County Director Orientation

October 25, 2022

Bre Benbenek, County Liaison
Terri Alexander, County Programs Administrator
Melissa Vincent, MEQC Lead Reviewer
Joshua Montoya, Local Partnerships & Programs Manager
Gina Robinson, Senior Policy Advisor/EPSDT Program Administrator

Ask Questions Throughout!

HCPF Organization Basics

- Executive Director Kim Bimestefer

- Community Living
- Health Programs
- Behavioral Health Incentives and Coverage
- Health Information
- Medicaid Operations
- Pharmacy
- Finance
- Cost Control & Quality Improvement
- Policy, Communications and Administration

Eligibility Partners Webpage

https://hcpf.colorado.gov/eligibility-partners

County Team Customer Management

Do you need help? Do you have a question? Does a case need to be escalated? There are two ways you can contact the HCPF County Relations team.

1. County Relations Web Form—try this method first. It allows you to enter details to help us resolve your issues. (https://hcpfdev.secure.force.com/HCPFCountyRelations)

2. County Relations E-mail—You can still contact us by email. Your email to us will automatically create a service ticket with your email included. (HCPF_CountyRelations@state.co.us)

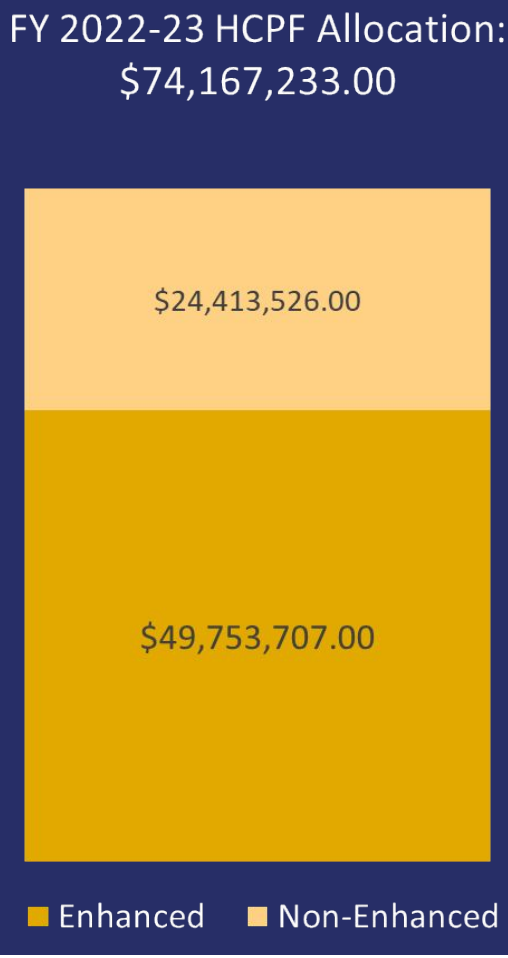
County Administration

County Programs and Funding

Joshua Montoya, Local Partnerships & Programs Manager
Bre Benbenek, County Liaison
Terri Alexander, County Programs Administrator

County Administration Allocation

- How is each county's county administration allocation formulated?
- How are costs split between different public assistance programs? Random Moment Time Sampling (RMTS)



75% Federal
15% State
10% Local

Enhanced Match

50% Federal
30% State
20% Local

Eligible for 75/25 Application, On-going Case Maintenance and Renewal*	Eligible for 50/50 Policy, Outreach and Post-eligibility
• Intake - Application/data receipt(i) • Acceptance- Edits, verification and resolution of inconsistencies(ii) • Eligibility determination (iii) • Outputs-Issuance of eligibility notices to customer, file updates and transactions to partners(iv) • On-going case maintenance activities, including intake activities related to renewals(v) • Customer service, including call center activities (vi) and out-stationed eligibility worker activities (vii) related to eligibility determination. • Maintenance and Routine Updates, including routine system maintenance, security updates, and other routine maintenance activities related to the Eligibility Determination System.	• Outreach and Marketing – General public outreach, beneficiary education and outreach, including explanation of eligibility policies, program and benefits. • Policy development and research even if related to eligibility determination standards and methodologies • Staff development and training even if related to eligibility determination, except for Operational Readiness training as defined in the response to question 3 below. • Community-based application assistance • Program integrity, including auditing efforts • Appeals of final eligibility system determinations • On-going case maintenance activities, including plan choice/counseling and enrollment • Customer service, including call center activities and out-stationed eligibility worker activities, related to beneficiary education, benefits, plan choice/enrollment, and civil rights complaints.

