**MEDICAID QUALITY CONTROL PILOT PROGRAM**

STATE MQC PILOT PROJECTS

**Update Number 3 (September 2001)**

## ALASKA

**PROJECT:** FAMILY MEDICAID NEGATIVE REVIEW WITH ELECTRONIC FEEDBACK

**Description:**

This MEQC pilot focused on the review efforts on Family Medicaid (Sec. 1931 Medicaid) during implementation of significant policy changes. The State also initiated the use of electronic feedback to caseworkers, supervisors, and policy staff.

**Purpose:**

Family Medicaid has enjoyed a period of relative stability, but an initiative to align many of the policies of our TANF, Food Stamps, and Family Medicaid programs mean a significant number of policy changes will be made this fall. The most significant change is the TANF program converting to prospective financial eligibility determinations. This is something that Family Medicaid has been doing all along, but in order to make prospective budgeting work effectively for each program, the State is also changing some Family Medicaid policies as well. Consequently, the State is concentrating its QC effort on this category in order to monitor the progress and accuracy of casework before, during, and after implementation of these policy changes.

QC reviewers will provide feedback to eligibility workers and supervisors electronically to facilitate efficient communication to eligibility workers and to assure expedient case corrections where needed.

**Design:**

The MEQC unit will be looking only at Family Medicaid application denials and case closures. In the initial months of the review, case accuracy will be determined according to existing Family Medicaid eligibility policy. If the case is found to be correct, the QC reviewer will evaluate whether the household would have been eligible or would have retained eligibility if one of eight different eligibility rules were either changed or eliminated. The policy changes being considered include increasing the resource limit, exempting real property for sale, eliminating excess averaging for nonrecurring lump sum payments, and a number of different income exemptions. This will give us valuable data when considering the cost and value of making changes for the sake of policy alignment with other assistance programs.

MEQC reviewers will record case review findings on an electronic case evaluation document (Excel form with drop-down boxes) and e-mail the document to the appropriate supervisor. If the QC finding is accepted, the eligibility worker corrects the case. If there is disagreement, the same electronic form is e-mailed to the Medicaid Policy Unit for adjudication. Its finding is also recorded on the e-form and distributed accordingly.

**Results:**

When this summary was posted this pilot project was just beginning. Individual case reviews completed so far show an excellent accuracy rate. It is too early to evaluate the effect of potential policy changes on these cases. The electronic case evaluation form appears to be well accepted and working efficiently. The most important benefit of this focused MEQC pilot will be the tracking of accuracy through the pending policy changes. Most policy changes will be implemented October 1, 2001.

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## ARIZONA

**PROJECT:** LONG TERM CARE

During this past year, Arizona has continued to concentrate pilot efforts on the Long Term Care program. In addition to an increased, stratified by local office sampling process, a new approach has been taken in the Corrective Action (CA) process. Since the pilot began in 1994, a statewide corrective action team has existed for the purpose of evaluating the errors and deficiencies cited at the end of each review period. Although this team has been effective in implementing corrective actions, it was decided to bring the corrective action process closer to the local office level. As a result, regional corrective action teams were formed, and in instances of large metropolitan offices, office-wide teams were formed, in addition to the statewide team.

Each regional or local office team was responsible for reviewing all error and deficiency cases at the end of each review period. Teams determined root cause, accountability and trends for their own offices or regions, and then determined corrective actions that would bring their error rates down. Teams wrote individual corrective action plans and divided their recommended corrective actions into two types- local office CA's and Administrative CA's. Corrective actions which could be implemented by the region or local office without administrative approval were to be implemented ASAP. Those corrective actions which needed administrative "blessing" or which would have a statewide impact were elevated to the statewide corrective action team for evaluation against other CA teams' recommendations. The statewide team then made recommendations for statewide CA based on the individual input from the regional and local office plans.

As a result, bringing the CA process down to the level of the local office helped to insure "buy-in" from the staff who would ultimately be responsible for implementing the CA's. Since the implementation of this process, the error rate has been reduced from 3.42% to 2.16% based on a stratified sample size of over 700 cases.

Arizona has been approved and has an 1115 waiver amendment pending to redesign their QC program to focus on the new populations of working families which Arizona will cover effective 10/01/02. Although the QC waiver will continue to target the LTC population, the sample stratification will be reduced to regional and total sample size reduced to approximately 400 cases per review period. In addition, Arizona will implement a 3-tiered sampling process for the new working population, implement a Management Evaluation Process, and conduct a Pre-determination Quality Control (PDQC) review on applications taken in hospital sites in the two largest Arizona counties.

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## CALIFORNIA

**PROJECT:** MEDI-CAL ELIGIBILITY QC GEOGRAPHIC SAMPLING PLAN PILOT PROJECT

The Federal Centers for Medicare and Medicaid Services (CMS) formerly known as the Health Care Financing Administration (HCFA) approved an extension of the Geographic Sampling Plan (GSP) pilot project for California. The renewed GSP authorizes the California Department of Health Services (DHS) to continue conducting geographic sampling of Medi-Cal Assistance Only (MAO) cases. The initial pilot was implemented on July 1, 1999 and was extended effective July 1, 2000 for the fiscal year 2000/2001. This latest extension is effective July 1, 2001 for fiscal year 2001/2002.

**Background:**

Prior to approval of the GSP pilot project, Medi-Cal Eligibility Quality Control (MEQC) reviewed a random sample of MAO cases for all 58 counties. The number of MEQC case reviews selected for each county was proportionate to its share of the statewide MAO beneficiary population. Because of this, small counties had only limited numbers of cases reviewed annually. These minimal numbers of case reviews did not accurately reflect the performance of these counties in determining Medi-Cal eligibility. Under the renewed GSP, this revised sampling strategy provides for MEQC case reviews in the 25 large counties in terms of MAO population. In addition to these MEQC reviews in the large counties, Periodic Case Reviews (PCRs) of 10 to 50 cases will be conducted in each of the small counties. The actual number of case reviews for each county will be determined by the size of its MAO population. This sampling strategy should minimize travel time and costs, increase MEQC efficiency, and enhance the accuracy and

usefulness of county reports. In consideration of the GSP, the state of California's Department of Health Services agrees to maintain the level of MEQC effort.

