Guidelines for Collecting, Analyzing and Displaying Health Coverage Eligibility Outcomes Data

SECOND EDITION

covering kids & families

Southern Institute on Children and Families

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GUIDELINES FOR COLLECTING, ANALYZING AND DISPLAYING HEALTH COVERAGE ELIGIBILITY OUTCOMES DATA

Second Edition

Prepared For

covering kids & families

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PREFACE

Over the past several years, states have taken significant action to simplify the Medicaid and the State Children's Health Insurance Program (SCHIP) enrollment and renewal processes for adults and children. In some instances, enrollment and renewal processes have been simplified for family coverage.

Simplification and coordination strategies play a key role in improving access to Medicaid and SCHIP. Collecting, analyzing and displaying data on eligibility outcomes will enable CKF coalitions and other organizations to identify and remove eligibility barriers that restrict access for eligible children, adults and families.

This report is an update of the *Guidelines for Collecting, Analyzing and Displaying Child Health Coverage Eligibility Outcomes Data* report previously published by the Southern Institute on Children and Families in March 1999 for *Covering Kids:* A National Health Access Initiative for Low-Income, Uninsured Children.

We are pleased to present this Second Edition and believe it can be extremely beneficial to CKF coalition members and other partners in continuing to focus on the implementation of simplification and coordination policies and procedures to help eligible, uninsured children, adults and families access the health care coverage they need.

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INTRODUCTION

Eligibility simplification of health care coverage programs is a major goal of grantees under The Robert Wood Johnson Foundation's *Covering Kids & Families* initiative.[1] Eligibility system data can play a major role in helping to identify simplification issues and solutions.

One of the initial steps to achievement of eligibility simplification is a review of Medicaid and the State Children's Health Insurance Program (SCHIP) eligibility data to determine the current outcomes of the eligibility system. Eligibility outcomes data provide states with information on the actual results of the application and renewal processes, as well as the reasons for denials and closures.

The purpose of this paper is to serve as a brief "how-to" guide on conducting a review of health coverage eligibility data. The paper describes who should be involved, the process and the data elements needed to conduct an analysis of decisions on Medicaid and SCHIP eligibility.

STUDY GROUP

A prerequisite for a review of eligibility data is the commitment and cooperation of state, regional and/or county eligibility agency directors who have responsibility for Medicaid and SCHIP, if separate from Medicaid. In states where the Temporary Assistance for Needy Families (TANF) agency is under contract with Medicaid and/or SCHIP to provide eligibility determination services, it is essential that the TANF director is also included. An eligibility data study is a true collaborative venture where the agencies need to commit staff to participate in the study, provide data for study and consider actions to address findings identified during the study.

The recommended approach to review eligibility data is through the formation of a technical study group with collective expertise on all facets of the eligibility process, as well as knowledge of how the computer system is designed to support the eligibility function. The team will meet several times during the first few weeks of design and then will need to hold regular meetings after data are available for analysis and interpretation.

[1] *Covering Kids & Families* is a $55 million program of The Robert Wood Johnson Foundation, with direction and technical assistance provided by the Southern Institute on Children and Families.

The state and local agency directors should appoint staff to the study group to include, at a minimum, the following areas:

- Medicaid, SCHIP and TANF eligibility policy experts;
- Computer systems managers and programmers; and
- Local eligibility supervisors and frontline eligibility staff.

