Colorado Department of Health Care Policy and Financing

Medical Eligibility Quality Improvement Plan (MEQIP) Manual

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Overview and Strategic Direction

The mission of the Colorado Department of Health Care Policy and Financing (the Department) is to improve access to cost-effective, quality health care services for Coloradans.

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

Administration

The Department is the single state agency responsible for the administration of the state's public health insurance programs. The Department oversees all medical eligibility sites which include county departments of human service sites, Medical Assistance (MA) sites and an eligibility and enrollment broker to administer CHP+. These sites accept medical assistance cases and determine eligibility for applicants. Each site is structured in its own unique way based on available resources, size, and geography.

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

A key component in the Department's oversight of the eligibility determination and enrollment process is a comprehensive monitoring program. The Department's monitoring of public and private partners is fundamental to ensure that public funds are spent effectively and provide health care for eligible Coloradans. For statutory authority and rule references see Appendix G.

Quality Assurance (QA)

The Department is continually monitoring and assessing the performance of eligibility sites through several different approaches. MEQIP is part of the QA activities that occur along with audits and reviews performed through the Medicaid Eligibility Quality Control (MEQC) pilots, Payment Error Rate Measurement (PERM) audits, County single statewide audits, Office of the State Auditor (OSA) audits, and other state or federal reviews. The Department's Monitoring and Quality Section within the Eligibility Division reviews the annual and quarterly improvement plans submitted by the eligibility sites for MEQIP. The Monitoring and Quality Section routinely performs on-site and desk reviews for quality assurance purposes and includes MEQIP within those reviews. Thus, it is imperative eligibility sites maintain records of the cases they have sampled and reviewed for the standardized quarterly report.

Targeted Improvements

The Department identified five performance improvement measures which have been categorized as critical activities through a variety of the Department's assessment efforts.

Eligibility sites are required to develop and implement business processes that assure timely processing, accuracy of data entry, proper case file documentation, accurate authorizations and accurate disenrollment's. Each eligibility site is required to develop and implement a procedure for reviewing the accuracy of the target improvement areas on four case files per number of medical eligibility workers per month and implement corrective action plans when the Department deems necessary. These target improvement areas are:

Timely Processing

Timely processing of applications results in increasing individual's access to medical assistance.

Data Entry

Accurate data entry assures the accuracy of determinations of both eligible and ineligible individuals.

Case File Documentation

Sufficient verifications in case files support the eligibility determinations. Two major areas of focus are: (1) The eligibility site's ability to produce the case for the Department and/or external auditors to review; and (2) the eligibility site's ability to obtain and maintain verification to support the eligibility determination.

Correct Authorization

Accurate authorizations, by reviewing wrap up prior to authorization, assure the accuracy of determinations of both eligible and ineligible individuals within CBMS. Incorrect authorizations increase payment errors, can cause funding discrepancies, and allow system errors to go unnoticed when a help desk ticket should have been submitted.

Accurate Disenrollment's

Ensuring case file samples are reviewed for individuals who become disenrolled from the program; the goal is to identify the amount of time between notification and the action to disenroll was done timely and extensions limited as defined by the Department.

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

Expected Outcomes

Through the continued use and compliance with the MEQIP standards the Department expects the following outcomes.

1. Eligibility determined in a timely and accurate manner according to federal guidelines.
2. Case files, across the state, to have sufficient documentation to support all eligibility determinations.
3. Data entry errors and inaccurate authorization errors to decrease.

4. Eligibility sites demonstrate adequate controls over timely processing, case file documents, data entry, and accurate authorizations.
5. The gathering and sharing of best practices across Colorado.
6. Predictability and consistency of results throughout Colorado.
7. The continued improvement of efficiently and effectiveness throughout eligibility sites.
8. Improved business processes through best practices and testing of business processes/steps.
9. Outcomes based on consistent and accurate statistics and information from available data sources. These statistics will show a consistent improvement of error rates across Colorado.
10. Improved picture of eligibility site needs through the monitoring of quarterly statistics.
11. Improved picture of statistics compared across Colorado.
12. Corrective action plans implemented as a result of the quality improvement plan.
13. Eligibility sites develop a program by which eligibility site staff is consistently trained with the right information at the right time.
14. Eligibility site staff adequately trained on the state eligibility determination system (CBMS) and on eligibility policies and procedures.
15. MEQIP results direct training by eligibility site trainers.
16. It is required that eligibility sites review 2 additional cases for individuals who become disenrolled from the program; the goal is to identify the amount of time between notification and the action to disenroll was done timely and extensions limited as defined by the Department.

Objectives

All eligibility sites shall participate in the MEQIP by:

1. Submitting an annual Quality Improvement Plan (QIP) to the Department.
2. Monitoring and evaluating their sites eligibility activities.
3. Performing supervisory case reviews to evaluate timely processing, data entry accuracy, case file documentation and accurate authorizations.
4. Submitting the MEQIP standardized quarterly report by the scheduled due dates.
5. Responding to all inquiries from the Department within the timeframes requested by the Department.
6. Upon request from the Department the site shall complete a quality improvement plan worksheet (Appendix F) or Plan Do Study Act (PDSA) (Appendix G).

MEQIP Process for Medical Eligibility Sites

The Annual Plan

The Annual Plan for medical eligibility sites is designed to provide a formal ongoing process to measure, monitor, and evaluate the quality of administrative eligibility activities. A report must be submitted to the Department **by March 31st of each year** identifying how the eligibility site shall perform self-monitoring of case reviews and staff; how the applications are selected; describes the entire review process; outlines trainings, training methods, and training results; contains methods to consistently monitor, review and improve performance.

