Assessment and Synthesis of Selected Medicaid Eligibility, Enrollment, and Renewal Processes and Systems in Six States

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EXECUTIVE SUMMARY

This report was produced by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota under contract to the Medicaid and CHIP Payment and Access Commission (MACPAC). The project sought to assess current processes and systems for Medicaid eligibility, enrollment, and renewal in six diverse states: Arizona, Colorado, Florida, Idaho, New York, and North Carolina.

SHADAC used a multi-case study methodology and key informant interviews with state and local agency staff and advocacy organizations to collect data on enrollment processes and systems for individuals whose income eligibility is based on Modified Adjusted Gross Income (MAGI). MACPAC was specifically interested in auto-enrollment and auto-renewal practices, the use of electronic data sources for verification, and the degree of integration with non-MAGI Medicaid populations and other public benefit programs. Our data collection strategy also assessed the extent to which states are achieving desired goals such as program efficiency and a simplified beneficiary experience.

This report summarizes how MAGI Medicaid populations apply to and are determined eligible for the Medicaid program, and describes state approaches to streamlining enrollment and renewal for these populations in light of statutory and regulatory requirements. Additionally, the full report discusses common themes (as identified by key informants across study states) related to the Medicaid program and beneficiary experiences, as well as future plans to further simplify and streamline practices. The content of this report is drawn from individual state summary reports that more thoroughly describe the MAGI Medicaid application, eligibility determination, and renewal processes (available separately).

The six study states varied widely in their Medicaid policy, program priorities, and the ages and capabilities of their eligibility systems; therefore, they took different approaches to streamlining their Medicaid enrollment and renewal processes. Some states prioritized real-time, no-touch enrollment and renewal for MAGI Medicaid populations, meaning same-day eligibility determinations or redeterminations with no worker involvement. Other states prioritized the involvement of eligibility workers in the process. All states focused on the transition to MAGI-based eligibility determinations and use of electronic data sources for verification of beneficiary information called for under the Patient Protection and Affordable Care Act (ACA). Highlights from the various state approaches include:

- **Arizona** facilitates access to multiple health and human services programs, including MAGI Medicaid, State Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). The state has a combined online application; however, Arizona's shared eligibility system is used only across health programs.
- **Colorado** emphasizes easy access to a variety of health and human services programs, including usability of its combined online application and ongoing improvements to its legacy shared eligibility system. Colorado's Medicaid agency accepts self-attested information as it relates to application requirements and conducts income verifications post-eligibility to facilitate high rates of MAGI Medicaid determinations in real time.
- **Florida** has a history of using shared eligibility processes and systems for health and non-health programs. For example, its combined online application pre-dates the ACA and supports applications for Medicaid, CHIP, SNAP, and TANF. In response to the ACA, Florida built new infrastructure alongside its legacy system to allow for processing of real-time determinations where possible.

- **Idaho** prioritizes a high-touch, either in-person or phone-based, approach to enrolling individuals in Medicaid and other health and non-health programs. The state achieves high rates of auto-renewal of MAGI Medicaid populations and supports a shared eligibility system across health and non-health programs.
- **New York**'s decision-making is built on integrating health programs, including exchange plans, supported by automation. To that end, New York's Department of Health created one application and eligibility system for all MAGI-eligible populations.
- **North Carolina** has emphasized benefit integration across health and human service programs, and this state values its tradition of county caseworker interaction. MAGI Medicaid and other programs are supported by North Carolina's shared eligibility system, although on separate information technology platforms.

Notably, not all study states had the ability or desire to process real-time MAGI Medicaid eligibility determinations and renewals. For example, North Carolina currently has no automated enrollment of the MAGI Medicaid population. In contrast, more than 90 percent of eligible individuals in New York experience automated eligibility determinations (see **Table ES-1**). While the six study states varied in how they defined auto-renewal of MAGI Medicaid populations and in the processes and systems they use to support it, respondents indicated that auto-renewal processes were easier to implement than automated eligibility determinations, as renewals required fewer verifications than initial applications.

Table ES-1. MAGI Medicaid Auto-Enrollment and Auto-Renewal Practices, 2018

Study State	Performs Real-Time Determination	50+% of Determinations Completed in <24 hours	Performs Automated Renewal	50+% of Renewals Automated
Arizona	✓		✓	✓
Colorado	✓	✓	✓	✓
Florida	✓		✓	
Idaho		✓	✓	✓
New York	✓	✓	✓	
North Carolina		Not reported		✓

Sources: Brooks et al. 2018; Data collected under the 2018 Assessment of Medicaid Eligibility, Enrollment and Renewal Processes and Systems project, Medicaid and CHIP Payment and Access Commission (MACPAC) contract number MACP18417T1.

Notes: In New York, "auto-eligibility determination" or "auto-enrollment" is a no-touch eligibility determination. The term auto-enrollment is not used because after someone receives an auto-eligibility determination, they often must choose a health plan.

The six study states prioritized different integration goals based on where they were when the ACA was enacted and how they were implementing the law. To date, the integration of MAGI Medicaid eligibility determinations with other health or human services programs may incorporate a unified administrative structure, a common online application, shared eligibility systems, and co-located workforces.

Interview responses across the six states revealed several key themes related to Medicaid program and beneficiary experiences:

- **Multi-benefit online applications enhanced beneficiary access to programs and reduced burden, but back-end eligibility systems are complicated to maintain.** Across study states, respondents said that their combined online applications support greater access to coverage and reduce beneficiary burden. The combined application can also help raise applicant awareness of other benefits for which individuals might be eligible. Respondents openly acknowledged that while their application pathways, systems, and processes are integrated from the customer point of

view, the back-end eligibility systems are often fragmented, outdated, or complicated to maintain. However, all respondents said their states' systems increased case workers' ability to quickly and easily get a holistic view of their clients' program participation. This has helped to reduce or shift eligibility staff workloads, especially for those serving individuals who receive multiple benefits.

- **Electronic data interfaces facilitated high rates of real-time eligibility determinations, auto-renewal, and reduced churn.** Respondents unanimously agreed that system connections with electronic data sources facilitated real-time eligibility determination and auto-renewal. States ranged from having connections that allowed workers to view electronic data in a central location to having more sophisticated linkages where data populate state information systems. In addition to supporting real-time determinations and more efficient application processing, these interfaces allow for more timely notifications to counties. This means that in states like Colorado, which has a county-administered Medicaid program, workers can more quickly begin work on cases also eligible for other benefits. Most respondents remarked that the efficiencies gained through data interfaces reduced administrative costs and fluctuations on and off the Medicaid program (known as churn), thereby improving continuity of care.
- **Robust rules engines were critical, but workers still need to understand policy.** Respondents emphasized that even with the right data sources, a robust rules engine (to automate the varied and complex eligibility rules across health and non-health programs) was critical to support successful streamlined eligibility determinations. Business rules allow eligibility workers to focus on the consumer and their specific situation, not the minutia of program rules. However, respondents felt policy knowledge was still important for eligibility workers.
- **Complex and varied programs rules remained a challenge for integration of MAGI Medicaid and other programs.** Updating eligibility rules engines to accommodate different program requirements in one system also remains a challenge for integration, as they may have different income counting rules or stricter verification requirements, such as in-person interview, than MAGI Medicaid. States also struggled with designing a single streamlined application that could collect information in a straightforward, easy to understand way.
- **Despite streamlined processes, demand for enrollment assistance was high.** Respondents uniformly agreed that streamlined application processes, including a combined online application, were helpful to people applying for Medicaid or other health and human service programs. However, in-person assistance was still in high demand, especially for certain populations (e.g., mixed-coverage families, populations in highly transient communities, largely immigrant communities, and communities with lower computer literacy).

The work of study states to accurately and efficiently enroll and renew Medicaid eligible populations into the program is not static, but rather focused on continuous improvement over time. Areas of ongoing activity include the following:

- **Monitoring of Medicaid and related policy changes continues.** Respondents were closely monitoring potential Medicaid policy changes in their states, such as Medicaid expansion proposals in Idaho and proposed Medicaid work requirements in Arizona. Also on the horizon are changes to several key federal funding streams, including an expiration of the Office of Management and Budget (OMB) Circular A-87 cost allocation exception waiver. When the waiver expires, states will have to charge human services programs for any efforts to integrate eligibility, enrollment, and renewal systems across health and non-health programs. Also forthcoming is a $26 million reduction in CMS grant funding to the ACA Navigator Program for plan year 2019, as well

reductions in the federal medical assistance percentage (FMAP) for Medicaid expansion populations.

- **Efforts to improve beneficiary correspondence are important and ongoing.** Four of the study states reported beneficiary confusion arising from correspondence about eligibility determination and renewal, and three of these states reported plans to improve this correspondence.
- **States continue to invest staff resources and funding to improve application and eligibility system infrastructure.** All six states are working to advance their application platforms to increase usability for individuals. Additionally, all six states were in the process of enhancing their eligibility systems through integration across health and non-health programs and movement away from legacy mainframe systems to rules-based systems and modular, cloud-based platforms.

INTRODUCTION

Simplifying and streamlining state Medicaid enrollment and renewal processes and systems has been a priority for state agencies for the last decade. While this work was underway in some states, momentum for these changes was due in large part to the passage of the Patient Protection and Affordable Care Act (ACA) in 2010. The ACA called for enhancements to Medicaid by 2014, including revised eligibility rules, a single streamlined application, and use of technology to verify and exchange data in support of near real-time eligibility determinations. Additionally, the Centers for Medicare & Medicaid Services (CMS) and other federal agencies provided states with guidance and incentives to modernize and integrate eligibility systems and efficiently enroll Modified Adjusted Gross Income (MAGI) Medicaid-eligible individuals into the program.

The Medicaid and CHIP Payment and Access Commission (MACPAC), as the legislative branch agency charged with advising Congress on Medicaid and the State Children's Health Insurance Program (CHIP), sought to better understand the post-ACA status of state systems and processes for supporting MAGI Medicaid program eligibility, enrollment, and renewal. To do so, MACPAC contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health to conduct an assessment of current Medicaid eligibility, enrollment, and renewal practices in six diverse states: Arizona, Colorado, Florida, Idaho, New York, and North Carolina. SHADAC's data collection strategy sought to clarify the extent to which states are achieving desired goals, such as program efficiency and simplified beneficiary experience.

In this report, SHADAC provides background information on the study's focus and the process used to select the six case study states and key informants, as well as the historical context of Medicaid eligibility and enrollment simplification. We then turn to the six case study states, presenting an overview of how MAGI Medicaid populations apply to and are determined eligible for the Medicaid program, and summarizing state approaches to streamline enrollment and renewal for these populations. Next, we present common themes, as identified by key informants, related to Medicaid program and beneficiary experiences across the states. Lastly, we summarize ongoing issues and future plans in the study states to address those issues and further simplify and streamline enrollment and renewal. This content is drawn from individual state summary reports (which were reviewed by state representatives) that describe the MAGI Medicaid application, eligibility determination, and renewal process in more depth (available separately).

METHODS

We used a case study method to collect data on Medicaid enrollment processes and systems, for individuals whose income eligibility is based on Modified Adjusted Gross Income (MAGI).[1] We chose the case study method in order to best address the complexity of Medicaid eligibility system modernization and the variety of policies and procedures states are implementing to meet federal and state demands. In addition, MACPAC was specifically interested in the automation of enrollment and renewal practices, the use of electronic data sources for verification, and the degree of integration with non-MAGI Medicaid populations and other public benefit programs.

