

BUSINESS REDESIGN: A NEW MODEL FOR MOVING FOWARD

EXECUTIVE SUMMARY

In the summer of 2010, the North Carolina Association of County Directors of Social Services (NCACDSS) developed a workgroup to assess program and policy simplification. Local departments continue to struggle with higher caseload numbers while being expected to still meet standards. The workgroup focused, primarily, on Economic Services programs in making recommendations which are designed to address the following four issues. Each concern listed below has implications of Health Care Reform running through it as a common thread.

1. Increasing Caseloads
2. Gaps in Participation
3. Inefficiencies in the System
4. Inconsistencies Across Programs

Some of the items noted in this document are in the process of being reformed; others have additional barriers that require further work. We do not want to hinder any of these things from happening by sending conflicting messages to our elected officials. Therefore, the intent of this document is not to be used for advocacy purposes, but rather as a guide for what has happened to date and to prepare for what is to come.

Recommendations

The recommendations from the NCACDSS workgroup to the NC Department of Health and Human Services (DHHS) can be broken down into three categories, as follows:

Simplify Programs

1. *Estimate gross monthly income using a standard base period.*
2. *Use Federal Poverty Level to determine eligibility for Subsidized Child Care (rather than State Median Income).*
3. *Remove resource tests requirements for programs with the exception of Adult Medicaid-Long Term Care and Special Assistance.*
4. *Adapt an overall policy regarding countable resources.*
5. *Maintain current definitions of household and whose income and resources are counted and make it consistent across programs.*

6. *Determine acceptable time limits for how long verification is valid.*
7. *Automate requirements under Alexander Law.*
8. *Stop counting life insurance policies in Adult Medicaid-Long Term Care.*
9. *Consider applying for additional Food and Nutritional Services (FNS) waivers, such as: a flat percentage self-employment deduction, and a reduction in reporting requirements and reinstatement.*
10. *Develop and implement a common reporting process.*

Align Eligibility Processes

11. *Develop common definitions for earned, unearned, and non-countable income that provides a single reference point for all programs.*
12. *Standardize a core set of (collected) eligibility information collected for all applicants.*
13. *Establish a single change reporting standard.*
14. *Simplify and align budgeting procedures for gross income across DHHS programs.*
15. *Establish a core set of verification standards across DHHS programs and accept verified information across programs.*
16. *Extend program certification dates for the purpose of aligning recertification periods*
Establish a single change reporting standard across programs.
17. *Develop a staffing classification to handle multiple programs.*

Improve Technology

18. *Rollout NC Fast. Develop and implement a centralized screening and intake process (NCFast) that requests and collects eligibility information across DHHS programs.*
19. *Develop a State Customer Support Center (Change Center).*
20. *Use EBT/Smart Cards to house multiple program benefits.*
21. *Promote new technology for screening/applications.*
22. *Utilize state systems to identify areas of fraud, abuse, or misuse.*

In addition, we are recommending two further studies:

- *Conduct a feasibility study on Special Assistance and Adult Medicaid-Long Term Care to assess how those programs could also achieve simplification.*
- *Continue simplification work in the adult and children social work services areas.*

OVERVIEW

In the summer of 2010, the North Carolina Association of County Directors of Social Services (NCACDSS) developed a workgroup to assess program and policy simplification. (See Appendix I for a list of the participants). The need for Business Redesign within Departments of Social Services exists to have a more effective, streamlined, and integrated approach to service delivery in order to meet the demands of increasing caseloads and Health Care Reform, as well as address gaps in participation, inefficiencies in the system, and inconsistencies across programs. Local departments continue to struggle with higher caseload numbers all the while being expected to still meet standards.

The workgroup feels that DHHS must reduce state/county administrative burdens as well as the burden on clients, through technologically innovative and customer-driven methods of enhanced access, simplified enrollment, eligibility determination, retention, and program coordination. Many citizens do not receive or keep the full package of benefits for which they qualify for due to complex, burdensome, and sometimes overlapping or contradictory eligibility and redetermination systems. Duplicative eligibility systems or processes within systems can hamper case workers, state/county administration, and citizens who seek multiple benefits, creating unnecessary work for caseworkers, increasing administrative costs, increasing the potential for errors, and straining the agencies and staff that are struggling to cope with state/county budget cuts.

The NCACDSS workgroup focused mainly on Economic Assistance programs in this brief which includes the following:

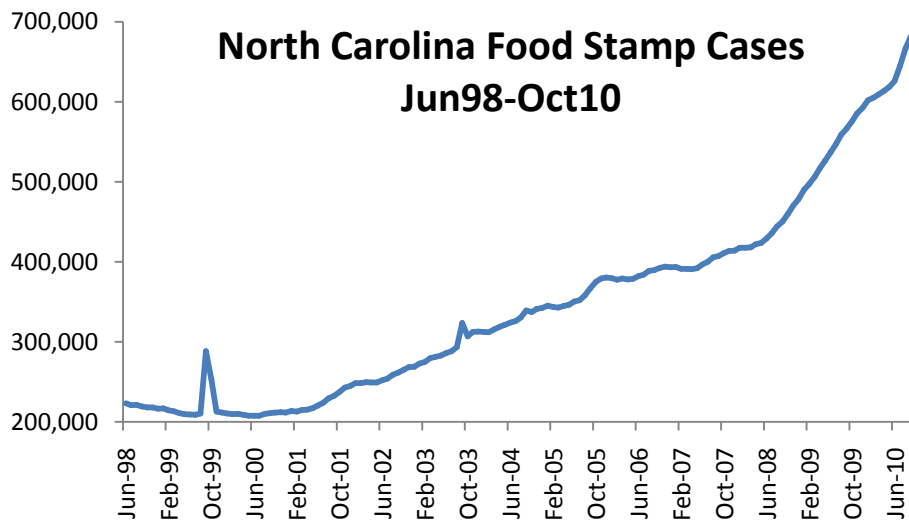
- Food & Nutritional Services (FNS)
- Medicaid
- Child Care
- Work First
- Energy Assistance
- Special Assistance (*tied to SSI regulations)
- Refugee Assistance

CONCERNS

To provide quality services to clients that are timely, accurate, and meet all mandated requirements, DHHS must help counties address concerns associated with caseload increases, gaps in participation, inefficiencies within systems, and inconsistencies across programs, each of which has a component in Health Care Reform.

