Office of the State Auditor

Dianne E. Ray, CPA
State Auditor

MEMORANDUM

Date: August 8, 2011

To: Members of the Legislative Audit Committee

From: Dianne E. Ray, CPA, State Auditor

Re: Federal Colorado Eligibility and Enrollment Review

The Centers for Medicare & Medicaid Services (CMS) Denver Regional Office performed a review of proposed remediation efforts implemented by the State of Colorado in response to issues identified with Medicaid eligibility determinations and redeterminations. The review was conducted from July 1, 2010, through December 7, 2010. CMS' review was performed to determine the State's compliance with applicable Federal law and regulations as related to Medicaid eligibility determination and redetermination. The Colorado Benefits Management System (CBMS) functionality and the State's administration of the Medicaid program were also the focus of the review.

CMS identified several substantial findings as a result of the review and has threatened Federal Financial Participation sanctions against the State, including disallowing Federal Funds for CBMS, unless immediate corrective actions are taken by the Colorado Department of Health Care Policy and Financing (Department) and the Governor's Office of Information Technology (OIT). CMS findings include:

- The State is out of compliance with the federal rules for timeliness of Medicaid eligibility determinations and redeterminations.
- The State is out of compliance with federal rules requiring that the Single State Agency maintain control over the operations of the Medicaid program.
- The State is out of compliance with federal rules requiring a reasonable period of time be allowed for applicants to present satisfactory documentary evidence of citizenship.
- The State is out of compliance with the federal rules for citizenship and alienage.
- The State is out of compliance with the federal rules regarding the termination of eligibility.

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- The State is out of compliance with federal rules regarding periodic redeterminations of Medicaid eligibility.

- The State is out of compliance with the federal rules for client notices.

- The State is out of compliance with the federal rules for documentation and maintenance of an adequate and complete eligibility history of Medicaid individuals.

Due to the serious nature of the findings contained in the review and the threat of federal sanctions against the State, we have asked representatives from the Department and OIT to be present at the August 23, 2011, hearing to further discuss the findings and their corrective action plans.

Attached to this memo is a copy of the federal Colorado Eligibility and Enrollment Review, Final Report, dated July 1, 2011, and a matrix prepared by the Office of the State Auditor containing our recommendations related to problems with the Department's Medicaid eligibility determinations and redeterminations.

State of Colorado
Department of Health Care Policy & Financing
Comparison of Findings Identified in the June 2011 Centers for Medicare & Medicaid Services (CMS) Report and Office of the State Auditor Statewide Single Audit Reports
Fiscal Years 2007 through 2010

Findings Identified in the June 2011 CMS Report	Year of Related Statewide Recommendation and Number	Department Response	Department of Health Care Policy & Financing's Provided Implementation Dates to OSA Recommendations[1]
1. The State is out of compliance with the federal rules for timeliness of Medicaid eligibility determinations and redeterminations.	2010-64	Agree	Ongoing through Spring 2011
	2009-64	Agree	Calendar Years 2010 through 2013
	2009-82	Agree	October 2009 through October 2010
	2008-54	a. Partially agree b. and c. Agree	June 2009 and ongoing
	2008-69	Agree	December 2008 through July 2009
	2007-50	Agree	April 1, 2008 and ongoing
2. The State is out of compliance with federal rules requiring that the Single State Agency maintain control over the operations of the Medicaid program.	2010-24	Agree	April 2012
	2008-91	Agree	June through December 2009
	2007-91	Agree	Ongoing
	2007-92	Agree	December 2008
3. The State is out of compliance with federal rules requiring a reasonable period of time be allowed for applicants to present satisfactory documentary evidence of citizenship.	2010-63, part a	Agree	Ongoing through 2013
	2010-67	Agree	January 2010 through 2013
	2009-53, parts a and b	a. and b. Agree	February 2010 through 2013
	2009-63	Agree	January 2010 through 2013
	2008-56	Agree	Ongoing.
	2008-72	Agree	Ongoing.
	2007-52	Agree	January 1, 2009

Findings Identified in the June 2011 CMS Report	Year of Related Statewide Recommendation and Number	Department Response	Department of Health Care Policy & Financing's Provided Implementation Dates to OSA Recommendations[1]
4. The State is out of compliance with the federal rules for citizenship and alienage.	2010-63	Agree	Ongoing through 2013
	2010-67	Agree	January 2010 through 2013
	2009-53, parts a and b	a. and b. Agree	February 2010 through 2013
	2009-63	Agree	January 2010 through 2013
	2008-56	Agree	Ongoing.
	2008-72	Agree	Ongoing.
	2007-52	Agree	January 1, 2009
5. The State is out of compliance with the federal rules regarding the termination of eligibility.	2009-64	Agree	Calendar Years 2010 through 2013
	2008-54, part c	Agree	June 2009
	2007-50	Agree	April 1, 2008 and ongoing
6. The State is out of compliance with federal rules regarding periodic redeterminations of Medicaid eligibility.	2010-60	Agree	Ongoing through June 2011
	2010-63	Agree	Ongoing through 2013
	2009-53	a. and b. Agree c. Partially agree	April 2010 through 2013
	2009-54	Agree	February 2010 through December 2010
	2009-64, part b	Agree	February 2010 through 2013
	2009-68, part a	Agree	November and December 2009
	2009-81	Agree	October 2009
	2008-56	Agree	Ongoing.
	2008-57	Agree	Ongoing.
	2008-58, part a	Agree	Implemented and ongoing.
	2008-68	Agree	November 2008 through January 2009 and ongoing
	2008-70, part b	Agree	May 2009
	2007-49	Agree	July 1, 2008
	2007-51, parts b and c	Agree	September 30, 2008 and ongoing.
	2007-52	Agree	January 1, 2009
	2007-53	Agree	January 1, 2009

Findings Identified in the June 2011 CMS Report	Year of Related Statewide Recommendation and Number	Department Response	Department of Health Care Policy & Financing's Provided Implementation Dates to OSA Recommendations[1]
7. The State is out of compliance with the federal rules for client notices.	2008-70, part c	Agree	May 2009
8. The State is out of compliance with the federal rules for documentation and maintenance of an adequate and complete eligibility history of Medicaid individuals.	2010-56, part d	Agree	July 2010 and ongoing
	2009-59, part c	Agree	February 2010 through 2013
	2008-71, part c	Agree	May 2008

Source: Analysis performed by the Office of the State Auditor matching the federal findings reported in the Centers for Medicare & Medicaid Services' June 2011 Colorado Eligibility and Enrollment Review to the audit recommendations reported in the Fiscal Years' 2007 through 2010 Statewide Single Audit Reports.

[1]Department of Health Care Policy & Financing implementation dates included in table represent range of all dates provided.

Colorado Eligibility and Enrollment Review

REVIEW AT
COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FINAL REPORT

July 1, 2011

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

COLORADO ELIGIBILITY AND ENROLLMENT REVIEW

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REVIEW AT COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DRAFT REPORT

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) Denver Regional Office (RO) performed a review of proposed remediation efforts implemented by the State of Colorado in response to issues identified with Medicaid eligibility determinations and redeterminations. The review was conducted beginning July 1, 2010 through December 7, 2010.

CMS examined State policies, procedures and actions taken to improve Medicaid eligibility and enrollment processes from 2007 to the current day. CMS' review was conducted in accordance with Federal regulations at 42 CFR 430.32 and 45 CFR Parts 92 and 95 and performed to determine the State's compliance with applicable Federal law and regulations as related to the Medicaid eligibility determination and redetermination. The Colorado Benefits Management System functionality and the State's administration of the Medicaid program were also a focus of the review. CMS identified several substantial findings as a result of the review, and is requiring that the State Medicaid Agency take corrective actions. The CMS findings include:

- The State is out of compliance with the federal rules for timeliness of Medicaid eligibility determinations and re-determinations;
- The State is out of compliance with federal rules requiring that the Single State Agency maintain control over the operations of the Medicaid program;
- The State is out of compliance with federal rules requiring a reasonable period of time be allowed for applicants to present satisfactory documentary evidence of citizenship;
- The State is out of compliance with the federal rules for citizenship and alienage;
- The State is out of compliance with the federal rules regarding the termination of eligibility;
- The State is out of compliance for federal rules regarding periodic redeterminations of Medicaid eligibility;
- The State is out of compliance with the federal rules for client notices; and
- The State is out of compliance with the federal rules for documentation and maintenance of an adequate and complete eligibility history of the Medicaid individuals.

The State concurred with the CMS findings, and agreed to implement corrective actions by date certain. The State concurrence with corrective actions was contingent on available funding. However, the State must comply with the federal rules without exception or condition related to funding.

If the State is not successful in completing corrective actions within the required time frames, the CMS may consider disallowing federal financial participation for the ongoing operation of the Colorado Benefits Management System.

BACKGROUND

The review was conducted beginning July 1, 2010 through December 7, 2010. These proposed remediation efforts followed a CMS post-implementation (P-I) review of the Colorado Benefits Management System (CBMS) previously conducted during June through August 2006 at the Department of Health Care Policy and Financing (HCPF) offices, local County Department of Human Services offices, the Office of CBMS, the ACS State Healthcare Services office and the Denver Health Medical Assistance (MA) site.

