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LEGISLATIVE PROGRAM REVIEW  
& INVESTIGATIONS COMMITTEE

**Medicaid Eligibility  
Determination Process**

DECEMBER 2004

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## MEDICAID ELIGIBILITY DETERMINATION PROCESS

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# Introduction

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## Study Purpose

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 scope of study approved by the committee required the review to evaluate the timeliness, efficiency, and effectiveness of the eligibility determination process for Medicaid in Connecticut. The study was to specifically analyze the impact the state employee layoffs, early retirements, and DSS office closings had on the process. Further, the study was to identify problems in the eligibility processing of applications, and propose remedies.

## Methods

The program review committee and its staff used the following methods and information sources for this study. Staff reviewed federal and state laws and regulations, as well as DSS policies, procedures, and training manuals governing the Medicaid program. Staff also reviewed a sample of DSS Medicaid vendor contracts, relevant court cases in Connecticut, and the general literature on Medicaid nationally.

Staff conducted 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 staff; Affiliated Computer Services (HUSKY enrollment broker); legislative fiscal and research offices; managed care organizations with Connecticut Medicaid contracts; elder law attorneys of the Connecticut Bar Association; Connecticut Legal Services; and staff of the Office of Policy and Management and Department of Administrative Services.

Committee staff conducted site visits and tours of all 12 DSS regional offices, and interviewed each office's staff about operations at each location. Staff also attended several meetings of the Medicaid Managed Care Council and its Consumer Access Subcommittee, and attended a number of HUSKY training forums, eligibility worker training session, and joint

Committee staff analyzed 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.

The committee held four public hearings in Hartford, Hamden, Danbury and Norwich in September 2004 to solicit testimony from clients, advocacy groups, DSS workers and others on Medicaid eligibility determination procedures.

## **Report Format**

The report contains five chapters. The first chapter contains a synopsis of Medicaid, including its key features and a profile of Connecticut's program. The second chapter describes how Connecticut operates its programs, including who determines eligibility, how it is determined, and the administrative resources devoted to operating the program. The third chapter provides a description of Connecticut's Medicaid program by population including eligibility criteria and processing time requirements, overall service features, and caseload data. Chapter Four discusses management and oversight of the Medicaid program. Chapter Five provides analysis of various aspects of Medicaid, including the timeliness of Medicaid application processing by different Medicaid populations as well as trends in the percentage of overdue applications and denial rates by office. Chapter Five also contains findings and recommendations in four main areas – 1) application processing; 2) impact of reductions in DSS staffing as a result of layoffs and early retirements; 3) the state's experience with some of the eligibility options and determination methods employed with various family Medicaid groups and issues around the state's contract for administration of the SCHIP program, the state's supplementary insurance for children who do not qualify for Medicaid; and 4) the department's operations and support services including on-line applications for family Medicaid, and an improved leadership role from central office to ensure district offices receive adequate support services.

## **Agency Response**

It is the policy of the Legislative Program Review and Investigations Committee to provide agencies subject to a study with an opportunity to comment on the report and the recommendations prior to final publication. A response from the Department of Social Services is provided in Appendix G.

## 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. (A glossary of Medicaid terms is provided in Appendix A.)

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. The state Medicaid agency must also have a medical assistance unit to develop, analyze, and evaluate the Medicaid program. A medical care advisory unit must be established to advise the agency's medical assistance unit on Medicaid services. The advisory unit in Connecticut 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 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 also 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 Chapters Two and Three.

Federal regulations impose 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.

**Table I-1. Medicaid Coverage: Groups and Services**

Coverage Groups	Medicaid Provision	Typical Populations
<p><b>Categorically Needy (Mandatory)</b></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"> <li>• Medicaid <i>requires</i> coverage to these groups</li> </ul>	<ul style="list-style-type: none"> <li>• Children under age 6 whose family income is at or below 133% of the federal poverty level (FPL)</li> <li>• SSI recipients in most states (CT an exception)</li> <li>• Children in adoptive or foster care</li> <li>• Persons under age 19 and born after 9/30/83, if family income is at or below FPL</li> <li>• 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</li> <li>• Individuals who met AFDC requirements in effect in 1996.</li> </ul>
<p><b>Categorically Related (Optional)</b></p> <p>Share characteristics with mandatory population, but eligibility criteria more broadly defined</p>	<ul style="list-style-type: none"> <li>• Medicaid gives states the option of covering any or all of these groups</li> </ul>	<ul style="list-style-type: none"> <li>• Children under 21 who meet the state's 1996 AFDC requirements</li> <li>• Individuals who would be eligible if institutionalized but who are receiving services under a home and community based waiver</li> <li>• Certain aged, blind, or disabled adults with incomes above those in mandatory coverage but below the FPL</li> </ul>
<p><b>Medically Needy (Optional)</b></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"> <li>• Totally at state option; if state chooses the option, there are federal requirements that certain groups and services must be covered</li> </ul>	<p>If option chosen, must cover:</p> <ul style="list-style-type: none"> <li>• Medically needy children under 19</li> <li>• Pregnant women who are medically needy</li> </ul>
Covered Services	Medicaid Provision	Typical Services
<p><b>Mandatory Services</b></p>	<ul style="list-style-type: none"> <li>• Medicaid <i>requires</i> a state to provide these services to categorically needy groups in order to have FFP</li> <li>• Basically, amount and duration of services under state purview</li> <li>• Rates paid are under state purview, but must be sufficient to enlist enough providers to give Medicaid client similar access as general population</li> </ul>	<ul style="list-style-type: none"> <li>• 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</li> </ul>
<p><b>Optional Services</b></p>	<ul style="list-style-type: none"> <li>• Medicaid approves 34 services that a state <i>may</i> offer and receive federal reimbursement</li> </ul>	<ul style="list-style-type: none"> <li>• Diagnostic services; clinic services; intermediate care facilities for the mentally retarded (ICF/MR); optometrist services and eyeglasses; transportation services; rehab and therapy</li> </ul>
<p><b>Services to Medically Needy</b></p>		<ul style="list-style-type: none"> <li>• If state has a program it <i>must</i> cover prenatal care, delivery for pregnant women, and ambulatory care for children</li> </ul>

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.

<b>Table I-2. 2004 Federal Poverty Levels by Size of Family</b>					
<b>Size of Family</b>	<b>50%</b>	<b>100%</b>	<b>185%</b>	<b>235%</b>	<b>300%</b>
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).

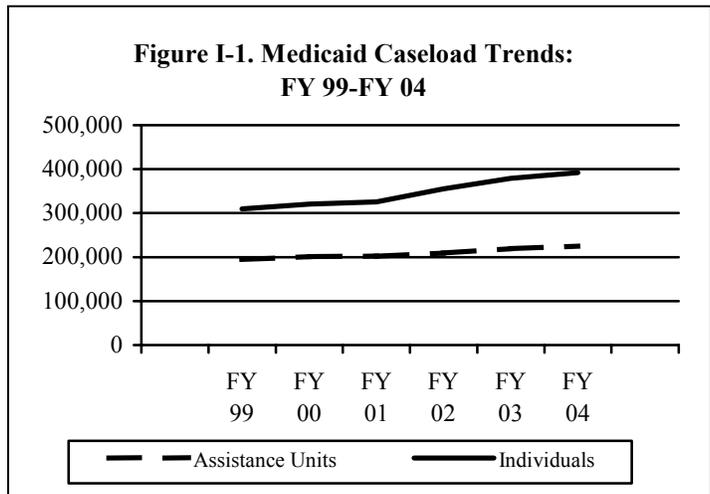


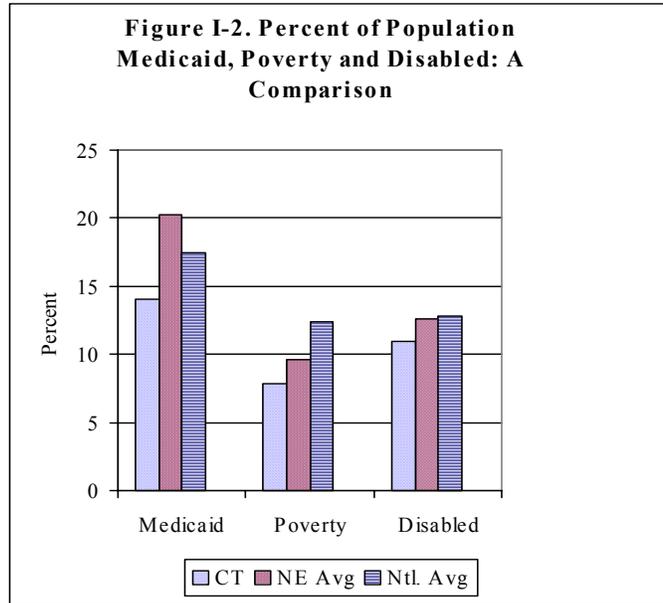
Figure I-2 presents a profile of Connecticut’s population compared with New England and the nationwide average for three demographic groups: those receiving Medicaid, those at or below the federal poverty level; and those indicating having a disability in the 2000 U.S. census. The poor and disabled populations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

Connecticut, in general, has a smaller percentage of its population receiving Medicaid<sup>1</sup> – 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.

<sup>1</sup> Centers for Medicaid and Medicare, FFY 02 national Medicaid recipient data.

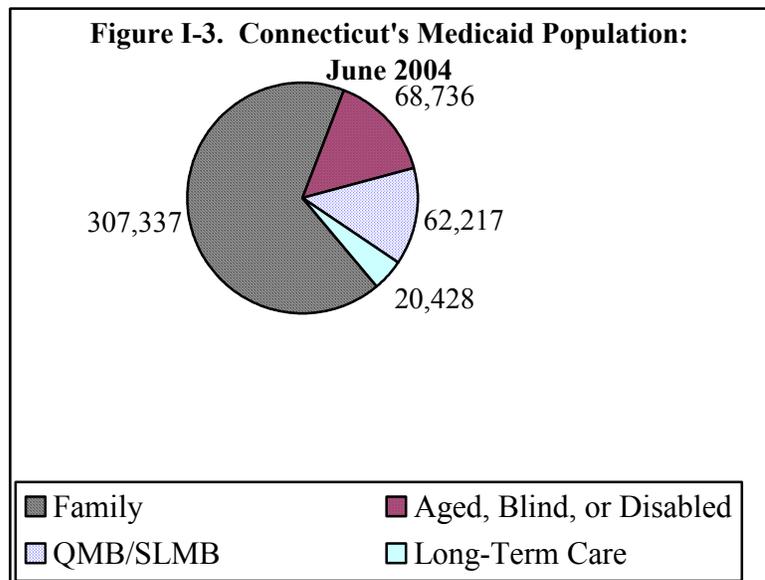
Connecticut also has a low percentage of its population considered poor.<sup>2</sup> Only 7.9 percent of the state's population (all ages) is at or below the federal poverty level. That places Connecticut at the third-lowest state ranking, below the New England average of 9.6 percent and substantially below the national average of 12.4 percent.

Figure 1-2 further 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.



### 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. (Because QMBs and SLMBs are frequently covered under another Medicaid coverage group, they are often not counted in Medicaid caseloads, including Figure I-1 above). Long-term care Medicaid recipients account for less than five percent of the total. (More detailed



Long-term care Medicaid recipients account for less than five percent of the total. (More detailed

<sup>2</sup> 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.

descriptions of the Medicaid population and eligibility requirements are discussed in Chapter Three.)

According to federal Centers for Medicare and Medicaid Services (CMS) documents, Connecticut Medicaid expenditures are estimated to total \$3.7 billion in FFY 04. The Connecticut state budget estimates the state's expenditures for Medicaid at almost \$3 billion for state FY 04. A more detailed discussion of Medicaid administrative expenses is contained in Chapter Two.



### 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 administrators who report directly to the DSS commissioner. Regional administrators 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;
- Adult Services – responsible for administering programs related to financial and medical support of elderly persons, and has lead responsibility for Medicaid to the Aged, Blind & Disabled 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. 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 also have phone-mail capabilities allowing clients to leave messages for DSS staff. Overall phone services vary among offices, however, as highlighted in Chapter 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 is 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, and allows more effective interaction between eligibility workers and clients. Some offices also have staff interpreter-clerks available to applicants and clients.

## **Eligibility Service Workers**

DSS regional workers involved with determining Medicaid eligibility are classified as 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 Chapter 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 also 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 conducted 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, although there may be times when training is mandated by the central office or regional administrators. General staff development training is also available at employees' requests. Any formal training agenda is set by agency management.

## 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)	<p>Operates as state's Medicaid Managed Care enrollment broker</p> <p>Provides outreach, education enrollment services for HUSKY A and B programs</p> <p>Determines eligibility for HUSKY B applicants</p> <p>Calculates monthly capitation fees due to managed care organizations for HUSKY A; submits to DSS for payment</p>	4/95 – 12/04 (full contract period, including extensions)	\$34.6 million (maximum contract value through 12/04)
United Way of CT	<p>Operates HUSKY Infoline</p> <p>Operates 211 Infoline</p>	7/03 – 6/04 (current contract period)	\$3.8 million (\$720,000 HUSKY; \$3.08 million 211 Infoline)
Colonial Cooperative Care, Inc.	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	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)	Provides "Healthy Start" services	7/03 – 6/04 (current contract period)	\$261,000
Stay Well Health Center (Waterbury)	Provides "Healthy Start" services	7/03 – 6/04 (current contract period)	\$261,000
Bridgeport Health Department	Provides "Healthy Start" services	7/03 – 6/04 (current contract period)	\$261,000
Hartford Health Department	Provides "Healthy Start" services	7/03 – 6/04 (current contract period)	\$261,000
Source: DSS contracts			

The state also 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 Chapter 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), as described later in the report. 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: 1) 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 2) 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**

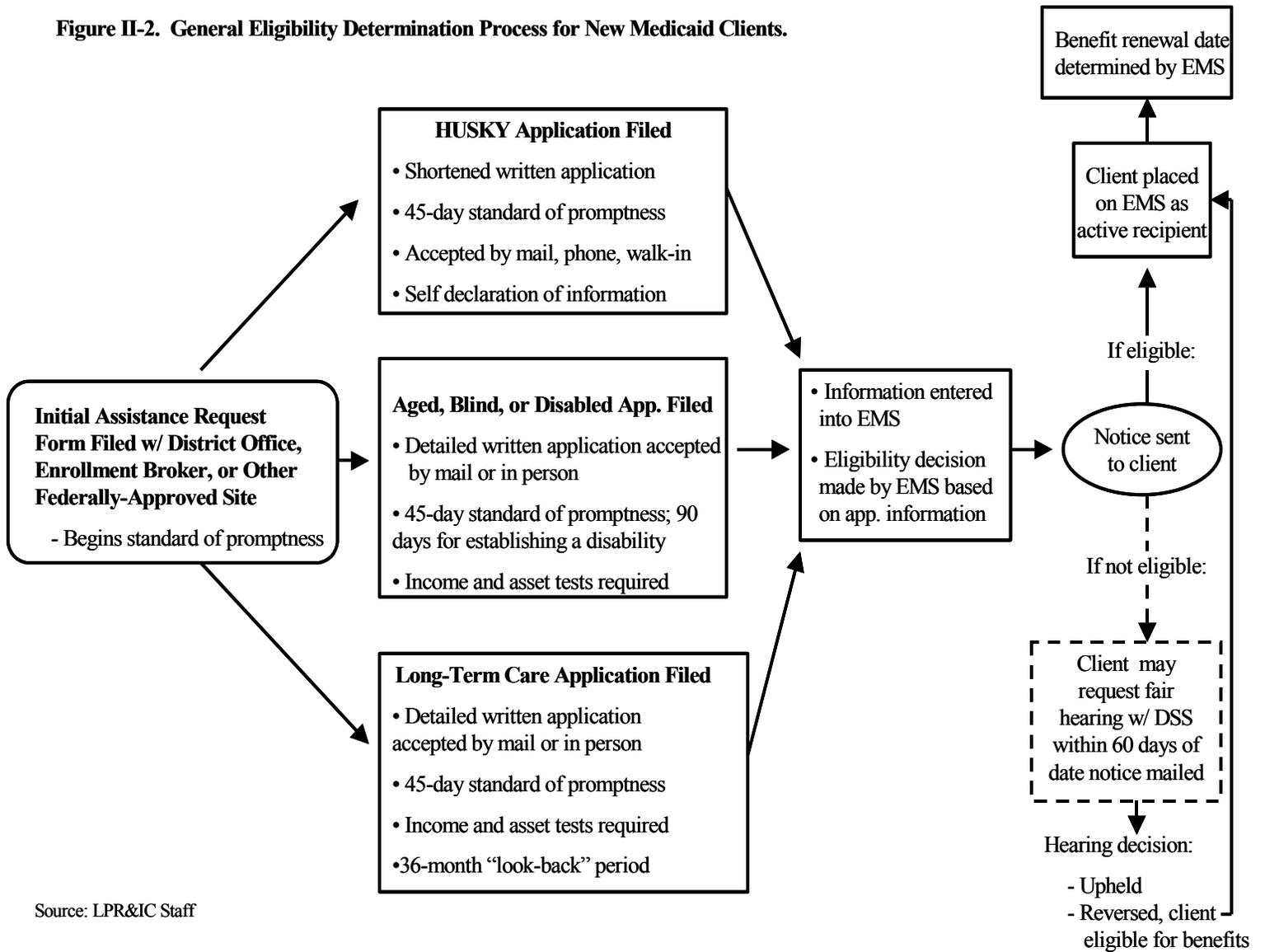
Different Medicaid programs have different application and eligibility requirements, as described in more detail in Chapter Three. Each new applicant must follow a basic process when applying for Medicaid, as highlighted in Figure II-2.

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 verifies against information collected from other databases (e.g., IRS, Social Security, wage and bank records, and DMV) may also be used in determining eligibility.

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



Source: LPR&IC Staff

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.

<b>Table II-2. General Application Requirements by Medicaid Population</b>						
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.

<b>Table II-3. Federal Standard of Promptness by Program.</b>	
<b>Program</b>	<b>Standard of Promptness</b>
1. State Administered General Assistance Cash	10 Days
2. Food Stamps	30 Days
3. 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 <b>expedited</b> 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>	

**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.

### **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 Chapter Four.

### **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 are:

- 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.

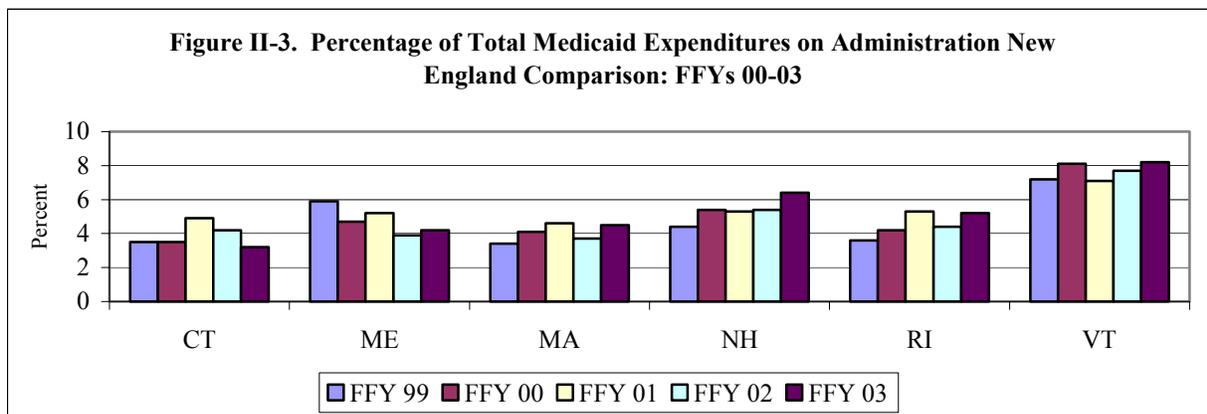
**Table II-4. Connecticut Medicaid Administrative Expenditures: FFYs 99-04**  
**(\$ in thousands)**

	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.



## Chapter Three

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### 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 chapter 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; and
- 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 chapter);

### 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.

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 processing," 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.)

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

<b>Family of 2</b>	<b>Family of 3</b>	<b>Family of 4</b>	<b>Family of 5</b>	<b>Family of 6</b>	<b>HUSKY Plan features</b>	<b>% of Federal Poverty Level</b>
under \$12,491	under \$15,671	under \$18,851	under \$22,031	under \$25,211	<b><u>HUSKY A</u></b> <i>Free</i> health care for parents who live with child or for a relative caregiver who lives with the child.	<b>100% or less</b>
under \$23,107	under \$28,990	under \$34,873	under \$40,756	under \$46,639	<b><u>HUSKY A</u></b> <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).	<b>185% or less</b>
\$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	<b><u>HUSKY B</u></b> Healthcare for children under 19; no monthly premium. Maximum co-payments \$760/year* <b>Eligible for HUSKY Plus.**</b>	<b>&gt;185% -- 235%</b>
\$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	<b><u>HUSKY B</u></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* <b>Eligible for HUSKY Plus.**</b>	<b>&gt;235% -- 300%</b>
over \$37,470	over \$47,010	over \$56,550	over \$66,090	over \$75,630	<b><u>HUSKY B</u></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	<b>&gt;300%</b>

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

**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: 1) size of the “assistance unit” (all individuals applying for HUSKY on an application); and 2) 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.

Departmental 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.

Presumptive eligibility 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.

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. Further, 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 chapter). The resulting income level must be at or below the Medically Needy Income Limit 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, and clients may apply in person, by mail, or by telephone. As mentioned above, 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.

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 ex-parte renewal 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.

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. 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.)

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. (Continuous eligibility is described in more detail in Chapter Five.)

*Guaranteed eligibility* allows a Medicaid recipient enrolled in a 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**

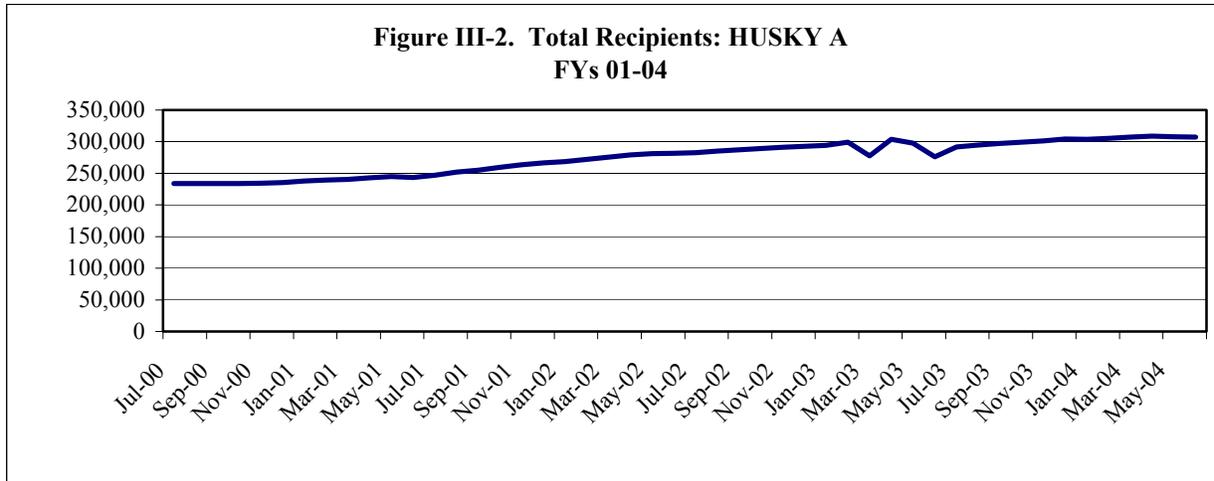
All HUSKY A and B clients are required to participate in the state's Medicaid managed care program. DSS automatically enrolls HUSKY A clients into a managed care plan if the client has not chosen one within 30 days of eligibility. HUSKY B clients also have 30 days to enroll, but are not automatically 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.

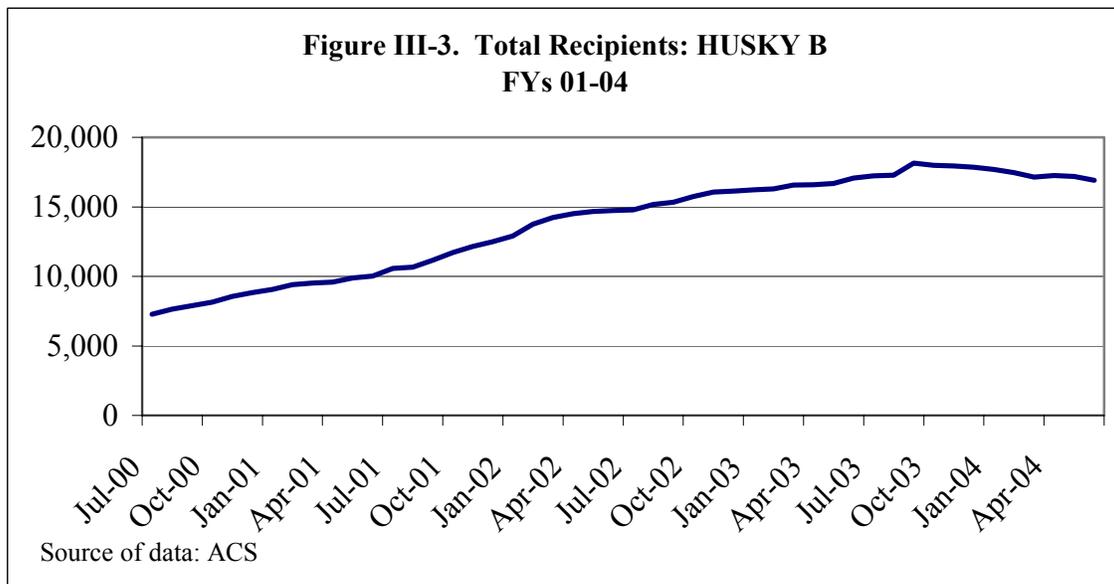
### **Workload**

**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.

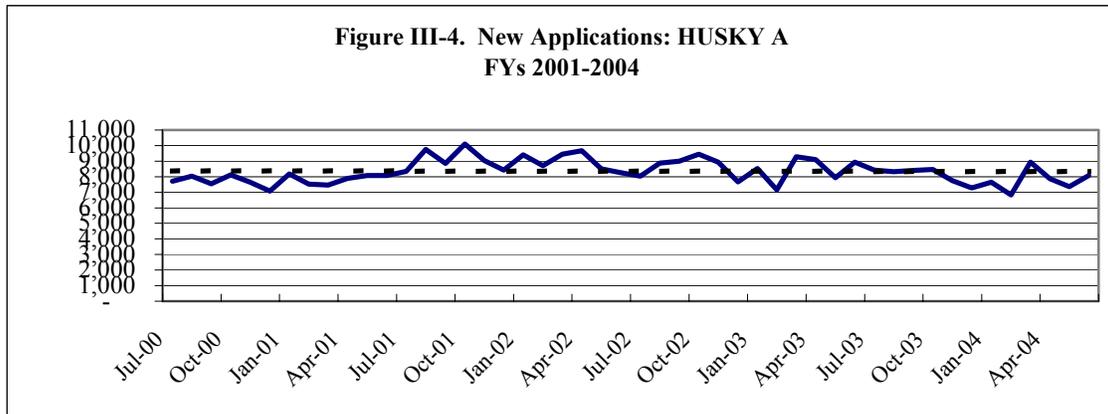


The figure shows a steady increase in *recipients* over the four fiscal years. The number of recipients increased from 233,980 per month to 307,337 (or 31 percent). The number of *households* (which may include multiple recipients) receiving assistance increased from 113,149 to 138,197 (or 22 percent.) Further, 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.