To identify the six study states and to hone study focus, SHADAC undertook several activities to assess state Medicaid agency practices for facilitating Medicaid eligibility, enrollment, and renewal. We scanned recent peer-reviewed and grey literature, reviewed relevant post-2013 federal guidance and incentives, and held discussions with select stakeholders.[2] SHADAC also leveraged an internal database of state-level measures to compare states across a range of applicable metrics.

We ultimately identified six candidate states (Arizona, Colorado, Florida, Idaho, New York, and North Carolina) where documentation showed steps toward implementing streamlined, automated, or integrated approaches to Medicaid enrollment and renewal. These states also represented diversity across a range of characteristics including Medicaid program size, adoption of the ACA Medicaid expansion, health insurance exchange type, current enrollment and renewal practices, geography, and political climate.[3] See **Table 1** for Medicaid and exchange program characteristics of each of the six case study states, including Medicaid eligibility levels.

[1] MAGI populations encompass most Medicaid applicants (the expansion population of adults without dependent children as well as children, pregnant women, and parents) whose income eligibility is based on a simplified income standard that is consistent with Internal Revenue Service (IRS) reporting. Medicaid applicants who require the traditional income and asset test review for determination are referred to as non-MAGI. The latter include populations such as the Aged, Blind, and Disabled (ABD); individuals eligible for Supplemental Security Income (SSI); individuals dually eligible for Medicaid and Medicare; individuals receiving long-term care services; and the medically needy.

[2] Stakeholders included individuals from the National Association of Medicaid Directors (NAMD) and the Kaiser Family Foundation (KFF)/Georgetown University team responsible for the annual 50-state survey of Medicaid and CHIP eligibility, enrollment, renewal, and cost-sharing policies. In addition, SHADAC spoke with a leading Medicaid policy and research analyst (with previous experience with the Maximizing Enrollment program), and federal Medicaid policy staff.

[3] Exchanges are government-regulated insurance marketplaces designed to increase access to and facilitate purchase of affordable health insurance for certain subpopulations.

Table 1. Medicaid Program Characteristics, Eligibility Levels, and State Exchange Type as of April 2018

Study State	Medicaid Expansion	Total Medicaid and CHIP Enrollment as of April 2018	Medicaid Growth Pre-ACA to April 2018	Children's Medicaid Eligibility as a Percent of FPL	Parent's Medicaid Eligibility as a Percent of FPL	Other Adult's Medicaid Eligibility	State Health Insurance Exchange Type
National	33 states adopted	73,765,374	23% (Median)	255% (Median)	138% (Median)	138% (Median)	39 states use Healthcare.gov
Arizona	Adopted (via Section 1115 waiver)	1,679,239	40%	205%	138%	138%	Healthcare.gov
Colorado	Adopted	1,331,971	70%	265%	138%	138%	State-based: Connect for Health Colorado
Florida	Not Adopted	4,252,113	15%	215%	33%	0%	Healthcare.gov
Idaho	Not Adopted	267,990	13%	190%	31%	0%	State-based: Your Health Idaho
New York	Adopted	6,509,389	15%	405%	138%	138%	State-based: New York State of Health
North Carolina	Not Adopted	2,045,929	28%	216%	43%	0%	Healthcare.gov

Sources: AHCCCS 2018a; Brooks et al. 2018; CMS 2018a; Colorado HCPF 2017; FL DCF 2018; FL 2017; FL DCF 2016; MACPAC 2018; Muldoon et al. 2017; NYC 2018; NC DMA 2018; Data collected under the 2018 Assessment of Medicaid Eligibility, Enrollment and Renewal Processes and Systems project, Medicaid and CHIP Payment and Access Commission (MACPAC) contract number MACP18417T1.

Notes: For Medicaid Growth, pre-ACA is defined as July through September 2013. Percentages include the five percentage point disregard established under the ACA, which can be applied to eligibility determination for MAGI Medicaid individuals. Medicaid eligibility for children is the upper income limit across all eligibility categories and programs, including CHIP. Medicaid eligibility for parents is the upper income limit for a family of three, and the other adult category refers to non-disabled adults. Florida CHIP programs, i.e., Healthy Kids, MediKids, and Children's Medical Services Managed Care Plan include premium payments. Both MediKids and Florida Healthy Kids include full-pay programs for those over 200 percent FPL. Medicaid eligibility for New York does not include eligibility for their Basic Health Program (BHP) established by the ACA for adults with incomes between 138 percent and 200 percent FPL. In New York, 19- and 20-year-olds living with parents are eligible for Medicaid up to 155 percent FPL. The Federally Facilitated Marketplace (FFM) conducts assessment for Medicaid eligibility in Arizona, Florida, and North Carolina. Arizona originally implemented a traditional Medicaid expansion, but in September 2016 the state received approval for a Section 1115 waiver to make changes to its expansion coverage (opting to enact things like premium contributions, cost sharing, and wellness incentives). Acronyms are as follows: CHIP – State Children's Health Insurance Program, ACA – Patient Protection and Affordable Care Act, FPL – Federal Poverty Level.

Once the six candidate states confirmed their participation in the study, SHADAC conducted semi-structured phone interviews with 48 individuals representing Medicaid eligibility and policy staff, information technology staff, other state and local agency staff, state exchange staff, and advocacy organizations (see **Appendix Table A-1**). In advance of telephone interviews, SHADAC also implemented a process to confirm information with key Medicaid eligibility and policy staff about each state's Medicaid program and eligibility systems. Additional detailed information on the study methods and interview guides can be found in Appendices A and B, respectively.

Our study has several important limitations. First, the eligibility systems and processes used by states are incredibly complex. We have done our best to describe these processes as we understand them. This study was not an audit and we relied on descriptions provided by key informants (verified with secondary data sources when available) in order to describe the current status of eligibility systems and processes. A state representative was provided the opportunity to review the descriptions of their systems and processes for clarity and to ensure we included accurate program details.

A second limitation is that a case study approach restricts our ability to generalize findings across states and across the nation more broadly. Third, we did not speak to beneficiaries directly through this study; findings related to beneficiary experiences were based on the perspective of other stakeholder groups, such as state agency staff and advocacy organizations. Fourth, states that have delegated the authority to make Medicaid/CHIP eligibility determinations to the Federally Facilitated Marketplace (FFM) were not represented among the six study states. Lastly, case study data collection did not focus on other aspects of Medicaid enrollment: namely outreach and consumer assistance, community partnerships, enrollment and credentialing of providers, and call center technology. However, if several key informants spoke to these topics during telephone discussions, we summarized findings in this report.

CONTEXT

Medicaid eligibility simplification was a requirement of the ACA (see **Exhibit 1**) and built on other statutory changes (such as the requirement to coordinate eligibility and enrollment in Medicaid with CHIP) enacted in the 1990s. To meet statutory and regulatory requirements, states had to make changes to policies as well as significant technological investments. Most state Medicaid eligibility systems, regardless of age, were not designed to easily incorporate the new MAGI-based income counting rules for Medicaid, nor could they be readily modified to address ACA requirements and CMS guidance, such as real-time determinations (i.e., no delay between submission of a complete and verifiable application and the response to the applicant), reasonably compatible verifications (i.e., consistent applicant information), or modularity standards (i.e., flexible design) (SHADAC 2012, CMS n.d.).[4]

Exhibit 1. Federal Guidance Regarding Streamlined Medicaid Eligibility Processes

- Use simplified Modified Adjusted Gross Income (MAGI) income eligibility rules for children, pregnant women, parents, and the new adult expansion group eligible up to 138 percent of the Federal Poverty Level (FPL).
- Offer a single streamlined application for all insurance affordability programs—e.g., MAGI Medicaid, State Children's Health Insurance Program (CHIP), advance payment of premium tax credits and cost-sharing reductions through an exchange, and any state-established Basic Health Program—that can be submitted online, over the telephone, in person, by mail, or through other commonly available electronic means. States may use a separate non-MAGI application.
- Verify customer data electronically at enrollment and renewal using a reasonably compatible standard, with paper documentation as a last resort. States can accept self-attestation with the exception of Social Security number, citizenship, and immigration status. An electronic service, known as the Federal Data Services Hub, provides connections for secure data verification.
- Make program information available in electronic and paper formats, including through a website, and provide accessible assistance for customers at application and renewal.
- Participate in a coordinated no wrong door eligibility and enrollment system that screens for and facilitates enrollment in and seamless transfers to and from all other insurance affordability programs.
- Employ advanced technology to support prompt and appropriate eligibility determinations to the greatest extent possible and facilitate efficient electronic data exchange.

Source: 42 CFR § 431-457 2011.

At the same time that states were implementing the mandatory changes in the ACA, they were also contemplating policy options under the ACA, such as whether to expand Medicaid and how to offer qualified health plan products via an exchange. This was further complicated by states planning for, or in some cases in the middle of implementing, upgrades to old legacy eligibility and Medicaid Management Information System (MMIS) systems.

CMS recognized the complex system challenges and aggressive timelines that states were facing in implementing the ACA requirements and allowed states a fair amount of flexibility. For example, in 2015 CMS provided additional guidance to State Medicaid Directors extending targeted enrollment opportunities; for example, enrolling individuals in Medicaid based on Supplemental Nutrition Assistance Program (SNAP) eligibility.

[4] In April 2011, CMS issued new standards and conditions that must be met by states in order for Medicaid technology investments to be eligible for enhanced match funding. Standards and conditions include modularity, Medicaid Information Technology Architecture (MITA), business results, industry standards, leveraging IT, reporting and interoperability. CMS provided updated guidance in 2015, including two State Medicaid Director Letters related to eligibility requirements, expanded MITA conditions, and Advanced Planning Document (APD) requirements.

The federal government also issued guidance to assist states in financing these large-scale systems changes. Under a rule known as the 90/10 rule, promulgated in 2011, CMS extended the enhanced federal matching rate for Mechanized Claims Processing and Information Retrieval Systems to include the "…design, development, installation, or enhancement of Medicaid eligibility determination systems" (42 CFR § 431-457 2011). This rule was slated to end in 2015 and states were working quickly to meet CMS standards to take advantage of this funding stream to modernize their Medicaid eligibility systems. Ultimately this rule was made permanent (CMS 2015). States were also under time pressure to take advantage of an exception granted through the Office of Management and Budget (OMB) (known as the cost allocation exception waiver or OMB Circular A-87) that allowed states to use enterprise-wide assets for Medicaid, exchange, and CHIP systems for other programs (such as food supports) without having to charge those programs (OMB 2004). The cost allocation waiver has been extended through December 2018.[5]

Within the context described above and given variations in decision making processes and priorities, each of the study states has a unique approach to streamlined eligibility and enrollment for MAGI Medicaid beneficiaries. The next section of this report describes these approaches.

[5] Additionally, states were addressing system and process changes to prepare for the conversion to the 10th version of the International Classification of Diseases Standards (ICD).

