



California Performance Review Analysis

Issue HHS 01: Transform Eligibility Processing

Executive Summary

The CPR findings and recommendations are fundamentally flawed. The report backs into a pre-determined solution – centralize, privatize and automate – that is not supported by the analysis. The CPR recommendations are based on an incomplete analysis of eligibility processing costs in California, a clear lack of knowledge about program rules and operations, and invalid comparisons of California's costs and the cost of eligibility processing in other states and the Healthy Families program.

The report consciously disregards the key problem: *badly constructed programs.* The CPR not only blames counties for the problems that are created and perpetuated by bad program construction at the state level, layers of complex and conflicting legislation and court decisions, and historically poor state regulation and oversight, but consciously skips over the fundamental question of how to simplify these programs, for reasons of timing and political expediency.¹ By ignoring the fact that initial and ongoing eligibility requirements would have to be massively simplified from their current form in order for a centralized system to function, the CPR spurs questions about potential unintended consequences, including reduced access for groups with special needs, less responsive customer service, and an increased risk of errors.

Counties welcome a discussion of how to make public assistance programs more straightforward and how to maximize the use of technology. Actualizing the CPR's vision would require a fundamental restructuring of Medi-Cal, CalWORKs and Food Stamps, encompassing huge changes to the program structure and the elimination of ongoing eligibility requirements – a true commitment to “blow up the boxes.” We have long advocated for changes that would enable the Medi-Cal, CalWORKs, and Food Stamps programs to become more efficient and effective, including collapsing multiple programs into broad categories of coverage for children and families with a single gross income test. We would be pleased if the CPR provided an opportunity to make these sweeping changes a reality. To date, however, there has been insufficient political courage to achieve the needed changes. Until this discussion takes place, the question of centralization and privatization vs. county administration is premature at best and, at worst, is a red herring that diverts attention from the need to fix the underlying problems with these programs.

Cross-state cost comparison based on poor methodology and inaccurate data. For Pennsylvania, the calculation left out more than \$150 million in annual eligibility costs for the Food Stamp program, thus drastically understating the cost per case in that state.² Overall, the CPR compares apples to oranges because it did not ensure it collected the same data from each state and it collected data from different time periods.

Executive Summary, Cont.

The CPR touts a technological solution that doesn't solve the problem. Counties agree that the One-e-App system mentioned throughout the report will be a welcome avenue for program entry via the Internet. Counties were partners in the roll-out of Health-e-App and are working with the One-e-App staff to pilot the program. However, One-e-App is not the universal remedy it is purported to be. This is because it:

- Does not *determine* eligibility – it only *screens* for eligibility.
- Does not obviate the need for clients to submit additional paper documentation.
- Does not automatically submit applications, but routes them through the Single Point of Entry to be printed out and mailed to the county.
- Is not designed for continuing eligibility work with Medi-Cal, Food Stamp, and CalWORKs recipients.
- Is not ready for statewide use – four counties are now piloting the program.
- Does not include CalWORKs or Food Stamps – just Medi-Cal, Healthy Families and local health initiatives. It may or may not be expanded in the future.

Pennsylvania's COMPASS system, held up by CPR as a model for California, is the source of just 4.3 percent of all applications received by the state of Pennsylvania. It has not replaced the state's eligibility information system or its county-based assistance offices.³

The CPR vastly overstates the potential savings associated with its recommendations. The report makes invalid assumptions about program costs and unrealistic cross-program comparisons, fails to suggest changes that would simplify or eliminate the true cost drivers in the programs, overstates the ability of One-e-App to function as a statewide eligibility determination system, underestimates the cost of implementing One-e-App statewide, and adopts a wildly optimistic timeframe for implementation. These shortcomings make the report's savings assumptions highly suspect.

Many statements are incorrect, misleading, and/or unsubstantiated. The analysis contains numerous factual errors and omissions, calling into question many of its findings and recommendations. Oddly, CPR staff did not contact CWDA regarding this section of the report. This is especially surprising because CPR staff did consult other private and non-profit technology and service vendors during their deliberations. Had CPR staff contacted CWDA for input on their analysis, we could have provided information about how Medi-Cal, CalWORKs, and Food Stamps are operated at the county level that would have helped to avoid many of these inaccuracies.⁴

Summary of Findings and CWDA Analysis

CPR Finding 1: County eligibility processing is “inefficient and costly.”

CWDA Analysis:

- **The report overstates California’s Medi-Cal eligibility costs.** Several flaws in the analysis lead to an erroneously inflated cost per case. The total costs are overstated and the number of cases is understated.
 - **Cost figures are overstated.**
 - It is based on a *budgeted* amount for 2004-05, not actual expenditures, which tend to run below budgeted amounts. Note that the cross-state comparisons were made against other states’ *past actual* expenditures.
 - It includes funding for county Medi-Cal eligibility workers to conduct eligibility determinations for In-Home Supportive Services recipients.
 - It includes costs that were anticipated for the 2004-05 fiscal year that will not materialize due to the Legislature’s rejection of the Administration’s proposal to shift the Breast and Cervical Cancer Treatment Program eligibility processing to the counties.
 - **Number of Medi-Cal cases is understated.**
 - The costs include application processing and continuing eligibility work for families that also receive CalWORKs. However, these CalWORKs cases were *subtracted* from the denominator, artificially inflating the cost per case. These cases should be included in the cost-per-case calculation.
 - According to Department of Health Services data, the number of Medi-Cal beneficiaries who are not also receiving CalWORKs was larger in April 2004 (the most recent month for which data are available) than is shown in the CPR report. Subtracting the public assistance families from the total statewide caseload of 6.5 million leaves about 5 million cases. In contrast, the CPR report used a figure of 3.9 million cases. About 1.2 million of the 5 million cases are aged, blind and disabled recipients of SSI/SSP, which may have been subtracted from the total caseload. Although counties do not do the intake for these cases, we do work with them periodically as continuing cases and to redetermine Medi-Cal eligibility upon the case leaving SSI/SSP (per the *Craig v. Bonta* decision). These cases should therefore be included in the cost-per-case calculation.
- **The report vastly overstates potential savings associated with Medi-Cal eligibility.**
 - **Unless the program is dramatically simplified, the savings cannot materialize.** The process of applying for Medi-Cal is complicated and requires the submission and verification of multiple documents. However, the only intake requirement addressed by the CPR is the documentation of assets, and even under the CPR recommendation, applicants still would be required to report asset information, and eligibility staff still would be responsible for verifying the value of assets. The CPR does not make any recommendations for simplifying other intake requirements. Without more changes to the front end of the system, savings will not materialize.
 - **The report fails to distinguish between initial eligibility work and continuing eligibility work.** The total cost of California’s Medi-Cal program as reported by the CPR includes both initial intakes and continuing eligibility work. The costs

for continuing eligibility represent the bulk of Medi-Cal administration expenditures. The report does not consider changes to any of the ongoing eligibility requirements such as the mid-year status report, the unnecessarily complicated annual renewal process or the SB 87 redetermination procedures. If none of these processes are changed, continuing eligibility work will not be reduced and savings will not materialize.

