Colorado Department Health Care Policy and Financing

Medical Eligibility Quality Improvement Plan December 2008

Improving access to cost-effective, quality health care services for Coloradans
colorado.gov/hcpf

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Overview and Strategic Direction

The mission of the Colorado Department of Health Care Policy and Financing (the Department) is to improve access to cost-effective, quality health care services for Coloradans. The Department has implemented a number of changes over the past year to meet its mission. The Department was reorganized to create efficiencies and better align functions. Under the new structure, all the policy and operational functions relating to Medicaid eligibility were combined under the Client and Community Relations Office, allowing a more unified focus on Medicaid eligibility and customer service. In addition, audit functions, information system changes and improvements were consolidated under the Administration and Operations Office. The Child Health Plan *Plus* (CHP+) and Long Term Care (LTC) Programs are managed within the Medical and CHP+ Program Administration Office.

The Department is committed to increasing and improving access to Medicaid and CHP+ through strategies that involve assessing existing processes and available data, implementing best practices, improving accountability, reducing barriers and collaborating with the Department's partners in the eligibility determination and enrollment activities. This Medicaid Eligibility Quality Improvement Plan (MEQIP) provides the framework to communicate the Department's vision, objectives and strategies, to collaborate with the Department's partners and to establish and provide a methodology to measure ongoing initiatives that improve access to Colorado's public health care insurance programs.

Administration

Colorado is a state-supervised, county-administered system for traditional social services, including programs such as public assistance, child welfare services, and the administration of medical assistance programs. The Colorado Department of Human Services has oversight of the county departments of human/social services (counties) for the traditional social services programs while the Department has oversight of the counties for the medical assistance programs. The local departments of social/human services in Colorado's 64 counties serve as the agents of the Department. Every county department of social/human services is structured in its own unique way based on available resources, size, and geography - no two counties organize their eligibility and enrollment activities in exactly the same way.

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

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

The Department retains ultimate accountability for all public health insurance programs that the Department administers, to ensure eligibility determinations and enrollments are accurate, timely, and conducted in accordance with federal and state laws and rules.

A key component in the Department's oversight of eligibility determination and enrollment is a comprehensive monitoring program. The Department's monitoring of public and private partners is fundamental to ensuring that public funds are spent effectively to accomplishing the Medicaid and CHP+ programs' purpose of providing health care for eligible uninsured children. Statutes specifically state that the Department must monitor the contractors that carry out administrative duties for CHP+ and supervise county departments of human/social services and MA sites for effective administration of medical assistance programs.

The Department has dedicated positions that specifically support and monitor the performance of the public and private entities engaged in eligibility and enrollment activities. These positions offer a single point of contact to communicate and coordinate policy changes, coordination of audit responses, and resolution of client issues. The positions are described as follows:

County Oversight Liaison

Senate Bill 06-219, created the County Oversight Liaison position. This position is responsible for communication with counties, reviewing county processes concerning all of the Department's programs including, but not limited to, Medicaid, CHP+, the Early Periodic Screening Diagnosis Treatment (EPSDT) program and Non-Emergent Medical Transportation (NEMT). This position also works with the counties to identify needed resources and information to support the counties' eligibility activities. In the last 24 months, the County Oversight Liaison has conducted site visits at 40 county departments of social/human services offices. Many county challenges have been identified through this process. The Department has established a CHP+/county workgroup that identified a need for increased policy training by the Department on CHP+ related policy issues and increase communication between ACS and the county departments of human/social services. In addition, this position co-chairs an advisory committee with the Colorado Social Services Director's Association (CSSDA) that was established in February 2006 to provide a high-level venue for improving communication between the Department and County Departments of Social/Human Services Directors. The committee is charged with discussing and providing input on issues and proposed actions that will have an impact on the Department's mission to improve access to cost-effective, quality health care services for Coloradans.

Medical Assistance Site Contract Manager

The MA Site Contract Manager has oversight of Denver Health and Hospitals and Peak Vista Community Health Center. This position manages the contracts with these MA sites ensuring compliance with Department policies and procedures. This position also determines the criteria for implementing new MA sites and is responsible for assuring complete compliance with relevant federal and state regulations and laws.

School-Based Medical Assistance Site Contract Manager

House Bill 06-1270 created the School-Based MA Site Contract Manager position to implement a demonstration project which allows qualified personnel to determine Medicaid and CHP+ eligibility for students enrolled in public schools. The demonstration project allows for no fewer than three school districts in both rural and urban areas to participate in the project. This position ensures proper monitoring, implementation, development and negotiation of contracts with the school MA Sites. This position works with an established advisory committee to promulgate rules and develop policy. The Department currently contracts with three (3) School MA Sites; Adams/Arapahoe 28J School District, Jefferson County School District R-1, and Pueblo School District 60.

