

Idaho

TANF/Medicaid State Review Draft Report

Background

Idaho is comprised of 83,564 square miles, including 1,153 square miles of inland water. It has twice the combined area of the six New England states. Its boundaries are both historical and geographic in derivation. The boundary with the Canadian province of British Columbia on the north follows the 49th parallel of latitude, while the southern border with Utah and Nevada follows the 42nd parallel. The State's northeastern border with Montana--in the Idaho panhandle--follows the Continental Divide, while the eastern border with Wyoming incorporates a small slice of Yellowstone National Park. On the west, Idaho's border with Oregon and Washington is a 480-mile (770-kilometer) straight stretch except between Weiser and Lewiston, where Hells Canyon of the Snake River serves as a natural boundary. Boise is the capital. Idaho is one of the Mountain States, but it is often also classified as part of the Pacific Northwest region, a region unified by the Continental Divide as an eastern boundary and by the Columbia River drainage basin, which covers virtually the entire area. The name is an invented one, formerly thought to be an Indian name (Ee-dah-hoe) meaning "gem of the mountains."¹

I. Description of Review Process, Review Team, and Case Review Methodology

A. Review Process

Federal Government representatives conducted an on-site review of certain aspects of Idaho's Medicaid program the week of September 20-23, 1999. The review team consisted of Bruce Greenstein and Liz Trias from the Health Care Financing Administration, and John Crossman, from the Administration for Children and Families (John Crossman participated in the Boise and Idaho Falls meetings only). Office of Civil Rights (OCR) staff did not accompany the review team on this trip, however OCR began a separate, independent review in early calendar year 2000.

¹ *Encyclopædia Britannica Online*
Idaho16.doc

This report contains information gathered through the review of the State documents, policies and procedures, case reviews, discussions with the State Department of Health and Welfare representatives, and other relevant parties identified below. As such, this report is limited to information gathered from these sources on the status of Idaho's Medicaid program as of a point of time in September 1999 with respect to the areas addressed.

Subsequent to the review, State and local advocacy groups were given the opportunity to comment on the review team's findings. This report may reflect these comments in whole or in part as well as information that updates the findings to reflect actions the State has taken since the review.

B. State Organization

The Idaho Department of Health and Welfare is the single State Agency that operates the TANF, Medicaid and Food Stamp program as well as various other programs. For the programs operated by the Idaho Department of Health and Welfare, the State is divided into seven regions. Each region has a director who has considerable discretion over policy. The review team observed that this arrangement is suited for a State that ranges from the deserts of the Nevada border and the mountainous panhandle that runs a length of the Canadian border. Regional Directors are relatively autonomous; they report directly to the single State agency director and are at the same organizational level as the Medicaid program and TANF program directors within the Department of Health and Welfare. This is a significant reason for which the review team believes contributes to the variation it found in the way the State's policies are carried out. Regional Directors oversee many diverse programs – Medicaid eligibility is only one of them. The staff that manage this aspect of the State's programs also manage other eligibility areas. From our discussions with staff and review of State procedures, the review team believes that Regional Directors tailor procedures to make operations in their region most efficient. The procedures detailed below apply to the State in general, although there is variation in policies among local offices.

C. State and Local offices visited, date of visit and interviewees:

September 20, 1999 – The review team held an entry conference with Director of the Department of Health & Welfare, Medicaid and TANF Directors and staff. The review team completed the interview protocol with State senior staff. The review team visited the Boise local office. The Regional Director, office administrator, caseworkers and front desk personnel were interviewed.

Boise is the State capital, and one of two metropolitan areas in Idaho. Approximately 387,800 people live in the Boise Metropolitan Statistical Area (MSA) which includes Ada and Canyon

Counties. Nampa and Caldwell are the major cities located within Canyon County.

September 21, 1999 – The review team visited the Idaho Falls local office in the morning and the Pocatello local office in the afternoon. Idaho Falls and Pocatello are two of the State’s larger towns and are surrounded by rural areas. The Regional Director, office administrator, caseworkers and front desk personnel were interviewed at each office.

September 22, 1999 – The review team met with and interviewed the Burley office administrator, lead workers, case workers, and front desk personnel. Burley is a small, agricultural-based town.

September 23, 1999 – The review team visited the Nampa local office and interviewed the office administrator, lead workers, case workers, and front desk personnel. Nampa is agricultural-based and many residents commute to Boise for work.

Paper files and computer case records were reviewed in each office visited. The review team worked with the State’s program and systems staff to develop a sampling frame that would represent certain populations of Medicaid applicants and enrollees, and the distribution of cases across regions and local offices using calendar year 1998 data. Disproportionate stratification was used to develop the primary sampling frame, then simple random sampling within each strata was used to draw cases for local office visits. Strata were chosen and the State drew universe level data. The strata included: List of all cases that received Medicaid in 1998; TANF and Medicaid denials and closures for 1998; Transitional Medicaid closures for 1998; and Medicaid application process timelines for 1998. The review team drew simple random samples from each stratum for each of the regions that were visited. Ten case files were prepared at each office for the review team to analyze. Computer records for the selected files were reviewed concurrently with the paper files. The results of the analysis of case files are reflected through this report. Overall, the review team found the cases and the actions within the case files to be consistent with the State’s policies, and in compliance with federal guidelines.

