Washington State
Medical and Public Assistance Eligibility Study
Initial Findings Report
February 19, 2014

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1. Executive Summary

Public Consulting Group (PCG) has conducted an extensive study of Washington's medical and public assistance eligibility systems, infrastructure and staffing models. This Initial Findings Report is the first of three (3) products that PCG will deliver to the Office of Financial Management (OFM) by June 30, 2014, to inform strategies for achieving three goals identified by the Legislature: simplifying procedures, improving customer service and reducing state expenditures. Through a comprehensive review of administrative data and meetings with key stakeholders, ranging from management staff at four key agencies – The Health Care Authority (HCA), Department of Early Learning (DEL), the Department of Social and Human Services (DSHS) and the Health Benefits Exchange (HBE) – to Community Services Offices (CSOs) and In-Person Assistors (IPAs), PCG has identified key findings that will inform recommendations for achieving OFM's goals. Key findings are as follows:

- Washington has adopted a new philosophy about how individuals apply for health benefits, which has far-reaching impacts. Some of this shift results directly from requirements of the Affordable Care Act (ACA) that mandate a "one-stop shopping" experience for all individuals seeking health insurance – regardless of income. Still, many low-income families that are accustomed to accessing services with the assistance of a caseworker are struggling to navigate new methods of accessing services.
- The long-term impact of the ACA on workloads and caseloads is difficult to quantify at this stage of implementation. Work on this study began less than two months after the October 1, 2013, implementation date – too early to evaluate a normative state of operations under ACA.
- ACA implementation has impacted the process for allocating the costs of eligibility determination across programs. Two key issues related to cost allocation are identified:
  - Under the pre-ACA model the DSHS Economic Services Administration (ESA) was able to allocate activities associated with the simultaneous processing of eligibility for multiple programs (Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF) and Modified Adjusted Gross Income (MAGI) Medicaid) to Medicaid for federal financial participation. Separation of most Medicaid eligibility determinations from that of the other programs limits the state's ability to maximize Federal funding in the same manner.
  - The HBE call center is receiving more calls than anticipated related to Medicaid eligibility determination and the current allocation method allocates less to Medicaid and the Children's Health Insurance Program (CHIP) than what this workload suggests.
- The creation of separate application processes for most Medicaid categories through HealthPlanFinder (HPF) and other public assistance programs through Washington Connection creates duplication that frustrates many customers and staff.
- Some stakeholders voiced concern that separating a formerly integrated eligibility process has created barriers to benefit access. The issues range from difficulties navigating a process that is more computer-oriented to a reduction in the face-to-face interactions that previously allowed staff to more easily identify individuals and families in need of more significant interventions.
- Washington is considered a leader in workload management practices that result in impressive application processing timeframes and, in general, efficient utilization of staff resources. Still, there may be options to provide a higher level of customer service.

The Initial Findings Report summarizes the baseline observations and measurements for the "As-Is" state of determining and processing eligibility. It takes into account documentation of Washington's medical and public assistance eligibility practices, the impact of the ACA on eligibility determination processing and in-person meetings with CSOs and consumer stakeholder groups to understand the varying perspectives. PCG will use this report as a platform for making recommendations to the State of Washington to ensure project goals are met.

2. Introduction

Purpose of the Study

As part of the operating budget bill enacted in 2013, The Washington State Legislature directed the OFM to conduct a

> *"…study of the state's medical and public assistance eligibility systems and infrastructure with the goal of simplifying procedures, improving customer service and reducing state expenditures. The study must also examine which state entities play various roles in the eligibility and data verification process in order to determine if eligibility processes can be further streamlined in light of changes related to the Affordable Care Act. The study must identify how costs will be allocated between state and federal funding sources and options for maximizing federal participation…"*

The OFM has contracted with PCG to conduct this study. PCG's work on this project will focus on the three goals identified by the Legislature – simplifying procedures, improving customer service and reducing state expenditures. Considering these goals not to be mutually exclusive, enhancements to the processes and administrative overhead are a natural progression from the level of changes that have been implemented over the last few months and years.

Washington has restructured eligibility determination processes with the implementation of the ACA. As implementation issues are addressed and the "dust settles," the state has an opportunity to shift from a focused implementation mode into an evaluation of process and program interoperability. This is an opportunity to take a comprehensive look at not only the processes within the programs and agencies, but more importantly the similarities (and duplications) between them and how service delivery and consumer support could be improved while increasing the efficiency of operations.

A variety of changes have been made in the way services are provided and staff has been relocated and reallocated to support the ACA. Modifications may be needed with respect to Cost Allocation Plans (CAP) and the Random Moment Time Study (RMTS) to more accurately reflect the new existing structure and enhance opportunities to gain federal financial support. This project will assess the existing CAPs. In addition, the impact on the allocation of costs is a vital consideration as *new* models for service delivery and operations are considered. Accordingly, PCG will analyze the implications of these models on the applicable CAPs.

Purpose of this Report

This Initial Findings Report provides an inventory of resources, policies and processes related to eligibility determination for Medicaid, TANF, SNAP and Working Connections Child Care (WCCC). The report is intended to serve as an "As-Is" snapshot of financial eligibility policy and eligibility determination processes for those programs and the cost allocation formulas that support the current model of service delivery. In effect, it will serve as a "baseline" by which to measure recommendations for change.

As this baseline is established, it is vital to note that Washington is less than three months into implementation of the ACA. The ACA represents the most significant change in the way medical assistance programs are delivered since the 1960s. Numerous implementation issues and glitches have impacted customers and staff and in some cases are identified in this report. However, the central focus of this report (and project as a whole) is not to point out challenges associated with ACA implementation. Instead, this "As-Is" report attempts to establish an "aspirational" baseline. This is a picture of how the current eligibility structure is expected to operate in a normative state. This will allow for meaningful, long-term recommendations to be considered, rather than temporary or corrective "fixes." Furthermore, the initial findings and observations included in this report generally relate to system characteristics that

would be expected to remain after a reasonable period dedicated to ACA implementation, including initiatives that are currently underway and not directly related to health care reform.

Additional Reports/Deliverables

This report represents the first of three project phases. In addition to this Initial Findings Report, PCG will complete the second phase of work with the presentation of Alternative Options and Recommendations. The primary purpose of the second phase report will be to propose a long term option or options for the state's eligibility infrastructure that achieve a balance between the project's three stated goals. In addition, the second report will include a gap analysis between current business processes and the operations of a proposed alternative model. Finally, the third phase of the project consists of an Implementation Plan – due June 30, 2014. The third deliverable will include the steps required for successful implementation, development of a communications plan that addresses the needs of a range of stakeholders and identification of the key metrics upon which the model will be measured. As part of the implementation work, PCG will also participate in discussions with the Center for Medicare and Medicaid Services (CMS) as needed in order to gain approval for modifications to cost allocation plans.

3. Approach

PCG utilized a multi-faceted approach for compiling the information on the eligibility processes for the four programs – TANF, SNAP, Medicaid and WCCC – that are the focus of this report. Meetings with the four relevant agencies – HCA, HBE, DEL and DSHS – focused on four primary topics: understanding business process, capturing the resources utilized in eligibility determination (including the scope and role of call centers), agency initiatives related to eligibility and discussion of CAPs. These meetings were held with agency management and staff with expertise in the focus areas. In advance of these meetings, the agencies were provided with a data request and in many instances the meetings generated additional request for data.

To gain knowledge of how current business processes are experienced by clients through multiple points of entry, PCG conducted meetings with additional groups:

- DSHS CSOs, in Tumwater and Shelton. Site visits to CSOs consisted of interviews with office management and observations of the office environment. These sessions were the basis for many of the process flows included in this document.
- Community-based organizations in Seattle that receive grants through the King County Health Department to provide in-person assistance to individuals seeking health care through the Washington HPF. This meeting provided additional insight to the implementation of the ACA in Washington.
- Medical Eligibility Determination Services (MEDS) unit at HCA. This meeting provided insight to some one of the key components of the ACA – the post-eligibility review that occurs following the establishment of eligibility through self-attestation.

In addition, to gain perspective from the Washington Federation of State Employees (WFSE), PCG met both with Federation leadership and a group of front-line staff identified by the union to provide feedback on the impact of ACA implementation on their work and the clients they serve.

PCG's overall approach in compiling the information for and completing this report is summarized in the following table:

Table 1 - Approach to the Report

Component	Notes
Review of Administrative Data	On November 5, 2013, PCG submitted a data request to OFM. OFM subsequently forwarded the request to DEL, DSHS, HCA and HBE.
Kickoff meeting	PCG met with staff from the OFM to discuss the project scope and approach. A follow-up meeting was also held with Legislative Staff and the Steering Committee to brief them on the upcoming activity and provide them an opportunity to ask questions.
Interviews with key agency stakeholders	During the weeks of November 18th and December 2nd, PCG met with management and/or executive level staff at HCA, DEL, DSHS and HBE. The primary purposes of these meetings was to provide an overview of the project, gain an understanding of current eligibility processes and workflow for the programs administered in their agencies, review current cost allocation processes and formulas and to identify current initiatives related to eligibility determination and processing.
CSO Site Visits	PCG conducted site visits to DSHS CSOs in Tumwater and Shelton. Interviews conducted with local management focused on workflow and the client experience in navigating the office environment
HCA MEDS unit site visit	PCG conducted a site visit to the HCA MEDS unit in Olympia. The primary purpose of this visit was to gain a greater understanding of that unit's role in the eligibility process for MAGI Medicaid.
Meetings with additional stakeholders	PCG met with The King County Health Department and several of that agency's grantees that offer In-Person Assister services to gain additional understanding of the staff and client experience at this point of entry. PCG conducted two meetings at the WFSE. In the initial meeting, PCG and OFM provided Federation management with background on the project and sought feedback; for the second meeting WFSE facilitated the participation of four front-line staff with a range of responsibilities who provided their feedback on eligibility processes in general and ACA implementation in particular.
Report development	The PCG team conducted multiple working sessions to develop workflow graphics, discuss applicable best practices and lessons from other states and identify key findings. Follow-up requests were submitted to stakeholders as needed.

Limitations/Considerations of this Report

This analysis has been conducted during a time of significant change in Washington and across the country. In order to develop a long term strategic plan for medical and public assistance eligibility, it is important to quantify the impacts of ACA implementation across the workloads of multiple agencies. At this early stage, much of the data that would be relevant to fully understand these impacts, is not yet available. For example:

- In the run-up to ACA implementation questions were raised about the "woodwork" effect – the degree that individuals who now have the opportunity to access health care (and previously never considered application for social service programs) would apply and also be identified as eligible for other services, such as SNAP or TANF benefits. Anecdotal information suggests that the opposite may be true – that the recertification process for Medicaid has caused individuals to lose benefits.
- HCA is conducting post-eligibility reviews for MAGI Medicaid on all cases in which there is a discrepancy identified in the self-attestation data and the other information available to HCA. Additional months of data on the outcomes of these reviews will be needed to determine more accurately which cases are most in need of review and which cases can have their eligibility determination automated based on the existing data from state and federal sources. It may be many months before a determination can be made on how to best operate the post-eligibility process and the long term impacts of this model of eligibility determination on workloads.

4. Background/Context

Enterprise-wide Changes Resulting from ACA and Exchange Implementation

The Patient Protection and Affordable Care Act (PPACA), commonly known as the ACA, was signed into law on March 23, 2010. Two major facets of the ACA mandate provided options and required decisions from state leadership responsible for the implementation of the new law:

- Whether to run a State, Federal, or State/Federal partnership Exchange Marketplace; and
- Whether to expand Medicaid to qualified childless adults.

Faced with the ACA options, mandates and timelines, Washington like many other states, chose to exercise the option to expand Medicaid eligibility to qualified childless adults and to create a state-based exchange marketplace model for access to Medicaid and commercial medical insurance products.

In addition, Washington made important choices in its governance structure. The Washington HBE was created in state statute in 2011 as a "public-private partnership" separate and distinct from the state. The HBE, a quasi-governmental organization, is responsible for the HPF website. With this change and the earlier creation of the DEL in 2006, the four programs that are the subject of this analysis are now administered through four entities with varying roles, structures and responsibilities. These entities include:

	Department of Social and Health Services
Mission	Improve the safety and health of individuals, families and communities by providing leadership and establishing and participating in partnerships.
Organization Type	Cabinet Level State Agency
Programs Responsible For	"Classic" Medicaid (Supplemental Security Income (SSI) related Medical, Medical Care Services (MCS), Long Term Care (LTC) and waiver services), Developmental Disability Services, TANF, SNAP, WCCC
Role	Administration and eligibility determination for SNAP and TANF and eligibility determination for Classic Medicaid and WCCC.

	Health Care Authority
Mission	Coordinated health care, with quality results, at the lowest cost.
Organization Type	Cabinet Level State Agency and the Single State Medicaid Agency
Programs Responsible For	Medicaid, Public Employees Benefits Board (PEBB) Program
Role	Oversees the state's two top health care purchasers — Medicaid and the Public Employees Benefits Board (PEBB) Program, as well as other programs and conducts post-eligibility verification.

	Health Benefit Exchange
Mission	Increase access to affordable health plans, organize a transparent and accountable insurance market to facilitate consumer choice, provide an efficient, accurate and customer-friendly eligibility determination process and enhance health plan competition on value: price, access, quality, service and innovation.
Organization Type	Public – Private Partnership or Quasi-governmental entity
Programs Responsible For	Washington Health Plan Finder (MAGI Medicaid, Qualified Health Plans (QHPs) and Advanced Premium Tax Credits (APTCs))
Role	Provides an online marketplace for individual, families and small businesses to shop for affordable health care coverage.

	Department of Early Learning
Mission	Develops, implements and coordinates system oversight to early learning policy and programs.
Organization Type	Cabinet Level State Agency
Programs Responsible For	Child Care Subsidy Programs (CCSP), Child Care and Development Fund (CCDF), WCCC
Role	Sets CCSP eligibility policies and processes; DSHS staff determine eligibility for programs under DEL purview.

Decoupling Apple Health Eligibility from Human Service Program Eligibility Determination

Medicaid has always had a categorical relationship component. Historically, there is what is often called simple Medicaid, which includes parents, children and pregnant women and there is what is referred to as "Classic" Medicaid, which covered foster care children, SSI cash recipients and individuals who are aged, blind and/or disabled (ABD). The eligibility process for Classic Medicaid is much more complicated because there are often face-to-face and medical verification requirements and a family's assets and resources must be considered as a part of the financial calculation.

The ACA changed the way income is calculated for simple Medicaid, by using the tax household for the income household, using MAGI in the income calculation and created new non-categorically related population and funding stream for non-pregnant adults without minor children. Simple Medicaid, Apple Health in Washington, is now commonly referred to as MAGI Medicaid nationally. The ACA however, didn't directly impact the way Classic Medicaid eligibility is determined.

As a result and as many states have done, Washington elected to decouple the MAGI Medicaid eligibility process from other human service programs at the DSHS, namely TANF, "Classic" Medicaid, and SNAP.

This allowed the ACA changes to be implemented in a more simplified method – concentrating the alignment of MAGI Medicaid with the commercial and private health programs, while not fully addressing the impact on and integration with the other human services programs. This method of decoupling MAGI Medicaid from Classic Medicaid and other human service programs avoided major disconnects with the way MAGI Medicaid defines households, considers disregards and calculates and verifies income. This approach reflects a national trend amongst state health and human service organizations in an effort to link public and private health through development of the health care exchange marketplaces.

This move also mirrored a nationwide trend to de-stigmatize the perception of Medicaid as a welfare program, in an attempt to create a universal public and private health insurance portal. To this end, Washington also chose to rename the State's Medicaid program to Apple Health.
Prior to ACA implementation, staff with the DSHS determined eligibility (using a common application) for TANF, SNAP, Child Care and Medicaid. With the implementation of ACA and MAGI Medicaid criteria, the Medicaid program was divided into two (2) separate classifications, including

- MAGI Medicaid – Called into effect by the ACA to determine eligibility for Medicaid and subsidized health insurance through Health Insurance Exchanges. The definition can be found under Internal Revenue Code Section 36B(d)(2)(B) and Public Health and Welfare Code Section 435.603(e).
- "Classic" Medicaid – Foster Care Children; SSI cash recipients; Aged, blind and disabled individuals.

To implement this change, the state created a separate and independent technology solution to automate MAGI eligibility decisions. The technology is accessed through the HPF web portal. Through the use of HPF, eligibility for MAGI Medicaid is determined in a much more simplified method. Income disregards have become generic, determinations can be made immediately through the web application using only self attestation as income verification and the redetermination process is passive, using existing income

data and electronic data exchanges for income verification. It is the short and long term impacts of the changes related to this shift which present many of the issues and questions to be addressed in this report and the project as a whole.

Points of Entry

The programs highlighted in this report serve a wide range of individuals with different capacities, preferences and needs. Some individuals are able – and prefer – to experience the application and eligibility determination process with minimal interaction with agency staff. Accordingly, Washington provides these individuals with the ability to apply online and – if an interview is necessary – conduct that meeting by phone. On the other hand, other Washingtonians not only require assistance in the application process, but can only be assessed effectively for a full array of needed services if they come in direct contact with a staff person capable of assisting and identifying pertinent issues. Two key challenges relative to points of entry are identified:

1. Some individuals who enter the application process without interacting with a staff person directly may not be aware of all the options available to them; and
2. Different points of entry for different programs cause some duplication of work and frustration on the part of clients and staff.

Figure 1 reflects the concept that a large number of individuals who come through the points of entry require only little or no interaction and that they are well served by applying online and either conducting no interview (as is the case for MAGI Medicaid), or be interviewed over the phone (preferably with most information already verified). Others require some degree of support and are benefited by some interaction with staff. Still others are in need of intensive case management (the bottom of the funnel). The challenge is to create a system that successfully identifies these individuals and families regardless of their point of entry and connects them with the most beneficial level of service. When this is achieved, case management resources are expended on those who truly need them.

Figure 1 - Client Interaction "Funnel"

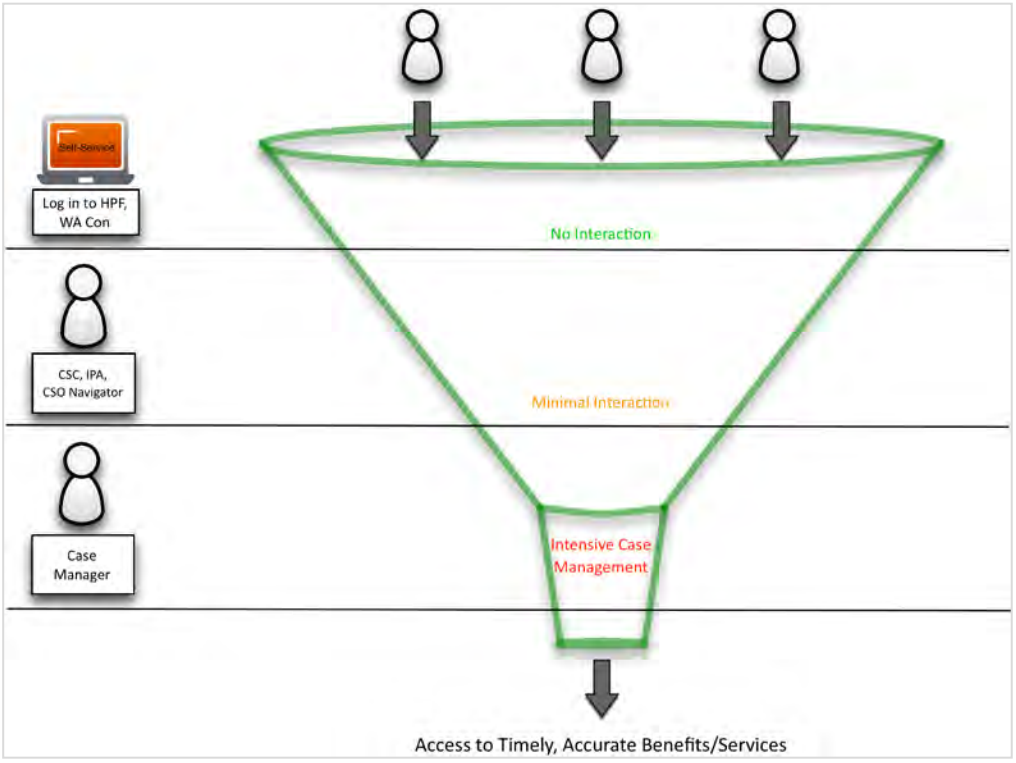
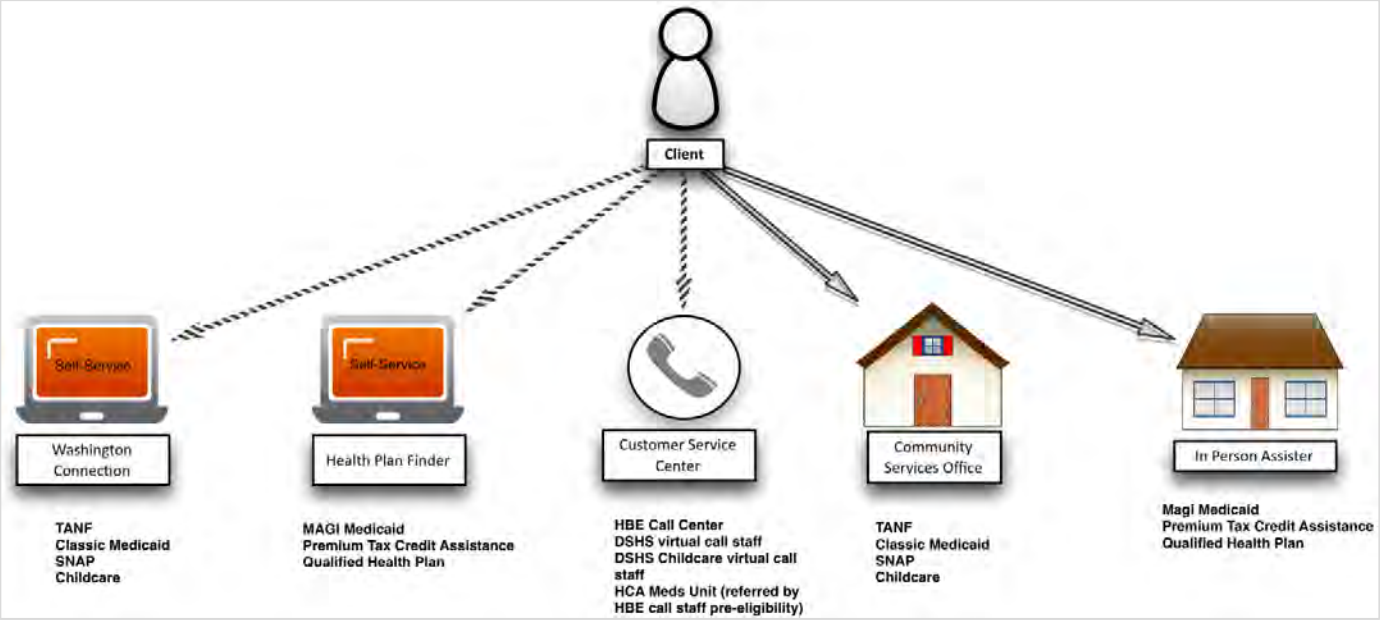


Figure 2 captures current points of entry and illustrates both the flexibility offered with respect to accessing services in different locations and modes and also some of the current limitations – specifically, that not all doors are open for all programs.