- The cost per case inappropriately includes spending for separate and specialized programs. The report includes funding for programs such as Express Lane Eligibility for National School Lunch Program recipients and the CHDP Gateway. These additional avenues for entering the Medi-Cal program would not likely be eliminated even if the HHS 01 recommendations were implemented in their entirety. These costs should not be included in the cost-per-case analysis and should not be assumed as potential savings.
- The report overstates California's Food Stamp cost per case. The amount used in the analysis includes projected spending on both Non-Assistance Food Stamp cases and cases where the family also receives CalWORKs.⁴ However, the CPR erroneously uses only the Non-Assistance Food Stamp case numbers, rather than the total caseload, to calculate the cost per case. This significantly overstates the cost per case.
- Report fails to make the case for CalWORKs and Food Stamps. The analysis focuses heavily on Medi-Cal, which is not representative of the CalWORKs and Food Stamps programs.
 - The analysis fails to support its assertions that CalWORKs and Food Stamps eligibility processing is inefficient, costly, slow, and inconvenient. The only evidence presented for the Food Stamp program is related to a penalty assessed years ago for errors that have long since been corrected. California is now considered a model for its Food Stamp quality assurance efforts and has received bonuses and awards for its improvement.
 - Comparing CalWORKs and Food Stamps to Healthy Families is illogical. We agree that the simplicity of Healthy Families is a model to be emulated when possible, but the programs are so different as to be incomparable.
 - Separating CalWORKs eligibility from employment services is risky. Separation of these program components could lead to coordination issues, errors in computing individuals' time on aid and tracking exemptions, and inadequate customer service. As counties work to implement the universal engagement provisions contained in the 2004-05 budget trailer bill, separating intake and ongoing eligibility determination from services becomes all the more ill-advised.
- Report overstates the capability of existing Internet-based application systems.
 - The CPR assumes that statewide use of One-e-App would, in and of itself, streamline program operations and achieve significant savings. Based on the pilots being conducted in four counties, the One-e-App will, at best, provide an additional avenue into the system for program applicants. It will not simplify the underlying requirements or determine program eligibility.

CPR Finding 2: “Other states’ eligibility costs are lower ... across all three programs.”

CWDA Analysis:

- The cost-per-case calculations are based on incomplete data – in some cases leaving out entire programs. Pennsylvania’s 2004-05 budget for Food Stamp administration is about \$170 million in state and federal funds. Its Medicaid administration is projected to cost another \$85 million.⁶ Background documents from the CPR show that the calculations for these programs were based on erroneous data showing a total expenditure of \$82.9 million for *both* programs.⁷
- Because CPR staff did not use a common metric to assess states’ costs, the report compares apples to oranges. Despite the fact that what constitutes eligibility spending likely differs from one state to the next, data was gathered from other states via phone interview. No metrics or benchmarks were used to ensure common definitions across states or to ensure that state-run systems were appropriately compared to California’s county-run system. As just two examples of the potential discrepancies, the CPR calculations for California’s cost per case included spending for staff development that was not reported by New York and for computer systems that was not received from either Pennsylvania or New York. The Pennsylvania numbers also exclude state-level management overhead costs, which should be included for a state-administered system.⁸ In contrast, the calculations for California included management overhead from the county-administered system.
- The comparison uses data from different points in time. The report does not look at similar periods of time across states, thus leading to an inaccurate comparison of costs. For example, California’s costs are based on the 2004-05 budget, not actual expenditures. In contrast, the costs from other states represent actual expenditures for past years. The New York numbers are based on calendar year 2003 expenditures that had been submitted by counties as of a point in time.⁹ The Pennsylvania numbers were for fiscal year 2002-03.¹⁰
- California’s program offers avenues of entry not used in other states. The Medi-Cal cost figures include funding for specialized programs not operating in other states, including Express Lane Eligibility for National School Lunch Program recipients – which California is the first to implement – and the CHDP Gateway.
- CPR selectively excluded states in order to support a predetermined conclusion. It is our understanding that cost-per-case information for Texas was left out of the analysis because it was higher than in California.¹¹ The nation’s third-largest county-administered state, Ohio, was not consulted.

CPR Finding 3: “Multiple technologies used by counties” can be reduced to one system.

CWDA Analysis:

- The report incorrectly asserts that “counties use at least 19 different technological platforms for eligibility processing.” Counties have five eligibility systems in use at the present time, and are migrating toward three systems.