The CMS conducted its review of CBMS remediation efforts in accordance with 42 CFR 430.32 and 45 CFR Parts 92 and 95 relative to the State's use of the system in the delivery of the Colorado Medicaid program. Colorado Medicaid consists of 6 high-level program groups (HLPGs): Family Medical, Adult Medical, Long-Term Care, Medical Savings Plan, Presumptive Eligibility and the Children's Health Plan Plus (CHP+). HCPF is the Federally designated Single State Agency responsible to the Federal government for administration of the State Medicaid programs and the Federal dollars expended on the program. HCPF is responsible to the Federal government for supervising the administration of the Medicaid program by Colorado's 64 counties and MA sites. The counties utilize CBMS in the administration of the benefit application process, to enter the client data necessary for the determination of eligibility and calculation of benefits where applicable and for client notification of the outcome of the application process. Based on the most recent Federal Fiscal Year (FFY) information available, Colorado's Medicaid program currently covers approximately 440,000 Medicaid eligible beneficiaries at an average annual cost to the State and Federal governments of $4 billion dollars.

The Colorado Department of Health Care Policy and Financing (HCPF), in conjunction with the Colorado Department of Human Services (DHS), implemented CBMS on September 1, 2004. Users include county, state, and MA site personnel. While the counties administer Colorado Medicaid at the local level for the State's beneficiaries, it is HCPF's responsibility to administer the program in compliance with Federal regulations and in partnership with CMS.

CBMS is an automated data processing system designed, developed and implemented by HCPF and DHS and other Federal funding partners, to provide a single integrated system. The CBMS system is designed to determine an applicant's eligibility for public assistance and calculates benefits in 12 HLPGs, including Medicaid, Special Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). In addition CBMS is utilized for client notification and administrative reporting and support in Colorado's State-supervised County-administered system.

Since CBMS' implementation, HCPF, DHS and the majority of CBMS users have continued to experience numerous and very serious difficulties with the system which have resulted in the erroneous termination or reduction in benefits for a significant number of Colorado beneficiaries. Other notable problems occurring over this period have included a backlog of client cases waiting processing at many county offices. This results in clients not receiving services.

CMS conducted its 2006 P-I review subsequent to numerous mitigation and system remediation activities performed within CBMS and its management by the State. In response to an injunction granted by Denver District Court against HCPF and DHS, the Departments were required to perform a series of improvements to CBMS and provide reports to the Court that, among other requirements, indicated a 40 percent improvement in application processing in 2-month intervals until compliance with Federal processing timeframes was achieved.

In the ensuing period, the Colorado Governor's Office of Information Technology (OIT) was established. OIT has been given responsibility for the information technology (IT) areas within CBMS and, with HCPF and DHS, shares equally in the administration of the system.

CMS' current review examined planned system upgrades and mitigation strategies employed by the State within CBMS and the county/Medical Application enrollment sites, and how those efforts translate to the effective and accurate delivery of the Medicaid program in Colorado.

SUMMARY OF FINDINGS

CMS noted several identifiable weaknesses in the State's remediation efforts with CBMS and related processes during its review which have been consolidated into 8 findings. These findings and their associated review areas are presented in a separate section of this report, and are followed by recommendations for corrective action or remediation to correct weaknesses that compromise the effective and accurate delivery of the Medicaid program to Colorado's beneficiary population.

CMS acknowledges Colorado State Government at all levels has produced several comprehensive reports regarding the problems with the Medicaid eligibility and enrollment process. The State has implemented several system and process remediations and plans to undertake additional mitigation efforts. We commend the State for these remediation efforts and want to especially recognize the innovations and extraordinary undertakings performed by the State especially the State Medicaid Agency. Many of these innovations are funded by a 42 million dollar grant issued by Health Resources Service Administration (HRSA). These are further described at the end of this report.

Some of the State remediation efforts noted by CMS are:

- Colorado Comprehensive Health Access Modernization Program;
- Maximizing Outreach and Retention and Enrollment Project;
- Eligibility Modernization: Streamlining the Application process (includes redesign of the CBMS system interfaces with Income Eligibility and Verification, System Social Security Administration for Citizenship Verification, Department of Motor Vehicle for Identification verification, Department of Health and Vital Statistics.);
- Business redesign effort with the county departments of human services;
- Overflow contracts with selected private contractors;
- Colorado Program Eligibility and Application Kit (PEAK) Web Application; and
- Securing a CMS Performance Bonus payment grant for removing barriers to eligibility and enrollment.

Unfortunately, and despite these efforts, the problems with timeliness of enrollment and eligibility determination persist at nearly the same level as found by CMS in our 2006 report. In addition to the timeliness and noticing issues two new very serious issues have been uncovered in this review. The termination of eligibility due to delays in eligibility redeterminations by the state or its agents violates Federal regulation. Denying or delaying eligibility while clients gather necessary citizenship and identity documents also violates Federal regulation. CMS recognizes the increased Medicaid caseload. however these two issues require the state's immediate attention and remediation.

OBJECTIVE, SCOPE and METHODOLOGY

OBJECTIVE

CMS' review objective was to determine if HCPF adequately and effectively implemented corrective actions that were identified through various reports and audits conducted on the CBMS system since its inception in 2004. CMS also reviewed the State's completed and proposed remediation efforts, and examined policies, procedures and corrective actions implemented by the State with regard to its ability to determine and re-determine Medicaid eligibility.

SCOPE

As part of its review objectives, CMS examined the following areas with regard to CBMS remediation and Medicaid program delivery:

- Timely Determination of Eligibility;
- CBMS Re-determinations of Medicaid eligibility;
- Client Notifications;
- Citizenship and Identity Documentation Requirement;
- Vanishing Medicaid Eligibility Spans.

Timely Determination of Eligibility

CMS identified two focus areas with the eligibility determination process per the Federal regulations below:

1. Timely determinations of Medicaid eligibility (42 CFR 435.911)

2. Appropriate effective date of Medicaid eligibility (42 CFR 435.914)

    - Retroactive eligibility
    - Full month eligibility

CBMS Re-determinations of Medicaid Eligibility

CMS identified two focus areas with the eligibility re-determination process per the Federal regulations below:

1. Periodic re-determinations of Medicaid eligibility (42 CFR 435.916)
2. Furnishing Medicaid (42 CFR 435.930)

Client Notifications

CMS identified one focus area with sub-areas regarding the client notification process per the Federal authorities below:

1. Notices (Section 1902(a)(3)of the Act and 42 CFR 431 Subpart E, 42 CFR 435.912, 42 and CFR 435.919)

    - Content: description of action, reason for action, effective date
    - Timeliness
    - Information on fair hearings
    - Continuation and reinstatement of services

Citizenship and Identity Documentation Requirement

CMS identified one focus area with the citizenship and identity documentation process per the Federal authorities below:

1. Satisfactory documentary evidence of citizenship and identity prior to enrollment in Medicaid (Section 1903(x) of the Act, 42 CFR 435.406 and 435.407)

Vanishing Medicaid Eligibility Spans

CMS identified one focus area with three sub-areas regarding the issue of vanishing med-spans per the Federal regulations below:

1. Case documentation and maintenance of records (42 CFR 435.913 and 42 CFR 431.17)

    - Date of applications
    - Date and basis for disposition
    - Basis for discontinuation

METHODOLOGY

In addition to conducting an entrance conference with HCPF and OIT staff on July 1, 2010, the CMS review team performed an extensive desk review of documentation. The review team also conducted interviews with CBMS users, client advocacy groups, OIT representatives responsible for CBMS operations and Maximus, the contractor responsible for CHP+ and Family Medical applications.

A list of documentation reviewed included:

- Federal Statistical Report of Applications;
- State's 2007 corrective action plans provided to CMS in response to the required mitigation of CBMS;
- Medicaid Eligibility Quality Control (MEQC) report findings;
- Colorado State Auditor Report 2007-2008;
- Public Knowledge Report to the State 2008;
- Denver District Court Plaintiffs' Motion June 2010;
- Linford and Co. LLP, CBMS Findings and Recommendations Document, April 2010; and
- OIT/CBMS Organizational Flow Documents, 18-Month Plan November 2010.

A list of interviews conducted included:

- Colorado Department of Health Care Policy and Financing;
- Colorado Legal Services;
- Colorado Center on Law and Policy;
- Jefferson County and Arapahoe County Department of Human Services staff;
- OIT/CBMS staff;
- Rebound Solutions; and
- Maximus.

Additional follow-up with HCPF and OIT staff, client advocates and other interviewees occurred throughout the review period via telephone and e-mail communications.

FINDINGS/RECOMMENDATIONS/OBSERVATIONS

CMS identified eight findings during the review. These findings in the following areas are presented with associated recommendations for corrective action or remediation to correct weaknesses that compromise the effective and accurate delivery of the Medicaid program to Colorado's beneficiary population. Recommendations, requirements and any observations for all review areas are presented in this section.