The following must be included:

1. Auditing, training, business process improvement efforts, current organizational chart, contact list, case review tool, customer service mission statement, complaint policy, process for completing a Medicaid application, and mission or vision statement
2. The complaint policy must include contact information where the individual can submit their concerns either orally, by letter, e-mail, or fax
3. Standardize protocols, tools and procedures to monitor and ensure the accuracy of the five key performance indicators
4. Analyze monthly or quarterly review findings and execute appropriate process improvement efforts

Annual Plan Process

Summary

The process below will provide guidance on how to monitor the quality measures defined in the MEQIP and how to report them to the Department. Eligibility sites are responsible for submitting a complete annual Quality Improvement Plan (QIP) by **March 31st** of each year. Ongoing standardized quarterly reports shall be submitted to the Department to monitor quality improvement measures. Forms provided in this process must be utilized to complete the QIP and quarterly reports.

Minimum Requirements

The following performance improvement measures are part of the minimum requirements submitted to the Department as a component of the annual QIP.

Performance Improvement Measures

- **Timely Processing Goal:** Ensure that applications are processed within timeframes established by federal regulation (42 C.F.R Sec. 435.911)
- **Data Entry Goal:** Ensure that accurate data is entered into the Colorado Benefits Management System (CBMS)
- **Case File Documentation Goal:** Ensure case files contain the information necessary to support the eligibility determination and authorization
- **Correct Authorizations Goal:** Ensure that before a program is authorized, wrap up windows are reviewed for each individual to determine if they are eligible for the

appropriate program. If an individual is passing for the incorrect eligibility, then review the data entry on the case and make the data error corrections. After the data entry corrections are completed and the individual continues to pass for the incorrect eligibility then submit a help desk ticket.

- **Accurate Disenrollment's:** Ensure case file samples are reviewed for individuals who become disenrolled from the program; the goal is to identify the amount of time between notification and the action to disenroll was done timely and extensions limited as defined by the Department.

Improvement Strategies

- Develop and maintain a business process that meets or exceeds federal guidelines for processing applications timely
- Develop an internal case review process which includes:
    - Review of a minimum of six randomly selected new applications and Re-determination, Re-certification or Reassessment (RRR) per the number of medical eligibility workers per month
    - These case reviews must be pulled from a sample that includes all medical programs
    - The sample of each county's internal review should include those from the new CBMS automated report that monitors Medicaid recipients who became ineligible are disenrolled from the program in a timely manner, as defined by the Department
    - Timely disenrollment to include a reasonable timeframe for the number of processing days for termination has been determined by the Department as **15 calendar days** for recipients who are determined to be ineligible
    - Timely disenrollment to include a reasonable timeframe for good faith extensions has been determined by the Department to a maximum of six months
    - Eligibility sites that receive application or RRR must be processed by the eligibility worker through CBMS determination and authorization
    - PEAK Real Time Eligibility applications will be excluded from case reviews since they are not completed by a worker
    - Add-A-Babies will be excluded from case reviews
    - At RRR, cases that do not have current income & resources will pend for updated verification. The Department expects to see a thorough review of changes to the case from applicants, RRR's or other high-level programs that may be attached. All verifications received must be processed timely.
    - The supervisory reviewer is responsible for pulling a random sample and documenting the methodology for randomization, all case reviews, submission of the quarterly report and annual quality improvement plan
    - Submit the monthly review findings each quarter to the Department electronically using the Standardized Quarterly Report
    - Reviews can be done at the eligibility site's discretion, if the basic guidelines are followed and within the reporting period
    - Errors entered into the "Data" tab must include all errors found within the five target improvement areas. The "Cases" tab must include every case number that was reviewed for that review period

    - The "Narrative" tab must include: the most common errors, type of errors, any issues that occurred during the month, best practices, concerns, discrepancies, outliers, reasons for significant changes in error rates (such as time away from work) internal training programs, and training in relation to quality improvement efforts
- Train eligibility site staff on the new tools and procedures
- Monitor the monthly error rates and establish processes to improve eligibility determinations; document these errors in the Standardized Quarterly Report
- Utilize results to develop future quality improvement efforts and goals

MA Timely Disenrollment

- The Department created four disenrollment reports that monitor and track all Medicaid disenrollment's. Eligibility sites are required to use the MA Timely Disenrollment report that captures high risk individuals, as defined by the Department as whereabouts unknown and not a Colorado resident, who were terminated for Medical Assistance in the previous month, when selecting the number of required cases for the monthly case file reviews.
- The goal is to identify and measure the amount of time between notification, and the action taken to disenroll the individual from Medical Assistance and ensuring the disenrollment was done timely and accurately as defined by the Department.
- The new reports are now available and can be used to pull the necessary random sample to satisfy the new requirements. Each eligibility site is required to review and randomly select 2 additional case reviews per worker from this report to ensure individuals are timely disenrolled from Medical Assistance. The results of the review will be entered in the MEQIP Quarterly Report under the new measure "Accurate Disenrollment." This process will begin in the Quarter 4 report (April, May, & June) submission to MEQIP is due August 1st, 2018.
- The report can be pulled any time after the 2nd Sunday of each month and is available in CSV, Excel or PDF format. The report location can be found in COGNOS under the Team Content>>Application Reports>>MA Audit>>MA Timely Disenrollment Report.

The Annual Quality Improvement Plan (QIP)

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

1. Establish a quality improvement plan that includes auditing, training, business process improvement efforts, current organizational chart and contact list, case review tool, customer service mission statement, complaint policy, document/chart of process for completing a Medicaid application, site mission and/or vision statement.
2. Develop and standardize protocols, tools and procedures to monitor and ensure accurate data entry, timely determinations, sufficient case file documentation, and accurate authorizations.
3. Conduct standardized case reviews in accordance with the Department's schedule.
4. Analyze monthly and/or quarterly review findings and execute appropriate process improvement efforts.

Conclusion

MEQIP is a tool for the Department and eligibility sites to continue quality improvement efforts. With this tool, important benchmarks are established for reliable measurement of current processes and procedures that are utilized throughout eligibility sites. MEQIP will guide the Department in supplying the appropriate resources to trainings, tools and communication as demonstrated through standardized quarterly reports and information supplied by the eligibility sites. MEQIP is pivotal in aligning the goals of the Department and eligibility sites towards continuous quality improvement.