Figure 2 - Client Points of Entry for Washington State Healthcare and Social Services by Program



5. Financial Eligibility Criteria Comparison

Areas of Eligibility

The laws and regulations that govern the programs that are the focus of this report – TANF, SNAP, Child Care and Medicaid – afford states differing degrees of flexibility in the development of eligibility criteria. In order to portray an accurate view of the "As-Is" landscape, it is first important to understand the levels at which these standards have been established in Washington. Significantly, programs are not mutually exclusive, thus there is potential for overlap in the programs. Sometimes unknowingly to the consumer, their eligibility can span several programs due to overlapping eligibility thresholds. For example, a family may face a sudden financial crisis due to loss of employment. In such a scenario, access to food is likely one of the first needs that becomes apparent and the household chooses to apply for SNAP benefits. It is only during the process of applying for that benefit that they become aware all or some household members are also eligible for Medicaid. The ability for applicants to access these programs in a seamless manner is viewed as an important component of human, social and health services delivery.

The financial eligibility for each program is detailed below to shed light on the eligibility thresholds currently in effect in Washington and how they can span several programs.

Medical

Effective January 1, 2014, Medicaid coverage was expanded to include single individuals between the ages of 19 and up to 65 with income up to 138% Federal Poverty Level (FPL) based on MAGI. Eligibility for children, pregnant women and adults with dependent children, is determined based on MAGI methodology. These groups receive services through the program now referred to as Washington Apple Health. The FPL limits for children and pregnant women applying for Washington Apple Health are shown in **Table 3**. Those that do not qualify for Washington Apple Health may still be found eligible for advance premium tax credits (APTC) and cost-sharing reductions (CSR) as long as their income is below the 400% FPL threshold.

When determining MAGI Medicaid eligibility, self-attested income is accepted and then verified in a stringent post eligibility process that involves verification through multiple data sources.

Classic Medicaid, which consists of eligibility for ABD individuals, foster care children and SSI recipients, will not use the MAGI methodology, but rather will continue to be processed as it is today.

Temporary Assistance for Needy Families

TANF is determined by family size, income and resources for households with at least one eligible child in the home or approved foster placement and may require participation in the WorkFirst Program. Eligible families must have countable resources of $1,000 or less and the family's gross earned income must be below the following levels.

Table 2 - TANF Eligibility Thresholds

# of Family Members	Max Earned Income	# of Family Members	Max Earned Income
1	$610	**6**	$1,472
2	$770	**7**	$1,700
3	$955	**8**	$1,882
4	$1,124	**9**	$2,066
5	$1,295	**10 or more**	$2,246

*http://www.dshs.wa.gov/manuals/wac/388-478-0035.shtml

Additional verifications aside from income, family size and resources include social security number, identity, questionable circumstances, pregnancy when applicable and alien status when applicable.

Supplemental Nutrition Assistance Program

Eligibility for the SNAP, also referred to as Basic Food, is determined by income and resources for non-categorically related households; however resources are excluded for families who are categorically eligible. The FPL limit for SNAP is 200%, but for non-categorically eligible households resources must also total below $3,250 if the assistance unit (AU) has either an elderly or disabled individual, or $2,000 for all other AUs.

Additional verifications aside from income and resources include social security number, identity of head of household, questionable circumstances and alien status when applicable.

Washington Connections Child Care

Eligibility for WCCC is determined by income and employment or TANF participation. Household income must not exceed 200% FPL and the caretaker(s) must be working or in a DSHS approved work activity. Children must also meet citizenship requirements.

Additional verifications aside from income and employment include activity/work schedule for parents and children, special needs, background checks when applicable and custody schedule when applicable.

Table 3 below provides a breakdown of the income and resource thresholds that must be met to be determined eligible for the Washington Public Assistance programs being examined. In addition, the table includes a column to capture the degree eligibility standards are mandated at certain level. These data points will assist in identifying the extent that streamlining of eligibility standards is an option.

Table 3 - Program-by-Program Eligibility Thresholds

Program	Income Threshold	Resource Threshold	State Flexibility?
MEDICAL			
MAGI Medicaid	138% FPL	N/A	State opted to expand
Classic Medicaid	75% FPL	$2,000 for individual $3,000 for couples	Yes*
Children's Health Insurance	210% FPL: Medicaid with no premium 210% – 312% FPL: Medicaid with premium ($60 max) 312% – 400% FPL: APTC or CSR	N/A	
Pregnant Women	193% FPL 194% – 400% FPL: APTC or CSR	N/A	
Long Term Care	300% FBR (Federal Benefit Rate)	$2,000 for individual $3,000 for couples	
DD	75% FPL	$2,000 for individual $3,000 for couples	
TANF	58% FPL**	$1,000	Complete state flexibility
SNAP	200% FPL	$3,250 AU has elderly or disabled individual; No resource test for other households	State opted to increase income beyond the federal 130% FPL using categorical eligibility option
WCCC	200% FPL	N/A	CCDF may serve up to 85% State Median Income

*PCG will complete a thorough assessment of options for flexibility in the 2nd phase of this project.

** Note that the FPL figure for TANF is an equivalent created for comparative purposes **only and reflects a household size of three.** **Table 2** captures gross income limits for that program.

6. Current Resources Used for Processing Eligibility

IT Inventory

With implementation of the ACA, eligibility determinations are processed across three different information technology (IT) systems, including:

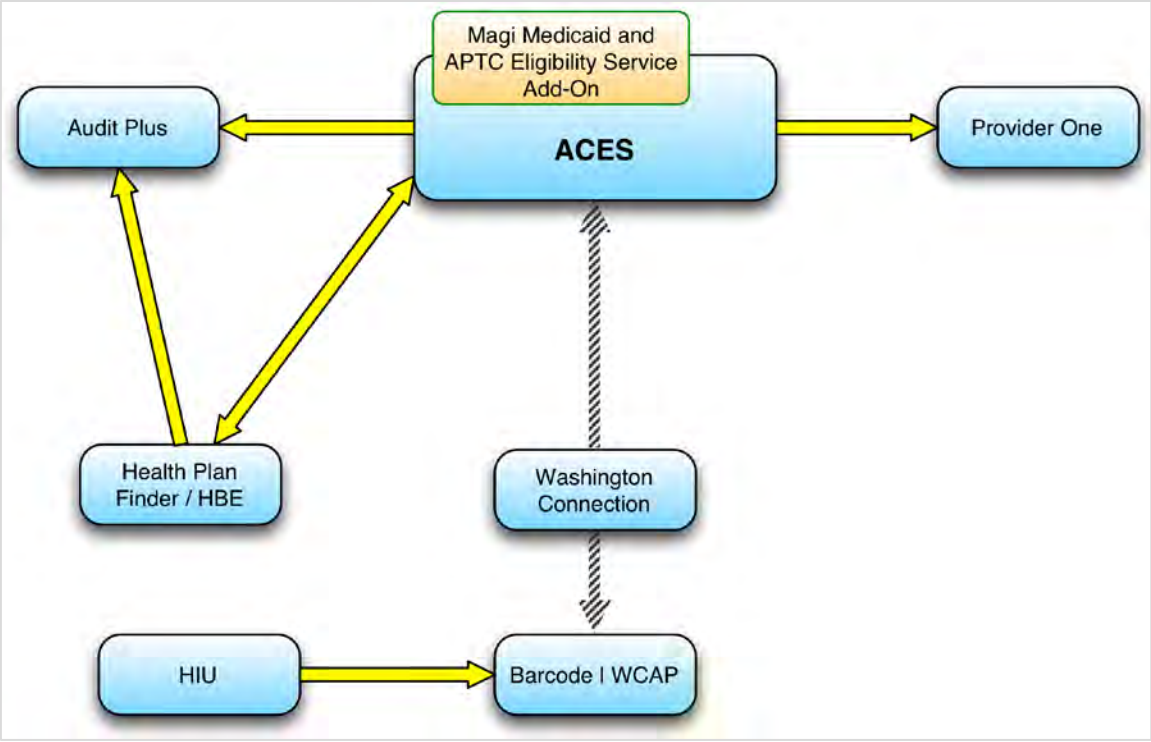
- Automated Client Eligibility System (ACES);
- HPF; and
- Washington Connection Authorization Program (WCAP), the child care subsidy eligibility system.

Several other solutions support customers and staff in applying for benefits and processing applications:

- Washington Connection (WACON) is a central webpage for the State of Washington Title XIX programs and public assistance and other resources. The application on WACON is accepted by DSHS and HCA for Title XIX programs, but directs applicants for MAGI Medicaid to the WA HPF Website.
- Provider One serves as the State of Washington's Medicaid Management Information System (MMIS), including recording Medicaid client/provider claims, providing claim adjudications and processing payments to Medicaid providers (excluding WCCC payments). Provider One receives eligibility information from ACES in batched format.
- Barcode is an agile IT system that is utilized by DSHS CSOs for document and workload management. Barcode capabilities include providing real-time workload queues, real-time client tracking and random moment time studies.
- The Document Management System (DMS) is a centralized document management system that supports the ability to scan and upload verification documents for easy access by staff responsible for eligibility determination. DMS is a module in Barcode and the Hub Imaging Unit (HIU) is responsible for scanning documents.
- KOFAX is an imaging system operated by HCA to image both HCA and HBE documents for those cases where eligibility is determined by HPF.
- AuditPlus is a general auditing tool used by HCA to determine post-eligibility determination audits. AuditPlus analyzes self-attestation data to determine if the data can be verified against data in ACES and ProviderOne. High risk self-attestations are moved into a queue in AuditPlus for HCA eligibility specialists to manually verify. AuditPlus is also used to audit other eligibility functions and other programs.

The relationships between these systems are represented in **Figure 3**.

Figure 3 - Eligibility IT Systems and Interactions



Note that many of the interactions illustrated here are one-way. In an optimal environment, a client would only be required to enter information in one place. At this time, WACON data does not populate HPF and HPF is currently sending a minimal amount of information to WACON. Significantly, HBE IT staff said that HPF, as currently designed, will never be able to accept data from WACON due to the interactive nature of the HPF application.

Eligibility Staff and Functions

Eligibility staffing levels and functions vary by program. **Table 4** outlines each agency's primary eligibility determination assignments, staffing numbers, call center assignments and system access.

Table 4 - Eligibility Staff and Functions by Agency

Agency	Primary Eligibility Determination Assignments	Number of Dedicated Staff	Individual Call Center	System Access
DSHS	SNAP	1,866[1]	YES	WA Connections ACES Barcode
	TANF			
	"Classic" Medicaid			
	WCCC			
WA HBE	MAGI Medicaid	80 – 200[2]	YES	None
HCA	Post-Eligibility Services	90[3]	YES	WA HPF ACES ProviderOne AuditPlus

Call Center Inventory

In addition to human resources within each agency, eligibility may be handled by three separate call centers across the State of Washington, including one each for HBE, HCA[4], DSHS/WCCC[5]. **Table 5** details each call center, including primary functions, dedicated call center staff, call center model, union status and noted functional limitations.

Call center models vary across the agencies to include both virtual and centralized call center structures. Virtual call centers house staff that work remotely (at home or in remote offices – such as CSOs), while centralized call centers provide a single point of location for call center employees.

[1] This figure includes the staff included in the Random Moment Time Sample for staff providing direct service, including Financial Service Specialist 1, 2, or 3; Social Worker 1 or 2; WorkFirst Program Specialist; Customer Services Specialist 1, 2 or 3; and WCCC call center workers.

[2] Call center staff numbers fluctuate according to Washington Health Plan Finder Director of Staff.

[3] Once fully staffed, plan is for 160 dedicated staff

[4] The HCA has two call centers. The HCA Medical Assistance Customer Service Center (MACSC) call center is available to answer questions from clients and providers, including plan selection, benefits, etc. and falls outside the scope of the eligibility determination study. The HCA Medical Eligibility Determination Services (MEDS) call center handles eligibility questions directed from the HBE call center during application assistance (pre-eligibility determination), and performs post-enrollment MAGI determinations, and are thus included as a part of the call center inventory.

[5] WCCC is a subset of the DSHS Call Center. It is a separate queue within the larger CSD call center system.

Table 5 - Call Center Inventory

Call Center	Primary Functions	Call Center Staff*	Call Center Model	Noted Limitations
DSHS	• Complete interviews and eligibility for applications, mid-certification reviews, annual eligibility reviews & change of circumstances for Cash, food, HEN Referral's and classic Medicaid • Assist individuals with Washington Connections application, case information and answer general questions • Centralized Hub Imaging Unit • Specialized provider and WASHCAP/WTAP teams • Application and Processing of eligibility related to WCCC (both TANF and non-TANF)	815**	Virtual	• Unable to provide assistance on MAGI Medicaid applications through WA HPF and must direct those inquiries to WA HBE Call Center or IPAs • Unable to easily verify SNAP income & eligibility on WCCC only cases
WA HBE	• Completes HPF applications (via phone and paper) • Main point of contact for eligibility –related questions • Provide system guidance on ACA-related programmatic questions, including MAGI Medicaid qualifications • Act as a liaison between MAGI Medicaid clients (pre-eligibility) and HCA staff for ACES data inquiries/corrections	80 – 200[6]	Central	• Unable to provide assistance on SNAP, TANF, or WCCC applications and must direct those inquiries to DSHS Call Center, CSOs, or Washington Connection
HCA MEDS	• Work with WA HBE call center staff to assist MAGI Medicaid clients in ACES data inquiries/corrections • Perform post-enrollment MAGI determination	70	Virtual	

*Call center staff for each agency included in this table are included in staff estimates in Table 3.
**This number listed in the minutes from 11/21 meetings with DSHS Program and Policy staff. A subset of 140 of the 815 Call Center Staff is responsible for the application and processing of eligibilityrelated to WCCC

[6] Call center staff numbers fluctuate according to Washington Health Plan Finder Director of Staff.

7. Key Data Points

Several key data points were collected through both an electronic data request and through onsite interviews with each agency. The results of this effort are displayed below in five areas: 1) application, verification and interview requirements; 2) caseload statistics; and 3) application disposition statistics; 4) application processing timeliness; and 5) call center metrics.

Noted gaps and limitations in the data collection effort are as follows:

- Although client population statistics were made available, the statistic from FY 2012 and FY 2013 represent eligibility determination policies and processes prior to ACA implementation. Data to show the post-ACA, duel-eligible population is not yet available.
- Data on workload impact due to the implementation of the ACA has not yet been made available due to the fact that the program went live October 1, 2013.

Program Requirements

Each agency has provided application, interview and verification requirements through their response to the data request. **Table 6** below displays current requirements across programs to assist readers in finding commonalities/differences between data and verification requirements.

Table 6 - Program Application, Interview and Verification Requirements

Program	TANF	SNAP	Classic Medicaid[7]	MAGI Medicaid	Childcare
STEP 1 – APPLICATION POINTS					
Paper	X	X	X	X	
Online	X	X	X	X	X
Phone[8]	X	X	X	X	X
Signature*	X	X	X	X	
Signed by Head of Household		X	X		
STEP 2 – INTERVIEW REQUIREMENTS					
Interview Required?	Yes	Yes	Yes	No	No
STEP 3 – MINIMUM VERIFICATION REQUIREMENTS					
SSN	X	X	X	X	
Identity	X	X			X
Resources when Questionable	X		X		
Pregnancy	X				
Citizenship / Alien Status	Alien Status	Alien Status	Both	Citizenship	X
Incapacity / Disability			Disability		
Head of Household Identity					X
Activity / Work Schedule					X
Special Needs					X

*E-signatures meet legal requirements

[7] Classic Medicaid includes coverage for Aged, Blind, and Disabled individuals, foster care children, and SSI recipients.

[8] Clients can do a SNAP/TANF Interview by phone, but cannot actually complete an application by phone due to signature requirements.

Application access (i.e. either paper or online) across programs is nearly identical, with the exception of WCCC. Furthermore, verification requirement criteria across programs are similar in many areas, especially income, SSN, resources and citizenship or alien status. Although WCCC appears to be an outlier in comparison to other programs, the potential for a single, streamlined application (including access points) has potential.

Caseload Statistics

Caseload statistics across programs was provided for the state fiscal years 2011, 2012 and 2013. **Table 7** below shows monthly averages by program type.

Table 7 - Number of Households and Clients (individuals) by Program Type (monthly averages)

Avg. Monthly	TANF (includes mixed fed/state cases)[9]		SFA (includes mixed fed/state cases)		SNAP (includes mixed fed/state cases)[10]		FAP (includes mixed fed/state cases)	
	Households	Clients	Households	Clients	Households	Clients	Households	Clients
SFY 2011	64,574	153,270	1,578	2,921	533,258	1,025,188	10,155	14,087
SFY 2012	53,920	125,151	1,392	2,610	577,361	1,091,078	10,535	14,825
SFY 2013	48,265	111,588	1,129	2,088	594,145	1,107,197	10,398	14,690

Avg. Monthly	Children's Health Insurance Program (CHIP)		Medicaid[11]		State-Funded Medical		Working Connections Child Care (WCCC)[12]	
	Households	Clients	Households	Clients	Households	Clients	Households	Clients
SFY 2011	21,696	31,301	926,500	1,183,380	1,162	1,162	35,030	60,316
SFY 2012	21,698	31,776	928,322	1,189,701	1,173	1,173	25,364	43,826
SFY 2013	21,755	32,143	936,654	1,195,535	1,194	1,194	25,220	43,323

One of the key components of the ACA is the establishment of a health insurance marketplace that gives people of all income levels access to healthcare coverage through an easy-to-use, streamlined application process. This would suggest greater access to benefits for a larger percentage of the Washington population. And, it has been estimated that as a result of the move from serving purely categorical related individuals and families to serving all adults under the new income threshold, enrollment in Washington State Medicaid would increase by up to 328,000 beginning in 2014.

A central question as this study progresses is the impact of the ACA on the DSHS workload. On the one hand, the "woodwork" effect could result in an increase in SNAP and TANF caseloads as individuals and families who previously did not attempt to access social services are identified as potentially eligible at the conclusion of their navigation in HPF. And, on the other hand, there will be some reduction in the number of individuals and families served by DSHS due to the number of cases that only receive MAGI

[9] Mixed households (e.g. a household with citizen children and an adult considered an ineligible alien for federal TANF) in TANF/SFA are counted in both the TANF caseload and in the SFA caseload. Therefore the sum of both programs creates duplication in the number of families counted.

