Nebraska Department of Health and Human Services: Efficiency and Effectiveness of ACCESSNebraska

Performance Audit Committee
Nebraska Legislature

December 2013

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Committee Report

Nebraska Department of Health and Human Services: Efficiency and Effectiveness of ACCESSNebraska

December 2013

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I. Committee Recommendations

Audit Summary and Committee Recommendations

Audit Summary

ACCESSNebraska is an automated system of eligibility determination for public assistance benefits initiated by the Department of Health and Human Services Children and Family Services Division (CFS) in September 2008. Developed with the intent of modernizing and streamlining service delivery, ACCESSNebraska replaced the face-to-face application process with a combined phone and online processing system. However, since the system became operational in 2009, it was plagued with significant problems.

In February 2013, the Legislative Performance Audit Committee (Committee) directed the Legislative Audit Office (Office) to conduct a performance audit of ACCESSNebraska. Specifically, the Committee directed the Office to assess implementation of selected provisions of LB 825 (2012), which was intended to improve client access to caseworkers and appropriated an additional three million dollars to the program. It also directed the Office to analyze selected measures of efficiency, including busy signals, call wait times, and backlogged work tasks, and to review literature on best practices for online and Web-based eligibility systems including call centers.

At the time the Committee approved the ACCESSNebraska audit, its members were aware of DHHS's plans to remove Medicaid calls from the ACCESSNebraska system on October 1, 2013. That change did occur and the report findings apply to the system as it functioned prior to that change. From October 1 forward, CFS was only responsible for applications for Economic Assistance programs such as Supplemental Nutritional Assistance Programs (SNAP, formerly Food Stamps), energy assistance and child care.

Key findings of the audit include:

- Recent average call wait times for four of five categories of calls were much higher than the DHHS goal of an average of three minutes or less. For one category of calls for July 2013, an estimated 10,914 to 16,347 callers experienced wait times of 45 minutes or more. The rate of busy signals for the same month was also far in excess of the department goal of five percent.
- During the one-year period that ended in August 2013,

average wait times for answered and abandoned calls increased more than 50 percent, even though the number of answered calls decreased during the period.

- Only one of five categories of calls met the DHHS goal of a call-abandonment rate of 10 percent or less. The other four categories had rates two to three times higher than the goal.
- DHHS is not in compliance with the statutory requirement that it contract with community-based organizations to assist ACCESSNebraska clients.
- DHHS is not in strict compliance with statutory requirements regarding dedicated caseworkers and specialized department employees, although the impact of this non-compliance is unclear because the goal of the statute is itself unclear. However, input from client advocates suggests the lack of a publicized process for requesting in-person contact with a worker or an ongoing, assigned caseworker may be a more significant concern than the availability of such workers.
- DHHS has no standard for determining an acceptable number of unfinished work tasks.

Committee Recommendations

Section I: Implementation of LB 825

Finding #1: DHHS stated that they used three of the four statutory factors in determining appropriate numbers of local office staff; however, they could not provide documentation that would have allowed us to verify that. We confirmed that the fourth factor could not be considered because the relevant data was not available. (p. 5)

Finding #2: Local office caseworkers are available for in-person assistance to clients and DHHS has a process for scheduling face-to-face appointments with local office case-workers through call center workers. (p. 7)

Recommendation: If the Legislature is still concerned that local office staffing is a problem, it may want to evaluate whether the four factors identified in the statute are the best measures to address this issue. If new measures are created, the department should maintain adequate documentation of

how it has met standards. Additionally, DHHS should assess whether or not the current process for requesting in-person assistance and face-to-face appointments is working and ensure that all clients know how to make such a request.

Finding #3: Since DHHS allows a client to request an assigned caseworker but retains the right to deny that request, DHHS is not in strict compliance with the statutory requirements regarding dedicated workers and specialized department employees. (p. 8)

Finding #4: The impact of DHHS's non-compliance with assigned worker requirements is unclear because the goals of the statutory requirements are somewhat unclear. However, input from client advocates suggests that the lack of a publicized process for requesting a single face-to-face contact with a worker or an ongoing assigned caseworker may be a bigger concern than the availability of such a worker. (p. 9)

Recommendation: The Legislature may want to clarify its intent regarding the statutory provisions dealing with dedicated caseworkers and specialized department employees, including the intended longevity of such a client request. DHHS should develop a *publicized* process for clients to request an assigned worker which accurately reflects the Legislature's intent.

Finding #5: DHHS met the statutory requirement that it determine an appropriate number of community support specialists. However, we make no assessment of whether nine positions are in fact sufficient to perform the required duties. (p. 10)

Finding #6: DHHS is not in compliance with the requirement of LB 825 that it contract with community based organizations to assist clients. (p. 11)

Discussion: As stated in our report, the Legislature's goal in requiring contracts with community-based organizations was to allow the department to maximize the use of local resources, since most clients have some relationship with community-based organizations. Additionally, establishing contracts with these entities would allow DHHS to define and monitor the duties of its community partners.

Recommendation: DHHS should establish contracts or other types of agreements with community-based organizations which would achieve the Legislature's goal.

Section II: Efficiency and Effectiveness of ACCESSNebraska

Finding #7: In July 2013, DHHS did not meet its goal of having five percent of incoming calls ring busy; in fact, busy signals were more than 400 percent of incoming calls that month. (p. 15)

Finding #8: Only the Case Aides queue met the Department's goal of an abandonment rate of 10 percent or less. The other four queues had abandonment rates two to three times higher than the goal. (p. 15)

Finding #9: Prior to October 2013, DHHS did not report the average wait time for abandoned calls as required by LB 374. (p. 17)

Finding #10: Recent average call wait times for the queues combined were much higher than DHHS's goal of an average of three minutes or less. (p. 18)

Finding #11: None of the queues met the Department's wait time goal of an average of three minutes or less for either answered or abandoned calls. However, the Case Aides queues came close with an average of four minutes for answered calls and five minutes for abandoned calls. (p. 19)

Finding #12: Between September 2012 and August 2013, the average wait time for answered and abandoned calls increased more than 50 percent for almost all queues. (p. 19)

Finding #13: The number of answered calls decreased from September 2012 to August 2013, so the number of calls was not a factor in the increased wait times. (p. 20)

Finding #14: The Case Aide queues had the lowest average wait times and the queues that dealt with family cases had the highest. (p. 21)

Finding #15: The maximum wait times for both answered and abandoned calls range from almost one hour to nearly two hours. (p. 22)

Finding #16: Between September 2012 and August 2013, the maximum wait time for answered calls increased more than 50 percent for most queues. (p. 23)

Finding #17: In August 2013, an estimated 10,914 to 16,347 callers in the Family Change and Family Interview (English/Other) queues experienced wait times of 45 minutes or more. (p. 26)

Finding #18: Average wait times for all queues disguise important differences in wait times among queues. (p. 26)

Finding #19: DHHS has no standard for determining an acceptable number of unfinished work tasks. (p. 27)

Finding #20: For 7 out of the 12 months presented, work tasks older than 5 days comprised approximately 75 percent of the total backlog. For 11 out of the 12 months presented, the older tasks comprised a majority of the total backlog. (p. 29)

Finding #21: DHHS did not meet its goal of reducing the backlog of work tasks older than five days to 25,000 by October 1, 2013. (p. 29)

Recommendation: DHHS should determine what an acceptable number of unfinished work tasks is at any given time, taking into account variances in work task priority and age, so as to prevent negative impact on clients' cases.

Efficiency and Effectiveness Recommendations

The audit results on selected efficiency and effectiveness measures are very concerning. DHHS has fallen dramatically short of its goals in all the areas we reviewed, reflecting a very high level of program dysfunction. The extremely high busy signal rate generally, and likelihood that family eligibility cases will experience very high wait times specifically, paint a picture of frustration before many clients even make contact with the program.

The report findings are based on the program's performance prior to the separation of the Medicaid calls from the Economic Assistance calls. While some initial indications are positive (such as reduced call wait times), it is too early to fully assess whether the changes that accompanied the separation will resolve the problems identified in the report.

Recommendation: The Legislature should consider requesting DHHS to report monthly call center performance data for both Economic Assistance and Medicaid to the Legislature covering at least October 2013 through March 2014. That data should include busy signals, answer and abandonment rates for each queue, and average and maximum wait times for each queue. The information should be provided for each day as well as aggregated for each month.

Recommendation: The Legislature should consider amending the reporting requirements of LB 374 to include: (1) the average and maximum wait times by skill set queue, rather than just "grand total" data that does not differentiate between individual queues; and (2) data on busy signals and work tasks.

Discussion: Very long times were a problem for most queues, but particularly so for the more complex family eligibility cases. It is unclear how such cases will be affected by the separation of the Medicaid calls, but there is a possibility of additional complications, given the need for the Economic Assistance and Medicaid systems to interact when families are eligible for services in both areas.

Recommendation: The Legislature should consider requiring DHHS to identify performance measures to track that would indicate a continuing problem in family eligibility cases or a developing problem in coordination between the Economic Assistance and Medicaid programs on cases of dual eligibility.

Recommendation: If program data indicate continuing problems despite the separation of the Medicaid cases, the Legislature may need to review key program aspects such as the adequacy of:

- Existing staffing;
- Call center software; and
- Call center staff training.

The Legislature may also need to consider whether existing program goals—such as an average wait time of three minutes or less—are appropriate. While short wait times are desirable, they need to be balanced with both the amount of time necessary to accomplish the work tasks and with the costs associated with the factors necessary to reduce them (for example, number of staff).

II. Legislative Audit Office Report

Legislative Audit Office Report

Nebraska Department of Health and Human Services: Efficiency and Effectiveness of ACCESSNebraska

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INTRODUCTION

ACCESSNebraska is an automated system of eligibility determination for public assistance benefits initiated under the leadership of former Department of Health and Human Services (DHHS)/Children and Family Services (CFS) Director, Todd Landry and approved by the Governor in September 2008. Developed with the intent of modernizing and streamlining service delivery, the Department of Health and Human Services (DHHS) asserted that the new system would save millions of taxpayer dollars by closing local offices and replacing the face-to-face application process with a combined phone and online processing system. However, since the system became operational in 2009, it has been plagued with significant problems. In response to these concerns, the Legislature has held several public hearings and in 2012, enacted LB 825, which was intended to improve client access to caseworkers and appropriated an additional three million dollars to the program.

In February 2013, the Legislative Performance Audit Committee (Committee) directed the Legislative Audit Office (Office) to conduct a performance audit of ACCESSNebraska at the Department of Health and Human Services. Specifically, the Committee directed the Office to answer the following questions about ACCESSNebraska as it existed prior to the October 1, 2013 Medicaid transition, which converted two of the four call centers to Medicaid- only processing (discussed more fully in Section I).

1. Has DHHS implemented the following requirements of LB 825:

    - staffed existing local offices with a sufficient number of caseworkers to provide in-person services to clients as set forth in § 81-3128;
    - established dedicated caseworkers and specialized department employees to provide in-person services to specific clients as set forth in § 81-3129;
    - established community support specialists as provided in § 81-3130; and

- established contracts with community-based organizations as required by § 81-3131?

2. Does ACCESSNebraska serve its clients efficiently and effectively as measured by:

   - caller wait times, abandonment rates and busy signals; and
   - backlogged work tasks?

Sections I and II of the report discuss each of these questions. In addition, we include as Section III, a summary of some of the available research about online and Web-based eligibility systems, including call centers, in other states.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The methodologies used are described briefly at the beginning of each section, with further detail included in the appendix.

We appreciate the cooperation and assistance of DHHS, the Department of Administrative Services, legislative staff and external stakeholders during the audit.

SECTION I: Implementation of LB 825

In this section, we report the results of our analysis of the Department of Health and Human Services' (DHHS or department) compliance with selected requirements of LB 825, passed in 2012.

Background

Before October 1, under ACCESSNebraska, a client applied for eligibility in one or more public assistance programs using an on-line application process.[1] The application was reviewed by an employee at one of four customer service centers located in Fremont, Lexington, Lincoln, or Scottsbluff, who communicated with the client regarding information needed for the application. Community-based organizations (CBOs), or "community partners," as DHHS refers to them, were also recruited to assist clients with their applications for services.

Call center employees work with clients on their applications but they do not make the eligibility determinations. Eligibility is determined by caseworkers in DHHS's local offices. A significant change under this system is that a client no longer has a designated worker; instead, the system uses universal case management, meaning any worker can respond to calls on any case.

Throughout the program's five-year history, the Legislature received significant public comment on problems with the program. During that time, the Health and Human Services Committee has held six hearings on bills or interim studies relating to the program. The Committee held the most recent hearing in October 2013.

In 2012, LB 825 was enacted in response to the overwhelming public dissatisfaction with the system, including but not limited to, excessive call wait times, erroneous benefit determinations, lost documentation, lack of staff with sufficient expertise to handle complex cases, lack of language access for non-English speaking individuals, and failure to

[1] Public assistance programs administered through ACCESSNebraska include: Medicaid; the Supplemental Nutrition Assistance Program or SNAP (formerly food stamps); Aid to Dependent Children (ADC); Aid to the Aged, Blind, and Disabled (AABD); Energy Assistance; Kids Connection (CHIP); and Child Care Subsidy.

effectively establish partnerships with CBOs. The bill had the goal of improving service to public assistance applicants by increasing direct access to caseworkers in local offices. Elderly and disabled clients were of primary concern to lawmakers because many of these applicants have difficulty using the automated telephone service and online application process.

In 2013, lawmakers' concerns were renewed by the Department's decision to significantly restructure the call centers. Effective October 1, 2013, the Lincoln and Lexington call centers transitioned to process only Medicaid eligibility. The remaining call centers in Fremont and Scottsbluff will continue to process applications for the other public benefit programs. According to DHHS, there are two separate telephone numbers and the ability for staff to transfer clients who need assistance with multiple programs. The Department made this change in conjunction with its development of a Medicaid-only application, which administrators state is needed to comply with the federal Affordable Health Care Act. Lawmakers were concerned that division of the application process would create new problems of coordination for people who apply for more than one program.

