Apply & Connect:

Opportunities and Challenges for Horizontal Integration of Health and Human Service Programs with the Implementation of California's Health Benefit Exchange and the Affordable Care Act

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Jim Jones, Jennifer Jordan &
Lisa Chan-Sawin

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Executive Summary

This report examines the options for how the major human services programs in California, including CalFresh (federal name SNAP), CalWORKS (TANF), Aged/Blind/Disabled Medicaid and Long Term Care Medicaid, could be horizontally integrated into California's Health Benefit Exchange and the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS).

The Affordable Care Act (ACA):

- Includes a large expansion and revision of the current Medicaid groups and rules, as well as provides states with the opportunity to establish Health Benefit Exchanges.
- Requires that states seamlessly integrate the Medicaid (Medi-Cal) and CHIP (Healthy Families Program) with the federal subsidy programs during the consumer's visit to the website, during a telephone conversation with the Exchange Call Center, or during an in-person visit with an Exchange representative when the required information and verification is available.
- Fundamentally changes the methodology used to determine financial eligibility by moving to the Modified Adjusted Gross Income methodology, which varies according to whose income and financial needs are counted together and what, as well as how, income is counted.
- Requires that the Health Benefit Exchange be interoperable, but not necessarily integrated, with human services programs (CalFresh, CalWORKS, etc.).

California currently has an integrated approach to the automated systems and business processes, with Medi-Cal and the human service programs (CalFresh, CalWorks, some child care programs and other local programs) co-existing in the processes and systems operated by county governments. Only the Healthy Families Program, California's Children's Health Insurance Program (CHIP), has a separate, but interoperable with Medi-Cal and the human service programs, process and system. (The Healthy Families Program is scheduled to be integrated into Medi-Cal in the coming year.)

In our research, which included the review of documents and statistics made available to us and extensive discussions with state leaders, Exchange board members, county leaders, advocates, vendor management, and eligibility workers, we found that:

- California is unique in terms of its geography and population, but also in the history and culture of the way that it administers its health and human services programs.
- In California, counties do much of the same work that state agencies do in other states, with the state agency acting in an oversight and supervisory role currently for the Medi-Cal, CalFresh and CalWORKS programs.
- Counties have, with state assistance, developed, implemented, and operated business processes and automated systems that manage the health and human service programs.
- In the three counties with whom we spoke, automated systems and business processes are equal or better than most other states, taking advantage of innovations, not only in the various county consortia systems and county business processes, but also across states.
- Health and Human Service program performance is, at best, uneven in California with:
    - Low participation, high rates of inaccurate terminations and denials and poor timeliness, but a good payment accuracy rate for CalFresh.
    - High participation and timeliness in the Medi-Cal program.
    - High rates of timeliness in the Healthy Families Program.

- California's cost per case is the highest in the nation in the CalFresh program in dollars, and second worst in terms of the administrative costs as a percentage of benefits.
- California uses a disproportionate share of the federal SNAP information technology dollars.
- The California Heath Benefit Exchange Board, State agencies, county human service directors, and advocates are committed to the continuation of a horizontally integrated system. However, federal deadlines for proving operational readiness of a State-facilitated exchange and a very limited amount of time to implement that Exchange have made horizontal integration a long term, not a short term, objective.
- The California Health Benefit Exchange has decided to use a state-based system, CalHEERS, as the system of record for MAGI Medi-Cal and the Exchange programs. The Statewide Automated Welfare Systems (SAWS) will remain the systems of record for non-MAGI Medi-Cal and human service programs.
- The California Health Benefit Exchange has chosen Accenture as the IT system developer for the Exchange. The notice of intent to award was made on May 31, 2012 and the Exchange announced that the contract had been signed on June 26, 2012. NOTE: Exchange staff were not able to share the contract and non-proprietary portions of Accenture's CalHEERS proposal before this report was completed. Therefore, assumptions were made about the CalHEERS model, especially how it will support the business model, as the report was developed.
- The Exchange must meet federal standards for operational readiness by January 2013, with enrollment of individuals and health plans beginning on July 1, 2013.

Based upon the information we have been provided and gathered, this paper provides two scenarios for proceeding with the creation of the California Health Benefit Exchange, including its system, CalHEERS, in a manner that can lead to the integration of human service programs administered by the counties, using their SAWS systems. These scenarios are meant to show options to be considered along a continuum, and various components can be chosen based upon available resources (time, staff, funds, etc.). Obviously, Scenario #1 will have a more positive impact on human services program enrollment, but it will require much more time, staff and funds to complete. It is possible that some additional automation in Scenario #1 would not be cost-effective considering that the longer term vision for CalHEERS appears to be full integration with other health and human services programs by December 31, 2015.

Activity/Order	**Scenario #1: Maximum Automation and Coordination**	**Scenario #2: Minimum Automation and Coordination**
Health Insurance then Human Services Applications via CalHEERS Web Portal or CalHEERS Call Center	• CalHEERS Web Portal collects information and verification to determine real-time eligibility for MAGI Medi-Cal and Exchange programs and facilitates selection and enrollment into a Qualified Health Plan. • Part of the CalHEERS process includes a real-time check with SAWS to import data available and to use eligibility for CalFresh for Express Lane Eligibility (ELE) for MAGI Medi-Cal for children. • CalHEERS Web Portal screens	• CalHEERS Web Portal collects information and verification to determine real-time eligibility for MAGI Medi-Cal and Exchange programs. • CalHEERS Web Portal screens for Human Services Programs. • If potential eligibility exists, CalHEERS Web Portal directs individual to the SAWS Web Portal or county office or allows them to print an application. • The individual enters their information into the SAWS Web Portal, calls the county, mails in an application or appears in-

	for Human Service Programs and collects additional information needed to determine human service program eligibility. • CalHEERS transmits data and verification documentation to SAWS so that eligibility can be determined. • The SAWS system creates case for county worker review and public interview. • County worker identifies missing information and verification. • County worker conducts an interview of the individual (phone or in-person). • SAWS determines eligibility, generates a notice and benefits.	person. • The county worker, during the review of the application, reviews the information collected in CalHEERS and uses some of that information to determine eligibility for human service programs. • County worker conducts an interview of the individual (phone or in-person). • SAWS determines eligibility, generates a notice and benefits.
Human Services then Health Insurance via SAWS Web Portal or Telephone Application	• SAWS Web Portal screens for MAGI Medi-Cal and Exchange program eligibility. • SAWS Web Portal links directly to CalHEERS Web Portal, providing common information. • CalHEERS Web Portal proceeds to ask those questions and secure that verification necessary to determine MAGI Medi-Cal and Exchange program eligibility. • If eligible, web portal directs individual through plan comparison and selection process, where s/he can enroll in a health plan.	• SAWS Web Portal screens for MAGI Medi-Cal and other Exchange program eligibility and directs the individual to the CalHEERS Web Portal. • SAWS provides only basic information to CalHEERS Web Portal. • CalHEERS determines eligibility for MAGI Medi-Cal and Exchange programs and guides individuals through health plan comparison and selection. • Once data has been entered through portal or by worker, SAWS determines eligibility for non-MAGI Medi-Cal and human services programs.
In-Person at County	• The county collects information form the individual via the SAWS Web Portal or a personal interview with the individual. • The county worker, during the interview process, enters information on SAWS pages that will be needed for the CalHEERS MAGI Med-Cal and	• Worker enters data into CalHEERS for determination of eligibility for MAGI Medi-Cal and Exchange Programs. • Worker enters data into SAWS for determination of eligibility for human service programs and Non-MAGI Medi-Cal.

	Exchange program eligibility determination and plan comparison and selection. • SAWS sends information to CalHEERS for a determination of eligibility in the system of record.	
Ongoing Case Maintenance and Renewals	• Individual reports changes via the web portal, phone call, mail or in-person to the county worker. • Changed information is shared by SAWS and CalHEERS based upon business rules for what data changes are needed by which set of programs. • Renewals in SAWS update Medi-Cal renewal dates in CalHEERS. • Renewals in SAWS or CalHEERS share changed information, if needed by the other set of programs, with the other system.	• Worker enters changes and renewals in both systems separately.

Introduction

Scope, Constraints & Assumptions

Leaders of the various state agencies and departments, California Health Benefit Exchange Board members, county leaders, eligibility workers, federal staff, advocates and stakeholders agree that California would like to create a Health Benefit Exchange that is horizontally integrated with human services programs. However, it is unclear what path the State should take to achieve this goal within the implementation timeframes specified in the Affordable Care Act (ACA). This report examines the factors that define and constrain how California can best integrate the eligibility and enrollment functions for Medi-Cal MAGI, the Healthy Families Program, the Insurance Affordability Programs (premium tax credit and cost sharing reduction), and the comparison and selection of a qualified health plan with the eligibility, verification and enrollment for CalFresh, CalWORKs, and Medi-Cal for the Aged, Blind & Disabled (ABD).

In-Scope for this Paper

- Discussion of how human service programs, including CalFresh, CalWORKS, and Medi-Cal for the Aged, Blind & Disabled, could best be integrated with the California health programs, including Medi-Cal and the Health Benefit Exchange, in terms of IT systems and business operations.
- Discussion of the current health and human service program administration, fiscal implications, and performance metrics.
- Description of the status of efforts to establish the California Health Benefit Exchange.
- Discussion of other states' approaches to the question of horizontally integrating their health and human service programs with the implementation of their Exchanges.
- Discussion of a State partnership with a Federally Facilitated Exchange (FFE), even though the California Health Benefit Exchange Board has elected not to pursue this option at this time.

Out-of-Scope for this Paper

- Integration with other human service programs beyond CalFresh, CalWORKS and Medi-Cal for the Aged, Blind and Disabled.
- The Small Business Health Options Program (SHOP) Exchange.
- Analysis of the current eligibility and enrollment model for human service programs that is administered by counties and supervised by the State.
- Full analysis of the effectiveness of business processes of the 58 counties.
- Analysis of county consortia and state automated eligibility systems to determine the system with the most comprehensive functionality.

Constraints and Assumptions for this Paper

- By federal law and regulation, the Exchange must demonstrate operational readiness to The Centers for Medicare and Medicaid Services (CMS) by January 2013 of California's Health Benefit Exchange, basically that the automated system will be ready to begin enrolling individuals and small employers for benefits beginning January 1, 2014.
- By federal regulation, the Exchange must begin to enroll individuals and families on October 1, 2013, and begin enrolling individuals and small employers on that date.
- By federal law, the Exchange must be self-sustaining by January 1, 2015.
- The Exchange must cost allocate the cost of planning, development, construction and ongoing operations across all benefiting programs, which includes the Medicaid Modified Adjusted Gross Income (MAGI) programs, but, if included together in the same IT system and business operation, would also

include cost allocation to Medi-Cal for the Aged, Blind and Disabled, CalFresh, CalWORKS, other State programs and other county (or other local) programs.

- As of July 8th, 2012, at 1 p.m. (CDT), the California Health Benefit Exchange had not posted on its website the contract and non-proprietary portions of the Accenture proposal with which Accenture was awarded the CalHEERS contract. Access to the contract terms and the Accenture proposal would answer many questions about how the CalHEERS system will function and how the business operations for the Exchange, including the eligibility determination for MAGI Medi-Cal and the connection to other human services programs, would be structured. Since these documents were not available, we have made assumptions about the CalHEERS functional design and the business operation from the RFP and supporting materials, as well as from documents produced by the Exchange. These assumptions are:

    - The Accenture proposal includes a solution that meets the technical and business requirements posed in the RFP for the Baseline Core Requirements System, including a plan to:
        - Build a separate CalHEERS not based on current SAWS (Baseline Model, not the alternative model in the RFP).
        - Meet CMS's seven standards and conditions for enhanced funding, including a separate Rules Engine.
        - Share business rules with SAWS that allow the county consortia systems to assess potential eligibility for MAGI Medi-Cal, for the Exchange subsidy programs and for the use of the Exchange.
        - Use data from SAWS to set up eligible MAGI Medi-Cal cases, including the Low Income Health Program, and to identify current CalFresh and CalWORKS individuals who may qualify under the MAGI Medi-Cal rules for the Premium Tax Credit Program or the Cost sharing Reduction program or are uninsured and are eligible to use the Exchange to purchase health coverage.
    - The signed contract supports a business operations model that includes two components:
        - A Centralized Service Center for intake, including handling general inquiries, application-specific inquiries, and eligibility and enrollment tasks for applications received through the web portal, telephone interaction, and mail.
        - Decentralized Service Centers, operated through current counties, that are responsible for in-person applications and all case maintenance for MAGI Medi-Cal and the Insurance Affordability programs, and households with a mix of Medi-Cal and Insurance Affordability program eligibility.

Background

At nearly 37.7 million residents, California is the United States' most populous state (more than Canada as of 2008) with one of every eight United States residents living in California. Three out of the ten largest U.S. cities are in California: Los Angeles, San Diego and San Jose. California is the third largest land mass, after Texas and Alaska, having 58 counties that range in size from 9.8 million in Los Angeles County to 1,175 residents in Alpine County. At the same time, California is the most diverse state in the union with 58% of its population Asian, Hispanic, African American, Native American or other groups. 26% of California's residents were born outside the U.S.

Despite robust and expansive health programs, including Medi-Cal and the Healthy Families Program, 2010 data indicates that 19% of California's population and 11% of California's children are uninsured.[1] Of the non-elderly adult population, including those adults without dependent children who could be eligible under the ACA Medicaid expansion, 21% of individuals in this group are uninsured.

California is not only unique in terms of the diversity of its people, cultures, and landscape, the huge population and enormous size, but also because of the unique way that the State has structured the administration of its health and human services. California is one of only two states that has multiple automated eligibility and enrollment systems created and operated by counties; those counties are responsible for many tasks that have traditionally fallen to the State.[2] Counties, who are responsible for the day-to-day administration of the health and human services programs, are also responsible for:

- Analyzing federal and State law and rules and program policy directives from the State program agency,
- Devising implementation plans that include identifying business requirements changes to the county or county consortium's automated eligibility and enrollment system and business operations processes, and
- Implementing those changes through new or revised process materials and staff training, as well as enhanced or modified IT systems.

These are functions that normally fall into the purview of state program agencies in the other 49 states.

In this unique environment, California is one of only fifteen states that are leading the nation in implementing the Health Benefit Exchange envisioned in the ACA. To be successful, California will need to choose the best strategy for developing and implementing business operations and IT systems within the extremely tight timeframes imposed by the ACA. January 1, 2014 seemed the distant future when the ACA was passed. In July 2012, the implementation timeline is daunting.

An Overview of Health Benefit Exchanges

The ACA allows states to establish Health Benefit Exchanges, where individuals and small employers can shop for health insurance coverage. The Health Benefit Exchange must allow the comparison and purchase of health insurance plans via a web portal, over the telephone, in-person and via mail. Individuals must be screened and enrolled in Medicaid (Medi-Cal), the Children's Health Insurance Program (CHIP or the Healthy Families Program in California) or enrolled in the new federal health insurance subsidy programs. The Health Benefit Exchange must seamlessly integrate the Medicaid/CHIP and federal subsidy program eligibility determinations. The Centers for Medicare and Medicaid Services (CMS), the federal agencies charged with implementing and administering Medicaid, CHIP and the Exchanges, expect State Exchanges to determine Medicaid/CHIP and federal subsidy eligibility during the consumer's visit to the website, during a telephone conversation with the Exchange Call Center, or during an in-person visit with an Exchange representative when complete information is provided and automated verification sources are available. For those instances where additional information or verification is required, while performance standards have not yet been published, the expectation is that eligibility determinations will happen much more quickly than they have under the current rules and with current systems.

The federal goal of the new Exchange is to create a world-class, seamless customer experience that allows the individual to choose how they will interact with the Health Benefit Exchange through various options, including a

[1] Kaiser State Health Facts (http://www.statehealthfacts.org/profileind.jsp?ind=125&cat=3&rgn=6)
[2] New York State has multiple automated systems, with a state system and another system implemented and operated in New York City.

web portal, telephone, mail or in-person. The ACA provides states with a tremendous opportunity to re-examine and re-engineer how the Medicaid/CHIP eligibility and enrollment process is administered and the opportunity to determine the level and extent to which human service programs should be integrated with the Medicaid/CHIP and federal health insurance subsidy programs.

The U.S. Department of Health and Human Services requires the Health Insurance Exchange to be interoperable, but not necessarily integrated, with human service programs. This requirement is based upon Section 1561(b)(5) of ACA that states that the Exchange must have the "Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate." Furthermore, as required by Section 1561 of the Affordable Care Act, the recommendations made by the HITECH Committee to the DHHS Secretary support this requirement. This is discussed in more detail in the Federal Perspective section of this paper.

The ACA allowed each state to create an American Health Benefit Exchange and demonstrate by January 1, 2013 to the federal government that the state will have a viable Exchange operating by January 1, 2014. In the event that the state elects not to create and operate an Exchange or does not demonstrate operational readiness, the federal government will operate a Federally Facilitated Exchange (FFE) for that state. States have also been given the option to operate an Exchange based upon a partnership between the State and the FFE. California has decided to create the California Health Benefit Exchange. (Further discussion of the State FFE Partnership model can be found in the California Health Benefit section of this analysis.)

All Health Benefit Exchanges must perform certain functions. The Exchange needs to:

- Certify health insurance plans that want to participate in the Exchange;
- Determine whether individuals are qualified to use the Exchange;
- Determine whether individuals have access to affordable health insurance through their employer;
- Determine if the individual or family qualifies for the federally-funded premium tax credit or reduced cost sharing (one step in this determination is that the individual doesn't qualify for Medicaid or CHIP);
- Screen and enroll adults and children into Medicaid and CHIP (in order for the Exchange, if operated separately from the Single State Medicaid Agency, to determine eligibility and enroll individuals into Medicaid, the Single State Medicaid Agency must officially allow this delegation of duties);
- Provide assistance in selecting a health plan, including providing a side-by-side comparison of plan components that will be used by the individual to choose a plan; and
- Assist individuals and families with their enrollment into the plan of their choosing.

