Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Financial Eligibility FTE Use & Associated Outcomes

ESSB 5693 Sec. 203 (1)(gg)

December 31, 2022

Developmental Disabilities Administration
Office of the Assistant Secretary
PO Box 45310
Olympia, WA 98504-5310
(360) 407-1500
www.dshs.wa.gov/dda

Washington State Department of Social & Health Services

Transforming lives

Executive Summary

Engrossed Substitute Senate Bill 5693 Sec. 203 (1)(gg) was passed during the 2022 legislative session and provided one-time funding for additional staff at the Department of Social and Health Services' Developmental Disabilities Administration to reduce the timeline for completion of financial eligibility determinations. It also requires a preliminary report that details how the funds were utilized and the associated outcomes, including, but not limited to, a description of how the timeline for completion of these determinations has changed. A final report of this information must be submitted no later than June 30, 2023.

DDA's Long-Term Care & Specialty Programs Unit, or LTCSPU, manages financial eligibility determinations for DDA clients and for those who are served on certain non-DDA services as well. Applications, renewals and case maintenance for a variety of benefits is maintained by a team of Public Benefits Specialists. Adequate staffing means that the timeliness and accuracy of work performed by the LTCSPU will be improved. This will provide better service to clients, allow them to receive Medicaid health insurance and long-term care services sooner and help meet required processing timeframes. DDA is grateful for the one-time funding for additional staff and recommends that the staff be funded on an ongoing basis.

Background

The LTCSPU was first formed in 2010 within DSHS' Economic Services Administration, Community Services Division. In 2014, the unit transitioned to DSHS' Aging and Long-Term Support Administration because the complex nature of Medicaid eligibility and long-term care was best supported by experienced staff who were subject matters experts in long-term care rules and policy.

In 2019, the LTCSPU moved to DSHS' Developmental Disabilities Administration, to manage financial eligibility for the DDA caseload, along with other specialty programs. This move was beneficial to DDA clients because it brought all DDA case management and financial eligibility staff under one umbrella.

The number of financial eligibility staff managing the DDA caseload has been inadequate since the unit was first established. When the unit transitioned from ESA to ALTSA, the worker to caseload ratio was 1:1,800 and there was a six-month backlog of assignments. In 2015, and each year thereafter, funding has been requested for additional staff. In 2022, the Legislature approved one-time funding for financial eligibility staff in FY23.

Deliverables and Status

JOB CLASS	Base FTEs *Prior to additional funding for FY23*	Permanent FTEs *added in FY23 for caseload adjustment*	SB5693 Non-Permanent FTEs	Total FTEs
Public Benefits Specialist 4	30	4	17	51
Public Benefits Specialist 5, supervisor	4	–	2	6
Social and Health Program Consultant	–	1	1	2
Administrative Hearing Specialist	1	–	–	1
LTC Specialty Program Manager	1	–	–	1
LTC Unit Manager	1	–	–	1
TOTAL	**37**	**5**	**20**	**62**

As of July 2022, all Public Benefits Specialist 4 and Social and Health Program Consultant positions were filled. In August 2022, supervisors were hired, completing the hiring of all the temporary project positions provided by the Legislature in SB 5693. Depending on their skill level when hired, it may take a year or more for a new hire to become proficient. Once all the new staff are trained and gain proficiency with managing the complex long-term care cases, processing times and assignment backlog will decrease, and we will be able to provide better customer service to clients.

Some of the responsibilities for Public Benefits Specialists working in the LTCSPU include processing and making eligibility decisions on initial Medicaid applications, annual eligibility reviews, case maintenance, administrative hearings and call center activities. Staff must also be proficient in determining eligibility for food assistance and cash programs, such as Basic Food under the federal Supplemental Nutrition Assistance Program, food benefits under the Washington Combined Application Project and the Aged, Blind, Disabled cash program with facilitation leading to Supplemental Security Income. In 2017, an internal work study was completed to determine staffing levels necessary to comply with assignment processing requirements. It indicated the ratio needed is 516 cases per Public Benefits Specialists (1:516). Additionally, an internal study was completed years before that indicated a preferred ratio of 1:400 to meet acceptable customer service and performance metrics.

