

Nebraska TANF/Medicaid Eligibility Review

I. Description of the Review Process:

A. Background

Prior to welfare reform, families who received cash assistance through the Aid to Families with Dependent Children (AFDC) program automatically received Medicaid coverage. The welfare reform provisions of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 amended Title IV-A of the Social Security Act to replace AFDC with a new State run Temporary Assistance for Needy Families (TANF) program. The link between Medicaid eligibility and cash assistance was severed, and Section 114 of PRWORA added a new Section 1931 to the Social Security Act. Under Section 1931, 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. 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 and 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 gave 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, providing States with more flexibility to expand Medicaid coverage to more low-income families.

In March 1999 the Health Care Financing Administration (HCFA) and the Administration for Children and Families (ACF), developed *A Guide to Expanding Health Coverage in the Post-Welfare Reform World, Supporting Families in Transition* to assist States and others in fully understanding the implications of welfare reform on the Medicaid program. Following the issuance of the guide HCFA, with assistance from ACF, and the Department of Health and Human Services Office for Civil Rights (OCR) conducted Medicaid eligibility reviews in every State. The purpose of these reviews was to ensure that all eligible families are enrolled in Medicaid irrespective of whether or not they receive cash assistance, that transitional medical assistance is awarded appropriately, and that cash and medical benefits are coordinated. The reviews were the next step in HCFA's continuing effort to work with States to improve the Medicaid enrollment process. The reviews focused primarily on the Section 1931 eligibility group as well as persons eligible under Section 4913, enacted by the Balanced Budget Act of 1997 to restore Medicaid eligibility to children who lost Supplementary Security Income (SSI) as a result of the new definition of eligibility established in the PRWORA.

B. Scope and Methodology

Federal Government representatives conducted an onsite review of certain aspects of the Nebraska Medicaid program the week of September 20 –24,1999. The review team consisted of the following people.

- Jackie Glaze, HCFA Regional Office
- Narinder Singh, HCFA Regional Office
- Candice Hall, HCFA Regional Office
- Sharon Taggart, HCFA Regional Office
- Cheryl Strickland, OCR Regional Office
- Gary Allen, ACF Regional Office

Prior to the on-site visit, the review team examined the Section 1931 Medicaid State Plan Amendment, program applications, and applicable portions of the Nebraska Administrative Code. September 20 – 21, 1999. The review team conducted interviews with the Nebraska Department of Health and Human Services (DHHS) administrator and eligibility staff to discuss policies and procedures pertinent to the review. The review team then divided into two smaller teams and visited a total of six local offices in the following counties on September 22 – 24, 1999.

- Douglas County (Omaha, NE)
- Columbus County (Platte, NE)
- Cass County (Plattsmouth, NE)
- Lancaster County (Lincoln, NE)
- Adams County (Hastings, NE)
- Beatrice County (Beatrice, NE)

Potential counties were identified based upon the decline in TANF enrollment compared to the size of the population in the county. The counties listed above were selected for the review because they had the largest percentage of decline in TANF enrollment compared to population size and were in close geographic proximity of the other counties selected for the review, ensuring efficient and cost effective travel. During the local office visits, interviews were conducted with income maintenance workers and supervisors. Additionally, 38 case files were reviewed from each county office, a total of 228 for the State review. The case files were randomly selected prior to the on-site visit and included the following types of cases.

- Active TANF
- Closed TANF
- Active Medicaid, including Transitional Medicaid
- Denied or terminated Medicaid, including Transitional Medicaid
- SSI cases related to Section 4913

Beneficiaries' case files were reviewed to determine whether families have been offered and/or provided Medicaid eligibility in accordance with Federal law. The review focused on cases in which TANF and/or Medicaid eligibility was denied

or terminated to ensure that actions were appropriate. The review did not focus on whether or not Medicaid eligible persons were placed in the appropriate category, so conclusions were not drawn about the extent to which the State properly identified the appropriate eligibility group for individual beneficiaries.

To ensure consistency within the review team, the review team developed standard forms for capturing case file data (see **Attachment 1**) and conducting interviews with local office staff (see **Attachment 2**).

This report contains information gathered through reviews of the State's documents, policies, and procedures as specified below, case reviews and discussions with State Medicaid representatives, consumer advocates. This report is limited to the information gathered from these sources on the status of the Nebraska Medicaid program at a point in time as of September 1999, as it relates to the specific areas of the review protocol.

State officials were given an opportunity to read and comment on this report, and their comments have been incorporated into the report. This report also contains input and comments from local advocate organizations with whom the review team met at the time of the initial site visit, and who reviewed a draft of this report on December 4, 2000.

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. **[A copy of the comments received from the State on the draft report reviewed by the State is appended to this report.]**

C. Acronyms

ADC - The name of Nebraska's cash assistance (TANF) program

ADC/MA - The name of Nebraska's Medicaid category for low income families (Section 1931 recipients)

DHHS- The Nebraska single state Medicaid agency

II. Analysis of Documentation:

A. Applications and Notices

Applicants may use one of the following three applications to apply for Medicaid:

- **DA-100:** Twenty-one page joint application used to determine eligibility for Medicaid, TANF, Child Care, Food Stamps, and Energy Assistance. Applicants must complete eleven pages of the application. Approximately one-fourth of the application is for office use, and the

additional pages explain the release of confidential information, and rights and responsibilities of the applicant.

