

TANF/MEDICAID STATE REVIEWS

I. Description of Review Process

Review Team and Sites Visited

Federal Government representatives conducted an on-site review of certain aspects of the Delaware Medicaid program on September 20 – 21, 1999 at the Delaware Department of Health and Social Services (DHSS), located in New Castle, Delaware. The review team consisted of Betty Wheeler, HCFA Regional Office, Team Leader and Margaret Montgomery, Temporary Assistance to Needy Families/Child Care, Administration for Children and Families. Also, the HCFA regional office conducted a limited scope assessment at the DHSS on May 25, 1999. Information contained in this report also reflects findings from that assessment. Interviews were conducted with State agency staff and caseworkers in the New Castle office of the Delaware Division of Social Services (DSS). A telephone interview was also conducted with a representative from a local advocacy group, Community Legal Aid Society, Inc., Wilmington, Delaware. The following report represents a moment in time review of the State policies, and a review of a limited number of open and closed recipient files. Subsequent to the review, the State and local advocacy organizations were given the opportunity to comment on this report. In some places, the report may reflect State comments. However, in Delaware, local advocate organizations were unable to afford themselves the opportunity to comment on this report prior to its issuance in final.

Background on Review Process

The 19 DSS offices located throughout the State process both TANF and Medicaid cases. Sampled cases were reviewed at the New Castle County DSS on the DHSS campus, in New Castle, Delaware. The reviewers examined a sample of 20 TANF and Medicaid denial and termination notices. The reviewers also examined actual case applications. The cases were examined to determine whether: 1) there were delays or waiting periods imposed during the application process, 2) denials and terminations were determined correctly, 3) notices of adverse actions explained the reasons for the actions/how to appeal the actions, and 4) medical assistance was inappropriately denied or terminated when TANF was denied or terminated.

II. Analysis of Documentation and Case Reviews

The State's eligibility policies are found in the DHSS Division of Social Services Medicaid/Medical Assistance Program Policy Manual (hereinafter referred to as the policy manual). The reviewers examined the State's policies and other written materials on TANF and Medicaid applications, denials, terminations, transitional Medicaid, continuation of Medicaid eligibility for disabled children who lose SSI benefits, etc. The materials included a description of the reason codes used by the State's automated eligibility system, the Delaware Client Information System (DCIS

II). The review found that the State's policies are in compliance with Federal requirements. Also, the review team found in the cases reviewed that the State's policies did not contribute to improper delays in processing applications or to erroneous denials and terminations. In fact, with the exception of one case where the incorrect reason for denial was used, all cases were processed within the limits set by Federal regulations and all case actions were correct.

State agency staff explained the State policies covering Transitional Medicaid and related welfare reform and system changes during orientation training provided to DSS caseworkers and other staff. A noteworthy feature of the State's procedures concerns processing applications for multiple assistance categories. Under the recent DSS redesign implementation and the DHSS "No Wrong Door" service integration, each caseworker received training and is now responsible for processing applications for all types of assistance, e.g. TANF, medical assistance, food stamps, and childcare assistance. Thus, potential barriers caused by requiring families to visit multiple sites or make multiple visits have been eliminated. Illustrative of the State's efforts to eliminate potential barriers to Medicaid coverage of families is the State's policy governing continued Medicaid eligibility for families who have reached the end of transitional Medicaid. When considering as part of a redetermination whether these families may be eligible for other Medicaid categories, the DCIS II eligibility determination module starts at the top of the "cascade" of Medicaid assistance categories.

Notices to families are automatically generated. Under this process, the State's Client Notices subsystem receives requests from the DCIS II to generate notifications of approval, denial, closure, and/or termination. The notices include a detailed fair hearing section. Also, the review found that eligibility notices generated by the DCIS II adequately informed recipients of the reasons for the adverse action and how to appeal the action. In addition, the review confirmed that a family's Medicaid coverage continues during the appeals process.

As noted above, the review of case records found that with one minor exception, determinations and redeterminations of eligibility were made timely and accurately. The one exception noted concerned a denial notice citation that differed from the information found in the case record. The notice, "Notice to Close Medical Assistance," stated that "the case was closed at the recipient's request." The case record indicated that "the case was closed because the family failed to submit required information". Although, the error had no effect on recipient eligibility in that case, there remains a potential for denial of due process, which the State should monitor. When eligibility is terminated because of failure to cooperate in the redetermination process, at least 10-days advance notice must be provided before the termination takes effect. The notice sent in such cases should explain not only that requested information was not provided timely but also what information had been requested and that if submitted before the effective date the recipient may continue to be eligible for Medicaid. The State reports that the computer system is programmed to provide 10-day advance notice for all adverse actions. However, there are circumstances such as termination at the recipient's request which do not require

advance notice, although the notice should explain what the recipient's reason for requesting termination had been.

III. Analysis of Findings From On-Site State and Local Office Reviews

Establishing a Section 1931 Eligibility Category and General Program Administration

The Delaware Department of Health and Social Services (DHSS), hereinafter referred to as "the State," is the single state agency responsible for administering public assistance programs. All assistance programs, including TANF and Medicaid are State administered by the 19 Division of Social Service (DSS) offices located throughout the State. In May 1995, the DHSS received a waiver under the authority of Section 1115 of the Social Security Act (the Act) for a welfare reform demonstration program, entitled "A Better Chance" welfare reform project. For cash assistance the waiver allowed higher income and resource standards and imposed certain time limits and work requirements.

