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Paving an Enrollment Superhighway: Bridging State Gaps Between 2014 and Today

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Executive Summary

The Affordable Care Act (ACA) is generating a sea change for state health coverage programs. By initiating a historic coverage expansion under Medicaid, creating new tax subsidies to support private coverage for low- and moderate-income individuals, and mandating individuals to have health insurance coverage, ACA promises to make health coverage more affordable and accessible than ever. States are playing a lead role in ACA's implementation and creating eligibility and enrollment systems that can screen, enroll, renew and transfer coverage among programs is a central component of their work. To support state efforts, ACA provides a transformative vision for eligibility and enrollment in public and publicly subsidized health coverage: an enrollment superhighway that is streamlined, modern, seamless, integrated, easy for consumers to use, and connects Medicaid, CHIP and Exchange coverage. Given the prominence of health coverage as a goal for health system reform, whether states can implement this vision for a simpler, streamlined enrollment system and ultimately enroll the estimated 32 million newly eligible individuals will be a critical test of ACA's success.

Although states have the lion's share of responsibility for implementing ACA, there are critical gaps between where states are today and ACA's enrollment superhighway vision for 2014. In addition, while ACA provides a vision and new tools for a vastly simplified system, it also creates new technical complexities that are sure to challenge states' abilities to achieve its intent and promise. Although these gaps and federal complexities are not insurmountable, understanding them is critical for federal and state policymakers working to implement reforms by 2014. This paper frames ACA's vision for an enrollment superhighway, then discusses the gaps states will experience between 2014 and today and opportunities to close these gaps in four key areas: 1) Consumer Experience; 2) Eligibility and Enrollment Policy; 3) Technology and Systems Infrastructure; and 4) Governance and Administration. While each of these areas are looked at individually for ease of discussion, they do not exist in silos — each are integrally connected to one another and the broader goal of streamlining enrollment.

ACA's Vision: An Enrollment Superhighway

The Affordable Care Act presents states with a vision that moves enrollment away from the complex, disconnected, paperwork-intensive, burdensome processes of the past. In its place, ACA, along with subsequent guidance, challenges states to adopt a modern, streamlined eligibility and enrollment system that includes the following elements:

1. *Assisted, easy-to-use process for consumers*: To fully achieve ACA's vision and the efficiencies it promises, states will need to deliver a first-class customer experience ensuring that consumers have the information and assistance they need to make enrollment simple and easy to navigate. Key ACA provisions include: a single application form for all programs that can be submitted online, by phone, by mail or in person; a minimum documentation standard for states that lowers the burden for applicants; assistance for consumers provided through Consumer Assistance/Health Insurance Ombuds Programs or Navigators; understandable coverage information; and consumer-friendly design and access.
2. *Seamless "one-stop" system*: The ACA requires state coverage programs to provide a seamless experience that allows individuals to apply only once for multiple programs through any "door." Medicaid, CHIP and Exchange coverage must provide integrated enrollment and renewal strategies and link state, federal and private systems electronically.

3. *Simpler eligibility rules*: States will operate coverage programs under dramatically simplified federal eligibility rules based on Modified Adjusted Gross Income (MAGI) for all subsidized coverage programs (Medicaid, CHIP, and tax-subsidized coverage offered through the Exchanges).
4. *Efficient, technologically advanced systems*: States have the opportunity, the charge and the support to apply the most advanced technologies to build systems that will work efficiently to support enrollment. Under ACA, these systems will need to be able to exchange data electronically; rely on data matching to determine eligibility; assure adequate privacy and security of data; provide internet-accessible enrollment portals and links; use common data elements and platforms to promote interoperability; and be built in a way to promote adaptability over time.

Gaps Between 2014 and Today and Steps to Close Them

1. Consumer Experience

Many state systems today offer an experience that is complex, burdensome, difficult to navigate, and requires substantial documentation and effort by consumers, often without accessible assistance. Some of the key challenges states face in improving the consumer experience by 2014 include:

- Rewriting eligibility rules to reflect the transition away from current complex Medicaid categories and requirements towards new simplified federal policies;
- Harmonizing differing eligibility requirements among coverage programs;
- Shifting the culture away from the stigmatizing welfare-era approach that many state Medicaid and CHIP programs still employ;
- Providing more robust consumer assistance programs to support enrollment;
- Improving the accessibility of the enrollment process for individuals with limited-English proficiency, low-literacy and disabilities;
- Minimizing needless coverage loss and gaps for a low-income population whose income and eligibility for coverage will likely change often during the year;
- Addressing the differences between how Medicaid/CHIP and private Exchange coverage will administer enrollment; and
- Helping families with members with mixed program eligibility status to navigate differing requirements.

Steps states can take to close these gaps include:

- **Adopting Technologies that Support Consumer Connections:** Beyond complying with requirements for online and telephonic enrollment, states will need to implement technologies that will offer consumers real-time electronic engagement with the enrollment process, including checking their eligibility status, reviewing benefits and cost-sharing, selecting plans, and updating personal information online. States can draw on existing models, including electronic "my account" pages that consumers can access and eligibility kiosks.
- **Enabling Meaningful Consumer Assistance and Engagement**: States can pursue partnerships with community-based organizations to support enrollment goals. Existing promising models include a "pay-for-performance" application assistance strategy that has proven successful in enrolling children, and consumer assistance helplines that provide an independent "feedback loop" to states.

- **Facilitating Coverage Transitions**: States will want to minimize coverage gaps, using strategies such as 12-month continuous eligibility and electronic referral systems used in Pennsylvania and Iowa to ensure continuity for individuals whose eligibility changes. States can also consider offering similar plan options for Medicaid, CHIP and Exchanges.
- **Ensuring Program Accessibility for Limited-English Proficient Individuals**: States can leverage CHIPRA's higher federal match for translation and interpretation for children in Medicaid and CHIP to improve enrollment services for adults.
- **Promoting Culture Change**: States will need to address eligibility worker culture, aligning agency goals and worker incentives to ensure it will support enrollment as a primary aim and will deliver a "first class" consumer experience.

2. Eligibility and Enrollment Policy

Today, Medicaid and CHIP eligibility and enrollment policies vary greatly among states and often do not support streamlined enrollment. While many states have adopted simplified policies for children, most states lag in adoption of these policies for Medicaid-eligible adults. Most states also will face significant challenges in expanding eligibility for adults given that the current median Medicaid eligibility level is well below the poverty level for most adults today. Perhaps the greatest challenge for state Medicaid and CHIP programs will be the culture shift that will be required for states to make enrollment a more explicit goal of their programs, while maintaining a high degree of program integrity. The requirement that states use the modified adjusted gross income (MAGI) standard to determine eligibility for most individuals offers a historic opportunity for simplicity and greater consistency. However, some of ACA's technical complexities (e.g., different eligibility rules for Medicaid, the possible need for parallel eligibility systems for non-MAGI eligible populations, requirements that states track "newly eligible" individuals for a higher matching rate, and conflicts between ACA's simplifications and existing federal and state policies) could hamper state efforts to achieve ACA's simplicity.

Steps states can take to close the gaps in streamlining policies include:

- **Simplifying Processes**: As states adopt required system changes, they should consider further process improvements that will reduce complexities and burdens and promote enrollment, such as streamlining renewals, adopting Express Lane Eligibility, or early adoption of ACA requirements like real-time online enrollment.
- **Simplifying Eligibility Policies**: Until further federal guidance, states can consider options to simplify and streamline eligibility policies. For example, state Medicaid programs can adopt eligibility rules that use IRS definitions of countable income and household to resolve conflicts between Medicaid and IRS rules.
- **Focusing on Culture Change**: To reinforce the shift toward a new coverage paradigm, states will need to change and redefine agency and worker culture to promote and reward enrollment as a desired goal.
- **Reviewing Conflicting Laws**: States can take affirmative steps to identify and address conflicts between the ACA's simplification intent and the state and federal laws now in effect.

3. Technology and Infrastructure

Despite steps toward modernization in recent years, many state Medicaid and CHIP programs rely on systems that are outdated, require manual and paper-driven processes, and fail to make critical electronic

connections to other systems. As states consider ways to close the technological divide, recent HHS guidance has the potential to change the landscape entirely. By offering new funding, the rule proposed by the Centers for Medicare and Medicaid Services (CMS) opens an opportunity for some states to consider completely upgrading their eligibility systems, but the requirements also create new expectations and challenges states will have to consider carefully. Key options states can consider to move forward include:

- **Developing a Medicaid Information Technology Architecture (MITA) Framework IT Proposal for CMS**: All states will want to consider leveraging the 90/10 enhanced federal funding available for upgrading Medicaid eligibility systems and infrastructure to promote improved efficiencies.
- **Evaluating Technology Needs**: States need to begin with an inventory of current technological assets (including hardware and software) and resources already available, as well as identifying areas of deficiency. This is an essential fist step to development of any new systems plans and should precede the development of requests for proposals from vendors to develop new systems, if possible.
- **Pursue Economies of Scale**: Wherever possible, states can seek to minimize costs to the state and the Medicaid program overall by pursuing economies of scale in systems investments and improvements. This can be accomplished through participation in state collaboratives, adoption of existing "plug and play" system modules, and reduction of duplicative eligibility systems.

4. Governance and Administration

Most states face important gaps between how current health coverage programs are managed and organized and ACA's vision of collaborative, seamless integration of Medicaid, CHIP, and Exchange coverage that allows states to offer Exchanges at the state, multi-state or federal level. More than two-thirds of states are experiencing changes in leadership that will complicate efforts to improve and simplify governance and administration of eligibility and enrollment systems. All of this change creates a degree of uncertainty and, for a time, an absence of leadership among key state agencies that can delay efforts to plan changes needed during the early phases of implementation. In addition, states will have to overcome the organizational tendency to operate programs in silos and ensure greater interconnectivity of systems. Given the need for greater uniformity, standardized practice and centralized communication that ACA will require, states may need to rethink the historic relationship between the state and localities in administering programs. The 20 states that have local agencies either administering or making a financial contribution to Medicaid will especially want a reexamination of local agencies' roles into their planning process.

States can pursue numerous opportunities to close these gaps including:

- **Demonstrating Leadership and Vision for Change:** Successful implementation will require strong focus and commitment from leaders inside and out of state government.
- **Identifying Opportunities for State Success in Health Care Reform**: States can use health care reform to gain support for longstanding health policy goals, such as overhauling and modernizing eligibility systems and infrastructure or improving health care quality.
- **Investing in Agency Collaboration:** States can encourage collaboration among interested agencies by fostering coordination among leading cabinet members, agency directors, governor's office, Medicaid, CHIP, insurance, and Exchange representatives.

- **Developing an Inventory of Local Functions:** States where localities now play a major role can analyze localities' current roles to identify core functions, areas of redundancy, mechanisms for accountability, transition issues and new roles.
- **Making Choices about Integration with Human Services Programs**: States will want to assess their own circumstances in deciding whether to integrate eligibility systems among related human service programs such as the Supplemental Nutrition Assistance Program, Temporary Assistance to Needy Families, and the free and reduced school lunch program.

Helping States Reach 2014

In addition to the specific steps noted above, there are also more general steps states and federal policymakers can take to help states prepare for the new eligibility and enrollment requirements under ACA. For states, key steps include: planning; making decisions on key issues such as whether they will be operating Exchanges; maximizing new funding opportunities; taking advantage of opportunities to learn from other states; and taking steps to ensure their implementation process is transparent. Federal policymakers also have a critical role to play in supporting state implementation efforts. Key steps for federal policymakers include: providing continued guidance; offering more federal models and standards; continuing to support opportunities for peer learning; promoting greater alignment of program requirements; and supporting eligibility/IT/MMIS systems coordination.