Prior to passage of SB 5693, DDA had 30 PBS4 line staff to manage approximately 36,000 cases, for a ratio of 1:1,200. For FY23, DDA gained 17 PBS4 staff for a total of 51 and the current caseload count is approximately 39,000, making the current ratio 1:764.

Within our current LTC specialty caseload of 39,000, we have a sub-set of approximately 3,000 cases that require management by individual staff who are trained on specific programs. These programs have eligibility rules and processes that are different than our main caseload, although

all of our staff must be familiar with general eligibility for each program we manage. Segregating these "sub-specialty" cases promotes greater consistency and accuracy. Workers who manage these cases must collaborate with facility staff and program managers who work in other agencies and on average, these cases take more time to manage.

For instance, staff who manage our Healthcare for Workers with Disabilities program must do an in-depth analysis of Social Security benefits, Social Security Substantial Gainful Activity standards, earned income, current and potential client responsibility for cost of care, current and potential assets, work related expenses for individuals and employers, along with monthly HWD premium calculations. HWD must be compared to all Medicaid programs that cover waiver and/or personal care and programs for clients who are not receiving DDA services, to ensure the client has the most economical coverage option. Coordination is required with the DSHS Office of Financial Recovery to make sure timely and accurate monthly invoices and premium non-payment notices are issued. Additional expertise is also needed for other sub-specialties, such as:

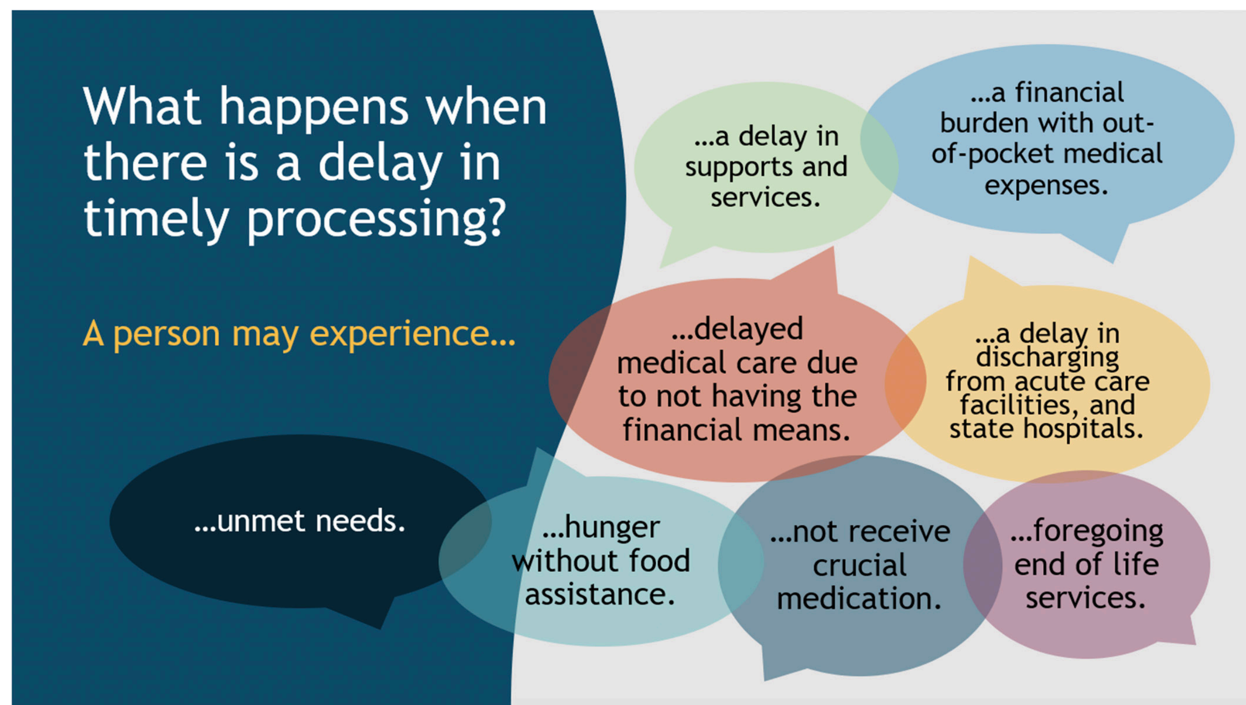
- Hospice.
- DDA Residential Habilitation Centers.
- State Hospital and acute care hospital admissions and discharges.
- Behavioral Health Adult Residential Treatment Facilities.
- Children's Long-term In-patient Psychiatric Facilities.

