



Ensuring Timely and Accurate Medicaid and CHIP Eligibility Determinations at Application

May 2024



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Objectives



This slide deck presents options and strategies that states can implement to help improve application processing timeframes and address application backlogs. Implementing these strategies will help states ensure timely access to Medicaid and CHIP coverage.

Context Setting

Existing Regulatory Framework: Timely Determination of Eligibility

*42 C.F.R. §§ 435.912
and 457.340.*

- Eligibility must be determined “promptly and without undue delay.”
- Eligibility determinations may not exceed 90 days for individuals applying for Medicaid on the basis of a disability, and 45 days for all other Medicaid and CHIP applicants.
- The timeliness standard covers the period-of-time from the date of application or transfer from another insurance affordability program (including the Exchange serving the state) to the date the agency notifies the applicant of its decision or transfers the individual to another insurance affordability program.
- Timeliness standards include time given to the applicant to provide additional documentation and for the state to process such information.

New Requirements to Streamline Application Processes

In March 2024, CMS issued final regulations on streamlining enrollment in Medicaid, CHIP, and the Basic Health Program. The final rule establishes new requirements that apply to the application process and will take effect 36 months after the effective date of the rule.

Provide a reasonable period-of-time, and no less than 15 calendar days, for an individual to respond to a request for additional information. Individuals must be able to submit follow-up information through all modalities through which applications are accepted.

42 C.F.R. §§ 435.907 and 457.330.

Establish a 90-day (or longer, at state option) application reconsideration period, from the date of the notice of ineligibility, for individuals denied for not providing all information needed by the state to make a determination.

Make the same streamlined application procedures available to all applicants (both MAGI and non-MAGI applications):

New 42 C.F.R. §§ 435.907(c)(4) and 435.916(b)(2)(iv)).

- Prohibit states from requiring in-person interviews for all applicants.
- Require non-MAGI applications and supplemental forms to be accepted through all modalities previously applicable to MAGI applications (online, by telephone, by mail, in person, and through other commonly available electronic means).

Over Two-Thirds of MAGI Applications Nationally are Processed Within One Week

On a regular basis, as part of the Medicaid and CHIP Eligibility and Enrollment Performance Indicators process, CMS reports MAGI application processing time data for states.

MAGI application processing time data represent the length of time it takes state Medicaid and CHIP agencies to conduct all final MAGI determinations for individuals at application, regardless of date of application.

Key Findings from the October - December 2023 MAGI Application Processing Time Report

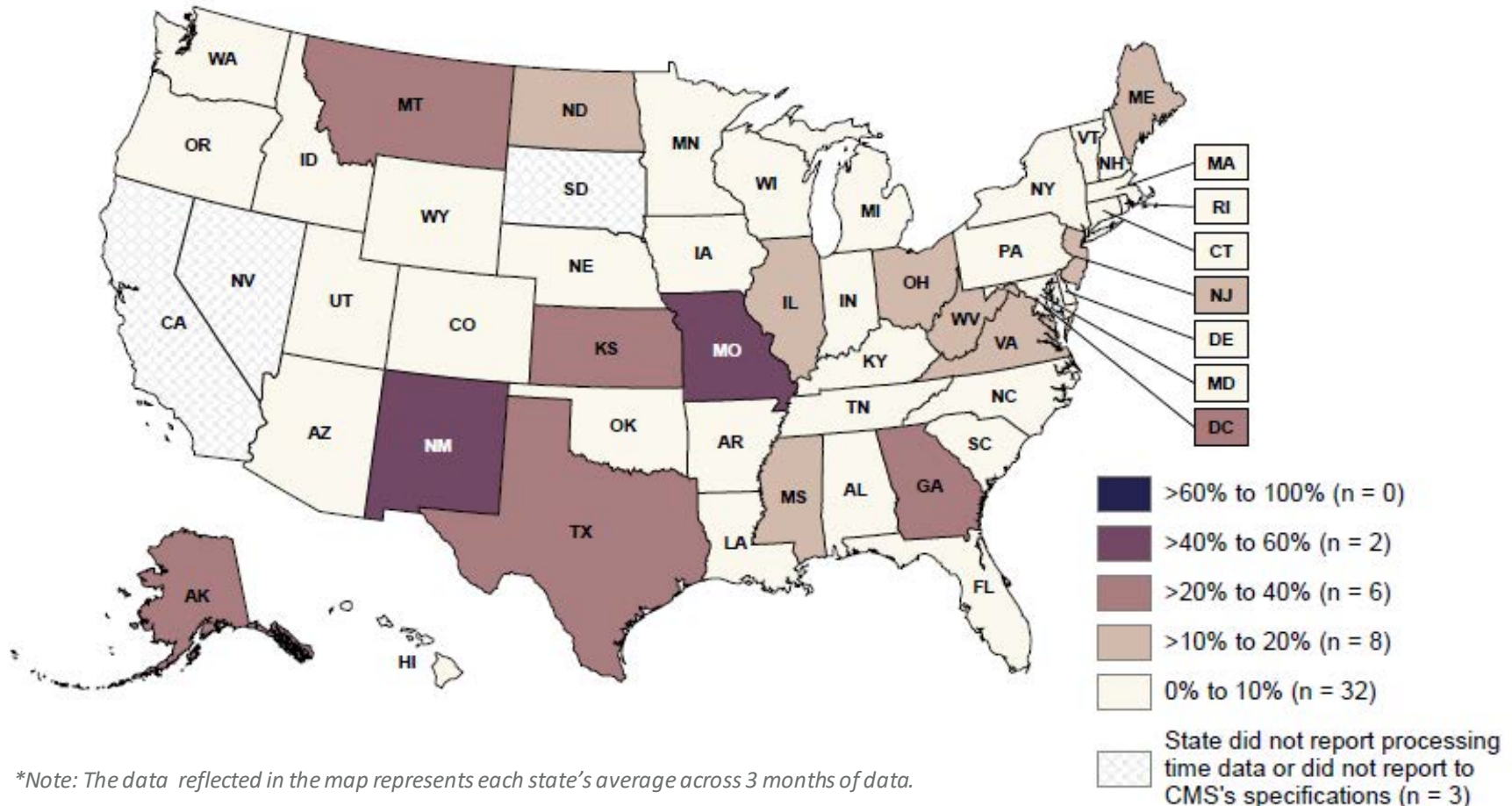
Among the states* that reported:

- Over half (54%) of MAGI determinations at application were made in under 24 hours.
- More than two-thirds (67%) of MAGI determinations were made within 7 days.
 - In 18 states, more than 60% of MAGI determinations were made within 7 days.
 - In 20 states, 40% or less of MAGI determinations were made within 7 days.
- 7% of MAGI determinations were made in more than 45 days.

**Note: California, Nevada, and South Dakota did not report October–December MAGI application processing time data that aligned with CMS's specifications. Data for these states are excluded from the national-level statistics presented in the report.*

MAGI Application Processing Times Vary by State

Percentage of Medicaid MAGI and CHIP Determinations at Application Processed in More Than 45 Days, October 2023 – December 2023



*Note: The data reflected in the map represents each state's average across 3 months of data.

Factors that May Influence Application Processing Timeframes



States with limited eligibility and enrollment capacity may be focusing on redeterminations, which, in turn, may cause application processing delays.



Limited systems capacity and lack of automation may increase manual workload and cause delays in processing applications.



States that have not updated their verification processes may need to rely on manual processes, which can lead to application processing delays.



States are processing late renewal information returned during the 90-day reconsideration period (which serve as applications and are subject to application processing timeline requirements).



States are processing new applications for individuals who lost coverage following a renewal and are reapplying (if past the 90-day reconsideration period).



State outreach/education campaigns may contribute to new beneficiaries submitting applications.








State efforts to expand Medicaid and CHIP coverage can increase application volume and lengthen processing times as a result.



States with insufficient staff levels/workforce capacity may face challenges handling a high volume of applications.

Critical Features That Contribute to Timely and Accurate Application Processing

-  An application design that effectively collects all required information and minimizes the need for additional action by the state and applicant to process the application.
-  A robust verification process that includes electronic data sources, as well as efficient and effective practices to minimize the need for additional documentation.
-  A well-trained and adequately resourced eligibility workforce that is sufficiently equipped to process applications.
-  A well-functioning eligibility system with interfaces to verification data sources that maximizes automated workflows and includes an automated rules engine and master client index to support the determination process.
-  Strong management and oversight of the process, including when determinations are made by other agencies.

Opportunities for States to Improve Application Processing Timeliness

States should review application data—by type (including account transfers), volume received, age of pending applications—and processes to inform implementation of strategies now and in the longer-term that will help ensure compliance with the federal timeliness requirements.

