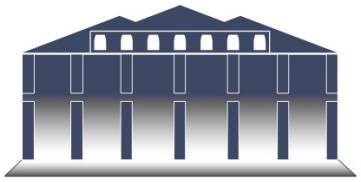
# Timeliness of Medicaid Eligibility Determinations Declined Due to Challenges Imposed by NC FAST and Affordable Care Act Implementation


**Final Report to the Joint Legislative Program Evaluation Oversight Committee**

**Report Number 2016-04**

**April 11, 2016**



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April 11, 2016

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Representative Craig Horn, Co-Chair, Joint Legislative Program Evaluation Oversight Committee

North Carolina General Assembly
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16 West Jones Street
Raleigh, NC 27601

Honorable Co-Chairs:

The 2013–15 Program Evaluation Division work plan directed the division to examine the effectiveness and efficiency of Medicaid eligibility determinations.

I am pleased to report that the Department of Health and Human Services and the county departments of social services cooperated with us fully and were at all times courteous to our evaluators during the evaluation.

Sincerely,

John W. Turcotte
Director

PROGRAM EVALUATION DIVISION
NORTH CAROLINA GENERAL ASSEMBLY

April 2016 Report No. 2016-04

# Timeliness of Medicaid Eligibility Determinations Declined Due to Challenges Imposed by NC FAST and Affordable Care Act Implementation

## Summary

The Joint Legislative Program Evaluation Oversight Committee directed the Program Evaluation Division to examine the effectiveness and efficiency of Medicaid eligibility determinations. In North Carolina, county departments of social services (county DSS offices) perform Medicaid eligibility determinations under the supervision of the Department of Health and Human Services (DHHS).

**County DSS offices failed to meet North Carolina's timeliness standard for processing Medicaid applications in Fiscal Years 2013–14 and 2014–15.** North Carolina's timeliness performance standard requires that Medicaid applications be processed within 45 days. The statewide timeliness percentage was 70% in Fiscal Year 2013–14 and 61% for Fiscal Year 2014–15. No county DSS office met its individual timeliness standard for Fiscal Year 2014–15.

**The decrease in the statewide timeliness percentage in Fiscal Years 2013–14 and 2014–15 coincided with a workload increase for county DSS offices.** The 43% increase in Medicaid applications processed by county DSS offices during Fiscal Year 2013–14 coincided with a 30% decrease in statewide timeliness percentage from Fiscal Year 2012–13.

**NC FAST implementation and enactment of the Affordable Care Act created conditions that affected the workload of county DSS offices and posed other challenges.** NC FAST implementation and changes to Medicaid eligibility policies mandated by ACA implementation increased the Medicaid workload and created backlogs that decreased the timeliness percentages for most county DSS offices.

**NC FAST offers DHHS the opportunity to proactively manage and monitor county DSS offices; however, the department needs additional resources and authority to hold counties accountable.** DHHS does not have explicit state authority to rescind a county DSS office's authorization to administer Medicaid eligibility or to compel a county to expend resources if an office fails to comply with state timeliness performance standards.

Based on these findings, the General Assembly should

- enact state law authorizing DHHS to intervene and take over county administration of Medicaid eligibility determinations when warranted;
- direct DHHS to report on the timeliness of Medicaid eligibility determinations for Fiscal Years 2015–16 and 2016–17; and
- appropriate $300,000 to DHHS to support utilization of NC FAST data for performance measurement and evaluation.

# Purpose and Scope

At its March 16, 2015 meeting, the Joint Legislative Program Evaluation Oversight Committee directed the Program Evaluation Division to evaluate the effectiveness and efficiency of Medicaid eligibility determinations in North Carolina. The directive requested that the Division study the accuracy, consistency, and timeliness of Medicaid eligibility determinations made by county departments of social services, including an examination of their processes, management, and performance. Throughout this report, county departments of social services will be referred to as county DSS offices.

Subsequently, the General Assembly enacted legislation requiring the Office of the State Auditor (OSA) to complete an examination of the timeliness, accuracy, and consistency of Medicaid eligibility determinations.[1] To prevent duplication of effort, the Program Evaluation Division and OSA agreed to focus on separate components, with OSA concentrating on the accuracy of determinations. OSA staff plan to review a sample of Medicaid cases processed during Fiscal Year 2015–16 to determine whether the Medicaid eligibility determinations for these cases were performed accurately and in a timely manner.

This evaluation focused on timeliness and was guided by four research questions:

1. How does North Carolina perform the Medicaid eligibility determination process?
2. How accurate, consistent, and timely are Medicaid eligibility determinations performed by county DSS offices?
3. How do county DSS offices ensure the accuracy, consistency, and timeliness of the Medicaid eligibility determination process?
4. How does the Department of Health and Human Services (DHHS) ensure the accuracy, consistency, and timeliness of the Medicaid eligibility determination process?

The Program Evaluation Division collected and analyzed data from numerous sources, including

- interviews with DHHS staff that oversee and monitor the performance of the Medicaid eligibility determination process by county DSS offices;
- a review of North Carolina and federal laws, regulations, and policies related to Medicaid eligibility and state supervision and county administration of public assistance programs;
- interviews with DHHS staff that manage the NC FAST (North Carolina Families Accessing Services through Technology) system and the Client Services Data Warehouse (CSDW);
- a review of NC FAST and Medicaid eligibility policy documentation provided to county DSS offices;
- a survey of county DSS directors;
- a survey of county Medicaid eligibility workers;
- site visits to 15 county DSS offices including observation of eligibility workers performing Medicaid eligibility determinations;

[1] Session Law 2015-7.

- observation of Medicaid and NC FAST training provided by DHHS at the 2015 Social Services Institute;
- analysis of Medicaid enrollment, financial information, and operational data for the 100 county DSS offices; and
- analysis of the timeliness and sources of Medicaid applications and recertifications processed by county DSS offices during Fiscal Years 2011–12 through 2014–15.

## Background

**Eligibility for Medicaid benefits is determined primarily by federal requirements.** However, states do have the option to choose whether to extend Medicaid benefits to certain populations. For example, North Carolina has chosen not to extend Medicaid benefits to adults under the age of 65 with incomes at or below 133% of the Federal Poverty Level who were otherwise eligible to receive benefits.

Generally, Medicaid benefits in North Carolina may be available to people who are

- age 65 or older;
- blind or disabled;
- infants and children under the age of 21;
- low-income pregnant women, individuals, and families;
- receiving Work First Cash Assistance;
- receiving State/County Special Assistance for the Aged or Disabled;
- in need of long-term care; or
- receiving Medicare.

Individuals meeting one of these eligibility categories must also

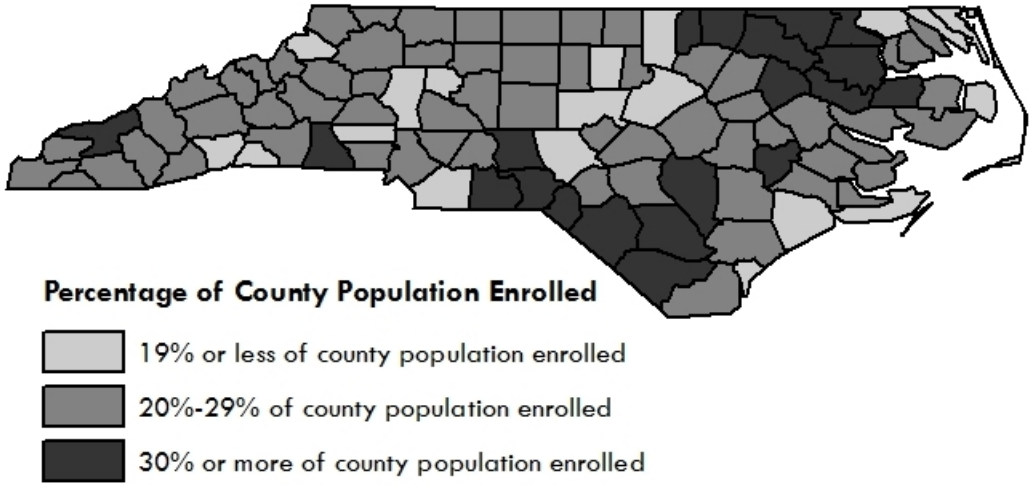
- be a US citizen or provide proof of eligible immigration status,[2]
- live in North Carolina, and
- have a Social Security number or have applied for one.

Automatic Medicaid eligibility occurs when individuals receive benefits from the federal Supplemental Security Income (SSI) program. Detailed information describing income and asset requirements for the different categories of Medicaid eligibility is located in Appendix A.

**The percentage of county population enrolled in Medicaid in North Carolina ranges from 10% to 40**%.[3] During Fiscal Year 2014–15, the Medicaid and Health Choice programs enrolled 2,289,777 individuals, or 22% of North Carolina's 2015 population. Exhibit 1 illustrates how Medicaid enrollment was distributed across the 100 counties.

[2] Individuals only applying for emergency services are not required to provide documentation of immigration status.
[3] See Appendix B for Medicaid enrollment by county.

## Exhibit 1: Medicaid Enrollment Ranges from 10% to 40% of County Population




*Source: Program Evaluation Division based on Fiscal Year 2014–15 Medicaid and Health Choice unduplicated enrollment data from the Department of Health and Human Services and 2015 county population data from the State Data Center.*

**The Medicaid program operates as a cooperative venture jointly funded by the federal and state governments.** States administer the program on a day-to-day basis within broad federal guidelines and receive federal matching funds for the cost of providing covered services and administering the program. North Carolina's Medicaid State Plan designates the Department of Health and Human Services (DHHS) as the single state agency responsible for administering Medicaid. The Division of Medical Assistance (DMA) is the DHHS division responsible for managing the day-to-day operation of the Medicaid program. The federal government supports state Medicaid administration by providing matching funds and establishing general programmatic guidelines. State Medicaid programs must operate within federal guidelines, but states retain broad flexibility in operating their programs.

**In North Carolina, eligibility for Medicaid and other public assistance programs is determined through a state-supervised and county-administered system.** Most states operate a state-administered social services system in which counties have little or no role in administering or financing state and federal programs. North Carolina is one of 11 states that provide social services programs through a state-supervised and county-administered system. Of these 11 states, 8 delegate the Medicaid eligibility determination process to county social services agencies.

**North Carolina's system reflects a historical emphasis on county administration of social services programs.** Since 1917, the State has used a state-supervised and county-administered system for public assistance programs and other social services programs. Such public assistance programs include Work First (formerly known as Aid to Families with Dependent Children), Food and Nutrition Services, and Special Assistance. The North Carolina Medicaid Program was added in 1970 as a federal and state entitlement program to purchase health and long-term care services for eligible low-income individuals. The N.C. Health Choice for Children Program was authorized in 1998 to provide health coverage for children. The Department of Health and Human Services (DHHS) supervises

county DSS offices that administer these state and federal public assistance programs.

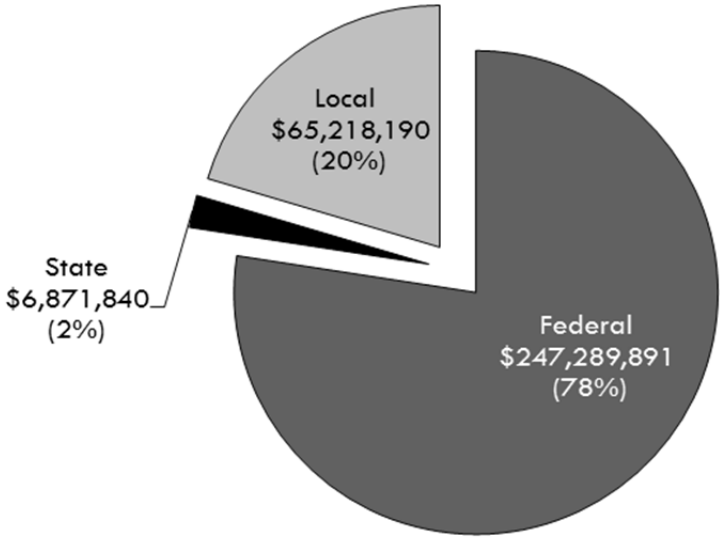
**Counties paid most of the nonfederal share for the Medicaid eligibility determination process during Fiscal Year 2014–15.**[4] During Fiscal Year 2014–15, total expenditures for the Medicaid program were $13.7 billion, with $607 million expended for administrative activities (4% of total Medicaid expenditures). Of the $607 million spent on administration, $319.4 million paid for Medicaid enrollment, or 53% of total expenditures for administration.

As shown in Exhibit 2, counties pay all but 2% of the nonfederal share of Medicaid enrollment costs.[5] Counties spent $65.2 million during Fiscal Year 2014–15 to support Medicaid enrollment activities.[6] The State pays for the remainder of the nonfederal share, which goes towards operating the enrollment and eligibility determination system and providing state oversight of the Medicaid enrollment process.[7]

Exhibit 2

Counties Paid Most of the Nonfederal Share for the Medicaid Eligibility Determination Process During Fiscal Year 2014–15

**Total Expenditures for Medicaid Eligibility Determinations = $319.4 million**




*Source: Program Evaluation Division based on Medicaid financial information from the Department of Health and Human Services.*

**The Centers for Medicare/Medicaid Services maintain requirements that state Medicaid programs must follow with respect to enrollment.** States are required to ensure that all individuals who want to apply for Medicaid coverage have the opportunity to do so and must furnish Medicaid coverage to applicants who are eligible with "reasonable promptness,"

[4] See Appendix C for financial information for each county DSS office.
[5] Counties are responsible for paying the nonfederal share of their cost for Medicaid administration, which ranges from 25% to 50% of the total cost.
[6] The Centers for Medicare/Medicaid Services authorized a 75% Federal Financial Participation rate for activities directly related to processing Medicaid eligibility effective January 1, 2014. All other Medicaid administrative activities have a 50% Federal Financial Participation rate.
[7] The Centers for Medicare/Medicaid Services pays an enhanced 90% Federal Financial Participation rate for the modernization of enrollment and eligibility systems and a 75% Federal Financial Participation rate for operation and maintenance of the systems. All other Medicaid administrative costs have a 50% Federal Financial Participation rate.

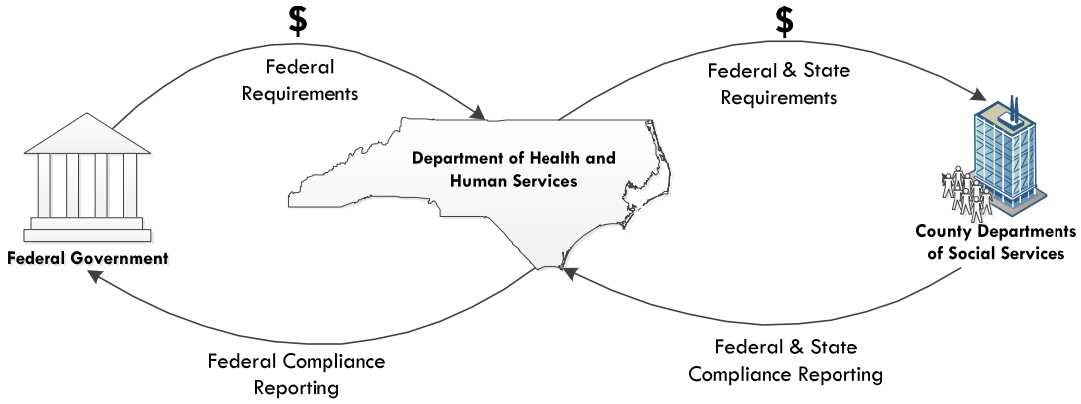
which is defined as being within 45 days for most Medicaid applications. States must limit their errors in making determinations that individuals are eligible for Medicaid and must provide "safeguards" to ensure that eligibility for coverage will be determined "in a manner consistent with simplicity of administration and the best interests of recipients." States cannot delegate the responsibility for making final eligibility determinations to private contractors, but it may delegate this task to state or local welfare agency personnel.

**County DSS offices must abide by federal and state rules and requirements in administering the Medicaid program.** DHHS supervises county administration of Medicaid eligibility determination by

- supplying federal funds to counties;
- providing technology to support eligibility determinations;
- issuing state and federal policies, regulations, and guidance;
- monitoring for compliance with federal and state requirements; and
- providing technical assistance and training to county DSS offices to assist them with program administration.

Even though North Carolina has chosen to delegate the Medicaid eligibility determination process to counties, the federal government holds state government responsible for complying with federal requirements and conditions. There is no direct relationship between the federal government and counties for Medicaid program administration; as a result, the State serves as the intermediary between counties and the federal government. The State must ensure county DSS offices are in compliance with federal requirements as a condition of receiving federal funds. Exhibit 3 shows how the federal government, state government, and county DSS offices interact with each other.

Exhibit 3: The Department of Health and Human Services Serves as the Intermediary Between the Federal Government and County DSS Offices




*Source: Program Evaluation Division based on interviews with staff from the Department of Health and Human Services and Saxon's Social Services in North Carolina (2008).*

**County DSS offices perform four major tasks for the eligibility determination process:**

- **Applications.** Medicaid eligibility workers must determine whether Medicaid applicants are initially eligible to receive Medicaid benefits. This process includes receiving and verifying information (i.e. income and assets, citizenship, residency) provided by the Medicaid applicant. Then the eligibility worker must apply the appropriate Medicaid policy and rules to determine whether the applicant is eligible or ineligible for Medicaid benefits and notify the applicant of their eligibility status (eligible or ineligible). If the individual is eligible for Medicaid, the worker must authorize the Medicaid benefits.
- **Recertification**. Medicaid eligibility must be recertified periodically to determine whether a recipient continues to qualify for Medicaid benefits. This process involves reviewing and verifying recipient information to determine whether changes have occurred that would require termination of Medicaid benefits. After the review is completed, the eligibility worker notifies the applicant of their eligibility status (eligible or ineligible). If the recipient is still eligible for Medicaid, the worker must reauthorize the Medicaid benefits for the appropriate time period.
- **Appeals.** Federal law requires that states offer Medicaid applicants and recipients the opportunity to appeal their eligibility decision if determined ineligible for Medicaid benefits. County DSS offices must notify Medicaid applicants and recipients that they can appeal their eligibility determination. County DSS offices also process the initial appeal to make sure the determination to deny eligibility was accurate, unless the appeal is related to denial of disability, which is handled by the Division of Disability Determination.[8]
- **Changes.** Medicaid recipients are required to notify the Medicaid program when changes in their circumstances occur. County DSS offices process these changes as reported. Examples of changes include having a new address, changes in case size (i.e. death of a spouse), and other changes in family circumstances. If the changes potentially affect an individual's eligibility, the worker must determine whether the individual is still eligible for Medicaid benefits.