- Two of the four (LEADER and ISAWS) are completely implemented, encompassing 36 of the 58 counties.
 - The third system (C-IV), which includes four counties, is due to be fully implemented by October 1, 2004.
 - The final system (CalWIN) which includes the remaining 18 counties, is due to be completed in July 2006, with a phase-in period that has already begun. Note that 17 of the 18 counties are using the same system now (CDS), and only one is using its own Legacy system.
 - In the next few years, the 35 ISAWS counties will be migrating to one of the other existing systems, choosing between CalWIN and C-IV. After this migration, the state will have only three systems in use.
- The report erroneously assumes that an Internet-based system like One-e-App can replace all four of the county eligibility systems, thus overstating potential savings. The One-e-App is not designed to provide services after the case has been enrolled. In contrast, the county welfare systems are designed to maintain ongoing eligibility and support welfare-to-work services in Medi-Cal, CalWORKs and Food Stamps.
 - Pennsylvania's COMPASS system is similar to One-e-App in that it takes application information and then transfers the information to the state's Client Information System (similar to our LEADER, ISAWS, C-IV, and CalWIN) for processing by state staff based in the counties. However, continuing case work is done using data stored in the Client Information System, not in COMPASS. The COMPASS system stores application information for a short period of time before deleting it, as does the Health-e-App, the precursor to One-e-App.
- The report presumes that – despite a long history of state procurement failures – a single eligibility system is achievable within an 18-month period. California has four eligibility systems because the state tried – and failed – for over two decades to implement a single statewide eligibility system. Then-Governor Wilson and the Legislature abandoned the single-system strategy in the mid-1990s because they gave up on a state-procured welfare automation system. The Legislature ultimately determined that a multiple-consortia approach had the best chance of success, and this strategy has proven to be a workable solution to eligibility automation.
- It would be both costly and risky to scrap the current systems and start anew. The state has just spent hundreds of millions of dollars and thousands of personnel hours developing these systems. The systems are governed by the state and the counties that utilize them in a strong joint oversight relationship. CalWIN, C-IV and LEADER utilize the most up-to-date technology and encompass the thousands of program changes that have taken place in the past decade. Further, the federal government has provided hundreds of millions of dollars toward the development of the systems over the past several years and could refuse to pay for a new system and/or require the state to pay back some or all of the funds it has already received and spent if it changes course in mid-stream.
- The report indicates that “the county systems do not automatically check for duplicates prior to enrollment,” a statement that is not accurate. The first thing that county staff do when processing an application for public assistance is to conduct a “file clearance” to determine if some or all of the individuals on the application

- already have entries in the computer system. Staff use data in the county eligibility system and in the state's MEDS system to identify and correct duplicate records.
- Counties report that this process would be extremely difficult to fully automate, because the process of doing a file clearance is more art than science. People spell their names in different ways, transpose their first and middle names, and use different last names for children and step-children, as just a few examples. A typical file clearance includes multiple data checks to identify all possible duplicate records, which are checked against the information on the application.
 - CPR indicates that the Healthy Families system “automatically” checks for duplicates. Based on interactions between county staff and the Single Point of Entry, it has been our experience that the process used at SPE often creates duplicate records that *counties* are required to identify and eliminate. In order to prevent duplicate records, a combination of manual and automated checks would be needed, similar to county eligibility staff work.
- The report fails to distinguish between front-end eligibility determination (“intake”) systems and back-end (“continuing”) case management systems. The report indicates that statewide implementation of the One-e-App system could replace the multiple eligibility systems currently in use. However, the One-e-App is not designed to provide services *after* the case has been enrolled, which the four county welfare systems are designed to do. These services range from sending annual renewal notices to the clients to keeping track of basic data such as address and phone number.

CPR Finding 4: “The 45-day statutory time limit for Medi-Cal eligibility is often exceeded. ... There is no penalty on counties for exceeding the statutory time requirement.”

CWDA Analysis:

- Counties do face penalties for exceeding the processing timeframes. The CPR fails to point out that the Legislature enacted a performance standards system in 2003-04 that requires counties to report to the state on five outcome measures, including the length of time it takes them to process applications. Counties that are found out of compliance with one or more measures are required to enter into a corrective action plan with the state. After entering into a corrective action plan, counties are monitored and are subject to fiscal penalties of up to 2 percent of their annual administrative allocations if they are not making progress toward the standards, increasing over time by an additional 2 percent each year if progress is not made.
- Not all cases are subject to a 45-day processing requirement. The federal government recognizes that individuals applying for Medi-Cal based on disability must be evaluated prior to their applications being processed. The states are thus given 90 days for these applications to be processed, with exceptions for times when unusual circumstances occur. In California, persons applying for Medi-Cal based on a disability must have a disability evaluation conducted by the Department of Social Services (DSS) before their application can be processed. DSS lacks the capacity to quickly conduct these evaluations, and delays are common. Centralizing and privatizing eligibility determinations would do nothing to change this.

- There are many legitimate reasons that the timeframes may be exceeded. These reasons have nothing to do with the efficiency of county eligibility operations, but are related to the complexity of the program, the need to interact with other programs and systems and the need to interact with applicants.
 - Counties are required to exhaust all possible avenues of eligibility prior to denying an application. California's Medi-Cal system has more than 35 separate programs encompassing more than 150 aid codes. Families, elder adults, people with disabilities, and children all have multiple points of entry and multiple programs for which they might be eligible, and they are required to submit multiple paper documents in order for their information to be verified. The program's complexity spurs an inordinately time-consuming process for applicants and staff to gather all necessary information about the complicated living arrangements, multiple income sources, and various assets and liabilities that individuals and families have.
 - Federal law grants states exceptions to the 45-day rule when unusual circumstances occur, such as times when the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action.
 - For mail-in applications, the 45-day clock begins to tick when the Single Point of Entry receives the application, not when the county receives it. The Single Point of Entry generally gets these applications to counties within a few days, but applications are at times delayed, thus extending the total processing time.
 - If an application is submitted without complete information or documentation, which often occurs, state law requires counties to seek the additional information necessary to make a determination of eligibility. It can take weeks in some cases to collect all of the necessary information, during which time counties generally give the applicant the benefit of the doubt and keep their application pending while they follow up to obtain the needed information.

CPR Finding 5: "Half of Medi-Cal eligible persons in a managed care plan are not enrolled for an additional 30 to 60 days."

CWDA Analysis:

- County human service departments are not responsible for enrolling beneficiaries in managed care plans. The plan enrollment process is conducted by the Department of Health Services and its contracted vendor, Maximus. Ironically, this finding calls into question the wisdom of centralization and privatization.

CPR Finding 6: "Medi-Cal applicants frequently are required to visit a county welfare office ... even when the original application is mailed."

CWDA Analysis:

- The vast majority of mail-in applications require follow-up by county staff in order to prevent unnecessary denials. If county staff did not follow up with applicants who fill out applications incorrectly or fail to include the necessary documentation, they would be forced to deny coverage to most of these families.