The State's amendment to its Medicaid Plan was approved on June 22, 1999 to add the new eligibility group pursuant to Section 1931 of the Act. The attached amendment's effective date was March 10, 1997. The amendment also specified that the A Better Chance welfare reform program would serve as the State's TANF program. Policy information on the de-linking of TANF from Medicaid and Medicaid eligibility under Section 1931 of the Act was disseminated to DSS caseworkers via the State's revised policy manual dated April 1998. Also DSS caseworkers and others received training from April to June 1998 which included State policy on de-linking Medicaid from TANF and transitional Medicaid. The training included the instruction to advise families not applying for TANF about Medicaid eligibility under other Medicaid categories. A family not applying for TANF may apply for Medicaid by completing the application for medical assistance only (and State Children's Health Insurance Plan (SCHIP)), the "Application for Health Insurance." Individuals may obtain these applications from hospitals, Federally Qualified Health Centers (FQHC), and other community sites for mailing to the DSS offices. The review of actual applications during the on-site review found that enrolled individuals who were not eligible for TANF were determined eligible for Medicaid under the Section 1931 eligibility category or other Medicaid categories.

Application Procedures: The Right to Apply Without Delay and to a Timely Determination of Eligibility

The State uses a joint TANF/Medicaid application form, "Application Form for Food Stamps, Cash Assistance, Medical Assistance, Child Care Assistance." The "Application for Health Insurance" application form is used for families seeking medical assistance only (including the Diamond State Health Plan, the State's managed care plan), or SCHIP (entitled Delaware Healthy Children Program) or Medicare beneficiary programs (QMB, SLMB, QI, QDWI). Also, based on

discussions with State eligibility workers, applications may be requested from any of the DSS offices in writing, in person, or over the telephone. Families may also call a toll-free telephone number to request an application. In addition, applications are available at hospitals, FQHCs, and other community sites. According to State agency headquarters staff the Medicaid portion of a TANF/Medicaid application is processed timely whether or not additional information is required in order to process the TANF portion. Medicaid applicant families are not required to observe a waiting period nor are they required to meet diversionary requirements. Both application forms instruct that individuals may claim good cause for refusing to cooperate in providing paternity information.

According to State agency headquarters staff, applications for all medical assistance services, other than for applicants who apply for Medicaid on the basis of disability are processed within 45 days. Applications based on disability are processed within 90 days. Timeframes for each phase in the application process are: 2 days to process/pend a case, 1 day to interface with DCIS II and, after all verifications are received, 5 – 7 days to make a final case disposition. The processing of the Medicaid portion of a joint application is not held up while waiting for TANF and/or food stamp verifications. The application filing date is used to determine the earliest date for which Medicaid can be effective. Staff interviewed was aware of the importance of protecting the filing date.

Sampled cases reviewed showed that applications were processed timely. The DCIS II module for calculating Medicaid eligibility has 56 aid categories, including TANF, SSI, Transitional Medicaid, and “Prospective Medicaid” (Medicaid for up to four months for recipients who become ineligible for 1931 Medicaid due to income from child support). Under the DCIS II, application information is run against the “cascade” of assistance categories until the family qualifies for a particular Medicaid category.

Assuring that Medicaid eligibility determinations of joint TANF/Medicaid applications are based on Medicaid, not TANF, policies, and procedures

As noted in Section II, the State’s revised eligibility policies clearly state that Medicaid determinations are made separately from TANF determinations. The State has trained DSS caseworkers on the new policy governing the de-linking of Medicaid from TANF. According to State agency headquarters staff, training included instructions for considering Medicaid eligibility distinct from TANF eligibility when a joint TANF/Medicaid application is reviewed.

The State’s DCIS II calculates eligibility for both TANF and Medicaid programs. The DCIS II coordinates program information for each case so that the Medicaid case indicates an eligibility determination for TANF and the TANF case indicates an eligibility determination for Medicaid. This process occurs whether an application for both TANF and Medicaid is made at the same time or at different times.

The application determination process begins when the DSS caseworker accepts an application for assistance (combined TANF/Medicaid, medical assistance only, SCHIP, or other types of assistance). According to state procedures the caseworker inputs completed application data into the Delaware Client Information System (DCIS II). The Eligibility Determination/Benefit Calculation (ED/BC) module of the DCIS II incorporates a set of eligibility rules that explore the most beneficial and comprehensive benefits for applicants and recipients. Applicant and recipient data proceeds through the module's "cascade" until medical assistance is determined for all individuals and family members or until all possibilities have been exhausted. The same logic enables the module to consider whether an individual or family unit is eligible for Medicaid even if the TANF/Medicaid application information leads to a determination of ineligibility for TANF (i. e., due to work requirements under Title IV of the Act or for some other reason.).

To deal with the challenges presented by de-linking of Medicaid from TANF and to assure the continuation of Medicaid coverage for families transitioning from TANF, the State revamped its eligibility system. This entailed revising its eligibility policy manual, conducting statewide training for all caseworkers, and others, and enhancing its client eligibility system. The improved eligibility process integrates the manual processes employed by the caseworker, i.e., interview, application data input, with the automated functions of the DCIS II.

Discussed in this paragraph are the steps followed to process an application for TANF/Medicaid received from a family who had formerly received assistance. The family had been previously determined eligible for Section 1931 Medicaid but became ineligible when the wage earner's income changed. The family was then approved for transitional Medicaid. The family went off the rolls after 24 months. Under the State's policy for transitional Medicaid recipients who come to the end of their transitional Medicaid coverage, the DCIS II eligibility determination module will consider eligibility from the top of the "cascade" of Medicaid eligibility categories.

- Because the joint application is for both TANF and Medicaid, a face-to-face interview is required for TANF (which is a possible barrier to enrollment for families). However, no face-to-face interview is required for Medicaid only.
- During the interview with the family, the caseworker completes the application and inputs the data into the DCIS II.
- The DCIS II runs the data through the Standard Filing Unit module. This module determines the composition of the family unit.
- The data is forwarded to the Eligibility Determination/Benefit Calculation (ED/BC) Module. This module runs the data against the eligibility criteria for each type of assistance in a "cascading" order.

