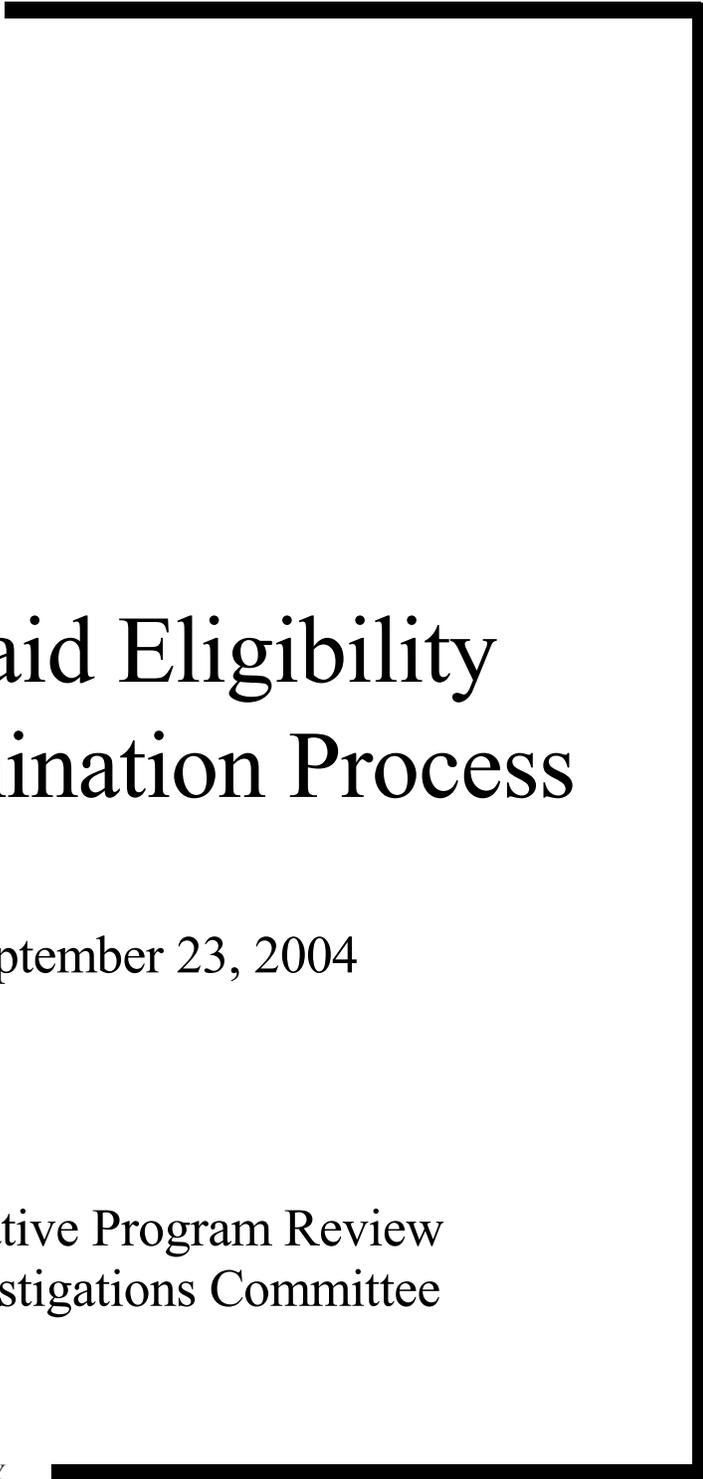


Staff Briefing



Medicaid Eligibility Determination Process

September 23, 2004

Legislative Program Review
& Investigations Committee

Study Purpose

- Evaluate the timeliness, efficiency, and effectiveness of the eligibility determination process for Medicaid in Connecticut.
- Analyze the impact the state employee layoffs, early retirements, and DSS office closings have had on the process.
- Identify problems in the eligibility processing of applications, and propose remedies.

Report Organization

- This report contains five sections:
 - a synopsis of Medicaid, including its key features and a profile of Connecticut's program;
 - a description of how Connecticut operates its Medicaid program, including who determines eligibility, how it is determined, and the administrative resources devoted to operating the program;
 - a description of Connecticut's Medicaid program by population, including eligibility criteria and processing time requirements, overall service features, and caseload data;
 - a description of management and oversight of the Medicaid program and operations;
 - an analysis of the eligibility determination process, timeliness issues and contributing factors; and
 - a glossary of common Medicaid terms is provided in Appendix A.

Methods

- Committee staff used the following methods and information sources for this study:
 - review of federal and state laws and regulations;
 - review of DSS policies and procedures;

- interviews with: DSS staff (central office and regional), advocacy groups, federal Centers for Medicare and Medicaid staff (Northeast Region), attorney general's office, American Federation of State, County, and Municipal Employees, Affiliated Computer Services (HUSKY enrollment broker), legislative fiscal and research offices, managed care organizations, elder law attorneys of Connecticut Bar Association; Connecticut Legal Services, Office of Policy and Management, and Department of Administrative Services;
- site visits and tours of eight DSS regional offices and interviews with staff about individual office operations (visits to the remaining offices will be conducted prior to the staff findings and recommendations report);
- attendance at Medicaid Managed Care Council meetings and the council's Consumer Access Subcommittee meetings;
- analysis of DSS Eligibility Management System (EMS) data, including new application activity, pending applications, assistance unit reports, and overdue applications. Program review staff analysis of data from the EMS system is the source of most of the charts, graphs, and tables contained in the report. When another source is used it is noted in the chart. Analysis will be conducted on application renewal workloads and regional differences for the next report;
- review of sample DSS Medicaid program vendor contracts;
- attendance at HUSKY training forum and eligibility worker training session;
- review of relevant court cases; and
- national literature review.

Preliminary Findings

- Medicaid is a complex program that is administered by an array of federal and state laws and regulations, Medicaid state plan provisions, and DSS policy and policy transmissions. Changes in any one of these can have a ripple effect on eligibility rules, and on how eligibility workers must apply them.

- Congress passed laws in the mid-to-late 1990s effectively loosening eligibility rules for Medicaid. Connecticut adopted many of these options (e.g., presumptive eligibility, continuous eligibility, and guaranteed enrollment) only to rescind them in 2003 as part of state budget reductions.
- Overall, Connecticut's Medicaid caseload has increased about 6 percent from July 1, 2002, to June 30, 2004. The number of DSS eligibility workers who process cases and provide case maintenance services decreased 24 percent for the same time period, mostly due to layoffs and early retirements. The average number of Medicaid cases per eligibility worker increased during this time by 41 percent, from 284 cases to 400 cases.
- The percentage of overdue pending Medicaid applications has grown from 27 percent in FY 01 to almost 34 percent in FY 04. Over the same period, the percentage of those considered "unexcused" has increased by 50 percent -- from 4.3 percent in FY 01 to 6.5 percent in FY 04.
- At the same time as caseloads were increasing and eligibility worker personnel levels decreasing, DSS closed four district offices and one sub-office, state budget reductions required major changes to the Medicaid program, including modifications to eligibility criteria, complicating eligibility determinations.
- Federal regulations establish timeliness standards – "standards of promptness" – for determining eligibility for Medicaid, but there is no required reporting on compliance with those promptness standards. The Centers for Medicaid and Medicare (CMS) instead relies on complaints brought to its attention by advocacy groups and others regarding timeliness issues.
- There are no national or "best practice" standards on Medicaid caseload that program review staff could identify to help determine an acceptable ratio of Medicaid cases to eligibility worker.

Section 1: A Synopsis of Medicaid

- Medicaid is a means-tested entitlement program that pays for medical care for certain low-income persons. Medicaid became effective in 1965 and is the nation's major program for funding health care services for the poor.
- The federal and state governments jointly finance Medicaid. The federal government reimbursement (known as federal financial participation or FFP) is at least half of a state's Medicaid expenditures, depending on a state's per capita income. Connecticut is reimbursed for services at the 50 percent level.
- Each state must have a designated single state agency to oversee the state's Medicaid program. In Connecticut, the agency is the Department of Social Services. Each state Medicaid agency must have a medical assistance unit to develop, analyze, and evaluate the Medicaid program. Also, a medical care advisory unit must be established to advise the agency's medical assistance unit on Medicaid services. In Connecticut, the advisory unit is the Medicaid Managed Care Council.
- To receive FFP, each state must submit a Medicaid plan that outlines what groups are covered and what services are provided. When a state makes modifications to the plan, it must submit the changes for approval to the Centers for Medicare and Medicaid Services (CMS) of the federal Department of Health and Human Services. The state plan technically serves as the contract between the state and federal governments.
- There are no requirements that a state participate in Medicaid, but if it does, Medicaid mandates that certain groups of individuals be covered and certain services be provided. Beyond mandatory coverage, states have the option to expand eligibility to other groups and to offer optional medical services. Table I-1 provides a summary of these groups and services.
- States may also apply to CMS for waivers to the mandated Medicaid features. Connecticut currently has been approved for six waivers, five of them for home and community-based services. The state has applied for two other waivers, which are pending.
- While states are given substantial flexibility in how they operate their Medicaid programs, there are requirements for processing applications promptly, known as standards of promptness (SOP). Specific time requirements are discussed in Sections Two and Three.

Table I-1. Medicaid Coverage: Groups and Services

Coverage Groups	Medicaid Provision	Typical Populations
<p>Categorically Needy (Mandatory)</p> <p>For individuals who receive federally-assisted cash payments, as well as related groups not receiving cash</p>	<ul style="list-style-type: none"> • Medicaid <i>requires</i> coverage to these groups 	<ul style="list-style-type: none"> • Children under age 6 whose family income is at or below 133% of the federal poverty level (FPL) • SSI recipients in most states (CT an exception) • Children in adoptive or foster care • Persons under age 19 and born after 9/30/83, if family income is at or below FPL • Protected groups who lose their cash assistance because of earnings or increased Social Security benefits, but who may keep Medicaid for a period of time • Individuals who met AFDC requirements in effect in 1996.
<p>Categorically Related (Optional)</p> <p>Share characteristics with mandatory population, but eligibility criteria more broadly defined</p>	<ul style="list-style-type: none"> • Medicaid gives states the option of covering any or all of these groups 	<ul style="list-style-type: none"> • Children under 21 who meet the state's 1996 AFDC requirements • Individuals who would be eligible if institutionalized but who are receiving services under a home and community based waiver • Certain aged, blind, or disabled adults with incomes above those in mandatory coverage but below the FPL
<p>Medically Needy (Optional)</p> <p>Would qualify under one of the mandatory or optional groups but incs. or assets are too high</p>	<ul style="list-style-type: none"> • Totally at state option; if state chooses the option, there are federal requirements that certain groups and services must be covered 	<p>If option chosen, must cover:</p> <ul style="list-style-type: none"> • Medically needy children under 19 • Pregnant women who are medically needy
Covered Services	Medicaid Provision	Typical Services
<p>Mandatory Services</p>	<ul style="list-style-type: none"> • Medicaid <i>requires</i> a state to provide these services to categorically needy groups in order to have FFP • Basically, amount and duration of services under state purview • Rates paid are under state purview, but must be sufficient to enlist enough providers to give Medicaid client similar access as general population 	<ul style="list-style-type: none"> • Inpatient and outpatient hospital services; prenatal care; vaccines for children; physician services; family planning and nurse mid-wife services; lab and x-ray; home health care for certain recipients; pediatric and family nurse practitioner services; federally qualified health center (FQHC) services; early and periodic screening, diagnostic and treatment (EPSDT) services for children
<p>Optional Services</p>	<ul style="list-style-type: none"> • Medicaid approves 34 services that a state <i>may</i> offer and receive federal reimbursement 	<ul style="list-style-type: none"> • Diagnostic services; clinic services; intermediate care facilities for the mentally retarded (ICF/MR); optometrist services and eyeglasses; transportation services; rehab and therapy
<p>Services to Medically Needy</p>		<ul style="list-style-type: none"> • If state has a program it must cover prenatal care, delivery for pregnant women, and ambulatory care for children

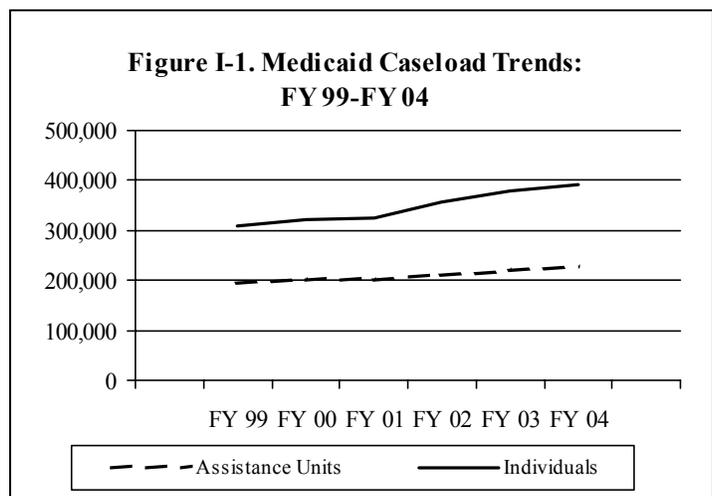
- Federal regulations also impose strict restrictions that allow only state or county government workers to determine eligibility for Medicaid.
- Medicaid eligibility may be retroactive to any or all of the three months prior to application if the person were eligible during the retroactive period.
- States may pay for Medicaid services either through managed care plans (like insurance companies) or through fee-for-service. Connecticut uses both payment systems depending on the Medicaid population served.
- Many of Medicaid's income eligibility requirements are based on a percentage of federal poverty levels (FPL) for households of a certain size. The federal poverty levels (annualized), as of April 1, 2004, are highlighted in Table I-2.

Table I-2. 2004 Federal Poverty Levels by Size of Family					
Size of Family	50%	100%	185%	235%	300%
1	\$4,655	\$9,310	\$17,224	\$21,879	\$27,930
2	\$6,245	\$12,490	\$23,107	\$29,352	\$37,470
3	\$7,835	\$15,670	\$28,990	\$36,825	\$47,010
4	\$9,425	\$18,850	\$34,873	\$44,298	\$56,550
For each additional person, add	\$1,590	\$3,180	\$5,883	\$7,473	\$9,540

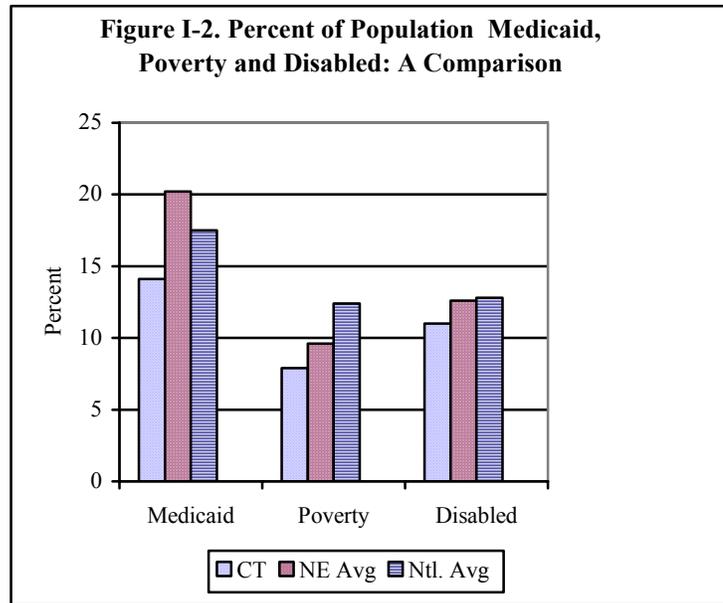
Source: Federal Register, February 2004

Summary Profile of Medicaid in CT

- Figure I-1 tracks the growth in Connecticut's average monthly Medicaid caseloads over the six-year period. In FY 99, there were 195,000 assistance units (i.e., families or households) on Medicaid. In FY 04, the number had grown to almost 225,000, a 15 percent increase. The number of individual recipients on Medicaid has increased from almost 310,000 in FY 99 to more than 392,000 in FY 04 (27 percent).



- Figure I-2 presents a profile of Connecticut's population compared with New England and the nationwide average for three demographic groups: those receiving Medicaid, those at or below the federal poverty level; and those indicating having a disability in the 2000 U.S. census. The poor and disabled populations were chosen for comparison since they are groups frequently served by Medicaid.



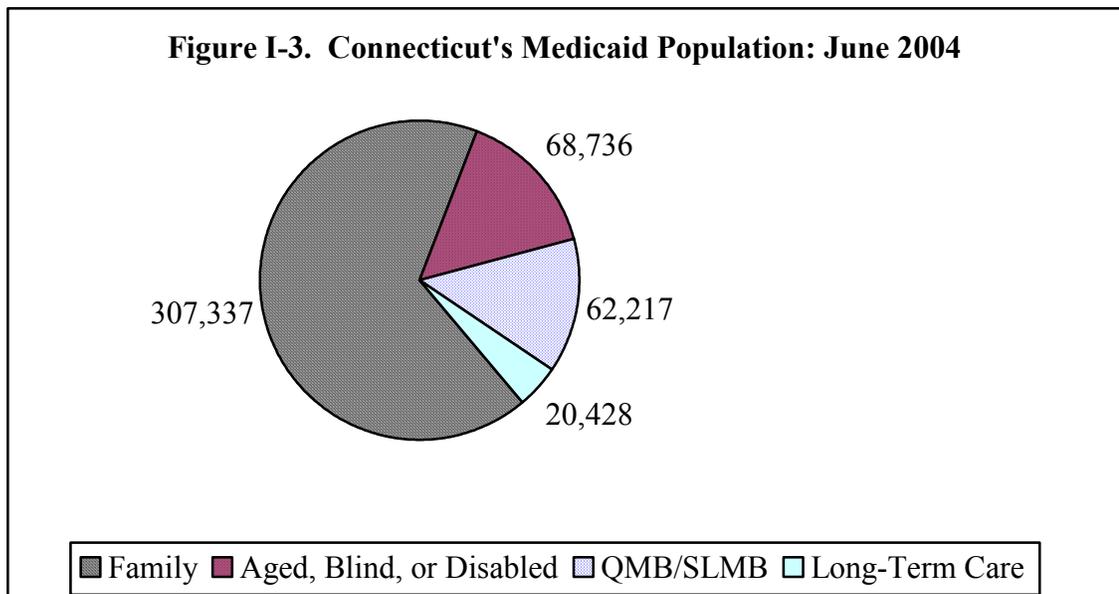
- Connecticut, in general, has a smaller percentage of its population receiving Medicaid¹ – 14 percent of Connecticut's population received Medicaid in FFY 02. Only eight states had a lower percentage of Medicaid recipients, and Connecticut's Medicaid population was below both the 20.2 average in New England and the 17.5 percent national average.
- Connecticut also has a low percentage of its population considered poor.² Only 7.9 percent of the state's population (all ages) is at or below the federal poverty level. That places Connecticut at the third-lowest state ranking, below the New England average of 9.6 percent and substantially below the national average of 12.4 percent.
- Figure 1-2 also compares Connecticut's disabled population with the New England and nationwide averages. Connecticut has a lower percent of its population who are disabled (11 percent) than the New England average (12.6 percent) or the national average (12.8 percent). Connecticut, like both New England and nationally, covers a higher percentage of its population through Medicaid than are in poverty or who are disabled.