- **DSS-500:** One-page application used in conjunction with computer-based software requiring a face-to-face interactive interview between the applicant and the local office worker. Eligibility is determined for the same programs as the DA-100. (As of December 2000, this form has been discontinued and is no longer in use.)
- **Kids Connection application:** One-page children's application that can be used to determine children eligible for SCHIP or Medicaid. It is attached to a brochure that provides information about the program, benefits, and income guidelines. This application may be mailed in and is not used to determine eligibility for any other programs. A face-to-face interview is not required for children completing this application because they are only applying for health coverage.

Children's applications may be mailed into a central location where the application is opened on the computer system. Eligibility is centrally determined if possible, otherwise forwarded to the appropriate local office if more information is needed. All other applications are received and processed by income maintenance workers at the local offices. Applicants using the DA-100 or DSS-500 must complete all sections of the application, even if they only wish to apply for Medicaid. Additionally, the computerized application used in conjunction with the DSS-500 requires income maintenance workers to complete all sections irrespective of whether or not the applicant wishes to apply for all programs. Applications do not indicate that Social Security Numbers (SSNs) are optional for other household members. State and local office staff indicated that applicants are verbally notified that the SSN is not required from everyone in the household for Medicaid eligibility, but applicants are strongly encouraged to provide the information.

Nebraska does not utilize any standard notices. All notices are generated by caseworkers. However, all notices must cite pertinent State regulation manual sections and include a statement that workers are required to provide adequate notice before taking any adverse action such as suspension, reduction, or termination of benefits.

Advocates expressed concern that appeal notices currently are in small print on the back of a form and occasionally the back does not get printed off. Advocates stated "clients are informed of the right to appeal during application and orientation processes when they are given too much information to properly process. It is our common experience that clients do not know of the right to appeal and that if they appeal within 10 days, they can preserve their benefits." Advocates suggest supplying appeal and mediation information on the front of

sanction notices and notices of conciliation in readable and understandable language and print.

Advocates explained that even though an adequate notice to clients is required to give the reason for loss or reduction of benefits, the reason is given as a regulation number from the Nebraska Manual of which a client has no realistic way to reference. Often the notice references an entire section, so if the client could reference it, it is not specific. Advocates suggest an adequate notice should give the regulation number and the actual corresponding words so that a client has a better opportunity of understanding why their benefits are being cut or reduced. Advocates further recommended that an adequate notice should explain what, if anything, a client could do to keep from losing the benefit or what and when they need to do something in order to get the benefit back.

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

A. Section 1931

Both the Medicaid and TANF programs are administered by the Nebraska DHHS, and have essentially the same financial eligibility requirements. Nebraska submitted a State Plan Amendment, effective October 1, 1996, to reflect the new Section 1931 group. Low-income families, children under age eighteen, children age eighteen eligible under AFDC criteria who are full time students in a secondary school or equivalent vocational or technical training, and pregnant women with no other eligible children are eligible. Medical assistance for persons eligible under this group, except pregnant women and children, may be terminated for failure to meet TANF work requirements.

The State also uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996 under the State's AFDC plan. Nebraska adopted an earned income disregard of the first 20% of gross earnings, child care as billed or paid up to the amount of earned income, and the additional earned income by family size according to a chart. An additional \$4,000 in resources for a one-person unit, \$6,000 for two or more, is disregarded, and interest income of \$10 per source, per individual is disregarded. The total value of one car used for employment or medical transportation is disregarded. Grants, scholarships, and work-study to a student of any age are excluded. Earnings of working children are disregarded, and parents' income up to 300% FPL is disregarded before being deemed to minor parents. Lump sums are considered resources in the month following the month of receipt with the exception of certain listed benefit payments which are totally disregarded for six months and then counted as resources if this is to the person's advantage.

The review team did not discover any information in case files to indicate that Section 1931 had not been implemented in Nebraska. However, because the

review team did not replicate budget calculations of persons determined eligible and ineligible, the review team cannot conclusively say that Section 1931 has been implemented exactly as outlined in the State plan amendment. However, State staff and local office staff indicated that Section 1931 had been implemented per the State plan amendment, and case files reviewed appear to support this statement. Advocates comment the delinking was not thoroughly implemented initially because of the imposition of a time limit on 1931 Medicaid by DHHS during 1998. Even though that time limit has been repealed, advocates expressed concern that clients may still be confused about linkage between Medicaid and cash assistance because the 1931 category is still called ADC/MA, and therefore clients may be less able to advocate for themselves.

B. Section 4913

Nebraska is a SSI criteria State, meaning the Medicaid agency makes its own eligibility determination for SSI recipients using the SSI eligibility criteria. They did not submit a Medicaid State Plan Amendment to cover children under Section 4913. However, State staff indicated that all children with a pending SSI appeal retained Medicaid eligibility throughout the appeals process. Additionally, using lists from the Social Security Administration (SSA), Nebraska identified approximately eight hundred cases that could have potentially lost eligibility because of the change in the definition of disability. State staff located in the central office manually tracked these children to ensure that they retained Medicaid eligibility. Nebraska central office staff continue to verify that children on the lists provided by SSA retain Medicaid eligibility by manually checking the lists against the Medicaid eligibility system. In a rare situation, some children protected by Section 4913 may experience a break in Medicaid coverage due to increased household earnings or a failure to report income. Nebraska central office staff follow up with the local offices any time one of these children is terminated to ensure the appropriateness of the decision. Eligibility is reinstated to any child who is improperly terminated. Children protected under Section 4913 receive the same amount, duration, and scope of services as other SSI eligible individuals.