LB 825 Provisions Assessed

The scope statement for this audit directed us to assess four key provisions of LB 825. These provisions require the department to:

- staff local offices with sufficient numbers of employees;
- establish dedicated caseworkers and specialized DHHS employees;
- establish an appropriate number of community support specialists; and
- establish a sufficient number of contracts with CBOs.

We discuss each provision in detail below.

Local office staffing

The closure of local DHHS offices was a key part of the design of ACCESSNebraska. A result of those closures was the significant reduction in the availability of DHHS workers for clients who needed help with the application process. In response to concerns that the reduction had a detrimental

effect on clients, LB 825 required DHHS to staff the remaining local offices with an appropriate number of caseworkers to provide in-person assistance to clients. In order to meet this goal, the department was directed to consider four factors: the need for staff to travel to the community partner organizations to assist clients; the volume of Economic Assistance cases in the counties served by the local office; the number of community partners in the counties served by the local office; and the volume of call center calls originating from counties served by the local office.

Children and Family Services (CFS) administrators told us they considered three of these four factors in determining appropriate staffing levels. They could not consider the fourth—the volume of calls received by the call centers—in their staffing determination because neither DHHS nor the Department of Administrative Services, which manages the call-center phone contracts, tracks the geographic origin of the calls by counties. We confirmed with the Department of Administrative Services that this information was not available.

Although the administrators said they took the other factors into account, they could not produce any evidence of actually having done so, either in meetings with auditors or in their subsequent written responses to auditors' questions. [2] However, we were told that the Economic Assistance administrators in the service areas provided input regarding staffing needs in their respective offices. The department did provide evidence that they were consulted but not that they considered the specific factors enumerated in statute.

Finding: DHHS stated that they used three of the four statutory factors in determining appropriate numbers of local office staff; however, they could not provide documentation that would have allowed us to verify that. We confirmed that the fourth factor could not be considered because the relevant data was not available.

Ultimately, DHHS determined that to comply with the local office staffing requirements of LB 825, it needed to retain 22.5

[2] DHHS administrators used the number of SNAP case numbers to meet the "volume of Economic Assistance cases" requirement in each county. SNAP figures were used because this program encompasses the greatest number of public assistance clients, estimated at 70 percent by department administrators.

employees that had been scheduled for layoffs in the Central and Western service areas and add 20 new workers. Table 1.1 shows the locations of local office staff added or retained as a result of LB 825.

In addition to the requirements relating to the number of local office staff, LB 825 required that caseworkers in local DHHS offices provide in-person services to department clients. CFS administrators stated that the local office caseworkers are available for in-person assistance to clients, and upon client request, call center staff will send clients to a contact person in the client's service area who can schedule an appointment with available staff. Call center workers can also connect the clients directly with local office caseworkers for phone interviews immediately.

Table 1.1. Number of Staff Added to Each Local Office as a Result of LB 825 (2012)

Local Office	Number of Staff Added
Alliance	1
Broken Bow	3
Chadron	1
Fremont	2
Gering	4
Grand Island	3
Hastings	4
Imperial	0.5
Kearney	5
Lincoln	2
McCook	2
Norfolk	1
Ogallala	1
Omaha	8
O'Neill	1
Ord	1
Pender	2
Total	**41.5**

It was not within the scope of this audit to survey clients to evaluate the sufficiency of local office staffing or other requirements of LB 825. However, we did talk to the Legislative Office of the Public Counsel (Ombudsman), which receives many calls regarding ACCESSNebraska, and Nebraska Appleseed, which has a working group of advocates, in order to obtain some feedback relating to these issues.

We note that neither office had received complaints about client access to caseworkers in the local offices, although they were aware of some issues with requests for face-to-face meetings through the call center being lost or miscommunicated. While this is not conclusive proof that these services are available, it suggests that any existing problems are on a much smaller scale than problems involving the call centers, about which both offices continue to receive a large volume of client complaints.

Finding: Local office caseworkers are available for in-person assistance to clients and DHHS has a process for scheduling face-to-face appointments with local office caseworkers through call center workers.

Dedicated caseworkers and specialized department employees

The second LB 825 requirement that we reviewed relates to DHHS assigning workers to clients in certain circumstances. A central feature of ACCESSNebraska is the "universal caseload," meaning that individual eligibility cases were no longer assigned to specific workers. Instead, call-center workers respond to questions about any case on which they answer a call. The Legislature was concerned that this type of system was having a detrimental effect on some types of clients, and included in LB 825 the direction for DHHS to designate caseworkers to deal with the more complicated types of cases.

LB 825 directed DHHS to designate dedicated caseworkers and specialized department employees to provide in-person assistance to specific clients. Upon the client's request, "dedicated caseworkers" are to be used for clients with chronic physical or mental disorders and the elderly and "specialized department employees" are to be utilized for complex cases

such as Medicaid waiver, [3] spousal impoverishment and disability cases. Additionally, the legislative history clearly indicates that one of the main purposes of the bill was to restore face-to-face contact with caseworkers and the human interaction component to the public assistance eligibility determination process.

CFS Administrators stated that the department does not use the statutory terminology to refer to *dedicated caseworkers* and *specialized department employees;* instead these employees are all referred to as *assigned caseworkers*. (This is a technical distinction that we do not believe has substantive impact on clients.)

According to CFS Administrators, clients can request an assigned caseworker through the call centers, local offices, or by contacting an administrator. However, the department does not always grant the client's request. Instead, DHHS officials have stated that they work with the client to determine whether an assigned caseworker is necessary. According to one CFS administrator, "Once a client is assisted, they are often okay with not having an assigned worker."

Spousal impoverishment and disability cases receive an assigned worker only until eligibility is determined and then return to the universal caseload. Certain types of Medicaid waiver cases are also given an assigned worker by the department. Other categories of clients do not receive an assigned worker unless they request one. DHHS stated that it is rare for a client to request to retain an assigned caseworker after the application phase. However, if a client request is granted, the caseworker is typically in the same geographical area where the client lives to allow for face to face interaction. After the call center transition to Medicaid, these practices may change.

Finding: Since DHHS allows a client to request an assigned caseworker but retains the right to deny that request, DHHS is not in strict compliance with the statutory requirements regarding dedicated workers and specialized department employees.

[3] Medicaid programs where states have been authorized to develop programs that differ from the standard federal requirements. States must apply for waivers if they want to develop a Medicaid program that has unique eligibility requirements or operates like a managed care organization.

The impact of this non-compliance is less clear because the statutory goals are somewhat unclear. If the goal was to expedite one-time assistance to the client, it appears that it is being met if the client is helped and no longer wants an assigned worker. However, if the purpose of this provision was to restore *ongoing* face-to-face interaction between clients and caseworkers throughout the life of the case, that goal may not be met if DHHS denies a request or if DHHS staff influence the client to decide an assigned worker is not necessary.

Our interviews with the Ombudsman's Office and Nebraska Appleseed suggest that the availability of assigned workers is not a major problem, based on the absence of a significant number of calls either has received. More complex cases, such those involving Medicaid waiver or a spousal impoverishment determination, do seem to be receiving an assigned worker.

Rather, the problem seems to be that there is no *publicized process* for requesting either a single face-to-face contact, or an assigned caseworker for the life of a case. Additionally, local office workers are limited in how much help they can give a client because once eligibility is determined, the case returns to the universal case load and therefore the local office worker cannot actually work the case; it must be handled by the call center.

Finding: The impact of DHHS's non-compliance with assigned worker requirements is unclear because the goals of the statutory requirements are somewhat unclear. However, input from client advocates suggests that the lack of a publicized process for requesting a single face-to-face contact with a worker or an ongoing assigned caseworker may be a bigger concern than the availability of such a worker.

Community support specialists

The third LB 825 provision we reviewed relates to the provision of an appropriate number of community support specialists. Community support specialists are DHHS employees who assist the community partners in helping clients.

LB 825 provided that DHHS shall determine an appropriate number of community support specialists to: act as liaisons between the department and the community partners; facilitate client assistance by community-based organizations (CBOs); provide training to CBOs; and respond to client problems. The bill did not specify how DHHS was to make the determination of the "appropriate" number of staff to fulfill these purposes.

The department had eight community support specialists at the time the bill was introduced and the legislation required DHHS to minimally maintain that number. After passage, and based on feedback from the CBOs, DHHS determined that one additional community support specialist was needed in the Southeast service area. This position was filled in December 2012.

Finding: DHHS met the statutory requirement that it determine an appropriate number of community support specialists. However, we make no assessment of whether nine positions are in fact sufficient to perform the required duties.

Input we received from the Ombudsman and Nebraska Appleseed regarding the department's use of community support specialists was very positive. Neither office could comment on the adequacy of current staffing levels; however, the feedback received from the CBOs was that these organizations are always in need of knowledgeable staff to act as liaisons between the community partners and DHHS.

Contracts with community-based organizations

The final LB 825 provision we reviewed required the department to enter into contracts with community partners that allows DHHS to have caseworkers at the CBOs at the times specified in the contracts. It also required the department to maintain sufficient numbers of contracts to assist all Nebraska citizens in establishing and maintaining eligibility for Economic Assistance programs.

Department administrators stated that DHHS has no contracts with CBOs because the Legislature did not appropriate enough money to comply with both the staffing and contracting requirements of LB 825. However, this

explanation is unsatisfactory because according to the administrators themselves, the community partners have never been compensated by DHHS for assistance they provide to clients and there was no requirement in the bill that the CBOs be paid. According to the bill's sponsor, the goal was to encourage the department to utilize the local resources as much as possible since most clients have some relationship with the CBOs.

Finding: DHHS is not in compliance with the requirement of LB 825 that it contract with community-based organizations to assist clients.

SECTION II: Efficiency and Effectiveness of ACCESSNebraska

In this section we report the results of our analysis of the efficiency and effectiveness of ACCESSNebraska to its clients prior to October 1 as measured by busy signals, call wait and abandonment times, and backlogged work tasks. Our evaluation is based on interviews and data received from DHHS and the Department of Administrative Services. Before presenting our analysis of call data, we give a brief overview of the ACCESSNebraska telephone system.

Call Process Prior to October 2013

ACCESSNebraska (AN) has 299 dedicated phone lines. If all lines are in use, the caller receives a busy signal. A caller who gets an open line is immediately connected to the AN Interactive Voice Response (IVR) system. Client inquiries may end at the IVR stage because the system has access to some basic case-specific information, such as account balances and issuance dates for benefits checks. For clients who want to speak to call center social services workers, the IVR transfers the calls into one of ten "skill set" queues (queues) based on callers' responses to IVR prompts that categorize calls.

Table 2.1. Queue Names

10 Skill Set Queues (5 Spanish; 5 English & Other Languages)
Case Aides—Answer general questions and transfer calls to other queues.
Interview Specialists **Adult Eligibility or Family Eligibility**—For pending eligibility applications, conduct interviews for a single adult or family, respectively.
Change Management Specialists **Adult Eligibility or Family Eligibility**—For cases in which eligibility is under review (single adult or family) respond to questions and information requests.

The queues – five in English and five in Spanish – include case aides, who answer general questions about cases or transfer clients to appropriate queues; change management specialists, who process all questions and requests for additional information for cases being reviewed; and interview specialists who, among other duties, conduct interviews for all pending applications. Both the change management and interview fields are further divided into adult or family queues, depending on whether the case involves eligibility solely for an adult or for an adult and other family members.

Once a caller is transferred from the IVR to the appropriate queue, he or she will speak to the next available social services worker at any of the four call centers. AN also offers a language line for clients who do not speak English or Spanish. In these cases, once staff in any of the queues identifies the need for interpreter services, he or she

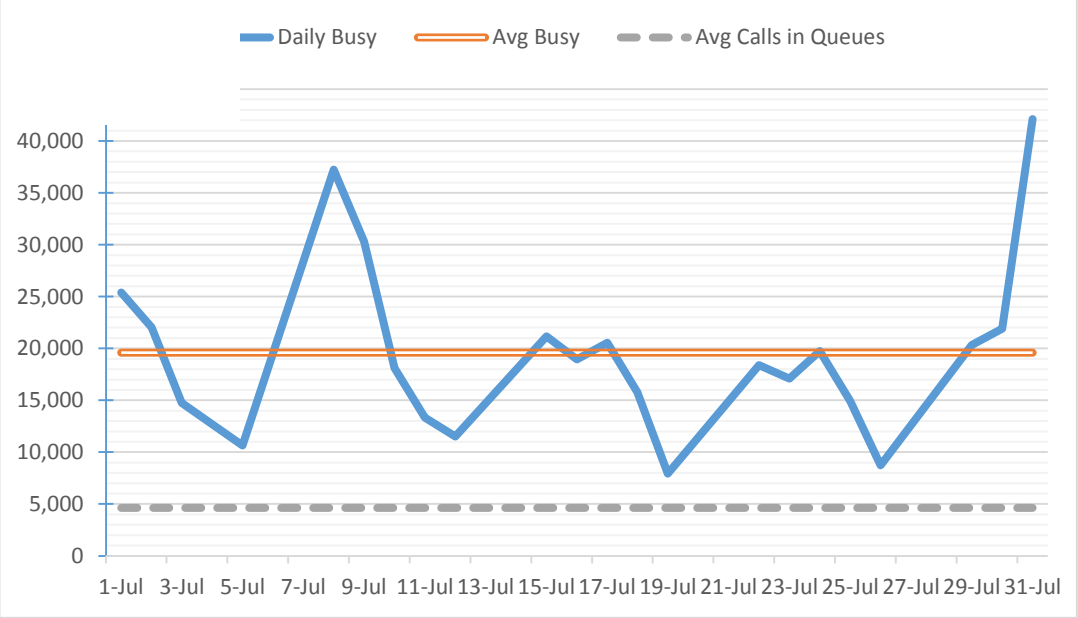
will call the language line and have a three-way discussion with the client and interpreter.