County DSS offices also answer questions about the Medicaid program and assist Medicaid recipients with accessing medical services.

This report evaluates how recent changes to Medicaid eligibility policies and the determination process have affected the timeliness, accuracy, and consistency of Medicaid eligibility determinations performed by county DSS offices. In addition, this report considers how DHHS supports and oversees county DSS offices as they perform Medicaid enrollment for North Carolina residents.

[8] Medicaid applicants and recipients have the option to appeal their denial or termination of benefits to the State if they disagree with the outcome of the local appeal process.

# Findings

**Finding 1: County DSS offices failed to meet North Carolina's timeliness standard for processing Medicaid applications in Fiscal Years 2013–14 and 2014–15.**

Federal regulations require state Medicaid programs to establish timeliness standards, which refer to the maximum period of time within which every Medicaid applicant is entitled to receive a determination of Medicaid eligibility. A state's timeliness standard cannot exceed 45 days for most Medicaid applicants.[9] During site visits, county DSS staff repeatedly mentioned the benefits of processing Medicaid applications in a timely manner and according to established standards. The primary benefit mentioned by county DSS offices was that an applicant would receive benefits within a reasonable time period and not forgo necessary health services.

The Department of Health and Human Services (DHHS) monitors county DSS office performance of Medicaid eligibility determinations using two indicators. Both standards are adjusted to exclude days when county DSS offices are closed and not required to process Medicaid applications (i.e., weekends and holidays).

- **Monthly Average Processing Time.** This indicator measures the average number of days to process Medicaid applications each month. The federal performance standard is 45 days for most Medicaid applications.
- **Percent Processed Timely.** This indicator measures the percentage of applications processed in a timely manner. North Carolina has established a performance standard of 85% or 90% based on county size.

**The statewide timeliness percentage for Medicaid applications processed by the 100 county DSS offices was 70% in Fiscal Year 2013–14, and subsequently declined to 61% in Fiscal Year 2014–15.** The Program Evaluation Division examined the timeliness of Medicaid eligibility determinations by county DSS offices for a four-year time period (Fiscal Years 2011–12 through 2014–15).[10] Historically, county DSS offices have performed well above the State's standards. As Exhibit 4 shows, the statewide percentage for timely processing of Medicaid applications during Fiscal Year 2011–12 was 97%, well above the 85% or 90% standard. The percentage declined to 87% in Fiscal Year 2012–13, but was still above North Carolina's 85% performance standard for smaller counties. Then, in Fiscal Year 2013–14, the statewide timeliness percentage decreased to 70%. Performance further declined to 61% during Fiscal Year 2014–15.

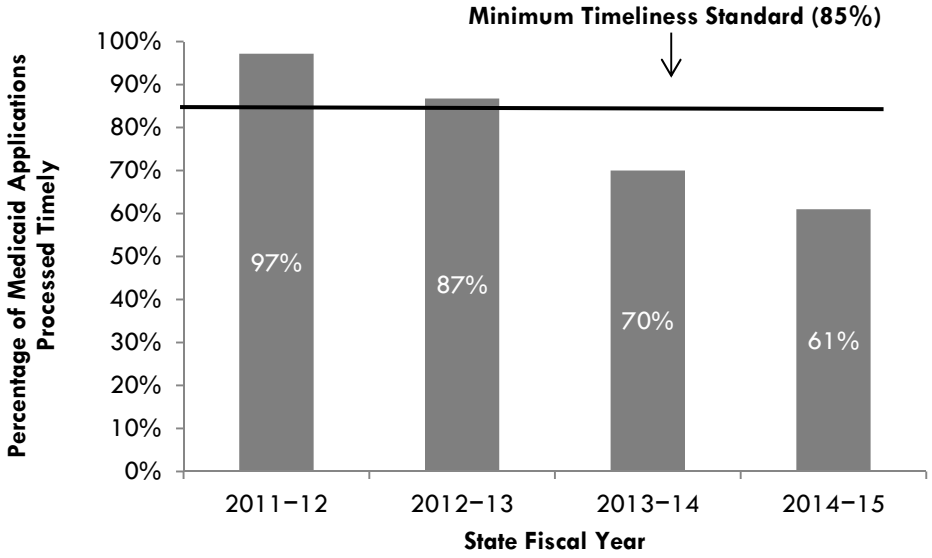
[9] Medicaid applications for disabled individuals are to be processed within 90 days.

[10] For Fiscal Years 2011–12 and 2012–13, the Program Evaluation Division used timeliness percentage data from the Eligibility Information System for each county DSS office. To compute the annual Percent Processed Timely for Fiscal Years 2013–14 and 2014–15, the Program Evaluation Division utilized the total number of applications processed and the annual adjusted Percent Processed Timely by county DSS offices based on three categories: applications processed within (1) EIS, (2) NC FAST's Medicaid MA module, and (3) NC FAST's Medicaid MAGI module. PED calculated the total number of applications for each of these three categories, and subsequently multiplied the total number of applications for each category by its respective Percent Processed Timely. For example, the total number of EIS applications was multiplied by the percentage of EIS applications that were timely. This procedure provided a total number of timely applications by category, which was then combined across the three categories. This sum of timely applications processed was then divided by the total number of applications processed in the respective fiscal year to determine each county's Percent Processed Timely.

The statewide timeliness percentage for processing Medicaid applications has decreased 30% since Fiscal Year 2012–13. As the exhibit shows, the statewide percentage of Medicaid applications processed in a timely manner has not met the minimum standard of 85% for the previous two fiscal years.

Exhibit 4:

Only 61% of North Carolina's Medicaid Applications Were Processed in a Timely Manner in Fiscal Year 2014–15




Note: Percentage of Medicaid Applications Processed Timely is based on the adjusted Percent Processed Timely for each fiscal year. Fifty-two counties are subject to an 85% processed timely standard, and 48 counties are subject to the higher 90% processed timely standard.

*Source: Program Evaluation Division based on data from EIS and NC FAST systems.*

**The number of county DSS offices meeting their respective timeliness standards dropped from all to none during the 4-year time period.** As shown in Exhibit 5, Program Evaluation Division analysis of timeliness data by fiscal year reveals that all county DSS offices met their standard in Fiscal Year 2011–12. However, in Fiscal Year 2012–13, the number of counties meeting their timeliness standard dropped to 49 offices. More concerning is that only four county DSS offices met their timeliness standard in Fiscal Year 2013–14, and no county DSS office met its timeliness standard during 2014–15. The statewide timeliness percentage for Fiscal Year 2014–15 was only 61% because the individual county DSS office timeliness percentages ranged from a low of 38% to a high of 83%. During Fiscal Year 2014–15, only 4 county DSS offices had timeliness percentages equal to or greater than 80% and 21 county DSS offices had timeliness percentages below 60%.[11]

[11] See Appendix D for annual timeliness percentages for the 100 county DSS offices for Fiscal Years 2011–12 through 2014–15.

## Exhibit 5: Since Fiscal Year 2011–12, the Number of County DSS Offices Meeting Timeliness Standards Has Dropped from All to None

| Fiscal Year | Number of County DSS Offices Meeting Timeliness Standard | Statewide Timeliness Percentage | Lowest County DSS Office Timeliness Percentage | Highest County DSS Office Timeliness Percentage |
|---|---|---|---|---|
| 2011–12 | 100 | 97% | 90% | 100% |
| 2012-13 | 49 | 87% | 69% | 94% |
| 2013–14 | 4 | 70% | 51% | 91% |
| 2014–15 | 0 | 61% | 38% | 83% |

Notes: Percent Processed Timely based on adjusted processing time. See Appendix D for individual county DSS office timeliness percentages for Fiscal Years 2011–12 through 2014–15.

*Source: Program Evaluation Division based on data from the Eligibility Information System (EIS) and NC FAST.*

During this time period, county DSS offices dealt with an increased workload and had to adapt to systemic and procedural changes to the Medicaid eligibility determination process. Finding 2 examines the increased workload for county DSS offices. Finding 3 discusses the systemic and procedural changes that affected the workload, and by extension the timeliness performance, of these offices.

**Finding 2. The decrease in the statewide timeliness percentage for processing Medicaid applications in Fiscal Years 2013–14 and 2014–15 coincided with a workload increase for county DSS offices.**

**The number of Medicaid applications processed by county DSS offices increased during Fiscal Year 2013–14 after declining during the previous two fiscal years.** As shown in Exhibit 6, the number of Medicaid applications processed by county DSS offices increased by 43% from Fiscal Year 2012–13 to Fiscal Year 2013–14. The number of Medicaid applications processed in Fiscal Year 2014–15 decreased 13% in comparison to Fiscal Year 2013–14, but was still 24% higher than the number of Medicaid applications processed in Fiscal Year 2012–13.

Exhibit 6:

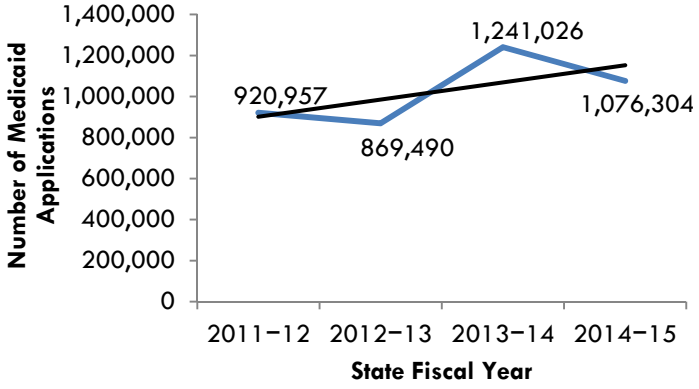
The Number of Medicaid Applications Processed by County DSS Offices Increased by 43% from Fiscal Year 2012–13 to Fiscal Year 2013–14

| Fiscal Year | Number of Medicaid Applications | Annual Percent Change |
|---|---|---|
| 2010–11 | 1,028,454 | – |
| 2011–12 | 920,957 | -10% ↓ |
| 2012–13 | 869,490 | -6% ↓ |
| 2013–14 | 1,241,026 | 43% ↑ |
| 2014–15 | 1,076,304 | -13% ↓ |

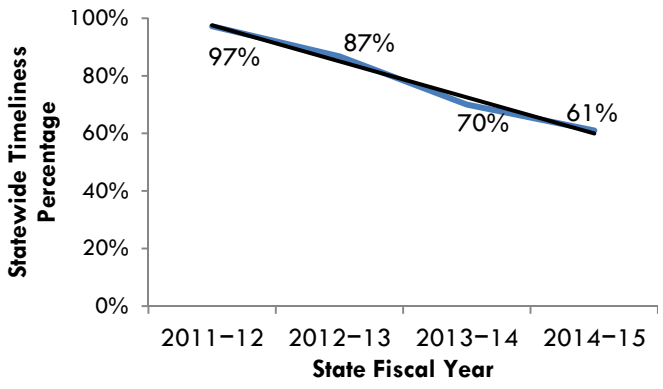
*Source: Program Evaluation Division based on Medicaid application data from the Eligibility Information System (EIS) and NC FAST.*

**The increase in Medicaid applications processed by county DSS offices coincides with the decrease in statewide timeliness percentage over the same time period.** As discussed in Finding 1, the statewide timeliness percentage decreased 30% in Fiscal Year 2014–15 when compared to Fiscal Year 2012–13. As Exhibit 6 shows, the Medicaid application workload increased 43% from Fiscal Year 2012–13 to Fiscal Year 2013–14. Exhibit 7 compares the increase in Medicaid applications processed by county DSS offices with the decrease in the statewide timeliness percentage. The trend lines for each graph show that increase in slope for the Medicaid applications coincides with the decrease in slope for the statewide timeliness percentage. Based on this comparison, the Program Evaluation Division concluded that increased Medicaid application workload was a major cause of the decline in statewide timeliness percentage during fiscal years 2013–14 and 2014–15.

Exhibit 7: The Increase in the Number of Medicaid Applications Processed by County DSS Offices Coincides with the Decrease in Timeliness




The slope of the trend line shows that the number of Medicaid applications processed is **increasing**.




The slope of the trend line shows that the statewide timeliness percentage is **decreasing**.

*Source: Program Evaluation Division based on Medicaid application and timeliness data from the Eligibility Information System (EIS) and NC FAST.*

**The statewide number of Medicaid applications processed per Medicaid eligibility worker increased 41% from Fiscal Year 2012–13 to Fiscal Year 2013–14.** The Program Evaluation Division calculated the statewide number of Medicaid applications processed per Medicaid full-time equivalent employee (FTE) for county DSS offices for Fiscal Years 2011–12 through 2014–15. The number of applications per FTE indicates the workload for employees processing Medicaid applications. As shown in Exhibit 8, the total Medicaid applications per Medicaid FTE grew from 224 to 316 applications from Fiscal Year 2012–13 to Fiscal Year 2013–14. Among the 100 county DSS offices, the number of Medicaid applications processed per Medicaid FTE ranged from 77 to 585 in Fiscal Year 2013–14 and from 50 to 342 in Fiscal Year 2014–15.

Exhibit 8:

The Number of Medicaid Applications Processed per Medicaid FTE Increased by 41% from Fiscal Year 2012–13 to Fiscal Year 2013–14

| | Fiscal Year | | | |
|---|---|---|---|---|
| | **2011–12** | **2012–13** | **2013–14** | **2014–15** |
| **Total Medicaid Applications** | 920,957 | 869,490 | 1,241,026 | 1,076,304 |
| **Total Medicaid FTE** | 3,747 | 3,885 | 3,929 | 5,263 |
| **Percent Change in Medicaid FTE** | – | 4% | 1% | 34% |
| **Total Medicaid Applications Processed per Medicaid FTE** | 246 | 224 | 316 | 204 |
| **Percent Change in Medicaid Applications per Medicaid FTE** | – | -9% | 41% | -35% |
| **Statewide Timeliness Percentage** | 97% | 87% | 70% | 61% |

Notes: FTE is the acronym for full-time equivalent employee.

*Source: Program Evaluation Division based on financial and application information from the Department of Health and Human Services.*

The Program Evaluation Division found that there is a statistically significant correlation between Medicaid applications processed per Medicaid FTE and the timeliness of each county DSS office.[12] Further analysis reveals that as the number of Medicaid applications each employee processes increases by one application, the Percent Processed Timely by the county DSS office decreases by .04%.[13] For example, an increase of 25 Medicaid applications processed per FTE would result in a 1% decrease in timeliness. One potential explanation for this finding is that a greater number of applications processed per FTE could indicate inadequate staff resources to process Medicaid applications in a timely manner.

**The number of Medicaid applications processed per Medicaid FTE subsequently declined 35%, or 112 applications per FTE, from Fiscal Year 2013–14 to Fiscal Year 2014–15.** This decline was caused by two factors:

- a 13% decline in the number of Medicaid applications processed (See Exhibit 6) and

[12] The correlation was statistically significant for Fiscal Year 2014–15 ($p < .0001$).
[13] The number of Medicaid applications per Medicaid FTE was a statistically significant predictor for Fiscal Year 2014–15 ($p < .05$).

- a 34% increase in the number of county DSS Medicaid FTE relative to Fiscal Year 2013–14.

County DSS offices increased the number of Medicaid FTE during Fiscal Year 2014–15 because the Federal Financial Participation (FFP) rate for Medicaid eligibility activities performed in NC FAST increased from 50% to 75%. This increase provided county DSS offices the opportunity to hire more permanent or temporary Medicaid eligibility staff without increasing county expenditures, and as a result county DSS offices utilized 1,334 more Medicaid FTE during Fiscal Year 2014–15 in comparison to Fiscal Year 2013–14.

However, the statewide timeliness percentage declined 9 percentage points from 70% to 61%, even after the large increase in the number of Medicaid FTE utilized by county DSS offices. The further decline in the statewide timeliness percentage likely reflects the learning curve for new Medicaid eligibility workers who must be trained before they are effective and efficient at Medicaid eligibility determinations. The statewide timeliness percentage should begin improving in Fiscal Year 2015–16 after new Medicaid eligibility workers are fully trained.

**In summary, increased workload affected the timeliness of Medicaid applications processed by county DSS offices during Fiscal Years 2013–14 and 2014–15.** The 43% increase in Medicaid applications processed by county DSS offices during Fiscal Year 2013–14 coincided with the 30% decrease in statewide timeliness percentage over the same time period. The statewide number of Medicaid applications processed per Medicaid eligibility worker also increased 41% from Fiscal Year 2012–13 to Fiscal Year 2013–14.

### Finding 3. NC FAST implementation and enactment of the Affordable Care Act created conditions that affected the workload of county DSS offices and posed other challenges.

