

Executive Summary

Medicaid Eligibility Determination Process

In March 2004, the program review committee authorized a study of the Department of Social Services' (DSS) implementation of the application and eligibility determination process for the Medicaid program. The study request was prompted by concerns that applications were taking too long to process, and that delays might be affecting client access to Medicaid. The study was also to determine how state employee layoffs, early retirements and DSS restructuring have impacted the administration of eligibility determination for the program.

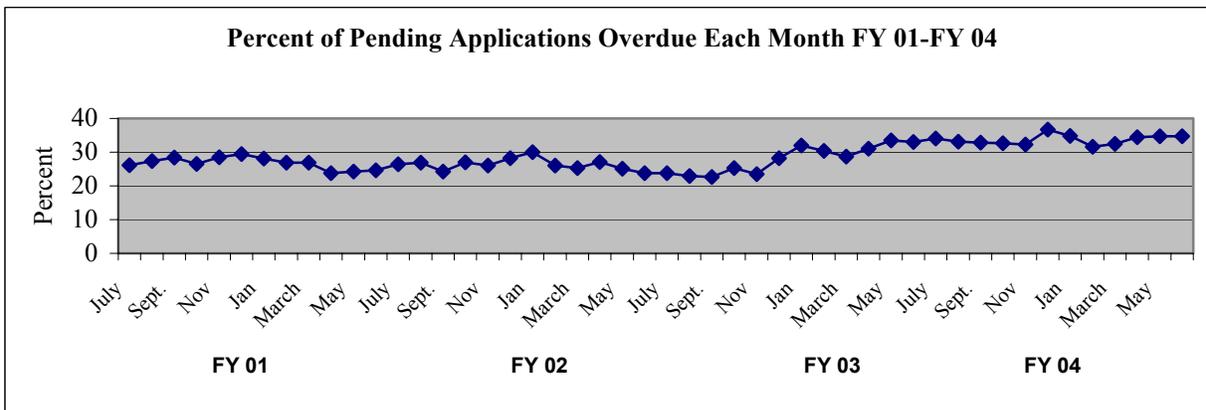
The report describes many of the programmatic aspects of Medicaid, including federal and state laws, regulations, and other requirements regarding Medicaid eligibility determination, as well as standards for timeliness (known as standard of promptness) and accuracy of determination decisions.

Application Processing

The study found that while there are specific time requirements established in federal regulation for determining Medicaid eligibility, typically 45 days for most applicants, the Centers for Medicaid and Medicare Services (CMS), the federal administering agency, requires no reporting on timeliness. Thus, seldom are sanctions imposed on states for deficiencies in timeliness, as they are when high Medicaid error rates for eligibility are incurred.

The report describes the processes and systems used by DSS to determine eligibility, including accepting applications, collecting and verifying eligibility information, and determining and redetermining eligibility for the major Medicaid populations. The major management and oversight mechanisms in place are also discussed.

The study examined statewide trends in Medicaid caseloads and applications by the major populations covered by the program. Specifically, the study found the percentage of all Medicaid applications that are overdue at the end of each month increased from 25 percent in FY 01, to about 34 percent in FY 04.



Executive Summary

However, the study found the extent of the problem of overdue applications varies considerably among the different Medicaid populations:

- pending long-term care applications that are overdue increased from 55 percent in FY 01, to 60 percent in FY 04;
- pending applications for the aged, blind or disabled Medicaid population that are overdue (beyond 90 days) increased from a monthly average of 23 percent in FY 01, to 28 percent in FY 04; and
- pending family Medicaid applications that are overdue each month increased from an average of 10 percent to 16 percent during the FY 01 to FY 04 period.

The report determined one of the oversight mechanisms of timeliness in regard to application processing is the result of a 1992 court-approved stipulated agreement between DSS and Connecticut Legal Services to settle a civil action. In the settlement, known as the Alvarez agreement, the parties agreed that no more than five percent of overdue pending applications for assistance, including Medicaid, could be “unexcused” (meaning DSS is responsible for lateness). Further, no more than 10 percent of the pending overdue applications could be considered “unexcused” in any one office. Using this measure, the study found the percent of unexcused overdue applications statewide has gone from a monthly average of 4.3 percent in FY 01, to 6.5 percent in FY 04.