MAGI MEDICAID STRUCTURE, PROCESSES, AND SYSTEMS

In response to the wide variations in their Medicaid policy, program priorities, and the ages and capabilities of their eligibility systems, the study states took different approaches to streamlining their Medicaid eligibility processes. Specifically, we explored with study states the options they offer individuals for applying for Medicaid, the systems and electronic data sources that support prompt and accurate eligibility determinations, and the extent to which their enrollment and renewal processes are automated, including state definitions of and goals for automation. Some states, such as Colorado, prioritized real-time enrollment and renewal for MAGI Medicaid populations, meaning same-day determinations without worker or beneficiary involvement. Other states, however, including Idaho and North Carolina, prioritized eligibility-worker involvement in the process. All states focused on the transition to MAGI-based eligibility determinations and use of electronic data sources for verification of beneficiary information. States were continuously balancing the need for accurate eligibility determinations with the desire to make Medicaid enrollment as streamlined as possible for beneficiaries.

Medicaid administration

Table 2 provides an overview of how the study states administer Medicaid as well as the primary entity responsible for eligibility determinations of MAGI Medicaid and other programs. Medicaid is administered statewide in four of the study states: Arizona, Florida, Idaho, and New York. Two of those states, Florida and Idaho, also separate the responsibility for Medicaid eligibility determinations from the agency that administers Medicaid (in Idaho these are two divisions under one agency umbrella, and in Florida these are completely separate, sister agencies). New York is unique among the study states in that only health coverage programs that use MAGI Medicaid eligibility criteria are state-run and programs where non-MAGI eligibility rules apply (e.g., the elderly and disabled) are administered by local Departments of Social Services.

Colorado and North Carolina administer Medicaid at the county level. This means that while a state agency oversees the program, county staff are responsible for the eligibility determination, enrollment, and renewal of Medicaid applications in their respective counties. Sometimes this led to challenges. In North Carolina, in particular, interview respondents commented that variation in training and staffing across the 100 counties led to difficulties in implementing uniform, streamlined Medicaid application and determination processes.

In all of the study states, the same entity determines Medicaid eligibility and eligibility for exchange plans. The three states with state-based exchanges (Colorado, Idaho, and New York) process eligibility for both exchange plans and Medicaid within the same agency. (At the time of our interviews, Colorado was in the process of separating eligibility determination of Advanced Premium Tax Credits [APTC], Cost-sharing Reductions [CSR], and exchange plans from that of other health and non-health programs in the state [also discussed in Medicaid Program and Beneficiary Experiences section].)[6] The other three states utilizing the federal exchange (Arizona, Florida, and North Carolina) opted to have the federal exchange first assess Medicaid eligibility and then transfer the account to the Medicaid agency (or in some cases, the county) for a final determination.

In all of the study states except New York, the county or agency that determines eligibility for MAGI Medicaid also determines eligibility for other human service programs, such as SNAP or Temporary Assistance for Needy Families (TANF).

[6] APTC and CSR are mechanisms for consumers to receive financial assistance to purchase health insurance coverage through an exchange. Advanced Premium Tax Credits (APTCs) may be used by consumers to lower their monthly premiums. Cost-sharing Reductions (CSRs) are extra discounts that lower the amount a consumer has to pay for deductibles, co-payments, and coinsurance.

Table 2. Medicaid Structure and Organization, 2018

Study State	State Medicaid Agency	Eligibility Determination					
		Primary Entity Responsible	MAGI Medicaid	Non-MAGI Medicaid	CHIP	Exchange Plans	Other Human Service Programs
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	**Department of Economic Security**	✓		✓	✓	✓
Colorado	Department of Health Care Policy and Financing (HCPF)	**Counties**	✓	✓	✓	✓	✓
Florida	Agency for Health Care Administration	**Department of Children and Families**	✓	✓	✓	✓	✓
Idaho	Division of Medicaid	**Division of Welfare**	✓	✓	✓	✓	✓
New York	Department of Health	**Department of Health**	✓		✓	✓	
North Carolina	Department of Health and Human Services	**Counties**	✓	✓	✓	✓	✓

Source: Data collected under the 2018 Assessment of Medicaid Eligibility, Enrollment and Renewal Processes and Systems project, Medicaid and CHIP Payment and Access Commission (MACPAC) contract number MACP18417T1.

Notes: Examples of other human service programs, include Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Subsidized Child Care Assistance and Refugee Assistance. Arizona, for programs where non-MAGI eligibility rules still apply (e.g., the elderly and disabled), the Arizona Health Care Cost Containment System (AHCCCS) conducts eligibility determination, enrollment, and renewal. In Idaho, the state's state-based exchange determines exchange eligibility for non-financial criteria. In New York, the Department of Health also determines eligibility for the state's Basic Health Program. In New York, for programs where non-MAGI eligibility rules still apply, eligibility, enrollment, and renewal are conducted by local Departments of Social Services, as is eligibility for other non-health public assistance programs, such as Cash Assistance, Food Stamps, and Home Energy Assistance. As of open enrollment for plan year 2019, Connect for Health Colorado will take over the responsibility for final eligibility determination for Advanced Premium Tax Credits, Cost-sharing Reductions, and exchange plans. Acronyms are as follows: MAGI – Modified Adjusted Gross Income, CHIP – State Children's Health Insurance Program.

Application options

As required by the ACA, all of the study states accept MAGI Medicaid applications via multiple modes: in person, mail, telephone, and online. One respondent in Florida stated: "We have what is called a no wrong door policy in which an individual can apply for Medicaid or CHIP or also for tax credits or benefits through any of the entry points." **Table 3** provides an overview of the states' online application options. Some states, such as New York, offered one online application option for Medicaid; other states, such as Florida and Colorado, offered more than one. All study states offered at least one online application that supports more than just MAGI Medicaid. For example, New York's shared online application supports MAGI Medicaid and other health programs including CHIP, the state's Basic Health Program, and exchange plans.[7] Four study states—Arizona, Colorado, Florida, and North Carolina—have a combined online application option that supports both health and non-health programs, including MAGI Medicaid, non-MAGI Medicaid, CHIP, and other human service programs such as SNAP and TANF.

[7] Under the ACA, states had the option of administering a Basic Health Program (BHP) to offer more affordable coverage to select individuals and in April 2015, New York became the second state to establish a BHP, which the state calls the Essential Plan (EP). To qualify, individuals must be below age 65, not eligible for Medicaid or CHIP, not eligible for affordable minimum essential coverage, and either be an individual with an income between 138 and 200 percent FPL who would otherwise be eligible to purchase an exchange plan or an individual with an income below 138 percent FPL who is lawfully present in the United States but does not qualify for federally financed Medicaid due to their immigration status. Coverage in these plans must be as comprehensive and affordable as an exchange plan that would have been purchased through the exchange.

Table 3. Application Options for MAGI Medicaid, 2018

Study State	Primary Online Application Portal	Shared Online Application					Total Monthly Application Volume	Percent Completed Online
		MAGI Medicaid	Non-MAGI Medicaid	CHIP	Exchange Plans	Other Human Service Programs		
Arizona	HEAplus	✓		✓		✓	Not reported	64%
Colorado	PEAK	✓	✓	✓	✓	✓	24,791	62%
Florida	ACCESS	✓	✓	✓		✓	276,017	89%
Idaho	idalink	✓	✓	✓	✓		8,530	19%
New York	NYSOH	✓		✓	✓		801,900	94%
North Carolina	ePASS	✓	✓	✓		✓	22,427	Not reported

Sources: Brooks et al. 2018; CMS 2018a; Data collected under the 2018 Assessment of Medicaid Eligibility, Enrollment and Renewal Processes and Systems project, Medicaid and CHIP Payment and Access Commission (MACPAC) contract number MACP18417T1.

Notes: In New York, NYSOH also serves as a shared online application for the state's Basic Health Program. The Monthly Application Volume is the total applications for financial assistance submitted at state level, April 2018 (Preliminary). Monthly Application Volume in New York includes renewal. Monthly Application Volume in Florida includes account transfers from the Federally Facilitated Marketplace (FFM) and assessed for CHIP. Examples of other human service programs, include Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Subsidized Child Care Assistance and Refugee Assistance. Acronyms are as follows: MAGI – Modified Adjusted Gross Income, CHIP – State Children's Health Insurance Program, HEAplus – Health-e-Arizona Plus, PEAK – Program Eligibility and Application Kit, ACCESS – Automated Community Connection to Economic Self Sufficiency, NYSOH – New York State of Health, ePASS – Electronic Pre-Assessment Screening Service.

A majority of individuals complete applications for Medicaid online (see **Table 3**). Most of the study states, however, noted that a large number of individuals rely on phone or in-person assistance, both at application and renewal, often to complete the online process. And, while consumer assistance was not a focus of this study, the role of assisters in the application process came up in many interviews (see below and section: Medicaid and Program Beneficiary Experience):

- **Arizona:** Applicants can apply with the help of a state worker through the Department of Economic Security (DES) or with the help of an enrollment assister at one of over 200 Community Partner organizations.
- **Colorado:** Applicants can apply with the help of county workers across the 64 counties, Department of Health Care Policy and Financing (HCPF) Medical Assistance sites (34 sites as of 2017), and enrollment assisters.
- **Florida**: Applicants can apply with the help of Department of Children and Families (DCF) local customer service centers, community partners (3,000 organizations), and enrollment assisters.
- **Idaho:** State prioritizes high-touch customer service and most individuals work with a state eligibility worker at application either in person or over the phone.
- **New York:** Almost all applicants to New York State of Health (NYSOH)—which serves MAGI Medicaid, CHIP, the state's Basic Health Program, and exchange plan enrollees—apply online; seventy-seven percent seek in-person enrollment assistance from a navigator, broker, or certified application counselor, and another seven percent seek assistance over the phone (NYSOH 2018).
- **North Carolina:** Respondents reported that most MAGI Medicaid applicants apply in person at local county Departments of Social Services.

Eligibility systems

In each of the study states, application information for Medicaid (whether it originates on paper or electronically) is fed into an eligibility system that connects with various electronic data sources to verify beneficiary information (see section: Electronic data sources). The eligibility systems are also supported by one or more business rules engines. These business rules engines automatically apply program rules and support automated eligibility determinations.

The study states' eligibility systems varied widely in age, structure (i.e., mainframe or web-based), and functionality. In **Table 4**, we identify the primary system each state uses to determine MAGI eligibility for Medicaid beneficiaries. In some cases, a state's online application is a part of its eligibility system. For example, North Carolina's ePASS is the online, consumer-facing portal of its NC FAST eligibility system. This is also true in New York. In other states, such as Idaho, the online application portal connects with the state's eligibility system, but is a separate information technology platform. All of the states used a shared eligibility system platform, meaning that their eligibility system supported (to various degrees) determinations for other programs, including non-MAGI Medicaid, CHIP, other health programs (such as the Basic Health Program) or other human service programs (such as SNAP, TANF, etc.).

States with shared applications do not necessarily support shared eligibility systems. For example, while SNAP and TANF share the combined HEAplus application with MAGI Medicaid in Arizona, SNAP and TANF eligibility determinations have not yet been integrated within the HEAplus eligibility determination system. In Colorado, CBMS is used to determine eligibility for only a subset of the programs for which beneficiaries can apply through the PEAK online application. On the other hand, while Idaho's shared application (idalink) is limited to health care programs, its shared eligibility system (Idaho Benefits and Eligibility System - IBES) supports health and non-health program eligibility determinations.

Five of six study states hosted online beneficiary accounts or portals with self-service case management features designed to ease the enrollment and renewal process for both beneficiaries and eligibility staff. All of our study states supported document management and imaging for both clients and staff, reducing the need for them to resubmit materials multiple times when information (e.g., Social Security number and birth certificate) remained the same. These features are fairly common—as of January 2018, over 30 states in the U.S. had online systems that allowed for some case management (e.g., report changes, authorize third-party access, etc.) (Brooks et al. 2018).