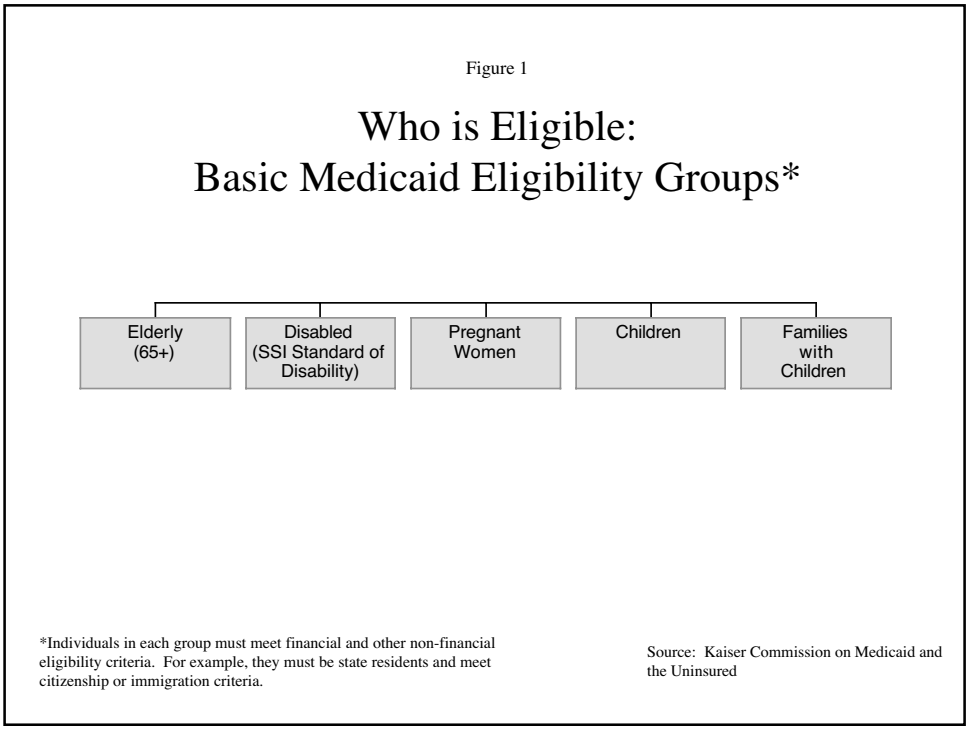
Advocates who have experience in helping families meet eligibility requirements also should be included. While ultimate responsibility for the study and the study report must be assigned to one team member, all team members must be involved and committed to working on the design and implementation of the study, as well as interpretation of the data.

SCOPE OF STUDY

Study Population

The first task of the study group will be to define the population for study. Medicaid has many eligibility categories and avenues for entry. Figure 1 shows the five basic categories for Medicaid eligibility.

Figure 1



The primary focus of the study should be on the eligibility process, over which the state, region or county has significant decision making authority. The eligibility groups that should be included in the study are described below.

- Medicaid children, including poverty related children and SCHIP children eligible under a Medicaid expansion;
- Children eligible for SCHIP coverage in states operating SCHIP as a separate and distinct program from Medicaid;
- Medicaid children and families receiving Transitional Medicaid;
- Children and families receiving TANF who are covered;
- Section 1931 families; and
- Parents and/or childless adults who are eligible due to expansions.

Another Medicaid eligibility group is composed of low-income, disabled individuals who receive cash assistance through Supplemental Security Income (SSI). A decision should be made as to whether to include the SSI population in a study with other Medicaid categories as mentioned above or to conduct a separate study of the Medicaid eligibility process for SSI individuals.

It is important to specify if the data represent individuals or cases. A case includes several individuals belonging to a family unit. There is not a preferred unit, but the study group should be clear. If case data are used, it is helpful to understand the make-up of an average case so the data can be translated to individuals.

Study Units

If possible, the data should be collected for each county or other local unit so unit by unit comparisons can be made in addition to comparisons with statewide data.[2] Local level data are important to determine the range of data findings across the state. This level of analysis helps to determine if special attention is needed in specific areas of the state.

Display of Study Findings

Before the data are gathered, the study group should decide how it will display the data. Designing the data tables in advance helps the team clarify exactly how the data should be gathered and what specific data are needed to complete a table.

Appendix A provides examples of data tables used in reports on eligibility outcomes. The tables are designed to communicate effectively with policymakers and other key stakeholders and to answer questions of interest to them.

[2] If data are not available on a county by county basis, then another unit of local data should be used.

STUDY DATA

When an application for Medicaid or SCHIP is filed, it is reviewed along with required verification documents, and a decision on eligibility is made. Decisions on initial Medicaid or SCHIP eligibility result in one of three outcomes:

- Approved;
- Denied; or
- Withdrawn at request of the applicant.