In the immediate term:

- Adopt available flexibilities to minimize manual work for eligibility workers and invest in workforce improvements to expand staff capacity.
- Implement flexibilities to increase real-time determinations and *ex parte* renewal rates.
- Take steps available under existing regulations and temporary waivers and flexibilities, as appropriate, to expedite access to care for individuals, pending a final determination of eligibility, including by adopting and expanding presumptive eligibility, updating verification practices (e.g., to adopt post-enrollment verification), and identifying and prioritizing processing of applications for individuals with high needs.

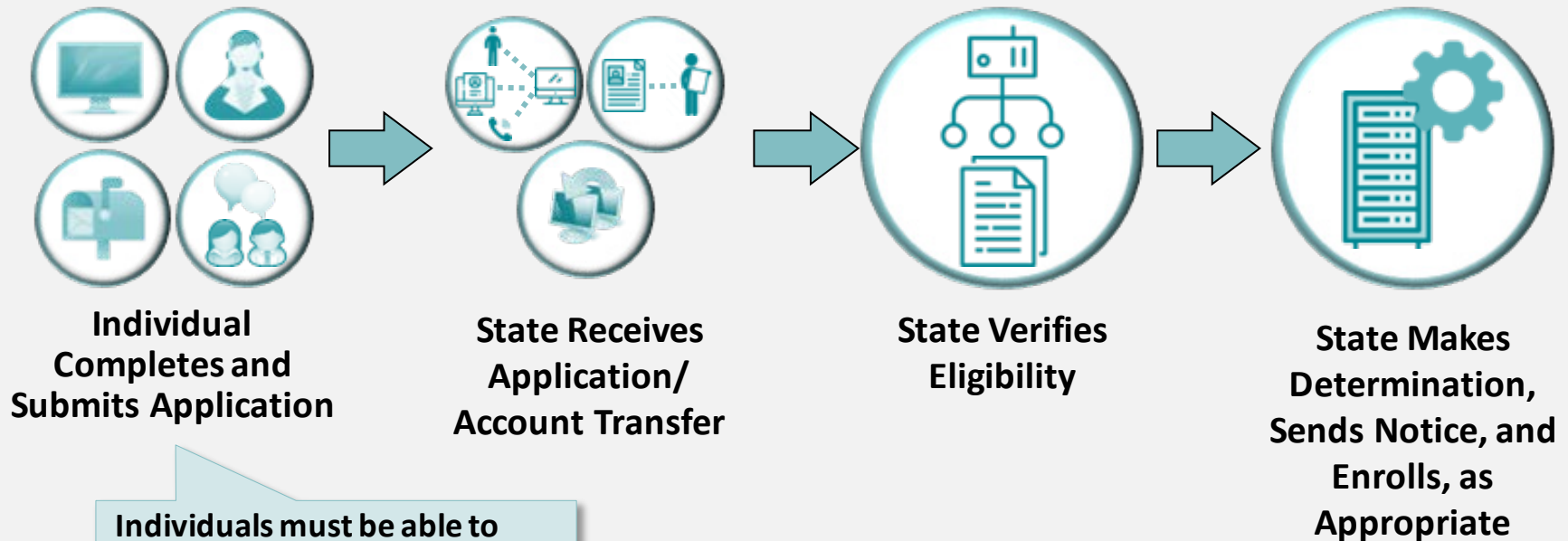
In the longer-term:

- Invest in modernized eligibility systems that include worker portals, electronic beneficiary accounts, interfaces to verification data sources, and automation.
- Increase availability of, and reliance on, electronic data sources for verification at application and renewal.
- Ensure effective communication and sufficient assistance for all individuals.

Subsequent slides in this deck provide detail on strategies that states may take up.

Application Process Workflow Overview

There are four integral steps to the application process workflow that impact application processing timeframes.



Individuals must be able to submit applications through the following modalities:

- (1) Online
- (2) Telephone
- (3) Mail
- (4) In-person
- (5) Through other commonly available electronic means

Immediate-Term Policies and Processes to Improve Application Processing and Mitigate the Impact of Backlogs on Applicants

Section 1902(e)(14), SNAP, and Presumptive Eligibility Strategies



Adopt section 1902(e)(14) strategies to:

- Help increase ex parte renewal rates and reduce churn, in effect reducing the volume of new applications. For example, adopt the Targeted SNAP/TANF Strategy, \$0 and 100% FPL Income Strategies, Streamlining Asset Determinations Strategy, Asset Verification System Strategy.
- Expand capacity for assistance through Medicaid and CHIP managed care plans and other partners to assist beneficiaries with completing and submitting their renewal form.



