Medical Assistance Wrap-Up

Colorado Business Process Reengineering Project

Public Consulting Group

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1. MEDICAL ASSISTANCE WRAP-UP

The two biggest factors impacting a Medical Assistance case are timeliness and accuracy. Timeliness is easy to measure – there are numerous reports agencies have available to them measuring their timeliness for applications and recertifications. Accuracy, meaning if approvals and denials are correct and if members are authorized into the correct Medical Assistance category, are much harder to track.

1.1. WHY IS WRAP-UP IMPORTANT?

One of the tools available to help with accuracy is CBMS Wrap-Up. It is also the best defense mechanism that can be used to prevent an error from even occurring. Wrap-Up is the most critical tool available to eligibility staff when they are processing a Medical Assistance case. It provides information related to each individual member and their eligibility for Medical Assistance benefits. While reading Wrap-Up is critical, there are times when it is skipped or mis-read, leading to incorrect authorizations and denials. These mistakes cost the member, the worker, the county, and the state money and time.

The CBMS Wrap-Up screens help ensure accurate and quality cases. The Wrap-Up screens provide detailed summaries of the information entered into the Interactive Interview screens and used to determine eligibility. Key points to remember about Wrap-Up include:

- Reviewing Wrap-Up can prevent errors.
- It's a quick way to verify the member is in the correct Medical Assistance category.
- Supervisors and quality assurance staff can use it for quick case reviews.

1.2. WHAT GETS IN THE WAY?

If Wrap-Up is used properly, there shouldn't be incorrect Medical Assistance authorizations or denials. This is because workers are authorizing only those cases where they know with certainty that the results showing in Wrap-Up are correct. Audits and case reviews indicate that not all workers are using wrap-up properly – cases are being incorrect approved and denied. Based on this, it may be true that:

- Workers don't understand Wrap-Up or that it is difficult to navigate.
- Agencies don't provide training specifically on how to read and use Wrap-Up.
- Workers aren't applying critical thinking skills – notice, stop, fix.
- Workers are rushing through or skipping Wrap-Up.

The answer is most likely a combination of these three things. The good news is that these can be addressed and fixed through training, organization, and process development.

1.3. TOOLKIT GOALS

This toolkit is intended to provide your agency with Lean strategies and methods that can help you improve the health of your Medical Assistance cases by improving your processes around the use of Wrap-Up. The overarching goal is to help your agency embrace a culture of proactive quality – putting an emphasis on quality up front. A major way to do that is through your use of the Wrap-Up functionality in CBMS.

1.4. HOW TO USE THIS TOOLKIT

This toolkit consists of several key resources. You'll start with the Wrap-Up self-assessment to determine what resources in the toolkit can help your agency develop your proactive quality culture.

- **Wrap-Up Self-Assessment** – a self-assessment for agencies to complete to understand their internal processes and use around Wrap-Up.
- **Building in Quality** – a summary on the Lean idea of building in quality; specifically, the importance of a proactive quality culture.
- **Cost of Medical Assistance Errors** – an informational resource outlining the value of Medical Assistance benefits and how much errors can cost both financially and in time.
- **Lean Methods To Create A Proactive Quality Culture** – two Lean methods to help you diagnose the "why" behind Wrap-Up not being used and how to organize resources to support workers.
- **Critical Thinking and Wrap-Up** – an informational resource outlining the value of critical thinking as a skill for eligibility technicians and how it can be used prior to and after running EDBC.
- **Navigating Post-Transformation Wrap-Up** – tips and tricks for workers to better understand how to navigate post-transformation Wrap-Up.

2. WRAP-UP SELF-ASSESSMENT

Complete this self-assessment to understand your agency's current practices and policies around Wrap-Up.

Question	Yes	No	Notes
Staff receive training in how to read and understand Wrap-Up.	☐	☐	
Staff understand how to navigate post-transformation Wrap-Up.	☐	☐	
Our internal case reviews track Wrap-Up usage.	☐	☐	
Wrap-Up errors are discussed with the worker.	☐	☐	
Staff have easy access to resources (documents) to help them when they have a question.	☐	☐	
Staff have easy access to a lead / supervisor when they have a question.	☐	☐	
We have established policies about how Wrap-Up should be used.	☐	☐	
Staff are instructed not to authorize a case if they don't think the results are correct.	☐	☐	
Staff understand the "value" of Medical Assistance benefits and how much a Medical Assistance error "costs."	☐	☐	

Current internal Medical Assistance **error rate**: _____%

How could we improve our use of the Wrap-Up screens in CBMS?

