Connecticut's TANF/Medicaid Review: Final Report

October 2001

I. DESCRIPTION OF REVIEW PROCESS

A. Scope of Review

Representatives from the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), and the Administration for Children and Families (ACF) conducted an on-site review of certain aspects of Connecticut's Medicaid program during the week of August 30, 1999. A follow-up review was conducted during week of March 20, 2000. We appreciate the State's willingness to accommodate a second review and believe that the opportunity to go back on-site greatly enhanced our understanding of its program. The Federal team for the first review consisted of Allen Bryan, CMS-Region I and Truong Tran, ACF-Region I. The review team for the follow-up review included Allen Bryan; Roberta Kelley, CMS-Region IV; and Logan Dreasky, CMS Central Office. Hereinafter, "review team" collectively refers to both teams together.

This report is based on information gathered through reviews of State documents, policies and procedures; case record reviews; and discussions with State Medicaid representatives and staff, consumer advocates and other relevant parties. Subsequent to the review, the State and local advocacy groups were given an opportunity to comment on the review team's findings. The report may reflect these comments, in whole or in part, as well as information provided to CMS staff pertaining to actions the State has taken since the reviews. Specific comments offered by the State and advocates on a draft of the report are addressed in part VI. A copy of the full comments from the State is appended.

Although the Office for Civil Rights (OCR) did not participate on either of the review teams that conducted the site visits, a copy of this report has been shared with OCR for its review and consideration. OCR is able to provide States with technical assistance with regard to civil rights compliance issues (e.g., requirements under Title VI of the Civil Rights Act of 1964 to provide translators and translated written materials to applicants and beneficiaries who do not speak English, and requirements under Title II of the Americans with Disabilities Act to ensure access for people with physical and mental disabilities.) The OCR regional office can provide additional information and assistance on civil rights issues.

The review focused on the following areas:

- The delinkage of Medicaid from cash assistance;
- The Medicaid application process;
- Procedures involving Medicaid denials, terminations and redeterminations; and
- Procedures for ensuring maximum duration of Medicaid coverage for families moving from welfare to work.

B. State and Local Offices Visited

During the initial visit, entrance and exit conferences were held with representatives of the Connecticut Department of Social Services (DSS or "the Department") in Hartford on August 30 and September 3, 1999, respectively. On-site reviews were conducted at the Hartford and Norwich District Offices on September 1 and September 2, respectively. The on-site reviews included a random sample of 20 cases taken from all approved Temporary Family Assistance (TFA) applications, TFA denials, and closed TFA cases from each of those offices. TFA is Connecticut's Temporary Assistance for Needy Families (TANF) program, approved under a §1115 waiver.

During the follow-up review, entrance and exit conferences were held with the Department on March 20 and March 23, 2000, respectively. The District Offices in Middletown and Hartford were visited on March 21 and 22. The on-site reviews included a random sample of 5 cases each taken from all approved Transitional Medicaid cases, TFA cases closed within the last 3 months, TFA denials within the last 3 months, and Medicaid cases that have undergone a redetermination of eligibility in the last 3 months. In addition, 3 cases were reviewed from each office of open TFA and TFA-related (§1931) cases.

C. Overview of Program Administration

The Department of Social Services administers a variety of public assistance programs, including TFA, Food Stamps and Medicaid. The Commissioner of Social Services heads the Department, with deputy commissioners for Administration and Programs. A regional administrator is responsible for each of five service regions -- North Central, South Central, Northwest, Southwest and Eastern – which have a total of 15 local, or district, offices. By statute, there is a statewide advisory council to the Commissioner, and each region must have a regional advisory council. Medicaid policy is set forth in the State's Uniform Policy Manual (UPM).

While the organizational structure of most District offices varies somewhat based on the size of the office and the population served, intake workers generally determine eligibility for TFA, Food Stamps and Medicaid and case maintenance workers manage active assistance cases from

day to day. Resource workers provide research support to the case maintenance units, primarily on assets and overpayments; social workers counsel clients; and child support workers perform the child support enforcement functions. Workers in larger offices can specialize in different assistance categories. Smaller offices may or may not have specialized employees. Only State workers are authorized to evaluate applications and make eligibility determinations, which is done using the State's computerized Eligibility Management System (EMS).

The State also has created a new position, Family Independence Representative (FI-Rep), to assist individuals in time-limited TFA cases. In smaller offices, these specialists may be responsible for a case from the date of application through closure. In larger offices, intake workers process the application and then transfer approved cases to an FI-Rep for ongoing case management. FI-Reps maintain closed cases for 60 days before transferring it to a case maintenance worker.

II. ANALYSIS OF DOCUMENTATION AND CASE REVIEWS

A. State Policy

1. TANF Policies and Procedures. The Personal Responsibility and Work Opportunity and Reconciliation Act (PRWORA) amended Title IV-A of the Social Security Act (the Act) to eliminate the Aid to Families with Dependent Children (AFDC) program and replace it with a new program, known as Temporary Assistance to Needy Families (TANF). Connecticut submitted a State Plan for its new TANF program, called Jobs First Temporary Family Assistance or "TFA," to the Federal Administration for Children and Families on September 27, 1996. As permitted under PRWORA, the State elected to maintain components of its AFDC §1115 research and demonstration waiver, originally approved by the Department of Health and Human Services on December 20, 1995, which were inconsistent with PRWORA.

To be eligible for cash assistance under TFA, family income must fall below an established standard of need, which, in turn, is based on 75 percent of the 1995 Federal poverty level (FPL). There also is an assets test. Maximum cash benefits are set at 73 percent of the standard of need. For recipients who have received TFA benefits in at least one of the previous four months, earned income is not counted until it exceeds 100 percent of the FPL. Thus, when a member of a family already receiving benefits gets a job, a raise, or more hours of work, the family can keep all earnings up to the Federal poverty level in addition to the cash assistance.

For families with an employable adult, there is a 21-month lifetime limit for TFA, with the possibility of one or more extensions if there is good cause for such adult's being unemployed or underemployed. Families in which there is no employable adult are not subject to any time limit.

There is no limit on the number of extensions that may be granted.

2. Section 1931 Medicaid Eligibility. Prior to the enactment of PRWORA, receipt of AFDC conferred automatic eligibility for Medicaid. In other words, eligibility for the two programs was linked. PRWORA severed this link, replacing it with a new provision (§1931 of the Act) for extending Medicaid coverage to low income families with children. Under §1931, States are required to cover low-income families who meet the AFDC income and resource standards and deprivation requirements in effect as of July 16, 1996 (i.e. before welfare reform). States with an §1115 AFDC were given the option to incorporate certain provisions such waiver into the criteria for eligibility under §1931. Section 1931 also gives states the option to lower the income standards for families, but not below the AFDC standards in effect as of May 1, 1988, or to increase their income or resource standards based on a percentage that does not exceed the percentage increases in the Consumer Price Index that have occurred since July 16, 1996. Finally, under §1931(b) of the Act, States can use income and resource methods that are less restrictive than the methods used under their AFDC State plan.

Connecticut submitted a State Plan Amendment (SPA) to implement §1931 effective April 1, 1999. Although the SPA had not yet been approved, Connecticut had implemented family coverage under §1931 prior to the site visit. The Regional Office approved the 1931 SPA in October 2000 (after the site visit).

Initially, the income and asset requirements for TFA and Medicaid under §1931 generally were the same. In June 1999, the General Assembly passed legislation raising the income limit for §1931 Medicaid to 185 percent of the FPL and eliminating the asset test. In May 2000, before the 1999 legislation became effective (and subsequent to the second Federal review), the legislation was amended to reduce the expansion for the §1931 coverage group to 150 percent of the FPL and to delay its implementation until January 1, 2001. Subsequent to the site visit, the state submitted a new §1931 SPA to reflect the 150 percent FPL. The Regional office requested additional information that the state has submitted. The Regional office is currently reviewing the revised SPA and will approve it shortly.

As explained in Policy Transmittal UP-99-6, issued on March 16, 1999, in implementing its SPA, the State established a separate eligibility category in its Eligibility Management System (EMS) for §1931 Medicaid: F07. F07 formerly was used for those eligible for, but not receiving, AFDC. The transmittal correctly states that cash assistance no longer guarantees Medicaid eligibility and references a memorandum issued on June 2, 1998, which, in turn, instructs staff to review Medicaid eligibility using TFA income and asset criteria whenever a family is denied cash assistance, discontinued from cash assistance, or put into a spend-down category. It further states that if Medicaid eligibility is established and the computer does not support such a determination, the worker should manipulate the data in the EMS to authorize eligibility and document this action in the narrative. Finally, Connecticut's policy guidance correctly provides

that Medicaid coverage should not be terminated for a TFA recipient who has failed to comply with TFA work requirements or other provisions which do not apply to Medicaid.