Caseload Increases

1. **Record FNS Growth.** The last three years have brought record growth to several economic assistance programs, the greatest of which is Food and Nutrition Services. In the last 36 months alone, the number of cases, state-wide, has grown 66%. This translates to over 270,000 new FNS recipients since October of 2008.



2. **Health Care Reform.** The Patient Protection and Affordable Care Act (PPACA) expands Medicaid to nearly all individuals under age 65 with incomes up to 133% of the federal poverty level (FPL) that will extend coverage in 2014 to large numbers of the nation's uninsured population. Low-income adults who do not have a disability or live with an eligible child will soon qualify for Medicaid when the program is expanded nationwide. There are an estimated 16 million individuals, nationwide, set to gain health insurance in 2014, with more than 660,000 of those living in North Carolina.

Gaps in Participation

While we have seen caseload increases in many programs, gaps in participation remain. According to United States Department of Agriculture (USDA) data, only about half of eligible working families receive Supplemental Nutrition Assistance Program (FNS).¹ Additionally, a recent health report stated that, on an average day in 2008, an estimated 7.3 million children in the United States were uninsured, 65 percent of who were eligible for Medicaid or the Children's Health Insurance Program (CHIP) but

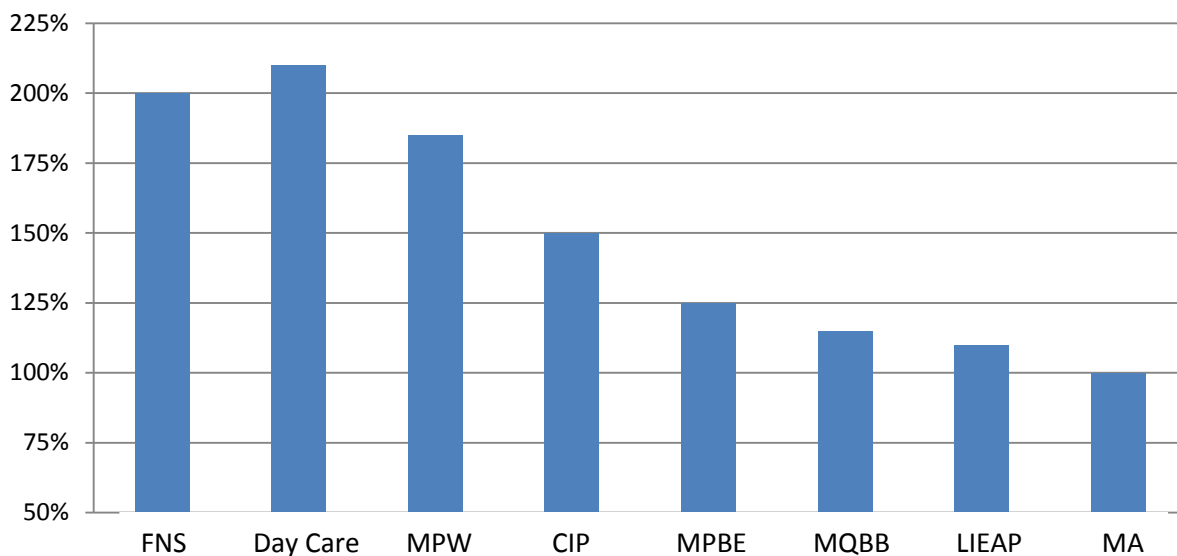
¹ U.S. Department of Agriculture (USDA). 2010a. "Trends in Supplemental Nutrition Assistance Program Participation Rates: 2001–2008." Alexandria, VA: Food and Nutrition Service, Office of Research and Analysis, U.S. Department of Agriculture.

not enrolled.² The need for more efficient processing of applications and renewals has become even more pressing with the enactment of the Patient Protection and Affordable Care Act (PPACA) or the Affordable Care Act (ACA), which promises an enormous expansion of Medicaid eligibility and a corresponding increased demand for eligibility determinations from social service agencies. This reinforces the urgent need for states to develop more efficient methods of determining eligibility for multiple programs, because millions of people newly eligible for health coverage will already be enrolled in FNS or other human services programs. Similarly, many individuals seeking health coverage will be eligible for other benefits. The state, therefore, needs to enhance system efficiency and effectiveness, improving accuracy of eligibility determination and customer service, eliminating unnecessary paperwork for both families and caseworkers, and serving more families with fewer burdens on caseworkers.

Inconsistencies across Programs

1. **Income Eligibility Levels.** All programs require that applicants meet certain income guidelines. These guidelines are different for nearly every program, and in some instances differ based on characteristics of the household (e.g. age of children). Most of these limits are based on the Federal Poverty Level (FPL), with the exception of Subsidized Child Care, which is based on State Median Income (SMI). Below, however, it is represented as FPL for consistency in comparison.