Rely on findings from other programs at application and renewal (e.g., section 1902(e)(14) Targeted SNAP/TANF Strategy, Express Lane Eligibility for children) to streamline enrollment into Medicaid.



Adopt **presumptive eligibility strategies**, including:

- Designating the state agency as a qualified entity to conduct presumptive eligibility determinations based on attested information on an application.
- Expanding the list of presumptive eligibility qualified entities (e.g., community health centers and other clinics that furnish health care) to make presumptive eligibility determinations.

Verification and Determination Strategies



Review and make changes to verification processes:

- Expand the reasonable compatibility standard at application and apply a threshold (e.g. number or percent) for MAGI and non-MAGI enrollees.
- Accept self-attestation of non-financial eligibility criteria (e.g., residency) and reasonable explanations of discrepancies in lieu of documentation.
- Conduct “post-enrollment verification” (i.e., determine eligibility based on an applicant’s attested information and conduct required verifications after enrollment).



Become a Medicaid and CHIP FFM Eligibility Determination State (if currently an Assessment State with the FFM or SBM on the Federal Platform); and/or consider temporarily accepting assessments as determinations.



Establish a 90-day (or longer) reconsideration period at application as soon as possible and before the final rule’s compliance deadline of June 2027 to simplify application processing when applicants return requested information needed to determine eligibility after being denied for failure to do so.

Workforce Strategies



- Implement targeted workforce strategies** to help ensure adequate staff capacity to process applications and connect applicants to care timely. For example:
- Redistribute unwinding-related renewals to temporarily shift eligibility staff to process applications; redistribute work across the state, county, or region; and/or establish overflow or specialized units.
 - Adopt workplace flexibilities (e.g., allow overtime, telework, and remote work; offer increased wages; provide bonuses and other financial incentives).
 - Expand use of outstation locations for eligibility workers to provide individuals with application assistance.
 - Partner with Navigators, assisters, managed care plans, providers, community groups, and other community-based organizations to support individuals with the application process, including facilitating online submissions and offering in-person assistance.



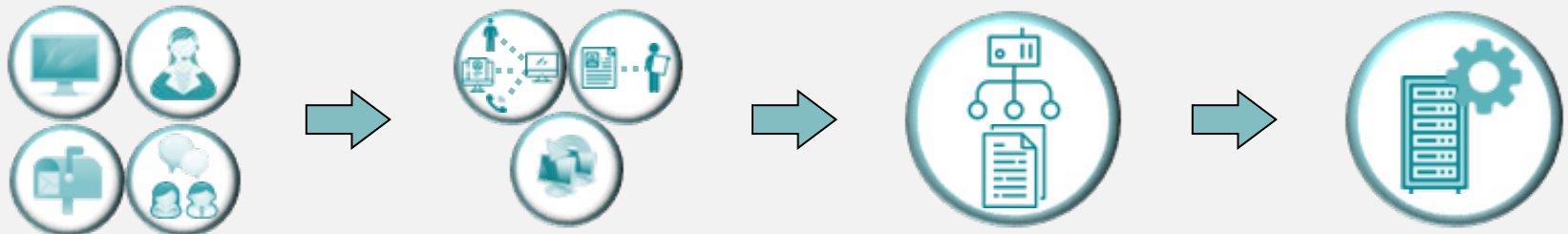
Ensure adequate in-person application assistance is available to increase application completeness and minimize requests for additional information.

Additional Policies and Processes to Improve Application Processing Timeliness

Overview of Additional Strategies

Strategies Within the Application Process Workflow

Individual Completes and Submits Application	State Receives Application/ Account Transfer	State Verifies Eligibility	State Makes Determination, Sends Notice, and Enrolls
<ol style="list-style-type: none"> 1. Provide and Enhance Consumer Assistance Tools 2. Encourage Use of Online Applications 3. Promote Telephonic Applications 4. Provide Effective Communication 5. Ensure Sufficient Assistance is Available 	<ol style="list-style-type: none"> 6. Automate the Receipt and Processing of an Application/ Account Transfer, including through a permanent transition to an FFM determination state 7. Create Efficiencies and Targets for Processing Paper Applications 8. Increase Workforce Capacity 	<ol style="list-style-type: none"> 9. Automate Verification 10. Leverage a Comprehensive Set of Electronic Data Sources 11. Apply a Reasonable Compatibility Threshold 12. Rely on Other Programs' Findings for Data Verification 	<ol style="list-style-type: none"> 13. Automate the Rules Engine 14. Extend the Reconsideration Period at Renewal and Implement a Reconsideration Period at Application 15. Enhance Workforce Training and Continuous Improvement 16. Use Management Reports and Dashboards



Statutory and Regulatory Framework for Medicaid/CHIP MAGI Applications

*SSA § 1943; 42 C.F.R. §§
435.907 and 457.330*

Single Streamlined or Approved Alternative Application: States must accept applications online, by telephone, in-person, by mail or through other available electronic means.

