



Legal Aid Society
OF THE DISTRICT OF COLUMBIA
MAKING JUSTICE REAL



CLOSING THE GAP BETWEEN POLICY AND REALITY:

**Preventing Wrongful Denials and
Terminations of Public Benefits in the
District of Columbia**

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EXECUTIVE SUMMARY

District of Columbia policymakers have built a strong safety net for low-income, vulnerable families and individuals. Nowhere has this commitment been better demonstrated than in the District's expansion of eligibility for public health insurance and Food Stamps (or Supplemental Nutritional Assistance Program (SNAP)) benefits. The District government has made an unwavering commitment to health care access through the creation and maintenance of the D.C. Health Care Safety Net Alliance (Alliance) program,¹ and the (almost unrivaled) expansion of Medicaid² and the Qualified Medicare Beneficiary (QMB) program.³ These programs have contributed greatly to the District's small percentage of children and adults who are uninsured, regardless of age, disability or immigration status.⁴ Additionally, the District government has reduced food insecurity through SNAP benefit expansions.⁵

However, as the following report demonstrates, the promise of a strong safety net has been steadily eroded for far too many District families due to the service delivery breakdowns they have encountered when attempting to apply and recertify for public benefits. Problems like these have always existed in the District and in other states. Public benefits programs are complicated and, particularly in tough budgetary times, there are often not enough staff to administer programs as efficiently as consumers deserve. To make matters more difficult, implementation of the Affordable Care Act (ACA) has proven to be a herculean task. Over the course of the last two years, the District government has had to totally overhaul its Medicaid policies and procedures, and the information technology infrastructure which supports its robust public benefit offerings. The haste and scope of the overhaul has put sizeable strain on existing resources, contributing to the service and communications issues documented in this report. And because of inadequate staffing, insufficient space, technological glitches, inadequate policy dissemination and communications efforts from the agencies tasked by the District of Columbia to implement the elements of the ACA — the Economic Security Administration (ESA) of the District Department of Human Services, District Department of Health Care Finance (DHCF), and the DC Health Benefit Exchange Authority⁶ — frontline service delivery and case processing have suffered.

However, the challenges and disruptions faced by the District are consistent with those experienced by other states and, in some cases, have been less severe. The fact that the District has performed better than other jurisdictions in the development and rollout of the DC Health Benefit Exchange and Medicaid expansions indicates that the District has the means and capability to meet these service delivery challenges and lead the country in program implementation as well as in policy development. But such leadership can only come with additional resources, strategic planning and coordination among ESA, DHCF and the Exchange.

This report draws on individual cases (reported by legal and social services organizations) to document and illustrate systematic breakdowns in the administration of public benefits programs in the District of Columbia. (The names of the individuals whose experiences are cited in this report, and certain facts about them, have been changed or omitted to protect their identities.) Because the breakdowns illustrated herein are not attributable to one person, agency or set of agency employees, they will only be remedied through system-wide planning and change. Accordingly, this report makes recommendations designed to address these problems at a systemic, rather than merely an individual or agency, level.

These breakdowns translate into real hardship for vulnerable District residents, like the ones featured throughout this report and in Appendix A. For example, Ms. Fox and Ms. Clark went without health insurance after receiving incorrect information from agency staff about how to apply or recertify for health insurance coverage. Lost paperwork resulted in benefits being cut off or inappropriately reduced for Mr. Abbott, Ms. Lewis and Ms. Epstein. And Ms. Dawson and Mr. Madison lost their benefits after they were turned away from ESA service centers without being able to recertify their eligibility. Their stories and others demonstrate the obstacles that too many District residents experience when they attempt to get and keep the public benefits upon which they and their families depend, despite the good intentions of policymakers and the leadership and staff of the agencies implementing these programs. These obstacles have led to food insecurity for individuals like Mr. Abbott and Mr. Madison; fear of seeking, or inability to obtain, necessary medical treatment for individuals like Ms. Bonilla, Ms. Hoffman and Ms. Lewis; and unpaid medical bills for individuals like Ms. Clark, Ms. Fox and Ms. Epstein.⁷ These difficulties cause anxiety and hardship for already stressed and stretched families and individuals.

Part I of this report draws on the stories of these and other individuals to illustrate the systemic breakdowns in service delivery that prevent many District families and individuals from obtaining or retaining the public benefits for which they are eligible. These problems include:

- Long wait times at service centers;
- Inaccurate or incomplete information provided by agency staff coupled with a lack of widely available policies and procedures;
- Violation of the “No Wrong Door” principle; and
- Lost application and recertification documents.

Part II of this report proposes recommendations designed to remedy the widespread errors that obstruct access to public benefits for far too many District residents. These include:

- Engage in (and release the results of) short-term and long-term planning through ongoing agency and advocate communications;
- Continue to improve technology as one piece of a comprehensive strategy for increasing efficient customer service;
- Hire more staff at all levels and divisions; deploy and train these staff more effectively; and hold staff accountable for providing quality, accurate service to consumers;
- Expand the space at service centers and find ways to conduct business outside of service centers;
- Promulgate and disseminate rules, policies and procedures through the development and implementation of a communications strategy;
- Improve and formalize procedures for handling mail, faxes and drop boxes, including the provision of receipts and other confirmation;

- Eliminate the in-person recertification requirements for the SNAP and Alliance programs; and
- Make services language accessible as required by the Language Access Act of 2004.

Some of these recommendations are already being acted upon by ESA, DHCF and the Exchange. But more must be done quickly so that the promise of a strong safety net will not continue to be obstructed by the improper delays and terminations in benefits that cause health and food insecurity for numerous District families like the ones featured in this report.

INTRODUCTION

The Affordable Care Act (ACA) has created a great deal of work for federal, state and local governments but it also provides these governments with an extraordinary opportunity (and some resources) to connect more of their citizens with health insurance and transform antiquated public benefits delivery systems. The District has not only implemented its own Exchange (DC Health Link, through which individuals can compare and enroll in private Qualified Health Plans (QHP's) and apply for financial assistance for these plans) but was the one of the earliest states to expand Medicaid to levels even higher than those proposed under the ACA.

The District has made progress in ACA implementation despite the sheer number of tasks that needed to be accomplished in the extremely short timeframes defined by federal law, including policy development, technological upgrades, staffing and training. Not only did the ACA present a complete paradigm shift in the way agencies approached and provided public health insurance, it also encouraged the complete overhaul of public benefits eligibility and case management systems. As such, the District had less than two years to design and implement an information technology platform that would: process the new policy and procedures of Medicaid and private health plans; pull data from and communicate with existing local data hubs and those of the federal government; and totally replace the District's antiquated public benefits eligibility and enrollment database. For a couple of states, the magnitude of these tasks led to complete system failure and reversion to federal systems. But the District has continued to move forward with implementation even with the truncated time frame.

However, what has gotten lost in this process are the real life consumers of public health insurance and other public benefits who depend on these life-sustaining programs and cannot afford to lose them. The transition described above, and the speed at which it has occurred, has led to numerous instances of wrongful benefit delays and terminations among public benefits consumers.

Surely there was no intent to cause these benefit disruptions. Nonetheless, they have occurred because of inadequate planning both for how to keep services going during this time of massive transition and how to ensure quality service delivery once implementation is complete. Inadequate staffing and insufficient preparation of existing staff have led to problems with face-to-face client interactions and dissemination of policy changes to the greater public. As a result, families have been unable to get medical care for their children, domestic violence survivors have been unable to pay their hospital bills, and others have faced food insecurity.

As the following report demonstrates, the District has been slow to respond to these service disruptions and has given consumers and their advocates little sense of when and how these disruptions will cease. Moving forward, the District must do a better job of ensuring that vulnerable individuals and families can apply for, receive and keep all of the essential public benefits for which they are eligible without undue delays, glitches and errors.