Although a withdrawn application results in the applicant not receiving Medicaid, it differs from a denial because it is an applicant decision, not an agency decision. For this reason, withdrawn applications are separated from agency denials for purposes of analysis.

Renewals of Medicaid or SCHIP eligibility result in one of three outcomes:

- Approved;
- Closed; or
- Withdrawn at request of the recipient.

Although Medicaid or SCHIP coverage is stopped when a case is withdrawn, withdrawn cases are separated from closures because withdrawn cases are recipient decisions rather than agency decisions for purposes of analysis.

Denial Reasons

Each state determines the computerized codes used for designating the reason for a denial of an initial application. Because the number of these specific denial codes may be large, it is necessary to group the denial codes. The following five basic categories of denial reasons relate to eligibility policy and are a helpful way to group data for analysis. These are:

- Excess income;
- Age not within eligibility criteria;
- Excess resources (in states with a resource/assets test);
- Failure to comply with procedural requirements, such as missing an appointment for an eligibility interview or failure to return required verification documents within the required time frame; and
- Other basic eligibility criteria, such as, undocumented alien, not deprived of parental support, child not in the home, and the applicant moved or cannot be located.

In a few states with separate SCHIP programs, applications are not recorded as denied in situations where sufficient information is not received. Unlike Medicaid, there is no requirement that application decisions be made within a specified period of time. In these situations, states notify the applicant that a decision cannot be made until all information

is received. If information is not received by the state agency, the case remains pending. This policy will understate the denial rate because even though coverage is not approved, the application is not recorded as a denial. Thus, in states with separate SCHIP programs, a review of pending cases including the length of time the case has been pending can be critical to understanding eligibility decisions.

Closure Reasons

Each state determines the computerized codes eligibility workers use for designating the reason a case is closed. As with denial reasons, there are many specific closure codes, and it is helpful to group them into basic categories. Closures can be grouped into the following categories:

- Excess income;
- Age not within eligibility criteria;
- Excess resources (in states with a resource/assets test);
- Failure to comply with procedural requirements, such as missing an appointment for a renewal interview or failure to return required verification documents or reports within the time frame;
- Failure to pay premiums; and
- Other basic eligibility criteria, such as, transitional period expired, child not in the home, and the recipient cannot be located.

Additional Data

More than likely, the study will indicate some areas in need of additional study. For example, a review of a random sample of case records may be needed to identify policy and procedural barriers to eligibility, especially when attempting to identify verification issues. Case file reviews can be conducted using a review guide to assure the collection of essential information on a consistent basis.

Another method of gaining in-depth information into areas identified by the analysis of eligibility data is to interview denied applicants or former recipients. Their experiences with the eligibility system are an invaluable source of information. As with any data gathering effort, protection of confidentiality is paramount.

ANALYSIS AND INTERPRETATION

Changes in Caseload Size

Changes in caseload size are determined by the net effect of the number of approvals and the number of closures within a time period. Outreach efforts are typically designed to increase the number of applications from eligible, uninsured children, adults or families and thereby increase the caseload. If systemic efforts are not directed at retaining those who are eligible, the number of children, adults or families covered by Medicaid or SCHIP can decline in the face of increasing applications. It is likely that declines in Medicaid coverage for children and families as a result of welfare reform can be traced to the lack of systemic efforts to prevent families from losing Medicaid when the family was no longer eligible for cash assistance under the TANF program.

The way to measure caseload is with the following equation.

	Number of cases at the beginning of the month
+	Number of approvals in the month
–	Number of closures in the month
=	Caseload

Approval and Denial Rates

An effective eligibility system results in approval for those who qualify under the eligibility criteria and denial for those who do not qualify. A basic data finding is the approval or denial rate of applications. The desired or appropriate denial rate should be determined for use as a benchmark as denial rates are monitored over time. Table A-1 in the appendix shows a model for displaying the rates.

Reasons for Denial

In order to understand why children or families are denied, the denial reasons should be analyzed. The question to be answered is: “Are children, adults or families denied because they are not eligible due to excess income or other eligibility criteria, or because they did not comply with a procedure within the eligibility system?”

