COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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December 23, 2024

MEMORANDUM

TO: The Honorable Glenn Youngkin
Governor, Commonwealth of Virginia

The Honorable Luke Torian
Chair, House Appropriations Committee

The Honorable Louise Lucas
Chair, Senate Finance and Appropriations Committee

Michael Maul
Director, Virginia Department of Planning and Budget

FROM: Cheryl J. Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Evaluation of Medicaid Eligibility Determination

This report is submitted in compliance with item 292.HH. of the *2024 Appropriations Act*, which states:

"*HH. Out of this appropriation, $500,000 from the general fund and $500,000 from nongeneral funds the first year shall be provided to the Department of Medical Assistance Services (DMAS) to hire a consultant, with Medicaid-specific knowledge related to eligibility determination, process-design and information technology, to evaluate Medicaid eligibility determination in the Commonwealth. The consultant shall conduct a systematic review and evaluate all aspects of Medicaid eligibility determination as performed by DMAS and local departments of social services (LDSS). This review shall include, but not be limited to, the following: (i) evaluate the current information technology systems; (ii) measure the accuracy, processing times and efficiency of current eligibility determination processes; (iii) determine how well the current structure and systems handle high volumes; (iv) assess the current level of automation and determine processes that could be streamlined; (v) analyze the overall cost-effectiveness of how eligibility is conducted, considering staffing costs and ongoing operational expenses; (vi) examine best practices in other states; and (vii) develop cost-effective options for enhancing eligibility determination in the Commonwealth including alternative delivery models. DMAS, the Department of Social Services, and LDSS shall provide full cooperation with the consultant and provide the necessary assistance to conduct the required evaluation.*

The consultant shall be required to report their findings and recommendations directly to the Governor, Department of Planning and Budget, and Chairs of the House Appropriations and Senate Finance and Appropriations Committees by December 15, 2024. The Director, Department of Planning and Budget, shall unallot this appropriation until the Department of Medical Assistance Services provides documentation of the contract's cost, and shall only allot the amount needed for the contract."

Should you have any questions or need additional information, please feel free to contact me at (804) 664-2660.

CJR/wrf

Enclosure

Pc: The Honorable Janet Kelly, Secretary of Health and Human Resources

CardinalCare
Virginia's Medicaid Program

DMAS

Evaluation of Medicaid Eligibility Determination

December 2024

Report Mandate:

Item 292.HH of Budget Bill HB30 states: Out of this appropriation, $500,000 from the general fund and $500,000 from nongeneral funds the first year shall be provided to the Department of Medical Assistance Services (DMAS) to hire a consultant, with Medicaid-specific knowledge related to eligibility determination, process-design and information technology, to evaluate Medicaid eligibility determination in the Commonwealth. The consultant shall conduct a systematic review and evaluate all aspects of Medicaid eligibility determination as performed by DMAS and local departments of social services (LDSS). This review shall include, but not be limited to, the following: (i) evaluate the current information technology systems; (ii) measure the accuracy, processing times and efficiency of current eligibility determination processes; (iii) determine how well the current structure and systems handle high volumes; (iv) assess the current level of automation and determine processes that could be streamlined; (v) analyze the overall cost-effectiveness of how eligibility is conducted, considering staffing costs and ongoing operational expenses; (vi) examine best practices in other states; and (vii) develop cost-effective options for enhancing eligibility determination in the Commonwealth including alternative delivery models. DMAS, the Department of Social Services, and LDSS shall provide full cooperation with the consultant and provide the necessary assistance to conduct the required evaluation. The consultant shall be required to report their findings and recommendations directly to the Governor, Department of Planning and Budget, and Chairs of the House Appropriations and Senate Finance and Appropriations Committees by December 15, 2024.

Evaluation of Medicaid Eligibility Determination

In compliance with Item 292.HH of Budget Bill HB30, this report presents a detailed assessment of Virginia's Medicaid Eligibility Determination processes and approach. Specifically, this report provides an overview of the current eligibility processes, methodology used for this assessment, a summary of strengths and challenges, solution options, and an appendix with additional supporting analysis and documentation. Throughout these sections, DMAS has addressed the General Assembly's requirements to conduct a systematic review which included, but was not limited to, the seven evaluation areas highlighted in Item 292.HH of Budget Bill HB30.

Table of Contents

1. Executive Summary

Virginia has contended with historic levels of change and growth in its Medicaid program in the last five years – driven from Medicaid expansion in 2019, the COVID-19 public health emergency (PHE) and resulting continuous eligibility requirements, and overall population and demographics changes. While growing access to Medicaid has come with many benefits for eligible Virginians, it also increased pressure on an already strained Medicaid eligibility determination system, impacting applicant experience and increasing the workload for eligibility teams across the Commonwealth.

Medicaid eligibility determination in the Commonwealth, similar to many states, struggles with fragmented responsibilities, outdated and inflexible technology, and underlying program complexity. Virginia is one of only 7 states with Medicaid eligibility being largely conducted and administered across 120 local department of social services agencies (LDSS) versus being centralized at the state level. Virginia is also one of 14 states where Medicaid eligibility is integrated with other social services, which gives Virginians the opportunity to apply for multiple benefits concurrently. While both features offer many benefits to Virginians, they also introduce coordination and complexity to the eligibility process. Despite the best efforts of those who administer, support, and apply for Medicaid, the experience of Medicaid eligibility in VA today is a maze of access points, variable processes, imperfect system interfaces, and confusing communication.

At the direction of the General Assembly, this assessment analyzed Medicaid eligibility determination across people and organizational structure, process, and technology and data systems. It leveraged 75+ interviews, 2 surveys (including one with over 1,300 staff), focus groups, data analysis, system testing, and external benchmarking research to assess the current program and identify potential improvements. Four themes emerged as critical to improve Medicaid eligibility:

1) Poor applicant experience with less digital, more manual processes

While Virginia exceeds the national average for Medicaid renewals with automatic verification ("ex parte"), it falls behind in other areas: 21% of new Modified Adjusted Gross Income (MAGI) applications take over 45 days to process (compared to 14% nationally), and only 19% are reviewed within 24 hours (compared to 43%).[1] This is partly due to a low rate of online applications: 40% in VA vs. 57% in NC, 63% in TN, and 79% in IN (states that have similarities with VA either because they have the same IT vendor, local administration of eligibility, and/or integration of benefits). CommonHelp, the main application digital portal in Virginia, offers a

[1] Centers for Medicare and Medicaid Services (CMS) MAGI Application Processing Time Snapshot, 01/2024-03/2024

poor user experience, driving applicants toward slower, manual methods like paper and phone. Even in those channels, applicants experience complex and difficult to understand paper application forms and notices, and the existence of multiple call centers and phone numbers create confusion for which path applicants can take. Only 14% of surveyed LDSS benefit programs specialists believe Virginians can navigate the eligibility process without significant challenges.

2) Outdated and inflexible technology systems

The Virginia Case Management System (VaCMS) – the main benefits eligibility IT system that processes applications and renewals – is based on 1990s era technologies that are heavily intertwined, making even small changes difficult and costly to make. LDSS agencies report many "outages" and technical errors with the system. Findings from system testing conducted for this assessment suggest system limitations such as timeouts and delays occur when the equivalent of 10-12% of LDSS eligibility staff (400 or more users) are processing cases concurrently. Further independent evaluation is warranted to understand drivers for these results. The system also has limited end to end real-time data reporting capabilities (beyond technical system performance) to provide state leaders with actionable information about eligibility determination. Poor user experience with VaCMS leads to the use of workarounds, further increasing variability in the process. Exacerbating these challenges with VaCMS is the Commonwealth's reliance on an external technology vendor to manage and operate the system without effective vendor management practices (e.g., absence of strong service level agreements limits Commonwealth's ability to make changes).

3) Insufficient governance structure across DMAS, VDSS, and LDSS agencies

Virginia's Medicaid eligibility governance structure creates complexities between state agencies and the 120 LDSS agencies. The Department of Medical Assistance Services (DMAS) oversees Medicaid overall, and its sister agency, the Virginia Department of Social Services (VDSS), oversees eligibility conducted by LDSS agencies and manages the eligibility IT system. This separation between DMAS and VDSS can create operational complexity, communication delays, and reduced visibility on performance. Challenges extend to the relationship between VDSS and LDSS agencies. VDSS has limited oversight over the Medicaid eligibility activities performed by LDSS agencies, with few mechanisms through which the Commonwealth can enforce eligibility process standards and performance expectations. Currently, the only performance target provided to LDSS agencies is completing 97% of Medicaid applications within federally required timelines. However, only 13 of 120 agencies (11%) meet this goal, and minimal supports are put in place to help the LDSS agencies achieve the target.

4) Inconsistency in eligibility processes and poor timeliness of applications

Medicaid eligibility processes and staff experiences vary greatly across the Commonwealth, impacting applicant experience and processing times. In the last year, Medicaid cases per worker ranged from 167 to 961 across LDSS agencies, a ~6x difference. A significant driver of this is the methodology used by VDSS to provide federal and state base funding to LDSS agencies, which does not reflect population growth or demographic changes since the formula was implemented 30 years ago. While additional federal funding can be drawn when agencies deplete their base, this comes at a higher local match (nearly 68%). Unfortunately, local governments have unequal resources to hire and pay staff, impacting turnover rates, and experience levels at LDSS agencies. These processes further differ between LDSS agencies and other channels (e.g., the DMAS CoverVA Call Center and the Virginia Insurance Marketplace) but evaluating differences is hampered by lack of comparable processing time data.

Strategies to improve Medicaid eligibility in Virginia

Virginia can take several steps— ranging from immediate actions to transformative approaches—to improve Medicaid eligibility effectiveness, timeliness, and user experience. Through benchmarking research, 10 strategies were identified to address the challenge areas above. **All 10 must be addressed to achieve significant improvement in the administration of the Medicaid eligibility;** however, there are different ways these strategies can be achieved, and this report also details specific options to achieve them.

1) Redesign and improve user experience: Best-in-class application portals and processes are built and operated with the end users (e.g., residents, staff) at the center of the design and operation. Given the poor Medicaid applicant experience today, the Commonwealth can pursue strategies to adopt a more digital, streamlined approach.

Strategy A:	**Strategy B:**
Enhance digital experience for applicants by adopting a 'digital first' channel strategy and leveraging live chat and AI-driven support tools.	Streamline processes, applications, notices, and written communications across channels ranging from establishing clear processes for routine updates to redesigning CommonHelp, the main application digital portal in Virginia, with human-centered design principles.

2) Invest in an improved technology ecosystem: Underpinning the ability to improve other process related challenges is an outdated and strained technology system driving delays, workarounds, and frustration for staff. The Commonwealth must invest in its technology infrastructure and processes (e.g., data and vendor management), to streamline processes.

Strategy C: Modernize VaCMS technology and processes by developing a shared "North Star" vision and conducting a full system diagnostic, initiating a comprehensive modernization journey, and establishing standardized DevOps processes.	**Strategy D:** Improve data and reporting capabilities through both staff and system upgrades.	**Strategy E:** Enhance management and governance of VaCMS IT vendors, by updating vendor contracts to align with best practices and establishing a vendor governance board.

3) Develop a stronger governance model across DMAS, VDSS, and LDSS: Strengthening ways of working and governance between state and local agencies is a key enabler to realizing improvements across the Medicaid eligibility system. The status quo in the Commonwealth will continue to complicate collaboration and oversight critically needed to maintain program consistency.

Strategy F: Strengthen collaboration between regional Medicaid consultants, VDSS, and DMAS leadership by institutionalizing collaboration between DMAS and VDSS and realigning central and regional Medicaid consultants to DMAS.	**Strategy G:** Increase collaboration between State and LDSS agencies by developing standardized performance metrics, incentives, as well as increasing the capacity of regional Medicaid consultants. More transformative options could consider de-integrating Medicaid eligibility from other benefit programs.

4) Drive consistency of accurate and timely processing: Variability in Medicaid eligibility continues to be a challenge in the current local administration of social services. The Commonwealth can explore ways to help LDSS agencies operate more efficiently, in a standardized way to improve outcomes for those they serve.

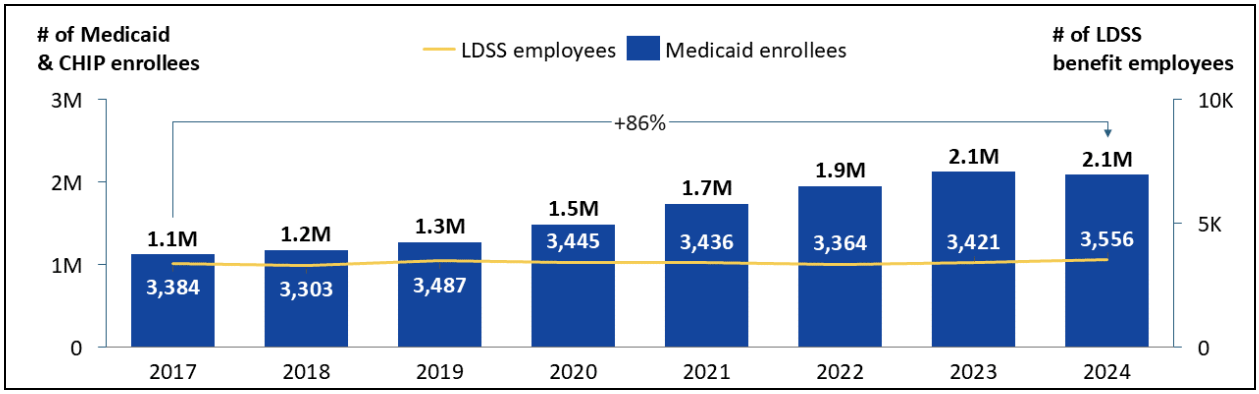
Strategy H: Identify, scale, and standardize best practices and processes by compiling a living best practices playbook and conducting end-to-end process redesign to standardize workflows.	**Strategy I:** Strengthen and develop LDSS workforce capacity and capabilities, such as by developing training content across levels, incorporating CoverVA representatives into training, and updating funding approach to LDSS agencies.	**Strategy J:** Balance workloads across Virginia and LDSS agencies, such as by facilitating work-sharing across LDSS agencies, providing central surge support, centralizing processing for certain application types, and /or centralizing specific steps of the eligibility determination process. Note, these options need to carefully consider impacts on the LDSS funding formula.

Overall, these strategies can significantly improve applicant and workforce experiences alike. Medicaid eligibility improvements will also benefit other integrated social services, allowing local and state teams to gain capacity for other high-need areas like child welfare all while improving eligibility outcomes for Virginians in need of affordable health care coverage.

2. Introduction

In recent years, the Commonwealth of Virginia has experienced historic levels of change and growth impacting the administration of its Medicaid program, which provides access to critical healthcare coverage for lower-income households and families, as well as qualifying adults who are over 65, disabled, or blind. From 2017 to 2023, Medicaid enrollment increased by over 86% or 1M members (to 2.1M) as more Virginians met eligibility income thresholds (see Figure 1).[2] This growth and change were primarily driven by the Commonwealth's 2019 Medicaid expansion, continuous eligibility provisions introduced by Center for Medicare and Medicaid (CMS) during the COVID-19 Public Health Emergency (PHE), and higher unemployment caused by the PHE.

Figure 1: Medicaid & Children's Health Insurance Program (CHIP) enrollment and Local Departments of Social Services (LDSS) employment between 2017 to 2024[3]



For context, Medicaid expansion in Virginia meant the adoption of the federal Affordable Care Act's (ACA) Modified Adjusted Gross Income (MAGI) eligibility category which allows states to receive federal match for covering adults under 65 in new expanded income groups. Enrollment numbers stayed high during the PHE because the federal government enacted the Families First Coronavirus Response Act (FFCRA) which established temporary continuous coverage, meaning anyone with Medicaid could keep it during the PHE without needing a periodic review (i.e., a "redetermination"). The federal government incentivized continuous coverage by providing an additional 6.2% federal match for Medicaid spending if states met these requirements during the PHE. However, this provision ended when the continuous coverage requirement was decoupled from the PHE via the federal Consolidated Appropriations Act. As of April 1, 2023, states resumed redeterminations for all Medicaid recipients, resulting in Virginia conducting

[2] DSS Human Resource (HR) Data, 2017-2024; DMAS Enrollment Report, 2017-2024; Note: LDSS benefit employees include LDSS Assistant Directors, Supervisors, Managers, and Employees

[3] DSS Human Resource (HR) Data, 2017-2024; DMAS Enrollment Report, 2017-2024; Note: LDSS benefit employees include LDSS Assistant Directors, Supervisors, Managers, and Employees

over 2.1 million Medicaid redeterminations in the last year.[4] This push to conduct redeterminations was called the "PHE Unwinding." Since Virginia's Medicaid expansion had started January 1, 2019 just before the COVID-19 pandemic, some new beneficiaries had never undergone a Medicaid annual redetermination before and the volume for benefits program specialists was unprecedented.

The recent surge in Medicaid enrollment, coupled with the PHE Unwinding, has further intensified the strain on the Commonwealth's already overburdened Medicaid eligibility determination system. LDSS agencies bear the brunt of this workload, processing over 80% of Medicaid applications and all renewals, while the remaining 20% is handled by the Cover Virginia Central Processing Unit and the Virginia Insurance Marketplace. Despite Medicaid enrollment growing by 86% (from 1.1 million to 2.1 million between 2017 and 2024), the LDSS workforce has only increased by 5% (from 3,384 to 3,556 employees)[5], leaving them stretched thin as they also manage other social services like Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). This misalignment between the rising demand for services and limited staff resources has led to mounting challenges.

Furthermore, the funding structure, heavily dependent on federal and local support, has restricted further workforce expansion. As a result, processing times for Medicaid applications under the MAGI criteria have been notably slow. In Q2 of 2024, 19% of MAGI applications took more than 45 days to process; this makes Virginia non-compliant with federal policy that requires MAGI applications be processed in 45 days and ranks it among the 10 slowest states. Additionally, only 21% of applications were processed within 24 hours, significantly below the national average of 44%.[6] If these processing times continue to worsen, Virginia risks being placed on a federal Corrective Action Plan by CMS, which could also result in financial penalties.

Improvements to the Medicaid eligibility system have great potential to enhance the experience for applicants and staff across the Commonwealth. Improving the accuracy and efficiency of eligibility processes for new applications and redeterminations is required for Virginia to fully realize this potential. In response to the General Assembly's request, this report provides a comprehensive assessment of Virginia's Medicaid eligibility determination system, looking across the people and organizational elements, processes, and IT / data systems involved in eligibility. It also provides a comparison to benchmarks and best practices of eligibility in other states. Finally, it provides a perspective on potential strategies and options for helping Virginia better deliver a more effective, accurate, and timely eligibility process.

[4] DMAS, Unwinding the COVID-19 Public Health Emergency: Medicaid Redetermination Plan, 06/2023

[5] DSS HR Data, 2017-2024; DMAS Enrollment Report, 2017-2024; Note: These figures exclude LDSS Directors; In 2017 and 2024, there were 116 and 118 Directors, respectively

[6] CMS MAGI Application Processing Time Snapshot Report, 04/2024-06/2024

3. Methodology

This assessment was conducted between August and October 2024 to address the seven evaluation areas requested by the General Assembly (see Figure 2). This assessment utilized an evaluative framework that looked across three key areas: people and organizational structure, process, and technology and data systems.

Figure 2: 7 Evaluation areas set by the General Assembly

07 Evaluation Areas	
01	Evaluate the current information technology systems
02	Measure the accuracy, processing times and efficiency of current eligibility determination processes
03	Determine how well the current structure and systems handle high volumes
04	Assess the current level of automation and determine processes that could be streamlined
05	Analyze the overall cost-effectiveness of how eligibility is conducted, considering staffing costs and ongoing operational expenses
06	Examine best practices in other states
07	Develop cost-effective options for enhancing eligibility determination in the Commonwealth including alternative delivery models

The assessment leveraged primary research approaches by gathering perspectives from interviews with over 75 stakeholders (e.g., Department of Medical Assistance Services (DMAS), Virginia Department of Social Services (VDSS), LDSS agencies, external stakeholders, and peer state agencies), a state-wide survey to all 120 LDSS agencies with 1,294 employee responses (out of a total of 3,674 employees), and a focus group with Virginia Health Care Foundation (VHCF) Medicaid outreach workers. Insights from interviews and surveys revealed critical pain points and potential solutions in the eligibility determination process for Medicaid. Primary research also included the review and analysis of relevant Commonwealth data sources such as Virginia Case Management System (VaCMS), CMS reporting, staffing volumes & vacancies, and requests for proposals (RFPs) from Virginia's eVA procurement databases. This assessment also conducted VaCMS performance testing by running scenarios mimicking real-world eligibility worker behavior and workloads at various capacities (40, 400, and 3000 active users processing cases).

The assessment also incorporated secondary research from external sources such as Kaiser Family Foundation (KFF), CMS, and US Census data. This research helped to shape interview guides and surveys, supplemented interview findings, and informed potential strategies for alternative administration models. Secondary research also included identifying eligibility best practices from other states and benchmarking seven comparable states: Kentucky, Colorado, Pennsylvania, Ohio, North Carolina, Georgia, and Tennessee. Specifically, benchmark research included nine interviews with experts from other states.

See Section 8.1 in the Appendix for additional details on the assessment's methodology

4. Overview of Virginia's Medicaid Eligibility Determination

Background on Medicaid Eligibility

Medicaid in Virginia today provides health coverage to certain adults, children, pregnant women, individuals ages 65 and older, and people with disabilities. Eligibility for Medicaid is based on financial and non-financial factors (e.g., status as a child, pregnant woman, or other eligibility category) as well as need (e.g., receiving long term services and supports).

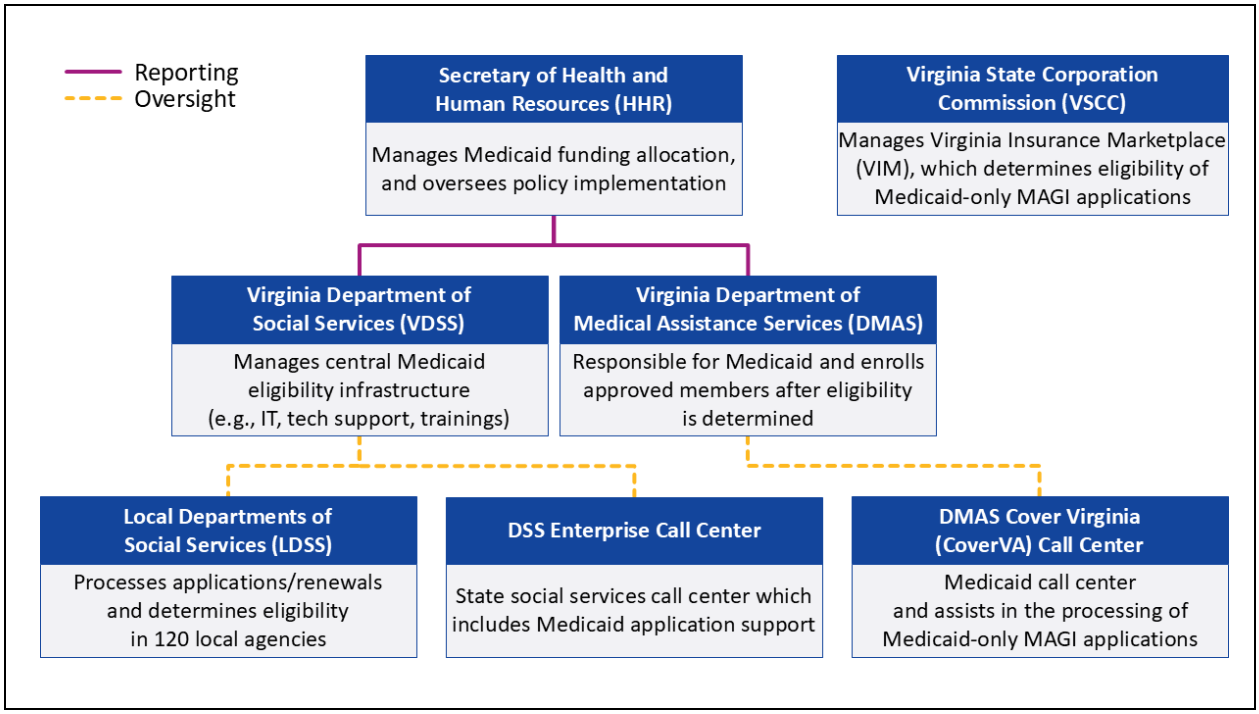
MAGI Applications: MAGI is the methodology set by the federal government for how an individual's income is counted and how family size is determined. Different income thresholds using MAGI income are used to determine Medicaid eligibility for children, pregnant women, and non-disabled adults. For example, in Virginia, children and pregnant women qualify for Medicaid with incomes up to 148% of the federal poverty level (FPL) and 205% FPL for Family Access to Medical Insurance Security (FAMIS) coverage, while non-disabled adult applicants (Medicaid Expansion) qualify with incomes up to 138% FPL.[7] Financial eligibility for children, pregnant women, and non-disabled adults only considers income, not assets. These applications are often referred to as MAGI applications and typically are faster and simpler to process than non-MAGI applications as they are largely based on income thresholds.

Non-MAGI Applications: Applicants who are aged 65 and older, blind, or disabled (ABD) and those applying for long term services and supports (i.e., long term care (LTC) applicants) must meet two types of financial requirements: income and assets. These applicants must also meet non-financial requirements such as age, level of disability, or the verified need for long term services and supports. Since these applications require a review of more than the applicant's gross income, they are referred to as non-MAGI applications. Given the nuances and complexities of the additional eligibility requirements, these applications typically take additional time and effort to review and determine eligibility.

[7] According to DMAS Eligibility website as of 10/2024

People & Organizational Structure of Medicaid Eligibility Determination in Virginia

Figure 3: Organizational chart of Medicaid eligibility determination in Virginia



DMAS is the state agency within Virginia's **Health and Human Resources (HHR)** secretariat that administers Medicaid and FAMIS programs, including oversight and compliance with CMS eligibility requirements. To support eligibility determination processes, DMAS works with **VDSS** (also part of HHR), the **Virginia Insurance Marketplace (VIM)** and contracts with a third-party vendor to run the **DMAS Cover Virginia (CoverVA) Call Center.**

Through a memorandum of understanding (MOU) with DMAS, VDSS is responsible for coordinating Medicaid eligibility policies with DMAS, offering technical assistance, training, and guidance on Medicaid eligibility policies and procedures to **LDSS agencies**, and overseeing the eligibility determination process in LDSS agencies (while also overseeing other social services and benefit programs). VDSS manages five regional offices, each staffed with a regional Medicaid consultant who supports local agencies with Medicaid eligibility. VDSS also manages infrastructure for processing applications, including VaCMS, the technology system used by eligibility workers to manage applications and determine eligibility, the applicant-facing CommonHelp portal, and the statewide DSS Enterprise Call Center that accepts applications.

There are **120 LDSS agencies** within Virginia. LDSS agencies are categorized into levels based on size, with Level I agencies being the smallest and Level III agencies being the largest.[8] LDSS agencies process Medicaid applications and redeterminations, as outlined in §62.3-501 of the Code of Virginia. LDSS agencies employ 3,556 people involved in the eligibility processes, and staffing levels vary across agencies.[9] While they have a statutory relationship and receive both state and federal funding from VDSS, LDSS agencies are ultimately accountable to their local governments. LDSS agencies also handle eligibility for other benefit programs such as SNAP, TANF, childcare, and energy assistance. 68% of surveyed benefit programs specialists report spending less than 50% of their time on Medicaid, meaning the majority of them serve as generalists supporting multiple social services programs.[10]

Since transitioning from the federally-facilitated marketplace in 2023, the state-based **Virginia Insurance Marketplace,** managed by Virginia's State Corporation Commission (SCC), determines financial assistance including federal premium subsidies and cost sharing reductions for residents who purchase private Qualified Health Plans through the marketplace. Virginia is a determination state, meaning the Virginia Insurance Marketplace can also automatically determine Medicaid eligibility for applicants who qualify for Medicaid under MAGI rules.

Finally, the **DMAS CoverVA Call Center** is run by a third-party vendor, Maximus, that operates the statewide Medicaid eligibility call center and a central processing unit (CPU) to assist in processing Medicaid MAGI applications. There is a federal CMS requirement that all states have a process for accepting telephonic applications, which the DMAS CoverVA Call Center fulfills.[11] DMAS CoverVA Call Center also handles applications for applicants in correctional facilities through the CoverVA Incarcerated Unit (CVIU).

See Section 8.4 in the Appendix for additional details on Virginia Medicaid eligibility stakeholders

[8] Each LDSS agency is assigned a level based on the size of their agencies; There are 33 Level I agencies, 59 LDSS Level II agencies, and 28 Level III agencies. Levels for each LDSS agency listed in Appendix 8.8

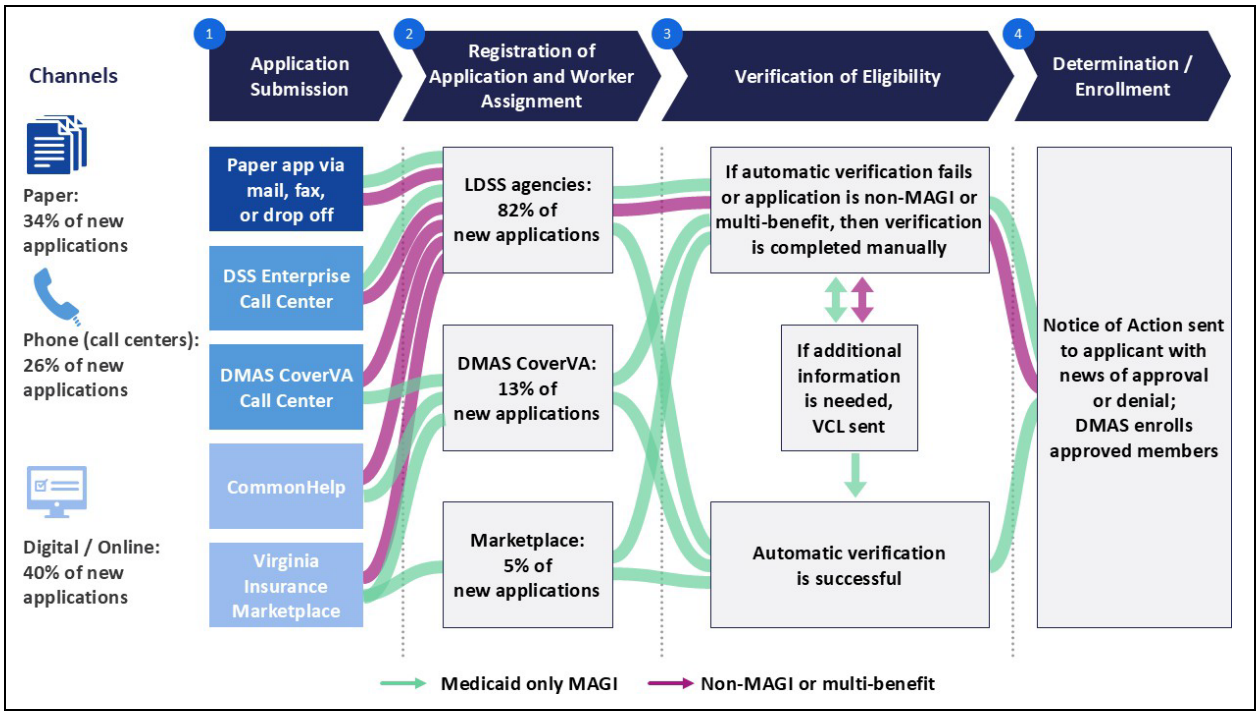
[9] 3,556 excludes 118 LDSS Directors

[10] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)

[11] According to CMS Informational bulletin "Ensuring Timely and Accurate Medicaid and CHIP Eligibility Determinations at Application," 05/2024

Process

Figure 4: New application flow across Virginia Medicaid eligibility channels



New applications: Virginia's Medicaid eligibility process for new applications involves four key steps outlined below. While these are the four standard steps taken in Virginia (as well as many other states in accordance with CMS policy), there are varying paths the process takes within each step, which can be mapped to challenges in the Commonwealth's eligibility system. Additional details on the challenges resulting from variability in these steps are described in Section 5 of this report.

1. **Application submission:** Applicants can submit applications through three primary channels: (i) paper submissions via mail, fax, or in-person at LDSS offices, (ii) phone applications through the DSS Enterprise or DMAS CoverVA Call Centers, and (iii) online applications using platforms such as CommonHelp or the Virginia Insurance Marketplace. Between January and July 2024, approximately 34% of Medicaid applications were submitted by paper, 26% by phone, and 40% digitally. [12] Virginia's integrated benefit eligibility system also allows applicants to apply for other social benefits, such as TANF and SNAP, alongside Medicaid.

[12] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024

2. **Registration of application and worker assignment:** All applications submitted online are loaded into VaCMS. Applications submitted telephonically are manually inputted into VaCMS with a process called Rapid Data Entry (RDE). Applications entered through RDE will enter a "Self-Direct" process to automatically verify eligibility.[13] LDSS benefit programs specialists can manually enter paper applications as well as those received through the LDSS email, fax, or in person. LDSS agencies then have the choice to utilize RDE or Application Registration (AR) to load the application into VaCMS. For applications going through LDSS and CoverVA, a worker is assigned to the application to begin supporting verification where needed.
3. **Verification of eligibility:** Once applications in VaCMS are assigned to a LDSS or CoverVA eligibility worker (i.e., this term includes LDSS benefit programs specialist and CoverVA eligibility worker), they can verify the application automatically or manually to see if it meets financial (e.g. income and asset thresholds – see Figure 4 above) and any relevant non-financial requirements (e.g., existing coverage, functional screening for ABD / LTC applicants). For applications submitted online or inputted through RDE, the system will attempt to register the application and determine eligibility through the automated Self-Direct process. If the automated process fails, the case will be assigned for manual review and verification. MAGI applications will be sent to CoverVA and non-MAGI/ multi-benefit applications will be sent to LDSS agencies. If additional information is needed, eligibility workers request further information (i.e., a verification check list "VCL"). This request is sent out via mail and by CommonHelp if the applicant opted into receiving digital correspondence. Applicants can then submit additional information via CommonHelp, by fax, by mail, or in-person.
4. **Determination / enrollment:** Once the benefit programs specialist or system determines eligibility, VaCMS generates and sends a status notification called the Notice of Action via mail to the applicant informing them of the outcome. If approved, the applicant is enrolled in Medicaid. If denied, the notice includes the reasons for denial and information on appeal rights, nondiscrimination language, and language/disability access information.

Per federal policy, 42 CFR 435.912, state Medicaid agencies must process all Medicaid applications within 45 days, or within 90 days if a disability determination is required (given the increased number of requirements that must be satisfied). In Virginia, MAGI applications are

[13] Note that all applications will be first attempted using the self-direct process but may fail due to being a non-MAGI and/or a multi-benefit application.

processed within a median of 13 days while Non-MAGI applications often take longer to process, a median of 41 days.[14]

Renewals: For renewals, existing Medicaid beneficiaries are automatically processed 2 months before renewal is due through a process called ex parte. The ex parte process allows Virginia to confirm a beneficiary's Medicaid eligibility without requiring the beneficiary to submit documentation or complete a form. Instead, the Commonwealth can use information that is already available to them, such as electronic income verification sources or information from other programs. 62% of renewals were approved ex parte in Virginia. All renewals are federally required to be first attempted ex parte; if the ex parte process does not lead to an automatic renewal, beneficiaries must complete and submit a pre-filled renewal form. Beneficiaries can submit renewal forms digitally through CommonHelp, by phone, or by paper (mail, fax, or drop-off). These renewals are processed by LDSS offices and largely follow a similar registration, verification of eligibility, and determination / enrollment path as new applications.

See Section 8.4 in the Appendix for additional details on the process for new applications and renewals

Technology & Data Systems

The IT system used to process Medicaid and other social benefit (e.g., SNAP, TANF, energy assistance) applications and renewals is VaCMS. VaCMS is owned by VDSS but operated and maintained by a third party vendor, Deloitte. The system supports intake, verification, and eligibility determination processes, integrating data from eligibility application channels to make determinations and manage caseloads across Virginia's 120 LDSS agencies. CommonHelp is the applicant facing portal and is technically an application that sits on top of the VaCMS system and feeds applicant information for Medicaid (and other social benefits) into VaCMS.

VDSS contracted with Deloitte in late 2012 to modernize the existing automated eligibility system called the Application Benefit Delivery Automation Project to meet the requirements from the 2010 Federal Affordable Care Act that offered enhanced Federal financial participation for Medicaid technology investments.[15] Due to Commonwealth requirements imposed by the Virginia Information Technologies Agency (VITA), these 2012-2013 replacement efforts were built on an existing technology infrastructure that was developed in late 1990s and early 2000s.

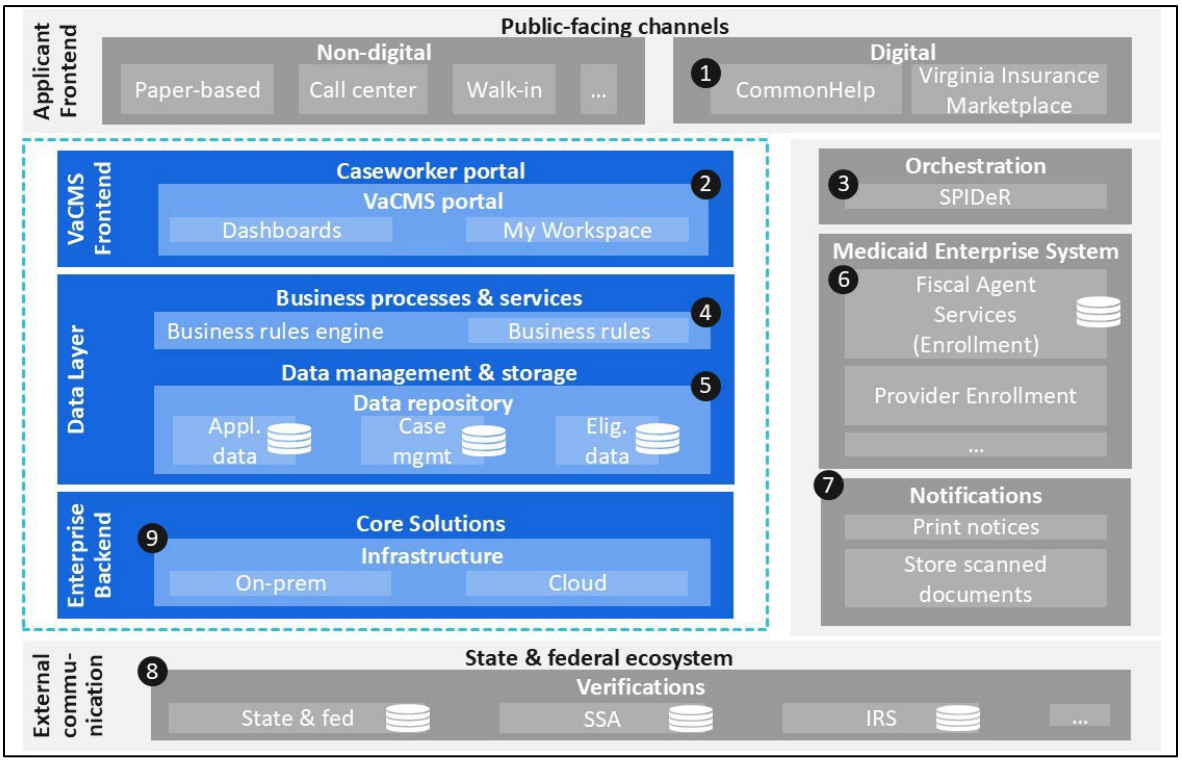
[14] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024

[15] Office of the State Inspector General Report, "Virginia Department of Social Services: Implementation of Virginia Case Management System," 03/2018

The core of VaCMS is its rules engine comprised of business rules and services, which use IBM's Websphere Application Server and WebSphere Operational Decision Manager (WODM Rules Server), now both part of the IBM Operational Decision Manager (ODM) suite. ODM was first available in the early 2000s, and WebSphere in 1998. These solutions were originally built to support the on-premise, monolithic systems considered best-in-class at the time. Though still functional today, newer cloud-native decision automation solutions provide the scalability and flexibility required to meet the modern demands of Medicaid systems. Additionally, the development tools that VaCMS depends on for updates and releases place constraints on the pace and scope of system improvements. Not only are these tools not designed for the rapid development and deployment models seen in modern DevOps environments, but they also result in siloed development operations and place constraints on the extent to which automation can be leveraged for software changes. The ongoing expenses related to system fixes and maintenance are substantial and exceed the projected cost of implementing a replacement solution.

In maintaining VaCMS for Medicaid eligibility and other social benefits, VDSS also interacts with other Commonwealth agencies. First, it communicates with the DMAS' Medicaid Enterprise System (MES). DMAS is responsible for MES, which is the separate system used to enroll applicants determined eligible for Medicaid (i.e., VaCMS does eligibility only while MES does enrollment). Second, it complies with VITA's IT standards and security policies. VITA sets IT standards and policies, plays a role in IT procurement and investment approvals, and manages Executive branch agency system infrastructure, or the lower layers of the technology stack. VDSS is responsible for managing all other layers of their technology stack in accordance with VITA IT policies, such as protecting DSS data that traverses the eligibility system.

Figure 5: Technology landscape for VaCMS

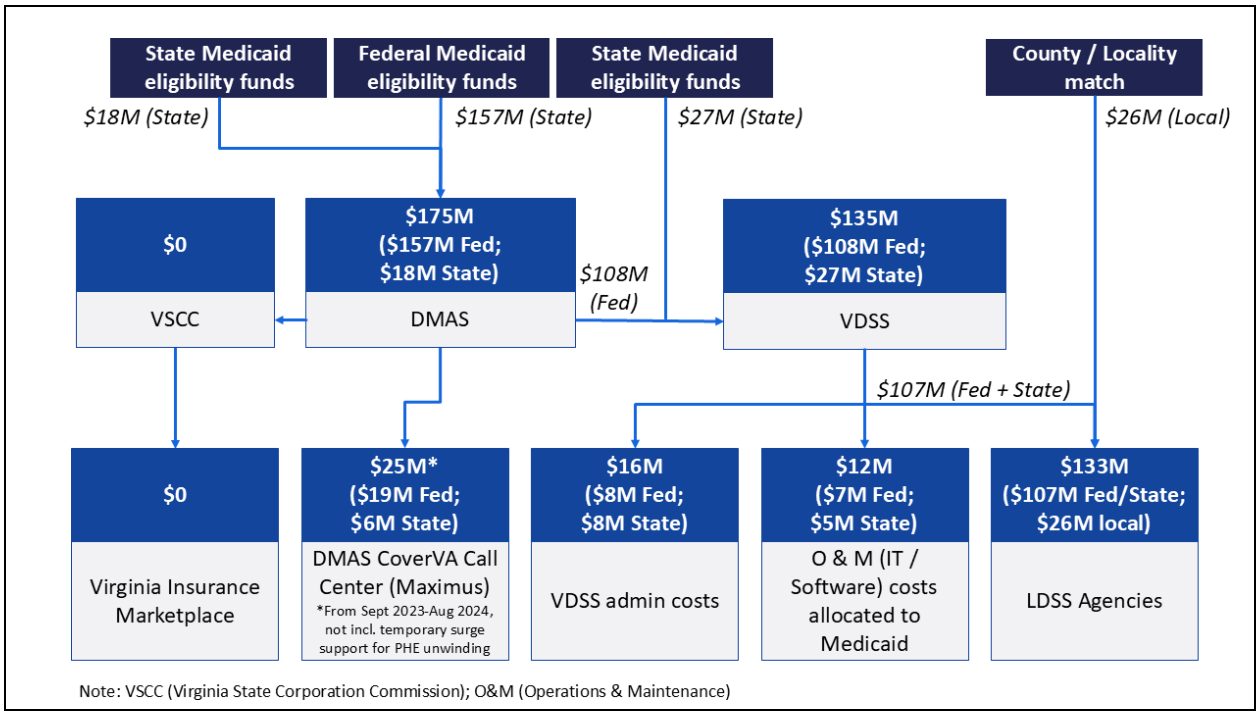


External to VaCMS VaCMS system components Indicates system boundary

1	Virginia applicants submit Medicaid applications through VDSS website's **CommonHelp portal**
2	Applications submitted in CommonHelp appear in **VaCMS portal** where caseworkers begin processing
3	Simultaneously, **SPIDeR** begins orchestrating preliminary verifications and records matching
4	The **business rules engine** provides logic to inform application processing workflows, decisions
5	Data is stored and retrieved as needed from **VaCMS databases** housed within the data repository
6	Data is exchanged with the **enrollment system & mainframe within the Fiscal Agent Services module of** Medicaid Enterprise System
7	**Notices** from VaCMS and Medicaid Enterprise System are generated and printed on demand; documents scanned and uploaded are retrieved
8	Application data is matched and verified with **state and federal databases** and sources to inform determinations
9	**VITA-managed infrastructure** houses the VACMS system, enables network connectivity

Medicaid Eligibility Funding Flows

Figure 6: Overview of Medicaid eligibility funding flows in FY2023[16]



Medicaid financing is inherently complex, particularly in the 7 states (i.e., Virginia, California, Colorado, Georgia, Minnesota, North Carolina, and North Dakota), where Medicaid is locally administered. In Virginia, Medicaid eligibility determination is funded by Federal, Commonwealth, and county/locality sources, with total Medicaid eligibility funding amounting to $228M in Commonwealth fiscal year (FY) 2023. All Federal funding for Medicaid eligibility staff, operations, and system development is managed by DMAS who distributes it to DMAS CoverVA Call Center and VDSS. Depending on the eligibility activity, CMS provides a federal funding match that typically ranges from 50% to 75% for Medicaid eligibility costs. State funding that acts as the state match to this federal funding goes to both DMAS and VDSS to cover VDSS administrative costs, eligibility IT systems, and local LDSS eligibility staff and operations for Medicaid eligibility. Counties and localities also contribute their own funds to

[16] Sources: DMAS Billing – Medicaid Federal Fiscal Year Summary, FY2023; DMAS CoverVA Call Center Monthly Invoice Binders, 09/2023 – 08/2024; CMS-64 Medicaid Financial Mgmt Report, FY2023; DSS Statewide Financial Summary, FY2023
Notes: VSCC has received one-off reimbursements for the federal portion of their Equifax contract and initial costs to set up Account Transfer logic within the VaCMS system, but they are not currently systematically reimbursed for Medicaid determinations; $12M is not comprehensive of all O&M costs (e.g., Medicaid specific change requests)

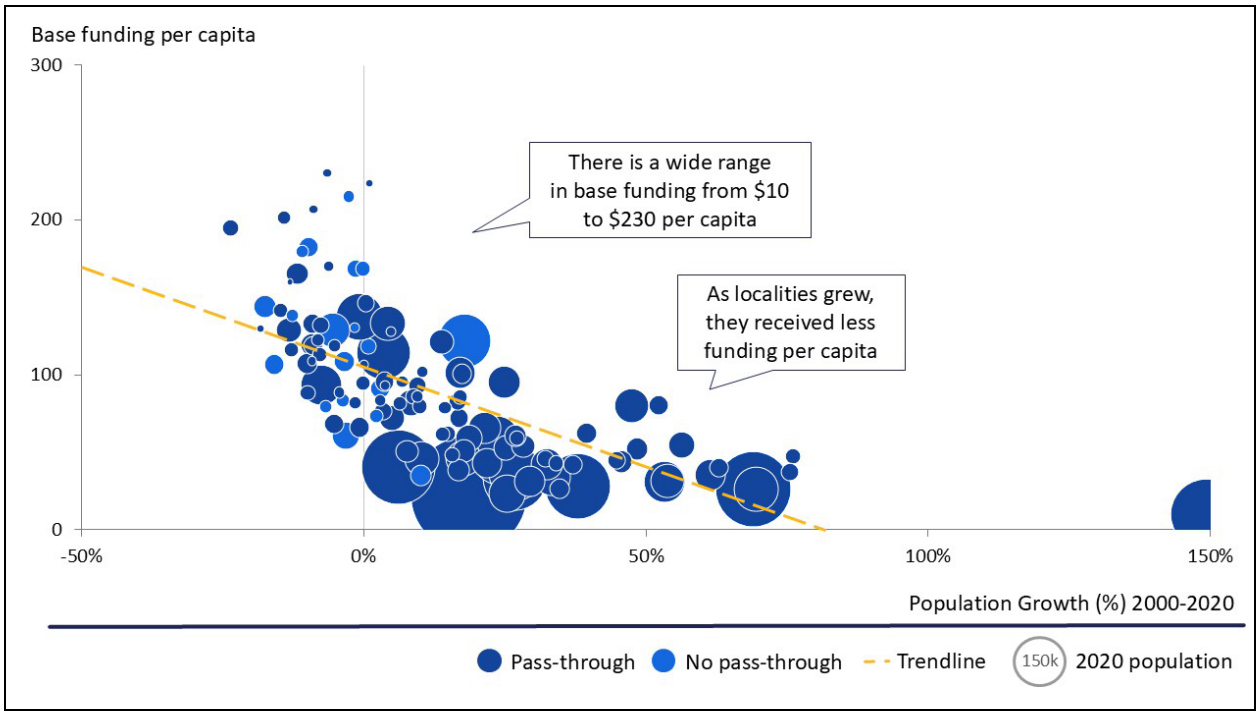
support local LDSS eligibility staff and operations, with a portion of that dedicated to Medicaid activities.

For integrated eligibility activities that support Medicaid, SNAP, TANF (etc.), Viriginia is required to distinguish how much of each shared activity benefits each program to appropriately claim federal reimbursement. To account for how much of LDSS spending goes toward Medicaid activities in an integrated benefit eligibility system, VDSS uses Random Moment Sampling (RMS) in which LDSS staff report on a quarterly basis the share of time they spend on Medicaid and other social services. This data is captured across all LDSS eligibility staff statewide, and a statewide average is determined for the percent of time spent on Medicaid. VDSS then uses this percent to allocate and report what share of its funding to allocate to Medicaid. This informs what VDSS invoices DMAS for Medicaid eligibility and helps VA comply with federal (CMS) cost allocation reporting requirements. In 2024, the Medicaid share was roughly 20% of VDSS funding.[17]

The funding each LDSS agency receives from VDSS to support eligibility staff and operations for all benefit programs, including Medicaid, comes in two forms: base funding and pass-through funding. The base funding is a fixed dollar amount which was determined over 30 years ago and has not been updated to reflect demographic shifts. For base funding, federal funding accounts for 54%, the Commonwealth provides 30%, and counties / localities must contribute a 15.5% match to receive it.[18] Due to the outdated funding methodology, 100 out of 120 LDSS agencies exhaust their base funds before the end of the fiscal year, with some doing so only a few months into the year.[19] As the base funding does not reflect recent demographic shifts, localities that have grown in the last few decades receive lower per capita funding compared to those that have had declining populations (see Figure 7 below).

[17] DSS RMS Statistics, 10/2023 - 09/2024
[18] DSS Statewide Financial Summary, FY2023
[19] LDSS Cost Allocation Reports, FY2023

Figure 7: Correlation between population growth and base funding per capita[20]



When LDSS agencies exhaust their base funding, they can access additional pass-through funding, which consists of 32.1% federal funds and requires counties or localities to cover the remaining 67.9%. The federal match rate is lower for pass-through funding as benefit eligibility line items (e.g., Medicaid which has a 50% federal match) are combined with services line items (e.g., that have a lower 12.5% federal match), resulting in a blended rate of 32.1%. The Commonwealth does not contribute to these pass-through funds. Due to the higher cost to localities, some local boards do not approve additional LDSS staff positions that would trigger the need for additional pass-through funding.

Finally, while funding for Medicaid eligibility determination is distributed across the state and LDSS agencies, the risk of incorrect determinations is not. If inaccurate eligibility processing occurs, CMS can choose to impose financial penalties on a state's Medicaid agency. That means in Virginia, DMAS is ultimately the responsible party for such financial penalties. In the event penalties are imposed, DMAS must return federal funds to CMS. However, DMAS does not have a process to "pass on" this cost and penalty to VDSS or LDSS agencies which may be responsible for the incorrect processing.

[20] State and LDSS Cost Allocation Reports; US Census Bureau, 2000-2020; LDSS Cost Allocation Reports, FY2023

Cost Comparisons of Medicaid Eligibility Across Channels

Across each of the entities involved in Medicaid eligibility (LDSS agencies, the DMAS CoverVA Call Center, and the Virginia Insurance Marketplace), there are significant differences in the volume of eligibility activity, scope of eligibility activity, overall costs, and performance. Actionable conclusions cannot be fairly drawn from currently available information, particularly due to the lack of comparable performance data (e.g., processing time by channel). However, there are differences in resourcing and volume of activity that warrant further consideration as the Commonwealth considers cost effectiveness in eligibility determinations. Below is a description of the activities, volume, and funding associated with each of the entities (see Figure 8)

- LDSS agencies handle the broadest scope processing ~720k application and renewal determinations annually. LDSS agencies also complete determinations for other benefit programs and provide in-person and telephonic customer service to Virginians. Funding for Medicaid-related staff and operations totaled ~$166M in FY2024.
- DMAS's CoverVA Call Center can receive all application types, although it is only authorized to assist with processing MAGI, Medicaid-only applications. All other application types are routed to LDSS agencies (during the PHE unwinding, CoverVA temporarily assisted with renewals). DMAS CoverVA also runs a call center that intakes Medicaid applications, telephonic renewals, telephonic reports of changes from members, and answers questions for Virginians. CoverVA's central processing unit assists with ~70k determinations annually, ~10% the volume of LDSS agencies. Funding from September 2023 through August 2024 totaled $25M. Note: this is not inclusive of an additional $19.5M in this same timeframe when CoverVA scaled up rapidly during the PHE unwinding by standing up a team of 245 eligibility staff when asked to temporarily assist with renewals during unwinding.
- The Virginia Insurance Marketplace has the narrowest volume and scope of work, processing ~21k Medicaid-only, MAGI applications annually, solely via automated processes. The Virginia SCC estimates about $5M in Medicaid-related costs in FY2024.