PART I: INDIVIDUAL PROBLEMS ILLUSTRATE A SYSTEMIC BREAKDOWN IN SERVICE DELIVERY

Numerous consumers have turned to legal and social services organizations after their efforts to apply or recertify for benefits have been stymied by errors at ESA service centers.⁸ Even prior to ACA implementation, it was not clear that ESA had the capacity and resources to administer adequately the complex joint federal and local programs under its purview. Although the agency was given some additional resources for ACA implementation, advocates and consumers are gravely concerned about ESA's ability to fulfill its many duties due to insufficient numbers of staff at all levels, inadequate space, outdated technology and few published policies.

The story of Ms. Norris implicates many of the problems plaguing ESA service delivery that will be discussed in this chapter.

Ms. Norris: a woman who struggles with health problems and cares for her nine-year-old great niece. On March 11, 2014, Ms. Norris attempted to apply for Medicaid for her nine-year-old great niece through the DC Health Link Assisters stationed at the H Street Service Center. The Assisters told her that they were unable to process her application and that she needed to meet with an ESA representative. Ms. Norris then returned to the waiting room to meet with an ESA representative. After waiting all day, she was eventually told by an Assister that all the ESA workers were gone and she would have to come back the next day.

When she returned to the H Street Service Center on March 12, 2014, she was given a form application to fill out to request Medicaid and other benefits for her great niece. While she waited to be called by ESA staff, she filled out the application (the application was a "recertification form" and on it, Ms. Norris asked for Medicaid, food stamps, and cash for children). When Ms. Norris was called to meet with an ESA staff member a few hours later, she was told that the application she had been given was not the right one. Rather than allow Ms. Norris to fill out the correct form right there, the ESA worker told her she would need to take the correct application home to complete it and then return to the service center.

Ms. Norris returned to the Service Center again the next day, and this time, after waiting for several hours, she was told that she would be given an appointment for March 18. When she arrived for that appointment, she was left at a computer by herself to complete her Medicaid application. Although she asked ESA staff members for assistance and asked to speak with a supervisor, Ms. Norris was left by herself to attempt to complete the application. She was not able to navigate the DC Health Link system by herself, and even after several hours of trying she did not successfully submit a Medicaid application that day.

Finally, after reaching out to an out stationed Assister, Ms. Norris was able to successfully submit a Medicaid application and she is waiting for it to be processed.

Ms. Norris also experienced difficulty applying for TANF for her great-niece. Eventually, her application was denied for failure to submit necessary documents which she had, in fact, submitted on March 21. Ms. Norris was finally approved for General Assistance for Children (a TANF-like program) after her lawyer contacted the agency on her behalf.

This section highlights the types of problems experienced by Ms. Norris and others in more detail. These problems include: (1) long wait times at ESA service centers; (2) provision of inaccurate or incomplete information by agency staff, coupled with a lack of widely available policies and procedures; (3) violation of the principle that there should be “no wrong door” for applying for public benefits; and (4) lost application and recertification documents.

Long wait times at service centers. Consumers and advocates routinely report long lines at service centers. Although many consumers begin lining up as early as 4:00 AM or 5:00 AM, these individuals report that they wait in line for hours, and at times are turned away by staff who state that the centers are over capacity. For example,

***Ms. Dawson, whose health insurance was terminated after she was turned away from an ESA service center without being able to recertify.** Ms. Dawson is a limited English proficient woman who works full-time to support herself. She attempted to recertify for Alliance in February 2014 at the Taylor Street Service Center. Ms. Dawson reports, however, that after waiting for several hours she was told to place her information in the drop box and was offered no opportunity for the face-to-face interview required for her recertification.*

A few weeks later, she received a notice that her Alliance would be terminated on March 31, 2014 for failure to recertify. Ms. Dawson could not get a day off work to return to the service center until the last day of her recertification period. She arrived at 5:30 AM and waited in line for several hours. However, she reports that, at 9:00 AM, she was told by an ESA worker that the service center had reached its “40 person maximum” for medical insurance recertifications for the day. Ms. Dawson was told that in the future she should get in line before 4:00 AM in order to be seen.

Thus, even though Ms. Dawson arrived at 5:30 AM to take the steps necessary to keep her Alliance coverage, she was forced to leave without recertifying. It was not until an attorney contacted ESA on Ms. Dawson’s behalf that her Alliance was finally recertified.

The long lines at service centers prevent individuals from complying with the steps necessary to obtain and retain benefits. They also impose other, less visible, burdens on District families. Individuals like Ms. Dawson must arrange to take entire days off work to be seen at service centers, which, at minimum, substantially reduces their income and may also jeopardize the jobs they rely on for their economic security. Moreover, consumers who are elderly, struggling with disabilities, or accompanied by small children experience additional hardship when they must wait outside in the bitter cold or intense heat without access to restrooms, climate control, or a place to sit.

Inaccurate or incomplete information provided by agency staff coupled with a lack of widely available policies and procedures. The ACA requires the use of Modified Adjusted Gross Income (MAGI) to calculate income and determine household size for most consumers applying for Medicaid — children, parents and childless adults without disabilities — and all who are applying for financial assistance for private plans purchased through DC Health Link. There are also new rules and procedures for applications and recertifications that have not been clearly and consistently disseminated. These new rules and processes are proving to be confusing for agency staff and are unknown to consumers. Therefore, even when consumers are not turned away, like Ms. Dawson and Ms. Norris were, they still frequently receive inaccurate, confusing or incomplete information about their applications or recertifications. For example,

Ms. Clark, who has unpaid medical bills because she received inaccurate information about how to apply for retroactive Medicaid coverage. Ms. Clark, a woman who suffers from chronic health conditions, applied for health coverage in January 2014 through DC Health Link. When Ms. Clark applied, she checked the box indicating that she had medical bills from the prior three months and wanted retroactive coverage, as Medicaid law allows.

However, when Ms. Clark's Medicaid application was approved, she did not receive the retroactive coverage. When Ms. Clark's advocate contacted ESA to see what had happened, the ESA representative stated that Ms. Clark needed to complete an additional form to receive retroactive benefits. This form had never been made available to Ms. Clark and was not posted on the ESA website. As a result, it took the intervention of an advocate before Ms. Clark was able to get retroactive Medicaid coverage. She is still working to make sure that her medical bills will be paid by Medicaid.

Ms. Gibson, whose daughter remains without health insurance despite several attempts to apply for coverage. Ms. Gibson is a single mother who works full-time to support herself and her daughter. In February 2014, Ms. Gibson went to the H Street Service Center to recertify for Alliance benefits. She asked to apply for Medicaid for her daughter, a U.S. citizen, but reports that the ESA representative told her she had to apply online and could not submit a paper application in person.

Ms. Gibson later attempted to complete an online application but the DC Health Link system would not allow her to apply online. She reports that, upon calling the DC Health Link customer service line, she was told that she could not apply online because she was not a citizen. Although she tried to explain that she was only applying for her daughter, not herself, she was told that nothing could be done.

In March, Ms. Gibson returned to the H Street Service Center and attempted to explain the situation. She submitted a paper copy of her daughter's Medicaid application. However, in April, she received a notice stating that her Medicaid application had been denied; the notice contained Ms. Gibson's name and not her daughter's name.

Ms. Gibson's daughter went several months without health insurance despite her mother's efforts. During that time, Ms. Gibson incurred medical bills for her daughter's asthma treatment that she could not afford to pay. Ms. Gibson is still working to make sure that her medical bills will be paid by Medicaid.

Violation of the “No Wrong Door” Principle. One specific and troubling manifestation of the problems within ESA service centers is the violation of the ACA's principle that there should be “no wrong door” for applying for health insurance. This means that whether an individual applies for health insurance online, with an in-person assister,⁹ through the DC Health Link Contact Center, or at an ESA service center, the result should be the same. In fact, “No Wrong Door” has been ESA policy for all public benefits for many years, predating implementation of the ACA. In practice, it means that:

- Individuals like Ms. Gibson should not receive different answers depending on where they go to apply for benefits;

- ESA and the Exchange must coordinate with each other on individual cases so that the burden is not on consumers like Mr. Kaplan to keep reapplying and following up with different people;
- ESA should not send consumers like Mr. Madison all over the city from one service center to another to transact business, regardless of the benefit at issue; and
- When a consumer submits recertification paperwork for one health program — such as non-MAGI Medicaid on the basis of being elderly or disabled — and is found ineligible for that Medicaid program, the consumer should be screened for (or at least informed of) potential eligibility under a MAGI category, such as a childless adult or parent of a child.¹⁰ Right now, the consumer just receives a termination notice and must submit a new application, according to advocates who have intervened in these cases.

