



# State Enrollment Experience: Implementing Health Coverage Eligibility and Enrollment Systems Under the ACA

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## Key Findings

- Effective collaboration and coordination across state agencies and with the federal government was critical to states' success in moving toward the seamless and timely eligibility determinations envisioned in the ACA.
- Eligibility and enrollment changes of this magnitude, especially involving the adoption of new technology, often take longer than anticipated. Timelines may shift, policies may evolve, and unexpected challenges are likely to arise.
- Flexibility was a common theme among successful states. Throughout ACA implementation, these states stayed nimble, developing innovative solutions, responding quickly and adapting to the changing policy landscape.
- Keeping key stakeholders, including other state agencies and partners, involved and informed throughout implementation enabled speedier adaptation and provided continuous feedback that helped the state quickly identify and address emerging issues.
- A dedicated federal point person to answer agency questions is invaluable to states, especially in a fast-paced environment with continuously evolving policies and regulations. Regular and transparent communication among federal and state partners is key.
- Effective leadership and a culture that prioritized enrollment as a goal were important factors in many states.

The Patient Protection and Affordable Care Act (ACA) included new eligibility and enrollment requirements, which have presented states with significant implementation opportunities and challenges. Although states had choices about whether to host a health insurance exchange or expand Medicaid, the ACA required all states to make major changes to Medicaid eligibility policy, including adding mandatory coverage of new groups, implementing streamlined eligibility and renewal processes, incorporating new eligibility and verification requirements, and coordinating enrollment systems with exchanges.<sup>1</sup>

As a result, states had to create or significantly update existing systems, collaborate and coordinate with other state and federal agencies, and develop new processes to support enrollment. States implemented these changes within a constrained timeframe, with much activity occurring between the Supreme Court ruling in *NFIB v. Sebelius* in summer 2012 and the first open enrollment period in fall 2013. In addressing the challenges of ACA implementation, many states and federal agencies were highly innovative, developing approaches that set a new standard for promoting effective enrollment in public programs.

Drawing on key informant interviews and ongoing engagement with states between 2013 and 2015, this brief examines states' early experiences implementing the ACA's eligibility and enrollment requirements; highlights promising practices and lessons learned; provides some context on the state experience; and concludes with possible areas of focus for future enrollment and implementation efforts. With the recent Supreme Court decision in *King v. Burwell*, there is new momentum for state and federal agencies to learn from early experiences with ACA implementation to further improve enrollment systems in future years.

This brief offers reflections to support continued growth and movement.

## Streamlining Eligibility and Enrollment Processes Under the ACA

The ACA envisioned a simpler, unified system of health coverage. Through a sliding scale of subsidies and modernized enrollment processes, it sought to provide more affordable and accessible coverage options to non-elderly individuals with family incomes between 0 and 400 percent of the federal poverty level (FPL).<sup>2</sup> As part of promoting access to coverage, the ACA required all states to make transformative changes, modernizing and streamlining their eligibility and enrollment systems, many of which relied on decades-old technologies and paper-based processes.<sup>3</sup> Key changes included:<sup>4</sup>

- **Adding new coverage groups to Medicaid:** States were required to expand Medicaid coverage to children with family incomes up to 133 percent of the FPL and to young adults up to age 26 who were in foster care and enrolled in Medicaid when they turned 18. States also had the option to add Medicaid coverage for non-elderly adults with family incomes up to 133 percent of the FPL.<sup>5</sup>
- **Creating a streamlined, automated enrollment process:** States had to adopt a single, streamlined application (or alternative application approved by the Secretary of HHS) for Medicaid, Children's Health Insurance Program (CHIP), and subsidized qualified health plans (QHPs) offered through the marketplace. States also had to accept applications online, by phone, by mail, or in person, and states were barred from requiring in-person interviews and from asking for more than the minimum information necessary to determine eligibility. Although some states already used a simplified application or electronic processing for Medicaid and CHIP programs, for most converting applications and systems required a significant shift in business operations and substantial coordination with federal officials.
- **Implementing new income eligibility rules:** With support and guidance from the Centers for Medicare and Medicaid Services (CMS), states were required to adopt a new modified adjusted gross income (MAGI) methodology for income determinations and convert their income categories to the new MAGI standards. States also had to incorporate the ACA's income counting rules for American Indians/Alaskan Natives.
- **Changing verification processes:** States had to adopt a new coordinated data-driven system that relied on a federal data services hub for verification of income, citizenship, and immigration status, along with available state-based data sources. Although many states had relied on paper documentation to verify eligibility, the ACA regulations required states to prioritize electronic data sources. States were also required to allow applicants to self-attest their pregnancy status, and CMS clarified states' option to use self-attestation for other requirements, including residency. And, for the first time, states had to create a plan documenting their MAGI-based eligibility verification processes and sources used and submit it to CMS.
- **Coordinating with state and federal marketplace agencies:** States were required to screen eligibility and transfer applications to appropriate insurance affordability programs (Medicaid, CHIP, and marketplace). For applications transferred to Medicaid or CHIP, states had to make a timely determination without requiring additional information. To do this, states set up data-sharing agreements and needed to be able to transfer account information electronically.
- **Streamlining the renewal process:** States had to implement new, simpler renewal processes that lowered burdens on enrollees. As part of this effort, states had to rely, to the greatest extent possible, on available information; make renewal decisions without requiring additional information from enrollees; use