Appendix A

Definitions

Accurate Authorization: Individuals, eligible and ineligible, are accurately determined and authorized within CBMS.

Annual Quality Improvement Plan: A report that is submitted to the Department by March 31st of each year which identifies how the eligibility site shall perform self-monitoring of cases and staff; how the applications are selected; describes the entire review process; outlines trainings, training methods, and training results; contains methods to consistently monitor, and review improve performance. Documents that must be included with the QIP are: Business Process Plan for Medical applications or Value Stream Map for Medical applications, Current Organizational Chart, Case Review Tool, Agency Phone/Contact List, Customer Service Mission Statement, Complaint Policy, Mission and/or Vision Statement. These reviews, findings, and documents will create best practices to improve the sites business process.

Case File Documentation: Case files must have sufficient documentation or verifications to support all eligibility determinations, authorizations and timely processing of case files.

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

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

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

Colorado Department of Health Care Policy and Financing (the Department): The Department is the single state agency responsible for administering the Medicaid program (Title XIX) and the State Child Health Insurance Program (Title XXI), known as the CHP+.

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

Data Entry Errors: Errors that result in inaccurate medical eligibility determinations and/or cost differentials.

Eligibility Site: Eligibility sites serve as agents of the Department and are charged with the administration of medical assistance programs and related activities in accordance with the rules of the state department. Counties and Medical Assistance sites are referred to as eligibility sites.

Eligibility Site Contact: An individual who is the MEQIP contact for an eligibility site. This individual can be the same person as the Eligibility Site Supervisory Reviewer.

Fiscal Year: Defined as a period from July 1st through June 30th.

Foster Care and Subsidized Adoption: Children who are enrolled in the Foster Care or the Subsidized Adoption program are automatically eligible for Medicaid; therefore, no application is submitted. These individuals are not a part of the Medical Eligibility Quality Improvement Plan.

Medicaid: Colorado Medicaid is public health insurance for families, children, pregnant women, persons who are blind or persons with disabilities and the elderly. Participants are required to must be a Colorado resident.

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

MEQIP: Medical Eligibility Quality Improvement Plan is the framework to measure ongoing initiatives that improve access to Colorado's public health care insurance programs. MEQIP includes the annual quality improvement plan and the quarterly supervisor reviews and improvement plans.

Timely Disenrollment:
A disenrollment is based on a change in circumstance that affects a member's eligibility and makes them ineligible for coverage within Health First Colorado (Colorado's Medicaid Program) or Child Health Plan Plus (CHP+). A timely disenrollment is defined as processing a change in circumstance and making a determination within 15 calendar days.

Supplemental Security Income (SSI): Individuals who receive SSI are automatically eligible for Medicaid; therefore, no application is submitted. These individuals are not a part of the Medical Eligibility Quality Improvement Plan.

Re-determination, Re-certification or Reassessment (RRR): A review of income, resources, and living arrangements to determine if an applicant remains eligible for a Medical Assistance program.

Standardized Quarterly Report: A report submitted to the Department quarterly which identifies the number of medical eligibility site workers being reviewed; the number of cases reviewed each month; the number of untimely processed applications and/or cases, and the number of errors for data entry, case file documentation, and inaccurate authorizations. Each quarterly report includes the CBMS case numbers reviewed for that quarter and a narrative section to address the most common errors, any issues that occurred during the month, best practices, concerns, discrepancies, outliers, and reasons for significant changes in error rates, etc.

Supervisory Review: Case reviews performed on a quarterly basis to evaluate timely processing, data entry accuracy, case file documentation and accurate authorizations for each eligibility site. These case reviews must be conducted by an eligibility site supervisor or a qualified individual designated by the supervisor to perform reviews, but ultimate responsibility falls on the eligibility site supervisor.

Timely Processing: Ninety days for applicants who apply for Medicaid based on disability; and forty-five days for all other applicants (as established in 42 CFR 435.911).

Untimely Processing: Applications that exceed the processing guidelines (as established in 42 CFR 435.911).

Performance Measures: Key areas in the eligibility determination process that have been identified for quality improvement strategies.

Appendix B

Medical Eligibility Quality Improvement Plan Tool Kit

Summary

This Tool Kit contains guidance on how to monitor the quality measures defined in the MEQIP and how to report them to the Department. Eligibility sites are responsible for submitting a complete annual Quality Improvement Plan (QIP) by March 31st of each year. Ongoing standardized quarterly reports shall be submitted to the Department to monitor quality improvement measures. Forms provided in this Tool Kit must be utilized to complete the QIP and quarterly reports.

Minimum Requirements

The following performance improvement measures are part of the minimum requirements submitted to the Department as a component of the annual QIP.

Performance Improvement Measures

- **Timely Processing Goal:** Ensure that applications are processed within timeframes established by federal regulation. (42 C.F.R Sec. 435.911 as stated in Appendix B)
- **Data Entry Goal:** Ensure that accurate data is entered into the Colorado Benefits Management System (CBMS).
- **Case File Documentation Goal:** Ensure case files contain the information necessary to support the eligibility determination and authorization.
- **Correct Authorizations Goal:** Ensure that before a program is authorized that each individual is reviewed and is eligible for the appropriate program. If an individual is incorrectly determined by CBMS submit a help desk ticket.
- **Accurate Disenrollment Goal:** Ensure case file samples are reviewed for individuals who become disenrolled from the program; the goal is to identify the amount of time between notification and the action to disenroll was done timely and extensions limited as defined by the Department.

Improvement Strategies

- Develop and maintain a business process that meets or exceeds federal guidelines for processing applications timely.
- Develop an internal case review process which includes:
    - Review of a minimum of four randomly selected new applications and Re-determination, Re-certification or Reassessment (RRR) per the number of medical eligibility workers per month.
        - These case reviews must be pulled from a sample that includes all medical programs.
        - These applications and RRR's must be processed through eligibility determination and authorization.
        - Auto-re-enrolled cases will have the same review process as any other case. The Department expects to see a thorough review of changes to the case from applicants or other high-level programs that may be attached.