F07 is used only for families who are denied, or do not apply for, cash assistance. A separate category, F01, is used for families who apply and are eligible for cash assistance, and eligibility under F01 is automatically conferred upon families eligible for cash assistance. While Connecticut may consider coverage under §1931 (i.e. F07) to be distinct from TFA-related Medicaid (F01), Federal law does not recognize this distinction. Both groups fall under §1931 and must be treated the same in policy and practice. Thus, while separating Medicaid eligibility for families into two groups and maintaining a link between TFA eligibility and Medicaid is permissible, it is so only if the eligibility criteria for coverage under, as well as State policy and practice implementing, the two groups is the same. Thus, states may not base §1931 Medicaid eligibility for cash recipients on less restrictive requirements than those that apply to families that do not receive cash assistance.

In violation of this rule, eligibility for TFA and F07 differ in the follow ways:

- Effective July 1997, TFA's degree of relationship rules were changed to allow any relative to receive assistance for a child. F07 Medicaid requires that the child live with a relative of a specified degree.
- A pregnant woman with no other children qualifies for TFA regardless of how long she has been pregnant, whereas under F07 she is only eligible for Medicaid if she is in her third trimester. (Note, however, that a pregnant woman with no other children in her first or second trimester may be eligible for Medicaid as either a qualified or poverty-level pregnant woman.)
- Finally, to be eligible for TFA, 18 year olds must be full-time students, whereas under F07 such children must be in school <u>and</u> expected to graduate by age 19. (Note, however, that an 18 year old who does not meet these requirements may be eligible for Medicaid as a poverty-level child, which requires family income to be below 185 percent of the FPL, or as a Ribicoff child.)

If Connecticut wants to continue to bifurcate the §1931 group and to maintain a direct link between TFA and F01 Medicaid eligibility, then the eligibility criteria for TFA and F07 must be aligned. Otherwise, the State must completely delink §1931 Medicaid eligibility from TFA and evaluate eligibility for the two programs independently of each other, regardless of whether or not a family is applying, or is eligible, for TFA.

3. <u>Protection for Disabled Children</u> – Section 211 of PRWORA made the definition of childhood disability under the Supplemental Security Income (SSI) program more stringent, and this change resulted in the loss of SSI benefits for some children. Under §1634 of the Act, states can link Medicaid eligibility for disabled individuals to receipt of SSI. Thus, in §1634 states, the

change in the definition of childhood disability change also resulted in a corresponding loss of Medicaid benefits. To remedy this unintended consequence, Congress enacted §4913 of the Balanced Budget Act. Section 4913 requires §1634 states to provide Medicaid to children who were receiving SSI benefits on August 22, 1996 and who, but for the change in the definition of childhood disability, would continue to be eligible for SSI benefits. Section 4913 also applies to states which do not link Medicaid eligibility to SSI, but which use SSI's definition of disability.

Connecticut is not a §1634 state (rather, it is a 209(b) State, in which Medicaid eligibility is not based on receipt of SSI) and it has not created an eligibility category for disabled children under 18. Therefore, §4913 does not apply to Connecticut.

B. Application and Enrollment

1. Eligibility and Enrollment Processes. The State uses a joint TFA/Medicaid/Food stamps application, although applicants can apply for one, two or all of the programs. The application is available in English and Spanish and is eighteen pages long. Depending on the assistance sought, not all of the application need necessarily be completed. Attached to the application are instructions, a document listing acceptable forms of verification and a check list of "Recipient/Agency Responsibilities." The State has not developed separate materials regarding the availability of Medicaid for low-income working families under §1931 or Extended Medical Assistance (EMA). Details regarding the different benefit programs, application and reporting requirements are explained by the caseworker.

Applications are available in the community, at outstation facilities and at the 15 district offices. Without assistance, the review team believes that it would be difficult for an individual to complete the application. Their completion, however, is intended to be an interactive process between the caseworker and applicant, either in a face-to-face interview or over the telephone, and caseworkers interviewed stated that they often preliminarily fill out the application and then go through it with the applicant step by step. When an application is initiated by phone, an intake worker takes information and mails out a completed application to the applicant for review, verification and signature. The applicant then returns the application for processing. As discussed above, families who apply, and are approved, for TFA automatically receive Medicaid benefits under eligibility category F01. Applications in which TFA is denied and Medicaid-only applications must be processed independently.

There are several differences in the application process and requirements for TFA (and related F01 Medicaid) versus F07 Medicaid. First, families applying for TFA must participate in a face-to-face interview, whereas families applying only for Medicaid do not. Second, as set forth in §8540.65 of the State's Uniform Policy Manual (UPM) the entire assistance unit may be disqualified from receiving TFA if a parent does not cooperate (1) with establishing paternity and securing child support; (2) in providing the social security numbers (SSNs) of all dependent

children in the assistance unit; or (3) with digital finger printing. While adult applicants who do not provide paternity information without good cause -- e.g., victims of domestic violence -- are properly sanctioned under Medicaid, only the adults who fail to provide such information, not the entire assistance unit, can be sanctioned under Medicaid; in no event can such sanctions be applied to children.[1]

Caseworkers interviewed stated that if a family is precluded from applying for TFA due to failure to cooperate with TFA-specific requirements, they initiate and process a request for Medicaid only. Although EMS was not programmed to automatically screen for §1931 eligibility at the time of the site visit, the State's computer system did prompt caseworkers to search for other Medicaid coverage groups and workers were advised through memoranda and policy directives of §1931 eligibility. The review team observed caseworkers keying in applications in which an applicant was denied Medicaid coverage under one category and EMS prompted the caseworker to review other eligibility categories prior to rejecting the application. In addition, if a caseworker believes that EMS is improperly closing or rejecting a case, the caseworker can manually cancel the action in EMS. This allows the caseworker to bypass the system and maintain or approve coverage.[2]

Parents who choose to apply only for Medicaid benefits for their children may do so using the joint Medicaid/TFA/FS application or a simplified application for HUSKY, Connecticut's SCHIP program. HUSKY applications are four pages long and are available at district and regional offices. They also are given out at various community events. Completed HUSKY applications are mailed to a State contractor, Benova, which screens applicants for potential Medicaid eligibility. Connecticut's HUSKY program is discussed in more detail in section I, below.

During the initial site visit, advocates expressed concern that caseworkers do not independently screen for §1931 eligibility when an applicant chooses not to participate in TFA. As part of the follow-up site visit, the review team reviewed records for active §1931 cases. In the records reviewed, the review team found that workers did check for eligibility under the F07 coverage group for both new applicants and individuals undergoing a redetermination of eligibility. While we can only base our conclusions on the cases reviewed, we recognize that a limited number of cases were selected, and that none involved situations in which Medicaid was denied to a non-TFA applicant or recipient.

To ensure that families are aware of their rights and that all applicants are properly evaluated for Medicaid eligibility, the review team encourages the State to monitor this issue through its

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1 In its response to this report, the State says that it has implemented a new procedure in EMS which automatically makes the children eligible for ongoing Medicaid coverage when a parent does not cooperate with child support; the worker no longer needs to initiate and process a request for Medicaid manually.

2 In its response to this report, the State reports that it has taken all steps necessary to ensure that the EMS system does not improperly discontinue or deny Medicaid when TFA benefits are discontinued or denied.

negative case action program and to develop outreach materials informing individuals of the availability of Medicaid for those who choose not to participate in, or who are not eligible for, TFA as well as the availability of EMA. Such outreach seems particularly important in light of the State's 21-month TFA time-limit. We also believe that a simplified mail-in application for families, like the one Connecticut has developed for children, could promote participation among low-income working families.

2. Social Security Numbers. Although federal law prohibits states from requiring the social security numbers of non-applicants for Medicaid, the review team found Connecticut's policy on this issue to be unclear. The joint application form for assistance includes a space for SSNs, but does not state that it is optional for non-applicants under Medicaid. 42 CFR 435.910 states that a Medicaid agency may only require the SSN of individuals requesting assistance and must provide the statute or other authority under which the agency is doing so. Caseworkers interviewed stated that they explain the requirements concerning the provision of SSNs and when they are not required. They further stated that they would not deny an application for a child if the information is not provided. However, as a practical matter, caseworkers indicated that they routinely collect parents' SSNs.

Based on our review of State policy and the joint application, it is unclear whether or not the provision of parents' SSN is voluntary if they are only applying for Medicaid for their children. During the second site visit, the State informed the review team that it would be issuing a memorandum to clarify policy on the voluntary nature of the provision of SSNs by non-applicants. In addition to clarifying its policy, the State also needs to modify its joint application to state clearly that SSNs are optional for non-applicants under Medicaid. The HUSKY application is clear that Social Security Numbers are optional for non-applicants.

3. Opportunity to Apply Without Delay and Timely Determinations

A Connecticut policy transmittal dated July 1, 1997, adding §8510.15(A) to the UPM, provides that an opportunity to file an application must be provided on the date the individual contacts the Department for assistance. Section 8520.05(f) states that all applications must be processed within 45 days from the date of receipt. Workers interviewed were aware of these policies and none of the case records reviewed exceeded the 45-day time limit.