_____

_____

_____

_____

How do we know if we're being effective with Wrap-Up? For example, is our Medical Assistance error rate low?

3. BUILDING IN QUALITY – A LEAN PRACTICE

Building in quality is a Lean practice supporting the overall effectiveness and quality of an organization. In manufacturing, it helps an organization ensure they are producing products without defects. In service-delivery, the focus is on ensuring the family or member is getting the correct type or amount of benefits.

Preventing an error is much easier than fixing an error. It's important to build in quality – meaning correct eligibility decisions – from the start. Building quality into your processes will make them more efficient and effective because it takes less time to do a quality check prior to authorizing than to fix an error. It's also important to build a quality culture that is **proactive** and not **reactive**.

3.1. REACTIVE QUALITY

Reactive quality cultures emphasize checking for quality after an eligibility decision is made. Errors are identified and reacted to **after** the case has been authorized. Reactive cultures don't add value to the customer – creating performance standards and having a case review process that will not stop an error from happening could be things to consider in your Business Process". A reactive culture could create bottlnecks in your process, customer service concerns, and unnecessary time fixing Medical Assistance cases.

When a case isn't authorized correctly and it is caught by a review – whether it's an internal case review, a state review, or a federal audit, it must be corrected. That means it gets sent back to the eligibility technician and / or county county to re-work and correct. Waste, as it is referred to in Lean, happens every time a case must be reworked because of an oversight or negligence. Some waste is unavoidable, but waste associated with incorrect authorizations is preventable. Incorrect authorizations that are caught and assessed can help you identify where there are opportunities for improvement or where training and process redesign should be focused.[1]

3.2. PROACTIVE QUALITY

Proactive quality cultures focus on building quality into the business process. Process designers explore the types of resources, knowledge, and triggers that can be embedded within the process to help a worker notice, stop, and take the correct action in the name of quality.

Some specific practices an agency can put into place to build a proactive quality culture are outlined below. There are also discussion questions to explore these practices at your site.

Do not accept or authorize an incorrect determination that can't be explained – Workers should be able to explain why the determination showing in wrap-up is correct. If they can't, they shouldn't authorize the case.

[1] https://kanbanize.com/lean-management/improvement/continuous-quality-improvement

What are our practices – what policies do we have in place to support a technician not authorizing a case when there is an error? Are any of our practices creating errors?

What policies do we have in place that support timeliness for the sake of accuracy (e.g. quotas for the number of cases that need to be processed each day)?

What instructions do we give to staff on actions to take when Wrap-Up results appear incorrect?

Incorrect decisions don't leave the person – Any questions about the accuracy of an eligibility decision are resolved by the person who ran EDBC. This means that if there are questions about the determination, the worker seeks out resources (desk aids or people) to help them resolve the question before they authorize the case.

What resources do we have that to help a worker resolve a discrepancy with Wrap-Up?

Can staff easily talk with a lead or supervisor when they have a question about their Wrap-Up results?

Teams proactively take action – Team / unit managers do what is necessary to fix an issue within their team – re-distribute work or resources.

Do teams have discretion to do what's necessary to fix issues?

Do supervisors look at errors across the team or only at the individual level?

Standardized work processes, quality, explicit policies give clear definitions – Value and quality become fundamental business requirements, which are properly communicated and expected at every stage of the workflow.[2]

Do we have work processes to support quality?

[2] https://kanbanize.com/lean-management/improvement/continuous-quality-improvement

Do our policies give clear definitions about the steps to take when an error is found or there is a question?

How quickly after a case is authorized might it be reviewed internally? How quickly are the results communicated with the worker, if they're communicated?