- Mail-in applications still require documentation of all of the following:
 - Identity
 - California residency
 - Immigration status
 - Income
 - Assets
 - Expenses
 - Pregnancy (if applying for pregnancy benefits)
- The mail-in applications have been simplified as much as possible, but they still are complex and difficult to properly fill out. County staff regularly contact clients to correct errors and confirm hand-written information that is unclear.
- Applicants frequently do not include all required documentation. Follow-up contact is therefore necessary. Although they are allowed to mail the requested follow-up information to the county, many applicants come to the welfare office in order to make copies of the required documents for free.
- State law requires some Medi-Cal applicants to apply in person. This includes persons who are homeless or do not have a mailing address and minors who are applying for confidential Minor Consent Services.
- State law requires some public assistance applicants to make at least one trip to the welfare office. State law requires applicants for CalWORKs and Food Stamp to be fingerprinted and for their prints to be checked for duplicate aid fraud via the Statewide Finger Imaging System (SFIS). Legislative attempts to eliminate the fingerprint requirement have been unsuccessful. The CPR recommendation for a wholly mail-in process is not possible for these clients unless the finger-imaging requirement is eliminated. However, the CPR does not recommend eliminating this requirement.
- Some applicants want to apply in person. Counties report that many applicants choose to apply in person, in order to ensure that they answer all questions properly and provide the appropriate documentation. Some simply feel more comfortable meeting face-to-face with an eligibility worker.

CPR Finding 7: “Medi-Cal applicants cannot apply from a provider’s office unless an outstationed county eligibility worker is present, creating a hardship for providers and applicants.”

CWDA Analysis:

- This statement is not accurate. Benefits can be established at provider offices for some applicants, without the presence of an outstationed eligibility worker.
 - The CHDP Gateway allows for immediate, temporary enrollment and receipt of benefits for children while they are at participating provider offices. The family is then given a full application to fill out and return to the county. Benefits continue for up to two months while the application is processed.

- Pregnant women can receive immediate, short-term “presumptive eligibility” from participating doctors’ offices or clinics, gaining them access to pre-natal care while their applications for Medi-Cal are processed.
- Infants born to a pregnant mother are deemed eligible for 12 months as long as the baby continues to live with the mother and the mother remains eligible for Medi-Cal. The mother is allowed to use her Medi-Cal card for the baby while she is waiting for the baby’s card, and providers’ offices have been given standardized, simplified enrollment forms to use for infants.
- Providers’ offices can assist applicants in filling out application forms. No outstationed eligibility worker needs to be present for this. The family would need to send in the application for processing along regular time frames.
- Certified Application Assistants can help with applications. CAAs often are stationed at local clinics to assist individuals with their application forms. They are not employees of the county, nor are they required to be.
- To the extent that presumptive eligibility for all applicants is a consensus public policy goal, this can be achieved with state law changes. Centralization and privatization, as recommended in the CPR report, would not move the state toward presumptive eligibility for all applicants in the absence of other changes to the program structure. Further, presumptive eligibility could be implemented within the current county-administered eligibility system.

CPR Finding 8: “Medi-Cal applicants have no convenient call-in opportunity for assistance in developing an application.”

CWDA Analysis:

- Assistance is available for individuals applying for aid. The mail-in application instructs applicants to call their local welfare office for assistance if they have questions. The list of welfare office numbers is available on-line, on a webpage linked from the Medi-Cal mail-in application page. Every local welfare office is also listed in the phone directory. Counties have procedures for helping applicants over the phone and will take information from an applicant via telephone to start the application process. In contrast, Healthy Families will only take applications over the phone for persons with disabilities.
- Certified Application Assisters are also available, though in fewer numbers. Local assisters are known to the welfare offices and should be known to providers’ offices. There are fewer CAAs than in recent years because of the elimination of the \$50 application assistance fee, but many organizations still provide individuals and families free assistance in filling out the application.
- Mail-in applicants receive confirmation letter with county contact person. County welfare departments are required to notify each applicant that their mail-in application has been received and provide the name and contact information for a county worker who can answer any questions the applicant may have.
- Program complexity ties up staff resources on paperwork and process, not customer service. If the program were simplified, there would be fewer calls and less time spent tracking down documentation, thus freeing staff to help applicants who need assistance.

CPR Finding 9: “CalWORKs eligible persons who obtain jobs must return to the county welfare office to maintain Medi-Cal eligibility.”

CWDA Analysis:

- There is no basis in fact for this statement. There is no requirement in state law that a CalWORKs eligible person who obtains a job must go to the county welfare office in person in order to keep their Medi-Cal. In fact, most CalWORKs recipients who obtain employment initially remain eligible for CalWORKs, due to the state’s earned income disregard policy, and therefore remain eligible for Medi-Cal.
 - Federal law requires Medi-Cal recipients to report to the county when certain changes occur, such as obtaining employment or increasing earnings, but these reports can be made over the phone or in writing. Most clients simply call their caseworker to report such changes.
 - State law requires recipients to make quarterly status reports (for CalWORKs and Food Stamps) and semi-annual status reports (for Medi-Cal). These are written reports that clients mail in to the county and do not require a visit to the welfare office.
 - Transitional or 1931(b) Medi-Cal is available to clients who leave CalWORKs due to increased earnings. As long as they have the necessary information, counties can determine eligibility for this program without requiring the client to come to the welfare office. As mentioned above, clients may be required to provide documentation of their current income and may choose to come to the welfare office to provide that documentation if they do not wish to pay for photocopies, but they are not required to visit the welfare office. Note that the CPR recommendations would not change the requirements for providing documentation of assets, income, and expenses.
 - State law also requires a redetermination of eligibility whenever a client becomes ineligible for their current Medi-Cal program. The first step in this redetermination process is an *ex parte* review of existing client case files, followed by a phone call to the client for additional information and a written information request, if necessary. The process does not require a visit to the welfare office; in fact, it was intentionally designed to require counties to use as much of their existing information as possible and to ask for additional information only when it is truly necessary. The CPR recommendations would not change these redetermination requirements.

CPR Finding 10: “A survey of Medi-Cal eligible persons found that 92 percent of Medi-Cal eligible persons say the eligibility process needs improvement.”