prepopulated, streamlined forms when there was insufficient information for renewal; allow individuals to renew electronically, by phone, in person, or by mail; and renew no more than once per year.

## State Choices Impacted Implementation

The extent of the changes required and how the new systems operate has varied based in part on each state's decision regarding marketplace functions. Sixteen states opted to enroll individuals through a state-based marketplace (SBM), where the state performs all marketplace functions; six states use a state partnership marketplace (SPM) model where the state performs consumer assistance, plan management functions, or both and the federal facilitated marketplace (FFM) manages eligibility determination processes; and the remaining 29 states rely on the FFM for all marketplace functions.<sup>6</sup>

In SBM states, the state performs eligibility and enrollment functions, usually through its own eligibility system, and manages plans and assistance organizations. In FFM states, the FFM performs all marketplace eligibility and enrollment functions relating to qualified health plans: eligibility, enrollment, plan management, consumer assistance and financial management. Although the FFM either assesses or determines Medicaid and CHIP eligibility for states, FFM state agencies remain responsible for other Medicaid and CHIP eligibility and enrollment systems and processes, including timely account transfers between federal and state systems. Consumers in FFM states can apply for and enroll in coverage through the FFM marketplace website, [healthcare.gov](http://healthcare.gov), or enter through the state's Medicaid or CHIP systems. SPM states' enrollment functions operate like FFM states, except these states may perform plan management or consumer assistance functions, or both. Both FFM and SPM states need to coordinate closely with federal agencies to ensure seamless eligibility and enrollment operations.<sup>7</sup>

FFM and SPM states could opt to be either assessment or determination states for Medicaid and

CHIP eligibility.<sup>8</sup> In assessment states, the FFM assesses an applicant's eligibility and state Medicaid and CHIP agencies make the final eligibility determination. In determination states, the FFM makes a determination of eligibility which the state Medicaid agency must accept and enroll the individual once an account is transferred. As of January 2015, 10 states had opted to be determination states and 27 states were assessment states.<sup>9</sup>

Assessment and determination states faced and adapted to different sets of challenges and functionality issues. For example, in the first year, the FFM had to transfer accounts using "flat files" that included basic information about applicants assessed or determined to be eligible for Medicaid or CHIP but did not capture enough information for states to make independent determinations.<sup>10</sup> As a result, assessment states had to gather additional information to support their own determinations. In addition, both groups of states reported that a significant percentage of individuals determined newly eligible for Medicaid by the FFM were already enrolled. These technical difficulties, combined with the volume of applications and the absence of fully automated systems created an enrollment backlog in some states as they manually worked through the case files.<sup>11</sup> Although FFM functionality was better during the second open enrollment period, interviewees said improvements are still needed.<sup>12</sup>

All state IT systems needed expanded capabilities. In many states, eligibility systems were outdated and the additional functions could not be added without building a new system or significantly updating an existing one. States are able to claim an enhanced federal match for developing their Medicaid IT systems: a 90 percent federal financial percentage (FFP) is available for design, development, and implementation of IT systems, and a 75 percent FFP is available for ongoing maintenance and operation.<sup>13</sup> To claim the enhanced match, states must have an approved advance planning document; comply with CMS's seven conditions and standards;<sup>14</sup> and appropriately allocate costs. States can also claim a 75 percent FFP for approved electronic eligibility determination system

operations, including staff time.<sup>15</sup>

Two Tri-Agency letters, sent jointly from CMS, the U.S. Department of Agriculture, and the Administration for Children and Families allow states to use the enhanced FFP to upgrade systems that support human services programs other than Medicaid, as long as the addition does not delay implementation of the ACA requirements and states appropriately allocate any additional costs of improvements for non-Medicaid programs.<sup>16</sup>

Under this guidance, states can also allocate costs for development and maintenance of state marketplace IT systems that serve Medicaid eligibility functions.