¹ Centers for Medicare and Medicaid Services, FFY 02 national Medicaid recipient data.

² Based on 2000 population statistics, U.S. Census Bureau. The threshold is the federal poverty level --\$18,850 for a family of four in 2004.

Connecticut's Medicaid Population

- A snapshot of Connecticut's Medicaid population, as of June 2004, is shown in Figure I-3. The figure shows a total of almost 459,000 Medicaid recipients in Connecticut. Most Medicaid recipients are in families (67 percent), while individuals who are Aged, Blind, or Disabled account for almost 15 percent. The next largest group – Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Beneficiaries (SLMBs) are dually eligible for Medicare and Medicaid – and account for about 13.5 percent. (QMBs and SLMBs are often not counted in Medicaid caseloads, including Figure I-1 above). Long-term care Medicaid recipients account for less than 5 percent of the total. (More detailed descriptions of the Medicaid population and eligibility requirements are discussed in Section Three.)



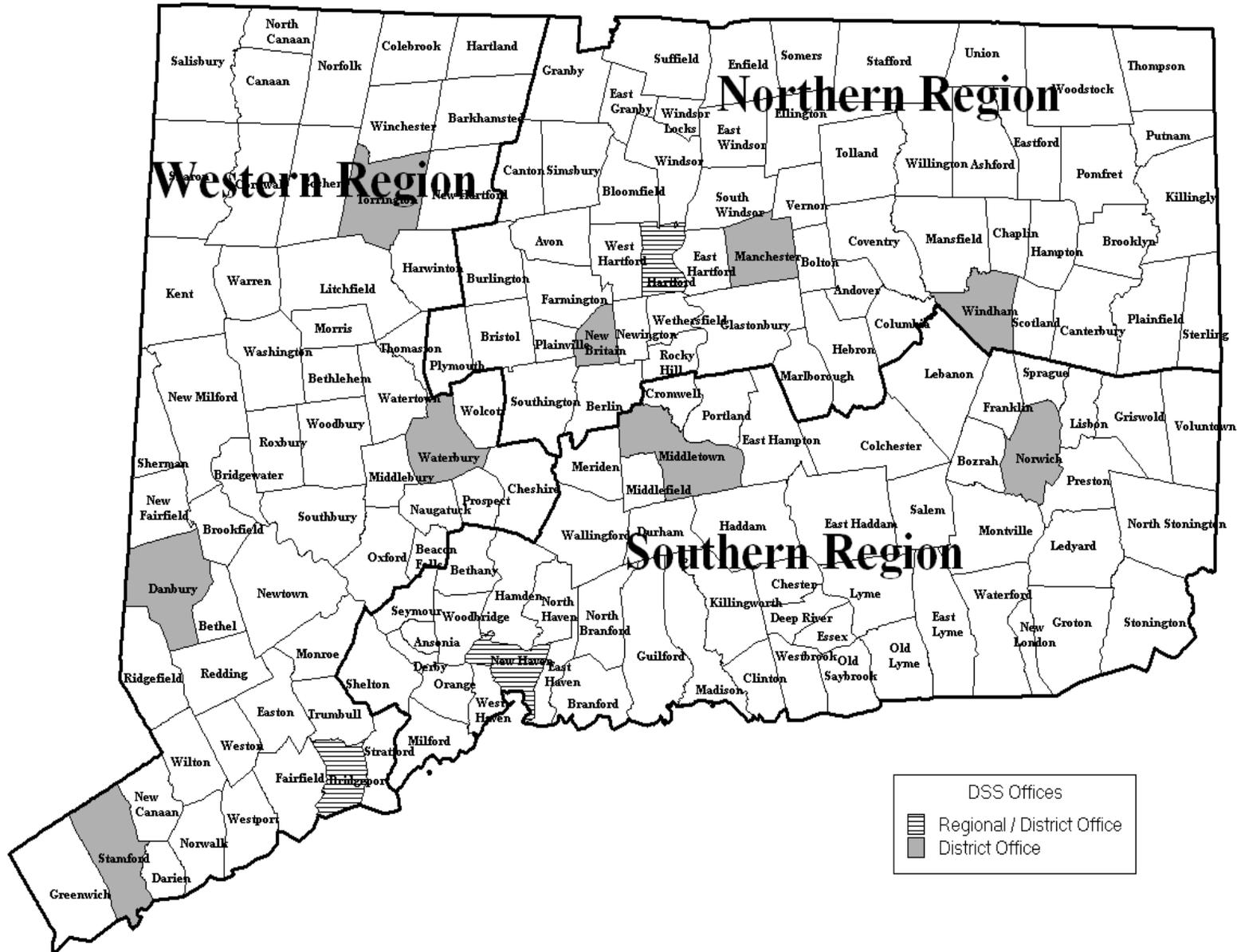
- Connecticut Medicaid expenditures are estimated to total \$3.7 billion in FFY 04. A more detailed discussion of Medicaid administrative expenses is contained in Section Two.

Section 2: Program Operations

Department Organization

- Medicaid eligibility is determined in the state's three human services regions.
 - Each region has a DSS regional office; nine additional district offices are located throughout the state. Figure II-1 shows a map of the department's regional and district offices (jointly referred to as field offices.)
 - Regions are headed by regional directors who report directly to the DSS commissioner.
 - Regional directors coordinate and oversee all offices within their specific regions. Each regional and district office has an office manager who reports to his/her respective regional director.
 - Offices in each region provide direct client services, including processing client applications, determining eligibility (initial and renewal), and maintaining client data for the department's Medicaid client databases.
- The DSS central office is responsible for overseeing the administration of the state's Medicaid program. Several units within the office have primary responsibility for Medicaid, including:
 - Family Services – provides central policy and program oversight, responsibilities for ensuring efficient program operation;
 - Medical Assistance – develops, analyzes, and evaluates the Medicaid program; and
 - Management Information System – manages the state's Medicaid databases.
- DSS restructured its regional and district office operations in early 2003.
 - Four district offices and one sub-office (Bristol, Meriden, Norwalk, Willimantic, and Ansonia), as well as the State Administered General Assistance (SAGA) office in New Haven, closed in 2003.
 - Clients living in towns served by the closed offices have been referred to other offices for their Medicaid services.

Figure II-1. DSS Field Office Organization



- DSS re-opened its Willimantic office on a part-time basis in March 2004. The office is currently open to clients three days per week.

Customer Service

- Each field office is required to maintain specific operating hours to serve the public (typically 8:30 a.m. to 4:30 p.m.). Applicants and clients generally use field offices on a “walk-in” basis for various reasons, including obtaining and submitting benefit applications, interviews, identification pictures and digital imaging, and for answers to benefits questions.
- Offices have phone-mail capabilities allowing clients to leave messages for DSS staff. Overall phone services vary among offices, as highlighted in Section Five.
- Drop-off boxes in field offices allow applicants and clients to submit specific information without standing in line, including address changes and other routine information not requiring interaction with DSS workers. Mail slots are available, although not at all offices, for submitting information after-hours.
- DSS initiated “processing time” in 2003 whereby eligibility staff are not available to applicants/clients on Wednesday and Thursday afternoons without a previously scheduled appointment. This time is used by eligibility workers to process paperwork.
 - Offices remain open to clients on a limited basis during this time to receive applications, but no direct contact is made with clients unless initiated by eligibility workers. (There is typically one eligibility worker assigned to assist walk-in clients during processing time.)
- Each DSS field office has an interpreter service available for clients needing language assistance. The service:
 - is available via telephone through a national provider;
 - offers assistance using numerous languages;
 - allows more effective interaction between eligibility workers and clients.

Eligibility Service Workers

- DSS regional workers involved with determining Medicaid eligibility are classified as either Eligibility Service Workers (ESW), Eligibility Service Specialists (ESS), or Eligibility Service Supervisors (ESUP).
- The positions are covered by collective bargaining and represented by American Federation of State, County, and Municipal Employees (AFSME).
- ESWs must have at least five years' experience in determining eligibility for public assistance clients, while ESSs are required to have at least six years' experience, and ESUPs seven years' experience. College education may be substituted for experience.
- ESW and ESS workers in each of the field offices provide the bulk of interaction between DSS and its Medicaid applicants and clients, including:
 - screening applications for completeness;
 - conducting intake interviews when required;
 - ensuring proper information is entered into the state's Medicaid eligibility management database;
 - determining eligibility; and
 - managing cases once eligibility has been determined. (Additional analysis of DSS eligibility staffing is provided in Section Five).
- It is important to note eligibility workers process applications and maintain caseloads for programs other than Medicaid, including Food Stamps, Temporary Family Assistance, State Supplement, and Refugee Medical Assistance.
- There is a high degree of autonomy in the way field offices are organized and operated resulting in variation in office operations and eligibility staff responsibilities. For example:
 - some offices require eligibility workers to oversee all aspects of a Medicaid case, which includes intake through case maintenance, regardless of the type of Medicaid program;

- other offices have more specialized eligibility staff focusing on individual aspects of cases, such as intake *or* case maintenance, within a particular program; and
- most, but not all, offices have eligibility staff specifically dedicated to long-term care cases due to their nature and relative complexity.

Outstationed Workers

- Although most DSS eligibility workers are located in district offices, a few are located at hospitals or other state agencies like the Department of Children and Families. These workers are paid for by the hospital or agency where they are stationed, but are counted in DSS eligibility worker numbers.

Training

- DSS contracts with the University of Connecticut School of Social Work to provide training for department staff through a uniform curriculum. A total of 21 UCONN trainers are available to DSS for training services.
- Three of the UCONN trainers are stationed in each region to assist with training efforts on a full-time basis. Training typically occurs for policies and procedures, systems, and organizational development.
- All new employees receive training during a probationary period.
- Workers are not required to attend a mandated number of hours of in-service training. There may be times when training is mandated by the central office or regional administrators.
- Training generally occurs at employees' requests and is available on varied topics. Workers, in conjunction with their supervisors, decide on any necessary training.

Contracts/Outsourcing

- DSS contracts with non-profit agencies throughout the state to help provide various services for its Medicaid clients. Examples of such contracts are provided in Table II-1.

Table II-1. DSS Contracts Dealing with Medicaid Eligibility: Examples

Agency	Primary Responsibilities	Term	Amount
Affiliated Computer Services (ACS)	<ul style="list-style-type: none"> Operates as state's Medicaid Managed Care enrollment broker Provides outreach, education enrollment services for HUSKY A and B programs Determines eligibility for HUSKY B applicants Calculates monthly capitation fees due to managed care organizations for HUSKY A; submits to DSS for payment 	4/95 – 12/04 (full contract period, including extensions)	\$34.6 million (maximum contract value through 12/04)
United Way of CT	<ul style="list-style-type: none"> Operates HUSKY Infoline Operates 211 Infoline 	7/03 – 6/04 (current contract period)	\$3.8 million (\$720,000 HUSKY; \$3.08 million 211 Infoline)
Colonial Cooperative Care, Inc.	<ul style="list-style-type: none"> Determines the disability and/or unemployability status of individuals requesting initial/on-going Medicaid disability coverage and/or SAGA/Norwich GA cash benefits 	8/98 – 6/08 (full contract period, including extensions)	\$6.7 million (maximum contract amount based on a per case rate)
New Haven Health Department	<ul style="list-style-type: none"> Provides "Healthy Start" services (focused health-related case mgt., care coordination, and HUSKY A application assistance services to eligible pregnant women) in contractor's service delivery area 	7/03 – 6/04 (current contract period)	\$367,300
United Community & Family Services (Norwich)	<ul style="list-style-type: none"> Provides "Healthy Start" services 	7/03 – 6/04 (current contract period)	\$261,000
Stay Well Health Center (Waterbury)	<ul style="list-style-type: none"> Provides "Healthy Start" services 	7/03 – 6/04 (current contract period)	\$261,000
Bridgeport Health Department	<ul style="list-style-type: none"> Provides "Healthy Start" services 	7/03 – 6/04 (current contract period)	\$261,000
Hartford Health Department	<ul style="list-style-type: none"> Provides "Healthy Start" services 	7/03 – 6/04 (current contract period)	\$261,000

Source: DSS contracts

- The state contracts with a private company (ACS) to provide administrative services for Healthcare for Uninsured Kids and Youth (HUSKY) A and B clients (described more in Section Three). Generally, ACS:
 - acts in an enrollment broker capacity for HUSKY A and B, including Medicaid managed care;
 - fully manages the state’s HUSKY B program, including determining eligibility, enrolling clients in managed care organizations, and providing case maintenance; and
 - processes HUSKY A clients and forwards to DSS any applications received from clients applying for HUSKY B benefits who may be eligible for HUSKY A benefits instead.

Outreach

- Several non-profit agencies throughout the state have contracts with DSS to assist Medicaid clients obtain benefits and services. For example, community action programs (CAPs) assist clients with case management-type functions, such as navigating the application and re-application processes. DSS is expanding its efforts with CAP agencies through an initiative called Human Service Infrastructure (HSI). Other programs, such as “Healthy Start,” help ensure pregnant women receive proper care during and after their pregnancies.
- Regardless of their orientation, the basic goal of third-party programs is to ensure clients in need of Medicaid services receive such services. However, workers for these agencies are limited to providing outreach, application assistance, and direct services – they cannot determine eligibility for Medicaid under Title XIX rules.

Eligibility Management System

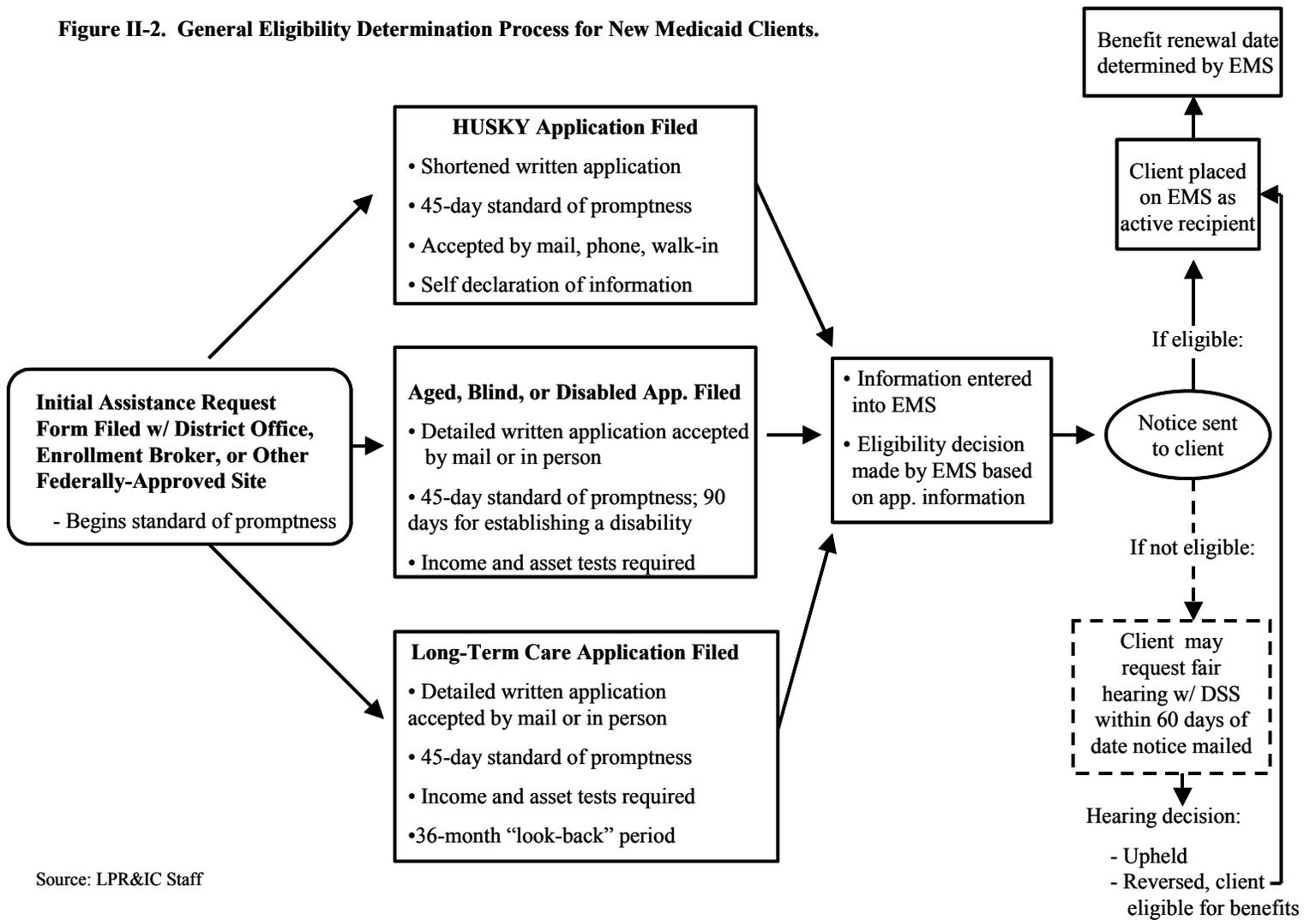
- DSS maintains several computer systems to help manage its Medicaid programs. Chief among the systems is the Eligibility Management System (EMS).
- EMS is the central computer system used by the department to determine initial and on-going eligibility for the state’s Medicaid clients. By federal regulation, only state (or county) government workers are permitted complete access to EMS to determine eligibility. According to DSS, the Eligibility Management System:
 - is a mainframe system initially developed in the 1980s consisting of 68 data bases, 1,529 programs, 336 screens, and over 4.4 million lines of code; and

- has a production staff on duty 24 hours a day to support the on-line system and the extensive batch processing conducted nights and on weekends.
- Further, the system:
 - determines eligibility and issues notices and benefits to approximately 227,000 assistance units and 390,000 Medicaid clients each month;
 - receives information entered on-line from over 1,500 terminals across the state; and
 - exchanges and matches data through interfaces with other state and federal agencies, as well as with towns, banks, insurance companies, and other entities to ensure the accuracy of information contained in the client and assistance unit database.
- EMS is a mainframe computer system. As such, it does not provide eligibility workers with the more “user-friendly” interface identified with personal computers. The system is “rigid,” meaning incorporating any type of programmatic or policy change is labor intensive, and is somewhat limited in producing management reports for analytical purposes.
- The system’s inflexibility often requires “work-arounds” to help process client cases more effectively. Work-arounds are processes designed to circumvent the computer system allowing for more flexible work procedures and easier implementation of any policy or procedural changes within Medicaid programs.