4. LEAN METHODS TO SUPPORT PROACTIVE QUALITY & WRAP-UP

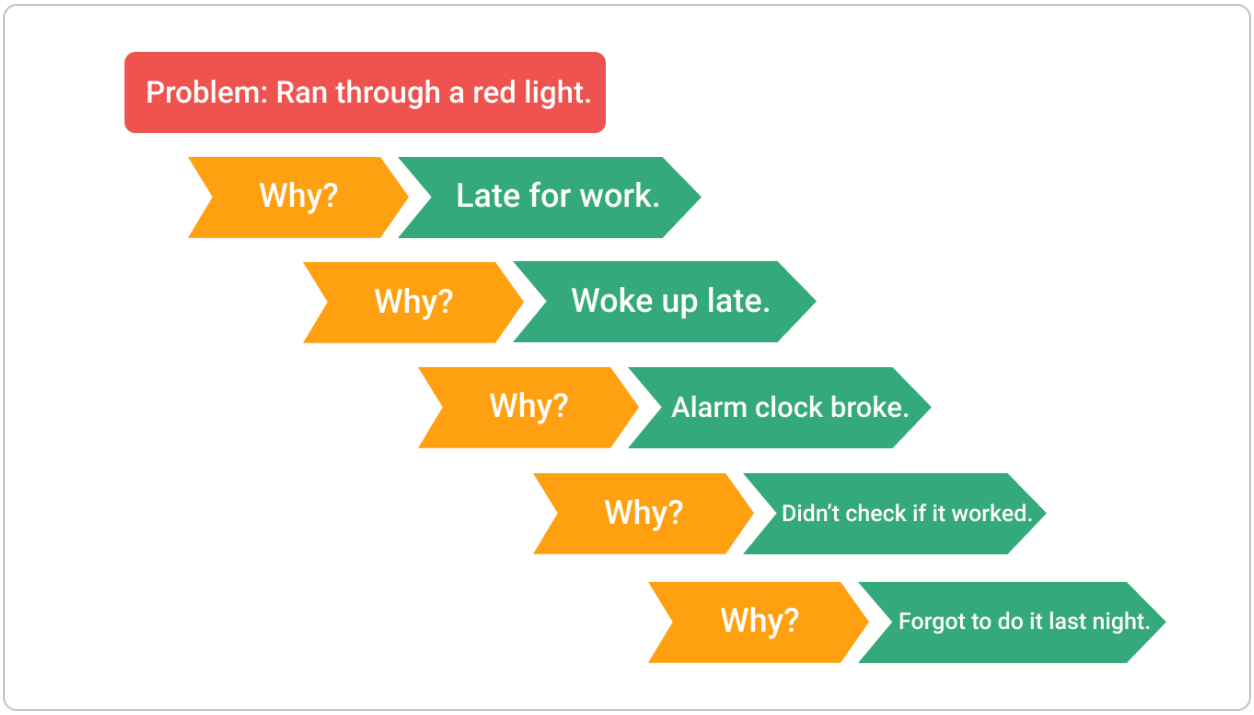
Common Lean methods, such as value stream mapping and waste walks, are a great place to start in building a proactive quality culture. Two less common, but equally effective, Lean methods are 5 Whys and 5S.

4.1. 5 WHYS

If you're having a problem at your site with staff not using Wrap-Up, try using 5 Whys. This is a great technique to help you really get to the root cause of a problem. The 5 Whys method is part of the Toyota Production System and its developer, Taiichi Ohno said "The basis of Toyota's scientific approach is to ask why five times whenever we find a problem… By repeating why five times, the nature of the problem as well as its solution becomes clear."[3]

By asking the question "why" five times, you may find the source of the problem is not what you expected. It will stop you from implementing a solution to a root cause that doesn't actually exist. At the core, the purpose of the 5 Whys method is to make sure you examine a certain problem in depth until it shows you it's true root cause. You may actually need to ask "why" more than 5 times (or less!)

Here's an example of a basic 5 Whys in action:[4]



[3] https://kanbanize.com/lean-management/improvement/5-whys-analysis-tool
[4] Ibid.

Steps to the 5 Whys

There are four steps to the 5 Whys method.

1. **Form a cross-functional team**. You want people from all parts of your agency who use Wrap-Up. This will help you get unique points of view and get enough information to actually make an informed decision.

2. **Define the problem**. With the team, define the problem you're trying to solve (i.e. we skip Wrap-Up, we don't understand Wrap-Up, etc.). Make a clear problem statement to help you define the scope of the issue you're trying to address.

3. **Ask why!** Have a single person act as the "team leader", the person responsible for asking why.