**Geographic Sampling Pilot Project:**

Based on the 2001/2002 GSP, MEQC case reviews will be conducted in the 25 large counties that comprise approximately 94 percent of the statewide MAO population. Continuation of the pilot allows the state to conduct PCRs of the 33 small counties. The PCRs will provide more efficient and accurate case sample information for the small counties. As a result of the extension of the GSP pilot project, the annual number of MEQC case reviews for the 25 large counties will increase to approximately 3,000. As this will provide more MEQC data, it should ensure more accurate measurement of state and county performance in the MAO program as well as suggesting possible Focused Review (FR) issues.

In the initial phase of the GSP pilot project, Program Review Section (PRS) was reviewing 10 randomly selected cases for each of the 33 small counties. This phase was completed by June 2001. This initial phase of the PCRs provided for enhanced MEQC coverage of small county MAO eligibility efforts and also provided criteria for future PCR prioritizations. This initial limited-scope of PCRs will be followed by more detailed and focused sampling reviews. Although MEQC staff are not doing home visits or third party verifications for the PCRs, staff continue to run Income and Eligibility Verification System and Medi-Cal Eligibility Data System matches for the cases selected for review. In the next phase of PCRs, 10 to 50 cases will be reviewed for each county utilizing a matrix that will include the following:

- MAO population in the county
- Results of prior PCRs
- Loss potential
- Prior MEQC and FR activity

The findings for the PCRs are being reported to each county in a summary report. The findings are for the county's information and consideration.

CMSs approval of the GSP pilot project freezes the MEQC dollar error rate for the State of California at 0.63 percent. This percent is the computed dollar error rate based upon the low end of the precision for fiscal year 1997, the most recently completed MEQC period prior to the inception of the GSP pilot project. The terms of the GSP pilot project preclude MEQC fiscal repercussions or sanctions for the duration of the pilot project.

As a part of the extension effective July 1, 2001, the dollar threshold level for a citeable MEQC error will increase from the current $100 to $250. Any discrepancy in the share of cost that is below $250 will be reported as a procedural error, not a citeable error. This increase will allow both PRS and county Medi-Cal program staff to focus attention on significant dollar issues. However, all MEQC findings will continue to be reported to the

counties for corrective action where appropriate, including dollar discrepancies of less than $250.

DHS provides an annual report to CMS on the findings of the MEQC pilot project. We anticipate that the pilot will be renewed annually and will continue for an indefinite period of time.

**Accomplishments:**

Under the GSP pilot project thus far, PRS has achieved the following accomplishments:

- Due to refinements in the MEQC review process, the number of MEQC case reviews has increased from 1,500 annually in 1998/1999 to an estimated 3,000 MEQC reviews in 2001/2002.
- Much more reliable data concerning error trends has resulted from only doing MEQC reviews in the 25 large counties.
- Coverage of the small counties has increased from as few as one or two cases annually to a minimum of 10 cases as part of the PCR process.
- The dollar error threshold has increased from $5, which had been in effect since at least 1979 to June 30, 1999, to $250 effective July 1, 2001.

**Summary:**

In addition to the random samples for the 25 large counties, the use of PCRs for the 33 small counties will increase efficiency and use of MEQC staff time and enhance accuracy of reported findings. DHS is confident the extension of the pilot project effective July 1, 2001 will continue to provide counties with more complete MEQC information and assist in our common quest for excellence in the Medi-Cal eligibility determination process.

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## COLORADO

**PROJECT:** MEDICAID DELINKING FROM TANF

**Purpose:**

To assure that Medicaid eligibility for families and children is determined independently of TANF financial eligibility.

**Sample:**

Over 98,000 simultaneous TANF/Medicaid closures from July 1997 through May 2001 were analyzed with respect to the use of Medicaid criteria in the reason codes. The

MEQC team monitored the revision of programming to automated systems. Over 7500 clients that were discontinued inappropriately have been reinstated to Medicaid with one-fourth to one-third expected to retain ongoing eligibility. MEQC is monitoring this process through sampling 10% of the redeterminations for reinstated clients.

**Summary of Findings:**

Inappropriate closures were reduced from 20% to less than 3%. One year after the programming changes, the number of clients receiving Families and Childrens Medicaid has increased by 10,000 (almost 10 per cent).

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## DISTRICT OF COLUMBIA

**PROJECT:** PHASE IV (QUALIFIED MEDICARE BENEFICIARY PROGRAM)

**Description:**

The Centers for Medicare and Medicaid Services, on a one-time-basis, allowed States to use MEQC personnel to help them understand problems about their eligibility systems that resulted in individuals who met eligibility criteria but were not enrolled in the QMB program. Under the pilot project, States would measure the impact of reducing enrollment obstacles, identify potential eligibles for enrollment in State Buy-In to Medicare or otherwise evaluate means to promote the Medicare Buy-In programs targeted to elderly and disabled individuals under Titles XVIII and XIX of the Social Security Act. It was believed that the pilot project findings would provide valuable information to facilitate the identification and enrollment of the targeted population.

**Purpose:**

For the District of Columbia Medicaid Pilot Project - PHASE IV, the District addressed the low enrollment of eligible beneficiaries in the Medicare Part B Buy-In program as identified in the 1999 Government Performance and Results Act. The Districts MEQC units identified as a pilot the enrollment of dual eligibles because of its priority and concern to the Federal and District of Columbia governments.

The Final Report may well serve as a tool to identify, for program components, areas that could be refined and/or re-engineered in the Districts' Qualified Medicare Beneficiary and Buy-In programs in order to ensure the best delivery of services. Programmatic and/or systemic areas requiring attention were highlighted in this report.

**Design:**

The initial project design called for a case selection based on the presence or absence of a "Q" in the Medicaid recipients' program code. Case selection was driven by the presence

or absence of a "Q" in a four position alphanumeric field. Ultimately, this approach was modified when it was determined that there was no consistency in identifying QMB clients by the Medicaid program code, either with or without a "Q." IMA and OIM management determined that there were sufficient automated systems in place to capture all potential QMB enrollees for inclusion in the full Buy-In process.