Application and Eligibility Determination Processes

- Different Medicaid programs have different application and eligibility requirements, as described in more detail in Section Three. Each new applicant must follow a basic process when applying for Medicaid, as highlighted in Figure II-2.

Figure II-2. General Eligibility Determination Process for New Medicaid Clients.



Source: LPR&IC Staff

- Prospective Medicaid clients must first complete an “application for benefits” to be submitted to DSS. The application has two parts:
 - Part 1 is a one-page assistance request form specifying which program(s) the client is applying for, basic demographic information, data regarding income and assets, information on household members, and who is applying for benefits. The form can either be mailed or delivered in person to any DSS office or ACS.
 - Part 2 of the Medicaid application requires more detailed written information from the applicant. All information must be completed, and the application signed, before benefits can be issued.

- Applications must be date-stamped when received either by DSS or ACS and applicant information is entered into the Eligibility Management System.
 - EMS examines the client’s application data (e.g., income, medical expenses, and child support) and automatically calculates whether the person is eligible for benefits.
 - The system also verify against information collected from other databases (e.g., IRS, Social Security, wage and bank records, and DMV) may also be used in determining eligibility.
 - Differences exist among offices in tracking applications before they are entered into EMS. Some offices maintain electronic logs to track applications and can quickly determine where in the process an application is and who is responsible for the application. Other offices are more limited in this capacity, with no formal tracking system.

- The application process differs somewhat depending on the type of program an applicant is applying for, as highlighted in Table II-2. For example, some programs, such as Food Stamps and cash assistance, require a face-to-face interview between the DSS eligibility worker and the client as part of the application process, while others do not. Similarly, some programs require clients to meet specific asset tests, while others do not.

Table II-2. General Application Requirements by Medicaid Population						
Population	Written Application	Face-to-Face Interview	Asset Test	Medical Exam	Self-Declaration of Income	Transfer of Assets
HUSKY A (Family)	Y	N	N	N	Y	N
HUSKY B (Family)	Y	N	N	N	Y	N
Aged, Blind, or Disabled (Adult)	Y	N	Y	Y (to determine disability; not for aged)	N	N
Long-term Care (Adult)	Y	N	Y	N	N	Y
Source: LPR&IC Staff.						

Standards of Promptness

- When DSS or ACS receives a signed copy of Part A of a client application and the form is date stamped, there is a specified number of days for DSS to act on the application and determine eligibility.
 - The timeframes – called standards of promptness – are required by federal regulation.
 - Different programs have different promptness standards. Table II-3 highlights the standards for various programs.
- **Information adequacy.** Eligibility cannot be determined unless all necessary information is entered into EMS. If information is not complete, an extension may be issued alerting the client information is still missing. Eligibility may be denied at the end of an extension if the information is not complete and the applicant does not have good cause for another extension. Pending applications awaiting additional information impact the department’s compliance with federal standards of promptness.

Table II-3. Federal Standard of Promptness by Program.	
Program	Standard of Promptness
State Administered General Assistance Cash	10 Days
Food Stamps	30 Days
Medicaid (except assistance to the disabled), TFA, State Supplement Assistance to the Aged or Blind, SAGA Medical, and Refugee Assistance	45 Days
Medical Assistance to the Disabled	90 Days
<p>Note: In cases when a client has no, or almost no, income or assets, food stamps must be issued on an expedited basis within <i>seven</i> days; expedited SAGA medical benefits may be issued within <i>four</i> days in cases where a food or medical emergency exists.</p> <p>Sources: 42 CFR 435.911; DSS</p>	

Eligibility Determination Notice

- EMS automatically generates eligibility determination notices to be sent to clients once a decision has been made.
- Applicants deemed eligible are maintained on EMS as active recipients for a set period of time until eligibility is redetermined, which is typically every 12 months.
- Applicants denied eligibility may appeal the decision using the department's fair hearing process.

Fair Hearing

- Assistance applicants or clients are entitled to a fair hearing if the department has: 1) denied their application for benefits; 2) not taken action on their application within the specified standards of promptness; or 3) either failed to take a required action, or has taken an erroneous action, according to the requestor.

- All fair hearings are presented before an impartial hearing officer of the department, typically an attorney. The officer will hear the case presented by the applicant/client and the department (usually through the ESW) and make a decision based on the information presented and any other information deemed necessary.
- Each DSS office has a hearing room available to clients, and hearings with DSS central office staff are conducted using tele-conferencing technology.
- DSS is required to send a notice to a client prior to discontinuing, terminating, suspending, or reducing benefits. The notice must inform the client of his/her right to a fair hearing.
- Clients for all Medicaid programs must request a fair hearing in writing within 60 days of the date the DSS notice was mailed.
- DSS is required to notify the requestor of the time, date, and location of the hearing prior to the hearing. The department has 30 days from the request receipt date to conduct a hearing and another 30 days to issue a decision (emergency housing issues have much shorter timeframes.) Extensions may be granted and clients may withdraw their requests.
- A client may request a reconsideration of the hearing decision and DSS is required to make a decision regarding the request. DSS may also unilaterally reconsider the decision after the hearing.
- Clients have the right to appeal any fair hearing decisions to court. Fair hearing activities are further discussed in Section 4.

Costs of Administering Medicaid in Connecticut

- Federally funded public assistance programs, including Medicaid, are entitled to FFP for indirect (i.e., administrative) costs to operate the programs. The costs may include indirect costs originating in the operating agency (DSS in Connecticut), as well as those related to central government services (e.g., payroll or auditing).
- Federal regulations require states to submit a cost allocation plan that must be approved by the federal government. In the case of Medicaid, federal approval is required by CMS.
- Quarterly, each state submits an expenditure report on forms issued by CMS that lists allowable expenditure categories along with the predetermined FFP rate for that activity.

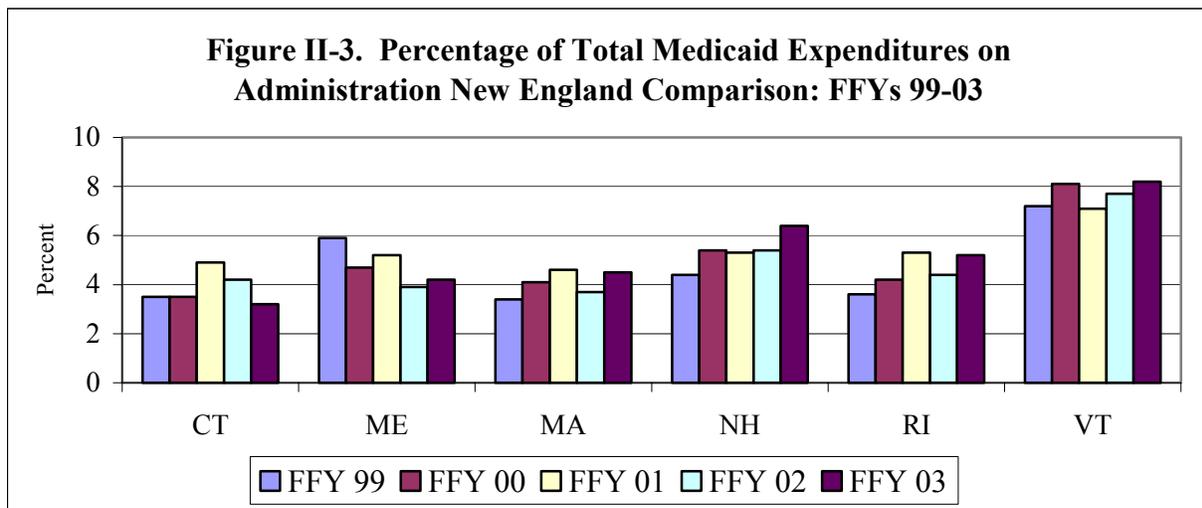
- In Connecticut, DSS' budget office prepares the budget submissions for Medicaid administration.
- Table II-4 below shows Connecticut's total Medicaid expenditures, the total administrative costs, and the total FFP for administration for FFYs 00 through estimated FFY 04.
- As the table shows, Connecticut administrative expenses appear to be low, not exceeding 5 percent of total Medicaid expenditures in any of the six federal fiscal years.
- Also of note:
 - the drop in administrative expenses from about \$145 million in FFY 02 to almost \$113.7 million in FFY 03; a decrease of 21 percent in one year;
 - the 43 percent increase in administrative costs between FFY 00 and FFY 01; and
 - the 35 percent increase in the FFP of administration between FFY 00 and FFY 01.

Table II-4. Connecticut Medicaid Administrative Expenditures: FFYs 99-04
 (\$ in thousands)

	FFY 99	FFY 00	FFY 01	FFY 02	FFY 03	FFY 04 (est)
Total Medicaid	\$3,069,523	\$3,257,920	\$3,379,453	\$3,459,786	\$3,506,633	\$3,726,429
Administration	\$108,575	\$115,938	\$165,604	\$145,109	\$113,739	\$138,566
FFP of Admin.	\$60,792	\$66,466	\$89,629	\$78,853	\$64,594	\$76,049
% Admin of Total	3.5%	3.5%	4.9%	4.2%	3.2%	3.7%

Sources: CMS Reports and DSS Quarterly Budget Report to CMS

- The table also shows Connecticut is expending a lower dollar amount on administration in FFY 04 (estimated) than it did in either FFY 01 or FFY 02. Percentages of total costs were also higher in those years than in FFY 04.
- To put Connecticut's administrative costs (as percentages) in context, program review staff compared the percentages with those of other states in the New England region (CMS Region 1), and the results are depicted in Figure II-3.
- While some allowances must be made for smaller states (like Vermont or New Hampshire) incurring a higher percentage of Medicaid totals on administration, Connecticut has almost always been the lowest-ranking New England state, using administrative-costs-to-total costs ratio.



Section 3: Medicaid Program by Population

- To be eligible for Medicaid, an individual must meet certain financial criteria and be part of a group that is categorically eligible for the program. Those typically include low-income children (and their parents or relative caregiver), pregnant women, low-income disabled and elderly, as well as children under state care.
- This section contains descriptions of the populations served, the eligibility criteria they must meet to be covered by Medicaid, and how that is verified. In addition, monthly workload measures are presented for the FY 01- FY 04 period, including the:
 - number of recipients in each Medicaid category;
 - number of all new applications, which includes all those in the categorically needy and medically needy groups, as well as those applications where an applicant is in active spend-down (described later in this section);
 - percentage of pending applications for each population that are overdue each month; and
 - for the HUSKY program, the percentage of eligibility decisions in each category beyond the standard of promptness each month for HUSKY.

HEALTHCARE FOR UNINSURED KIDS AND YOUTH (HUSKY)

- HUSKY is Connecticut's public health insurance program principally for children under age 19. Other groups, including family members and pregnant women, are also eligible under certain circumstances. The HUSKY program is also referred to as "Family Medicaid."
- HUSKY comprises three component programs:
 - *HUSKY A* – the state's traditional Medicaid program, under Title XIX of the Social Security Act (SSA), providing free medical insurance for eligible clients with household incomes at or below 185 percent of the Federal Poverty Level.
 - *HUSKY B* – medical insurance provided for free or at low-cost to uninsured children in families with household incomes above 185 percent to 300 percent of FPL (also called State Children's Health Insurance Program or SCHIP – under Title XXI of SSA). Families with incomes above 300 percent of FPL may purchase insurance at discounted group rates.

- *HUSKY Plus* – supplemental insurance for HUSKY B children with special physical and/or behavioral health needs and where family incomes are between 185-300 percent FPL.
- Income level and family size are the key factors used to determine which HUSKY program someone is eligible. Figure III-1 provides a full detail of income levels and plan features by program.
- HUSKY is structured to comply with federal requirements established by Title XIX of the Social Security Act to maximize federal reimbursement of Medicaid expenditures. Most medical assistance qualifies as Medicaid under Title XIX and is reimbursed in Connecticut at 50 percent by the federal government. Federal reimbursement for HUSKY B is 65 percent.
- *Transitional medical assistance* is available for up to two years for anyone whose income is beyond 100 percent FPL and leaving the Temporary Family Assistance (TFA) program for employment.

ELIGIBILITY

Who Determines

- Federal law requires Medicaid eligibility be determined by the state governmental entity responsible for overseeing the Medicaid program. In Connecticut, HUSKY A eligibility is determined by DSS eligibility workers.
- A private company under contract with the state (ACS) serves as the state's enrollment broker and acts as a clearinghouse for the HUSKY program. Among its duties, ACS screens all HUSKY applications it receives and decides if applicants qualify for HUSKY A or HUSKY B based on the application information. Applications for HUSKY A are sent to DSS for eligibility determination. ACS makes eligibility determination decisions for HUSKY B applicants, since HUSKY B is not under Title XIX rules.
- Other qualified entities, such as Federally Qualified Health Centers (FQHC), school based health clinics, and community action programs, may conduct outreach services, including accepting HUSKY applications, but the applications must be forwarded to DSS or ACS for processing and eligibility determination.

How Long

- According to federal requirements, all HUSKY A eligibility determinations must be made within 45 days of when a signed application is received by either DSS or ACS.

Figure III-1: HUSKY Family Income Guidelines (effective April 1, 2004-March 31, 2005)

Family of 2	Family of 3	Family of 4	Family of 5	Family of 6	HUSKY Plan features	% of Federal Poverty Level
under \$12,491	under \$15,671	under \$18,851	under \$22,031	under \$25,211	HUSKY A <i>Free</i> health care for parents who live with child or for a relative caregiver who lives with the child.	100% or less
under \$23,107	under \$28,990	under \$34,873	under \$40,756	under \$46,639	HUSKY A <i>Free</i> health care for children under 19; and pregnant women (note: for eligibility of pregnant women, unborn child is also counted as a family member).	185% or less
\$23,107 to \$29,352	\$28,990 to \$36,825	\$34,873 to \$44,298	\$40,756 to \$51,771	\$46,639 to \$59,244	HUSKY B Healthcare for children under 19; no monthly premium. Maximum co-payments \$760/year* Eligible for HUSKY Plus.**	>185% -- 235%
\$29,353 to \$37,470	\$36,826 to \$47,010	\$44,299 to \$56,550	\$51,772 to \$66,090	\$59,245 to \$75,630	HUSKY B Health care for children under 19; \$30 monthly premium for first child; \$50 maximum monthly premium per family regardless of number of children; \$1,660 maximum of co-payments and premiums per family, per year* Eligible for HUSKY Plus.**	>235% -- 300%
over \$37,470	over \$47,010	over \$56,550	over \$66,090	over \$75,630	HUSKY B Health care for children under 19: <i>Group premium rate</i> , currently ranging from \$158 to \$230 monthly per child; no maximum on co-payments	>300%

Note 1: The maximum annual aggregate income cost sharing for HUSKY B clients may not exceed five percent of the family's gross annual income.

Note 2: Childcare expenses are deducted from income. HUSKY B coverage may not be available if a child has been covered by health insurance through a parent's employer during the past two months; exceptions to this waiting period include loss of employment and financial hardship.

*HUSKY B co-payments - \$5 per medical office visit; \$3 generic prescription, \$6 brand-name prescription.

**HUSKY Plus: supplemental coverage for special physical and behavioral health care needs.

Sources: DSS; LPRI&IC Staff

- There is no federal timeliness standard for determining eligibility for HUSKY B applicants. By contract with DSS, ACS is required to forward all signed HUSKY A applications to DSS within two days of receipt, and make eligibility determinations for HUSKY B applicants within 30 days of receipt of the application.
- Applications for pregnant women applying for HUSKY A benefits are to be processed using state-mandated presumptive eligibility (described below). Benefits must be authorized no later than the day after receipt of the minimum verifications provided by the applicant. (These are not federal requirements, because presumptive eligibility for pregnant women is not in the state's federally-approved Medicaid plan.)

Criteria Considered

- HUSKY applicants must *at least* be:
 - Connecticut residents;
 - U.S. citizens, or “qualified non-citizens” as defined by federal law; and
 - within specified income limits based on family size (see Figure III-1).
- HUSKY is principally aimed at insuring children under age 19, although there are 18 different coverage groups eligible for benefits, and individuals may meet eligibility requirements in a number of ways.
- Examples of other groups covered by HUSKY A, in addition to children, include:
 - parent(s) with related children in the home or adult related caretakers of HUSKY A-eligible children and with household incomes below 100 percent FPL;
 - pregnant women under 185 percent FPL;
 - caregivers receiving cash assistance; and
 - “medically needy” caregivers who meet all the eligibility requirements for cash assistance, but whose income exceeds the limitations for those programs, may qualify if their medical expenses exceed the amount of their "excess" income (i.e., the income above the applicable limit); no separate application is required.