Figure 8: Comparison of scope of work, funding, and volume across LDSS agencies, Cover Virginia, and the Virginia Insurance Marketplace[21]

	LDSS Agency	DMAS CoverVA Call Center	VA Insurance Marketplace
Scope of Work	**Large/ broad scope:** All application & renewals for all benefit programs	**Medium scope:** MAGI + Medicaid-only applications; renewals during unwinding; Incarcerated Unit	**Narrow scope:** MAGI + Medicaid-only applications
FY2024 Costs	**~$166M:** Local staff and ops for Medicaid benefits	**~$25M*:** Call center, incarcerated unit, and central processing unit	**~$5M:** Estimated costs by VSCC
FY2024 Production *(Excludes ~600k ex-parte renewals)*	**~720k determinations** (~350k applications; ~370k non-exparte renewals) **~95k Rapid data entries (RDE)**	**~70k determinations** (~55k CPU and CVIU applications; ~15k non-exparte renewals) **~145k RDEs, and ~26k transfers to LDSS**	**~21k determinations** (~21k applications) **~43k transfers to LDSS & CoverVA**

*From Sept 2023-Aug 2024, not incl. temporary surge support for PHE unwinding

Cost Impact of Overdue Renewals

Delays in renewal redeterminations contribute to additional per-member-per-month (PMPM) spending on beneficiaries who remain on Medicaid and may no longer meet eligibility requirements. Delays were especially pronounced during the recent PHE unwinding, when DMAS and VDSS worked to redetermine all 2.1M Medicaid enrollees. The unwinding period highlighted existing challenges with overdue renewals demonstrating that they can lead to significant deviations between forecasted enrollment and actual enrollment (due to ineligible Medicaid members remaining enrolled beyond their forecasted date). As a result of delayed redeterminations and changes to what had been originally forecasted by DMAS, an additional $194M in supplemental payments needed to be carried over from the FY2024 to the FY2025 state general budget (see Figure 9 below from the October 15th, 2024 Virginia Senate Finance & Appropriations Committee, in which the red bars, which indicate the difference between forecasted and actual enrollment, represent the $194M in supplemental payments).[22]

[21] DSS Medicaid Invoices to DMAS, 09/2023 – 06/2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, Medicaid Renewal Report considering 06/2024 - 09/2025; Monthly Reporting Metrics, 2024; DMAS CoverVA Call Center Monthly Invoices, 2024; DMAS CoverVA Call Center Annual Ops, 2023 Report; VA Insurance Marketplace applications processed count, 11/2023 – 09/2024; Expert interviews

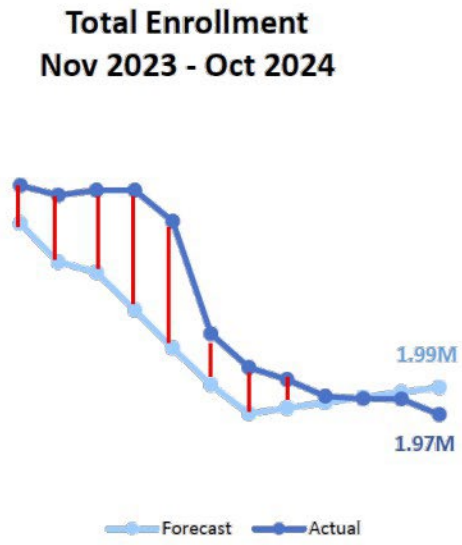
[22] Commonwealth's Senate Finance & Appropriations Committee on 10/15/2024

Figure 9: Background exhibit presented by DMAS to the Commonwealth's Senate Finance & Appropriations Committee on October 15, 2024[23]

Enrollment as of 10/1/2024

Selected Categories	Forecast	Latest	Variance*
Non-Long Term Care (LTC)	148,455	141,572	-6,883
LTC Nursing Facilities	20,752	19,241	-1,511
LTC HCBS	58,915	62,278	3,363
Caretaker Adults	141,083	138,667	-2,416
Pregnant Women	27,170	28,342	1,172
Children	588,242	582,384	-5,858
Expansion - Caretaker	139,411	128,436	-10,975
Expansion - Non-Caretaker	511,829	485,674	-26,155
Title XIX Total	**1,813,414**	**1,776,517**	**-36,897**
MCHIP	83,040	96,148	13,108
FAMIS Kids	85,614	92,766	7,152
FAMIS MOMS	3,424	4,181	757
Title XXI Total	**176,880**	**197,489**	**20,609**
Total Enrollment	**1,990,294**	**1,974,006**	**-16,288**

**Variance = + / - 10% of forecast*



While forecasting has improved in more recent months, there continue to be budgetary impacts from ongoing overdue renewals. As of October 2024, over 71K renewals were overdue across the Commonwealth. Every month roughly 150,000 Medicaid members must be redetermined, gradually adding to the existing backlog.[24]

[23] Commonwealth's Senate Finance & Appropriations Committee on 10/15/2024

[24] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024; DMAS Eligibility Redetermination Tracker, 10/2024 – Note pulled from 10/16/2024 report date

5. Assessment of Virginia's Medicaid Eligibility Determination

As this assessment examined the various people, process, and tech/data system components of the Commonwealth's Medicaid eligibility determination efforts, several strengths and challenges were identified. While there are challenges to be addressed, it is important to first note where Virginia performs comparably better than other states in certain areas of Medicaid eligibility. These include:

- **No wrong door**: Virginia offers multiple channels for Medicaid applications (e.g., LDSS agencies, CommonHelp, the DMAS CoverVA Call Center, the Virginia Insurance Marketplace, and a centralized DSS Enterprise Call Center) to meet federal requirements related to multiple application sources. Some states do not offer as many channels, reducing access points for their residents. For example, North Carolina lacks a centralized call center, putting the burden on local agencies to maintain capabilities to receive telephonic applications (which is a CMS requirement all states must meet).
- **Procedural terminations**: During unwinding, Virginia disenrolled 55% because of procedural or administrative reasons, much lower than 69% nationally.[25]
- **Ex parte:** Virginia conducted a higher percentage of renewals through its ex parte process than the national average (62% vs. 50% nationally) in Q1 2024.[26]

In addition to these benchmarks, interviews and surveys of stakeholders in Virginia's eligibility process highlighted the following areas where they find the process effective for them:

- **DMAS and VDSS Task Force**: In preparation for the Medicaid unwinding process, the Secretary of Health and Human Resources convened a task force between DMAS and VDSS starting in January 2022. The task force met monthly, improved data transparency between stakeholders, and built alignment on key actions, such as unified communication to LDSS agencies to address PHE unwinding operations. This success was driven by clear objectives and collaboration, particularly in managing the redetermination process and increased ex parte determinations by 12%.[27]
- **Reporting and Collaboration**: More than 75% of LDSS workers report having access to reporting that enables them to monitor their caseload for Medicaid applications; and over half of LDSS workers report having effective collaboration among their local agency staff in supporting eligibility determinations. [28]

[25] KFF, "An Examination of Medicaid Renewal Outcomes and Enrollment Changes at the End of the Unwinding," 09/2024
[26] CMS, "April 2024 Medicaid and CHIP CAA Reporting Metrics," 07/2024
[27] Based on pre-March 2020 ex parte baseline of 50% from October 2023 Virigina Task Force on Medicaid Eligibility Redeterminations Report Out and April 2024 ex parte of 62%
[28] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)

- **Regional Medicaid Consultants**: According to LDSS supervisors, VDSS regional Medicaid consultants provide useful knowledge to LDSS benefit programs specialists and help them better evaluate complex applications.

Virginia can build on these strengths to bolster its Medicaid eligibility efforts. However, this assessment revealed there are significant pain points despite these strengths. These pain points culminate into four key challenge areas that require attention from the Commonwealth:

Figure 10: Summary of challenge areas and pain points that emerged from assessment

1. Poor applicant experience with less digital, more manual processes	2. Outdated and inflexible technology systems	3. Insufficient governance structure across DMAS, VDSS, and LDSS agencies	4. Inconsistency in eligibility processes and poor timeliness of applications
• Application forms, processes, & user-interface systems are **not intuitive and difficult for applicants to navigate** • Only **~40% of new applications are submitted digitally,** lagging peer states (57% in NC, 63% in TN, and 79% in IN)	• VaCMS is based on **legacy, monolithic infrastructure,** making it difficult and costly to update and modernize • **Data gaps and limitations** are a barrier to understanding system performance • **Heavy reliance on tech vendor with few accountability clauses** in vendor contract limits flexibility / control and increases costs	• Current operating model and ways of working lead to **accountability & collaboration issues** between DMAS and VDSS, as well as between State and LDSS agencies • Performance reporting from State and LDSS agencies is **not standardized, and leaders do not have consistent visibility** to inform efforts to support & oversee LDSS agencies	• Existing processes and systems are **not user-friendly for LDSS staff** leading them to create their own workarounds • LDSS agencies have **workforce capacity and capability gaps**

Challenge Area #1: Poor Applicant Experience with Less Digital, More Manual Processes

While Virginia's "no wrong door" offers multiple channels for accessing eligibility, the user experience varies across these channels and lacks the application of best practices in human-centered design to ensure an efficient, accurate, timely, and positive experience for applicants, staff, and other stakeholders.

Key pain points observed in this area include:

The application forms and notices are complex and difficult to understand

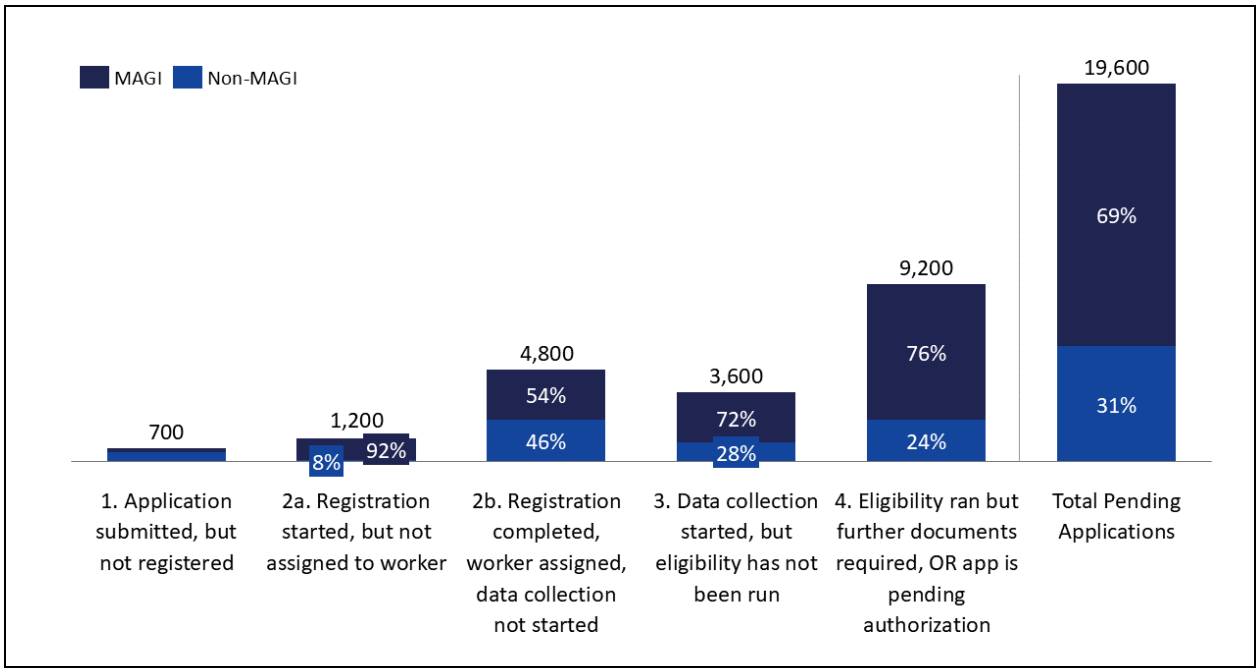
- Benefits program specialists and stakeholders report that legal jargon confuses applicants and causes incomplete submissions and errors. For example, according to interviews with the Virginia League of Social Services Executive (VLSSE), LDSS agencies often see around 20% of applications that do not have signatures in the right place.
- Only 14% of LDSS workers surveyed agreed with the statement "Eligible Virginians are able to successfully navigate the Medicaid eligibility determination process without significant challenges".[29]

Current communication methods between applicants and LDSS staff add time to processing and create delayed responses

- Virginia is ranked amongst the bottom ten states in terms of timely mail deliveries, yet staff primarily use mail to communicate with applicants and beneficiaries.[30]
- In September 2024, LDSS benefit programs specialists waited an average of 15+ days to receive additional information from applicants for 25% of pending (i.e., not fully processed) applications in the last step eligibility determination (see Figure 11 below).[31]
- According to VHCF outreach workers, mail deliveries sometimes lead to applicants receiving verification checklists to provide additional information at or after deadlines. LDSS directors noted that this delay is in part a result of mail system delays. For instance, centralized VDSS mail goes to Lynchburg for printing but is then sent out of state to Greensboro, North Carolina for sorting and mailing.

[29] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)
[30] USPS Service Performance Dashboard, FY2024
[31] VDSS Appmetric Report, 09/15/2024

Figure 11: Overview of pending (i.e., not fully processed) applications per process stage and application type[32]



Multiple entry points make the process confusing for Virginians to navigate

- There are multiple websites managed by different stakeholders (VDSS, DMAS, each LDSS, the DMAS CoverVA Call Center, and the Virginia Insurance Marketplace) that have outdated or conflicting information creating confusion for potential applicants on what is the source of truth.
- There are four phone different hotlines with different phone numbers for applicants, creating confusion on their differences and which one an applicant should use.
- Applicants get confused when they apply through one channel (e.g., the health insurance marketplace), but receive requests for information through another (e.g., the LDSS office).[33]

Low digital uptake driving application and notification communication through lower channels

- 40% of new Medicaid applications are submitted digitally, with 34% through CommonHelp and 6% via the Virginia Insurance Marketplace. This proportion is low

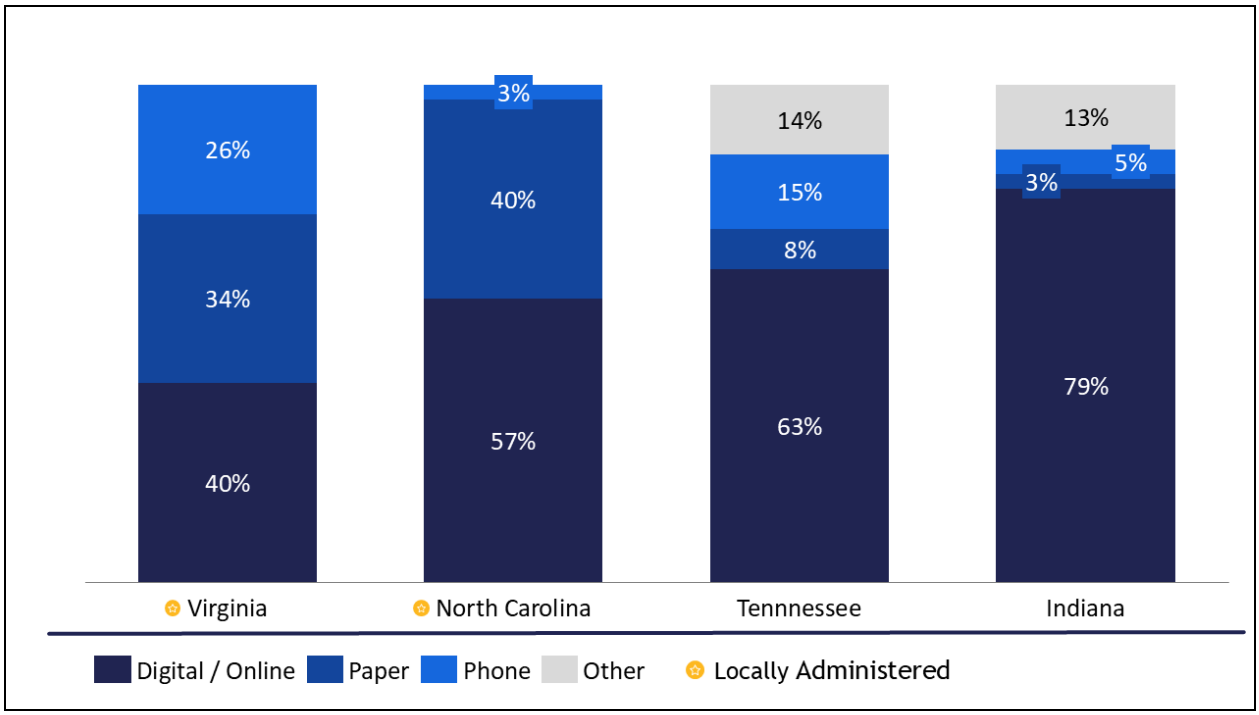
[32] VDSS Appmetric Report, 09/15/2024; In Appmetric Report Stage 0 corresponds to Step 1 on this slide, Stage 1.2 corresponds to Step 2a, Stage 2 corresponds to Step 2b, Stage 3.1 corresponds to Step 3, Stage 3.2 corresponds to Step 4

[33] Interviews with LDSS Directors and Staff, 08/2024-10/2024

compared to 57% in North Carolina, 63% in Tennessee, and 79% in Indiana (see Figure 12).

- Only 20% of VHCF outreach workers, who specialize in eligibility applications and are very familiar with CommonHelp, submit documents via CommonHelp when assisting applicants due to system complexity and delays.[34]
- 77% of Virginians request notifications by mail only compared to a minority who choose to be alerted to notifications by email or text (15% by email and 8% by phone).[35]

Figure 12: New applications by channel mix (%)[36]



[34] VHCF Outreach Worker Survey, 09/2024 (n=26)
[35] DSS Internal Report on Individuals Requesting Notifications, 08/2024
[36] Note: Digital / online incl. applications transferred electronically from exchange; While digital is 40% of Medicaid, it's ~15% of all social services apps; Source: Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024; NC: Expert Interview, 11/2023 – 09/2024; TN: Expert Interview, 01/2024 – 07/2024; IN: Expert Interview, 08/2024

Challenge Area #2: Outdated and Inflexible Technology Systems

Like many states with an integrated benefit eligibility structure and local administration, Virginia relies on VaCMS as a tool to establish a rules-based approach to making eligibility determinations across the Commonwealth. However, both VaCMS and the CommonHelp portal (which is applicant-facing) currently create a number of pain points for applicants, LDSS workers, and state staff that interact with the systems. As a result, the systems are challenged to support more automated, consistent, and timely outcomes on Medicaid eligibility determination. It is important to note that while this assessment focused on Medicaid eligibility, the challenges observed have implications across other benefits which these systems support. Key pain points observed in this area include:

VaCMS is based on legacy (30+ year-old), monolithic technology infrastructure, making it difficult and costly to update and modernize

- In a recent Systems Integration (SI) and operations and maintenance (O&M) RFP for the VaCMS system VDSS described the system as follows: "The legacy technologies on which the systems are built are outdated and "siloed," vertically integrated to support delivery of a defined and narrow range of services and not well-integrated with other processes and systems that deliver related services to the same community." [37]
- VaCMS is a legacy system that is heavily dependent on tools and components that no longer adequately support today's software development processes or business needs. Many of the core technologies in VaCMS were first introduced decades ago: Oracle databases date back to 1979, the operating system to the 1980s, and the rules engine likely to the early 2000s. While some modern tools have been implemented, their effectiveness is limited by dependencies on outdated infrastructure. This tooling and infrastructure additionally contribute to longer development operations release cycles to implement fixes to the system, as VaCMS supports a limited set of modern automation capabilities.
- The VaCMS core is monolithic, or so tightly integrated that small errors or changes can bring down the whole system quickly, and minor changes are time- and cost-intensive. As policy evolves and the volume of applicants and data grows, scaling the monolithic components of the system will be costly and complex.
- In contrast with newly modularized Medicaid Enterprise System (MES) which handles enrollment, Virginia's eligibility determination system lacks resilience, lengthens eligibility processes, and increases risk of operational and business disruption. Repeat audit findings on data access reviews and least privilege (e.g., only allowing access to

[37] DSS Salesforce System Integrator RFP #ITS-22-051, 2023

users necessary to accomplish assigned tasks), record retention, and proactive risk management indicate that security, privacy & compliance considerations require more attention.[38]

- Lack of a shared future-state vision or long-term strategy to modernize and maintain the system supporting Medicaid (and other benefit programs) results in in a fragmented and complex technology landscape that lacks standardization and acts as a barrier to operational efficiency, agility, and realizing a return on technology investments.

Performance testing of the VaCMS non-production test system suggests capacity and performance limitations of the production VaCMS

- Results from independent system testing on VaCMS's testing system conducted for this assessment identified over 40% of users disconnect from this system due to timeouts and errors when approaching up to the equivalent of 400 concurrent users in VaCMS. The 60% who complete transactions face delays across most pages in the system, particularly those requiring VaCMS to gather data from multiple places.
- When approaching the real-world equivalent of ~3,000 concurrent users in the testing system, results indicate that more than 75% will timeout, disconnecting the browser. For the 25% who are not disconnected, they face delays across all pages in the system, and may wait up to 2-3 minutes, and up to 10 minutes between each separate interaction (e.g., a click of a page). If this remains true in the production environment, this would make it difficult for the state to set fair minimum processing standards for workers.
- While there were several limitations and time constraints on the testing conducted for this effort, results warrant further independent evaluation as they were conducted on VaCMS's non-production systems which may have configuration differences from production, and they imply VaCMS may have an average response time of up to 50,000 milliseconds. Whereas in other Medicaid and government systems average response times are closer to about 4,000 milliseconds, and best-in-class private sector examples (such as Netflix, Facebook, Google) operate under 100 milliseconds.[39]
- Prior to this assessment, comprehensive performance testing on the non-production system was conducted in May 2023 by the operations and maintenance vendor. Bringing in independent evaluator periodically is best practice when performance

[38] Office of the Comptroller Commonwealth of Virginia Single Audit Report, 06/2023, Office of the Comptroller Commonwealth of Virginia Single Audit Report Corrective Action Plan, 03/2024; Office of the Comptroller Report on Statewide Financial Management and Compliance for the Quarter Ended March, 2024

[39] BCG benchmarking and analysis

testing and stress testing a system. Additionally, the non-production system must be configured so that it is a real-world replica of the production system.

Data gaps and limitations are a barrier to reporting and understanding eligibility determination performance

- There is limited centralized or cross-LDSS agency data governance in place to standardize, mandate, or enforce data policy across the eligibility determination lifecycle. Interviews, survey responses, and documentation collected during this assessment did not support the existence of robust technical controls related to application data exceptions, overwriting, or software-enabled workarounds to maintain data quality.
- Although some real-time data capabilities have been introduced, VaCMS still relies heavily on scheduled or delayed exchanges and processing of data, which limits real-time responsiveness, scalability, and data accuracy. For example, account transfers from the Virginia Insurance Marketplace are submitted by a daily batch at night, adding delays to enrolling members who have received eligibility determinations instantly.
- Data discrepancies observed across eligibility (VaCMS) & enrollment (DMAS' MES) systems result in a lack of authoritative 'system of record', limiting record traceability and longitudinal insights due to challenges retaining a unique ID for each client. Consequently, this lack of authoritative system of record creates additional burdens for DMAS when validating and preparing tracking reports to CMS.
- A lack of self-service capabilities for accessing data and generating reports leaves agencies dependent on the VaCMS vendor, causing delays and limiting access to operational data. This can also trigger additional costs to the Commonwealth.
- VDSS has a limited number of staff with strong data capabilities, hindering the ability to comprehensively manage data, produce actionable insights and support decision making. VDSS is beginning to address these gaps with new hires in continuous quality improvement (CQI) teams, but additional work is needed to develop actionable data insights.

Heavy reliance on tech vendor and few accountability clauses in vendor contract limits flexibility / control and increases costs

- Commonwealth eligibility stakeholders are highly dependent on the VaCMS vendor because of few effective accountability clauses in the vendor's contracts and a small team of VDSS staff with limited bandwidth to successfully oversee and evaluate vendor timelines and costs.

- Service Level Agreements (SLAs) are not being utilized as extensively as in other states. Indiana uses SLAs to establish reasonable vendor performance standards, include O&M patches under protected fixed costs (e.g., implementing Windows patches) and drive fast resolution of incidents. Instead, Virginia's VaCMS O&M contract leaves the door open for ongoing change orders to keep up with any necessary policy / program change:

> Excluded from Supplier's base scope of Maintenance and Support activities is any enhancement assistance that may be required to provide ongoing policy and program changes from the state and/or federal entities and any changes that occur relating to software and hardware versions necessitating changes to the VaCMS Application
>
> **- Virginia's VaCMS O&M Contract**

- Virginia has a small and under resourced team to provide oversight and control over the IT system vendor. Other states have stronger vendor management processes, for example:
    - North Carolina brought their NC FAST system in-house and only use RFPs for major technical transformations
    - Rhode Island hired teams of staff and external experts to validate vendor assertions and hold routine governance forums to oversee and review system changes in a rigorous and standardized manner
- Transactional nature of state-vendor ways of working, coupled with contractual gaps has resulted in a backlog of requests that is extensive. As of December 2023, VaCMS recorded over 200 remaining enhancements out of 570 that need to be prioritized and implemented over the next 3-5 years to meet federal compliance requirements.[40]

Challenge Area #3: Insufficient Governance Structure across DMAS, VDSS, and LDSS Agencies

While the PHE unwinding period prompted DMAS and VDSS to collaborate effectively on redeterminations, the current ways of working and operating model leads to accountability and collaboration breakdowns between DMAS and VDSS, as well as between DMAS/ VDSS and LDSS agencies.

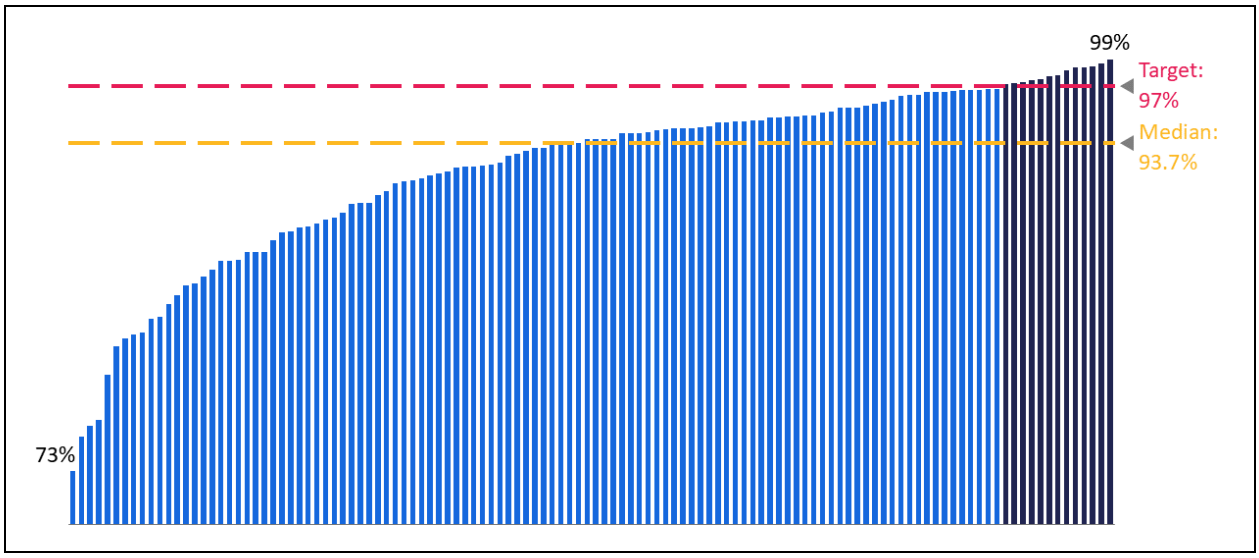
[40] VDSS IT Strategic Plan for 2024-2026 (December 5, 2023)

Key pain points observed in this area include:

The current ways of working and operating model lead to accountability and collaboration roadblocks between DMAS and VDSS, as well as between the State and LDSS agencies on Medicaid eligibility

- While DMAS is responsible for adhering to federal regulations, it has limited visibility into performance at the local level given VDSS controls funding that goes to LDSS agencies as well as data reporting from the VaCMS system. While state leaders interviewed in this assessment indicated recent PHE unwinding task force efforts improved communication and visibility between VDSS and DMAS, routine reporting and visibility into LDSS agency performance on Medicaid eligibility determination remains limited. Most DMAS leaders interviewed for this assessment report having to make multiple requests and navigating the VDSS organization to answer questions on Medicaid eligibility.
- The structure of local Medicaid eligibility administration at LDSS agencies, which report to local county governments (e.g., county boards), makes it inherently more challenging for the Commonwealth to maintain visibility and oversight of Medicaid eligibility. Other than withholding reimbursement for administrative expenses granted by §63.2-408 in the Code of Virginia (which could exacerbate issues if applicants do not have alternative resources), VDSS has limited oversight and accountability over LDSS agencies. VDSS has authority to issue Corrective Action Plans; however, they have not conducted any in the last ~18 months for Medicaid eligibility. This timeframe coincided with the PHE unwinding efforts that created unprecedented demand and circumstances for LDSS agencies, and therefore Corrective Action Plans were not a priority for VDSS but are an available lever for oversight going forward.
- VDSS set a 97% compliance target for Medicaid timeliness for all agencies; however, only 13 of 120 LDSS agencies (11%) had an average rate at or above the 97% compliance target in the first half of 2024 (see Figure 13 below). Beyond this compliance target, there are no clear expectations for what defines good performance for LDSS agencies and no routine standard report card view that can help agencies understand how they perform relative to others. For example, efforts to identify processing times by application type for each LDSS agency and compare them were not feasible during this assessment due to data tracking limitations. Other states like NC use report card views to establish oversight and set expectations between the state and LDSS agencies. In NC, these are also used to identify when corrective action plans are necessary.

Figure 13: Percentage of Medicaid applications processed under federal processing deadlines by LDSS agency[41]

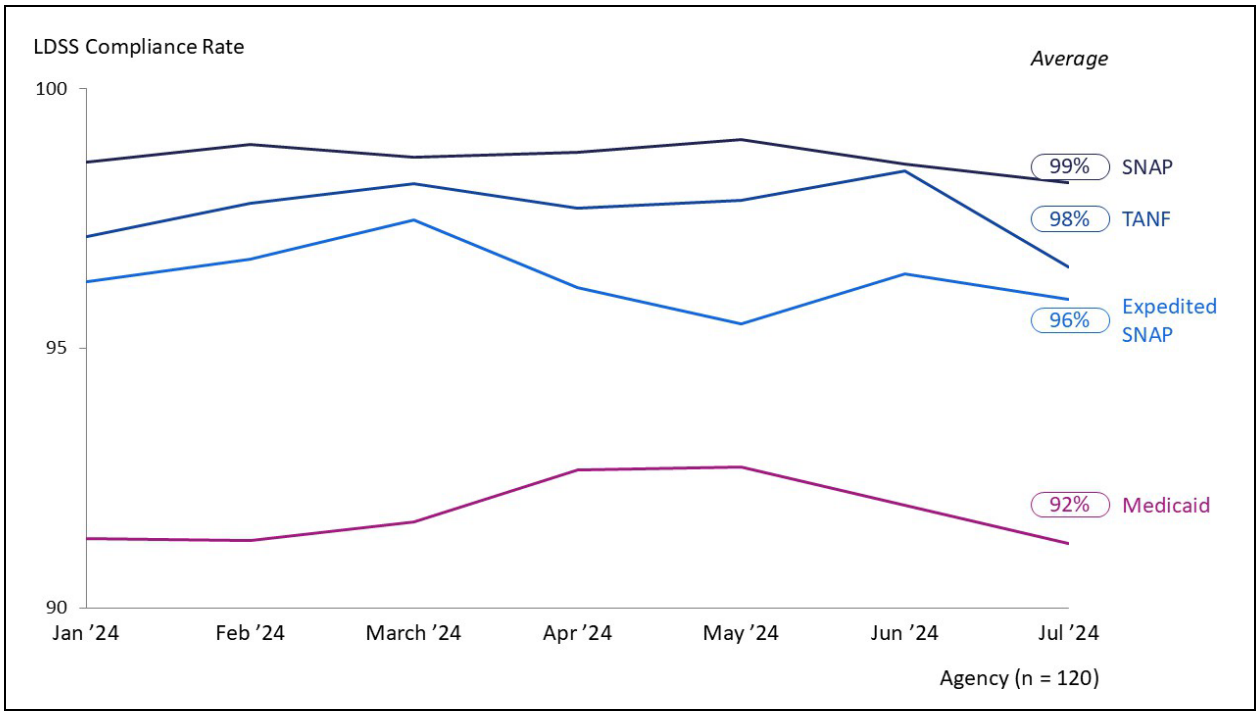


LDSS agencies prioritize other programs like SNAP and TANF over Medicaid, impacting Medicaid eligibility determination timeliness

- Average monthly compliance rates of SNAP (~99%), expedited SNAP (~96%), and TANF (~98%) surpass Medicaid's rate of ~92% (see Figure 14 below).[42]
- Medicaid is inherently more complex than many other social services programs as there are several different eligibility categories with different income thresholds and other requirements. However, LDSS workers largely report spending time on more than just Medicaid: 68% of LDSS workers in a recent survey reported spending less than half their time on more Medicaid.[43] This means they support Medicaid, SNAP, TANF, and many other social services benefits and must understand the intricate eligibility requirements and policies for each.
- SNAP is often prioritized over Medicaid due to the 7-day processing requirement at the federal level for expedited SNAP and the enforcement of federal penalties for delays and errors.

[41] Performance Improvement and Measurement Reporting (PIMR) Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024
[42] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024
[43] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)

Figure 14: LDSS Application timeliness rates for SNAP, expedited SNAP, TANF, and Medicaid[44]



Processes and resources differ across the 120 LDSS agencies

- The 120 agencies exhibit wide variability in vacancy rates (0-56%), number of workers per supervisor (2-74), percentage of applications in each month that are pending (12-65%), and median caseloads (e.g., applications and renewals) per worker (167-961) (see Figure 15 below).[45]
- Existing processes and systems are not user-friendly for eligibility staff, causing them to develop their own workarounds. This leads to inconsistent experiences for both applicants and staff, resulting in variability in Medicaid timeliness compliance rates across LDSS agencies (73% to 99%).[46]

[44] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024
[45] DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025
[46] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024

Figure 15: Performance and workforce variability by agency level and across all agencies[47]

	Level I (n=33)	Level II (n=59)	Level III (n=28)	Range and averages across all 120 LDSS agencies
Performance				
PIMR LDSS MA timeliness rate	92.9%	92.5%	89.3%	**73-99% (91.8%)**
Average % of applications currently pending vs. resolved in Sept '24	40%	43%	44%	**12-65% (43%)**
Workforce				
MA cases per worker / year	339	345	401	**136-796 (356)**
Vacancy rate	17%	10%	16%	**0-56% (16%)**
Workers per supervisor	5.3	8.7	10.8	**2-74 (8.5)**
% of surveyed LDSS staff who said current workforce capacity to manage Medicaid caseload is not sufficient	41%	53%	74%	**62%**

Regional Medicaid consultants (who are VDSS staff) provide oversight and support to LDSS agencies, but are overstretched

- LDSS does not directly report to VDSS but to their local / county governments. VDSS's regional Medicaid consultants act as the primary conduit between the state and local agencies. They update LDSS agencies on the latest Medicaid determination policies, answer questions on complex applications, and track metrics.
- Due to challenges in existing eligibility processes, Medicaid consultants report spending up to a quarter of their time on VaCMS tech escalations, reducing their ability to support and provide more substantive oversight on non-tech needs.[48]
- Further, the number of VDSS regional consultants has not changed in recent years as Medicaid enrollment has increased. The ratio of five Medicaid consultants for 120 LDSS agencies is also lower than equivalents in peer states. For example, NC has 13 staff in an equivalent regional consultant role for 100 agencies and GA has 14 for 159 counties.

[47] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024; BCG Survey of all LDSS Agencies, 09/2024 (n=1294); DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025; Level for each LDSS agency can be found in Appendix 8.8

[48] Interview with VDSS regional Medicaid consultants, 09/2024

Challenge Area #4: Inconsistency in Eligibility Processes and Poor Timeliness of Applications

While Virginia currently demonstrates a higher percentage of ex parte renewals than the national average, challenges exist in achieving consistent, accurate, and timely processing of new applications and non-ex parte renewals. Currently, 21% of MAGI applications take more than 45 days to process (compared to 14% nationally), and only 19% are reviewed within 24 hours (versus 43% nationally).[49]

Key pain points observed in this area include:

Existing processes & systems are not user-friendly for eligibility staff, leading them to workarounds and process variability

- When LDSS workers run into issues or are confused about how to use the VaCMS system, some report using workarounds to move a case forward.
- Over an 11-month period from August 2023 to June 2024, 11,292 VaCMS tickets were submitted due to substandard user interface, performance/interface challenges, and backend data reconciliation issues between systems. [50]
- LDSS agency staff report that VaCMS outages impact their ability to access the system and process cases.
- CoverVA, which assists with processing of MAGI-only applications, is responsible for sending non-MAGI applications they receive to LDSS agencies via VaCMS. Some LDSS agency staff report receiving these non-MAGI applications late (sometimes right around the deadline). The causes for the delayed receipt of these applications vary from potential issues with VaCMS, CoverVA

> "When VaCMS prevents someone from moving forward in the determination process, a LDSS worker will sometimes force VaCMS into proceeding by inputting incorrect information. The LDSS worker will then document what is incorrect and return at a later time to correct the application.
>
> **-Director at LDSS agency**

> "VaCMS reliability is often my biggest challenge with my current caseload. Often, I am deep within the case and [VaCMS] will timeout, kicking me completely out. The times where we are experiencing lagging takes a lot of time out of my day, making it difficult to process things from start to finish in one sitting.
>
> **-LDSS Benefit Programs Specialist**

[49] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024
[50] VaCMS RFP-72036 "VaCMS Operations and Maintenance and Enhancements"

operational delays, or incomplete and incorrect information provided by applicants (e.g., applicants that seem to be MAGI end up being non-MAGI and therefore out of scope for CoverVA).

Efforts to integrate and automate determinations do not always increase LDSS worker capacity or efficiency as intended

> If you are an agency that has sufficient staffing and dedicated intake staff who has capacity, then RDE can be a time saver. However as none of my agencies have that level of staffing, RDE is a duplication of efforts. Agencies will also avoid utilizing RDE as it starts the self-direct process which can sometimes cause more problems as well.
>
> **-Regional Medicaid Consultant**

- After manually inputting applications into VaCMS via RDE, Medicaid-only, MAGI applications can be automatically verified for eligibility. However, if the automatic system fails due to incomplete or incorrect information from the applicant or if the application is a duplicate application submitted through a different channel, then some LDSS agencies manually input the paper application into AR. Therefore, some LDSS benefit programs specialists will hedge against potential RDE issues by skipping RDE and just using AR.
- 65% of LDSS staff strongly disagree or disagree that process bottlenecks rarely occur in the Medicaid eligibility determination process.[51]

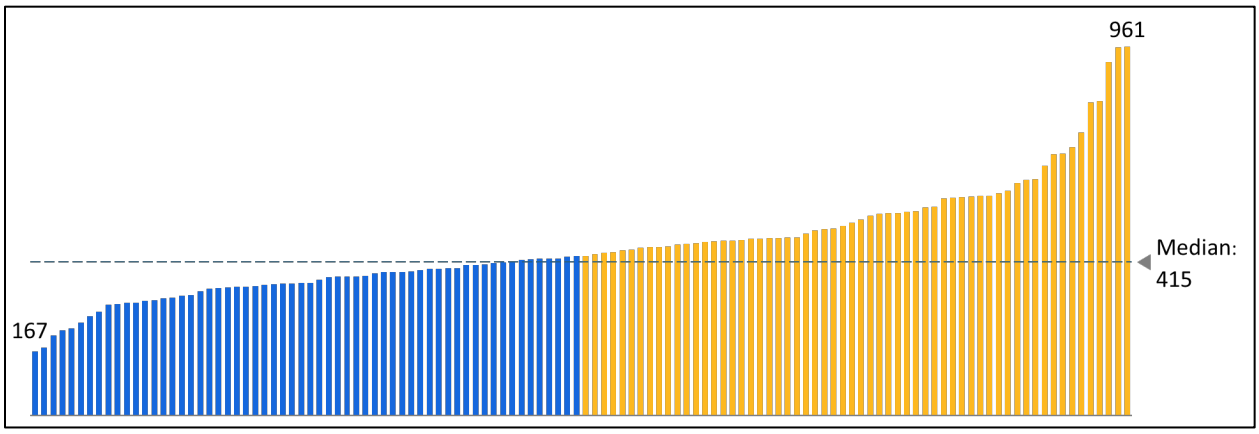
LDSS agencies have varying degrees of workforce capacity and capability gaps that are impacting processing times

- LDSS benefit worker capacity (incl. benefit programs specialist, managers, supervisors) has not kept up to increase in Medicaid enrollment as average caseload per worker has more than doubled from 198 in 2017 to 415 in 2024[52,53]
- Caseloads per worker varies widely from 167 to 961 across LDSS agencies (see Figure 16 below)[54]

[51] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)
[52] JLARC Medicaid Expansion: Eligibility Determination Commission Briefing, 10/2019
[53] DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025
[54] Ibid.

- ~55% of applications assigned to a benefit programs specialist and have had no action taken, have been open for over 16 days.[55]
- 62% of LDSS staff report insufficient workforce capacity to manage Medicaid eligibility caseloads.[56] Turnover rates average 18% across all LDSS agencies.[57]
- LDSS agencies also have varying wages for the same roles, making it more difficult for agencies with lower salaries (and less budget) to compete for talent. For example, Level I agencies' median salary is $54.9K and Level III agencies' median salary is $63.9K.[58]
- Only 42% of LDSS staff agree that the provided Medicaid eligibility determination training allows them to successfully do their job. Workers also report that training focuses primarily on MAGI applications – despite over half of LDSS workers surveyed process at least some non-MAGI.[59]

Figure 16: Average annual Medicaid caseload per worker across 120 LDSS agencies[60]



See Section 8.5 in the Appendix for additional details on strengths and challenges across the People & Organizational Structure, Process, and Technology & Data System framework

[55] VDSS Appmetric Report, 09/15/2024
[56] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)
[57] DSS HR Data, 2024
[58] Ibid.
[59] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)
[60] DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025

6. Strategies & Options

To sufficiently address each of the four challenge areas described in Section 5, this assessment proposes 10 strategies to improve Medicaid eligibility determination. Each strategy has a range of options for how it can be achieved. These options range from core improvements to longer-term transformational changes and have varying tradeoffs. **However, all challenge areas and strategies must be addressed in some way to make meaningful improvement on the overall eligibility system**. Specifically, investing in an improved technology ecosystem and modernizing VaCMS is integral to a digital-first strategy that enhances the overall experience for applicants. It is also a key enabler for other process improvement efforts to drive greater consistency across Medicaid eligibility processes in the Commonwealth. Moreover, developing stronger governance and collaboration models will also be foundational to any process improvement and user experience strategies. All these strategies are interconnected and if the Commonwealth only pursues a few piecemeal, incremental options it will not adequately target all the drivers of its current challenges. The strategies and a summary of the options are described in Figure 17 and the descriptions below. Note that some of the options included are denoted as transformational changes versus the others which are core enhancements. Transformational changes would require a longer-term significant change from the status quo, whereas the other options are core enhancements or improvements to the status quo.

Additionally, section 8.2 in the Appendix provides detailed descriptions and considerations on options' potential impact, required resources, estimated timelines, risks, and interdependencies. Option timelines were considered independently of one another (given uncertainty which options the state might choose to pursue). However, a comprehensive roadmap to address all 10 of these strategies will be needed and such a comprehensive plan will inherently have an impact on specific timelines of each option given interdependencies that exist. To take this on, Option 12 to institutionalize a joint DMAS-VDSS Steering Committee is a key enabler to provide the governance structure to develop such a roadmap.

Figure 17: Strategies and options to achieve each of the 4 challenge areas

Strategies	Options (● = Longer-term, transformational change)
1. Redesign and improve user experience	
A. Enhance digital experience for applicants	**1.** Adopt 'digital first' channel strategy (including self-service tablets and mobile) and enhance digital communications **2.** Develop live chat support/AI-driven assistance to guide applicants ●
B. Streamline processes, applications, notices, and written communications across channels	**3.** Redesign applications, notices, mail communication, and websites with human-centered design principles; build applicant facing digital support **4.** Connect applicant-facing eligibility channels with streamlined phone numbers and websites, improve handoff coordination, and consolidate call centers **5.** Redesign CommonHelp, leveraging human-centered design principles ●
2. Invest in an improved technology ecosystem	
C. Modernize VaCMS technology and processes	**6.** Develop a shared "North Star" vision for VaCMS and conduct a full system diagnostic ● **7.** Initiate a comprehensive modernization journey for VaCMS ● **8.** Establish standardized DevOps and product management processes ●
D. Improve data and reporting capabilities	**9.** Stand up a data team, define shared data roles and responsibilities, and establish/ centralize data governance **10.** Onboard Master Data Management solution and reconcile systems of record ●
E. Enhance management and governance of IT vendors	**11.** Enhance management and governance of VaCMS IT vendors
3. Develop a stronger governance model across DMAS, VDSS, and LDSS	
F. Strengthen collaboration between regional Medicaid consultants, VDSS, and DMAS leadership	**12.** Design and institutionalize a joint DMAS-VDSS Steering Committee on Medicaid Eligibility **13.** Realign central and regional Medicaid consultants to DMAS
G. Increase collaboration between State and LDSS agencies	**14.** Increase the capacity of regional Medicaid consultants to provide oversight and support to LDSS agencies **15.** Align on operational and policy-based metrics to set performance expectations with LDSS agencies **16.** Set expectations and develop incentives and/or penalties to hold LDSS agencies accountable ●

	17. De-integrate Medicaid from current local administration structure to provide direct state execution and control over Medicaid eligibility ●
4. Drive consistency of accurate and timely processing	
H. Identify, scale, and standardize best practices and processes	**18.** Establish a living playbook of best practices and working group to support knowledge sharing **19.** Conduct end-to-end redesign of existing processes and develop standardized workflows ●
I. Strengthen and develop LDSS workforce capacity and capabilities	**20.** Develop training content across staff levels and roles, and incorporate CoverVA representatives **21.** Build talent pipeline through partnerships and internship programs **22.** Develop support tools (e.g., AI-driven applications) to streamline processes ● **23.** Update cost allocation plans to maximize allowable federal funding ● **24.** Update allocation formula to reflect demographic shifts and provide adequate funding for LDSS agencies ●
J. Balance workloads across Virginia and LDSS agencies	**25.** Provide guidance to support formal work-sharing between LDSS agencies **26.** Provide central surge support to LDSS agencies **27.** Centralize processing by application type and / or certain eligibility steps ●

Strategies to Address Challenge Area #1: Redesign and Improve User Experience

Strategy A: Enhance Digital Experience for Applicants

With only ~40% of applications submitted via more automated digital channels, Virginia lags other peer states like North Carolina (57%) and Indiana (79%).[61] Increasing the usage of digital channels can make the application process more efficient for applicants and eligibility workers alike. Adopting a "digital first" strategy could also help reduce reliance on mail, where LDSS and outreach workers report delivery delays can lengthen application timelines and lead to redundant requests for information.

Improving the applicant experience in digital channels can further increase uptake, user satisfaction, and timely application processing. For example, having a positive initial digital experience may make it more likely that applicants will not opt out of electronic communication, which could make a meaningful impact as only 15% of Virginians request to receive electronic notifications today.[62] This digital first strategy could extend to including self-service tablets in LDSS offices where applicants could apply online but also receive real-time in-

[61] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024; Interviews with Peer States, 09/2024
[62] DSS Internal Report on Individuals Requesting Notifications, 08/2024

person assistance if needed, increasing comprehension and comfort with the digital format. Developing live chat support and AI-driven assistance can also help applicants successfully navigate the online application because it would have visibility into the actions being taken by the applicant in real time to provide tailored guidance. Reducing reliance on phone-based assistance would also free up eligibility staff time to focus on the analytical work of the eligibility determination itself, helping to increase capacity and timeliness.

Strategy B: Streamline Processes, Applications, Notices, and Written Communications across Channels

Only 14% of LDSS workers surveyed agreed that eligible Virginians can navigate the process without substantial challenges, with LDSS staff citing legal jargon and inconsistent information across the multiple websites and helplines as major sources of confusion.[63] To address this, Virginia can undertake a redesign process for applications, notices, and websites with human-centered design principles and applicant experience at the forefront. This process should include input from applicants, eligibility workers, community partners, technologists, communications professionals, and DMAS and VDSS legal and policy experts to ensure that the resulting tools meet member needs while remaining compliant with federal and state laws and regulations. Additionally, all communication modalities, including phone numbers and websites, can be better connected, streamlined, and cross-checked for accuracy to support easier navigation for applicants. Developing a process for consistent updates to information across all remaining websites and phone numbers will be critical to sustaining initial improvements. Additionally, improving the coordination of application handoffs, particularly between CoverVA and LDSS, can reduce delays, as 27% of transferred applications currently take over 45 days to process.[64] Lastly, Virginia can evaluate opportunities to consolidate call centers (e.g., DSS Enterprise Call Center, DMAS CoverVA Call Center) to centralize capacity (e.g., language assistance services), reduce duplication of efforts (e.g., standardized trainings), and further streamline handoffs (e.g., remove unnecessary handoffs between call centers).

For further transformational change, redesigning the applicant-facing portal (i.e., CommonHelp) using human-centered design principles can motivate more applicants to submit applications digitally, and may lead to higher number of applications processed within 24 hours. While some funding has already been set aside in the recent state budget for redesigning CommonHelp, it is critical that this is done as part of a broader “digital first” effort and with modernization improvements to the back-end of VaCMS, otherwise any improvements to the portal will not be fully realized.

[63] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)
[64] VDSS Appmetric Report, 09/15/2024

Strategies to Address Challenge Area #2: Invest in an Improved Technology Ecosystem

Strategy C: Modernize VaCMS Technology and Processes

The many challenges with VaCMS all point to a comprehensive approach to modernization, as marginal incremental efforts will only create more technical debt, continue to drive up maintenance costs over time, and never fully resolve underlying root causes to the delays and errors experienced by users. To address these challenges, VDSS can begin by collaborating broadly with Medicaid eligibility and technology stakeholders to co-develop a unified "North Star" vision for the modernization effort. Doing this up-front visioning will align decision-making across VDSS, VITA, DMAS, LDSS, and other stakeholders, helping to smooth the invariably challenging project of a major system upgrade effort. In parallel, conducting a full, independent VaCMS diagnostic including the programmatic needs for other social services it supports outside of Medicaid, will be critical for understanding the gaps between the current architecture and “North Star” future state. Ultimately, these steps will help set up a comprehensive modernization journey for VaCMS that includes establishing a unified technology governance structure and developing an implementation roadmap to close the gaps to achieve the “North Star” vision. This roadmap should initiate moving the back-end of VaCMS to a microservices-oriented architecture to make the system much more flexible and cost effective to maintain in the long run. A microservices approach will allow VaCMS to break down the existing monolith into a set of independent services which will be easier to manage, update, and maintain. These individual components communicate and work together efficiently, but are developed, changed, and replaced independently, and each is powered by its own resources. Coupled with front-end improvements to the system using human-centered design to enhance usability and automate processes, this approach can also enable a more user-friendly and reliable system to drive greater standardization across LDSS agencies. Through this modernization journey, Virginia can also establish standardized development, operations, and product management processes. These “DevOps” approaches can also be deployed near-term to have immediate impact in parallel to the longer-term overhaul.

Strategy D: Improve Data and Reporting Capabilities

Data quality and reporting issues hinder accurate tracking and performance management throughout the eligibility process. Competing sources of truth between VDSS and DMAS, along with data duplication, mismatches and inconsistent client IDs, prevent effective data sharing and reporting. Improving data and reporting capabilities is essential to correct data quality issues that arise throughout the eligibility and determination processes. As a first step, Virginia could establish clear data quality standard operating procedures (SOPs) and guardrails to

support and streamline accurate, efficient, and automated data transfers. Additionally, creating a dedicated VDSS data team with defined roles and responsibilities and centralized data governance will enable more consistent management of data processes. Lastly, a Master Data Management (MDM) solution has the potential to transform data quality by reconciling systems of record, enabling real-time synchronization of data, and maintaining a single, trusted system of record for client information. This will support more accurate, consistent, and up-to-date data across all systems. An MDM solution would need to be done in concert with VITA and DMAS to ensure it is in sync with adjacent systems and the broader Commonwealth architecture strategy.

Strategy E: Enhance Management and Governance of IT Vendors

Currently, Virginia, like many other states, faces challenges with "vendor lock-in" due to the scale and complexity of IT investments in an outdated system. The current VaCMS steering committee structure is also not harnessing its full potential to robustly and consistently evaluate system needs and changes. Enhancing management and governance of IT vendors is critical to increase transparency and decrease over-dependency on vendors. One proposed solution is to establish an IT procurement governance board with senior leaders and technical experts at the table. This board would be charged with overseeing VaCMS procurement strategy, monitoring vendor performance, and establishing a robust internal review process for any system changes. Efforts to enhance vendor contracts should also include more outcome-based performance accountability clauses and thresholds (e.g., SLAs, Quality Assessment Plans), helping the Commonwealth achieve maximum value and service quality for its investments. Additionally, embedding internal or independent software developers and product owners with vendors will improve transparency, facilitate knowledge transfer, and align system changes with the Commonwealth's best interests. Finally, periodic, independent system testing should be used to validate system functionality and inform ongoing system enhancement and modernization efforts.

Strategies to Address Challenge Area #3: Develop a stronger governance model across DMAS, VDSS, and LDSS

Strategy F: Strengthen Collaboration between Regional Medicaid Consultants, VDSS, and DMAS Leadership

DMAS is ultimately responsible for fulfilling CMS Medicaid requirements, but it has limited visibility into performance data given that VDSS controls the reporting from the VaCMS system. Additionally, lack of formal collaboration structures means that DMAS and VDSS are too often

unaware of each other's processes and communication with LDSS agencies, creating accountability challenges. Virginia should build on the improved collaboration during the PHE unwinding – which was highlighted as a strength in interviews and surveys for this assessment – to institutionalize a more formal interagency governance body and operating model across DMAS, VDSS, and regional Medicaid consultants. This would enable coordinated decision-making, communication, and proactive performance improvements to be made without relying on ad hoc task forces and personal relationships with leadership that changes across administrations. To implement this solution, DMAS and VDSS can establish a joint Steering Committee on Medicaid Eligibility, supported by an updated Memorandum of Understanding (MOU) to ensure collaboration is not dependent on these informal relationships.

Additionally, realigning central and regional Medicaid consultants under DMAS can strengthen DMAS's coordination with LDSS agencies. This option could enhance DMAS's ability to disseminate Medicaid policy updates to benefit programs specialists and gain insights from on-the-ground staff. This reorganization of Medicaid consultants would not affect VDSS's oversight of LDSS agencies, as VDSS continues to oversee other social services.