The report concluded that there are substantial variations among offices in the timeliness of application processing. While there is a strong correlation between staffing level reductions and percentages of overdue applications, that does not appear to be the sole factor causing office variation. The committee concluded that, in addition to such quantitative factors, DSS management must also examine other qualitative elements to determine what contributes to office variations in performance and service.

The study also found that, while there was not an increase in the overall denial rate of family Medicaid applications statewide, there were substantial differences in denial rates among offices. However, the higher denial rates appeared historical in offices, rather than a recent implementation of strategy to reduce overdue applications.

Impact of Staffing Reductions

The study analyzed the impact state employee layoffs and early retirements had on DSS, and specifically the eligibility worker classes. The committee concluded DSS has been harder hit by staffing reductions than many state agencies, and recommends restoring 14 positions lost to early retirements in the eligibility classifications.

Executive Summary

Eligibility Determination by Program

The report examined some of the different eligibility options and determination methods employed with various family Medicaid groups. Specifically, the state's experience with options like presumptive eligibility for pregnant women, presumptive eligibility for children, and continuous eligibility for children were addressed. The committee recommended that statutes and policy regarding presumptive eligibility for pregnant women be revised, and that presumptive eligibility for children be re-established. The committee also found timeliness issues with long-term care applications and recommends DSS seek official CMS modifications to the processing of new applications and renewals in that program.

The study also examined the SCHIP program, the state's supplementary health insurance program for children who do not qualify for Medicaid. The processing time standards for that program are inadequately defined in the vendor contract, and thus it is difficult to measure the contractor's performance in terms of timely processing or referral. The committee also found other deficiencies with the contract for SCHIP administration and proposes the contract be rewritten and new proposals sought.

Operations and Support Systems

The report examined operations and support issues, including the department's computerized system for determining Medicaid eligibility and proposes that DSS begin work on a long-term plan to upgrade the department's automated eligibility management system. The committee recommends that DSS provide online application capability for HUSKY (i.e., the streamlined enrollment process for family Medicaid) by July 2006. The report concluded that DSS Central Operations should take more of a leadership role and a "quality management" approach in ensuring the district offices receive adequate support services to fulfill their charge to provide efficient and effective client services.

In all, the committee adopted 31 recommendations, which are listed below.

1. DSS should continue its initiative to revise and update its notices and forms. DSS should first assess which notices are the most problematic in terms of creating client confusion and have the greatest impact on their eligibility. DSS should proceed with its modifications to the redetermination issuance process. Staff also recommends the redetermination forms be modified. These notices to the client should be more concise, with the date of return clearly indicated – not in the same type and size text as the body of the letter.
 - Where possible, supervisors and trainers should bring training in "time management" and "priority-setting" directly to the workers. The training should be designed for those who need it, and offered as part of the everyday work experience. DSS should also help workers prioritize their work, which might include color-coding redetermination envelopes by month so that workers can act on the ones about to terminate first.

Executive Summary

- DSS should form a work group, with representatives of eligibility workers, supervisors, and the MIS division, to identify which worker alerts could be eliminated. The standard should be “helpfulness to the worker”, and include only those alerts that, unless acted upon, will impact a client’s eligibility. DSS must ensure workers use all means to keep both case files, including EMS case notes, and client information current.
2. Supervisors need to closely monitor all overdue redetermination cases to ensure workers are obtaining the required information in a timely manner, and that redeterminations are not extended indefinitely. Alternatively, if a redetermination case becomes overdue for three consecutive months, the case should be automatically discontinued.
 3. DSS Regional Administrators need to explore reasons for office variation in overdue applications and redeterminations, and denial rates. Further, now that DSS efforts at equalizing staff and supervisors among offices have been put in place, agency management should monitor whether these variations continue. DSS management needs to identify the qualitative factors that foster good performance in some offices, and attempt to implement them in all offices. DSS should report on its findings to the Human Services Committee by July 1, 2005.
 4. DSS should require, as part of the state’s Medicaid managed care enrollment broker contract, that the enrollment broker review its enrollment data and submit address changes electronically to a central location within DSS, such as the Administrative Services Division. A DSS data processing technician located in the central office should be responsible for regularly updating address changes on the department’s eligibility management system. Once the address changes have been made in EMS, all applicable eligibility staff should be notified of the changes.
 5. Restore 14 more positions of the ERIP losses in the eligibility classes.
 6. DSS should develop uniform signs in English and Spanish, stating regular hours of operation and dedicated processing times, and that offices are open during processing times, but transactions are limited. The signs should be posted in all the offices, the DSS website, and in any brochures on office and program services.
 7. DSS should develop a campaign to promote mailing all applications and other forms to the appropriate office when a face-to-face interview is not required. Simple steps might help, like a cover sheet with the application noting in large text that the application can be mailed, rather than delivered, to a DSS office.
 8. C.G.S. Sec. 17b-277 should be amended to eliminate presumptive eligibility and require DSS implement a system of “expedited eligibility” determination for pregnant women instead.