- Uninsured adults living in households with HUSKY A-eligible children are not automatically eligible for HUSKY. Only parents and “caretaker relatives,” as defined by statute and DSS policy, are eligible.
 - Close to 20 definitions of “caretaker relative” exist in policy.
 - Such relatives must live with, and be responsible for, the day-to-day care and supervision of the dependent child.
 - A caretaker relative cannot be absent from the household for more than 90 consecutive days.
- The two key eligibility factors examined when determining eligibility for either HUSKY A or HUSKY B are:
 - size of the “assistance unit” (all individuals applying for HUSKY on an application); and
 - income of the “household unit” (the number of people in the assistance unit and selected others whose incomes are counted for eligibility purposes.)
 - neither HUSKY program considers family assets to determine eligibility.
- *Presumptive eligibility* (PE) is required for pregnant women with incomes under 185 percent of the federal poverty level. Applicants must be granted benefits within 24 hours from the time all required minimum information is received. Verification of other eligibility factors must be completed by the end of the second month following the month of application.
 - The policy requires applicants to prove three conditions when applying for Medicaid: 1) pregnancy; 2) identity; and 3) income if more than 85 percent of the income limit. All other verification factors may be postponed.
 - Benefits are discontinued if none of the required information is submitted within 30 days of initial application. If some, but not all, of the information is submitted during the initial 30 days, the applicant has an additional 30 days to provide the information before benefits are discontinued.
 - Postponed eligibility factors must be completed by the end of the second calendar month following the month of application.
 - PE is a state-mandated policy outlined in statute and DSS policies and procedures. PE is not in Connecticut’s Medicaid Plan, meaning it is not

sanctioned by the federal government and provisions for federally designated PE do not apply. There is also no presumptive eligibility for HUSKY B.

- Eligibility determination for pregnant women applying for benefits under PE must be made by DSS, even if the application is received at a federally approved auxiliary location. Federal PE requirements allow such locations to make eligibility decisions, which is not the case in Connecticut because PE is not in the state Medicaid plan. Also, under federally-defined presumptive eligibility, if a person is later determined to be ineligible, federal reimbursement is not affected.
 - PE was used for children beginning in late-2000, but was eliminated by the legislature in 2003.
- A goal of the HUSKY program is to enroll and retain clients without undo delay. Self-declaration of various factors, such as income, is a step to quicken the eligibility process.
 - Self-declaration allows HUSKY applicants and clients to include certain information on their application/reapplication without having to provide backup paperwork for proof, including: income of any legally liable adult; citizenship (unless non-citizen); social security number; and age.
 - The types of information that may be self-declared varies somewhat, depending on whether an adult or child is applying for benefits.
 - Although the guiding principle for eligibility workers regarding HUSKY is to accept self-declared information, backup records may still be necessary if the worker believes the supplied information is either incomplete or incorrect.
 - Workers may access other information databases, such as state wage records, federal tax information, or Social Security data, if needed for clarification purposes.
 - Using self-declared information puts the onus on DSS to clarify the information rather than on the client to verify the information through paper records.
 - The only time additional verification is necessary from an applicant/client is when non-citizens apply for HUSKY A or B for themselves and not on behalf of a child, and a citizenship check is done.

- Newborns who meet the eligibility criteria for HUSKY are retroactive to date of birth provided an application is submitted within 30 days of the birth date.
- When income for the adults in a family is too high to receive HUSKY A benefits, they may qualify for benefits as medically needy through “spend-down” – the process whereby a family’s income is reduced by the amount of medical bills incurred (described later in this section). The resulting income level must meet the 100 percent FPL threshold before the person is eligible for HUSKY A. All unpaid bills must be sent to DSS for the family to receive credit for the expenses.
- One restriction for HUSKY B is that children may not be covered by health insurance from a parent’s employer for a period of two months prior to applying for HUSKY (which may be extended to four months by DSS if deemed necessary for families to maintain employer-sponsored insurance).
 - DSS may waive the waiting period under certain circumstances – such as the death of a parent or loss of employment – other than voluntary termination.

Verification

- A common application is used to apply for either HUSKY A or HUSKY B.
 - Clients may apply in person, by mail, or by telephone.
- DSS and ACS accept HUSKY application information that is self-declared by the applicant without requiring backup paperwork (i.e., income, citizenship). Eligibility workers may check other systems to verify the information if questions arise.
- The person requesting benefits is required to include his/her social security number on the application, along with declaration of citizenship, household information, and childcare and other expenses.
- Extensions may be granted, usually in 10-day increments, if additional information is required or further verification is necessary. There is no formal limit on the number of extensions as long as an applicant continues to show good cause and the extension is approved by either DSS or ACS. If the necessary information is not submitted within the required timeframe, the application is deemed incomplete and may be denied.

Redetermination

- HUSKY clients must renew their benefits every 12 months. The renewal process allows DSS to review a client’s need, eligibility, and benefit level and is designed to provide for continuous program participation without interruption of benefits.

- **Redetermination process.** A renewal application is required, but most of the information is considered self-declared for processing purposes.
 - An “ex parte” renewal process for the HUSKY program initiated by DSS in 2001 allows the department to accept renewal applications from clients – even if there is incomplete or missing information – on two conditions: 1) the form must be signed by the client; and 2) the client must participate in at least one other program administered by the department.
 - DSS can then use the client’s information from those other programs or sources to complete the HUSKY renewal application.
 - The process is used to reduce the number of families who lose their medical benefits because they do not submit the appropriate information. Clients may still be required to clarify information if the department believes its information is no longer accurate or correct.

- EMS automatically generates notices to clients 75 days prior to their benefit termination date informing them of this date and that renewal information is required. EMS sends another notice warning clients of a discontinuation of benefits 15 days prior to their actual discontinuation date.
 - HUSKY clients have a 30-day period after eligibility has been discontinued to renew their benefits without having to resubmit a formal application, as long as there a good cause reason exists for the delay (i.e., illness, extenuating circumstances.)

- DSS mails HUSKY clients a renewal application with preprinted information about a client already on file with DSS. Clients only have to make any necessary changes to the information and include any other relevant information to complete the renewal process.

- Renewal information from HUSKY clients may be mailed to DSS or ACS, or delivered in person. EMS issues another notice to the client once the redetermination decision has been made.

Eligibility Options for HUSKY

- An option within the state Medicaid plan – *continuous eligibility* – allows children to remain eligible for HUSKY for a period of up to 12 months even if the household structure or family income changed that would otherwise have made the child ineligible.

- The process was implemented in mid-1998, but was eliminated by the legislature in 2003.
- *Guaranteed eligibility* allows a Medicaid recipient enrolled in an Managed Care Organization (MCO) to retain eligibility services the MCO provides even if the enrollee loses eligibility due to various circumstances, such as increased family income.
 - The extended enrollment period may not exceed six months from when the recipient was enrolled in the MCO. The legislature eliminated guaranteed eligibility in 2003.

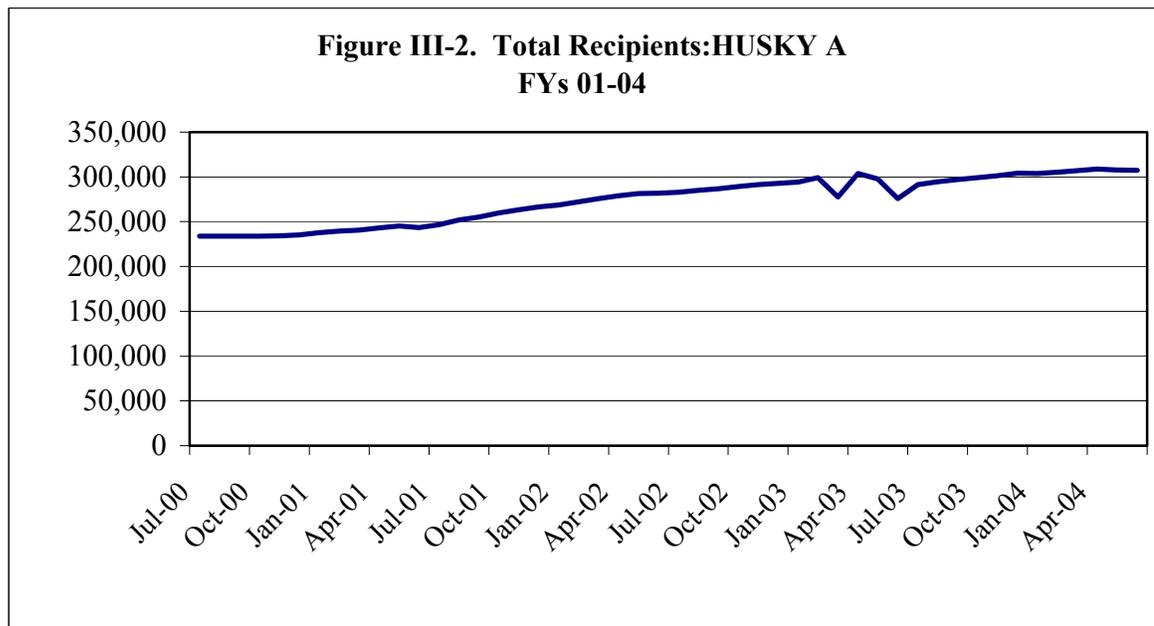
METHOD OF PAYMENT

- All HUSKY A and B clients are required to participate in the state's Medicaid managed care program.
- DSS automatically enrolls HUSKY A clients into a managed care plan if the client has not chosen one within 30 days of eligibility. HUSKY B clients also have 30 days to enroll, but are not automatically enrolled if the time lapses. HUSKY B clients may be denied services by providers if not enrolled in a managed care plan. HUSKY A clients not enrolled receive services on a fee-for-service basis.
- Four Managed Care Organizations (MCOs) have contracts with DSS to provide services to HUSKY A clients; three of the MCOs participate in HUSKY B.
- ACS is responsible for ensuring HUSKY clients are enrolled in an MCO and calculating the capitated rates paid to MCOs by DSS.
- HUSKY A coverage may begin as early as the third month prior to application if the client would have been eligible had the client applied during that time.
- HUSKY B clients are responsible for cost-sharing, either by paying monthly premiums or co-payments or both, as highlighted above in Figure III-1. There is no cost sharing for HUSKY A clients.

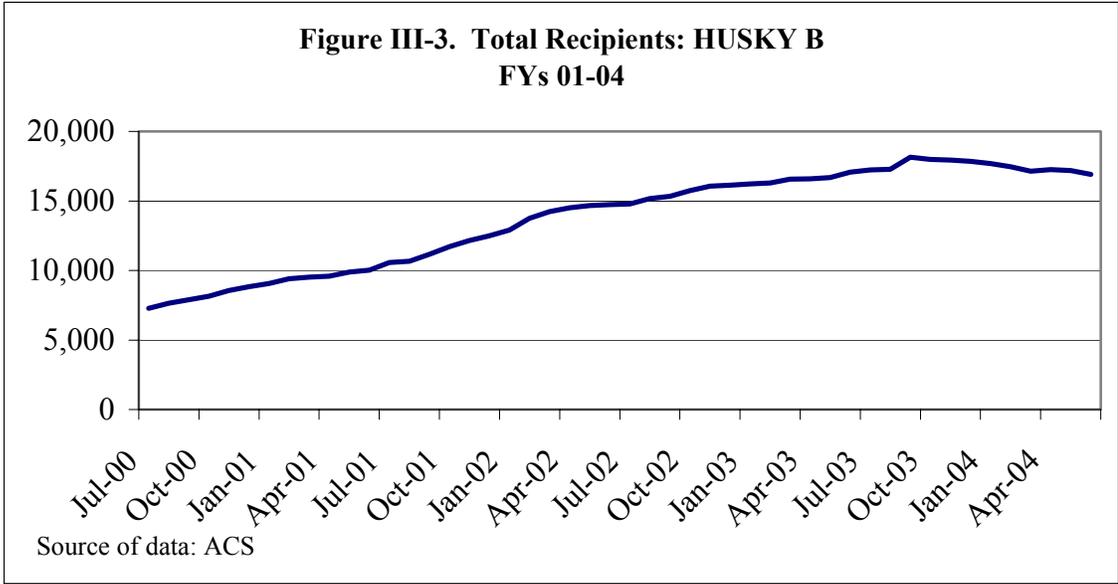
WORKLOAD

Caseload

- Figure III-2 highlights the total number of people receiving HUSKY A benefits for fiscal years 2001-2004. The caseload totals include individuals in the TFA program receiving medical benefits and individuals receiving Family Medicaid and not receiving cash assistance.
- The figure shows a steady increase in *recipients* over the four fiscal years. The number of recipients increased from 233,980 per month to 307,337 (or 31 percent). The number of *households* (which may include multiple recipients) receiving assistance increased from 113,149 to 138,197 (or 22 percent.)

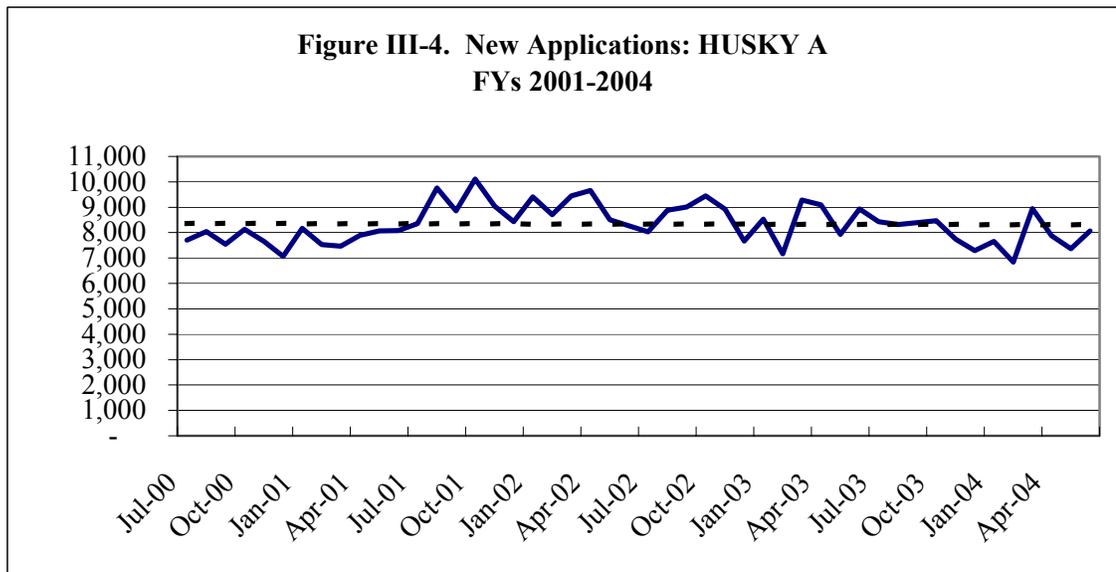


- In one workload assessment conducted by a district office in early 2002, it was estimated that Family Medicaid applications averaged 1 hour and 15 minutes to process.
- Figure III-3 shows the total recipients for HUSKY B for fiscal years 2001-04. The figure shows the number of recipients steadily increased through late 2003. Since then, a gradual decrease in monthly recipients has occurred.

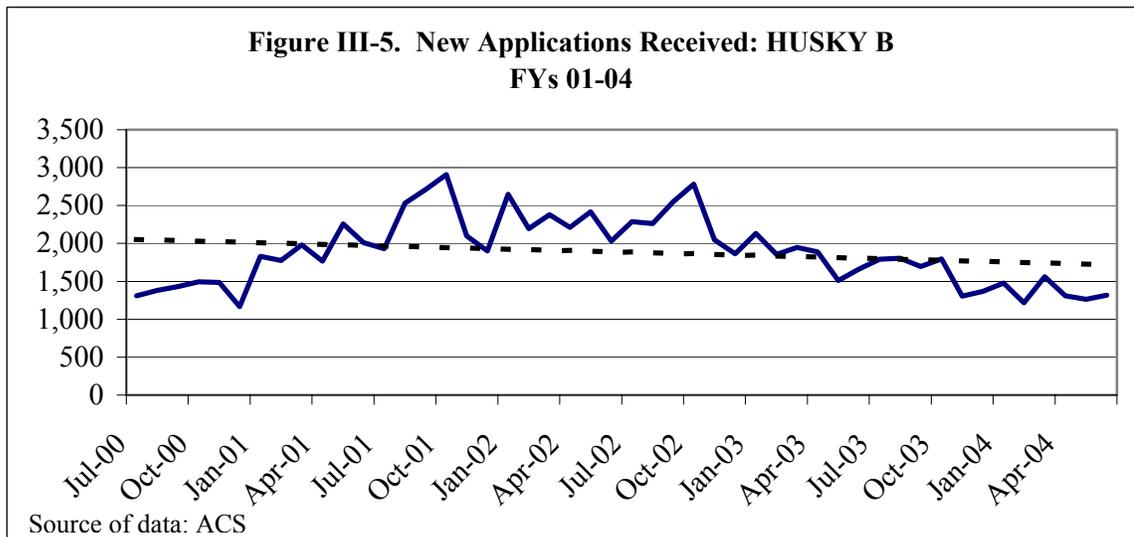


Applications

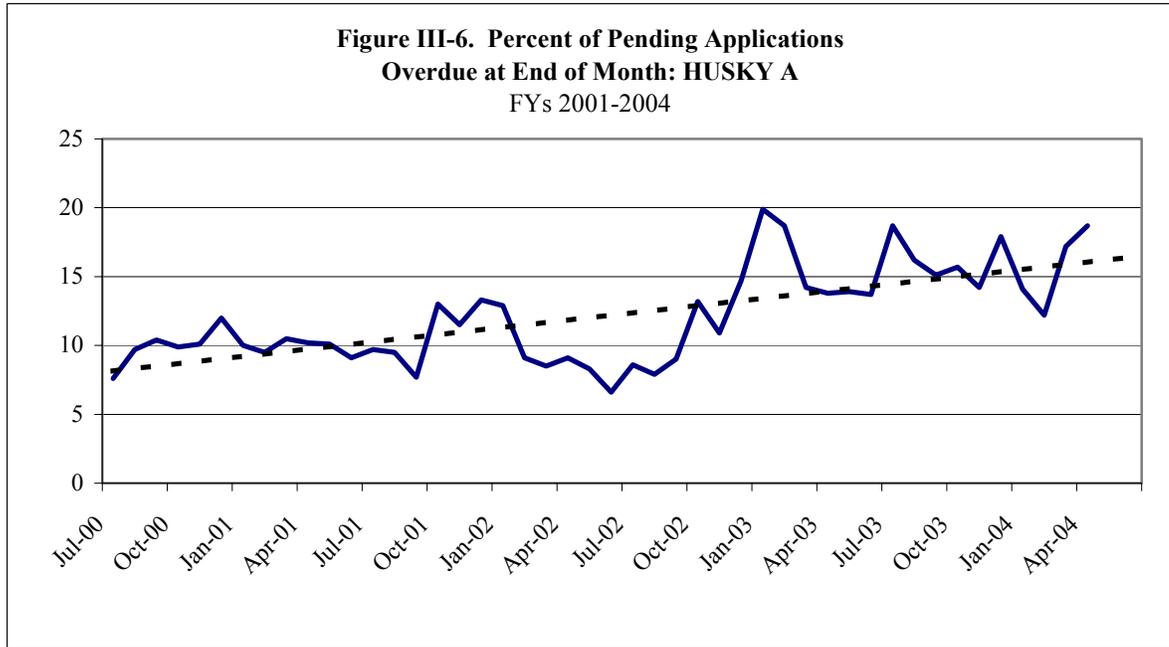
- A key workload indicator is the trend in the number of new assistance applications DSS receives at the beginning of each month. Figure III-4 shows the number of new applications for HUSKY A received monthly for FYs 2001-04. The figure includes new applications for the categorically needy, medically needy, and spend-down groups.