Presumptive Eligibility Site Contract Manager

The Presumptive Eligibility (PE) Site Contract Manager is responsible for promulgating rules, approving/denying PE certification applications and re-certifications for existing PE sites every two years, providing technical and policy training, monitoring performance, ensuring compliance with federal and state regulations and laws, and identifying needs and solutions for PE Sites. This position works to expand the number of PE Sites statewide. The PE Site Contract Manager oversees the performance of approximately 100 PE Sites statewide.

Child Health Plan *Plus* Eligibility and Enrollment Contract Manager

The CHP+ Eligibility and Enrollment Contract Manager oversees the contract procurement, management, and annual renegotiation process. This includes modifications to deliverables and performance standards using historical data, new policies and new legislation. The Contract Manager also provides program and policy direction to Department staff and community partners. In addition, this position also evaluates national standards, national benchmarks, other states experiences, and current state activities in the area of the eligibility and enrollment for state programs, and uses judgment to determine which are appropriate for CHP+. On a monthly basis, contract performance standards are measured and evaluated with respect as to whether the objectives were met. Operational and quality issues are resolved through this position based on data reporting and feedback from the community partners.

Eligibility Section

The Department also staffs a Medicaid Eligibility Section of 14 full time equivalents (FTEs) that specialize in three main areas: project management, program management and quality improvement. The Project Management Unit (four FTEs) implements program policy and regulations into Colorado Benefits Management System (CBMS), creates and implements new operating training materials, manuals, and user processes.

The unit also updates procedures when CBMS changes are implemented. The Program Manager Unit (six FTEs) develops, maintains and administers rules and policies for the major medical eligibility programs. The Program Manager Unit also drafts and implements State Plan Amendments, creates and implements new policy training materials and manuals, and reviews applicant appeals. The Quality Improvement Unit (four FTEs) conducts monitoring and quality efforts over eligibility sites, creates and implements training materials and manuals, and offers technical policy assistance to counties and MA sites.

Audits Section

The Audit Section consolidates many of the auditing functions throughout the Department. There are eight dedicated staff in this Section. Primary functions include: coordination of all audits on the Department, subrecipient monitoring of the counties, the Payment Error Rate Measurement Program (PERM) and the Medicaid Eligibility Quality Control (MEQC) Unit. These functions are further discussed in the Quality Assurance Methods section of this document.

Authority

(See Appendix A for statutory authority and rule references).

Goals for Eligibility Business Model

The following represents the Department's goals and approach to establish guidelines for eligibility business processes.

- Applicants/Clients should receive notice of their eligibility and redetermination status in a timely and accurate manner according to federal guidelines.
- Applicants/Clients should receive their eligibility determination and redetermination in a timely and accurate manner according to federal guidelines.
- Applicants/Clients deserve predictability and consistency of results throughout Colorado.
- Coloradans should expect that the public health insurance programs administered by the Department are run efficiently and effectively.
- Case file documentation should meet minimum standards across the state and is adequate to support all eligibility determinations.
- Applicants/Clients deserve to be treated with dignity and respect.
- County and MA site staff should be adequately trained on the Colorado Benefits Management System (CBMS) and on eligibility policies and procedures.
- County and MA site staff should demonstrate adequate controls over case file documents and data entry.
- Outcomes should be measurable based on consistent and accurate statistics and information from available data sources.

Objectives

- The Department, in conjunction with the counties and MA sites, will form an MEQI Committee by October 2008.

- The MEQI Committee will provide a checklist and procedure to ensure that all required documentation is included in the case file by December 2008 and counties and MA sites will implement by January 2009.
- The MEQI Committee will provide a procedure for reviewing accuracy of data entry by December 2008 and counties and MA sites will implement by January 2009.
- The MEQI Committee will provide a procedure for reviewing the timely processing of applications by December 2008 and counties and MA sites will implement by January 2009.
- All county and MA site staff will receive ongoing training on CBMS and medical assistance program policies.
- The MEQI Committee will implement an MEQI web page that includes tools and resources needed by January 2009.
- Counties and MA sites will respond to inquiries from the Department with respect to MEQC, PERM, and audit findings within the timeframes requested by the Department.