- States may use the model single streamlined application or an approved alternative.
- Alternative applications must:
 - Request information for all insurance affordability programs, including Medicaid, CHIP, and coverage in a Qualified Health Plan.
 - Only ask applicants for information related to determining eligibility for health coverage or to administering the State Plan. Responses must not be required for questions not needed for an eligibility determination.
 - Be no more burdensome on the applicant than the model application. Applications must target questions to the appropriate people on the application, request necessary information, omit unnecessary questions, and clearly indicate whether questions are optional.

1. Provide and Enhance Consumer Assistance Tools

States are encouraged to develop consumer-friendly tools that help applicants provide complete and accurate information.

Applications must be easy to navigate. They must use plain language and be easy to read and comprehend in order to yield complete and high-quality information from the applicant.

States may consider implementing consumer assistance tools such as:

- User-friendly terminology, FAQs, and help pages.
- Hover functions with helpful explanatory text.
- Online chat functionality.
- Clear explanations of why the applicant is being asked to provide sensitive information, including why a non-applicant may want to voluntarily provide their social security number to streamline income verification.
- Call center support that can swiftly be accessed during the application process. Establishing Medicaid-only lines and enhancing interactive voice response (IVR) systems can aid this process.
- Ability to upload documentation into the online application/consumer portal. (States can accept scanned copies and/or digital photos of documentation via the portal or email/text to avoid delays associated with mailing.)

States can conduct active outreach through multiple modalities, including telephone, text messaging, and email to follow up with applicants who need to submit documentation to resolve inconsistencies or provide information or documentation.

2. Encourage Use of Online Applications

States should consider promoting use of the online application but must continue to ensure that all application modalities (phone, paper, in-person, etc.) are available and accessible.

Applications submitted online benefit from states' automated processes and limit dependency on staff and paper-based processes to complete the eligibility determination.

The impact of increased use of online applications on processing timeframes depends on a number of key factors, including the design of the state's application and the degree of system automation.

States can implement outreach, consumer communication, and marketing strategies to drive individuals to the state's online application portal or to assisters that use the online portal, including by adding language on paper applications that encourages applicants to apply online.

States are strongly encouraged to utilize an online application that dynamically populates and enables applicants to submit accurate and complete information, based on the applicant's unique circumstances. A dynamic application allows states to:

- Collect all the information needed to determine eligibility (including by tailoring questions based on the applicant's circumstances and responses).
- Integrate validations and data sources (e.g., run validations/checks and alert the applicant if they have missed answering key questions).

3. Promote Telephonic Applications

States can promote telephonic applications as an alternative to paper or in-person applications and should consider call center capacity and training.

Telephonic applications typically leverage the online application platform and can therefore benefit from a state's automated processes.

- Most states have call center workers input eligibility information into the online application or worker portal; telephonic applications then follow online application workflows.

The level of impact this practice will have depends on:

- The design of states' online applications and automated verification processes; and
- Whether a state has low call center wait times and abandonment rates (necessary to process telephonic applications timely).

States must provide the ability for applicants to sign applications telephonically.

Similar to promoting the use of online applications, states can implement outreach, consumer communication, and marketing strategies to drive applicants to call centers staffed with well-trained workers to submit an application.

4. Provide Effective Communication

States must communicate effectively with individuals who have limited English proficiency (LEP) or are living with a disability.

As a best practice, states can:

- Review language access plans to provide written translation of applications into multiple languages (and determine which languages by a review of census and other local data sources).
- Ensure applications are translated into multiple languages by qualified translators and reviewed for cultural competence.
- Review and enhance access to and availability of qualified oral interpreters to support the application process:
 - Hire multilingual staff who speak frequently spoken languages and conduct training.
 - Partner with community-based organizations with interpretation services.
 - Provide qualified telephonic interpreters.