- Fluctuation in new applications from month-to-month over the period ranged from an actual decrease of up to 1,400 applications from one month to the next, to an increase of over 2,100 applications between months, making workload unpredictable.
- Although the number of new applications received for HUSKYA fluctuated between FYs 01-04, the overall trend for the period was relatively unchanged.
 - October 2001 marked the high in applications received (10,108).
 - A low of 6,838 applications were received in February 2004.
 - The number of new applications averaged 8,337 per month.
- Figure III-5 highlights the number of new HUSKY B applications (signed) received per month for FYs 01-04. The number received generally increased until late 2001, leveled off somewhat until late 2002, and has been declining through mid-2004.

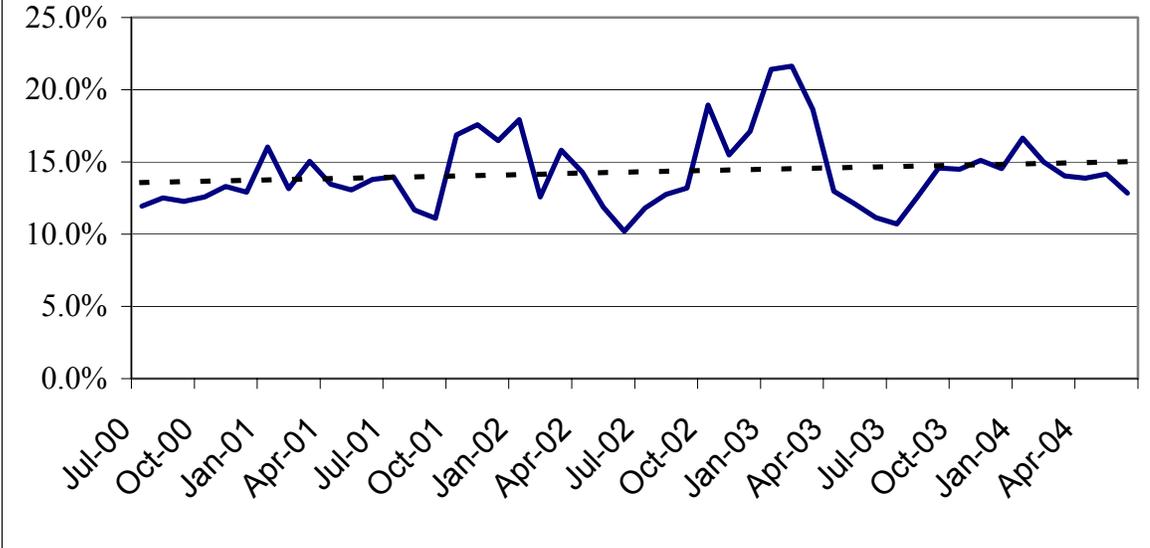


- Figure III-6 shows the percent of pending HUSKY applications at the end of the month that were overdue for FYs 01-04. Using this measure, the percent of such applications has more than doubled since July 2000, from almost eight percent to just under 19 percent. The linear trendline also shows a steady increase over the time period. There is not standard of promptness for HUSKY B.



- Figure III-7 shows program review staff analysis of the percentage of new HUSKY A applications (categorically needy) where a decision was made beyond the 45-day federal standard of promptness.
 - Application dispositions for categorically needy include: 1) granted; 2) denied; 3) withdrawn by the applicant; or 4) cancelled.
- The figure indicates this percentage generally fluctuated between 10 and 20 percent over the four-year period. On average, the trend in overdue decisions has increased by roughly one to two percent over the time span analyzed. The overall trend for the period analyzed had a modest, but steady, increase.

Figure III-7. Days Beyond Standard of Promptness to Process New Applications: HUSKY A (Categorically Needy Only) FYs 2001-2004



LONG TERM CARE

- Long-term care (LTC) is a covered mandatory service under Medicaid.
- Two primary criteria for coverage are: 1) the person is currently or planning to be a resident of a certified skilled nursing facility; and 2) the person meets the income requirements, including an asset test.

ELIGIBILITY

Who Determines

- As with other eligibility determinations, federal regulations mandate that eligibility for Medicaid long-term care be determined by state or county government employees. In Connecticut, DSS determines all DSS applications. DSS typically assigns eligibility workers to a designated unit that works solely on long-term care applications. Generally, a written application may be submitted; the applicant does not need a face-to-face interview.

How Long

- In general, the standard of promptness (SOP) for determining eligibility for long-term care applications is 45 days.

Criteria Considered

- Application needs to be filed with DSS.
- Because of the financial exposure long-term care imposes on the state budget – the average cost of nursing home care in Connecticut is about \$92,000 a year – there is a public interest in ensuring that only truly needy persons are deemed eligible. Several tests are used to determine eligibility.
 - The current income/asset limit is about \$1,600 a month, although certain assets are exempt.
 - An examination for *transfer of assets* is conducted. Federal law requires that a prohibition on asset transfers apply to applicants for long-term care and to Home and Community Based Waiver programs.

- The transfer of asset *look-back period* mandated by federal law is 36 months from the date of institutionalization or the date of application, whichever is later.³ (For certain trusts, the look-back period is 60 months.)
- If assets were transferred during the 36-month period, the state withholds payment for services during a penalty period. The assessment of assets applies to the applicant and the applicant's spouse if he or she still lives in the community.
- The *penalty period* is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing home care in the state to arrive at the number of months for the non-payment (penalty) period. There is no time limit on the penalty period.

Verification

- Social Security Number (SSN) and declaration of citizenship are required on application.
 - SSN used to check computerized government records of the Social Security Administration, the Internal Revenue Service, and state Departments of Motor Vehicles (DMV) records, and Department of Labor (DOL) information on wages and unemployment compensation.
- Based on information provided on the application and results of the government records check, DSS may also verify the information with other sources like banks, employers, and insurance companies. A detailed checklist is used by DSS long-term care eligibility workers to determine income and assets (See Appendix B).
- In making the application, the client agrees to:
 - the verification procedures;
 - the state recovering monies from a client's estate -- provided there is no surviving spouse or child who is either under 21 or disabled; and
 - the state placing a lien against countable property.
- If the applicant for long-term care is over 20 and younger than 65, and not already receiving disability payments, he/she must also submit documentation from a physician establishing disability, as well as grant written permission for DSS to obtain hospital and other medical records.

³ Connecticut has submitted a waiver request to CMS to extend the look-back period to 60 months and to modify the penalty period.

METHOD of PAYMENT

- Persons receiving long-term care are *not* in a Medicaid managed care program. DSS sets the rates for individual nursing homes. The Medicaid recipient in long-term care is required to spend all but a minimal amount per month (\$57 personal needs allowance) toward his/her care and the state pays the remainder of the daily rate to the nursing home. Medicaid payments are made monthly to nursing facilities.

WORKLOAD

- There are two overall measures of workload in dealing with Medicaid population on long-term care – *overall caseload* and *numbers of applications*.
- Program review staff concludes, through interviews with DSS staff and observations at DSS offices, that application processing for long-term care is more labor intensive than for other types of Medicaid cases, while the case management or maintenance, once the person becomes eligible, is less time-consuming.
- In an assessment conducted in one district office on caseload times, it was estimated that a long-term care Medicaid application took a total of 10 hours and 15 minutes to process compared to 1 hour and 15 minutes for a family Medicaid application.
- Factors that make LTC cases more time-consuming are the volume of financial records that must be examined and the complicated tests and calculations DSS staff must conduct prior to approving an LTC application. For example, workers determine:
 - what assets the spouse still living in the community can keep – known as the communal spouse protected amount (CSPA);
 - if any assets were transferred – whether they are exempt by law -- and if not, what penalty period should be assessed; and
 - the minimum monthly needs allowance (MMNA) for the spouse still living in the community to determine the community spousal allowance (the MMNA allows a portion of the income for the long-term care client to go to the community spouse so he/she will not become impoverished).

Caseload

- As Figures III-8 and III-9 indicate, while the overall Medicaid caseload has been increasing-- 13.6 percent over the five-year period – the long-term care Medicaid population has been declining – from an average monthly caseload of 22,160 in FY 00 to 20,408 in FY 04, a decrease of about 8 percent.

Figure III-8. Trend in Medicaid Long-term Care Cases FY 00 -FY 04

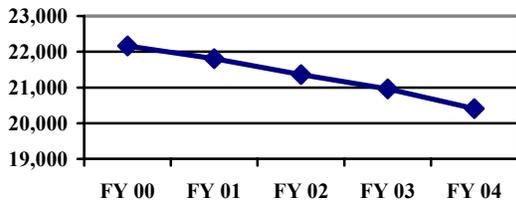
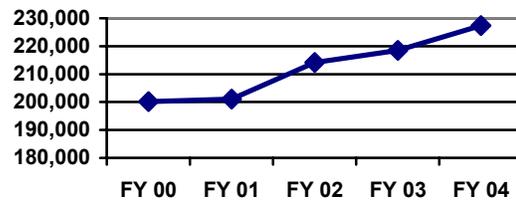
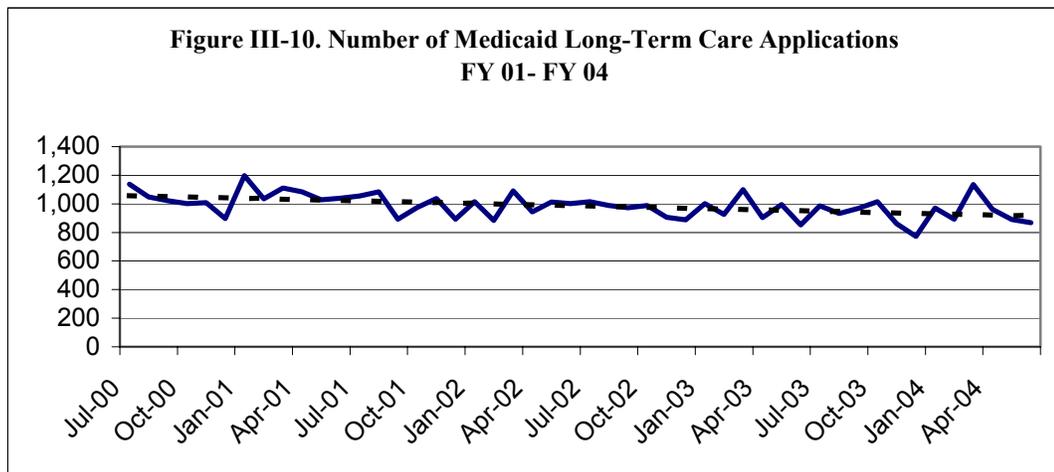


Figure III-9. Trend in Medicaid: All Cases FY 00 - FY 04

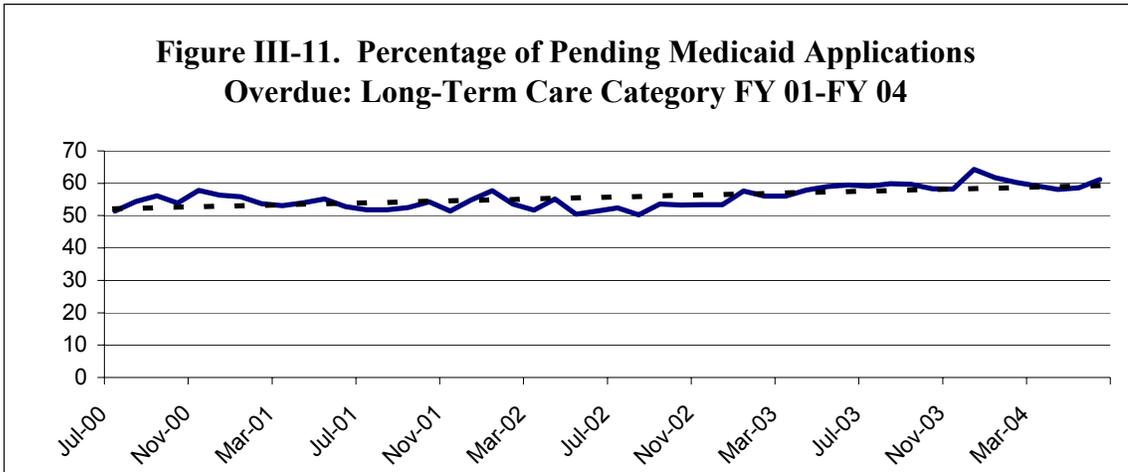


Applications

- Applications for Medicaid long-term care have also been decreasing, as shown in Figure III-10. Between FY 01 and FY 04, the number of applications -- including medically needy and those in active spend-down -- decreased by about 10 percent, from an average of 1,042 applications per month in FY 01 to 938 a month in FY 04.



- As noted above, the review of LTC applications is complicated. Thus, while applications for long-term care have decreased, the percent overdue continues to be problematic, with more than half of all pending applications in that category overdue each month, as shown in Figure III-11.
- The problem has worsened over the four-year period – from a monthly average of slightly less than 55 percent overdue during FY 01 to almost 60 percent overdue each month during FY 04.



- Legal advocates of elderly LTC applicants indicate that delays in determining eligibility can have serious financial consequences for their clients and/or the nursing facilities where their clients reside. For example, if, after an extended application review period, a client living in a nursing home is found ineligible, the client may be facing a significant nursing home bill that he/she cannot pay and one the nursing home cannot absorb.

AGED, BLIND or DISABLED

- To qualify for Medicaid on the basis of a disability, the applicant must be determined to be disabled and not have countable income or assets over a certain amount.

ELIGIBILITY

- If a person is receiving *cash assistance* under the State Supplement Program,⁴ also known as Aid to the Aged, Blind or Disabled (AABD), the person is automatically eligible for Medicaid. Others may be eligible by meeting the age (65) or disability requirement and having low-income.

Who Determines

- DSS eligibility services workers determine Medicaid eligibility for the Aged, Blind and Disabled (ABD) population. Typically, workers are assigned to adult or family programs. ABD falls under adult programs.

How Long

- The federally required standard of promptness is 90 days for Medicaid applications where disability must be established.

Criteria Considered

- The applicant must file an application.
- If the applicant is filing because of a disability, the disability must first be established.
- The agency determining the disability depends on the program.
 - The federal Social Security Administration contracts with a unit of DSS (the Disability Determination Unit of the Bureau of Rehabilitation Services) to determine disability for Social Security Disability and Supplemental Security Income (SSI) programs.⁵
 - The Department of Social Services contracts with Colonial Cooperative Care, a private health care management entity based in Norwich, Connecticut, to perform disability assessments for Medicaid-only cases (and State Administered General Assistance (SAGA)).

⁴ State Supplement is a cash benefit for persons receiving a low monthly Social Security, Supplemental Security Income, Veteran's benefit, or private pension check.

⁵ In most states, persons receiving federal SSI automatically qualify for Medicaid. Connecticut is one of only 11 states that have more restrictive standards.

- DSS has a medical review team in-house that conducts other reviews (e.g., work exemptions, nursing home care) not done by the above.
- For blind clients, the state Board of Education and Services for the Blind or SSA can certify the applicant's disability.
- Criteria for disability determination are the same under all programs (except SAGA). The disability:
 - must be severe enough to prevent "substantial, gainful, employment" (i.e., earn at least \$700 a month)
 - must last (or be predicted to last) at least 12 consecutive months

Second, the applicant must meet the income and asset test.

- The asset limit is \$1,600 for an individual and \$2,400 for a couple.
- The income test applies a complicated series of steps to reduce the applicant's gross income by disregarding certain types of income and legitimate expenses to arrive at maximum allowable income. The applicant's *maximum gross income* cannot exceed \$1,600 a month, and the *maximum allowable income limit* is approximately \$775 a month for an individual.
- In 1999, the federal "Ticket to Work" legislation loosened Medicaid eligibility rules to allow working disabled persons who have a medically determined disability, but who can still perform substantial, gainful activity, to qualify. Connecticut authorized this Medicaid program coverage for state residents in 2000 (P.A. 00-213). The levels of income (up to \$75,000 annually) and assets (up to \$10,000) are higher, with broader types of assets excluded. Premiums are assessed if income minus certain expenses exceeds 200 percent of poverty. Persons who qualify under this program are counted in the Aged, Blind or Disabled category.

Verification

- Eligibility workers must receive the proper documentation verifying the applicant's disability.
- Checks are made of the same records as with other Medicaid populations to verify factors such as income and assets, and citizenship status.

Redetermination

- Eligibility for Medicaid must be re-established every 12 months for the Aged, Blind or Disabled population if they are categorically needy.

