

# **A State Guide to Online Enrollment for Medicaid and SCHIP**

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by

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## EXECUTIVE SUMMARY

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This document summarizes findings and issues identified by an Enrollment and Online Applications Workgroup sponsored by the National Academy for State Health Policy (NASHP). The group examined the advantages, disadvantages, and implementation issues surrounding online enrollment for Medicaid and the State Children's Health Insurance Program (SCHIP). This report is designed to serve as a source of information for states considering, designing, and/or implementing online enrollment.

Online enrollment in this document refers to a person's ability to apply for a Medicaid or SCHIP program at a specific Internet website. The applicant fills in and transmits information that becomes the basis for an electronic record that exists for the duration of his or her family's enrollment in Medicaid or SCHIP. Once the applicant data is submitted, the online enrollment system provides an immediate, initial assessment of the applicant's eligibility.

Online enrollment has several advantages compared to paper applications.

- Applying on the web can increase customer convenience for applicants with busy lives.
- When high volumes of applications are received over the web, state administrative costs can be reduced. California, Georgia, and Pennsylvania are beginning to experience a high enough volume of electronic applications that some savings can be attributed to these systems.
- Applications submitted online are more complete and have fewer errors than those completed on paper and then transcribed into information system databases.

Online enrollment systems may also present some drawbacks.

- In some cases, the development costs may not outweigh, or may not quickly enough outweigh, the costs of implementation.
- Online enrollment systems can be complex to design for Medicaid programs because of the Federal requirement to collect written signatures.
- In addition, online enrollment systems that can collect premiums online can be challenging to design and operate.

In some situations states find that an administrative change, such as the simplification of the state's existing application process, may be a more efficient remedy to a problem than the implementation of an online enrollment system.

Overall, online enrollment systems have clearly increased the satisfaction of those applying for Medicaid and SCHIP in several states. At least seven states offer online enrollment statewide to Medicaid and/or SCHIP applicants, and five more are operating pilot programs. Online enrollment and other web-based state agency services hold the promise of delivering high quality customer service along with the potential for reducing application processing costs.

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## INTRODUCTION: WHAT IS ONLINE ENROLLMENT?

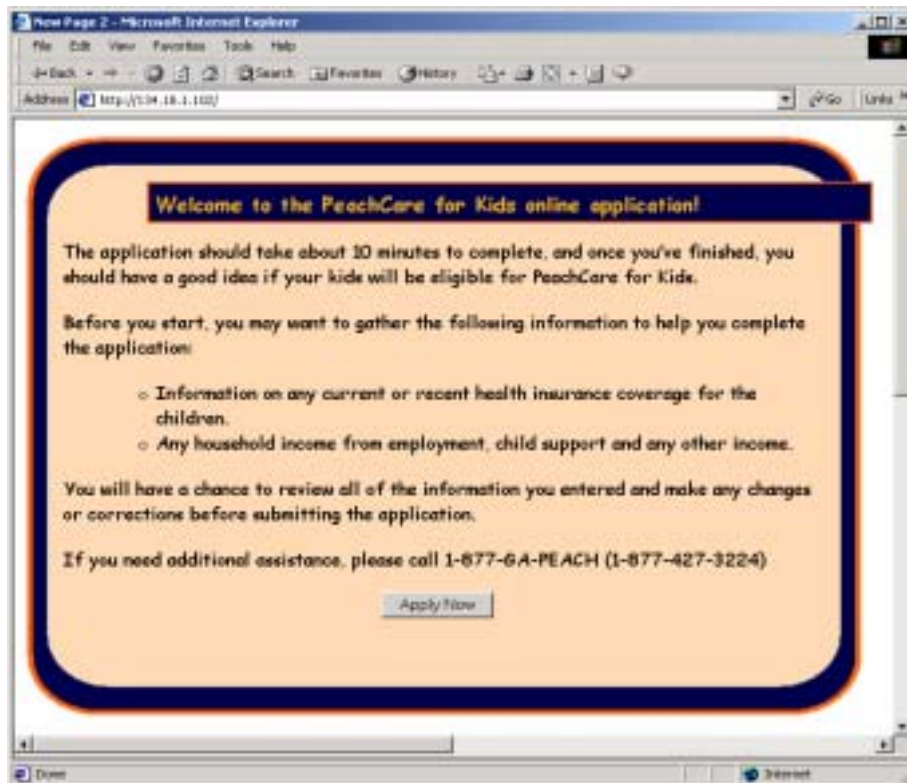
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Online enrollment in this document refers to a person's ability to apply for a Medicaid or SCHIP program at a specific Internet website. See Figure 1 below for a representation of the first page of one state's online application.