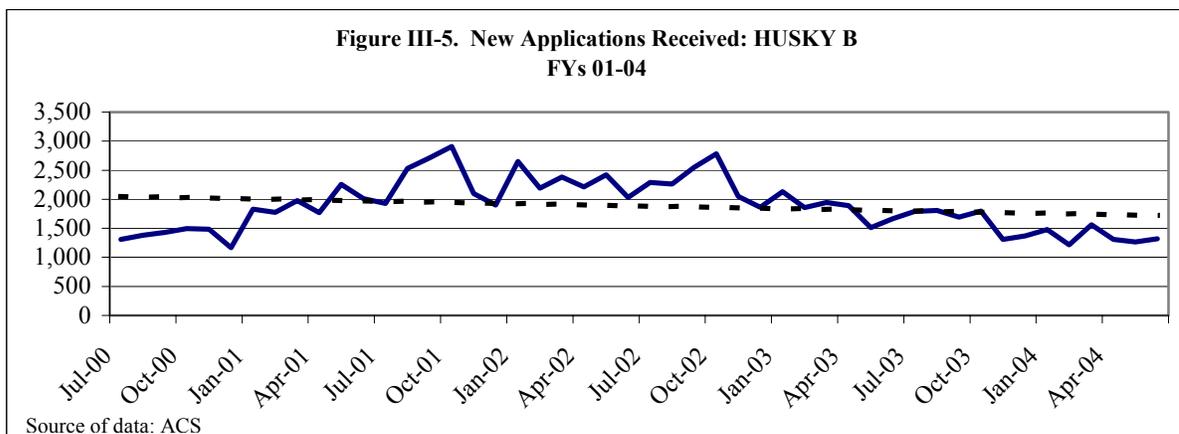


**Applications.** A key workload indicator is the trend in the number of new assistance applications DSS receives at the beginning of each month. Figure III-4 shows the number of new applications for HUSKY A received monthly for FYs 2001-04. The figure highlights the fluctuation in new applications from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



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), with a low of 6,838 applications 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. As the figure shows, the number received generally increased until late 2001, leveled off somewhat until late 2002, and has been declining through mid-2004.



## LONG-TERM CARE

Long-term care (LTC) is a covered mandatory service under Medicaid. The 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. A written application must 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.** 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. As such, 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 assets *look-back period* mandated by federal law is 36 months from the date of institutionalization or the date of application, whichever is later.<sup>3</sup> (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.** A Social Security Number (SSN) and declaration of citizenship information are required on the long-term care application. The social security number is 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.

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

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: 1) the verification procedures; 2) 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 3) the state placing a lien against countable property. If the long-term care applicant 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.

### **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**

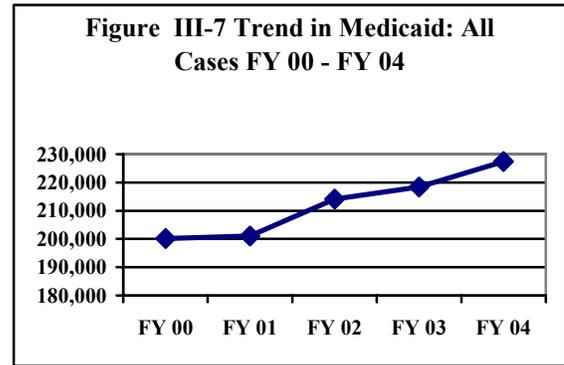
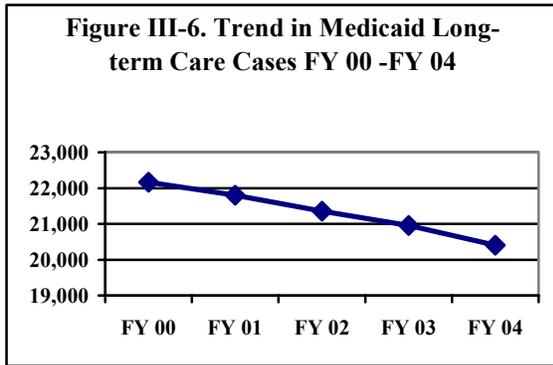
There are two overall measures of workload in dealing with Medicaid population on long-term care – *overall caseload* and *numbers of applications*.

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.

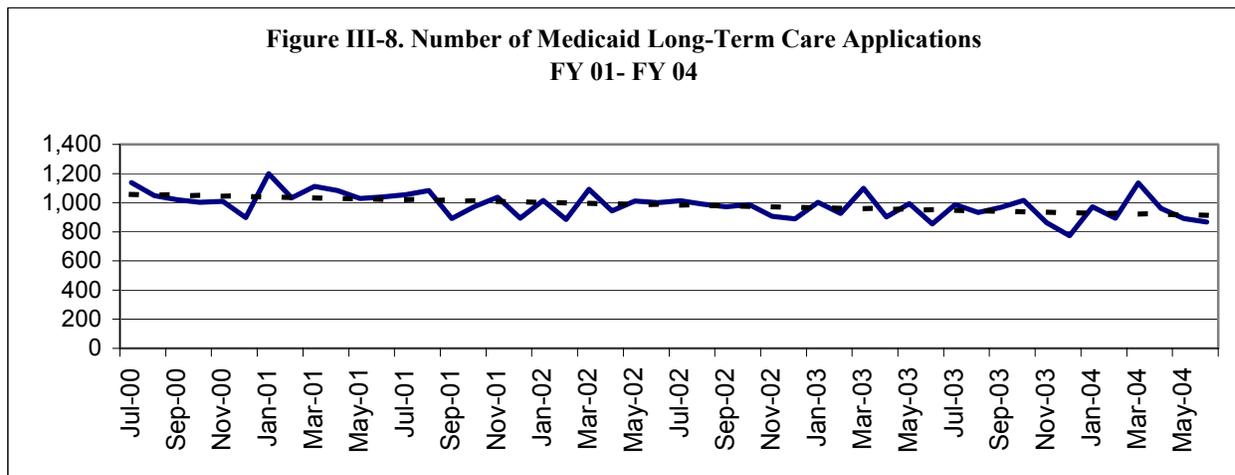
Factors that make LTC cases more time-consuming are the volume of financial records that must be examined and the complicated tests and calculations DSS staff must conduct prior to approving an LTC application. For example, workers determine:

- 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-6 and III-7 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.



**Applications.** Applications for Medicaid long-term care have also been decreasing, as shown in Figure III-8. 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.



## **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,<sup>4</sup> 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.<sup>5</sup> 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)). 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). First, the disability must be severe enough to prevent "substantial, gainful, employment" (i.e., earn at least \$700 a month) and 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, which is the medically needy income limit of \$476 for most of the state and \$574 in Fairfield County. When this amount is combined with the unearned income disregard the allowable amounts translate to about 85 percent of the FPL for all but Fairfield County, where it is about 98 percent of the FPL.

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

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

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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.

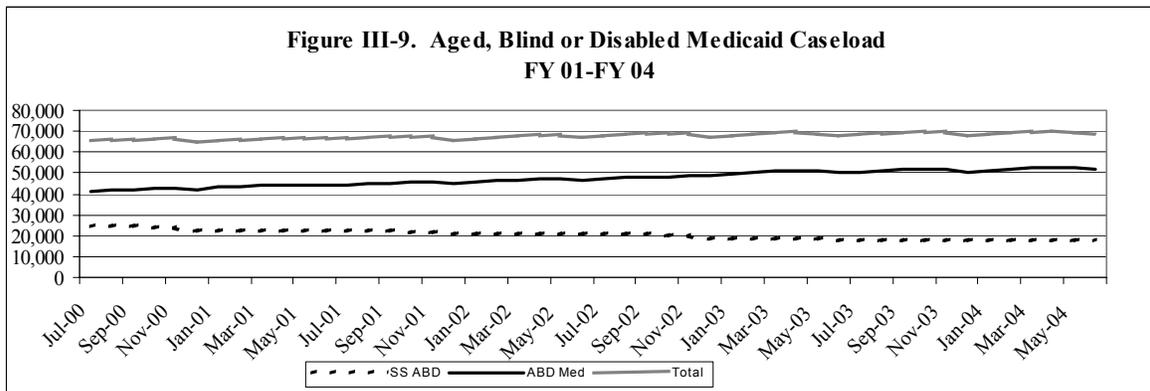
**Method of Payment**

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.

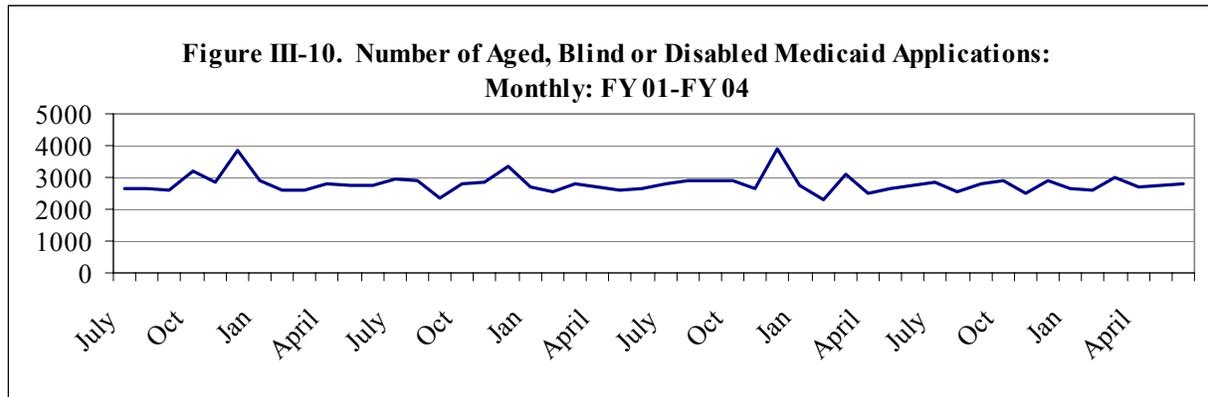
**Workload**

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-9. 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.



**Applications.** The other major workload indicator is applications received. The number of new applications received each month for Medicaid Aged, Blind or Disabled is shown in Figure III-10. As the figure shows, the number of new applications has remained fairly steady over the 4-year period, at between 2,500 and 3,000 per month.



## 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.

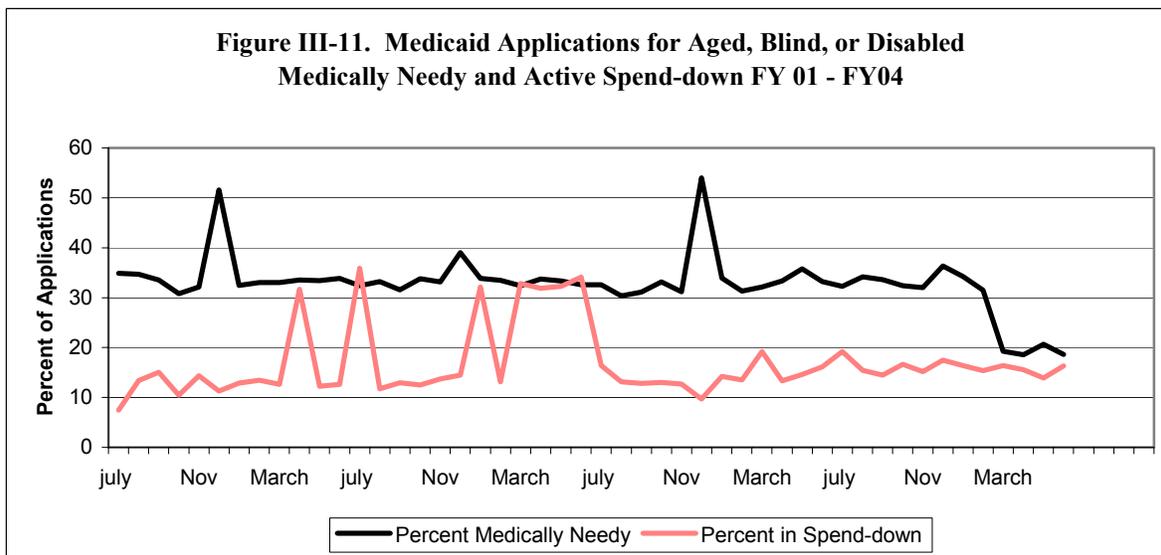
## **Workload**

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-11 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. In some cases, QMBs or SLMBs may also be covered under another Medicaid coverage group.

**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.** Clients *must* already be receiving Medicare, and some *may* already be receiving Medicaid under another coverage group. Those who qualify as a QMB, with resources at or below twice the SSI standard (\$4,000 for an individual or \$6,000 a couple) 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.

Clients qualifying 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. Only those at or below the 120 percent of FPL are eligible for full Medicaid benefits under another coverage group. This group must also meet the asset test, but there is no asset test for those above the 120 percent of FPL.

**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. As discussed above, some may be receiving Medicaid benefits under another coverage group and be counted there. However, 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.

### MANAGEMENT AND OVERSIGHT

A number of 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. Examples of such mechanisms are provided below.

#### Federal and State Oversight

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 three percent. DSS officials have indicated Connecticut's error rate has always been below that threshold.

DSS also has a Medical Audits Division focused on ensuring payments are made for legitimate services to appropriately credentialed and approved providers. The division tries to detect fraud and abuse, and works 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.

In early summer 2004, the CMS Region One Office in Boston received an informal complaint 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 to CMS is contained in Appendix D.) CMS staff conducted field visits in Connecticut to determine the scope of the problem, and intends additional visits early in 2005.

The DSS fair hearing process also serves as a check on eligibility determinations, including those in Medicaid, as described in Chapter 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 on the Medicaid program 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.

<b>Table IV-1. Fair Hearing Requests: January 1, 2000- June 15, 2004 Medicaid Program and Process Delay Issues</b>					
	<b>Calendar Year</b>				
	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004 (to 6/15)</b>
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					

Table IV-2 shows the outcomes for the hearings requested on the Medicaid program. It is important to note that while a hearing is requested, it may not be held. In fact, the total numbers under “Decisions Issued” (on left hand side of table) indicate that less than 30 percent of hearings requested are actually held. Of those hearings that are held, decisions favor DSS slightly more frequently than the client. Typically more than two-thirds of the requested hearings are not held (as shown by the second “Total” column as a percent of the “Grand Total”). Often the hearing is not held because the client either does not show or the request is withdrawn. The other frequent reason for not holding a requested hearing is that the case is resolved in favor of the client before it gets to a hearing.

<b>Table IV-2. Fair Hearing Results: January 1, 2000 –June 30, 2004 –Medicaid Program</b>									
	<b>Decisions Issued</b>				<b>Closed without a Decision</b>				
<b>Year</b>	<b>Favor Appellant</b>	<b>Favor DSS</b>	<b>Split</b>	<b>Total</b>	<b>No Show/ Withdrawal</b>	<b>No Jurisdiction</b>	<b>Change for Appellant</b>	<b>Total</b>	<b>Grand Total</b>
2000	204	197	48	<b>449</b>	868	56	307	<b>1,231</b>	<b>1,680</b>
2001	185	237	56	<b>478</b>	827	47	273	<b>1,147</b>	<b>1,625</b>
2002	118	203	43	<b>364</b>	828	126	344	<b>1,297</b>	<b>1,661</b>
2003	116	192	31	<b>339</b>	1,224	225	689	<b>2,138</b>	<b>2,477</b>
2004	50	112	19	<b>181</b>	596	179	345	<b>1,120</b>	<b>1,301</b>
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 Kids*<sup>6</sup> 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. 2<sup>nd</sup> 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.
- *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;

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<sup>6</sup> *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.

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- 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*;<sup>7</sup> 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.

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<sup>7</sup> 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) 3<sup>rd</sup> 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.

## ANALYSIS, FINDINGS, AND RECOMMENDATIONS

Committee analysis shows an increasing problem of processing Medicaid applications in a timely fashion, especially in some of the programs. The committee finds a number of contributing factors 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.

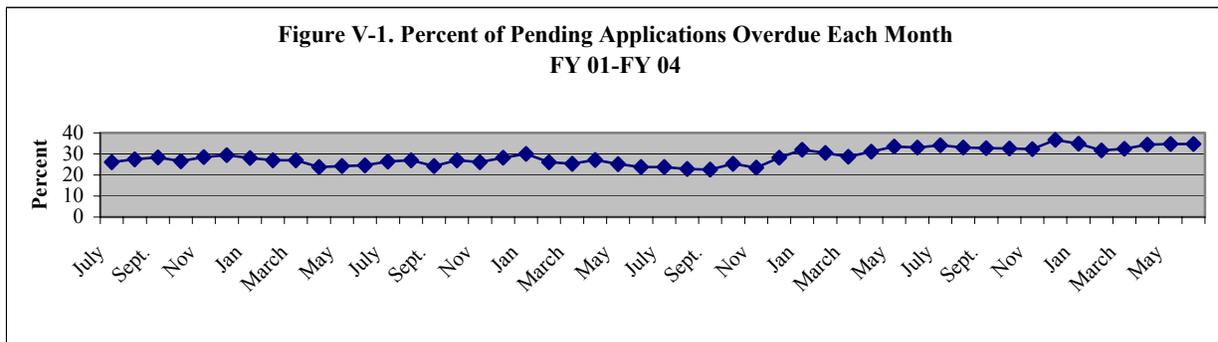
The committee recognizes the efforts that DSS is making to address the problem of timely eligibility determination (e.g., dedicated processing time), but recommends areas where the department could make additional administrative improvements. The committee also recommends a number of statutory changes that should assist with Medicaid eligibility determinations.

### Applications Processing

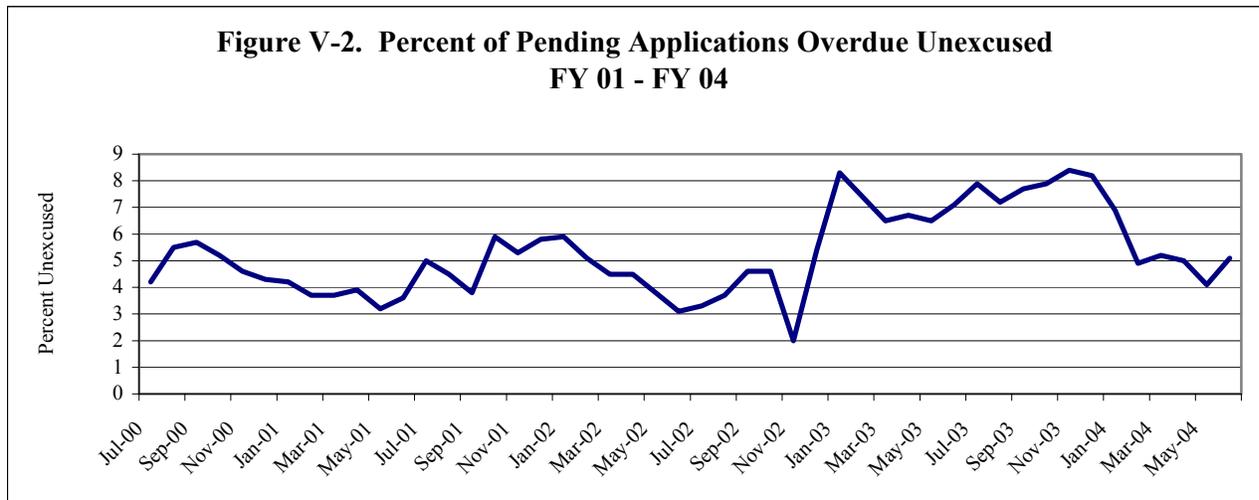
#### Overdue Applications

Federal regulations require that eligibility for Medicaid be determined by the designated state agency (i.e., Department of Social Services) within a certain time period, known as the standard of promptness (SOP). The SOP is typically 45 days for most Medicaid applications, and 90 days if the client must establish a disability in order to become eligible. Extensions may be granted to applicants in order to obtain documents, or fulfill other requirements to establish eligibility.

Figure V-1 shows the percent of pending applications overdue beyond the SOP for Medicaid in Connecticut has been increasing. From FY 01 through FY 04 the percentage of all pending Medicaid applications that are overdue each month has increased from about 27 percent to 34 percent.



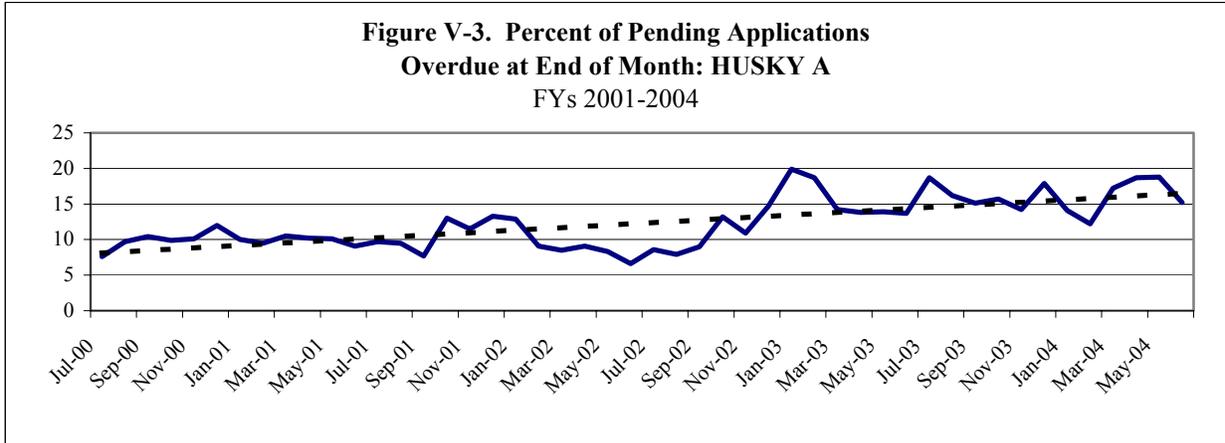
Chapter Four indicated one of the oversight mechanisms of eligibility determination processing in place resulted from a stipulated agreement to settle a lawsuit in the early 1990s. Known as the “Alvarez agreement”, it requires DSS to meet a timeliness standard where no more than five percent of overdue pending applications can be considered unexcused. Using that measure, the trend is depicted in Figure V-2 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 –a substantial increase. 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 to any real timeliness improvements.



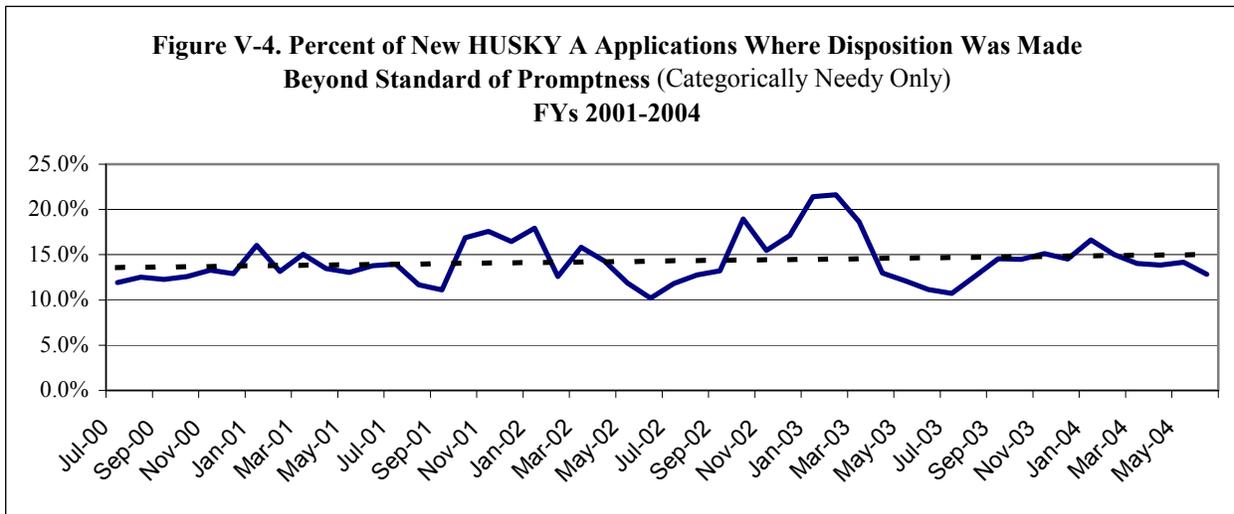
The extent of the problem of overdue applications varies considerably among the different Medicaid populations. The analysis below shows the variation of applications considered overdue in each of the three major program categories.

### **Family Medicaid (HUSKY A)**

Figure V-3 shows the percent of pending family Medicaid (HUSKY A) applications at the end of the month that were overdue for FYs 01-04. Based on the data in the graph, the average percentage of overdue applications was 10 percent in FY 01; in FY 04 this monthly average had grown to slightly more than 16 percent. The trendline also shows a steady increase over the time period. There is not standard of promptness for HUSKY B.



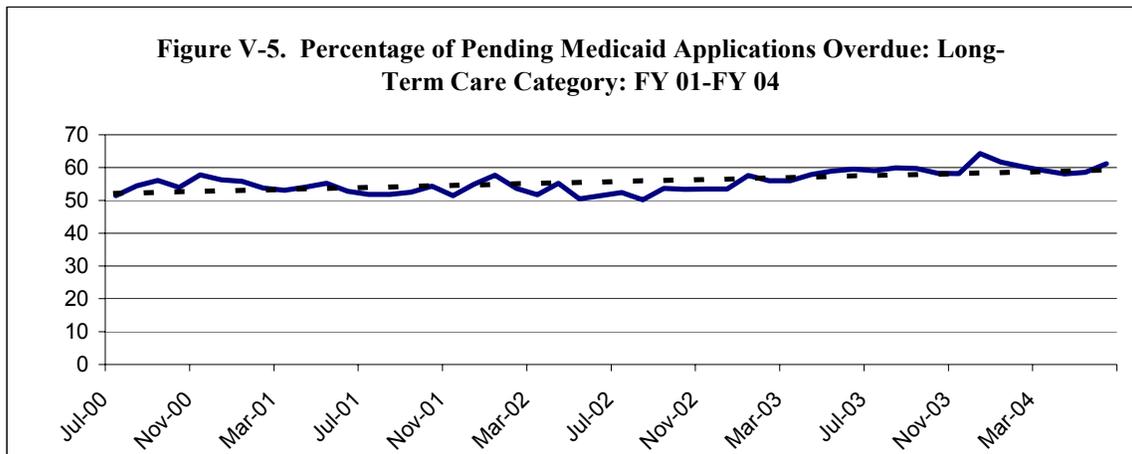
Another way of looking at overdue applications is whether the decisions were made beyond the 45-day federal standard of promptness (SOP). Application dispositions for categorically needy include: 1) granted; 2) denied; 3) withdrawn by the applicant; or 4) cancelled. Figure V-4 shows the results of this analysis – indicating the percentage of new HUSKY A applications (categorically needy) where a decision was made beyond the 45-day SOP. 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.



## Long-Term Care

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 V-5. 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.

