Eligibility Quality Assurance (EQA) Case Review Process Manual

April 1, 2023

COLORADO
Department of Health Care Policy & Financing

Table of Contents

I. EQA Program Overview

A. Program Background and Purpose

The Eligibility Quality Assurance (EQA) program provides the eligibility sites and the Department of Health Care Policy and Financing ("the Department") with information about the accuracy of eligibility determinations for Medicaid and Child Health Plan Plus (CHP+). The EQA program is executed through monthly reviews of eligibility determinations completed in the Colorado Benefits Management System (CBMS). The findings of these reviews are intended to provide timely information about errors in the eligibility determination process.

B. County Incentives Program – Accuracy Incentive

EQA's review results are used by the County Incentives Program. Approximately two months after the review is complete, the results are uploaded to the Department's Medical Assistance Performance (MAP) Accuracy dashboard. Instructions for operationalizing the Accuracy Incentive can be found on the HCPF County Incentives Program website (https://hcpf.colorado.gov/county-incentives-programs).

C. Manual Purpose and Audience

This manual is intended to provide eligibility sites with guidance for EQA case reviews and will be in effect throughout the state fiscal year. It will be updated annually at the beginning of the state fiscal year. Suggestions for updating this manual should be emailed to hcpf_moo_eqr@state.co.us. This guidance is specific to the EQA program and should not be used for any other audits performed by the Department or external auditors. This manual may not capture every potential scenario that EQA may encounter.

D. Eligibility Site Responsibilities

All eligibility sites are required to participate in EQA reviews. The EQA team samples approximately one-to-five cases from every eligibility site every month, for a total of 120 cases per month. Eligibility sites are responsible for providing EQA with case files and responding to error findings in accordance with the timeframes established by EQA in Section IV and Section VI of this manual.

EQA has provided links to the rules/regulations, state guidance, and other guides that EQA uses to review accuracy. However, the manual does not provide an exhaustive list of the numerous resources used by EQA when reviewing accuracy. As outlined in 10 CCR 2505-05 1.020.3.4.a, it is the responsibility of the County Department Director to organize operations and staff functions to assure the effectiveness and efficiencies of operations of the County Department and compliance with applicable State and federal requirements, laws, and regulations, including establishing adequate internal controls. This includes knowledge and information sharing, such that the County Department Director can assure knowledge of and compliance with applicable State and federal requirements, laws, and regulations.

E. Definitions

Action Type: Initial Application, Annual Redetermination, or Change. This is the type of action processed on the authorization date.

Aid Code: Category of assistance in CBMS.

Authorization Date: The date that eligibility was approved, denied, or terminated for the sampled client. This date is pulled from Medical Assistance (MA) Individual Eligibility in CBMS.

Case List: A list of the clients sampled for monthly review by the Department's EQA program.

Case File: Documentation that supports the eligibility determination completed by the eligibility site on the authorization date.

Code of Colorado Regulations (CCR): State rules that operationalize federal statutes and/or regulations.

Electronic Document Management System (EDMS): The CBMS Electronic Document Management System, also known as Perceptive.

Eligibility Site: Is defined in 10 CCR 2505-10 8.100 as a location outside of the Department that has been deemed by the Department as eligible to

accept applications and/or determine eligibility for applicants. This includes county departments of human/social services (counties), Medical Assistance (MA) Sites and Eligibility Application Partner (EAP) sites.

Error: Any action taken during the eligibility determination that violates established state rules, regulations, HCPF Memo Series and/or other state guidance.

Error That Impacts Eligibility: An error that caused the individual to be:

- Enrolled when they should have been denied; or
- Denied/terminated when they should have been approved; or
- Enrolled in the wrong aid code.

Error That Does Not Impact Eligibility: A procedural error. If the error had not occurred, the member would have still been approved, denied, terminated or enrolled in the aid sampled for review.

Incorrect Approval: The sampled client was enrolled in Medical Assistance when they were ineligible for Medicaid and CHP+ due to an error that impacts eligibility.

