Report to the Legislature

Examining Processes and Systems to Expeditiously Link Persons Released from Correctional Facility and Institutional Confinement to Medical Assistance Prior to Release

As Required by Engrossed Substitute House Bill 2687,
Budget Proviso Studies

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In collaboration with the Washington Association of Sheriffs, Police Chiefs, the Department of Corrections, the Regional Support Networks, Department Field Offices, Institutions for Mental Diseases, and Correctional Institutions

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Purpose

Section 209(14) of the 2008 Supplemental Budget Engrossed Substitute House Bill (ESHB) 2687 directed the Department of Social and Health Services (DSHS), in collaboration with other State agencies and local entities, to identify and analyze current barriers that may prevent referral of potentially eligible confined individuals for expedited medical coverage application processing upon their release from confinement. This legislation acknowledges the need for people to have access to medication and treatment upon release from confinement to make a seamless and successful transition back to the community.

In a step toward possibly expanding expedited application processing beyond the confined individuals with mental health disorders set forth in House Bill (HB) 1290 (2006) and HB 1088 (2007), and suspending rather than terminating individuals' DSHS medical benefits eligibility upon confinement, the 2008 Legislature, in ESHB 2687 Section 209(28), also directed DSHS and its partners to complete a feasibility study that analyzes the processes, systems, modifications, costs, and benefits necessary to:

- Suspend eligibility for individuals who were receiving medical assistance when their confinement began, reactivate their medical coverage immediately upon release without filing a new application, and implement changes to facilitate eligibility recertification before or immediately after release from confinement.
- Improve efficiency and expand the scope of the expedited medical assistance reinstatement and eligibility determination process established under RCW 74.09.555 beyond persons with mental disorders and including both those who received DSHS medical coverage when admitted and those who did not have DSHS medical coverage when admitted, but who may be eligible at release.
- Provide mental and medical health evaluations to determine incapacity or disability for purposes of medical assistance prior to the person's release from confinement.
- Notify DSHS in a timely manner when a person previously enrolled in medical assistance is confined to and released from a psychiatric institution, prison, jail, juvenile institution or detention.

In response to the ESHB 2687 legislative directive, a feasibility study workgroup was formed. Combined with the appendices, this report captures the information shared during workgroup discussions and data shared. Specifically, the workgroup identified the following two overarching objectives:

1) Suspending DSHS medical benefits eligibility[1] for current DSHS clients when they are admitted to a psychiatric hospital, prison, jail, juvenile institution, or juvenile detention facility, and
2) Building upon the HB 1290 expedited medical benefits application process to link confined individuals not already determined eligible for DSHS benefits to medical coverage prior to release from confinement.

When considering the feasibility of achieving these objectives, the workgroup examined whether DSHS medical eligibility suspension and expansion of eligibility determinations for these confined populations are possible, if they should be done, and how they can be accomplished. Ultimately, the workgroup answered "yes" to these questions and concluded that the most critical aspects for achieving the two identified objectives are:

1) Effective, timely communication between the facilities and DSHS, and
2) Improving access to required incapacity/disability assessments to determine eligibility.

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[1] For the purposes of this report, the suspension processes outlined herein, and the development of a communication tool, suspension of DSHS medical benefits eligibility refers to an internal, technical process for identifying those individuals as

goals. This report reflects development of a suggested model for implementation of suspension of eligibility processes for confined individuals who received DSHS medical benefits immediately prior to confinement; an expanded HB 1290 expedited application process for those who were not DSHS medical assistance clients at admission, but who may be financially and categorically eligible for such benefits upon release; an effective means for communicating the information necessary to facilitate suspension, re-activation, eligibility recertification during confinement, application, and/or re-application for DSHS medical benefits; options for obtaining sufficient medical and mental health assessments while potentially eligible individuals are confined; and estimated costs.

The Role of the Feasibility Study Workgroup Focus Groups

The feasibility study workgroup was divided into the following three focus groups, based on the identified objectives for this study and related crucial issues:

- Communication
- Suspension
- Incapacity/Disability Assessments

Individual focus groups to discuss these discrete issues and develop options for addressing each of them were necessary due to the breadth of them and the challenges they pose.

Improving Communications

Because there is currently no single system for tracking admissions and releases to and from psychiatric hospitals, jails, prisons, juvenile institutions or juvenile detention facilities, the Communication focus group zeroed in on this as an aspect of the study requiring intense examination. The lack of an easily accessible, universal communication tool for all facilities was identified by the larger workgroup as a significant barrier to providing DSHS mental and medical health coverage to eligible individuals upon release from confinement. In particular, this is a barrier because:

- DSHS cannot take the first step of suspending an otherwise eligible individual's medical coverage upon confinement if DSHS is not first aware that the individual has been confined.
- Eligibility cannot be reactivated after suspension if DSHS is not informed that the individual will soon be or has been released.
- DSHS cannot adequately assist individuals who did not previously receive medical benefits, but who may be eligible, if these people are not referred to DSHS for eligibility determinations.
- DSHS' ability to link individuals with medical coverage when they are released from confinement is impaired if existing medical evidence from these facilities cannot be shared timely with DSHS eligibility staff.

The Communication focus group's concern about ensuring effective communication between DSHS and facilities regarding entries and releases led the group to create a plan for communication using a web-based application. Once developed, the proposed communication tool could be used to notify DSHS about facility admissions and releases, initiate the medical benefits application processes for those who may be eligible prior to release from confinement, suspend eligibility for DSHS medical coverage for those receiving coverage at the time of confinement, and allow easy reactivation of eligibility for medical coverage at the time of their release.

Currently, eligibility for medical benefits for DSHS clients entering psychiatric institutions, jails, prisons, juvenile institutions, or juvenile detention facilities is terminated rather than suspended. This means that a new application for medical benefits must be completed before or when a former DSHS client is released from one of these facilities in order to help ensure post-release re-connection with needed benefits.

The Suspension focus group examined the feasibility of suspending rather than terminating eligibility for DSHS medical benefits for individuals receiving DSHS medical coverage immediately prior to confinement. Within the constraints of federal and state law, the focus group determined that suspending eligibility for some but not all DSHS medical coverage programs is possible.

These include:

- Supplemental Security Income (SSI)-eligible.
- Categorically Needy SSI-related and Medically Needy (MN) SSI-related without spenddown (not the SSI-related with spenddown cases which are few in number).
- Children's Medical/*Apple Health for Kids (AHFK).*
- Medical Care Services for General Assistance—Unemployable (GA-U) and ADATSA[2].
- General Assistance—Expedited Medicaid Disability (GA-X and GA-D).

Eligibility for those who receive DSHS medical coverage through the Medicaid Family Medical/TANF-related and Medicaid SSI-related with spenddown programs should be terminated on admission to a facility. This is because suspending, rather than terminating, and then simply reactivating such cases when these DSHS individuals are confined and then released could easily result in incorrect use of federal financial participation (FFP) and state dollars.

In accordance with recent correspondence from the federal Centers for Medicare and Medicaid Services (CMS) that indicates stopping the clock on required certification periods is impermissible, eligibility reviews would be required during the period of confinement based on timeframes currently required by federal rule. To prevent claims payment and inappropriate use of federal financial participation (FFP) during confinement, confined individuals would be recertified for coverage according to schedule, but in "suspense" status until they are released. To avoid multiple, potentially costly re-certifications and re-assessments while DSHS clients are confined, the focus group also determined that suspension of eligibility will be available for those in certain identified DSHS medical coverage groups only when their expected period of confinement is 24 months or less.

Obtaining Necessary Assessments

Experience from the HB 1290 expedited application process prior to release for confined individuals with mental health disorders who are likely eligible for DSHS medical benefits has highlighted difficulties related to the existence of varying medical evidence requirements for determining eligibility for various DSHS medical benefits programs, along with different certification periods and the timing of required assessments. The availability of medical assessments necessary for eligibility determinations may vary not only by DSHS medical coverage program types but also by the type of facility where potentially eligible individuals are confined because certain DOC facilities may have more medical and mental health professionals available to perform assessments than other DOC facilities and/or county jails. Even when medical care is provided while individuals are confined and

[2] Of the five DSHS medical coverage groups for which suspension of eligibility during confinement is an option, those who are eligible for MCS coverage will initially have their eligibility suspended upon admission to a facility but then may later have it terminated if there is insufficient medical evidence available while confined to re-determine incapacity. If there is sufficient medical evidence available during confinement, the eligibility for clients in this DSHS medical program will

The Incapacity/Disability Assessments focus group examined the following: How to complete medical assessments prior to release from confinement for individuals who:

1) Fall into a DSHS medical coverage group for which suspension of eligibility is not an option,
2) Fall into a DSHS medical coverage group for which suspension of eligibility is an option and who require recertification, or
3) Did not previously receive DSHS medical benefits, but who may be eligible for medical coverage upon release.

The availability of sufficient objective medical evidence prior to release has historically been a barrier to expediting DSHS medical eligibility determinations for the incarcerated, in particular.

To address this challenge, DSHS proposes consultative examination standards established by the Division of Disability Determination Services (DDDS). The standards require that a licensed physician or psychologist perform the consultative exam. This medical information obtained would:

- Meet both incapacity and disability criteria for different program eligibility categories,
- Streamline the application process,
- Support Supplemental Security Income (SSI) approvals at initial determination,
- Reduce duplication of effort between Community Services Division (CSD) and DDDS, and
- Enable DSHS to move clients more quickly from state-only funded services to federally matched services.

Possible Implementation Model

Based on lessons learned from the HB 1290 and HB 1088 experiences, along with available data, the feasibility study workgroup determined that suspending DSHS medical benefits eligibility and expanding the expedited medical benefits application process for confined individuals prior to release is possible, and also developed a potential model for accomplishing these objectives. The workgroup suggests five phases for implementing the new business model:

Phase I: Design and build the web-based communication tool
Phase II: Pilot suspension cases in a mid-sized facility
Phase III: Implement suspension statewide
Phase IV: Pilot incapacity/disability assessments in a mid-sized jail facility
Phase V: Implement new assessment processes statewide

Limited Interim Pilot Project

Although workgroup members determined that developing an effective communication tool (Phase I above) is the essential cornerstone to successfully suspending and reactivating medical eligibility for DSHS clients and for expanding the HB 1290 process for those who may be eligible prior to release from confinement, the tool's development requires time and resources. In recognition of this, some workgroup members suggested a more limited DOC pilot project in the interim that expands on the expedited application and assessment process set forth in HB 1290, utilizes a new medical evidence template developed by Economic Services Administration (ESA), and uses telemedicine when available and appropriate.

This interim pilot project is a stand-alone option, independent of the five implementation phases outlined above, and does not include a broad-based communication tool or suspension of eligibility for DSHS medical benefits for confined individuals. Instead, this pilot project would function as a precursor to Phases I through V until the

Costs associated with the development and use of the proposed communication tool cannot be determined until the specific business requirements for the new system are identified, including its use by facility staff and workload impact. Programming changes to ProviderOne (the new DSHS Health and Recovery Services Administration [HRSA] claims payment system), would also be required to suspend payment claims for confined clients. Estimates for this work are calculated in programming time and statewide suspension implementation can likely be done at reasonable cost. Due to staffing requirements, medical and mental health assessments are the most costly component of the workgroup's proposed plan and should be the final two phases implemented due to costs and complexities. A small interim pilot project in a DOC facility will require fewer resources than conducting assessments for the entire population whose DSHS medical benefits eligibility is suspended and for those individuals who may likely be eligible, and it may be conducted while the necessary communication tool set forth in Phase I of the full implementation plan is being designed and developed.

SECTION I. INTRODUCTION

Background

Since 2005, the Washington State Legislature has been interested and involved in expediting DSHS eligibility determinations for confined populations and providing timely post-release medical assistance benefits to these individuals. This reflects a growing understanding that many eligible individuals, who have been institutionalized or incarcerated, need access to publicly-available benefits upon release in order to successfully re-enter their communities and reconstruct their lives. There has been growing concern about reconnecting those who lost DSHS medical coverage upon admission to a psychiatric hospital, prison, jail, juvenile institution or detention when they are released from confinement.

Federal rule prohibits states from using federal financial participation (FFP) to provide Medicaid coverage to individuals while they are confined.[3] Because of this, the Medicaid benefits of many were terminated upon confinement and there was no formal process in place for re-application prior to release. Some individuals experienced lengthy delays in getting reconnected to DSHS medical coverage upon their release from confinement.

Efforts to improve and expedite the medical benefits application and re-application process for confined individuals began in earnest in 2005 with the passage of HB 1290. The purpose of this legislation was to expedite the application process for adults with serious mental illness who were DSHS clients immediately prior to or within five years of confinement. Pursuant to this legislation, in January 2006 DSHS started helping confined individuals with mental health issues begin their applications for public benefits while still institutionalized in order to ensure access to those benefits immediately upon release.

This effort to connect or re-connect eligible institutionalized individuals with necessary services upon release continued with the passage of HB 1088 in 2007. This legislation expanded and improved publicly-funded mental health services for children, including a phased-in expedited medical determination process for children in the juvenile justice system.

Due to funding limitations, DSHS was directed by the Governor to phase in the HB 1290 application process in selected areas of the State. Appendix 1-1 contains a map that shows the community services offices (CSOs), correctional facilities, psychiatric hospitals, and regional support networks (RSNs) that currently process expedited medical applications as required under HB 1290. Expedited determinations are completed statewide

The Juvenile Rehabilitation Administration (JRA) and all juvenile courts have established protocols for completing expedited medical determinations for all youth leaving the juvenile justice system.

Since implementing these new expedited application procedures, beginning in January 2006 (HB 1290) and October 2007 (HB 1088), many successes have been realized and many challenges and opportunities have been revealed. The successes of HB 1290 include out-stationed Economic Services Administration (ESA) staff in many jails; collaborative, inter-agency focus on prisoner re-entry issues; and piloting electronic sharing of medical eligibility status and history with jails. Challenges include: increased applications from facilities; finding better ways to serve clients who release very quickly from jails; improving access to existing medical evidence from DOC; serving all clients; increasing access to medical records; assisting persons dually diagnosed with mental health and substance abuse issues; suspending DSHS clients' eligibility upon entry into a facility; and expediting eligibility for those not yet in DSHS medical programs. HB 1088 has been successfully implemented in the JRA institutions; however, a great deal of this work is being done by JRA staff who received no funding or full-time equivalent (FTE) allotment. The Juvenile Courts have the same challenges as adult jails with short stays and quick, often unpredictable releases from detention. The Juvenile Courts also have not received any funding or FTE allotment for this work.

To address some of these challenges, ESHB 2687, Sections 207(14) and 209(28), directed DSHS to present a feasibility study to the Governor and the legislature. The Governor and the 2008 Washington State Legislature asked the Department of Social and Health Services (DSHS), to collaborate with the Washington Association of Sheriffs and Police Chiefs, Department of Corrections, RSNs, and Institutes for Mental Diseases to identify the barriers preventing potentially eligible confined individuals from being referred for expedited medical eligibility determinations prior to release, and to explore ways of ensuring that eligible individuals receive medical coverage immediately upon release from confinement (see Figure 1-1).

Toward this end, although using federal matching funds to provide Medicaid coverage to individuals while they are confined in a psychiatric hospital, prison, jail, or juvenile facility is prohibited, the Centers for Medicare and Medicaid Services (CMS) recommended that states "suspend" rather than "terminate" eligibility for Medicaid benefits for such individuals. This option has the potential to allow for reactivation of Medicaid benefits for a confined individual immediately upon release, which may facilitate their transition from facility to community. For individuals who did not have Medicaid benefits or other DSHS medical coverage at the time of confinement, it may be possible to determine their eligibility while they are confined and then suspend that eligibility until their release.

Feasibility Workgroup Study

An important part of the legislative charge in ESHB 2687 was the formation of a workgroup, with membership dictated by the proviso (see Figure 1-1). The workgroup included representatives from the Washington Association of Sheriffs and Police Chiefs, Department of Corrections, RSNs, Institutes for Mental Diseases, juvenile institutions, juvenile detention facilities, correctional facilities, and three legislative members. Names of workgroup members and affiliations are provided in Appendix 1-2. Between June 2008 and November 2008, six workgroup meetings were held. Many smaller focus group meetings were also held between those dates. The large workgroup divided into three focus groups: Communication, Suspension, and Incapacity /Disability Assessments.

Elements

The focus groups met regularly for several months to (1) identify barriers and find practical and effective

Illness" and *Helping Inmates Obtain Federal Disability Benefits"* confirm that the barriers and opportunities identified by these focus groups and the proposed solutions were on target.

This research literature identified the following elements for ensuring successful transition from confinement to community:

- Dedicating staff to medical benefits determination and associated tasks,
- Centralizing the process of medical and cash assistance claims,
- Screening for mental health issues upon entry to prison or jail,
- Screening for prior DSHS medical benefits upon entry to prison or jail,
- Suspending rather than terminating Medicaid benefits for inmates,
- Helping prisoners complete applications,
- Arranging expedited review and processing of applications,
- Sharing information across agencies, including through interagency agreements and task forces,
- Using web-based applications, combining benefit applications, and
- Eliminating in-person requirements for applications.

The approaches considered and the elements incorporated by the workgroup when conducting this feasibility study were influenced by the above-referenced best practices and the following assumptions:

- Legislation will be passed to support the following:
  - Electronic signatures for on-line medical applications.
  - Mandatory use of a new web-based communication tool by institutions and facilities.
  - As-needed contracts between Economic Services Administration

Figure 1-1. Engrossed Substitute House Bill 2687 Budget Proviso Studies

Section.207.(14)
(14) The department in conjunction with the House Bill No. 1290 work group, shall identify and analyze barriers preventing city, county, and state referrals of persons potentially eligible for expedited application processing authorized under RCW 74.09.555. The department, in conjunction with the House Bill No. 1290 work group, shall report its findings and recommendations to the appropriate committees of the legislature no later than November 15, 2008.

Section.209.(28)
(28)(a) $100,000 of the general fund—state appropriation for fiscal year 2009 is provided solely for a feasibility study to examine process and systems that would expeditiously link persons released from confinement in state and local correctional facilities and institutions for mental diseases to medical assistance benefits for which they qualify. The study shall present an analysis of the costs and benefits associated with:

(i) Suspending eligibility for persons who were receiving medical assistance at the time their confinement began, such that upon the person's release from confinement, medical assistance benefits would immediately resume without the filing of a new application. In the evaluation of eligibility suspension, the department shall examine process modifications that would allow confined persons to recertify eligibility before or immediately after release from confinement;
(ii) Improving the efficiency and expanding the scope of the expedited medical assistance reinstatement and eligibility determination process established under RCW 74.09.555, including extending the process to persons other than those with mental disorders, both for persons who had been previously eligible before confinement and for persons who had not been eligible before confinement;
(iii) Providing medical and mental health evaluations to determine disability for purposes of the medical assistance program before the person's release from confinement; and
(iv) Notifying the department in a timely manner when a person who has been enrolled in medical assistance is confined in a state correctional institution or institution for mental diseases or is release from confinement.

(b) In conducting the study, the department shall collaborate with the Washington association of sheriffs and police chiefs, the department of corrections, the regional support networks, department field offices, institutions, for mental diseases, and correctional institutions. The department shall submit the study to the governor and the legislature by November 15, 2008.

- Funding to support implementation and on-going costs.

- The communication system will be developed prior to implementing new suspension and application processes.
- A new waivered program or state program was not a feasible option for consideration.

Creating a new DSHS program for this population was put forth by the workgroup as one possible approach for guaranteeing that confined individuals would have medical coverage immediately upon release without violating: (a) any federal eligibility determination requirements and timelines or (b) CMS' prohibition against using FFP for services delivered to confined individuals or to individuals ineligible for Medicaid. However, this option of creating a new DSHS health care program specifically for previously confined individuals would likely require significant systems changes and could be costly. Given current budget constraints and other alternatives that were examined, it was considered the least viable option.