## Promising Practices

States innovated and adopted new strategies that, according to interviewees, appeared to increase enrollment, improve efficiency or coordination, and make eligibility systems run more smoothly. Some examples of these practices are detailed in the text below.

## Targeted Enrollment

In anticipation of the first open enrollment period in 2014, CMS offered five targeted and streamlined enrollment strategies to help states manage the transition to new eligibility and enrollment systems:<sup>17</sup>

1. Implementing MAGI rules on October 1, 2013
2. Extending the renewal period for certain individuals
3. Facilitating enrollment through administrative transfers of eligibility data from other programs.
4. Enrolling parents based on children's eligibility.
5. Adopting 12 months of continuous eligibility (without regard to changes in circumstances) for parents and other adults through the Medicaid section 1115 waiver authority.<sup>18</sup>

These optional approaches were created to help states efficiently identify and enroll eligible individuals and alleviate administrative burdens during this high-volume period, and more than two-thirds of states implemented one or more of them.

Seven states used income data from the Supplemental Nutrition Assistance Program (SNAP) to

identify Medicaid-eligible individuals.<sup>19</sup> Officials and stakeholders in Arkansas and West Virginia reported that using this strategy increased enrollment and contributed to smooth enrollment processes:

- In Arkansas, SNAP eligibility rules aligned with Arkansas' Private Option Medicaid expansion program and ARKids First, the state's CHIP program. Arkansas' Medicaid agency mailed letters to potentially eligible SNAP recipients that clearly listed all Medicaid-eligible individuals in the household. The state identified the individuals and mailing addresses from information already provided to the Department of Human Services (DHS), which administers both SNAP and Medicaid. To enroll, recipients simply signed and returned the letter to DHS. Once the state received the signed letters, officials automatically enrolled children in ARKids First and mailed an ID card and sent adults a plan selection letter, giving applicants up to 12 days to select a Private Option plan through the state's web portal or be enrolled in a default plan if they did not select one. Arkansas officials reported that they had enrolled 61,000 people, or roughly 40 percent of new Medicaid enrollees, using this strategy by the end of the first enrollment period.
- West Virginia also successfully used this strategy and credited this low-touch approach with about half of all Medicaid enrollments during the first year. The state initially sent letters with enrollment information to 118,000 SNAP recipients in September 2013. County staff and in-person assisters called to follow up on the mailing. The state then sent follow-up letters to 17,000 individuals in November 2013 and made another round of follow-up calls. Through this process, the state was able to enroll approximately 72,158 people, more than half of the 133,000 individuals who were newly enrolled during the first open enrollment period.<sup>20</sup>

## Eligibility System Functionality

The ACA catalyzed long-overdue improvements to state eligibility systems, many of which were out-

dated and featured cumbersome operations, high administrative costs, ineffective data use, obstacles for consumers, and other inefficiencies.<sup>21</sup> All the states represented in the interviews used the ACA's requirements and enhanced funding to modernize their systems. State officials reported that taking a proactive, tailored approach to system updates resulted in improved performance, greater efficiency, and reduced burdens for consumers and state workers. For example, Kentucky officials reported that Medicaid and marketplace officials coordinated heavily in the design and implementation of that state's IT system, including holding joint design and testing sessions and supporting close collaboration between the very "hands on" IT staff and policy staff throughout the process.

Several states that allowed extra time to test eligibility system technology before making it available to consumers reported positive results. For example, Ohio Medicaid officials reported delaying their system launch until December 2013 to test the functionality and said that as a result, the system performed well and gained consumer confidence at a critical time when FFM was underperforming. Connecticut officials reported that their system worked well because they started early and tested it multiple times before launch.

### Eligibility System Processing

The ACA assumes an eligibility process that allows applications and data to flow seamlessly across agencies to match customers with the appropriate health coverage program (usually either Medicaid, CHIP or subsidized qualified health plans purchased through an exchange). This kind of seamless processing would occur most easily within a single integrated system serving all programs. Twelve states had adopted such a system as of January 2015.<sup>22</sup>

Nearly all of these states also built automated "rules engines" that interface with the state and federal data sources needed to verify application information. Automated eligibility decisions, coupled with electronic verification using both federal and state data sources, enable states to conduct

efficient, real-time eligibility determinations. Using integrated eligibility systems prevents delays in handoffs of information between the marketplace and Medicaid and CHIP eligibility systems.<sup>23</sup> Kentucky, one interviewed state that implemented an integrated system, reported that their state's integrated eligibility system and automated rules engine virtually eliminated miscommunication among programs in the eligibility process and improved efficiencies for state workers during the first year of open enrollment.