        - The supervisory reviewer is responsible for pulling a random sample and documenting the methodology for randomization, all case reviews, submission of the quarterly report and annual quality improvement plan.
    - Submit the monthly review findings each quarter to the Department electronically using the Standardized Quarterly Report.
        - Reviews can be done at the eligibility site's discretion, as long as the basic guidelines are followed and within the reporting period.
        - Errors entered into the "*Data"* tab must include all errors found within the four target improvement areas. The "*Cases"* tab must incl*ude e*very case number that was reviewed for that review period.
        - The "*Narrative"* tab must include: the *most* common errors, any issues that occurred during the month, best practices, concerns, discrepancies, outliers, reasons for significant changes in error rates, internal training programs, and training in relation to quality improvement efforts.
- Train eligibility site staff on the new tools and procedures.
- Monitor the monthly error rates and establish processes to improve eligibility determinations; document these in the Standardized Quarterly Report.
- Utilize results to develop future quality improvement efforts and goals.

MEQIP Reporting Period

MEQIP Quarterly Report	**Reporting Period**	**Due Date** (Please note: if the due date falls on a non-working day then submit the report the 1st working day after due date)
MEQIP Quarter 1 Report	July, August, & September	November 1st
MEQIP Quarter 2 Report	October, November, & December	February 1st
Revised Annual Plan	July 1st- June 30th	March 31st
MEQIP Quarter 3 Report	January, February, & March	May 1st
MEQIP Quarter 4 Report	April, May, & June	August 1st

*Sites that do not submit a quarterly report will automatically receive 0% accuracy for each of the 4 Performance Improvement Measures.

*Sites that do not perform all of the case reviews per the number of workers will automatically receive a 3% accuracy deduction for each of the 4 Performance Improvement Measures.

Random Sampling Methodology

For the MEQIP case reviews, the defined population is the new applications and RRR's for the respective quarter. A sample must be pulled from within the population from the quarter being reported. Each site must decide what sampling methodology to utilize. A sampling methodology is a procedure for selecting a subset of individuals from within a population. There are a variety of methods and programs that use random generators for selection.

Simple random sample is choosing a subset of individuals/cases (a sample) from a larger set (population or universe). Each individual/case is chosen randomly and entirely by chance, such that each individual/case has the same probability of being chosen at any stage during the sampling process, and each subset of individuals/cases has the same probability of being chosen for the sample as any other subsets.

Systematic sampling relies on arranging the target population according to some ordering scheme and then selecting elements at regular intervals through that ordered list. Systematic sampling involves a random start and then proceeds with the selection of every k^{th} element from then onwards. In this case k= (population size/sample size). It is important that the starting point is not automatically the first in the list but is instead randomly chosen from within the first to the k^{th} element in the list. A simple example would be to select every 10^{th} individual/case name from a list (an 'every 10th' sample, also referred to as 'sampling with a skip of 10').

Appendix C

Case Review Tool

Each eligibility site must utilize a case review tool to perform the quarterly reviews. The tool must be submitted with the annual QIP.

Acceptable tools shall include, but are not limited to, the following:

All Medical Programs	
Income	Timely Processing
Citizenship	Data Entry
Identity	Case File Documentation
Effective Begin and End Dates	Authorization
Case Comments	
Adult Medical Programs (additional requirements)	
Disability Determination	Resources
5615	Expenses
ULTC 100.2	

If your eligibility site would like an example of a MEQIP case review tool please contact the MEQIP inbox at meqip@hcpf.state.co.us.

Medical Eligibility Site Annual Quality Improvement Plan

Complete this form and submit to the Department for review. If you have any questions on the information being requested, reference the MEQIP Manual or contact Medicaid.Eligibility@hcpf.state.co.us.

Eligibility Site Information:

Site Name: _____

Date Submitted to the Department: _____

Annual QIP for Fiscal Year: _____

Site Contact Name: _____

Site Contact Phone Number: _____

Site Contact Email: _____

Section 1: Eligibility Site Documents

Include a copy of each of the below documents. If your site does not have this document, explain why and give a date when this document will be sent to the Department.

1. Business Process Plan for Medical applications (written description of your process)
   or
   Value Stream Map for Medical applications (picture of your process - Appendix E)
2. Current Organizational Chart
3. Case Review Tool
4. Agency Phone/Contact List
5. Customer Service Mission Statement
6. Complaint Policy
7. Mission and/or Vision Statement

Section 2: Eligibility Site Processing Information

Enter the number of support staff who assist in Medical Assistance program determinations: _____

Enter the number of technicians who process Medical Assistance applications and RRRs for the following:

- Family Medicaid (FM) and Child Health Plan *Plus* (CHP+) only: _____
  - Explanation: | |

- Long-Term Care (LTC) and Adult Medicaid (AM) only: _____
    - Explanation:

- Total Number of technicians who work Medical programs: _____
    - Explanation:

- Combination Cases (Example: FM and Food Assistance): _____
    - Explanation:

Enter the average caseload per technician for the following:

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

Section 3: Sampling Methodology

Identify the sampling methodology used by your site for identifying applications and/or RRRs for MEQIP case reviews.

Enter the contact information for the person who pulls the sample for review:

Job Title: _____

Name: _____

Phone: _____

Email: _____

Explain how the sample is pulled. Please be specific (Reference Appendix B of the manual):

Example sample review:

Enter the frequency of the sample reviews (weekly, monthly, quarterly, etc.):

Additional Comments:

Section 4: Review of Performance Improvement Measures

This section should include information detailing maintenance of review materials and the internal review process for the four key performance improvement measures for your site: timely processing, case file documentation, data entry, and accurate authorization. Reviews should be conducted by a supervisor.

Enter the contact information for the person performing the reviews:

Job Title: _____

Name: _____

Phone: _____

Email: _____

Explain how the reviews are performed at your site. Please be specific (Reference Section Appendix B of the manual).

Describe the review process at your site:

How are repeat errors addressed?

Who corrects errors found in the review samples?

How are review materials maintained?