The review team did not find any instances in the case files in which Medicaid was improperly terminated due to the change in the SSA definition of disability. State staff indicated that they had identified two cases that were closed improperly, but when detected, the two cases were reopened.

C. Application Procedures

The following application policies and procedures were confirmed in interviews with State and local office staff, and the review team did not find any information in the case files that conflicted with these policies and procedures.

Persons wishing to apply for Medicaid may use the DA-100 or DSS-500 application described in Section II of this report, and children may also use the Kids Connection application to apply. An application may be made in a variety of ways, depending on which application form is used. The Kids Connection application has been widely distributed in community settings to increase enrollment in Medicaid and SCHIP and may be obtained in a variety of places including schools, hospitals, pharmacies, local offices, and by calling the State toll-free hotline. Kids Connection applications may be mailed in for processing. Persons who go to a county office to apply for benefits may use either the DA-100 or the DSS-500. Persons who call a local office to request benefits may use a DSS-500. Although persons who request benefits over the phone must go to the county office to complete the interactive interview, the date of the initial phone request will be protected as the application date for purposes of determining retroactive eligibility. If a person choosing to use the DSS-500 does not complete the interactive interview in the local office within 14 days, a DA-100 is mailed to them. (Subsequent to the review, the use of the DSS-500 has been discontinued.)

Applicants may apply for Medicaid benefits at any time and do not have to complete any type of pre-application process. Instructions for completing the application appear to be adequate, and questions on the application appear to be clear and concise. The review team did not find any policies or procedures in place that explicitly interfere with a person's right to apply for Medicaid without delay, but it was unclear if applicants are given the opportunity to bypass TANF application requirements if they only wish to apply for Medicaid. State and local office workers indicated that they verbally tell families that they may qualify for Medicaid even if they are ineligible for cash assistance, although due to the structure of the DSS-500 and DA-100 most families apply for both TANF and Medicaid. TANF and Medicaid eligibility are processed simultaneously. Although TANF participants must complete a job search contract, this is not done until after the person is determined eligible for TANF, and this policy does not appear to impact the application process itself.

State and local office staff indicated that applicants receive an explanation of all of the benefits for which they may potentially qualify. Applicants are not required to participate in all of the programs for which they are eligible, but, aside from the Kids Connection application that children may use, no provisions are in place to allow persons to apply only for Medicaid benefits. The State and local office staff both verified from interviews that the applicants are asked for what benefits they wish to apply, and eligibility is only determined for those programs. However, advocates cited several instances of individuals who only wanted health benefits being required to apply for all benefits and not being allowed to apply for only Medicaid.

An initial face-to-face interview is required for ADC cash, 1931, and ADC-related Medically Needy groups. The State does not require an initial face-to-face interview for any of the poverty level children's programs. At the time of the

review, a face-to-face interview was also required for the annual redeterminations of the above programs. However, this face-to-face requirement has since been waived.

Eligibility is determined in the local office. Typically the same worker determines eligibility for all programs on the application (e.g. TANF, Medicaid, Food Stamps). In some of the larger local offices, one worker determines eligibility and another worker maintains the case file. In smaller local offices, the same worker typically determines eligibility and maintains the case file. Income maintenance workers normally specialize either in cases subject to TANF work requirements or cases not subject to TANF work requirements. Cases involving TANF work requirements are considered to be more labor intensive than other cases, so these income maintenance workers normally have a smaller caseload.

In accordance with 42 CFR 435.911, Nebraska requires income maintenance workers to make eligibility determinations for non-disabled individuals within 45 days of the date of application. This processing timeframe begins with the applicant's request for assistance, even if the application is not completed the same day assistance is requested. Income maintenance workers must document the reasons for any delays and notify the applicant of the reason. State and local office staff indicated that most applications are processed in an average of less than thirty days. Case files sampled were consistent with this time frame, and no instances of untimely processing were found in the case files.

Once determined eligible, children under the age of nineteen receive twelve months of continuous eligibility regardless of changes in circumstances. Case files reviewed indicated that this policy had been implemented appropriately and that children are receiving twelve months of continuous eligibility. Income maintenance workers indicated that this policy had decreased the amount of work required of them and also provided continuous care to children. State and local office staff were pleased with the results of providing continuous eligibility. Advocates comment, however, that there is some confusion when the review comes up and the individual then loses eligibility.

D. Proper Medicaid Eligibility Determination When TANF Benefits are Denied or Terminated

State and local office staff indicated that when an application for TANF benefits is denied, every possible category of Medicaid eligibility is explored by the computerized eligibility system. The system first determines eligibility for eligibility under 1931, followed by poverty level groups, other possible eligibility groups, and finally SCHIP. However, this review did not focus whether Medicaid eligible persons were placed in the appropriate category, so conclusions were not drawn about the extent to which the State properly identified the appropriate eligibility group for individual beneficiaries.

State and local office staff indicated that when a family is on the verge of losing eligibility for TANF or TMA, an ex parte redetermination is performed to investigate eligibility under any other Medicaid eligibility group. When TANF benefits cease, ongoing eligibility under 1931 is assessed. Information in the case file is reviewed before the family is contacted as well as the worker's wage file. The worker's wage file is maintained in a separate database created by employers reporting wages on a quarterly basis to the unemployment compensation agency. If ongoing eligibility for Medicaid can be established, the family is notified of their continued eligibility. When an ex parte review cannot be made because additional information is needed, the income maintenance worker will contact the family for additional information. The review team did not find any instances in the case files that contradicted this policy and did review cases in which persons became eligible under different categories such as ADC medically needy to poverty level Medicaid. However, because the case file reviews did not focus on specific contacts made to families or specific documentation provided by families, the review team cannot say conclusively that these changes in eligibility resulted from an ex parte redetermination.

