Medicaid Eligibility, Enrollment, and Renewal Processes and Systems Study

CASE STUDY SUMMARY REPORT – COLORADO

Prepared for:

Medicaid and CHIP Payment and Access Commission (MACPAC)

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October 19, 2018

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ACKNOWLEDGEMENTS

This project was conducted by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health, Division of Health Policy and Management. It was funded through a contract with the Medicaid and CHIP Payment and Access Commission (MACPAC). The findings, statements, and views expressed are those of the authors and do not necessarily represent those of MACPAC.

Authors of six state summary reports and a synthesis report were Emily Zylla, Caroline Au-Yeung, Elizabeth Lukanen, and Christina Worrall. Authors would like to acknowledge the many contributions made to this effort by MACPAC staff members Martha Heberlein and Kate Kirchgraber. We would also like to thank the 48 key informants in Arizona, Colorado, Florida, Idaho, New York, and North Carolina for sharing their time and insights about their experiences implementing streamlined Medicaid eligibility, enrollment, and renewal practices in their respective states. Finally, we would like to recognize Jeannine Ouellette and Andrea Stewart for their work reviewing and proofing the reports, and Lindsey Lanigan and Ann Conmy for their work on the layout, exhibits, and production of the reports.

INTRODUCTION

Over the last decade, simplifying and streamlining state Medicaid enrollment and renewal processes and systems have been a priority for state agencies. These changes were accelerated with the passage of the Patient Protection and Affordable Care Act (ACA) in 2010. The ACA called for enhancements to Medicaid, including the implementation of revised eligibility rules, a single streamlined application, and use of technology to verify and exchange data in support of near real-time eligibility determinations.[1] Additionally, the Centers for Medicare & Medicaid Services (CMS) and other federal agencies provided states with guidance and incentives to modernize and integrate eligibility systems in order to efficiently enroll Medicaid-eligible individuals.

As the legislative branch agency charged with advising Congress on Medicaid and the Children's Health Insurance Program (CHIP), the Medicaid and CHIP Payment and Access Commission (MACPAC) sought to better understand the post-ACA status of state systems and processes used to support Medicaid program eligibility, enrollment, and renewal. To do so, MACPAC contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health to conduct an assessment in selected states of current Medicaid eligibility, enrollment, and renewal practices, and the extent to which they are achieving desired goals (such as program efficiency and simplified beneficiary experience).

A case study approach was used to collect data regarding the state of practices associated with enrolling the Medicaid population for which income eligibility is determined based on Modified Adjusted Gross Income (MAGI). Specifically, we assessed auto-enrollment and auto-renewal practices, the use of electronic data sources for verification, and the degree of integration with non-MAGI Medicaid populations and other public benefit programs. Case studies did not focus on other aspects of Medicaid enrollment, namely outreach and consumer assistance, community partnerships, enrollment and credentialing of providers, and call center technology.

The study focused on six states (Arizona, Colorado, Florida, Idaho, New York, and North Carolina) where documentation showed steps toward implementing streamlined, automated or integrated approaches to Medicaid enrollment and renewal. States were selected based on a literature scan as well as discussions with MACPAC and external experts and represented diversity across a range of characteristics including Medicaid program size, exchange type, adoption of the ACA Medicaid expansion, current enrollment and renewal practices, geography, and political climate.

This case study summary report includes findings from Colorado based on: telephone interviews with eight key informants conducted in May and June of 2018; a review of publicly available and state-provided documents (e.g., verification plans submitted to CMS); and data collected from state agencies in advance of telephone discussions on the organization of the state's Medicaid program, eligibility system, and other information technology resources to support MAGI Medicaid eligibility determination. (See the Appendix for a copy of the data collection form used to gather information in advance of telephone interviews.) Key informants in Colorado represented state Medicaid eligibility, policy, and information technology divisions, county agencies, the state-based exchange, and an advocacy organization with perspective on enrollment assistance in the state.

The case study begins with an overview of Medicaid in Colorado and a high level description of how individuals apply and their eligibility is determined for MAGI Medicaid populations. Included in this

[1] According to CMS guidance, real time refers to no delay between submission of a complete and verifiable application and the response to the applicant. (CMS n.d.)

overview section are case study findings related to the approaches Colorado is taking to streamline enrollment and renewal for MAGI Medicaid populations. Next, we present key themes, as identified by key informants, related to Medicaid program and beneficiary experiences, including successes and challenges of Colorado's approaches. Lastly, we summarize ongoing issues and future plans in the study state to further simplify and streamline enrollment.

STRUCTURE OF MAGI MEDICAID ENROLLMENT AND RENEWAL

Colorado Medicaid, known in the state as Health First Colorado and Child Health Plan *Plus* (the State's Children's Health Insurance Program [CHIP]), resides in the Colorado Department of Health Care Policy and Financing (HCPF), which has oversight over all aspects of Medicaid program administration, including eligibility determination at application and renewal. The program is county administered, meaning that staff in the 64 counties across the state work with HCPF and state systems to facilitate Medicaid eligibility determination, enrollment, and renewal for county residents. County workers also facilitate enrollment in other human service programs. As of 2017, HCPF has 34 Medical Assistance sites that support beneficiaries with applications for HCPF programs (Health First CO 2017).[2]