Section II. DSHS Medical Coverage and the Jail/Prison Client Population[6]

To gain a better understanding about the number of individuals who could be impacted by (1) suspending DSHS eligibility for those who had coverage upon entry to a facility and reactivating their eligibility at release, and (2) expanding the expedited application process for those who may potentially be eligible prior to release, the workgroup consulted with staff in the DSHS Research and Data Analysis Division (RDA). The data and charts below for state fiscal year (SFY) 2005 show:

- The percentage and number of individuals who had DSHS coverage at certain time points prior to confinement and after release in relation to the overall confined population,
- The type of DSHS coverage they had, and
- The type of facility to which they were confined.

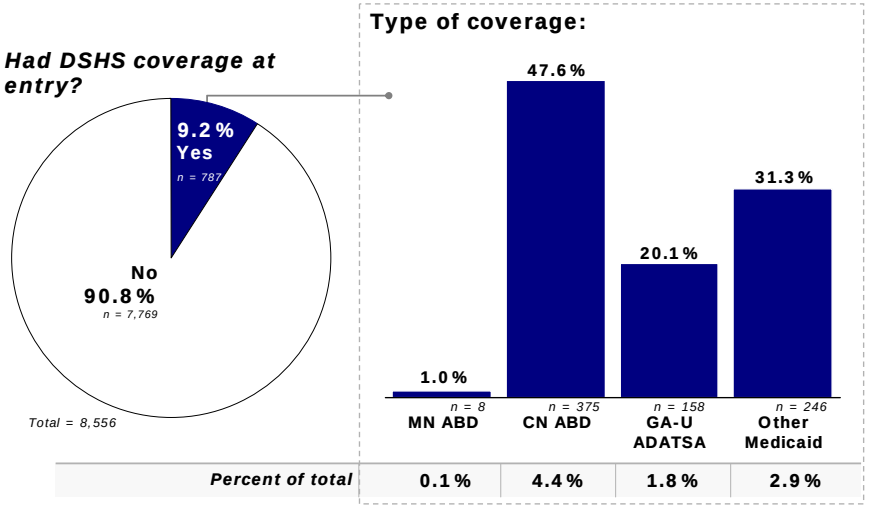
Also included are data and charts related to the impact of jail stays on continuity of DSHS medical coverage eligibility.

Jail and Prison Inmates Who Had DSHS Medical Coverage Prior to Confinement

Upon entry, one in nine persons admitted to Department of Corrections (DOC) facilities during SFY 2005 had DSHS medical coverage[7] (Figure 2-1). Nearly half (47.6%) of these 787 individuals received Categorically Needy (CN) scope of coverage as the result of being determined Aged, Blind, or Disabled (ABD). Only a very small percentage (1.0%) received Medically Needy (MN) ABD coverage.

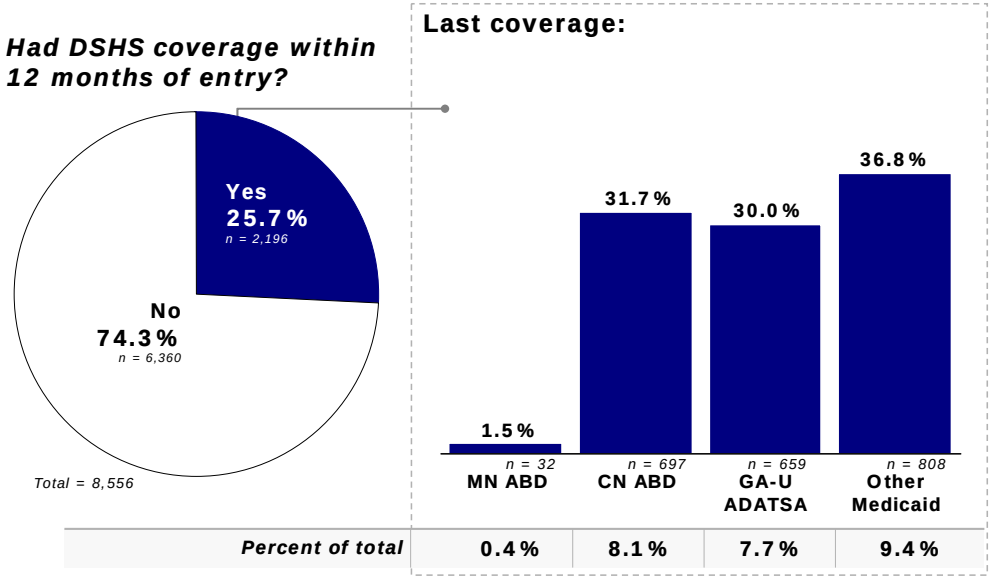
[6] Data presented in this section was not available for state psychiatric hospitals, juvenile institutions, or juvenile detention facility

SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.



Within 12 months prior to entry, one in four people admitted to the Department of Corrections had DSHS medical coverage (Figure 2-2). The largest percentage (36.8%) of this group of 2,196 individuals received "Other Medicaid" coverage, such as Family Medical/TANF-related.

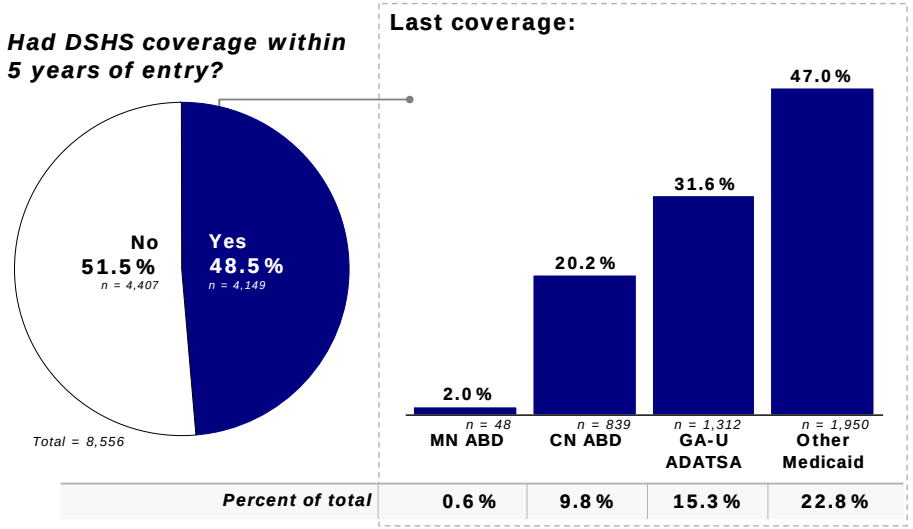
Figure 2-2. DSHS medical coverage within 12 months prior to entry | SFY 2005 DOC Admissions



SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.

Within the five years prior to entry, one half of those admitted to the Department of Corrections had DSHS coverage (Figure 2-3). Of the 4,149 individuals who had DSHS medical coverage up to five years prior to entering a DOC facility, 47% had "other Medicaid" coverage. Those with a short-term mental incapacity or physical disability who qualified for the DSHS General Assistance Unemployable (GA-U) program or with alcohol

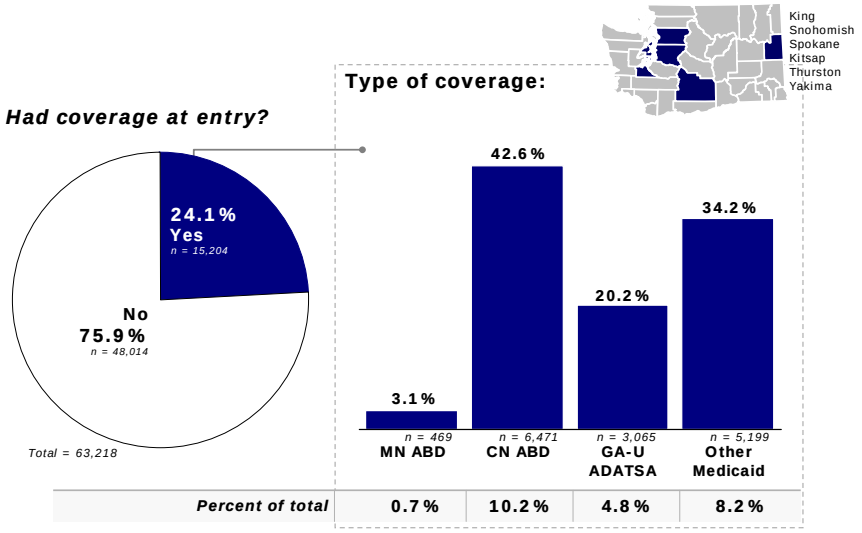
Figure 2-3. DSHS medical coverage within 5 years prior to entry | SFY 2005 DOC Admissions



SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.

Upon entry, one in four persons admitted to local jails in SFY 2005 had DSHS coverage (Figure 2-4). Counties included are King, Snohomish, Spokane, Kitsap, Thurston, and Yakima. As with the 1 in 9 individuals who entered DOC facilities in SFY 2005 who had DSHS medical coverage at admission, more than 40% of the DSHS admittees to jails were receiving CN ABD coverage at the time of their entry.

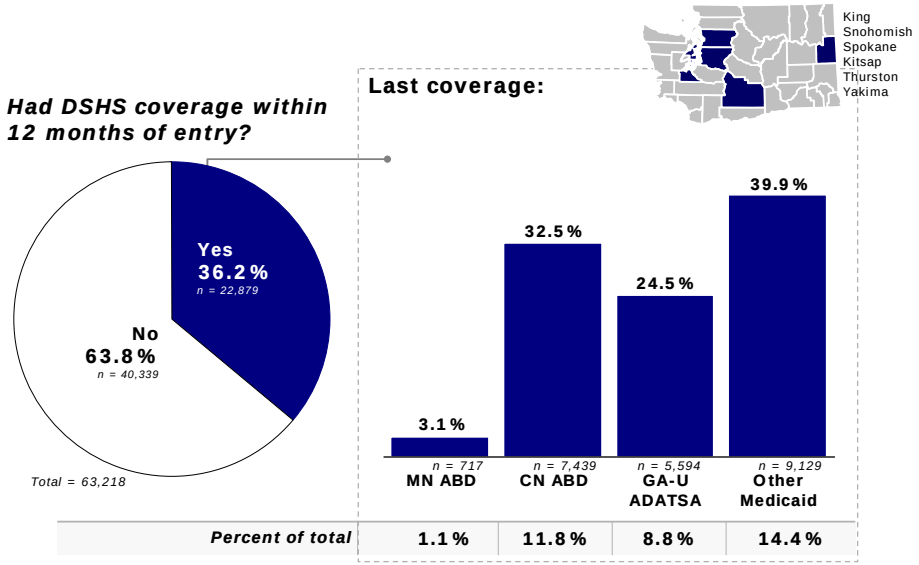
Figure 2-4. DSHS medical coverage upon entry | SFY 2005 Local Jail Admissions



SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.

Within 12 months of entry, one-third of those admitted to local jails had DSHS coverage (Figure 2-5). Counties

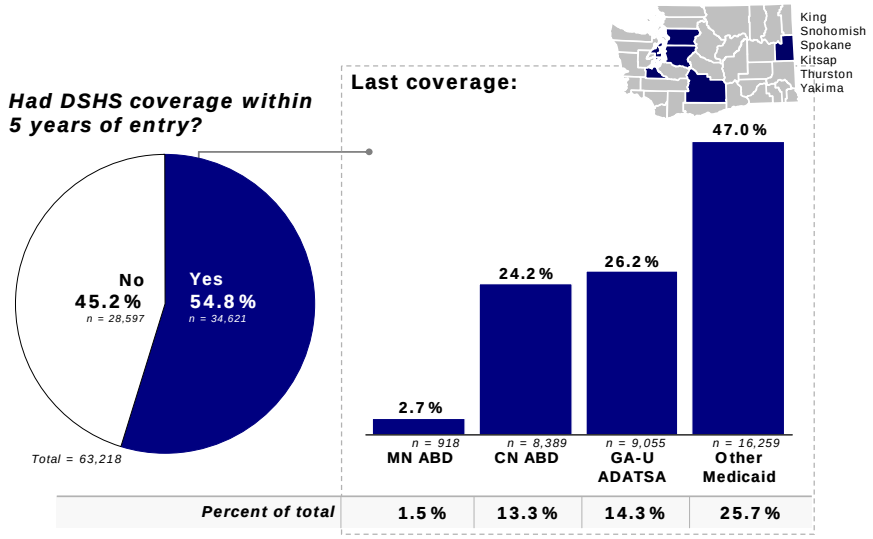
Figure 2-5. DSHS medical coverage within 12 months of entry | SFY 2005 Local Jail Admissions



SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.

Within the five years prior to entry, over half of those admitted to local jails had DSHS coverage. Counties included are King, Snohomish, Spokane, Kitsap, Thurston, and Yakima (Figure 2-6). As with the admitted to DOC facilities in SFY 2005 who had DSHS medical coverage in the past five years, nearly half (47%) of those admitted to jails in SFY 2005 with DSHS medical coverage in the five years before entry had "other Medicaid" coverage.

Figure 2-6. DSHS medical coverage within 5 years of entry | SFY 2005 Local Jail Admissions

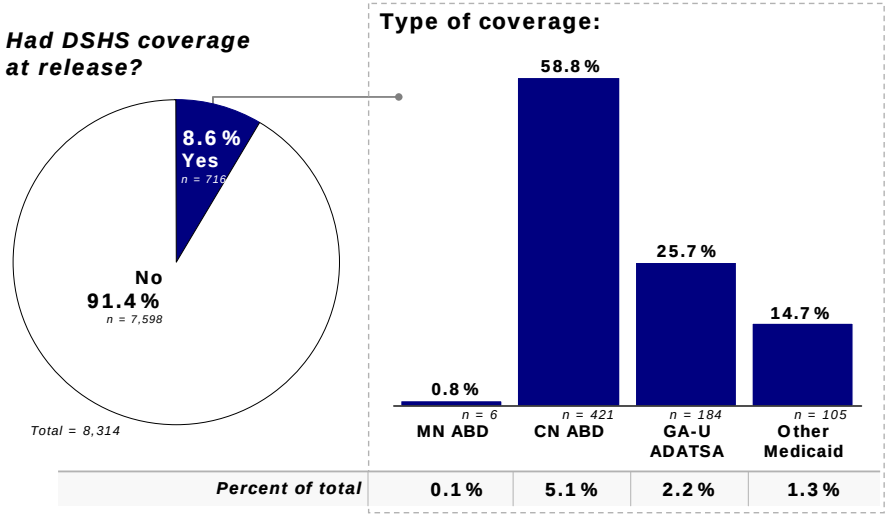


SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.

Jail and Prison Inmates Who Had DSHS Medical Coverage after Release

Upon release, one in nine persons released from DOC facilities in SFY 2005 had DSHS medical coverage (Figure 2-7). By far, the largest percentage (58.8%) of these 716 individuals received CN ABD coverage.

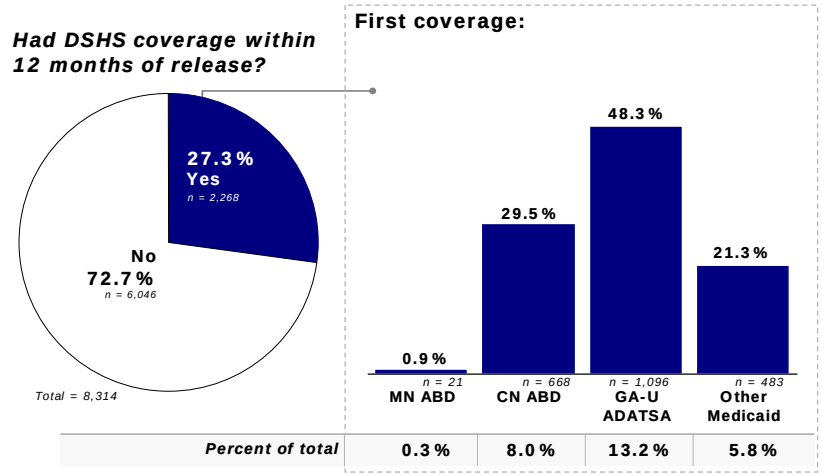
Figure 2-7. DSHS medical coverage within 1 month of release | SFY 2005 DOC Releases



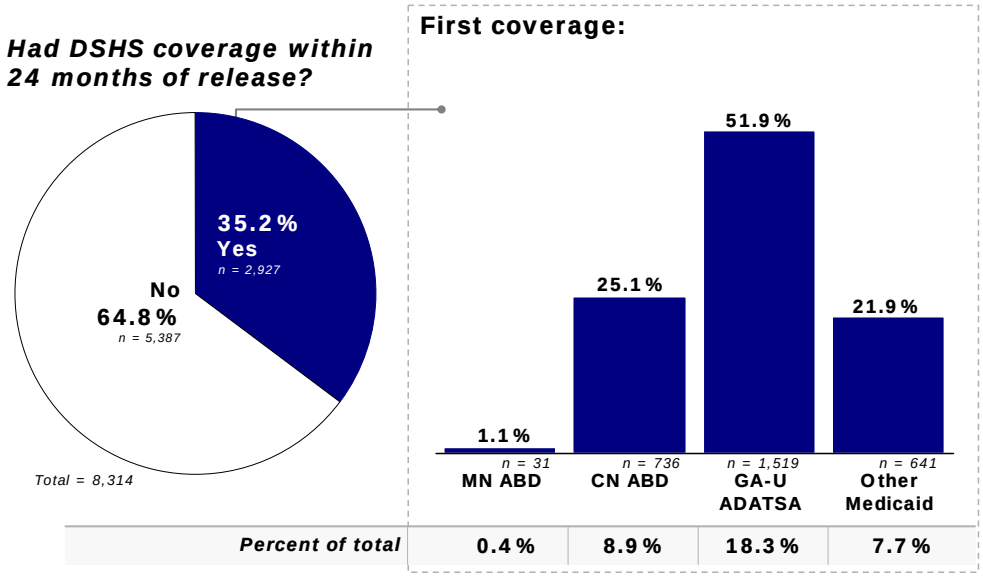
SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.

Within 12 months after release from a DOC facility, one in four people had DSHS medical coverage (Figure 2-8). Of these 2,268 individuals, 48.3% qualified for DSHS medical coverage through the GA-U or ADATSA program.

Figure 2-8. DSHS medical coverage within 12 months after release | SFY 2005 DOC Releases



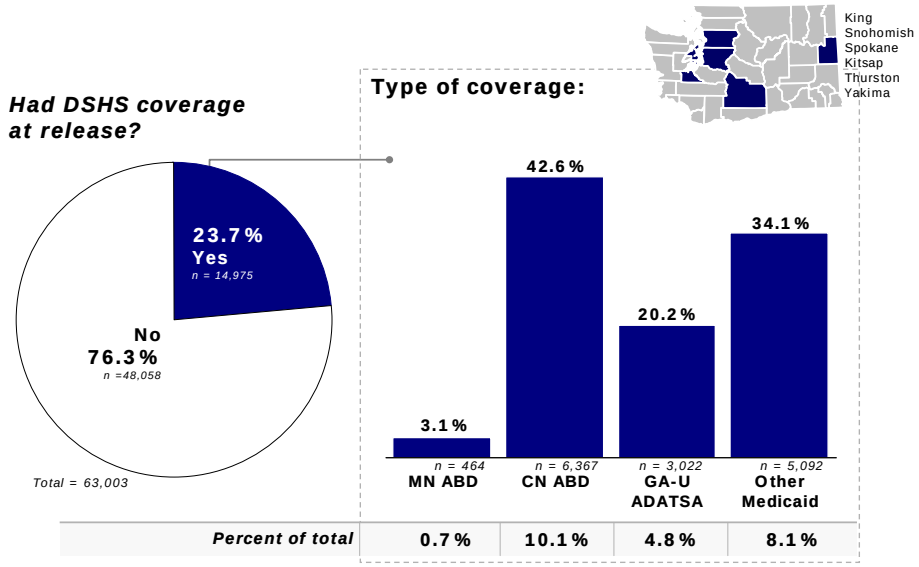
SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.



SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.

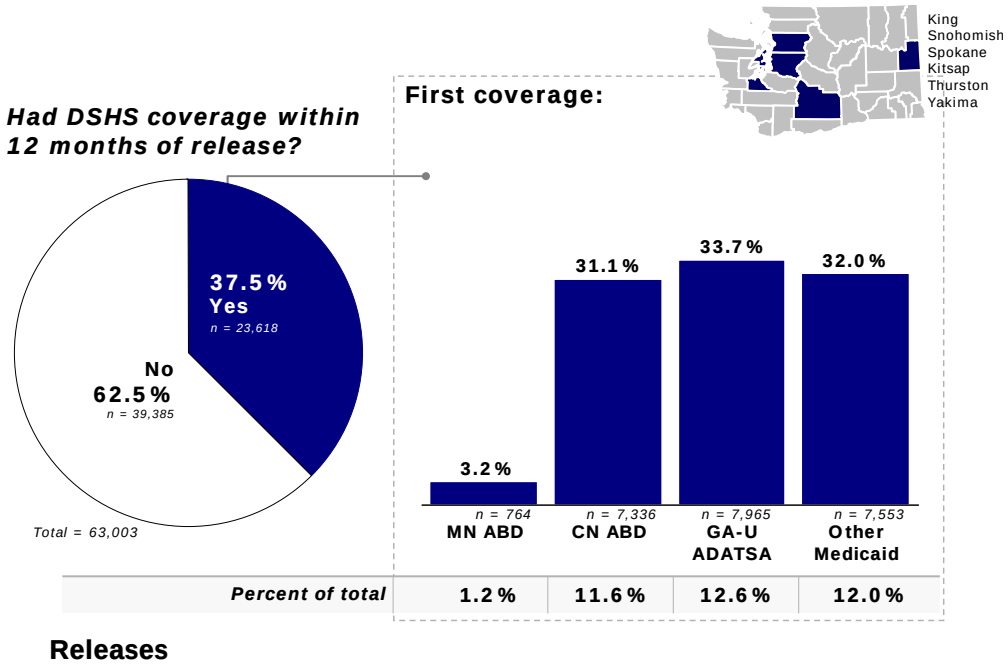
Within one month of release from local jails, almost one in four persons in SFY had DSHS medical coverage (Figure 2-10). Counties included are King, Snohomish, Spokane, Kitsap, Thurston, and Yakima. As with those releasing from DOC facilities, the largest percentage of the nearly 15,000 individuals who had DSHS medical coverage at the time of release from jail in SFY 2005 were those who qualified for CN ABD coverage (42.6%).

Figure 2-10. DSHS medical coverage within 1 month after release | SFY 2005 Local Jail Releases



SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.

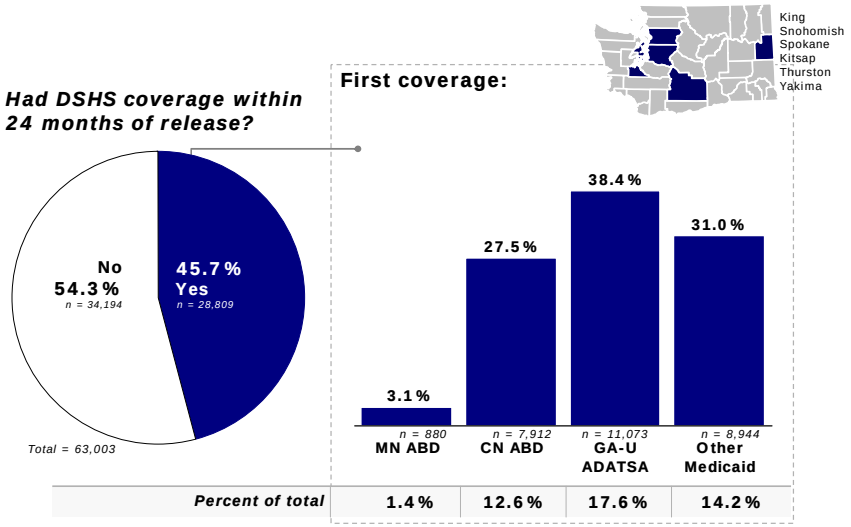
Within 12 months after release, one-third of those released from local jails in SFY 2005 had DSHS coverage



SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.

Within the two years after release from local jails, almost half had DSHS medical coverage (Figure 2-12). Counties included are King, Snohomish, Spokane, Kitsap, Thurston, and Yakima. Nearly 48% of these 28,809 individuals qualified for GA-U or ADATSA coverage.

Figure 2-12. DSHS medical coverage within 2 years after release | SFY 2005 Local Jail Releases



SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, June 2008.

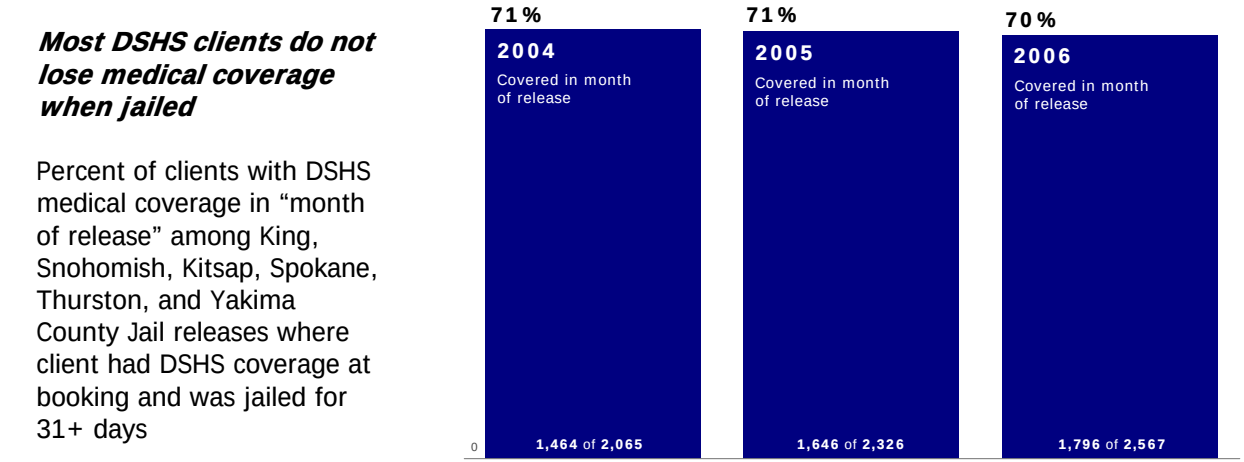
The conventional wisdom that most DSHS clients who are jailed for 31 or more days lose eligibility for DSHS medical coverage is inaccurate (Figure 2-13). In fact, most DSHS clients currently retain eligibility when they are jailed:

- Historically, 7 of 10 DSHS clients have retained eligibility when jailed for 31 days or more.
- DSHS eligibility workers may not know that a client has been jailed, which would make it unlikely that the jail stay would result in a break in eligibility unless it coincided with recertification.
- The chance that a client loses eligibility increases with length of stay.

Figure 2-13. DSHS medical coverage in month of release for those jailed for more than 31 days

Most DSHS clients do not lose medical coverage when jailed

Percent of clients with DSHS medical coverage in "month of release" among King, Snohomish, Kitsap, Spokane, Thurston, and Yakima County Jail releases where client had DSHS coverage at booking and was jailed for 31+ days



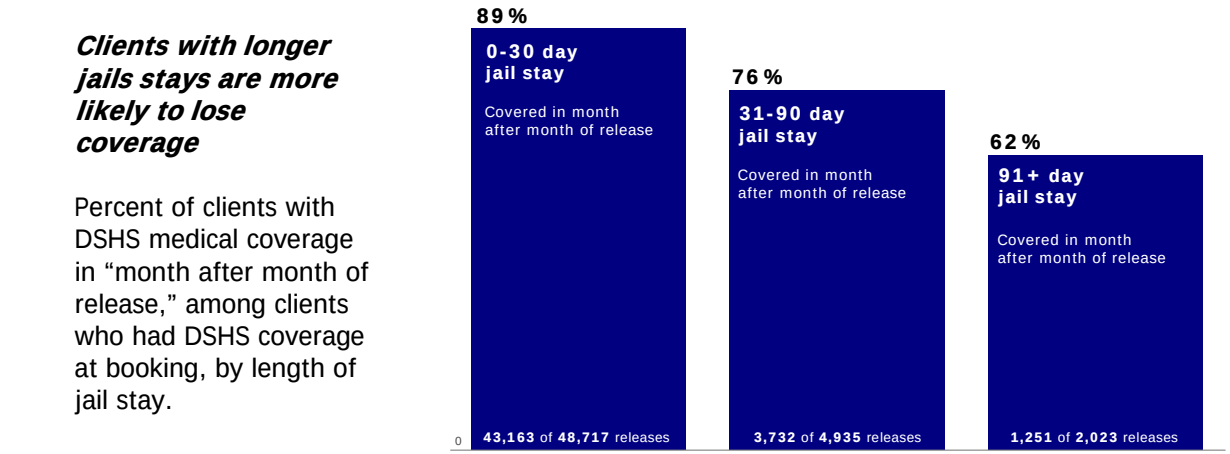
SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, December 2007.

Clients with longer jail stays are more likely to lose eligibility, but most still retain eligibility for DSHS medical coverage (Figure 2-14). The chart below represents coverage in 'month after month of release' among clients who had DSHS coverage at booking, by length of jail stay. Jail releases were from CY 2004 to CY 2006.

Figure 2-14. Impact of jail length of stay on DSHS medical coverage, CY 2004 to CY 2006

Clients with longer jails stays are more likely to lose coverage

Percent of clients with DSHS medical coverage in "month after month of release," among clients who had DSHS coverage at booking, by length of jail stay.



SOURCE: DSHS Planning, Performance and Accountability Administration, Research and Data Analysis Division, December 2007.

Communication Challenges

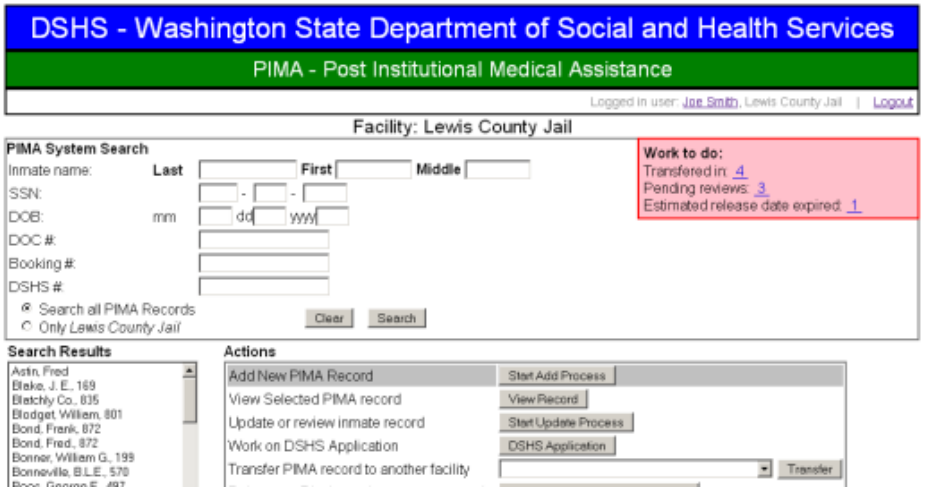
There is currently no single system for tracking admissions and releases to and from psychiatric hospitals, jails, prisons, juvenile institutions or juvenile detention facilities. The lack of an easily accessible, universal communication tool for all facilities was identified by the larger workgroup as a significant barrier to providing DSHS mental and medical health coverage to eligible individuals upon release from confinement.

As one workgroup member pointed out, DSHS cannot take the first step of suspending an otherwise eligible individual's medical coverage upon confinement if DSHS is not first aware that the individual has been confined. Likewise, eligibility cannot be reactivated after suspension if DSHS is not informed that the individual will soon be or has been released. DSHS cannot assist individuals who did not previously receive medical benefits but who may be eligible, if these people are not referred to DSHS for eligibility determinations and assessments. Sharing existing medical evidence from these facilities in a timely manner with DSHS eligibility staff enables them to link individuals with medical coverage when they are released from confinement.

After reviewing data regarding the number of DSHS clients admitted to and released from facilities, it become obvious to the Communication focus group members that using traditional telephone or email methods to communicate admissions, releases, referrals, and/or applications is not workable or practical. All agreed that a new, user-friendly communication system and process is needed which (a) is not time-consuming, (b) uses entry and release data to initiate suspension and reactivate eligibility, and (c) includes an electronic benefits application for those not known to DSHS but who may be eligible for benefits.

Based on these preliminary requirements, the group considered current research that recommends web-based communication tools as a best practice for facilitating re-connection with public benefits upon release from confinement. To assist the discussion, the following were developed: a screen mock-up (Figure 3-1) of the proposed Post Institutional Medical Assistance (PIMA) tool, a business flow diagram for potential interactions with the DSHS current Automated Client Eligibility System (ACES) (Figure 3-2), and an online DSHS medical "smart" application that poses questions based on individual responses and skips questions that are not applicable.

Figure 3-1. Screen Mock-up



As illustrated below in Figure 3-2, the PIMA tool would be designed to:

- Check individual's DSHS eligibility status in ACES upon entry to a facility;
- Suspend eligibility for individuals who received certain DSHS medical benefits coverage immediately prior to confinement, in order to prevent claims payments while confined, by sending notice to ACES;
- Send notice to ACES to terminate eligibility for individuals who received certain DSHS medical coverage benefits for which suspension is not an option;
- Track individuals as they move into and between facilities, and their anticipated release dates;
- Send notice to ACES to reactivate eligibility for individuals whose coverage was suspended upon confinement when they are released from the facility;
- Interface with ACES where feasible and/or send eligibility worker alerts and other case updates such as facility transfer information

For individuals entering an institution who did not have DSHS medical benefits coverage immediately prior to confinement or who received medical benefits through a DSHS coverage group for which suspension is not an option, the workgroup decided that it would be useful for PIMA to also:

- Ask five short questions intended to screen whether individuals are likely eligible for a DSHS medical program.
- Initiate a "smart" application (i.e., one which quickly guides applicants through the process based on individualized responses by skipping questions that are not applicable) if any of the five questions are answered "yes," and permit electronic signature of the application.
- Send the application to DSHS document management system (DMS) with an alert to the appropriate eligibility staff for further processing 45-60 days prior to release date[8]

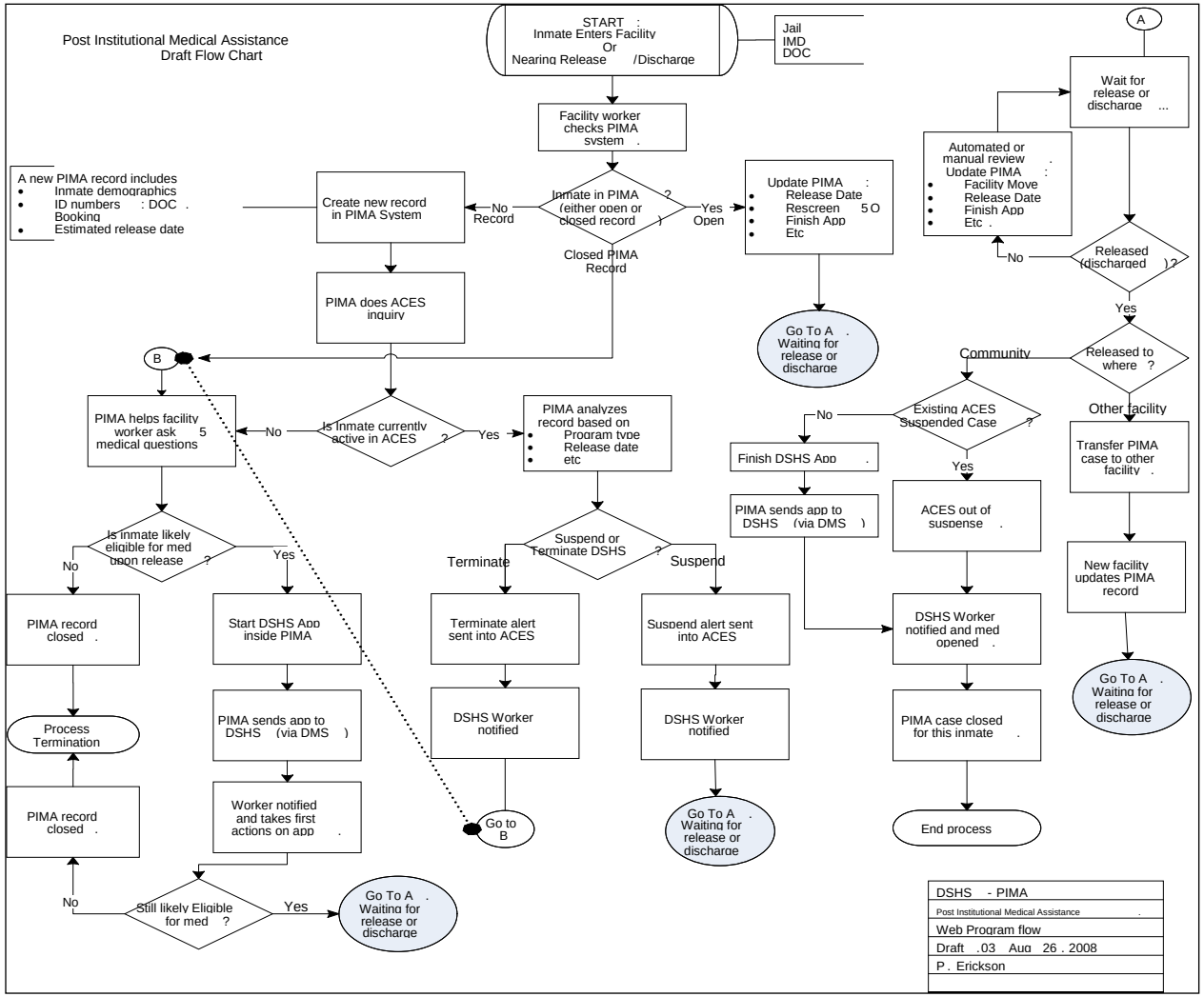
As a new system, PIMA must go through the normal software development lifecycle, including identification and definition of all business and technical requirements and then system design, development, testing, and implementation. Planning and development of the PIMA communication tool requires:

- Oversight by the Department of Information Services (DIS) and DSHS Information System Services Division.
- Coordination between two separate systems that would need to be modified: ACES and ProviderOne.

Who will use this Tool and how?

Staff at institutions, jails, and prisons whose responsibilities include admission and release are the intended users for the PIMA communication tool. The PIMA tool requires input at admission, transfer, and release. Key client demographic information is also required such as name, date of birth, Social Security number (if known), a DSHS client identification number, date of entry into the facility, and anticipated date of release.

Upon entry of this information, the PIMA tool would notify the user whether the person is an (1) active DSHS client, (2) former DSHS client, or (3) not known to DSHS. Subsequent processing steps in the PIMA system would depend on this initial identification (see Figure 3-2). To be a useful tool, individual's information in the PIMA system would require periodic updates when release dates change or there are transfers from one facility to another.



Interface with other Systems

The PIMA communication tool would also be designed to interface with various systems in order to support suspension, termination, re-activation, application, and/or re-application for DSHS medical benefits for confined individuals. Modification of those systems may be necessary to successfully coordinate with PIMA and effectively communicate information.

Since the number of persons entering and releasing from institutions is large, and release dates are often unpredictable in terms of length of stay, the PIMA communication tool would need to be designed to either automatically update DSHS eligibility or alert a DSHS case worker when new information is entered in PIMA. To do so, the PIMA tool would need to be connected with ACES. A web-based communication tool that interfaces with ACES and provides a certain level of automation is possible. This type of communication tool could send alerts to DSHS case workers via ACES, or—if clear business rules can be defined—go further by initiating ACES updates, such as address changes, suspension, and reactivation.