4. **Take action.** Invite the team to come up with countermeasures you can try to address the root cause. Create an action plan and implement a PDSA cycle.

4.2. 5S METHOD

The 5S method and tools are the Lean approach to organizing the workspace so it is effective and efficient. A great way to apply this method to help with Wrap-Up is by exploring the resources you have available to eligibility staff – both human and non-human. What helps a worker when they have a question or need to problem-solve the information they're seeing in Wrap-Up? Implementing 5S can help support eligibility processes, making them run more smoothly and reduce the potential for waste and errors.

Steps in 5S

There are five steps or phases that make up this method. These steps use the example of organizing resources (desk aids, training material, etc.), either in paper or electronic form.

1. **Sift** – This phase is focused on removing resources that aren't needed. They may be irrelevant due to system changes / enhancements or they may just simply not be used by anyone. Unneeded resources can be archived or trashed.

As you look at each resource, consider the following questions:

- What is the purpose?
- When was it last used?
- How frequently is it used?
- Who uses it?[5]

After reviewing the resources, consider tagging them as being kept or removed. Then have a designated period of time where all eligibility staff can review the documents and provide feedback on if the document should be retained or not.

Sort – This phase is focused on organizing the resources you're keeping. You want to make sure the resources are in the best possible location – they aren't going to be helpful if no one can find them. Keep in mind the adage: **"a place for everything and everything in its place."**

The goal is to store resources in a place where they're easy to access when they are needed and their location helps to increase efficiency and decrease waste.[6]

Some questions you should consider:

- How should resources be grouped / organized?
- Where would it be most logical to store resources?

Shine – The focus for this phase is to make sure the resources are cleaned up and shined. For electronic storage, you want to consider:

- How easy you can make it for staff to access the resources – do they have to click into multiple sites or folders?
- How many sub-folders should we use?
- What is the naming convention you're using?
- Are the resources the most current version?
- Can we link to state sites that will contain the most current version?
- Should resources be downloadable?

[5] https://www.5stoday.com/what-is-5s/
[6] https://www.convergencetraining.com/blog/5s-plus-safety-6s-safety

If staff have certain resources at their workspace, consider going to the workspace to assess if those resources are visible and cleaned up. Are they the most current version?

Standardize – One of the biggest challenges with resources is keeping them up to date and organized. As new ones get added, are old ones removed or archived? As new processes or enhancements are made, are resources updated? Create a process to ensure the organized resources you've spent the last three phases doing stay that way! Two key points to consider if you are centralizing your resources include:

- How should things be saved? Who should save them?
- How should things be removed? Who should remove them?

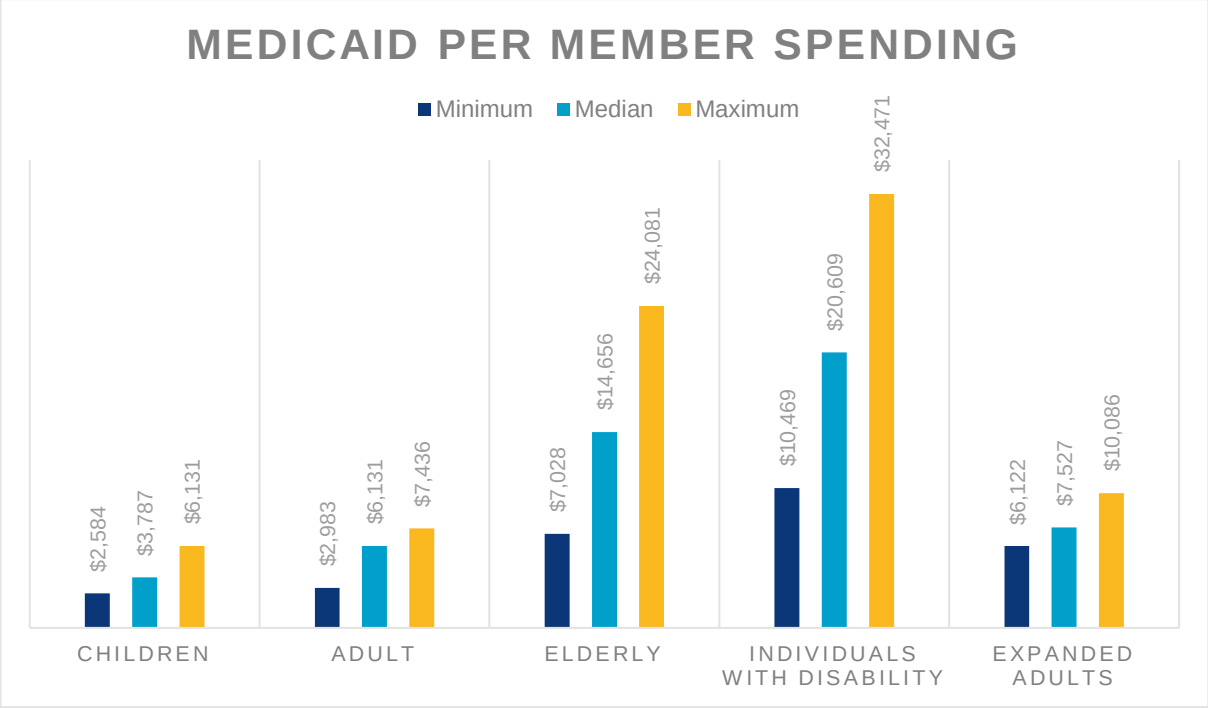
Sustain – Reinforce the idea of having an organized (and hopefully centralized) spot for your resources. You can do this by communicating where to find the resources and also by keeping them up to date and organized!