Initially, it was determined to be relevant to measure results based on data sources. These results would serve to assist QMB outreach staff with the identification of the best possible sources of potential QMB enrollees. Potential data sources of enrollees were:

- Annual SSA Leads Data
- State Data Exchange (SDX)
- MMIS Extract file of End Stage Renal Disease Patients, and
- ACEDS database cases with potential QMB enrollees

With regard to SSA Leads Data, once a year, CMS mails Dear Beneficiary letters to a target sample of newly enrolled Medicare beneficiaries. The targeted individuals consist of those whose Social Security incomes are less than 100% of the federal poverty level, do not receive Supplemental Security Income and for whom no third party is paying their Medicare premiums. States also receive the same data, annually and monthly, to be used for outreach activities.

SDX data, however, is produced for States by SSA and is created from the SSI record. It contains a record of all persons within a State who are eligible for the basic SSI payment or state supplement. It provides a method of identifying people who may be eligible for Buy-In; however, there is no indication on the SDX whether the individual has established eligibility for Medicare. Clients with end-stage renal disease (ESRD) were identified on the Medicaid Management Information System database by the diagnosis code submitted by Medicaid providers for billing purposes.

**Results:**

MEQC PHASE IV is the fourth Medicaid Pilot Project approved by the Region III CMS Office. The purpose of the pilot project was to address the low enrollment of eligible beneficiaries in the Medicare Part B Buy-In program as identified in the 1999 Government Performance Results Act.

**About the Potential QMB Enrollees:**

Manual samples of individuals, drawn from SSA Annual Leads data, the SDX file, and persons identified with end-stage renal disease, were surveyed. Ninety-six percent (96%) of the cases came from the SSA Annual Leads Data. Potential QMB enrollees consist of individuals from the following categories: SSI recipients, 65 and older; categorically needy, age 65 and older; certain medically needy age 65 and older; individuals receiving SSA Title II disability benefits for more than 24 months; and persons who have end-stage renal disease. A fairly equal amount of aged and disabled individuals were surveyed.

Eight hundred sixty-one (861) cases were assessed for barriers to enrollment in the QMB program. A follow-up survey was conducted on persons who had been assessed and identified as QMB eligible.

MEQC screened out 236 cases. The most significant reason was that 37% were not disabled for 24 months, and 33% were not eligible for Medicare Part A benefits.

Additional cases were screened on selected individuals, and it was determined that 56% were over income; 21% were over income and resources; and 12% - 15% had no Medicare Part A coverage which is a requirement to become QMB eligible. Eighty-four (84%) of the surveyed clients had Medicare Part A and B; a fraction of the clients had Part B Medicare only. Of the 186 clients interviewed, 83-85% stated they were not aware that the programs existed or were available. This question was asked two different ways. All potential enrollees, extracted from monthly SSA Leads Data, should have received a letter from the MAA, Senior Deputy Director giving them information on the Buy-In program and encouraging them to enroll.

Fifty-four percent (54%) of the surveyed individuals did not feel that simplifying or shortening the QMB application would make them any more willing to enroll in the program. Also, 56% of the surveyed individuals stated that lessening the proof of eligibility would not encourage enrollment.

Eighty percent (80%) of the survey individuals have bank accounts of less than $4,000 for one person or $6,000 for a couple. Based on income, forty-nine percent (49%) of the individuals were potentially eligible for QMB that pays Medicare premiums, deductibles, and coinsurance charges.

Seventy-six (76%) of the responses indicate potential enrollees were improperly evaluated. The assumption is that training reinforcement is needed, as it relates to programmatic issues. Thirty-seven percent (37%) of the information received from SSA was not updated in the ACEDS system. This may have contributed to non-participation in the QMB program.

**From the Administrative Perspective:**

An administrative overview of the QMB/Buy-In process was created to supplement the data collected from the potential enrollees and because of the complexity of the program and related reporting requirements. Information obtained provides an informed overview of the Buy-In process, whether it is manual or automated.

The Medical Assistance Administration did a "clean-up" of the Buy-In data file because the amount of the CMS bill was greater than the report from ACEDS. Although the State has not had this system for years, MAA indicated that "MATS" recipients were also being included as ongoing Buy-In members and collaboratively with OIM, these recipients were terminated; deceased people were also removed from the interface.

Processing for the inclusion of Buy-In recipients can take from three to six months according to CMS. If a patient is in BENDEX but MMIS is unable to add it to the Third Party Liability Master file, the MMIS system would make an erroneous payment. DOH is recovering $5 million paid erroneously over the last two years.

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## FLORIDA

**PROJECT:** INCREASE IDENTIFICATION AND PARTICIPATION OF ELIGIBLE MEDICARE BENEFICIARIES IN THE MEDICAID PROGRAM

**Description:**

Florida's first pilot project began in October 1999 targeting Medicaid recipients (excluding SSI recipients) who were potentially eligible for QMB or SLMB/PBMO programs but not receiving these benefits. This project was developed in conjunction with the Florida Agency for Health Care Administration (AHCA), which has primary responsibility for administering Florida Medicaid programs, while the Department of Children and Families (DCF), determines eligibility.

**Purpose:**

For this pilot project, MEQC reviewed samples of aged, blind and disabled recipients approved for Medicaid in community care, waiver programs or nursing care facilities. MEQC completed a limited desk and systems review of the individual's eligibility for Medicaid and the Medicare buy-in programs. Any necessary verification was by letter and telephone. Follow up was made to verify correct processing. The project consisted of three phases.

**Design:**

During the first phase, MEQC reviewed 2098 cases on Buy-In file output reports (error reports listing clients whose Buy-In did not process successfully). MEQC determined Medicaid and Buy-In eligibility and advised AHCA or DCF of actions necessary for an eligible case to process correctly on the Buy-In system and to remove ineligible cases.

In the second phase, MEQC examined 3807 active Medically Needy cases to assess their Medicare status and insure enrollment in a Buy-In program, if eligible.

For the third phase, MEQC reviewed 2535 QMB closure cases to verify the negative action was taken correctly and to determine if the client remained eligible for the SLMB/PBMO programs or other Medicaid services at the time of closure.