Incorrect Denial: The sampled client was denied Medical Assistance when they were eligible for Medicaid or CHP+ due to an error that impacts eligibility.

Incorrect Program/Category: The sampled client was eligible for Medical Assistance but enrolled in the wrong aid code due to an error that impacts eligibility. This includes instances where the sampled client was enrolled in CHP+ when they were eligible for Medicaid or enrolled in Medicaid when they were eligible for CHP+.

Incorrect Termination: The sampled client was terminated from Medical Assistance when they were still eligible for Medicaid or CHP+ due to an error that impacts eligibility.

Incorrect With Errors That Do Not Impact Eligibility: The sampled client was correctly enrolled, denied, or terminated from Medical Assistance but there was a procedural error.

Modified Adjusted Gross Income (MAGI): Methodology for determining income and household composition/family size for family and children's programs (Medicaid and CHP+).

Missing Documentation Error: The eligibility site failed to provide documentation that supports the data entry in CBMS. This includes missing case comment errors.

Data Entry Error: When data entry is incorrect because:

- The eligibility site did not data enter information that was provided by the client and there are no case comments that explain the discrepancy; or
- The data entry in CBMS does not match the application/supporting documentation and there are no case comments that explain the discrepancy; or
- The state's data entry instructions were not followed.

Observation: An observation is an error that occurred when updating information for an unrelated household member and/or before or after the action sampled for review. Observations are not tracked on the MAP dashboards and do not impact the site's overall accuracy results.

Over Verification Error: The eligibility site denied, terminated, or delayed eligibility to a client for failing to provide documentation that they were not required to provide.

Public Assistance Reporting Information System (PARIS): PARIS is a data matching service that matches recipients of public assistance to check if they receive duplicate benefits in two or more states.

Sampled Client: The individual sampled for review.

System Error: Any error caused by the state's Program Eligibility and Application Kit (PEAK) or CBMS.

Undetermined: The reviewer was unable to confirm the accuracy of the eligibility determination because the eligibility site did not provide the case file documentation that supports the action taken in CBMS.

II. Sampling and Individual Review

EQA samples one individual from a case with an authorization completed by a worker at the eligibility site. This individual is the sampled client. While sampling happens at an individual level, the review will include other members of the sample client's monthly budget unit (MBU). For example, if a child is sampled for review, the accuracy of their parent's income and household information will be reviewed to ensure that the child's income and household composition were calculated correctly.

III. Scope of Review

EQA's case review is a review that includes all the elements described in the tables at the end of this document (Appendices A, B, and C) and any additional elements used to determine the appropriate program, eligibility category/aid code, and whether the eligibility determination process was completed correctly on the authorization date sampled for review. This also includes a review of verifications that may have been processed by the eligibility site in the past, such as verification of citizenship and immigration status. This also includes a review of case comments as required by HCPF OM 22-035, or whichever later Operational Memo supersedes OM 22-035.

EQA also reviews systems actions and assigns system errors. System errors should not be assigned to the eligibility site. Should the eligibility site receive an error that they believe is a system error, please follow the rebuttal process outlined in Section VI of this manual.

IV. Case File Request Process

EQA requests case files from the eligibility sites on the second Friday of every month. If the eligibility site is unable to produce documentation that supports the eligibility determination, they may receive a Missing Documentation error.

If citizenship/identity or immigration status documentation was processed by another eligibility site in the past, the eligibility site should notify EQA that the other eligibility site has that documentation. Eligibility sites will not be assigned errors if the other eligibility site no longer has the documentation.

How the eligibility site provides the case files will depend on which document management system they use.

A. Non-EDMS Users

The case files must be emailed to hcpf_moo_eqr@state.co.us within 10 business days of the request. EQA will not use your paperless system to retrieve documents under any circumstances. You are responsible for finding those documents in your paperless system and emailing them to EQA.

B. EDMS Users

The eligibility site must confirm that the appropriate documentation is scanned into EDMS and send an email to hcpf_moo_eqr@state.co.us confirming that the requested documentation is in EDMS.