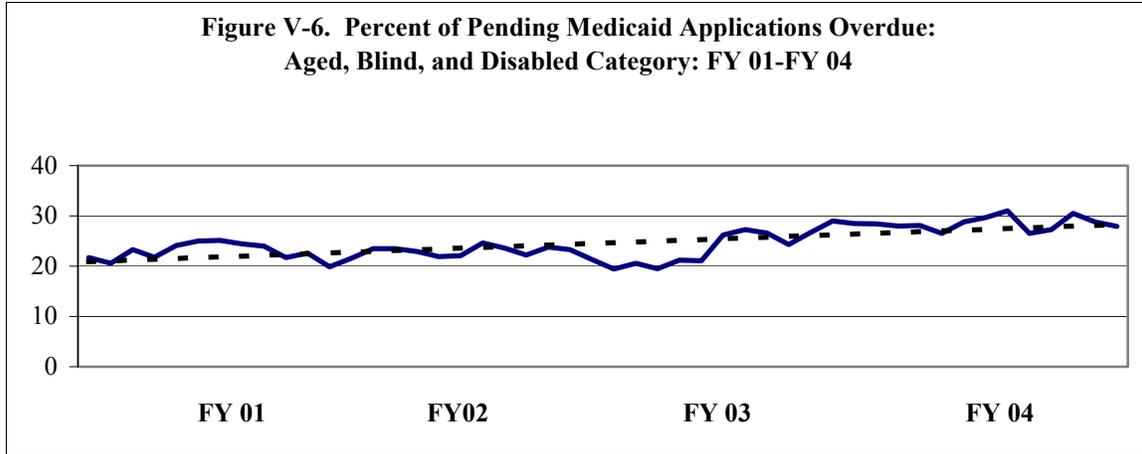
Another reason for a high percentage of overdue applications, according to DSS, is that it is customary for people in nursing homes to apply before they are eligible for LTC while they spend down their assets. The department holds up the application until the applicant has spent down to a level where the person qualifies for Medicaid, but the application is considered “overdue” beyond the 45-day period.



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

Figure V-6 shows the percent of overdue Medicaid applications in the Aged, Blind or Disabled category of those pending at the end of each month. As the graph shows, the percent overdue has risen slightly over the period from almost 23 percent in FY 01 to more than 28 percent in FY 04.



### Other Eligible Populations

As noted in Chapter Three, the vast majority of QMB/SLMB applicants are receiving full Medicaid benefits under another coverage group, and the benefits received under this category may be supplementary. However, the applications must still be processed in a timely manner and are a considerable portion of staff workload. 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 V-1.

	<b>FY 01</b>	<b>FY 02</b>	<b>FY 03</b>	<b>FY 04</b>
<b>QMB</b>	30.2	29.6	27.6	34.6
<b>SLMB</b>	24.8	33.1	18.5	35.3

Source: LPR&IC Staff Analysis

### Office Variation

The above analysis examined overdue applications on a statewide basis. The study scope also called for a review of variation among the district offices. Because family Medicaid accounts for the bulk of applications for the program, the committee limited its examination of DSS district office application processing to family Medicaid. Analysis of new family applications for Medicaid is depicted in Table V-2, and results show the following:

- The range in percentages of overdue family applications among offices has grown from 6 to 16 percent in FY 01, to a spread of 3 to 38 percent in FY 04, which indicates a growing variation in processing timeliness among offices.
- Increasing caseloads and decreasing staffing levels as documented in this report have had varying impact on application processing. Five offices – Hartford, Bridgeport, Danbury, Norwich and New Haven – have experienced increased percentages of overdue family applications between FY 03 and FY 04. Middletown, Stamford, New Britain and Torrington have seen a decrease in percentage of overdue applications in FY 04, while Manchester and Waterbury remained virtually unchanged.

**Table V-2 Percentage of Family Medicaid Applications Overdue (Avg. Monthly) FY 01- FY 04**

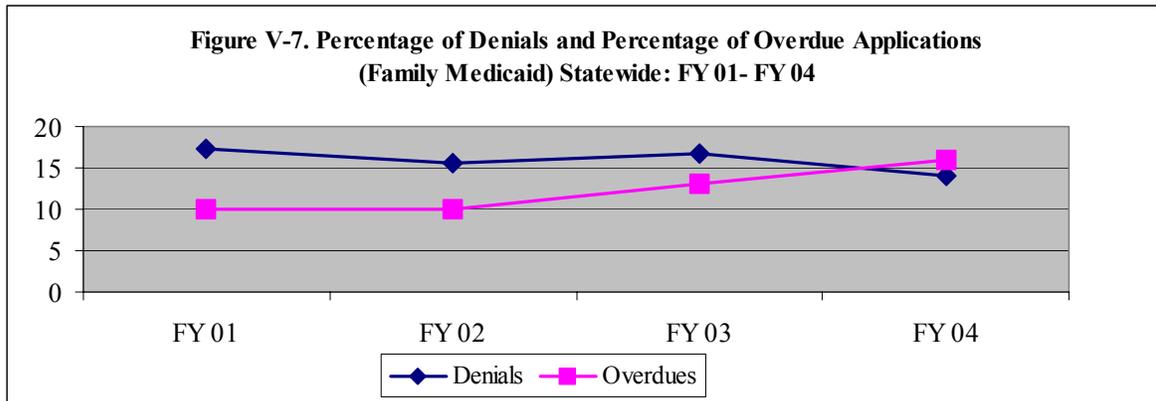
	FY 01	FY 02	FY 03	FY 04
<b>Hartford</b>	10	12	16	38
<b>Manchester</b>	14	15	14	14
<b>New Britain</b>	11	13	18	13
<b>New Haven</b>	9	7	5	6
<b>Middletown</b>	7	8	7	5
<b>Bridgeport</b>	6	8	11	16
<b>Stamford</b>	16	13	19	17
<b>Norwich</b>	11	11	16	29
<b>Danbury</b>	9	7	9	11
<b>Waterbury</b>	10	9	6	6
<b>Torrington</b>	9	5	4	3
<b>Statewide</b>	10	10	13	16

Source: LPR&IC Staff Analysis of Overdue Applications

To explain why some offices have been able to maintain, or even improve, the timeliness of processing Medicaid applications, program review compared several factors including:

- office application denial rates to percentage of overdue applications for family Medicaid;
- recent staffing losses by office, primarily due to early retirements and layoffs;
- office staffing to Medicaid caseloads ratios; and
- current ratio of supervisors to eligibility workers in each of the offices.

**Denial rates and overdues.** First, committee staff examined the statewide trend in denials of family Medicaid applications to assess whether denial rates had increased as a way to deal with the overdue applications. The results are shown in Figure V-7, and indicate a downward trend in yearly denial rates -- from 17 percent to 14 percent, while the yearly rate of overdue applications increased from 10 percent to 16 percent over the FY 01- FY 04 period.



While the variation in eligibility denials among the offices is substantial, as shown in Table V-3, none of the offices appear to be increasing denial rates as a way of addressing overdue applications. Offices that have a higher denial rate than the statewide average in FY 04 (e.g., Stamford, Danbury) have typically denied a higher percentage throughout the four-year period. In fact, in many offices, the average monthly percentage of denials has declined over the four years examined.

**Office variation in denial rates.** Some of the variation in denial rates by office can perhaps be explained by *the differences in populations served*. For example, it is plausible that Stamford and Danbury deny more applicants than other offices because their clients do not meet eligibility requirements, like income. However, it is more difficult to explain why fairly substantial differences in denial rates exist when comparing offices like Hartford with New Haven or Bridgeport, since those offices serve similar populations. *The committee was unable to pinpoint reasons for variations since DSS does not track reasons for denials, nor could program review determine if some offices issued more extensions than other offices prior to issuing an award or denial.*

Analysis of overdue applications and denials by office indicates that, generally, *DSS locations with consistently high denial rates do not have as high a percentage of overdue applications as those offices with lower denial rates.* For example, New Haven has had a higher than average denial rate over the four-year period, but a fairly low percentage of overdue family Medicaid applications. Hartford and Norwich, on the other hand, have had lower than average denial rates, but both offices have had increasing percentages of overdue applications. (A graphic depiction of each office's denial and overdue ratios is contained in Appendix E) *The committee believes this analysis suggests that denial rates are historical by office, and again do not indicate an increasing statewide trend in denials in an effort to lower the backlog of overdue applications.*

<b>Table V-3. Percentage of Family Medicaid Applications Denied By Office: FY 01 –FY 04</b>				
	FY 01	FY 02	FY 03	FY 04
<b>Statewide Avg.</b>	17	16	17	14
<b>Hartford</b>	12	11	12	10
<b>Manchester</b>	18	16	17	11
<b>New Britain</b>	11	9	12	9
<b>New Haven</b>	18	14	16	18
<b>Middletown</b>	15	14	16	13
<b>Bridgeport</b>	18	15	17	18
<b>Stamford</b>	38	31	30	26
<b>Norwich</b>	13	11	10	10
<b>Danbury</b>	22	21	22	21
<b>Waterbury</b>	22	16	14	13
<b>Torrington</b>	13	10	10	11
<b>Central office</b>	9	19	27	8

Source: LPR&IC Staff Analysis of DSS Application Data

**Staffing loss impact.** Since July 2002, eligibility worker staffing levels have been reduced about 25 percent statewide, while caseloads have increased. This has resulted in a per-staff workload increase of 40 percent, and certainly has been one of the contributing factors in the increasing percentages of overdue applications. Beginning in early 2004, DSS has attempted to redistribute the staff through an “equalization” effort, described earlier in the report.

Committee staff examined whether the equalization initiative has been successful by comparing the office-to-statewide staffing ratio for each office to each office’s Medicaid cases (assistance units) as a percent of the total Medicaid cases statewide. The staffing data include the three eligibility worker classes – worker, specialist, and supervisor – for FYs 03 and 04. The results are shown in Table V-4.

The table shows that in FY 04, no more than a one percent difference exists between office staffing and Medicaid caseload, as percentages of the statewide totals. *Based on this, program review finds that eligibility staffing to Medicaid caseload ratios by office is evenly distributed. Thus, imbalances in staffing by offices should not be a contributing factor in one office having a higher percentage of overdue applications than another.*

Table V-4. Medicaid Cases and Staffing By Office Percent of Statewide Totals (average monthly) FY 03 – FY 04				
	FY 03		FY 04	
	% Cases	% Staffing	% Cases	% Staffing
<b>Hartford</b>	16	18	16	17
<b>Manchester</b>	7	7	7	7
<b>New Britain</b>	6	6	7	8
<b>New Haven*</b>	18	21	20	19
<b>Middletown</b>	3	4	4	5
<b>Bridgeport</b>	12	13	13	14
<b>Stamford</b>	4	4	4	4
<b>Norwich*</b>	10	8	9	8
<b>Danbury</b>	3	3	4	4
<b>Waterbury</b>	9	10	9	10
<b>Torrington</b>	3	2	3	3

\*Norwich and New Haven had dramatic reductions in caseloads late in FY 04. About 10,000 cases were switched from Norwich to Willimantic (which reopened part time in Feb/March of 2004. About 7,000 cases were transferred from New Haven to Middletown in June of FY 04.

Source: LPR&IC Staff Analysis of DSS Application Data

**Staffing reductions.** *The committee concludes that DSS has succeeded in fairly equalizing staffing levels among offices to match Medicaid caseload.* However, some offices have experienced greater actual reductions in staffing than others. Committee staff analyzed the percentage reduction in staffing by office compared with the percentage of overdue applications. The results are shown in Table V-5.

*Committee staff correlated the percentage change in staffing with the percentage change in overdue applications and, as might be expected, there is a significant relationship between staffing reductions and overdue applications by office.*

However, program review does not believe it is the total contributing factor to overdue applications. For example, staffing reductions alone cannot explain the experiences with overdue applications in Hartford compared to New Haven. In Hartford, overdue application percentage more than doubling from FY 03 to FY 04 -- the greatest increase by far of any office -- while its staffing reduction was 20 percent. New Haven's staffing was cut 23 percent, yet New Haven's overdue rate increased by only 20 percent. Further, Stamford had its staffing reduced by 15 percent, yet managed to lower its overdue application rate by 10 percent.

<b>Table V-5. Comparison of Staffing Changes and Percent of Applications Overdue: Average Monthly: FY 03 and FY 04</b>						
	<b>FY 03</b>	<b>FY 04</b>		<b>FY 03</b>	<b>FY 04</b>	
	Avg. Monthly Staffing		% Change	% Applications Overdue		%Change
<b>Hartford</b>	139	111	-20%	16	38	+137%
<b>Manchester</b>	52	46	-12%	14	14	0%
<b>New Britain</b>	42	50	+17%	18	13	-28%
<b>New Haven</b>	159	122	-23%	5	6	+20%
<b>Middletown</b>	30	31	+2%	7	5	-28%
<b>Bridgeport</b>	97	90	-8%	11	16	+45%
<b>Stamford</b>	28	23	-15%	19	17	-10%
<b>Norwich</b>	63	54	-14%	16	29	+81%
<b>Danbury</b>	24	23	-6%	9	11	+22%
<b>Waterbury</b>	78	65	-17%	6	6	0%
<b>Torrington</b>	15	16	+5%	4	3	-25%

Source: LPR&IC Staff Analysis of Overdue Applications

**New applications.** As a possible explanation for Hartford’s increasing overdue problem, committee staff examined the number of new applications for family Medicaid received each month during FY 04 in Hartford and New Haven to compare workload. *The results show that New Haven received a greater number of applications in every month of FY 04. The number of new applications New Haven received averaged 1,412 per month, while Hartford’s monthly average was 1,037, almost one-third less. Thus, the Hartford office’s dramatic increase in overdue applications cannot be explained by a greater or increasing number of new family Medicaid applications.*

New Haven also incurred greater office disruptions during FY 04 than most offices. New Haven temporarily absorbed Meriden’s caseload, until those cases were transferred to Middletown. Further, New Haven SAGA -- which previously had been administered at a separate location with staff assigned exclusively to that program -- was absorbed into the New Haven office with the staffing reductions outlined in Table V-5.

**Eligibility supervisors.** Committee staff examined eligibility supervisor ratios in each of the offices as a potential indicator of timely application processing, speculating that the better-performing offices (with a lower overdue rate) would have had a lower ratio of workers to supervisors.

The results, shown in Table V-6, include the supervisor-to-worker ratio as well as the percent change in overdue applications between FY 03 and FY 04. The ratio of supervisors to workers is very close among all the offices, except Torrington. In that office, the ratio was more than double the statewide average, yet Torrington has managed to decrease its overdue family Medicaid applications by 25 percent. Further, New Haven and Norwich have the same ratios, yet

the increase in percentages of overdue applications was very different. *Thus, in FY 04 the number of workers a supervisor must oversee does not appear to greatly contribute to the overdue application problem. However, the change in supervisor ratios from FY 03 to FY 04, as the change in staffing overall, may be a factor.*

<b>Table V-6. Comparison of Supervisor-to-Worker Ratio By Office: FY 03 and FY 04</b>			
	<b>FY 03</b>	<b>FY 04</b>	<b>FY 03 to FY 04 % Increase in Overdue Apps</b>
<b>Statewide Avg.</b>	1 to 8.5	1 to 8.6	
<b>Hartford</b>	1 to 7	1 to 9	+137%
<b>Manchester</b>	1 to 7	1 to 8	0%
<b>New Britain</b>	1 to 7	1 to 8	-28%
<b>New Haven</b>	1 to 12	1 to 10	+20%
<b>Middletown</b>	1 to 10	1 to 9	-28%
<b>Bridgeport</b>	1 to 7	1 to 8	+45%
<b>Stamford</b>	1 to 6	1 to 7	-10%
<b>Norwich</b>	1 to 10	1 to 10	+81%
<b>Danbury</b>	1 to 12	1 to 11	+22%
<b>Waterbury</b>	1 to 8	1 to 7	0%
<b>Torrington</b>	1 to 17	1 to 18	-25%

Source: LPR&IC Staff Analysis of DSS Staffing

*The committee believes the overall staffing reductions are significantly related to the increases in overdue applications. However, varying office experiences suggest it is not the sole factor, and other reasons may be ones that are not readily quantifiable. This suggests that issues of performance will not entirely be addressed by increasing staffing, or even supervisory levels, alone. The department must explore further those qualitative issues that foster good performance in some offices, despite staffing cuts and increasing caseloads, while other offices appear less able to manage application backlogs.*

## **Redeterminations**

The focus of the analysis above has been on the processing of new applications. However, the Department of Social Services must also periodically determine whether clients continue to be eligible for Medicaid, typically every 12 months.

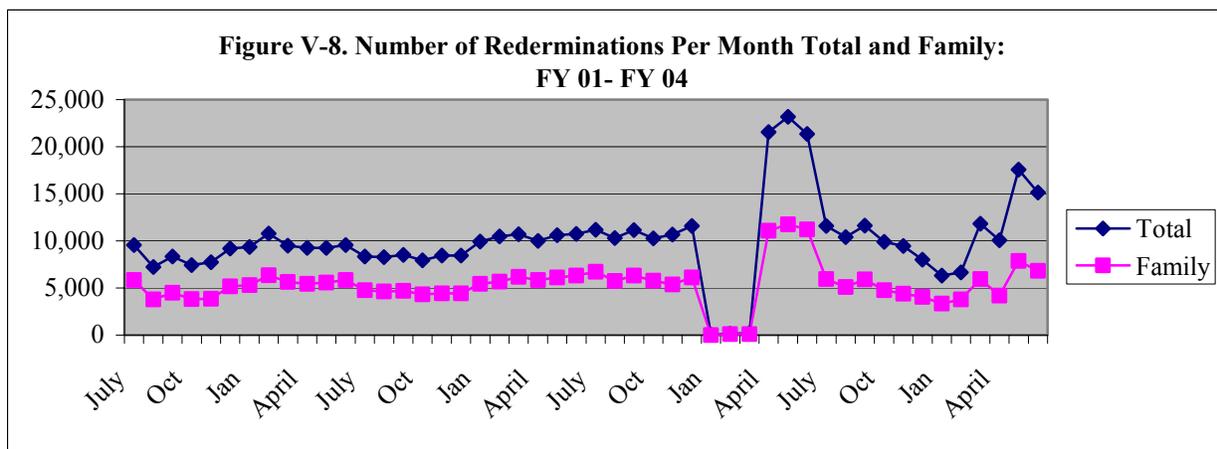
**Process.** The department’s automated eligibility management system (EMS) generates a notice to a Medicaid client about 75 days prior to the client’s 12-month expiration date. The notice is sent automatically by the system with the client’s eligibility information. The client must verify that nothing has changed with the information, and send the information back to the client’s case manager. The client can renew Medicaid eligibility by mail; he or she does not need to come to a DSS office.

The renewal information is supposed to be received by DSS 30 days after the notice is sent. If the information is not returned, and a renewal action is not entered into the EMS system by the caseworker, the system will generate a second notice to the client that the information has not been received and includes the benefit termination date. If needed, a third, final notice is sent two days prior to the termination date telling the client he/she is discontinued. However, the client, in effect, can be reinstated during a 10-day grace period following the termination date, without filing a new application.<sup>8</sup>

In addition, if eligibility has not been reestablished by the end of the redetermination period, DSS continues to provide Medicaid if it appears the client(s) will remain eligible if: 1) DSS is responsible for not completing the redetermination, or 2) the client has good cause, such as illness or other circumstances beyond the client's control. The caseworker enters a continuance code in the EMS system for that circumstance.

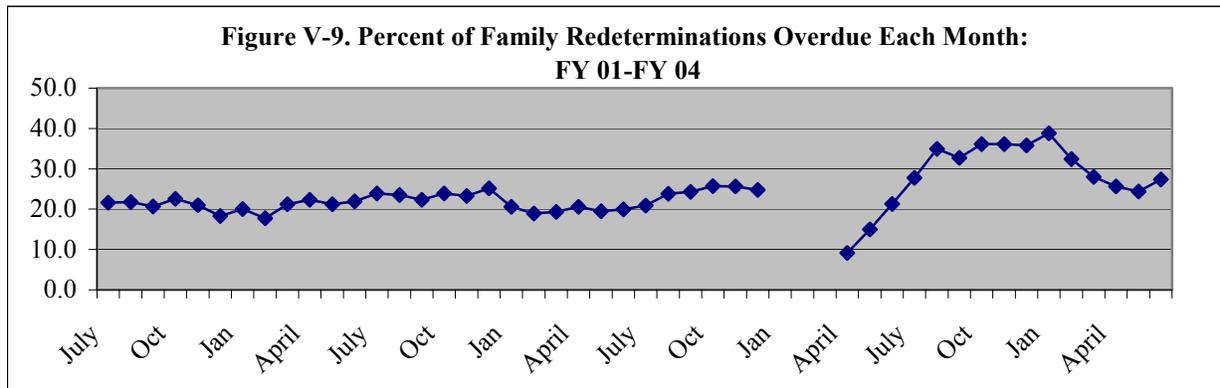
**Redetermination activity.** Figure V-8 shows Medicaid redetermination activity statewide for FYs 01 through 04, including the total for all programs and those for Family Medicaid. As the figure shows, the Family redeterminations generally track the total renewals over the period, and account for about half of all renewals.

As Figure V-8 shows, from January to March 2003, DSS suspended the issuance of renewals while the department closed offices and reduced and transferred staff. When the department resumed the redetermination process, the number of renewals spiked to more than 20,000 per month from April to June 2003.



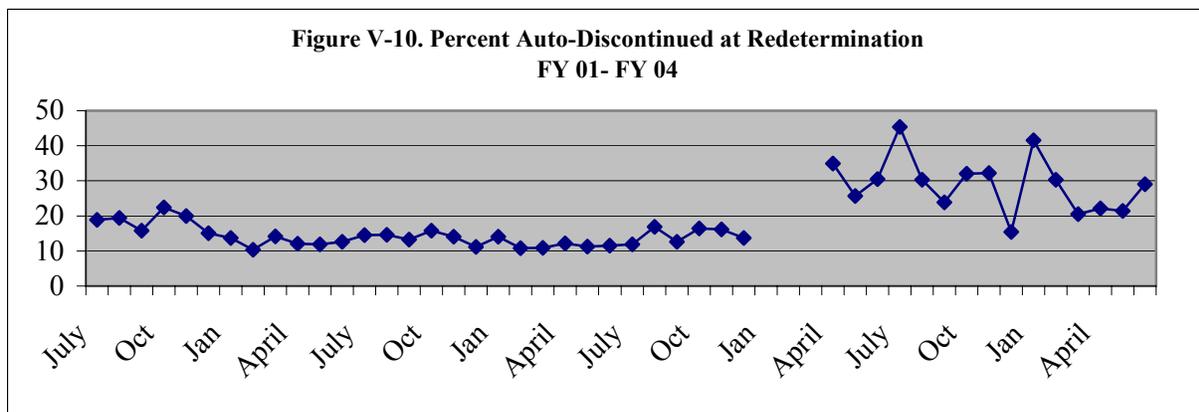
<sup>8</sup> The department is currently modifying its notification process for redeterminations, in response to concerns raised by legal and client advocates. For example, the second notice will inform the client benefits will be terminated in 10 days if the process is not completed. The third notice—the discontinuance – will no longer be issued.

Figure V-9 shows the percent of family Medicaid redeterminations overdue each month. Prior to the office closings and staff reductions, the percentage was typically between 20 to 25 percent. Following the resumption of redetermination processing in April 2003, the first few months had low overdue percentages, due to a lapse in issuing renewal notices. Between August 2003 and January 2004, the overdue renewals increased to between 35 and 40 percent, before declining to the more typical 25 percent level seen in previous months. (The period of renewal suspension appears as a break in the line in Figure V-9.)



Unlike with new applications, when renewals are overdue, the client remains eligible as long as the worker continues the case. However, this could mean that Medicaid payments are made during that overdue period for clients who later are determined ineligible. DSS does not have data to track how many clients with overdue renewals are later found ineligible.

**Automatic discontinuance.** One of the actions that can be taken in a redetermination case is that the system automatically discontinues the case because the client has not complied with the procedures to continue eligibility, most often not returning the renewal information as required. Figure V-10 shows the percentage of automatic discontinuances for family cases during FYs 01-04. Typically, automatic discontinuances had been steadily fewer than 15 percent of redetermination cases prior to January 2003. However, as the figure shows, once renewal issuances resumed in April 2003, the automatic discontinuances became much more erratic, and were generally more than 25 percent of redeterminations issued each month.



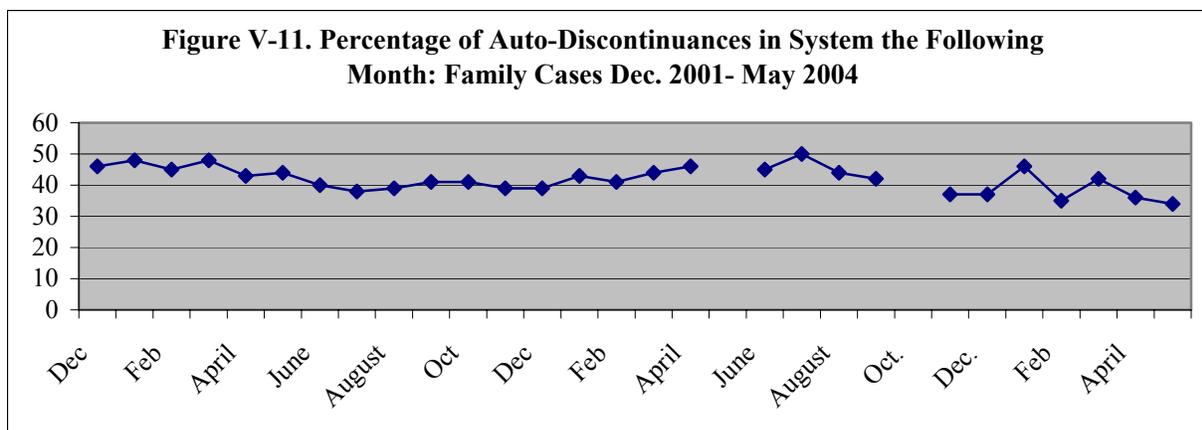
DSS provided a partial explanation for the increase in automatic discontinuances. Connecticut had a federal waiver that automatically placed families that did not submit the renewal information -- but whose increased income otherwise qualified them for a two-year Medicaid extension -- into that designated coverage group. That waiver ended in 2001, and since then there has been a gradual transition to automatically discontinuing families that do not submit the renewal information to qualify for the earning extension.

The committee believes another contributing factor is that, given the increasing workloads and staff reductions, eligibility staff are less likely to extend a case where the client has not completed the process necessary to redetermine the case. Without a worker's intervention to continue a case, EMS will automatically discontinue the case at the end of the redetermination period.

Further, once a worker continues a case, it is up to the worker to track the client's information to ensure it comes in; otherwise, the system continues the client as eligible indefinitely. At the same time, the system recognizes the redetermination as overdue. The more redetermination cases a worker extends without taking an eligibility action, the greater the cumulative percentage of redetermination cases that are overdue, as shown in Figure V-9.

**Return to system.** The automatic discontinuances can substantially reduce a caseworker's workload, with the EMS automatically taking the actions to discontinue a case when client does not return the renewal information. However, not all automatic discontinuances remain discontinued cases. If the client gets the information to the worker within 10 days after the final date of the redetermination, the case is reinstated without the client having to file a new application. If the client returns after the 10 days, a new application must be filed, and eligibility must be determined based on the information from the new application. Reinstatements and new applications create additional steps for the caseworker that could have been avoided had the client renewed before benefits terminated.