As defined in this document, online enrollment is more than the capacity to download a copy of a program's application from a website. Rather, in online enrollment systems the information that is entered by the applicant is sent electronically to the state agency or contracted eligibility determination agency. The electronic record becomes the person's application for themselves, or more likely, for their children to enroll in a Medicaid or SCHIP program. At renewal, the family may either submit updated electronic information or a paper application depending on the program's rules.

Often the electronic application may not be enough to constitute a complete application. Income documentation or a written signature may need to follow the electronic application by mail or fax after the electronic application is submitted to the state.

**Figure 1. A page from Georgia's PeachCare for Kids online application**



Online enrollment provides an immediate, initial assessment of the applicant's eligibility status. Although the eligibility determination may change upon review of subsequently filed documentation, the applicant receives a tentative eligibility determination as soon as he or she submits an application via the Internet. The applicant is then provided with instructions on how to submit any supporting documentation and timelines required for doing so.

This report is intended to inform state policy makers who are considering online enrollment for their Medicaid or SCHIP programs. It includes information from four states (California, Georgia, Pennsylvania, and Texas) that have already implemented online enrollment and from three states (Florida, Louisiana, and New Jersey) that have pilot programs in place. More information about the online enrollment systems in these states can be found in Appendices A and B. This paper is informed by the experiences of a NASHP workgroup that was comprised of ten states interested in pursuing online enrollment and that focused on this topic between February and August of 2002. More information about the workgroup can be found in Appendix C.

## STEP 1: SHOULD YOUR STATE IMPLEMENT ONLINE ENROLLMENT?

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The answer to this question depends on your state's objectives for developing the capacity to allow enrollees to apply over the Internet. Some states will view online enrollment as an added convenience for busy parents to enroll themselves or their children at any time of the day or night through the web. Others will choose online enrollment as a potential way to cut down on the administrative costs of mailing and processing paper applications. Some of the potential positive aspects of online enrollment include the following.

### Pros ✓

- **Online enrollment makes it more convenient for low-income parents to apply for Medicaid and SCHIP.**

The states that have already implemented online enrollment report very high levels of satisfaction from both parents and the community-based agencies that provide application assistance. (For a snapshot of current state online enrollment systems, see Appendices A and B). Applicants report that they are very happy with the process, with the immediate, albeit tentative, eligibility determination, and with the rapid acknowledgement from the state that their application has been received and is complete.

#### *Evidence:*

- California reports that 90 percent of applicants would rather apply online using Health-e-App; 95 percent of Certified Application Assistants (CAAs) preferred using Health-e-App to the paper application.
- In California, online applications are processed 20 percent faster than paper applications.
- Georgia reports that 23 percent of applicants indicated that they likely would not have applied if they had not been able to apply online.
- Texas' CHIP e-Z Application staff report that applicants are informed of their eligibility status 20 to 30 percent faster when they submit an online application.

- **Online enrollment offers the potential to lower administrative costs.**

Online enrollment has significant potential to reduce the administrative costs of enrolling children in Medicaid and SCHIP. Many of the costs of printing and mailing application materials can be avoided, particularly if applicants are allowed to choose online their health plan and provider. With online provider selection, the state can avoid mailing thick documents, such as provider participation lists, to enrollees.

Applicants essentially carry out their own data entry function when they fill out their application online. Costs associated with incorrect transcription of handwriting can be avoided.

It can be less expensive to move an electronic application through a state agency than to move a paper file, and electronic files do not have the same problems associated with the loss or misplacement of paper files.

Online enrollment is likely to reduce administrative processing costs when volumes get high enough. States should explicitly consider how to divide the benefits of these administrative cost savings between the state and, if applicable, the contractor providing application processing services.

*Evidence:*

- As of September 2002, Pennsylvania was receiving about 1,200 Medicaid and SCHIP applications per month online, two percent of total applications.
- As of September 2002, California was receiving about 2,800 Medicaid and SCHIP applications per month online, or almost 10 percent of their total applications.

- **Online enrollment ensures more complete and more accurate applications.**

With an online application, it is possible to program various help and error checking features to assist applicants as they work through the application, and this assistance can result in fewer errors and more complete applications. Some states offer applicants several pop-up help screens to get more information about how to complete a particular part of the application. Online applications typically do not allow an applicant to proceed to the next screen if critical information, such as a child's birth date, is missing. Online applications will not allow an "impossible" entry to be made in certain fields, for example the first two digits of a date of birth year must be "19" or "20." This feature is sometimes called "instantaneous error checking."

Also, because the applicant types his or her own name, address, and other information, data entry problems resulting from transcribing handwriting are avoided. For these reasons, online applications can be more complete and more accurate than paper applications, which makes them faster and less expensive to process.