The Health Benefit Exchange will serve three groups of qualifying individuals and their families:

- Those individuals and families with incomes above 400% of the Federal Poverty Level (FPL), $92,200 for a family of four, who want to select a health insurance plan from the individual/non-group market;
- Those individuals and families with incomes above the Medi-Cal and Healthy Families Program income limits, who will qualify for a federal premium tax credit and for reduced cost sharing. This includes adults with incomes greater than 138% FPL, $31,809 for a family of four, and children with income greater than 250% FPL, $57,625 for a family of four; and
- Children and non-elderly adults who qualify for Medi-Cal under the new MAGI rules, which will include, at least, an income limit 138% FPL for adults and, because of ACA's maintenance of efforts requirements, 250% FPL for children. (This group does not include persons who might qualify for

Medicaid on the basis of a disability or because of a long term care need. It also does not include anyone who is entitled to Medicare.)

Federal Perspective on the Horizontal Integration

The ACA requires that Exchanges integrate the determination of eligibility for Medicaid, CHIP and the federal health insurance subsidies. The ACA does not direct states to integrate Medicaid and federal subsidy health care programs with the human service programs, but it does require states to ensure that the systems that determine eligibility for the human services programs and the Exchange be interoperable.

As defined by Wikipedia, interoperability "is a property referring to the ability of diverse systems and organizations to work together (inter-operate)." The term is often used in a technical systems engineering sense, or alternatively in a broad sense, taking into account social, political, and organizational factors that impact system to system performance.

While interoperability was initially defined for IT systems or services and only allows for information to be exchanged (see definition below), a more generic definition could be:

"Interoperability is a property of a product or system whose interfaces are completely understood to work with other products or systems, present or future, without any restricted access or implementation."

This generalized definition can then be used on any system, not only information technology systems. It defines several criteria that can be used to discriminate between systems that are "really" interoperable and systems that are sold as such but are not because they don't respect one of the aforementioned criteria, namely:

- Non-disclosure of one or several interfaces
- Implementation or access restriction built in the product/system/service.

As directed by the ACA, the HITECH committee provided recommendations to the U.S. DHHS Secretary to implement the provisions of Section 1561 of the ACA. These recommendations speak extensively to both integration and interoperability.[3] Specifically, the HITECH 1561 recommendations include the following statements:

> "The core of these recommendations is the belief that the consumer will be best served by a health and human services eligibility and enrollment process that…connects consumers not only with health coverage, but also other human services such as the Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families (TANF) program."
>
> "We recommend that Federal agencies required by Section 1411 of the Affordable Care Act to share data with States for verification of a consumer's initial eligibility, renewal and change in circumstances for Affordable Care Act health insurance coverage options (including Medicaid and CHIP) use a set of standardized Web services that could also support the eligibility determination process in other health and human services programs such as SNAP and TANF."

[3] http://healthit.hhs.gov/pdf/electronic-eligibility/aca-1561-recommendations-final2.pdf

> "Federal agencies and States should express business rules using a consistent, technology-neutral standard format, congruent with the core data elements identified through the NIEM (See Appendix B in the footnoted link for an explanation of National Information Exchange Model (NIEM) process.) Upon identification of a consistent standard, Federal agencies and States should clearly and unambiguously express their business rules (outside of the transactional systems)."
>
> "To allow for the open and collaborative exchange of information and innovation, we recommend the Federal government maintain a repository of business rules needed to administer Affordable Care Act health insurance coverage options (including Medicaid and CHIP), which may include an open source forum for documenting and displaying eligibility, entitlement and enrollment business rules to developers who build systems and the public in standards-based and human-readable formats."
>
> "To allow for seamless integration of all health and human services programs, business rules for other health and human services programs such as SNAP and TANF should be added to the repository over time."

From Appendix A (Consumer Centric Approach in the footnoted link) of the 1561 Recommendations, we recommend that "Key components of a consumer-mediated approach include…(s)eamlessly integrating systems that serve the consumer in pursuit of health coverage (e.g., health insurance Exchanges, Medicaid, CHIP, private insurance) and human services programs (e.g. SNAP, TANF)."[4]

From Appendix D (Business Rules in the footnoted link) of the 1561 Recommendations, we "support integration across systems and across programs to support a seamless user experience by addressing program hierarchy and providing capacity for addition of other programs."[5]

Since the enactment of the ACA, CMS has encouraged states to keep existing links between the Exchange health insurance programs, including Medicaid and CHIP, and the human service programs. The Food and Nutrition Service has contributed managerial and staff resources to encourage states to keep the link between programs as well. The Administration for Children and Families (ACF) has issued Your Essential Interoperability Toolkit: An ACF/HHS Resource Guide.[6] The toolkit includes:

- A Joint letter to human services agency heads from ACF, USDA, OCCIIO (now CCIIO) and CMS, which encourages states to link ACA activities with human services to ensure that federal efforts are well coordinated and demonstrates the commitment by federal agencies to work collaboratively.
- A copy of Executive Order 13563: Improving Regulation and Regulatory Review, which "calls on federal agencies to carefully analyze existing rules and increase coordination across agencies and to simplify and harmonize redundant, inconsistent and overlapping requirements, thus reducing costs."
- A White House Memorandum on flexibility, which directs federal agencies to work closely with states and other governments to identify areas of flexibility in order to reduce unnecessary regulatory and administrative burdens and redirect resources to services that are essential to achieving better outcomes.
- A copy of the ACA Section 1561 Recommendations (see above).

[4] http://healthit.hhs.gov/pdf/electronic-eligibility/appendix-a.pdf
[5] http://healthit.hhs.gov/pdf/electronic-eligibility/appendix-d.pdf
[6] http://www.acf.hhs.gov/interop/toolkit.pdf

- A description of the Advanced Planning Document (APD) process and the final federal rules "governing state systems development for Medicaid, Child Welfare and Child Support Enforcement, as well as the cost allocation of system development costs for the Temporary Assistance for Needy Families block grant."
- A description of the "enhanced Medicaid funding for eligibility determination."
- A description of the National Human Services Interoperability Architecture that "ACF has contracted with Johns Hopkins University School of Public Health and Applied Physics Laboratory to develop."
- A description of the human services domain – National Information Exchange Model (NIEM) – and explanation that ACF will be the Domain Steward for a new Human Services NIEM domain.

On August 10, 2011, executive managers from the Administration for Children and Families, CMS's Centers for Information and Insurance Oversight and Center for Medicaid and CHIP Survey and Certification, and the USDA's Food and Nutrition Service issued the Tri-Agency letter.[7] This letter makes it clear that states can claim the enhanced Medicaid/CHIP funding for the development and enhancement of eligibility systems even when the system enhancement or component being built benefits more than Medicaid/CHIP, but also benefits TANF or SNAP. Clearly, ACF, USDA/FNS and CMS are very serious about and very diligent in their efforts to make changes within the constraints of current federal law to ensure that human services systems and the new Health Insurance Exchanges will be interoperable.

However, it is also clear that the primary objective of CMS is to implement an efficient, cost-effective, and consumer friendly health insurance exchange program that attracts individuals and families to use the Exchange initially, and on an ongoing basis, including those populations who are not eligible for Medicaid, CHIP, SNAP, TANF or other human service programs, and that this effort must be completed within the timeframes laid out in the ACA. Interoperability with human service programs is required as a condition of receiving both grant funding and enhanced federal funding for the development and maintenance of the Exchange. Integration of the Exchange with human service programs, according to CMS, is a decision that states must make.

While integration is a goal, there remain significant differences between the policies of the TANF program, the CalFresh program, the ABD and Long Term Care (LTC) Medicaid programs and the new Medicaid MAGI groups. For instance, the policies defined who is included in the group for the determination of eligibility and the distribution of benefits:

- The TANF program is based around the concept of a dependent child and the caretaker.
- The CalFresh program, although some members of a family are mandatory, uses the people within four walls of a dwelling who purchase and prepare food together.
- The ABD Medicaid program is based upon the individual and his/her spouse who live together.
- The LTC Medicaid program bases its group concept around the individual in need of long term care services (as determined by a level of care or functional assessment) and the spouse who is not enrolled in LTC Medicaid; and,
- The MAGI, as stated previously, relies on who has been or would be included on the tax form.

This means that the MAGI group includes members who are not in the household, who are not a spouse, who are not a minor child, and, in some limited cases, may not be related to the individual filing the tax return. Specifically, the MAGI group of an individual may include his or her child for whom s/he pays child support and that the child, who lives with the other parent, will not be included in the group of the other parent. CalFresh and CalWORKs would both include the child in the household of the parent with whom the child lives. ABD

[7] https://www.cms.gov/Medicaid-Information-Technology-MIT/downloads/TriAgencyLetter.pdf

Medicaid and LTC Medicaid would allow a deduction for the support of the child from the custodial parent's income.

SNAP law, regulations and guidance require that a merit selection, civil service worker:

- Handle all interactions with applicants and recipients, except when handled by a not-for-profit organization that has been approved for that contact by FNS.
- Enter data into eligibility system and determine eligibility.
- Complete an in-person or telephone interview (with FNS approval) at each application and at renewal.

Medicaid law, regulations and guidance require that a public worker be responsible for the determination of eligibility. CMS has elected to interpret this provision more loosely than FNS, allowing states to use non-public workers for the administration of the program if they do so using an automated eligibility system that has been designed and implemented by public workers. In terms of the Exchange operations, the new health reform law does not restrict or define the use of non-public workers to handle eligibility or enrollment duties.

Expansion of Medicaid will not only increase Medicaid members, but may also greatly increase SNAP participation in California and across the country. In Wisconsin in 2009, Medicaid was expanded through an 1115(a) demonstration project waiver that required a $60 annual enrollment fee, 12 months with no health insurance, had a very thin benefit package and a hard federal budget cap (about 50,000 members). SNAP participation from the inception of BadgerCare Plus Core Plan for Adults Without Dependent Children increased in less than 12 months by 140,000 individuals or nearly 20%. California, because of its Bridges to Reform wavier and General Relief/Assistance program, may not see as large of an increase, but should expect an increase in participation with any effort to integrate CalFresh with the Exchange programs.

It's important to note that the public may see (or may want to see) the human services programs as distinct from health insurance, including Medicaid/CHIP, in light of the ACA. For some, both CalWORKS and CalFresh fit within the traditional definition of "welfare" programs, whose goal is to provide a safety net to a low-income, needy population and to promote the self-sufficiency of the individual and household. The cost of these programs to the taxpayer increases with the addition of each individual to the program. The ACA recasts the Medicaid and CHIP programs as health coverage subsidy programs for federally mandated health insurance. The goal of the new Medicaid/CHIP programs is to provide a continuum of coverage with a sliding scale of federal and state assistance based upon income. As the program enrolls more people the total cost will increase; the amount for each individual is likely to decrease as the risk of high health care costs for one is spread across a larger risk pool. On the other hand, some see these programs, especially nutrition assistance, as part of health and wellness and a natural connection to health coverage. California, in particular, has led the nation in promoting healthy food as part of total health and well-being – examples include the State's Nutrition Education Network and private sector examples like Kaiser Permanente's "Thrive" campaign.

Affordable Care Act Eligibility and Enrollment Processes

Provisions of the ACA standardize the eligibility determination for non-disabled/non-elderly adults and children with:

- A single set of mandatory nonfinancial eligibility requirements;
- The use of the MAGI methodology to determine whose income and needs within a household will be counted in determining eligibility; and

- The use of the MAGI methodology to determine which income types will be counted and what deductions will be subtracted from that income.

States will decide which income limit will be used to determine adult eligibility as long as the adult income limit is at least 138% (133% income limit with a 5% disregard) of the FPL. (The U.S. Supreme Court's decision on the constitutionality, which included language in the majority decision that indicated that the requirement to expand Medicaid to the new coverage under threat of the loss of all Medicaid federal funding was coercive, has caused several states to reevaluate whether they will add the new coverage group.) The children's income limit must remain at the same level as it was on March 23, 2010 through 2018, so for California it must remain at 250% FPL (or an equivalent income limit based upon the ACA's MAGI methodology). This change in methodology is important in this discussion because it illustrates a significant simplification of current Medicaid and CHIP income eligibility methodologies and the standardization of income methodologies across all state Medicaid and CHIP programs for the non-elderly and non-disabled.

If the experiences of states such as Florida, Wisconsin and Massachusetts are indicative, the number of individuals who choose to interact with the Exchange in-person will be greatly reduced as individuals become more comfortable with the new methods to apply, renew and manage their own benefits. This may be mitigated in California since the SAWS and Healthy Families Program systems have web portals and Customer Service Centers and therefore many individuals may have become accustomed to these types of interactions. However, the Exchange is expected to, by relying on trusted third party data from both federal and state sources, determine MAGI eligibility for a majority of applicants, as those individuals are using the web portal; therefore, this will be a new experience to those Californians using the SAWS and Healthy Families Program's online applications.

In addition, the need for an eligibility worker to verify the information provided by the consumer should decrease dramatically. This will occur for two reasons: changes in federal law and regulation regarding verification, and the implementation of a new federal data services hub. It will also be minimized because of the changes in federal regulations, which allow for the use of reasonably compatible documentation and self-attestation for MAGI program eligibility as adequate verification of eligibility factors, such as income. The extent that this will reduce the need for consumer verification will be dependent upon State and Exchange decisions concerning how best to implement those concepts. The new federal data services hub, when implemented, will increase a State's ability to access real-time, online information from federal sources. The federal data services hub will include, at a minimum, the following information:

- U.S. Citizenship Documentation from the Social Security Administration,
- Immigration Status Information (for persons who are not U.S. citizens) from the U.S. Department of Homeland Security, and
- Income Information (from tax records) from the Department of Treasury's Internal Revenue Service.

Additionally, States are expected to use state and other trusted data sources to verify information provided by the consumer in real-time. State information could include State Wage, Unemployment Insurance, as well as Express Lane Eligibility information available from the CalFresh, California's School Meals, and CalWORKS programs.

California's Health and Human Services Programs

California's human service delivery system exists to help California's most vulnerable families and individuals meet their basic needs in the areas of health, nutrition and financial self-sufficiency. National research on best practices in providing for economic stability and community health shows that a front-end integrated services

delivery model creates the best outcomes for low income families. When government services and systems are siloed, a family might find the time to take care of one need, but then not be able to find the time, or know where, to get other needs met; these are the basic needs of food, shelter, clothing, child care and medical care, among others.

Although we were unable to access data regarding co-participation of individuals in multiple programs, there is and will be a tremendous amount of overlap between the individuals and families covered by Medi-Cal/Healthy Families Program, as well as those receiving federal health insurance subsidies, with human service programs. Evidence from other integrated states suggests that this overlap could be nearly 60%.

County Foundation

California relies more on its county human services agencies for the administration of its health and human services programs than any other state in the union. The 58 California counties, with more than 1,000 offices across the State, support:

- CalFresh (including CalFresh Employment &Training program),
- Medi-Cal,
- County Medical Services Program (indigent medical care),
- CalWORKS,
- Refugee Cash Assistance (RCA),
- Immigrant Cash Assistance,
- CalLearn,
- Foster Care, KinGAP, and Adoption Assistance,
- General Assistance/Relief, and
- Assorted other local support programs that provide cash or supportive services based upon financial need.

According to the California Welfare Directors Association, county human service agencies process the applications for assistance of more than 400,000 families monthly and manage the cases of more than 8 million recipients, with 1.5 million participating in CalWORKS, 4.7 million in Medi-Cal, and 3.9 million in CalFresh. Demand for these programs has increased 60% during the economic downturn in 2009, with 1 million new families added to Medi-Cal, and 2 million new households added to CalFresh.

The administration of eligibility and enrollment in the Medi-Cal program is integrated with CalFresh and the CalWORKS programs, as well as some child care and other State and local programs. County eligibility workers determine eligibility for and enroll individuals and households into Medi-Cal, CalFresh, and CalWORKS. The same data, data exchange services, and tools used to determine Medi-Cal are generally used to determine eligibility for CalFresh and CalWORKS.

The counties use one of three automated systems, called the Statewide Automated Welfare Systems (or SAWS), which we describe in greater detail in the Information Technology section of this report, to assist them in the determination of eligibility, calculation and distribution of benefits, and case management activities. The LEADER system is used by Los Angeles County, the C-IV system is used by 39 counties and CalWIN is used by 18 counties. All three systems have their own web portal where individuals can apply for benefits online. Those portals include one, BenefitsCal.org, that acts as a distributor to the three different web portals based upon the user's location. All of the systems are horizontally integrated across Medi-Cal, CalWORKs, CalFresh and other human service programs, except for the Healthy Families Program, which is administered by MRMIB's vendor

MAXIMUS, using the MAXe2 system. (A more detailed discussion of the systems is found in the Information Technology section.)

Each program has its own unique requirements. For instance, even though counties handle case processing over the phone, over the web, through the mail and in-person, the different programs have different requirements for what business can be conducted in what manner. Medi-Cal has no requirements that an in-person or telephone interaction occur. CalFresh, while it does not require an in-person interaction between a worker and an applicant or recipient, does require that either an in-person or telephone interview occur before eligibility is determined and benefits issued at the time of application and annual re-certification. CalWORKS does require in-person interaction at the time of application and renewal.

Because of the unique policy and processing requirements of the programs, counties tend to assign work to staff based upon the programs of assistance being received by the individual or family. For instance, in one county, while intake is handled by one worker, case work, even though task-based, is assigned for cases receiving CalWORKS to one set of workers, cases receiving CalFresh to another set of workers and open Medi-Cal cases to workers with that skillset and those responsibilities. While this particular county did not split work between multiple workers if the case was open for multiple programs, this practice seems to exist in other counties. This could be very frustrating and confusing to both workers and to the individuals they are serving. It is gratifying to see this practice being replaced with assignments to a single worker, regardless of program receipt combinations.

While all counties use one of the three SAWS systems and follow State policy initiatives and directives, each county creates its own set of business processes that fit its local community values, level of resources, and vision for health and human service programs. While it is true that some basis for differences in business process exist, it's important to note that the overall work that each agency does is, at its core, the same across all counties.