Washington Association of Sheriffs and Police Chiefs (WASPC) jail booking and reporting system may be a practical way to reduce manual entries and updates for jail staff. This would reduce the workload associated with keeping DSHS informed. It may also be useful for the PIMA tool to interact with the DOC prison system's database in the future. If possible, interfacing with JRA's Automated Client Tracking System (ACT) and the Juvenile Court System JUVIS (Juvenile Information System) may be helpful. These interfaces could significantly reduce the costs associated with manual staff updates to PIMA by eliminating double data entry.

Possible Next Steps

The PIMA communication tool is the cornerstone to successfully suspending and reactivating medical eligibility for DSHS clients and for determining eligibility for those who may be eligible prior to their release from institutions. Without this over-arching communication system, there is little likelihood that DSHS will be able to obtain information about entries, releases, suspension, reactivation, referrals, or applications in a timely fashion to ensure medical benefits eligibility determinations prior to release from confinement and to link eligible individuals with access to needed medical benefits coverage upon release. The workgroup acknowledges that PIMA training will be a significant component of developing this communication tool.

Legislation requiring institutions to use the PIMA data communication tool, as described above, may be necessary. Many workgroup members, including DOC and jail representatives, felt that uniformity, consistency, and, ultimately, effectiveness in communication can be achieved only if all facilities are mandated to use a single system. Otherwise, the communication between the facilities and DSHS regarding admissions, releases, applications, assessments, and/or reapplications may remain fragmented and unreliable. Committing to the PIMA communication tool increases the likelihood that eligible persons may receive DSHS medical coverage on release from confinement.

Legislation permitting electronic signatures on DSHS medical benefits applications would enable quicker and more efficient application processing. On-line applications are an integral part of the PIMA communication tool process for individuals who did not receive DSHS medical benefits coverage immediately prior to confinement.

Section IV. Suspending DSHS Medical Coverage Eligibility for Certain Populations

Suspension Considerations

Currently, eligibility for medical benefits for DSHS clients entering psychiatric institutions, jails, prisons, juvenile institutions, or juvenile detention facilities is terminated rather than suspended. This means that a new application for medical benefits must be completed before or when a former DSHS client is released from one of these facilities in order to help ensure post-release re-connection with needed benefits.

Rather than automatically terminating eligibility for DSHS medical coverage when DSHS clients are confined, the Suspension focus group spent several weeks examining the feasibility, benefits, and costs of suspending these clients' eligibility. A 2004 CMS Memorandum and ESHB 2687, Section 209 (28) served as the starting points for this extended discussion. CMS advised states not to terminate medical assistance eligibility for confined clients but to instead suspend their eligibility. For individuals who were not already eligible for coverage but who filed applications for Medicaid while confined, CMS directed States to timely process those applications prior to the applicants' release (see Figure 4-1 for the excerpted suspension language from the CMS memo[10]).

"...states should not terminate eligibility for individuals who are inmates of public institutions or residents of IMDs based solely on their status as inmates or residents. Instead, states should establish a process under which an eligible inmate or resident is placed in a suspended status so that the state does not claim FFP for services the individual receives, but the person remains on the state's rolls as being eligible for Medicaid (assuming the person continues to meet all applicable eligibility requirements). Once discharge from the facility is anticipated, the state should take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility. If an individual is not already eligible for Medicaid prior to discharge from the facility, but has filed an application for Medicaid, the state should take whatever steps are necessary to ensure that the application is processed in a timely manner so that the individual can receive Medicaid-covered services upon discharge from the facility..." (Appendix 4-1)

During the focus group discussions, many questions about suspension and eligibility requirements arose. For example, does suspension stop the certification period clock or must states conduct eligibility reviews at least once every 12 months as required by the United States Code of Federal Regulations (CFR) for Medicaid cases? A DSHS letter was drafted and sent to CMS asking for further clarification (see Appendix 4-2). CMS' response of November 3, 2008 states that "[t]he Agency must act in accordance with 42 CFR 435.916 by maintaining the annual redetermination requirements to review the conditions of Medicaid eligibility, such as age, income, marital status, and resources, to validate an individual's circumstances and continuing eligibility."

The suspension focus group decided that annual eligibility reviews, in accordance with the timelines currently required by federal rule for recertification of eligibility, should be completed for every individual whose eligibility for DSHS medical coverage was suspended. This is consistent with CMS' recent guidance, which indicates that stopping the clock on required certification periods during confinement is impermissible.

To avoid multiple, potentially costly re-certifications and re-assessments while DSHS clients are confined, the focus group also determined that suspension of eligibility will be available for those in certain identified DSHS medical coverage groups only when their expected period of confinement is 24 months or less.

Some focus group members expressed concern about DSHS clients who are confined to psychiatric institutions, jails, prisons, juvenile institutions, or juvenile detention facilities for very short periods and the impact that suspension or termination of eligibility for DSHS medical programs may have on the continuity of their coverage. Some suggested programming the PIMA communication tool in such a way that it can delay suspension or termination for the first 30 days of a DSHS client's confinement or until the end of the month/eligibility cycle during which a client is admitted—in the event that she or he is released before the 30 days are up or the end of the cycle. However, given the real-time capabilities of the PIMA communication tool described above, eligibility can be suspended or terminated immediately to ensure that any medical claims submitted to DSHS do not pay during the period of confinement, and suspended eligibility can be reactivated promptly upon release, based on the date of release entered into PIMA. For individuals whose eligibility was terminated upon confinement, a re-application process can be initiated by the PIMA system prior to the date of their anticipated release.

After much discussion, the suspension focus group concluded that suspending eligibility for DSHS clients who received coverage through certain medical programs is possible, although eligibility for those who receive medical coverage through the Medicaid Family Medical and Medicaid SSI-related with spenddown programs should be terminated on admission to a facility. See Table 4-1 below for more details about suspension or termination of eligibility by medical coverage program.

SUSPENSION OR TERMINATION OF ELIGIBILITY BY MEDICAL COVERAGE PROGRAM							
Client's Medical Program	Terminate eligibility and screen for expedited medical application prior to release	Suspend eligibility	Maintain financial eligibility and eligibility reviews	Incapacity review required every 3-6 or 12 months	Incapacity re-determined only if sufficient medical evidence is available	Assessments completed by doctors during suspension	Assessments completed by doctors for expedited medical applications
Medical Care Services GA-U [11]		X	X	X	X		X****
Medicaid GA-X and GA-D [12]		X	X	X		X	
Medicaid SSI Grant [13]		X***					
Medicaid SSI Related [14]		X	X			X	
Medicaid SSI Related with spenddown [15]	X *						X
Medicaid Family Medical (TANF related) [16]	X **						X
Children's Medical/*Apple Health for Kids* [17]		X	X				X*****

* Coverage for this medical eligibility group is terminated because there is a high likelihood that these individuals will not meet all applicable Medicaid eligibility requirements at release which could result in inappropriate use of Federal Financial Participation (FFP) if coverage is only suspended and then automatically reactivated. The Department may be able to re-determine eligibility with an expedited medical application and assessment prior to release.

** Coverage for this medical eligibility group is terminated because these individuals may no longer qualify for TANF on release from confinement, but the Department may be able to re-determine eligibility for this program or others with an expedited medical application and assessment prior to release.

*** Social Security Administration may terminate SSI coverage if the individual is confined longer than one year but will likely reinstate coverage at release. Although the reinstatement process may take several weeks, the risk of inappropriate use of FFP is low if the State suspends medical coverage at admission and reactivates it prior to SSA reinstatement of SSI.

**** If GAU coverage that was originally suspended is terminated because sufficient medical evidence for the required incapacity review is not available during confinement, the Department may be able to re-determine eligibility with an expedited medical application and assessment prior to release.

***** If a child ages out of *Apple Health for Kids (AHFK)* on reaching age 19 and has a disability, the Department may be able to determine eligibility with an expedited medical application and assessment prior to release.

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[11] Medical Care Services is a limited scope of care program financed by state funds and provided to general assistance (GAU) and ADATSA clients.

[12] Medicaid GA-X and GA-D is federally matched categorically needy scope of care medical assistance.

[13] Medicaid SSI Grant is federally matched categorically needy scope of care medical assistance for persons receiving SSI cash benefits through SSA.

[14] Medicaid SSI Related is federally matched categorically needy medical assistance for aged, blind or disabled person not receiving an SSI cash grant.

[15] Medicaid SSI Related with spenddown is federally matched limited scope of care medical assistance referred to as "medically needy" (MN) Medicaid.

[16] Medicaid Family Medical (TANF-related) is federally matched categorically needy medical assistance provided to families receiving TANF

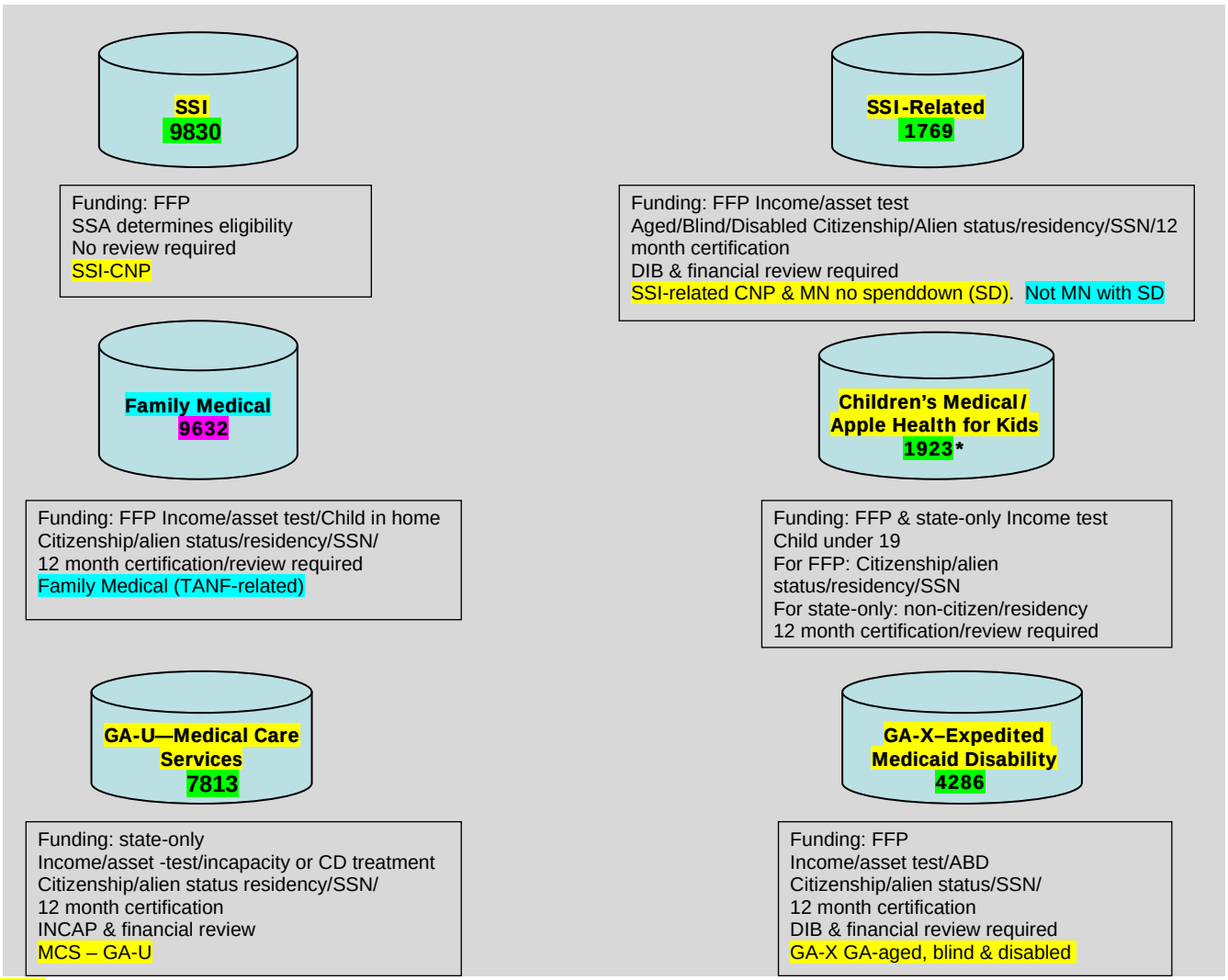
For Which Medical Coverage Programs is Suspension of Eligibility Feasible?

The Suspension focus group formulated a plan for suspending eligibility for several medical coverage programs. The group determined there is a low likelihood of inappropriately using of Federal Financial Participation (FFP) and state funding when suspending and reactivating eligibility for individuals in the following medical coverage groups:

- Supplemental Security Income (SSI)-eligible,
- Categorically Needy SSI-related and Medically Needy (MN) SSI-related without spenddown (not the SSI-related with spenddown cases which are few in number),
- Children's Medical/*Apple Health for Kids (AHFK)*,
- Medical Care Services for General Assistance—Unemployable (GA-U) and ADATSA, and
- General Assistance—Expedited Medicaid Disability (GA-X and GA-D).

Figure 4-2 illustrates the various DSHS medical coverage groups and the possibility for suspension or termination of eligibility for individuals within each group. The annual number of DSHS clients in each group for whom eligibility is expected to be suspended is also set forth. For example, it is anticipated that the eligibility for 9,830 Medicaid SSI clients will be suspended per year.

Figure 4-2. Impacted Medical Coverage Programs



Yellow	Highlighted Text	Low risk programs for suspension and appropriately claiming FFP
Green	Highlighted Number	Expected cases suspended per year (data from RDA)
Blue	Highlighted Text	High risk programs for suspension and inappropriately claiming FFP
Pink	Highlighted Number	Expected cases terminated per year (data from RDA)

*This figure does not include the number of children confined in county juvenile detention facilities

Table 4-2 below shows the annual number of DSHS cases in which eligibility is expected to be suspended, by facility type and medical coverage group. DSHS clients entering jails account for most of the individuals for whom eligibility may be suspended, and nearly all of those jail-confined clients fall in two medical coverage groups: SSI and General Assistance, including GA-X. Of the total 25,621 cases that may be suspended each year, 23,510 are from the jail population. Only 589 DSHS clients who enter DOC facilities are expected to be in a medical coverage program for which suspension of eligibility is an option.

Table 4-2. DSHS Medical Coverage Groups Selected for Suspension Anticipated Number of Eligibility Suspensions per Year by Facility Type (based on 2006 data)

	DOC/Prisons	Jails	MHD	JRA	Program Total
SSI	254	8816	648	112	9830
SSI-Related	28	1540	200	1	1769
Children/AHFK*	39	1426**	2	456	1923
General Assistance	186	7606	20	1	7813
GA-X	82	4122	82	0	4286
Facility Total	589	23510	952	570	**25621**

* These figures do not include the number of children confined in county juvenile detention facilities.

** Most of these children are anticipated to be 18 years of age. Children in jail comprise only 6% of the total number of anticipated jail bookings listed in this table.

Why Not Suspend Eligibility for TANF and Spenddown Cases?

Figure 4-2 above identifies the two medical coverage groups for which suspension of eligibility is too risky: Family Medical/TANF-related and Medically Needy (MN) spenddown cases.

Suspending rather than terminating and then simply reactivating such cases when these DSHS individuals are confined and then released could easily result in incorrect use of FFP and state dollars.

The following hypothetical situation illustrates why suspending eligibility for Family Medical/TANF-related clients entering a facility could be problematic:

- *A two-parent household has two children and receives Family Medical/TANF-related benefits.*
- *The head of household or non-head of household becomes incarcerated and eligibility for Family Medical/TANF-related benefits is suspended at admission/intake.*
- *The suspension of eligibility for the confined individual stops benefits for the entire household.*
- *The result is that there are no benefits available for the remaining members of the household.*

Due to various family situations, TANF cases require professional review and the expertise of a DSHS eligibility worker to determine how to protect benefits for those remaining in the household. A worker must decide if a new case needs to be opened, or if a household member can simply be removed without affecting benefits for the remaining household members. In single-parent households, children may end up in foster care or with a relative while the parent is incarcerated; therefore, new cases need to be created in these situations. Upon terminating the eligibility of a TANF client who is confined, the workgroup recommends that the PIMA communication tool immediately send an alert to a financial worker to act on the change in the family's circumstances so as not to harm the remaining household. When a release date is known, another alert may be sent to a financial worker to review the circumstances prior to the individual's release from confinement and to either add the person back to the household or take some other appropriate action.

MN spenddown cases are also too complex for suspension of eligibility to be a viable option. Eligibility for the MN with spenddown program is determined by base periods and income over the income limit. Base periods and spenddown amounts are calculated in three- or six-month periods, but base periods may end while DSHS clients are confined. If this happens, a new application and calculation of new base periods is required. Consequently, simply suspending and reactivating this type of DSHS medical coverage eligibility is not possible.

Figure 4-2 above indicates that eligibility for approximately 9,632 Family Medical/TANF-related cases and a very small number of MN spenddown cases will be terminated annually. The PIMA communication tool will prompt DSHS financial workers to initiate the expedited medical application process for these clients prior to their release. Since these clients were eligible for a DSHS medical program at admission to a psychiatric hospital, jail, prison, juvenile institution, or juvenile detention facility, they will likely be eligible again at release.

How Suspending and Reactivating Eligibility Works

At admission/intake to a psychiatric hospital, jail, prison, juvenile institution, or juvenile detention facility, a staff member will check PIMA for the admittee's DSHS status by entering the individual's demographic data into PIMA. PIMA will then indicate whether the individual is currently receiving DSHS medical benefits. If the individual has current DSHS medical coverage in a program for which suspension of eligibility is an option and will be released from confinement within 24 months, PIMA will suspend the client's eligibility and send ProviderOne a flag to stop claims payment for that client. The release date entered into PIMA will prompt ACES to reactivate the case at the appropriate time and give ProviderOne the data to permit the system to begin paying client claims as of the date the client is released from the facility.

Of the five DSHS medical coverage groups for which suspension of eligibility during confinement is an option, those who are eligible for MCS GA-U coverage will initially have their eligibility suspended upon admission to a facility, but then may later have it terminated if there is insufficient medical evidence available while confined to re-determine incapacity. If there is sufficient medical evidence available during confinement, the eligibility for clients in this DSHS medical program will remain suspended and will be reactivated upon release, as described above. However, if there is insufficient medical evidence available and eligibility is terminated for MCS GA-U clients, the PIMA tool will initiate the expedited medical application process prior to their release.

In contrast, eligibility for those in the Medicaid GA-X/GA-D and Medicaid SSI-related with no spenddown programs will remain suspended throughout confinement because medical assessments required re-determining disability will be conducted while they are confined and their eligibility is suspended. Likewise, children eligible for Children's Medical/*Apple Health for Kids* coverage will remain suspended throughout confinement unless they reach the age of 19 while still confined. Upon reaching the age of 19, a child's eligibility will be terminated unless he or she has a disability and DSHS is able to determine eligibility for an appropriate medical program with an expedited medical application and assessment prior to release.

Possible Next Steps

Savings may be realized as a result of using the PIMA communication tool to suspend a client's eligibility for certain DSHS medical coverage programs upon confinement, rather than simply terminating eligibility. For example, if a client's eligibility is suspended upon admission to a facility and his or her certification period does not expire prior to release from confinement, an eligibility review will not be necessary and the client's eligibility can simply be reactivated at release. However, if DSHS terminates the client's eligibility on admission to the facility instead of suspending it, an application and assessment is required to re-determine eligibility.

By deciding not to terminate eligibility for individuals eligible for certain DSHS medical coverage programs at the time of admission to a facility, the savings offset is a result of the difference in staff hours between processing applications, completing eligibility reviews, and conducting medical assessments versus using the PIMA communication tool to prompt ACES to reactivating eligibility. If a client's certification period expires during confinement, an eligibility review and, if necessary, medical assessment, will take place while the client is still confined; a new certification period will be calculated; and eligibility will again be suspended and then reactivated on release.