CWDA Analysis:

- The full survey findings implicate the complexity of the program more than the fact that counties administer it. The survey of 2,402 current and recent beneficiaries, conducted in 2000 by the Medi-Cal Policy Institute, found that people who use Medi-Cal want it to be simpler and more convenient, overall. The same survey found that:
 - 78 percent believed that too much paperwork and documentation are required to enroll, and 72 percent said that too much paperwork and documentation are required to remain enrolled or get recertified. This is consistent with a recent federal report that urges states to reduce paperwork

- requirements both at the front end of the system and when conducting annual redeterminations.
- 80 percent said that the eligibility and social service workers they have encountered are helpful, with 44 percent having had a county worker go out of their way to help them with a problem or answer a question.
 - 92 percent said that Medi-Cal is a good program, with 84 percent of respondents agreeing that “Medi-Cal is worth the hassle because of what you get in return.” This mixed review lends further support to efforts to make Medi-Cal less of a “hassle” for everyone involved with the program.
- 100 percent of county human services departments would agree with the statement that the eligibility process needs improvement.
 - Counties have served on numerous working groups on program simplification and continue to do so despite little improvement from these efforts.
 - Counties support program simplification, paperwork reduction, and making programs simpler for applicants and for staff. They note, however, that reducing work for applicants will backfire if it simply pushes the same work back to the staff level, since the work still is required and no time is saved. The CPR recommendation regarding asset documentation, which still would require verification by eligibility staff, is an example.

Finding 11: “What’s wrong with this picture?”

CWDA Findings:

- The scenario indicates that a mail-in application would have been the preferred way for the woman to proceed, even though her child was already sick and the mail-in process typically takes longer than coming to the welfare office in person.
 - The mail-in application itself instructs families who have an immediate need for care to go to their local welfare office to apply for Medi-Cal benefits. While there may be a wait to meet with a worker, the turnaround time for an in-person application is much quicker than for a mail-in application.
 - If the county had sent the woman a mail-in application, she would have had to wait for the application to be delivered. She then would have had to fill out the application, gather the necessary documentation and make copies of the documentation, then mail the application to the Single Point of Entry and wait for it to be screened and forwarded to the appropriate county for processing.
 - Counties can be flexible about their hours of operation, and many have staff available to meet with applicants outside of normal business hours, although the recent budget cuts have reduced their flexibility to some degree.
 - Counties also can take information over the phone to begin the application process more quickly. Note that the Healthy Families program will not take application information over the phone unless the applicant has a disability.
- Many counties have outstationed workers or Certified Application Assistants at local clinics and hospitals who are able to help families in situations like the one described. Following are some examples of the structures that exist around the state.

- One county would refer the woman to a local clinic where a certified application assister could help her fill out an application and then send the application to the county with the required documentation, allowing the woman to apply for benefits without having to come to the county office.
 - Another county has outstationed workers at two hospitals where an application could be filled out and processing begun at the emergency room. This county noted that using costly emergency room services is not ideal, but indicated that they would want to ensure that the child received care as quickly as possible.
 - One smaller county has a worker outstationed at a local clinic one morning each week, so the woman could get care for her child and apply for assistance at the same time, reducing her time away from work.
 - The woman also could pick up an application at the county office without having to wait in line and return later that day or the following day to hand it to the county and provide the necessary documentation.
- The child could be eligible for coverage through the CHDP Gateway.
 - Counties could provide the woman with a list of CHDP providers in her area. The child could then get screened for Medi-Cal coverage and, if eligible, would receive immediate short-term coverage while the mother submitted the full application to the county.
 - Note that an expansion of accelerated coverage options for children and parents would be a helpful policy change to ensure that all members of a family receive needed medical care while their applications are being processed. However, the CPR does not include this recommendation.

CPR Finding 12: “Medi-Cal eligibility quality control reviews of the 25 most populated counties ... indicate that there is an average error rate of 11 percent.”

CWDA Analysis:

- Nearly all counties meet legislatively mandated performance standards. The county performance standards review process was conducted for the first time in the 2003-04 fiscal year. The 25 largest counties, representing 94 percent of the statewide caseload, were measured on five standards. To be in compliance, they were required to meet each measure for at least 90 percent of cases.
 - Processing non-disability applications within 45 days. According to the data we received from the Department of Health Services, the average success rate across these 25 counties was 91.29 percent. Twenty of the counties were in compliance, while five entered into corrective action plans.
 - Processing disability applications within 90 days. Twenty-two of the 25 counties met this requirement. The average success rate was 94.96 percent.
 - Mailing annual redetermination packets in a timely manner. All of the counties met this requirement, with an average success rate of 98.84 percent.
 - Completing annual redeterminations timely. Again, all of the counties met this requirement, with an average success rate of 97 percent.
 - Mailing notices timely if the redetermination finds a client ineligible. Only one county failed to meet this requirement. The average success rate was 97.73 percent.

- Errors often stem from program complexity. Interactions across programs, different rules for different programs, inconsistent definitions, incomplete instructions from the state, and manual processes caused by recurring program changes all create opportunity for errors. If the programs were simplified as we have indicated above, a lower error rate would almost certainly result.

CPR Finding 13: “The state is currently assessed over \$100 million in penalties ... for errors in Food Stamp eligibility processing in Los Angeles County.”

CWDA Analysis:

- The state does not currently face this penalty. The state and the federal government have reached a settlement agreement in which most of the penalty has been forgiven and the remainder will be forgiven if the state’s error rate remains low.
- California’s Food Stamp error rate has dropped dramatically. The \$100 million penalty was for the state’s federal fiscal year 2001 error rate, which was greatly impacted by the implementation of LEADER and by state’s policy of requiring monthly reporting by clients.
 - Even the USDA pointed this factor out to the state as one reason for its high errors, and suggested that the monthly reporting requirement be changed. As the USDA indicated, “A state using monthly reporting penalizes itself.”¹²
 - County representatives met regularly with state and federal officials over many months to discuss the reasons for their high error rates, and undertook internal program and process changes that have reduced the state’s error rate from 17.37 percent in FFY 2001 to 7.96 percent for FFY 2003. The state also is moving to a system of quarterly reporting that will be fully implemented in the 2004-05 fiscal year.
- USDA has praised California’s performance improvements.
 - In the past month, the state received a \$6.8 million award from the federal government for its improved error rate. The funds have been used to offset the penalty owed by the state. This bonus represents more than 20 percent of the bonus funds disbursed to states for their federal fiscal year 2003 error rates.
 - According to the USDA, California saved more money during federal fiscal year 2003 than any state in the history of the Food Stamp program.

CPR Finding 14: “Although currently being cleared, Los Angeles County is carrying 122,000 ineligible persons in Medi-Cal as a result of an inability to reconcile with the state data eligibility file, MEDS.”

CWDA Analysis:

- It is not accurate to state that the two systems cannot reconcile. The state MEDS system and the county systems do not interface in real-time, so they must be compared against each other periodically to ensure accuracy. Most counties have done this “reconciliation” regularly but until recently, the necessary interface to reconcile MEDS and Los Angeles County’s LEADER did not exist. LEADER and MEDS have now been reconciled and the caseload is up-to-date.