DHHS Program Income Limits by % Federal Poverty Level



2. **Income and Resource Tests.** All programs establish the household or individual gross income as part of the eligibility determination process. While the gross income amount is not always the amount that determines whether an individual is income-eligible, it is the common starting point for all programs. **Most** programs, including FNS, Work First, Refugee Assistance, LIEAP, Special Assistance and many types of Adult Medicaid, require that recipients meet a resource test. Other programs, including CIP and Subsidized Child Care and Medicaid for Infants and Children, do not have a resource test. Notably, resources are also not counted for FNS applicants deemed categorically eligible. Across programs,

² Kenney, Genevieve M., Victoria Lynch, Allison Cook, and Samantha Phong. 2010. "Who and Where Are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?" *Health Affairs* Web First, September 3

resource limits range between \$2,000 and \$3,000, but Adult Medicaid programs set the resource in accordance with SSI resource limits.

3. **Income Budgeting Method.** In order to arrive at a gross monthly income, programs collect income information over a given period of time (base period) and convert to a monthly amount. Household composition and whose income and resources are counted during eligibility determination varies significantly among programs. FNS counts all members of a household who live together and purchase their food together, while other programs (Work First, Subsidized Child Care, Family and Children's Medicaid) consider people who are financially responsible for a child. For LIEAP, everyone who lives at the same residence is counted, regardless of their relationship to one another. In Subsidized Child Care, families who exceed the income limit can also qualify in some situations, if they are in a crisis situation as determined by the child care social worker.
4. **Verification Requirements.** Requirements around verification of demographic information, income, citizenship and resources vary widely across all programs.

Identity: For example, all programs, with the exception of Subsidized Child Care, verify the identity of applicants. **Most** programs require third party verification or documentation to prove identity; exceptions include Energy Assistance programs, and Subsidized Child Care. There are often issues with the name used in FNS not agreeing with Medicaid to the Aged, Blind and Disabled (MAABD), indicating a need for DHHS to enforce consistency between programs

Age: most programs only require third party documentation/verification of age if questionable. Subsidized Child Care does not require verification for age/date of birth (DOB).

Residence: Similarly, **most** programs require third-party verification/documentation of residence. Energy Assistance and Subsidized Child Care, however, only require documentation if it is questionable. Conversely, other Medicaid programs require two forms of third party verification/documentation in order to verify residency.

Income: When it comes to income nearly all programs require third party verification for income. In this case, the only exception is the Crisis Intervention Program, which only requires verification/documentation if questionable.

5. **Certification and Reporting Periods.** For ongoing programs that include a traditional cycle of apply-and-recertify, such as FNS and Medicaid programs, certification periods are typically 6 or 12 months. Exceptions include seasonal or one-time benefits, which include LIEAP, CIP and Refugee Assistance. In addition to requirements around certification periods, programs have various reporting guidelines, but most require that recipients report changes within a certain brief amount of time. Medicaid programs generally require that clients report changes that could affect eligibility **within 10 days**. Subsidized Child Care and Special Assistance require that individuals report changes **within five days**. FNS requires that recipients report changes by the **10th of the month** following the change. Work First reporting requirements **vary** based on whether the case is "child-only" and the type of Work First benefits being received.
6. **Initial Interview Requirements & Recertification Options.** FNS, Work First, Subsidized Child Care, Refugee Assistance, Special Assistance, CIP and LIEAP (if not through FNS match), require an initial face-to-face interview. In most cases, these face-to-face interviews can be waived if there is a hardship. Medicaid programs generally do not require a face-to-face interview. For programs that require a face-to-face interview, integrated eligibility could reduce several interviews into a single interview. Fewer

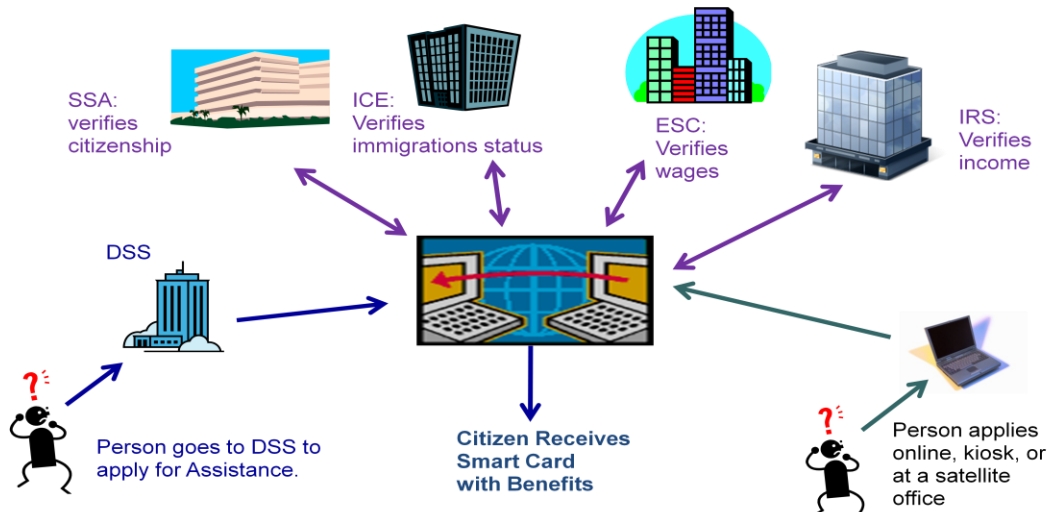
face-to-face requirements exist for recertification, and mail-in and telephone options are more acceptable for recertification. Mail in applications for Adult Medicaid Long Term Care and Disability determinations are extremely complex because there is so much information needed up-front that is not provided with the mail in application. For example, specific release forms for disability determination needing signature of client are not available with the mail in application.