All of these practices are contrary to ESA’s stated policy, violate the “no wrong door” principle and place the burden on the consumer to continually reapply for benefits and follow up with the agency, which is difficult.

Below are several examples of “no wrong door” problems and their impact on families and individuals.

Ms. Fox, whose family went without health insurance for several months because she was not given the correct application by ESA staff. Ms. Fox, a single mother who works full-time to support her family, applied for Medicaid and SNAP for herself and her daughters at the Fort Davis Service Center in January 2014. Ms. Fox was apparently given the Combined Benefits Application that (prior to October 2013) had been used to apply for both benefits. Although Medicaid applicants must now use the separate DC Health Link application, no one at the service center explained this to Ms. Fox. Therefore, Ms. Fox believed that her Medicaid application had been accepted and no additional steps were required.

While awaiting a decision on her Medicaid application, Ms. Fox was the victim of domestic violence and required emergency medical attention. After receiving this treatment, Ms. Fox called ESA and was told that the agency had no record of her application. After an advocate reached out to ESA, the agency located Ms. Fox’s application but stated that this application could not be processed for Medicaid. The agency stated that Ms. Fox would have to reapply all over again by completing a DC Health Link application. In the meantime, several months had passed during which Ms. Fox had been unable to access necessary medical care and medications. During this time, Ms. Fox was also unable to afford necessary vaccinations for her daughter, jeopardizing her daughter’s ability to continue attending school.

Mr. Madison, who lost his SNAP benefits due to confusing information about which service center he needed to visit. Mr. Madison suffers from several health conditions and relies on Social Security payments and SNAP benefits to support himself. In spring 2013, Mr. Madison attempted to recertify for SNAP. Having received a notice stating that his case file had been transferred to a different service center, Mr. Madison went there to recertify. That service center, however, told him that his information was not in the system, and that he would have to go back to his previous service center.

Mr. Madison did so the next day, arriving around 6:00 AM. After waiting in line for several hours and passing through security, Mr. Madison attempted to clarify with the front desk whether he was at the right service center. He explained that he had received a notice in the mail stating that his case had been transferred to a different service center and he wanted to be sure he was in the right place. The person at the front desk became angry with Mr. Madison. When Mr. Madison asked to speak with a supervisor, the person at the front desk instructed security to remove Mr. Madison from the building. Mr. Madison was thus unable to recertify, and his SNAP benefits were terminated. As a result, Mr. Madison went without SNAP benefits for several months.

Lost application and recertification documents. Many benefit applicants and recipients are unable to obtain and retain their benefits because of ESA's limited ability to receive and timely process documents, associate them with the appropriate case and track them in the event of disputes.¹¹ ESA service centers have "drop boxes" which consumers are encouraged to use for their documents. However, these drop boxes create their own challenges for staff and consumers, as no receipts are issued when applications or other verification documents are submitted. As seen below, and in the case of Ms. Norris, individuals encounter problems when they attempt to use these drop boxes, when they mail, fax, or email documents to ESA, and even when they provide their documents to ESA caseworkers in person.

Mr. Abbott, who received reduced SNAP benefits for several months due to improper documentation of his paperwork. *Mr. Abbott is a married father of two with limited English proficiency who relies on SNAP benefits and his wife's income to support the family. Believing that his family's SNAP benefits were too low, Mr. Abbott went to an ESA service center on three separate occasions to attempt to correct the problem. According to Mr. Abbott, although he brought proof of income with him on each visit — and met with the same ESA caseworker each time — the caseworker claimed to have no record of receiving this documentation. In addition, although Mr. Abbott has limited English proficiency, Mr. Abbott reports that the ESA caseworker conducted two of these meetings in English without offering Mr. Abbott the services of an interpreter. Mr. Abbott sought the help of an advocate who contacted ESA and confirmed that Mr. Abbott's benefits were too low; in fact, the advocate learned, Mr. Abbott's benefits were half of what they should have been. Although eventually reimbursed for the difference, Mr. Abbott and his family received the lower SNAP benefits for several months.*

Ms. Inslee, whose SNAP benefits were terminated despite several attempts to recertify. *Ms. Inslee is an elderly woman who relies on her part-time wages, Social Security benefits, and SNAP benefits to support herself. Last summer, Ms. Inslee received a mid-year recertification form in the mail for her SNAP benefits. Ms. Inslee reported that when she called ESA to ask about this form, she was told that as long as she filled it out by September 30, 2013, she would continue to receive her SNAP benefits. Ms. Inslee placed her recertification form and supporting documents in the drop box at her service center before the end of September.*

The next month, however, Ms. Inslee did not receive her SNAP benefits. Ms. Inslee reports that, after calling ESA several times, she was told that her recertification papers had been received by ESA but not properly entered in the computer.

A few days later, Ms. Inslee went in person to the service center and was told that her SNAP benefits for October had been uploaded. She was asked to complete another recertification form, which she did. Despite doing so, however, she received a notice the next month stating that she did

not submit required information and that her recertification had been denied. Thus, she did not receive any SNAP benefits in November. Eventually, she worked with an advocate and received her SNAP benefits.

Mr. Kaplan, who went for several months without Medicaid because ESA could not locate his application. *Mr. Kaplan is an elderly individual who works full-time to support himself. In late 2013, Mr. Kaplan filed an online application for Medicaid. After receiving a notice that additional information was necessary, he went to the Taylor Street Service Center in January 2014. He waited in line for several hours to provide the necessary documents, and, upon doing so, was given a date-stamped receipt.*

In February 2014, he went back to Taylor Street to check on the status of his application and was assured that it was being processed. Still having heard nothing about his application some time later, Mr. Kaplan went to the H Street Service Center to again check on the status of his application. This time, however, he was told that ESA had no record of his application.

Mr. Kaplan then called DC Health Link to see what he could do. He was told that he would need to file a new application. This application was finally approved in April 2014, several months after he first attempted to apply for health coverage.

Ms. Lewis, whose family remains without health insurance due to lost paperwork. *Ms. Lewis is a mother of two who attempted to apply for health insurance for her children online through the DC Health Link website in February 2014. When the system would not permit her to scan the required documents, Ms. Lewis reports that she then sent these documents through email and fax several times, but several weeks passed and she received no response on the application.*

While waiting for the application to be processed, Ms. Lewis's son was injured and required emergency medical attention. When she got to the emergency room, she was told that she would be billed for any treatment because she had no Medicaid coverage. Because she could not afford these costs, she left the emergency room without her son being treated for his injury.

Ms. Lewis spoke with an advocate who contacted ESA and learned that Ms. Lewis's application had been denied for failure to provide required information. Apparently, none of Ms. Lewis's many prior faxes or emails had been successful. Ms. Lewis now must reapply for health insurance all over again, and her children remain uninsured.

Ms. Epstein, who lost her QMB benefit due to ESA's failure to process her recertification. *Ms. Epstein, a woman who suffers from several chronic health conditions, received her recertification form for the QMB program in early December 2013. Ms. Epstein submitted her recertification form in December, well in advance of the February deadline, to avoid delays. Ms. Epstein reports that, in early January, she confirmed with ESA that the agency had received her recertification and was assured it would be processed. However, when Ms. Epstein went to her physician's office in March, she was told that her QMB benefit was no longer active and that she would be responsible for paying her Medicare deductible and co-insurance costs. The failure to process her recertification has left her with over \$1,000 of co-insurance bills.*

The problems described above impose formidable obstacles to individuals' ability to obtain and retain benefits that are essential to their health, food security and financial well-being. Many of these individual matters have been (or are being) resolved with the intervention of legal or social services organizations. However, there is good reason to believe that many individuals who have not found their way to such organizations are going without food and medical care because of their inability to navigate these error-ridden application and recertification processes.