Table 4. Medicaid Eligibility Systems Characteristics and Functionality, 2018

Study State	System Name	Year Implemented	Eligibility System Integration					Self-service Case Management for Clients	Document Management or Imaging Tools
			MAGI	Non-MAGI Medicaid	CHIP	Exchange Plans	Other Human Service Programs		
Arizona	HEAplus	2013	✓		✓			✓	✓
Colorado	CBMS	2004 - Major modification 2013	✓	✓	✓	✓	✓	✓	✓
Florida	ACCESS FLORIDA System	1990s - Major modifications 2004 & 2013	✓	✓	✓		✓	✓	✓
Idaho	IBES	2010	✓	✓	✓	✓	✓	✓	✓
New York	NYSOH	2013	✓		✓	✓		✓	✓
North Carolina	NC FAST	2013	✓	✓	✓		✓		✓

Source: Data collected under the 2018 Assessment of Medicaid Eligibility, Enrollment and Renewal Processes and Systems project, Medicaid and CHIP Payment and Access Commission (MACPAC) contract number MACP18417T1.

Notes: Eligibility system integration refers to integration at the application stage and does not address integration at renewal. Examples of other human service programs, include Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Subsidized Child Care Assistance and Refugee Assistance. Examples of client self-service case management include being able to check application status, report changes, and renew coverage. Document or imaging tools include being accessible by clients and staff. Some study states have other application portals; the one listed in the primary application portal used for MAGI Medicaid enrollment. In New York, non-MAGI Medicaid is administered by local Departments of Social Services and is not integrated with the NYSOH system. NYSOH also performs eligibility determinations for the state's Basic Health Program, in addition to CHIP and Exchange Plans. In North Carolina, NC FAST supports multiple programs, but is actually two separate platforms on the back end; one that houses MAGI Medicaid enrollment information, and one for all other non-MAGI programs, including SNAP and other human service programs. Acronyms are as follows: MAGI – Modified Adjusted Gross Income, CHIP – State Children's Health Insurance Program, HEAplus – Health-e-Arizona Plus, CBMS – Colorado Benefits Management System, ACCESS– Automated Community Connection to Economic Self Sufficiency FLORIDA System, IBES – Idaho Benefits and Eligibility System, NYSOH – New York State of Health, NC FAST – North Carolina Families Accessing Services through Technology.

Electronic data sources

All six of the study states use electronic verification processes to determine potential eligibility for MAGI Medicaid. For income verification in particular, states relied on more than just the Federal Data Services Hub, often using their own connections to state or private data sources in order to access more recent data than may be available through the Federal Data Services Hub (see **Table 5**).[8] For example, several states verify income through a direct connection to the Work Number data source. North Carolina, Arizona, Colorado, and Idaho also indicated that some of their connections with both federal and state data sources predated the ACA; in these cases, states have chosen to use their own interfaces because they already have processes in place for accessing or transferring data. One North Carolina respondent explained: "We had a multi-benefit system and the Hub was limited to only being able to be used for Medicaid and Health Choice [the state's CHIP program]." Both Arizona and Idaho use an existing connection with the Social Security Administration (SSA), which allows the information to be used to support eligibility determinations for other programs such as SNAP and TANF. Respondents in Arizona expressed frustration because they understood that SSA data accessed through the Federal Hub could only be used to verify factors for SNAP and/or TANF if the applicant is *also* applying for Medicaid, which requires the state to maintain a completely separate mechanism for verifying citizenship: for example, for SNAP and/or TANF-only applications.[9]

[8] The Federal Data Services Hub is an electronic resource developed and maintained by CMS that provides data verification services to state-based exchanges, the federally facilitated exchange, and all Medicaid agencies regardless of expansion adoption. Data sources provided through the hub include those from relevant federal agencies such as the Social Security Administration, the Department of Homeland Security, and the Internal Revenue Service, as well as proprietary data sources, such as the Work Number.

[9] One respondent in Arizona stated that the option to use SSA Composite data sources for SNAP- or TANF-only cases was at one point offered to states by the Social Security Administration, and Arizona expressed an interest in pursuing the option; however, the agreement was never executed because of an obstacle on the federal side.

Table 5. Select Data Sources Used to Verify Income for MAGI Medicaid, 2018

Study State	Federal Data Services Hub	Direct Link to Social Security Administration	State Unemployment Insurance	State Wage Data	Direct Link to Work Number	Notes
Arizona	✓	✓	✓	✓	✓	State will utilize the Federal Data Services Hub for some income. Arizona's CMS verification plan noted no use of IRS data through the Hub due, in part, to data lags.
Colorado			✓ IEVS	✓ IEVS	✓ select counties	IEVS is an automated interface with the Colorado Department of Labor and Employment. IEVS is used to verify earned and unearned income and unemployment post-eligibility determination.
Florida	✓		✓	✓	✓	Work Number is accessed via the Federal Data Services Hub for income verification and used to support Public Benefits Integrity.
Idaho	✓	✓		✓	✓	Work Number is used for all applications where wages or work is reported (pre-ACA link).
New York	✓		✓	✓		New York considered using the Work Number, but the number of employers submitting data relative to the population was limited.
North Carolina				✓	✓	Connections to the Work Number data source are completed manually by a county worker.

Sources: CMS 2018b; Data collection and verification under the 2018 Assessment of Medicaid Eligibility, Enrollment and Renewal Processes and Systems project, Medicaid and CHIP Payment and Access Commission (MACPAC) contract number MACP18417T1.

Note: Acronyms are as follows: MAGI - Modified Adjusted Gross Income, ACA - Patient Protection and Affordable Care Act, IEVS – Income Eligibility and Verification System.

All of the study states are using electronic data to verify non-income eligibility requirements and some are using unique state data sources. For example, New York uses data from the New York State Department of Corrections and Community Supervision (DOCCS) to verify incarceration status, indicating that the data are more timely and accurate than data from federal sources. Idaho uses vital statistics at renewal and post-enrollment to verify household composition. In North Carolina, the state relies on data from the Department of Motor Vehicles (DMV) to support residency verification.

The states' ability to process streamlined eligibility determinations is affected by whether they accept self-attestation of eligibility factors (see **Table 6**). For example, four states (Colorado, Idaho, Florida, and New York) accept self-attestation of residency. Conversely, Arizona and North Carolina do not, and in North Carolina a state law requires that applicants provide at least two documents to verify residency

(NC SL 10 § 108A-55.3 2015). All respondents in North Carolina indicated that this policy hinders the state's ability to further automate enrollment processes for Medicaid. While the state statute does not prohibit a no-touch application determination, the state's ability to electronically verify two sources of residency information is extremely limited, despite its reliance on data from the DMV.

Colorado was unique among study states in that it also accepts self-attestation of income, which is then verified during a post-eligibility determination process. To accomplish this, Colorado leverages the Income and Eligibility Verification System (IEVS), an interface automated in 2011 in partnership with the Colorado Department of Labor and Employment (CDOLE), which includes earned income, unearned income, and unemployment compensation. Income information in IEVS is not available until the quarter after income is attested to on the application.[10] Respondents felt strongly that Colorado's post-eligibility verification of income facilitated the state's high rates of real-time eligibility determination (more than 75 percent).

Table 6. Select Use of Self-Attestation for Eligibility Verification, 2018

Study State	Income	Residency	Age	Application for Other Benefits
Arizona				
Colorado	✓ - V	✓	✓	✓
Florida		✓	✓	✓
Idaho		✓		✓
New York		✓		✓ - V
North Carolina			✓	

Sources: CMS 2018b; Data collection and verification under the 2018 Assessment of Medicaid Eligibility, Enrollment and Renewal Processes and Systems project, Medicaid and CHIP Payment and Access Commission (MACPAC) contract number MACP18417T1.

Note: ✓- V indicates that states allowed self-attestation but required post-eligibility verification.

Auto-enrollment and renewal

Study states used different approaches when it came to automating enrollment and renewal for the MAGI Medicaid population (see **Table 7**).[11] As suggested earlier in this report, not all study states had the ability or desire to process real-time MAGI Medicaid eligibility determinations at application, which usually referred to same day processing of determinations. For example, respondents in North Carolina explained that there is currently no automated enrollment of the MAGI Medicaid population, a decision that was influenced by a historical emphasis on the county caseworker interaction. While their eligibility system performs data checks and makes a preliminary assessment, a county worker needs to verify and approve every individual for Medicaid enrollment.

In contrast, respondents in New York reported that more than 90 percent of eligible individuals experience automated eligibility determinations. These eligibility determinations are made in real time, based on automated rules and data verification processes built into the system as applied to the information provided by the beneficiary or consumer. New York's automated eligibility determinations can be characterized as "no touch," insofar as they do not require a worker to individually determine or manually calculate eligibility for coverage. Colorado also reported that three-quarters of its MAGI Medicaid population was auto-enrolled at application, meaning same day determinations without worker or beneficiary involvement.

[10] One county reported using the Work Number proprietary data set (which is stored in CBMS) to verify income more quickly. While not needed for MAGI Medicaid cases, it facilitated verification for other public assistance programs.
[11] Study states also used different terminology when referring to their practices for automating Medicaid enrollment and renewal.

Florida distinguishes between "no-touch" and "partial-touch" eligibility determination for MAGI-eligible individuals. The state relies more on partial-touch determinations, which require worker involvement to review certain factors, such as income, by checking interfaces with other data sources and imaged documents prior to Medicaid approval or denial. State respondents say they do as much "no-touch" or real-time determinations as they can, meeting DCF's goal of processing 20 percent of cases as "no touch." These cases are most likely MAGI Medicaid only cases (rather than households that are eligible for other public assistance programs as well) and that electronic data sources have successfully verified income, citizenship, and identity. In response to the ACA, Florida built the infrastructure alongside its legacy system to begin processing these real-time eligibility determinations for a subset of MAGI Medicaid applicants.

States cited several common factors that facilitated auto-enrollment practices including: the existence of an online application, applicants having income that can be verified electronically, automation of program rules through a robust business rules engine, and real-time interfaces with electronic data sources for verification purposes.

Table 7. MAGI Medicaid Enrollment and Renewal Practices, 2018

Study State	Performs Real-time Determination	50+% of Determinations Completed in <24 hours	Performs Automated Renewal	50+% of Renewals Automated
Arizona	✓		✓	✓
Colorado	✓	✓	✓	✓
Florida	✓		✓	
Idaho		✓	✓	✓
New York	✓	✓	✓	
North Carolina		Not reported		✓

Sources: Brooks et al. 2018; Data collected under the 2018 Assessment of Medicaid Eligibility, Enrollment and Renewal Processes and Systems project, Medicaid and CHIP Payment and Access Commission (MACPAC) contract number MACP18417T1.

Notes: In New York, there is a distinction between "auto-eligibility determination" and "auto-enrollment." Auto-eligibility determination was described as "no-touch" eligibility determination. The term auto-enrollment is not used because after someone receives an auto-eligibility determination, they often must choose a health plan. In Florida, "auto-assignment" is the term used by the Agency for Health Care Administration (AHCA) for mandatory enrollment into a managed care plan post-eligibility determination.

