13 - 0079

Alignment of Public Assistance Programs' Policy and Procedures: Report and Recommendations

Minnesota Department of Human Services

January 2013

Legislative Report

Minnesota Department of **Human Services**

For more information contact:
Minnesota Department of Human Services
Health Care Eligibility and Access
P.O. Box 0989
St. Paul, MN 55155-0989
(651)431-2283

This information is available in alternative formats to individuals with disabilities by calling (651)431-2283.

TTY users can call through Minnesota Relay at (800) 627-3529.

For Speech-to-Speech, call (877) 627-3848.

For additional assistance with legal rights and protections for equal access to human services programs, contact the agency's ADA coordinator.

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $82,731.82 This figure includes the considerable time the project team, sponsors, and business owners spent developing this report's content and recommendations.

Printed with a minimum of 10 percent post-consumer material. Please recycle.

Table of Contents

I. Executive summary

The 2011 Legislature passed legislation entitled "Redesigning Service Delivery" which requires the Commissioner of Human Services, in collaboration with counties, to study and implement a variety of changes to the human services delivery system. (See Laws of Minnesota 2011, First Special Session, Chapter 9, Article 9.) Section 15 of this article focuses on alignment of public program policy and procedures. The section states:

> *The commissioner of human services, in consultation with counties and other key stakeholders, shall analyze and develop recommendations to align program policy and procedures across public assistance programs to simplify and streamline program eligibility and access. The commissioner shall report to the chairs and the ranking minority members of the legislative committees with jurisdiction over these issues by January 15, 2013 with draft legislation to implement the recommendations.*

Minnesota's public assistance programs include Medical Assistance (Minnesota's version of Medicaid), MinnesotaCare, the Supplemental Nutrition Assistance Program (SNAP), Child Care Assistance Program, Minnesota Family Investment Program (MFIP, Minnesota's version of Temporary Assistance for Needy Families), Refugee Programs, Emergency Assistance, and state funded cash programs.

A variety of factors have led to great differences in policy and procedures across these programs. Federal oversight is the responsibility of several different federal agencies; including the Centers for Medicare and Medicaid (Medical Assistance, most of MinnesotaCare), the U.S. Department of Agriculture (SNAP) and the U.S Department of Health and Human Services (MFIP). These agencies do not necessarily coordinate their policy and procedural efforts. Aligning programs to possess similar eligibility factors can lead to program cost increases in one or more of the programs aligned, complicating legislative attempts at alignment. It is also true that over the years the Minnesota Legislature has made changes to specific programs which have led to policy and procedure differences between the changed programs and other existing public assistance programs.

To address the legislative requirement of Article 9, Section 15, a workgroup consisting of representatives of county agencies, Department of Human Services (DHS) areas that administer Public Assistance programs and MN.IT-DHS met regularly throughout calendar year 2012 to discuss and develop recommendations. The workgroup reviewed past alignment-related research as well as previous efforts at simplification. The workgroup found that past efforts have often been unsuccessful for a variety of reasons, including the lack of a consistent approach to developing solutions and recommendations

The workgroup's recommendation is that DHS, in collaboration with county agencies, implement a process they have developed to accept suggestions for alignment, simplification, and streamlining from county agencies and other eligibility determining entities. These suggestions will be analyzed, prioritized, and if viable acted upon on. A pilot of this proposed process was conducted and results are summarized in section VI of this report.

II. Legislation

Laws of Minnesota 2011, First Special Session, Chapter 9, Article 9, Section 15. The commissioner of human services, in consultation with counties and other key stakeholders, shall analyze and develop recommendations to align program policy and procedures across all public assistance programs to simplify and streamline program eligibility and access. The commissioner shall report back to the chairs and ranking minority members of the legislative committees with jurisdiction over these issues by January 15, 2013, with draft legislation to implement the recommendations.

III. Introduction

This report is submitted to the Minnesota Legislature pursuant to Laws of Minnesota 2011, First Special Session, Chapter 9, Article 9, and Section 15.

Legislators, county representatives, stakeholders, and Department of Human Services (DHS) representatives have long expressed interest in alignment and simplification of public assistance program policies and procedures.

- The 2009 Minnesota Legislature directed DHS, in cooperation with county agencies and organizations that advocate for families and children, to develop a plan that would align income and asset methodologies, standards, and procedures for families and children in Medical Assistance and MinnesotaCare (Insert legislative cite.) DHS utilized funding from Minnesota's State Health Access Program to contract with the Lewin Group to develop a plan. While the Lewin Group produced a partially completed report, the contract with them was terminated when passage of the Affordable Care Act created questions regarding the viability of alignment of MinnesotaCare and Medical Assistance.

- The 2009 State-County Results, Accountability and Service Delivery Reform Act established the Steering Committee on Performance and Outcome Reforms. Among other objectives, the Steering Committee was charged to "take into consideration that the goal of implementing changes to program monitoring and reporting the progress toward achieving outcomes is to significantly minimize the cost of administrative requirements and to allow funds freed by reduced administrative expenditures to be used to provide additional services, allow flexibility in service design and management, and focus energies on achieving program and client outcomes."

- The 2011 Minnesota Legislature charged the Commissioner of Human Services, in consultation with counties and other key stakeholders, to analyze and develop recommendations to align program policy and procedures across public assistance programs to simplify and streamline program eligibility and access.

- The 2011 Minnesota Legislature charged the Commissioner of Human Service to issue a request for information (RFI) for an integrated services delivery system for health care programs, food support, cash, and child care assistance and to develop an integrated service delivery framework that must simplify and streamline human services eligibility and enrollment processes. The Legislative Report was issued January 13, 2012. The first Annual Report was issued May 15, 2012.

- The 2012 Minnesota Legislature, in Laws of 2012, Chapter 247, Article 3, Section 28, passed legislation requiring the Commissioner of Human Services, in consultation with county human services representatives, to analyze differences in asset limit requirements across several human services programs (not including Health Care programs) with the goal of the analysis being to establish a consistent asset limit across human services programs and minimize the administrative burdens on counties in implementing asset tests. A report on this work will be issued to the 2013 Legislature.

This report summarizes the work and recommendations of a joint state/county workgroup assembled to implement the 2011 Legislative requirement. It contains background on the challenges of achieving program alignment, reports on the approach the workgroup developed over the course of months of work, and contains recommendations for action.

This report was prepared by staff of the Health Care Eligibility and Access Division of the Department of Human Services, in consultation with representatives of county agencies and of other program areas of the Department of Human Services. A complete list of names and affiliations of workgroup members can be found in the Appendix.

IV. Approach to developing recommendations

In developing its recommendations, the joint county/state workgroup focused on several public assistance programs—the Minnesota Investment Program (MFIP), the Supplemental Nutrition Assistance Program (SNAP,) and the Medical Assistance Program (MA), MinnesotaCare, Child Care Assistance Program (CCAP), Group Residential Housing (GRH), Minnesota Supplemental Aid (MSA), and General Assistance (GA). However, the full range of Minnesota's public assistance programs will be considered if the recommendations in this report are accepted.

Legislators, county agencies, human services stakeholders, and DHS program areas have previously identified eligibility and verification variances between programs as causing a substantial administrative burden for counties and confusion for program recipients. Many applicants request multiple programs, for example MFIP, SNAP, CCAP and Medical Assistance. Differences in eligibility limits and/or verification requirements cause confusion for the applicant as well as complications for the case worker.

Past approaches to program alignment have targeted specific programs or specific policies and procedures. For example, the 2009 Minnesota Legislature targeted Medical Assistance and MinnesotaCare for alignment, while the 2011 legislation does not narrowly target but rather requires recommendations for alignment of policy and procedures across all public assistance programs including Health Care Programs, SNAP, CCAP, and MFIP. While allowing flexibility in the development of recommendations, the charge of the legislation offers stiff challenges given the complexity of programs and the varying federal and legislative requirements.

