



December 21, 2004

Overview of the Reinvestigations of Medicaid Recipients

Jennifer Hill

Overview

During the past year there has been much discussion of the caseload increases of the Medicaid program. While caseloads have increased, due to economic and market factors, thousands of families are leaving Medicaid each month. The escalating cost of health care and the corresponding expenditures in the Medicaid program are bringing extensive scrutiny to the application and annual reinvestigation process for enrollees. Elected officials are targeting the applicants and their families for increased proof of eligibility in the areas of residency, permission to obtain detailed financial information for nursing home applicants and ongoing income reporting. Currently there are procedures and policies that address these issues.

Questions have been raised regarding the process by which individuals are approved for and can continue their benefits. Both the Department of Social Services Medicaid Eligibility Performance Audit of May 2004, and the Committee on Legislative Oversight Program Evaluation, Applications Process and Eligibility Verification of Medicaid of December 2004 imply that many Medicaid applicants may either no longer be eligible or should not have been on Medicaid to begin with due to verification, asset reporting and re-verification issues. Other issues that both reports address are the absence of Social Security numbers for some Medicaid enrollees and their families and the level of scrutiny currently in DSS procedure.

Neither of the reports substantiated how or where the savings from implementing more stringent processes would come. According to the Committee on Legislative Research, Oversight Division, in Fiscal Note for SCS for HCS for HB 1566, May 2004, the "DOS did not address the savings that would result from conducting annual income and eligibility verification reviews of recipients of Medicaid." The DOS, the State Auditor's office or Legislative Oversight have information or processes to accurately determine savings from strict procedural adherence. Additionally, neither mentions the erosion of the DOS budget and where severe staffing reductions may also be affecting the re-investigation rates.

Families are leaving Medicaid

Although there have been significant caseload increases over the past several years, there are also significant numbers of families that leave Medicaid each month. Over 81,000 parents and children have had their cases closed over the past eight months¹ In fact in the

October report for MC+ and CHIPS, 7,379 applications were approved and 7,982 cases were closed.² Case closures due to reinvestigation process are yielding a high number of cases being closed each month.

Recent legislative changes that reduced eligibility for parents of low-income families have resulted in many parents being uninsured. A recent analysis of March 2001 and March 2004 Current Population Surveys by the Center on Budget and Policy Priorities reveals that “In the year 2000, less than one-fifth (18.8%) of the low-income parents in Missouri lacked health insurance coverage. By 2003 the proportion without insurance had surged to almost one-third (29.6%). The main reason was that Medicaid coverage fell sharply: the percentage of low-income Missouri parents covered by Medicaid fell from 30.8% in 2000 to 22.9%.”³ Medicaid eligibility changes from 100% of the poverty level in 2001 to the current 75% of the poverty level, combined with loss of employer-sponsored insurance, are the primary reasons for the increase.

Costs to complete annual redeterminations in timely manner are known

During the 2003 legislative session, HB 1566 was the central vehicle in attempts to re-define eligibility and change the process for verification and annual reinvestigations. The Committee on Legislative Research, Oversight Division prepared a fiscal note in which they estimated the cost of completing the annual redeterminations.

The enforcement of annual re-investigations for Medicaid to bring it up to date would require approximately 40% of the caseload to be reinvestigated.

This would require the FSD to do reinvestigations on approximately 500,000 recipients annually or 42,000 per month. FSD already performs 23,000 reinvestigations per month. The FSD would need additional caseworkers and support staff to do the additional reinvestigations that are not already being performed.

Part of the additional 19,000 reinvestigations would be covered by Integrity Initiative proposals in the Governor Holden’s 2004 budget. The changes would automate the connection between food stamp recertification and corresponding Medicaid cases. This means that the over 54% of Medicaid recipients who also receive food stamps will be automatically reinvestigated when their food stamps are reauthorized. There is also an additional connection to be implemented with the Missouri Dept of Labor for access to the job data and cross- referencing for assets with the Missouri Dept. of Revenue.

Additional reinvestigations will total about 9,120 (per month) based on current caseloads. Currently DSS has 1,674 caseworker positions, and 520 case manager positions. The total number of additional caseworkers needed to complete the currently required work would be 182.4. Eighteen supervisors and 50 clerical staff based on 4 professional staff to one clerical would also be required, for a total of 251 new FTEs.

This would cost the state \$6.4 million in the first ten months and \$6.3 million in FY 2005, \$6.5 in FY 2006.