States are also working to integrate these modernized Medicaid and CHIP eligibility systems with other human service programs to identify and simplify enrollment for the millions of low-income individuals who are enrolled in assistance programs but not in Medicaid. For example, if all states expand Medicaid, more than 90 percent of recipients of SNAP, Temporary Assistance for Needy Families (TANF), and housing subsidies will qualify for Medicaid.<sup>24</sup> As of January 2015, 19 states reported that their Medicaid eligibility systems were integrated with at least one other human service program's system, and another 12 states were planning to integrate in 2015.<sup>25</sup>

### Coordination Among State Agencies and With Federal Partners

Several states reported that effective coordination among state agencies and with federal partners were key to strong enrollment performance.

- Arkansas officials, for instance, reported that Insurance Department and Medicaid officials coordinated closely on the development and implementation of their enrollment efforts, including through regular cross-agency meeting and reporting.
- Kentucky state officials reported that in 2010 they formed a team of staff from Medicaid, community-based services, TANF, Insurance, health policy, and IT that coordinated implementation through weekly meetings during implementation.
- Washington state officials also reported holding regular meetings with IT, Medicaid, Insurance, and marketplace officials and said that a key element of their success was their work

through that process to manage scope and governance and to tighten and clarify responsibilities.

All these states also reported close coordination and consultation with the Center for Consumer Information and Insurance Oversight (CCIIO) and the Center for Medicaid and CHIP Services at CMS.<sup>26</sup>

States also reported that having timely, accurate information from federal partners was essential, both to improving the accuracy of Medicaid and the FFM or state determination process and to lowering the resource burden for states. Although nearly all states praised federal agency partners' engagement and appreciated new structures to improve communication, some expressed concern that tight timelines and the rulemaking process in the first year of implementation limited their access to timely information.

States noted that the State Operations and Technical Assistance (SOTA) phone calls that CMS has hosted since spring 2012 are an effective model for communicating with and supporting states. CMS holds SOTA calls with state officials as a group and conducted monthly calls with individual states before and during ACA implementation, providing technical assistance and support on policy and operational issues. Subject matter experts are typically on the calls to provide updates and answer questions, which states said is especially valuable. Several states also praised CCIIO's support for implementation but expressed concerns about the rulemaking delays that created challenges during the first year when states had to scramble to make late changes to new systems in response to revised policies.

### **Renewal Simplification Strategies**

During the second year of open enrollment, states for the first time renewed QHP enrollees and enrolled new customers at the same time. Renewing coverage for existing enrollees is essential to avoid coverage gaps, but state approaches varied.<sup>27</sup> The ACA required states to ensure that renewal processes for Medicaid, CHIP and mar-

ketplace coverage are streamlined, integrated, and user-friendly. Several states reported that adopting auto-renewals, beginning the processing of QHP renewals before open enrollment, and using pre-populated forms helped streamline processes for agency staff and promoted continuity of coverage for consumers. Connecticut officials reported that using a QHP auto-renewal process, combined with other outreach, resulted in an 80 percent retention rate among those eligible to renew in the second year.

### **Real-Time Feedback Loop and Transparency**

A number of states reported that they scheduled weekly calls during the open enrollment period with organizations providing enrollment assistance to consumers and other stakeholders to get feedback and track problems with state and federal systems. These states said the calls helped them identify emerging issues, quickly address problems, and elevate concerns with federal agency partners where external help was needed. Some of these states also used the calls to share updates and changes to the system so that assistance organizations understood new systems and process changes. For example, California officials reported using periodic calls to update eligibility workers and consumer advocates throughout the state on changes to the system and to hear about issues and concerns. Before implementation, Washington state officials established monthly outreach meetings and provided trainings that reached over 1,900 community partners. During the first year of implementation, Washington officials organized Friday Forum meetings with assistance and stakeholder organizations to discuss the latest issues and areas for coordination. The state also continued holding community partner webinar trainings to discuss issues and system changes during the second year of implementation. Kentucky, Montana, and Ohio, also reported convening or participating in similar stakeholder meetings. Some states, most often those with state-based exchanges, also supported transparency in implementation by posting updates, information, and enrollment data on state websites.

