WASHINGTON STATE

MEDICAL AND PUBLIC ASSISTANCE ELIGIBILITY STUDY
ALTERNATIVE OPTIONS AND RECOMMENDATIONS REPORT

SEPTEMBER 2014

Table of Contents

Table of Tables

Table of Figures

1. Acknowledgments

Public Consulting Group (PCG) would like to acknowledge the many individuals who committed time, effort and resources to collecting data, participating in work sessions and providing feedback on this study. The efforts of staff representing the following entities were invaluable in shaping this report:

- Office of Financial Management (OFM)
- Washington State Legislature
- Washington State Department of Social and Health Services (DSHS)
- The Washington State Health Care Authority (HCA)
- Department of Early Learning (DEL)
- Washington Health Benefit Exchange (HBE)
- Washington Federation of State Employees (WFSE)
- King County Health Department

The information gathering for this study began in mid-November 2013 - a mere six weeks after the roll-out of the Affordable Care Act. During this time of significant change, the following are just some of the individuals who contributed to this effort: at HBE, Richard Onizuka, Molly Voris and Brad Finnegan; at DSHS, David Stillman, Babs Roberts, Kelci Karl-Robinson and Dori Shoji; at HCA, MaryAnn Lindeblad, Manning Pellanda, Susan Lucas, Thuy Hua-La and Mary Wood; at DEL, Bette Hyde, Lynn Shanafelt and Bob McLellan. Rich Pannkuk and Rayanna Williams at OFM provided continual feedback and support.

2. Introduction

The State of Washington, Office of Financial Management, has contracted with Public Consulting Group (PCG) to conduct a study of Washington's medical and public assistance eligibility systems and infrastructure, with three central goals:

- Simplify procedures;
- Improve customer service; and
- Reduce state expenditures.

This report, "Alternative Options and Recommendations," documents the second and final phase of this study. The options considered focused on a range of models to redesign eligibility determination processes and business operations in call centers and offices where individuals and families seek medical and public assistance.

In Phase I of the project, PCG produced an Initial Findings Report, which provided an inventory of the resources, policies and processes currently in place for eligibility determination for Medicaid, cash, food and child care. The report established a "baseline" for the development of options and recommendations to achieve the goals of the project.

3. Executive Summary

The Public Consulting Group (PCG) conducted a study of Washington's medical and public assistance eligibility systems, infrastructure and staffing models. This Alternative Options and Recommendations Report is the second and final work product associated with this study, and informs strategies for achieving three goals identified by the Legislature: simplify procedures, improve customer service and reduce state expenditures.

In the first phase of the project, PCG developed an Initial Findings Report that summarized the "as-is" state of determining and processing eligibility across the identified programs. It takes into account documentation of Washington's medical and public assistance eligibility practices, the impact of the Affordable Care Act (ACA) on eligibility determination processes and feedback provided through in-person meetings with Community Service Offices (CSOs) and consumer stakeholder groups.

Options for consideration were developed from key findings from the initial phase of the project, best practices implemented in other states and ideas offered by stakeholders. Working sessions with key agencies – The Health Care Authority (HCA), Department of Early Learning (DEL), the Department of Social and Human Services (DSHS), the Health Benefits Exchange (HBE) and the Office of Financial Management (OFM) – provided a vision of medical and public assistance eligibility which can be distilled into three key concepts:

- Access to medical, cash, food and child care assistance should be available through a single point of entry
- Measures should be taken to reduce barriers to access
- Duplication of application and eligibility work should be minimized

Four key strategies were considered from a cost and feasibility perspective: existing structures should be maintained if dismantling them would threaten the successes achieved thus far; current system functionality should be leveraged; options should facilitate claiming of additional Medicaid funding; and, when possible, recommendations should have the potential to be implemented independently.

This work culminated in eight recommendations for achieving the project's goals:

- Expand the scope of an existing shared governance structure to drive vertical integration of medical and public assistance programs and promote continuous improvement with a focus on consumers' needs and outcomes.
- Expand Healthplanfinder access to staff outside of the HBE to support a single point of entry for accessing cash, food, child care and medical benefits. Two additional recommendations support this concept:
  - Establish an integrated call center routing system that transfers consumers interested in both medical and public assistance programs to the DSHS call center. This creates a more streamlined process for consumers wishing to apply by phone for multiple public assistance programs by speaking with a single caseworker.
  - Develop an integrated online application routing system to support a single point of entry for consumers applying online, allowing them to apply for medical, cash, food and child care assistance once from a single portal.

- Add child care responsibilities to WorkFirst case managers statewide, fostering streamlined service delivery.
- Implement a targeted enrollment strategy to auto-enroll individuals in Modified Adjusted Gross Income (MAGI) Medicaid based on Supplemental Nutrition Assistance Program (SNAP) eligibility.
- Establish a "rolling renewal" process through the auto-triggering of MAGI Medicaid renewals based on SNAP recertification.
- Implement a Master Client Index to improve client identity verification and create a foundation for enterprise-wide reporting, analysis and data sharing.

These recommendations support a client experience that offers individuals the choice to pursue health care coverage with or without other social service supports. These initiatives seek to identify and assist individuals and families who are interested in and may be eligible for programs such as cash, food and child care– these Washingtonians will be served in a single interaction (whether electronic, telephonic or in-person) whenever possible. By the same token, a client's choice to pursue health insurance assistance independent of other social service programs is respected and supported. Finally, these recommended processes generate efficiencies that can create long-term savings for Washington.

4. Strengths of Current State

As options and recommendations have been developed for this report, two important themes emerged that informed the process: Washington's system of medical and public assistance eligibility excels in many respects and many issues that generated concern at initial ACA implementation in October and November 2013 have since been addressed.

Washington has implemented a state-based exchange to comply with the ACA, focusing on the vertical integration of health insurance access across all income levels, from the Medicaid-eligible population to individuals at the highest income levels shopping for health insurance on the marketplace. The state's implementation stands in contrast to less successful efforts (and outright failures) in other parts of the country.

The following table documents enrollment data across both Medicaid and Qualified Health Plans (QHPs) for 10/1/13-2/20/14:

Table 1: Enrollment Data from October 1 to February 20

[1]Enrollments Completed	
Qualified Health Plans	101,857
Medicaid Newly Eligible Adults[2]	202,168
Medicaid Previously Eligible but not Enrolled	102,238
Medicaid Redeterminations (Previously Covered)	311,670
Total	717,933

A report released by Avalere Health includes Washington as a leading state in exchange enrollments (QHP line in chart above); through February 2014, the state has surpassed initial projections, standing at 109 percent of expected enrollments.[3] Another area that has improved drastically since information was gathered for the initial findings report is wait times for callers to the HBE. The following table reflects the significant reduction:

Table 2: Average HBE Caller Wait Time

Month	Overall Initial Wait Time Average (minutes)
Oct-13	19.3
Nov-13	23
Dec-13	12.5
Jan-14	2.2
Feb-14	1.3
Mar-14	1.1

[1] http://www.wahbexchange.org/news-resources/press-room/press-releases/feb-26-enrollment-report

[2] Uninsured Adults Newly Eligible for Medicaid Under the ACA with Incomes below 138 percent of FPL: 308.000. Source: http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf

[3] http://avalerehealth.net/expertise/managed-care/insights/nationwide-enrollment-tracking-toward-5.4m-by-the-end-of-march-enrollment-i

In addition to these successes related to medical coverage, Washington has excelled in many aspects of workload and performance management in other programs, as evidenced in part by SNAP quality control data showing application processing timeframes above 90 percent.

Acknowledgment of the strengths of Washington's current system is vital. And the state's relative success in rolling out ACA may be attributable in part to the decision to bifurcate eligibility between Medicaid and the other public assistance programs by simplifying the development of the tools needed to establish vertical integration for the range of Insurance Affordability Programs (IAPs). However, it also contributed to some of the issues identified in the initial findings. Accordingly, there are areas in which improvements are possible and needed.

One example is the number of individuals who receive benefits administered by the Economic Services Administration (ESA) in DSHS, who, by all indications, should be eligible for Medicaid yet remain uncovered. The following table illustrates this dynamic for a specific population – single person Food Assistance households that, based on ESA estimates, are eligible for Medicaid but are not enrolled.

Table 3: Single Person Food Assistance Households

Month/Year	Number of MAGI Eligible SNAP/FAP Single Person Households	Number of MAGI Eligible SNAP/FAP Single Person Households Receiving MAGI Medicaid	Number not receiving MAGI
Oct13	200,838	23,066	177,772
Nov13	199,299	22,629	176,670
Dec13	198,193	22,142	176,051
Jan14	203,289	87,833	115,456
Feb14	204,638	97,162	107,476
Mar14	204,913	110,390	94,523
Apr14	205,006	115,744	89,262

While the chart illustrates that strides have been made, it also highlights an area with potential for improvement.

Additional Context

As described in the initial findings report, ACA changed the way eligibility is determined for the majority of Medicaid categories. Among the differences is the use of the tax filing household to define household composition and a greater reliance on electronic verification services and self-attestation of applicant data. This has facilitated a "horizontal" alignment of eligibility requirements across the health insurance affordability programs – Medicaid, CHIP and the exchange subsidy programs advance premium tax credits (APTC) and cost-sharing reduction (CSR). However, it also has created a "vertical" disconnect with eligibility requirements applicable to cash, food and child care. Like many other states, Washington has decoupled Medicaid eligibility determination activities from their previously integrated eligibility determination process. This bifurcation of Medicaid eligibility from DSHS' integrated eligibility process has caused a serious reduction in the department's ability to support its administrative costs with Medicaid funding. PCG contacted selected states to gain additional perspective on this issue.