The six study states defined auto-renewal differently and varied in their processes and systems to support auto-renewal of MAGI Medicaid populations.[12] For example, in Arizona, auto-renewal of MAGI Medicaid eligibility refers to no-touch renewal that is entirely automated. Forty-five to sixty days prior to a beneficiary's renewal due date, the HEAplus eligibility system prompts a renewal. The system then checks the relevant electronic data sources at the federal and state hubs, and information obtained from these checks is subjected to reasonable compatibility rules against the information on file. If the system has enough information to approve ongoing eligibility—even with a change in coverage category—it will do so. The eligibility system then generates and sends the beneficiary a prepopulated form that 1) shows the information that was used to complete the renewal; 2) states that the beneficiary was found to remain eligible; and 3) asks the beneficiary to contact the Department of Economic Security (DES) if any of the listed information has changed. If beneficiaries are approved for renewal and have no change of information to report, coverage is automatically renewed.

[12] While commonly used in recent literature to describe auto-renewal practices implemented by state Medicaid agencies, the term *ex parte* was only used by one study state to describe automated practices for a subset of its MAGI Medicaid population.

Idaho also achieves high rates of auto-renewal (referred to in the state as re-evaluations), but does so using different practices. The state created different workflows and verification requirements for three different types of households (referred to as buckets). The buckets include 1) MAGI Medicaid only; 2) families with multiple health coverage types (exchange plan, MAGI Medicaid, and CHIP); and 3) non-MAGI Medicaid. In addition, Idaho aligned the timing of re-evaluations for all health care programs to be consistent with open-enrollment. Respondents observed that the distinct workflows streamline the renewal process for both workers and consumers. Supporting these workflows, IBES has a "you are here" timeline that populates in idalink and explains what steps beneficiaries have taken and what actions, if any, they need to take and when. Because IBES is an integrated system, it can also leverage information submitted for other programs to support auto-renewal in health care programs. As one respondent explained: "The one nice thing is that because our system is integrated, if they [a beneficiary] are also on SNAP benefits, then if they come in for a SNAP renewal that may not be aligned with our Medicaid renewals, if we get new information then we would take that information and apply it for changes for Medicaid."

Both New York and Florida report rates of auto-renewal in the 25–50 percent range (Brooks et al. 2018). New York supports automated renewals, meaning an eligibility determination at renewal based on recently updated information and available data sources, using online accounts. Beneficiaries who have given the state permission to use electronic data for redeterminations will receive a notice that includes a list of people associated with the household's account, their eligibility status, and current income range. Recipients are instructed to log into their account to report changes. The consumer does not have to take action, provided there are no relevant changes to report.

In Florida, auto-renewal of MAGI Medicaid cases refers to a "low worker touch" process in which DCF verifies eligibility using electronic data sources. Upon worker review and approval, DCF then sends notices to customers that their cases are being renewed. In the event that Medicaid cases cannot be renewed using existing information, customers are required to re-enter income information either on paper or electronically (rather than verify existing data on prepopulated forms). State staff described different processes for auto-renewals for combined cases, i.e., customers with both health and non-health assistance. For example, for customers with both SNAP and MAGI Medicaid, Florida extends Medicaid 12-month renewals with SNAP recertification if income reported at a customer's SNAP six-month recertification demonstrates continued eligibility for Medicaid (although Medicaid would not be terminated if a customer's SNAP assistance was not renewed).

In general, respondents across the states indicated that auto-renewal processes were easier to implement than automated eligibility determinations because fewer verifications need to take place at renewal than at initial application. Respondents cited several common factors that facilitated auto-renewal including: electronic interfaces in shared eligibility systems and the ability to verify beneficiary factors such as income at the renewal date of another program, like SNAP. Several respondents also cited states' continuous eligibility policies for children as effective for streamlining Medicaid renewal.

However, some states reported challenges with aligning the timing of Medicaid renewals with other programs. Idaho, for example, initially aligned the timing of auto-renewals for all health care programs to be consistent with open-enrollment, but has since decided to move away from aligned renewal timing in order to ease workloads on enrollment staff. In Florida, staff and enrollment assisters had mixed opinions about the usefulness of beginning a new 12-month Medicaid eligibility period with SNAP recertification. On the one hand, Medicaid coverage could be extended with little worker involvement, even if customers might lose SNAP coverage. On the other hand, beneficiaries might perceive that their Medicaid coverage was at risk when their SNAP eligibility was being checked.

Integration of MAGI Medicaid with other health and human service programs

Many of the study states had been supporting processes and systems integrating Medicaid with other health and human service programs before the passage of the ACA. Florida, for example, was one of the first states to launch a combined online application for Medicaid and other human service programs in 2005. Colorado implemented a shared eligibility system (CBMS) that supports both health and human service programs in 2004. Half of the study states mentioned work to clarify and align program requirements across Medicaid and human service programs, which informed the development and maintenance of integrated systems.

As federal guidance regarding streamlining Medicaid eligibility processes was released in 2011, states deliberated over when, to what extent, and how to address non-MAGI and other non-Medicaid or non-exchange populations. Each of the six case study states prioritized different integration goals based on where they were at the time and how they were implementing the ACA. To date, the integration of MAGI Medicaid eligibility determination with other health or human services programs appears in four ways across the study states: via a unified administrative structure, a common online application, shared eligibility systems, and co-located workforces.

Two states, Idaho and New York, reorganized their health care administrative structures to support streamlined and integrated eligibility determinations. In Idaho, for example, a single administrative structure (the Division of Welfare) supports eligibility determinations for all health and human service programs, including exchange determinations. And, specifically, within that division, the Bureau for Operations Design (with its team of developers, process engineers, policy and operations staff, automation liaisons, and other staff) maintains the eligibility system and manages the logistics of the system changes, staff training, and worker and customer communication supports for all programs. This structure removes the need for duplicative structures to support siloed programs.

Respondents in New York saw the ACA as an opportunity to integrate existing health insurance programs with the new MAGI offerings. They stated that this integration took priority over other things, such as integrating MAGI Medicaid with other human service programs. To support this, the state made an early and deliberate decision to administer all health insurance programs, including the new state-based exchange (NYSOH), and the state's Basic Health Program under the state Department of Health. In addition, the state passed legislation in 2012 that shifted the administration of Medicaid, including eligibility and enrollment decisions, from county and New York City governments to the state Department of Health (NYSOH 2017).[13]

A multi-benefit online application was another common way states integrated their MAGI Medicaid with other health and human service programs. As mentioned earlier and shown in **Table 3**, each of the six study states offers some kind of combined online application, although New York is the only study state that does not support human service programs through its online application and both Arizona and New York have separate application processes for their non-MAGI Medicaid populations. Over the last eight years, Colorado has seen an increase in the number of non-medical programs supported by its PEAK online application. Similarly, an additional seven program areas (for a total of nine, including Medicaid and CHIP) were integrated into North Carolina's ePASS by December 2017.

Across all six study states, respondents universally reported that their state's commitment to supporting an integrated eligibility system with a robust rules engine was critical to achieving the integration of MAGI Medicaid with other health and human services programs. **Table 4** provides an overview of the

[13] See Looking Forward section for a description of New York's plans to further integrate its systems to include all health and non-health services.

extent of programs supported by a common eligibility system; two states, Arizona and New York, reported health-only integration at the time of interviews, while the other four states reported integration of non-health programs, as well. Respondents in Arizona praised the integration of eligibility determination systems across MAGI Medicaid programs, noting benefits for both beneficiaries and program administrators. Prior to this integration, MAGI Medicaid families regularly moved back and forth between state agencies as they experienced eligibility changes. Respondents also pointed out that the integrated Medicaid eligibility system supported accuracy of eligibility for entire households. For example, household files in Arizona are linked within HEAplus such that the system automatically calculates the ramifications of any modifications within a household for other household members across programs. Similarly, New York's NYSOH account is at the family level. One state official described it this way: "Let's say people in the household are APTC and CHIP…They may have different requirements, they may have different end dates, but to the maximum extent possible, [we] keep that all together at the account level so that it's clear. So [mixed families are] not handled separately. They are handled in an integrated manner."

Respondents in three states—Idaho, Colorado, and New York—also mentioned supporting the integration of MAGI Medicaid with other programs via their eligibility workforce. Colorado respondents described an example of county eligibility workers or Medical Assistance staff co-located with exchange navigators. Eligibility workers in Idaho support all health and non-health services, and are trained to have "informed choice discussions" with potential enrollees, outlining all of the services for which they may be eligible. In New York, some counties support in-person assistance or allow assister organizations to co-locate in order to provide support at local Departments of Social Services offices (which determine eligibility for non-MAGI Medicaid and non-health public assistance programs, such as cash assistance, food stamps, and home energy assistance).

MEDICAID PROGRAM AND BENEFICIARY EXPERIENCES

As described above, study states used various approaches to support streamlined enrollment and renewal practices for MAGI Medicaid populations while safeguarding determination accuracy. This section includes effects of state enrollment and renewal processes and systems that were commonly reported by key informants, as they relate to the experiences of beneficiaries and the administration of the Medicaid program. There was consistency across study states in terms of the positive effect of combined online applications on beneficiary access to programs and the program efficiencies gained through connections to electronic data sources and business rules software systems. While study states demonstrated commitments to shared eligibility systems that support the integration of MAGI Medicaid with other health or human services programs, processes and systems are complex and involve ongoing quality assurance, maintenance, and enhancements. Gains have been made by study states in terms of streamlined eligibility determination and enrollment processes and systems, but in-person assistance was still in high demand for certain populations.

Combined online application enhanced beneficiary access to programs and reduced burden, but back-end eligibility systems are complicated to maintain

Respondents from all study states said that their combined online applications support greater access to coverage and reduce beneficiary burden. That is in part because with combined online applications, individuals can submit required information just once, rather than having to submit the same information multiple times through different avenues. For example, one respondent in Idaho explained that idalink reduces beneficiary confusion because it serves as an application for all health coverage programs: “I think the one thing that is great about our idalink application is that we don’t specify if you’re applying for MAGI or non-MAGI or the tax credit for the exchange. We just call it health coverage assistance. And based on the logic that's built into idalink, if you say that you're disabled, then you're going to be presented with questions for ABD (Aged, Blind, and Disabled) or non-MAGI Medicaid as well as the regular MAGI.”

Other respondents pointed out that besides streamlining the application process, the combined application can also help raise applicant awareness of benefits for which individuals might be eligible. In Arizona, for example, the HEAplus application lists the multiple benefits for which applicants can apply, requiring the applicant to proactively select the benefits in which they are interested before they begin the application. To this end, applicants first provide all information relevant to their application for health programs, including their health plan selection.[14] Then, if they have indicated a desire to apply for SNAP or TANF, they provide additional information, while the relevant information from their health programs application carries over. If an assister (if the applicant is using one) observes that the applicant is potentially eligible for a benefit in which they had not initially indicated an interest, the assister can press further to again gauge applicant interest in applying: “[W]hen they sit down with us, they might say, you know what, I’m only interested in applying for Medicaid at this time. But then HEAplus might potentially screen them eligible for SNAP benefits and we’ll offer that to them, or even TANF if they want. We’ll say, hey, you might potentially be eligible for these other programs. Are you interested? So [the combined application] really helps I think, one, streamline the process; but then at the same time, provide an extra knowledge about hey, I might be potentially eligible for something else that might help me in my time of need.”