## Managing Eligibility System Volume

During open enrollment periods, some states experienced higher than anticipated volume on newly launched eligibility systems, due in part to the success of consumer outreach strategies. High volume strained IT system and support staff. Some states worked to mitigate volume to reduce burdens and ensure effective distribution of resources. For example, in the second year, California and Idaho opened their marketplace sites early for renewals, and Oklahoma monitored call center and eligibility worker peak-flow times and reorganized staff and hours of operation to improve performance.

## Strong Leadership and Enrollment Culture

Although difficult to quantify as a success factor, several officials and stakeholders said their success was due in part to strong leadership from a state official and a culture that supported streamlined enrollment as a priority goal. Representatives from one assistance and provider organization said of their state's official, "[he] brought people together and worked really hard in a very difficult political environment. He helped forge partnerships and move things forward." Another official praised his state's agency director for being "proactive in reaching out to federal officials and asking questions." Stakeholders providing enrollment assistance mentioned that a significant factor in their success was that the marketplace was state-led and said that alignment around coverage as a policy goal helped move their work forward.

## Remaining Challenges and Future Opportunities

Although integrating and advancing state and federal eligibility and enrollment systems has presented historic challenges for state and federal agencies, achieving the ACA's policy and system goals has the potential to provide states with a less costly and more efficient, consumer-friendly, and effective means for enrolling and retaining eligible individuals. State and federal agencies continue to refine processes and systems in order to optimize the consumer experience, improve efficiency, and minimize confusion and administrative burdens on

staff and stakeholder entities providing assistance. The federal government has made a significant investment in ensuring that processes are more streamlined and has demonstrated a strong commitment to working with states to further optimize system functionality. In making transformative changes, state leaders have shown themselves willing and able to think differently and to innovate around health coverage programs.

Looking to the future, state agency leaders identified key challenges and future opportunities to improve eligibility and enrollment operations in years ahead.

## Providing Accurate and Timely Technical Support and Communications

Several states reported ongoing challenges with receiving electronic account files from the FFM. Some states have found that the information contained in those files was inaccurate due to technical issues with the data hub and disconnects with state systems. Reported problems have included erroneous identity verification, failure to detect Medicaid-enrolled individuals, and cases where applicants "looped" between Medicaid and marketplace entities without a final determination of coverage. Although states interviewed praised the SOTA calls that CMS hosted and CCIO's operational support, some said they wanted CMS to give state interests greater consideration in future implementation efforts and wanted a more streamlined process for elevating and resolving cases involving a pending eligibility decision. Many FFM states suggested it would be helpful to have federal technical experts to address questions related to eligibility systems or account transfer issues on SOTA calls. Officials said some IT system funding issues raised policy concerns but were handled just with state IT staff, and they wanted a venue for discussions that bridged policy and technical work. Some officials also mentioned wanting more opportunities for cross-state learning and information sharing and said that technical assistance would be valuable.

## Streamlining System Processes

Medicaid directors and CMS are working on a number of system and policy improvements to increase efficiency and improve communication between federal and state agencies, including stabilizing system timelines and testing, eliminating redundancies between state and federal systems, improving formats, for shared information upgrading notices and communication about coverage, and aligning eligibility policies.<sup>28</sup> A high-priority request for states is that the FFM perform a “Medicaid Check” for applicants identified as Medicaid eligible by the FFM before transfer to the state. In some states, the FFM’s transfer of Medicaid-eligible individuals led to additional costs, dual enrollment in Medicaid and the marketplace, or consumers who looped back and forth between both systems. Some states and stakeholders also had concerns about the number of cases where coverage decisions were delayed or unresolved because of discrepancies between how state and federal agencies determined eligibility and challenges with tracking a case to resolution.

Some states are still deploying technology to make them fully compliant with the ACA’s requirements, and officials will need to invest time and resources to ensure that their own systems and processes are efficient, leverage existing data and technology to the greatest extent possible. To support that goal, states may look for opportunities to simplify eligibility processes by aligning systems with other human service programs, engaging in process-mapping efforts or secret shopper reviews to identify and resolve gaps, and investing in emerging technologies to support a streamlined experience. For example, Kentucky officials are planning to implement a new system for the next open enrollment period that will use text messages to send information and reminders to applicants in rural areas, who may be more likely to have access to cell phones than computers.