PCG received a response from Nebraska, where, prior to ACA, an integrated eligibility process was in place for Medicaid, SNAP, TANF and/or child care where eligibility workers participated in a random moment time study which was used to allocate costs of eligibility activities among Medicaid, SNAP, TANF and/or child care programs.

Nebraska reported that in the post-ACA structure, MAGI Medicaid eligibility determination occurs primarily through an automated, real-time process in which eligibility workers are not involved. The state maintains a group of dedicated Medicaid eligibility workers to aid in the process. As a result, Medicaid is no longer part of the integrated eligibility operations.

Nebraska indicated it has had no reductions in staffing levels due to these changes as it has been able to reallocate positions between the Division of Medicaid and Long Term Care and the Division of Children and Family Services. The state indicated that it did expect to experience a reduction in Medicaid funding for its integrated eligibility operations, and no other funding sources have been identified to fill gaps in SNAP and TANF eligibility costs created by the loss of Medicaid funding.

PCG worked with two states that have reorganized their integrated eligibility structure by establishing a dedicated team of Medicaid eligibility workers who handle only eligibility for MAGI Medicaid. Both states have taken advantage of the Medicaid enhanced funding available to cover the costs of the dedicated group of Medicaid eligibility workers, and in both cases, eligibility for Medicaid remains within the same agency. However, as in Washington, these workers are not able to cost allocate their work across multiple programs.

DSHS faces a significant budget shortfall – as much as $28 million – because many of the Medicaid applicants it served prior to ACA implementation are either accessing their health care benefits in a self-service manner or receiving assistance through the HBE or other entities outside of DSHS. A significant percentage of these individuals continue to receive cash, food, and/or child care through DSHS and many others still apply but may not be eligible. Yet DSHS is not able to allocate administrative expenses related to their eligibility determination to the Medicaid program. We assessed alternatives for the potential to reduce administrative costs and maximize federal claiming through cost allocation, and while we did not find any one option that would increase federal claiming needed to fully address the budget gap, several of the options offer some additional federal funding through proper cost allocation methods.

As part of the Phase I report objectives, PCG was asked to document the current cost allocation plans that support the eligibility process and call center activities associated with Medicaid, cash, food and child care for DSHS, HCA and HBE.

During PCG interviews with HBE and HCA, it was noted the HBE Call Center was receiving an overwhelming number of calls to assist MAGI Medicaid clients complete the application process. As a result, PCG noted concerns in the Phase I report that the current HBE call center approved cost allocation method of 5.76 percent to Medicaid and CHIP based on the Milliman analysis may be significantly understating the work on Medicaid and CHIP. However, there were not enough data available at this time on the call center activities to recommend an alternative methodology.

The data requested for PCG's Phase II report included a request for information on any changes to the cost allocation methodologies of eligibility operations for DSHS, HCA or HBE and cost

allocation results since October 1 through April 30, 2014 to perform the funding impact analysis. PCG received expenditure data containing cost allocation results by funding source data for all three agencies for the period of October 1, 2013 through April 30, 2014 (this data were provided by DSHS). PCG used the expenditure data for the purposes of analyzing the General Fund-State (GF-S) impact for each recommendation included in this report. The cost allocation data provided for HBE indicated the state share of HBE call center costs for the period were 58 percent and federal share of 42 percent, with 42 percent of the costs allocated to Medicaid and CHIP, significantly higher than the 5.76 percent allocation noted in the Phase I report. In addition, the data did not provide for any share of costs allocated to the Exchange grant. The HBE cost allocation results, for the period beginning on October 1, 2013 and ending on April 30, 2014, increase federal Medicaid and CHIP funding for call center operations, which seems appropriate based on the high volume of calls the HBE call center receives from Medicaid/CHIP consumers.

5. Approach for Phase II

The process for completion of Phase II is summarized in four steps:

- Options development
- Visioning
- Options consideration and feedback
- Recommendations selection

Options Development

PCG documented several policies, process changes and initiatives with potential to achieve (or impact) one or more of the goals of the project: simplify procedures, improve customer service, and reduce state expenditures. These options were based on needs/issues identified in the Phase I report, counsel from OFM, agency and legislative staff and best practices from other states. Several findings from Phase I of the project highlighted issues for which possible solutions were offered for consideration, summarized in the following table:

Table 4: Phase I Initial Findings

Findings From Phase I	
Finding 1	Clients had difficulty navigating multiple access points for health care during initial ACA transition
Finding 2	Separation of Medicaid eligibility determination from other public assistance programs limits the state's ability to maximize Federal Title XIX funds
Finding 3	Current Health Benefit Exchange cost allocation method allocates fewer Title XIX funds to Medicaid and CHIP than workload suggests
Finding 4	Separation of the MAGI Medicaid and public assistance applications creates duplication that frustrates customers, community assisters, and staff
Finding 5	Separation of MAGI Medicaid and public assistance application processes creates barriers to benefits

Visioning

Washington's health and human services delivery system is already employing many national best practices related to efficiency and effectiveness. We felt it was important to bring together participants from all four agencies and OFM in order to build on the success of the current system, and identify criteria for evaluating options to address the findings from Phase I. Participants from DEL, HCA, DSHS, HBE and OFM came together in February 2014 to answer the following visioning question:

> "It's July 2017; WA's medical and public assistance eligibility system is simple and customer friendly and state administrative costs have been reduced through streamlining and efficiency. What happened? What were the most critical action steps taken by the state to achieve this vision for service delivery?"

The group came to consensus on the most important action steps.

The following "Areas of Opportunity" describe the future state for Washington's medical and public assistance eligibility process:

1. Empowering customers to make choices about what they want;
2. Broadening universal access to services;
3. Simplifying and streamlining eligibility so it is consumer-friendly;
4. Operationalizing an efficient and effective consumer-driven system;
5. Improving outcomes for families; and
6. Increasing consistency of rules so eligibility is easier for consumers and agencies.

Some additional comments, not reflected in the Areas of Opportunity, are important to highlight:

- MAGI Medicaid is now a part of a commercial marketplace for health benefits and managed like an insurance product. Long-term sustainability for the whole system depends on successfully managing the commercial products, so the system needs to work for middle and upper income consumers too.
- The primary goal of public assistance programs is to help individuals and families achieve self-sufficiency, which means if programs are successful, low-income consumers will increase their income and move into the private health insurance marketplace rather than receiving Medicaid.

These comments speak to the importance of creating a horizontal integration of programs that help individuals and families achieve income mobility, so they can eventually sustain and support the vertical integration of health benefits. It is not an "either-or" proposition.

The complete Areas of Opportunity matrix is found on the following page.

Table 5: Areas of Opportunity

Areas of Opportunity	Empowering customers to make choices about what they want	Broadening universal access to services	Simplifying and streamlining eligibility so it is consumer-friendly	Operationalizing efficient and effective consumer-driven system	Improving outcomes for families	Increasing consistency of rules so eligibility is easier for consumers and agencies
Outcomes	Opportunity to make an informed decision	Multiple access points (i.e. doctors office, non-profits, schools)	Family tells story one time	Collaborative administration with specialty focus	Medical is universal single payer, not tied to employment	Eligibility rules the same
	Value add for customer	Multiple points of access (phone, online, in person)	Consumer/customer focused	Strive for continued improvement with focus on customer needs	No child goes hungry – many right doors	Consistency of rule – at all levels of government and programs
		Information anywhere anytime	Perspective of client/customer	Automatic enrollments/renewals i.e., older adults on SS for food)	Consider social determinants of health	
		Whole family insurance coverage	Easy straight forward application – standard core questions	Sufficient Resources People Money		
		Primarily electronic application (24-7)		Many options for additional assistance		
		Service anywhere anytime		Access driven – consumer		
		Service info targeted to individual need		Innovative technology – integrating systems		
		Eliminates stigma				

Option Consideration and Feedback

To elicit feedback on specific options for achieving the goals of the project, an "Options Workshop" was conducted in March 2014 with the same group of stakeholders who participated in the visioning session. Participants were asked to consider this question:

> "What innovative and substantial action steps should Washington take to streamline and simplify health and human services eligibility and enrollment?"

The strategies identified by the large group have been classified as follows:

Strategy #1: Increase interoperability/Integration of in-person services

- » Locate HBE staff in DSHS CSO's and HCS MEDS unit to assist consumers with HPF applications
- » Allow DSHS CSO staff and HCS MEDS staff to assist consumers with HPF applications to increases universal access

Strategy #2: Increase interoperability/integration of phone services

- » Gather and analyze data on where people are calling, the services they are seeking and the total time required to complete their business.
- » Maintain different 800#s, but build on the triaging happening in each of the call centers and create options for warm transfers between call centers (shorter term). One barrier to this option is the Exchange board policy on transfers. Also, long hold times would prevent operators from staying on line.
- » Create single 800# with unified menu option to route to correct worker/service – longer term). The call centers have a "virtual hold" option for call backs, which could help mitigate the long wait times.
- » Develop more self-service options to avoid calls, while maintaining multi-modal options for service.

Strategy #3: Streamline intake of consumer information

- » Create a simplified combined application so information is gathered in a streamlined way upfront.
- » Utilize information gathered upfront to auto-populate the back-end rules engines for each service the consumer appears to be eligible for, regardless of whether or not the consumer is initial aware of their eligibility.