[14] If the applicant does not select a managed care plan, the HEAplus application system uses an algorithm to automatically select a plan for them from their geographical services area. The applicant has up to 90 days from their initial enrollment to choose a different plan from the one that was selected for them.

Application portals were often designed to offer customers direct access to public assistance any time of the day, any day of the week, which facilitated access. While not a new innovation, self-service portals and document management and imaging systems were described by respondents as efficient for beneficiaries and workers. One Florida respondent shared, “It really provides good customer service for the applicants. They don’t have to come to a place, they don’t have to mail documentation.” Individuals in Florida can upload documents to their MyACCESS accounts, and workers can access images of these documents for verification purposes.

Respondents openly acknowledged that while their application pathways, systems, and processes are integrated from the customer point of view, the back-end eligibility systems are often fragmented, outdated, or complicated to maintain. In Florida, for example, to comply with ACA requirements, the state developed a separate open platform that sits alongside the legacy system and facilitates real-time eligibility determinations for all Medicaid and CHIP applicants. According to one state respondent, “There was no way to do the MAGI changes within the existing system. It couldn’t have been done in the timeframe that we had, nor the money that was available. So they built a separate new system and connected it.” The legacy system continues to determine eligibility for SNAP and TANF. One respondent explained: “The fact that our rules for the food assistance and the cash are still in our mainframe, that’s really seamless to our staff and to our customers. It’s a little more difficult on the programming side and a little more costly and it takes us sometimes longer to make programming changes. But as far as how it affects the customers and the staff, that still remains seamless to them.” Colorado respondents spoke to the complexity of maintaining and enhancing its legacy shared eligibility system for health and human service programs, known as CMBS. One respondent observed, “Every time we change [CBMS], we redeploy 14 million lines of code. And that is risky. We frequently introduce defects, nearly every build, so we have an ongoing process to alleviate those.”

In Arizona, while the HEAplus application is combined across health (i.e., MAGI Medicaid and CHIP) and non-health programs (i.e., SNAP and TANF), the HEAplus eligibility system is only shared across health programs (i.e., MAGI Medicaid and CHIP). While information regarding the application for health programs is processed using the modular, cloud-based HEAplus eligibility determination system, application information regarding SNAP and TANF is processed separately. These data are routed from the HEAplus application using an electronic interface to a 30-year-old legacy mainframe eligibility system (AHCCCS 2018, State of Arizona 2012). Final eligibility determination information for SNAP and TANF is communicated to the applicant from this legacy mainframe system.

And in North Carolina, although multiple programs are supported by the state’s shared eligibility system, NC FAST, the system is actually two separate platforms on the back end; one that houses MAGI Medicaid enrollment information, and one for all other non-MAGI programs, including traditional Medicaid, SNAP, and other human service programs. NC FAST caseworkers can see information across the two platforms. Demographic information updated in one system is automatically updated in the other, but program-specific information (such as income) can only be updated in its respective platform.

Although not all states' eligibility systems were completely integrated across programs, all respondents did feel that their states' systems allowed case workers to quickly and easily get a holistic view of their clients' program participation. This has helped reduce or shift eligibility staffs' workloads, especially for those working with individuals who receive multiple benefits. One respondent in North Carolina explained: "Prior to this we had a totally separate system for our SNAP program, and then we had an eligibility system that included all of the Medicaid and our state supplemental assistance programs and the workforce or TANF cash program….So those systems didn't talk to each other, so you didn't know what was in one versus the other. If you had one household, you had to contact the other worker or go into the two different systems. So [now] the demographic data and everything is consistent in NC FAST. I can see what the other program files have." Respondents in North Carolina also saw real-time sharing of information as especially helpful in county-administered Medicaid programs because when people move between counties, their program information is instantly available (rather than needing to be sent back and forth as paper files).

Electronic data interfaces facilitated high rates of real-time eligibility determinations, auto-renewal, and reduced churn

Respondents unanimously agreed that efficiencies were gained through system connections with electronic data sources, which facilitated real-time eligibility determination and automated renewals. Connections ranged across study states from the ability to view data from electronic sources in a central location to more sophisticated data linkages where data from electronic sources populate state systems.

In New York, state staff explained that given the sheer number of beneficiaries seeking health coverage through NYSOH (4.4 million people a year), automated verification using electronic data was the only way to efficiently process the large volume of applications. One respondent remarked that "The system in many cases is able to do an evaluation of eligibility and assess those data sources without a human touching it. So that's clearly a feature that's better than the old system was." State staff credit the use of both federal and state data as supporting this process. They specifically highlighted links to state data that were more timely than the federal data accessed through the Federal Data Services Hub (e.g., data from the State Wage Information Collection Agency [SWICA], State Unemployment Compensation, and incarceration status information from the New York State Department of Corrections and Community Supervision [DOCCS]).

Electronic data sources support real-time determinations, which not only facilitated more efficient processing of applications but also timely notifications to counties to begin work on cases eligible for other benefits. One Colorado respondent quantified the results of state processes and systems (including the use of electronic data sources) to support real-time Medicaid eligibility determinations. "We took determinations from 45 days to 45 minutes for 70 to 80 percent of the applications processed via PEAK. What that allowed us to do was go from 30,000 applications per month pre-ACA to 60,000 applications processed per month without increasing the county workforce. And I think that was a big deal."

Assisters in multiple states also praised the online application together with the integrated eligibility system and use of electronic data to verify information as a means of speeding the processing time. An assister in New York explained, "Well, eligibility…does get determined much quicker than when we did paper applications, that's for sure, because we used to have to wait 30 days [until] the district [local Departments of Social Services] made a decision. Now, we can possibly get a decision immediately, or within a week." They also mentioned that a combined application for multiple health programs and automated eligibility verification has made them more efficient and allows them to see more people and spend their time on challenging or more involved cases as opposed to manually processing paper applications for everyone.

According to some state and assister respondents, however, despite robust rules and electronic use of data, verifying income remains one of the biggest challenges states face. Some beneficiaries are required to provide additional documentation; this is especially true for those with unstable incomes (e.g., individuals who are self-employed, seasonally employed such as farm workers, or frequently change jobs) that cannot be verified with electronic data sources. In Colorado, for example, while post-eligibility verification of income facilitated real-time eligibility determination, the period for reporting income data (quarterly income), as well as the frequency of post-eligibility verification (at least three times per year) often created confusion for both beneficiaries and county workers. This happened often because beneficiaries were not accustomed to thinking about their income in three-month increments, they experienced income fluctuations, or the quarterly verification may have triggered correspondence from the state about a discrepancy that was confusing.

Most respondents thought that the efficiencies gained through interfaces with federal, state, and proprietary electronic data sources reduced administrative costs and churn, thereby improving continuity of care. One Idaho respondent explained, "Not only is there a business perspective, but more importantly, it mitigates the risk of gaps in coverage. That's the single most critical item. So Sally Consumer is enrolled this year, she's happy. She's got meds, and they're regular meds and they're really important to her, like life threatening, got to have the meds. If she's not auto-renewed, Sally's got to remember to call and renew herself. And imagine if Sally is forgetful and goes to renew her life-dependent prescription the second week of January and says, oh, I forgot; I didn't know that I had to renew my plan.…[T]here's some real-world customer impacts that are far more important than the business reasons, but that's a real risk.…For Sally who's auto-renewed and is forgetful, she's going to be able to get her meds, she's going to have coverage, and she's going to have quality of life because there's continuity there."

Robust rules engines were critical, but workers still need to know policy

Respondents emphasized that even with the right data sources, a robust rules engine was critical to support successful streamlined eligibility determinations. Respondents in Idaho, for example, remarked that their state's customer service-focused approach is only possible because IBES's robust business rules have automated the varied and complex eligibility rules across health and non-health programs. They mentioned that IBES allows the eligibility worker to focus on the consumer and their specific situation, not the minutia of program rules. The process was described as faster, more efficient, and supportive of better customer service. One respondent explained that the focus of the eligibility worker is to have "a quality conversation with that customer about whatever their situation is and then relying on our system to be the one to handle all the heavy lifting about what the rules need to be…[and] determine what all the person is eligible for." Another respondent echoed this sentiment in describing her previous role as an eligibility worker: "What I was doing was spending a significant amount of time reviewing all of that stuff and checking interfaces and kind of figuring out what my questions would be.…[A]ll of those things are [now] eliminated.…[A] person will walk in and you have this informed choice discussion where you can say 'tell me about your situation.'"

A couple of respondents also explained that the system supports a quality control step as well, whereby workers can review with customers how the information they entered was processed and make corrections, if needed. In fact, some respondents felt that state's rules-based processes have helped reduce inaccurate Medicaid determinations. One North Carolina respondent explained, "I can give you a couple of examples though about how the rules-based system helped inaccuracy. Because what we've had sometimes is, a worker will call in a ticket that the system is not doing something correctly. And then we look at it, the system is doing it correctly. So we think that gosh, before the system, were they doing it wrong? We have seen that because of the rules-based engine."

We heard conflicting views on whether the implementation of business rules engines has helped reduce the amount of Medicaid policy rules an eligibility caseworker needs to know. For the most part, however, respondents felt policy knowledge was still important. One North Carolina interviewee explained, "The workers absolutely have to know policy. Now, does NC FAST know policy? Yeah. And if you have the correct evidence in there, sometimes there's those little exceptions to policy that workers don't see very often, and they'll try to fight the determination because they think it's wrong. And then we say, 'Oh, remember Exception B, or C, or D? It is right.' But they have to know policy to the point that they know the evidence that they're putting in there is accurate, and that the determination that they're getting is correct."

Complex and varied programs rules remained a challenge for integration

One challenge commonly cited with states' efforts at integration of MAGI Medicaid and other programs was that of updating eligibility rules engines to accommodate requirements of different programs in one system (since programs have different income counting rules or stricter verification requirements than MAGI Medicaid, e.g., in-person interview). One informant from Idaho explained, "It does create some policy and logistical challenges that we've had to spend a lot of time kind of reconciling and figuring out how do we come up with one standard for this program that makes sense to staff, makes sense to customers, but also meets all of the various regulations for each individual coverage category. And I'd say that's probably the biggest cost associated with trying to integrate the coverage groups. We think it's worth it.…[F]or other states that are looking at moving towards something like our structure, you really need to spend a lot of time comparing policies, comparing verification standards and requirements, comparing QC [quality control] standards, and making sure that when you're rolling out processes and standards for your staff, that you're meeting those standards for each of the programs individually." Another respondent from Idaho commented, "I definitely don't want to downplay how much work it is. I also think it's somewhat dangerous to try to make it easier. Medicaid rules are incredibly complex. When you throw MAGI and non-MAGI and tax credit all together, they are some of the most complex public policy I think that exists out there."

States struggled to build not only business rules engines that could handle complex Medicaid policies, but also to design a single streamlined application that could collect information in a straightforward, easy to understand way. Several states structured their online applications so that they are dynamic, meaning that additional relevant questions appear depending on the information already entered. Other states struggled with combining application information. Exchange customers in Colorado, for example, were a user group that reportedly found the state's combined Medicaid, exchange, and human service program application through PEAK cumbersome. Because the information required at the beginning was designed for Medicaid program purposes, exchange customers felt the intake questions were excessive and not in line with private coverage industry standards. One interviewee commented, "The question we get a lot is, 'Well why aren't you just like Orbitz? I just want to be able to easily click through and compare. I don't want to have to put in pages and pages and pages of information in order just to see how much my plan's going to cost or see how much tax credit I could get.'" In response to some of these challenges, Colorado's exchange Board of Directors decided in 2018 to separate exchange eligibility determination from that of other health and non-health assistance programs in the state.