- The ED/BC determines that the family's income and resources exceed the limits for TANF but that the family is eligible for Section 1931 Medicaid.
- The DCIS II's determination is displayed on the caseworker's computer screen.
- The caseworker reviews and confirms the determination of approval.
- The DCIS II generates a notice to the family entitled "Notice of Medicaid Approval."

Is Medicaid eligibility being properly considered when TANF benefits are terminated for any reason?

The State's policy manual correctly states that Medicaid should not be automatically terminated when a TANF case is closed. A component of training provided DSS caseworkers on the de-linking of TANF from Medicaid included advising families when processing TANF closure determinations that they may still be eligible for Medicaid. In such cases, the family is not required to submit a separate application. Also, staff interviewed by the reviewers confirmed that they must determine if TANF applicants or recipients would be eligible for Section 1931 Medicaid or any other type of Medicaid coverage before taking an action to close or deny the Medicaid case. As further provided in the State's policy manual, individuals who are under any TANF sanction are eligible for Medicaid under Section 1931.

Caseworkers have specific authorization to finalize eligibility determinations, including terminations of TANF. No supervisory reviews are performed prior to terminations to assure that caseworkers have screened cases for continued Medicaid eligibility. However, caseworker supervisors on a monthly basis review a sample of denied and/or terminated cases to ensure that ongoing Medicaid eligibility is considered when TANF benefits are stopped. Each case record for a family unit is all inclusive, i.e., it contains information on the family's TANF, Medicaid, food stamps, and child care assistance. State supervisory staff reported that the eligibility system has built in checks to be sure that errors are minimized.

Redeterminations of eligibility for Medicaid are required at least once a year but may occur more frequently for cases with changing income or other circumstances. In addition, written program policy and procedures require that ex parte reviews of eligibility for all Medicaid groups be performed when there is a change that may affect Medicaid eligibility. According to the State's policy manual, caseworkers must utilize information already existing in the case file when conducting redeterminations. If the information has been provided for another program, or is in the case file, the individual does not have to take any action to continue Medicaid benefits.

Even though the State has a policy of ex parte review at redetermination times, it appears that at regularly scheduled redeterminations, individuals (or families) are

automatically sent a new application, asked to complete certain portions of the application, and required to provide verification of income. Self-declaration is allowed for all other factors. Upon receipt of the application, the caseworker inputs data in the DCIS II. The ED/BC module determines eligibility for the current category of assistance, or if changing circumstances indicate, another assistance category. For example, a family receiving Section 1931 Medicaid has experienced an increase in income. The ED/BC determines that the unit is no longer eligible under Section 1931 Medicaid and determines that the unit is eligible under transitional Medicaid. A review of case records and computer notices reflects that redeterminations were conducted in accordance with State procedures.

We are concerned that the State is not conducting an ex parte review at the regularly scheduled redetermination times. Instead, the State automatically sends individuals (or families) new applications without first checking other available information, such as information available from the TANF, food stamps, or SSI programs. HCFA's Dear State Medicaid Director letter of April 7, 2000 provides that States are required to conduct ex parte reviews of ongoing eligibility, to the extent possible. By relying on information available to the State Medicaid agency, States can avoid unnecessary and repetitive requests for information from families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage.

Maintaining Coverage for Families Who Leave Public Assistance

As indicated above, Delaware has policies and procedures in place designed to assure that all individuals who are eligible for transitional Medicaid benefits do in fact get them. Delaware's transitional Medicaid coverage provides for 24 months of coverage (including 4 months if child support income would cause Medicaid ineligibility). A redetermination of Transitional Medicaid is done at the end of the first 12 months of coverage. At that time a determination is made whether the family's income is at or below 185% of poverty. At the end of the second 12 month period, the family is re-screened for eligibility under another Medicaid category or the SCHIP program. The caseworker performs an ex parte review and may request the family to mail in any additional information to make a determination.

The State's procedures provide that under the authority of Section 1925 of the Act, a denial of TANF eligibility due to increased earnings at work does not affect continued eligibility for Medicaid. Caseworkers must determine if TANF applicants or recipients would be eligible for Section 1931 Medicaid or any other type of Medicaid coverage before taking an action to close or deny the Medicaid case. The family is not required to submit a separate Medicaid application. A parent's social security number is optional where the application is for a child only. With respect to Section 1931 Medicaid or other medical assistance categories, family unit data is run against the DCIS II "cascade" when family circumstances change from eligibility for Section 1931 Medicaid to transitional Medicaid coverage and from transitional Medicaid coverage back to Section 1931 Medicaid or another medical assistance

category. Notices of denial/closure from one category of assistance advise families that they may be eligible under another medical assistance category.

Subsequent to the review, the review team learned that the State will close a cash or 1931 case upon request by the recipient, without any verification that the recipient has increased earnings. However, the State will not move such a recipient to transitional Medicaid without verification of increased income. We are concerned that the State's practice in this area may be a barrier to eligible families receiving TMA, and we encourage the State to reevaluate its current practice.

Section 4913 Eligibility

Delaware has an agreement under Section 1634 of the Act to deem individuals determined eligible for SSI by the Social Security Administration (SSA) as eligible for Medicaid. With respect to Section 4913 eligibility, the Delaware Division of Social Services Manual sets forth, "Section 4913 of the Balanced Budget Act (BBA) provides that children who were receiving SSI payments on August 22, 1996, and who but for the enactment of the new disability definition under Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996, would continue to be paid SSI, are mandatory categorically eligible for Medicaid. This provision is effective for those children who lost their SSI payment on or after July 1, 1997."