Strategy #4: Increase the interoperability of IT systems and the integration of customer data

- » Increase the interoperability of Washington Connection and ACES, which will require time, money and IT resources.
- » Develop a taxonomy and hierarchy of customer data to improve the ability of systems to share customer data where appropriate.
- » Deploy a single eligibility system for Medicaid, cash, food & childcare, while considering the impact on HBE.

Strategy #5: Increase auto-enrollment using cross-program data when possible

- » Pursue Centers for Medicare and Medicaid (CMS) "strategy 3" to enroll SNAP households (HH) not receiving health benefits in MAGI Medicaid.
- » Pursue a Food and Nutrition Service (FNS) waiver to allow auto-eligibility for one or two-person SNAP HH's based on MAGI eligibility.

» Trigger MAGI Medicaid renewals when an associated SNAP case re-certifies.
» Align TANF and Working Connections Child Care eligibility with MAGI Medicaid eligibility.

Strategy #6: Establish shared governance of IT, Policy and Operations for health and human services

» Establish IT and data governance to increase systems interoperability, especially around consumer demographic information.
» Establish shared governance structure for operational units, like call centers and in-person service delivery offices.
» Establish a cross-program policy review committee to consider the impact of program changes on other health and human services programs.

Agencies were also given the opportunity to comment on options in writing. Each agency was provided a matrix that included the options identified by PCG, descriptions of the options and a column for comments. In addition, agencies had the option to "score" each of the options in the three areas that are the focus of the project (simplification, customer service and reducing state expenditures/maximizing federal funding) and a fourth measurement that captures complexity and time associated with implementation.

"Scoring" was based on a 1-5 scale to measure impact across the four areas
1 = Significant Negative Impact
2 = Some Negative Impact
3 = Negligible or no Impact
4 = Some Positive Impact
5 = Significant Positive Impact

(For implementation complexity/time, a "1" was equated with an initiative w/a lengthy implementation period and/or is very complex; while a "5" represented limited implementation barriers).

Not all agencies completed the scoring matrix or provided comments on all the options; however, a significant amount of feedback was submitted and utilized in consideration of options for recommendation.

Recommendations Selection

Using the feedback provided by agencies, the focus of recommendations was narrowed down to:
1. Create a single point of entry;
2. Reduce barriers to access; and
3. Reduce duplication of application and eligibility work.

By viewing the options through this focused lens, PCG targeted options that provided the most value to the state. The next step was to determine which of these options could be implemented in a logical, cost effective, and manageable fashion. To do this, PCG identified the following strategies for implementation:

1. Maintain current processes that have proven to be successful;
2. Leverage current system functionality;
3. Facilitate claiming of additional Medicaid funding; and
4. Support recommendations that can be implemented independently.

Options that utilized all or most of these strategies were selected for recommendation. Additionally, several options were modified or rolled up into one recommendation that utilized the above strategies, and are discussed in more detail later in the report. Options that did not adhere to most or all of the criteria above, were not selected and are listed in the following table. Rows with a "✓" indicate that the option met at least one of the strategies for recommendation, but didn't meet enough to be a priority.

Table 6: Options Not Recommended

Options Not Recommended	Maintain Current Processes	Leverage Current System Functionality	Additional Medicaid Claiming	Independent Implementation
Create consolidated single call center for DSHS, HBE, and HCA				
Consolidate subsidy system and all learning and care programming under DEL				✓
Whole family health insurance coverage, rather than determining eligibility at the individual level				✓
Create "universal" workforce for eligibility determination		✓		✓
Place MAGI post-eligibility responsibility currently at HCA under DSHS				✓
Imaging centralization/consolidation		✓		✓
Place all Medicaid eligibility responsibility at HCA				✓
Adopt tracking tools for LTC case metrics		✓		✓
Convert HBE to State agency				✓
Standardized, uniform verification requirements across all programs		✓		✓
Determine SNAP eligibility based on information from the MAGI determination process				✓

Several of these options warrant more specific comment and acknowledgement:

Consolidate subsidy system and all learning and care programming under DEL
PCG is aware of some interest in shifting responsibility for child care eligibility from DSHS to DEL. And, while it is important to focus on the early education component of the subsidy program, there remains a financial eligibility function that is most efficiently administered by an agency that is collecting this information for other programs serving those at or below 200 percent FPL.

Determine SNAP eligibility based on information from the MAGI determination process/ Standardized, uniform verification requirements across all programs
The idea of authorizing Food Assistance in the same manner as MAGI Medicaid – whereby applicants provide information online and (potentially) receive an immediate eligibility determination based on self-attestation and post-eligibility reviews triggered by data matches – has tremendous potential for efficiency and administrative cost savings. As caseloads grow, a process that allows for self-service eligibility determinations could ease the pressures of increased workloads. However, a Section 17 waiver would be required to address the differences in income and household definitions between SNAP and MAGI Medicaid. And, the current political environment on the federal level is not conducive to facilitating such an initiative, in part because the concept of self-attestation raises concerns about program integrity. In the short term, the State should focus on efficiencies that allow Food Assistance recipients to be deemed eligible for Medicaid because this is a strategy that the federal government has already recommended to states. Similarly, the concept of standardized, uniform verification requirements across all programs has potential but is largely outside of the state's control.

Create consolidated single call center for DSHS, HBE and HCA/Create "universal" workforce for eligibility determination
While there are some areas in which reducing duplication can be achieved by consolidating staff responsibilities, some of the work that the stakeholder agencies conduct is best delivered by staff with specialized training. Implementation of the "Uber-worker" concept would be extremely difficult and not necessarily translate into improved service delivery or cost savings. For example, in a universal workforce model, a single worker would need a strong knowledge of billing and claims information for customers and providers, plan changes and managed care exemptions, eligibility requirements for cash, food, childcare, Long-term Care and MAGI Medicaid, and the process for choosing a plan and paying a premium.

6. Recommendations

The approach described in the previous section resulted in eight recommendations:

- **Expand a shared governance structure** to support the vertical integration of programs that serve low-income families, and promote continuous improvement with a focus on consumers' needs and outcomes. Washington already has a foundation for this recommendation in the form of the Executive Management Team developed specifically for ACA implementation; PCG recommends that this group be supplemented with representatives from all applicable agencies, including the Department of Early Learning.
- **Expand Healthplanfinder access** to staff outside of the Health Benefit Exchange (HBE). This is an essential first step in facilitating the single point of entry approach across medical, cash, food, and child care benefits. Although not required for the expansion of access to Healthplanfinder, the two following recommendations support this concept:
  - *Establish integrated online application routing* to more efficiently serve customers seeking multiple benefits online. A common online entry point would support an applicant's ability to choose both medical and other public assistance programs simultaneously and enter data **only once.** Applicants wishing to apply for a combination of programs including medical would do so by applying through the HPF and then then completing an interview with DSHS which is required for the programs that agency administers. The HPF information is transferred to the DSHS system because it is the system of record for Medicaid. The DSHS worker gathers any additional information needed for the cash, food, and child care eligibility determination during the customer interview (phone or in-person). Through the reuse of common application data across several public assistance programs, the State would increase the efficiency of the application process, reduce costs associated with time spent completing multiple applications, and expand access to health and human service programs.
  - *Establish an integrated call center routing process t*o more efficiently serve customers seeking multiple benefits by phone. A common phone entry point would support an applicant's ability to choose both medical and other public assistance programs simultaneously and provide data only once. Interested parties would be transferred to the DSHS call center. This creates a more streamlined application for consumers wishing to apply for multiple public assistance programs by speaking with a single caseworker.
- **Authorize all WorkFirst Case Managers to complete child care eligibility for WorkFirst participants** at initial applications and make updates to child care cases when contacted by customers. This provides an improved level of customer service by allowing one worker instead of two to complete actions to support the customer. This initiative was being piloted during the information gathering for Phase I of this report, and plans are already in place to implement statewide.
- Promote expanded benefit access by creating processes to **auto-enroll selected individuals in MAGI Medicaid based on SNAP eligibility.** PCG recommends this be applied to one person SNAP households and those with at least one child.
- Create a rolling renewal process through the **auto-triggering of selected MAGI** Medicaid renewals based on SNAP recertification, reducing costs associated with the recertification process.
- Implement a **Master Client Index** to standardize identification processes across all public assistance programs and create linkages with additional systems to support reporting, analysis, and data sharing.

PCG estimated General Fund – State costs and savings associated with the recommendations are summarized in the chart below.

Table 7: Recommendations Costs and GF-State Savings

Recommendation	GF-State Cost	GF-State Savings	GF-State Impact (1 year)	GF-State Impact (5 year)
Expand shared governance structure				
Extend HPF access to DSHS eligibility staff » Integrate call center routing » Integrate online application routing	$380K	($4.1M)	($3.7M)	($20.5M)
Authorize WorkFirst case managers to complete child care eligibility				
Auto-enroll food recipients in MAGI Medicaid (one time)	$330K	($1.2M)	($841K)	($841K)
Auto-renew recertification for food recipients in MAGI Medicaid	$199K	($758K)	($559K)	($3.6M)
Implement a master client index	$900K		$900K	$900K
Total	$1.8M	($5.0M)	($4.2M)	($24M)

Recommendations Overview

The following section provides specifics regarding each recommendation with respect to the benefit it provides, the project goal/s that it supports, the likely timeframe for implementation, key gaps to achievement, and the estimated budget impact.