In developing its recommendations, the state/county workgroup was able to review and consider a report produced by Manatt Health Solutions that was prepared for purposes of planning and preparation for implementation of the Affordable Care Act. The Manatt report contains a template comparing federal eligibility rules for the following programs: Medicaid, CHIP (Childrens' Health Insurance Program), TANF, CCAP, and SNAP. For Medicaid/CHIP, the template includes the streamlining requirements of the ACA and the implementing regulations to date. Among the eligibility criteria they considered are:

- Household composition (who is counted in the household)
- Household income
- Income counting
- Income disregards
- Eligibility levels
- Budget periods
- Income verification
- Residency
- Residency verification
- Age/Date of Birth verification
- Citizenship/Immigration status verification
- Social Security Number
- Asset limits
- Change reporting
- Redetermination process
- Application process

The Manatt report is available upon request.

A combination of factors impacts any efforts at simplification and alignment. As a review of the Manatt report reveals, Public Assistance programs are complex with an array of eligibility rules and factors that differ from one program to another. Any effort at alignment requires careful analysis of the financial and client impacts of the alignment across all programs.
Aligning eligibility rules across programs can also lead to program cost increases in one or more of the programs aligned, depending on the nature of the alignment. There can also be an initial cost if eligibility systems must be reprogrammed to accommodate changes. In times of budget limitations, the increased cost can create a significant obstacle to Public Assistance programs alignment.

A joint county/state workgroup met throughout calendar year 2012 to discuss viable strategies for program and procedural alignment and simplification. The workgroup reviewed previous alignment efforts and considered the complexity of eligibility rules across the array of public assistance programs, as displayed in the Manatt report. The workgroup concluded that in order to achieve the intent of the legislation—alignment of program policy and procedure-a model would need to be developed to allow proper analysis and prioritization of alignment proposals. The efforts of the workgroup resulted in an operations model for state/county collaboration on

alignment, streamlining, and simplification efforts. The model process will enable consistent issue identification and prioritization.

V. Development of Model to Align Public Assistance Programs' Policy and Procedures

There were several guiding principles used during the development of the improvement process. It was decided that the process:

- Should contain a "front door" readily accessible by counties and other partners whereby problem areas or improvement suggestions can be submitted for consideration. Technology will be employed where possible to enhance ease of use and accessibility.
- MN.IT must be fully engaged in any technological solutions. For any alignment proposals requiring technology solutions, there must be complete vetting and approval through the IT prioritization process.
- Must align with other initiatives to prioritize work and to develop measurable solutions and recommendations.
- Should contain a method for prioritization, so that business impact, client impact, and other factors can be considered in determining which proposals for alignment and simplification can be advanced.
- Should employ continuous process improvement strategies, following Governor Dayton's May 2011 direction to agencies to use those methods. The workgroup consulted with and included the DHS program area responsible for the department's continuous improvement strategy.
- Should employ documented repeatable processes and tools to foster consistency.

Outline of the Model to Align Public Assistance Programs' Policy and Procedures

1. **Submit item:**
   A county agency or organization submits a request (endorsed by their management) to simplify, streamline, or align a policy or process related to one or more of the relevant public assistance programs.
   - The model assumes that counties and other entities submitting proposals will have an internal endorsement process in place.
   - The model assumes a technology solution will be available to submit, track and communicate about these requests.

2. **Triage and Problem Solve:**
   DHS, in consultation with county representatives and MN.IT-DHS, and other partners triages submitted suggestions, and completes a problem statement which includes a root cause analysis on those requests that are viable.

- The problem statement also conducts an initial risk assessment, identifies impacts on other programs and requests initial cost information.

3. **Prioritize Items:**
   DHS in collaboration with county representatives prioritizes the submitted items.
   - Priority scores are based on initial and ongoing cost, effort, benefit and impacts.
   - Executive leadership from counties and DHS approves a prioritized list of items.

4. **Solution Development and Recommendation:**
   DHS convenes a project team that includes county representative, MN.IT-DHS and other partners to develop solutions and make recommendations regarding the prioritized items.
   - Recommendations are based on analysis of proposed solutions that includes level of effort, cost and time frame as well as pros and cons
   - Executive leadership from counties and DHS approves or rejects the recommended solution.

5. **Implement:**
   DHS, in collaboration with the county agencies, MN.IT-DHS, and other partners implements the approved recommendations using standard project management tools and methods.
   - DHS in its role as oversight agency retains final authority on policy and systems changes.
   - On an ongoing basis, DHS in collaboration with county representatives evaluates the effectiveness of implemented changes.

Attachment A of the Appendix contains a diagram of the recommended improvement process.

VI. Pilot of the Model to Align Public Assistance Programs' Policy and Procedures

The state/county workgroup decided to employ elements of the proposed process on an actual alignment proposal. The workgroup identified alignment and simplification ideas using actual proposals from county agencies/staff: Cost Effective Health Insurance (CEHI), Assets (Vehicles), Self-Employment Income, Household Composition, Negative Verification, and IEVS Matches. Suggestions for changes were considered using elements of the State/County Improvement process designed by the workgroup:

- Topics were previously suggested by county representatives and DHS staff as a potential alignment opportunity. They were among a number of suggestions considered by the county/state workgroup.

- Following the process outlined on pages 10 and 11 of this report, representatives of the county/state workgroup completed a problem statement for each proposal which included a root cause analysis, across multiple public assistance programs. This problem statement identified impacts on all public assistance programs.
- Using a prioritization tool adopted by the workgroup, the proposals for Cost Effective Insurance and Negative Verifications proceeded to the solution development step. Note - it was determined that system changes/resources would not be necessary to achieve simplification, streamlining, or alignment.

1. Cost Effective Health Insurance

County workers are required to gather information on health insurance costs for applicants for Medical Assistance who have insurance, and agencies must also make cost effectiveness determinations. This is a very burdensome process for county agencies and also leads to lack of uniformity in how cost effective determinations are made. The initial county proposal was to centralize the function at DHS.

- The root cause analysis of the problem was conducted, highlighting the local agency burdens mentioned previously. Consultations with DHS staff who manage the Cost Effective Health Insurance process revealed that improvements in some elements of the process were made in recent years. The recommendation of the workgroup was that additional consultations between DHS and county representatives are necessary to make substantive changes in the process so as to improve it for all concerned. Continuous improvement methods should be employed to arrive at recommendations for change.

2. Negative Verifications: Requesting Verifications for Ineligible Applicants

County and state eligibility staff are required to request verifications from applicants even when they are ineligible based on information they provided on the application form. This requirement exists for all public assistance programs. The workgroup, in collaboration with policy staff from the affected programs, analyzed the requirement for potential implementation across multiple Public Assistance programs

- The analysis of the problem revealed that this is a time consuming eligibility action for all eligibility staff. Exact numbers and costs for these types of actions are impossible to produce as they cannot be distinguished from denials for other reasons. There would be no systems implications for change in this area, as the change would be in the action taken by the worker.

- The county/state workgroup, serving as the project team in this pilot of the Model process, consulted with subject matter experts in the various programs as necessary. These experts were required to research program rules to determine if possible solutions are viable, legally sound solutions.
- Based on this analysis and review, the county/state workgroup made the following recommendations as related to Negative Verifications:

    - Any change alleviating this verification requirement will apply only to income and asset verifications.
    - If eligibility appears "close" based on thresholds of allowable income and assets, verification will continue to be required.
    - SNAP has greater leeway to change at this time.
    - Legislative language has been proposed for MFIP and if enacted will be implemented as legislation instructs.
    - State funded cash programs, GRH, GA, and MSA, will consider proposals for the 2014 Legislative Session.
    - Health Care Programs have several factors including Health Care Reform implementation which require any changes wait until January 2014.
    - CCAP will monitor the impact of the change on the Cash and SNAP program and consider proposals for change in the 2014 Legislative session.