[10] Mixed households in SNAP/FAP are also counted in both the SNAP caseload and in the FAP caseload. Therefore the sum of both programs creates duplication in the number of families counted.

[11] Note that two coverage groups in one "traditional" household (e.g. a parent/s and children) equates to two households.

[12] The WCCC data are provided by OFM Forecasting Division. Data are lag-adjusted.

Medicaid and do not fall under the DSHS umbrella. **Table 8** illustrates the degree that individuals receiving Medicaid were also receiving cash or food benefits for the months of July 2012 thru June 2013. Note that the information below **does not** reflect CHIP cases. **Therefore, this information does undercount the volume of overlap (although not necessarily the percentage) between SNAP/TANF and programs that require application through the HPF.** Individuals rather than cases are being used for this analysis because one household for SNAP/TANF purposes may include more than one Medicaid coverage group. See footnote above.

To complete the picture, **Table 9** displays data on the number of Basic Food (SNAP) and TANF recipients who did not also have Medicaid during FY13. These statistics represent months prior to ACA implementation and provides some indication of the potential for growth in the SNAP-eligible population who will also receive Medicaid. Note, however, that the SNAP-eligible population does include some groups not likely to fall into the new Medicaid category for adults, particularly those over 65.

Table 8 - Medicaid Clients Who Also Receive TANF or SNAP

	Total Medicaid Clients	Medicaid Clients Receiving TANF and/or SNAP	%
Jul-12	1,189,843	767,660	0.65
Aug-12	1,193,150	770,982	0.65
Sep-12	1,190,917	768,027	0.64
Oct-12	1,194,251	768,552	0.64
Nov-12	1,192,740	768,365	0.64
Dec-12	1,191,612	768,518	0.64
Jan-13	1,196,383	773,517	0.65
Feb-13	1,196,573	773,591	0.65
Mar-13	1,198,743	772,908	0.64
Apr-13	1,200,118	772,727	0.64
May-13	1,201,306	772,458	0.64
Jun-13	1,200,784	770,521	0.64

Table 9 - SNAP/TANF Recipients Without Medicaid

	TANF			Basic Food		
	Total Clients	Clients with Medicaid	Clients w/o Medicaid	Total Clients	Clients with Medicaid	Clients without Medicaid
Jul-12	117,978	117,978	-	1,120,312	768,081	352,231
Aug-12	117,886	117,886	-	1,124,973	771,397	353,576
Sep-12	116,359	116,359	-	1,122,087	768,633	353,454
Oct-12	115,220	115,220	-	1,121,099	769,321	351,778
Nov-12	114,257	114,257	-	1,120,564	769,363	351,201
Dec-12	115,787	115,787	-	1,118,567	769,630	348,937
Jan-13	117,434	117,434	-	1,125,276	774,667	350,609
Feb-13	115,113	115,113	-	1,125,393	775,071	350,322
Mar-13	112,336	112,336	-	1,122,607	774,182	348,425
Apr-13	109,794	109,794	-	1,121,491	774,195	347,296
May-13	107,382	107,382	-	1,120,656	773,975	346,681
Jun-13	104,582	104,582	-	1,119,684	772,529	347,155

Applications and Dispositions

A key metric in setting a baseline is to establish the volume of work being performed and across human services programs, applications and their dispositions is a meaningful indicator. **Figures 4 – 6** capture the number of applications received, approved and denied over the previous three fiscal years.

Perhaps most notable in these figures is the significant drop in TANF, SNAP and child care applications from FY 12 to FY 13, accompanied by a small increase in Medicaid applications over that same period. This statistic will be particularly important to track in FY 14 to evaluate the impact of ACA – not only on Medicaid applications and approvals, but on the degree that increased access to health programs results in more applications for other programs.

Figure 4 - Applications and Disposition (FY 2011)

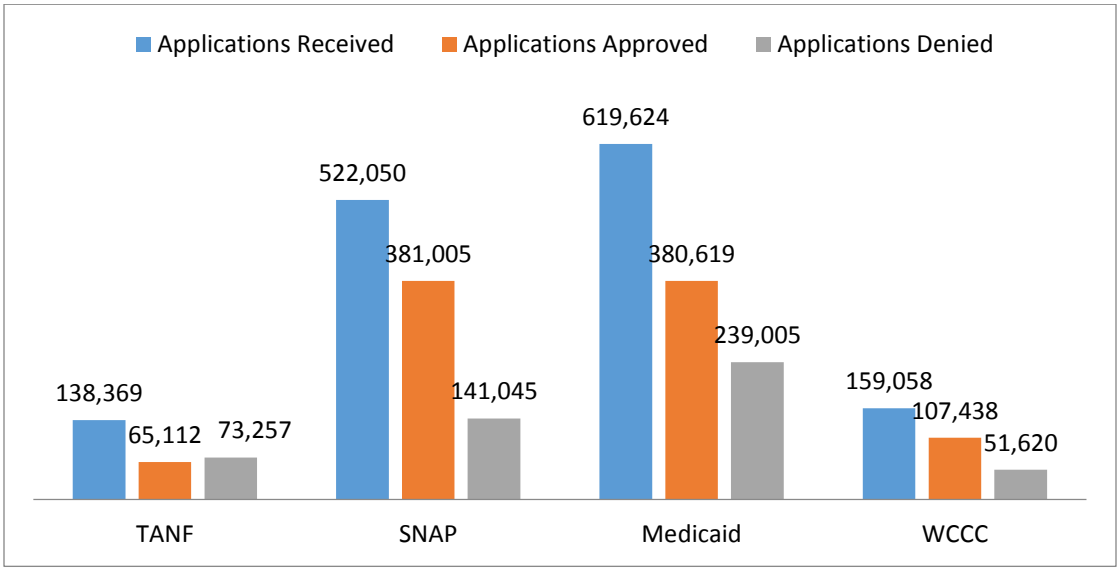


Figure 5 - Applications and Disposition (FY 2012)

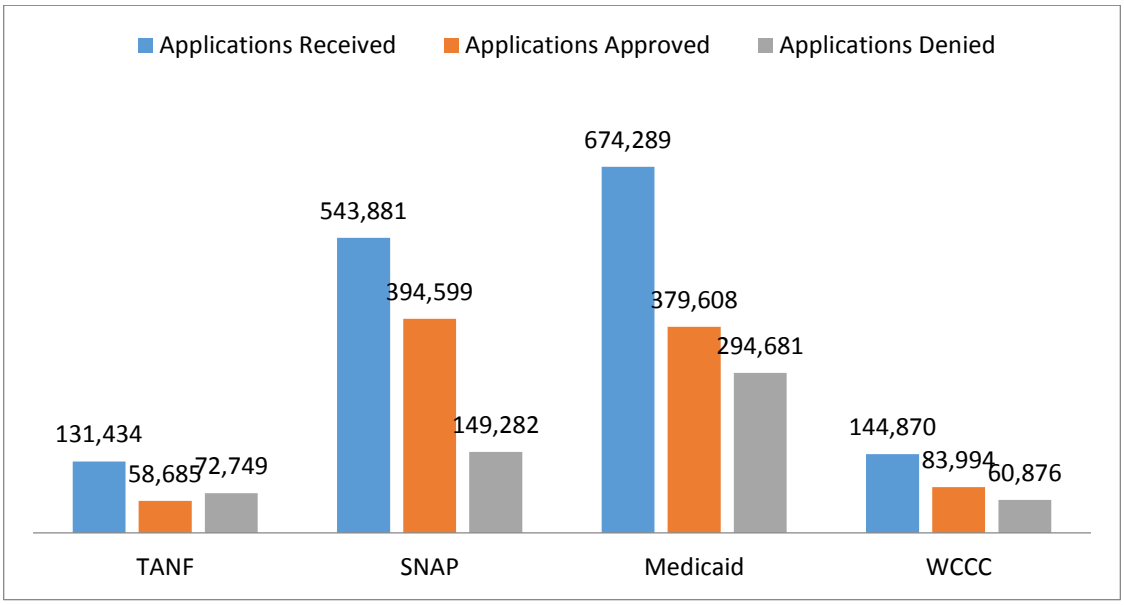
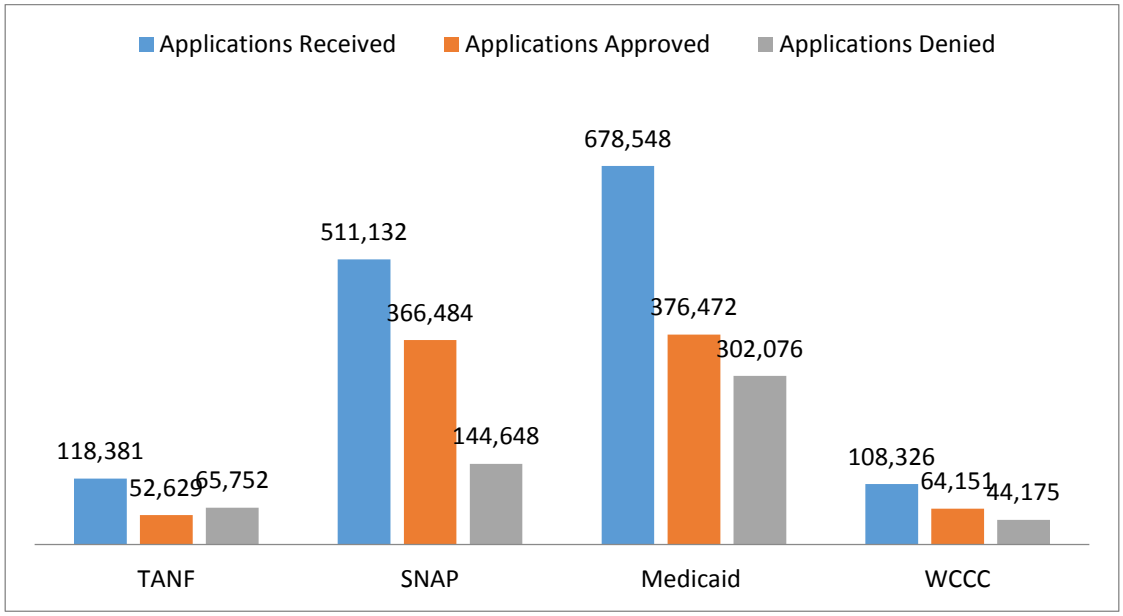


Figure 6 - Applications and Disposition (FY 2013)



Application Processing Time

Application processing times are another key performance metric; simply put, they reflect the period of time an applicant must wait to know whether they will be able to receive the benefit for which they applied. As new models of eligibility determination are evaluated, the impacts on processing times must be considered and weighed. For example, if a proposed model significantly improved the chances that an individual or family would receive the most advantageous service, would an increase in processing time be acceptable? Questions like these will be vital to address as this project continues.

In addition, it must be noted that the concept of processing times has changed dramatically for MAGI Medicaid. One of the hallmarks of the ACA is the concept that an individual can go online and receive a decision on their eligibility in real time. Therefore, a different type of performance metric may be in order – for instance, a measure of the percentage of applications for which an immediate disposition is provided.

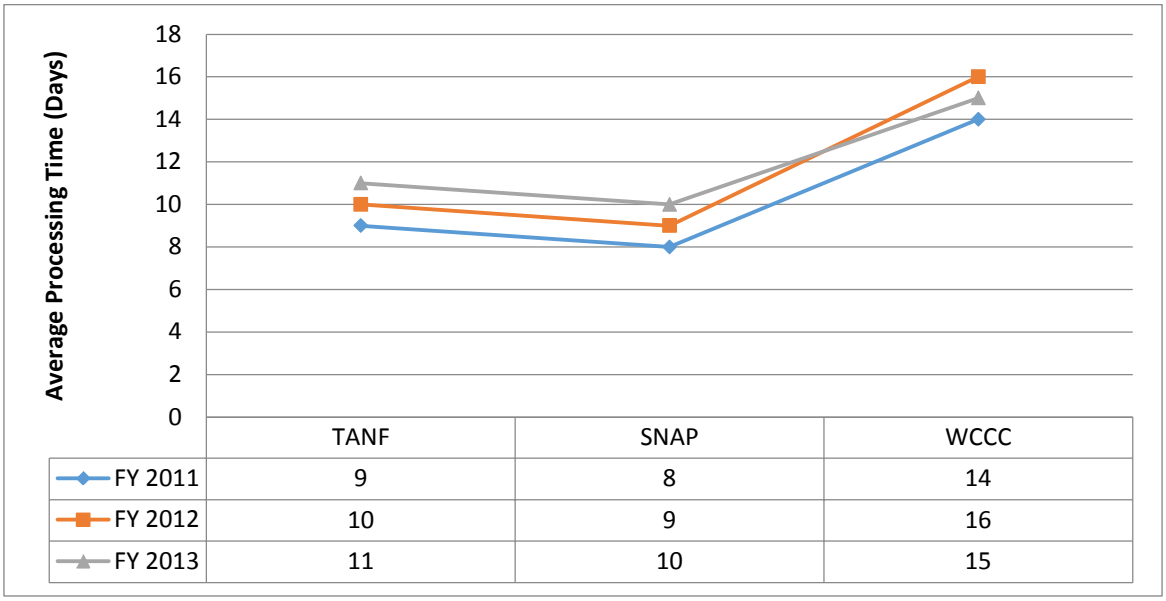
Table 10 includes the processing times required by each program.

Table 10 - Application Timeliness Standards

Program	Timeliness Standard
SNAP	30 days (exception: expedited – 7 days)
TANF	30 days
Child Care	45 days
Medicaid	Pregnant women – 15 calendar days Disability programs – 60 calendar days All other Medicaid/CHIP programs – 45 days

Figure 7 displays the average application processing time by program over the time period provided (FY 2011 – 2013), excluding Medicaid application processing time. Given that MAGI Medicaid determinations are intended to be made in real time, days required to process under ACA and in previous fiscal years will not be comparable.

Figure 7- Average Application Processing Time (Days)



	TANF	SNAP	WCCC
FY 2011	9	8	14
FY 2012	10	9	16
FY 2013	11	10	15

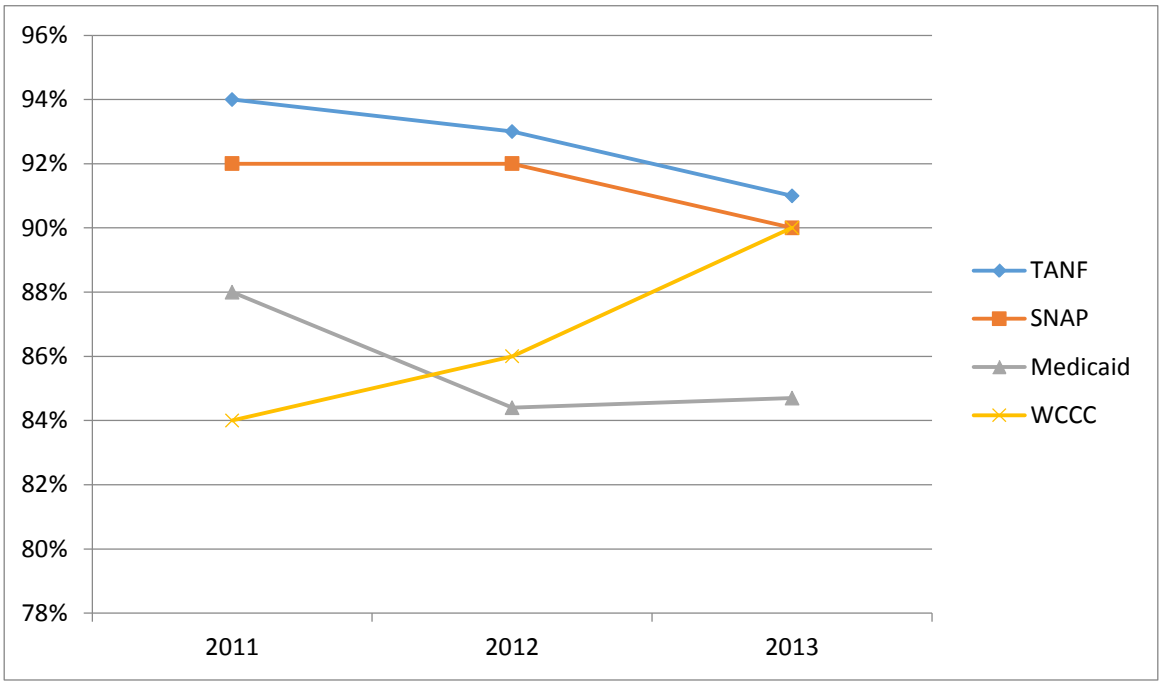
While average application processing times provide some perspective, they are just that – averages. It is illustrative to also identify the number of applications processed within a very short period, signifying a high level of customer service for applicants in need of benefits (or at least the knowledge that they do not qualify). **Table 11** displays the percentage of applications that received "same-day" processing – defined as cases processed the same day as the interview.

Table 11 - Percentage of Applications Processed the Day of Interview (FY 2011 - 2013)

	TANF		SNAP		WCCC	
Month	Total Applications	% of Same Day Apps Processed	Total Applications	% of Same Day Apps Processed	Total Applications	% of Same Day Apps Processed
Jul-10	11,985	35.3%	41,510	35.6%	12,832	27.8%
Aug-10	13,094	35.7%	44,838	35.3%	15,546	25.5%
Sep-10	12,734	33.7%	46,121	34.4%	15,979	24.7%
Oct-10	11,873	35.8%	45,327	35.7%	12,025	27.8%
Nov-10	7,031	71.7%	25,812	71.1%	11,181	28.1%
Dec-10	13,541	69.7%	46,805	72.1%	11,567	26.6%
Jan-11	12,059	71.1%	46,355	74.9%	12,574	25.7%
Feb-11	9,606	69.8%	40,836	72.2%	11,486	25.4%
Mar-11	12,109	72.4%	52,270	77.8%	13,233	40.2%
Apr-11	10,906	70.5%	43,042	74.3%	13,672	46.1%
May-11	11,228	70.0%	41,820	73.7%	13,570	39.7%
Jun-11	12,213	71.1%	47,314	74.0%	15,393	35.4%
Jul-11	11,187	71.1%	43,890	74.6%	12,903	33.7%
Aug-11	12,677	69.7%	47,709	73.4%	15,714	39.2%
Sep-11	11,404	71.0%	45,959	74.7%	16,814	29.8%
Oct-11	11,067	68.0%	47,625	71.9%	11,016	22.9%
Nov-11	11,313	69.1%	44,762	72.6%	9,598	24.2%
Dec-11	11,938	67.3%	46,572	71.1%	9,776	18.2%
Jan-12	10,829	66.7%	45,690	71.8%	11,086	18.9%
Feb-12	9,698	66.0%	45,630	70.4%	11,713	18.9%
Mar-12	10,613	68.7%	47,847	72.4%	12,034	18.2%
Apr-12	10,207	69.6%	44,361	72.2%	11,588	19.9%
May-12	10,824	68.4%	43,249	72.0%	11,546	19.2%
Jun-12	9,677	69.5%	40,587	72.6%	11,082	16.4%
Jul-12	10,317	67.3%	41,530	69.7%	11,132	11.5%
Aug-12	10,960	65.5%	43,901	68.5%	12,498	9.9%
Sep-12	9,618	66.3%	39,214	69.5%	11,271	14.4%
Oct-12	11,388	64.3%	48,153	67.2%	11,214	20.0%
Nov-12	10,404	66.8%	42,775	70.0%	8,845	17.9%
Dec-12	10,343	63.8%	43,261	67.1%	6,685	29.0%
Jan-13	10,944	67.2%	47,009	73.4%	7,995	29.4%
Feb-13	8,252	62.3%	40,561	68.2%	6,369	34.7%
Mar-13	8,768	65.3%	42,397	70.1%	7,186	33.7%
Apr-13	9,475	66.9%	42,751	71.2%	7,952	31.6%
May-13	9,295	64.9%	42,195	69.7%	8,292	30.5%
Jun-13	8,617	65.6%	37386	70.5%	8,889	20.8%

Figure 8 shows the percentage of applications considered to be processed timely, averaged over twelve (12) months.

Figure 8 - Percentage of Applications Processed Timely (FY 2011 - 2013)



Call Center Metrics

As call centers continue to play a significant role in the eligibility determination process, their performance in areas of customer service is a metric that must be considered. DSHS provided performance data for five queues, or functions, within its call center structure. **Table 12** captures some key statistics from November 2013. Call Center data should be viewed in the context that customers access services through multiple entry points; for instance, there are also wait times associated with walking in to a CSO for information and/or an interview. **Tables 13 and 14** include performance data from the HCA Customer Services Center.