Strategy G: Increase Collaboration between State and LDSS Agencies

As Virginia enhances collaboration at the Commonwealth level, it can present a unified voice to strengthen coordination with local LDSS agencies. Structurally, the Commonwealth has limited control over the administration of Medicaid eligibility at LDSS agencies because they report to local county governments (e.g., county boards). This diffuse reporting structure also means that processes and procedures differ across the 120 LDSS agencies, often with differing "home-grown workarounds" being developed to address the technical challenges (detailed further under Strategies H, I, and J). This consistency challenge is exacerbated in part because VDSS's regional Medicaid consultants are stretched thin compared to other states. For example, Virginia has 5 regional consultants for 120 agencies while North Carolina has 13 for 100 agencies.[65]

Another solution to improving the Commonwealth's oversight and collaboration with LDSS agencies is to align on a comment set of updated operational and policy-based metrics. This would enhance transparency and establish accountability expectations between VDSS and LDSS agencies. For example, the Commonwealth could replicate a "report card" approach used in North Carolina to establish clear metrics and thresholds, as well as visibility on how LDSS agencies compare with one another.

Virginia can then use these aligned metrics to develop incentives, such as performance bonuses for high-performing LDSS agencies or Corrective Action Plans for underperforming ones, which

[65] Interviews with Peer States, 09/2024

can further hold LDSS agencies accountable and drive improvements in Medicaid processing. If there is further desire for transformational change, Virginia could consider fully de-integrating Medicaid eligibility from the current local administration structure and directly administering the Medicaid eligibility function at the state level (similar to what Tennessee and other states have done), ensuring greater prioritization and accountability of Medicaid. However, this option would involve complicated disentangling of funding flows and an assessment of the impacts to the local social services delivery model.

Lastly, the Commonwealth can increase regional Medicaid consultants' capacity by hiring additional consultants, load balancing their workload from managing around 24 agencies each to the peer state standard of 8-12 agencies. This would allow for more dedicated support for each LDSS agency.

Strategies to Address Challenge Area #4: Drive Consistency of Accurate and Timely Processing

Strategy H: Identify, Scale, and Standardize Best Practices and Processes

One common theme throughout the different aspects of the Medicaid eligibility determination process was the overall variation of approaches taken by different LDSS agencies and individual LDSS benefit programs specialists. A number of these variable processes are driven by underlying VaCMS challenges, which drive manual workarounds. In those instances, fixing the technological root cause is often the optimal solution. However, in the interim, while a longer-term VaCMS modernization effort is pursued, Virginia can take near term steps such as developing a living playbook that outlines best practices and building a community of practice that supports knowledge sharing. For example, the playbook could articulate a system challenge, the planned timeline and approach to fixing the underlying system issue, and the recommended near-term workaround that the community of practice has coalesced around, rather than putting that burden on individual workers.

A more transformational approach would be to conduct an end-to-end redesign of existing processes and to develop standardized workflows. For optimal results, this would be done in conjunction with the modernizing VaCMS technology and processes, discussed in Strategy C.

Strategy I: Strengthen and Develop LDSS Workforce Capacity and Capabilities

With vacancy rates reaching as high as 50% in some agencies and only 42% of LDSS staff surveyed feeling adequately trained, LDSS agencies face workforce capacity and capability

gaps.[66] Addressing these core issues is critical for LDSS agencies to improve Medicaid determination backlogs, enhance service delivery, and prevent staff burnout while supporting efficiency during peak workloads.

To address one of the root causes to caseload and vacancy / turnover rate variation, the Commonwealth can update the outdated funding allocation formula for LDSS agencies to have the base funding better reflect population and demographic shifts. While this would inherently have a significant budget impact to the Commonwealth, it would correct decades of underinvestment and reduce the issue that not all local governments can equally sustain higher match for passthrough funding to meet LDSS workforce needs. To offset some of the increased cost, the Commonwealth could also pursue an effort to maximize federal Medicaid administrative claiming and update the cost allocation plan. Other longer-term efforts to address LDSS workforce capacity gaps include establishing university partnerships and internship programs to help build a talent pipeline for caseworkers.

To strengthen LDSS workforce capabilities, the Commonwealth can develop comprehensive training content tailored to various staff levels and roles, as well as better matching the training to the complexity of the work. For example, workers currently report that training focuses primarily on MAGI applications, despite the vastly increased complexity of non-MAGI applications and the fact that over half of LDSS workers process both MAGI and non-MAGI applications. Building training modules that effectively instruct LDSS benefit programs specialists on these more complex cases can both increase their comfort, as well as improve the overall timeliness and accuracy of LTC and other non-MAGI determinations. This can be considered near-term as part of the recently funded Training Academy for LDSS.

Strategy J: Balance Workloads across Virginia and LDSS Agencies

Caseloads per eligibility staff vary widely from 167 to 961 depending on agency, indicating the possibility that caseloads can be redistributed to balance workloads and thereby reduce bottlenecks (e.g., 25% of pending applications have been assigned to workers but have not begun processing).[67] To address this, Virginia could implement formal work-sharing protocols between LDSS agencies to manage application overflow during peak times by standardizing case transfers, workflows, and accountability, ensuring VaCMS tracks case progress, and establishing clear policies—all aimed at providing guidance, reducing risk, and encouraging LDSS participation in work-sharing. Another option is to create a central surge support team that can provide temporary assistance to LDSS agencies during periods of high caseloads, staff

[66] DSS HR Data, 2024; BCG Survey of all LDSS Agencies, 09/2024 (n=1294)

[67] DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025

shortages, or public health emergencies. During down times, this team could work on training development and delivery, maintaining standardized guidance across websites and application channels, and supporting the work of the Medicaid consultants. This central team could also serve as another step in the career path of a benefit programs specialist.

A more transformational approach would be to centralize processing by application type (e.g., MAGI, non-MAGI) or specific eligibility steps (e.g., intake, determinations) to improve efficiency. For example, Virginia can centralize the more complex non-MAGI applications to a more specialized team of highly skilled benefit programs specialists. This would give LDSS agencies more bandwidth to focus on the less complex case types and provide greater consistency in the eligibility process. A major consideration across this more transformational change is whether and how to shift federal and state Medicaid funding currently flowing to LDSS agencies to a new centralized processing unit. The impact on LDSS agencies would need to be further evaluated given the very complex and legacy funding approach that was identified during this assessment.

See Section 8.2 in the Appendix for additional details on options for each strategy

7. Conclusion

As Commonwealth leaders consider the improvement strategies and options described above, they will inherently face tradeoffs in time, resources, and complexity to address the major challenges experienced in Medicaid eligibility today. Given the scale of the challenges, most of these strategies and options will take over a year to implement, necessitate additional funding, or require legislative authority. Furthermore, several of the proposed options are also interdependent in nature or are complementary to other options which may impact implementation timelines and considerations. There are, however, several proposed options that can be done in the near term (i.e., roughly over the next 12 months) with minimal resourcing or authority required. These include:

- Updating vendor contracts to align with industry best practices, integrating internal technical experts into vendor teams, and strengthening an updated vendor governance board (#11) to enhance the management and governance of IT vendors. This is particularly timely given the operations and maintenance contract for VaCMS was solicited during the timeframe of this assessment.
- Designing & institutionalizing a joint DMAS-VDSS Steering Committee (#12) and aligning on operational and policy-based metrics to set performance expectations for LDSS agencies (#15) to strengthen collaboration between DMAS, VDSS, and LDSS agencies.
- Establishing a living playbook of best practices and working group to support knowledge sharing across LDSS agencies (#18) and (#20) developing training content across staff levels and roles to standardize processes and strengthen LDSS and CoverVA eligibility workforce (particularly through the recently funded Training Academy).

Leaders will have to thoughtfully balance shorter term improvements with steps toward longer term options that address core underlying drivers of the challenges such as modernizing CommonHelp and VaCMS, updating funding methodologies to LDSS agencies, and larger process changes to centralize parts of the eligibility process. This reinforces the need to address all challenges and strategies in some manner and will require thoughtful planning for a comprehensive statewide effort. When implementing these options, it is also critical to have leadership support and dedicated time for change management and proper communication, ensuring that DMAS, VDSS, LDSS, community stakeholders, and Virginians understand the changes being pursued, the rationale behind them, and the impact on each group.

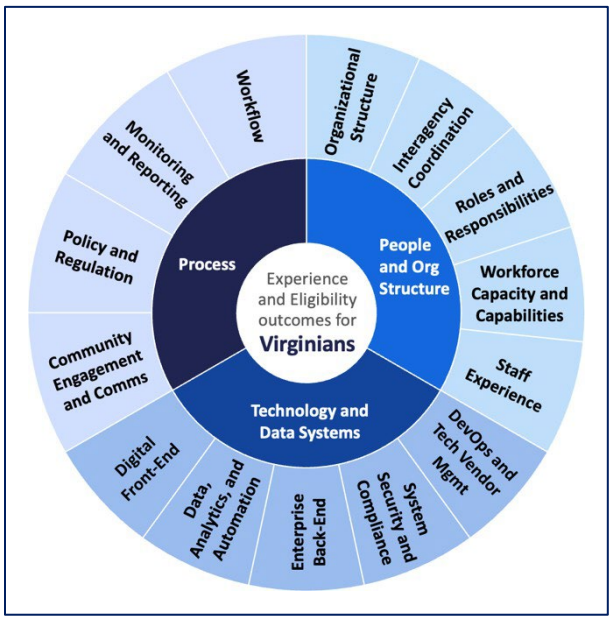
Finally, while the challenges and strategies identified in this report are focused on Medicaid eligibility, many of them also impact the delivery of other social services given the integrated structure of Medicaid eligibility. By improving Medicaid eligibility processes, systems, and governance, there will be direct and indirect benefits for state and local staff capacity to support other areas of high need for vulnerable Virginians, such as child protective services, foster care, and adult protective services.

8. Appendices

Table of Contents:

8.1 Assessment Methodology

Figure 18: Assessment framework



The Process, People & Organizational Structure, and Technology & Data Systems framework maps to the General Assembly's requirements as noted in Figure 19 and expands on those requirements to provide a comprehensive assessment of Medicaid eligibility determination.

To address the seven requested evaluation areas by the General Assembly (see Figure 19 below), this assessment utilized an evaluative framework that looked across three key areas:

- *People & Organizational Structure:* including interagency coordination, roles & responsibilities, and workforce. These areas address the General Assembly's requirements i, ii, v, vi, and vii.
- *Process:* including eligibility determination workflows, monitoring & reporting, stakeholder engagement, and policy/regulation. These process dimensions address all the General Assembly's requirements.
- *Technology & Data Systems:* including both the digital front end and enterprise back end of the eligibility IT system, management of IT vendor(s), data, analytics and automation, and system security. These process dimensions address all the General Assembly's requirements.

The assessment was conducted between August and October 2024.

Figure 19: Assessment framework and General Assembly Evaluation Areas

General Assembly's Evaluation Areas	Relevant Framework Components to Inform Evaluation Areas
1. Evaluate the current information technology systems	• Process • People and Org Structure • Tech and Data Systems
2. Measure accuracy, processing times and efficiency of current eligibility determination processes	• Process • People and Org Structure • Tech and Data Systems
3. Determine how the current structure and systems handle high volumes	• Process • Tech and Data Systems
4. Assess the current level of automation and determine processes that could be streamlined	• Process • Tech and Data Systems
5. Analyze the overall cost effectiveness of how eligibility is conducted, considering staffing costs and ongoing operational expenses	• Process • People and Org Structure • Tech and Data Systems
6. Examine best practices in other states	• Process • People and Org Structure • Tech and Data System
7. Develop cost-effective options for enhancing eligibility determination in the Commonwealth including alternative delivery models	• Process • People and Org Structure • Tech and Data Systems

Primary Research

This assessment was informed by an array of stakeholder perspectives representing the Medicaid eligibility determination ecosystem. Perspectives and experiences were captured through stakeholder interviews, an LDSS employee survey, and a focus group workshop with VHCF outreach workers. Findings helped inform an understanding of the current eligibility system and evaluate the experience these stakeholders have with eligibility determination processes.

In total, the assessment gathered insights from interviews with over 75 individuals representing key stakeholder groups. Internal stakeholders included a wide range of Commonwealth government stakeholders, including but not limited to members of DMAS, VDSS, 10 geographically varied LDSS agencies, Virginia State Corporation Commission (VSCC), and VITA. External stakeholders included nonprofit organizations such as the Virginia Poverty Law Center (VPLC) and VHCF, Medicaid providers and provider associations, Medicaid managed care organizations (MCOs), and Medicaid eligibility officials and experts from peer states. In addition to the 10 LDSS agencies interviewed, all 120 LDSS agencies were surveyed. The survey captured responses from 1,294 benefits employees (~35% of LDSS benefits staff) about their experience on Medicaid eligibility determination.

To obtain additional applicant perspectives, focus groups were conducted with outreach workers from VHCF's Project Connect, a program that helps Virginians apply for and renew applications for Medicaid and FAMIS benefits.[68] During the focus group, outreach workers identified key pain points along Medicaid eligibility processes, prioritized pain points of highest impact, and discussed potential solutions.

This assessment also conducted VaCMS performance testing by running scenarios mimicking real-world eligibility worker behavior and workloads at various capacities (40, 400, and 3000 active users processing cases).

See Section 8.6 in the Appendix for additional details on performance tests

Secondary Research

This assessment also utilized secondary research to better understand the Commonwealth's existing Medicaid eligibility ecosystem. External data sources analyzed included the KFF, CMS, US Census data. Internal data sources from state agencies analyzed included available data from VaCMS, CMS reporting, staffing volumes and vacancies, and RFPs from Virginia's eVA procurement databases. The secondary research supported the development of interview guides, surveys, and supplemented learnings from interviews. Secondary research also supported capturing best practices in other states and the development of potential strategies and options for alternative eligibility models.

See Section 8.3 in Appendix for additional details on these state benchmarks

[68] VHCF, "Project Connect Grants," 10/2024

8.2 Strategies & Options

The table below summarizes all proposed 27 options to improve the Commonwealth's Medicaid eligibility determination. Options differ on the type of change, resources required, estimated timeline, and anticipated programs impacted. With regards to estimated timelines, they assume individual implementation, yet interdependencies between options could impact the overall timeline of a comprehensive plan to address all 10 strategies (i.e., given constraints in resources, overall timelines could end up being much longer). Information on interdependencies is included within each option's description.

Proposed Options	Type of Change[69]	Resources required	Est. time	Program(s) impacted[70]
Strategy A: Enhance digital experience for applicants				
1. Adopt 'digital first' channel strategy (including self-service tablets and mobile) and enhance digital communications	Core Enhancement	Additional costs; Legislative action	1-2 years	All programs
2. Develop live chat support/AI-driven assistance to guide applicants	Transformational	Additional costs; Legislative action	1-2 years	All programs
Strategy B: Streamline processes, applications, notices, and written communications across channels				
3. Redesign applications, notices, mail communication, and websites with human-centered design principles; build applicant facing digital support	Core Enhancement	Additional costs; Legislative action	1-2 years	All programs
4. Connect applicant-facing eligibility channels with streamlined phone numbers and websites, improve handoff coordination, and consolidate call centers	Core Enhancement	Additional costs; Legislative action	1-2 years	All programs
5. Redesign CommonHelp, leveraging human-centered design principles	Transformational	Additional costs; Legislative action	1-2 years	All programs

[69] Note that some options included are denoted as transformational changes versus others which are core enhancements. Transformational changes would require a longer-term significant change from the status quo, whereas the other options are core enhancements or improvements to the status quo.

[70] Some options impact Medicaid only, and other options impact Medicaid along with other social services programs given the integrated nature of Medicaid in Virginia.

Strategy C: Modernize VaCMS technology and processes				
6. Develop a shared "North Star" vision for VaCMS and conduct a full system diagnostic	Transformational	Additional costs; Legislative action	~3-6 months	All programs
7. Initiate a comprehensive modernization journey for VaCMS	Transformational	Additional costs; Legislative action	3+ years	All programs
8. Establish standardized DevOps and product management processes	Transformational	Additional costs; Legislative action	6-12 months	All programs
Strategy D: Improve data and reporting capabilities				
9. Stand up a data team, define shared data roles and responsibilities, and establish/ centralize data governance	Core Enhancement	Additional costs; Legislative action	6-12 months	All programs
10. Onboard Master Data Management solution and reconcile systems of record	Transformational	Additional costs; Legislative action	1-3 years	All programs
Strategy E: Enhance management and governance of IT vendors				
11. Enhance management and governance of VaCMS IT vendors	Transformational	Potential for net savings	6-12 months	All programs
Strategy F: Strengthen collaboration between regional Medicaid consultants, VDSS and DMAS leadership				
12. Design and institutionalize a joint DMAS-VDSS Steering Committee on Medicaid Eligibility	Core Enhancement	Net neutral; No legislative action	<6 months	Medicaid
13. Realign central and regional Medicaid consultants to DMAS	Core Enhancement	Net neutral; Legislative action	6-12 months	Medicaid
Strategy G: Increase collaboration between State and LDSS agencies				
14. Increase the capacity of regional Medicaid consultants to provide oversight and support to LDSS agencies	Core Enhancement	Additional costs; Legislative action	<6 months	Medicaid
15. Align on operational and policy-based metrics to set performance expectations with LDSS agencies	Core Enhancement	Net neutral; No legislative action	<6 months	Medicaid (potential for other programs)
16. Set expectations and develop incentives & penalties to hold LDSS agencies accountable	Transformational	Net neutral; No legislative action	6-12 months	All programs
17. De-integrate Medicaid from current local administration	Transformational	Additional costs; Legislative action	2-3 years	All programs

structure to provide direct state execution and control over Medicaid eligibility				
Strategy H: Identify, scale, and standardize best practices and processes				
18. Establish a living playbook of best practices and working group to support knowledge sharing	Core Enhancement	Net neutral; No legislative action	6-12 months	Medicaid (potential for other programs)
19. Conduct end-to-end redesign of existing processes and develop standardized workflows	Transformational	Additional costs; Legislative action	1-2 years	Medicaid (potential for other programs)
Strategy I: Strengthen and develop LDSS workforce capacity and capabilities				
20. Develop training content across staff levels and roles, and incorporate CoverVA representatives	Core Enhancement	Net neutral; No legislative action	6-12 months	Medicaid
21. Build talent pipeline through partnerships and internship programs	Core Enhancement	Net neutral; No legislative action	1-2 years	All programs
22. Develop support tools (e.g., AI-driven applications) to streamline processes	Transformational	Additional costs; Legislative action	1-2 years	All programs
23. Update cost allocation plans to maximize allowable federal funding	Core Enhancement	Produces net savings; Legislative action	6-12 months	All programs
24. Update allocation formula to reflect demographic shifts and provide adequate funding for LDSS agencies	Transformational	Additional costs; Legislative action	6-12 months	All programs
Strategy J: Balance workloads across Virginia and LDSS agencies				
25. Provide guidance to support formal work-sharing between LDSS agencies	Core Enhancement	Additional costs; Legislative action	6-12 months	Medicaid
26. Provide central surge support to LDSS agencies	Core Enhancement	Additional costs; Legislative action	1-2 years	Medicaid
27. Centralize processing by application type and / or certain eligibility steps	Transformational	Additional costs; Legislative action	1-2 years	Medicaid (potential for other programs)

Challenge Area 1: Poor Applicant Experience with Less Digital, More Manual Processes

To address this challenge area the Commonwealth must consider ways to accomplish the following strategies:

- A: Enhance digital experience for applicants
- B: Streamline processes, applications, notices, and written communications across channels

Strategy A: Enhance Digital Experience for Applicants

This strategy addresses how to increase the use of digital processes to simplify the application process and improve the overall digital experience for applicants. This strategy can be achieved through the following options:

- #1 Adopt a 'digital first' channel strategy (including self-service tablets and mobile) and enhance digital communications
- #2 Develop live chat support / AI-driven assistance to guide applicants

#1: Adopt 'digital first' channel strategy (including self-service tablets and mobile) and enhance digital communications
Description
Type of change: Core Enhancement Incorporate a 'digital first' channel strategy for CommonHelp so applicants can navigate, submit documents, and track applications on any device. This includes: • Implementing new processes that prioritize a digital channel. For example, when ex parte renewals fail, sending a QR code of the pre-filled application so members can more easily submit a renewal via CommonHelp. • Installing self-service tablets in LDSS agencies so in-person applicants can use CommonHelp instead of paper applications. Tablets alone may have limited impact; to be effective, they must be paired with a supportive process. For example, by having staff assist applicants as they complete applications on tablets, agencies can accelerate the intake process while still offering the personal support of in-person LDSS staff. Additionally, using this technology outside of LDSS agencies at local community centers or public libraries could increase access points at different times times of the day and in more rural areas where applicants find it easier to reach them. • Launching a mobile friendly application where applicants can submit, easily upload documentation, and monitor their applications via their smartphone. Applicants can use mobile app to regularly check status of existing benefits and provide avenue for communication in case there are any follow up requests. As part of 'digital first' strategy, improve digital communications between applicants and eligibility staff by: • Adding centralized no-reply email for all LDSS agencies. This email function could send information requests and application updates via text and email alerts in addition to mandated mail. • Creating a centralized email address where applicants can correspond with benefit programs specialists, providing two-way digital communication (e.g., email) between LDSS workers and applicants. • Establish standardized processes for applicant correspondence across LDSS agencies to ensure that they are returned in a timely and effective manner.
Pain point(s) addressed and est. impact

Pain point(s) addressed: The application processes and systems are not intuitive and are difficult for applicants to navigate leading to a higher share of paper applications that take more time to process and are less automated.

Est. impact:

- Only 40% of applications are submitted via digital channels in Virginia today. [71] By prioritizing digital channels, the share of applications submitted digitally may increase and reach parity with other peer states (57% in NC, 63% in TN, and 79% in IN). [72] A focus on digital channels (e.g., CommonHelp applications, and email correspondence) can increase processing times.
- Virginia is among the bottom 10 states in mail delivery timeliness, increasing the likelihood that mail correspondence is either lost or delayed before a member / applicant can meet an impending deadline.[73] In September 2024, for 25% of pending applications in the last step of eligibility determination, LDSS workers waited 15+ days on average to receive additional information from applicants.[74]
- Improving digital communications, including the ability to upload additional information, can reduce the turnaround time between applicants sending their information to LDSS and can help reduce the number of total pending applications.
- Tablets in LDSS agencies could allow applicants to complete applications faster and only relying on LDSS staff for assistance as needed. This could alleviate some of the strain on LDSS worker capacity.

Example Benchmark(s)

- **Pennsylvania** introduced MyCOMPASS PA mobile app in 2016 that allows customers to check benefits and application statuses, report changes, and upload documentation directly from their phones. State experts explain mobile app has been critical factor in faster processing times.[75, 76]
- **Kentucky** implemented a text message and email outreach campaign to inform applicants when an application was still pending or required additional information. This innovation – along with other strategies – resulted in Kentucky receiving the Robert Wood Johnson Foundation Medicaid Innovation Aware in 2022. This resulted in:
  - Increase of completed applications from 22% to 75%
  - Onboarding of up to 120,000 presumptive eligibility applications per month[77]
- **Georgia** launched 400 kiosks across 300 public libraries to facilitate access to Georgia Gateway platform, the state's online social benefits application portal. This provided applicants more flexibility to access their benefits as the libraries operated on the weekends and had internet access in rural parts of the state.[78]

Implementation considerations

Est. resources required	*Est. Timeline*
Requires additional costs / funding: • Technology team to create new VDSS mobile application and use CommonHelp interface to connect with the application	**1-2 years:** • Evaluate current contracts and vendors to identify whether it is beneficial to amend existing contracts

[71] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024
[72] Interviews with Peer States, 09/2024
[73] USPS Service Performance Dashboard, FY2024
[74] VDSS Appmetric Report, 09/15/2024
[75] Interview with Pennsylvania Office of Income Maintenance (OIM) Subject Matter Experts, 10/2024
[76] Commonwealth of Pennsylvania, "MyCOMPASS PA"
[77] Robert Wood Johnson Foundation, "2022 Medicaid Innovation Award - Kentucky: Enrollment Innovations," 2022
[78] DHS, "DHS and Georgia Public Library Service partner to provide more than 400 self-service kiosks at libraries across Georgia," 10/2024

• Upfront and maintenance costs for tablets and support infrastructure • Existing CommonHelp vendor to expand its capacity to handle increased digital traffic • Marketing to push Virginians to use online channels to apply for social benefits	• Launch RFP to solicit a technology vendor who can create and manage new launched VDSS social benefits app • Coordinate with CommonHelp vendor to modify its infrastructure to accommodate increased traffic through its platforms • Procure the required number of tablets desired to service selected community centers and/or LDSS agencies • Submit change requests to integrate new email and texting functions into VaCMS • Train benefit programs specialists on updated digital applications processes • Conduct a marketing campaign to increase awareness of online social benefit applications, including improved interface and new mobile app

Interdependencies and risks

Interdependencies:

- This option is complimentary to:
  - #2: Developing live chat / AI-driven assistance. Live chat / AI chat feature can be used as a first point of contact when applicants have questions, and more complex inquiries can be escalated using the two-way communication email.
  - #3: Redesigning applications, notices, mail communication, and websites with human-centered design principles as it will help make the digital first experience better to have applications and communication that are not only optimized for digital and mobile modalities but also more streamlined.
- This option is dependent on #5: Redesigning CommonHelp. Without first fully implementing a 'digital-first strategy' and enhancing the user experience, efforts to increase digital applications and communication may be ineffective. Additionally, CommonHelp needs to be optimized for tablet and mobile channels before deploying this effort.

Risks:

- Users may be hesitant to use digital channels due to previously poor experiences and may continue to use phone or paper options. To mitigate and propel digital, CommonHelp and additional infrastructure should be modified. A marketing campaign is critical to inform Virginians about recent updates, emphasizing an improved user experience going forward.
- LDSS agencies previously offered self-service tablets, but applicants did not utilize them in large numbers. In the past, applicants would call a remote call center and complete their application via phone when they encountered a problem with the tablet application. To support optimal tablet use, LDSS staff will need to be available to help answer applicants' questions when they use the self-service tablets in the office.
- Existing eligibility staff may be more comfortable with non-digital application and communication methods. Implement additional trainings so workers are more comfortable with digital processes and understand the value of these more automated pathways.

#2: Develop live chat support / AI-driven assistance to guide applicants

Description

Type of change: Transformational Change

Develop live chat support and / or AI-driven assistance to guide applicants through the online application process. This includes:

- Implementing new chat functionality into the CommonHelp platform
- Sourcing staff to operate the live chat functions, potentially using existing DMAS CoverVA Call Center or DSS Enterprise Call Center resources.
- Collaborating with a vendor to launch and train new AI-driven assistance features that can work on the CommonHelp portal.
- Creating scripts and logic trees to help either live chat agent or AI-driven assistance troubleshoot frequently faced obstacles during the online application process.
- Implementing processes to document most frequently asked questions from live chat / AI assistance and distill insights for future iterations on CommonHelp / application process
- Instituting workflows to escalate questions that the live chat / AI-driven assistance cannot resolve (e.g., providing a phone number to call or nearest LDSS agency to visit).

Pain point(s) addressed and est. impact

Pain point(s) addressed: The application processes and systems are challenging for applicants to navigate, often taking over an hour to complete. Applicants frequently experience confusion about required paperwork, and outreach workers report longs wait times or unreturned calls when contacting LDSS agencies for assistance.

Est. Impact:

- Offering chat resources to applicants can increase the share of digital applications completed online, as it would provide faster, better guidance throughout the process. Currently, many applicants begin the process online but encounter difficulties, leading them to transition to phone or in-person applications. Currently, 40% of new applications are submitted through CommonHelp or the Virginia Insurance Marketplace, 26% via phone, and 34% through paper (vs 57% digital in North Carolina, 63% in Tennessee, and 79% in Indiana).[79,80]
- Introducing live chat support or an AI-driven chat function can reduce application completion time by easing the volume of inquiries handled by phone (e.g., current median processing time of 13 days for MAGI applications, 41 days for non-MAGI applications).[81] With real-time assistance available through chat, applicants would encounter fewer obstacles, enabling eligibility staff to concentrate on their core determination responsibilities rather than customer service calls.

Example Benchmark(s)

- **New Mexico** Health Care Authority launched an enhanced YES.NM.GOV portal in September 2024, offering a mobile-friendly, streamlined experience to apply for, renew, and manage health and human services, including SNAP, Medicaid, and cash assistance. A key feature of the portal is its 24/7 chat bot, which provides real-time assistance to applicants, helping them navigate the application, renewal, and benefits management process. New Mexicans across the state contributed with feedback to the redesign of YES.NM.GOV. Volunteers from various communities, including immigration specialists, disability advocates, and multilingual testers, participated in usability testing to ensure the site effectively serves

[79] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024
[80] Interviews with Peer States, 09/2024
[81] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024

the diverse needs of all residents. The chat service is available in both English and Spanish to support accessibility.[82]	
Implementation considerations	
Est. resources required	*Est. Timeline*
Requires additional costs / funding for: • Vendor costs to integrate live chat and / or AI chat functionality into CommonHelp application • Additional customer service staff dedicated to managing live chat for CommonHelp obstacles • Funding required for ongoing maintenance and updates to AI chatbots as policies, regulations, and eligibility processes evolve	**1-2 years:** • Work with CommonHelp vendor to incorporate live chat support • Create scripts and logic trees for live chat agent or AI-driven assistance • Develop processes to document most frequently asked question from live chat / AI assistance • Develop workflows to escalate questions that the live chat / AI-driven assistance cannot resolve • Collaborate with DMAS CoverVA or DSS Enterprise Call Centers to staff live chat feature • In parallel, contract with vendor to build and train AI model to triage low complexity questions during an online application • Pilot initial chat features before full CommonHelp rollout
Interdependencies and risks	
Interdependencies: • This option is complementary to #1: Launching a 'digital first strategy' because it will help applicants troubleshoot digital applications and renewals. • This option is dependent on #5: Redesigning CommonHelp as it is a necessary step before adding in a chatbot functionality. If CommonHelp is not updated to improve user experience, a chatbot may not be effective. **Risks:** • Live chat or AI-driven assistance can sometimes give incorrect information, causing misunderstandings and confusion for applicants, particularly with more complex applications (e.g., ABD, LTC). • Live chat may struggle to handle high volumes of inquiries during peak times (e.g., open enrollment). • Live chat will need to properly incprorate Responsible AI (RAI) concepts to minimize the risk of an erroneous recommendation/direction that could impact applicants. • Incorrectly assessing staffing needs for live human supported chat could result in either understaffing, leading to long wait times and poor user experience, or overstaffing, which wastes resources if not enough applicants use the chat service. • Applicants may feel uncomfortable or distrustful when interacting with an AI system, especially for sensitive or critical processes like Medicaid applications.	

[82] New Mexico Health Care Authority, "New Mexico Health Care Authority Unveils Enhanced YES.NM.GOV Portal," 09/2024

Strategy B: Streamline Processes, Applications Notices, and Written Communications across Channels

This strategy is about addressing the complexity of the Medicaid application process by simplifying forms used by applicants and redesigning how applicants engage with existing Medicaid systems. Across the continuum of high vs lower impact, Strategy B includes 3 options:

- #3 Redesign applications, notices, mail communication, and websites with human-centered design principles; build applicant-facing digital support
- #4 Connect all points of entry and communication mechanisms with streamlined phone numbers and websites, and improve handoff coordination
- #5 Redesign CommonHelp, leveraging human-centered design principles

#3: Redesign applications, notices, mail communication, and websites with human-centered design principles; build applicant-facing digital support

Description

Type of change: Core Enhancement

First, establish an effort to make applicant-facing communication easier to understand and more accessible by:

- Conducting user design sessions with applicants, eligibility workers, community partners, technologists, communications professionals, and DMAS and VDSS legal and policy experts to redesign existing application, notices, mail/email communication, and website content to focus on user needs and solicit feedback on how to improve accessibility (e.g., include accurate translations for top 5 languages in VA).
- Piloting updated language with applicants and eligibility workers to determine if accessibility has improved with proposed modifications, while remaining compliant with federal and state requirements.
- Developing a user-friendly digital checklist accessible so applicants know what information they need to complete the application before starting (e.g., a Medicaid version of REAL ID digital checklists many state DMVs have created in recent years for driver's licenses).
- Deploying direct mail marketing vendor to improve both mail and e-mail / digital communication open rates and engagement with applicants. These vendors can apply mailing and e-mail design best practices to improve applicant engagement and responsiveness.

Second, establish a process to continually revisit and update forms by:

- Creating working group applicants, eligibility workers, community partners, technologists, communications professionals, and DMAS and VDSS legal and policy experts that meets at a regular cadence (e.g., quarterly) to discuss feedback on the new applications, notices, mail communication, and forms to address solutions for ongoing pain points and support compliance with programmatic changes.
- Periodically conducting focus groups with applicants to understand how to continually improve the applicant user experience.

In parallel, establish a digital help center with visual aids, frequently asked questions (FAQs), and global search functionality to promote easier navigation and troubleshooting for applicants by:

- Partnering with navigators / community partners to draft user guides to troubleshoot common obstacles applicants face during the eligibility determination process.
- Creating a centralized digital help platform where individuals can readily access FAQs and search for solutions to their problems.

Pain point(s) addressed and est. impact

Pain point(s) addressed: The applications, notices, and other communications are long, not intuitive, and difficult for applicants to navigate. Currently, ~20% of applications are signed in the wrong place, indicating complexity in filling out the application. [83] Only 14% of LDSS staff surveyed believe that eligible Virginians can successfully navigate the Medicaid eligibility determination process without significant challenges.[84]

Est. impact:

- Application redesign and a digital help center can lead to fewer applicant errors and result in more applications processed automatically (e.g., only 19% of Virginia's MAGI applications are processed within 24 hours).[85]

Example Benchmark(s)

- **Michigan** streamlined its social benefits application to allow 90% of people to apply for a social program in under 20 minutes and reduce processing time by 42% for back-office staff.[86]
- **North Carolina** enhanced its Medicaid communication by developing communication toolkits. The toolkits provide clear, easy-to-understand resources to inform beneficiaries about unwinding, Medicaid expansion, and application processes. The toolkits include ready-to-use templates, FAQs, and colorful outreach materials in multiple languages.[87]

Implementation considerations

Est. resources required	*Est. Timeline*
Requires additional costs / funding: • Due to VaCMS system limitations, there will be additional costs to implement form / notice changes (e.g., a recent simple VDSS home office address change was estimated at $400k) • Communication / direct mail vendor costs to design colorful outreach materials and communication toolkits for mail and digital use • Minimal costs to reallocate existing full time equivalents (FTEs) to manage quarterly working group and help desk	**1-2 years:** • Evaluate and document Federal and State regulatory requirements for applications, notices, mail communication, and forms • Identify most frequently accessed applications, notices, mail communications, and forms to prioritize which to redesign first • Conduct design sessions to update existing applications, notices, mail communication, and forms • Collaborate with a communication agency to develop appealing and easy-to-understand outreach materials for mail and digital communication • Pilot and refine content prototypes • Update channels (e.g., paper, phone, digital) to reflect updates • Issue RFP to launch help center platform on DMAS / VDSS websites

[83] Interview with VLSSE, 08/2024

[84] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)

[85] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024

[86] Civilla, "Project Reform," 2024

[87] North Carolina Department of Health and Human Services, "CCU Unwinding Toolkit," 2023

Interdependencies and risks

Interdependencies

- This option is complementary to #5: Redesigning CommonHelp since the new application, form, and notice content will be integrated into the portal. This option is also complimentary to #2: Developing live chat capabilities to guide applicants as the new application language will inform chat scripts.
- This option is complementary to Strategy C: Modernize VaCMS technology and processes and Strategy E: Enhance management and governance of IT vendors which could make future design changes simpler and less costly.

Risks:

- Updating applications, notices, mail communication, and forms may create confusion for applicants in the near-term. Proper training and communication through LDSS agencies, the DMAS CoverVA Call Center, and the Virginia Insurance Marketplace will be needed to mitigate this confusion and better inform the help desk to assist applicants.

#4: Connect applicant-facing eligibility channels with streamlined phone numbers and websites, improve handoff coordination, and consolidate call centers

Description

Type of change: Core Enhancement

Consolidate points of entry that create confusion for applicants, streamlining the many different phone numbers and websites by:

- Establishing one applicant-facing phone number that is used across channels and can triage and reroute applicants to the application that is most appropriate for their needs.
- Creating a single centralized website that serves as the one "source of truth" for all Medicaid eligibility information and have all other websites / portals (e.g., DMAS, each LDSS agency, DMAS CoverVA Call Center, Virginia Insurance Marketplace, CommonHelp) link / direct users to the single centralized website.
- A more transformative option would be to consolidate call centers (e.g., DSS Enterprise Call Center, DMAS CoverVA Call Center) to standardize the telephonic application experience for users, however that would have implications for other social services that the DSS Enterprise Call Center supports.

Improve handoffs across channels (e.g., DMAS CoverVA Call Center to LDSS agencies, DSS Enterprise Call Center to LDSS agencies, Virginia Insurance Marketplace to DMAS CoverVA Call Center and LDSS agencies) by:

- Standardizing transfer protocols (e.g., Standardize case notes to simplify handoffs, processes to inform LDSS agency of late transfers).
- Creating processes that allow for expedited transfers between DMAS CoverVA Call Center, LDSS agencies, DSS Enterprise Call Center, and the Virginia Insurance Marketplace (e.g., dedicated phone numbers for transfers).

Pain point(s) addressed and est. impact

Pain point(s) addressed: The application processes and systems are complex and challenging for applicants to navigate, with multiple call centers, phone numbers, websites, and pathways creating confusion about the correct resources to use. Additionally, delays sometimes occur when applications are transferred between channels; for instance, LDSS staff report delays with non-MAGI applications received from the DMAS CoverVA Call Center.

Centralizing Channels

Est. Impact:

- Reduces complexity and makes it easier for applicants to understand how and where to apply, increasing the use of automated processes by decreasing number of duplicate applications.
- Allow for information to be more centrally controlled and updated when policies or processes change.
- Consolidating call centers will provide users a since point of contact to answer questions and assist in filling out applications. It could also increase efficiencies by centralizing resources (e.g., optimizing language assistance services for Limited English Proficiency applicants), reducing duplication of efforts (e.g., improving the efficiency in training delivery so training can be more consistent, current, and comprehensive), and streamlining handoffs (e.g., remove unnecessary handoffs and clarify responsibilities for telephonic applications regardless of application type).

Improving Handoffs

Est. Impact:

- Can reduce number of applications that are processed past their federally required deadlines. 27% of applications transferred from CoverVA to LDSS agencies are older than 45 days vs 16% of applications that are not re-routed from another channel. [88] Improved hand-offs could allow LDSS to process applications transferred from CoverVA in a timelier manner and decrease the average processing times.

Example Benchmark(s)

- **Ohio** launched a County Shared Services (CSS) Model in 2014, where applicants can call a single number and be routed to a caseworker based on their zip code. The CSS model has been adopted by 77 of Ohio's 88 counties, helping standardize the eligibility processes in the state. Participation in CSS is optional, and counties have the flexibility of how and in what capacity to use the service. As of April 2019, 77 out of 88 counties use CSS. 67 counties operate in eight groups and 10 in stand-alone metro counties.[89]
- **Kentucky** transitioned to a statewide model, where cases are handled by multiple workers rather than being assigned to a single dedicated caseworker. A key aspect of this system's success is strict adherence to note-taking guidelines. All staff must take detailed notes and review them thoroughly before beginning any task to ensure continuity and prevent information from being lost.[90]
- **New York** established the Human Services Call Center (HSCC) as part of their Statewide Call Center Consolidation project. From 2013 to 2017, HSCC completed the transition of calls from 39 different lines across 10 agencies and handled over 2 million calls. The HSCC was able to answer 85% of calls within five minutes and agencies confirmed that the HSCC provided excellent service while allowing agency staff to focus on their core mission. To enable this, the HSCC business analysists worked closely with agencies to define calls to transition, build a robust statewide knowledge base with clear and consistent content, and provide weekly reporting on call center performance. [91]

[88] VDSS Appmetric Report, 09/15/2024

[89] Ohio Auditor of State, "Ohio's Medicaid Eligibility Determination Process," 11/2020

[90] Interview with Kentucky Department of Medicaid Services Subject Matter Expert, 10/2024

[91] New York State Office of Children and Family Services, "Human Services Call Center," 10/2024

<table>
<tr><th colspan="2">Implementation considerations</th></tr>
<tr><td>Est. resources required</td><td>Est. Timeline</td></tr>
<tr><td>Requires additional costs / funding for:
Upfront and ongoing vendor costs to unite hotlines and websites (e.g., migrating phone systems)
Extensive change management to reconcile system logic and workflows
Produces net savings:
Consolidating call centers can reduce costs associated with maintaining separate call centers (e.g., ~$24M per year for DMAS CoverVA Call Center and ~4.7M per year for Medicaid portion of DSS Enterprise Call Center)[92]</td><td>1-2 years:
Evaluate current contracts and vendors to identify whether streamlining channels requires an RFP or can be amended
Launch RFP for vendor to create centralized phone line and website
Align and instruct new centralized vendor on transfer decision tree
Test and launch consolidated website and phone line
For consolidating call centers
Assess current call centers to align on which call center to maintain
Map out workflows for consolidated call centers
Begin data and system migration
Train all eligibility staff on new call center processes
Develop and implement communication plan for both applicants and community partners to support rollout of consolidated call centers</td></tr>
<tr><td colspan="2">Interdependencies and risks</td></tr>
<tr><td colspan="2">Interdependencies:
This option is complementary to #3 redesigning applications, notices, mail communication, and websites as it supports an easier to use process for applicants to engage in Medicaid eligibility determination.
Risks:
If errors occur in executing a single phone line and routing applicants to a common website, this could further frustrate and deter applicants. To mitigate, it is critical to ensure proper functionality and test new processes before launching new centralized communication mechanisms.
Consolidating multiple call centers creates a single point of failure, meaning that any downtime with the call center can lead to widespread service interruptions.</td></tr>
</table>

[92] DMAS CoverVA Call Center estimates based on invoices after unwinding / renewal support concluded from May to August 2024; DSS Enterprise Call Center is from DSS Finance estimates for FY24

#5: Redesign CommonHelp, leveraging human-centered design principles

Description

Type of change: Transformational Change

Rebuild and redesign CommonHelp to enhance user experience for both applicants and eligibility workers by:

- Soliciting feedback from stakeholders & users to understand the strengths and areas of improvement for CommonHelp.
- Creating guest functionality for applicants to review CommonHelp application without needing to create an account.
- Providing a user-friendly digital checklist accessible outside of creating a user account so applicants know what information they need to complete the application before starting.
- Shortening application by reevaluating the necessary information to make determinations and limiting the number of required data fields.
- Incorporating dynamic elements to prompt and guide applicants as they complete applications.
- Enhancing accessibility for Virginians with disabilities by complying with Sections 504, 508, and Web Content Accessibility Guidelines (WCAG) 2.2 standards.
- Using interpreter services to translate CommonHelp application for non-English speakers instead of relying on Google Translate.
- Enhancing integration with public databases to prepopulate an applicant's information into their CommonHelp application based on existing government records.
- Incorporating multi-factor authentication and reducing the number of security questions applicants often forget when registering for an account.
- Redesigning CommonHelp's user interface to incorporate human-centered design principles and best practices.
- Mocking up user interfaces and testing the flow / functionality with focus groups of key stakeholders and users.
- Releasing multiple pilots to get real-time feedback on the updates / changes, and iterate the design based on the feedback to achieve an interface that works for the users.
- Testing new functionalities and co-developing with stakeholders and applicants who directly work with and use the portal.
- Improving the mobile interface so applications can be conducted more easily on mobile devices (particularly for applicants without computer access).

Pain point(s) addressed and est. impact

Pain point(s) addressed: Application processes and systems are challenging and unintuitive, with only 14% of LDSS staff confident Virginians can navigate the system effectively.[93] Currently only 34% of new applicants are leveraging CommonHelp (40% of all new applicants are using CommonHelp and the Virginia Insurance Marketplace) and only ~20% of VHCF outreach workers use CommonHelp.[94,95]

Est. Impact:

- Implementing successive iteration cycles focused on end-users' needs will address many criticisms of the CommonHelp platform, encourage more applicants to apply digitally, and potentially increase the number of applications processed within 24 hours (currently only 19% of Virginia's MAGI applications meet this timeframe).[96]

[93] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)

[94] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024

[95] VHCF Outreach Worker Survey, 09/2024 (n=26)

[96] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024

Example Benchmark(s)

- **Kentucky** redesigned and launched their application portal "kynect" in October 2020, focusing on user-centric design and the integration of multiple state benefit programs, including Medicaid, SNAP, and TANF. This redesign allowed for easier navigation and access across devices, including mobile phones.[97] Key components of the user-centric design were:[98, 99]
  - A mobile-first approach, optimizing the platform for mobile devices to cater to on-the-go users.
  - Adoption of plain language standards, aligning with a 6th-grade reading level to help users from diverse backgrounds easily navigate the site.
  - Implementation of guided workflows that break the application into smaller, manageable tasks, using clear instructions and prompts to help users submit accurate and complete applications.
  - Implementation of omni-channel notifications to keep users informed about their application status through regular updates, reducing missed deadlines.
  - Implementation of multi-factor authentication.
  - From January to September 2021, more than 105,000 applications were submitted, ~1 million documents uploaded. During this period, Kynect saw a 180% increase in daily usage.

Implementation considerations

Est. resources required	*Est. Timeline*
Requires additional costs / funding: • Design team needed to create and test prototypes with intended end users • Vendor required to iterate on design team's prototypes, test new CommonHelp portal with existing technology infrastructure, and manage redesigned CommonHelp	**1-2 years:** • Release an RFP to select a vendor to assist design team in creating prototypes and manage final product • Evaluate existing CommonHelp platform and distill learnings into a new prototype • Launch multiple pilots for redesigned CommonHelp and iterate • Release redesigned CommonHelp to the entire state

Interdependencies and risks

Interdependencies:

- This option is complementary to #3: Redesigning applications, notices, mail communication, and websites notices, as similar language will be used in the new CommonHelp interface; and #2: Developing live chat / AI-driven assistance to help guide users during the application process.
- This option may impact options in Strategy I: Strengthen and develop LDSS workforce capacity and capabilities and Strategy J: Balance workloads because a new CommonHelp tool may incentivize more applicants to submit applications online. More online applications can lead to more applications determined automatically, leading to fewer applications and renewals processed manually.

Risks:

- A new CommonHelp may not interface well with other existing tools (e.g., VaCMS).
- Poor contract terms with vendor may limit the number of updates Virginia can make to CommonHelp.
- Near term, updates to CommonHelp may confuse current applicants, navigators, and outreach workers who are familiar with the existing portal. If applicants struggle to adapt, it may lead to incomplete or incorrect submissions.

[97] Cabinet for Health and Family Services, "Kynect Benefits," 10/2020

[98] SPUR, "Redesigning Benefits Access: Lessons from Kentucky," 11/2020

[99] Cabinet for Health and Family Services, "Governor Beshear Announces Re-launch of Kynect for Kentuckians," 10/2020

Challenge Area 2: Outdated and Inflexible Technology Systems

To address this challenge area the Commonwealth must consider ways to accomplish the following strategies:

- C: Modernize VaCMS technology and processes
- D: Improve data and reporting capabilities
- E: Enhance management and governance of IT vendors

Strategy C: Modernize VaCMS Technology and Processes

This strategy is about building effective technology governance, defining a shared vision and strategy for modernization, and ensuring that near- and long-term decisions enable incremental progress towards this future state. This is the foundation upon which the Commonwealth can build the IT systems and infrastructure required to support the various eligibility systems and data assets. Options include:

- #6: Develop a shared "North Star" vision for VaCMS and conduct a full system diagnostic
- #7: Initiate a comprehensive modernization journey for VaCMS
- #8: Establish standardized DevOps and product management processes

#6: Develop a shared "North Star" vision for VaCMS and conduct a full system diagnostic

Description

Type of change: Transformational Change

Develop a shared "North Star" vision

- VDSS and DMAS agency leaders should co-develop a shared future state "North Star" vision for VaCMS. This would include designing or enhancing a system architecture strategy, framework, and standards, and committing to a set of guiding principles that align to federal policy.
- This "North Star" should be informed by feedback and input from users and stakeholders impacted by VaCMS across Medicaid eligibility and other programs.
- Critically, VDSS will need to work closely with VITA and ensure the enhanced system architecture strategy is aligned with MES and broader statewide architecture standards. A root cause to challenges VaCMS faces today is the broader architecture standards that apply to the whole state by VITA and these need to be refreshed and modernized in concert with modernizing VaCMS. Otherwise, efforts to modernize VaCMS will be done in a silo and could be out of sync with statewide architecture.
- The future state vision should also consider federal CMS modularity mandates and guidance to ensure the system is compliant.

In parallel, conduct a full system diagnostic

- A comprehensive VaCMS technical assessment of the current state can be performed, extending beyond Medicaid eligibility and including the system performance for other benefits determined by the system. The assessment should be conducted by state or independent resources.
- This assessment should be conducted by an independent assessor and provide an outside in perspective of system performance relative to comparable benchmarks.

Pain point(s) addressed and est. impact

Pain point(s) addressed: VaCMS is comprised of a diverse set of technology components in various stages of the technology lifecycle, ranging from modern, integrated tools to those at end-of-life. Some of these components

place outsized constraints on dependent Medicaid processes and limit the functionality of adjacent technologies within VaCMS' tightly integrated system. System testing conducted raised questions about system capacity and warrants the need for further VaCMS evaluation, especially beyond the functionality for just Medicaid eligibility.

Est. impact:

- Catalyze early design and planning efforts for modernization of VaCMS, enabling VDSS to incorporate this vision into current and future business decisions.
- Lay the foundation for a modernization journey and establish stakeholder buy in on the future state
- Understand the gaps between the current technologies and future state .

Example Benchmark(s)

- **Ohio's** Medicaid modernization aligned state agencies under a unified architectural vision, resulting in reduced operational silos and modernized IT infrastructure that increased efficiencies across business operations.[100]

Implementation considerations

Est. resources required	*Est. Timeline*
• "North star" vision: While working with internal and external stakeholders to define a vision could be done with internal resources, it is likely that external vendor support will be necessary to provide visioning support, support aggregation and synthesis of stakeholder feedback, and facilitate decision making. This could range from $1-2M. • Full system diagnostic: System diagnostics conducted by independent vendors will cost a few million dollars depending on scope and vendor capabilities.	• ~3-6 months

Interdependencies and risks

Interdependencies:

- Other options that are interdependent with this visioning and diagnostic effort include #7: Initiating a comprehensive modernization journey for VaCMS, #8: Establish standardized DevOps and product management processes, and #11 Establishing an initiative to strengthen vendor management practices

Risks:

- Change management activities to sufficiently include the right stakeholders at the table for visioning exercises will be critical to ensuring the success of this effort.
- Without ongoing communication and steps to relay updates and outcomes of both the visioning and diagnostic, there is a risk that both parts of this option will not establish the needed foundation for a more comprehensive modernization journey.

[100] Ohio Department of Medicaid, "The Ohio Department of Medicaid Next Generation Population Health and Quality Strategy," 2022

#7: Initiate a comprehensive modernization journey for VaCMS

Description

Type of change: Transformational Change

Given all the challenges identified with VaCMS currently on Medicaid eligibility (e.g., outdated and monolithic technology architecture making it difficult and expensive to make any changes, poor user experience, system functionality issues, limited real-time data reporting), the Commonwealth should consider a full system modernization journey. Key success factors and phases to this journey include:

Phase 1: Strengthen and unify the technology governance structure

Today there is a lack of transparency, understanding of decision-making authority, and standard evaluation criteria related to how IT investment and procurement decisions are made, specifically as related to the tradeoffs between near-term cost versus future time and cost implications, as well as whether decisions are being made strategically, with an eye towards a defined future state vision. While a VaCMS steering committee has been in place, its membership, evaluation criteria, and process are not resulting in effective improvements to the overall system. A stronger governance structure will be a foundational step for modernization and must:

- Bring senior leaders to the table to support review and decision making.
- Include the right technical expertise to adequately evaluate and interpret proposals that come before the governing body.
- Support consistency in decision-making across VDSS, VITA, DMAS, and other state stakeholders to ensure that all parties are moving toward the same objectives, hence reducing organizational siloes, wasted investments, and misaligned initiatives.
- Develop a way for stakeholders of VaCMS to be at the table with state agencies to support the modernization journey – including staff from across LDSS agencies, the DMAS CoverVA Call Center, the DSS Enterprise Call Center, and the Virginia Insurance Marketplace, as well as outreach workers, association groups like the VLSSE and Virginia Benefit Programs Organization, etc.
- Establish a transparent prioritization framework to support prioritizing and triaging competing system needs or updates between programs in the Commonwealth's integrated benefit structure.

Phase 2: Develop an implementation roadmap for a modernization journey

- Once the North Star vision and current state technical assessment are completed, the governing body can establish an initiative and working team to develop a roadmap to guide the modernization of VaCMS toward the "North Star" future vision.
- The roadmap should leverage the current state assessment, stakeholder feedback, and benchmarks to establish a phased timelines with milestones, owners, and key performance indicators (KPIs).
- The architecture strategy should follow a "use case" based approach – meaning the governance team in place will need to identify the key use cases that the architecture must support, and understand how to close the gap between the current state and desired North Star future state for each use case.
- A roadmap will also need to:
    - *Transition the system to a modular architecture built on microservices and human-centered design principles*. This shift will reduce current, tight integration and dependencies, making it easier to implement updates and adapt to future needs with greater flexibility. Microservices are focused, bite-sized snippets of code that that split a big, complex system into small, loosely coupled and easier-to-manage pieces. These individual components communicate and work together efficiently, but are developed, changed, and replaced independently, and each is powered by its own resources. They can also be deployed separately or at scale, with minimal impact to the broader system, and at a fraction of the time and cost associated with system

monoliths like VaCMS. Microservices are most effective when shared and reused within and across agencies in perpetuity, ensuring standardization, reducing technical debt, and increasing flexibility.

- *Address front-end user experience issues by deploying human-centered design*. Due to the tightly coupled nature of the system which introduces interdependencies across the tech stack, a true redesign of the frontend must be coordinated with changes to the data layer, given where some of the issues originate. To enable a modern and user-friendly frontend when changes are possible, human-centered design will be critical. VDSS should design, test, and iterate on functionality leveraging continuous feedback from caseworker and other state users as the ultimate customers. These users should be placed at the center of development, testing, and resulting improvements. In addition to agency-level stakeholders, VaCMS human-centered design should involve all 120 LDSS to capture caseworker needs and ensure technology improvements benefit the collective whole of the users they are intended to help.

Phase 3: Implement the roadmap in an agile approach and leverage standardized DevOps

- Implement the roadmap and provide rigorous oversight through the new technology governance structure to track and monitor KPIs, provide issue resolution, manage overall resourcing commitments, and continually ensure operational decisions are being made with the "North Star" vision in mind.
- Leverage standardized development and operations ("DevOps") practices to ensure consistent, secure, and more rapid development cycles. (See option #8 for more details on this approach which. While less desirable, this can also be done as a stand-alone option in the current VaCMS system.)
- Conduct pilots to confirm value and efficacy with users outside of the VaCMS production environment and ensure that pilot testing is done with clear success metrics and comprehensive end-user feedback.
- Facilitate a 'retrospective' following the pilot phases, to identify challenges, process inefficiencies, and other pain points. Leverage lessons learned to inform ongoing and planned DevOps, and enable incremental improvements related to development processes and ways of working.