During discussions with State staff the reviewers were referred to HCFA letter dated October 2, 1998. The letter advises that the SSA would provide electronic lists to the States of SSI children who no longer meet the new definition of disability and have exhausted SSA's administrative appeal process or never appealed their original decision. After some initial research, State staff verified that the SSA had submitted a listing of children, who were no longer eligible for SSI due to changes in the definition of disability; one list was received in 1998 and another in 1999. Data on the SSA listings has been stored in the DCIS II system pending reformatting and distribution to DSS caseworkers for processing. At the time of the on-site visit, no redeterminations had been conducted for the children based on the 1998 and 1999 listings. However, even though the SSA lists identifying potential 4913 children were never distributed to caseworkers, caseworkers are nonetheless alerted to changes in SSI benefits on an ongoing basis and process Medicaid benefits accordingly, as described below.

The reviewers were assured by State staff that, although the special SSA child lists were not used, no children affected by PRWORA had been determined ineligible for Medicaid. State staff advised the reviewers that the monthly SDX listing provided by SSA is used to identify children who have lost eligibility due to welfare reform. The SDX Ineligibility Report lists all children who have lost eligibility due to both welfare reform and other reasons. The Protected SSI I file protects eligibility for individuals who have lost SSI for reasons other than welfare reform, such as increases in Social Security benefits, employment, attainment of age 18 or any other

non-disability reason. The DCIS II creates a Protected SSI II file for each child who has lost eligibility due to welfare reform.

State staff advised the reviewers that information contained on the SSA SDX Ineligibility Reports is used to protect the Medicaid eligibility of children listed on the report, whether the loss of SSI eligibility was due to changes in disability rules (SSI II files) or for some other reason (SSI I files). These reports are received by the DCIS II which creates a Protected SSI file for each child. This information is transferred electronically to the caseworker as an on-line alert with the changed SDX information. The DCIS II generates Alerts (source of information about a change in a recipient's eligibility status) to appropriate DSSC caseworkers for processing. Caseworkers read the Alerts and process the data for the DCIS II "cascade" to determine the next most beneficial and comprehensive benefit for each child until all possibilities of Medicaid coverage have been exhausted. The "cascade" has 56 categories of assistance ranging from Nursing Home Medicaid to Family Planning. The 18th category listed on the cascade is SSI-Related Medicaid. This category includes the groups of people who have lost their SSI benefits, e.g. 4913 children, Pickle Amendment children, etc.

State policy provides that when a Section 4913 eligible child experiences a break in Medicaid coverage due to increased household earnings, medical improvement, or failure to comply with an administrative requirement, the caseworker follows the same process as explained above. This process, i.e. ex parte, is seamless to the family unless additional information is required to help make a determination of Medicaid eligibility.

Although the State reported that no children have been terminated from Medicaid who were receiving SSI on August 22, 1996 and who lost SSI on or after July 1, 1997, they acknowledged that they should have accessed data from the SSA listing in order to conduct redeterminations of eligibility or disability. They further acknowledged that they will be accessing this data shortly.

Applications and Notices

See the above sub-section on Application Procedures for comments on the application and reapplication process. Individuals or families seeking joint TANF/Medicaid, food stamps, and/or childcare assistance need only complete one application. If TANF is denied, the applicant need not fill out a Medicaid-only application. A shortened, 2 sheet, 4-sided application form is used to apply for medical assistance only or SCHIP. As also noted in the sub-section on Application Procedures, the State has recently simplified the application process whereby a single caseworker processes all types of assistance applications. Because there is no "wrong door," potential barriers caused by requiring families to visit multiple sites or make multiple visits have been eliminated. When processing TANF closures/terminations, families are advised that they may still be eligible for Medicaid.

In discussions with State staff concerning the issue of “public charge,” the reviewers were advised that the recently revised application form for medical assistance only and SCHIP contains the statement “alien verification information will not affect any public charge determination or lead to deportation proceedings.” During discussions with State staff the reviewers noted that this statement is not contained on the joint TANF/Medicaid application form and asked whether there were plans to also revise this form. The reviewers also advised the State staff that such a revision should specify that this statement applies only to the Medicaid portion of the application. Federal policy generally prohibits non-citizens applying for Medicaid from being subject to being found a “public charge” by INS which is not the case for individuals applying for other categories of assistance such as TANF. The reviewers were told that the form would be revised to reflect Federal policy.

Notices to individuals are generated by the DCIS II. State procedures concerning client notices specify that “the automation of the Client Notice process helps Delaware meet both State and Federal policy requirements, as well as adhere to the Ortiz court decision, to create Notices and Letters that are concise and accurate. Notices generated by the DCIS II are the prescribed printed communication from the agency to the client that 1) advises that the application has been approved or denied, 2) gives the reason for the action, 3) states the rights and responsibilities of the client, 4) shows budget computations, and 5) gives detailed instructions for requesting a fair hearing. In addition, eligibility workers may override the system generated notice to customize the notice prior to printing and issuance to address individual circumstances. All notices concerning eligibility determinations and redeterminations contain the standard statement “If you do not agree with this action, you have the right to ask for a hearing. Read the last page of this to see how to ask for a hearing.”

The reviewers obtained and examined copies of notices for both TANF/Medicaid and medical assistance only. There was no evidence that Medicaid was denied or terminated when TANF was denied or terminated. There was one finding, however, concerning the notice’s explanation of the recipient’s right to a hearing. Of the 25 notices reviewed, 11 did not contain this statement. In a subsequent discussion with State staff concerning the absence of this statement on the sampled notices, it was explained that the amount of information contained in the text of the notice may have “bumped” this statement to the next page. Because 11 of the notices in the sample did not include a second page containing this explanation, the reviewers suggested to the State that this statement should be highlighted on all notices so that it is not inadvertently overlooked when the notice runs to more than one page. Aside from this observation, the reviewers found that the notices were sufficient in explaining why individuals and families were denied Medicaid benefits.