5. HOW MUCH DOES A WRONG AUTHORIZATION COST?

Do you know the value of Medical Assistance benefits? Unlike cash and food programs, it's hard to know the exact value of Medical Assistance benefits – there isn't a specific dollar amount a worker can see in Wrap-Up. This lack of transparency can make it easier to take less care or time when authorizing Medical Assistance versus the others which do show a specific value. Medical Assistance benefits are extremely valuable and may be much more valuable than food assistance or cash benefits.

5.1. WHAT DOES MEDICAL ASSISTANCE COST?

Spending per Medical Assistance member varies depending on the eligibility group. The Center for Medicaid and Medicare Services (CMS) used specific expenditure and system data across 12 states to demonstrate the per enrollee costs in 2017. When considering all costs across the five different groups, the median cost per member was **$8,221** per year.[7] The chart below shows the minimum, median (average), and maximum annual amount spent per member across all states by eligibility group.[8]



[7] https://www.medicaid.gov/state-overviews/scorecard/how-much-states-spend-per-medicaid-enrollee/index.html

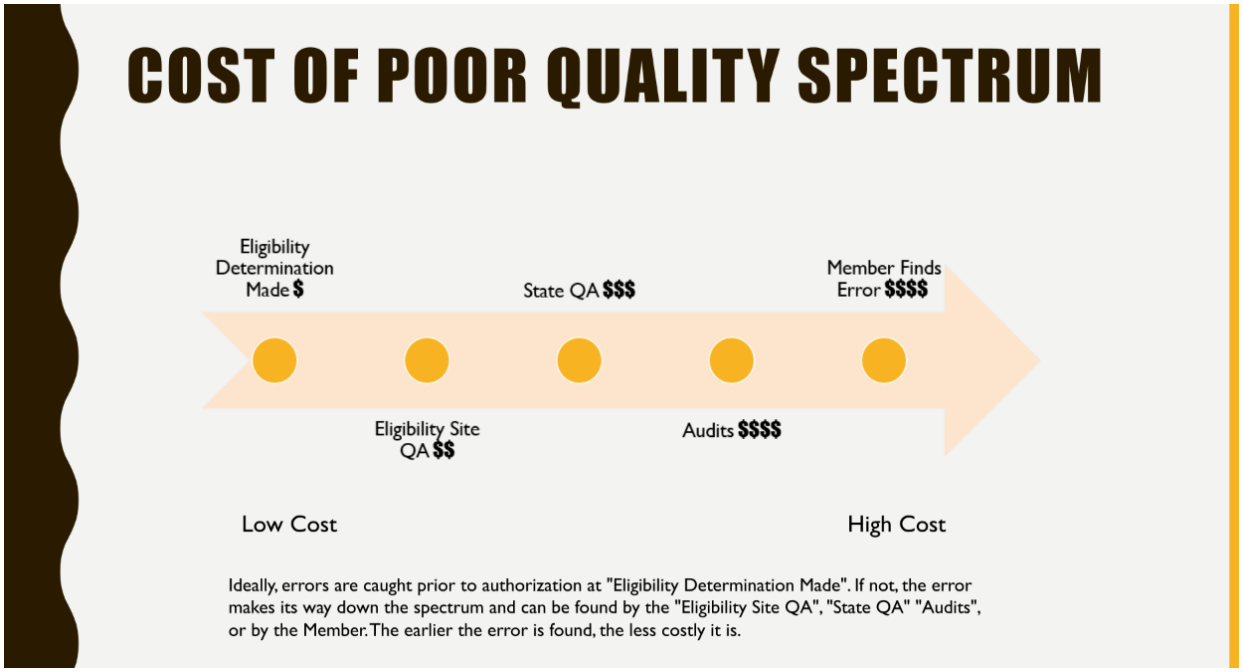
[8] Expanded Adults include those Medicaid categories that were created as a result of the Affordable Care Act. Adults is limited to those categories for Medicaid that existed prior to the Affordable Care Act.