Pain point(s) addressed and est. impact

Pain point(s) addressed: VaCMS is comprised of a diverse set of technology components in various stages of the technology lifecycle, ranging from modern, integrated tools to those at end-of-life. Some of these components place outsized constraints on dependent Medicaid processes and limit the functionality of adjacent technologies within VaCMS' tightly integrated system. System testing raised questions about system performance at moderate to high user volumes, which is also in line with complaints LDSS workers vocalized in surveys and interviews for this assessment.

Est. impact:

- Enable rapid, cheap, and modular system enhancements that can be quickly developed on top of existing capabilities and tested, rather than costly change requests.
- Improve system stability, as issues in a single microservice will not impact other areas of the system
- Initiate the transformation journey through incremental and strategic modernization investments, maximizing return on investment.
- Increase productivity by replacing inefficient technologies and capabilities adversely impacting system performance, eligibility processes, and user experience with their modern counterparts.
- Improve functionality and value delivered to VaCMS users, while enabling VDSS and vendors to implement and improve new ways of working.

Example Benchmark(s)

- **California** adopted a cloud-first, microservices-oriented modernization approach resulting in a 50% increase in system responsiveness, 90 second system recovery compared to 90mins historically, followed by a record number of enrollments.[101]
- **New York's** modular Medicaid Information System (NYMMIS) applied microservices to enable modular integration with federal systems, improving scalability and performance.
- **Wyoming** replaced its legacy MMIS system with a modern, modular platform within 19 months, which has increased efficiency, reduced administrative burden and lowered costs.
- **Kansas** became the first state to achieve CMS's Streamlined Modular Certification following implementation of a fully modular platform, which received federal matching funds from the day it was released to users. Impressively, CMS found no serous defects or findings during assessment, which is an unprecedent achievement, especially given the system's scale and complexity. This modular, cloud-based solution enables greater agility and scalability, streamlining services like claims processing, provider enrollment, and program management to better serve Kansas Medicaid beneficiaries and providers.

Implementation considerations

Est. resources required	*Est. Timeline*
• Full scale modernization requires significant investment and faces risk of cost overruns and delays if not executed strategically and in alignment with best practices. • Upfront cost of refactoring services should be considered against savings achieved through reduced downtime, improved scalability, and system modularity. • There are several levers states can adopt to increase likelihood that investments in modernization are not wasted, projects are completed on time and on budget, and that anticipated value is delivered, such as through strategic, incremental investments, agile development, and technology and architecture approaches selected for future state systems.	• Phase 1 - Establishing a new VaCMS governance structure: ~6 months • Phase 2 - Determining the technical strategy and developing a modernization roadmap: ~3-6 months • Phase 3 - Implementing the roadmap: 2-3 years

Interdependencies and risks

Interdependencies:

- It is most important that option #6: Developing a shared "North Star" vision for VaCMS and conducting a full system diagnostic) be conducted in concert with this option. Other options that are interdependent with this modernization effort include #8: Establishing standardized DevOps and product management processes; #9 Standing up a data team to support VaCMS; #10 Onboarding a Master Data Management (MDM) solution; and #11 Establishing an initiative to strengthen vendor management practices.

Risks:

- Vendor contracts and system dependencies add complexity, making the effort challenging and resource-intensive.

[101] National Association of State Chief Information Officers (NASCIO) State IT Recognition Awards, "Digital Services: Government to Citizen. Covered California and the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)," 2024

- Lack of alignment, governance, or best-in-class development methodologies and talent may introduce unanticipated time, costs, and tradeoffs in the quality and value of the resulting eligibility capabilities.
- Modernization of public sector systems and technologies via microservices is a relatively new strategy, for which there is not one single approach proven to be more effective, or to yield the most benefits. The The Department of Labor's "Open Unemployment Insurance (UI)" initiative, research, and subsequent 'phase 1' report released by Georgetown University[102] notes that "Questions still remain for some about core migration strategy, e.g., whether to "lift and shift" entire systems into the cloud and then modernize them, or modernize "on the way" to take advantage of migration."

#8: Establish standardized DevOps and product management processes

Description

Type of change: Transformational Change

To modernize Virginia's Medicaid systems and support long-term sustainability, it is essential to establish standardized, agile development and operations (DevOps) as well as product management processes. Given the Commonwealth's current reliance on vendors, building a state-owned DevOps function will require a phased approach that combines internal capability and capacity building with vendor governance.

This approach would also draw from the architecture governance recommended in option #6, which is required to guide future development initiatives. It will also depend on the transformation from waterfall to agile and other evolved state-vendor ways of working, as discussed in solution option #11.

DevOps would enable this governance to be operationalized and enforced, aligning technologies across teams and adjacent systems. In this model, vendors would be held to standardized DevOps practices, tools, and testing aligned with Virginia's long-term architecture goals

Initially, a "greenfield" approach can help develop foundational, in-house DevOps capabilities focused on high-priority areas. To support a standardized DevOps framework within Virginia's Medicaid systems, implementing a secure, centralized DevOps infrastructure that emphasizes the use of standardized toolchains, reusable components, and secure repositories Is recommended.

First, VDSS, DMAS, and VITA should take an inventory of the DevOps talent, state-mandated processes, and DevOps tooling/technology assets currently available to establish their DevOps "baseline." Over time, these stakeholders should grow and maintain an up-to-date inventory of DevOps tools, using a standard toolchain across all development teams to drive consistency, efficiency, and security.

Next, the Commonwealth should build a secure, shared repository for reusable components, automation scripts, and configurations. This repository will streamline development by enabling teams to leverage pre-validated components, promoting consistency, and minimizing duplication of effort. This approach fosters collaboration and enhances innovation by leveraging secure, shared repositories, promoting secure code and component reuse (e.g., microservices), and partnering with stakeholders across the Commonwealth to incrementally share, embed, and standardize these reusable services.

[102] Georgetown University Beeck Center for Social Impact and Innovation, "Unemployment Insurance IT Modernization Grant Projects: Phase 1 Summary Report," 2024

Third, workflows that prioritize reusable code and infrastructure-as-code practices should be designed, enabling quicker deployments, easier maintenance, and enhanced security. Additionally, reusable components will reduce errors and improve code quality across applications.

Investing in training and capacity building will be crucial, allowing Virginia's workforce to gradually assume control over previously vendor-dependent areas. Cross-training and knowledge-sharing practices can help the Commonwealth's DevOps capabilities grow sustainably.

Integrating human-centered design principles into all user-facing development efforts will foster a more responsive and streamlined system, encouraging users to engage with digital channels. Establishing feedback loops between system developers and Medicaid users will enable continuous improvement, ensuring that the evolving needs of caseworkers and program participants are prioritized.

Finally, the Commonwealth should require vendors to align with Virginia's DevOps standards, mandating the use of these shared repositories, toolchains, and automation practices.

This standardized approach will not only expedite progress against system backlogs but also decrease total cost of ownership by reducing dependencies on individual resources and minimizing errors through automation. The standardization and harmonization of system infrastructure and reusable code will drive operational efficiencies, unlocking economies of scale, and improving integration across state and federal benefits ecosystems. Early detection of defects and security vulnerabilities will further reduce rework and protect system integrity, ensuring long-term sustainability and scalability.

Pain point(s) addressed and est. impact

Pain point(s) addressed:

- Manual processes and lack of standardized, vendor-preferred DevOps pipelines and tooling slow the development lifecycle.
- Insufficient use of DevOps automation increases manual tasks, reducing efficiency and increasing deployment risks.
- Communication gaps between development and operations teams slow issue resolution and feature delivery.
- The absence of real-time monitoring limits the ability to proactively detect and resolve system issues and results in service disruptions.
- Lack of human-centered design principles integrated into DevOps processes result in questions around usability and functionality, as well as value delivered to the ultimate customer and stakeholder.

Est. impact:

- Enable rapid development cycles, reduce manual interventions, and help ensure that environments are consistent and reproducible, hence maximizing developer productivity while removing agency siloes.
- Accelerate progress against system backlogs to rapidly deliver software fixes, new features, and changes in support of new policy mandates.
- Automate deployment pipelines end-to-end to decrease Total Cost of Ownership, reduce resource and talent dependencies, and limit instances of human error.
- Standardize system infrastructure and technologies via reusable code and components to improve productivity and streamline O&M, unlocking economies of scale such as through procurement bargaining power.
- Improve the depth of integration and compatibility of MES data and technologies across the Commonwealth, CMS, and federal benefits ecosystems.

Identify defects and embed security earlier in the development process to prevent costly fixes and rework down the line.

Example Benchmark(s)

- **IRS** faced challenges with non-repeatable deployment processes. They formed a dedicated DevOps team to automate their pipeline, reducing lead times for new builds and improving collaboration across teams. They successfully automated over 16,000 hours of manual work annually. Reduced person-hours for specific tasks from 30 hours to 4 hours.
- **United States Citizenship and Immigration Services (USCIS)** increased its delivery cadence, or the pace at which system fixes and changes are deployed, by 356%, with releases at least once daily, after its digital transformation.[103] The agency adopted agile ways of working and infused human-centered design into development processes to manage its growing caseload and deploy more functionality, faster. Additional outcomes included a 70% reduction in data required from applicants, a 15% reduction in its backlog, and an 80% decrease in processing times for pre-screenings. Applicants also saw waiting times for security checks drop to less than 24h, from more than a week. USCIS notes that these successes can be attributed to leadership buy-in and development experimentation.
- **Kentucky's** DevOps test plan and governance model are well-established, with clear roles outlined for the Office of Application & Technology Services (OATS) and vendors. Engineers leverage automation tools for testing, and a shared repository for code and testing scripts.

Implementation considerations

Est. resources required	*Est. Timeline*
• Investments required include tooling, automation platforms, licensing fees, state resources, and implementation costs. Over time these recommendations, if fully implemented, will result in outsized benefits as well as cost savings and cost avoidance over time	• Post-modernization of VaCMS, full scale implementation would be achieved in 6-12 months

Interdependencies and risks

Interdependencies:

- This approach would draw from the architecture governance recommended in option #6, which is required to guide future development initiatives. It will also depend on the transformation from waterfall to agile and other evolved state-vendor ways of working, as discussed in solution option #11.

Risks:

- Current tech stack & legacy DevOps tooling limits automation in current VaCMS pipelines, which will delay full automation.
- Additional risks include the diversity of systems, resistance to change, integration challenges with legacy systems, current vendor ways of working / lack of state visibility into DevOps, and skills gaps within internal teams, as well as the dependency on modernization.

Strategy D: Improve Data and Reporting Capabilities

This strategy is about improving Medicaid business process efficiencies and delivering enhanced benefits services to Virginians through enhanced data quality, streamlined intake and verifications, and across the continuum of high vs lower impact and feasibility, Strategy D includes three options:

[103]USCIS, "Completing an Unprecedented 10 Million Immigration Cases in Fiscal Year 2023, USCIS Reduced Its Backlog for the First Time in Over a Decade," 2024

- #9: Stand up a data team, define shared data roles & responsibilities, and establish / centralize data governance
- #10: Onboard Master Data Management (MDM) solution and reconcile systems of record

<table>
<tr><th colspan="2">#9: Stand up a data team, define shared data roles & responsibilities, and establish / centralize data governance</th></tr>
<tr><td colspan="2">Description</td></tr>
<tr><td colspan="2">Type of change: Core enhancements

• Establish a more robust Medicaid eligibility specific data team within VDSS that has clear accountability over Medicaid eligibility performance data and supports routine reporting and analysis to senior VDSS and DMAS leadership. This team would expand on an existing small number of FTEs VDSS currently has that are stretched given competing demands for broader VaCMS data needs.
• Create clearly defined roles and responsibilities (e.g., data stewards, data analysts) within this new data team to support faster decision-making and promote data ownership.
• Implement data governance controls and centralized standard operating procedures (SOPs) .
• Implement technical data guardrails and controls and establish centralized standard operating procedures (SOPs) for data usage for VDSS, DMAS, and LDSS agencies utilizing and accessing eligibility data.
• Reflect data guardrails and controls into VaCMS to reduce the ability for users to create overrides and workarounds.
• Establish transparent process for making data requests and for making updates to routine reporting.</td></tr>
<tr><td colspan="2">Pain point(s) addressed and est. impact</td></tr>
<tr><td colspan="2">Pain point(s) addressed: VDSS currently lacks the dedicated resources and talent to enhance the current state of data and support key data processes such as data quality oversight or federally mandated reporting.

Est. impact:
• Centralizing data governance will lead to improved inter-agency data sharing and security, reducing redundancy and improving decision-making.
• Create uniform practices and standards to improve accuracy, reduce inconsistencies, and enhance overall reliability of data.</td></tr>
<tr><td colspan="2">Example Benchmark(s)</td></tr>
<tr><td colspan="2">• Rhode Island onboarded a dedicated data team responsible for managing and analyzing data and reporting processes, resulting in process efficiencies and improved compliance. To reduce reliance on external vendors, Rhode Island established an internal tech and data team within Medicaid. This team includes a Director of Technology, a Chief Data Officer, and 3-4 program leads who manage tickets, handle requirements, and are highly familiar with the system and data to efficiently address data requests.</td></tr>
<tr><td colspan="2">Implementation considerations</td></tr>
<tr><td>Est. resources required</td><td>Est. Timeline</td></tr>
<tr><td>• Upfront costs are required for the number of FTEs added to a data team
• Potential vendor support to facilitate establishing SOPs and data governance
• Costs should be considered against the value of reducing data errors and redundancy, and potentially yielding savings through better program performance management</td><td>• Upon budget approval to fund new positions – 6-12 months to onboard and build new team and supporting processes</td></tr>
</table>

Interdependencies and risks

Interdependencies:

- Other options that are interdependent with this effort include #10: Onboarding a Master Data Management (MDM) solution; and #11: Establishing an initiative to strengthen vendor management practices.

Risks:

- Requires upfront coordination and training to implement new data controls and SOPs.
- Requires LDSS agency buy-in for any SOPs and controls put in place.
- Need to maintain regular updates to comply with any evolving federal reporting requirements.

#10: Onboard Master Data Management (MDM) solution and reconcile systems of record

Description

Type of change: Transformational Change

VDSS can partner with DMAS and other Commonwealth agencies involved in Medicaid eligibility (i.e., SCC) to procure and implement a shared Master Data Management (MDM) solution to streamline data exchange, synchronize data in real time, consolidate and maintain accurate, consistent, and up-to-date client information across systems and provide a single, trusted system of record, and benefits such as longitudinal record traceability.

Master Data Management is all about organizing, sorting, synchronizing, and making important and accurate information easy to find and use across complex ecosystems. For example, updates to data in one system are reflected across all systems governed by the MDM in real time; the opposite of which is true today.

Across interviews and surveys, LDSS and other front-line staff have consistently pointed to issues with the quality of data entering VaCMS following intake and as it traverses VaCMS and the enrollment mainframe. There are currently multiple points across the various paths that represent flows of data that introduce quality issues. One example is client ID generation and linking of records using this unique identifier. Records often fail to match, resulting in duplicated records for the same individual. The lack of a centralized MDM approach prevents accurate association of data across systems and over time.

- **Challenges**: Without a strong MDM system, data may not be consistently deduplicated or reconciled. As a result, systems like VaCMS might display multiple records for the same individual, requiring manual reconciliation.
- **Examples**: In one scenario, an applicant submits a Medicaid application via the DMAS CoverVA Call Center, but due to the lack of a unified MDM system, the application gets assigned a new client ID in VaCMS, resulting in duplicated records. Manual data entry further introduces variations in identifying information, exacerbating the issue.

This solution can be implemented in a way that maintains control and ownership over certain data, or alternatively, in a federated manner so as to enable shared control across agencies.

Pain point(s) addressed and est. impact

Pain point(s) addressed: VDSS and DMAS each maintain competing 'systems of record' for Medicaid and benefits programs. For VaCMS, data quality is impacted by data mismatches, versioning challenges, and an inability to successfully and consistently implement unique client IDs. Cross-program data sharing and real-time synchronization would enable seamless, up-to-date information sharing across programs.

Est. impact:

- Improve service efficiency across programs by maintaining consistent, accurate datasets that update client information in real-time.
- Enhance the user experience of Medicaid staff by reducing processing bottlenecks introduced through data mismatch, reducing process redundancy and streamlining verification processes.
- Reduce discrepancies and inconsistencies in data across programs by ensuring real-time data updates across Medicaid, SNAP, and other systems.
- Introduce a single trusted and centralized system of record for VA benefits data.
- Unlock member intelligence by linking and matching patient records.
- Bolster security and compliance.

Example Benchmark(s)

- **Georgia** Gateway is an integrated eligibility system that ensures a unique client identifier across multiple programs, including Medicaid, SNAP, TANF, and childcare services. The system manages client identity data using an MDM solution that links records across different state agencies. This solution has reduced the need to create new clients by 40 percent. The average response time is less than 500 microseconds.
- **Texas** TIERS manages client information across Medicaid, SNAP, TANF, and other state services using an MDM solution with a centralized Master Client Index (MCI) to consolidate and manage unique identifiers for individuals across programs. This MDM platform ensures real-time updates across departments, such as when an individual changes addresses or applies for additional benefits. All updates are reflected across the system, improving response times and reducing discrepancies in client information.
- **New York's** Master Client Index is part of the state's broader New York State Medicaid Management Information System (NYMMIS) and other integrated systems. The MCI links data across multiple human services programs, ensuring that each client has a unique identifier that is recognized statewide. The system integrates through a centralized data hub, using Enterprise Master Person Index (EMPI) software. The state employs real-time data synchronization to update and correct records across different agencies as soon as information is changed in one system.
- **Maryland's** Total Human-services Integrated Network (MD THINK) solution was developed in response to the observation that social programs data was stored in disparate systems owned by several agencies, and that residents often had to share their personal information several times to prove eligibility. THINK leverages MDM capabilities and cloud-based infrastructure to 'break down data siloes' by consolidating all information in one place, which results in streamlined benefits operations and a better experience for benefit program participants.

Implementation considerations

Est. resources required	*Est. Timeline*
• While significant upfront costs are required for procurement of a MDM solution and system integration depending on the scale and scope selected, long-term savings come from reduced operational inefficiencies, faster eligibility verification, and reduced fraud	• Dependent on number of participating agencies and systems, as well as the availability of dedicated data resources or outsourced services this could take 1-3 years to implement

Interdependencies and risks

Interdependencies:

- Other options that are interdependent with this effort include #5: Modernizing VaCMS; #9: Standing up a Medicaid Eligibility data team and data standards; and #11: Establishing an initiative to strengthen vendor management practices.

Risks:

- The value of an MDM solution is best realized if implemented across VA benefits programs, requiring a cultural shift and improved collaboration by DMAS, VDSS, and other stakeholders. Change management will be required to enforce changes and processes to utilize this solution.

Strategy E: Enhance Management and Governance of IT Vendors

This strategy, and the single option provided, is about increasing transparency into day-to-day operations while reducing dependencies on vendors, such as through redesigned IT procurement governance and commercial agreements, embedding internal resources into vendor teams and evolving state-vendor ways of working, and ensuring periodic and independent systems testing (e.g., Independent Verification and Validation (IV&V). This single option solution bundles a set of critical initiatives that will deliver outsized and ongoing value to the broader technology ecosystem and the Medicaid people and processes it enable

- #26: Enhance management and governance of VaCMS IT vendors

#11: Enhance management and governance of VaCMS IT vendors

Description

Type of change: Transformational Change

Exacerbating the IT challenges with VaCMS is the Commonwealth's heavy reliance on an external technology vendor, coupled with ineffective contracting and vendor management practices. Furthermore, the absence of strong service level agreements (SLAs) limits the Commonwealth's control and flexibility in making changes to VaCMS, leading to increased ongoing costs. Prior to a large scale VaCMS modernization effort, and ideally any further IT decision or system change, the VDSS should overhaul its IT procurement and investment governance, with an eye towards redefining how IT vendor contracts are designed, the ways in which the Commonwealth and vendors should engage and collaborate and approach for system testing. At minimum, VDSS should:

- Establish a new and more effective vendor governance board for VaCMS (and other supporting eligibility technologies) to enhance accountability and oversight, and explore alternative strategies to improve procurement processes, safeguard against vendor lock-in, and make investment recommendations based on cost vs. value considerations. Additionally, to assure change, this governance board or forum must establish a standard & structured way to assess vendors, as well as be empowered with some degree of decision-making authority. Learnings from the existing VaCMS steering committee in place show the need for senior leaders to be part of this governance board and for clear process expectations on how investment proposals and change requests need to be structured for consideration by the board. Having independent technical experts on this board to adequately assess and review proposals is critical. The new vendor governance board must also appropriately document the outcomes and cost implications of decisions. Ultimately it would be beneficial to have a North Star vision defined for modernization to inform decision making and help weigh near term priorities against the Commonwealth's longer-term goals.

- Include more robust outcome-based, continuous improvement and performance accountability clauses and thresholds (e.g., SLAs, Quality Assessment Plans) into vendor contracts and interagency agreements to ensure vendors implement ongoing enhancements of high quality that are in the best interests of the Commonwealth, align with industry best practices, and are held accountable to established contracts. Just as systems can become outdated and monolithic, so too can vendors. The Commonwealth should avoid procuring a single vendor to develop as well as test, operate and manage systems, and significantly

limit or prohibit multi-year sole sourcing. Instead, consider ongoing vendor performance reviews aligned to contractual continuous improvement clauses to support alignment with VDSS strategy and vision.

- Evolve state-vendor ways of working from waterfall to agile and embed internal technical experts into vendor teams to enhance transparency and collaboration and ensure that the vendor maintains high standards in operations and maintenance. Encourage a culture of experimentation, and enable technical teams to 'fail fast,' and rapidly reset to consider a different approach. The agile model is especially critical to facilitating such a culture and its DevOps processes. Assign an internal or independent Product Owner to oversee and strategically manage the direction of VaCMS O&M and modernization on behalf of the Commonwealth, and in alignment with the North Star vision.

- Procure periodic independent systems testing services (such as independent verification and validation (IV&V) services) to re-test and validate the VaCMS functionality and capacity, and make recommendations for systems performance enhancements.

Against the backdrop of a broader VaCMS modernization journey, this option should be considered a foundational component to any technical implementation.

Est. impact and pain points addressed

Pain points addressed:

- Heavy reliance on an outside technology vendor to support O&M and lack of robust governance board to support vendor oversight and manage state costs.
- Few effective service level agreements (SLAs) that limit the Commonwealth's control and flexibility in making changes to VaCMS, ultimately impact ongoing costs for maintaining the system.
- Past system testing conducted by the same vendor responsible for O&M does not provide an independent assessment on a regular basis.

Est. impact:

- **Procurement governance:** An effective governance board will make informed recommendations or decisions that balance short-term cost with long-term value, and allow expert perspectives on technology, teaming, and budget to be equally considered. This is likely to result on a measurable return on technology investments over time.
- **Contracts and interagency agreements:** Outcome-based, modular contracts will result in assurance that appropriate levels of quality in performance are achieved, that payment is made only for services that meet those levels, and the agencies relying on these vendors to support key business processes partner to ensure value is delivered to all parties involved.
- **Ways of working and testing methods:** Embedding internal or independent talent with vendors will increase transparency, enable operational continuity and transfer of institutional knowledge, and assurance that system changes are approached with the best interests of the Commonwealth in mind. Additionally, a dedicated product owner operating independently of the vendor team can align decisions with the North Star vision, and prioritize the needs of the customers it serves. Unlike a project manager, who focuses on planning and monitoring projects, a product owner's focus is on the goals and mission of the agency, the value of the product to its users, and the collective technology team's quality of work and well-being. Last, independent testing will deliver results without potential conflicts of interest, and bring a piece of mind to VDSS and its staff, whose work-life balance and livelihood depend on VaCMS.

Example Benchmark(s)

- **Indiana** effectively leveraged its Medicaid eligibility IT vendor, Deloitte, by implementing a robust incident management system to ensure quick prioritization and resolution of workflow disruptions, minimizing the impact on benefits processing. They negotiated specific Service Level Agreements (SLAs) that held

Deloitte accountable for critical incident management and system maintenance, including regular patching (e.g., Windows and Java updates) under a protected fixed-cost model to avoid unplanned expenses. Indiana successfully introduced these new SLAs by using consistent language across the state's RFPs and contracts with Deloitte and other IT vendors, strengthening their negotiating position.

- **Rhode Island** Medicaid established a dedicated vendor management team as part of its remediation of the Unified Health Infrastructure Project (UHIP), the state's Integrated Eligibility System. This included a robust governance structure across agencies to ensure timely and effective system enhancements from their IT vendor, Deloitte. In addition, the state leveraged the expertise of recently retired private-sector tech executives who were able to credibly improve vendor accountability and implement best practices, drawing on their industry knowledge and experience. Now, the UHIP team, made up of project managers, contract managers, and release managers (~10 people), oversees the scope of work and maintains a strong vendor relationship. The governance structure includes a weekly working team meeting to track progress and manage upcoming system changes, as well as regular Steering Committee meetings of agency directors to review and approve major changes.

Implementation considerations

Est. resources required	*Est. Timeline*
• The transition to improved vendor management practices is likely to incur up-front costs but deliver outsized savings over time, such as through strategic technology investments that deliver a return on investment, accelerated delivery of higher quality software improvements, and productivity and efficiency gains • An example is the advantage of embedding internal tech resources alongside key vendors. The cost of bringing in a developer or upskilling current employees in the skills required to work alongside technology vendors is tiny in comparison to the cost and scale of challenges incurred with vendor-led, custom software projects	• While there are various dimensions to this option, value can be realized quickly as recommendations are adopted – as early as in the first 6-12 months • The VaCMS O&M RFP is currently under review, and near term value can be realized by adjusting this RFP to include additional SLAs, etc.

Interdependencies and risks

Interdependencies

- Other options that are interdependent with this effort include #7: Modernizing VaCMS; #8: Establishing standardized DevOps and product management processes; #9: Standing up a Medicaid Eligibility data team and data standards; and #10: Onboarding a Master Data Management (MDM) solution.

Risks

- The biggest risks to procurement governance and improved vendor ways of working are related to change management, given that similar efforts have been attempted in the past and failed, as well as the historically siloed nature of the VDSS and VITA organizations.

Challenge Area 3: Insufficient Governance Structure across DMAS, VDSS, and LDSS Agencies

To address this challenge area the Commonwealth must consider ways to accomplish the following strategies:

- F: Strengthen collaboration between regional Medicaid consultants, VDSS, and DMAS leadership
- G: Increase collaboration between State and LDSS agencies

Strategy F: Strengthen Collaboration between Regional Medicaid Consultants, VDSS, and DMAS Leadership

This strategy aims to fortify and institutionalize collaboration between DMAS, VDSS, and the regional Medicaid consultants. Across the continuum of high vs. lower impact and feasibility, the Strategy F includes two options:

- #12: Design and institutionalize a joint DMAS-VDSS Steering Committee on Medicaid Eligibility
- #13: Realign central and regional Medicaid consultants to DMAS

#12: Design and institutionalize a joint DMAS-VDSS Steering Committee on Medicaid Eligibility

Description

Type of change: Core Enhancement

Based on interviews and the current ways of working documented between the two agencies, a core enhancement to the Medicaid eligibility governance model would be to more clearly institutionalize DMAS and VDSS collaboration by updating the MOU between DMAS and VDSS to ensure that collaboration is not solely reliant on the current set of informal relationships.

- This would begin by establishing a permanent Medicaid eligibility leadership team or "Steering Committee" with key leadership roles from both agencies including but not limited to the DMAS Director, DMAS Deputy of Administration & Coverage, Commissioner of Social Services, DSS Deputy Commissioner of Human Services, DSS Chief Deputy Commissioner.
- The stand up of this formalized Steering Committee would require first documenting the areas in which DMAS and VDSS need to collaborate, e.g.: funding of Medicaid eligibility, VaCMS updates, policy changes to comply with any state and federal regulations, data and reporting, etc.
- Then leadership will need to develop and agree upon a charter for the committee that outlines the types of decision rights each agency has independently vs. what the Steering Committee oversees, the cadence for meetings, approach to agendas and the topics leadership needs routine visibility on, process for escalating issues to the Steering Committee, process for staff to brief the Steering Committee, process for coordinating and briefing the Secretary of Health and Human Resources (HHR) or other state leaders as needed, etc.
- The Steering Committee can also determine when special improvement initiatives or task forces are required to ensure focused collaboration on key issues. The recent PHE unwinding task force is a good example of what this Steering Committee could establish.
- Additionally, this Steering Committee could have oversight over broader Medicaid eligibility efforts leadership decides to pursue from this report.
- The Steering Committee could also establish a stakeholder advisory forum to inform improvement efforts and engage periodically with the SteerCo leadership on Medicaid eligibility.

Pain point(s) addressed and est. impact

Pain point(s) addressed: Given the bifurcated relationship DMAS and VDSS have on Medicaid eligibility, leaders interviewed indicate the current ways of working are more informal and not permanently institutionalized. This can create lack of visibility on Medicaid eligibility (in both directions) and limits communication that could more proactively address performance improvements. Additionally, developing a more formal operating model will prevent the need for HHR or other state leaders to intervene in an ad hoc manner. Overall, it is an organizational

design best practice to have robust collaboration mechanisms and a clear operating model for accountability and decision making.

Est. impact:

- Institutionalizing a governance model can promote the type of strong collaboration between DMAS and VDSS that was built during PHE unwinding endures.
- Improve data sharing across agencies to inform decision making and jointly provide oversight on LDSS Medicaid eligibility performance.
- Ensure that technology investments (e.g., CommonHelp upgrades) are made with joint alignment of agencies.
- Coordinate on federal and state reporting requirements and briefings to senior leaders on Medicaid eligibility.

Example Benchmark(s)

- **Indiana:** Collaboration across agencies was mandated from the Secretary of Health and reinforced through state agency leadership. This has allowed Indiana's Medicaid and social services (DFR) agencies to engage their IT vendor with a united front to ensure that changes are made with both policy and technical considerations.[104]
- **Rhode Island**: Uses a structured inter-agency governance model to manage Medicaid system changes and ensure collaboration across state departments (e.g., weekly working meetings to manage upcoming system changes and address tickets (with 12 Deloitte representatives, ~10 people from the Unified Health Infrastructure Project Team, including 1 project manager, 1 contract manager, 1 release manager, and 4-5 benefit managers); weekly Steering Committee meetings with all agency directors to sign off on change requests and ensure alignment across benefit programs).[105]

Implementation considerations

Est. resources required	*Est. Timeline*
Net neutral: • Forming the working group requires no additional funding but does require leadership support and time from existing staff • Potential costs could be incurred if program management and strategic design support is required to support the SteerCo stand up	**<6 months:** • Assess current collaboration structures and gaps • Design Steering Committee governance structure, clarify roles and decision rights through establishing a charter, and formalize communication channels • Stand up and refine governance model as needed

Interdependencies and risks

Interdependencies:

- This option would be supported by option #15 Establishing clearer and more regular operational and policy-based metrics, as these metrics could inform Steering Committee / senior leadership decisions.

Risks:

- To ensure the right people are in the room to make decisions, the Steering Committee must include those with accountability and authority to make decisions on behalf of their respective organizations as it relates to Medicaid eligibility. Other interagency efforts often expand membership and senior leaders begin to deprioritize these forums or send junior delegates on their behalf. That will weaken the vision and value of this entity.

[104] Indiana Department of Health, "2021-2025 Strategic Plan," 06/2022

[105] Interview with RI Medicaid Subject Matter Experts, 09/2024

#13: Realign central and regional Medicaid consultants to DMAS

Description

Type of change: Core Enhancement

VDSS currently manages six central and five regional Medicaid consultants who support LDSS agencies with Medicaid eligibility (e.g., trainings, oversight, clarity of program policies). This solution option would realign the central and regional Medicaid consultant state staff that currently sit in VDSS to DMAS to allow the consultants to have direct line to the needs of DMAS regarding eligibility. This would mean moving the local engagement and technical assistance support to DMAS, while keeping the overall oversight of LDSS agencies with VDSS given the other social services VDSS oversees. Making this organizational change would require:

- Transfer of budget and funding for the five regional Medicaid consultants and six central Medicaid consultant staff from the VDSS budget to DMAS.
- DMAS leadership would need to determine where in DMAS these teams should report. The most logical option is likely under the Deputy of Administration & Coverage given the ownership that deputy has over Medicaid eligibility services and policy. This will help ensure that Medicaid guidance to LDSS agencies is closely aligned with DMAS' objectives and are compliant with CMS and state regulations.
- Given the integrated nature of Medicaid with other benefits at the local level, new ways of working to stay coordinated with VDSS regional counterparts will need to be defined. It will also be important for these regional Medicaid consultants to stay connected with VDSS VaCMS and CommonHelp resources.
- Coordination with VDSS on how to support LDSS agencies under corrective action plans as it relates to Medicaid eligibility.

Pain point(s) addressed and est. impact

Pain point(s) addressed: Current ways of working and operating model lead to accountability and collaboration issues between DMAS and VDSS, as well as between the state and LDSS agencies. By aligning the central and regional Medicaid consultant teams to DMAS it would support more direct coordination between DMAS (which has ultimate accountability for Medicaid policy) with the LDSS agencies receiving support and technical assistance from this consultant team.

Est. impact:

- Enhanced ability to quickly disseminate Medicaid policy updates and trainings, and closer connectivity to the policy leaders in DMAS.
- Strengthened collaboration between DMAS and regional Medicaid consultants can accelerate the flow of feedback on policy implementation, enabling DMAS to respond more quickly to on-the-ground insights.
- Collaborative problem-solving can be enhanced by combining LDSS agency challenges, identified by regional Medicaid consultants, with policy expertise and best practices provided by DMAS from other state agencies (currently 45% of LDSS staff surveyed disagree that the current organizational structure between LDSS agencies, state / regional VDSS, and DMAS support efficient Medicaid eligibility determination).[106]
- This option may also support greater prioritization of Medicaid eligibility determination at the LDSS agency level with DMAS putting more focus on this benefit (e.g., Currently, Medicaid applications meet timeliness targets only 92% of the time vs 99% for SNAP and 98% for TANF).[107]

[106] ~~BCG Survey of all LDSS Agencies,~~ 09/2024 (n=1294)

[107] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024

Example Benchmark(s)

- **In North Carolina,** regional Medicaid consultants are under operational support team with 13 FTEs. This team conducts quarterly workplans to share best practices and identify similar challenges. When there are performance issues at the county level, members of the operational support team go to county offices to triage issues. This team collaborates with counterparts from other benefit programs; however, if performance targets are not met, a county agency may have multiple corrective action plans, each tailored to the specific benefit program.[108, 109]

Implementation considerations

Est. resources required	*Est. Timeline*
Net neutral: • Realigning existing staff from VDSS to DMAS should have minimal impact on costs and funding flows (i.e., should maintain existing Federal match levels for administration, just move funding flows from VDSS to DMAS) • Some change management would be required to integrate the consultants into DMAS to realize the full value of them being part of the DMAS agency, however, the LDSS agencies would not see a change in the current employees filling these consultant roles	**6-12 months post budget authorization** • Map roles and confirm which roles will be transferred from VDSS to DMAS • Engage stakeholders to communicate the pending realignment which roles will move • Review legal and policy frameworks to ensure funding flows are maintained, understand any HR implications • Formalize the transfer and onboard consultants into DMAS

Interdependencies and risks

Interdependencies:

- This option would be enhanced by the option #14: Increasing regional Medicaid consultant capacity (i.e., add more consultants to the state team) to provide support to LDSS agencies.
- This option would be supported by the option #15: Aligning and setting expectations with LDSS agencies on operational and policy-based metrics.

Risks:

- This option retains some additional organizational complexity by keeping parts of Medicaid eligibility in DMAS and other parts in VDSS.
- Potential for coordination challenges between Medicaid and other benefit programs as LDSS agencies will need to report to multiple entities.

[108] ~~North Carolina Medical Journal, "~~Keeping North Carolina Insured: Strategies to Maintain Coverage," 2023

[109] Interview with North Carolina Medicaid, 09/2024

Strategy G: Increase Collaboration between State and LDSS Agencies

This strategy is about increasing accountability and compliance with Medicaid goals by strengthening collaboration between the Commonwealth and LDSS agencies for Medicaid eligibility determination. Across the continuum of high vs. lower impact and feasibility, Strategy G includes four options:

- #14 Increase the capacity of regional Medicaid consultants to provide oversight and support to LDSS agencies
- #15 Align on operational & policy-based metrics to set performance expectations with LDSS agencies
- #16 Set clear expectations and develop incentives & penalties to hold LDSS agencies accountable
- #17 De-integrate Medicaid from current local administration structure to provide direct state execution and control over Medicaid eligibility

#14: Increase the capacity of regional Medicaid consultants to provide oversight and support to LDSS agencies

Description

Type of change: Core Enhancement

Increase capacity of regional Medicaid consultants to provide sufficient oversight, address programmatic challenges, and facilitate LDSS-specific trainings by:

- Increasing the number of regional Medicaid consultants.
- Hiring VaCMS-specific consultants to escalate VaCMS tickets and address IT-specific issues.

Pain point(s) addressed and est. impact

Pain point(s) addressed: Regional Medicaid consultants are overstretched and do not have the capacity to provide sufficient oversight and support to LDSS agencies. Regional Medicaid consultants today spend a growing portion of their time focused on assisting LDSS staff with VaCMS specific issues.

Est. impact:

- Maximizes the regional Medicaid consultants' Medicaid-specific experience and programmatic expertise to support LDSS agencies.
- Decreases the number of agencies per consultant (Virginia has ~24 LDSS agencies per consultant) to peer state levels (8-12 per consultant), allowing regional Medicaid consultants to spend more time with each LDSS agency.[110,111]
- By adding VaCMS consultants, regional Medicaid consultants can focus entirely on Medicaid programming, freeing up the 25% of their time currently spent on handling VaCMS ticket escalations.[112]

Example Benchmark(s)

- **North Carolina** has 13 regional Medicaid consultants per 100 local agencies (~8 per consultant).[113]
- **Georgia** has 14 regional Medicaid consultants per 169 local agencies (~12 per consultant).[114]

[110] VDSS Organizational Chart
[111] Interviews with Peer States (North Carolina and Georgia)
[112] Interviews with DSS regional Medicaid consultants, 09/2024
[113] Interview with North Carolina Medicaid, 09/2024
[114] Interview with Former GA Chief Deputy Division Director in the Dept of Human Services, 08/2024

Implementation considerations	
Est. resources required	*Est. Timeline*

Requires additional costs / funding:
• ~5 FTEs to either:
  ○ Double current capacity of regional Medicaid consultants
  ○ Assign 1 VaCMS consultant per region to support all programs
• Minimal change management required as roles for Medicaid consultants already exist, and the Eastern Region previously had a VaCMS consultant
	<6 months:
	• Post the job, review applications, conduct interviews, and complete background checks
	• Timeline may be expedited if hiring from within VDSS or from a LDSS agency

Interdependencies and risks	
Interdependencies: • This option is complementary to option #20: Developing training content for LDSS agency staff. **Risks**: • Given high vacancy and turnover rates, it may be challenging to recruit and retain regional Medicaid consultants. • LDSS agencies may perceive the addition of regional consultants as more oversight, which could lead to resistance and poor cooperation.	

#15: Align on operational & policy-based metrics to set performance expectations with LDSS agencies
Description
Type of change: Core Enhancement Identify and agree on operational and policy-based metrics to increase oversight, set expectations with LDSS agencies, and standardize reporting. Examples include: • Conducting assessments to identify target operational metrics (e.g., caseload per workers; call center metrics; channel mix; % automation / no-touch applications). • Defining policy-based metrics to ensure compliance with state and federal requirements (e.g., revisit 97% compliance to processing applications <45 days; set targets for ex parte rates). • Developing report cards with clear expectations and consequences for missing targets (e.g., Failing report cards for consecutive months triggers a corrective action plan). • Creating a centralized performance dashboard to track relevant operational and policy-based metrics.
Pain point(s) addressed and est. impact
Pain point(s) addressed: The current operating model creates collaboration challenges between DMAS and VDSS, as well as between the state and LDSS agencies. Additionally, performance reporting from LDSS agencies and at the state level lacks standardization, limiting consistent visibility for state leaders. **Est. impact:** • Improves accountability and transparency of performance across DMAS, VDSS, and LDSS.

- Prioritizes Medicaid (e.g., Currently, Medicaid applications meet timeliness targets only 92% of the time vs 99% for SNAP and 98% for TANF).[115]
- Establishes clear benchmarks to help LDSS agencies understand what optimal performance looks like.
- Provides key data points and metrics to help LDSS agencies advocate for local / county funding (e.g., highlighting how caseload per worker compares to other agencies and with state targets).
- Helps regional Medicaid consultants quickly identify and triage more systematic issues at the LDSS and regional level rather than the individual application / renewal level.
- Streamlines and consolidates the number of reports and metrics that DMAS, VDSS, and LDSS staff need to pull to understand current performance (e.g., LDSS agencies currently pull down at least six different reports on a weekly basis and often need to dedicate a supervisor to crosswalk results across reports).

Example Benchmark(s)

- **North Carolina's** Monthly Report Card tracks county performance on key metrics such as Percent Processed Timely (PPT) and Average Processing Time (APT) for both MAGI and non-MAGI population. Compliance thresholds for PPT was set at 45 days for MAGI and 90 days for non-MAGI. APT compliance thresholds were set to account for size of counties 85% for smaller Level 1 counties and 90% for larger Level 2 and Level 3 counties. To pass the report card, counties must hit the compliance target for all four metrics (PPT for MAGI, PPT for Non-MAGI, APT for MAGI, APT for non-MAGI).[116, 117]
- **Pennsylvania's** legislature passed regulations to process all MAGI applications within 30 days, 15 days shorter than CMS' guidelines. State and regional leadership monitor local agencies through dashboards and monthly reports that are based on the 30-day target. If a determination cannot be made in 30 days, the local agencies must send a notice to the applicant explaining the delay and extending the timeline to 45 days.[118]

Implementation considerations

Est. resources required	*Est. Timeline*
Net neutral: • Minimal funding required but requires buy-in and time from DMAS, VDSS, and LDSS leadership to lead and participate in working groups	**<6 months:** • Stand up working group to identify and define operational and policy-based metrics • Develop a centralized performance dashboard to track aligned upon metrics • Pilot and refine metrics with LDSS agencies and other external stakeholders (e.g., Virginia League of Social Service Executive, Virginia Benefit Programs Organization)

Interdependencies and risks

Interdependencies:

- Dependent on options in Strategy D: Improving data and reporting capabilities to ensure accurate and timely monitoring of LDSS agency performance.

Risks:

- Difficulty in establishing consistent operational and policy metrics due to variations across the 120 LDSS agencies.

[115] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024

[116] North Carolina Department of Health and Human Services, "MA-2306: Application Processing Corrective Action Procedures"

[117] Interview with North Carolina Medicaid, 09/2024

[118] Interview with Pennsylvania Office of Income Maintenance (OIM) Subject Matter Experts, 10/2024

- Data inconsistency and accuracy issues may lead to misguided decisions at the DMAS, VDSS and LDSS agency levels.
- LDSS agencies may resist increased oversight, especially if data accuracy issues cause them to be wrongly flagged for missing performance targets.

#16: Set clear expectations and develop incentives & penalties to hold LDSS agencies accountable

Description

Type of change: Transformation change

Set clear expectations for aligned operational and policy metrics, and implement accountability mechanisms to ensure all LDSS agencies meet these standards. Steps to achieve this include:

- Clarify roles and responsibilities across DMAS, VDSS, and LDSS to improve accountability for meeting operational and policy metrics.
    - DMAS guides policy metrics for Medicaid applications to meet CMS requirements.
    - VDSS, including central and regional Medicaid consultants, monitors each LDSS agency's Medicaid performance and implements incentives and penalties.
    - Each LDSS agency monitors their own performance and actions any directives sent by VDSS.
- Leverage newly created report card and dashboards to monitor individual LDSS agency's performance.
- Create a working team to establish minimum standards all LDSS agencies must meet.
- Outline key mechanisms to implement when LDSS agencies achieve / miss aligned expectations
    - E.g., Potential mechanisms could be improved funding for LDSS agencies which show improvement in Medicaid processing or have implemented Corrective Action Plans to address low performance.

Pain point(s) addressed and est. impact

Pain point(s) addressed: The current ways of working and the operating model create collaboration challenges between DMAS and VDSS, as well as between the state and LDSS agencies. Additionally, performance reporting from LDSS agencies and at the statewide level lacks standardization, limiting consistent visibility for state leaders.

Est. impact:

- Medicaid processing times meet timeliness targets at lower rates (92%) compared to TANF (98%) and SNAP (99%). Higher SNAP processing rates are partly explained by penalties imposed on agencies if targets are not met.[119]
- Creating accountability mechanisms can motivate LDSS agencies to prioritize Medicaid applications and improve their Medicaid application processing overall.

[119] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024

Example Benchmark(s)	
• **North Carolina's** county report cards track PPT and APT. If a county fails the Report Card for three consecutive months or five times in 12 months, they are placed under a Corrective Action Plan, though they can submit waivers citing external factors like staffing shortages.[120, 121]	
Implementation considerations	
Est. resources required	*Est. Timeline*
Net neutral: • Minimal net funding is required but will require engagement with DMAS, VDSS, and LDSS leadership to implement • Utilize existing central and regional Medicaid consultants to provide oversight and institute Corrective Action Plans	**6-12 months** • Create working team to assign roles and responsibilities across DMAS, VDSS, and LDSS • Collaborate on what operational and policy metrics to track and which incentives and penalties are constructive (e.g., Corrective Action Plans, funding changes) to motivate LDSS agencies to meet Medicaid expectations • Pilot new accountability mechanism and evaluate their impact on LDSS agency's Medicaid processing • Roll out to broader LDSS agencies after incorporating initial learnings
Interdependencies and risks	
Interdependencies: • This option also complements option #14: Increasing the number of regional Medicaid consultants to monitor LDSS agency performance and support the implementation of incentives and penalties (e.g., funding tied to attendance at additional training sessions). • This option is dependent on option #15: Aligning on operational & policy-based metrics. This allows LDSS agencies to have a clear understanding of the benchmarks they are evaluated against. **Risks:** • Incentives based on adjusted reduced funding requires the VDSS commissioner to receive authorization from the state board of social services before filing a request to withhold funds with the state comptroller. Instead of withholding funds, consider incentivizing LDSS agencies with greatest improvement in Medicaid processing to receive additional funds. This will need to be validated with existing state regulations and codified if authority does not exist. • LDSS agencies may feel overburdened by Medicaid performance monitoring in addition to other existing metrics. To mitigate, collaborate with other program directors (e.g., TANF, SNAP) to create unified performance / accountability metrics. This will limit a patchwork approach of different program report cards LDSS workers are evaluated against.	

[120] Interview with North Carolina Medicaid, 09/2024

[121] North Carolina Department of Health and Human Services, "MA-2306: Application Processing Corrective Action Procedures"

#17: De-integrate Medicaid from current local administration structure to provide direct state execution and control over Medicaid eligibility

Description

Type of change: Transformational Change

De-integrate Medicaid eligibility from other benefit programs (e.g., SNAP, TANF) and shift responsibility of processing Medicaid applications and redeterminations from VDSS / LDSS to DMAS by:

- Assuming responsibility and operational control over the eligibility determination process (e.g., setting up a distinct policy and oversight structure).
- Creating a new MOU that outlines roles and responsibilities between DMAS, VDSS (e.g., manage VaCMS), and LDSS (e.g., provide in-person intake support to applicants) for Medicaid eligibility.
- Repurposing a portion of the LDSS vacancies to build out a specialized staff dedicated to Medicaid. The current vacancies may not suffice as vacancies make up 16% of staff and random moment sampling (RMS) estimates that 20% of eligibility staff's workload is on Medicaid.
- If unable to build out Medicaid-specific eligibility staff, increasing scope and utilization of CoverVA's central processing unit to assist processing of applications and renewals.
- Eventually standing up a separate application and renewal IT platform that is designed for Medicaid and overseen by DMAS.

Pain point(s) addressed and est. impact

Pain point(s) addressed: Current ways of working and operating model lead to collaboration and accountability issues between DMAS and VDSS, as well as between the state and LDSS agencies.

Est. impact:

- Prioritizes Medicaid (e.g., Currently, Medicaid applications meet timeliness targets only 92% of the time vs 99% for SNAP and 98% for TANF).[122]
- Streamlines the Medicaid applications, renewals, and processes by no longer requiring applicants and LDSS staff to navigate eligibility requirements across programs.
- Trains and develops specialized staff with deep expertise on Medicaid eligibility (e.g., only 42% of LDSS staff agree or strongly agree that the provided training allows them to successfully do their job).[123]
- Enables Medicaid to quickly adapt to federal changes without having to align with VDSS, if DMAS stands up a system dedicated to Medicaid.
- Enhances accountability and oversight by tailoring performance metrics specifically to Medicaid.

Example Benchmark(s)

- Following ACA, **Tennessee** de-integrated their Medicaid program from other program benefit eligibility operations (e.g., SNAP, TANF). Tennessee absorbed the staff vacancies from local agencies to build out a centralized determination office. Through a MOU, local agencies provided navigators to support the intake process and answer questions from applicants. Through this process Tennessee also developed a new eligibility system that was heavily automated and more compliant with ACA guidelines. Although still de-integrated, Tennessee is now working to streamline the application process for the user by having their system interface with the IT system for other benefits to automate multiple benefit programs at the same time.[124]

[122] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024
[123] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)
[124] Interview with TennCare, 09/2024

- On average, states that did not integrate benefit eligibility processed more MAGI cases within 24 hours (47%) compared to states with integrated benefit eligibility (like Virginia) that processed fewer MAGI cases within 24 hours (22%). Additionally, states that did not integrate benefit eligibility processed more of their cases within CMS' 45-day guidelines (89%) compared to states with integrated benefit eligibility (85%).[125]

Implementation considerations

Est. resources required	*Est. Timeline*
Requires additional costs / funding: • If counties do not fund this transition, requires an additional ~$25-30M a year (e.g., County / localities provided $26M in funding to LDSS agencies in FY23) from the Commonwealth to maintain current Medicaid staffing and operations • Requires additional costs for change requests to update current IT systems and to design and build a Medicaid-specific eligibility system • Requires additional FTEs to process applications and renewals as well as an expansion of the Administration & Coverage team to provide operational oversight of eligibility determinations • Significant change management is required including engaging key eligibility and Medicaid stakeholders early, redesigning processes, transitioning IT systems (e.g., separating databases, creating new interfaces), and creating external communications plan	**2-3 years:** • Significant planning and stakeholder engagement to define the scope and goals of the de-integration • Design and develop new policies and procedures to manage eligibility determination • In the short term, work with VDSS and VSCC to upgrade technology platforms and systems to follow new processes • In the long term, issue RFP to build a new Medicaid-specific eligibility system • Pilot testing of de-integrated model with one region to gather feedback and refine • Launch change management and communications plan with the rollout of the updated processes and systems

Interdependencies and risks

Interdependencies:

- Dependent on options under Strategy A: Enhancing digital experience for applicants to facilitate centralization of eligibility determination.

Risks:

- Pushback from LDSS agencies and staff who may feel that they are losing autonomy.
- Loss of additional funding from county / locality match.
- Increased administrative burden on DMAS to manage the operations of eligibility determination.
- Potential loss of workarounds that best addressed the needs of the local community (e.g., utilizing paper / in-person channels for applicants who do not have reliable access to the internet).
- If using a vendor to assist in eligibility determinations (e.g., CoverVA), vendor costs may rise as DMAS could become dependent on the vendor, reducing its leverage in future contract negotiations.

[125] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024

Challenge Area 4: Inconsistency in Eligibility Processes and Poor Timeliness of Applications

To address this challenge area, the Commonwealth must consider ways to accomplish the following Strategies:

- H: Identify, scale, and standardize best practices and processes
- I: Strengthen and develop LDSS workforce capacity and capabilities
- J: Balance workloads across Virginia and LDSS agencies

Strategy H: Identify, Scale, and Standardize Best Practices and Processes

This strategy is addressing the inconsistency in accurate and timely processing of Medicaid applications by standardizing processes and supporting knowledge sharing between agencies. Across the continuum of high vs. lower impact and feasibility, Strategy H includes two options:

- #18 Establish a living playbook of best practices and working group to support knowledge sharing
- #19 Conduct end-to-end redesign of existing processes and develop standardized workflows

#18: Establish a living playbook of best practices and working group to support knowledge sharing
Description
Type of change: Core Enhancement Establish a structured approach for identifying, compiling, and continuously updating best practices from LDSS agencies, Medicaid consultants, and CoverVA by: • Developing a 'living' statewide playbook that can be regularly updated to reflect changes, new insights, and improvements. • Capturing common best practices and standardized processes for Medicaid and across other benefit programs, providing clear guidelines for LDSS staff. • Forming a working group composed of LDSS eligibility staff, regional Medicaid consultants, and CoverVA representatives, meeting quarterly to share learnings and agree on standardized Medicaid eligibility approaches. • Reviewing and refining the playbook and training materials during quarterly meetings to ensure they remain current and aligned with eligibility worker needs. • Utilizing regional Medicaid consultants to support LDSS agencies in implementing best practices.
Pain point(s) addressed and est. impact
Pain point(s) addressed: Existing processes and systems are not user-friendly for eligibility staff, causing them to develop their own workarounds. This leads to inconsistent experiences for both applicants and staff, resulting in variability in processing times across channels and LDSS agencies. **Est. impact:** • Drive process consistency across LDSS agencies and decrease the variability in Medicaid timeliness compliance rate, ranging from 73% to 99% across LDSS agencies.[126]

[126] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024

- Strengthen the existing regional support model by providing a mechanism to coordinate on best practices and reinforce standardized processes.
- Foster continuous process improvement and keep LDSS agencies aligned with state-wide operational and policy objectives.