Neither DHHS nor the Office of the Chief Information Officer (OCIO) have direct access to the data on calls into ACCESSNebraska. Windstream maintains the call data, and the two state agencies can access a variety of summary data through established report formats. Because of the tremendous volume of data, Windstream retains the most detailed data for shorter periods of times than the less detailed data. For example, data on the average wait time and maximum wait time by 15-minute periods in a single day are maintained only for the past 30 days, while the monthly averages are maintained much longer.

Busy Signals

As mentioned earlier, a call receives a busy signal if the lines into the IVR system are all in use. Windstream maintains data on the number of busy signals that occur but cannot determine the number of callers who received them. DHHS's original goal was for busy signals to account for no more than five percent of incoming calls.

Chart 2.1. Number of Busy Signals by Day, July 2013



Source: Graph prepared by the Legislative Audit Office using Windstream data.

In July 2013, 430,864 calls received a busy signal compared to 102,058 calls that ended up in a queue (that is, were

answered or abandoned).[1] There was a wide range of busy signals per day—7,919 (July 19) to 42,127 (July 31)—with an average of 19,585 per day. Chart 2.1 shows the average and actual number of busy signals, as well as the average number of calls that ended up in a queue (4,639), for each day.

Finding: In July 2013, DHHS did not meet its goal of having five percent of incoming calls ring busy; in fact, busy signals were more than 400 percent of incoming calls that month.

Abandoned Calls

An "abandoned" call is one in which the caller hangs up before he or she is connected to a call center employee. DHHS's goal is for 10 percent or less of all incoming calls to be abandoned.

For September 1, 2012, to August 31, 2013—the most recently completed 12-month period at the time of the audit—the call centers received about 1.2 million calls, of which 906,363 (74 percent) were answered and 323,686 (26 percent) were abandoned.[2]

While the rate for all queues shows that DHHS did not meet its goal of 10 percent or less overall, a review of the individual queue rates shows that the Case Aides queue did meet the goal, with an abandonment rate of nine percent. For the remaining four queues, the abandonment rate ranged from 21 percent to 36 percent as shown in Chart 2.2 on page 16.

Finding: Only the Case Aides queue met the Department's goal of an abandonment rate of 10 percent or less. The other four queues had abandonment rates two to three times higher than the goal.

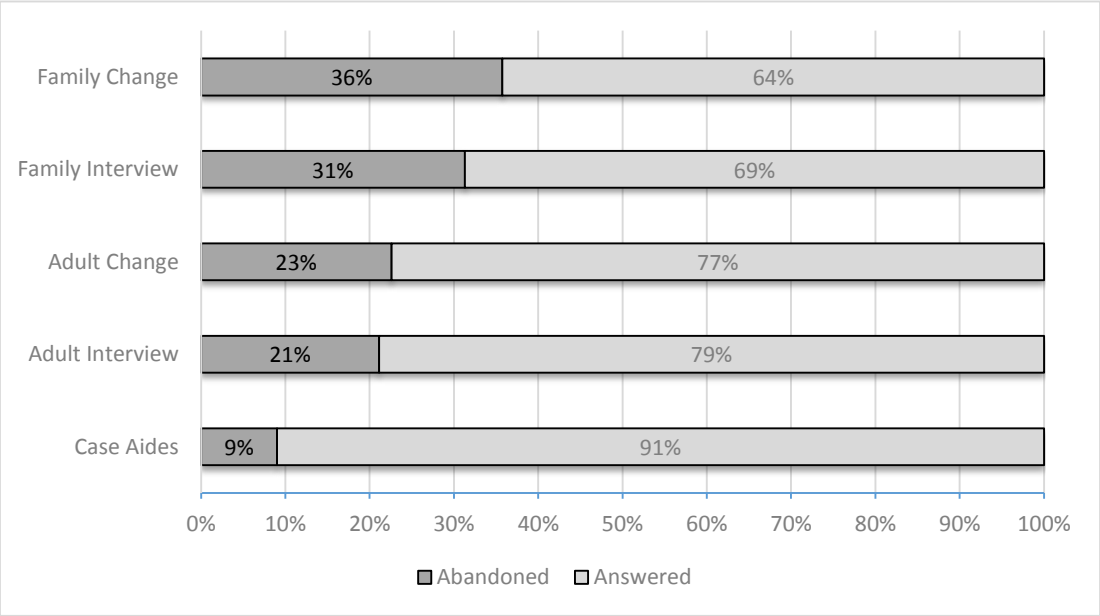
Wait Times

"Wait time" is the amount of time a caller is on hold after he or she is transferred by the IVR system to a specific queue. We report on how long callers waited before hanging up without

[1] For most of the analysis in this section we used data from August 2013. Due to concerns from the OCIO that the August busy signal data might be less reliable, we used July data for this analysis instead.
[2] The number of answered and abandoned calls is 2,059 calls (0.2 percent) less than the total number of calls. According to the OCIO, these were likely calls that rang at the call center employees' desks but were not answered and were returned to the queue.

talking to a call center employee (abandoned calls) and how long they waited when they were connected to call center employees (answered calls). Wait times for individual calls were not available, so we report on average wait times and maximum wait times instead.

Chart 2.2. Abandoned Calls by Queue, Sept. 2012 to Aug. 2013



Source: Graph prepared by the Legislative Audit Office using Windstream data.

Our key findings relating to wait times are that recent data showed DHHS was not meeting its goal of an average wait time of three minutes or less and it was not uncommon for wait times in two queues to be 45 minutes or more. The Case Aides queues, which handle simpler questions, had wait times close to the three-minute goal but the other queues, especially those dealing with family eligibility, were much higher. We estimate that thousands of callers with family eligibility cases waited 45 minutes or more in August 2013.

We also found that the average wait time and the maximum wait times got worse, not better: both increased considerably for all queues from September 2012 to August 2013.

Finally, we found some slight differences between the English/Other and Spanish queues—all with a positive impact for the Spanish-speaking callers—but the numbers involved were so small that we are hesitant to read too much into the differences.

A detailed analysis of these issues follows.

Reporting Requirement (LB 374, 2011)

DHHS is required to report to the Legislature quarterly data on ACCESSNebraska, including the average wait time for answered and abandoned calls. We found DHHS had been reporting the average wait time for answered calls but did not start reporting the average for abandoned calls until October 2013.

Finding: Prior to October 2013, DHHS did not report the average wait time for abandoned calls as required by LB 374.

Average Wait Times

DHHS's goal is to have average wait times of three minutes or less, a rate recommended as an industry standard by the software provider for the call center computer system. To determine whether that goal was being met, we reviewed data reported by DHHS and additional data from Windstream.

Average Wait Times—All Queues

In September 2013, DHHS reported the following average rates for answered calls for the most recently completed quarter:

- 15:29 (minutes and seconds) for April 2013;
- 17:59 for May 2013; and
- 22:45 for June 2013.

For our analysis of wait times, we began with call center data from September 1, 2012, to August 31, 2013, which was the most recently completed 12-month period at the time of the audit. Data for that period showed the average wait time was 21 minutes for answered calls and 16 minutes for abandoned calls. (DHHS reports wait times in minutes and seconds, but we report them in minutes only with the seconds rounded to the nearest minute.)

Additionally, as we discuss later in this section, the average wait times DHHS is required to report do not reflect differences among the queues of which policymakers should be aware.

Finding: Recent average call wait times for the queues combined were much higher than DHHS's goal of an average of three minutes or less.

Average Wait Times by Queue

As mentioned earlier, DHHS tracks call information using 10 queues, which are broken down into two groups: English/Other—five primarily for English-speaking clients and including other (non-Spanish) languages through an interpreter service; and Spanish—five for Spanish-speaking clients. Calls in the Spanish queues made up just six percent of all answered calls.

We found noticeable differences among the queues. The Case Aide queues had the lowest average wait times and the Family Change and Family Interview queues had the highest averages. Additionally, for answered calls, the Spanish Family Change queue had an average wait time somewhat lower than its English/Other counterpart. The complete breakdown is shown in the following table.

Table 2.2. 12-Month Average Wait Times, Sept. 2012 to Aug. 2013

Queue	Average Wait (Minutes)	
	Answered Calls	Abandoned Calls
Family Change (English/Other)	32	17
Family Change (Spanish)	26	17
Family Interview (English/Other)	31	18
Family Interview (Spanish)	28	18
Adult Interview (English/Other)	19	14
Adult Interview (Spanish)	18	13
Adult Change (Spanish)	17	13
Adult Change (English/Other)	16	12
Case Aides (English/Other)	4	5
Case Aides (Spanish)	4	5

Source: Table prepared by the Legislative Audit Office using Windstream data.

Finding: None of the queues met the Department's wait time goal of an average of three minutes or less for either answered or abandoned calls. However, the Case Aides queues came close with an average of four minutes for answered calls and five minutes for abandoned calls.

Average Wait Times—Change Over Time

In addition to reviewing the average wait times for the whole 12-month period, we looked at whether the rates for each queue had gone up or down from the first to the last month of that period. We found that the average wait time increased for both answered and abandoned calls. In all cases, there were ups and downs in the averages throughout the 12-month period; however, all trended upwards from April or May 2013 to August 2013.

For answered calls, the Case Aides queue showed the largest increases (200 percent for Spanish and 150 percent for English/Other), but the wait times were so low initially that even with the increases, the wait times only reached five to six minutes; far lower than any other queue. Increases in the other queues ranged from 45 percent to 118 percent.

The Family Interview (Spanish) and Adult Interview (Spanish) queues started at about the same place as their English/Other counterparts but increased less over time.

The complete breakdown is shown in Table 2.3 on page 20.

We also reviewed the change in average wait times between September 2012 and August 2013 for *abandoned* calls and found that the Case Aides (English/Other) queue had the largest increase but only reached five minutes. Increases in the other queues ranged from 47 percent to 79 percent.

Finding: Between September 2012 and August 2013, the average wait time for answered and abandoned calls increased more than 50 percent for almost all queues.

If the number of calls increased significantly over the 12-month period, that could be a factor in the increased wait times; however, we found the opposite was true. The number

Table 2.3. Monthly Average Wait Times for Answered Calls, Change Over Time

Queue	Average Wait Time (minutes)		Amount of Increase	
	Sept 2012	Aug 2013	Minutes	Percent
Case Aides (Spanish)	2	6	4	+200%
Case Aides (English/Other)	2	5	3	+150%
Family Interview (English/Other)	22	48	26	+118%
Family Interview (Spanish)	22	40	18	+82%
Adult Interview (English/Other)	17	36	19	+112%
Adult Interview (Spanish)	20	29	9	+45%
Family Change (Spanish)	18	37	19	+106%
Family Change (English/Other)	25	45	20	+80%
Adult Change (English/Other)	13	26	13	+100%
Adult Change (Spanish)	16	26	10	+63%

Source: Table prepared by the Legislative Audit Office using Windstream data.

of calls answered (all queues) dropped from 89,449 in September 2012 to 66,337 in August 2013. Calls to all of the queues except one decreased during that time. The exception was the Family Interview queue, which increased by 126 calls.

Finding: The number of answered calls decreased from September 2012 to August 2013, so the number of calls was not a factor in the increased wait times.

Average Wait Times, Answered Calls—August 2013

To further understand the differences in average wait times at the queue level, we looked in more detail at data on answered calls in August 2013. For each queue, we reviewed the average wait time for each of the 22 business days in August.[3] We

[3] We did not have complete data for August 30 so we used data from July 31 instead. Therefore, the 22 days we used were from 7/31/2013 through 8/29/2013.

found that the Case Aide queues had much lower daily averages than did the other queues. For every day in August, the average wait time for the Case Aides queues was 15 minutes or less.

The Family Interview and Family Change queues had the highest average wait times. For the Family Interview queues, 21 of the 22 days had an average wait time between 31 and 63 minutes. Only one day had an average under 30 minutes. The Family Change (English/Other) also had only one day in the month with an average wait time under 30 minutes, although the Family Change (Spanish) queue had three such daily averages. For of the rest of the days, the average was between 31 and 60 minutes.

For the Adult Change and Adult Interview queues, about half of the days had averages below 30 minutes and half had averages above 30 minutes.

The complete breakdown is shown in the following table.

Table 2.4. Daily Average Wait Times for Answered Calls, 24 Business Days in August 2013

Queue	Minutes						
	0 to 15	16-30	% < 30	31-45	46-60	Over 60	% > 30
Case Aides (English/Other)	22	0	100%	0	0	0	0
Case Aides (Spanish)	22	0	100%	0	0	0	0
Adult Change (English/Other)	3	9	55%	8	2	0	45%
Adult Change (Spanish)	4	8	55%	8	2	0	45%
Adult Interview (Spanish)	4	8	55%	9	1	0	45%
Adult Interview (English/Other)	3	7	45%	6	6	0	55%
Family Change (Spanish)	0	3	14%	19	0	0	86%
Family Change (English/Other)	0	1	5%	11	10	0	95%
Family Interview (English/Other)	0	1	5%	7	13	1	95%
Family Interview (Spanish)	1	0	5%	17	3	1	95%

Source: Table prepared by the Legislative Audit Office using Windstream data.

Finding: The Case Aide queues had the lowest average wait times and the queues that dealt with family cases had the highest.

Maximum Wait Times

The maximum wait time describes the longest single wait time in a given time period. Since, by definition, the average wait times level out the highest and lowest numbers in the group, we reviewed the maximum wait time data for both answered and abandoned calls to get an idea of the longest times clients waited.