Additional comments:

Section 5: Monitoring and Training

Explain your site's process for utilizing the case review results in the following areas.

Training protocols:

Performance measurements:

Areas for improvement:

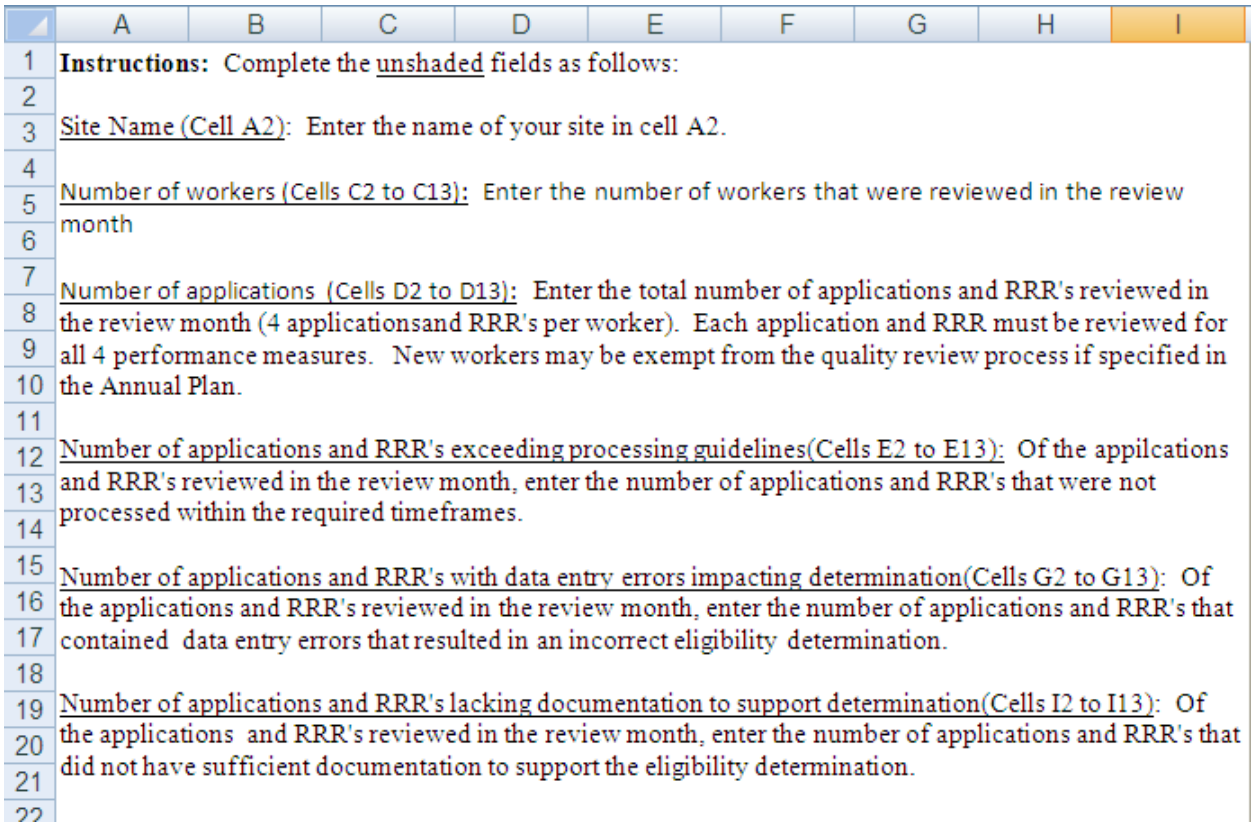
Efficiencies:

Business process improvements:

Additional comments:

Appendix D

How to Complete the Standardized Quarterly Report



Instructions: Complete the unshaded fields as follows:

Site Name (Cell A2): Enter the name of your site in cell A2.

Number of workers (Cells C2 to C13): Enter the number of workers that were reviewed in the review month

Number of applications (Cells D2 to D13): Enter the total number of applications and RRR's reviewed in the review month (4 applicationsand RRR's per worker). Each application and RRR must be reviewed for all 4 performance measures. New workers may be exempt from the quality review process if specified in the Annual Plan.

Number of applications and RRR's exceeding processing guidelines(Cells E2 to E13): Of the appilcations and RRR's reviewed in the review month, enter the number of applications and RRR's that were not processed within the required timeframes.

Number of applications and RRR's with data entry errors impacting determination(Cells G2 to G13): Of the applications and RRR's reviewed in the review month, enter the number of applications and RRR's that contained data entry errors that resulted in an incorrect eligibility determination.

Number of applications and RRR's lacking documentation to support determination(Cells I2 to I13): Of the applications and RRR's reviewed in the review month, enter the number of applications and RRR's that did not have sufficient documentation to support the eligibility determination.

Instructions Tab

Please note that the first tab in the **Standardized Quarterly Report** is instructions on how to complete the report.

	A	B	C	D	E	F	G	H	I	J	K	L
1	Site Name	Review Month	Number of workers	Number of applications and RRR's reviewed	Number of applications and RRR's exceeding processing guidelines	Timely processing	Number of applications and RRR's with data entry errors impacting determination	Data entry	Number of applications and RRR's lacking documentation to support determination	Documentation	Number of applications and RRR's incorrectly authorized	Accurate Authorization
2	Site Name	Jan-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
3	Site Name	Feb-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
4	Site Name	Mar-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
5	Site Name	Apr-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
6	Site Name	May-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
7	Site Name	Jun-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
8	Site Name	Jul-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
9	Site Name	Aug-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
10	Site Name	Sep-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
11	Site Name	Oct-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
12	Site Name	Nov-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
13	Site Name	Dec-12				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!