II. Analysis of Documentation

A. Documentation

The review team obtained and reviewed documents on Idaho’s regulations, procedures and policy guidelines related to Medicaid. We found that each of the State’s seven regions had also developed a variation of these policies and procedures that were unique to their individual offices. A review of these documents found no significant problems related to the processes for determining eligibility under Medicaid and all seemed to be in accordance with federal guidelines.

B. Findings on Applications and Notices

At the time of our review, Idaho was in the process of developing a new four-page application form that would replace the old 17-page joint application. The new application will be the only one used and will be a joint application for all programs, which includes cash assistance, food stamps, Medicaid and the State Children's Health Insurance Program (SCHIP). The form is simple, concise and easy to complete. This new application form is a result of the State moving to a customer service approach by simplifying and streamlining the application process.

The State has informed us that they implemented the new application in October, 1999. The application is visually pleasant, clear and concise. When applying for Medicaid-only, the application makes clear that Social Security numbers and immigration status are required for applicants only, but when an applicant is applying for Food Stamps, the application asks for SSNs for those in the household. The form is a joint application and applicants can apply for cash assistance, childcare, medical coverage (including SCHIP), telephone assistance, and food stamps. The State avoids using the term "Medicaid" because of the negative reputation, but uses SCHIP by name, which seems to have a positive connotation. If an applicant fills out a joint application for TANF and medical assistance, but TANF is denied, the applicant does not need to fill out a separate Medicaid application.

The new application should eliminate most problems associated with longer applications in prior use. Staff is also available to help fill out the application and answer questions about the applications in local offices.

The review team obtained and reviewed copies of actual notices for Medicaid and found them to be adequate in informing beneficiaries about their rights and benefits. All notices were sufficient in explaining reasons for denial and or termination of Medicaid benefits. The State's eligibility system has a list of system-generated notices, which a worker can choose as appropriate. Notices are printed in English. The State has appointed a group to develop bilingual notices. The group intends to rewrite the notices in English and translate the notices into Spanish.

III. Analysis of Findings from On-site State and Local Office Reviews

A. Eligibility Categories

Establishing a Section 1931 Eligibility Category

The welfare reform provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) amended title IV-A of the Social Security Act (the Act)

by eliminating the Aid to Families with Dependent Children (AFDC) program and replacing it with a new program, known as the Temporary Assistance to Needy Families (TANF). Prior to the enactment of PRWORA, receipt of AFDC conferred automatic eligibility for Medicaid. PRWORA severed the link between receipt of AFDC cash assistance and Medicaid. Section 114 of PRWORA added a new Section 1931 to the Act. Under Section 1931 of the Act, states are required to extend Medicaid eligibility to low-income families who meet the pre-welfare reform AFDC income and resource standards, i.e., the AFDC standards in effect as of July 16, 1996. Under Section 1931 of the Act, states have the option to lower their income standards, but not below the AFDC standards in effect as of May 1, 1988. States also have the option 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. Section 1931(b) of the Act also gives states the option to use income and resource methods that are less restrictive than the methods used under the AFDC State plan as of July 16, 1996.

Idaho has an approved 1931 State plan amendment (SPA) implementing the Section 1931 group, effective July 16, 1996. The State Plan indicates that the State uses the AFDC standards and methodologies in effect as of July 16, 1996.

In Idaho, families receiving TANF benefits automatically receive Medicaid. The eligibility standards for the 1931 group are the same for those for TAFI (Temporary Assistance for Families in Idaho), the cash assistance program. If a family is eligible for cash assistance, they are eligible for Medicaid. A review of state documents show specific policy clarifications of AFDC concepts related to Medicaid. The State made several clarifications during the implementation of Welfare Reform and the de-linking of Medicaid and the new TANF programs. All of the state documents reviewed by the team seemed to be in compliance with federal requirements.

A review of Regional training documents indicates that the State has incorporated “de-linking” into its training modules. The basic concepts reviewed in the training modules include: (1) Medicaid eligibility is no longer tied to cash assistance; (2) the ‘de-linked’ program cannot be more restrictive than the Medicaid program which existed prior to de-linking.”

The team was informed that each region conducts continuing training for their staff on Medicaid and TANF issues throughout the year. According to a set of regional documents describing the State TANF program, referred to as the Self-Reliance Program, clients typically access services by visiting a local office directly, or by calling the main office. Customer service representatives at the main reception areas receive training on their date of hire to familiarize them with the forms that clients complete and with the different benefit programs. Subsequent training is offered to this staff whenever there are policy changes to the benefit programs.