Example Benchmark(s)

- In 2023, **North Carolina** developed 30 statewide best practice recommendations to enhance efficiency and consistency across all counties. To capture and implement these practices, the Medicaid Operational Support Team (OST), consisting of 13 employees, partnered with Accenture to conduct on-site visits to the 100 counties over several months. Their work focused on identifying best practices in select counties and implementing these practices through local on-site visits and trainings.[127, 128]

Implementation considerations

Est. resources required	*Est. Timeline*
Net neutral: • Working groups can be formed with existing state staff (e.g., central and regional Medicaid consultants), LDSS agency representatives, and partners (e.g., Virginia League of Social Service Executives, Virginia Benefit Programs Organization) • Allocate time from existing FTEs to coordinate and maintain best practices and playbooks • Best practices can be integrated into current training materials and the new Training Academy	**~6-12 months:** • Capture best practices through on-site visits to LDSS agencies, prioritizing top-performing agencies across all regions and agency levels • Engage LDSS agencies in the best practice development to ensure buy-in • Define workgroup membership, meeting cadence, and logistics, such as meeting locations, communication channels, and resources for administrative support • Document best practices into the playbook via regular workgroup meetings • Establish a dedicated task force consisting of LDSS leadership, Medicaid consultants, and CoverVA representatives to oversee the creation and updates of the playbook • Share best practices across LDSS agencies by conducting on-site visits, hosting training sessions, and facilitating collaborative workshops to ensure buy-in and practical application of the playbook

Interdependencies and risks

Interdependencies:

- This option is complementary to option #20: Developing training content across staff levels and roles. The playbook can help inform and upgrade training content as well as reinforce learnings by serving as a quick reference guide.

[127] Interview with North Carolina Medicaid, 09/2024

[128] North Carolina Medical Journal, "Keeping North Carolina Insured: Strategies to Maintain Coverage," 2023

Risks:

- LDSS agencies may be resistant to adopting new standardized processes captured in the playbook, especially if they feel their local practices are more effective, slowing down the implementation of best practices and reducing the overall impact of the playbook.
- LDSS and state staff may have limited bandwidth to participate in a workgroup forum and may not proactively contribute to learnings.
- Without a regularly identifying and refining best practices, the playbook will quickly become outdated.

#19: Conduct end-to-end redesign of existing Medicaid eligibility processes and develop standardized workflows

Description

Type of change: Transformational Change

Redesign Medicaid eligibility processes using human-centered design to develop standardized workflows across agencies (incl. DMAS, VDSS, LDSS), considering the specific needs of the LDSS agency levels (I-III), and population needs (MAGI, Non-MAGI). Feedback from eligibility workers, vendors, and stakeholders will be critical to inform the redesign to ensure workflows are tailored to the distinct processes and needs of each agency and population.

An approach to implement this option could include the following:

- Establish a workgroup or task force comprised of key stakeholders and participants in Medicaid eligibility processes including both applicants and benefit workers. VaCMS technology experts should also be at the table to support areas of processes that interact with the system.
- Develop a long list of key processes that are critical to process improvement and impact overall processing times and experience. For example, communication processes for renewals, navigating non-MAGI application challenges, engaging with applicants on data collection and status updates of their application, and interacting with the CoverVA on non-MAGI application handoffs.
- Prioritize processes for the task force to redesign and develop a roadmap to tackle the redesign and standardization of these processes.
- Hold process mapping exercises to document data and information about how processes work today. Identify variability in the processes and the reasons driving variability.
- Bring key stakeholders involved in the process to an interactive workshop facilitated by the task force to reflect on pain points, offer suggestions, and provide their experiences with the process.
- Incorporate workshop feedback with LEAN methodology to develop new, streamlined process maps
- Gather stakeholder feedback on proposed process improvements and make iterations as necessary, weighing tradeoffs with the goal of the process.
- Pilot the new process and adjust as needed.
- Rollout new processes and integrate new standard operating procedures (SOPs) into training materials.

Pain point(s) addressed and est. impact

Pain point(s) addressed: Existing processes & systems are not user-friendly for LDSS staff; LDSS staff spending significant time developing manual and/or bespoke workarounds to address worker and applicant needs; applicants experience varying service levels and processing times due differing processes across local agencies.

Est. impact:

- Standardized workflows can streamline eligibility determination processes, reduce operational inefficiencies, and improve performance across local agencies. Currently, only 26 of 120 agencies are considered “high performing”, achieving higher compliance in Medicaid application timeliness while

handling higher caseload per worker than the median LDSS agency. By redesigning end-to-end processes and drawing upon best practices from these high performing agencies, performance can be improved across all agencies.[129,130]

- Opportunity to decrease variability in Medicaid timeliness compliance rate across LDSS agencies (currently ranging from 73% to 99%).[131]
- Simplifying processes can enhance user experience and employee satisfaction for LDSS staff, potentially reducing average current turnover rate of 18%.[132]
- Using a task force and interactive workshop approach to redesigning processes at the table can support stakeholder buy-in and ensure the applicants and staff impacted are part of the effort.

Example Benchmark(s)

- **Kentucky** received the Robert Wood Johnson Foundation Medicaid Innovation Award in part for its innovations in simplifying its Medicaid application process. When Kentucky Medicaid receives an application in the eligibility system, it follows a hierarchical review process for different types of benefits. The system verifies applicant information through federal data hubs and checks for potential member matches to avoid duplication within the system, streamlining the overall process.[133]
- **Michigan** launched a redesign initiative that reduced its 40+ page social benefits application by 80%, streamlining the process for 2.5 million residents and cutting processing time by 42%.

Implementation considerations

Est. resources required	*Est. Timeline*
Requires additional costs / funding: • Requires dedicated staff to stand up the effort and organize, coordinate, research, and lead process redesign workshops • Requires buy-in and time from DMAS, VDSS, and LDSS leadership to lead and participate in working groups • Potential costs may include a vendor who can bring in expertise in LEAN and agile methodology and conduct benchmarking where available. However, a "train the trainer" model can be used to minimize vendor costs and build the process improvement skill in-house at VDSS and DMAS (e.g., with regional Medicaid consultants) • When the Michigan Department of Health and Human Services (MDHHS) underwent a similar effort in 2018-2020, they partnered with a	**~1-2 years:** • Michigan's effort took roughly 2 years from starting the redesign to implementation • Conducting user research through surveys, interviews, and on-site visits to LDSS offices, understanding local demands and capturing best practices • Designing and standardizing workflows, tailored to different agency levels and populations • Updating systems to accommodate redesigned processes • Testing and rolling out new processes statewide by piloting workflows in selected LDSS offices, gathering feedback, refining workflows, and hosting statewide training sessions to ensure adoption

[129] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024

[130] DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025

[131] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024

[132] DSS HR Data, 2024

[133] Robert Wood Johnson Foundation (RWJF), "2022 Medicaid Innovation Award - Kentucky: Enrollment Innovations," 2022

local nonprofit. This could be another lower-cost option to conduct this work • Costs incurred associated with updating tech systems (e.g., VaCMS and CommonHelp) to implement redesigned processes • Change management and training, to ensure staff buy-in and adoption of new processes • Longer term, savings are possible in the staff time saved in this effort. For example, Michigan's effort halved processing time for caseworkers, freeing up their capacity for other priorities	
Interdependencies and risks	
Interdependencies: • This option will overlap and have an interdependency with option #18: Establishing a living playbook of best practices and working group to support knowledge sharing. The playbook and best practices should reflect standard SOPs and new processes designed in this option. **Risks:** • There is a risk of oversimplifying workflows without fully considering local nuances, differing agency levels, and specific population needs (MAGI vs. Non-MAGI), which could result in inefficiencies or dissatisfaction among LDSS staff and applicants. To mitigate this, local engagement and participation of these stakeholders in the process redesign effort will be critical. • Implementing new processes has a risk of disrupting ongoing operations, which could lead to temporary delays and decrease in service levels. Implementation planning should carefully factor in these considerations.	

Strategy I: Strengthen and Develop LDSS Workforce Capacity and Capabilities

This strategy is about improving Medicaid eligibility determinations, reducing backlogs, and minimizing staff burnout by addressing workforce capacity and capability gaps. Across the continuum of high vs lower impact and feasibility, Strategy I includes four options:

- #20 Develop training content across staff levels and roles, and incorporate CoverVA representatives
- #21 Build talent pipeline through partnerships and internship programs
- #22 Develop support tools (e.g., AI-driven applications) to streamline processes
- #23 Update cost allocation plans to maximize allowable federal funding
- #24 Update allocation formula to reflect demographic shift and provide adequate funding for LDSS agencies

#20: Develop training content across staff levels and roles, and incorporate CoverVA representatives
Description
Type of change: Core Enhancement

Expand the current training programs and develop training content tailored to various staff levels (e.g., leaders, seasoned staff, new hires):

- Leadership training and mentorship:
  - Provide targeted leadership training for new and existing directors, emphasizing both technical and soft skills, such as best practice processes, report interpretation, and people management.
  - Implement a mentorship program where seasoned directors support new directors during their transition from benefit programs specialist / supervisor to director.
- Refresher and policy-update trainings:
  - Develop refresher courses for existing staff to reinforce their knowledge on eligibility processes, including training on new VaCMS functionality.
  - Revisit cadence and content of trainings around major policy and system changes to ensure that eligibility staff stays up to date with the latest updates.
  - Incorporate CoverVA representatives into refresher and policy update trainings to ensure alignment across service channels and improve coordination.
- New hire onboarding:
  - Expand content of the new hire onboarding and training, with sessions on case management, system navigation on VaCMS, and handling various application types.
  - Incorporate CoverVA representatives into onboarding sessions to ensure consistency across service channels and improve coordination.

Pain point(s) addressed and est. impact

Pain point(s) addressed: LDSS agencies face workforce capacity and capability gaps as vacancy rates are as high as 56% in some LDSS agencies and only 42% of LDSS staff agree that provided training allows them to successfully do their job.[134]

Est. impact:

- Improve agency performance and Medicaid timeliness compliance rate through strong leadership, implementing consistent best practice processes, and reducing turnover (on average, LDSS directors with <3 years of tenure have a lower Medicaid timeliness compliance rate of 90.4% vs 92% for leaders with over 3 years of tenure).[135]
- Improve timely processing and reduction of overdue pending applications (18% of pending new applications are older than 45 days).[136]
- Enhance coordination with CoverVA, e.g., leading to more seamless and timely case transfers (27% of applications transferred from CoverVA to LDSS agencies are older than 45 days).[137]
- Shorten application handling times (currently 55min estimate to complete average application, 40min estimate to complete redetermination), and reduce errors and appeals due to staff being well-trained in new policies and system changes.[138]
- Increase workforce capacity by accelerating the ramp-up time for new hires, enabling them to handle complex cases, like LTC, earlier (e.g., Currently it takes 1-2 years for eligibility staff to be trained on Non-MAGI / complex cases).[139]

[134] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)
[135] DSS HR Data, 2024; PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024
[136] VDSS Appmetric Report, 09/15/2024
[137] VDSS Appmetric Report, 09/15/2024
[138] DMAS Processing Time Estimates, 2024
[139] Interviews with LDSS Directors and Staff, 08/2024-10/2024

Example Benchmark(s)

- **North Carolina** utilizes a Medicaid OST that offers policy clarifications, process improvements, and training for all 100 counties. The OST consists of 13 people and conducts on-site visits to provide in-person training and hands-on operational support. The OST has developed 30 statewide best practice recommendations, which are actively implemented to standardize and enhance processes across counties.[140, 141]

Implementation considerations

Est. resources required	*Est. Timeline*
Net neutral: • Leverage and dedicate staff time (e.g., existing trainers, Medicaid consultants, and partners like VLSS and BPRO) to update and develop the refresher and new hire training content • Incorporate CoverVA representatives into trainings will incur minimal to no additional costs • Utilize existing central and regional Medicaid consultants to deliver leadership, experienced and new hire training, and provide policy and system updates	**6-12 months** • Develop new leadership training programs and establish a mentorship model to support new directors transitioning from eligibility roles • Create and roll out refresher and policy-update trainings, incorporating best practices identified across LDSS agencies to standardize processes statewide • Update and expand new hire trainings, with enhanced focus on case management, system navigation, and handling complex applications • Integrate CoverVA representatives into both refresher and new hire trainings to promote alignment and improve coordination across agencies

Interdependencies and risks

Interdependencies:

- This option is complementary to option #14: Increasing regional Medicaid consultant capacity to support the development and delivery of new trainings and policy & system updates.

Risks:

- If attendance is optional, LDSS staff may struggle to prioritize training as competing responsibilities or tasks may take precedence.

#21: Build talent pipeline through partnerships and internship programs

Description

Type of change: Core Enhancement

Develop a talent pipeline to recruit benefit programs specialists and reduce current vacancy rates by:

- Partnering with local universities and community colleges (e.g., host career fairs and seminars) to create a consistent recruitment pipeline.
- Establishing a paid internship program to provide hands-on experience to potential recruits.
- Creating fast-track hiring processes for interns (e.g., Reduce interview rounds or pre-screening steps) to seamlessly transition interns to full-time roles.

[140] Interview with North Carolina Medicaid, 09/2024

[141] North Carolina Medical Journal, "Keeping North Carolina Insured: Strategies to Maintain Coverage," 2023

Pain point(s) addressed and est. impact

Pain point(s) addressed: LDSS agencies have workforce capacity and capability gaps with vacancy rates across LDSS agencies in 2024 at ~16%, with some agencies reaching as high as 50%.[142]

Est. impact:

- Establishing a paid internship program and partnering with local universities and community colleges will provide LDSS agencies with a steady pipeline of qualified candidates.
- With a consistent flow of new hires, agencies can distribute workloads across LDSS staff (e.g., Dinwiddie with a high caseload per worker (920), and high vacancy rate (56%)).[143]
- By gaining hands-on experience during internships, interns will require less post-hiring training, leading to faster onboarding.

Example Benchmark(s)

- **North Dakota's** Department of Children and Family Services partnered with the University of North Dakota's Department of Social Work to fund training for current child welfare workers. The goal is to help social work students enhance their leadership and practice skills to meet the growing demands of the state.[144, 145]
- **Connecticut's** Department of Children and Families partnered with the University of Connecticut to offer year-long internships, giving students hands-on training in case management and direct interaction with individuals and families.[146]

Implementation considerations

Est. resources required	*Est. Timeline*
Net neutral: • Utilize existing HR workforce to deepen partnerships with local universities and junior colleges • Repurpose a portion of funding for vacancies to paid internship programs	**1-2 years:** • Develop structured internship programs for different focus areas (e.g., application processing, front office support) • Build partnerships with local universities and colleges and plan regular engagements, e.g., at internship fairs, career days, or guest lectures

Interdependencies and risks

Interdependencies:

- This option is complementary to option 20: Developing training content for new hires, including interns, to support quick onboarding and effective performance in their roles.

Risks:

- Low conversion of interns to full-time staff could waste resources spent on training and increase the need for additional recruitment efforts to fill vacancies.
- Time gap between internships and full-time employment may be too long to address current vacancies.

[142] DSS HR Data, 2024

[143] DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025

[144] Child Welfare Information Gateway, "Workforce Part 3: Child Welfare Scholars," 03/2018

[145] National Child Welfare Workforce Institute, "University Partnership Program Profile: North Dakota," 04/2017

[146] UConn Today, "New Social Work, DCF Partnership Prepares Students to Work With Latino Families," 12/2020

- Overburdened LDSS staff may not have capacity to effectively supervise or mentor interns & new hires.

#22: Develop support tools (e.g., AI-driven applications) to streamline processes

Description

Type of change: Transformational Change

Develop and pilot support tools / AI-driven applications to streamline specific steps within the Medicaid eligibility determination process to reduce manual workloads and improve overall process efficiency. Potential tools / applications include:

- Robotic Process Automation (RPA): RPA applications can be deployed to automate repetitive, manual tasks involved in eligibility determination, such as document processing, form validation, and eligibility data entry.
- Knowledge-Based Chatbot: A knowledge-based chatbot can assist eligibility workers by providing real-time responses to policy and procedural questions. This can help optimize workloads by reducing the time spent looking up information in lengthy manuals, databases, or e-mails.
- Notification tools: Notification tool can be used to automate and streamline the tracking and follow-up of pending eligibility applications. These applications can send reminders and alerts to staff when specific tasks need attention, reducing manual tracking. Additionally, notification tools can automatically remind applicants to submit missing documents or renew their Medicaid coverage.

Developing these tools would require:

- Partnering with external vendors to define use cases and design tools / applications.
- Piloting the tools in testing environments before integrating them with VaCMS and CommonHelp.
- Creating feedback and monitoring mechanisms to identify errors and improve performance of the tools / applications.

Pain point(s) addressed and est. impact

Pain point(s) addressed: Existing processes & systems are not user-friendly for LDSS staff as only 36% of LDSS staff believe VaCMS' automated processes reduce manual work.[147]

Est. impact:

- Reduce processing time by further automating processes:
    - RPA can reduce the number of manual tasks such as document processing, data entry, and form validation, allowing workers to focus on more complex tasks and process applications faster.
    - Knowledge-based chatbots can reduce time spent searching through lengthy and complicated policy documents and improve speed of decision-making.
    - Notification tools can automatically track pending applications and send reminders to staff or applicants, ensuring timely follow-ups and reducing delay caused by missed tasks or incomplete applications.
- Reduce burden on workforce by automating low-value, repetitive tasks to improve job satisfaction and reduce staff turnover.
- Reduce errors in eligibility determination process by using knowledge-based chatbots to provide real-time, accurate information to eligibility workers.

[147] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)

Example Benchmark(s)	
• **Tennessee** developed an AI-powered tool called LTSS (AI)dvisor, designed to help medical eligibility workers, nurses, and lawyers quickly answer policy and process questions. Previously, the team had to manually search through a 1,500-page manual, which could take hours to find the necessary information. The LTSS (AI)dvisor is currently in testing, but it shows promise in delivering concise answers almost immediately, significantly improving productivity and ensuring the consistency and accuracy of the information provided to members.[148] • **Maryland** uses RPA in its eligibility workflow with an AI/ML-trained bot that verifies consumer documents like pay stubs, Social Security cards, and driver's licenses. The bot, trained on a large dataset, uses Optical Character Recognition (OCR) to scan, extract data, and assess document quality. It then compares the document to trained models to ensure it meets quality standards. This automation removes the need for eligibility workers to manually check documents, cutting the processing time from over a week to just a few hours.[149] • **Ohio** developed various bots to help review and process applications. Collectively, the Ohio Benefits Program Family of Bots (Bots) has reviewed and processed over 500,000 cases, saving county caseworkers over five years of working hours. For example, the MyCare Bot automatically shifts individuals on legacy waivers to MyCare waivers to prevent interruption of benefits and has processed over 6,000 waivers, saving approximately 500 operational hours.[150]	
Implementation considerations	
Est. resources required	*Est. Timeline*
Requires additional costs / funding: • Significant capital and time investment, as well as engagement with external vendors to develop, pilot, and integrate tools / applications with existing systems • Funding to develop data security and compliance measures to ensure tools / applications meet HIPAA and other regulatory requirements • Funding for infrastructure upgrades to support the increased demand on servers, data storage, and network capacity • Funding for ongoing maintenance and support, including updates to tools / applications as policies, regulations, and eligibility processes evolve • Funding and time investment to train LDSS staff on using tools / applications effectively	**~1-2 years:** • Collaborate with external vendors to design and develop tools / applications (RPA, knowledge-based chatbots, and notification tools) • Pilot tools / applications within selected LDSS agencies to gather feedback on functionality, ease of use, and overall impact on workflows and existing infrastructure (e.g., servers) • Train LDSS staff on effective use of tools / applications, providing hands-on workshops, manuals, and ongoing support • Rollout of tools / applications statewide after successful piloting, followed by ongoing monitoring and updates

[148] The Wall Street Journal, "TennCare CIO on Transformation, Gen AI, and Finding That 'Wow' Factor," 03/2024
[149] CIO, "CIO 100 US: 9 Award-Winning Government IT Projects," 07/2022
[150] National Association of State Chief Information Officers (NASCIO), "The Ohio Benefits Program is "Bot" In – The Ohio Benefits Family of Bots," 08/2022

Interdependencies and risks

Interdependencies:

- This option is dependent on the options under Strategy C: Modernize VaCMS technology and processes, Strategy D: Improve data and reporting capabilities, and Strategy E: Enhance management and governance of IT vendors to support the design, rollout, and maintenance of various tools / applications.

Risks:

- Staff reluctance to trust or use tools / AI-enabled applications may limit their effectiveness.
- Malfunctions or downtime in tools / applications could disrupt the eligibility process, causing delays and adding to staff workloads.
- Data security and privacy risks may arise if tools / applications and data are not properly secured (e.g., encryption, vulnerability management).

#23: Update cost allocation plans to maximize allowable federal funding

Description

Type of change: Core Enhancement

Update cost allocation plan to appropriately claim and maximize federal reimbursement by:

- Partnering with a vendor that specializes in cost allocation plans and Medicaid administrative claiming.
- Reviewing existing RMS results, payrolls, and expenses (including indirect costs) to understand current administrative allocation weights.
- Evaluating existing cost allocation plan to ensure costs are accurately allocated to appropriate cost pools.
- Identifying potential changes to allocation methods (e.g., identifying optimal balance between base funding and pass-through funding, identifying opportunities to leverage enhanced Federal Match Rates)
- Updating and submitting cost allocation plan to CMS.
- Implementing processes to review and update the cost allocation plans on a regular basis (e.g., every two years).

Pain point(s) addressed and est. impact

Pain point(s) addressed: LDSS agencies have workforce capacity gaps due to funding challenges.

Est. impact:

- Cost allocation plan updates can maximize federal funding by identifying previously untapped areas to access enhanced federal match rates (75% or 90% instead of the standard 50%) where allowable.
- Refining RMS methodology to ensure that the Commonwealth is maximizing federal funding (e.g., RMS recorded that 20% of benefit and services staff time was spent on Medicaid eligibility).[151]

Example Benchmark(s)

- **Maryland** increased its allowable federal Medicaid administrative claiming by adding Maryland Access Point, a single-entry point to Medicaid Home and Community-Based Services options counseling and resource navigation to its Cost Allocation Plan. Developing the cost allocation model for this program included a Random Moment in Time Study and Cost Pool Model. This work showed that of $22.8 million in annual expenditures, $12 million, (or 53%) was Medicaid claimable at a 50% match rate, bringing $6M

[151] DSS RMS Statistics, 10/2023 - 09/2024

in new federal funds into the state to support the program and freeing up that same level of state funds previously expended on this program to be used for a different purpose or to expand the reach of the program.[152]

Implementation considerations	
Est. resources required	*Est. Timeline*
Produces net savings: • Although hiring an external vendor will incur costs, updating cost allocation plans can result in net savings by maximizing federal funding	**6-12 months:** • Issue an RFP for a vendor that specializes in cost allocation • Evaluate existing cost allocation plan • Identify potential changes to allocation methods and update cost allocation plan

Interdependencies and risks

Interdependencies:

- The option is dependent on various options under Strategy D: Improving data and reporting capabilities to support access to accurate and real-time data to update cost allocation plans.

Risks:

- DMAS / DSS must ensure cost allocation plans fully comply with CMS regulations to avoid financial penalties or disallowances.
- If approval of the cost allocation plan is slow or requires revisions, reimbursement may be delayed, creating a short-term funding gap.

#24: Update allocation formula to reflect demographic shift and provide adequate funding for LDSS agencies

Description

Type of change: Transformational Change

Stand up a working group to develop new funding formulas with key decision makers who understand how to release state funding (e.g., Secretary's Office, Senate / House Financing Committee members). Activities include:

- Reviewing previous efforts conducted on updating funding formula (e.g., 2021 Reallocation of Local Staff and Operations Funding Workgroup).
- Aligning on relevant metrics (e.g., caseload, localities' ability to pay, performance) to inform funding formulas.
- Developing and evaluating impact of new allocation methodologies on all 120 LDSS agencies
- Creating a list of key considerations for implementing the funding formulas (e.g., Setting a funding floor to cover basic agency needs).
- Evaluating the ratio of base vs pass-through funding for LDSS agencies across all benefit programs as Federal funding covers 54% of the base funding but only 32% of the pass-through funding.
- Establishing a permanent working group to review and update the funding formula regularly (e.g., every 4-5 years).

[152] Maryland Medicaid Administrative Claiming Panel, 8/2023

Pain point(s) addressed and est. impact	
Pain point(s) addressed: LDSS agencies have workforce capacity gaps due to funding challenges. Base funding is insufficient for 100/120 LDSS agencies and pass-through funding is more difficult to realize due to high local match rate (67.9%).[153] **Est. impact:** • Allows the new base funding formula to better reflect demographic shifts, as the outdated 30+ year-old methodology has resulted in counties with growing populations receiving less funding per capita. From 2000-2020, counties that grew in population received less funding per capita and thus had higher caseloads per worker (~474 Medicaid cases) compared to counties with population decline which had a lower caseload per worker ratio (~384 Medicaid cases).[154] • Decreases variability of funding per capital (e.g., base and pass-through funding per capita ranges from $35 to $263 per locality).[155] • Promotes a workforce that reflects the growing number of Medicaid enrollees as average caseload per worker has more than doubled from 198 in 2017 to 415 in 2024.[156,157]	
Example Benchmark(s)	
• **Georgia** conducts a zero-based budgeting exercise every roughly eight years in which each agency builds their budget from the ground up. Georgia's Department of Human Services used active caseloads from SNAP, TANF, and Medicaid, along with time study data on 'workable caseloads,' to estimate the optimal number of workers needed to serve the population.[158] • In December 2023, **Virginia's** Board of Education asked the General Assembly to update the Commonwealth's school funding formula. This formula determines the contributions of state and local governments to meet Virginia's Standards of Quality. The request followed a July 2023 report by the Joint Legislative Audit and Review Commission, which found that Virginia spends 14% less per student compared to other states. The joint subcommittee tasked with updating the funding formula will submit the initial recommendations and implementation plan to the Governor and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by November 1, 2024.[159]	
Implementation considerations	
Est. resources required	*Est. Timeline*
Requires additional costs / funding: • Forming the working group requires no additional funding but does require leadership support and time from existing staff	**6-12 months:** • Stand up working group to define goals, evaluate current formulas, and design a new funding formula

[153] State and LDSS Cost Allocation Reports; LDSS Cost Allocation Reports, FY2023

[154] DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025; US Census Bureau, 2000-2020

[155] State and LDSS Cost Allocation Reports; US Census Bureau, 2000-2020; LDSS Cost Allocation Reports, FY2023

[156] JLARC Medicaid Expansion: Eligibility Determination Commission Briefing, 10/2019

[157] DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025

[158] Interview with Former GA Chief Deputy Division Director in the Dept of Human Services, 08/2024

[159] Joint Legislative Audit and Review Commission (JLARC), "Virginia's K-12 Funding Formula," 2023

• If the updated funding formula limits reductions to local DSS agencies, overall costs to base funding will increase • Counties and localities could save costs by shifting pass-through funding to base funding, which qualifies for a higher federal match rate. Although state funding will increase, the locality / county savings will offset the additional state costs	• Engage key stakeholders to receive feedback and refine funding formula • Develop roadmap to implement new funding formula and create communication plan to inform counties and LDSS agencies
Interdependencies and risks	
Interdependencies: • The option is dependent on various options under Strategy D: Improving data and reporting capabilities to support access to accurate and real-time data to inform a new allocation formula. **Risks:** • LDSS agencies in areas with declining populations may see a decline in funding, which could disrupt their current workloads and lead to resistance to changing the formula.	

Strategy J: Balance Workloads across Virginia and LDSS Agencies

This strategy is about balancing workloads across LDSS agencies to address the wide variety of caseloads per eligibility staff. Across the continuum of high vs lower impact and feasibility, Strategy J includes three options:

- #25 Provide guidance to support formal work-sharing between LDSS agencies
- #26 Provide central surge support to LDSS agencies
- #27 Centralize processing by application type and / or certain eligibility steps

#25: Provide guidance to support formal work-sharing between LDSS agencies
Description
Type of change: Core Enhancement Establish formal work-sharing protocols between LDSS agencies to manage application overflow during peak periods and / or staffing shortages by: • Developing clear guidelines for case transfers, including standardized forms to document handoffs, timeliness for handoffs, communication protocols, and required case notes. • Addressing funding flow considerations and evaluate whether funding should be shared with LDSS agencies managing redistributed cases from other agencies. • Standardizing processes to promote consistency in case handling (e.g., clear workflows for application processing across application types, such as MAGI, Non-MAGI, SNAP, and TANF, incl. error resolution and processing time expectations). • Ensuring VaCMS provides robust functionality to adequately track case progress, ownership and allows for comprehensive case notes. • Establishing clear accountability and responsibility for case processing, appeals, and renewals (e.g., explicit definition of which LDSS agency is responsible for the case at each processing step, with accountability shifting once a case is officially transferred and received by another office).

While DMAS / VDSS cannot enforce work-sharing, formal guidance can make it easier and less risky for LDSS agencies to participate in work-sharing (e.g., by ensuring that agencies are not held accountable for errors made by other agencies). These arrangements can also be included as part of emergency preparedness efforts.

Pain point(s) addressed and est. impact

Pain point(s) addressed: Applicants experience varying processing times due to the varying workforce capacity and capability gaps across LDSS agencies (e.g., varying levels of vacancy rates and differing levels of personnel roles).

Est. impact:

- Current Medicaid cases per worker range widely from 167 to 961 per year depending on the LDSS agency. This option has the potential to more evenly load balance some of those cases for participating LDSS agencies.[160]
- Potential to improve the current median Medicaid LDSS compliance rate of 93.7% by shifting Medicaid applications to agencies with capacity to more quickly process the application.[161]

Example Benchmark(s)

- **Georgia** (which also administers eligibility at the county level) established a case-sharing system across localities with clear, state-developed guidelines for handoffs and accountability. The system prioritizes sharing of cases with simpler applications, such as MAGI, pregnant women, and expedited SNAP, allowing for efficient processing across counties. More complex populations, such as ABD, remain within the originating county, handled by specialized eligibility workers, given the need for specialist knowledge and the higher risk of errors.[162]

Implementation considerations

Est. resources required	*Est. Timeline*
Requires additional costs / funding: • Additional funds for agency / staff taking on additional cases • Minimal costs to reallocate existing FTEs to develop guidelines and manage work sharing pilots • Change management initiatives, incl. communication plans, staff training, and workshops to provide clarity and increase adoption of work-sharing optionality	**6-12 months:** • Design of clear guidelines incl. the development of clear handoff processes • Piloting work-sharing with limited number of agencies • Broader rollout with change management and staff training on new workflows

[160] DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025

[161] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024

[162] Interview with Former GA Chief Deputy Division Director in the Dept of Human Services, 08/2024

Interdependencies and risks

Interdependencies:

- The option is dependent on various options under Strategy D: Improving data and reporting capabilities to enable the timely identification and reduction of backlogs through work-sharing.
- Given the nature of the integrated social services system at LDSS agencies in the Commonwealth, this option has the potential to impact and support workload sharing across social services benefits, not just Medicaid, if the Commonwealth decides to pursue this option.

Risk:

- Transferring cases could increase the likelihood of errors, especially if there are gaps in communication or if responsibility and accountability rules are not clearly set.
- If LDSS agency that receives the overflow makes an error, the host agency then has to address the applicant's concerns despite having minimal context.
- Even with templatized guidance to make this easier, LDSS agencies may not want the added operational complexity associated with workload sharing.

#26: Provide central surge support to LDSS agencies

Description

Type of change: Core Enhancement

Establish central surge support team(s) to provide temporary assistance to LDSS agencies during periods of high caseloads, staffing shortages, or public health emergencies. These surge teams can be deployed to handle overflow and support LDSS agencies that are unable to manage their current workload. This can be done in a few ways, for example:

- Extend the CoverVA contract to offer surge support for LDSS agencies in processing Medicaid determinations more efficiently. This approach, previously implemented during the PHE unwinding, has a precedent but may require additional funding if existing LDSS funding remains unchanged. However, longer term this would involve identifying additional funding if current LDSS funding streams for eligibility are left intact. The scope of surge support could be limited to MAGI, Medicaid-only applications (which is what CoverVA is currently trained to support), or extended to both MAGI and non-MAGI Medicaid only applications. However, the latter would require additional training for CoverVA staff. As is currently the case with CoverVA, all final determinations would ultimately have to be done by the LDSS / DMAS staff working with CoverVA, and that might require additional state staff capacity depending on the volume.
- Stand up a new centralized support team comprised of DMAS staff that can process and finalize Medicaid determinations. This centralized team would be statewide and trained / specialized to support non-MAGI applications that are more time consuming and require immediate attention to avoid further processing delays for a local agency in need. This would likely involve identifying additional funding if current LDSS funding streams for eligibility are left intact, given current funding flows are not based on a specific, set volume of Medicaid cases an agency receives.

In either scenario, there will need to be clear accountability and responsibility for case processing, appeals, and renewals (e.g., explicit definition of which LDSS agency is responsible for the case at each processing step, with accountability shifting once a case is officially transferred and received by the central team).

Pain point(s) addressed and est. impact

Pain point(s) addressed: Applicants experience varying processing times due to the varying workforce capacity and capability gaps across LDSS agencies (e.g., varying levels of vacancy rates and differing levels of personnel roles).

Est. impact:

- Surge team can rapidly address bottlenecks caused by large caseloads at certain LDSS agencies (e.g., delays until first touch of application; applications pending checklist send, applications pending authorization).
- Triages backlogs during periods of high demand or workforce shortages at a specific agency.
- With a narrow scope of only processing Medicaid determinations (e.g., no reprioritization of applications from other programs), surge teams can quickly and systematically process determinations.
- During down times, team could work on training development and delivery, maintaining standardized guidance across websites and application channels, and supporting the work of the Medicaid consultants.

Example Benchmark(s)

- **In Pennsylvania**, counties typically process cases locally but transfer caseloads to a centralized unit when weekly volumes exceed manageable levels. County managers review case volumes and backlogs on a weekly basis and manually decide if, and how many, cases should be shifted to the central processing unit for timely processing. Overall, ~5% of cases are processed by the centralized unit. PA has ~6,000 total staff, with 770 employees working in the centralized processing unit (~13%). These employees take phone calls and take on ancillary / overflow work as needed. While Pennsylvania is different than Virginia in that it is state administered eligibility (i.e., state workers sitting in county offices), the local management and triaging would be similar in Virginia's locally administered environment.[163]

Implementation considerations

Est. resources required	*Est. Timeline*
Requires additional costs / funding: • Costs to establish surge support teams, including recruiting, onboarding, and training of new staff or vendor support • Ongoing operational costs of a centralized unit, including payment for staff and infrastructure • Design costs and time commitment to create processes and coordination mechanisms between central unit and LDSS agencies for triaging overflow • Change management initiatives, incl. communication on processes to shift workload to centralized processing unit	**1-2 years:** • Quantify scope of central surge support team • Evaluate current contracts and vendors to determine whether to contract with a vendor or staff a central unit with state employees • Recruiting and training of surge support team and/or standing up contract support • Developing protocols for case transfer and coordination between regional units and LDSS agencies • Testing and piloting the surge support process with volunteering pilot agencies before broader rollout

Interdependencies and risks

Interdependencies:

- The option is dependent on various options under Strategy D: Improving data and reporting capabilities to enable timely identification of overflow requiring additional support.

Risk:

- Communication and change management steps would need to be taken to make processes clear for LDSS agencies on when and what type of application overflow can be sent to the central surge support team. These change management efforts would need to address LDSS agency concerns about what happens to

[163] Interview with Pennsylvania Office of Income Maintenance (OIM) Subject Matter Experts. 10/2024

their existing funding flows, as well as, how accountability for applications processed by the central team is handled.

- Delayed processing if communication and coordination between LDSS agencies and surge support teams is not well-coordinated.
- Confusion could occur to applicants who experience their case being transferred to a different unit instead of their local agency.

#27: Centralize processing by application type and / or certain eligibility steps

Description

Type of change: Transformational Change

Centralize specific parts of the Medicaid eligibility determination process to improve efficiency, give LDSS agencies more bandwidth, and provide greater consistency in the eligibility process. This could involve centralizing entire application types (e.g., MAGI, LTC, ABD) or specific steps within the eligibility determination process (e.g., intake, verification, or determination) to a statewide processing unit. Strategic choices available for this option include:

- Centralize application type or steps in the determination process:
    - By application type: MAGI, Medicaid-only applications would be the most streamlined to centralize and require the least amount of specialized training. These are currently supported by the Virginia Insurance Marketplace and CoverVA and the contract could be extended to all MAGI, Medicaid-only applications. Or non-MAGI (e.g., LTC or ABD) applications could be centralized to a more specialized team of highly skilled benefit workers who can more efficiently process these usually more complex cases by benefiting from their specialized expertise. A key consideration on this design choice is the degree to which specialization is beneficial vs. in-person local support is beneficial. For example, some would argue non-MAGI applications require and benefit from more in-person LDSS agency engagement.
    - By step: Again, a key tradeoff to consider is what part of the process is optimal to have at a local level (with in-person engagement available) vs. benefit from specialized support that may yield greater efficiencies. One choice could be to centralize all intake steps of the application process at a statewide level through a vendor like CoverVA or through a centrally staffed unit. This would enable more consistent approaches to intake and tee-up the applications for processing and review by the LDSS agencies. An alternative approach could be to centralize the final determination step which is currently the stage where the greatest volume (47%) of applications is pending.
- Centralize at a statewide level or regional level:
    - Statewide: Establishing a central processing unit at the statewide level would result in the highest chance for success at creating more consistency in the process. There would also be more economies of scale in having one team versus multiple regional teams. Currently existing statewide options include CoverVA or the Virginia Insurance Marketplace which both could theoretically take on additional scope.
    - Regional: Establishing a central processing unit at the regional level may still result in some regional level variation but allow for applications to still be processed closer to the applicant's home. This option could even allow for some in-person visits to a regional office or location. This would also enable LDSS agencies to form relationships with the regional team for application handoff and coordination. This approach would require regions to be designed, which if not aligned to the existing VDSS regional structure, could create confusion.
- Contract with a vendor or staff a central unit with state employees
    - Contract with a vendor: A vendor would allow for more flexibility and adjustments in year over year application volume changes. It could also more easily train and adjust specialized

resourcing needs. However, as is the case with CoverVA, there will still need to be state staff (e.g., from DMAS or VDSS) that perform the eligibility authorization step given federal requirements. Additionally, contracting the work out leaves room for annual negotiations on price with a vendor.

- Staff with state employees: This may be less flexible than a vendor but allow for the full process and authorization step to be done by one unit. Staffing internally, instead of depending on a vendor, enables the Commonwealth to retain more leverage during annual vendor negotiations.

A major consideration across this more transformational change is whether and how to shift federal and state Medicaid funding currently flowing to LDSS agencies to a new centralized processing unit, and the impact on LDSS agencies will need to be further evaluated.

Pain point(s) addressed and est. impact

Pain point(s) addressed: Applicants experience varying processing times due to the varying workforce capacity and capability gaps across LDSS agencies (e.g., varying levels of vacancy rates and differing levels of personnel roles).

Est. impact:

- Centralizing specific applications or steps of the eligibility determination process offers more sustainable, long-term system improvements, making it more impactful than short-term solutions like caseload sharing or surge capacity.
- Specialized teams focused on designated tasks or applications can lead to more accurate, and timely determinations. For example, focusing on centralizing non-MAGI applications could significantly reduce the current median processing time of 41 days.[164]
- Centralizing specific steps of the eligibility process, such as intake and registration, could reduce bottlenecks and pending applications in these steps (e.g., currently 10% of pending applications are waiting for registration and worker assignment).[165]
- Improving processing efficiency, reduces application variations and backlogs, and alleviates strain on LDSS agencies and their workforce allowing them to focus on other application types or steps.

Example Benchmark(s)

- **Maryland** centralized processing for its MAGI applications, allowing for rapid and automatic determinations of MAGI cases (~94% of MAGI cases are processed within 24 hours, 0% after 45 days).[166] Meanwhile, more complex cases such as ABD are still managed locally by LDSS agencies, allowing vulnerable populations to receive the personal assistance they often require.[167]
- **Ohio** centralized intake steps through a County Shared Services (CSS) Model since 2014, distributing cases to the applicant's local LDSS agency. If the responsible agency has a large backlog, cases are rerouted to a regional cluster to support timely processing. The CSS model has been adopted by 77 of Ohio's 88 counties, helping standardize the eligibility processes in the state to a caseworker in the applicable group to apply for or renew Medicaid. Participation in CSS is optional, and counties have the flexibility of how and in what capacity to use the service.[168]

[164] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024
[165] VDSS Appmetric Report, 09/15/2024
[166] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024
[167] Interview with Maryland Department of Health, 09/2024
[168] The Ohio Department of Medicaid State of Ohio, "Program Integrity 2021 Annual Report," 04/2022

<table>
<tr><th colspan="2">Implementation considerations</th></tr>
<tr><td>Est. resources required</td><td>Est. Timeline</td></tr>
<tr><td>Requires additional costs / funding:
If LDSS agency funding is left intact ($26M in FY2023) this will require additional funding to expand a third party's (e.g., CoverVA's or the Virginia Insurance Marketplace) centralized processing unit or build a new team within VDSS
If LDSS agency funding is partially changed to divert a portion of funding allocated to the centralized activity, then it may cost the Commonwealth less in net new expenses to stand up or expand this centralized unit. However, this may still not be enough and there would be ongoing costs to run the centralized unit / manage vendors
VaCMS change request costs to reroute certain application types or specific steps of the eligibility process to a centralized unit</td><td>1-2 years:
For reference: CoverVA's CPU was stood up in roughly a year after ACA rules went into effect
Evaluate current contracts and vendors to determine whether to contract with a vendor or staff a central unit with state employees
Initial design and development of new processes, coordination mechanisms, and infrastructure for centralized processing, including staff recruitment and onboarding
Pilot testing of centralized processing with select LDSS agencies to refine workflows and coordination
Full rollout of the centralized unit overtaking a specific application type or specific steps of the eligibility determination process for all LDSS agencies</td></tr>
<tr><td colspan="2">Interdependencies and risks</td></tr>
<tr><td colspan="2">Interdependencies:
The strategic choices in this option are dependent on options under Strategy D: Improving data and reporting capabilities to understand root cause of delays / errors, especially if specific steps of the eligibility determination process are centralized. This data will help inform the optimal design and can also be critical to ongoing transparency on handoffs between a centralized processing unit and LDSS agencies.
The workload balancing guidelines and other surge support options would not be necessary if this option is pursued.
Risks:
If communication and coordination between central units and local LDSS agencies are not seamless, there is a risk that cases may experience delays in processing (e.g., if centralized unit does not reroute applications to local agencies in a timely manner).
Depending on whether some of the existing federal and state funding is shifted from LDSS agencies to the centralized unit, or kept intact, it may create LDSS resistance for adopting this change.
The shifting of funding (if that occurs) could also impact current resourcing models for LDSS agencies and has the potential to affect resourcing for programs outside of Medicaid, given the current integrated benefit structure that exists in the Commonwealth.</td></tr>
</table>

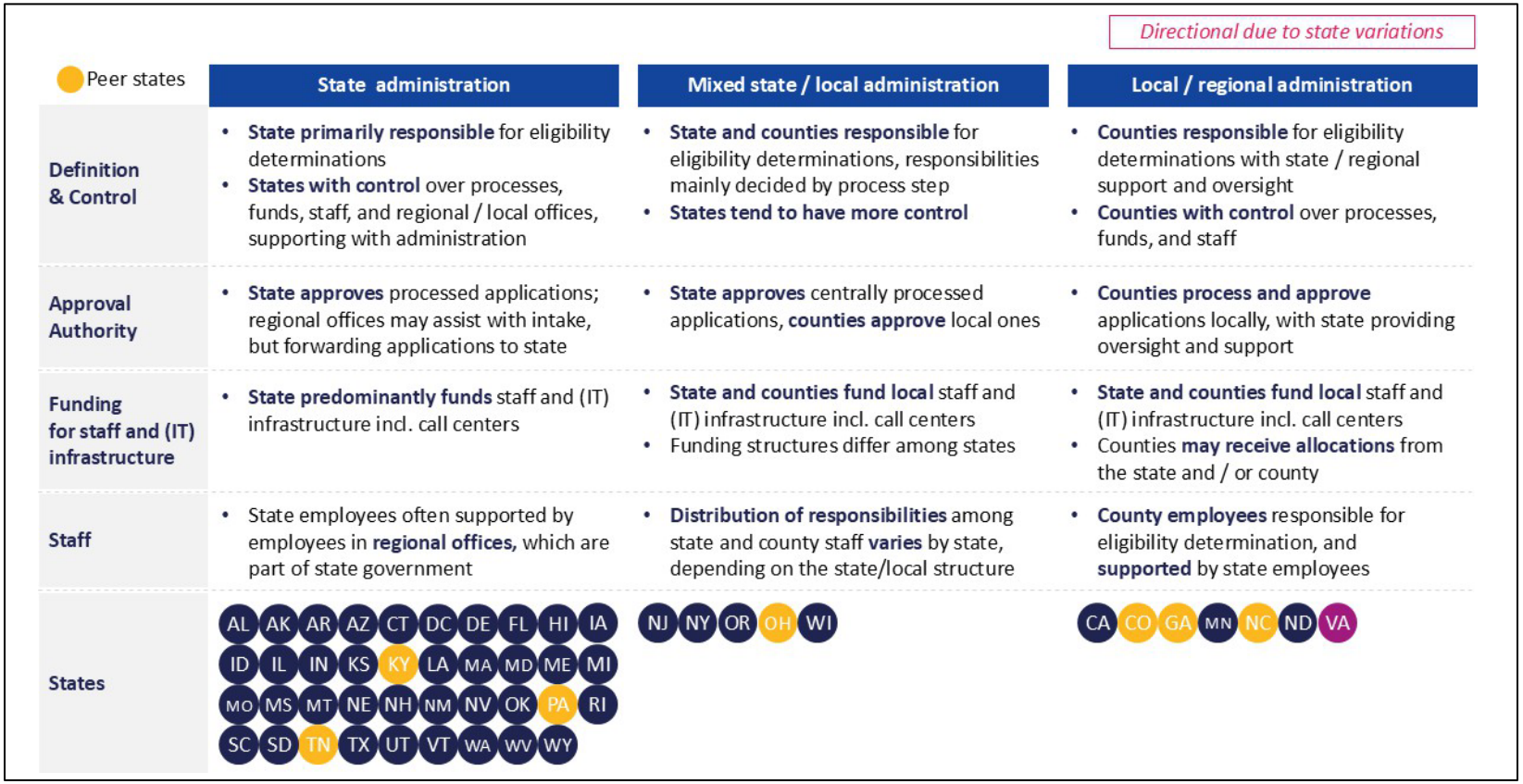
8.3 External Benchmarks

This assessment benchmarked Virginia against all 50 states' MAGI processing rates and completed deep dives into seven comparable states, which included 9 interviews to identify other state practices. These states were evaluated based on the following 5 factors:

- **Medicaid eligibility determination structure** to identify learnings in the context of a locally administered Medicaid program. Virginia's Medicaid eligibility is locally administered, meaning Medicaid determination is largely done by workers LDSS agencies.[169] See Figure 20 below for additional details.
- **Benefit eligibility integration** to learn how states conduct eligibility and balance priorities when benefit eligibility is integrated. Virginia integrates eligibility determination for Medicaid with other social services such as SNAP, TANF, and energy assistance if an applicant is interested in those benefits. See Figure 21 below for additional details.
- **System Vendor** to learn how states best manage large information technology vendors. Virginia currently contracts with Deloitte to administer its eligibility system.
- **Payment & marketplace structure** to understand other state experiences managing Medicaid eligibility determination when there are other entities involved (e.g., MCOs and state-based insurance marketplaces).
- **State demographics** to learn from states with comparable cultural and operational contexts to Virginia. The Commonwealth is home to 8.6 million Virginians, is in the South Atlantic region, and delivers Medicaid benefits to 2.1 million as of August 2024

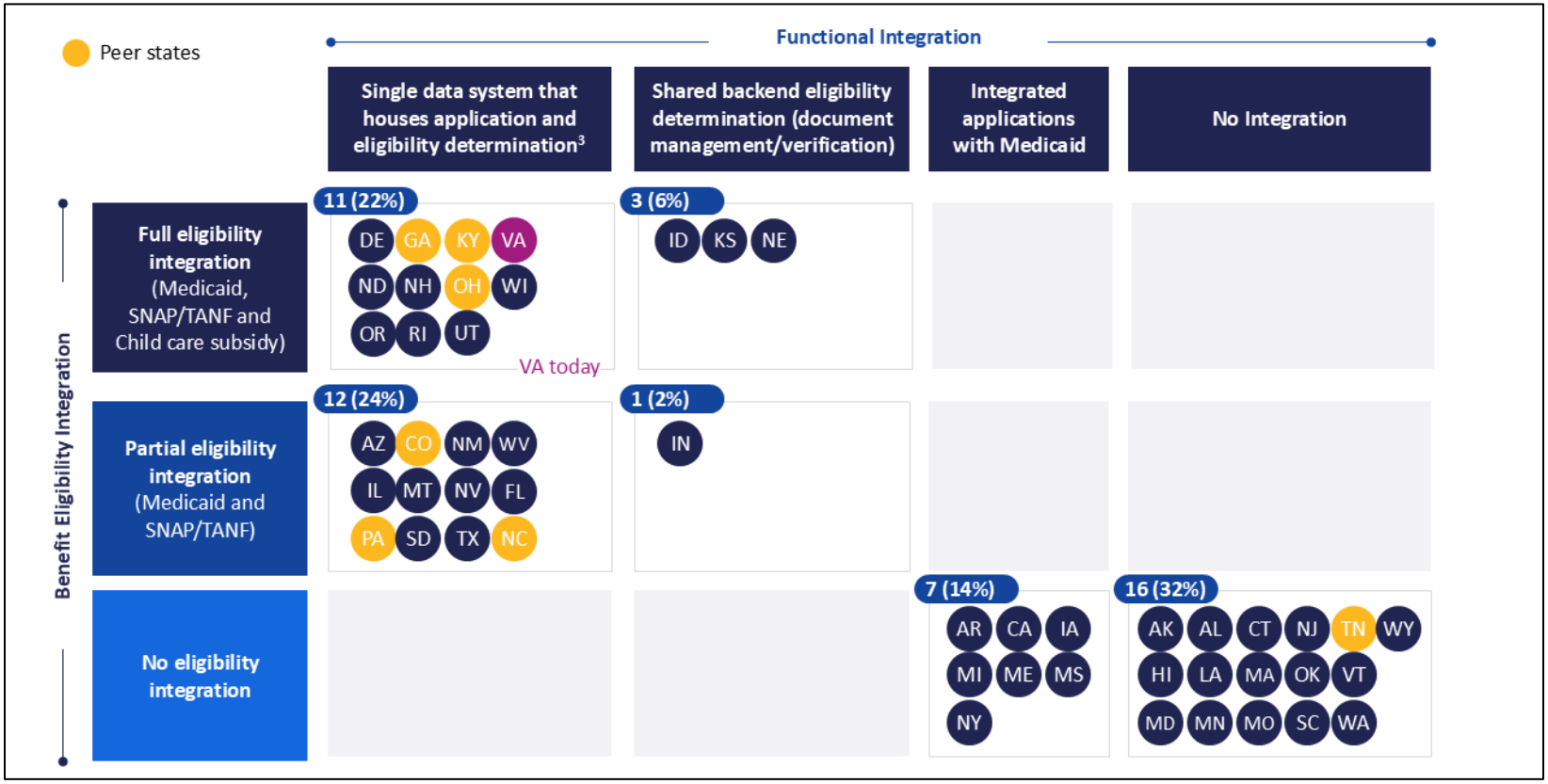
[169] Note: Some applications such as those through Cover Virginia are processed at the state level

Figure 20: Medicaid eligibility determinations by state, mixed, and local administration [170]



[170] KFF, "Staff Responsible for Processing Applications and Renewals in Medicaid and CHIP," 05/2024

Figure 21: State by benefit eligibility integration and functional integration[171]



[171] KFF, "Staff Responsible for Processing Applications and Renewals in Medicaid and CHIP," 05/2024; CodeforAmerica.org

MAGI Processing Rate by State

To understand why Virginia's MAGI case processing time was below the national average, this assessment mapped all 50 states' case processing times and overlayed factors such as Medicaid administrative structure, integration of benefit eligibility, and IT vendor.