A client's return to the system the following month is not unusual. The percentage of cases that come back the month after being discontinued is tracked in Figure V-11. The figures shows between 40 to 50 percent of clients return to the system, within one month after an automatic discontinuance, although the last few months appear to be somewhat lower.



Further, these data only capture cases that return *the following month* after being automatically discontinued at redetermination. If the data on returning cases were tracked for a number of months, the percentage returning would likely be even higher.

## **Recommendations**

*The committee believes there needs to be more proactive steps taken before a redetermination case becomes overdue or is automatically discontinued, especially given the high percentage of cases that come back into the system the following month. The department is already working on some measures, while others need to be initiated.*

**Notices and Forms.** 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. DSS has been working with a consultant to revise some of its forms and notices. The committee believes, while probably all its notices should be examined, **DSS should first assess which notices are the most problematic in terms of creating client confusion and have the greatest impact on their eligibility.**

The department is planning to eliminate the last notice in the redetermination process –the termination. Instead, DSS plans to send the last reminder – with the termination date included – 10 days before termination. **The committee recommends that DSS 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.**

**Time management.** 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. In addition to retraining in program areas, the DSS training unit has already begun to work with supervisors and workers on “time management” and “priority setting”. These elements can be as important in workers efficiently and effectively processing applications as their knowledge of program policy and procedures. However, most training is not mandatory, and workers cannot be evaluated on participation in training.

**The committee recommends where possible, supervisors and trainers bring that type of training directly to the workers, especially those who need it, 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.**

The eligibility management system 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. These “worker alerts” also need to be addressed to be of more benefit to a worker’s processing and maintaining a case. **DSS should form a work group, with**

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**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.**

***Case information.*** 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. **DSS must ensure workers use all means to keep both case files, including EMS case notes, and client information current. Specific recommendations in this area are discussed in other chapters of the report.**

***Overdue redeterminations.*** 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.

***Management analysis.*** 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.

## **Change of Address**

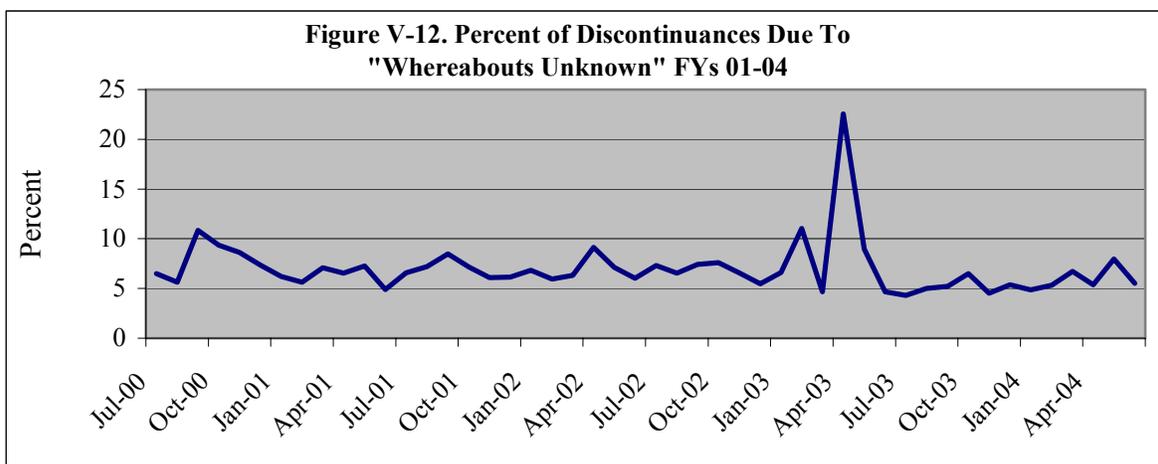
Application processing, and assessing clients’ continued eligibility, is reliant on maintaining current information about clients, including where they live. Clients are required to notify DSS if any pertinent information, including a change in address, occurs; however, many do not.

Committee staff visits to DSS district offices revealed the offices experience a large volume of mail returned as “undeliverable.” The main reason mail is returned is because it was sent to the address on record but the client was no longer living there.

If a mailing comes back as undeliverable, DSS makes a second attempt to contact a client by mail. If the client cannot be reached, the caseworker will enter a “whereabouts unknown” discontinuance code onto EMS and the client’s benefits will be discontinued. Further, a discontinuance for any assistance program the client is on will affect benefits in all programs. For example, if a client’s food stamps notice comes back twice as undeliverable, that client will not only be discontinued from food stamps, but any other assistance the client receives, including Medicaid.

Committee staff analyzed monthly EMS discontinuance data for family Medicaid for FYs 01-04 to determine how many clients are discontinued due to “whereabouts unknown” (i.e., address changes). The monthly reports on total discontinuances include households (or assistance units) who are discontinued from one Medicaid coverage group but then transferred to another group due to a change in the client’s circumstances. Committee staff excluded these “transfers” from the overall analysis since Medicaid coverage was not actually discontinued.

Figure V-12 shows, over the period analyzed, a monthly average of seven percent of client households had their medical benefits discontinued because their whereabouts could not be determined. Overall, discontinuances due to whereabouts unknown remained relatively constant over the period. However, the dramatic increase in Spring 2003 coincided with the department’s suspension, and subsequent resumption of redeterminations and is not indicative of the overall period analyzed.



As mentioned, clients are required to contact their DSS eligibility worker with any address change, although this is not always done. Instead, clients may contact their managed care organization directly to report changes. Also, at the time of medical service, clients may tell their provider of an address change in response to a standard updating of information requested by providers. The provider may then contact the client’s managed care organization regarding the change. Address changes may also come through Affiliate Computer Services – the state’s Medicaid managed care enrollment broker.

Several years ago, DSS developed procedures whereby clients would report address changes using a post card system. The system was designed to have the post cards available in different locations (e.g., doctors’ offices) so family Medicaid clients could quickly indicate their address changes and send the card back to DSS. The post cards would be sent to the department’s central processing unit. The unit, which processed presumptive eligibility applications for children, would then enter any changes onto the department’s eligibility management system. The procedures were never implemented because the central processing unit was eliminated due to staff layoffs.

At present, there is no system between either ACS or managed care organizations (MCOs) and DSS – including electronic interface – to exchange client address change information. DSS has been reluctant in the past to allow non-state entities access to its eligibility management system. However, without some type of interface between DSS and either the state’s enrollment broker or MCOs, the department may not have the most current addresses for its clients if any changes were reported to either entity and not to DSS.

This issue has been a frequent discussion topic of the Medicaid Managed Care Council’s Consumer Access Subcommittee. Program review staff attended subcommittee meetings throughout the year when the address change issue was discussed. At one point, one MCO (Community Health Network (CHN)) was going to try a test project using a post card process whereby clients reporting address changes to the MCO would be sent a post card reminding them to contact their DSS caseworker with the change, but the plan never fully materialized.

The subcommittee was recently presented a proposal by DSS to have the department and CHN develop a pilot program for exchanging address information. The concept being discussed is that CHN, by early 2005, through limited access to various EMS screens, would be able to verify addresses against its records and then electronically transmit any changes through an EMS “alert” directly to the client’s DSS eligibility services worker. The caseworker would manually update EMS with the new address. The MCO would then reconcile client information using the next enrollment reports received from DSS (usually within 30-45 days) to see if the change was made. If the worker did not update EMS, a list of client address changes would be sent to the central DSS Family Services division where a worker would update EMS.

At this time, DSS management information systems staff is currently in the process of establishing CHN’s access to EMS and testing the applicable EMS screens necessary to begin the project. CHN already has limited access to EMS for its work within the SAGA program, a key reason CHN is being used for the address change pilot program.

Although the test project for the address change interface is being planned to include DSS and an MCO, the committee believes ACS, as the state’s Medicaid managed care enrollment broker, should have the interface with DSS and be assigned specific responsibility for ensuring client address changes are made. ACS may be the most effective and efficient source of information given it is responsible for maintaining client information for all enrollees, and not those limited to a particular MCO.

**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.**

**Rationale.** The committee believes the initiative to allow an outside entity limited access to EMS is a positive move toward more efficiently updating address changes. However, a centralized and comprehensive address change process through the state’s enrollment broker, rather than the decentralized one being pursued by DSS, is preferable for several reasons. First, eligibility service workers do not need to have their workload increased. Workers currently receive numerous “alerts” through the EMS e-mail system as a way to manage their client workload. The proposed pilot program would have an MCO sending an eligibility worker an e-mail every time an address change occurs for clients within that worker’s caseload. Given the number of messages workers currently receive through EMS, address updates sent directly from MCOs may not receive immediate attention from workers and would then be processed by DSS central office staff anyway under the current pilot program.

Second, updating address changes through EMS is strictly an administrative function. Eligibility workers should be relieved of as many extraneous administrative functions as possible, allowing them to focus more on eligibility determination and client service. Since updating addresses is not an eligibility issue, the function should be done by a data processing technician on a centralized basis, similar to the system used by DSS to add newborns onto EMS.

Third, implementation of this recommendation would give the department and the enrollment broker more control than with the decentralized one proposed. Also, communication and coordination would be targeted to DSS and the enrollment broker only, instead of involving multiple MCOs under a decentralized process. Centralization and single responsibility would further increase overall efficiency and effectiveness. It would also help solve DSS’ issue with providing too many non-state entities access to EMS.

CHN currently serves about 54,000 of the 307,000 Medicaid and TFA clients enrolled in managed care organizations, or approximately 18 percent of all enrollees. CHN receives about 200 address changes per week from its members. Expanding this experience to the entire family Medicaid population, committee staff estimates 5,000 assistance units change addresses per month, which translates roughly to four percent of the family Medicaid assistance units requesting address changes in any given month. Thus, DSS should anticipate receiving about 250 address changes per day once the electronic interface process for address changes is fully implemented.

The committee believes DSS should be able to implement the recommended address change process within existing staff resources. However, if, after six months, the department determines an additional staff person is necessary, it should submit a formal request for additional staff through the budget process.

The committee also believes there should be cost savings associated with a new process. A more efficient process should reduce the number of redetermination forms sent to wrong addresses, thus lessening the number of new applications submitted by clients who did not contact DSS within the requisite time period and decreasing eligibility workers’ time spent to process those new applications.

## DSS Staffing Losses

### 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-7 shows the impact of the layoffs and ERIPs on DSS' workforce compared to other state agencies. Table V-7 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 used for comparison.

<i>Table V-7. Comparison of Staff Reductions in State Agencies</i>			
<b>Agency</b>	<b>FY 03</b>	<b>FY 05</b>	<b>% Reduction</b>
State Library	90	61	32.22
<b>DSS</b>	<b>2,239</b>	<b>1,692</b>	<b>24.43</b>
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
<b>Totals</b>	<b>28,252</b>	<b>25,352</b>	<b>10.2</b>

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**

One 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-7 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.

**Refill rates.** The budget reduction from ERIP was expected from two sources. First, not all positions lost to early retirement would be refilled, and second, those positions allowed to be refilled would be refilled at lower salary levels.

The Office of Policy and Management established two ERIP refill rates. For direct care or hazardous duty workers, three of four positions could be refilled; for all other positions, only one in three workers. OPM required agencies to submit plans on how the refills would be implemented. The only other factor considered in the refill rate was if a position was totally federally funded. If so, the position was exempt from the agency's rate. However, if there was only partial federal reimbursement, that position was considered in the overall refill ratio.

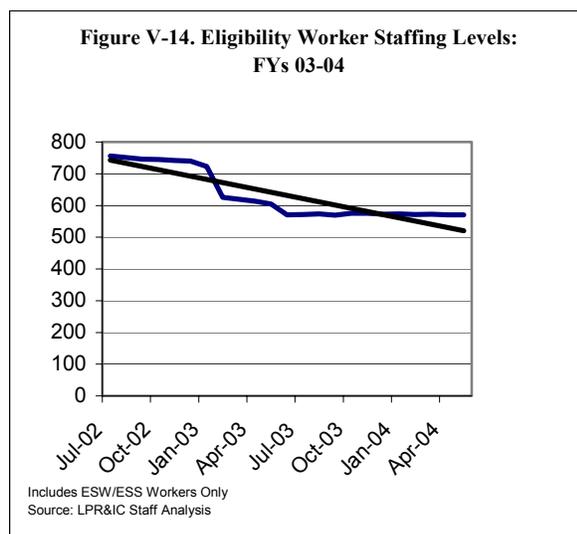
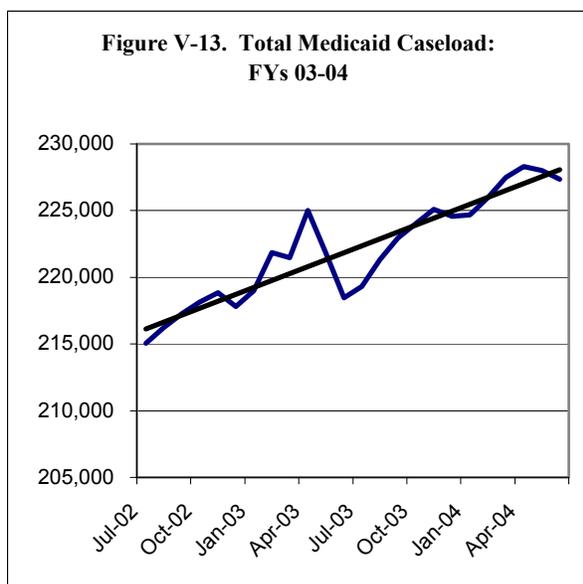
Exemptions and agency compliance with ERIP refill rates have varied. Further, it was up to agencies outside the executive branch, or those operating under judicial consent decrees, whether to comply with refill plans or not. According to OPM, certain agencies have not complied.

DSS had 295 employees take early retirement, 96 of them in the eligibility worker classes. DSS was allowed a refill rate of one in three; 207 positions were cancelled agency-wide. *However, only 46 of the cancelled positions were in the eligibility classes -- worker, specialist, and supervisor—meaning in those classes, about 50 positions (one in two) were refilled.*

There are a number of reasons for the higher refill rate among eligibility classes. First, *DSS was allowed to refill some eligibility worker positions lost to ERIP on an emergency basis, before an ERIP plan was submitted to OPM. Second, the vast majority of the refills in the three classes were filled at the worker (i.e., lowest) level. For example, only one specialist position, of the 21 ERIP losses, was refilled at that level, and only two of the 17 supervisor positions lost to ERIP were refilled at that level. Third, while DSS has refilled a higher rate of its eligibility worker positions lost to ERIP (about 1 in 2), it has had to consequently refill fewer in the rest of the department (1 in 5).*

### Impact on Workload

Figure V-13 shows Connecticut’s total Medicaid caseload for FY 03 and FY 04 increased from 215,000 to 228,000 households (6 percent). Figure V-14 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.

Since the beginning of FY 03, DSS has seen its staff reduced 25 percent agency-wide as a result of layoffs and early retirements. Assessing whether DSS has taken a deeper cut than most agencies, and whether eligibility workers are especially impacted, is somewhat difficult to determine because of lack of clear comparative data before and after the reduction in the state employees workforce.

*Based on personnel data available, the committee concludes that staff reductions were deeper in DSS than the statewide average and in many large state agencies. DSS has refilled many more of its allowed position refills where they have a higher impact on client services – in the eligibility classes-but the department has had to absorb a higher level of lost positions in the rest of the agency.*

*The full impact of staff reductions in DSS is difficult to quantify, but as the analysis above indicates, it has resulted in a considerable increase in per-worker caseload. Further, staff reductions in the eligibility classes, along with office closings, and worker and client caseload transfers, have led to poor morale, which numbers cannot measure.*

*The committee also finds staffing reductions have contributed to increasing processing times; statewide, overdue applications for all Medicaid programs has increased from 10 percent of pending applications in FY 01 to 16 percent in FY 04.*

*The program review committee believes more of the position cuts due to ERIP should be restored. Greater weight should have been placed on refilling positions that deal directly with clients, as eligibility workers do. If a third refill rate -- in the middle of the two used -- had been established allowing a 2 for 3 refill rate for eligibility workers only, DSS would have been able to refill 64 positions rather than 50. Thus, committee believes the 14 positions recommended below would get the eligibility class to that refill rate.*

*Further, the program review committee believes that OPM should have considered the federal reimbursement levels in the refill rates it allowed. Since eligibility worker costs are reimbursable at 50 percent, this class should have been allowed a higher refill rate than the original 1 for 3, without impacting the rest of DSS' ratio.*

*To bring the refill rate for the eligibility classes to a more realistic ratio of 2 for 3, the committee recommends that 14 positions in the eligibility classes be restored.*

**Rationale.** The committee does not propose that eligibility worker staffing return to pre-layoff and ERIP levels for two reasons. First, office variations in performance, as discussed previously, indicate staffing levels may not be the entire cause of problems in application processing. Second, the layoffs were part of collective bargaining negotiations. Workers

affected made an informed decision recognizing the impact on their employment status and workload if a compromise on wage concessions could not be reached. The committee believes replacement of those positions would circumvent that process.

**Cost.** Program review estimates the recommended restoration of staff will cost approximately \$1 million, half of which should be reimbursable by the federal government. The committee estimates each eligibility worker salary to be about \$50,000 (mid-range of the job class of eligibility specialist) plus 40 percent fringe. At \$70,000 per position x 14 positions, the total is \$980,000.

**Outstationed workers.** Federal law allows the state Medicaid agency to place workers who can determine eligibility at hospitals and other locations where Medicaid applicants are likely to seek medical services. In FY 02, there were 10 such outstationed workers, who were counted in the overall DSS staffing numbers. Currently, there are eight; the reductions in those staff are included in the analysis above.

DSS is planning to restore some of the outstationed workers, but intends to begin with placing them in nursing homes. These workers would be able to process Medicaid long-term care applications only, which should help reduce the backlog of those applications and decrease the percentage of overdue long-term care cases.

## **DSS Efforts After Staffing Reductions**

The Department of Social Services has initiated other efforts to mitigate the impact of staffing reductions and caseload increases. Some have been more successful than others, and other efforts have just begun so their success is yet undetermined.

**Staff equalization.** 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. *Overall, DSS’ efforts to balance the staffing and caseload have been successful. As shown earlier, caseload and staffing ratios of the state totals for FY 04 are less than one percent apart in every district office.*

**Dedicated processing time.** The committee believes the “*dedicated processing time*” initiated in all offices in FY 03 is a necessary and effective strategy in managing greater workloads with fewer resources. This strategy dedicates two afternoons a week for caseworkers to process applications and make eligibility determinations only, without interruption of phone calls or appointments. This is an efficient and productive way to conduct business -- all eligibility workers are performing this function at the same time and distractions are minimized, allowing all workers to focus solely on processing applications and determining eligibility.

The committee believes, however, the dedicated processing time initiative should have been better communicated. Poor communication by DSS about dedicated processing time left clients, advocacy groups and others with a perception that offices were *closed* during that time. As noted earlier in this report, offices are not closed and most transactions can still take place; the caseworker is just not available to the client during those hours.

Perhaps enough time has passed since the initiation of this strategy so that all parties have a clear perception of dedicated processing time and its purpose. However, DSS should continue to provide communication about dedicated processing time, its purpose, and the benefits of quicker eligibility determination to clients. Signs are posted in most offices alerting the public to the dedicated processing times, but are not consistent in their information.

**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.**

**Reducing office traffic.** Many transactions do not require a client to come to the office. For example, Medicaid does not require a face-to-face interview to file an application or have benefits renewed. Clients often need to use public transportation, which can be time-consuming, inconvenient, and costly. Further, unnecessary walk-in traffic at DSS offices can delay regularly scheduled appointments, contribute to waiting room congestion, add to security concerns, and cause client frustration. Every attempt should be made to lessen the necessity for clients to come to a DSS office.

**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.**

**Human Services Infrastructure initiative.** Another strategy developed by DSS to lessen the impact of staff reductions and office closures has been what DSS calls the “Human Services Infrastructure” initiative, or HSI. This initiative is a collaborative effort between the department and the community action agencies (CAAs), entities largely funded through federal community service block grant funds. The entire initiative is fairly comprehensive and long-term. However, some of the shorter-term efforts, such as CAAs helping clients with the application processing to lessen the DSS workload, appear to be unsuccessful.

Program review obtained samples of the memoranda of understanding (MOU) between DSS district offices and the local CAAs. The agreements call for an HSI liaison to be appointed from each DSS office and CAA. According to committee staff interviews with district office staff, these liaisons have all been appointed.

The MOUs also require the CAAs to: 1) assist customers in completing DSS application forms; 2) collect the required documentation for DSS to determine eligibility; and 3) complete the HSI referral form, along with the application and documents, and transmit to DSS.

DSS provided program review with aggregate data on the referrals made by the CAAs to DSS offices. Statewide, for the quarter from July 1 to September 30, 2004, the 12 CAAs made 214 referrals to DSS for all assistance programs. Given that DSS receives approximately 14,000 Medicaid applications a month, the 214 referrals represent less than one percent. This confirms what committee staff heard anecdotally when it conducted DSS office visits during the summer and fall. All offices reported extremely low referral activity, and indicated deficiencies in the quality and completeness of applications referred.

DSS district staff believe that, in most instances, clients being served by the CAAs are already receiving DSS services, hence the low referral numbers. Also, federal regulations allow only state or county staff to determine eligibility, so the CAA can only transfer the applications to DSS for eligibility determination. But, if the CAAs are not transferring complete applications, this does not lessen DSS' work or save workers' time. However, the committee tabled recommendations that would have changed the functions in the existing contracts and memoranda of agreements between the Department of Social Services and the community action agencies.

***Flexible hours.*** In October 2004, DSS administration began to allow workers more flexible schedules, resulting from an memorandum of understanding between the state and the union representing eligibility workers. The flexible schedule includes a four-day workweek (Wednesdays off), with extended hours for those four days, or working a five-day workweek, with earlier or later than regular hours of business. Early indications are this might not have been coordinated well with other department operations and may have negative outcomes.

For example, while workers might start at 7:00 a.m., the computer systems are not available to workers until 8:00 a.m. Similarly, computer systems are not available to anyone working after 5:00 p.m. While the MIS division is working on extending the hours of computer operations, it has not yet occurred.

In addition, scheduling flexible work hours for workers adds to the responsibilities of supervisors, who are already supervising more people since layoffs and early retirements. Establishing office-area and functional coverage with fewer workers available during the normal business hours becomes a scheduling and management dilemma. Further, many of the contacts an eligibility worker needs to make – calling for medical records, or calling other agencies, banks, nursing homes – would seem more accessible during regular hours. Workers in the building before and after regular hours may also add to the security issues. The committee believes attempts should be made to maintain good labor relations, but that the ultimate objective to serve clients efficiently and effectively should not be sacrificed either.

## **Eligibility Determination by Program**

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. However, the criteria for each group, the manner in which the criteria are verified, and who can determine eligibility all vary. These factors all impact the application processing and timeliness of the determination. This section describes and analyzes the application processing and eligibility decisions for several groups in the family Medicaid program, and long-term care.

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## **Presumptive Eligibility for Pregnant Women**

Federal law allows states to include in their state Medicaid plans the option of providing ambulatory prenatal care services to pregnant women during a temporary period of presumptive eligibility (PE), as long as the applicant's gross family income does not exceed the applicable income level of eligibility under the state plan.

Presumptive eligibility means that eligibility has not been determined, but is granted on a temporary basis. Federal guidelines allow qualified entities, as defined in law, to determine whether a person is "presumptively" eligible for covered services. Examples of qualified entities include those: 1) eligible for Medicaid payments under the state plan; 2) providing services comparable to outpatient hospitals, rural health clinics, or clinics under the direction of a physician and determined by the state to be capable of making PE determinations; 3) receiving federal funds (e.g., mobile health centers or community health centers); or 4) participating in particular federal supplemental food programs, including schools.

The presumptive eligibility period begins on the date a qualified entity determines the pregnant woman meets the minimum income criterion for presumptive eligibility. PE ends the earlier of: 1) the day full Medicaid eligibility is determined if an application is filed; or 2) the last day of the following month when PE was determined if an application for full Medicaid is not filed.

Qualified entities have five working days after the PE determination date to notify the applicable state agency that presumptive eligibility was granted. Federal law also requires qualified entities to inform the pregnant woman at the time PE is determined that a full application for Medicaid is required no later than the end of the month following in which PE date was determined.

During the PE period, a pregnant woman may receive prenatal ambulatory care services. If a pregnant woman is later determined ineligible for full Medicaid, federal reimbursement is still available for services rendered during the time of presumptive eligibility.

### **Connecticut Requirements**

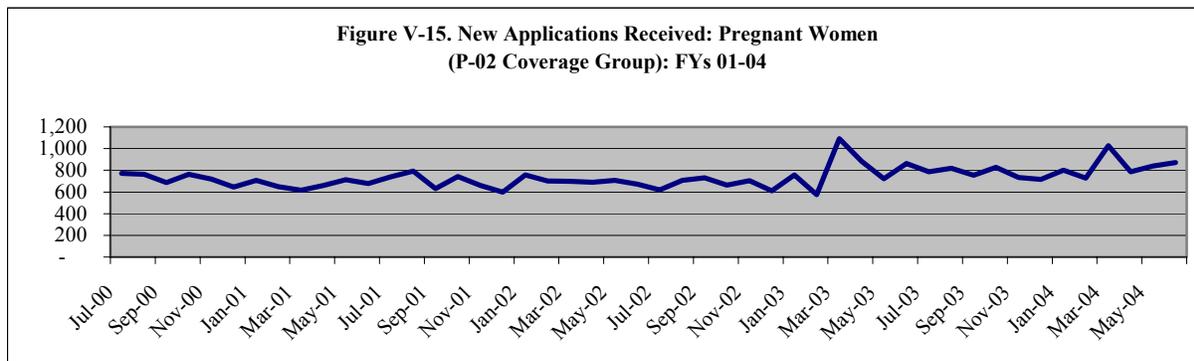
Connecticut law requires DSS to implement "presumptive eligibility" for pregnant women in accordance with applicable federal law and regulations. However, Connecticut has never included the option of presumptive eligibility, as described above, in its state Medicaid plan. The state law requiring presumptive eligibility determinations for pregnant women went into effect September 1991. At that time, DSS administration decided not to implement the option of presumptive eligibility as outlined in federal law.

**DSS system for processing pregnant women applications.** *DSS, through its policies and procedures, implements a system of "expedited eligibility" for pregnant women applying for medical coverage. The DSS system is not based on the federal model of presumptive eligibility.*

DSS policy states pregnant women with incomes not exceeding 185 percent of the federal poverty level must be granted Medicaid benefits within one day from when required minimum information is received. The minimum information includes applicant identity (including citizenship status), proof of pregnancy, and family income. By policy, verification from the applicant is required if the declared income is more than 85 percent of the income limit, even though the department, since 2001, has accepted self-declared statements of income from applicants.

Applicants have 30 days from the date of application to submit all minimum required information. If the minimum information is not received by DSS by the deadline, eligibility is denied. Eligibility determination by DSS must be made no later than the day after receipt of the required minimum information. Once granted, the client is placed in a separate Medicaid coverage group for pregnant women (i.e., P-02).