Program Assurances: Implementation at the Local Level

According to State headquarters staff, caseworkers have been thoroughly oriented to the de-linking of Medicaid from TANF, Medicaid under Section 1931, transitional Medicaid, and prospective Medicaid. Caseworkers have specific authorization to

make Medicaid eligibility determinations. Each case record for a family unit is all inclusive, i.e. it contains information on the family's TANF, Medicaid, food stamps, and child care assistance. Each caseworker handles approximately 170 "multiple" cases that include 220 medical assistance only cases (individuals within a family could be eligible under different categories such as poverty level children, 1931 family, etc.), 15 SCHIP, 88 food stamp only cases, 28 TANF cases, and 35 child care cases *for an average workload of 543 cases.*

Responsibility for assuring that Medicaid policies are accurately and consistently implemented at the caseworker level rests with the DSS. Local level caseworkers receive instruction from the DSS through written policy and procedures and training. At the local DSS level, supervisors of the assistance units in each local DSSC are responsible for assuring that Medicaid policies are accurately and consistently implemented. This responsibility is carried out via a review on a monthly basis of a statistical sample of cases. The cases are also reviewed to confirm that caseworkers timely process Alerts, Worklist Items (the source of information about changes in the client's eligibility status), or information obtained via telephone calls. The DHSS Quality Control Unit, Audit and Recovery Management Services, retrospectively reviews statistically valid samples of case load determinations and actions. Accuracy and timeliness in the processing of Medicaid case actions are standards that are used to help measure employee performance.

Civil Rights Issues

Although the Office of Civil Rights (OCR) did not participate on the review team that conducted the site visit, a copy of this report has been shared with OCR for its further 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 for providing translators and translated written materials to applicants and recipients who do not speak English, accessibility for people with physical and mental disabilities under title II of the Americans with Disabilities Act, etc.) If you have further questions or concerns about civil rights issues, we encourage you to contact your OCR regional office.

State staff informed the review team that the State provides translation services for beneficiaries who have limited English proficiency. Bi-lingual staff are available at most DSS offices to serve the State's large population of Spanish-speaking families. For others, the State has translation contracts with Hispanic community organizations. Also, application forms and informational materials for TANF/Medicaid, medical assistance only, and SCHIP are printed in Spanish as well as English. In addition, the State uses the services of the AT&T language interpretation system for other non-English speaking families. The State also uses a telecommunication device (TDD) for deaf individuals.

Reaching Families Potentially Eligible for Medicaid

When processing TANF closures/terminations, families are advised that they may still be eligible for Medicaid. Information on continued Medicaid coverage is also contained in educational and informing materials. Under a Robert Wood Johnson grant, the State has developed a colorful and easy to read brochure, "Leaving Welfare For Work Isn't As Scary As It Seems." The brochure explains that "families who get off of welfare because of work may still get family health coverage for parents and children for up to two years! Its **Transitional Medicaid.**"

With respect to outreaching to potentially Medicaid eligible individuals, State staff advised that children under age 19 and pregnant women may apply for Medicaid at various outstations; e.g. hospitals, FQHCs, and community sites. Applications obtained at these locations must be completed and submitted to the DSS offices for processing. No studies have been conducted on the effectiveness of one location over another. However, the State reviews a sample of applications received from the various locales to try to identify by mail zip code number the areas with the heaviest demand for information and applications. The State also reviews and analyzes data from their 800 number to determine heavier demands in certain zip code areas and evaluates the outreach activities conducted by the Health Benefits Manager and DSS.

State Children's Health Insurance Program (SCHIP)

The Electronic Data Systems (EDS) is the enrollment broker for the State's SCHIP program (Delaware Healthy Children Program). The EDS has implemented a multi-pronged strategy to outreach families and communities.

The State's first strategy involved an integrated community-based outreach effort in conjunction with a statewide media/public relations campaign. The theme of the campaign was "Give your kids something they really can't live without. Affordable health care." Next, written outreach materials were disseminated to public and private schools, including Head Start programs, other Federal programs servicing children, and community organizations. With respect to the schools, in January 1999 the Governor of Delaware signed a letter sent to all parents of school-age children advising them of the SCHIP program. An added benefit of the January 1999 letter SCHIP outreach initiative was being able to find and enroll eligible children in Medicaid.

Federal programs that have arrangements to channel SCHIP information to families are the Division of Child Support, Division of Public Health, Division of Services for Aging and Adults with Physical Disabilities, Division of Social Services, and Child Mental Health under the DHSS, the Delaware Department of Labor, and the Delaware Department of Education. Outreach efforts included providing training and workshops to Federally funded programs, community organizations, e. g. Girl Scouts, Latin American Community Center, and schools.

In addition to the above, SCHIP and Medicaid outreach is conducted through three major initiatives: 1) Delaware Covering Kids Project, 2) New Castle County Initiative, and 3) Kent-Sussex County Pilot Initiative. Also, applications can be obtained from hospitals, FQHCs and the 19 DSS offices throughout the State. The State also

operates a 1-800 telephone number that interested families may call to obtain information. Applications disseminated by the above outreach sources or by mail must be submitted to the DSS office for processing. Printed flyers and posters and other materials are printed in both English and Spanish. In addition, "A Facts for Employers" brochure has been distributed by the Delaware Department of Labor to connect families to benefits for low income and working families.

Under the State's SCHIP program, families seeking SCHIP enrollment are first screened for Medicaid. The form used to apply for medical assistance only and SCHIP contains the statement that "I understand that I must apply for and accept other benefits that I may be eligible to get such as Medicaid." Upon determination of eligibility, families are advised to contact the EDS to select a managed care organization and primary care provider. SCHIP beneficiaries are required to enroll in one of the two managed care organizations contracted under the State's Diamond State Health Plan.

The program is a separate state health insurance program for children under age 19 in families with incomes up to 200 percent of the Federal Poverty Level, who are not eligible for Medicaid. Delaware's current Medicaid program, which is run under an 1115 waiver, covers children up to age 6 in families with incomes up to 133 percent of the FPL and children from age 6 through age 18 in families with incomes up to 100 percent of the FPL.