5.2. WHO PAYS?

Medical Assistance is jointly financed by states and the federal government – the federal government matches state Medical Assistance funding. Some states, including Colorado, mandate that counties contribute to the non-federal share of Medical Assistance costs.[9] This means your county dollars go towards Medical Assistance costs. Incorrect authorizations therefore cost all stakeholders money, from the county up to the federal government.

5.3. WHY IS THIS IMPORTANT?

Medical Assistance errors cost money – a lot of money. They also can cost a lot of time, time in researching the case, in the number of people involved, etc. The cost of a Medical Assistance error increases the longer the case is in error, as seen in the graphic below:



Also remember in some instances, Medical Assistance errors can't be fixed. When taking all of this into consideration, it's clear that verifying eligibility in Wrap-Up is particularly important! Let's look at some specific ways how Medical Assistance errors cost money and time:

Financial Errors

Capitation Fees – Colorado uses a capitation model for Medical Assistance. This means that Colorado Medical Assistance pays a set "cap" or per member per month payment to providers to provide care to individuals who are enrolled in Medical Assistance. The state pays this "cap" regardless of if the member goes to the doctor – it is paid to "hold" that spot in Medical Assistance. When members are incorrectly

[9] http://www.naco.org/sites/default/files/documents/Medicaid_02.19.18.pdf

authorized for Medical Assistance, the state pays more money than they should have to hold that spot.

Medical Assistance Match – The federal government matches state and local spending based on a member's Medical Assistance category. Some categories (like those created with ACA) are eligible for a higher match (90% federal money to 10% state / county money) and some categories are eligible for a lower match (50% each). States may be required to repay the federal government in instances when the member was enrolled in the wrong category and the higher match was paid.

Incorrect Approval in a Guaranteed Program – Approval in a guaranteed program means the member will stay in that program through the end of the designated program period (e.g. one year for a needy newborn). In most instances, it's impossible to fix an incorrect approval. This can cost all stakeholders money because they must pay for the Medical Assistance services even though the approval was incorrect.

In some instances, it's possible for a member to be auto re-enrolled into a guaranteed program. Since their circumstances may have changed and they may have reported those changes, it's particularly important to work all changes received on a Medical Assistance case prior to the RRR auto re-enrolling!

Time Errors

Incorrect Category – A member who is approved for the incorrect Medical Assistance category may not be able to get the services they need – a pregnant woman approved for MAGI Adult may go to the doctor for a pre-natal visit and not have the visit covered because her med-spans show MAGI Adult. This can cause delays and headaches to the member and to the provider.

In some instances, being approved for the incorrect category can be life or limb threatening. Members who are in the incorrect non-MAGI program may be denied access to critical services because of their med-spans.

Worker & Management Time – Medical Assistance errors take up the time of at least two people – the person who found the error and the person who must fix the case. Depending on when the error is caught, more people may get involved – for example, a federal auditor finds an error that gets passed down to the state for review before getting passed down to the county.

Sometimes, when a member or a provider escalates, many people can become involved. Often these escalations (particularly for non-MAGI errors) go all the way up to HCPF. In some instances, multiple people may become involved when a Medical Assistance determination is incorrect.