Quality Assurance Methods

The Department is continually monitoring and assessing the performance of the county and MA sites through a number of different approaches. Monitoring is conducted through MEQC, PERM and site visits. The CHP+ program monitors quality through contractual agreement with the Eligibility and Enrollment Contractor. Contract performance for the other MA sites is monitored by the MA Site and School MA Site Contract Managers.

Medicaid Eligibility Quality Control

The MEQC Unit assesses eligibility determinations to assure accuracy and timeliness of the eligibility determination to avoid inappropriate payments and client determination delays. The following represents the results of an extensive study that examined the accuracy of eligibility determinations for Medicaid and CHP+. The study also examined timely processing of applications, timely and accurate noticing, and whether the medical spans were open for health care providers to bill. Tables 1 and 2 below illustrate the results from this study. In addition, the Department sent site-specific results to the county departments and MA sites who, based on the results of study, were required to submit a MEQC quality improvement plan.

Case Error Rate by Component Period of Review: March 2006 - February 2007 Active Study*		
Eligibility component (EC) Description	**Total Cases with EC in Error**	**Percentage of Errors (Error Rate)**
Whether the authorization of any application or re-determination as based on information entered into CBMS is correct to determine any CBMS caused errors.	5	0.83%
Whether the data was entered correctly based on verifications in the client file to determine individual case worker or applicant error.	123	20.53%
For active cases, whether the client's medical span was open for health care providers to bill for the correct period of time.	2	0.33%
Whether the application was timely processed after receipt of all necessary client information according to the timelines in federal or state law or regulations.	107	17.86%
Whether the system produced a timely and accurate notice regarding the sampled application or re-determination authorization.	15	2.50%

Table 1

*Active Study. The active study includes a random sample of 599 cases for individuals or families determined eligible for Medicaid or CHP+ during the audit period.

Case Error Rate by Component Period of Review: March 2006 - February 2007 Negative Study**		
Eligibility component (EC) Description	**Total Cases with EC in Error**	**Percentage of Errors (Error Rate)**
Whether the authorization of any application or re-determination as based on information entered into CBMS is correct to determine any CBMS caused errors.	1	0.43%
Whether the data was entered correctly based on verifications in the client file to determine individual case worker or applicant error.	22	9.40%
For active cases, whether the client's medical span was open for health care providers to bill for the correct period of time.	0	0.00%
Whether the application was timely processed after receipt of all necessary client information according to the timelines in federal or state law or regulations.	17	7.26%
Whether the system produced a timely and accurate notice regarding the sampled application or re-determination authorization.	37	15.81%

Table 2

**Negative Study. The negative study includes a random sample of 234 cases for individuals or families that are determined not to be eligible or terminated from Medicaid or CHP during the audit period. Cases with no action during the audit period were not be selected.

Payment Error Rate Measurement (PERM)

The PERM program is required by the Centers for Medicare and Medicaid Services (CMS) to comply with the Improper Payments Information Act of 2002. The purpose of

the program is to examine the accuracy of eligibility determinations and claims payment to ensure that the Department only pays for appropriate expenditures. The Department completed the eligibility portion of the reviews and will be identifying any corrective actions. The findings are used to correct procedures and errors that are made by the county or MA sites when determining eligibility.

Stratum	1	2	3
Summary of Active Medicaid Sample	**Applications**	**Redeterminations**	**All Other Cases**
Total cases reviewed	168	168	168
Number (percent) of correct cases	160 (95.2%)	160 (95.2%)	165 (98.2%)
Number (percent) of incorrect cases	0 (0.0%)	2 (1.2%)	1 (0.6%)
Number (percent) of undetermined cases	8 (4.8%)	6 (3.6%)	2 (1.2%)

Exhibit ES-1: Summary of Medicaid Active Case Sample Review Results. The cases in Stratum 3, All Other Cases, had the highest rate of accuracy.

Stratum	1	2	3
Summary of Active CHP+ Sample	**Applications**	**Redeterminations**	**All Other Cases**
Total cases reviewed	168	168	168
Number (percent) of correct cases	162 (96.4%)	164 (97.6%)	158 (94.0%)
Number (percent) of incorrect cases	4 (2.4%)	3 (1.8%)	3 (1.8%)
Number (percent) of undetermined cases	2 (1.2%)	1 (0.6%)	7 (4.2%)

Exhibit ES-2: Summary of CHP+ Active Case Sample Review Results. The cases in Stratum 2, Redeterminations, had the highest rate of accuracy.