*Evidence:*

- California reports that application errors were reduced by 40 percent using online compared to paper enrollment.
- Texas reports that while 60 percent of paper applications are complete, 90 percent of online applications are.

## Cons X

For some states, however, the costs of implementing online enrollment may not be worth the advantages of these new systems. In addition, some state and federally imposed program features can make online enrollment more complex to implement in some states than in others.

- **The costs of implementing an online enrollment system may be too steep.**

For some states, the costs of creating a web-based component of their information systems may be too steep to merit the investment. Upfront development costs have ranged from \$40,000 to over one million dollars depending on the state and the features of the online programming. Furthermore, training costs for state agency staff and for staff at community-based agencies can be substantial. Some states may meet their objectives more efficiently by putting this funding into outreach or other administrative streamlining efforts, such as simplifying current paper application procedures.

- **The volume of electronic applications may be lower than expected at first.**

It has been difficult for states that have implemented online enrollment to predict with accuracy what volume of electronic applications they will receive in the first year of operations. It is therefore hard to predict when the volume of electronic applications, and their associated cost savings, will become large enough to offset the development and implementation costs.

It may take months or years for the volume of online enrollment to increase to the point where significant cost savings are captured. California, Georgia, and Pennsylvania are currently receiving the highest volume of electronic applications, although none of these states implemented its system with administrative savings as the major goal. Instead, they were trying primarily to improve customer convenience.

### *Evidence:*

- Georgia received 35,000 online applications in 2001, its first year of operations.
- By contrast, in Texas, in 2001 only 10,000 applications came through their website, a small number compared to the 1.1 million applications received through the mail.

- **Online enrollment can be more difficult to implement for Medicaid than for SCHIP.**

Online enrollment can be more difficult to implement for Medicaid programs than for SCHIP programs, because written signatures are required for Medicaid and states have more flexibility about what type of signatures are required for SCHIP. States with online enrollment have used several approaches to complying with the signature requirement. See the discussion of electronic signatures on page 11 for more information.

- **Online enrollment may be more difficult to implement in states requiring income and other documentation than in states that accept self-declaration on their applications.**

One quarter of Medicaid programs and almost one third of SCHIP programs accept self-declaration of income, meaning that applicants provide detailed information about how much and what types of income they earn, but they are not required to submit copies of pay stubs or tax returns. Applicants are informed that their applications may be audited, which would require them to provide documentation confirming their declarations.

State programs that accept self-declaration of income are in a better position to consider or implement online enrollment because it is more likely that the application in these states can be fully completed online. States with online systems that require income documentation must ask applicants to fax or mail these documents to the state and must then match them to the electronic application. Eleven states have SCHIP programs that accept self-declaration of income: Alabama, Arizona, Connecticut, Florida, Georgia, Maryland, Michigan, Mississippi, Vermont, Washington, and Wyoming.<sup>1</sup> In addition, 13 states accept self-declaration of income for regular children's Medicaid: Arkansas, Connecticut, Florida, Georgia, Idaho, Maryland, Michigan, Mississippi, Oklahoma, Vermont, Washington, Wisconsin, and Wyoming.<sup>2</sup>

- **Online enrollment may be more complex when premiums are payable online.**

Building a payment function into an online enrollment system can add complexity to the system. Issues such as who pays the credit card company transaction charges, how to accept checks, and how to process debit cards must be addressed. States that do not build monthly premium payment into their online system may have a simpler online enrollment process to design, implement, and operate.

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<sup>1</sup> As of January 2002, from Donna Cohen Ross and Laura Cox, *Enrolling Children and Families in Health Coverage: The Promise of Doing More* (Washington, DC: Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2002), 36.

<sup>2</sup> Ibid.

Although more difficult, it is not impossible to design and implement online enrollment systems for programs with income documentation and premium payments, and several states have done so. California and Pennsylvania, for example, have these program features, and they have two of the highest volume electronic application systems in the country.

## STEP 2: WHAT OBJECTIVES CAN BE FULFILLED BY ONLINE ENROLLMENT?

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Online enrollment can be used to meet a variety of objectives ranging from improving customer convenience to reducing administrative costs. To guide the decision-making and design of a state's online enrollment system, it is important to identify the main objectives for implementing online enrollment.