Recommendation 1:	Expand shared governance structure
Benefits	Promotes horizontal integration and timely, mutually beneficial decision making
Supports	✓ Improves customer service ✓ Simplifies procedures
Time frame	Short-term implementation
Key Gaps	ACA executive management team does not include all agencies supporting eligibility functions
Budget Impact	Budget neutral

What it does

This recommendation establishes a cross-agency structure to facilitate:

- » Horizontal integration of medical and public assistance programs for low-income individuals and families (at or below 200 percent federal poverty level);
- » Vertical issue resolution; and
- » Identification of and action on future opportunities across programs.

PCG facilitated two meetings for the purposes of this report and received comments that it was the first time that key leaders with HBE, HCA, DSHS and DEL had been brought together with the purpose of discussing enterprise-wide eligibility goals. These comments underscored the importance of a structure that supports work to increase efficiency, improve customer service and reduce state expenditures related to programs that serve individuals and families at or below 200 percent of the FPL.

Low-income consumers are likely to be eligible for a package of services that are intended to help them stabilize and eventually improve their lives. They are also more likely to be in crisis and in need of case management support. For these reasons, we believe ensuring coordination across health and human service agencies that serve low-income families is as important as coordination within the health continuum.

Successful cross-agency partnerships are intended to increase interoperability and integration of health and human services programs and promote continuous improvement with a focus on consumers' needs and outcomes. Other states have implemented cross-program governance charters, advisory committees, policy review committees and other governance structures to ensure equitable program coordination.

Gaps

Currently, the ACA Executive Management Team meets regularly to govern the "vertical" integration of health programs in the state-based marketplace, but it does not include all agencies supporting eligibility functions.

Integral to the process of streamlining services across agencies is the concept of a project charter, created by the leadership team which is made up of members from the relevant agencies. As described in a separate Initial Findings Report, South Carolina (SC) is one example of a state working to overcome challenges presented by the segregation of work across programs that are commonly accessed by low-income populations. The SC charter consists of three main sections and is a recommended template for WA (see Appendix B – Sample Governance Structure Charter for an example template):

- » *Project Scope* - outlines breadth and vision for the customer experience and the agencies included in the effort. It also summarizes the organizational structure of the governance team, project leadership team and cross-agency workgroups that lead projects aimed at policy simplification, data sharing and process streamlining.
- » *Project Management Approach* - describes the function, membership and decision making authority for each of the workgroups.
- » *Decision Making Hierarchy* - lists the criteria used to determine when decisions must be brought to the governance team for decision-making.

Budget Impact

This recommendation is budget neutral. PCG recommends expanding the existing ACA Executive Management Team to include managers from all four agencies involved in eligibility and enrollment for medical care coverage and public assistance (HBE, DSHS, HCA and DEL).

Recommendation #2:	Extend HPF access to DSHS and HCA eligibility staff
Benefits	Allows DSHS and HCA to: › Assist families applying for both MAGI Medicaid and Classic Medical, cash/food/child care › Allocate additional administrative costs to Medicaid
Supports	› Improves customer service › Simplifies procedures › Promotes reduction in GF-State spending
Time frame	Short term
Key Gaps	› Staff training › Security access › Personal identification information confidentiality requirements › Labor considerations
Budget Impact*	› 1 year net savings – approx. $3.7 million › 5 year net savings – approx. $20.5 million

*Also includes the costs associated with the call center and online application routing recommendations.

What it does

This recommendation allows access and direct entry into Healthplanfinder by DSHS and HCA eligibility staff. It represents a significant change from the current approach, in that workers who are conducting eligibility determinations for food, cash and/or child care (either call center or in-person) would also be authorized to conduct direct entry into HPF - with the acknowledgement that HPF technology completes the eligibility determination.

Currently, DSHS workers who conduct eligibility determinations for food, cash, and child care are restricted by access from entering and submitting applications in Healthplanfinder. This often complicates the process for the applicant by requiring multiple customer service interactions and duplication of eligibility information. It also removes the agency's ability to receive federal financial participation from the Medicaid program in the form of an administrative match. It was clear to PCG that low-income customers are seeking upfront help with the HPF. By allowing DSHS and HCA workers to assist their customers with the HPF, DSHS and HCA would have the potential to receive increased federal financial participation from Medicaid in the form of an administrative match.

Two groups of Financial Service Specialist within the Economic Administration Services should be targeted for added access to Healthplanfinder at DSHS:

» Call Center staff
» Community Service Office (CSO) staff

In addition, the state should consider providing MAS staff in the MEDS unit at HCA the rights to HPF data entry.

In the call center environment, a food assistance applicant who is also seeking assistance with the application for medical care coverage will have their information entered into the HPF by the DSHS call center worker (rather than refer the individual to the HBE service center). The worker would initially enter the required information into Healthplanfinder. Following the completion of the HPF, and potentially a real-time medical eligibility determination, the customer data would be transferred from the HPF to the DSHS system- the Automated Client Eligibility System (ACES). The DSHS call center worker would complete the additional required fields and verifications in ACES to complete the eligibility determination for food benefits. Similarly, a worker seeing a customer in-person at a CSO could enter information in HPF on behalf of that individual during the office visit (a role similar to that of assister organizations, except the worker is also determining eligibility for other programs)[4]. Implementation of this recommendation could be piloted and phased in - for example, initially only a few selected CSOs (and no call center staff) could be given the additional responsibility and expansion plans could be revised as dictated by the pilot.

Gaps

Staff training

DSHS staff will require some training to address all household and income scenarios that an applicant might present. Primarily the training will focus on new system navigation and the procedural changes that will accompany the new process. And, while it is expected that the significant majority of the customers served by DSHS will fall at an income level that does not require plan selection in Healthplanfinder, a process will need to be established to refer the applicant to another resource in those situations.

Security access

Workers will need to be assigned HPF identification codes and passwords so they will have the ability to submit applications on behalf of an individual or household, similar to In-person Assisters (IPA). The worker will also have to meet personal identification information (PII) confidentiality requirements.

Budget Impact

The estimated savings reflected below will be achieved through a workload reduction at HBE and increased Medicaid funding at DSHS. To achieve these savings there will be investments in training of DSHS staff as well as a minor workload increase incurred by the additional responsibility of completing the HPF application. Detailed calculations for those savings and additional explanation of the data utilized are found in the Appendix; net estimated savings are illustrated in the chart below.

[4] Note that work is in progress to increase the volume of data that is pre-populated in ACES using data entered by the applicant/recipient in WaConn. This is not included as a recommendation (as work is already underway) but its continued development strengthens the streamlining and efficiency efforts this recommendation supports.

Key assumptions/points of emphasis associated with the calculated savings include the following:

- The model used for these cost estimates is based on a concept that customers who would be served by HBE and are currently DSHS customers will be served primarily by DSHS if staff have access to HPF.
- The total touch time for staff at DSHS who enter information in Healthplanfinder first, then complete additional data entry in ACES is less than the total touch time for work done severalty by DSHS and HBE.
- Staffing costs at HBE represent the amount the agency pays their vendor per FTE in the Customer Service Representative position, inclusive of benefits, salary, overhead, and overtime; costs for DSHS are based on salary, benefits, and OT for the Financial Services Specialist III position.

Table 8: Extend HPF Access to DSHS Eligibility Staff Budget Impact

Agency	Investment	GF-S Portion of Investment	GF-S Savings	1st Year Net	5 Year Net
DSHS HCA HBE DEL			($4,170,701)	($4,170,701)	($20,853,505)

Recommendation #3:	Integrate online application routing
Benefits	› Provides means for customers to apply for programs administered by DSHS and HBE with minimal duplicate data entry › Reduces customer online application and interview time by 15-40 minutes
Supports	› Improves customer service › Simplifies procedures › Promotes reduction in GF-State spending
Time frame	Long term
Key Gaps	Full evaluation of requirements, including addition of single- point-of-entry menu
Budget Impact	Investment of at least $368,214

What it does

This recommendation provides customers with the ability to request Medicaid, cash, food, and child care benefits when applying online without entering duplicate information. In the current state, many stakeholders contend that undue burden is placed on a consumer who wishes to be considered for food, cash, childcare and Medicaid, when they are asked to provide much of their personal and household information twice by applying through both Washington Connection (or in person) and through the Healthplanfinder. The current solution also requires online applicants to create separate accounts, satisfy identity management requirements for both applications and perform account management with two agencies (including updates to application data, receiving notices/alerts and

benefit status, checking application status, completing renewals and updating applications). In addition, for applicants who seek food, cash, and/or childcare first, the DSHS workers must data entry the entire application from scratch.

Finding a way to reuse common application data, as well as creating centralized account creation and maintenance access between these applications would increase efficiency for both the consumers and the state, improve effectiveness, reduce cost and expand access to these programs.

The purpose of an online application is to gather the information required to make an eligibility decision. HPF and WaConn have different eligibility, verification and processing requirements, but often have a substantial amount of overlapping data needed by both programs to render a decision.

The most cost effective and efficient way to utilize common fields between the two applications for applicants who wish to be considered for Medicaid/IAPs from HPF as well as programs supported by WaConn, is to first obtain the minimum data required to constitute an application for cash, food, and child care. Once that is complete, the applicant is directed to complete HPF. Unlike WaConn, the application data that is entered into HPF automatically populates ACES. After the HPF application is submitted and ACES is populated with the application data, the applicant is informed that they will be required to complete an interview for the DSHS administered programs as dictated by current policy. When the interview is conducted, the worker only needs to gather and enter into ACES, some additional items (such as resources, shelter costs, child care expenses, etc.) to determine eligibility for the public assistance programs. Although the DSHS worker may need to verify information, neither the applicant nor the worker need to resubmit the information obtained in the HPF.