DSHS does not anticipate that legislation is required for DSHS to begin using suspension as the medical assistance management tool for institutionalized and incarcerated clients.

Section V. Completing Medical Assessments Prior to Release

Of the three feasibility study focus groups, the one for Incapacity/Disability Assessments faced a more daunting challenge: How to complete medical assessments prior to release from confinement for those individuals who (1) fall into a medical coverage group for which suspension of eligibility is not an option, (2) require recertification while DSHS medical benefits eligibility are suspended, or (3) were not receiving DSHS medical benefits at the time of admission to a facility but who may be eligible for medical coverage upon release? As was found by the HB 1290 Workgroup, the availability of sufficient objective medical evidence prior to release has historically been a barrier to expediting DSHS medical benefits determinations for confined individuals, especially those who are incarcerated.

Experience from the HB 1290 expedited application process prior to release for confined individuals with mental health disorders who are likely eligible for DSHS medical benefits has highlighted difficulties related to varying medical evidence requirements for determining eligibility for various DSHS medical benefits programs, along with different certification periods and the timing of required assessments. The availability of medical assessments necessary for eligibility determinations may vary by not only by DSHS medical coverage program types but also by the type of facility where potentially eligible individuals are confined because certain DOC facilities may have more medical and mental health professionals available to perform assessments than other DOC facilities and/or county jails. Even when medical care is provided while individuals are confined and medical evidence is available, DSHS eligibility staff may encounter difficulties accessing that information.

The type of medical or mental health professionals who may perform the necessary medical assessments has also presented a barrier to expediting medical assistance applications. For example, the Regional Support Network (RSN) has limited resources to provide medical documentation and evaluations from master's level mental health professionals. Mental health assessments by these practitioners may provide sufficient medical evidence to determine eligibility for certain medical programs but not others.

Requirements for Determining Incapacity or Disability for GA-U

Objective medical evidence of a physical or mental health incapacity or disability is required to determine eligibility at application and review for the DSHS General Assistance—Unemployable (GA-U) program, which provides state-funded medical coverage. In order to be eligible for the GA-U program an individual must have a documented mental or physical incapacity that keeps him or her from performing substantial work for at least 90 days.

Medical evidence may be accepted from a broad range of health professionals[18] when determining eligibility for GA-U rather than GA-X, but the GA-U program offers only the Medical Care Services (MCS) scope of benefits. MCS provides limited medical coverage, which does not include outpatient mental health benefits. In contrast, individuals whose disability is expected to last longer than twelve months are presumed to be going onto SSI and are eligible for General Assistance—Expedited Medicaid (GA-X), a separate state- and federal-funded program that provides full-scope categorically needy (CN) coverage.

Requirements for Determining Disability for SSI and GA-X

An estimated 44 percent of incapacitated GA-U recipients also meet SSI disability criteria. According to these criteria, "…an individual shall be considered to be disabled if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve month…"[19]

[18] E.g., a physician, medical doctor, doctor of osteopathy, doctor of dental surgery or doctor of medical dentistry, advanced registered nurse practitioner, physician assistant, etc. (see WAC 388-448-0020 for a more complete list, which also includes those who may provide supplemental supporting medical evidence) may provide the required medical evidence.
[19] 42 USCS 1382c(a)(3)(A)

Clients meeting these criteria typically receive General Assistance Expedited Medicaid (GA-X). GA-X benefits include SSI facilitation, Medicaid eligibility, and mental health services; however, unlike GA-U incapacity determinations, GA-X approvals for physical or mental health disabilities can be determined only by a physician or psychologist who must certify that an individual's condition is likely to meet SSI disability criteria[20].

Streamline Application Process and Reduce Duplication of Efforts

Since the issuance of DSHS medical assistance benefits for all eligible applicants continues to be the primary goal of medical benefits suspension and expansion of the expedited application process, the focus group concluded that all medical assessments for confined DSHS clients and applicants who meet financial eligibility criteria should follow the Division of Disability Determination Services (DDDS) consultative examination standards. These include the following:

- Performed by a licensed physician or psychologist
- Presented in a typed narrative format
- Includes a review of all available medical evidence
- Payment based on DDDS consultative exam rates of $180 - $203
- Allow for travel paid at DDDS compensation rate of $48 an hour

This approach ensures medical information that:

- Meets incapacity and disability criteria for different program eligibility categories
- Streamlines the application process
- Supports SSI approvals at initial determination
- Reduces duplication of effort between CSD and DDDS
- Allows GA-U applicants, who meet SSI disability criteria, to be approved for GA-X at application and provide solid medical documentation required for a SSI determination.

Completion of Assessments Prior to Release

The available medical and mental health staff that may perform assessments which meet DDDS standards for consultative exams varies by facility type and location. This was cited by some members of the focus group as a barrier to obtaining medical assessments and expediting the DSHS medical application process while individuals are still confined. To address this, the group proposed using onsite staff, in facilities where they are available; contracting with outside medical and mental health professionals to go to the facilities; and/or using communication technology, such as telemedicine capabilities that many DOC facilities may already have[21], to complete the assessments. Instituting DDDS standards will require additional documentation for more people, space for exams at the facilities, and allocation of additional travel costs for those practitioners who are not located onsite.

Assessments will be completed during confinement for individuals whose DSHS GA-X medical coverage eligibility was suspended at admission when assessments are required for recertification of eligibility. For those who are potentially eligible for DSHS medical coverage[22], assessments will be completed as part of the expedited application process prior to release.

Application and recertification of incapacity/disability-related DSHS medical benefits for those confined in Department of Corrections (DOC) facilities, county jails, state psychiatric hospitals, juvenile institutions, or juvenile detention facilities require medical assessments. The following estimates[23] are based on release data compiled by RDA and the current 60 percent approval rate for eligibility for incapacity/disability-related DSHS medical benefits.

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[20] Ongoing treatment for these individuals does not have to be provided by a physician or psychologist, but GA-X assessments must be completed by them.

[21] Recent budgetary decisions may constrain DOC's ability to utilize telemedicine during this pilot project.

[22] Including those whose eligibility was terminated at admission; GA-U clients whose eligibility was initially suspended but was then terminated during confinement, due to insufficient available medical evidence for re-certification; and children who may have reached the age of 19 during confinement.

[23] The data presented in this section were not available for juvenile institutions or juvenile detention facility populations.

DOC Applications and Recertification

DSHS anticipates receiving 3,668 applications annually from individuals confined in DOC facilities who may potentially be eligible but who did not receive DSHS medical benefits prior to confinement. This is based on data about disability-related DSHS medical benefit approvals within 24 months of release from DOC for those with no prior DSHS coverage. In contrast, DOC estimates that 2,742 potentially disabled inmates may apply for DSHS medical benefits through the expedited medical application process prior to release, but this number does not include inmates who may meet the less stringent GA-U incapacity criteria. If eligibility for DSHS medical benefits is suspended rather than terminated for those admitted to DOC facilities, an additional 268 inmates are estimated to need medical assessments or evaluations for recertification in the first year. The number of DSHS clients for whom eligibility will be suspended when entering DOC facilities will likely increase over time with a proportionate decrease in initial applications and assessments through the expedited medical application process.

As part of the application process for the GA-U and GA-X DSHS medical programs, medical evidence is required. In DOC facilities, this evidence may be gathered by onsite staff practitioners or those who are contracted on an as-needed basis. However, although health care may be provided to inmates while they are confined, focus group members identified limited access to those facility medical records by DSHS eligibility staff as a barrier to obtaining the required medical evidence.

County Jail Applications and Recertification

DSHS anticipates receiving 7,390 applications annually from individuals confined in county jails who may be eligible but who did not receive DSHS medical benefits prior to confinement. This is based on data of disability-related DSHS medical benefit approvals within 24 months of release from county jails for those with no prior DSHS medical coverage. If eligibility for DSHS medical benefits is suspended rather than terminated for those admitted to jails, an estimated additional 224 inmates will need medical assessments for recertification in the first year. The number of DSHS clients for whom eligibility will be suspended when entering jails will likely increase over time with a proportionate decrease in initial applications and assessments through the expedited medical application process.

County jails may have access to medical records for these suspended and potentially eligible individuals, but these records often do not provide adequate medical evidence to make a disability determination, they may not meet the requirement of “current” medical evidence, and they may not have been provided by a medical or mental health professional who meets the DDDS consultative exam standards.

Psychiatric State Hospital Assessments

DSHS anticipates receiving 515 medical benefits applications annually for individuals confined in state psychiatric hospitals who did not received DSHS prior to institutionalization but who are identified by staff as incapacitated or disabled. This estimate is based on data of DSHS medical benefits application approvals for this population within 24 months of discharge. Since these DSHS expedited medical benefit application assessments will be performed by experienced qualified medical professionals, applicants from these facilities will likely meet incapacity or disability criteria and be determined eligible for DSHS medical benefits prior to release.

Chart notes will likely be available and adequate to determine ongoing incapacity/disability for those institutionalized clients whose eligibility was suspended on confinement. Assessments by DSHS during confinement should not be necessary for ongoing incapacity/disability determinations and recertification for these clients.

Total Assessments

An estimated 12,065 assessments, excluding those that may be required in juvenile institutions or juvenile detention facilities, will be performed in the first year of implementing the proposed model for suspending DSHS medical benefits eligibility for confined clients and expanding the expedited medical application process prior to release (Table 5-1).

Table 5-1. Anticipated Number of Annual Assessments by Facility Type

ANTICIPATED NUMBER OF ANNUAL ASSESSMENTS BY FACILITY TYPE*			
Facility Type	Application Assessments	Recertification Assessments	Total By Facility Type
Department of Corrections	3,668	268	3,936
Jails	7,390	224	7,614
Psychiatric Hospitals	515	0	515
TOTALS	11,573	492	12,065

*The data presented in this section were not available for juvenile institutions or juvenile detention facility populations.

Possible Next Steps

Legislation may be required which permits DSHS and/or the facilities to contract for professional-level medical and mental health assessments that can be conducted while the applicant/client is confined.

The additional documentation required for consultative exams that meet DDDS standards and increased travel requirements may necessitate higher compensation rates in order to recruit qualified medical professionals to perform medical assessments for confined applicants and recipients.

Section VI. Implementation Options and Cost Estimates

Overview of Possible implementation Plan and Costs

Based on lessons learned from the HB 1290 and HB 1088 experiences along with available data, the feasibility workgroup determined that suspending DSHS medical benefits eligibility and expanding the expedited medical benefits application process for confined individuals prior to release is possible. The workgroup developed a potential 5-phase model for accomplishing these objectives. However, the model presented here and the systems to support it require time for development, testing, piloting, and training. DSHS, psychiatric hospitals, DOC/prisons, jails, juvenile institutions, and juvenile detention facilities must “get it right” when serving this population, and ultimately, the communities in which these individuals live and work.

To this end, the workgroup suggests the following five phases and timelines for implementation:

- As the cornerstone to the success of this project, the PIMA communication tool with all its automated features and potential for interfaces with institution, jail, and prison inmate tracking systems must first be developed.
- The second and equally important phase involves determining whether suspension of eligibility works as planned. Piloting suspension in a mid-sized facility gives an opportunity for live testing, training, and system adjustments as needed.
- Expanding the suspension of DSHS medical benefits eligibility throughout the entire state is the third phase. This will impact more than 25,000 clients per year, reduce the burden of application processing for DSHS for individuals who were already determined eligible and better serve our clients by ensuring greater continuity of medical coverage. Because psychiatric hospitals, prisons, jails, juvenile institutions, and juvenile detention facilities will likely need time to become familiar with this new process, implementation of phase three may require up to six months or more.

- Phase four involves one of the more difficult and costly aspect of meeting this proviso's goals: conducting disability/incapacity assessments and eligibility determinations while a DSHS client whose eligibility is suspended or a potentially eligible DSHS client is confined. The workgroup suggests piloting the proposed assessment process in a mid-sized facility beginning six months after implementation of statewide suspension.
- Phase five, the most costly and challenging phase of implementation, involves broader contracting for professional level medical assessments statewide and perhaps using new, innovative technology such as telemedicine. Both require adequate time for developing the resources necessary for success. The workgroup recommends waiting twelve months after implementing statewide suspension to implement statewide assessments and expedited applications.

This phased-in approach and the cost estimates associated with each phase are discussed in further detail below. Gradual implementation will provide sufficient time to develop a sophisticated communication tool that interfaces with ACES and ProviderOne, to pilot suspension of medical eligibility and in-facility assessments, and then go statewide with a new, comprehensive approach to the management of medical eligibility for the confined and likely eligible population as directed by the ESHB 2687 Budget Proviso.

Estimated costs associated with the various phases were provided by each stakeholder agency and DSHS administrations. Included below are the costs associated with:

- Developing a communication tool.
- The use of that tool by staff at psychiatric hospitals, DOC facilities, jails, juvenile institutions, and juvenile detention facilities.
- Suspending eligibility for DSHS clients who receive coverage through certain medical programs on entry to a facility.
- Caseload growth in the number of individuals who may be potentially eligible for DSHS medical benefits.
- Reapplication for individuals whose DSHS medical coverage eligibility was terminated at admission to a facility, such as those who received Family Medical/TANF-related coverage.
- Assessments.
- A limited interim pilot project with DOC.

More detailed data is contained within several spreadsheets that can be viewed in the Section VI appendices.

Phase I: Development of the PIMA Communication Tool

The first step toward implementing a model that facilitates suspension of DSHS medical coverage eligibility and expansion of the DSHS expedited medical application process prior to release from confinement is development of an easy-to-use, timely communication tool. Development of the PIMA communication system requires a full needs assessment and establishment of specific business rules and parameters. ACES and ProviderOne will interface to prevent claims payment when PIMA sends notice that eligibility for a confined DSHS client should be suspended or terminated. Both ACES and ProviderOne will require modification in order to do so, and this effort must be coordinated between the three systems.

Costs for developing PIMA are estimated in terms of time and capacity within existing resources. DSHS technology programming services are contracted, and technology projects, such as ACES and ProviderOne, compete for programming hours based on a prioritization schedule by importance to the Department. ACES programming requirements are estimated in quarterly release cycles, and ProviderOne uses programming hours as a way of articulating costs.

ESA ITS estimates that development of the PIMA communication tool in coordination with ACES will require approximately four quarterly release cycles. These include:

- Two quarterly release cycles to gather business requirements, business rules, and design of the system

- Two quarterly release cycles for programming and testing of PIMA

ProviderOne must stop claims from processing when the ACES interface provides client eligibility suspension data. This ACES notification to ProviderOne will stop claims from processing for suspended cases. ProviderOne estimates programming costs to develop this capability at about 400 programming hours for design and collaboration with ESA ITS.

ProviderOne, which is currently under development, cannot accept requests for changes to the system until six months after it is implemented. At this time, it is estimated that ProviderOne may be implemented during summer 2009. It is anticipated that the PIMA tool could be fully developed by January 2010 or later depending on competing interests for programming time.

Table 6-1. Total Phase I Estimated Time for PIM Design and Implementation

ACES estimated	Two quarters to develop business requirements and rules, and to design the system. Two quarters for programming and testing the PIMA tool and ACES suspension functionality.
ProviderOne estimated	Four hundred programming hours for design and ACES collaboration.

Phase II: Thurston County Jail Suspension Pilot

The second phase of implementation involves pilot testing the concept of suspending DSHS medical benefits eligibility for confined individuals who receive coverage through certain medical programs that are deemed low-risk for inappropriately using FFP. Thurston County Jail is a mid-sized jail facility and its staff has an already-established, collaborative working relationship with DSHS. These factors and its close proximity to the agency stakeholders involved in this endeavor make it an ideal site to pilot eligibility suspension. It is anticipated that this pilot project could be implemented upon completion of PIMA and ProviderOne programming.

A six-month eligibility suspension pilot project in Thurston County Jail, if implemented, would cost the jail an estimated $44,325[24] for jail personnel to enter admission and release data into the DSHS PIMA system. After these data are entered into PIMA, ACES will be notified and eligibility suspended for the estimated period of confinement.

ESA estimates the costs of maintaining suspended medical coverage eligibility for DSHS clients confined in Thurston County Jail at $ 4,000 to fund the .07 FTEs needed for case maintenance including financial eligibility and SSI facilitation.

Table 6-2. TOTAL COMBINED PHASE II SUSPENSION ESTIMATES

Thurston Co Jail Suspension Pilot staffing PIMA communication tool	44,325
ESA estimated costs of maintaining suspended medical coverage eligibility reviews	4,000
Total of estimated costs	**48,325**

Phase III: Statewide Suspension of DSHS Medical Eligibility upon Confinement

Statewide suspension of DSHS eligibility upon admission to state psychiatric hospitals, prisons, jails, juvenile institutions, and juvenile detention facilities could be implemented six months after the start of the Thurston County Jail pilot project assuming that the pilot is successful and encounters few or no start-up issues. The annual estimated costs of using the PIMA communication tool to determine whether an admitting individual is currently receiving DSHS medical coverage, to enter admission and release data into the PIMA system, to use the PIMA system to track transfers of individuals while they are confined, to maintain suspended eligibility in the ACES system, and/or to perform eligibility reviews are presented for Juvenile Rehabilitation Administration (JRA), Economic Services Administration (ESA), Department of Correction (DOC), and county jails.

[24] Thurston County Jail estimated the annual cost of checking all jail admissions with PIMA for active medical coverage at $88,650. The estimated dollar amount of $44,325 represents costs for a six month pilot and translates to approximately 2 FTEs.

Table 6-3. Total Combined Phase III Statewide Suspension Estimates

JRA estimated annual suspension costs	14,535
ESA estimated annual suspension costs	304,000[25]
DOC estimated annual suspension costs - admissions	189,471
DOC estimated annual suspension costs - transfers	302,467
Jails[26] estimated annual suspension costs-admissions & releases	2,332,894
Total of statewide suspension estimates	**$ 3,143,367**[27]

Phase IV: Thurston County Jail Pilot for Assessments Prior to Release

Assuming that implementing eligibility suspension statewide is successful, a pilot project for expanding the HB 1290 expedited application process and supporting the suspension process by completing incapacity and disability assessments prior to release from confinement could be initiated as soon as statewide suspension is operating as planned. Assessments are needed prior to release for those DSHS clients whose eligibility was terminated upon confinement, for individuals not known to DSHS at confinement but who may potentially be eligible due to medical or mental health issues, and for GA-U clients whose eligibility was initially suspended at admission to a facility but then later terminated because there was insufficient medical evidence available for recertification. Assessments may also be needed by DSHS GA-X clients whose eligibility is suspended but who may require recertification during confinement in order to comply with CMS guidance and federal regulations.

Conducting medical and mental health assessments for those who may be eligible prior to release from confinement and those whose eligibility was suspended upon confinement will require contracting with licensed physicians and psychologists. Preparing for this phase and planning for future statewide implementation of assessments prior to release will be the most challenging element of this project. To support these challenges, a twelve month pilot should be considered.

Also included with the costs of implementing a pilot project for assessments prior to release in Thurston County Jail are the ongoing costs of statewide suspension.

Table 6-4. Total Phase IV Costs for Thurston County Jail Pilot Project for Expanded Assessments Prior to Release

JRA estimated annual costs	14,535
ESA estimated pilot costs, including total cash and case maintenance	3,059,931[28]
ESA estimated annual costs of suspension statewide	304,000
DOC estimated annual costs of suspension statewide	491,938
Jails estimated annual costs of suspension statewide	2,332,894
Jails estimated pilot assessment costs	88,650
TOTAL COMBINED PHASE IV COSTS	**$ 6,291,948**

Phase V: Suspensions and Assessments Statewide

Upon completion of the assessment pilot, statewide implementation of assessments for confined individuals will be the last and final phase-in effort. Depending on the start date for the PIMA development and implementation, a fully phased-in program should be possible within two to three years, depending on the length of the pilots, the difficulties that could arise, and other competing factors. The estimated annual cost associated with this phase provides a comprehensive picture of the cost of managing medical eligibility for DSHS clients whose eligibility is suspended during confinement and those who may potentially be eligible for DSHS medical coverage prior to release.