MAGI Processing Rates by Medicaid Administration Structure

On average, county / locally administered states process 25% of MAGI cases within 24 hours compared to 33% for state administered and 45% of mixed states (see Figure 22 below). County / locally administered states also have a slightly higher rate of applications processed in more than 45 days at 17% compared to 14% for state administered and 10% for mixed states. This suggests that there may be inefficiencies in locally administered models. Virginia outperforms three similar county / locally administered states (e.g., Georgia, North Carolina, and North Dakota) in processing cases within 24 hours, but only outperforms two similar states in the percentage of cases that take more than 45 days to process (e.g., Georgia and North Dakota).[172]

MAGI Processing Rates by Integration of Benefit Eligibility

On average, states with full or partially integrated benefit eligibility determination processed 22% of MAGI cases within 24 hours compared to 47% for states with no integration of benefit eligibility determination (see Figure 23 below). States with full or partially integrated determination also have a slightly higher rate of applications processed in more than 45 days at 15% compared to 11% for states with no integration of benefit eligibility. Virginia generally underperforms compared to most other states with full or partial integration in both cases processed within 24 hours and cases processed in over 45 days.[173]

MAGI Processing Rates by IT System

On average, states with the same eligibility system vendor as Virginia, Deloitte, processed 26% of MAGI cases within 24 hours compared to 39% for states with a different system vendor or model (see Figure 24 below). There was negligible difference in percentage of cases processed > 45 days based on whether a state had (14%) or did not have (13%) the same system vendor. Virginia lagged other states using a Deloitte system in both those cases processed within 24 hours and those cases processed over 45 days.[174]

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[172] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024; KFF, "Staff Responsible for Processing Applications and Renewals in Medicaid and CHIP," 05/2024

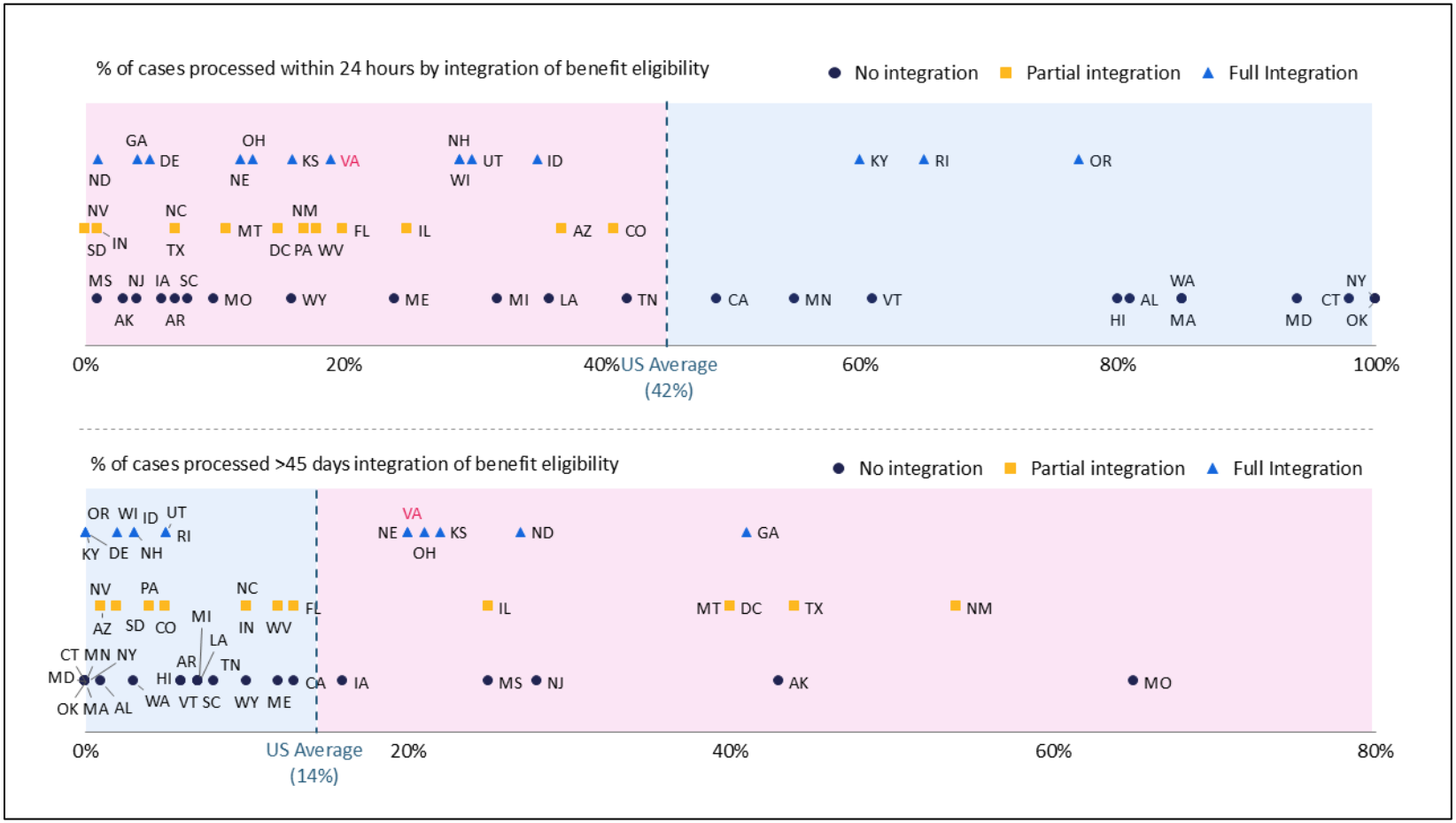
[173] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024; KFF, "Staff Responsible for Processing Applications and Renewals in Medicaid and CHIP," 05/2024

[174] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024; KFF, "Staff Responsible for Processing Applications and Renewals in Medicaid and CHIP," 05/2024

Figure 22: Application processing by county/state administration[175]

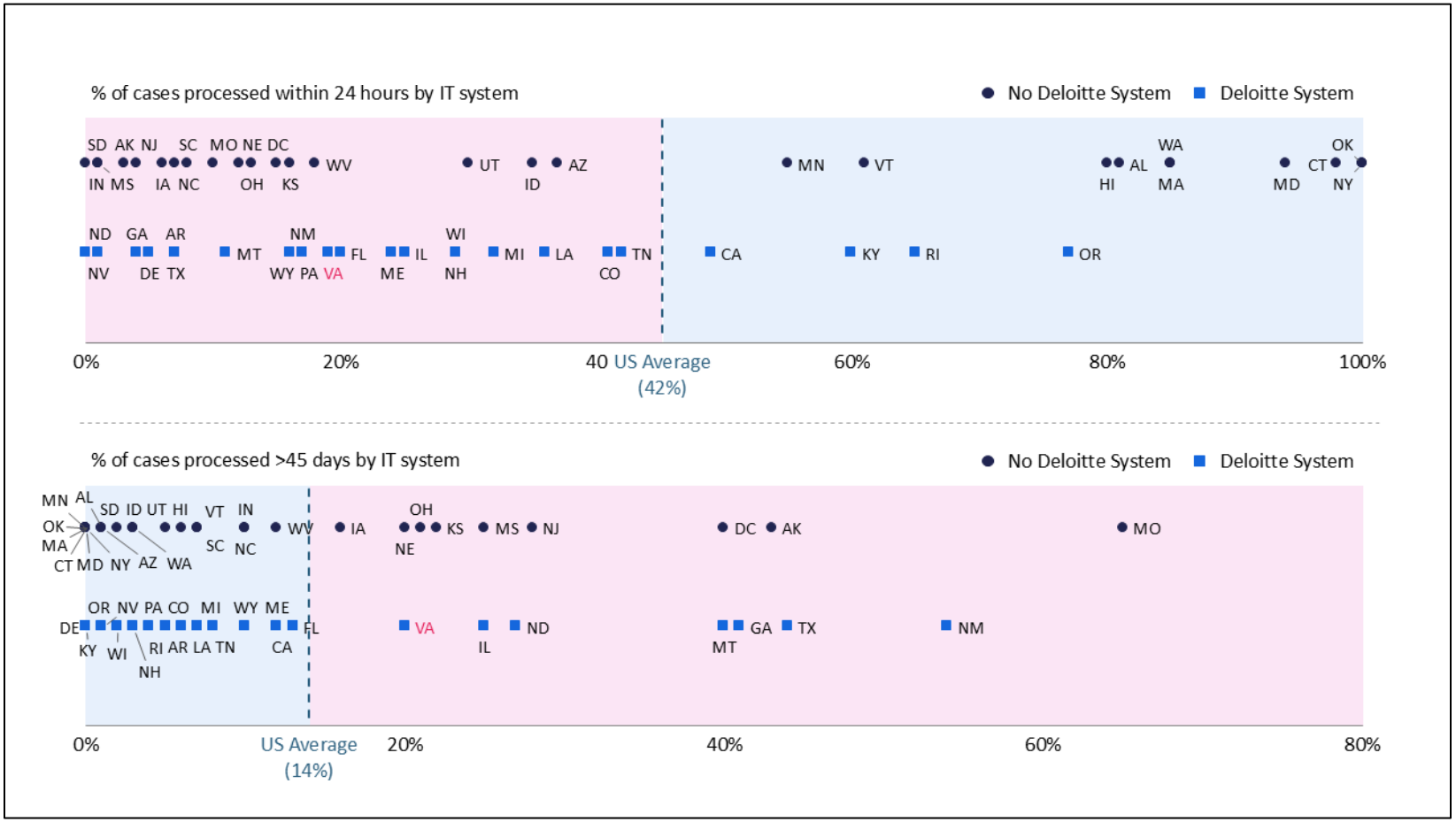
[175] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024; KFF, "Staff Responsible for Processing Applications and Renewals in Medicaid and CHIP," 05/2024

Figure 23: Application processing by integration of benefit eligibility[176]



[176] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024; KFF, "Integration of Medicaid and Non-Health Program Eligibility Systems," 05/2024

Figure 24: Application processing by IT system[177]



[177] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024; KFF, "Medicaid for Millions in America Hinges on Deloitte-Run Systems Plagued with Errors," 06/2024

Additional Details on 7 Peer States

After the 50-state analysis, this assessment conducted further deep dives on 7 peer states: Colorado, Georgia, Kentucky, North Carolina, Ohio, Pennsylvania, and Tennessee (see Figure 25 below). These states were similar to Virginia across 4 or more categories, including (1) Medicaid eligibility determination structure, (2) benefit eligibility integration, (3) system vendor, (4) payment and marketplace structure, and (5) state demographics,).

Compared to these states, Virginia outperforms in two key areas. First, the Commonwealth has a lower percentage (55%) of enrollments terminated for procedural or administrative reasons during renewals than the national average of 69% and six of the seven peer states. Virginia also excels in its ex parte renewal rate, achieving 62%, which is above the national average of 50% and comparable to states like North Carolina (67%) and Georgia (62%) in April 2024.

However, Virginia underperforms in the speed of processing new applications. Only 19% of MAGI applications are processed within 24 hours, well below the national average of 43% and significantly behind states like Kentucky (60%) and Colorado (41%). Moreover, 21% of Virginia's applications take more than 45 days to process, which is worse than states like Pennsylvania (4%) and Kentucky (0%). This highlights that while Virginia is strong in renewals, it faces challenges in the timeliness of processing new Medicaid applications.

Figure 25: Peer states and key metrics[178]

	Virginia	Colorado	Georgia	Kentucky	North Carolina	Ohio	Penn.	Tenn.
Eligibility Determination Structure	**Local**	Local	Mixed	State	Local	Mixed	State	State
Integration of Benefit Eligibility	**Full**	Partial	Full	Full	Partial	Full	Partial	None
System Vendor	**Deloitte**	Deloitte	Deloitte	Deloitte	Other	Other	Deloitte	Deloitte
Payment and Marketplace Model*	**2.0% FFS SBM**	0% FFS SBM	25.0% FFS SBM	10.0% FFS SBM	3.0% FFS FFM	9.4% FFS FFM	2.8% FFS SBM	0% FFS FFM
Demographics • CDC Geo region	**South Atlantic**	Mountain	South Atlantic	East South Central	South Atlantic	East North Central	Mid Atlantic	East South Central
• Population size	**8.6M**	5.9M	11.0M	4.5M	10.8M	11.8M	13.0M	7.1M
• % population w/ Medicaid[4]	**24.3% (2.1M)**	19.4% (1.1M)	18.1% (2.0M)	31.5% (1.4M)	25.2% (2.7M)	24.5% (2.9M)	23.7% (3.1M)	20.3% (1.4M)
• Medicaid spending / per enrollee	**$7.7k per enrollee**	$8.4k	$4.7k	$7.2k	$6.8k	$7.7k	$9.0k	$5.7k
New Applications % of MAGI applications processed in <24 hours	**19%**	41%	4%	60%	7%	14%	17%	43%
New Applications % of MAGI applications processed in >45 days	**21%**	5%	41%	0%	10%	21%	4%	8%
Renewals % ex parte	**62%**	27%	62%	58%	67%	69%	8%	43%
Renewals % disenrollments terminated for procedural or admin reasons as a % of total renewals	**55%**	56%	74%	56%	85%	70%	53%	79%

*Note for marketplace models: state-based marketplace (SMB) & federally-facilitated marketplace (FFM)

Leads VA | Similar to VA | Lags VA

[178] Sources: KFF, "Staff Responsible for Processing Applications and Renewals in Medicaid and CHIP," 05/2024; KFF, "Integration of Medicaid and Non-Health Program Eligibility Systems," 05/2024; KFF, "Medicaid for Millions in America Hinges on Deloitte-Run Systems Plagued with Errors," 06/2024; CMS, "National Health Expenditure Fact Sheet"; CDC, "Geographic Division or Region"; US Census, 2022; CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024; KFF; April 2024 CMS Reporting Metrics for Renewals; CMS, "April 2024 Medicaid and CHIP CAA Reporting Metrics," 07/2024; KFF, "An Examination of Medicaid Renewal Outcomes and Enrollment Changes at the End of the Unwinding," 09/2024

Colorado

Overview: Colorado, like Virginia, operates under a county-administered Medicaid system with only partial integration of benefit eligibility such as Medicaid, SNAP, and TANF. This structure creates significant variations in processes, service delivery, and outcomes across counties.

Key challenges include high vacancy and turnover rates, inconsistent processes across counties, low accessibility of the PEAK application system, and the complex, siloed nature of state and county operations, all of which contribute to processing delays and strain resources.

Similar to Virginia, in 2023 Colorado did an assessment of the challenges in its eligibility administration in response to a legislative mandate, and is currently working to develop, propose, and implement strategies to address these challenges. The State agencies propose that the highest priority recommendations were: 1) Create opportunities for State and County collaboration and policy documentation, 2) Develop service delivery standards for public and medical assistance programs, 3) Improve hiring and retention practices, and 4) Continue improving the current training model.[179]

Key takeaways and learnings from Medicaid eligibility in Colorado:

People & Organizational Structure
High turnover of workforce Majority of eligibility staff have less than 3 years of experiences, while new hires require at least 1 year of training. 21% of staff are considering leaving and 9% plan to leave within the next two years. The significant number of junior staff and initial reduced productivity of new hires results in slower application processing and lower case throughput per employee.[180]

[179] Colorado Legislative Council, "Public Assistance Funding Model Comprehensive Assessment and Recommendations," 06/2024

[180] Public Consulting Group LLC, "Assessing Best Practices in the Administration of Public and Medical Assistance Programs in County-Administered States Executive Summary," 06/2023

High vacancy rates

In 2023, Colorado had 185 vacant positions, approximately 15% of the workforce across the state. New employees require a training period of two years to reach full productivity, but the average tenure is only three years, which adds to the vacancy challenge.[181]

The high number of vacancies has increased the caseload for current staff, causing delays for beneficiaries. Additionally, filling these positions incurs high costs due to overtime, recruitment, training, and the lower productivity of newly hired staff.[182, 183]

Variation in organizational structure of counties and state

County and state organizational structures differ significantly: the state operates in siloed program structures, while counties gain cross-program insights. Counties are responsible for managing three separate government bodies and siloed responses.

This fragmented structure slows down processes, as counties must reach agreements across distinct entities, making it difficult to implement standardized practices efficiently.[184]

Correcting client-made errors in PEAK

PEAK is difficult to navigate for beneficiaries due to its complexity and limited user friendliness. Furthermore, eligibility workers do not receive proper PEAK training. This combination leads to significant applicant errors in PEAK which eligibility workers must correct, ultimately increasing workload and delaying service delivery. Limited user-friendliness also results in frustration for both beneficiaries and staff.[185]

[181] Public Consulting Group LLC, "Assessing Best Practices in the Administration of Public and Medical Assistance Programs in County-Administered States Executive Summary," 06/2023
[182] Public Consulting Group LLC, "Assessing Best Practices in the Administration of Public and Medical Assistance Programs in County-Administered States Executive Summary," 06/2023
[183] Interview with Colorado Medicaid Expert, 08/2024
[184] Interview with Colorado Medicaid Expert, 08/2024
[185] Public Consulting Group LLC, "Assessing Best Practices in the Administration of Public and Medical Assistance Programs in County-Administered States Executive Summary," 06/2023

Process

Process variation among counties

County variations stem from each county setting its own standards for the application process to support timely care access. For instance, some counties offer differing walk-in options with self-check-in kiosks, while others do not.[186] This inconsistency leads to some beneficiaries receiving benefits more quickly than others.

Misaligned policies that are difficult to navigate

Colorado's Medicaid program has over 620 pages of policy, which govern eight programs. The collection of policy language has limited search functionality and has high degree of misalignment. Leading to errors in assessments and slowing down application processing times[187]

Technology

Data quality issues sparked by ongoing information migration

Significant challenges arise from poor data quality, including issues with availability, accuracy, and completeness. Additionally, limited access to historical data and blocked system interfaces—often due to unavailable IT support after hours—worsen the problem.[188] These issues require manual workarounds, increase backlogs, and create process inefficiencies, placing added strain on already limited eligibility resources

Lack of data quality controls

The lack of data verification, testing, or ongoing monitoring has resulted in negatively impacted beneficiaries. Frequent errors in correspondence create accessibility issues and misinformation, sometimes leading to the incorrect termination of benefits.[189] These issues and the incorrect termination of benefits could lead to legal challenges, especially as this issue has an outsized impact on vulnerable populations.

[186] Public Consulting Group LLC, "Assessing Best Practices in the Administration of Public and Medical Assistance Programs in County-Administered States Executive Summary," 06/2023
[187] Public Consulting Group LLC, "Assessing Best Practices in the Administration of Public and Medical Assistance Programs in County-Administered States Executive Summary," 06/2023
[188] Public Consulting Group LLC, "Assessing Best Practices in the Administration of Public and Medical Assistance Programs in County-Administered States Executive Summary," 06/2023
[189] Colorado Office of the State Auditor," Medicaid Correspondence Performance Audit," 09/2023

Georgia

Overview: Georgia is comparable to Virginia in Medicaid eligibility due to its county-based administrative structure and full integration of benefit eligibility operations. Like Virginia, two separate agencies oversee Georgia's Medicaid program and determine Medicaid eligibility: the Georgia Department of Community Health and the Division of Family and Child Services, respectively. While the Georgia Department of Community Health (DCH) oversees the program, local county staff under the Division of Family and Children Services (DFCS) handle eligibility determination.

In recent years, Georgia has improved its operations by implementing new technology RPA bots to automate what was previously done manually. Georgia has also faced significant workforce challenges, losing 16% of its workforce over five years. In response, the state conducted focus groups to uncover the root causes of these issues. Virginia can adopt Georgia's RPA and focus group strategies to increase the number of applications processed within 24 hours and gain deeper insights into the challenges faced by its determination staff.

Key takeaways and learnings from Medicaid eligibility in Georgia:

People and Organizational Structure
High staff turnover / vacancy rates and retention challenges led to improvement efforts Georgia experienced low retention and high turnover as evidenced by Division of Family and Child Services workforce decreasing from ~7,300 to 6,100 workers from 2017-2022 (-16%), having a 17% vacancy rate in eligibility and call center staff (as of January 2023), and salaries only increasing by only 2% from $26-32k between 2017 and 2022.[190,191] Workforce challenges have contributed to a large backlog of Medicaid renewals and gaps in customer service, leading to delays of / errors in new applications and renewals.[192,193]

[190] Georgia Budget and Policy Institute, "Overview: 2024 Fiscal Year Budget for Human Services," 02/2023
[191] KFF, "Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision" [Table 22], 03/2023
[192] Georgia Department of Community Health (DCH), "DCH & DHS Announce $54 Million in New Funding to Support Medicaid Renewals," 12/2023
[193] Georgia Recorder, "Georgia Plans 'Strategic Surge' to Check Medicaid Eligibility After 150K Children Lose Coverage," 12/2023

Georgia addressed their workforce challenges by conducting a quarterly forum with staff from local offices. These forums were divided up by local office size to help identify root causes to turnover challenges. For example, challenges identified included: handoff issues between call center and local office staff and salary compression issues where newer staff were getting higher salaries than seasoned workers.[194,195] These quarterly forums also provided local staff the opportunity to share their concerns with decision makers beyond their supervisors.

Process

High number of disenrollments for procedural reasons during unwinding

During the PHE unwinding, Georgia saw low response rates on renewals. Contributing factors included: (1) outdated addresses, (2) unclear communication and inaccessible language in renewal notices, (3) individuals perceiving renewal notice as a scam, (4) challenges navigating the Gateway system and platform accessibility issues due to the lack of a mobile version.[196,197] As of October 2023, 48% of Georgia's completed Medicaid renewals were terminated due to procedural reasons, placing the state with the 5th highest rate of procedural disenrollments in the US.[198]

Efforts to improve applicant experience and process

Georgia sought to improve the applicant experience and eligibility processes by hiring approximately 150 contracted workers to assist with eligibility determination and customer service. Although the contractor handled the pre-work, state staff had to spend time correcting it, reducing the expected time efficiencies. This is an important learning for future efforts utilizing added supported and centralized activities to improve processes. Contractor support must be accurate, with robust processes and standardization in place to yield efficiencies.

Georgia also partnered with the Georgia Public Library Service to provide 400 free self-service kiosks at 300 Georgia public libraries[199]. This made it easier for Georgians who could not visit DFCS offices during regular hours, as the library is open in the evenings and on weekends. The kiosks utilized Google Chrome to provide applicants with technology interface they are already familiar with. Furthermore, the kiosks were outfitted with various accessibility options

[194] Georgia Budget & Policy Institute, "Overview: 2024 Fiscal Year Budget for Human Services," 02/2023
[195] Interview with Former GA Chief Deputy Division Director in the Dept of Human Services, 08/2024
[196] Georgia Public Broadcasting, "What is 'Medicaid Unwinding'? Unclear Messaging Could Leave Thousands Without Coverage," 06/2023
[197] Interview with Former GA Chief Deputy Division Director in the Dept of Human Services; 08/2024
[198] KFF, "Understanding Medicaid Procedural Disenrollment Rates," 09/2023
[199] DHS, "DHS and Georgia Public Library Service partner to provide more than 400 self-service kiosks at libraries across Georgia," 10/2024

including a Spanish-language option, zoom and font size adjustment, dictation, and alt-text image descriptions.

Technology

Migration off legacy mainframe infrastructure

Like many states, Georgia is prioritizing a shift from monolithic, legacy common business-oriented language-powered mainframe (COBOL) to a cloud-based infrastructure. Georgia implemented a "data bridge" to facilitate data collection and routing. This allowed Georgia to collect data from different systems, process it efficiently, and route it properly.

Large volume of repetitive manual work on straightforward cases

Repetitive manual work to validate 'straightforward' cases (e.g. renewal for LTC residents) increased burden on staff and postponed the service availability. Georgia hired Java developers to develop an RPA bot to automate and accelerate supervisor case reviews, tagging them for approval or further review based on policy and rules. Over 15 implemented RPA bots (via UIPath) reduced time spent on manual case reviews by ~25%. However, the need for manual follow-up still creates a bottleneck, limiting the full potential of automation.

System-rooted errors & inefficient ways of working

System-rooted system errors adversely impacted tens of thousands of Georgia enrollees. GA's IT system lacked modularity and impeded state visibility. Georgia attempted to resolve these challenges by maintaining control of some systems (e.g., eDoc system) and layering tech workarounds 'outside' of systems (e.g., RPA bots). These gave the state improved visibility, operational control, and oversight in a cost-effective way, within budget constraints.

Kentucky

Overview: Kentucky operates through a state-based administration under the Cabinet for Health and Family Services (CHFS), contrasting with Virginia's county-based structure. While both states utilize the same system vendor and maintain fully integrated benefit eligibility operations, Kentucky processes MAGI applications faster (e.g., 60% processed < 24 hours, 0% processed >45 days).[200] The state's Medicaid program is administered by the Department for Medicaid Services (DMS), with the Department of Community Based Services (DCBS) maintaining county-level offices for eligibility determinations and application processing.[201]

A key driver of Kentucky's timely application processing is their Integrated Eligibility and Enrollment Solution (IEES) that streamlines and automates the application and renewal processes for multiple benefit programs, with real-time eligibility determinations.[202] Prior to the system modernization, Kentucky's legacy enrollment system suffered from significant operational and technological deficiencies. These deficiencies resulted in extensive wait times, application backlogs requiring staff overtime, and limited customer access to benefit information.[203, 204]

In addition to centralizing all program applications and processes into a single platform, Kentucky also centralized oversight of all IT system updates through the Office of Application Technology Services (OATS).[205] With a dedicated team of 20 staff members, OATS oversees the state's eligibility system vendor and implemented a ticketing system and helpdesk to manage technical issues. The agency also implements monthly system updates to address identified technical issues and enhance functionality.[206]

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[200] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024
[201] Commonwealth of Kentucky," Department for Medicaid Services," 10/2024
[202] National Association of State Chief Information Officers (NASCIO), "NASCIO 2018 State IT Recognition Awards – Kentucky: Integrated Eligibility and Enrollment Solution: IEES," 03/2018
[203] National Association of State Chief Information Officers (NASCIO), "NASCIO 2018 State IT Recognition Awards – Kentucky: Integrated Eligibility and Enrollment Solution: IEES," 03/2018
[204] Commonwealth of Kentucky, "Integrated Eligibility & Enrollment System (IEES) RFP – Attachment Q: Business Functions And Processes IEES," 07/2022
[205] Interview with Kentucky Department of Medicaid Services, 10/2024
[206] Interview with Kentucky Department of Medicaid Services, 10/2024

Key takeaways and learnings from Medicaid eligibility in Kentucky:

People & Organizational Structure
Case ownership Kentucky transformed its eligibility processing from a localized model to a statewide system, enabling workers to handle cases through a shared repository across counties rather than restricting cases to a specific county. Furthermore, Kentucky follows a task-based system, with workers handling specific tasks, e.g., income verification instead of owning and processing a specific case.[207] By implementing a shared repository and task-based system, Kentucky improved processing efficiency and reduced regional bottlenecks. This new approach requires staff to enter standardized case notes and review previous case notes before proceeding, ensuring continuity and consistency in case management across the state.[208, 209]
Process
Continuous Medicaid coverage during the PHE During the PHE, Kentucky transformed its Medicaid enrollment system by implementing a comprehensive "one-stop-shop" approach that integrated multiple assistance programs and included automated renewals, fast-track processing, and digital outreach campaigns.[210] The state's streamlined system included an expedited application process that enabled screeners to identify eligibility for additional benefits while also allowing virtual assessments from nursing facility residents.[211] These innovations led to significant improvements, including a 23% increase in Medicaid enrollment, a dramatic rise in upfront application completion from 22% to 75%, and ~120,000 presumptive eligibility applications onboarded per month.[212]

[207] Interview with Kentucky Department of Medicaid Services, 10/2024
[208] Interview with Kentucky Department of Medicaid Services, 10/2024
[209] Division of Family Support, "Operation Manual Volume IVB: MAGI Medicaid, APTC/CSR, and QHP," 07/2024
[210] Robert Wood Johnson Foundation (RWJF), "2022 Medicaid Innovation Award - Kentucky: Enrollment Innovations," 2022
[211] Robert Wood Johnson Foundation (RWJF), "2022 Medicaid Innovation Award - Kentucky: Enrollment Innovations," 2022
[212] Robert Wood Johnson Foundation (RWJF), "2022 Medicaid Innovation Award - Kentucky: Enrollment Innovations," 2022

Technology

System modernization - IEES

Kentucky's legacy eligibility and enrollment system suffered from significant operational and technological deficiencies that resulted in extensive wait times, application backlogs requiring staff overtime, and limited customer access to benefit information.[213, 214]

To address this, Kentucky implemented IEES which streamlined eligibility determinations for multiple programs into a single process flow, reducing duplication of effort by collecting information only once.[215] IEES contains multiple modules, each serving a unique function. These include:

1. Business Intelligence (BI) Solution which provides integrated reporting across programs by utilizing two main platforms: operational reporting via a transactional database for daily monitoring, and analytical reporting through a data warehouse for executive dashboards and trend analysis.[216]
2. Benefind, a customer-facing self-service portal, aimed at addressing the challenges members faced in accessing their benefit information.[217]

With the implementation of IEES, CHFS reported the following results:[218]

- Savings of approximately $20 million in IT and operational costs
- Elimination of the 45-minute annual recertification interview due to the enhancement for automated process that verifies Medicaid recipients' information during their annual recertification
- Elimination of the mandatory 10-percent overtime for staff due to reduced administrative tasks and increased automation through Benefind
- Reductions in instances of overpayments and issuance of incorrect benefits

[213] National Association of State Chief Information Officers (NASCIO), "NASCIO 2018 State IT Recognition Awards – Kentucky: Integrated Eligibility and Enrollment Solution: IEES," 03/2018
[214] Commonwealth of Kentucky, "Integrated Eligibility & Enrollment System (IEES) RFP – Attachment Q: Business Functions And Processes IEES," 07/2022
[215] National Association of State Chief Information Officers (NASCIO), "NASCIO 2018 State IT Recognition Awards – Kentucky: Integrated Eligibility and Enrollment Solution: IEES," 03/2018
[216] Commonwealth of Kentucky, "Integrated Eligibility & Enrollment System (IEES) RFP – Attachment Q: Business Functions And Processes IEES," 07/2022
[217] Commonwealth of Kentucky, "Integrated Eligibility & Enrollment System (IEES) RFP – Attachment Q: Business Functions And Processes IEES," 07/2022
[218] Commonwealth of Kentucky, "Integrated Eligibility & Enrollment System (IEES) RFP – Attachment Q: Business Functions And Processes IEES," 07/2022

North Carolina

Overview: Like Virginia, North Carolina operates under a county-based administrative system where local county agencies are responsible for administering Medicaid eligibility and has integrated benefit eligibility processes.

The state focused on improving its eligibility determination processes, especially in preparation for Medicaid expansion in 2023. Key initiatives include deploying tools like the ePASS portal, improving community outreach (e.g., by implementing automated texts and calls, and automating several eligibility steps to reduce manual work). Automation examples include straight-through processing (STP) for automatic Medicaid renewals without manual review, and real-time data verification to instantly validate income and residency using electronic sources.

Additionally, North Carolina prioritized consistency across its 100 counties by introducing standardized processes and best practices. The state leverages a centralized team, the Operational Support Team (OST), to capture best practices and improve processes through on-site visits and targeted training sessions.

Key takeaways and learnings from Medicaid eligibility in North Carolina:

People & Organizational Structure
Utilization of regional Medicaid consultants to provide oversight and support North Carolina's 13 regional Medicaid consultants / NC Medicaid Operational Support Team (OST), create quarterly work plans to share best practices to standardize processes, identify common challenges, and monitor the monthly performance report cards. These report cards are updated on a monthly basis and track the % of application processed timely (85% for smaller counties and 90% for larger counties) and the average processing time (45 days for MAGI, 90 days for non-MAGI) applications. Missing the target for any of these goals indicates a failure for the month. When county agencies fail their report card, the regional Medicaid consultants visit to identify challenges and provide appropriate trainings. If issues continue to persist (e.g.,

county fails three months in a row or five times in 12 months) counties must implement a corrective action plan.[219, 220]

High vacancies & turnover rates

Following Medicaid expansions, caseloads were the highest in the history of the NC Medicaid program and county offices were experiencing staffing shortages. North Carolina conducted quarterly county surveys to gather data on staffing, vacancies, application / recertification progress, and call volume. The state developed a County Staffing Tool to forecast the number of staff needed for application and recertification processing based on caseloads. The North Carolina Department of Health and Human Services also allocated $8.3M to counties to support preparation for expansion implementation ahead of the Medicaid expansion legislation funding in June 2023.[221]

Introduction of financial penalties decreased work-sharing

North Carolina conducts Recipient Eligibility Determination Audits (REDA) with 33% of counties every year to ensure benefits are provided only to those individuals eligible for Medicaid. If a county has inappropriately approved someone for Medicaid, the county must repay the Medicaid health care costs for that individual.[222] Since 2017, county agencies have been increasingly reluctant to share cases with other county agencies due to concerns that errors made by those agencies will reflect poorly on the primary agency during audits.

Process

Leveraging community partners to improve processing

North Carolina expected significant challenges with the launch of its Medicaid expansion in December 2023, due to the confusion caused by policy changes during the PHE and the ongoing unwinding process.

North Carolina developed a communication strategy to increase awareness to support Medicaid expansion by (1) creating a Medicaid expansion toolkit for distribution to health plan partners, community organizations, LDSS agencies, and the public; (2) launching a portal for stakeholders to receive updates on Medicaid expansion; (3) forming the External Implementation Partners Workgroup with providers, and community organizations to support Medicaid expansion implementation; (4) holding biweekly meetings with community

[219] North Carolina Medical Journal, "Keeping North Carolina Insured: Strategies to Maintain Coverage," 2023
[220] Interview with North Carolina Medicaid, 09/2024
[221] North Carolina Medical Journal, “Keeping North Carolina Insured: Strategies to Support County Departments of Social Services and Continuous Enrollment,” 03/2024
[222] North Carolina Medical Journal, “From Continuous Coverage to Medicaid Expansion: North Carolina’s Changing Public Payer Landscape,” 03/2024

voices to craft messages; and (5) training organizations to deliver Medicaid expansion presentations in English (~350 organizations) and Spanish (~100 organizations).[223, 224]

North Carolina also educated community organizations on the Electronic Pre-Assessment Screening Service (ePASS) portal to assist with digital submissions of applications. The State recorded step-by-step demonstrations for applications in both English and Spanish for community organizations using the ePASS portal and developed an accompanying reference guide providing further detailed information.[225]

Integrating new policies

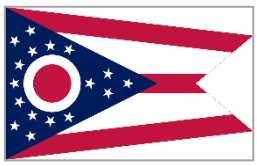
North Carolina implemented policy flexibilities offered by CMS to streamline processes, including: (1) updating beneficiary addresses using U.S. Postal Service forwarding or National Change of Address (NCOA) without requiring additional verification; (2) increasing the "reasonable compatibility" threshold for data matches from 10% to 20%, reducing the need for additional beneficiary information and expediting application processing; (3) updating the residency requirement to one form of verification down from two; and (4) automatically renewing Medicaid eligibility for ABD population with incomes below 100% FPL and assets under the reserve limit. North Carolina also educated counties on policy changes by utilizing the NC Medicaid Operational Support Team (OST) and convened a monthly DSS County Workgroup focused on expansion and the CCU since 2022.[226]

Technology

Developed eligibility system capabilities in-house

After developing NC FAST, North Carolina's benefits and services management system, North Carolina brought the system in house. Although they will utilize RFPs for specialized technical support, there is a team of developers that are housed within the North Carolina Health and Human Services' (HHS) office of the CIO. By bringing the capabilities in house, NC Medicaid can quickly make change results or updates to the system without having to navigate and negotiate vendor contracts. Collaboration between the NC FAST team and NC Medicaid is high as they both report to NC HHS and are frequently embedded in relevant meetings.[227]

[223] North Carolina Medical Journal, "From Continuous Coverage to Medicaid Expansion: North Carolina's Changing Public Payer Landscape," 03/2024
[224] Interview with Deputy Medical Director at NC Department of Health and Human Services; 09/2024
[225] North Carolina Department of Health and Human Services (NCDHHS), "Navigating ePASS: Guide to Providing Application Assistance," 10/2023
[226] North Carolina Medical Journal, "From Continuous Coverage to Medicaid Expansion: North Carolina's Changing Public Payer Landscape," 03/2024
[227] Interview with Deputy Medical Director at NC Department of Health and Human Services; 09/2024



Ohio

Overview: Ohio has a state-supervised, county-based Medicaid administration that integrates the benefit eligibility process. While Ohio and Virginia face similar MAGI processing times exceeding 45 days at 21%, Virginia demonstrates faster initial application processing (under 24 hours) than Ohio (19% vs 14%).[228] The state's Medicaid program is overseen by two primary agencies determining eligibility: the Ohio Department of Medicaid (ODM) and the Ohio Department of Jobs and Family Services (ODJFS).[229] The ODM determines eligibility policy, criteria, and payment policy, while the Department of Job and Family Services (OJFS) supports 88 local offices processing applications and managing enrollment for Medicaid, TANF, SNAP, and Child Care Assistance.[230] While counties handle the majority of applications, Ohio established a central processing unit to provide in-house support for processing aging, pending applications.[231]

Ohio successfully enhanced operational efficiency through the implementation of eight specialized RPA and Artificial Intelligence systems (i.e. AI "bots"), which significantly reduced manual work and application backlogs.[232] However, Ohio continues to have challenges with variability in county-level performance due to differences in county size, local management structures, and varying levels of participation in the county shared services model (CSS). The CSS is an opt-in shared call center designed to streamline Medicaid phone applications across counties.[233]

[228] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024
[229] Ohio Auditor of State, "Ohio's Medicaid Eligibility Determination Process," 11/2020
[230] Ohio Auditor of State, "Ohio's Medicaid Eligibility Determination Process," 11/2020
[231] Kaiser Family Foundation, "State Health Facts: Staff Responsible for Processing Applications and Renewals in Medicaid and CHIP," 05/2024
[232] National Association of State Chief Information Officers (NASCIO), "The Ohio Benefits Program is "Bot" In – The Ohio Benefits Family of Bots," 08/2022
[233] Ohio Auditor of State, "Ohio's Medicaid Eligibility Determination Process," 11/2020

Key takeaways and learnings from Medicaid eligibility in Ohio:

People & Organizational Structure
County Activities Dashboard and Financial Incentives To address variability across counties, Ohio implemented comprehensive performance tracking through a County Activities Dashboard. This dashboard monitors six key areas, including redeterminations, SNAP, and Medicaid applications, providing both statewide and county-level metrics from the Ohio Integrated Eligibility System.[234] The dashboard tracks metrics such as ex parte renewals, manual renewals, application processing times, and pending applications, enabling data-driven operational management. In addition, through House Bill 33, the state established a $5 million performance incentive program to incentivize timely processing of Medicaid applications. Two types of incentives were issued based on performance during SFY24: (1) $2 million were distributed to counties each month if they met the 90% caseload processing benchmark for the seven-month period from 09/2023 through 03/2024 as indicated on the ODM county activities dashboard. The amount allocated to each county per month was proportional to the county's overall Medicaid caseload. (2) $3 million were distributed to the top five counties with greatest improvement in renewal backlog and top five counties with greatest improvement in application backlog each quarter between December 2023 and June 2024, as a percentage of their overall Medicaid caseload for both metrics.[235]
Process
Centralized County Supports Ohio established a centralized support infrastructure, which includes a County Engagement Unit. This unit has dedicated managers who conduct quarterly meetings to address questions, identify training needs, review reports, and discuss best practices. Additionally, Ohio created a CPU to provide in-house support for processing pending applications. The CPU also offers ongoing assistance through statewide webinars, combined training programs, and a monthly newsletter. These efforts help promote consistent eligibility processing across counties.[236]

[234] Ohio Department of Medicaid, "County Activities Dashboard Desk Aid," 10/2023
[235] Ohio Department of Job and Family Services, "Fiscal Administrative Procedure Letter No. 119," 03/2024
[236] The Ohio Department of Medicaid State of Ohio, "Program Integrity 2021 Annual Report," 04/2022

Technology

Backlog in Ohio's Medicaid eligibility determinations

The Ohio Auditor of State conducted an audit of the State's Medicaid eligibility process, which found that Ohio was out of compliance with federal processing times. At its peak in January 2018, there was a backlog of 68,894 cases, likely leading to long wait times for beneficiaries to access benefits.[237]

Through interviews and focus groups with county caseworkers, Ohio identified that system alerts and manual processes were overwhelming caseworkers, leading to large backlogs.

To address this issue, an interagency team was formed in 2020. This team implemented "sprints" to update system functionality, to correct system defects and to enhance automation.[238] As a result of these efforts, the team successfully reduced the volume of alerts by ~40% , helping caseworkers more efficiently process applications and focus on the alerts that genuinely require manual resolution.[239]

RPA and AI Bots

Ohio implemented RPA and AI bots through partnerships between state agencies and 88 county departments, deploying eight specialized bots that processed over 500,000 cases and saved more than five years of caseworker hours. The bots included:[240]

- **The Baby Bot:** Processes newborn Medicaid eligibility.
- **MyCare Bot:** Handles MyCare waiver flips in Ohio Benefits system.
- **Department of Rehabilitation and Correction Bot:** Processes Medicaid eligibility for newly incarcerated individuals.
- **Quality Assurance Bot:** Reviews SNAP cases for accuracy.
- **Long Term Care Pending Record Removal Bot**: Cleans up irrelevant long-term care records.
- **Pregnancy Bot:** Reviews and processes alerts for new pregnancies.
- **Interim Reporting Bot**: Processes scanned Interim Reports for SNAP compliance.
- **SSP Case Linking Bot:** Reviews case linking requests for Ohio Benefits access.

[237] Ohio Auditor of State, "Ohio's Medicaid Eligibility Determination Process," 11/2020
[238] The Ohio Department of Medicaid State of Ohio," Concurrent Enrollment Response Letter," 03/2024
[239] The Ohio Department of Medicaid State of Ohio," Concurrent Enrollment Response Letter," 03/2024
[240] National Association of State Chief Information Officers (NASCIO), "The Ohio Benefits Program is "Bot" In – The Ohio Benefits Family of Bots," 08/2022

Pennsylvania

Overview: Pennsylvania differs from Virginia with its state-based administration under the Department of Human Services (DHS). While both states share the same system vendor, Pennsylvania's Medicaid system is only partially integrated with other benefit eligibility operations. Despite this, Pennsylvania matches Virginia's MAGI application processing times (<24 hours) but outperforms Virginia in meeting the federal 45-day requirement for new applications.[241]

The state uses a unified application form for multiple benefits programs, operates a centralized processing center to support eligibility determinations for any type of benefit, and implemented a fast-track application process that utilizes data from SNAP, Low-Income Home Energy Assistance (LIHEAP), and TANF to identify individuals eligible for Medical Assistance (Medicaid).[242, 243]

Key takeaways and learnings from Medicaid eligibility in Pennsylvania:

People & Organizational Structure
Workload Distribution Pennsylvania county offices can experience staffing limitations or high application volume but still i meet state and federal application requirements by leveraging a centralized processing center that provides overflow support.[244] If County Assistance Offices (CAOs) - state-managed entities based locally who support eligibility and determination processing for the state's benefits programs - are experiencing processing challenges, the state can redistribute the CAO workload to the centralized processing center.[245] Approximately 5% of the annual application volume is processed by the centralized processing center.[246] **Monitoring and Reporting Processes:**

[241] CMS MAGI Application Processing Time Snapshot, 01/2024-03/2024
[242] Interview with Pennsylvania Office of Income Maintenance (OIM), 10/2024
[243] Benefits Data Trust (BDT), "Fast Track: A quicker road to Medicaid enrollment," 12/2019
[244] Interview with Pennsylvania Office of Income Maintenance (OIM), 10/2024
[245] Interview with Pennsylvania Office of Income Maintenance (OIM), 10/2024
[246] Interview with Pennsylvania Office of Income Maintenance (OIM), 10/2024

Pennsylvania also maintains robust monitoring processes, including monthly reports and dashboards, to measure timeliness across offices and organizational levels, with management reviewing work item completion and staff performance.[247]

Process

Fast-Track Enrollment

Paper Medicaid applications were often overly burdensome on members and applications required significant time and resources to process with eligibility specialists.[248]

To address this, in 2016, DHS implemented the Medicaid Fast Track enrollment initiative. This increased Medicaid enrollment by streamlining and automating enrollment processes for both applicants and caseworkers, by automatically screening applicants for Medicaid when they apply for SNAP and/or LIHEAP.[249] DHS also partnered with Benefits Data Trust (BDT) to design and launch Fast Track, which included a targeted outreach mail and phone campaign.[250]

- BDT sent over 140,000 outreach letters and received a nearly 50% response rate
- Out of the more than 70,000 calls and forms received, BDT submitted over 67,000 Fast Track consent forms to the state

The Fast Track process led to the following results:[251]

- Of the 37,000 people who consented to enroll in Medicaid, 55% were enrolled through Fast Track
- Reduced application time from 45 minutes to under 5 minutes
- Eliminated need for caseworker processing in most cases

State regulation - application processing requirement

While federal regulations require that states process Medicaid applications within 45-days, Pennsylvania implemented regulations in which CAOs must make an eligibility determination within 30 days, with exceptions to LTC cases.[252, 253] Per the state's Medical Assistance Eligibility Handbook, "If a determination cannot be made in 30 days, the CAO must send a

[247] Interview with Pennsylvania Office of Income Maintenance (OIM), 10/2024
[248] Benefits Data Trust (BDT), "Fast Track: A quicker road to Medicaid enrollment," 12/2019
[249] Ibid.
[250] Ibid.
[251] Ibid.
[252] Interview with Pennsylvania Office of Income Maintenance (OIM), 10/2024
[253] Pennsylvania Department of Human Services, "Medical Assistance Eligibility Handbook,"

notice to the applicant explaining why a determination cannot be made and saying that the 30-day period will be extended to 45 days."[254]

Technology

System Improvements and Mobile App Launch

Pennsylvania continues to further streamline its Medicaid eligibility process through enhanced real-time data exchanges and automated verifications.[255] These improvements reduced duplicate data entry for applicants and minimized the need for manual caseworker review. In addition, the state's introduction of the MyCOMPASS PA mobile app in 2016 enabled applicants to upload documentation directly from their phones, further accelerating processing times.[256, 257]

[254] Pennsylvania Department of Human Services, "Medical Assistance Eligibility Handbook,"
[255] Interview with Pennsylvania Office of Income Maintenance (OIM), 10/2024
[256] Ibid.
[257] Commonwealth of Pennsylvania, "MyCOMPASS PA"

Tennessee

Overview: Tennessee and Virginia both have over 20% of their population covered by Medicaid and contract with the same eligibility system vendor. Unlike Virginia, Tennessee's Medicaid eligibility is determined at the state level and is no longer integrated with other benefit eligibility processes. The state's Medicaid program, TennCare determines eligibility, and the Tennessee Department of Human Services handles eligibility determinations for other benefit programs like SNAP and TANF.

Due to its de-integrated nature, TennCare has sole responsibility and accountability over their Medicaid eligibility program. Additionally, TennCare is a leader in vendor management and has effectively collaborated with their eligibility system vendor to automate processes and provide immediate access to programmatic and operational data.

Key takeaways and learnings from Medicaid eligibility in Tennessee:

People & Organizational Structure
De-integration of Medicaid from other benefit programs Tennessee Medicaid (TennCare) previously partnered with Department of Human Services to determine Medicaid eligibility along with other social service benefits (e.g., SNAP, TANF). Due to ACA requirements, TennCare de-integrated Medicaid eligibility from other benefit programs and moved state TennCare eligibility staff to a centralized location in 2014. TennCare's decision to de-integrate was driven by concerns that the current eligibility system might not meet ACA requirements.[258] A key challenge in de-integration was estimating the number of employees needed. Tennessee leveraged staff vacancies from local agencies to build out a centralized determination office. However, over the years, TennCare required more employees and asked for new funding from the state legislature – ultimately expanding from a workforce of 250 to a workforce of 700 over the last 10 years.[259]

[258] Interview with TennCare, 09/2024
[259] Interview with TennCare, 09/2024

Process

Efficient processes due to specialization and automation

Since 2018, 1.3M of 2.3M, or58% of new applications were processed automatically via 'no-touch', and the remaining 1M were processed manually as they required additional information from applicants. [260]

Stakeholders attribute efficiency to: centralizing into a state-wide team, de-integrating from other social benefit determinations, and implementing a new eligibility system after the ACA roll out. DHS and TennCare's de-integration permits eligibility workers to solely focus on Medicaid applications instead of balancing priorities from other benefit programs. [261]

Leveraging local county offices

In county benefit offices staffed by Department of Human Services (DHS), applicants can apply for TennCare at self-service kiosks. While applicants use the self-service kiosk, a DHS intake worker is available to answer application questions. If questions require escalation, applicants can call a special customer service line available through county offices.[262]

Technology

Effective Vendor management

To optimize eligibility systems, TennCare collaborates closely with its vendor. TennCare staff have regularly scheduled meetings in addition to ad-hoc meetings on specific change requests. TennCare's policy team approximately spends 50% of their time working with their IT vendor. This enabled TennCare to effectively prioritize change requests, particularly during the PHE and unwinding period, when many federal requirements were being implemented.[263]

Real-time access to data

TennCare has immediate access to data to support their decision-making processes. Key stakeholders can readily pull real-time data from their eligibility tool, allowing them to see the number of applications processed and by channel source (e.g., online, phone, paper). Stakeholders attribute well-functioning data capabilities to the good working relationship with their eligibility system vendor. [264]

[260] Interview with TennCare, 09/2024
[261] Ibid.
[262] Ibid.
[263] Ibid.
[264] Ibid.

8.4 Supporting Details on the Overview of Medicaid Eligibility in Virginia

People & Organizational Structure of Medicaid Eligibility Determination in Virginia

DMAS is the single state agency responsible for all aspects of Medicaid. This includes ensuring compliance with the Centers for Medicare and Medicaid Services requirements regarding eligibility decisions and associated costs. DMAS does not directly provide program administration but works with the VDSS and contracts with CoverVA to determine eligibility.

The **DMAS CoverVA Call Center** is run by a third-party vendor, Maximum, that operates the statewide Medicaid eligibility call center and a central processing unit to assist in the processing Medicaid-only MAGI applications. There is a federal CMS requirement that all states have a process for accepting telephonic applications, which the DMAS CoverVA Call Center fulfills.[265] The DMAS CoverVA Call Center also accepts telephonic renewals and change reports from members - more calls are for renewals than applications. Medicaid-only MAGI applications are applications where the applicant is only applying for Medicaid, not other public benefits such as SNAP or TANF, and the applicant is applying for coverage as a MAGI applicant (e.g., child, pregnant woman). The DMAS CoverVA Call Center also manages a separate call center and eligibility team for applicants in state correctional facilities and local and regional jails– known as the CoverVA Incarcerated Unit.

VDSS is responsible for coordinating Medicaid eligibility policies with DMAS, offering technical assistance, training, and guidance on Medicaid eligibility policies and procedures to LDSS agencies, and providing state-level oversight of the eligibility determination process. VDSS oversees five regional offices, each staffed with a Medicaid consultant who supports local agencies with Medicaid eligibility determinations (e.g., oversee implementation of Medicaid eligibility policies and provide technical assistance). VDSS also manages the centralized infrastructure used by LDSS agencies to process applications, including but not limited to the DSS Enterprise Call Center, a state-wide call center that can accept applications across benefit programs and respond to inquiries, and VaCMS, the technology system used by LDSS workers to manage applications and determine eligibility.

There are **120 LDSS agencies** within Virginia. LDSS agencies are categorized into levels based on size and include: 33 Level I agencies that are small, 59 Level II agencies that are medium, and 28 Level III agencies that are large.[266] These LDSS agencies are responsible for processing Medicaid applications and redeterminations and providing related social services. Responsibility for processing Medicaid applications and redeterminations are cited in §62.3-501 of the Code of

[265] According to CMS Informational bulletin "Ensuring Timely and Accurate Medicaid and CHIP Eligibility Determinations at Application," 05/2024

[266] Each LDSS agency is assigned a level based on the size of their agencies. Level for each LDSS agency can be found in Appendix 8.8

Virginia: “except as provided for in the state plan for medical assistance services pursuant §32.1-325, application for public assistance shall be made to the local department and filed with the local director of the county or city in which the applicant resides.”

Local departments of social services employ 3,556 people involved in social benefit eligibility, including intake and eligibility staff, as well as 118 directors in 2024. LDSS agencies vary in staffing and resources. While they have a statutory and funding relationship with VDSS, LDSS agencies are ultimately accountable to their local county governments (e.g., receive hiring authority from local county boards).

In addition to processing Medicaid applications, LDSS agencies work directly with individuals applying for other benefit programs and process applications for SNAP, TANF, childcare, and energy assistance. Most benefit programs specialists surveyed are generalists, meaning they support multiple kinds of benefit applications. 68% of survey respondents (n=1294) indicated that they spend <50% of their time on Medicaid applications and renewals).[267] A significant portion of benefit programs specialists also handle complex non-MAGI cases including applications and renewals that require a review of financial assets and other eligibility criteria.

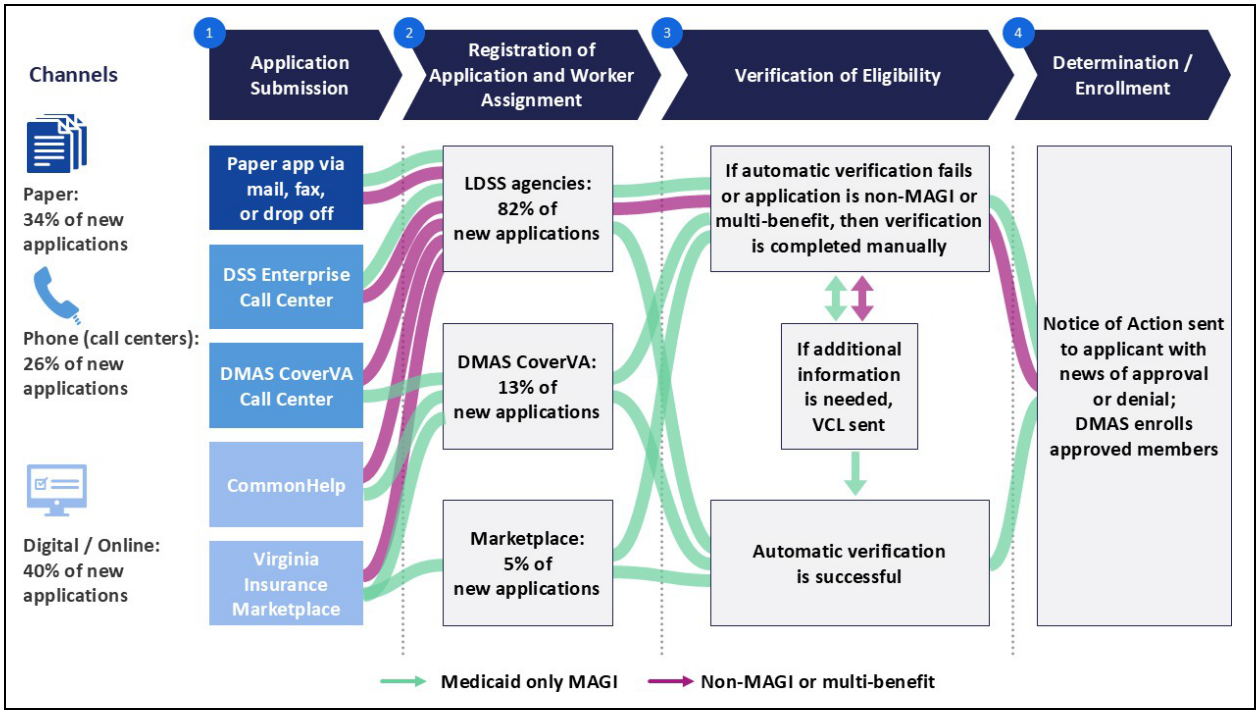
The **Virginia Insurance Marketplace** is Virginia’s health insurance marketplace and is a division under Virginia’s State Corporation Commission, an independent state agency. Virginia transitioned from the federally-facilitated (HealthCare.gov) in 2023 to a state-based health insurance marketplace. The marketplace determines financial assistance including federal premium subsidies and cost sharing reductions for residents who purchase Qualified Health Plans through the marketplace.[268] The marketplace also automatically determines eligibility for applicants who submit MAGI applications for Medicaid. MAGI applications can be automatically approved and sent to VaCMS through an "account transfer." Within VaCMS, the account transfer is recorded and authorized. VaCMS then sends the enrollment transactions to DMAS’s MES, which handles the enrollment process (just like any other approved application). If an application cannot be approved automatically by the Marketplace, it is still sent to VaCMS as part of an "account transfer" batch and then forwarded to CoverVA CPU or LDSS agencies for processing.

[267] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)

[268] Virginia’s Insurance Marketplace, “Virginia Health Benefit Exchange Introduction,” 10/2023

Process of Medicaid Eligibility Determination in Virginia

Figure 26: New application flow across Virginia Medicaid eligibility channels



To enroll in Virginia Medicaid, new applicants must be deemed eligible and existing beneficiaries must be annually renewed. This process has four key steps: (1) application submission, (2) registration of application and worker assignment, (3) verification of eligibility, and (4) determination / enrollment. Each step varies greatly depending on which application channel and method is used.

1. Application submission: Applicants have three channels to apply for eligibility:

(i) a paper application submitted through the mail, via fax, or in-person at LDSS agencies,
(ii) a phone call to the DSS Enterprise, DMAS CoverVA, or Virginia Insurance Marketplace Call Centers, or
(iii) digitally (online) using CommonHelp or through the Virginia Insurance Marketplace.