The sub-specialty cases are managed by seven PBS for a ratio of 1:429 (for 3,000 cases). Staff who manage these cases are not available or only available part-time to manage the general DDA caseload, which focuses on clients receiving DDA services at home, through supported living or in a residential facility. If we subtract seven PBS staff from the current total of 51 and subtract the sub-specialty cases from our total of 39,000, it leaves a more accurate general caseload ratio of 1:818, compared to 1:764 mentioned above.

Problem Statement

Delays in timely processing of applications and not meeting the federally mandated standards of promptness for applications, eligibility renewals and change of circumstances can result in fines and loss in federal matching funds.

When there is a delay in timely processing of initial applications or reviews a client may experience negative outcomes such as hunger due to lack of food assistance benefits, delays in medical care, missing prescription medications, going without personal care or waiver services or even a delay in beginning hospice care due to a lack in medical coverage. A financial burden to the individual for out-of-pocket expenses or overpayments might be incurred or there could be a delay in hospital discharges.



Case Processing

Once approved for a DDA service by a Case Resource Manager who completed a functional eligibility assessment, clients must then complete an application to determine financial eligibility for Medicaid benefits by PBS staff. Receipt of services requires both functional and financial eligibility determination. Financial eligibility for Medicaid requires an initial determination, annual reviews thereafter and case reviews each time there is a change in circumstances for a client.

Initial application processing times require:

- Medical applications be processed within 45 days of receipt.
- Requests for additional information from the applicant are sent within 20 days of receipt of the initial application.

Annual eligibility reviews require:

- Notice with renewal form provided 45 days prior to the end of the certification period, to be completed, signed and returned.
- A complete review of all eligibility factors must be completed at least every 12 months (with certain exceptions) prior to the end of the certification period.

Circumstance changes require:

- Clients in an institution – processing changes the month they happen, or for income, a six-month estimation with a reconciliation of actual amounts.
- Clients receiving HCBS Waivers – processing changes the first of the following month; unless it is a loss or reduction of income, then changes must be processed in the month the change happened.
- Not processing reported changes timely may result in an overpayment or underpayment to the client.

Standard of Promptness is the number of days the Department must process an application for benefits and starts the day after the application is received for each program. The promptness standards for Food and Medical benefits are federally mandated.

Program	SOPs in Calendar Days
BASIC FOOD - Expedited	7
BASIC FOOD - Non-Expedited	30
CASH - Aged, Blind, or Disabled (GA), all types	45
MEDICAL - Disabled	45
MEDICAL - auto-screened S03 Program	30
ALL OTHER PROGRAMS	45

In recent years, the Legislature has invested in significantly increasing slots on DDA waivers to help meet client needs. As caseloads increase so does the workload for financial staff to ensure clients who are filling the slots are Medicaid eligible. The average initial processing time for any assignment was 18.2 days in FY 2019, 34.91 days in FY20, 47.54 days in FY21, and 52.39 days in FY22, which reflects a significantly growing caseload while staffing ratios have remained the same. With an increasing caseload, the number of documents needing be processed also increases. The average total number of assignments waiting to be processed between January and July 2022 was 16,503.

These are the FY23 averages since hiring new staff:

2022	Number of Average Working Days Since: Ready to Work *(initial processing time)*	Average Total Cases	Average Pending Documents/Assignments	Average Pending Case Action Ticklers
July	58.09	7,155	9,521	5,548
August	58.62	6,524	8,230	5,431
September	53.43	6,269	8,089	5,019
October	55.80	5,979	7,709	4,544

The use of overtime and the addition of non-permanent project positions for FY23 has helped lower the backlog, but the backlog will return when the project positions end. New hires are assigned work that matches their skill level and they have been able to reduce the backlog of documents to be processed. Seasoned staff are assigned more difficult work which takes longer to process, but seasoned staff are also occupied with mentoring new hires. While the overall average processing time has not significantly reduced, the backlog of pending assignments has been reduced.