A recommendation including these elements was developed by the workgroup and submitted to the relevant program areas at DHS. Implementation of the recommendation will simplify negative verification of income and assets for MFIP, GA, MSA, GRH and SNAP programs. Depending on how it works, it may provide a model for similar simplification for Health Care Programs and the CCAP.

VII. Report recommendations

In order to align program policy and procedure, a Model utilizing collaboration between county and state representatives, systematic analysis and prioritization of proposals, and buy in from executive leadership at the DHS and county level should be implemented. The complexities in requirements across the range of public assistance programs, the different federal agencies overseeing the programs, possible program cost increases with alignment—all combine to make alignment and simplification very difficult. An approach based on the Model outlined in this report can lead to solutions that are analyzed, vetted, and implemented. The success of the Model pilot in identifying a method to simplify the Negative Verification process for most public assistance programs demonstrates the viability of the model.

The Model described in this report will require some commitment of resources by both the county and the state to be successful. DHS, as the oversight agency will require resources for the different pieces of the process.

- DHS should ensure that a portal exists by which county agencies and other entities can submit proposals and ideas for change. There must be a technology solution available to allow for submission and tracking of these proposals.
- DHS should oversee the triage and problem solution process. This would entail extensive communication between county and state, assembling of project teams and workgroups, ensuring the participation of MN.IT-DHS for program/procedure changes requiring system changes, and managing the prioritization process.
- As project teams are assembled to work specific proposals, DHS should draw in the necessary program areas and subject matter experts. DHS will schedule meetings, maintain any database tracking for proposals, etc.
- DHS should ensure the necessary approvals for developed solutions are obtained from County and DHS executive leadership.
- As proposals are analyzed and move through the process, outcome measures reflecting the success of a particular solution should be developed, implemented, and tracked.

VIII. Implementation language

Implementation of the Model to Align Public Assistance Programs' Policy and Procedures does not require additional or new legislative authority. However, language for individual alignment, streamlining, or simplification efforts will be composed on an as needed basis.

VIII. Appendix

Appendix A: Overview Diagram

Appendix B: Request for Change Template

Appendix C: Problem Statement and Description Template

Appendix D: Priority Example

Appendix E: Solution and Recommendations Development Template

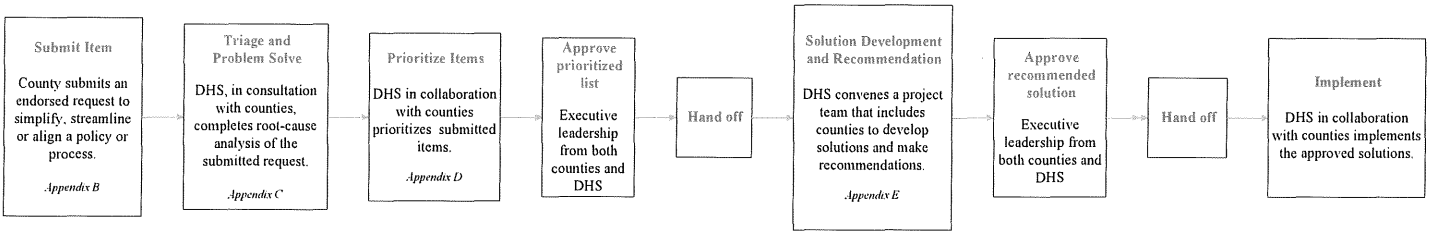
Appendix F: Cost Effective Health Insurance Solution and Recommendations

Appendix G: Verifications for Ineligible Applicants Solution and Recommendations

Appendix H: Project Participants and Roles

Appendix A

Model to Align Public Assistance Programs' Policy and Procedures



Counties – representatives from individual counties

Experts – experts from DHS business areas, MN.IT or other associated agencies

Stakeholder – agencies or individuals who are impacted by, or are interested in, the issue being considered

January 2013

Request for Change Form

Submitter Name:	**Title:**
Phone:	**Email:**
Organization:	**Department:**

1. **What program(s) are affected by your suggestion?**
   (Drop-down menu that allows multiple choices)

   ☐ MA ☐ LTC ☐ MinnesotaCare ☐ MA-EPD

   ☐ QMB/SLMB/QI ☐ SNAP ☐ MFIP/DWP ☐ GA

   ☐ MSA ☐ EA ☐ EGA ☐ CCAP

   ☐ GRH ☐ Other _____

2. **What are the problem areas?**

   ☐ Application ☐ Reviews/redetermination ☐ Income

   ☐ Health Insurance ☐ Budgeting ☐ Assets

   ☐ Citizenship ☐ Household composition

   ☐ Other _____

3. **What would be required to remedy this issue?**

   ☐ Policy change ☐ Process change

   ☐ System change
   (Drop-down with system choices, i.e. MAXIS, MMIS)

   ☐ Other _____ ☐ Unknown

4. **Problem statement/description: Please describe the problem.**

5. **Why is this an issue?**

6. **Population Impact – Who is affected by this, and to what extent?**

7. **What do you suggest to remedy the issue?**

8. **How would this correct the problem?**

9. **Stakeholders – Who may impact or be impacted by this effort?**

Problem Statement/Description

Problem Scope:
What is included in this problem, what is not included in this problem?

Problem Background:
What background (if any) is necessary to understand this problem?

As-is Considerations:
What "as-is" points need to be considered in decision making?

- How many people are affected?
- What are the program costs (*e.g., cost of errors)*?
- What county costs/resources are used?
- What state costs/resources are used?
- Is other work diverted?
- How are other programs impacted?
- What are the risks of not dealing with this problem (taking no action)?

Context:
(big picture considerations; upcoming changes; other related projects.)
What parameters must be taken into consideration in the analysis?

Candidate Solution

Is there a potential solution which may appear to deliver the desired results?

Analysis

Risks

Compared to the "as-is" situation, what are the risks of taking action?

One-Time Net Cost/Effort

Compared to the "as-is" situation, what might be the a one-time expenditure of funds and effort to resolve this problem required for initial implementation?

Compared to other problems, is it likely that this one-time net cost / effort would be:

☐ Low ☐ Medium ☐ High

Ongoing Cost/Effort

Compared to the "as is" situation, what might be the ongoing expenditure of funds and effort to resolve this problem after initial implementation?

Compared to other problems, is it likely that this ongoing net cost/effort would be:

☐ Low ☐ Medium ☐ High

Ongoing Benefit / Impact

After implementation, what is the likely ongoing benefit or positive impact? If appropriate, note ways that the benefit might be partially offset by negative results.

Compared to other problems, is it likely that this ongoing benefit/impact would be:

☐ Low ☐ Medium ☐ High

Other Considerations

What, if any, other points should be considered that are not characterized by the above three dimensions (e.g., political viability, urgency of opportunity, improvement of public perception)?

Stakeholders

Who may impact or may be impacted by this effort?