PART II: PROPOSED SOLUTIONS TO SYSTEMIC PROBLEMS IN OBTAINING AND RETAINING PUBLIC BENEFITS IN THE DISTRICT

The individual stories discussed above illustrate the systemic problems that District residents encounter when attempting to apply and recertify for public benefits. While these problems might be explained away as temporary disruptions on the path towards creating a more effective and efficient system, ESA, DHCF, and the Exchange have not given advocates and consumers any realistic estimate of how and when things might improve.

The problems identified herein will not be solved without thoughtful, creative and strategic planning, accompanied by performance accountability. Agency officials at ESA, DHCF and the Exchange report that they are aware of many of these issues and are working on operational improvements to address them. The following recommendations are designed to add to and support these efforts: (1) engage in (and release the results of) short-term and long-term planning through ongoing agency and advocate communications about implementation; (2) continue to improve technology as one piece of a comprehensive strategy for increasing efficient customer service; (3) hire more agency staff at all levels and divisions, deploy and train these staff more effectively, and hold staff accountable for providing quality, accurate service to consumers; (4) expand space at service centers and find ways to conduct business outside of service centers; (5) promulgate and disseminate rules, policies and procedures through the development and implementation of a communications strategy; (6) improve and formalize procedures for handling documents submitted by consumers, including the provision of receipts and other confirmation; (7) eliminate the in-person recertification requirements for the SNAP and Alliance programs; and (8) make services language accessible to those with limited English proficiency.

Engage in (and release the results of) short-term and long-term planning through ongoing agency and advocate communications. It will take time to change processes and procedures that have existed for many years. But all three agencies — ESA, DHCF, and the Exchange — must engage in ongoing discussions with each other and with advocates and consumers so that they can continually evaluate ESA procedures and staffing levels, understand what is and is not working, and consider necessary changes. The collection and analysis of qualitative and quantitative data collection related to the status of ACA implementation and its impact on other programs will be important for this process.¹²

These discussions could happen through a new working group composed of advocates and consumers with detailed knowledge about program operations who would focus solely on these operations issues. This working group could operate under the auspices of the existing Medicaid Expansion and Eligibility Working Group or the Health Benefit Exchange Authority's Executive Board. Although these conversations have happened in some form throughout the development and implementation of the ACA in the District, there have not been sustained, public discussions at a sufficient level of detail on these implementation matters. Through such discussions, advocates and consumers can share their resources, expertise and feedback with agency staff to assist them in the development of policy and program improvements.

Continue to improve technology as one piece of a comprehensive strategy for increasing efficient customer service. The complete replacement of the current, antiquated Automated Client Eligibility Determination System (ACEDS) case management system by the new DC Access System

(DCAS) — an online case-management, and cross agency and database (federal and local) data matching and verification — will surely mitigate many service delivery problems.¹³ The rollout of DCAS will occur in three phases, with each phase requiring several iterations of software patches and upgrades.

The transition from ACEDS to DCAS has shown that technological change is not easy or quick and has demonstrated the need to provide for extensive back-ups and supports until the technology is fully operational. When the MAGI Medicaid eligibility determinations and cases were transferred to DCAS in “Release 1,” there were numerous glitches and technological challenges that required significant staff interventions to fix individual accounts and applications to allow processing. The transition also led to the identification of technological deficits that were supposed to be included in the initial rollout, and which are being addressed on a rolling basis.

The next two big transitions to DCAS will occur in the fall of 2014 and sometime in 2015. In September 2014, a new “passive renewal” process for the MAGI Medicaid population will be implemented.¹⁴ Then, at some point in 2015, a fully operational “Release 2” of DCAS will be implemented, which will include application portals for remaining ESA programs (such as SNAP, TANF, Alliance and non-MAGI Medicaid) to help consolidate program operations. Until that happens, though, the majority of the programs administered by ESA will still rely on matching and data runs with the antiquated ACEDS system. Therefore, staff must work with both ACEDS and DCAS in many cases, which makes processing applications and recertification paperwork even less efficient than under ACEDS alone. And when Release 2 occurs, it seems quite likely that this transition will experience the same glitches and continuing reliance on ACEDS that occurred with the MAGI Medicaid transition earlier this year.

Therefore, for the foreseeable future, ESA, DHCF and the Exchange will have to support the technological improvement process with sufficient staff and formal, widely disseminated policies and procedures. The following recommendations discuss these supports in more detail.

Hire more staff at all levels and divisions; deploy and train these staff more effectively; and hold staff accountable for providing quality, accurate service to consumers. ESA, DHCF, and Exchange staff are working very hard to implement complicated programs for low-income people in complex situations that are not always contemplated when policies are developed. The District has already invested significant resources in training both existing and new staff to help them better understand the programs they are implementing. Additionally, ESA is in the process of deploying “SWAT” teams with specialized knowledge who will work at service centers on medical assistance problems.

However, the problems above suggest that these efforts have not yet resulted in hoped for progress. Moreover, it appears that ESA has engaged in limited, if any, strategic planning to determine how many staff are actually needed to perform the agency’s many functions or how to deploy them more efficiently and creatively to improve operations. Adoption of the following recommendations would help in this planning and hiring process.

Produce both a short-term and long-term staffing plan. ESA, DHCF and the Exchange should be thinking about what type of staffing plan will be needed in the short term (for example, until the completion of Release 2) and in the long term (after DCAS has been operational for some period of time and ACEDS is completely retired). These plans should account for all known peak

periods when additional staff should be needed — such as annual enrollment periods and passive renewal implementation dates — as well as ongoing staffing improvements such as increasing language accessible services and shoring up managerial and policy staffing. These plans would both guide short-term hiring decisions to help with client inflows during what could be a confusing time and give the agency a full staffing goal around which the agencies and advocates can coalesce and support.

Organize staff to maximize efficiency. Frontline staff should be organized so that consumers can be triaged to staff with differing levels of knowledge and expertise depending on their presenting issue. The agency should now consider creating, intensively training and deploying other teams of specialists to help with more complicated cases in each benefits program and not just for medical assistance. In such a system, all ESA workers would have a baseline level of knowledge of all programs. Consumers with simple renewal or other matters — such as proving their identity during the open season for QHP enrollment — could be triaged through a more generalist “express lane.” Then, depending on the subject matter and complexity of their business, consumers could be sent to other teams for assistance.¹⁵

Provide ongoing training and support and hold staff accountable for providing quality services. The provision of ongoing training and support to all workers as well as a commitment to hold workers accountable for providing accurate and efficient customer service are essential for the success of such an effort. While the agencies have committed to ongoing training, it is unclear whether they have any plans to implement any ongoing quality control measures — such as secret shoppers or other mechanisms — to assure that services are being provided efficiently and effectively.

Hire additional managers, supervisors and policy staff at ESA and DHCF to support the frontline system. These staff play a vital role in developing policies and disseminating those policies to staff, advocates and consumers. They can also help with quality control issues by ensuring that consumers are provided with accurate information and treated with dignity and respect.