Table 12 - DSHS Call Center Metrics - November 2013

Queue	*Queue Explanation*	Average Speed Answer*	Abandoned Call % (caller chooses to disconnect)	Call Completed %	Disconnected Call % (unable to get through at all due to high volume)
Blue ER	Eligibility interview (recertification)	57:19	30.9%	33.3%	35.8%
Green App	Eligibility interview (new SNAP application)	54:36	34.8%	53.1%	12.0%
Grey Changes	Changes to open cases (TANF/SNAP)	21:42	19.5%	80.1%	0.3%
Purple Childcare	All child care calls	1:35	5.9%	94.1%	0.0%
Yellow Navigator	Live operator – triage	3:27	0.6%	78.0%	21.4%

*Note that wait times are deceptive – callers may choose to get a call back and in those instances they are not waiting on hold the entire length of the wait time.

Table 13 - HCA Medical Assistance Customer Services Center

Month	Client Calls				Combined Calls (includes client and provider calls)		
	Number of Calls Attempts	Number of Calls Answered	Avg. Speed of Ans. (in minutes)	Percent of Calls Answered	Number of Calls Attempts	Number of Calls Answered	Percent of Calls Answered
Nov-13	37,685	24,421	8.8	64.8%	51,432	30,595	59.4%
Oct-13	38,565	29,826	4.4	79.6%	54,719	38,997	71.3%
Sep-13	32,082	24,655	3.8	76.8%	46,316	32,219	69.6%
Aug-13	29,791	23,726	4.4	79.6%	44,510	32,243	72.4%
Jul-13	30,701	24,948	4.2	81.3%	45,988	34,602	75.2%
Jun-13	31,404	22,001	4.2	70.1%	46,800	30,244	64.6%
May-13	35,511	22,312	6.9	62.8%	53,117	31,045	58.4%
Apr-13	35,841	21,271	8.3	59.3%	53,321	30,734	57.6%
Mar-13	52,561	27,411	9.5	52.2%	68,688	35,476	51.6%
Feb-13	48,003	24,661	10.2	51.4%	63,104	32,029	50.8%
Jan-13	61,245	27,607	13.8	45.1%	78,069	34,780	44.6%
Dec-12	45,389	23,438	8.7	51.6%	58,634	31,134	53.1%
Nov-12	62,736	21,853	19.2	34.8%	79,344	28,952	36.5%

Table 14 - HCA Medical Assistance Customer Services Center

Call Center Proviso Data			
Month	**Percent Answered** *during phone hrs	**Non-Phone Work**	**Inventory Completed**
Nov-2013	Overall 59.4% Client 64.8% Provider 44.9%	Client : 2 Day Provider: 5 Days	Client : 1727 Provider: 977 Combined: 2704
Oct-2013	Overall 71.3% Client 79.6% Provider 56.8%	Client : 1 Day Provider: 5 Days	Client: 1964 Provider: 1094 Combined: 3058
Sep-2013	Overall: 70% Client: 76.8 Provider: 53.1	Client: 1 days Provider: 5 days	Client: 1,424 Provider: 896 Combined: 2,320
Aug-2013	Overall: 72.4% Client: 79.6 Provider: 57.9	Client: 3 days Provider: 4 days	Client: 1,403 Provider: 1,207 Combined: 2,610
Jul-2013	Overall: 75% Client: 81 Provider: 63	Client: 5 days Provider: 7 days	Client: 1,576 Provider: 1,377 Combined: 2,953
Jun-2013	Overall: 54% Client: 70 Provider: 54	Client: 2 days Provider: 5 days	Client: 1,788 Provider: 1,121 Combined: 2,909
May-2013	Overall: 58% Client: 62 Provider: 55	Client: 2 days Provider: 9 days	Client: 1,890 Provider: 1,947 Combined: 3,837
Apr-2013	Overall: 60% Client: 62 Provider:54	Client: 2 days Provider: 15 days	*new data collection
Mar-2013	Overall: 52% Client: 52 Provider: 50	Client: 3 days Provider: 11 days	
Feb-2013	Overall: 51% Client: 51 Provider: 49	Client: 5 days Provider: 9 days	
Jan-2013	Overall: 44 Client: 45 Provider: 43	Client: 7 days Provider: 7 days	
Dec-2012	Overall: 53 Client: 52 Provider: 58	Client: 7 days Provider: 8 days	
Nov-2012	Overall: 37 Client: 35 Provider: 43	Client: 7 days Provider: 12 days	

8. Current Initiatives Related to Eligibility

Eligibility Processing/Workload Management

Washington's implementation of the ACA is clearly the primary initiative related to eligibility for health benefits. While other programs remain tied to models that often place the onus on a caseworker to track down (or an applicant to provide) information required to take disposition on an application, the process as designed under the ACA calls for applicants for health benefits to receive an eligibility determination in real time if possible using a combination of self-attestation and available databases.

The HCA in ongoing partnership with the HBE, implemented the ACA on time, but experienced a fair number of system and operational challenges. Working diligently to make system fixes to achieve the federal expectation of a simplified, streamlined and consumer-friendly Insurance Affordability Program interoperable enrollment system, as of January 16, 2014, the HCA has 434,044 individuals successfully enrolled in a Medicaid program since October 1, 2013. As of January 9, 2014, this includes 135,000 newly eligible adults, which exceeds the initial expectations for January 2014. Since implementation, the new integrated HPF enrollment system has been updated regularly to refine and meet performance expectations. The HCA continues to partner with the Exchange and DSHS on continued system upgrades to achieve expected performance outcomes for internal and external consumers. The HCA is also developing, with the HBE, the system tools to provide a Medicaid managed care shopping experience for 2015.

The DSHS Community Services Division (CSD) has worked to improve, simplify and streamline eligibility on a statewide level since 2000, when the division first implemented call centers, electronic document management and streamlined eligibility for individuals also receiving SSI. Since then, eligibility business process efforts have been implemented for in-person, phone, online and paper methods.

Between 2009 and 2011, CSD completed Phase I of a business process reengineering effort. During this phase, the division shifted from caseload based eligibility work to a standardized task-managed work flow. In this model, also known as the "universal caseload," eligibility workers aren't assigned specific cases; rather, they perform specific tasks which provide a more seamless and efficient process. This centralization and generic case management technique has become a trend in Health and Human Service organizations across the country. DSHS evaluated the caseload/case worker structure and realized that as processes and systems become more standardized, case maintenance could become more generic and be migrated to a task-based environment. Currently clients are triaged according to what type of business they need to conduct and routed and tracked accordingly. Scheduled appointments have been eliminated for eligibility related activities (but not for case management of social services or WorkFirst clients) and procedures for verifying eligibility have been standardized and streamlined to increase same day processing. One statewide call center with a single toll free number is now utilized (in the past, there were 42 separate call centers) for eligibility with a standard scope of services and set of processes. The call center/workflow alternative is more suited to effectively managing the workload. Use of online applications has been increased by including kiosks availability in all local offices.

Additional changes were made between 2011 and 2013. During this period, case maintenance was also consolidated into statewide pools of work according to type and work is performed by a "universal" statewide workforce depending on processing priorities. The Barcode system has automated queuing of the statewide workload and lobby waiters and dishes work to the next available worker based on skills and abilities, rather than workers seeking out work.

It should be noted that "Fast-track" eligibility determination approaches and the universal caseloads do have shortcomings. The universal caseload concept creates the equivalent of an assembly line – as work

flows in, the next available staff person and answers the call, inputs the verification, or takes whatever task has been assigned to them in their "queue." In this model, the client is not able to develop a relationship with a specific caseworker – or vice-versa. When developed effectively, it is those relationships that can allow workers to identify issues that must be addressed and for clients to feel comfortable enough to disclose information that could be beneficial.

Department of Early Learning and DSHS: Policy/Program Initiatives

DEL and CSD have undertaken several initiatives to improve program outcomes and customer service in child care. The two agencies were challenged to find ways to more efficiently authorize child care subsidy benefits while accurately determining household eligibility. As a result, two child care process pilots have been developed at select CSOs to meet those goals:

- Childcare benefits are an essential support to enable TANF recipients to participate in required work activities through the WorkFirst program, so WorkFirst Program Specialists in six pilot sites are also completing the associated child care eligibility processing for those families in the WCAP system. Staff report that this extra step, while it does take extra time and extends the length of time a client spends in the office, provides a more streamlined eligibility process. In addition, this initiative allows the WorkFirst Program Specialists to take action on the child care case when a client is non-compliant with their WorkFirst component. In the past, this task was often delayed or not completed at all because the responsibilities were not centralized with a single worker.
- Staff at the Shelton office also noted that if the parent has not selected a provider at the point that the office interview is conducted, they are given the option to contact the WCCC call center to report that information, rather than return to or contact the CSO.
- CSO offices are also the physical location in which child care call center staff are located. Typically, these workers are not involved in seeing clients in person at that location. However, in some locations these staff are available to conduct in-person interviews with clients who walk in the office, providing a more integrated experience for the client.

Both of these initiatives are contributing to providing same-day services. In addition, DEL has implemented several policies designed to improve the customer experience. These largely reflect a change in DEL's philosophy, from focusing on enforcement and reconciliation between "time in care" and "time parents are in an approved activity", to supporting work and economic stability for families. DEL believes that access to subsidies and quality of early childhood education should be balanced to achieve the goals of childhood development, work support and program integrity. These policy changes include:

- Establishment of "true" 12 month eligibility periods, reducing the frequency by which working parents must recertify.
- Implementation of the "110 hour "rule, which simplifies the establishment of full time child care.
- Modification of school schedules – Initiation of the changes in child care hours associated with summer break well in advance, reducing the workload that has slowed service.

Perhaps most significantly, CSD staffing has been increased through the hiring of previously unfilled positions, producing an improved level of customer service in the virtual call center. This is reflected in an increase in the percentage of applications processed timely, up to 90% in 2013, compared with 84% in 2011.

Department of Early Learning IT Initiatives

DEL is in the planning stages of a significant overhaul of the information technology system that supports the child care subsidy program. The Social Service Payment System (SSPS), utilized for payments to child care providers, is a complex legacy mainframe system and WCAP (a module in the Barcode system, which is programmed in an arcane language) is the eligibility system used by CSD workers.

The agency currently has two pending associated RFPs:

- A new electronic time and attendance system based upon software as a service, which would include payment processing, in order to address the planned end of SSPS and improve program integrity; and
- An authorization interface that will replace WCAP. Note that DEL has a contracted business analyst who examined all available options (including remaining with WCAP and integrating into ACES) and made a recommendation that that neither of these choices was optimal.

9. Cost Allocation Plan Analysis

This section of the report documents current cost allocation plans that support the eligibility process and call center activities associated with Medicaid, TANF, SNAP and WCCC. An overview of federal cost allocation requirements and documentation of current cost allocation processes that support eligibility operations is provided in the following sections.

As noted previously, prior to October 1, 2013, eligibility for SNAP TANF, WCCC and most categories of Medicaid services was determined by direct client services and support staff in the CSD within the ESA of DSHS Call center activities supporting the eligibility processes were also mostly handled by DSHS. Financial eligibility for Medicaid long term care was and continues to be handled by DSHS, Aging and Long Term Support Administration Home and Community Field Administration; specifically the Community Field Office Financial unit. Finally, the HCA handled eligibility for Basic Health Plus (a children's Medicaid program), CHIP and certain other small categories of Medicaid including the Breast & Cervical Cancer Treatment Program. As of July 1, 2013, financial eligibility for Medicaid developmental disabilities programs moved from ESA, CSD to the DSHS, Developmental Disabilities Administration (DDA), Community Services, Field Services section.

With implementation of the ACA and the requirement to establish a HBE and determine eligibility for Medicaid based on MAGI rules, the eligibility operation landscape within Washington. Eligibility for the MAGI Medicaid population shifted to HCA and HBE while eligibility determination services for SNAP, TANF, WCCC and Classic Medicaid remains at DSHS, along with long term care and developmental disabilities. The cost allocation structure for the following eligibility operational units located within DSHS, HCA and the HBE were reviewed by PCG:

- DSHS, ESA, CSD Direct Client Staff Unit – handles the following eligibility functions:
  - CSD eligibility workers located in the local CSOs who are available to provide in-person services for SNAP, TANF and Medicaid as well as state cash, food assistance and Medical programs and a federal Refugee Cash assistance program.
  - CSD statewide virtual call center workers who provide the same services as the CSOs, only over the telephone (Medicaid only applications are all handled through the mail without an in-office interview). The only exception is for TANF applicants, who once determined financially eligible, must meet in person with their WorkFirst Program Specialist to develop their Individual Responsibility Plan and other related activities. The call center workers also assist clients with eligibility for the WCCC program.
- DSHS, ALTSA, Home and Community Field Administration, Community Field Office Financial Unit – handles financial and service eligibility for long term care programs.
- DSHS, Developmental Disabilities Administration, Community Services, Field Services – handles financial eligibility for Medicaid developmental disabilities programs.
- HCA MEDS – manages accurate and timely medical program eligibility decisions for clients seeking only CHIP, certain categories of Medicaid, state health programs and as of October 1, 2013, this unit handles post eligibility for new Medicaid MAGI applicants.

- HBE Exchange Call Center – assists applicants with questions on the HBE subsidy programs (APTC, Cost Sharing Reductions (CSR)), Small Business Health Options Program (SHOP) and questions on QHP options. In addition, the HBE Call Center Exchange triages calls concerning eligibility for MAGI Medicaid to be handed off to the HCA MEDS.

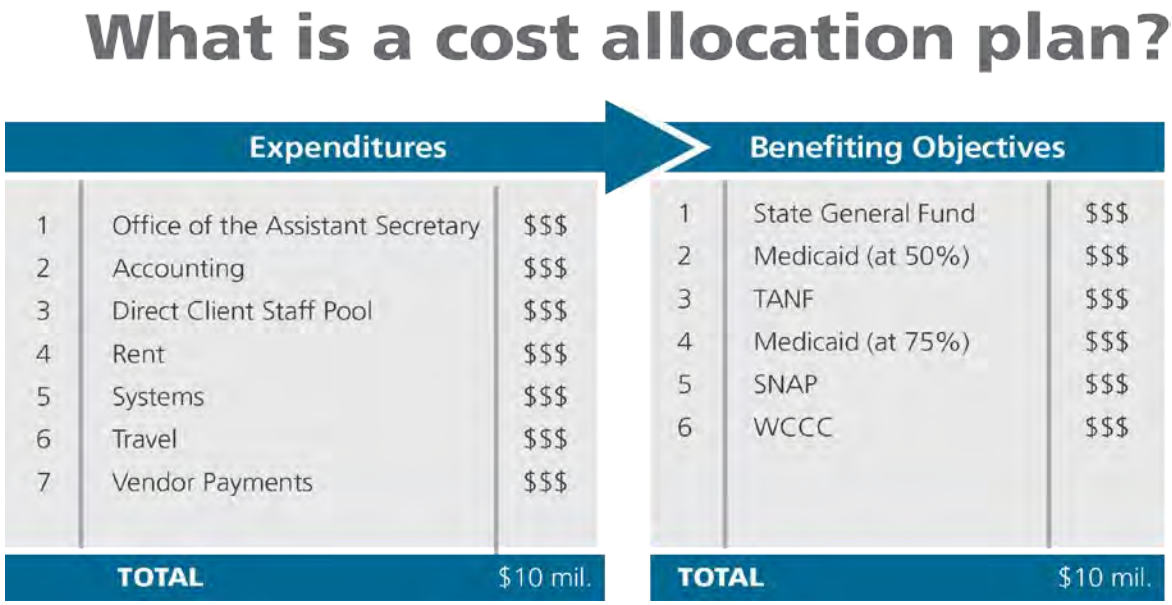
Overview of Federal Cost Allocation Plan Requirements

Federal Office of Management and Budget, Circular A-87 (OMB A-87), now located at 2 CFR Part 225, Cost Principles for State, Local and Indian Tribal Governments establishes the principles and standards for determining costs for federal awards carried out through grants, cost reimbursement contracts and other agreements with State and local governments and federally-recognized Indian tribal governments.

Where an accumulation of indirect costs (cost incurred for a common or joint purpose benefitting more than one cost objective) will ultimately result in charges to a federal grant, OMB A-87 requires a CAP in the form of either an indirect cost rate or full cost allocation plan.

A CAP is a sorting of expenditures for a given department, agency, or other governmental entity incurred through its efforts to carry out public assistance programs. The cost allocation plan is a requirement in order to receive reimbursement for administrative (i.e., non-direct service) costs tied to federal programs. The goal is to allocate all costs to benefiting programs, both those eligible for federal reimbursement and those that are state, local, or grant funded. Costs in a CAP are allocated via "cost pools" that group like expenditures that can be allocated in the same manner. There are two key documents, or series of documents, that comprise a cost allocation plan. The first is the "narrative." The narrative describes each unit or department at an agency, what tasks it performs and how these costs are allocated and contains the sections required in 45 CFR 95.507. The second key document, which usually consists of multiple documents, shows via spreadsheets or database reports, how the costs are actually allocated. The spreadsheets represent the "results" of the plan and must be prepared on a quarterly basis. A "best practices" plan demonstrates that the spreadsheets follow the details in the narrative. **Figure 9** shows a high level view of a cost allocation plan.

Figure 9 - High Level Cost Allocation Plan



Specific Cost Allocation Requirements for the Public Assistance Agency

Code of Federal Regulations, Title 45 and Part 95 requires that public assistance agencies including Medicaid, CHIP and TANF are required to prepare a full public assistance cost allocation plan (PACAP).

Title 45, Part 95, further stipulates that the agency must promptly amend the cost allocation plan when certain events occur to impact the validity of the approved cost allocation procedures, including changes to agency organizational structure, the addition of a new federal program, function, or activity, or a change in federal law.

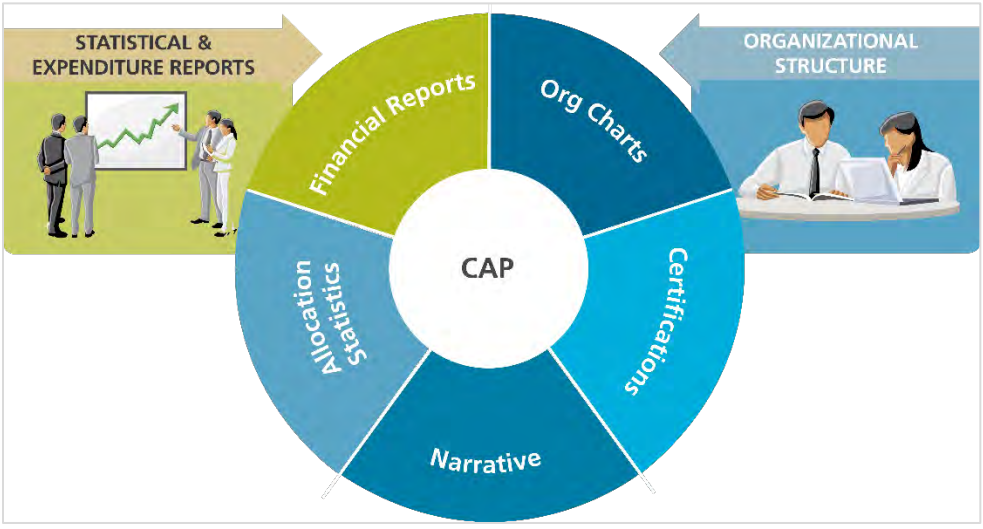
States must claim federal financial participation (FFP) for costs associated with a program in accordance with the approved PACAP. If costs are not claimed in accordance with an approved plan or the State has failed to submit an amended plan as required, costs improperly claimed will be disallowed.

Medicaid regulations (Title 42, Part 433.34) take cost allocation requirements a step further by stipulating that the Medicaid agency State Plan must provide that the agency will have an approved cost allocation plan on file that is in accordance with the requirements contained in subpart E of Title 45, part 95. Subpart E also sets forth the effect on FFP if the requirements contained in that subpart are not met.

Title 42, CFR 457.228 also requires the State Plan must provide that the agency responsible for CHIP will have an approved cost allocation plan on file with the Department in accordance with the requirements contained in subpart E of 45 CFR part 95. Subpart E also sets forth the effect on FFP if the requirements contained in that subpart are not met.

Figure 10 describes the type of information required in order to compile a PACAP.

Figure 10 - PACAP Types of Information



PACAPs and plan amendments must be submitted to the federal cognizant agency for negotiation and approval.

The PACAP is comprised of the elements in **Table 15** below.

Table 15 - PACAP Elements

Requirement (45 CFR 95.507)
An organizational chart showing the placement of each organizational component.
A listing of all federal and non-federal programs performed, administered, or serviced.
A description of the activities performed by each organizational component and where not self-explanatory an explanation of the benefits provided to Federal programs.
The procedures used to identify, measure and allocate costs to each benefitting program and activity, including activities with different FFP rates.
The estimated cost impact resulting from proposed changes to a previously approved Plan.
A statement stipulating that wherever costs are claimed for services provided by a governmental agency outside the Public Assistance agency (PA) they will be supported by a written agreement which includes, at a minimum, the specific service(s) being purchased, the basis upon which the billing is made by the provider agency and a stipulation that the billing will be based on the actual costs incurred (45 CFR 95.507 (b) (8) (i) - (iv)).
If the PA programs are administered by local government agencies under a State supervised system, the State PA agency's cost allocation plan will also include a cost allocation plan(s) for the local agency.
A certification by a duly authorized official of the State PA agency containing the statements shown in 45 CFR 95.507 (b) (8) (i) - (iv).
Other information as necessary to establish the validity of the procedures used by the State PA agency to identify, measure and allocate costs.

