented CSCs to provide better customer service and reduce the amount of client inquires on eligibility workers. Each CSC is completely decentralized and has its own processes, resources and tools. Some of the more effective CSC models within Colorado staff highly trained eligibility technicians and reportedly resolve up to 75 percent of client inquiries and concerns. Though the majority of the decentralized CSCs lack any sophisticated call management software or tools, some sites will be investing in software to assist in handling the call volume and to help monitoring performance measures.

- ***Louisiana:*** Louisiana's Medicaid agency operates nine regional offices. Louisiana is currently transitioning to a CSC model where every incoming call is automatically directed to the central CSC number. The State has reached a point where their CSC's are now handling most applications for Medical Assistance by telephone. Similar to Utah, Louisiana also makes extensive use of telecommuters in their CSCs. In October 2008, Louisiana's CSCs handled over 80,000 calls. About half of those were handled by their IVR system.

- ***Florida:*** Florida has set up regional CSCs located throughout the State. Clients could choose to be routed to the centralized IVR system or be routed to a live eligibility technician in their region. Similar to Utah, many of the Florida CSC eligibility technicians work from home due to the flexibility of the CSC system and access to the electronic case file.

Public Knowledge recommends that the Department implement a centralized CSC and 24-hour IVR system to provide clients with an additional access point to Medicaid and CHP+ services. CSCs can either be operated using internal resources or by an outside vendor who not only provides the technology, but also the staff resources for the operation. Public Knowledge believes either option could work in Colorado, as long as the centralized CSC is closely supervised by Department staff that manage the operation based on pre-established performance measures and employ consequences for not meeting standards.

5.2.3. Expand the Involvement of Community-Based Organizations (CBOs) in Eligibility and Enrollment Processes

The traditional model of eligibility and enrollment involves minimal outreach to those who might be eligible for services. Under this model, everyone wishing to apply for Medicaid or CHP+ is required to come to an office. The office then processes the application, determines eligibility, and maintains the case until services are no longer needed.

Many jurisdictions have learned that seeking out those who need medical services is less costly in the long run than waiting until an illness becomes chronic and more costly to treat. This is particularly true for children, which is one reason states participating in the SCHIP (CHP+ in Colorado) program are required to describe their outreach methods in their state plans and to coordinate enrollment in their SCHIP programs with the Medicaid program. According to a study conducted by the Government Accounting Office (GAO), "states must specify in their SCHIP plans how they have established a system that identifies, refers, and enrolls eligible children in the appropriate program – a process called 'screening and enrollment (United States General Accounting Office, 2000)." The same GAO study pointed out that when states aggressively pursue SCHIP outreach activities, they tend to find many children who are eligible for Medicaid, thus extending health care benefits to a vulnerable population, which in many cases was not aware such benefits were available to them. For more details on the GAO study, please see Appendix I.

Also, states are now experimenting with having CBOs perform virtually every component of the eligibility determination process. Colorado has done a commendable job of involving CBOs in the process, but may wish to do even more to increase the number of Medicaid and CHP+ eligible people participating in the program particularly in under-served populations.

CBO Involvement Considerations

Expanding eligibility services within the community would help reduce the amount of cases that come to eligibility sites. This incentive would be welcomed at many counties. Some counties have already set up Medical Assistance (MA) sites and report positive results. CBOs can be fairly easily recruited or removed from the eligibility process depending on population trends and client demand.

Medical Assistance sites at more CBOs provide additional options for the client to access eligibility and enrollment services. With added eligibility and enrollment services in the community, clients could go to the site that best meets their demographic needs.

In addition, staff handling parts of the process at or near the point of service are more likely to have some existing information about the client's needs, resources and circumstances and may be able to assist the client with the application so it can be processed more quickly by the state or county.

Relationships with participating CBOs must be managed in order to ensure that consistent and quality eligibility practices are used. Also, training will need to be developed and provided to sites to ensure applications and redetermination information is being properly gathered. If managed well, though, there is minimal risk associated with this option.