METHOD of PAYMENT

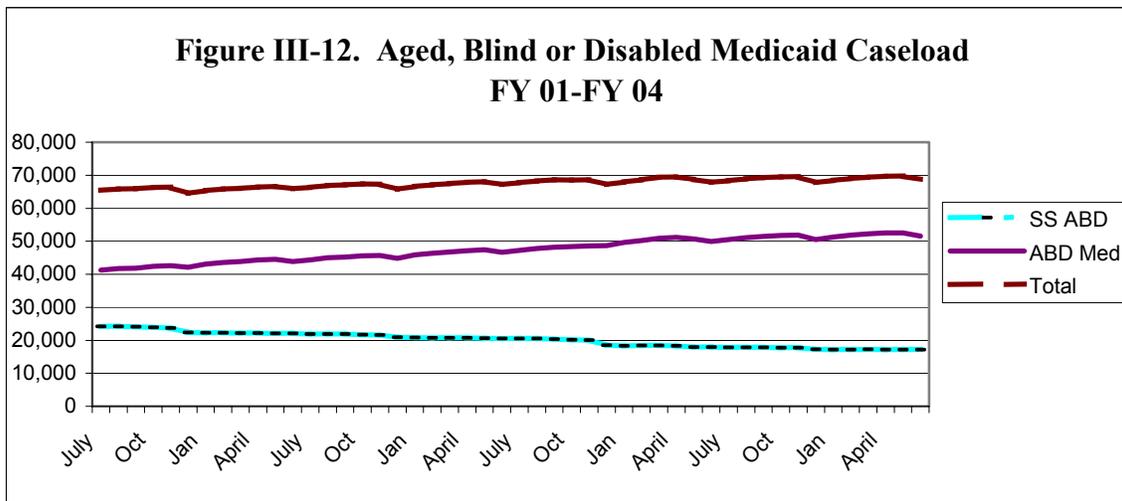
- All Aged, Blind or Disabled Medicaid recipients are covered under fee-for-service, and are not in managed care. Providers bill for service and are reimbursed at the Medicaid rate for that service. There had been co-pay provision instituted in 2003 for Medicaid recipients, but it was removed during the 2004 legislative session.

WORKLOAD

- Time assessments conducted in the Norwich DSS office indicate Aged, Blind or Disabled Medicaid applications averaged 45 minutes to process (once all material is ready for determination).

Caseload

- The caseload for the Aged, Blind or Disabled population under Medicaid is shown in Figure III-12. The top line shows the total caseload. It indicates the overall caseloads have grown only slightly over the four-year period (less than 5 percent). However, the make-up of the caseload has changed, with those receiving Medicaid-only because of disability (no state cash assistance) has increased by 20 percent, while those receiving Medicaid as well as a State Supplement has declined 24 percent over the four-year period.



MEDICALLY NEEDY POPULATIONS

ELIGIBILITY

- Connecticut is one of 35 states that operate an **optional** Medicaid program covering the medically needy. In general, this option covers the same groups of individuals as those in the categorically needy population, except they do not meet all the requirements, usually because their incomes are too high to make them categorically eligible. Operating this program allows individuals to use their medical expenses to “spend-down”, or reduce their excess income to a level that makes them eligible for Medicaid.

Who Determines

- Eligibility is determined by DSS eligibility workers in the district offices. Workers typically are assigned to determine eligibility by population (e.g., adult vs. family) and are not dedicated solely to medically needy eligibility determination.

How Long

- There is no standard of promptness for medically needy applications while they are being evaluated during the spend-down period.

Criteria Considered

- States have the option of using a period of one to six months to assess medical expenses against income to determine an applicant’s eligibility as medically needy. In Connecticut, the assessment period for spend-down is six months.
- Eligibility is approved when the applicant’s medical expenses reduces income to below a certain level known as Medically Needy Income Level (MNIL). Once a person has reached that level, the eligibility is established for the remainder of that period – six months in Connecticut.
- Generally, federal requirements specify the MNIL cannot be more than 133 percent higher than the state’s AFDC 1996 levels for a comparable-sized family. In Connecticut, this translates to a countable income level of \$476 a month for an individual (\$574 is used for Fairfield County). These levels were established in 1991 and have not been updated since then. (See Appendix C for a state comparison of income and resource eligibility levels.)

- In addition to meeting the income requirements, applicants must meet a resource test (e.g., countable assets, like a bank account, or cash value insurance policy). Connecticut's resource level of \$1,600 is the lowest of any state operating a medically needy program. Resources cannot be counted in the month they are received but if the \$1,600 level is reached in any subsequent month, eligibility can be affected.

Verification

- In determining whether an applicant is medically needy the eligibility worker examines medical expenses incurred to determine if they qualify and if they offset the applicant's income by enough to reach the MNIL.
- The process for establishing eligibility is complicated for both the applicant and the worker. The applicant must keep documentation of all medical expenses, and the eligibility worker must obtain and examine them, verify if they qualify, and calculate whether they offset the applicant's income enough to determine him/her eligible. If he or she does qualify, the person is put on the active caseload for the remainder of the six-month eligibility period.

Redetermination

- If the client is receiving Medicaid in the medically needy category because of medical expenses, the client's eligibility remains until the end of that six-month period. The recipient's eligibility must be redetermined at the end of six months.
- If the applicant is in active spend-down, medical expenses have not yet qualified him or her for Medicaid, and the applicant's medical expenses are reviewed at the end of each month.

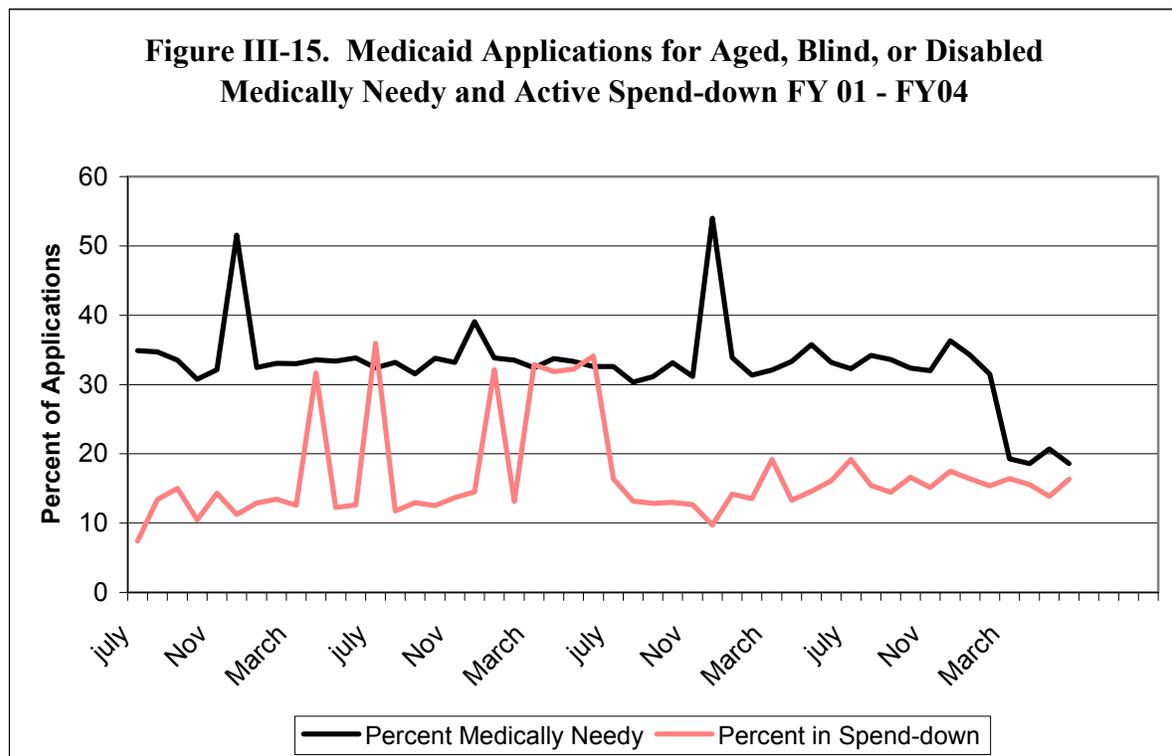
WORKLOAD

- Medically needy clients are not counted separately in caseload data. Rather, they are counted in one of the following population groups – 1) family; 2) aged, blind or disabled; or 3) long-term care.

Applications

- The percentage of new Family Medicaid applications considered medically needy is quite small – averaging 8 percent monthly over the four fiscal years.
- Similarly, the percentage of all new long-term care applications that are considered medically needy (both considered eligible and in active spend-down average 12 percent per month during FY 01 through FY 04.

- The percentage of new ABD applications in the medically needy category and in active spend-down, however, is much higher than for Family or LTC. Figure III-15 shows the percentage of both these types of applications out of all ABD applications. As depicted, medically needy applications typically account for about one-third of all ABD applications, while those in active spend-down on average account for another 15 to 20 percent.
- Medically needy applications are more labor intensive, since those that are determined eligible are considered active only for the remainder of the six-month period. Applications in active spend-down must have their medical expenses evaluated each month to determine if eligible. In addition, as the figure shows, there is, at times, great volatility from month to month in medically needy and spend-down applications, making workload difficult to predict.



OTHER ELIGIBLE POPULATIONS

ELIGIBILITY

- Persons receiving Medicare who are also low-income may qualify for some type of assistance from Medicaid. There are primarily two categories of those eligible – the Qualified Medicare Beneficiary (QMB) and the Specified Low-income Beneficiary (SLMB) – and income dictates which group the applicant qualifies.

Who Determines

- DSS workers in the district offices determine eligibility.

How Long

- The federal standard of promptness is 45 days for these applications.

Criteria Considered

- Client is already receiving Medicare.
- Those who qualify as a QMB, with resources at or below twice the SSI standard (\$2,000) and income at or below 100 percent of FPL, do not have to pay their Medicare premiums and may also have some of their medical expenses -- that Medicare does not cover – reimbursed by Medicaid.
- Those who qualify as SLMBs have higher incomes than those in the QMB category, but are still considered poor. They must meet income levels at less than 120 percent, 135 percent, or 175 percent of poverty, respectively. Depending on their income levels, applicants will get help with all or some of the monthly Medicare premiums.

Redetermination

- Eligibility must be redetermined every 12 months.

WORKLOAD

- Often, those in the QMB and SLMB categories are not considered in the Medicaid caseload numbers. While they may not be entitled to the full array of services Medicaid provides, since they are primarily Medicare recipients, their applications must be processed, income and assets verified and eligibility determined, and reestablished at annual renewal.

Caseload

- Over the four fiscal years examined, the average monthly number of QMB clients increased from 44,128 in FY 01 to 46,547 in FY 04 (5.4 percent). At the same time, the number of cases in the SLMB categories more than doubled -- from 7,167 in FY 01 to 15,615 in FY 04.

Applications

- The number of new applications in these categories declined over the four-year period. The average monthly new applications in the QMB category in FY 01 was 1,124; by FY 04 that number had declined 17 percent -- to 916 per month. SLMB applications also declined -- by 26 percent -- from a monthly average of 540 in FY 01 to 397 in FY 04.
- From the DSS caseload and application numbers, it appears the number of cases where eligibility must be established for the first time is declining, but once eligibility has been established, these recipients remain eligible for an extended period.

Overdue Applications

- While the number of new QMB and SLMB applications has been declining, the percent of those pending that are overdue has been generally increasing, particularly in FY 04, as shown in Table III-1.

	FY 01	FY 02	FY 03	FY 04
QMB	30.2	29.6	27.6	34.6
SLMB	24.8	33.1	18.5	35.3

Source: LPR&IC Staff Analysis

Section 4: Management And Oversight

- A number mechanisms for managing and overseeing the Medicaid program are aimed at preventing fraud and abuse, reducing errors, and ensuring that payments are made for only eligible clients and for covered services.
 - DSS operates a federally required Medicaid Eligibility Quality Control (MEQC) system that reviews eligibility and payments based on a sample of active cases. The federally established national standard error rate for Medicaid is 3 percent. DSS officials have indicated Connecticut's error rate has always been below that threshold.
 - DSS has a Medical Audits Division focused on ensuring payments are made for legitimate services to appropriately credentialed and approved providers, and to detect fraud and abuse, and work with legal authorities when a crime may have been committed.
 - DSS is audited by the Auditors of Public Accounts (state auditors), both as a state agency and under the single state audit requirement as a recipient of federal funds and grants. Under the single state audit ending June 2003, state auditors examined Medicaid eligibility records for timeliness, but the major thrust was on allowable costs.
- There are federally imposed standards of promptness for making Medicaid eligibility determinations, but no ongoing federal oversight of these requirements exists. CMS does not require reporting on timeliness of processing, and does not know if a problem exists unless it receives a complaint. In the absence of reporting, there are no comparative statistics to aid in state management and oversight.
 - CMS Region One Office in Boston received an informal complaint in early summer of 2004 regarding the timeliness of Medicaid eligibility determination, and asked DSS to indicate what steps it intends to take to address the problem. The department's response is contained in Appendix D.
 - CMS staff conducted field visits in Connecticut to determine the scope of the problem, and intends additional visits in a few months.
- The DSS fair hearing process also serves as a check on eligibility determinations, including those in Medicaid, as described in Section Two. The vast majority of appeals involve the actual decisions, but "process delay" is also grounds for appeal.

- Table IV-1 shows the number of statewide requests for hearings for calendar years 2001 through June 15, 2004. The table also shows the appeals made on the issue of delay. However, the hearing tracking system does not simultaneously define program and issue, so some of the “process delays” may be for other than Medicaid.

Table IV-1. Fair Hearing Requests: January 1, 2000- June 15, 2004 Medicaid Program and Process Delay Issues					
	Calendar Year				
	2000	2001	2002	2003	2004 (to 6/15)
Medicaid	1,686	1,669	1,641	2,505	1,111
Process Delay	72	72	97	171	72

Source of Data: DSS Office of Administrative Hearings and Appeals

- Advocacy and interest groups. In addition to federal or state-imposed management mechanisms, DSS operations are under public scrutiny by client advocacy groups. Often, representatives of these groups serve as members on official advisory groups (e.g., Medicaid Managed Care Council or its subcommittees). Other times, such groups are part of nationwide efforts to ensure that human services public policy is implemented effectively (e.g., The Covering Kids4 project). At times, these groups may also collaborate or partner with DSS to deliver a service or implement a policy, either informally or through a grant or contract.
- Court cases. The Department of Social Services is frequently named in civil actions -- 11 civil cases have been filed against DSS since 1999. At least two of those cases involve Medicaid:
 - *Rabin et al. vs. Wilson-Coker* was brought in 2003 in response to the state’s effort to limit Husky A transitional medical assistance by reducing the income from 150 percent of poverty to 100 percent. The U.S. 2nd District Court of Appeals decided for the plaintiffs in March 2004, and those clients impacted remained eligible for Medicaid. Currently, the state has a motion filed for a reconsideration of the decision, but no action has been taken on that motion.

⁴ *Covering Kids and Families* is part of a nationwide initiative funded by the Robert Wood Johnson Foundation. Currently operating in 46 states, the project is aimed at ensuring better health access for low-income children and families. In Connecticut, the project supports statewide intervention and local projects that promote health care access.

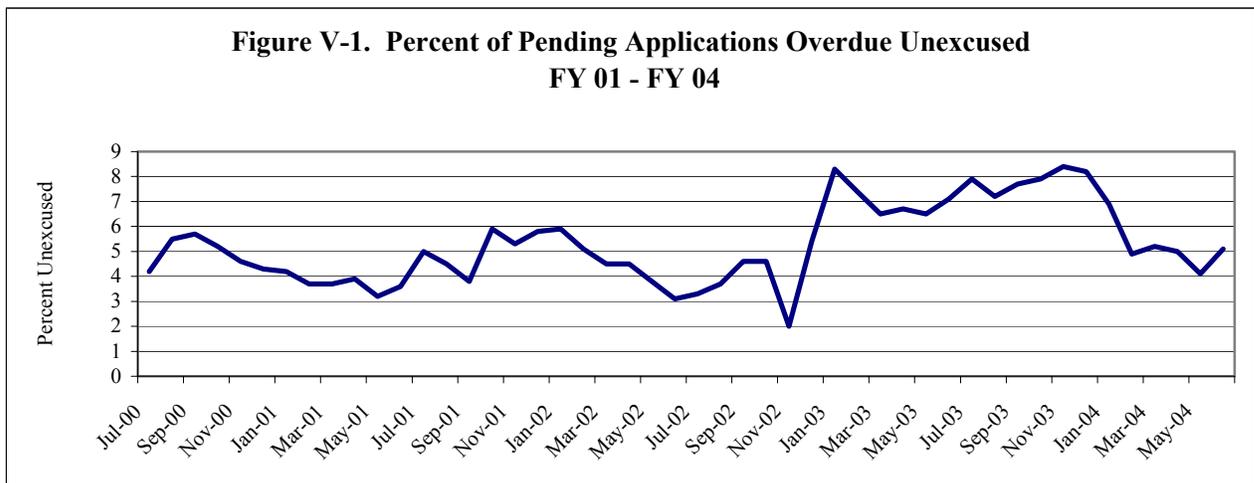
- *Raymond et al. vs. Rowland et al.* is an ongoing case. The plaintiffs allege that DSS is not making reasonable accommodations under the Americans with Disabilities Act to ensure access to DSS' programs and services. The case cites the 2003 DSS office closures as one action that deprives the plaintiffs of access. Parties are still in the discovery phase.
- **Alvarez Stipulated Agreement.** In 1990, a civil action was brought against DSS charging the agency was not processing Medicaid (and other) applications for assistance in a timely manner. In 1992, the plaintiffs, represented by Connecticut Legal Services, and DSS entered a court-approved stipulated agreement, known as the "Alvarez agreement". In the settlement, the parties agreed:
 - DSS will provide monthly reporting on overdue (beyond the standard of promptness) and pending applications and make the reports available to plaintiffs' attorneys;
 - no more than 5 percent of all overdue pending assistance applications (including Medicaid) statewide should be reported as *unexcused*, and no more than 10 percent of pending applications of any one office should be reported as *unexcused*; ⁵ and
 - DSS should designate a staff person in each office to deal with emergency cases or applications subject to unexcused delays. The staff person, called a client representative, must satisfactorily address the problem within two working days.