2015 Agency Letter

County Financial Audits

- County Financial Rules
- Financial Internal Controls -
  - Invoice Approval Process
  - Proper supporting documents
- Employee time reporting
  - Proper documentation for those that work on more than one program or cost pool
    - Estimates may not be used unless trued up the following month
  - Proper distribution of fringe (Jury Duty, Vacation, Sick, Holidays)

County Incentives Program and Grants

Terri Alexander
County Administration Compliance Supervisor

County Incentives Program

- R6 Budget Request – Program Initiation in 2014
- Reimbursement of county's local share spent on Medicaid administration
- R6 Budget Request – Increases in 2019 and 2022
- Total available for program is ~ $8.2 million - This is an increase of ~$2.5 million in FY 22-23!
- Incentives are developed based on Executive Director priorities and operationalized through county feedback

Incentives Funding Model

- Based on % local share, not to exceed actual local share
- Payments are annual through CFMS, made after Settlement Accounting closeout
- Funding is unrestricted once earned
- Unearned incentives are redistributed to counties who did earn the incentive

FY 2022-23 Incentives

Accuracy Performance - 40%

Entire payment earned if both measures met; 50% if only one measure met

- Inaccurate Eligibility Determination Rate
- Errors That Do Not Impact Eligibility

Performance Compliance- 30%

- Comply with the Director level Medical Assistance Performance (MAP) Dashboard measures.

Customer Service – 30%

- Tier 1 (A,B, or C): Call Center related benchmarks/deliverables
- Tier 2 (A or B): member survey outreach and/or customer service improvement plans

County Grant Program

- Competitive Grants
  - $500,000 available to county departments of human/social services to improve eligibility infrastructure, business processes, customer service, cybersecurity, or other department priorities
  - Cost Allocation: 100% of Medicaid projects, or 40% of projects that also impact other public assistance programs
- Targeted Grants
  - $500,000 set aside for the Department to approach counties to meet outcomes or complete specific projects

County Grant Program

- The Competitive Grant Application:
  - **Released in April or May 2023**
    - Counties will be provided an application deadline (2-3 weeks).
  - **Preferred projects:** Align with the Department's Strategic Policy Initiatives, which are part of the Department's Performance Plan.
  - The Grant is a **competitive application:**
    - Submit Application: Scored Application + Interview = Approved/Partially Approved/Denied
  - Throughout the Grant year: Quarterly Matrix Report & Check-in, Site (or Virtual) Visit, and Year End Report Out

- Examples of funded projects
  - Quality Assurance, Reducing Medicaid Errors, Increase Providers, Cybersecurity, Member Outreach

Health First Colorado (Medicaid) Operations and Administration

Joshua Montoya
Local Partnerships & Programs Manager

Eligibility Division

- The Eligibility Division teams are here to support counties in eligibility processes. We do this through:
  - Eligibility Policy
  - Systems – CBMS, PEAK and TAG
  - Eligibility Audit Research team
  - Process and Performance Improvement team
  - Contracts & MA/EAP sites
  - Staff Development Center
  - Eligibility Communications
- Medicaid Operations Office (COO-Ralph Choate)
  - Client Services (Member Contact Center)
  - Provider & Fiscal Agent
  - Compliance

Public Health Emergency Funding

FY 2020-21:

Joint Budget Committee (JBC) **budget supplemental** to address county and state workload related to the end of the PHE

- Finance sub-PAC voted on allocation plan
- Counties submitted staffing plans

FY 2021-22:

- Public Health Emergency extended, HCPF submitted budget supplemental to ensure funds available in FY 2022-23

FY 2022-23:

- ~$18 million allocated for end of PHE work
- Updated SOW based on federal guidance

Overflow Processing Center

- Part of 21-22 JBC Supplemental Request
  - Funded for ongoing operations
  - Support Counties with end of PHE workload, backlog, and other Medical Assistance work
- TImeline
  - Contract awarded to Prowers County
  - Fully staffed and trained
  - Pilot program with a few Counties began May 2022
  - OPC to be operational beginning 11/1 and will begin to accept requests from Counties
  - Operational memo coming soon!
- Work
  - MAGI, Non-MAGI, LTC, Apps, Renewals, Changes

Consolidated Return Mail Center

- 2018 budget request created the Centralized Return Mail Center (CRMC)
  - Centralized the processing of all returned mail
  - The contract awarded to Prowers County
- Fully rolled out
  - All CBMS-generated return mail
    - Except “homeless” status or ACP
    - September 2022 fix based on county tickets
    - if counties are still receiving returned mail that isn’t those two categories, please open a HDT and copy Monie Mangus

Questions?

Oversight & Accountability

How the Department holds counties and sites accountable

Joshua Montoya, Local Partnerships & Programs Manager
Terri Alexander, County Administration Compliance Supervisor
Nicole Duran-Jones, Performance Improvement Supervisor
Melissa Vincent, Eligibility Quality Assurance Supervisor

What is Oversight & Accountability?