Implementation of the ACA led to considerable growth in Medicaid enrollment (70 percent) between the July through September 2013 period and April 2018 (CMS 2018a). During that time, Colorado adopted a number of provisions to support streamlined eligibility in Medicaid and to expand coverage. In January 2014, Colorado expanded Medicaid under the ACA and implemented 12-month continuous eligibility for Medicaid and CHIP (Child Health Plan *Plus*, CHP+) eligible children, regardless of changes in the family's circumstances (e.g., changes to household income or size) (Colorado HCPF 2015). As of April 2018, total Medicaid and CHIP enrollment was 1.3 million individuals, or 24 percent of the state population (CMS 2018a, Census 2017). Colorado also established a state-based health insurance exchange called Connect for Health Colorado, a quasi-governmental organization designed to support the purchase of health insurance plans and assess Medicaid eligibility. **Table 1** provides an overview of MAGI Medicaid eligibility and Advanced Premium Tax Credit (APTC) thresholds in the state.[3]

Table 1. Colorado MAGI Medicaid Eligibility and Advanced Premium Tax Credit (APTC) Thresholds, by Coverage Group, 2017

Coverage Group	100% FPL	200% FPL	300% FPL	400% FPL
Pregnant Women	200% (Medicaid)		> 200%-400% (APTC)	
Children (Age 0-18)	142% (Medicaid)	142%-265% (CHP+)	>265%-400% (APTC)	
Parents & Caretaker Relatives	138% (Medicaid)	> 138%-400% (APTC)		
Adults (Age 19-65)	138% (Medicaid)	> 138%-400% (APTC)		

Sources: Brooks et al. 2018; CO HCPF 2017.

Notes: Eligibility levels are reported as a percentage of the Federal Poverty Level (FPL). Percentages include the five percentage point disregard established under the ACA, which can be applied to eligibility determination for MAGI Medicaid individuals. CHP+ refers to the State Children's Health Insurance Program – CHIP, where enrollment fees and co-payments may apply. Medicaid eligibility for parents is the upper income limit for a family of three. Acronyms are as follows: MAGI – Modified Adjusted Gross Income, CHP+ – Child Health Plan *Plus*.

[2] Medical Assistance sites provide an additional location for individuals and families in Colorado to apply for Medicaid and CHIP. HCPF certifies Medical Assistance sites on a rolling basis. Sites accept and process applications and use CBMS to determine eligibility for Medicaid and CHIP. According to HCPF's website, sites include community health centers, hospitals, schools, and other state approved agencies.

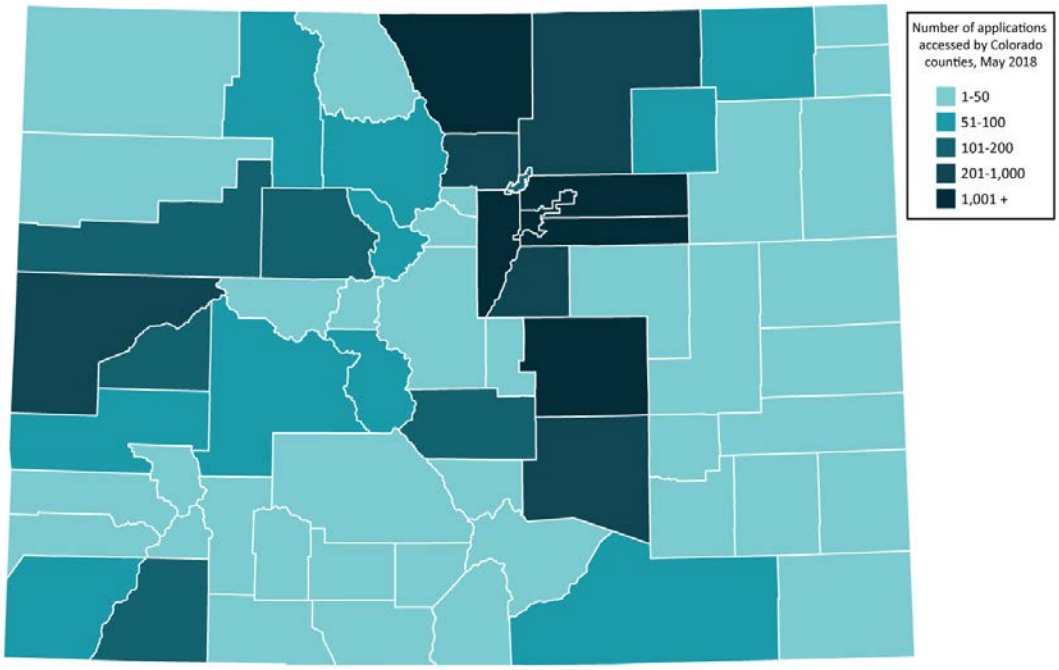
[3] APTC is a mechanism for consumers to receive financial assistance, i.e., lower monthly premiums, to purchase health insurance coverage through an exchange. Cost-sharing Reductions (CSR), extra discounts that lower the amount a consumer has to pay for deductibles, co-payments, and coinsurance, are another mechanism.

Application options and eligibility systems

Colorado offers a streamlined application process such that individuals can use a single application to apply for Medicaid, CHIP, health insurance coverage available through the exchange, as well as a variety of human services programs offered in the state. Consistent with the ACA, Colorado's combined application can be submitted through multiple modes: in person, mail, telephone, and online.

Colorado residents can submit applications for Medicaid and other coverage online in two ways: the HCPF's cloud-based Program Eligibility and Application Kit (PEAK)—a consumer-facing portal—and Connect for Health Colorado, the state's exchange website. Respondents reported that MAGI-determined populations more frequently apply using the PEAK combined application, although monthly PEAK use varies considerably by county. (See **Exhibit 1** for a map of PEAK use in May 2018 by county.) Not surprisingly, respondents observed increased use of the Connect for Health Colorado's website during annual open enrollment periods. The combined paper application also continues to be commonly used at county human services departments.