[25] This figure includes the annual costs of 3.47 FTEs needed for case maintenance, including financial eligibility determination and SSI facilitation.

[26] Thurston County Jail (DSHS pilot preference) represents about 3.8% of the average daily jail population in the state (based on CY 2005 data from WASPC). When TCJ's costs are extrapolated to the entire state, the annual estimated cost for jails for jails to provide admission and release data to DSHS using the recommended communication tool PIMA is $4,665,842.

[27] This estimate does not include potential costs to HRSA resulting from caseload growth attributable to the quicker suspension/reactivation process rather than the longer termination/re-application process.

[28] This figure includes payments for psychological and medical assessments, cash benefits to clients after release, and the 6.58 FTEs needed for completion of initial applications and case maintenance.

Table 6-5. Total Phase V Costs of Suspensions and Assessments Statewide

JRA	14,535
ESA	26,574,043[29]
DOC	1,742,687
JAILS	4,665,842
HRSA[30]	156,163,353
TOTAL ESTIMATED COST FOR STATEWIDE SUSPENSION & ASSESSMENTS IMPLEMENTATION	**$189,160,460**

Limited Interim Pilot Project in a DOC Facility

Due to the time and resources required to develop the PIMA communication tool and implement the medical assistance eligibility suspension process, some workgroup members discussed the possibility of implementing a more limited, six-month DOC pilot project in the interim which expands on the expedited application and assessment process set forth in HB 1290, utilizes a new medical evidence template developed by ESA, and uses telemedicine when available and appropriate. This proposed interim pilot project does not include the essential broad-based communication tool or suspension of DSHS medical benefits eligibility for confined individuals.

The expanded HB 1290 process that will be tested during this pilot project includes determining eligibility not only for those individuals who were previously DSHS clients and have mental health disorders but also for those who (1) may likely be eligible and/or (2) may have incapacity or disability issues other than or in addition to a mental health disorder. The medical evidence template that will also be tested during this DOC pilot project is designed to help health care professionals uniformly capture the information necessary to make incapacity or disability determinations for confined individuals prior to release. When there is a need for it and if equipment and other necessary resources are available[31], telemedicine may also be used in this pilot project to test its feasibility and usefulness with the expanded 1290 assessment process. Most assessments in this DOC pilot project will presumably be conducted by on-site health care professionals but telemedicine could be appropriate in certain circumstances, such as when additional information is required.

This pilot project is a stand-alone option independent of the five implementation phases outlined above. However, lessons learned from this pilot could be used to more fully develop the proposed full implementation plan. For example, the new medical evidence template or telemedicine could later be used in Phases IV and V described above if they are found to be useful in this DOC pilot project.

A DOC facility, such as the Washington Corrections Center for Women (WCCW) located at Purdy, Washington, that has already implemented the HB 1290 process was recommended by DOC as a pilot site rather than a county jail as outlined in Phase IV above. This is because some DOC facilities:

- Employ on-site health care professionals,
- Have already established relationships and smaller scale communication methods with local CSOs as part of the HB 1290 process,
- May be equipped with telemedicine capabilities, and
- Have a more stable inmate population.

[29] This includes payments for psychological and medical assessments, cash benefits to clients after release, and the 72.01 FTEs needed annually for completion of initial applications and case maintenance.

[30] First year HRSA costs for anticipated caseload growth resulting from assessments that find additional individuals eligible for DSHS medical programs. The estimated cost in the second year of implementation is $444,464,927, based on the estimated number of individuals assessed who are deemed medically eligible on release from confinement. See Section VI appendices for detailed data.

HRSA Caseload Growth Assumptions and Costs:

- Includes only estimates for the program costs of covering individuals who were not receiving DSHS medical coverage prior to incarceration (excluding TANF).
- Does not include any estimated costs for clients who received DSHS medical coverage prior to incarceration.
- Does not include any estimated administrative costs.

[31] Recent budgetary decisions may constrain DOC's ability to utilize telemedicine during this pilot project.

As a result, it may be possible to more quickly and easily implement an expanded expedited application/assessments pilot project at a DOC facility such as WCCW. In addition, because the PIMA communication tool was identified by workgroup members as an essential component for expanding the expedited application and assessment process in jails, this alternative DOC pilot project is proposed as a precursor to the full implementation plan of Phases I through V (and, specifically, Phase IV which involves pilot testing expanded assessments in a county jail) until that tool becomes available. This interim pilot project could be implemented in a selected DOC facility as early as July 1, 2009.

Associated with a small pilot of this nature are the costs of:

1) Additional DOC assessments for qualifying inmates under the expanded HB 1290 process.
2) ESA's duties related to:
   (a) Expedited application processing beyond the current HB 1290 caseload,
   (b) Maintaining that additional caseload, and
   (c) Paying cash benefits to these additional individuals throughout the six-month pilot period.

(See Appendix 6-4).

ESA's costs include making eligibility determinations based on the medical evidence that is supplied using the new template. Further, ESA costs assume a 60% application approval rate, or a total of 42 (23 GA-U and 19 GA-X) eligible individuals out of 70 applicants.

DOC cost estimates are for a six-month pilot project at WCCW, which includes performing an additional 70 incapacity/disability assessments for those inmates who may likely be eligible upon release under this expanded HB 1290 pilot project. WCCW will not need to contract with health care providers outside the facility and can adjust current staffing to accommodate additional workload for this pilot project. It should be noted that these estimated DOC costs are specific to WCCW and are not generalized to other DOC facilities, due to current staffing levels.

Table 6-6. Estimated Costs of Limited Interim DOC Pilot Project

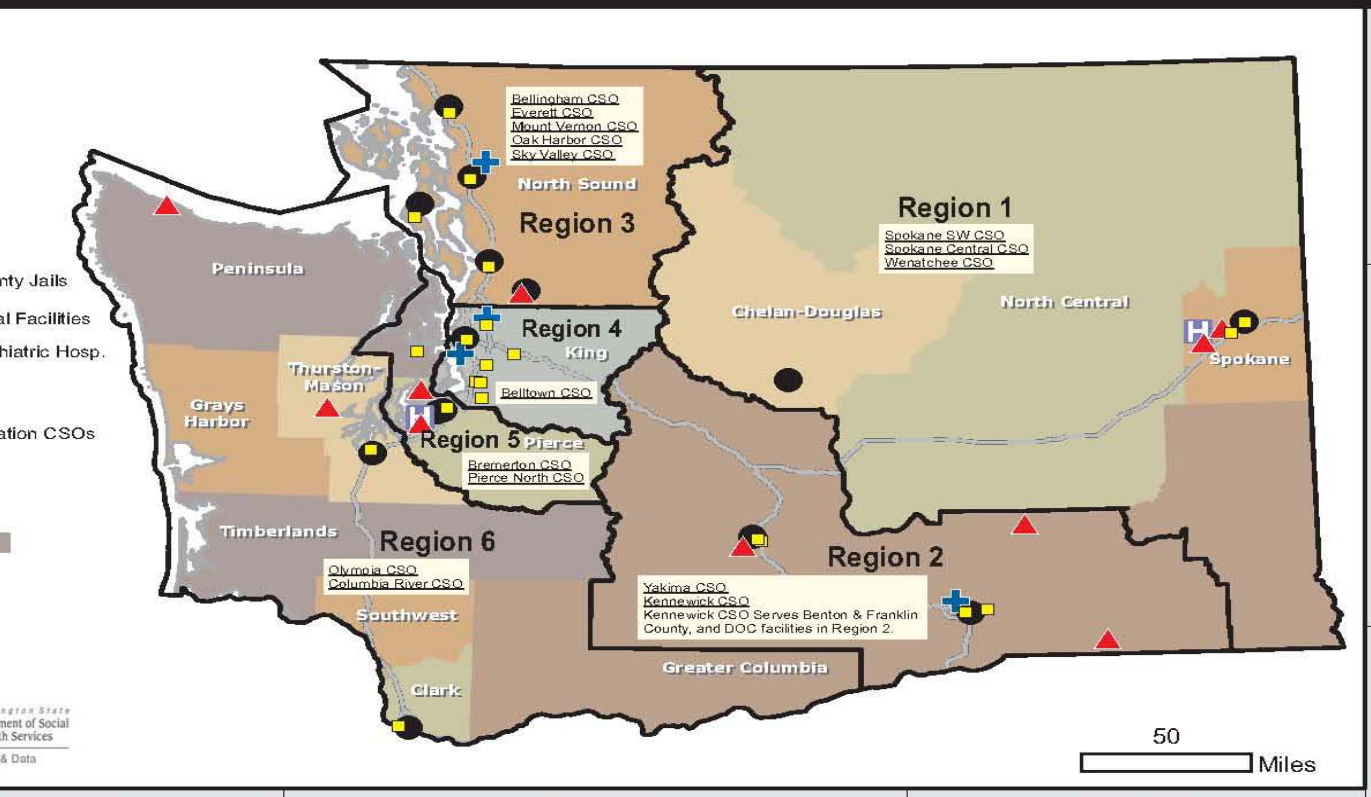
Estimated number of individuals releasing from WCCW who may be eligible for DSHS medical benefits	DOC estimated costs for additional assessments by prison medical physicians and psychiatrists /psychologists prior to release, and associated staffing	ESA estimated costs for additional expedited application processing, caseload maintenance, and associated staffing[32], and cash grants	TOTAL ESTIMATED COSTS
120[33]	$25,010[34]	$202,151[35]	**$227,281**

[32] 0.57 FTE.
[33] Roughly 70 of this total are anticipated to be new applications not already captured via the current HB 1290 processes.
[34] This figure includes the cost of assessments for 70 additional individuals (at approximately $323 per person), as well as the additional clinical and administrative staffing time required (i.e., 0.2 FTE for Psychologist 3 and 0.1 FTE for PSW3).
[35] Assumes DOC will complete all assessments during the pilot project period, with no cost to ESA.

APPENDICES

1-1. Map HB1290 Status Report Implementation Target Sites

E2SHB 1290 Expedited Medical Determinations: Implementation Target Sites June 2008



Region 1

Jails
Jail
ns Center
Corrections
ections

Local Partners
Chelan-Douglas RSN
Greater Columbia RSN
North Central RSN
Spokane RSN
DASA
SSA

spital

Region 2

City and County Jails
Benton County Jail
Columbia County Jail
Franklin County Jail
Kittitas County Jail
Walla Walla County Jail
Yakima County Jail
Yakima City Jail

DOC Facilities
Coyote Ridge Corrections Center
Washington State Penitentiary
Ahtanum View Correctional Complex
Yakima County Comm. Justice Center

IMD Facilities
Lourdes Psychiatric Hospital

Local Partners
Central WA Comprehensive Mental Health
- local RSN provider
Columbia Behavioral Health RSN
Kittitas County
Yakima Valley Memorial Hosp. Psychiatric

Region 3

City and County Jails
Island County Jail
Bellingham County Jail
Mt. Vernon County Jail
Oak Harbor County Jail

Local Partners
Compass Health
- mental health provider
North Sound RSN

DOC Facilities
Monroe Correctional Complex

IMD Facilities
North Cascade Secure Detox Program

Region 4

City and County Jails
KCCF
KCRJC

IMD Facilities
West Seattle Psychiatric Hosp
Fairfax Psychiatric Hospital

Region 5

City and County Jails
Kitsap County Jail
Pierce County Jail

DOC Facilities
Washington Corr. Ctr. for Wome
McNeil Island CC
Rap House Work/Training Relea
Lincoln Park Work/Training Rele

IMD Facilities
Western State Hospital

Local Partners
Kitsap Mental Health Services
Pierce County Human Services

Region 6

City and County Jails
Thurston County Jail
Clark County Jail

DOC Facilities
Washington Correctional Cente
Larch Mountain Corrections Ce
Clallam Bay Corrections Center
Olympic Corrections Center
Stafford Creek Corrections Cen
Cedar Creek Corrections Cente
Mission Creek Corr. Ctr. for Wo

Local Partners
Thurston-Mason RSN
Behavioral Health Resources
- mental health provider
Clark County RSN
Lifeline Connections
- mental health provider
Clark County DASA

Appendix 1-2. ESHB 2687 Feasibility Study Workgroup Membership & Affiliations

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RICE, ELIZABETH	DSHS/ESA/CSD	360-725-4614	riceea@dshs.wa.gov
ROBERTS, MARY	HOUSE OF REPRESENTATIVES	360-786-7950	roberts,maryhelen@leg.wa.gov
ROBERTS, VICTORIA	DSHS/HRSA/DASA	360-725-3715	roberv@dshs.wa.gov
SALTRUP, THOMAS	DOC/SW 0U1 HEALTH SVCS	360-725-8700	tesaltrup@doc1.wa.gov
SCHAUB, DAN	DSHS/JRA/CENTRAL OFFICE	360-902-7752	schaudl@dshs.wa.gov
SHOJI, DORI	DSHS/ESA/OSD	360-725-4353	shojid@dshs.wa.gov
SPANSKI, HOLLI	LEWIS COUNTY JUVENILE COURT	360-740-2621	hjspansk@co.lewis.wa.us
SPANTON, CINDY	KING COUNTY DEFENDER ASSOC	206-849-7464	cindy.spanton@seattle.gov
STERN, MARC	DOC/SWTUM1	360-725-8700	mfstern@doc1.wa.gov
STEWART, GINGER	DSHS/ESA/OSD	360-725-4512	stewagk@dshs.wa.gov
THOMPSON, DEBORAH	THURSTON CO SHERIFF'S OFFICE	360-786-5510 ext 7770	thompsd@co.thurston.wa.us
TORNATORE, DIA	DSHS/HRSA/OAS	360-725-1269	tornadl@dshs.wa.gov
WALLS, MICHAEL	DOC/SWTUM1/SW 0U1 HEALTH SVCS	360-725-8700	mtwalls@doc1.wa.gov
WESTENHAVER, MARK	DSHS/ESA	360-725-4893	westemc@dshs.wa.gov
WESTON, DAVID	DSHS/MHD/HQ	360-902-0782	westoDB@dshs.wa.gov
WOOD, MARY	DSHS/HRSA/DESD	360-725-1329	woodme@dshs.wa.gov
WRZESINSKI, CHANDRA	LEWIS COUNTY SHERIFF'S OFFICE	360-740-2617	cdwrzesi@co.lewis.wa.us
ZIEGLER, ALLEN	DSHS/SCC COMMUNITY PROGAMS	360-902-8258	zieglwa@dshs.wa.gov

APPENDIX 4-1. 2004 CMS MEMORANDUM

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group (DEHPG)

TO: State Medicaid Directors
CMS Associate Regional Administrators for Medicaid

CC: Charlene Brown, CMSO Deputy Director

FROM: Glenn Stanton
Acting Director
Disabled and Elderly Health Programs Group (DEHPG)

SUBJ: Ending Chronic Homelessness

DATE: May 25, 2004

The United States Interagency Council on Homelessness, recently chaired by HHS Secretary Thompson, is working to develop and implement a comprehensive national approach to end chronic homelessness in the United States through interagency, intergovernmental, and intercommunity collaborations. CMS has been supporting the efforts of the council in several ways. First, we worked with our federal partners to release a new tool on our website entitled *First Step on the Path to Benefits for People who are Homeless.* The *FirstStep* product is an easy-to-use, interactive tool designed to assist case managers and outreach workers in helping people who are homeless to gain access to mainstream programs. The tool may be found on the CMS website at http://www.cms.hhs.gov/medicaid/homeless/firststep/index.html.

Second, I am pleased to announce that we have posted a report on our website that is entitled *Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples.* This report focuses on practices that have increased Medicaid access for people experiencing chronic homelessness, including assisting people leaving psychiatric facilities and correctional facilities to obtain Medicaid quickly. We hope this report will provide useful information about state efforts as you address chronic homelessness issues in your state. The report may be found on CMS's website at http://www.cms.hhs.gov/promisingpractices/ or at http://www.cms.hhs.gov/medicaid/homeless/.

Finally, CMS is encouraging states with this letter to "suspend" and not "terminate" Medicaid benefits while a person is in a public institution or Institute for Mental Disease (IMD). Persons released from institutions are at risk of homelessness; thus, access to mainstream services upon release is important in establishing a continuum of care and ongoing support that may reduce the demand for costly and inappropriate services later.

As a reminder, the payment exclusion under Medicaid that relates to individuals residing in a public institution or an IMD does not affect the *eligibility* of an individual for the Medicaid program. Individuals who meet the requirements for eligibility for Medicaid may be enrolled in

the program before, during, and after the time in which they are held involuntarily in secure custody of a public institution or as a resident of an IMD. The statutory federal financial participation (FFP) exclusion applying to inmates of public institutions and residents of IMDs affects only the availability of federal funds under Medicaid for health services provided to that individual while he or she is an inmate of a public institution or a resident of an IMD.

Thus, states should not terminate eligibility for individuals who are inmates of public institutions or residents of IMDs based solely on their status as inmates or residents. Instead, states should establish a process under which an eligible inmate or resident is placed in a suspended status so that the state does not claim FFP for services the individual receives, but the person remains on the state's rolls as being eligible for Medicaid (assuming the person continues to meet all applicable eligibility requirements). Once discharge from the facility is anticipated, the state should take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility. If an individual is not already eligible for Medicaid prior to discharge from the facility, but has filed an application for Medicaid, the state should take whatever steps are necessary to ensure that the application is processed in a timely manner so that the individual can receive Medicaid-covered services upon discharge from the facility.

Given the high incidence of substance abuse, mental illness, and physical illness among those who have been incarcerated or otherwise held in involuntary custody, I encourage states to coordinate prison health services and other health care services provided during involuntary confinement with Medicaid services. By working with parole officers and other social services professionals who deal with inmates and residents of IMDs who are to be released, State Medicaid programs can assure that eligible persons are enrolled in Medicaid prior to release and can create an ongoing continuum of care for these individuals, regardless of the source of funding for such care.

In closing, I want to thank you for your ongoing efforts to improve access to Medicaid for all persons, and particularly for those who are homeless.

APPENDIX 4-2. 2008 STATE TO CMS SUSPENSION CLARIFICATION REQUEST

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Health and Recovery Services Administration
626 8th Avenue S.E. • P.O. Box 45502
Olympia, WA 98504-5502

August 18, 2008

Ms. Barbara Richards, Associate Regional Administrator
Division of Medicaid and Children's Health Operations
DHHS/CMS/DMSO
Mail Stop RX-48
2201 6th Avenue
Seattle, Washington 98121

Dear Ms. Richards:

We have been directed by our state legislature in its 2008 session to complete a feasibility study concerning suspension of medical benefits for state residents who become incarcerated in a correctional institution or institute for mental diseases (IMD), for the purpose of expeditious reinstatement of medical benefits upon release.[1] In this study, we are being asked how to implement the direction given to us by the Centers for Medicare and Medicaid Services (CMS) in its May 25, 2004, letter to State Medicaid Directors, which recommended that states should "suspend" and not "terminate" Medicaid benefits while a person is in a public institution or IMD. In this letter, states were advised to maintain an eligible inmate on the state's rolls as being eligible for Medicaid during incarceration and to take whatever steps are necessary to ensure that the eligible individual is placed in payment status "so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility."