- 7. Resource Determination.** Countable resources are generally common among FNS, Work First, Refugee Assistance and Energy Assistance. In Medicaid and Special Assistance, and particularly Adult Medicaid-Long Term Care, however, countable resources are significantly different from those programs. This could mean significant changes for Medicaid and Special Assistance resource requirements. It is important to consider that Health Care Reform calls to eliminate the asset test for most participants. This may provide some justification for removing resource tests from other programs.

Inefficiencies in the System

- 1. Duplication and Unnecessary Work.** There appears to be an enormous amount of effort that Social Services staff put into unnecessary functions which are commonly generators of unproductive administrative costs. Some of these functions include frequent reviews, printing copies of verifications for multiple programs, duplication of forms and collection of the same information and time spent interviewing clients to gather the same information. Unnecessary and repeated work is frustrating for staff, which in turn can negatively affect customer service. It is also costly for citizens when they skip a month or more of benefits and miss work to reapply. Some families fall through the cracks because they do not realize they can reapply, or get disheartened with the process and choose to go without. Stabilizing access and retention are also likely to reduce administrative costs associated with the needless closing and reopening of cases. The importance of this can be seen in decreased time spent collecting information, less frequent interviews, reduced paperwork for staff and clients and a more seamless system of providing benefits to eligible clients.
- 2. Health Care Reform.** Social Services will no longer be the **only** point of entry for eligibility determination as Health Care Reform will require a “no wrong door” approach. States may allow citizens multiple modes of enrollment including in person, by phone, by mail, or online via the Internet from the comfort of their own home (likely through NCFast), at a public library, or at various community organizations. We will need to streamline eligibility, simplify enrollment, and streamline the assets test for most groups. We will also need to create a new formula to determine financial eligibility to include a new modified adjusted gross income, an equivalent income test, and eliminate asset tests for new categories but not for existing categories. There will likely continue to be multiple methodologies for determination. North Carolina will need to develop new training for eligibility workers, revise manuals and rules, create new job classifications, and advocate for possible legislative changes. (See Appendix II for additional information on Health Care Reform).

Application and Enrollment

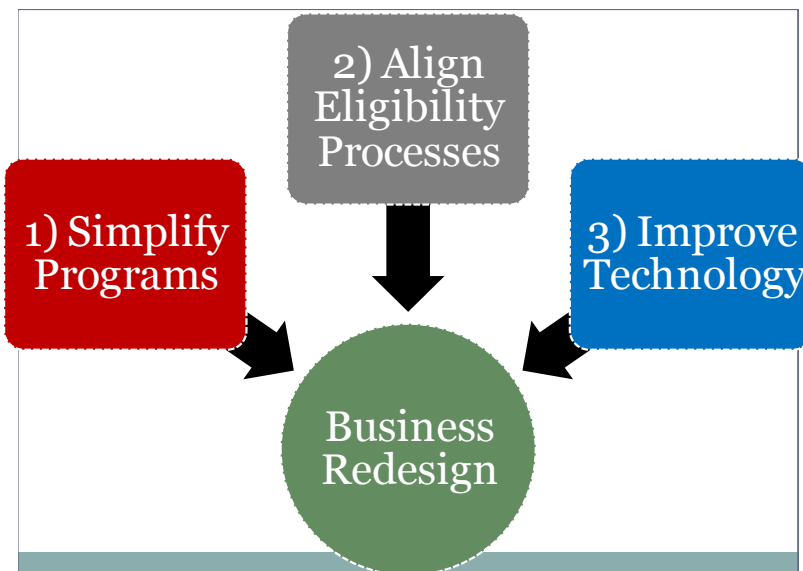


RECOMMENDATIONS

Based on our analysis (the methodology of which consisted of countless workgroup sessions as well as interviews with DSS Directors around the state —for questions asked, please see Appendix III), we advocate for implementing recommendations in three categories. The goal of these recommendations is three-fold: 1) to address climbing caseload numbers across all Economic Services programs, 2) to reduce system inefficiencies as well as inconsistencies across programs, and 3) ensure North Carolina is positioned for successful implementation of Health Care Reform.

Three Categories of Recommendations

We recommend DHHS implement 22 recommendations and two further studies in the categories shown:



Simplify Programs

1. **Estimate gross monthly income using a standard base period.** Provide overall guidelines and concepts for counting income that reinforce “prudent person” concept. Aim to collect a “reasonable estimate” of “current and representative” income.
2. **Use Federal Poverty Level to determine eligibility for Subsidized Child Care (rather than State Median Income).** Subsidized Child Care and any other programs that use SMI should use FPL so that clients can more easily be screened for programs.
3. **Remove resource tests requirements for programs with the exception of Adult Medicaid-Long Term Care and Special Assistance.** With the implementation of categorically eligible rules, FNS drastically reduced the number of applicants required to meet a resource test. And with the emergence of Health Care Reform – which abolishes the resource test for the new, higher-income Medicaid population – there is a strong justification for removing the resource test for Family and Children’s Medicaid programs in North Carolina. Given the different nature of the resource test in Adult Medicaid Long Term Care programs and Special Assistance; it may not, however, be prudent to remove the resource test.
4. **Adopt an overall policy regarding countable resources.** DHHS consider revamping resource rules to align more closely with Work First resource policies and procedures, counting only liquid assets, ones that can be converted within five days. Also, motor vehicles should not be counted if there is not an active title. Generally customers no longer have the vehicles and it takes much time and paper to clear these vehicles out of their names. Below are recommendations for resource types that would be counted:
 - Bonds
 - Cash
 - Checking Accounts
 - CDs
 - Combined Funds
 - Loans (deposited in accounts)
 - Lump Sums (non-recurring)
 - Mutual Funds
 - Promissory Note
 - Savings Account
 - Severance Pay
 - Stocks
 - Time Share Contracts
 - Transferred Resources
 - Trust Funds (including UTMA)
5. **Maintain current definitions of household and whose income and resources are counted.** While aligning income types, verifications and other components of the eligibility process have a relatively minor impact on whether a family is actually eligible for a program, redefining household concepts for each program could have a drastic impact. While DHHS should request/collect information about all potential members of a household at initial intake/screening – and case workers should use that information to *construct* program households – it should not redefine program-specific definitions of households. We should have a standard way to collect household info to ensure that it is applied consistently.

6. **Determine acceptable time limits for how long verification is valid.** Income verified within these time limits would not need to be re-verified if an applicant applies or recertifies for a different program. DHHS must determine how long reported income information is valid from the time of initial entry (recommend a 30 day base period).
7. **Simplify or eliminate requirements under Alexander Law.** The requirements under Alexander are often detrimental and inflexible to a DSS' ability to be creative and efficient with staffing and resources; there are ways we can utilize technology with models of accessing our community to ensure that the intent/spirit of Alexander are met without the current rigid time and processing standards.
8. **Stop counting life insurance policies in Adult Medicaid-Long Term Care.** Generally we verify life insurance and routinely do not end up having to count the same, or the countable amount is very minimal so the impact of life insurance on eligibility is minimal. Elimination of this policy would save time, paper and postage. Currently life insurance is not counted in Family and Children's programs. Also, we should revisit the Low Income Subsidy and see that letters are mailed to potential applicants rather than automatically generating applications. There is a great deal that goes into processing these cases and often these cases end up being denied and customers are upset that we are contacting them
9. **Consider applying for additional Food and Nutrition Services (FNS) waivers.** Some considerations are as follows:
 - Self-Employment Deduction Standard-Allows flexibility to develop a method to calculate the cost- at a flat percentage. Currently 16 states have adopted the simplified method for determining costs of doing business for self employed applicants. Benefits and considerations of the standard deduction include:
 - Simplification – easier for workers to budget/fewer computational errors; clients do not have to provide as much verification; workers do not have to itemize.
 - Flexibility to develop a method to calculate this cost; can use the same standard used for the TANF program
 - Must be cost neutral, requires approval from FNS
 - Clients with higher expenses may receive fewer benefits.
 - Waiver of Face-to-Face Interview-Currently, NC has a waiver of the face-to-face interview at recertification. NC's application for a broader waiver of face-to-face interview for all clients at both recertification and certification was denied. Regulation stipulates that State agencies conduct a face-to-face interview at initial certification and at least once every 12 months thereafter, as part of the certification process. States may opt to request a waiver to the requirement that all households receive a face-to-face interview, either at initial certification or at recertification. In lieu of the face-to-face interview, interviews are conducted by telephone, although the state still retains the option of conducting a face-to-face interview if it is determined that one is appropriate, or if the applicant requests a face-to-face interview. Eligibility workers gather the same information and take the same actions during a telephone interview as during a face-to-face.

- Simplified Reporting-Certification Length-With passage of the Farm Bill, Section 4109, *State Option to Reduce Reporting Requirements*, provided that households subject to reporting on a periodic basis submit reports not less often than once every 6 months. State agencies have opted to certify simplified reporting households for 12 months, with an interim report at 6 months. Households in which all members are elderly or disabled with no earned income may be given up to 24 month certification periods with a 12 month interim reporting requirement.
- Reinstatement of Eligibility Waiver-In FNS, State agencies can reinstate eligibility without requiring households to file a new application if the household provides verification required to reestablish eligibility during the calendar month following the effective date of closure.

10. Develop and implement a common reporting process which says that all clients must report changes in household income and composition composition—including changes in legal responsibility or custody of a minor within the same timeframe/days. Clients should not be asked/required to figure out which changes might impact eligibility status or the level of the benefit. Because this would apply across programs, base reporting requirements would likely be based on the program with the lowest income limits. The current system of having one set of reporting requirements for FNS households with income below 130% of poverty and another set of reporting requirements for households with income over 130% is confusing.

- DHHS should work toward eliminating complex rules for counting **education** income for all programs, virtually making all education income non-countable. This would likely require federal approval.
- DHHS should develop an overarching rule for not counting **lump-sum payments** as income.
- DHHS should develop an overarching rule for differentiating between **lump-sum payments** and those made on a consistent basis.
- DHHS should develop an overarching rule for counting **payments made directly to a client**, and not counting payments made to a third party on behalf of the client (housing assistance).
- DHHS should develop overarching policies for **military payments**, counting all taxable pay and not counting combat pay.
- DHHS should develop overarching policies to not count **Indian Payments**, but count gambling proceeds.
- Whether income is counted as “earned” or “unearned” makes a difference for some programs, especially Medicaid which is not allowed to make income rules more restrictive.³

- DHHS could focus more generally on whether certain income information is *collected*, relying on simple system rules to determine whether income is earned or unearned for a particular program.