Segment 1.4 Prioritizing Among Problem Statements

October 22, 2012

In order on white board

		A One-Time Cost / Effort	B Ongoing Cost / Effort	C Ongoing Benefit / Impact	Grid Score A, B, C	D Other Consdns	Other Consdns Score	TOTAL SCORE
1	**Negative Verification**	Low	Low	Medium	65	Medium	6	**71**
2	**Household Composition**	High	Low	Medium	40	Low	1	**41**
3	**Self-Employment**	High	Low	High	55	None	0	**55**
4	**Cost Effective Health Insurance**	Low	Low	Medium	65	Low	5	**70**
5	**Assets**	Medium	Low	Medium	50	Low	5	**55**
6	**IEVS**	Medium	Low	Medium	50	Low	2	**52**

In order by score

1	**Negative Verification**	Low	Low	Medium	65	Medium	6	**71**
2	**Cost Effective Health Insurance**	Low	Low	Medium	65	Low	5	**70**
3	**Self-Employment**	High	Low	High	55	None	0	**55**
3	**Assets**	Medium	Low	Medium	50	Low	5	**55**
5	**IEVS**	Medium	Low	Medium	50	Low	2	**52**
6	**Household Composition**	High	Low	Medium	40	Low	1	**41**

Analysis of Options and Recommendations for Draft Recommendation

Problem Statement/Description:
One or two sentences that describe what the problem is

Reasons:
What are the primary reasons this project is being considered?

Problem Scope:
What is included in this problem, what is not included in this problem?

Background:
What background, if any, is necessary to understand this problem?

State Mandates:
What is current state law?

Federal Mandates:
What is current federal law?

As-Is Situation:
What is the current policy, practice, process, and systems?

- **Current Minnesota policy for this item:**

- **Current practice and how it is processed:**

- **Systems currently used:**

Stakeholders:
Who are the stakeholders involved?

Options for Implementation

- *Outline the options and other possible considerations for implementation.*

- *Include alternatives and costs for MAXIS, MMIS, and program area.*

- *What are the issues and potential impacts?*

- *How will you know if this solution is successful?*

Option 1

- **Outline of Steps:**

- **Plan for Implementation:**

- **Level of Effort, Timeframe and Costs:**

- **Pros and Cons:**

Option 2

- **Outline of Steps:**

- **Plan for Implementation:**

- **Level of Effort, Timeframe and Costs:**

- **Pros and Cons:**

Option 3

- **Outline of Steps:**

- **Plan for Implementation:**

- **Level of Effort, Timeframe and Costs:**

- **Pros and Cons:**

Recommendations
Explain the recommendation, justification, and criteria for success

- **Recommendations:**

- **Justification for the Recommendations:**

- **How will we know if this solution is successful?**

Appendices

- **Supporting Documentation:**

- **Alternative Estimates for Implementation:**

Cost Effective Health Insurance (CEHI) Analysis of Options and Recommendations

Problem Statement/Description

Currently, counties are required to gather health insurance cost information from clients that have access to private health insurance. Workers are expected to contact employers for coverage type and cost data, then compare cost data to decide which option is the most cost effective. Coverage decisions are now made by financial workers (FW). FW are overburdened with a high caseload, may not be equipped, nor have the time, to perform this type of specialized work. The risk of not identifying cases and realizing costs savings to the Medicaid program are higher in light of the current model.

If realized, Medicaid program cost savings is important, the function needs to be better supported and positioned in a way that enables knowledgeable staff to perform this work efficiently and effectively to capture cases that may be missed due complexity of the work and lack of knowledge on the part of county staff.

Reason

While the root cause of the problem is complex and may require further investigation, there are knowns that need to be addressed:

1. From a county perspective, the upfront process is complicated, primarily manual, and entails multiple steps that need to be completed and may involve time delays awaiting information the county needs to make a determination.
2. The same employers may be contacted by county staff multiple times, asking for the same coverage information for different clients, frustrating both the financial workers and employers receiving requests for duplicate information.
3. Effective cost insurance determinations involve a disproportionately small population disbursed across the state and involve a lot of Medicaid dollars. It may not be feasible for a county to hire full- or part-time staff with insurance and accounting knowhow.
4. County staff that infrequently encounter cases of this nature are at risk of forgetting how to do it and may lose time trying to figure out the process on a by-case basis.
5. Many counties do not have the depth of knowledge required by this function and are at risk of losing staff who may be sole source, due to county staff size and turnover. An aging workforce may trigger additional loss of trained staff.
6. Training staff in each of the 87 different counties to perform this specialized function comes at a cost. Having untrained staff do the work increases risks of errors.
7. Realizing cost savings and complying with federal requirements are priorities.

Problem Scope

1. Develop options to process cost-effective health insurance
   - To ensure maximum cost savings
   - To comply with federal requirements
   - To reduce errors

2. Recommend an option that is feasible given the current environment at the state, and counties and is cost effective.

Problem Background

To date, both DHS and counties have separately tried to find solutions to the problem needed to improve the process using Lean Kaizen methodology. They have, to some extent, improved the process, noting the problem still impacts counties and state's ability to maximize saved Medicaid funds.

The DHS Lean Kaizen developed forms that are clear cut and appear simple. They include instructions for how to determine CEHI and simplified forms for employers and county staff to complete. DHS also recommended changes to the MMIS screens where CEHI information is recorded. These changes are in the MMIS queue, but no timeline for these changes has been developed.

County Lean Kaizen efforts have occurred in larger counties and focus on how the individual county processes cases. These efforts generally reduce the number of hand-offs among county staff, but do not address the overall all complexity.

NOTE: Concerns raised in this document may or may not involve the complete set of functions/activities now associated with CEHI at state and county levels.

Data from Pat..

- **31,635 clients on CEHI**
- **$51,303,381.58 colleced from insurance carriers (FFS claims)**
- **$21,303,381.58 (paid in premiums)**
- **More than 800,000 MPHC cases**

Data from Counties

- **Ramsey 1.75 allotted, 3.0 required**

State/Federal Mandates and Current Policy/Practice

State Mandates

What is current state law?

Program	State Law
Medical Assistance	**256B.0625** Subd. 15.**Health plan premiums and co-payments.** (a) Medical assistance covers health care prepayment plan premiums, insurance premiums, and co-payments, if determined to be cost-effective by the commissioner. For purposes of obtaining Medicare Part A and Part B, and co-payments, expenditures may be made even if federal funding is not available.

	(b) Effective for all premiums due on or after June 30, 1997, medical assistance does not cover premiums that a recipient is required to pay under a qualified or Medicare supplement plan issued by the Minnesota Comprehensive Health Association. Medical assistance shall continue to cover premiums for recipients who are covered under a plan issued by the Minnesota Comprehensive Health Association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later. State Plan HCFA-PM-91-8: "The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer based cost-effective group health plans. When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h). "
MinnesotaCare	N/A

Federal mandates

What is current federal law?

Program	Federal Law
Medical Assistance	The federal Medicaid application of this term is under section 1906 of the Social Security Act. It became a state option in 1997. Sec. 1906. [42 U.S.C. 1396e] (a) Each State plan— (1) may implement guidelines established by the Secretary, consistent with subsection (b), to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this title in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2)); (2) may require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this title and subject to subsection (b)(2), notwithstanding any other provision of this title, that the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and (3) in the case of such enrollment (except as provided in subsection (c)(1)(B)), shall provide for payment of all enrollee premiums for such

	enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916), and shall treat coverage under the group health plan as a third party liability (under section 1902(a)(25)). (b)(1) In establishing guidelines under subsection (a)(1), the Secretary shall take into account that an individual may only be eligible to enroll in group health plans at limited times and only if other individuals (not entitled to medical assistance under the plan) are also enrolled in the plan simultaneously. (2) If a parent of a child fails to enroll the child in a group health plan in accordance with subsection (a)(2), such failure shall not affect the child's eligibility for benefits under this title. (c)(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1903(a), to be payments for medical assistance. (B) If all members of a family are not eligible for medical assistance under this title and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible— (i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account payment of all such premiums), but (ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals. (2) The fact that an individual is enrolled in a group health plan under this section shall not change the individual's eligibility for benefits under the State plan, except insofar as section 1902(a)(25) provides that payment for such benefits shall first be made by such plan. (d) [Stricken.[310]] (e) In this section: (1) The term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986[311], and

	includes the provision of continuation coverage by such a plan pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974[312]. (2) The term "cost-effective" has the meaning given that term in section 2105(c)(3)(A).[313] means, as established by the Secretary, that the reduction in expenditures under this title with respect to an individual who is enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required under this section with respect to such enrollment. --- [310] P.L. 105-33, §4741(b)(2); 111 Stat. 523. [311] See Vol. II, P.L. 83-591, §5000(b)(1). [312] P.L. 78-410, Title XXII, P.L. 83-591, §4980B, and P.L. 93-406, Title VI. [313] P.L. 111-148, §10203(b)(1), struck out "means, as established by the Secretary, that the reduction in expenditures under this title with respect to an individual who is enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required under this section with respect to such enrollment." and inserted "has the meaning given that term in section 2105(c)(3)(A).", effective as if included in the enactment of P.L. 111–3, February 4, 2009.
MinnesotaCare	N/A

Current policy, practice, process, and systems
What is the "as-is" situation?