In the State’s, “What is Medicaid? A guide to medical assistance for low-income people,” the

separation of TANF and Medicaid is explained in the, “Where To Apply In Idaho,” section. “Local offices of Health and Welfare take applications for Medicaid. They also manage other types of public assistance, including Food Stamps, Temporary Assistance for Families in Idaho, and Aid to the Aged, Blind and Disabled.” The guide makes clear that local offices take applications for Medicaid, and that the local offices also manage other public assistance programs. The guide explains the State’s application process in plain simple language:

“If you apply for medical or financial assistance, you will work with either an Eligibility Examiner or a Self-Reliance Specialist to find out what help is available. You may request an application in person or by telephone, but your application must be submitted in writing. A friend or relative may help you apply. Parents may apply for children. If you do not speak English, you may ask for a translator.”

The review team found evidence that a Medicaid-only group for families not receiving cash assistance existed in the State. One of the sampling strata contained cases of families that were receiving Medicaid-only. The review team reviewed records these Medicaid-only cases. Based on its review, the team concluded that State policies, documents, and procedures do not produce barriers for applicants interested in medical assistance only. Furthermore, the State’s new short application makes it very clear that the application can be used for applying for medical assistance with or without applying for any other programs.

Section 4913

Section 211 of the PRWORA revised the definition of childhood disability under the Supplemental Security Income (SSI) program. The new SSI childhood disability definition is more stringent than the old definition and resulted in the loss of SSI benefits for some children. Under Section 4913 of the Balanced Budget Act (BBA), states must provide Medicaid to children who were receiving SSI benefits on August 22, 1996, provided they meet current SSI income and resource standards and the definition of childhood disability in effect prior to the 1996 revised definition.

With the enactment of Section 4913 of the BBA, HCFA issued policy guidance to states, through a letter to State Medicaid Directors on November 13, 1997 and a State Medicaid Manual transmittal in May 1998, to explain how children protected under Section 4913 were to be handled. For children meeting the Section 4913 criteria whose Medicaid eligibility had not been interrupted, states were advised to continue the child on Medicaid and that eligibility did not have to be redetermined at that time. If, however, the child’s Medicaid eligibility had erroneously been terminated, states were instructed to reinstate the child’s Medicaid and then perform a redetermination of whether the child continued to meet the non-disability SSI eligibility criteria. In either case, states were supposed to conduct redeterminations at least as

frequently as every 12 months, in accordance with Federal regulations at 42 CFR 435.916, with the 12-month period beginning on the date the child becomes a Medicaid-only case.

Additionally, states were instructed to use information contained in their files to locate children protected under Section 4913, whom the State had terminated from Medicaid, and also to attempt to find any protected children who could not be located using information in the State's files. To assist states in this endeavor, SSA was making available lists of children whose cash benefits were terminated effective July 1, 1997, or who lost such benefits after that date due to a finding, including a finding of non-cooperation with the disability redetermination process, because the child no longer met the new definition of childhood disability under PRWORA. States were encouraged to request these lists from SSA, and HCFA issued additional guidance to states regarding identification of children protected under Section 4913 and use of the SSA lists through letters to State Medicaid Directors on May 29, 1998 and October 2, 1998.

The State of Idaho has issued a series of policy letters dating from 1996 on the Section 4913 population. Idaho reported receiving two files from the Social Security Administration containing information about children who lost their Supplemental Security Income (SSI) benefits who were section 4913 eligible. One file contains Social Security data from July 1 through August 23, 1997, and the second file from August 24 through October 25, 1997. The State distributed the list of eligibles to the regional offices. Through a memorandum issued in December of 1997, the State informed program managers that children who lost their SSI when child disability was redefined, but who still met the former definition of disability, were considered disabled for Medicaid purposes. The memo continued to state that, "Many of the children listed have delinquent disability review dates. These children need to have their disability reviewed under the old child disability rules prior to the next redetermination."

Workers were directed to follow up on child participants who lost SSI by checking the SDX computer files. Workers were also instructed to make sure that the 4913 eligibles received a review by the Review Medical Unit (RMU) before the end of twelve months after their SSI benefits terminated. There was no instruction issued with regard to redetermining the non-disability SSI criteria. Those determined eligible were placed in a specially designated Medicaid category.

The State did not follow-up with its regional offices regarding the status of the 4913 children and SDX files were not reconciled with findings from regional offices. Therefore, Idaho's central office had no way of knowing how many of the affected children were left without health care coverage.

The HCFA Regional Office will be following up with the State to ensure that Section 4913 children were not improperly terminated from the program. As instructed in HCFA's April 7,

2000 and June 6, 2000 Dear State Medicaid Director letter, Idaho must complete a cross-match of its children on the roles against the most recent lists (April 2000) issued by SSA and immediately reinstate any children who were terminated due to an improper redetermination, including not using the current SSI non-disability criteria when conducting redeterminations. The State should assure some permanent mechanism for flagging these children, so that they will be properly determined under 4913, even in the event of a break in eligibility.