Timely Determination of Eligibility

Finding #1: HCPF is not in compliance with the Federal regulations at 42 CFR 435.911, Timely Determination of Eligibility. The regulation requires eligibility to be determined within 90 days for applicants who apply on the basis of disability and forty five days for all other applicants.

Federal regulations at 42 CFR 435.911 require that the State agency must determine eligibility for Medicaid within ninety days for applicants who apply for Medicaid on the basis of disability and forty-five days for all other applicants. Since the CBMS inception on September 1, 2004 there have been backlogs and delays in processing of Medicaid applications. In addition to receiving and responding to numerous complaints from clients and advocacy groups, the Denver Regional CMS Office has continually monitored the Departments' CBMS Federal Statistical Reports, application processing timeframe status, on a regular basis.

The chart below illustrates that a significant percentage of cases exceed Federal application processing timeframes indicating that HCPF is still not complying with timely processing guidelines. As shown on the latest Federal Statistical Report available at the time of the review (Monthly Period Ending August 2010), the numbers of pending cases exceeding Federal timeframes as a percentage of reported pending cases for the Adult Medical Assistance, CHP+, Family Medical Assistance, Long Term Care, Medicare Savings Program, and Presumptive Eligibility HLPGs are as follows:

Adult Medical	CHP+	Family Medical	Long term care	Medicare savings program	Presumptive Eligibility
26%	61%	50%	42%	40%	94%

These percentages are of concern to CMS because a significant proportion, approximately half, of all applications are not processed within the Federal requirements. Of particular concern, is the percent of applications exceeding regulatory timeframes for Long Term Care, the Medicare Savings Program and Presumptive Eligibility applications.

Since 2006, State staff indicated that the report is not accurate, yet attempts to correct it have been stymied by budget issues. CMS will still review these reports against the regulatory timeframes.

This concern was previously cited by CMS in the 2007 CBMS Post-Implementation report from 2004. This report demonstrates that these delays have been persistent for the past several years.

Based on a 2009 HCPF report, approval of Family Medicaid Assistance is over 13% untimely, for CHP+ is 19.91% untimely, and for Adult Medical Assistance is over 41% untimely. The table below shows untimely processing for the three programs since January 2009.

Month	Family Medical	CHP+	Adult Medical
January 2009	14.95%	29.58%	47.70%
February 2009	16.06%	21.37%	44.70%
March 2009	18.02%	22.84%	40.15%
April 2009	15.67%	21.29%	38.81%
May 2009	16.33%	21.84%	43.12%
June 2009	14.24%	21.13%	40.03%
July 2009	14.14%	21.53%	41.65%
August 2009	12.15%	16.86%	41.40%
September 2009	12.54%	15.81%	41.21%
October 2009	13.35%	19.91%	41.31%

The length of the delays in determining eligibility is also very long. Approximately 24 percent of late applications are still not processed 60 days after the 45th day when the applications should have been processed. These long delays means many Medicaid/CHP+ clients and Medicaid/CHP+ providers are subject to significantly late payments for medical services.

Based on documents secured during the course of our review, the delays in timeliness are caused by certain deficiencies in the CBMS system, the lack of technological improvements that could reduce the workload of county and contractor eligibility staff and county eligibility offices having inadequate resources to process Medicaid and CHP+ applications.

The CBMS system has long been characterized as difficult for users to navigate with very slow processing time, as referenced in the State Auditors report on the system in 2007-2008. The Public Knowledge Report issued in 2008 which reviewed the eligibility and enrollment system as used by the largest counties in the State also cited the slow processing speeds and cumbersome CBMS navigation system. The Public Knowledge report found lack of timeliness as a problem shared by all the counties covered in the report. As recently as July 2010, in a letter addressed to Governor Ritter from the County Human Services Directors Association, the slow processing of applications within the CBMS system is viewed as a significant barrier to efficient Medicaid program delivery. The slow processing times reached a critical stage in the summer of 2010 as CBMS was operating beyond capacity. In interviews with members of OIT, they indicated the critical nature of the delays in processing times of the CBMS was being addressed through a long

overdue system refresh effort where servers and other hardware/software applications were upgraded. As a result of the refresh efforts, the number of 'problem tickets' were drastically reduced between June 2010 and November 2010. The delay in the refresh efforts was due to the transition from Electronic Data Systems (EDS), the original designer of the CBMS, with the replacement contractor Deloitte, the firm that now operates the CBMS system. CMS interviews conducted in late calendar year 2010 with several users of the CBMS system cited the CBMS system as routinely slow and difficult to navigate, even after the refresh initiative was implemented.

CMS has reviewed the OIT contract with Deloitte and finds it includes stringent conditions regarding the processing speed of the CBMS system with strong provisions for remedies regarding such processing speeds. CMS believes no remedies have been cited under the new contract due to the need to implement the new refresh effort. CMS requests that HCPF and OIT closely monitor the processing times of the CBMS system and utilize the remedy provisions in the contract as necessary.

The Medicaid and CHP+ programs are the largest user of the CBMS system. Based on OIT statistics the Medicaid/CHP+ caseload was 566,429 cases per month with a fiscal outlay of $322,225,876 per month. The food stamp and cash assistance programs had 153,800 cases per month and $11,497,801 in payments per month. Clearly the Medicaid/CHP+ program and clients face the greatest exposure to the inadequacies of the CBMS system.

CMS notes that HCPF, as the Single State Agency does not have a direct contract with OIT regarding scope of work, performance standards or conditions governing payments. There is a three-way agreement that involves DHS, OIT and HCPF. This three-way agreement does not include a sufficient scope of work statement or performance standards. These provisions do not provide oversight authority to the Single State Medicaid Agency over CBMS operations. As such, CMS does not believe HCPF, as the Single State Agency has adequate oversight authority as required in Section 1902(a)(5) of the Act and 42 CFR 431.10 of the Federal regulations that the Single State Agency maintain control over the program.

OIT has an annual pool of 19,000 hours for system changes during the course of a year. These system change hours are for all the programs served by CBMS. Generally the use of the hours is split evenly between the Medicaid/CHP+ program and cash assistance and food benefit program. OIT leadership recognizes these 19,000 hours are not adequate to address the incredible design change needs of the CBMS system.

OIT recognizes the need for the current CBMS system capacity to be increased to accommodate the expected additional users on the system. This need will become increasingly critical as HCPF has identified the use of additional Medical Application sites, the PEAK online application and overflow contractors as one the best ways to improve system processing times.

Requirements

CMS requires that the State submit a detailed corrective action plan outlining how processing timeframes for Medicaid applications will be improved in order to come into compliance with regulatory timeframes. Please submit this corrective action plan within thirty days from the final issuance of this report.

CMS requires that the State submit a monitoring report to CMS on a quarterly basis, this report should include a corrective action plan describing how the State will be in compliance with regulatory timeframes. Performance statistics should include CBMS processing times, and county processing times of applications.

CMS recognizes that implementing a plan to improve the timely processing applications will require time and effort. The state has already outlined a plan to fix these problems. CMS would expect a 25% improvement in the processing of Medicaid/CHP+ applications within one year of release of this report. CMS considers a 25% reduction in the processing delays of Medicaid applications over one year's time to be reasonable. CMS would expect the state to be 100% compliant with the Federal requirements within two years of the release of this report.

If the timeframes for processing Medicaid applications are not reduced and/or CBMS continues to be a significant barrier to the timely processing of applications, CMS may consider disallowing Federal Funds for the CBMS system. Federal regulations at 42 CFR 435.911, 42 CFR 435.902 and 42 CFR 431.15 require Federal funds be expended for the efficient and effective administration of the Medicaid program. The 45 CFR 95.612 makes it clear that CMS can disallow Federal Financial Participation (FFP) when the State fails to fulfill its commitment as authorized in the approved advance planning document. In view of the long history of CBMS failures to process Medicaid/CHP+ applications in an effective or efficient manner, the loss of ongoing Federal funding would be justified.

Recommendation

HCPF also instituted an "overflow process for counties". This has been done through an interagency agreement with the Department of Personnel and Administration (DPA) to assist HCPF with the "Overflow Project". The agreement specifies that DPA must process all applications within 45 calendar days of receipt of a complete application, and adhere to all State and Federal guidelines regarding the determination of Medicaid and CHP+ eligibility. The Maximus contract includes provisions that failure to meet such performance standards include the use of fiscal sanctions. HCPF reported that an application processed by DPA costs approximately $13.08. Additionally. HCPF provided some County statistics for processing an application that ranged from a low of $19.81 to a high of $123.33. The County costs for processing applications all appear to exceed the DPA number. The DPA contract included provisions for an expansion of the scope of work beyond the limit of 500 applications per month. Performance statistics of the former CHP+ contractor ACS (the contract now held by Maximus) revealed applications (most months) were processed on time 95% of the time. The 95% statistic was provided to CMS

in a July 2008 through October 2010 document entitled the "ACS Performance Standards and Actuals Report". These statistics indicate that DPA and Affiliated Computer Services (ACS) are able to perform the work for less money and more efficiently, thus meeting Federal timeliness regulations.