Exhibit 1. Colorado (CO) Program Eligibility and Application Kit (PEAK) Use by County



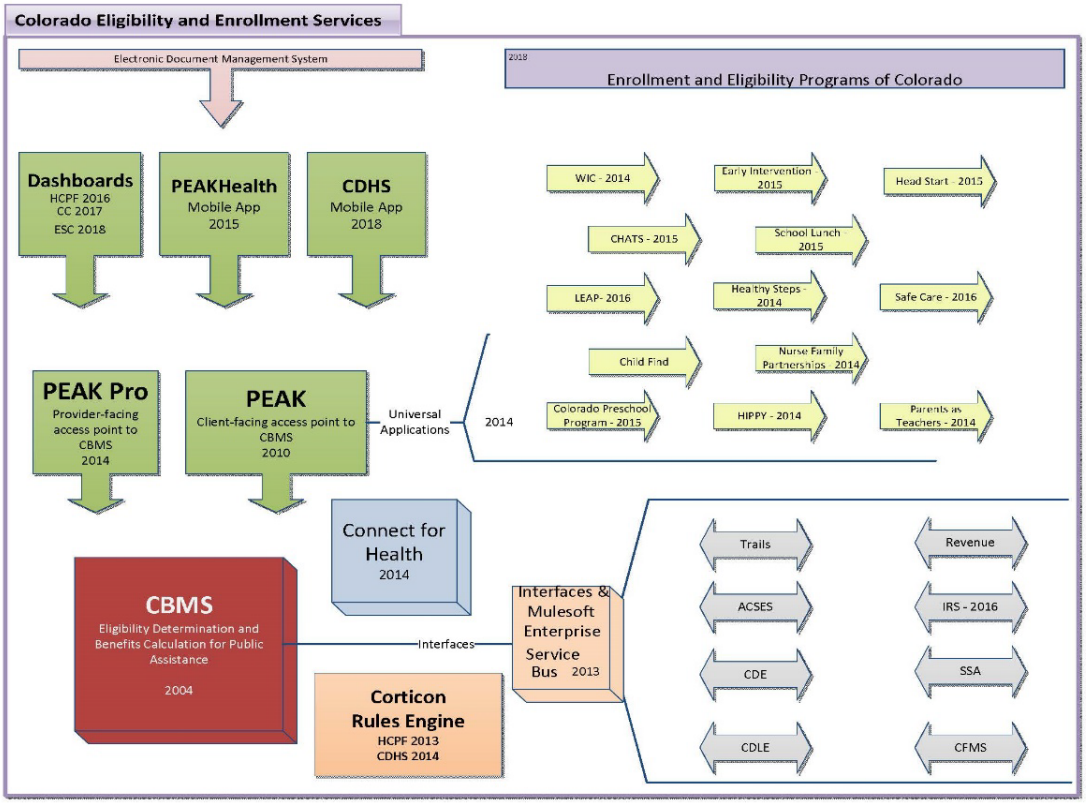
Source: CO PEAK 2018.

Individuals can view the status of their application, upload documents, and report changes about themselves or their family members all in PEAK, either online or through their mobile devices. One county agency representative described how a PEAK feature provided information to individuals faster and without county worker involvement: "I think when we were able to put the status of the application on PEAK, it reduced the number of calls coming into counties. So I submit my application and then 30 days later I hear something was the old model. So people would call. Well now, they can go in and see that it's received or it is pending, pending exactly what might be holding up the application due to Social Security card or income. So that status piece has been great." One large county put kiosks in office lobbies (instead of paper applications) to encourage use of PEAK, which freed up county worker time to focus on other cases. PEAKPro Access—an online tool to help authorized entities assist beneficiaries to enroll in and renew benefits—was made available to select community organizations. One respondent felt that this feature helped facilitate access to the online application for hard-to-reach populations.

Application information for Medicaid, whether it originates on paper or electronically from PEAK or Connect for Health Colorado, is fed into a shared eligibility system (SES) known as the Colorado Benefits Management System (CBMS). CBMS is used to determine eligibility and calculate benefits, and serves as the official record of eligibility for Medicaid and several other public assistance programs. See **Exhibit 2** for a depiction of information flows associated with Colorado's enrollment and eligibility services and how CBMS connects with electronic data sources to verify beneficiary information.

Supporting CBMS is a business rules engine, which automates the application of program eligibility rules. This information technology resource was implemented for Medicaid in 2013 and for human service programs in 2014. Respondents noted that this robust rules engine was critical in facilitating streamlined eligibility determinations and enrollment.

Exhibit 2. Colorado Enrollment and Eligibility Program Information Flow



Source: CO OIT 2018.
Note: Acronyms are as follows: PEAK – Program Eligibility and Application Kit, CBMS – Colorado Benefits Management System.