Policy and managerial staff also play a valuable role in working with advocates to resolve agency errors quickly and informally, which helps get benefits to consumers more quickly without the need for time-consuming appeals. Advocates have long had success resolving issues with existing policy staff, managers and appeals staff, who, while still helpful, are clearly extremely busy and pulled in many different directions. DHCF staff have been receiving requests for assistance with Medicaid problems through a new email address, which has expanded the agency’s ability to respond quickly to problems, and ESA policy and managerial staff continue to work with advocates. In order to continue and expand these efforts, ESA and DHCF should hire more of these staff and designate contacts whose job it would be to work with advocates and consumers to informally resolve matters.¹⁶

Expand the space at service centers and find ways to conduct business outside of service centers. ESA is currently engaged in a multi-year renovation of existing service centers. The Fort Davis Center has been renovated, while the H Street Center’s renovation will be completed this year. There are also plans to expand the Taylor Street Service Center, which is currently extremely crowded, as well as the Congress Heights Center in 2015, and create self-help centers to divert consumers with MAGI Medicaid and private insurance matters. The self-help centers will have a couple of specialized staff and several computer stations to help consumers process identity

verification and applications for medical assistance. Additionally, ESA has told advocates that the agency has purchased several kiosks (or stand alone computer stations) that would allow a consumer to upload documents and update personal information at the service center or other off-site location without meeting with an agency representative. Finally, ESA is also working to implement an Interactive Voice Response System (IVR) and expand its call center so that consumers can conduct some business over the phone. All of these improvements will certainly help to reduce congestion and confusion in existing service centers.

The agency should also expand its use of in-person assisters both inside and outside service centers. Advocates note that the recent addition of in-person assisters at two of the ESA service centers has had significant and positive results for consumers. Consumers report relief and appreciation for the in-person assister's help in navigating the application process and resolving problems. As part of the continued effort to divert consumers from the ESA service centers, ESA could fund and deploy assisters to perform mobile verifications or electronic document intake at libraries, recreation centers, community tax centers, and other community venues. Assisters could also perform in-person face-to-face re-certifications for Alliance once the program is included in DCAS, although, as will be discussed below, this report recommends eliminating the face-to-face recertification requirement entirely.

Promulgate and disseminate rules, policies and procedures through the development and implementation of a communications strategy. There has always been a great deal of confusion in the community among consumers and their advocates about eligibility for public benefits and the processes for securing these benefits; this confusion has been greatly exacerbated by the implementation of the ACA. There are two components to this recommendation. First, ESA, DHCF and the Exchange must formally promulgate rules and policies so that agency decisions can be understood and incorrect decisions can be appealed.

Second, and most importantly in the short term, whatever policies and procedures are in place must be disseminated widely and consistently to the public. The Council should provide resources to DHCF and ESA to create and execute a communication and outreach strategy; this would include hiring a communications coordinator for all outreach activities. Such a coordinator can work with the agencies to assemble and disseminate the work they are doing and work with advocates to draw upon their resources and expertise to inform the community about program and policy changes.

Even while this communication strategy is developed and funding is secured, all three agencies must update their websites to provide up to date, specific and consistent information. For example, the new Combined Health Application and the Retroactive Medicaid Application are apparently posted on DC Health Link. The DHCF website has some fact sheets available explaining some of the new rules and processes and is working to update its website to provide more up to date, detailed information to consumers and advocates.

However, most consumers and advocates look at the ESA website to learn about the policies and procedures governing applications for public benefits such as Medicaid, Alliance, TANF and SNAP. The ESA website does not have the new Combined Health Application nor does it explain that the agency will not consider a Combined Benefits Application for either prospective or retroactive eligibility for MAGI Medicaid. Additionally, the relevant agency websites do not contain the same explanation of detailed new eligibility rules, policies and procedures for Medicaid and financial assistance that are currently in place.¹⁷

Therefore, we recommend that all three agencies immediately do the following: (1) create a Medicaid tab on their websites that explain — in detail — the difference between eligibility and the process of applying for and retaining MAGI and non-MAGI Medicaid; (2) post on this page the Combined Health Application, Combined Benefits Application and Retroactive Medicaid Application with an explanation of the difference between the three applications; and (3) post policy and programmatic updates as they are implemented. Furthermore, ESA should take down the Medicaid portions of the ESA Policy Manual that deal with MAGI populations and instead refer individuals to the Medicaid tab on the website for information about these programs.

Improve and formalize procedures for handling mail, faxes and drop boxes, including the provision of receipts and other confirmation. Consumers consistently complain that despite having mailed, faxed or dropped off requested documents at ESA, their applications or recertifications have been denied for failure to submit those very documents. Again, improved technology will help to address these problems, as will passive renewal for the MAGI Medicaid population. However, formal procedures and accountability for tracking submitted documents is still necessary to support these advances. Consumers should get receipts no matter how their documents are submitted, whether it be in-person, electronically, by mail or through the drop box. At the very least, ESA should immediately provide receipts to all customers who leave their documents in service center drop boxes. Carbon copies and/or electronic records of the receipt should be kept so that staff can confirm and track document intake. These improvements would ensure fewer erroneous denials and terminations, while reducing foot traffic and long wait-times as consumers gain confidence in the safety of their submitted documents.

Eliminate the in-person recertification requirements for the SNAP and Alliance programs. The requirement that SNAP and Alliance beneficiaries recertify in-person and (for Alliance beneficiaries) every six months has significantly reduced the number of Alliance beneficiaries, flooded service centers (especially Taylor Street and H Street) and led to increased program costs.¹⁸ At the same time, it is not clear that the in-person recertification requirements do anything to reduce fraud — the stated purpose behind adoption of the policy. Across the country, to facilitate access to benefits, states have eliminated the requirement that SNAP beneficiaries apply or recertify in-person. According to interviews with local and state SNAP offices in 45 states, all but 5 states implemented waivers for in-person interviews at some level,¹⁹ and meanwhile error rates across the country continue to decline to all-time lows.²⁰

The language in the 2015 Budget Support Act directing ESA and DHCF to make recommendations to the Council about the future of the Alliance program and the processes for applying and recertifying for benefits is a positive step. The following recommendations would eliminate some of the problems described above: (1) eliminate the in-person application and recertification requirement for both the Alliance and SNAP; (2) increase recertification periods for the Alliance program to one year; and (3) create alternative ways to apply and recertify for Alliance benefits, specifically through the community health centers that serve as the medical home for Alliance beneficiaries. Implementation of these recommendations would free staff to concentrate on investigating suspicious or dubious applications, while lowering the time and language barriers for eligible enrollees to apply and recertify.

Make services language accessible as required by the Language Access Act of 2004.²¹ As bad as the problems above are for those who speak English as their first language, the challenges faced by limited and non-English speakers are even more pronounced. As the story of Mr. Abbott

illustrates, individuals who are limited and non-English proficient are still not routinely provided with language accessible services; this is particularly true for individuals who speak a language other than Spanish. Without Language Access Act compliance by ESA, DHCF and the Exchange, those for whom English is not their first language will continue to experience barriers to benefit receipt even when the above problems have been addressed.

CONCLUSION

While ESA, DHCF and the Exchange report that they are working to address the problems discussed above, more must be done sooner so that improper delays and terminations in benefits will not continue to cause health and food insecurity for too many District families. The scope and depth of the District's comprehensive public benefit system — as well as the many challenges faced by the consumers who access this system — will always require an element of coordinated in-person consumer assistance and forward planning for the staff and resources of ESA, DHCF and the Exchange. Therefore, solutions lie both in improving technology — which is currently underway as ESA replaces the legacy ACEDS system with DCAS, federal data systems mature, and a streamlined and coordinated public benefit application is developed — and investing the necessary resources to ensure adequate staffing to serve consumers and develop and disseminate policies and procedures.

Policymakers, consumers, advocates, as well as agency staff and leadership share the same overarching goal — ensuring the orderly delivery of essential public benefits to eligible, vulnerable District residents. No one wants Mr. Abbott to be unable to feed his family; no one wants Ms. Fox's daughter to be kicked out of school because she could not get vaccinated; and no one wants Ms. Dawson to lose her job because she had to take multiple days off work in order to keep her health insurance. The recommendations proposed here would build on the positive efforts that ESA, DHCF and the Exchange have already identified and, in some cases, are making to avoid these results. Adopting these proposals would expand the capacity of ESA, DHCF and the Exchange to adapt to a changing public benefits landscape and would ensure that the promise of a strong safety net does not remain elusive for the District's most vulnerable individuals and families.

APPENDIX A

Client Stories

The names of the individuals whose experiences are cited in this report, and certain facts about them, have been changed or omitted to protect their identities. None of the disclosures made herein constitute any waiver of attorney client privilege. Status is accurate as of May 21, 2014 to the best of the authors' knowledge.