Because of the freedom that each agency has to create its own processes, both county leaders and the CWDA state that this encourages innovation to improve customer service, efficiency and effectiveness of their operation. When one county innovates, many times that improvement is shared with other counties who may actually 'leapfrog' the donor county, creating a new model for others to emulate. Business process improvements have included the implementation in some counties of:

- Task-based business models that assign work based upon task (application, renewal, quarterly or semi-annual report processing, change processing, answering calls, etc.) rather than the traditional assigned caseload model.
- Customer Service Centers that are responsible for telephone inquiries and in many cases also act as Change Centers that are responsible for entering all changes reported by recipients.
- Kiosks that allow applicants and recipients to apply for or renew benefits, report changes or submit documentation from a dedicated, specialized computer that reduces the need for them to wait in line for assistance from a county worker and overall reduces workload and improves customer service.
- Many counties are in the process of implementing Electronic Document Management Systems that eliminate the need for paper case files, storing electronic images of notices, letters, forms and documents supplied to verify information provided by the applicant or recipient. EDMS systems can improve the process of entering verifications to complete the eligibility determination, but they also allow any trained worker with access to the electronic case file to handle case processing for any case. If these electronic case files are available across county lines (a stated goal of the county systems consortia and of the CWDA), then individuals and families who have applied in one county will not have to provide the same documentation when they move to another county.

- Several counties, notably San Bernardino County, have implemented Activity and Case Tracking Systems that assist managers and staff in monitoring workload, distributed tasks and managed work.
- One county we interviewed was looking at the implementation of a Lobby Management System that would assist in organizing the flow of applicants and members who interact with the agency in-person to the appropriate work stations within the county.

Several individuals we talked with as part of this study cited a great deal of variation between counties in terms of their level of performance. Some individuals we talked with called this the "tyranny of geography," saying that the level of service provided in one county could be very different, in terms of customer service, efficiency, etc., from the next contiguously located county. Counties with serious issues, such as those reported in the press about San Diego County, are perceived as remaining as outliers for too long. Many of these same individuals stated their belief that this variation could be alleviated by requiring more uniformity of processes, a single automated system, and greater accountability.

Program Specifics

As described previously, a State Health Benefit Exchange is required to screen and enroll non-disabled and non-elderly adults and children into Medicaid and State CHIP. This function is currently performed in California using the SAWS systems for Medi-Cal and human service programs and the MAXe2 system for the Healthy Families Program. For the most part, individuals who wish to apply for and enroll in Medi-Cal have been required to submit an application to either a county human or social services agency or to a community Medicaid site, run by a hospital, clinic or other community entity. For the majority of applications and for ongoing cases, a county eligibility worker:

- Handles the collection of the data and documentation needed to determine eligibility;
- Enters that data into the automated eligibility system;
- Reviews the decision generated by the automated eligibility system;
- Corrects that decision, when necessary; and
- Handles ongoing case maintenance (renewals, change processing, answering questions, resolving problems, etc.) for the duration of the time that the individual or family is eligible for Medi-Cal.

One of the statements that we heard as we began the research for this report was that in certain counties the collective bargaining agreement between the county and the union representing eligibility workers restricted the number of applications that a worker could process in a single work day. We were unable to substantiate this statement; however, we were able to confirm that in four counties the labor agreement does set a limit on the number of cases that can be assigned to a single worker. The eligibility workers' union, SEIU, explained that these limits were put in place to indicate to local government the point at which caseload increases rose to the level that additional eligibility staff were needed. One of these counties, San Diego County, was alerted by the union of this staffing issue, and is now in the process of hiring more eligibility staff to address this issue. In one county, which is moving from a caseload-based model to a task-based model, the caseload-per-worker measure will no longer be valid and will be removed from the labor agreement during the next bargaining session.

When the Children's Health Insurance Program was created in late 1997, California, like many other states, elected to separate that program from Medi-Cal for uninsured children with incomes greater than that allowed for Medi-Cal families. California implemented the Healthy Families Program (HFP) using a vendor to build and maintain an eligibility system and to determine eligibility as allowed by Title XXI of the Social Security Act. California has continued to use a vendor for this function ever since. While the separation of the Medicaid and CHIP programs in states may have achieved the goal of not creating a stigma related to participation in the CHIP program, as many believe has been the case for Medicaid programs, it has also created operational and

administrative issues, most of which are focused on getting children into the "right" program for the sake of the federal funding and the slightly different federal rules associated with those programs. California has implemented many procedures, both automated and manual, that allow individuals to move between Medi-Cal and the HFP. It's very important to note that these "hand-offs" are not without their problems, which can result in a delay in the determination of eligibility. According to the vendor, it takes between four and 15 days to process an HFP application that comes directly to the vendor and, when the application is made first to the county where Medi-Cal was denied or terminated, may require 45 days from the date of application to the determination of HFP eligibility.

In late June 2012, the leaders from the California State Legislature and Governor Brown agreed on a state budget compromise which included a provision that would shift all of the 880,000 children in the Healthy Families program into Medi-Cal managed care, beginning January 1, 2013. This effectively ends the separate Healthy Families program and creates an integrated Medi-Cal program that includes children eligible under both the Title XIX (Medical Assistance) and Title XXI (Children's Health Insurance Program) of the Social Security Act. Under the terms of the Maintenance of Effort provisions of the ACA, California cannot reduce the eligibility of these children until 2019.

The data needed to determine eligibility and some of the eligibility rules are very similar between programs. This similarity has been enhanced by the Farm Bills of 2002 and 2008, which allowed states to modify their SNAP program to more closely align it with either the TANF or the Medicaid/CHIP programs. States have been actively encouraged by the federal government to simplify their Medicaid, CHIP and human service programs to better serve the populations that are eligible for these benefits and to improve the efficiencies and cost effectiveness of the administration of these programs. In addition, integration with other human service programs allows for the individual and/or family to be handled in a holistic manner for all manner of human and social services programs. In California, the differences between the human services programs and the new rules that will be used to determine eligibility for children and non-elderly, non-disabled adults under the ACA are:

- Who is included in the group to receive benefits:
    - CalFresh groups those persons living together who purchase and prepare meals together. Minor children living with a parent or parents are always included, as are spouses with spouses.
    - MAGI rules are based upon tax filing status for those who file taxes and familial relationships for those living together. This means that a tax filing household would include the primary tax filer, his or her spouse, their minor children and any other persons for whom the tax filer provides more than a set percentage of their financial needs during the year. This could include adult children, other relatives or non-related individuals. For those who do not file taxes, the group will be the individual applying for assistance, his or her spouse (or an unmarried co-parent of children in the household) and the minor children of the couple.
    - CalWORKS groups together the immediate family of parent or parents and their minor children.

- What income counts:
    - CalFresh is required to count certain income sources, including SSI and child support income, but can, based upon changes in federal law in 2002 and 2008, align exempt income policies with those of the TANF program or the Medicaid program. CalFresh aligns currently with the CalWORKS program and does not align to the same degree with the Medi-Cal program.
    - CalWORKS counts all earned and unearned income.
    - MAGI does not count child support income and does not count SSI income.

- What deductions are allowed from income:

- CalFresh allows deductions for dependent care, medical expenses, utility expenses and shelter expenses, although both medical expenses and utility and shelter expenses can be standardized and therefore streamlined.
- In determining eligibility, CalWORKS deducts $90 for each employed individual in the family and then exempts the first $225 of earnings and 50% of the remainder in determining the size of the cash grant. Additionally, the first $50 of child support payments received is not counted, but the State retains any amount greater than $50 to offset the CalWORKS grant.
- MAGI only allows deductions associated with those deducted during the calculation of adjusted gross income on the tax form (depreciation and business expenses for self-employment, etc.) and other added deductions (income from foreign sources, interest income, etc.).

The following table compares the MAGI Medi-Cal and CalFresh eligibility rules:

Type	MAGI Rules	CalFresh (SNAP)
Wages	Gross income, but subtracts pre-tax deductions, like a health savings account or a Roth IRA.	Gross Income without regard to pre-tax deductions.
Self-employment income	Uses tax income calculation, so allows for depreciation and business expenses to be deducted.	Uses a different calculation for self-employment income, including some, but not all, of the same deductions.
Need based assistance payments, like SSI, TANF and Workers Compensation.	Not Counted	Counted
Child support income received	Not Counted	Counted
Workers compensation payments	Not counted, not unless they are for retirement plan benefits	Counted
Signature	All applying adults (or authorized rep) and each tax filer (if different) have to sign application for assistance and have to sign enrollment page.	One responsible person, but have to sign application and renewals.
Interview required	Not Allowed	An interview is required and must be done in person or over the telephone with a public worker at time of application and at the annual renewal.

Other health insurance access and coverage	Eligibility requirement for PTC/CSR and coverage by other insurance needs to be identified for Medi-Cal for coordination of benefits purposes.	Not Applicable
Migrant or seasonal farm worker	Not Applicable	Eligibility Requirement
Verify	MAGI income Age Pregnancy TPL Health Insurance Access and Coverage (for PTC)	Enrollment in disability program Hours worked (if SNAP E&T) Child support obligation and payment Utility and/or medical expenses, if claimed. If questionable, should verify Dependent care expenses Resources (if part of eligibility requirements) Shelter expenses
Budgeting period for income	Current monthly for MAGI MA and projected annual for PTC	Monthly Income is budgeted prospectively.
Change reporting	Changes that affect eligibility or enrollment, which includes income, household composition, and if changing address changes available health plans, address.	SNAP's Simplified Reporting policy option, which California has adopted, allows households to report only those income changes, between official reviews of eligibility that would make the household ineligible.
Renewal	States are allowed to push the renewal forward in Medicaid by 12 months at any redetermination, including SNAP interim reporting and any change reported that results in a redetermination of eligibility.	For most households, six month interim reporting and annual reporting are required.

Performance

In terms of performance, California, like many other states, has various successes and challenges in the administration of its programs. Unfortunately, California's SNAP participation rate is very low. California ranked last among the 50 states and the District of Columbia in terms of participation of eligible persons in the CalFresh program in 2007, 2008 and 2009. California enrolled 53% of eligible persons in 2009 and enrolled only 36% of eligible persons in working families in 2009. While a more complete discussion of both administrative cost and participation are offered below by the Public Policy Institute of California, individuals we spoke with from the federal government, state government, counties, and advocacy agencies offered these possible reasons for the low participation rate:

- California does not do a sufficient job of promoting the program and has yet to put the CalFresh program on an equal footing, in terms of status, with the CalWORKS and Medi-Cal programs.
- California is the only state that has 'cashed out' its SNAP benefits for persons receiving Supplemental Security Income (SSI) payments and those individuals aren't counted in terms of participation. This has been cited in the footnotes of the report by the report's researcher, Mathematica Policy and Research.
- California has many foreign-born residents who are not residing in the state legally or who have an immigration status that does not allow them to receive benefits (this is partially handled in the participation calculation).
- In many Californian communities, the culture is such that eligible individuals eschew participation in a government program, either because of a sense of independence and self-sufficiency or because of a general mistrust of government.
- Up until January 1, 2012, California required fingerprinting as a condition of eligibility for CalFresh, impacting the participation rate.
- California is one of a few states that have not fully implemented a federal policy option that allows many individuals receiving benefits to report only those changes that would end their eligibility in the program and to report on a semi-annual basis. (California is in the process of moving forward with the implementation of the 'Simplified or Reduced Reporting' policy.)
- Because California ties its CalFresh and CalWORKS programs so tightly together, and is so successful with its CalWORKS program, many individuals in working families are not aware that they could receive CalFresh benefits.

On the issue of participation, the Public Policy Institute of California issued a report in September 2011, California's Food Stamp Program: Participation and Cost Challenges for the State, that analyzed several of these issues, explaining:

> "California's demographics differ from other states, as does its economy and one longstanding CalFresh policy. Upon examination, however, none of these can explain its lower CalFresh participation rate during the last decade.
>
> Demographics. California is home to more noncitizens than any other state; these noncitizens may be reluctant to avail themselves of CalFresh assistance, and this could be depressing participation. Census data from 2008 show that among the 29 percent of all California households with incomes under 200 percent of the federal poverty level, 8 percent were noncitizen households—double the share among low-income households in the rest of the country. Although unauthorized immigrants are ineligible for the program, their citizen children are eligible if they meet other requirements. Ineligible parents may be unaware of their children's eligibility or be reluctant to apply because of their own status. Unauthorized immigrants may also avoid the application process for their children because they think they themselves will be deported, or be denied citizenship in the future. Although the USDA's Food and

Nutrition Service issued instructions a decade ago that made clear that neither of these actions would be taken because of a food stamp application, concern may still linger.

But other demographic characteristics might attenuate any effect that a large immigrant population has on participation. California's low-income population is younger and has lower educational attainment compared to other states. These two factors tend to increase CalFresh participation compared to other parts of the country." [8]

In terms of the 2010 CalFresh program performance, among the 53 states, districts and territories, California ranked:

- 46th with a 79.49% timeliness for SNAP applications;[9]
- 48th with a 14.67% negative error rate. [10] This represented an increase in the negative error rate from FFY2009 of .78%
- 36th with an active payment accuracy error rate of 4.81%.[11] This represented a 0.45% increase from the FFY 2009.

In terms of Medicaid and CHIP program participation, the Kaiser Family Foundation on its website lists California as having the 15th best Medicaid/CHIP participation rate (among the 50 states and the District of Columbia) among children.[12] The California Department of Health Care Services monitors the performance of those 25 counties with the most Medi-Cal participants in terms of their application timeliness for those that involve a disability determination and those that do not and whether the county has mailed a review notice out 60 days prior to the renewal date, mailed out the regular renewal notice, and sent a notice of termination to those families who have not completed their renewal process. The results for 2010 were very good.

- Regular Applications: 93% (84% to 100%)
- Disability Applications: 97% (88% to 100%)
- Review Notice 60 days from Renewal: 99% (93% to 100%)
- Renewal Mailed: 96% (90% to 100%)
- Failure to Renew Notice Mailed: 97% (90 to 100%)

CDHCS also monitors the efficacy of the transition between Medi-Cal and the Healthy Families Program for these same counties. They monitor whether a notice was sent when eligibility for Medi-Cal ended and there is potential eligibility for a child in the Healthy Families Program to families of these children informing them of the HFP within five working days from the determination of a share of cost. In 2011, this occurred in 97% of the cases studied. There is a great deal of variation between the 25 counties in terms of whether the counties sent annual redetermination forms for these children to the HFP within five working days from the determination of a share of cost if the parent has given consent to send this information to the HFP. While this had been done in 86% of cases, one county only sent 57% of the redetermination forms to the HFP.

[8] Caroline Danielson and Jacob Alex Klerman

[9] Application timeliness is measured as part of the state and federal SNAP quality control process and looks at a sample of applications processed either within 7 days for those cases that met the criteria for priority service processing or 30 days for applications that did not qualify for priority service processing.

[10] Negative error rate is measured as part of the state and federal SNAP quality control process and looks at a sample of cases to determine if the reduction or termination of benefits was done correctly.

[11] Active payment accuracy error rate is measured as part of the state and federal SNAP quality control process and looks at a sample of cases to determine if benefits that were issued were correct and, if not, the percentage of benefits that were provided in correctly. This includes both overpayments and underpayments.

[12] www.statehealthfacts.org

Fiscal Summary - Health and Human Services Programs

As noted in California Department of Social Services Local Assistance Appropriation Tables for 2011-2012 and the United States Department of Agriculture, Food and Nutrition Service's (USDA-FNS) National Databank, funds allocated for administrative functions, from both federal sources and non-federal, are as follows:

Program	Administrative Allocation[13]	Average Monthly Total Recipients	Administrative Cost per Recipient
Medi-Cal	$ 1,389,032,000[14]	7,642,700	$181.74
CalWORKS (TANF)[15]	$ 630,683,000	1,474,923	$427.60
CalFresh/ SNAP (includes Nutrition Education and Employment Training Costs)[16]	$ 1,274,317,542	3,672,980	$346.94

CalFresh

Expenditure data from the United States Department of Agriculture, Food and Nutrition Service's (USDA-FNS) national databank confirms that California is an outlier nationally in terms of administrative costs related to the SNAP-eligible. FNS data shows that California spends more per CalFresh case than any other state, and the percentage of administrative costs to benefits costs was second worst. In FFY 2011, California spent $1,274,317,542 in total SNAP funds to administer its program. There were, on average, more than 3,672,980 individuals (1,600,000 households) receiving CalFresh benefits each month with nearly $6.5 billion in total benefits issued in FFY2011. California's administrative costs totaled over 19% of benefits; this calculates as an administrative cost per case per month of $65.84. To give some context, in 2011 the average administrative cost per case per month in the U.S. was $27.06 or 9.5% of benefits. The best state was South Carolina with an administrative cost per case per month of $9.37. New Jersey had the worst percentage with administrative costs at 22.0% of benefits and 2nd worst administrative cost per case per month of $60.02.

However, in comparing California's performance to that of other state SNAP programs, it is important to note that the FNS administration cost data includes two significant line items that are specific to California. California has a large Nutrition Education component ($150,259,000—roughly 11.8% of the state's SNAP administrative costs in 2011) as well as an Employment Training Program ($85,038,000 total funds in FY 2011-12). Furthermore, the federal participation rate does not reflect California's 1.2 million SSI recipients who receive a cash substitute for SNAP, thereby further skewing comparison of the administration cost per case across states. Every other state includes SSI recipients in their SNAP program. Since SSI clients have fixed incomes, and in many large states are administered via a low-cost Combined Application Program (CAP) , the administrative cost per case for these recipients is much lower than the cost for low-income families and individuals. While California's

[13] Administrative basic costs include the costs for general administration, coordination and overhead for the programs such as the salaries and benefits of staff performing activities related to eligibility determination, preparation of budgets, monitoring programs, fraud units, services related to accounting, litigation, payroll and personnel, and costs for the goods and services required for the administration of the program such as supplies, equipment, utilities, and rental and maintenance of office space.