State and local office staff indicated that Medicaid eligibility redeterminations are conducted on an annual basis or when a change in circumstances is reported. To complete an annual redetermination, the income maintenance worker provides the family with a redetermination form that is completed through the mail. An abbreviated form is used for poverty level groups and SCHIP. Face to face interviews are not required for annual redeterminations. Some groups may be required to provide three months of income verification. Upon becoming aware of a change in circumstances, the income maintenance worker will complete a new budget for the family, and the family is sent a redetermination form to be completed through the mail. Because of the twelve-month continuous eligibility provision, children's eligibility is not affected by changes in circumstances.

Families who continue to receive cash assistance undergo annual redeterminations for Medicaid eligibility. These redeterminations are included with TANF redeterminations. (Subsequent to the review, Nebraska eliminated the face-to-face interview requirement for TANF redeterminations.)

The review team did not find any instances in the case files in which Medicaid was terminated improperly. In the case files reviewed, most terminations were a result of the family moving out of State or increased income that made the family ineligible. One termination from TMA resulted from a failure to provide quarterly reports, although the child in the household remained eligible. No cases were found in which denials or terminations from Medicaid and TANF occurred simultaneously. The review team felt that notices sent to persons whose Medicaid benefits were denied or terminated were clear, understandable, and contained adequate information about the reason for denial as well as appeal rights. However, no analysis was made about the reading level at which the notices are

written, so the review team cannot make conclusions about the clarity or understandability of the notices to beneficiaries.

E. Section 1925: Transitional Medical Assistance

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

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

Although Transitional Medical Assistance (TMA) is limited to twelve months under Medicaid, Nebraska has an approved Section 1115 waiver that extends TMA coverage to twenty-four months.

At the time of the review, individuals were eligible for TMA if they lost eligibility for *cash assistance* for any of the following reasons:

- Increased earnings
- Increased hours of employment of the parent, caretaker or guardian included in the household

When a family lost eligibility under cash assistance the income maintenance worker manually determines TMA and sent a Form TMA-1, “Notice of Eligibility for Transitional Medical Assistance” to notify the family that they are no longer eligible for Medicaid under cash assistance but are eligible for TMA.

Nebraska's TMA policy at the time of the review was not in compliance with Federal law. Subsequent to the review, however, Nebraska issued a Manual Bulletin on September 7, 2000, correcting its policy. By changing the definition of "receiving a grant", the Bulletin assures that workers evaluate TMA eligibility

for anyone financially eligible but not receiving an ADC grant in three of the last six months preceding a case being closed for increased earnings or increased hours of employment. In accordance with HCFA's April 7, 2000 Dear State Medicaid Director letter, the Bulletin instructs workers to reopen "ADC" cases that were closed inappropriately since December 1997 using the new definition.

To maintain eligibility for TMA, family units are required to report gross monthly earnings and child care costs on a quarterly basis to the local office. Families have twenty-one days after the end of each quarter to submit reports. Thus, the first report is due by the twenty-first day of the fourth month, although families who fail to submit this first report will continue to be eligible for TMA since the first six months is not based on income. Families must submit quarterly reports to the local office for months seven through twenty-four. State staff indicated that in accordance with the Section 1115 waiver, families with incomes between 100 and 185 percent of the Federal poverty level are also subject to monthly premiums after the first six months.

Families may lose TMA eligibility before the end of the twenty-four month period for the following reasons.

- The family unit becomes eligible for cash assistance and is eligible for Medicaid under 1931
- The family unit moves out of state
- No earnings in one or more quarters during the second six months of TMA unless the lack of earnings was due to involuntary loss of employment, illness, or other good cause
- There is no longer a child in the family unit
- Failure to meet quarterly reporting requirements

Income maintenance workers must track TMA eligibility manually and redetermine eligibility for Medicaid or the State Children's Health Insurance Program (SCHIP) before TMA expires. Additional information will not be requested from the family if the file contains sufficient information. The review team did not find any instances in the case files in which TMA was not provided appropriately. However, the review team was unable to assess the scope of how many ADC/MA recipients who lost ADC/MA due to increased earnings or hours of work should have received TMA, but weren't properly assessed for it because of Nebraska's incorrect TMA policy at the time of the review.

F. Implementation at the local level

Nebraska's Medicaid program is administered by the State with the local offices implementing much of the policy. Nebraska does not conduct reviews of local offices to ensure that policies are being implemented appropriately or consistently, and the local offices rarely communicate with each other. This is a major concern for advocates. They are also concerned that not all caseworkers have knowledge of the program or successfully communicate the rules to the

consumer. Based upon interviews with State central office and local office staff as well as advocate concerns and case reviews, the review team believes that income maintenance workers are given considerable flexibility and do not always use consistent processes. For instance, notices are not standardized, and the review team saw great variability in the content of notices, including level of detail, contact information, and clarity. Additionally, interviews with local office staff indicate that applicants are encouraged to fill out either the DSS-500 or the DA-100, whichever the caseworker prefers. Local office workers are responsible for ensuring that redeterminations are conducted at appropriate times, such as those conducted when TMA is about to expire. Workers can set alerts on the system to serve as reminders, however, there is no automated support system to assist them in tracking these redetermination dates. No systematic process exists at the State level to monitor the appropriateness of denials or terminations.