County Single Audits

The Department is required to oversee and monitor subrecipients as defined in the U. S. Office of Management and Budget Circular A-133 Compliance Supplement. The counties are agents of the Department and administer the eligibility determinations. Most of the 64 counties meet the threshold of federal funding specified by the A-133 which requires they have a single audit of those programs annually to ensure they are in compliance with federal and state law, regulations, and policies. The Department tracks and reviews the single audits, conducts desk audits and on-site visits to the counties to review for allowability of reimbursed administrative expenses, issues management decision letters, performs follow-up to ensure that the county's corrective actions are completed, and recovers unallowable costs.

Audit Coordination

The Department is routinely audited by the Colorado Office of the State Auditor, the U.S. Office of the Inspector General, and CMS. These audits assist in ensuring Department compliance with federal and state laws and regulations. In addition, performance audits aid the Department in achieving higher efficiency and improved processes. Many of these external audits have identified opportunities for improvement in eligibility determinations. This includes, but is not limited to, timely processing, case file documentation, and data entry errors.

Medical Assistance Contractor Oversight

Contractors are held to specific performance measures based on application processing, including renewals, customer service, reporting and other areas. If the contractor does not meet the contractual performance measures, liquidated damages may be initiated, contracts may be terminated or other appropriate measures may be taken. The Department's contract managers monitor performance measures. Contract managers are responsible for auditing application files and monitoring customer service phone calls on a monthly basis. This process can identify the need for training in order to achieve accuracy. The files for the quality audit are pulled randomly and may be based on reports from CBMS, other MA sites, counties and other community partners that have identified issues.

In addition to monthly audits, the Department also requires reports based on the previous months data which includes, but is not limited to, application processing time, data entry quality, customer service data, enrollment fee posting and appeals.

System Reports

The Department regularly reviews and monitors eligibility site performance through established system generated reports. These reports are utilized to provide insight into applications that have exceeded the established processing timeframes. As a result of these reports, the Department works with county and MA sites to identify areas where additional training and support are needed. Additional reports are constantly being identified and developed to monitor different aspects of the program administration in the attempt to create more administrative efficiencies.

Complaints and Appeals

The Department researches and responds to complaints from applicants, clients, CMS, legislators, the Office of Civil Rights (OCR), advocates and others. Complaints and appeals are monitored and researched to identify opportunities for improvement and training. The Department plans to begin tracking and trending both complaints and appeals in correlation to the findings from MEQC, PERM, external audits and system generated reports.

In addition, the Eligibility and Enrollment vendor for CHP+ is responsible for coordinating all appeals and grievances according to 10 CCR 2505-3, Section 600 with the county or MA site that determined the initial eligibility.

Improvement

After reviewing the variety of assessment activities, the Department has identified areas to improve, as well as, the processes and tools the Department intends to use to meet the Quality Strategy's objectives. The MEQIP provides the Department with the framework to successfully implement and maintain a quality strategy for future improvement.

Targeted Improvements for Calendar Year 2009

In order to support the MEQIP, the Department has created a MEQI Committee to enable and allocate the necessary resources to ensure a successful and strong program that implements quality improvement initiatives, monitors performance and identifies goals

and objectives. The committee was formed in October 2008 and will assist the Department in analyzing the performance data, creating new performance measures and advising the Department on best practices, standards and performance initiatives.

The MEQI Committee will implement three priority improvement areas for the 2009 calendar year. These three areas have been identified as critical activities through a variety of the Department's assessment efforts. These priority improvement areas are:

Timely Processing of Applications

Applications that exceed the processing guidelines (as established in 42 CFR 435.911), create cyclical inefficiencies and inappropriate user 'workarounds' within the system. The untimely processing of applications results in delays in individual's access to medical assistance. County and MA sites are required to develop and implement a procedure for reviewing the processing of applications, implement corrective action plans for thresholds identified by the Department, and report this information quarterly to the Department.

Data Entry

Inaccurate data entry has been identified as the source for incorrect determinations of both eligible and ineligible individuals. Although not all data entry errors result in incorrect eligibility determinations, the integrity of the data is compromised. County and MA sites are required to develop and implement a procedure for reviewing the accuracy of data entry on a certain number of case files each month, implement corrective action plans for thresholds identified by the Department and report this information quarterly to the Department.