As discussed in Findings 1 and 2, the decrease in the timeliness for processing Medicaid applications during Fiscal Years 2013–14 and 2014–15 coincided with an increase in the number of Medicaid applications processed by county DSS offices. Based on discussions with county DSS directors and Department of Health and Human Services (DHHS) staff, the Program Evaluation Division identified two circumstances occurring simultaneously during Fiscal Years 2013–14 and 2014–15 that affected workload and timeliness:

- implementation of the NC FAST system that had to be expedited to meet the requirements of the Affordable Care Act, and
- initiation of new federal Medicaid eligibility determination policy required by the Affordable Care Act effective January 1, 2014.[14]

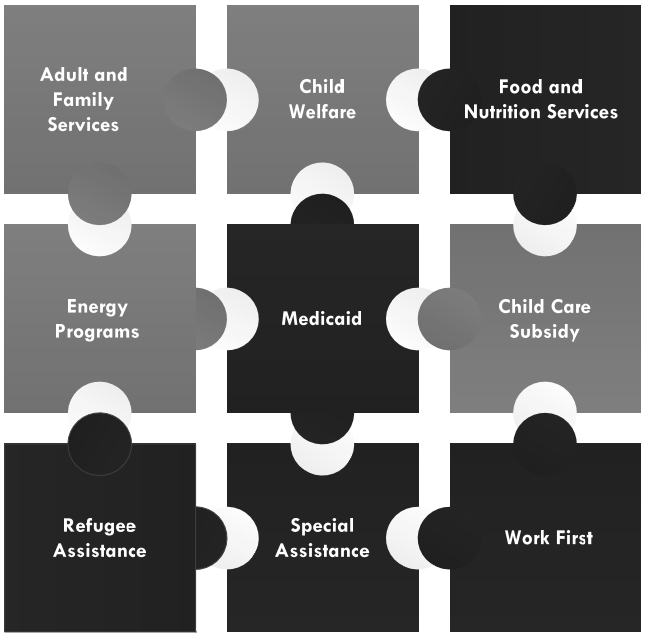
**The NC FAST system delivers state economic benefits and human services at the county level by offering an integrated, cross-functional service delivery approach.** DHHS began developing the North Carolina Families Accessing Services through Technology (NC FAST) system in 2003

[14] The Affordable Care Act refers to two pieces of federal law: the Patient Protection and Affordable Care Act (P. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P. L. 111-152).

and contracts for its development were awarded in 2008. Ultimately, NC FAST will replace 19 legacy systems and link nine programs providing economic benefits and social services for families. As Exhibit 9 shows, county DSS offices are currently using NC FAST to process eligibility determinations for Medicaid and four other economic benefit programs. The state and federal business rules for Medicaid and other economic benefit programs are built into the system, replacing the paper-based eligibility determination process used previously. NC FAST will share client data across the nine programs and the 100 counties, making it easier to provide services to families as their needs change or they move to a different county.

Exhibit 9

NC Fast Will Replace 19 Legacy Systems and Link 9 Economic Benefits and Social Services for Families




Note: Programs shaded in black are currently using NC FAST for eligibility determination. The NC FAST module for the Energy Assistance and Child Care Subsidy Programs will be implemented in 2016, and the modules for Child Welfare Services and Adult and Family Services will be implemented in 2017.

*Source: Program Evaluation Division based on information from the Department of Health and Human Services.*

**The implementation of the Affordable Care Act altered the NC FAST schedule.** The federal Affordable Care Act (ACA) was enacted in 2010. The law requires states to develop consumer-friendly enrollment processes for Medicaid and children's health insurance programs that coordinate with HealthCare.gov. In general, the Affordable Care Act compelled North Carolina to

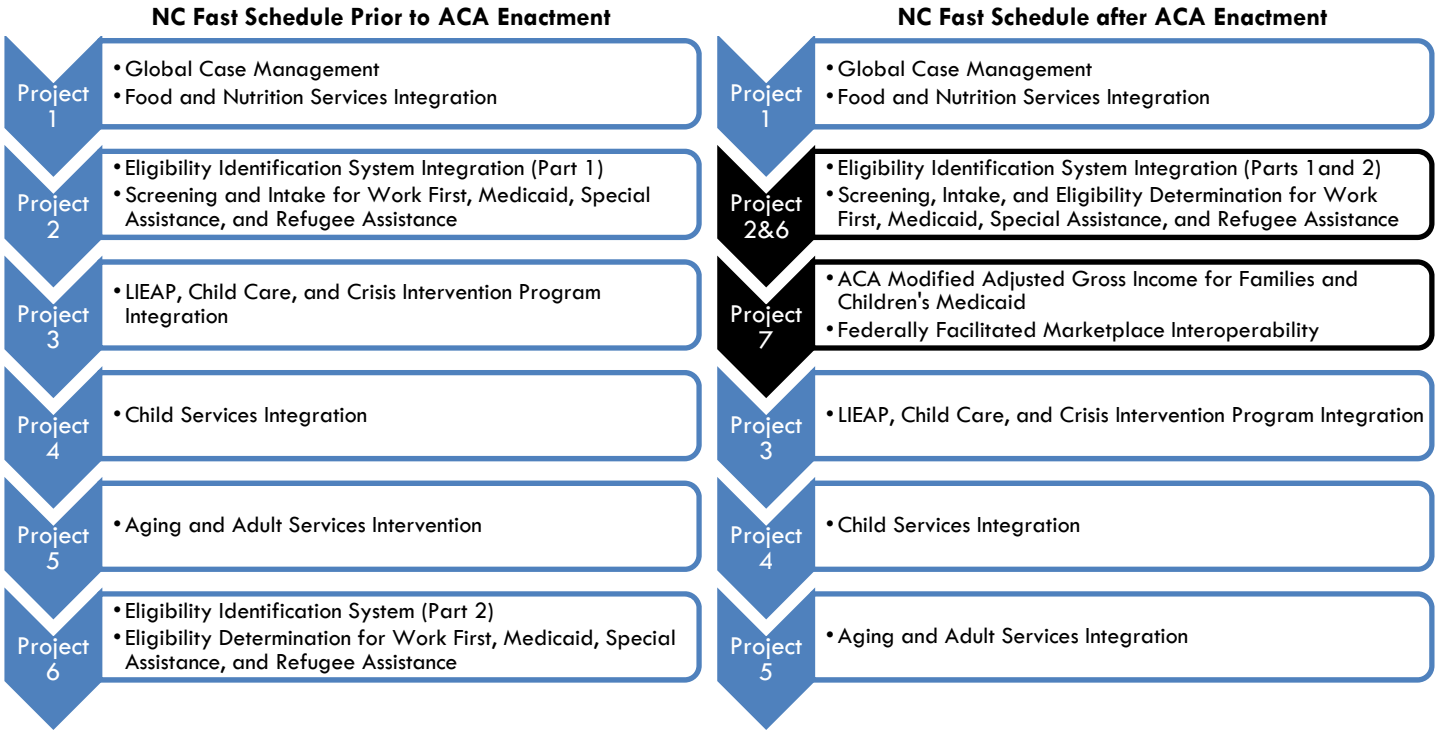
- create an enrollment system that ensures applicants are screened for and enrolled in the appropriate Medicaid program, with minimal collection of information and documentation;
- coordinate efforts between Medicaid and HealthCare.gov;
- operate a streamlined enrollment process and foster administrative simplification by using uniform income rules forms as well as paperless verification procedures; and
- use technology-enabled web portals to securely exchange and utilize electronic data to support eligibility determinations.

All states must meet these requirements even if they choose not to expand their Medicaid program or operate a State Health Exchange. To assist with meeting these requirements, the federal government authorized enhanced Medicaid funding for the development and operation of eligibility and enrollment systems. This enhanced funding has paid for 72% of the $348.6 million cost to develop the NC FAST system through December 2015.

**The federal ACA requirements caused DHHS to alter implementation plans for NC FAST to meet the October 1, 2013 ACA deadline.** When the ACA became law, DHHS was already developing the NC FAST system for determining eligibility and delivering state economic benefits and social services, including Medicaid, at the county level. The initial schedule for NC FAST anticipated six projects, with the eligibility determination module for Medicaid and other economic benefits scheduled as the sixth and final project. To meet the ACA implementation date of October 1, 2013, DHHS was compelled to alter the NC FAST project schedule (Exhibit 10 shows the original and revised NC FAST schedules).

First, Projects 2 and 6 were combined into a single project. This adjustment meant that all aspects of the Eligibility Information System integration including screening, intake, and eligibility determination for Medicaid and other public assistance programs had to be designed, built, and implemented at the same time. DHHS also added Project 7 to accommodate ACA requirements that the Medicaid and Health Choice Programs use Modified Adjusted Gross Income (MAGI) to determine eligibility for families and children and that NC FAST be able to interface with HealthCare.gov. Project 7 was scheduled to be designed, built, and implemented concurrently with the combined Project 2&6.

## Exhibit 10: DHHS Altered the NC FAST Implementation Schedule to Meet ACA Requirements



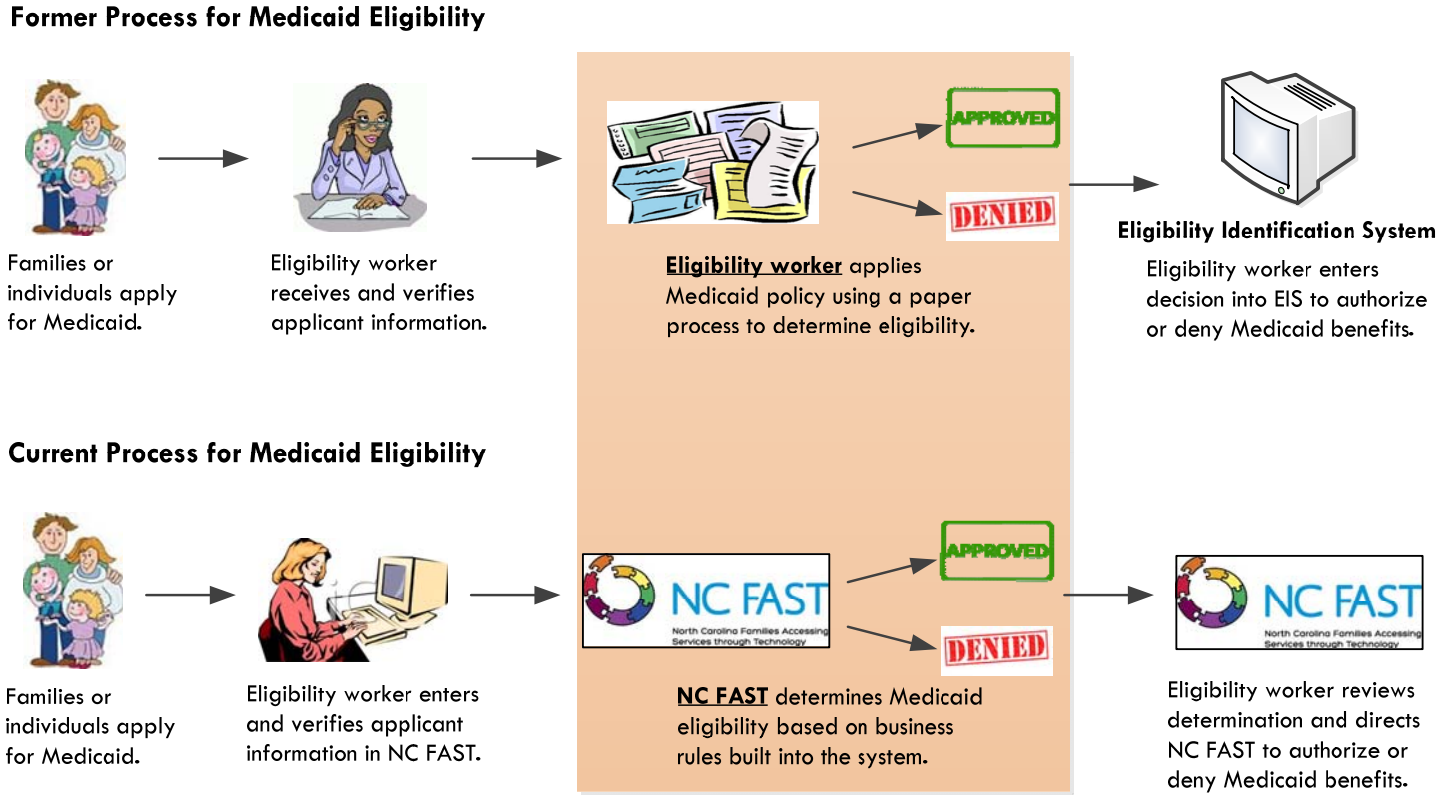

Note: LIEAP is the acronym for Low-Income Energy Assistance Program.

*Source: Program Evaluation Division based on NC FAST scheduling information from the Department of Health and Human Services.*

**Implementation of NC FAST changed how eligibility workers determined Medicaid eligibility.** Before NC FAST implementation, a Medicaid eligibility worker performed eligibility determinations using a paper-based process. The worker received and verified applicant information, applied Medicaid policy to determine an applicant's eligibility to receive Medicaid, and entered the determination into the Eligibility Information System (EIS). The eligibility worker had to know and understand Medicaid policy in order to determine whether an applicant was eligible for Medicaid. As shown in Exhibit 11, NC FAST changes how a worker determines Medicaid eligibility.

The eligibility worker now enters and verifies applicant information in the NC FAST system, but the worker no longer determines eligibility because NC FAST uses business rules programed into the system to determine eligibility. The eligibility worker reviews the eligibility determination and directs NC FAST to authorize or deny Medicaid benefits. The eligibility worker must still understand Medicaid policy in order to address correct evidence for the various programs, enter all data needed for an eligibility determination, evaluate the determination performed by NC FAST, prepare appeals, and explain program requirements to applicants/beneficiaries and others.

## Exhibit 11: Implementation of NC FAST Changed the Process for Determining Medicaid Eligibility




*Source: Program Evaluation Division based on interviews with county DSS offices and the Department of Health and Human Services.*

**The shortened timeframe for NC FAST implementation affected the amount of time eligibility workers had to learn a new and different way to determine Medicaid eligibility.** DHHS only had 57 days to pilot the system, provide training, and launch the Medicaid eligibility modules to all 100 county DSS offices so that they could begin using NC FAST for Medicaid eligibility determinations by the ACA deadline of October 1, 2013. The Medicaid modules were loaded into NC FAST in July with pilot county DSS offices using NC FAST for Medicaid eligibility determinations in early August. By October 1, 2013, all county DSS offices were using NC FAST to process Medicaid applications.

The abbreviated implementation period is important because performing the eligibility determination process in NC FAST is very complex. Medicaid eligibility workers had to quickly learn how to navigate the system to determine Medicaid eligibility. DHHS provided online training and job aids demonstrating how to use NC FAST, but the learning curve for many eligibility workers was steep. Processing Medicaid applications took longer because workers were learning how to use the system on the job. Eligibility worker now must enter complete information into NC FAST so the system can determine eligibility, and workers stated that entering the necessary information is time consuming. The increased processing time resulting from eligibility workers learning and gaining an understanding of the NC FAST system affected the timeliness percentage for county DSS offices. As eligibility workers become more familiar with the NC FAST system and faster at entering the required information, timeliness should improve.

**Staff turnover at county DSS offices has affected the statewide timeliness percentage for processing Medicaid applications.** Staff turnover affects a county DSS office's timeliness by reducing the number of workers available to process Medicaid applications. Replacement workers must be trained and will experience a learning curve until they fully understand Medicaid eligibility policy and know how to use the NC FAST system. The Program Evaluation Division's county DSS director survey asked two different questions about staff turnover in recent years. First, directors were asked whether turnover among Medicaid eligibility workers had decreased, stayed about the same, or increased since July 1, 2013: 73 directors reported that turnover among workers had increased.[15] Second, the survey asked county DSS directors whether staff turnover had affected workload: 80% of directors reported that staff turnover since January 1, 2012 had increased or substantially increased their workloads.[16] During site visits, county DSS directors noted an increased use in family and medical leave as eligibility workers struggled to learn the system. Some workers chose to retire because they did not have the necessary computer skills to use NC FAST and did not want to learn how to use the system.

**Conversion of existing Medicaid cases from the 33-year-old legacy system to NC FAST increased the Medicaid workload for county DSS offices during Fiscal Year 2014–15.** NC FAST implementation required county DSS offices to migrate 1,272,033 existing Medicaid cases from the legacy computer system to NC FAST. After converted case files were moved into NC FAST, Medicaid eligibility workers could perform a recertification of benefits. Prior to NC FAST, recertifications of Medicaid benefits were manually performed by eligibility workers. The worker would then enter the eligibility decision into the legacy system. The NC FAST system automatically performs this recertification function for the caseworker based on information entered into the system. However, because only limited information was available to be transferred from the legacy system to NC FAST, Medicaid eligibility workers had to build a new case file in NC FAST before each existing Medicaid client could be recertified. According to county Medicaid staff, building a case file is similar to entering a new application and requires more time to perform than recertifying a case that already existed in NC FAST. The increased time to perform Medicaid recertifications in NC FAST caused most county DSS offices (92) to have recertification backlogs during 2015 as eligibility workers completed the conversion process. After eligibility workers perform the one-time conversion process, future Medicaid recertifications should be easier and less time-consuming.[17]

**County DSS offices reported that NC FAST system availability issues and defects affected their ability to provide timely Medicaid eligibility determinations for some applicants and recipients.** As with the introduction of any new software system–particularly one that was implemented ahead of its original schedule–NC FAST has experienced issues that affected users:

[15] July 1, 2013 is when county DSS offices began preparations for using NC FAST for Medicaid eligibility determinations.
[16] Overall NC FAST implementation began in January 2012 with the implementation of the Global Case Management and Food and Nutrition Services modules.
[17] The conversion process was completed in early 2016.

- **NC FAST system availability.** Medicaid eligibility workers must use NC FAST to determine eligibility for applicants and recipients because the system authorizes benefits. If eligibility workers cannot access the NC FAST system, they cannot perform eligibility determinations.[18] Issues with NC FAST system availability can occur for several reasons. First, the NC FAST system may experience an outage when some or all core business functions are unavailable. County DSS offices receive email notifications when system outages occur and when the system is again available. During Fiscal Year 2014–15, NC FAST had two critical incidents when the NC FAST system was unavailable to county DSS offices and six major incidents when one or more core business functions were not operable.

  Second, the NC FAST system relies on the North Carolina Identity Management Service (NCID) operated by the Department of Information Technology for user authentication and system security, and when the NCID system experiences issues, county eligibility workers cannot access NC FAST even though the system is available. During calendar year 2015, NCID problems affected NC FAST system availability 10 times. Finally, county issues with internet access (such as available bandwidth) may also affect NC FAST availability. NC FAST staff assists county DSS offices with solving these local problems.

- **NC FAST system defects.** Timeliness is also affected when there are system defects that prevent NC FAST from determining eligibility or authorizing benefits for some types of Medicaid applications or recertifications. When these system defects occur, NC FAST staff provide temporary procedures which allow cases to be processed in a timely manner until the defect is corrected. In many of these situations, Medicaid eligibility workers follow NC FAST guidelines and determine eligibility using a paper-based process and later enter the determinations into NC FAST so benefits can be authorized.