[14] May 2012 Medi-Cal Estimate County Administration Funding Summary, 2011-12 County Administration Base Costs

[15] DSS May 2011 Local Assistance Appropriation Table

[16] FNS National Databank data, FY 2011 Cost per Case Admin Cost Federal and State

cash-out program is administered in a similar fashion to other states' programs, SSI cases are not counted in the state's participation rates, while SSI cases in other states are counted.

CalFresh administrative costs increased 26% during the period of 2009-2011. Certification related expenses made up 63.8% of the total program administrative costs and were a significant driver of the administrative expense trend. While the state reported a sizable increase in administrative costs, the increase in amount of benefits issued outpaced the rise in the administrative cost; benefit expenditures increased 48% during the three year period.

CalWORKs

In FY 2011-2012 DSS allocated an estimated total of $630,683,000 to CalWORKS program administration costs.[17] The total CalWORKS eligibility expenditure is projected to be approximately $596.0 million (nearly 95% of the total administration costs).[18] Fluctuation in caseload is the major component of the year-to-year change in administrative allocation. DSS projected a 5.4% increase in the CalWORKS caseload and a 1.0% growth in eligibility expenditure in FY 2010-11. The CalWORKS caseload is projected to decrease by 0.5% in FY 2011-12, resulting in a 0.1% decrease in CalWORKS eligibility expenditures.

Medi-Cal

In 2011-2012 DHCS estimated a total of $3,022,185,000 for total Medi-Cal program administration, 48.3% of which is directed to counties for eligibility related administration. The Medi-Cal county administrative allocation consists of two components: (1) the base and (2) policy changes. The base estimate consists of the costs identified for staff costs, staff development, and support costs related to Medi-Cal eligibility determination. Base costs are covered at a ratio of 50% federal funds and 50% General Funds. Base costs are adjusted to reflect the estimated fiscal impact on eligibility costs of recent changes or other functions not incorporated in the base allocation.

Similar to other programs, the increase in estimated caseload is a significant factor in year-to-year administrative cost allocation fluctuation. In FY 2010-2011 DHCS estimated there would be 4,628,694 average monthly certified eligibles (before adding the impact of policy changes) based on the May 2010 Estimate. In FY 2011-2012 DHCS estimated there would be 4,729,300 average monthly certified eligibles. The county administrative budget for FY 2011-2012 is $1,389,032,000 – a 4% increase over the 2010-2011 allocation.

Allocation of Common Intake Costs

Californians are automatically eligible for Medi-Cal with no share of cost if they receive benefits from SSI/SSP, CalWorks, Refugee Assistance, Foster Care, or Adoption Assistance. The federal Department of Health and Human Services Division of Cost Allocation directed the California DSS to distribute costs for the eligibility determination activity among the benefiting programs. The majority of eligibility workers' common intake administrative costs are allocated among CalWORKS, CalFresh and Medi-Cal. In FY 2009-10, the total CalWORKS eligibility expenditures were approximately $590.4 million and the Medi-Cal common costs were approximately $62.3 million. Therefore, it is assumed that Medi-Cal costs represent approximately 10.6 % of the total CalWORKS eligibility expenditures in FY 2010-11 – approximately $62.9 million.[19]

[17] This total program allocation includes $6.5 million for the CalWORKS administrative basic expenditures for Recent Noncitizen Entrants (RNE). Of the $6.5 million, $3.2 million reflects the federally eligible recipients in mixed households. RNEs Funds are TANF ineligible, 100 percent General Fund.

[18] DSS Local Assistance Estimate Methodologies

[19] DSS Local Assistance Estimate Methodologies

As the Medicaid MAGI population moves into the Exchange and out of the common intake process, the amount of funding needed to maintain program eligibility services will shift but may remain relatively constant. CalFresh and CalWORKS will be responsible for a larger portion of the total common intake expenditure which may result in the need for reallocated non-federal (General Fund or county) revenue to support human service programs. However, with the new federal funding for operations for Medicaid eligibility, less General Fund and county fund dollars would be needed to fund the health services administration costs.

Sources of Non-Federal Funding

Counties have historically shared responsibility for funding the state's health and social service programs. In 1991, California enacted a major change in the state and local government relationship, known as realignment, which codified the county/state responsibilities regarding nineteen health, mental health and social services programs—transferring programs from the state to county control and altering program cost-sharing ratios. Realignment provided new revenue sources consisting of dedicated tax revenues from a half-cent increase in the state sales tax and vehicle license fee to pay for these changes. Counties received some assurance of a dedicated revenue source that would grow over time and were granted increased flexibility in managing some of the realigned programs, most notably in mental health.

Realignment increased the county share of non-federal costs for certain health and social services programs, and reduced the county share for others. Most notably, prior to realignment, the federal, state, and local governments shared costs for AFDC (TANF didn't start until 1997) grant payments, program administration, and welfare-to-work services. Realignment changed the nonfederal cost-sharing ratios for the state and county governments for a 50% county share to a 30% county share, with a net decrease in county costs of about $210 million in 1991-92.[20]

The cost sharing ratio set up in the realignment has been somewhat diluted over time for some programs. The Legislature replaced the AFDC program with the CalWORKS program in response to the 1996 federal welfare reform legislation. This legislation fixed the county share of costs for administration, employment services, and support services (such as child care) at their 1996-97 dollar levels, which left the state to absorb increases in program costs. Additionally the legislation created a performance incentive program for the counties. In its evaluation of the effect of the 1991 Realignment, the Legislative Analyst's Office noted that "compared to the modest changes in this area made by realignment, welfare reform has provided counties with significant financial benefits."[21]

Today the entire CalWORKs Single Allocation, which includes funding for CalWORKs administration (eligibility and enrollment-related activities), Employment Services (welfare-to-work kinds of services) and Stage 1 Child Care, are funded 100% from federal (TANF) and the state General Fund. The mix of TANF and General Fund varies from year-to-year, depending upon the amount of General Fund dollars needed to meet the established MOE.

However, counties are still required by statute to contribute 30% of the non-federal share of costs (or 15% of overall CalFresh Admin costs) to support CalFresh administration. For Medi-Cal, the state and federal government each contribute half of the administrative costs. Counties do not have a share in funding Medi-Cal

[20] Legislative Analyst's Office. Realignment Revisited: An Evaluation of the 1991 Experiment In State-County Relations. February 2001.
[21] Legislative Analyst's Office. Realignment Revisited: An Evaluation of the 1991 Experiment In State-County Relations. February 2001.

administration. As noted in the section above, the county administration budget for 2011-2012 is estimated to be $1,389,032,000, all of which is funded by federal and state dollars.

Available Funding

Several federal programs provide various levels of funding to build and operate eligibility systems. Federal funding opportunities include the following:

- CMS will provide 100% federal funding, through a series of grants, for the development of a Health Insurance Exchange. Federal funding is available to operate the Exchange through 2014, but the Exchange must be self-sustaining from that point forward.
- CMS will provide 90% federal funding through an approved plan that meets certain federally specified rules (use of a rules engine, Service Oriented Architecture, transferability to other states, etc.) to develop a new Medicaid or CHIP eligibility system or to modify an existing system. This includes the portion of an Exchange that would be used by the Medicaid and CHIP program. This enhanced funding ends on December 31, 2015. CMS also provides 75/25 operational funding for qualifying systems. Unlike the 90/10 enhanced system development funding, this level of funding does not have an end date.
- Any Medicaid changes that "benefit" SNAP and TANF programs are eligible to receive the same enhanced development funding (90/10) approved for Medicaid based upon the August 10, 2011 Tri-Agency letter.
- Additionally, the FNS provides 50% federal funding for building, maintaining or enhancing automated SNAP eligibility systems that do not benefit Medicaid/CHIP and 50% federal funding for all other SNAP administrative costs. FNS requires prior approval of RFPs and contracts and requires an approved APD before funding is provided.
- The Administration for Dependent Children and Families requires states to use a portion of their TANF block grant or TANF Maintenance-of-Effort funds to develop and enhance and operate TANF eligibility systems. As stated above, the Tri-Agency letter does allow states to claim 90/10 funding for the development and enhancement of eligibility systems that benefits Medicaid/CHIP, but also provides functionality for TANF.

How much federal funding will be needed (and provided) in California and to whom it will be allocated is dependent upon the model chosen by the State and what conditions CMS, ACF and USDA/FNS place on approval of that federal funding.

Information Technology

SAWS

California's Statewide Automated Welfare System (SAWS) is a 50-year evolutionary effort to automate county administrative functions for publicly funded health and human services programs, including functions such as eligibility and benefit determination, enrollment, and case maintenance at the county level. Today's SAWS encompasses three distinct SAWS systems operated by three county-based consortia which have evolved, along with their respective systems, over time. The current systems are:

- Los Angeles Eligibility, Automated Determination, Evaluation and Reporting (LEADER) Consortium
- Welfare Client Data System (WCDS) Consortium (also known as CalWIN)
- Consortium IV (C-IV)

The purpose of the consortium concept is to facilitate county collaboration in meeting their business needs in the areas of system planning, development, implementation, operations, and maintenance. This structure allows counties to pool resources and achieve economies of scale while still retaining some flexibility to meet specific county needs. State project management and oversight for SAWS is provided by the California Health and Human Services Agency (CHHS), California Department of Social Services (CDSS), California Department of Health Care Services (CDHCS), and California Office of Systems Integration (OSI).

These automated systems require a large and continued financial commitment by counties, the State and the federal government (See Table IT-1: SAWS systems costs), which share in the cost of development, maintenance and operations. Given the scale and complexity, these systems take multiple years and hundreds of millions of dollars to develop and maintain. Over the years, California's Legislature has consolidated the total number of SAWS systems from four to three currently, and have mandated migration to two in 2017, reducing the state's financial burden of maintaining multiple systems and also assisting in standardizing the eligibility determination processes of the state's health and human services operations. Currently, the three SAWS systems are a direct result of almost half a century's evolution, consolidation, innovation, and competition between these systems.

Table IT-1: SAWS Systems Cost

Table IT-1: SAWS Systems Cost (in Millions)				
SAWS System	**Development**	**Maintenance & Operation**		
		2010-11	**2011-2012**	**2012-13**[22]
ISAWS (fully implemented in 35 counties in 1998)	$110	$20	n/a	n/a
LEADER (fully implemented in LA County in 2001)	$110	$31	$31	$16
C-IV (fully implemented in 4 counties in October 2004, now up to 39 counties)	$477[23]	$46	$71	$77
CalWIN (fully implemented in 18 counties in 2006)	$525	$78	$76	$81
LRS (Leader Replacement)	$76/475[24]	n/a	n/a	n/a
Totals	**$1,697**	**$175**	**$178**	**$174**

Current SAWS Systems Reflect Their Evolutionary History

In the 1970s, many counties developed or purchased their own stand-alone information management systems catering to each county's specific data management and eligibility process needs. Over time, as counties began sharing strategies and best practices around their use of such systems, it became apparent that many were building systems that had similar functionality. It became clear that a different strategy was needed to achieve economies of scale and allow counties to share in the cost of building such systems.

In 1984, the Legislature passed Senate Bill 1379 requiring implementation of SAWS. Initially, the State had made several attempts to build a single, statewide automated welfare system to deliver and support some of California's major health and human services programs. One of two such early pilot systems was developed in

[22] 2012-13 from the Governor's May Revision Budget
[23] Original development and implementation costs for 4 original counties was $274.1M, and the development and implementation costs for adding 35 counties was $202.6M.
[24] May Revise budgets a total of $75.5 million in 2012-13 for the LRS, which is slated to begin development in July 2012. This is out of an estimated $475 million total build cost.

Napa County and known as the Napa Automated Public Assistance System (NAPAS). The Request for Proposal for this system was released in 1987 with a contract awarded in 1988. The system development and implementation phases were completed in Napa County in 1991. In 1992, following implementation of the two SAWS pilot systems, an in-depth evaluation was conducted to determine the future direction of the SAWS Project. The NAPAS system was selected for implementation statewide. NAPAS was modified to operate in a multi-county environment, and maintenance and operations activities were transferred from Napa County to the State. To test multi-county operations, the NAPAS system was implemented in 14 additional counties under the Interim Statewide Automated Welfare System (ISAWS) project. The system was renamed ISAWS and was operated by the State.

In 1995, the Legislature ultimately concluded that a single statewide system was not feasible at the time. The California Budget Act of 1995 established a four county consortium strategy as the foundation for achieving statewide welfare automation, which included ISAWS, LEADER (a system developed by Los Angeles County) and CalWIN (a system developed by a Bay Area collaborative). The purpose of the consortium concept was to facilitate the collaboration of counties in automating their business processes. The consortium concept was intended to provide flexibility to county health and human service departments while balancing choice with the reality of limited funding.

With the adoption of the consortium strategy in 1995, the 15 ISAWS counties became the ISAWS Consortium, one of the four consortia in the SAWS Project. Twenty additional counties elected to join the consortium and implementation was completed in these counties in July 1998. The ISAWS Consortium ultimately included the following 35 counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Joaquin, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

In 1996, Merced, Riverside, Stanislaus and San Bernardino counties came together to form Consortium IV (C-IV). In December 1997, state and federal approval was given to develop the C-IV system. System development began in March 2001, and implementation was completed in all four counties in October 2004.

Meanwhile, in 2000, the ISAWS counties concluded that ISAWS was no longer meeting their business needs. A large number of maintenance change requests were pending, which, until made, required manual processing by eligibility staff (also known as “workarounds”). In addition, the aging ISAWS technology placed the future viability of the system in doubt and placed the counties' ability to deliver services at risk. After reviewing the alternatives to the continued use of the ISAWS system, the counties concluded that transferring another SAWS system to the ISAWS Consortium was the best available alternative. At that time, only the LEADER system had been developed but not yet implemented throughout Los Angeles County.

Los Angeles began building the LEADER system in November 1995 to replace 22 legacy systems. LEADER was fully implemented in April 2001, and is one of the largest client-server systems in the world.[25] It is integral to the county’s administration of various public programs and is the core tool used by workers to determine eligibility, benefit calculation and issuance, case maintenance, reporting, and case management for CalFresh (at that time known as the Food Stamps program), CalWORKs, Medi-Cal, Refugee Cash Assistance and the General Relief (GR) programs. LEADER is managed and run through county administration through the Los Angeles County Department of Public Social Services, which reports to the County Board of Supervisors. While the Board

[25] The LEADER application has approximately 850 screens developed in PowerBuilder and roughly 13,000 programs with over 9 million lines of code in Common Business Oriented Language (COBOL). The LEADER system uses a proprietary Relational Database Management System (RDMS 2200) that runs on multiple Unisys enterprise servers, and currently maintains approximately 6 terabytes of data.

makes the majority of decisions impacting the development and functionality of LEADER, major changes require State and federal approval.

In the Bay Area, 18 counties came together to form the Welfare Client Data System (WCDS) Consortium and began building the CalWIN SAWS system. While not a formal, stand-alone organization, WCDS Consortium is governed through a board comprised of the 18 county directors. Decisions are made through a steering committee, and each county signs an agreement with the CalWIN vendor. The WCDS Consortium includes the following eighteen California counties: Alameda, Contra Costa, Fresno, Orange, Placer, Sacramento, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Tulare, Ventura, and Yolo.

By November 2001, both the CalWIN system and the Consortium IV (C-IV) system were in the middle of development. The ISAWS Consortium reconsidered their options for a replacement system and agreed to eventually disband the consortium with each county choosing to join either the WCDS or C-IV. Joining the LEADER Consortium was not considered a viable alternative at the time given that the ISAWS Consortium is comprised of primarily small and medium counties. ISAWS county directors did not believe the existing LEADER system and LEADER governance structure would meet the needs of the ISAWS counties.

In late 2004, functional and technical reviews of the CalWIN and C-IV systems were conducted. Based on the results of these reviews, all 35 ISAWS Consortium counties identified the C-IV system as their preference for migration. The 35 ISAWS counties officially joined Consortium IV in June 2007. The State's fiscal crisis delayed efforts to move forward with ISAWS migration planning, but ISAWS was ultimately transitioned into C-IV in 2010. (A migration refers to the process of moving the process and data housed in one system to another.) The migration cost about $210 million ($130 million General Fund) and brought the number of consortia to three.[26]

The C-IV system, the newest built SAWS system, is a web-based automated system. As of June 2010, the 39 C-IV Member Counties are organized into seven (7) Regions as illustrated in the table below.

[26] Legislative Analyst's Office. Consolidating California's Statewide Automated Welfare Systems, February 2012.

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Riverside	San Bernardino	Kern	San Joaquin	Merced	Humboldt	Butte
Imperial		Monterey	Stanislaus	Madera	Mendocino	Shasta
		Kings	Marin	Tuolumne	Yuba	Tehama
		San Benito	Napa	Calaveras	Sutter	Siskiyou
				Amador	El Dorado	Del Norte
				Inyo	Lake	Lassen
				Mariposa	Nevada	Trinity
				Mono	Glenn	Plumas
				Alpine	Colusa	Modoc
						Sierra
Total Users*	Total Users*	Total Users*	Total Users*	Total Users*	Total Users*	Total Users*
2,646	3,404	2,009	1,964	1,140	1,452	1,378
Total Persons Served Count**	Total Persons Served Count**	Total Persons Served Count**	Total Persons Served Count**	Total Persons Served Count**	Total Persons Served Count**	Total Persons Served Count**
566,389	617,059	474,447	424,450	201,660	195,008	178,505

* Data as of 03/2011

**Data as of SFY 2009/10

As a Joint Powers Authority, C-IV Consortium is a single legal entity, separate from its member counties, governed and administered by a Board of Directors comprised of seven County Welfare Directors, one from each of the seven regions.

Last year, the Legislature enacted ABX1 16 (Blumenfield), Chapter 13, Statutes of 2011, which authorized the decrease in the number of SAWS systems from three to two through the migration of C-IV's 39 counties and LEADER into the LEADER replacement system (LRS) that will be built upon C-IV infrastructure. According to the IAPD, LEADER's dated technology could no longer meet the business needs of the county. Additionally, LEADER was built using proprietary hardware and software, which meant that only the development vendor had the ability to maintain and modify the system. These maintenance services are not easily replaced, and the State has had to enter into multiple "sole source" contracts with the development vendor for continued support. Sole source contracts are generally more expensive than contracts that have been competitively bid, where competition tends to drive down costs. The development of LRS is estimated to take four years to design, develop and implement at an estimated total cost of $475 million.