Align Eligibility Processes

11. Develop common definitions for earned, unearned, and non-countable income that provides a single reference point for all programs. Income types, amounts and recipient should be recorded at initial intake/screening and verified/documented if possible. Although adjustments to gross income will still need to be made at the program level – either automatically or manually –the Department of Health and Human Services (DHHS) gross income will provide case workers with a reliable starting point. If implemented correctly, case workers will be able to assume that income information was collected in a consistent way during intake/screening or during application for a difference DHHS program. Specific recommendations include:

- a. Align countable and non-countable income types across programs.
- b. Develop a common definition for Earned Income, Unearned Income and Non-countable Income that provides a single reference point for all programs.

12. Standardize a core set of collected eligibility information collected for all applicants/recipients.

Applicants should be encouraged to provide basic information of all household members at initial intake/screening (in addition to typical information such as name, address, phone number, etc.). Counties should use the broadest definition of household to explain which individuals the client should include. Specific recommendations (which should be transferable among programs) include:

- Request/collect the age of all members of the household during initial intake. Accept applicant statements unless questionable. If questionable, verify through SOLQ.
- Request/collect residency verification/documentation at initial intake for all programs. Accept applicant’s statement unless questionable.
- Request/collect household composition verification/documentation at initial intake only if questionable. Otherwise, accept client statement.
- Request/collect the relationship of all household members at initial intake. Use the broadest definition of household to explain which individuals the client should include.
- Request/collect SSNs of all household members at initial intake and verify online. Explain the enumeration process to clients without SSNs.
- Request/collect immigration/alien status during initial intake.
- Request/collect third party verification/documentation of income for all household members at initial intake.
- Request/collect third party verification/documentation of citizenship only if questionable. Otherwise, accept statement.
- Collect additional verifications (not listed above) as needed for each program. Instruct case workers to document the type of verification received. In instances, where

documentation may exist in other programs, case workers should utilize previously verified information when possible.

- 13. Establish a single change reporting standard across programs.** DHHS should require clients to report on the same schedule (within ten days of change, for example) so that there is a universal rule across programs. To support program integrity, DHHS should clarify and emphasize reporting requirements to clients.

EXAMPLE: Change Reporting Standard →

Recipients must report and verify changes in household circumstances to the Department no later than ten days after the date the change becomes effective. Examples of information that must be reported include:

- Any increase or decrease in income;
- Any change in the number of individuals living in the household
- Any changes in legal responsibility or custody of a minor child

- 14. Simplify and align budgeting procedures for gross income across DHHS programs.** Beyond aligning the definition of income and whether certain types are countable/non-countable, DHHS should reconfigure budgeting procedures so that the DHHS gross income amount is calculated consistently at intake/screening and at the program level.

EXAMPLE: Budgeting Procedure →

- Establish monthly income by collecting verifications of all earned and unearned income.
- Earned Income is the total amount of compensation received from work or services performed and include wages, self-employment and payment from roomers/boarders
- Convert weekly or bi-monthly income into monthly amounts using the following formula: Weekly*4.33
- Collect most recent paystubs from current employment for most recent month. Any applicant who reports employment is required to provide verification of employment via paystubs or employer's signed affidavit of terms of employment and hours worked.
- If the applicant cannot obtain employer's affidavit or provide paystubs, confirm monthly amount with the applicant.
- Individuals who are self-employed must provide the following documentation: Most recent years tax filing including IRS Schedule C if the application is made within the first six months of the calendar year OR Chart of Accounts detailing income and business expenses for the current or most recent quarter including IRS Form 1099 as applicable.

- 15. Establish a core set of verification standards across DHHS programs and accept verified information across programs.** DHHS should establish a core set of verification requirements that apply across programs. During intake, continue to collect/request income at an individual level (tying each individual to income) and record the relationship among household members. Encourage applicant to provide basic information (DOB, relationship) of *all* household members at initial intake. Use the broadest definition of household (LIEAP/FNS) to explain which individuals the client should include. Accept applicant statements unless questionable. If questionable, verify through SOLQ. If needed, Work First maintains responsibility to verify age at recertification. If

age/DOB of applicant or household member has been verified by *any* program, age/DOB has been verified for *all* programs. While these will not entirely satisfy all verification requirements for programs, these are the most common and therefore can be leveraged most often among programs.

- Require third party verification or documentation of applicant identity for all programs. If identity of applicant has been verified by any program, identity is accepted as verified for all programs. If needed, Work First maintains responsibility to verify age at recertification.
- If age/DOB of applicant or household member has been verified by any program, age/DOB has been verified for all programs.
- Require one form of third party verification/documentation of residency for all programs. No longer require two forms of verification/documentation for Medicaid programs. If residency of applicant or household member has been verified by any program, residency has been verified for all programs.
- If SSN of applicant and household members has been verified by any program, it has been verified for all programs.
- If Alien/Immigration Status of applicant and household members has been verified by any program, it has been verified for all programs.
- If citizenship of applicant and household members has been verified by any program, it has been verified for all programs.
- If DHHS gross income of applicant and household members has been verified by any program, it has been verified for all programs.