B. Application and Enrollment

Provide the Opportunity to Apply Without Delay

The process of applying for Medicaid and SCHIP is straightforward. An application can be obtained by several methods. Clients can obtain an application in the front lobby of a local Health and Welfare office; one can be picked up from a local Health and Welfare office; one can be requested by phone; or applications can be picked up at an outreach facility or event.

When visiting a Health and Welfare office, clients can talk to a greeter in the lobby; or they come to a customer service representative in the main reception area with any questions or concerns that they may have. Any customer service representative can help someone fill out an application or other Health and Welfare forms. In the local office, an employee can answer questions for those that need help, and help individuals/families fill out the application. According to State staff, in most offices, there are bi/multilingual staff that can provide help in different languages.

According to the State's application, if a family is applying for Medicaid-only, they can mail in an application or be seen on a walk-in basis, whichever the applicant prefers. If the application is for Medicaid or SCHIP only, then a face-to-face interview is not necessary. Completed applications for medical-only can be mailed in or dropped off to the local Health and Welfare office.

When a family is applying for other benefits in addition to medical (e.g. Food Stamps, cash benefits) then a face-to-face interview is required. Caseworkers handle applications as one complete package, which means that caseworkers try to make a determination on each of the programs (e.g. Medicaid, cash and food stamps) at the same time. If applying for the State's TANF program, known as TAFI, a TAFI caseworker (called Self-Reliance Specialist (SRS)) screens the application to determine eligibility. If found eligible, the client is scheduled to see an SRS. At this time, they are also given information about community resources to address immediate needs. If the client is work-ready at the time of the interview, the caseworker will refer the client to Goodwill/Working Solutions, the State's work service contractor, to be scheduled to attend an orientation session. Working Solutions staff conduct an orientation session every Wednesday. If the client is not work-ready at the time of the interview, the SRS

completes a Personal Responsibility Contract and a Self-Reliance Assessment Form.

If they do not fall within the TAFI guidelines or decide not to pursue TAFI, the client is scheduled to see the next available Family Medical caseworker, the same day, if possible. If all same-day appointments are filled, they are scheduled for the next available appointment for the following day.

During the initial interview with the SRS, the family situation is reviewed and a list of items needed to determine eligibility is given to the client. However, if a case has enough information to determine Medicaid eligibility when the case is pending due to insufficient information for cash or food stamps, then according to State staff, caseworkers will expedite the Medicaid eligibility determination.

The Family Medicaid unit sees clients on a walk-in basis during regular business hours. According to State staff, the State makes special accommodations for those individuals that can't make it into the office because of work, school, location or transportation difficulties. Special accommodations varied in the region the team visited and included extended office hours and transportation arrangements.

Caseworkers process applications manually. Using a chart with a hierarchy of Medicaid categories and corresponding income levels, caseworkers manually determine what category of eligibility in which to place applicants. However, if no category is selected, the EPICS system defaults to the Section 1931 category.

Process applications in a timely fashion

The review team analyzed a State-produced report on Medicaid application process timelines. A cursory survey of the lengthy report reveals that the overwhelming majority of applications were determined in 30 days or less. A small percentage was determined in 31 – 45 days and a very small percentage was in excess of 90 days (this may be due, in part, to outstanding Social Security disability determinations). The report provides determination timeframes for Case Numbers, but no other information is provided about the applicant/client.

Civil Rights Issues

Although the Office for 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 beneficiaries 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.

The material that the State submitted to the review team shows the State's activity in accommodating families with Limited English Proficiency. The materials include: results of a Hispanic Issues Satisfaction Survey, report to the Governor on Hispanic Initiatives, Cultural Competency Training material, copies of Civil Rights Communication Policy, directory of Department's statewide bilingual staff, and instructions for use of the AT&T phone line interpreters.

Idaho field offices have various resources available to staff in providing interpretive services to limited English proficiency beneficiaries. The review team obtained a Directory of Interpreter Resources of employees within the Department of Health and Welfare who are proficient in a variety of languages. In addition, interpreter services are available through the AT&T Language Line, refugee centers, contracted services as well as other resources for the deaf and blind. The predominant language spoken in Idaho after English is Spanish. Many of the State's brochures, booklets, and forms, including the application are available in Spanish. In some of the field offices, bilingual staff available at the front desk to assist limited English proficiency beneficiaries with their application.

C. Maintaining Coverage for Families who Leave Public Assistance Programs

Providing Transitional Medicaid for Families

The review team found Idaho's written procedures, manuals, and training documentation for Transitional Medicaid to be in accordance with federal policy.

In Idaho, the policies and practices of Transitional Medicaid eligibility that the review team observed in the state's central office and the local office's visited appeared to be in compliance with federal guidelines. The State puts families into Transitional Medicaid when the families' income rises above the 1931 limit. Families are then eligible for Transitional benefits for up to 12 months. In an interview with one local office, the review team learned that cases that become ineligible due to earned income, whether the case is open for cash assistance and Medicaid or Medicaid-only, are reviewed to determine if the individual or family is eligible for Transitional Medicaid. In some instances, further information may be needed to make this determination and other Medicaid eligibility categories are explored. However, in most cases, the eligibility worker would key this information into the automated system and the system would process Transitional Medicaid eligibility. As a follow up, supervisory reviews of case closures include a review of Transitional Medicaid Eligibility. Idaho has a passive reporting process in place for the

Transitional Medicaid. If a family's income conditions have not changed, they are not required to send any documentation back to the Department of Health and Welfare.