States must provide auxiliary services free of charge, including applications and other written materials in large print or Braille, and offer access to sign language interpretation and/or a teletypewriter (TTY) system, consistent with the Americans with Disabilities Act (ADA) and section 1557 of the Affordable Care Act.

5. Ensure Sufficient Assistance is Available

States are encouraged to establish out-stationed workers, expand capacity in local offices, and work with community partners to provide assistance to individuals to complete and submit Medicaid applications and related documentation.

States can expand use of outstation locations and expand capacity in local offices so that eligibility workers may provide individuals with additional in-person application assistance. In-person application assistance can help increase application completeness and minimize the need to request additional information.

States can partner with Navigators, assisters, and community-based partners to support beneficiaries with the application process (e.g., encouraging individuals to apply, providing support with uploading documentation to online portals).

States can identify specific roles that additional workers—contractors, vendors, or other temporary workers—can play in supporting application processing efforts.

States may request section 1902(e)(14) waiver authority to allow Medicaid and CHIP managed care plans to assist beneficiaries with completing and submitting the application and related documentation. States may make this an optional or mandatory activity for their managed care plans. Managed care plans must limit their assistance in accordance with federal guardrails.

6. Automate the Receipt and Processing of an Application/ Account Transfer

States are strongly encouraged to automate all workflows including the ingestion of information from a telephonic or online application, or an account transfer, into the state's eligibility system without worker intervention.

Minimizing manual data entry can expedite processing timeframes, reduce errors, and alleviate the administrative burden on eligibility workers.

Applications where information is automatically ingested into the system and triggered for processing are much more likely to be processed in near- to real-time than applications that require manual intervention (depending on the degree of automation in the workflow).

Automating verification of eligibility against electronic data sources within the online application process can minimize the need for follow-up on applications.

- Can either be embedded into the application or automatically initiated without worker touch immediately upon application submission.
- Identifies inconsistencies or enables the system to make a real-time eligibility determination without requiring additional information from the applicant.

States that rely on the FFM for Marketplace determinations are also encouraged to submit a state plan amendment (SPA) to become an FFM Eligibility Determination-State and streamline enrollment for eligible individuals by accepting certain FFM eligibility decisions.

7. Create Efficiencies and Targets for Processing Paper Applications

States may preserve eligibility worker time by employing contractors or support staff to complete data entry and by establishing clear timelines for processing paper applications.

Some states bifurcate the process of sorting applications/entering data and eligibility determination processing and use contractors or other support staff to complete data entry.

For example:

- Utilize a “distribution unit” to sort applications, enter them into the system, and transfer them to eligibility workers for processing.
- Scan and send paper applications to a state data entry vendor and require the vendor to input paper applications into the eligibility system promptly (e.g., within 3 days of receipt).

(This practice helps increase efficiency by dedicating eligibility staff to the eligibility determination process.)

States can set clear expectations and timelines for the number of days within which a paper application must be entered and determined upon receipt.

- States that have established internal timelines for processing paper applications tend to have a higher percentage of applications that are processed in under 7 days.

8. Increase Workforce Capacity

States are encouraged to develop processes to effectively manage workforce to ensure sufficient capacity to process applications.

States may:

- Redistribute work across state, regional, and county staff.
- Implement “overflow” workforce strategies that redirect pending applications to a centralized unit or regional/county office that has available capacity.
- Identify specific populations (e.g., mixed-program families) or types of applications (e.g., applications with self-employment income) that are more difficult to process and create a specialized unit with workers tasked with completing those eligibility determinations.
 - This practice diverts the most complex or time-consuming applications from the standard queue for more efficient processing by specialized workers and enables other workers to focus on timely processing of other applications.
- Leverage additional full-time employees—contractors, vendors, or other temporary workers—to play a role in supporting application processing. States may also train additional full-time employees to support non-application related work (e.g., data entry, call center staffing) to free up other staff for application processing.

Statutory and Regulatory Framework for Verifying Medicaid and CHIP MAGI Eligibility

*SSA § 1137; 42 C.F.R. §§
435.945, 435.948, 435.949,
435.952(c)(2)(ii), and 457.380*

Electronic Verification:

- Must use electronic data if available.
- Can request documentation only if electronic data is not available and establishing a data match would not be effective.
- Within federal guidelines, states have flexibility to determine which federal and state data sources to use and when to use them (frequency and timeframe).
- Must access certain data sources if useful in verifying eligibility.

Documentation:

- Can be requested when electronic data is unavailable.
- Must be requested when electronic data is not reasonably compatible (unless state accepts reasonable explanation).