16. Extend program certification dates for the purpose of aligning recertification dates. For applicable programs, DHHS should extend recertification dates in order to align them with other program recertification dates. The implementation of this policy would give case workers the ability to push out recertification to the next closest recertification date (of another program). As a starting point, DHHS should consider aligning redetermination dates for Work First clients who receive multiple benefits. We should also assess Transitional Medicaid Benefits and see if conducting quarterly Transitional Medicaid authorization (TMA) with the transitional benefit report is cumbersome. Recommend reverting back to straight 12 months extended Medicaid instead of TMA. If this is not possible, request to simply key the c's (the "c" is what is keyed in the screen to let EIS know the report has been received so the case does not terminate) to get the customers through the 12 months TMA instead of doing quarterly income tests, etc. Additionally, we should assess whether it is possible to convert households with multiple MIC cases into 1 MIC case at review. This would eliminate a huge number of reviews in that we would only have to do one per year. For many families, caseworker's are doing multiple reviews because the children have different certification periods. DHHS should do away with Transitional FNS, or change it to match Transitional Medicaid policy. The Transitional FNS policy is not working as it was intended. (recommend certification periods being the same if base periods are the same).

17. Develop a staffing classification to handle multiple programs. When queried, DSS Directors across the state indicated that state personnel classifications weren't keeping up with the

changing times. More and more offices want to move to a more “generic” caseworker, but find there isn’t a system in place to hire and classify that type of staff person.

Improve Technology

18. Rollout NC Fast.

- Automate all state forms and eliminate the need to keep forms and “turnaround forms” in paper versions
- Allow customers to see the status of their online application, check on benefits, provide updated information (change in situation), schedule a meeting with a case worker, etc.
- Allow others to use OLV to obtain a real time validation for the child receiving FNS or use the FNS Application (once approved) to generate WIC and Free & Reduced School Lunches.
- Interface NCFAST with the NC Board of Elections and automate the Voter Registration/Preference forms into NCFAST.
- Interface NCFAST to access Housing and Urban Development (Section 8) information
- Develop a centralized screening and intake process (NCFAST) that requests and collects eligibility information across DHHS programs. This includes screening for all relevant programs upon initial intake, sharing client eligibility information across programs, aligning recertification periods and coordinating any required program-specific appointments. Develop and implement an intake script that ensures legal and privacy requirements are upheld. This script would 1) include an explanation of how additional information would be used to determine other program eligibility (now or in the future) and 2) stress the components of the screening/intake that are optional. Upon application and/or redetermination, county staff should consider whether clients may be eligible for multiple DHHS-administered benefits based on income information.
- Allow staff from all programs to view case information received through other program applications or initial screening/intake, and instruct case workers to use this information as much as possible. This will be a key to the successful implementation of integrated eligibility. DHHS should make it a priority to ensure that case workers across programs will have access to client information collected through the initial intake/screening process and through other programs. This information should be maintained and displayed in a clear, user-friendly manner to promote – or require – use.
- Send alerts to workers when a client’s certification period has expired, and if a program is terminated (including the termination code/reason).

19. Develop a State Customer Support Center (Change Center). DHHS should establish a single reporting standard across programs. Once established, this center can assist customers with navigation over the phone which would allow changes to be received and entered by one worker for ALL relevant programs. This center could also see that review packets and recertification’s are completed virtually and sent from the state, or notify/queue counties via a notification if they need to assist a customer further.

20. **Use EBT/Smart Cards to house multiple program benefits.** Programs can include, child/day care, work first, child support, FNS, WIC, & Medicaid. DHHS should eliminate paper Medicaid cards and use 'smart cards' to give the client's eligibility status to medical providers.
21. **Promote new technology for screening/applications.** One of the most common words you'll hear Directors say in this changing environment is "kiosks". Clients *must* be able to apply in a variety of locations – in the bricks and mortar buildings that currently exist, online through EPass/NC FAST, through the mail, via a call center, and at conveniently located kiosks.
22. **Utilize state systems to identify areas of fraud, abuse, or misuse.** Program Integrity has to be the cornerstone of any efforts to streamline the system. Data systems will be needed to identify areas of fraud, abuse, misuse. NC must pursue those who fail to disclose or falsify application information. There is existing software that can help in this effort which searches many state and federal systems for information and can assess information before eligibility is determined to assist with stopping unnecessary payments up front. Information submitted that is incomplete or needs additional information to process should be handled at the state level. There will be "electronic data matching" which cross references income with state unemployment agencies, wage information reported to SSA and the IRS, and immigration status with customs enforcement. This information will be streamlined once entered into NC FAST and would match information with vital records, employment history, tax records and other data. This "electronic data matching" will enhance the ability to prevent potential fraud by providing and verifying essential data required to determine eligibility and continued eligibility. This may increase front end investigations, however, it will minimize potential dollar losses before they occur. We will be able to ensure the integrity of the programs and the agency without increased dollar loss and also keep potential overpayments created by agency error to a minimum, which in turn will not create hardships on families that are already in need of assistance.

Further Studies

- Conduct a feasibility study on Special Assistance and Adult Medicaid-Long Term Care to assess how those programs could also achieve simplification and provide recommendations to achieve such (recommend making SA and LTC rules match).
- Continue simplification work in the Adult and Children Social Work Services areas. The Economic Services area is not alone in this type of environment. The same barriers that exist in ES with excessive paperwork and duplication of services occur in the Children's Services and Adult Services area. If we can simplify policies, procedures, and protocols in one area we should be able to do the same elsewhere. The goals would in these areas is the same, to improve customer service and reduce administrative cost. The outcomes for individuals and families should be our driving force and not the process it takes to get them to those outcomes.

APPENDIX I: POLICY SIMPLIFICATION COMMITTEE

Stoney Blevins, Transylvania County
Dontae Latson, Union County
Mandy Stone, Buncombe County
David Atkinson, Carteret County
Sonya Toman, Beaufort County
John Benton, Moore County
Nancy Coston, Orange County
Joe Raymond, Forsyth County
Phillip Hardin, McDowell County
Earl Marett, Johnston County
Colleen Turner, Gates County
David Smith, Burke County
Mary Wilson, Mecklenburg County
Jay Burrus, Dare County
Nicki Perry, Franklin County
Tracy Turner, NCACDSS
John Eller, Catawba County-Chair

Erin Henderlight with Buncombe County should be noted for her assistance during this project.