Conclusion

The Affordable Care Act presents an historic opportunity for states to re-invent and create new eligibility and enrollment systems to produce a simpler, streamlined enrollment "superhighway." This transformed system requires states to reorient themselves to a new coverage imperative where the issue for states is not whether an individual is covered but in what program and at what payment rate. This system presents great opportunities for efficiencies in how eligibility is determined that can save states money, time, and complexity. While this paper begins an examination of key issues and opportunities for states, deeper examination of these issues will be needed to assist in guiding states along this new road. For states, 2014 is tomorrow, and states beginning their journey with a clear vision and road map will be ready for what's ahead. With guidance, support, and an appetite for change, states can be at the leading edge of transforming eligibility and enrollment systems in the years to come

Introduction

The Affordable Care Act (ACA) is generating a sea change for state health coverage programs. By initiating a historic coverage expansion under Medicaid, creating new tax subsidies to support private coverage for low- and moderate-income individuals, and mandating individuals to have health insurance coverage, ACA promises to make health coverage more affordable, accessible and integral to Americans' lives than ever, providing coverage to an estimated 32 million additional individuals by 2019. However, a central linchpin to ACA's success in improving coverage will be the creation of eligibility and enrollment systems that enable eligible individuals to enroll. To accomplish this goal, ACA provides a transformative vision for eligibility and enrollment in public programs and other health coverage, promoting what one state official has called "radical simplification." Eligibility and enrollment systems under a reformed health coverage system will become an enrollment superhighway: streamlined, modern, seamless, integrated, and easy for consumers to use, linking Medicaid, CHIP and Exchange coverage for individuals and families. Given ACA's focus on coverage goals, whether states can implement this vision for simpler, streamlined enrollment systems and ultimately enroll the 32 million newly eligible individuals will be a critical test of ACA's success.

ACA provides a transformative vision for eligibility and enrollment in public programs and other health coverage, promoting what one state official has called "radical simplification."

States have the lion's share of responsibility for implementing ACA, but there are critical gaps between where states are today and ACA's enrollment superhighway vision for 2014. Many current Medicaid and CHIP enrollment systems are complex and difficult for consumers to use, and include stigmatizing rules and require burdensome documentation to prove eligibility. Eligibility systems are decades-old and difficult to manage. Organizational structures are siloed and disconnected. In addition, while providing a vision and new tools for a vastly simplified system, ACA also creates new technical complexities that will challenge states' abilities to achieve its intent and promise. Although these state gaps and federal complexities are not insurmountable, understanding them is critical for federal and state policymakers as they work towards implementing reforms. For states, 2014 is right around the corner. Understanding the gaps between today and 2014 and the pressure states are experiencing to plan for change, this paper is intended to help states prepare for the road ahead.

This paper frames ACA's vision for an enrollment superhighway, then discusses the gaps states will experience between 2014 and today and opportunities to close these gaps in four key areas: 1) Consumer Experience; 2) Eligibility and Enrollment Policy; 3) Technology and Systems Infrastructure; and 4) Governance and Administration. For each area, this paper provides a brief discussion of current state practice including how it differs from ACA's vision, challenges states face including complexities created by ACA, and options for states to close the gaps, including discussions of best practices that might model success for states. While each of these areas are looked at individually for ease of discussion, they do not exist in silos — each are integrally connected to one another and the broader goal of streamlining enrollment. The paper concludes with a brief overview of key options for state and federal policymakers as they work together to bridge the gap to 2014.

This paper was funded through a grant from the California HealthCare Foundation (CHCF). Its content is drawn from expert knowledge and opinion, research and NASHP's experience from its role as the National Program Office for Maximizing Enrollment: Transforming State Health Coverage, a Robert Wood Johnson Foundation funded program, and other work. Some content for this paper was drawn from key informant interviews with state and federal policymakers and experts on state enrollment systems.

ACA's Vision: An Enrollment Superhighway

The enactment of the Affordable Care Act presents states with a transformative vision that re-imagines eligibility and enrollment systems for public and publicly subsidized health coverage. Moving states away from the complex, disconnected, paperwork-intensive and burdensome processes of the past, ACA challenges states to adopt a more streamlined, modern, interconnected, assisted, and seamless system to apply for and enroll in coverage. Preliminary guidance and notice of proposed rulemaking issued by the Centers for Medicare and Medicaid Services, including with the Office of Consumer Information and Insurance Oversight (OCIIO)[1], reinforce the importance of states adopting "consumer-friendly" systems that are "simple and seamless" in identifying eligibility for multiple coverage programs. The U.S. Department of Health and Human Services Office of the National Coordinator Health Information Technology Enrollment Workgroup (hereafter HIT Enrollment Workgroup) Recommendations further support this vision, outlining new standards and protocols that aim to "encourage adoption of modern electronic systems and processes that allow a consumer to seamlessly obtain and maintain the full range of available health coverage and other human services benefits."[2] There are several key elements of this vision.

ACA challenges states to adopt a more streamlined, modern, interconnected, assisted, and seamless system to apply for and enroll in coverage

1. Assisted, Easy-to-Use Process for Consumers

ACA's approach to eligibility and enrollment focuses on ensuring that consumers seeking to enroll have the information and assistance they need to make the process simple and easy to navigate. Key provisions in ACA and subsequent guidance include:

- **Multiple Methods to Apply***:* Individuals will be able to submit an application for coverage online, by phone, by mail or in person.[3]
- **Single Application Form**: Medicaid, CHIP, Basic Health and tax subsidies available for coverage offered through the Exchanges will all use a standardized application form created by the Secretary of HHS.[4]
- **Minimum Documentation Standard***:* Individuals using the single application form will not have to provide additional documentation unless the information they provide is inconsistent with electronic data or insufficient to determine eligibility.[5]
- **Consumer Assistance/Health Insurance Ombuds Program (CA/HIOPS):** States can apply for CA/HIOPS grants to provide enrollment information, referrals and assistance to consumers and resolve tax subsidy eligibility issues.[6]
- **Navigators:** Grants will also be awarded to navigators, who will educate the public, share information, facilitate enrollment, and refer to CA/HIOPS programs, providing help in culturally and linguistically appropriate ways.[7]
- **Outreach and Enrollment for Vulnerable/Underserved Populations:** States will establish outreach and enrollment assistance to vulnerable and underserved populations eligible for Medicaid and CHIP.[8]
- **Uniform, Understandable Explanation of Coverage:** Insurers must provide consumers accurate summaries of benefits, cost-sharing exceptions and limitations in a standard, understandable format.[9]

- **Consumer-Friendly Design and Access***:* Eligibility and enrollment systems must meet the needs of all consumers, comporting with all federal Civil Rights laws, and should be designed to ensure ease of use by a consumer, including helping the individual to meaningfully choose among options, provide support for real-time data entry and decision making, and allowing individuals to save, retrieve and submit information as needed. In addition, individuals must be able to check on and update their benefit status and information as needed.[10]
- **"First Class Customer Experience":** Federal guidance supports this vision, outlining the "consumer-centric" approach that states should take when designing systems and indicating that federal agencies expect states to deliver a "first class" experience to consumers. Consumers' experience should be on par with the level of customer service that they get when they make purchases from online retailers such as Amazon or Expedia and should seamlessly coordinate enrollment and data-sharing among Medicaid, CHIP and Exchanges and between Exchanges, plans, employers and navigators.[11]

These provisions, paired with ACA's seamless "one stop" approach, envision a system that is simple, easy to use, accessible and facilitated for consumers.

2. Seamless "One-Stop" System

ACA contemplates a dramatically streamlined eligibility and enrollment process that allows for a seamless, "one-stop" approach for individuals applying, enrolling in, and renewing coverage through Medicaid, CHIP or an Exchange. ACA's new tools to implement this vision include:

- **Applying Once**: The single, streamlined form for all programs, combined with a mandate that agencies work together in a seamless way to promote enrollment, means individuals will only have to apply once for coverage and have multiple program determinations flow from that application.
- **"No Wrong Door":** An individual seeking coverage can apply at any agency operating Medicaid, CHIP, Basic Health or tax subsidy programs and all agencies must either be able to determine coverage or electronically transfer information for a determination.[12]
- **Seamless Unified Process for Enrollment and Renewal**: There will be a single unified process for individuals to apply, receive determinations and renew enrollment in Medicaid, CHIP, Basic Health and tax subsidy coverage.[13]
- **Interconnected state, federal and private systems**: Post-reform eligibility and enrollment systems for Medicaid, CHIP, and publicly subsidized coverage offered through Exchanges will be required to accept and share data electronically. Interfaces among systems will be vital to allow states to process applications for Medicaid, CHIP and subsidy coverage quickly and accurately.

3. Simpler Eligibility Rules

The Affordable Care Act simplifies eligibility rules dramatically, offering the promise of improved efficiency for states and clearer understanding by applicants about their eligibility for coverage. The Act also promotes consistency in how a state applies eligibility rules within and among agencies, both by creating a common eligibility standard and requiring reciprocity in eligibility determinations. Key provisions include:

- **Streamlined Eligibility Test:** Except for certain exempt groups, eligibility for Medicaid, CHIP and tax subsidies will be based on a common income standard that relyies on an individual's Modified Adjusted Gross Income (MAGI) to determine eligibility.[14] States will no longer be able to use

income deductions (e.g., childcare expenses, child support payments, some earned income, etc.), asset or resource tests in determining eligibility.[15]

- **Simplification of Medicaid Eligibility Criteria***:* Eligibility for Medicaid is expanded to include all individuals with income under 133 percent of the Federal Poverty Level (FPL) plus a standard income disregard of 5 percent of income, bringing the upper limit to 138 percent of the FPL.[16]
- **Interoperability of Eligibility Rules**: ACA empowers Exchanges to make Medicaid and CHIP determinations and also enables Medicaid agencies that seek authority to make tax subsidy determinations for Exchange coverage.[17]

4. Efficient, Technologically Advanced Systems

The Affordable Care Act envisions a modern set of eligibility systems that use the most advanced technologies, complement each other, and work efficiently to support enrollment. Key provisions include:

- **Capacity to Exchange Data Electronically:** States must develop secure, electronic interfaces that allows an exchange of data so that eligibility for coverage for multiple programs can flow from a single application.
- **Data Matching Programs**: Medicaid, CHIP, Basic Health and tax subsidy programs will match data electronically to determine eligibility, relying on third-party data for verification of eligibility to the greatest extent possible.[18]
- **Privacy and Security**: Electronic interfaces and data exchange created by Exchange, Medicaid and CHIP agencies must comport to HIPAA privacy requirements and ensure security of data.[19]
- **Internet-Accessible Enrollment Portals and Links:** Exchanges and states will host Internet portals linking Medicaid, CHIP and the Exchanges that will allow individuals to compare, apply, or renew coverage online.[20]
- **Uniform Data Elements**: To support the "consistent, efficient and transparent exchange of data elements" between federal programs and states, federal and state agencies will have to develop common, standardized core data elements for data exchanged across health and human service programs.[21]
- **Modular, Reusable Components**: States are directed to employ a "modular, flexible approach to systems development," including open interfaces, exposed programming, and isolated components that can be more easily upgraded, maintained and shared over time.[22]
- **Consistent, Technology-Neutral Format for Business Rules:** States are directed to create business rules for new systems that are separate from core programming and available in formats understandable to laypeople and machines and accessible and adaptable by other states.[23]
- **Service-Oriented Architecture***:* States are directed to use Web Services Architecture/Service-Oriented Architecture methodologies for system design and development to ensure that components of functionality within a system will work with an overall web-based design.[24]

Gaps Between 2014 and Today

There are significant gaps between ACA's vision of an enrollment superhighway for 2014 and the reality of state practice today, both in terms of how business is done and the culture of enrollment. In addition, while providing a vision and new tools for a vastly simplified eligibility and enrollment system, ACA also creates new technical complexities that will challenge states' abilities to achieve its intent and promise. This section discusses gaps in four key areas:

1. Consumer Experience
2. Eligibility and Enrollment Policy
3. Technology and Systems Infrastructure
4. Governance and Leadership

For each of these areas, this section provides a brief discussion of where states are today and opportunities for closing the gaps between 2014 and today.