- **NC FAST Helpdesk.** In addition to systemwide defects, eligibility workers may encounter other problems processing Medicaid cases and must then request assistance from the NC FAST Helpdesk. Until the issue is resolved by the NC FAST Helpdesk, the Medicaid application or recertification cannot be processed, which can affect timeliness. County DSS directors and workers noted in their surveys and during site visits that waiting for a Helpdesk resolution could cause some Medicaid applications to be untimely.[19]

  The Program Evaluation Division analyzed NC FAST Helpdesk tickets for January through July 2015 and determined that the average resolution time for Medicaid eligibility tickets is 23 days, which represents 51% of the time allowed (45 days) for an eligibility determination to be made by the county DSS office for most Medicaid applications. The Program Evaluation Division found that 19% of the 15,682 Medicaid Helpdesk tickets analyzed for the time

[18] During NC FAST system outages or downtimes, county DSS staff can still perform activities related to Medicaid eligibility, such as obtaining documents and other paper-based processes, particularly if the office utilizes a stand-alone document management system.
[19] The NC FAST Helpdesk has an escalation process for tickets that are deemed to be an emergency for a Medicaid applicant.

period were still unresolved at the end of June 2015. The wait time for these unresolved tickets ranged from 64 to 189 days, which means that some Medicaid applicants are waiting beyond the 45 day timeliness standard to receive Medicaid benefits if they are ultimately determined to be eligible.[20]

- **Tracking NC FAST Helpdesk tickets.** County DSS directors identified tracking NC FAST Helpdesk tickets for problem cases as a new activity for their offices. County offices maintain a list of Medicaid cases with Helpdesk tickets to ensure that problems are resolved. Designated county staff must contact the NC FAST Helpdesk to check the status of pending tickets or wait for Helpdesk staff to contact them. The need for additional communication and ticket tracking should be resolved when DHHS receives the latest version of the Helpdesk ticket tracking system, which will allow read-only access for county DSS offices, enabling them to check the status of pending Helpdesk tickets.

**NC FAST implementation has adversely affected Medicaid eligibility workers.** Exhibit 12 shows that a majority of Medicaid eligibility workers expressed concern with the implementation of NC FAST and responded that using the system has not improved their job satisfaction.[21] A majority (59%) of eligibility workers report that the NC FAST system is not easy to use and 40% believe that they have not had sufficient training on using it. Finally, a majority (55%) of eligibility workers believe that the NC FAST system does not allow them to process Medicaid applications and recertifications in a timely fashion.

Based on their survey responses, Medicaid eligibility workers experienced difficulties with using the NC FAST system and feel the transition from the old paper-based system has affected timeliness. Medicaid eligibility workers also were asked if the NC FAST system had improved since they started using it, and 56% of workers responding to the survey did agree that the NC FAST system had in fact improved.

[20] The data that the Program Evaluation Division used to conduct the Helpdesk ticket analysis may not be reflective of all cases affected by a system defect because county DSS offices have been instructed by NC FAST staff not to submit multiple tickets for the same problem.

[21] The Program Evaluation Division conducted a survey of county Medicaid eligibility workers and supervisors to measure their satisfaction with the system. Workers were asked if they agreed or disagreed with statements describing their interactions with the NC FAST system. The following rating scale was used: strongly disagree, disagree, neither disagree nor agree, agree, and strongly agree.

## Exhibit 12: Medicaid Eligibility Workers Expressed Concern with the Implementation of NC FAST

| Eligibility Worker Response to Statements about NC FAST | Disagreed | Neither Disagree nor Agree | Agreed |
|---|---|---|---|
| Overall, I am satisfied with the NC FAST system. | 54% | 24% | 22% |
| Using the NC FAST system has improved my job satisfaction. | 60% | 25% | 15% |
| The NC FAST system is easy to use. | 59% | 21% | 20% |
| The NC FAST system allows me to complete Medicaid eligibility applications and recertifications in a timely fashion. | 55% | 25% | 20% |
| I have received sufficient training on using the NC FAST system. | 40% | 26% | 34% |

Notes: Medicaid eligibility workers and supervisors in the 100 counties were offered the opportunity to complete this survey. 1,790 workers and supervisors from 94 counties completed the survey. The Disagreed column combines the strongly disagreed and disagreed ratings. The Agreed column combines the strongly agreed and agreed ratings.

*Source: Program Evaluation Division based on a survey of Medicaid eligibility workers and supervisors.*

**In addition to learning how to use NC FAST, Medicaid eligibility workers had to quickly gain an understanding of new federal Medicaid eligibility guidelines as required by the Affordable Care Act.** The new Medicaid policy uses different financial methodologies when determining Medicaid eligibility for certain program groups (families and children) and redefines the financial household by eliminating the use of certain income disregards and utilizing the tax filing status of an applicant. The Modified Adjusted Gross Income (MAGI) methodology uses the adjusted gross income of a tax filer according to federal tax rules.

DHHS began disseminating administrative letters describing the new Medicaid policies in August 2013 and offered webinars describing how to apply the ACA/MAGI rules to Medicaid applications. Medicaid workers had limited time to learn the new policies. Applications had to be accepted beginning October 1, 2013, to correspond with the Federal Marketplace open enrollment even though MAGI rules were not effective until January 1, 2014. Individuals who applied by any method from October 1 through December 31, 2013, had to be evaluated for Medicaid under the 2013 rules first. If not eligible under the 2013 Medicaid rules, the applications then had to be evaluated for MAGI rules effective January 1, 2014.

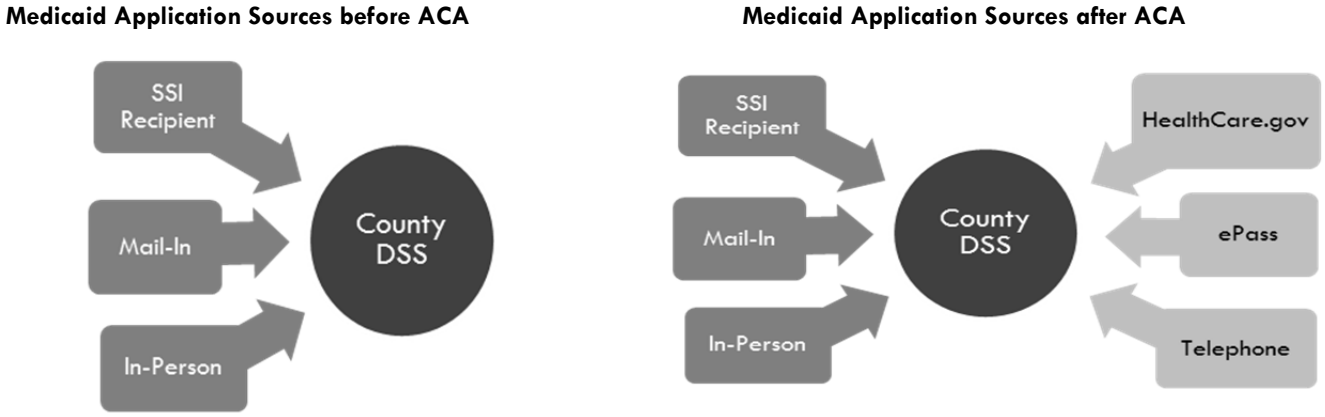
At the same time, eligibility workers were also starting to use the NC FAST system to process Medicaid applications. Most county DSS directors (97 of 100 directors) perceived that implementation of the ACA/MAGI rules increased workload. During site visits at county DSS offices, directors and Medicaid eligibility staff discussed how implementing the NC FAST Medicaid modules and the new Medicaid policy affected timeliness because workers were overwhelmed with all of the changes occurring at the same time.

**The Medicaid workload was further increased when county DSS offices began receiving Medicaid applications from new sources in January 2014.** Before ACA implementation, county DSS offices received Medicaid applications from two sources: in-person applications and mail-in applications. In addition, the federal Social Security Administration provided information for Supplemental Security Income (SSI) recipients who

are automatically enrolled in the Medicaid program. As shown in Exhibit 13, the implementation of ACA added three other sources for Medicaid applications:

- **HealthCare.gov website.**[22] HealthCare.gov is a public web portal maintained by the federal government. Individuals apply for health insurance through this portal during annual open enrollment. The website identifies applications that may be eligible for Medicaid and electronically transfers these applications to NC FAST, which then transfers the application to a county DSS office based on the applicant's residency information.
- **ePASS**. ePASS is a public web portal maintained by NC FAST that Medicaid applicants can use to apply online for Medicaid and other economic benefits. NC FAST transfers the application to a county DSS office based on the applicant's residency information.
- **Telephone.** As now mandated by ACA, Medicaid applicants can apply for Medicaid via telephone by calling a county DSS office.

## Exhibit 13: County DSS Offices Received Medicaid Applications from New Sources after ACA Implementation




*Source: Program Evaluation Division based on Medicaid application data from the Eligibility Information System (EIS) and NC FAST.*

**Medicaid applications received through HealthCare.gov and ePASS increased the Medicaid workload for county DSS offices.** County DSS offices processed 50,381 Medicaid applications from HealthCare.gov during Fiscal Year 2013–14 and 111,592 during Fiscal Year 2014–15. Only 10% of the 2013–14 applications were approved, and only 13% were approved for 2014–15. Most of the Medicaid applications received from HealthCare.gov were duplicates or were applications from individuals already on Medicaid, applicants found to be ineligible for Medicaid, or applicants who withdrew their application after being contacted by the county DSS office. However, Medicaid eligibility workers have to spend time processing each application from HealthCare.gov regardless of the eligibility determination outcome, and these applications substantially increased the workload for county DSS offices. County DSS directors noted during site visits that Medicaid applications received from HealthCare.gov

[22] Also known as the Federally Facilitated Marketplace (FFM).

were more likely to be missing information, creating more follow-up work by Medicaid eligibility workers in order to process. Individuals applying through HealthCare.gov also were more likely to withdraw their Medicaid applications because they were surprised to learn that they had applied for Medicaid.

Starting in Fiscal Year 2013–14, applicants for economic benefits also could apply for Medicaid online using ePASS. County DSS offices processed 37,406 Medicaid applications received through ePASS during Fiscal Year 2013–14 and 87,669 during Fiscal Year 2014–15. Some Medicaid applicants may be using ePASS instead of applying in person or by mail, so it cannot be assumed that 100% of the ePASS applications represent an increase in workload. However, 86 of the 100 county DSS directors perceived that ePASS applications had increased Medicaid workload.

**The increased number of Medicaid applications processed during Fiscal Years 2013–14 and 2014–15 created backlogs that decreased the timeliness percentage for most county DSS offices.** County DSS directors reported on whether their office experienced a backlog of Medicaid applications on the Program Evaluation Division survey; 83 directors responded that their county DSS office did experience a backlog and 17 reported that their office did not have a backlog. Program Evaluation Division analysis found that the county DSS offices reporting no backlog had an average timeliness percentage in Fiscal Year 2014–15 that was 10 percentage points higher than offices reporting a backlog (75% versus 65%).[23]

Medicaid applications from HealthCare.gov were a major source of backlogs for North Carolina and other states during Fiscal Year 2013–14. County DSS offices did not begin receiving applications from this source until January 2014, causing applications from October through December 2013 to accumulate. Many of the Medicaid applications received from HealthCare.gov for 2013 were already untimely when county DSS offices received them. By June 2014, DHHS was reporting that county DSS offices had approximately 100,000 overdue Medicaid applications that had exceeded the timeliness standard. Many of the applications received from HealthCare.gov during the first ACA enrollment period were actually processed during Fiscal Year 2014–15 as county DSS offices worked to reduce the backlog. In addition to the applications from HealthCare.gov, Medicaid eligibility workers also processed over 293,000 more mail-in applications during Fiscal Year 2013–14—an 88% increase in the number of mail-in applications in comparison to Fiscal Year 2012–13.

**In summary, the implementation of the NC FAST system and enactment of the Affordable Care Act created conditions that affected the workload of county DSS offices.** NC FAST implementation and changes to Medicaid eligibility policies mandated by ACA changed how Medicaid eligibility workers determined eligibility and affected staff turnover and satisfaction. The one-time conversion of existing Medicaid cases from the legacy system to NC FAST increased the Medicaid workload for county DSS offices during Fiscal Year 2014–15. In addition, ACA implementation increased the

[23] The difference between the timeliness percentage for county DSS offices with and without a backlog was statistically significant ($p < .05$).

Medicaid workload and created backlogs that decreased the timeliness percentages for most county DSS offices.

**Finding 4: The NC FAST system offers the Department of Health and Human Services the opportunity to proactively manage and monitor the performance of county DSS offices; however, the department needs additional resources and authority to hold counties accountable.**

**NC FAST provides access to real-time data and reporting on processing Medicaid eligibility applications and recertifications.** The shift from a paper-based process to an automated system for determining eligibility offers new opportunities for county DSS offices and the Department of Health and Human Services (DHHS) to manage and monitor the Medicaid eligibility determination process. NC FAST provides benefits in the following areas:

- **Consistency.** County DSS offices must use the NC FAST system to determine Medicaid eligibility and to authorize Medicaid benefits. NC FAST ensures consistent Medicaid eligibility determination among the 100 county DSS offices because eligibility policy is built into the system's business rules. Prior to NC FAST implementation, eligibility workers used their knowledge of Medicaid eligibility policy to determine eligibility, and differences in Medicaid policy interpretation sometimes caused variations in how Medicaid eligibility was determined. With NC FAST, a Medicaid applicant should receive the same Medicaid eligibility determination regardless of which county DSS office or eligibility worker processes the application. This consistency may reduce the number of Medicaid eligibility determination errors caused by inaccurate Medicaid policy interpretation.
- **Workload versus caseload.** NC FAST allows DHHS and county DSS offices to manage the eligibility determination process differently because client information for Medicaid and other economic benefits is integrated when it is entered into the system. Having client information integrated across multiple economic benefit programs allows county DSS offices to manage workload instead of caseload. As a result, county DSS offices can assess their workload needs and divide the work among the available staff rather than just assigning cases to a worker that specializes in a single program. Eligibility determination becomes activity-based, allowing county DSS offices to consider assigning the eligibility workload across economic benefit programs, with some workers processing applications and other workers handling recertifications and changes. Focusing on workload allows DHHS to assist county DSS offices by reviewing business processes, analyzing workflow to improve performance and timeliness, and considering regionalization of some activities such as responding to Medicaid applicant and recipient phone calls.
- **Accountability.** NC FAST tracks the entire Medicaid eligibility determination process for applications and recertifications in real time down to the individual eligibility worker level. The system tracks timeliness against the 45-day window from when a worker enters a Medicaid application until the eligibility determination process is

completed. This continuous tracking means that DHHS and county DSS offices can monitor timeliness daily and know the number of applications or recertifications that are pending and overdue (untimely). The workload for an individual eligibility worker can be monitored, which allows a county DSS office to measure worker performance and identify problems. With NC FAST reporting real-time information across all economic benefit programs, county DSS directors can use the data to determine how to allocate staff resources. At the same time, DHHS staff can use NC FAST data to measure performance and hold county DSS offices accountable for meeting state and federal performance standards for timeliness and accuracy.

**To effectively utilize the data that NC FAST provides, DHHS needs more robust data analysis capability and resources to support county DSS offices.** DHHS has recently paid the NC FAST vendor to develop reports that allow the department and county DSS offices to better analyze workload and performance. These reports were developed in response to county DSS directors' concerns about the availability of reliable and accurate reports identifying pending Medicaid applications and recertifications. For example, these new reports identify pending Medicaid applications and recertification by county, supervisor, and eligibility worker and will allow county DSS offices to identify problems and trends so that timeliness can be improved. DHHS can use the same information to spot county DSS offices that need attention because their performance data indicates they are not meeting timeliness standards. However, DHHS has noted that they do not have dedicated staff to analyze NC FAST reports on a routine basis or to provide training for county DSS offices on how to effectively use NC FAST data to manage the Medicaid eligibility determination workload. The lack of staff focused on NC FAST data analytics limits DHHS's ability to effectively use NC FAST data to develop performance standards for county DSS offices and monitor the data to measure performance. Improved data analysis would allow DHHS to assist the State and county DSS offices in tracking Medicaid enrollment trends and providing real-time data models and dashboards that can be used to assist and improve Medicaid business processing by county DSS offices.

**County DSS offices use the Client Services Data Warehouse (CSDW) for monitoring and evaluating performance, but staff supporting the CSDW has been reduced in recent years.**[24] The CSDW collects, among a vast array of other data, eligibility and enrollment data from Medicaid and other economic services programs, and it allows users to query and download current and historical information. Daily NC FAST transactions for Medicaid eligibility determinations performed by the 100 county DSS offices are loaded into the CSDW each night, providing a historical record of activity. State and county DSS staff can query data stored in the CSDW to create reports and combine data across multiple programs. Staff of the Performance Management Section within DHHS's Division of Social Services assist county DSS offices with using the CSDW by creating standard queries for routine data needs and can develop specialized queries as requested.

[24] According to DHHS officials, the lack of recent training on using the CSDW is due to funding reductions that limited travel for training activities and reduced the number of staff. Currently, 4 full-time equivalent employees and 10 contracted staff assist county DSS offices and DHHS with a variety of data needs, including federal reporting and requested queries from county DSS offices.

County DSS staff also can develop their own queries to extract data from the CSDW, but due to limited resources the Performance Management staff has not provided training on using the CSDW since 2008, which was before NC FAST implementation.

Performance Management staff stated their limited size combined with their responsibilities across multiple DHHS programs affects their ability to respond to county DSS offices' requests to develop desired pre-packaged reports within the CSDW. Understanding and utilizing the data downloaded from NC FAST can often be challenging and only county DSS offices with dedicated resources for such efforts are able to realize the full potential of NC FAST data stored in the data warehouse. When the Performance Management staff received documentation to explain data from NC FAST in 2015, they noted the documentation was helpful but incomplete. The data and its interrelationship with NC FAST is quite complex, and as a result more staff time and effort is required to develop queries for county DSS offices. Currently, the Performance Management staff can only react to data requests from individual county DSS offices. With more resources, the Performance Management Section could develop data queries for NC FAST data for use by the county DSS offices and provide training on using the CSDW.