The Oversight and Accountability Program was implemented in 2020 due to federal and state audit findings that may result in the repayment of federal funds due to error rates and the Department's desire to improve the member experience. The Program consists of a subset of programs and tools that include:

- Strengthening the County Administrative Ruleset (10 CCR 2505-5 1.010 and 1.020) that governs county operations to include of oversight and accountability for county departments
- Creation of Oversight programs that include: Management Evaluation (ME) Reviews, Department-level Eligibility Quality Assurance reviews, Medical Assistance Performance (MAP) Dashboards and performance management process and Desk Review Program
- Creation of Accountability tools including Department Management Decision Letters (MDLs) to issue Improvement Action Plans (IAPs) and Corrective Action Plans (CAPs), Fiscal Sanctions, and County Incentives Program, Performance Compliance and Accuracy Incentives.

Previous Audit Findings vs 3% federal target

Year	Audit	Error Rate	Sample Size
2015	OSA: SSWA (State)	3%	60
2015	OIG: A-07-18-02812 (Federal)	4%	140
2015	OIG: A-07-16-04228	28%	60
2017	OSA: SSWA (State)	18%	40
2018	OSA: SSWA (State)	28%	200
2018	OSA: SSWA System Issues (State)	14%	29
2019	OSA: SSWA (State)	26%	125

Oversight & Accountability: The Process

1. HCPF sets an expectation and issues guidance
2. County/Site implements new guidance
3. HCPF conducts regulatory-compliance review
4. HCPF issues findings
5. County/Site cures non-compliance
6. If non-compliant, MDL is issued
7. IAP/CAP required. Submission of documentation may also be required.
8. If continued non-compliance, sanctions may implemented, including fiscal sanctions

Issuing Guidance and Setting Expectations

As the federally-required single state agency for Medicaid, HCPF has the statutory authority to promulgate rules and requirements for counties and eligibility sites through:

- Regulations in Volume 8 (Eligibility Determination) and Volume 10 (County Administration)
- Memo Series: Policy, Operational or Informational Memos
- Staff Development Center: Trainings, Desk Aids and Supports for Eligibility Staff

Types of O & A Regulatory Reviews

For a Management Decision Letter to be issued, the Department must complete a regulatory review as defined at 10 CCR 2505-5 1.020.10. These include:

- Federal and State Audits (PERM, MEQC, OSA, OIG, etc.)
- HCPF Eligibility Quality Assurance
- Site Audit (ME Review Program) or Desk Review (Desk Review Program)

Current Guidance for Review Programs

- External Regulatory Reviews - State & Federal Audits
  - Payment Error Rate Measurement (PERM)
    - HCPF OM 22-018
- HCPF Internal Regulatory Reviews
  - Management Evaluation Review Program
    - HCPF OM 21-005
  - MAP Dashboard Program
    - HCPF OM 21-079
  - Desk Review Program
    - Operational Memo in progress
  - Eligibility Quality Assurance
    - HCPF is re-issuing with county feedback

Federal and State Audits

Review findings from federal and state audits can result in a Management Decision Letter for each site. These audits include, but are not limited to:

Payment Error Rate Measurement (PERM): Determines federal clawbacks for error rates above the 3% federal requirement, every 3 years

Medicaid Eligibility Quality Control (MEQC): Conducted in PERM off-cycles and conducts reviews based on federal requirements

Office of State Auditor (OSA): Annual single, statewide audit

one-page fact sheet coming soon!

Eligibility Quality Assurance

Eligibility Quality Assurance (EQA)

- Reviews 120 MA individuals per month for accuracy of Apps, Renewals, Changes
  - All Sites included in the sample
- Performance data used in the Medical Assistance Performance (MAP) Accuracy Dashboard for Contract compliance

PERM/MEQC

- Desk Review process to issue CAPs for PERM/MEQC findings
- Leveraging EQA to measure improvement from CAPs
- Data is provided to the Accountability Team

What will QA Reviews look like for my team?

- Sites should expect to be reviewed every month
  - 1-5 reviews per eligibility site per month

- Sites will receive approximately 2-3 emails from QA every month that will -
  - Request case files for next month's reviews;
  - Share the results of the current month's reviews; and
  - Provide QA's final decision on rebuttals from prior month's reviews

ME Review Program

The HCPF Management Evaluation (ME) Review Program is an on-site, 360° review of the site's operations; every county and site scheduled in three year period.

Non-compliance findings from each review are communicated through the issuance of a Preliminary Report. The site is allowed 30 calendar days to "cure" (fix) the findings by implementing steps to address non-compliance.