While ownership of CBMS resides in the Governor's Office of Information Technology, several agencies participate on an Executive Steering Committee that oversees and allocates resources toward both PEAK and CBMS.[4] Participating agencies include HCPF, the Department of Human Services, Office of Information Technology, Connect for Health Colorado, as well as county agencies. The Office of Information Technology is currently in the design stages to shift CBMS to a web-based platform (Salesforce 2018). Colorado has adopted an aggressive timeline for this major system replacement effort

[4] Since 2008, information technology resources that support the state have been consolidated under the Office of Information Technology.

due to the expected expiration of the Office of Management and Budget (OMB) cost allocation exception waiver in December 2018 (known as OMB Circular A-87).[5]

Electronic verification for MAGI Medicaid beneficiaries

Colorado verifies eligibility factors for MAGI Medicaid in one of three ways: self-attestation, real-time verification, and post-eligibility review. See **Table 2** for a description of some of the verification practices and electronic data sources accessed. To the extent possible under the law, Colorado allows beneficiaries to self-attest factors of eligibility such as age, residency, and household composition. Social Security number and citizenship (where self-attestation is not allowed) are verified in real time through pre-ACA state interfaces with electronic data from the Social Security Administration rather than the Federal Data Services Hub.[6] Data from the Colorado Department of Motor Vehicles is used to verify identity.

Colorado verifies beneficiary income information during a post-eligibility determination process. To do so, Colorado leverages the Income and Eligibility Verification System (IEVS), an interface automated in 2011 in partnership with the Colorado Department of Labor and Employment (CDOLE).[7] IEVS houses earned income, unearned income, and unemployment compensation. According to state respondents, IEVS reduced the need for paper verifications, which decreased burden on individuals and eligibility workers. One respondent commented, "[IEVS] reduced the need for members to…have to get paystubs or employer letters or whatever it may be."

Income information in IEVS is not available until the quarter after income is attested on the application. When the self-attested income is not reasonably compatible with the data in IEVS, the individual receives a notice, known as an IEVS discrepancy letter, from HCPF asking for an explanation of the difference, or proof that the income information in IEVS is inaccurate.[8] If a person does not provide either a reasonable explanation for the discrepancy or proof that the IEVS amount is inaccurate within 90 days of the notice, their eligibility is re-determined based on the IEVS data, which may result in a loss of Medicaid eligibility and termination of coverage.

[5] OMB Circular A-87 allowed states to use enterprise-wide assets for Medicaid, exchange, and CHIP systems for other programs (such as food supports) without having to charge those programs.

[6] The Federal Data Services Hub is an electronic resource developed by the Centers for Medicare & Medicaid Services (CMS) that provides data verification services to state-based exchanges, the federal facilitated exchange, and all Medicaid agencies regardless of expansion adoption. Data sources provided through the hub include those from relevant federal agencies such as Social Security Administration (SSA), the Department of Homeland Security (DHS), and the Internal Revenue Service (IRS).

[7] One county with whom we spoke reported using the Work Number proprietary data set (which is stored in CBMS) to verify income more quickly. While not needed for MAGI Medicaid cases, it facilitated verification for other public assistance programs.

[8] The IEVS letter is separate from a Verification Checklist (VCL) letter, which is mailed to individuals or households when additional information is needed to determine or continue eligibility for assistance, at application or renewal. Examples of what may be requested on a VCL included bank statements, Social Security cards, and proof of identification.

Table 2. Colorado Verification Practices for MAGI Medicaid at Application and Renewal

Select Eligibility Factor	Self-Attestation	Financial and Non-Financial Data Sources			Notes
		Federal Agency	State Agency	Private	
Income	Yes – V	N/A	Income Eligibility and Verification System (IEVS) from Colorado Department of Labor and Employment (CDOLE)	Work Number (select counties)	IEVS used to verify earned/unearned income and unemployment post-eligibility determination.
Residency	Yes	N/A			
Social Security Number	Not allowed	State Data Exchange, Social Security Administration (SSA)			Colorado chose existing state feed over Federal Data Services Hub.
Citizenship	Not allowed	SSA			Colorado chose existing state feed over Federal Data Services Hub.
Immigration Status	Not allowed	Federal Data Services Hub, Department of Homeland Security (DHS), Systematic Alien Verification for Entitlements (SAVE)			
Age	Yes	N/A			
Medicare	Yes				
Application for Other Benefits	Yes				
Multiple Factors			Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF)		SNAP, TANF reported changes available to support Medicaid determinations.

Sources: CMS 2018b; Data collection and verification under the 2018 Assessment of Medicaid Eligibility, Enrollment and Renewal Processes and Systems project, Medicaid and CHIP Payment and Access Commission (MACPAC) contract number MACP18417T1.

Notes: "Yes – V" indicates that states allowed self-attestation but required post-eligibility verification. The Internal Revenue Service (IRS) data is utilized by Connect for Health Colorado. Acronyms are as follows: MAGI - Modified Adjusted Gross Income, N/A – Not Applicable.

Auto-enrollment and renewal

Auto-enrollment in Colorado refers to the process of determining eligibility in real time without beneficiary or worker involvement. Respondents in Colorado reported that the state sets a high goal, 75 percent, for auto-enrollment of its MAGI Medicaid population at application. Colorado has been able to meet or exceed this goal, according to recent data which was confirmed by respondents (Brooks et al. 2018). Respondents indicated several key facilitators of auto-enrollment of MAGI Medicaid populations: 1) online application, 2) automated rules, 3) interfaces with electronic data sources for verification purposes, and 4) the post-eligibility verification of income (described more in the next section).

Respondents described auto-renewal of MAGI Medicaid eligibility in the state in two ways. The first, known as medical cases, refers to no-touch renewal for members with medical coverage only. These members receive a Pending Verifications at Redetermination packet (either in paper form, electronically, or both). This prepopulated form contains information that was either previously provided by the beneficiary (such as at application or when updating a change) or populated through state data interfaces. The packet also conveys whether HCPF needs additional information. Colorado state stakeholders believed the prepopulated renewal form was effective as a tool to improve accuracy of beneficiary data. One state representative explained, "[I]f they haven't engaged with us in a year, sometimes they're not going to remember what data they had in over a year. So, by having this in front of them, it just helps them along to figure out, 'Oh yeah, that's the same,' or 'Oh, maybe I should change that.'" However, several county and other community stakeholders reported that beneficiaries needed help to explain the packet from the state.