The client or clients would continue to receive Food Stamps and childcare benefits if already receiving them. TAFI cases would continue to be managed in the TAFI Team for a period of 90 days to ensure clients receive the appropriate transitional Medicaid and childcare services. After this 90-day period and when the client has been closed to TAFI, the case would be transferred from the TAFI team to a Family Medicaid Unit Team.

At the end of the 12-month period of Transitional coverage (if the family gets to the end of their Transitional Medicaid eligibility period) caseworkers manually redetermine the case placing the children in another eligibility category, including SCHIP. The review team did not find any evidence that the State redetermined parents for other eligibility categories after termination from Transitional Medicaid. Also, the review team did not find evidence that the State is doing ex-parte redetermination at the end of TMA in accordance with federal guidelines. These areas need to be investigated further.

Procedures Related to Denial/Termination of Medicaid

According to State staff, since the State utilizes a joint application, an applicant may apply for several programs on the same application. In that event, the eligibility office schedules an interview and requests that the applicant(s) bring all necessary documentation and information with them to the interview. If the applicant fails to show up for the interview, or does not provide all of the required information, the eligibility worker will either reschedule the appointment, or ask the applicant to mail in or drop off the required information. If the applicant is found to be ineligible for all programs for which the applicant is applying, a denial notice will be sent out with fair hearing rights. If the applicant is found to be ineligible for one program (e.g. TANF), but eligible for another program or programs, then the State will send out a letter making the applicant aware that they are eligible for one or some, but not all programs that for which they applied. Fair hearing information goes out with those notices as well.

As noted above, Idaho has made it very clear to all staff that all Medicaid determinations are made separately from TAFI determinations. When a TAFI case is denied or terminated, Medicaid is not automatically denied or terminated. The computer handles each program separately so that termination from one program has no bearing on any of the other programs. With regard to the State's computer system, the training guide informs staff, "that all Medicaid programs must be applied for and triggered separately from any other program. For example, the MA group (Low Income Families and Children) is not automatically built in EPICS (the State's eligibility system) when the applicant applies for TAFI."

The State's training guide: Medicaid for Families and Children, Module 9, Medicaid Coverage Groups contains assurances that the state has implemented de-linking policies and is actively promoting them. The guide directly states, "Discuss with learners that individuals not eligible for financial assistance can be eligible for Medicaid." The Introduction section of the training guide goes on to instruct staff to, "Explain that we will be looking in some detail at the various Medicaid categories. No Medicaid is ever closed until the SRS (Self-Reliance Specialist) has determined that each participant in the budget unit is ineligible for any coverage group."

The training guide ensures caseworkers are informed about the State's position regarding the possible indifference of an applicant towards Medicaid: "The participant may not consider medical coverage important. The SRS should encourage the participant to cooperate in obtaining and retaining medical coverage while keeping in mind that the value systems do not change overnight. S/he should refer the participant to the local district health department offices for educational services if appropriate."

The State's policy for failure to comply with TAFI work requirements is that, for the first occurrence, the participant is sanctioned making them ineligible for Medicaid for one calendar month. For any other subsequent occurrence, the participant is ineligible for three calendar months. A participant is subject to the sanction unless the participant is pregnant or is a minor child who is not head of the household.

Redeterminations

According to State staff, Idaho is fulfilling its obligation to only deny or terminate Medicaid after all possible avenues for eligibility have been exhausted. Idaho determines applications for all Medicaid programs. According to State staff, applications submitted for the SCHIP are examined for eligibility for all other Medicaid categories before the SCHIP category is determined.

The State's eligibility computer system generates a notice advising the client that a redetermination of eligibility is due. This notice lists the information/documentation that the client needs to submit by the redetermination date and is mailed so the household receives it 45 days in advance of the redetermination due date. Some regional policies are to complete the redetermination in conjunction with Food Stamp recertification, if applicable. According to State staff, caseworkers will exhaust the information contained in the client's file to complete the redetermination before a second request is made for any new information. If additional information is needed to make the redetermination, the caseworker will contact the client by phone or by person. The caseworker either enters the redetermination into the eligibility system, or closes the Medicaid if the client does not respond and eligibility cannot be determined. In the case of TAFI or Medicaid case closures, the state's computer information system alerts the

caseworker to check for other MA categories prior to closing the case.

According to State policies and observed procedures, when ongoing eligibility is being reviewed, the SRS refers to a hierarchical chart of eligibility categories and manually determines which category is appropriate. A new application form is required for future benefits when a time-limited Medicaid category, such as Transitional Medicaid or four-month extended Medicaid expires.