Local office supervisors are responsible for ensuring that policies are followed consistently. To do this, they conduct some case reviews of each income maintenance worker. If a local office worker has a question, they may directly contact the State central office by phone or e-mail to receive clarification. Nebraska also conducted a statewide training via satellite in 1997 upon the implementation of welfare reform to educate local office workers about program changes. Questions and answers from the training were distributed in written form as a follow-up to the training. New workers are informed of program policies and procedures in the training they receive upon being hired.

IV. Civil Rights Issues:

Federal Office of Civil Rights (OCR) staff participated on the Nebraska review, including the site visits, and a copy of this report will be shared with OCR for further review and consideration. OCR is able to provide technical assistance to States to ensure compliance with civil rights (e.g., Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act, etc). Further questions or concerns about civil rights issues should be directed to the OCR regional office.

Based upon interviews with State and local office staff, the review team found that Nebraska has a written policy for interpreter services for persons with limited English proficiency. To meet the needs of immigrant populations, Nebraska works closely with Catholic Social Services and Refugee Social Services. Some local office workers indicated that they suggest individuals bring an interpreter, but one will be made available to them if they do not. (In comment, advocates questioned how interpreters and quality were monitored.) A question about the need for an interpreter and language preference is included on the application. All local offices had procedures in place to ensure that interpreters were available as well as ensuring that information was available to sensory impaired individuals.

Based upon interviews with State and local office staff, the review team found that Nebraska has written policies in place addressing accommodation of the

visually impaired, deaf, and disabled. Visually impaired persons may complete interviews over the phone, and the income maintenance worker will read information to them if they come into the local office. Sign interpreters are available in all local offices, and TDD is available in most. Income maintenance workers indicated that they have conducted home visits and phone interviews for disabled applicants who are unable to come into the office.

Each local office visited by the review team had a notice of nondiscrimination posted that stated that services are provided without regard to race, color, national origin, disability or age. A notice of nondiscrimination was also included in the application.

V. Other Issues:

A. Reaching Families Potentially Eligible for Medicaid

Nebraska has produced pamphlets for the public with information about Medicaid eligibility, but most outreach efforts have occurred since the implementation of SCHIP. A comprehensive outreach strategy has been implemented for children through SCHIP, although outreach has not been conducted specifically targeted to the families who may be eligible under section 1931. State staff indicated that the SCHIP outreach effort had been successful at enrolling many children in Medicaid as well.

Nebraska has two FQHCs, one of which is a presumptive eligibility site but has elected not to be an outstationed site. State staff indicated that all FQHCs and DSHs are offered the opportunity to be an outstation site, and all Medicaid eligible populations can be served at any outstation location. Nebraska also has two FQHC look-alikes that are currently not outstationed sites, although discussions regarding outstationing are ongoing.

Nebraska has some immigrant populations, consisting primarily of Hispanics and Asians. State staff indicated that they include individuals working in meat packing plants, foreign university students, and other immigrants. The State and particularly local office workers indicated that many of these families are afraid to apply for Medicaid due to concerns about repercussions from Immigration and Naturalization Services (INS) that may occur for persons who apply for or receive Medicaid, including deportation and public charge. State staff indicated that some efforts have been made to address this but that the process was frustrating because any progress made deteriorates when a single bad experience permeates the community. State staff indicated that heavy INS activity, including raids and deportations, erected further barriers to alleviating the fears of immigrant communities. For example, Nebraska indicated that an INS raid scared away about half of the work force in one meatpacking plant, and Bosnian refugees with work status were currently being recruited to replace the previous work force.

State staff was aware of HCFA's May 26, 1999 Dear State Health Officials letter informing States about the INS public charge Notice of Proposed Rulemaking (NPRM) of the same date but this letter was not distributed to the local offices. The INS NPRM clarified that the receipt of Medicaid or SCHIP benefits will not be considered in making a public charge determination. However, the majority of local office workers interviewed were not aware of the policy clarification. State staff indicated that since public charge was a determination made by INS and the State Department, not HCFA, it was not within the purview of the Medicaid program to issue guidance about public charge. State staff had heard of instances in which Medicaid has been used as grounds for a public charge determination since the new INS guidance was issued and the new regulation published. Staff also informed the review team that Nebraska goes beyond what is federally required to cover Legal Permanent Immigrants if otherwise eligible from the month of their entry into the country. This coverage is with State funds only until they are in the country long enough to be eligible under the Federal/State Medicaid program.

B. SCHIP Screen and Enroll

State and local office staff indicated that when a children's application for Medicaid and SCHIP is received, the system first determines eligibility under 1931, followed by poverty level groups, other possible eligibility groups, and finally SCHIP. No contrary information was discovered in case files reviewed. However, this review did not focus whether Medicaid eligible persons were placed in the appropriate category, so conclusions were not drawn about the extent to which the State properly identified the appropriate eligibility group for individual beneficiaries.

C. Optional State Medicaid Policies

Effective August 1, 1998, Nebraska provides twelve months of continuous eligibility for children under age 19 on Medicaid or SCHIP, regardless of changes in circumstances. Continuous eligibility may not, however, extend past the child's nineteenth birthday if it occurs during the twelve months.