**Application activity.** Figure V-15 shows the number of new applications received monthly by DSS under the P-02 coverage group for fiscal years 2001-2004. The department received an average of 737 applications per month during that period. The overall trend of applications received has generally ranged around 700 per month, but increased during FY 04 to roughly 800 applications a month.



Committee staff planned to analyze the overall timeliness of processing pregnant woman applications. However, *there is no management report regularly produced by EMS or analyzed by the department showing the length of time taken to process applications for pregnant women, whether processing times are consistent with the department’s standard that all minimum required information be submitted within 30 days, or whether eligibility decisions are made within one day from when the minimum information is received.*

DSS created an “ad hoc” report for program review from its eligibility management system showing the length of time taken to process pregnant women applications in October 2004. The department measured the number of days from the date of application to the application disposition date. Table V-8 shows the results.

<b>Table V-8. Pregnant Women Application Processing Times: October 2004*</b>							
	<b>Days to Process: From application date to disposition date</b>						
Disposition	<b>0 to 4</b>	<b>5 to 7</b>	<b>8 to 10</b>	<b>11 to 15</b>	<b>16 to 30</b>	<b>Over 30</b>	<b>Totals</b>
Granted	156	70	39	51	84	86	486
Denied	62	25	12	23	74	160	356
Other**	2	1		2	5	18	28
Totals	220	96	51	76	163	264	870
*P-02 coverage group only.							
**Other includes cancelled and withdrawn applications.							
Source: LPR&IC Staff Analysis of DSS Data.							

Table V-8 shows, of the total 870 dispositions for pregnant women applications in October 2004, 606 dispositions (70 percent) were within the 30-day limit established by DSS for applicants to submit the minimum required information of proof of pregnancy, income, and citizenship status.<sup>9</sup> What cannot be determined from the data, however, is the actual time DSS took to process the applications and whether the one-day processing time policy was followed.

The table also shows dispositions for 264 applicants (30 percent) were made beyond 30 days, meaning either the minimum information was not submitted within the required timeframe or DSS did not process the application on time if the information was submitted within the 30-day limit.

Of the 486 applications *granted* eligibility, 400 (82 percent) were made within 30 days of the application date, meaning the required information was submitted on time. This also indicates the remaining 18 percent of applicants granted eligibility beyond the 30 days, were either given extensions to the expedited eligibility period, which is not provided for in policy, or the proper information was submitted within the 30-day period and DSS took longer than the required one day to grant the case (except those processed by day 31).

Of the 356 applications *denied* eligibility, 196 (55 percent) were denied – based on the application information – within the 30-day limit. The remaining 160 applications (45 percent) were denied eligibility beyond 30 days. Further complicating the denial rates for the P-02 coverage group is the fact that women who do not have legal immigrant status are not eligible for full Medicaid, or even for prenatal care or other services under P-02, but are eligible for the labor and delivery services under P-02 emergency care. Due to the way EMS is designed, the woman would be granted Medicaid for the month her baby was born to cover the medical services provided at that time, but then denied benefits for the following month because she would not meet citizenship requirements to continue Medicaid coverage. The case would be recorded as denied.

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<sup>9</sup> The data are only for one month and may not be wholly indicative of processing times over a longer period of time. However, this issue has been under examination since this study began and committee staff believes the timeliness issue would have improved by October 2004.

Upon further review by DSS, the department concluded the vast majority of denials was due to non-citizens receiving emergency services the prior month and then denied Medicaid in the current month. Given this, the percentage of pregnant women application denials would actually be lower, since women are in fact *granted P-02 eligibility* for emergency labor and delivery services in that month and then *denied* under P-02 coverage the following month.

*There is no formal policy or procedure directing eligibility workers to send notices to pregnant applicants indicating missing information for eligibility. The central office notes that practices regarding contacting applicants vary among district offices – some offices send notices, while others do not.*

In interviews with committee staff, DSS district office managers and supervisors confirmed *timeframes vary as to how quickly applications for pregnant women are processed once the minimum required information is received*, ranging from roughly several days to several weeks. Other offices noted their processing times are within the required one-day turnaround.

*The department does not differentiate assistance applications for pregnant women from the regular HUSKY applications it receives. Historically, applications from Healthy Start programs had included a special stamp alerting workers the applications were for pregnant women. This process is no longer used due to the decline in the number of Healthy Start programs. Without a quick way to clearly distinguish applications for pregnant women for expedited processing, the chances increase that such applications could be overlooked during the normal course of business and not processed as quickly as required.*

*Many DSS policies and procedures for processing pregnant women applications have not been updated since 1991, and at least one important policy – requiring income verification beyond a certain level – is outdated since the department began accepting self-declared statements of income based on federal requirements and does not reflect current practice.*

Because of the regional differences in policy implementation, the DSS central office sent written clarification in early 2004 to its regions regarding the department's one-day processing time for applications. According to committee staff interviews with district office managers and supervisors, and staff analysis of processing times, however, the notification has not worked and "expedited eligibility" is not occurring in many instances for pregnant women applications.

Based on the above analysis, the committee recommends:

- **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.**
- **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 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.**
- **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.**
- **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.**
- **DSS should emphasize to providers that complete applications are a key component to determining eligibility and having services covered for payment.**
- **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.**

**Rationale.** The committee believes clarification of the “expedited eligibility” for pregnant women policy, emphasis on qualified entities submitting complete applications for their clients, and more proactive steps by DSS prior to denying applications, should ensure more complete applications, a greater percentage of applicants granted eligibility, and an increase in medical coverage for pregnant women.

With regard to processing timeframes, though, committee staff did not do a file review to determine processing times among all the district offices, staff believes the recommended five-day determination period provides a more realistic timeframe than the one-day standard in place for offices to process pregnant women applications. The extended period is necessary given variations in current processing times, cuts in the number of eligibility determination workers, and an increase in overall caseloads.

The committee also believes moving to the expedited eligibility determination process is preferable to a system of presumptive eligibility for pregnant women, given the information staff received from the department regarding reasons for the high denial rate occurring in October 2004. As well, assigning presumptive eligibility to entities other than DSS could increase the number of applicants without legal citizenship status receiving Medicaid benefits on a presumptive basis. DSS also indicates full Medicaid benefits are available to pregnant women under the state's expedited eligibility system, whereby only ambulatory prenatal care benefits are available under the federal guidelines for presumptive eligibility.

## **Newborns**

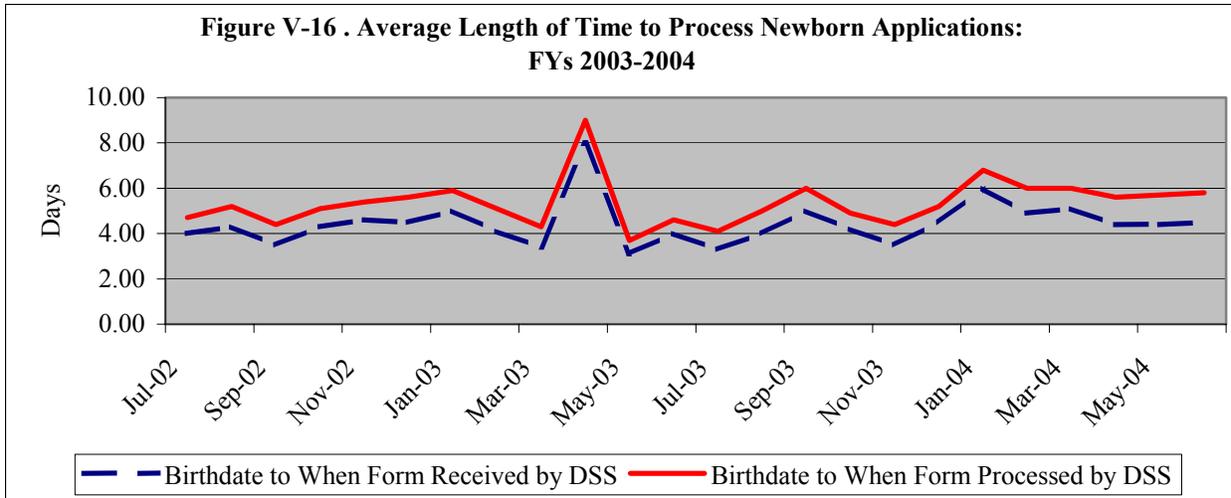
DSS has a centralized process in place to enroll newborns, whereby upon the birth of a child, hospitals have a maximum of five days to fax the required newborn Medicaid request form to a central newborn unit within DSS. DSS processing technicians within the unit are responsible for processing the forms, ensuring the mothers are already receiving assistance through either Medicaid or TANF, and entering the appropriate information onto the department's eligibility management system. The newborn unit cannot grant or deny eligibility, but only add newborn information to the system, which guarantees hospitals payment for the service related to the birth. Further, EMS issues a client identification number for each newborn eligible for Medicaid. The number is put on the form, which is faxed back to the hospital.

If a mother is not already receiving assistance, the central unit notifies the hospital. The unit also sends a weekly list of new mothers not receiving Medicaid to district offices for follow-up by caseworkers. The DSS district office will then send an application to the new mother. If the hospital has an outstationed worker, the worker may initiate the application process for the mother.

A separate database containing relevant information about the newborn application process is maintained by the central unit. The database tracks various factors, including the length of time it takes hospitals to submit the forms and DSS to process them and provide coverage for the newborns. DSS notifies hospitals on a quarterly basis as to how well they are processing newborn forms. More frequent communication occurs if necessary.

Committee staff analyzed the unit's data to determine if there are delays in processing newborn applications and where those delays may occur. Figure V-16 shows: 1) the average length of time all hospitals took to submit the required form to DSS following a birth; and 2) the overall time taken from the date of a child's birth to when the request form is processed by DSS and a client Medicaid number is determined for the child.

*As the figure shows, the amount of time hospitals took to submit newborn Medicaid eligibility forms for FYs 2003 and 2004 averaged 4.4 days. This average is below the unit's required standard of five days. On average, it then took DSS 0.9 days to process the forms. Thus, the overall process, from date of birth to when DSS processes the newborn application form, averaged 5.4 days for FYs 2003-04. Therefore, the committee found the process for enrolling newborns on the Medicaid program is performed in a timely manner.*



The figure also shows an increase in early 2003 and again in early 2004 in the time hospitals took to submit the newborn forms. The DSS central newborn unit notes, and committee staff confirmed during its district office visits, that *state layoffs and early retirements, and the elimination of the department's central unit for processing presumptive eligibility for children, caused confusion among some hospitals regarding the process used to file newborn applications and where they should be sent. To lessen the confusion, the newborn unit contacted hospitals to clarify the process. Since early 2004, the time factors highlighted in the above figure have recovered and remained relatively steady.*

## Continuous Eligibility for Children

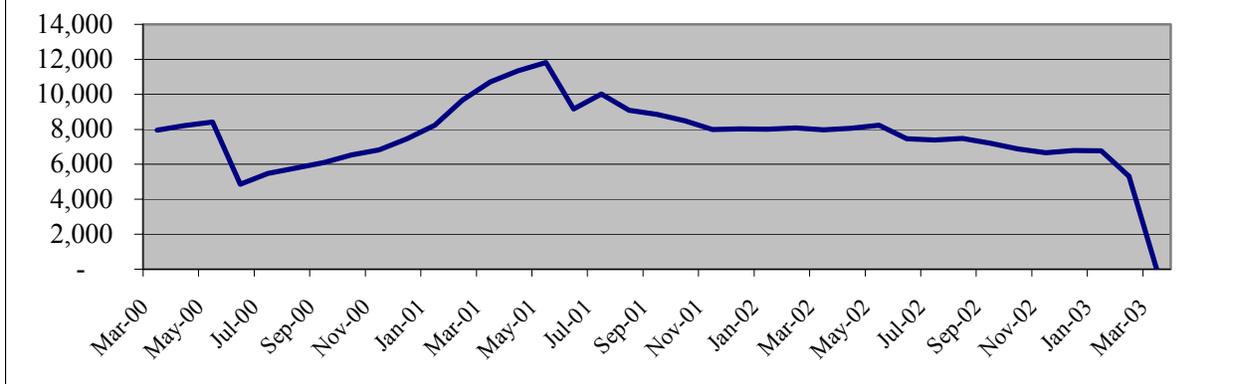
Federal law give states the option in their state Medicaid plan to allow children to retain medical coverage for up to 12 months after their enrollment or renewal, regardless of a change in family circumstances that might affect eligibility. "Continuous eligibility" (CE) was devised to promote continuity of care and assure families, providers, and managed care plans that coverage would be maintained for a predictable period of time.

Connecticut included continuous eligibility as an optional coverage group in its state Medicaid plan effective July 1998. By policy, CE allowed children under age 19 and enrolled in HUSKY to remain eligible for coverage for up to 12 months from the date a child was determined eligible. In practice, the DSS eligibility management system used CE as the last coverage group before a child would be discontinued from HUSKY A.

As a budget reduction measure, the CE program was eliminated by the legislature effective March 2003, with an estimated cost savings of \$11.9 million for FYs 04-05.

**Continuous eligibility activity.** Committee staff examined EMS reports for the continuous eligibility coverage group to identify the total number of children covered. Data for the three-year period from March 2000 through March 2003, when CE was eliminated, were analyzed. Figure V-17 shows the results.

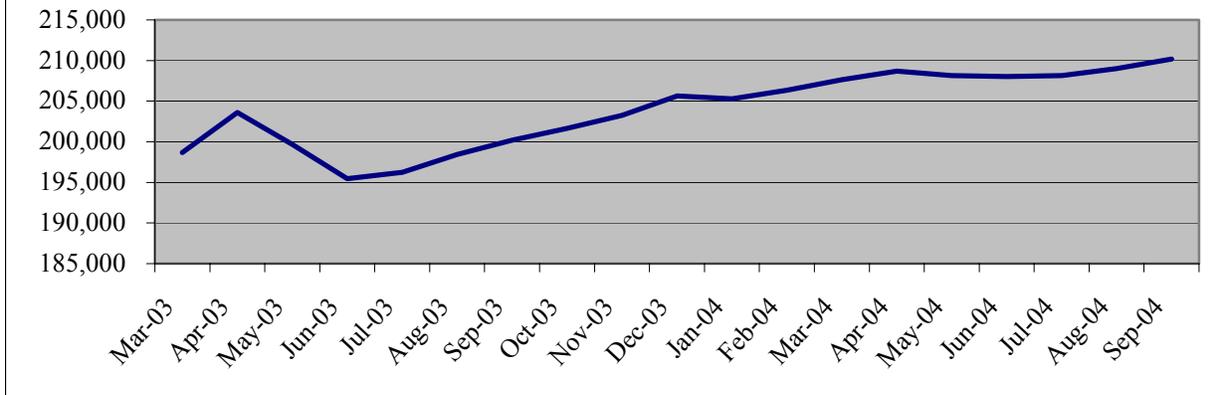
**Figure V-17. Continuous Eligibility Recipients:  
March 2000-March 2003**



The figure shows the number of children receiving medical benefits under the continuous eligibility coverage group between March 2000 and March 2003 reached a peak of 12,000 children in mid-2001. For the full three-year period, however, the trend of children covered under continuous eligibility gradually declined, and only 5,300 children were receiving medical benefits in February 2003, just prior to when the program ended. *On average, 7,900 children a month received benefits over the time span analyzed. Data for that time period showed children receiving CE each month averaged 4.2 percent of the total HUSKY recipients under age 19. Since continuous eligibility was the last coverage group selected for children, one assumes those children would have lost their coverage except for the existence of continuous eligibility.*

Committee staff also examined the total number of HUSKY A recipients (under age 19) to see if there was a decline in recipients following the discontinuation of the CE program. Figure V-18 shows *there was a decline of about 8,200 (4 percent) HUSKY A recipients under age 19 from March 2003 to June 2003, the months immediately following the termination of the continuous eligibility program.* This decline would be expected given 5,300 clients were receiving medical coverage through CE at that time the program ended. However, that decline was short-lived. Beginning in June 2003, the number of HUSKY recipients began steadily increasing through September 2004. *Thus, while it is clear there was a sharp drop in HUSKY recipients in the several months immediately following the termination of CE, it is difficult to quantify how many of those children eventually became eligible for HUSKY A at a later time or were enrolled in HUSKY B.*

**Figure V-18. HUSKY A Recipients (<Age 19) After Termination of CE:  
March 2003-September 2004**



## Presumptive Eligibility for Children

### Federal Guidelines

The Balanced Budget Act of 1997 gives states the option under their Medicaid programs to grant assistance to children under 19 using “presumptive eligibility.” As with presumptive eligibility for pregnant women under federal guidelines, qualified entities in the community determine whether a child is initially (i.e., presumptively) eligible for Medicaid based on the information supplied by the applicant.

An abbreviated application can be used and children immediately become eligible for Medicaid based on a child’s age and family income. A qualified entity has five working days to notify the state agency that a presumptive eligibility determination was made. Entities must also notify the child’s parent/custodian that an application for Medicaid is required by the end of the month following the PE decision in order to qualify for continued medical services.

Medicaid coverage during the presumptive eligibility period ends the earlier of: 1) the day on which a decision for Medicaid benefits has been made based on a full application; or 2) the last day of the month following the date when presumptive eligibility was determined if a full Medicaid application has not been received. Under federal guidelines, children are entitled to all Medicaid services during the presumptive eligibility period, and federal reimbursement is provided. If a child is later determined ineligible for Medicaid, federal reimbursement is still provided for services rendered during the time of presumptive eligibility.

### Connecticut’s Process

**Presuming eligibility.** *Connecticut law established presumptive eligibility for children in 1997, and inclusion in the state’s Medicaid plan was effective October 2000. Once the option for presumptive eligibility for children was adopted in the state Medicaid plan, Connecticut was required to implement the program according to federal laws and regulations. The legislature*

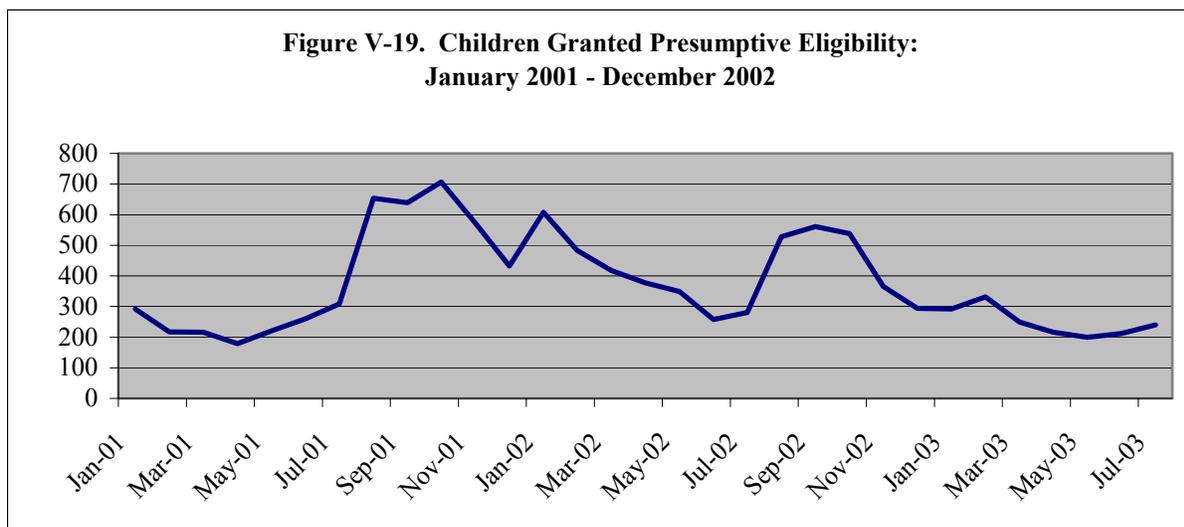
terminated presumptive eligibility for children in August 2003, and the provision was eliminated from the state plan effective September 2003.

During program operation, all presumptive eligibility applications for children were processed through the department's centralized eligibility processing unit (CPU) and based on self-declared information from the client. Qualified entities had to submit a one-page application form (i.e., fast form) within five days of making the eligibility determination. Clients were given a temporary voucher, good for five days, by the qualified entity at the time of application identifying them as eligible for Medicaid whenever and wherever services were sought.

Once the DSS central processing unit received the one-page presumptive eligibility application, the unit used that information to pre-fill a full Medicaid application. The unit then sent the partially completed application to the client, along with a temporary Medicaid card. The card replaced the voucher and covered clients during the period of presumptive eligibility.

The CPU was disbanded at the end of 2002 as a result of agency layoffs. The department's Fraud and Recovery unit temporarily administered the program from January 2003 until elimination of the program in August 2003.

Figure V-19 shows the number of children who were granted presumptive eligibility from January 2001 through July 2003. The data were derived from monthly tracking reports specifically kept by the central PE unit and by EMS for the months following the unit's elimination. The figure shows *the number of children granted PE during the period analyzed fluctuated between 200 and 800 a month, with an overall gradual decline in cases granted. The monthly average of presumptive eligibility cases granted was 371.*



**Determining full eligibility.** Once a case was granted presumptive eligibility, it was incumbent upon the applicant to complete a full application for Medicaid before the period of presumptive eligibility ended. A problem identified with presumptive eligibility for children, and testified to by DSS before the appropriations committee last year, was the high percentage of clients who were subsequently denied HUSKY A coverage mainly because they did not complete

the full application process prior to the end of the presumptive eligibility period. This included clients who did not return the full application for Medicaid mailed to them by the CPU, or who did not submit required verification of information.

Committee staff analyzed data maintained by the central processing unit for the number of times HUSKY A coverage was either granted or denied for children initially receiving services under presumptive eligibility. As shown in Table V-9, *during calendar year 2001, 53 percent of children originally granted presumptive eligibility were then granted HUSKY A coverage, while 47 percent were not. For calendar year 2002, 59 percent of children granted PE were then granted HUSKY A coverage, while 41 percent were not.*

<b>Table V-9. Presumptive Eligibility for Children Activity: January 2001—August 2003</b>		
	Final HUSKY A Granted by DSS Following PE	Final HUSKY A Denied by DSS Following PE*
January 2001 – December 2001	2,365 (53%)	2,129 (47%)
January 2002 – Dec. 2002**	3,073 (59%)	2,161 (41%)
January 2003 – August 2003***	Data not available	
* Reasons for denial include applicant non-cooperation with completing a full application, applicant already insured, or applicant over-income. Where appropriate, referrals were made for possible coverage under HUSKY B.		
** The centralized presumptive eligibility unit within DSS was disbanded in late 2002.		
*** Presumptive eligibility for children was eliminated in August 2003.		
Source of Data: DSS Central PE Unit Monthly Tracking Reports		

The main reason clients receiving services under presumptive eligibility were denied HUSKY A eligibility was because they did not complete the full application necessary for HUSKY A coverage. In fact, CPU data show that *of the 2,129 PE children denied HUSKY A coverage following PE during 2001, 1,660 (78 percent) were denied because they did not complete the full HUSKY application. In 2002, of the 2,161 PE children denied HUSKY A coverage, 1,534 applicants (71 percent) were denied because they did not complete the full HUSKY application.*

**Application form.** As mentioned above, prior to the elimination of presumptive eligibility for children, the department used a separate application for PE. The “fast form” was used for the PE period and the client then had to submit a regular HUSKY application when applying for regular Medicaid.

The committee believes *requiring clients to complete and submit two separate applications – even though the PE application was only one page – added an unnecessary step to the application process. It also created additional work for DSS, caused client confusion, and contributed to families not completing the regular Medicaid application process. A revised process using the same application for PE and regular Medicaid would greatly enhance the process, while also ensuring children were granted immediate access to care.*

*There was also no limit on how frequently clients could use presumptive eligibility as a means to obtain medical coverage without applying for regular family Medicaid. Without such a limit, there was no incentive for clients to submit their full HUSKY application after service had been received and the immediate health care need was addressed.*

The program review committee received testimony at its recent public hearings on this study that *presumptive eligibility for children should be re-established as a way to increase access to health care for children quicker than through the application process currently used for Medicaid. Healthcare access is increased through presumptive eligibility, yet as committee staff's analysis shows, that access is only temporary if a completed application for full Medicaid is not submitted.*

Re-establishment of presumptive eligibility for children would have a fiscal implication. The Office of Policy and Management and the legislature's Office of Fiscal Analysis estimate cost-savings of \$2.8 million in FY 04 and \$3 million in FY 05 as a result of eliminating presumptive eligibility for children. These estimated savings are gross savings, which include federal reimbursement. Estimated net savings to the state from eliminating presumptive eligibility is half the amounts shown after factoring out federal reimbursement. Based on those savings estimates, resumption of the PE option for children would likely cost around \$1.5 million annually.

Based on the above analysis, the program review committee recommends:

**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:**

- **quickly determine presumptive eligibility by the qualified entity; and**
- **transmit the application and necessary information to DSS allowing the department to determine eligibility for HUSKY A benefits.**

**Rationale.** The committee believes restoring presumptive eligibility for children would increase access to immediate medical care for children. The percent of children applying for full HUSKY benefits would also increase with a more efficient and effective application process, as recommended. Further, if the on-line application process for HUSKY, as recommended later, is implemented, it should provide for quicker application processing and eligibility determination.

Although the cost savings during FY 05 from eliminating presumptive eligibility are estimated at roughly \$3 million, federal reimbursement is available for half the costs associated with PE. Thus, the estimated FY 05 state expenditure for resuming presumptive eligibility for children would be approximately \$1.5 million.

## **State Children's Health Insurance Program (SCHIP)**

The State Children's Health Insurance Program (SCHIP), established in 1997 under Title XXI of the Social Security Act, allows states to provide medical coverage to a broader group of children with higher family incomes than those covered under Title XIX Medicaid. Federal reimbursement for this program is 65 percent.

Connecticut implemented its SCHIP program in early 1998. The program is administered separately from the state's Medicaid program, but services to families are provided under a managed care structure similar to Medicaid. In Connecticut, the SCHIP program is referred to as "HUSKY B," while the state's Medicaid program is "HUSKY A." As of September 2004, a total of 14,647 children were enrolled for medical coverage in one of the three managed care organizations serving the HUSKY B program.