According to HCFA guidance issued in a Dear State Medicaid Director letter on April 22, 1997, when an individual is about to lose Medicaid because of the loss of eligibility for cash assistance (such as the loss of AFDC benefits through the transition from AFDC to the State's TANF program, or the loss of SSI benefits in states that provide Medicaid to individuals because they receive SSI), the State is required to make an ex parte redetermination of the individual's Medicaid eligibility under any other eligibility group. The term "ex parte redetermination" means a redetermination made by one party, the State, without the involvement of any other party such as the recipient. Thus, an ex parte redetermination is based to the maximum extent possible on information contained in the individual's Medicaid file including information available through the SDX or BENDEX that the State believes is accurate. If the State is able to make a decision that the individual continues to be eligible for Medicaid, the beneficiary should be notified. The review team found no evidence that the State is routinely doing ex-parte redeterminations in accordance with these requirements.

D. Reaching Families Potentially Eligible for Medicaid

Public Charge

The State has all current Immigration and Naturalization Service (INS) documents and uses them to make the Public Charge issue as clear as they can in the local offices, outreach efforts and state policy; however problems with this issue still persist. According to State staff, the immigrant and migrant worker community is still skeptical of State government assurance without the policy being clearly articulated by the Immigration and Naturalization Service (INS). Idaho's economy relies on agriculture and the State's agribusiness relies on immigrant labor. The INS has reportedly cracked down on immigrant and migrant labor leaving the immigrant community circumspect of government interaction. Idaho has asked the INS for policy clarification on INS letterhead in order to be more convincing to their potential clients. The State is still waiting for INS to respond. In the absence of INS documentation, the State continues to do outreach in the immigrant community with community leaders.

Outstationing Eligibility Workers

According to State staff, the State has out-stationing arrangements with Federally Qualified Health Centers. The review team was told that some Regions have staff travel to rural towns or place staff in places such as district health departments to take applications, but could not confirm whether and to what extent initial application processing was available at all required sites. Some regions that are geographically large, and with a low population density have small Health and Welfare offices.

E. State Children's Health Insurance Program Review (SCHIP)

Screen and Enroll Requirements

In July 1999, Idaho implemented SCHIP through a Medicaid expansion that covered children between 133-160% of FPL. Effective July 1998, the Idaho State Legislature lowered the SCHIP eligibility level to 150% of FPL. When a family applies for medical assistance, the application is reviewed for the type of medical assistance the family would qualify for, including SCHIP. Idaho has, historically, found many people qualify for medical assistance (i.e. pregnant woman and low-income children's Medicaid) before looking at eligibility criteria for SCHIP. The State's philosophy, as articulated by State representatives, is that medical coverage is medical coverage, and the State will review every possible level of eligibility before an applicant is denied coverage.

In Region III, according to State staff, SCHIP is discussed and reviewed at every staff meeting in the Caldwell office. SCHIP is also a standing item on workers' individual conferences with discussion about why more families are not eligible. The staff discusses places where brochures are available, number of brochures available, number of brochures distributed, plus other outreach efforts. Outreach on SCHIP has been extensive in Region III. Materials are being distributed to doctors' offices, pharmacies, libraries, and housing projects for migrant and seasonal farmworkers, subsidized housing representatives, as well as the Treasure Valley Referral Center.

F. Optional Policies for Medicaid -- Outreach Activities and Eligibility Expansions

Maintaining Coverage for Families Who Leave Public Assistance and Reaching Families Potentially Eligible for Medicaid

The review team believes that Idaho has been aggressive in implementing their customer service approach to providing Medicaid. The state recently implemented a shortened application for its public assistance programs, including Medicaid. Since the visit, in October 1999, Idaho implemented self-declaration of income and 12 months continuous eligibility for children.

Outreach

State staff advised that Idaho conducts outreach on a regional basis. Major communication and media efforts are coordinated by Central Office staff. The outreach activities vary around the state depending on the population (immigrants, non-English speaking, etc.), by geography (urban/rural/very rural), and by priority. For example, in Region IV, the Self-Reliance Program is divided into outreach teams. Each team submits a plan. Activities include providing monthly service to Duck Valley Indian Reservation; working with Grandparents as Parents support group; visiting and taking applications at junior high and middle schools regarding SCHIP and Medicaid; spending volunteer hours in the Head Start garden; and twice monthly visits to St. John's Clinic where staff take applications for all programs. The Region is also working with stakeholders to provide SCHIP outreach and community resource peer professionals to improve communication and delivery of services.

G. Ensuring Administrative Efficiency and Medicaid Quality Control

The Negative Case Action Program

Idaho has an internal case review system. Supervisory reviews of caseworker's files are conducted. A 100% case file review is done for new caseworkers, and negative case actions are periodically reviewed at the regional level.