Mr. Abbott: a married father of two with limited English proficiency who relies on SNAP benefits and his wife's income to support the family.

Believing that his family's SNAP benefits were too low, Mr. Abbott went to an ESA service center on three separate occasions to inquire about this issue. Mr. Abbott reports that although he brought proof of income with him on each visit — and met with the same ESA caseworker each time — the caseworker claimed each time to have no record of receiving the proof. In addition, although Mr. Abbott has limited English proficiency, the ESA caseworker conducted two of these meetings in English without offering Mr. Abbott the services of an interpreter. Mr. Abbott sought the help of an advocate who contacted ESA and confirmed that Mr. Abbott's benefits were too low; in fact, the advocate learned, Mr. Abbott's benefits were half of what they should have been. Although eventually reimbursed for the difference, Mr. Abbott and his family received the lower SNAP benefits for several months.

Ms. Bonilla: a single mother with limited English proficiency who has difficulty reading. Ms. Bonilla has no source of income apart from SNAP.

In July 2013, Ms. Bonilla went in person to the Taylor Street Service Center to complete her Alliance recertification. Ms. Bonilla reports that the ESA caseworker told her that no additional information was needed and that her recertification would be processed promptly. However, when Ms. Bonilla went to a scheduled medical appointment, she was told that she no longer had Alliance coverage. Indeed, Ms. Bonilla received a letter from ESA in September 2013 stating that her Alliance coverage had been terminated because she failed to recertify.

Ms. Bonilla sought help from an advocate who contacted ESA on her behalf. The agency confirmed that Ms. Bonilla should have been receiving Alliance coverage back to August 2013. Ms. Bonilla, however, had already missed several medical appointments because she believed she no longer had health insurance.

Ms. Clark: a woman who suffers from chronic health conditions.

Ms. Clark applied for health coverage in January 2014 through DC Health Link. When Ms. Clark applied, she requested retroactive coverage for the prior three months as permitted under Medicaid law because she had medical bills from that time. However, Ms. Clark's approval notice listed an active date for benefits that was only two weeks before the application date. When Ms. Clark's advocate contacted ESA on Ms. Clark's behalf, the advocate was told that Ms. Clark had to complete an additional form to receive retroactive benefits. This form had never been made available to Ms. Clark and was not posted on the ESA website. With the assistance of her advocate,

Ms. Clark has now been awarded retroactive Medicaid coverage, and she is working to make sure that her medical bills will be paid by Medicaid.

Ms. Clark also struggled to obtain a replacement EBT card from ESA. She was sent away from one service center that claimed she needed a photo ID to obtain a replacement card. They sent her back to the service center where she applied, stating that the service center would have proof of her original application. However, that service center said there was nothing they could do for her and sent her back to the first service center. It was not until Ms. Clark's advocate wrote a letter on her behalf citing relevant sections of the ESA Policy Manual that Ms. Clark, after several trips to service centers, was able to obtain her replacement card.

Ms. Dawson: a limited English proficient woman who works full-time to support herself.

Ms. Dawson attempted to recertify for Alliance in February 2014 at the Taylor Street Service Center. She reports that, after waiting for several hours, she was told to place her information in the drop box, which she did. According to Ms. Dawson, she was offered no opportunity for the face-to-face interview necessary to complete her recertification.

A few weeks later, she received a notice that her Alliance would be terminated on March 31, 2014 for failure to recertify. Ms. Dawson could not get a day off work to return to the service center until the last day of her recertification period. She arrived at 5:30 AM and waited in line for several hours. However, she reports that, at 9:00 AM, she was told by an ESA caseworker that the service center had reached its "40 person maximum" for medical insurance recertifications for the day. Ms. Dawson was told that in the future she should get in line before 4:00 AM in order to be seen.

Thus, even though Ms. Dawson took off the whole day from work to resolve the issue with her Alliance, she was forced to leave without recertifying. It was not until an attorney reached out to ESA on Ms. Dawson's behalf that her Alliance was finally recertified.

Ms. Epstein: a woman with several chronic health conditions.

Ms. Epstein received her recertification form for the QMB program in early December 2013. She submitted her recertification in December, well in advance of the February deadline, to avoid delays. Ms. Epstein reports that, in early January, she confirmed with ESA that the agency had received her recertification and was assured it would be processed. However, when Ms. Epstein went to her physician's office on March 10, 2014, she was told that her QMB benefit was no longer active and that she would be responsible for paying her Medicare deductible and co-insurance costs. The failure to process her recertification has left her with over \$1,000 of co-insurance bills.

Ms. Fox: a single mother who works in the medical field to support her family.

In January 2014, Ms. Fox applied for Medicaid and SNAP for herself and her daughters at the Fort Davis Service Center. Ms. Fox was apparently given the Combined Benefits Application that (prior to October 2013) had been used to apply for both benefits. Although Medicaid applicants must now use the separate DC Health Link application, Ms. Fox reports that no one at the service center explained this to her. Indeed, when Ms. Fox called ESA after receiving no word on her application for several weeks, she reports that she was told only that her application was pending.

While still awaiting a decision, Ms. Fox was the victim of domestic violence and required emergency medical attention. After receiving this treatment, Ms. Fox again called ESA and this time was told that the agency had no record of her application. She then consulted with an advocate who reached out to ESA on her behalf.

The agency located Ms. Fox's application but stated that Ms. Fox would need to complete a separate DC Health Link application before she could begin receiving Medicaid coverage. Ms. Fox found time away from work to go back to the service center to reapply using the DC Health Link application. There, however, the lines were too long for her to be seen.

In the meantime, Ms. Fox and her daughter remained without health coverage until (with the intervention of an advocate and in-person assister) her application was finally approved. Ms. Fox is concerned about the bills she received following her emergency medical treatment. Without health coverage for several months, she was also unable to pay for the vaccinations her daughter needed in order to attend school and went without her own diabetes medications.

Ms. Gibson: a single mother who works full time to support herself and her daughter.

In February 2014, Ms. Gibson went to the H Street Service Center to recertify for Alliance benefits. She asked to apply for Medicaid for her daughter, a U.S. citizen, but reports that the ESA representative told her that she had to apply online and could not submit a paper application in person.

Ms. Gibson then attempted to complete an online application a few weeks later but the DC Health Link system would not allow her to apply online. She called DC Health Link's customer service line but was told that she could not apply online because she was not a citizen. Although she tried to explain that she was only applying on behalf of her daughter, not herself, she was told that nothing could be done.

In March, Ms. Gibson returned to the H Street Service Center and attempted to explain the situation. She submitted a paper copy of her daughter's Medicaid application. However, in April, she received a notice stating that her Medicaid application had been denied; the notice contained Ms. Gibson's name and not her daughter's name.

Despite Ms. Gibson's efforts, her daughter went several months without health insurance. During that time period, Ms. Gibson incurred medical bills for her daughter's asthma treatment that she could not afford to pay. Ms. Gibson is still working to make sure that her medical bills will be paid by Medicaid.

Ms. Hoffman: an elderly woman with severe COPD

Ms. Hoffman has been enrolled in the QMB program since 2010. She does not qualify for free Medicare Part A coverage and did not enroll in Medicare Part B when she first became eligible. The QMB program enabled the District to enroll her into both Part A and Part B benefits and provided her with free Medicare drug coverage that gives her access to affordable prescription medications.

In October 2012, Ms. Hoffman sent her QMB recertification form to ESA. In February 2013, she received notice from Social Security that her Medicare Part A and Part B benefits had been terminated for non-payment. ESA stated that the agency did not receive her recertification paperwork and subsequently stopped paying her Medicare premiums. In addition to losing her health benefits, Ms. Hoffman's Medicare drug coverage was terminated, forcing her to pay over \$200 each month (instead of \$5.10) for the full cost of her medications.