Between January to July 2024, 34% of Medicaid applications were submitted via paper, 26% via phone (Cover VA and DSS Enterprise Call Centers) and 40% via online (includes CommonHelp and the state based marketplace).[269] Due to Virginia's integrated social benefit eligibility system, while applying for Medicaid, individuals can also apply for other programs, such as TANF, SNAP, childcare, and energy assistance. CommonHelp is the VDSS digital portal used for

[269] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024

both Medicaid and other DSS benefit programs. It is important to note that CommonHelp is the intake portal for many other application types outside of Medicaid and only ~15% of DSS cases overall are submitted through CommonHelp.

2. Registration of application and worker assignment: Applications are received and inputted into VaCMS automatically or manually based on the submission channel and application type.

- **Digital/online**: All applications submitted via CommonHelp are loaded into VaCMS. Application start processing with the automated self-direct process.[270] If there are no errors in the application, eligibility determination can be made and automatically sent to DMAS for enrollment. If there are errors (e.g., missing information, duplicate application) or the application is non-MAGI or for multiple benefits, a LDSS or CoverVA eligibility worker (i.e., this term includes LDSS benefit programs specialist and CoverVA eligibility worker) must manually load the application into VaCMS.
- **Phone:** Applications submitted via the DSS Enterprise and DMAS CoverVA Call Centers are manually inputted into VaCMS with RDE. Medicaid-only MAGI applications entered through RDE will enter the self-direct process to automatically verify eligibility.
- **Paper:** LDSS staff manually enter paper applications and those received through the LDSS email, fax, or in person. LDSS agencies then have the choice to utilize RDE or AR to load the application into VaCMS.

Once the information is submitted into VaCMS, the system will attempt to automatically register the application through self-direct. If this process fails or the applicant is non-MAGI or multi-benefit, an eligibility worker will manually register the application. Following this step, the case will be assigned to a CoverVA or LDSS eligibility worker.

3. Verification of eligibility: Once assigned, the eligibility worker can verify the application automatically or manually to see if it meets financial and non-financial requirements. If the application was submitted digitally or input using RDE, the eligibility worker first attempts to verify the application through an automatic process. If RDE is not available, the eligibility worker manually enters the application. Regardless of automatic or manual verification, if additional information is required to verify eligibility, the eligibility worker will send out a request for additional information (i.e., a verification check list). This request is sent out via mail and by CommonHelp if the applicant opted into receiving digital correspondence. Applicants can then submit additional information via CommonHelp, by fax, by mail, or in-person.

[270] Note that all applications will be first attempted using the self-direct process but may fail due to being a non-MAGI and/or a multi-benefit application.

Once all information is received, the automated system or eligibility worker conducts both a financial (e.g. income and asset thresholds) and a non-financial review (e.g., residency status, existing health insurance coverage, functional screening for ABD / LTC applicants).

4. Determination / enrollment: Once the benefit programs specialist or system determines eligibility, VaCMS generates and sends a status notification called the Notice of Action via mail:

- If approved, a Notice of Action stating their approval is sent and the member is enrolled into Virginia Medicaid
- If denied, a Notice of Action stating their denial is sent, which explains the reason(s) for denial along with information on appeal rights, nondiscrimination language, and language/disability access information.

Per federal policy, 42 CFR 435.912, state Medicaid agencies must process all Medicaid applications within 45 days, unless a disability determination is required. States have 90 days to process Medicaid applications that require a disability determination. In Virginia, MAGI applications are processed within a median of 13 days while Non-MAGI applications often take longer to process, a median of 41 days, given the increased number of requirements that must be satisfied.[271]

Renewals: For renewals, existing Medicaid beneficiaries are automatically processed 2 months before renewal is due through a process called ex parte. The ex parte process allows Virginia to confirm a beneficiary's Medicaid eligibility without requiring the beneficiary to submit documentation or complete a form. Instead, the Commonwealth can use information that is already available to them, such as electronic income verification sources or information from other programs. 62% of renewals were approved ex parte in Virginia. All renewals are federally required to be first attempted ex parte; if the ex parte does not lead to an automatic renewal, beneficiaries must complete and submit a pre-filled renewal form. Beneficiaries can submit renewal forms digitally through CommonHelp, by phone (note: only the DMAS CoverVA Call Center accepts telephonic renewals), or by paper (mail, fax, or drop-off). These renewals are largely follow a similar receipt / intake, verification of eligibility, and determination / enrollment path as applications.

[271] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024

Figure 27: MAGI application flow across Virginia Medicaid eligibility channels

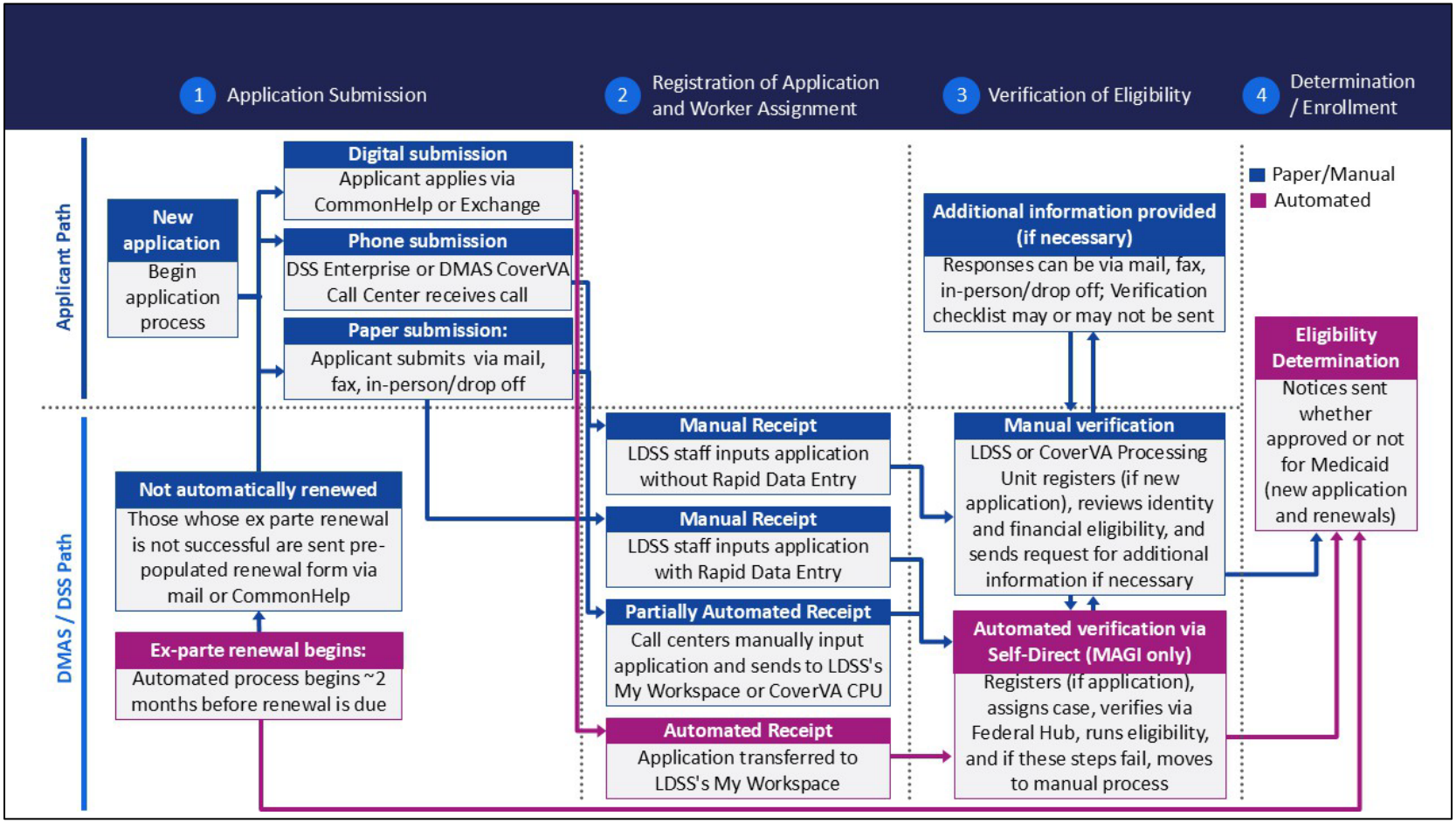
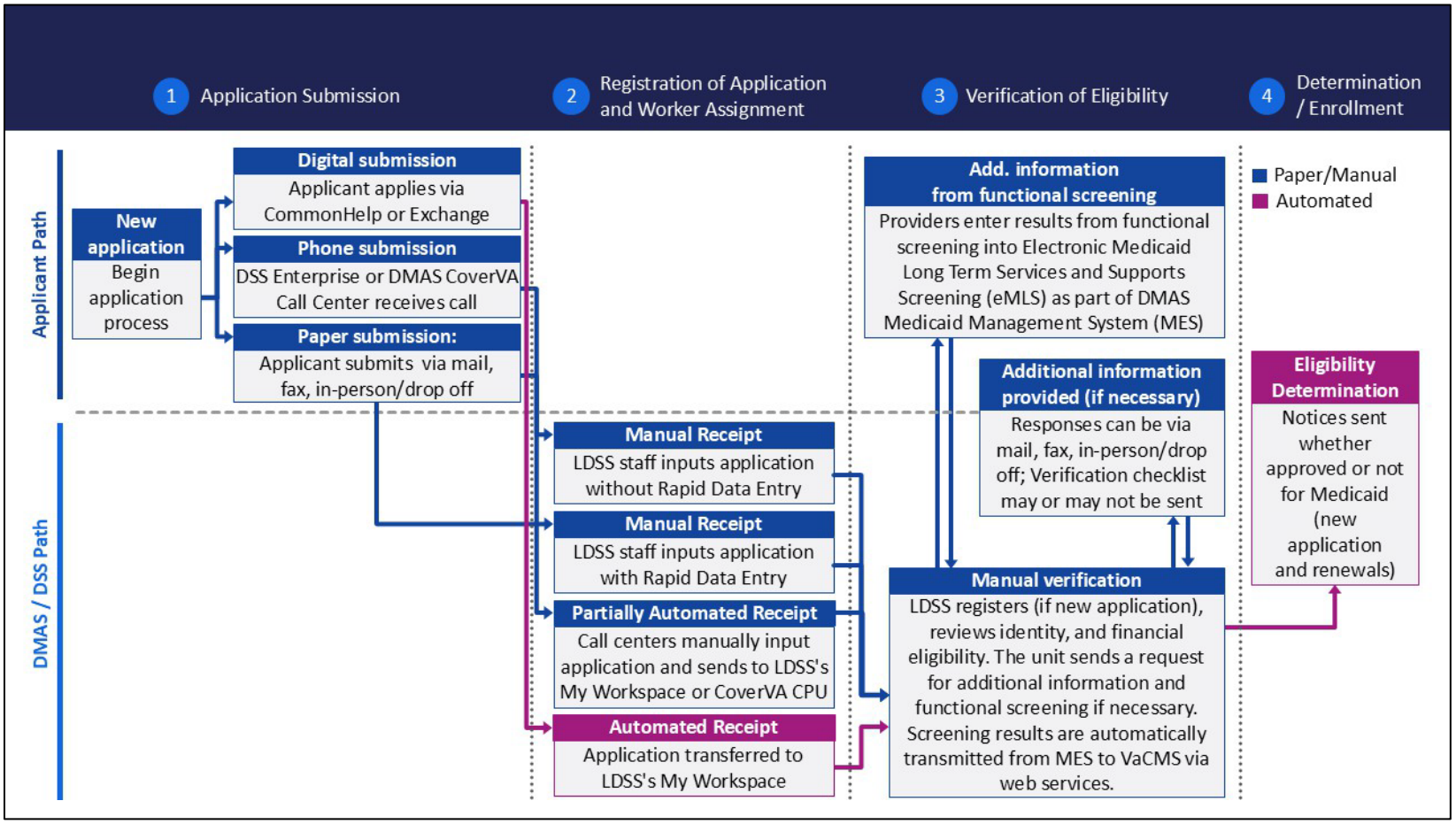


Figure 28: Non-MAGI application flow across Virginia Medicaid eligibility channels



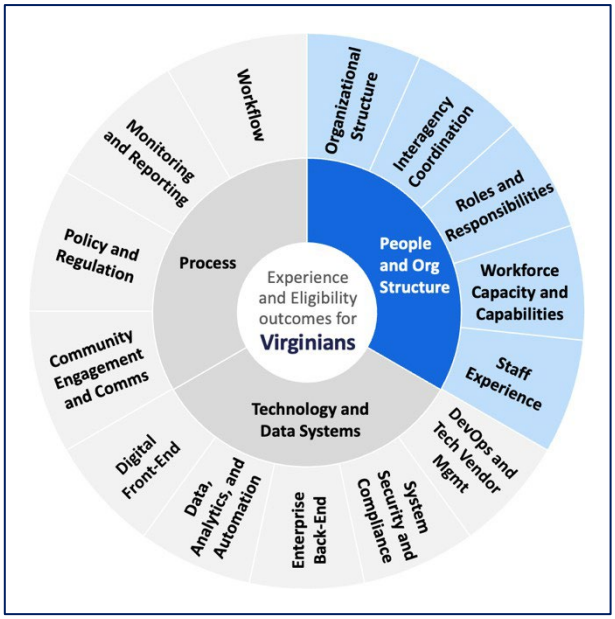
8.5 Supporting Details on People & Organizational Structure, Process, and Technology & Data System Strengths and Challenges

This assessment's approach to identify best practices and benchmarks looked across this framework of people & organizational structure, process, and technology & data systems to pull together customized best practices that consider the Commonwealth's needs. This section provides a more detailed version of this framework's sub-pillars.

People & Organizational Structure

Organizational Structure

Figure 29: People and Organizational Structure framework



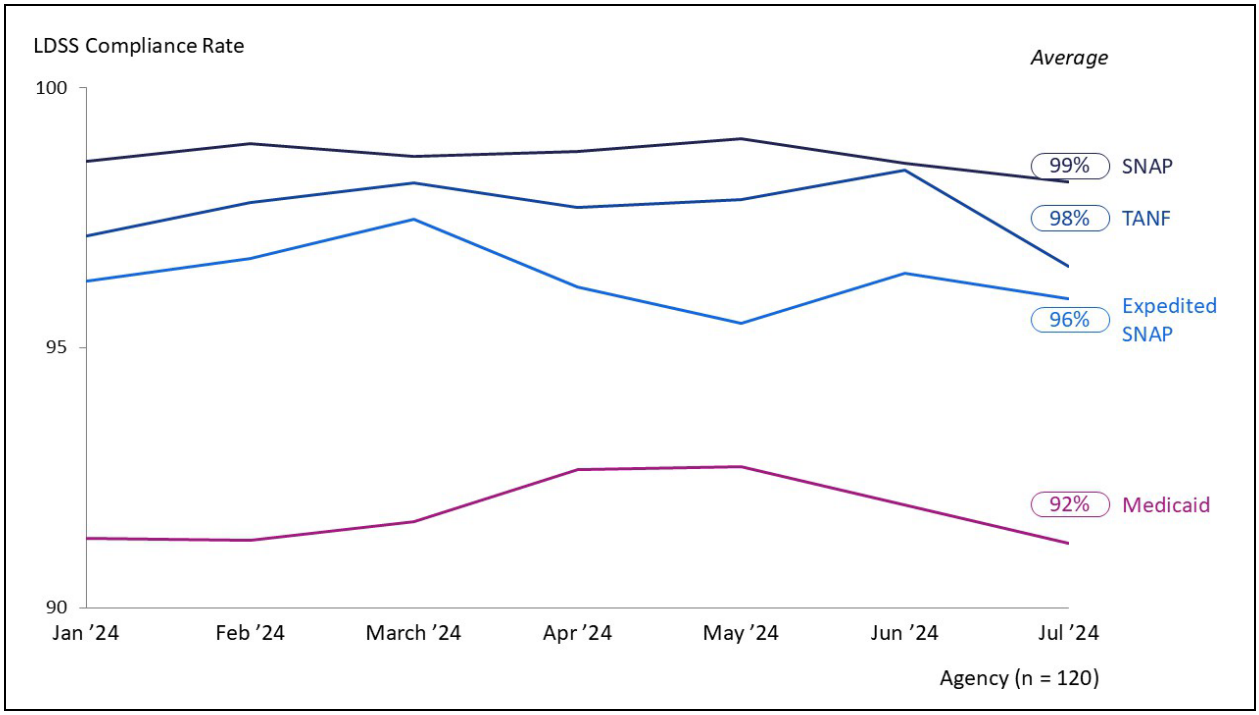
Strengths: Virginia's decentralized Medicaid eligibility determination process gives benefit programs specialists more local context, enhancing their ability to better understand and relate to applicants. Considering the numerous interactions involved in the Medicaid eligibility process (e.g., a phone call with an LDSS worker or coming into the LDSS agency to drop off / fill out an application), it is beneficial to have benefit programs specialists who understand the applicants' backgrounds.

Challenges: To achieve this local context, DMAS contracts with VDSS who then oversees LDSS agencies. This structure presents significant challenges with regards to accountability. The structural division between DMAS, VDSS, and local agencies complicates accountability, as DMAS has limited legal authority to enforce policies at the local level. While DMAS provides Medicaid funding to VDSS and is responsible for meeting federal requirements, it has little oversight over how VDSS and LDSS agencies process applications. Additionally, the organizational structure results in a more localized focus on eligibility determination. While this supports strong local autonomy, it can also make cross-county work-sharing more challenging, as agencies tend to prioritize county-level goals over broader state objectives.

LDSS agencies often prioritize programs such as SNAP over Medicaid. Average monthly compliance rates of SNAP (~99%), expedited SNAP (~96%), and TANF (~98%) surpass Medicaid's rate (~92%). SNAP is often prioritized over Medicaid due to the 7-day processing requirement at the federal level for expedited SNAP and the enforcement of federal penalties for delays and errors.

> Being customer centric, if you are applying for SNAP you are food insecure. We want to help you get food. On the flip side, if a renewal is due, there is more complacency. If they get Medicaid for an extra month, it's not as big a deal as not getting food on the table.
>
> - **Director at LDSS Agency**

Figure 30: LDSS Application timeliness rates for SNAP, expedited SNAP, TANF, and Medicaid[272]



Interagency Coordination

Strengths: In January 2022, the Secretary of HHR convened a united task force between DMAS and VDSS to prepare for the PHE unwinding which resulted in overall improved collaboration between the two agencies. The task force, which met at least monthly, improved transparency between the agencies, promoted alignment on key objectives and provided unified communications to LDSS agencies. The collaboration developed through this unwinding task force has fostered strong relationships between the DMAS and DSS leadership teams that continues today.

[272] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024

Challenges: Without institutionalizing the governance model and processes that helped increase collaboration between DMAS and VDSS, there is a risk that the agencies may become siloed again in the future. Additionally, data sharing between the two agencies is challenging, resulting in fragmented and incomplete information that prevents real-time insights into eligibility determinations and service delivery. For example, the lack of financial breakdowns for LDSS agencies (e.g., number of applications processed, Medicaid costs) makes it difficult for the DMAS Finance team to accurately forecast enrollment.

A key challenge in collaboration between the Commonwealth and LDSS agencies is that LDSS agencies, reporting mainly to county governments, lack incentives to adopt guidance from DMAS or VDSS. Other than withholding reimbursement for administrative expenses granted by §63.2-408 in the Code of Virginia, VDSS has limited control over LDSS agencies. VDSS has authority to issue Corrective Action Plans; however, they have not conducted any in the last ~18 months for Medicaid eligibility. This timeframe coincided with the PHE unwinding efforts that created unprecedented demand and circumstances for LDSS agencies, and therefore Corrective Action Plans were not a priority for VDSS but are an available lever for oversight going forward.

Collaboration between DMAS and LDSS agencies tends to be limited with each operating largely within their own spheres of responsibility. While DMAS provides oversight, funding, and policy guidance, LDSS agencies maintain significant autonomy at the local level, which often results in variability in how Medicaid eligibility processes are implemented.

Roles & Responsibilities

Strengths: In Virginia, Medicaid eligibility is determined by workers who are also responsible for processing eligibility for other benefit programs like SNAP, TANF, and child welfare subsidies. This allows applicants who are applying for multiple benefits to have a streamlined experience that is often managed by a single point person, as opposed to being shuffled between multiple departments to apply for benefits.

> “We start with the local level to try to get issues resolved. Then we engage the regional consultants and DMAS who send it back to the LDSS agency. We get ping ponged between the various groups
>
> **-Virginia Healthcare Foundation Outreach Worker**

Challenges: Only 39% of surveyed LDSS workers said that roles and responsibilities were clearly defined, making it difficult to address escalations. [273] DMAS staff have expressed that it is challenging to identify who is responsible for escalated issues, and they are often uncertain if they are overstepping their role when handling these cases. This also creates

[273] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)

confusion and difficulties for community partners working to resolve overdue applications and renewals. VPLC navigators estimate that 70% of their appeals are a result of an inability to reach LDSS staff.[274] Outreach workers that work with applicants indicated that cases are often bounced back and forth between agencies, with neither taking full responsibility, resulting in significant delays.

Capacity & Capabilities

Strengths: Regional Medicaid consultants provide LDSS workers with a resource for resolving questions about complex or edge-case Medicaid applications. LDSS agencies report that Medicaid consultants were instrumental in helping with data entry queries, new policy clarifications, and in preventing roadblocks for their benefit programs specialists.

Challenges: Staffing levels for LDSS benefit workers (including benefit programs specialists, managers, and supervisors) have not kept pace with demand, as the average caseload per worker has more than doubled from 198 in 2017 to 415 in 2024.[275,276] As a result, the LDSS workforce is stretched thin, with 62% of surveyed LDSS workers reporting they lack the capacity to manage their Medicaid caseload.[277]

> "A working group developed a new template with drop downs that made inputting information for appeals easier. However, an LDSS agency did not know and used an older version.
>
> **-DMAS Staff**

Vacancy rates across all LDSS agencies is 16% with some areas, such as the City of Richmond, have reached as high as 50%.[278] LDSS agencies have noted that differences in salaries (e.g., Level I agencies' median salary is $54.9K and Level III agencies' median salary is $63.9K) and policies (e.g., remote working) has led to additional recruitment challenges.[279]

LDSS agencies also face challenges in securing sufficient headcount due to funding constraints. The base funding is often exhausted by 100 out of 120 agencies during the fiscal year, after which they must rely on pass-through funding, which requires a higher local match. As a result, some local boards are hesitant to approve additional staff positions that would trigger the need for this more costly funding.

[274] Interview with VPLC, 09/2024
[275] JLARC Medicaid Expansion: Eligibility Determination Commission Briefing, 10/2019
[276] DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025
[277] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)
[278] Interview with DMAS Stakeholder, 08/2024
[279] DSS HR Data, 2024

Only 42% of LDSS staff agreed that the provided Medicaid eligibility training allowed them to successfully do their job.[280] New hires require up to six months of training for MAGI cases and as long as two years for LTC cases. Furthermore, training varies widely across the LDSS agencies. Some counties provide in-house training and others rely on external trainers who may not follow VDSS guidance. Some counties retrain new hires on local practices that contradict standardized training, creating disparities across offices. The retirement of specialized workers has also led to capability gaps, particularly in LTC cases, where long training times and a shift to generalization has slowed processing.

> To fill positions, we have a high match rate. Our employees cost the city a lot, making it harder to get positions
>
> **-Director of LDSS Agency**

Staff Experience

Strengths: Virginia's LDSS workers have relatively longer tenures than other states. The average tenure is over 7 years as compared to other states like Colorado where most eligibility workers have less than 3 years of experience.[281]

Challenges: Average turnover rate across all LDSS agencies ranges significantly from 0% to 75%, with an average of 18%. Surveyed LDSS workers highlighted that poor VaCMS performance, lack of support around complex policies, and high caseloads were the largest challenges they experienced when conducting Medicaid eligibility determinations. Interviewed staff indicated that frequent outages, delays, and data bridging issues (e.g., duplicate IDs) with VaCMS were particularly frustrating as it wasted the staff's time. LDSS staff also highlighted that frequent policy changes without sufficient notification or correlated system updates also created challenges. LDSS agencies have noted that some policy updates are communicated only days before they take effect, leaving little time for agencies to adapt, creating confusion and increasing the burden on workers already dealing with high caseloads.

> You'll have lots of applications coming in and then the system deadlocks. I have a list of all the times VaCMS is down – it's a very frustrating system
>
> **-LDSS Agency Staff Member**

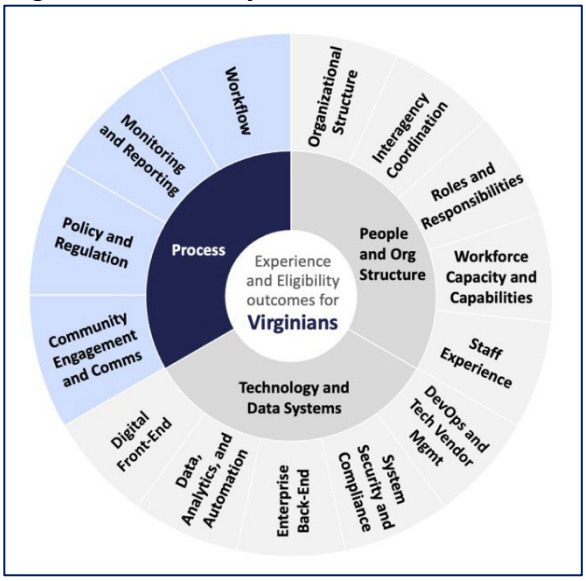
> **There are so many changes coming down the pipe, before you get used to it, they would change it again. It's very frustrating for the workers**I.t's very frustrating
>
> **-LDSS Agency Staff Member**

[280] BCG Survey of all LDSS Agencies, 09/2024 (n=1294)
[281] DSS HR Data; Public Consulting Group LLC, "Assessing Best Practices in the Administration of Public and Medical Assistance Programs in County-Administered States Executive Summary," 06/2023

Process

Workflow

Figure 31: Process framework



Strengths: Virginia offers multiple channels for submission, such as CommonHelp, the DSS Enterprise Call Center, the DMAS CoverVA Call Center, the Virginia Insurance Marketplace, and LDSS agencies. This range of choices enhances accessibility, particularly for those who prefer direct support.

Challenges: The Medicaid eligibility workflow faces two key challenges, variability in workflows and heavy reliance on paper applications.

Application processing vary significantly across localities. The 120 agencies show significant variation in vacancy (0-56%), worker-to-supervisor ratios (2-74), % of pending applications per month (12-65%), and caseloads per worker (167-961).

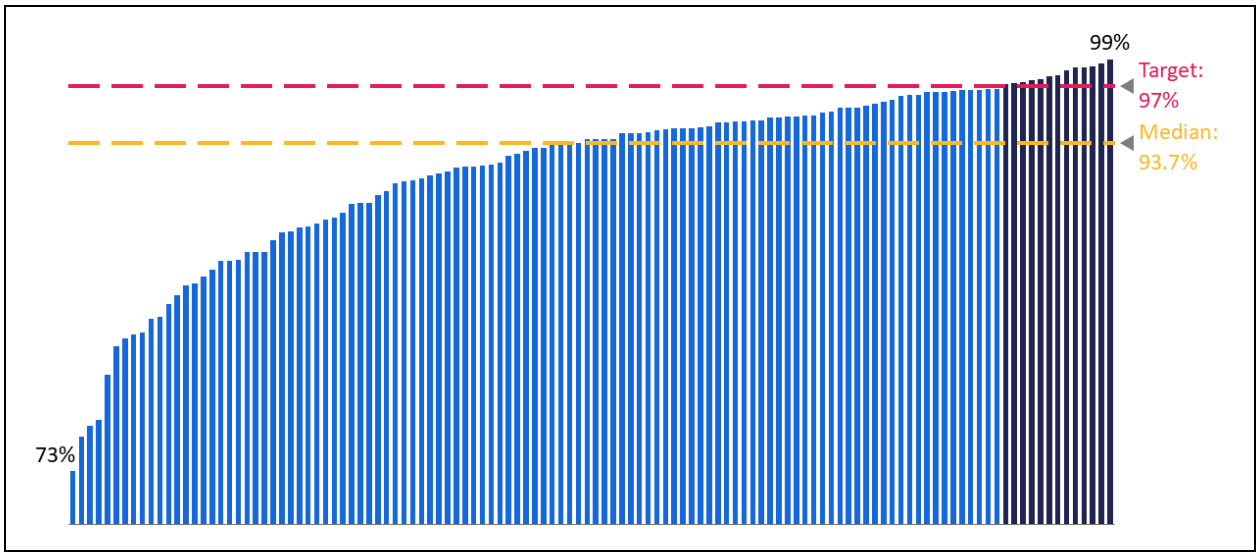
Figure 32: Performance and workforce variability by agency level and across all agencies[282]

	Level I (n=33)	Level II (n=59)	Level III (n=28)	Range and averages across all 120 LDSS agencies
Performance				
PIMR LDSS MA timeliness rate	92.9%	92.5%	89.3%	**73-99% (91.8%)**
Average % of applications currently pending vs. resolved in Sept '24	40%	43%	44%	**12-65% (43%)**
Workforce				
MA cases per worker / year	339	345	401	**136-796 (356)**
Vacancy rate	17%	10%	16%	**0-56% (16%)**
Workers per supervisor	5.3	8.7	10.8	**2-74 (8.5)**
% of surveyed LDSS staff who said current workforce capacity to manage Medicaid caseload is not sufficient	41%	53%	74%	**62%**

[282] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024; BCG Survey of all LDSS Agencies, 09/2024 (n=1294); DSS HR Data, 2024; 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025; Level for each LDSS agency can be found in Appendix 8.8

This leads to inconsistent experiences for both applicants and staff, resulting in variability in Medicaid timeliness compliance rates across LDSS agencies (73% to 99%). Only 13 of the 120 LDSS agencies meet the 97% target for meeting the Medicaid application processing times (e.g., 45 days for MAGI) (see Figure 33).[283]

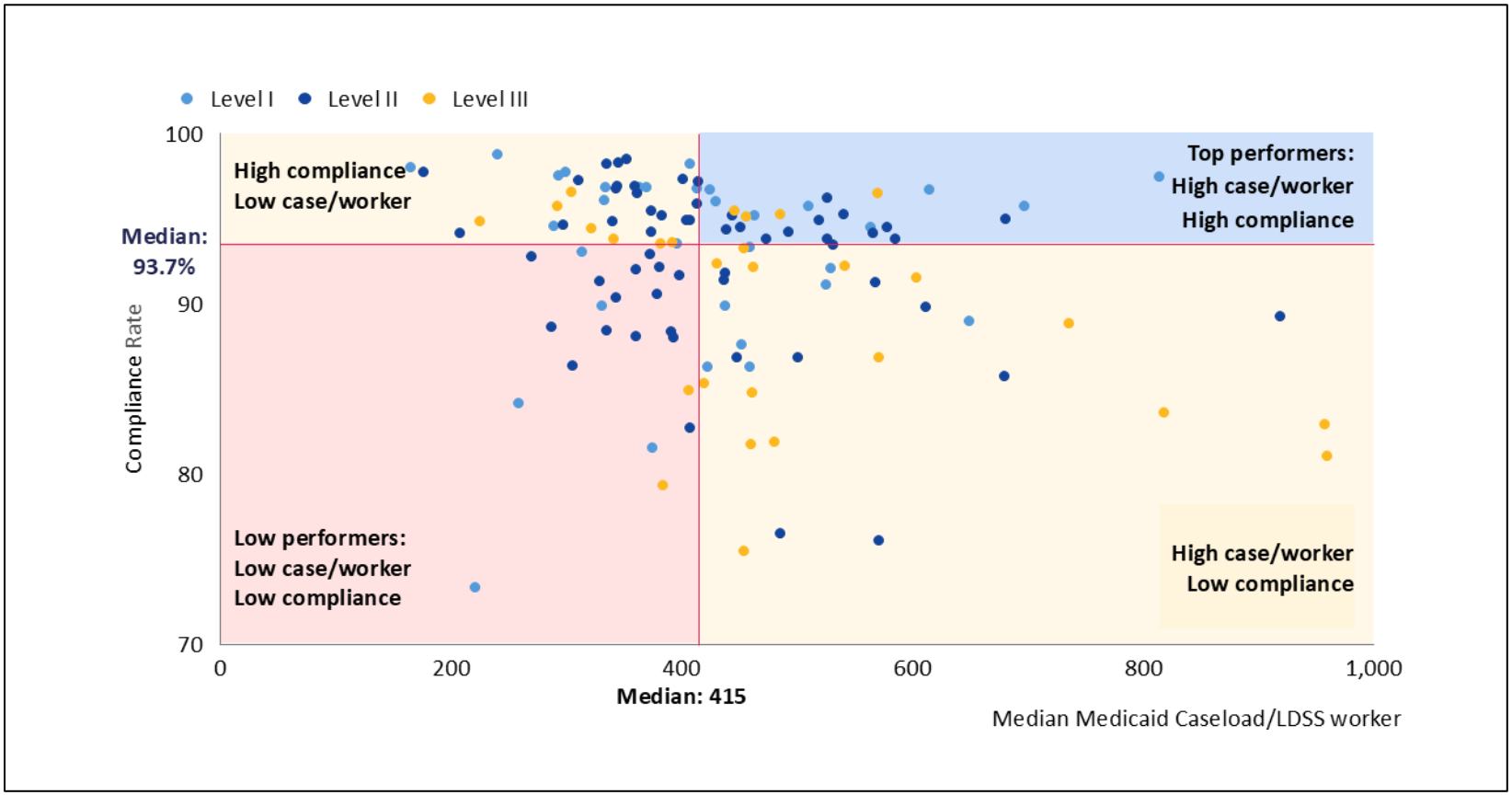
Figure 33: Percentage of Medicaid applications processed under federal processing deadline by LDSS agency[284]



Performance of LDSS agencies can be gauged on their Medicaid timeliness compliance rate and caseloads per worker. High-performing LDSS agencies are those that can achieve high timeliness compliance rates while managing high caseloads per worker (see Figure 34 below). While no single metric (e.g., agency level / size, funding, vacancy rate, supervisors per worker, leadership tenure) explains why some agencies perform better, regional Medicaid consultants can identify best practices from high-performing agencies and spread them to lower-performing ones to improve outcomes.

[283] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024
[284] PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024

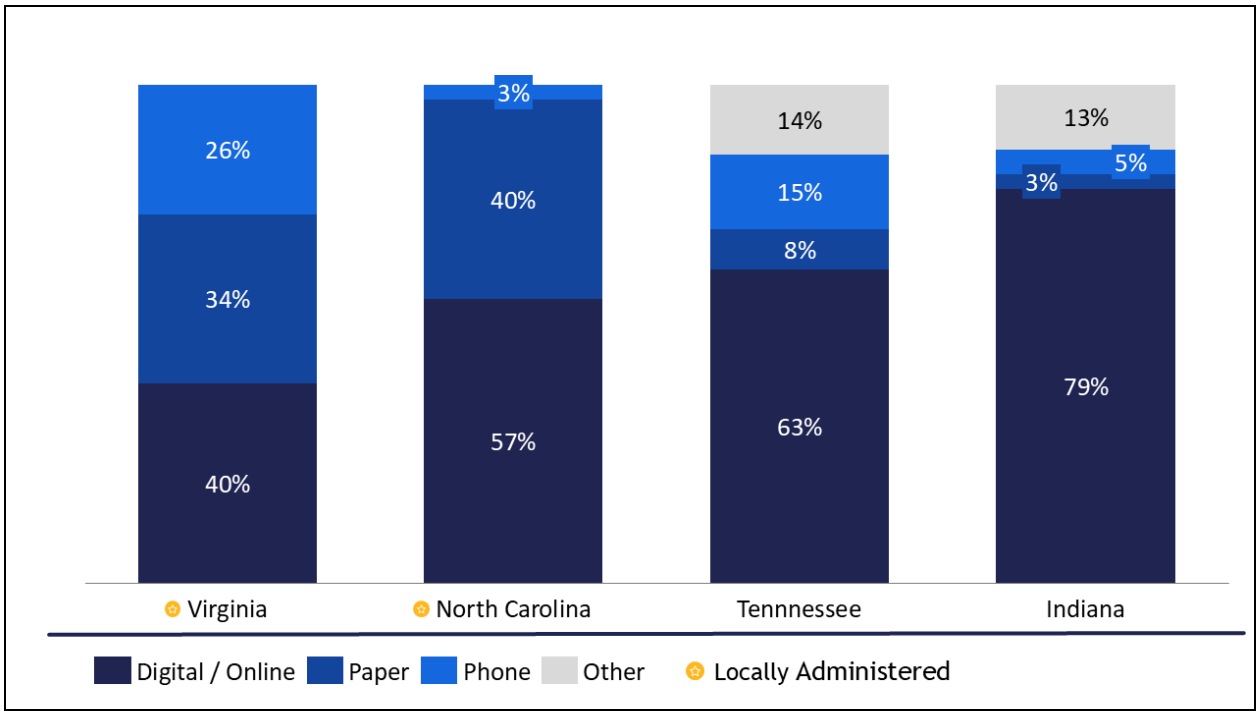
Figure 34: Medicaid caseload per worker and LDSS Medicaid compliance per agencies[285]



[285] Note: Average LDSS Medicaid compliance rate, 01/2024 - 07/2024. Source: 12-Month New Application Count by Agency, 10/2023 – 09/2024, including all denied and approved applications per month, excluding pending applications except for 09/2024, Medicaid only and Medicaid with Benefits Reports considering 06/2024 - 09/2025; DSS HR Data, 2024; PIMR Report with LDSS Medicaid Compliance Rates, 01/2024 - 07/2024

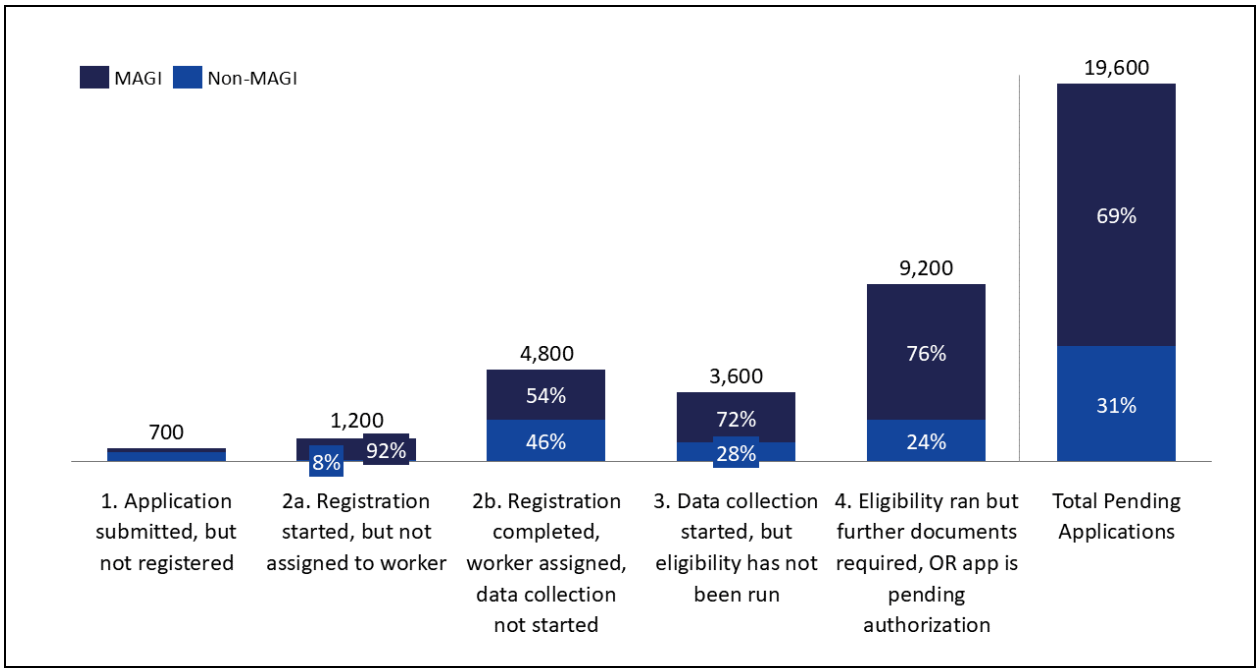
The second key workflow challenge is the high use of paper applications. 40% of new Medicaid applications are submitted digitally with 34% through CommonHelp and 6% via the Virginia Insurance Marketplace. A 40% online application submission is low compared to 57% in North Carolina, 63% in Tennessee, and 79% in Indiana (see Figure 35).[286,287] Furthermore, only 20% of VHCF outreach workers – those most familiar with Medicaid eligibility system – report submitting applications via CommonHelp.[288] Aside from reliance on paper, LDSS current communication methods (e.g., mail) slow its processing speed. As seen on Figure 36, over 50% of pending applications require additional materials or applications are pending authorization. Applications that require additional information are sent verification checklists via mail. Per conversations with VHCF workers, applicants may not receive their checklists until at or after the deadline for submission, resulting in delayed processing at the LDSS agency level.

Figure 35: New applications by channel mix (%)[289]



[286] Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024
[287] Interviews with Peer States, 09/2024
[288] Project Connect Outreach Survey, 09/2024 (n=26)
[289] Note: Digital / online incl. applications transferred electronically from exchange; While digital is 40% of Medicaid, it's ~15% of all social services apps; Source: Virginia's Monthly Reporting to CMS, 01/2024 - 07/2024; NC: Expert Interview, 11/2023 – 09/2024; TN: Expert Interview, 01/2024 – 07/2024; IN: Expert Interview, 08/2024

Figure 36: Overview of pending (i.e., not fully processed) applications per process stage and application type[290]



Monitoring & Reporting

Strengths: Virginia successfully launched a public facing Unwinding Renewal Dashboard after the end of the continuous coverage period, allowing for improved tracking of the entire Medicaid population as redeterminations began. The tracker allows the user to monitor the number of members who require a determination, members whose coverage was renewed, and whose coverage was denied. The tracker has an additional layer of granularity to convey these figures at the county level.[291]

Challenges: As previously noted, the current operating model (local administration of Medicaid eligibility at LDSS agencies) lead to accountability and monitoring challenges between the Commonwealth and LDSS agencies. While DMAS is tasked with meeting CMS requirements, its insight into LDSS agency performance is limited because VDSS oversees both the funding for LDSS agencies and data reporting through the VaCMS system. Despite some improvements in communication and visibility between VDSS and DMAS following recent PHE unwinding efforts,

[290] VDSS Appmetric Report, 09/15/2024; In Appmetric Report Stage 0 corresponds to Step 1 on this slide, Stage 1.2 corresponds to Step 2a, Stage 2 corresponds to Step 2b, Stage 3.1 corresponds to Step 3, Stage 3.2 corresponds to Step 4

[291] DMAS, "Eligibility Redetermination Tracker"

regular reporting on LDSS performance in Medicaid eligibility determination remains insufficient.

At the regional level, Medicaid consultants, who are staffed by VDSS, are tasked with providing oversight over LDSS agencies. However, the number of regional Medicaid consultants have stayed constant despite significant increases in Medicaid enrollment. With only five Medicaid consultants covering 120 LDSS agencies, Virginia has fewer consultants compared to peer states like North Carolina, which has 13 consultants for 100 agencies, and Georgia, with 14 for 159 counties. Additionally, regional Medicaid consultants report spending up to 25% of their time handling VaCMS tech escalations, further limiting their capacity to provide oversight of LDSS agencies.

The reporting process is inefficient and lacks consistency across systems. LDSS agencies use multiple reports from various data sources, but it is often unclear where the data originates from and which data source supersedes the other. This forces both VDSS and LDSS leadership to spend significant time reconciling delayed and inconsistent reports, leading to issues like inaccurate performance tracking, where applications processed within the grace period are still flagged as overdue.

Policy & Regulation

Strengths: Relative to other states, Virginia performed well during unwinding. Of those disenrolled during unwinding, 55% were disenrolled because of procedural reasons (vs. 69% nationally), placing Virginia in the top 10 states. [292] This was largely a function of instituting the unwinding task force where DMAS and VDSS met regularly to build alignment and guide LDSS agencies during the unwinding period.

> “Understanding policy is a big concern. You almost have to be a lawyer to deal with LTC policy – we are not equipped with the legal knowledge and we don’t have the training in our toolbelt.
>
> -**Benefit Program Supervisor at LDSS Agency**

Challenges: Despite their leadership in redeterminations, difficulties integrating new policies limit Virginia’s Medicaid eligibility determination process due to Medicaid’s complexity and system limitations. LDSS benefit programs specialists can find it difficult to adapt to policy updates for complex determinations, such as those involving ABD and LTC populations, due to limited training and experience with these cases. Significant delays between the introduction of new policies and necessary IT system changes exacerbate this

[292] KFF, “An Examination of Medicaid Renewal Outcomes and Enrollment Changes at the End of the Unwinding,” 09/2024

issue. It can take up to a year for systems to fully integrate updates, forcing staff to rely on workarounds, which complicates training and daily operations. These delays often cause a snowball effect of errors, leading to further system issues and impacting overall accuracy and performance.

Community Engagement & Communications

Strengths: DMAS has strong relationships with external community stakeholders, such as MCOs nursing facilities, providers, and especially with VHCF. VHCF maintains regular communication with DMAS and VDSS through quarterly meetings to discuss challenges and policy updates.

Challenges: A significant challenge for Medicaid applicants in Virginia is the confusion caused by unclear and complex notices they receive during the eligibility process. These notices often contain difficult-to-understand language and unclear instructions, making it hard for applicants to know what steps they need to take. In addition to the complex language used in mail notices, community stakeholders report that many applicants who prefer non-English communications still receive notices in English or receive poorly translated versions. These translations often contain errors, such as accent marks in Winding font or inaccuracies resulting from reliance on tools like Google Translate.

Providers and MCOs face challenges navigating the eligibility determination process because each LDSS agency operates differently. With varying processes, communication methods, and points of contact across agencies, providers—especially those serving members in multiple localities—must often rely on trial and error to engage effectively with LDSS agencies. This inconsistency makes it difficult to streamline interactions and manage eligibility determinations.

> “All 120 agencies have a different way to communicate. Some require faxes, other require working with a dedicated POC. It would be great for my clinical team to have one consistent approach”
>
> **-CEO of Home Care gency**

Navigators from VPLC and outreach workers from VHCF adjust their support to fit the unique processes of each LDSS agency. They tailor their approaches based on the applicant's type and locality to support timely determinations (e.g., writing

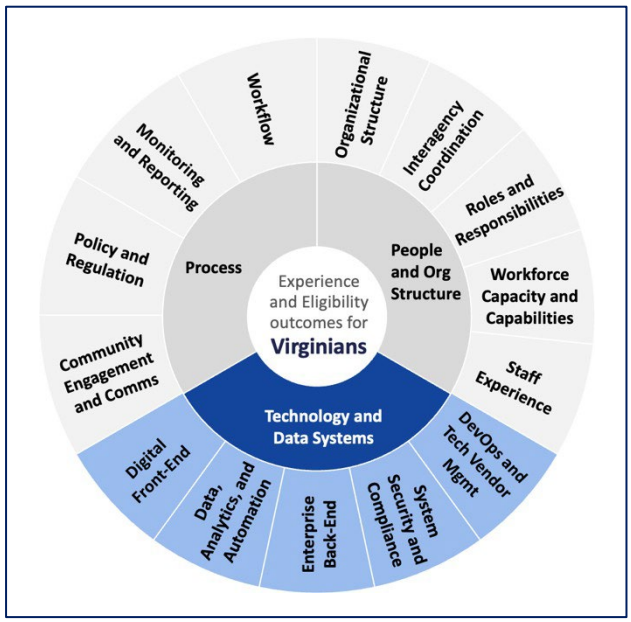
> The process varies so much by locality. But when I have a strong relationship with an LDSS worker, I learn exactly what workarounds or hacks I can do to get an application processed on time.
>
> **-VHCF Outreach Worker**

"pregnant application" in sharpie on the cover page of faxed applications to promote expedited processing).

Technology & Data Systems

Digital Front-end

Figure 37: Technology and Data System framework



Challenges: The digital front-end of Virginia's Medicaid eligibility system presents significant usability issues, unreliable case management systems, and lacks seamless integration for users. CommonHelp is regarded by many users as 'unusable' due to poor performance, site latency, and lack of mobile responsiveness. The platform's navigation and accessibility barriers (e.g. insufficient translation services and disability accommodations) complicate its functionality. For example, users are unable to review eligibility requirements without first creating an account; a hurdle described as a 'locked front door.' This issue creates a bottleneck in the application process, pushing many users toward call centers or walk-in offices.

On the staff side, the VaCMS front-end is a frequent source of frustration with employees reporting that the system extends processing times between 3 to 4 times. [293] LDSS staff report the VaCMS portal has connectivity issues, poorly designed workflows, multiple interfaces, and non-intuitive navigation to guide users through over 3000 screens. This makes it difficult for eligibility staff to do real-time data entry during interviews. Additionally, the system lacks a seamless mechanism for users to navigate across different service channels. While some controls are in place, such as tracking numbers generated by CommonHelp, they are unreliable, often requiring users to repeat steps like identity proofing.

Data Analytics & Automation

Challenges: Data inconsistencies and underutilization of automation limit the potential opportunities to enhance LDSS's experience with the Virginia's Medicaid eligibility system. The

[293] VDSS, "Investing in Tools for a Human-Centered Benefits Experience," 06/2023

current collaboration between VDSS and DMAS lacks a trusted system of record – evidenced by data discrepancies frequently emerging between eligibility and enrollment systems. For example, when altering the date range of a single record in VaCMS, rather than simply updating that record, the system instead produces multiple conflicting versions in the database.

Automation, while present in some areas, has not been consistently implemented. For instance, after manually inputting applications into VaCMS via rapid data entry RDE, Medicaid-only, MAGI applications can be automatically verified for eligibility. However, if the automatic system fails, then some LDSS agencies manually input the paper application into AR. Therefore, some LDSS benefit programs specialists will avoid RDE just use AR from the beginning. At the same time, simple verification processes, such as flagging questionable data like expenses exceeding income, remain manual, further slowing down the system's capabilities.

Enterprise Back-end

Challenges: The enterprise back end of Virginia's Medicaid eligibility system is heavily reliant on a monolithic, legacy infrastructure and myopic fixes that impose significant limitations on system agility and long-term sustainability. VaCMS is built on a 15-year-old legacy code base that now requires over 1 million lines of code. Any set of changes to this system requires substantial investment, which VDSS staff report can cost approximately $1 million and take from 6 to 12 month to roll out.

Decision-making around back-end system and technology investments is often driven by short-term budget constraints, neglecting the long-term implications. This short-term approach leads to temporary fixes that fail to address the root causes of system inefficiencies. Consequently, the accumulation of technological debt increases both the cost and complexity of maintaining the system, making future upgrades and overhauls even more challenging.

Security

Challenges: Security within Virginia's Medicaid eligibility system is impacted by digital record retention practices and the growing costs of maintaining large volumes of data. The integration of benefit eligibility in Virginia, combined with challenges with retention practices (e.g., different requirements for each program, some files being subject to multiple requirements) has led to significant data accumulation in databases.[294] This accumulation not only increases data storage costs but also heightens security risks as the volume of sensitive information grows. In some cases, records may be physically purged prematurely rather than archived, creating potential issues if those records are needed later for verification or legal purposes.

[294] Interview with VDSS Stakeholder, 09/2024

These practices complicate effective data management and increase vulnerabilities within the system, necessitating a more consistent and secure approach to record retention.

Development Operations & Technology Vendor Management

Challenges: Development operations and technology vendor management within Virginia's Medicaid eligibility system face significant inefficiencies due to extensive backlogs, limited vendor oversight, and outdated workflows. The VaCMS system is subject to vendor dependencies, including restrictions on the number of changes allowed each year. These constraints reduce the number of critical system updates the Commonwealth is able to make. As of December 2023, over 200 enhancements remain out of 570 identified for federal compliance with more than 11,000 tickets related to VaCMS change request and other issues submitted between August 2023 and June 2024, thus limiting eligibility workers current ability to engage with tools most effectively.[295] In addition to this backlog of required changes, there is a lack of transparency in assessing the cost, timeline, and quality of system changes delivered by vendors. This is due to transactional nature of the vendor relationship and contractual gaps, increasing risks for the Commonwealth and benefits recipients. Finally, reliance on waterfall methodologies limits developer productivity and slows the pace of necessary modernization. A 2018 State Inspector General audit bolsters this point when it recommended to consider agile development methodology l to help project teams respond to unpredictability and provide opportunities to assess the direction of the project across its lifecycle.[296]

[295] VDSS IT Strategic Plan for 2024-2026 (December 5, 2023)
[296] Office of the State Inspector General Report, “Virginia Department of Social Services: Implementation of Virginia Case Management System,” 03/2018

8.6 VaCMS Performance & Capacity Testing Report

Introduction

As part of the overall assessment of Medicaid eligibility determination and to address the General Assembly request to "determine how well the current structure and systems handle high volumes," independent VaCMS performance testing was conducted between September and October 2024. This performance testing focused on quantifying system efficiency, processing times, capacity, ability to handle high volumes, and other performance dimensions.

This report is organized into the following sections:

- **Test plan and preparation**: Provides details on the pre-testing activities and interactions with the state team, the issues encountered in conducting testing as well as the resolutions / work arounds performed to overcome the issues. It includes a summary of the test scenario, goals of the test and output results for each scenario.
- **Key results and findings:** Provides details on the actual tests performed, and their results as aligned to tests and initial objectives.
- **Additional observations:** Provides information on additional observations and made by the testing team, and outlines a set of benchmarks that offer a point of comparison to VaCMS performance.

Test Plan and Preparation

Goal and Objectives

1. Determine the maximum concurrent user capacity for VaCMS using common scenarios
2. Identify system bottlenecks based on end-user response times
3. Evaluate the performance of critical transactions
4. Describe impact to processing timelines and user experience

Assumptions

The following, initial assumptions apply to all the details provided in this test plan. It is expected that any constraints / modifications to the assumptions result in changes to the test plan and subsequent execution of tests.

Business requirements assumptions

- The business requirements defined in 2023 related to user loads are still valid in 2024 and will be used to inform the test plan.[297]

Test environment assumptions

- VDSS will provision testers access to relevant testing environment(s) to conduct independent tests on the system directly. VDSS will also name a point of contact from the state technical team to support any system-specific questions or test preparation activities required.
- The environment provided for testing will allow online creation of customer accounts in customer portal.
- The environment websites for customer and worker portals will be accessible over the internet from United States.
- Any human-checks in the application / account creation / login process such as Captcha / Multi-Factor Authentication / SMS / other should be turned off to allow scripted access to the platforms.
- Worker Portal should allow multiple concurrent sessions for the same credentials provided to us so that multi-user access can be simulated. Alternately, please provide separate user ids with worker / supervisor roles.
- The max user load for each test is listed as part of each test plan scenario. This number is subject to change based on any system constraints or performance bottlenecks encountered during the execution of the tests.