- **Current MN policy for this item**

Program	Current MN Policy+
Medical Assistance	Current policies regarding cost-effective health insurance are addressed in Minnesota Health Care Programs Manual (HCPM) 15.10.05 - Cost Effective Health Care Coverage - MA
MinnesotaCare	CEHI does not apply to MinnesotaCare. However, other health insurance of a MinnesotaCare enrollee is entered into the MMIS- TPL Subsystem as payor of first resort.

- **Current practice and how processed**

Program	Current Practice and Processes
Medical Assistance	The current practice and processes for determining cost-effective health insurance are addressed in HCPM 15.10.05.05 - Determining Cost Effectiveness Current practice and processes for determining Medicare cost-effective premiums are addressed in HCPM 15.10.05.10 – Medicare Cost Effective Premium Requirements Current practice and processes for reimbursing MA enrollees for cost-effective health insurance premiums are addressed in HCPM 15.10.05.15 - Cost Effective Premium Reimbursement
MinnesotaCare	N/A

- **Systems currently used**

Program	Current Systems
Medical Assistance	MMIS – TPL Subsystem
MinnesotaCare	N/A Note: Cost-effective health insurance does not apply to MinnesotaCare. However, other health insurance of a MinnesotaCare enrollee is entered into MMIS – TPL Subsystem.

Stakeholders

Who are the stakeholders?

Population
Clients
Eligibility workers
DHS HCA Member and Provider Services Division Benefit Recovery section
DHS policy and training staff
County accounting groups
DHS appeals staff
Advocates and community partners
DHS OIG
Systems
Legislature
Employers
Insurance companies

Options for Implementation

- *Outline the options and other possible considerations for implementation.*
- *Include alternatives and costs for MAXIS, MMIS, and program area.*
- *What are the issues and potential impacts?*
- *How will you know if this solution is successful?*

Option 1

- **Outline of steps**
  - Centralize CEHI functions at either a regional or state level.
  - Organize a continuous improvmement team that includes counties and DHS to streamline the process, reduce variation and develop recommendations for managing CEHI going forward. Utilize prior LEAN work completed by DHS and by Olmstead County as a basis for this effort.

- **Plan for Implementation**
  - Depending on the outcomes from the Continuous Improvement team, implement approved recommendations.

- **Level of effort, time frame and costs**
  - The range is from six weeks to six months, depending upon CI methods selected. Staff and leadership should anticipate an average of eight hours per person, per week.
  - Analysis is needed to determine if regionalization or centralization is best, given health care reform and development of new eligibility determination system.
  - Funding for staff who are centralized is needed.

- Implementation will be one year after necessary legislation or other approvals are received.

- **Benefits and Considerations**

  Benefits

  - Opportunity to carefully analyze data to determine the root cause of variation and inefficiencies
  - Opportunity to identify best practices and establish standard work
  - Opportunity to establish performance measures going forward
  - Opportunity to increase revenue
  - Ability to concentrate knowledge, while providing back-up for staff movement
  - Ability to ensure quality control
  - Implementation of health care reform and new eligibility determination system may provide opportunity to centralize in ways not previously considered
  - Relationship development with employers and overall less staff time and effort
  - Opportunities for technology and other efficiencies
  - Decreased county and state administrative costs

  Considerations

  - No immediate solution
  - There could be significant upfront cost.
  - Funding needs to be cobbled together.
  - Lack of DHS and county staff to undertake this effort.
  - Staffing levels, roles, and responsibilities need to be determined.
  - Funding is an unknown.

Option 2

- **Outline of steps**
  - Organize a continuous improvmement team that includes counties and DHS to streamline the process, reduce variation and develop recommendations for managing CEHI going forward. Utilize prior LEAN work completed by DHS and by Olmstead County as a basis for this effort.
  - Administration remains with 87 counties with support from DHS.
  - Opportunities for technology solutions and other efficiencies could be identified.

- **Plan for Implementation**
  - Depending upon the outcomes from the continuous improvement team, implement approved recommendations.

- **Level of effort, time frame and costs**
  - DHS Staff - Benefit Recovery, Health Care Eligibility and Access, MMIS, Financial Operations, Lean Kaizen facilitators
  - County staff - FW from large, medium and small counties, accounting staff
  - Ranging from six weeks to six months, depending upon methods selected. Staff and leadership should anticipate an average of eight hours per person, per week.

- **Benefits and Considerations**

Benefits

- Opportunity to carefully analyze data to determine the root cause of variation and inefficiencies
- Opportunity to identify best practices and standard work
- Opportunity to establish performance measures going forward
- Opportunity to increase revenue
- Opportunity to identify technology solutions

Considerations

- Does not alleviate one of the main causes of variation – 87 counties administering
- Continued lack of knowledge depth
- Lack of DHS staff to undertake this type of effort
- Lack of county staff to undertake this type of effort

Recommendations

While Option 1 is the preferred option, at this point in time, there is not enough information available relating to how this function operates at both state and county levels and across counties. Regardless of the approach, we need a more comprehensive analysis of methods and process at state and county levels in order to specify a detailed solution.

Justification for the Recommendations

Pursuing the team's recommendation to look at the process in more detail will enable decision-makers to make informed decisions and allow all parties to better understand the problem's root cause and optimize limited resources. If no action is taken, problems and risks described in this document will persist and potential savings will not be realized.

How will we know if this solution is successful?

In addition to increased program and administrative dollars saved, other types of measures will need to be developed as part of the continuous improvement effort if it is moved forward for implementation.

Appendices

Supporting documentation

- DHS Lean Kaizen
- Olmsted Lean Kaizen
- Data Warehouse Report - ***Total Count of Recipients with Paid Cost Effective Insurance Claims & Total TPL Payment Amounts from FFS Paid Claims***

(Supporting documentation is available upon request.)

Alternative estimates for implementation

Negative Verifications:
Requesting Verifications for Ineligible Applicants
Analysis of Options and Recommendations

Problem Statement/Description

- Currently, eligibility workers are required to request verifications from applicants, even when information provided on the application indicates they are not likely to be eligible.
- Requesting verifications from clients, even if they appear to be ineligible, is time-consuming and often costly for both clients and staff.
- It also provides unclear feedback to clients and less useful data for analysis by denying benefits based on lack of verification, rather than on not meeting eligibility criteria.

Introduction

Reason

- Requiring negative verification across the board wastes the time (and often money) of both clients and county staff.
- It would be better to allow workers the option of pursuing those applicants who might qualify, while denying applicants who by self-report don't qualify. This would:
  - Reduce confusion while providing applicants with better feedback as to why they were denied, while still permitting them to subsequently provide documentation demonstrating eligibility.
  - Provide better data by differentiating more clearly between applicants who don't meet eligibility criteria versus those who don't provide verification.
  - Reduce unnecessary work by both clients and eligibility staff.
  - Reduce wait times for clients by freeing up eligibility workers to concentrate on applicants who are more likely to be eligible for services.
  - Streamline processes and increase alignment across programs.