A private company, Affiliated Computer Services-State Healthcare (ACS), under contract with the state, carries out four main functions under Medicaid and SCHIP. The company: 1) is the state's Medicaid managed care enrollment broker for both HUSKY programs (since 1995); 2) serves as the state's single point of entry provider for family Medicaid (since 1998); 3) calculates monthly capitation fees due to managed care organizations for HUSKY A (since 2001); and 4) determines eligibility for HUSKY B applicants (since 1998). *The contract cost for the 18-month period of July 2003 through December 2004 is budgeted at \$6.9 million, with administrative costs totaling \$817,000 (12 percent.)*

### **Application Processing**

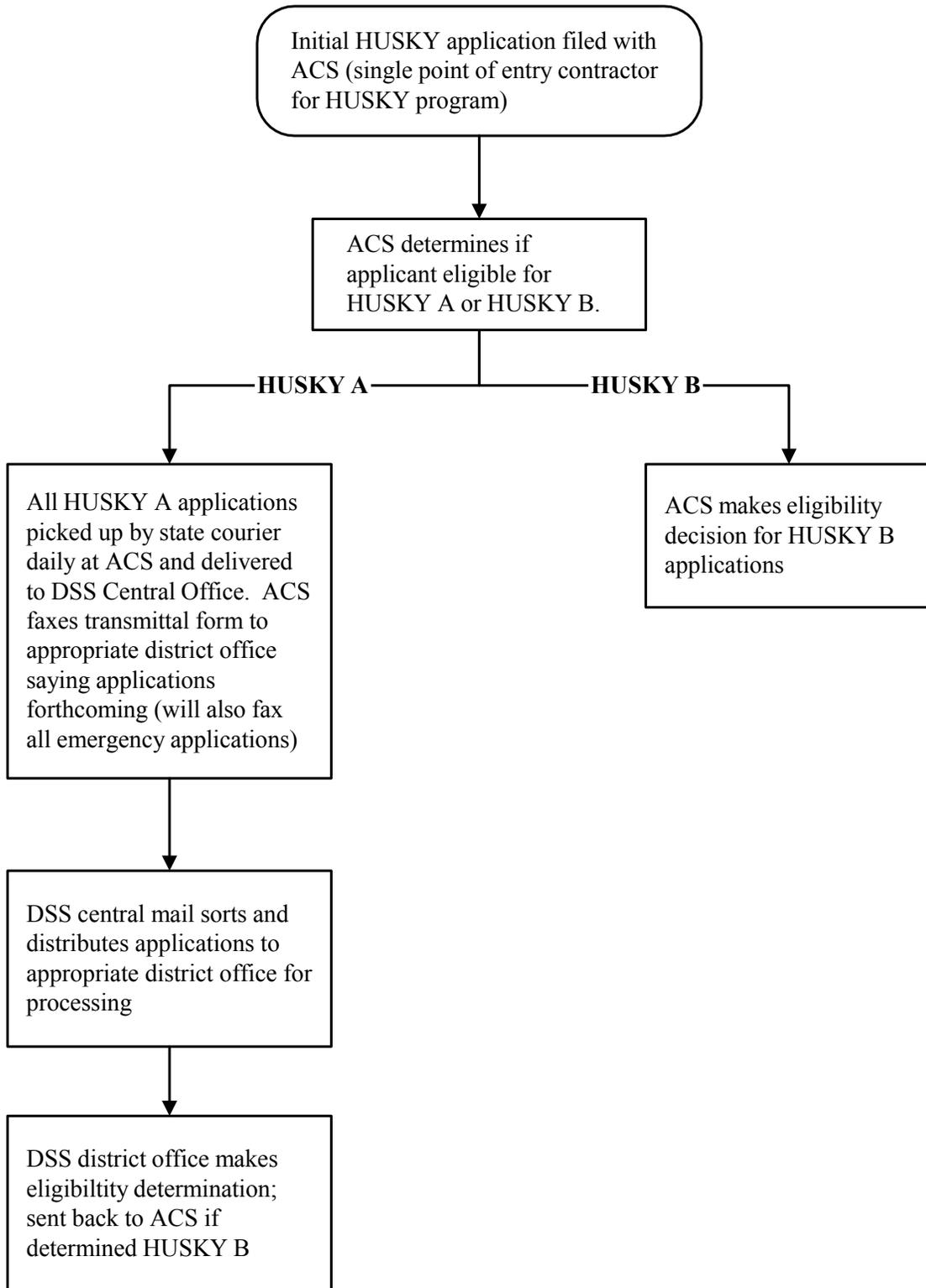
As the single point of entry provider, ACS is the state's clearinghouse for the HUSKY program. In this capacity, ACS: processes all HUSKY applications it receives, either by mail or phone; screens applications to determine if applicants are eligible for HUSKY A or HUSKY B; refers all HUSKY A applications to DSS; and determines eligibility for HUSKY B applications. (HUSKY B is not under Title XIX Medicaid rules, which require that only a state agency can make the eligibility determination for Medicaid applications.)

Figure V-20 outlines the steps taken to process new HUSKY applications through the single point of entry system. The same application form is used to apply for either HUSKY A or HUSKY B. The HUSKY application process emphasizes a mail-in system, whereby applications are mailed to ACS. However, HUSKY applications are also filed directly with DSS offices. A more detailed application is also filed directly with district offices whenever someone is applying for an assistance program(s), such as food stamps or TANF, in addition to medical insurance.

A contract with DSS outlines ACS' various responsibilities. For example, ACS is required by contract to collect specific client information as part of its eligibility screening process. This includes obtaining any missing information on the application or verifying items, such as questionable income. The contract also speaks to turnaround times, as discussed below.

The state courier service makes a daily mail stop during the week at ACS to collect applications and other mail. Applications determined by ACS to be HUSKY A are then delivered to the DSS central mail center for sorting and distribution to district offices.

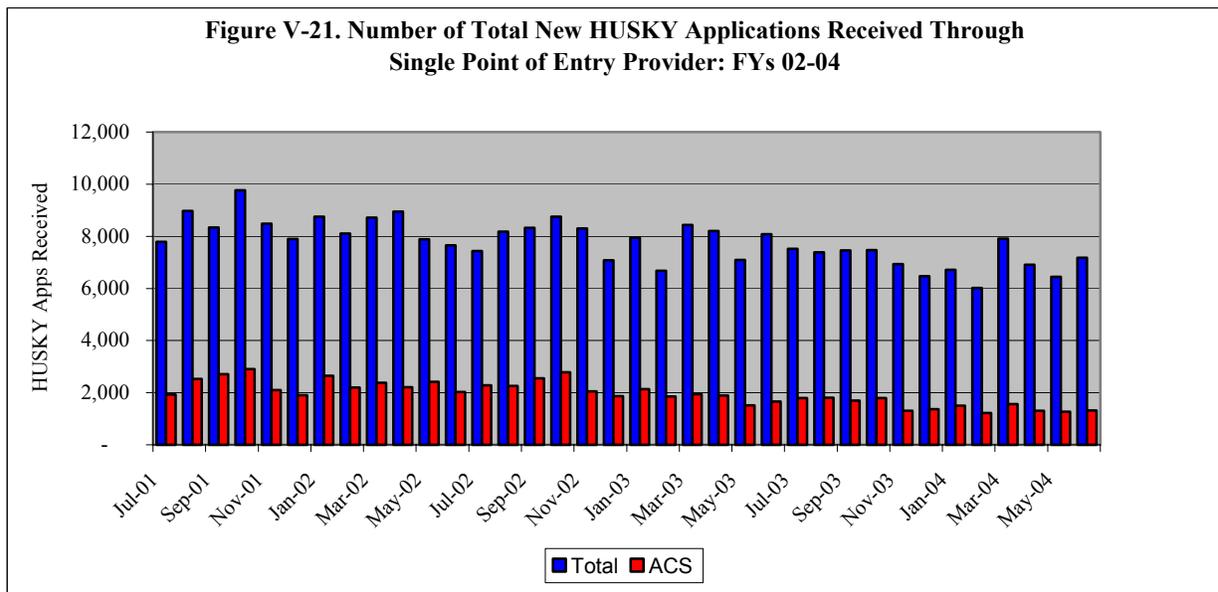
**Figure V-20. Single Point of Entry Application Process For New HUSKY Clients**



Source LPRI&IC

ACS faxes a transmittal form to district offices informing them of any forthcoming applications. (Applications considered emergencies are faxed directly to the appropriate district office for processing.) Once HUSKY A applications are received at the district offices, DSS eligibility workers determine the applicant’s eligibility.

Even though ACS is the state’s single point of entry for receiving HUSKY applications, applications are also received directly by the department’s various district offices. As a way to determine the proportion of Medicaid applications received by ACS, committee staff analyzed the number of new HUSKY applications received through ACS compared to the total family Medicaid applications received by DSS statewide for FYs 02-04. Figure V-21 illustrates the results.

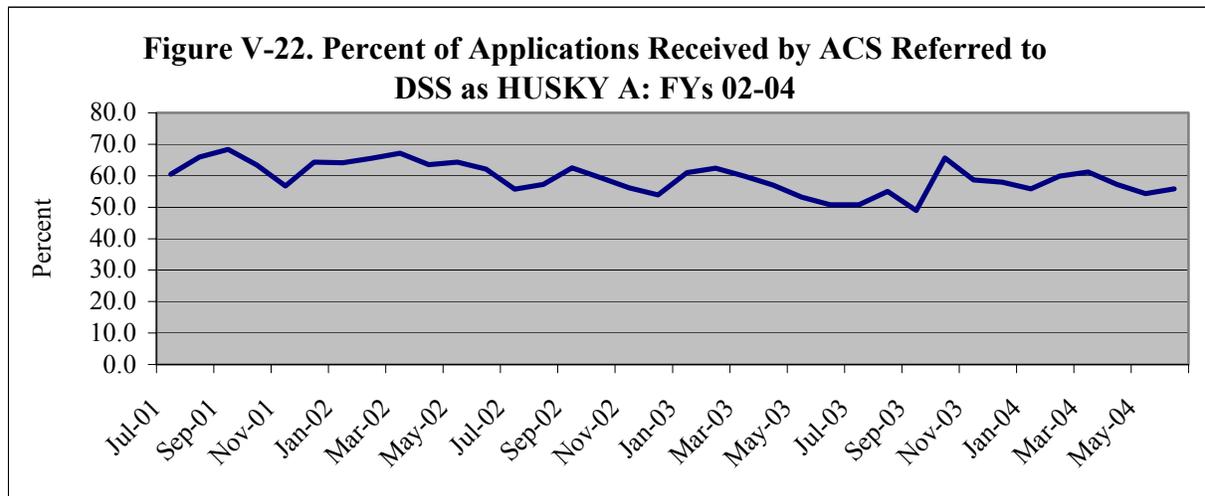


The numbers in Figure V-21 were derived from both EMS and ACS data on application activity showing total new family Medicaid applications received by district offices and ACS. The figure shows ACS received between 1,400 and 2,900 applications a month for the period analyzed, while the total applications received by DSS during that time ranged from 6,000 to 9,800. Although not shown in the figure, on average, ACS received 25 percent of all new family Medicaid applications submitted monthly for the time period analyzed. *This indicates that despite efforts to streamline the HUSKY application process using the single point of entry provider, DSS is still receiving the vast majority of applications for family Medicaid in its district offices.*

The relatively low percentage of applications processed by ACS is partially due to the fact that applicants applying for programs (like TANF or food stamps) in addition to Medicaid, use a different application than those only applying for HUSKY. The more detailed applications have to be processed through DSS, and not ACS, but are counted in the monthly Medicaid application activity data for DSS district offices. In other words, the percentage of applications received through DSS would be lower if it only processed HUSKY applications, rather than applications

that also included other programs. Regardless, the bulk of applications for family Medicaid are processed through DSS and not the state’s single point of entry provider.

ACS application activity information was also analyzed to assess the percent of new applications processed each month by ACS and ultimately referred to DSS to determine HUSKY A eligibility. Figure V-22 shows *between FYs 02-04, a monthly average of 60 percent of the applications processed by ACS were referred to DSS as HUSKY A.* This trend has gradually decreased over the period analyzed.



The high percentage of applications referred to DSS as HUSKY A is significant for several reasons. First, ACS is required by contract to pre-screen applicants (i.e., collect income, demographic, residency, and household information) to make an initial determination whether the applicant is eligible for HUSKY A or HUSKY B. Second, *the time it takes ACS to gather information from applicants who are ultimately referred to DSS, counts against the 45-day federal standard of promptness DSS has to determine a Medicaid applicant’s eligibility.* Once a signed application is received by ACS, the standard of promptness period begins. If the information collected by ACS for cases referred to DSS is either questionable, missing, or takes too long to collect, a delay in meeting the standard of promptness could occur.

### Application Timeliness

The overall time it takes ACS to process HUSKY applications is crucial to DSS’ meeting the standard of promptness for Medicaid. ACS supplied committee staff with application processing time data for FY 04, as shown in Table V-10. The table highlights the time it took ACS to refer HUSKY A applications, from the date a signed application was received at ACS, to the date it was referred to DSS as HUSKY A. It should be noted, the ACS contract requires all signed applications have the “appropriate action” taken within 30 days of receipt, meaning applications, whether HUSKY A or HUSKY B, must be processed within that time period. The contract also requires all applications referred to DSS be done so “within two days of processing.” (Contract provisions are discussed in more detailed below.)

<b>Table V-10. Time at ACS for HUSKY A Applications Referred to DSS: FY 04</b>				
	<b>1-10 Days</b>	<b>11-20 Days</b>	<b>21-30 Days</b>	<b>&gt; 30 Days*</b>
Total Applications (n=14,277)	8,552	3,455	1,028	1,242
Percent of Total	59.9	24.2	7.2	8.7
<p>*ACS contract terms specify a 30-day limit to process all signed applications from the date received.  <b>Note:</b> For the period analyzed, ACS received an average of 1,190 applications per month and the average processing time was just under 12 days.  Source: LPR&amp;IC Staff Analysis of ACS Data</p>				

Table V-10 also shows for FY 04, *91 percent of applications determined HUSKY A were referred within the 30-day timeframe.* ACS notes the nine percent of applications processed beyond 30 days was generally due to waiting for missing information requested from an applicant. However, *for the 16 percent of applications referred to DSS after 21 days, a good portion of the time for meeting the standard of promptness has already lapsed.*

Realizing applications must be processed quicker, DSS and ACS are working on a revised process whereby ACS, will make all HUSKY A referrals to DSS within 10 days, even if there is missing information. Implementation of the new procedure is anticipated by the start of 2005.

Table V-10 also shows the average time it took ACS to refer HUSKY A applications to DSS was just under 12 days for FY 04. This is relevant because, although the contract requires “appropriate action” be taken on applications within 30 days of receipt, it also requires all referrals to DSS be made within “two days of processing.” What is not clear in the contract, however, is the meaning of the term “processing.” Although this discrepancy needs to be resolved within the contract language, the committee believes applications can be processed by ACS quicker given much of the relevant information contained in a HUSKY application is now self-declared by the applicant. This means that unless the required information is either missing or questionable, an application should be processed without the client having to submit additional material to “verify” the application information, thus shortening the overall processing time.

### **Contract**

The state originally entered into a contract for enrollment broker services in 1995. The single point of entry function and the passive billing (i.e., determining capitation rates) responsibilities were added as amendments to the original enrollment broker contract in 1998 and 2001, respectively. *Although the contract has been amended several times, it has never formally been rebid since its inception in 1995.*

*Original language in the 1998 amendment to expand the contractor's scope of services speaks to "proposed" performance standards, but has never been revised to reflect formal performance standards, or updated to account for programmatic changes. For example, as mentioned above, the single point of entry provider responsibilities within the contract require ACS to forward all signed applications to DSS within two days of "processing," even though the term processing is ambiguous and not clearly defined in the contract language. Whether "processing" means from the time the application is received or from the time ACS collects the required information to determine initial eligibility, is not addressed in the contract.*

The committee believes *the larger issue, however, is for DSS and ACS to find the proper balance between ACS processing HUSKY A referrals quickly, but sending DSS applications that have proper and complete information so that eligibility workers can make a determination, which is the whole intent of the single point of entry system.* The department and ACS are currently discussing whether the process should be changed to reflect more reasonable processing standards, balanced with the level of information ACS would collect and forward to DSS as part of the referrals. The committee believes this process change needs to occur and be formally outlined in the contract, as recommended below.

There is also *no provision in the current contract for sanctions of any kind, other than termination, if contract terms and performance standards are not met.* Additional administrative measures to correct procedural or performance deficiencies, such as requiring a "plan of correction," are not addressed in the contract. Outlining a progressive enforcement procedure in the contract would provide DSS and the contractor with a clearer understanding of the ramifications if contract terms and performance standards are not upheld.

Based on the above analysis, the program review committee recommends:

**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.**

**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 applications submitted to DSS for eligibility determination.**

**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.**

**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.**

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**The state's enrollment broker should be responsible for implementing the revised change of address system, as recommended earlier in this report.**

**Rationale.** The committee believes the single point of entry provider/enrollment broker contract needs to be re-bid with more formalized performance standards and enforcement processes and as a way to ensure the most efficient and effective processes are in place. The current contract language is outdated and vague in several areas, as highlighted above. A new contract, with an emphasis on application processing, should eliminate ambiguities in the current contract language. Also, limiting the life of the contract and outlining a specified process for identifying and correcting areas of poor performance, including sanctions, should help ensure adequate contractor performance.

Further, with six years' experience with the single point of entry system, DSS should better anticipate what the volume of HUSKY application activity the contractor will assume and gauge the contract amount accordingly. Also, the recommendation to limit the number of times Medicaid clients can change MCOs in a given year, as recommended below, should reduce the enrollment broker administrative activity, thus reducing anticipated costs in that area.

### **Provider Access Under Managed Care**

The committee wished to assess whether or not Medicaid clients have adequate access to service providers. Committee staff analyzed three sources used by DSS to gauge that access for HUSKY A clients, including: 1) MCO network adequacy measures for key types of providers (e.g., physicians and specialists in internal medicine, pediatrics, obstetrics and gynecology, dentists, and behavioral health providers); 2) the current annual quality review of managed care organizations done by the DSS external review contractor; and 3) reasons MCO enrollees change plans as tracked by the state's Medicaid managed care enrollment broker, ACS.

**Network adequacy tracking.** DSS determines current MCO network enrollment capacity levels based on a ratio of providers to Medicaid clients calculated using the number of fee-for-service (FFS) providers accepting Medicaid clients in 1994, the year preceding the state's switch to Medicaid managed care, and the number of Medicaid clients at that time. The department then measures overall member enrollment against the capacity levels to identify those MCOs with high network capacity levels by type of provider. The ratio of Medicaid clients to fee-for-service providers has not changed since it was originally calculated in 1994.

MCO contracts specify that if enrollment within an MCO reaches or exceeds 90 percent capacity for a certain type of provider (e.g. dentists), the plan has 30 days to add providers to maintain acceptable network capacity levels. DSS monitors the MCO's progress on a monthly basis to ensure efforts are made to add providers.

If a managed care organization reaches 100 percent capacity for a particular provider type within a county, DSS issues a warning letter to the MCO identifying the problem. The department has the option of suspending the MCO's enrollment for that particular county until the problem is corrected. The MCO contracts provide for corrective action plans when enrollment is suspended, and allow sanctions for each month enrollment suspension continues beyond the corrective action date.

Committee staff examined monthly reports for June through November 2004 to assess whether any MCOs experienced access issues with particular types of providers. The reports also show whether any warning letters have been issued or enrollment suspensions are in effect.

Overall, the reports showed: 1) no MCO ever reached 100 percent capacity for any type of provider; 2) no warning letters were sent to any MCO; and 3) no enrollment suspensions were issued due to network inadequacy. Specific concerns highlighted in the reports, however, showed several instances where a managed care organization was over the 90 percent threshold for a particular county, but for dentists only. DSS noted it is monitoring this issue to ensure the MCO network does not reach full capacity and warrant an enrollment suspension, thereby limiting access. Long-term, DSS is planning a dental carve-out to begin in February 2005 to address dental access.

**Annual quality review.** Federal regulations require state Medicaid agencies to conduct an annual quality review of each managed care organization to determine if operations and practices are adequate to serve Medicaid enrollees. In Connecticut, DSS contracts with an external company to conduct the reviews, and the most recent completed annual review was done in late 2002 – the department was granted a waiver by CMS for its 2003 review. Also, while the 2004 review has been conducted, the contractor’s report is still in draft form, and not available for examination.

One area examined during the 2002 quality review is “access and services availability,” in which several components are measured against specified standards developed by DSS. The areas reviewed for this particular category included: 1) availability of both emergent and urgent care; 2) the MCO’s responsiveness in scheduling timely appointments; 3) the MCO’s monitoring activities to handle member inquiries and access issues; 4) the MCO’s preventative health assessments; 5) provisions for early and periodic screening, diagnosis, and treatment services (EPSDT); and 6) provisions for prenatal care services. The quality review report gave Connecticut’s Medicaid MCOs an acceptable (or above) rating on each of the criteria evaluated for “access and service” availability.

**Client MCO changes.** ACS, as the state’s Medicaid managed care enrollment broker, tracks reasons that enrollees change plans. Committee staff examined the monthly tracking data for FY 04. Although client reasons for changing MCOs are varied, there were several that would possibly indicate problems with accessing care, including:

- cannot find primary care physician (PCP)/dentist taking new patients;
- client’s PCP left plan;
- continuous inappropriate denial of care;
- denial of services;
- language barriers with providers;
- long waiting times at doctor’s office;
- longer than one day wait for urgent care, three day wait for non-urgent care, or one month for visit;
- plan’s providers too far or problems with plan’s transportation; and
- trouble getting durable goods or prescriptions.

In total, these issues accounted for only 5.2 percent of the reasons clients changed managed care plans during FY 04.

*Overall, based on the above methods to gauge Medicaid clients' access to care, the committee concludes access is not problematic. However, the committee finds the way DSS calculates MCO enrollment capacity levels, based on 1994 fee-for-service and Medicaid client figures, is outdated and sets higher enrollment capacity levels than if the levels were determined using a more current, and broader, methodology.*

**Unlimited plan changes.** Adequate access to care and continuity within a managed care plan are important components of health care for Medicaid clients. Currently, however, clients are allowed to switch MCOs any number of times in a given year. According to data from ACS, a total of 35,294 HUSKY A recipients changed managed care plans during FY 04, an average of 3,000 recipients changing per month. This represents 12 percent of the average monthly MCO enrollment for HUSKY A for that year.

Allowing clients an unlimited number of changes to their managed care plans also creates administrative problems, and presents issues regarding continuity and coordination of care. If clients know they can frequently change plans, they may be more apt to make such changes for reasons other than what would normally be considered "good cause." Also, given clients' ability to change managed care organizations any number of times, providers most likely experience record keeping problems when clients change plans and MCOs undoubtedly incur greater administrative costs associated with enrolling new members. Therefore, the committee recommends:

**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.**

The committee believes implementing a limit on the number of times Medicaid clients can change their managed care plans is a more efficient system than the process of unlimited changes currently in place, both administratively and from a continuity of care perspective. Allowing clients to switch managed care plans a maximum of twice per year, unless good cause is determined, should help decrease administrative processing on part of DSS, the state's enrollment broker, managed care organizations, and providers. The recommendation is also within federal guidelines, which require enrollment periods of no longer than 12 months without allowing clients to change plans. Further, clients should experience greater continuity of care by staying with a health plan for a longer minimum time period than is currently required. Implementing this recommendation may also result in cost savings for DSS in its contract with the state's Medicaid managed care enrollment broker if fewer clients switch managed care plans during the year.

Unlike Medicaid clients, HUSKY B clients may change managed care plans one time per year. If, however, a HUSKY B client has a "good cause" reason for wanting to change plans, such as the client's primary care provider is no longer in the current plan, a change may be

requested. ACS examines the request based on guidelines provided by DSS and decides whether to grant or deny. Under the proposed recommendation, Medicaid clients would also be allowed to change their managed care plan more frequently than twice a year for “good cause reasons” as determined by DSS.

### **Medicaid Fee-for-Service Access**

There are no similar provisions for adequacy for Medicaid clients who are in fee-for-service (FFS), and not in managed care. With FFS, federal regulations require that Medicaid rates established in the state be sufficient to enlist enough providers to ensure Medicaid clients have similar access as among the general population.

Without similar measures in place as for MCOs, adequacy of access for the FFS population was more difficult for program review to determine. A listing of all current Medicaid providers is listed on Connecticut’s medical program website (not DSS’). That listing indicates a total number of about 5,700 providers of all types and specialties statewide. However, this listing includes nursing homes, clinics and substance abuse facilities. It also includes providers listed multiple times, if they have different locations or have more than specialty. Thus, it does not seem to provide a true picture of provider adequacy.

Further, as the website cautions, these providers may not be taking *any* new patients, may not be open for additional Medicaid clients, or may limit those appointments to certain hours or days of the week. Again, the listing itself is not a very reliable adequacy measure.

However, according to the list, the number of general practice physicians for adults statewide is only 234, a seemingly low number considering there are about 60,000 adults in FFS Medicaid. Also, in visits to DSS offices, department staff indicated that getting an appointment with some provider specialists, like orthopedics or psychiatry, can be very difficult, and clients may have to wait months.

Measuring adequacy of client access to providers was beyond the scope of the study, and there are no clear standards in place – like provider to patient ratios – by which to evaluate adequacy. Thus, the committee makes no finding about the adequacy of number of providers in Medicaid fee-for-service, but believes DSS should better communicate the website information on providers participating in Medicaid to make it more accessible.

### **Long-Term Care**

As highlighted earlier, long-term care cases declined about 8 percent – from 22,160 in FY 00, to 20,408 in FY 04. At the same time, new applications for long-term care also decreased – from an average of 1,042 applications per month in FY 01, to 938 in FY 04. However, the percentage of overdue applications (i.e., beyond the 45-day SOP) for long-term care continues to be problematic. Fifty-five percent of pending applications were overdue in FY 01; by FY 04, almost 60 percent were overdue.

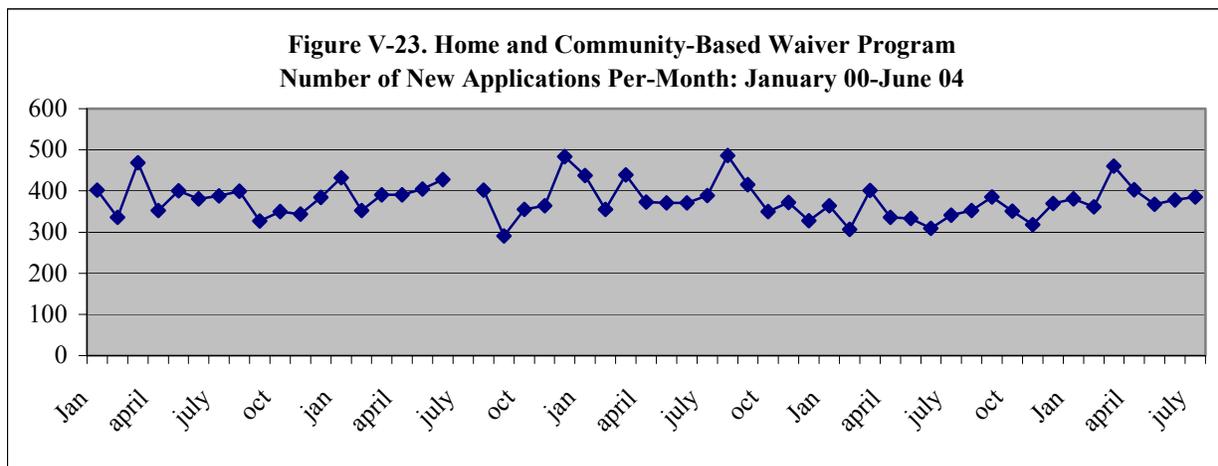
Processing initial applications for Medicaid long-term care is labor-intensive because DSS must examine financial records and conduct complicated tests and calculations before granting eligibility. For example, if a spouse is still living in the community, DSS staff must determine what assets can be protected for that spouse, what income the community spouse can keep as a monthly needs allowance, and whether assets the applicant transferred during the look-back period (36 months) were exempt by law, and, if not, what penalty should be assessed.

Adding to processing delays is the difficulty in obtaining all the financial records necessary to determine the application. If the client does not have these records, they must be obtained from banks, insurance companies, or other financial institutions, and there are often delays in DSS obtaining the records. Frequently, the applicant may not be physically or mentally able to obtain or organize the necessary documents, and family members and/or attorneys often become involved.