Non-compliance findings not "cured" within the cure period are issued a Management Decision Letter with the Final Report.

The site must complete either an IAP for noncompliance with documented expectations or CAP for noncompliance with Federal/State rule or subregulatory guidance.

The site is then continuously monitored for compliance with IAP/CAP.

Desk Review Program

The HCPF Desk Review Program is an ad-hoc, as needed review of a specific aspect, process or policy of the site's operations.

Desk Reviews can be conducted only on a specific site, on multiple sites, or all sites, depending on Department need.

Desk Reviews are conducted by Department staff, and non-compliance findings are communicated to the site via the same processes as ME Review Program (Preliminary/Final Reports).

Desk Reviews may or may not include a cure period.

The site must complete either an IAP for noncompliance with documented expectations and CAP for noncompliance with Federal/State rule or subregulatory guidance.

The site is then continuously monitored for compliance with IAP/CAP.

Medical Assistance Performance (MAP)

Four Dashboards: Applications, Renewals, Ongoing Case Maintenance, Accuracy

Measure Types: Compliance, Outcome, Diagnostic

Compliance Measures

- Application Timely Determinations (3 measures):
- Renewal Timely Determinations (3 measures):
- Accuracy (2 measures):

Timely Determinations (and Renewals) Example:

- Performance measured with 3 measures that work in tandem
  - Timeliness
  - Pending (past 45 or past 90)

Medical Assistance Performance

What will the MAP Dashboards look like for my team?

Four Dashboards per Eligibility Site

- Applications
- RRRs
- Changes
- Accuracy

Each Dashboard Includes

- Dashboard itself
- Definitions
- Performance numbers in an XmR (Process Control) Chart

Location

- HCPF SharePoint page
- Includes the reports used to create the MAP Dashboards under “Statewide Data Documents” > “2022 Reports”

MAP Process

HCPF MAP Measure Owners:

- Review performance monthly
- Process based on PuMP and Lean Six Sigma (statistics)
- Look for precision (how close to target) and variation (how widespread performance is)
- Issues MDLs based on signals in the data AND not meeting the target

2 Outliers = IAP	Short Run = IAP	Long Run = CAP

MDLs trigger the county/site to create IAPs/CAPs to work with Continuous Improvement team to create the necessary plan (Technical Assistance).

Management Decision Letters

- Management Decision Letters (MDLs) are the State Department's method of formal non-compliance noticing
- MDLs are typically split into several different categories, such as administrative and performance
- MDLs **cannot** be issued without a review.
- MDLs are **not** a review, they are only the formal non-compliance noticing process for HCPF

Issuing an MDL

- County Relations staff work with the regulatory review programs to draft MDLs upon discovery of non-compliance
- Noticing sent to the County or Site Director
  - The County Oversight Administrator (COA) issues MDLs for administrative non-compliance, while the County Programs Administrator (CPA) issues MDLs for performance non-compliance.
- The MDL issued to the County or Site Director communicates the non-compliance finding and requires the site to submit an Improvement Action Plan or Corrective Action Plan.

Improvement Action/Corrective Action Plans

- Process is defined at 10 CCR 2505-5 1.020.11.
- Improvement Action Plans are informal plans implemented with technical assistance to address non-compliance.
- Corrective Action plans are formal plans implemented to address non-compliance that, left unaddressed, can lead to fiscal sanctions.
- The site must complete an IAP/CAP within 30 calendar days if notified of the requirement to complete an action plan.

Non-Compliance Technical Assistance (TA)

- 1.020.11.4.c
  - Counties/MA Sites may request technical assistance to create action plans
    - If an action plan is rejected, the county or site is required to participate in a technical assistance meeting
- 3 Types of Non-Compliance TA
  - O & A Process Overview and IAP/CAP Form Assistance - County Relations Inbox
  - Continuous Improvement - Request Form
  - Overflow Processing Center - Request Form

Required Elements of an Action Plan

- 1.020.11.4.b
  - All action plans must include the following
    - Specific non-compliance issue
    - Specific actions to be taken to correct non-compliance
    - Specific time frames for completion, not exceeding six (6) months
    - Name of the contact person responsible for each corrective action
    - Documentation demonstrating the actions to address non-compliance

Approving/Rejecting Action Plans

- Action plans are reviewed internally to ensure minimum standards and regulatory compliance
  - Ensuring the plan includes all of the necessary content
- Twice monthly, the HCPF IAP/CAP Committee meets to discuss action plans and approve/reject them
  - Committee votes to proceed with plans

Approved or Rejected Plans

- If the Plan is approved by the Committee, the county or site director is notified and must implement the plan. The Department monitors implementation of the plan.

- If the Plan is rejected by the Committee, the county/site is required to participate in Technical Assistance before re-submitting the plan.