Recommendations to streamline the application processes, update and integrate computer systems, and have a central case file would all enhance caseworkers' ability to perform their jobs. Some of these measures are being implemented and FSD is currently making changes to the systems that will allow updates between food stamps, Medicaid and temporary assistance.

Staffing and Budgetary Reductions in DSS

The Department of Social Services budget has been disproportionately affected by the budget cuts. Nearly 40% of all state budget cuts (\$500 million), were directed at the Department of Social Services. These reductions have resulted in loss of staffing and direct cuts to services. For example, reductions in Medicaid eligibility have affected approximately 113,927 individuals.

Staffing in all departments has also been reduced significantly in the last four years. According to the "*Serving the People of Missouri, Program and Service Delivery*" report issued annually by the Department of Social Services, staff has been cut by 1,200.39 FTE since FY 2001, which includes current staffing reductions. That is a total reduction of 12.4 % of the entire DFS staff during that period. The bulk of the cuts came from the Family Services Division. This division is responsible for temporary assistance, Medicaid, and food stamp programs. Caseworkers or case managers and clerical staff help applicants complete the applications, obtain needed services and re-investigate as required by law and policy.

The FY 2005 budget signed in June 2004 recommended and implemented permanent elimination of 10% of all vacancies. This exacerbated the staffing problem that occurred when a state-wide hiring freeze left many positions open. During the past two fiscal cycles, the legislature has opted to eliminate those positions rather than fill them. These short-sighted policies are preventing the Family Support Division from obtaining caseworkers who would be able to enroll and maintain the cases according to state and federal law.

FSD Income Maintenance Caseworkers are currently staffed at 46% of need according to caseload standards currently in statute. While staff has been reduced, the demands of Medicaid caseload increases are resulting in the need for caseworkers to process and determine eligibility for approximately 16,766 new cases each month.

Application approval timeframes are short and enforceable

Timeliness for applications is based on federal regulations for Medicaid, with some basis in state law. The general rule is that the timeframe is 45 days from date of application, unless you need to establish a disability, in which case it is 90 days. State law also provides that there shall be an expedited eligibility process for pregnant women, (a 15 day application processing timeframe). Additionally, a state law requires that if a nursing home Medicaid application is not processed within 60 days of having all information, the person is automatically eligible until a decision is made

Savings from enforcement not stated in critical reports

The current Oversight report as well as the May '04 Auditors report, did not put a cost on the recommendations for systems changes or an estimate of savings the state would recoup through such changes.

In testimony during the Interim Medicaid Cost Containment hearings of 2003, DMS staff stated that "few cases are closed due to no longer being income eligible." According to the Committee on Legislative Research, Oversight Division, in Fiscal Note for SCS for HCS for HB 1566 the "DOS did not address the savings that would result from conducting annual income and eligibility verification reviews of recipients of Medicaid." They instead applied rate for billing mistakes and fraud reported by the HHS Office of the Inspector General for FY 2002. At this time we must conclude, without further study, neither the DOS, the State Auditor's office nor the Oversight Committee has information or process to accurately determine savings from strict procedural adherence.

This leaves in question the assumption that there are many recipients who would no longer qualify if their reinvestigations were being done, thus reducing the state Medicaid expenditure.

Study of case closures reveals why many families are leaving Medicaid

Quality Control Study recently found that annual redeterminations are failing even when the process is followed correctly. For the 48% of the cases who cannot be cross checked based on food stamp income must be reinvestigated to determine if they are still income eligible. The current process excludes those who refuse to provide additional information, and seems to be working.

A sample was done and of 31 cases, which was 82% of the total were closed for non-cooperation. Non-cooperation is the FSD language for no reply to contact through the mail which requires recipients to provide an update to their file to determine if they have continuing eligibility.

All of these cases were in the process of annual review in which a form is sent to the most current address, and these were returned. Available data showing that 15 of those participants' quarterly earnings remained consistent according to other information that FSD had available to them, but the receipt of their income information did not negate the need for the reverification. In the second sample 29 or 69% of the cases reviewed were under an annual reverification and were also closed for failure to cooperate.⁴

This is the primary basis for our contention that large numbers of recipients will simply lose their coverage if large scale reinvestigations are implemented. The experience of mass enforced reverifications in the TennCare program are a good example of what should be avoided to prevent massive case closures and ensuing legal actions.