HCPF currently has a contract with Maximus to determine eligibility for CHP+ and Family Medical. Maximus will also begin accepting applications from the PEAK system. CMS commends the State for implementing the contract with Maximus to perform eligibility determinations. During discussion with Maximus and HCPF staff, it was noted that Maximus has contractual Service Level Agreements (SLAs) to determine eligibility within five days of receipt of the application. Additionally, Maximus utilizes an imaging process and has instituted a paperless environment. The Maximus contract includes provisions for an expansion of the scope of work for additional populations along with renegotiation provisions for volume increase based on current workload volumes. In discussions with the Maximus managers, it was learned the contractor is prepared to expand their capacity to process additional applications and has obtained additional workspace for such an expansion.

CMS recommends that the HCPF implement the same timeliness contract standards for the county workers that determine eligibility for Medicaid and CHP+. CMS also recommends that the HCPF expand the role of DPA and Maximus to allow for a greater number of applications to be processed by them.

CMS recommends that HCPF continue its efforts in working with the Counties to improve application processing and determine the cause of delays in the use of CBMS or the administration of the Medicaid program. CMS site visits found the Counties' use of work around manuals is greatly reduced from four years ago. In the 2004 CMS review of the Colorado system, we had found extensive 'work arounds' had been developed due to the problems with the new CBMS system. The reduced reliance on such 'work arounds' reflects real progress in the operational aspect of CBMS.

Additionally, CMS recommends that given the ongoing issues with eligibility determinations and timeliness, the State consider expanding out-stationed locations to process applications for certain low-income eligibility groups. Although the State currently does have some community based organizations/locations other than county offices where clients may apply, an opportunity exists for the State to expand to other locations. By increasing capacity through expansion of out-stationed locations, this could reduce the burden on county caseworkers and improve the State's timely processing application time frames.

CMS recommends that HCPF implement an electronic scanning of all Medicaid and CHP+ documentation. This would streamline the eligibility application process and decrease the problems associated with client paper work and documentation being lost or not tracked. The loss of documentation creates delays in eligibility determinations and inappropriate termination of eligibility. This has been noted by various advocacy groups and the Colorado State Auditors.

State Response:

The Department agrees with both the Requirements and Recommendations and has been working toward accurately measuring and improving processing times through a variety of strategies. The Department agrees to comply with all of the Requirements of Finding 1. The Department conditionally agrees to comply with all of the Recommendations of Finding 1, contingent upon obtaining necessary funding for the Electronic Document Management System (EDMS) and the consideration of expanding the roles of DPA and Maximus.

Medicaid enrollment runs countercyclical to economic conditions. During this economic downturn, Medicaid enrollment in Colorado has increased to unprecedented levels. Double digit annual growth rates in the last three years have put increasing pressure on the Department, counties, medical assistance sites, and the eligibility system to determine eligibility for these low-income individuals and families. As can be seen in the table below, the increasing rate of unemployment has coincided with large increases in Medicaid caseload. Since the economy entered a recession following state fiscal year (FY) 2007-08, annual Medicaid caseload has increased by over 160,000 individuals, or 41%.

	Total Medicaid Caseload	Total Employment	Unemployment Rate
FY 2005-06	402,218	2,255,000	4.71%
% Change From Prior Year	-	-	-
FY 2006-07	392,228	2,305,000	3.87%
% Change From Prior Year	-2.48%	2.22%	-17.83%
FY 2007-08	391,962	2,351,000	4.09%
% Change From Prior Year	-0.07%	2.00%	5.68%
FY 2008-09	436,812	2,306,000	6.68%
% Change From Prior Year	11.44%	-1.91%	63.33%
FY 2009-10	498,797	2,220,000	8.75%
% Change From Prior Year	14.19%	-3.73%	30.99%
FY 2010-11 Year-to-date	552,927	2,223,000	8.97%
% Change From Prior Year	10.85%	0.14%	2.51%

Despite these challenges, the Department has implemented the following strategies to ensure timely and accurate application processing:

Measurement of Application Processing Timeliness

While a number of reports are currently in use to measure the processing times, a uniformly accepted methodology has not been implemented. For example, the Financial Statistical Report for Applications referenced in Finding 1 calculates the processing time based on the date that benefits start and Medicaid allows benefits to start up to three months prior to the application date, thus adversely skewing the processing time. Current

reports also incorrectly include duplicative counts of applications, thus further skewing the processing times. As a result, the Department has initiated a concentrated effort to clearly and consistently define the measurement of the time it takes to process an application. The Department is working with its partners and stakeholders to evaluate the reporting variances and to establish reporting standardization across all medical programs. The Department also recognizes that until a standardized measurement is implemented, that performance will continue to be measured utilizing the existing reports. The Department anticipates that a standardized methodology to measure medical application processing times will be implemented by the fall of 2011.

Application Processing Improvement Efforts

Colorado Eligibility Process Improvement Collaborative (CEPIC). The Department commits to taking a multi-pronged approach to improving timeliness for all medical programs. The Department was awarded a grant from the Colorado Health Foundation to contract with the Southern Institute on Children and Families Process Improvement Center (SICF) to lead eligibility process learning collaboratives. In the summer of 2010, SICF began work with 15 county teams to assist the counties in improving the efficiency, effectiveness and quality of processes within our public programs that support lower-income children and families, with a focus on eligibility services, and specifically the timely processing of applications. The Center teaches executive leaders and front-line workers process improvement principles and guides them in the application of these principles to generate process improvements in programs through Process Improvement Collaboratives. The Department chose county teams that represented diversity in terms of their size, geography, resources and the various ways in which business activities are organized (generalist v specialist and task-based v caseload). Many of the county teams selected for this initiative also participated in our Eligibility Modernization project in which Public Knowledge staff mapped out the current business processes in use by counties and Medical Assistance (MA) Sites.

Overflow and Additional Resources. Since April 2009, the Department has been offering additional resources to assist the county departments of social/human services with the increased number of applications submitted to the counties as a result of the current economic downturn. This assistance is for applicants applying only for "family and children's medical" programs administered by the Department. The Overflow Application Process for counties accommodates applications that have not yet been worked or entered into CBMS. It is estimated that over 14,280 medical-only applications have been diverted from a number of counties for processing at alternative Medical Assistance (MA) Sites. In February 2011, the Department was awarded a grant from the Colorado Health Foundation to continue the Overflow Application Process for another year, to assist with the backlogs due to a combination of the economic downturn and the health care expansions. The Department obtained additional funding to expand the Overflow Application Process capacity to approximately 4,000 applications per month for the remainder of State Fiscal Year 2010-2011; however some counties have chosen to not take advantage of this additional assistance. In the month of March 2011, the Overflow

Application Process was only able to obtain 1,390 applications from counties and 1,067 add-a-babies from providers and partners.

The Department also recognizes that resources need to be made available in different ways. With available funding from the Department's professional services budget line (approximately $36,000), the Department funded twenty-two (22) additional staff across three of Colorado's larger counties (Denver, Jefferson and El Paso) in May and June 2010. These staff provided for a focused effort in processing application backlogs averaging an approximate 30% reduction in pending caseloads. From September through November 2010, the Department funded (approximately $7,500) two additional staff at Denver county to assist again with the ongoing application backlogs, both of which have become permanent employees at Denver county. The Department is offering this type of assistance again in 2011 to some of the larger counties.

Training. The Department provides enhanced and specialized technical training that is not comparable to any of the CBMS training offered through the Office of Information Technology, which include targeting reasons for delays and correct processing. The training is provided upon request through over-the-phone support, on site or in a computer lab. The Department also provides face-to-face trainings statewide on at least an annual basis that integrates the medical policy with the day-to-day operations. To increase transparency, the Department created a designated email inbox that allows eligibility workers a single source for requesting and receiving policy and operational clarifications regarding medical eligibility. The Department also conducts intensive trainings for new MA Sites. In March 2011, the Department implemented a computer training lab that can accommodate 14 participants for concentrated, hands-on training of both medical policy and operations for both new and existing eligibility sites. With the opening of the computer training lab, the Department plans to offer a robust medical eligibility training curriculum that encompasses a variety of delivery methods.

Expanding Out-stationing. In combination of the economic downturn and the health care expansion, the Department continues to increase its Presumptive Eligibility (PE) Sites, Certified Application Assistance Sites (CAAS) and MA Sites. The Department is in the final stages of completing the certification procedures, which will allow organizations to become certified more easily. Upon finalization of the certification process, the Department will immediately increase from four to seven MA Sites, providing intensive computer lab training to the three new MA Sites. To assist applicants in finding help with the application process, the Colorado Trust funded the development of a new online search engine and mapping capabilities for the Department's list of out-stationed sites that was implemented in December 2010.

Medical Eligibility Quality Improvement Plan (MEQIP). MEQIP was established as the framework to communicate the Department's vision, objectives and strategies to improve the Medicaid and CHP+ eligibility determination process. Representatives from the counties, MA Sites and Department comprise the Medical Eligibility Quality Improvement Committee (MEQIC) which was created to assist and advise the Department in implementing the MEQIP. Supervisory case reviews include a review of four cases per

worker per month evaluating timely processing, data entry accuracy and supporting case file documentation.