Closing an IAP/CAP

- In most cases, action plans close automatically once the timeline detailed in the plan has passed
- Once the action plan has closed, the COA/CPA and County Relations Manager issue a notification of completion
- If the committee objects to the closing of an IAP/CAP, the action plan remains open until brought into compliance
- IAP/CAPs that are left in non-compliance are converted
  - i.e., IAPs are converted to CAPs, and CAPs are converted to fiscal sanctions

Fiscal Sanctions

- After a county has been determined to be non-compliant with its CAP, the Department has the authority to begin the process to implement fiscal sanctions
- There are a total of three (3) notifications over the course of 60 calendar days
  - First two (2) can be appealed and/or cured to avoid fiscal sanctions
  - Last notification cannot be appeals or cured

Fiscal Sanctions (cont.)

- Fiscal sanctions are taken directly from the Medical Assistance portion of the Director's salary
- The funding is withheld directly from the county's monthly settlement in the County Financial Management System
- Fiscal Sanctions guidance for counties is currently in development

County Administration New Guidance

Finance and Accounting (10 CCR 2505-5 1.010)
County Administrative (10 CCR 2505-5 1.020)

New County Administrative Rules include requirements for, but not limited to:

- Granting Access to Statewide Automated Systems (1.20.4)
- Confidentiality (1.20.5)
- Non-Discrimination (1.20.6)
- Accessibility/ADA (1.20.7)
- Communications (1.20.8)
- Audits, QA, and Reviews (1.020.10)
- Non-Compliance Findings and Action Plan Processes (1.020.11)

New County Administration Sub-Regulatory Guidance

To assist in the implementation of the new County Administrative Rules, HCPF is drafting new Operational Memos for each section of the rules. These memos are currently being approved and/or revised and will be issued in the coming months.

- County/Site Quality Assurance/Quality Control Plans (QA/QC)
- Merit Based Staffing Requirements
- County Customer Service and Call Center Expectations
- County Civil Rights Plan
- County Communications to Medical Assistance Applicants and Members
- State Requirements for Eligibility Site Medical Assistance Training
- Administrative Desk Reviews
- Eligibility Site Knowledge and Information Sharing
- County Access to Statewide Systems

Questions?

Benefits and Coverage

Bre Benbenek, County Liaison
John Laukkanen, Pediatric Behavioral Health Liaison
Gina Robinson, Program Administrator

Department Programs

Health First Colorado (Colorado's Medicaid Program)

Child Health Plan *Plus* (CHP+)

Old Age Pension (OAP) Medical Programs

Colorado Indigent Care Program (CICP)