The denial reason of "failure to comply with procedural requirements" points to system barriers. A truly simplified eligibility process should produce almost no procedural denials.

The two major reasons for procedural denials are:

- Missing an appointment for an eligibility interview, commonly known as "no-show."
- Failing to return requested verification documents.

Denials for procedural reasons do not indicate whether or not a child, adult or family qualifies under the eligibility criteria. One study documented the likelihood of eligibility after examining a representative sample of 100 case records denied for failing to return verification documents. The case records were reviewed and income and resource eligibility were determined from the information in the record. It was found that 76 percent of these cases were probably eligible if the requested verification had been returned and if it substantiated the information stated by the applicant.[3]

Procedural Denials Due to No Shows

If a relatively high number of procedural denials can be traced to "no shows," then a number of policy options can be examined. Face-to-face interviews are a state option. Many states have discontinued the practice of face-to-face interviews, particularly in light of more applicants having full work schedules and being unable to leave work during the typical 8:00 am-5:00 pm eligibility office work day. The following list of questions is not intended to be complete but to stimulate thinking about the process of appointments.

- Are applicants given a choice about appointment times, or are they sent a time and date in the mail?
- What is the readability level of the appointment notice?
- Are applicants given a specific and dedicated time for an interview, or are they given a time to check in and then wait for an interview on a first-come, first-serve basis?
- Are interviews scheduled before or after regular office hours and on weekends?
- Are interviews held at locations other than the eligibility office?
- Are local telephone systems adequate and user-friendly?
- If face-to-face interviews are required, is there an adequate and reliable transportation system for applicants to use to get to the eligibility office?
- Is there a purpose for the face-to-face interview that cannot be met in other ways?

Procedural Denials Due to Failure to Return Verification

If a relatively high number of procedural denials are for failure to return verification documents requested by the eligibility staff, then verification policies and procedures should be examined. Because this is an area where policy and practice are not always aligned, it is important to understand which documents are not being returned. The following list of questions is not intended to be complete but should stimulate thinking about verification and the process.

- Does eligibility staff request more verification than required by policy?
- Are eligibility staff requesting applicants to submit documents that the eligibility staff can obtain from other agency files?

[3] Sarah C. Shuptrine, Vicki C. Grant, and Genny G. McKenzie, Improving Access to Medicaid for Pregnant Women and Children, prepared for The Robert Wood Johnson Foundation and Grady Memorial Hospital (Columbia, SC: Sarah Shuptrine and Associates, February 1993) p. 37.

- Are standardized, multi-program checklists given to applicants that list documents to provide the eligibility staff, or are applicants asked to bring only required verification documentation specific to their application and circumstances?
- Is it easy or difficult to actually speak to eligibility staff by calling the eligibility office?
- Do office policies require eligibility staff to offer and provide assistance to applicants in obtaining the required verification?
- What verification documents are most likely not to be returned?
- How much time are applicants given to return verification documents?

Information on simplification measures taken by the Medicaid Department of Louisiana is presented on page nine.

Processing Time

Typically, eligibility workers must make a decision on Medicaid eligibility within 45 days or less from the date the application was filed. In some instances, states and counties have been challenged on the length of time it takes to render an eligibility decision. The time it takes to make an eligibility decision should be balanced against the potential impact on denial rates. An unintended consequence of placing too much emphasis on reducing processing time is that denials can increase because required verification documents are not returned within shortened time periods.

Table A-2 in the appendix shows a model for displaying denial reasons.

Reasons for Case Closure

At some point after children, adults or families are approved, their eligibility for continuing coverage must be reviewed. For most children and families, a review must be made at least every 12 months, but a state can choose to review eligibility more frequently. Except in states that have adopted the continuous eligibility option for children, recipients are required to report immediately any changes in income or household size so eligibility can be reviewed.