Case File Documentation

Case files must have sufficient documentation to support all eligibility determinations. The Department's review has shown this to be a concern in two areas: (1) The eligibility site's inability to produce the case for the Department and/or external auditors to review; and (2) documentation to support the eligibility determination is not obtained or maintained by the eligibility site. The Department must ensure that internal controls over case file documentation are strengthened; the MEQI Committee will develop a checklist and procedure to ensure that all case files meet all of the required elements. The MEQI Committee will also develop and implement an eligibility site internal process to review a certain number of case files each month, identify thresholds for which corrective action plans will be required for improvement and to report this information quarterly to the Department.

Attached to this MEQIP is a Tool Kit (see Appendix D) for county and MA sites to use. This Tool Kit outlines the Department's benchmarks, methodology and guidelines for achieving quality in the three areas identified for improvement of eligibility determinations.

Future Improvements

The improvement strategies listed below have been identified to be included in future quality improvement plans. The activities identified below will not be directly addressed

within calendar year 2009. The MEQI Committee will review the following improvements and will collaboratively prioritize performance goals and measures for 2010. It is important to create the basic infrastructure and goals, and to reasonably identify a manageable and progressive work plan.

Customer Service

Treating all applicants/clients with dignity and respect. The Department seeks to measure customer service through evaluating the county and MA sites':

1. system for phone and written correspondence
2. reporting on the numbers of complaints and appeals and their disposition
3. reporting on the staffing levels to adequately support the eligibility determination functions and maintain a high level of quality
4. procedures for urgent or expedited application requests
5. benchmarks
6. in-house customer service training

Monitoring

Assisting county and MA sites in self-monitoring and developing their individualized site plans. The Department seeks to measure monitoring efforts through evaluating the county and MA sites':

1. quality improvement plans
2. written policies and procedures related to the quality improvement plan
3. corrective action plans implemented as a result of the quality improvement plan
4. active participation and meaningful contribution in the MEQI Committee

Training

Developing a program by which eligibility site staff is adequately and consistently trained with the right information at the right time. The Department seeks to measure training efforts through evaluating the county and MA sites':

1. internal training programs
2. training in relation to quality improvement efforts
3. knowledge of the subject trained through testing and on the job performance

Reporting

Ensuring that reporting is accurate and used to improve and monitor performance. The Department seeks to measure the effectiveness of reporting through evaluating the county and MA sites':

1. reports submitted to the Department in coordination with improvement efforts
2. internal processes that incorporate the use of reports as a daily business process

Business Processes

Continually evaluating processes to identify efficiencies and best practices. The Department seeks to measure the county and MA sites' efforts in continuous quality improvement through:

1. reports submitted to the Department utilizing an approved template outlining their continuous quality improvement efforts

2. collaboration across county and MA sites to share lessons learned, best practices, and new found efficiencies

Designing an Eligibility Quality Improvement Plan

The Eligibility Quality Improvement Plan is designed to provide a formal ongoing process by which the counties and medical assistance sites utilize objective measures to monitor and evaluate the quality of administrative eligibility activities. The following represent some of the elements that should be considered as part of development of an Eligibility Quality Improvement Plan for 2009:

1. Establish a quality improvement plan that includes auditing, training and reporting plans to ensure that staffs are performing according to baseline measurements.
2. Implement a separate Quality Department or a few dedicated individuals who work closely with training staff, monitoring performance and reporting quality control findings.
3. Define realistic expectations based on current baseline measurements throughout all county and MA sites.
4. Develop and standardize protocols, tools and procedures to monitor and ensure accurate data entry, timely determinations, and sufficient case file documentation.
5. Conduct standardized case reviews.
6. Analyze monthly and quarterly review findings and execute appropriate process improvement measures.

Conclusion

This MEQIP is a tool for the Department to begin the implementation of quality improvement for the State's medical eligibility processing. With this tool, important benchmarks will be established for reliable measurement of current processes and procedures that are utilized throughout the county departments and MA sites. Currently, there are many processes in place to monitor and support county and MA sites in the medical eligibility determinations, however, the Department's focus needs to be redefined and promulgated to meet the needs of the county and MA sites and improve access to services for clients. This MEQIP will guide the Department in supplying the appropriate resources to trainings, tools and communication as demonstrated in the quarterly reports and information supplied by the county and MA sites.

As part of the implementation of the MEQIP, the Department has developed a detailed work plan (see Appendix C). This implementation plan includes the formation of the MEQIC, development and implementation of resources for counties and MA sites along with future reporting requirements and an ongoing structure for future improvements. This plan is pivotal in aligning the goals of the Department, the counties, and MA sites toward continuous quality improvement.