- Safeguards have been put into place to avoid future problems. Statutory changes enacted as part of the 2004-05 budget deliberations require all county eligibility systems, not just the Los Angeles system, to reconcile quarterly with MEDS. Counties also will be required to work through all eligibility-related alerts they receive from MEDS in a timely fashion. The state and counties are working together to prepare instructions to counties explaining which alerts are to be prioritized for purposes of the law.

CPR Finding 15: “The implications for utilization of an Internet-based application system in multiple programs are significant for better customer service, cost savings, and error prevention.”

CWDA Findings:

- As envisioned by the CPR, a centralized, Internet-based system would require the programs to be reconstructed from the ground up in order to work. Should the Administration and the Legislature decide to implement the HHS 01 recommendations, Medi-Cal, CalWORKs, Food Stamps, and Healthy Families would need to be literally “blown up” and reconfigured to be vastly simpler and much more synchronized. Centralization and privatization are not pre-requisites to this reform.
- Though expanding Internet access options is a good idea, establishing only one point of entry to the programs would restrict access for clients. The report indicates that the Internet-based One-e-App can be used in all 58 counties as the point of entry to services for Medi-Cal, Food Stamps, and CalWORKs. Pennsylvania’s Internet-based COMPASS system is used as an example of the possibilities for California. However, COMPASS is just one of many ways that individuals and families apply for benefits in Pennsylvania. Less than 5 percent of that state’s applications are received via COMPASS, and Pennsylvania state staff indicated to us that, while COMPASS is useful and adds a new means of accessing services, it is not expected or intended to replace the existing system of county-based eligibility offices.
- A centralized, Internet-based system could increase the risk of errors. The Medi-Cal, CalWORKs and Food Stamp programs regulations are immensely more complex than the Healthy Families program. Eliminating the ability to meet face-to-face with clients in favor of an Internet- and telephone-based system increases the likelihood of errors, increases the potential misunderstanding of requirements and regulations and thereby increases the state’s risk of federal penalties. Enhanced quality control systems would need to be in place to ensure that the contractor performed as desired. Advocates have noted a number of problems with the current Healthy Families contractor that would need to be addressed, and could be exacerbated by the addition of three new programs.
- The 18-month timeline provided in the report is wildly optimistic. Even if the Legislature and Governor agreed to a radical reconstruction of eligibility processes, it could take many months for the federal government to approve the waivers that would be necessary to implement such a system. It would take still longer to complete a procurement process for the statewide Internet-based system, to bring that system to scale, and to contract with a vendor for the eligibility operations.

CPR Finding 16: “The Healthy Families model can be applied to other programs.”

CWDA Analysis:

- CPR assumes that the relevant portion of the Healthy Families model is who runs the program – the private contractor hired by the state. Our analysis indicates that the simplified program structure – what the program looks like – is the fundamental part of the Healthy Families “model” that makes centralization and privatization possible. Replicating this model first requires a fundamental program simplification. The CPR consciously bypassed this prerequisite.
- Healthy Families processing is faster because the program is less complex. We fully support reducing complexity in the Medi-Cal, CalWORKs, and Food Stamp programs. In their current form, these programs are square pegs that cannot be pounded into the round model of Healthy Families administration. However, the CPR does not detail the major changes that would be required in order for the simple model used by Healthy Families to work for the three other programs.
 - The complexity in Medi-Cal, CalWORKs, and Food Stamps is driven by state legislation, executive branch decisions, and court decisions. The federal government allows a simpler system for front-end eligibility determinations and annual redeterminations than California has implemented to date.
 - Healthy Families has one program for children only; children are either eligible or they are not. In contrast, Medi-Cal has more than 35 programs encompassing more than 150 different aid codes, and covering children, families, elder adults, and persons with disabilities.
 - Healthy Families has one monthly premium structure and one set of copayments. In contrast, those ineligible for free Medi-Cal coverage may be eligible with a share of cost, a system that is difficult to understand and utilize.
 - CalWORKs and Food Stamps use different rules from the other programs and, in some cases, from each other.
 - Categorical eligibility for Medi-Cal is conferred on individuals receiving CalWORKs and SSI/SSP, requiring coordination with those systems. Healthy Families does not have these program overlaps.
- Healthy Families processing is faster because counties do some of the work. Missing from the CPR analysis is an acknowledgement that a significant amount of the work for applications that first go to the county for a Medi-Cal determination is done by county Medi-Cal staff. This work – ranging from calculation of family size, income and deductions to the gathering of necessary documentation – is used by the Healthy Families program to make eligibility determinations. When it created Healthy Families, the state mirrored many of the income and deduction rules that apply to Medi-Cal, enabling the Healthy Families program to operate more simply because the vendor can use the work already done by counties in its determinations. For some types of applications forwarded to Healthy Families, counties are even required to fill out a transmittal form detailing the main data elements needed by the Healthy Families contractor in order to determine eligibility.

- Healthy Families program administration is not error-free.
 - According to a letter sent by the Los Angeles-based National Health Law Program to the Managed Risk Medical Insurance Board, the Healthy Families oversight body,¹³ common problems include:
 - “Members cannot get through the member services line; wait times are extremely long and when call is transferred, there is continuous ringing with no answer.”
 - “Members who leave a message obtain call-backs one to two weeks later, not within 48 hours as stated [in the contract].”
 - “Authorized representatives [working on behalf of the clients] are told that the best time to call the member services line is after normal business hours (6:00 pm).”
 - “Call-backs from Maximus staff have little or no information about the case or the authorized representative.”
 - The National Health Law Program noted in April that “numerous 2004 applications have not been processed, at least 50 percent of which were mailed to Single Point of Entry more than 20 days ago.” Recent conversations with client advocates indicate that these issues continue and that MRMIB has been advised of the ongoing concerns.
 - The NHLP also indicated that “a number of applications with a clear Medi-Cal share of cost are being mailed to the local counties rather than being processed for Healthy Families enrollment.” Counties note that they often intercede with Healthy Families on behalf of clients.
 - Families have been erroneously dropped from coverage due to errors by the Healthy Families contractor, such as lost payment checks.