According to State staff, TFA applications pending due to TFA requirements that do not apply to Medicaid can be processed for Medicaid separately. For example, Medicaid eligibility would be determined independently if any individual in the assistance unit needing medical coverage immediately or if the applicant requested that the Medicaid portion of the application be processed. Otherwise, the entire application is held until the missing information is provided or outstanding requirements are met.

According to State staff, the major reason that processing Medicaid eligibility is held up is the administrative difficulty associated with approving Medicaid independent of TFA. The problem is that TFA eligibility cannot be processed if an applicant is already receiving Medicaid – e.g., was independently approved for Medicaid under F07. Thus, once the outstanding TFA information is provided or requirements met, the worker must close out the F07 case before processing the TFA application. Assuming that TFA benefits are approved, the assistance unit will then be placed in Medicaid category F01. This process requires manual intervention in EMS, and caseworkers perform them simultaneously so as to avoid any break in coverage. Although no cases processed in this manner were reviewed, caseworkers interviewed possessed a thorough understanding of the process and stated that they make every effort to process the application quickly when necessary. The review team found that the caseworkers interviewed appeared to be genuinely concerned that families receive all benefits available to them, including Medicaid.

4. <u>Civil Rights Requirements</u>. In our review of the application process, we also reviewed Connecticut's compliance with Title VI of the Civil Rights Act of 1964 and its implementing regulations, found at 45 CFR §§80.3(a), (b)(1)(I-vi); Section 504 of the Rehabilitation Act of 1973 and its implementing regulations, found at 45 CFR §§84.52 (a)(4) and (d)(1); and Title II of the Americans with Disabilities Act. Although the Office for Civil Rights (OCR) did not attend the site visits, a copy of this report will be shared with OCR for its further review and consideration.

All of the buildings at all locations visited by the review team appeared accessible to the physically disabled, with ramps, elevators and parking spaces reserved for disabled individuals. With respect to accommodating individuals with limited English proficiency (LEP), both of the district offices that we visited during the second site visit had bilingual staff who spoke Spanish, Russian and Polish. According to the State, the larger offices hire translators, whereas in the smaller offices the set up is more informal, with bilingual caseworkers assisting clients as needed. The State provides written materials in English and Spanish and has a contract with the International Language Institute to translate written materials into other languages as necessary. Connecticut also has access to TDD communication for the hearing impaired and its file system identifies applicants with LEP as well as those with hearing and visual impairments so that caseworkers can make appropriate accommodations.

Section 1005.5 of the UPM sets forth the State's written policy regarding provisions for individuals with limited English proficiency (LEP) as well as for hearing or visually impaired individuals. A memorandum dated June 30, 1989, issued to District Directors and Appropriate Central Office Managers, also explains how caseworkers can obtain interpreter/translator services through the International Institute of Connecticut. A memorandum regarding effective communication with LEP individuals was issued to Regional Administrators on January 30, 1997. Despite official policy, however, caseworkers interviewed demonstrated limited knowledge of the process for obtaining interpreters or providing assistance to visually or hearing-

impaired applicants. We believe that caseworkers would benefit from training on current policies and procedures.

5. Public Charge. Pursuant to CMS guidance, State officials issued a policy on public charge to all employees in the form of an e-mail message dated September 18, 1997. DSS representatives stated that new staff members are provided with training on public charge. Documentation reviewed indicates that the State's policy on public charge is consistent with Federal policy, and caseworkers interviewed appeared to have a through understanding of the issue.

C. Maintaining Coverage for People Who Leave Public Assistance

1. Providing Transitional Medical Assistance. Under Section 1925 of the Social Security Act, states must provide extended Medicaid benefits ("transitional Medicaid" or TMA) to families who, because of hours worked or income from employment or loss of the earned income disregard, lose their eligibility for Medicaid under the Section 1931 group. It is important to note that it is the loss of coverage under Section 1931 – not the loss of TANF assistance – that is now the trigger for transitional Medicaid. States are required to provide an initial six-month period of TMA and, subject to certain reporting requirements and the income limit explained below, an additional six months of coverage. To be eligible for TMA, a family must have received Medicaid under Section 1931 in three out of the preceding six months before becoming ineligible. No income limit applies to families for the initial six-month period of TMA. However, the second six-month period is limited to families whose earned income (less necessary childcare expenses) does not exceed 185% of the Federal Poverty Level for the size of the family.

States must also provide transitional Medicaid (TMA) when eligibility would otherwise be lost due to child support income. Four months of coverage are available when child support payments trigger TMA eligibility.

Connecticut, which calls these extended benefits Extended Medical Assistance (EMA), has a waiver under §1115, which permits it to provide EMA benefits to families for up to 24 months without quarterly reporting requirements. EMA may be terminated sooner if (1) the assistance unit moves out of state; (2) all members of the assistance unit die; (3) there is no longer a child in the home under 19 years of age; or (4) the assistance unit applies and is found eligible for Medicaid under another coverage group. Originally, it also authorized the provision of EMA if an adult member of the assistance unit became employed within six months of the date that he or she was terminated from cash assistance. As described below, the state modified that provision of its EMA policy. The EMA waiver is scheduled to expire September 30, 2001, at which time the state will revert to the statutory rules for §1925.

Eligibility group F03 is used for families placed on EMA. The initial site visit revealed that the

State incorrectly was providing transitional coverage at the loss of TFA, rather than the loss of §1931 Medicaid. As part of the mandatory exit interview for TFA, caseworkers were informing individuals of the availability of EMA, and EMS automatically was moving recipients losing cash assistance from the F01 (TFA-related) coverage group to F03. Advocates reiterated the concern that families losing TFA were being automatically transferred to EMA.

To address this problem, the State informed CMS that it had identified 5,441 families who had been incorrectly placed in EMA. EMA for these families was scheduled to expire sometime after November 1999. Through its Management Information System (MIS), the State then extended the EMA eligibility period for the affected families by six months, to sometime between July and December 2000, at which point caseworkers were to determine whether or not Medicaid eligibility could be established in any other group. Case records reviewed during the March 2000 site visit confirmed that the extension of benefits had been successful.

In 1999, the General Assembly passed legislation raising the income limit for the §1931 coverage group to 185 percent of the FPL. By extending EMA for these families, the State maintained, families who should have remained covered under §1931, as well as those whose EMA should have started at a later date, would not be harmed, since virtually all affected families would have incomes under 185 percent of the FPL and therefore be eligible for coverage under §1931 when the extension of their EMA expired.

In May 2000, however, before this legislation became effective, it was amended to reduce the income-eligibility expansion for the §1931 coverage group to 150 percent of the FPL and to delay implementation of the expansion until January 1, 2001. As a result, the State reported that it again extended the affected families' EMA, this time until sometime between January and June 2001. Inasmuch as the reviews took place prior to this second extension, the review team is not able to confirm the success of the second extension or on the ultimate disposition of the cases at issue once that extension expired.

With respect to correcting policy applicable to subsequent families, the review team on the second site visit found that Connecticut has changed its policy to base EMA on the loss of §1931 Medicaid. Section 2540.09 of the Uniform Policy Manual (UPM) now provides EMA coverage to low-income families (F07 and F01) if an adult in the assistance unit is employed at the time F01 or F07 eligibility is terminated; an adult member of the assistance unit becomes employed within 6 months of the date F01 or F07 eligibility is terminated; or Medical Assistance is discontinued due to excess child support. The policy was clarified in a memorandum to the Regional Administrators and Field Managers on October 8, 1999.

The State also issued a memorandum on October 28, 1999, clarifying that individuals losing TFA (and therefore F01 Medicaid) should be screened for other Medicaid eligibility groups before they are given EMA. Specifically, caseworkers were directed to determine eligibility for

coverage under F07. Should eligibility under F07 subsequently end, EMA can then be initiated. In this way, the transitional benefits are saved until needed. Consistent with the new policy, case records reviewed during the second site visit included families who had been enrolled in §1931 F07 Medicaid following the loss of TFA, rather than being automatically enrolled in EMA.

The review team found that caseworkers were familiar with the new policy. However, because §1931 eligibility is captured under two categories (F01 and F07) and the automatic transfer to EMA had not been computerized, its implementation was administratively cumbersome and caseworkers had to manually screen families losing TFA for F07 Medicaid. To address these problems, the Department issued interim instructions on a work-around for the EMS system and submitted a work order to update the system.[3]

D. Procedures Related to Denial/Termination

1. TFA Terminations. TFA recipients are required to attend an exit interview prior to the expiration of their cash assistance. During the exit interview, the caseworker explains exemptions to and extensions of TFA beyond the ordinary time limit and completes a redetermination of benefits, including Medicaid.

Families who remain eligible for TFA also remain eligible for TFA-related F01 Medicaid. Families no longer eligible for TFA are to be evaluated first for Medicaid eligibility under F07 and then for Extended Medical Assistance if eligibility under F07 cannot be established. This policy is explained to caseworkers in a memorandum dated October 28, 1999. The memorandum also explains how to work around the EMS system, pending system modifications to accommodate the new policy.[4]

The policy set forth in the October 1999 memorandum applies only to recipients who attend their exit interview. During the initial site visit, advocates expressed concern that the Medicaid benefits of families who do not show up for the 20-month exit interview were automatically being terminated. Cases reviewed by the review team confirmed that this was a problem.