⁵ Excused reasons are: 1) agency has not had 10 days to secure information after extension; 2) applicant does not currently meet eligibility requirements, but is expected to; 3) applicant has not had 10 days to submit information after extension 4) only missing information is the physician report; 5) client has good cause; or 6) 3rd party delay (client pursuing verification). Unexcused reasons are: 1) awaiting DSS medical review team or medical consultant decision; 2) EMS problem prevents disposition; 3) reason not entered; or 4) case is ready, but worker has not yet processed.

Section 5: Analysis and Preliminary Findings

Medicaid Application Processing: An Increasing Problem

- Workload measures for the Medicaid program discussed in Section 3 showed caseloads and new applications increasing for almost all categories. Overall, DSS receives about 13,000 to 14,000 new Medicaid applications each month. The average monthly applications grew from 13,343 a month in FY 01 to about 14,312 a month in FY 02 -- a 7.2 percent increase. Applications remained at about 14,120 a month in FY 03, before leveling off to slightly fewer than 13,000 in FY 04.
- The percent of overdue pending applications is also increasing – from an average of 26 percent overdue in FY 01 to almost 35 percent overdue in FY 04. The percentage of eligibility determinations that were made beyond the SOP (either 45 or 90 days) also grew from about 15 percent to just under 20 percent. Of particular concern is the increasing percentage of Family Medicaid pending applications that are overdue, or where eligibility decisions were made late.
- Section 4 indicated one of the oversight mechanisms of eligibility determination processing in place resulted from a stipulated agreement to settle a lawsuit in the early 1990s. Known as the “Alvarez agreement”, it requires DSS to meet a timeliness standard where no more than 5 percent of overdue pending applications can be considered unexcused. Using that measure, the trend is depicted in Figure V-1 and shows the percent of overdue unexcused applications has gone from a monthly average of 4.3 percent in FY 01 to 6.5 percent in FY 04 –an increase of about 50 percent. While it has declined in the last part of FY 04, that might be due to increased vigilance in staff coding overdue applications as excused cases rather than any real timeliness improvements.



- The number of fair hearing requests for the Medicaid program increased by 52 percent from 2002 to 2003, and the number of hearing requests related to process delay jumped 76 percent in that one year. The increase in hearing requests indicates a problem regarding eligibility decisions as well as timeliness. But the growing number of hearings can compound the workload problem, since eligibility worker time must be spent preparing for and attending hearings rather than processing applications and making eligibility decisions.

Contributing Factors

- Program review staff analysis shows a number of factors contribute to the problem of processing Medicaid applications, including: DSS eligibility worker reductions; office closings and shifting caseloads; an inflexible mainframe eligibility management system; a management structure that is largely decentralized; oversight mechanisms that focus primarily on expenditures and reducing errors rather than on timeliness or client satisfaction; and myriad changes to the Medicaid program prompted by state budget cuts in 2003, some of which were reversed in the 2004 session.

BUDGET REDUCTIONS (2003)

- The State of Connecticut faced a severe budget shortfall at the end of 2002 and early 2003. A November/December special session was called. The governor asked state labor unions to make wage concessions. Almost none of the bargaining units would agree and about 2,500 state workers were laid off, including 245 in DSS.
- During the 2003 legislative session, another budget-saving measure was passed. The Early Retirement Incentive Plan (ERIP), effective from March through June 2003, reduced the state workforce by another 4,640 positions. Table V-1 shows the impact of the layoffs and ERIPs on DSS' workforce compared to other state agencies. Table V-1 shows that DSS' staff reduction was almost 25 percent and is significantly higher than the statewide average of 10.2 percent for the agencies program review staff used for comparison.

Table V-1. Comparison of Staff Reductions in State Agencies			
Agency	FY 03	FY 05	% Reduction
State Library	90	61	32.22
DSS	2,239	1,692	24.43
DEP	465	367	21.08
DMV	699	595	14.87
DPH	549	447	18.58
DECD	116	97	16.38
DMHAS	3,536	3,079	12.92
DHE	31	27	12.90
DMR	4,561	4,015	11.97
UConn	2,632	2,344	10.94
DOT	3,629	3,262	10.11
UCHC	998	913	8.52
SDE	1,767	1,714	3.00
DOC	6,940	6,739	2.90
Totals	28,252	25,352	10.2
Source: OFA Budget 2003-2005 Revisions			

- Expected agency budget reductions were initiated on a percentage of agency expenditures. DSS – because it pays for assistance and benefits programs – is considered a high-cost agency and had to come up with a steep budget reduction plan, including closing four offices in Bristol, Meriden, Norwalk, and Willimantic, and a sub-office in Ansonia (Willimantic has since reopened on a part-time basis). The New Haven office that handled only SAGA cases also closed.
- The caseloads from those offices were transferred to other DSS locations, sometimes split between two different offices. In the case of Meriden, caseloads were transferred twice, first to New Haven, then to Middletown.
- At the same time, the human services regions were reduced from five to three, requiring a realignment of office reporting and an expansion of supervisory and management responsibilities for regional administrators.
- Connecticut, in the late 1990s, expanded its Medicaid program several times, adopting features that Congress authorized in acts passed in the mid-to-late 1990s. However, to reduce state expenditures, Connecticut, like many other states, took actions to limit its Medicaid program in 2003. The legislature: eliminated presumptive eligibility for children; guaranteed eligibility; attempted to reduce the

transitional Medicaid income limits; introduced co-pays for some Medicaid recipients; and increased co-pays and premiums for others.

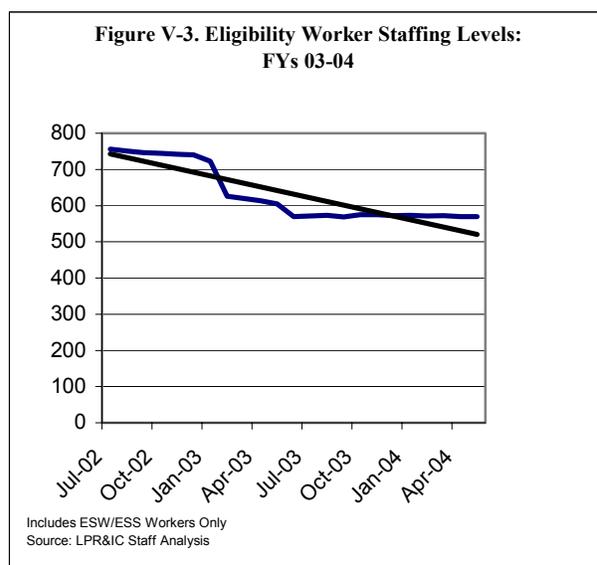
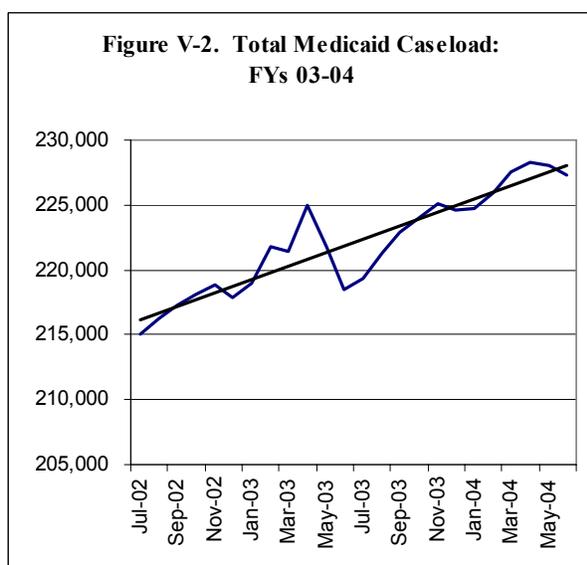
- This had a two-pronged effect: 1) the changes in criteria limited eligibility; and 2) the eligibility workers had to implement all the changes, which had to be incorporated into policy manuals, transmittals, and the computerized eligibility management system. Many of these changes were reversed in 2004, but their administrative impact on the state's Medicaid program was still significant.

WORKFORCE

- The most apparent factor contributing to delays in processing Medicaid applications is the decrease in personnel to make eligibility determinations. The number of workers in the three eligibility worker classes – ESW, ESS and Supervisor – totaled 845 in July 2002; in July 2004 there were 636, a reduction of 25 percent. The reduction in eligibility personnel is similar to DSS loss in personnel overall during FY 03 and FY 04, as Table V-1 above indicated.
- It took a period of time after the layoffs and early retirements for DSS to assess the impact of the reductions because anyone who was laid off could “bump” another worker with less seniority or in a lower class, even if in another office. Also, anyone called back to refill an ERIP position had to be taken in order from reemployment lists required by statute and collective bargaining contracts.
- OPM established a refill rate for DSS of one for every three positions lost to ERIP. Program review staff continues to analyze the number of refilled positions in the eligibility classes. Complicating both the refill process, as well as obtaining comparative position counts, has been the advent of CORE-CT during 2003.
- To cope with the staffing reductions and office closings, DSS implemented an “equalization” strategy in early 2004. The department took the statewide caseload and the number of eligibility workers and derived an average per-worker caseload. (These caseloads were not weighted but based on numbers only.) Some offices had higher and others had lower than the average per-worker caseload. To “equalize”, staff transfers – first voluntary and then involuntary – were made to arrive at more even caseload numbers. While evening out caseload, equalization appears to committee staff to have further destabilized staffing after the workforce reductions, and taken a toll on staff morale.

WORKLOAD

- Figure V-2 shows Connecticut's total Medicaid caseload for FY 03 and FY 04 increased from 215,000 to 228,000 households (6 percent). Figure V-3 shows the staffing levels for eligibility workers for the same time period decreased from 756 to 576 (just under 24 percent). These data clearly show while the state's Medicaid population was rising, the number of DSS workers processing Medicaid applications and providing case maintenance services for Medicaid clients was decreasing – both factors contributing to increased application processing times. On a per-worker basis for ESW and ESS staff, average Medicaid caseload increased 41 percent over the period analyzed, from 284 cases to 400 cases.



- No national Medicaid caseload measures exist, but the National Association of State Medicaid Directors, at program review staff's request, informally polled some of its states and shared the results. While certainly not a scientifically derived measure, the few states that responded appear to have caseloads (typically caseloads include food stamps, TANF, and cash assistance to the elderly, blind, and disabled, as well as Medicaid) of between 450 and 500 cases.
- Program review staff examined per-worker caseloads in Connecticut (average monthly cases for all major assistance programs/number of eligibility workers and specialists). The results show average caseloads in Connecticut were about 490 in FY 02; in FY 04, the average caseload per worker had grown to 620, an increase of 26.5 percent.

- Most applications can be done by mail, but an increasing caseload often results in more office visits and more phone calls to caseworkers.

OTHER FACTORS

- **Retraining.** Due to the department’s recent staff reductions and reassignments in staffing and caseloads, persons who might not have worked in a particular program or had to perform a particular function (i.e.; intake vs. case maintenance) for many years, have to be retrained in their new responsibilities, adding more time to caseload processing.
- **Dedicated processing times.** To also address the increasing workload, all DSS offices instituted formal “processing times.” On Wednesday and Thursday afternoons, workers are unavailable to clients – either in person or by phone—because the time is set aside to process applications and redeterminations, or take other steps to determine eligibility. Clients coming into the office may still drop off applications, schedule appointments, or conduct other transactions, but they may not see their case manager or intake worker unless an emergency situation exists. Clients are supposed to be able to leave messages by phone as well. However, while the intent of the strategy was to speed up eligibility processing by allowing staff to work on cases without distraction, perceptions have been that workers are not accessible to clients, and in some cases, that offices are “closed” during those periods, which is not the case.

ADMINISTRATIVE SUPPORT SYSTEMS

Increases in workload, in theory, can be made more manageable by improvements in technology, including computerized systems and communications. This is not the case in DSS.

- As discussed in Section Two, the Eligibility Management System is about 20 years old, requires “work-arounds”, and is heavily reliant on manual programming. Sixty-four separate codes exist for Medicaid population categories alone. DSS workers must enter data from written applications into the system; it has no on-line capabilities.
- Both DSS staff and client advocates indicate that client notices automatically generated by EMS can be confusing or confrontational. Instead of clarifying a situation, the notice often generates client calls or visits to a caseworker, creating additional work. EMS also generates dozens of “alerts” to the caseworkers each day, often bogging them down with inconsequential messages, rather than prioritizing actions needed on a case.

- Since only DSS workers can access the EMS system to make changes, the restriction can have negative consequences for clients. For example, if clients move, they are required to inform their caseworkers of their address change. Frequently, family Medicaid clients inform their health care plans thinking they have fulfilled the notice requirement. DSS is then either not informed, or does not promptly make the change if and when it gets the information from the managed care organization. If DSS mails the renewal information to the old address, and the client doesn't receive it, Medicaid eligibility will terminate, and the client will not know that until the next time he/she seeks medical services. This change-of-address issue and potential remedies have been discussed at one of the Medicaid Managed Care Council subcommittees over the past few months, but no satisfactory resolution has been found to date.
- One of the provisions of the federal Personal Responsibility and Work Opportunity Reconciliation Act (welfare reform) of 1996 requires states to sever the link between eligibility for cash assistance and Medicaid. The EMS system in Connecticut has not yet accomplished this, and reports generated by the system still call family assistance AFDC. Committee staff intends further analysis to determine that this is a system issue only, and that a client's eligibility for Medicaid is determined for that program only and is not decided on the cash assistance criteria.
- Much of the eligibility determination process will always be reliant on paper forms, such as medical forms to establish disability, and utility and rental bills to establish a client's expenses. However, EMS does have the capacity for the caseworker to enter notes to keep the electronic file current. DSS indicates the importance of using EMS for case notes has been stressed with supervisors, but there is no real way to monitor compliance. Committee staff checked the case notes with the "ready reference" (i.e., most current) paper files in a few cases in three offices, and found variation in the comprehensiveness of EMS case notes compared to the paper files.
- Federal regulations indicate that information systems upgrades are federally reimbursable at 90 percent. Given the shortcomings of the EMS system, workers' complaints about it, and the federal cost allowance, it is unclear to committee staff why DSS has not explored new technologies for eligibility determination. DSS did examine a system upgrade in the early 1990s, but no significant system changes were made. The current EMS may be viewed as a "workhorse" that continues to do the basic job of eligibility determination, and a new system may not be as reliable. Also, there may not be the staff resources in DSS' Information Technology Services to oversee such a massive overhaul.

- Phone call volume varies from office to office – fewer than 10,000 incoming calls during March 2004 in Middletown, to almost 119,000 incoming calls for the same month in Hartford. Phone systems also vary among offices, and in some instances, the systems do not seem to have sufficient capacity for call volume, nor are recorded messages customer-friendly. For example, during the spring of 2004, program review staff called the Hartford DSS office several times on several different days and heard a voice-recorded message that office hours were 8:30 a.m. to 4:30 p.m., Monday through Friday, and to call back. However, the calls were made during those times.
- Internal communication capabilities among DSS offices are also varied, often inadequate. When committee staff visited district offices earlier this summer, some offices had “Outlook” with e-mail capabilities, while others did not.
- The physical conditions at DSS offices, both from a client and worker standpoint, were also varied. In some cases, public transportation to the office (e.g., Norwich) is limited. Sometimes, in order to be on a bus route, the offices are in congested areas, where security may be an issue. Staff did note the presence of local police on duty (in addition to security officers) at some offices. At Willimantic, however, an officer was on duty one of the days the office was closed.
- At Willimantic also, there is no drop-off box accessible to clients when the office is closed, especially important at this office as it has only part-time hours. In another office, there were hand-written signs in English-only. Because the system is still so paper-driven, files and file cabinets take up considerable space. In some offices, the district office managers indicated they were waiting to have some of the historical files archived off-site; there are just no staff to file and box.
- Offices also vary in their ability to track applications. In some offices, an application is logged into an electronic tracking system, in others logged in by hand. In still other offices, there is no tracking of an application until it has been entered into EMS and processing has begun. Thus, one office may have the ability to satisfactorily respond to an inquiry from a client who calls about an application while another office may not know if the application has been received, or to which worker it has been assigned.
- DSS workers continually respond to different priorities. Eligibility workers also process applications and determine eligibility for other programs like food stamps and family cash assistance. As Section Four indicates, management and oversight mechanisms are primarily focused on error rates because federal reimbursement can be affected, or financial penalties can be imposed. For example, the state’s food stamp program, which is totally federally funded by the U.S. Department of Agriculture, is currently implementing a corrective action plan. The program, rather than pay a \$2 million penalty because of high error rate in FFY 01, is now under intense scrutiny. A consultant has been hired to examine the entire program,

including questioning a great many actions taken by eligibility workers. While the state's food stamp error rate has come down, the action plan has also made food stamps a priority over Medicaid and other assistance programs.

- Connecticut's Medicaid expenditures allocated to administration appear to be lower than other states in the CMS region, as shown in Section Two.

APPENDICES

APPENDIX A

GLOSSARY OF COMMON MEDICAID TERMS

Balance Budget Act (of 1997). An act of Congress that created the State Children's Health Insurance Plan and loosened a number of eligibility criteria for the existing Medicaid program.

Categorical Eligibility. A policy of restricting Medicaid eligibility to individuals in certain groups or categories, such as children, the elderly or people with disabilities.

Categorically Needy. Certain groups of Medicaid beneficiaries who qualify for the basic mandatory package of Medicaid benefits.

Centers for Medicare and Medicaid Services (CMS). The agency in the federal Department of Health and Human Services with responsibility for all Medicaid matters.

Children's Health Insurance Program (SCHIP). Enacted by the 1997 Balanced Budget Act as Title XXI of the Social Security Act, SCHIP is a federal-state matching program of health care coverage for uninsured low-income children.

Continuous Eligibility. An option available to states under federal Medicaid law whereby children enrolled in Medicaid may remain eligible for a continuous period of 12 months, regardless of changes in income and family status.

De-linking. Informal term referring to the breaking of the historical link between eligibility for cash assistance (like TANF) and Medicaid.

Enrollment Broker. Term used to describe an organization, usually a private entity, that contracts with the state, to inform Medicaid beneficiaries about the Medicaid program, and handle enrollment functions to managed care organizations.