1. Consumer Experience

Where States Are Today

Today, consumers often experience the Medicaid and CHIP eligibility determination and enrollment process as complex, paperwork-intensive, stigmatizing and burdensome. Gaps between the vision for 2014 and today are discussed below.

State eligibility requirements are often extensive, requiring an applicant to provide original documentation of citizenship and identity, resources and assets, income, and in some cases childcare, transportation, and other expenses

Complicated Eligibility Rules: State eligibility requirements are often extensive, requiring an individual applying to provide original documentation of citizenship and identity, resources and assets, income, and in some cases childcare, transportation, and other expenses. Medicaid and CHIP eligibility systems are often not well integrated and require individuals to reapply for coverage if they are determined ineligible.

Differing Requirements: State Medicaid and CHIP eligibility requirements can differ among a given population (e.g., children at different income levels) and between populations (e.g., parents and children). These requirements also differ among states. For example, while nearly all states have eliminated in-person interview and asset test requirements for children applying for Medicaid or CHIP, only 86 percent of states have eliminated the in-person interview and less than half of states (47 percent) have eliminated asset tests for parents.[25] Navigating the maze of different requirements involved in a claim for benefits is often far from simple for consumers.

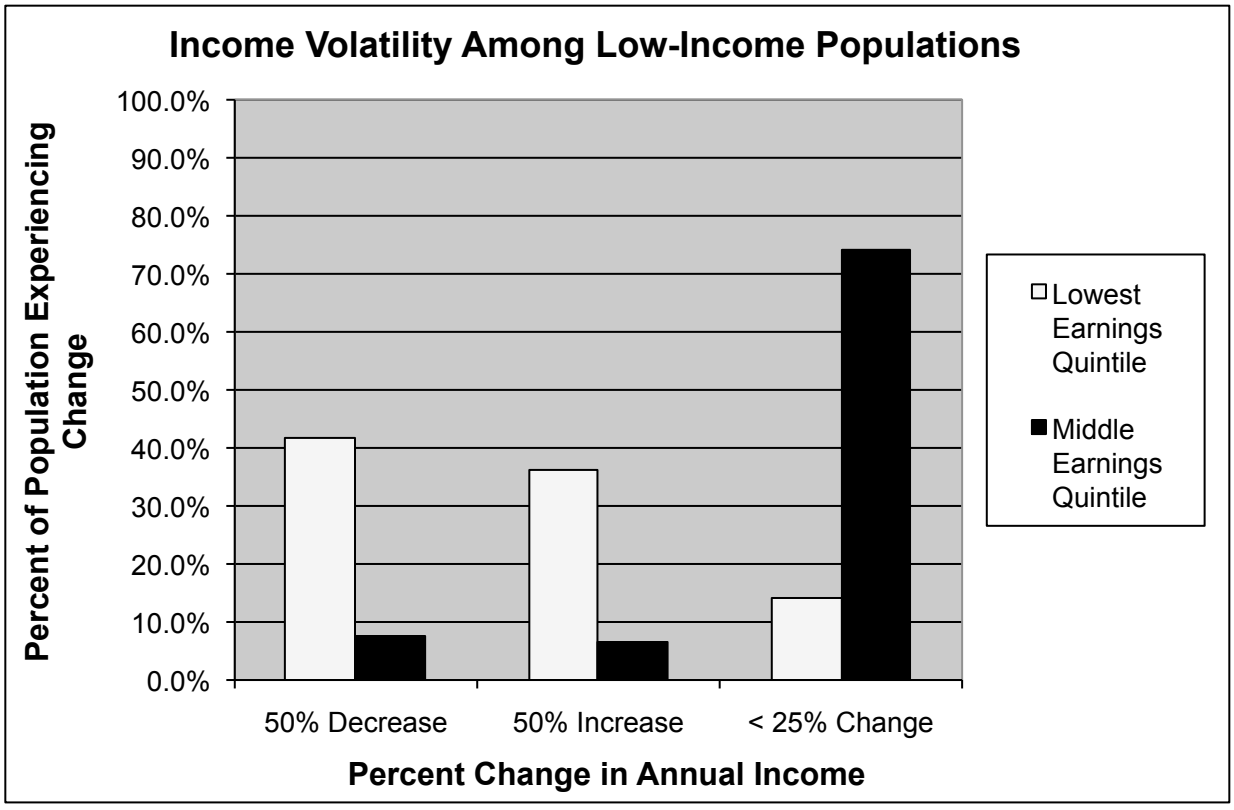
Welfare-Era Culture Deters Enrollment: Despite the formal de-linking of Medicaid from TANF/AFDC cash-assistance benefits in 1996, many states still employ a welfare-era approach to determining eligibility for Medicaid that stigmatizes beneficiaries and ultimately deters enrollment. This approach requires invasive questions, puts the burden on consumers to provide multiple documentations of income and assets, and relies on outdated methods of communication that are inefficient, time-consuming and ineffective. Consumers accustomed to buying plane tickets on Expedia, or making purchases on Amazon and

downloading information/confirmation instantly will expect a higher degree of customer service, faster response times, and a more transparent process than is delivered today.

Limited Consumer Assistance Infrastructure: With as many as 32 million new individuals estimated to enroll in coverage before 2019, including 16 million in Medicaid, states will face a dramatically increased volume of applications and demand for assistance. While some states have a well-developed consumer assistance infrastructure today for targeting non-elderly populations (most often targeting outreach and assistance to children and families)most states are unprepared for the level and type of assistance consumers will require to ensure enrollment. Although Congress recognized this need by creating the availability of grants for consumer assistance and health insurance ombuds programs and navigators, the fact that not all states have applied for grants suggests some states fail to recognize the critical role that consumer assistance programs must play in future enrollment efforts.[26]

Diminished Access for Diverse Populations: More than 23 million Americans are limited English proficient (LEP) today, representing on average nearly one in ten Americans.[27] Under Title VI of the Federal Civil Rights Act of 1964, all entities receiving federal funds (including state Medicaid and CHIP agencies) are required to ensure appropriate access to services for LEP populations.[28] Despite this requirement, many states still struggle to provide accessible enrollment services due to a number of factors, including a lack of resources, low awareness of the need for LEP services and an absence of institutional priority.[29] New materials will be needed to provide understandable formats that take into account limited English proficiency, low literacy and educational attainment levels, and disabilities.

"Churning" of Low-Income Populations: Most states now experience a high degree of "churning" or instability of coverage for low-income individuals enrolled in public programs, due in part to frequent fluctuations in income. According to a 2008 Congressional Budget Office report, workers with relatively



low earnings tend to have larger fluctuations in their earnings than those with relatively high earnings.[30] Anecdotal experience from Massachusetts showed as many as 25,000 individuals whose Medicaid eligibility changed on a monthly basis.[31] While managing this churn of individuals already presents significant administrative costs to states, state costs associated with churn will likely increase when states are responsible for continuous enrollment in multiple programs.

Differences Between Public And Private Coverage Administration: While Medicaid and CHIP program eligibility will still be determined monthly based on current income, eligibility for private subsidized coverage offered through exchanges will be based on income reported in the prior tax year and enrollment will continue for a full year at the individual's option.[32] Another important difference between Medicaid and private coverage options is that Medicaid can provide retrospective enrollment, while private tax-subsidized coverage (if it follows current private coverage models) will likely only enroll prospectively at the beginning of the month. In addition, becoming ineligible for coverage due to an increase in income will have different implications for consumers enrolled in public and private subsidized coverage. While Medicaid- or CHIP-enrolled individuals who become ineligible will merely be disenrolled and offered the option to enroll in public subsidized coverage, individuals enrolled in publicly subsidized Exchange coverage will be required to repay part of the tax credit they received if their actual earned income is more than was estimated at the point of enrollment.[33] This creates real and serious financial consequences for low-income individuals and may serve as a deterrent to enrollment in subsidies for individuals.

Mixed Status Families: Although families whose members' immigration or program eligibility status varies already face challenges navigating their eligibility, ACA may exacerbate these challenges by creating new restrictions on enrollment based on citizenship status and income. While ACA allows legal immigrants to purchase private coverage through the Exchange, it does not change the current bar on legal immigrants enrolling in public programs within the first five years of living in the U.S. Although 21 states have taken up the option under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to allow legal immigrant pregnant women or children to enroll in Medicaid or CHIP, many other states have not. This means that for many families, coverage options will differ based on immigration status or where they live. Families may also find themselves enrolled in different coverage options based on age, with children being more likely to be eligible for Medicaid or CHIP due to higher income eligibility levels for those programs. A key challenge for states will remain communicating effectively with parents to help them understand options, why they differ, factors affecting enrollment, and how to coordinate access to providers to ensure a more seamless experience for families.

Closing the Gap

There are a number of steps that states can take to meet ACA's requirements and achieve its vision for an improved consumer experience.

Adopting Technologies that Support Consumer Connections: Technology can support state efforts to achieve a simpler, more assisted, and more interactive eligibility and enrollment system. Beyond adopting online and telephonic enrollment, states can improve consumers' enrollment options by implementing technologies that will allow consumers to electronically check on the status of their benefit determination, learn about their benefits and select plans, inquire about cost sharing, and update personal information online. Technology can also support state efforts to ensure the application process is accessible to diverse populations. Models for states to consider include:

- **Customer-Facing Accounts***:* Massachusetts has initiated a "My Account Page" on its Virtual Gateway eligibility website that allows applicants and enrollees to track progress on their application, update their address, and change income information. Although its use is still limited, this type of tool has the potential to improve consumers' access to benefit information, increase program transparency, and make it easier for states to maintain contact with a more transient low-income population.
- **Audio Visual Application Assistance Kiosks***:* Alabama has implemented a pilot in county public health departments and community health centers that provides an automated kiosk to assist applicants in filling out an electronic application for benefits in English and Spanish. While these kiosks are still being tested and many applicants appear to need additional personal assistance to use them, early experience suggests these kiosks may hold promise in providing new ways to reach limited English proficient and low literacy populations.

Enabling Meaningful Consumer Assistance and Engagement: States can pursue partnerships with community-based organizations to maximize opportunities for consumer engagement and achieve enrollment goals. Adopting health care reform advisory committees that include consumer representation and promoting a transparent process that will allow for consumer input into proposed program changes are practices recommended by advocates to ensure consumer engagement. Two promising models for partnerships to improve consumer assistance include:

- **"Pay for Performance" Model for Application Assistance:** Illinois works with community-based application assisters to help consumers fill out applications, but pays these organizations a higher rate for successful applications.[34] This "pay for performance" model encourages assisters to more carefully review applicants' eligibility and the application materials before submission. This model assists states by providing outreach to hard-to-reach populations while improving efficiencies by improving the quality of applications submitted.
- **Consumer Assistance Helpline:** The Health Care for All consumer assistance helpline in Massachusetts provides support for consumers as they navigate federal, state and private health insurance coverage options. This helpline, run by an independent, non-profit, statewide organization located in Boston, not only provides real-time assistance to help consumers understand their rights and options but also tracks issues raised by consumers in a database and shares periodic reports with state agencies to provide continuous feedback on problems with state programs.[35]

Facilitating Coverage Transitions: States will want to minimize coverage gaps when eligibility changes and smooth transitions for consumers, states and, where possible, plans and providers. Options for states to promote continuous coverage include:

- **Twelve-Month Continuous Eligibility**: States are now permitted to implement 12-month continuous eligibility in Medicaid or CHIP for children, allowing them to remain enrolled regardless of family income changes. Continuous eligibility has helped states improve retention of eligible children. Although not specifically addressed under ACA, states could seek a waiver under Section 1115 of the Social Security Act to apply 12-month continuous eligibility for adult populations.
- **Continuity of Coverage**: States may avoid a gap in access to services for individuals whose eligibility changes throughout the year if they require health insurers to offer similar plan options for Medicaid, CHIP and Exchange coverage. Providing similar plans means individuals can stay in the same plan or care network when their eligibility changes and avoid needless disruptions in care.