2. Redeterminations and Ex Parte Reviews. Redeterminations of Medicaid eligibility are scheduled every 12 months. Connecticut also provides 12 months of continuous coverage for children under 19 years of age, and recipients enrolled in a managed care plan receive a one-time six-month guaranteed-eligibility period. (Since children are granted 12 months of continuous eligibility, for practical purposes, the six-month guarantee period is only relevant for adults.) Unlike continuous eligibility for children, this six-month guarantee is not renewed following a

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3 In its response to this report, The State reports that reprogramming the computer to assess F07 eligibility prior to EMA was completed on July 1, 2000.

4 In its response to the review team's report, the State reports that it has fully implemented changes to EMS to enable automatic evaluation for §1931 eligibility of families losing TFA.

redetermination.

The review team found that the State's redetermination process does provide some safeguards to protect recipients from improper termination. Two months prior to the scheduled redetermination date, EMS generates a redetermination notice to the recipient to complete. If the recipient fails to respond within 15 days, the system generates a second notice. Caseworkers interviewed stated that they also attempt to contact non-responsive individuals via telephone to ensure that they are aware of the need to respond (although, as discussed above, caseworkers do not contact TFA recipients who do not show up for a TFA exit interview). If an incomplete redetermination form is returned to the caseworker, the system keeps the case open until the entire file is complete. Office supervisors also receive reports of outstanding redeterminations to ensure that all redeterminations are processed in a timely manner.

In conducting a redetermination of eligibility, caseworkers have been instructed to limit their review to changes in circumstances. Section 1545.23 of the UPM states that caseworkers should not require excess verification and that unchanged circumstances do not need to be verified. In addition to reviewing ongoing Medicaid eligibility, caseworkers are to inform families if any member appears to be eligible for another benefit program and to take appropriate action accordingly.

Before closing a case, the system prompts workers to check for eligibility under other categories. However, this is predominantly a manual exercise and the State must rely on caseworkers to follow proper policy and procedures when closing a case. The State does not have formal policy requiring supervisory reviews of all cases prior to closure, although the case records reviewed indicated that supervisory reviews are randomly conducted.

As part of the review process, states are required to conduct an *ex parte* review of recipients' ongoing Medicaid eligibility before requesting additional information from the recipient and/or closing a case. However, the review team found no State policy on *ex parte* reviews and the case record review indicated that *ex parte* reviews are not being routinely conducted. Advocates also expressed concern that workers had not received adequate training on the conduct of *ex parte* reviews or on the new eligibility categories. In a Dear State Medicaid Director letter dated April 7, 2000, CMS set forth detailed instructions on the conduct of *ex parte* reviews. Connecticut must adopt an *ex parte* process in accordance with that guidance. Doing so will help to streamline the redetermination process and ensure that eligible individuals and families do not lose coverage.

Finally, the advocates were concerned that, because the majority of Medicaid recipients are enrolled in managed care plans, many do not realize that they are enrolled in Medicaid and thus do not respond to the Medicaid redetermination notice. [5]

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5 In its response to this report, the State indicated that it has revised its mail-in Medicaid redetermination notice to

3. Notices. We are concerned that notices are confusing, lengthy, and not sufficiently informative. Notices discuss all programs applied for, resulting in letters with as many as 20 pages or more which often were difficult to follow. The review team also found notices regarding guaranteed or continuous eligibility to be confusing and to contain seemingly contradictory information. Below are specific comments regarding the notices reviewed during the site visits.

- The notification letter regarding the approval of EMA provides limited explanatory information regarding the benefit and contradictory information on the period of eligibility. The first paragraph in the notice provides the effective date and gives a 24-month eligibility period. The second paragraph states that children under 19 years of age will remain eligible for 12 months, even if the family income increases or other circumstances change which otherwise would render the child ineligible. This, undoubtedly, is confusing to many families. The State indicated that it does not believe that, in practice, continued eligibility for EMA is being reviewed after 12 months. Therefore, families approved for EMA should continue to receive Medicaid for the full 24 months. Connecticut should align its policy and practice and the notification letter should contain consistent information explaining that EMA is a guaranteed benefit for a specified time period and the conditions under which EMA could be terminated.

- Although the notification letters regarding the approval of TFA provide information on the availability of EMA when §1931 Medicaid benefits terminate, they do not provide information on the availability of Medicaid coverage independent of cash assistance. We recommend that notices be amended to include explanatory language on the availability of Medicaid coverage unrelated to TFA.

- All denial and termination letters contain an attachment regarding hearing rights. The review team believes that the notices provide sufficient information regarding the right to request a hearing, how to initiate a request and the continuation of benefits if the request is received within 10-days from the date the notice was mailed.

E. Computer Systems

Problems with the State's Eligibility Management System and the actions which the State has taken to address them are discussed throughout this report. The following is a brief summary of such problems:

- When a joint application is held due to missing information needed to determine

address this concern.

eligibility for TFA, EMS requires manual intervention to approve a family first for §1931 Medicaid and later for TFA. In such cases, the family is placed first into Medicaid

coverage group F07. Then, when the TFA application is complete, the caseworker must terminate coverage under F07 prior to approving TFA benefits. Once TFA has been approved, the family automatically is placed in Medicaid coverage group F01.

- At the time of the review, EMS automatically was transferring families losing TFA benefits from Medicaid coverage group F01 to F03 (Extended Medical Assistance), rather than checking first for §1931 eligibility under F07. Following the State's correction of its policy, the assessment of families losing TFA benefits for Medicaid eligibility under F07 had not been automated. In addition, the review team found that EMS was not programmed to recognize the loss of coverage under F07 as the trigger for EMA. The State, addressing this problem in part, reports that reprogramming EMS to assess F07 eligibility prior to EMA was completed on July 1, 2000.

- At the time of the report, families who failed to show up for their TFA exit interview were automatically being terminated from Medicaid.[6]

- There is a significant lag time between when policy is changed and when the system is updated. We recommend that the State give priority to systems changes to reflect new policy as soon as possible.

F. Caseloads

The Department does not have clear guidelines regarding maximum caseloads, and caseloads vary widely from office to office. The Hartford district office employs specialized workers in three units: (1) family units, which handle all types of family cases, including TFA, Food Stamps, and/or Medicaid; (2) adult units, which manage adult-only cases, such as Adult Medicaid, Food Stamps, State Supplemental Assistance and State Administered General Assistance; and (3) combined units. During the follow-up site visit, the Hartford office reported caseloads of 225 active cases per worker in the family units, 600 active cases in the adult units, and 400 active cases in the combined units. The Middletown office, which does not have specialized workers, reported 125 cases per FI Rep (who handle time-limited TFA cases) and 500 cases per case

6 In its response to this report, the State reports that it has taken all steps necessary to ensure that the EMS system does not improperly discontinue or deny Medicaid when TFA benefits are discontinued or denied. In addition, the State says that it has implemented a new procedure in EMS which automatically makes the children eligible for ongoing Medicaid coverage when a parent does not cooperate with child support; the worker no longer needs to initiate and process a request for Medicaid manually.

maintenance worker (who handle all other types of cases). Due to differences in the staff structure in each office, it is difficult to compare caseloads. Nonetheless, the review team found a general consensus that current caseloads are difficult to manage and that reduced caseloads would reduce potential errors.

G. Coordination with Other Public Assistance Programs

Administering both the Medicaid Program and TFA within DSS greatly enhances coordination in communicating changes in policy. Further, the District offices for various benefit programs are co-located, housing assistance workers (who handle TFA, Medicaid and Foods Stamp benefits on a one client per worker basis) as well as workers providing child support and social work services. Co-location of these programs appears to facilitate the verification of information and the processing of an applications. For example, caseworkers interviewed stated that they can go down the hall and quickly verify child support information.

H. Program Assurances: Implementation at the Local Level

Connecticut uses a series of processes to ensure that Medicaid policies are correctly implemented at the local level. Memoranda explaining changes in policies and procedures are sent to Regional Administrators and Field Office Managers. A contact person available to respond to questions also is identified. Changes in policy and procedures also can be e-mailed directly to all caseworkers to ensure that they receive information in a timely manner. Caseworkers, in turn, can then contact the Department with any questions on new policies and obtain a timely response. The Department also operates a family support line, which caseworkers, Regional and District office staff can call with questions. Caseworkers interviewed felt that this system of communication has been effective in disseminating changes in policy. Finally, the Department and/or Regional Administrators can require workers to attend training on new policies.

In an effort to ensure that policies are being correctly implemented, the State has established a Corrective Action Panel in each region. The Panels review reports generated by negative case action reviews, and are responsible for developing appropriate corrective action plans. A corrective action specialist follows up with the appropriate office to evaluate the effectiveness of any corrective measures implemented. Finally, supervisors work with caseworkers to correct errors and can limit a worker's authority to take final action on a case (e.g. terminate or approve benefits) without supervisory approval. The negative case action reviews are discussed in part IV.