V. Case File Request Documentation

The eligibility site must provide the documentation that supports the eligibility determination completed on the authorization date. The eligibility site is responsible for researching this information in CBMS and identifying the documents that are needed to prove the accuracy of the eligibility determination. At a minimum, the eligibility should always send the following documentation for all case requests:

- Citizenship/immigration status verifications;
- All of the financial verifications that were used to determine eligibility (e.g. income, resources, self-employment ledgers) within the three months leading up to the eligibility determination;
- All of the verifications that prove Non-MAGI and Long-Term Care eligibility on the authorization date; and
- Completed applications, renewal forms, and the corresponding signature pages

The documentation you are required to submit will vary depending on the aid code and program mode the case was in the authorization date. The program modes are Initial Application (IN), Redetermination (RD), and Ongoing (ON). Please see Attachment A – Documentation for Case File Requests for the more commonly reviewed aid codes and an explanation of what is needed for those aid codes when they were in a specific program mode on the authorization date. This information must be provided, or your site may receive a Missing Documentation error.

VI. Review Results and Error Findings

EQA will send the results of the case reviews to the eligibility site within three business days after the last business day of the month.

Upon receiving the results of the case review, the eligibility site must review the report provided by EQA and respond to any error findings identified in the report.

- If the report DOES NOT contain errors a response is not required.
- If the report DOES contain errors, a response is required within 10 business days.

Eligibility sites must respond to each error noted on the Review Results spreadsheet in 10 business days. Responses must be emailed to hcpf_moo_eqr@state.co.us by the due date. When responding to an error, you may either concur with the error or rebut the error.

A. Concur

If you agree with the error, type "CONCUR" in the Site Response column on the Review Results spreadsheet. Use the Site Explanation column to describe the corrective action taken by your eligibility site.

B. Rebut

If you disagree with the error, type "REBUT" in the Site Response column on the Review Results spreadsheet. Use the Site Explanation column to explain why you disagree. You must provide sufficient evidence to support

your rebuttal. EQA will examine your rebuttal and respond by the end of the month in which review results were received and rebuttals accepted.

Examples of evidence for a rebuttal include, but are not limited to:

- Federal or state rules that support your argument;
- Departmental communications, trainings, written policy clarifications, memos, or other written instructions given by the Department; and/or
- Explanation of how you have a different interpretation of the rules or communications used by EQA in their error citation.

Rebuttals received after the due date will not be reviewed and the error will stand. If the site does not respond to the error finding at all the error will stand. It is critical that your eligibility site respond to error findings within the timeframe.

If your site receives an error that you believe is a system error and should not be attributed to your eligibility site, please rebut the error and send screenshots providing that PEAK and/or CBMS are responsible for the error. If you submitted a help desk ticket (HDT) for a particular issue and are using that to rebut the error, you must provide a printed copy of the HDT that shows what you submitted, and the response(s) received from the help desk. If you only provide the HDT number without additional information your rebuttal will not be considered.

VII. EQA Resources

This section includes references and resources used for EQA reviews. When assessing the accuracy of the eligibility site's actions, EQA review's cases against the following resources:

- Code of Colorado Regulations (CCR) Volume 8
- HCPF Memo Series, Agency Letters, Director Letters. See Attachment B - Memos, Agency Letters, Director Letters for a list of some of the memos, agency letters, and director letters that may be used by EQA when reviewing accuracy. Eligibility sites are responsible for staying up to date

on memos released by the Department, including and later Operational Memo superseding previous memos and/or letters.