### Objective Setting Options

The ten states participating in NASHP's Enrollment and Online Application Workgroup, or SWOT Team,<sup>3</sup> identified four primary objectives for implementing online enrollment:

- Too many incomplete applications. Incomplete applications slow the process for the applicants, are administratively burdensome, and can be costly for state programs.
- Too much time for enrollment processing. The current paper application enrollment process can be lengthy for applicants and for the program due to mail delays, data entry time requirements, and the need to clarify incomplete or hard-to-read applications.
- Too many enrollees drop off at renewal time. Enrollees who do not respond to re-verification requests are disenrolled from the program without the benefit of an eligibility redetermination. Allowing online renewal as a choice for families may encourage them to provide the necessary information so that children who remain eligible can remain enrolled.
- The eligibility determination process is often fragmented between the Medicaid and SCHIP agencies in the state. The process is often more lengthy than it needs to be because two agencies are involved, coordination is difficult, and some processes are redundant (data must be entered twice in order to load a single family into both information systems).

Most states that have chosen to implement an online enrollment process did so for enrollee convenience or to increase access by providing another avenue to apply for the programs. Administrative cost savings may have been fortunate byproducts of their online system but were not the driving force behind the implementation of these new systems.

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<sup>3</sup> SWOT stands for strengths, weaknesses, opportunities and threats. This and other NASHP SCHIP SWOT teams are comprised of a group of state officials who use quality improvement techniques to improve the administration of SCHIP programs. See Appendix C for more information about this SWOT Team.

## STEP 3: WHAT ARE ONLINE ENROLLMENT IMPLEMENTATION ISSUES?

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Once objectives are clearly articulated, decision making about program specifics can proceed. In the design and implementation of an online enrollment system, the following features of such a system should be considered.

### Costs: How Much Will It Cost?

Implementation can consist of two major cost categories: programming costs and training costs. While it will certainly cost money to develop the web-based capacity to accept online applications and have data fed into current eligibility databases, it may also take significant resources to train state and community-based staff how to use the web-based system. California, for example, found that training community-based application assistants (CAAs, who include community providers and other community-based organizations) was more resource intensive than the state had anticipated.

There is a wide range in the development and operational costs of various states' online enrollment systems.

- California's pilot program in San Diego County in 2001 cost \$50,800 to start up and \$14,000 per year to operate. California's statewide roll-out, including training for thousands of CAAs and other enrollment entities, is expected to cost just under \$2 million. (This figure does not include funds spent by the California HealthCare Foundation to develop the system.)
- Georgia's online enrollment system cost the state \$40,000 to install, and it incurs monthly telephone charges. Georgia was able to negotiate a low development cost because it was expected that the administrative contractor would benefit from having online enrollment expertise.
- Texas spent just over half a million dollars to design and implement its statewide online applications.
- Washington State worked with a community college to create an online e-mail application and spent about \$50,000 to do so.<sup>4</sup>

California's initial development costs were expensive because much of the work was being done for the first time and included extensive consulting with users of the system, such as applicants and staff at CAAs.

Pennsylvania has a comprehensive contract with Deloitte and Touche to assist in carrying out a multi-year effort to make many state services available online, and the state reports that it is difficult to tease out what the Medicaid and SCHIP-related costs are.

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<sup>4</sup> Brendan Krause, *Enrollment Hits the Web: States Maximize Internet Technology in SCHIP and Medicaid*, (Washington, DC: National Governors Association, 2002), 6.

### **Time: How much time will it take to implement?**

As with costs, there is variation in the length of time it has taken different states to implement online enrollment. States that were among the first to design and implement online systems experienced some of the longest development times. California implemented its pilot program in San Diego County in January 2001, and Health-e-App went statewide in the summer of 2002. Georgia, by contrast, took only four months to develop its online enrollment package. States that are piloting or implementing online enrollment now, such as Indiana and Arizona, report going live with online enrollment pilot projects within several months.

### **Access: Who will the website be available to?**

Web-based enrollment system can be accessible to state enrollment workers, community-based organizations, and/or to individuals. Most states have made their online enrollment systems available to both community agencies and to individuals. Georgia, Pennsylvania, and Texas, for example, allow applicants to apply wherever they have access to the web. Applicants have applied for these programs from home, work, libraries, and other public Internet locations. Other states, primarily for security reasons, have limited access to community-based partners. California limited access to Health-e-App to certified community partners in order to comply with security provisions laid out by state information technology oversight authorities.

### **Target population: Will only higher income enrollees use the Internet?**

While there may be an initial hypothesis that web-based enrollment will be used predominantly by applicants at the higher end of the eligibility scale, several states that have implemented online enrollment have not found this to be the case. Few formal studies have been conducted yet, but early reports indicate that enrollees at all income levels are ready and willing to use the Internet.

For example, Georgia found that more lower-income families than expected enrolled online. About 25 percent of Georgia applicants who file a paper application are eligible for Medicaid, while 75 percent are eligible for SCHIP (and thus slightly higher income).<sup>5</sup> By contrast, approximately 50 percent of online applicants are eligible for Medicaid, and 50 percent are eligible for SCHIP. In addition, Georgia reports that the average income of online enrollees is 120 percent of the federal poverty level, a lower average than some who were involved in the online system's development had expected.