Overview of DSHS and HCA Public Assistance Cost Allocation Plans

As separate State agencies, DSHS and HCA maintain separate public assistance cost allocation plans (referred to as CAP throughout remainder of this section) which have been approved by the Division of Cost Allocation (DCA). Both CAPs are updated regularly to reflect changes to the structure or functions within the organization through submission of CAP amendments. DSHS and HCA use a similar format for their CAP narrative which is based on each agency's organizational structure. PCG reviewed the DSHS and HCA complete CAP narrative to gain a general understanding of how each CAP is organized in order to complete this review.

Department of Social and Health Services Cost Allocation Plan Narrative

The DSHS CAP is organized by Division with a separate CAP narrative section for each Division including the Executive Management and the Financial Services Administration which functions include oversight and support of all DSHS Divisions. The CAP is organized according to the classic top down organizational structure to provide for an appropriate allocation of costs down from the highest level department and divisional central oversight and support units to lower tier units that perform specific functions and activities to administer DSHS programs. Each organizational unit is further organized into unique cost pools based on the functions and activities performed by staff. Staff performing similar functions and activities are organized into distinct cost pools to be allocated to the programs that benefit from the functions and activities performed based on an appropriate allocation method which the DSHS CAP refers to as a base. DSHS organizes all bases used in the CAP by number. The CAP documentation includes a summary document for each base used in the CAP which includes a description of each base, why it is appropriate for the cost pool and the funding sources impacted. For example, Base 471 is titled "RMTS Pool" and is used to allocate costs of the Direct Client Services Staff cost pool.

The ESA section which houses the DSHS eligibility operations for TANF, SNAP, WCCC and Classic Medicaid is organized with the first cost pool as the Office of the Assistant Secretary. This cost pool includes the Assistant Secretary and immediate staff, the Executive Secretary of ESA and the Statewide Community Engagement Manager. These staff are responsible for oversight for all ESA units and the

programs administered. This cost pool is allocated across all ESA based on a full time equivalent (FTE) statistic. A full time equivalent statistic measures workers in a way that makes them comparable even though they may work a different number of hours per week.

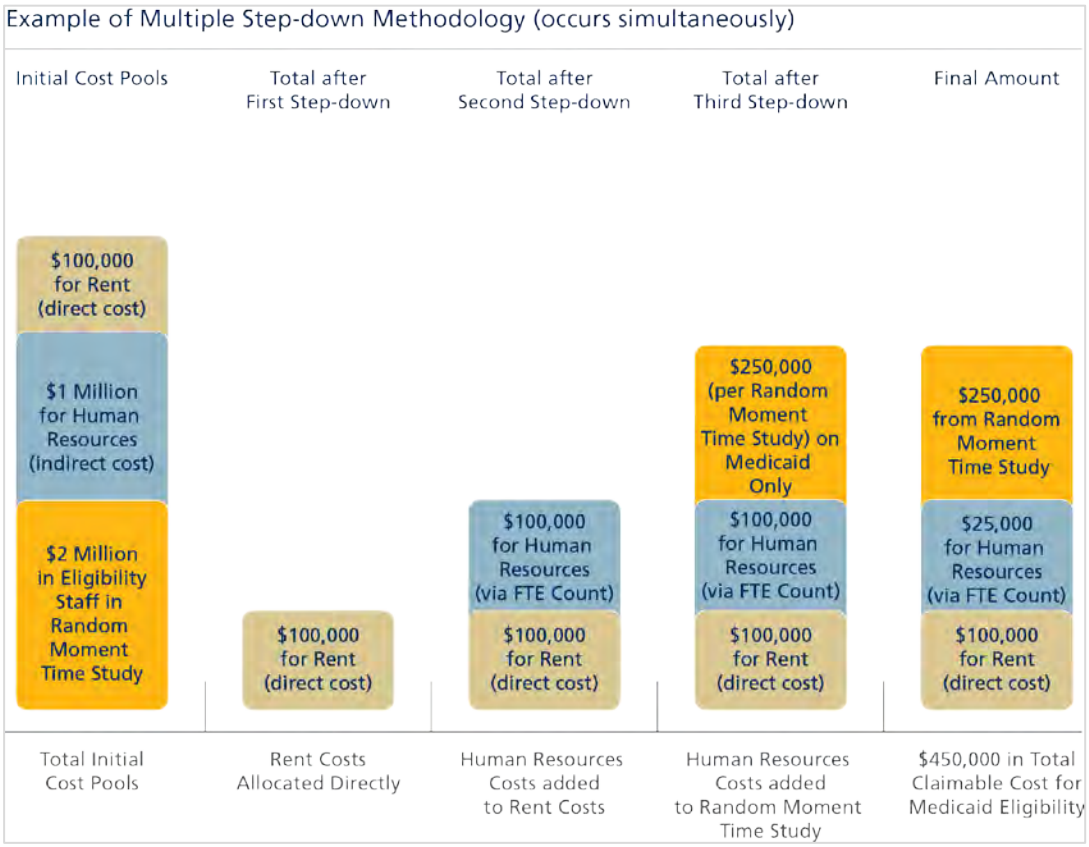
The next cost pool in the ESA CAP is the Chief Operating Office, followed by the Senior Policy Advisor and then Finance Accounting. All of these cost pools provide support across all or most ESA units and are allocated down to these units based on an FTE across ESA or the specific ESA units supported. Further down in the ESA CAP is the CSD which handles the eligibility operations for TANF, SNAP, WCCC and classic Medicaid.

The CSD section begins with the Regional Management cost pool which is allocated through the Field Office Staff Pool based on FTEs disbursed, base 476. The CAP narrative base description document describes base 476 FTEs Disbursed as being reflective of the work performed by the staff at the agency. The document states "This method allows DSHS to allocate administrative charges in proportion to the staffing level required to meet program needs." FTEs are based on actual person months and are reported by funding source. This information is obtained on a monthly basis from the Agency Financial Reporting System (AFRS) at DSHS and is used on a rolling period with a one month lag. For example, the FTEs for July would be used in the September CAP. Further down in the CSD section is the Direct Client Staff Pool which houses the eligibility workers. This cost pool is examined more closely in the following section.

The DSHS CAP structure provides for costs to flow or "step" from higher level units (cost pools) down and across lower level cost pools they provide oversight and support in order to recover the indirect costs associated with the various state and federal programs administered by DSHS.

Figure 11 shows how a simple step down process works (numbers are illustrative only):

Figure 11 - CAP Step-down Methodology



Health Care Authority Cost Allocation Plan Narrative

The HCA CAP narrative is organized in a similar manner using the classic top down approach based on the organizational structure to provide for an appropriate allocation of costs down from the highest level department and divisional central oversight and support units to lower tier units that perform specific functions and activities to administer HCA programs including the MEDS which performs MAGI Medicaid eligibility.

DSHS and HCA Cost Allocation Plan Processing Operations

The OFM statewide AFRS, Enterprise Reporting (ER) and the Cost Allocation System (CAS) are the systems used for accounting and allocating department costs to federal and state funding resources. AFRS is the accounting system of record for all state agencies. Daily, the system provides expenditure data to CAS for reporting purposes and cost allocation.

CAS was developed by the State for the purpose of allocating Department expenditures to benefiting federal and state programs and determining the federal share of those transactions. CAS is housed as a separate table structure of AFRS. Daily, CAS receives a copy of all accounting expenditure transactions processed in AFRS, cost allocates those transactions according to the rules prescribed in the automated cost allocation plan as either a direct distribution to a federal or state program or by statistical formulas which distribute to multiple cost objectives which may send costs to federal and/or state funding sources or to a lower tier cost pool to be allocated further through the "step down" process where costs will ultimately flow down to federal and state funding sources based on the base of these related cost pools. The statistics (bases) are the allocation methods (bases) identified in the approved cost allocation plan.

A journal is processed in the system to reverse the original transaction and posts two new lines to record the state and federal share of the transaction based on the cost allocation results. AFRS retains all four lines with a Cost Allocation Funding Type (CAFT) identifying the individual lines. However, the end result is the original transaction is replaced by the cost allocation journal and charging state and federal funds accordingly.

The CAS system processes the cost allocation plan on a daily basis and posts the information directly into the accounting system to be used for federal reporting. In order to process CAP results on a daily basis, the DSHS CAP uses prior month statistics in the CAP. This is due to the nature and timing of the cost allocation plan processing which occurs at the end of a period for which DSHS and HCA is at the end of the month. DSHS and HCA prepare the CAP statistics through a combination of manual and automated processes. The prior month statistics are applied to current period transactions as the daily CAP processing takes place. Most states process their cost allocation plans quarterly by applying current quarter statistics with current quarter results as is required by OMB A-87. This information is used to prepare the federal claim and draw federal funds. States that need to draw federal funds on a biweekly or more frequent basis for cash flow purposes generally post accounting transactions based on budgeted data for the quarter, requiring a reconciliation between budget to actual costs per the quarterly cost allocation plan and any over or under drawing of federal funds must be adjusted in the accounting system. While the DSHS and HCA approach saves this reconciliation process from occurring it creates a disconnect between the application of the cost allocation base results and the expenditures to which they apply. In addition, due to the complexity of the current DSHS and HCA CAP process, it is difficult for the Agencies to run any sort of analysis to determine the impact of changes to the CAP. DSHS also noted limitations in being able to provide cost allocation results that included the indirect costs associated with each cost pool.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Economic Services Administration, Community Services Division, Direct Client Staff Pool
The CSD Direct Client Staff Pool is used to capture CSD operations associated with determining eligibility for TANF, SNAP, WCCC and Classic Medicaid (with the exception of long term care) as well as state cash, food assistance and Medical programs and a federal Refugee Cash assistance program. Direct client staff serves customers both in the office and on the phone. The following staff are included in the cost pool:

- Financial Service Specialists
- Social Workers
- Family Planning Specialist Workers
- SSI Workers
- Customer Service Specialists
- Community Workers
- Clerical Support
- Call Center Employees
- WorkFirst Program Specialists
- Direct Level Supervisors
- Field Staff Trainers

The supervisors of the staff pool consist of first-line financial and social supervisors and field staff supervisors. Charges included within the cost pool include salary, benefits and travel costs. The majority of costs associated with this cost pool are allocated based on the ESA RMTS Pool Non-Admin Support (Base 471 and Base 474), which uses the results from the RMTS to allocate costs of this cost pool with the following exceptions:

- Direct Level Supervisors are allocated through base 473 FTE's disbursed which allocates costs of each supervisor to across the staff they are supervising or providing support to.
- Field Staff Trainers are allocated through base 479 FTE's disbursed which allocates costs across the staff the trainers provide training to.

As previously noted, indirect costs associated with DSHS Executive Management and other central services as well as ESA Executive Management central service and support units flow down to the Direct Client Staff Pool to be further allocated down to benefitting federal and state programs based on the RMTS results. Please see the following section for an overview of the ESA RMTS process.

The RMTS is the preferred method of allocating costs of eligibility workers that perform a wide range of activities across multiple federal and state programs. A detailed review of the RMTS is provided in the following sections.

Aging and Long Term Support Administration, Home and Community Field Administration, Community Field Office Financial Staff
The ALTSA Field Office Financial Staff determine financial eligibility for Medicaid long term care and developmental disabilities programs. This work includes referring clients for long term care services. The process includes an analysis of the client's current income and resource information and a review of whether any transfers of assets have occurred within the 5 years prior to application. Costs for the Field Office Financial Staff are allocated to benefiting federal and state programs based on a participant days/client counts statistic. This unit receives indirect costs associated with department-wide DSHS administrative costs as well as ALTSA central administrative costs and cost associated with Home and

Community Services offices administration as a result of the step down allocation process. These higher level costs are allocated down to the Financial Staff primarily through a full time equivalent statistic.

The participant days/client count statistic is a common and reasonable statistic for allocating the costs of a long term care eligibility unit.

Developmental Disabilities Administration, Community Services, Field Services Staff
Beginning on July 1, 2013, financial eligibility for Medicaid developmental disabilities programs transferred from the ESA, CSD, Direct Client Staff unit to DDA Community Services, Field Services Staff. The DDA CAP describes the Community Services unit as providing services to 31,850 developmentally disabled persons in the local communities. Planning, authorization and monitoring are coordinated by Field Services staff located in the regional office. Costs for the field services staff providing financial eligibility services are allocated based on case/person count statistic.

The case/person count is an appropriate statistic for allocating costs of determining eligibility for developmental disabilities programs.

HCA

Health Care Authority, Division of Eligibility and Service Delivery Medical Eligibility Determination Services
MEDS is responsible for making accurate and timely medical program eligibility decisions for clients seeking coverage under Children's Basic Health Plus and enrolling clients into managed care plans; Maternity benefits for Basic Health women; CHIP; Take Charge family planning, Breast and Cervical Cancer Treatment Program; and Apple Health for Kids and as of October 1, 2013, the MEDS is determining eligibility for the MAGI Medicaid population. The majority of the costs are allocated primarily through Base 554513, which uses case/enrollment counts to allocate between 75 percent Medicaid FFP, CHIP and state only. However, Medical Assistance Specialists are solely dedicated to Medicaid or CHIP and are charged directly to these programs.

MEDS was reimbursed at the Medicaid regular administrative 50% FFP rate. However, MEDS submitted an Operational Advance Planning Document (OAPD) to request enhanced 75% FFP based on CMS guidance issued on April 25, 2013, indicating that enhanced 75% funding available for new eligibility systems certified by CMS covers the costs of certain activities performed by Medicaid eligibility workers. HCA indicated they had several discussions with CMS to clarify the Medicaid eligibility functions that qualify for enhanced FFP and based on these discussions and written guidance from CMS they have restructured the entire MEDS staff team to only perform application and on-going case maintenance and renewal activities which qualify for the 75% FFP. The enhanced match was approved by CMS on December 16, 2013.

The case/enrollment count is a reasonable allocation method for allocating costs of a Medical eligibility unit that provides services across Medicaid, CHIP and state funded medical programs which are so closely interrelated it makes it difficult for a worker to determine which program a person they are assisting may be qualified for.

HEALTH BENEFIT EXCHANGE

Exchange Call Center
As noted previously in the report the HBE is a quasi-governmental entity. The HBE is not a public assistance agency and therefore not required to have a public assistance cost allocation plan. However, where the HBE is performing services that benefit federal grants including Medicaid, the HBE must comply with OMB A-87 regulations to develop cost allocation methodologies to ensure federal claims for

these services are fair and equitable. HCA and HBE have a Service Level Agreement (SLA) in place to support call center activities. The HBE bills HCA on a monthly basis for the total allocated amount. The HBE requested approval for funding of the call center which includes the cost allocation methodology for the call center in an OAPD submitted to CMS.

The Exchange Call Center provides assistance to consumers by answering questions about health insurance eligibility, application and enrollment, including the availability of tax credits and cost sharing reductions. The Exchange Call Center also helps consumers navigate through the ACA APTC, Small Business Health Options Program (SHOP) and the non-subsidized uninsured seeking services related to QHPs and answer general questions concerning health coverage availability and eligibility. The Exchange Call Center is the first point of contact for all customers with questions about applying for health insurance through HPF including individuals eligible for Medicaid MAGI and CHIP. The Exchange Call Center works closely with HCA to transfer callers needing assistance with Medicaid and CHIP eligibility questions while remaining on the line to ensure the online enrollment application is properly completed. The following positions are included in this cost pool:

- Customer Resource Specialist
- Call Center Manager
- Quality Assurance Manager
- Training Manager
- Information Technology Manager

The cost allocation methodology for the Call Center is based on a methodology that distributes costs on the relative scale of membership utilizing the system to obtain coverage. Exchange and Medicaid enrollments projected for 2014 were used to estimate the relative scale of utilization between these two programs. These projections are part of a market impact analysis performed by Milliman, Inc. Next, the Exchange information technology functions were evaluated to determine which functions benefited the Exchange only and which functions benefitted both the Exchange and Medicaid. This analysis determined that an estimated 18% of the Heath Plan Finder functionality is shared between Medicaid recipients and non-Medicaid recipients and 82% is not shared. The final calculation works out to be 5.76% of costs are allocable to Medicaid/CHIP and 94.24% is allocable to the grant. This cost allocation methodology was approved by CMS on December 20, 2013.

During our interviews with HBE and HCA it was noted the HBE Call Center is receiving an overwhelming number of calls to assist MAGI Medicaid clients complete the application process. These calls are handled jointly with MEDS so that a representative from the HBE Call Center and MEDS remain on the line while the MEDS staff member assists the caller with specific questions pertaining to Medicaid. The level of calls HBE receives from MAGI Medicaid consumers is expected to go down as HBE and HCA work through initial issues with Health Plan Finder. However, given the fact that anticipated enrollment (based on Milliman study) through the HBE is projected to include 1,071,000 MAGI Medicaid consumers compared to 408,000 for non-MAGI Medicaid consumers, it seems reasonable that HBE will continue to experience a high volume of calls from MAGI Medicaid consumers and raises concerns that the current approved cost allocation method to allocate only 5.76% of total call center costs to Medicaid and CHIP is significantly understated. Increasing HBE Call Center revenue by allocating costs of the Call Center fairly and equitably between state and federal programs will be a critical factor as the HBE eventually becomes self-sustaining in FY 2016. There is not enough data available at this time on the level and nature of the call center activities to recommend an alternative methodology. However, this is an area we will explore in phase 2 of the project.

Review of ESA Random Moment Time Study

The ESA, CSD Direct Client Service Workers participate in a RMTS to document their work activities. ESA uses the results from the RMTS to allocate costs of the Direct Client Service Worker cost pool and

certain indirect costs associated with headquarters and regional operations to the proper state and federal funds and programs.

General Random Moment Time Study Overview

When staff work on multiple activities or programs, the DCA preferred methodology for allocating costs to federal programs is a RMTS. In certain cases, agencies must complete a RMTS (e.g., Income Maintenance workers, child welfare workers, etc.) because DCA has determined this method is the only one appropriate to ultimately segregate allowable from unallowable program costs.

A RMTS is a tool used to analyze work being done by employees over a specified time period. The end result of the RMTS is a series of percentages reflecting the proportion of time spent on the various types of activities performed by workers. The RMTS results are used to extrapolate to the entire specified population of workers.

The RMTS method polls participants on an individual basis at random time intervals over a given time period and totals the results to determine total activities and programs worked on for the entire population of eligible staff over that same period.

The use of a RMTS allows the agency to accurately document staff activities relating to administrating federal and state programs. RMTS results are used to allocate expenditures and determine the appropriate claiming under federal programs. Each state's RMTS program must follow federal guidelines as outlined by OMB A-87 and be approved by DCA. Proper administration and monitoring of the RMTS is critical to ensuring the accuracy and integrity of results.

When an RMTS is used to allocate worker activities it is important to ensure statistical validity. DCA provides specific guidance on how to develop a sample that is statistically valid which includes the following formula:

$$N = \frac{P(1-P)}{\left(\frac{SE}{T}\right)^2}$$

Where N = Sample Size
P = Anticipated Rate of Occurrence of the Activities being Observed
SE = Desired Sample Precision (e.g., .02, .03, .05, etc.)
T = Confidence Level Factor (1.96 for 95%)

A 15% over-sample should be used with any calculation.

The moments will typically be generated for the corresponding claim period. OMB A-87 Attachment B Selected items of cost, 8. Compensation for personal services, h. (6) (iii) - it states "results must be statistically valid and applied to the period being sampled. Any variation must be approved by DCA in advance as it is technically against federal regulations.

Economic Services Administration Random Moment Time Study

The ESA, CSD Direct Client Service Workers complete an RMTS. ESA uses the results from the RMTS to allocate costs of the direct client service workers and certain indirect costs associated with headquarters and regional operations to the proper state and federal funds and programs.

A separate and distinct sampling universe has been defined for the purposes of the ESA RMTS. The universe includes field staff / direct workers who are involved in the day to day administration within each CSD Community Service Office field offices. Participants in the RMTS include all workers

identified by ESA as having direct client contact. The following positions have been determined to relate to these functions.

- Financial Service Specialist 1, 2, or 3;
- Social Worker 1 or 2;
- WorkFirst Program Specialist;
- Customer Services Specialist 1, 2 or 3; and
- WCCC call center workers (Financial Service Specialists 1, 2 and 3)

Only filled positions are included in the RTMS pool. There are currently approximately 1866 workers who participate in the RMTS.