Member Delays – An incorrect Medical Assistance determination leads to incorrect med-spans. Med-spans aren't updated in real time - they can take up to 48 hours to be updated. This means a member whose case is corrected must wait until at least the next day to either visit the pharmacy or go to the doctor.

- Cases that are authorized before 4 PM will have the med-span updated after midnight the same day.
- Cases that are authorized after 4 PM will have the med-spans updated within 48 hours.

6. CRITICAL THINKING & WRAP-UP

Critical thinking skills are some of the most crucial skills eligibility staff can employ in their daily work. Critical thinking is defined as "deliberately and systematically processing information so that you can make better decisions and generally understand things better".[10] In short – it's thinking about thinking.[11]

6.1. ELEMENTS OF THOUGHT

There are four main elements of critical thinking eligibility staff should employ in their daily work and most importantly, prior to and after they run EDBC are outlined in the table below:[12]

When	Element	Definition	Example questions
Pre-EDBC	Information / Analysis	The ability to collect and process information and knowledge to make an accurate eligibility decision.	• What information am I using to determine eligibility? • What other information do I need? • What Medical Assistance rules need to be applied?
	Inferences / Conclusion	Assessing whether the knowledge about the case and the program rules is sufficient and reliable.	• What is my expected EDBC result? • Is there another way to interpret the information the client or CBMS provided?
Post-EDBC	Evaluation	The ability to make an accurate eligibility decision based on the available information.	• Does the information I received support the eligibility result? • Does the eligibility result match what I know about Medical Assistance policy?
	Interpretation	Concluding the meaning of the eligibility result from EDBC.	• Is the EDBC result correct?

6.2. PRE-EDBC

Pre-EDBC is one of the phases in the eligibility process where staff should be employing their critical thinking skills. Specifically, staff should be thinking through and assessing the information that was provided by the member and using their knowledge of Medical Assistance program rules to interpret that information to make an eligibility decision. Eligibility staff should always be thinking about the results they expect to see before they run EDBC – **will the member(s) pass or fail? What category will they be in?**

Thinking about what they expect to see is important, even though CBMS has eligibility rules programmed into it – even a computer system can make a mistake.

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[10] https://collegeinfogeek.com/improve-critical-thinking-skills/
[11] https://zety.com/blog/critical-thinking-skills
[12] Rand, R. and Elder, L. (2020). *The Miniature Guide to Critical Thinking: Concepts and Tools* (8th edition). Rowman & Littlefield.

The worker's expected results should be based on the verification provided and their knowledge of Medical Assistance rules. Some that they might want to consider prior to running EDBC include:

- To what extent is my expected result supported by the information the member provided and my knowledge of Medical Assistance rules?
- How can I make sure my expected result is based on correct interpretation of Medical Assistance rules?
- How clear, accurate, and relevant was the information the member provided?
- Have I gathered enough information to make an accurate eligibility decision based on Medical Assistance rules?

6.3. POST-EDBC

After running EDBC, the worker should check Wrap-Up – were their expectations correct or do they see something different? At this phase, workers should be focused on ensuring what they put into the Interactive Interview screens match the results in Wrap-Up and that the results follow Medical Assistance rules. If the results are different, they should be raising questions around why those results are different and what steps they should take next.

Some questions workers might ask themselves after running EDBC are:

- Does the verification received support the eligibility decision EDBC is giving?
- Are the expected results and the EDBC results consistent with each other?
- Is it possible the expected result wasn't correct and there was another possible result?
- Where can I go for help?