Expected Testing Process

The expectations for performance testing process included the following phases of execution:

Phase 1 – Analysis & scope verification: This phase involves manual navigation through the web application with inputs from the client on the business process / web workflows which should be part of the testing. Parameters such as maximum user load, duration of the tests, server limitations etc. are also identified in this phase. Any critical parameters such as test SSNs, DOBs etc. are also to be identified in this phase.

Phase 2 – Scripting: The testing team will create automated scripts of navigating through the websites and generate executable script files which can do an automated execution of the workflow. The testing team will also work on parameterizing the various steps so that they are

[297] In requirements set forth by the business to inform the O&M vendor's 2023 performance testing efforts, the vendor was directed to assume VaCMS might be accessed by up to 6,000 workers instead of the 4,400 – 4,600 users per month expected historically. These numbers reflect production environment thresholds, which are halved in test to approximate real-world equivalents

repeatable (for example using dynamic user ids during account creation, dynamic test SSNs / DOB etc.)

Phase 3 – Sanity checks and verification: The testing team now executes the scripts for small user loads, and with the help of the web portal admin/supervisor views, verifies the data is accurately captured and entered for each user.

Phase 4 – Test executions: The actual execution of the tests happens in this phase. Tests are executed for the identified scenarios from Phase 1 and output reports are generated.

Tests, Scenarios, and Tools

Tests and supporting scripts were developed that defined a set of incremental user volumes/loads based on business requirements, 'types' of tests to assess performance across various performance dimensions, and scenarios and their underlying sets of transactions. These tests were intended to guide the approach and enable a comprehensive understanding of VaCMS performance. Additionally, what constituted a test's success and failure was defined. The following tests and test thresholds were defined:

Max User Volume (Load): This number is subject to increase or decrease based on the initial test results as well as any constraints placed on the environment. As testers became more familiar with VaCMS and associated performance expectations, such as the aforementioned business requirements, plans were outlined to test the following numbers of users across scenarios, using 50% of users in the test environment to approximate 100% users in production, given that TEST-PERF is roughly half the capacity of production. Planned tests include:

- 1 user, and 20 user tests to sanity check that tests were executable, correctly configured, and compatible with the test environment.
- Incremental tests of 20, 50, 250, 500, 1000, 2000, and 3000 users each. As the system allowed, testing expected to increase thresholds until max capacity ("max user load") was identified.

Only a typical caseworker login role was to be used (no admin/supervisor login).

The following types of tests were to be executed:

- **Spike Test:** Increase load up to max user load over 1 hour, maintain for 30 minutes, then ramp down.
- **Endurance/Soak Test:** Maintain 2/3rd max workers creating applications simultaneously for 4 hours.
- **User Load Distribution:**
    - Application results in a determination of non-eligible: 30%

- Application eligible for Medicaid: 70%

The following 5 common case scenarios were to be utilized:

- Initial Application Registration (via Rapid Data Entry) for a three-member household
- Locality Inbox and Case Assignment
- Clearance and Client ID Generation (Integration with SPIDeR) for a three-member household
- End to end case intake & processing to assess Medicaid, SNAP and TANF eligibility
- Registration of Medicaid recipients and Case Creation in FAS /mainframe (ex-MMIS)

The total number of unique, underlying transactions across these scenarios totaled roughly 105 transactions.

All tests were to be recorded, scripted and parameterized using JMeter Load Testing Tool and executed via Blazemeter.

Performance Metrics & Success Criteria

As part of the test execution, many performance metrics for each system were to be captured. The 3 key performance indicators used to determine the system performance scoring are response time (also commonly called 'latency'), throughput, and error rate. Definitions and criteria provided below:

- **Response Time:** Amount of time that occurs between the initiation of a transaction, such as by the users, and the response from the system. Successful, slow, and failed response thresholds are as follows:
  - Success: < 4 seconds – Transactions taking less than 4 seconds on average
  - Slow: 4 - 20 seconds – Any transaction that takes over 4 seconds, but less than 20 seconds
  - Failure: > 20 seconds – Any transaction taking over 20 seconds on average
- **Throughput:** Transactions per second, (i.e., how many server hits are being accepted without failures per second throughout the duration of the test).
- **Error Rate:** Defined as percentage of transactions that did not complete within the failure limit (20 seconds) or received errors from the backend compared to the total number of transactions. Each invocation of a backend service from the UI is a transaction.

Modified Testing Process

Given both technical and process challenges during the testing timeframe, the performance test plan was ultimately modified in the following ways:

Analysis & scope verification: Scope was narrowed significantly, with the aim of identifying specific performance thresholds vs. more comprehensively assessing the system.
Phase 2 – Scripting: 2023 testing scripts were used as the foundation in this refined approach. They were then modified several times due to both inconsistencies within the script and environment compatibility issues. Following evaluation of the scripts provided, several modifications were required to ensure they matched the scenarios and tests, followed best practice, and were effective in the new environment.
Phase 3 – Sanity checks and verification: Several rounds of troubleshooting and additional modifications were needed to ensure the script was compatible with the new environment. Finally, single user and 20 user tests confirmed compatibility late in the execution testing week.
Phase 4 – Tools, test execution and access to results: With the assistance of the DSS team, live remote sessions were conducted to enable execution of tests over zoom leveraging performance tools already present in the environment.
Due to the limited time available for conducting the tests, details were prepared for a subset of indicated tests and relied on the DSS team to execute test by running the relevant commands on the JMeter servers and provide the results from their tools.

Key Results and Findings

Despite the abbreviated scope of tests executed, test results were sufficient for providing several insights into the performance of the system. These results are summarized across this section in alignment with the stated objectives.

Results by Test

Tests Executed, Results, and Overall Impact to Scope

Ultimately, after narrowing the scope of the initial test plan to a modified plan the scope was further reduced. Three (3) planned tests were executed that resulted in 'usable' data, such as data that was not impacted by environment misconfigurations or code inconsistencies in the script. The tests that rendered results were:

1. **Sanity Tests and script verification** using 1, and 20 users simultaneously intaking cases with average think time of 15 – 20 seconds between each page interaction. This test was

solely used to confirm that VaCMS performance is not impacted at these low user counts.

2. **Load tests with 200 active users** simultaneously intaking cases with average think time of 15-20 seconds between each page interaction and a ramp up period of 400 seconds for all 200 users to get online intaking cases.
3. **Load test with up to 3000 active users** simultaneously intaking cases with average think time of 15-20 seconds between each page interaction and a ramp up period of 3000 seconds total for all users to get online and processing cases (one user logging in per second).

The full spectrum of planned tests, including soak tests and endurance tests were not executed. Additionally, some transactions, such as those beginning in the high 70s of ~105 transactions, went untested. The bulk of these involved mainframe data exchanges, which would have provided valuable insights into VaCMS performance when interacting with this data ecosystem.

Test #1: Single User Equivalent[298]

Scenario: 1 User accessing VACMS, average think time of at least 10 and a maximum of 20 seconds between each page click randomly distributed across all the transactions executed.

Goals: To verify the load test scripts are working as intended for a complete transaction.

Output: This user test was successfully completed.

Test #2: 20 Users

Scenario: 20 users accessing VACMS, ramping up within a period of 40 seconds (1 new user logging in every 2 seconds), average think time of at least 10 and a maximum of 20 seconds between each page click randomly distributed across all the transactions executed.

Goals: To verify the script successfully executes at a moderate load rate without errors.

Output: The test successfully completed without errors.

Test #3: 200 Users

Scenario: 200 users accessing VACMS, ramping up within a period of 400 seconds (1 new user logging in every 2 seconds), average think time of at least 10 and a maximum of 20 seconds between each page click randomly distributed across all the transactions executed.

Goals: To test a moderate load level where 200 users are actively working on case intake in VACMS.

[298] Stated user loads are actual numbers tested in the test environment, representing 50% of the production equivalent

Output: Approaching user loads in the 100-200 range, results indicate that the system began behaving unreliably. A high percentage of users experienced errors. For those not disconnected, response times were prolonged across some pages. For example, testing began observing errors at 14.37 Hits/s primarily in the DCHIP[299] page due to server requests timing out after 5 minutes. This indicates that there was some performance bottleneck in this page which is preventing timely responsiveness on load, and lack of response even after 5 minutes of the user waiting.

Test #4: Up to 3000 Users

Scenario: Load 2 Test Servers (JMeter Servers generating traffic), with ~1500 users on each server (total 3000, or to max capacity) with a ramp-up period of 50 minutes. Average think time of 10-20 seconds between each transaction in case processing steps (each click).

Goals: To simulate peak loads of 3000 users (6000 users in production) simultaneously logged in and processing cases in VACMS.

Output: The test terminated automatically at around 760 users on each server active for a total of ~1500 users. However, even the terminated test provided key insights into the system's behavior – specifically around the ~880 total user mark.

At ~880 users (434 users on JMeter Server 1 and 440 users on Server 2) concurrently processing cases, the response times and error rates climbed up as observed in the 200-user test, but it exceeded 75% error rates with a corresponding spike in response times. At ~1500 users total, lengthy response times were observed across every page in the system at this load. The overall responsiveness of each page click degraded to at least 10 seconds for simple transactions and timed out at 5 minutes for data processing transactions such as submitting a form to be saved in the database.

At ~1500 active users (but not concurrent), the test terminated automatically.

Results and Findings by Test Objective

The overall observations of system load handling capacity based on the executions in Perf-Test environment are outlined below. Considering the performance test is at 50% server capacity of production environment, both actual user counts used in the test environment as well as estimated production concurrent user capacity counts are included in the table.

[299] This page and associated bottleneck(s) identified are detailed in section 4.2.3. This page is likely associated with the Division of Children's Health Insurance Program, and accessed to mimic a transaction involving CHIP eligibility

Specific issues deemed 'critical' or 'high' are detailed in the observations and recommendations section. The following results are provided in alignment with each stated objective of this exercise.

Determine the Maximum Concurrent User Capacity for VaCMS Using Common Scenarios

Test results show that there are severe system load and capacity limitations in the testing environment, suggesting VaCMS may lack the ability to support eligibility business operations during periods of increased demand. As only a narrow series of tests were conducted, it can be estimated that approaching 200 users in the testing environment, significant degradation begins to occur. However, this number could also be far lower than the 200 users tested, as the previous testing increment was only 20 users. At some point between ~200 and ~ 1500 users, the system is considered 'at capacity,' and unstable. These numbers suggest that VaCMS cannot support users or loads beyond these numbers, which are just half of the anticipated load provided in by the business in 2023. Further testing is required to determine the root causes and potential fixes.

Related to load, the system handled around 2 system requests per second (e.g., page clicks or submitted data) for 20 users and up to 40 requests per second in the 3000-user test before failure rates skyrocketed. Results are summarized in Figure 39.

Figure 38: Test results

Perf Test Concurrent User Count[300]	Requests Per Second ('server hits')	Perf-Test Error Rate	Prod Concurrent User Count	Pass / Fail
20	2.04 Hits/s	0%	40	Pass
200	14.97 Hits/s	40%	400	Fail
200 to ~880 (incomplete 1500 active user test was terminated when 1538 users were active)	40.89 Hits/s	75%	~1800 (concurrent) 3000 (active)	Fail

Identify System Bottlenecks Based on End-User Response Times

Several bottlenecks were found, including timeouts, failures, and system-wide delays. Related to timeouts and system failures, there were significant delays (up to 5 minutes or more) at high

[300] Stated user loads are actual numbers tested in the test environment, representing 50% of the production equivalent

loads, such as on critical transaction pages, indicating severe bottlenecks in handling simultaneous requests. Max responses times exceeded 10 minutes, though most of these transactions would have been disconnected prior to reaching this threshold. This is supported by transaction-level results; as transactions are executed, the sample size decreases as users disconnect.

Pages such as the "DCHIP" page had high failure rates, particularly when managing data from integrated systems. Related to system-wide delays, for tests beyond 400 users, response times for even simple page interactions rose significantly, indicating that the system architecture was unable to scale effectively.

Based on the results, caseworker user experience will be adversely impacted due to slow response times, high error rates during peak periods, and increasing numbers of system crashes, timeouts, and delays as the number of caseworkers entering and active in the system increases. Specific examples include:

High error rates during peak times: The system struggles with high concurrent users, resulting in a large portion of users facing errors or system unavailability, especially when the system scales beyond ~200 concurrent users, though this figure may be lower. During peak application periods, such as open enrollment or Medicaid renewal periods, users might experience system outages, long delays, or failures, preventing them from completing transactions.

User experience degradation: Given the timeouts and delays experienced in high-volume scenarios, users will likely find the system increasingly frustrating to use, particularly during critical times. Most users will see their processing timelines increase, as delays increase.

System inefficiencies: A lack of cache control headers on static resources means that application servers are handling requests that could be offloaded, leading to unnecessary strain on the system. This is further explored in the observations section.

Evaluate the Performance of Critical Transactions

The following types of transactions result in error rates above 10%. Note that each row in the table below is representative of several separate transactions associated with that transaction. For example, there are several transactions associated with transaction 76_SNAP Work Requirement such as the input of data across several fields and/or pop-up windows on the page.

Figure 39: Transaction type error rate

Txn ID	Threshold	Description	Error rate
53	RelationshipDetails	Transaction that involve selecting or entering relationship details for family members or household members relevant to program eligibility	66%
40	HouseholdAddressSummaryEditHomeless	Transactions associated with editing and verifying the household address information	48%
76	SNAPWorkRequirements	Transactions associated with data input and verification of SNAP work requirements during the application process	35%
1	Launch (Login page)	Transactions required to login a user	27%
43	ClientInformation2	Transactions associated with accessing or updating client information, such as demographic details, identification information, or other personal data required for program enrollment	21%
24	GetLocality	Transactions retrieving locality information, such as state, county, city, or zip code details, such as used to determine eligibility or calculate benefits	11%

Describe Impact to Processing Timelines and User Experience

The testing found the following as related to user experience and processing timelines.

Figure 40: Testing user experience summary

Perf Test Concurrent User Count[301]	Impact
20	The system could handle 20 users with no significant performance issues. Caseworkers would not feel any system slowdown at this number
200	Over 40% of users were disconnected after encountering errors, particularly on pages involving high data integration (e.g., the DCHIP page). Any load beyond this increment had increased error rates The 60% who complete transactions face delays across most pages in the system, particularly on those that require VaCMS to gather information from multiple places
200 to 880 (incomplete 1500 active user test was terminated when 1538 users were active)	More than 75% of users were disconnected due to errors and timeouts. The majority of the users experience this simply from navigating beyond the first few pages in a case intake process. For the 25% who were not disconnected, they might wait up to 10 minutes between each separate interaction (e.g., a click of a page)

Additionally, users were found to face long cumulative wait times for each application processed, increasing these timelines. Delays and wait times may increase overall application processing timelines in proportion with the number of transactions required. For example, for cases requiring 100+ user-facing transactions, each of which then initiates a series of backend processes, the cumulative time a user might spend waiting on the system can be calculated by. Multiplying 100 transactions by average rate of response. As some averages were measured on the order of minutes, there is high likelihood that system performance significantly lengthens these timelines.

To better illustrate transactions with outsized delays from a user perspective, several diagrams, known as sequence diagrams, are included below to visually represent 'bundles' of

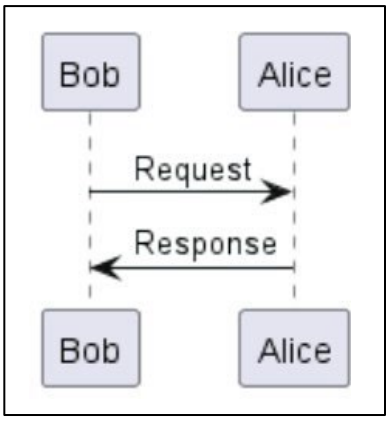
[301] Stated user loads are actual numbers tested in the test environment, representing 50% of the production equivalent

transactions, or common use cases or processes that adversely impact user experience (UX). Quantifying delays and errors by process (e.g., user login) or use case (e.g., submit and verify SNAP work requirements) is more representative of what an LDSS user and others familiar with application processing will experience in terms of performance challenges.

These sequence diagrams show examples of processes and use cases impacting UX based on test results, and show the actions a user takes in terms of system requests, as well as how different parts of the system then interact on the backend (e.g., server hits), and the response back to the user.

The simple sequence diagram shown here, using a common "Bob and Alice" example, illustrates this concept. Bob (user) engages with Alice (system), such as to make a request, or ask a question. Alice responds back to Bob accordingly. To read the diagrams associated with caseworker - VaCMS interactions, start at the top left with the caseworker (e.g., Bob) and move downwards and right, following the arrows that indicate the direction of each system (Alice) action. Arrows that extend from, or back to the user on the left-hand side are transactions the user experiences on the frontend, such as navigating to the next page, and then seeing the next page display. They will not experience the backend activity initiated to complete this user request.

Figure 41: Bob and Alice sequence diagram



The response times and error rates shown in diagrams 42-44 indicate the impact a user is likely to 'experience' between their initial interaction with the system and the result. For example, Figure 42 demonstrates the following:

> Users logging in to VaCMS alongside ~200 - ~880 or more users concurrently may face delays between the time they submit their credentials and the time the system responds and lets them into the system. Between 880-1500 users, approximately 29% experience errors at login and may be disconnected. For those who are not disconnected, users can expect to wait an average of 36 seconds. For those users who experience worse than average wait times, such as responses in the 90th and 95th percentile, waits times will range from 1 minute 7 seconds to 2 minutes. Last, users who experience maximum wait times but do not disconnect will wait more than 4 minutes.

Please note that the bundling of transactions and the use of testing scripts partially derived from 2023 testing efforts mean that both the response time estimates and the details of individual requests and system responses are directional and illustrative rather than exact. These figures provide a general view of system performance rather than precise measurements

of specific interactions and latency. A detailed, independent system performance test should be executed to validate the above findings.

The 3 use cases shown in Figures 42-44 are provided as examples of those likely to adversely impact user experience, and to illustrate some of the backend processes typically invisible to users:

- ***Caseworker logs into VaCMS as system approaches ~880-1500 concurrent users***
- ***Caseworker Submits SNAP work requirements & Clock Details for joint SNAP/Medicaid/TANF case***
- ***Caseworker Records Household Member Relationship Details***

Figure 42: Caseworker logs into VaCMS as system approaches 880-1500 concurrent users

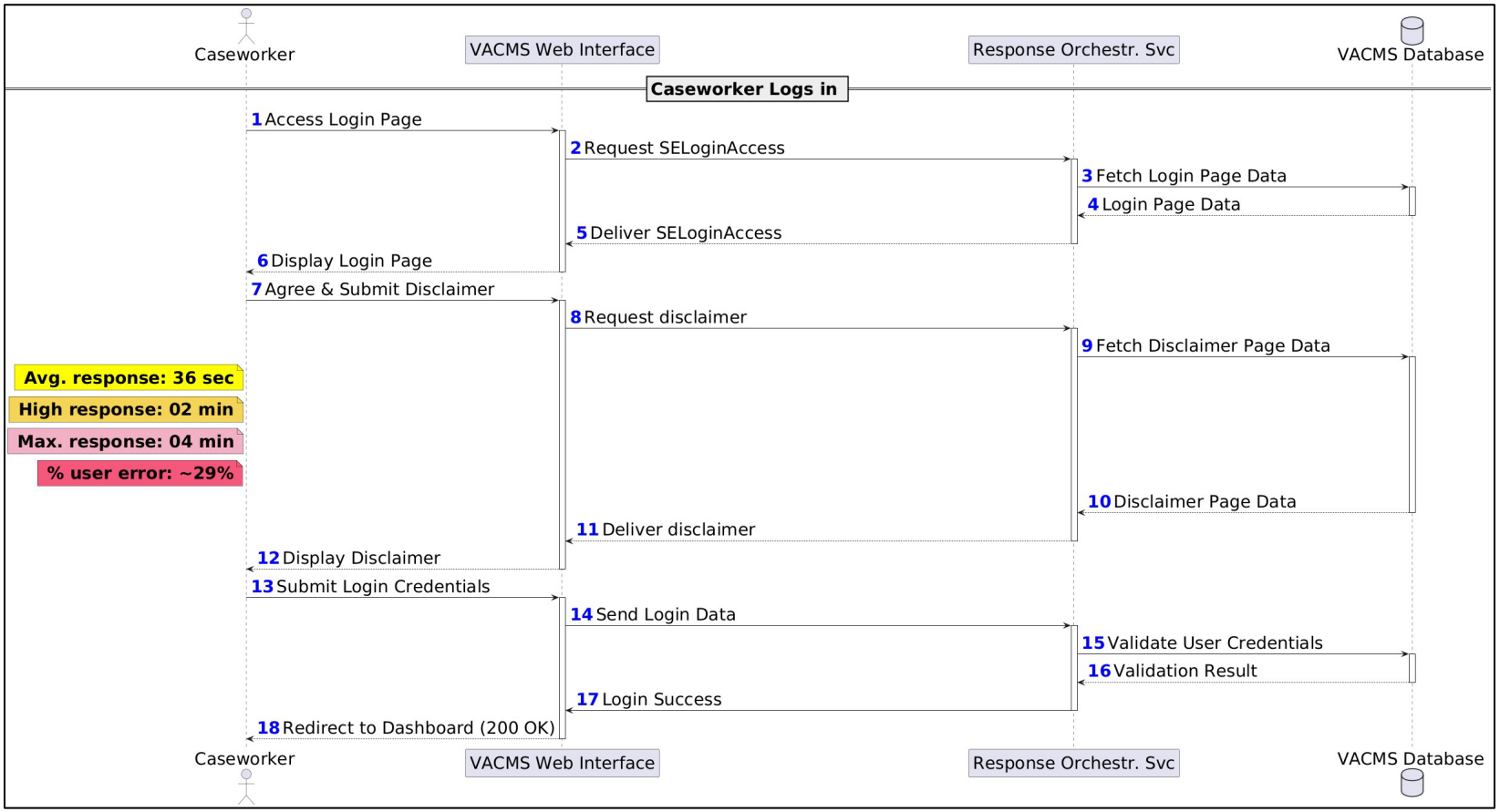


Figure 43: Caseworker submits SNAP work requirements & clock details for joint SNAP/Medicaid/TANF case

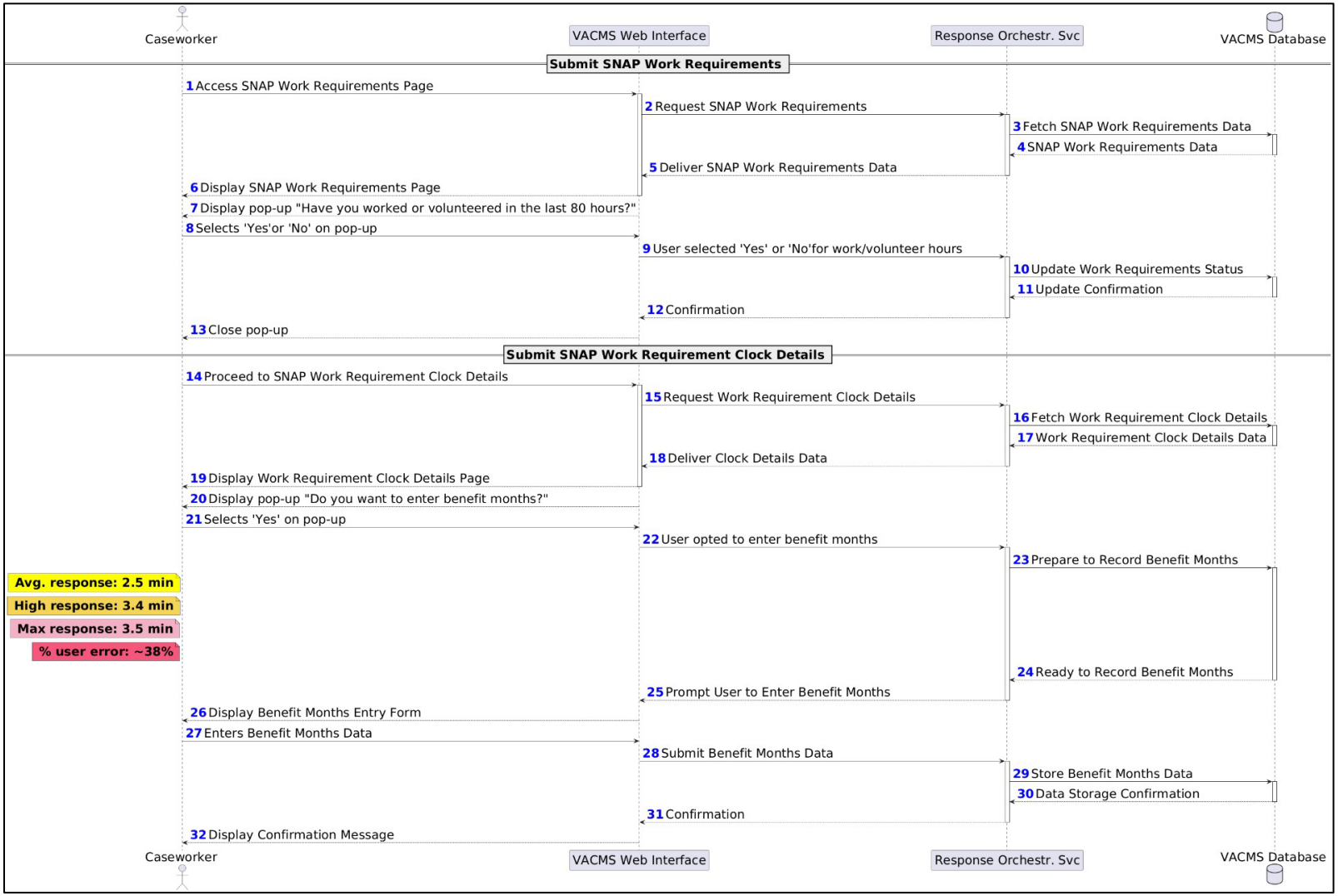
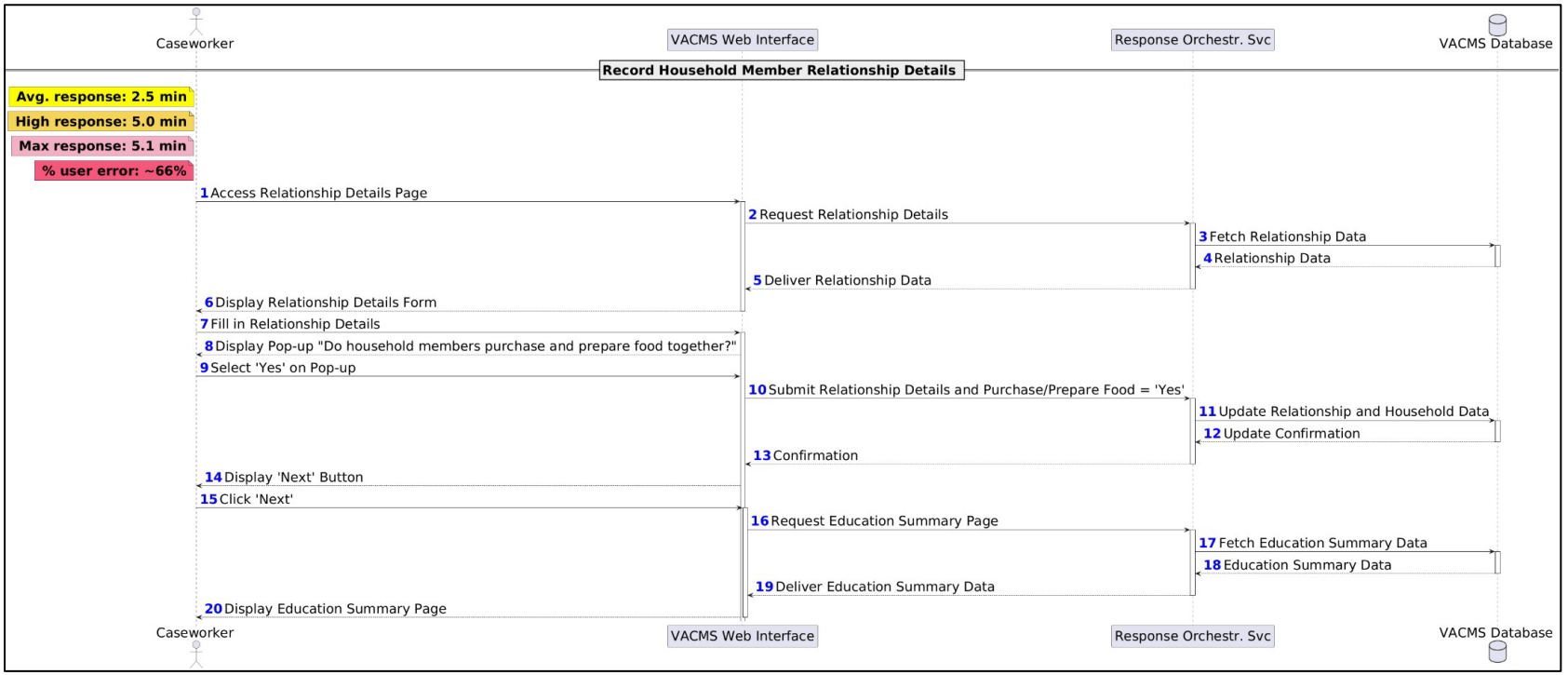


Figure 44: Caseworker records household member relationship details



Additional observations

High and critical issues

3 total high and critical issues were identified across the course of testing in the testing environment.

Issue #1 (Critical) – Severe degradation of system performance and system response times in certain pages even at 200 User load. These high response times fail the transactions due to waiting times beyond 5 minutes at which point the browser disconnects and times out of the request. This is evident at a very minor load level of 200 users where over 40 percent of the users failed the load test (there by only about 120 users completed the case intake scenario). This could potentially be a bottleneck with any integrations with other systems, or due to required tuning on database queries.

Figure 45: Test Execution Issue #1

The pages that have severe performance issues are listed below (along with their page id)

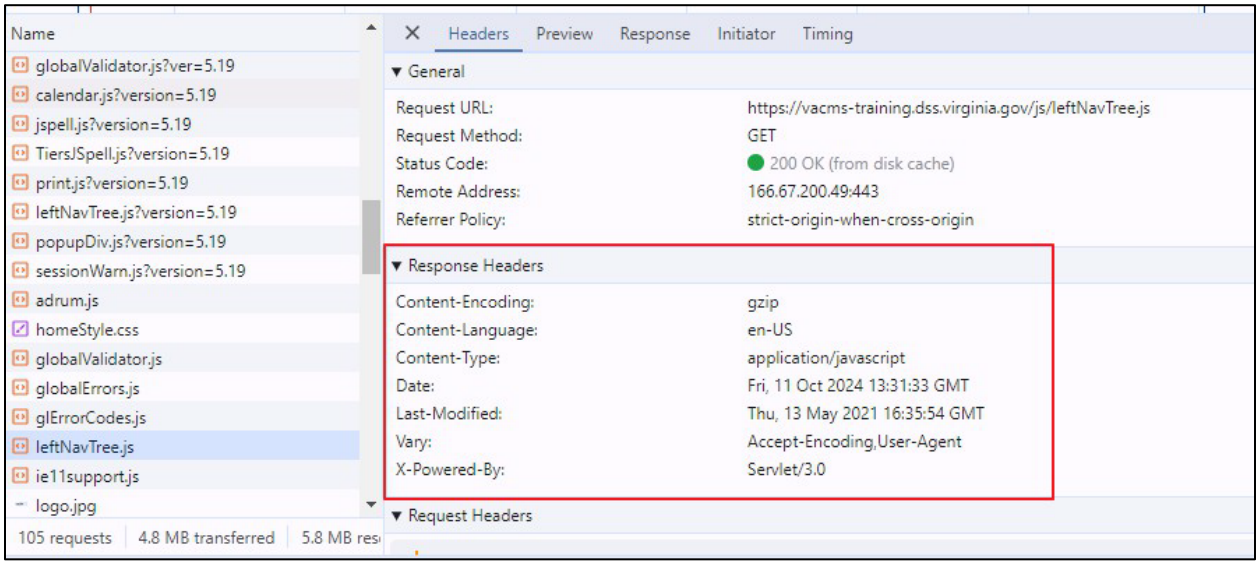
1. Page Id: DCHIP – 37.3% of the 400 users failed at this step in case intake.
2. Page Id: MWSGL – 4.5% of the 400 users failed at this step in case intake.

Issue #2 (Critical) – Overall degradation of system responsiveness observed at around 1530 users (760 from each JMeter server) for every page in the 3000-user test. Average response times for every page including the ones that do not process any data declined to greater than 10 seconds. The server was not able to handle any requests and degraded response times and timeouts were observed.

Issue #3 (High) – Static resources do not have Cache-Control headers, and they are served by application servers (Servlet/3.0) instead of using a web server / reverse proxy to reduce Application Server Load. This results in additional HTTP requests reaching the application

servers on every click, and utilizing the app server thread pool for static resources instead of being utilized for serving data requests (dynamic requests).

Figure 46: Response header example



Performance benchmarks

The testing leveraged benchmarks to understand 'what good looks like,' for both best-in-class systems (Netflix, Facebook, Google), how well other state systems support benefits programs, and assessed how VaCMS performs in comparison (see Figure 47 below).

Testing results imply VaCMS may have an average response time of up to 50,000 milliseconds. Whereas in other Medicaid and government systems average response times are closer to about 4,000 milliseconds, and best-in-class private sector examples (such as Netflix, Facebook, Google) operate under 100 milliseconds.[302]

[302] BCG benchmarking and analysis

Figure 47: Performance benchmarks compared to testing results

Performance metrics	Best-in-class (e.g., Netflix, Facebook, Google)	Medicaid & other Government benefit systems	VaCMS test results 400 production equivalent users	VaCMS test results 3000 production equivalent users
Avg response time	~<100ms to 10ms	~4,000ms	Up to 50,000ms	Up to 120,000ms
90% response time	~150ms to 15-20ms	~20,000ms	Up to 300,000ms	Unknown
Error rates	<0.01% to 0.1%	2% to 5%	~40%	~75%

8.7 Summary of LDSS Employee Survey

A survey was launched to employees at all 120 LDSS agencies to capture their perspectives on Medicaid eligibility determination. This online survey was open for two weeks, from September 3, 2024, to September 13, 2024. 1,294 employees responded to the survey, representing about 35% of all 3,674 LDSS benefits staff, including Directors. Respondents were asked demographic questions, along with questions about the processes, people & org structures, and tech & data systems involved in the Medicaid eligibility determination process. The complete list of the 35 survey questions and responses is listed below.

Section 1: Introduction

1. Employees from 128 out of 133 counties and localities responded to the survey. Of respondents that indicated their LDSS agency, the following agency sizes were represented.	
Agency size	% of respondents
Level I (small)	10%
Level II (medium)	42%
Level III (large)	47%

2. Do you support intake and review of Medicaid applications and/or renewals?	
Response	% of respondents
Yes	93%
No	7%

3. Do you support Medicaid eligibility appeals?	
Response	% of respondents
Yes	73%
No	27%

4. Do you supervise other workers in your agency?	
Response	% of respondents
Yes	29%
No	71%

5. How long have you been working at your local DSS agency?	
Response	% of respondents
Less than 1 year	7%
1 to 3 years	21%
3 to 5 years	12%
Over 5 years	59%

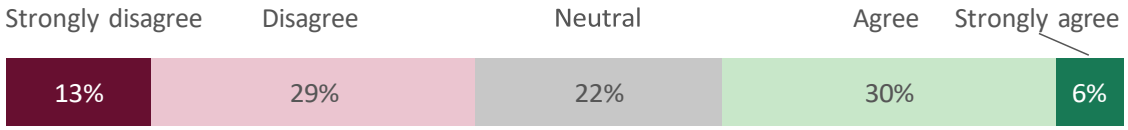
6. On average, how many total cases (across SNAP, TANF, Medicaid, Energy assistance, etc.) do you handle per week?	
Response	% of respondents
Less than 10 total cases per week	8%
11-20 total cases per week	25%
21-30 total cases per week	24%
31-40 total cases per week	14%
41-50 total cases per week	10%
More than 50 total cases per week	20%

7. What % of your time do you spend on Medicaid eligibility and renewal applications?	
Respondents reported spending 48% of their time on average on Medicaid eligibility and renewals. The following data shows the distribution of responses across quartiles.	
Response	% of respondents
0-25%	22%
26-50%	46%
51-75%	16%
76-100%	16%

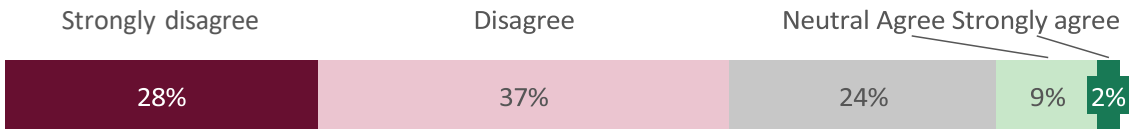
8. What type of Medicaid applications do you primarily work with? (Please select all that apply)?	
Note: Due to the "select all that apply" nature of this question, the total percentages across answer choices will sum to greater than 100%.	
Response	% of respondents
MAGI applications for adults	56%
Children and families	58%
Pregnant Women	48%
ABD and / or Long-Term Care	53%
I work evenly across applications	28%
N/A - I do not support Medicaid applications	5%

Section 2: Process[303]

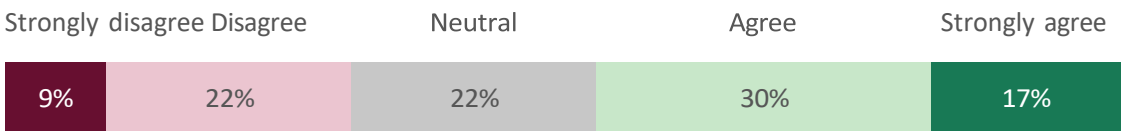
9. The current Medicaid eligibility processes support timely determinations and renewals



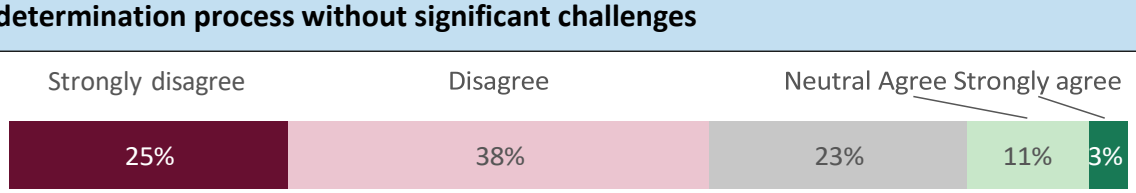
10. Process bottlenecks rarely occur in the Medicaid eligibility determination process



11. I rarely need to ask for help to process applications in my queue

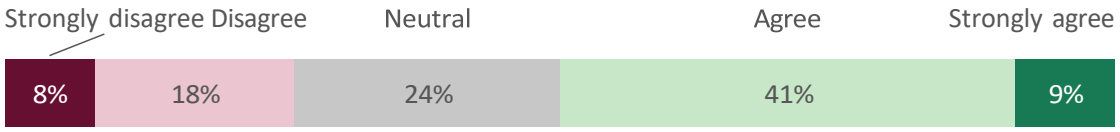


12. Eligible Virginians are able to successfully navigate the Medicaid eligibility determination process without significant challenges

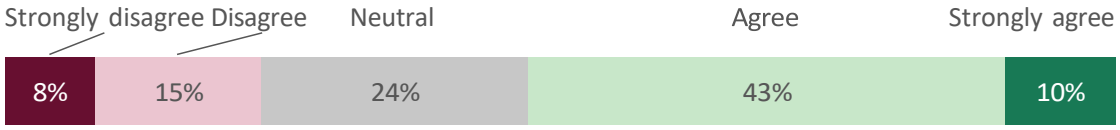


[303] Note: Respondents who said "N/A" to the following Likert scale questions were excluded

13. I have timely and accurate access to information that helps me track individual cases



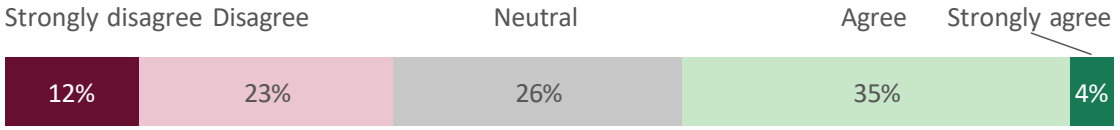
14. I have timely and accurate access to information that helps me track caseload progress and manage my caseload overall



Section 3: People & Org Structure[304]

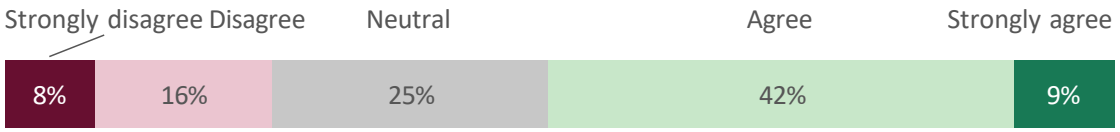
15. The current organizational structure and the relationships between my local DSS agency, state / regional DSS and DMAS support rapid and accurate Medicaid eligibility determinations

16. Medicaid eligibility determination roles and responsibilities are clearly defined at both the local and state level

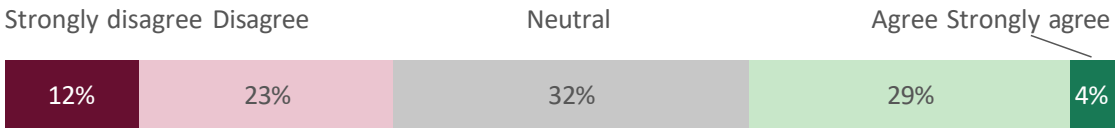


[304] Note: Respondents who said "N/A" to the following Likert scale questions were excluded

17. There is effective collaboration among local DSS agency staff involved in Medicaid eligibility determinations

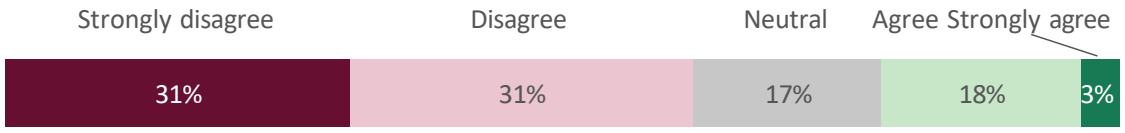


18. When needed, there is effective coordination with DMAS staff involved in Medicaid eligibility determinations

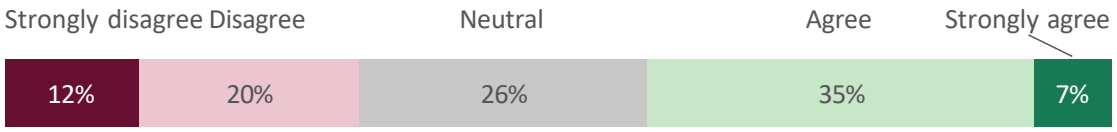


19. How does CoverVA impact the case workload in your local agency? (Free Response)	
Most common response themes	Approximate % of respondents
Frequent errors in application processing resulting in additional work for LDSS staff	35%
Processing delays and late case transfers to LDSS agencies, often near the 45-day deadline	20%
Unsure / no large impact	10%

20. There is sufficient workforce capacity to manage our Medicaid eligibility caseload



21. The Medicaid eligibility determination training provided to me allows me to successfully do my job



Section 4: Tech & data systems[305]

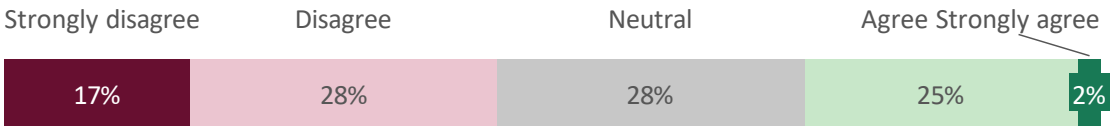
22. The Virginia Case Management System (VaCMS) is intuitive and easy to use

23. I am satisfied with the speed and reliability of VaCMS during peak usage times

24. VaCMS provides timely feedback and easy-to-understand notifications when actions are required or when there are updates to a Medicaid eligibility determination case

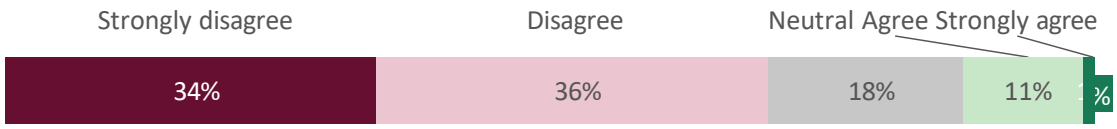
[305] Note: Respondents who said "N/A" to the following Likert scale questions were excluded

25. Clear and specific guidance is provided when there are changes to VaCMS processes on Medicaid eligibility determination

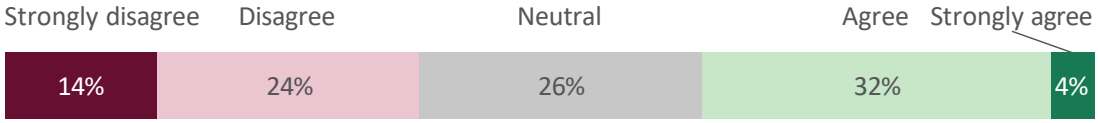


26. I am able to quickly learn and adapt to updates or changes in VaCMS

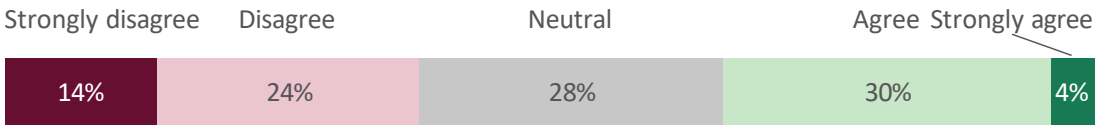
27. VaCMS provides clear and understandable error messages and guidance to resolve issues



28. VaCMS's automated processes reduce the amount of manual work (e.g., data entry) required for eligibility verification

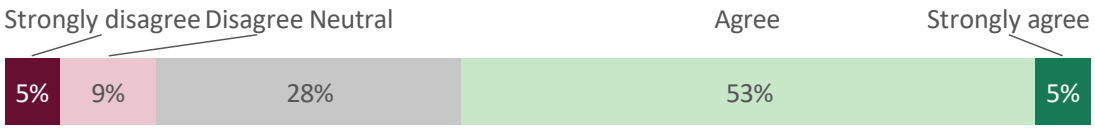


29. VaCMS's automated processes allow me to focus more on complex Medicaid eligibility determination cases that require human judgment

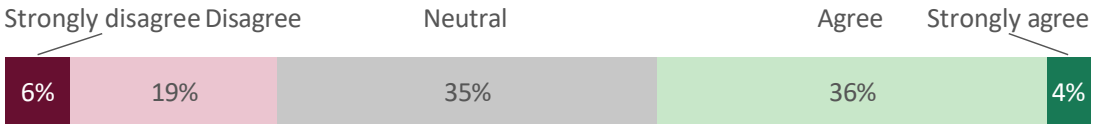


30. CommonHelp's automated processes reduce the amount of manual work required for eligibility verification

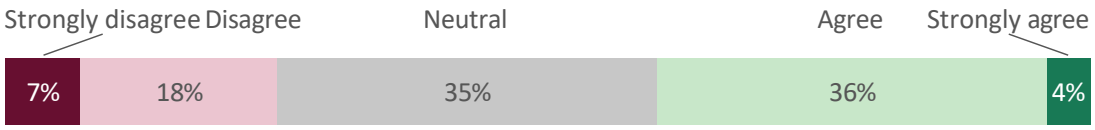
31. I am able to access reporting that enables me to monitor my caseload for Medicaid applications



32. I find that data captured in reports are accurate and support my decision-making process



33. I find it easy to access the Medicaid eligibility determination data I need within VaCMS to perform my duties effectively



34. What are the biggest challenges you experience in the current Medicaid eligibility determination process? (Free Response)	
Most common challenges described	Approximate % of respondents
Poor VaCMS performance, including frequent outages, delays, and data bridging issues	50%
Lack of support around complex policies (i.e. frequent policy changes without sufficient notification or correlated system updates)	10%
Staffing shortages and high caseloads	10%

35. What changes or suggestions do you have to improve the current Medicaid eligibility determination process? (Free Response)	
Most common suggestions provided	Approximate % of respondents
Tech overhaul, including improvement of VaCMS system reliability, processing speeds, user friendliness, and integration with MES and other application channels (e.g. DMAS CoverVA Call Center)	50%
Workforce improvements, including increased staffing capacity and enhanced LDSS & DMAS CoverVA Call Center training programs	25%
Case management improvements, including additional guidance on case management best practices and streamlined processes to reduce manual work and errors	10%

8.8 LDSS Agency Levels

Locality	Region	LDSS Level
Accomack	Eastern	II (Two)
Albemarle	Piedmont	III (Three)
Alexandria	Northern	III (Three)
Alleghany/Covington/Clifton Forge	Piedmont	II (Two)
Amelia	Central	I (One)
Amherst	Piedmont	II (Two)
Appomattox	Piedmont	I (One)
Arlington	Northern	III (Three)
Bath	Piedmont	I (One)
Bedford Co.	Piedmont	III (Three)
Bland	Western	I (One)
Botetourt	Piedmont	I (One)
Bristol	Western	II (Two)
Brunswick	Eastern	II (Two)
Buchanan	Western	II (Two)
Buckingham	Central	II (Two)
Campbell	Piedmont	II (Two)
Caroline	Central	II (Two)
Carroll	Western	II (Two)
Charles City	Central	I (One)
Charlotte	Piedmont	II (Two)
Charlottesville	Piedmont	III (Three)
Chesapeake	Eastern	III (Three)
Chesterfield/Colonial Heights	Central	III (Three)
Clarke	Northern	I (One)
Craig	Piedmont	I (One)
Culpeper	Northern	II (Two)
Cumberland	Central	I (One)
Danville	Piedmont	III (Three)
Dickenson	Western	II (Two)
Dinwiddie	Eastern	II (Two)
Essex	Central	I (One)
Fairfax Co.-City/Falls Church	Northern	III (Three)
Fauquier	Northern	II (Two)
Floyd	Western	I (One)
Fluvanna	Central	II (Two)
Franklin	Eastern	II (Two)
Franklin Co.	Piedmont	II (Two)

Frederick	Northern	II (Two)
Fredericksburg	Northern	II (Two)
Galax	Western	I (One)
Giles	Western	II (Two)
Gloucester	Eastern	II (Two)
Goochland	Central	I (One)
Grayson	Western	II (Two)
Greene	Northern	I (One)
Greensville/Emporia	Eastern	II (Two)
Halifax/South Boston	Piedmont	II (Two)
Hampton	Eastern	III (Three)
Hanover	Central	II (Two)
Henrico	Central	III (Three)
Henry/Martinsville	Piedmont	III (Three)
Highland	Piedmont	I (One)
Hopewell	Central	II (Two)
Isle Of Wight	Eastern	II (Two)
James City	Eastern	II (Two)
King & Queen	Central	I (One)
King George	Northern	I (One)
King William	Central	I (One)
Lancaster	Central	I (One)
Lee	Western	II (Two)
Loudoun	Northern	III (Three)
Louisa	Northern	II (Two)
Lunenburg	Central	I (One)
Lynchburg	Piedmont	III (Three)
Madison	Northern	I (One)
Manassas City	Northern	II (Two)
Manassas Park	Northern	I (One)
Mathews	Eastern	I (One)
Mecklenburg	Piedmont	II (Two)
Middlesex	Central	I (One)
Montgomery	Western	II (Two)
Nelson	Piedmont	I (One)
New Kent	Central	I (One)
Newport News	Eastern	III (Three)
Norfolk	Eastern	III (Three)
Northampton	Eastern	II (Two)
Northumberland	Central	I (One)
Norton	Western	I (One)
Nottoway	Central	I (One)
Orange	Northern	II (Two)

Page	Northern	II (Two)
Patrick	Western	II (Two)
Petersburg	Central	III (Three)
Pittsylvania	Piedmont	II (Two)
Portsmouth	Eastern	III (Three)
Powhatan	Central	II (Two)
Prince Edward	Central	II (Two)
Prince George	Eastern	II (Two)
Prince William	Northern	III (Three)
Pulaski	Western	II (Two)
Radford	Western	I (One)
Rappahannock	Northern	I (One)
Richmond	Central	III (Three)
Richmond Co.	Central	I (One)
Roanoke (City)	Piedmont	III (Three)
Roanoke Co./Salem	Piedmont	III (Three)
Rockbridge/Buena Vista/Lexington	Piedmont	II (Two)
Rockingham/Harrisonburg	Northern	III (Three)
Russell	Western	II (Two)
Scott	Western	II (Two)
Shenandoah	Northern	II (Two)
Shenandoah Valley (Augusta/Staunton/Waynesboro)	Piedmont	III (Three)
Smyth	Western	II (Two)
Southampton	Eastern	II (Two)
Spotsylvania	Northern	III (Three)
Stafford	Northern	II (Two)
Suffolk	Eastern	III (Three)
Surry	Eastern	II (Two)
Sussex	Eastern	II (Two)
Tazewell	Western	II (Two)
Virginia Beach	Eastern	III (Three)
Warren	Northern	II (Two)
Washington	Western	II (Two)
Westmoreland	Central	II (Two)
Williamsburg	Eastern	I (One)
Winchester	Northern	II (Two)
Wise	Western	III (Three)
Wythe	Western	II (Two)
York/Poquoson	Eastern	II (Two)

8.9 Acronyms

Term	Definition
ABD	Aged, Blind, and Disabled
ACA	Affordable Care Act
AR	Application Registrations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CPU	Central Processing Unit (CoverVA)
CVIU	CoverVA Incarcerated Unit
DMAS	Department of Medical Assistance Services
FAMIS	Family Access to Medical Insurance Security
FFCRA	Families First Coronavirus Response Act
FFM	Federally-Facilitated Marketplace
FPL	Federal Poverty Level
FTE	Full Time Equivalent
FY	Fiscal Year
HHR	Health and Human Resources
KFF	Kaiser Family Foundation
LDSS	Local Departments of Social Services
LTC	Long-Term Care
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organizations
MES	Medicaid Enterprise System
MOU	Memorandum of Understanding
O&M	Operations & Maintenance
PHE	Public Health Emergency
PIMR	Performance Improvement and Measurement Reporting
PMPM	Per Member Per Month
RDE	Rapid Data Entry
RPA	Robotic Process Automation
SBM	State-Based Marketplace
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families
VaCMS	Virginia Case Management System
VDSS	Virginia Department of Social Services
VHCF	Virginia Health Care Foundation
VIM	Virginia Insurance Marketplace
VITA	Virginia Technologies Agency
VLSSE	Virginia League of Social Services Executives
VPLC	Virginia Poverty Law Center
VSCC	Virginia State Corporation Commission

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage. The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives an approximate dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.