- **Electronic Referrals**: Iowa and Pennsylvania have created electronic referral between Medicaid and CHIP programs to promote seamless transitions, effective coordination among agencies and prevent gaps in coverage. Iowa's Medicaid and CHIP programs use different eligibility systems to determine and track eligibility, but the state developed a system that can electronically refer children ineligible for Medicaid to CHIP for eligibility determination.[36] Pennsylvania developed a system called the Healthcare Handshake, which uses the state's online application system for social service programs (called COMPASS) to exchange eligibility information as a referral between Pennsylvania's Department of Insurance, which administers CHIP, and the Department of Public Welfare, which administers Medicaid, when an individual's income changes their eligibility.[37] State experience with automating referrals has shown increased efficiencies in program administration, including faster referral processing times, reduced risk of errors due to manual data entry or lost paperwork, and cost savings from reduced staff time and lower costs to mail and process paper applications.[38]

Ensuring Programs Respond to the Needs of Diverse Populations: Experts have identified a series of concrete steps states can take to improve the accessibility of eligibility and enrollment processes for limited English proficient (LEP) populations. Key recommendations include that states designate a lead staff person responsible for improving LEP access, involve the community in improvement planning, create a plan, screen for language needs at the first point of contact, hire bilingual staff and contract interpreters to fill the state's translation needs, provide telephone interpretation lines, translate written documents, and assess client satisfaction with services.[39] States can also leverage existing resources for children to improve accessibility for adults:

- **CHIPRA Enhanced Match for Translation and Interpretation Services:** CHIPRA increased the federal matching rate for language assistance services (translation and interpretation) provided to children through either the Medicaid or CHIP program from the administrative rate of 50 percent to the greater of either 75 percent or 5 percent above the state's regular match rate.[40] States that apply for increased matching funds to support their initiatives to improve language assistance services for children can leverage this investment for broader impact with newly eligible adult populations.[41]

Promoting Culture Change: States will want to take a closer look at the culture of health coverage eligibility work to ensure it will support the delivery of a "first class" consumer experience. More detailed discussion of some ideas to support state implementation of culture change appear in the Eligibility and Enrollment Policy discussion, below.

2. Eligibility and Enrollment Policy

Where States Are Today

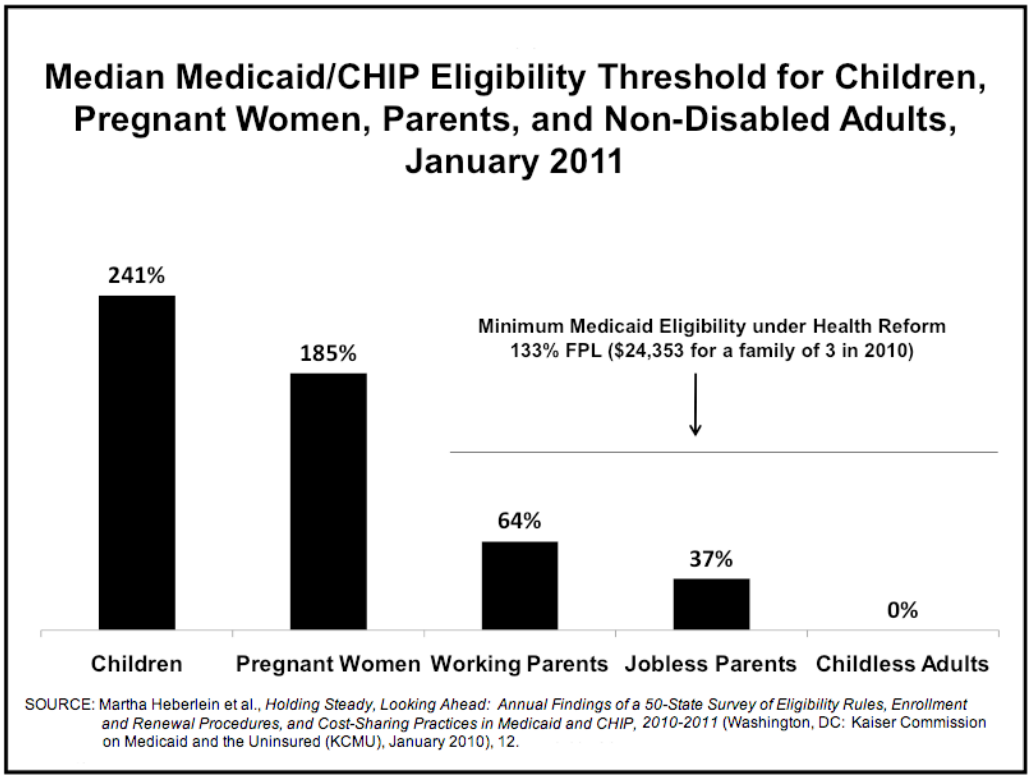
Today, Medicaid and CHIP eligibility and enrollment policies vary greatly among states and often do not support a simplified and streamlined enrollment process designed to promote enrollment. Gaps between states' current policy approaches and ACA's requirements for 2014 are discussed below.

Variation in Adoption of Simplifications: Medicaid and CHIP programs vary in their adoption of enrollment simplification strategies. Key strategies that research indicates may have a positive impact on enrollment include eliminating asset tests and face-to-face interview requirements, providing administrative verification of income at enrollment or renewal, utilizing ex-parte renewals, allowing for an annual renewal period, or providing for 12-month continuous eligibility regardless of income changes.[42] While many states have adopted a number of these strategies for children, adoption is not universal. Impor-

tantly, states still lag in their adoption of these strategies for parents. For example, in 2010, more than half of all states still required asset tests and 13 percent of states still required a face-to-face renewal at enrollment for parents.[43] By contrast, during the same period only three states required an asset test and two states required face-to-face interviews at enrollment in Medicaid for children.[44] Despite state progress with strategies for children, few states have implemented an enrollment model that matches ACA's simplified enrollment vision, including "no wrong door" enrollment, integrated and seamless eligibility systems, electronic data sharing and minimum documentation burdens. For this reason, all states will have significant policy changes to undertake in implementation.

Despite state progress with strategies for children, few states match ACA's simplified enrollment vision, including "no wrong door" enrollment, integrated and seamless eligibility systems, electronic data sharing and minimum documentation burdens

Current Eligibility Levels Low: Today, state Medicaid eligibility levels for adults are, on average, much lower than the mandated coverage for individuals under 138 percent of the FPL required under ACA. The 2010 median Medicaid eligibility level for low-income parents was 37 percent of the FPL for jobless parents and 64 percent of the FPL for working parents.[45] The 2009 median Medicaid eligibility level for the elderly and individuals with disabilities was higher, at 75 percent of the FPL.[46] Most states do not now provide Medicaid eligibility for adults without dependent children and states that do often limit eligibility or enrollment.[47] Given the current variation in Medicaid eligibility levels for adults, most states will need to implement new policy frameworks to accommodate a major expansion of Medicaid coverage or adapt current policies to the new requirements. In addition, the creation of tax-subsidized coverage options for individuals under 400 percent of the FPL through Exchanges will require states to create entirely new eligibility and enrollment policy for newly eligible populations.



Emphasis on Program Integrity Over Enrollment as Goal: Perhaps the greatest challenge for many state Medicaid and CHIP programs is the culture shift needed to re-imagine eligibility and enrollment systems for which increasing enrollment is an explicit goal. Medicaid program rules have traditionally operated to prevent ineligible individuals from enrolling.[48] This emphasis on program integrity over enrollment has been reinforced by federal audits, including quality control and payment error rate management (PERM) reviews. Because these reviews penalize states for enrolling individuals for whom the federal review finds insufficient documentation of eligibility, states have been wary about supporting steps that would, in their view, undermine the accuracy of determinations.[49] However, ACA's new coverage imperative changes the game for states. Going forward, the critical role for state agencies will no longer be to decide whether or not an individual should be covered, but where an individual belongs – in Medicaid, CHIP, Basic Health, tax-subsidized, or other private coverage. States will have to prioritize enrollment while maintaining a high level of program integrity.

New Challenges to Simplification Under ACA: ACA's promise of simpler policies may be undermined by some of its new complexities, including the different eligibility rules required for Medicaid, the potential need for parallel and "shadow" eligibility systems, and ambiguities about the continued application of state and federal laws that conflict with ACA's vision. Each of these is discussed in turn below.

- **Different Eligibility Rules for Medicaid:** While ACA purports to simplify eligibility rules by requiring Medicaid, CHIP and tax-subsidized Exchange coverage to use MAGI to determine income for most populations, the Act also creates new complexities by including language that requires states to determine a Medicaid applicant's income at the point-in-time they apply and apply Medicaid countable sources of income rules. It is unclear how states would satisfy the point-in-time requirement. Requiring paper documentation of income like pay stubs returns states to the old-style paper chase, but there is currently no available electronic means of obtaining reliable, current income information for most or all beneficiaries. In either case, this requirement could be construed to require the creation of new systems to determine current income.
- The "countable sources of income" requirement poses implementation challenges for states about how to reconcile conflicts between Medicaid and federal tax rules that differ on countable income. A key issue for which states need guidance is how to define household income groups. While states have historically determined household income groups for Medicaid based on the number of individuals living in a household, tax law defines an income group based on a unit made up of tax filers and dependents. Given that states will be unable to determine family income without a standard determination on the number of individuals in the household group, further guidance is critical. Importantly, any new Medicaid-only requirements are likely to undermine the goal of simplicity since different tests require different processes. To implement this requirement, states would likely have to either create an accurate way to screen out likely Medicaid-eligible individuals or apply the new rules to all applicants. This adds a layer of complexity in a provision designed to simplify the process.
- **Parallel and "Shadow" Eligibility Systems:** States are charged with creating new, simpler eligibility rules for most individuals, while also using the old eligibility rules for the roughly 25 percent of the Medicaid population that will be excluded from the new MAGI-based eligibility test (non-MAGI population). States are also required to track "newly eligible" individuals who would not have been eligible for coverage prior to enactment in order to be able to claim the higher federal matching rate that ACA provides for the cost of their coverage. This provision could be con-

strued to require states to maintain dual systems for eligibility for MAGI and non-MAGI populations and a "shadow" eligibility system that can determine eligibility under pre-ACA rules for every new enrollee to determine whether the individual would have been covered pre-enactment. These provisions undermine state plans to promote simplicity and could lead to confusion and errors in classification. States need further guidance on alternatives to be able to simplify systems.[50]

- **Conflicts with Existing Federal and State Policies**: There are a number of federal and state laws that now apply to Medicaid and CHIP eligibility policy that ACA did not specifically address, leaving a question as to whether they will continue to apply. Examples of these types of provisions include states' fingerprinting requirements for enrollment in some health and human service programs and state laws that require counties of residence to determine eligibility. Another example is state and federal laws that require unmarried custodial parents who apply for Medicaid to assign their medical support rights (for themselves and any children) to the state.[51] Assignment might require an individual to sign a specific document or occur automatically, depending on state law. This requirement has been shown to create barriers and deterrents to enrollment and may pose other risks for the custodial parent and the child.[52] These are only a few examples of laws that may exist at the federal and state level that will require further review and possible legislative or administrative action prior to 2014.

Closing the Gap

There are a number of steps states can take to close the gaps to reach the goal of simplified policies and practices.