**NC FAST enhances DHHS's mechanisms for supervising and monitoring county DSS offices' performance of Medicaid eligibility determinations.** As the single state agency responsible for administering Medicaid, DHHS has delegated the responsibility for managing the day-to-day operation of the Medicaid program to the Division of Medical Assistance (DMA). Two DMA units provide oversight for Medicaid eligibility determination and enrollment as performed by county DSS offices:

- **Recipient and Provider Services.** This unit's responsibilities include monitoring county DSS offices' compliance with Medicaid eligibility policies and timeliness standards.
- **Compliance and Program Integrity.** This unit's responsibilities include monitoring the accuracy of Medicaid eligibility determinations and identifying errors caused by erroneous determinations.

In addition, two other DHHS units assist DMA with providing oversight of county DSS offices:

- **Economic Benefits Policy Governance Board.** This board's responsibilities include monitoring federal requirements and state policy directives and developing an integrated policy manual for Medicaid and other economic benefit programs. Work on an integrated eligibility policy manual is ongoing with the intent that eligibility policies will be aligned for Medicaid and other economic benefits programs in a single easily accessible location to limit the number of sources county DSS employees consult in determining eligibility. DHHS has completed the first phase of creating an integrated policy manual by combining and streamlining income eligibility policies. County DSS offices will continue to use the old eligibility policy manuals, supplemented by administrative letters

and policy training provided by DHHS, until the integrated eligibility policy manual is complete.

- **Operational Support Team (OST).** This team's responsibilities include providing Medicaid policy support, business process review, and workflow analysis for county DSS offices for Medicaid and other economic benefit programs. DHHS created the OST in 2014 by combining existing eligibility policy staff from Medicaid and other economic benefits programs to eliminate program silos and provide cross-area policy support for county DSS offices. In general, county DSS offices support the OST concept. However, directors noted that eligibility workers were expected to know both Medicaid policy and NC FAST navigation, but that OST's NC FAST knowledge was limited until recently, which made it difficult for the OST to provide enhanced support and policy interpretation for counties. Although DHHS was aware of county DSS directors' concerns, DHHS had to place priority on other immediate needs relative to program administration and county support due to limited staff. DHHS remains committed to the original concept laid out for OST and is working toward realizing those goals.

Exhibit 14 describes in greater detail how these units monitor and support county DSS offices as they perform Medicaid eligibility determinations and enroll eligible North Carolina citizens into the Medicaid program.

## Exhibit 14: DHHS Mechanisms for Supervising and Monitoring Medicaid Eligibility Determination Functions for County DSS Offices

| **Division of Medical Assistance Recipient and Provider Services** | **Division of Medical Assistance Compliance and Program Integrity** |
|---|---|
| • Develop and maintain Medicaid eligibility policies based on federal and state law and regulations<br>• Report monthly eligibility and enrollment information to federal government<br>• Monitor county DSS offices' compliance with Medicaid eligibility policy and timeliness standards<br>• Provide support to NC FAST to ensure system business rules apply Medicaid policy correctly | • Conduct annual quality control monitoring of Medicaid eligibility determinations<br>• Identify errors caused by erroneous Medicaid eligibility determinations<br>• Recommend corrective actions to county DSS offices to correct and prevent errors<br>• Determine training needs to ensure Medicaid policy is applied accurately |
| **Economic Benefits Policy Governance Board** | **Operational Support Team** |
| • Monitor federal requirements and state policy directives<br>• Research policy changes and their impact on clients, counties, and the State<br>• Analyze and monitor new policies<br>• Provide oversight and direction of changes to NC Administrative Code and policy manuals<br>• Develop an integrated policy manual across all economic benefit programs<br>• Work with NC FAST and county DSS offices to ensure that policies are appropriately implemented | • Provide Medicaid policy support for county DSS offices and NC FAST Helpdesk<br>• Provide business process review and workflow analysis for county DSS offices<br>• Monitor NC FAST reports and other data to identify problem areas<br>• Create and deliver Medicaid policy training for county DSS offices<br>• Support DMA and county DSS offices in developing and implementing corrective action plans |

*Source: Program Evaluation Division based on documents from the Department of Health and Human Services.*

**Federal law directs DHHS administration of the Medicaid program in North Carolina including supervision of county DSS offices.**[25] DHHS has the authority to delegate the performance of Medicaid eligibility determinations to local agencies under its supervision. However, under federal law, DHHS retains the responsibility to ensure that Medicaid policies and rules for eligibility determination are applied appropriately. This federal authority means that DHHS can take corrective action as needed, including rescinding the delegation of authority to county DSS offices, if DHHS finds Medicaid eligibility determinations are not being performed in a timely manner or are inaccurate.

**DHHS monitors the accuracy of Medicaid eligibility determinations performed by county DSS offices based on federal requirements.** The Quality Assurance Section of DMA's Compliance and Program Integrity Unit periodically reviews a random sample of Medicaid eligibility case records. The samples consist of individuals who are receiving Medicaid (active cases) and individuals who were deemed ineligible (negative cases). Active cases are reviewed to determine whether Medicaid recipients' eligibility was determined correctly. Inactive cases are reviewed to determine whether applicants were improperly denied Medicaid benefits. State administrative rule directs DMA to notify county DSS offices when errors have occurred

[25] 42 CFR 431.10.

and to identify the necessary corrective action. If the county DSS office refuses to take corrective action, DMA must take action to correct the erroneous Medicaid eligibility determination. The OST assists county DSS offices to ensure that corrective action is completed on all identified cases. Based on the errors identified by Quality Assurance staff, OST develops and provides training for county DSS offices to help prevent common eligibility determination errors.

**State administrative rules direct how DHHS monitors the timeliness of Medicaid eligibility determinations.** As discussed in Finding 1, DMA's Recipient and Provider Services unit uses the Monthly Average Processing Time and the Percent Processed Timely measurements to monitor the monthly timeliness of Medicaid eligibility determinations performed by county DSS offices. Based on county size, county DSS offices must process 85% or 90% of most Medicaid applications within the 45-day time period required by federal law. If DMA determines that a county DSS office is out of compliance with timeliness standards for three consecutive months or five months out of any consecutive 12 months, it can direct the county DSS office to convene a local corrective action team to design and implement a corrective action plan to improve timeliness. If a county DSS office fails to meet timeliness standards in the three months after the local corrective action plan is initiated, the administrative rule directs DMA to convene a state corrective action team to design a corrective action plan. The state corrective action plan can include employing additional staff, altering office procedures, purchasing office equipment, retaining private consultants, reopening and correcting cases, and ordering the DHHS to assist in the operation of a county DSS office. If a county DSS office fails to meet timeliness standards in the three months after state corrective action is initiated, administrative rules direct DMA to request that the Local Government Commission determine the county's capacity to expend resources to bring it into compliance.

**DHHS does not have explicit authority to compel a county to expend resources so that its county DSS office can comply with the timeliness standards for Medicaid eligibility determinations.** Even if the conclusion is made that a county has the capacity to expend resources to allow its county DSS office to meet previously unmet timeliness standards, DMA does not have the authority to require the county to spend money to hire more staff or take other measures to ensure compliance. This limitation to DMA's authority is important because the State does not control staffing at the local level. Per G.S. § 108A-54(a), county governments must pay the nonfederal share for Medicaid eligibility workers, which means county DSS offices determine their staffing levels for Medicaid eligibility based on county funding levels.

DHHS staff stated that the state-supervised and county-administered system can create a push-pull relationship with regards to determining adequate staffing for processing eligibility determinations. Before the implementation of NC FAST, DMA did not have enough data to calculate appropriate staffing levels for county DSS offices. The NC FAST system provides real-time data on Medicaid eligibility workload and timeliness that can be used by DMA, OST, and county DSS offices to determine the number of Medicaid eligibility workers needed to meet timeliness standards based on a county's Medicaid workload. The NC FAST data makes it easier to estimate the

appropriate staffing levels for county DSS offices, but a county government can still choose not to expend more money to increase staff resources and DMA cannot require them to do so.

**DHHS does not have clear state authority to rescind a county DSS office's authorization to administer Medicaid eligibility if it fails to comply with state timeliness performance standards.** This lack of explicit authority in state law impedes DHHS's ability to take over the Medicaid eligibility determination function if a county DSS office fails to comply with standards and the county government does not provide adequate resources for the DSS office to comply. Even if DHHS took over a county's administration of Medicaid eligibility, DHHS does not have the authority to require the county to continue funding the nonfederal share of administrative costs or to pay the nonfederal share of additional costs that may be incurred to comply fully with state timeliness performance standards. As a result, Medicaid applicants living in a county failing to comply will not receive an eligibility determination in a timely manner, and the North Carolina Medicaid program could face federal sanctions for not meeting timeliness standards.

**State law for county provision of child welfare services provides mechanisms for DHHS to intervene and take over when services are not provided in accordance with state law and rules.**[26] Exhibit 15 compares the state intervention authority for county provision of child welfare services and Medicaid eligibility administration. The first difference is that the state intervention authority for child welfare services is in state law, which provides stronger authority than the administrative rule for Medicaid eligibility administration. The mechanisms for initiating corrective action are similar because both authorities require a corrective action plan and in both cases the county DSS office has an opportunity to implement the plan and comply with state requirements. However, as the exhibit shows, DHHS has more authority to intervene if there is a threat to the safety and health of children in a county. DHHS can take over county child welfare services after a written notice and hearing, if it determines that a county DSS office's failure to provide services is a threat to the safety and welfare of children in the county. The intervention authority also specifies that the county must continue funding during the State takeover of services and must pay the nonfederal share of additional costs necessary to operate at the level required to comply fully with state law. The state administrative rule for Medicaid does not give DHHS authority to take over if a county DSS office fails to meet the local or state corrective action plan, limiting DHHS's ability to hold county DSS offices accountable for adhering to state timeliness standards.

[26] G. S. § 108A-74.

## Exhibit 15: Comparison of State Intervention Authority for Child Welfare Services and Medicaid Eligibility Administration

| | County Provision of Child Welfare Services | County Provision of Medicaid Eligibility Administration |
|---|---|---|
| **State Intervention Authority** | State Law (G. S. § 108A-74) | State Administrative Rule (10A NCAC 23C .0203) |
| **Corrective Action Trigger** | DHHS determines county DSS not providing child welfare services in accordance with state law and applicable rules | DHHS determines county DSS office noncompliant with timeliness standard for 3 consecutive months, or 5 months out of any 12 consecutive months |
| **Corrective Actions or Interventions** | • DHHS provides technical assistance and monitors service provision by county DSS staff<br>• DHHS establishes corrective action plan to correct inappropriate policies and procedures<br>• DHHS advises county DSS personnel on appropriate policies and procedures<br>• If intervention fails after 60 days, DHHS withholds State and federal child welfare services administrative funds until services provided in accordance with State laws and rules | • DHHS directs county DSS office to convene local corrective action team to design corrective action plan to improve timeliness<br>• If county DSS office fails to meet timeliness standards in three months after local corrective action plan initiation, DHHS convenes state corrective action team to design corrective action plan that can include ordering state to assist in the operation of a county department<br>• If county DSS office fails to meet timeliness standards in three months after state corrective action initiation, DHHS requests the Local Government Commission to determine the county capacity to expend resources to bring the county into compliance |
| **State Takeover Trigger** | DHHS determines that county DSS office failure to provide services poses a substantial threat to the safety and welfare of children in the county | None |
| **Action Required before State Takeover** | DHHS issues written notice to county officials and holds hearing | Does not apply |
| **Actions during State Takeover** | • DHHS withholds state and federal funding for child welfare services<br>• DHHS ensures provision of services through contracts with public or private agencies or by direct DHHS operation<br>• County DSS director divested of service delivery powers<br>• County must continue existing funding of services during state takeover<br>• County must pay nonfederal share of additional cost that may be incurred to operate the services at the level necessary to comply fully with state law and rules | Does not apply |

*Source: Program Evaluation Division based on review of N. C. Gen. Stat. § 108A-74 and 10A NCAC 23C .0203.*

**In summary, NC FAST enhances DHHS's mechanisms for supervising and monitoring county DSS offices, but DHHS has limited ability and authority to hold them accountable.** The system provides real-time data on Medicaid eligibility workload and timeliness that can be used to measure the performance of county DSS offices. However, DHHS's authority to hold county DSS offices accountable for meeting state timeliness performance standards for Medicaid eligibility administration is undefined. The state intervention law governing county provision of child welfare services offers a potential model for strengthening DHHS's authority to hold county DSS offices accountable for performing Medicaid eligibility determinations in a timely manner.

## Recommendations

**Recommendation 1. The General Assembly should direct the Department of Health and Human Services to report on the timeliness of Medicaid eligibility determinations performed by county DSS offices for Fiscal Years 2015–16 and 2016–17.**

As discussed in Finding 1, county DSS offices failed to meet North Carolina's timeliness standards during Fiscal Years 2013–14 and 2014–15. The implementation of the NC FAST system and enactment of the Affordable Care Act created conditions that increased the workload of county DSS offices and posed other challenges to making timely Medicaid eligibility determinations (See Findings 2 and 3). Departmental staff and county DSS directors have reported that they expect timeliness to improve during Fiscal Year 2015–16 because

- Medicaid application and recertification backlogs have been reduced or eliminated,
- Medicaid eligibility workers have learned how to use the NC FAST system and processing times have improved,
- new Medicaid eligibility workers hired during Fiscal Year 2014–15 are fully trained, and
- the increased workload caused by the implementation of the Affordable Care Act has stabilized.

The General Assembly should monitor the timeliness of Medicaid eligibility determinations performed by county DSS offices by requiring the Department of Health and Human Services (DHHS) to report annually for Fiscal Years 2015–16 and 2016–17. The report for each fiscal year should include the following information:

- the annual statewide percentage for processing Medicaid applications in a timely manner;
- the statewide average number of days to process Medicaid applications for each month;
- the annual percentage of Medicaid applications processed in a timely manner by each county DSS office;
- the average number of days to process Medicaid applications for each month for each county DSS office;
- the number of months during the fiscal year that each county DSS office met its timeliness performance standard; and
- the number of months during the fiscal year that each county DSS office failed to meet its timeliness performance standard.

To supplement the descriptive statistics, the report should also describe any corrective action activities conducted by DHHS and county DSS offices. If the performance metrics for processing Medicaid applications in a timely manner do not show significant improvement, the report should describe how DHHS plans to assist county DSS offices in meeting North Carolina's timeliness standards for processing Medicaid applications.

DHHS should be directed to submit this report to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division. The due date for the Fiscal Year 2015–16 report should be November 1, 2016, and the due date for the Fiscal Year 2016–17 report should be November 1, 2017.

**Recommendation 2. The General Assembly should enact state law authorizing the Department of Health and Human Services to intervene and take over county administration of Medicaid eligibility determinations when necessary.**

As discussed in Finding 4, the Department of Health and Human Services (DHHS) has limited state legal authority to hold county DSS offices accountable for meeting performance standards for Medicaid. State administrative rules direct how DHHS monitors the timeliness of Medicaid eligibility determinations and provides a corrective action process, but DHHS does not have clear state authority to compel a county to expend resources so that its county DSS office can comply with the timeliness standards. In addition, DHHS does not have explicit state authority to rescind a county DSS office's authorization to administer Medicaid eligibility determinations if it fails to comply with state timeliness performance standards.

To strengthen DHHS supervision and oversight of county DSS offices administering Medicaid, the General Assembly should enact state law authorizing DHHS to intervene and take over county administration of Medicaid eligibility determinations when a county DSS office fails to take corrective action after failing to comply with timeliness performance standards. Using the state intervention law for county administration of child welfare services as a model, the state intervention authority for taking over county administration of Medicaid eligibility determinations should include the following components:

- **Corrective action trigger.** DHHS determines that a county DSS office is noncompliant with its Medicaid timeliness performance standard for 3 consecutive months or 5 months out of any 12 consecutive months.
- **Corrective action plan.** DHHS and the county DSS office jointly develop a corrective action plan to improve timeliness. The corrective action plan would specify the implementation time period, but the time period cannot exceed 12 months. The corrective action plan can include employing additional staff, altering office procedures, purchasing office equipment, retaining private consultants, reopening and correcting cases, and any other actions deemed necessary.
- **State takeover trigger.** The county DSS office fails to meet the timeliness performance standard in the time period specified in the joint corrective action plan.

- **Action required before State takeover.** DHHS issues a written notice to county officials at least 90 days prior to the department taking over county administration of Medicaid eligibility determinations.
- **State action during takeover.** DHHS withholds federal funds for Medicaid administration from the county DSS office and ensures administration of Medicaid eligibility through contracts with government agencies as permitted under federal law or through direct operation by DHHS including supervision of county Medicaid eligibility workers. County DSS office is divested of Medicaid administration authority.
- **County action during takeover.** County continues to pay the nonfederal share of Medicaid administration of eligibility determinations during the state takeover and pays the nonfederal share of additional costs incurred to comply with the Medicaid timeliness performance standard.
- **Resumption of county control of Medicaid administration.** DHHS works with county officials to enable Medicaid administration to be returned to the county if and when the department has determined that Medicaid eligibility determinations can be performed in a timely manner by the county DSS office and in accordance with state law and applicable rules. After county resumes control of Medicaid administration, DHHS restores federal funding.

This proposed legislation enhances DHHS's ability to hold county DSS offices accountable for adhering to state timeliness standards and ensures applicants receive an eligibility determination in a timely manner.

**Recommendation 3. The General Assembly should appropriate $300,000 to the Department of Health and Human Services to support better utilization of NC FAST data for performance measurement and evaluation of Medicaid eligibility determinations performed by county DSS offices.**

As discussed in Finding 4, NC FAST data could enhance how the Department of Health and Human Services (DHHS) monitors and supervises the Medicaid eligibility determination process performed by county DSS offices. DHHS has identified the need for a more robust data analysis capacity to effectively utilize the data that NC FAST collects and to provide resources to support county DSS offices' use of NC FAST data from the Client Services Data Warehouse (CSDW).