I. State Children's Health Insurance Program

Prior to the passage of Title XXI of the Social Security Act, which created the State Children's Health Insurance Program (SCHIP), Connecticut used an income disregard under §1902(r)(2) of

the Act to cover children born on or after October 1, 1983 up to 185 percent of the Federal poverty level in its poverty level groups. On October 29, 1997, the Governor signed legislation creating the Health Insurance for Uninsured Kids and Youths (HUSKY) Plan, the State's SCHIP program. Connecticut's Title XXI State Plan was approved by CMS on January 20, 2000 and an amended plan was approved on July 14, 2000.

HUSKY, which provides services through managed care, is a combined Medicaid expansion and a stand-alone program. Under the former, Medicaid eligibility has been expanded to cover children under 19 born before October 1, 1983 with household incomes up to 185 percent of the FPL. The stand-alone program officially covers children under 19 in families with incomes up to 235 percent of the FPL. The use of an earned income disregard, however, effectively brings coverage for these children up to 300 percent of the FPL. Cost-sharing is required for coverage under the stand-alone program, and there is an unsubsidized buy-in option available to children in families with incomes above 300 percent FPL.

In addition to coverage under Title XXI, the State also includes the family and children's Medicaid eligibility groups which pre-date SCHIP (i.e. §1931 and the poverty level groups) under the HUSKY umbrella. Thus, all children and families receive services through HUSKY, which has the following three components:

- HUSKY Part A includes Medicaid for families and children under §1931, Medicaid for pregnant women and children under the poverty-level groups, and the Medicaid expansion component of the State's SCHIP program.
- HUSKY Part B, which provides health services to children through the stand-alone program.
- HUSKY PLUS, a new coverage option for children eligible for HUSKY B who require intensive physical or behavioral health services.

The State has contracted with Benova to conduct eligibility determinations for and enrollment in the stand-alone program. Benova is responsible for screening HUSKY applications for Medicaid eligibility, as required under Title XXI. In an effort to facilitate coordination between the Medicaid program and HUSKY, a DSS caseworker has been assigned to the Benova office. This caseworker assists in screening applications for children who may be eligible for HUSKY Part A and is available to provide technical assistance on Medicaid eligibility policy in general.

Applications of potentially Medicaid-eligible children are forwarded to DSS for processing. If the DSS worker believes that the applicant is not Medicaid eligible, he or she will contact the caseworker located at Benova to work through the case. If the child is determined eligible for Medicaid, the DSS worker will complete processing the application. If the child is found not to be Medicaid eligible, the application is returned to Benova.

Medicaid termination notices include a paragraph on the availability of insurance through HUSKY B. DSS caseworkers interviewed by the review team were knowledgeable about the availability of health insurance under HUSKY B for children losing Medicaid coverage, and many workers indicated that they often provide clients with the toll free number for HUSKY B.

No automatic evaluation of eligibility for HUSKY B, however, is done when a child loses Medicaid.

The State also has issued a work plan for HUSKY A. As part of the work plan, the State has made a tentative decision to mail a HUSKY redetermination form along with the TFA redetermination notices and to inform recipients that they can complete and mail the HUSKY application if they do not want cash assistance or Food Stamps. The HUSKY redetermination form differs from the HUSKY application in that it requires income and asset information, needed to determine Medicaid eligibility. A target date of September 30, 2000, was established to implement this decision. While this would help to ensure ongoing coverage for children, it will not help to facilitate, and could actually hinder, ongoing coverage for parents or other adult caretakers, since they cannot apply for Medicaid using a HUSKY form. The State is considering the development of a joint Medicaid/SCHIP application. If such a form is developed, sending it along with TFA redetermination notices, after conducting an *ex parte* review, could help both children and parents maintain uninterrupted coverage.

J. Outstationing Eligibility Workers

States are required to provide pregnant women and children opportunities to apply for Medicaid at locations other than welfare offices. In particular, unless a state has demonstrated that it has an equally or more effective plan, it must establish outstation locations at each disprorpotionate share (DSH) hospital and at each Federally Qualified Health Center (FQHC) participating in the State's Medicaid program.

In Connecticut, the Department has outstationed employees at DHS's to accept and assist individuals in filling out Medicaid applications. These workers may process such applications to completion or refer applications to the regional or district office for processing. In addition, the state funds healthy start sites located in FQHCs that can accept applications for Medicaid for pregnant women and young children. DSS also has outstationed workers at a Maternal and Child Health grantee established to provide social support service to pregnant women and children. There are 24 outstation facilities in all. While workers at several locations are able to process applications to completion, most outstationed workers forward completed applications to the regional or district office for processing.

K. Optional Policies for Medicaid Eligibility

Connecticut provides broad coverage under its Medicaid program. Below is a summary of optional policies adopted by Connecticut to date.

- Continuous eligibility. The State provides for 12-months of continuous eligibility for children under 19 years of age.
- Guaranteed eligibility. The State provides for a one-time six-month period of guaranteed eligibility for individuals enrolled in a managed care plan.
- Less restrictive financial methodologies. The State has adopted less restrictive methodologies to expand family coverage under §1931 to 150 percent of the FPL. It also has adopted less restrictive methodologies to expand coverage for children up to 235 percent of the FPL.
- Presumptive eligibility. Connecticut implemented presumptive eligibility for children under 19 years of age on October 1, 2000.

III. CONSUMER ADVOCACY GROUPS

During the first onsite review, the review team met with representatives from Connecticut Legal Services (CLS) and various other advocacy groups. All expressed concern that notification letters were difficult to understand; that families being terminated from TFA because of earned income are not being tested for §1931 eligibility; and that families who do not show up for their TFA exit interview are being terminated from Medicaid. Some advocates also expressed concern that since the State has mandatory managed care for low-income families with children, many do not understand that they are on Medicaid and that this has resulted in some families not cooperating with the State during redeterminations.

Prior to the follow-up visit, CMS staff again contacted Connecticut Legal Services. In general, CLS believed that the State generally was doing a good job in developing policies to ensure that poor families have access to health care. While representatives of the organization felt that problems in implementing policy persist, they also recognized that the Department had been actively working to address implementation issues and urged that these efforts be completed as soon as possible. CLS identified in particular the Department's efforts (1) to program EMS to assess §1931 eligibility independent of cash eligibility; (2) to program EMS to assess §1931 eligibility prior to eligibility for EMA or other more restrictive categories (the State reports that this was completed July 1, 2000); (3) to improve notices to clients concerning their potential eligibility for Medicaid under §1931 or other coverage groups (this has been included in the

State's work plan); and (4) to begin to take affirmative measures to locate families that may have been erroneously denied or terminated from Medicaid since October 1, 1996 (the effective date

of the Department's §1931 policy), and to inform such families of their past or possible future eligibility for the program. The advocates also cited favorably ongoing training for staff on eligibility rules.

The advocates urged that the location and reinstatement of families erroneously denied or terminated from Medicaid be completed as soon as possible. They also were concerned that the State had not developed plans to implement *ex parte* reviews of clients' eligibility prior to termination of Medicaid coverage.

Post Site-Visit Advocate Comments

Subsequent to the site visit, Connecticut Legal Services, the Connecticut Health Policy Project, the Children's Health Council and the Connecticut Medicaid Managed Care Council reviewed a copy of the draft report. Although each organization submitted separate comments, in the discussion which follows, these commenters collectively are referred to as "the advocates."

1) Outstationing

The extent of the "processing" of applications by outstationed workers, the advocates opine, "is unclear in the report as is the outcome of the process." They report that specific information documenting the efficacy of the onsite workers is lacking, as is evidence of uniform contractual performance measures. The advocates query whether there are disincentives for facilities to aggressively address their uninsured client populations and say they have received reports of one large teaching hospital refusing onsite access to a community HUSKY outreach group.

CMS Reply: As stated in the report, State employees told the review team that most outstationed workers do an initial review of applications submitted to them, but then send completed applications to a regional or district office for processing. We are not aware of any disincentives for facilities to assist uninsured patients in obtaining Medicaid coverage; to the contrary, we believe that they have strong incentives to do so. While permitting community outreach groups onsite access to assist patients in completing applications may be an effective strategy and we encourage the State, DSH hospitals, FQHCs and other facilities serving uninsured populations to work with such community groups in developing effective outreach and enrollment strategies, doing so is not required. Finally, inasmuch as outstationed workers generally are employed by either the State or the facility, we are unclear as to who the advocates feel should be subject to contractual performance measures.

IV. ENSURING ADMINISTRATIVE EFFICIENCY AND MEDICAID QUALITY CONTROL

The Management Information Systems department (MIS) is responsible for operating the State's negative case action program. MIS selects a random sample of at least 210 case records, based on denial codes, which are forwarded to the quality control division for review and analysis. Findings on each case are forwarded to Medicaid eligibility managers, systems managers and other staff. Negative case action reviews are conducted on a quarterly basis. Every six months a summary of findings is given to Regional Administrators, Field Managers, and the Corrective Action Panel in each district. As noted above, the Panels are responsible for developing a corrective action plan, and a Corrective Action Specialist regularly reviews local offices to evaluate the effectiveness of corrective actions taken. The State indicated that it is reviewing the feasibility of developing an alternative negative case action program to target specific problems.