For the period of September 2012 through August 2013, we again found noticeable differences among the queues:

- For answered calls, the Case Aide (Spanish) queue had the lowest maximum wait time—49 minutes—and the Family Change (Spanish) queue had the highest maximum wait time—1 hour and 48 minutes.
- For abandoned calls, the Adult Interview (Spanish) and the Case Aides (Spanish) queues had the lowest maximum wait times—53 and 54 minutes, respectively. The Family Interview queue had the highest maximum wait time—1 hour and 41 minutes.[4]

The complete breakdown is shown in Table 2.5 on page 23.

Finding: The maximum wait times for both answered and abandoned calls range from almost one hour to nearly two hours.

Maximum Wait Times—Change Over Time

In addition to reviewing the maximum wait times for the whole 12-month period, we looked at whether the rates for answered calls in each queue had gone up or down from the first to the last month of that period.

In all cases, there were ups and downs in the maximums through the 12-month period; however, all trended upwards from April or May 2013 to August 2013. The Case Aides queue showed the largest increases (110 percent for Spanish and 100 percent for English/Other). Increases in the other queues ranged from 37 percent to 78 percent, as shown in Table 2.6 on page 24.

[4] This is actually the second highest time for the Case Aides (English/Other) queue during this period. We omitted the highest—1 hour and 55 minutes—because it happened during a period in which Case Aides were temporarily assisting with Change Management calls, which we determined made it an anomaly.

Finding: Between September 2012 and August 2013, the maximum wait time for answered calls increased more than 50 percent for most queues.

Table 2.5. 12-month Maximum Wait Times, Sept. 2012 to Aug. 2013

Queue	Maximum Wait Time (hours:minutes)	
	Answered Calls	Abandoned Calls
Family Change (Spanish)	1:48	1:21
Family Change (English/Other)	1:43	1:40
Family Interview (Spanish)	1:43	1:24
Family Interview (English/Other)	1:42	1:41
Adult Interview (English/Other)	1:30	1:12
Adult Interview (Spanish)	1:14	:53
Adult Change (English/Other)	1:27	1:20
Adult Change (Spanish)	1:16	1:00
Case Aides (English/Other)	1:02	1:01[4]
Case Aides (Spanish)	:49	:54

Source: Table prepared by the Legislative Audit Office using Windstream data.

Maximum Wait Times, Answered Calls—August 2013

As with the average wait times, we reviewed the maximum wait times for each day in August for each queue. The Case Aides queues had noticeably lower maximum wait times than the other queues; for the majority of days in August, the maximum wait time was less than 30 minutes and very few were more than 45 minutes.

In contrast, the Family Interview and Family Change queues had no days with a maximum wait time of 30 minutes or less and, combined, had only one day with a maximum of 45 minutes or less. For the other 21 days, the maximum was 46 minutes or more, with a high of 92 minutes. The daily maximum wait times for the Adult Change and Adult Interview queues were slightly lower than for the Family

Interview and Change queues: the vast majority were over 30 minutes, but fewer were over 46 minutes.

Table 2.6. Monthly Maximum Wait Times for Answered Calls, Change over Time

Queue	Maximum Wait Times (minutes)		Amount of Increase	
	Sept 2012	Aug 2013	Minutes	Percent
Case Aides (Spanish)	20	42	22	+110%
Case Aides (English/Other)	31	62	31	+100%
Adult Change (English/Other)	49	87	38	+78%
Adult Change (Spanish)	16	26	10	+63%
Adult Interview (English/Other)	53	90	37	+70%
Adult Interview (Spanish)	54	74	20	+37%
Family Interview (Spanish)	52	86	34	+65%
Family Interview (English/Other)	64	92	28	+44%
Family Change (English/Other)	52	85	33	+64%
Family Change (Spanish)	49	78	29	+59%

Source: Table prepared by the Legislative Audit Office using Windstream data.

We were concerned about the wait times of 30 minutes or more and looked at them in more detail.

Very High Wait Times

Beyond the CFS goal that calls be answered, on average, in three minutes or less, there is no set standard for what is "too long" for callers to wait to get through to call center employees. We decided that a wait time of 45 minutes or more was "very high" but acknowledge that others might select a higher or lower number.

Because of limitations in the available data, we could not report the actual number of wait times lasting 45 minutes or more in the month we reviewed. Instead, we estimated that number based on the average and maximum wait times at the

smallest increment compiled by Windstream: daily 15-minute periods.[5] For each 15-minute period during which calls are answered (for example, 8:00 to 8:15 a.m.), Windstream calculates the average wait time and identifies the maximum wait time.

We reviewed the 15-minute wait time data for the Family Change (English/Other) queue on August 22 and 23, 2013. We chose that queue because it had higher overall average wait times and chose those days because one had the highest average wait time for the month (50 minutes) and one had the lowest average wait time (27 minutes). Although the average wait times varied, the days had about the same number of answered calls: 1183 and 1199, respectively.

For each day, we identified the 15-minute periods that had a *maximum* wait time of 45 minutes or more. We found that:

- On August 22, 36 of 40 (90 percent) 15-minute periods had a maximum wait time of 45 minutes or more. The wait times ranged from 46 minutes to 1 hour and 16 minutes; and
- On August 23, 20 of 40 (50 percent) 15-minute periods had a maximum wait time of 45 minutes or more. The wait times ranged from 47 minutes to 1 hour and 25 minutes.

These data show that *at a minimum*, 36 callers on August 22 and 20 on August 23 waited 45 minutes or more to be connected with a call center employee. Many of the periods with a maximum wait time of 45 minutes or more also had average wait times of 45 minutes or more, suggesting that additional wait times in those periods were at least 45 minutes long.

We tested different scenarios and found that typically 50 to 75 percent of the actual wait times in these periods would have to have been for 45 minutes or more in order to get such a high average.[6] We applied the 50 and 75 percent figures to the actual number of calls in the 15-minute periods with an average and maximum wait times of 45 minutes or more on August 22 and 23. The result was an estimate of 467 to 701 actual wait times of 45 minutes or more on August 22, and 189

[5] Appendix I contains additional information on our methodology for this analysis.
[6] An example: one 15-minute period with 28 answered calls had a maximum wait time of 60 minutes and an average wait time of 57 minutes. To reach that average with 28 calls and a maximum of 60 minutes, *at least* 22 of the actual wait times had to have been for 45 minutes or more (79 percent).

to 284 on August 23. These figures are shown in Table 2.7.

Table 2.7. Family Change (English/Other) Queue, Estimated Number of Calls with Wait Times of 45 Minutes or More

Date	15-minute Periods with Maximum & Average Wait Times ≥ 45 Minutes	
	Actual Number of Calls	Est. Number with Wait Times ≥ 45 Minutes
August 22	934	467 to 701
August 23	378	189 to 284

Source: Table prepared by the Legislative Audit Office using LAO analysis based on Windstream data.

Because all of the 22 business days in August had similar proportions of 15-minute periods with very high average and maximum wait times, we also applied our estimates to all days. This resulted in a range for the month of 8,606 to 12,920 estimated actual wait times of 45 minutes or more.

Finally, we also found that the Family Interview (English/Other) queue had a similar distribution of 15-minute periods with maximum and average wait times of 45 minutes or more. We applied the above percentages to the 6,994 calls answered by that queue, resulting in an estimate of 2,308 to 3,427 wait times of 45 minutes or more.

Combining the two queues, we estimate that 10,914 to 16,347 call wait times lasted 45 minutes or more.

Finding: In August 2013, an estimated 10,914 to 16,347 callers in the Family Change and Family Interview (English/Other) queues experienced wait times of 45 minutes or more.

As mentioned at the beginning of this section, DHHS is required to report the average wait times for answered and abandoned calls. The above data reflect important points about the wait times of individual queues that are not evident from the broader averages. In particular, although August 23 had a much lower average wait time than did August 22, both days had many long wait times of 45 minutes or more.

Finding: Average wait times for all queues disguise important differences in wait times among queues.

Work Task Backlog

Work tasks are automated messages telling the DHHS worker that work may need to be completed on a client master case.[7] Work tasks are created in three situations: (1) when certain case actions occur (for example, when an application is received for expedited SNAP benefits, the system creates the work task, "interview needed"); (2) when certain alerts exist (for example, "mail received" or "application received," the system creates the work task "alerts exist"); and (3) when a worker determines that certain actions must be taken based on policy/procedure. Some work tasks can only be completed by lead workers and supervisors. The AN system receives 500 to 600 new work tasks per day and workers are able to complete 400 to 500 per day.

Table 2.8 on page 28 provides data regarding the backlog of work tasks by tracking the monthly number of total unfinished work tasks from September 2012 through August 2013.

One factor affecting the number of unfinished work tasks is the periodic application of MESAs, which are automated processes to determine eligibility based on changes which affect a large number of clients. For example, MESAs will run to apply an annual cost of living allowance (COLA) or a federally approved standard utility allowance (SUA). Although MESAs save manual work for staff, they can create many work tasks if the computer cannot automatically process the information. It is difficult to determine how many work tasks will be created by a given MESA run.

Because the time to complete a work task depends on the nature of the individual task, we cannot make a determination about the total amount of staff time it would take to reduce the backlog. It is also unknown what an acceptable number of backlogged work tasks is – the department has stated that there are no federal standards governing this and the department itself has set no internal goal.

Finding: DHHS has no standard for determining an acceptable number of unfinished work tasks.

[7] The master case contains data about the public assistance household and is created when a client first applies for assistance.

Table 2.8. Unfinished Work Tasks, Sept. 2012 to Aug. 2013

Month	High	Low	Average
September 2012	43,024	26,505	36,565
October 2012	57,194	37,173	51,936
November 2012	81,259	53,040	67,407
December 2012	82,287	57,758	66,645
January 2013	65,993	61,784	64,092
February 2013	71,981	63,081	67,726
March 2013	72,802	60,488	65,654
April 2013	69,276	60,531	65,439
May 2013	81,574	65,229	74,855
June 2013	88,126	77,534	85,334
July 2013	77,270	51,841	65,583
August 2013	56,269	48,494	52,207

Source: Table prepared by the Legislative Audit Office using DHHS data.

Work tasks older than five days

The department tracks work tasks older than five days separately from newer work tasks. Table 2.9 shows the average monthly number of work tasks which have been in the system more than five days from September 2012 to August 2013. It also shows these numbers as a percentage of the total average unfinished work tasks for that month.

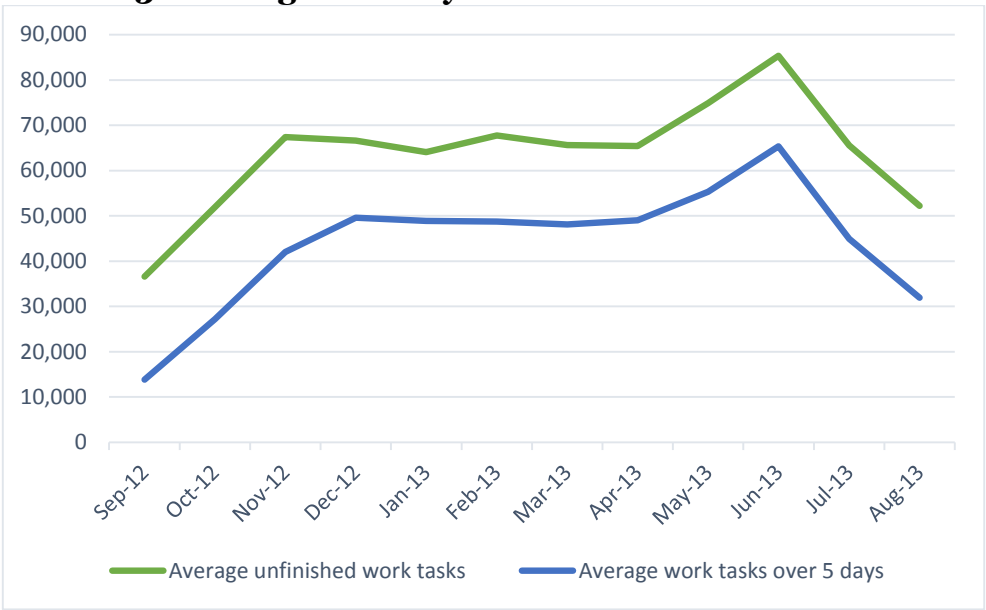
Table 2.9. Work Tasks Older Than 5 Days, Sept. 2012 to Aug. 2013

Month	High	Low	Average	% of All Unfinished Work Tasks (Average)
September 2012	19,753	3,672	13,838	38%
October 2012	33,952	17,331	27,214	52%
November 2012	59,241	32,429	42,044	62%
December 2012	60,819	43,659	49,619	74%
January 2013	50,319	47,004	48,856	76%
February 2013	52,357	45,163	48,715	72%
March 2013	52,424	44,836	48,074	73%
April 2013	51,393	45,975	49,012	75%
May 2013	64,230	47,433	55,297	74%
June 2013	68,992	59,388	65,328	77%
July 2013	57,283	32,783	44,919	68%
August 2013	33,769	28,897	31,892	61%

Source: Table prepared by the Legislative Audit Office using DHHS data.

Chart 2.3 shows both the average unfinished work tasks and the work tasks over five days for the September 2012 to August 2013 time period.

Chart 2.3. Average Monthly Work Tasks



Source: Chart prepared by the Legislative Audit Office using DHHS data.

Finding: For 7 out of the 12 months presented, work tasks older than 5 days comprised approximately 75 percent of the total backlog. For 11 out of the 12 months presented, the older tasks comprised a majority of the total backlog.

DHHS administrators stated that their goal was to reduce the number of work tasks older than five days to 25,000 by the time of the October 1 Medicaid transition. However, on the date of the transition, this number was 38,122. The department did reduce this figure to 28,095 on September 9, 2013, but due to a SNAP MESA run on September 15th, 17,069 new work tasks were added.

Finding: DHHS did not meet its goal of reducing the backlog of work tasks older than five days to 25,000 by October 1, 2013.