During FY99, the State had focused its attention on the SCHIP program to measure the accuracy rate of denials and closures. In November 1999, the State began to focus its attention on Low-Income Families and children with regard to the TANF program and was conducting ongoing Negative Case Action reviews to determine accuracy of terminations and denials for the Medicaid program. At the time of the review, the State was not conducting Negative Case Action reviews on adults, potentially affected by the delinking of TANF from Medicaid eligibility. The State has plans to begin conducting Negative Case Action reviews for adults in the near future.

Coordination Between Medicaid and Other Public Assistance Programs

The State uses a joint application for its programs. Cash, medical, Food Stamps and childcare are considered at the same time. According to State staff, the State will determine the application for one program at a time when part of the application (or for a specific program) is pended due to insufficient information. Otherwise, when an application is considered and approved, a caseworker will open each individual under each program for which they are eligible. When information is submitted for one program's requirements (e.g. Food Stamp report, or TANF income report) that information is used by the State to satisfy other programs' requirements.

State representatives indicated that Idaho has a strong work program and uses the orientation to educate clients about the interaction between the different State programs. The orientation highlights that Medicaid can continue after a family is no longer receiving cash assistance or has exhausted the 24-month limit on TANF.

Program Assurances

The review team management, caseworkers, and front desk staff were asked about the adequacy of training, policy updates, and supervisory reviews. Problems were not found. Regions use different techniques to do training and inform staff about policy updates, but there were many commonalities. Regional training workshops, e-mail and staff meeting were all utilized to keep staff up to date about new state policies and new methods within regions. Regions have staff dedicated to training staff from offices within their regions.

H. Computer Systems

Automated Eligibility and Enrollment Activities

According to State staff, Idaho's computer system, EPICS, is an older system and the State's increasing complex demands on it are exceeding the system's abilities. The State has begun the procurement process for a contractor to develop, procure and implement a new system. There were no signs in the review that the State's current computer system has caused problems for clients. (This may be because the system defaults to Section 1931 eligibility if the caseworker does not manually specify some other category.) The State believes that with a new system, State's staff and clients will be able to access services and maintain files more efficiently. The lack of a high degree of automation means that caseworkers have to manually determine the proper eligibility category for applicants.

IV. Consumer Advocacy Groups/Relevant Studies

An Idaho advocacy group, The Idaho Community Action Network (ICAN) released a study on Feb. 22, 1999. The ICAN report was critical of the state's treatment of applicants at several local offices around the state. The report focused on issues such as the intake process, information and document requirements, determination time, SCHIP as a part of Medicaid, and ethnic discrimination. The review team contacted ICAN prior to the review. ICAN did not conduct a follow-up survey and denied the state's request to review the cases in question. The review team took into account the allegations in the report and included several of the local offices cited in the report in the review team's itinerary.

In order to address the issues contained in ICAN's report, the State conducted two series of participant focus groups under the Simplified Access to Service project. Focus groups were held in four regions with two groups, one English speaking and in most regions a Spanish speaking. Participants were asked their opinion regarding the forms, the States outreach efforts and service provided by the Department. According to the State, actions were taken based on the comments received from these focus groups. Focus groups and other customer feedback mechanisms are becoming a part of the State's on-going quality improvement efforts.

Although HCFA and ICAN were not able to meet prior to this review, the issues contained in ICAN's report were part of the Review Protocol, and therefore reviewed. As this report shows, the review team did not find the same problems cited in ICAN's report. This possibly was due to the passage of time from the ICAN review and the HCFA review.

V. Promising Effective Practices

Idaho places a high value on self-sufficiency. Therefore, jobs and work are essential for the transition to self-sufficiency. However, the State views health care, childcare and help with groceries as the way that Idaho can help families become self-sufficient. This puts caseworkers in a situation that may seem to be a difficult juxtaposition – working hard to get clients off of cash assistance, but trying to use the other tools available (Medicaid, Food Stamps and child care) to aid in the transition. The review team observed this commitment from caseworkers in rural Idaho all the way up to the single state agency director in Boise.

Streamlined Application Process The State is in the process of implementing an improved customer service model that features a shortened application, self-declaration, and continuous eligibility.

Passive Reporting Requirements Idaho has a passive reporting process in place for the Transitional Medicaid. If a family's income conditions have not changed, they are not required to send any documentation back to the Department of Health and Welfare.

Opportunity to Apply The Family Medicaid unit sees clients on a walk-in basis. In the local offices visited by the Review Team, special accommodations have been made for those individuals that can't make it into the office because of work, school, location or transportation difficulties. Special accommodations varied in the regions the team visited and included extended office hours and transportation arrangements.

V. Next Steps

1. Ex-parte Redetermination

The review team found no evidence that the State is routinely doing ex-parte redeterminations in accordance with Federal requirements. The State needs to come into compliance with guidelines for ex-parte redeterminations set forth in HCFA's April 7, 2000 State Medicaid Director letter.

State Response:

Effective November 1, 2000, the state began an ex-parte redetermination process in accordance with Federal requirements. This process was designed in accordance with provisions outlined in the Federal directive issued to states on April 7, 2000. The state has forwarded the new policy descriptions to the regional office.