Appendix A

Statutory Requirements – Colorado Revised Statutes Cites

25.5-1-118. Duties of county departments

(1) The county departments or other state designated agencies, where applicable, shall serve as agents of the state department and shall be charged with the administration of medical assistance and related activities in the respective counties in accordance with the rules of the state department.

25.5-4-102. Legislative declaration

It is the purpose of the "Colorado Medical Assistance Act" to promote the public health and welfare of the people of Colorado by providing, in cooperation with the federal government, medical and remedial care and services for individuals and families whose income and resources are insufficient to meet the costs of such necessary services and to assist such individuals and families to attain or retain their capabilities for independence and self-care, as contemplated by the provisions of Title XIX of the social security act. The state of Colorado and its various departments, agencies, and political subdivisions are authorized to promote and achieve these ends by any appropriate lawful means, through cooperation with and the utilization of available resources of the federal government and private individuals and organizations.

25.5-4-205. Application - verification of eligibility - demonstration project - rules - repeal.

(1) (a) Determination of eligibility for medical benefits shall be made by the county department in which the applicant resides, except as otherwise specified in this section. Local social security offices also determine eligibility for Medicaid benefits at the same time they determine eligibility for supplemental security income. The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private service contractor that administers the children's basic health plan, Denver health and hospitals, a hospital that is designated as a regional pediatric trauma center, as defined in section 25-3.5-703 (4) (f), C.R.S., and other MA sites determined necessary by the state department to accept medical assistance applications, to determine medical assistance eligibility, and to determine PE. When the state department determines that it is necessary to designate an additional MA site, the state department shall notify the county in which the MA site is located that an additional MA site has been designated. Any person who is determined to be eligible pursuant to the requirements of this article and articles 5 and 6 of this title shall be eligible for benefits until such person is determined to be ineligible. Upon determination that any person is ineligible for medical benefits, the county department, the state department, or other entity designated by the state department shall notify the applicant in writing of its decision and the reason therefore. Separate determination of eligibility and formal application for benefits under this article and articles 5 and 6 of this title for persons eligible as provided

in sections 25.5-5-101 and 25.5-5-201 shall be made in accordance with the rules of the state department.

25.5-4-104. Program of medical assistance - single state agency

(1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

(2) The state department may review any decision of a county department and may consider any application upon which a decision has not been made by the county department within a reasonable time to determine the propriety of the action or failure to take timely action on an application for medical assistance. The state department shall make such additional investigation as it deems necessary and shall, after giving the county department an opportunity to rebut any findings or conclusions of the state department that the action or delay in taking action was a violation of or contrary to state department rules, make such decision as to the granting of medical benefits and the amount thereof as in its opinion is justifiable pursuant to the provisions of this article and articles 5 and 6 of this title and the rules of the state department. Applicants or recipients affected by such decisions of the state department, upon request, shall be given reasonable notice and opportunity for a fair hearing by the state department.

Regulations - Code of Federal Regulations Cites

Title 42 Sec. 435.911 Timely determination of eligibility.

(a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed—
(1) Ninety days for applicants who apply for Medicaid on the basis of disability; and
(2) Forty-five days for all other applicants.

(b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.

(c) The agency must determine eligibility within the standards except in unusual circumstances, for example—
(1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or
(2) When there is an administrative or other emergency beyond the agency's control.

(d) The agency must document the reasons for delay in the applicant's case record.

(e) The agency must not use the time standards—
(1) As a waiting period before determining eligibility; or
(2) As a reason for denying eligibility (because it has not determined eligibility within the time standards).

Appendix B

Definitions

Centers for Medicare and Medicaid Services (CMS): The Centers for Medicare and Medicaid Services (CMS) is the federal oversight agency for Medicaid and CHP+.

Child Health Plan *Plus* (CHP+**):** The Children's Basic Health Plan or State Child Health Insurance Program provides basic health insurance coverage for uninsured children and pregnant women of low-income families. The Children's Basic Health Plan is a non-entitlement, non-Medicaid program that delivers coverage in accordance with the principles of private insurance. The Children's Basic Health Plan benefit package is substantially equivalent to the level of coverage mandated by the State for small, privately insured groups. The Children's Basic Health Plan offers a wide variety of services to children including check-ups, immunizations, doctor visits, hospital services, prescribed medications, mental health services, dental services, hearing aids, and glasses.

Colorado Benefits Management System (CBMS): The Colorado Benefits Management System is the State's integrated eligibility determination system that processes eligibility for 36 medical and financial assistance programs administered by the Department or the Department of Human Services.