Section III: Online and Web-based Eligibility Systems in Other States

In order to provide the Legislature and the Committee with information about online and Web-based eligibility systems, including call centers, so that members can better address the problems with ACCESSNebraska, our Office reviewed literature about the systems in other states. In this section we begin by providing a brief summary of the benefits and challenges of automated systems. Next, we present highlights from the articles we thought were the most current and informative, considering the issues faced by ACCESSNebraska. We conclude with brief descriptions of the call centers in Florida and Utah, two states that Nebraska consulted in the development of ACCESSNebraska.

Benefits and Challenges Presented by Automated Public Assistance Systems

Increased demand for public benefits, driven by continuing economic pressures on families and individuals, coupled with state government budget reductions, have prompted public and private entities to develop more efficient, Web-based methods for processing applications. Some states have transitioned to online systems for efficiency and as a way to reduce state workforce and shift more of the application tasks onto the applicants.

Online and web-based public assistance eligibility systems, including call centers, provide many benefits to clients, as well as the economy as a whole. Advantages to clients include: increased flexibility (i.e., reduction of multiple trips to the office and out of office service); easier access to case information and the ability to report changes; reduction in verification requirements; and increased efficiency. These benefits may be particularly helpful to the elderly or people who work during public assistance office hours.

Advantages to the economy include increased sales tax revenue as a result of enrollment of individuals for SNAP.[1]

[1] The USDA estimates that every dollar in food stamp benefits generates $1.84 in economic activity.

One study found that as much as an estimated $65 billion in public benefits remained unclaimed by individuals or families due to perceived stigma attached to receipt of public assistance, confusion about eligibility requirements, and complicated application processes.

Of course, challenges to automation also exist: for example, inadequate technology or staffing can reduce the level of service to clients; call centers without access to electronic records or with substandard document imaging systems can increase the likelihood of clients receiving erroneous information. Financial resources can be a major determinant of the sophistication of Web-based benefit tools, but a majority of states now have some form of integrated online and Web-based public assistance eligibility system with capabilities beyond the printable application *(see Appendix 2)*. However, very little research has been conducted on the impact of online technologies.

Literature Reviewed

Karissa Hughes, "Review of the Research: Call Centers and Web-based Eligibility Systems," *Southern Area Consortium of Human Services, Academy for Professional Excellence, San Diego State University School of Social Work,* December 2010

This article provides a summary of the call center and web-based eligibility systems in eight states and recommendations based on their experiences.[2]

According to Hughes' research, successful call management has four characteristics.

- The number of tasks completed in a month by an individual, a unit and the service center as a whole increases;
- Workers understand and approve of how tasks are assigned;
- Staff work together to complete a common goal and

[2] These states are: Florida, Idaho, Massachusetts, New York, Texas, Utah, Washington and Arizona.

strive to keep the common workload manageable; and

- Supervisors have confidence that staff will seek out tasks rather than having to push tasks upon them.

Recommendations to achieve successful call management include:

- Develop software which allows the mass electronic importation and assignment of tasks into a task management tool;
- Monitor *average handle time (AHT)*, which is the total amount of handle time divided by total number of calls handled. Handle time includes the amount of time talking on the phone, time on hold and the time completing after call work. This is important because it helps predict the number staff needed during specific time frames in order to minimize call wait times; and
- Develop a productivity calculator. This is a report that compares the number of completed tasks and handled phone calls by an individual to the number of hours that person worked in a month, considering total available hours to work. This practice shifts the performance measure focus to the outputs of staff (positive) rather than what has not been completed (negative). Additionally, using percentages instead of actual numbers allow an employee to see how they compare to others in their unit without sharing specific scores and is a way to recognize efficiency. It also allows the agency to set percentages of acceptable performance as work increases or decreases.

Finally, Hughes presents specific recommendations from other states based on their experiences. Some of these are:

- Increase access points in the community with combined community partnership (Florida);
- Provide more in-depth interviews for high risk cases (Florida);
- Measure and respond to customer volume. Have flexible staffing models to address daily volume of

calls (Idaho);

- Ensure the technology has the capacity to handle increased usage before implementing a process that relies on it heavily (Massachusetts);
- Call center workers need to have experience; errors made due to inexperience can significantly delay application processing time (Texas);
- Implement new systems gradually; use pilots and bring up the system in multiple stages (Utah);
- Find system fixes for abandoned calls and provide a way for clients to be routed back to the same worker if their call is disconnected causing the client to have to repeat information all over again (Utah);
- Involve your customers, e.g., through customer surveys (Washington); and
- Use an *outbound* IVR (e.g., to remind clients of appointments (Arizona).

United States Government Accountability Office, *Food Stamp Program: Use of Alternative Methods to Apply for and Maintain Benefits Could be Enhanced by Additional Evaluation and Information on Promising Practices,* May 2007

This report surveyed the 50 states to present data regarding the application for public assistance benefits through online and Web-based systems and call centers. GAO presented valuable information based on its survey, regarding measures states used to evaluate the performance of online services, as well as the measures used to evaluate call centers.

Performance Measures for Online Services;

- Number of applications submitted online;
- Number of applications terminated before completion;
- Customer satisfaction;

- Timeliness of application processing;
- Accuracy of information contained on the Web site;
- Payment accuracy; and
- Administrative cost savings.

Performance Measures for Call Centers:

- Number of transactions completed through the call center;
- Number of calls answered during a specified time period;
- Customer satisfaction;
- Abandonment rate;
- Call length;
- Average answer speed;
- Hold time;
- Accuracy of information provided by call center staff;
- Number of calls transferred to other systems;
- Administrative cost savings;
- Payment accuracy;
- Timeliness of application processing;
- Number of times a client calls about a particular issue; and
- Rate of first contact resolution.

Florida and Utah

As mentioned above, following are brief descriptions of the online and Web-based systems, focusing on call centers, in Florida and Utah. We talked to call center administrators in both states and our impression was that both have developed successful systems, at least as evidenced by overall call center wait times: 10 minutes in Florida and 8 minutes in Utah.

ACCESS Florida

ACCESS Florida call centers were first established in 2004 and were rolled out in stages by geographic area. Originally, each of the state's six social services regions had its own call center and took calls only from within its region. By 2012, the state adopted a single 800 number for all call centers. Once the system became statewide, it experienced a "blockage" rate (the percentage of callers who could not access the IVR) of 70 percent. The blockage rate is now approximately six percent.

Call centers were established by the Florida Department of Children and Families (DCF), in large part, because of state government cuts and a drive toward modernization that resulted in a staff reduction of 50 percent.

ACCESS Florida administrators attributed the success of its system to the following factors:

- An expanded IVR system that reduced the percentage of calls transferred into the call centers from about 90 percent to approximately 50 percent;
- Specialization. At one time, call center staff conducted interviews as well as being responsible for completing work tasks. Now, although call center staff occasionally conduct interviews, these workers' primary responsibilities are to answer general process questions and to update case information. *Virtual Intake Unit* workers are responsible for conducting interviews, while work tasks are completed by *Case Maintenance Unit* staff. A separate, eligibility unit makes eligibility determinations and this unit rarely has direct contact with clients; and
- A real-time, self-service Web site.

Utah (eREP)

Development of eREP (electronic Resource and Eligibility Product) began in 2002 and is a rules-based eligibility determination system for 25-30 programs including TANF (formerly ADC), SNAP, Medicaid and child care assistance. Additionally, there are three online tools which assist the client in interacting with eREP: 1) *Utah Helps* is a benefit screener and allows clients to submit applications online; 2) *myCase* allows clients to receive information about active

cases; and 3) *Utah Cares*, which started as a resource and referral site and has become *Utah 2-1-1 Information and Referral*, a program of Utah Food Bank Services. This online system shifts case management responsibilities from state staff to clients and has allowed Utah to reduce its eligibility workforce. Moreover, eREP is able to determine a client's eligibility within a 96% accuracy rate using federal and state databases for matching.

Utah also has three call centers that serve the entire state. Prior to the conversion to an online and Web-based system, eligibility staff were organized by regions. All regions are now merged into one statewide system and all interactions are conducted by phone.[3]

After the conversion, Utah experienced many of the same problems as Nebraska in terms of excessive call wait times, which ranged from 20 to 90 minutes. Utah addressed this issue by hiring an "optimizer" to determine the volume of staff needed; organizing teams by program; and clearly defining expectations regarding the length of time staff was to spend on the phone. Cases are assigned to specific workers, but any worker on the team must be able to respond to questions about any case assigned to the team. More complex cases are assigned to more experienced workers and teams. Staff spend half of the day on the phone and the other half working their cases. Like Nebraska, eREP also has a queue system, but utilizes many more queues (60).

Finally, Utah instituted a pay for performance plan where incentive payments are given to workers who *both* maintain a 90% accuracy rate *and* a 90% call answer rate.

[3] Certain populations with access issues have special teams (e.g., Native Americans, refugees and long term care clients). However, even among these groups there is a 90% online usage rate; the remaining 10% grant third party access to a family member or community based organization to assist them. This option is available to the elderly or those without computer/internet access.

APPENDIX 1: Call Wait Time Analysis—Methodology

Available Data

We were unable to obtain individual call-level data because Windstream does not provide that information to DHHS or OCIO. On our behalf, the OCIO requested Windstream provide call wait time data for August 2013 compiled into increments such as 0 to 10 minutes, 11 to 15, etc. However, because Windstream does not currently report the data in that way, they requested $3,000 for their developers to design a report that would compile the data. We chose to rely on existing compilations instead.

Very High Wait Times

Queue Selection

All queues except for Case Aides had some 15-minute periods with both a maximum and average wait time of 45 minutes or more. We chose the Family Change (English/Other) queue for additional review because it had a high number of those periods as well as the most calls of any queue. Consequently, it was the queue with the most wait times of 45 minutes or more.

We applied our estimates for that queue (described below) to the Family Interview (English/Other) queue, which had a similar number of 15-minute periods with both a maximum and average wait time of 45 minutes or more, but had fewer calls.

The Adult queues had fewer days with at least one maximum wait time of 45 minutes or more. And those days had lower proportions of 15-minute periods with an average and maximum wait time of 45 minutes or more.

Similarity Between Family Change and Family Interview Queues

Queue	Days in August 2013 with at least one maximum wait time of 45 minutes or more	For each day: Range of 15-minute periods with at least one maximum wait time of 45 minutes or more
Family Change (English/Other)	22 (all)	20 to 39
Family Interview (English/Other)	22 (all)	18 to 39
Adult Change (English/Other)	17	2 to 32
Adult Interview (English/Other)	18	2 to 35

Specific Day Selections

For our in-depth review, we selected the day with the lowest average wait time during the month of August for the Family Change (English/Other) queue, and one of the three days with the highest average wait time that month (shown below).

Date	Average Wait Time	Answered Calls	Maximum Wait Time	15-min periods with Max ≥ 45 minutes	15-min periods with Max & Average ≥ 45 minutes
August 2	50:08	1,158	1:21	39	36
August 12	49:41	1,230	1:17	39	33
August 22	49:59	1,183	1:11	36	31

We chose the 22nd because, of the three, it had the fewest number of 15-minute periods with both the maximum wait time and average wait time of 45 minutes or more, which made it the most conservative choice.

The other date we chose, August 23, was highly unusual. It was the only day in the month with many 15-minutes periods that had average wait times of 15 minutes or less. The 23rd had 14 such periods, whereas most of the days had only one. (Two days had two, and one day had four.) The unusual number of periods with low average wait times offset the periods with high averages to create the lower daily average of 27 minutes.

Scenarios for Estimating the Number of Wait Times of 45 Minutes or More

For the Family Change (English/Other) queue, we identified the 15-minute periods with maximum wait times of 45 or more: 36 on August 22 and 20 on August 23. Of those periods, most also had average wait times of 45 minutes or more: 31 on August 22 and 18 on August 23.

In an Excel spreadsheet, we created scenarios for different 15-minute periods using the number of wait times, the maximum wait time and the average wait time. We entered the maximum in a spreadsheet and tried different combinations of times to determine the minimum number of times equal to or over 45 minutes that were needed to reach the average for that period.

In the body of the report, we used an example from August 23 because of its relative simplicity. The 15-minute period had 28 calls, an average wait time of 57 minutes, and a maximum wait time of 60 minutes. We found that there had to be at least 22 wait times of 45 minutes or more (79 percent) to get the average of 57 if the maximum could be no more than 60. It's worth noting that the other 6 wait times had to be 44 minutes—meaning that all 28 wait times were quite high.

We created similar scenarios for the thirty-one 15-minute periods on August 22 that had both an average and maximum wait time of 45 minutes or more. We found that for most

of those periods (21) over 50 percent of the wait times were for 45 minutes or more. (The percentages ranged from 56 to 90 per 15-minute period.) The other 10 periods had less than 50 percent of their wait times under 45 minutes. (The percentages ranged from 21 to 49 percent.)

August 22 Family Change (English/Other)

All 15-minute periods with calls	40
15-minute Periods with Average and Maximum Wait Times of 45 Minutes or More	31
Of the 31, number of periods that had more than 50 percent of wait times of 45 minutes or more (range per period: 56 to 90)	21
Of the 31, number of periods that had less than 50 percent of wait times under 45 minutes (range per period: 21 to 49%)	10

From these tests, we concluded that if the average and maximum wait time for a 15-minute period were 45 minutes or more, in most instances at least 50 percent and often 75 or more of the calls had wait times of at least 45 minutes.

On August 22, there were 934 calls in the 15-minute periods with a maximum and average wait time of 45 minutes. Applying the 50 and 75 percent figures, results in an estimate of 467 to 701 wait times of 45 minutes or more

On August 23, there were 378 calls in the 15-minute periods with a maximum and average wait time of 45 minutes. Applying the 50 and 75 percent figures, results in an estimate of 189 and 284 wait times of 45 minutes or more.

Note that some very long waits times on those days are excluded from these estimates, such as those in the 15-minute periods with a maximum of 45 minutes or more but an average of less than 45 minutes (each day in August had at least one for the family queues).

