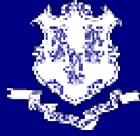

OLR RESEARCH REPORT

January 17, 2013 2013-R-0016

MEDICAID — ELIGIBILITY, ADMINISTRATION, AND PROVIDER PARTICIPATION

You asked a series of questions about the Medicaid program. Specifically, you want to know (1) what the procedure is for becoming eligible for Medicaid; (2) how long the Department of Social Services (DSS) has legally to approve a Medicaid application; (3) the average, longest, and shortest amount of time it takes DSS to approve an application; and (4) how many medical providers participate in the program and what percentage of all providers this number represents.

SUMMARY

The Medicaid program consists of many coverage groups with their own eligibility criteria. While a low income and few assets have been the program's primary pathway to eligibility, historically, an applicant's age or health status also mattered. For example, until 2010, healthy childless adults between ages 19 and 64 could not qualify for Medicaid. But the 2010 federal Affordable Care Act requires Medicaid coverage of childless adults with incomes up to 138% of the federal poverty level (FPL) (P.L., 111-148, as amended by the Health Care and Education Reform Act, P.L. 111-152, hereafter collectively referred to as the ACA).

Federal regulations prescribe timeframes for processing Medicaid applications to ensure that individuals get timely access to necessary health care. For most applicants, this is 45 days from the time the Medicaid eligibility worker receives the application. A longer period is

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allowed for processing applications for people with a disability. Data from DSS indicate that application rates have soared in the last few years. Although we are not certain of DSS' capacity to process the applications it receives expeditiously, these data also show that DSS has had difficulty doing so. DSS is pursuing modernization efforts to strengthen its ability to meet these deadlines with greater frequency.

DSS reports that emergency Medicaid applications are processed on the day they are received. It is unable to say what the average or longest processing times are.

We are in the process of determining the state's Medicaid provider participation rates. At this juncture, DSS is reporting that 11,753 physicians are participating in Medicaid and 1,394 dentists serve Medicaid recipients. These figures include out-of-state providers. Historically, participation in Connecticut and nationally has been low. Low provider reimbursement rates have been the major reason for this. According to an August 2012 *Health Affairs* study, nationally in 2011, 69.4% of physicians accepted new Medicaid patients, compared with 81.7% of people with private insurance. In Connecticut, which had the fourth lowest rate (behind New Jersey, California, and Florida), only 60.7% of physicians were accepting new Medicaid patients. Over the last several years, DSS has taken steps to address provider participation, most notably by increasing the rates it pays HUSKY dental providers. This action was in response to a class action suit.

The ACA requires states to pay Medicaid to primary care physicians at the generally higher Medicare rates in 2013 and 2014, with the federal government paying the difference between the old and new rates. This is expected to increase the number of clinicians that become participating providers. According to a new report by the Kaiser Family Foundation, Connecticut's rates will rise by 41%. Rhode Island is increasing its rates by 198%. Alaska and North Dakota rates will not rise at all.

MEDICAID ELIGIBILITY

The state's Medicaid program provides fully subsidized health insurance to most very-low-income state residents. The coverage category into which someone falls generally depends on the applicant's age and whether he or she has a disability. Table 1 provides a listing of some of the major Medicaid categories and their eligibility criteria.

Table 1: Select Medicaid Coverage Groups and Their Eligibility Requirements

Medicaid Coverage Group	*Income Limits*	*Asset Limit [1]*	*Who is Covered*
HUSKY A	185% of the federal poverty level (FPL)[2]($35,316 annually for a family of three)	None	Children under age 19 and caretaker relatives
HUSKY C	143% of the Temporary Family Assistance (TFA) benefit level-$506.22 per month for one person, plus $302 of unearned income is disregarded; spend-down option for individuals with higher incomes	$1,600 for one person, $2,000 for couple (for couples living in community; higher limits for nursing home resident's spouse after assessment	Aged, blind, disabled adults
HUSKY D (also called Medicaid for Low-Income Adults or LIA)	$512.05 per month, plus $150 earnings disregard; spend-down option for people with higher incomes	None (DSS has submitted request to impose $10,000 asset limit)	Adults between 19 and 64
Home- and community-based services waivers (e.g., Connecticut Home Care Program for Elders, Personal Care Assistance)	300% of maximum monthly SSI benefit ($2,130 per month for a single person in 2013)	Generally, $1,600 for single person	Generally elderly and individuals with disabilities
Medicare Savings Programs (includes Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualified Individuals	QMB-$1,983.03 monthly for single person in 2013 SLMB--$2,169.23 in 2013 QI--$2,308.28 in 2013	None	Medicare beneficiaries Medicaid pays certain Medicare Part B cost sharing (e.g., premiums)
Family planning (new in 2012)	250% of the FPL	None	Individuals of child-bearing age not otherwise eligible for Medicaid

[1] DSS also has rules about non-liquid assets (e.g., automobiles and life insurance policies) that can affect an applicant's eligibility.
[2] In 2012, 100% of the poverty level for a family size of one is $11,170; for two it is $15,130; and for three, $19,090. The new poverty guidelines will not take effect until March 2013.