An applicant who enters through either the HPF or WaConn, would be presented with a menu with options to:

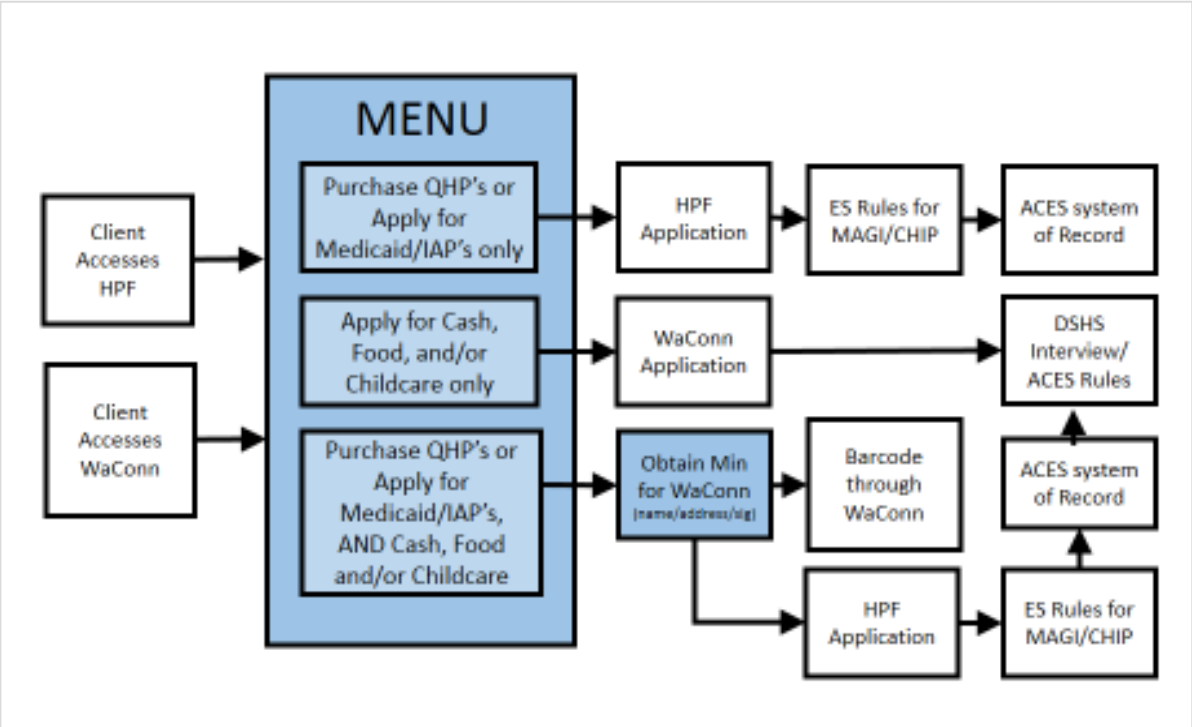
- Purchase QHP's or Apply for Medicaid/IAP's only
- Apply for Cash, Food, and/or Childcare only
- Purchase QHP's or Apply for /Medicaid/IAP's, AND Cash, Food and/or Childcare

Note that the exact language of the menu items should be jointly determined during requirements gathering by the state and the web designer.

If the applicant selects option #1, they will be linked only to the existing HPF application. If the applicant selects option #2, they will be linked to the existing WaConn application. If the applicant selects option #3, the applicant will be directed to the HPF application after entering the minimum data required to constitute an application for cash, food, and/or child care, receive an eligibility determination for MAGI, and be notified that they will need to contact DSHS for an interview, to gather only the additional information required for a food, cash, and/or child care eligibility decision.

The flowchart below provides a high-level visual of the process. New system functionality is shaded in blue.

Figure 1: Online Application Routing



Gaps

It will be necessary to complete a full evaluation of the detailed requirements to implement this enhancement, which should include the following functionality:

- Linkages from both public facing applications to the Menu screens
- Menu screen and linkages to the online applications
- Modifications to HPF to accept a designation from Menu screen that indicates a multiple program applicant, to provide additional signoffs and follow-up information.

Budget Impact

Savings associated with this recommendation is included with the expansion of access to Healthplanfinder to staff at DSHS. With respect to the investment required to support a front-end menu that routes the user to the appropriate application, DSHS provided a high-level cost estimate (without design requirements) of approximately $3.6 million in costs to that agency. At the time of this writing, the HBE is unable to estimate the cost of this improvement. PCG has assumed that these investments would be eligible for the 90-10 funding allowed for modernization of eligibility and enrollment systems provided they are completed prior to the end of the enhanced funding period.

It should also be noted that this recommendation, while it does establish new functionality to support routing to the appropriate application, does not propose changes to the rules engine in ACES or the question sequences in HPF or WaConn. PCG did consider more significant IT options, including adding questions to WaConn for Medical. The costs associated with larger projects, up to a new integrated system, could have reached $100-150 million.

Table 9: Integrate Online Application Routing Budget Impact

Agency	Investment	GF-S Portion of Investment	GF-S Savings	1st Year Net	5 Year Net
DSHS	$3,682,140	$368,214		$368,214	$368,214
HCA					
HBE	TBD	TBD			
DEL					

Recommendation #4	Integrate call center routing
Benefits	› Increases awareness of available programs for customers › Customer makes one call instead of two › Provides single dial-in number for DSHS, HBE, HCA call centers › Routes likely MAGI eligible population to DSHS • Supports cost allocation to Medicaid › Allows HBE to focus resources on QHP population
Supports	› Improves customer service › Simplifies procedures › Reduces start expenditures
Time frame	Short-term implementation
Key Gaps	› Modification to interactive voice response technology › Dependent on implementation of HPF access at DSHS
Budget Impact	› Small Implementation cost (about $10,000) › Overall savings identified in 'Extend HPF Access' recommendation

What it does

This recommendation provides a single contact center number with a single call center automated system that is able to guide the customer through a menu that provides an option for medical care coverage and public assistance applications. This recommendation involves the creation of a single contact center number that facilitates automatic customer routing to MAGI Medicaid, Classic Medicaid, and cash/food/child care via interactive voice response technology.

The development of this recommendation began when key stakeholders were asked the question "What innovative and substantial action steps should Washington take to streamline and simplify

health and human services eligibility and enrollment?" From this core question, one of the overarching strategies that emerged was to increase interoperability/integration of phone services.

To execute this strategy, the areas of focus built on the triaging that takes place in each of the call centers and creating additional options for warm transfers between call centers.

In the current state, customers that are applying or may be eligible for multiple public assistance programs face a fragmented application process when applying over the phone. For example, a customer who wishes to apply for both a health insurance affordability program and food and cash over the phone must dial two different call centers and speak with separate call center case workers that are unique to the public assistance program. This recommendation solves this problem through the simplification of procedures for both the customers and state.

Gaps

Integrated call center routing is dependent on DSHS call center staff having the authorization to conduct direct entry into Healthplanfinder. As referenced in that recommendation, this is a significant change from the current approach in that DSHS workers determine eligibility for cash, food and/or child care, but do not conduct data entry in HPF.

Additionally, establishing a single contact number with integrated call center routing capabilities requires the implementation of interactive voice response technology. While not an overly complex modification to existing infrastructure, a work order to do this is expected to cost approximately ten thousand dollars of up-front costs between DSHS, HCA, and HBE.

Budget Impact

The savings this recommendation produces is accounted for in the "Extend HPF access to DSHS eligibility staff" recommendation. Integrated call center routing supports the savings associated with HPF access by directing interested applicants to DSHS, which reduces workload at HBE and creates the potential for increased Medicaid claiming at DSHS. The investment shown below represents improvements to Interactive Voice Response (IVR) functionality.

Table 10: Integrate Call Center Routing Budget Impact

Agency	Investment	GF-S Portion of Investment	GF-S Savings	1st Year Net	5 Year Net
DSHS	$5,000	$5,000		$5,000	$5,000
HCA					
HBE	$5,000	$5,000		$5,000	$5,000
DEL					
Total	$10,000	$10,000		$10,000	$10,000

Recommendation #5	Authorize WorkFirst case managers to complete child care eligibility
Benefits	› "One stop shopping" for WorkFirst participants who are also eligible for child care › Recognizes the importance of child care in successfully meeting WorkFirst participation requirements
Supports	› Improves customer service › Simplifies procedures
Time frame	Short-term implementation
Key Gaps	Additional training for WorkFirst Case Managers
Budget Impact	Neutral

What it does

This recommendation allows the same Case Manager to complete all child care eligibility processing for families receiving cash assistance. This is contrary to the current state, where WorkFirst (TANF) participants generally interact with a Case Manager for assessment and development of a work plan, and then are asked to contact the ESA call center to set up the child care assistance they need to participate in work activities. The recommended concept has several benefits:

- Allows the WorkFirst participant to be served across multiple programs in a single interaction;
- Promotes program integrity by establishing a strong link between child care assistance and participation in work activities; and
- Provides an additional opportunity for a WorkFirst Case Manager to discuss barriers to self-sufficiency and the importance of dependable child care.