V. PROMISING PRACTICES

1. Phone-In Applications. Medicaid applications can be initiated over the phone. Caseworkers obtain information from applicants and mail out a completed application for verification, signature and return. No face-to-face interview is required. This process facilitates the application process and is widely used by caseworkers.

2. Notice and Opportunity to Respond in Redetermination Process. Although Connecticut does not conduct *ex parte* reviews, the extent of the notice and opportunity given to clients to complete the redetermination process is commendable. As discussed in section II.D.2., recipients receive notice two months prior to their redetermination date. If the client does not respond, a second notice is sent. Recipients are asked to verify only changed circumstances, and EMS maintains incomplete redetermination forms until sufficient information to reevaluate the individual's eligibility is provided. There is no limit to how long such cases will remain open, provided that the recipient provides some response to the notice. If the recipient fails to respond to the notice at all, however, the case will be closed. Supervisors also receive a monthly list of the cases for follow-up with caseworkers.

3. Continuous Eligibility and Enrollment. In addition to providing 12 months of continuous eligibility for children under 19, Connecticut also provides 6 months of guaranteed eligibility to individuals enrolled in a managed care plan.

4. Presumptive eligibility. Connecticut implemented presumptive eligibility for children under 19 years of age on October 1, 2000.

VI. NEXT STEPS

Connecticut Legal Services, the Connecticut Health Policy Project, the Children's Health Council and the Connecticut Medicaid Managed Care Council reviewed a copy of the draft report. Although each organization submitted separate comments, in the discussion of next steps which follows, these commenters collectively are referred to as "the advocates."

1. De-Linking TFA/Medicaid

Connecticut has not fully delinked TFA and Medicaid. Further, it appears that the general public may not be aware of the ability to apply for Medicaid separately from TFA, as many people still believe that Medicaid is tied to the receipt of cash assistance. For administrative purposes, Connecticut has chosen to maintain a link between Medicaid and TFA and to create a separate §1931 Medicaid category for those not receiving or applying for TFA.

In order to ensure compliance with §1931, the State needs either to completely delink the two programs or to ensure (1) that the §1931 eligibility requirements for families that receive cash assistance and families that do not are aligned and (2) that families losing cash benefits are properly evaluated for §1931 eligibility prior to being evaluated for EMA or other more restrictive coverage groups. We also recommend that the State take measures – including modification of its computer system – to ensure that no families are improperly denied or terminated from Medicaid, and that those who have been improperly denied or terminated are reinstated, in accordance with the April 7, 2000, Dear State Medicaid Directors letter.

State Response: The State reports that it is attempting to address client confusion on delinkage through notices and procedural changes. Specifically, the State says that it (1) has added text to all closure notices making it clear that Medicaid and HUSKY are available, encouraging former recipients to reapply and providing a toll free number which they can call to do so; (2) has modified its TFA voluntary closure notice to instruct clients to contact their worker immediately to have their health benefits reinstated if they do not want to terminate both TFA and Medicaid benefits; (3) has issued a directive instructing eligibility staff to explore ongoing Medicaid coverage for families voluntarily requesting that their TFA case be closed; and (4) as discussed below, is working on revising its TFA exit interview and redetermination notices to offer clients the opportunity to complete their Medicaid redetermination by mail if they do not want to attend the scheduled interview.

The State also maintains that any lack of alignment between its TFA and §1931 eligibility criteria is minor. As discussed in the report, the review team found three groups of individuals affected by the differences in eligibility criteria: pregnant women in their first or second trimesters, 18-year old students not expected to graduate by age 19, and relatives of TFA-eligible children who

would not be eligible for Medicaid independent of TFA because the degree of relation exceeds that permitted under Connecticut's July 16, 1996 AFDC State Plan.

The State explains that individuals falling into the first two groups are covered under other Medicaid eligibility categories. With respect to the third group, the State says that a recent EMS data report turned up no cases in which a relative receiving TFA benefits for a child was receiving Medicaid under F01 but would not have been independently eligible for coverage under F07. Thus, while agreeing that its policy currently is incorrect, the State asserts that, in practice, there have been no violations. It also maintains that any technical violation will be rectified when Medicaid has been fully delinked from TFA.

Concerning possible improper denials or terminations of Medicaid, the State explains that it has taken all steps necessary to ensure that its Eligibility Management System does not improperly discontinue or deny Medicaid when TFA benefits are discontinued or denied. While the State acknowledges that improper terminations and denials can result from worker error, it maintains that this has never been a major problem in Connecticut. The State reports that it is developing a reinstatement plan in response to the April 7, 2000 Dear State Medicaid Director letter and expects to begin implementing corrective action in the near future.

Advocate Comments: The advocates agree that several minor distinctions between Connecticut's F01 and F07 coverage groups violate §1931, but they also agree that these distinctions are minor and affect few families. Nonetheless, these differences, they say, hinder the efforts of Covering Connecticut's Kids in working with the State to simplify Connecticut's program and enhance outreach efforts, and they urge CMS to find a way to allow the State to continue providing Medicaid to these individuals. The advocates believe that the best outcome would be to have the TFA and Medicaid rules in alignment by allowing TFA's more liberal rules to carry over to Medicaid.

The advocates also point out that, in checking the State's practice in screening families who are not TFA-eligible for Medicaid, the review team reviewed only active cases; no cases involving denials were reviewed. The advocates remain concerned that all families are not being appropriately screened for Medicaid and recommend a review of denied cases.

The advocates commend the Department's efforts to locate and reinstate recipients who may have been inappropriately terminated or denied §1931 Medicaid. However, given the amount of time which has elapsed since the families were terminated or denied assistance, they are concerned that the Department is relying on outdated addresses and therefore will not be successful in contacting most families. The advocates are particularly concerned about families saddled with debt for back medical bills which should have been covered by Medicaid and feel that a general publicity and outreach campaign is essential.

CMS Reply: The steps outlined by the State to address client confusion are indeed positive ones. However, there undoubtedly are former clients and others who have not received nor, unless

they reapply for TFA benefits, are likely to receive the notice described by the State. We also agree with the advocates that the State's efforts to locate families previously terminated from or denied §1931 Medicaid will be hindered by the passage of time. Therefore, we encourage the State to launch a general publicity campaign to inform the general public of delinkage and the greater availability of Medicaid coverage for low-income working families. With respect to progress in reinstating improperly terminated families in accordance with the April 7, 2000 Dear State Medicaid Directors letter, we will continue to follow up with the State.

As we stated previously, fully delinking §1931 Medicaid from TFA will rectify the problems stemming from the lack of alignment between the State's TFA and §1931 Medicaid eligibility criteria. Modifying the §1931 Medicaid eligibility criteria so as to match TFA's more liberal rules likely would help to simplify the program and enhance outreach and enrollment, and we encourage the State to do so. However, as long as the eligibility criteria for the two programs differ, we cannot, as the advocates urge, provide Federal financial participation to the State to cover under the State plan TFA-eligible individuals who do not meet the eligibility criteria for the State's §1931 coverage group.

Finally, we are mindful the shortcoming in the case record review pointed out by the advocates and encourage the Department to review cases involving the denial of benefits as part of its negative case record reviews and in monitoring proper implementation of State policy.

2. Application and Outreach Materials

The review team concluded that it would be difficult for an individual to independently complete an application. A simplified mail-in application for families, like the one Connecticut has developed for children, could promote participation among low-income working families. If such a form were developed, sending it with TFA redetermination notices could help both children and parents maintain uninterrupted coverage.

The review team also encourages the State to develop outreach materials informing individuals of the availability of Medicaid for individuals who choose not to participate in, or who are not eligible for, TFA as well as the availability of EMA, particularly in light of the State's 21 month TFA time-limit.

Advocate Comments: The advocates disagree with the review team's finding that the difficulty clients face in completing an application independently is mitigated by the availability of caseworkers to provide assistance. (See §II.B.1.) Despite the significant sums paid by the State for assistance, the advocates assert that the State does not monitor the availability or quality of the assistance paid for and it is difficult for clients in practice to get effective help. Most clients,

they maintain, prefer to receive assistance from trusted community sources rather than anonymous toll-free lines or strangers, since the application process is rarely a simple, one-time

event, but rather a process which can take months and require significant documentation. Use of a trusted community resource also enables the development of a long-term relationship that can provide ongoing assistance to clients in accessing care, i.e. in choosing a health plan and primary care provider, making and keeping appointments and following through on treatment. By way of example, the advocates point to the Healthy Start program, a statewide network of community maternal and child health providers which had success in connecting hard-to-reach families with care, but for which State support, they say, has eroded.

The advocates also assert that the simplified mail-in application for children is not, in fact, simple: "At four pages (and tiny font), two pages of confusing instructions, lots of unnecessary questions and about 6 or 8 inches of legal warnings, that application is still problematic . . . and in some respects is worse." The advocates urge the Department to use CMS' application prototype and to test any new application with clients before finalization.