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<sup>5</sup> In Georgia, 1- to 5-year-olds in families with incomes up to 133% of the federal poverty level (FPL) and 6- to 18-year-olds in families up to 100% FPL are eligible for Medicaid. SCHIP in that state covers children between those income levels and 235% FPL.

## **Languages: What languages should be your website use?**

Most states that have implemented online enrollment have significant Spanish-speaking populations, and have created both English and Spanish versions of their websites. California's Health-e-App also has an audio version to facilitate use by applicants with limited vision. The Commonwealth of Pennsylvania Application for Social Services or COMPASS website is in English and Spanish. The TexCare Partnership has electronic applications in English and Spanish.

## **Electronic signatures: What are the issues?**

States have undertaken a variety of approaches to obtaining signatures for beneficiaries who apply online. Whereas Medicaid programs require a written signature, SCHIP regulations are not so specific and provide more flexibility to states in designing enrollment procedures.

States have used the following techniques to collect signatures with their online applications:

- *Fill out the application online, print the signature page, sign it, and mail it in.*

This approach meets signature-gathering requirements, but it creates a barrier for applicants without access to a printer. Some applicants may not follow through with mailing in the signature. State staff will need to follow-up with submitted electronic applications that are missing the signature page. Despite drawbacks, several states use this approach, including Pennsylvania and Texas.

- *An electronic signature pad.*

In addition to the option to print and mail a signature page, California has equipped interested CAAs with an electronic signature pad. This device is attached to a computer and consists of a small screen and an electronic pen, similar to what customers use to sign for a UPS package or to sign their credit card slips at some retail stores. California had to pass a new state law that allowed this type of electronic signature to qualify as a written signature for Medicaid. This approach avoids the need to print and mail in paper, but it is costly to supply electronic signature pads. This strategy works when electronic applications are coming in from a specified set of community agencies, but is not feasible for online applications from applicants' homes.

- *Accept an electronic assurance at the point of application and follow-up with a written signature at renewal.*

States with short renewal periods for Medicaid, three or six months, may be able to

accept an electronic assurance from an applicant and obtain a written signature at the first renewal. In this situation, both Medicaid and SCHIP applicants would click on a button that indicates that they are attesting that the information is correct and that they agree with specific conditions. Medicaid applicants would be informed of the need to collect their signature within the next several months in order to retain coverage.

As Medicaid and SCHIP continue to embrace new technologies and web-based encounters with their enrollees, it may be time to reevaluate the need for and purpose of collecting signatures written with ink on paper. A number of options now exist for verifying and authenticating the identity of applicants. They include:

- Assign a personal identification number (PIN) to an applicant, who subsequently uses that PIN when applying for a program. This is the approach the Internal Revenue Service takes for federal electronic tax filing. Similarly, Secretaries of States use this approach to allow state residents to renew automobile registration online.
- Assign a user name and ask the person to supply and verify his or her own PIN or security code. This option is similar to the above, except that the PIN is created and verified by the user, rather than assigned by the state agency. Several companies doing business on the Internet have adopted this approach.
- Allow electronic applications and inform the applicant that her application or enrollment is complete when she signs the back of her enrollment card, which is subsequently mailed to her. The applicant keeps the enrollment card with her, and presents it her provider when she obtains services. This process is similar to the one used for credit cards and U.S. passports.
- Enable applicants to apply online in the presence of application assistants who are authorized to collect, verify, and hold on file a signature for the enrollee. This method is only viable with applications that are filed with the assistance of a third party, but it could obviate the need to fax material after the electronic application is filed.

How to collect a signature via the Internet is a process that still needs development and clarification for Medicaid and SCHIP programs. Trade-offs will need to be made between efficiency and the legal requirements to collect written signatures on paper. Fortunately, several industries and government agencies have experience and working models that are designed to assure that applications for services are made securely over the Internet.

### **Tentative eligibility: What are applicants told after they click “Submit?”**

Several states with online enrollment provide tentative eligibility approval, process the application, and then mail ineligible notices, if warranted, instead of providing immediate

ineligibility notices. Texas's e-Z Application states that it will estimate the child's eligibility and make a final decision once all the paperwork is submitted.

### **Capacity: How many features should be carried out online?**

The following list illustrates the range of functions states have chosen to put online for Medicaid and SCHIP.