Simplifying Processes: As states adopt required system changes, they should consider adopting further process improvements that will reduce complexities and burdens and promote enrollment. One tool that will aid states in accomplishing this goal is a process mapping exercise to understand how systems work in practice and identify areas where policy differs from practice and barriers to enrollment.[53] Other ideas include:

- **Streamlining Renewals:** Although most process improvements under ACA target improved eligibility and enrollment systems for entry into coverage, a critical strategy for state success in this effort will be focusing on strategies to streamline renewal processes as well. Ensuring that eligible individuals are renewed for coverage promotes efficiencies by allowing states to maximize their investment of the costly enrollment process and minimize the likelihood that eligible individuals will "churn" on and off of coverage, requiring reenrollment annually. A number of states, including Louisiana and Massachusetts, have implemented administrative renewals that provide a paperless renewal process for individuals determined to be continuously eligible for coverage. Other strategies have targeted minimizing the burden on beneficiaries to renew, including Louisiana's practice of allowing individuals to signal their affirmation of a pre-populated renewal form by dialing a toll-free number to activate a Medicaid card.
- **Express Lane Eligibility (ELE):** Express Lane Eligibility is a strategy created under CHIPRA that allows state Medicaid and CHIP agencies to borrow findings from other federal and state programs to determine eligibility for children. Louisiana implemented Express Lane Eligibility to automatically enroll SNAP-enrolled children into Medicaid in February of 2010 and has seen impressive results. In a single month, Medicaid enrolled 15,000 previously uninsured children. While the process has required significant resources to implement, Louisiana's experience with borrowing data from other programs may be a positive model for other states.[54] While ELE is currently only applicable to child populations under CHIPRA, some states are considering seeking a waiver to implement ELE strategies for adult populations.
- **Early Adoption of ACA Requirements:** States can prepare for implementation of major changes by piloting them on a smaller scale or adopting components system-wide before the final implementation

date. A number of states are currently planning early implementation or are already implementing components of ACA's eligibility requirements. Examples include Oklahoma's adoption of electronic, real-time, online enrollment and verification of eligibility, Utah's use of electronic case records and data-sharing programs, and Wisconsin's creation of an integrated acquisition of proof model (called "iSWAP") for capturing and verifying eligibility data from other federal and state sources and an electronic portal and enrollment tool for all health programs. These early pilots are helping states to understand possible barriers to successful implementation. Federal and state policymakers can maximize the benefit of these early adopters' experience by using learning collaboratives to spread these lessons with other states.

Simplifying Eligibility Policies: Until further federal guidance, states can consider a number of options to simplify and streamline eligibility policy. For example, state Medicaid programs can set up integrated eligibility systems that use the tax definitions of countable income and household groups to resolve possible conflicts between Medicaid and IRS rules. States with concerns about the difficulty of determining current income for all new beneficiaries could provide for a default rule that assumes MAGI is current income unless an individual chooses to update income. This would minimize the number of incidences of checking for income and simplify the determination process while ensuring that individuals for whom MAGI is not accurate are being determined eligible based on more recent information. States could sample a number of cases to determine their error rate on ineligible individuals enrolling and take corrective steps to modify their processes if the error rate is above a certain percentage. States could also use sampling or estimates based on prior enrollment to determine future enrollment of "newly eligible" individuals.

Focusing on Culture Change: To reinforce the shift toward a new coverage paradigm states will want to consider ways to redefine agency and worker culture to promote and reward enrollment as a desired goal. Fostering culture change has been identified as a critical step by a number of states that have implemented streamlined procedure. One worker from a state that adopted streamlined technologies but failed to see enrollment gains noted that worker culture can inhibit state progress on enrollment and advised other states to address this challenge directly as part of a comprehensive reform effort.

Louisiana's Model for Culture Change: Louisiana transformed eligibility worker culture through a number of steps, including:

- Engaging in process improvement work with local offices;
- Educating caseworkers about the lives and challenges facing low-income beneficiaries;
- Requiring caseworkers to work in the field helping to enroll individuals on a periodic basis;
- Showcasing local offices that develop new successful strategies for simplifying enrollment;
- Deterring case closures by requiring supervisors to sign off on closures; and
- Changing performance reviews to focus on enrollment as a positive goal.

As a result of these efforts and the implementation other streamlined procedures, Louisiana reduced their percentage of low-income uninsured children and decreased the percentage of eligible children disenrolled for procedural reasons at renewal from 22 percent in 2001 to less than 1 percent today.[55]

Reviewing Conflicting Laws: States can take affirmative steps to address conflicts between ACA's intent and the laws now in effect. For example, there is nothing in federal law that requires a state to fingerprint an individual to determine Medicaid eligibility and these types of laws clearly create a barrier to enrollment. States could assemble a review committee and review all existing laws relating to eligibility for Medicaid,

CHIP or other human service programs that might undermine ACA's intent to simplify enrollment and recommend that the legislature amend requirements as needed.

3. Technology and Systems Infrastructure

Where States Are Today

Although states are increasingly modernizing their systems to take advantage of new, more efficient technologies, many state Medicaid and CHIP programs still rely on systems that are outdated, require manual and paper-driven business processes, and fail to electronically connect to other state programs or federal systems that can provide needed data. Although there are a few notable exceptions, state systems overall will require significant investments of planning and resources to meet ACA's requirements by 2014. Key gaps between ACA's vision for 2014 and today are noted below.

Many state Medicaid and CHIP programs still rely on systems that are outdated, require manual and paper-driven business processes, and fail to electronically connect to other state programs or federal systems that can provide needed data.

Gaps in Use of Technology to Simplify and Automate Enrollment: Although states have made important strides in the past decade in adopting new technologies for application and enrollment in Medicaid and CHIP, widespread adoption of available technologies still lags. While all Medicaid and CHIP programs now provide an application form online, fewer states allow for online submission, even fewer allow for electronic signature, and only eight states now accept documentation electronically with electronic submissions.[56] Anecdotal evidence suggests that few states have automated processes that use business rules to drive determinations— instead, business processes are often manual, paper-driven, and disconnected from other systems. One common example of this is that many states with online applications are not able to capture data submitted electronically – these applications are often either scanned as a file into an electronic case record or manually entered into data fields in an electronic eligibility system. In addition, while most states are using data matching to verify eligibility in some form, fewer states are using these data matches to replace paper documentation requirements, as ACA would require. Few states also appear to be using telephone enrollment, although a growing number of states are providing for telephone renewals for children (29 percent of Medicaid and 31 percent of CHIP programs).[57] These gaps in adoption of technology mean states face major changes ahead.

Outdated "Legacy" Eligibility Systems: Most existing Medicaid eligibility and enrollment systems are outdated, difficult to program, and disconnected from other systems. State eligibility data systems generally range from 4 to 30 years old, and even state systems updated in the past 10 years are not "state of the art" and will require significant updates to meet ACA's requirements.[58] In the past, states have often used workarounds to adjust their systems as necessary. Such workarounds have left state systems less flexible, and can limit state opportunities for future improvements.[59] A recent description of New York's eligibility system illustrates the kind of problems many states face:

> The Medicaid eligibility determination and enrollment process is largely manual and there is no one statewide system for any part of eligibility...[T]here are two separate [Welfare Management System] systems that contain the eligibility records (New York City and Rest of State). These systems do not communicate well with each other due to different field lengths and edits. There are multiple imaging systems across the state and documents cannot be shared easily across districts. New York City has made the most progress in

> developing technological solutions to enrollment with EDITS, their automated renewal process, and various tracking systems. However, despite these advances, there is still no automation of the eligibility determination itself in any county.[60]

Scope of Required Changes: An early assessment of the scope of changes that will be needed for Medicaid systems includes the following:

> (B)uilding an interface with the Exchange, changes to state databases, re-coding of business rules; system changes to incorporate all Medicaid groups for an electronic determination; interfaces that would need to be built; modifying reporting, encounter data processing, letter functions and anything else currently being used for Medicaid populations; making methodology changes; educating eligibility staff about the changes; making policy changes, and more specific changes associated with reform provisions, including MAGI test.[61]

In addition to these significant modifications to Medicaid systems, rules and business processes, states will at the same time need to be building a new Exchange framework that can interface electronically with Medicaid, CHIP and federal systems as well as meet federal guidelines. This is a daunting set of tasks for state agencies now facing historic budget cuts, staffing shortages, mandated furloughs, hiring freezes, and staff retirements.

Funding Incentives Favoring Claims Over Eligibility Systems: State eligibility system modernization efforts have lagged in part due to the significant investment of time and resources required. Federal funding for Medicaid eligibility systems upgrades has been limited in the past two decades, with federal funding available only to pay for half the cost under Medicaid's administrative matching rate. By contrast, over the same time period, Medicaid claims processing systems have been eligible for more generous federal support, with a 90 percent federal financial participation (FFP) rate available for development of new Medicaid Management Information Systems (MMIS) and a 75 percent FFP rate available for maintenance of such systems.[62] As a result, state claims processing systems are often more advanced and disconnected from eligibility systems.

Redundant and Disconnected Systems: The federal funding model has led to great variation within and among state systems and nominal interconnections among states, which in turn has resulted in significant inefficiencies in how the federal Medicaid program is administered. Federal Medicaid dollars fund state administrative expenses, including the cost of administering and maintaining inefficient and disconnected Medicaid and CHIP infrastructures, paying 50 cents out of every dollar spent. Despite the federal mandate that states share new system plan-

Promising Models for Interconnected, Standardized Verification Systems

Two notable exceptions to the lack of interconnection among states or with federal systems are the Electronic Verification of Vital Events System (EVVES) and the Social Security Administration (SSA) citizenship documentation electronic data match. The EVVES is an electronic system developed and implemented in 2002 that allows participating states and the federal government to obtain immediate confirmation of the birth or death of an individual electronically in lieu of paper documentation. As of November 2010, 22 states were participating and another nine states, the District of Columbia, and the Northern Mariana Islands were preparing to participate.[63] Electronic matching of SSA data to verify citizenship and identity for Medicaid and CHIP eligibility began in 2010 and now is used by at least 29 states.[64] Many states have reported successes in transitioning to electronic data matching with SSA, including lower administrative costs and a faster verification process.[65] The SSA also reports a 94 percent average matching rate among states participating.[66] While still not adopted by all states, these systems lay a foundation for more robust data exchange in the future.

ning documents with other states to maximize efficiencies, each state adapts systems to its own specifications without broad federal standards, so federal Medicaid dollars are effectively paying for similar eligibility systems in 51 states and four territories. The absence of common minimum standards has also meant it is often difficult for states to share eligibility information with other states or sometimes within the state, leading to further inefficiencies of time delays and administrative costs when eligibility information is shared across state or county lines.

Aggressive Timeframe for Implementation: ACA's vision for transformative change and aggressive timeframe for implementation pose challenges for states. While state systems must be operative by January 1, 2014, states must be ready to enroll individuals by fall of 2013 and must be ready for federal inspection of progress by as early as January 2013, when the federal government will assess whether it will institute a federal Exchange for the state. Functionally, this gives states less than two years to develop a plan, enact any legislation or rule changes necessary to implement the plan, create a request for proposals, review proposals, select a vendor, implement new systems, and test system changes. Compared to the usual two-to-five year timeframe for state procurement and implementation of new eligibility systems, ACA requires states to move at lightening speed.

Federal Guidance

Federal guidance providing new standards and resources for state implementation of IT systems issued in the fall of 2010 holds great promise and may completely change the landscape for states. Federal guidance included four separate initiatives:

- *CMS Proposal to Increase Federal Funding for Medicaid Eligibility Systems*: On November 3, 2010, CMS issued a notice of proposed rulemaking (NPRM) proposing to allow states to claim enhanced federal matching funds for the development and maintenance of eligibility system upgrades that meet new criteria to promote efficiencies and system integration. Key requirements include that states seeking funding:
    - Use a modular, flexible approach to system development and separate, accessible business rules;
    - Align and advance Medicaid Information Technology Architecture roadmaps;
    - Align new systems with existing and new standards, including HIPAA security and privacy, accessibility standards for diverse populations and ONC HIT Enrollment Workgroup recommendations for standards and protocols for electronic transmission of information;
    - Promote sharing, leverage, and re-use of Medicaid technologies and systems within and among states and reduce redundancies of systems development within and among states;
    - Produce transaction data, reports and performance information to enable evaluation and advance continuous improvement efforts; and
    - Ensure seamless coordination and integration with the Exchange, allowing interoperability with health information exchanges, public health agencies, human services programs and community organizations providing outreach and enrollment services.