Ms. Hoffman submitted a new QMB application in late February 2013 and she was approved for the QMB program starting April 1, 2013. However, as of April 2014 — more than a year later — ESA has still not re-enrolled Ms. Hoffman into Part A or Part B benefits.

Ms. Hoffman also remains unable to access affordable prescription coverage through Medicare Part D. Currently, she is paying over \$200 per month for two prescription medications and is not taking the primary medication to relieve the symptoms of her COPD because of the cost. If she were enrolled in Medicare, the full cost of a twelve-month supply of all three medications would be \$95. To date, ESA has not provided Ms. Hoffman or her advocate with any explanation as to why her re-enrollment has been delayed for such a long period of time.

Ms. Inslee: an elderly women who works part-time and relies on her part-time wages, Social Security benefits and SNAP benefits to support herself.

Last summer, Ms. Inslee received a mid-year recertification form in the mail for her SNAP benefits. When she called ESA to ask about this form, she was told that as long as she filled out the form by September 30, 2013, she would continue to receive her SNAP benefits. Ms. Inslee placed her recertification form and supporting documents in the drop box at the service center before the end of September.

The next month, however, Ms. Inslee did not receive her SNAP benefits. Ms. Inslee reports that, after calling ESA several times, she was told that her recertification papers had been received but not properly entered in the computer.

A few days later, Ms. Inslee went in person to the service center and was told that her SNAP benefits for October had been uploaded. She but she was asked to complete another recertification form, which she did. However, in November 2013, she received a notice stating that her recertification had been denied because she did not submit required information, and she did not receive any SNAP benefits that month.

Mr. Jackson: an elderly veteran who relies on Social Security and SNAP benefits to support himself.

Mr. Jackson applied for QMB in October 2013 because he was eager to get financial assistance to help cover his health care costs. By late December, however, Mr. Jackson had received no word from ESA regarding his application.

When Mr. Jackson's advocate contacted ESA regarding this issue, the agency determined that Mr. Jackson had already been approved for QMB back in November but that no eligibility notice had

ever been released in ACEDS. As a result, Mr. Jackson was unaware for several months of whether he had QMB coverage.

Mr. Kaplan: an elderly individual who works to support himself.

In late 2013, Mr. Kaplan filed an online application for Medicaid. After receiving a notice that additional information was necessary, he went to the Taylor Street Service Center in January 2014. He waited in line for several hours to provide the necessary documentation and, upon doing so, was given a date-stamped receipt.

In February 2014, he went back to Taylor Street to check on the status of his application and was assured that his application was being processed. Still having heard nothing about his application some time later, Mr. Kaplan went to the H Street Service Center to again check on the status of his application. This time, however, he was told that ESA had no record of his application.

Mr. Kaplan then called DC Health Link to see what he could do. He was told that he would need to start over and file a new application. This application was finally approved in April 2014, several months after he first attempted to apply for health coverage. During the months he was waiting for health insurance, Mr. Kaplan went without check-ups and other preventative care because he was worried about the cost.

Ms. Lewis: a mother of two who applied for Medicaid for her children in February 2014.

Ms. Lewis attempted to apply for Medicaid for her children through the DC Health Link website but the system would not permit her to scan the required documents. Ms. Lewis reports that she then sent these documents through email and fax several times, but received no response on her application after several weeks had passed

While waiting for the application to be processed, Ms. Lewis's son was injured and required emergency medical attention. When she got to the emergency room, she was told that she would be billed for any treatment because she had no Medicaid coverage. Because she could not afford these costs, she left the emergency room without her son being treated for his injury.

Ms. Lewis spoke with an advocate who contacted ESA and learned that her application had been denied for failure to provide required information. Apparently, none of Ms. Lewis's many prior faxes or emails had been successful. Ms. Lewis now must reapply for health insurance all over again, and her children remain uninsured.

Mr. Madison: a man who struggles with health problems and relies on Social Security payments and SNAP to support himself.

Mr. Madison attempted to recertify for SNAP benefits in spring 2013. Having received a notice stating that his case file had been transferred to a different service center, Mr. Madison went there to recertify. That service center, however, told him that his information was not in the system and that he would have to go back to his previous service center to recertify.

Mr. Madison did so the next day, arriving around 6:00 AM. After waiting in line for several hours and passing through security, Mr. Madison attempted to clarify with the front desk whether he was

at the right service center. He explained that he had received a notice in the mail stating that his case had been transferred to a different service center and wanted to make sure he was in the right place. The person at the front desk became angry with Mr. Madison. When Mr. Madison asked to speak with a supervisor, the person at the front desk instructed security to remove Mr. Madison from the building. Mr. Madison was thus unable to recertify, and his SNAP benefits were terminated. As a result, Mr. Madison went without SNAP benefits for several months.

Ms. Norris: a woman who struggles with health problems and cares for her nine-year-old great niece.

On March 11, 2014, Ms. Norris attempted to apply for Medicaid for her nine-year-old great niece through the DC Health Link Assisters stationed at the H Street Service Center. The Assisters told her that they were unable to process her application and that she needed to meet with an ESA representative. Ms. Norris then returned to the waiting room to meet with an ESA representative. After waiting all day, she was eventually told by an Assister that all the ESA workers were gone and she would have to come back the next day.

When she returned to the H Street Service Center on March 12, 2014, she was given a form application to fill out to request Medicaid and other benefits for her great niece. While she waited to be called by ESA staff, she filled out the application (the application was a “recertification form” and on it, Ms. Norris asked for Medicaid, food stamps, and cash for children). When Ms. Norris was called to meet with an ESA staff member a few hours later, she was told that the application she had been given was not the right one. Rather than allow Ms. Norris to fill out the correct form right there, the ESA worker told her she would need to take the correct application home to complete it and then return to the service center.

Ms. Norris returned to the Service Center again the next day, and this time, after waiting for several hours, she was told that she would be given an appointment for March 18. When she arrived for that appointment, she was left at a computer by herself to complete her Medicaid application. Although she asked ESA staff members for assistance and asked to speak with a supervisor, Ms. Norris was left by herself to attempt to complete the application. She was not able to navigate the DC Health Link system by herself, and even after several hours of trying she did not successfully submit a Medicaid application that day.

Finally, after reaching out to an Assister stationed at Bread for the City, Ms. Norris was able to successfully submit a Medicaid application and she is waiting for it to be processed.

Ms. Norris has also been attempting to obtain TANF for her great niece. At the March 18 appointment, Ms. Norris was told that she needed to submit additional documentation before she could begin receiving TANF benefits. When Ms. Norris returned on March 21 to submit this documentation, ESA staff refused to give her a receipt, stating that ESA no longer gives receipts at all. ESA staff instead instructed her to put the documents in the drop box. She went to the desk and waited for ESA staff to watch her put the documents in the drop box. However, on March 28, she received a letter stating that she had failed to submit the necessary TANF proofs. Before seeking assistance from a lawyer, Ms. Norris tried to call ESA to explain that she already submitted the relevant documentation, but no one returned her phone calls.

After a lawyer got involved, ESA stated that it had located some of the relevant documentation but was missing other documents Ms. Norris had submitted. After Ms. Norris resubmitted these documents, ESA took steps to process her application and ultimately approved her to receive General Assistance for Children benefits.

APPENDIX B

District of Columbia Information Technology Background

Since 1993, ESA has administered virtually all District public benefits programs using the Automated Client Eligibility Determination System (ACEDS). The system makes eligibility and benefit determinations for TANF, Food Stamps (SNAP), Medicaid, Interim Disability Assistance (IDA), DC Healthcare Alliance, and other locally run programs, as well as tracking demographic and household information for enrollees. The system also interacts with local District agencies, as well as Federal data depositories.

In 2012, using funding offered through the ACA, the District began a \$50 million overhaul of its public benefit IT system, building a social, health and human service client case management system known as DC Access System (DCAS). The system is currently operating as the back-end IT system for DC Health Link and in future years, will completely replace and augment the operations of ACEDS for other public programs. It is expected that all programs will be integrated into DCAS sometime in 2015.