To better understand the outcomes of the review process, the reasons for closure should be analyzed. Reviewing the reasons for stopping coverage is an important step to assure that cases are being closed only when children, adults or families no longer qualify under eligibility criteria. Similar to denials, system barriers may be present when a high percentage of closures are due to failure to comply with procedural requirements or failure to return required documents. Table A-3 in the appendix shows a model for displaying closure reasons.

The Medicaid Department in Louisiana Uses Data From Other Agencies for Eligibility Decisions

In Louisiana, the Department of Social Services (DSS) administers Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP). The Bureau of Health Services Financing in the Department of Health and Hospitals (DHH) administers Medicaid and LaCHIP, the state's Medicaid expansion program. Information from the computer systems of other agencies is used to help facilitate the application and renewal processes for Medicaid and LaCHIP.

Application Process

Louisiana has streamlined the application process for Medicaid and LaCHIP. The following policies are in place:

- Joint application
- Mail in application
- No face-to-face interview
- No asset test
- Twelve-months continuous eligibility
- Reduced income verification requirements

If a family is unable to provide verification documentation and the family currently receives Food Stamp benefits, the information in the family's FSP record is used to verify income for applications.

Renewal Process

Louisiana utilizes ex parte reviews (relying on information available to Medicaid workers from other computer systems) to complete the renewal process for many families. For instance, if a child is receiving benefits from the FSP, a Medicaid renewal form is not sent. While they do not have access to the physical FSP case record, Medicaid caseworkers have inquiry rights to the FSP eligibility system and use the information in that FSP case to make an eligibility decision. Approximately 60 percent of the Title XIX (traditional Medicaid category) children have eligibility extended at renewal in this manner. A notice is then sent to the family informing them that the renewal has been completed.

In addition, Medicaid caseworkers are informed via a nightly computer interface between the Medicaid and TANF computer systems of TANF denials and closures. These "work flow" notices are used to automatically screen for continued Medicaid eligibility. Medicaid caseworkers have access to the TANF information systems to help ensure that benefits lost in one program do not result in a loss of coverage in Medicaid and LaCHIP.

These simplified renewal processes have helped the state to reduce its rate of procedural closures at renewal to eight percent.

Information obtained from J. Ruth Kennedy, Medicaid Deputy Director. For further details, please contact Ms. Kennedy at the following address:

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Number and Percentage of Cases Closed

An important measure of the eligibility process is the number of covered persons who have their cases closed and the percentage of the caseload that is closed. It is administratively inefficient, as well as disruptive to families and providers, when eligible cases are closed and families have to reapply.

A study of closures in one state showed that in 12 months the state closed 61,133 children's Medicaid cases. Of these total case closures, 32,514 were closed only once, and a number were closed more than once, resulting in the churning phenomenon.[4] If the extent of churning is high, the possible causes should be investigated. The study points out, "Churning is costly, as well as disruptive to families and providers."[5] In this state's case, 57 percent of Medicaid infants were automatically closed upon reaching their first birthday because of a computer code that automatically generated closure action. In this case, churning could have been minimized for some children by implementing practices and procedures to assure eligibility is determined under all Medicaid categories before a closure action is taken, as required by federal law. Another strategy to minimize churning is the adoption of 12-month continuous eligibility for children.

If the data are reviewed over an extended time frame, such as 12 months, duplications should be removed to determine the extent that individuals are losing coverage and then returning. The unduplicated set of numbers gives a count of cases or individuals closed without counting a person more than once. The set of numbers that are not unduplicated gives a count of caseworker or system actions to close cases. This count includes families that lose coverage, reapply and receive coverage and lose coverage again.

Table A-4 in the appendix shows a model for displaying the percentage and number of cases closed.

Another measure to review is the percentage of individuals closed at renewal. This measure reveals information not seen in an overall closure rate. The example below illustrates the increased sensitivity of looking at closures at renewal of this level.

Example:

County X had a caseload of 60,000 cases. Of the caseload, 2,000 cases, or 3.3%, are closed. However, 4,500 cases were due for renewal and 1,850 were closed. The closure rate at renewal was 41.1%.[6]

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[4] Sarah C. Shuptrine and Genny G. McKenzie, South Carolina Medicaid Eligibility Study, prepared for the South Carolina Children's Hospital Collaborative (Columbia, SC: Sarah Shuptrine and Associates, December 1998) p. 7-8.