Effective August 1, 1998, Nebraska also adopted presumptive eligibility for children in Medicaid and SCHIP. Any Medicaid provider or other qualified provider can determine presumptive eligibility for only children, only pregnant women, or both after receiving a mandatory training session from Nebraska DHHS. At the time of the review, there are currently sixty-seven sites in Nebraska where children can be determined presumptively eligible, most of which are located in the cities of Omaha, Lincoln, Kearney, and Grand Island. To be determined presumptively eligible, a parent, guardian, conservator, relative or another individual acting on behalf of the child fills out a presumptive eligibility application, which is similar to the Kid's Connection application. Presumptive

eligibility may then be determined by the qualified entity based only on reported income. Although income verification must still be provided at a later date, no new application is needed since the presumptive eligibility application is used to determine Medicaid or SCHIP eligibility. The application is forwarded to the local office by the qualified entity, and the income maintenance worker must determine eligibility within forty-five days. Presumptive eligibility is continuous until the local HHS office determines that the child is not eligible on an ongoing basis for either Title XIX or Title XXI.

Nebraska also has a Health Insurance Premium Payment (HIPP) program that pays premiums and cost sharing for employer sponsored health insurance for Medicaid beneficiaries. Families eligible for Medicaid, including TMA, may participate in this program if it is cost-effective to do so and insurance is available through their employer, but children eligible under SCHIP may not participate in this program. Nebraska has relatively few participants in the HIPP program, and all HIPP cases are managed centrally by one employee at the Nebraska DHHS.

Advocates that met with the Review Team suggested that the State further expand its Medicaid program in the following ways:

- Expand the Kids Connection Medicaid Program to their parents.
- Eliminate the 100-hour rule. Many families work steadily and regularly every month but remain poor and uninsured. The 100-hour rule eliminates Medicaid eligibility for adults in a family where one of the adults works 100 or more hours in a month.
- Support legislation to remove the termination of adult Medicaid from the Employment First sanction for refusal to work.
- Expand continuous eligibility to pregnant women.

D. Ensuring Administrative Efficiency and Medicaid Quality Control

Nebraska does not utilize a Medicaid Eligibility Quality Control (MEQC) program but instead operates a pilot project that focuses on client service delivery. This pilot has been in operation for several years. Local office supervisors are responsible for ensuring that policies are implemented correctly, including proper denials. Negative case actions that are focused on client service delivery are monitored through local office supervisory reviews, although the process is not based on statistical sampling. Nebraska does not collect data about negative case actions, although they do receive a copy of every request for a fair hearing. State staff indicated that no noteworthy trends have been found in these appeals, and they did not believe cases had been erroneously denied or terminated.

E. Computer Systems

Local office workers use personal computers hooked into a Local Area Network (LAN). Data is stored centrally on a mainframe. State staff indicated that all

Section 1931 changes had been incorporated into the system. Income maintenance workers input data, and the computer determines eligibility. Eligibility for SCHIP, however, must be computed manually. Additionally, the computer does not track eligibility under TMA other than identifying the starting date, so workers must manually track the TMA expiration date to ensure that an adequate redetermination occurs. (Advocates comment that this is a big problem.) The system does not produce any standard notices. All notices are created manually by income maintenance workers and typed into the system. Although a history of case actions is maintained indefinitely, case file narratives are maintained electronically in the system and are often times not printed. The State indicated that program improvements have been implemented since the federal review to maintain notices in the system for a year online, but remain in a historical file indefinitely that can be accessed by the worker through the Production Support Unit.

The interactive interview conducted by local office workers in conjunction with the DSS-500 application is also computerized. The interview is structured rigidly, and workers are required to enter data for all fields.

After review of the report, advocates expressed a significant concern regarding the rigidity of the eligibility system being employed by HHS. For example, the commentor states: "This system presents numerous barriers at all levels ranging from case and supervisory level to management level. I once had a local office worker describe to me the problems of screening a person who only wanted Medicaid and Food Stamps. The worker described to me how she had to "trick" the N-FOCUS to reject for ADC but accept for the stamps and Medicaid by putting in an income that was higher than what the woman actually had."

VI. Consumer Advocacy Groups

To receive input from consumer advocacy groups about the de-linking of Medicaid from cash assistance, the review team convened a meeting as part of the on-site review that included the Nebraska Appleseed Center, Voices for Children, Catholic Charities, and Father-One (Father's Assembling to Honor Rights). One Nebraska DHHS representative observed the meeting. The review team specifically sought input on the following issues:

- Delay or diversion from applying for Medicaid
- Inappropriate termination or denial of benefits
- Beneficiary education about Medicaid appeal rights
- Beneficiary education about TMA
- Other issues

A. General Concerns with Welfare Reform

Overall, meeting participants were dissatisfied with the way Nebraska had implemented welfare reform. They believe that instead of keeping families

together, the welfare reform program has caused families to split up so that their income is low enough to qualify for assistance. Meeting participants indicated that Nebraska was supposed to have an “assessment/choice model” in which beneficiaries are made aware of their needs and resources before being put to work, but a “work first model” had actually been implemented in violation of the State law. Participants indicated that the assessment process is insufficient, health needs are not adequately assessed, and caseworkers fail to adequately understand of the importance of Medicaid for families who are transitioning to work. After review of the report, advocates emphasized that Nebraska caseworkers do not tell clients what the difference is between 1931 and TMA or how/when they could get these types of aid.