CBMS Application Processing Improvement Efforts
In the fall of 2010, the Office of Information Technology (OIT) installed/upgraded systems to improve overall processing times and capacity.

Interfaces and Express Lane Eligibility. The Department was awarded a $42 million grant under the federal Health Resources and Services Administration's State Health Access Program (HRSA SHAP), providing funding critical to creating an infrastructure that will support our increasing capacity needs. The Department is implementing the following interfaces and express lane eligibility to simplify an individual's application process and lessen the workload of the eligibility site worker.

- Department of Revenue, Division of Motor Vehicle. Interface will allow verification of identity for applicants.
- Social Security Administration. Interface will allow verification of citizenship and identity for applicants.
- Department of Labor and Employment, Income and Eligibility Verification System. Interface will allow verification of earned income for applicants.
- Department of Public Health and Environment, Vital Records. Interface will allow verification of citizenship for applicants. Currently a pilot is in progress with 5 eligibility sites and 4 users at each site. The pilot will continue until the Department implements the automated interface to allow verification of citizenship for applicants.
- Department of Education, Free and Reduced Lunch. Automating the use of eligibility determinations from other programs to determine and redetermine eligibility for medical programs.
- Department of Revenue, Division of Taxation. Automating the use of eligibility determinations from other programs to determine and redetermine eligibility for medical programs.

Intelligent Data Entry (CBMS Web Portal). The Web-Based Intelligent Data Entry (IDE) enhancement will serve as the keystone to the overall vision for an integrated service delivery model for the State. This enhancement aims at realigning CBMS with the needs of the eligibility workers as well as the collective mission of the Departments by reducing cross program contention and improving the productivity of the CBMS workers. The IDE enhancement focuses on achieving these objectives by improving the Application Initiation and Interactive Interview modules of the CBMS system and resolving cross program contention issues by streamlining the data collection process by program priorities. It is projected to reduce global annual application processing hours by 53,000 hours.

Program Eligibility and Application Kit (PEAK) Web Application. The Colorado Program Eligibility and Application Kit (PEAK) is a Web-based portal designed to provide clients and community partners with a modern and easily accessible tool to apply for public assistance benefits. In October 2009, Phase I of PEAK was implemented that allows new CBMS clients to screen themselves for potential program eligibility ("Am I

Eligible?") and allows our existing clients to check on their benefits ("Check My Benefits"). In summer of 2011, applicants will be able to apply for our family and children's programs online ("Apply for Benefits") and existing clients will be able to report changes, such as changes in their address or income online ("Report My Changes"). Future phases of PEAK will permit clients to process their redeterminations online, functionality will be expanded to adult programs, and all of the expansion populations under the Health Care Affordability Act and will become the platform for further improving the user interface. Please refer to the PEAK Website at http://www.colorado.gov/PEAK//.

CMS Response:

We recognize the State's response is contingent on obtaining necessary funding for the Electronic Document Management System. However, CMS holds the State responsible for compliance with federal law and rules regardless of the availability of funding. Additionally, the State may face Federal Financial Participation sanctions if the corrective actions are not completed by the agreed upon dates. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15th of each month (for the previous month) on an ongoing basis until compliance goals are achieved. The reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

Finding #2: The Single State Agency currently does not maintain control over the operations of the Medicaid program (Section 1902(a)(5) of the Act and 42 CFR 431.10 of the Federal regulations).

Requirement

The state Medicaid Agency must complete a new contract with OIT to assure its oversight and control responsibilities are in place regarding Medicaid operations within CBMS. We strongly recommend this contract include a detailed scope of work, performance standards and provisions for HCPF as the single state Medicaid agency to monitor and address the performance issues of OIT and CBMS. This new contract should be in place within six months of release of this report. CMS requires that the State submit a copy of this contract upon completion.

Recommendation

CMS notes that the State has commenced numerous workgroups and taskforces to address the timeliness issue and which have resulted in, among others, the following actions:

- There is currently change request #2135 which was scheduled to be implemented in January 2011. This will allow the functionality to differentiate between a worker-caused delay and a client-caused delay. There will also be reports available that will document these two distinct differences.

- The State has also started a quality eligibility group that will identify new methods for improving timely processing and monitor corrective action plans obtained from the eligibility sites. These will be based on current and previous audit findings regarding timely processing.

- OIT recognizes the 19,000 hours of system changes hours is insufficient for making changes to a system as complicated and troubled as CBMS. CMS recommends an increase in these services hours.

- Most importantly, the HRSA funded CBMS system enhancements do not reside within the 19,000 hour pool or include a redesign of the CBMS system interfaces with Income Eligibility and Verification System (IEVS), Social Security Administration for Citizenship Verification, Department of Motor Vehicle for Identification Verification, Department of Health and Vital Statistics. These are especially critical to improve the processing times of Medicaid/CHP+ applications and should be implemented as soon as possible. We understand these system enhancements have been delayed due to the need to complete the system refresh effort. Now that the system refresh has been completed these new system enhancements should be implemented to remedy the slow processing of applications.

State leaders have acknowledged the possibility of developing a stand -alone Medicaid and CHP+ eligibility system. The consideration of a stand-alone system is based on the additional complexity the State has experienced with an integrated system. An integrated system places various policy rules and definitions in conflict with each other to be subject to a longer processing time to make any system changes. For instance, the Medicaid definition of income is less complex a definition than the one used for the financial programs such as food stamps or TANF. A system change to Medicaid on income must cause the definitional requirements for these programs to be designed into the system. Such design complexity results in increased programming that can take months or even years to complete. CMS recommends that, should the ongoing remediation efforts not improve timeliness of application processing, HCPF consider new investments and strategies such as a stand-alone Medicaid system.

State Response:

The Department agrees with both the Requirements and Recommendations. The Department agrees to comply with all of the Requirements of Finding 2. The Department conditionally agrees to comply with all of the Recommendations of Finding 2, contingent upon obtaining necessary funding to increase the CBMS maintenance hours and to consider new investments/strategies such as a stand-alone Medicaid system.

The Department agrees to collaborate with the Governor's Office of Information Technology (OIT) to develop a formal agreement or Memorandum of Understanding that assures the Department's oversight and control responsibilities for Medicaid and CHP+ operations within CBMS, and will obtain prior approval of the scope of work from CMS.

If the Department is unable to reach a mutual agreement with OIT, the Department will begin conversations regarding a stand-alone Medicaid and CHP+ eligibility system.

CBMS Change Request 2135. The CBMS Change Request #2135 was implemented on January 31, 2011. This change helps the Department differentiate between a worker or client caused delay in application processing by enabling eligibility site workers to pend a case for a State Helpdesk ticket and to allow a client the "Good Faith" effort. This change also generates a verification checklist for required verifications based on the eligibility site worker's data entry and allows workers to authorize Family Medicaid and CHP+ clients at the individual level instead of the case level and automates the Recertification Notice for Family Medicaid guaranteed clients.

The Second Phase of this CBMS Change Request was implemented on April 30, 2011. This change automates the:

- addition of Family Medicaid when a CHP+ case household income decreases and income is at or below 133% FPL and the determination of Family Medicaid;
- addition of CHP+ when a Family Medicaid case household or individual is denied or terminated for being over income for Family Medicaid and the determination of CHP+; and
- reassessment of eligibility for the Recertification Notice of the Family Guaranteed clients, resets the redetermination due date and identifies and suppresses overlapping redeterminations and recertification notices.

The Second Phase also includes the respective reports that will standardize the methodology to measure medical application processing times.

Medical Eligibility Quality Improvement Plan (MEQIP). MEQIP was established as the framework to communicate the Department's vision, objectives and strategies to improve the Medicaid and CHP+ eligibility determination process. Representatives from the counties, MA Sites and Department comprise the Medical Eligibility Quality Improvement Committee (MEQIC), which was created to assist and advise the Department in implementing the MEQIP. Supervisory case reviews include a review of four cases per worker per month evaluating timely processing, data entry accuracy and supporting case file documentation.

19,000 annual hours for system changes. Currently, financing of the CBMS is shared by the Colorado Department of Human Services (DHS) and the Department. Each department's share of the financing is based on Random Moment Sampling conducted by an outside vendor that telephones county departments of social/human services employees to ask what program the employees are working on at the moment of the call. A large proportion of the time, county employees mention a social services program such as Temporary Aid to Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP). A small proportion of the time, county employees will mention Medicaid.

The Department is currently researching whether such an instrument is the most appropriate measure of relative program utilization of the Colorado Benefits Management

System. The Department recognizes the extensive client relationship building and maintenance role that the county departments of human/social service workers play navigating a multitude of public service benefits and the time periods required. The Department is investigating other measures that may provide a more appropriate indicator of the utilization of the Colorado Benefits Management System by programs administered by the two departments. These other measures include the relative number of applications processed for the various assistance programs; resulting caseload for the relevant programs; the number of correspondence clients and applicants; or the relative total dollar amounts of assistance provided to clients of the programs managed by the two state departments.