Federal Guidance, continued

While this funding is optional, the proposal requires states to transition any existing MMIS projects they have underway to meet these standards within three years (or within one year for proposed MMIS projects) or lose the enhanced federal funding for the project and receive only the usual 50 percent Medicaid administrative match rate. This proposal also creates incentives for states to develop and implement plans quickly, creating a window of opportunity for funding for eligibility systems that will end for any projects that are not proposed and funded before December 31, 2015.[67]

- *CMS-OCIIO Guidance for Exchange and Medicaid IT Systems*: On the same day CMS issued its proposed rule, CMS and OCIIO issued guidance (called Version 1.0 in recognition of future forthcoming detailed guidance) to help states with the design, development, implementation and operation of technology and systems projects to support ACA implementation. The guidance clearly indicates HHS' expectation that new state Exchange and IT systems will deliver a "first-class customer experience" and seamless coordination between Medicaid, CHIP and Exchanges and among different actors in the system (plans, employers, agencies, providers and navigators). The guidance encourages states to collaborate internally, including representation from all stakeholder agencies (Medicaid, CHIP and Exchanges) as they develop new Exchange systems and infrastructures. The guidance also lays out new standards for the technical architecture of Exchange and IT systems. This provision adds more detail about required standards, including expectations that states will develop modular, interoperable, and integrated systems that use a service-oriented architecture to ensure interfaces with other information systems and system performance that to the greatest extent possible provides real-time decision making and information.[68]
- *OCIIO Innovator Grants*: On October 29, 2010, OCIIO announced a federal grant opportunity for states and state collaboratives to apply for federal funding to support the development of innovative Exchange IT systems. The idea for this grant is that leading states and state collaboratives can get federal support to pilot promising models that other states will be able to replicate as they develop IT systems and infrastructures. Two-year grants were awarded to seven state collaboratives representing 13 states on February 15, 2011. These awards ranged in size from $6.2 million to $54.5 million, and will enable the collaborative states to provide leadership for other states in developing "consumer-friendly, cost-effective IT systems" that can promote efficiencies at the federal level by reducing duplication in development and implementation of new systems.[69, 70]
- *ONC HIT Workgroup Recommendations*: Pursuant to the requirements of section 1561 of ACA, the ONC HIT Enrollment Workgroup was created and charged with developing standards and protocols for interoperability and security of information systems to support electronic enrollment of eligible individuals in federal and state health and human services programs. On September 3, 2010, the Workgroup reported detailed recommendations outlining requirements for a "consumer-centric" approach that features an easy to use online system, accommodates a range of users with different language and literacy needs, seamlessly integrates private and public coverage systems, connects with other human service programs and provides strong privacy and security protections. These recommendations were adopted by the Secretary of HHS and have provided the basis for other guidance discussed above.

Closing the Gap

As states consider ways to close the technological divide, recent HHS guidance has the potential to change the landscape entirely. By offering new funding, the CMS proposed rule to increase the federal matching rate for Medicaid eligibility systems opens an opportunity for some states to consider completely upgrading their systems. But the new requirements also create new expectations and challenges states will have to consider carefully. States should also note that investments in technology and systems infrastructure have been shown to reap great dividends in improved efficiencies. Especially during today's austere budget climate, states simply cannot overlook opportunities to simplify and streamline systems as a means of improving system-wide efficiencies. Below are several options that states can consider when moving forward.

Developing a MITA Framework IT Proposal for CMS: All states will want to consider leveraging the new 90/10 funding available to develop upgraded Medicaid eligibility systems and improve IT infrastructures. Despite state budget challenges and the new requirements that states develop a broader plan for IT integration, the proposed rule offers a generous and unique opportunity that for many states is long overdue. States should consider committing the resources needed, either from their own staff or by partnering with a foundation, research institution, or stakeholder group, to develop and propose a new framework for state IT systems that integrates eligibility, claims and clinical data. This new framework must be rationally organized and allow all entities to use the available data to maximum effect to promote enrollment, program integrity, and the delivery of quality health care. A key component of this work will be ensuring the development and implementation of privacy, security and accessibility standards to accompany any new systems.

Evaluating Technology Needs: States need to begin with an inventory of current technological assets (including hardware and software) and resources already available to support their work, as well as an honest assessment of deficiencies. Some tools are currently in development that can assist states with this inventory. States may also want to consider working with an outside organization to help with the assessment to ensure it can be done quickly. Once a state has completed this assessment, it can then make important choices about future plans, including whether to "rip and replace,"[71] reuse existing systems in another way, or develop a less invasive "middleware"[72] approach to adapt current systems to new requirements.[73] This is work that states will need to complete quickly, but will be an essential predicate to any development of new systems plans and should precede the development of requests for proposals from vendors to develop new systems, if possible.

Pursue Economies of Scale: Wherever possible, states can seek to minimize costs to themselves and federal Medicaid spending by pursuing economies of scale in systems investments and improvements through:

- **State collaboratives**: If states work together in development of new systems, they can not only benefit from the knowledge and experience of other states, but can lower the net cost to their own state on the investment. For example, a state that partners with just one other state to develop a combined MMIS proposal would spend only five percent towards the cost of development, not 10 percent. States that partner on an Innovator Grant or use components that are developed through that proposal can save federal and state governments the costs of development and thereby promote greater efficiencies in implementation.
- **Adoption of existing "plug and play" system modules:** To the greatest extent possible, states may want to consider ways to use modular components that can be used off the shelf from other states. This will also lower opportunity costs for states and ensure improved efficiencies overall. It also increases the likelihood that future systems can be developed to communicate easily among states.

- **Reduction of duplicative internal systems:** States will want to reduce the number and diversity of eligibility systems used within the state. For example, it will likely not be cost-effective for states to maintain different eligibility systems that serve different regions of the state (cities or localities) or separate programs (e.g., Medicaid and CHIP). Where possible, states can seek opportunities to streamline and replace existing systems to maximize capacity and simplify structures. CMS' proposed rule clearly states that the federal intent is not to fund duplicative and redundant systems. States should seek to promote simplicity.
- **Building on federal and interstate systems:** A number of interstate systems already in place are increasing efficient administration of Medicaid, CHIP and other human service programs for states. Although most states are now using at least either EVVES or the SSA data match option, many states are still lagging in adoption. At a minimum, states can adopt the EVVES and SSA electronic data match systems in 2011 to smooth the transition to other more complex data matching systems in the future. In addition, states should prepare to integrate the new federal gateway for electronic verification data that federal agencies are developing, likely to be announced early in 2011.

4. Governance and Administration

Where States Are Today

States face important gaps between how current health coverage programs are managed and organized and ACA's vision of collaborative, integrated organization that supports Exchanges at the state, multi-state or federal level and promotes seamless coordination among programs.

Political Changes: At the beginning of 2011, 29 states experienced a change in leadership due to the election of new governors. This changes the landscape for states in two important respects. First, as with any change in leadership, there will be many new political appointees serving at the cabinet level in charge of health, insurance, and eligibility agencies, as well as some new Medicaid directors, Exchange and health care reform leads and other subcabinet positions. Second, a number of new governors ran on platforms specifically opposing health care reform – now that they are charged with providing leadership on implementation of ACA at the state level, it is unclear what these new leaders will do. All of this adds a degree of uncertainty and, for a time, an absence of leadership among key state agencies that can delay efforts to plan and implement changes needed during this early phase of ACA implementation.

Siloed Agency Operations: State agencies administering health and human service programs often operate in silos today, and are usually completely removed from the agencies that regulate the private insurance market. Thirty-eight states operate separate CHIP programs, many of which conduct eligibility and enrollment separately from Medicaid programs. Despite the delinking of Medicaid from Temporary Assistance for Needy Families/Aid to Families with Dependent Children (TANF/AFDC) in 1996, in most states, health and welfare/human service programs have remained linked due to the fact that the eligibility work and processes are managed by the same social service department eligibility caseworkers and agency. As many as 42 states claim to integrate Medicaid eligibility systems with those of other social service programs.[74] Although state Medicaid agencies contribute a significant percentage of the funding to support state eligibility agencies, some Medicaid officials report they are often competing with other programs like TANF and Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) when they need to make programming changes to the system, making it harder to administer their eligibility systems and adapt to change. In addition, most state insurance agencies and other agencies that play a role in regulating the private market are completely separate from Medicaid and CHIP. These agencies will need to change how they work together to implement a coordinated, integrated business process across programs.

Local Administration of Medicaid: Medicaid eligibility is often administered at the local level today. According to the National Association of Counties, as many as 20 states, representing just over half of the American population, either administer Medicaid at the local level or rely on financial contributions from local entities to fund Medicaid.[75] Under the current system, local administration can lead to great variation among localities in the quality of the eligibility processes, how rules are enforced, caseworkers' attitudes about the program, and the resources available for enrollment efforts. In many cases, states currently have minimal control over county performance or standards for work. At the same time, local administration provides a degree of accountability at a level that may be unavailable in a large state and movement to statewide administration may pose concerns from stakeholders about meaningful accountability. Given ACA's expectation that Exchanges will be run at the state, multi-state or federal level, states will likely have to reexamine the roles local entities have played in Medicaid administration. While local entities can clearly continue to play a role as an in-person entry point for eligibility and to assist applicants in need, states may find that having a state-wide program administered differently by many localities is no longer an efficient model and may want to define new rules of engagement with localities for the future.

Horizontal Integration of Human Service Programs: The prospect of transforming Medicaid from a program that is "horizontally linked" with other human service agency based programs to a separate system that is "vertically" linked with other health programs, as may be required given ACA's specific requirements, holds a number of challenges for states. A significant concern for human service agencies is the potential loss of funding for eligibility systems work when Medicaid is now a major contributor and state budgets cannot easily fill the gap. Importantly, many of the low-income individuals newly eligible for Medicaid will also be eligible for SNAP, TANF and other programs, and there is a concern that de-linking eligibility systems could lead to a loss of benefits and could promote inefficiencies if states have to determine eligibility multiple times.[76] Perhaps most importantly, states that seek to maintain integrated eligibility for human service and health coverage programs will face increasingly different program requirements. Examples of these differences often cited by states between SNAP and Medicaid program eligibility are that SNAP requires a more precise income determination, more frequent redeterminations (every six months), different rules about the household filing unit, and requires a personal interview that most Medicaid programs have eliminated. States will face challenges in reconciling these different requirements and maintaining a horizontally integrated eligibility system in the coming years.

Closing the Gap

States can pursue numerous avenues to close the gap in their governance and administration capacity to take on ACA's eligibility and enrollment mandate.

Demonstrating Leadership and Vision for Change: A key component identified by states in successful past reform initiatives has been having leaders who are willing to make politically difficult choices and promote the changes in organizational culture needed to make reforms real and meaningful. Successful implementation of ACA will require vision and tenacity from leaders inside and outside of state government, including governors, agency and division directors, key legislators, advocates, providers and other interested stakeholders. Only with strong and sustained commitment can the transformative changes envisioned in ACA come to fruition.

Identifying Opportunities for State Success in Health Care Reform: States can view health care reform as a means to gain support for some longstanding health policy goals. Key examples include leveraging generous federal financing to overhaul and modernize eligibility systems and infrastructure. States can also pursue quality improvement goals by using their expanded market power created by their oversight of Medicaid and Exchange coverage to implement new quality or payment standards. New state leaders should work to identify their own key priorities for state success in reform and work to achieve them by setting up structures to support implementation and assist the state's efforts to comply with new eligibility and enrollment requirements.

Key steps would include setting up an advisory committee of interested stakeholders to ensure input, creating an oversight group of leading cabinet members and agency directors to promote collaboration, making key choices about state roles in sponsoring an Exchange, creating a timeline for implementation steps and holding public meetings to provide transparency and accountability in the process.

Investing in Agency Collaboration: States can take important steps forward by encouraging collaboration among interested agencies. One means of ensuring collaboration during the planning phases are for states to promote coordination among leading cabinet members, agency directors, and governor's staff, including membership from Medicaid, CHIP, insurance, and any new Exchange entities. Relationship building and frequent discussion and consultation on plans among these leaders are essential to ensure that systems will be designed to support integration over time.