The process recommended here had already been implemented in a limited number of pilot counties during Phase I of this study. PCG understands that in the interim and DSHS is commitment to expanding to the statewide level. Also, note that the Work First Case manager does not take permanent responsibility for the child care case. Work not completed by the case manager and ongoing case maintenance continues to be completed through the call center's child care queue.

Gaps

Training WorkFirst case managers in child care policy and systems is the primary gap to bridge for implementation of this recommendation. An incremental implementation may be the most feasible method to roll out this initiative statewide.

Budget Impact

This recommendation is deemed to be cost-neutral. This determination is based on two cost/savings drivers within DSHS - a reduction in calls to the child care queue in the call center, offset by the additional time to complete child care work by the WorkFirst case manager.

Recommendation #6	Auto-enroll food recipients in MAGI Medicaid
Benefits	› Expanded benefit access • Up to 89,000 additional enrollments in one-person Food Assistance households • A minimum of 14,000 children in multi-person Food Assistance households › Reduction in workload at HBE
Supports	› Improves customer service › Simplifies procedures › Promotes reduction in GF-State spending
Time frame	Short-term implementation
Key Gaps	› Process to establish Medicaid application › CMS waiver required › Additional ACES-HPF interoperability
Budget Impact	1 year net savings – approx. $841,000

What it does

The recommendation stems from the Center for Medicare and Medicaid Services (CMS) guidance to states on 5/17/13 to allow an individual to be enrolled in Medicaid based on SNAP eligibility. For Washington State, PCG recommends selected individuals automatically enroll in MAGI Medicaid if found eligible for food through the food application process. Individuals whose eligibility is established in this manner do not have to go through the regular application process (via Healthplanfinder in Washington) for MAGI Medicaid enrollment – an asset in enrolling individuals who may not have easy access to a computer or have not recognized the opportunity for coverage presented by ACA. Furthermore, the process reduces workload at HBE by eliminating the need for the target population to complete the application process.

Due to the differences in the definition of household composition between MAGI and SNAP, PCG recommends this strategy – at least initially – be implemented for one person food assistance households and households with at least one child. Data provided by DSHS-ESA indicates that as of April 2014, these numbers total at least 105,000 individuals – 89,245 persons who are the only member of a SNAP household, and at least 14,125 children who are members of a SNAP household with at least one child not on medical.

Note that this option would be limited to those households below 138 percent FPL (per SNAP income calculation methodology) and those that elect to receive medical care coverage.

Gaps

CMS guidance outlines several requirements for implementation. The state must:

- Request a waiver to allow the state to enroll non-elderly, non-disabled SNAP participants;
- Explain why the option is needed to better implement its eligibility and enrollment system and meet its administrative responsibilities;
- Define the timeframe for utilizing the strategy;

» Explain how minimum requirements for an application to be enrolled in Medicaid (including requirement to obtain a signature) will be obtained; and
» Describe how to obtain any missing non-financial information necessary for a Medicaid eligibility determination.

The waiver requirements above illustrate operational changes that might be necessary to implement – most notably the means by which the signature is obtained. This is a key decision point, and options include card activation as a proxy for signature or making contact with the state through an interactive voice response – both requiring little worker interaction.

Budget Impact

DSHS provided a high-level cost estimate without design requirement gathering and indicated $3.3 million in IT investments (primarily related to analysis, design, and development) would be needed to implement the Auto-enrollment recommendation. CMS guidance on this targeted enrollment strategy specifically cites the enhanced 90-10 matching under the waiver to OMB Circular A-87, and this is reflected in the portion of that investment expected to be paid for with a General Fund-State allocation. Savings are realized by bypassing the application process at HBE – costs avoided by enrolling these individuals without the time and effort typically required. Detailed calculations for those savings are found in the Appendix; net estimated savings are illustrated in the chart below.

PCG does not believe this option provides potential for additional claiming of Medicaid administrative funds in DSHS as it uses data already collected to facilitate MAGI enrollment. Key assumptions/points of emphasis associated with the calculated savings include the following:

» A time savings at HBE of 45 minutes for unenrolled children and 35 minutes for single person households was assumed; the latter are generally less complex than the average.
» Calculations assume the individuals targeted for this initiative would not access Healthplanfinder via self-service.
» No discount was applied for a percentage of the target population that would have eventually enrolled absent this targeted enrollment strategy, or those that would decline the option to enroll entirely.
» The average cost of one Customer Service Representative at HBE represents the amount the agency pays their vendor per FTE in that position, inclusive of benefits, salary, overhead and overtime.
» Because this option is one-time in nature, it does not attempt to consider the impact caseload growth on potential savings.

Table 11: Auto-enroll Food Recipients in MAGI Medicaid Budget Impact

Agency	Investment	GF-S Portion of Investment	GF-S Savings	1st Year Net	5 Year Net
DSHS	$3,299,800	$329,980		$329,980	
HCA					
HBE			($1,170,577)	($1,170,577)	
DEL					
Total	$3,299,800	$329,980	($1,170,577)	($1,170,577)	N/A (one-time savings)

Recommendation #7	Auto-renewal of MAGI eligibility at food recertification
Benefits	› For recipients, savings of 25-45 minutes required for self-service recertification or calling HBE › Reduced workload for agencies › Opportunity for allocation of administrative functions at DSHS to Medicaid
Supports	› Improves customer service › Simplifies procedures › Reduces GF-State spending
Time frame	Long-term implementation
Key Gaps	› Additional ACES – HPF interoperability › Requires CMS approval
Budget Impact	1 year net savings - $558,613 5 year net savings - $3,588,635

What it does

This recommendation supports efficiency and simplification for individuals whose eligibility for Medicaid has already been established by creating a "rolling renewal" process for MAGI Medicaid when food eligibility is recertified. It should be acknowledged that HCA plans to begin automated MAGI renewals effective in October 2014. At that time, only if matches show that income is greater than program limits would the customers have to recertify (via HPF or call to customer service center). However, under the rolling renewal concept, states can also extend eligibility for MAGI and CHIP for 12 additional months anytime food information is updated. This recommendation is another means of providing streamlined service to a low-income individual or family receiving both food and MAGI benefits.

According to the Center on Budget and Policy Priorities[5], nationally approximately 75-80 percent of SNAP recipients are virtually certain to qualify for Medicaid. This group includes SNAP households that include at least one individual who is not elderly or receiving SSI. This is because most SNAP recipients have incomes at or below the income limit for MAGI (138% federal poverty level), and SNAP rules on counting income result in counting more income than MAGI rules. These figures led PCG to recommend that Washington food recipients auto-renew MAGI Medicaid eligibility upon food recertification in order to simplify procedures and reduce the work burden on Washington State through fewer recertification processes.

Gaps

This recommendation would require significant enough changes that we are characterizing it as a long-term option. However, PCG believes the potential savings justify the required investments in

[5] See "HHS Announces Opportunity to Streamline Health Coverage for SNAP Participants," June 11, 2013, http://www.cbpp.org/files/6-11-13fa.pdf .

IT, state plan amendments, and operational changes. Furthermore, the Health and Human Services (HHS) guidance suggests ways states can implement the option with as little effort as possible[6]. Some programming will be required, including:

» Triggering of Washington Apple Health renewal letters in HPF whenever SNAP recertifications trigger the Medicaid renewal;
» Selecting the types of cases for which the rolling renewal process if most feasible (i.e. single person SNAP households); and
» Ensuring eligibility continues for some Medicaid programs should SNAP income exceed the Medicaid standard before the full twelve month certification period.

HHS approval is required for implementation; however, the HHS guidance released in May 2013 offers states a "simple, streamlined request and approval process" for the new options contemplated in the guidance. States are asked to provide an explanation of: 1) why the option is important for administrative efficiency, 2) a description of how the state will obtain the minimum requirements for an application (a signature), 3) a discussion of how the state will verify citizenship status (federal data hub), and 4) information on which SNAP participants will be included in the option.

Budget Impact

A five-year net savings for this option is estimated to be approximately $3.6 million in general fund state dollars. Key assumptions/points of emphasis associated with the investments and calculated savings include the following:

» DSHS would incur costs associated with system enhancements, however CMS guidance specifically cites the ability of states to use enhanced (90%) matching under A-87 for these changes.
» Consideration would need to be given regarding the SNAP case actions that would result in an extension of the MAGI certification period.
» Workload savings are realized by auto-renewing MAGI households who would otherwise have called the HBE contact center for assistance with their MAGI renewal. Estimates are based on 50% of monthly single person SNAP households renewing through with HBE assistance. A lower touch time than average is used due to the less complicated nature of the current renewal process for the target population.
» This recommendation is included in part as a means to explore new ways to maximize the federal Medicaid dollars supporting work conducted at DSHS. By auto-triggering the renewal for MAGI/CHIP anytime the SNAP is recertified (or some other change is made to the SNAP case), the SNAP eligibility process could be cost-allocated to Medicaid. PCG is not aware of any states that have implemented this concept and there are key considerations with respect to CAP impact:
    - If the action the worker is performing is solely devoted to SNAP eligibility and the auto-renewal of Medicaid is a function in the system, the worker costs would be allocated to SNAP but the system cost should be allocated to both programs.
    - The worker activity may be allocable to both programs pending federal approval if there is an approved policy in place that allows the auto enrollment in both programs through certain activities performed by a worker determining eligibility for SNAP. This would

[6] See "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014," http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-13-003.pdf.

require changes to the time study to add specific activities related to the auto enrollment activities. The time study should also capture client identification number in order to determine the total cases that were enrolled in all three programs and provide support for claiming.