In developing models for suspension of medical benefits for this feasibility study, we are mindful of the obligations we have under federal law to ensure that federal financial participation (FFP) is not paid for services received while an individual is incarcerated (42 CFR 435.1009(a)(1)), and to furnish Medicaid to those who are eligible to receive it, until such a time as these individuals are found ineligible (42 CFR 435.930(b)). However, we, and our Legislature, want to meet the goal set out in the Secretary's 2004 letter; i.e. to ensure access to essential health and mental health services immediately upon discharge from public institutions for persons eligible for services. To make this goal a reality, we are requesting CMS to comment on the following issues for the purpose of providing further guidance to a state implementing a program of Medicaid suspension:

1. Per 42 CFR 435.916(a), states must re-determine eligibility of Medicaid recipients with respect to circumstances that may change at least every 12 months. With respect to redeterminations of financial eligibility for a person who is incarcerated:

    a. Does a state violate this regulation by suspending redetermination of financial eligibility while the person is in a public institution, medical benefits are suspended, and the client is unable to receive medical services paid with federally matched funds?

[1] The request of the state legislature may be found in ESHB 2687, Section 209(28).

b. Would it be inconsistent with CMS' directive concerning suspension of Medicaid to "stop the clock" on financial redeterminations during the period of incarceration, and allow for a reasonable time period for financial eligibility to be redetermined following release from incarceration?

2. When a Medicaid recipient becomes incarcerated, Medicaid benefits are placed in suspension and reinstated following release, is it permissible to redetermine eligibility according to the redetermination schedule that would apply if incarceration and suspension had not occurred?
   a. If redetermination would have otherwise occurred during the period in which Medicaid benefits were suspended due to the client's incarceration, does the state have a reasonable period of time to redetermine eligibility, especially if updated financial information must be gathered.

   b. If the agency receives information about a change in circumstances of an individual which may affect the individual's eligibility during a period in which Medicaid is suspended due to incarceration, when must redetermination occur-reference 42 CFR 435.930(b)?

3. Is there any time limit to the period in which eligibility for a Medicaid program may be suspended?

4. Does anything prevent states from determining Medicaid eligibility for a person when he or she is booked into a public institution, and placing that person directly into a suspend status for the duration of the incarceration?

   a. Does any time limit apply to this procedure?

   b. If states cannot suspend Medicaid for a client in this circumstance, how long can states pend applications received from persons who are incarcerated, for determination upon release? (Reference 42 CFR 435.911).

Our study is due to the Legislature by November 15, 2008. In order for us to evaluate the costs and benefits of the options set forth in the budget proviso, please provide any guidance you may have as soon as possible.

Please call me ((360) 725-1863), if you have questions about our request. Thank you for your anticipated rapid assistance.

Sincerely,

Douglas Porter, Assistant Secretary
Health and Recovery Services Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

NOV 3 2008

Douglas Porter, Assistant Secretary
Health and Recovery Services Administration
Department of Social and Health Services
Post Office Box 45080
Olympia, Washington 98504-5080

Dear Mr. Porter:

Thank you for your letter of August 18, 2008, concerning the suspension of medical benefits for state residents who become incarcerated in a correctional institution or institute for mental disease (IMD), for the purpose of expeditious reinstatement of medical benefits upon release. The Agency specifically asks the Centers for Medicare & Medicaid Services (CMS) to clarify eligibility policy for a State implementing a program of Medicaid suspension of eligibility, to ensure access to essential services immediately upon discharge from a public institution. In response to your request, CMS provides the following clarifying information to address the concerns regarding redetermination policy.

Determination and redeterminations of eligibility are subject to the rules in 42 CFR 435.911 and 42 CFR 435.916. According to 42 CFR 435.916(a), the State is required to redetermine the eligibility of Medicaid recipients at least every 12 months or as their circumstances change. The section further states in 42 CFR 435.16(c) when the agency has information about the anticipated changes in a recipient's circumstances, it must re-determine eligibility at the time the information is learned. The Agency must act in accordance with 42 CFR 435.916 by maintaining the annual redetermination requirements to review the conditions of Medicaid eligibility, such as age, income, marital status, and resources, to validate an individual's circumstances and continuing eligibility. We have listed your questions, with our answers, below.

Question: "Does a State violate this regulation by suspending redetermination of financial eligibility while the person is in a public institution?"

Answer: Yes. Federal regulations do not provide for the carve-out of financial eligibility in the redetermination process. All aspects of eligibility should be reviewed, including categorical eligibility requirements, and financial status of the beneficiary. It is possible for changes in income and/or resources to occur in these instances.

Question: "Would it be inconsistent with CMS' directive concerning suspension of Medicaid to "stop the clock" on financial determinations during the period of incarceration, and allow for a reasonable time period for financial eligibility to be redetermined following release from incarceration?"

Answer: Yes, it is inconsistent with CMS' directive. Federal regulations mandate that the Medicaid agency conduct a redetermination at least every 12 months or sooner if there is a known or anticipated change in circumstance.

Question: When a Medicaid recipient becomes incarcerated, Medicaid benefits are placed in suspension and reinstated following release. Is it permissible to redetermine eligibility according to the redetermination schedule that would apply if incarceration and suspension had not occurred?

Answer: See our answer above. Redeterminations must occur within 12 months of the last eligibility determination. If the State suspends eligibility, the redetermination process would still be maintained, based on the eligibility date.

Question: When a Medicaid recipient becomes incarcerated and the eligibility is suspended, does the State have to do a redetermination if it learns of a change in circumstances during the incarceration?

Answer: Yes. Requirements at 42 CFR 435.916 specify an agency must conduct a redetermination at least every 12 months or sooner if there is a known or anticipated change in circumstance. The regulation further states in 435.916(c) an agency must promptly redetermine eligibility when it receives information about changes or anticipated changes impacting eligibility. It is conceivable that a Medicaid eligible individual can experience changes in status that could affect eligibility status while institutionalized (i.e., changes in age, marital status, disability status). However, in an instance when a redetermination application of a client is not returned and information is not provided to the worker, eligibility should be terminated, and appropriate notice should be given per 42 CFR 435.919. The institutionalized individual should be encouraged to contact the Medicaid agency upon release to reapply for Medicaid coverage. At that point in time, the State would make a determination of eligibility based on the individual's current circumstances.

Question: Is there any time limit to the period in which eligibility for a Medicaid program may be suspended?

Answer: No. Federal regulations do not prescribe any time limitations for eligibility suspensions.

Question: Does anything prevent states from determining Medicaid eligibility for a person when he or she is booked into a public institution, and placing that person directly into a suspend status for the duration of the incarceration?

Answer: Anyone filing an application for Medicaid is entitled to a response from the State regarding eligibility. As individuals placed in public institutions are not considered eligible for benefits, they should be advised that they are currently not eligible for Medicaid, and should contact their local eligibility office upon release from prison, or institutionalization, and request an application at that time.

We appreciate your inquiry, and look forward to working with you in the future. If you need further information or assistance regarding this matter, please contact me or Maria Garza at maria.garza@cms.hhs.gov, or by telephone at (206) 615-2542.

Sincerely,

Barbara K. Richards
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Appendix 6-1. Juvenile Rehabilitation Administration Cost Estimate Data

TIME SPENT ON MEDICAL PROCESS						
EMPLOYEE	**HOURS PER MONTH**	**FTE EQUIVALENT**	**Monthly Salary**	**Salary Cost Per Year**	**Benefit Cost Per Year**	**Total**
Dorman, Chris	5.0	0.036	4,526	1,968	649	2,617
Jones, April	2.5	0.018	4,526	984	325	1,309
Merrit, Jeff	7.5	0.054	4,090	2,667	880	3,548
McElfresh, Brian	7.5	0.054	3,819	2,491	822	3,313
Rosenkrautz, Teresa	7.5	0.054	4,322	2,819	930	3,749
	30.0	**0.217**	**$ 21,283**	**$ 10,928**	**$ 3,606**	**$ 14,535**

APPENDIX 6-2. THURSTON COUNTY JAIL COST ESTIMATE DATA

	Population by Category		
	AGE	**Amount**	% of population
	Age 18 years of Age	91	1.46%
	60 and over	112	1.80%
		TOTAL	**3.26%**
	MEDICAL		
	Mental Health	1138	18.35%
	Medical	233	3.75%
		TOTAL	**22.10%**
	DRUGS/ALCOHOL		
	Chemical Dependency	1572	25.35%
		TOTAL	**25.35%**
GRAND TOTAL			**50.71%**
Number of Clients	**Job Task**	**Time Allocated**	**Total hours per week**
6,201[36]	DSHS Client Check	10 mins	20 hours
3145 [37]	Smart Application	30 mins	30 hours
3145 [38]	Release and address update	10 mins	10 hours
		TOTAL	60 hours
2	FTE-Entry Level Correction's Deputy	**$88,651.**	$177,302.

[36] 2007 Total Population
[37] 50.71% of Total Population
[38] 50.71% of Total Population

Appendix 6-2. Thurston County Jail Cost Estimate Data

	Population by Category		
	AGE	**Amount**	% of population
	Age 18 years of Age	91	1.46%
	60 and over	112	1.80%
		TOTAL	**3.26%**
	MEDICAL		
	Mental Health	1138	18.35%
	Medical	233	3.75%
		TOTAL	**22.10%**
	DRUGS/ALCOHOL		
	Chemical Dependency	1572	25.35%
		TOTAL	**25.35%**
GRAND TOTAL			**50.71%**
Number of Clients	**Job Task**	**Time Allocated**	**Total hours per week**
6,201[39]	DSHS Client Check	10 mins	20 hours
3145 [40]	Smart Application	30 mins	30 hours
3145 [41]	Release and address update	10 mins	10 hours
		TOTAL	60 hours
2	FTE-Entry Level Correction's Deputy	**$88,651.**	$177,302.

[39] 2007 Total Population
[40] 50.71% of Total Population
[41] 50.71% of Total Population

Appendix 6-3. Department of Corrections Cost Estimate Data

First Year Estimate	FTEs	Salary	Benefits	Goods/ Services	Computer	Travel	Start-up	Total
Admissions to Prison:	2.6	$ 117,913	$ 42,449	$ 7,979	$ 1,330	$ 1,330	$ 18,470	$ 189,471
Moves while in Prison:	4.2	$ 187,705	$ 67,574	$ 12,900	$ 3,360	$ 1,525	$ 29,403	$ 302,467
60 Days Prior to an Offender Release (PIMA Application):	1.0	$ 43,031	$ 15,491	$ 2,899	$ 840	$ 1,088	$ 6,763	$ 70,112
60 Days Prior to an Offender Release (Mental/Medical Evaluation):	5.4	$ 801,683	$ 224,471	$ 54,458	$ 4,824	$ 13,513	$ 81,687	$ 1,180,637
	13.3	$ 1,150,333	$ 349,985	$ 78,235	$ 10,354	$ 17,456	$ 136,323	$ 1,742,687

Second Year Estimate	FTEs	Salary	Benefits	Goods/ Services	Computer	Travel	Start-up	Total
Admissions to Prison:	2.6	$ 117,913	$ 42,449	$ 7,979	$ 1,330	$ 1,330	$ -	$ 171,000
Moves while in Prison:	4.2	$ 187,705	$ 67,574	$ 12,900	$ 3,360	$ 1,525	$ -	$ 273,064
60 Days Prior to an Offender Release (PIMA Application):	1.0	$ 43,031	$ 15,491	$ 2,899	$ 840	$ 1,088	$ -	$ 63,349
60 Days Prior to an Offender Release (Mental/Medical Evaluation):	5.4	$ 801,683	$ 224,471	$ 54,458	$ 4,824	$ 13,513	$ -	$ 1,098,950
	13.3	$ 1,150,333	$ 349,985	$ 78,235	$ 10,354	$ 17,456	$ -	$ 1,606,364

Note: Funding to interface ACES with OMNI would eliminate staffing needs (4.2 FTES) to manually update DOC movement codes. The cost associated with this programming change would require a contract with the OMNI Vendor.

Appendix 6-4. Economic Services Administration Cost Estimate Data

Economic Services Administration						
Expanded 1290 Expedited Medical Determinations - Phased In						
Total Costs: Phase Two - Five						
	FY10	*FY11*	*FY12*	*FY13*	*FY14*	*FY15*
FTE's	*0.05*	*3.61*	*36.85*	*64.3*	*75.72*	*75.48*
Staff Costs	*$3,000*	*$336,000*	*$3,433,000*	*$5,814,000*	*$6,735,000*	*$6,627,000*
Benefits to Clients	*$0*	*$388,951*	*$6,562,516*	*$19,170,289*	*$16,392,014*	*$15,285,051*
Assessments	*$0*	*$192,321*	*$2,559,463*	*$4,965,992*	*$4,965,992*	*$4,965,992*
TOTAL	*$3,000*	*$917,272*	*$12,554,978*	*$29,950,281*	*$28,093,006*	*$26,878,043*
Economic Services Administration						
Expanded 1290 Expedited Medical Determinations						
Phase Two						
	FY10	*FY11*	*FY12*	*FY13*	*FY14*	*FY15*
FTE's	*0.05*	*0.02*	*0*	*0*	*0*	*0*
Staff Costs	*$3,000*	*$1,000*	*$0*	*$0*	*$0*	*$0*
Benefits to Clients	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Assessments	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
TOTAL	*$3,000*	*$1,000*	*$0*	*$0*	*$0*	*$0*

Economic Services Administration						
Expanded 1290 Expedited Medical Determinations						
Phase Three						
	FY10	*FY11*	*FY12*	*FY13*	*FY14*	*FY15*
FTE's	*0*	*2.08*	*3.47*	*3.66*	*3.47*	*3.47*
Staff Costs	*$0*	*$197,000*	*$310,000*	*$319,000*	*$304,000*	*$304,000*
Benefits to Clients	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Assessments	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
TOTAL	*$0*	*$197,000*	*$310,000*	*$319,000*	*$304,000*	*$304,000*
Economic Services Administration						
Expanded 1290 Expedited Medical Determinations						
Phase Four						
	FY10	*FY11*	*FY12*	*FY13*	*FY14*	*FY15*
FTE's	*0*	*1.51*	*2.98*	*1.85*	*0.24*	*0*
Staff Costs	*$0*	*$138,000*	*$267,000*	*$162,000*	*$23,000*	*$0*
Benefits to Clients	*$0*	*$388,951*	*$1,371,611*	*$326,795*	*$30,614*	*$0*
Assessments	*$0*	*$192,321*	*$159,639*	*$0*	*$0*	*$0*
TOTAL	*$0*	*$719,272*	*$1,798,250*	*$488,795*	*$53,614*	*$0*

Economic Services Administration						
Expanded 1290 Expedited Medical Determinations						
Phase Five						
	FY10	*FY11*	*FY12*	*FY13*	*FY14*	*FY15*
FTE's	*0*	*0.00*	*30.40*	*58.79*	*72.01*	*72.01*
Staff Costs	*$0*	*$0*	*$2,856,000*	*$5,333,000*	*$6,408,000*	*$6,323,000*
Benefits to Clients	*$0*	*$0*	*$5,190,905*	*$18,843,493*	*$16,361,400*	*$15,285,051*
Assessments	*$0*	*$0*	*$2,399,824*	*$4,965,992*	*$4,965,992*	*$4,965,992*
TOTAL	*$0*	*$0*	*$10,446,729*	*$29,142,485*	*$27,735,392*	*$26,574,043*

Appendix 6-5. Health and Recovery Services Administration Caseload Growth Cost Estimate Data

Estimated Cost of Expansion

Table 1:

Potential Medically-Eligible Individuals Released from Correctional Institutions[1] in State Fiscal Year (SFY) 2006 by Medical Eligibility Group (MEG)

	Medical Eligibility Group							
Type of Institution	**SSI[2]**	**SSI-Related[3]**	**TANF[4]**	**Children[5]**	**Other**	**GA-U/ ADATSA[6]**	**GA-X[7]**	**Total**
Department of Corrections	154	131	652	10	-	1,572	344	2,863
County Jails	636	1,976	16,924	214	4	19,682	1,796	41,232
State Mental Hospitals	116	192	22	1	-	83	124	538
Juvenile Rehabilitation	10	2	170	333	-	11	2	528
Total	916	2,301	17,768	558	4	21,348	2,266	45,161

Source: DSHS Research and Data Analysis

[1] Includes individuals who were not receiving Medical Assistance prior to incarceration, with the exception of Temporary Assistance to Needy Families (TANF)

[2] Individuals who are potentially eligible for Supplemental Security Income (SSI) from the Social Security Administration. SSI recipients are eligible for Medicaid coverage

[3] Individuals who are potentially eligible for Medicaid coverage under a Blind/Disabled program

[4] Individuals who are potentially eligible for Medicaid coverage under the Temporary Assistance to Needy Families program

[5] Individuals who are potentially eligible for Medicaid coverage under the Other Children (up to 200% of the Federal Poverty Level) program

[6] Individuals who are potentially eligible for Medical Care Services (MCS) coverage under the General Assistance - Unemployable / Alcohol and Drug Abuse Treatment Support Act programs

[7] Individuals who are potentially eligible for Medicaid coverage under the General Assistance - Presumptive SSI program

Table 2:

Estimated Number of Released Individuals that Would be Deemed Medically-Eligible in a State Fiscal Year (SFY) by Medical Eligibility Group (MEG)

	100.0%	<< Assumed Percentage of Released Persons that will be Approved for Medical Assistance						
	Medical Eligibility Group (MEG)							
Type of Institution	**SSI[1]**	**SSI-Related[2]**	**TANF[3]**	**Children[4]**	**Other**	**GA-U/ ADATSA[5]**	**GA-X[6]**	**Total**
Department of Corrections	154	131	652	10	-	1,572	344	2,863
County Jails	636	1,976	16,924	214	4	19,682	1,796	41,232
State Mental Hospitals	116	192	22	1	-	83	124	538
Juvenile Rehabilitation	10	2	170	333	-	11	2	528
Total	916	2,301	17,768	558	4	21,348	2,266	45,161

[1] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Supplemental Security Income (SSI). SSI recipients are eligible for Medicaid coverage*

[2] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under a Blind/Disabled program*

[3] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under the Temporary Assistance to Needy Families program*

[4] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under the Other Children (up to 200% of the Federal Poverty Level) program*

[5] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medical Care Services (MCS) coverage under the General Assistance - Unemployable / Alcohol and Drug Abuse Treatment Support Act programs*

[6] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under the General Assistance - Presumptive SSI program*

Table 3:

Average Estimated Medical Cost per Person per Month by State Fiscal Year (SFY) and Medical Eligibility Group (MEG)

	Medical Eligibility Group																				
	SSI[1]			SSI-Related[2]			TANF[3]			Children[4]			Other			GA-U/ADATSA[5]			GA-X[6]		
Applicable Forecast MEG	(1250) CN Blind/Disabled			(1250) CN Blind/Disabled			(1215) CN TANF			(1265) CN Other Children			(1250) CN Blind/Disabled			(1920) GA-U			(1250) CN Blind/Disabled		
State Fiscal Year	State[7]	Federal	Total	State[7]	Federal	Total	State[7]	Federal	Total	State[7]	Fed	Total	State[7]	Fed	Total	State[7]	Fed	Total	State[7]	Fed	Total
SFY2007	$308.32	$305.71	$614.03	$308.32	$305.71	$614.03	$115.44	$118.28	$233.72	$77.68	$84.96	$162.63	$308.32	$305.71	$614.03	$483.03	$67.49	$550.52	$308.32	$305.71	$614.03
SFY2008	$322.57	$335.32	$657.89	$322.57	$335.32	$657.89	$119.49	$127.57	$247.06	$80.09	$91.86	$171.96	$322.57	$335.32	$657.89	$515.07	$74.73	$589.80	$322.57	$335.32	$657.89
SFY2009	$341.61	$353.65	$695.26	$341.61	$353.65	$695.26	$125.53	$132.13	$257.66	$83.77	$94.70	$178.48	$341.61	$353.65	$695.26	$576.33	$83.71	$660.03	$341.61	$353.65	$695.26
SFY2010	$362.51	$363.84	$726.35	$362.51	$363.84	$726.35	$129.75	$132.50	$262.25	$86.39	$94.45	$180.84	$362.51	$363.84	$726.35	$591.22	$90.51	$681.74	$362.51	$363.84	$726.35
SFY2011	$379.49	$378.73	$758.22	$379.49	$378.73	$758.22	$133.49	$135.38	$268.86	$88.64	$96.00	$184.64	$379.49	$378.73	$758.22	$604.13	$97.79	$701.92	$379.49	$378.73	$758.22