## Improving Eligibility Verification Systems

Many states continue to have challenges with eligibility verification. Due to delays in system functionality and issues with integration across state,

federal and, in some cases, county-based systems, many states still have to manually review cases for accuracy and have ongoing problems with income and citizenship verification. Although some states are already using electronic connections to create a state data hub for verification purposes, other states aren’t yet fully utilizing the data available from other state programs. States have also expressed great interest in being able to access the federal data services hub, which provides social security and tax-based income information for applicants, across health and human services programs, to integrate and align eligibility verification processes. Sharing hub information is currently barred by federal rules that protect personal tax information, so a policy change would be needed to allow greater integration. Continued communication between federal and state officials to identify issues and challenges with the federal data hub will likely improve its functionality in future years.

## Tracking and Managing Coverage Gaps and Errors

Most states that were interviewed for the first open enrollment period did not yet have systems in place to track eligibility changes, midyear transfers, reasons for coverage loss, or the outcome of eligibility changes (e.g., loss of coverage or transfer to another coverage program). However, states’ experiences with Medicaid and CHIP enrollment suggest that loss of coverage due to eligibility changes or failure to renew is a significant risk for low-income populations.<sup>29</sup> Individuals who lose coverage but remain eligible will likely re-enroll, creating a phenomenon known as “churn,” disrupting continuity of coverage for individuals, undermining states’ ability to monitor and improve health outcomes, and increasing administrative costs. State and federal agencies can focus on improving tracking of reasons for coverage loss and the outcome of eligibility changes throughout the year and at renewal, to improve their capacity to understand coverage trends and whether procedural barriers are a factor in disenrollment.<sup>30</sup> Another important area for future tracking is states’ experiences with erroneous enrollments and their financial impact, in unnecessary payments and fines. Increasing state and federal ca-



capacity to track and understand these trends will be essential to ensure that the ACA's investment in coverage yields lasting coverage gains.

## Financing and Sustaining Systems

Several states reported that funding for eligibility and enrollment efforts was constrained, either due to limits on Medicaid budgets or expiring federal support for state-based marketplaces. Some states reported finding successful solutions involving external partners, such as leveraging financial or in-kind support from state-based foundations. In Ohio, a private foundation hosted and

supported a coalition of interested stakeholders to work with the state on ACA implementation. In California, a private foundation provided the state share of Medicaid matching funds needed to finance state outreach efforts. SBMs are considering policy options to provide financial sustainability in 2016. Some SBMs have implemented or are pursuing cost-reimbursement strategies to ensure that costs associated with the significant percentage of Medicaid eligibility cases handled by marketplaces entities are accurately allocated to Medicaid.<sup>31</sup>

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## Conclusion

Over the past few years, state and federal officials have undertaken the historic task of modernizing and streamlining eligibility and enrollment systems to meet ACA requirements to improve access to coverage for low-income individuals. This brief highlights some of states' early promising practices, lessons learned, remaining challenges, and future opportunities for state and federal officials to consider as they move forward. With the Supreme Court's decision upholding the constitutionality of federal marketplace subsidies in FFM states in *King v. Burwell*, states have greater certainty about the continued availability of ACA coverage programs, which may offer new momentum for federal and state agencies to invest new resources in learning and improving enrollment systems for future years. Regardless of future roles for state and federal agencies under the ACA or other programs, state lessons about investing in system improvements, coordination among agencies and stakeholders, strong leadership that can remain flexible and adaptive in a dynamic environment, and creativity in the face of logistical and other challenges, are valuable models for future implementation.

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## Methodology

Between 2013 and 2015, NASHP, with funding from the Robert Wood Johnson Foundation, investigated the experiences of federally facilitated marketplace (FFM) states—states using the federal health insurance exchange—working to prepare for and enroll consumers in coverage under the ACA. In 2013, NASHP hosted a meeting of FFM state officials. In spring 2014, NASHP conducted key informant interviews with state officials and stakeholders in 10 states that had successful enrollment and proportionally represented state exchange and expansion choices (Arkansas, California, Connecticut, Florida, Kentucky, Ohio, Montana, North Carolina, Washington, and West Virginia). The group included six FFM states (including three SPM states) and four SBM states.<sup>32</sup> To get a broader perspective, NASHP sought to interview at least three representatives in each state: two state officials from different agencies, either Medicaid, CHIP, or Insurance Departments, and one stakeholder involved with enrollment activities. NASHP also facilitated a learning network of FFM state leaders on a bimonthly basis throughout 2014 and convened an in-person meeting at its 2014 State Health Policy Conference. Finally, NASHP hosted a webinar in December 2014 and surveyed key informants from the 10 states in early 2015 to identify strategic changes and lessons learned from the second open enrollment period.