Benefits Compared to Costs

There would be minimal costs of expanding CBOs. Some training and quality management, however, would need to be expanded to ensure effective working relationships with CBOs. Federal match incentives exist that could help alleviate some of the administrative costs for the additional involvement of CBOs. In addition, medical providers may be willing to cover the administrative costs in exchange for decreasing the time required to complete application and redetermination processes and securing quicker clients access to benefits. CBOs also have something to gain themselves by processing Medicaid and CHP+ applications. Denver Health, for example, provides health care services to all people, regardless of ability to pay. As a Medical Assistance site, Denver Health can screen patients for Medicaid and CHP+ eligibility and use Medicaid funds for eligible patients, saving their other funding sources for patients that are not Medicaid eligible.

If CBOs save state eligibility technicians 15-30 percent of total application time through pre-screening and helping clients to be aware of verifications that need to be provided for 50 percent of clients, they could save the state between $636,000 and $1.27 million annually.[6]

CBO Implementation Approach

Some additional Department resources would be needed in order to increase the use of CBOs in outreach and enrollment, but this option is a quick win for the Department. Public Knowledge is aware that the Department has an initiative to standardize a Quality Management Plan. Public Knowledge recommends the Plan address the need to monitor Medical Assistance and presumptive eligibility sites to build the infrastructure for additional CBOs to be involved in eligibility and enrollment processes.

Examples

- ***Pennsylvania:*** To provide clients with additional access points, Pennsylvania has partnered with CBOs around the State to extend Medicaid and SCHIP enrollment services. Pennsylvania trains community members to be "Power Users" and perform eligibility services. Each Power User is given access to the web-based automated client eligibly system to determine eligibility. Once eligibility is determined, the case is transferred to the State.

- ***Arizona:*** Not only do Arizona CBOs assist in the application processing, Arizona's CBOs have also provided valuable input in the design of their client notifications. Arizona's Division of Member Services worked with their partner nursing homes and senior centers to

[6] Total application time is the combined value of time estimated by Deloitte spent across all counties on three activities — a) Application Initiation (AI), c) Interactive Interview (II) and d) Eligibility Determination and Benefit Calculation (EDBC) Wrap-up and Authorization.[3] For a complete definition of these activities see Deloitte's study, entitled *Colorado Workload Study Final Report*, attached in Appendix H.

study the readability of their client notifications. Volunteers were given sample notifications to review, then were tested on the content. The studies greatly improved the overall quality of Arizona's client notifications.

- ***Colorado:*** Several eligibility sites have partnered with CBOs to increase Medicaid and CHP+ access to clients. El Paso County has recently partnered with Peak Vista Medical Center (Peak Vista) to perform Medicaid eligibility services for Peak Vista clients. Although the partnership is relatively new, the County has reported that it has been a positive experience. Peak Vista eligibility technicians currently process about one to three applications a day, alleviating the County from the added work. Denver Health Medical Center has developed eleven MA sites within the City and County of Denver. The MA site has a contract with the Department to process eligibility for both Medicaid and CHP+ programs. Denver Health Medical Assistance estimates that they process over 55,000 applications a year.

The State currently administers a Level Three or hybrid CBO model. Both county partners and the Department have built strong relationships with CBOs and have benefited from the assistance the advocates provide. Public Knowledge recommends that the State continue to maintain this hybrid model but focus on adding additional CBOs as well as expanding CBO responsibilities to increase the effectiveness of each CBO.

5.2.4. Develop Web-Based Services for Clients and CBOs

Web-based services create a flexible option for clients to receive customer service, and a tool for CBOs to use in application assistance. Many states (currently 13) are using Internet technology in the eligibility and enrollment process.

The objective of most state online applications, one of the primary features of web-based services for clients, is to relieve some of the intake and data entry work for eligibility technicians while increasing access for clients. Other features of web-based service include: online redeterminations and change reporting, the ability to check on the status of documents submitted to an EDMS, and the ability to check benefit account status. Most web-based services for clients also include a pre-screening tool and answers to Frequently Asked Questions about programs and services.