**Results:**

Phase 1 – Of the 2098 Buy-In output error file cases reviewed, MEQC completed 1790 cases with a finding of eligible or ineligible for Buy-In services. A total of 1058 cases or 59% were determined eligible for buy-in assistance. No action was required on 252 cases as corrections had already processed; 56 cases were not completed due to receipt of SSI, correct closure of Medicaid or death of the client. At the end of this phase, all 2098 cases were removed from the latest Buy-In error report, and only 161 newly added cases were listed. MEQC found 88% of the eligible cases had not processed correctly due to incorrect entries in the eligibility computer system. In 64% of the ineligible cases, errors were due to reconciliation problems between the eligibility and Medicaid systems.

Phase 2 – MEQC reviewed 3807 Medically Needy cases and found 2739 clients were ineligible for Buy-In services due to excess income or resources, and 29 were ineligible due to technical eligibility reasons. Only 139 cases were found eligible for QMB, and 600 cases were found eligible for SLMB or PBMO programs. Also, 118 clients found potentially eligible for Medicare were advised to contact SSA for enrollment. A total of 182 cases needed no additional actions due to correct Buy-In services, death, receipt of SSI, moved out of state or refusal to cooperate with the agency. MEQC findings showed 72% of these clients were ineligible for Buy-In services and had been processed correctly by the agency. Only 19% required further actions to approve Buy-In services.

Phase 3 – Of the 2535 cases terminated from the QMB program, 962 were found ineligible and 473 cases were found eligible for Buy-In services; 14 clients were potentially eligible for Medicare and referred to SSA; 1086 cases required no further action due to ineligibility for any Medicaid program; and 241 cases were still pending actions by AHCA and DCF at the end of the project. MEQC found 59% of the negative actions had been processed correctly by the agency. Only 18.05% cases needed additional actions to correct the Buy-In services.

Recommendations made by MEQC for both agencies regarding the findings from this project included: a) the Buy-In error reports should be examined and worked on a regular and timely basis; b) a less complicated procedure for system entries regarding Medicare insurance; c) adding SLMB and PBMO approvals to the eligibility system; d) additional training for eligibility workers in SSI-related Medicaid policy and Buy-In procedures; and e) a Medicaid system enhancement that would remove the client from Buy-In when the case is closed for Medicaid.

**Future Projects:**

Florida's next pilot project will review new approvals for KidCare to determine the accuracy of information provided by the client on a simplified application form. MEQC is also involved in reviewing the timeliness of disability applications due to a court order.

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## INDIANA

**PROJECT:** CHIP MEDICAID EXPANSION CASE REVIEW

**Description/Purpose:**

Indiana's CHIP Medicaid expansion program is called Hoosier Healthwise for Children, our health care program for children of working families. Indiana targeted children in this group for our FFY 2001 MEQC pilot project. Indiana is committed to ensuring that all Hoosier families applying for Hoosier Healthwise benefits are enrolled accurately and expeditiously, if they are eligible. As we meet our enrollment goals, program integrity remains a priority. The MEQC project goal is to increase program accuracy while reducing state and federal misspent dollars. At the same time, our project contributes to the operational improvement of Indiana's Medicaid program.

**Design:**

MEQC staff is conducting a minimum of 2500 case file reviews of children under age 19 during the annual review period. Enrollment centers have been established in Indiana to provide for the receipt and initial processing of applications at locations other than local Division of Family and Children (DFC) offices. The project purpose is to identify training needs, review accuracy and timeliness of case processing, and compare quality of case processing of applications initiated at enrollment centers with those fully processed at local offices. A worksheet was developed to capture results, which are then entered into a database. Both the hard copy and automated cases are being reviewed. Focus includes application date, household composition, relationship, earned and unearned income, health insurance, and accuracy of enrollment center coding on ICES (Indiana Client Eligibility System). Cases are found correct, deficient but eligible, or potentially ineligible due to deficient element(s).

**Results:**

Project is still in progress. First quarter results (October - December 2000) were incorporated in an Administrative Letter from the Division of Family and Children Director to all local office directors, regional managers, and eligibility staff.

Potential ineligibility was cited in 7% of the cases. Cases were cited as potentially ineligible if information in the case file indicated that the client was over the most liberal income standard, or if review staff was unable to determine eligibility due to insufficient verification or documentation.

Reasons for potential ineligibility include:

- redetermination not completed (49%)
- earned income (40%)

- childcare expense (6%)
- other (6%)
  *failure to budget reported RSDI
  *failure to budget reported child support
  *failure to budget reported educational income

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## KENTUCKY

**PROJECT:** KENTUCKY CHILDREN'S HEALTH INSURANCE PROGRAM (KCHIP)

**Description:**

Kentucky implemented its first MEQC Pilot Project on October 1, 2000. The project targeted cases containing Title XIX Kentucky Children's Health Insurance Program (KCHIP) – Medicaid expansion program – children. The Pilot ran for two consecutive six-month periods (October 2000 – March 2001 and April 2001 – September 2001). The state continued to complete traditional MEQC reviews and added a separate KCHIP Questionnaire designed by representatives from the Cabinet for Health Services/Department for Medicaid Services, Cabinet for Families and Children, Department for Community Based Services, and the Division of Quality Improvement (Quality Control Branch/Quality Initiatives Branch).

**Purpose:**

The purpose for this Pilot Project was to determine the validity of self-declaration. This Pilot Project, with the creation of some new reports, helped to provide our agency with the data necessary to support our goal in implementing this Pilot Project.

**Design:**

Kentucky's Pilot Project involved a sample pull of 2000 cases in the I (101% - 150% Medicaid Income Scale) and P (foster care and subsidized adoption) categories. Samples were run one time per month with a total of 170 cases pulled to allow for dropped cases.

The Pilot Project involved face-to-face interviews with the Medicaid recipients, independent verification of eligibility, and contact with employers to verify the availability of health insurance and whether or not health insurance for the children was dropped by the children's parents.

Along with the traditional Medicaid Quality Control review, a Questionnaire was designed to capture data from the review so that it could be entered on a KCHIP database. There were four main components to this Questionnaire – 1. QC Review Results; 2. Answers Obtained from Client Interviews; 3. Answers Obtained from Case

Review and Review Process; and 4. Answers Obtained from Employers. Each section collected data concerning income, health insurance, household composition, etc.