To improve DHHS's data analysis capacity, the General Assembly should appropriate $300,000 from the General Fund to the department. These funds would support seven new positions to support the following DHHS units:

- **Operational Support Team (OST).** To improve Medicaid application and recertification processing, this unit would receive three Business System Analysts to interpret Medicaid data by combining and analyzing diverse types of data from several data warehouses to extract actionable data discoveries and new trend analytics for DHHS divisions and operational support staff and counties. These positions would develop statistical models and methods to predict, quantify, and forecast various Medicaid business metrics that can be used to develop solutions and recommended business process changes. Data analysis

performed by these positions would allow DHHS to quickly identify which county DSS offices need attention because they are not meeting performance standards for timeliness. The OST also can use the data analysis performed by these positions to develop performance standards for county DSS offices, monitor the data to measure performance, and provide better guidance to county DSS offices on how to improve the timeliness and accuracy of Medicaid eligibility determinations. These positions can also assist with training county DSS offices on how to effectively use NC FAST data to manage the Medicaid eligibility determination workload.

- **Performance Management Section and the CSDW.** This unit would receive four Human Services Evaluator/Planner positions to assist county DSS offices in using the CSDW to analyze NC FAST eligibility data for Medicaid and other economic services programs. With these additional staff resources, the Performance Management Section can provide CSDW training for county DSS offices and develop NC FAST or other data queries for use by the 100 counties. These staff can develop internal queries and reports to assist DHHS with monitoring county DSS office performance.

The Program Evaluation Division estimates that these seven new positions would require recurring total expenditures of $600,000, with $300,000 coming from the General Fund after federal cost-sharing is applied.[27]

## Appendices

Appendix A: Medicaid Eligibility Guide

Appendix B: County DSS Office Financial and Staffing Information for Medicaid Administration

Appendix C: County Medicaid Enrollment and DSS Office Workload Information

Appendix D: Percentage of Medicaid Applications Processed Timely by County DSS Offices

## Agency Response

A draft of this report was submitted to the Department of Health and Human Services and the North Carolina Association of County Directors of Social Services to review. Their responses are provided following the appendices.

## Program Evaluation Division Contact and Acknowledgments

For more information on this report, please contact the lead evaluator, Carol Shaw, at carol.shaw@ncleg.net.

Staff members who made key contributions to this report include Jim Horne, Brent Lucas, and Pam Taylor. John W. Turcotte is the director of the Program Evaluation Division.

[27] The $600,000 estimated cost assumes 3 business system analysts with salaries and benefits at $274,000, 4 Human Services Evaluator/Planner positions with salaries and benefits at $297,000, and $29,000 for other operating costs associated with new positions. The estimate assumes a 50% federal financial participation rate.

# Appendix A: Medicaid Eligibility Guide

## MEDICAID ELIGIBILITY

| GROUP | BENEFITS | BASIC REQUIREMENTS ** | | | | | |
|---|---|---|---|---|---|---|---|
| | | **Basic Eligibility Requirement** | **Whose Income and Resources Count** | **Income Limit (updated 04/15)** | **Resource Limit (updated 04/2015)** | **Deductible/ Spend down** | |
| Beneficiaries of Cash Assistance Programs<br><br>AAF, S-ABD, MSB<br>SSI cases | Full Medicaid coverage | Beneficiaries of the following cash assistance programs are automatically entitled to Medicaid. No separate Medicaid application or Medicaid eligibility determination is required. The cash assistance programs are:<br>• Supplemental Security Income (SSI) – Federal cash assistance program for the aged, blind, and disabled.<br>• State/County Special Assistance – State cash assistance program for aged and disabled individuals, primarily who are in adult care homes.<br>• Special Assistance to the Blind – State cash assistance program for blind individuals.<br><br>NOTE: Work First Family Assistance – NC program under the federal Temporary Assistance to Needy Families law that provides cash assistance to families with children. EXCEPTION: This program has been de-linked and a separate Medicaid application is now required. SPECIAL ASSISTANCE/COUNTY ASSISTANCE AND SERVICES TO THE BLIND- have been de-linked from Medicaid. A separate application is required. | | | | | |
| Aged<br>MAA | Full Medicaid Coverage | Age 65 or older | 100% of Poverty<br>1 – $ 981/mo<br>2 – $1,328 /mo | SSI Limits<br>1 - $2,000<br>2 - $3,000 | Yes | If income exceeds income limit and the indicator is "yes," the individual or family may be able to be eligible for Medicaid if they can meet a deductible. See discussion of Medical Deductible on page 2 of this same column.<br><br>**Individuals in nursing facilities** generally do not have to meet a deductible to be eligible for Medicaid. However, they must pay all of their monthly income, less a $30 personal needs allowance and the cost of medical expenses not covered by Medicaid or other insurance to the nursing facility. Medicaid pays the remainder of their cost of care. | **Protection of income for spouse at home:** $1,966.25/mo up to $2,980.50/mo<br><br>**Protection of resources for spouse at home:** $23,844 up to $119,220.<br><br>**Transfer of resources:** When a person gives away resources and does not receive compensation with a value at least equal to that of the resources given away, he may be penalized. Medicaid will not pay for care in a nursing facility or care provided under the Community Alternative Placement program or other in-home health services & supplies for a period of time that depends on the value of the transferred resource. |
| Blind<br>MAB | Full Medicaid Coverage | Blind by Social Security Standards | 100% of Poverty<br>1 – $ 981/mo<br>2 – $1,328 /mo | SSI Limits<br>1 - $2,000<br>2 - $3,000 | Yes | | |
| Disabled<br>MAD | Full Medicaid Coverage | Disabled by Social Security Standards | 100% of Poverty<br>1 – $ 981/mo<br>2 – $1328 /mo | SSI Limits<br>1 - $2,000<br>2 - $3,000 | Yes | | |
| Health Care for Working Disabled (HCWD)<br>MAD | Full Medicaid Coverage | * **See Footnote** | 150% of Poverty<br>1- $1,472<br>2- $1,992 | Min. CSRP limit<br>$23,844 | No | | |
| Qualified Medicare Beneficiaries<br>MQB-Q | Payment of Medicare premiums and deductibles and co-insurance charges for Medicare covered services | Entitled to Medicare Parts A & B | 100% of Poverty<br>1 – $ 981/mo<br>2 – $1,328 /mo | 1 - $7,160<br>2 - $10,750 | No | | |
| Specified Low Income Medicare Beneficiaries<br>MQB-B | Payment of Medicare Part B premium | Entitled to free Medicare Part A | 120% of Poverty<br>1 - $1,177/mo<br>2 - $1,593/mo | 1 - $7,160<br>2 - $10,750 | No | | |
| Qualifying Individual<br>MQB-E | Payment of Medicare Part B Premiums | Entitled to free Medicare Part A | 135% of Poverty<br>1 - $1,325 mo<br>2 - $1,793/mo | 1 - $7,160<br>2 - $10,750 | No | | |
| | **NOTE:** Total number of eligible individuals is limited to available funds | | | | | | |

# Appendix A: Medicaid Eligibility Guide

| GROUP | BENEFITS | BASIC REQUIREMENTS ** | | | | |
|---|---|---|---|---|---|---|
| | | Basic Eligibility Requirement | Income Limit (update 4/15) | Resource Limit (updated 01/13) | Deductible/Spend down | |
| Working Disabled<br><br>MWD | Payment of Medicare Part A premiums | Lost entitlement to free Medicare A due to earnings but still has disabling impairment | 200% of Poverty<br>1 - $1,962/mo<br>2 - $2,655/mo | 2X SSI Limits<br>1 - $4,000<br>2 - $6,000 | No | |
| Families & Children<br><br>MAF- N/C | Full Medicaid coverage | Parents/Caretaker relatives must be living with and caring for a child to whom they are related who is under age 19.<br><br>Children must be under age 21. | 1 - $434/mo<br>2 - $569/mo<br>3 - $667/mo<br>4 - $744/mo<br>5 - $824/mo | **OBSOLETE for MAF-C/N** | Yes | If income exceeds income limit and the indicator is "yes" the individual or family may be able to be eligible for Medicaid if they he can meet a deductible<br>**Medicaid Deductible**:<br>When an individual/family is ineligible for Medicaid due to income over the income limit, they may become eligible by meeting a Medicaid deductible. The deductible is determined by subtracting the Medically Needy Income Limit (MNIL) (*see limits below)* from the countable monthly income to determine the monthly excess income. Medicaid deductibles are generally determined for 6 months, so the monthly excess income is multiplied by 6 to determine the 6-mo. deductible. Once medical bills for which they are responsible totaling the amount of the deductible are incurred, they are authorized for the rest of the 6-mo. period. Medicaid cannot pay for any of the bills applied to the deductible.<br>**M - Resource Limit:**<br>All Deductible cases have a resource limit: $3,000 for families and children and $2,000 (1) and $3,000 (2) for aged, blind and disabled. |
| MAF-M | Full Medicaid coverage at the moment the deductible is met. | Parents/Caretaker relatives must be living with and caring for a child to whom they are related who is under age 19.<br>Children must be under age 21. | 1 - $242/mo<br>2 - $317/mo<br>3 - $367/mo<br>4 - $400/mo<br>5 - %433/mo | **Only MAF-M must meet resource** | Yes | |
| Pregnant<br><br>Women<br><br>MPW | Coverage is limited to<br><br>treatment for conditions that affect the pregnancy. | Medical verification of<br><br>pregnancy | 196% of Poverty<br><br>1 - $1,923/mo<br>2 - $2,602 /mo<br>3 - $3,282/mo<br>4 - $3,961 /mo<br>5 - $4,641/mo | | Yes | |
| Children under age <1<br>MIC-1 | Full Medicaid Coverage | Be under age 1 | 194%-210% of Poverty<br>1 - $2,060/mo<br>2 - $2,788/mo<br><br>3 - $4,244/mo<br>4 - $4,972/mo<br>5 - $5,700/mo | | Yes | |
| Children under age <1<br>MIC-N | Full Medicaid Coverage | Be under age 1 | 194% of Poverty<br>1 - $,1903/mo<br>2 - $2,576/mo<br>3 - $3,248/mo<br>4 - $3,921/mo<br>5 - $4,593/mo | | Yes | |

# Appendix A: Medicaid Eligibility Guide

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Children 1-5 MIC-1 | Full Medicaid Coverage | Age must be 1-5 | New MAGI Methodology (Modified Adjusted Gross Income). A tax household must be established for each individual. | 141%-210% of Poverty<br>1 - $2,060/mo<br>2 - $2,788/mo<br>3 - $3,516/mo<br>4 - $4,244/mo<br>5 - $4,972/mo | | | |
| Children 1-5 MIC-N | Full Medicaid Coverage | Age must be 1-5 | New MAGI Methodology (Modified Adjusted Gross Income). A tax household must be established for each individual. | 141% of Poverty<br>1 - $1,383/mo<br>2 - $1,872/mo<br>3 - $2,361/mo<br>4 - $2,850/mo<br>5 - $3,339/mo | | Yes | |
| Children 6-18 MIC-1 | Full Medicaid Coverage | Age must be 6 - 18 | New MAGI Methodology (Modified Adjusted Gross Income). A tax household must be established for each individual. | 107% - 133% of Poverty<br>1 - $1,305/mo<br>2 - $1,766/mo<br>3 - $2,227/mo<br>4 - $2,688/mo<br>5 - $3,149/mo | | Yes | |
| Children age 6 thru 18<br><br>MIC-N | Full Medicaid Coverage | Age must be 6 - 18 | New MAGI Methodology (Modified Adjusted Gross Income). A tax household must be established for each individual. | 107% of Poverty<br>1 - $1,050/mo<br>2 - $1,421/mo<br>3 - $1,792/mo<br>4 - $2,163/mo<br>5 - $2,534/mo | | Yes | |
| Title IV-E Children IAS | Full Medicaid Coverage | Be an Title IV-E adoptive or foster child | Medicaid eligibility is automatic. There is no income or resource determination. | | | No | |
| State Foster Care Children (HSF) | Full Medicaid Coverage | State Foster Care Children are evaluated as Families and Children's Group above.<br>(If not eligible for HSF, then evaluate for other children's programs.) | | | | Yes | |
| MFC-Medicaid for Former Foster Care | Full Medicaid Coverage | Be 18-20 and had been a Title IV-E or State foster child on 18th birthday | None | None | None | No | |
| Breast & Cervical Cancer Medicaid MAF-W | Full Medicaid Coverage | A woman who has been screened and enrolled in the NC Breast &Cervical Cancer Control Program and is otherwise ineligible for Medicaid | Medicaid eligibility is automatic. There is no income or resource determination. | | | No | |

# Appendix A: Medicaid Eligibility Guide

| GROUP | BENEFITS | BASIC REQUIREMENTS ** | | | | | |
|---|---|---|---|---|---|---|---|
| | | Basic Eligibility Requirement | Income Limit (update 4/13) | Resource Limit | Deductible/Spend down | | |
| Family Planning MAF-D | Family Planning exams & services. Screening & treatment for STI. Screenings for HIV. Sterilizations. | No AGE limit | 195% of Poverty<br>1 - $1,913/mo<br>2 - $2,589/mo<br>3 - $3,265/mo<br>4 - $3,941/mo<br>5 - $4,617/mo | No resource limit | No | There is no deductible or spend down provision for Family Planning coverage. If a beneficiaries income increases to more than 185%, he will be ineligible for family planning coverage | |
| NC Health Choice (NCHC) | Coverage of the NC State Employees Health Plan, plus vision, hearing, & dental | Be an uninsured child over age 5 & under age 19. | 211% of Poverty<br>1 - $2,070/mo<br>2 - $2,802/mo<br>3 - $3,533/mo<br>4 - $4,264/mo<br>5 - $4,996/mo | No resource limit | No | There is no deductible or spend down provision for NCHC. If a child is ineligible due to too much income, they will be evaluated for Medicaid with a deductible. | Income over 159% of poverty must pay enrollment fee.<br>1 - $1,560.01<br>2.-.$2111.01<br>3 - $2,662.01<br>4 - $3214.01<br>5 - $3765.01 |

* For Basic Coverage, the beneficiary does not have to meet the Social Security SGA requirement to be disabled. For Medically Improved coverage, the beneficiary does not have to meet the Social Security medical requirements for disability

******This chart addresses benefits and basic eligibility requirements. Other requirements (such as citizenship/alien status, incarceration, & state residence) which can also affect eligibility or the level of benefits are not reflected on this chart.

## Appendix B: County DSS Office Financial Data and Staffing Information for Medicaid Administration

| County Name | Fiscal Year 2011–12 Total Expenditures | Fiscal Year 2014–15 Total Expenditures | % Change Total Expenditures | Fiscal Year 2011–12 Total FTE | Fiscal Year 2014–15 Total FTE | % Change Total FTE |
|---|---|---|---|---|---|---|
| Alamance | $ 2,638,151 | $ 4,471,256 | 69% | 43.50 | 84.20 | 94% |
| Alexander | 535,601 | 941,843 | 76% | 10.06 | 20.48 | 104% |
| Alleghany | 375,567 | 484,341 | 29% | 6.24 | 8.57 | 37% |
| Anson | 909,318 | 899,871 | -1% | 17.34 | 15.20 | -12% |
| Ashe | 1,832,476 | 2,191,549 | 20% | 25.68 | 33.70 | 31% |
| Avery | 644,661 | 761,257 | 18% | 10.29 | 13.92 | 35% |
| Beaufort | 1,657,427 | 1,780,403 | 7% | 27.89 | 38.26 | 37% |
| Bertie | 1,016,782 | 1,216,879 | 20% | 16.46 | 24.55 | 49% |
| Bladen | 1,530,507 | 1,670,181 | 9% | 26.32 | 31.69 | 20% |
| Brunswick | 2,249,766 | 3,460,304 | 54% | 30.06 | 42.38 | 41% |
| Buncombe | 11,278,922 | 15,667,104 | 39% | 141.41 | 170.68 | 21% |
| Burke | 1,968,648 | 3,053,482 | 55% | 35.88 | 57.96 | 62% |
| Cabarrus | 4,338,265 | 5,184,888 | 20% | 67.01 | 102.72 | 53% |
| Caldwell | 1,574,170 | 1,988,380 | 26% | 28.61 | 45.45 | 59% |
| Camden | 335,514 | 482,320 | 44% | 5.49 | 8.44 | 54% |
| Carteret | 1,944,134 | 1,970,578 | 1% | 32.34 | 34.20 | 6% |
| Caswell | 662,061 | 698,505 | 6% | 13.28 | 15.65 | 18% |
| Catawba | 4,983,235 | 5,759,618 | 16% | 84.36 | 98.64 | 17% |
| Chatham | 1,376,683 | 1,566,702 | 14% | 19.78 | 30.37 | 54% |
| Cherokee | 1,022,546 | 1,135,742 | 11% | 16.47 | 20.40 | 24% |
| Chowan | 647,445 | 668,704 | 3% | 11.06 | 14.18 | 28% |
| Clay | 445,276 | 513,696 | 15% | 5.25 | 8.51 | 62% |
| Cleveland | 2,746,935 | 3,563,443 | 30% | 48.87 | 69.66 | 43% |
| Columbus | 2,344,485 | 2,339,419 | 0% | 47.87 | 69.69 | 46% |
| Craven | 3,061,640 | 3,797,492 | 24% | 50.98 | 65.86 | 29% |
| Cumberland | 8,093,867 | 11,778,490 | 46% | 136.95 | 245.08 | 79% |
| Currituck | 655,793 | 788,606 | 20% | 9.54 | 11.98 | 26% |
| Dare | 1,450,167 | 1,688,483 | 16% | 20.99 | 23.35 | 11% |
| Davidson | 2,183,060 | 2,741,027 | 26% | 41.19 | 75.82 | 84% |
| Davie | 569,509 | 758,566 | 33% | 8.93 | 14.38 | 61% |
| Duplin | 2,174,146 | 2,357,412 | 8% | 39.48 | 53.33 | 35% |
| Durham | 7,294,808 | 9,255,976 | 27% | 96.35 | 114.25 | 19% |
| Edgecombe | 1,866,379 | 2,244,054 | 20% | 37.85 | 52.99 | 40% |
| Forsyth | 8,778,997 | 9,125,247 | 4% | 138.70 | 177.84 | 28% |
| Franklin | 1,691,515 | 2,307,591 | 36% | 27.64 | 44.06 | 59% |