Respondents described another type of auto-renewal for financial cases in the state known as ex parte renewals. Financial cases are defined as those in which a resident was receiving both medical (e.g., MAGI Medicaid) and non-medical (e.g., SNAP) coverage. Medicaid renewal for these cases could be initiated automatically based on the SNAP renewal timing. In these cases, SNAP data is used to conduct the ex parte renewal for Medicaid. While Colorado respondents could not report a specific goal for either auto-renewals or ex parte renewals, they reported that the state was meeting the federal standard (95 percent) for timely renewals, meaning completed within 45 days. Another study found that at least 75 percent of Colorado MAGI Medicaid cases were auto-renewed (Brooks et al. 2018).

Facilitators of timely and low-touch renewals highlighted by stakeholders included the electronic interfaces in the shared eligibility system, the ability to verify eligibility factors such as income at the renewal date of another program (such as SNAP), and the prepopulated form. Several respondents also cited Colorado's continuous eligibility for children as an effective policy for streamlining Medicaid enrollment. Continuous eligibility for children took effect in March 2014 for MAGI Medicaid beneficiaries and October 2015 for non-MAGI Medicaid beneficiaries (Colorado HCPF 2015). Under continuous eligibility, children maintain Medicaid and CHIP coverage for up to 12 months, regardless of changes (such as household income or size) in the family's circumstances during the year (Colorado HCPF 2015). After initial verification of self-attested income in the first quarter of their enrollment period, there is no beneficiary interaction with PEAK or CBMS. While quarterly income checks in IEVS continue, any income changes do not affect eligibility of children in the household; however, they may still affect eligibility for adult household members (Colorado HCPF 2015).

Integration of MAGI Medicaid eligibility determination with other health or human services programs

Colorado agencies had a vision, predating the ACA, for horizontal integration of Medicaid and other health and human services programs. To support that vision, the state developed both a shared eligibility system (CBMS) that includes both health and human services programs, and a combined online application (PEAK). CBMS, first implemented in 2004, now supports eligibility determination and benefit amounts for Medicaid, CHIP, Connect for Health Colorado, SNAP, Colorado Works (the state's Temporary Assistance for Needy Families [TANF] program), and Child Care Assistance Program. PEAK design began in 2009, and by 2011 the state launched PEAK as a statewide combined online application for medical, food, and cash assistance. At the time of interviews, PEAK supports application or screening for 13 programs. Respondents reported that while the PEAK application has supported an increasing number of non-medical programs over the last eight years, CBMS only determines eligibility for a subset of these programs.

Challenges commonly cited with the state's integration of MAGI Medicaid and other programs were the difficulties updating CBMS's rules engine to accommodate different program requirements (which are often stricter than MAGI Medicaid) in one system. As one respondent explained, "Because we do have an integrated system, something for example that Medicaid could do to streamline…may not be viable from a CDHS [Colorado Department of Human Services] perspective. So, it kind of stops us from [seeing] how far we can take it and vice versa." However, one respondent reported state progress in terms of alignment of requirements across the MAGI Medicaid and SNAP programs: "One of the innovations within our state was to align our Medicaid expansion to our food assistance requirements. That simplifies things so much more in terms of if you're at this level, you are most likely eligible for food and Medicaid. And just aligning those thresholds across programs and coming to some consensus about where those thresholds should be, are—it's something very simple it seems. But in terms of trying to implement and implement a universal [combined] application or help a client who is on multiple programs with multiple renewal dates and multiple income levels of when they may or may not fall off of a program, suddenly you start to realize that complexity becomes overwhelming for the client."

Respondents noted the substantial costs of maintaining and enhancing a shared eligibility system. For example, one respondent mentioned that the state's vendor budget for CBMS maintenance and enhancements is up to 120,000 hours of work per year, adding: "Every time we change [CBMS], we redeploy 14 million lines of code. And that is risky. We frequently introduce defects [in] nearly every build, so we have an ongoing process to alleviate those." However, respondents universally shared the perspective that the benefits of a shared eligibility system, especially in terms of the beneficiary experience, outweighed the costs. Both state and community stakeholders articulated the value of having one system processing eligibility determination for more than one program, as multiple agencies were able to both financially and operationally leverage the same technology.

Colorado also supports integration of Medicaid with other health programs through CBMS by co-locating staffing resources at the state and local levels to assist beneficiaries through application, eligibility determination, enrollment, and renewal. For example, Connect for Health Colorado has onsite HCPF Medicaid Assistance staff with edit privileges in CBMS. These workers are able to address issues experienced by mixed-coverage households that the exchange cannot do on its own. Respondents felt that having county eligibility workers or Medical Assistance staff co-located with exchange navigators facilitated application and renewal processing for mixed-coverage families. One respondent commented, "[The exchange] doesn't have to transfer mixed-household cases into different customer service queues."