ESA maintains the roster of participants in a table in the Barcode System. The roster table is reviewed and updated on a quarterly basis. Positions that are vacant and will not be filled during the reporting month are not included in the sample.

A random sample of workers is drawn during the month preceding the sampling month. The samples are generated using the facilities of the RTMS function within the Barcode System, which is maintained by Information Technology Integration and Services. The Barcode RMTS database generates 1,500 "moments" for the month at random from combinations of eligible workers and minutes available during the sampling month. Each sampled moment is identified on the sample control list. The sample is stored in the Barcode RMTS Database and also posted for access by the RMTS Coordinators.

The current statewide sample size is 4,500 samples per quarter (1,500 samples per month).

Each sampled worker receives an electronic notification at 5 minutes before the designated sample time that contains a hyperlink to the RMTS sample. If the sample is not completed within a 15 minute time frame after the sample time, the worker receives notifications every 5 minutes until the sample is completed. If the sample is not completed by 30 minutes past the sample time, then the Coordinator is notified that the sample has not been completed. If the sample worker is not available to complete the sample, the Coordinator is to complete the sample and will only be allowed to complete the section indicating that the sample worker is "not on the job" and the reason why. If the sample is not completed by the time of 1 hour past the sample time, then the automated RMTS process will lock the sample, preventing it from it being completed. The sample will then be considered as not completed.

The RMTS administrator serves as the single point of contact for CSD CSO RMTS administrators and coordinators and is responsible to oversee the RMTS and generating the monthly RMTS samples in Barcode.

The CSO Administrators are responsible for ensuring that the RMTS sample is completed properly in accordance with the approved RMTS policies and procedures. The CSO Administrators oversee an RMTS Coordinators within each CSO. CSO Administrators are responsible for informing the RMTS Administrator of the names and contact information for the CSO-RMTS Coordinators. CSO Administrators are responsible for informing staff when a sampled worker is on the job and working, the RMTS Sample must be completed within one hour of the sample time.

CSO-RMTS Coordinators review and update the Barcode list of employees to be sampled to ensure all eligible workers are included for the RMTS sampling. RMTS coordinators are responsible for administering the sample. If a sample worker is not signed in or does not respond, the RMTS coordinator is notified with a hyperlink to the RMTS sample form. The RMTS Coordinator is responsible for responding for sample workers who are not on the job at the sample time. The RMTS Coordinator must indicate why the sample worker didn't respond by checking in employee development training, on

annual/sick leave, vacant position, alternate schedule, or other. The RMTS Coordinator is only authorized to indicate the worker was not on the job and why.

How a Sample Worker Completes a Moment

As noted earlier, the RMTS participant pool of workers includes a combination of financial eligibility workers as well as social workers and WorkFirst program specialists who work with clients on WorkFirst participation and case management activities. As of October 1, 2013, all financial eligibility workers work on multiple programs and social workers and WorkFirst program specialists are normally focused on WorkFirst. However, some workers are also responsible for determining eligibility for TANF and they may also assist with an application for food assistance programs. In addition some social workers are focused on incapacity decisions and SSI facilitation. As a result, all the workers are combined in the single RMTS.

Sampled workers are responsible for accurate and timely responses to RMTS moments. Samples must be completed within the hour following the requested sample time. As noted earlier, when a sampled worker is not logged in or does not respond, the RMTS Coordinator is responsible for responding to the moment by reporting the worker status as "Performing other activities, away from the office, or not on the job." The RMTS Coordinator must also check one of the following activities indicating why the worker is not available to complete the moment:

- In Employee Development Training;
- On Annual/Sick Leave;
- Vacant Position (completed by the RMTS Coordinator);
- Alternate Schedule; or
- Other (break, meeting, lunch, navigator, working off-site, issuing EBT Cards, etc.

When a sampled worker is available to respond to a moment, the worker completes the worker status section by reporting the "Sampled worker was on the job performing financial eligibility determination, WCCC, WorkFirst Participation of Case Management Activities." Next, the worker is directed to provide more detail on the activity being performed and the programs impacted by choosing from a number of program/ activity codes based specific to the duties they might be performing as follows:

Financial Eligibility Determinations – the sampled worker is directed to mark as many boxes as necessary to identify the type of program(s) affected by the worker's action at the time of the sample. This section is defined to include all functions relating to eligibility/re-eligibility determination for all cash grant, medical and food stamp cases. Included are such activities as gathering, verifying, recording and documenting data, protective payee, eligibility determination, authorizing benefits, assigning applications, verifying and processing overpayments, referral to other programs/resources, assisting with applications or review etc.

WorkFirst Participation & Case Management Activities – is designed to allow the sample worker to only check one box that identifies the type of program/activity being performed at the sample time.

Table 16 shows the various program/ activity choices included in the RMTS and the funding source for each program/activity before the transfer of eligibility for the Medicaid MAGI group to HCA and the current funding source as of January 1, 2014.

Table 16 - RMTS Program/Activities and Funding Source

Category of Service	Program/Activity Code	Activity Description	Funding Pre-ACA (before 1/1/2014)	Funding Post ACA as of 1/1/2014
Financial Eligibility	BASIC FOOD	Excluding the Food Assistance Program (FAP). Includes activities related to determining eligibility and issuance of food benefits for the federally funded basic food program. The basic food program benefits are distributed using Electronic Benefit Transfer (EBT) system. EBT activities that relate to basic food program will be included in this category.	SNAP at 50% FFP	No Change
Financial Eligibility	FOOD ASSISTANCE PROGRAM	Includes activities related to determining eligibility and issuance of food benefits for the state funded Food Assistance Program for citizens and legal immigrants that meet rules in WAC 388-400-0045. FAP benefits are distributed using the Electronic Benefit Transfer (EBT) system. EBT activities that relate to the food assistance program will be included in this category.	100% State General Fund	No Change
Financial Eligibility	CEAP	Consolidated Emergency Assistance Program is a once-per-year cash assistance program available to families or pregnant women who have an emergency and are undocumented or Non-Compliance Sanction re-applicants.	100% State General Fund	No Change
Financial Eligibility	CATEGORICALLY NEEDY AND MEDICALLY NEEDY	Categorically Needy and Medically Needy Programs	Medicaid at 50% FFP	No Change
Financial Eligibility	DIVERSION ASSISTANCE	Diversion Assistance. An emergency cash benefit available to families that meet the eligibility criteria for TANF or SFA but do not need ongoing monthly cash assistance due to anticipated income as described in WAC 388-432-0005.	TANF Maintenance of Effort at 100% State General Fund	No Change
Financial Eligibility	PII AND STATE MEDICAL	PII & State Medical - This category of medical programs is defined to include the following ACES medical coverage group codes: M99, PO4, PO5, WO2 and WO3.	100% State General Fund	No Change
Financial Eligibility	REFUGEE ASSISTANCE – MEDICAL	Refugee Assistance. Provides cash grant and medical assistance to refugees who are not categorically eligible for any other federally funded program (non-TANF and less than 8 months in the U.S.).	Refugee Assistance 100% FFP	No Change
Financial Eligibility	STATE FAMILY ASSISTANCE	State Family Assistance (SFA) – Cash assistance for immigrant families with dependent children and pregnant women that do not meet federal requirements but qualify for state benefits.	TANF Maintenance of Effort at 100% State General Fund	No Change
Financial Eligibility	TANF	TANF eligibility – This program provides cash and medical assistance to low-income families with dependent children. WorkFirst activities such as developing the Individual Responsibility Plan (IRP), case management, monitoring, referrals and related activities are to be reported in section 3B.	TANF	No Change
Financial Eligibility	TANF TITLE XIX ADMINISTRATION	TANF Eligibility with Medical – This program provides cash and medical assistance to low-income families with dependent children. WorkFirst activities such as developing the Individual Responsibility Plan	Medicaid at 50% FFP	The automatic split to Medicaid was eliminated beginning

Category of Service	Program/Activity Code	Activity Description	Funding Pre-ACA (before 1/1/2014)	Funding Post ACA as of 1/1/2014
		(IRP), case management, monitoring, referrals and related activities are to be reported in section 3B. [Note this is not an activity code choice on the time study but rather an automatic split in the RMTS system when TANF is selected because the because the medical assistance unit is included with the cash program]		1/1/2014. Effective 1/1/2014 workers select Categorically Needy and Medically Needy when processing change of status requests for Medicaid MAGI clients until renewal time.
Financial Eligibility	PWA CASH ASSISTANCE	Pregnant Women Assistance – A cash assistance program for pregnant women ineligible for TANF.	100% State General Fund	No Change
Financial Eligibility	ABD CASH & MEDICAL ASSISTANCE	Aged, Blind, or Disabled (A,B,D) Assistance Program A cash (A,B,D) and medical assistance program for single or married adults without dependents who are unable to work for at least 12 months due to disability.	Medicaid at 50% FFP	100% State General Fund [ABD is now a cash only program]
Financial Eligibility	MCS/ALCOHOL and DRUG ADDICTION TREATMENT and SUPPORT ACT (ADATSA)	Medical Care Services – A housing and essential needs and medical assistance program for single or married adults without dependents who are unable to work for at least 90 days due to incapacity.	Medicaid at 50% FFP	As of 01/2014, MCS medical is state funded only and the ADATSA program is terminated
Financial Eligibility	REFUGEE ASSISTANCE – CASH	Refugee Assistance. Provides cash grant and medical assistance to refugees who are not categorically eligible for any other federally funded program (non-TANF and less than 8 months in the U.S.).	Refugee Assistance Grant	No Change
Financial Eligibility	DISABILITY/INCAPACITY DETERMINATION	Incapacity Determination – Activities wherein social workers evaluate whether or not applicants and recipients are eligible for housing and essential needs and Medical Care Services programs due to incapacity.	Medicaid at 50% FFP	100% State General Fund
WCCC, WorkFirst, Case Management	DCS GOOD CAUSE NON-COOPERATION	DCS Good Cause Non-cooperation Determination – Includes the examination of a claim by a TANF client to determine if good cause exists for failure to cooperate with the Division of Child Support.	TANF	No Change
WCCC, WorkFirst, Case Management	FAMILY PLANNING CASE MANAGEMENT	Family Planning Case Management – Case management activities that provide educational, medical and social referral services to all Medicaid eligible men and women, helping them become self-sufficient and avoid unintended pregnancy by planning and spacing the birth of their children.	TANF MOE 100% General Fund	No Change
WCCC, WorkFirst, Case Management	FIRST STEPS CASE MANAGEMENT	First Steps Case Management. Case management activities that provide additional medical care and enhanced services to Medicaid eligible women and infants.	Medicaid at 50% FFP	No Change

Category of Service	Program/Activity Code	Activity Description	Funding Pre-ACA (before 1/1/2014)	Funding Post ACA as of 1/1/2014
WCCC, WorkFirst, Case Management	FOOD STAMP EMPLOYMENT & TRAINING	Food Stamp Employment and Training (FSET) – All activities wherein staff determine exemptions, good cause and applicable activities for Basic Food recipients that would potentially fall under FSET provision.	SNAP at 50% FFP	No Change
WCCC, WorkFirst, Case Management	REFUGEE CASEWORK	Refugee Casework – Activities related to evaluating the client's needs and referring them to a service that is provided exclusively to refugees. This includes case management for TANF, RCA, or other refugee clients who are referred to a contractor for services, including non-cash assistance, that are only offered to refugees.	Refugee Assistance Grant	No Change
WCCC, WorkFirst, Case Management	SSI FACILITATION	SSI Facilitation – Includes activities relating to the SSI application, reconsideration, ongoing treatment monitoring, hearing and appeals council.	Medicaid at 50% FFP	100% State General Fund
WCCC, WorkFirst, Case Management	SSI INTERIM ASSISTANCE	SSI Interim Assistance Reimbursement Agreements (IARA) – Includes all activities related to explaining, signing, maintaining and transmitting general assistance repayment agreements to SSI.	100% General Fund	No Change
WCCC, WorkFirst, Case Management	TEEN PARENT, WORKFIRST ACTIVITIES	Teen Parent – Includes activities such as a home visit to access living situation and connecting with support services such as childcare.	TANF MOE 100% General Fund	No Change
WCCC, WorkFirst, Case Management	WORKFIRST PROGRAM ACTIVITIES	WorkFirst Program Activities. All activities (other than those specific to Teen Parents as described above) related to case management and social services for parents in the self-sufficiency activities of WorkFirst.	TANF	No Change
WCCC, WorkFirst, Case Management	CHILDCARE SUBSIDY PROGRAMS	Working Connection Child Care, all activities – Includes all activities related to the DSHS childcare subsidy program.	CCDF & TANF Used for CCDF (100% State General Fund)	No Change

Applying Random Moment Time Study Results to the Direct Client Staff Pool

The RMTS sample is generated on a monthly basis. At the end of the month, the RMTS administrator runs the monthly RMTS report which summarizes all the results of the worker responses. When a worker selects a single program/activity the response is reported as a single hit to the program/activity code and counted as "1" hit against the activity. In the case of the financial eligibility determination activities when a worker selects multiple codes the response is split proportionally to add up to "1" for that particular moment. For example, if a worker selected Basic Food, TANF, Categorically Needy and Medically Needy the response would be split 1/3 to Basic Food, 1/3 to TANF and 1/3 to Categorically Needy and Medically Needy to add up to "1" moment. Prior to January 1, 2014 and the move of the MAGI Medicaid to HCA, all hits to TANF were automatically split between TANF and Medicaid (TANF Title XIX Administration in Program/Activity Code Chart Above) because Medicaid eligibility was automatically included as part of the eligibility for the TANF cash assistance benefit. As of January 1, 2014, workers have been instructed to select TANF and Categorically Needy and Medically Needy when processing change of status requests for a TANF client also receiving Medicaid until such time as the case if up for renewal and eligibility for Medicaid moves to HCA.

The monthly results of all hits are tabulated by percentages. Hits posted to activity codes associated with a worker performing other activities, away from the office, or not on the job (In Employee Development

Training, On Annual/Sick Leave, Vacant Position, Alternate Schedule or Other) are removed and the hits posted to activities pertaining to a worker being on the job performing financial eligibility determination, WCCC, WorkFirst Participation of Case Management Activities are recalculated to distribute 100% to the various federal and state funding sources. This information is used to update the statistics in the CAS to be used for the upcoming month. The current structure which allows DSHS to allocate current period based on prior period statistics without a reconciliation to actual statistics is an exception to federal guidance and best practices. This approach creates a disconnect between the RMTS effort and the associated costs of the activities. Generally when costs are consistent from period to period this would not present a serious issue. However, in those situations where an agency has a reorganization or a separation of functions within a cost pool unit the impact is much greater and may result in over or under claiming. As noted earlier in the report the DSHS CAP and RMTS methodology is approved by the DCA.

Prior to the transition of eligibility for MAGI Medicaid population moving to HCA, approximately 33% of the costs of the Direct Client Staff Pool was allocated to Medicaid. ESA staff indicated this was largely due to the streamlined application process that allowed an individual or family to apply for multiple programs including Medicaid using a single application. As a result, a worker's processed eligibility for multiple programs simultaneously. The comparison of Medicaid clients who also receive SNAP and TANF (Table 7 on page 20) shows that during 2012 and 2013 approximately 64% of Medicaid clients also received SNAP and TANF. The bifurcation of the MAGI Medicaid out of the process eliminates ESA's ability to allocate activities associated with the simultaneous processing of eligibility for multiple programs (SNAP, TANF and Medicaid) for a large number of clients to Medicaid. DSHS will still need to perform eligibility for TANF and SNAP for this population, however, they will lose the ability to allocate a portion of the costs associated with this activity to Medicaid. As a result, costs associated with these activities will be distributed across the TANF and SNAP only. This impacts the direct costs associated with the eligibility worker cost pool as well as the indirect costs that are allocated down to the eligibility worker RMTS through the cost allocation plan step down approach.

In addition, DSHS will be experiencing a loss in claiming associated with current clients that will transition to MAGI Medicaid who are currently only receiving Medicaid as these folks begin to transition to HCA. Beginning January 1, 2013, current DSHS clients that are considered MAGI Medicaid eligible are being transitioned to HCA at the time of their renewal of eligibility. DSHS is expecting a drop in activity hits on the RMTS to the activity codes that impact Medicaid. While the MAGI Medicaid cases remain at DSHS until their renewal date there will be a lot less work associated with these cases. PCG was not able to project the impact this change will have on DSHS RMTS results for FY 14 and FY 15 and the federal claiming is not able to be determined at this time due to the fact the changes went into effect as of October 1, 2013 and the limited data available at this point and the limited time frame for completing part 1 of this project. We do provide an analysis of the each agency's federal and state actual expenditures for FY 2013 based on the results of the cost allocation plan.

FY 2013 Actual Expenditures for Eligibility Operations

The following section provides information of the FY 13 Actual Costs of Each Eligibility Operational Unit with the exception of the DDA Community Services Field Services Eligibility Operations and the HBE Exchange Call Center which began operations in SFY 14. FY 13 costs associated with determining eligibility for developmental disabilities is included in the ESA total. This information is based on actual expenditures charged to federal and state programs as a result of each Agency's cost allocation plan. This information will be used as a baseline for trending and forecasting of eligibility operations under various business models to be presented in the next phase of the study.

Tables 17 - 19 reflect actual expenditures primarily for salary, fringe, travel and minor costs for goods and services charged directly to the cost pool. The totals do not reflect indirect costs associated with these activities. These totals are based on actual cost allocation results.

Table 17 - HCA, MEDS FY 2013 Expenditures

Division	Medicaid Federal	CHIP Federal	Refugee Federal	Total Federal	Total State
HCA, MEDS	2,806,550	25,418	1,568	2,833,536	1,947,654

* FY 14 Budgeted Numbers for MEDS Indicate Total Federal Funding of 7.8 million Federal and 3.1 million state (includes document scanning)

Table 18 - DSHS CSD Direct Client Staff Unit FY 2013 Expenditures

Division	Medicaid Federal	SNAP Federal	TANF Federal	WCCC Federal	Refugee Federal	Child Support Federal	Total Federal	Total State
DSHS CSD, Direct Client Staff Unit	27,185,880	24,551,936	12,908,486	2,702	475,631	1,860	65,126,494	89,160,002

Table 19 - FY 2013 ALTSA, Community Field Office Financial Unit FY 2013 Expenditures

Division	Medicaid Federal	Money Follows the Person Federal	Total Federal	Total State
ALTSA, Home and Community Field Office	4,341,582	192,504	4,534,086	4,556,778

10. Best Practices

Work Support Strategies

The Work Support Strategies (WSS) Initiative, led by a partnership of three national organizations – the Urban Institute, CLASP (the Center for Law and Social Policy) and the Center on Budget and Policy Priorities – provides a select group of states the opportunity to design, test and implement more effective, streamlined and integrated approaches to delivering key supports for low-income working families, including health coverage, cash assistance, nutrition benefits and child care subsidies.

Since a planning year site visit to Washington in 2011 (as the workload management practices are considered a national model), six of the original nine states were chosen to receive three-year implementation grants to support their plans to implement innovative strategies to streamline services aiding low-income working families. The states are about halfway through the implementation phase and there are some early lessons learned and best practices that could inform how Washington approaches program integration post-ACA. The following state summaries provide information learned through this initiative with WSS states and in many cases illustrate that Washington is not unique in the challenges it faces.

Colorado has 64 counties that vary from highly urban to rural and sparsely populated; the 10 largest counties contain 85 percent of the population. Colorado's public benefit system is state supervised and county administered. The Department of Human Services (DHS) manages Food Assistance, Colorado Works, child care, energy assistance and other economic security programs, while the Department of Health Care Policy and Financing (HCPF) manages Medicaid and other health and medical programs. Food Assistance, Medicaid and cash assistance programs are administered through the state's automatic

benefits system, Colorado Benefits Management System (CBMS). Other work support programs are managed through discrete automated systems. At the county level, most programs are administered together by the same workers. Because counties have the flexibility to operate programs independently – and that includes setting service delivery practice and priorities – program procedures vary considerably.

Colorado has opted for Medicaid expansion and customers have access to health programs through their state based marketplace. Unlike Washington, where there is currently a disconnect between client data in WACON and the HPF, in Colorado the application process between Medicaid and Connect for Health Colorado (C4H) is relatively seamless. Colorado chose to use their multi-benefit online application for medical, food and cash assistance programs – called Program Eligibility and Application Kit (PEAK) – as the front-end system for Medicaid. Applications that come in through PEAK that are over-income for Medicaid are routed to C4H seamlessly and vice-versa from C4H to PEAK for Medicaid determinations. Since PEAK and C4H share application data, the consumer isn't required to resubmit application data between health and human service programs even in the case of a household receiving multiple benefits.