#### *Health plan and provider selection*

Some states simply allow enrollees to apply for Medicaid and SCHIP online, while others allow applicants to select health plans and providers online at the time of application. This capacity makes the online system more complex, but it also significantly cuts down on paper mailings and follow-up with accepted applicants. California's Health-e-App allows applicants to select specialty, location, and language preferences for their primary care provider, and then offers a list of providers that meet the profile and are currently accepting new patients.

#### *Broker and community-based agency tracking of applications*

Many states rely on community partners to conduct outreach and to help applicants complete the applications. Some states pay community-agencies for these outreach services. Online enrollment systems can be built with a component for community-based application assistants to track the applications for the people they have assisted. While this adds some programming and training complexity, states that have done this report very high satisfaction from their community partners who can now monitor their work and anticipate when they will be paid. California has an application tracking component for its CAAs. Louisiana is developing this capability in its new online enrollment system.

#### *Premium payment*

States that require premium payments need to consider whether they will support electronic payments. California, for example, allows applicants to pay their premium with a credit card or automated funds transfers from a bank account. Enrollees can also print a payment page with their account information encoded in a bar code, which they can bring to a Rite Aid drugstore where the bar code is scanned and premium payment is accepted.

#### *Web-based community partner training*

Some states have developed a web-based module to train community partners in how to use the online enrollment system.

#### *Other social services*

Through COMPASS, Pennsylvania has chosen to take a comprehensive approach to improving customer service by creating web-based enrollment for several social services. This type of web-based, one-stop shopping for many social services takes Medicaid and SCHIP online enrollment one step further by allowing applicants to screen themselves

and enroll in the services for which they are eligible and interested. As of April 2002, Pennsylvania residents can apply in English and Spanish for Medicaid (pregnant women and children), SCHIP, cash assistance, and food stamps. In February 2003, COMPASS plans to add screening for long-term care and home and community-based services. In April 2003, low-income heat subsidies and childcare subsidies are expected to be included.

Pennsylvania's ability to offer a comprehensive array of services on the web stems from a three-year initiative of former Governor Tom Ridge to improve state agencies' customer service orientation. Early in that initiative the state sought to make applications for state services as seamless as possible and adopted the motto "any form is a good form," enabling state agencies to accept information from applicants with relatively little regard to the specific form on which the information was submitted. Information systems improvements using that principle followed.

Similarly, in December 2002, the Maine Department of Human Services launched an automated client eligibility system that allows state staff to assist applicants and determine eligibility for any combination of 45 state-administered programs. Maine reports that processing time can be reduced to 24 hours compared with the previous average processing time of four to five days.

### **What kind of support from other entities is needed to implement online enrollment?**

The states participating in the NASHP workgroup provided information and strategies for communicating with various stakeholders throughout the process of developing an online capability. They recommend:

- Considering what is needed to gain approval from your state control agencies. California spent considerable energy getting approval from state offices that oversee information technology projects for the state.
- Obtaining and keeping Governor's office support. California's and Pennsylvania's online systems, in particular, were strongly supported by their governors' offices. These states worked with the governor's office extensively and shared successes with them.
- Considering Medicaid's and SCHIP's roles in broader campaigns to put state services online. Several states are moving as many services as possible onto their state's website, and Medicaid and SCHIP programs in these states can benefit from participating in this larger state government strategy.
- Working closely with advocates and community-based agencies. All the states providing online systems discussed the importance of consulting often and actively with advocacy and community outreach organizations.

### **Is online enrollment the best solution to meet your objective?**

Some states may find that another intervention may meet their stated objective better or more cheaply than online enrollment. For example, a shorter application or self-reporting of income data might add more to customer convenience than an online application would.

## **STEP 4: WHAT FUNCTIONS SHOULD BE CONSIDERED AS COMPONENTS OF ONLINE ENROLLMENT SYSTEMS?**

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Once the overall objective and design decisions are made the process of documenting the specifications of an online enrollment process can begin. Ultimately, the specifications can be used as a basis for writing the state's request for proposals from contractors. In some cases, the contractor could be another arm of state government, for example, Louisiana is working with the University of New Orleans, and Washington State worked with one of the state's community colleges.

Online enrollment systems typically perform the following functions:

- Checking for illogical or inconsistent fields.
- Not allowing an applicant to proceed when information is missing.
- Offering applicants help while applying online. Several states have adopted creative ways to offer help screens to guide the applicant as they work their way through the application. Texas's e-Z Application has help screens right next to each section the applicant is filling out. California offers a "help" button that can be clicked at any point during the application. Most states also offer a live help-line that an enrollee can call to speak to a person if he or she needs help.
- Jumping back to earlier parts of the online application. Several states allow the applicant to easily jump back to previous screens, if, for example, they need to add another child or adult for whom to report income. This is more convenient for applicants than requiring them to "back" through all the screens they have already filled out.
- Allowing an applicant to come back hours or days later to complete the application. If the person cannot complete the application in one sitting, several states issue an ID number and password to allow the person to complete the rest of the application within a certain time frame, such as 30 days. The ability to start filling out an application, stop and come back to it later is important for applicants applying from home, who may need to call the help-line to ask a question.
- Allowing health plan and primary care practitioner selection, if applicable.
- Providing language preferences and locations of providers, if applicable.
- Accepting payment online from credit cards or automatic fund transfers, if payment is required before enrollment takes effect.