Data Tab (complete the un-shaded fields as follows):

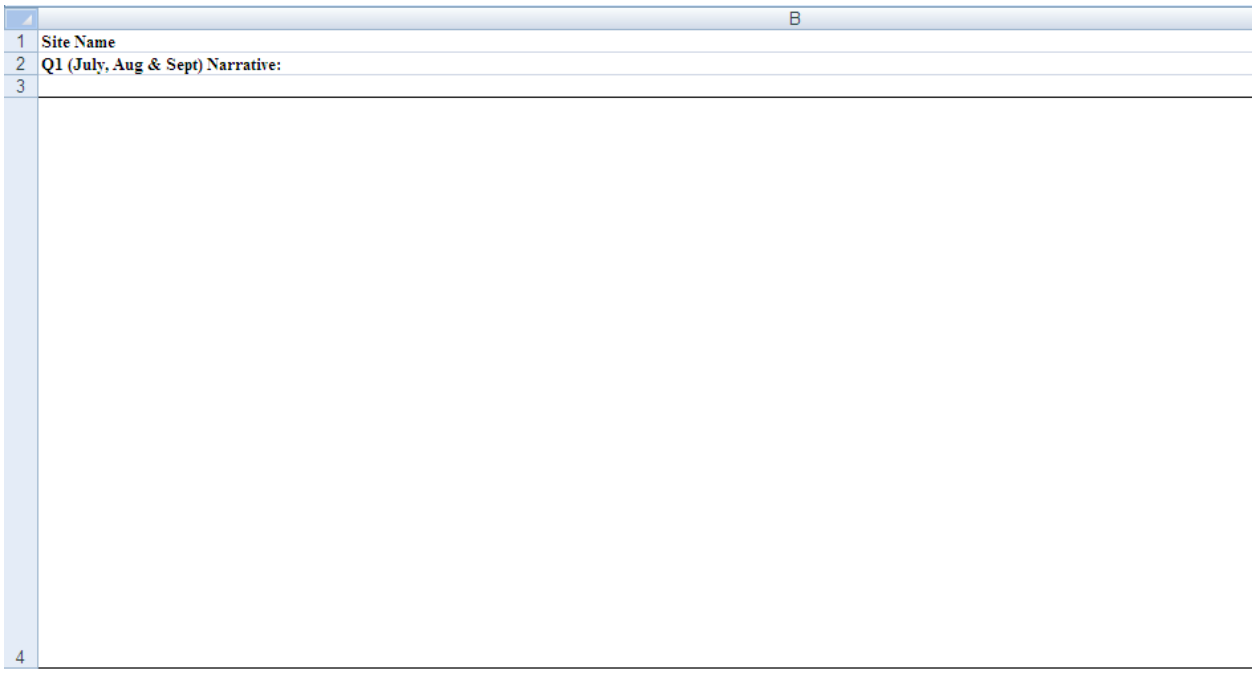
- **Site Name (Cell A2)**: Enter the name of your site in cell A2.
- **Number of workers (Cells C2 to C13)**: Enter the number of workers that were reviewed in the review month.
- **Number of applications and RRRS (Cells D2 to D13)**: Enter the total number of applications and RRR's reviewed in the review month (4 applications and RRR's per worker). Each application and RRR must be reviewed for all 4 performance measures.
- **Number of applications and RRR's exceeding processing guidelines (Cells E2 to E13)**: Of the applications and RRR's reviewed in the review month, enter the number of applications that were not processed within the required timeframes.
- **Number of applications and RRR's with data entry errors impacting determination (Cells G2 to G13)**: Of the applications and RRR's reviewed in the review month, enter the number of applications that contained data entry errors that resulted in an incorrect eligibility determination.
- **Number of applications and RRR's lacking documentation to support determination (Cells I2 to I13)**: Of the applications and RRR's reviewed in the review month, enter the number of applications that did not have sufficient documentation to support the eligibility determination.
- **Number of applications and RRR's inaccurately authorized (Cells K2 to K13)**: Of the applications and RRR's reviewed in the review month, enter the number of applications that were not accurately authorized.

	A	B	C	D
1	Q1 (July, Aug, & Sept) Case #'s	Q2 (Oct, Nov, & Dec) Case #'s	Q3 (Jan, Feb, & March) Case #'s	Q4 (April, May, & June) Case #'s
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				

Cases Tab

For each quarter complete the **Cases tab** by listing the CBMS case number of each reviewed case under the applicable quarter column.

- **Cases:** Use the mouse to click in the applicable quarter column and in row 2 type the first CBMS case number. Continue down the column until all CBMS case numbers, that were reviewed for that quarter, have been entered.