Almost every state, including Colorado, allows individuals to download applications online for many programs, including Medicaid and CHP+. The paper applications can then be submitted in person, by mail, or faxed to an eligibility site. This is not considered an online application from a modernization perspective. Clients must be able to electronically submit an application for it to be considered web-based. With federal regulations that allow for the acceptance of electronic signatures, clients can easily submit an application or redetermination online.

13 states have now made it possible for applications to be submitted online. Log-in protocols, much like those used by banks and other financial institutions, are used as electronic signatures so the system can verify that the information is being submitted by the client or their authorized representative. Most state websites include a self-screening tool that allows individuals who are not certain if they qualify for benefits to see if the application process is worthwhile. Some state have interfaces with their eligibility systems to capture the online submission so that it can be validated and processed by eligibility technicians without data entry.

Web-Based Services Considerations

The risk associated with implementing web-based services for clients is fairly low, since many states have already released online applications to the public and have developed standards and guidelines for implementing them. Login protocols, much like those used by banks and other financial institutions, are used so the systems can verify the identity of the person submitting information.

Also, as more customer service in the commercial and retail industries moves to the Internet, online applications are likely to be more accepted by clients. Currently, an average of 20 percent of all applications are submitted online in states that have fully implemented. In those states, clients and their advocates appreciate the convenience of services 24-hours a day and the flexibility to apply for and maintain their benefits online.

Developing online applications, particularly when combined with a self-screening tool, saves a significant amount of time in the eligibility process. Providing online educational tools allows client questions to be answered without having to call an eligibility technician. Self-screening tools could also reduce the amount of ineligible applicants being submitted to eligibility sites. In states where web-based services allow applicants to check on status online, it has resulted in a significant decrease in phone calls to eligibility technicians.

Web-based services would also enhance the current eligibility process by reducing the amount of data entry required in the application process, assuming the web-based application interfaced with the client eligibility system.

Benefits Compared to Costs

Some up-front costs would be associated in the development and implementation of web-based services including an online application. The Center to Promote Health Care Access (OneEApp) responded to the State's RFI and proposed an estimated cost of designing, developing, implementing and maintaining an online application would cost an estimated $6.2 million dollars for a three-year time period. Arizona reported their online application to cost under $5 million dollars by using an in-house IT staff (cost includes design, development and implementation). Wisconsin's reputable online application, ACCESS, was developed using free Open Source code. Five other states have used ACCESS as a basis for their online applications. West Virginia estimated it spent approximately $4 million to tailor and enhance their version of ACCESS.

Massachusetts estimated that their online application saved eligibility technicians eleven minutes per application, dropping their application initiation time by 55 percent, from 20 minutes to nine minutes. Louisiana reported cutting application initiation time spent by eligibility technicians by 75 percent from 20 minutes to five minutes. According to activity times calculated in Deloitte's workload study from the spring of 2007, Colorado spends an average of 17 minutes per application on application initiation. Using time and cost estimates from the same Deloitte report, a reduction of 25-55 percent of that time would reduce the cost of application initiation in Colorado by between $766,000 and $1.7 million per year.

In addition, Massachusetts compared the average turnaround time for online applications versus paper applications. Whereas their paper applications had an average turnaround time of 5.15 days, they were able to cut that by 65 percent to 3.25 days with online applications.

Web-Based Services Implementation Approach

Implementation of web-based services should be done in stages, starting with one program and basic functionality and adding more programs and functionality over time.

In order to implement web-based services, the Department would need to make certain that Colorado's Information Technology infrastructure, particularly with respect to telephony and web resources, will support it. Money and efforts would be required to procure the hardware and software needed to build the system and interface with CBMS. Although there are Open Source online applications from other states available for free, they would need to be customized to meet Colorado's needs.

Many states have first worked with CBOs who are trained to use the tool to assist clients submitting the online application. For example, Utah is currently developing an online application, but before making it available to the general public, it is being tested in a controlled environment in their field offices. Utah allows individuals to send in applications online, but the client must submit from kiosks located in field offices where an eligibility technician is available for assistance. They will not make the online application available to the public until they are comfortable with the performance. New York required pilot counties to develop process improvement plans with their community partners before they could pilot their new online application.