APPENDIX II: HEALTH CARE REFORM DETAILS

There are an estimated 16 million individuals, nationwide, set to gain health insurance in 2014. Forty-four percent (44%) lack employment and are in families where no one is employed. Premium tax credits will be awarded to individuals and families with incomes between 133% and 400% of the FPL based on a sliding income scale. There will be no asset tests or use of income disregards to determine eligibility for children and most adults. Asset rules will still be used for long term care and home and community based services. Undocumented immigrants are not eligible for Medicaid, but coverage for pregnant immigrants is being discussed. Categorical restrictions will be eliminated and these changes establish Medicaid as the coverage pathway for low-income people in the national framework for near universal coverage.

The new Medicaid law requires mandatory eligibility of children ages 6-19 who are at or below 133% of the FPL. This will have some impact to NC Health Choice. Some children currently covered by the children's health insurance program will be transitioned to Medicaid coverage. The law will also create new non-Medicare eligible adults under age 65 without dependent children who are currently not eligible for the program. Medicaid eligibility rules for the elderly and disabled will not change under health reform. All Medicaid services, however, including those considered optional for adults, must be covered for children. Medicaid will focus on community-based services to assist citizens with incomes up to 150% of the FPL (who are eligible for institutional level of care), so they may remain in the least restrictive environment that could serve individuals.

Efforts to increase coordination of care for dually eligible citizens (those eligible for Medicaid and Medicare) will occur and there will be more focus on prevention and wellness. Also there will be a requirement to conduct outreach efforts to vulnerable populations that include children, homeless youth, individuals with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and former foster youth (covered until age 25-these children must also be given the opportunity to designate a medical power of attorney before aging out of the foster care system).

The Patient Protection and Affordable Care Act (PPACA) will create an additional "Community First Choice" option to provide habilitation services or attendant services for eligible citizens at or below 150% of the FPL that will be consumer directed. North Carolina (NC) will also amend the 1915i options to parallel with the Home and Community-Based Services (HCBS) waivers (eligibility, services and target groups) that will impact our work with Adult Care Homes. The Money Follows the Person (MFP) funding will be expanded, residency requirements in eligible facilities will be shortened, and Community Resource Centers (formerly known as Aging and Disability Resource Centers) will be expanded. There will be an option for "health home" for those who have at least two chronic conditions or who are considered at risk (those with mental health, substance abuse, asthma, diabetes, heart disease, overweight/obesity, etc...).

In addition, the newly created Health Insurance Exchange will:

- Offer standardized information to help consumers choose between plans and develop rating system based on quality and cost.
- Offer navigators to provide information about health plan choices and help the public enroll.
- Work with NCFAST to determine eligibility and enroll (if eligible for Medicaid or CHIP).
- Certify people who are exempt from insurance mandate and provide information to IRS.
- Develop patient navigators which must:
 - Have relationship with employers, employees, consumers
 - Conduct public education activities, distribute fair and impartial information, facilitate enrollment in qualified health plans, provide referrals to the consumer assistance or health information ombudsman program, and provide information in culturally and linguistically appropriate manner

● ● ● | Medicaid Expansion

- Expands Medicaid to cover all low-income adults under age 65 (including childless adults) with incomes up to 133% FPL, based on modified adjusted gross income (begins FY 2014) (Sec. 2001, 2002)

Family Size	133% FPL/yr. (2009)
1	\$14,404
2	\$19,378
3	\$24,352
4	\$29,327

- In determining Medicaid and CHIP eligibility, the state will apply a 5% income disregard (Sec. 1004 of Reconciliation)



3

These estimates include individuals who will become eligible because of mandatory Medicaid expansion (i.e. “expansion” population), and people who are currently eligible but not enrolled (i.e. “woodwork” population).

** Depending on the source, this number has been as high at 850,000 new eligibles.

*Current Medicaid monthly averages 1.4 million active cases up to approx 1.8 million per year

APPENDIX III: QUESTIONS FOR DIRECTOR FEEDBACK

1. With an understanding of the changing demographics of our client base (more working poor, older Americans, technologically savvy clients) how do you believe that clients wish to access our services? How can we adapt to meet these wants?
2. Thinking about the requirement under Health Care Reform that there is “No Wrong Door”: What would this look like to you in terms of client access to public assistance?
3. What needs to happen to give the client a one-stop experience?
4. What technologies or tools do we need to make this experience better for clients while managing our internal workloads?
5. What can we change from an organizational capacity standpoint? In other words, how do we need to change our current business model for serving public assistance clients?
 - a. How can HR help?
 - b. How can Finance help?
6. How are we utilizing the options available from the state personnel classification system to meet client needs/wants? Is there a different way we could classify staff?
7. What other some other places in the community where your clients receive services? (For example, Salvation Army, local shelter, Health Department).
 - a. How can these agencies/organizations help us solve these problems?
 - b. Why should we lean on them?
8. How can some of the more routine caseworker activities (changes, reviews) be made more seamless for both the client and the caseworker? Is there an easier process for this?
9. What should quality assurance and program integrity look like in light of health care reform, deeming, and, “No Wrong Door”?
10. Where do you think the expansion of policy changes like deeming would have the most impact?
11. What opportunities do you have to shift resources in your county?