Estimate for other days in August

To get an estimate for the entire month, we multiplied the daily ranges by the number of business days in August, adjusting for the daily proportion of 15-minute periods with a maximum and average wait time of 45 minutes or more.

More than 50 percent of the 15-minute periods on August 22 had average and maximum wait times of 45 minutes or more. Of the remaining business days, 15 had similar proportions. The resulting range was 7,472 (16 x 467) to 11,216 (16 x 701) for the month.

Less than 50 percent of the periods on August 23 had those high averages and maximums and five other days had similar proportions. The resulting range was 1,134 (6 x 189) to 1,704 (6 x 284) for the month.

The combined total was 8,606 (7,472 + 1,134) to 12,920 (11,216 + 1,704).

	50%	75%
August 22	467	701
15 similar days	7,005	10,515
Total	7,472	11,216
August 23	189	284
5 similar days	945	1,420
Total	1,134	1,704
Combined Total	8,606	12,920

Estimating for the Family Interview Queue

The calculations above deal with only those 15-minute periods that had an average and maximum wait time of 45 minutes or more. Of *all the calls answered* (26,510) in the Family Change (English/Other) queue, 8,606 is 33 percent and 12,920 is 49 percent.

Applying those percentages to the 6,994 calls answered by the Family Interview (English/Other) queue in August 2013 results in an estimate 2,307 to 3,427 calls with average and maximum wait times of 45 minutes or more.

The combined figures for the two queues make up our total estimate of 10,914 to 16,347 for August 2013.

Queue	All Answered Calls August 2013	33% of All	49% of All
Family Change (English/Other)	26,510	8,606	12,920
Family Interview (English/Other)	6,994	2,308	3,427
August Total	33,504	10,914	16,347

Note that this estimate does not include all of the wait times of 45 minutes or more in August 2013 because both of the adult queues also had some, which we did not estimate.

Family Change (English/other) Queue - August 22, 2013

Skillset By Application

Report Interval: 7/ 1/2013 8:00:00 AM - 8/30/2013 5:59:59 PM (GMT-06:00)
Site Name: SONCCMS01
Table Name: iSkillsetStat

15-minute periods with average + maximum wait times of 45min. or more.

Date	Time	Skillset Answered	Skillset Answered After Thresh	% Ansd After Thresh	Answer Delay	Average Answer Delay	Maximum Answer Delay
8/22/2013 :							
	08:00	42	13	30.95	00:44:20	00:01:03	00:11:10
	08:15	20	20	100.00	06:10:46	00:18:32	00:23:47
	08:30	20	20	100.00	10:33:29	00:31:40	00:37:00
	08:45	24	24	100.00	16:43:45	00:41:49	00:46:28
	09:00	39	39	100.00	27:24:14	00:42:10	00:51:00
	09:15	22	22	100.00	20:32:51	00:56:02	01:01:06
	09:30	37	35	94.59	34:25:21	00:55:49	01:03:43
	09:45	32	31	96.88	33:29:31	01:02:48	01:07:39
	10:00	53	50	94.34	49:42:07	00:56:16	01:04:39
	10:15	30	27	90.00	25:41:32	00:51:23	01:01:19
	10:30	31	30	96.77	29:37:46	00:57:21	01:02:33
	10:45	27	27	100.00	24:16:05	00:53:56	01:05:58
	11:00	26	26	100.00	26:51:17	01:01:58	01:06:26
	11:15	36	34	94.44	35:46:43	00:59:38	01:08:47
	11:30	44	44	100.00	41:03:59	00:56:00	01:02:28
	11:45	23	22	95.65	18:04:55	00:47:10	00:54:55
	12:00	20	19	95.00	14:26:51	00:43:21	00:58:17
	12:15	25	23	92.00	19:50:50	00:47:38	01:02:13
	12:30	21	20	95.24	18:02:56	00:51:34	01:03:59
	12:45	29	29	100.00	28:02:22	00:58:01	01:06:03
	13:00	29	28	96.55	28:34:17	00:59:07	01:06:49
	13:15	56	55	98.21	48:26:25	00:51:54	01:03:31
	13:30	34	33	97.06	24:32:04	00:43:18	00:52:10
	13:45	28	28	100.00	21:55:44	00:46:59	00:57:13
	14:00	34	34	100.00	26:15:37	00:46:21	00:55:26
	14:15	26	25	96.15	16:51:15	00:38:54	00:58:36
	14:30	34	30	88.24	27:41:46	00:48:53	01:02:12
	14:45	25	25	100.00	23:20:11	00:56:00	01:02:46
	15:00	28	28	100.00	27:02:11	00:57:56	01:00:27
	15:15	25	25	100.00	24:20:11	00:58:24	01:00:57
	15:30	21	21	100.00	19:38:17	00:56:07	00:58:29
	15:45	35	33	94.29	29:40:40	00:50:53	01:00:10
	16:00	28	28	100.00	27:33:16	00:59:03	01:02:53
	16:15	30	30	100.00	30:14:50	01:00:30	01:03:17
	16:30	21	20	95.24	19:35:31	00:55:59	01:05:20
	16:45	22	22	100.00	19:06:54	00:52:08	01:07:48
	17:00	18	18	100.00	19:01:23	01:03:25	01:11:16
	17:15	28	28	100.00	29:04:54	01:02:19	01:07:38
	17:30	36	36	100.00	30:24:10	00:50:40	00:56:49
	17:45	24	24	100.00	10:48:31	00:27:01	00:40:23
	18:00	0	0	0.00	00:00:00	00:00:00	00:00:00
	18:15	0	0	0.00	00:00:00	00:00:00	00:00:00
	18:30	0	0	0.00	00:00:00	00:00:00	00:00:00
Daily 8/22/2013		1183	1126	95.18	985:39:47	00:49:59	01:11:16

Family Change (English/Other) Queue - August 23, 2013

Skillset By Application

Report Interval: 7/ 1/2013 8:00:00 AM - 8/30/2013 5:59:59 PM (GMT-06:00)
Site Name: SONCCMS01
Table Name: iSkillsetStat

Date	Time	Skillset Answered	Skillset Answered After Thresh	% Ansd After Thresh	Answer Delay	Average Answer Delay	Maximum Answer Delay
8/23/2013 :							
	08:00	39	26	66.67	02:51:19	00:04:24	00:11:52
	08:15	43	43	100.00	11:45:06	00:16:24	00:23:23
	08:30	103	103	100.00	29:13:15	00:17:01	00:23:31
	08:45	113	96	84.96	11:13:17	00:05:57	00:13:56
	09:00	62	1	1.61	00:06:55	00:00:07	00:00:18
	09:15	42	1	2.38	00:05:28	00:00:08	00:00:26
	09:30	37	4	10.81	00:05:50	00:00:09	00:00:29
	09:45	36	4	11.11	00:05:56	00:00:10	00:00:36
	10:00	27	0	0.00	00:03:22	00:00:07	00:00:13
	10:15	34	1	2.94	00:04:39	00:00:08	00:00:25
	10:30	34	0	0.00	00:03:26	00:00:06	00:00:12
	10:45	35	5	14.29	00:11:00	00:00:19	00:03:01
	11:00	18	18	100.00	01:42:07	00:05:40	00:11:06
	11:15	34	33	97.06	04:18:42	00:07:37	00:12:06
	11:30	26	26	100.00	04:28:24	00:10:19	00:14:45
	11:45	24	22	91.67	05:02:07	00:12:35	00:16:50
	12:00	19	19	100.00	05:43:25	00:18:04	00:21:37
	12:15	22	21	95.45	08:04:09	00:22:00	00:28:39
	12:30	19	19	100.00	08:28:40	00:26:46	00:32:58
	12:45	14	14	100.00	08:31:30	00:36:32	00:41:15
	13:00	22	22	100.00	16:17:58	00:44:27	00:46:55
	13:15	8	8	100.00	06:13:49	00:46:44	00:54:09
	13:30	20	20	100.00	18:48:57	00:56:27	01:00:17
	13:45	20	20	100.00	20:21:51	01:01:06	01:04:41
	14:00	27	27	100.00	27:47:29	01:01:46	01:07:23
	14:15	36	36	100.00	35:46:53	00:59:38	01:05:54
	14:30	29	29	100.00	27:05:31	00:56:03	01:01:46
	14:45	20	20	100.00	20:24:43	01:01:14	01:06:35
	15:00	28	28	100.00	26:46:49	00:57:23	00:59:49
	15:15	19	19	100.00	19:39:45	01:02:06	01:04:40
	15:30	20	20	100.00	21:28:21	01:04:25	01:07:03
	15:45	28	28	100.00	29:58:57	01:04:15	01:06:56
	16:00	24	24	100.00	25:18:59	01:03:17	01:07:36
	16:15	22	22	100.00	24:28:32	01:06:45	01:10:15
	16:30	13	13	100.00	14:42:20	01:07:52	01:10:59
	16:45	13	13	100.00	16:05:14	01:14:15	01:17:05
	17:00	10	10	100.00	12:55:34	01:17:33	01:23:18
	17:15	18	18	100.00	24:18:25	01:21:01	01:25:24
	17:30	23	23	100.00	27:14:02	01:11:03	01:18:46
	17:45	18	18	100.00	12:12:02	00:40:40	00:55:42
	18:00	0	0	0.00	00:00:00	00:00:00	00:00:00
	18:15	0	0	0.00	00:00:00	00:00:00	00:00:00
	18:30	0	0	0.00	00:00:00	00:00:00	00:00:00
	18:45	0	0	0.00	00:00:00	00:00:00	00:00:00
	Daily 8/23/2013	1199	874	72.89	530:04:48	00:26:32	01:25:24

15-minute periods with average & maximum wait times of 45 min. or more

APPENDIX 2: Services Available Online

Services Available Online

State	*Policy Manual*	*Printable Application*	*Save & Return to Complete Later*	*Eligibility Screener/Calculator*	*Check Application Status*	*Renew Benefits*	*Update Information*	*View Benefit Information*	*Program Data*[1]
AL	X	X	X	SNAP					X
AK	X	X		X					
AZ	X	X	X	X	X	X	X	X	X
AR	X	X	X	X	X		X	X	X
CA	X	X	X	X	X	X	X	X	X
CO	X	X	X	X	X	X	X	X	X
CT	X	X							X
DE	X	X	X	X	X	X	X	X	
DC	X	X							X
FL	X	X	X	X	X	X	X	X	X
GA	X	X	X	X	X	X	X	X	X
HI		X							X
ID	X	X							X
IL	X	X	X	X	X				X
IN	X	X	X	X	X		X	X	X
IA	X	X	X	X		CHIP			X
KS	X	Medicaid	X	X					X
KY	X	X							X
LA	X	X	X	SNAP	X	X	X	X	X
ME	X	X	X	X		X			X
MD	X	X	X	X			X		X
MA	X	X	SNAP	X				X	X
MI	X	X	X	X	X	X	X	X	X
MN	X	X	X						X
MS	X	X							X
MO	X	X	X	SNAP			X	X	X

[1] This includes program data and statistics, such as the number of individuals or households in each county or city that participate in public benefit programs.

APPENDIX 2: Services Available Online

State	*Policy Manual*	*Printable Application*	*Save & Return to Complete Later*	*Eligibility Screener/Calculator*	*Check Application Status*	*Renew Benefits*	*Update Information*	*View Benefit Information*	*Program Data*[1]
MT	X	X	X	X					X
NE	x	X	X	X	X	X	X	X	
NV	X	X	X					X	X
NH	X	X	X	X	X	X	X	X	X
NJ	X	X	X	X	X				X
NM	X	X		X					X
NY	X	X	X	X	X	X	X	X	X
NC	X	X		X					X
ND	X	X	X	X		CHIP			X
OH	X	X	X	X	X	X	X	X	X
OK	X	X							X
OR	X	X		SNAP					X
PA	X	X	X	X	X	X			X
RI	X	X		X					X
SC	X	X	X	X					X
SD	X	X							X
TN	X	X	X	X	X	X	X	X	X
TX	X	X	X	X	X	CHIP		X	X
UT	X	X		X					TANF
VT	X		X	X	X	X		X	X
VA	X	X	X	X	X	X	X	X	X
WA	X	X	X	X		X	X		X
WV	X	X	X	X		X	X	X	TANF
WI	X	X	X	X		X	X	X	X
WY	X	X	X	X		X			
Total	50	51	37	41	21	24	21	23	47

Source: "Online Services for Key Low-Income Benefit Programs: What States Provide Online with Respect to SNAP, TANF, Child Care Assistance, Medicaid and CHIP," Center on Budget and Policy Priorities, Revised May 1, 2013, pp. 4-5.

III. Fiscal Analyst's Opinion

State of Nebraska

LEGISLATIVE COUNCIL

www.nebraskalegislature.gov

Legislative Fiscal Office
PO Box 94604, State Capitol
Lincoln, NE 68509-4604

November 27, 2013

Martha Carter
Legislative Performance Audit Committee
P. O. Box 94604, State Capitol
Lincoln, NE 68509

Dear Martha,

I have reviewed the Performance Audit of the efficiency and effectiveness of ACCESSNebraska and provide the following assessment of whether the recommendations can be implemented within the current budget of the Department of Health and Human Services. This is difficult to assess due to the major changes recently implemented which occurred too late for the auditors to include in their evaluation.

As noted in the Performance Evaluation report, the call centers' functions changed on October 1, 2013, with Medicaid split from economic assistance programs. The Legislature funded 117 additional positions in Medicaid to handle the additional caseload anticipated due to implementation of the Affordable Care Act. Thirty eight positions were added to economic assistance.

The separation of Medicaid and economic assistance may bring more efficiencies, as the work will be more specialized and the increase in staff has the potential to ease call wait times. However, the data provided in the performance audit, shows that call wait times and abandonment times far exceed the agency's goals and what would be considered to be reasonable wait times and abandonment rates, so the additional workers may not be sufficient.