<u>**Examples**</u>

- ***Florida:*** The majority of applications in Florida are submitted online. Anyone applying for or renewing Medicaid benefits can do so online, at state-run offices or any of 2,500 "partner" agencies including churches, libraries, food banks, senior centers, and homeless shelters. If an applicant comes into one of Florida's regional offices, the applicant is directed to a kiosk and asked to fill out their online application. If the client is in need of assistance, trained clerical workers are available to guide the applicant through the process.

- ***Arizona:*** Arizona implemented their web-based services in phases. They initially implemented an online application and made it available only to community-based organizations that were trained in eligibility and enrollment. The State then added a comprehensive client tool that allows clients to apply online for both Medicaid and SCHIP, renew benefits, update client information, and even check the status of their case.

- ***Louisiana:*** Louisiana built an online application in-house. The application went live in 2007 and allowed clients to apply online for Medicaid, SCHIP and other programs. Despite the high levels of clients without a computer, Louisiana reports that over 12 percent of their applications are submitted online. The State estimates that applications submitted online are processed fifteen minutes faster than paper applications.

Public Knowledge recommends that the Department develop a centralized set of web-based tools for their clients. A centralized online application and client tools would promote consistent practice among the eligibility sites and CBOs, as well as minimize confusion for clients by providing a single website to access. It would also decrease the amount of training and maintenance needed to administer the web-based services. Centralizing web-based services would also increase the

likelihood of interfacing online submitted data to the State's automated client eligibility system, which would maximize efficiency and reduce the amount of data entry on local eligibility technicians.

5.2.5. Replace Paper Documentation with Electronic Client Data Where Possible

Many states have upgraded their automated client eligibility systems to include interfaces to systems such as Vital Statistics, Labor and Wage, as well as Social Security information. Client data from the external systems automatically populates the automated client eligibility system, saving workers valuable time in data entry and document verification.

Some states have developed gopher systems like Utah's e-Find that acts as a search engine for client documentation. The eligibility technician could fill out basic information on the client and desired documentation, and E-Find will search all systems for a match. Other states have created a web-portal for their eligibility technicians so that they can more quickly access external systems to search for client data.

Electronic Client Data Considerations

Eligibility technicians would need admission to systems they were not previously allowed to access, which may result in some pushback from other departments who administer the external systems. This pushback can be motivated by revenue concerns, as some agencies, such as Vital Statistics, are partially self-funded by the fees associated with obtaining a certified copy of records.

Deficit Reduction Act (DRA) verification requirements were reported as one of the biggest challenges in the current eligibility and enrollment processes, so there is an argument for subsidizing agencies like Vital Statistics in order to save administrative resources by reducing the time and effort associated with client verification.

Obtaining certified copies of citizenship and identity documentation is expensive and time consuming for clients. Eliminating this need could greatly simplify enrollment processes for clients. With automatic verification of documentation, applications could be processed quicker thus decreasing the wait-times associated with Medicaid and CHP+ applications.

Whenever new electronic forms of client data are made available to eligibility technicians, security profiles will need to be managed and monitored, especially related to protected health information. Many states have already navigated the federal regulations and created profiles that could be used as a starting place for Colorado.

Benefits Compared to Costs

Depending on the scope of interfaces, the development, testing and implementation costs could vary. The use of external interfaces could also save the State time in processing new applications as well as making redeterminations. If through the use of interfaces with external systems, total application time could be cut by ten percent per application, the State would save $848,000 per

year.[7] If interfaces with external systems saved five percent of redetermination time, the State would save $157,000 per year.[8]

There are additional financial savings that could be realized by clients, who currently have to pay for original copies of documents such as birth certificates.

Electronic Client Data Implementation Approach

Not many years ago, the only option for states desiring more electronic client data was to create additional interfaces with their automated client eligibility system. Since then, two other options have become popular because of their relative simplicity in implementation - web portals that provide single sign-on for eligibility technicians, and E-Find systems that retrieve electronic data when it is available for a specific client from a pre-defined list of sources. These stand-alone systems are also easier to change when there are changes in Medicaid or CHP+ eligibility policies.