The advocates concur that there must be better efforts on the part of the State (e.g. a media campaign) to inform the public about delinkage and the greater availability of Medicaid coverage to families, now available to adults and children in families up to 150 percent of the Federal poverty level, and to destigmatize Medicaid's association with welfare.

CMS Reply: Regarding the advocates' allegations on the ineffective nature of the assistance provided by the State, we recognize that advocates know the day-to-day obstacles faced by clients and we encourage the State to work with them in ensuring that State dollars earmarked for application assistance obtain the most effective assistance available.

In addition, while we believe that Connecticut's four-page HUSKY application for children represents a great improvement over the 18 page application which others must use, that application possibly could be further simplified. We encourage the State to re-examine the shortened application and work with the advocates in improving both applications as appropriate. CMS has developed a model application prototype that is currently on our website. Moreover, in response to a national need, CMS contracted with Maximus to develop additional model applications and notices in English and in Spanish. Additional information about the application project can be found at http:\\smerf.maximus.com. CMS staff also are available to provide technical assistance on this issue.

3. Improper Termination for Failure to Participate in the TFA Exit Interview

As noted above, the review team identified cases in which Medicaid was terminated due to failure to attend the 20-month TFA exit interview. We recommend that the State correct policy on this issue to ensure that individuals who lose TFA benefits are not terminated from Medicaid

without an independent review of Medicaid eligibility based on Medicaid rules.

State Response: The State agrees that its exit-interview procedures need to be revised, but disagrees with the characterization of this finding. The State asserts that it does not terminate individuals for failure to attend the TFA exit interview, but rather for failure to complete the Medicaid redetermination process, which can be done by mail. The State maintains that the problem is that affected individuals do not receive clear notice of the option to complete the Medicaid redetermination process by mail and reports that it is revising its exit interview notice to make this option clear.

In its response the State also reports that, once Medicaid and TFA are fully delinked in EMS (which it hopes to accomplish by the end of 2001), it plans to stagger the redetermination cycles of individuals receiving both benefits to make it clear that eligibility for the two programs is not connected.

Advocate Comment: Advocates agreed with CMS' recommendation that the State redouble its efforts to ensure that clients are aware of the need for and the process of renewal. Advocates further stated that attendance at exit interviews must never be a condition to retain medical assistance.

CMS Reply: We appreciate the clarification of the problem and urge the State to develop the corrective measures outlined as expeditiously as possible. We also urge the State to ensure that the 12 months of continuous eligibility for children is not interrupted because a family "fails to complete the Medicaid redetermination process" at the time of the TFA exit interview.

4. Transitional Medical Assistance

During the follow-up site visit, the review team found that the State's new policy (i.e. screening families losing TFA for §1931 eligibility first and recognizing the termination of §1931 benefits as the trigger for EMA) was being implemented correctly. However, the review team also found that the process was administratively cumbersome because the EMS does not automatically recognize loss of Section 1931 eligibility as a trigger for EMA, and we are concerned that at least some families still may lose coverage inappropriately as a result of being placed on EMA. Similarly, the extension of EMA for families incorrectly placed in EMA instead of the §1931 F07 coverage group was also a positive step, but we remain concerned that some families at issue (particularly those at incomes above 150 percent of the FPL, the current maximum income eligibility level for §1931 coverage) still may be prematurely terminated from coverage.

State Response: The State does not believe there is any danger that families placed erroneously into EMA instead of §1931 will lose coverage as it has again extended the redetermination periods for all EMA recipients who had earned income below the FPL when they began the

transitional coverage, rescheduling their review for between January and June 2001. The State also reports that EMS was modified effective July 1, 2000 to first test eligibility for Medicaid-

only 1931 coverage group (F07) before placing the family in a transitional Medicaid group.

CMS Reply: The measures the State has taken appear promising and we urge the State to follow up to ensure that the families at issue, particularly those with earned incomes above 150 percent of the FPL, who have (or should have) received 1931 coverage in three out of the last six months, do not lose or have not lost Medicaid coverage prematurely. The State also should modify EMS so that the loss of §1931 eligibility triggers EMA.

We note that the State's EMA waiver expires on September 30, 2001 at which time the State will have to revise its EMA policy to bring it into compliance with the statute. If the State wishes to provide more than 12 months of EMA, the State has flexibility to do so. For example, under Section 1931, the State could exclude all earnings for 12 months beginning with the month that the family would otherwise be ineligible under the Section 1931 group. This policy would allow the family to remain eligible under the Section 1931 group for 12 months regardless of earnings and, at the end of the 12 months, the family would be eligible for 6-12 months of EMA. If the State wishes to explore this or other policy options, we are available to provide technical assistance.

5. Clarification on Requests for Social Security Numbers

State policy on the provision of Social Security Numbers for non-applicants is unclear. The application form for assistance includes a space for SSNs, but does not indicate that it is optional for nonapplicant household members. Nor is it clear whether or not the provision of parents' SSNs is voluntary if they are applying for benefits only for their children. We were pleased to learn from the State during the second site visit that it is taking measures to clarify policy on the provision of SSNs. As part of the State's correction efforts, the application must be revised and caseworkers trained on the circumstances under which an SSN may and may not be required.

State Response: The State agrees with this finding and reports that it is taking steps to correct the problem. Specifically, the State's new HUSKY application and renewal form indicates that provision of an SSN is optional for those not seeking assistance and the State reports that it also plans to revise all other applications to so indicate. In addition, the State indicated that it was clarifying State policy and planned to include this issue in a December 2000 training for eligibility workers.

CMS Response: It appears that the steps that the State has taken as well as those it plans to take should effectively address this problem.

6. Redetermination Procedures

Many advocates expressed concern that individuals enrolled in managed care plans may not realize that they are enrolled in Medicaid and thus not respond to the redetermination notice. When an individual fails to respond to all notices regarding a redetermination, the State will close out the case. We recommend that redetermination notices inform recipients that their managed care plan is a Medicaid plan and that they must respond to the redetermination notice.
State Response: The State is not certain that this is a major problem. However, the State sees an advantage to encouraging Medicaid recipients to comply with the redetermination requirements by portraying the process as a renewal of their medical insurance and has revised its mail-in Medicaid redetermination notice accordingly.

Beginning with the mailing at the end of October 2000, the State reported that it was using the new notice and the new HUSKY Application/Renewal Form for redeterminations of eligibility for recipients in the 185 percent of the FPL children's poverty coverage group. The State further stated that it plans to expand the use of this notice with a new HUSKY Renewal Form to include the 1931 coverage group beginning in January 2001 when the asset test no longer applies to this group. The State reports finding that it is losing many program participants because of their failure to follow through with their annual redeterminations and it believes that this will be an effective strategy in retaining eligible participants in the program.

Advocate Comments: As noted in the advocate comments to next step #2, above, the advocates do not believe that the new HUSKY Application/Renewal Form is simple. They also point out that, in section II.D.2., the report assumes that the redetermination and continuous eligibility periods are aligned, but that this is not always the case. The advocates believe that the State's implementation of continuous eligibility has resulted in some confusion. They support the State's efforts to deal with some of the continuous eligibility issues and hope that the work plan for the State's Supporting Families initiative will improve the continuous eligibility process.

CMS Response: The revision of the redetermination notice and Renewal Form, so that families, including parents, are notified of the steps necessary to complete renewals of their medical insurance, is a positive step. As discussed in next step #2, above, we would encourage the State to work with advocates in considering further simplifications to its forms. As stated in CMS's reply in next step #3, also urge the State to ensure that the 12 months of continuous eligibility for children is not interrupted because a family fails to complete the Medicaid redetermination process. Finally, we remind the State that the HUSKY Application/Renewal Forms should not be sent out until after the State has completed an *ex parte* review, discussed in the next item.

7. *Ex Parte* Reviews

We are concerned that the State does not have policy regarding *ex parte* reviews. The State needs

to implement and train caseworkers on an *ex parte* review process in accordance with the guidance contained in CMS's April 7, 2000 Dear State Medicaid Director letter.

State Response: The State agrees with the need to develop an *ex parte* policy and procedures to use information from other sources. However, the State also asserts that, because the same workers administer the TFA, Medicaid and Foodstamp processes, an *ex parte* process has been in effect "to a certain extent." The State continues to state that it needs to develop procedures to use information from other sources, however limited for *ex parte* reviews at redetermination.

CMS Reply: We are glad that the State recognizes the need to adopt an *ex parte* policy and are available to provide technical assistance on the development of appropriate procedures. In addition, we would appreciate clarification from the State on what *ex parte* processes currently are followed by workers jointly administering the three programs, as well as whether or not such processes are formal or informal.

8. Notices

We are concerned that notices are confusing and not sufficiently informative. Because notices provide information on all programs applied for, they often are difficult to follow and many contain what appears to be contradictory information. As discussed in section II.D.3, notification letters regarding the approval of EMA provide limited explanatory information regarding the benefit and contradictory information on the period of eligibility. Notices regarding the approval of TFA provide information on the availability of EMA at the end of TFA, but do not provide information on the approval of Medicaid coverage independent of cash assistance. Finally, notification letters regarding guaranteed or continuous benefits were confusing. Specific deficiencies are discussed in section II.D.3. Notices should contain clear, correct and easily understood information. We recommend that the State modify its notices accordingly.