- *No Wrong Door*: Virginia's implementation of a "no wrong door" policy in 2002, allowing individuals to submit a joint application for Medicaid or FAMIS (Virginia's CHIP program) either at a Department of Social Services or Central Processing Unit agency, resulted in a 43 percent increase in quarterly Medicaid enrollment when it was implemented.[77]

Developing an Inventory of Local Functions: As states consider whether and how to include local agencies in future eligibility and enrollment efforts, a necessary first step is to categorize all of the roles local agencies are now playing in Medicaid and/or CHIP administration, including: financing and labor contributions; oversight and maintenance of eligibility systems; acting as a front door for programs in localities to provide in-person support for applicants; directly contracting with plans and/or overseeing specific programs; and conducting program integrity activities. As part of this inventory, states can seek to determine:

- Core functions that localities should retain, either because they cannot be performed at the state level or because they fit well with the vision for in-person, accessible enrollment in ACA;
- Redundant areas where consolidation or centralization of functions promotes efficiency and simplicity;
- Mechanisms for accountability that are needed to promote integrity of operations for any functions administered at the state level;
- Transition issues that might arise if states take on new roles; and
- Key options for states and localities to consider for new roles.

From this inventory, states can more easily work with localities and other stakeholders to develop a plan that outlines any changes in roles needed while taking into account all of the implications. An excellent model of this type of rigorous analysis can be found in a November 2010 report issued by New York's Medicaid agency articulating transition plans from local to state Medicaid administration. [78]

As states consider whether and how to include local agencies in future eligibility and enrollment efforts, a necessary first step is to categorize all of the roles local agencies are now playing in Medicaid and/or CHIP administration.

Making Choices about Integration with Human Services Programs: As states consider new structures for administration of eligibility systems, they will need to decide early in their planning process how much to integrate new systems with eligibility for other human service programs. CMS recently announced they are working with the USDA Food and Nutrition Service to create a unified Medicaid-CHIP-SNAP application that will clarify minimum eligibility requirements for all three programs. Apart from applications, states will need to assess their own circumstances about how they integrate eligibility. Some states will look to integrate the entire eligibility and enrollment system, others may look to create an automated referral process, and still others may look at different options. One idea states

may want to pursue is seeking a waiver from HHS to pilot a "reverse ELE" program where they can use an income finding from Medicaid or CHIP to determine eligibility in SNAP, TANF, the Women, Infants and Children Supplemental Nutrition Program (WIC), or other programs. A "reverse ELE" approach promotes efficiency by allowing the state to more easily enroll individuals enrolled in subsidized health coverage.

In addition to the specific steps noted above, there are also more general steps states and federal policymakers can take to help states prepare for the new eligibility and enrollment requirements under ACA.

Key Steps for States

Planning: States very quickly need to develop plans that will enable implementation of new eligibility and enrollment systems. This includes creating a planning process with input from all affected agency leads and stakeholders, creating specific goals and creating timelines for decision making based on ACA's requirements. States should consider whether they will need to issue new authority for procurement to enable them to meet timeframes and work closely with legislators to ensure all are equally informed about the federal requirements and timeframes.

Key Decision Points: As part of their planning process, states will need to decide early in 2011 whether they will be sponsoring Exchanges, what role Medicaid eligibility systems and other functionalities will play in state-run Exchanges, needed system upgrades, and the desired degree of integration with human service programs.

Financing: States should carefully consider ACA's new funding opportunities and look for ways to leverage funding to support their eligibility and enrollment goals. Where there are opportunities to partner with private foundations and research institutions to support goals, especially developing assessments and plans for change, states should pursue these aggressively, as they can pay great dividends and move the process forward.[79]

Peer Learning: States have a growing number of opportunities to learn from each other about key elements of reform implementation through federal efforts to convene, formal networks of states working together as grantees and informal means. Where possible, states should maximize their opportunities to learn from each other and not "recreate the wheel," since many of the challenges they are facing have likely been faced by other states. More than ever, states should pursue opportunities to build on what works.

States should maximize their opportunities to learn from each other and not "recreate the wheel," since many of the challenges they are facing have likely been faced by other states.

Transparent Process: While the aggressive timeframes for implementation may tempt some states to make policy choices behind closed doors, there are a number of advantages to using an informed, transparent process including public meetings for even part of the planning efforts. First, the state will gain input from interested stakeholders in a consolidated way and can assess which stakeholders can partner with states in implementation. Second, it keeps the public informed about the state's process so there are fewer surprises with implementation. Finally, public processes create accountability and can ensure that all government partners in the process adhere to deadlines and keep the process moving. Overall, the advantages and efficiency of some form of public process far outweigh alternatives.

Key Steps for Federal Policymakers

Continuing Guidance: The federal guidance provided so far has offered helpful markers for states as they chart their course. States will need this guidance to continue, including the finalization of the Medicaid eligibility proposed rule, early in 2011. However, additional guidance should take into account states' development of implementation plans and provide some flexibility and safe harbors for good faith compliance already underway. States will need some recognition that they need to move forward in the absence of guidance given ACA's

aggressive timeframes and a signal of flexibility that they will not be penalized if they take steps to implement before they get final word on federal interpretation.

States may need to move forward in the absence of guidance given ACA's aggressive timeframes and a signal of flexibility that they will not be penalized if they take steps to implement before they get final word on federal interpretation.

Providing More Federal Models/Structure: While states appreciate flexibility, there may be some areas where it is inefficient for states to be recreating a function 51 times or where more federal intervention will provide greater assistance to states. One key area for possible intervention is in the creation of minimum standards and clear guidelines for IT vendor contracts. States will be entering into contracts 51 times with different vendors and are at a distinct disadvantage in negotiating without clearer indications from federal policymakers about the minimum functionalities needed and the requirements they should include. It is also inefficient from a federal perspective for the federal government to pay the cost of states recreating this 51 times. More structure and oversight is clearly needed. States also need more guidance on models and parameters for development of systems. While the innovator grants are a helpful tool to promote collaboration and sharing, the timeframe of development of systems over the next two years is simply too slow for states to adopt the models developed and be ready for implementation.

Continue Support for Peer Learning: HHS has already made a great start by hosting a number of conferences in the fall of 2010 to support peer learning, including a conference for Medicaid eligibility directors, an Exchange grantee conference and others. Federal representatives have also attended privately convened meetings of states to promote improved communication and peer learning. Supporting peer learning through these in-person and virtual rapid knowledge transfer environments will greatly enable states to make faster progress in their implementation efforts.

Promote Greater Alignment of Program Requirements: Federal agencies are already working to develop a streamlined application for Medicaid, CHIP and SNAP, but more can be done to align eligibility and enrollment requirements for all federally sponsored human service programs. Recent efforts by HHS Secretary Sebelius and Agriculture Department Secretary Vilsack have been promising, but state experience shows it takes sustained commitment and leadership to promote coordination among agencies. To support this goal, federal policymakers could convene a summit of health and human service agencies to discuss opportunities to streamline federal requirements so that program eligibility requirements for these programs that serve a common low-income population in need can be administered more efficiently and can more easily reach eligible individuals. Where needed, legislative recommendations for alignment could be made. The reauthorization of the SNAP program in 2012 provides a good opportunity for consideration of some possible alignments.

Supporting Eligibility/IT/MMIS Systems Coordination: Federal policymakers can play a critical role in supporting state efforts to better coordinate IT systems to conform to a new Medicaid Information Technology Architecture. Specifically, federal agencies could convene a policy meeting that brings together state health care reform eligibility leads with health information exchange coordinators, MMIS leads, and chief information or technology officials to discuss options and ideas for helping states move forward and learn from each other.

Conclusion

The Affordable Care Act represents a critical crossroads for state Medicaid and CHIP programs and presents an opportunity for states to re-imagine current and new eligibility and enrollment systems more holistically to produce a simpler, streamlined enrollment "superhighway." This transformed system requires states to reorient themselves to a new coverage imperative where the issue for states is not whether an individual is covered but in what program and at what payment rate. This system presents great opportunities for efficiencies in how eligibility is determined and a complete reorganization of work processes that can save states money, time, and complexity.

States will face critical challenges along the way and will not only have to overcome the major gaps that exist between this new vision represented by ACA and where they are today, but also will need federal guidance and internal planning that reconciles the internal inconsistencies that ACA appears to create. Given the uniqueness of state systems, laws, political outlook, and resources, states would be well-served by a brief but intensive review of their eligibility systems, resources and options before investing in major change. Further federal guidance and resources will also ease the burden on states, especially if federal guidance can provide models states can replicate or build on, not reinvent. In all their efforts, federal and state policymakers should strive to find efficiencies in how they are implementing these provisions while promoting creativity, innovation and problem solving by states and localities. For states, 2014 is tomorrow, and states that begin their journey today will be ready for what's ahead. With guidance, support, and an appetite for change, states can be at the leading edge of transforming eligibility and enrollment systems in the years to come.

Endnotes

1 On January 31, 2011, the Office of Consumer Information and Insurance Oversight (OCIIO) became the Center for Consumer Information and Insurance Oversight (CCIIO). Since this paper references documents created before the change, references to the agency in this paper are to OCIIO.

2 Office of the National Coordinator for Health Information Technology (ONC), *HIT Policy & Standards Committee Enrollment Workgroup Recommendations* (Washington, DC: Department of Health and Human Services (HHS), September 3, 2010).

3 *Patient Protection and Affordable Care Act (ACA)*, Public Law 111-148, 111th Cong., 2nd sess., (23 March 2010), sec. 1413(b)(1)(A)(ii).

4 *ACA*, sec. 1413(b). Tax credits and cost-sharing reductions are referred in this paper as "tax subsidies."

5 *ACA*, sec. 1413(b)(2).

6 *ACA*, sec. 1002. Additional funds are authorized for appropriation in future years.

7 *ACA*, sec. 1311(i).

8 Target populations include: children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS. *ACA*, sec. 2201, creating new *Social Security Act (SSA)* sec. 1943(b)(1)(F).

9 *ACA*, sec. 1001, creating new *Public Health Service Act* sec. 2715.

10 Office of Consumer Information and Insurance Oversight (OCIIO) and Centers for Medicare and Medicaid Services (CMS), *Guidance for Exchange and Medicaid Information Technology (IT) Systems: Version 1.0* (Washington, DC: HHS, November 3, 2010), 5; ONC *HIT Policy & Standards Committee Enrollment Workgroup Recommendations*, 9.

11 OCIIO and CMS, *Guidance for Exchange and Medicaid Information Technology (IT) Systems: Version 1.0*, 3; ONC, *HIT Policy & Standards Committee Enrollment Workgroup Recommendations*, 7.

12 *ACA*, sec. 1413(b)(1)(A)(iii).

13 *ACA*, sec. 1413(a).

14 Individuals who are elderly, medically needy, eligible for Medicare cost sharing and eligible for Medicaid due to other program eligibility are still subject to current Medicaid eligibility rules and processes. For example, there are no changes to current resource or asset tests and no changes to current income documentation requirements. For individuals applying for home and community-based services, individual assessments are still required. *ACA*, sec. 2201, creating new *SSA* sec. 1943(b)(5).

15 *ACA*, sec. 2002(a).

16 Ibid.; *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152, 111th Cong., 2nd sess., (March 30, 2010), sec. 1004(e), revising *SSA* sec. 1902(e)(14) as amended by *ACA* sec. 2002(a).

17 *ACA*, sec. 1413(a); *ACA*, sec. 2201, creating new *SSA* sec. 1943(b)(2).

18 *ACA*, sec. 1413(c)(2).

19 *ACA*, sec. 2201, creating new *SSA* sec. 1943(b)(1)(D).

20 *ACA*, sec. 2201, creating new *SSA* sec. 1943(b)(1)(A).