Optional Policies for Medicaid Eligibility

Individuals eligible under the State's A Better Chance welfare reform waiver (for TANF benefits) are automatically eligible for Medicaid. The State has also amended its State plan to use less restrictive income and/or resource methodologies than those in effect as of July 16, 1996. In addition, the State has also adopted the policy of presumptive eligibility for pregnant women. Also, applications for the Medicaid and SCHIP programs may be taken over the telephone.

Another strategy for reaching populations potentially eligible for Medicaid is the use of the joint TANF/Medicaid application form. It contains the statement "I understand that I may be eligible for 24 months of Transitional Medicaid if my cash assistance case is closed due to increased earnings or hours and/or loss of earned income disregards due to the time limitations. This policy is also explained during the caseworker's interview with the applicant.

Ensuring Administrative Efficiency

The State's DCIS II calculates eligibility for both the TANF and Medicaid programs. The State's DCIS II coordinates program information for each case so that the Medicaid case indicates an eligibility determination for TANF or that the TANF case indicates an eligibility determination for Medicaid. This is the process whether an application for both TANF and Medicaid is made at the same time or at different

times. The State has provided training to caseworkers and other staff on welfare reform requirements as they relate to Medicaid, e.g. Transitional Medicaid, Section 1931, and Prospective Medicaid.

State staff informed the review team that the State has not conducted analyses or reviews to identify any barriers to obtaining Medicaid when families become ineligible for TANF. State policy provides, however, that ineligibility for cash assistance under TANF does not mean automatic ineligibility for Medicaid. Workers must determine if TANF applicants or recipients would be eligible for Section 1931 Medicaid or any other type of medical assistance coverage before taking an action to close or deny the Medicaid case. This process helps minimize any potential barriers to continuing Medicaid when TANF is terminated.

As required under 42 CFR 431.812(a), the State operates a conventional Medicaid quality control program for reviewing active cases. In addition, the State operates a negative case action program to determine whether cases are being correctly denied and/or terminated. The State's error rate is less than 3%.

Computer Systems

The Medicaid eligibility determination and redetermination process is linked to the TANF eligibility determination and redetermination process. Under the Delaware Client Information System (DCIS II), DSS caseworkers accept applications for assistance (combined TANF/Medicaid, medical assistance only, SCHIP, and other types of aid). Information obtained from the application is input into the Standard Filing Unit. This module calculates the make-up of the family unit. The data is then sent to the Eligibility Determination/Benefit Calculation (ED/BC) module. This module runs the data against the eligibility criteria for each type of assistance in a "cascading" order. For example, ineligibility for A Better Chance (TANF), prompts the system to calculate eligibility for the next category of assistance, which would be for Refugee Cash Assistance. There are 56 medical assistance categories ranging from Nursing Home Medicaid through Family Planning.

The ED/BC module has the logic to consider whether a family unit is eligible for Medicaid if processed application TANF/Medicaid information leads to a determination of ineligibility for TANF. This same logic permits the ED/BC module to identify Medicaid eligibility options when a member of the family unit loses TANF eligibility due to work requirements under Title IV of the Act or for some other reason.

Upon reaching a determination of eligibility or ineligibility, the decision is confirmed by the caseworker and the system automatically generates a letter of notification of approval or denial. A letter of denial includes the reason for denial and explains the individual's right to a fair hearing. When an individual applies for Medicaid and TANF through a joint application and the individual does not qualify for TANF, the denial notice informs the individual that the TANF denial may not mean ineligibility for Medicaid.

IV. Consumer Advocacy Groups

One reviewer spoke over the telephone with Ms. Deborah Gottshalk of the Community Legal Aid Society, Inc., Wilmington, Delaware, concerning the State's delinking of Medicaid from TANF. Specifically, Ms. Gottshalk was asked to share any information she had concerning Delawarean's continued access to Medicaid once they were delinked from TANF. Ms. Gottshalk said that her organization conducted a survey in the third week of February 1999 on continued access to public assistance during welfare reform. See attached for a copy of the "Welfare Reform in the First State – Snapshots of Low-Income Families." She explained that the National Welfare Monitoring and Advocacy Partnership (NWMAP) developed a survey to assess the impact of welfare reform on low-income families. It was supported by the National Coalition for the Homeless and the Children's Defense Fund. Using the NWMAP instrument, a local community organization trained staffs from mainly community-based non-profit agencies to poll a small sample (273) of families who had sought public assistance. The resulting "snapshot" of findings showed that the majority (85.4%) of families currently receiving ABC benefits were also receiving Medicaid. Also the majority of families (84.8%) who had their ABC benefits reduced in the past 6 months were still receiving Medicaid. In assessing the availability of support services when losing eligibility for A Better Chance (waiver welfare reform program serving as the State's TANF program), the report shows that 69.3% of the respondents were receiving Medicaid.

Anecdotally, she recounted that only one problem has come to the attention of her group. This concerned an individual who was found financially ineligible for medical assistance but the DCIS II failed to roll-over the individual to the SCHIP program. She also mentioned that the advocacy group is concerned about the number of sanctions being imposed on TANF beneficiaries. The DHSS commissioned an independent group, ABT Associates, to assess access to assistance under the A Better Chance waiver program. The group reports a majority of sanctions against TANF benefits were not due to recipient non-compliance but rather a failure to understand the reporting requirements, e.g. changes in financial status.

V. Promising Effective Practices

The review found that the State has been engaged in several efforts to help ensure that as many children and families as possible obtain health insurance. In particular, it has upgraded its automated system, streamlined its application process, restructured caseworker responsibility, provided training on the implementation of welfare reform, and undertaken a multi-faceted approach to outreaching families and the community.