[5] Ibid.

[6] Excerpt taken from *Supporting Families After Welfare Reform* National Program Office, Supporting Families Story: The Movement Toward Quality Improvement (Columbia, SC: Southern Institute on Children and Families) To be published 2003.

CONCLUSION

A study of eligibility data is an excellent way to gain an objective view of the eligibility process at application and renewal. Eligibility data provide states, regions and counties with information on the actual results of the application and renewal processes, as well as the reasons for denials and closures. Such a study creates a baseline for monitoring change over time, especially as simplification reforms are implemented.

Study groups may find it helpful to review a report that relates eligibility decisions to data and to simplification and coordination options. The report is entitled *Covering Kids & Families Primer: Understanding Policy and Improving Eligibility Systems* and it presents information on options that states may adopt to simplify their eligibility decisions systems.[7]

[7] Vicki C. Grant and Nicole Ravenell, *Covering Kids & Families Primer: Understanding Policy and Improving Eligibility Systems* (Columbia, SC: Southern Institute on Children and Families) December 2002.

APPENDIX A

Table A-1:
Approval and Denial Rates of Medicaid/SCHIP
Applications by County, State and Time Period

Table A-2:
Medicaid/SCHIP Application Denial Reasons
by County, State and Time Period

Table A-3:
Case Closure Reasons for Medicaid/SCHIP
by County, State and Time Period

Table A-4:
Percentage and Number of Medicaid/SCHIP
Case Closures by County, State and Time Period

TABLE A-1
APPROVAL AND DENIAL RATES OF MEDICAID/SCHIP APPLICATIONS BY COUNTY, STATE AND TIME PERIOD

[Children 18 and Under or Adults and Parents]

Area	Number of Applications Approved and Denied	Percentage of Applications Approved	Percentage of Applications Denied
State	#	%	%
County 1			
County 2			
County 3			
County 4			
County 5			
County 6			
County 7			
County 8			
County 9			
County 10			
Source:			

TABLE A-2
MEDICAID/SCHIP APPLICATION DENIAL REASONS
BY COUNTY, STATE AND TIME PERIOD

[Children 18 and Under or Adults/Parents]

Area	Percentage of Applications Denied	Number of Applications Denied	Number of Individuals Denied	Percentage of Applications Denied By Reason				
				Excess Income	Excess Resources	Age	Failure to Comply with Procedures	Other
State	%	#	#	%	%	%	%	%
County 1								
County 2								
County 3								
County 4								
County 5								
County 6								
County 7								
County 8								

Source:

TABLE A-3
CASE CLOSURE REASONS FOR MEDICAID/SCHIP
BY COUNTY, STATE AND TIME PERIOD

[Children 18 and Under or Adults/Parents]

Area	Total Case Closures	Total Number Of Persons	Percentage of Case Closures By Reason					
			Excess Income	Excess Resources	Age	Failure To Comply With Procedures	Failure to Pay Premiums	Other Basic Eligibility Criteria
State	#	#	%	%	%	%	%	%
County 1								
County 2								
County 3								
County 4								
County 5								
County 6								
County 7								
County 8								

Notes: 1) The data are not unduplicated. 2) The estimate of persons is based on X persons per Medicaid case. 3) "Other" includes cases where a determination cannot be made because the family did not respond, cases where the family has moved or can't be located, cases where the certificate period has ended, cases withdrawn by recipients, cases with no eligible child and non-residents.
Source:

TABLE A-4
PERCENTAGE AND NUMBER OF MEDICAID/SCHIP CASE CLOSURES BY COUNTY, STATE AND TIME PERIOD

[Children 18 and Under or Adults/Parents]

Area	Percentage of Caseload Closed	Percentage of Cases Closed at Renewal	Total Number of Case Closures
State	%	%	#
County 1			
County 2			
County 3			
County 4			
County 5			
County 6			
County 7			
County 8			
County 9			
County 10			

Note: The data are unduplicated cases.
Source:

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