Interfaces and Express Lane Eligibility. The HRSA grant is providing funding critical to creating an infrastructure that will support our increasing capacity needs. The Department is implementing the following interfaces and express lane eligibility to simplify an individual's application process and lessen the workload of the eligibility site worker.

- Department of Revenue, Division of Motor Vehicle. Interface will allow verification of identity for applicants.
- Social Security Administration. Interface will allow verification of citizenship and identity for applicants.
- Department of Labor and Employment, Income and Eligibility Verification System. Interface will allow verification of earned income for applicants.
- Department of Public Health and Environment, Vital Records. Interface will allow verification of citizenship for applicants. Currently a pilot is in progress with 5 eligibility sites and 4 users at each site. The pilot will continue until the Department implements the automated interface to allow verification of citizenship for applicants.
- Department of Education, Free and Reduced Lunch. Automating the use of eligibility determinations from other programs to determine and redetermine eligibility for medical programs.

Department of Revenue, Division of Taxation. Automating the use of eligibility determinations from other programs to determine and re-determine eligibility for medical programs.

CMS Response:

We recognize the State's response is contingent on obtaining necessary funding to increase the CBMS maintenance hours along with considering the new investments such as stand-alone Medicaid system. However, CMS holds the State responsible for the corrective actions regardless of the availability of funding. Additionally, the State may face Federal Financial Participation sanctions if the corrective actions are not completed by the agreed upon dates. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15th of each month (for the previous month). The progress reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

Citizenship and Identity Documentation

Finding #3: HCPF is not in compliance with Federal regulations at 42 CFR 435.406 and 435.407(j), reasonable opportunity period to present satisfactory documentary evidence of citizenship by delaying Medicaid benefits while clients are gathering necessary citizenship and identity documentation during a reasonable opportunity period.

Please be aware that Section 1903(x) of the Social Security Act and Federal regulations at 42 CFR 435.406 and 435.407 require States to obtain satisfactory documentary evidence of citizenship and identity prior to enrollment in Medicaid. Section 211 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), amended Section 1903(x) of the Act to specify that states must allow an individual to declare citizenship and must not deny, delay, reduce, or terminate Medicaid eligibility while the documentation is gathered during a reasonable opportunity period. FFP is available for claims that occur during the reasonable opportunity period, even if eligibility is ultimately terminated due to lack of documentation. Additionally, CHIPRA provided authority for enhanced Federal Financial Participation (FFP) for states to verify citizenship for individuals newly enrolled using a data file match with the Social Security Administration (SSA).

Requirement

CMS requires that Colorado submit a corrective plan to CMS within sixty days of the final issuance of this report. Colorado should come into compliance with this regulation within 180 days of the final issuance of this report.

Recommendation

CMS recommends that, given the number of Medicaid eligible individuals in Colorado and the caseload size carried by local eligibility technicians, the State take advantage of two system interfaces that can significantly reduce the burden of providing documentation on the applicant and decrease additional administrative time spent by eligibility workers on this process.

The first system interface that CMS recommends Colorado implement is an electronic match with the Colorado Department of Public Health and Environment Vital Records Section. Numerous states around the country have found that this electronic verification of birth certificates for applicants born in the state of residency has significantly reduced the administrative burden of documenting citizenship for Medicaid eligibility purposes.

The second system interface that CMS recommends Colorado implement is the verification of a declaration of citizenship for individuals newly enrolled in Medicaid using a data match with the Social Security Administration (SSA) pursuant to Sections 1902(a)(46)(B) and 1902(ee) of the Act.

State Response:

The Department agrees with both the Requirements and Recommendations and agrees to comply with all of the Requirements and Recommendations of Finding 3.

Citizenship Interfaces. The HRSA grant is providing funding critical to creating an infrastructure that will support our increasing capacity needs. The Department is implementing the Vital Statistics and Social Security Administration (SSA) interfaces in calendar year 2011 to simplify an individual's application process and lessen the workload of the eligibility site worker.

- Social Security Administration (SSA). Interface will allow verification of citizenship and identity for applicants.
- Department of Public Health and Environment, Vital Records. Interface will allow verification of citizenship for applicants. Currently, a pilot is in progress with five eligibility sites and four users at each site. The pilot will continue until the Department implements the automated interface to allow verification of citizenship for applicants.

CMS Response:

CMS concurs with the State regarding the corrective actions. CMS encourages HCPF to review the December 2009, State Health Official letter which provides guidance on the availability of enhanced FFP for File Match Systems with the Social Security Administration. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15th of each month (for the previous month) until compliance goals are achieved. The reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

Finding #4: HCPF is not in compliance with 42 CFR 435.406(b) citizenship and alienage. It has been determined that CBMS is not programmed to deny and/or terminate Medicaid eligibility after the reasonable opportunity period has passed and the individual has not provided satisfactory documentation of citizenship and identity. Currently this process takes place manually by worker action and therefore is subject to errors and delays.

Requirements

CMS requires that, within sixty days of the formal issuance of this report, CBMS be programmed to provide Medicaid benefits to otherwise eligible individuals during the reasonable opportunity period when clients are gathering citizenship and identity documentation.

CMS requires that, within sixty days of the formal issuance of this report, CBMS be programmed to terminate Medicaid eligibility after the reasonable opportunity period has ended and the individual has not provided satisfactory documentation of citizenship and identity.

Recommendation

CMS recommends that CBMS be programmed to automate the termination of Medicaid eligibility for clients after the reasonable opportunity period has ended and the individual has not provided satisfactory documentation of citizenship and identity.

State Response:

The Department agrees with the Requirements and Recommendations of Finding 4. The Department agrees to comply with the Requirements and Recommendations of Finding 4, however is unable meet the required timeline. The Department submitted high-level business requirements to the Governor's Office of Information Technology (OIT) in April 2010 that describes the necessary CBMS changes to provide Medicaid to individuals during the reasonable opportunity period and then to terminate benefits if the individual has not provided satisfactory documentation of citizenship and identity. The high-level business requirements initiate a CBMS Change Request, which is necessary to program changes into CBMS. This CBMS Change Request is targeted for implementation in January 2012, which is outside of the required timeline. To minimize the impact on applicants until the system change is implemented, the Department will incorporate a good faith process to allow affected clients to receive eligibility from their application date once the documentation is received.

CMS Response:

CMS concurs with the State's plan for corrective actions. However, until the changes are fully implemented, the State remains out of compliance with the federal rules. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15th of each month (for each previous month) until compliance goals are achieved. The progress reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

CBMS Re-determinations of Medicaid Eligibility

Finding #5: HCPF is not in compliance with the Federal regulation at 42 CFR 435.916 which require that the Medicaid agency re-determine the eligibility of Medicaid recipients at least every 12 months. Colorado inappropriately terminates clients' eligibility during the redetermination process. Additionally, Federal regulations at 42 CFR 435.930(b) establish that the State must continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible. The default logic and policy that denies eligibility due to delays by the county or

application sites processing of redeterminations does not comply with Federal regulations.

During the review, CMS received input from advocacy groups establishing that redetermination of Medicaid eligibility is a significant problem due to the delay in processing renewal packages sent by the clients. Additionally, these groups reported that they have identified cases where Medicaid eligibility was terminated due to lack of redetermination even though the client submitted the redetermination package. Finally, CMS received reports that there is a lack of an effective systemic process to continue Medicaid benefits during an appeal pursuant to the Federal regulations 42 CFR 431.230.

According to the July 29, 2008 letter to HCPF from Sherman & Howard, "The overall rate of redeterminations is very high. For example, according to the *Summary of Medical Applicant Redeterminations* for April 2008 the total number of redeterminations (statewide) was 72, 219, and of this total, the number of denials was 53, 232. These redetermination denials represented 73.7% of the total denials." The high trend continued for May 2008 and June 2008.

During interviews with HCPF staff, it was determined the current State policy is that Medicaid eligibility is terminated when there are delays in the processing of the renewal of eligibility for any reason, including non-client based reasons for the delay. CMS received information that redeterminations are often put in a "pending status" by the county workers. The counties currently have a work around so that clients still receive Medicaid benefits while in this "pending status". If the work around is not done then the State CBMS system will deny the case due to its current programming tables.

Requirement

CMS requires the state to submit a corrective plan to ensure that CBMS be programmed to default to an eligibility status for clients while redeterminations are being processed. The reprogramming of CBMS should occur within 180 days of the final issuance of this report.

HCPF should immediately provide written instructions to the counties to use the 'pending status' process to avoid inappropriate terminations of Medicaid eligibility.

State Response:

The Department agrees with the Requirements and agrees to comply with all of the Requirements of Finding 5.