Examples

- ***Pennsylvania:*** Pennsylvania's automated client eligibility system interfaces to over forty external systems including the Social Security Administration, Internal Revenue System, numerous state agency systems, employment and training contractors, managed care providers, J.P. Morgan Electronic Financial Services (Electronic Funds Transfer), child support system, and others.

- ***Louisiana:*** Louisiana has developed an interface between their automated client eligibility system and their sister agency's welfare system which includes information on Food Stamp, TANF, child welfare and other assistance program clients. If a Food Stamp or TANF client submits a redetermination for benefits, the redetermination information automatically completes their Medicaid renewal. This saves valuable time for both eligibility technicians and clients.

Public Knowledge recommends that the Department implement a centralized method of automating the client verification process. Based on the best practice research as well as feedback from eligibility sites, any form of automation in this time-consuming step could greatly increase overall efficiency and timeliness in application processing. Centralizing this effort would allow each eligibility site to have equal access to the timesaving benefits, resulting in a more efficient eligibility and enrollment processes throughout the State.

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[7] Total application time is the combined value of time estimated by Deloitte spent across all counties on three activities — a) Application Initiation (AI), c) Interactive Interview (II) and d) Eligibility Determination and Benefit Calculation (EDBC) Wrap-up and Authorization.[3] For a complete definition of these activities see Deloitte's study, entitled *Colorado Workload Study Final Report*, please see Appendix H.

[8] Redetermination time is the value of time estimated by Deloitte spent across all counties on one activity — f) Eligibility Recertification (RRR).[3] For a complete definition of these activities see Deloitte's study, entitled *Colorado Workload Study Final Report*, please see Appendix H.

5.3. Modernization Implementation Plan

As stated earlier, freeing the eligibility tasks from paper forms and manual routing is a prerequisite for several other modernization options. Acquiring an EDMS capable of triaging, tracking, and assigning cash, food, and medical assistance case files should be an integral part of the procurement process that follows in the second phase of this project.

Involving more community-based organizations (CBOs) is low risk, fairly easy to implement, and is likely to have a positive impact on customer service and access. Public Knowledge believes it is a short-term strategy the Department should pursue concurrently with other modernization efforts.

Developing web-based services and implementing additional interfaces to systems with client data closely tied for third in the prioritization. Many states have pursued additional interfaces and other forms of electronic client data after implementing their EDMS because it is the first time they see reliable data on the amount of paper documentation submitted for eligibility each month. The natural next step is to want to eliminate some of that paper by either simplifying policies or obtaining it electronically. Public Knowledge recommends that the Department implements the electronic client data interfaces after the EDMS is implemented.

Similarly, developing web-based services would naturally follow the implementation of CSCs. CSCs functions can be replicated on the web with 24-hour access for clients who are comfortable using the Internet. CBOs that advocate for or assist clients with benefit applications can also benefit from the added flexibility with web-based services. Additionally, once online applications have been implemented it is important to provide a single point of contact for client questions and follow-up, typically in the form of an 800 number for a centralized CSC. Because of these inter-dependencies, it is recommend that the Department establish a centrally managed CSC prior to implementing an online application. However, due to the time required to acquire and customize another state's web-based services application, the project may have to be managed concurrently.

In order to implement these new programs, the Department will need additional resources for project management, requirements definition, procurement, and contracts management and supervision. The Department will need to determine how many of those additional resources they want to procure through a contract with a vendor, versus establishing new State positions in the Department. Texas, one of the larger states that outsources many components of its human services programs, recommends thinking very carefully about the balance of responsibilities between the State and the vendor. The Texas Human Services Agency is in the process of taking back some responsibilities that were outsourced in the past.

Based on the RFI responses from private and non-profit vendors, there are organizations with significant experience in other states providing the enhanced eligibility services described in this report. Such vendors also claim to have proprietary systems that can be implemented to meet the Department's needs relatively quickly.