In **Idaho**, seven divisions of the Idaho Department of Health and Welfare (IDHW) manage nearly all of Idaho's public health and human services benefit programs. The division of Welfare oversees Idaho's self-reliance programs, including child support, SNAP, child care assistance, TANF and Aid to the Aged, Blind and Disabled. The Division of Welfare also determines Medicaid eligibility, but other aspects of the program are the responsibility of the Division of Medicaid. The Division of Welfare's self-reliance programs are overseen by a core team in the state-level central business office and are administered through 19 field offices and four dedicated processing units that house call center, central mail, child care eligibility processing, Medicaid redetermination and other statewide teams.

Idaho has opted not to expand Medicaid, but is at the head of the national curve with regard to data, complete program integration and offering multiple entry points for clients. Idaho received CMS approval to delay implementation of MAGI Medicaid rules until January 1, 2014. Once implemented, low-income clients will continue to be able to access the full array of services through IDHW either in-person, over the phone, or electronically.

North Carolina is one of about 10 states nationally in which public programs are overseen by the state but administered at the county level. In North Carolina, this means that each of the 100 counties operates the programs in its own way, while the state agencies issue policy and regulations. The state policy processes for Medicaid, SNAP and child care subsidies are entirely separate even though they are housed in the same department (Department of Health and Human Services). Also, counties generally administer the three programs separately, using different workers and different eligibility processes for each program. Clients often must duplicate their paperwork and visit multiple offices, making it difficult and confusing to obtain and keep benefits.

North Carolina has come to realize that in spite of these circumstances integration, productivity and customer outcomes can be improved through efforts such as policy simplification and alignment. They have a very clearly articulated goal for county administration – families in North Carolina will tell their story once and receive the services they need.

To that end, in the first 18 months of the Work Support Strategies grant North Carolina has:

- Instituted a cross agency policy committee to help overcome these barriers. Created in early 2012, the Economic Benefits Policy Governance Board is comprised of policy directors from Medicaid, TANF, SNAP, Child Care Subsidy, CHIP and Energy programs and is committed to planning, testing and producing policy in partnership.
- Began development of an integrated eligibility manual for staff. As the culmination of several years of discussion, planning, discussing policy and through many drafts the first section – Income – of the North Carolina Integrated Policy Manual was posted on July 15, 2013. The team that worked on developing this manual worked diligently to create the aligned policy manual's first section that looked closely at policy, aligning and streamlining across work support programs where there was state flexibility to do so.
- Conducted a certification periods alignment pilot for SNAP and Medicaid that was successful and rolled out to the entirety of the state in mid-2012. The ultimate goal of this policy was to reduce the number of "touches" that are required to establish eligibility and the number of interactions a client is required to have with their local DSS agency to recertify multiple benefit programs by working to align SNAP and Medicaid certification cycles.
- In conjunction with the policy streamlining efforts of the last 18 – 24 months, North Carolina has worked with their new integrated case management system, NCFAST, to develop the technology that will ensure customers' interactions with the county DSS are completely integrated. This streamlined process is now what drives the integration of services for customers in North Carolina. Beginning October 1, applications at the state or county-level are being be taken for all SNAP, Medicaid, TANF and ACA programs, with integration happening between the FFM, ePASS and NC FAST.

North Carolina has not opted for Medicaid expansion and will use the federally facilitated marketplace.

Rhode Island's work support programs are state administered through the Department of Human Services and include SNAP, Medicaid (Rite Care), Child Care, Child Support and RI Works (TANF).

Rhode Island has opted to expand Medicaid. They have a state-based marketplace and have a "No Wrong Door" approach for customers seeking Medicaid who request assistance in the local offices. DHS is working to provide alternative self-service options to the traditionally paper-based application process. DHS is rolling out a self-service portal in early 2014, through which Rhode Islanders can submit an integrated application for all public and private health and human services programs. The state also created a full service contact center, which provides for a seamless route to DHS for individuals who would also like to apply for SNAP, TANF, or Child Care in addition to the applicable health insurance affordability program. In contrast to Washington's model, RI is implementing a service delivery model that is truly "no wrong door" in that low-income citizens seeking health coverage can still apply at a local human services office, in addition to being able to apply through their SBM. Common application data is shared between all public assistance programs as well as the exchange. In contrast, the model currently in place in WA limits a customer's ability to receive in-person help in completing an application for MAGI Medicaid when they present at a CSO. Instead, the individuals is referred to a kiosk, the 800 # for HBE, or an IPA that is not on-site.

In **South Carolina** the Department of Health and Human Services (DHHS) administers Medicaid and CHIP, while responsibility for SNAP, TANF and child care subsidies falls under the Department of Social Services (DSS). Despite considerable overlap in their clientele and the fact that programs sometimes share the same local office space, DHHS and DSS have different leadership and caseworkers; use distinct computer and case file systems and establish their own eligibility and enrollment processes for their work support programs. Even when their eligibility offices are located in the same building, each agency has its own lobby windows and receptionists, requiring applicants to stand in two different lines if they seek both Medicaid/CHIP and social services programs. Traditionally, information provided by

clients to one agency is not shared with the other. The segregation of work support programs into these "silos" causes considerable confusion for clients and makes program operations less efficient. Complicating matters further, the various local offices that serve clients do not have standardized eligibility determination, enrollment and retention processes.

However, South Carolina has been working to overcome these challenges and has been making great strides in cross agency communication. DHHS and DSS are collaborating to streamline Medicaid, FI/TANF and SNAP eligibility and retention processes to reduce the burden on families who qualify for the services and to improve communication and collaboration between the two agencies. Integral to this process is the project charter created by the leadership team made up of members from both agencies.

The charter consists of three main sections: Project Scope, Project Management Approach and a Decision Making Hierarchy. The Project Scope outlines scope and vision for the client experience and the agencies. It also includes the organizational structure consisting of the governance team, project leadership team and cross-agency workgroups who will lead projects aimed at policy simplification, data sharing and process streamlining. The Project Management Approach describes the function, membership and decision making authority for each of the workgroups. It is assumed that the governance team is empowering the workgroups to get the work done to meet the needs of the project goals. The Decision Making Hierarchy is a list of criteria that workgroups and the project leadership team use to determine when decisions must be brought to the governance team for decision-making. Given that Washington's post-ACA service delivery model has created new entities and governance relationships that previously were managed under one umbrella agency, it might benefit those four entities to develop a charter similar to what was developed in South Carolina/

Targeted Enrollment Strategies for Medicaid

In a letter to State Health Officials dated May 17, 2013, CMS offered strategies for facilitating Medicaid and CHIP enrollment. These "targeted enrollment strategies" identify individuals likely to be eligible for Medicaid and for whom eligibility information is already available in a state's files. These options allow states to identify, enroll and renew individuals without the need for them to complete an entirely new application and help alleviate demands on the new eligibility and enrollment system. One of these options – referred to as "Strategy 3" – uses the individual's eligibility for SNAP to enroll them in Medicaid.

Washington has contacted with CMS regarding Strategy 3 and conservations are continuing regarding implementation. To date five states have successfully implemented this strategy and several more are considering it for 2014. One early adopter, Illinois, identified single adult SNAP recipients potentially eligible for the new ACA adult group and enrolled over 40,000 of those individuals in the expanded Medicaid with a greatly simplified application (two questions) and expedited process to add medical assistance to their SNAP case. Per CMS guidance, a state interested in implementing Strategy 3 must request a waiver under section 1902(e)(14)(A) authority to allow the state to enroll non-elderly, non-disabled SNAP participants.

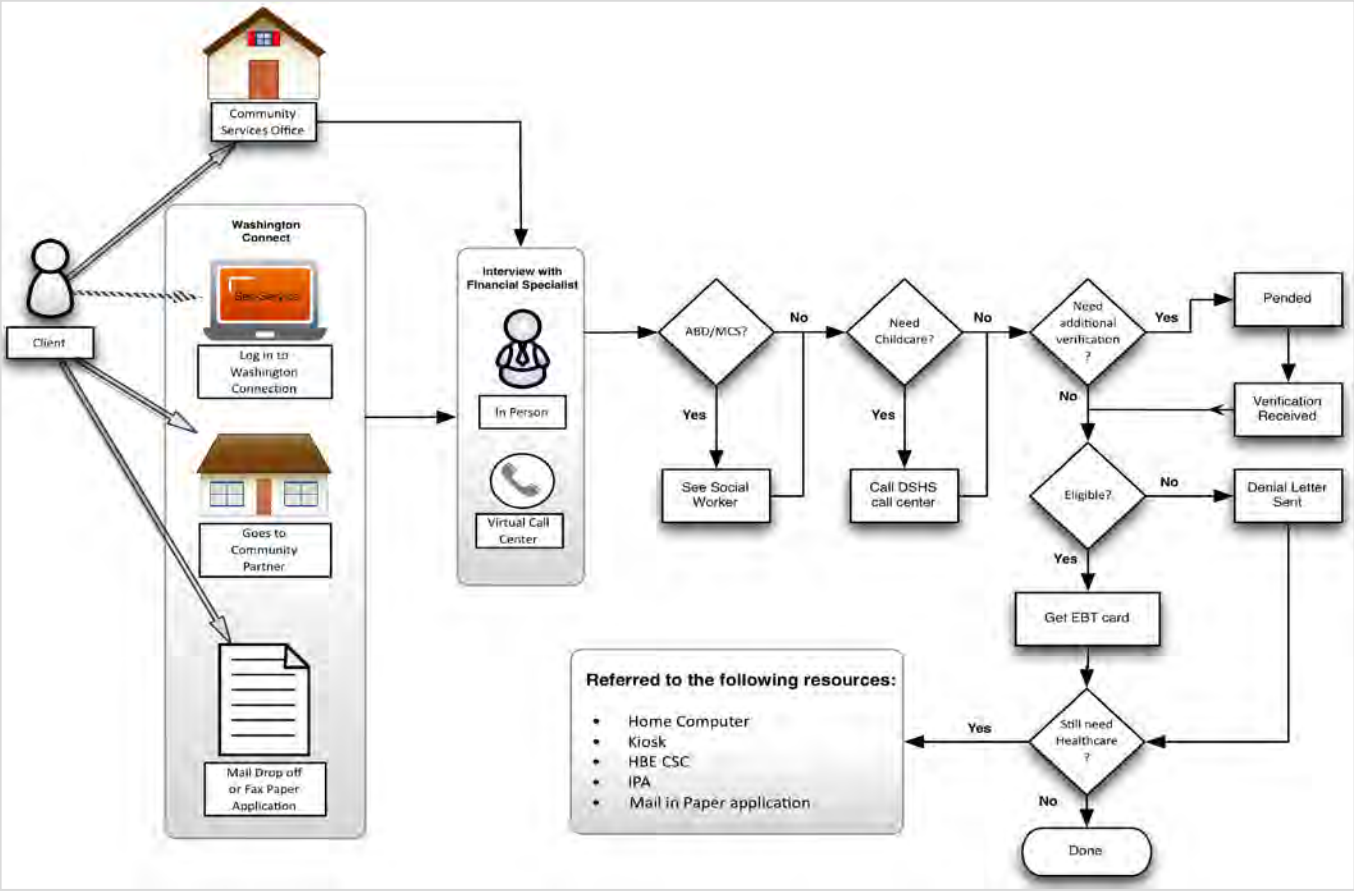
11. Current Process Mapping

Process mapping allows for a visual representation of the steps an individual must follow as they navigate the eligibility determination process. This section provides several process mapping flows created through interactive interviews with CSOs, HCA and the Washington HBE to show the client points of entry, steps required to receive benefits and applicable referrals at the end of each process. Furthermore, to enhance the view from the client's perspective, potential case studies have been included at the conclusion of each process map.

DSHS Assistance Programs Process Flow

Figure 12 illustrates the points of entry for the programs administered by DSHS. In addition, it highlights the process required when an individual also is in need of health care (excluding "classic" Medicaid).

Figure 12- Washington State DSHS Entry Points (includes Classic Medicaid)

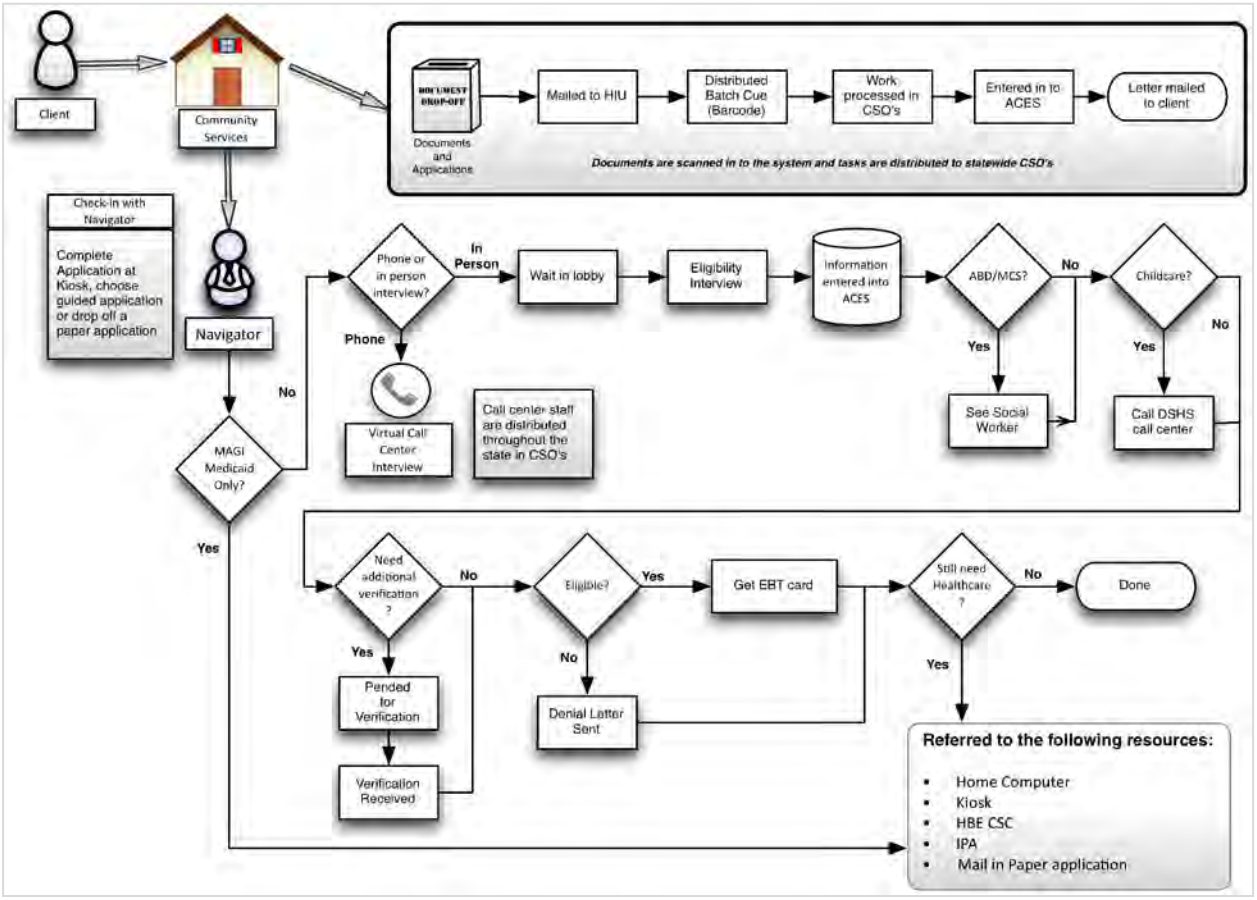


Case study: John Thomas, a resident and student at the University of Washington (on scholarship) is interested in determining if he is eligible for assistance programs through the State of Washington. John has the following options to apply for DSHS programs:

- Community Service Office – John may walk into his CSO and fill out a paper application or submit an electronic application on the kiosks provided. He may wait to see a financial specialist in person or go home and phone the statewide virtual call center.
- Log into Washington Connection – John may log into Washington Connect and fill out the application online. Subsequently, he would phone the call center or go into a CSO for the required interview.
- Go to a community partner – John may seek assistance from a community based organization that either formally or informally provides assistance to applicants.
- Mail or Drop off the paper application – John may mail in a paper application or drop it into the application drop box at his local CSO. In any event, he must either phone the call center or go into his local CSO for the required interview.

Figure 13 illustrates how a customer who is interested in applying for TANF, SNAP, child care and MAGI Medicaid experience the process when their point of entry is a Community Service Office.

Figure 13 - DSHS Community Services Office



Note: "HIU" is the Hub Imaging Unit. When a document is left in a CSO drop box or mailed in, it is forwarded to this unit, which is responsible for imaging. The document will then be available in BarCode for processing.

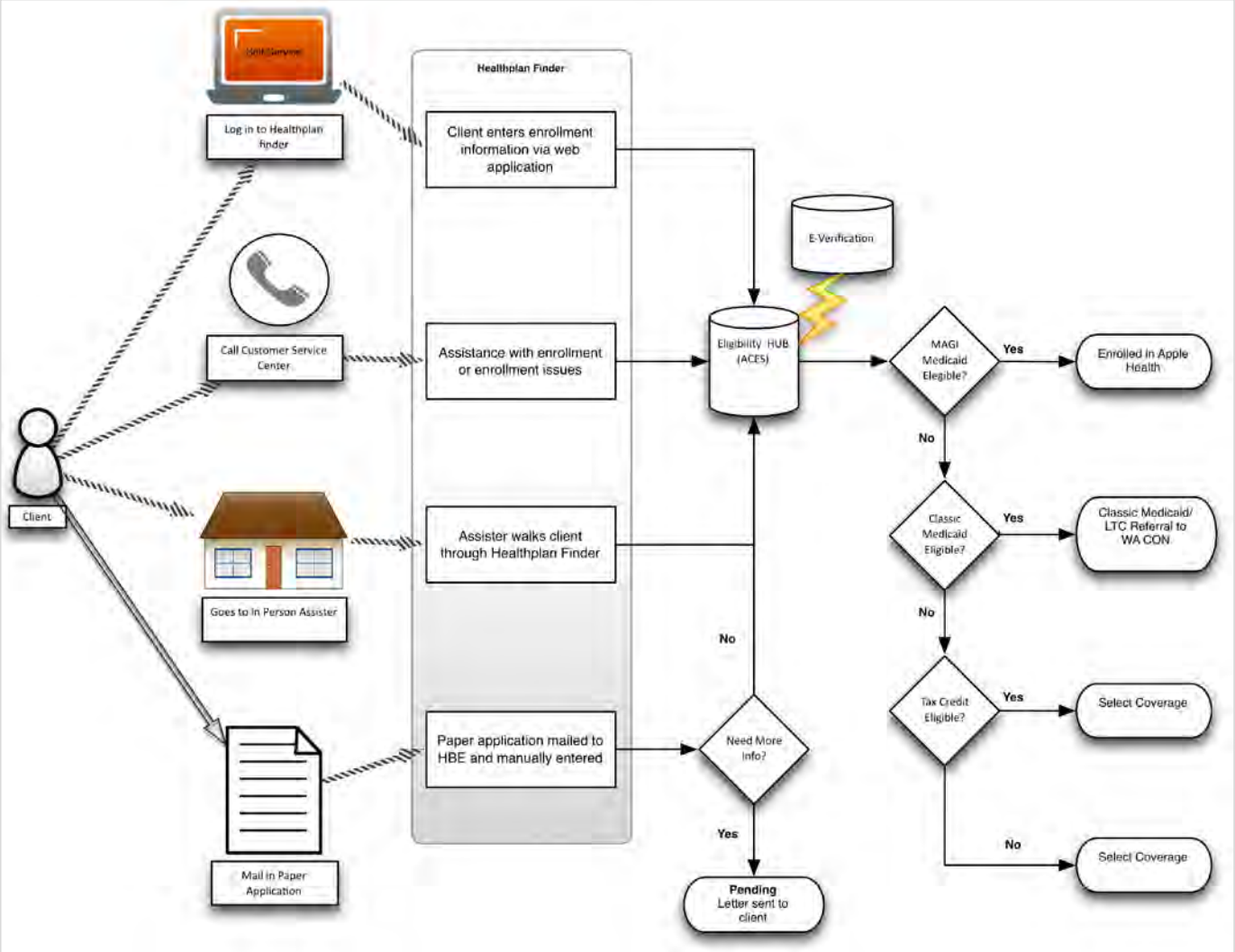
Case study: Ann Smith, a single mother is seeking eligibility assistance for SNAP, TANF, WCCC and Medicaid. She is not classified as aged, blind or disabled. Ann will face the following as she navigates eligibility determination for these programs:

- With the exception of areas being served through on-site child care services pilot projects, Ann will have to call a different worker in order for WCCC benefits to be authorized.
- After eligibility for TANF and/or SNAP is approved, Ann will be directed to go through a separate application process (HPF) for Medicaid because she is not considered eligible for "Classic" Medicaid.
- If Ann decides to apply in the HPF at the CSO and needs assistance in navigating HPF, she will typically need to go to a different location to receive that help. Currently, staff members located at CSOs are prevented from providing assistance in HPF.