Colorado Department of Health Care Policy and Financing (the Department): The Department is the single state agency responsible for administering the Medicaid program (Title XIX) and the State Child Health Insurance Program (Title XXI), known as the Children's Basic Health Plan. In addition to these programs, the Department administers the Colorado Indigent Care Program, the Old Age Pension State Medical Program, the Comprehensive Primary and Preventive Care Grant Program, the Primary Care Fund as well as the Home and Community Based Services Medicaid Waivers.

Colorado County Departments of Human/Social Services (counties): The county departments shall serve as agents of the state department and shall be charged with the administration of medical assistance and related activities in the respective counties in accordance with the rules of the state department.

Medicaid: Colorado Medicaid is public health insurance for families, children, pregnant women, persons who are blind or persons with disabilities and the elderly for Colorado residents.

Medical Assistance (MA) sites: An MA site is a site certified by the Department to accept the Colorado Public Health Insurance for Families application and determine eligibility by using the Colorado Benefits Management System (CBMS).

Presumptive Eligibility (PE): Presumptive Eligibility is the process of presuming eligibility for Medicaid or CHP+ based on self-declared income and family size. Clients are considered enrolled in one of the programs immediately; for up to 60 days. A completed Colorado Public Health Insurance for Families application must be submitted before the end of the 60 days and final eligibility determined for continued enrollment.

Appendix C

Medical Quality Improvement Implementation Plan
October 2008- June 2010

Task	Due Date	Person(s) Responsible
Formation of MEQIC	October 2008	Department Staff
Establish logistic, meetings and administration of MEQIC	October 2008	MEQIC
Review and finalize MEQIP by MEQIC	December 2008	MEQIC
Review and finalize MEQIP by the Department	January 2009	Department Staff
Develop case file documentation check list	February 2009	Department Staff
Approval of case file documentation check list	February 2009	MEQIC
Develop a Medical Eligibility Review Procedure and Guidelines for reviewing data entry, timely processing and case file documentation	February 2009	MEQIC
Approval of Medical Eligibility Review Procedure and Guidelines for reviewing data entry, timely processing and case file documentation	February 2009	Department Staff
Develop EQI web page that includes tools and resources needed by the Department, counties and MA sites	February 2009	Department Staff
Approve and implement the EQI web page	February 2009	Department staff
Counties and MA sites submit individual quality improvement plans	May 1, 2009	Counties and MA sites
Department provides feedback on site specific quality improvement plans	May 29, 2009	Department staff
Develop priorities quality improvement measures for next calendar year	October 2009	MEQIC
Counties and MA sites submit July – September findings electronically	November 1, 2009	Counties and MA sites
Update and revise MEQIP	December 2009	MEQIC
Approval of MEQIP	January 2010	Department Staff
Department provides feedback on site specific July – September results	January 2010	Department Staff

Task	Due Date	Person(s) Responsible
Counties and MA sites submit October – December findings electronically	February 1, 2010	Counties and MA sites
Department provides feedback on site specific quarterly results	April 2010	Department staff
Counties and MA sites submit January – March findings electronically	May 1, 2010	Counties and MA sites
Department provides feedback on site specific quarterly results	June 2010	Department staff

Appendix D

Colorado Department Health Care Policy and Financing

Medical Eligibility Quality Improvement Plan Tool Kit December 2008

Summary

This Tool Kit contains guidance for reporting the minimum requirements to the Department to monitor the quality measures defined in the MEQIP. All county and MA sites are responsible for submitting a Medical Eligibility Site Quality Improvement Plan (Annual Plan) by March 6, 2009. Ongoing reports will be submitted to the Department to monitor quality improvement measures. The forms provided in this tool kit must be utilized to complete the Annual Plan and quarterly reports.

Minimum Requirements

The following measures are to be a part of the minimum requirements submitted to the Department as a component of the Annual Plan.

Performance Improvement Measure 1: Timely Processing

Goal

Ensure that applications are processed within timeframes established by federal regulation. (42 C.F.R Sec. 435.911 as stated in Appendix A)

Improvement Strategy

- Develop/maintain a business process that meets or exceeds federal guidelines for processing applications timely.
- Develop an internal review process which includes:
    - Review of a minimum of four random initial applications per eligibility technician per month.
        - These applications should be processed through eligibility determination and authorization.
        - Reviewer will be responsible for pulling a random sample and documenting the methodology for randomization.
    - Submit monthly review findings electronically quarterly to the Department.
        - Reviews can be done at the county department or MA site's discretion of when to review, as long as the basic guidelines are followed. The basic guidelines will be provided as a part of the Medical Eligibility Review Procedure and Guidelines (Procedure).
        - May 1st (for review period January –March)
        - August 1st (for review period April- June)
        - November 1st (for review period July- September)
        - February 1st (for review period October –December)
- Train eligibility site staff on the new tools and procedures.
- Monitor the monthly error rates and establish processes to improve eligibility determinations. Error rates should be determined utilizing the calculation provided in the Procedure.