Delays in determining eligibility can have serious financial consequences for clients and/or nursing homes, if a client is already residing there. For example, if, after an extended application review period, a client living in a nursing facility is found ineligible, the client faces a significant bill for care that he or she cannot pay. According to the association representing nursing homes in Connecticut, the nursing facility must absorb the loss, possibly creating a substantial cash flow problem.

**Home- and Community-Based Waiver (HCBW) program.** In 1995, Connecticut was granted a Medicaid waiver, which allows services to be provided to a client in the community if the person would otherwise be placed in a nursing home. The five-year waiver was renewed in 2000, and there are currently more than 10,000 recipients in the waiver program.

Applications for the waiver program undergo a similar, comprehensive review as long-term care applicants. DSS staff examined financial and asset records for the three years prior to the application. Initial applications for this program currently total about 400 a month, about half the number of new long-term care applications filed, as shown in Figure V-23.



As noted earlier, because nursing home care is expensive (about \$92,000 a year on average) and long-term, there is a public interest in ensuring that only persons who are truly needy are granted eligibility. The examinations required to prove that need are especially pertinent in an affluent state like Connecticut, but policies indicating which financial transactions require additional follow-up and verification may be overly stringent.

*However, given: the number of applications received per month for both long-term care and the HCBW program; the need for a comprehensive review of financial records; the consistently high percentage of overdue pending applications at the end of the month; and the increased involvement of attorneys in this area, the committee finds the 45-day standard of promptness to determine eligibility is unrealistic.*

**Therefore, the committee recommends that DSS, working with the governor's office and the legislature's Human Services Committee, 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.**

Allowing a longer period of time to process applications will mean that fewer applications are over the SOP. However, it will not mean that eligibility is determined more quickly. To help expedite the process, the committee recommends the following:

**When DSS first receives a long-term care application, the eligibility worker should immediately contact the client, or whoever is making the application on the client's behalf, to inform that person that the DSS eligibility worker is reviewing the case. The eligibility worker should explain that the process is complex, and heavily reliant on the review of financial and asset documents.**

**The policy setting the guidelines in investigating applicant checking accounts should be changed to require workers to only question amounts that might affect eligibility.**

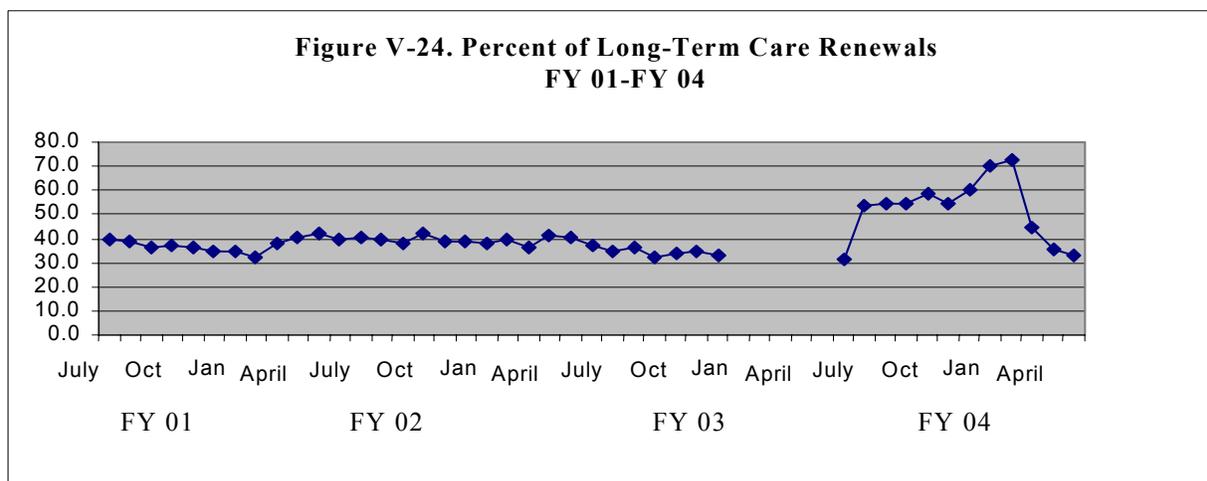
**Rationale.** Implementing these steps should help expedite the process by improving early communication about who the eligibility worker is and how the eligibility process will be handled. The policy on transfer of assets concerning checking accounts and the amounts that need investigation -- \$500 if not part of a normal pattern, and "questionable" \$1,000 amounts -- has not been updated since 1993. The committee believes specific amounts should not be in policy, but allow worker discretion to investigate or require verification for amounts that might affect eligibility. This is similar to the policy established for savings accounts.

### **Redeterminations for Long-Term Care**

As with other Medicaid cases, long-term care clients must have their eligibility renewed each year. DSS offices typically process 1,200 to 1,300 long-term care renewals each month.

Discussions with DSS staff indicate that long-term care clients' circumstances rarely change, which should make redeterminations relatively simple. In fact, *more than 90 percent are awarded renewed benefits, and typically less than one percent are automatically discontinued because of failing to complete the redetermination process.*

Despite this, a problem exists with overdue renewals in this Medicaid category as well. Figure V-24 shows that, generally, between 30 and 40 percent of long-term care renewals had been overdue from FY 01 through mid-FY 03. However, after the staffing reductions and the suspension and subsequent resumption of renewal processing in May 2003, the percentage of overdue long-term care renewals increased to well over 50 percent for a few months, before declining to its more typical 30-40 percent level in the last couple of months of FY 04.



Further adding to the overdue problem in late FY 03, was a change in what had been a DSS informal practice. Without official approval, DSS had been informally operating a two-year renewal for long-term care clients by broadening the scope of an existing waiver giving DSS the ability to redetermine elderly food-stamp clients only once every two years. However, the state auditors cited DSS for this when the single-state audit was conducted in 2003. The department then resumed one-year redeterminations for long-term care.

The committee concludes that DSS continues to issue benefits to these clients beyond their renewal periods. Workers understand that the vast majority of clients will be renewed when the eligibility worker has time to review the documentation, with little risk of continuing eligibility for someone who will be denied.

*The committee believes that since the nursing home population is such a stable one -- whose eligibility for Medicaid is "long term" and whose eligibility circumstances do not generally change, the renewal period ought to be extended. Therefore, the committee recommends that DSS submit a waiver request to CMS to allow a two-year redetermination period for long-term care clients.*

The department could use the statistics on its redetermination activity to support such a request. With less than one percent denied because of failure to comply and the vast majority being awarded at renewal time, the committee concludes that yearly renewals are not a good use of staff or EMS resources. If those resources could be redirected to determining eligibility for initial long-term care applications, it would help reduce delays, as well as the financial impacts on clients and nursing facilities if found ineligible after a prolonged review period. DSS should formally request a waiver to ensure they meet all rules and regulations and therefore cannot be cited in future audits.

## **Operations and Support Systems**

### **Eligibility Management System**

Eligibility workers rely heavily on DSS's computerized eligibility management system (EMS) to determine a client's initial and continued eligibility for the state's major public assistance programs, including Medicaid. Program review staff believes an overhaul of the current eligibility management system would greatly assist in reducing application processing times and increasing access to needed benefits for eligible persons. However, staff also recognizes that such an overhaul will take considerable time and resources to develop.

The current EMS is a mainframe system initially developed in the 1980s, and consists of 68 databases, more than 1,500 programs, 336 screens and over 4 million lines of code. As highlighted in this report, the system determines eligibility, issues notices, and calculates and sends benefits to about 227,000 households. It maintains the eligibility information for almost 400,000 Medicaid clients each month.

It receives information entered from over 1,500 terminals across the state, and EMS exchanges and matches data with other state and federal agencies, as well as with towns, banks, insurance companies, and other entities to monitor and verify information concerning clients and their eligibility.

The EMS system does not provide eligibility workers with the more "user-friendly" interface identified with personal computers, and the system is "rigid", requiring programming or reprogramming each time a change in policy or eligibility criteria is made. Because of the system's technological deficiencies, eligibility workers are often required to "work-around" or circumvent the system to implement a policy or procedural change in the Medicaid program.

Despite its flaws, workers and DSS management defend the system, stating Connecticut's Medicaid error rate has never been above the three percent national standard, that it is less prone to security breaches, and that it adequately performs the functions to determine eligibility and issue benefits to almost 400,000 people.

The committee believes that DSS has been able make additions, adaptations, and modifications to the EMS system over the years so that the department could adequately deliver its programs and services to clients. Certainly in comparison to systems in other states, Connecticut's is reliable. However, the capacity of EMS may be reaching its limits, and the committee believes DSS should begin planning now for a replacement system so that it can be done in an orderly, planned way, rather than reacting to a crisis if the EMS system were to fail.

Committee staff called a number of states about their computerized EMS systems and learned that those states that had introduced a new computerized eligibility system had planned for the system for at least five years. New eligibility management systems are also expensive – Maine spent \$22 million for its Automated Client Eligibility System (ACES), and Colorado is reported to have spent more than \$100 million on its new computerized eligibility system. (See Appendix F for states surveyed and a summary of responses.)

The committee believes there is recognition within DSS that EMS will need to be significantly upgraded or replaced. While DSS has not submitted EMS replacement to the Office and Policy and Management as a budget option, OPM indicated to committee staff that DSS had sent OPM a letter sometime in the last three years alerting OPM that the system would need to be addressed and that it would require significant financial support. According to OPM, the estimated cost for the new EMS system was in the “tens-of-millions of dollars”, and OPM stated there was no money for such an option.

The committee believes the EMS system is absolutely essential to the eligibility determination process. It seems risky to keep relying on an old, overburdened system without planning for a significant upgrade or replacement. Since the planning process in other states has been lengthy, it would seem that Connecticut could also expect a long time frame to design and implement a new system. Recognizing the lengthy process, the committee recommends:

**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.**

**Rationale.** The committee recognizes a system replacement for EMS will take time, but believes if approached in an organized fashion it will go more smoothly and be less of a distraction to clients and staff than if the situation becomes urgent. The program review committee also recognizes that with the staffing cuts and office closures, the department is hard-pressed to conduct daily operations, without having to plan for and implement a system overhaul. However, if done as a long-term project, it should not impact as heavily on everyday staff functions.

There must also be a commitment of state monies for such a project. DSS must begin pressing its need for a new EMS system to OPM and the Legislature, and those involved in the budget process must find financial support. As indicated earlier, Connecticut spends a lower percentage on Medicaid administration than any other New England state. The committee believes increasing the administrative costs to help pay for such a crucial part of the Medicaid system is fiscally responsible.

Further, if DSS could identify other sources of funding, and not seek only state monies, it would demonstrate the need for, and commitment to, the project. It appears some federal funding should be available, but the exact percentage of costs reimbursable is unclear, depending on plan submissions and approval as well as what other programs in addition to Medicaid would be included in a new system. Given the system will take years to develop and implement, funding could be budgeted each year as the project is developed, or the possibility of bonding the project as a capital improvement could be explored.

**Updating notices.** A related EMS initiative, in which DSS has already made progress, is updating many of the notices created by EMS and sent to clients so the notices are shorter and easier to understand. Advocacy groups and others believed the notices were too long and too confusing. The initiative, funded by the Robert Wood Johnson Foundation, was implemented in two phases. The first phase, begun in February 2001, was to identify issues with the notices with a major focus on family Medicaid. The first phase used Arthur Andersen Consulting, who conducted focus groups in the regions involving staff and consumer groups, including legal aid attorneys, to identify issues with the notices. The second phase was to develop new notices and program DSS software to generate the replacement notices. DSS used Maximus consultants for the second phase, but indicates that considerable DSS staff time also was needed to implement the changes. Most of the 16 notices that were modified are still being piloted.

The committee believes this is clear demonstration that DSS actively works to improve the application and eligibility determination process. In this case, DSS partnered with advocacy groups and other consumers, secured outside funding for the project, appointed committed staff to the initiative, and is in the final stages of piloting and implementation.

**The committee recommends that DSS continue its process of upgrading notices to include programs in addition to family Medicaid. The committee also recommends that DSS begin a review of the worker alerts generated by EMS, with the objective of keeping only those that are helpful to workers.**

**The committee recommends that both initiatives 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.**

**De-linking in EMS.** 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. As discussed in the “change-of-address” issue, this link can have negative consequences to the client, discontinuing his or her Medicaid benefits because of returned undeliverable notices for another program.

Further, severing the link has become more important since October 1, 2004, when more stringent requirements for those time-limited TFA clients to keep appointments for employment assessments went into effect. DSS indicates the delinking of family cash assistance and Medicaid should be complete in early 2005. Given the impact the continued tie in the EMS system can have on a client’s Medicaid eligibility, the department clearly needs to meet that deadline.

**The program review committee recommends that DSS 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.**

## **Online Application**

Currently, Connecticut does not offer system capability for clients or others to file an application online. Other states have begun offering electronic application processing as a way to improve access to the Medicaid program. At least eight states have some form of statewide online enrollment for family Medicaid and SCHIP, and another eight states have more limited pilot programs underway.

Committee staff reviewed the literature regarding online Medicaid applications and contacted many of the states currently providing online capabilities to draw from their experience, and assess what, if any, elements Connecticut might wish to adopt with such a system. (See Appendix F)

According to one report, all states that have these capabilities refer to their systems as “ ‘online enrollment’ or ‘online application’; the individual functionality differs greatly across efforts.”<sup>10</sup> However, as the report’s assessment indicates, state systems fall into one of the following four basic types:

- **Online enrollment with an automated “back end”:** This system uses an automated process to capture, save and transmit the applicant’s data to the Medicaid programs’ eligibility database. This approach offers the greatest administrative efficiency because the data are automatically sent to a computerized eligibility system; however, security measures must be implemented to protect the transmission, storage, and retrieval of the applicant’s data. Georgia’s SCHIP and Medicaid for children programs (PeachCare) use this type of system -- where most applicants can self-declare income and electronic signatures are accepted. Michigan, Pennsylvania, and

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<sup>10</sup> California HealthCare Foundation “Public Access to Online Enrollment for Medicaid and SCHIP”, May 2003

most of California also use this type of system, even though hard copy signature pages and income documentations are often needed separately to complete the application.

- **Online applications submitted electronically to the program:** This system captures, saves, and transmits data from the user and submits it to the program. Eligibility staff then print the applications and process the information as if received in the mail. This system does not have the same security issues, but is duplicative, requiring data to be entered twice. Users are notified electronically that their application has been received, and sometimes of the tentative eligibility. Utah, Washington, and some California counties, operate this type of system.
- **Online application assistance tools:** With this system, users enter their eligibility data into a web-based application assistance program that provides helpful information and flags any errors in the form. At the end of the process, users are notified of their apparent eligibility for various types of programs, and advised to print the application and submit it by mail. Texas uses this type of screening system, and is in the final stages of developing an RFP to incorporate full online application capability.
- **Online applications available to download:** With this system, applications are available to print. The applicant can then complete and mail in. Many states have this capability, and it saves the cost of mailing an application, or the client coming in the office to complete it, but it does not really provide online access.

**Other variations.** Some states allow anyone with Internet access to file an application, while others such as California limit access to agencies that are “certified application assistants.” Most states have the applications available in English or Spanish. Some states limit online access to Medicaid, or just family Medicaid, while others, like Pennsylvania and Washington, allow access to other major assistance programs like food stamps, long-term care, and school lunch programs.

The costs of planning, developing and implementing these systems also vary among states. Georgia was able to develop its system in four months at a cost of only \$40,000. Washington indicates the state children’s Medicaid portion of online access cost about \$50,000, while in Texas, total costs were about \$600,000.

California’s Health-e-App took about two years to develop. The tool was piloted in 2001 in one county and was approved for statewide use in 2002. California’s online system cost about \$1 million. Initially, staff in California’s Medicaid agency believed the state could claim an enhanced federal match (90 percent for development, and 75 percent for operational costs) but later learned the project was eligible only for the standard 50 percent reimbursement. California

did manage to leverage its state funding with private monies from the California Health Foundation.

Development of Pennsylvania's system (COMPASS) was begun in October 2001 and the first applications (Medicaid for pregnant women and children and SCHIP) were transmitted in October 2002. The initial cost of that program was about \$500,000 for family Medicaid and SCHIP.

**Participation:** While online application capability clearly increases ways to apply for Medicaid programs, it is still a minor contributor to the overall application volume received in the states that employ such systems. For example, Georgia appears to have the highest participation – over 60,000 applications were received over a two-year period. Similarly, Utah had a high participation rate with its online application system. Utah allows applications only during open enrollment periods. The first two-week period where online application capability was available was in June 2002, and during that period 1,122 applications (18 percent of all) were received. In the next open enrollment period in November 2002, the number had increased to 4,191, or 45 percent of all applications.

Participation was significantly less in Washington and Pennsylvania, where applications transmitted online accounted for only five percent of all the applications.

*The committee finds that other states' experiences with online access vary. While participation rates in filing online are not uniformly high, and costs and planning and development times vary significantly, the committee believes the increased client access to Medicaid is worth the effort. The committee believes Connecticut should develop online access capabilities and therefore recommends:*

**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.**

**Rationale.** The system should increase access by giving clients, qualified entities and other organizations another access tool. It should also allow community access agencies to submit an application immediately, on behalf of the client, and not rely on the client to “do it later”. Making successful transmittal subject to full completion of the application should significantly reduce the submission of incomplete applications, and subsequent denials because of lack of complete information. In addition, this will reduce the high percent of overdue applications related to incomplete filings.

Even if participation starts out slow, it is likely to increase rapidly, as in the state of Utah. Further, the committee believes online access is a favorable alternative to in-person office traffic, or to mailed or faxed applications, which are more apt to be misplaced or lost.

The committee believes the online application should be initially limited to HUSKY (family Medicaid) because the application is short, simple, and requires only self-declaration of income and no supporting documentation such as asset information.

Some monies have already been allocated for this project during the 2004 legislative session. In the budget adjustments for FY 05, the legislature allowed DSS to keep up to \$200,000, which would have otherwise lapsed in June 2004, for the procurement of MIS systems, specifically the development of statewide online Medicaid and HUSKY enrollment. DSS could solicit matching private funding, perhaps from the Robert Wood Johnson Foundation, which promotes efforts to ensure better health care access for low-income children and families.

The committee believes that the timeframe recommended is a realistic one, especially given the number of states that have already implemented such systems. Connecticut would not be pioneering these efforts, but could borrow from other states’ experience in development, marketing and implementation. DSS indicates it is already surveying other states’ capabilities as a first step in the planning process.

## **Support Operations**

DSS staff also rely on other systems and operational support services to conduct the business of determining eligibility and assisting the client. As noted earlier, variations and deficiencies among offices in phone systems, e-mail capability, office space, mail service, drop box availability, and security are examples of operational support issues.

**Security.** During business hours, some offices have only one security officer on duty, while others have more than one private security officer and a local police officer on duty as well. In fact, one local police officer was on duty when an office committee staff visited was closed. Committee staff asked local office managers about this variation when staff conducted office visits in the summer and fall, and was told those decisions were made at the central office, not in the district.

Staff asked the Director of Operations at the DSS central office about the arrangement for security and the need for local police at some offices. He could not recall when the local police arrangements had begun, or the reasons, but thought it might have been as a result of risk assessments conducted by the state Department of Public Works (DPW). However, committee

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staff reviewed all four of the risk assessments DPW conducted of currently operating DSS offices,<sup>11</sup> and found that in three of the four office assessments, the office already had local police on duty. The other office did not have a local police arrangement, nor was one recommended in the assessment.

Committee staff asked for the written contracts or personal service agreements DSS has with local police, for offices where that is part of the security, but was not able to obtain them. Thus, committee staff was not able to determine what functions local police are required to perform, nor what DSS is expending for the coverage. Staff review of the DPW assessments also indicated that incident reporting to DSS was a private security function, and the Hartford office assessment stated that there were no published “posted orders” (i.e., duties to perform) for police officers on duty.

At a time when DSS has cut its core services (eligibility workers) and closed offices, the committee questions the continuation of such agreements with local police departments for officer coverage at some offices.

**Thus, the committee recommends that as contractual arrangements for police coverage expire, DSS substantiate the need for their continuation to the Office of Policy and Management and the Appropriations sub-committee responsible for DSS financial oversight.**

**Rationale.** The committee believes DSS should be called to justify such expenditures at a time when core services and staff are reduced. Further, to allow a contract for police services to be provided at a closed office is certainly not a good use of scarce resources.

The committee also questions the need for this added police coverage at DSS offices when other state agencies serving a high volume of needy clients are adequately served with private security services.

If DSS retains these contracts, it should require established standards of performance and not include hours of coverage when offices are not open.

**Phone systems.** Variation also exists with the phone systems in district offices, including capacity for the number of messages that can be left on an individual’s voice-mail, the messages clients hear when they call an office, and ability to assess call volume in any given office.

The DSS Director of Operations indicates that there are two phone systems in place at the DSS offices – one in the three largest offices, and a second system in place for all the other offices. The systems were installed eight or nine years ago, but the hardware is still at “industry standard”, according to the operations director.

However, district office staff indicates the phones are problematic. Also, when committee staff asked for call volume through central office operations, it was difficult to get, and for some offices, not available. *According to central office operations, the systems need to be*

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<sup>11</sup> The requirement for DPW to conduct such assessment became effective in 1999 (P.A. 99-220). Thus, all of these assessments occurred after that.

*programmed to handle the necessary changes, the hard drives the systems depend on need to be defragmented, and district office staff need to be better trained in the use of the systems.*

**Copy and mail.** Central Office Operations is also responsible for all copying for the regions and for the bulk of DSS mailing, including all the EMS-generated mailings, and central office mail. DSS is also included in the state courier route that picks up and delivers mail from different state agencies, ACS (DSS' enrollment broker), and its regional offices. *DSS office staff did not indicate any problems with the central mailing and copying system, although there was confusion in some offices about how they were getting applications and mailings from ACS.*

However, at least one office has a problem with the local postal service in that the DSS office is not on the pick-up route. *Thus, one staff member from the DSS office is designated each day to deliver the mail to the local post office.*

**Electronic communication.** As noted during committee staff's office visits, not all DSS offices had access to "Outlook", with e-mail capabilities. Central Office Operations has since indicated that all offices now have that service. However, *the committee finds the department is still too reliant on paper rather than electronic communication. While policies are available online, departmental transmittals explaining policy are still mailed to workers, and most management reports generated from EMS are copied and sent to managers.*

Further, *DSS' website, while generally helpful, could provide additional client information and/or make links to other sites more apparent.* For example, the names of medical providers available in the fee-for-service Medicaid program are listed on different sites than DSS' and a link is not provided.

**Physical plant.** Office conditions vary, although some of that is due to what office space is available in areas accessible to clients, and to the lease agreements that DPW and DSS are able to work out with landlords. However, Central Office Operations should not see its role end with the lease agreement. *Central Office Operations should ensure that certain office features -- like drop-off boxes, standard signage, and a comfortable waiting area for clients -- are standard among all offices.*

*Further, offices should not have to wait weeks or months to have files awaiting archiving sent to storage, as was noted to committee staff during district office visits.* These file boxes take up valuable working space and detract from both the appearance and operations of the office.

*Thus, the committee finds considerable deficiencies in the support operations that district office eligibility staff need to conduct their jobs. The committee believes these support functions should not be the responsibility of each office, but should be provided in a coordinated fashion by Central Office Operations.*

**Therefore, the committee recommends that DSS Central Office Operations 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.**
- **Communicating to the district offices exactly what support services are available – like the courier delivery—and how to access those services.**
- **Assume a “quality management approach” where Central Office Operations is 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.**

**Rationale.** These types of services and support are crucial to any operation, but especially so when workers are dealing with clients daily. Workers rely on these support systems to function efficiently so that processes and procedures for assisting clients go smoothly. Central Office Operations ought to be more proactive in ensuring this is the case, rather than trouble-shooting only when problems occur. Further, Central Office Operations should not see its role as limited to purchasing or contracting for a service or system. It needs to communicate the service to staff, communicate and/or train them in how to use it, and continuously collaborate with the offices to identify problems, and work on support solutions to constantly improve work processes and outcomes.



# **APPENDICES**

## APPENDIX A

### GLOSSARY OF COMMON MEDICAID TERMS

**Balanced Budget Act (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 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 is 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; 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 lose 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

### Convalescent Case Processing Checklist

Applicant		Convalescent Home	
Agent 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	
<b>Median</b>	<b>\$400</b>	<b>55%</b>	<b>\$2,000</b>	<b>\$530</b>	<b>55%</b>	<b>\$3,000</b>	<b>1994</b>
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 <sup>2</sup>	No Limit	N/A	No Limit	No Limit	N/A	No Limit	1988
Michigan <sup>3</sup>	\$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 <sup>4</sup>	---	---	---	---	---	---	---
Utah	\$382	53%	\$2,000	\$468	48%	\$3,000	1999
Vermont <sup>5</sup>	\$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](http://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. <sup>1</sup> Connecticut has two income standards, based on the region. <sup>2</sup> 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. <sup>3</sup> Michigan has regional income standards. Standards in this table show the highest regional standards. <sup>4</sup> 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. <sup>5</sup> Vermont uses a higher income standard for Chittenden County only.