Colorado Dental Health Care Program for Low-Income Seniors

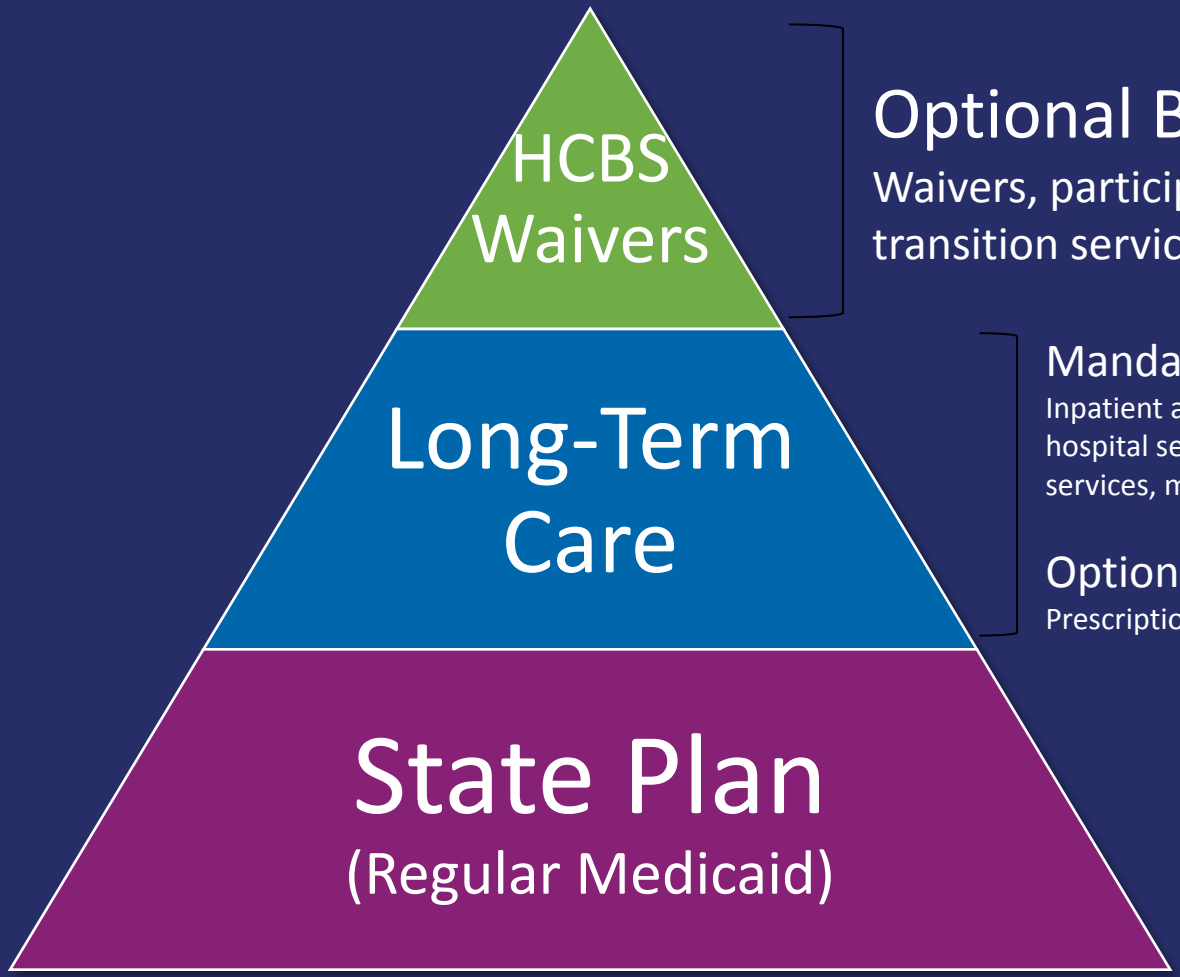
Medicaid State Plan Benefits

Physical Health Plan. The Health First Colorado physical health plan covers health care having to do with the body, including vision services and prescription drugs.

Dental Health Plan. Health First Colorado covers dental and orthodontia services through DentaQuest.

Behavioral Health Plan. Health First Colorado covers mental health and substance use care services through the Regional Accountable Entities (RAE)

Benefits Pyramid



Optional Benefits:
Waivers, participant-directed services, transition services

Mandatory Benefits:
Inpatient and outpatient hospital services, physician services, laboratory and x-ray services, more…

Optional Benefits:
Prescription drugs, dental services

Mandatory Benefits:
Inpatient and outpatient hospital services, physician services, laboratory and x-ray services, more…

Optional Benefits:
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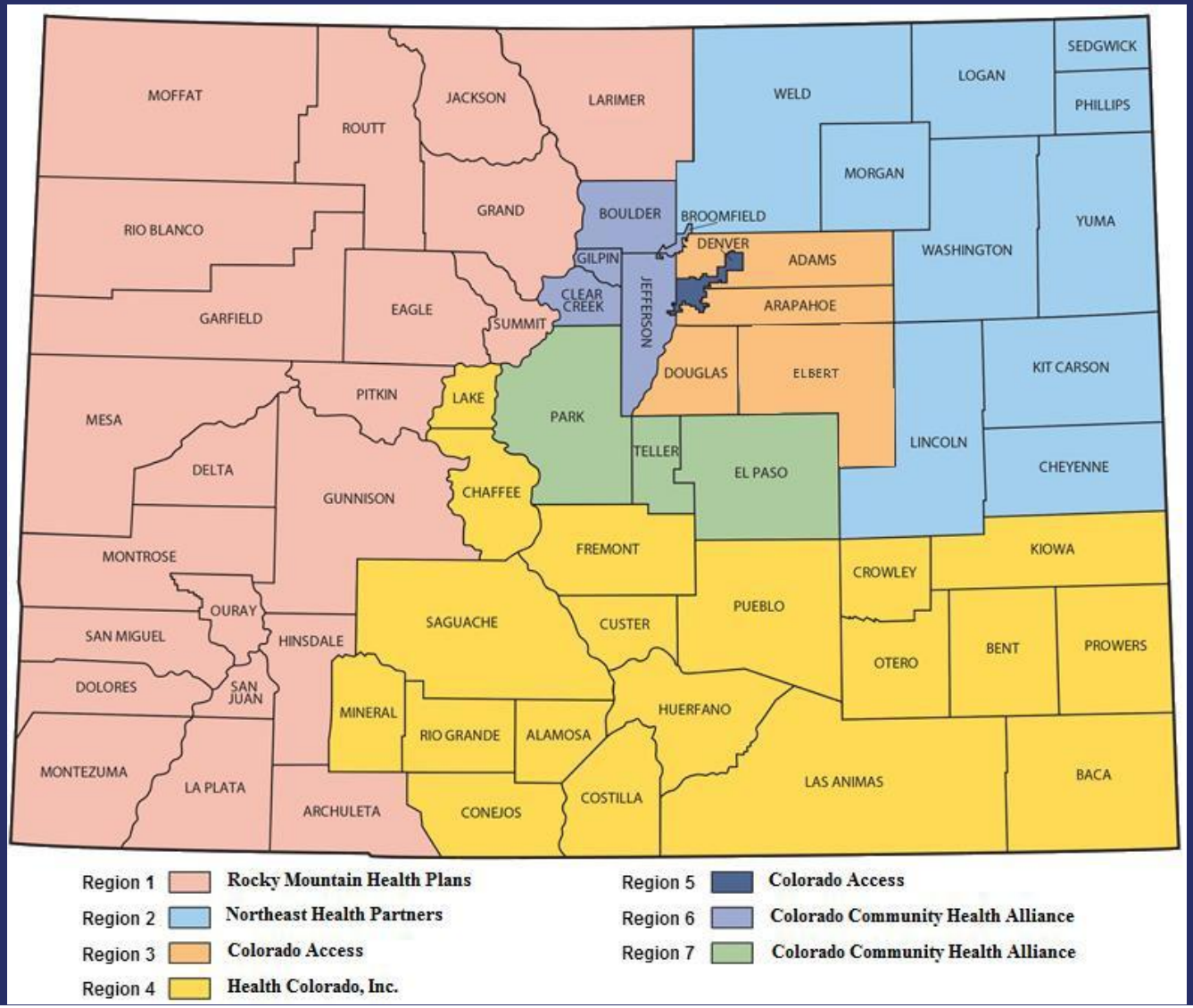
Join Physical & Behavioral Health