Administrative Renewals. The HRSA grant is providing funding critical to creating an infrastructure that will support our increasing capacity needs. The Department is implementing Administrative Renewals to simplify an individual's redetermination process and lessen the workload of the eligibility site worker. Administrative renewals will automate the ex parte process, by utilizing current information available from other programs within CBMS as well as the interfaces targeted for implementation in the

summer of 2011. Individuals who are found eligible through the automated process will continue to receive benefits without worker intervention. Individuals who are found ineligible through the automated process will receive a preprinted form of their eligibility information requesting that it be reviewed, updated and returned. Eligibility site workers will then enter the information into CBMS and redetermine eligibility. Individuals whose information is correct on the preprinted form do not need to return the form and eligibility will be redetermined automatically with the existing information on file. All individuals who receive the preprinted form will also receive the 10-day noticing if their eligibility will be terminated. This new functionality will continue Medicaid eligibility to individuals until they are determined ineligible.

CMS Response:

CMS concurs with the State's plan for corrective actions. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15th of each month (for the previous month) until the compliance goals are achieved. The progress reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

Finding #6: HCPF is not in compliance with Federal Regulations at 42 CFR 435.916(c) Periodic redeterminations of Medicaid eligibility. Federal Regulations state, "The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility." Medicaid redeterminations denials are, on occasion, inappropriately undertaken due to loss of paperwork at the counties because of a lack of scanning equipment. Additionally, county processes are so dissimilar that eligibility determinations are not uniformly implemented across the state.

According to the July 29, 2008 letter to HCPF from Sherman & Howard, "The overall rate of redeterminations is very high. For example, according to the *Summary of Medical Applicant Redeterminations* for April 2008 the total number of redeterminations (statewide) was 72, 219, and of this total, the number of denials was 53, 232. These redetermination denials represented 73.7% of the total denials." The high trend continued for May 2008 and June 2008.

The Public Knowledge 2008 report found all 64 counties use different eligibility processes that cause inconsistency and inefficiencies with a potential of Medicaid applications and redeterminations being processed incorrectly. The Public Knowledge report recommended development of a county business model improvement effort. HCPF has worked with the counties to improve its processes.

Requirements

CMS requires that the following information be submitted sixty days from the final issuance of this report as follows:

- Description of processes and procedures that the State (via county administration) utilizes to re-determine Medicaid eligibility benefits.
- Description of the safeguards and monitoring that takes place to ensure timely tracking and processing of Medicaid eligibility redeterminations. For example, whether counties have to date-stamp all redetermination packages upon receipt and subsequently enter them in the system for tracking and assignment.
- Supervisory-level oversight of the redetermination process to ensure timeliness and that no submitted packages are lost in the process.
- A report showing the number of redetermination cases that were pending (for the last available month) per county including the number of packages received and the number of packages pending redetermination.
- A report showing the percentage of terminated cases, for the last available month, that were terminated due to redetermination failure.

Recommendation

CMS is concerned with the high percentage of denials and recommends that, in addition to the CBMS remediation regarding a default eligibility status during the redetermination process, the State develop a report that tracks redetermination cases that have not been processed timely.

In response to CMS' recommendation regarding redetermination of Medicaid eligibility contained in the 2007 Post Implementation (P-I) Report of CBMS, the State replied that it did not have a report regarding outstanding redeterminations. Additionally, the State responded that it was going to start a process to create such report. It has been more than three years since the State committed to begin tracking timeliness of Medicaid eligibility redeterminations.

State Response:

The Department agrees with both the Requirements and Recommendations. The Department agrees to comply with all of the Requirements and Recommendations of Finding 6.

The Department is automating income verification and administrative renewals in the summer of 2011 that will significantly reduce the need for paper verifications at redetermination. Contingent upon obtaining necessary funding, the Department will work toward implementing an Electronic Document Management System (EDMS).

Income Verification. The Department is implementing an interface with the Department of Labor and Employment, Income and Eligibility Verification System that will allow for the automated verification of earned income for applicants. Individuals will only need to provide paper verification of earned income if the information obtained through the interface is greater/less than $750.

Administrative Renewals. The HRSA grant is providing funding critical to creating an infrastructure that will support our increasing capacity needs. The Department is implementing Administrative Renewals to simplify an individual's redetermination process and lessen the workload of the eligibility site worker. Administrative renewals will automate the ex parte process, by utilizing current information available from other programs within CBMS as well as the interfaces targeted for implementation in the summer of 2011. Individuals who are found eligible through the automated process will continue to receive benefits without worker intervention. Individuals who are found ineligible through the automated process will receive a preprinted form of their eligibility information requesting that it be reviewed, updated and returned. Eligibility site workers will then enter the information into CBMS and redetermine eligibility. Individuals whose information is correct on the preprinted form do not need to return the form and eligibility will be redetermined automatically with the existing information on file. All individuals who receive the preprinted form will also receive the 10-day noticing if their eligibility will be terminated. This new functionality will continue Medicaid eligibility to individuals until they are determined ineligible.

CMS Response:

We recognize the State' s response is contingent on obtaining necessary funding for the Electronic Document Management System. However, CMS holds the State responsible for compliance with Federal rules regardless of the availability of funding. Additionally, the State may face Federal Financial Participation sanctions if the corrective actions are not completed by the agreed upon dates. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15th of each month (for the previous month) until the compliance goals are achieved. The reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

Client Notification Issued by CBMS

Finding #7: HCPF is not in compliance with Federal Regulations at 42 CFR 431.211, which requires that the State or local agency must mail a notice at least 10 days before the date of action.

CMS reviewed various reports which identified proper noticing as an issue within the State's delivery of the Medicaid program. The reports reviewed were the CMS CBMS P-I Report, the 2005 Family and Children Active MEQC Pilot Project, the 2005 Nursing Family Active Pilot Project, and the 2008 Public Knowledge Report.

These reports cite various problems such as proper noticing, content, unnecessary repetitive volume of notices and contradictory notices. Also, CMS interviewed advocacy groups and information they provided indicating that clients will often receive numerous notices within the same week which indicate different 'actions'. Some of the notices indicate that Medicaid has been discontinued and others indicate the client has been found eligible for Medicaid. Federal Regulations at 42 CFR 435.912 require that the agency

must send each applicant a written notice of the agency's decision on his or her application, and, if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of his or her right to request a hearing.

Also, Federal Regulations at 42 CFR 431.210 establish that notices must contain the following elements: "(a) a statement of what action the State intends to take; (b) the reasons for the intended action; (c) the specific regulations that support, or the change in Federal or State law that requires the action; (d) an explanation of: (1) the individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or (2) in cases of an action based on a change in law, the circumstances under which a hearing will be granted; and (e) an explanation of the circumstances under which Medicaid is continued if a hearing is requested."

CMS noted that CBMS-generated notices denying Medicaid applications due to incomplete applications and missing required documentation did not specify which portions of the application were incomplete or which documents were missing.

CMS has also reviewed reports regarding notices and notes the following issues:

- Notices contain incorrect spans of Medicaid eligibility and continue to reflect older dates for new spans (sometimes going back to three and four years).
- Notices continue to have contradictory information such as "you are eligible for Medicaid" and in the same notice "your Medicaid benefits have been terminated."
- Clients continue to receive multiple contradictory notices at the same time.
- Many of the legal citations in the notices are incorrect or do not apply to the action being taken. Since the noticing is tied to the integrated nature of the system, one system that implements several programs with different definitions of income results in a complex set of programming instructions that often must compete with each other. This complexity may also extend to the county workers who have to keep in mind all the competing definition of the various programs and causes for a longer eligibility review time.
- The use of county-generated notices rather than CBMS notices.

Requirement

CMS requires that, within sixty days of the final issuance of this report, develop a corrective action plan addressing the notification issues cited above and identifying activities that it will take to improve the CBMS notification process and bring it into compliance with Federal regulations at 42 CFR 431.210-211. Please note, if the corrective actions are not completed within twelve months from the date of this report being issued, CMS will consider deferring funding for CBMS.

Recommendations

CMS recommends that, with regard to terminations without proper advance notice to clients and notifications content, the State assess whether these are system-generated

problems that need to be resolved through system remediation or whether they are problems arising from user error and need to be addressed through training.

With regard to the use of county-generated notices rather than CBMS notices, CMS recommends that HCPF work with the counties to enhance CBMS notices to capture the information that the counties feel is lacking and needs to be represented in their notices.

State Response:

The Department agrees with both the Requirements and Recommendations and agrees to comply with all of the Requirements and Recommendations of Finding 7. The following initiatives address client noticing.

CBMS Change Request 2135. The CBMS Change Request #2135 was implemented on January 31, 2011. This change generates a verification checklist for required verifications based on the eligibility site worker's data entry, thus eliminating the need for eligibility site workers to create their own notices.

Citations and Language. Over the past year, the Department has reviewed all of the medical correspondence notices, updated legal citations, and revised language, and submitted these changes to the Governor's Office of Information Technology (OIT) in March 2011. OIT is in the process of updating CBMS with the new notices.

CMS Response:

CMS concurs with the State's plan for corrective actions. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15th of each month (for the previous month) until the compliance goals are achieved. The reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

Vanishing Medicaid Eligibility Spans

Finding #8: CMS found that, in an analysis performed by HCPF, when a valid eligibility span in CBMS is retroactively removed, historical records of the span are also removed from the Medicaid Management Information System (MMIS) in a majority of the vanishing cases. Clients in these cases are defined as having "uncertain eligibility history", because there is uncertainty around the past eligibility status of the clients.