- Matching online applications with income, signature, or other documentation that arrives later by mail or by fax. Several states urged careful consideration of how applications are to be matched with income or signature documentation sent in later. California's system creates a bar code that is part of the fax cover sheet for income documentation, which can be matched to the rest of the electronic application. Other states issue identification numbers to serve the same purpose.
- Linking from a single point of entry to Medicaid agencies and/or to counties. Some states invested significantly in their online enrollment system's "back-end," the place where the electronic information goes after it is submitted by the applicant. (The "front-end" often refers to the web-based interface with the applicant). Automating the transfer of applicant data from a single point of entry (usually a private administrative contractor) to state Medicaid agencies and to county agencies can create substantial efficiencies. It also requires Medicaid information systems to be able to receive data securely from another source. With many states operating what are considered "legacy information systems" based on older technology, making this link work well can require a considerable initial investment.

To support a successful online application system, states may need to make some accommodations to their current operations. For example, it will be important to have procedures in place to check whether those applying online also have submitted a paper applications in order to avoid duplications. In addition, all of the states participating in the NASHP workgroup offered a toll-free number for applicants to call with questions as they fill out the application online.

## CONCLUSION: ONLINE ENROLLMENT

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Online enrollment systems for Medicaid and SCHIP programs are becoming more widespread. As of December 2002, at least seven states were operating online enrollment systems available throughout the entire state. These were California, Georgia, Michigan, Pennsylvania, Texas, Utah, and Washington. Pilot projects were underway in limited portions of the state in at least five more states: Arizona, Florida, Indiana, Louisiana, and New Jersey. By the fall of 2002, a combined total of approximately one hundred thousand families in these states had applied for Medicaid and SCHIP coverage for their children using a state-sponsored website. Customer evaluations of all of the statewide online programs have been overwhelmingly positive.

States are currently assessing the potential these systems have to save administrative dollars. No state currently has more than 10 percent of its applicants applying online, so at least initially dual processes (paper and web-based) must be kept in operation.

Start-up and statewide implementation costs have ranged from approximately \$40,000 to about \$2 million. Implementation timeframes from design to statewide operation have varied from four months to a year-and-a-half. The structure of Medicaid and SCHIP web-based enrollment systems vary as well. Some states only permit certified community partners to have access to the website, while most states allow individuals to apply from home at any hour of the day. Early evidence shows that applicants have a wide range of incomes, and states have *not* found that only the higher income eligible population will use web-based enrollment. Most statewide online enrollment systems are available in both English and Spanish.

Several outstanding issues persist around the use of electronic signatures for web-based enrollment. By law, Medicaid applicants are required to provide a written signature when applying for the program. Most states with online enrollment require applicants to print and mail-in a signature page after their submission of an electronic application. This extra step reduces the potential convenience and efficiency offered by the web. Some additional options and definition from CMS of what may constitute an electronic signature would be of value to states considering online enrollment.

States have many choices to make in deciding how to design an online enrollment system. By late 2002, they also have several successful models that have been implemented by other states from which to learn.

In sum, it seems clear that online enrollment can improve the accessibility and level of customer service offered to applicants of state-sponsored health coverage. Online enrollment offers the promise of a cheaper and faster way for residents to apply for public health care programs, as well as for many other state services. Through this use of technology, Medicaid and SCHIP programs can increase convenience to their customers, and potentially save administrative costs over the long run.

## **APPENDIX A: OTHER RESOURCES**

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### **Websites of States with Online Enrollment:**

#### **California**

Health-e-App

[www.healthapp.org](http://www.healthapp.org)

#### **Georgia**

PeachCare for Kids

[www.peachcare.org](http://www.peachcare.org)

#### **Michigan**

MiChild e-application

<http://eform.state.mi.us/michild/intro1.htm>

#### **Pennsylvania**

COMPASS

[www.compass.state.pa.us](http://www.compass.state.pa.us)

#### **Texas**

TexCare Partnership e-Z application

[www.texcarepartnership.com](http://www.texcarepartnership.com)

#### **Utah**

CHIP online application and renewal

[www.utah.gov/government/onlineservices.html](http://www.utah.gov/government/onlineservices.html)

(The enrollment site is only opened during open enrollment periods, but the renewal site is active.)