Problem Scope

- **In-Scope**
  - Changing from requiring across-the-board negative verifications to worker-denied applications based on application information where it is warranted.
  - Analysis to determine "as-is" policy, processes, laws and systems for Minnesota Public Assistance Programs (MPAP) to limit negative verifications, while in the applications period
  - Analysis of the populations served by the specific MPAP during the application period
  - Analysis of the impacts on staff determining eligibility at the state and county levels
  - Development of options and recommendations to reduce negative verification

- **Out of Scope**
  - Verifications in circumstances besides application

- Changing eligibility criteria

Problem Background

- SNAP has begun working toward eliminating negative verification requirements and has received permission from FNS to deny a SNAP application using a client statement of income at initial application, and interviewing when over the gross income limit for their household size.
- MFIP has assessed this issue and is proposing legislation to eliminate negative verification requirements.
- Because our programs are so intertwined, it makes sense to review this policy for other programs in the hope that we could achieve streamlining, simplification and alignment across programs.
- We assume that counties are generally following application policy, process, and timelines as prescribed from DHS.
- It is difficult to get concrete numbers on this topic, because it is not possible to know exactly how many applicants are denied specifically for over income or assets, rather than for failure to comply or verify. However, participating counties estimate that 40-50% of clients who are denied at application for failure to return verification are actually income or asset ineligible.
- Clients may spend time and money to return the requested documentation, only to be told they are ineligible.
- The act of requesting this additional documentation is time-consuming for eligibility workers and other enrollment staff who must spend time completing request forms, updating systems and mailing out the requests for additional information.
- There is cost involved in both time and resources spent to mail out these additional request forms.
- Eliminating required negative verifications would be most beneficial if any process or policy goes across the board. However, there would still be significant benefit even if only one or two processes or policies were simplified, streamlined and aligned.
- In the future when VerifyMN is fully functional, we assume that it will be easier to verify income. This has the potential to alter any process implemented to deal with negative verifications.

State/Federal Mandates and Current Policy/Practice

State Mandates

Program	State Law
CCAP	Income MN Statutes 119B.025, Subd 1. Factors which must be verified. (a) The county shall verify the following at all initial child care applications using the universal application: (1) identity of adults; (2) presence of the minor child in the home, if questionable; (3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative caretaker, or the spouses of any of the foregoing;

	(4) age; (5) immigration status, if related to eligibility; (6) Social Security number, if given; (7) income; (8) spousal support and child support payments made to persons outside the household; (9) residence; and (10) inconsistent information, if related to eligibility. MN Rules 3400.0040, Subp. 3 Documentation of eligibility information. A. An applicant for child care assistance must document the: (1) citizenship status or participation in a program that makes a child exempt from this documentation requirement for all children for whom child care assistance is being sought; (2) relationship of the children in the family to the applicant; (3) date of birth of the children in the family; (4) date of birth of the applicant if the applicant is under 21 years of age; (5) identity, income eligibility, and residence for all members of the applicant's family, including members temporarily absent from the household as defined in part 3400.0020, subpart 40a; and (6) work, education, or training activity status for all applicants as defined in Minnesota Statutes, section 119B.011, subdivision 2. Assets -- Minnesota has opted to have no asset test
SNAP	Income 7CFR 273.2 Minnesota has opted to have no asset test
MFIP	Income 256J.21 Assets 256J.20
GA	*MN Rule 9500.1215 (Documenting, Verifying and Reviewing Eligibility), subp. 4 says:* **Factors to be verified.** The county agency must verify the factors of program eligibility in items A to C at the time of application, when a factor of eligibility changes, and at each redetermination of eligibility. B. The county agency must verify the information in sub items (1) to (6) when that information is acknowledged by an applicant or recipient or obtained through a federally mandated verification system: (1) receipt and amount of earned income, including gross receipts from self-employment; (2) receipt and amount of unearned income;

	(3) termination from employment; (4) ownership and value of real property; (5) ownership and value of personal property; and (6) dependent care costs of an employed filing unit member at ıe time of application, redetermination, or a change in provider.
GRH	GA rule and MSA statute also apply to GRH since individuals must meet a basis of eligibility for GA or MSA in order to qualify for GRH.
MSA	***MSA** applicants could have gross income over the MSA standard if they're not receiving SSI. There is statutory language that would prohibit negative verification. MS 256D.405 (Verification and Reporting Requirements), subd. 1 says:* **Verification.** The county agency shall request, and applicants and recipients shall provide and verify, all information necessary to determine initial and continuing eligibility and assistance payment amounts. If necessary, the county agency shall assist the applicant or recipient in obtaining verifications. If the applicant or recipient refuses or fails without good cause to provide the information or verification, the county agency shall deny or terminate assistance.
Medical Assistance	**9505.0095 VERIFICATION OF ELIGIBILITY INFORMATION.** The local agency shall verify the eligibility factors, in determining the medical assistance eligibility of the applicant. The local agency must not require an applicant or recipient to verify more than once an eligibility factor not subject to change and available in existing medical assistance files of the local agency. The applicant shall provide all necessary information and documents and give the local agency written authorization to contact sources who are able to verify the required information to the local agency. An applicant who refuses to authorize verification of an eligibility factor including a social security number shall be denied medical assistance eligibility. Minn. Stat. §256B.056 Subd. 4b.**Income verification.** The local agency shall not require a monthly income verification form for a recipient who is a resident of a long-term care facility and who has monthly earned income of $80 or less. The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification.

	Subd. 5a.**Individuals on fixed or excluded income.** Recipients of medical assistance who receive only fixed unearned or excluded income, when that income is excluded from consideration as income or unvarying in amount and timing of receipt throughout the year, shall report and verify their income annually. Subd. 5b.**Individuals with low income.** Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income on a semiannual basis. Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the 60-day postpartum period to update their income and asset information and to submit any required income or asset verification. (b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage if this is determined to be cost-effective. (c) The commissioner shall verify assets and income for all applicants, and for all recipients upon renewal.
MinnesotaCare	**9506.0030 APPLICATION; ENROLLMENT; COVERAGE.** **Subp. 2.** **Necessary information for eligibility determination.** A. Applicants must provide all information necessary to determine eligibility for MinnesotaCare and potential eligibility for medical assistance, including: (1) Social Security number; (2)

	proof of permanent residency; the signature of an applicant on the application attesting to permanent residency meets the affidavit requirement under Minnesota Statutes, section 256L.09, subdivision 4, clause (3); (3) household composition; (4) availability of other health coverage, including access to employer-subsidized health coverage; (5) gross annual family income; and (6) any additional information needed by the commissioner to determine or verify eligibility.

Federal mandates

Program	Federal Law
CCAP	Income cannot exceed 85% of the State Median Income (SMI) for a family of the same size. Regulations do not give direction on negative verification (i.e., denials without income or asset verification if client states over the income or asset limit) 45 CFR §98.20.
SNAP	Income The State shall verify income through the use of information (if any) obtained using the applicant's social security numbers, as provided to determine eligibility for food stamps. 7 USC. § 2020(e). 7 CFR 273.9(b)-(d). Assets $2,000 for an individual, $3,000 for aged or disabled. See regulations below for included/excluded resources. 7 USCS 2014 Allows for state option for no asset limit or test. MN has taken this option. 256.029, 256E0.0515
MFIP	45 CFR 233.20(a)(4). ***Statute:*** The State must verify income eligibility using wage and other income databases using the SSA, IRS, wage reporting systems, SWICA. 42 USC 1320b-7.