New York recognized the complexities of integrating a broad array of programs within their eligibility system; therefore, the state intentionally prioritized integrating MAGI Medicaid with other health programs before attempting a more robust integration of non-MAGI Medicaid and other human services programs. Respondents in New York felt that this step-wise approach was particularly effective in allowing them to achieve automated eligibility determinations for more than 90 percent of their large volume of Medicaid applicants.

Despite streamlined processes, demand for enrollment assistance was high

Respondents uniformly agreed that streamlined application processes, including offering a combined online application, were helpful to people applying for coverage in Medicaid or other health and human service programs. However, in-person assistance was still in high demand, especially for certain populations (e.g., mixed-coverage families, populations in highly transient communities, largely immigrant communities, and communities with lower computer literacy). Applicants come to state agency or community assister offices as a result of several common factors, including lack of computer access, difficulty understanding the application questions, need for help interpreting notices, and need for assistance with documentation. One respondent in New York observed, "I think [enrollment assisters] provide an incredible assistance and support for people and can assist them with entering the information that they need appropriately and correctly so that they can get their determination."

In New York, for example, 84 percent of MAGI Medicaid enrollees receive assistance. Based on our interviews, assisters can spend between 20 minutes (for a single adult) and 90 minutes (for a large, complex family) on the enrollment process. They commented that questions on how to report income (such as which fields should contain which income streams) and how to provide documentation are the primary reasons people seek application assistance. In another large state, Florida, while tens of thousands of Medicaid cases are processed monthly without assister involvement, respondents representing enrollment assisters mentioned spending time with consumers on documentation and verification of income, especially for individuals whose income fluctuates month to month, as well as on verifying eligibility for public assistance for non-citizens.

Idaho continues to prioritize in-person and phone-based application support. State eligibility workers, who support all health and non-health services, described accessing eligibility support through the Idaho Division of Welfare as the best way for people to connect with both Medicaid and other services for which they likely qualify. One respondent explained, "Most of those patients I work with have complicated situations. And most likely, if they qualify for Medicaid, they will also qualify for some other state programs, whether it's food stamps or WIC, etc.…So I usually tell them to go straight to the Health and Welfare office because they can do it all in one appointment, one stop.…And I have not heard one person come back and say they [the Department of Health and Welfare] wouldn't see me or they didn't have time for me or they were too backed up, they couldn't see me. So I feel like…our Health and Welfare is fairly accessible for people."

Both assisters and eligibility workers also helped beneficiaries interpret notices, such as denial notices or notices of case action (which require additional information from beneficiaries). One Florida respondent described notices in this way: "What I'm finding, again, regardless of whether it's in English or in Spanish, and regardless of whether it's in the native language of the person, the person doesn't understand. It's almost like being in a candy store where you have too many different candies to choose from. They get so much information with so many dates and so many deadlines, and they don't understand what it means. It's not written in simple English, it's not clear, they don't get it." In Colorado, respondents described how beneficiary confusion over notices caused downstream effects on county agency workloads: "The volume of notifications that are sent out automatically by the system, the fact that the language comes from a policy perspective rather than from a consumer or a client perspective, has been hugely problematic in our state. It drives a lot of phone calls, a lot of confusion, a lot of rework because the client just doesn't understand. And they'll receive a notice that says 'you're denied' and 'you're approved' all in the same notice."

Respondents in Arizona commented on two unique resources in their state—a community assister portal and a partner hotline—that support community partners as they help applicants using the HEAplus online application. Respondents felt the community assister portal facilitated the application process because information is online and the assister could walk applicants through their process and the application questions: "We're able to show them what we're doing as well and then explain to them why we're asking those questions that we're asking…it's an extra benefit to have that assister in front of you because they are there to help clarify the questions for you and say, this is what we're really asking." Arizona respondents also highlighted the HEA Partner Hotline as particularly helpful. "In case we have any questions [on an application] or there's some sort of hiccup along the way, we have access to a phone line specifically for community partners that allows us to make inquiries or talk to somebody about why an application was denied if we see that everything was provided. So we have that special connection with DES and AHCCCS [Arizona Health Care Cost Containment System] to provide some additional information for the applicant." Calling the hotline puts the application in the queue of a DES worker with whom the community assister can then communicate. Assisters are also able to use the HEA Partner Hotline to expedite an application due to emergency medical needs, which assisters emphasized as an important capability.

LOOKING FORWARD

Not surprisingly, states' efforts to accurately and efficiently enroll and renew Medicaid eligible populations into the program are not static, but rather focused on continuous improvement over time. When the ACA first passed in 2010, states varied widely in their Medicaid eligibility and enrollment practices; however, all states faced challenges around ACA implementation, including implementing simplified eligibility rules and making decisions about integrated and modernized systems. Eight years later, with flexibility afforded by CMS, states have made a range of decisions regarding ACA implementation; however, states continue to search for areas to increase program effectiveness, including improving beneficiary experience. The following section highlights the areas where study states are focusing their transformation efforts in the near future. These areas include monitoring of ongoing Medicaid and related policy changes, efforts to improve beneficiary correspondence, and ongoing improvements to application and eligibility system infrastructure.

Monitoring of Medicaid and related policy changes continues

As respondents reflected on Medicaid enrollment and renewal practices, key informants in Idaho and Arizona were closely monitoring potential state Medicaid policy changes with significant implications for Medicaid eligibility, enrollment, and renewal systems in their states. Also on the horizon are forthcoming changes to several key federal funding streams that have the potential to affect Medicaid programs and systems.

Idaho's state legislature has not been supportive of Medicaid expansion; however, Reclaim Idaho, a volunteer-led community organization, successfully collected more than 56,000 signatures to place a Medicaid expansion measure on the November 2018 ballot (Weixel 2018). Roughly 43,000 uninsured adults would be eligible for Medicaid if Idaho expanded (Garfield et al. 2018). Respondents at the state said that they are monitoring the expansion effort and the type of action the legislature might take and that some ideas will be easier to implement than others. "[If the ballot measure passes] it's kind of up to the legislature as to how they want to do Medicaid expansion. They can just leave it alone and do kind of a plain vanilla expansion, which would make it real easy for everybody, or they can get creative and say, 'Yeah, we want work requirements.' [T]ime limits have been tossed around, although I know that CMS has never approved those."

In Arizona, the state is preparing to implement proposed Medicaid work requirements—an effort that requires substantial information technology (IT) resources, thus impeding the effort toward some other desired HEAplus eligibility system enhancements. The proposed work requirements are part of a pending Section 1115 Waiver program, titled "AHCCCS Works," under which adults between the ages of 19 and 55 who do not qualify for an exemption would be required to work, seek employment, attend school, or participate in an Employment Support and Development program for at least 20 hours per week in order to qualify for Medicaid (AHCCCS 2017). The IT staff time and attention required for preparing to implement these waiver requirements within the HEAplus eligibility system is, in the words of one respondent, "going to hamper a lot of our improvement efforts because everything has to stop while we work on that."

In addition to state-level Medicaid policy changes, states must also manage forthcoming changes to key federal funding streams. The OMB Circular A-87 cost allocation exception waiver expires after December 2018, at which time states will have to charge human services programs for any efforts to integrate eligibility, enrollment, and renewal systems across health and non-health programs. (Colorado is expediting its CBMS improvement efforts to account for this coming change—discussed further below.)

Also forthcoming is a $26 million reduction in CMS grant funding to the ACA Navigator Program for plan year 2019, as well reductions in the federal medical assistance percentage (FMAP) for Medicaid expansion populations, which will decline from 94 percent in 2018 to 93 percent in 2019 and 90 percent in 2020 (CMS 2013).

Efforts to improve beneficiary correspondence are important and ongoing

Four of the study states reported beneficiary confusion arising from correspondence about eligibility determination and renewal, and three of these states reported plans to improve this correspondence. In Colorado, efforts to improve beneficiary correspondence have been particularly extensive. There, beneficiary notice issues rose to the attention of the state legislature in 2016, when an interim study committee on communication between the state Medicaid agency and Medicaid beneficiaries was created. The committee ultimately supported four bills to address consumer notice issues. Simultaneously, county agency staff serving on an integrated program team fielded a study to quantify the worker time devoted to addressing notice confusion. The program team then testified during a legislative session and three related bills passed in 2017, including new requirements to conduct regular client correspondence audits as well as to implement and test improvements to simplify consumer notice content and to ensure beneficiary comprehension. The state plans to continue efforts to improve the correspondence engine of CBMS, which generates various notices.

Florida hopes to establish a new, more robust notice platform (i.e., the system that generates the notices) when resources become available. According to respondents, discussions are taking place regarding this new platform, which would ideally allow notices to be more case-specific (for example, current notices that describe applicants as ineligible are not considered to be sufficiently explicit in terms of an explanation) and improve notice readability.

In New York, NYSOH has modified its Assister Dashboard such that beneficiary notices are now available to enrollment assisters. This means assisters can now access the notices directly to help clarify them for beneficiaries. One assister explained, “[Assisters] can log into the [the Assister Dashboard] account, and they can go into notices, and they can actually see whatever notice that individual is referring to and read it themselves. So, that’s very helpful.” A state official remarked that New York plans to improve the notices themselves in the coming year: “There’s always room for improvement and in this next year we’ve got some targets for…further improving our consumer notices.”

States continue to invest resources and funding to improve application and eligibility system infrastructure

Study states expressed the ongoing goal of improving consumer and program staff experience, and reported a commitment to enhancing application and eligibility system infrastructure through the investment of staff resources and funding. All six states are working to enhance their online applications to increase usability for applicants, and were in the process of improving, or were hoping to improve, their eligibility systems through integration across health and non-health programs and movement away from legacy mainframe systems to rules-based systems and modular, cloud-based platforms.

Some states described specific improvements either planned or underway for their application platforms. All respondents in Colorado, for example, mentioned the continuing work to make its combined online application, PEAK, more user-centered. The partnership between Colorado and Code for America (a nonprofit focused on using technology and community input to create user-centered solutions in government) was cited by respondents as a key strategy for improving both the member and county worker experiences with the PEAK Report My Changes feature. Respondents in North Carolina reported that the state is exploring additional self-service case management and document

management features for its ePASS application, as well as mobile tools that would make it easier for individuals to submit applications and update information via a smartphone. The state is also soliciting citizen feedback on the wording of application questions, and considering ways to incorporate additional smart logic so that applicants can answer fewer questions.

Several states reported plans to improve or expand their eligibility systems in order to integrate eligibility determination across health and non-health programs. Respondents from New York cited plans to develop an integrated eligibility system that includes all health and non-health services. Supporting this, the state recently released for public comment a request for proposals that seeks a vendor to support the design, development, and implementation of the New York State Integrated Eligibility System (IES). The director of this effort characterizes this as a planned $500 million effort spanning more than five years to "modernize and integrate health and human services systems used by state and local workers in social service district offices to administer benefits and services and issue payments to clients and vendors." IES will replace more than 15 legacy systems (Joscelyn 2017, NYU n.d.).