Regional Accountable Entity

Physical Health Care	Behavioral Health Care
Fee For Service Rate	Behavioral Health Capitation

Accountable Care Collaborative



Role of RAEs

Responsible for physical and behavioral health

- Pay administrative medical home payments
- Administer capitated behavioral health benefit
- Work with provider network to assist in coordinating care across disparate providers

Primary Care Medical Provider (PCMP) Network

- Must have a contracted network of PCMPs to serve as medical home for members
- Provide practice support, including data support
- Assist PCMPs participating in the Department's Alternative Payment Model

Role of RAEs

Behavioral Health Provider Network

- Must have a contracted statewide network of behavioral health providers to provide services under the capitated behavioral health benefit
- Credentialing of contracted behavioral health providers
- Utilization management of covered behavioral health services
- Reimbursement of behavioral health providers for all services covered under the capitated behavioral health benefit

Early and Periodic Screening, Diagnostic, and Treatment

EPSDT is a mandatory preventive and comprehensive health benefit for most Medicaid-eligible individuals under the age of 21 for most any state that accepts federal funding.

EPSDT provides infants, children, and adolescents with access to comprehensive, periodic evaluations of health, development, and nutritional status, as well as vision, hearing, mental health and dental services.

Child Welfare and EPSDT

Some benefits require prior authorization requests (PARs) before the service can be provided. Medical providers are responsible for submitting PARs.

Children under the age of 18 do not have co-payments. Former foster care children ages 18-26 do not have co-payments (for medical services).

Non-emergent medical transportation (NEMT) to and/or from Medicaid medical appointments is available when a client has no other means of transportation.

Child and youth well care is a priority, and additional services are provided under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.

Just ASK

Providers who feel a service or item is medically necessary can and should ask for that service even if it is not listed as a covered services – this is possible because of the EPSDT program!

Follow the direction on the ColoradoPAR website for how to make an EPSDT request

Payment of Services while Out of State

- Medicaid does not cover services across state lines. However, if a Health First Colorado member is temporarily out of the state but still a resident of Colorado, they may receive some Health First Colorado (Colorado's Medicaid Program) benefits under three conditions:
- It is a medical emergency.
- Health would be endangered if they were required to return to Colorado for the medical care/treatment.
- The treating health care provider enrolls in the Health First Colorado program.

Payment of Service while Out of State

If all three conditions are not met, the services will not be covered.

Any child leaving the state should look for a contracted provider in the area they are visiting and use that provider if at all possible.

If a child is placed out of state, the county should look at ICAMA or other CDHS programs for local coverage.