- Utilize results to develop future quality improvement efforts and goals.

Measurement
This will be provided in the Procedure.

Performance Improvement Measure 2: Data Entry

Goal
Ensure that accurate data is entered into the eligibility system by comparing data entered against the application and case file.

Improvement Strategy
- Develop a procedure to quality check data entry of medical eligibility cases
- Develop an internal review process which includes:
    - Review of a minimum of four random initial applications per eligibility technician per month.
        - These applications should be processed through eligibility determination.
        - Reviewer will be responsible for pulling a random sample and documenting the methodology for randomization.
    - Submit monthly review findings electronically quarterly to the Department.
        - Reviews can be done at the county department or MA site's discretion of when to review, as long as the basic guidelines are followed. The basic guidelines will be provided as a part of the Procedure .
        - May 1st (for review period January –March)
        - August 1st (for review period April- June)
        - November 1st (for review period July- September)
        - February 1st (for review period October –December)
- Monitor the monthly error rates establish processes to improve eligibility determinations. Error rates should be determined utilizing the calculation provided in the Procedure.
- Utilize results to develop future quality improvement efforts and goals.

Measurement
This will be provided in the Procedure.

Performance Improvement Measure 3: Case File Documentation

Goal
Ensure case files contain the information necessary to support the eligibility determination.

Improvement Strategy
- Develop a procedure to maintain appropriate case file documentation.
- Develop an internal review process which includes:
    - Review of a minimum of four random initial applications per eligibility technician per month.
        - These applications should be processed through eligibility determination.
        - Reviewer will be responsible for pulling a random sample and documenting the methodology for randomization.
    - Submit monthly review findings electronically quarterly to the Department.
        - Reviews can be done at the county department or MA site's discretion of when to review, as long as the basic guidelines are followed. The basic guidelines will be provided as a part of the Procedure .
        - May 1st (for review period January –March)
        - August 1st (for review period April- June)
        - November 1st (for review period July- September)
        - February 1st (for review period October –December)
- Monitor the monthly error rates and establish processes to improve eligibility determinations. Error rates should be determined utilizing the calculation provided in the Procedure.
- Utilize results to develop future quality improvement efforts and goals.

Measurement
This will be provided in the Procedure.

2009 Medical Eligibility Site Annual Quality Improvement Plan

Eligibility Site: _____

Date Submitted to the Department: _____

Eligibility Site Contact Name: _____

Eligibility Site Contact Phone Number: _____

Eligibility Site Contact Email: _____

Section 1: *County Department or Medical Assistance (MA) Site Mission and/or Vision* *(Describe briefly the mission and/or vision of the section or agency responsible for medical eligibility determinations)*

_____

_____

_____

_____

_____

County Department or MA Site Background Information

Number of technicians that process Medical Program application:

- Family Medicaid (FM) and Child Health Plan *Plus* (CHP+): _____
- Long-Term Care (LTC) and Adult Medicaid (AM): _____
- Combination Cases (example FM and Food Assistance): _____

Number of support staff that assist in medical determinations: _____

Average Caseload per technician:

- Family Medicaid (FM) and Child Health Plan *Plus* (CHP+): _____
- Long-Term Care (LTC) and Adult Medicaid (AM): _____
- Combination Cases (example FM and Food Assistance): _____

Section 2: *Sampling Methodology*

Identify the sampling methodology to be used for identifying applications to review (Please explain the number of quality reviews that will be performed, who will be pulling the sample, how the sample will be pulled, when reviews will be performed and any other pertinent information.):

_____

_____

_____

_____

Section 3: *Review of Performance Improvement Measures*

Internal review process for the three key performance measures: timely processing, case file documentation and data entry. (Please explain your review process, who will be conducting the reviews, how you will maintain your review materials, and include a copy of your review guide.):

_____

_____

_____

_____

Section 4: *Monitoring and Training*

Explain your process for utilizing the review results, including but not limited to progressive feedback, training protocols, measuring performance, identifying areas for improvement and efficiencies:

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Section 5: *Additional Comments*

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