- State policy and procedure manuals, desk aids, and trainings
    - Document Library on TrainColorado.com
    - Training Topics, Reference Documents, and Guides
    - CO Learn trainings

Appendix A: Non-Financial Eligibility Criteria

Non-Financial Eligibility Criteria	Considerations
Citizenship Immigration Status	• Was citizenship/immigration status verified according to 10 CCR 2505-10 8.100.3.G and 10 CCR 2505-10 8.100.3.H? • If citizenship/immigration status was verified prior to the authorization date under review, did the site have those verifications and provide them to EQA for review as required by HCPF Agency Letter 11-008?
Residency	• Was residency/address data entered into CBMS correctly? • Did the caseworker act on PARIS hits where required?
Age/Date of Birth (DOB)	• Was the correct DOB data entered into CBMS?
Social Security Number (SSN)	• Was the correct SSN data entered into CBMS?
Pregnancy Status	• Was Pregnancy correctly updated with Expected Due Date and Number of Unborn(s)?
Other Health Insurance	• Was CBMS correctly updated with Other Health Insurance information, if applicable?
Emergency Medical Condition	• For individuals that do not meet citizenship/immigration requirements and have an emergency medical condition, did the caseworker correctly follow the process for Entering a Life of Limb Threatening Emergency for Emergency Medicaid into CBMS? • Did the caseworker accept the individual's self-attestation of an emergency medical condition without requiring additional verification, as required by HCPF OM 21-056?
Retroactive Assistance	• Did the caseworker follow the process for Entering Retroactive Medical Assistance into CBMS?

Appendix B: Financial Eligibility Criteria

Financial Eligibility Criteria	Considerations
Household Composition/MBU	• For MAGI cases, did the caseworker correctly data enter Household Relationships, Marital Status, and Individual Tax Information? If this information was not correctly data entered, did it cause the MBU to be out of compliance with 10 CCR 2505-10 8.100.4.E? • For non-MAGI cases, did the caseworker correctly data enter Household Relationships and Marital Status?

Income	• Was income data entered correctly? If income was not data entered correctly, did the incorrect data entry cause the total household income calculation to be out of compliance 8.100.4.C or 8.100.5.E - 8.100.5.L?
	
	• EQA's review of income data entry includes but is not limited to:
	  • CBMS Online Help instructions in the income screens
	  • User Guides in CBMS Community
	  • Process Manuals and Interface Action Guides on Train Colorado
	  • HCPF OM 21-018
	
	• Did the site request and process income verifications correctly?
	  • MAGI - 8.100.4.B, 8.100.4.C
	  • Non-MAGI/LTC 8.100.5.E through 8.100.5.L
	  • 8.100.7 C
	  • HCPF OM 20-071
	  • HCPF OM 21-045
	
	• Did the site maintain income verifications in the case file and provide them for review, as required by HCPF Agency Letter 11-008?

Reasonable Compatibility	• If the client responded to an income discrepancy letter, did the caseworker update the Reasonable Compatibility tab and Additional Information tab on the Reasonable Compatibility page? 8.100.4.C.2
Resources/Assets	• Were resources data entered into CBMS correctly? Review of resources include but is not limited to:

	• CBMS Online Help instructions in the income screens/windows • User Guides in CBMS Community • Process Manuals and Interface Action Guides on Train Colorado • 8.100.5.E through 8.100.5.M • 8.100.7.E • If applicable, were Asset Verification Program (AVP) records worked prior to requesting verifications from the client, as required by HCPF Agency Letter 17-010? • Did the site maintain resource verifications in the case file and provide them for review, as required by HCPF Agency Letter 11-008?
Transfer of Assets	• Did the caseworker appropriately follow-up on any transfer of assets, if applicable? 8.100.7.G

Appendix C: Medical and Other Non-MAGI Criteria

Medical and Other Non-MAGI Criteria	Considerations
Medicare	• Was the sampled client's Medicare information data entered into CBMS?
Disability Determinations	• If the client indicated that they needed a disability determination, was this information data entered into CBMS to trigger the disability application? • Was the client's disability information correctly data entered into CBMS?
LTC Level of Care Assessment	• Was the Level of Care received prior to approving the client for LTC or HCBS? • Was the Level of Care information correctly data entered into CBMS? • Did the site maintain the level of care in the case file and provide it for review, as required by HCPF Agency Letter 11-008?
5615 Information Sharing	• Was information from the 5615 correctly data entered into CBMS? For example, if the case management agency reported the client passed away, was this information acted upon and the Demographics screen updated with the date of death?