**Results:**

Kentucky is in the final phase of our initial Pilot Project and our preliminary findings are based on information entered into our database during the first 10 months of the Project. There are a total of 1082 cases received and 985 cases were found to be eligible. A total of 97 cases were found to be ineligible. Of the 97 cases, 56 cases or 57.73% were ineligible due to having income that exceeded the agency guidelines, and 32 cases or 32.99% were ineligible because the children had existing medical insurance that covered hospital/physician services. The remaining error cases were ineligible because of other technical requirements.

This resulted in an error rate of 8.96%. Specific data on the remainder of our survey findings may be obtained from the designated person listed below. Effective June 1, 2001, self-declaration of income was no longer considered acceptable verification and all income had to be verified.

**Future Projects:**

Kentucky is in the process of requesting a one-year extension of the present Pilot Project. We will be changing our present Questionnaire so that data can be obtained relevant to the Medicaid changes effective 7/01/01 which relate to interest bearing accounts, dividends, and the $30 gift exclusion per household member.

Even though self-declaration will not be an issue, we feel that an extension of the KCHIP Pilot will enable us to more accurately identify problem areas and causation factors in our Medicaid programs.

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## MINNESOTA

**PROJECT:** MINNESOTA FAMILY INVESTMENT PROGRAM LONGITUDINAL STUDY

**Description:**

The Minnesota Department of Human Services is conducting a five-year longitudinal study of the Minnesota Family Investment Program (MFIP) to examine the participant outcomes related to employment, poverty and welfare dependency. Data collection for the study began in May 1998 and will end in October 2003 with the last report tentatively planned to be issued in December 2005. Data is collected at periodic intervals using the same sample throughout the five-year study period. The study is documenting changes in the lives of 1,000 MFIP Applicants and 1000 Recipients whether they are on MFIP, exit MFIP, rebound (exit and return to MFIP) or leave the state. Applicants are those people new to public assistance and Recipients are those people who had two or more months of assistance history of MFIP when the sample was selected.

The reports generated for the study are organized around the key outcomes of MFIP which are: 1) getting and keeping a job 2) leaving and staying off MFIP, and 3) increasing earnings and decreasing poverty. Within these key outcomes we are looking closely at four subgroups of the sample of the Applicants and Recipients. The four subgroups within the two samples are: 1) on MFIP and not working, 2) on MFIP and working, 3) off MFIP and not working, and 4) off MFIP and working. Survey and administrative data are combined to document employment and health care measures, and the use of income and employment to support such activities as childcare assistance, housing subsidies, child support and community services.

The baseline report, first in a series was issued in August 1999. This report used participant survey and administrative data from May 1998 - October 1998 for those who either converted from AFDC to MFIP or entered the system as new Applicants during that time period. One significant finding from that report was that ten percent (10%) of working Applicants and thirteen percent (13%) of working Recipients qualified for employer health insurance benefits; however, only 7% of working Applicants and 6% of working Recipients elected to take employer health coverage, usually because the cost of employer coverage was prohibitive.

The second report titled Six Months After Baseline - Recipients and the third report titled Six Months After Baseline - Applicants, found that at six months, 24% of Recipient and 20% of Applicant exiters had employer coverage. Forty seven percent (47%) of Recipient exiters had MA or Extended MA coverage and 63% of Applicant exiters had MA or/Extended Medical coverage. Eighteen percent (18%) of Recipient exiters and twelve percent (12%) of Applicant exiters had no health coverage. Eleven percent (11%) of Recipient exiters had other coverage (spouse, non-custodial parent, participant's parent, tribal programs, COBRA) and seventeen percent (17%) of Applicant exiters had other coverage.

The fourth report titled One Year After Baseline was issued in December 2000 and focused on employment outcomes of participants in both the Applicant and Recipient samples. Health care coverage highlights from the study showed that both the Recipient and Applicant exiter groups reported similar employer coverage rates at 25% and 24%

respectively. Medicaid was the most common source of health care coverage at 62% for Recipients and 59% for Applicants. Twenty one percent (21%) of Recipient exiters and 17% of Applicant exiters were uninsured. The remaining 13% of Recipients and 25% of Applicants were covered by MinnesotaCare, non-custodial parents or by other types of insurances through spouses, second parents in the home, participant parents, tribal programs, COBRA or CHAMPUS. Recipient exiters paid average monthly premiums of $78 and Applicant exiters paid an average of $70.

The next report, Eighteen Months After Baseline - Applicants and Recipients focuses on those study participants who have exited from the program and in some instances rebounded. This report intensively examines health care issues for the uninsured exiters. In addition to analysis of administrative and participant survey data, a review was undertaken of the uninsured exiters in the sample to determine potential eligibility for the Medicaid, MinnesotaCare or General Assistance/MA programs. This report is scheduled to be issued in August 2001.

Other reports in the next year are scheduled for release in January 2002 (focusing on child well being issues) and June 2002 (focusing on teen parents) and associated health care concerns of both groups. Health care coverage is an important component to participants sustaining self-sufficiency and this study provides healthcare and cash program management with information on health care coverage as it relates to the success or failure of the MFIP participants to exit and remain off welfare. The MFIP Longitudinal Study executive summaries and full reports can be found on the DHS web site www.dhs.state.mn.us.

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## NEW MEXICO

**PROJECTS:** CHILDREN (TPL FROM NCP/EMPLOYER) & TRANSFER OF RESOURCES

**Description:**

New Mexico continues to review Medicaid categories that involve children and the potential for coverage by other insurance, either from the absent parent or the employer if any household member is employed. The second part of this project is designed to review the Institutional Care cases and for transfer of resources to become eligible or unreported information regarding resources.

**Findings:**

To date the summary of findings on the Medicaid for children was that the majority of the household members that are employed did not opt for the company's insurance because it was too expensive or the individuals were only employed part-time and were not eligible

for insurance. There was a small percentage of employed recipients where the employer had no insurance to offer their employees. New Mexico found very few absent parents that did have their children on their health insurance.

In the area of the Institutional Care cases, New Mexico found no transfer of resources intentionally to become eligible or any unreported resources.