Executive Summary

- DSS uniform policies and procedures should reflect the wording change from “presumptive eligibility” to “expedited eligibility.” DSS should also require applications for pregnant women considered non-emergencies be processed within five days once all required information is received from the applicant. All emergency applications should be processed using a one-day standard.
 - DSS should begin routinely analyzing the length of time it takes to process applications for pregnant women to ensure applications are processed in accordance with the department’s specified policy.
 - DSS should review all policies and procedures regarding expedited processing of pregnant women applications to ensure they are applicable, coordinated, and understood by eligibility staff. The department should also ensure all appropriate staff are continually kept informed of the department’s policies and procedures regarding expedited eligibility for pregnant women, including any changes or updates.
9. DSS should develop a system (e.g., using a color-coded application/envelope) to clearly identify applications submitted by pregnant women for medical assistance as a way to differentiate such applications from others received by the department.
 10. DSS should increase its efforts with outreach workers and other qualified entities to review how to assist clients with completing applications to ensure the necessary information is submitted to DSS allowing quicker eligibility determinations.
 11. DSS should emphasize to providers that complete applications are a key component to determining eligibility and having services covered for payment.
 12. DSS should develop a policy requiring eligibility workers to inform applicants who have not submitted complete applications of any outstanding information required to complete their applications so eligibility decisions can be made promptly.
 13. The legislature should re-establish a program of presumptive eligibility for children by July 1, 2005. Funding should be restored to DSS to fully implement the program.
 - The presumptive eligibility process administered by DSS should be modified to better ensure clients/qualified entities fulfill application requirements for regular Medicaid at the same time presumptive eligibility is determined. At a minimum, a single application should be used to: 1) quickly determine presumptive eligibility by the qualified entity; and 2) transmit the application and necessary information to DSS allowing the department to determine eligibility for HUSKY A benefits.

Executive Summary

14. DSS should develop a request for proposals for a new contract for the department's HUSKY single point of entry and enrollment broker services currently provided by an outside vendor. DSS should also decide whether or not to separate the single point of entry and enrollment broker functions, which are combined in the present contract.
15. The single point of entry provider contract language for the HUSKY program should include: formalized performance standards; specified time limits required to process HUSKY applications; and an established level of review required by the vendor to assess eligibility as either HUSKY A or HUSKY B prior to referring an application to DSS, measured by the percent of complete application submitted to DSS for eligibility determination.
16. DSS should place a maximum of five years on the life of any new HUSKY single point of entry provider and/or enrollment broker contract(s). Any new contract(s) should include a specified process for identifying and correcting non-compliance with contract terms, including corrective action plans and punitive sanctions, when applicable.
17. DSS should regularly monitor the performance of the state's single point of entry provider for the HUSKY program – with an emphasis on application processing – to ensure contract terms and performance standards are consistently achieved.
18. The state's enrollment broker should be responsible for implementing the revised change of address system.
19. DSS should place a limit on the number of times Medicaid Managed Care clients may change managed care plans to once every six months. More frequent changes may be made if the client has a "good cause" reason to make a plan change, as determined by DSS.
20. DSS, working with the governor's office and the legislature's Human Services Committee, should submit a waiver request to the Centers for Medicare and Medicaid Services (CMS) extending the standard of promptness for long-term care applications to 90 days. Longer-term, DSS, the governor's office and the legislature should also begin working to have the regulations concerning standard of promptness, as it applies to long-term care, changed.
21. Eligibility workers assigned to long-term care cases should make early contact with the client, or whoever is making the application on the client's behalf. This will help the client know who at DSS is reviewing the case. The eligibility worker should explain at the outset that the process is complex, time-consuming, and heavily reliant on the review of financial and asset documents.
22. The policy setting the guidelines in investigating applicant checking accounts should be changed to require workers to only question amounts that might affect eligibility.
23. DSS should submit a waiver request to CMS to allow a two-year redetermination period for long-term care clients.