Appendix D



**STATE OF CONNECTICUT**

*DEPARTMENT OF SOCIAL SERVICES*

**OFFICE OF THE COMMISSIONER**

Patricia A. Wilson-Coker, JD, MSW  
COMMISSIONER

August 6, 2004

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1-800-842-4524

FAX  
(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  
Page Two

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  
Page Three

- 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,

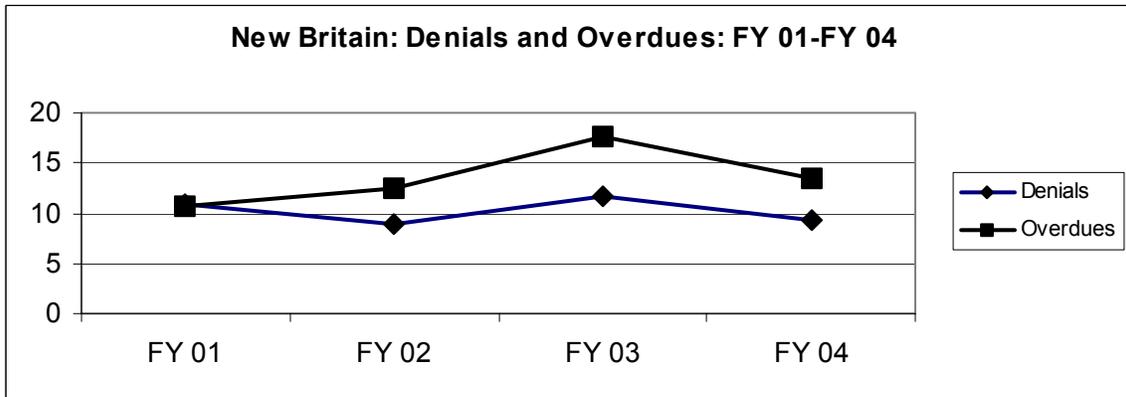
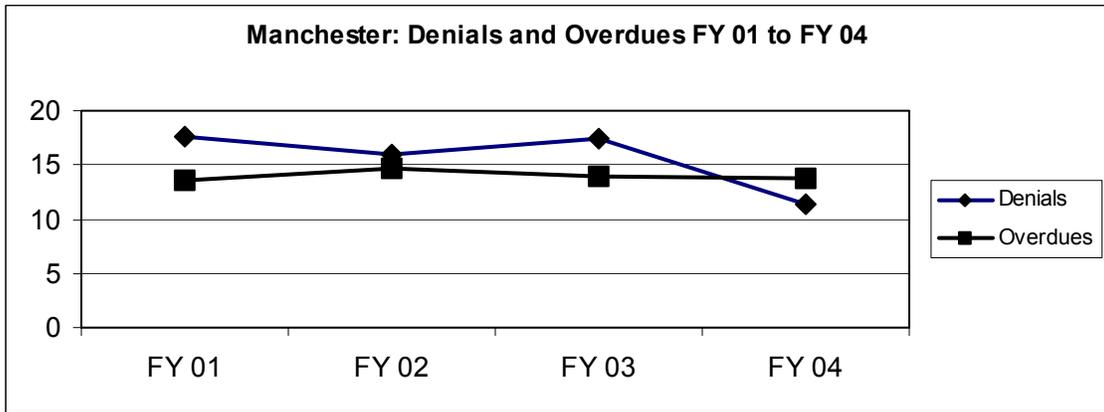
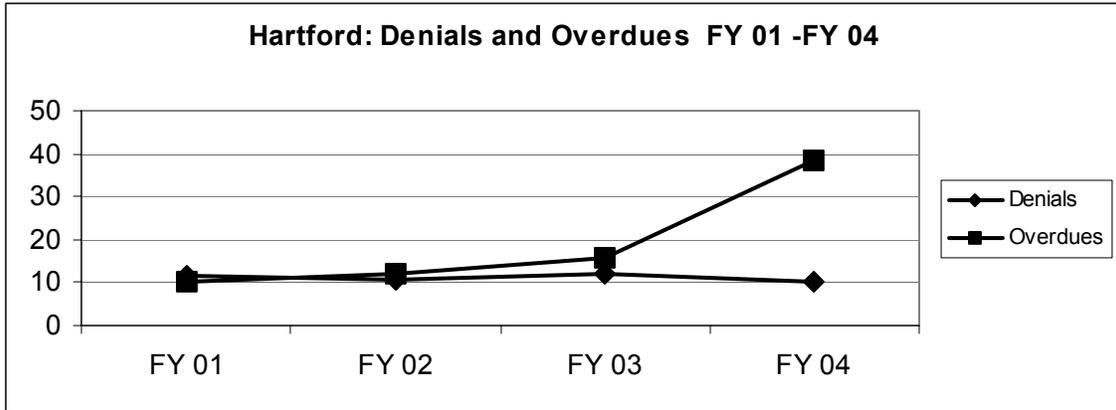


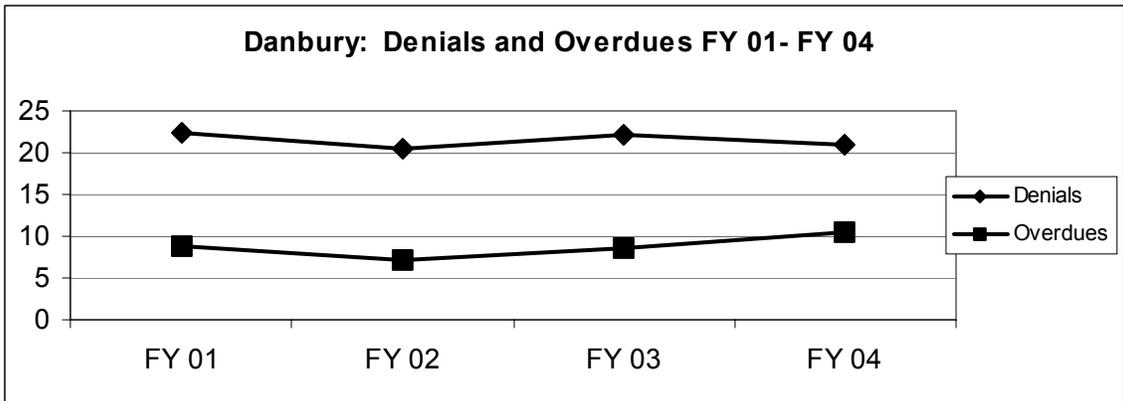
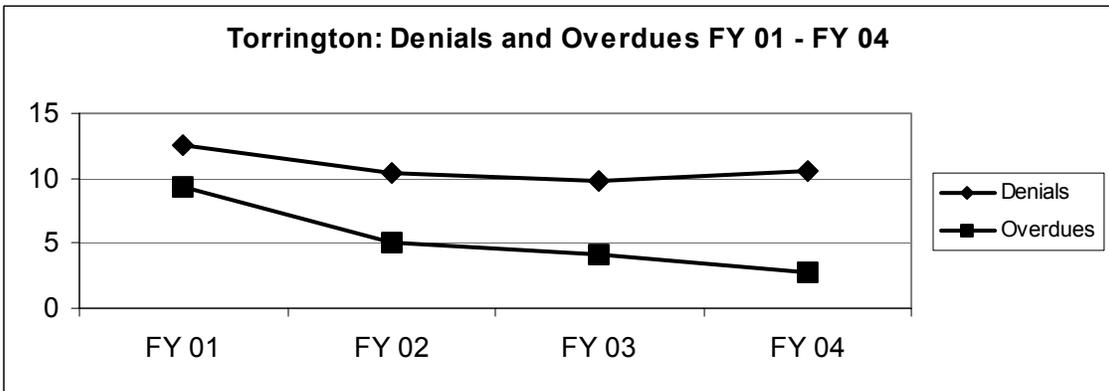
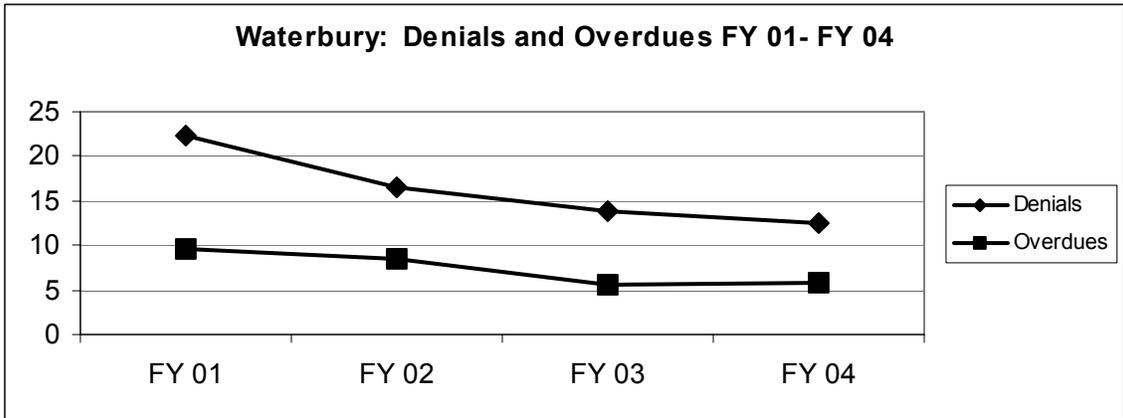
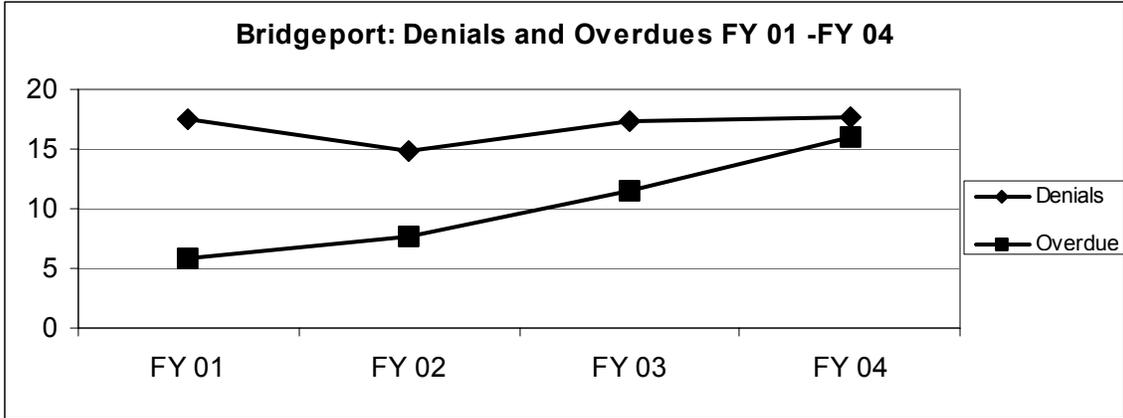
Patricia A. Wilson-Coker  
Commissioner

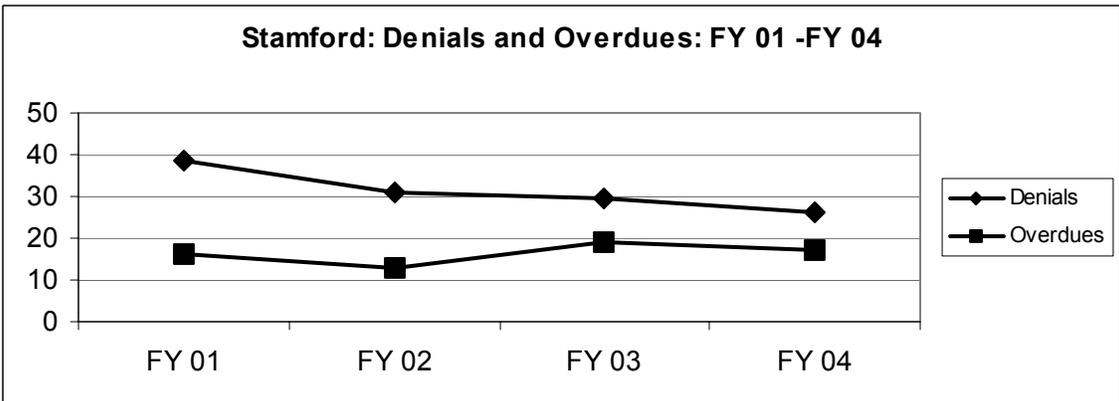
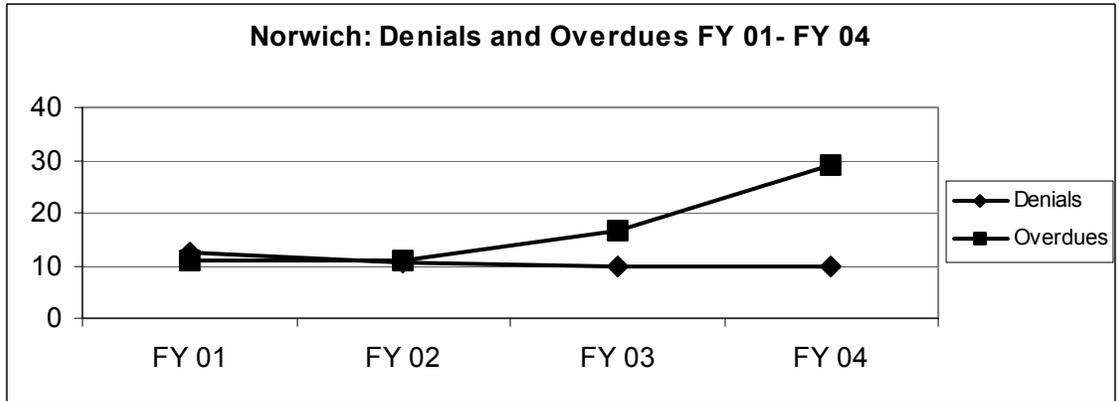
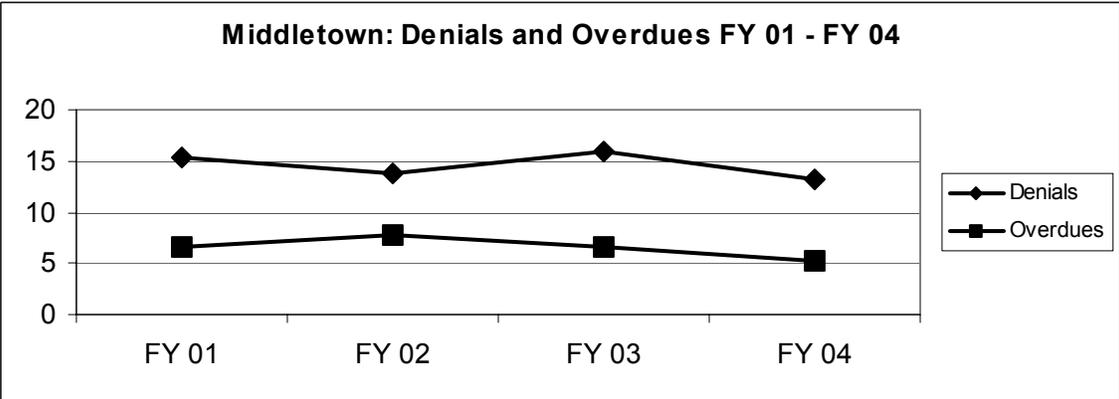
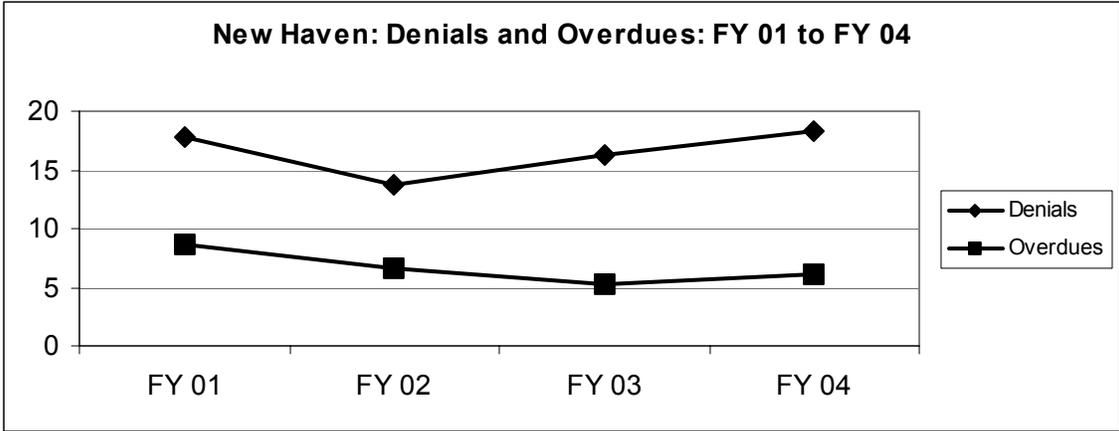
PW-C:kl

cc. Claudette Beaulieu  
Michael Starkowski  
Regional Administrators  
Kevin Loveland

**APPENDIX E: Percent of Denials and Overdue by Office  
Family Medicaid Applications**







# Appendix F

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## OTHER STATES SURVEY

Committee staff conducted a phone survey of 10 states to collect information on their eligibility management systems, whether those states had online application capabilities, and, if so, how those systems operated, how long they had taken to develop, and the costs. Below is a summary of the survey results.

### **Pennsylvania**

Pennsylvania operates a mainframe eligibility management system originally developed in the 1980s. The system conducts eligibility for all major assistance programs. An online application process (COMPASS) was developed in 2001 as a “front end” component to the mainframe system. COMPASS allows applications for various assistance programs to be submitted via the Internet, although a hardcopy signature page is still required from the applicant. Initial costs to develop the online capacity totaled approximately \$500,000, and included state and federal funding and grants. The system was implemented within a year, with the use of in-house staff and an outside consultant.

### **Texas**

Texas is in the beginning stages of developing a new eligibility management system to replace its “SAVERR” mainframe system that is 25 years old. The state legislature originally appropriated \$55 million in 1999 to begin developing a new integrated, web-based system “TIERS”, with an additional \$137 million appropriated in 2001. The new system is being piloted in five offices statewide before full conversion takes place. The state also provides online capacity to screen/evaluate a person’s potential eligibility “across multiple health and human service programs” based on information the person enters online. Proposals are currently being sought for a fully automated, web-based application process that would be a component of TIERS.

### **South Carolina**

South Carolina recently implemented a new Medicaid eligibility management system in 2002. The new system replaced one that was 20 years old. Planning for the new system took approximately six years, with the use of Clemson University as an outside consultant. Internal staff was also used for planning, design, and implementation. The system is considered “more automated” than its predecessor, but will not automatically determine an applicant’s eligibility as originally designed, due to budget cutbacks. There is no online functionality to the system, including web-based application processing, although a planning committee is beginning to examine this issue.

### **New Hampshire**

In late 1998, New Hampshire implemented a new eligibility management information system replacing its 20-year old mainframe system. The new system’s approximate cost was \$23

million, and funding came from state and federal sources. Planning took just under three years, with the use of a consultant and in-house resources. The system allows for automated eligibility determination for various benefit programs, although no web-based application process was part of the original design, due to limited funding. The state does have an online “screening” tool (Wired Wizard) for potential clients to determine what programs they may be eligible for based on information they submit using a web-based questionnaire. The tool can screen potential eligibility for over 60 different programs, and has been in place since 2000.

## **Vermont**

Vermont uses a mainframe eligibility management system developed in 1984. Although the system’s underlying software is frequently updated, there are no current plans to implement a new system. The state is developing a web-based screening function to help potential applicants determine which programs they may be eligible for based on information they enter online. The tool will be capable of screening eligibility for all of the state’s assistance programs. This process is being developed using in-house resources.

## **Rhode Island**

Rhode Island has mainframe system, an updated adaptation of the Vermont system, which was established in the late 1980s. It performs the eligibility determinations and case maintenance functions for all the major assistance programs. Rhode Island has no plans to upgrade the system, and has no online application capability.

## **Colorado**

Colorado just recently implemented a new eligibility management system for all its major assistance programs. The state started planning for the new system 10 years ago, and the development of the system took three to four years. The new system replaced a 30-year-old Legacy system that really did not determine eligibility, but served more as a program database. The new system cost more than \$100 million dollars, but reports in the Denver newspapers indicate the first months of system operations have not been smooth, with many people not receiving their assistance. The new system has no online application capabilities at this time.

## **Maine**

In 2002, Maine began using a new web-based Oracle system known as ACES (Automated Client Eligibility System). It replaced a 30-year-old mainframe Legacy system, which like Colorado’s, did not really determine eligibility and benefits, but functioned more as a database. Maine spent about \$22-\$23 million on its new system, and used a consultant for project development. The consultant continues to be paid to providing training and other ongoing services. The project received 50% matching federal funds; according to Maine officials, the state had missed deadlines for the higher 90% federal reimbursement. The transition to the new system caused problems because the state had to enter data from the old system and paper files. During that period, workers were not as carefully determining client

eligibility and the state's error rate went up. The system has no online enrollment capabilities at this time.

### **California**

California operates a 30-year-old mainframe system that is used by 58 counties or local government agencies to determine eligibility for all assistance programs, including about 6.5 million Medicaid clients monthly. A very preliminary proposal was put forth by a statewide group appointed by Governor Schwarzenegger to examine overall state government performance, but nothing has reached the planning and development or financing stage. California does give online application capabilities to "certified application assistants" primarily workers at community-based agencies. These assistants can then help clients complete and transmit their applications electronically. Health-e-App, as the program is called, began as a pilot in the San Diego area in 2001, and went statewide in 2002. Only applications for Medicaid for children are currently accepted electronically, but there are plans to expand that. The Health-e-App system cost between \$1-\$2 million to develop, and the application assistants are paid \$50 for each completed application received. Some federal funding was available for system development, although not as much as initially expected. Some private funding was obtained to match state monies.

### **Washington**

Washington has a relatively online system that was begun in 1997. It uses an online blended application and replaced an old system that was primarily a database, and relied on a lot of manual calculations to determine eligibility. The new system provides online application functions, but the applications do not yet interface with ACES, the eligibility management system. On line applications account for only about 5 percent of applications, which state officials find disappointing, but believe is adequate to continue the capability.

Appendix G



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

Patricia A. Wilson-Coker, JD, MSW  
COMMISSIONER

February 9, 2005

TELEPHONE  
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Carrie E. Vibert  
Director  
Legislative Program Review and  
Investigations Committee  
State Capitol, Room 506  
Hartford, CT 06106

Dear Ms. Vibert:

Thank you for providing the department with the opportunity to comment on the Committee's final report entitled *Medicaid Eligibility Determination Process*. Your staff has done a commendable job of reviewing and analyzing a very complex program and the equally complicated processes that the department must follow in determining and maintaining the eligibility of the close to 400,000 Connecticut residents who participate in Medicaid.

As your report points out, the department's ability to perform these Medicaid eligibility functions has been tested following an approximate 25% reduction in staff levels that occurred in early 2003. Your report also includes references to the several initiatives the department has undertaken to attempt to improve and streamline our processes in response to these reductions in staff resources. Indeed, many of your recommendations provide for the department to keep working on initiatives already underway.

In general, the department agrees with most of the report's recommendations. There are a few exceptions and I have identified these on the attached document, which explains the department's objections or concerns.

I am also concerned that several of your recommendations assume the department has sufficient resources to implement them. This may not be the case or it may be impossible to implement in the timeframes included in the recommendation. Just as the department suffered significant reductions in front-line eligibility staff, we also lost a large percentage of our staff in the central office program, management information, and operational support units that will be responsible for implementing many of your recommendations. This will impede our ability to respond as timely as we would like. We are however committed to continuous improvement in our agency operations and will make every effort to implement your recommendations. However, the department cannot support recommendations that depart from the Governor's budget recommendations, such as the implementation of presumptive eligibility for children and additional staff beyond those allocated in the department's budget.

Sincerely,

A handwritten signature in black ink, appearing to read "Patricia A. Wilson-Coker".

Patricia A. Wilson-Coker  
Commissioner

PW-C:kl

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G-1

## CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

### Agency Response to the Recommendations Contained in the Legislative Program Review and Investigations Committee's Final Report Entitled *Medicaid Eligibility Determination Process*

#### Committee Recommendation (Page 59):

**DSS should form a work group, with representatives of eligibility workers, supervisors, and 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.**

#### Agency Response:

*The department has had an "Alerts Work Group" for eight or nine years. The work group includes the types of staff included in the recommendation. It will continue to make recommendations for changes to the alerts generated by EMS. However, the department does not agree with the premise that alerts should only be generated when they will impact the client's eligibility. The alerts component prompts the worker to take action in other circumstances, such as processing recoveries of overpayments and responding to computer interface matches. The latter types of alerts are quite voluminous and burdensome to the workers, but follow-up on such information from the Internal Revenue Service and State Labor Department is mandated by federal law .*

#### Committee Recommendation (Page 59):

**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.**

#### Agency Response:

*The department agrees with the first recommendation, concerning supervisory monitoring, but disagrees with the alternative recommendation regarding automatic discontinuance. Federal Medicaid law requires that Medicaid eligibility continue until such time as the department determines that a client is ineligible. It is not proper to discontinue benefits because we cannot complete a redetermination within a specified time period. Sometimes a redetermination must remain incomplete because of third party delays in providing information. An example is when we are waiting for a medical report from a physician to determine whether a client continues to meet the program's disability criteria.*

#### Committee Recommendation (Page 62):

**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.**

Agency Response:

*The department is not opposed to this recommendation in principle. However, we believe it would be more effective to have address changes reported by the managed care organizations, rather than the enrollment broker, since they are a direct point of client contact for address changes. Also, regarding the processing of such address changes by the Administrative Services Division, the department does not have sufficient staffing resources to implement this process. We estimate that there are between 600 and 1,000 address changes reported to the department each week. It would take more than one processing technician to handle this level of activity and notify the regional worker of the change so that he or she can take related actions such as updating shelter expenses and household composition. If and when staff resources can be allocated for this purpose the department would be willing to pursue this recommendation.*

**Committee Recommendation (Page 75):**

**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.**

Agency Response:

*The department already has such a policy. Please see Uniform Policy Manual Section P-1505.40. Eligibility workers are instructed to review applications within seven days of receipt and issue a W-1348, "Application Requirements List", to the applicant by the end of this time period detailing the eligibility factors that must be verified to complete their application. The applicant is given ten days to respond to this request for information. If he or she responds during this time period the worker is to review the material submitted within seven days. If there are still outstanding items they are to issue another W-1348 with another ten-day deadline. This iterative process continues until the application is complete or the applicant fails to respond.*

**Committee Recommendation (Page 95):**

**„the committee recommends that DSS, working with the governor's office and the legislature's Human Services Committee, 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. (Page 95)**

Agency Response:

*In general the department agrees with this recommendation. However, we need to point out that any federal waiver would have to be sought under the authority of Section 1115 of the Social Security Act. CMS may require a research and demonstration component to any such waiver. This would require resources beyond those currently available to the department.*

**Committee Recommendation (Page 97):**

**The committee believes that since the nursing home population is such a stable one -- whose eligibility for Medicaid is "long term" and whose eligibility circumstances do not generally change, the renewal period ought to be extended. Therefore, the committee recommends that DSS submit a waiver request to CMS to allow a two-year redetermination period for long-term care clients. (Page 97)**

**Agency Response:**

*The department agrees that these types of cases tend to be very stable and a two-year redetermination would be justified where the client's assets are not close to the asset limit. In addition, elderly and disabled Medicaid residents residing in the community on fixed incomes also tend to have very stable circumstances, warranting a longer redetermination period. The department agrees with the recommendation that a waiver be pursued with the caveat that such a waiver might only be granted by CMS if it has a research and demonstration component. The department does not have the resources to support such a research effort. The department also believes this is another area where we should pursue changes to federal law to permit the state the option of a two-year redetermination period.*

**Committee Recommendation (Page 99):**

**DSS should begin taking the initial planning steps for an EMS replacement now. First, the department should attempt to secure funding from 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.**

**Agency Response:**

*The department does not believe there is the level of urgency to the need to replace EMS that is contemplated by this recommendation. Although we acknowledge that the current system is not "state of the art", it performs reliably and generally adequately supports Medicaid and other program eligibility determinations. We do agree that planning for a new system is needed. However this is a major undertaking requiring dedicated project staff that are currently not available to the department. It is also a costly undertaking as development costs will probably be in range of \$20 to \$40 million. It doesn't appear reasonable to undertake a major initiative of this type prior to the state committing the resources for system development.*

**Committee Recommendation (Pages 100-101):**

**The program review committee recommends that DSS 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.**

**Agency Response:**

*The department has been working on the de-linking of TFA and Medicaid eligibility in EMS for several years. Our current target date for implementation is May 1, 2005.*

*The department does not fully understand and therefore cannot agree with the committee's recommendation to de-link other assistance programs from Medicaid. First, the eligibility for other programs is not linked to Medicaid in the same manner as the TFA program. Second, if the intent is to totally separate the client eligibility processes this would be an inefficient use of state resources and create additional burdens on our clients, as many individuals and families rely on more than one program.*

**Committee Recommendation (Page 106):**

**..., the committee recommends that as contractual arrangements for police coverage expire, DSS substantiate the need for their continuation to the Office of Policy and Management and the Appropriations sub-committee responsible for DSS financial oversight.**

**Agency Response**

*The department has recently reviewed all of its security arrangements. All of the schedules for guards and police officers were reviewed by local and central office management and adjusted based on the level of security needed with the premise that a lower priced security guard be used rather than a police officer whenever possible. The department does not agree with the recommendation concerning the specified level of oversight from OPM and the legislature.*