APPLICATION PROCESS

Federal Law's Standard of Promptness for Processing Medicaid Applications

Federal Medicaid law generally requires that states process Medicaid applications in a timely fashion. Specifically, it requires state agencies to "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals" (42 USC § 1396a(8)). Federal regulations establish the actual timeframes or "standards," requiring state Medicaid agencies to both

establish and notify applicants of them. These are 90 days for applicants who apply for Medicaid on the basis of a disability and 45 days for all other applicants (42 CFR § 435. 911).

Application Activity, Processing Timeframes and Delays, and Caseload Growth

The state's Medicaid caseload has grown at a tremendous rate during the last few years. The recession clearly has been a factor, as has DSS' expansion of Medicaid coverage to include additional individuals. For example, it converted the State-Administered General Assistance medical assistance program to the Medicaid LIA program in 2010; by November 2012, nearly 40% of the monthly Medicaid applications were for the Medicaid LIA program alone. DSS also established one additional coverage group in 2011 and one in 2012: one for tuberculosis patients and another for family planning, respectively.

We are still awaiting information on current and historical DSS staffing levels to determine whether the agency has hired additional staff to help handle the increased application volume. According to a DSS presentation to the legislature in 2011, the department experienced a 30% increase overall in households that it served between 2008 and 2010, while staffing levels decreased by 8% during this period. A June 2012 *CT Mirror* story reported that the number of DSS eligibility workers shrunk by 25% between 2001 and 2011. This story also reported that the Malloy administration had hired 175 new eligibility staff, which included 60 who would handle Medicaid applications and redeterminations of eligibility. Even with increases in staffing, DSS has had a difficult time meeting its mandate to process Medicaid applications promptly, and the unexcused delays have worsened over time, as shown in Table 2.

The extent to which applications are overdue varies considerably among the different Medicaid groups. For example, historically more than 50% of long-term care Medicaid applications have been overdue. This in large part is due to DSS staff having to verify asset transfers that could affect the applicant's eligibility.

The criteria for the different Medicaid coverage groups, the manner in which criteria are verified, and who can determine eligibility all vary. For example, children and women who are pregnant, seeking family planning services, or wish to be screened for breast and cervical cancer are presumed to be eligible for benefits as long as the family's gross income does not exceed the state limits. "Qualified entities" grant eligibility on a temporary basis and DSS follows up and verifies that the family is actually eligible or the coverage ends at the end of the following month.

Based on the data in column 2 of Table 2, the number of Medicaid applications received during the month of November in 2012 was 205% higher than the number who applied during that same month in 2008. The number of program enrollees jumped by 58% during this time.

Table 2: Medicaid Application Activity, Enrollments, and Overdue Applications

Year (during month of November)	*Number of Medicaid Applications Received*	*% Change*	*Number and Percentage of Overdue Applications*	*Percentage of Overdue Applications Unexcused*	*Number of Assistance Units*	*No. of Enrollees*
2012	25,968	32%	5,973/48%	11%	448,604	685,917
2011	19,616 [1]	68	6,896/55	7	417,317	644,138
2010	11,693	(10)	2,813/46	5	272,982 [2]	495,028 [2]
2009	13,001	53	4,399/51	4	260,844	460,662
2008	8,501	NA	3,169/45	7	247,585	432,886

Source: DSS, various monthly reports

[1] This figure includes "Medicaid only" (e.g., HUSKY A families), LIA, and certain other categories of recipients. Just under 7,500 of these applications were LIA applications.

[2] These figures do not include 57,983 Medicaid LIA enrollees as DSS continued to separate them from the total Medicaid count until July 1, 2011 even though DSS began granting Medicaid eligibility before that date. Additionally, effective November 2011 and March 2012, DSS started offering Medicaid coverage for tuberculosis treatment and family planning services (as required by the ACA), respectively, to individuals not otherwise eligible for Medicaid and these individuals are counted in 2012.

[3] In its monthly reports on application activity, the department indicates which applications are overdue. The report separates "excused" overdue applications from "unexcused" ones. Examples of excused delays include DSS not having used the full 10 days to secure information and a third-party delay (e.g., the applicant is trying to verify whether there may be third-party coverage for the medical care). Unexcused absences include computer problems or a delay in the DSS medical review team determining whether a client meets certain functional eligibility requirements (e.g., disability).

Application Processing and Modernization Efforts

People may apply to DSS for assistance in person or by mail. DSS must ensure that the applications are complete and then verify the information they contain, particularly the financial information. This means, for example, that staff must ensure that applicants claiming to have a certain amount in a bank account have submitted the latest monthly statement. For long-term care Medicaid applicants, eligibility workers must also address the federal "look-back" rules that require states to look back five years to see if assets were transferred during that period.

As part of its modernization initiative, DSS hopes to have the application process fully automated later in 2013. Moreover, as the state begins to implement additional ACA provisions, it is possible that administrative efficiencies can be achieved. One ACA provision requires that any individual applying for health care assistance that might be eligible for public health insurance (Medicaid or SCHIP) or insurance subsidies through the exchange be considered for eligibility for all three through a single application form and eligibility process (ACA, § 2201). The federal Department of Health and Human Services (HHS) secretary is charged with coming up with the application. States may create their own, with HHS approval.

ADDITIONAL RESOURCES

Legislative Program Review and Investigations Committee, *Medicaid Eligibility Determination Process*, 2004

OLR Report 2009-R-0242, *Physician Participation in the Medicaid Program*
OLR Report 2012-R-0057, *Connecticut Medicaid: Exempt Resources*

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