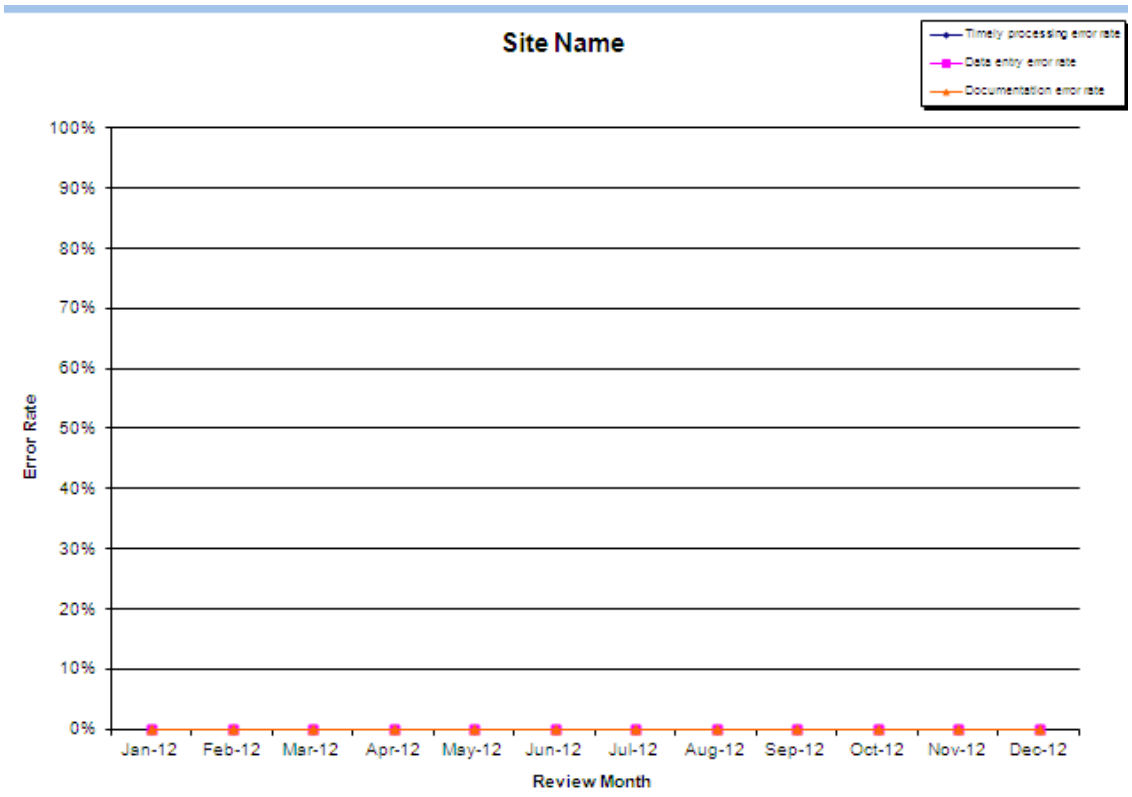
Narrative Tab

For each quarter complete the applicable **Narrative tab**

- **Narrative (Cells B4)**: Use the mouse to click in cell B4 and begin typing. After you have completed typing the narrative push enter.

In the narrative tab include: the most common errors, any issues that occurred during the month, best practices, concerns, discrepancies, outliers, reasons for significant changes in error rates, internal training programs, training in relation to quality improvement efforts, knowledge of the subject trained through testing, and on the job performance.

Please note that if you correctly complete the Data tab your site name will appear on each of the **Narrative tab**.



Performance Measure Summary tab

If you correctly completed the **Data tab** your site's name will appear on the **Performance Measure Summary tab** and your chart will be populated from the data, you entered on the **Data tab**.

Appendix E

A Business Process Plan for Medical applications (written description of your process) may be submitted in lieu of a Value Stream Map for Medical applications. If you choose to submit a value stream map you may use the below document to help you in the creation of one. Both a Business Process Plan for Medical applications or a Value Stream Map for Medical applications must include data (delay time, lead time, work in progress).

Drawing a Value Stream Map

A value stream map is a picture of a service from start to finish. It is similar to, although not the same as a process map or a flow chart. A value stream encompasses all of the steps in a process, those steps that add value to delivering a service and those steps that do not add value to delivering the service. The value stream is how work flows and it is about the movement of people and information.

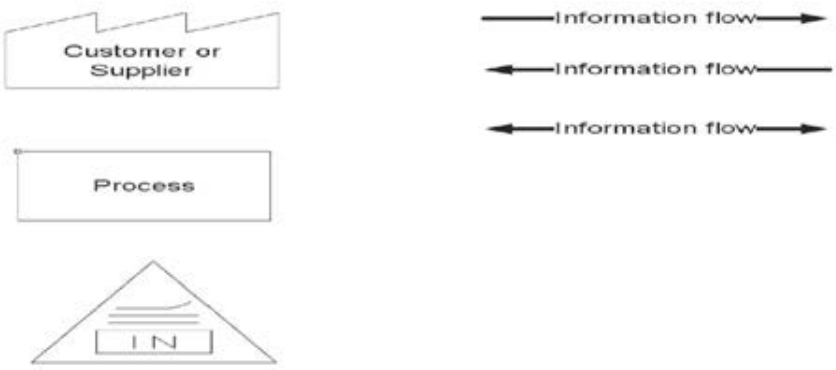
Preparing a value stream map is an initial step in the development of business process improvement.

The goal of value stream mapping is to learn about your system from the customer's perspective and from the perspective of your colleagues in the system. A value stream map is a learning tool; do not become paralyzed by searching for the perfect data or designing a perfect value stream map.

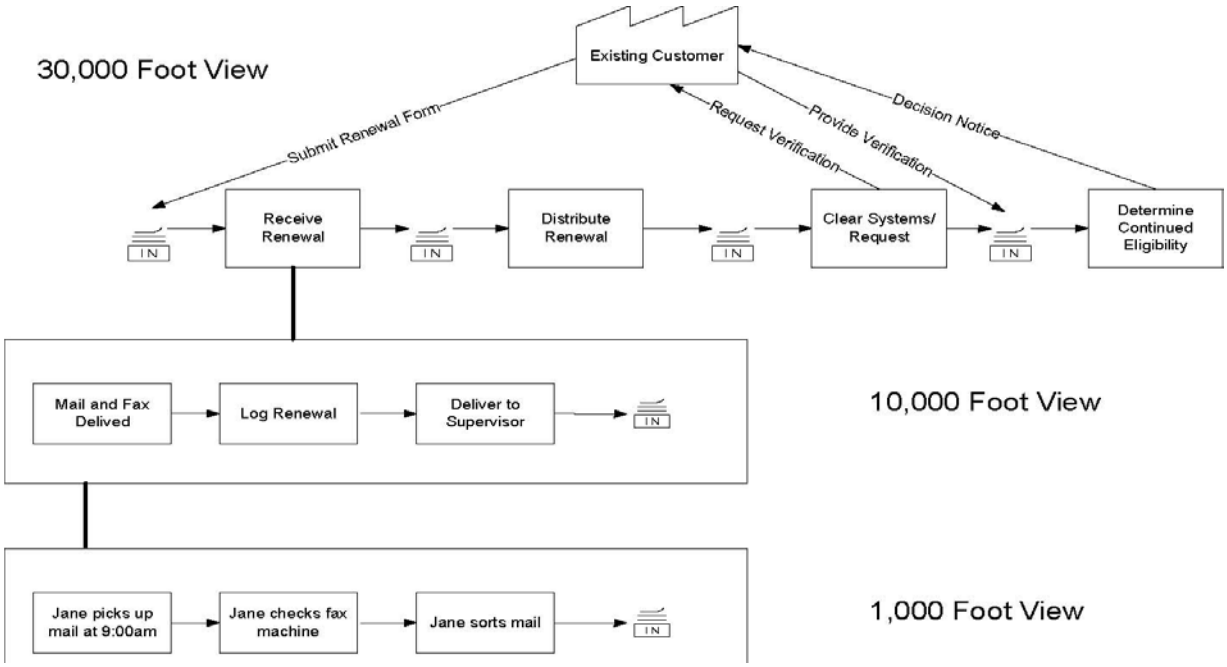
The instructions for drawing your value stream map are below. You can use a software application like PowerPoint, Visio, or you can draw by hand.