CBMS functionality currently permits county and medical assistance site workers to change data to an existing medical eligibility span within the system. This change may result in the medical eligibility span "vanishing" retroactively without an audit trail or a record of the original medical eligibility span.

As a result of the Vanishing Medical Span (VMS) there are various problems and risks for Medicaid clients that include but are not limited to:

- When a medical eligibility span is eliminated, resulting medical services are denied to clients;
- The eligibility status of affected clients is determined to be unjustifiably uncertain;
- An estimated tens of millions of dollars in capitations where clients 'look' ineligible in CBMS yet could be actually eligible; and
- Reconciliations in the capitated programs that have not been completed could result in several million dollars outstanding which could be owed the State/CMS.

Requirement

CMS requires that, within sixty days of the final issuance of this report, the State will submit a project plan with specific timeline for correcting the VMS by December 31, 2011 and which will ensure the elimination of the VMS problem by that date.

Recommendation

CBMS recommends that HCPF perform system changes within CBMS to eliminate the VMS Problem.

State Response:

The Department agrees with the Requirements and the Recommendations of Finding 8. The Department agrees to comply with the Requirements and Recommendations of Finding 8, however is unable to meet the required timeline of December 31, 2011.

The Department maintains paper or electronic application files for all eligible individuals, which can be used to determine if the individual is eligible. The Department also provides ongoing training and technical support to county departments of human/social services on how to correctly enter medical applications into CBMS. To prevent the electronic records from being deleted retrospectively, the Department, in coordination with the Governor's Office of Information Technology, developed a project plan in October 2009 to implement changes into the CBMS system. The Department is targeting the implementation to correct the Vanishing Medicaid Eligibility Spans in August 2012.

CMS Response:

CMS concurs with the State's plan for corrective actions. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15th of each month. The progress reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

OBSERVATIONS (GENERAL)

The following is a list of various issues reported by interviewed workers and advocacy groups. CMS did not include these reported claims as findings, but only as observations given the lack of substantial evidence for each claim. We request that the State respond to the accuracy of the following claims and issues.

- CMS found that HCPF staff have limited access to the CBMS eligibility files. CMS recommends that HCPF staff be given full access to CBMS so that reliance on a third-party is limited. During our review we requested client specific information and the State was unable to provide a list of Medicaid eligibles from CBMS. According to 1902(a) (5) of the Act and 42 CFR 431.10, the Single State Agency must maintain control over the program. Dependence on an outside entity appears to be out of compliance with the statute and regulation. CMS believes that HCPF should have the final authority with OIT in determining which projects have priority. Since the majority of the funding flows from HCPF to OIT, the HCPF should have control over the timeliness and priority of work products.

  State Response:

  The Department agrees with this observation and intends to include this requirement in the formal agreement or Memorandum of Understanding with the Governor's Office of Information Technology (OIT).

  CMS Response:

  CMS concurs with the State's response. Please provide a copy of the formal agreement or Memorandum of Understanding within 30 days of receipt of this report.

  CMS requests that HCPF review policy to determine if it is being correctly applied in the following areas:

  1. Is CBMS correctly calculating spousal impoverishment and post-eligibility treatment of income?

  State Response:

  No. CBMS is not calculating spousal impoverishment and post-eligibility treatment of income correctly. This change has been identified but is not currently on the Department's 18 month calendar. While the Department will begin work on this change within 2012, the Department provides ongoing training and technical support to county departments of

human/social services on how to correctly enter medical applications into CBMS.

CMS Response:

CMS appreciates the State's response, and the State must implement corrective actions immediately. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15th of each month (for the previous month) until compliance goals are achieved. The reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

2. Is CBMS correctly applying the transfer of asset penalties to the client's Medicaid eligibility? Pursuant to 1917(c), penalties due to disposition of assets for less than fair market value should only be applied to long-term benefits instead of towards Medicaid eligibility in its totality.

State Response:

No. CBMS is not calculating the transfer of asset penalties correctly. The Department has identified this change and it is currently on the Department's 18 month calendar. While the targeted implementation date is July 2012, the Department provides ongoing training and technical support to county departments of human/social services on how to correctly enter medical applications into CBMS.

Currently CBMS does not approve applicants for Medicaid while serving a period of ineligibility. This change has been identified but is not currently on the Department's 18 month calendar. The Department will begin work on this change within 2012.

CMS Response:

CMS appreciates the State's response, and the State must implement corrective actions immediately. CMS will monitor the State's progress. The State must submit monthly progress reports to CMS by the 15th of each month (for the previous month) until the compliance goals are achieved. The reports must include details regarding the implementation of corrective action steps and progress towards full compliance with federal rules.

3. Is CBMS correctly assessing client eligibility for Transitional Medicaid Assistance when a 1931 eligible recipient loses eligibility due to increased income or hours of work? Is CBMS correctly screening clients for four-month extended eligibility period due to increase in child support?

State Response:

Yes. CBMS is correctly assessing eligibility for the Transitional Medical Assistance when a 1931 eligible recipient loses eligibility due to an increase in income or work hours.

Yes. CBMS is correctly screening clients for four-month-extended eligibility due to an increase in child support or spousal support.

CMS Response:

CMS duly notes and appreciates the State's response.

PROMISING PRACTICES

While reviewing several documents and conducting interviews during this review, it was noted that the State is in the process of developing and implementing new initiatives and programs that could significantly improve the eligibility determination and redetermination processes for Medicaid and CHP+ benefits in Colorado. The following is a brief list of some of the State's noted best practices:

- Colorado Comprehensive Health Access Modernization Program (CO-CHAMP)

  In 2009, the Health Resources and Services Administration of the United States Department of Health and Human Services awarded Colorado a five-year competitive Federal grant to support health care reform initiatives. This State Health Access Program (SHAP) funding was granted for seven comprehensive and interrelated projects totaling approximately $42 million over five years that seek to provide greater access to health care, increase positive health outcomes and reduce cost-shifting.

  CO-CHAMP projects include:

  - Maximizing Outreach Retention and enrollment (MORE);
  - Eligibility Modernization: Streamlining the Application Process;
  - Benefit Design for New Populations;
  - CHP+ at Work Premium Assistance;
  - Community Multi-Share Expansion Project;
  - 3-Share Community Start-up Pilot; and
  - Evidence Based Benefit Design Pilot.

From the aforementioned projects, CMS notes that the second item related to Eligibility Modernization is of major importance as it pertains to Colorado's Medicaid and CHP+ eligibility and enrollment functions. The following specific activities that the State will

seek to implement under this project can significantly assist in addressing the chronic problems associated with delays in the processing of new Medicaid applications and redeterminations as well as reducing the administrative resources currently devoted to eligibility functions at the county level:

- System interfaces between CBMS and IEVS (Income Eligibility and Verification System with Department of Labor and Employment); SSA (Social Security Administration for Citizenship Verification); DMV (Department of Motor Vehicle for Identity Verification); Vital Statistics (automated retrieval for Citizenship Verification with Department of Public Health and Environment); and

- Express Lane Eligibility, including administrative renewals.

These activities currently have a target implementation date of summer of 2011. CMS encourages the State to ensure the timely implementation of these activities in order to expedite processing timelines, reduce administrative costs at the county and state level and ultimately improve access to Medicaid and CHP+ benefits for all Colorado residents.

- Colorado Program Eligibility and Application Kit (PEAK) Web Application

  The PEAK is a Web-based portal designed to provide clients and community partners with a modern and easily accessible tool to apply for public assistance benefits. Currently, the State has implemented phase 1 of this project which allows applicants to self-screen for Colorado public assistance benefits, including Medicaid and CHP+, on the internet prior to completing an application. CMS commends the State for this initiative that moves the State closer to eligibility simplification and modernization. The PEAK project's phase 2 activities, including full web-based access to Medicaid and CHP+ application processing, would continue to enhance the State's ability to process applications in a timely basis as well as reduce burdens created by paper-based processes for Colorado applicants. CMS understands that, originally, Phase 2 of this initiative was scheduled to be implemented in 2010, but due to delays this has not taken place. CMS requests that the State provide a new revised timeline specifying when this second phase will be implemented.

  State Response:

  Phase 1 of PEAK was implemented in October 2009. Phase 2 of PEAK implementation will be completed in the summer of 2011.

- Intelligent Data Entry – the governor's Office of Information Technology (OIT), the Colorado Department of Human Services (CDHS) and the Department contracted with Deloitte consulting to implement the Web-Based Intelligent Data Entry (IDE) enhancement. This enhancement aims at realigning the Colorado Benefits Management System (CBMS) with the needs of the eligibility workers as well as the collective mission of the Departments. Once implemented, this project could also reduce administrative costs associated with paper-based processes and further the

State's efforts of modernizing Medicaid eligibility processes. CMS requests a timeline for implementation of this enhancement.

State Response:

IDE (CBMS Web) was fully implemented on April 30, 2011.