21 ONC, *HIT Policy & Standards Committee Enrollment Workgroup Recommendations*, 3.

22 OCIIO and CMS, *Guidance for Exchange and Medicaid Information Technology (IT) Systems: Version 1.0*, 7.

23 Ibid.

24 Ibid.

25 Martha Heberlein et al., *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010-2011* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured (KCMU), January 2010), 58.

26 Thirty-six states, the District of Columbia, and three U.S. territories have received grants. CCIIO, *Consumer Assistance Program Grants: How States Are Using New Resource to Give Consumers Greater Control of their Health Care* (Washington, DC: HHS, October 2009).

27 Melanie Au et al., *Improving Access to Language Services in Health Care: A Look at National and State Efforts* (Princeton, NJ: Mathematica Policy Research, April 2009), 1.

28 U.S. Department of Health and Human Services (HHS), "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," *Federal Register* 68, no. 153 (August 2003): 47311.

29 Mara Youdelman et al., *Providing Language Services in State and Local Health-Related Benefits Offices* (Washington, DC: Commonwealth Fund, January 2007), vi.

30 About 86% of workers in the lowest earnings quintile experienced at least a 25% change in earnings from 2002 to 2003. By contrast, only about 16% of those in the highest quintile experienced at least a 25% change in earnings during the same period. Health and Human Resources Division, CBO, *Recent Trends in the Variability of Individual Earnings and Household Income* (Washington, DC: June 2008), 6. Much of this income volatility is due to a significant fluctuation in hours worked or gaps in employment. Low-income working individuals often have part-time, temporary, service, labor, or operator or transportation jobs, the types of jobs that typically feature low hourly wages, unpredictable hours, periods of lost wages and ineligibility for paid leave. "Deferred Payment Plan Policies and the 'Working Poor,'" *FSC'S Law & Economics Insights*, Fisher, Sheehan and Colton, Public Finance and General Economics, March/April 2002.

31 Philip Poley (public comments, National Academy for State Health Policy (NASHP) 23rd Annual State Health Policy Conference, New Orleans, LA, October 2010).

32 *ACA*, sec. 2002(a), revising *SSA* sec. 1902(e)(14)(H); *ACA*, sec. 1411 and sec. 1412.

33 *ACA* would have required consumers who receive tax-subsidized Exchange coverage and become ineligible to repay no more than $400, or $250 for those filing taxes as unmarried individuals, but the Medicare and Medicaid Extenders Act of 2010 increased these limits significantly, requiring consumers to repay between $600 and $3,500, depending on their income levels. *ACA*, sec. 1401(a), creating new *Internal Revenue Code of 1986* sec. 36B(f)(2)(B)(i); *Medicare and Medicaid Extenders Act of 2010*, Public Law 111-309, 111th Cong., 2nd sess., (15 December 2010), sec. 208.

34 Maureen Hensley-Quinn, *On the Spot in Illinois: Working toward Reaching and Enrolling All Children and Adolescents* (Portland, ME: NASHP, October 2008), 5.

35 Carrie Tracy, Elisabeth R. Benjamin and Christine Barber, *Making Health Reform Work: State Consumer Assistance Programs* (New York, NY: Community Health Advocates, Community Service Society of New York, September 2010), 10.

36 Under Iowa's process, the Medicaid eligibility system automatically refers the case to the CHIP eligibility system, electronically populating an application, notifying the caseworker and the parent of the referral and processing the referral in the same day. Southern Institute on Children and Families, *Medicaid and CHIP Retention: A Key Strategy to Reducing the Uninsured* (Columbia, SC: March 2009), 16.

37 Ibid.,17.

38 Ibid.

39 Mara Youdelman et al., *Providing Language Services in State and Local Health-Related Benefits Offices*, vii-ix.

40 *Children's Health Insurance Reauthorization Act*, Public Law 111-3, 111th Cong., 1st sess., (4 February 2009), sec. 201(b).

41 Sherice Perry et al., *Improving Language Access: CHIPRA Provides Increased Funding for Translation Services* (Washington, DC: Families USA, February 2010), 2.

42 For further discussion of research documenting the impact of simplification strategies for enrollment of children in Medicaid and CHIP, see Victoria Wachino and Alice M. Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children* (Portland, ME: Maximizing Enrollment for Kids, NASHP and the Robert Wood Johnson Foundation (RWJF), February 2009).

43 Martha Heberlein et al., *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010-2011*, 58.

44 Ibid., 46.

45 Vernon K. Smith et al., *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends* (Washington, DC: Health Management Associates and KCMU, September 2010), 18.

46 Ibid.

47 While 24 states had some programs to cover adults without dependent children in 2009, eligibility levels and accessibility of coverage varied, with nine programs closing enrollment during 2009 and three states requiring work criteria for eligibility. Samantha Artiga, *Where are States Today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults* (Washington, DC: KCMU, December 2009), 2.

48 Beth Morrow and Dawn Horner, *Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices* (Washington, DC: Children's Partnership and KCMU, May 2007), 8.

49 Louisiana's experience implementing dramatic simplifications, including a strong focus on renewals, while at the same time maintaining a PERM error rate that is of the national average suggests that states' fear of increased error rates as a result of simplifications may not be well-founded. Don Gregory, "Balancing Eligibility Simplifications and PERM" (presentation, CMS conference, Medicaid/CHIP Eligibility and Enrollment: On the Road to 2014, Denver, CO, September 16, 2010); Tricia Brooks, *The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP* (Washington, DC: Center for Children and Families, Georgetown University Health Policy Institute, February 2009), 1.

50 While States are keenly aware of their financial interest in whether an individual is classified as "newly eligible," this classification also has important ramifications for individuals' rights. Individuals who are inappropriately classified as "newly eligible" will receive either a "benchmark" or "benchmark equivalent" benefit plan, but the individual may as a result miss out on needed benefits not included in the benchmark plans. In addition, individuals who are eligible for Medicaid because they are eligible for Social Security Disability Insurance benefits should be eligible for Medicare after being enrolled for 24 months, but it is unclear whether the waiting period on Medicaid will begin if individuals are inappropriately classified.

51 Pat Redmond, *A Medicaid Perspective on Medical Support Cooperation: A Study of Procedures in Five States* (Washington, DC: Center on Budget and Policy Priorities for KCMU, April 2005), 10-11.

52 Paula Roberts, *Child Support Cooperation Requirements and Public Benefits Programs: An Overview of Issues and Recommendations for Change* (Washington, DC: Center for Law and Social Policy, November 2005), 14.

53 The Maximizing Enrollment Self-Assessment Toolkit includes a process mapping exercise states can use free of charge at www.maxenroll.org.

54 ELE decisions are exempt from the MAGI income eligibility standard, and this may encourage states to think differently about implementation post-reform.

55 Don Gregory, "Balancing Eligibility Simplifications and PERM" (presentation, CMS conference, Medicaid/CHIP Eligibility and Enrollment: On the Road to 2014, Denver, CO, September 16, 2010)

56 In 2010, 32 states (63%) allowed electronic submission of Medicaid applications for children, and 29 states (57%) allowed electronic submission of Medicaid applications for parents, while 27 of 38 CHIP programs (71%) allowed for electronic submission. For electronic signatures, 29 states (57%) have adopted for children in Medicaid; 26 states (51%) for adults; and 23 states (60%) in CHIP. Martha Heberlein et al., *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010-2011*, 50.

57 Donna Cohen Ross et al., *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009*, 44.

58 National Association of State Medicaid Directors (NASMD), untitled report on survey of state estimates of eligibility system costs (Washington, DC: American Public Human Services Association, 2010), 1.

59 Gwyn Volk and Anne Jacobs, *The Impact of Health Care Reform on State Operations* (Navigant Consulting, Inc., for State Coverage Initiatives, RWJF and Academy Health, February 2010), 6.

60 New York State Department of Health, *New York State Medicaid Administration November 2010 Report* (New York, NY: November 30, 2010), 10.

61 NASMD, untitled report on survey of state estimates of eligibility system costs, 1.

62 While MMIS enhanced federal financial participation was originally allowable for eligibility system improvements, funding for eligibility system improvements was limited in 1989 and has been unavailable since then. In November 2010, HHS issued a Notice of Proposed Rulemaking (NPRM) that proposes to restore the enhanced FFP for eligibility system development and maintenance. HHS, CMS, "Medicaid; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities," *Federal Register* 75, no. 215 (November 2010): 68583. This rule is discussed in greater detail below.

63 National Association for Public Health Statistics and Information Systems. "Electronic Verification of Vital Events (EVVE)." Retrieved December 20, 2010. http://www.naphsis.org/index.asp?bid=979.

64 Twenty-seven states are using in Medicaid for parents; 21 state CHIP programs are using. Martha Heberlein et al., *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010-2011*, 48 and 58.

65 California reported a savings of $6 million annually resulting from the change; other states have also reported comparable savings. Donna Cohen Ross, *New Citizenship Documentation Option for Medicaid and CHIP Is up and Running: Data Matches with Social Security Administration Are Easing Burdens on Families and States* (Washington, DC: Center for Budget and Policy Priorities, April 20, 2010), 3-5; Rene Mallow, "Citizenship Documentation" (presentation, CMS conference, Medicaid/CHIP Eligibility and Enrollment: On the Road to 2014, Denver, CO, September 2010).

66 Donna Cohen Ross, *New Citizenship Documentation Option for Medicaid and CHIP is up and Running: Data Matches with Social Security Administration Are Easing Burdens on Families and States* (Washington, DC: Center for Budget and Policy Priorities, April 20, 2010), 2.

67 HHS, CMS, "Medicaid; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities."

68 OCIIO and CMS, *Guidance for Exchange and Medicaid Information Technology (IT) Systems: Version 1.0*, 5-8.

69 HHS, "HHS Announces New Competitive 'Early Innovator' Grants for States that Lead the Race to Develop IT Systems for State Exchanges," press release, 29 October 2010.

70 HHS, "States Leading the Way on Implementation: HHS Awards 'Early Innovator' Grants to Seven States," press release, 16 February 2011.

71 The choice to completely replace current eligibility and enrollment systems.

72 Software that serves as a link between two or more programs or systems that cannot normally communicate effectively.

73 Estimates for the cost of new systems can range from $35 million to $200 million. House Committee on Agriculture, *Field Hearing to Review Federal Nutrition Program: Hearing before the Subcommittee on Department Operations, Oversight, Nutrition and Forestry*, 111 Cong., 2nd sess., January 25, 2010 (testimony of Claudia Page).

74 Food and Nutrition Service, *Supplemental Nutrition Assistance Program State Options Report, Eighth Edition* (Washington, DC: Department of Agriculture, June 2009), 16.

75 Census Bureau and Bureau of Labor Statistics, *Current Population Survey Annual Social and Economic Supplement* (Washington, DC: Department of Commerce, September 2010); the 20 states in which Medicaid eligibility is administered at the county or local level include Arizona, California, Colorado, Florida, New Hampshire, Idaho, Iowa, Michigan, Minnesota, Montana, North Carolina, North Dakota, New Jersey, New Mexico, Nevada, New York, Ohio, South Carolina, Wisconsin and Virginia. National Association of Counties e-mail message to authors, September 10, 2010.

76 House Committee on Agriculture, *Field Hearing to Review Federal Nutrition Program: Hearing before the Subcommittee on Department Operations, Oversight, Nutrition and Forestry* (testimony of Claudia Page).

77 Victoria Wachino and Alice M. Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children*, 20.

78 New York State Department of Health, *New York State Medicaid Administration November 2010 Report*.

79 Recent examples of state foundations supporting state reform planning efforts include the NYS Health Foundation and the California HealthCare Foundation (CHCF) each providing funding to support the creation of a reform planning paper for New York and California, respectively. Patricia Boozang et al., *Implementing Federal Health Care Reform: A Roadmap for New York State* (New York, NY: Manatt Health Solutions for NYS Health Foundation, August 2010); William Bernstein et al., *Implementing National Health Reform in California: Changes to Public and Private Insurance* (New York, NY: Manatt Health Solutions for CHCF, June 2010).