1 The first box to draw relates to the applicant who is the supplier of the request for an eligibility determination and the customer.
2 Next draw the process boxes for application determination.
3 Draw an inbox that immediately precedes each process box.
4 Draw arrows for process direction.
5 Draw arrows for information flow.
6 Draw as the process is not how it should be.

Use the below mapping icons to draw out your process:



For this value stream map, we are going to look at your Medical application process from a 30,000-foot level. The picture below is an attempt to help you gauge the degree of detail.



Every value stream map needs data

The data you will need to collect is:

- Process Time (PT) – Actual time an item is touched (worked on); exclude interruptions. Example: A worker updates an address, but during this time the worker receives a phone call. The PT is the time it takes to update the address only, not to answer the phone.

- Delay Time (DT) – Time work item is delayed, not touched, sitting in an inbox, drop box, on a desk (any time the application is waiting). Example: A worker updates an address, but during this time the worker receives a phone call. The DT is the time it takes to answer the phone, not update the address.

- Lead Time (LT) – Total time to complete a process step; LT=PT+DT. Example: A worker updates an address, but during this time the worker receives a phone call. The LT is the time it takes to answer the phone and update the address.

- Work in Progress – A count of work, number of applications that is in front of the current one. Example: You put an application in an inbox and there are 3 applications already in the inbox, your work in progress is 3 (3 applications in front of the current one).

You may use the Case Time Sheet, to gather your data attach it to at least one new Medical application (when it is first received) have each person that touches this case complete a section (Date and Time begin and end, action, handoff, and initials). Count the time in minutes, hours or days as appropriate for at least one person or take an average of two to three workers. A worker can keep their own time, or an observer can use a stopwatch and record the time. Because measuring time can produce anxiety, it is important to communicate that the purpose is to better understand the process to make improvements. Include this data on your 10,000-foot value stream map.

Case Time Sheet

DATE & TIME (action started and ended)	**ACTION: Describe what you did** (attached screen shots, entered into log, called client...)	**Work in Progress: # of applications in front of current one**	**THE NEXT AREA & PERSON** (where is the case taken?)	**INITIALS** (person completing task)
Date & Time (start):				
Date & Time (end):				
Date & Time (start):				
Date & Time (end):				
Date & Time (start):				
Date & Time (end):				
Date & Time (start):				
Date & Time (end):				

Appendix F

Quality Improvement Plan Worksheet

This worksheet may be utilized if an eligibility site needs to submit a quality improvement plan based on errors or findings.

Review Criteria	Quality Improvement Plan (QIP) Submission	YES/NO	Department Comments
If cited for submitting MEQIP quarterly report (over 10 days), define the corrective action plan that will ensure timely submission in the future.		☐	
Address each case error and provide the approriate corrective action plan.		☐	
The date the quality improvement plan will be completed including training all staff.		☐	
The name and contact information of the supervisor responsible for the implementation of the CAP		☐	

Appendix G

Plan Do Study Act (PDSA)

This worksheet may be utilized if an eligibility site needs to submit a quality improvement plan based on errors or findings.

Colorado Eligibility Process Improvement Collaborative **P**lan, **D**o, **S**tudy, **A**ct Cycle Reporting		
Reporting Team:	**Report Date:**	
Project Aim Statement:		
Strategy:		
Cycle #:	**Beginning Date:**	**Completion Date**:
Plan		
Plan: We plan to…. **Plan**: In order to … **Plan**: Prediction … **Plan**: We will collect the following data… (Note: The plan should include **who** will do **what**, **when** and **where** the test will take place.)		
Do (The Action Plan)		
Do: What we did was…		
Study (Analysis)		
Study: What happened was… **Study: We learned that…** **(Include how the results relate to the prediction)** **Study: Surprises…**		
Act		
Act: What decisions were made based on what was learned?		
Act: What we plan to do next is …		

Appendix H

Statutory Requirements – Colorado Revised Statutes Cites

25.5-1-118. Duties of county departments

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

25.5-4-102. Legislative declaration

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

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

(1) (a) Determination of eligibility for medical benefits shall be made by the county department in which the applicant resides, except as otherwise specified in this section. Local social security offices also determine eligibility for Medicaid benefits at the same time they determine eligibility for supplemental security income. The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private service contractor that administers the children's basic health plan, Denver health and hospitals, a hospital that is designated as a regional pediatric trauma center, as defined in section ***25-3.5-703*** (4) (f), C.R.S., and other MA sites determined necessary by the state department to accept medical assistance applications, to determine medical assistance eligibility, and to determine PE. When the state department determines that it is necessary to designate an additional MA site, the state department shall notify the county in which the MA site is located that an additional MA site has been designated. Any person who is determined to be eligible pursuant to the requirements of this article and articles 5 and 6 of this title shall be eligible for benefits until such person is determined to be ineligible. Upon determination that any person is ineligible for medical benefits, the county department, the state department, or other entity designated by the state department shall notify the applicant in writing of its decision and the reason therefore. Separate determination of eligibility and formal application for benefits under this article and articles 5 and 6 of this title for persons eligible as provided in sections ***25.5-5-101*** and 25.5-5-201 shall be made in accordance with the rules of the state department.

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

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

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

Regulations - Code of Federal Regulations Cites

Title 42 Sec. 435.911 Timely determination of eligibility

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

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

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

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

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