DDA Financial Call Center

The DDA LTC and Specialty Programs Unit manages a call center with a toll-free line for anyone who is interested in learning more about services and financial eligibility. Clients, authorized representatives, care providers and DDA case managers also call to inquire about case status, to report changes, to complete required interviews and to provide information. Prior to August 2022, the average call hold time for a team member was 10 minutes. The average amount of time that a person waited on hold before abandoning a call was 8 minutes. Approximately 21 percent of all calls went unanswered. The average time spent on each call, which includes taking case actions, was 18 minutes. Since adding new hires who have attained adequate skill levels the customer experience has improved in most areas. The call center is also using a new platform with features that have aided performance. The average hold time between August and October has reduced to 4 minutes and 32 seconds.

In order to have low hold times at base staffing levels, the unit must have maximum staff coverage in the call center. Consequently, to process documents the unit must periodically close the call center to work on pending assignments (documents received and other case actions). It is a challenging balance to manage a call center and manage pending assignments, since delays in processing documents can drive up call volume. Being able to adequately staff the call center will improve customer service, lessen caller frustration and provide a better experience for both customers and staff.

Training & Knowledge

The rules and policies that the members of the Long-Term Care & Specialty Programs Unit must know to make decisions about eligibility for Medicaid and other benefits are abundant and complex. Required basic training can take six to 12 months to complete, and an additional six months to complete the necessary long-term care trainings. After training is completed, it takes one year or longer to become proficient in long-term care processes, skills and knowledge of rules. PBS basic training includes a variety of topics:

Public Benefits Specialist (PBS)

Overview - CORE TRAINING

Culture & Poverty Awareness

Trauma Informed Approach • Verbal De-escalation • Communication

Introduction to (eligibility) Systems

Screening Applications • Interviewing and Processing • Finalizing Applications • Documentation Templates • Processing Changes • Introduction to Systems Applications Using • Electronic Case Records

Basic Food (Assistance) Principles

General Eligibility • Interview Requirements • Processing Applications • Expedited Services • Assistance Units • Citizenship and Immigration • Income • Income Deductions • Work Requirements • Resources • Case Maintenance • Change of Circumstances • Working Family Support (WFS) • Reconsiderations • Elderly Waiver • Document Management System • Washington Connection • Online Services Access • Mid-Certification Reviews (MCRs) • UTAB Verifying Unemployment Income • Working with Justice Involved Individuals • The Business of Benefit Errors • Worst Case Scenario

Eligibility Interviewing

Interviewing for Accuracy • Dealing with difficult situations and behaviors

• Asking the right questions to get the most complete and accurate answers

Public Benefits Specialist (PBS)

...continued Overview - CORE TRAINING

Call Agent Technical Training

Cash Programs for Adults

Adult Cash Programs Overview • Program Requirements for ABD and MCS • Program Requirements for Refugee • Processing Changes for Adult Cash Programs

Classic Medical Programs

Classic and Other Medical Programs • SSA/SSI • SSI and WASHCAP • Classic Medical/SSI Related General Eligibility • Classic Medical/SSI Related Resources and Income • Establishing Base Periods for Spenddown • SSP and Income Allocation • Medical Changes & Redeterminations • Specialty Medical and Review • Verifying Liquid Resources for Classic Medical • NGMA Referrals