These anecdotes are not intended to call the entire Healthy Families contract into question. However, they do indicate that any system dependent on human contact and decision-making has its share of difficulty. Recommendations made by the NHLP include proper training of Maximus and MRMIB staff on Healthy Families enrollment and eligibility, followed by regular training updates; proper staffing levels to ensure calls are answered within the contractual requirements; and proper staffing to ensure that applications are processed according to contractual timelines.
- Fast eligibility determination is not the only measure of program success. Retaining eligible families on the program and ensuring they get the care that they need are also important factors in determining whether a program is meeting the needs of its clients. While counties are not completely responsible for these outcomes in Medi-Cal, they have partnered with community-based organizations to discuss ways of increasing program retention.
- We welcome and encourage discussions about how to apply the best aspects of the simplified Healthy Families model to all program eligibility processes.
 - We have supported in the past, and continue to support, the exploration simplification ideas such as collapsing programs and having a single gross income test, and streamlining the federally required annual renewal through the use of pre-filled annual redetermination forms, renewal by phone and rolling renewals that re-set the annual redetermination date based on updated information in other programs. Other states have implemented these

and other approaches, encouraged and supported by the federal government.¹⁴

- We agree with the CPR proposal to eliminate the documentation of asset information, but only if it does not require a new verification process for staff.
 - It is unclear what data sources would be used to verify the asset information. Consumer financial information is subject to strict privacy laws and is not readily accessible. The CPR report indicates that “the data and systems exist to ensure accuracy” but does not provide information on what these systems entail or how readily they can be accessed by eligibility workers.
 - Requiring additional verification of assets would not ease the overall complexity of the program and would not truly make the program easier for clients. Requiring staff to verify asset information via other sources could add time to the eligibility determination process. In some cases, just asking the clients for paper documentation might be easier than attempting to verify the information electronically.

CPR Finding 17: “The Healthy Families program contacts the families of eligible persons once a month to collect premiums, which is at least as administratively burdensome as income redetermination.”

CWDA Analysis:

- Healthy Families staff do not “contact” recipients monthly. The program automatically mails a monthly bill to its clients and keeps track of payments that have been received. If a family fails to pay for two months in a row, the family is dropped from coverage. The family receives a reminder notice to pay their bill, which is also automatically generated. Note that Healthy Families has a process for sending letters of discontinuance to families dropped from coverage, but a recent call to the program revealed that the system sometimes is delayed in sending these letters.
- Healthy Families workload is minor in comparison to the substantial, often manual, workload for Medi-Cal, CalWORKs, and Food Stamps.
 - Medi-Cal requires counties to send a notice of action at least 30 days in advance of coverage being discontinued. If the notice isn’t sent, the case cannot legally be discontinued. For most cases, county staff are required to conduct an *ex parte* review of existing case files to see if eligibility should continue, and follow up with a phone call and a written information request if additional information is needed. If a Medi-Cal client comes back within one month after being dropped from the program, their coverage must be reinstated. Clients are required to report certain changes in their circumstances within 10 days to Medi-Cal, and may voluntarily report changes in income, household size, and expenses at any time. Healthy Families does not have these requirements.
 - Clients submit quarterly reports to counties for CalWORKs and Food Stamps and semi-annual reports for Medi-Cal. CalWORKs and Food Stamps also require an interim report when income exceeds a given threshold for the size of the family and are required to accept voluntary reports at any time. Healthy Families does not have these requirements.

- If a county has information in one of the programs that would affect eligibility in one or both of the other programs, federal law requires it to take action in those programs, as well. Failure to act can result in an error being charged to the state/county in quality assurance reviews.

CPR Finding 18: “Healthy Families applicants may apply on-line using an Internet-based application that is continuously available.”

CWDA Analysis:

- This statement is incorrect. Though most other states with Internet-based application submission systems allow individuals to apply for themselves, California does not. Access to Health-e-App is restricted to Certified Application Assisters and approved Enrollment Entities. Individuals who wish to apply using the Health-e-App must do so through one of these organizations. The One-e-App pilots are similarly constructed.
- If California wishes to expand Internet-based eligibility determination for all programs, it must first adopt changes to the initial and ongoing eligibility requirements that simplify the program and make an Internet-based system possible – and then trust individuals to fill out the applications on their own.

CPR Finding 19: “At least three counties are in the process of developing ... One-e-App for Medi-Cal, CalWORKs, Food Stamps, and other program eligibility.”

CWDA Analysis:

- The pilot counties are not using One-e-App for CalWORKs or Food Stamps. One-e-App is being piloted in four counties, all of which operate on the CDS/CalWIN system. According to the California Healthcare Foundation, the pilots do not include CalWORKs or Food Stamps, instead focusing on Medi-Cal, Healthy Families, and the counties’ local children’s health initiatives. It is our understanding that the pilot counties are considering whether to expand to the other programs, but are still evaluating the decision.
- One-e-App does not determine eligibility. The system screens for eligibility for Medi-Cal but does not make an eligibility determination. This work would still need to be done by county staff or, if the CPR recommendation were adopted in its entirety, by a state staff person. The federal government prohibits private vendors from making eligibility determinations and has thus far refused to waive this requirement.
- It is unlikely that One-e-App would be ready for statewide use in the 18-month window given in the CPR report.
 - One-e-App would need to be tailored to electronically transfer data to each eligibility system. This is vital because it would otherwise require an eligibility worker or county clerical staff to print out the One-e-App information and manually re-enter the information into the county eligibility system, thus increasing the processing time and increasing the risk of transcription errors.



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- One-e-App also would need to be refined to make an eligibility determination rather than just screen for eligibility, or a statewide eligibility system would need to be implemented in order for the process to be centralized.

- The state would likely wish to pilot the use of One-e-App for CalWORKs and Food Stamps, which are not part of the initial county pilots, prior to a statewide rollout.

- One-e-App is not designed for ongoing case management. As with the Pennsylvania COMPASS system, One-e-App is another means of access – one of many doors – into the eligibility system. It was not designed to be a continuing casework system for Medi-Cal, CalWORKs, and Food Stamps. The system would need significant development to incorporate this capability and replace the county-based systems currently in use.