LRS will leverage the latest advances in service oriented architecture and technology to enhance functionality, adaptability, and scalability, as well as to improve data integrity, communication, user-friendliness and productivity, to effectively support rapidly evolving welfare programs and operations. During development of the RFP, decisions were made to include business and functional requirements for additional programs, such as Welfare to Work and Foster Care related programs, currently automated in systems other than LEADER. Thus, in addition to replacing the existing LEADER System, the LRS will replace a number of other systems, including several legacy systems.[27] LRS will integrate these multiple systems into a single system, automating manual

[27] Includes GAIN (Greater Avenues for Independence) Employment and Reporting System (GEARS), General Relief Opportunities for Work (GROW) System, and Department of Children and Family Services (DCFS) Systems, which consists of five legacy systems: Automated

processes to streamline services to the public and improving communication between public assistance agencies and providers.

For a timeline of key SAWS development, please see Appendix A of this document.

Comparison with Other Systems

California's SAWS systems are incredibly large and complex systems. According to a 2010 Medi-Cal Eligibility Data System (MEDS) Assessment, using accepted industry techniques based upon counting lines of code and converting the counts to "function points", a measure of software functional size, each SAWS (LEADER, CalWIN or C-IV) is nearly 15,000 function points in size for *each* consortium system. In contrast, the State's MEDS system is roughly 4,000 function points, and 75% of information technology (IT) systems worldwide are smaller than the MEDS system.

According to a 2010 study by the National Association of State Workforce Agencies, a state government's average benefits system, as of 2010, is 22 years old. The oldest of these systems, as of 2010, were 41 and 42 years old, respectively. Only eight states, California being one of them, had modernized their systems, meaning they can fully support web-based features and current database technology. California SAWS systems are between 10 and 20 years old, and all support web-based features. In comparison, MEDS is over 30 years old.

Programmatic and Functional Similarities across SAWS

California counties have greatly benefited from sharing best practices and lessons learned over time as the various SAWS systems have evolved. Today, there are many similarities across the three SAWS systems. While all SAWS systems are responsible for the eligibility and enrollment functions for the three largest public programs (CalFresh, Medi-Cal, and CalWORKS), a number of them also support various other State and local programs:

C-IV Programs	CalWIN	LEADER
• CalWORKS • CalFresh • Medi-Cal • Foster Care • Adoption Assistance Program (AAP) • Cash Assistance Program for Immigrants (CAPI) • Child Care Programs • Emergency Assistance (EA) • Employment Services (WtW, FSET) • Kinship Guardianship Assistance Program (KinGAP) • Refugee Assistance Program	• CalWORKs • CalFresh • Medi-Cal • Foster Care • Adoption Assistance Program (AAP) • Cash Assistance Program for Immigrants (CAPI) • Employment Services (WtW, Child Care, FSET) • Kinship Guardianship Assistance Program (KinGAP) • Refugee Assistance Program • CMSP • County specific employment programs • In-Home Supportive Services	• CalWORKs • CalFresh • Medi-Cal • Refugee Assistance Program • General Relief (GR) Programs

Provider Payment System (APPS), Adoption Assistance Payments System (AAPS), Integrated Financial System (IFS), Welfare Case Management Information System (WCMIS), and EW Works, developed and maintained internally by DCFS staff and consultants.

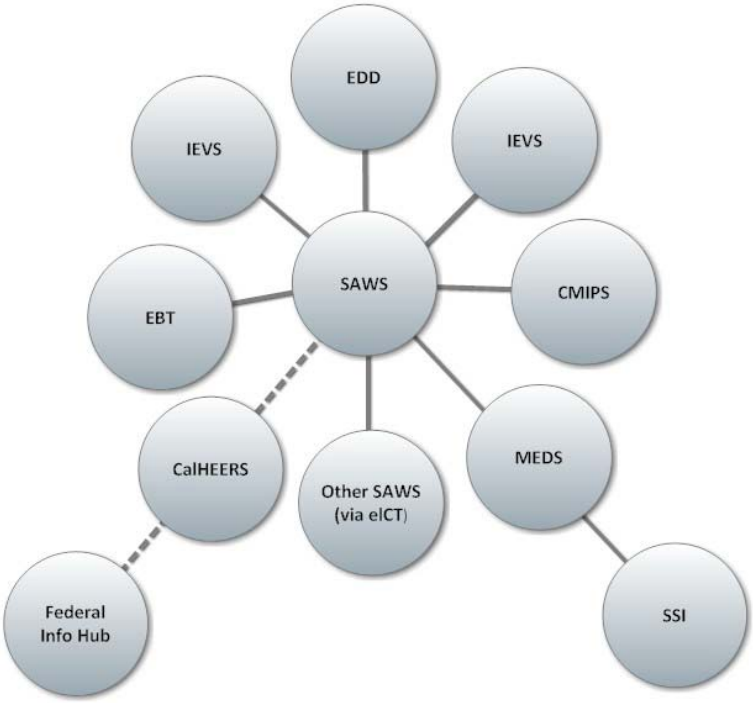
C-IV Programs	CalWIN	LEADER
	• Cal-Learn and General Assistance/General Relief	

To facilitate the various business processes required, each SAWS connects to a number of State databases and systems, including MEDS and Income and Eligibility Verification System (IEVS) run by the California Department of Health Care Services, the Case Management, Information and Payrolling System (CMIPS), and Electronic Benefits Transfer (EBT) System run by the California Department of Social Services, to name a few, and data from the Social Security Administration for SSI through MEDS. In the near future, SAWS will need to connect to the State's health benefits exchange eligibility system, CalHEERS, and potentially, depending upon the model chosen to implement California's Health Benefit Exchange, to the federal data hub (please see chart on following page).

All of the SAWS systems use the MEDS Statewide Client Index (SCI) system to manage and identify individuals applying for and accessing program benefits. SCI is a combination of applications and telecommunication infrastructure run by the State that was developed in 1994 to allow access to beneficiary information for file clearance purposes. SCI establishes a standardized index by assigning a unique identifier, known as the Client Index Number (CIN), for each beneficiary. The CIN allows cross-referencing to identification numbers assigned and utilized by other assistance programs. SCI provides a method to identify duplicate records, un-duplicate records, and link to the beneficiary's other records.

In addition to the functionality related to eligibility and enrollment, the SAWS systems also provide business functionality that allows counties to aggregate and analyze data needed for state and federal reporting. These business functions allow counties to track various applicants by population type. Counties believe this is a significant difference between California's SAWS systems compared to many states where there is no electronic data aggregation for county reporting purposes.

SAWS Connections to other Systems:



In the past two years, the SAWS systems have also adopted and implemented a number of strategic initiatives that are currently in progress or completed. These initiatives are aimed at linking the disparate SAWS systems, providing online functionality, and addressing gaps in SAWS infrastructure to increase interoperability and information sharing across systems in anticipation of increased demand due to federal health reform implementation.

Web Service Portals: As of February 2012, all of the SAWS systems offer online applications for CalFresh, Disaster CalFresh, Medi-Cal, CalWORKS and CMSP. For example, a major component of the C-IV system is C4Yourself, a web portal to the C-IV system that allows customers to apply for CalFresh, Medi-Cal, CalWORKS, and CMSP. It is a secure self-service, public-facing, web-based portal that streamlines the way data is collected using an interactive interview approach. Customers enter information to apply for CalFresh, Medi-Cal, CalWORKS, and CMSP online and the data transfers to the C-IV System, where eligibility is determined by an eligibility worker. Customers also have the ability to complete and submit their annual renewals, access their quarterly/mid-year status reports, and view the status of their case/benefits. All 39 C-IV counties currently accept applications through C4Yourself. CalWIN and Leader also have similar web portals. CalWIN's portal, Benefits CalWIN, also provides potentially interested applicants the ability to see if they are potentially eligible prior to submitting an application.

Electronic Document Imaging: A significant part of the eligibility process hinges on the ability of counties to receive documents from beneficiaries. Currently 57 counties have an Electronic Document Management System (EDMS), and the last county, Los Angeles, is in the middle of implementing an EDMS. The complete rollout of EDMS in Los Angeles is scheduled for completion in June 2013.

Interactive Voice Response (IVR) Call Center Systems: Each SAWS has also implemented an IVR system that allows beneficiaries to access information via the phone. For example, Access CalWIN is a centralized and standardized IVR system from which beneficiaries can obtain up-to-date case information for the CalFresh,

CalWORKs, Medi-Cal and General Assistance programs. This automated self-service system has the ability to answer the most common questions asked by applicants and recipients (CalWIN estimates that 50% of their calls are now being handled without human intervention). CalWIN is planning to expand the use of IVR, including access to additional program information and increasing the number of languages available through IVR. In some counties, the IVR systems are integrated with a live-person call center.

Statewide Web Portal: In addition, the consortia have developed a statewide website that routes potential applicants to the correct county SAWS system. The statewide website, benefitscal.org, is currently available in English and Spanish.

Electronic Information Sharing between SAWS: Perhaps the most significant improvement in sharing information, the SAWS have established an automated electronic Inter-County Transfer system (eICT), which allows counties using separate SAWS systems to share information electronically in a batch process. This is a significant improvement and step forward in establishing a seamless statewide system from the beneficiary's perspective.

A number of other pilots and initiatives are also underway to test new methods of information sharing and submission, including the use of smart phone apps to access case information, mobile phone apps for document uploads, expanded call center services (nine counties are in the middle of building call centers), and self-service document receipt stations, to name a few. Please see Appendix B for additional information.

Ability to Horizontally Integrate Already Inherent in SAWS Systems

The SAWS systems, from a data collection perspective, are already horizontally integrated. The application system is built upon the SAWS2 Form, which encompasses questions from all health and social services programs.[28] Thus, each SAWS system already has the main elements needed for horizontal integration incorporated, as each system already collects the data needed for each program to determine eligibility for CalFresh, CalWORKS and Medi-Cal. As an application is completed for one of these programs, the SAWS could use the same information to populate an application for another program and, supplemented with any additional information needed, allow an eligibility worker to help an individual apply for another program with a click of the button. And the SAWS systems currently have the ability, at the county eligibility worker level, to see if a beneficiary is potentially eligible for another public program at the point of application.

However, the SAWS systems are not horizontally integrated with the Healthy Families Program and they do not have – and no system in the country at this point has – the capability to determine eligibility for Medi-Cal using the new MAGI methodology, nor are they capable of determining PTC/CSR eligibility. None of the SAWS systems' web portals is capable of handling real-time eligibility, nor are they connected directly to state and federal data sources to access online verification resources. (Only Oklahoma's eligibility system has real time eligibility and verification functionality at this juncture, but Oklahoma is, like all other states, completing the necessary policy, business and IT analysis to determine how best to implement the MAGI eligibility rules.) Finally, these systems were not designed to handle health plan comparison, selection and enrollment.

The systems discussed above were developed independently and at different times. Their architectures vary, due largely to the different time periods during which they were conceived, designed and developed. While California has a wealth of functionality upon which to build, the individual systems' differentiating factors will present a challenge to creating an integrated, interoperable technical environment to support the Exchange, Medi-Cal and the Healthy Families Program in the short run. In the longer run, the State is contemplating

[28] A copy of the SAWS2 is available online here: http://www.cdss.ca.gov/cdssweb/entres/forms/English/SAWS2.pdf

program restructuring and will have to significantly "refresh" these systems in order to take advantage of opportunities to rethink and simplify the IT solution that supports the eligibility processes of the Health Benefit Exchange and other health and social services programs.

The California Health Benefit Exchange

California was the first state in the nation to enact enabling legislation that established an independent entity within California state government called the California Health Benefit Exchange.[29] The Exchange is comprised of a five member board and is responsible for planning and implementing the State's health exchange system. California was awarded a $1 million planning grant in 2010, which the Exchange used to study the feasibility of building a state-run Exchange. One of the outcomes of that planning effort was California's Level One Establishment Grant application, which resulted in a $39 million award from CMS on August 15, 2011. California has submitted its Level 1.2 Level One Grant. The California Health Benefit Exchange Board has met numerous times in closed and public sessions, and both Board Members and staff have consulted with a broad range of stakeholders across the State.

At its October 21, 2011 meeting, the Board adopted the following mission statement and values, which will guide the development, implementation, and operation of the Exchange:

> "The vision of the California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care. The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.
>
> The California Health Benefit Exchange is guided by the following values:
>
> - Consumer-focused: At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.
> - Affordability: The Exchange will provide affordable health insurance while assuring quality and access.
> - Catalyst: The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.
> - Integrity: The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
> - Partnership: The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders.

[29] SB 900 (Alquist), Chapter 659, Statutes of 2010 and AB 1602 (Perez), Chapter 655, Statutes of 2010.

- Results: The impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians.[30]"

In their March 2011 report, Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid, the Urban Institute estimated for California that, of its more than 34 million non-elderly residents:

- 10,624,000 individuals (31.1%) live in households with income that is below 138% FPL (the new Medicaid coverage group's mandatory level)
- 11,739,000 individuals (34.4%) live in households with income that would qualify them for the insurance affordability programs of the ACA (income between 138% and 400% FPL)
- 11,790,000 individuals (or 34.5%) live in households with incomes that exceed the insurance affordability program's upper limit of 400% FPL[31]

The report also estimated that the implementation of the ACA would result in a 10.6% decrease in the number of non-elderly uninsured individuals in California. More than 3.6 million Californians would have health coverage upon full implementation of the ACA. The University of California Berkeley Labor Center estimates that by 2016, "Up to 2.8 million Californians may be eligible for subsidized coverage through the Exchange. Of these individuals, up to 2.4 million individuals could be eligible for some level of subsidy." [32]

California's Level One Establishment Grant also includes a summary of the analysis done by State and Exchange Staff to determine the gap between the Information Technology systems that existed in the State and the "to be" model representing a fully-functional Exchange. As stated in the grant application, after reviewing both county and state systems, "The principal gaps in this area can be summarized as follows:

- **Support for new program eligibility determinations.** As is true elsewhere, system logic to support premium tax credits, reduced cost-sharing, Modified Adjusted Gross Income (MAGI) processing and other ACA-specific functionality does not exist in our current systems.
- **Integration of QHP-related functionality.** Current public program websites have no functionality to support reviewing and comparing QHP information online, and making related cost calculations. Health-e-App does offer functionality to support plan selection and initial premium payment for Healthy Families managed care plans.
- **Online, real time eligibility determination and information verification.** The design of these systems did not contemplate online, real time eligibility determination. Additionally, and to some degree as a consequence, no online verification of customer submitted information is provided.
- **Support for SHOP and employer related functions.** With no analogous function in the public program environment, these systems offer no functionality in this area.

While other gaps have been noted in the analysis, none rise to the level of significance of those summarized above. For example, while functionality analogous to Navigator support does not currently exist for the Medi-Cal websites, it is currently being developed, and the long history of application assistors using the website in the

[30] http://www.healthexchange.ca.gov/Pages/HBEXVisionMissionValues.aspx
[31] March 2011, Matthew Buettgens, John Holahan and Caitlin Carroll. Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid - Timely Analysis of Immediate Health Policy Issues (http://www.urban.org/uploadedpdf/412310-Health-Reform-Across-the-States.pdf)
[32] California Health Benefit Exchange Level 1 Establishment Grant Application, pp. 5-6

Healthy Families program provides a relevant model. Likewise, expanded functionality for submitting coverage and managing the renewal process are in development for the current systems." [33]

It is clear that the first priority for the Board and for the staff of the California Health Benefit Exchange is to develop an Exchange within the time constraints required by federal law, regulation and guidance. Understandably, because of the very short time left to implement an Exchange, a lesser priority is to increase the number of entry points available for Californians to access health coverage and other human service programs.

As stated on the website, Politico.com, on May 29, 2012:

> "California provides one of the most dramatic illustrations of the challenge pro-health reform states are facing. The Golden State was the first to authorize the creation of a state exchange after the health law passed. But it still hasn't signed a contract with an IT vendor, even though its deadline for announcing a developer passed two months ago, said Micah Weinberg of the Bay Area Council, an advocate close to the exchange development process. And the existing state of its systems for enrolling people in public insurance programs means it's going to be a huge jump to get ready for 2014."[34]

Because of tight federal deadlines to demonstrate operational readiness and without an IT vendor under contract at that time, the California Health Benefit Exchange board in May 2012 briefly considered pursuing a partnership with the Federally Facilitated Exchange (FFE). On May 16, 2012, CMS issued guidance on the partnership model.[35] "As discussed in the Exchange final rule and described more fully in this guidance, States will have the option to enter into a Partnership with an FFE. Under a State Partnership model, a State may administer plan management functions, in-person consumer assistance functions, or both. In non-Partnership FFE States, FFEs will perform these functions." [36] Under the State Partnership model, the FFE would either determine initial eligibility for Medi-Cal, Healthy Families Program, the premium tax credit and cost sharing reduction programs or would assess eligibility for the Medi-Cal and Healthy Families programs, and if individuals were determined to be potentially eligible, those individuals would be referred to the State eligibility system for a final determination. The March 27th Medicaid and CHIP regulations lay out the rules for that eligibility determination, and further CMS guidance on this process and the performance standards expected of States is expected soon. It is clear that CMS's expectation for this process is the same as would be expected of one in a State Health Insurance or Benefit Exchange and that no additional steps could be added to the process. With a fully-functional MAGI eligibility system it is conceivable that CMS would take over the function if States were unable to comply with the regulations. The FFE Partnership model does require the State partner, or perhaps in this case, the county consortia partners, to develop eligibility software for the MAGI Medi-Cal and the Healthy Families Program coverage groups.