1. **Streamlining Applications**. The review team found that individuals or families seeking joint TANF/Medicaid, food stamps, and/or childcare assistance need only complete one application. If TANF is denied, the applicant need not fill out a Medicaid-only application. A shortened 2 sheet, 4 sided, application form is used to

apply for medical assistance only or SCHIP. In addition, through discussion with State staff concerning the issue of “public charge,” the review team found that the State recently revised its application form for medical assistance only and SCHIP to contain the statement “alien verification information will not affect any public charge determination or lead to deportation proceedings.”

2. **Streamlining Application Process.** As also noted above in the sub-section on Application Procedures, the State has recently simplified the application process whereby a single caseworker processes all types of assistance applications. Because there is no “wrong door,” potential barriers caused by requiring families to visit multiple sites or make multiple visits have been eliminated.

3. **DCIS II Computer Eligibility System.** With respect to the delinking of Medicaid from TANF system, the State has upgraded its DCIS. The upgraded DCIS II includes the logic to ensure that TANF negative case actions do not adversely impact continued Medicaid until all other categories of Medicaid are exhausted.

4. **Training.** With respect to enabling DSS staff to implement the delinking of Medicaid from TANF, caseworkers received in-depth training on PRWORA repeal of AFDC, the new TANF program, Transitional Medicaid, and the new Section 1931 Medicaid eligibility group. The training covered changes brought about by PRWORA, the Section 1931 Medicaid eligibility group, technical, and financial eligibility requirements. In addition, under the DHSS “No Wrong Door” service integration, caseworkers have been trained to handle all types of applications for assistance, e.g. TANF, medical assistance only, SCHIP, food stamp, childcare, etc.

5. **Outreach.** With respect to outreach, the DHSS implemented a statewide campaign to integrate community-based outreach efforts with a statewide media/public relation campaign. The theme of the campaign was “Give your kids something they really can’t live without. Affordable health care.” Next, written outreach materials were disseminated to public and private schools, including Head Start programs, other Federally funded programs servicing children, and community organizations. In January 1999 the Governor of Delaware signed a letter sent to all parents of school-age children advising them of the SCHIP program.

Also, an example of several major outreach projects underway in the State concern the Delaware Covering Kids Project. This project is a coalition of public-private partnerships and includes community-based groups, health care providers, social service agencies, and State agencies, and the Department of Education. Project participation required these groups to complete internal inventories and resource assessments. This facilitated the statewide coordination and management of existing activities and organizational ability to reach the target audience of families with incomes up to 200% of the Federal Poverty Level.

VII. Next Steps - Areas of Concern

Based on the reviewers' observations from the September 20, 1999 on-site review and May 25, 1999 visit, the issues noted below are brought to the State's attention for appropriate response.

1. **Supervisory Review Procedures.** The State's procedures covering applicants and recipients in the 19 DSS offices call for supervisors for each Case Unit to review, on a monthly basis, a sample of case determinations made by DSS caseworkers. With respect to the one inconsistency found during case reviews, it is recommended that the State remind Case Unit supervisors and case workers of the importance of accurately annotating the hard-copy case record and accurately inputting data into the DCIS II.

State Response: Case record documentation of eligibility is critical and we are working with staff to ensure that eligibility decisions are recorded in the on-line case notes.

HCFA Reply: The State's response addresses the Federal concern.

2. **Outreach Outcomes Measurements.** With respect to reaching potentially Medicaid eligible individuals through the DHSS' outreach campaigns, the review found that no studies have been conducted on the effectiveness of using one site over another to distribute information about the program. It is suggested that the State conduct an analysis of sampled data showing sites by zip code number to discern why some sites have a heavier demand than other sites. Also, the State should ensure that sites with the highest demand for Medicaid and SCHIP information material have sufficient resources. Also, it would be beneficial to follow-up on the many outreach activities to measure impact and outcomes, e.g. the actual numbers of SCHIP and Medicaid enrollees resulting from different outreach activities.

State Response: We do review and analyze data from our 800 number to determine heavier demands in certain zip code areas and evaluate the outreach activities conducted by the Health Benefits Manager and DSS.

HCFA Reply: We are pleased to learn that the State is analyzing data to determine demand needs by zip code, and encourage the State to continue to measure impact and outcomes of its outreach activities.

3. **Highlighting Fair Hearing Statement on Notices.** With respect to notifying individuals of their rights to a fair hearing, reviewers found that 11 of 25 of the sampled notices did not contain the statement giving instructions on a recipient's right to a hearing ("If you do not agree with this action, you have the right to ask for a hearing. Read the last page to see how to ask for a hearing.") The State should take appropriate action to ensure that this statement is highlighted on all notices so that it is not inadvertently overlooked when the notice runs to more than one page.

State Response: The banner statement regarding the right to ask for a hearing appears on all notices. The statement is not “bumped” off because of lengthy text in a notice. The statement would be printed on the next page of the notice.

HCFA Reply: Our concern arose because so many of the notices reviewed during our visit did not contain the statement in question, possibly because the notice was more than one page long. For this reason, we believe the statement should be highlighted in such a manner that even if the notice runs to more than one page the appeal rights statement is not overlooked by the recipient.

4. **Medicaid/SCHIP coordination.** With respect to coordination of Medicaid and SCHIP, the State should assure that families who fail to meet Medicaid criteria are correctly rolled over to SCHIP.

State Response: This problem with the eligibility cascade has been corrected.

HCFA Reply: The State's response addresses the Federal concern.