Overall, the case reviews for New Mexico remain excellent. To date only one case was found to be potentially in error.

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## NEW YORK

**PROJECT:** REVIEW OF MEDICAID ELIGIBILITY DETERMINATIONS (1999)

**Description:**

New York State has a state supervised, county administered program. In 1999, a major part of our waiver project efforts were assigned to reviewing NYC's (the largest social service district in the State) recertification determinations for recipients living in the community.

**Purpose:**

Quality Control eligibility reviews were conducted to obtain information on eligibility determinations made by New York City (NYC) Medicaid staff (known as Medical Assistance Program or MAP in NYC). Monthly samples were drawn from the active case population of Medicaid Only community cases that consisted of the following categories: Low Income Families, Medically Needy - ADC Related, Pregnant Women and Children determined eligible under the Federal Poverty Level, and Single Adults and Childless Couples. MAP and the State Department of Health analyzed data for corrective action purposes.

**Design:**

Auditors determined case eligibility and correct category of assistance for sampled individuals by reviewing agency files and other government records, making collateral contacts with third parties such as employers and landlords, and interviewing recipients.

This audit reported on two types of errors, findings and variances. Findings were defined as errors that affected Medicaid coverage. Variances were defined as errors in some aspect of client eligibility that did not affect client Medicaid Eligibility.

To the extent possible auditors based their determinations on information that was available to the MAP caseworkers. However, due to problems with case record retrievals, we were often unable to determine the source of the error nor assign cause to either the agency or client. Therefore in many error determinations the cause appears to be shared by the agency and client.

Three hundred ninety six cases were selected for review. Fifty were dropped from review, 46 of which were due to the client's failure to cooperate or the auditors' inability to locate the client.

**Findings:**

The project found that 91 of the 280 completed reviews required corrections in budgeted earned income. Countable QC findings existed in 37 of the 91 cases, the remaining 54 cases contained variances which did not affect client eligibility. MAP failed to budget any earned income in 10 of the 54 cases with variances. In the remaining 44 cases the agency budgeted incorrect earned income. We could not determine fault for these 54 variances.

Nineteen cases were found to have variances in household composition. Three additional cases contained eligibility findings in this element.

Five of nine cases with differences in Social Security income had findings involving an ineligible case member or an understated liability.

A total of 29 cases had variances in unearned income, five of which resulted in eligibility findings.

**Results:**

As a result of auditors' difficulties in securing client cooperation, MAP has considered implementing procedures to call in uncooperative cases for early recertification.

At the end of 1999, MAP implemented a program to image all case records and making the imaged records available to auditors. When fully implemented, the elimination of paper records may fully address the recurrent problems Quality control has encountered in retrieving case records.

**PROJECT:** REVIEW OF ELIGIBILITY DETERMINATIONS (2000).

**Purpose/Design:**

A sample of 324 cases was randomly selected from the physical case records of cases that had successfully undergone recertification during the months of January through June 2000. Unlike the 1999 project, this audit examined case eligibility in the same month or one month following the local district's completion of the recertification. In the 1999

project, the recertification could have occurred up to twelve months prior to our sample selection month.

The cases examined were of the same type examined in the 1999 project:

- Low Income Families (LIF)
- Medically Needy ADC Related
- Pregnant Women and Children determined eligible under the Federal Poverty Level
- Single and childless couples

**Findings:**

- In 305 completed reviews we found 68 cases (22%) with errors that affected client eligibility for Medicaid.
- 56 of 68 cases had eligibility errors in earned income.
- 53 of 56 cases with earned income errors were agency caused. It appeared that the eligibility workers had enough information in the case record to make a correct determination, but they failed to act upon the information. In two cases the clients provided incomplete information which was not appropriately followed up by the eligibility worker.
- Twelve of 68 cases contained errors in elements other than earned income. Four had errors in resources, four had unearned income errors, three had errors in household composition, and one had an error in childcare expenses. In 10 of these 12 cases the error was caused by the eligibility worker's failure to correctly apply information provided by the client.

**Results:**

As a result of our findings, MAP has reevaluated their recertification workflow, staff assignments and their recertification interview process. MAP has taken the following actions:

- Assigned clients with earned income to one-on-one interviews with eligibility workers instead of attending group interviews.
- Assigned experienced staff to the Reception area to ensure that cases are routed correctly.
- Experienced workers now work with less experienced workers in one section that is responsible for all case changes.
- Supervision and case reviews will occur more frequently.
- Increased training will be conducted for new workers.

**PROJECT:** MEDICAID IMPLICATIONS OF TANF CASE CLOSINGS (2001)

**Purpose:**

Reviews are being conducted at various social service centers to assess the effect the closing of ongoing TANF cash assistance cases has on household member eligibility for continuing Medicaid coverage.

**Design:**

State auditors evaluated the appropriateness of the agency's decision to either terminate Medicaid at the time of TANF case closing, automatically grant an extension of Medicaid coverage, or refer the case to the NYC HRA Medicaid Assistance program (MAP) for a separate determination of case member eligibility.

Auditors reviewed the TANF case record to ensure that the documentation supported the reason for the TANF case closing. We also assessed the closing code entered in the electronic system to determine if it provided the most advantageous Medicaid coverage for all case members. Case decisions to terminate TANF and extend or close Medicaid were evaluated for timeliness and correctness of action. When documentation was missing or insufficient to support MA or TANF case actions, we attempted to contact the client and/or other individuals.

Auditors also conducted a limited process review of agency procedures used in the closing of TANF cases and the determination of Medicaid eligibility.

**Results:**

At this time a draft report is under construction based on the results of a 150 case sample from one social services center. 23 cases were determined not to meet sampling criteria and were dropped from review. Overall, when a TANF case is closed, continuation of Medicaid is properly determined for TANF case members.

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**PENNSYLVANIA**

**PROJECT:** MANAGED CARE CASE REVIEW

**Description/purpose:**

The purpose and focus of this project is to review eligibility factors of managed care (MC) cases and compare error findings to fee for service (FFS) cases. Project was implemented October 1997 and has been approved through September 2001.