New CalHEERS Framework

The Affordable Care Act, and its Health Benefit Exchange requirements, will play a significant role in the way California and its counties are preparing for and developing future eligibility systems. California was the first state in the nation to move forward with establishing a state-based exchange. California's Health Benefit Exchange includes the creation of an eligibility system, CalHEERS, that at its core provides one unified statewide eligibility and enrollment framework for private insurance coverage, as well as the Healthy Families Program and

[33] California Health Benefit Exchange Level 1 Establishment Grant Application, p. 31
[34] http://www.politico.com/news/stories/0512/76825.html#ixzz1wN6cuXbj, By J. LESTER FEDER | 5/29/12
[35] http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf
[36] The final rule was published at 77 Fed. Reg. 18310 (March 27, 2012) (to be codified at 45 C.F.R. parts 155, 156 and 157).

Medi-Cal. California's Health Benefit Exchange will share in the governance of CalHEERS with the corresponding State departments running Medi-Cal and the Healthy Families Program.

The Exchange clearly expresses in the CalHEERS RFP that the system will be the technical and functional foundation to accommodate the integration of the Medi-Cal Eligibility Data System (MEDS) in its first phase. This initial phase would also provide for an integrated and seamless "no-wrong door" approach to health coverage programs. The RFP also calls for a future phase of CalHEERS development that would expand eligibility services and functionality to integrate non-health human services programs into CalHEERS through horizontal integration of health and social services programs.

CalHEERS Baseline Functionality

The CalHEERS Baseline System, as described in the RFP,[37] needs to provide the following functionality:

- Screen for potential eligibility for non-MAGI Medi-Cal.
- Send and receive other health services program application, case Data and Document to/from SAWS.
- Interface seamlessly with SAWS on the disposition of non-MAGI program eligibility determination.
- Keep households that contain MAGI and non-MAGI members as a unified case in the member account features.
- Notify the applicant that they may be eligible for other State programs and direct them to the appropriate links (e.g., CalWORKS and CalFresh).
- Collect and send basic application Data, along with any documents provided by the application, to the System of record for that program to complete the application process.

Baseline System – Alternative Case Data Management Model

The RFP directed proposers to include not only a proposal for the baseline functionality but also a model for case data management for MAGI Medi-Cal Cases "where the case Data is centralized and operated by the Exchange and accessible to all Users. Non-MAGI case Data remains operated by counties in SAWS as part of the baseline system[38]." Within this approach:

- The Functionality, components, business rules, correspondences, and reports associated with the ASHS Programs shall be developed in CalHEERS.
- MAGI Medi-Cal case Data shall be stored in current SAWS (i.e., CalWIN, C-IV, or LEADER). The SAWS shall become the System of record for MAGI Medi-Cal cases.
- CHIP and AIM case Data shall be stored in their respective versions of the current Healthy Families Administrative System (MAXe2). The Functionality within MAXe2 shall continue to exist as it does currently, and real-time interfaces shall be developed to facilitate eligibility determination in CalHEERS and case Data storage in SAWS and MAXe2. The MAXe2 System shall remain as the System of record for the enrollment of consumers in the Healthy Families and AIM programs.

[37] CalHEERS Request for Proposal, pp. 4-13 and 4-14, http://www.healthexchange.ca.gov/Solicitations/Pages/HBEX4.aspx
[38] CalHEERS Request for Proposal, Table 12, p. 4-6, http://www.healthexchange.ca.gov/Solicitations/Pages/HBEX4.aspx

CalHEERS Expanded Functionality

The RFP also required proposers to describe how they would provide the state with an option, purchased separately, that would expand the functionality and service to include other health services programs and other non-health services program by December 31, 2015. The Expanded System was to include the Core Enhancement Functionality and Services to Support the Core Functionality and Services of the State's strategic vision of CalHEERS. This includes the integration of other non-health services programs, and integration of MEDS functionality. The state has the option to purchase this additional functionality, which would be implemented by December 31, 2015.

Ultimately, the triumvirate of the Department of HealthCare Services, the Managed Risk Medical Insurance Board, and the Exchange envisions CalHEERS to be a fully integrated, automated system that provides a first-class consumer experience and delivery of services through a web portal that accommodates different consumers' access needs and facilitates and simplifies the end-to-end process to attain and maintain health coverage. Utilizing a "no wrong door" approach, the system must provide a consistent consumer experience for all entry points and enable customer service by phone, online access, or in-office to process applications across affordability programs for families with members eligible for or enrolled in different programs. Such a system must contain the business rules and technical capabilities to determine online, real-time eligibility for the Healthy Families Program and for MAGI Medi-Cal eligibility, as well as enable administrative maintenance functionality (e.g., record retention, secure destruction, and storage, etc.) and case maintenance tasks.

Furthermore, the RFP calls for a system that presents content in a culturally sensitive format, provides straightforward navigation, and has simple tools or methods to help consumers to provide or obtain coverage information. In addition to providing assistance in English and Spanish, with links to phone, online chat, or IVR assistance in the Medi-Cal Managed Care Threshold languages, the system would also enable access for persons with disabilities and Limited English Proficiency (LEP) and meet all Americans with Disabilities Act (ADA) requirements.

CalHEERS Integration with Non-MAGI Health and Human Services Programs

While the Expanded Functionality includes the full integration of non-MAGI health and human service programs, such as CalFresh and CalWORKS, the RFP states the following requirements for horizontal integration for the baseline functionality:

- Download and print an application with pre-populated information if consent is provided (or blank if consent is not provided) for an applicant to apply for full health care coverage or other non-health services.[39]
- Notify the applicant that they may be eligible for other State programs and direct them to the appropriate links (e.g., CalWORKs and CalFresh).[40]
- Screen individuals for non-MAGI eligibility criteria (e.g. blind or disabled, etc.) and send a referral, including application data and document images, to the appropriate SAWS.[41]
- Send basic application information, upon consumer request and/or consent, to the appropriate SAWS in order to process for other non-health services.[42]

[39] CalHEERS Request for Proposal, Attachment 2, Business Requirement 24, http://www.healthexchange.ca.gov/Documents/Solicitation%20HBEX4%20-%20Attachments%201-18-12.zip
[40] CalHEERS Request for Proposal, Attachment 2, Business Requirement 57, http://www.healthexchange.ca.gov/Documents/Solicitation%20HBEX4%20-%20Attachments%201-18-12.zip
[41] CalHEERS Request for Proposal, Attachment 2, Business Requirement 71, http://www.healthexchange.ca.gov/Documents/Solicitation%20HBEX4%20-%20Attachments%201-18-12.zip

The RFP also specifies that counties will continue to determine eligibility and maintain case data for Non-MAGI Medi-Cal cases and the human services programs. Coupled with "no wrong door requirements" where all points must lead to coverage, CalHEERS and SAWS will be required to interface with each other to share information bi-directionally in order to meet requirements to provide seamless and timely transition between health programs with no gaps in service, particularly for populations that fall in and out of eligibility for Medi-Cal or Healthy Families. The RFP also calls for leveraging existing systems, where appropriate, and requires the vendor to build the system on an architecture that is scalable, flexible, modular, and dynamic.

The RFP requires that the vendor demonstrate their plan to use the Enroll User Experience 2014 design or a similar approach that provides a design on par with the Enroll UX 2014 design. The Enroll UX 2014 design project, funded by eight non-profit foundations, is developing, as the UX2014.org website says, "a first class user experience design for health benefit exchanges". [43] Eleven states and the federal government are participating in the design, making it available for every health insurance exchange to use in its operations. The project will offer design standards and detailed design specifications for an online health insurance portal that will make it easier for consumers to understand the coverage they may be eligible for and will support their enrollment decision-making. Through this best-in-class user experience, eligible consumers across the country would be able to enroll in and retain health insurance coverage more easily and efficiently. By bringing the design industry's best thinking to bear on this effort, and then making it available to every state exchange, the Enroll UX 2014 design project hopes to prevent duplication, save money, and improve the quality of the enrollment experience. Such a design can offer an alternative to IT development firms' user interfaces and can shorten the cost and time required to build an Exchange.

As noted in the RFP, none of the existing systems currently have the functionality to meet all the requirements of CalHEERS. Major gaps noted in the Level 1 Establishment Grant application include:

- **Online, Real-Time Eligibility Determination and Information Verification:** Existing SAWS systems do not provide real-time eligibility determination in their web portals and do not include real-time determination for tax credits, cost-sharing reductions, exemptions, or small business eligibility. It is unclear what would be required for such functionality to be built into SAWS.
- **Integration of Plan Comparison and Selection:** Current public program websites and SAWS systems do not support health plan selection, including the capability to allow the user to compare and select a health plan online, which is a critical component of a health benefits exchange.
- **Support for SHOP and Employer-Related Functions:** Public programs do not have analogous functionality to provide health plan services and programs for small businesses. Thus SAWS systems offer no functionality in this area.
- **Support for New Programs, Eligibility Determination, Financial, Reporting, and Other Administrative Processing:** As is true elsewhere, system logic to support premium tax credits, cost-sharing reductions, MAGI eligibility and other ACA-specific functionality does not exist in current systems. However, counties believe that SAWS systems can be modified to incorporate MAGI rules, and have indicated that they intend to incorporate these rules as part of SAWS functionality.
- **Functionality to Support Assisters:** Existing SAWS systems have recently developed online support and functionality for submitting applications and managing the renewal process for individual applicants, which may be leveraged for use by Assisters. However, it is unclear to what extent current efforts can be leveraged.

[42] CalHEERS Request for Proposal, Attachment 2, Business Requirement 75, http://www.healthexchange.ca.gov/Documents/Solicitation%20HBEX4%20-%20Attachments%201-18-12.zip

[43] One of the co-authors of this report, Jim Jones, is part of the Enroll UX 2014 project through a contract with the California HealthCare Foundation.

CalHEERS Conversion

The RFP states that the Vendor will need to convert Data provided by the SAWS Consortia (i.e., CalWIN, C-IV, and LEADER) to populate CalHEERS. The Vendor shall have the responsibility for the extraction and/or conversion of Data from SAWS to CalHEERS to support several distinct business processes:

- As part of the pre-enrollment process that begins July 1, 2013, the Vendor shall initiate activities to identify and reach out to individuals who, on the basis of their current information contained in SAWS related to their participation in other human service programs, are likely to be eligible for subsidized coverage through MAGI Medi-Cal or the Exchange. The Vendor shall establish an interface to receive Data extracts from SAWS into the System and use the Data to conduct outreach to these beneficiaries with the offer of enrollment in coverage.
- Some beneficiaries (e.g., beneficiaries in the Low Income Health Program) are eligible for automatic enrollment into MAGI Medi-Cal beginning January 1, 2014 and shall be pre-enrolled into the system to facilitate their transition. The Vendor shall convert the beneficiary Data from SAWS or other sources, into CalHEERS to initiate their eligibility and enrollment processes.
- After January 1, 2014, when existing Medi-Cal beneficiaries complete their semi-annual status reports or annual redeterminations, they may be determined eligible for MAGI Medi-Cal. If that occurs, their case Data shall be transferred through the established interface into CalHEERS, which will be the system of record for the MAGI Medi-Cal program. Through the normal status reporting and redetermination process for Medi-Cal, CalHEERS will become the system of record for MAGI Medi-Cal case data over a period of approximately one (1) year.
- The Vendor shall provide detailed specifications of Data expectations to the SAWS Consortium to Support the conversion effort. After the Data is provided, the Vendor is required to conduct multiple mock conversion executions to appropriately and successfully load the System.

In the Vendor Question and Answer document[44] and subsequently in an update of the RFP for Section 4.6.1.3, the Exchange clarified that the "Vendor shall have the responsibility for the extraction and/or conversion of Data from SAWS to CalHEERS to support several distinct business processes:

- As part of the pre-enrollment process that begins July 1, 2013, the Vendor shall initiate activities to identify and reach out to individuals, who, on the basis of their current information contained in SAWS related to their participation in other human service programs, are likely to be eligible for subsidized coverage through MAGI Medi-Cal or the Exchange. The Vendor shall establish an interface to receive Data extracts from SAWS into the System and use the Data to conduct outreach to these beneficiaries with offer of enrollment in coverage.
- Some beneficiaries (e.g., beneficiaries in the Low Income Health Program) are eligible for automatic enrollment into MAGI Medi-Cal beginning January 1, 2014 and shall be pre-enrolled into the system to facilitate their transition. The Vendor shall convert the beneficiary Data from SAWS or other sources, into CalHEERS to initiate their eligibility and enrollment processes.

[44] Solicitation HBEX4 – Request for CalHEERS Development and Operations Services: Vendor Questions and Answers, http://www.healthexchange.ca.gov/Documents/SolicitationHBEX4-VendorQandA_021612.pdf

- After January 1, 2014, when existing Medi-Cal beneficiaries complete their semi-annual status reports or annual redeterminations they may be determined eligible for MAGI Medi-Cal. If that occurs, their case Data shall be transferred through the established interface into CalHEERS, which will be the system of record for the MAGI Medi-Cal program. Through the normal status reporting and redetermination process for Medi-Cal, CalHEERS will become the system of record for MAGI Medi-Cal case data over a period of approximately one (1) year."

There remain a number of issues that will be discussed and resolved as design and business requirements are defined involving the movement of individuals from the current Medicaid methodology for families, pregnant women and children to the MAGI methodology and the timing of that move. In the federal regulations, 42 CFR §435.603(3) and §435.916, it is clear that for ongoing cases, the new MAGI methodologies will not be applied until March 31, 2014 or the next regularly scheduled renewal, whichever is later. Additionally, any child who loses his/her eligibility due to the shift to the MAGI methodology will remain eligible for one year.

CalHEERS and Data Exchanges

An important part of the new Exchange eligibility determination process is the ability to access and use data from other trusted third party sources to both provide information needed to determine eligibility for programs in CalHEERS as well as to verify information provided by individuals and families to the Exchange using that data.

CalHEERS Baseline Key Functionality for application information verification includes supporting field level validation and verification and interfacing with the State and/or federal systems to conduct verifications of specific fields (i.e., income, citizenship, tribal affiliation, incarceration). Per the RFP, "the Vendor is required to work collaboratively with CalHEERS' external partners to develop and implement interfaces and/or integrate systems for purposes of exchanging application, case, and other Data to Support continuation of Services or reporting in the destination System. The Vendor is required to design a solution that integrates the CalHEERS Functions and provides customers with a secure, comprehensive and unencumbered User experience when dealing with CalHEERS. The Vendor is required to interface with the federal, State and SAWS external partners:

- Federal Systems Interfaces (IRS, DHS, SSA)
- Medical Eligibility Data System (MEDS)
    - Statewide Client Index
    - Income Eligibility and Verification System (IEVS)
    - Employment Development Department (EDD) Insurance Carriers (for QHP information)
    - Financial Institutions (issuance of payments and receipt of payments)
- Statewide Automated Welfare Systems"[45]

Additionally, vendors are required to ensure that "The CalHEERS System shall interface with MEDS, which includes all MEDS associated functionality and databases (SCI, App Tracking, IEVS, SAVE, etc.) to transmit and obtain client information in batch and real-time as needed for the CalHEERS business process implementation[46]." When asked in the Vendor Question and Answers, the Exchange explained that "the State expects external partners to be responsible for their side of the interface and provide required information to

[45] CalHEERS Request for Proposal, p. 4-54, http://www.healthexchange.ca.gov/Solicitations/Pages/HBEX4.aspx
[46] CalHEERS Request for Proposal, Attachment 2, Business Requirement 108, http://www.healthexchange.ca.gov/Documents/Solicitation%20HBEX4%20-%20Attachments%201-18-12.zip

CalHEERS. The state expects the prime vendor to be responsible and accountable for the overall testing including end-to-end of these systems and CalHEERS."[47]

CalHEERS Imaging and Document Management

CalHEERS will have its own Imaging and Document Management System. The RFP states in Section 4.7.6.3 that the "Call Center must be supported with an Imaging and Document Management System Function to perform electronic document capture, management, and distribution. The System will receive scanned, faxed, or online information and associate them with an account and store the links to the appropriate data services. This tool will allow Users to view and update their account information as well as any associated documents."[48] It is not clear how the CalHEERS Imaging and Document Management System will interact with the Electronic Document Management Systems that have been developed by and for counties; however, the RFP requires that "The CalHEERS System shall provide the functionality to transfer any new received document images to the SAWS upon receipt for referred applications."[49]

CalHEERS Procurement Timeline

- January 18, 2012 - The Exchange released the CalHEERS RFP (there were amendments to the original RFP issued on 1/26/12, 2/10/12, 2/18/12 and 2/22/12).
- March 5, 2012 – Proposals were due to the California Health Benefit Exchange.
- April 4, 2012 – The tentative date, from the RFP, that the Exchange expected to issue a Notice of Intent to Award the CalHEERS contract.
- April 17, 2012 – The tentative date, from the RFP, that the Exchange expected to sign the CalHEERS contract with the vendor.
- April 18, 2012 – The tentative date, from the RFP, that the Exchange expected the CalHEERS vendor to begin work.
- May 31, 2012 – The Exchange announced that they had issued a notice of intent to award the CalHEERS contract to Accenture.
- June 26, 2012 – Contract with Accenture was signed after being reviewed and approved by CMS. (Note: As of 5 p.m. CDT, July 8th, 2012, the California Health Benefit Exchange had not posted on its website the contract and non-proprietary portions of the Accenture proposal with which Accenture was awarded the CalHEERS contract.)

Exchange Service Center

The Exchange is currently working to determine the direction that the Exchange will take in relation to the creation of the Exchange's Service Center. From the Board's Options Brief "Consumer-Centric Exchange Customer Service Center" that was distributed in draft form for discussion on June 15, 2012, a set of the potential principles for the Service Center was presented for consideration. Those principles are to:

1. Provide a first-class consumer experience.
2. Offer comprehensive, integrated and streamlined services.
3. Be responsive to consumers and stakeholders.