| County Name | Fiscal Year 2011–12 Total Expenditures | Fiscal Year 2014–15 Total Expenditures | % Change Total Expenditures | Fiscal Year 2011–12 Total FTE | Fiscal Year 2014–15 Total FTE | % Change Total FTE |
|---|---|---|---|---|---|---|
| Gaston | $ 4,991,585 | $ 5,547,048 | 11% | 74.67 | 102.88 | 38% |
| Gates | 474,766 | 550,810 | 16% | 7.89 | 10.20 | 29% |
| Graham | 438,396 | 433,300 | -1% | 7.80 | 9.65 | 24% |
| Granville | 1,206,532 | 1,679,854 | 39% | 21.82 | 28.86 | 32% |
| Greene | 491,712 | 530,792 | 8% | 10.03 | 11.83 | 18% |
| Guilford | 11,213,776 | 13,059,407 | 16% | 145.99 | 195.15 | 34% |
| Halifax | 2,120,196 | 2,449,141 | 16% | 38.34 | 42.97 | 12% |
| Harnett | 2,761,496 | 3,246,398 | 18% | 46.17 | 54.14 | 17% |
| Haywood | 1,909,145 | 2,154,144 | 13% | 27.99 | 47.86 | 71% |
| Henderson | 3,515,604 | 4,386,257 | 25% | 53.28 | 82.75 | 55% |
| Hertford | 927,215 | 914,320 | -1% | 17.21 | 17.85 | 4% |
| Hoke | 1,114,494 | 1,236,946 | 11% | 18.39 | 21.43 | 17% |
| Hyde | 541,423 | 567,915 | 5% | 8.21 | 8.79 | 7% |
| Iredell | 2,838,088 | 3,759,845 | 32% | 47.38 | 70.66 | 49% |
| Jackson | 1,143,126 | 1,252,774 | 10% | 13.84 | 17.77 | 28% |
| Johnston | 3,485,067 | 5,688,282 | 63% | 67.83 | 89.80 | 32% |
| Jones | 390,422 | 538,868 | 38% | 7.54 | 12.97 | 72% |
| Lee | 1,652,375 | 2,052,426 | 24% | 27.00 | 39.52 | 46% |
| Lenoir | 2,107,942 | 2,404,500 | 14% | 35.50 | 46.39 | 31% |
| Lincoln | 1,960,299 | 2,330,841 | 19% | 31.19 | 43.73 | 40% |
| Macon | 932,800 | 1,294,102 | 39% | 13.29 | 25.00 | 88% |
| Madison | 721,956 | 830,107 | 15% | 15.50 | 20.96 | 35% |
| Martin | 1,229,058 | 1,087,374 | -12% | 23.05 | 23.15 | 0% |
| McDowell | 1,312,708 | 1,758,854 | 34% | 24.96 | 36.37 | 46% |
| Mecklenburg | 21,286,851 | 26,643,345 | 25% | 254.22 | 339.51 | 34% |
| Mitchell | 604,445 | 661,744 | 9% | 10.65 | 13.49 | 27% |
| Montgomery | 819,966 | 985,234 | 20% | 15.28 | 17.22 | 13% |
| Moore | 1,980,593 | 2,560,816 | 29% | 30.04 | 48.37 | 61% |
| Nash | 2,483,905 | 2,806,281 | 13% | 40.73 | 54.28 | 33% |
| New Hanover | 5,116,676 | 6,029,166 | 18% | 70.64 | 92.78 | 31% |
| Northampton | 1,040,973 | 1,318,759 | 27% | 18.73 | 26.05 | 39% |
| Onslow | 3,350,152 | 3,460,787 | 3% | 59.64 | 69.13 | 16% |
| Orange | 2,877,230 | 3,589,359 | 25% | 36.79 | 42.66 | 16% |
| Pamlico | 611,965 | 890,703 | 46% | 11.24 | 19.63 | 75% |
| Pasquotank | 1,686,542 | 1,905,181 | 13% | 32.78 | 41.68 | 27% |
| Pender | 1,675,526 | 2,049,572 | 22% | 29.75 | 34.21 | 15% |
| Perquimans | 527,320 | 642,823 | 22% | 10.41 | 15.85 | 52% |

| County Name | Fiscal Year 2011–12 Total Expenditures | Fiscal Year 2014–15 Total Expenditures | % Change Total Expenditures | Fiscal Year 2011–12 Total FTE | Fiscal Year 2014–15 Total FTE | % Change Total FTE |
|---|---|---|---|---|---|---|
| Person | $ 1,434,393 | $ 1,887,882 | 32% | 25.11 | 37.71 | 50% |
| Pitt | 3,315,064 | 5,260,739 | 59% | 46.67 | 98.61 | 111% |
| Polk | 527,199 | 718,381 | 36% | 9.17 | 13.57 | 48% |
| Randolph | 2,547,723 | 2,911,445 | 14% | 43.67 | 46.47 | 6% |
| Richmond | 1,362,492 | 1,714,548 | 26% | 27.17 | 35.30 | 30% |
| Robeson | 4,809,696 | 5,624,306 | 17% | 84.52 | 104.72 | 24% |
| Rockingham | 2,495,208 | 2,264,706 | -9% | 38.68 | 36.57 | -5% |
| Rowan | 2,931,487 | 3,163,825 | 8% | 50.66 | 53.88 | 6% |
| Rutherford | 1,637,608 | 2,501,226 | 53% | 28.59 | 48.26 | 69% |
| Sampson | 2,648,940 | 2,885,252 | 9% | 50.19 | 60.12 | 20% |
| Scotland | 1,212,183 | 1,555,423 | 28% | 23.11 | 31.27 | 35% |
| Stanly | 1,113,353 | 1,449,534 | 30% | 18.66 | 23.64 | 27% |
| Stokes | 828,786 | 904,445 | 9% | 15.21 | 23.21 | 53% |
| Surry | 2,095,321 | 2,095,136 | 0% | 38.63 | 43.81 | 13% |
| Swain | 452,378 | 677,207 | 50% | 9.16 | 14.99 | 64% |
| Transylvania | 837,237 | 1,099,084 | 31% | 11.90 | 16.46 | 38% |
| Tyrrell | 373,111 | 539,624 | 45% | 6.21 | 8.80 | 42% |
| Union | 3,637,699 | 4,669,140 | 28% | 52.22 | 90.90 | 74% |
| Vance | 1,467,083 | 1,790,902 | 22% | 25.05 | 39.13 | 56% |
| Wake | 9,785,105 | 20,932,458 | 114% | 149.53 | 337.64 | 126% |
| Warren | 1,106,580 | 1,247,636 | 13% | 22.12 | 27.57 | 25% |
| Washington | 728,147 | 761,977 | 5% | 13.86 | 15.02 | 8% |
| Watauga | 1,064,242 | 1,032,206 | -3% | 15.22 | 17.95 | 18% |
| Wayne | 2,569,491 | 3,223,674 | 25% | 48.28 | 68.60 | 42% |
| Wilkes | 1,304,282 | 1,477,881 | 13% | 23.48 | 31.13 | 33% |
| Wilson | 3,430,567 | 4,681,126 | 36% | 58.59 | 87.51 | 49% |
| Yadkin | 890,020 | 973,726 | 9% | 14.83 | 17.88 | 21% |
| Yancey | 558,268 | 876,781 | 57% | 10.13 | 18.62 | 84% |
| **State Totals** | **$237,584,444** | **$301,531,755** | **27%** | 3,746.50 | 5,263.33 | **40%** |

## Appendix C: County Medicaid Enrollment and DSS Office Workload Information

| County Name | Fiscal Year 2011–12 Total Applications | Fiscal Year 2014–15 Total Applications | % Change | Fiscal Year 2011–12 Total Enrollment | Fiscal Year 2014–15 Total Enrollment | % Change | Structure | Backlog of Apps | Fiscal Year 2014–15 % Population Enrolled | Fiscal Year 2014–15 Enrollment Per FTE | Fiscal Year 2014–15 Applications Per FTE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alamance | 13,968 | 16,340 | 17% | 35,478 | 37,331 | 5% | Universal Apps | Yes | 23% | 443 | 194 |
| Alexander | 3,678 | 3,791 | 3% | 8,674 | 8,333 | -4% | Non-Universal | No | 22% | 407 | 185 |
| Alleghany | 995 | 1,145 | 15% | 2,963 | 2,886 | -3% | Universal Apps | Yes | 25% | 337 | 134 |
| Anson | 3,107 | 2,524 | -19% | 8,236 | 8,002 | -3% | Universal Apps | No | 29% | 527 | 166 |
| Ashe | 2,297 | 2,841 | 24% | 6,756 | 6,621 | -2% | Universal Apps | Yes | 23% | 196 | 84 |
| Avery | 1,493 | 1,489 | 0% | 4,139 | 3,913 | -5% | Non-Universal | Yes | 23% | 281 | 107 |
| Beaufort | 4,782 | 5,246 | 10% | 13,615 | 13,258 | -3% | Universal Apps | Yes | 26% | 347 | 137 |
| Bertie | 2,397 | 2,817 | 18% | 7,007 | 6,681 | -5% | Non-Universal | Yes | 30% | 272 | 115 |
| Bladen | 4,511 | 4,580 | 2% | 11,796 | 10,921 | -7% | Non-Universal | Yes | 30% | 345 | 145 |
| Brunswick | 10,207 | 11,826 | 16% | 23,831 | 24,653 | 3% | Universal Apps | Yes | 20% | 582 | 279 |
| Buncombe | 26,625 | 31,920 | 20% | 55,373 | 55,512 | 0% | Universal Apps | Yes | 22% | 325 | 187 |
| Burke | 9,446 | 10,389 | 10% | 22,785 | 22,126 | -3% | Non-Universal | Yes | 24% | 382 | 179 |
| Cabarrus | 17,136 | 18,403 | 7% | 38,644 | 40,779 | 6% | Universal Apps | Yes | 20% | 397 | 179 |
| Caldwell | 9,192 | 9,753 | 6% | 22,153 | 21,828 | -1% | Non-Universal | Yes | 25% | 480 | 215 |
| Camden | 648 | 674 | 4% | 1,600 | 1,499 | -6% | Universal Apps | No | 14% | 178 | 80 |
| Carteret | 5,574 | 7,321 | 31% | 12,542 | 13,238 | 6% | Universal Apps | No | 18% | 387 | 214 |
| Caswell | 2,210 | 2,142 | -3% | 6,432 | 6,380 | -1% | Universal Apps | Yes | 27% | 408 | 137 |
| Catawba | 14,162 | 15,415 | 9% | 36,896 | 37,449 | 1% | Universal Apps | Yes | 23% | 380 | 156 |
| Chatham | 4,552 | 4,669 | 3% | 10,809 | 10,874 | 1% | Universal Apps | Yes | 15% | 358 | 154 |
| Cherokee | 3,182 | 3,779 | 19% | 7,408 | 7,346 | -1% | Universal Apps | No | 25% | 360 | 185 |
| Chowan | 1,775 | 1,777 | 0% | 4,338 | 4,137 | -5% | Universal Apps | No | 29% | 292 | 125 |
| Clay | 1,156 | 1,217 | 5% | 2,747 | 2,597 | -5% | Non-Universal | Yes | 23% | 305 | 143 |
| Cleveland | 10,693 | 12,030 | 13% | 30,098 | 30,425 | 1% | Universal Apps | Yes | 30% | 437 | 173 |
| Columbus | 7,224 | 8,726 | 21% | 20,447 | 19,662 | -4% | Non-Universal | Yes | 33% | 282 | 125 |
| Craven | 9,193 | 10,098 | 10% | 21,513 | 22,318 | 4% | Universal Apps | Yes | 20% | 339 | 153 |
| Cumberland | 30,547 | 46,293 | 52% | 81,074 | 85,708 | 6% | Non-Universal | Yes | 25% | 350 | 189 |
| Currituck | 1,762 | 1,950 | 11% | 3,897 | 3,821 | -2% | Non-Universal | Yes | 16% | 319 | 163 |
| Dare | 3,633 | 4,063 | 12% | 6,212 | 6,305 | 1% | Universal Apps | Yes | 19% | 270 | 174 |
| Davidson | 17,324 | 17,242 | 0% | 40,088 | 38,916 | -3% | Universal Apps | Yes | 22% | 513 | 227 |
| Davie | 3,308 | 3,417 | 3% | 8,234 | 8,024 | -3% | Universal Apps | Yes | 18% | 558 | 238 |
| Duplin | 5,960 | 7,234 | 21% | 16,680 | 17,078 | 2% | Non-Universal | No | 27% | 320 | 136 |
| Durham | 27,214 | 31,906 | 17% | 61,204 | 62,537 | 2% | Universal Apps | Yes | 21% | 547 | 279 |
| Edgecombe | 7,006 | 8,470 | 21% | 21,907 | 21,510 | -2% | Universal Intake | Yes | 37% | 406 | 160 |
| Forsyth | 36,863 | 39,719 | 8% | 80,835 | 83,498 | 3% | Universal Apps | Yes | 22% | 470 | 223 |
| Franklin | 5,438 | 6,617 | 22% | 15,020 | 15,262 | 2% | Non-Universal | Yes | 23% | 346 | 150 |

| County Name | Fiscal Year 2011–12 Total Applications | Fiscal Year 2014–15 Total Applications | % Change | Fiscal Year 2011–12 Total Enrollment | Fiscal Year 2014–15 Total Enrollment | % Change | Structure | Backlog of Apps | Fiscal Year 2014–15 % Population Enrolled | Fiscal Year 2014–15 Enrollment Per FTE | Fiscal Year 2014–15 Applications Per FTE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Gaston | 26,483 | 25,900 | -2% | 56,481 | 56,505 | 0% | Universal Apps | Yes | 27% | 549 | 252 |
| Gates | 923 | 894 | -3% | 2,518 | 2,439 | -3% | Universal Apps | No | 19% | 239 | 88 |
| Graham | 1,213 | 1,409 | 16% | 2,855 | 2,722 | -5% | Non-Universal | Yes | 29% | 282 | 146 |
| Granville | 4,809 | 5,321 | 11% | 12,498 | 12,252 | -2% | Universal Intake | Yes | 19% | 425 | 184 |
| Greene | 2,135 | 2,024 | -5% | 5,877 | 5,671 | -4% | Non-Universal | Yes | 27% | 480 | 171 |
| Guilford | 42,055 | 51,807 | 23% | 105,385 | 116,091 | 10% | Universal Apps | Yes | 22% | 595 | 265 |
| Halifax | 7,006 | 6,794 | -3% | 20,200 | 18,965 | -6% | Non-Universal | Yes | 35% | 441 | 158 |
| Harnett | 11,791 | 11,262 | -4% | 27,775 | 28,758 | 4% | Non-Universal | Yes | 22% | 531 | 208 |
| Haywood | 6,406 | 6,830 | 7% | 14,786 | 15,093 | 2% | Universal Apps | Yes | 24% | 315 | 143 |
| Henderson | 9,975 | 10,482 | 5% | 21,801 | 22,187 | 2% | Non-Universal | Yes | 19% | 268 | 127 |
| Hertford | 2,193 | 2,528 | 15% | 7,824 | 7,546 | -4% | Universal Apps | Yes | 29% | 423 | 142 |
| Hoke | 5,108 | 6,102 | 19% | 12,829 | 14,054 | 10% | Non-Universal | Yes | 25% | 656 | 285 |
| Hyde | 451 | 579 | 28% | 1,459 | 1,617 | 11% | Non-Universal | Yes | 28% | 184 | 66 |
| Iredell | 13,705 | 14,969 | 9% | 32,064 | 32,290 | 1% | Non-Universal | Yes | 19% | 457 | 212 |
| Jackson | 3,293 | 4,396 | 33% | 8,367 | 8,718 | 4% | Universal Apps | Yes | 20% | 491 | 247 |
| Johnston | 18,363 | 22,003 | 20% | 43,753 | 45,540 | 4% | Universal Intake | Yes | 23% | 507 | 245 |
| Jones | 1,000 | 1,271 | 27% | 2,716 | 2,636 | -3% | Non-Universal | Yes | 26% | 203 | 98 |
| Lee | 6,387 | 6,022 | -6% | 16,116 | 16,670 | 3% | Non-Universal | Yes | 27% | 422 | 152 |
| Lenoir | 7,623 | 7,104 | -7% | 19,427 | 19,426 | 0% | Universal Apps | Yes | 32% | 419 | 153 |
| Lincoln | 6,722 | 7,786 | 16% | 16,416 | 16,493 | 0% | Universal Apps | Yes | 19% | 377 | 178 |
| Macon | 3,679 | 4,570 | 24% | 8,621 | 8,741 | 1% | Non-Universal | No | 25% | 350 | 183 |
| Madison | 2,213 | 2,674 | 21% | 5,700 | 5,613 | -2% | Non-Universal | Yes | 26% | 268 | 128 |
| Martin | 2,811 | 2,856 | 2% | 7,752 | 7,318 | -6% | Universal Apps | No | 30% | 316 | 123 |
| McDowell | 5,074 | 5,646 | 11% | 12,992 | 13,045 | 0% | Universal Apps | Yes | 29% | 359 | 155 |
| Mecklenburg | 79,799 | 116,157 | 46% | 202,860 | 223,980 | 10% | Universal Apps | Yes | 22% | 660 | 342 |
| Mitchell | 1,509 | 1,804 | 20% | 4,148 | 3,994 | -4% | Universal Intake | Yes | 26% | 296 | 134 |
| Montgomery | 3,259 | 3,496 | 7% | 8,984 | 8,385 | -7% | Universal Apps | Yes | 30% | 487 | 203 |
| Moore | 7,438 | 8,187 | 10% | 17,154 | 16,734 | -2% | Non-Universal | Yes | 18% | 346 | 169 |
| Nash | 10,730 | 10,795 | 1% | 26,479 | 27,104 | 2% | Non-Universal | Yes | 26% | 499 | 199 |
| New Hanover | 17,234 | 16,538 | -4% | 38,537 | 39,914 | 4% | Universal Apps | Yes | 18% | 430 | 178 |
| Northampton | 2,691 | 2,385 | -11% | 7,530 | 6,979 | -7% | Non-Universal | Yes | 31% | 268 | 92 |
| Onslow | 13,760 | 17,183 | 25% | 28,928 | 35,369 | 22% | Universal Apps | Yes | 17% | 512 | 249 |
| Orange | 6,938 | 9,705 | 40% | 16,732 | 17,977 | 7% | Universal Intake | Yes | 12% | 421 | 227 |