A full implementation schedule will need to be developed as a part of the Department's procurement process in Phase II of the CEMP project. Based on the Leadership Team's feedback and Public Knowledge's recommendations for implementation, a high-level timeline for the Department's modernization efforts is presented below.

This is a representation of what an implementation schedule might look like. The timeline does not account for funding issues, availability of project management resources, contract delays or unforeseen changes in political priorities.

1. Develop requirements for EDMS, CSC, and web-based services (begin January 2009).

2. Expand medical assistance and presumptive eligibility sites in CBOs and create a quality management plan to monitor performance (March 2009).

3. Begin contracts with one or more vendors to develop modernized tools and services (December 2009).

4. Implement a centrally managed CSC for Family Medical-only and CHP+ clients and integrate with existing customer service centers in the Department. Initial services provided could include a central point-of-contact for application assistance, inquiries on case status, reporting address changes and adding needy newborns, and referrals to eligibility sites and Medicaid Assistance (MA) sites (March 2010).

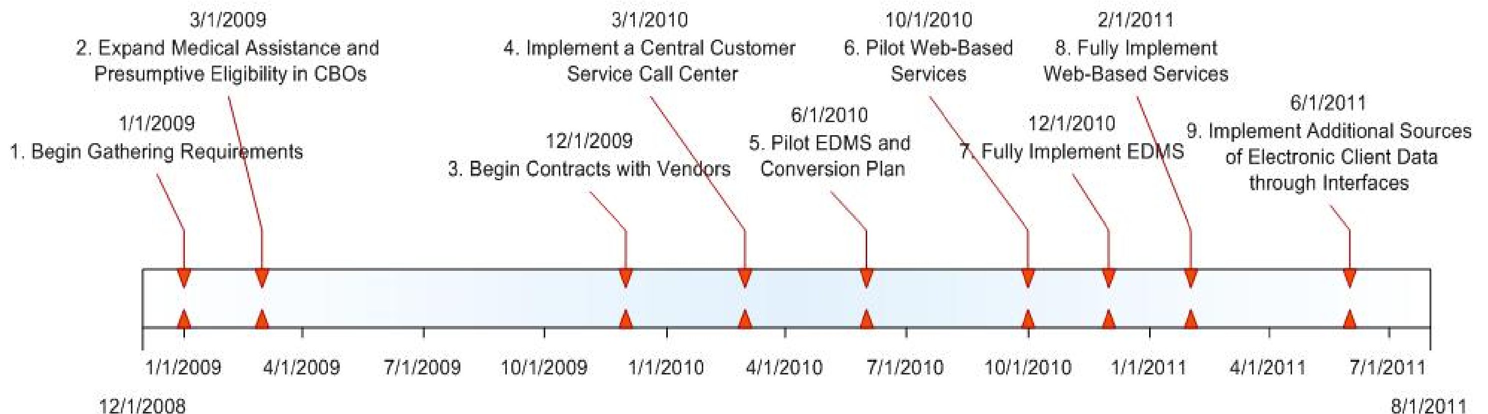
5. Pilot a comprehensive EDMS and implement a conversion plan for counties with existing electronic case files (June 2010).

6. Pilot new web-based services with a CBO providing application assistance and eligibility sites, and supported by a centrally managed CSC (October 2010).

7. Fully implement a comprehensive EDMS and convert existing electronic case files (December 2010).

8. Fully implement new web-based services supported by the centrally managed CSC (February 2011).

9. Implement additional sources of electronic client data through interfaces or other means (June 2011).



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Appendix A – Request for Information (RFI) Response Summary

Appendix B – Best Practice Interview Guide

Appendix C – Best Practice Research Results

The following tables represent the collection of states' eligibility and enrollment models analyzed in the best practice research.

Appendix D – States with Online Medicaid Applications

Appendix E – Site Visit Interview Protocols

Appendix F – County Process Maps

Attached are the Process Maps for each county that outline the steps for the application, redetermination and case maintenance process for both the Family Medical and Adult Medical programs.

Appendix G – Options Analysis Results

Appendix H – Colorado Workload Study

Appendix I – Medicaid and SCHIP: Comparison of Outreach, Enrollment Practices and Benefits