Child Welfare and EPSDT

Volume 7 – specifically requires counties to follow EPSDT periodicity schedule

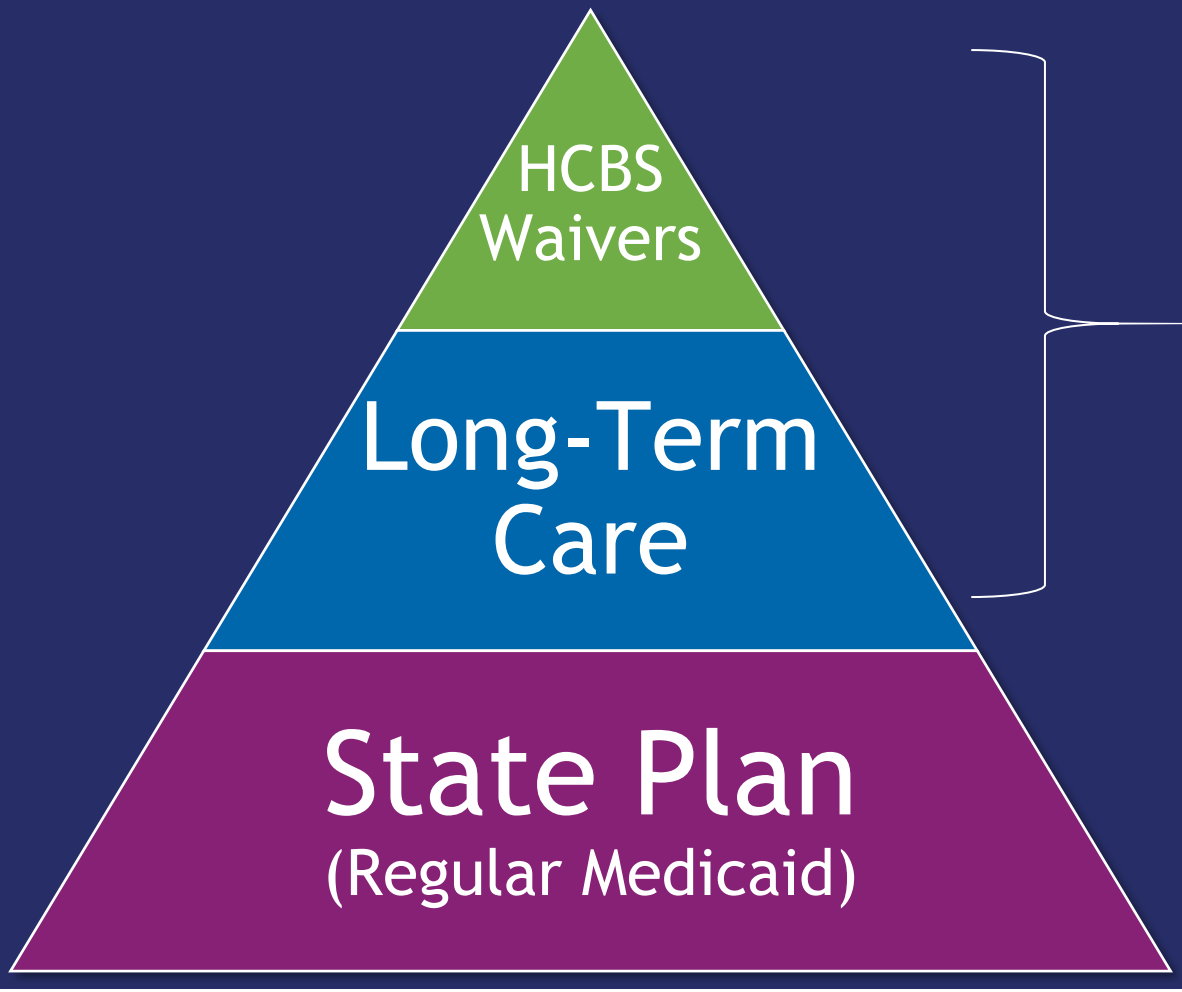
Bright Futures has a separate periodicity schedule for children who are in out of home placement

- Testing, well care, etc. can be provided as often as medically necessary.
- Medicaid will not deny a well child visit because one was completed 3 months ago.

Long Term Services and Supports

Waivers and Case Management Agencies

Overview



Long-Term Care, HCBS Waivers, Program of All-inclusive Care for the Elderly (PACE)

What are Long-Term Services and Supports?

At Home (e.g. personal or family home; group homes; assisted living facilities)

In Community (e.g. day programs; supported employment)

Within Institutions (e.g. nursing homes; intermediate care facilities)

Long-Term Services and Supports System

Direct Services

- At home
- In community
- In facilities

Case Management

- Community Centered Boards (CCBs)
- Single Entry Points (SEPs)

Case Management Agencies

- Conduct functional eligibility and provide on-going case management services to individuals who are determined both financially and functionally eligible for Medicaid
- **Single Entry Points:** functional eligibility assessments for most waiver services
- **Community Centered Boards:** functional eligibility assessments for intellectual & developmental disability (IDD) waivers

Questions?

Thank you!