	Assets ***Regulation***: Resources should not exceed $1,000 45 CFR 233.20(a)(3).
GA	None – state-funded program
GRH	None – state-funded program
MSA	None – state-funded program
Medical Assistance	None
MinnesotaCare	**CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS** **III. 2. Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

Current MN policy for this item

Program	Current MN Policy
CCAP	CCAP does not have statewide policy on requesting verifications if clients' stated income is over the CCAP limit (note: assets are not counted in CCAP).
SNAP	SNAP (per FNS) can deny if clients state during the interview that they are over the income limit without asking for paper verifications (note: assets are not counted).
MFIP	MFIP – according to statute – cannot deny for over income/assets without verification of income/ assets. Legislation is being proposed to allow denials cases where clients state in an interview that they are over income.
GA	State rule requires verification of income and assets
GRH	State law and rule requires verification of income and assets
MSA	State law requires verification of income and assets
Medical Assistance	**Verification of certain eligibility factors is required. Mandatory Verifications** This section provides basic policy requirements for mandatory verification. Additional detail is provided in the topic-specific sections identified in the links. Many verification requirements vary between programs and sometimes within programs. The items listed below apply to all programs, although not necessarily to every individual within each program. See the topic-specific links for a complete description of each requirement and to whom it applies. • U.S. Citizenship and Identity. • Immigration Status. • Social Security Number. • Income. • Inconsistent Information. • IEVS Matches. • PARIS Matches. **MA Verification Only** Verify the following information when needed for MA eligibility under a particular basis: • Blindness and disability for people claiming a blind or disabled basis of MA eligibility. See Disability Determinations. • Eligibility for state and Title IV-E adoption assistance. See Adoption Assistance. • Enrollment in Medicare Part A when required for eligibility for QMB, SLMB, QWD, or QI. See Medicare Savings

	Programs. • Assets. See Verification of Assets for specific program policy. • Pregnancy. See MA Pregnant Women for specific verification policy requirements. • Asset Reductions. See MA Excess Assets for more specific program policy. • Medical expenses to meet a spenddown.
MinnesotaCare	**Mandatory Verifications** This section provides basic policy requirements for mandatory verification. Additional detail is provided in the topic-specific sections identified in the links. Many verification requirements vary between programs and sometimes within programs. The items listed below apply to all programs, although not necessarily to every individual within each program. See the topic-specific links for a complete description of each requirement and to whom it applies. • U.S. Citizenship and Identity. • Immigration Status. • Social Security Number. • Income. • Inconsistent Information. • IEVS Matches. • PARIS Matches. **MinnesotaCare Verification Only** Verify the following information for MCRE eligibility: Employer-Subsidized Insurance (ESI) when applicable. Pregnancy. See MCRE Pregnant Women for specific verification policy requirements. Verify the following assets for MCRE eligibility. These are the only assets requiring verification for MinnesotaCare. • A Continuing Care Retirement Community (CCRC) Entrance Fee, if applicable. • Worker's Compensation settlements, if the reported amount causes assets to exceed the asset limit. See Verification of Assets for specific policy requirements. Exception: Do not verify income, access to ESI or pregnancy for children applying for or enrolled in MinnesotaCare for Certain Children Exiting Foster Care or a Juvenile

	Residential Correctional Facility.

Current practice and how processed

Program	Current MN Practice on Applications
CCAP	Asks clients to provide income dollar amounts.
SNAP	Does not ask client to provide an income dollar amount. The CAF asks clients if they have income. It is assumed that workers will gather this information during the interview.
MFIP	Same as SNAP
GA	Same as SNAP
GRH	Same as SNAP
MSA	Same as SNAP
Medical Assistance	Asks client provide income and asset dollar amounts. Also asks for detailed information about types of assets and types of income.
MinnesotaCare	Same as MA

Program	Current MN Practice on Interviews
CCAP	No interview requirements.
SNAP	An interview is required, though it may be phone or in-person.
MFIP	An in-person interview is required.
GA	Same as SNAP
GRH	Same as SNAP
MSA	Same as SNAP
Medical Assistance	Same as CCAP
MinnesotaCare	Same as CCAP

Systems Currently Used

Program	Current MN Practice on Systems
CCAP	Denials occur through MEC[2]
SNAP	Denials occur through MAXIS
MFIP	Same as SNAP
GA	Same as SNAP
GRH	Same as SNAP
MSA	Same as SNAP
Medical Assistance	Denials occur through MAXIS
MinnesotaCare	Denials occur through MMIS

Stakeholders

Population
Clients
Eligibility workers and managers

DHS policy and training staff
DHS appeals staff
Advocates and community partners
OIG
Legislature

Options for Implementation

Assumptions

- Multiple options are available for moving from requiring negative verifications to requiring them in many fewer situations.
- A negative verification threshold will be established: Income between $50-$ 100 within the FPG or based on worker experience; assets if clients are within $100 of the asset limit or based on worker experience. Exceptions: denials will not occur if asset reduction or spenddowns are programmatically allowed.
- Denied applications will follow current policy for specific program.
- Align as much as possible across programs over a two year period.

Proposed Measuring Methodology

- Recommend estimating potential cost savings by estimating time savings by program, then multiplying by the dollar cost of eligibility work as indicated in the Income Maintenance Random Moment Study (IM-RMS), which is ordinarily used to claim federal administrative revenue for operating these programs.

Individual Program Options

SNAP Option

1. Worker receives application (CAF or ApplyMN), but no interview.
2. Based on how the client answered Question 1 in the expedited criteria – *How much income will your household get this month?* – **and** based on the applicant's verbal confirmation during the interview of their income, the eligibility worker informs the client they are over the gross income limit for their household size.
3. The worker informs the client they will deny the application based on the client statement of income, unless the client would like to submit the verification of income. If the client declines, the eligibility worker **must** enter a MAXIS CASE/NOTE detailing that the interview occurred, client statement of income and what the gross income limit is for that household size showing the reason for the denial.
4. If the client's income is close to the gross income limit ($50 over), the eligibility worker should request verification of income to ensure the denial is proper.
5. If during the interview, the client is hesitant about the income amount even though they appear to be over the gross income limit, request the verification. If in doubt by either the client or the worker, request verification. In both of these scenarios, it is up to the client to choose whether to submit requested verifications or not.
6. The eligibility worker enters the stated income in MAXIS STAT panel and uses *other* as the verification code.

7. Client will receive a proper denial notice stating their income is over program regulations for their household size. This notice includes a budget with the declared income, as well as the appeal rights.
8. If there was a complete misunderstanding of income stated, the client can submit verification of income for a reconsideration of eligibility. If this is done within 30 days of the date of application, the case can be reinstated and if eligible, benefits go back to the date of application.
9. If the client asks for reconsideration between 31 and 60 days from the date of application, submits verification and is determined eligible, benefits will be pro-rated from the date the verifications were received in the second month period. A new application is not needed in either of those scenarios.
10. Case notes (MAXIS) stating that client verbally confirms over income during the interview (must be complete in order to avoid QC error).

Systems

- There are no system impacts.

Benefits

- Under current practice, case is pended for 30 days, which results in errors if not denied within the timeframe. FNS counts it an error if the worker denies the case a day early or a day late. The proposal would help reduce this particular error rate.
- Good customer service – clients should not have to submit verification of something they have already been told makes them ineligible. Most of the time, clients do not submit the requested verification when they have already been told they are not eligible.
- Client gets a clear notice of why the case is denied (over income or over assets), rather than failure to return requested verification.
- DHS will get more accurate data on why applications are denied, rather than the generic failure to return requested verifications.
- Process simplification – eligibility worker gets the case off their desk immediately – no more pending case and then having to remember to deny the case on the right day (has to pend for 30 days).
- Saves money in postage and forms for clients and eligibility entities by not having to send a request for verification. It also eliminates a pending notice right before the end of the 30-day period.
- Simplifies and streamlines processes.