9. Automate Verification

Maximizing automation of electronic verification provides numerous benefits for states and applicants and significantly contributes to more timely application processing.

Defining “Automated Verification”

- Development of electronic interfaces with multiple data sources.
- Establishment of automated calls from the application or eligibility system to the interfaces, without the need for a worker to trigger the action.
- Automatic assessment of reasonable compatibility.
- May allow for automated and embedded verification checks within the application and for the system to generate and issue a verification documentation checklist or reminder when information cannot be verified electronically.

Automated electronic verification:

- Streamlines the eligibility determination and renewal process for applicants and beneficiaries.
- Minimizes labor-intensive manual verification processes for states (e.g., collection of additional documentation), thereby increasing efficiencies and decreasing administrative burden.
- Utilizes states’ limited resources more effectively.
- Reduces potential inaccuracies due to human error.

10. Leverage a Comprehensive Set of Electronic Data Sources

States can combine the use of federal, state, and commercial data sources to enhance their ability to efficiently verify applicant information electronically and to identify data inconsistencies that require resolution.

- Provides more accurate, timely, and comprehensive information.
- Helps verify information for a significant proportion of applicants and reduce consumer and state administrative burden.
- Can be automated in a cost-effective way, with the verification call to the data source embedded in the application process.
- Allows data already within state systems to be leveraged.
- Enables integration of non-hub data sources into a “state hub.” States commonly include data on quarterly wages, new hires, unemployment, SNAP/TANF and others.

11. Apply a Reasonable Compatibility Threshold at Application

States have the option to apply a reasonable compatibility threshold for MAGI and non-MAGI populations at application beyond minimum requirements in regulation.

When both the attestation of information and the data source are at or below the eligibility threshold, the state **must** find the individual eligible regardless of the difference between the attested information and the data source (42 C.F.R. § 435.952).

If at application the information provided by the individual is below the eligibility threshold and the data sources are above the threshold, states have the option to apply a reasonable compatibility threshold, which allows for a grace difference of a certain percentage (e.g., 10% or 20%) or a dollar amount.

- States may use a reasonable compatibility threshold for **income** for both MAGI and non-MAGI beneficiaries.
- States may use a reasonable compatibility threshold for **assets** (whereby a state would compare the attested information against the information available through the Asset Verification System) for non-MAGI beneficiaries only.

States should submit an update to their MAGI Verification Plan to establish or adjust the reasonable compatibility threshold.

Applying or increasing the reasonable compatibility threshold can reduce the need for a state to request verification from a large number of applicants, thereby expediting the application process.

12. Rely on Other Programs' Findings for Data Verification

States can adopt flexibilities to rely on findings from other programs at application and renewal to reduce the administrative burden on state eligibility workers and improve application processing timeframes for data verification.

Section 1902(e)(14) Targeted SNAP/TANF Strategy

States may request Section 1902(e)(14) waiver authority to determine Medicaid eligibility at application and renewal based on financial findings that show SNAP or TANF gross income program and/or assets (if applicable) are below applicable Medicaid limits, despite the differences in household composition and income-counting rules between programs.

Express Lane Eligibility (ELE) SPA Option

Under Sections 1902(e)(13) and 2107(e)(1) of the Social Security Act, states may rely on findings for income, household size, and most other factors of eligibility from “Express Lane” agencies (e.g., SNAP, TANF, WIC, Head Start) to efficiently enroll and renew eligible children in Medicaid and CHIP.

Facilitated Enrollment SPA Option

States may use this option to determine financial eligibility for a MAGI-based Medicaid eligibility group using gross household income determined by SNAP or other means tested benefit programs. States must ensure that individuals enrolled through this strategy are certain to be income-eligible using MAGI-based methods.

Statutory and Regulatory Framework for Eligibility Determinations

42 C.F.R. § 431.10

Oversight:

- The single state agency is responsible for determining eligibility in accordance with 42 C.F.R. Part 435. If the single state agency delegates the authority for eligibility determinations to an eligible agency, it must ensure the delegated agency complies with all relevant laws, regulations and policies (applicable to local regions, counties, or state agencies responsible for Medicaid determinations).
- State Medicaid agencies that delegate eligibility determinations to other entities must establish agreements with those entities. The agreements must:
 - Clearly delineate roles and responsibilities of the state Medicaid agency and the delegated entity.
 - Address quality control and oversight by the state Medicaid agency, including reporting requirements.
 - Include assurances that the delegated entity will comply with all relevant regulations.
- The Medicaid agency must take corrective action against delegated agencies when there is noncompliance.