Federal Response:

We commend the State for revising its ex-parte redetermination process to comply with Federal requirements.

2. Section 4913

The review team found that the State did not follow-up with its regional offices regarding the status of the 4913 children.

The HCFA Regional Office will be following up with the State to ensure that Section 4913 children were not improperly terminated from the program. As instructed in HCFA's April 7, 2000 and June 13, 2000 Dear State Medicaid Director letter, Idaho must complete a cross-match of its children on the roles against the most recent lists (April 2000) issued by SSA and immediately reinstate any children who were terminated due to an improper redetermination, including not using the current SSI non-disability criteria when conducting redeterminations. The State should assure some permanent mechanism for coding these children, so that they will be properly determined under 4913, even in the event of a break in eligibility.

State Response:

The State has developed a code for use in EPICS that will allow us to identify these 4913 children in the event of a break in eligibility. We are also planning to sample these cases and review them to determine if appropriate action has been taken on them.

Federal Response:

We commend the State for taking action to develop a code for EPICS to identify 4913 children in the event of a break in eligibility. We will continue to work with the State to ensure that the appropriate action has been taken on 4913 children who have lost eligibility due to the revised definition of disability.

3. Terminations at the end of Transitional Medicaid

We are concerned that Idaho is not redetermining families at the end of TMA to assess ongoing Medicaid eligibility. At the end of the 12-month period of Transitional coverage (if the family gets to the end of their Transitional Medicaid eligibility period) caseworkers appeared to attempt to manually redetermine the case placing the children in another eligibility category, including SCHIP (although the review team did investigate what information the caseworkers used to make that assessment for children). The review team did not find any evidence that the State redetermined parents for other eligibility categories after termination from Transitional Medicaid. For parents, a new application form is required for future benefits when a time-limited Medicaid category, such as Transitional Medicaid or four-month extended Medicaid, expires.

We are also concerned that we did not find evidence that the State is doing ex-parte redetermination at the end of TMA in accordance with federal guidelines.

The end of Transitional Medicaid should be treated as a routine redetermination. The State should conduct “ex parte” reviews of eligibility and, only if necessary, should send out redetermination forms to families to obtain additional information. In some cases, there is the possibility that family members may be eligible for Section 1931 coverage again or a medically needy group.

State Response:

Thank you for the clarification that when time limited Medicaid ends, it should be treated as a routine determination. We will be providing clarification on this issue to our field staff and are enclosing a draft copy of that clarification. We will instruct them to use the newly developed renewal process for transitional Medicaid cases.

Federal Response:

We commend the State for revising its redetermination process to comply with Federal requirements and for taking steps to provide clarification on this issue to field staff.

4. Notices

We are concerned that notices are printed in English only, although the State has proposed to develop new notices in Spanish. This is an area for further follow-up.

State Response:

Idaho has started a project to simplify and standardize language in all notices. The subsequent phase of the project is to translate notice language into Spanish. The state expects to implement the project by the fall of 2001.

Federal Response:

We commend the State for simplifying and standardizing language in notices, and translating them into Spanish. We recommend the notices be translating into other languages as well.

5. Outstationing Sites

The review team could not confirm whether and to what extent initial application processing was available at all required outstationing sites. We need to follow-up with the State to ensure that application processing is available at all required sites.

State Response:

Idaho has contracts with Federally Qualified Health Centers to provide application assistance. Their duties include: taking applications; assisting applicants in completing the application; assuring that the information on the application is complete; providing information and referrals; obtaining the required documentation to complete the processing of the application, including verification of legal non-citizen status (including verification through Systematic Alien Verification Eligibility); conducting any necessary interviews; forwarding completed applications and necessary verification to the Department's field offices; and responding to inquiries from DHW staff on applications submitted.

We also have a Memorandum of Understanding with the Idaho Primary Care Association (IPCA) who acts as the Department's liaison with the FQHCs. Our Medicaid program specialist attends the quarterly meetings held by IPCA for the outstationed eligibility workers employed by the FQHCs. We are working with DSHS hospitals in Idaho to establish outstationing sites.

Federal Response:

We appreciate the additional information on Idaho's FQHCs. On January 18, 2001, HCFA issued a Dear State Medicaid Director letter concerning outstationing requirements. The basic outstationing requirement is that a State must establish outstation locations at each DSH hospital and each FQHC participating in the State's Medicaid program. We need to confirm that initial application processing is available at all required outstationing sites.

6. Public Charge

Idaho has asked the INS for policy clarification on INS letterhead in order to be more convincing to their potential clients. The State can find INS letterhead clarification on this issue at the INS website at www.ins.gov/graphics/publicaffairs/summaries/public.htm.

State Response:

The State expects to distribute the INS clarification to all staff by the end of January 2001. The State has redesigned the public charge posters, information sheet and training packet through a collaborative effort that included State staff and community partners. The redesigned information was issues in English and Spanish in November 2000.

Federal Response:

We commend the State for distributing the INS clarification to staff members, and for redesigning public charge outreach and training materials.