The Washington Health Benefit Exchange Process Flow

The process flow in **Figure 14** below illustrates an individual's options for accessing assistance through HPF.

Figure 14 - Washington State Healthcare Entry Points (Excludes Classic Medicaid)



Case study: Mary Jo Rollins is a single mother with two children that is interested in applying for health insurance under the new mandate. She knows that other assistance programs have been available to her in the past and would like to determine her eligibility for them, again. Her progression through this process is as follows:

- Mary Jo is directed to the Washington HPF to apply for insurance and after applying is determined eligible for MAGI Medicaid at 138% FPL.
- At the end of her HPF application she is directed to another site to apply for other assistance programs that she has been assessed "potentially eligible" for.
- As Mary Jo clicks on the link, she is redirected to Washington Connection and requested to fill out an additional application.

This flow represents the process for accessing healthcare through HPF and does not attempt to illustrate the issues that have made enrollment difficult for many Washingtonians. And, while this report is not intended to highlight implementation issues, it is important to acknowledge some of the barriers most often voiced in stakeholder meetings.

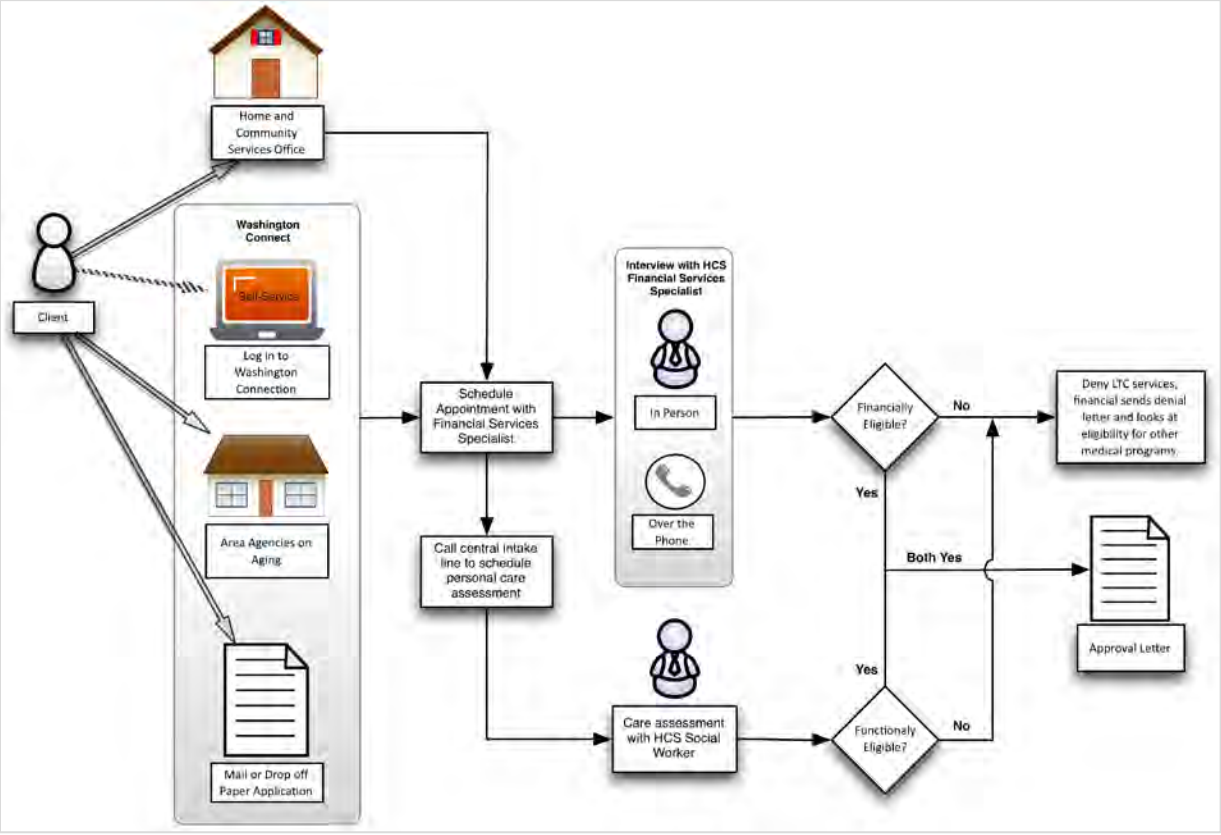
For those requesting a determination of Medicaid eligibility in the HPF, but having an existing or previous relationship with DSHS, the new HPF system must often reconcile application data with previous historic household demographic data contained in the ACES system. Seemingly small discrepancies between data entered in the HPF and that which exist in ACES result in an error that stops the process and delays approval. The reconciliation of the application data between these two systems must be accomplished prior to HPF issuing an eligibility determination. It has been estimated that up to 70 percent of the errors generated by HPF applications can be attributed to reconciliation of discrepancies between application data received through the application process within the HPF and prior existing demographic information contained in ACES.

The process of correcting these errors requires coordination between multiple agencies. The HCA is the single state agency which the Washington Legislature has designated to administer the Washington Medicaid program. Since the HBE is not a state agency, staff members from that organization don't have access to ACES and must work with resources from HCA to resolve discrepancies between the two systems.

The Long Term Care Process Flow

The process of applying for Long Term Care – handled through DSHS' Home and Community Services Division – differs from other programs addressed in previous work flows. This process is captured in **Figure 15**.

Figure 15 - Eligibility Process for Long Term Care



Case study: Michael Sanders is an elderly man with limited income and resources who lives at home alone. As Michael has aged, he has found it increasingly difficult to care for himself and can't afford to hire assistance for his everyday needs. Michael decides to apply for medical long term care service assistance through Medicaid. His progression through this process is as follows:

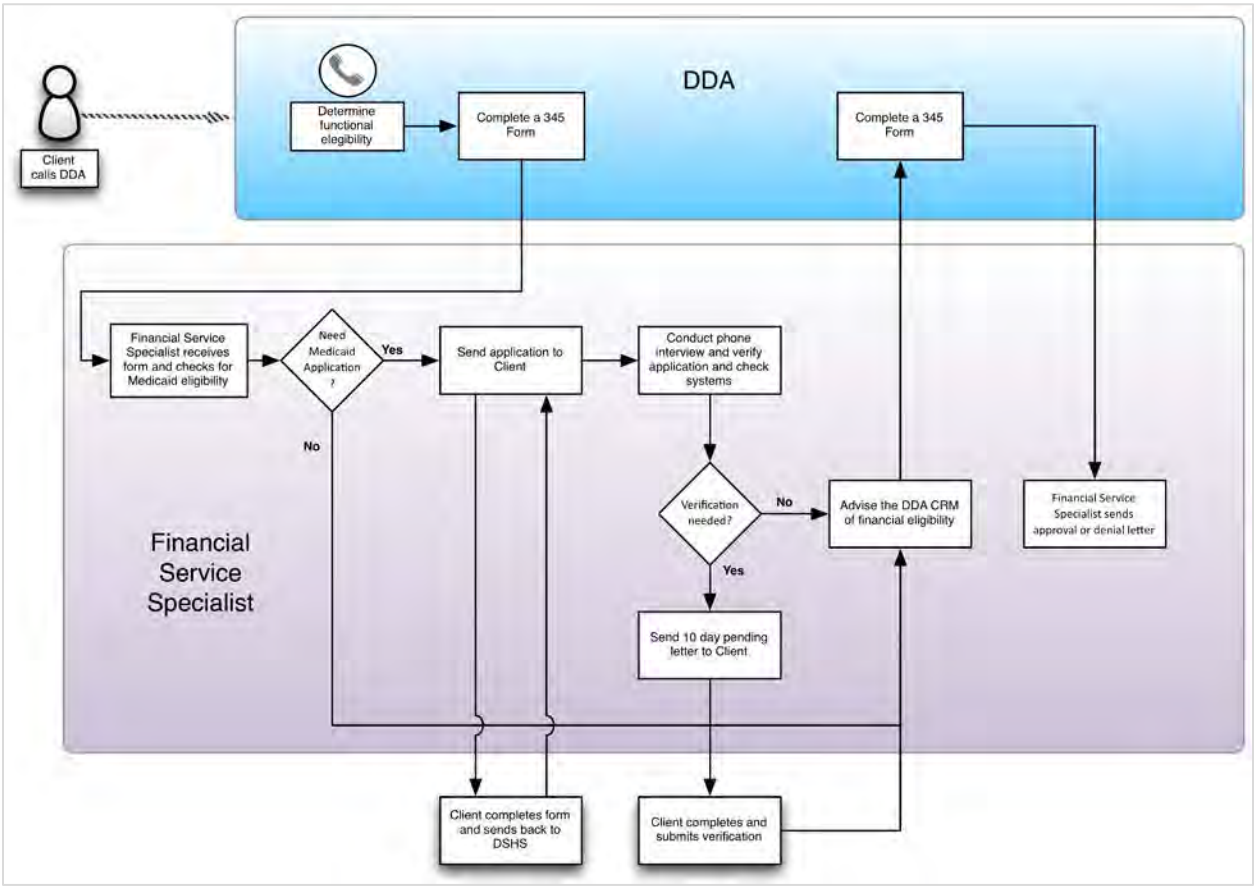
- Michael first must fill out and turn in an application for Medicaid, indicating he is applying for help for long term care services. He may do so in person at a local Home and Community Services (HCS) office, by mail, or online at Washington Health Connections.
- Once Michael has completed the application, he will schedule a financial review with an HCS financial service specialist either in-person or over the phone. At this stage Michael will explain in more detail the answers he has provided on his application form.
- In addition to the Financial Review, Michael will undergo a Personal Care assessment, in which a HCS social worker will visit Michael at his home. The social worker will talk with Michael at length to understand day-to-day activities and inform Michael of his care options.

If Michael is determined both financially and functionally eligible, he will receive an approval letter and decide on a care option that best works for him.

Developmental Disability Process Flow

The process of applying for Developmental Disabilities assistance – also handled through DSHS' Home and Community Services Division – is captured in **Figure 16** below.

Figure 16 - Eligibility Process for Developmental Disabilities



Case study: Stephen Bury is a ten year old boy diagnosed with autism. Stephen Bury and his mother, Sally, live in the Spokane Valley, where Sally struggles to care for Stephen on a daily basis. Sally decides to apply for assistance on the behalf of Stephen through the DDA.

As a resident of the Spokane valley, Sally calls her local DDA office using the toll free number 1-800-462-0624 and requests an application packet be mailed to her address. Sally completes and signs the application with all applicable materials required to substantiate autism as an eligible condition and mails it back to the DDA.

DDA will then notify Stephen of his eligibility determination via written notice. If determined eligible, Stephen will undergo an assessment, usually done at the residence of the applicant, for the level of service needed.

12. Key Initial Findings

Washington has adopted a new philosophy about how individuals apply for health benefits, which has far-reaching impacts.

Washington has adopted a "vertical" approach to health care access. HPF is designed to serve individuals at all levels of income – from those eligible for Medicaid (with the exception of the "classic" categories) to those eligible for premium tax credits and including customers who simply need health insurance and are not eligible for any government support.

This concept is very much in line with requirements of the ACA.

While the new approach streamlines the process for some customers, the current division of responsibilities limits the ability of staff who most commonly come in contact with the neediest individuals and families from providing assistance in the new Medicaid application process. DSHS staff is restricted from helping customers with HPF. In many instances, these staff is working with individuals who are unable or unwilling to utilize other methods of assistance.

The long term impacts of the ACA on caseloads are difficult to quantify at this stage of implementation.

Pre-implementation estimates suggested a reduction in the workload for DSHS due to the number of cases that were MAGI Medicaid only. However, as Washington considers new models for its medical and public assistance programs, the question of how much ACA implementation actually impacts caseloads and workloads has yet to be answered. It is too early in the implementation process to reach any conclusions.

Washington demonstrates many best practices with respect to workload management, but there are areas needing improvement.

DSHS has adopted many recognized best practices designed to gain efficiencies, including the concept of "universal caseloads" and advanced document and workload management tools. These allow management to monitor where resources need to be focused and dedicate staff to those tasks. Still, through site visits and interviews, PCG identified areas in which efficiency can be improved:

- CSO staff (not call center staff that are physically located at CSO offices) are not always needed to meet with clients if the office is operating with a low volume of walk-in traffic on a given day. Today, they are able to access BarCode and work on pending cases throughout the state. However, they are not able to conduct phone interviews, which could reduce wait times for clients attempting

to be serviced through that method. In November 2013, wait times for eligibility interviews (new apps and recertifications) were both between 50 and 60 minutes.
- In some instances, child care call center staff has availability to assist with other tasks. However, as time permits, staff can only assist with other tasks based on their skill level with other systems/programs.

And, while the workload management tools being utilized allow work to be spread more evenly across the state, there are inherent features of this model that alter the nature of client-staff relationships. The argument can be made that an important aspect of customer service is lost when these relationships are not cultivated.

Duplication of work is a concern

Echoing the concerns heard in many states, stakeholders voiced the concern that the removal of MAGI Medicaid from DSHS' responsibilities creates a duplicative process. While some additional auto population exists – and more is planned – when a client starts in HPF and is referred into Washington Connection, the current design does not support auto-population of data in the other direction. In addition to the burden of applying through two separate processes for Medicaid and other social service programs, once approved, renewal periods may not be synched, causing confusion and frustration on the part of customers. However, the value of auto-renewals, the data match renewals and the renewal each and every time a change is reported by a family in HPF cannot be measured. Families whom report changes at least 1 year in HPF may never receive a yearly renewal as they will be renewed at each change of circumstance.

In-Person Assister Agencies (IPAs) face barriers to providing optimal service

IPAs often provide services to the populations facing significant challenges. However, these entities face challenges that limit their effectiveness.

- IPAs have to take the same route as a customer to contact HBE. The exchange call center is very difficult to reach and IPAs are expected to access staff there no differently than a client who is not utilizing an IPA
- Clients are assigned to a single IPA, so when a client forgets their username and password and the IPA is unavailable the client faces a barrier when continuing their application. IPAs do not have the ability to terminate partnerships, so there is no way to transfer a client to another IPA, which is also problematic when a client seeks services at a different location.

A key question related to this finding is which of these issues can and will be solved in the short term and which would continue beyond a reasonable implementation period.

Benefit access is a concern

Front line DSHS staff, Federation representatives and representatives from agencies providing in-person assistance expressed concern that individuals and families are facing new barriers related to ACA implementation that stymie their ability to access needed services. Some of these issues are expected to be rectified in the coming months, including the errors that are currently common while navigating the HPF. However, other issues related to service access are likely to extend beyond a reasonable implementation period.

- The process for those applying for Medicaid through HPF is not conducive to the identification of at-risk individuals and families. While, the HPF mirrors the paper application process that was in place for all mail-in applications and does make a referral for families potentially eligible for cash and SNAP., observers noted that a general reduction in person-to-person interaction has occurred, thereby reducing the opportunity of staff to more easily identify issues that should be addressed.

- Homeless teens can apply by themselves in HPF, but must call the HBE customer service center. This has frustrated online applicants and agencies assisting them.
- The language used in the HPF exceeds the reading level of many of the individuals the tool is supposed to serve (The USDA Food and Nutrition Service produces prototype application materials at the 8th grade level – 6th grade, excluding the required privacy, penalty and disclosure statements).
- CSD financial service specialists are unable to assist low-income individuals with the HPF application.

Bifurcation of MAGI Medicaid shifts the ability to maximize Federal funding of integrated eligibility operations through cost allocation

Prior to the transition of eligibility for MAGI Medicaid population moving to HPF's algorithm, approximately 33% of the costs of the Direct Client Staff Pool was allocated to Medicaid. ESA staff indicated this was largely due to the streamlined application process that allowed an individual or family to apply for multiple programs including Medicaid using a single application. As a result, a worker's processed eligibility for multiple programs simultaneously. A client eligibility report provided by the State shows that during 2012 and 2013 approximately 64% of Medicaid clients also received SNAP and TANF. The bifurcation of the MAGI Medicaid out of the integrated eligibility process eliminates ESA's ability to allocate activities associated with the simultaneous processing of eligibility for multiple programs (SNAP, TANF and Medicaid) to Medicaid. The workload for this group is not reduced. Costs associated with these activities must now be distributed across the TANF and SNAP only. The automated data matching and real time determination through the web portal will reduce administrative costs for Medicaid. This is true wherever the work is performed.

In addition, DSHS will be experiencing a loss in claiming associated with current clients that will transition to MAGI Medicaid who are currently only receiving Medicaid as these folks begin to transition to HCA. Beginning January 1, 2013, current DSHS clients that are considered MAGI Medicaid eligible are being transitioned to HCA at the time of their renewal of eligibility. DSHS is expecting a drop in activity hits on the RMTS to the activity codes that impact Medicaid. While the Medicaid MAGI cases remain at DSHS until their renewal date there will be a lot less work associated with these cases. PCG was not able to project the impact this change will have on DSHS RMTS results for FY 14 and FY 15 and the federal claiming is not able to be determined at this time due to the fact the changes went into effect as of October 1, 2013

The HBE Call Center allocation method is not aligned with current call center activities

During interviews with HBE and HCA it was noted the HBE Call Center is receiving an overwhelming number of calls to assist MAGI Medicaid clients complete the application process. These calls are handled jointly with MEDS so that a representative from the HBE Call Center and MEDS remain on the line while the MEDS staff member assists the caller with specific questions pertaining to Medicaid. The level of calls HBE receives from MAGI Medicaid consumers is expected to go down as HBE and HCA work through initial issues with HPF. However, given the fact that anticipated enrollment (based on the Milliman study) through the HBE is projected to include 1,071,000 MAGI Medicaid consumers compared to 408,000 for non-MAGI Medicaid consumers, it seems reasonable that HBE will continue to experience a high volume of calls from MAGI Medicaid consumers and raises concerns that the current approved cost allocation method to allocate only 5.76% of total call center costs to Medicaid and CHIP is significantly understated. Increasing HBE Call Center revenue by allocating costs of the Call Center fairly and equitably between state and federal programs will be a critical factor as the HBE eventually becomes self-sustaining in FY 2016. There is not enough data available at this time on the level and nature of the call center activities to recommend an alternative methodology. However, this is an area we will explore in phase 2 of the project.

Appendix A – Glossary of Acronyms

Acronym	Description
ABD	Aged, Blind, or Disabled
ACA	Affordable Care Act
ACES	Automated Client Eligibility System
ADATSA	Alcoholism and Drug Addiction Treatment and Support Act
AFB	Application for Benefits
AFRS	Agency Financial Reporting System
AFSCME	American Federation of State, County and Municipal Employees
APTC	Advanced Premium Tax Credit
AU	Assistance Unit
CAFT	Cost Allocation Funding Type
CAP	Cost Allocation Plan
CAS	Cost Allocation System
CCDF	Child Care and Development Fund
CCSP	Child Care Subsidy Program
CHIP	Children's Health Insurance Program
CLASP	Center for Law and Social Policy
CMS	Center for Medicare and Medicaid Services
CSD	Community Services Division
CSO	Community Service Office
CSR	Cost Sharing Reduction
DCA	Division of Cash Assistance
DDA	Developmental Disabilities Administration
DEL	Department of Early Learning
DHS	Department of Human Services
DMS	Document Management System
DSHS	Department of Social and Human Services
EBT	Electronic Benefits Transfer
ER	Enterprise Reporting
ESA	Economic Services Administration
FFE	Federally Facilitated Exchange
FFP	Federal Financial Participation
FPL	Federal Poverty Level
FSS	Financial Service Specialist
FTE	Full Time Equivalent
HBE	Health Benefit Exchange
HCA	Health Care Authority
HCS	Home and Community Services
HHS	Department of Health and Human Services
HIU	Hub Imaging Unit
HPF	Health Plan Finder
IPA	In-Person Assister

IT	Information Technology
LTC	Long Term Care
MAGI	Modified Adjusted Gross Income
MCS	Medical Care Services
MEDS	Medical Eligibility Determination Services
MMIS	Medicaid Management Information System
OAPD	Operational Advance Planning Document
OCIO	Office of the Chief Information Officer
OFM	Office of Financial Management
PACAP	Public Assistance Cost Allocation Plan
PCG	Public Consulting Group
PEBB	Public Employees Benefits Board
PPACA	Patient Protection Affordable Care Act
QHP	Qualified Health Plan
RMTS	Random Moment Time Study
SHOP	Small Business Health Options Program
SLA	Service Level Agreement
SNAP	Supplemental Nutrition Program
SSI	Supplemental Security Income
SSPS	Social Service Payment System
TANF	Temporary Assistance for Needy Families
WACON	Washington Connection
WCAP	Washington Connection Authorization Program
WCCC	Working Connections Child Care
WFSE	Washington Federation of State Employees
WIC	Women, Infants and Children Nutrition Program
WSS	Work Support Strategies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