Error Rates. The percentage of Medicaid payments made by the state on the basis of erroneous Medicaid eligibility determination. Cannot exceed 3% in Medicaid, without a penalty.

Eligibility Management System. A state's computer system for checking and verifying information to determine a client's eligibility for Medicaid. Federal regulations require a system but states may establish parameters for system.

Fair Hearing. Because Medicaid is an entitlement program, individuals have a statutory right to appeal denials or terminations to a higher administrative level. In Connecticut, DSS has a Fair Hearings unit.

Federal Financial Participation (FFP). Federal matching funds paid to states for allowable expenditures for Medicaid services or administrative costs.

Federal Poverty Level. The federal government's working definition of poverty used as the reference point for the income standard for the income standard for certain categories of Medicaid eligibility,

Federally Qualified Health Center (FQHC). States are required to include services provided by FQHCs in their basic Medicaid benefits package.

Fee-for-Service. A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide at a state-established rate.

Financial Eligibility. In order to qualify for, an individual must meet both categorical and financial eligibility requirements. Financial eligibility requirements vary from state to state and from category to category, but they generally include limits on the amount of income and the amount of resources an individual is allowed to have in order to qualify.

Home- and Community-Based (HCBS) Waiver. Also known as the "1915 (c)" waiver, it allows the provision of Medicaid services at home and in the community to beneficiaries at risk of institutionalization in a nursing facility or facility for the mentally retarded.

Look-back period. The period of time examined by eligibility workers to ensure no improper transfer of assets took place that would make a person ineligible or incur a penalty period.

Managed care organization (MCO). An entity that has entered into a risk contract with a state Medicaid agency to provide a specified package of benefits to Medicaid enrollees, in exchange for a monthly capitation payment on behalf of each enrollee.

Mandatory. State participation in Medicaid is voluntary. If a state elects to participate, as all do, the state must offer coverage for certain services to certain populations.

Medically needy. A term used to describe an optional Medicaid eligibility group made up of individuals who qualify for coverage because of high medical expenses.

Medicaid Management Information System (MMIS). A state's computer system for tracking Medicaid enrollment, claims processing, and payment information.

Optional. Term used to describe Medicaid eligibility groups or services categories that states may cover if they choose, and for which they will be receive federal reimbursement.

Outstationing. The placement of state or local Medicaid eligibility workers at locations other than welfare offices. State Medicaid agencies are required to outstation workers at certain hospitals and FQHCs to accept Medicaid applications from low-income children and pregnant women.

Poverty-level groups. The term for eligibility groups, both mandatory and optional, for whom Medicaid income eligibility is determined on the basis of a percentage of the federal poverty level.

Presumptive eligibility. The option available to states to extend limited Medicaid coverage (with federal matching payments) to certain groups of individuals from the point a qualified provider determines that the individual's income does not exceed the eligibility threshold until a formal determination of eligibility is made by the state Medicaid agency.

Qualified Medicare Beneficiary (QMB). A Medicare beneficiary with income or assets too high to qualify for full Medicaid coverage, but who is eligible to have Medicaid pay their Medicare premiums and cost sharing requirements.

Resources. Sometimes referred to as assets, resources are items of economic value that are not income (like savings accounts, or an automobile).

Single state agency. The agency within state government designated as responsible for the administration of the state Medicaid plan and to administer the Medicaid program. In Connecticut, the single state agency is the Department of Social Services.

Specified Low-income Medicare Beneficiary. Medicare beneficiary with income or assets to qualify for full Medicaid coverage, but who are eligible for Medicaid to pay monthly Medicare premiums.

Spend-down. For most Medicaid eligibility categories, having countable income above a specified amount will disqualify an individual from Medicaid. However, in some eligibility categories – individuals may qualify for Medicaid even though their countable incomes are higher than the income standard by using their medical expenses to reduce their income.

Standard. In the context of Medicaid eligibility determinations, the dollar amount of income or resources that an individual is allowed to have and qualify for Medicaid.

Standard of Promptness. The amount of time established in federal regulations in which a decision must be made to determine eligibility for Medicaid.

Supplemental Security Income (SSI). A federal entitlement program that provides cash assistance to low-income aged, blind or disabled individuals. Individuals receiving SSI are eligible for Medicaid in all but 11 states (including Connecticut), where more restrictive standards apply.

Temporary Assistance for Needy Families (TANF). A block grant program that makes federal matching funds available to states for cash and other assistance provided to low-income families with children. Replaced its predecessor, Aid to Families with Dependent Children (AFDC). States may, but are not required to, extend Medicaid coverage to all families receiving TANF benefits; but states are required to extend Medicaid to families with children who meet the eligibility criteria states had in effect under AFDC in 1996.

Title XIX. Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., is the federal statute that authorizes the Medicaid program. Medicaid is sometimes referred to as “Title 19”.

Transfer of Assets. Refers to the practice of disposing of countable resources such as savings, stocks bonds or real property for less than fair market value in order to qualify for Medicaid coverage.

Transitional Medical Assistance (TMA). Refers to Medicaid coverage for families with children leaving welfare to become self-supporting through work. States are required to continue Medicaid benefits to families who their cash assistance due to an increase in earnings. The transitional coverage extends for up to 12 months as long as the family continues to report earnings.

Waivers. Various statutory authorities under which the Secretary of Health and human services may, upon request of a state, allow the state to receive federal Medicaid matching funds for its expenditures even though it is no longer in compliance with certain requirements or limitations of the federal Medicaid statute.

Source: Adapted from a glossary developed by the Kaiser Commission on Medicaid and the Uninsured

Appendix B

Convalescent Case Processing Checklist

Applicant		Convalescent Home	
Patient ID#		Street	
Program	AU #	City & State	
Program	AU #	Contact/Phone	
Level of Care	Admission Date	Provider ID	
DOI	Lookback Date	Paid Thru Date	
W10/352 requested	W10A to MRT	MRT Approval Rec'd	
M2T received	Birth Certificate	Date of Birth	
Medicare Card	XMEN printed	Social Security #	
Short term stay	S.T. Letter	Rental Diversion	
Medicaid outside of CT	Medicaid State	Contact / Phone #	
Health Insurance	Policy #	Premium	W1685
Health Insurance	Policy #	Premium	W1685

AREP #1	Phone hm
Street	Phone wk
City, State Zip	
AREP #2	Phone hm
Street	Phone wk
City, State Zip	

Social Security	
Pension Co. & phone	Monthly Amt.
Pension Co. & phone	Monthly Amt.
Interest Income Source	Monthly Amt.
Dividend Income Source	Monthly Amt.
Property sold during lookback period	E109 to resources for FMV
Car #1	Car #2
Life Ins. Co & phone	FV CSV Policy #
Life Ins. Co & phone	FV CSV Policy #
Life Ins. Co & phone	FV CSV Policy #
Bank Name	Account #
Bank Name	Account #
Bank Name	Account #
Bank Name	Account #
Bank Name	Account #
Irrevocable Burial Contract / Funeral Home	Value
Burial Plot Location	
Stock Account	Account #
Savings Bonds	Total Value
Trust/Annuity	E109 to resources
Non Home Property	4 Sale Address E109 to resources
Transfers	W495 & W495A
Marital Status	If there is a community spouse obtain the following information
Property/Mortgage	Property Taxes Home Insurance
Water/Sewer	Social Security Pension

Prepared by the Department of Social Services
Office of Organizational and Skill Development

Appendix C

Medically Needy Income Limits (MNIL) and Resource Standards, 2001

State	Individual			Couple			MNIL Last Changed
	MNIL in \$	MNIL as % of FPL	Resource Limit	MNIL in \$	MNIL as % of FPL	Resource Limit	
Median	\$400	55%	\$2,000	\$530	55%	\$3,000	1994
Alabama	---	---	---	---	---	---	---
Alaska	---	---	---	---	---	---	---
Arkansas	\$108	15%	\$2,000	\$217	22%	\$3,000	1988
Arizona	---	---	---	---	---	---	---
California	\$600	83%	\$2,000	\$934	97%	\$3,000	1989
Colorado	---	---	---	---	---	---	---
Connecticut*	\$575/\$476	80%/66%	\$1,600	\$734/\$575	76%/59%	\$2,400	1991
Delaware	---	---	---	---	---	---	---
District of Columbia	\$377	53%	\$2,600	\$397	41%	\$3,000	1994
Florida	\$180	25%	\$5,000	\$241	25%	\$6,000	1992
Georgia	\$317	44%	\$2,000	\$375	39%	\$4,000	1991
Hawaii*	\$418	51%	\$2,000	\$565	51%	\$3,000	1993
Idaho	---	---	---	---	---	---	---
Illinois*	\$283	40%	\$2,000	\$375	39%	\$3,000	1990
Indiana**	---	---	---	---	---	---	---
Iowa	\$483	67%	\$10,000	\$483	50%	\$10,000	1990
Kansas	\$475	66%	\$2,000	\$475	49%	\$3,000	1997
Kentucky	\$217	30%	\$2,000	\$267	28%	\$4,000	1989
Louisiana	\$100	14%	\$2,000	\$192	20%	\$3,000	1985
Maine	\$315	44%	\$2,000	\$341	35%	\$3,000	1991
Maryland	\$350	49%	\$2,500	\$392	41%	\$3,000	1994
Massachusetts ²	No Limit	N/A	No Limit	No Limit	N/A	No Limit	1988
Michigan ³	\$408	57%	\$2,000	\$541	56%	\$3,000	1992
Minnesota*	\$482	67%	\$3,000	\$602	62%	\$6,000	2001
Mississippi	---	---	---	---	---	---	---
Missouri*	---	---	---	---	---	---	---
Montana	\$525	73%	\$2,000	\$525	54%	\$3,000	2001
Nebraska	\$392	55%	\$4,000	\$392	41%	\$6,000	1988
Nevada	---	---	---	---	---	---	---
New Hampshire*	\$544	76%	\$2,500	\$675	70%	\$4,000	2001
New Jersey	\$367	51%	\$4,000	\$434	45%	\$6,000	Never
New Mexico	---	---	---	---	---	---	---
New York	\$625	87%	\$3,750	\$900	93%	\$5,400	2001
North Carolina	\$242	34%	\$2,000	\$317	33%	\$3,000	1990
North Dakota*	\$475	66%	\$3,000	\$491	51%	\$6,000	2001
Ohio**	---	---	---	---	---	---	---
Oklahoma*	\$259	36%	\$2,000	\$325	34%	\$3,000	2000
Oregon	\$413	58%	\$2,000	\$526	54%	\$3,000	1991
Pennsylvania	\$425	59%	\$2,400	\$442	46%	\$3,200	1990
Rhode Island	\$625	87%	\$4,000	\$667	69%	\$6,000	2001
South Carolina	---	---	---	---	---	---	---
South Dakota	---	---	---	---	---	---	---
Tennessee	\$241	34%	\$2,000	\$258	27%	\$3,000	1999
Texas ⁴	---	---	---	---	---	---	---
Utah	\$382	53%	\$2,000	\$468	48%	\$3,000	1999
Vermont ⁵	\$791/\$733	111%/102%	\$2,000	\$791/\$733	82%/76%	\$3,000	2001
Virginia*	\$336	47%	\$2,000	\$406	42%	\$3,000	2001
Washington	\$557	78%	\$2,000	\$592	61%	\$3,000	2001
West Virginia	\$200	28%	\$2,000	\$275	28%	\$3,000	1994
Wisconsin	\$592	83%	\$2,000	\$592	61%	\$3,000	1998
Wyoming	---	---	---	---	---	---	---

Source: *Aged, Blind, and Disabled State Summaries*, National Association of State Medicaid Directors, based on standards in effect on October 2001. (See www.nasmd.org/eligibility). **Notes:** 209(b) states are indicated with an asterisk (*). **Indiana and Ohio are 209(b) states that do not have MN programs, but the 209(b) statute requires them to allow individuals to spend-down to the cash assistance level. States marked with (---) do not have medically needy programs. In 2001, the FPL for an individual was \$716/month in the contiguous US and \$824 in Hawaii. For couples, the FPL was \$968 in the contiguous US and \$1,113 in Hawaii. ¹ Connecticut has two income standards, based on the region. ² Massachusetts does not have an income limit for non-institutionalized people with disabilities. For the elderly and people in institutions the income standard is 100% of FPL and the resource limit is \$2,000 and \$3,000 for individuals and couples, respectively. ³ Michigan has regional income standards. Standards in this table show the highest regional standards. ⁴ Texas operates a medically needy program, but it does not cover people with disabilities or the elderly. In 2001, the MNIL for a working parent with two children was \$395 (32% of FPL). Source: *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000*, Center on Budget and Policy Priorities, February 2002. ⁵ Vermont uses a higher income standard for Chittenden County only.

Appendix D



Patricia A. Wilson-Coker, JD, MSW
COMMISSIONER

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

August 6, 2004

TELEPHONE
(860) 424-5008

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1-800-842-4524

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(860) 424-5129

Bruce D. Greenstein
Associate Regional Administrator
Department of Health and Human Services
Centers for Medicare and Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, MA 02203

Dear Mr. Greenstein:

I am writing to respond to your letter of June 28, 2004, received by me on July 7, 2004, concerning timely Medicaid eligibility determinations at time of application and redetermination.

As you are probably aware, the State of Connecticut has been through some very difficult fiscal circumstances during the past couple of years. These resulted in significant reductions in staff throughout state government through state employee layoffs in January 2003 and an early retirement incentive program between April and June 2003. The Department of Social Services lost approximately 500 staff during this period. Unfortunately these reductions in staff had an adverse impact on our ability to maintain the levels of service we had achieved in prior years. One area where service has suffered has been the timely processing of applications for assistance.

We have been working hard to reestablish our prior service levels. Our timeliness has improved from a low of 34% of all applications pending beyond the standard of promptness in December 2003 to 25% overdue applications during the last two months. Our goal is to reduce the overdue applications to 18% of all pending applications, a percentage that we believe is consistent with the rate of overdue applications attributable to allowable reasons, such as those mentioned in your letter (e.g. delays by the applicant or a third party in providing required documentation). It is my expectation that we can achieve this goal by the end of the calendar year.

We have taken or are planning to take the following actions:

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Bruce D. Greenstein
August 6, 2004
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1. We have redistributed staff between our regional offices to equalize resources commensurate with the caseload distribution. This action, just completed in June 2004, will result in more stable and consistent workloads for our eligibility staff.
2. We have allocated 137,500 hours of overtime to our regional offices for use during the current state fiscal year. The use of overtime has been a major contributor to the gains we have made since December and will be an important factor in continuing to improve the timely processing of applications. Our regional administrators will allocate overtime to the offices with the largest numbers and percentage of overdue applications. Currently eight of our twelve offices are exceeding the 18% goal mentioned above.
3. We are in the process of hiring some dedicated eligibility staff to handle the applications for special populations. Positions are currently being filled for eligibility workers who will be dedicated to serving clients of the departments of Correction, Mental Retardation, and Children and Families. We expect these dedicated workers will provide workload relief to our regional office operations permitting them to process the applications of their remaining clients in a more timely fashion.
4. On a longer term basis, we are working to review all of our eligibility process policies and practices in order to identify those that consume time and resources while providing little or no measurable improvement to program integrity and limiting program access or retention. Examples of these efforts completed or currently underway include:
 - We recently updated our Verification and Documentation Guidelines for eligibility staff to be consistent with current policy, such as self-declaration of income in the HUSKY program, and to discourage verification that is not required by policy.
 - We are revising many of our Medicaid and TANF notices and forms with the assistance of the MAXIMUS's Center on Health Literacy through a grant from the Robert Wood Johnson Foundation's *Supporting Families After Welfare Reform* Initiative. Our goal is to increase the readability and clarity of these notices and forms, thus reducing contact between clients and eligibility workers for explanations of their content.
 - We have changed our redetermination process for TANF families who exempt from time limits to a mail-in rather than interview process.

Bruce D. Greenstein
August 6, 2004
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- We have conducted joint training with eligibility and HUSKY outreach staff on such topics as self-declaration of income, non-citizen and child support requirements, thus improving our eligibility processes in these areas.

Regarding the matter of timely processing of Medicaid redeterminations, last October we corrected our Eligibility Management System to establish one-year redetermination periods for all Medicaid cases, with the exception of spenddown cases, which have a six-month review period corresponding to their spenddown period.

I hope I have adequately responded to your concerns. I want to assure you that we are doing everything in our power with the resources available to the department to eliminate the number of overdue applications. If you have further questions regarding this matter please let me know or contact Kevin Loveland, Director of Family Services, at 860-424-5031.

Sincerely,



Patricia A. Wilson-Coker
Commissioner

PW-C:kl

cc. Claudette Beaulieu
Michael Starkowski
Regional Administrators
Kevin Loveland

Appendix E

Issue Areas/Areas for Further Analysis

MEDICAID ELIGIBILITY DETERMINATION PROCESS

- Assess workloads and timeliness of eligibility redeterminations (renewals).
- Analyze whether renewal notices result in terminations because of address issues.
- Assess district office variation in caseloads, applications, and applications overdue.
- Analyze refilling of positions lost to ERIP, and whether differences exist between refilling eligibility service worker positions and other positions in DSS.
- What impacts – positive or negative – DSS efforts to address the budget cuts, legislative changes, and staffing reductions have had on eligibility processing. (For example, analyze the impact of dedicated processing times and Human Services Initiative.)
- Assess other states' eligibility management systems to determine if models exist that could streamline or improve the efficiency of Connecticut's eligibility determination process. Also identify what obstacles might exist in Connecticut adopting another EMS system.
- Analyze whether a client's Medicaid eligibility is determined independent of eligibility for other programs.
- Continue to conduct field office visits, interview staff, and observe processes for determining eligibility.
- Assess whether Medicaid provisions in statute (or recent modifications) are incorporated into State Medicaid Plan. If differences exist, determine problems posed in eligibility determination.
- Conduct further analysis of Connecticut's administrative expenses for Medicaid.
- Assess overall coordination between DSS and ACS (state's HUSKY enrollment broker).
- Conduct additional analysis of EMS data to further identify reasons for process delays.