Source: Monthly per capita costs for SFY2007 through SFY2011 from the Medical Assistance Expenditures Forecast Summary, October 2008, Version K

[1] Individuals receiving Supplemental Security Income (SSI) from the Social Security Administration. SSI recipients are eligible for Medicaid coverage

[2] Individuals receiving Medicaid coverage under a Blind/Disabled program

[3] Individuals receiving Medicaid coverage under the Temporary Assistance to Needy Families program

[4] Individuals receiving Medicaid coverage under the Other Children (up to 200% of the Federal Poverty Level) program

[5] Individuals receiving Medical Care Services (MCS) coverage under the General Assistance - Unemployable / Alcohol and Drug Abuse Treatment Support Act programs

[6] Individuals receiving Medicaid coverage under the General Assistance - Presumptive SSI program

[7] State funds include General Fund - State, the Health Services Account, and the Tobacco Prevention and Control Account

Table 4: Estimated Medical Costs per month in the 2011-2013 Biennium by State Fiscal Year (SFY), Fund Source, and Medical Eligibility Group (MEG)

	Medical Eligibility Group (MEG)																							
Applicable Forecast MEG	SSI[1]			SSI-Related[2]			TANF[3]			Children[4]			Other			GA-U/ADATSA[5]			GA-X[6]			Total		
Month	Caseload (Persons)	Cost (Dollars) State[7,8]	Federal[8]	Caseload (Persons)	Cost (Dollars) State[7,8]	Federal[8]	Caseload (Persons)	Cost (Dollars) State[7,8]	Federal[8]	Caseload (Persons)	Cost (Dollars) State[7,8]	Federal[8]	Caseload (Persons)	Cost (Dollars) State[7,8]	Federal[8]	Caseload (Persons)	Cost (Dollars) State[7,8]	Federal[8]	Caseload (Persons)	Cost (Dollars) State[7,8]	Federal[8]	Caseload (Persons)	Cost (Dollars) State[7,8]	Federal[8]
July 2010	76.33	$ 28,968	$ 28,910	191.75	$ 72,767	$ 72,621	1,480.67	$ 197,650	$ 200,448	46.50	$ 4,122	$ 4,464	0.33	$ 126	$ 126	1,779.00	$ 1,074,751	$ 173,964	188.83	$ 71,660	$ 71,517	**3,763.42**	**$ 1,450,044**	**$ 552,050**
August 2010	152.67	$ 57,935	$ 57,819	383.50	$ 145,534	$ 145,243	2,961.33	$ 395,300	$ 400,897	93.00	$ 8,244	$ 8,928	0.67	$ 253	$ 252	3,558.00	$ 2,149,502	$ 347,928	377.67	$ 143,320	$ 143,033	**7,526.83**	**$ 2,900,088**	**$ 1,104,100**
September 2010	229.00	$ 86,903	$ 86,729	575.25	$ 218,301	$ 217,864	4,442.00	$ 592,951	$ 601,345	139.50	$ 12,365	$ 13,392	1.00	$ 379	$ 379	5,337.00	$ 3,224,253	$ 521,891	566.50	$ 214,981	$ 214,550	**11,290.25**	**$ 4,350,133**	**$ 1,656,150**
October 2010	305.33	$ 115,871	$ 115,639	767.00	$ 291,068	$ 290,485	5,922.67	$ 790,601	$ 801,793	186.00	$ 16,487	$ 17,856	1.33	$ 506	$ 505	7,116.00	$ 4,299,004	$ 695,855	755.33	$ 286,641	$ 286,067	**15,053.67**	**$ 5,800,177**	**$ 2,208,200**
November 2010	381.67	$ 144,838	$ 144,548	958.75	$ 363,835	$ 363,106	7,403.33	$ 988,251	$ 1,002,242	232.50	$ 20,609	$ 22,320	1.67	$ 632	$ 631	8,895.00	$ 5,373,754	$ 869,819	944.17	$ 358,301	$ 357,583	**18,817.08**	**$ 7,250,221**	**$ 2,760,250**
December 2010	458.00	$ 173,806	$ 173,458	1,150.50	$ 436,602	$ 435,728	8,884.00	$ 1,185,901	$ 1,202,690	279.00	$ 24,731	$ 26,784	2.00	$ 759	$ 757	10,674.00	$ 6,448,505	$ 1,043,783	1,133.00	$ 429,961	$ 429,100	**22,580.50**	**$ 8,700,265**	**$ 3,312,300**
January 2011	534.33	$ 202,774	$ 202,368	1,342.25	$ 509,369	$ 508,349	10,364.67	$ 1,383,551	$ 1,403,138	325.50	$ 28,853	$ 31,249	2.33	$ 885	$ 884	12,453.00	$ 7,523,256	$ 1,217,746	1,321.83	$ 501,621	$ 500,617	**26,343.92**	**$ 10,150,309**	**$ 3,864,350**
February 2011	610.67	$ 231,741	$ 231,277	1,534.00	$ 582,136	$ 580,970	11,845.33	$ 1,581,202	$ 1,603,587	372.00	$ 32,974	$ 35,713	2.67	$ 1,012	$ 1,010	14,232.00	$ 8,598,007	$ 1,391,710	1,510.67	$ 573,281	$ 572,133	**30,107.33**	**$ 11,600,354**	**$ 4,416,400**
March 2011	687.00	$ 260,709	$ 260,187	1,725.75	$ 654,903	$ 653,592	13,326.00	$ 1,778,852	$ 1,804,035	418.50	$ 37,096	$ 40,177	3.00	$ 1,138	$ 1,136	16,011.00	$ 9,672,758	$ 1,565,674	1,699.50	$ 644,942	$ 643,650	**33,870.75**	**$ 13,050,398**	**$ 4,968,451**
April 2011	763.33	$ 289,677	$ 289,097	1,917.50	$ 727,670	$ 726,213	14,806.67	$ 1,976,502	$ 2,004,483	465.00	$ 41,218	$ 44,641	3.33	$ 1,265	$ 1,262	17,790.00	$ 10,747,509	$ 1,739,638	1,888.33	$ 716,602	$ 715,167	**37,634.17**	**$ 14,500,442**	**$ 5,520,501**
May 2011	839.67	$ 318,644	$ 318,006	2,109.25	$ 800,437	$ 798,834	16,287.33	$ 2,174,152	$ 2,204,932	511.50	$ 45,340	$ 49,105	3.67	$ 1,391	$ 1,389	19,569.00	$ 11,822,260	$ 1,913,602	2,077.17	$ 788,262	$ 786,683	**41,397.58**	**$ 15,950,486**	**$ 6,072,551**
June 2011	916.00	$ 347,612	$ 346,916	2,301.00	$ 873,204	$ 871,456	17,768.00	$ 2,371,803	$ 2,405,380	558.00	$ 49,461	$ 53,569	4.00	$ 1,518	$ 1,515	21,348.00	$ 12,897,011	$ 2,087,565	2,266.00	$ 859,922	$ 858,200	**45,161.00**	**$ 17,400,531**	**$ 6,624,601**
July 2011	992.33	$ 376,580	$ 375,825	2,492.75	$ 945,971	$ 944,077	19,248.67	$ 2,569,453	$ 2,605,828	604.50	$ 53,583	$ 58,033	4.33	$ 1,644	$ 1,641	23,127.00	$ 13,971,761	$ 2,261,529	2,454.83	$ 931,582	$ 929,717	**48,924.42**	**$ 18,850,575**	**$ 7,176,651**
August 2011	1,068.67	$ 405,547	$ 404,735	2,684.50	$ 1,018,738	$ 1,016,698	20,729.33	$ 2,767,103	$ 2,806,277	651.00	$ 57,705	$ 62,497	4.67	$ 1,771	$ 1,767	24,906.00	$ 15,046,512	$ 2,435,493	2,643.67	$ 1,003,242	$ 1,001,233	**52,687.83**	**$ 20,300,619**	**$ 7,728,701**
September 2011	1,145.00	$ 434,515	$ 433,645	2,876.25	$ 1,091,505	$ 1,089,319	22,210.00	$ 2,964,753	$ 3,006,725	697.50	$ 61,827	$ 66,961	5.00	$ 1,897	$ 1,894	26,685.00	$ 16,121,263	$ 2,609,457	2,832.50	$ 1,074,903	$ 1,072,750	**56,451.25**	**$ 21,750,663**	**$ 8,280,751**
October 2011	1,221.33	$ 463,483	$ 462,554	3,068.00	$ 1,164,272	$ 1,161,941	23,690.67	$ 3,162,403	$ 3,207,173	744.00	$ 65,949	$ 71,425	5.33	$ 2,024	$ 2,020	28,464.00	$ 17,196,014	$ 2,783,420	3,021.33	$ 1,146,563	$ 1,144,267	**60,214.67**	**$ 23,200,707**	**$ 8,832,801**
November 2011	1,297.67	$ 492,450	$ 491,464	3,259.75	$ 1,237,039	$ 1,234,562	25,171.33	$ 3,360,054	$ 3,407,622	790.50	$ 70,070	$ 75,889	5.67	$ 2,150	$ 2,146	30,243.00	$ 18,270,765	$ 2,957,384	3,210.17	$ 1,218,223	$ 1,215,783	**63,978.08**	**$ 24,650,752**	**$ 9,384,851**
December 2011	1,374.00	$ 521,418	$ 520,374	3,451.50	$ 1,309,806	$ 1,307,183	26,652.00	$ 3,557,704	$ 3,608,070	837.00	$ 74,192	$ 80,353	6.00	$ 2,277	$ 2,272	32,022.00	$ 19,345,516	$ 3,131,348	3,399.00	$ 1,289,883	$ 1,287,300	**67,741.50**	**$ 26,100,796**	**$ 9,936,901**
January 2012	1,450.33	$ 550,386	$ 549,283	3,643.25	$ 1,382,573	$ 1,379,805	28,132.67	$ 3,755,354	$ 3,808,518	883.50	$ 78,314	$ 84,818	6.33	$ 2,403	$ 2,399	33,801.00	$ 20,420,267	$ 3,305,312	3,587.83	$ 1,361,543	$ 1,358,817	**71,504.92**	**$ 27,550,840**	**$ 10,488,951**
February 2012	1,526.67	$ 579,353	$ 578,193	3,835.00	$ 1,455,340	$ 1,452,426	29,613.33	$ 3,953,004	$ 4,008,967	930.00	$ 82,436	$ 89,282	6.67	$ 2,530	$ 2,525	35,580.00	$ 21,495,018	$ 3,479,276	3,776.67	$ 1,433,203	$ 1,430,333	**75,268.33**	**$ 29,000,884**	**$ 11,041,001**
March 2012	1,603.00	$ 608,321	$ 607,103	4,026.75	$ 1,528,107	$ 1,525,047	31,094.00	$ 4,150,654	$ 4,209,415	976.50	$ 86,558	$ 93,746	7.00	$ 2,656	$ 2,651	37,359.00	$ 22,569,768	$ 3,653,239	3,965.50	$ 1,504,864	$ 1,501,850	**79,031.75**	**$ 30,450,928**	**$ 11,593,051**
April 2012	1,679.33	$ 637,288	$ 636,012	4,218.50	$ 1,600,874	$ 1,597,669	32,574.67	$ 4,348,305	$ 4,409,863	1,023.00	$ 90,679	$ 98,210	7.33	$ 2,783	$ 2,777	39,138.00	$ 23,644,519	$ 3,827,203	4,154.33	$ 1,576,524	$ 1,573,367	**82,795.17**	**$ 31,900,973**	**$ 12,145,101**
May 2012	1,755.67	$ 666,256	$ 664,922	4,410.25	$ 1,673,641	$ 1,670,290	34,055.33	$ 4,545,955	$ 4,610,312	1,069.50	$ 94,801	$ 102,674	7.67	$ 2,909	$ 2,904	40,917.00	$ 24,719,270	$ 4,001,167	4,343.17	$ 1,648,184	$ 1,644,883	**86,558.58**	**$ 33,351,017**	**$ 12,697,151**
June 2012	1,832.00	$ 695,224	$ 693,832	4,602.00	$ 1,746,408	$ 1,742,911	35,536.00	$ 4,743,605	$ 4,810,760	1,116.00	$ 98,923	$ 107,138	8.00	$ 3,036	$ 3,030	42,696.00	$ 25,794,021	$ 4,175,131	4,532.00	$ 1,719,844	$ 1,716,400	**90,322.00**	**$ 34,801,061**	**$ 13,249,201**

[1] Individuals who will be added to the Medical Assistance caseload due to their eligibility for Supplemental Security Income (SSI). SSI recipients are eligible for Medicaid coverage

[2] Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under a Blind/Disabled program

[3] Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under the Temporary Assistance to Needy Families program

[4] Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under the Other Children (up to 200% of the Federal Poverty Level) program

[5] Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medical Care Services (MCS) coverage under the General Assistance - Unemployable / Alcohol and Drug Abuse Treatment Support Act programs

[6] Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under the General Assistance - Presumptive SSI program

[7] State funds include General Fund - State, the Health Services Account, and the Tobacco Prevention and Control Account

[8] Assumes per capita costs for SFY2012 and SFY2013 are the same as the forecasted per capita costs for SFY2011

Table 5:

Estimated Annual Medical Costs in the 2011-2013 Biennium by State Fiscal Year (SFY), Fund Source, and Medical Eligibility Group: in Thousands of Dollars[1]

	Medical Eligibility Group																							
	SSI[2]			SSI-Related[3]			TANF[4]			Children[5]			Other			GA-U/ADATSA[6]			GA-X[7]			Total		
Applicable Forecast MEG	(1250) CN Blind/Disabled			(1250) CN Blind/Disabled			(1215) CN TANF			(1265) CN Other Children			(1250) CN Blind/Disabled			(1920) GA-U			(1250) CN Blind/Disabled					
State Fiscal Year	State	Federal	Total	State	Federal	Total	State	Federal	Total	State	Federal	Total	State	Federal	Total	State	Federal	Total	State	Federal	Total	State	Federal	Total
SFY2012	$ 2,259,477	$ 2,254,953	$ 4,514,430	$ 5,675,827	$ 5,664,461	$ 11,340,288	$ 15,416,716	$ 15,634,970	$ 31,051,686	$ 321,499	$ 348,198	$ 669,698	$ 9,867	$ 9,847	$ 19,714	$ 83,830,568	$ 13,569,175	$ 97,399,743	$ 5,589,493	$ 5,578,300	$ 11,167,794	**$ 113,103,448**	**$ 43,059,904**	**$ 156,163,353**
SFY2013	$ 6,430,820	$ 6,417,943	$ 12,848,763	$ 16,154,277	$ 16,121,928	$ 32,276,205	$ 43,878,346	$ 44,499,529	$ 88,377,875	$ 915,037	$ 991,026	$ 1,906,062	$ 28,082	$ 28,026	$ 56,108	$ 238,594,695	$ 38,619,959	$ 277,214,654	$ 15,908,558	$ 15,876,701	$ 31,785,259	**$ 321,909,814**	**$ 122,555,112**	**$ 444,464,927**

[1] *Assumes a start date of July 1, 2011 and that all persons released from incarceration who are immediately be eligible for Medical Assistance will eventually have applied for assistance within 24 months of release. Cost estimates in today's dollars for subsequent fiscal years will be equal to the estimate for SFY2013*

[2] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Supplemental Security Income (SSI). SSI recipients are eligible for Medicaid coverage*

[3] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under a Blind/Disabled program*

[4] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under the Temporary Assistance to Needy Families program*

[5] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under the Other Children (up to 200% of the Federal Poverty Level) program*

[6] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medical Care Services (MCS) coverage under the General Assistance - Unemployable / Alcohol and Drug Abuse Treatment Support Act programs*

[7] *Individuals who will be added to the Medical Assistance caseload due to their eligibility for Medicaid coverage under the General Assistance - Presumptive SSI program*

[8] *State funds include General Fund - State, the Health Services Account, and the Tobacco Prevention and Control Account*

APPENDIX 6-6. LIMITED INTERIM PILOT ECONOMIC SERVICES ADMINISTRATION / DEPARTMENT OF CORRECTIONS COST ESTIMATE DATA

Economic Services Administration						
Expanded 1290 Expedited Medical Determinations						
Section VI, Subsection G of Report: Limited DOC Interim Pilot Project						
	FY10	*FY11*	*FY12*	*FY13*	*FY14*	*FY15*
FTE's	*0.31*	*0.21*	*0.05*	*0.00*	*0.00*	*0.00*
Staff Costs	*$26,000*	*$17,000*	*$5,000*	*$0*	*$0*	*$0*
Benefits to Clients	*$104,584*	*$43,920*	*$5,647*	*$0*	*$0*	*$0*
Assessments	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
TOTAL	*$130,584*	*$60,920*	*$10,647*	*$0*	*$0*	*$0*

ESA Cost Estimates for Feasibility Report Section VI, Subsection G

Limited interim stand-alone pilot project in DOC facility (Purdy).

Assume DOC will complete all assessments with no cost to ESA.

Assume 70 new applications will be processed.

Assume July 1, 2009 start date.

FTE(S) FOR ANTICIPATED APPLICATIONS					
# of Anticipated Applications	Total Staff Hours 2.9 per application	Staff Hours		FTEs	
		SW2 (75%)	FSS3 (25%)	SW2 (75%)	FSS3 (25%)
70	203.0	152.3	50.8	0.09	0.03

Assume a total of 2.9 staff hours to complete initial application (75% Social Worker 2 & 25% Financial Service Specialist 3).

# OF APPLICATION ANTICIPATED FOR APPROVAL: GA-U & GA-X&D					
Population	# of Anticipated Applications	Approval Rate	# of Recipients	Type of Benefits	
				GA-U (55%)	GA-X&D (45%)
DOC	70	60%	42	23	19
TOTAL	**70**		42	23	19

Assume 60% approval rate.

55% of approved applications are GA-U & 45% of approved applications are GA-X or GA-D.

CASH BENEFITS TO CLIENTS					
Type of Benefit	# of Recipients	FY10	FY11	FY12	FY13
GA-U	23	$82,723	$22,059		
GA-X & D	19	$21,861	$21,861	$5,647	
TOTAL	**42**	**$104,584**	**$43,920**	**$5,647**	**$0**

Per 2007 ESA Briefing Book, GA-U monthly benefit = $299.72 w/ a 15.2 average length of stay & GA-X monthly benefit = $319.60 with a 27.1 average length of stay. Assume 70% SSI recovery rate.

FTEs ASSOCIATED W/ MAINTENANCE OF GA-U CASES								
	FY10		FY11		FY12		FY13	
# of Recipients	SW2	FSS3	SW2	FSS3	SW2	FSS3	SW2	FSS3
23	0.01	0.00	0.01	0.01				

GA-U: 6 month MCR (.25 hours) & 6 month incapacity review (.5 hours) completed in same year as initial application.
Annual financial review (.5 hours) & incapacity review (.5 hours) completed in year 2.
MCR & financial review conducted by FSS3. Incapacity reviews conducted by SW2.
Average length of stay is 15.2 months.

FTEs ASSOCIATED W/ MAINTENANCE OF GA-X & D CASES								
	FY10		FY11		FY12		FY13	
# of Recipients	SW2	FSS3	SW2	FSS3	SW2	FSS3	SW2	FSS3
19	0.18	0.00	0.18	0.01	0.05			

GA-X&D: 6 month MCR (.25 hours) completed in Year 1.
6 month MCR (.25 hours) & annual financial review (.5 hours) completed in year 2.
SSI Facilitation (includes annual incapacity review): Columbia River CSO staff average 104 cases per month or 15.6 hrs per case per year.
MCR & financial review conducted by FSS3. SSI Facilitation conducted by SW2.
Average length of stay is 27.1 months.