**Sample:** 1,397cases were reviewed October 1999 - September 2000.

**Findings:**

For the period of October 1999 - September 2000, 782 managed care cases were reviewed with 43 cases found in error for a case error rate of 5.5%. Out of a total MC sample case benefit amount of $230,789 QC cited $13,300 in error which was a payment error rate of 5.76%. 615 FFS cases were reviewed with 37 cases found in error for a case error rate of 6.0%. Out of a total FFS sample case benefit amount of $564,745 QC cited $11,746 in error which was a payment error rate of 2.08%.

**PROJECT:** NEGATIVE CASE REVIEW

**Description/Purpose:**

The purpose and focus of this project is to ensure that medical assistance is continued for each eligible person when TANF benefits are terminated. The project was implemented October 1999 and has been approved through September 2001.

**Sample:**

2,881 cases were reviewed October 1999 - September 2000.

**Findings:**

For the period October 1999 - September 2000, 2,881 cases were reviewed with 149 cases found in error for a case error rate of 5.2%.

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**TENNESSEE:**

**PROJECT:** FOCUSED REVIEW OF NON-TANF FAMILY AND CHILDREN CASES

Tennessee began a Focused Medicaid Quality Control review of Family and Children cases effective October 2000. Approximately thirty-three (33) cases per month are selected from the non-TANF universe that includes:

- Pregnant women and infants up to one year old who meet the income standards based on 185% of the federal poverty guidelines for the family size.
- Children born on or after October 1, 1983 who have obtained the age of one year but who have not obtained the age of six years old where family income does not exceed 133% of the federal poverty guidelines.
- Children age six or older who were born after October 1, 1983 whose family income does not exceed 100% of the federal poverty guideline.
- Pregnant women who meet the income and resource standards of the TANF cash assistance program.

- Children eligible based on medically needy standards where the family income has to spend down to qualify.
- Children who are not eligible for TANF cash assistance based on sibling income.

In addition, approximately twenty (20) cases per month are selected from the universe consisting of all denied applications and terminated assistance groups regardless of category of eligibility. All currently assigned Quality Control review staff are conducting MEQC reviews.

The selected cases are reviewed to determine the following:

- The accuracy of budget computations.
- Completion, documentation, and accuracy of eligibility determinations for those cases with two parents in the home.
- Whether appropriate medical expenses were used to meet spend down.
- Overall Medicaid eligibility of approved Family and Children cases.
- Validity of denied and terminated case actions.

The Department of Human Services staff is reviewing the result of the focused Quality Control reviews for management and corrective action (including training) purposes. Management uses the review results to determine training needs by reviewing the error prone data elements and the most common error codes. Corrective action is handled primarily through release of bulletins (policy/procedural directives), memoranda, and training.

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## TEXAS

**PROJECT:** MEDICARE SAVINGS PROGRAMS REVIEW

**Description:**

During FFY 2001 Texas is reviewing QMB, SLMB, and QI-1 cases in which the eligibility determinations were made by Texas Department of Human Services (DHS) staff as well as Social Security Administration (SSA) staff. From May through December 2000, two SSA offices, one in Dallas and one in San Antonio, conducted demonstrations in which their staff determined eligibility for QMB, SLMB, and QI-1. DHS staff continued to determine eligibility for these programs for the remainder of the state. Both DHS and SSA used the streamlined process for eligibility determination; this included use of a shortened application form and eligibility determinations based on client declaration of most income and resource elements. The results of the 2001 MQCs pilot will provide the agency with information to compare the accuracy of the cases worked by DHS vs. SSA. Information will also be available to compare the accuracy of the two SSA pilot sites.

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**UTAH**

**PROJECT:** FOCUSED REVIEW OF FAMILY RELATED MEDICAID CASES, AGED, AND DISABLED ACTIVE AND NEGATIVE CASES. JULY, 1999 TO SEPTEMBER, 2000 -REPORT ISSUED 3/2001

**Purpose:**

To determine if Medicaid clients are being well served by two different departments determining eligibility throughout the state.

**Results:**

The overall eligibility error rate statewide was 2.9%. Considering the number of programs reviewed (652) and the high concentration of the pull in error prone F (Family) category, this would appear to be relatively low error rate. The majority of errors (17) were in the F Category cases vs. (2) in the A (Aged) and D (Disabled) category cases. The majority of the errors were from the Department of Workforce Services (DWS) (13 out of 19) vs. (6 out of 19) for Department of Health (BES). The number one cause of the errors (42%) was client not reporting earnings or an increase in earnings in a timely manner to the local office. The second highest cause of the errors (15.8) was a result of improper coding of household members.

Out of the 240 negative cases pulled for review, 8% or 20 cases were found to be in error. BES had 3 or 15% of the negative errors cited. DWS had 17 or 85% of the negative errors cited. Due to the fact that DWS had more than 5 times the number errors in the negative actions would indicate that more training is needed for workers on how to handle Medicaid cases when they close. When a particular Medicaid case closes, there are many instances when the client or members of the household may still be eligible under another category type.

Survey results were also tabulated from clients indicating the majority of clients who responded to the survey questions are satisfied with the application process and for the most part are treated with courtesy and respect by workers. However based on comments and suggestion made on the surveys, there does appear to be more client satisfaction with those clients who had cases with BES. Out of the 58 clients from BES who gave comments and suggestions, there were 19 or 33% reporting being very satisfied. Out of the 53 clients who gave comments and suggestions from DWS, 8 or 15% reported being very satisfied with the process.

Results of the audit have been given to both departments for corrective action. All findings on cases are sent directly to the workers and supervisors for corrective action, if needed or to let them know if the case was correct.

**PROJECT:** HMO COORDINATION OF TPL BENEFITS, 2001

**Purpose:** To determine if HMOs are utilizing the full potential of TPL.

**Description:**

Medicaid Quality Control reviewed four HMOs in the state of Utah who currently enroll Medicaid clients in their systems. A random number of clients who showed being enrolled in the HMO and having TPL during a 12-month period were selected to review. An audit was made to determine if the HMO was accessing and utilizing data supplied by the state and/or recipients.