## End Notes

1. Alice M. Weiss, Abigail Arons, and Julien Nagarajan, *States' Medicaid ACA Checklist for 2014*, (Washington, DC: National Academy for State Health Policy, State Health Reform Assistance Network, and Robert Wood Johnson Foundation, 2013).
2. Alice M. Weiss and Laura Grossman, *Paving and Enrollment Superhighway: Bridging State Gaps Between 2014 and Today*, (Washington, DC: National Academy for State Health Policy, California Healthcare Foundation, 2011).
3. Ibid.
4. Alice M. Weiss, Abigail Arons, and Julien Nagarajan, *States' Medicaid ACA Checklist for 2014*.
5. Although the ACA originally required states to expand Medicaid coverage to non-elderly adults with family incomes up to 133 percent of the federal poverty level, the Supreme Court's decision in *NFIB v. Sebelius* made that requirement unenforceable by HHS and many states opted out of the expansion. As of June 2015, 30 states had chosen to expand Medicaid coverage to this new adult group.
6. State Reform, *Where States Stand on Exchanges* (Washington, DC: National Academy for State Health Policy, 2014). Three SBM states are relying on the federal marketplace as an eligibility system IT platform for the 2015 plan year and three FFM states are operating state-based Small Business Health Options Program (SHOP) exchanges.
7. Stan Dorn and Rebecca Peters, *Opportunities under the Affordable Care Act for Human Services Programs to Modernize Eligibility Systems and Expedite Eligibility Determination*, (Washington, DC: Urban Institute, 2014).
8. Kaitlin Sheedy, *Coordinating Eligibility and Enrollment: Assessment vs. Determination Model* (Washington, DC: National Academy for State Health Policy, 2013); Brooks, Tricia, *Tech Tuesday: Medicaid Assessment or Determination by the Federal Marketplace*, Center for Children and Families Health Policy Blog (June 4, 2013) <http://ccf.georgetown.edu/all/tech-tuesday-medicaid-assessment-or-determination-by-the-federal-marketplace>.
9. Tricia Brooks, et. al, *Modern-Era Medicaid: Findings from a 50 State Survey on State Eligibility, Enrollment, Renewal and Cost-Sharing Practices as of January, 2015* (Washington, DC: Kaiser Family Foundation, 2015). This number includes all 34 FFM/SPM states, plus the three SBM states that are using healthcare.gov to support eligibility functions.
10. Center for Medicaid and CHIP Services, *State Medicaid Director Letter, New Flexibility: Using Account Transfer Flat Files to Enroll Individuals in Medicaid and CHIP*. (Washington, DC: Department of Health and Human Services, 2013).
11. States that experienced enrollment system challenges or were unable to process cases within the 45-day timeframe required by CMS to develop and submit mitigation plans that outlined the state's efforts to address the barriers to compliance.
12. Medicaid directors have voiced similar concerns in a March 2015 letter to CMS. In that letter, state Medicaid directors shared with CMS a list of priority improvements to increase the accuracy of FFM determinations and the efficiency of federal and state operations for the 2016 open enrollment period. National Association of Medicaid Directors: letter to the Centers for Medicare and Medicaid Services, March 23, 2015, [http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd\\_letter\\_to\\_cms\\_medicaid\\_exchange\\_issues\\_150323.pdf](http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_letter_to_cms_medicaid_exchange_issues_150323.pdf). CMS later expanded the scope of data sent to states to include enough information to support a determination, including Social Security Numbers and dates of birth. Among the prioritized improvements was a request that the FFM check Medicaid enrollment at the beginning of the eligibility determination process to avoid duplicate enrollments.
13. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Federal Register* 76, no. 75 (April 19, 2011). pp. 21949 – 21975.
14. Centers for Medicare and Medicaid Services, *Enhanced Funding Requirements; Seven Conditions and Standards* (Washington, DC: U.S. Department of Health and Human Services, 2011), MITS-11-01-v1.0.
15. 42 USC § 433.116(j). *Medicaid Program Eligibility Final Rule* (2011). Although the 90 percent FFP for IT system development and implementation was originally only available for costs incurred or services performed through December 31, 2015, CMS proposed in April 2015 to extend the availability of the enhanced FFP indefinitely and to extend funds for integrated systems until 2018. In proposing to extend the funds, CMS recognized that state eligibility and enrollment systems are in varying stages of completion and reasoned that an extension would enable states to further improve and integrate systems. Centers for Medicare and Medicaid Services, *Proposed Rule: Medicaid Program: Mechanized Claims Processing and Information Retrieval Systems* (Washington, DC: Department of Health and Human Services, 2014), RIN 0938-AS53.
16. U.S. Department of Health and Human Services, *Federal Policy Guidelines: Letter to State Exchange Grantees; Medicaid and CHIP Directors; Health and Human Service Directors*, January 23, 2012.
17. Center for Medicare and Medicaid Services, *State Health Officials Letter; State Medicaid Director's Letter: SHO #13-003; ACA #26, Facilitating Medicaid and CHIP Enrollment and Renewal in 2014*, May 17, 2013.
18. Centers for Medicare and Medicaid Services, *Targeted Enrollment Strategies* (Washington, DC: Department of Health and Human