Stakeholders shared examples of county-level innovation to further streamline eligibility, enrollment, and renewal processes for caseloads that spanned health and human services assistance programs. Arapahoe County, in particular, the third most populous county in the state and a county with high PEAK use, needed a solution to more efficiently and effectively manage the workflow of combined cases, meaning cases eligible for both health and non-health programs. At the same time, they sought to improve the client experience with respect to providing required documentation to verify application or renewal data. The result was HS Connects, an electronic document and workflow system supporting county residents, which launched in 2015. HS Connects stores and processes client information that may be needed for more than one program and shares it with county workers. When clients mail or drop off hard-copy materials at either of Arapahoe County's two office locations, they are scanned into the HS Connects system and automatically placed into a worker queue, according county rules and priorities as well as information from CBMS. With respect to MAGI Medicaid cases, respondents reported increased timeliness and quality of processing of determinations over the last couple of years. At the time of our interviews, HS Connects was being adopted by several other counties, both large and small.

MEDICAID PROGRAM AND BENEFICIARY EXPERIENCES

As described above, HCPF decision-making related to current streamlined enrollment and renewal practices for MAGI Medicaid populations emphasizes easy access to a variety of health and human service programs. Findings in this section summarize key themes, as identified by interview respondents, related to Medicaid program and beneficiary experiences. The Department has created one combined application for multiple health and human services programs; respondents highlighted both PEAK successes and challenges. HCPF accepts self-attested information and conducts income verifications post-eligibility to facilitate high rates of MAGI Medicaid determinations in real time. Respondents shared the issues associated with frequent post-eligibility income verification processes and recent changes to client notices.

PEAK served as an effective "no wrong door" to public assistance

Almost all respondents highlighted the benefits to individuals that resulted from having one place where they could go to apply for any assistance, rather than having to submit the same information multiple times through different avenues. One state agency respondent described PEAK in this way: "The neat thing is, we have been growing that over time, adding other programs that are outside of Medicaid, SNAP, and TANF, so that clients in Colorado have one place to go where they can apply for benefits including Healthy Steps, Nurse Family Partnerships, Parents as Teachers, Safe Care, School Lunch Program, Early Intervention. So, for a person in Colorado trying to go one place to get assistance, I think that's been great." Another stakeholder discussed the effect of PEAK, as well as CBMS, on county workers: "The majority of our cases are receiving multiple benefits, and so if I had to go in and enter income on three different systems because someone is getting three different programs, the amount of workload and time that that would take for counties to determine eligibility would be significant. Rather than being able to enter it one time and run it once for all the programs."

Issues with coherence of PEAK application affected its use by both consumers and program staff

Several respondents reported that the wording and sequencing of application questions, as well as the likelihood for error in how beneficiaries enter income information in PEAK may have steered both beneficiaries and workers away from using PEAK and toward use of the paper application. One county representative explained, "The information coming in, how the client puts the information in, may adversely affect their determination. So, as counties, county workers go in and have to rework those cases. Which then leads to a feeling like the online application doesn't work, which then leads to folks promoting the use of the paper application over the online application." One county shared that they have instituted manual workarounds to avoid electronic transfer of specific application information that introduces errors in CBMS.

Exchange customers were another user group that reportedly found the combined application through PEAK cumbersome. One county representative described the current exchange integration: "Basically someone goes through an application on PEAK, if they are denied Medicaid, the system would give them their Premium Tax Credit amount and then they would move over [to the exchange site] and shop." Because the information required at the beginning of the PEAK application was designed for Medicaid program purposes, exchange customers felt the intake questions were excessive and not in line with private coverage industry standards. One respondent remarked, "The question we get a lot is, 'Well why aren't you just like Orbitz? I just want to be able to easily click through and compare. I don't want to have to put in pages and pages and pages of information in order just to see how much my plan's going to cost or see how much tax credit I could get.'"

In response to some of these challenges, the exchange introduced changes for 2016 open enrollment, including the development of an expedited path to enter income information for beneficiaries seeking determinations for coverage through the exchange only.[9] Applicants applying for Medicaid and CHIP used the standard pathway based on monthly income and expenses (Connect for Health 2015). Also, as of 2018, the exchange Board of Directors made a major decision to separate exchange eligibility determination from that of other health and non-health assistance programs in the state. (This decision is discussed further in the Looking Forward section.)

Relatively high rate of real-time eligibility determinations for MAGI Medicaid applicants led to faster case referrals to counties

As noted earlier, respondents attributed the state's high rate of real-time MAGI Medicaid eligibility determinations to self-attestation of several eligibility factors, interfaces with both federal and state electronic data sources for verification purposes, automated rules engines, electronic document management, and the post-eligibility verification of income. One respondent quantified the effect of state processes and systems to support real-time Medicaid eligibility determinations. "We took determination from 45 days to 45 minutes for 70 to 80 percent of the applications. At least the Medicaid applications processed via PEAK. What that allowed us to do was go from 30,000 applications per month pre-ACA to 60,000 applications processed per month without increasing the county workforce. And I think that was a big deal." Real-time determinations not only facilitated more efficient processing of applications, but also timely notifications to counties to begin work on cases eligible for other benefits.

[9] The expedited pathway was an option for citizens who filed taxes and had access to their total household taxable income.

Cases that were reported as more likely to fail real-time eligibility determination at application included those unable to provide a valid Social Security number at application, those with income discrepancies, and those with insufficient information to determine whether the applicant is new to public assistance. One respondent also suggested that real-time determinations were hindered by how CBMS interfaces with electronic data sources. Specifically, this respondent reported that CBMS could only access electronic data sources within a specified window at the end of the application process. If the data sources were not accessible during that window, information could not be verified, and correspondence would be required.