Similarly, to improve the user experience, Arizona plans to move SNAP and TANF eligibility determinations away from the costly legacy mainframe system and integrate them with HEAplus. Integration of SNAP and TANF eligibility determination with HEAplus was planned for 2017. However, according to a recent AHCCCS request for information regarding HEAplus enhancement, the integration has been postponed until necessary improvements to the current HEAplus eligibility system can be put into place (AHCCCS 2018b).

Florida state agency staff indicated that they are continuing efforts to obtain funding to house rules engines for health and non-health programs (i.e., SNAP and TANF) under one modernized platform. However, system enhancements to support state innovations to streamline enrollment are costly. Respondents mentioned that the state's legacy shared eligibility system requires a huge investment of time and resources and that changes prompted by policy or IT upgrades in the old legacy system are expensive and challenging. One respondent explained, "It's just not programmed in such a way that you can easily change one thing without breaking everything else."

In the above cases, eligibility system changes are future oriented. But modifications are already underway in Colorado, where eligibility is integrated across health and non-health programs but still reliant on a legacy mainframe system, CBMS. Colorado's Governor's Office of Information Technology (which owns CBMS) is currently in the design stages to shift CBMS to a web-based platform. Colorado has adopted an aggressive timeline for this major system replacement effort due to the expected expiration of the OMB cost allocation waiver.

Respondents from all states were optimistic that they would continue to make progress toward streamlined eligibility processes and new or expanded eligibility systems. One interviewee from North Carolina commented, "I would just end with, I think we're getting there. We went through a rough patch and I think with any new process I think it's extremely difficult. I think we took on an extremely difficult [effort] to pioneer…you know, just completely change our process. So, we've had mass exit of retirements, and turnover as a result of this being a big project to take on. But I would end with, we are so much better than where we were, and we're only getting better. And I think that eventually this is going to be a really good process."

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APPENDICES

APPENDIX A: DISCUSSION METHODOLOGY

To gain a full picture of states' practices associated with enrolling the MAGI Medicaid population, we conducted interviews with state Medicaid eligibility, policy, and information technology systems staff who were identified for their ability to speak to the details of MAGI Medicaid eligibility, enrollment, and renewal practices. As a first step, we contacted each state's Medicaid Director, requesting their assistance in identifying the individuals who were involved in day-to-day implementation of MAGI Medicaid practices. Based on discussions with Medicaid Directors or their designees, we employed a chain-referral sampling methodology to identify additional interviewees across key informant groups, including state exchange staff, other state and local agency staff, and advocacy organization representatives. To protect the identities of the interviewees, their names and organizations were not included in the report. We have, however, summarized the types of interviewees to whom we spoke by state and provided sample position titles (see **Appendix Table A-1**).

Table A-1. Medicaid Eligibility, Enrollment, and Renewal Processes and Systems Study Discussions Completed (May–July, 2018)

State	Medicaid Eligibility and Policy Staff	State Information Technology Systems	State Exchange Staff	Other State and Local Agency Staff	Advocacy Organization	Total
Arizona	2	1	N/A	0	3	6
Colorado	3	1	1	2	1	8
Florida	10	0	N/A	0	2	12
Idaho	2	2	1	0	2	7
New York	2	0	1	0	4	7
North Carolina	3	1	N/A	3	1	8
Total	**22**	**5**	**3**	**5**	**13**	**48**

Sample titles for the interviewee categories include the following:

- **Medicaid Eligibility and Policy Staff:** Deputy Administrator, Policy Manager, Program Administrator, Continuous Improvement or Quality Manager
- **State Information Technology Systems:** Systems Administrator, Eligibility Systems Manager, Director of Data Analytics, Operational Design Staff
- **State Exchange Staff:** Executive Director, Policy Director
- **Other State and Local Agency Staff**: Division Manager, Project Director**,** Medicaid Supervisor**,** County Department of Human or Social Services Director
- **Advocacy Organization:** Program Director, Eligibility Manager, Outreach and Enrollment Specialist, In-Person Assister

We used a multi-site case study methodology with both closed- and open-ended discussion guides. We developed a closed-ended data collection form for Medicaid policy and eligibility staff only. The purpose of this form was to gather consistent information across study states on their overall Medicaid program, the structure of eligibility determination at enrollment and renewal in the state, and supporting eligibility systems. SHADAC prepopulated forms so that state stakeholders could more easily review and confirm or correct information in advance of telephone discussions.

Open-ended discussion guides included core questions across stakeholder discussions to facilitate meaningful comparisons as well as customized questions. Appendix B includes the core list of potential questions developed for our state Medicaid agency discussions. Stakeholder guides were customized based on the following criteria: role and organization of the interviewee, state context (e.g., Medicaid program size and structure), scans of recent and related online news and state requests for proposals, and theme probes based on previous discussions. To support the development of individual stakeholder guides, the research team developed detailed profiles for each of the study states, which included links to recent news and press releases regarding ongoing political or policy debates related to Medicaid eligibility and enrollment practices and systems in each state. Finally, in advance of all discussions, we conducted a search of publicly available information on the stakeholder and organizational affiliation to inform our discussions.

Discussions were one hour in length and were conducted over the phone. Two to three SHADAC researchers participated in each discussion with a senior researcher taking the lead in directing the questions. Interviews were recorded and transcribed verbatim. The lead researcher who participated in the discussions reviewed the transcriptions and made corrections when necessary. We used a theme-content analysis approach. A senior researcher reviewed each of the transcripts and identified key themes, focusing on Medicaid program or beneficiary experiences. The themes were sorted and organized by state in a case study format. A key contact from each study state was provided an opportunity to review their respective draft case study report in order to ensure that it provided correct program details.

APPENDIX B: STATE INTERVIEW GUIDE

MACPAC ELIGIBILITY, ENROLLMENT, & RENEWAL PROCESSES AND SYSTEMS STUDY

MASTER TELEPHONE DISCUSSION GUIDE—MEDICAID STAFF

Opening

1) Introductions
2) Individual/Group Reflection (30 seconds only): name one state Medicaid eligibility, enrollment, or renewal strategy that stands out as having a positive impact on program efficiency or beneficiary experience.

Application Options

3) What are the most frequently used points of entry for MAGI-eligible individuals to apply for Medicaid in [state], e.g., online application, county offices, call centers, healthcare.gov, or marketplace?
4) Can you identify the most notable features of your online application that facilitate enrollment of MAGI Medicaid populations? What is the impact of these changes on beneficiaries, on program administration? Do benefits of implementation outweigh the costs?

Auto-Eligibility Determination and Electronic Verification

5) How does your state define automated eligibility determinations (e.g., no or low touch/real time or near real time)?
6) What has been your state's vision or goal for automated eligibility determination for the MAGI Medicaid populations? Are you regularly tracking whether it is being met? How do you balance the tension between ease of application and accurate determination?
7) What are the most common reasons applicants receive an auto-eligibility determination, i.e., reasons may include factors associated with the process or characteristics of the applicant?
8) What are the most common reasons applicants fail to receive an auto-eligibility determinations, i.e., reasons may include factors associated with the process or characteristics of the applicant?
9) The Affordable Care Act (ACA) called for use of electronic data sources to verify beneficiary information. What electronic data sources are the most effective in achieving auto-eligibility determination for the MAGI Medicaid population and why? At what point in the enrollment process are these data sources used? Was this data linkage in place prior to the ACA?
10) What resources did you have to put in place to be able to access this data source electronically, e.g., lead-time, staff hires and/or training, information technology or business rules engines, data use agreements, notices?
11) Can you describe the impact of this data linkage? For example, do you have information on the cost effectiveness and/or benefits associated with this data linkage, e.g., reduced administrative costs, facilitated accurate or timely determinations, eliminated burden on individuals or agency?
12) How seamless is the flow of information between online application and electronic verification for MAGI Medicaid populations? For example, is applicant information automatically inputted into a rules engine, which facilitates timely and accurate determinations?

13) Are there other effective practices or systems you employ to facilitate auto determinations and electronic verifications for MAGI Medicaid populations?
14) Are there other barriers or challenges that your state has encountered as it relates to achieving your desired goals related to auto-eligibility determination and electronic verification?

Auto or Ex Parte Renewals

15) How does your state define auto or ex parte renewals? Does this term apply to annual and mid-year renewals?
16) What are your state's goals for auto renewal for the MAGI Medicaid populations? Are you regularly tracking whether it is being met?
17) What are the most common reasons beneficiaries receive auto renewals, i.e., reasons may include factors associated with the process or characteristics of the beneficiary?
18) What are the most common reasons beneficiaries fail to receive auto renewals, i.e., reasons may include factors associated with the process or characteristics of the beneficiary?
19) What have been the most effective processes or systems in achieving auto renewals for the MAGI Medicaid population? Why? What has been the impact of specific processes or systems, e.g., increased retention rates, reduced staff workload and beneficiary burden?
20) What is working well with respect to processing mid-year eligibility status changes electronically? Why?
21) What has been most effective with respect to use of prepopulated forms to facilitate auto renewal?
22) Are there barriers or challenges that your state has encountered with prepopulated forms, e.g., beneficiary comprehension, length. How have you handled these barriers?

Eligibility Systems, IT Resources, and Integration

23) We would like to confirm with you the type of online applications your state supports for MAGI Medicaid eligible populations to apply for coverage. What programs does/do the online application(s) support? Into what eligibility system(s) does application data flow?
24) Customize for each state: What are the advantages of a MAGI/Marketplace or MAGI/Other Medicaid or MAGI and/or Other Medicaid/Other Non-Health Care online application? What are the disadvantages? If applicable, Has your state considered developing a multi-benefit or combined application that allows individuals to apply for Medicaid and other non-health care benefits at the same time (e.g., food stamps)? Why or why not? For those states with a combined online application, What is the impact of the combined applications on Medicaid program efficiency and beneficiary experience?
25) We understand from the data collection form your primary system for determining MAGI Medicaid eligibility is [system name] and that it supports [program names]. You also mentioned above that application data are stored in [system name(s)]. What considerations or factors led to the development of your eligibility determination system in its current form? What are the advantages of this approach? What are the disadvantages? *If applicable,* Has your state considered developing an eligibility system that is integrated with [names of non-health care programs and benefits]? Why or why not? *For those states with an integrated eligibility system,* What has been the impact of your integrated eligibility system on Medicaid program efficiency and beneficiary experience?

26) According to the completed data collection form, you identified [name other IT resources] as critical to supporting MAGI-eligibility determination and renewal. Why do you invest in these resources and what impact have they had?

27) Are there other characteristics of your current eligibility determination system or IT resources that you consider to be key facilitators or barriers to streamlined, data-driven eligibility, enrollment, and renewal for MAGI Medicaid eligibles? All Medicaid eligibles?

Lessons, Levers, Future Plans

28) Please identify which state policies or federal policies, rules, and guidance stand out as having either helped or hindered current streamlined, data-driven Medicaid eligibility, enrollment, and renewal practices?

29) Thinking ahead, are there changes you are planning to make to MAGI Medicaid eligibility, enrollment and renewal processes and systems that you expect to impact program efficiency or beneficiary experience? What challenges, successes, or other factors have influenced these plans? Do they extend to other Medicaid populations?

Closing

30) We will be conducting interviews with other stakeholders, such as other agency program staff, case workers, information technology vendors, and advocates. Do you have recommendations for us on who we should approach?

31) Are there questions we haven't asked or topics not covered that you think are important to discuss before we close?

Thank you very much for your time.