The TennCare experience

TennCare, the waiver program for the uninsured under an 1115 Waiver in 1993, allowed the state to cover adult and children to 100% of the poverty level. There were two distinct

programs, applications and administering agencies that provided the health care coverage; the Department of Health was responsible for TennCare and the Department of Human Services was responsible for Medicaid.

CMS had been pushing TennCare to streamline their process with a single application and administering agency, the Department of Human Services. In order to do this, all recipients of TennCare were required to re-apply for benefits. The new application contained more stringent eligibility requirements that require the applicant be below 100% of poverty, certified and uninsurable and qualified with a medically- eligible condition.

The process began in July 02 when they gave the approximately 400,000, of the 600,000 total recipients, a notice that they must come in and reapply. They had three months to notify these recipients and the entire process was to be completed by July 2003.

Staffing to complete this massive undertaking was increased. According to Dept of Human Services staff, they hired about 250 additional caseworkers. This number was based on a time and motion study done on how long it takes to fill out the new application. It turned out they were understaffed and temporary employees were hired. In hindsight, the Department admits they should have hired almost twice the original number, or at least 400 caseworkers, and more clerical staff.

The reinvestigations took longer due to additional verification requirements. Previous to this the applications were based on declarations by the applicants. Other changes were required to enhance systems management and develop an appointment tracking system.

The number of enrollees went down by 250,000 in one year. Some changes in the process that occurred between then and now are that a certificate of uninsurability is no longer required because the insurance companies were charging a fee for applicants to obtain the certification with no real investigation into their insurability. Some went into the regular Medicaid system if their incomes were within the eligibility guidelines. The state was sued because so many cases were closed; the state had to offer a second opportunity to reapply for those whose cases were closed. That process was ongoing until the recent collapse of the TennCare program due to lack of state funding.⁵

Who would be most affected?

In December of 2003 of the overdue cases, 114,943 were Aged, Blind and Disabled (50.8% of that groups total) and 7,849 were QMB/SLMB (65.7% of those who are elderly, but don't qualify for full Medicaid benefits). In both cases the recipient would be on a fixed income and the reasons to reinvestigate nominal. We agree with the Oversight Draft that these cases can be updated through the use of automation, thus saving the caseworkers' time.

The majority of recipients who would be affected are children. Over 500,000 children are currently on the MC+ and CHIPs rolls. Over 300,000 of the children on Medicaid also qualify for food stamps. This is a very low income population and there is no

statistical data to suggest that large numbers would not qualify due to income changes if the reinvestigations were done in a timely manner.

Annual Redeterminations:

How many currently done: 23,000

How many would need to be done: 42,000

How many caseworkers do we have: approx 2,220 including case managers

How many additional workers would be required?: 251 FTE total new staff

What are current staff levels according to caseload standards? 46% of need

How many are covered by Integrity Initiative (cross checked w/foodstamps)? 54%

How many reinvestigations are overdue on the elderly? More than 110,000

How much would the cost be? Approximately \$6.5 million annually

How much would state save in waste, fraud and abuse? There are no current estimates

Conclusion

There is no demonstrable evidence that there would be cost savings due to recommendations in the State Auditor’s report, or the Oversight Committee Report. However Oversight did estimate the cost of bringing the re-investigations up-to-date to be at least \$6.5 million a year with increased staffing. No additional costs were outlined for systems changes that would affect all applications and the entire computer database of the caseload of over 900,000 Medicaid, food stamps and temporary assistance families, elderly and disabled Missourians. Conversely without proper measures in place to verify and re-verify a family’s income, it is likely that tens of thousands of working poor families and children will lose their health care coverage. It is unlikely the State can achieve significant cost savings by implementing the recommendations of the Oversight Committee report.

Created for the *Missouri HealthVoice* Campaign to Protect Medicaid, a public outreach arm of the *Missouri Budget Project*. Contact Information: *Missouri Budget Project*, 4130 Lindell Blvd. St. Louis, MO 63108; 314-652-1400; www.mobudget.org

¹ DSS Monthly Management Report, Table 6, Medicaid Eligibility, May, June, July, August, Sept., Oct, 2004.

² Ibid.

³ “The Erosion of Health Insurance for Low-income Parents in Missouri, 2000-2003”, Leighton Ku, PhD, Center on Budget and Policy Priorities, December, 2004.

⁴ Medicaid Eligibility Quality Control (MEQC), Summary Information for Federal FY 2003, State: Missouri.

⁵ Interviews with TennCare officials, July 2004, November 2004.