7. NAVIGATING POST-TRANSFORMATION WRAP UP

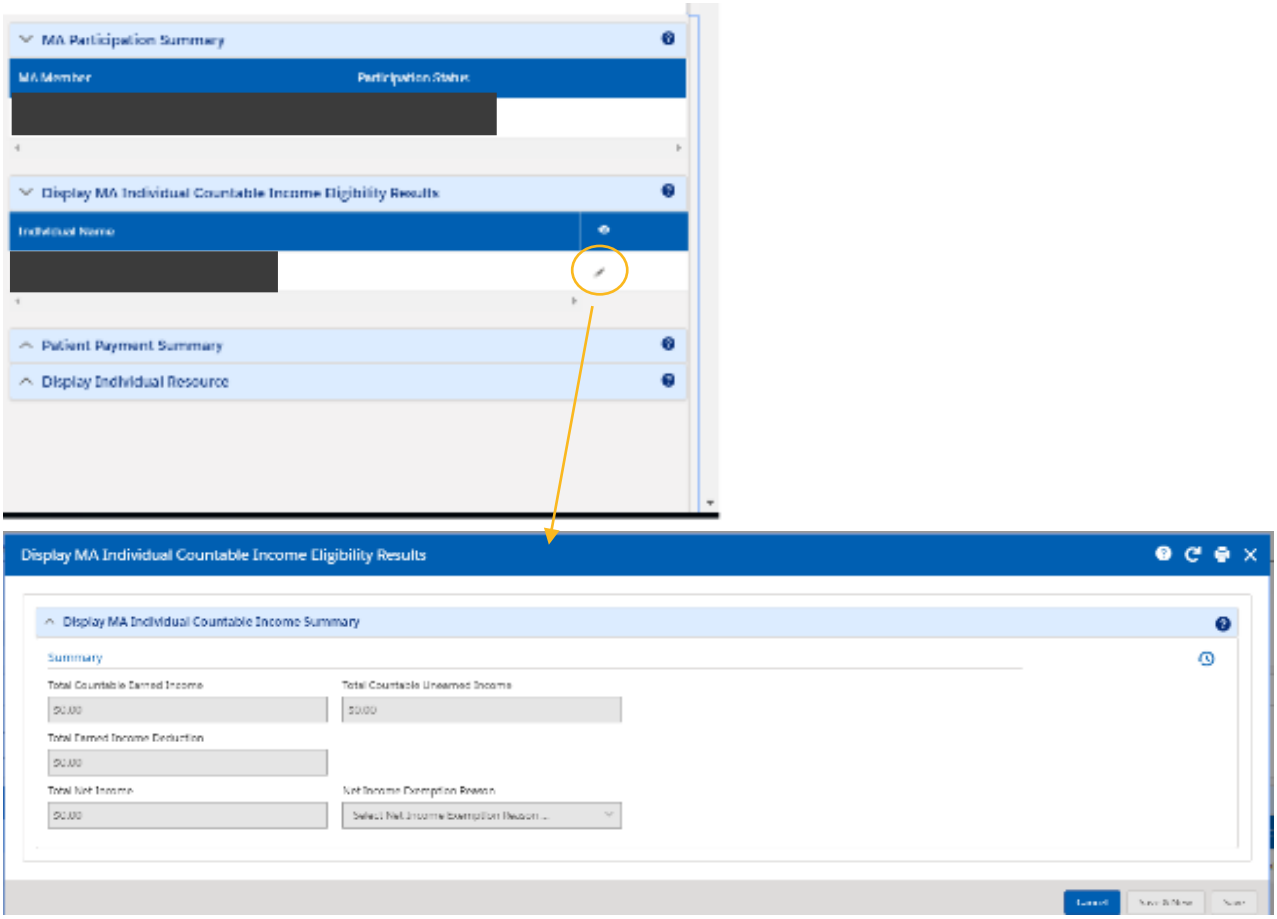
CBMS Transformation in June 2020 introduced new screen layouts and design. One area where there were some major changes was in the Wrap-Up screens. In an ongoing assessment conducted for the Colorado Business Process Reengineering Project, half of the respondents indicated workers have stopped using Wrap-Up because the screen flow and layout had changed. Respondents also indicated there is too much information on the screen and they struggle to find what's important.

7.1. TIPS AND TRICKS

Below are some tips and tricks to help staff more easily navigate post-transformation Wrap-Up:

^ Symbol – this icon indicates that you can expand on that piece of information on the Wrap-Up screen.

Eye or Pencil Icon – this icon indicates that you can edit the record.



Finding Missing Information – Pre-Transformation Wrap-Up displayed all of the income being used to determine a member's eligibility, even if the income wasn't earned / received by that member. Post-Transformation, the only income that will display in Wrap-Up under the member is their specific income. It's very important that a worker write down, remember, or otherwise track the income for all members in the budget unit to make sure the correct income is being counted. This will require the worker search under each member to see the income being used in the eligibility determination.