| County Name | Fiscal Year 2011–12 Total Applications | Fiscal Year 2014–15 Total Applications | % Change | Fiscal Year 2011–12 Total Enrollment | Fiscal Year 2014–15 Total Enrollment | % Change | Structure | Backlog of Apps | Fiscal Year 2014–15 % Population Enrolled | Fiscal Year 2014–15 Enrollment Per FTE | Fiscal Year 2014–15 Applications Per FTE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Pamlico | 1,235 | 1,302 | 5% | 2,787 | 2,891 | 4% | Non-Universal | Yes | 22% | 147 | 66 |
| Pasquotank | 4,086 | 4,631 | 13% | 10,325 | 10,579 | 2% | Universal Apps | No | 26% | 254 | 111 |
| Pender | 5,986 | 5,901 | -1% | 13,107 | 13,748 | 5% | Non-Universal | Yes | 24% | 402 | 172 |
| Perquimans | 1,179 | 1,309 | 11% | 3,266 | 3,199 | -2% | Non-Universal | No | 23% | 202 | 83 |
| Person | 4,221 | 4,393 | 4% | 9,733 | 9,907 | 2% | Universal Apps | Yes | 24% | 263 | 117 |
| Pitt | 16,427 | 19,256 | 17% | 38,299 | 39,561 | 3% | Universal Apps | Yes | 21% | 401 | 195 |
| Polk | 1,408 | 1,727 | 23% | 3,982 | 3,833 | -4% | Non-Universal | Yes | 17% | 282 | 127 |
| Randolph | 13,607 | 14,579 | 7% | 36,441 | 36,117 | -1% | Universal Intake | Yes | 24% | 777 | 314 |
| Richmond | 6,948 | 7,180 | 3% | 17,095 | 16,801 | -2% | Universal Apps | No | 36% | 476 | 203 |
| Robeson | 18,553 | 21,760 | 17% | 54,766 | 53,911 | -2% | Universal Apps | Yes | 38% | 515 | 208 |
| Rockingham | 8,104 | 9,615 | 19% | 24,805 | 24,350 | -2% | Universal Apps | Yes | 25% | 666 | 263 |
| Rowan | 18,883 | 15,420 | -18% | 36,987 | 36,161 | -2% | Universal Apps | Yes | 25% | 671 | 286 |
| Rutherford | 8,136 | 8,124 | 0% | 19,269 | 19,421 | 1% | Non-Universal | Yes | 27% | 402 | 168 |
| Sampson | 9,433 | 10,444 | 11% | 21,930 | 21,287 | -3% | Universal Apps | Yes | 33% | 354 | 174 |
| Scotland | 4,983 | 5,081 | 2% | 13,842 | 14,035 | 1% | Universal Apps | Yes | 40% | 449 | 163 |
| Stanly | 5,606 | 6,212 | 11% | 14,654 | 14,669 | 0% | Non-Universal | Yes | 23% | 620 | 263 |
| Stokes | 4,252 | 4,978 | 17% | 9,806 | 10,306 | 5% | Universal Apps | Yes | 21% | 444 | 215 |
| Surry | 7,926 | 7,842 | -1% | 20,738 | 20,026 | -3% | Universal Apps | Yes | 26% | 457 | 179 |
| Swain | 1,917 | 2,726 | 42% | 4,953 | 4,774 | -4% | Universal Intake | Yes | 32% | 319 | 182 |
| Transylvania | 2,909 | 3,148 | 8% | 6,993 | 6,984 | 0% | Non-Universal | No | 20% | 424 | 191 |
| Tyrrell | 427 | 436 | 2% | 1,166 | 1,087 | -7% | Non-Universal | No | 24% | 124 | 50 |
| Union | 17,703 | 17,854 | 1% | 34,212 | 35,649 | 4% | Universal Apps | Yes | 16% | 392 | 196 |
| Vance | 6,620 | 6,954 | 5% | 18,251 | 17,973 | -2% | Non-Universal | Yes | 39% | 459 | 178 |
| Wake | 66,293 | 87,611 | 32% | 134,904 | 143,171 | 6% | Universal Apps | Yes | 14% | 424 | 259 |
| Warren | 2,310 | 2,598 | 12% | 6,784 | 6,467 | -5% | Non-Universal | No | 30% | 235 | 94 |
| Washington | 1,615 | 1,337 | -17% | 4,549 | 4,226 | -7% | Universal Apps | Yes | 32% | 281 | 89 |
| Watauga | 2,453 | 3,368 | 37% | 5,566 | 5,619 | 1% | Non-Universal | Yes | 10% | 313 | 188 |
| Wayne | 13,140 | 14,087 | 7% | 34,632 | 35,563 | 3% | Universal Apps | Yes | 28% | 518 | 205 |
| Wilkes | 6,596 | 8,064 | 22% | 18,294 | 17,695 | -3% | Non-Universal | Yes | 25% | 568 | 259 |
| Wilson | 8,942 | 17,662 | 98% | 23,821 | 24,391 | 2% | Non-Universal | No | 29% | 279 | 202 |
| Yadkin | 3,212 | 3,365 | 5% | 8,920 | 8,629 | -3% | Universal Apps | Yes | 22% | 483 | 188 |
| Yancey | 1,813 | 2,038 | 12% | 4,893 | 4,486 | -8% | Universal Apps | Yes | 26% | 241 | 109 |
| **Totals** | **920,957** | **1,076,304** | **17%** | **2,228,765** | **2,289,770** | **3%** | | | | | |

## Appendix D: Percentage of Medicaid Applications Processed Timely by County DSS Offices

| County | Fiscal Year 2011-12 | Fiscal Year 2012-13 | Fiscal Year 2013-14 | Fiscal Year 2014-15 |
|---|---|---|---|---|
| Alamance | 93.3% | 89.4% | 66.4% | 58.7% |
| Alexander | 99.0% | 90.9% | 83.0% | 77.4% |
| Alleghany | 99.2% | 92.2% | 76.3% | 83.1% |
| Anson | 97.4% | 89.6% | 76.2% | 74.0% |
| Ashe | 95.8% | 86.0% | 77.1% | 66.0% |
| Avery | 99.1% | 90.0% | 85.6% | 75.4% |
| Beaufort | 97.4% | 89.8% | 76.8% | 74.4% |
| Bertie | 97.8% | 91.7% | 77.2% | 70.9% |
| Bladen | 98.1% | 91.3% | 76.6% | 68.0% |
| Brunswick | 95.4% | 89.1% | 67.4% | 62.7% |
| Buncombe | 95.2% | 84.7% | 69.2% | 64.7% |
| Burke | 94.8% | 86.7% | 75.3% | 64.9% |
| Cabarrus | 95.8% | 82.1% | 70.2% | 62.7% |
| Caldwell | 97.7% | 85.9% | 68.9% | 66.6% |
| Camden | 98.0% | 78.8% | 68.8% | 70.7% |
| Carteret | 97.6% | 91.5% | 71.2% | 75.9% |
| Caswell | 98.6% | 87.7% | 83.8% | 76.2% |
| Catawba | 99.0% | 91.8% | 74.6% | 69.2% |
| Chatham | 96.6% | 86.0% | 66.0% | 67.2% |
| Cherokee | 99.3% | 87.9% | 78.7% | 74.1% |
| Chowan | 99.1% | 86.9% | 76.9% | 70.7% |
| Clay | 98.3% | 91.5% | 83.9% | 76.8% |
| Cleveland | 98.6% | 94.1% | 76.4% | 79.2% |
| Columbus | 98.4% | 90.9% | 79.6% | 50.7% |
| Craven | 98.2% | 89.4% | 73.5% | 78.0% |
| Cumberland | 96.9% | 87.5% | 56.3% | 60.7% |
| Currituck | 98.8% | 82.2% | 74.7% | 67.8% |
| Dare | 98.6% | 89.4% | 66.0% | 78.9% |
| Davidson | 97.8% | 87.3% | 75.9% | 72.0% |
| Davie | 97.2% | 88.5% | 67.6% | 53.8% |
| Duplin | 98.8% | 92.4% | 75.1% | 75.5% |
| Durham | 96.8% | 80.9% | 62.4% | 61.2% |
| Edgecombe | 97.8% | 89.2% | 86.4% | 67.6% |
| Forsyth | 95.7% | 86.0% | 64.6% | 44.5% |

| County | Fiscal Year 2011-12 | Fiscal Year 2012-13 | Fiscal Year 2013-14 | Fiscal Year 2014-15 |
|---|---|---|---|---|
| Franklin | 98.7% | 88.2% | 75.7% | 70.2% |
| Gaston | 98.8% | 92.0% | 78.2% | 64.4% |
| Gates | 98.8% | 83.5% | 76.2% | 76.3% |
| Graham | 93.2% | 85.1% | 53.0% | 43.4% |
| Granville | 97.8% | 79.2% | 64.6% | 61.3% |
| Greene | 95.9% | 87.7% | 75.4% | 70.7% |
| Guilford | 94.9% | 80.3% | 70.1% | 65.2% |
| Halifax | 97.8% | 87.7% | 77.7% | 70.9% |
| Harnett | 96.8% | 88.3% | 79.5% | 59.5% |
| Haywood | 98.3% | 85.2% | 71.1% | 76.2% |
| Henderson | 96.1% | 85.6% | 71.8% | 74.9% |
| Hertford | 99.0% | 90.2% | 76.4% | 66.9% |
| Hoke | 97.0% | 86.7% | 72.0% | 54.4% |
| Hyde | 90.3% | 80.4% | 65.3% | 54.2% |
| Iredell | 95.7% | 82.1% | 72.6% | 60.4% |
| Jackson | 97.8% | 87.3% | 76.1% | 61.9% |
| Johnston | 98.0% | 90.9% | 70.8% | 70.9% |
| Jones | 98.2% | 88.8% | 91.2% | 62.0% |
| Lee | 96.8% | 89.5% | 80.9% | 70.6% |
| Lenoir | 98.4% | 93.2% | 84.1% | 79.9% |
| Lincoln | 97.0% | 87.0% | 69.9% | 70.3% |
| Macon | 97.4% | 88.4% | 74.7% | 75.0% |
| Madison | 98.7% | 82.1% | 75.2% | 69.8% |
| Martin | 98.3% | 89.6% | 79.6% | 66.1% |
| McDowell | 98.6% | 94.3% | 81.7% | 74.0% |
| Mecklenburg | 95.8% | 81.3% | 66.6% | 45.8% |
| Mitchell | 95.8% | 83.0% | 75.1% | 67.0% |
| Montgomery | 99.2% | 91.2% | 85.5% | 75.7% |
| Moore | 97.4% | 89.2% | 74.8% | 66.4% |
| Nash | 94.7% | 82.4% | 68.6% | 67.6% |
| New Hanover | 97.3% | 86.7% | 72.1% | 70.5% |
| Northampton | 98.8% | 86.0% | 75.5% | 59.7% |
| Onslow | 97.4% | 85.7% | 63.2% | 60.8% |
| Orange | 94.9% | 82.3% | 50.9% | 53.9% |
| Pamlico | 97.2% | 87.6% | 74.9% | 50.1% |
| Pasquotank | 99.0% | 83.5% | 74.4% | 68.4% |

| County | Fiscal Year 2011-12 | Fiscal Year 2012-13 | Fiscal Year 2013-14 | Fiscal Year 2014-15 |
|---|---|---|---|---|
| Pender | 95.9% | 81.8% | 58.7% | 55.8% |
| Perquimans | 100.0% | 94.6% | 79.8% | 74.4% |
| Person | 93.8% | 84.3% | 68.8% | 68.3% |
| Pitt | 90.4% | 73.9% | 52.8% | 52.2% |
| Polk | 96.4% | 86.5% | 72.3% | 67.0% |
| Randolph | 98.3% | 82.0% | 66.5% | 57.7% |
| Richmond | 96.9% | 88.6% | 64.1% | 72.8% |
| Robeson | 94.3% | 87.4% | 72.1% | 54.8% |
| Rockingham | 99.1% | 91.4% | 87.1% | 67.9% |
| Rowan | 97.0% | 85.3% | 67.3% | 59.0% |
| Rutherford | 96.4% | 87.2% | 77.2% | 71.1% |
| Sampson | 98.1% | 91.5% | 69.4% | 72.3% |
| Scotland | 98.3% | 88.4% | 71.7% | 67.1% |
| Stanly | 98.8% | 93.8% | 80.7% | 68.9% |
| Stokes | 98.3% | 86.7% | 73.2% | 66.3% |
| Surry | 96.9% | 86.8% | 76.8% | 63.9% |
| Swain | 97.7% | 78.2% | 72.8% | 63.7% |
| Transylvania | 98.9% | 89.4% | 84.2% | 74.3% |
| Tyrrell | 96.8% | 86.5% | 84.1% | 78.5% |
| Union | 95.5% | 84.1% | 73.9% | 63.5% |
| Vance | 97.6% | 85.8% | 74.7% | 59.3% |
| Wake | 94.3% | 69.4% | 52.2% | 37.9% |
| Warren | 97.9% | 92.4% | 87.8% | 82.7% |
| Washington | 99.7% | 90.0% | 74.4% | 65.9% |
| Watauga | 97.2% | 81.8% | 61.2% | 49.7% |
| Wayne | 97.8% | 88.5% | 77.4% | 77.3% |
| Wilkes | 96.6% | 84.6% | 81.5% | 65.9% |
| Wilson | 96.1% | 83.8% | 69.7% | 82.5% |
| Yadkin | 97.0% | 89.2% | 67.6% | 63.2% |
| Yancey | 94.5% | 69.3% | 61.4% | 58.2% |
| **State Timeliness Percentage** | **97%** | **87%** | **70%** | **61%** |

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**North Carolina Department of Health and Human Services**
**Division of Medical Assistance**

Pat McCrory
Governor

Richard O. Brajer
Secretary

Dave Richard
Deputy Secretary for Medical Assistance

April 4, 2016

John W. Turcotte, Director
Program Evaluation Division
300 N. Salisbury Street, Suite 100
Raleigh, NC 27603-5925

Dear Mr. Turcotte,

Thank you for the opportunity to respond to the recent evaluation on the "Timeliness of Medicaid Eligibility Determinations Decline Imposed by NC FAST and the Affordable Care Act implementation".

Let me first thank you for the spirit of cooperation that your staff exhibited throughout this review. They were professional at all times and clearly committed to drafting a report that is designed to improve our system. The report confirms the impact on the Medicaid Eligibility processes created by the unprecedented changes imposed by Federal requirements while we were instituting our new NCFAST system.

While we are confident the Department of Health and Human Services (DHHS) and the counties are making significant progress your recommendations will enhance our ability to improve our processes. DHHS agrees with your evaluation and recommendations to improve the effectiveness and efficiency of our eligibility determination system.

The three recommendations reporting the timeliness of determinations; building performance metrics in NC FAST; and providing access to other systems along with changing statutory authority are targeted and feasible to implement. We do recognize implementing a system to allow DHHS intervention if a county is not meeting performance standards will require a close working relationship with the counties to effectively implement. If this recommendation is enacted we are committed to working with county leadership to assure that it is a tool for performance improvement.

Again, thank you for a comprehensive evaluation. DHSS and the County DSS will continue to work towards a more efficient and effective Medicaid eligibility determinations to better serve our State and beneficiaries.

Sincerely,

Dave Richard

Attachment: DHHS Technical Response

www.ncdhhs.gov
Tel 919-855-4100 • Fax 919-733-6608
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Mailing Address: 2501 Mail Service Center • Raleigh, NC 27699-2501
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ncacdss

*A Future Oriented Source of Leadership*

April 1, 2016

Mr. John W. Turcotte, Director
North Carolina General Assembly
Program Evaluation Division
300 N Salisbury Street, Suite 100
Raleigh NC 27603-5925

Dear Mr. Turcotte:

Thank you for providing the North Carolina Association of County Directors of Social Services (NCACSSS) the opportunity to respond to the final "Report on Timeliness of Medicaid Eligibility Determination Decline Due to Challenges Imposed by NC FAST and Affordable Care Act Implementation".

The evaluation process provided counties and NCACDSS the opportunity to showcase business operations, knowledge of the Medicaid program and our trained and dedicated staff. NCACDSS appreciated the opportunity to participate in the evaluation and the consideration shown to all county DSS offices and in particular the 15 selected for site visits.

NCACDSS offers the following response from a county perspective to these very complicated issues described in this Report. Below are other important root cause factors that we believe the General Assembly should be aware of that impacted the decrease in timeliness for processing Medicaid applications.

- While the Report's focus was Medicaid, it is important to mention the additional workload for County DSS offices with FNS caseload increases of 75% between 2008 and 2013. This was an impact on the same workforce that is responsible for MA applications/recertifications.

- Additional planned NC FAST rollout of other new programs, Child Care, Energy Assistance, Medicaid Transportation, will impact of the workforce and County infrastructure.

- While the State and Counties have invested a great deal in an integrated system, USDA (FNS) and CMS (Medicaid) appear to be moving in two different directions. USDA is

focused on same day benefits achieved by face to face consumer interface, and CMS is moving toward a self-directed consumer model relying on access through technology.

- A County's ability to meet timeliness and quality standards is dependence upon NC FAST providing accurate and reliable data.

In spite of the past and ongoing challenges, we have made much progress in meeting the Medicaid timeliness standard. Finally, we hope this Report serves as a tool to promote stronger statewide support and supervision as well as targeted focus of resources from DHHS to improve the functionality, reliability and flexibility of the NC FAST system.

We appreciate PED's robust assessment and partnership throughout this process and look forward to the final report.

Sincerely,

Susan McCracken, President