Executive Summary

24. DSS should begin taking the initial planning steps for an EMS replacement now. First, the department should attempt to secure funding through a variety of sources: federal funding, grants, or matching private grants with state funding. Second, by July 1, 2005, DSS should designate a planning team, with representatives of “end users” (i.e., eligibility workers), DSS and DoIT management information personnel, as well as agency management and budget personnel, to begin a comprehensive needs assessment as a foundation for system planning. These steps should occur before a request for proposal is developed, and consultants secured.
25. DSS should continue its process of upgrading notices to include programs in addition to family Medicaid. DSS should also begin a review of the worker alerts generated by EMS, with the objective of keeping only those that are helpful to workers.
26. Both initiatives should be implemented as long-term, in-house projects, within allowable resources. Project teams developed to examine EMS alerts should include eligibility workers who can help decide which “alerts” are of no value in managing workload. Further, a prioritization system -- those with greatest impact on client eligibility given the highest priority-- could be established for those alerts maintained on the system.
27. DSS should complete the de-linking of the TFA and Medicaid eligibility in the EMS system by March 1, 2005. Other EMS links between other client assistance eligibility (e.g., food stamps) and Medicaid should be completed by October 1, 2005.
28. By March 1, 2005, DSS should begin the planning and development for online access for HUSKY applications only. The system should consist of an automated transfer of the application data to the EMS system. The online application should provide electronic signature capabilities, and the transmittal should be blocked if essential information and a signature are missing.
 - As part of that initial phase, DSS should estimate the costs for such a system and explore matching any state funding with private grant monies, and also determine the amount of federal reimbursement available.
 - The online application should be transmitted through Internet access. Security measures should be developed as part of the planning and development phase.
 - By March 1, 2006, the system should be ready to pilot. The department should work with its community partners – the CAP agencies, qualified entities, hospitals, Voices for Children, and other advocacy groups – to promote the use of such a system. By July 1, 2006, the system should be available statewide.
29. As contractual arrangements for police coverage in the local offices expire, DSS should be required to substantiate the need for their continuation to the Office of Policy and Management and the Appropriations sub-committee responsible for DSS financial oversight.

Executive Summary

30. DSS Central Office Operations should take a greater leadership role in providing support services in the district offices. This should include, but not be limited, to:

- Assuring vendor servicing of the phone systems to upgrade software, maximize capacity of phone message capabilities, standardizing phone messages at each office, and tracking phone volume. Further, DSS central operations, through the phone system vendors, should provide better training to district office personnel so they can use the phone system to provide maximum benefit and service.
- Working with DSS regional administrators and district office managers to ensure that certain service standards are met in each office, including: uniform, good quality signage in English and Spanish; availability of drop boxes for clients to submit materials after hours; comfortable chairs; and good lighting in the waiting areas.
- Intervening with other agencies, like the U.S. Postal Service, to ensure that basic services, such as mail pick-up, are provided. Also, other services provided under contract, like the archiving of files, should be provided promptly. Further, if offices lack clerical staff to prune files and box them, some workable solution must be found to address that issue, including:
 - a swat team be formed of clerical staff from several offices and the central office to go from office to office filing and boxing for certain days for several weeks until offices are caught up; or
 - one day each calendar quarter could be designated (in addition to dedicated processing times) as “file day,” where designated staff in an office perform just that function.
- Improving internal electronic communication and reporting so there is less reliance on paper. Where possible, the Central Operations Unit should also work with outside institutions, like banks, to increase capabilities for electronic transfer of documents.

31. Communicating to the district offices exactly what support services are available – like the courier delivery—and how to access those services. Central Office Operations should assume more of a leadership role and a “quality management approach” by continuously working with district office managers to improve their facilities and work processes so that core services – determine eligibility, serve clients, issue the appropriate benefits – are provided efficiently.