» Detailed calculations for savings are found in the Appendix; net estimated savings are illustrated in the table below.

Table 12: Auto-renewal of MAGI Eligibility at Food Certification Budget Impact

Agency	Investment	GF-S Portion of Investment	GF-S Savings	1st Year Net	5 Year Net
DSHS	$1,988,920	$198,892	($127,565)	$71,327	($438,933)
HCA					
HBE			($629,940)	($629,940)	($3,149,702)
DEL					
Total	$1,988,920	$198,892	($757,505)	($558,613)	($3,588,635)

Recommendation #8	Implement a Master Client Index
Benefits	› Increased application efficiency through improved client ID › Reduced costs associated with client identity administration/maintenance to correct duplicated client IDs › Potential for linkages with additional systems for reporting, analysis, data sharing
Supports	› Improves customer service › Simplifies procedures
Time frame	Long-term implementation
Key Gaps	Feasibility study for determination of most effective approach – options: › Current ACES client ID › Separate service, with data stored independently of existing systems Requirements/design/development
Budget Impact	Minimum $900,000 investment of General Funds - State

What it does

This recommendation involves implementing a master client index in order to standardize identification processes across all Washington State public assistance programs and create linkages with additional systems to support reporting, analysis, and data sharing. In the current state, there is no singular source of identification shared across multiple agencies for any client. Client information is stored in separate systems without standards for record format or content. With a Master Client Index (MCI), client data would be securely shared across health and human services programs and agencies. Each client would have a single, identifiable number that could also link individual information related to education, child welfare, housing, and other agencies/services. This allows for an enterprise-wide view of an individual that is not possible today and present opportunities for generating efficiencies and analytics. With an MCI, each individual's identifier would be linked to a record containing client information used to verify identity and provide services to the client.

Updates made in any of the participating systems to a particular record could automatically be available to other systems. The individual data would be shared, but business rules for each agency would remain separate.

Having a Master Client Index would help to eliminate duplicate efforts across agencies to validate data, insuring that there is only one primary record for each client regardless of what agency needs access. MCI access could be expanded to state agencies outside the programs that are the focus of this study, making access simpler for customers and providing valid, verified data. For example agencies could:

- Use already reported information when establishing identity at application
- Share verifications already reported to one agency
- Improve service coordination for individuals receiving services at multiple agencies
- Identify where income and other information is reported differently at different programs
- Enhance analytics with information across programs

Gaps

The initial "gap" associated with development of a Master Client Index involves requirements gathering. It is that process of defining scope that will likely uncover a range of gaps that will inform the cost, design and implementation of such a project. Depending on the scope (the number of separate identifiers to be linked and assigned a common identifier), data cleansing will be a significant issue to address. Similarly, as additional programs/agencies/systems are linked by a single identifier, the establishment of data governance plans and procedures will become more complex.

Budget Impact

Development of a Master Client Index linking no less than four separate systems requires a significant investment starting at $8-$10 million. A variety of factors will determine costs, including but not limited to the age of legacy systems, the number of user groups, the manner in which data is pulled from the various systems, and whether updates are executed in real time or via batch process. The investment of General Fund – State expenditures assumes a 90 percent federal match for design, development, and implementation of infrastructure. The scope of the project would likely inform whether this match rate is permissible – i.e. if the population included encompasses non-Medicaid recipients.

PCG has not estimated a savings associated with implementation of an MCI, as its long term fiscal benefits cannot be calculated without knowledge of the breadth and scope of its use. Improvements in identity proofing, reporting, and analytics do have clear potential to result in savings to the state in the long term.

Table 13: Implement a Master Client Index Budget Impact

Agency	Investment	GF-S Portion of Investment	GF-S Savings	1st Year Net	5 Year Net
DSHS HCA HBE DEL	$9,000,000	$900,000		$900,000	$900,000

Appendix A – Savings Calculations

The following tables provide the detail of the cost/savings calculations described in the Recommendations Section of the report for:

1. Auto-enrolling Food Recipients in MAGI;
2. Auto-renewal of MAGI eligibility at Food Recertification; and
3. Expansion of Healthplanfinder access to DSHS eligibility staff. Note that this recommendation also considers the potential impact of integrated call center routing and the integrated online application routing.

Table 14: Auto-enroll Food Recipients in MAGI Medicaid ("Strategy 3") Savings Calculations

Future

Target single person household SNAP recipients	Reduction workload on HBE	Avg. Touch Time	Hours of Staff Effort	Hours Worked per FTE per Month	Number of FTE Required	Avg. Cost per FTE	ONE TIME Savings in staff	SGF Portion - HBE State Share based on Percentage of State Share of Expenditures at 58% Based on HBE Cost Allocation for Oct 1 to Apr 30, 2014
89,262	89,262	35	52,070	158	330	$5,083	$1,675,232	$971,634
SNAP HHs with at least one child not on medical	**Reduced workload on HBE**	**Avg. Touch Time**	**Hours of Staff Effort**	**Hours Worked per FTE per Month**	**Number of FTE Required**	**Avg. Cost per FTE**	**ONE TIME Savings in staff**	**SGF Portion - HBE State Share based on Percentage of State Share of Expenditures at 58% Based on HBE Cost Allocation for Oct 1 to Apr 30, 2014**
14,215	14,215	45	10,661	158	67	$5,083	$343,004	$198,943
							Total	$1,170,577

Table 15: Auto-Renewal of MAGI Eligibility at Food Recertification Savings Calculations (p. 1 of 2)

Current at HBE	Metric	Scope of population	Monthly Number of MAGI Cases with SNAP	% of cases that will auto-trigger	Avg. Touch Time	Hours of Staff Effort	Hours Worked per FTE per Month	Number of FTE Required	Avg. Cost per FTE
	HBE	Single Person HHs	9,645	50%	45	3,617	158	22.89	$5,083
	HBE	Single Person HHs	9,645	50%	25	2,009	158	12.72	$5,083
	Source		Per DSHS	Assumption	Touch times may vary given simplicity of one person HH's		Per HBE		$61,000 annually per HBE

Current cost	SGF Portion (HBE State Share based on Percentage of State Share of Expenditures at 58% Based on HBE Cost Allocation for Oct 1 to Apr 30, 2014)		
$1,396,437	$809,933		
$775,798	$449,963	Average	$629,948

Table 16: Auto-Renewal of MAGI Eligibility at Food Recertification Savings Calculations (p. 2 of 2)

Future at ESA	Scope of population	Monthly Number of MAGI Cases With SNAP	% of cases that will auto-trigger	Avg. Touch Time	Hours of Staff Effort	Hours Worked per FTE per Month	Number of FTE Required	Avg. Cost per FTE
Metric								
ESA	Single Person HHs	9,645	50%	30	2,411	138	17.47	$4,867
Source		Per DSHS	Assumption					Financial Services Specialist 3; Salary, Benefits, OT

Future at ESA	Current cost	SGF Portion*	SGF Portion**	SGF Portion***
	$1,020,518	$510,259	$446,477	$382,694
	Savings		$63,782	$127,565

*Calculation assumes CMS approves partial allocation of auto-trigger to Medicaid. We used estimates of 0/25/50% to show potential impact. SNAP share is 50% SGF and MAGI is 25% SGF. This would have to be submitted to CMS and approved. 0%
** 25%
*** 50%

Table 17: Expand Healthplanfinder Access to DSHS Eligibility Staff Savings Calculations (p. 1 of 3)

Current	Metric	Current Applicable Volume at HBE	Avg. Touch Time	Hours of Staff Effort	Hours Worked per FTE per Month	Number of FTE Required	Avg. Cost per FTE	Current cost	SGF Portion
	HBE	101,304	45	75,978	158	481	$5,083	$29,333,421	*$17,013,384*
	Source	Averages February and March call Volume at HBE*	Per HBE	Volume X Touch Time/60	Per HBE		$61,000 annually per HBE	FTEs X avg. cost X 12	HBE State Share based on Percentage of State Share of Expenditures at 58% Based on HBE Cost Allocation for Oct 1 to Apr 30, 2014.
	Metric	Current Applicable Volume at ESA	Avg. Touch Time	Hours of Staff Effort	Hours Worked per FTE per Month	Number of FTE Required	Avg. Cost per FTE	Current cost	SGF Portion
	ESA	31,352	35	18,289	138	133	$4,867	$7,740,132	*$4,721,480*
	Source	ESA Clients not receiving any medical + monthly average clients applying for both**	Per ESA	Volume X Touch Time/60	Per ESA		Financial Services Specialist 3; Salary, Benefits, OT	FTEs X avg. cost X 12	ESA Share is based on Percentage of state share at 61% based on ESA Eligibility Worker cost allocation for Oct 1 to Apr 30, 2014.
								CURRENT SGF PORTION COMBINED	$21,734,865

*Multiplied by % of enrollments completed related to new MA.
**ESA clients not receiving any medical (Feb-Apr avg./12) + monthly average (Oct-Apr) clients applying for both MAGI and other ESA program in same month.