One county representative with whom we spoke did report lower success (under 50 percent) with real-time eligibility determinations and auto-enrollments in the county, due in part to the inability to verify electronically whether the applicant was new to public assistance and the CBMS system. However, state agency staff reported that Colorado as a whole met or exceeded its goal of 75 percent of MAGI Medicaid cases determined eligible in real time. According to one state agency respondent, "We are looked at [by] other states on how we have done real-time eligibility because of the ACA."

Frequent post-eligibility income verification generated beneficiary confusion and worker involvement

While post-eligibility verification of income facilitated real-time eligibility determinations, the period for reporting income data (i.e., quarterly income), as well as the frequency of verification (at least three times per year) often created confusion for both beneficiaries and county workers. This happened frequently because beneficiaries were not accustomed to thinking about their income in three-month increments, they experience income fluctuations, and the quarterly verification may have triggered correspondence from the state about a discrepancy that was confusing.

Beneficiaries who had an IEVS discrepancy, meaning their self-attested income and the income data from IEVS were not reasonably compatible, received an IEVS letter that was not consumer friendly. Beneficiaries' confusion about IEVS notifications caused downstream effects on county agency workloads. One county representative explained, "Client correspondence has been a massive workload issue. The volume of notifications that are sent out automatically by the system, the fact that the language comes from a policy perspective rather than from a consumer or a client perspective, has been hugely problematic in our state. It drives a lot of phone calls, a lot of confusion, [and] a lot of rework because the client just doesn't understand. And they'll receive a notice that says you're denied and you're approved all in the same notice. And oftentimes county staff for instance don't even understand."

Changes mandated to improve and monitor client notices

Beneficiary notice issues rose to the attention of the state legislature in 2016. The Interim Study Committee on Communication between HCPF and Medicaid Clients was created and supported four bills to address consumer notice issues. Simultaneously, county agency staff serving on an integrated program team fielded a study to quantify the worker time devoted to addressing notice confusion and testified during a legislative session. Three bills passed in the 2017 legislative session, including new requirements to conduct regular client correspondence audits as well as the implementation and testing of improvements to simplify consumer notice content and ensure beneficiary comprehension. The state plans continued improvements to the correspondence engine of CBMS, which generates various notices such as the IEVS letter and redetermination packet. Several respondents spoke positively about the recent formatting and language revisions to client correspondence notices (e.g., clearer timelines for action).

LOOKING FORWARD

As respondents reflected on Colorado's MAGI Medicaid enrollment and renewal practices, they identified several ongoing issues that are being closely monitored, including process and system changes.

Efforts to improve PEAK usability continue

All respondents mentioned the ongoing work to increase access to PEAK, including making PEAK more user-centered. At the time of our interviews, a PEAK Outreach Initiative was currently underway, and a PEAK Usability Study had already been completed in select counties. Results from the PEAK usability study pointed to a great deal of confusion about wording, definitions, and sequencing of questions on the PEAK application. According to one respondent, "[I]n so many ways our PEAK system is a policy-driven system, not a consumer-driven system." One key improvement strategy cited in interviews was a partnership between Colorado and Code for America, a nonprofit devoted to using technology and community input to create user-centered solutions in government to improve member and county worker experiences with the PEAK Report "My Changes" feature. CBMS is also planning to hire a client experience manager to represent the client view of PEAK. Finally, Colorado has, over the last two years, launched a state and county dashboard that displays PEAK take-up, use, and results, which provides decision makers with data to inform outreach or practice transformation interventions.

Exchange plan determination processes are to be separated from CBMS

As of open enrollment for 2019, Connect for Health Colorado will take over the responsibility for final eligibility determination for APTC, cost-sharing reductions (CSR), and exchange plans from the state. As stated earlier, respondents reported ongoing challenges with CBMS's ability to support accurate and cost-effective APTC and CSR determinations. In addition, one respondent cited a CMS audit stating that aspects of the exchange's reliance on CBMS resulted in some deficiencies (Levinson 2015).[10]

Several potential benefits to the exchange customers have been cited, including a new online application that is more consistent with exchange requirements, improved correspondence, and more exchange cases determined eligible in real time. Potential benefits cited to the exchange included ownership over technology costs (Connect for Health 2018).

County and community stakeholders with whom we spoke expressed concern, however, about how this decision may affect the "no wrong door" practice, as well as their ability to effectively serve mixed-coverage households. The current understanding of the new process is that if a Medicaid-eligible individual applies through the new Connect for Health online application, it will be possible to screen and refer the case to PEAK and CBMS for final determination. However, once the new system is operational, local stakeholders expect to have less information available to them to help mixed-coverage households. One stakeholder commented, "In the new system, we're told we won't be able to see their [subsidy or tax credit] amount. We'll only be able to see that they've been approved or denied. So, it just may reduce the amount of information we're able to help give before [workers] have to call Connect for Health."

Another respondent reflected on the separation and how it might affect the county workforce: "I think it means that we're going to be reliant on Connect for Health Colorado to be providing a lot of that case support and customer support that we traditionally have been able to do in-house. And I can see that slowing down the process and potentially slowing down and creating a barrier. Because we'll have to ask a client to come back because we won't have a tax credit to help them shop."

[10] A Department of Health and Human Services Office of Inspector General report from December of 2015 found internal control deficiencies in three areas: performing verifications for applicants who enrolled in an exchange plan but no other insurance affordability programs, accessing electronic data to assess whether applicants were federal employees, and resolving eligibility data inconsistencies.