Services, 2014). Most states (36) opted to delay renewal periods, with fewer choosing to implement other strategies. No states implemented the continuous eligibility strategy for adults.

19. Ibid. Arkansas, California, Illinois, Michigan, New Jersey, Oregon, and West Virginia used data from the Supplemental Nutrition Assistance Program (SNAP) to identify Medicaid-eligible individuals.

20. West Virginia Department of Health and Human Resources, “Second Round of Medicaid Automatic Enrollment Letters Sent,” news release November 21, 2013, [http://www.wvdhhr.org/communications/news\\_releases/Press%20Release--Secretary%20Bowling%20Announces%20Second%20Round%20of%20Automatic%20Enrollment%20Letters%20for%20Medicaid.pdf](http://www.wvdhhr.org/communications/news_releases/Press%20Release--Secretary%20Bowling%20Announces%20Second%20Round%20of%20Automatic%20Enrollment%20Letters%20for%20Medicaid.pdf)

21. Phone interview with WV Medicaid Officials, May 21, 2014; Stan Dorn and Rebecca Peters, Opportunities under the Affordable Care Act for Human Services Programs to Modernize Eligibility Systems and Expedite Eligibility Determination.

22. Tricia Brooks, et. al, Modern-Era Medicaid: Findings from a 50 State Survey on State Eligibility, Enrollment, Renewal and Cost-Sharing Practices as of January, 2015.

23. Manatt, Report from the States: Early Observations about Five State Marketplaces (Los Angeles, CA: State Health Network, 2013) .

24. Stan Dorn, et al., Overlapping Eligibility and Enrollment: Human Services and Health Programs Under the Affordable Care Act (Washington, DC: Urban Institute, 2013).

25. Tricia Brooks, et al., Modern-Era Medicaid: Findings from a 50 State Survey on State Eligibility, Enrollment, Renewal and Cost-Sharing Practices as of January, 2015.

26. CMS used a variety of strategies to address states’ technical and operational challenges. For example, it leveraged the Eligibility Technical Assistance Group, a monthly forum where state Medicaid and CHIP leaders discuss eligibility policy and operational changes, highlight emerging implementation strategies and hear concerns. CMS also developed learning collaboratives, including one for FFM states, to gain a deeper understanding of state operations and develop new policies to address state needs. To engage state Medicaid, CHIP, Insurance, and IT teams, CMS created monthly State Operations Technical Assistance (SOTA) calls, group technical assistance meetings, and gate reviews in state-based exchange states to review state progress toward exchange development milestones. These convenings provided important opportunities for state agencies and federal partners to develop new policy strategies, discuss challenges and future needs, and provide support.

27. State Reform, Marketplace Renewal Strategies During the ACA’s Second Open Enrollment Period (Washington, DC: National Academy for State Health Policy, 2015).

28. National Association of Medicaid Directors: letter to the Centers for Medicare and Medicaid Services, March 23, 2015.

29. Jessica Stephens and Samantha Artiga, Getting into Gear for 2014: Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the ACA (Menlo Park, CA: Kaiser Family Foundation, 2013).

30. All states are participating in a Medicaid and CHIP Eligibility Review Pilot, which allows the states and CMS to review the accuracy of caseworker and system determinations. This pilot, is intended to help states more rapidly identify and correct system and process errors and is replacing Payment Error Rate Management eligibility reviews for all states until 2017.

31. Electa Draper, “Colorado Health Insurance Exchange Could Double its Fees in 2016,” Denver Post, May 11, 2015. At least four large SBMs are cost-allocating to Medicaid, with reimbursements ranging from \$15 million to \$29 million, according to an exchange official in Colorado, which is planning to implement Medicaid cost-reimbursement in 2016.

32. The 10 key informant states interviewed included six FFM/SPM states: Arkansas, Florida, Montana, North Carolina, Ohio, and West Virginia; and four SBM states: California, Connecticut, Kentucky, and Washington.

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The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: [www.nashp.org](http://www.nashp.org).

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