- Costs to develop One-e-App for statewide use are likely understated.
 - It has been our experience that developing interfaces with existing data bases is complex, costly, time-consuming, and prone to failure. The state has all but abandoned plans to link the four county eligibility systems for just these reasons, instead creating a separate data system that receives data from counties to track time on aid and exemptions for CalWORKs purposes.
 - If the One-e-App is envisioned as a front end to the system, then the cost for development appears to be in the ballpark. However, if the One-e-App is intended to replace existing county eligibility systems, determine eligibility, provide continuing case work, and store data over time, the development costs are significantly understated based on the SAWS system experiences.
 - Additionally, the state could face federal fiscal penalties for abandoning the four-consortia approach, and may be unable to obtain federal financial participation for the new system.

CPR Finding 20: “Healthy Families costs only \$77” per eligible person.

CWDA Analysis:

- The entire cost analysis compares apples to oranges. CalWORKs, Food Stamps, and Medi-Cal are very different from the Healthy Families program. The CPR assumes that they could be run in the same manner at the same cost using a wafer-thin analysis that overlooks key program complexities and bypasses the question of how the programs would need to be restructured.

- Healthy Families costs are understated. As noted above, the analysis does not account for eligibility work done in advance by county eligibility staff for those applications that come to Healthy Families via the counties. Failing to account for this overlap improperly understates the cost per Healthy Families eligible.



Endnotes

¹Interview with CPR staff, September 13, 2004

²Interview with Bob Molnar, Pennsylvania Office of Budgeting for Income Maintenance Programs, September 23, 2004.

³Interview with Cindy Good, Pennsylvania Department of Public Welfare, September 16, 2004

⁴CWDA was not consulted on HHS 01 prior to the report's release. CWDA was consulted about other portions of the broader CPR report, such as ways to improve the state-county relationship.

⁵California Department of Social Services Estimates Branch.

⁶Interview with Bob Molnar, September 23, 2004.

⁷California Performance Review background documents shared with CWDA.

⁸New York: Interview with Richard Radzysinski, Chief New York State Accountant in the Office of Temporary Assistance and Disability, September 15, 2004. Pennsylvania: Interview with Bob Molnar, September 23, 2004.

⁹Interview with Richard Radzysinski, *ibid*.

¹⁰California Performance Review background documents shared with CWDA.

¹¹Interview with CPR staff, September 13, 2004

¹²December 2001 Letter from USDA to Department of Social Services.

¹³April 15, 2004 letter from National Health Law Program to Irma Michel, MRMIB.

¹⁴*Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*, U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, August 2001. (CMS Pub. No. 11000)

The *County Welfare Directors Association of California* (CWDA) is a non-profit association representing the human service directors from each of California's 58 counties. The Association's mission is to promote a human services system that encourages self-sufficiency of families and communities, and protects vulnerable children and adults from abuse and neglect.

For more information, contact CWDA at (916) 443-1749 or visit our website at www.cwda.org.

Medi-Cal Complexity, Healthy Families Simplicity

Medi-Cal	Healthy Families
<u>Length of time to make eligibility determination:</u>	
45 Days	10 Days
<u>Applications may be received via:</u>	
<ul style="list-style-type: none"> - Single Point of Entry - CHDP Gateway - Walk-in at county office - Other county-administered program - Referral from Healthy Families - Free School Lunch program (pilot counties) - Presumptive Eligibility at doctors office 	<ul style="list-style-type: none"> - Single Point of Entry - CHDP Gateway - Referral from Medi-Cal
<u>Documentation required for:</u>	
<ul style="list-style-type: none"> - U.S. citizenship or immigration status - Income - Assets - Deductions - California residency - Pregnancy 	<ul style="list-style-type: none"> - U.S. citizenship or immigration status - Income - Deductions
<u>Separate programs:¹</u>	
<p>150+ separate aid codes under multiple categories. Major aid categories include:</p> <ul style="list-style-type: none"> - 1931(b) - 1931(b) Sneeede - Transitional Medi-Cal/Four-Month Continuing - Medically Needy Only (Share of Cost) - Medically Needy Only Sneeede (Share of Cost) - Childrens Percentage Programs <ul style="list-style-type: none"> o 200% for children 0 to 1 o 133% for children 1 to 6 o 100% for children 6 to 19 - Former Foster Care Children - Minor Consent - Pregnancy Programs - Pickle - Aged/Disabled Federal Poverty Level Programs - 250% Working Disabled - Disabled Adult Child Programs - Long-Term Care Programs - Specified Low-Income Medicare Beneficiaries - Separate coverage programs for persons in need of: <ul style="list-style-type: none"> o Dialysis o Tuberculosis services o Intravenous Nutrition services o Breast and Cervical Cancer treatment 	<p>One program for children up to age 19 who are ineligible for no-cost Medi-Cal and with family income up to 250% of the federal poverty level.</p>
<u>Reporting Requirements</u>	
<ul style="list-style-type: none"> - 10-day reporting requirement for changes in: <ul style="list-style-type: none"> o Income, family composition, resources; or o Other circumstances that may affect their eligibility for benefits. - Semiannual, client-completed redetermination form requiring a client signature to continue coverage (most counties cannot pre-print client information). 	<ul style="list-style-type: none"> - No interim reporting of changes - Annual pre-filled redetermination form
<u>Follow-up information/documentation required for eligibility:²</u>	
<ul style="list-style-type: none"> - Statement of Citizenship/Immigration Status - Rights and Responsibilities - Other Health Coverage Form - Child Support Form (if a parent is absent) - Retroactive Coverage Form - Student Education Expenses - In-Kind Income/Housing Verification - Property/Resource Verification - Vocational/Work History - Authorization to Release Medical Information - Supplemental Statement of Facts - Motor Vehicle Worksheet 	<ul style="list-style-type: none"> - Health plan information/choice of plan - Monthly premium - Documentation of status as American Indian or Alaska Native for waiver of premiums/copays.
<u>State-required follow-up information provided to applicant:</u>	
<ul style="list-style-type: none"> - "Your Rights" brochure - "Medi-Cal: What it Means To You" booklet - Brochures on EPSDT, CHDP, and WIC - Medi-Cal, Long-Term Care Information Notices - Transitional Medi-Cal Information Form - Mental Health Benefit Statement - Voter Registration Information/Form - Information Regarding Citizenship/Immigration 	<ul style="list-style-type: none"> - Healthy Families Handbook - Welcome Letter - Welcome Phone Call

¹Which programs an application is reviewed for depends on type of applicant. The county works through each potential program in a pre-determined order until it finds the application eligible.

²Failure to provide required information could lead to delay or denial of benefits.