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APPENDIX

PRE-TELEPHONE DISCUSSION DATA COLLECTION FORM

MACPAC ELIGIBILITY, ENROLLMENT, & RENEWAL PROCESSES AND SYSTEMS STUDY

PRE-TELEPHONE DISCUSSION DATA COLLECTION FORM: COLORADO

We realize that your agency is extremely busy. In order to maximize our time together on the telephone, we are requesting that you review this form to verify blue text or enter in the blue shaded areas information about your current Medicaid program and supporting eligibility systems. Please make any corrections directly on/in the document. This form should take about 10 minutes to complete.

1) **Name of Medicaid Agency:** Department of Health Care Policy and Financing

2) **What is the PRIMARY agency responsible for Medicaid eligibility determination at ENROLLMENT if different from Medicaid agency above:**

3) **What is the PRIMARY agency responsible for Medicaid eligibility determination at RENEWAL (if different from #3):**

4) **Please confirm other governmental or quasi-governmental agencies/organizations/programs that regularly work with the PRIMARY agency above on Medicaid eligibility determination:**

Agency Name	Agency Type	Involved at Enrollment (Check if yes)	Involved at Renewal (Check if yes)
	Separate CHIP	☐	☐
	Other State Agencies	☐	☐
Connect for Health Colorado	State-based Marketplace	☒	☒
	Federally Facilitated Marketplace	☐	☐
Enter specific areas if not statewide:	County or City Agencies	☒	☒
Enter name:	Other Medical Assistance Sites	☒	☒

5) **Please identify and describe the primary computer or information technology (IT) system currently used by agency staff to support individual Medicaid eligibility determination, re-determination, and/or tracking for Colorado's MAGI Medicaid populations.**

System Name: Colorado Benefits Management System / Program Eligibility and Application Kit

Year System Implemented: 2004/2009

If not replaced in the last 10 years: Major System Modification? **Yes** X **No** ☐ **N/A** ☐

Year of Major System Modification: 2013/2015

Vendor(s) Used for Recent System Replacement/Major Modification: Deloitte

System Statewide: **Yes** ☒ **No** ☐

If no, please describe geography covered: ---

6) Please identify the other programs/benefits for which individual eligibility is determined and/or tracked through the primary Medicaid eligibility system named in Question #6 above.

Name of Program/Benefit	Type of Program/Benefit	Integrated at Application (Check if yes)	Integrated at Renewal (Check if yes)
Child Health Plan *Plus*	CHIP	☒	☒
Health First Colorado	Other Non-MAGI Medicaid programs	☒	☒
Connect for Health	Other non-Medicaid health insurance programs (marketplace, commercial plans, etc.)	☒	☒
SNAP	SNAP	☒	☒
Colorado Works	TANF	☒	☒
Child Care Assistance Program	Child care	☒	☒
	Child support	☐	☐
Enter names:	Other non-health programs/benefits	☒	☒

Source: https://www.colorado.gov/hcpf/program-list.

7) Please provide an estimate (in Column A) of the timeliness of MAGI Medicaid eligibility determination at application and the extent to which renewal is automated in Colorado. Alternatively, please verify the survey data (in Column B) from the source cited below.

	A. Percent of Applications (estimate)	B. Percent of Applications (Kaiser/Georgetown Survey)*
MAGI eligibility determinations are completed within **24 hours** of application		**50-75**
MAGI eligibility determinations are completed within **one week** of application		
MAGI cases are **auto-renewed** (also known as ex parte renewal, passive renewal, or administrative renewal)		**75+**

*Source: Brooks, T., Wagnerman, K., Artiga, S., and Cornachione, E. 2018. Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2018: Findings from a 50-State Survey. Washington, DC: Georgetown University Center for Children and Families and Kaiser Commission on Medicaid and the Uninsured. http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-Enrollment-Renewal-and-Cost-Sharing-Policies-as-of-January-2018

8) Please confirm that the Medicaid/CHIP Eligibility Verification Plan for Colorado on record with CMS is up to date. The information we have for Colorado is found here:

https://www.medicaid.gov/medicaid/program-information/eligibility-verification-policies/downloads/colorado-verification-plan-template-final.pdf

Is this the most current verification plan? **Yes** ☒ **No** ☐

If not, where can we access the current verification plan?
Please provide link or attach with date.

9) Please indicate which IT resources are used to support eligibility determination and renewal for Colorado's MAGI Medicaid populations, including year implemented.

Information Technology Resources	Start Year	MAGI Medicaid only? (Check if yes)	Is this resource used at application (Check if yes)	Is this resource used at renewal (Check if yes)
Multi-benefit/combined online application for health and non-health insurance (e.g., food stamps) programs	2013	N/A	☒	☒
Online eligibility screening tools		☐	☐	☐
Self-service case management for clients, e.g., to check application status, report changes, renew		☐	☒	☒
Document management or imaging tools for clients, e.g., to support upload and routing		☐	☒	☒
Mobile applications for clients		☐	☒	☒
Document management or imaging tools for staff		☐	☒	☒
Staff portals		☐	☒	☒
Navigator/assister portals		☐	☒	☒
Business rules engines to automate calculations based on rules and logic		☐	☒	☒
Eligibility system interface with MMIS, e.g., claims		☐	☒	☒
Other IT resources, e.g., applications/tools, online accounts or portals, system modifications or interfaces				
Specify other IT resource:		☐	☐	☐
Specify other IT resource:		☐	☐	☐

10) Of the IT resources listed above, which would you describe as most critical to supporting MAGI Medicaid eligibility determination and renewal? Rank the top three.

#1	**CO.gov/PEAK—multi-benefit online application**
#2	Self-service case management for clients
#3	Business rules engines to automate calculations based on rules and logic

Thank you for your time!