Additionally, the department recently moved the interviews for economic assistance to the local offices and eliminated them for Medicaid. The interviews had the highest wait times and abandonment rates, so moving that process from the call centers to local offices for economic assistance cases and not

requiring them for Medicaid will reduce the volume of calls to the centers, so shorter wait times and the reduction in the abandonment rates should follow. However, this may have created new problems with backlog at the local offices. Because this occurred after the audit, the impact is not included, but is a major factor in whether the recommendations can be implemented within existing appropriations.

The categories of specific recommendations are as follows:

Section I: Implementation of LB 825

1) DHHS should assess whether or not the current process for requesting in-person assistance and face-to-face appointments is working and ensure that all clients know how to make such a request.
2) The Legislature may want to clarify its intent regarding the statutory provisions dealing with dedicated workers and the intended longevity of such client request.
3) DHHS should establish contracts with community-based organizations.

The fiscal impact of this section is unclear. The assessment of the process for requesting in-person interviews can be handled with existing resources. If the outcome results in a significant volume increase, additional staff may be needed.

Similarly, the clarification of the longevity of cases assigned to a dedicated worker has no impact, but if the Legislature makes changes different from the current practice, then additional resources may be needed.

The contracts with the community organizations do not have a fiscal impact. The statute does not require monetary remuneration for the arrangements with the community organizations. It would be a benefit to many community organizations to enter into such contracts to either assist their clients in obtaining assistance for either services provided by the community organization or assisting clients for whom they advocate.

Section II: Efficiency and Effectiveness of ACCESSNebraska

1) DHHS should begin reporting information as required.
2) DHHS should determine what an acceptable number of unfinished work tasks is at any given time, taking into account variances in work task priority and age, so as to prevent negative impact on clients' cases.
3) The Legislature should consider requesting DHHS to report monthly performance data for economic assistance and Medicaid covering October 2013 to March 2014.
4) The Legislature should consider amending the reporting requirements under LB 374 regarding wait times and abandonment rates.
5) The Legislature should consider requiring DHHS to identify performance measures to track problems in family eligibility cases and the potential problem of coordinating economic assistance and Medicaid cases.
6) If problems persist, the Legislature may need to review key program aspects such as the adequacy of existing staffing, call center software and call center staff training.
7) The Legislature may need to consider whether the program goal of an average of three minutes or less is appropriate, balanced between the amount of time necessary to accomplish the work tasks and the costs associated to reduce them.

This section has recommendations for additional reporting and tracking by DHHS. In FY 10 through FY 13 the agency's administrative budget received unspecified General Fund reductions totaling $12 million. By necessity, some of the FTE reductions were central office staff who conduct research and prepare reports. Although these additional reporting requirements alone would not require additional

resources, combined with other numerous reporting requirements and the budget cuts, the staff that perform these functions are stretched in meeting all of the workload demands. The reports recommended in this audit may not require more resources, but the agency will have difficulty absorbing additional tasks.

The recommendation to evaluate the adequacy of existing staff, call center software and staff training would require additional resources. The amount is unknown. As noted above, recent changes have the potential to improve call wait times and the separation of Medicaid from economic assistance may improve wait times and reduce the number of abandoned calls. However, the extraordinarily long wait times and high abandonment rates would indicate that existing resources are far short of what is needed to achieve reasonable wait times and abandonment rates. Moving the interviews to local offices for economic assistance and eliminating them for Medicaid also will help, but for economic assistance it may be creating a new backlog situation for the local offices. If the resources continue to be inadequate even with the recent process changes and the additional of staff, then more funding will be necessary to carry out these recommendations.

Overall, additional costs seem likely, however, the magnitude and timing are dependent on several causal factors that have yet to occur.

Sincerely,

Liz Hruska
Legislative Fiscal Office

IV. Background Materials

BACKGROUND MATERIALS

The "background materials" provided here are materials (in addition to the Office's report) that were available to the Committee when it issued the findings and recommendations contained in Part I of this report. They include:

- The agency's response to a draft of the Office's report;
- The Legislative Auditor's summary of the agency's response; and
- The Office's draft findings and recommendations (provided for context).

Department of Health & Human Services
DHHS
NEBRASKA

Kerry T. Winterer
Chief Executive Officer

State of Nebraska
Dave Heineman, Governor

December 5, 2013

RECEIVED
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LEGISLATIVE AUDIT

Martha Carter
Legislative Audit Office
P.O. Box 94604, State Capitol
Lincoln, NE 68509

Dear Ms. Carter,

This letter is in response to your performance audit report entitled "Nebraska Department of Health and Human Services: Efficiency and Effectiveness of ACCESSNebraska". Below is our response that we would like included in the published version of your report.

Finding #1:

The Department considered the following statutory factors when making staffing decisions call center volumes were not available and therefore, not considered:

1. The need for staff to travel to the community-based organizations;
2. The volume of economic assistance cases in the counties served by the existing local office;
3. The number of community-based organizations in the counties served by the existing local office.

The consideration of the above factors occurred primarily during verbal internal discussions within the Department, and as a result documentation is limited. The following documentation of consideration of the statutory factors was provided to the Legislative Audit Office:

1. Copies of emails between the Division of Children and Family Services (CFS) Administrators.
2. A map of Nebraska containing SNAP cases by county, which was created by the Department as a measure of the statutory factor relating to the volume of economic assistance cases.

The Division of Medicaid and Long-Term Care (MLTC) reviewed the need for staff based on Medicaid caseload numbers by county. MLTC then determined the number of staff needed for each office.

Finding #3:

On September 30, 2013, CFS began assigning a dedicated worker to every case. The assignment begins prior to the client interview, and ends with the eligibility determination. Refugee and Medically Handicapped Children cases have dedicated workers on an on-going basis. CFS grants requests for a dedicated worker made by a person with chronic

physical or mental disorders or by an elderly person that requires the provision of medical and personal care services on a recurring or continuing basis. CFS will grant all such requests, and will consider requests from all other clients. CFS believes that having a dedicated worker can present disadvantages to clients. One disadvantage is that a dedicated worker is not always immediately available to a client. Many clients who have requested a dedicated worker have withdrawn their request after being informed of the advantages and disadvantages of both options.

On July 1, 2013, MLTC began the transition of assigning caseloads to workers with expertise in handling extremely complex Medicaid eligibility determinations. We also transitioned existing assigned cases from Economic Assistance to Medicaid and Long-Term Care based on the individual's need and/or request due to special circumstances such as complex medical coordination.

MLTC identified cases involving individuals who receive the following services as assigned cases: nursing homes, assisted living, Personal Assistance Support and Services (PASS), Medicaid waiver (Aged &Disabled; Traumatic Brain Injury; Katie Beckett), Medicaid Insurance for Workers with Disabilities (MIWD), Disabled Adult Children (DAC), State Medical Review Team (SRT), presumptive eligibility for pregnant women, Chip, and Emergency Medical Assistance for Aliens (EMSA).

Finding #4:

In order to ensure that clients are aware of their right to face-to-face assistance and the process for making a request for a dedicated worker, the Department will develop a written information document.. The document will be posted on the ACCESSNebraska website and in local offices, and will also be distributed to community-based organizations. CFS does accommodate face to face interviews when requested.

An individual can request a face to face contact at any time with MLTC.

Finding #6:

In response to LB 825, the Department established workers at local offices where there is always work available. The Department feels this is the best use of resources while also being available to Community Based Organizations.

The Department believes the goal of the legislation was achieved because the Department is using local resources as much as possible. The Department does work with hundreds of community partners (see listing attached as Exhibit 1) who provide different levels of services to citizens of the State of Nebraska. The community partners do this work on a voluntary basis and they determine what level of service they will provide. A monthly community partner call is held with the Community Support Specialists and the community partners to provide them an update on the Department and to get feedback from them. The Community Support Specialists are in contact with the community partners and address their needs and concerns.

MLTC has a memorandum of understanding with OneWorld Community Health Center, Inc. to collaborate on and support the outreach and enrollment of individuals in Medicaid and CHIP. MLTC also works collaboratively with Community Action of Nebraska and the Ponca Tribe in their role as navigators. Four Community Support Specialist positions were moved to MLTC with the transfer of staff from CFS. The Community Support Specialists work as a team to develop presentations that they deliver to community based organizations regarding Medicaid eligibility and questions with the implementation of the Affordable Care Act in Nebraska. The Community Support Specialists work with policy and program specialists to provide accurate information to inquiries. They also work

directly with field operations to ensure an accurate and timely response to inquiries from community organizations and the public.

Finding #9:

This was corrected with the most recently submitted LB 374 report on October 24, 2013. (see report attached as Exhibit 2)

Findings #12 & #13:

To address challenges, changes were made that began in October 2012 where staff began spending more time with clients with the goal of answering the client's questions on the first call. Staff also spent more time in wrap up activities in order to process the application so clients would have access to their benefits within a shorter timeframe. This resulted in staff taking more time to handle the call. Staff took the time to look for submitted documents, thoroughly reviewing the case and answering all of the client's questions on the first call. Starting on December 3, 2012, Customer Service Center staff was allowed to process the case if all information was in. This resulted in staff spending more time on a call and in wrap up.

The transition of staff due to Medicaid eligibility from CFS to MLTC occurred from July through September 2013. This resulted in movement of staff. The supervision of the Lincoln and Lexington Customer Service Centers, the Lincoln Document Imaging Center and approximately 40% of local office staff moved under the direction of MLTC.

There were many days where the Department experienced technical difficulties that impacted staff performance and wait times. (See Exhibit 3)

The following average call wait time standards for CFS have been set and will begin December 2, 2013:

> Each queue average wait time is not to exceed 15 minutes. This will be evaluated on a daily basis. If the 15 minute criterion continues to be met, management will consider lowering it after a three month period. If not being met, management will determine if a new average wait time for each or all queues is required.

CFS continues to assist clients in local offices in addition to the Customer Service Centers.

MLTC assumed leadership of the Lincoln and Lexington Customer Service Centers on July 1, 2013. Since that time we have added part time staff to both locations to assist us with handling calls during high call volume (lunch hours and end of the day). We are training all our staff on the multiple budgeting and eligibility requirements for the Medicaid program so that any worker can handle a call from any queue. In addition, workers in local offices handle the inquiries from those individuals and providers assigned to them which assist in lower call volumes for the Customer Service Centers. A review of our abandonment rate indicates that most callers abandon prior to three minutes therefore we are unable to assess their reasoning. In October 2013 the call abandonment rate for the Lincoln and Lexington Customer Service Centers was 15.67%.

In addition, MLTC is responsible for training the existing staff on the changes being implemented on October 1, 2013 related to the Affordable Care Act. Those changes included a new policy manual, new process guides, new budgeting process for a large portion of individuals applying for Medicaid, and additional eligibility groups such as former foster care. MLTC has been providing constant training opportunities to new and existing staff. This ensures that they accurately determine eligibility based on the existing policies as well as the new criteria for January 2014. Any child, parent, or relative caregiver denied

Medicaid due to income/resources from October 2013 through December 2013 must be reviewed to see if they might be eligible under the new rules in January 2014.

Impact of System Outages:

Exhibit 3 details the number of times there were outages (phone or otherwise) in the Customer Service Centers and/or Local Offices. Any time there is an outage, it creates a problem in providing quality customer service. Depending on what kind of outage occurs, it can result in the following:

- staff usually having to sign off and back on again,
- all calls in the queue are disconnected requiring the clients to call back,
- the worker de-escalating the call so they can help the client with what they called for to begin with, this makes the call last longer.

Impact of Medicaid Eligibility Transition:

The effective date of MLTC staff and CFS staff performing only the work respective of their areas (Medicaid and Economic Assistance) was Monday, September 30, 2013.

Prior to the September 30th date, a lot of training took place to help staff be best prepared for their roles following the transition. CFS provided training during non-work hours and paying staff overtime in order to reduce the impact on customer service.

As of September 30, 2013, the phone lines were also split for each division. The phone menu options also changed to reflect the respective areas. The Economic Assistance phone menu was simplified from the previous ACCESSNebraska phone menu. The queues were changed to align with the skill levels of staff and the types of calls that come in. For example, there is no longer a family queue. The queues are based on program areas such as Supplemental Nutrition Assistance Program (SNAP)/Energy and Aid to Dependent Children(ADC)/Child Care to name a few.

The divisions are able to transfer calls to the other and allow clients to get assistance through the most appropriate phone queue. When possible, one division can take the information from the client and share it with the other division either through email or in the case narrative so the client does not need to speak with each division. An example of this would be an address change.

There is also a cross-divisional team made up of different levels of staff from each division to assist with on-going internal and external communications. They determine areas to help communicate changes to better serve the client.

CFS moved the majority of the interviewing responsibility from the Customer Service Centers to the local offices. Workers in the local office now assign themselves a case at time of interview and return that it to the universal system after the decision on the case is made.

The wait times in all four Customer Service Centers has reduced dramatically since September 30, 2013. The average wait time for the month of October for CFS was 7:43. The average wait time for the month of October for MLTC was 6:21.

Additional information:

Work tasks are being reviewed for which should be categorized as priority over others. Although there is already a "high priority" work task queue, these will also be reviewed to determine their level of priority. By January 1, 2014, work task queues will be sorted out and averaged for time to complete the work and given to field to complete work tasks based on priority.

For the most part, staff is able to complete as many work tasks as are created. However, there are different times of the month and year that result in additional work tasks being added. An example would be the first and fifteenth of the month. More work tasks are created because a new application or renewal may be due from the client and if that is not received a letter needs to be sent to the client and the case may need to be closed.

The number of work tasks added in Economic Assistance in October was 75,087 and 71,290 were completed. Although staff is working large numbers of work tasks, there are also a large number of new work tasks being created on a daily basis.

The number of work tasks added for MLTC in October was 79,781 and 57,708 were completed. As our staff became more proficient in their skillset, the number of work tasks completed grew. In addition, several of the staff was assigned to cases that required their expertise to ensure an accurate eligibility determination occurred so they were not able to focus solely on work task completion activities.