Family Cash

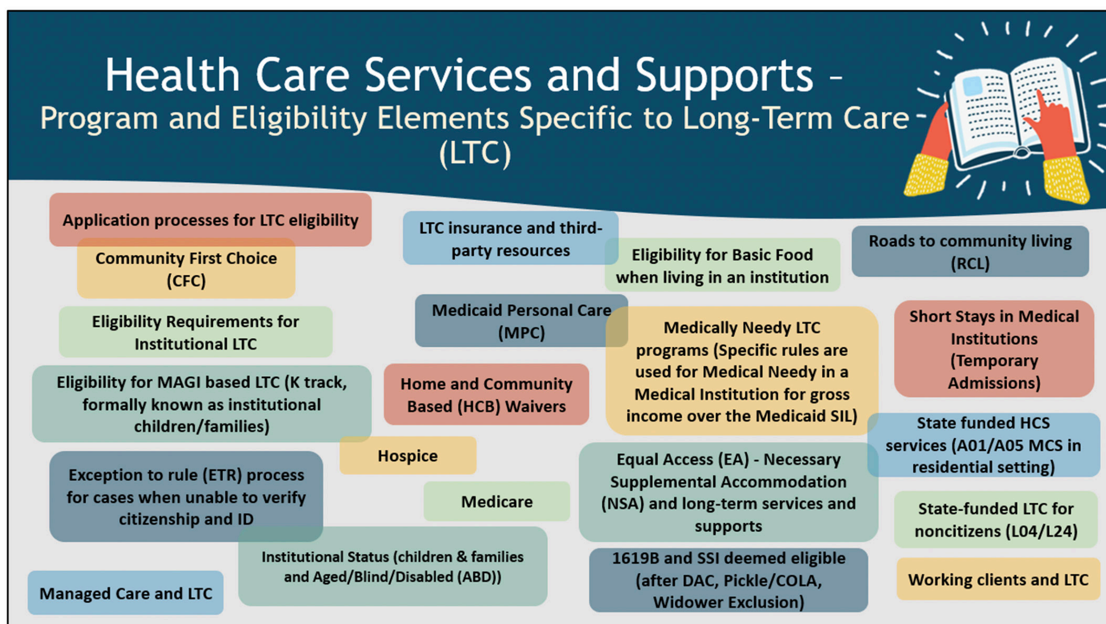
Households • Program Requirements • Child Support • Minor Parents • Resources • Income • Changes • WorkFirst Overview

Additional Training

Consolidated Emergency Assistance Program (CEAP) Diversion Cash • Assistance (DCA) • Additional Requirements for Emergent Needs (AREN) • Automating Exception to Rule Requests • FRED Referrals • Vendor Payments, Affidavits and Warrant Replacements • Basic Food Disqualifications for Sanctioned WF Parents • Immigrant Eligibility • Sponsor Deeming Exemption Steps

Training specific to long-term care is called LTC CORE and includes a variety of complex topics:

PBS staff who manage cases with institutional and home and community-based services are required to have extensive knowledge in advanced program and eligibility elements. Specific program knowledge includes classic Medicaid (non-MAGI-based), Modified Adjusted Gross Income Medicaid (MAGI-based) and long-term services and supports, which includes determining what a client's responsibility is towards their cost of care (room and board and participation):



Processing initial applications, annual renewals, and changes in circumstances requires financial staff to consider all the eligibility elements for dozens of programs and services along with expert use of case management systems:

Although we have many new PBS 4 staff, most are not yet ready to fully contribute towards reducing our backlog or to help in the call center. Depending on their skill level when hired, it may take a year or more for a new hire to become proficient. Seasoned workers help with onboarding and mentoring new staff, which means they have less time to manage cases. Recently hired PBS staff will require more on the job training within the unit, since the next offering of LTC CORE training is not until March 2023. DDA currently does not have any funding for financial training staff and must rely on trainers at ALTSA and ESA.

Conclusion

DDA is grateful for the one-time funding from the Legislature and recommends that it continue so that backlogs do not recur, and the individuals and families served by DDA continue to have access to quality customer service. The LTCSPU has a concentrated caseload of some of the most vulnerable of Washington's citizens. Adequately staffing the team means that staff can have personal contact to help people become or maintain their Medicaid eligibility and prevent negative outcomes.

DDA will provide the Legislature with a final report by June 30, 2023, demonstrating that maintaining our recent staff additions will improve the timeliness of application processing, eligibility reviews and case maintenance actions while reducing call wait times for clients. Once recent hires are fully trained and have experience with this complex work, clients will receive appropriate services much sooner than they do now and within federal-mandated standards of promptness. PBS staff will be able to be more proactive in case management, reaching out to help clients who have not responded to requests for information or who are in jeopardy of losing eligibility. This preliminary report provides baseline information and current progress with which the final report will provide a comparison.