DCAS offers coordinated eligibility and enrollment functionality, as well as online case-management, and cross agency and database (federal and local) data matching and verification. The goal is for DCAS to make application, enrollment, and maintenance of public benefits as seamless as possible, while easing administrative burdens and decreasing error rates in the eligibility determination and enrollment processes.

ENDNOTES

¹ The D.C. Health Care Safety Net Alliance program provides coverage for adult immigrants who have income below 200 percent of the Federal Poverty Level and do not qualify for Medicaid because of their immigration status.

² The District implemented the ACA's Medicaid expansion early and increased eligibility beyond the federal law's 133 percent of the Federal Poverty Level ceiling to provide Medicaid to otherwise ineligible childless adults with income up to 200 percent of the Federal Poverty Level. Prior to the passage of the ACA, the District provided Medicaid to children and pregnant women with incomes below 300 percent of the Federal Poverty Level and parents with incomes below 200 percent of the Federal Poverty Level. Childless adults without disabilities and with incomes under 200 percent of the Federal Poverty Level were covered under the Alliance.

³ The Qualified Medicare Beneficiary program (QMB) covers Medicare premiums, deductibles and cost sharing for Medicare beneficiaries with incomes below 300 percent of the Federal Poverty Level. The program also entitles beneficiaries to premiums and copayment assistance for prescription drugs through Medicare Part D.

⁴ Kaiser Family Foundation, *State Health Facts: Health Insurance Coverage of the Total Population* at <http://kff.org/other/state-indicator/total-population/?state=dc> (last visited on April 22, 2014) (stating that 25 percent of District residents get Medicaid, compared to 49 percent who receive employer sponsored coverage and 8 percent who are uninsured) (based on 2011-2012 data).

⁵ In response to the recession and the growing crisis in the District's low-income communities, the District of Columbia City Council passed, and the Mayor signed into law, a significant expansion to the SNAP program as part of the Fiscal Year 2010 Budget Support Second Emergency Act of 2009. *See* Fiscal Year 2010 Budget Support Second Emergency Act of 2009, Bill 18-0443, Act 18-207, §§ 5080-5083 (2009). Included in the "Food Stamps Expansion Act of 2009" were two critical policy changes. First, through the LIHEAP Heat and Eat program, all SNAP recipients in the District are provided with a minimal Low Income Home Energy Assistance Program (LIHEAP) benefit which entitles them to the maximum Standard Utility Allowance which can offset beneficiaries' gross income in some cases. The second policy expanded "categorical eligibility" for SNAP, thus, effectively, increasing the income eligibility limit for SNAP benefits. As a result of these expansions, more District residents are eligible for SNAP than they were prior to 2009, and many recipients receive higher benefits than they would have received in the absence of the Heat and Eat program.

⁶ The District of Columbia Department of Health Care Finance (DHCF) sets policies for the Medicaid, QMB and Alliance programs. The District of Columbia Health Benefits Exchange Authority ("the Exchange") sets policies for DC Health Link (the public marketplace to purchase insurance and receive financial assistance created by the Affordable Care Act). The Economic Security Administration (ESA) is an agency of the District of Columbia Department of Human Services and is responsible for determining eligibility for public health insurance programs (including Medicaid, Alliance and financial assistance for private insurance plans purchased through DC Health Link), SNAP and TANF, among other cash assistance benefits

⁷ *See* Appendix A for all of the stories contained in this report.

⁸ Historically, ESA has administered eligibility determinations for many of the vital safety net programs relied on by vulnerable District residents. Therefore, when it came time to administer the ACA in the District, it made sense for ESA (along with its partners in policy development and implementation – DHCF and the Exchange) to assume the responsibility of determining eligibility for Medicaid (under its new rules that rely on the use of Modified Adjusted Gross Income (MAGI) to determine income and household size for parents, children and childless adults who are not elderly or disabled) and subsidies for those purchasing Qualified Health Plans (QHPs) through DC Health Link.

⁹ In-person assisters work for organizations that have received grants from the District government to go out into the community and enroll eligible individuals in health insurance plans through DC Health Link.

¹⁰ *See supra* note 8 for information on MAGI Medicaid.

¹¹ Sometimes even when documents are received and noted in the computerized eligibility system, benefits are still not approved. Advocates have reported instances when recertification paperwork is shown in ACEDS as "received" but the

benefits are not “authorized.” When this happens, benefits are terminated as if the paperwork were not “received” in the first place.

¹² Useful information would include: the length of wait times, the number of applications received and processed and the number of recertifications processed actively and passively in a given month or week. Additional qualitative data could include customer surveys, secret shoppers (who go to service centers as consumers and report back on their experiences) and community surveys of advocates.

¹³ See Appendix B for background on the DCAS and ACEDS systems.

¹⁴ Starting on September 1, 2014, MAGI Medicaid recipients will be passively renewed into Medicaid if existing databases have enough information to make an eligibility determination. If sufficient information exists to renew eligibility, the agency will send the consumer a notice of continued eligibility and enrollment. If sufficient information does not exist, the consumer will be sent a pre-populated renewal form in order to collect the missing information. Forms will be auto-generated 60 days before renewal date. The District postponed the start of this new recertification process from January 1, 2014 in order to account for some of the technological challenges arising from the transition to DCAS.

¹⁵ Possible teams could include: (1) MAGI and Qualified Health Plan financial assistance applications and questions; (2) complex SNAP and TANF cases; (3) Alliance and other benefits involving non-citizens; (4) non-MAGI Medicaid and QMB; and (5) long-term care and waiver programs.

¹⁶ Although the Health Care Ombudsman (housed in the Department of Health Care Finance) provides help to consumers and advocates, it does not appear that these staff have the authority to resolve issues on their own.

¹⁷ ESA and DHCF staff report that they are working to update their websites. Additionally, ESA will start to use “No Wrong Door” posters that will inform consumers (and staff) that whatever ESA service center they come to can assist with their application, recertification or other benefits issue.

¹⁸ At the Medical Care Advisory Committee (MCAC) on April 9, 2014, DHCF presented data showing that despite decreasing enrollment in the Alliance, the cost of insuring Alliance members has increased. For example, in April 2011, the per member, per month cost of one Alliance enrollee was about \$150. That figure is currently around \$200 per member, per month. See “DHCF Presentation for FY 2015,” April 2015, available at <http://dhcf.dc.gov/page/dc-medical-care-advisory-committee> (last accessed Apr. 27, 2014). Thus, the agency hypothesizes, as Alliance enrollment decreases, the people that remain in the program tend to be sicker and drive up the capitated rates.

¹⁹ US Department of Agriculture. “Performance Measurement for Supplemental Nutrition Assistance Program Modernization Initiatives: Individual State Findings,” December 2012. Pg 19-20. http://www.fns.usda.gov/sites/default/files/SNAPModernization_Profiles_0.pdf

²⁰ Center on Budget and Policy Priorities. “Policy Basics: Introduction to the Supplemental Nutrition Assistance Program (SNAP), March 2014, available at <http://www.cbpp.org/cms/index.cfm?fa=view&id=2226>.

²¹ The Language Access Act of 2004 (“Act”) defines DHS as a “covered entity with major public contact.” D.C. Code § 2-1931 (3)(B)(iv). Under the Act, covered entities with major public contact must provide oral language services (using either bilingual staff or an interpreter) to any person with limited or no-English proficiency who seeks to access or participate in the services, programs, or activities offered by the agency. D.C. Code § 2-1932 (a). In addition, DHS and other covered entities with major public contact are required to provide written translations of vital documents into any non-English language spoken by a limited or no-English proficient population that constitutes 3% or 500 individuals, whichever is less, of the population served or encountered, or likely to be served or encountered, by the covered entity. D.C. Code § 2-1933 (a). The Act also requires covered entities with major public contact to gather data about the languages spoken by this population, to create a detailed biennial language access plan, and to maintain a language access coordinator. D.C. Code §§ 2-1932(b), 2-1934 (a)-(b).