A Continuous Quality Improvement (CQI)has been implemented into ACCESSNebraska. The Research, Planning and Evaluation Administrator oversee the quality and data related to ACCESSNebraska for CFS. The data collection and measurement is provided by this team for management to adjust processes as necessary to improve the quality of work and service to customers.

CFS is working with a consultant through the United States Department of Agriculture-Food and Nutrition Services consultant. Their first on site visit took place the week of November 4, 2013. They will be working with CFS over the next 18 months. They will help CFS identify greater efficiencies in the daily work as well as estimate average time to do certain tasks of a worker's day. This will also help CFS set continued goals for average wait times and realistic work task number goals. Their next on site visit is the week of January 6, 2014.

MLTC added additional staff positions to focus on quality assurance activities related to the eligibility determinations. Those additional staff positions have begun reviewing the work of the new staff as they complete training. Our new trainees have reached average competency rankings of 95% upon completion of training modules.

The Department would like to thank you and your staff for your work on this audit. If you have any questions or comments on our responses, please contact me or our Internal Auditor, Kevin Nelson.

Sincerely,

Kerry T. Winterer, Chief Executive Officer
Nebraska Department of Health and Human Services

Cc: Kevin R. Nelson, CPA, Internal Auditor, Department of Health and Human Services
Thomas D. Pristow, Director, Division of Children and Family Services
Vivianne M. Chaumont, Director, Division of Medicaid and Long-Term Care

Legislative Auditor's Summary of Agency Response

This summary meets the requirement of Neb. Rev. Stat. § 50-1210 that the Legislative Auditor briefly summarize the agency's response to the draft audit report and describe any significant disagreements the agency has with the report or recommendations.

Department of Health and Human Services (DHHS) Response

The Department's response contained no significant disagreements with the draft report or recommendations.

Most of the Department's comments were connected to specific findings. Following is a restatement of the findings (only those on which the Department commented), a brief summary of their comments, and a final comment by audit staff.

Finding #1: DHHS stated that they used three of the four statutory factors in determining appropriate numbers of local office staff; however, they could not provide documentation that would have allowed us to verify that. We confirmed that the fourth factor could not be considered because the relevant data was not available.

DHHS response: DHHS reiterated that they did consider the statutory factors but acknowledged that documentation supporting that consideration was limited. (December 5, 2013 letter, p. 1)

Audit Office comment: DHHS did provide evidence to support a statement included in the body of the report that they received input from local offices in determining the staffing needed under LB 825, and we changed the text to reflect that.

Finding #3: Since DHHS allows a client to request an assigned caseworker, but retains the right to deny that request, DHHS is not in strict compliance with the statutory requirements regarding dedicated workers and specialized department employees.

Finding #4: The impact of DHHS's non-compliance with assigned worker requirements is unclear because the goals of the statutory requirements are somewhat unclear. However, input from client advocates suggests that the lack of a publicized process for requesting a single face-to-face contact with a worker or an ongoing assigned caseworker may be a bigger concern than the availability of such a worker.

DHHS response: Under the system in place since October 1, 2013, assigned workers are provided more frequently by the Children and Family Services Division (CFS) for economic assistance cases and by the Medicaid and Long-Term Care Division (Medicaid) for Medicaid cases. However, for some of the economic assistance cases, the assigned worker is available only until eligibility has been determined, not throughout the life of the case. CFS believes that in some cases, having a dedicated worker is less helpful for a client if, for example, the worker is not readily available when the client needs help, and

states that some clients who request an assigned worker later withdraw that request. CFS will also publish a process to inform clients of their right to face-to-face assistance and the process for requesting a dedicated worker. (December 5, 2013 letter, pp. 1 & 2)

Audit Office comment: As noted in the body of the audit report, we believe the relevant statute requires CFS to provide an assigned worker if one is requested by a client, and that the practice of denying such requests violated a strict reading of the statute. We also acknowledged, however, that the legislative intent for that requirement was not entirely clear. We believe the best course of action at this point may be for the Legislature to consider a bill on this subject, which would provide an opportunity to determine whether the same level of need exists now that certain Medicaid categories are receiving assigned workers.

Finding #6: DHHS is not in compliance with the requirement of LB 825 that it contract with community based organizations to assist clients.

DHHS response: The Department does not believe that contracts are needed and believes it has achieved the goal of LB 825 because it is "using local resources as much as possible." The Medicaid and Long-Term Care Division does have a memorandum of understanding with one community organization. (December 5, 2013 letter, p. 2)

Audit Office comment: The Department remains out of compliance with the statutory requirement. The Legislature may want to consider and, if necessary, clarify whether formal contracts are necessary or whether a memorandum of understanding or letter of agreement would be sufficient.

Finding #9: DHHS is not reporting the average wait time for abandoned calls as required by LB 374.

DHHS response: The Department began reporting this information in its October 2013 report to the Legislature.

Audit Office comment: The finding will be changed to reflect that the information is now being reported.

Finding #12: Between September 2012 and August 2013, the average wait time for answered and abandoned calls increased more than 50 percent for almost all queues.

Finding #13: The number of answered calls decreased from September 2012 to August 2013, so the number of calls was not a factor in the increased wait times.

DHHS response: The Department described a number factors that affected call wait times between September 2012 and August 2013, including:

- Internal changes intended to allow call center staff to answer clients' questions on the first call;
- The movement of some CFS staff to Medicaid beginning July 1, 2013;
- Phone and computer problems that restricted what workers could accomplish and, in some cases, disconnected all clients who were waiting to talk to a worker;
- Training needed for Medicaid staff as a result of the federal Affordable Care Act; and
- Other changes related to the establishment of separate eligibility systems for Medicaid and the economic assistance programs.

The Department also indicated that as of December 2013 CFS has established a new goal of an average wait time for each queue of 15 minutes, which it will evaluate daily and consider adjusting in three months. (December 5, 2013 letter, pp. 3 & 4)

Audit Office comment: We do not dispute that the factors cited played a role in the increased length of wait times in the 12 months we reviewed. We think the goal of a 15-minute average is more realistic than the existing 3-minute average goal. What remains unclear is whether the resource issues (staffing as well as phone and computers) that contributed to the long waits prior to October 2013 have all been resolved. As noted in the Legislative Fiscal Office response to the draft audit report, both the CFS and Medicaid systems now have additional staff for eligibility determinations. (November 27 letter, p. 1) Additionally, in a follow-up to the agency's response, CFS indicated that the phone and computer system problems have decreased. Whether these changes are enough to resolve the problems documented in the report cannot be determined at this time.

Additional DHHS Comments

The Department reported that the backlog of work tasks discussed in the audit report has been greatly reduced and that both the CFS and Medicaid systems are closer to keeping up with the work tasks. By January 1, 2014, the Department expects to have calculated the average time for completion for various work tasks and prioritized the order in which they should be completed. (December 5, 2013 letter, pp. 4 & 5)

The Department also reported new initiatives to improve its quality assurance efforts, including working with a consultant from the federal Department of Agriculture to improve efficiencies in the economic assistance programs. (December 5, 2013 letter, p. 5)

Additional Audit Office Comments

The Department attached two lengthy exhibits to its response but agreed that the exhibits did not need to be printed in the final report. The Audit Office will make them available either by request or on the legislative Web site.

Draft Findings and Recommendations

The following are the Legislative Audit Office's findings and recommendations for this report.

Section I: Implementation of LB 825

Finding #1: DHHS stated that they used three of the four statutory factors in determining appropriate numbers of local office staff; however, they could not provide documentation that would have allowed us to verify that. We confirmed that the fourth factor could not be considered because the relevant data was not available.

Finding #2: Local office caseworkers are available for in-person assistance to clients and DHHS has a process for scheduling face-to-face appointments with local office caseworkers through call center workers.

Recommendation: If the Legislature is still concerned that local office staffing is a problem, it may want to evaluate whether the four factors identified in the statute are the best measures to address this issue. If new measures are created, the department should maintain adequate documentation of how it has met standards. Additionally, DHHS should assess whether or not the current process for requesting in-person assistance and face to face appointments is working and ensure that all clients know how to make such a request.

Finding #3: Since DHHS allows a client to request an assigned caseworker, but retains the right to deny that request, DHHS is not in strict compliance with the statutory requirements regarding dedicated workers and specialized department employees.

Finding #4: The impact of DHHS's non-compliance with assigned worker requirements is unclear because the goals of the statutory requirements are somewhat unclear. However, input from client advocates suggests that the lack of a publicized process for requesting a single face-to-face contact with a worker or an ongoing assigned caseworker may be a bigger concern than the availability of such a worker.

Recommendation: The Legislature may want to clarify its intent regarding the statutory provisions dealing with dedi-

cated caseworkers and specialized department employees, including the intended longevity of such a client request. DHHS should develop a *publicized* process for clients to request an assigned worker which accurately reflects the Legislature's intent.

Finding #5: DHHS met the statutory requirement that it determine an appropriate number of community support specialists. However, we make no assessment of whether nine positions are in fact sufficient to perform the required duties.

Recommendation: None.

Finding #6: DHHS is not in compliance with the requirement of LB 825 that it contract with community based organizations to assist clients.

Discussion: As stated in our report, the purpose of the contracting requirement was to allow the department to maximize the use of local resources, since most clients have some relationship with community based organizations. Additionally, establishing contracts with these entities would allow DHHS to define and monitor the duties of its community partners.

Recommendation: DHHS should establish contracts with community based organizations.

Section II: Efficiency and Effectiveness of ACCESSNebraska

Because the majority of Section II findings, and the related recommendations, highlight similar underlying issues relating to efficiency and effectiveness, we have combined the discussion and recommendations at the end of this section.

Finding #7: In July 2013, DHHS did not meet its goal of having five percent of incoming calls ring busy; in fact, busy signals were more than 400 percent of incoming calls that month.

Finding #8: Only the Case Aides queue met the Department's goal of an abandonment rate of 10 percent or less. The other four queues had abandonment rates two to three times higher than the goal.

Finding #9: DHHS is not reporting the average wait time for abandoned calls as required by LB 374.

Recommendation: DHHS should begin reporting this information as required.

Finding #10: Recent average call wait times for the queues combined were much higher than DHHS's goal of an average of three minutes or less.

Finding #11: None of the queues met the Department's wait time goal of an average of three minutes or less for either answered or abandoned calls. However, the Case Aides queues came close with an average of four minutes for answered calls and five minutes for abandoned calls.

Finding #12: Between September 2012 and August 2013, the average wait time for answered and abandoned calls increased more than 50 percent for almost all queues.

Finding #13: The number of answered calls decreased from September 2012 to August 2013, so the number of calls was not a factor in the increased wait times.

Finding #14: The Case Aide queues had the lowest average wait times and the queues that dealt with family cases had the highest.

Finding #15: The maximum wait times for both answered and abandoned calls range from almost one hour to nearly two hours.

Finding #16: Between September 2012 and August 2013, the maximum wait time for answered calls increased more than 50 percent for most queues.

Finding #17: In August 2013, an estimated 10,914 to 16,347 callers in the Family Change and Family Interview (English/Other) queues experienced wait times of 45 minutes or more.

Finding #18: Average wait times for all queues disguise important differences in wait times among queues.

Finding #19: DHHS has no standard for determining an acceptable number of unfinished work tasks.

Finding #20: For seven out of the 12 months presented, work tasks older than five days comprised approximately 75 percent of the total backlog. For 11 out of the 12 months

presented, the older tasks comprised a majority of the total backlog.

Finding #21: DHHS did not meet its goal of reducing the backlog of work tasks older than five days to 25,000 by October 1, 2013.

Recommendation: DHHS should determine what an acceptable number of unfinished work tasks is at any given time, taking into account variances in work task priority and age, so as to prevent negative impact on clients' cases.

Efficiency and Effectiveness Recommendations

Discussion: The results of our analysis on selected efficiency and effectiveness measures are very concerning. DHHS has fallen dramatically short of its goals in all the areas we reviewed, reflecting a very high level of program dysfunction. The extremely high busy signal rate generally, and likelihood for family eligibility cases of very high wait times specifically, paint a picture of frustration before many clients even make contact with the program.

The report findings are based on the program's performance prior to the separation of the Medicaid calls from the economic assistance calls. While some initial indications were positive (such as reduced call wait times), it was too early to fully assess whether the changes that accompanied the separation would resolve the problems we identified.

Recommendation: The Legislature should consider requesting DHHS to report monthly performance data for economic assistance and Medicaid to the Legislature covering at least October 2013 through March 2014. That data should include busy signals, answer and abandonment rates for each queue, and average and maximum wait times for each queue. The information should be provided for each day as well as aggregated for each month.

Recommendation: The Legislature should consider amending the reporting requirements of LB 374 to include: (1) the average and maximum wait times by skill set queue, rather than just "grand total" data that does not differentiate individual queues; and (2) data on busy signals and work tasks.

Discussion: Very long times were a problem for most queues, but particularly so for the more complex family eligibility cases. It is unclear how such cases will be effected by the separation of the Medicaid calls, but there is a possibility of additional complications, given the need for the economic assistance and Medicaid systems to interact when families are eligible for services in both areas.

Recommendation: The Legislature should consider requiring DHHS to identify performance measures to track that would indicate a continuing problem in family eligibility cases or a developing problem in coordination between the economic assistance and Medicaid programs on cases of duel eligibility.

Recommendation: If program data indicate continuing problems despite the separation of the Medicaid cases, the Legislature may need to review key program aspects such as the adequacy of, among other things:

- Existing staffing;
- Call center software; and
- Call center staff training.

The Legislature may also need to consider whether existing program goals—such as an average wait time of three minutes or less—are appropriate. While short wait times are desirable, they need to be balanced with both the amount of time necessary to accomplish the work tasks and with the costs associated with the factors necessary to reduce them (for example, number of staff).