B. The Application Process

Complex eligibility guidelines were believed to be a barrier for individuals applying for Medicaid and meeting participants noted their had been a decline in Medicaid enrollment. They indicated some of the decline in Medicaid enrollment could be attributed to increased child support collection efforts and not entirely to TANF. Advocates further surmised that the decline in Medicaid enrollment was due to improper imposition of a time limit on Section 1931 eligibility during 1998-99 when Section 1931 was still linked to ADC/TANF. **(Please note that data from the State shows that the State has not experienced a decline in Medicaid enrollment. The data shows that Nebraska has experienced an increase in enrollment of children in Medicaid and SCHIP. State reports show that the total number of children enrolled in Medicaid and SCHIP in August 1998 was 87,770. In August 1999, enrollment in Medicaid and SCHIP increased 21.6% to 106,744 children.)**

Concern was raised about several instances of individuals who only wanted health benefits being required to apply for all benefits and not being allowed to apply for only Medicaid. Meeting participants believed that Nebraska may be seeking to improve statistics for getting people off of welfare by making people apply for TANF that they know will move off of the program quickly. It was not clear whether applicants who refuse to comply with requirements for other programs such as TANF or Food Stamps were being determined eligible for Medicaid appropriately. Concern was raised about the inability to track this issue since many people simply request to close their case when they are asked to provide information for other programs. After review of the report, advocates added that consumers also request to close the case when they believe they will not get any assistance or are burned out on the resistance they face. Although an improper determination may not occur, the joint application process may prevent families from receiving Medicaid benefits.

C. Beneficiary Education About Medicaid Appeal Rights and TMA

Meeting participants believed that Nebraska should make more of an effort to educate beneficiaries about appeal rights and transitional Medicaid benefits. Many beneficiaries may not realize they have the right to appeal eligibility decisions. Participants indicated that the number of appeals has not appeared to increase since the implementation of welfare reform, but since the majority of people denied coverage do not appeal the decision, the number of appeals is not a good indicator of how things are working. Meeting participants believed most people eligible for TMA were receiving coverage since the determination was automatic, but felt many people may not be aware that they have coverage or what benefits they receive or, (advocates added after the review), that it is time limited and only secure for the first 6 months.

D. Implementation at the Local Level

Concern was raised that Medicaid is not administered consistently across the State. Meeting participants believe that income maintenance workers are not adequately trained on policy. For instance, individuals who handed out food stamps before welfare reform are now being asked to perform case management functions that they are not qualified to do.

Advocates believe caseworkers are overworked, that there is a high turnover of caseworkers and that there is a lack of caseworker support and morale. They have expressed a concern that although Nebraska statute specifies 70 cases, they believe some caseworkers have 125 or more. They also believe training of caseworkers is an issue; that it is difficult to teach caseworkers all they need to know, which leads to inconsistency between caseworkers.

Meeting participants believed that caseloads are too high to effectively implement the “assess/choice model” of welfare reform Nebraska claims to be doing and recommended that Nebraska hire more caseworkers, increase salaries, and improve training.

E. Issues Related to Mental Health

Concern was raised that mental health issues are not appropriately assessed at the time of application for Medicaid and are not given adequate consideration. Meeting participants believed that people with mental health issues who apply for Medicaid might often be denied or terminated for failure to comply with all requirements without considering barriers caused by having mental health issues. The mental health services network was criticized as inadequate and not providing appropriate services. Meeting participants believed it difficult to provide mental health services under the Medicaid program due to extensive reporting requirements.

F. \$500 Million Fund

Advocates expressed a concern about how Nebraska is using, and plans to use, its allotment of the \$500 Million Fund that was established to help States cover administrative expenditures, including system changes, needed to effectively "delink" Medicaid from welfare.

VII. Promising Effective Practices:

A. Application Simplification for Children

Nebraska has taken several promising measures to simplify the application process for children. A one-page, mail in, joint SCHIP/Medicaid application was developed and translated into Spanish, Russian, Arabic, and Vietnamese. Nebraska established a toll-free number that families may call with questions or to request additional information and eliminated the resource test and face-to-face interview for children. Nebraska also adopted twelve-month continuous eligibility for children, a practice that has been cited by State and local office staff as a positive change.

B. Presumptive Eligibility

Nebraska has effectively implemented presumptive eligibility and at the time of review, had sixty-seven presumptive eligibility sites across the State. As explained in the Kids Connection Study Committee, September 2000 Report to the Legislature, "Presumptive eligibility allows a child with an immediate medical need to be determined eligible on a temporary basis during the time that the Health and Human Services (HHS) Local Office is processing the child's medical application. The presumptive eligibility application form is also an application for CHIP (Title XXI) and the children's medical assistance programs in Medicaid (Title XIX) so the family does not need to complete an additional application. Nebraska is one of seven states that has implemented presumptive eligibility for children."

To ensure that presumptive eligibility determinations are as accurate as possible, Nebraska requires that a State-conducted training session be completed before becoming a presumptive eligibility site. Each staff member who will be determining presumptive eligibility must attend the training.

C. Ex Parte Redeterminations

When an ex parte redetermination is performed, information in the case file is reviewed before the family is contacted as well as the worker's wage file. The worker's wage file is maintained in a separate database created by employers reporting wages on a quarterly basis to the unemployment compensation agency.

VIII. Next Steps

A. SSN Requirements

The review team is concerned that it may be unclear to applicants that the SSN is only required for those individuals applying for assistance. Applications do not indicate that Social Security Numbers (SSNs) are optional for other household members. State and local office staff indicated that applicants are verbally notified that the SSN is not required from everyone in the household for Medicaid eligibility, but applicants are strongly encouraged to provide the information.