**Objectives:**

- Ensure that all available TPL information is being utilized by the HMOs.
- Determine the accuracy of the TPL information that is sent by DOH to the HMOs.
- Evaluate what the HMO is doing with information provided by DOH.
- Evaluate the HMOs efforts to identify TPL in possible tort cases.
- Evaluate if the HMOs are providing feedback to ORS on the accuracy of information in their systems, i.e., are they notifying ORS of changes.
- Evaluate if changes or information reported by the HMO to ORSIS is being acted on.
- Determine if claims denied by insurance agencies are properly followed up on.

State of Utah Medicaid Quality Control Unit finished the Eligibility Audit in March of 2001. This audit was requested by the Department of Health to ensure that the F related Medicaid programs were being carried out in both departments.

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## WASHINGTON

**PROJECT:** MEDICAID DENIALS.

**Goal:**

Determine whether applicants were correctly denied, received clear denial notices and were subsequently opened on Medicaid; whether correct denial codes were used.

**Sample:**

Random statewide sample of Medicaid denials during the months of March, April and May 1999. Reviewers conducted desk audits through the Automated Client Eligibility System (ACES).

**Findings:**

Of the 1011 denials reviewed, only 13% were Adverse, (i.e. applicants did not receive Medicaid). Remainder received Medicaid under another assistance unit, program or state. The majority of the Adverse denials used the correct reason codes, received denial notices and were correct denials. Nearly one-third were subsequently opened on Medicaid. Report completed.

**PROJECT**: WHEELCHAIRS.

**Findings:**

The majority of clients had received the wheelchairs and accessories the Medical Assistance Administration (MAA) authorized and were very satisfied with their supplier and the wheelchair. At Home clients had longer waits to receive their wheelchair than NF clients did. The majority of all clients had no major problems with their wheelchairs and said the wheelchair met their needs. At Home clients had 3 times as many major problems as NF clients, and were 3 times more likely than NF clients to have unmet needs. Report completed.

**PROJECT**: TANF TERMINATION/MEDICAL REDETERMINATIONS.

**Findings:**

Initial findings of incomplete redeterminations resulted in changes to ACES (including automated Medicaid continuation) to automate the redetermination process and statewide training. Secondary sample selected to determine the results of these changes showed redeterminations had been completed correctly for the majority of terminated cases. Report completed.

**PROJECT**: DISPOSABLE INCONTINENT SUPPLIES.

**Findings:**

The majority of the 507 clients interviewed were very satisfied with their provider's service, although providers did not offer them a choice of products and put them on an auto-delivery system clients sometimes found hard to turn off. On average, most clients received the same amount of products for which their providers billed MAA, but they got about 10% more products than they used. Nearly two-thirds received multiple products and used them at the same time, overwhelmingly because they needed the extra absorbency. Almost three-quarters did not know MAA monthly maximums for products. Nearly all Adult Foster Homes and Foster Care homes failed to store products for individual clients separately. Most clients reported a high level of satisfaction with their supplies; the most common complaint was lack of absorbency. Reviewers noted the poor quality of many products, especially generic ones—shrink-wrapped, anonymously, with no brand, size or amount identification—comparing them to "gauze" and "cheesecloth."

Immediate corrective action resulted in changes to Billing Instructions and policy to add quality standards, add limitations on multiple product use, and eliminate miscellaneous billing codes for an estimated savings of $17,000/month. Report completed.

**PROJECT**: DACs (DISABLED ADULT CHILDREN)

**Findings:**

About one-third of the cases reviewed were DACs. About two-thirds of all cases on the list had been worked, two times more Non-DACs than DACs, with action taken on 72%. Errors found included: 25% incorrect codes (including income codes), and 25% of DACs were on the wrong Medicaid program (e.g., MN instead of CN). Field staff had not taken action on one-third of the code errors and two-thirds of the DACs who were on the wrong program. Report completed.

**PROJECT**: NURSING FACILITY TRUST ACCOUNTS.

**Findings:**

Completed surveys for 1137 clients, 57% had a NF trust account. Two-thirds had account information entered in ACES. About one-quarter had countable income deposits; the majority had been reported and entered in ACES. Nearly three-fourths had expenditures; only 3 were potentially inappropriate. Mean balance was about $260 in each sample month; half had an end of month balance below $75, another 25% below $300. About 15 were resource ineligible in one or more of the sample months—5 had trust accounts not entered in ACES. Report completed.

**PROJECT**: MEDICALLY NEEDY (MN).

**Goals:**

Simplify MN program for clients with spenddown; determine level of client understanding of spenddown and how it works; identify barriers to client participation, accuracy in provider billing and accurate staff eligibility decisions; identify error prone areas needing simplification or additional training.

**Sample:**

Part A: Statewide random sample of MN clients, some active and some pending spenddown, during October and November 2000. Part B: Same as A, except sample months of November 2000, and February 2001. Part C: Statewide random sample of MN denials during February and March 2001. Part D: Same as Part B.

**Findings:**

Project consisted of 4 parts. Part A: Face-to-face interviews with clients, half active MN and half pending spenddown. Part B: Eligibility desk audits through ACES, half active MN and half pending spenddown. Part C: Eligibility desk audits through ACES, MN denials. Part D: Case record review of Part B cases. Survey completed, analysis in progress.

**PROJECT**: NEW CLIENT ACCESS.

**Goals:**

Determine the extent of problems that new Medicaid clients experience in accessing medical care; whether new clients seek care in an ER as a result of access problems; whether any identified access problems differ according to certain variables—adults vs. children, rural vs. urban, Healthy Options (Washington's managed care program) vs. Fee-for-Service, voluntary vs. mandatory (Healthy Options) counties.

**Sample:**

Telephone interviews with clients newly eligible for Medicaid since January 1, 2001, who had not received Medicaid in the previous 6 months and lived in one of 10 counties.

**Findings:**

Survey in progress.

**PROJECT**: CLIENTS WITH ASTHMA.

**Goals:**

Determine: the level of access Medicaid clients with asthma have to medical care, specialists and medicine; whether these clients have access to asthma-related equipment—nebulizers, inhalers, spacers and peak flow meters; the level of client satisfaction with the quality of care they receive.

**Sample:**

Home visits with a random statewide sample of clients (sub-samples of adults and children) who have been hospitalized for asthma-related problems in 2000.

**Findings:**

Survey to begin late August or early September 2001.

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