[47] Solicitation HBEX4 – Request for CalHEERS Development and Operations Services: Vendor Questions and Answers,#90 http://www.healthexchange.ca.gov/Documents/SolicitationHBEX4-VendorQandA_021612.pdf
[48] CalHEERS Request for Proposal, p. 4-76, http://www.healthexchange.ca.gov/Solicitations/Pages/HBEX4.aspx
[49] CalHEERS Request for Proposal, Attachment 2, Business Requirement 148, http://www.healthexchange.ca.gov/Documents/Solicitation%20HBEX4%20-%20Attachments%201-18-12.zip

4. Assure cost-effectiveness.
5. Optimize best-in-class staffing to support efficient eligibility and enrollment functions.

The Service Center's purpose will be to help "individuals, assisters, navigators, agents, QHP providers, QHPs, small business owners and their employees through toll free phone, web, live chat, e-mail, fax and paper mail. The Service Center must support native languages, live chat, SHIP, QHP, as well as correspondence processing, customer complaints and follow-up." Services include general inquiries, application for subsidized coverage, and purchasing unsubsidized coverage, inquiries from persons already enrolled in the program, as well as fielding calls for customers who have overlapping program needs with non-health programs. These calls will be distributed to the appropriate county or state agencies.

The Exchange staff have developed and presented for comment four options for a Service Center model. (It was clearly noted that "Under any option counties will be handling applications from any client who presents in person at county offices.")

1. Statewide Service Center – State-Staffed Option
2. Statewide Service Center – Contracted Services Option
3. Statewide Service Center – State Central Distributed Branches Option (integrated, selected networks of established call centers. These could include specific counties, providers, or other established distributed call centers.
4. Statewide Service Center – Distributed Consortia-Based Option = use participating counties through the SAWS consortia. Linked network of state and consortia-based county call center networks using state and county resources.

The distinction between the roles and responsibilities is that under Options 1 through 3, the Service Center will also provide standardized training and business process support to achieve a common customer experience, and in Option 4, the Service Center would also be responsible for CalFresh and CalWORKS.

Level 1.2 Establishment Grant

On June 29, 2012, the California Health Benefit Exchange applied for a Level 1.2 Establishment Grant. In the grant application, on page 9, the description of program integration includes the tenets of vertical integration of health coverage programs within the Exchange, but does not mention horizontally integrating with non-health services programs. Additionally, on page 27 of the grant application, plans during the grant period include planning "done in conjunction with DHCS and MRMIB and county welfare departments and other service providers as services center functions need to be designed and operated in conjunction with related functions supporting applicants and enrollees in other health subsidy programs such as Medi-Cal and Healthy Families, as well as other public programs."

The Exchange's efforts towards horizontal integration of human services program were further clarified during a presentation provided by David Maxwell-Jolly, Chief Operating Officer of the California Health Benefit Exchange at a California Health Benefit Exchange Board Meeting on June 19, 2012, in which he was describing the Level 1.2 Establishment Grant Application. In response to a stakeholder comment that the Exchange should ensure that the Level 1 Establishment Grant included specific plans, actions and timeframes to integrate programs such as CalWORKS, CalFresh, etc., a slide stated that "the Exchange's primary near-term focus must be to ensure that critical operations are implemented by 2014. The Exchange recognizes the importance of horizontal integration with other human services programs, and this integration will be considered for 2015. Given this timeframe, building in specific deliverables for the period between August 2012 and June 2013 is inappropriate."

Other States

In their report, Paving an Enrollment Superhighway Bridging State Gaps Through 2014 and Today, Alice M. Weiss and Laura Grossman from the National Academy of State Health Policy point out that, "According to the National Association of Counties, as many as 20 states, representing just over half of the American population, either administer Medicaid at the local level or rely on financial contributions from local entities to fund Medicaid." The Food Research and Action Center (FRAC) reports that ten states use counties for the eligibility determination for the Supplemental Nutrition Assistance Program or SNAP (CalFresh in California). Those states are California, Colorado, Minnesota, New Jersey, New York, North Carolina, North Dakota, Ohio, Virginia, and Wisconsin. It should be noted that the State of New York enacted a state law in 2010 that requires the state to transition from county to state administration within five years (by 2015), so there will only be nine states that use county administration. These are normally states that have a history of strong county government leadership in the area of human service programs, including social service programs like behavioral health programs, domestic abuse programs, Alcohol and Other Drug Abuse programs, etc.

Many states, including California, have integrated their SNAP, TANF, Child Care, and/or Low Income Energy Assistance Program with their Medicaid programs. Many of the households served by Medicaid and CHIP are similar to those served by the human service programs. While we do not have statistics on the amount of this overlap between programs, it is important to note that CalFresh serves households with incomes below 130% FPL. Medi-Cal currently provides coverage to children with incomes below 250% FPL and many adults with incomes below 200% FPL, resulting in a large number of individuals and families who should be participating in both programs.

Our research indicates that the following states have taken these approaches to horizontal integration with the design of their Exchange:

- Arizona, Illinois and Utah are designing their Exchanges to be fully horizontally integrated at implementation.
- New York is designing their Exchange to be interoperable with a separate human services program automated eligibility system at implementation, but with a second implementation phase to become fully horizontally integrated.
- Massachusetts is designing their Exchange to begin and remain interoperable with the human services program automated eligibility system.

Scenarios

Because of the complexity of the implementation of the Exchange, this report provides two scenarios, rather than a set of options. These scenarios are meant to show a continuum of various options, which can be evaluated and chosen based upon available resources (time, staff, funds, etc.). Obviously, Scenario #1 will have a more positive impact on human services program enrollment, but it will require much more time, staff and funds to complete. However, some of the automation described in Scenario #1 may not be cost effective considering that the longer term vision for CalHEERS appears to be full integration with other health program and human services programs. The Exchange, DHCS and DSS will need, with input from stakeholders, to weigh short term integration efforts against the longer term vision.

Each scenario includes a description of the automation and business processes. These scenarios and the options described in each are based upon the assumptions we described in the Introduction. To reiterate the assumptions:

- The Accenture proposal includes a solution that meets the technical and business requirements posed in the RFP for the Baseline Core Requirements System, including a plan to:
    - Build separate CalHEERS not based on current SAWS (Baseline Model, not the alternative model in the RFP), including a separate web portal (CalHEERS) from the SAWS web portals.
    - Meet CMS's seven standards and conditions for enhanced funding, including a separate Rules Engine.
    - Share business rules engine with SAWS that would allow the county consortia system to assess potential eligibility for MAGI Medi-Cal, for the Exchange subsidy programs and for the use of the Exchange.
    - Use data from SAWS to set up eligible MAGI Medi-Cal cases, including the Low Income Health Program, and to identify current CalFresh and CalWORKS individuals who may qualify under the MAGI Medi-Cal rules for the Premium Tax Credit Program or the Cost sharing Reduction program or are uninsured and are eligible to use the Exchange to purchase health coverage.
- The signed contract supports a business operations model that includes two components:
    - A Centralized Service Center responsible for intake, including handling general inquiries, application-specific inquiries, and eligibility and enrollment tasks for applications received through the web portal, telephone interaction, and mail.
    - Decentralized Service Centers, operated through current counties, which would be responsible for in-person applications and all case maintenance for MAGI Medi-Cal, PTC and mixed cases.

Additionally, in these scenarios, we assume that the Call Center would use the Web Portal to collect information during application, case maintenance or renewal, so the process between the Call Center and Web Portal would be similar. We also assume that the Client Index Number from the State Client Index would be used to ensure that individuals applying and receiving benefits in either system are identified and authenticated as a unique individual within both SAWS and CalHEERS and is used to maximize the ability to accurately exchange data with other trusted state data sources.

Each Scenario explores four different processes:

1. The consumer seeks health insurance coverage first through the CalHEERS Web Portal or by calling the Exchange Service Center.
2. The consumer seeks human service program benefits first through the SAWS Web Portal or through a telephone contact with the county agency.
3. The consumer seeks health insurance coverage or human service program benefits in-person at the county agency.
4. Ongoing case maintenance processing, including the report of changes in circumstance and renewals.

Finally, regardless of the scenario, the plan for coordination between Exchange Service Center business process, CalHEERS, the SAWS systems and county business operations should consider the following concepts to make movement for customers and business staff between the Exchange and County Human Services systems and business processes as easy as possible:

- **Login/Security:** Having a single login/password for both the CalHEERS and SAWS systems would make moving between the system, regardless of which operational options are chosen, easier for Exchange Service Center staff and for county workers, who will need to access both systems.
- **Terminology & Codes:** In both SAWS and CalHEERS, using the same terms for common concepts, such as using the phrase 'job income' versus 'earnings', and using similar ways and methods to input data into SAWS and CalHEERS, will make it easier for staff to use both systems consistently, increasing their productivity and reducing the numbers of errors they make.
- **Data Format:** Any ways to normalize data, including format, field length and other data attributes between CalHEERS and SAWS will make for easier sharing of data between the systems, regardless of whether that is done via automated services or manually.
- **Synchronization of Data:** CalHEERS and the SAWS system need to remain in-sync in terms of the data used for eligibility and enrollment that is common between systems, as well as the Medi-Cal eligibility status for the case.

Scenario #1: Maximum Automation and Coordination

1. From Insurance to Human Services (Web Portal / Call Center):

CalHEERS Web Portal: An individual goes to the single web portal of CalHEERS to get health coverage for himself. The web portal collects or supplies all of the information, including verification, necessary to determine eligibility for MAGI Medi-Cal, the premium tax credit and reduced cost sharing programs. Part of the CalHEERS process includes a real-time check with SAWS to import data available or to use for Express Lane Eligibility for MAGI Medi-Cal for children. The portal then moves the individual through the plan comparison and selection process, where the individual selects a plan, enrolls in that plan and pays a premium.

Human Services Program Screening & Questions: After plan selection or at the time that the system determines the individual is ineligible to use the Exchange or ineligible for Medi-Cal or Exchange programs, the CalHEERS Web Portal would explain to the individual that he, based upon information he has provided and confirmed, appears to be eligible for other human services or for non-MAGI Medi-Cal. It explains that the individual needs to provide a little more information. It asks the individual if s/he would like to proceed. If the answer is 'yes', the CalHEERS Web Portal will need to ask about:

- HH Composition: Need to determine if the individuals listed as part of the household for the Exchange is complete from the standpoint of including all individuals in the four walls of the

dwelling who purchase and prepare food together. For those individuals, he will be asked to provide basic demographic information (SSN, date of birth, gender, relationship to primary person, etc.).

- Income
  - Earnings: Need to determine, if there are earnings, whether the earnings included pre-tax deductions.
  - Self-Employment Income: Need to determine the correct self-employment income amount. CalHEERS could, if the information stored includes the detailed self-employment income calculation, calculate the correct self-employment income by using that data.
  - Other Income: Need to ask whether anyone is receiving public assistance benefits, child support income, or other unearned income. Some or all of this data could be available from other systems (child support system, etc.) which could be done real-time or added after the information was transmitted to SAWS.
  - Expenses: Additional information would need to be provided by the individual concerning medical expenses, shelter and utility expenses and child care expenses.
  - Signature: Need for a signature from a responsible person to complete the application for CalFresh.

SAWS: CalHEERS would then transmit (or allow SAWS access to) the data collected, both during the Exchange eligibility and enrollment process, and during the additional human services referral process to the appropriate SAWS system. Additionally, CalHEERS would send or allow access from SAWS to all of the verification documentation collected during the Exchange eligibility and enrollment process. This could be done by sending that data to the Electronic Document Management System for each of the three consortia systems. SAWS would import the information and populate the SAWS data screens.

County Worker Action: The worker would review the information and verification information, then enter appropriate information into SAWS necessary from the verification material. The worker would also need to determine whether the individual qualified for expedited CalFresh benefits and take the necessary steps to expedite the interview. The worker would also need to identify any missing information or verification and take the necessary steps to collect that data. The county would then contact the individual to set up a telephone or in-person interview with a county eligibility worker. After the information and verification were all entered and the interview completed, the worker would determine eligibility in SAWS. SAWS would issue the appropriate notices of decision for CalFresh and any other programs, and, if the individual was eligible, would send data to the CalFresh EBT system.

2. From Human Services to Health Insurance (Web Portal or Call Center):

SAWS Web Portal: An individual goes to the SAWS Web Portal and enters information necessary to apply for CalFresh, Non-MAGI Medi-Cal and/or CalWORKS. While this information may only include that data needed to submit an application and establish a filing date (name, address or signature), if there is enough information available, the SAWS Web Portal, after submission of the portal application, would use the business rules available through CalHEERS and the information collected to screen for MAGI Medi-Cal and Exchange program eligibility. If the individual appears to be eligible, the SAWS Web Portal links directly to the CalHEERS Web Portal, transmitting the information collected that would populate pages in the CalHEERS Web Portal where there is commonality in data definition.

CalHEERS Web Portal: The CalHEERS Web Portal would analyze what information has been supplied from the SAWS application and then schedule questions needed to determine MAGI Medi-Cal and Exchange program eligibility. If all information needed to determine human service program eligibility has been supplied, the additional questions for MAGI Medi-Cal and the Exchange programs will include:

- Household Composition: Need to identify any individuals who are not listed on the tax return of the household. If the household will be filing taxes, the information gathered in SAWS for CalFresh and CalWORKS would be sufficient.
- Earnings: CalHEERS will need to know if there are any pre-tax deductions from gross income. If the individual is not eligible for MAGI Medi-Cal, CalHEERS will need to collect information necessary to determine the household's projected annual income for premium tax credit and cost sharing reduction program eligibility.
- Self-Employment: If SAWS does not supply specific information about the self-employment income calculation (gross, business expenses, business losses, depreciation, etc.), the Web Portal will need to query existing data sources or ask detailed questions to calculate self-employment income for MAGI Medi-Cal and the Exchange programs.
- Insurance Access and Coverage: For MAGI Medi-Cal, unless the SAWS Web Portal has collected third party liability information for the Non-MAGI Medi-Cal, the Web Portal will need to ask questions regarding current coverage for coordination of benefits reasons. For the Exchange programs, the Web Portal will need to ask questions about access to health coverage and coverage by health insurance through public programs and through an employer.
- Signature: Each adult will need to sign the application, as well as the primary tax payer, if the household is eligible for the Exchange programs and the primary tax payer is not requesting help paying for coverage for him or herself.

The CalHEERS Web Portal then determines eligibility for MAGI Medi-Cal, the premium tax credit and reduced cost sharing programs, providing the eligibility results in real-time for the individual. Finally, the CalHEERS Web Portal moves the individual (or anyone in the household who was eligible, or wanted unsubsidized coverage) through the plan comparison and selection process, where s/he can enroll in a health plan.

SAWS: The information from the SAWS Web Portal would be received by SAWS and used to populate the data entry pages. Additionally, SAWS checks for missing information and verification that could be supplied by CalHEERS, populating blank fields for that data source. If data conflicts between the CalHEERS and SAWS data are identified, these would be displayed for the County Worker for resolution.

County Worker Action: The worker would review the information and verification information, then enter appropriate information into SAWS necessary from the verification material. The worker would also need to determine whether the individual qualified for expedited CalFresh benefits and take the necessary steps to expedite the interview. Regardless, the worker would identify any missing information or verification and take the next steps to collect that data. The county would then contact the individual to set up a telephone or in-person interview with a county eligibility worker. After the information and verification were all entered and the interview completed, the worker would determine eligibility in SAWS. SAWS would issue the appropriate notices of decision for CalFresh and any other programs, and, if the individual was eligible, would send data to the CalFresh EBT system.

3. In-Person at County Agency

An individual appears at the county agency and requests human services benefits and/or health program coverage. The county collects information from the individual using the CalHEERS Web Portal, through a personal interview with the individual or having provided access to the CalHEERS Web Portal to the individual within their agency location. The county worker, during the interview process, enters information on SAWS pages that will be needed for the CalHEERS, MAGI Med-Cal and Exchange program eligibility determination and plan comparison and selection. SAWS will transmit this data to CalHEERS where a real-time eligibility determination will occur.

4. Ongoing Case Maintenance and Renewals

Changes: When changes to information that affect eligibility and/or enrollment in the health coverage programs and human service programs are reported or identified, the county worker will enter those changes in a single system, probably SAWS, and those changes will be transmitted to the CalHEERS system. In both systems, eligibility will need to be automatically re-determined based upon existing change processing rules. Changes that result in an adverse impact to benefits will require the generation of a proper notice of decision. Any change that is reported must be acted upon by the worker, even if the case is eligible for and receiving CalFresh with its simplified reporting policies.

Renewals: When renewals, including interim and annual renewals, for CalFresh and CalWORKS are completed and the household is also eligible for MAGI Medi-Cal in the Exchange, SAWS will update CalHEERS, so that CalHEERS can update the renewal date for MAGI Medi-Cal. Similar to change reporting, the system receiving the updated data through the renewal process, via web portal or through a county worker, will need to transmit common data to the other system for update, evaluation of impact as it relates to the need for additional verification and/or the need to redetermine program eligibility.

Scenario #2: Minimum Automation and Coordination

1. From Insurance to Human Services (Web Portal / Call Center):

CalHEERS Web Portal: An individual goes to the single web portal of CalHEERS to get health coverage for himself. The web portal collects all of the information, including verification, necessary to determine eligibility for MAGI Medi-Cal, the premium tax credit and reduced cost sharing programs. The portal then directs the individual to plan comparison and selection pages, where the individual selects a plan, enrolls in that plan and pays a premium. CalHEERS would notify SAWS of MAGI Medi-Cal or Insurance Affordability program eligibility.

Human Services Program Screening & Questions: After plan selection or at the time that the system determines the individual ineligible to use the Exchange or ineligible for Medi-Cal or the Exchange programs, the CalHEERS Web Portal would explain to the individual that he, based upon information he has provided and confirmed, appears to be eligible for other human service programs, including CalFresh, or for non-MAGI Medi-Cal. The CalHEERS Web Portal would direct the individual to the SAWS Web Portal or county office, or it could allow the individual to print an application for human services programs or other health coverage programs with basic information already collected.

SAWS Web Portal: The individual would use the SAWS Web Portal to enter all of their information into the Web Portal as is the current practice.