42 C.F.R. § 432.30

Training:

- Must provide initial and ongoing training for staff of all levels in order to improve the operation of the Medicaid program.

13. Automate the Rules Engine

States can automate systems' rules engines, including a link to the master client index, when determining Medicaid and CHIP eligibility.

An automated rules engine:

- Includes the underlying rules for each eligibility group and cascades through groups to check for eligibility without manual intervention.
- Assembles the household for each application to determine eligibility.
- Calculates household income.
- Includes logic, linked to the master client index, to identify applicants who may already be enrolled.
- Helps to identify people who were formerly enrolled and are reapplying, or who have submitted duplicate applications.
- Links to other workflows as needed, including notices.

The automated rules engine enables states to process applications faster and with fewer errors as compared to prior manual or paper-based processes.

14. Extend the Reconsideration Period at Renewal and Implement a Reconsideration Period at Application

States may utilize available flexibility to ensure MAGI and non-MAGI populations can have their eligibility reconsidered without completing a new application in full. Extending the reconsideration period (or adopting a new one for non-MAGI individuals) at renewal and implementing a reconsideration period at application may alleviate administrative burden on states.

At Renewal. For beneficiaries enrolled on a MAGI basis, states must adopt a reconsideration period at renewal of at least 90 days) for individuals who return their renewal form after they are disenrolled. This requirement will apply to non-MAGI populations in June 2027 consistent with the CMS' eligibility and enrollment final rule, though states are encouraged to provide a 90-day (or longer) reconsideration period for beneficiaries enrolled on a non-MAGI basis prior to the compliance deadline.

Reminder: For MAGI populations, states must reconsider eligibility without requiring the individual to fill out a full new application if the renewal form/documentation is returned within 90 days after the date of termination, or a longer period elected by the state (42 C.F.R. § 435.916).

At Application. To reduce the burden on eligibility staff associated with reprocessing full applications for individuals who do not complete an initial application process, states may also establish a 90-day (or longer) reconsideration period at application for individuals applying on a MAGI or non-MAGI basis before the final rule's compliance deadline of June 2027.

States are encouraged to conduct additional outreach efforts during the reconsideration period to remind individuals that if they did not complete the application process or lost coverage for not returning their renewal form, they can still be reconsidered for Medicaid or CHIP. Also consider conducting targeted outreach to specific populations, such as those disenrolled for procedural reasons, or groups that are more likely to still be eligible for coverage, like children.

15. Enhance Workforce Training and Continuous Improvement

States can provide initial and ongoing training to ensure their workforce understands eligibility rules and enrollment processes and to ensure they are consistently and appropriately applied.

- A well-trained workforce that is equipped to handle all aspects of application processing is essential to timely processing.
- Specialized training may be offered to different units or teams to support certain tasks or workflows.
- A robust eligibility manual is a critical resource tool.
- Ongoing training is critical to ensure workforce stays abreast of changing policies and procedures.

16. Use Management Reports and Dashboards

States can develop management reports that monitor processing timeframes and performance.

States should establish tracking and management tools or reports that provide data on processing timeframes and other indicators of performance.

- Data should be broken out by application type (Medicaid MAGI, LTSS, disability-based determinations), region/office, and other relevant factors.
- Data should also track the number of applications received, pending applications—including the age of applications, determinations completed, and other operational standards—including client wait times at offices and call center statistics (wait times, dropped calls, length of calls).

These tools will help states track performance and spot issues to be addressed. Most are already reported by states as part of the monthly Performance Indicator Reporting process.

Summary

- While many states have made significant improvements in application processing, the unwinding period has placed added pressures on states.
- As states continue unwinding and beyond, they must consider strategies to ensure timely application processing by strengthening processes at all steps of the application process.
- In the meantime, states are strongly encouraged to adopt strategies to (1) ensure that eligible individuals have access to coverage and care, and (2) improve processing timeliness to ensure compliance with requirements to:
 - Determine eligibility promptly and without undue delay.
 - Ensure eligibility determinations do not exceed 90 days for applicants based on disability and 45 days for all other applicants.
 - Accept applications through all modalities (online, by telephone, by mail, in-person).
 - Comply with the other federal requirements detailed in this deck.
- State should contact the unwinding mailbox at CMSUnwindingSupport@cms.hhs.gov for more detail or assistance.