State Response: The State agrees with the need to review and simplify its notices. The State says that its TFA approval notice should have a section that informs the recipients that they also have been separately approved for Medicaid coverage, in order to help reinforce that Medicaid is a separate program. The State plans to remove much of the language from its lengthy TFA approval notice that describes the program and its requirements and to place this in a program brochure that will be inserted in the approval notice mailing. In this way the approval notice will be shorter and more likely to be read and understood by the recipient.

The State reports two major challenges in developing simplified notices that also are legally sufficient. The first is automatically translating the computer's action into easily understood language. Often an eligibility change is the result of the changed circumstances of one family member, which then has an impact on the eligibility of the entire family. The State explains that when EMS generates an action affecting the entire family, the entire picture is not captured by

the notices component of the system. For example, when the only eligible child turns 19, causing the entire case to close, the explanation generated is "no eligible members." The reason that there are no eligible members is not passed to the notices component of the system and

reprogramming the system to do so would be a major undertaking.

The second challenge is that Medicaid is a very complex program, which cannot be easily explained. For example, the concepts of continuous and guaranteed eligibility -- sort of "shadow eligibility periods"-- are not easily understood by eligibility workers, let alone clients. Thus, the State argues, the issue isn't only the choice of language for the notice, but the abstract conceptual design of the Medicaid program itself. The State says that "we need to reconsider whether we want or need to explain these concepts in our notices prior to the time when the notices come into effect."

Advocate Comments: Advocates agree with CMS' concern that client notices are confusing. They have recommended that a supplementary notice be included in mailings to clients. This notice could be on bright paper, with a warning that the information included is important to critical benefits, and offer productive, community-based assistance for more information. Advocates urge the Department to style the supplementary notices on those distributed by community organizations, as these are more likely to be read and trusted by clients.

CMS Response: We commend the changes the State is making to its TFA approval notices and appreciate the challenges it faces in developing effective, legally sufficient notices. We currently are working with a contractor, Maximus, to develop model notice language in English and in Spanish and will be sharing those models with the states as soon as they are completed. Part of that project will include an Internet Discussion Group on such challenges, and we strongly urge Connecticut to participate in that group. More information can be found at http://maximus.smerf.com. In addition, CMS's 1999 guide, "Writing and Designing Print Materials for Beneficiaries," contains useful suggestions which can help in writing understandable notices. This guide is available by requesting copies from CMS, Office of Internal Customer Support, Administrative Services Group SLL-B-15, 7500 Security Boulevard, Baltimore, MD 21244-1850. Finally, we are prepared to provide other technical assistance to States to improve their notices, upon request.

9. Computer Systems

We are concerned that the time it takes to update EMS to conform with new policy is excessive and creates problems in the proper administration of the program. We recommend that the State give priority to systems changes to reflect new policies as soon as possible. Until such changes are made, some additional supervisory review is necessary to ensure that manual overrides are being consistently applied as appropriate.

State Response: The State agrees with the need to implement changes to its Eligibility Management System to reflect programmatic and policy changes as quickly as possible, but

points out the difficulties presented by the complexity of the computer programs in doing so. The State also points out that, with the exception of delinking §1931 Medicaid coverage for TFA

recipients from TFA, all changes to EMS to correctly determine eligibility for §1931 and other family Medicaid coverage groups have been implemented. Therefore, there is no need for additional supervisory review related to manual work-arounds at this time. The State says it is unrealistic to expect reprogramming will always happen quickly given the rapid pace of programmatic change and the complexity of its programs. Currently, the de-linking project is awaiting its turn in the MIS queue after several other priority projects – including the generation of Special Reports for the Medicaid Reinstatement Project and systems modifications to reflect a new Medicaid Work Incentives Coverage Group, created pursuant to the Ticket to Work and Work Incentive Improvement Act of 1999, the expansion of §1931 eligibility effective January 2001, various changes in the Food Stamp program, and changes in eligibility criteria resulting from the expiration of the State's AFDC Research and Demonstration Waiver. The State reports that it is doing its best to program and test these changes as quickly as possible.

The State reports that, effective July 1, 2000, all families who lose TFA eligibility are automatically tested for ongoing §1931 coverage, with the exception of a limited number of terminations effected by manual intervention which apply to both TFA and Medicaid (which would happen, for example, when a client moves out of state or voluntarily terminates all benefits). The July 1 change ensures that families are retained in the Medicaid-only §1931 coverage group (F07) before being placed in a transitional Medicaid coverage group. Changes to EMS also have been made to automatically continue the Medicaid eligibility of children when the family loses TFA for failure to cooperate with child support requirements.

Advocate Comments: The advocates believe that Connecticut's EMS, while once state-of-the-art, is now inadequate to meet the growing, complex needs of the program. The advocates believe that the State needs to invest in a new system that will eliminate the need for manual intervention and alert staff of a loss of child health coverage. A new system also could allow electronic application which would result in more timely eligibility determination.

CMS Reply: The changes to EMS which the State already has implemented undoubtedly will help to streamline the State's application process. Pending modifications will further improve the process. We encourage the State, through its negative case action reviews or other mechanism, to ensure that any changes made effectively implement correct policy. In light of the recent expansion in §1931 coverage, we particularly would encourage the State to review whether, in addition to TFA terminations, denials of TFA applications are being evaluated for §1931 eligibility. We also are interested to know how the State is resolving the problem of processing Medicaid eligibility when information pertinent only to TFA eligibility is outstanding. Until the modifications of EMS are complete, (i.e. the delinkage of 1931 from TFA), some type of back-up measure, such as supervisory review, is needed, as is set forth in our April 7, 2000 Dear State Medicaid Director Letter.

Although there are many priorities the State is juggling in operating the Medicaid program, it is necessary to point out that PRWORA, which delinked Medicaid from TANF, became effective

almost four years ago. Furthermore, Congress created a $500 million fund to provide enhanced Federal matching funds for States to tackle the administrative burdens associated with welfare reform and the delinkage of Medicaid from cash assistance. These funds can be used to cover the expenses associated with the systems changes needed in Connecticut. However, a significant portion of the State's allotment from this fund has not been spent.

10. Communication Barriers to Applying for Assistance

As noted above, we believe that caseworkers would benefit from training on existing policies and procedures to accommodate LEP, hearing and visually impaired applicants.

State Response: The State agrees with the need for training in this area. It states that the rapid pace of programmatic change has caused the State to focus its training resources on new programs. There is a need to reinforce existing policies and procedures in this area to ensure that it is not limiting program access to LEP individuals.

Advocate Comments: The advocates report that OCR has been investigating DSS's compliance with title VI in its operation of the TFA program and suggest that we look more closely at the title VI issues in light of OCR's investigation. They also state that they are concerned about the ability of DSS staff to recognize, and to provide appropriate assistance to, persons with mental impairments, and point out that the report does not discuss accommodations for such individuals. In addition to overall training, the advocates feel that training for workers on how to serve clients with mental disabilities is needed.

CMS Response: CMS acknowledges the State's response and will be sharing it, along with a copy of this report and the advocates' comments, with OCR. As previously stated, OCR is the agency responsible for monitoring states' compliance with title VI. OCR also is available to provide technical assistance to the State as it develops policy and training materials in this area.

11. Caseloads

We are concerned that the State has not issued any definitive guidance regarding the maximum caseloads assigned to workers. Due to the differences in the staff structure in each office, it is difficult to compare caseloads, which may vary widely from office to office. Nevertheless, interviews with State employees revealed general consensus that current caseloads are difficult to manage. Both supervisors and caseworkers felt that additional employees and reduced caseloads would allow the workers additional time to review cases and reduce potential errors.

Advocate Comments: The advocates agree that high caseloads has resulted in frustrated workers

who are hindered in their ability to serve the clients well. They state that options that could benefit families are inconsistently volunteered by overburdened caseworkers.

General Post-Site Visit Advocate Comment

One advocate commended the State for the measures it has taken to address the various problems discussed in this report. The advocate stated: "Looking back, the tone of these comments may be unnecessarily harsh. The department recognized retention as a potential problem early in welfare reform and took significant, proactive, internal steps to address the problem. DSS has taken steps to remedy problems uncovered in the course of this evaluation, even before the final report is complete. Undoubtedly this explains Connecticut's remarkable performance in retaining welfare-leavers relative to other states. I commend the department for their recognition of this serious issue and renew the offer of the CT Health Policy Project to assist the department and CMS in any way to ensure that every eligible Connecticut resident both enroll and remain in Medicaid, and productively access critical health care services."

CMS Reply: We agree that Connecticut has actively worked to resolve problems identified, and we too commend the State for the steps which it has taken.

VII. APPENDIX

Appendix I - State's October 12, 2000 responses to draft report.