County Worker Action: The county worker would either enter information from the paper application, from an in-person interview with the individual or would review information provided via the SAWS Web Portal. The worker would determine whether the individual qualified for expedited CalFresh benefits and take the necessary steps to expedite the interview. Regardless, the worker would identify any missing information or verification and take the next steps to collect that data. If the information was not collected through an in-person process, the county worker would then contact the individual to set up a telephone or in-person interview with a county eligibility worker. After the information and verification were all entered and the interview completed, the worker would determine eligibility in SAWS. SAWS would issue the appropriate notices of decision for CalFresh and any other programs and, if the individual was eligible, send data to the CalFresh EBT system.

2. From Human Services to Health Insurance (Web Portal or Call Center):

SAWS Web Portal: An individual goes to the SAWS Web Portal and enters information necessary to apply for CalFresh, Non-MAGI Medi-Cal and/or CalWORKS. While this information may only include that data needed to submit an application (name, address and signature), if there is enough information available, the SAWS Web Portal would use business rules available through CalHEERS and the information collected to screen for MAGI Medi-Cal and Exchange program eligibility. If the individual appears to be eligible, the SAWS Web Portal would link directly to the CalHEERS Web portal.

CalHEERS Web Portal: The CalHEERS Web Portal then uses the basic information (case name, address, etc.) supplied by SAWS to begin the application process. Using information collected and confirmed in real-time from trusted third party sources or from the individual, the web portal determines eligibility for MAGI Medi-Cal, the premium tax credit and reduced cost sharing programs, providing the eligibility results in real-time for the individual. The CalHEERS Web Portal would then direct the individual (or anyone in the household who was eligible, or wanted unsubsidized coverage), through the plan comparison and selection process, where s/he can enroll in a health plan.

SAWS: The information from the SAWS Web Portal is received by SAWS and populates the data entry pages. Additionally, the worker checks for missing information and verification that might exist in CalHEERS, entering this data into blank fields.

County Worker Action: The worker would follow the normal process for entering and reviewing information and verification information. The worker will determine whether the individual qualifies for expedited CalFresh benefits and will take the necessary steps to expedite the interview. Regardless, the worker would identify any missing information or verification and take the next steps to collect that data. The county would then contact the individual to set up a telephone or in-person interview with a county eligibility worker. After the information and verification were all entered and the interview completed, the worker would determine eligibility in SAWS. SAWS would issue the appropriate notices of decision for CalFresh, CalWORKS and any other programs and, if the individual was eligible, send data to the CalFresh EBT system.

3. In-Person at County Agency

An individual appears at the county agency and requests human services benefits and/or health program coverage. The county collects information from the individual and enters information into CalHEERS and/or SAWS depending upon the type of request made.

4. Ongoing Case Maintenance and Renewals

Changes: Workers will enter changes into both systems.
Renewals: Workers will need to enter data for the renewals for MAGI Medi-Cal and the Insurance Affordability programs in CalHEERS and for the non-MAGI Medi-Cal and human services programs in SAWS. When a renewal is completed in SAWS for a case that includes anyone who is eligible for MAGI Medi-Cal in CalHEERS, the worker will need to indicate this in CalHEERS to update the MAGI Medi-Cal renewal date.

About the Authors

Jim Jones is a Senior Consultant with Sellers Dorsey with extensive expertise in Medicaid, CHIP and Supplemental Nutrition Assistance Program (SNAP) policy and operations. He has also provided strategic planning and technical support for Health Insurance Exchange planning and eligibility and enrollment programs. He continues this work at Sellers Dorsey. Mr. Jones had a long career with the State of Wisconsin, serving as Deputy Administrator of Wisconsin's Division of Health Care Access and Accountability, SNAP Program Director and Deputy State Medicaid Director. His accomplishments include the implementation of BadgerCare Plus, streamlining enrollment processes and leading the development of Wisconsin's Health Benefit exchange as Project Director, including the development of a web-based prototype of the Exchange in 2010.

Jennifer Jordan is a consultant at Sellers Dorsey, managing client projects and addressing day-to-day concerns with a keen eye to project timelines and budget. Currently, her work is focused on Medicaid financing initiatives involving safety net hospitals and other stakeholders in several states including California, Florida, Illinois and Washington. Ms. Jordan's experience includes health policy development and implementation, program analysis and evaluation, Medicaid program operations, political and community organizing, strategic positioning as well as Federal and state health policy issues. Prior to joining the firm, Jennifer implemented three federal grants at the Department of Insurance in the State of Illinois and represented the Department's interests in Illinois Health Information Exchange (HIE) and other HITECH Act planning. Ms. Jordan attended the University of Chicago where she earned both a Certificate in Health Policy and Administration and a Master of Public Policy. She also holds a BA in Political Science from Macalester College in St. Paul, Minnesota.

Lisa Chan-Sawin is the Director of Policy & Operations at Harbage Consulting. She has expertise in health insurance regulation, public coverage programs, such as Medicare, Medicaid, and Healthy Families, delivery system transformation and health IT policy, including telehealth and data exchange. Lisa recently served as a Senior Consultant at the California Senate Health Committee, covering a number of health policy issues, including health insurance regulation, ACOs, data transparency, prescription drug policies, and health IT and privacy policies. At the Health Committee, she worked on many significant pieces of legislation including small group insurance market reform, rate regulation of health insurance carriers, the establishment of the State Medicaid electronic medical records incentive program and the statewide health information exchange. Prior to her time at the Senate, she held positions with the California Coverage & Health Initiatives and the California Assembly Health Committee. She has provided consulting services for a number of public and private entities, including local, county and state governments, clinic and hospital systems, as well as many non-profits and foundations. Lisa has a Masters in Health Administration from the University of Southern California.

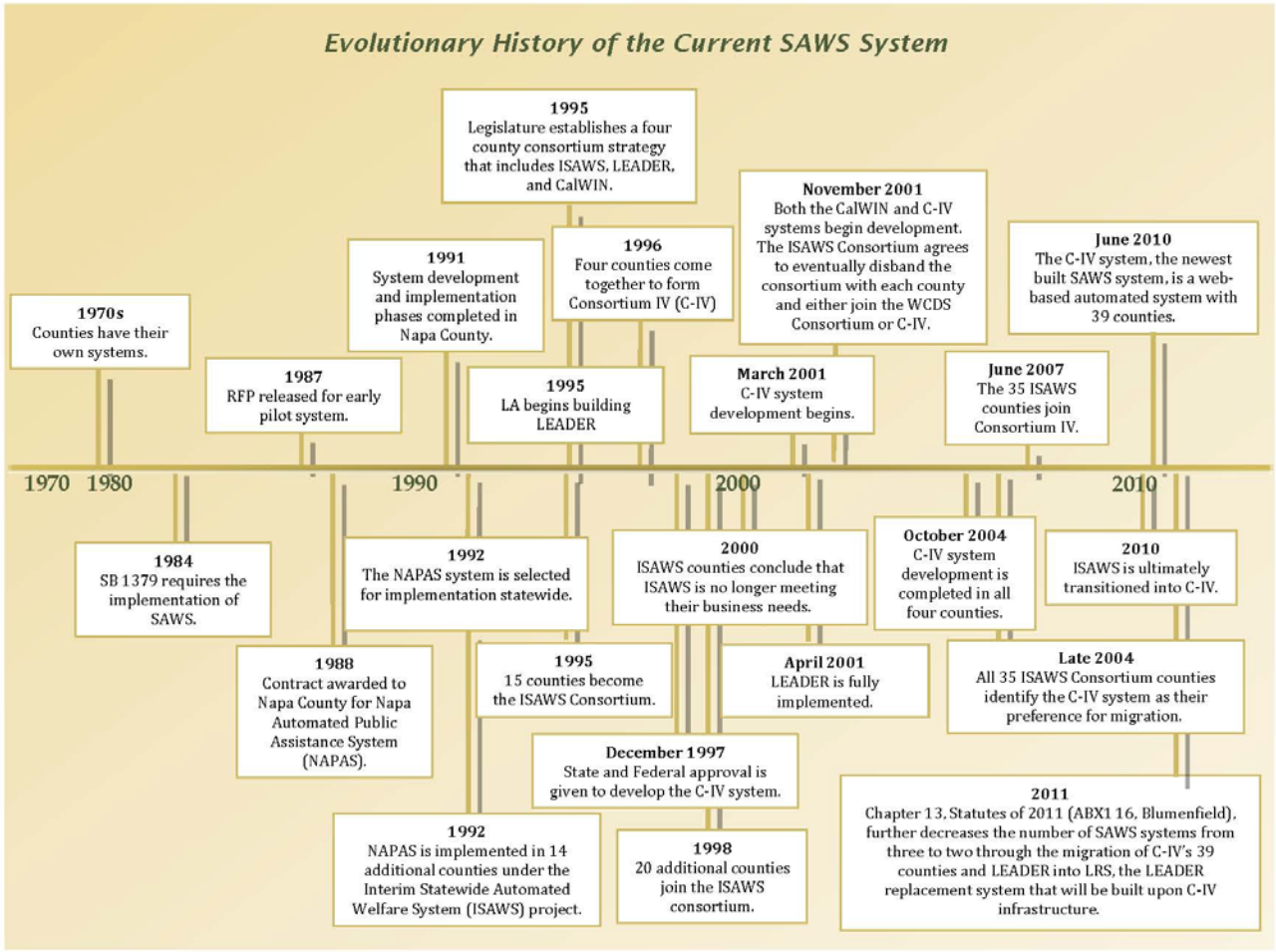
About Sellers Dorsey

Sellers Dorsey is a national consulting firm specializing in Medicaid, health reform, and health finance and policy. We help our clients understand, navigate, and succeed in Medicaid, the Children's Health Insurance program, and health reform implementation. Our clients include national and regional health plans, state Medicaid agencies, hospitals and health systems, health care trade associations, advocacy organizations, universities, local governments, medical and information technology firms, and manufacturers. In addition to serving many national organizations, we have worked with more than 30 states.

Note

The Alliance to Transform CalFresh contracted with Sellers Dorsey to conduct an independent assessment of horizontal integration in California in the context of the Affordable Care Act. This assessment was funded by the California Endowment, the California HealthCare Foundation, the Sierra Health Foundation, the Food Research and Action Center, and the San Francisco Food Bank. The contents of this report do not necessarily reflect the views or policy positions of the Alliance to Transform CalFresh, its funders, or its five participants: the California Association of Food Banks (Convener), the California Family Resource Association, the California Food Policy Advocates, Catholic Charities of California, and the Western Center on Law and Poverty. The authors are solely responsible for the contents of this publication.

Appendix A


Evolutionary History of the Current SAWS System
1970
1980
1990
2000
2010
1970s
Counties have their own systems.
1984
SB 1379 requires the implementation of SAWS.
1987
RFP released for early pilot system.
1988
Contract awarded to Napa County for Napa Automated Public Assistance System (NAPAS).
1991
System development and implementation phases completed in Napa County.
1992
The NAPAS system is selected for implementation statewide.
1992
NAPAS is implemented in 14 additional counties under the Interim Statewide Automated Welfare System (ISAWS) project.
1995
Legislature establishes a four county consortium strategy that includes ISAWS, LEADER, and CalWIN.
1995
LA begins building LEADER
1995
15 counties become the ISAWS Consortium.
1996
Four counties come together to form Consortium IV (C-IV)
December 1997
State and Federal approval is given to develop the C-IV system.
1998
20 additional counties join the ISAWS consortium.
2000
ISAWS counties conclude that ISAWS is no longer meeting their business needs.
March 2001
C-IV system development begins.
April 2001
LEADER is fully implemented.
November 2001
Both the CalWIN and C-IV systems begin development. The ISAWS Consortium agrees to eventually disband the consortium with each county and either join the WCDS Consortium or C-IV.
June 2007
The 35 ISAWS counties join Consortium IV.
October 2004
C-IV system development is completed in all four counties.
Late 2004
All 35 ISAWS Consortium counties identify the C-IV system as their preference for migration.
June 2010
The C-IV system, the newest built SAWS system, is a web-based automated system with 39 counties.
2010
ISAWS is ultimately transitioned into C-IV.
2011
Chapter 13, Statutes of 2011 (ABX1 16, Blumenfield), further decreases the number of SAWS systems from three to two through the migration of C-IV's 39 counties and LEADER into LRS, the LEADER replacement system that will be built upon C-IV infrastructure.

On-Line Services

Updated: February 23, 2012

	Functionality	LA YourBenefitsNow	BenefitsCalWIN	C4Yourself
Apply for Benefits	CalWORKs	✓	✓	✓
	CalFresh	✓	✓	✓
	Medi-Cal	✓	✓	✓
	Disaster CalFresh	✓	✓	✓
	CMSP	✓	✓	✓
	Assistor Role	June 2012	September 2012	✓
Manage Benefits	Check benefits	✓	September 2012	✓
	Date benefits were paid	✓	September 2012	✓
	Date next benefits will be paid	✓	September 2012	✓
	Complete annual benefit reassessment	December 2012	✓	✓
	Change address	June 2012	Available now with QR7 reporting To be expanded in future	✓
	Report change in household members	June 2012	✓	✓
	Report a change in income	June 2012	✓	✓
	Submit scanned documentation	Begin June 2012 with QR7 via mobile app	✓	✓
	View correspondence	Future Enhancement	Future Enhancement with eNOA implementation	✓
	View Notices of Action	Future Enhancement	Future Enhancement with eNOA implementation	Future enhancement with eNOA implementation
	Due date for next reassessment	✓	September 2012	✓
	Schedule appointments	July 2012	Future Enhancement	Future enhancement
	Auto-Populate Client Identifying Information for reporting	✓	✓	✓
Get Information	Find out where the nearest office is located	✓	✓	✓
	Get office hours	✓	✓	✓
	Telephone numbers for local offices	✓	✓	✓

SAWS ENHANCEMENTS

Updated February 23, 2012

COMPLETED INITIATIVES
On-Line Application CalWORKs, CalFresh, Disaster CalFresh, Medi-Cal & CMSP
Statewide URL English – http://www.benefitscal.org (.com & .net) Spanish – http://www.beneficioscal.org (.com & .net)
Online Client Reporting Client Option
Eligibility Redetermination Web Submission Client Option
In-Coming Interactive Voice Response (IVR)
Automated Inter-County Transfer

INITIATIVES IN PROGRESS	
Document Imaging	Currently Available in 57 counties & 10 Los Angeles District Offices Completion scheduled for June 2013
On-Line Client Reporting Option	Currently Available in 57 counties To be piloted in Los Angeles in June 2012 Completion scheduled for December 2012
Out-Going Interactive Voice Response (IVR)	Currently Available in LA, C-IV & Alameda Counties Available to remaining CalWIN counties in June 2012
Assistor Role*	C-IV launched full support for community assistors in January 2012 Los Angeles will deploy this functionality in June 2012 CalWIN will deploy in August 2012
Expanded Online Client Services	Clients are currently able to access a wide array of information and supply updates online. The Consortia are continually enhancing this service. (See the attached list of services)
Low Income Health Program Support (LIHP)	Automation has been complete to support the CMSP LIHP program in both CalWIN & C-IV. CalWIN & C-IV also offer all non-CMSP counties support with citizenship verification, communication with MEDS, and reporting. Los Angeles & CalWIN are developing full eligibility determination & cases management support.

PILOT & PLANNED ACTIVITIES	
Mobile Van	Los Angeles County has deployed a mobile van fully equipped with the technology needed to access their LEADER system so that applicants can be interviewed and eligibility completed in remote locations such as community events, health fairs, schools, and community centers.
Online Access Stations	Counties are experimenting with several approaches for providing online access for applicants and clients in both Social Service offices and in the community. Locations include non-profits organizations, other county offices, community centers, and other locations that potential clients visit. These include full functioning kiosks (terminal with online access, printer, document scanner, and work surface), as well as computer work stations with printer/scanners.
Document Receipt Stations	CalWIN and C-IV Counties are testing self-service stations where clients can swipe their Benefit Issuance Card (BIC) or Electronic Benefit Card (EBT) to identify themselves, scan documents for submittal and print a receipt.
Message Board	By December 2012 – Los Angeles County plans to pilot a client Message Board queuing clients that an email message has been sent to them.
Mobile Access to Information	Beginning in September 2012, clients in CalWIN counties will be able to use their smart phone to access to their case information including check benefits, date benefits were paid, date next benefits will be paid, and next reassessment due date. This ability requires the highest level of internet security to preserve Client data confidentiality, which will be implemented as part of the MyBenefits Portal on-line system also available in September 2012.
Mobile Phone Document Upload	By July 2012 – Los Angeles will pilot an app that allows clients to upload and email photos of documents needed to complete their QR7 report. If successful, this capability will be expanded countywide by December 2012 and then to include other documentation submittal. CalWIN is working towards this capability too.
Disaster CalFresh Benefits Mobile App	By 2012, CalWIN will launch a mobile app for smart phones that will allow disaster victims to apply for CalFresh benefits, along with the capability to send a picture of the identification (which is the only required documentation).
Lobby Information Systems	Counties have deployed several approaches to serve individuals visiting their offices in a professional, efficient manner that keeps the visitor informed. These include greeters, visitor registration kiosks, message boards advising clients of their status (similar to the devices used in Kaiser pharmacies), and phones for access to the county call center.
Customer Services Using Handheld Devices	San Bernardino County is piloting using handheld devices to register clients visiting their offices. Los Angeles County will launch a similar pilot by October 2012.
Call Centers**	Counties are increasingly making use of Call Centers to respond the clients efficiently. Twenty counties have fully operational call centers; at least two additional counties plan to open call centers in 2012. The remaining counties are monitoring these efforts for potential implementation in the future.
eNOAs	The SAWS Consortia are all working with state agencies to provide clients with an option to receive their Notices of Action (NOAs) electronically. Once the necessary federal waivers are received this service can be implemented.

* Assistor Role includes the ability for community organization staff to access SAWS application portal with a single log on and produce regular reports on individuals assisted.

** Currently Call Centers are most frequently used to support the Medi-Cal program, although some counties also include CalFresh and CalWORKs.

Note: This chart reflects the automated functionality available to counties. Individual county implementation schedules are not reflected.