Table 18: Expand Healthplanfinder Access to DSHS Eligibility Staff Savings Calculations (p. 2 of 3)

Future	Metric	MAGI Application Volume	Avg. Touch Time	Hours of Staff Effort	Hours Worked per FTE per Month	Number of FTE Required	Avg. Cost per FTE	Future cost	SGF Portion
	HBE	60,719	45	45,539	158	288	$5,083	$5,083	*$10,197,290*
	Source	Current Applicable Volume at HBE - Current Applicable Volume at ESA*	Per HBE	Volume X Touch Time/60	Per HBE		$61,000 annually per HBE	FTEs X avg. cost X 12	HBE State Share**
	Metric	Volume of unserved Medical w/ ESA Cases	Avg. Touch Time	Hours of Staff Effort	Hours Worked per FTE per Month	Number of FTE Required	Avg. Cost per FTE	Future cost	SGF Portion***
	ESA	40,586	80	54,114	138	392	$4,867	$22,902,127	*$8,511,979*
		40,586	48	32,469	138	235	$4,867	$13,741,276	*$6,221,766*
		40,586	56	37,880	138	274	$4,867	$16,031,489	*$6,794,320*
		40,586	64	43,291	138	314	$4,867	$18,321,701	*$7,366,873*
	Source	Current Applicable Volume at ESA + estimate of additional calls diverted to ESA		Volume X Touch Time/60	Per ESA		Financial Services Specialist 3; Salary, Benefits, OT	FTEs X avg. cost X 12	

Table 19: Expand Healthplanfinder Access to DSHS Eligibility Staff Savings Calculations (p. 3 of 3)

Future	FUTURE SGF PORTION COMBINED	With ESA Touch Time at	(HBE + ESA)	With ESA Touch Time at	Difference (Savings)
		48	$16,419,057	48	$5,315,808
		56	$16,991,610	56	$4,743,255
		64	$17,564,163	64	$4,170,702
		80	$18,709,269	80	$3,025,595

*Estimate of additional calls diverted to ESA (under 125 percent poverty, not on SNAP).
**HBE state share based on percentage of state share of expenditures at 58 percent based on HBE cost allocation for Oct. 1 to Apr. 30, 2014.
*** ESA share is based on same calculation for state share of current time assuming worker spends same amount of time on TANF, SNAP and etc. as does now without interoperability. Additional time spent by worker would be all in HPF and all MAGI at 25 percent state share. Formula takes future cost line item and deducts current cost total and applies Medicaid MAGI 75/25 funding split and then adds back total current costs to capture current cost share in the calculation. Workers should be able to move thru ACES faster having already gathered much of the information.

Appendix B – Sample Governance Structure Charter

The following serves as a template for a charter to support Recommendation #1 – Expand Shared Governance Structure.

I. Project Scope

(Define the scope and vision of the project here).

II. Project Management Approach

Governance Team

Function. The Governance Team acts as the executive team for State health and human services programs. The board has three key functions: 1) To provide strategic direction for the overall project **(for WA, "project" is an ongoing effort to improve customer service, create efficiencies, and save state dollars/maximize federal contribution/Achieve the vision articulated in sessions to prepare recommendation)** and the project team; 2) To make timely decisions based on requests and recommendations brought to them from the Project Leadership Team; and 3) To make the final decisions when the Project Leadership Team is unable to come to a consensus and/or resolve any conflicts that arise.

Membership. The Governance Team will consist of executive leadership from the health and human services agencies. (Add table with list of Governance Team members).

Decision making Authority. Governance Team members from the agencies have equal decision making authority on all aspects of the project. When decisions are escalated to the Governance Team, a unanimous decision is required to finalize decisions.

Note: Ex officio members of groups do not have decision making authority and will not participate in official voting; however, they will participate on the various groups to provide perspectives from which they represent.

Project Leadership Team

Function. The Project Leadership Team (PLT) is the project management team for State health and human services programs. It is responsible for ensuring goals are met and in making decisions that affect implementation of initiatives and progress.

Membership. The PLT consists of Governance Team members, state health and human services programs agency coordinators, workgroup chairs and other key staff from the health and human services agencies. (Add table for a list of PLT members).

Decision making Authority. The PLT participates in the decision making process as delineated in the section, "Decision Making Hierarchy." All PLT members will have an opportunity to share their perspectives prior to voting. Once perspectives are shared, a Governance Board member or other designated member will call for a vote. A two-thirds majority of the membership is considered a consensus to make decisions. If consensus cannot be reached among the PLT, decisions will be escalated to the Governance Team.

Workgroups

Function. The governance team sponsors three (3) core workgroups—Policy and Procedures Workgroup, Technology Workgroup and Data Workgroup. The workgroups are responsible for completing key activities as delineated in State health and human services program's work plan.

Membership. The workgroups consist of PLT members and other staff from the health and human services agencies. (Add table for a list of workgroup members).

Decision making Authority. Workgroups participate in the decision making process as delineated in the section, "Decision Making Hierarchy." All PLT members will have an opportunity to share their perspectives prior to voting. Once perspectives are shared, a Workgroup Co-Chair(s) or other designated member will call for a vote. A two-thirds majority of the membership is considered a consensus to make decisions. If consensus cannot be reached among the workgroup members, decisions will be escalated to the PLT; if consensus is not reached by the PLT, decisions will be escalated to the Governance Team. Consultant Project Management staff will facilitate the decision making process.

Ad Hoc Committee

Function. Ad Hoc Committees are formed when project activities require the expertise and consultation from a specialized division to assist in gathering the information necessary for making decisions or obtaining approval. They are formed for the length of time it takes to complete project activities requiring ad hoc committee member expertise.

Membership. Examples of Ad Hoc Committees are Legal Counsel, Human Resources, and Contracts. PLT and Governance Team members will identify the members of Ad Hoc Committees. Ad Hoc Committees will also have membership from the PLT. When necessary, Governance Team members will participate on an Ad Hoc Committee.

Decision making Authority. Like ex-officio members, Ad Hoc Committee members that are not members of the workgroups, PLT, or Governance Team, will have no decision-making authority. They will participate to provide expertise from the areas in which they represent.

Decision Making Hierarchy

For state health and human services programs, the assumption is that the Governance Team is empowering the PLT and workgroups to get the necessary work done to meet state health and human services programs goals and achieve its vision. Below is a list of criteria that workgroups and the PLT will use to determine when decisions must be brought to the Governance Team for decision making. If the criteria are **not** listed, then the workgroups and/or PLT have the authority to make decisions.

Consideration Areas	The Project Leadership Team/Workgroup Chairs must ask Governance Team for permission when
Budget impact	1. Activities would require funds to be moved from one major budget category to another (e.g. personnel, travel/supplies, contractual agreements); 2. There is a need for outsourcing activities that are not currently budgeted; 3. Outsourced activities require changes in the scope of work of any contractors; 4. Activities require additional dollars from other agency funds; 5. Requests for new initiatives/activities that would either require new money or to redirect money; 6. Activities would result in the need for agency commitment of new/additional funds (i.e. activities that expand the population to be served); or 7. Activities that require enhanced match dollars.
Legislative impact	1. Activities requires changes to state plans; 2. Activities require changes from federal rules/guidelines; 3. Activities require changes to agency budget (see above) or state proviso.
Impact on external stakeholders (i.e. public perception, advocacy groups)	Workgroup chairs have concerns there may be an impact on perception of the agencies by the general public, advocacy groups or other stakeholders.
Impact on Other Agency Priorities/Resources; Impact on Other Agency	Workgroup chairs determine there may be an impact on current agency priorities and/or resources (i.e. reallocation of significant and sustained resources from other projects that were not originally assigned to project).
Conflict/lack of consensus among Workgroup members/Project Leadership Team	Members disagree on the activities/tasks to be done.

Process for Bringing Decisions to the Governance Team

Although there will be other mechanisms for approaching the Governance Team for decisions, the primary mechanism will be a regularly scheduled call on ('X"). Preparation for the call and the call format will be as follows:

- An agenda and PowerPoint presentation(s) will be emailed to the Project Leadership Team (which includes Governance Team members) by close of business the Monday prior to the Wednesday call. The agenda will be prepared by the Project Management Team and the PowerPoint presentations will be prepared by the workgroup chairs or members who are requesting a decision. The Project Management Team will email the agenda and PowerPoint presentation(s) to the Project Leadership Team.
- The PowerPoint presentation will include the following information:
  - A summary of the nature of the decision request-- the who, what, when, where, how and/or why?
  - Background information related to the question: have we faced this before, what was done then, did it work/not work, what, if any, is the anticipated impact
  - Relevant data to support the decision-making process (i.e. historical data, data supporting recommendations)
  - Recommendations determined by the workgroup with identified pros and cons
- If the Governance team is unable to provide a decision on the call, they will have until the second Monday after the weekly call in which the request is received to provide a decision. If they are not able to make the decision by the second Monday, they will provide an explanation and a date of when they can provide the decision.

Ground Rules

The PLT developed working agreements to provide clear guidance on how the various groups within the governance structure will work together:

- Keep in mind the Big Picture—the vision to improve the service to citizens seeking TANF, SNAP, Working Connections Child Care, and Medicaid eligibility.
- When developing ideas and recommendations, keep in mind their impact on all programs, while also not forgetting about the importance of the details (Operationalize!).
- Assume people's intentions are good.
- Attend and be on time to meetings.
- Participate in meetings.
- Give everyone the opportunity to provide feedback and input at meetings.
- Be clear about a meeting's purpose, its goals, and who should be attending and the rationale for their attendance.
- Have a facilitator at all meetings who is in charge of putting topics in the "parking lot" if they are deemed to be best discussed in a "side bar" conversation.
- Ground Rules are posted at all meetings.
- Agendas at all/most meetings.
- Decisions do not change unless future decisions conflict with previous decisions. There will be a process for discussing the conflict before a decision is changed.
- Include 10 minutes at the beginning of meetings on the agenda scheduled for fellowship/chit-chat.

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