Clients

- There are approximately 253,000 SNAP cases in Minnesota.

CCAP Option

1. Make no changes to CCAP policy in the 2013 Legislative session. CCAP will monitor the impact of this change in other programs, and will gather feedback from county CCAP staff and other partners.

2. Consider change for 2014 session based on this assessment.

Benefits

- Opportunity to gather additional input from counties on an issue about which they have not raised concerns with DHS CCAP staff.

Clients

- There are approximately 35,000 children and approximately 20,000 CCAP cases in an average month.

MFIP Option

1. Propose legislation for MFIP that mirrors the proposed SNAP process for both income and assets.
2. Implement process if approved by legislature.

Benefits

- Similar to SNAP

Clients

- There are approximately 43,000 family cash cases (MFIP and DWP).

MSA/GRH/GA Option

- Propose legislation and rule change that mirrors the SNAP process for both income and assets, with the exception of pro-rating benefits for MSA.

Benefits

- See SNAP

Considerations

- Ensure changes to MSA do not affect our MOE.
- The effect VerifyMN and other electronic verification processes will have on process.

Clients

- There are approximately 21,000 GA cases in Minnesota.
- There are approximately 19,000 GRH cases in Minnesota.
- There are approximately 30,000 MSA cases in Minnesota.

Health Care Option

1. No changes to Health Care policy are recommended until January 2014. Beginning January 1, 2014, electronic verification will be the primary source of verification when available. New rules for the MAGI population will allow self-attestation for some eligibility criteria. Alignment across all health care programs will be implemented to the extent possible. These changes are being discussed as part of the health care reform and system modernization initiatives.

2. Verification requirements are currently standard across health care programs for the most part. For medically-needy populations, it is not possible to deny eligibility for being over-income. It is also required that applicants be provided an opportunity to reduce assets to achieve eligibility when they are subject to an asset test. Creating new rules for some populations would add complexity to the health care program requirements, rather than streamlining and simplifying.

Benefits

- Similar to SNAP

Considerations

- Implementation of health care reform and new eligibility determination system
- Some functionality issues because of MMIS (for MinnesotaCare)
- This is a possibility because cases can be reopened much more easily after a denial.
- May not want to deny right away without addressing other things such as spenddown.
- May not want to deny right away for clients who have the opportunity to reduce assets.
- May want to concentrate on certain eligibility types such as AX (no spenddown, no assets).
- MinnesotaCare cannot begin until the month following the month in which eligibility is determined and a premium is paid. Reopening a case if it is determined that an enrollee was actually eligible would delay coverage.

Clients

- There are approximately 814, 000 health care clients.[1]

Combined Options

Option 1

1. Move forward with SNAP option
2. Move forward with MFIP option
3. Request legislation in a year for MSA, GRH, GA
4. Consider CCAP change for 2014 session. CCAP will monitor the impact of this change in other programs and will gather feedback from county CCAP staff and other partners.
5. Delay health care options pending implementation of health care reform and the new eligibility determination system.

Benefits

- It would allow us to conduct additional analysis to prepare for legislation.
- It would allow one program to move forward.
- It would be relatively easy to implement.

[1] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4932-ENG

Considerations

- Eligibility entities may apply SNAP policy to other programs.
- Does not realize full client service and worker goals to reduce workload for workers and confusion for clients.
- Impact of electronic verification system requirements on this process (VerifyMN).

Option 2

1. Move forward with SNAP option
2. Move forward with MFIP option
3. Request legislation this year for MSA, GRH, GA
4. Consider CCAP change for 2014 session. CCAP will monitor the impact of this change in other programs and will gather feedback from county CCAP staff and other partners.
5. Delay health care options pending implementation of health care reform and the new eligibility determination system.

Benefits

- This allows all cash and SNAP programs to be the same.
- Except for legislative language, it is relatively easy to implement.

Considerations

- It is difficult to get legislation prepared in time.
- There is lack of support for this option from some areas, pending deeper analysis of the policy.

Recommendations

Recommendations

It seems clear that a major reduction in required negative verifications would save time and cost to clients, improve the clarity of our feedback to clients, provide us with clearer data, reduce unnecessary work, reduce wait times and increase the efficiency of eligibility staff.

We recommend pursuing the Option 1.

Justification for the Recommendations

This would:

- Implement this process for programs that currently have legislative authority or have requested legislative authority, which will reduce confusion while providing applicants with better feedback as to why they were denied and still permit them to provide documentation demonstrating eligibility.
- Allow programs that do not have legislative authority, either pending or in place, to conduct the necessary analysis to bring legislation forward.
- Provide better data by differentiating more clearly between applicants who don't meet eligibility criteria and those who don't provide verification.
- Reduce unnecessary work by both clients and eligibility staff.
- Reduce wait times for clients by freeing up eligibility workers to concentrate on applicants who are more likely to be eligible.

- Reduce errors for denials
- Streamline processes and increase alignment across programs.

How will we know if this solution is successful?

- Increase in denials that indicate over income or over assets rather than failure to verify.

Appendices

Supporting documentation

Alternative estimates for implementation

Section 15
Alignment and Simplification of Program Policy and Procedures
Project Roles

Project Leadership

Article 9 Program Sponsor:	Kate Lerner and Stephanie Radtke
Project Sponsor:	Troy Mangan
Project Manager:	Julie Johnson

Business Owners Roles and Responsibilities

- Assist the project manager and sponsor with resolving issues and risks
- Allocate or secure needed resources
- Resolve organizational barriers
- Communicate with respective business areas
- Approve continuous process improvement model
- Approve other high-level deliverables
- Approve programs and other factors to be use in analysis
- Identify and approve opportunities for streamlining, simplification and alignment

Business Owner - Membership

Greg Poehling	MN.IT@DHS
Mark Toogood	Transition to Economic Stability
Karen Gibson	Health Care Eligibility and Access
Mary Orr	Community Partnerships and Child Care Services
Dan Papin	Washington County
Nicole Names	Pope County

Business Advisors and Project Team Members Roles and Responsibilities

Business advisors will also fill the role of project team members. They will assign people as needed for specialized work or that requires subject matter expertise.

- Develop and test continuous process improvement model
- Develop taxonomy or glossaries across programs
- Identify and record policy and procedures for business areas
- Gather input and feedback from partners and stakeholders on deliverables (e.g., counties, community partners, business area representatives, etc.)
- Identify and collaborate for streamlining, simplification and alignment
- Analyze, evaluate and recommend options for legislative report
- Draft and review legislative report
- Communicate with respective business areas

Patty Berry	MNIT@DHS, MMIS
Beth Grube	Transition to Economic Stability – Adults Cash
Karla Larsen	MNIT@DHS, Transition Support Systems

Section 15
Alignment and Simplification of Program Policy and Procedures Project Roles

Troy Mangan	Health Care Eligibility and Access
Bob Paulsen	DHS/Commerce
Elizabeth Roe	Community Partnerships and Child Care Services – Child Care Assistance Program
Deborah Schlick	Transition to Economic Supports – Families Cash
Dale Simonson	Transition to Economic Stability – SNAP
John Sellen	Hennepin County
Nancy Walker	Southwest HHS *(Lincoln, Lyon, Murray, Pipestone & Rock Counties)*
Dave Sayler	Wilkin County
Dale Parks	Crow Wing County
Jane Martin	Ramsey County
Marti Fischbach	Ramsey County
Teresa Saybe	MinnesotaCare Operations Tribes
Linda Nelson	DHS – Continuous Process Improvement
Sandy Carlton	HCA – Business Planning and Optimization *(consultant)*
Bonnie Martin	HCA – Communication Business analysis Data analysis