#### **Washington**

Online Community Service Office

[www.access.wa.gov](http://www.access.wa.gov) and

[https://wws2.wa.gov/dshs/onlineapp/introduction\\_1.asp](https://wws2.wa.gov/dshs/onlineapp/introduction_1.asp)

## **States With Pilot Online Enrollment Projects**

### **Arizona**

On June 17, 2002, Arizona launched a pilot online enrollment project in Pima County modeled on California's system. Arizona's online system is called "Health-e-Arizona," and is being tested with the El Rio Center, a community health center in Tucson.

### **Florida**

The Florida Healthy Kids Corporation has operated a five-site pilot online enrollment project since August 2001. The pilot is operated by the state's third party administrator.

### **Indiana**

Indiana is piloting its own version of California's system, which it calls "Ind-e-App." The pilot is expected to begin in November 2002 with the Marion County Health and Hospital Corporation.

### **Louisiana**

Louisiana's LaCHIP program pilot tested an online enrollment system during the summer of 2002.

### **New Jersey**

New Jersey is developing an online enrollment pilot project for NJ KidCare during the fall of 2002.

## **Other Resources**

California HealthCare Foundation

[www.chcf.org](http://www.chcf.org)

National Governors Association

[www.nga.org](http://www.nga.org)

(See especially the "Enrollment Hits the Web" paper.)

Covering Kids

[www.coveringkids.org](http://www.coveringkids.org)

## APPENDIX B: SUMMARY MATRIX OF STATES' ONLINE ENROLLMENT SYSTEMS

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State	Program type	Income documentation	Date started	Contractor	Volume of applications*	Implementation costs
California	SCHIP and Medicaid	One month documentation	9/2002	EDS Deloitte Consulting	2,800/month	Just under \$2 million
Georgia	SCHIP and Medicaid	Self-declare	2001	DHACS	2,700/month	\$40,000
Michigan	SCHIP and Medicaid	Self-declare	2002	NA	NA	NA
Pennsylvania	SCHIP and Medicaid	One month documentation	7/2002	Deloitte and Touche	1,200/month	Several hundred thousand
Texas	SCHIP	One month documentation	9/2001	ACS	800/month	Several hundred thousand
Utah	SCHIP	One month documentation	10/2002	NA	4,500/month during open enrollment period	NA
Washington	SCHIP and Medicaid	Self-declare	2002	State	NA	\$50,000

\*As of September 2002.

## APPENDIX C: NASHP ONLINE ENROLLMENT SWOT TEAM

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In June and August 2002, the National Academy for State Health Policy (NASHP) convened a group of states interested in online or web-based enrollment. NASHP's SCHIP Implementation Center makes extensive use of SWOT Teams, which focus on state programs' Strengths, Weaknesses, Opportunities and Threats. SWOT Teams use basic quality improvement principles to identify problems and to develop, test, and refine solutions.

Well-established quality improvement methods can offer some help for addressing administrative problems. NASHP SWOT Team states have found five steps useful in their improvement work:<sup>6</sup>

1. Focus on customers: kids and their family as customers;
2. Identify the current process: adding online enrollment to the current enrollment process as a sequence of interrelated steps with a common aim;
3. Use a model for improvement: a simple, yet powerful model to structure our tests of change;
4. Create flow maps: a specific tool to diagram the new process; and
5. Review and report findings: regular assessment of progress and barriers.

The SWOT Team on enrollment and online applications had its first meeting in Chicago, Illinois, on June 28, 2002, a meeting funded by the David and Lucile Packard Foundation. The workgroup's second meeting was held in Portland, Maine, on August 15, 2002. This meeting was made possible by additional support from the California HealthCare Foundation.

The purpose of the second meeting was to present and discuss California's Health-e-App, Georgia's PeachCare for Kids online application, Pennsylvania's COMPASS program, and Texas' e-Z application for TexCare Partnership. These four systems were selected to be representative of online systems currently operated by state Medicaid and SCHIP programs.

Representatives from nine states attended the August 15, 2002. At the time, each of these states was considering online enrollment for their state Medicaid and/or SCHIP programs. In the morning, representatives from California, Georgia, Pennsylvania, and Texas presented demonstrations of online enrollment systems. In the afternoon, they answered questions and provided additional details about their systems.

The information and feedback captured during the two meetings of the workgroup provided much of the source material for this report.

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<sup>6</sup> Adapted from James Schlosser, Trish, Riley, Cynthia Pernice, *Increasing Retention and Preventing Disenrollment in SCHIP: Five Step to Improvement* (Portland, ME: National Academy for State Health Policy), August 2001.