Advocates believe this discourages immigrant populations from applying. They are also concerned that “verbally notified” is not a consistent process.

The State should consider stating directly on the application itself that Social Security Numbers are not required for those not applying to receive benefits and not at all for children to receive Kids Connection Medicaid.

B. Application Process

We are concerned that aside from the Kids Connection application that children may use, no provisions are in place to allow persons to apply only for Medicaid benefits. The State and local office staff interviewed stated that the applicants are asked for what benefits they wish to apply, and eligibility is only determined for these programs. However, advocates cited several instances of individuals who only wanted health benefits being required to apply for all benefits and not being allowed to apply for only Medicaid. In addition, the applications for families required that all questions be answered regardless of the program benefits that the family may be seeking.

This concern was also raised by consumer advocates, who were unclear whether applicants who refuse to comply with requirements for other programs such as TANF or Food Stamps were being determined eligible for Medicaid appropriately. The review team did not identify any instances of improper determinations in the case file reviews, but advocates indicated that many people may simply request to close their case when they are asked to provide information for other programs. Case file reviews would be incapable of assessing the frequency with which this occurs. Additionally, although case files of families receiving Medicaid and not TANF were reviewed, it was not possible to ascertain from the case files whether these families had completed a face-to-face interview during the application process or if they had applied for TANF as well as Medicaid.

The State may want to consider developing a separate application for Medicaid-only applicants.

State Response to Initial Advocate Comments regarding Application Process:

We take issue with the advocacy agencies comments. They have no substantiation to back up these comments. Clients are not forced to apply for other benefits in Nebraska. We have not received any cases documenting that any families in Nebraska have been discouraged from applying for Medicaid because they were offered other benefits such as Child Day Care, Food Stamps, or Energy Assistance. We have had clients complain that their worker did not explain their right to other programs, especially Child Care, and as a result they lost a month's benefits.

Advocate Response to State Response:

“The State replies that clients are not forced to apply for other benefits. This is true, but I think the state is not listening to advocates on this issue. No one I know of is asserting that families are “forced” to apply for more than one benefit, but that they are not *informed* well enough to make that decision. They are sometimes not told that it is okay to apply only for those services they want.” – Voices for Children

“The State notes there is no documentation that any Nebraska families have been discouraged from applying for Medicaid because they were offered other programs. In Kids Connection meetings we have often heard anecdotally that in some instances families who apply for Kids Connection, which requires very little information to be provided, have been asked to supply additional, sometimes burdensome information in order to be considered for additional programs. Again, this is an instance where I feel families just aren't getting the information they need to make an informed choice. I feel that they might not understand that they have the right to say no, I don't want to supply extra information. In the Kids Connection context, a check-off box will soon be employed to allow families to choose to receive information on other benefits, which will help to address the issue. This solution will not, however, affect the overlap between other Medicaid programs and other available programs.” – Voices for Children

Nebraska Appleseed suggests the State:

- send eligibility workers into the field to educate the population about Medicaid eligibility; for example, schools, community centers, clinics, and health fairs
- provide a comprehensive and understandable Facts Benefits Sheet/Brochure that outlines the programs, eligibility requirements, time limits if any, responsibilities of clients for redetermination, and appeal and mediation information
- include in the Fact Sheet information on the right to appeal any adverse decision, including information that appealing within 10 days will preserve the client's benefits

- clarify good cause reasons for not participating in Employment First activities

Federal Response:

Concerns involving informed beneficiary choice and the process for obtaining Medicaid-only benefits continue to surface throughout the advocate community. The advocates believe the State has certainly addressed these concerns on an individual basis, but not the correlating systemic process. We encourage the State to review these issues by taking another look at the information provided to applicants about their benefit options and to review possible improvements in an applicants' ability to apply for Medicaid-only.

C. Implementation at the Local Level

The review team is concerned that training and oversight of local offices may not be sufficient to ensure that policies are implemented consistently across the State. Nebraska does not conduct reviews of local offices to ensure that policies are being implemented appropriately or consistently, and the local offices rarely communicate with each other. Income maintenance workers are given considerable flexibility and do not always use consistent processes. No systematic process exists to monitor the appropriateness of denials or terminations.

Consumer advocates concurred with these identified concerns. In particular, advocates gave the following suggestions for improving caseworker effectiveness, training, and supervision:

- 1) reduce caseworker caseload to 70, the number recommended in the Nebraska statute;
- 2) standardize notices to decrease inconsistencies
- 3) decrease caseworker turnover; improve support and morale of caseworkers; utilize exit interviews of caseworkers; listen to why they leave or are unhappy
- 4) standardize training for all service areas, generated from the Central Office

D. Lack of follow-up on negative case actions

The review team found that in Nebraska, negative case actions that focus on client service delivery are monitored through local office supervisory reviews, although the process is not based on any systematic case sampling. Nebraska does not collect data about these negative case actions, although they do receive a copy of every request for a fair hearing. In accordance with 42 CFR 435.812, as part of its mandatory Medicaid eligibility quality control (MEQC) program, Nebraska is required to conduct negative case reviews measured through sampling and review procedures. Based on this, Nebraska should develop a case sampling process.

X. Attachments

- A. Standard form used by review team for capturing case file data
- B. Standard form used by review team for conducting interviews with local office staff