5. **Enrollment/Data Trends.** As set forth above (in Section IV of this report, "Consumer Advocacy Groups), a survey was conducted in February 1999 by the National Welfare Monitoring and Advocacy Partnerships entitled "Welfare Reform in the First State Snapshots of Low-Income Families." Even though the findings show that a majority (85.4%) of families receiving ABC, as well as a majority who had ABC reduced in the 6 months prior to the review, were receiving Medicaid, the survey also showed for December 1998, a 35.8% decrease in TANF (ABC) caseloads, with just under 47.2% of those respondents who lost ABC being offered Medicaid. Given this data, and because children consistently comprise about two thirds of the State's cash assistance recipients, we are concerned whether all individuals, especially children, who are eligible to continue to receive Medicaid when losing TANF (ABC) benefits are actually offered and receiving Medicaid. It is suggested that the DSS closely monitor the implementation and operation of its policies governing transitional Medicaid to families negatively impacted by welfare reform.

It was noted during the reviewer's conversation with the Community Legal Aid Society, Inc. staffperson that the findings from the February 1999 survey will be followed-up by another survey in February 2000. The regional office will contact the advocate for the findings from that survey.

State Response: Our statistics show a 8.7% increase in total eligibles from June 1999 to June 2000. When any cash assistance is terminated, DCIS does an independent determination of Medicaid eligibility.

HCFA Reply: We are pleased to learn that DCIS does an independent determination of Medicaid eligibility when cash assistance is terminated. We would be interested in learning about a categorical breakdown of new eligibles, to better understand what is happening to persons whose cash assistance is terminated. As set forth in number 7

below, a change in procedure by the State for moving persons onto TMA might increase Medicaid coverage for persons losing cash assistance.

6. **Section 4913.** Although the State reported that there have been no terminations from Medicaid of Section 4913 children who lost SSI because of welfare reform, we are concerned about the failure of the State to use the lists produced by SSA to identify Section 4913 children. Our expectation, as set out in HCFA's Dear State Medicaid Director's Letter is that the State will use the most recent lists provided by SSA this past April to identify Section 4913 children, and to identify any Section 4913 children that may have been improperly terminated.

State Response: As of August 15, 2000, we have reviewed the SSA listing of 4913 children and are able to identify them.

HCFA Reply: HCFA is pleased to learn that the State by its letter of August 22, 2000 that the State has completed its match of 266 names furnished by the SSA against the State's eligibility files. The match found that 73 had aged out; 10 had moved out of State; 84 were still receiving SSI; and 28 had been closed for various reasons such as whereabouts unknown. The remaining 71 children needed to have their eligibility redetermined under Section 4913. Subsequently, the State reported by telephone contact with regional office staff that the State has been unable to complete these redeterminations. The State needs to redetermine the 71 outstanding cases and to notify HCFA when the 71 cases have been redetermined under Section 4913.

7. **TMA.** Subsequent to the review, the review team learned that the State will automatically close a cash or 1931 case upon request by the recipient due to increased earnings, without any verification that the recipient has increased earnings. However, the State will not transfer the case to transitional Medicaid without verification of increased income. We are concerned that the State's practice in this area may be a barrier to eligible families receiving TMA, and we encourage the State to reevaluate its current practice. In the event that the State does not modify this practice, the State should assure that its 10 day adverse action notices clearly explain what a recipient would need to do to remain on TMA, even when a recipient requests that the case be closed.

State Response: It has been our practice to close a case upon the request of the recipient. We will remind staff to ask if the request to close is because of increased earnings. If the request is due to increased earnings, we will request verification of income. Verification of the income may show that the family is still eligible under Section 1931 Medicaid. In addition, we will modify the notice to include an explanation of TMA.

HCFA Reply: The State's proposed action addresses our concern. We agree that the purpose of requesting income verification is to determine if the family remains eligible for Medicaid but the State needs to check for eligibility under all possible categories, not just Section 1931. Also, we suggest a written policy statement reminding caseworkers to ask families closing their cases, if they want to explore continuing Medicaid even though they have increased earnings. We suggest the explanation of TMA in the notice include a statement that, although the family may have employer-sponsored health insurance, that benefit package may be limited and continued Medicaid under TMA may cover additional services. For example, the employer benefit package may not cover dental care or eye care and these services may be available under Medicaid.

8. **Ex Parte Reviews.** We are concerned that the State is not conducting an ex parte review at the regularly scheduled redetermination times. Instead, the State automatically sends individuals (or families) new applications without first checking other available information, such as information available from the TANF, food stamps, or SSI programs. HCFA's Dear State Medicaid Director letter of April 7, 2000 provides that States are required to conduct ex parte reviews of ongoing eligibility, to the extent possible. By relying on information available to the State Medicaid agency, States can avoid unnecessary and repetitive requests for information from families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. The April 7 letter explains that information that the State or Federal government currently relies on to provide benefits under other programs, such as TANF, Food Stamps or SSI, should be considered accurate to the extent that those programs require regular redeterminations of eligibility and prompt reporting of changes in circumstances. Even if benefits are no longer being provided under another program, information from that program should be relied on for purposes of Medicaid ex parte reviews as long as the information was obtained within the State's time period for conducting Medicaid redeterminations, unless the State has reason to believe the information is no longer accurate.

State Response: We will issue instructions to staff to rely on the information available from other programs and conduct an ex parte review if possible.

HCFA Reply: HCFA is pleased that the State will issue instructions to staff to conduct an ex parte review if possible. We suggest including information contained in the case record as part of the review.

9. **Modification to Joint Application.** During discussions with State staff the reviewers noted that a statement explaining public charge policy is not contained on the joint TANF/Medicaid application form and also advised the State staff that such a

revision should specify that this statement applies only to the Medicaid portion of the application. Federal policy generally prohibits non-citizens applying for Medicaid from being subject to being found a “public charge” by INS which is not the case for individuals applying for other categories of assistance such as TANF. The reviewers were told that the form would be revised to reflect Federal policy.

State Response: The joint TANF/Medicaid application form is in the process of being revised.

HCFA Reply: *We commend the State for taking prompt action to address this concern. We are interested in obtaining a copy of the joint application when it is revised.*